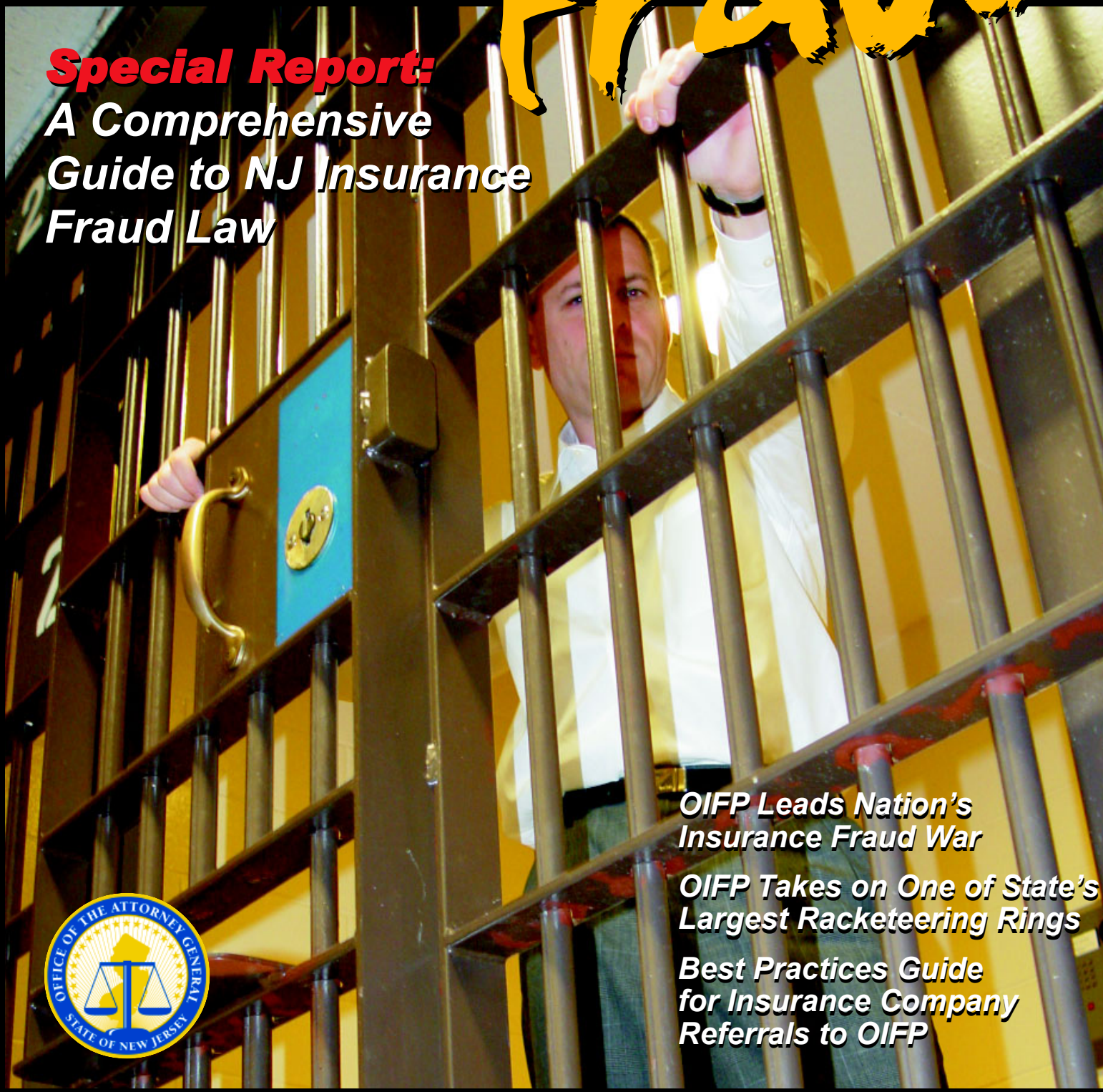
NEW JERSEY

# INSURANCE Fraud



**Special Report:**
A Comprehensive Guide to NJ Insurance Fraud Law

OIFP Leads Nation's Insurance Fraud War

OIFP Takes on One of State's Largest Racketeering Rings

Best Practices Guide for Insurance Company Referrals to OIFP

2004 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor

Inside Front Cover

# Annual Report of
# The New Jersey Office of the Insurance Fraud Prosecutor
## for Calendar Year 2004

Submitted
March 1, 2005
(Pursuant to *N.J.S.A.* 17:33A-24d)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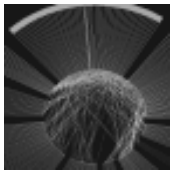
# Contents















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# A Message from The Insurance Fraud Prosecutor

*Greta Gooden Brown*

## Taking the War on Insurance Fraud to the Next Level

We are pleased to present the sixth Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor (OIFP). As with all of our programs at OIFP, we strive to improve our prior year's efforts in every respect, and this year's Annual Report is no exception. In this year's Report, we not only summarize OIFP's accomplishments in 2004, we also provide a handy reference guide for all who are interested in combating insurance fraud in New Jersey and elsewhere, be they government officials, industry executives, or concerned citizens.

In addition to our usual statistical summaries, case synopses, and narrative descriptions of OIFP's functions and programs, we have included in this year's Annual Report a wealth of highly informative materials, including an article recounting the events culminating in the creation and shaping of OIFP, a section providing a comprehensive guide on New Jersey's insurance fraud laws, a "best practices guide" for insurance company referrals to OIFP, a detailed explanation of how the Health Insurance Portability and Accountability Act (HIPAA) affects law enforcement, an interview with the Executive Director of the Coalition Against Insurance Fraud, a directory of key official contacts, and other useful reference materials.

Unfortunately, as this year's Annual Report demonstrates only too clearly, insurance fraud continues to maintain its dubious distinction as one of the underground economy's largest growth industries. Indeed, the current pandemic of insurance fraud continues to adversely impact not only private insurance carriers, but also governmental programs that provide various forms of social insurance, including health insurance, unemployment insurance, disability insurance, workers' compensation insurance, and various programs administered by the Social Security Administration. Losses caused by those who loot these programs deplete the programs' resources and diminish the benefits otherwise available to those among us who must genuinely depend upon them for their very subsistence. Whether as an opportunistic crime or an organized criminal enterprise, insurance fraud permeates our society and drains our economic vitality.

The good news, however, is that OIFP continues to redefine the manner in which government attacks insurance fraud. As it has from the very beginning, OIFP remains committed to fight all forms of insurance fraud. From OIFP's birth as a fraud-fighting organization six years ago, it has screened over 60,000 reports of suspected insurance fraud, imposed over 4,500 fines totaling more than $22 million, obtained orders for over $46 million in civil and criminal restitution, pursued criminal prosecutions resulting in the conviction of approximately 840 insurance fraudsters and sent nearly 300 of them to jail for a total of 648 years. Now, as a new day dawns, OIFP is prepared and poised to take the war against insurance fraud to the next level.

While our mandate to lead New Jersey's fight against insurance fraud is broad, our core function remains the investigation, prosecution, and imposition of criminal and civil sanctions against insurance cheats. To this end, 2004 was another banner year for OIFP in the number of defendants sentenced to jail terms for committing insurance fraud and the amount of restitution ordered on behalf of those victimized by insurance fraudsters. Indeed, In 2004, OIFP obtained more restitution and greater jail sentences than in any other year in OIFP's history.

Most notably in 2004, the number of those sentenced to jail for committing insurance fraud significantly increased over those sentenced to jail in 2003. In 2004, criminal prosecutions by OIFP resulted in the imposition of jail sentences totaling 199 years of incarceration, an increase of over 70% from the prior year. Gains in the amount of restitution ordered for victims were similarly noteworthy, more than doubling from 2003 to over $16 million in 2004. Together with County Prosecutor Insurance Fraud Units funded by OIFP, in 2004, New Jersey filed criminal insurance fraud-related charges against 527 defendants, 93 of whom were sentenced to a total of 258 years in jail. OIFP, alone, accounted for over 79% of the jail time meted out to those convicted of insurance fraud.

In 2004, OIFP recorded an impressive 100% conviction rate. Among OIFP's more notable trial convictions in 2004 were guilty verdicts obtained against Linda Clements-Wright, an insurance company claims specialist who stole nearly $600,000 in bogus claim settlement monies, and Eliezer Martinez, a Medicaid provider who submitted nearly $140,000 in fictitious counseling claims to the Medicaid Program. Most significantly in 2004, OIFP again ratcheted up its efforts to identify, infiltrate, and dismantle organized insurance fraud conspiracies, as evidenced by the successful prosecution of the insurance fraud ring headed by kingpin, Anhuar Bandy, who was sentenced to spend the next 29 years of his life behind bars. This conviction represents New Jersey's first successful prosecution of a staged accident ring as a criminal racketeering enterprise.

As in years past, OIFP was recognized in 2004 by others in the international fraud-fighting community as a fraud-fighting model to be admired, studied, and emulated. OIFP and its staff received

awards in 2004 from the International Association of Arson Investigators, the International Association of Special Investigative Units, the United States Social Security Administration, and the New Jersey Vehicle Theft Investigators Association. OIFP's public awareness campaign garnered awards for its creativity and effectiveness, and, once again, officials from throughout the international fraud-fighting community called upon OIFP for guidance and assistance. Over the years, OIFP has also conducted hundreds of training sessions benefitting thousands of law enforcement and insurance industry professionals engaged in fighting insurance fraud.

Although the acclaim and acknowledgement received by OIFP and its staff are well deserved, we can and must do even better if we are to succeed in taking our war on insurance fraud to the next level. However, if we are to sustain New Jersey's unparalleled success in waging a successful war on insurance fraud, and if we are to take that challenge to the next level, we will continue to depend upon the full cooperation, assistance, and support of our colleagues in law enforcement and other government agencies, as well as the insurance industry and the citizens of New Jersey.

One of our most important goals at OIFP has been to develop a relationship with our insurance industry partners borne out of mutual respect and responsible stewardship. Today, I am proud to say that this partnership is one of the premier public/private partnerships in the fraud-fighting arena and is the cornerstone of OIFP's success. Similarly, our relationship with our allies in law enforcement and other government agencies has developed to the point where government bureaucracy no longer impedes our efforts to combat insurance fraud effectively. Were it not for the statewide coordination of all anti-insurance fraud efforts envisioned and mandated by our Legislature when it created OIFP, insurance fraud cases handled by disparate State and local agencies would otherwise escape the notice of others having the jurisdiction and authority to impose additional or complementary sanctions.

As in quantum physics, the whole is truly greater than the sum of its parts in New Jersey's fight against insurance fraud. As evidenced in this Report, our many partners in the war against insurance fraud in New Jersey have joined to produce far greater results than if they had continued to work in isolation, as was the case prior to OIFP's creation in 1998. As reflected in this Report, OIFP has fulfilled our Legislature's visionary plan by implementing a comprehensive, collaborative, and cohesive approach to fighting insurance fraud in New Jersey.

Even greater challenges lay before us, however, if we are to take our war on insurance fraud to the next level. By its very nature, insurance fraud is often inconspicuous and difficult to detect. Invariably, insurance fraud referrals present obstacles that must be overcome in order to successfully investigate and prosecute these cases. As word of our successes at OIFP spreads, it comes as no surprise that determined insurance cheats are becoming more sophisticated, more organized, and more motivated than ever before. The simpler and more commonplace types of insurance fraud that sometimes seemed so abundant in the early days of OIFP are becoming fewer and farther between. Consequently, maintaining OIFP's high level of criminal and civil prosecutions today, and in the future, has become an ever-increasing challenge which grows harder with each passing day.

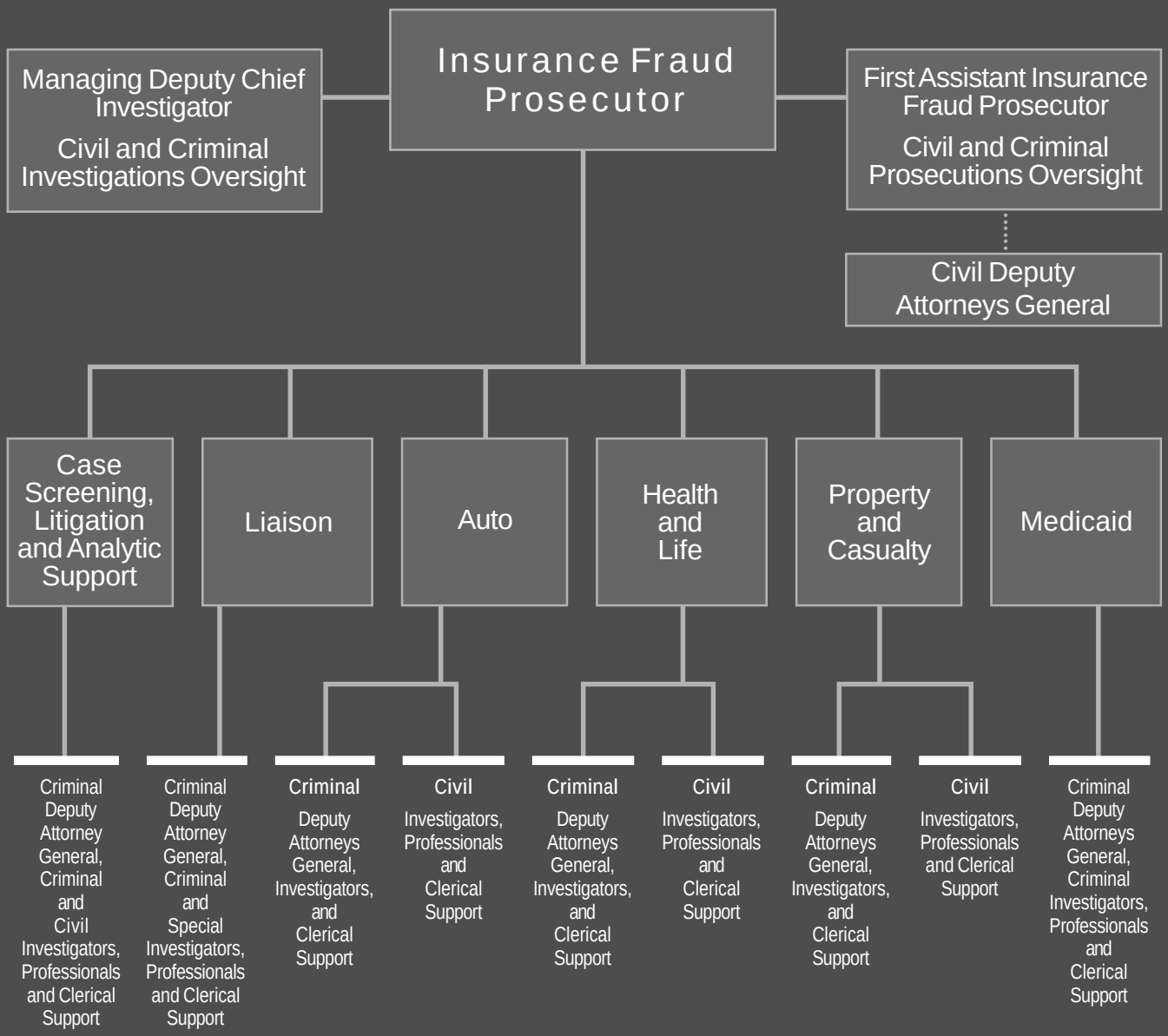
In response, OIFP must continue to develop the skills, know-how, and tools necessary to detect and investigate fraud effectively. We must increasingly focus our efforts and resources on complex, labor-intensive, and time-consuming investigations that target the most damaging and costly organized insurance fraud rings and enterprises. Such investigations are long term in nature, involve large multi-party conspiracies, and frequently require highly-specialized linguistic and technical expertise.

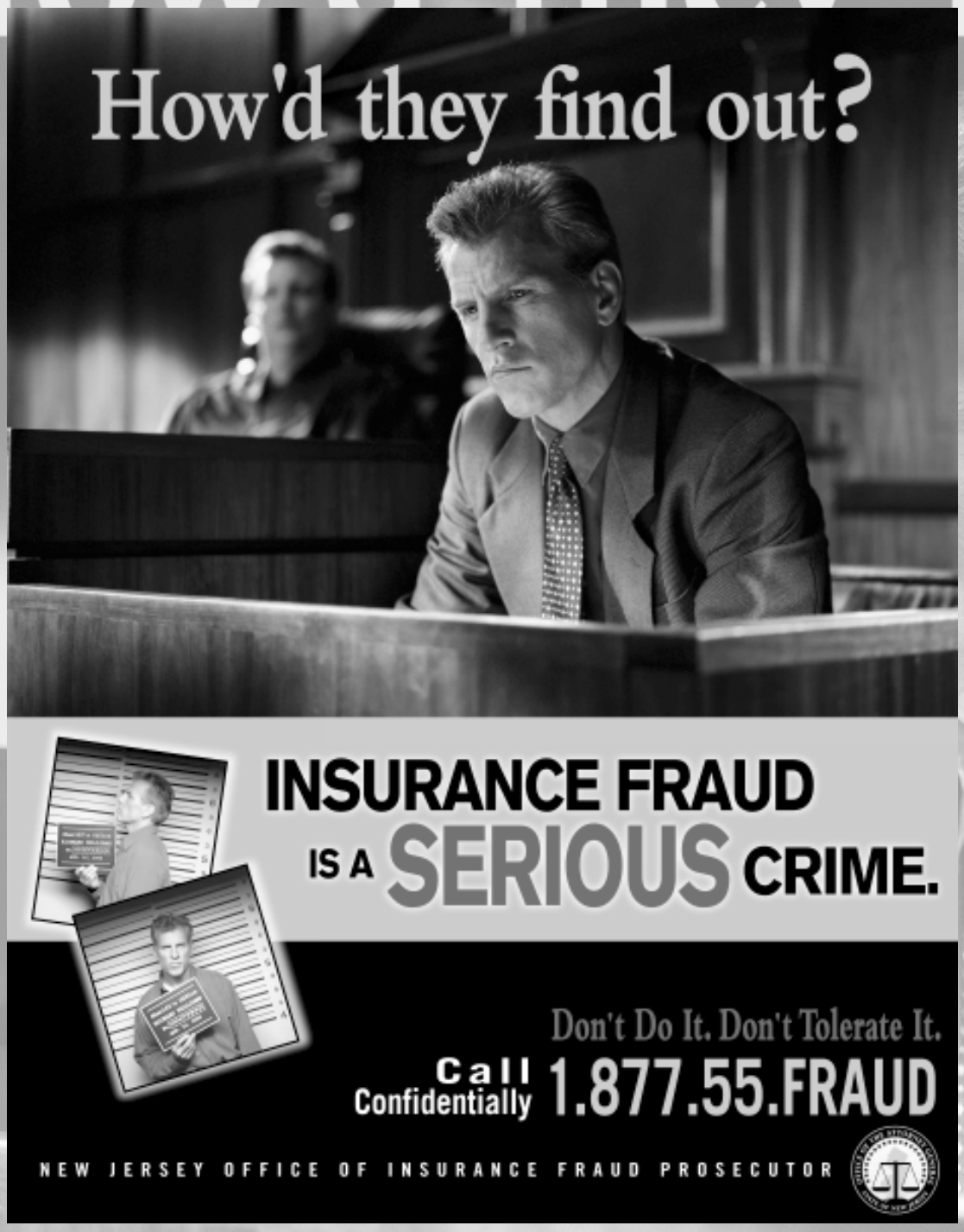
Undoubtedly, OIFP owes a debt of gratitude to the tireless efforts of our partners in the insurance industry and the law enforcement community. Without their support and assistance, OIFP's success would not be possible. Nor would OIFP's success be possible without the enlightened leadership of Attorney General Peter C. Harvey and Vaughn L. McKoy, Director of the Division of Criminal Justice. Yet, we in New Jersey now find ourselves at a critical juncture in the war on insurance fraud. As insurance fraudsters continue their ceaseless quest to exploit vulnerabilities in our system of insurance, and as they become ever more secretive and sophisticated, we must become even more vigilant in our efforts to quash their schemes. To remain ahead of the curve, we must double our efforts and apply our resources more effectively and efficiently than ever before.

Taking our war on insurance fraud to the next level will require more from each and every one of us. It will require the assurance of adequate and stable funding, an informed judiciary, and the continuing support of the insurance industry, the law enforcement community, and the citizens of New Jersey. For our part, in taking the war on insurance fraud to the next level, we at OIFP commit to taking the battle to our foes, reclaiming the economic vitality of our insurance system for the benefit of all New Jerseyans, and dedicating ourselves to fight insurance fraud as aggressively and effectively as possible.

*Respectfully submitted,*
**Greta Gooden Brown**
New Jersey Insurance Fraud Prosecutor

# Office of the Insurance Fraud Prosecutor

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# OIFP Leads Nation's Insurance Fraud War

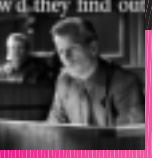
by Stephen D. Moore

## The $100 Billion Industry

It seemed that Vito Gruppuso had found that profitable niche in the world of business that most of us can only dream of. He brokered expensive, high-end insurance policies for more than 100 housing, retail, and office complexes throughout the United States in a sophisticated premium financing arrangement involving loans from banking institutions. Unfortunately, Gruppuso didn't always use those funds to buy insurance for his trusting clients. Rather, an investigation by New Jersey's Office of the Insurance Fraud Prosecutor (OIFP) revealed that he had, in fact, stolen more than $100 million in his profitable little niche. Mr. Gruppuso is now expected to spend much of his future behind bars and to make restitution to his victims in the tens of millions of dollars.

Anhuar Bandy was living the American dream. He had worked hard to become the proud owner of a string of chiropractic clinics in Northern New Jersey...and he wasn't even a chiropractor. In fact, he had no educational background or experience whatsoever in the field of health care. Yet, in the short span of three years, his clinics earned him millions of dollars of income. Bandy, however, was an excellent organizer. He devised, planned, and organized an entire ring of thieves who conspired to stage automobile accidents and file phony medical claims. After a lengthy undercover investigation by OIFP, Bandy and 27 other co-conspirators, were charged in ten separate State Grand Jury indictments with multiple counts of conspiracy, racketeering, Health Care Claims Fraud, theft by deception, and possession of a firearm without a permit. Bandy's fraud ring "staged" more than 90 automobile accidents which resulted in 24 insurance companies paying more than $2 million in fraudulent automobile accident and personal injury medical claims. Bandy was sentenced to 29 years in State prison and ordered to pay a $100,000 fine and an amount of restitution as yet to be determined.

Dr. Carl Lichtman successfully combined multi-level marketing techniques with a psychology degree to grow his counseling practice into a multi-million dollar money machine. Lichtman lost his Midas touch, however, when an investigation by OIFP revealed that nearly 200 of the "patients" participating in his elaborate kickback scheme never received the treatment for which he had billed some 35 insurance carriers and other insurers, including the New Jersey Health Benefits Plan. Lichtman had established a "referral" system to recruit new patients in return for a recruiting fee of $750 per new patient and 25 percent of the insurance proceeds for the nonexistent treatments. The toppling of

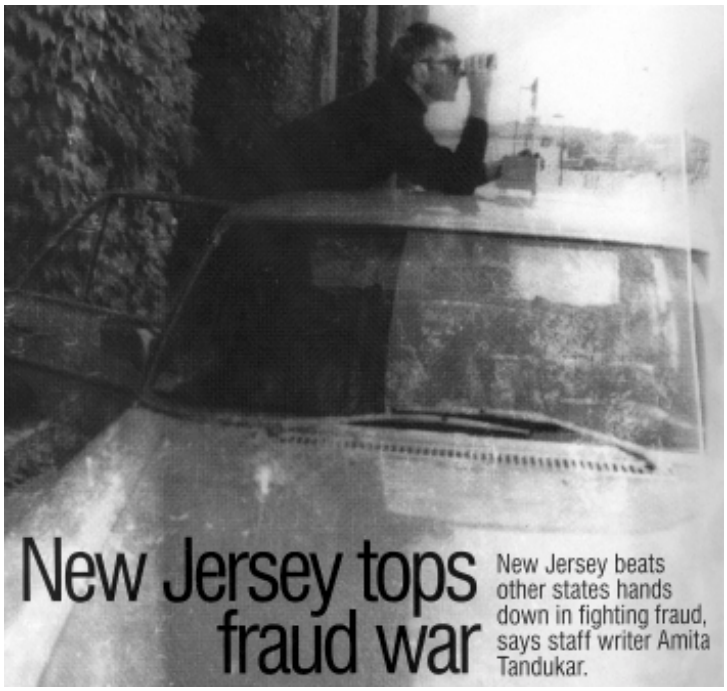


# OIFP Leads Nation's Insurance Fraud War

Lichtman's bogus patient pyramid by OIFP resulted in the successful prosecution of approximately 190 people, including many former teachers and other public employees who lost their right to hold public employment when convicted. Lichtman was sentenced to spend five-and-a-half years behind bars, make restitution of approximately $2 million, and sign a $200,000 judgment.

You would think Donna Vitullo would have been delighted when investigators came knocking on her door to inform her they had recovered the 1988 Porsche she had previously reported stolen. Instead, she "fessed up" to committing insurance fraud. Her vehicle, it seems, had been hauled from the bottom of a remote lake in the New Jersey Pinelands, where fishing expeditions by law enforcement officials yielded numerous other vehicles which had also been disposed of by their owners in conjunction with phony insurance claims. Ms. Vitullo was but one of many people who are caught by OIFP and County Prosecutors every year ditching their SUVs, sports cars, and other vehicles to file insurance claims in order to get out from under a heavy loan payment, a substantial lease-end mileage charge, or the sour recurring costs of owning a "lemon."

*"New Jersey tops fraud war: New Jersey beats other states hands down in fighting fraud, says staff writer Amita Tandukar: (Article from Fraud International Issue 22 May-June 2004: Reprinted with the permission of Fraud International copyright 2004)*




Let there be no doubt; insurance fraud is big business, very big business. Studies conducted over the past ten years have pegged the amount of our nation's losses attributable to insurance fraud in the range of $100 billion to $200 billion per year. While a 2000 study estimated that insurance fraud costs U.S. insurance consumers $96.2 billion in higher premiums in 1999, the same study estimated that fraud costs our domestic economy as much as $530 billion annually in total costs of goods and services. According to a 1992 study by the U.S. Government Accounting Office (GAO), fraud and abuse in our country's Medicare and Medicaid systems had also reached as much as $100 billion annually; and that study estimated that fraud, alone, accounts for approximately 10 percent of our nation's health care spending.

Other studies have suggested that, if the "enterprise" of insurance fraud were a corporation, it would rank in the top 25 of the Fortune 500 list of America's companies and would be considered a growth industry unto itself. But insurance fraud is not a legitimate enterprise and it can be devastating to both legitimate companies and individuals alike. At least 30 percent of the 302 property and casualty insurance companies that became insolvent between 1969 and 1990 were reportedly due to fraudulent activities. And it has been estimated that, on a personal level, insurance fraud costs the average American household as much as $1,000 annually, including

the addition of as much as $200 to $300 in insurance premiums to every family's automobile insurance policy.

Insurance fraud displays its many faces in persons and places both strange and familiar. Insurance fraud is as simple and common as lying on an application for automobile or life insurance and as veiled and complex as a sophisticated fraud ring comprised of crooked doctors, corrupt lawyers, and phony accident victims. It may be committed by a hardened career criminal, but as a crime of opportunity, it may just as likely be committed by your next-door neighbor. And, contrary to what sometimes seems the "conventional wisdom," insurance fraud is not a victimless crime. Every time someone commits insurance fraud, the pockets he picks are ultimately the pockets of those of us who purchase the protection afforded by insurance.

Because states which are most densely populated, such as New Jersey, tend to generate higher rates of crime and automobile accidents, both of which correlate closely to the incidence of insurance fraud, it is those most densely populated states that are most adversely impacted by the current pandemic of insurance fraud. Indeed, New Jersey has long held the dubious distinction as having the highest automobile insurance rates in the country.

## A Gathering Storm

After years of climbing automobile insurance rates, fueled in large part by the hidden costs of insurance fraud, the automobile insurance crisis in New Jersey had grown to epic proportions by the spring of 1998. Many motorists were finding they had to spend more to insure their cars than they had left to put dinner on their tables at night, if they were even able to find an insurer. Despite New Jersey's compulsory automobile insurance laws, many simply chose to drive without any insurance at all, sometimes purchasing fake insurance cards on the black market to avoid New Jersey's severe penalties for driving without insurance, which included hefty fines and mandatory drivers' license revocation.

Unless drastic measures were taken immediately, the situation was going to get worse, much worse, before it got better. When the New Jersey Legislature convened hearings nearly eight years ago in a desperate effort to grapple with the State's automobile insurance crisis, it quickly became clear that, as a major contributing factor to New Jersey's skyrocketing insurance rates, the problem of rampant insurance fraud would have to be addressed in a dramatic fashion.

As in other states, New Jersey's approach to dealing with the problem of insurance fraud had been piecemeal and fragmented. The relatively few criminal investigations and prosecutions for insurance fraud in New Jersey were usually undertaken by a modestly staffed unit within the New Jersey Attorney General's Division of Criminal Justice, and even more infrequently, by one of the State's 21 County Prosecutors' Offices. Although, in 1983, the New Jersey Legislature created the Division of Insurance Fraud Prevention within the Department of Banking and Insurance, its Civil Investigators were armed with only the narrow authority to impose civil fines for a limited array of various types of insurance fraud.

Prior Legislatures had attempted repeatedly without success to reform New Jersey's insurance laws in a futile effort to contain New Jersey's ever-increasing insurance rates. But this time it would be different. Unlike the manner in which legislation had all too often been hastily enacted in response to emergent problems or the demands of political expediency, this time the New Jersey Legislature pursued its mission with a fervor, foresight, and

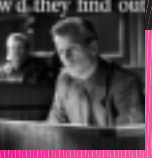
*Acting Governor Richard J. Codey was instrumental in establishing the Office of the Insurance Fraud Prosecutor in his role as a member of the Joint Committee on Automobile Insurance Reform in 1998.*

focus to detail akin to that of a constitutional convention.

While the challenge of crafting legislation to deal with the monumental problem of insurance fraud engendered broad bipartisan support, it would come as little surprise that one of its main proponents was a prominent legislator with professional experience as a licensed insurance producer, the State Senate's Minority Leader, who would years later unexpectedly find himself as Acting Governor, Richard Codey. The principal issue confronting then Senator Codey and his legislative colleagues was not whether to mount an unprecedented offensive on insurance fraud, but how to go about it in the most effective way possible.

In the hearings which ensued, many ideas were floated, debated, deflated, and sunk: how to ensure continued medical coverage for those injured in auto accidents while controlling spiraling medical costs; how to establish an effective mechanism for resolving disputes between insureds and insurers; how to reform the antiquated rating system; and how to attack insurance fraud.

It was an idea whose time had come, and not a moment too soon. While the concept had long been bandied about the corridors of the State House, it appears to have first been formally proposed by New Jersey Manufacturers Insurance Company at a Senate Commerce Committee hearing in May of 1997 when, in remarks prepared and submitted by Bernard Flynn, the Company requested that "consideration should be given to the creation of a single State Insurance Fraud Prosecutor to coordinate infor-



# OIFP Leads Nation's Insurance Fraud War

mation and action among the various agencies involved in fighting fraud. Such a person could be designated administratively by the Attorney General to facilitate anti-fraud efforts creating little, if any, additional bureaucracy. The form the position takes is less important than the substance. Serious fraud cases must result in serious criminal penalties to deter future conduct."

The call for a special State prosecutor to investigate and prosecute insurance fraud was echoed nine months later, in February 1998, by the President of the New Jersey State Bar Association, Jay H. Greenblatt, when, in prepared remarks before the Joint Committee on Automobile Insurance Reform, he stated, "we call for the immediate appointment of a special prosecutor from the ranks of the Office of Attorney General, with sufficient staffing expertise to aggressively prosecute fraud and deter future conduct. People don't cheat on their income taxes because they fear consequences. Automobile insurance fraud must be prevented in the same way."

As in planetary alignment, it was the rarest and most auspicious of moments, when the insurance industry and the legal profession would mutually agree upon a key element of insurance reform: the dire need for a dedicated State prosecutor to lead New Jersey's war on insurance fraud. From that moment forward, the solution to attacking New Jersey's fraud monster became where, rather than whether, an Insurance Fraud Prosecutor would stand in the pantheon of public officialdom, and the task at hand was to craft a blueprint to guide the Prosecutor's efforts while providing the Prosecutor with the resources required to get the job done right.

The New Jersey Office of the Insurance Fraud Prosecutor was finally established on May 19, 1998, when the Legislature enacted the Automobile Insurance Cost Reduction Act of 1998 (AICRA). In an unusually detailed preamble to the law borne of the auto insurance crisis, the Legislature described and defined many of the causes of New Jersey's insurance crisis, including the problems associated with insurance fraud, and clearly defined its goals and objectives for dealing effectively and appropriately with those problems. As explained in the preamble, the high cost of automobile insurance in New Jersey presented "a significant problem for many lower income residents of the State, many of whom have been forced to drop or lapse their coverage in violation of the State's mandatory motor vehicle insurance laws...."

It also recognized that, "fraud, whether in the form of inappropriate medical treatments, inflated claims, staged accidents, falsification of records, or in any other form, has increased premiums, and must be uncovered and vigorously prosecuted, and while the pursuit of those who defraud the automobile insurance system has heretofore been addressed by the State through various agencies, it has been without sufficient coordination to aggressively combat fraud, leading to the conclusion that greater consolidation of agencies which were created to combat fraud is necessary to accomplish this purpose...."

While most of the Act dealt with a variety of detailed and complicated regulatory measures to reform New Jersey's automobile insurance laws, several critical pages spelled out in great specificity the Legislature's expectations and mandate for New Jersey's new Insurance Fraud Prosecutor. AICRA vested the Insurance Fraud Prosecutor and OIFP with broad authority and responsibility for investigating all types of insurance fraud, and for conducting and coordinating civil, criminal, and administrative investigations and prosecutions of insurance and Medicaid fraud in New Jersey. AICRA also empowered OIFP and the Insurance Fraud Prosecutor to oversee and coordinate the anti-insurance fraud efforts of law enforcement and other public agencies and departments throughout New Jersey with those of the insurance industry.

AICRA established OIFP as a law enforcement agency within the State's Division of Criminal Justice in the Department of Law and Public Safety with a primary objective of criminally investigating and prosecuting insurance fraud. However, in order to consolidate civil and criminal authority for investigating insurance fraud in a single agency, AICRA also required that the entire civil investigative staff of the Department of Banking and Insurance be transferred to the fledgling agency.

Among other things, AICRA required that a section of OIFP "be designated to be responsible for establishing a liaison and continuing communication between the office... any professional board in the Division of Consumer Affairs in the Department of Law and Public Safety, the Department of Banking and Insurance, the Division of State Police, every county prosecutor's office, such local government units as may be necessary or practicable and insurers." OIFP was also charged with establishing a statewide fraud enforcement policy for all State and local agencies, including the promulgation of detailed guidelines for investigating and prosecuting insurance fraud. The Insurance Fraud Prosecutor was also required to establish and maintain databases for all cases in which fraud is suspected, and incorporating comprehensive information with respect to various types of insurance claims made against private insurers.

## A Record of Accomplishment

### *An Immediate and Growing Impact*

The enactment of AICRA in May of 1998 was followed several weeks later by Governor Whitman's issuance of Reorganization Plan No. 007-1998 on June 25, 1998, which specified, in broad terms, those steps to be taken to effect the transfer, consolidation, and reorganization of numerous functions of the respective agencies affected by AICRA, particularly the Departments of Banking and Insurance and of Law and Public Safety. The entire reorganization and the official establishment of the New Jersey Office of the Insurance Fraud Prosecutor was to be completed within 60 days.

Immediately after the enactment of AICRA, the officials charged with its implementation sprang quickly into action. On July 17, 1998, the Commissioner of the Department of Banking and Insurance and the Attorney General, as head of the Department of Law and Public Safety, entered into a detailed Memorandum of Agreement "to effectuate the timely and efficient transfer of the functions, powers, duties and responsibilities relating to insurance fraud investigation and prosecution from the Department of Banking and Insurance to the Department of Law and Public Safety."

Those charged with the arduous task of actually effectuating the change promptly turned their full attention to reviewing, identifying, and addressing those thousands of details necessary to create a new and unprecedented governmental agency to oversee the anti-insurance fraud efforts of the entire State of New Jersey. Their charge was monumental, entailing, among other things, the establishment of three regional offices located, respectively, in the southern, central, and northern portions of the State; the transfer of the entire civil investigative staff from the Department of Banking and Insurance to the Division of Criminal Justice within the Department of Law and Public Safety; the integration of the Insurance Fraud Unit and the Medicaid Fraud Section of the Division of Criminal Justice into the newly-created OIFP; and the conducting of screening, background investigations, and hiring of additional qualified investigative, prosecutorial, and administrative and clerical support staff.

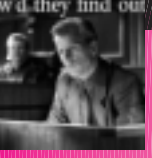
On October 28, 1998, a seasoned prosecutor from the Division of Criminal Justice, Edward M. Neafsey, was sworn in as New Jersey's first Insurance Fraud Prosecutor. By late 1998, the foundations had been laid for the nascent agency, at long last, to realize the vision the legislators and insurers had labored so long and hard to fashion: a definitive model to attack insurance fraud through a statewide program. Early in 1999, the civil investigators transferred from the Department of Banking and Insurance physically joined with criminal investigators and prosecutors from the Division of Criminal Justice, as they established their central headquarters in Lawrenceville and satellite offices in Whippany and Cherry Hill, and quickly went about the business of building the new governmental agency from the ground up.

And from those first heady, tumultuous days of OIFP, it rapidly emerged as one of the nation's premier insurance fraud-fighting institutions.

## Blueprint for Success

The crafting of OIFP's structure may be viewed, in retrospect, as noth-

*Insurance Fraud Prosecutor Greta Gooden Brown accepts the New Jersey Vehicle Theft Investigators' Association Robert A. Ziegler Award for the successful OIFP "Give and Go" prosecution. (l. to r.) Joanne Roberts, Assistant Vice President of Selective Insurance Company; Deputy Chief Investigator Richard Falcone; Deputy Chief Investigator Sheila Brown; State Investigator Jose A. Vendas; State Investigator Jaroslaw Pyrzanowski; Insurance Fraud Prosecutor Greta Gooden Brown; Deputy Attorney General Michael Monahan; Supervising Deputy Attorney General Tina Polites; and State Investigator Marc Cafone.*





ing short of the most successful blueprint for the operation of a dedicated insurance fraud-fighting agency in history. First and foremost, in designating OIFP as New Jersey's lead agency to implement a comprehensive program for the investigation and prosecution of insurance fraud, the Legislature vested OIFP under AICRA with authority and responsibility for investigating every type of insurance fraud, and with the tools for conducting and coordinating criminal, civil, and administrative investigations and prosecutions of insurance and Medicaid fraud throughout the State. Moreover, to provide for the most effective and well integrated strategy possible to combat insurance fraud throughout the State, the Legislature empowered OIFP under AICRA to oversee and coordinate the anti-fraud efforts of law enforcement and other public agencies in New Jersey with those of the insurance industry.

OIFP was officially established as a law enforcement agency within the State's Division of Criminal Justice under the direction of a State Insurance Fraud Prosecutor, appointed by the Governor, confirmed by the Legislature, and overseen by the New Jersey Attorney General, with a singular mission to pursue insurance fraud wherever found, in whatever form, as aggressively and effectively as possible. AICRA also required that, in order to unify both criminal and civil authorities for investigating and prosecuting insurance fraud in one agency, the civil enforcement functions previously in the Division of Insurance Fraud Prevention in the Department of Banking and Insurance would be transferred to the newly established OIFP. While criminal and civil authority for insurance fraud was now consolidated in OIFP, those functions would now be administered in separate criminal and civil bureaus within OIFP which, in turn, would be comprised of several specialized sections. Specialization within OIFP was further refined by a major reorganization in 2002 which resulted in the creation of specialized insurance fraud sections, mirroring classifications in the insurance industry, in both the criminal and civil bureaus.

As a result of the restructuring, OIFP-Criminal was broken down into sections focusing on auto fraud, health and life fraud, and property and casualty fraud, as well as the Medicaid Fraud Section. OIFP-Civil was similarly structured along the lines of specialized teams of Civil Investigators who were assigned to investigate cases of possible violations of the New Jersey Insurance Fraud Prevention Act (Fraud Act) and, where appropriate, seek restitution and civil fines.

Because of the greater burden of proof required in criminal cases, that of proof "beyond a reasonable doubt," OIFP-Civil has frequently been able to impose fines or obtain restitution in cases where the facts would be unable to sustain a successful criminal prosecution. Inasmuch as civil actions are subject to a longer ten-year Statute of Limitations, civil actions may also be undertaken in lieu of a criminal prosecution in many cases where a criminal prosecution is barred by the shorter five-year Statute of Limitations applicable to criminal prosecutions. While the imposition of penalties at the conclusion of an OIFP-Civil investigation is frequently an effective alternative outcome to a criminal prosecution, the imposition of civil penalties is often a complement to a successful criminal prosecution wherein both civil and criminal penalties are imposed.

Ultimately, the objective yardstick by which the success of any endeavor must be measured is that of its performance as reflected in the number and quality of matters it has pursued to a successful conclusion. Today, OIFP continues to thrive and post some of the best numbers in its relatively brief existence as a law enforcement agency. Since it commenced operations six years ago, OIFP has reviewed and screened over 60,000 matters of suspected or actual insurance fraud, issued 4,546 civil Consent Orders and agreements, imposed approximately $22 million in civil fines, convicted nearly 840 persons of insurance fraud or insurance fraud-related offenses, obtained restitution totaling $46,347,499, and sentenced 289 people to jail terms totaling over 648 years.

## Knowledge is Power

OIFP recognized early that information, knowledge, and intelligence are essential to the success of any investigative law enforcement agency and that OIFP would be no exception. OIFP has striven, from its inception, to expand the channels through which it obtains information and to implement mechanisms to ensure that information is shared, utilized, and employed as effectively as possible to identify, investigate, and pursue appropriate action against insurance cheats.

OIFP's system to manage information begins with a carefully designed Section for receiving, screening, assigning, and tracking up to 10,000 new cases annually, known within OIFP as the Case Screening, Litigation and Analytical Support Section (CLASS). Every referral to OIFP, whether from the mandatory reporting of suspicious claims by insurance carriers, OIFP's hotline or Web site, law enforcement or other public agencies, citizen complaint letters or walk-ins, first undergoes an "intake" process in which each referral is promptly date stamped and entered into OIFP's case tracking system known as Law Manager. Case numbers are assigned, existing databases are searched for overlapping information, and cases are screened by specially trained Civil Investigators to

determine whether the referral contains sufficient information to initiate a civil or criminal investigation.

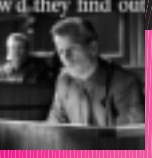
Where it appears that a criminal investigation is warranted, the matter is referred to a Supervising Deputy Attorney General who, in most instances, makes the final determination as to whether to open a formal criminal investigation. The screening process typically involves the obtaining of background information on the person suspected of committing insurance fraud through queries of a variety of governmental and public records databases. Cases warranting investigation are coded according to the type of alleged insurance fraud, such as automobile, life, or disability, and assigned for further investigation to the most geographically appropriate of OIFP's three regional offices. Subsequent to the assignment of cases, Analysts and Technical Assistants in the CLASS Unit frequently continue to assist in the investigations, employing a variety of sophisticated software applications to analyze the complex relationships existing among individuals, businesses, and their financial relationships. Through its Liaisons, OIFP has also established, and maintains, databases of information through collaborative and cooperative arrangements with other law enforcement agencies, other governmental agencies, and the Department of Banking and Insurance.

Finally, after years of planning and collaboration with insurance industry representatives, OIFP went online in 2004 with its All Claims Database which encompasses comprehensive data submitted by insurance carriers regarding New Jersey automobile insurance claims involving a theft or an accident. The Database's utility will be enhanced with a software tool which is arguably the most powerful "data mining" application available. By "mining" such claims data, OIFP expects to be able to identify fraudulent patterns and trends amidst an otherwise incomprehensible myriad of data.

*New Jersey Attorney General Peter C. Harvey discusses OIFP's insurance fraud-fighting efforts with New Jersey Network News at the Seventh Annual Insurance Fraud Summit.*

An effective strategy to wage war on insurance fraud requires both the enlistment of critical allies, such as those in the insurance industry, law enforcement, and other governmental agencies having a stake in addressing insurance fraud, and arming those allies with the knowledge, skills, and expertise necessary to do the job. Law enforcement and OIFP's other partners in the war on insurance fraud must have, or develop, a thorough understanding of what constitutes insurance fraud and the "red flag" identifiers that should alert an officer or investigator to the possibility that a particular matter may involve insurance fraud and may warrant further investigation. Law enforcement officials whose primary responsibilities are to investigate or prosecute insurance fraud must have an even more sophisticated knowledge and expertise with respect to the unique characteristics of insurance fraud.

As the State's designated leader in the war on insurance fraud, OIFP in its infancy quickly went about the task of implementing programs to share its own expertise through an ambitious and comprehensive program for the training and instruction of law enforcement and insurance industry officials throughout the State. Through its County Prosecutor Liaison, OIFP has provided annual in-service instruction on many facets of insurance fraud to Assistant Prosecutors and investigative personnel in County Prosecutors' Offices in the State's 21 counties. Through its Insurance Industry Liaison,



# OIFP Leads Nation's Insurance Fraud War


*Supervising Deputy Attorney General Stephen D. Moore with NJSIA President Kevin Crimmins after appearing as a guest speaker on behalf of OIFP at the December 2004 NJSIA meeting.*

OIFP has instituted a joint training program with experienced insurance industry professionals to offer training to investigative staff from both OIFP and insurance industry special investigative units. Through its Law Enforcement Liaison, OIFP has scheduled quarterly law enforcement coordination meetings in each of its three regional offices which provide opportunities to share information and intelligence among law enforcement agencies at every level in New Jersey and neighboring states, including municipal police departments, County Prosecutors' Offices, the New Jersey State Police, and federal agencies such as the Federal Bureau of Investigation and the United States Postal Inspector's Office.

OIFP continued in 2004 with its innovative program of training and instruction and, in addition to the regularly scheduled training opportunities provided by OIFP's Liaisons, participated in many seminars and symposia, such as OIFP First Assistant Prosecutor, John Smith's, presentation to the Chubb Insurance Company in New York and presentations for New Jersey's Institute for Continuing Legal Education, as well as for insurance industry investigators and personnel.

## Leading a Coordinated Effort

OIFP's success in fighting insurance fraud is due, in great part, to the manner in which it has responded to the Legislature's mandate that it lead a comprehensive effort to marshal and utilize all possible resources in both the public and private sectors to combat insurance fraud. In recognizing that a greater consolidation of resources was necessary to effectively carry out this mandate, AICRA required that OIFP establish a section of the Office for the specific purpose of acting as liaison with law enforcement and other public agencies and the insurance industry. OIFP's Liaison Section has been designated by the State's Insurance Fraud Prosecutor to serve as the Office's primary vehicle to foster communication, cooperation, and coordination among fraud fighters throughout New Jersey.

To ensure that the Liaison Section of OIFP is able to effectively coordinate the many overlapping responsibilities and activities of the public agencies and insurers which investigate or come into contact with insurance fraud in New Jersey, OIFP assigned experienced professionals to serve as County Prosecutor, Law Enforcement, Insurance Industry, and Professional Boards Liaisons. Each Liaison is responsible for insuring that all OIFP investigations are coordinated with the activities of those agencies or entities falling within their purview.

## County Prosecutors

By virtue of their local presence throughout the State, County Prosecutors in New Jersey have developed, and maintain, an intimate familiarity with the landscape of criminal activities within their respective jurisdictions. Consequently, their knowledge of the demographics of crime within their counties and their ability to cultivate informants and identify potential criminal suspects often enables them to investigate and prosecute insurance cheats and organized insurance fraud enterprises which might, in many cases, avoid detection by a centralized State agency such as OIFP.

It was in recognition of this critical role of the State's County Prosecutors that AICRA provided a mechanism to fund their efforts at fighting insurance fraud within their respective counties. From its creation in 1999, the New Jersey County Prosecutor Insurance Fraud Reimbursement Program, administered by the Attorney General through the Insurance Fraud Prosecutor, has provided funding for fraud-fight-

ing personnel and equipment in 20 of New Jersey's 21 counties.

The funding has served to enhance the ability of County Prosecutors to investigate and prosecute insurance fraud by supporting or contributing to the salaries of 38 detectives and investigators, 11 assistant prosecutors and 6 technical and administrative support staff, and by encouraging and allowing counties to undertake new and innovative initiatives carefully designed to catch insurance cheats within their respective jurisdictions.

The County Prosecutor Insurance Fraud Reimbursement Program requires that counties work closely with OIFP's County Prosecutor Liaison and coordinate their activities with OIFP on a continuing basis. Among other things, County Prosecutors submit Cumulative Monthly Reports which include pertinent identifiers with respect to all persons within their jurisdictions under investigation for possible insurance fraud. The information in these reports is scrutinized by the County Prosecutor Liaison and incorporated in OIFP's own databases to ensure that the investigative and prosecutorial activities of OIFP and County Prosecutors do not duplicate or undermine each other. This information also enables OIFP, in many cases, to open corresponding civil cases where the suspected insurance fraud may subject the perpetrator to civil penalties pursuant to the provisions of the Insurance Fraud Prevention Act.

The reporting of subjects under investigation by County Prosecutors in 2004 enabled OIFP to open nearly 712 civil investigations, few of which would have come to OIFP's attention but for the reporting protocol of County Prosecutors under the terms of the Reimbursement Program. Further, in 2004, County Prosecutor Insurance Fraud Units and personnel funded by OIFP charged 313 defendants and obtained 129 convictions by guilty plea or trial, resulting in jail terms totaling more than 51 years. Some of the most notable cases handled by units funded by OIFP are summarized in this Annual Report.

Unfortunately, as a result of five years of flat funding levels in the OIFP budget, budgetary pressures nearly resulted in the elimination of the County Prosecutor Reimbursement Program at the close of 2004. Efforts by the Attorney General and Insurance Fraud Prosecutor saved the program from elimination in 2005, though funding was reduced by nearly 20 percent. Budgetary pressures in 2004 did, however, require the elimination of a program funded by OIFP which supported the Insurance Fraud Unit of the New Jersey State Police, which focused on the use or sale of counterfeit insurance identification cards.

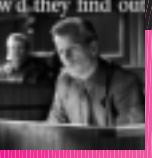
## Law Enforcement

OIFP also coordinates its activities with many law enforcement agencies other than County Prosecutors' Offices, ranging from local and county police departments, to County Sheriffs' Departments, to the New Jersey State Police, and to federal law enforcement agencies such as the Federal Bureau of Investigation and the United States Postal Inspector's Office, as well as law enforcement agencies in nearby states. OIFP has assigned a Law Enforcement Liaison whose primary responsibility is to coordinate OIFP's investigations and prosecutions with those of other law enforcement agencies both in and beyond New Jersey's borders. OIFP has also vested the Law Enforcement Liaison with responsibility for administering a number of other law enforcement support protocols and services such as the issuance of documentation used in undercover investigations including fictitious insurance cards and pretext insurance policies which provide undercover investigators with the critical documentation necessary for successful undercover sting operations.

The Law Enforcement Liaison is assigned responsibility for distributing training and other informative materials, such as OIFP's roll call training videos, to local police departments throughout New Jersey. The Law Enforcement Liaison is also responsible for distribution of over 1,000 copies of the OIFP Uninsured Motorists Identification Directory (UMID), which provides law enforcement agencies with a comprehensive directory of insurance company hotline phone numbers to verify insurance coverage. Among the Law Enforcement Liaison's other responsibilities is the scheduling of periodic regional insurance fraud meetings throughout the State in which many law enforcement agencies participate to share intelligence and information and learn from guest speakers with special expertise in areas such as health care fraud, fraud rings, and insurance fraud forensics.

## Insurance Industry

In enacting AICRA, legislators recognized that the insurance industry was an integral partner in order for government to be successful in addressing the State's insurance fraud problem. Consequently, AICRA expressly required that OIFP establish a formal liaison with the insurance industry for the purpose of ensuring effective coordination and open channels of communication. Such coordination is particularly important because the vast majority of OIFP's insurance fraud cases are opened from referrals received by insurance carriers, which are required by regulation to report all cases of suspected fraud. OIFP's Insurance Industry Liaison maintains appropriate standards for referrals from insurance companies and acts as OIFP's primary point of contact with the insurance in-





dustry. Through its Industry Liaison, OIFP provides technical guidance and assistance and sponsors Working Groups which meet regularly to identify areas of common concern and explore the manner in which OIFP and the insurance industry can work constructively together to further their respective efforts to combat insurance fraud. Many of the recommendations incorporated in OIFP's Annual Reports have sprung from discussions in the Working Groups. In 2004, the Industry Liaison and his staff provided guidance and assistance to those in the insurance industry on 875 occasions.

The Industry Liaison also represents OIFP in numerous meetings with insurance industry officials and in-

**Fraud crackdown credited for GEICO's return to N.J.**

surance industry trade associations throughout the year affording both OIFP and the insurance industry the opportunity for open and ongoing communications regarding issues of mutual interest. In 2004, the Industry Liaison attended meetings of the National Insurance Crime Bureau, the Insurance Council of New Jersey, the New Jersey Special Investigators Association, the Anti-Fraud Association of the Northeast, the Delaware Valley and national meetings of the International Association of Special Investigative Units, and the New Jersey Vehicle Theft Investigators Association. In conjunction with this participation in industry trade associations and his communications with insurance carriers, the Industry Liaison also frequently conducts insurance fraud training concerning the structure and operations of OIFP and requirements for reporting fraud by insurance companies. In 2004, the Industry Liaison offered training or instruction to nearly 1,789 insurance industry personnel as part of his official responsibilities. OIFP's Industry Liaison was, again in 2004, instrumental in orchestrating both the Annual New Jersey Insurance Fraud Summit and the Annual Conference of the New Jersey Special Investigators Association.

OIFP also works closely, through the Industry Liaison, with New Jersey's Department of Banking and Insurance, coordinating investigations and tracking OIFP cases which involve professionals licensed by the Department, which includes public adjusters, real estate agents, and licensed insurance producers. In 2004, the Industry Liaison tracked 82 such cases in coordination with the Department.

## Professional Licensing Boards

According to the Health Insurance Association of America, over three-quarters of health care fraud is committed by health care professionals. The New Jersey Legislature rightly recognized that any effort to contain insurance fraud in New Jersey would have to make provision for ensuring that crooked health care professionals would not benefit from a system of enforcement in which the "right hand didn't know what the left hand was doing." Accordingly, AICRA expressly provides that OIFP should coordinate its activities with the professional boards in the Division of Consumer Affairs which license, among others, those employed in the field of health care. OIFP's Professional Boards Liaison has been charged with responsibility for providing and maintaining a mechanism that ensures effective coordination between OIFP and professional licensing authorities which have the power to impose such sanctions as license suspension, license revoca-

tion, and fines. To that end, OIFP's Professional Boards Liaison has established, and maintains, a database of professional licensees who have been the subject of complaints to either a County Prosecutor's Office, OIFP, or one of New Jersey's many professional licensing boards.

OIFP's database of professional licensees includes information concerning the nature and source of the referral or complaint and the status of any proceedings brought by the Enforcement Bureau of the Division of Consumer Affairs, the enforcement arm of the professional licensing system in New Jersey. The database also includes information concerning the status of any investigation or prosecution of a listed licensee by a prosecuting authority such as OIFP, a County Prosecutor, or their counterparts in the federal or another state system.

The Professional Boards Liaison administers a protocol pursuant to which professional licensing boards are promptly notified whenever OIFP initiates an investigation of any licensee within the board's jurisdiction, and OIFP is promptly notified whenever any of the professional boards receive a complaint against one of their licensees which involves insurance fraud. In addition to daily communications between the Professional Boards Liaison and the various licensing boards, the Liaison conducts quarterly meetings with key members of the Enforcement Bureau and OIFP's investigative and prosecutorial staff, designated the Liaison and Continuing Communications Group, to share information regarding the status of any proceedings, planned or pending, against any licensee in the database involving any type of official action such as the bringing of administrative charges, the initiation of an investigation or prosecution, or the imposition of civil fines.

By ensuring the timely and continuing exchange of information concerning licensees within their respective areas of concern, OIFP's Professional Boards Liaison and the professional boards ensure that actions taken by any one agency do not adversely impact upon the actions taken by any other agency. This sharing of information also serves to enhance each agency's ability to effectively conduct its own investigations and determine what, if any, further action should be taken against a licensee.

In 2004, the Liaison and Continuing Communications Group monitored 634 active cases of suspected insurance fraud. Since it was established in 1998, the Group has reviewed and disposed of 198 cases by way of civil or criminal actions undertaken by OIFP, licensing sanctions taken by a professional licensing board, or by administrative closure. Of those monitored in 2004, 12 licensees were indicted, 8 pled guilty or were found guilty after a trial, and 7 received sentences ranging from 2 years of probation with restitution and fines, to jail terms of up to 7 years. Coordination by the Professional Boards Liaison also assisted professional licensing boards with the imposition of 33 disciplinary actions against licensees in 2004.

Like his colleagues in the Liaison Section, the Professional Boards Liaison communicates daily with his counterparts in other agencies such as the Board of Medical Examiners, and the Nursing, Pharmacy, Dentistry, and Chiropractic Boards. Within OIFP, the Professional Boards Liaison also works closely with OIFP's intake unit, the Case Screening, Litigation and Analytical Support Section (CLASS), so that referrals to OIFP involving professional licensees are entered into the database which he maintains, and to ensure that cases involving professional licensees are appropriately assigned and coordinated among the investigators and attorneys in both OIFP's criminal and civil sections.

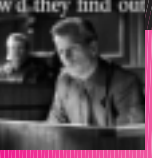
## A Growing Reputation

### *Recognition and Acclaim*

As in years past, OIFP's prominence in the field of insurance fraud is perhaps best reflected by the recognition and acclaim the agency and its staffers have received from others joined in the fight on insurance fraud. While OIFP's record of success has yielded great dividends to New Jersey's citizens, the benefits of its efforts, and the recognition of those benefits, have spread well beyond New Jersey's relatively small geographic bounds. Indeed, the New Jersey model for fighting insurance fraud has garnered the attention of government and insurance industry officials not only throughout the United States, but throughout the world; and the manner in which OIFP has approached the war on insurance fraud has been widely studied, praised, and emulated.

Among the honors which OIFP received in 2004 was its selection for the Outstanding Achievement Award of the International Association of Arson Investigators, recognizing OIFP's successes in attacking arson frauds and cracking a major arson insurance fraud ring. OIFP was also presented with the Ziegler Award of the New Jersey Vehicle Theft Investigators Association in 2004, which is awarded to an individual or group that "has shown extraordinary initiative or achieved outstanding results in the area of auto theft." OIFP was also the recipient in 2004 of the Attorney General Award for Fraud Prevention, awarded by the New Jersey Attorney General in recognition of OIFP's outstanding achievements.

OIFP's Medicaid Fraud Unit was recognized as a national leader in the fight against Medicaid fraud in June of 2001 when it was featured prominently throughout a United States General



# OIFP Leads Nation's Insurance Fraud War

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Accounting Office report as a notable example of a Medicaid Fraud Control Unit which was particularly well run. That report, GAO-01-662, State Efforts to Control Improper Payments Vary (2001), recognized New Jersey's Medicaid Program for its stringent enrollment requirements, its use of readily available software for analyzing claims for unusual patterns prior to making payment, and for conducting pre-enrollment site visits to the premises of potentially high risk enrollees. Because of its effectiveness, OIFP's Medicaid Fraud Unit was one of only four such units selected nationally by GAO for a site visit as part its preparation for the issuance of its report.

In 2004, OIFP's public awareness campaign was also once again recognized for its creativity and effectiveness, garnering the Creativity 34 Award of Distinction awarded by *Creativity*, an Advertising Age magazine devoted to creative excellence. The *Creativity* Awards are awarded annually to national global advertising and design agencies. OIFP's public awareness campaign has been similarly recognized in previous years by leaders in the marketing and advertising world. In the past, OIFP's television and radio commercials have earned OIFP first-place trophies from the New Jersey Business Marketing Association, the New Jersey Advertising Club, and the New Jersey Communications and Marketing Association.

OIFP has also been the recipient of many prestigious awards in prior years, such as its selection in 2003 by the International Association of Chiefs of Police (IACP) as a national finalist for its Excellence in Criminal Investigations Award. The Award recognizes quality achievements in the management and conduct of criminal investigations and promotes the sharing of information on successful programs. It is presented nationally to the law enforcement agency, unit, task force, or inter-agency task force which most demonstrates exceptional innovation and excellence in criminal investigations.

OIFP's staffers were also again recognized in 2004 as outstanding members of our nation's insurance fraud-fighting community. OIFP's Insurance Industry Liaison, John Butchko, was presented with the Outstanding Service Award by the International Association of Special Investigative Units, which recognizes individuals who have demonstrated unusual commitment and made outstanding contributions in the fight against insurance fraud. Other OIFP staffers were honored at the Regional Commissioner's Honor Award Ceremony of the United States Social Security Administration for their investigative efforts in combating fraud, waste, and abuse in Social Security Administration programs. The New Jersey Director of the Division of Criminal Justice also cited the outstanding accomplishments of many OIFP staffers, including Administrative Assistant Pat Miller, Supervising State Investigator Ciro Sebasco, and State Investigator Andrea Hayes who received special Director's Awards.

In years past, OIFP staffers have received awards by such organizations as the American International Group, the Detectives Crime Clinic of Metropolitan New Jersey and New York, the Delaware Valley Chapter of the International Association of Special Investigation Units, the Society of Investigators of Greater Newark, and the Western New Jersey Chap-

ter of the American Society for Industrial Security, to name but a few.

OIFP's accomplishments in the field of fighting insurance fraud have also been noticed by those reporting on insurance fraud or by those in other jurisdictions charged with responsibility for fighting insurance fraud. An article in *Fraud International* magazine in 2004, entitled "New Jersey tops fraud war," observed that, "New Jersey beats other states hands down in fighting fraud...." In late summer, a headline in a major New Jersey daily trumpeted, "Fraud crackdown credited for GEICO's return to N.J." In the accompanying article, billionaire Warren Buffet credited New Jersey's "get tough" stand against insurance fraud for GEICO Insurance Company's decision to return to New Jersey after an absence of nearly 30 years. In 2003, the *New Jersey Lawyer*, a weekly newspaper for the New Jersey legal profession, reported, "Jersey's insurance fraud prosecutions tops in U.S.," based upon a national survey and study by the Coalition Against Insurance Fraud. OIFP's successes and accomplishments have also been covered by such prominent publications as the Coalition Against Insurance Fraud's *Fraud Focus*, Mealey's *Litigation Report-Insurance Fraud*, and similar periodicals of regional and national stature. OIFP has also been cited as an example of a highly effective fraud-fighting agency in at least one leading college textbook, *Criminology*.

## A Community Presence

As one of the world's recognized leaders in fighting insurance fraud, OIFP has assumed responsibility for sharing its expertise with others engaged in the war on insurance fraud, both here and abroad. The New Jersey Insurance Fraud Prosecutor, OIFP, and its staffers are routinely called upon by law enforcement officials for guidance and advice in fighting fraud from within New Jersey, from other states, and from other countries around the globe.

In 2004, Insurance Fraud Prosecutor Greta Gooden Brown was a featured speaker at numerous conferences and meetings in a variety of venues, including the American Bar Association Health Fraud 2004 Program in New Orleans, the Puget Sound Special Investigators in Washington State, the New Jersey Insurance Fraud Summit, and meetings of the Insurance Council of New Jersey and the New Jersey State Bar Association. The Insurance Fraud Prosecutor was also invited in 2004 to deliver a keynote address at the II International Seminar on Insurance Fraud in Bogota, Colombia. Similarly, in 2003 and prior years, the Insurance Fraud Prosecutor spoke before the Asia-Pacific Fraud Conference in Australia, the National Health Care Anti-Fraud Association in Washington, D.C., the Delaware Valley Chapter of the International Association of Special Investigation Units, the New Jersey Special Investigators Association, and the New Jersey Judicial College.

OIFP's Executive Staff were also frequent speakers at conferences, seminars, and similar events in 2004, addressing the New Jersey Special Investigators Association, the International Association of Special Investigation Units, the New Jersey Insurance Fraud Summit, the New Jersey Chiefs of Police Association, the American Physical Therapy Association, the New Jersey Institute for Continuing Legal Education, the Insurance Fraud Executive Council in Charleston, South Carolina, and the Health Care Compliance Certification Program of Seton Hall University.

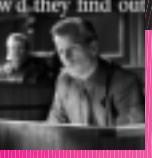
As a model for waging a statewide campaign against insurance fraud, OIFP has frequently been called upon by officials from other jurisdictions in the United States and abroad for guidance and counsel as to the most effective ways of establishing their own fraud-fighting programs. In past years, OIFP has hosted dignitaries and contingencies from Japan, Columbia, and several provinces in Canada, as well as from other states such as New York, to provide them with information and insight as to how to best establish an effective fraud-fighting agency. OIFP continues to routinely field inquiries from officials from other states with respect to a variety of matters concerning the best practices for fighting insurance fraud.

## Raising the Public's Consciousness

OIFP understood from its earliest days that, while its primary mission was the effective investigation and prosecution of insurance fraud, New Jersey's ultimate success in addressing its insurance fraud problem would likewise require a sea change in the public's awareness and attitudes regarding insurance fraud. Various studies over the years have shown that insurance fraud is little understood and lightly taken by most members of the public. Such studies also suggest that nearly two-thirds of Americans tolerate insurance fraud to some degree, including up to a third who believe it is acceptable to "pad" insurance claims to compensate for deductibles or prior premiums paid.

Successful prosecutions, in and of themselves, achieve a real and tangible, albeit small, measure of deterrence in many cases by removing guilty culprits from society. The greater deterrence from successful prosecutions, however, is derived by making the general public aware of the consequences of committing insurance fraud, as well as by making the public aware of the added costs they directly incur as a consequence of those who successfully commit insurance fraud.

Prior to the advent of OIFP, it was rare to hear of anyone being pros-





ecuted for insurance fraud, not only because such prosecutions actually were relatively rare in the larger scheme of things, but also because those prosecutions which were successfully undertaken usually received little or no notice by the public. Consequently, OIFP embraced a comprehensive, proactive, multi-pronged approach to informing the public of the nature, scope, and consequences of insurance fraud in New Jersey. OIFP routinely issues press releases with respect to significant events in most of its major insurance fraud prosecutions, including indictments, guilty pleas, trial convictions, and sentences. OIFP has also over the years conducted an ambitious media campaign in both the print and broadcast media. OIFP maintains an informative Web site and produces and distributes informative publications such as brochures and posters to warn the public of the consequences of committing insurance fraud and to encourage the reporting of instances of suspected insurance fraud to OIFP.

## A Friendlier Market for Automobile Insurance

While the savings attributable to OIFP's efforts are impossible to quantify, it is undeniable that OIFP's proven track record of success in pursuing insurance cheats and its award-winning message of deterrence have been instrumental in transforming New Jersey's once abysmal automobile insurance market to one where new insurers are joining, old insurers are returning, and current insurers are paying dividends and rebates to their insureds. And while a variety of circumstances, including the relaxing of a stringent regulatory environment, have contributed to making the New Jersey automobile insurance market more attractive and profitable to insurance companies, it is clear that OIFP's well-publicized successes in fighting insurance fraud have been a major factor in this amazing transformation.

For the first time in many years, automobile insurers are actively seeking approval to market their products to New Jersey motorists, reversing a ten-year trend in which New Jersey drivers saw more than twenty automobile insurance carriers flee the State. At the end of 2003, Mercury Insurance, a large west coast insurance carrier, became the first new carrier in seven years to seek to enter the New Jersey automobile insurance market. State Farm, the largest auto insurer in the State, initiated a voluntary statewide rate reduction of 4.1 percent, suspended its practice of dropping 4,000 policyholders a month, and withdrew from its plans to pull out of the New Jersey market altogether. USAA, Liberty Mutual, and Allstate Insurance Companies lowered their rates, and New Jersey Manufacturers Insurance Company announced the payment of some $60 million in dividends to nearly 350,000 New Jersey policyholders, averaging approximately $173 per policy.

Perhaps most significantly, the GEICO Insurance Company, which had fled from New Jersey after it switched to a no-fault system of insurance nearly 30 years ago, recently returned to New Jersey, crediting its return, in large part, to New Jersey's crackdown on insurance fraud. At a news conference in Trenton this past summer, billionaire and Chairman of GEICO Insurance Company's corporate parent, Warren Buffet, explained that New Jersey's tough stand against insurance fraud starting in the late 1990s (which coincided with the creation of OIFP), was an important reason for his company's decision to finally return to New Jersey.

## A Catalyst for Reform

Consistent with its legislative mandate to lead New Jersey's fight against insurance fraud, AICRA expressly empowered OIFP to craft recommendations to enhance New Jersey's ability to deal with all aspects of the insurance fraud problem. From its inception, OIFP has incorporated proposed recommendations in its Annual Reports for regulatory and legislative reforms to strengthen law enforcement's hand in dealing with insurance fraudsters and to close loopholes through which creative and unscrupulous individuals try to "game the system." Among the recommendations advanced by OIFP over the years which have been embodied in legislation or regulation are requirements for the inclusion of anti-counterfeiting technology in insurance identification cards, changes in insurance regulations concerning "eligible persons" which permit insurance carriers to restrict coverage in the open insurance market for those individuals who have committed insurance fraud, and the establishment of a program offering a reward of up to $25,000 for those who report insurance fraud.

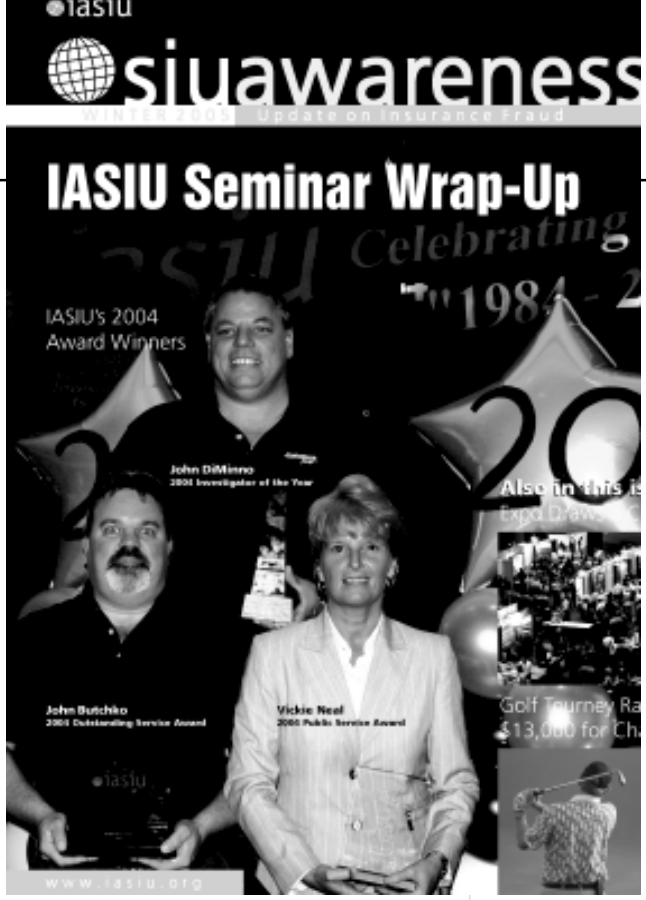
Perhaps most significantly, OIFP's participation was instrumental in the enactment of legislation in June of 2003 which created what is arguably the toughest criminal insurance fraud law in the country. Resembling in many respects New Jersey's Health Care Claims Fraud Act of 1997, Public Law 2003, Chapter 89, created the crime of "Insurance Fraud" in New Jersey as a distinct and clearly defined crime allowing State prosecutors to charge insurance fraudsters with serious criminal offenses involving most types of insurance fraud without having the former burden of aggregating thousands of separate fraudulent acts to reach what had been a monetary threshold of $75,000 for a second degree crime.

## Prospects for the Future

Are we, at long last, beginning to "win" the war on insurance fraud? Follow-up studies on the effectiveness of OIFP's media campaign suggest that New Jersey's citizens are growing far more knowledgeable, and consequently intolerant, of insurance fraud and its negative impact on New Jersey's quality of life. And it would appear that OIFP's continuing track record of successful investigations and prosecutions has taken a significant toll on those who would dare to commit insurance fraud in New Jersey. The investment of our insurance industry and citizens in OIFP has undeniably yielded tremendous dividends. Yet, it is virtually axiomatic that, "the more you learn, the more you learn you don't know." In the field of insurance fraud, OIFP has found that, the more it investigates and prosecutes insurance fraud, the greater and more complex appears the magnitude of the problem.

The prospects for OIFP's continuing success, indeed, New Jersey's success, in its war on insurance fraud, will, of necessity, depend upon the continuing support of both the insurance industry and State government. Despite provision in the law allowing for an increase in OIFP's annual budget, its budget has, in actual dollars, remained essentially static over the past five years. When taking into account the effects of inflation over that period, OIFP's budget has actually decreased in terms of its ability to support its staffing and programs.

As a consequence of these growing fiscal pressures, OIFP was regrettably compelled to terminate its financial support of the New Jersey State Police Insurance Fraud Unit, which it had funded since its inception. It was also forced to decrease the funding it has provided to County Prosecutors to support their insurance fraud programs. It is only with continued support and the funding necessary to continue OIFP's programs, that the citizens of New Jersey can expect that OIFP will be able to continue to expand the war on insurance cheats and spread its message of deterrence; that those who commit insurance fraud pick all of our pockets and will be called to account through civil and criminal prosecutions. The continuing success of New Jersey's war on insurance fraud ultimately depends not only upon the leadership, accomplishments, or expertise of OIFP and its staff of dedicated professionals, but also upon those who determine whether OIFP's funding will, in real dollars, continue to shrink in the shadow of creeping inflation.




*OIFP Special Assistant John J. Butchko (lower left) is awarded the International Association of Special Investigative Units' 2004 Annual Outstanding Service Award. (Reprinted with the permission of SIU Awareness and the International Association of Special Investigative Units.)*

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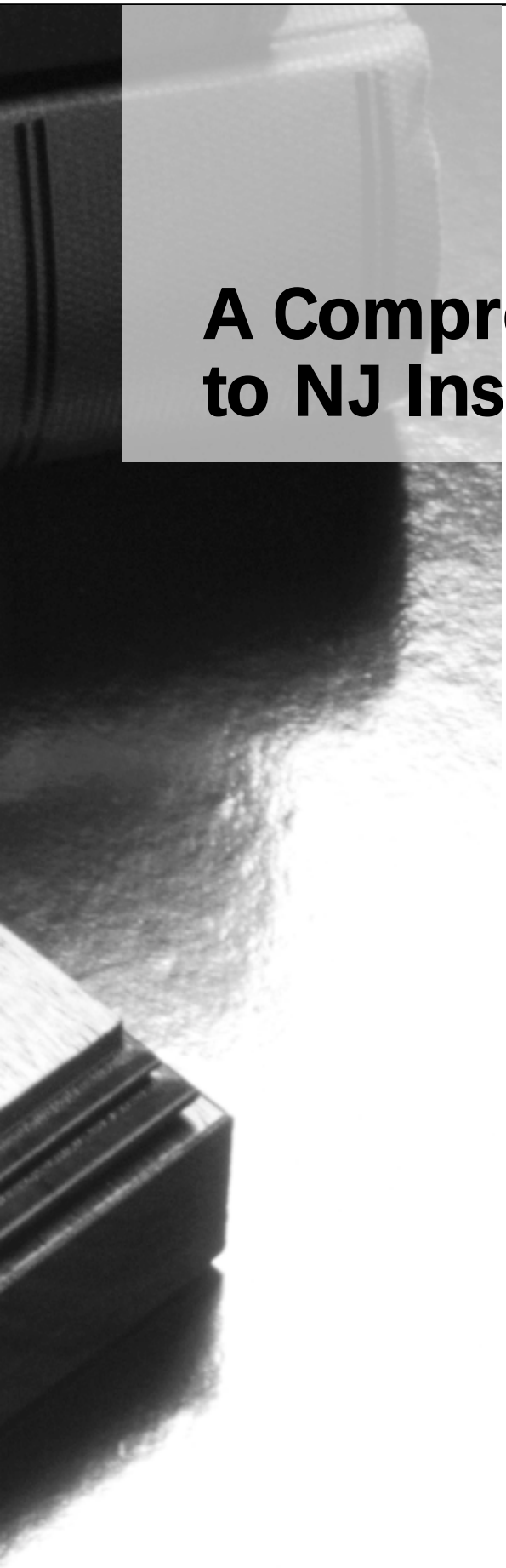
# A Comprehensive Guide to NJ Insurance Fraud Law



# A Comprehensive Guide to NJ Insurance Fraud Law

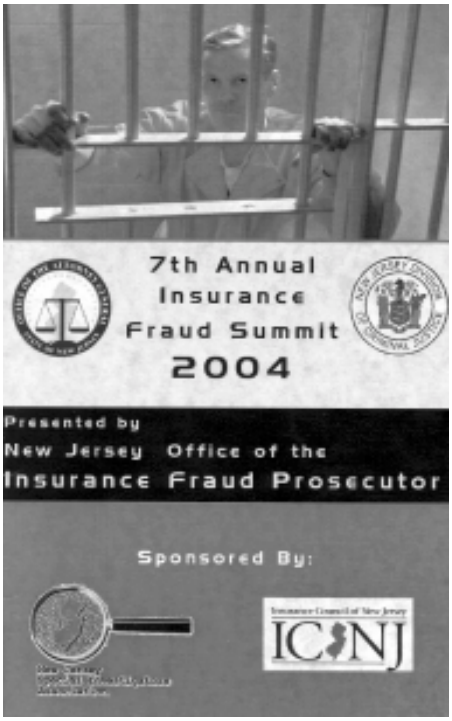
by John J. Smith

Studies have shown that, in the United States, insurance fraud, in all its various forms, costs the insurance industry as much as $100 billion each year. Until 1998, law enforcement's approach to insurance fraud in New Jersey was ad hoc, relying on criminal statutes, such as Theft by Deception,[1] that proved to be ineffective in deterring most fraud. Coordination between the insurance industry and law enforcement was lacking. Data in the possession of insurance carriers showing patterns of fraud was seldom shared with law enforcement, and vice versa. However, beginning in 1998, the State of New Jersey responded to the insurance fraud crisis with several bold initiatives. The Legislature significantly amended the Insurance Fraud Prevention Act[2] and created the Office of the Insurance Fraud Prosecutor (OIFP). This provided coordination of law enforcement's anti-insurance fraud efforts and provided a central repository for fraud data gathered by both law enforcement and the insurance industry. The Legislature enacted criminal statutes specifically to combat insurance fraud, such as Health Care Claims Fraud,[3] Criminal Use of Runners,[4] and, recently, Insurance Fraud.[5] These initiatives have given New Jersey's prosecutors more tools to effectively address the insurance fraud epidemic.

Through OIFP and specific criminal and civil statutes designed to combat insurance fraud, New Jersey attacks insurance fraud with criminal prosecutions, civil fraud penalties, and professional licensing sanctions for licensees who commit violations of the Insurance Fraud Prevention Act (the Act).[6] OIFP routinely conducts both criminal and civil insurance fraud investigations, as well as investigations of suspected fraud directed at government-sponsored insurance programs, including Medicaid. Since 2000, OIFP has conducted a total of 30,349 such investigations many resulting in the imposition of civil insurance fraud penalties or criminal convictions.[7]

OIFP's successes in 2004 and prior years is largely attributable to a legislative blueprint that creates a

1 N.J.S.A. 2C:20-4. Under the traditional approach of charging insurance cheats with Theft by Deception, prosecutors were unable to seriously threaten first-time offenders with incarceration in State prison unless the theft exceeded $75,000. Therefore, the vast majority of those engaged in insurance fraud faced nothing more than a term of probation. 2 N.J.S.A. 17:33A-1, *et seq.* (Hereinafter referred to as the Act.) 3 N.J.S.A. 2C:21-4.2, *et seq.* 4 N.J.S.A. 2C:21-22.1. 5 N.J.S.A. 2C:21-4.4, *et seq.* 6 N.J.S.A. 17:33A-1, *et seq.* 7 In calendar years 2000, 2001, 2002, 2003, and 2004, OIFP opened 519, 409, 508, 474, and 464 criminal investigations, respectively, and 6,589, 4,986, 4,639, 3,525, and 8,236 civil insurance fraud investigations, respectively. Because many law enforcement agencies and prosecutorial agencies lack the expertise and resources to commit to complex insurance fraud investigations, much insurance fraud is likely not investigated or prosecuted.




comprehensive single State agency whose sole focus and mission is to fight insurance fraud as well as specific criminal and civil statutes designed to combat insurance fraud.

## Insurance Fraud Prevention Act

An understanding of New Jersey's response to the serious problem posed by insurance fraud, and the statutory basis for OIFP, begins with an analysis of the Act. Enacted in 1982 and substantially amended by the Automobile Insurance Cost Reduction Act (AICRA) in 1998,[8] the Act provides for a comprehensive law enforcement response to insurance fraud including investigations, prosecutions, and anti-insurance fraud programmatic efforts, all of which are necessary to address criminal conduct widely considered "acceptable" by many people.[9] This sweeping approach to combating insurance fraud, combined with the imposition of civil insurance fraud penalties and professional licensing sanctions, serves as a deterrent to insurance fraud-related conduct, while the programmatic efforts undertaken by OIFP, including a relentless media campaign, are designed to illuminate the serious consequences associated with such criminal conduct.

An examination of the Act, the purpose of which is to "[c]onfront aggressively the problem of insurance fraud in New Jersey,"[10] demonstrates the comprehensive and aggressive approach taken with respect to this serious law enforcement issue. Among the significant provisions of the Act are the following:

1. Identification of the conduct which constitutes civil insurance fraud.[11] In most cases, conduct which violates the Act and constitutes civil insurance fraud consists of presenting or causing to be presented any written or oral false statements in support of an insurance claim.[12] Therefore, the focus of the investigation is to identify those false statements and obtain evidence to prove their falsity. Because the same fraudulent conduct can violate both the Act as well as many criminal statutes, one of the most difficult decisions made by law enforcement is whether to approach the conduct as a civil insurance fraud matter, a criminal insurance fraud matter, a

8 "Automobile Insurance Cost Reduction Act," Laws of 1998, Chapter 21, 5/19/98. 9 In a poll conducted in 2002 in connection with OIFP's media advertising campaign, 43% of respondents did not believe insurance fraud to be a substantial problem. However, following a wave of anti-insurance fraud advertisements, 83% of respondents considered insurance fraud to be a substantial problem. *See* New Jersey Office of the Insurance Fraud Prosecutor, Advertising and Public Relations Study by Grafica, Inc. (June, 2002). 10 N.J.S.A. 17:33A-2. 11 N.J.S.A. 17:33A-4. Conduct which constitutes *civil* insurance fraud as set forth in the Act can also constitute certain crimes, including Health Care Claims Fraud, N.J.S.A. 2C:21-4.2, *et seq.*, Insurance Fraud, N.J.S.A. 2C:21-4.4, *et seq.*, Theft by Deception, N.J.S.A. 2C:20-4 and Falsification of Medical Records, N.J.S.A. 2C:21-4.1. 12 Likewise, in several criminal statutes used to prosecute insurance fraud, including Health Care Claims Fraud, N.J.S.A. 2C:21-4.2, *et seq.*, and Insurance Fraud, N.J.S.A. 2C:21-4.4, *et seq.*, the focus is on the presentation of false written or oral statements in support of an insurance claim.

professional licensing matter, or any combination of the three. The answer to this dilemma is seldom clear at the time of referral. Indeed, the only means of making the appropriate determination is through a thorough analysis of a quality insurance company referral which will support a quality investigation.[13]

2. Imposition of penalties for civil violations of the Act.[14]
   The civil insurance fraud penalties found in the Act are substantial. Under the Act, a civil fine of up to $5,000 may be levied for a first violation, up to $10,000 for a second violation, and up to $15,000 for each subsequent violation.[15] Each false statement, or fraudulent omission, in a single claim may be considered separate violations of the Act. In fact, multiple violations can be contained within a *single document* submitted in the same insurance claim.[16] These civil penalties, therefore, are predicated on identifying and proving individual fraudulent statements or omissions made to support a claim or to obtain an insurance benefit.
3. Avoidance of litigation through entry of a civil Consent Agreement.
   The Act provides that civil insurance fraud cases may be resolved through a written agreement between the State and the subject of the investigation in which the subject agrees to pay a civil fine, thereby avoiding litigation. These agreements are known as Consent Agreements, more commonly known as Consent Orders.[17] If the subject elects not to enter into a Consent Order, with the concomitant payment of a civil insurance fraud fine, the matter is referred to Deputy Attorneys General in the Division of Law for review and the possible filing of a civil lawsuit.[18]
4. Recovery of compensatory damages following civil litigation, including costs of litigation and attorneys' fees.
   In addition to civil insurance fraud fines, the costs of investigation and attorneys' fees can be recovered by the State upon the successful conclusion of a civil lawsuit.[19] Similarly, the Act provides that insurance companies[20] damaged as the result of insurance fraud may sue and recover compensatory damages, including investigative expenses, costs of suit, and attorneys' fees.[21] Moreover, successful claimants can recover *treble* damages if the defendant who committed insurance fraud has engaged in a "pattern" of violating the Act.[22]

13 Among the factors which inform the decision to commence a criminal or civil investigation include: (1) whether or not the preliminary evidence is sufficient to meet the criminal standard of proof beyond a reasonable doubt; (2) whether the fraudulent conduct constitutes a serious (second degree) or less serious (third or fourth degree) crime based on the grading and sentencing provisions found in the New Jersey Criminal Code; (3) whether, in the case of conduct constituting a less serious crime, the civil penalties available under the Act (*e.g.*, substantial monetary fines and/or professional licensing sanctions) would be more likely to deter the defendant and others similarly situated than would lesser criminal sanctions (*e.g.*, probation or Pre-trial Intervention); and, (4) the venue where the case is likely to be laid, as experience has revealed that juries in urban counties are less likely to view insurance fraud as a serious crime when compared to the crimes of violence routinely encountered in such counties. 14 N.J.S.A. 17:33A-5. 15 Ibid. 16 *See* Merin v. Maglaki, 126 N.J. 430, 599 A.2d 1256 (1992). For this reason, some civil insurance fraud penalties can be more severe than the available criminal penalties for conduct constituting a third or fourth degree crime. 17 N.J.S.A. 17:33A-5(d). 18 N.J.S.A. 17:33A-5(a) and (b). The Statute of Limitations for civil insurance fraud actions brought by the State is ten years. N.J.S.A. 2A:14-1.2(a). The Statute of Limitations for civil insurance fraud actions brought by private insurance carriers is six years. N.J.S.A. 17:33A-7(e). 19 N.J.S.A. 17:33A-5(b). There is no similar provision for recovery of costs of investigation or attorneys' fees as restitution in a criminal case. 20 N.J.S.A. 17:33A-7(a). 21 Insurance carriers who file civil lawsuits pursuant to the Act must provide OIFP with notice of the suit. N.J.S.A. 17:33A-7(c). Following a review of the matter, OIFP may institute a criminal or civil investigation or join the lawsuit. If OIFP joins the lawsuit and prevails, it may seek a judgment for civil fines, court and investigative costs, as well as reasonable attorneys' fees. N.J.S.A. 17:33A-7(d). 22 N.J.S.A. 17:33A-7(b). "Pattern" is defined as "five or more related violations of (the Act). Violations are related if they involve either the same victim, or same or similar actions on the part of the person or practitioner charged with violating (the Act)." N.J.S.A. 17:33A-3.

5. Apportionment of costs of administering the Act among insurance carriers doing business in New Jersey.
   The Act provides that the costs of administering the Act, including the cost of operating OIFP, shall be apportioned among insurance carriers doing business in New Jersey based on the percentage of the net premiums received by such insurance companies.[23]
6. Mandatory reporting of violations of the Act.
   The Act provides that any person who believes that a violation of the Act has occurred *shall* notify OIFP.[24] Any person so reporting a suspected violation of the Act "in good faith and without malice" is immune from civil liability for libel or violation of privacy.[25]
7. Subpoena Power.
   The Act provides further that health insurers and private passenger automobile insurers shall submit to the Department of Banking and Insurance a plan for the prevention and detection of insurance fraud.[26] The Act provides OIFP with civil insurance fraud subpoena power in order to conduct thorough civil investigations of violations of the Act following referral of such matters.[27] As a law enforcement agency, OIFP also can and routinely does open criminal grand jury investigations which result in the issuance of grand jury subpoenas and the return of indictments.[28] The Act provides that imposition of civil insurance fraud penalties does not preclude criminal prosecution based on the same conduct.[29]

## The Burden of Proof in Civil Insurance Fraud Penalty Actions Is Preponderance of the Evidence

In civil proceedings to recover a statutory penalty under the Act, the State satisfies the burden of proof if it establishes a defendant's violation by a preponderance of the evidence.[30] In general, the burden of proof in civil actions is presumed to be the preponderance standard.[31] The Legislature is keenly aware of the "preponderance presumption," as is evidenced by its prescribing a higher burden when it has seen fit to do so.[32]

23 N.J.S.A. 17:33A-8(g). Similar state law provisions have been challenged in Minnesota, Massachusetts, and California on the theory that private funding provided by the insurance industry to law enforcement disqualified law enforcement by creating a conflict of interest. Those challenges were unsuccessful in disqualifying law enforcement. 24 N.J.S.A. 17:33A-9(a). The vast majority of referrals to OIFP, which have ranged between approximately 6,000 and 14,000 annually, are made by insurance carrier representatives. 25 N.J.S.A. 17:33A-9(b). Analogous to this provision is a provision contained in the Insurance Fraud statute, discussed *infra.* *See* N.J.S.A. 2C:21-4.7(e). 26 N.J.S.A. 17:33A-15. These plans are known as Insurance Fraud Detection Plans. 27 N.J.S.A. 17:33A-10. 28 OIFP routinely conducts criminal investigations of insurance fraud through State Grand Juries or grand juries empaneled in any of the 21 counties. OIFP utilizes grand jury subpoenas to compel the attendance of witnesses and production of records. However, the Appellate Division recently held that grand jury subpoenas cannot be used to obtain a person's bank records in the custody of a third party bank because persons, to include insurance claimants, possess "a right to privacy" in bank records in the possession of the bank. This opinion, if upheld on appeal, will adversely impact insurance fraud and other financial crimes investigations. The decision is on appeal to the New Jersey Supreme Court. See State v. McAllister, 366 N.J. Super., 251 (2004), petition for certification granted 180 N.J. 151 (2004). 29 N.J.S.A. 17:33A-14. OIFP routinely conducts parallel civil and criminal investigations of suspected insurance fraud-related conduct. 30 Department of Health v. Concrete Specialties, Inc., 112 N.J. Super. 407, 411 (App. Div. 1970); Department of Conservation and Economic Development, Division of Fish and Game v. Scipio, 88 N.J. Super. 315, 322, cert. denied, 45 N.J. 598 (1965); State v. Cale, 19 N.J. Super. 397, 399 (App. Div. 1952). 31 *See* Hyland v. Aquarian Age 2000, Inc., 148 N.J. Super. 186, 191 (App. Div. 1977). 32 *See*, *e.g.*, N.J.S.A. 2A:15:5.12a (punitive damages awarded only if plaintiff proves with clear and convincing evidence that defendant acted willfully).

The absence of language in the Act prescribing a standard of proof other than the preponderance standard indicates that the Legislature did not intend to have a higher standard of proof apply. Should the Legislature have so intended, it would have prescribed a higher burden as it has done on other occasions.

The clearly stated purpose of the Act is to:

> ...confront aggressively the problem of insurance fraud in New Jersey by facilitating the detection of insurance fraud, eliminating the occurrence of such fraud through the development of fraud prevention programs, requiring the restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims.[33]

The imposition of any standard of proof beyond the presumed preponderance standard would run contrary to this purpose to aggressively pursue civil fraud penalties. The Court has recognized that "[i]nsurance fraud is a problem of massive proportions that currently results in substantial and unnecessary costs to the general public in the form of increased rates."[34]

Moreover, the State now has the ability to pursue violations of the Act administratively.[35] New Jersey has long recognized that the usual burden of proof for establishing claims before State agencies in contested administrative actions is by a fair preponderance of the evidence.[36] This further demonstrates the Legislature's intent to establish a preponderance of the evidence standard for violations of the Act.

The preponderance standard has been routinely applied to civil penalty actions as being consistent with constitutional due process protections. Other proceedings wherein the preponderance standard has been applied include: actions for false claims under the federal False Claims Act,[37] actions to recover civil penalties for violation of the Alien Immigration Act,[38] proceedings under the Securities Exchange Act,[39] and administrative actions to revoke occupational licenses.[40]

Even though the higher "clear and convincing" burden of proof may apply to certain types of common law fraud, the elements necessary to establish statutory violations under the Act are distinct from the elements required to prove common law fraud. Common law fraud historically has required that the person so charged has (1) knowingly made a (2) material misrepresentation to another, (3) intending to induce reliance, and upon which misrepresentation such other person in fact (4) reasonably relied to his (5) detriment, suffering damages as a result.[41]

Unlike common law fraud, however, a violation of the Act does not require that the defendant has had any intention to commit fraud; that another reasonably relies upon a false statement; or that any fixed damages be sustained in a particular case. Instead, for there to be a violation of the Act, the defendant, for example, must have prepared or made with the intent to be presented to the insurer (1) a written or oral statement for the purpose of obtaining an insurance policy or pursuing a claim for benefit, (2) containing false or misleading information, (3) knowing that the information was false or misleading, and (4) the false statement was material to the application or claim.[42] Nowhere in the Act is it required that the defrauded party actually suffer a loss for there to be a violation. Therefore, as in other civil penalty actions, the State satisfies its burden of proof if it establishes that the defendant violated the Act by a preponderance of the evidence.

33 N.J.S.A. 17:33A-2. 34 Merin v. Maglaki, 126 N.J. 430, 436-37 (1992). *See also* 1997 N.J. Laws c.353 § 1 (Legislative findings and declarations regarding Health Care Claims Fraud); N.J.S.A. 2C:21-4.4 (Legislative findings regarding Insurance Fraud). 35 *See* N.J.S.A. 17:33A-5. 36 In re Polk, 90 N.J. 550, 560 (1982). 37 Brooks v. United States, 64 F.3d 251, 255 (7th Cir. 1995). 38 United States v. Regan, 232 U.S. 37 (1914).39 Herman & Maclean v. Huddleston, 459 U.S. 375, 389-90 (1983). 40 Polk, *supra*, 90 N.J. at 550. 41 Bell Atlantic Network Services, Inc. v. P.M. Video, Corp., 322 N.J. Super. 74, 95-96 (App. Div. 1999). 42 N.J.S.A. 17:33A-4 sets forth actions which violate the Act.

## Office of the Insurance Fraud Prosecutor

In 1998, OIFP was established within the Division of Criminal Justice by amendment to the Act.[43] In addition to granting broad powers to investigate and prosecute civil and criminal insurance fraud,[44] the Legislature mandated OIFP perform the following functions, among others:

1. Provide a liaison and communicate with other State agencies with respect to the detection, investigation, and prosecution of insurance fraud.[45]
2. Receive referrals of insurance fraud matters for investigation, as well as provide information to and coordinate information among referring entities.[46]
3. Develop, on behalf of the Attorney General, a statewide insurance fraud enforcement policy in consultation with the County Prosecutors.[47]
4. Fund insurance fraud units within the County Prosecutors' Offices.[48]
5. Provide assistance to County Prosecutors in prosecuting cases.[49]
6. Establish and maintain a comprehensive database including referrals, all reports of fraud investigations and prosecutions or litigation, and the disposition of those proceedings.[50]
7. Prepare a standard reporting form for the submission of claims information by insurance carriers, including information regarding stolen vehicles, automobile accidents, injuries sustained in those accidents, and medical service providers treating those injuries, for the purpose of identifying patterns of fraud, with the claims information received to be shared with other law enforcement agencies.[51]
8. Confer with other governmental entities to coordinate insurance fraud enforcement activities, share information, and provide assistance as necessary.[52]
9. Formulate and evaluate proposals for legislative, administrative, and judicial initiatives to strengthen insurance fraud enforcement.[53]
10. Act as a liaison for the Executive Branch with other Federal and State agencies involved in insurance fraud enforcement, including the Judicial Branch.[54]
11. Provide an Annual Report to the Governor and the Legislature regarding OIFP activities.[55]
12. Make recommendations on licensing sanctions, including suspension or revocation, to the appropriate licensing board when a professional holding a State license or certification is adjudicated guilty of fraud.[56]

The Act provides that the Insurance Fraud Prosecutor shall have access to all information concerning insurance fraud enforcement activities in the possession of all State departments and agencies, and will meet on a regular basis with State departments and agencies and County Prosecutors to set goals and strategies for the effective detection, investigation, and prosecution of insurance fraud.[57] In addition, signaling the coordination of efforts between law enforcement and the insurance industry, the Act provides that State and local law enforcement agencies, including the New Jersey State Police, shall make automobile accident reports available to insurance carrier investigators.[58]

43 N.J.S.A. 17:33A-16. 44 *See, e.g.*, N.J.S.A. 17:33A-20, "Statewide fraud enforcement policy," and N.J.S.A. 17:33A-23, "Access to agency information." 45 N.J.S.A 17:33A-18(a). Specifically, OIFP is required to communicate with the Department of Health and Senior Services, the Department of Human Services, the Professional Boards in the Division of Consumer Affairs in the Department of Law and Public Safety, the Department of Banking and Insurance, the Division of State Police, all 21 County Prosecutors' Offices, and local government agencies. 46 N.J.S.A. 17:33A-18. The term "referring entities" as used in the Act means insurance companies as well as other law enforcement and governmental agencies. 47 N.J.S.A. 17:33A-20. 48 N.J.S.A. 17:33A-28. In calendar year 2004, 19 of the 21 New Jersey County Prosecutors' Offices had Insurance Fraud Units funded by OIFP. 49 N.J.S.A. 17:33A-20. 50 N.J.S.A. 17:33A-22(a). 51 N.J.S.A. 17:33A-22(b). *See* All Claims Database Regs. Chapter 88. N.J.A.C. 13:88-2.2. 52 N.J.S.A. 17:33A-24(a). Among other methods by which OIFP discharges this obligation is through law enforcement in-service training seminars regarding statutory changes and trends in insurance fraud activity. 53 N.J.S.A. 17:33A-24(b). Such recommendations are frequently made part of the Annual Report published by OIFP. 54 N.J.S.A. 17:33A-24(c). 55 N.J.S.A. 17:33A-24(d). OIFP Annual Reports for the calendar years 1999-2004 are available on the OIFP website at ***www.njinsurancefraud.org.*** 56 N.J.S.A. 17:33A-25. 57 N.J.S.A. 17:33A-27. 58 N.J.S.A. 17:33A-29.

## Health Care Claims Fraud

Beginning in 1998, the New Jersey Legislature recognized that, given the serious and pervasive problem of insurance fraud, existing criminal statutes were inadequate to address thefts and frauds committed against insurance companies and other types of insurers. Indeed, prior to 1998, most criminal insurance frauds were prosecuted as thefts. In order to impose a State prison sentence on an offender with no prior indictable convictions, the State needed to prove that more than $75,000 was stolen or attempted to be stolen.[59] Even though the New Jersey Criminal Code permitted prosecutors to aggregate individual insurance claims of lesser dollar amounts if they proved a "continuing course of conduct,"[60] many false insurance claims are for far less than $75,000; therefore, many individuals engaged in insurance fraud activity, such as the filing of false health care claims, never faced serious consequences for their criminal acts.

To address this deficiency in the Criminal Code, and "to enable more efficient prosecution of criminally culpable persons who knowingly, or with criminal recklessness, submit false or fraudulent claims for payment or reimbursement for health care services,"[61] the New Jersey Legislature enacted the Health Care Claims Fraud statute.[62] Effective July 15, 1998, the Health Care Claims Fraud statute substantially increased the criminal penalties for fraud relating to health care claims while significantly lowering the threshold dollar amount whereby an offender (including one with no prior criminal record) is subject upon conviction to a State prison sentence.

The penalties for violating the statute depend on whether the offender qualifies as a practitioner or non-practitioner. Generally, a "practitioner" is broadly defined as any person "licensed, registered or certified by *any* State agency" in New Jersey or "in another jurisdiction," including health care professionals.[63] While the statute provides very stiff penalties for practitioners and non-practitioners alike, the most severe penalties are reserved for the practitioner offender, as follows:

A. A practitioner who *knowingly* commits a single act of Health Care Claims Fraud in the course of providing professional services[64] is guilty of a crime of the second degree (i.e., the presumption of a State prison sentence of between five and ten years applies).[65]
B. A practitioner who *recklessly* commits a single act of Health Care Claims Fraud in the course of providing professional services is guilty of a crime of the third degree (i.e., the presumption of no incarceration applies).[66]
C. A non-practitioner who *knowingly* commits *five or more acts* of Health Care Claims Fraud, and who thereby obtains or seeks to obtain *in excess of $1,000*, is guilty of a crime of the second degree.[67] Otherwise, a non-practitioner who *knowingly* commits Health Care Claims Fraud is guilty of a crime of the third degree.[68]
D. A non-practitioner who *recklessly* commits Health Care Claims Fraud is guilty of a crime of the fourth degree.[69]

All "acts" of Health Care Claims Fraud constitute separate and distinct offenses.[70] In keeping with the broad reach of the statute, multiple acts of Health Care Claims Fraud may be contained even in a *single claim document*. In other words, each and every

59 N.J.S.A. 2C:20-2 and N.J.S.A. 2C:43-6. 60 N.J.S.A. 2C:20-2(b)(4). 61 1997 N.J. Laws c. 353 § 1(d). 62 N.J.S.A. 2C:21-4.2, *et seq.* "Health Care Claims Fraud" is broadly defined as "making, or causing to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omitting a material fact from, or causing a material fact to be omitted from, any record, bill, claim or other document, in writing, electronically or in any other form, that a person attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted for payment or reimbursement for health care services." N.J.S.A. 2C:21-4.2. 63 N.J.S.A. 2C:21-4.2. "Practitioner" is defined as "a person licensed in this State to practice medicine and surgery, chiropractic, podiatry, dentistry, optometry, psychology, pharmacy, nursing, physical therapy, or law" and "any other person licensed, registered or certified by any State agency to practice a profession or occupation in the State of New Jersey or any person similarly licensed, registered, or certified in another jurisdiction." A non-practitioner, therefore, is any other person who does not fit within the above definition. 64 N.J.S.A. 2C:21-4.3(a). Unlike the crime of Theft by Deception, N.J.S.A. 2C:20-4, which is graded according to the amount stolen (*e.g.*, theft in the second degree if in excess of $75,000), a practitioner can be convicted of Health Care Claims Fraud in the second degree regardless of the amount "obtained or sought to be obtained." 65 Common to all penalties for violation of the statute, for both practitioners and non-practitioners alike, and without regard to the level of culpability, is exposure to a criminal fine in an amount of up to five times the pecuniary benefit obtained or sought to be obtained. *See* N.J.S.A. 2C:21-4.3(a)-(d). 66 N.J.S.A. 2C:21-4.3(b). For purposes of the statute, "a person acts recklessly with respect to a material element of an offense when he consciously disregards a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that, considering the nature and purpose of the actor's conduct and the circumstances known to him, its disregard involves a gross deviation from the standard of conduct that a reasonable person would observe in the actor's situation." N.J.S.A. 2C:21-4.3(h). 67 N.J.S.A. 2C:21-4.3(c). 68 Ibid. 69 N.J.S.A. 2C:21-4.3(d). 70 N.J.S.A. 2C:21-4.3(e).

*Supervising Deputy Attorney General Tina Polites discusses auto fraud trends during a workshop at the Seventh Annual Insurance Fraud Summit.*

false misrepresentation or omission in a single document constitutes separate "acts" of Health Care Claims Fraud.[71] Moreover, consistent with the "zero tolerance" policy for fraud committed by practitioners, a conviction for recklessly violating the statute will result in a mandatory license suspension of at least one year, while a second conviction for recklessly violating the statute, or a first conviction for knowingly violating the statute, will result in mandatory *permanent* license forfeiture and debarment from the profession.[72]

The statute also contains three inferences which the trier of fact may accept:

A. The falsity or misleading nature of a statement contained in a treatment record or other claim document, in the case of a practitioner, where the practitioner, in recommending a course of treatment, failed to examine or otherwise assess the condition of the patient.[73]
B. The falsity or misleading nature of a statement contained in a treatment record or other claim document, in the case of any *person* (e.g., medical office personnel) who submitted or attempted to submit documents alleging more treatments or procedures than could have been performed during a period of time in which the treatments or procedures were alleged to have been performed.[74]
C. That a practitioner has read and reviewed any treatment record or other claim document submitted where the practitioner has signed or initialed the document.[75]

An examination of criminal cases resulting in convictions under the Health Care Claims Fraud statute demonstrates its reach and broad application. For example, a defendant may be convicted of Health Care Claims Fraud even if the defendant sustained actual injuries and sought treatment for those injuries if the injuries were sustained during the course of staging a fictitious slip and fall. In such a case, the Superior Court, Appellate Division, recently held that a defendant who was a licensed insurance agent, and who submitted 19 claims with a value of approximately $5,400 pursuant to a health insurance policy issued by an insurance company, was properly convicted of Health Care Claims Fraud.[76] The defendant argued that even if he intentionally

71 Ibid. 72 N.J.S.A. 2C:51-5(a)(1)-(3). 73 N.J.S.A. 2C:21-4.3(f)(1). 74 N.J.S.A. 2C:21-4.3(f)(2). An example of this could be the submission of the results of the same diagnostic tests, each of which is alleged to take 20 minutes to complete, allegedly conducted on 50 patients on the same day. 75 N.J.S.A. 2C:21-4.3(f)(3). 76 State v. Bruce Tarlowe (decided by the Appellate Division A-3063-02T2 on June 24, 2004).

staged a false slip and fall accident in a grocery store by faking his fall on a lettuce leaf, he nonetheless actually injured himself doing so. The Court rejected the defendant's "actual injury" defense reasoning that if he were injured while staging a fake slip and fall insurance claim, even if his injuries were real, he committed Health Care Claims Fraud. The defendant's conviction and three-year prison sentence were upheld.

## Criminal Use of Runners

Many of the more complex insurance fraud schemes involve coordination among and between several individuals, each performing different roles to assure the success of the fraud operation. For example, in the case of a corrupt health care office that routinely submits false or fraudulent medical records in support of contrived Personal Injury Protection (PIP) claims for services never rendered, the success of the fraud will depend on complicity between the health care professional, the office staff, and, perhaps, the patients. Indeed, many of those patients, if they exist at all, have no injuries and have never been seen or treated by the health care practitioner, thus their treatment charts fabricated out of whole cloth. Frequently, to secure a steady stream of new patients, thereby assuring the ongoing profitability of the fraud ring, the corrupt health care facility will engage the services of "runners" to procure those patients. To find those patients, "runners" sometimes bribe public officials for access to recent motor vehicle accident reports. In addition, "runners," who may be paid several hundred dollars for each patient referral, often solicit others to become patients by participating in staged or fictitious "paper" accidents, and complain of non-existent injuries, with the promise, or hope, of a lucrative bodily injury lawsuit at the end.[77]

Recognizing the critical but pernicious role played by "runners" in insurance fraud rings, and in the despicable practice of "ambulance chasing" on behalf of personal injury attorneys, the Legislature criminalized the practice of using "runners" through enactment of the Criminal Use of Runners statute.[78] Effective July 12, 1999, the statute imposes the same severe criminal sanctions on the "runner"[79] and other persons, including a provider,[80] who utilize the "runner." Indeed, knowingly acting as a "runner" and knowingly using, soliciting, directing, hiring, or employing a "runner" are violations of the statute, constituting crimes of the third degree.[81] However, providing an indication of the seriousness with which the Legislature viewed the "runner" problem, the presumption of non-incarceration, *i.e.*, probationary treatment that normally attaches to a third degree crime committed by an offender with no prior indictable convictions,[82] does not apply. Rather, a conviction under the statute will typically result in the imposition of a State prison sentence between three and five years *regardless* of the offender's lack of a prior criminal record.[83]

77 For examples of such cases prosecuted by OIFP, see OIFP 2003 Annual Report at 84-87, 102-03, 105-06, and 108-09. 78 N.J.S.A. 2C:21-22.1. According to the comments accompanying the legislation, the act of "running" "facilitates fraud and serves no legitimate purpose" and, moreover, exposes "the client, patient or customer (to) inadequate or inappropriate care or services." 1999 N.J. Laws c. 162. For statutory proscriptions of similar conduct, *see also* N.J.S.A. 2C:40A-4 and N.J.S.A. 2C:40A-5. 79 A "runner" is defined under the statute as "a person who, for a pecuniary benefit, procures or attempts to procure a client, patient or customer at the direction of, request of or in cooperation with a provider whose purpose is to seek to obtain benefits under a contract of insurance or assert a claim against an insured or an insurance carrier for providing services to the client, patient, or customer." N.J.S.A. 2C:21-22.1(a). Specifically excluded from the definition are those who attempt to procure clients, patients, or customers for a provider through public advertisements, or who make referrals to a provider "as otherwise authorized by law." Ibid. 80 A "provider" is defined under the statute as "an attorney, a health care professional, an owner or operator of a health care practice or facility, any person who creates the impression that he or his practice or facility can provide legal or health care services, or any person employed or acting on behalf of any of the aforementioned persons." Ibid. 81 N.J.S.A. 2C:21-22.1(b). 82 *See* N.J.S.A. 2C:44-1(e). 83 N.J.S.A. 2C:21-22.1(c). To overcome the presumption of incarceration, the defendant must show "that imprisonment would be a serious injustice which overrides the need to deter such conduct by others." Ibid. The language in this section is identical to that found in N.J.S.A. 2C:44-1(d), establishing the presumption of incarceration for crimes of the first or second degree. In cases discussing the presumption of incarceration under N.J.S.A. 2C:44-1(d), courts have regularly held that the presumption is not easily overcome and that the burden on the defendant is a heavy one. *See, e.g.*, State v. Soricelli, 156 N.J. 525, 533-34 (1999); State v. Libra, 357 N.J. Super. 500, 508-10 (App. Div. 2003).

## Insurance Fraud Statute

On June 3, 2003, the State of New Jersey came full circle in its legislative retort to insurance fraud activity with the enactment of the comprehensive Insurance Fraud statute.[84] Conceived as a complement to Health Care Claims Fraud and Criminal Use of Runners, but much broader in scope, Insurance Fraud[85] imposes harsh criminal penalties for fraudulent conduct, in all its various forms, committed against not only private insurance carriers but self insurers, health maintenance organizations (HMOs), and government-sponsored insurance plans as well.[86]

Analogous to the Health Care Claims Fraud statute upon which it was patterned, Insurance Fraud substantially increases the criminal penalties for fraud relating to any insurance claim while significantly reducing the threshold monetary amount whereby an offender becomes subject upon conviction to a State prison sentence. Indeed, any person who knowingly

84 N.J.S.A. 2C:21-4.4, *et seq.* The full text of the Legislative Findings, codified at N.J.S.A. 2C:21-4.4, reveals the seriousness with which the Legislature views this activity: ***a.*** Insurance fraud is inimical to public safety, welfare and order within the State of New Jersey. Insurance fraud is pervasive and expensive, costing consumers and businesses millions of dollars in direct and indirect losses each year. Insurance fraud increases insurance premiums, to the detriment of individual policy holders, small businesses, large corporations and governmental entities. All New Jerseyans ultimately bear the societal burdens and costs caused by those who commit insurance fraud. ***b.*** The problem of insurance fraud must be confronted aggressively by facilitating the detection, investigation and prosecution of such misconduct, as well as by reducing its occurrence and achieving deterrence through the implementation of measures that more precisely target specific conduct constituting insurance fraud. ***c.*** To enable more efficient prosecution of criminally culpable persons who knowingly commit or assist or conspire with others in committing fraud against insurance companies, it is necessary to establish a crime of "insurance fraud" to directly and comprehensively criminalize this type of harmful conduct, with substantial criminal penalties to punish wrongdoers and to appropriately deter others from such illicit activity. ***d.*** In addition to criminal penalties, in order to maintain the public trust and ensure the integrity of professional licensees and certificate-holders who by virtue of their professions are involved in insurance transactions, it is appropriate to provide civil remedial provisions governing license or certificate forfeiture and suspension tailored to this new crime of insurance fraud and other criminal insurance-related activities. ***e.*** To enhance the State's ability to detect insurance fraud, which will lead to more productive investigations and, ultimately, more successful criminal prosecutions, it is appropriate to provide members of the public with significant incentives to come forward when they may have reasonable suspicions or knowledge of a person or persons committing insurance fraud. The establishment of an Insurance Fraud Detection Reward Program will enable the Insurance Fraud Prosecutor to obtain information which may lead to the arrest, prosecution and conviction of persons or entities who have committed insurance-related fraud. 85 Similar to Health Care Claims Fraud, a person commits Insurance Fraud: [I]f that person knowingly makes, or causes to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omits a material fact from, or causes a material fact to be omitted from, any record, bill, claim or other document, in writing, electronically, orally or in any other form, that a person attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted as part of, in support of or opposition to or in connection with: (1) a claim for payment, reimbursement or other benefit pursuant to an insurance policy, or from an insurance company or the "Unsatisfied Claim and Judgment Fund Law," P.L.1952, c. 174 (C.39:6-61 *et seq*.); (2) an application to obtain or renew an insurance policy; (3) any payment made or to be made in accordance with the terms of an insurance policy or premium finance transaction; or (4) an affidavit, certification, record or other document used in any insurance or premium finance transaction.N.J.S.A. 2C:21-4.6(a). 86 "Insurance company" is broadly defined as: any person, company, corporation, unincorporated association, partnership, professional corporation, agency of government and any other entity authorized or permitted to do business in New Jersey, subject to regulation by the State, or incorporated or organized under the laws of any other state of the United States or of any foreign nation or of any province or territory thereof, to indemnify another against loss, damage, risk or liability arising from a contingent or unknown event. "Insurance company" includes, but is not limited to, an insurance company as that term is defined in section 3 of P.L.1983, c. 320 (C.17:33A-3), self-insurer, re-insurer, reciprocal exchange, inter-insurer, hospital, medical or health service corporation, health maintenance organization, surety, assigned risk plan, joint insurance fund, and any other entity legally engaged in the business of insurance as authorized or permitted by the State of New Jersey, including but not limited to any such entity incorporated or organized under the laws of any other state of the United States or of any foreign nation or of any province or territory thereof. N.J.S.A. 2C:21-4.5. This definition is much broader than the definition of "insurance company" found in the Insurance Fraud Prevention Act, *supra*, which does not presently include HMOs, self-insurers, or government-sponsored insurance plans. *See* N.J.S.A. 17:33A-3.

commits *five or more acts* of Insurance Fraud, and who thereby obtains or seeks to obtain *in excess of $1,000*, is guilty of a crime of the second degree.[87] Otherwise, the knowing commission of Insurance Fraud is a crime of the third degree.[88]

Insurance Fraud shares other similarities to Health Care Claims Fraud. As in Health Care Claims Fraud, each "act" of Insurance Fraud constitutes a separate and distinct offense.[89] And, like that statute and the civil Act, multiple misrepresentations or omissions contained in even a *single document* will constitute separate "acts" of Insurance Fraud.[90] Moreover, the trier of fact may infer that a person has read and reviewed any claim document containing that person's initials or signature.[91]

There, however, the similarities end. While Health Care Claims Fraud specifically applies to fraudulent health care claims and medical-related insurance claims, Insurance Fraud has applicability across *the whole spectrum* of insurance-related fraud. Indeed, among other types of fraud now subject to the criminal penalties of the statute are application fraud,[92] including automobile rate evasion or reverse rate evasion[93] and workers' compensation insurance premium fraud,[94] [95] other frauds historically addressed as civil violations of the Act, and insurance premium financing transactions.[96]

## Restitution

Obtaining restitution on behalf of victims of insurance fraud is a central objective and recurrent theme in New Jersey's statutes enacted to address the insurance fraud epidemic. Indeed, disgorging insurance cheats of their ill-gotten gains is a "major priority" for OIFP in both criminal *and* civil actions.[97] To that end, OIFP conducts comprehensive investigations not only to develop evidence to support criminal prosecutions and civil litigation but also to identify and locate the money stolen from insurance companies and other victims of insurance fraud. However, the ability to obtain restitution at

*New Jersey Division of Criminal Justice Director Vaughn McKoy addresses insurance professionals at the Seventh Annual Insurance Fraud Summit.*

87 N.J.S.A. 2C:21-4.6(b). 88 Ibid. 89 Ibid. "Acts" of Insurance Fraud may include "acts" of Health Care Claims Fraud. 90 Ibid. 91 N.J.S.A. 2C:21-4.6(c). 92 N.J.S.A. 2C:21-4.6(a)(2). Application fraud consists of the submission of false or misleading insurance applications to obtain insurance coverage for persons not entitled to same, or at a lower premium rate. Examples include automobile insurance applications (*e.g.*, failing to report poor driving history, misrepresenting principal driver, or misrepresenting location where vehicle is principally garaged), and employer-sponsored group health insurance applications (*e.g.*, a small business falsely listing persons as employees to obtain a lower group premium rate). 93 Rate evasion and reverse rate evasion occur where an insured misrepresents the state (or region of the state) in which he resides, or misrepresents the state (or region of the state) in which his automobile is principally garaged (e.g., in a suburban or rural area rather than an urban area) in order to obtain a lower automobile insurance premium rate. 94 These matters may include the submission of a workers' compensation insurance application misrepresenting the number of employees or the type of work done by the employees, or failing to disclose a past workers' compensation claims history, or failing to disclose the cancellation of prior workers' compensation insurance policies for non-payment of premium, all for the purpose of obtaining lower insurance premiums. 95 *See also* N.J.S.A. 34:15-57.4 (proscribing the submission of false statements or misrepresentations in connection with a workers' compensation application) and N.J.S.A. 34:15-79 (penalizing the failure to provide workers' compensation insurance). 96 N.J.S.A. 2C:21-4.6(a)(3) and (4). Insurance premium financing is common in commercial settings. Frequently, insurance carriers require commercial insurance coverage be paid in full at the time the coverage is bound. However, many smaller business owners do not have the cash on hand and require a loan from a premium financing institution to obtain the coverage. In most cases, insurance agents or brokers arrange for premium financing for those commercial clients, with the broker receiving the financing monies from the lender, to be remitted to the insurance carrier. Typical examples of fraud in insurance premium financing situations include the outright theft by an insurance broker (as the fiduciary of the client) of the financing monies received from a lender, failure of the broker to remit to the client unearned premiums (*e.g.*, where a policy is cancelled or coverage is deleted), and "double dipping" (where the broker applies for premium financing with two or more lenders for the same policies, apparently on behalf of the client, retaining for himself the proceeds of the additional loan). 97 N.J.S.A. 17:33A-26. *See also* N.J.S.A. 17:33A-2; N.J.S.A. 17:33A-5(a) and (b).

the conclusion of criminal cases is sometimes hampered by several practical and legal factors.

For restitution to be imposed at the conclusion of a criminal case, the State must establish both that the victim suffered a loss[98] and that the defendant has the ability to pay.[99] [100] In making the "ability to pay" determination, the sentencing court must consider all financial resources of the defendant, including probable future earnings.[101] In establishing the amount of restitution, the Court's goal is not to make the victim whole (although that may be accomplished) but, rather, to "provide the victim with the fullest compensation for loss that is *consistent with the defendant's ability to pay.*"[102] Therefore, both statutorily and by judicial decision, the imposition of restitution in criminal insurance fraud cases is presently limited by the defendant's ability to pay.

There are other limitations to the imposition of restitution. While many investigations of less complex insurance fraud matters are successful in determining the exact amount of the insurance company's loss,[103] in other, more complex cases, the amount of the insurance company's actual loss is much less apparent, and the ability to recover restitution in an amount approaching the total loss is much less certain. For example, in claims involving automobile accidents later proven to be fictitious or staged, the costs of health care services rendered to patients allegedly injured in those accidents will be billed by health care providers to the driver's automobile Personal Injury Protection (PIP) insurance carrier, notwithstanding that the alleged injuries are non-existent. In those cases, absent an undercover law enforcement investigation that infiltrates a corrupt medical office, or cooperation of medical office personnel, it is extremely difficult to obtain compelling evidence that a health care provider submitted PIP claims *knowing* the accident was staged or otherwise fictitious and, therefore, the claimant "patients" were not injured.[104] [105] Accordingly, unless sufficient proofs can be developed to charge the deep-pocketed health care provider and/or lawyer for complicity in the fraud, including some evidence that some medical services were billed but not rendered, the PIP carrier will not likely recover those costs as criminal restitution, even though considered a "loss" by the carrier. Inasmuch as the imposition of restitution in criminal insurance fraud cases is limited by both the defendant's ability to pay and by practical limitations related to the available proof of knowing conduct on the part of health care providers and others, additional avenues to obtain restitution should be considered.[106]

98 For purposes of establishing restitution or imposing fines, the New Jersey Criminal Code defines "loss" as: the amount of value separated from the victim or the amount of any payment owed to the victim and avoided or evaded and includes any reasonable and necessary expense incurred by the owner in recovering or replacing lost, stolen or damaged property, or recovering any payment avoided or evaded, and, with respect to property of a research facility, includes the cost of repeating an interrupted or invalidated experiment or loss of profits. N.J.S.A. 2C:43-3(e). 99 N.J.S.A. 2C:44-2(b). Upon such a showing, the Court "shall" impose restitution as a condition of the sentence. Ibid. This sometimes requires law enforcement to conduct a complex financial investigation to locate money and assets in addition to obtaining evidence of the underlying fraud. Sometimes such investigations are not feasible or practical. 100 *See* State v. McLaughlin, 310 N.J. Super. 242, 263-65 (App. Div.), *certif. den.*, 156 N.J. 381 (1998) (where court affirmed conviction and ten-year prison sentence for insurance fraud-related theft but vacated restitution imposed in amount of $271,305 and remanded matter to trial court for hearing to establish the defendant's ability to pay). 101 N.J.S.A. 2C:44-2(c)(2). Information regarding the defendant's financial resources, among other information, is provided to the Court in the pre-sentence report prepared by the Probation Department. N.J.S.A. 2C:44-6(b). However, due to manpower constraints of the Probation Department preventing a thorough analysis of the defendant's financial resources, the financial complexities of many insurance fraud cases and the seemingly countless methods by which white collar criminal defendants attempt to hide assets, the sentencing court will often have an incomplete picture of the defendant's true "ability to pay." In some cases, law enforcement will conduct a financial investigation in addition to, or as part of, the investigation to prove fraud. Financial investigations are complex, time consuming, and resource intensive. 102 Ibid. (emphasis added). In no case will the amount of restitution exceed the victim's loss. N.J.S.A. 2C:43-3(h). 103 This is true most often in single incident insurance fraud claim cases. Examples include (1) property loss claims which are inflated or "padded" through fraudulent receipts used to establish the amount of the loss, and (2) owner-initiated automobile "give-up" cases where an automobile insured "gives-up" his automobile to another to be chopped up, re-tagged (changing the Vehicle Identification Number, or VIN) and sold, or otherwise concealed so that a fraudulent automobile theft claim can be submitted to the automobile insurance carrier. In these cases, the amount of the insurance carrier's loss is likely to be a sum certain. 104 Likewise, it is extremely rare to obtain evidence that a lawyer has represented an alleged motor vehicle accident victim in a lawsuit for non-economic losses *knowing* the accident was staged and, therefore, that the claimant was not really injured. 105 This is different than the corollary issue of "medical necessity" of the diagnostic tests and treatments provided to the patient. The issue of "medical necessity" is frequently a matter of subjective medical opinion and is a challenging issue to prove as fraud beyond a reasonable doubt in a criminal case, or even by a preponderance of the evidence in a civil case. 106 Obtaining restitution through a civil case, where the burden of proof is lower and the rules of evidence are not as stringent, may be advisable for some of these cases.

*OIFP attorneys update investigators on insurance fraud law. (l. to r.) John J. Smith, AAG; Steven Farman, DAG; John Krayniak, SDAG; Melaine B. Campbell, SDAG.*

Additionally, in more complex insurance fraud matters (including, for example, a corrupt medical provider who regularly submits fraudulent or fictitious health care claims), the prosecutor is confronted with practical considerations that may impact the amount of restitution ultimately available following a successful criminal trial. Those considerations, including the presentation of a streamlined prosecution to allow for a clearer, more manageable case to the jury (and because the defendant would not be exposed to any greater criminal penalties were all claims successfully prosecuted) and the availability of witnesses or of other corroborating evidence, may compel the prosecutor to seek a limited number of charges against the defendant even though the investigation may have yielded evidence of hundreds of fraudulent claims. In such a case, the restitution amount available to the insurance carrier following a trial conviction is limited to the amount of loss alleged in the charges proven beyond a reasonable doubt, notwithstanding that the actual loss sustained by the insurance carrier from the fraud was greater.

Moreover, not all expenses incurred by insurance carriers are presently considered to be directly related to the fraud and, therefore, recoverable in a criminal proceeding as restitution. Indeed, at least one New Jersey trial court has held that the costs of an insurance carrier's investigation, including attorneys' fees incurred during the investigation, are not permitted to be included in the criminal restitution order since they are analogous to the recovery of the costs of prosecution by the State which costs are not permitted as part of restitution.[107] These costs may, however, be recovered in a civil action brought pursuant to the Act.[108]

Since recovery of restitution for insurance companies is a high priority, it is frequently negotiated by prosecutors when a defendant agrees to plead guilty before trial. In those cases, in return for other sentencing considerations, including the prosecutor's agreement to seek a shorter sentence of imprisonment, the prosecutor may require the defendant to agree to pay a greater amount of restitution than would be available following a conviction at trial.[109] Furthermore, in the case of a negotiated plea, the prosecutor may also obtain restitution on charges that are dismissed pursuant to the plea, provided a factual basis admitting guilt is given by the defendant and the victim's loss and the defendant's "ability to pay" are otherwise established.[110] In those cases, therefore, the amount of restitution will better approximate the total amount of the victim's loss.[111]

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107 State v. Robin Ellison, Indictment #I-2202-05-0697 (Law Div. May 23, 2003); *See also* State v. Topping 248 N.J. Super 86 (1991). 108 *See* N.J.S.A. 17:33A-7(a). 109 *See* State v. Corpi, 297 N.J. Super. 86 (App. Div.), *certif. den.*, 149 N.J. 407 (1997). 110 *See* State v. Bausch, 83 N.J. 425, 435-36 (1980); State v. Krueger, 241 N.J.Super. 244, 253-54 (App. Div. 1990). 111 OIFP has made innovative use of N.J.S.A. 2C:20-21 to enjoin defendants from dissipating stolen insurance claims money. This statute allows the State to obtain an injunction which has the effect of "freezing" bank accounts and other assets into which stolen claims money can be traced. Similarly, OIFP, in conjunction with the Civil Forfeiture Unit within the Division of Criminal Justice, has utilized the Civil Forfeiture statute, N.J.S.A. 2C:64-1 *et seq.* to obtain restitution for insurance company victims.

# OIFP Takes on One of State's Largest Racketeering Rings

# OIFP Takes On One of State's Largest Racketeering Rings

by Melaine B. Campbell

OIFP achieved a significant victory in 2004 by dismantling a major staged accident fraud ring. When a jury returned guilty verdicts for racketeering, conspiracy, Health Care Claims Fraud, and related charges in State v. Anhuar Bandy, et al., the saga of OIFP's prosecution of Anhuar Bandy and his racketeers came to a successful close. New Jersey Attorney General Peter C. Harvey announced: "These convictions represent the dismantling of one of the largest phony accident rings in the history of the State. Aside from stealing money from insurance companies, thereby contributing to higher auto insurance rates, these criminals put at risk the lives and safety of New Jersey's drivers."

Anhuar Bandy and Elvin Castillo masterminded and orchestrated a massive staged accident ring in order to funnel accident participants as patients through several Bandy-owned or operated chiropractic clinics. The clinics were the Elizabeth Injury Center in Elizabeth, the Amboy Injury Center in Perth Amboy, Prospect Spinal Trauma Center in Newark, Plainfield Injury Center in Plainfield, and the Golden Medical Center in Elizabeth. The clinics ceased operations following the OIFP investigation.

The extensive OIFP investigation included physical and electronic surveillance of the targets; undercover penetration of the staged accident ring; execution of search and arrest warrants; a detailed review of thousands of insurance, patient, business, and financial records; and interviews of witnesses. Law enforcement officers on the federal, state, county, and local levels participated in the investigation that ultimately uncovered evidence of numerous staged accidents and the submission of fraudulent insurance claims exceeding $2 million.

## An Anonymous Tip Opens the Door

The Governor's Office received an anonymous tip by letter. The letter's author claimed several chiropractic clinics located throughout the State were involved in a large-scale staged accident ring and were submitting false automobile insurance claims and Personal Injury Protection (PIP) claims to insurance companies. Simultaneously, New Jersey-based insurance carriers began investigating suspicious accidents in the Perth Amboy area and cooperating with the Insurance Fraud Division (IFD), OIFP's predecessor, in the Department of Banking and Insurance.

Following the creation of OIFP, State Investigator Ciro Sebasco, experienced in complex insurance fraud cases, led the ensuing criminal investigation. The office manager for the Elizabeth Injury Center operated by Bandy began to cooperate with OIFP. Later, OIFP placed an undercover of-

ficer in the Elizabeth Injury Center to gather evidence concerning the staged accident ring. The undercover officer obtained valuable information concerning suspected staged accidents while working in the clinic.

To bring an end to the danger defendants presented to the motoring public by staging accidents in the public thoroughfares of New Jersey, OIFP infiltrated the ring with undercover operatives. OIFP also proactively minimized the effects of threats and intimidation directed at witnesses by the

**Jury convicts pair in phony accidents**

racketeers. Through the use of informants, undercover OIFP investigators were introduced to Bandy's racketeers, Alejandro Ventura, a/k/a Alex, a "runner" operating out of the Elizabeth Injury Center, and Victor Almonte, a/k/a Bacana. OIFP subsequently participated in three staged accidents with the racketeers. These accidents occurred in Linden, Edison, and Union Township, New Jersey. A fourth accident was staged directly with the OIFP investigators by Bandy.

Based upon the information developed from the investigation, including OIFP's direct monitoring of staged accidents by the targets, OIFP conducted court-authorized interceptions of wire and electronic communications utilized by Bandy and his co-conspirators. The conspirators utilized telephones, including "cloned" cell phones and electronic paging devices, to arrange staged accidents and to maintain contact with each other. Conspirators utilized the stolen cell phone numbers as disposable commodities in an effort to avoid detection by law enforcement. Hundreds of conversations were captured on the interceptions and translated.

OIFP, along with federal, state, county, and local law enforcement agencies, executed search and arrest warrants that generated volumes of evidence concerning the staged accident ring. Documentary evidence included patient files, billing records, check registers, corporate documents, disbursement journals, and tax

*OIFP Deputy Attorneys General Walter Krako and Marysol Rosero, who tried State v. Bandy et al., question State Investigator Ciro Sebasco.*

records. OIFP analysts isolated the staged accidents and the Bandy "runners" responsible for each one. They also quantified the billings generated and payments made by insurance carriers for questionable collisions. OIFP analysts then prepared charts showing the dates and locations of staged accidents, the operators and passengers in the vehicle, the Bandy clinics utilized for treatment, the amounts billed and paid by the insurance carriers, and the dates claims were closed for each separate accident.

## OIFP Proves the Racketeering Case

A State Grand Jury returned ten indictments. Anhuar Bandy and Elvin Castillo were charged in one of the indictments with second degree conspiracy to commit racketeering, racketeering, conspiracy to commit Health Care Claims Fraud, theft by deception, and Health Care Claims Fraud, as well as third degree theft by deception. The State presented ample evidence that the chiropractic clinics in question were owned, operated, and controlled by Bandy, even though he was not licensed as a chiropractic physician. Moreover, the evidence established that Bandy headed the large-scale staged accident ring that operated out of his clinics. By staging accidents, the racketeers generated patients who were then referred to Bandy's clinics for treatment. False insurance claims were then filed for patients.

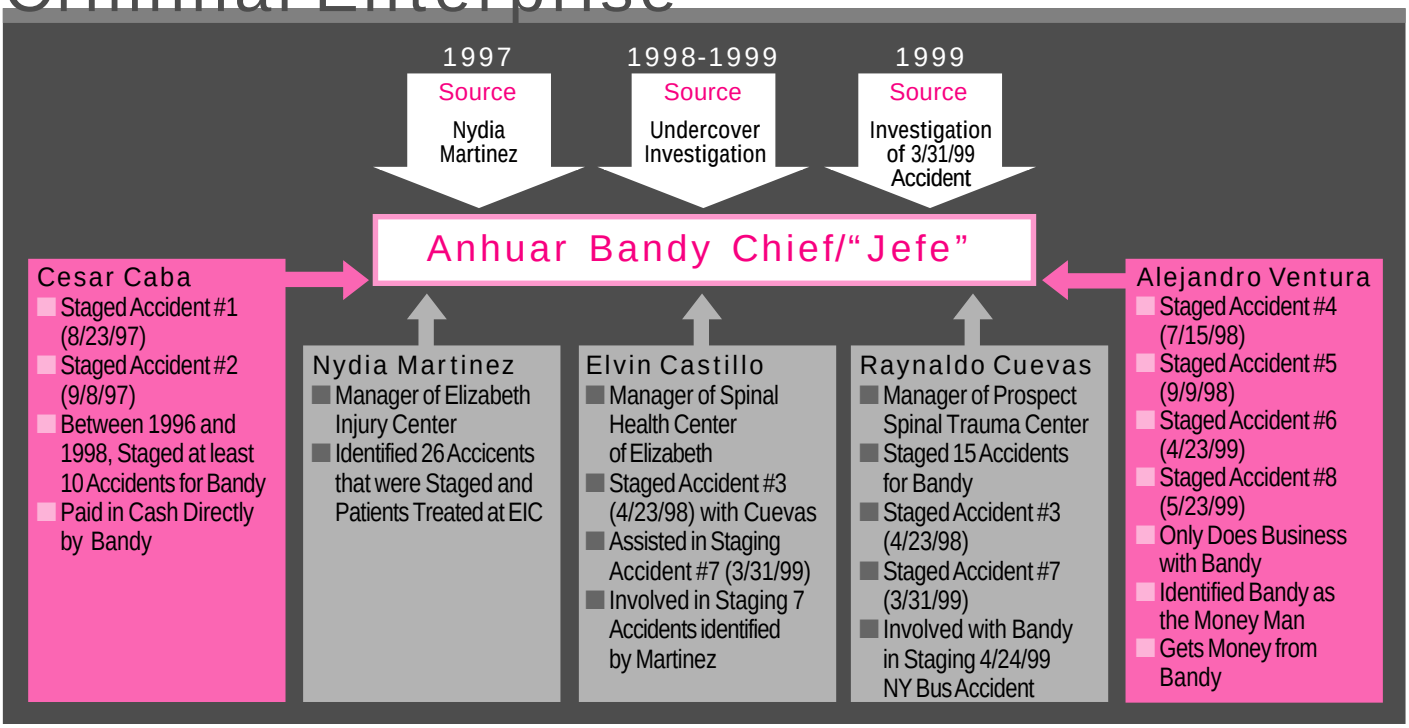
The State tried Bandy and Castillo in Union County. Following a six-week trial, the jury convicted both defendants on all the charges. Bandy was sentenced to 29 years and Castillo to 13 years in State prison. Twenty-five co-defendants entered into plea agreements with the State, some of them testifying as State's witnesses during the trial. Another co-defendant remains a fugitive.

*State Investigator Ciro Sebasco receives a Director's Award from NJ Division of Criminal Justice Director Vaughn McKoy for his work in the State v. Bandy et al. case.*

Division of Criminal Justice Director Vaughn McKoy noted: "This was the first time that the Office of Insurance Fraud Prosecutor brought racketeering charges against defendants in connection with a staged accident ring. These convictions represent a major milestone in our efforts to combat insurance fraud."

***Melaine B. Campbell*** *is a Supervising Deputy Attorney General and serves as a Special Assistant to the Insurance Fraud Prosecutor. She has been a prosecuting attorney for over 24 years, serving terms as an Assistant Prosecutor in Hunterdon County and Acting County Prosecutor in Somerset County.*

## Criminal Enterprise




## Staged Collision Summary

26 Staged Collisions
*From 2/25/95 Through 10/14/97*

*77 Patients Treated*

*Claims Submitted to Insurance Carriers*

| Insurance Company Company | Total Paid | Total Paid to Elizabeth Injury Center |
|---|---|---|
| Material Damage Adjustment | $228,286.27 | $73,144.27 |
| Allstate | $205,494.65 | $58,108.65 |
| Continental | $133,546.10 | $4,137.50 |
| National General | $76.322.17 | $22,060.79 |
| Prudential | $43,303.13 | $16,438.69 |
| Progressive Casualty | $36,712.28 | $18,620.29 |
| National Continental Progressive | $31,594.54 | $4,257.00 |
| Clarendon National | $22,001.45 | $7,937.20 |
| Ohio Casualty | $20,566.24 | $20,566.24 |
| Parkway | $18,114.00 | 9,179.80 |
| State Farm | $14,577.25 | $4,730.25 |
| Eagle | $9,894.21 | $4,572.03 |
| Wasau | $482.40 | $482.40 |
| Totals | $840,894.69 | $244,235.11 |

*Total Payments for the above claims that have been certified by the carriers*

# ABP
# Defendants Summary

| Racketeering Defendants | Sentence | Criminal Sanctions* and Restitution | Civil Consent Orders Issued |
|---|---|---|---|
| Anhuar Bandy | 29 Years State Prison | $100,155 Fines; Restitution $14,898 | $1,440,000 |
| Cesar Caba | 15 Years State Prison | $155 Fines | |
| Elvin Castillo | 19 Years State Prison | $50,775 Fines; Restitution $64,116 | $270,000 |
| Raynaldo Cuevas | 6 Years State Prison | $5,155 Fines; Restitution $6,474 | $10,000 |
| Victor Almonte (Bacana) | 5 Years State Prison | $155 Fines; Restitution $162 | $10,000 |
| **Other Defendants** | | | |
| Joel Cuevas | 9 Years State Prison | $155 Fines | $5,000 |
| Ramon Reyes | 3 Years Probation | $155 Fines | $5,000 |
| Angelita Guerrero | 3 Years Probation and 180 Days County Jail | $465 Fines | $5,000 |
| Ramon D. Arias | 3 Years Probation | $2,655 Fines | $5,000 |
| Dignorah A. Flores | 3 Years Probation | $2,155 Fines | $5,000 |
| Mohamed Attalla | 3 Years Probation | $155 Fines | $5,000 |
| Fernando Sanchez | 3 Years Probation and 220 Days County Jail | $155 Fines; Restitution $3,648 | $3,000 |
| Nydia Martinez | 3 Years Probation and 30 Days County Jail | $155 Fines | $2,500 |
| Josue Cespedes | 3 Years Probation and 6 Days County Jail | $155 Fines | $2,500 |
| Raudi Arias | 3 Years Probation | $2,655 Fines | $5,000 |
| Jessica Montalvo | 3 Years Probation | $155 Fines; Restitution $2,658 | $2,500 |
| Mayreni Guerrero | 3 Years Probation | $155 Fines; Restitution $2,000 | $5,000 |
| Samuel Alvarez a/k/a Samuel Ortega | 3 Years Probation | $655 Fines | $1,500 |
| Jacqueline Vasquez | 3 Years Probation | $155 Fines | $1,500 |
| Kenia D. Gonzalez | 3 Years Probation | $655 Fines | |
| Widania A. Montanez | 3 Years Probation | $155 Fines | $5,000 |
| Luis Henriquez-Uzeta | 2 Years Probation | $155 Fines | |
| Humberto Diaz | 1 Year Probation | $355 Fines; Restitution $5,859 | $5,000 |
| Juana D. Nunez** | 1 Year Pre-Trial Intervention Program | | $2,500 |
| Francisco Marcelino | 3 Years Pre-Trial Intervention Program | | $5,000 |
| Emily M. Nieves | 3 Years Pre-Trial Intervention Program | | $5,000 |
| Jose Rafeal Perez (Diego Ivan Torres) | 3 Years Pre-Trial Intervention Program | | |

* Criminal sanctions include criminal, VCCB, Safe Streets, and LEOTEF fines.

** Nunez was also sentenced to 60 hours of community service.

# $100 Million Scam Part of Growing Trend in Insurance Professional Fraud Uncovered by OIFP

# $100 Million Scam Part of Growing Trend in Insurance Professional Fraud Uncovered by OIFP

by Lewis Korngut

Vito Gruppuso stole over $100 million in the largest insurance fraud scheme ever prosecuted by the State of New Jersey. Gruppuso's case is indicative of a growing trend in insurance fraud scams being perpetrated by some licensed insurance/securities agents and some other licensed insurance professionals. Difficult economic times have intensified competition in the insurance industry and increased insurance rates. While most insurance professionals tighten their belts, others choose to defraud both insurance companies and unsuspecting individuals. Often, it's the promise of lucrative commissions and easy access to money that lures agents to fraudulent schemes.

## Insurance Agent Stole Over $100 Million

An investigation by the Office of the Insurance Fraud Prosecutor (OIFP) revealed Gruppuso's theft of more than $100 million. Gruppuso, a licensed insurance agent, was the owner and former president of National Program Services (NPS), an insurance brokerage servicing the commercial community.

Gruppuso pled guilty on January 30, 2004, and admitted that he failed to remit approximately $15.8 million of insurance premiums obtained from his insurance customers, primarily commercial businesses, to the Virginia Surety Insurance Company between May of 1998 and March of 2003. Gruppuso also admitted to stealing $6,320,055 from AIG Insurance Company, $3,746,524 from Wausau Insurance Company, and $4.9 million from XL Reinsurance Company as part of the scheme. Gruppuso used the money to finance his expensive lifestyle and his business ventures.

OIFP's investigation also revealed that Kemper Insurance Company, through a bonding company known as Universal Bonding Insurance Company (UBIC), suffered $48 million in losses as a result of fraud committed by Gruppuso. Gruppuso's premium loan finance company, United Premium Services (UPS), provided insurance premium finance loans. Allegedly, many of those fictitious loans defaulted because Gruppuso and another individual falsely placed the insurance risks with a commercial risk management plan known as AIMCO, which was created to provide insurance coverage for certain commercial real estate properties. Gruppuso wrongfully placed ineligible commercial insureds who sought insurance for only one year into the AIMCO risk management program for three years and, without the knowledge of those insured, falsely financed their insurance premiums through his premium financing business for three years. This scheme enabled Gruppuso to have easy access to vast sums of money intended only

# Ex-broker charged with stealing $300,000

to be used by those who needed to borrow money to finance insurance coverage. Eventually, AIMCO became aware of this aspect of Gruppuso's fraud and pulled out of the program. UBIC was called upon to reimburse lenders for more than $90 million representing premium finance loan money stolen through Gruppuso's company, UPS. Since UPS's premium finance loans were purportedly backed by Kemper Insurance in its capacity as a lender, through UBIC, Kemper was required to pay the defaulted loans.

## Insurance Broker Charged with Stealing Life Savings of Senior Citizen

A State Grand Jury has indicted former insurance broker and financial planner Michael Chamberlain with stealing nearly $300,000 from the retirement accounts of a 78-year-old senior citizen. Chamberlain, a licensed securities broker, is charged with theft by unlawful taking, misapplication of entrusted property, and forgery. The indictment alleges that Chamberlain systematically looted the victim's annuity accounts, invested the monies for his own benefit, and ultimately purchased a resort home valued at more than $400,000 in Florida. If convicted, Chamberlain faces possible prison time, a fine of up to $355,000, and the loss of his New Jersey securities license. He could also be ordered to pay restitution to the victim.

The alleged victim is a decorated WW II veteran who was shot down over the Philippines. In 2003, the senior was notified by the Internal Revenue Service that he owed more than $56,000 in back taxes from taxable withdrawals from his annuity accounts. When he contacted Chamberlain to inquire about the status of the accounts, the senior was allegedly told that the monies had been invested and stolen. As a result of the alleged fraud, the senior is without retirement funds, nearly penniless, and living in a room in a retirement home.

*Civil Investigator Bud Fifield and State Investigator Earl Washington document evidence obtained while executing a search warrant at the office of an insurance professional.*

## Insurance Company Claims Processing Specialist Convicted of $614,000 Theft

Linda Clements-Wright was convicted, following an eight-day trial, of conspiracy, theft by unlawful taking, and money laundering for stealing over $614,000 from Allstate Insurance Company while employed as a Claims Processing Specialist.

The jury found that Clements-Wright fraudulently issued more than


*Insurance Fraud Prosecutor Greta Gooden Brown announced charges against Michael Chamberlain for allegedly scamming more than $300,000 from a senior citizen. Senior investors were also given investment tips and were encouraged to report fraud to law enforcement authorities.*

150 insurance claim checks totaling over $614,000. The fraudulent checks were issued to at least 11 friends and relatives who were not entitled to the monies. OIFP presented evidence at trial that Clements-Wright had devised several schemes whereby unauthorized persons would receive and cash Allstate claim checks and then split the money. One scheme involved cashing claim checks payable to purported elderly Allstate claimants living in senior care facilities who were unable to directly receive the funds. Clements-Wright paid a ten percent commission to conspirators who cashed the claim checks; Clements-Wright kept the balance of the monies. In another scheme, Clements-Wright issued unauthorized insurance claim checks to purported claimants for unreported property damage claims. Six co-conspirators who cashed insurance claim checks for Clements-Wright in the schemes previously pled guilty to conspiracy charges.

## Agent Scammed Family and Friends

Camden County insurance provider Peter Clark is serving a three-year prison sentence for stealing more than $429,000 in a complex insurance fraud and investment scheme in which he convinced family and friends to invest in non-existent investments.

Clark, 36, pled guilty before Camden County Superior Court Judge Linda G. Baxter to crimes contained in a criminal Accusation that charged Clark with theft by failure to make required disposition of property received and theft by deception. The Court sentenced Clark on August 6, 2004, to three years in State prison and ordered him to pay $390,484 in restitution. Clark, as part of the sentence, also surrendered his insurance license to the Division of Banking and Insurance.

Clark was an independent insurance agent with contracts to write annuity and/or insurance policies for various insurance companies and brokers. Clark admitted he purchased several annuity policies for himself and family members between June 7, 2001, and October 28, 2003, in order to receive commissions for the sales. The personal checks he submitted to pay for premiums were returned for insufficient funds. OIFP's investigation determined that Clark fraudulently collected unauthorized commissions from the following insurance companies:

- American National Insurance Company: **$56,034**
- Allianz Life Insurance Company: **$36,125**
- Conseco Services LLC: **$38,500**
- American Equity Investment Life Insurance Company: **$9,400**
- American Investors Life: **$6,717**
- ING USA Annuity & Life Insurance Company: **$44,603**
- Midland National Life-Annuity Division: **$15,961**
- North American Company Life and Health Insurance: **$9,948**

Clark also admitted that from January 1, 1999, through December 31, 2000, he defrauded at least ten people, including his mother and other family members, by convincing them to invest a lump sum of money in phony investments that would pay the investor 12 percent annual interest. The investment accounts were non-existent. Clark used the monies for personal expenses. This case was referred to OIFP by Allianz Life Insurance Company of North America.

## Public Adjuster was Leader of "Arson-for-Profit" Ring

Marc Rossi operated the biggest "arson-for-profit" ring ever uncovered in Mercer County. OIFP successfully prosecuted all seven individuals who made up the ring. The leader of the ring was public adjuster Marc Rossi. Rossi, a former investigator with the Mercer County Prosecutor's Office, pled guilty to operating an "arson-for-profit" and insurance fraud scheme responsible for at least six burned buildings. The Court sentenced him to eight years in prison and ordered him to pay a total of $537,673 in restitution to six insurance companies.

Rossi owned and operated Rossi Adjustment Services, a Trenton-based insurance claims adjusting firm. Rossi planned the setting of fires to at least six buildings. In most cases, Rossi knew the owners of the buildings he

# $100 Million Scam Part of Growing Trend in Insurance Professional Fraud Uncovered by OIFP

## Investment Tips for Senior Investors

- Map out financial goals before meeting with a financial planner, broker, or investment advisor
- Know your investment professional
- Understand your investment
- Understand how a financial professional is making money by selling an investment
- Exercise caution when buying investments
- Understand your account statements
- Never be afraid to ask questions at any stage of the investment process

targeted for arson. While the fires were still raging, Rossi would appear at the scene to entice building owners to give their insurance claim adjusting business to Rossi over competing adjusters. Once hired, Rossi advocated for the property owner and attempted to receive the highest dollar amount from the insurance company. Rossi received a percentage of the settlement for his efforts.

As part of his guilty plea, Rossi admitted he purposely caused property damage to an apartment he owned in Bordentown to collect an insurance claim reimbursement. He also pled guilty to participating in a conspiracy to inflate costs and steal money from a construction project involving the East Windsor Police Athletic League. Rossi further pled guilty to offering a bribe to a member of a Hamilton Township volunteer fire company to obtain work for his insurance adjustment business.

One of the businesses that Rossi targeted for arson was the Country Barrel Inn, a historic Mercer County landmark located in Hamilton, New Jersey. The fire completely destroyed the building valued at over $350,000. Investigators suspected arson when they found a broken beer bottle with a wick sticking out of it and noticed pour patterns on the ground. Pour patterns generally indicate use of an accelerant which causes the fire to burn. When the Bureau of Alcohol, Tobacco, and Firearms offered a reward for tips, a caller gave investigators a list of names including Rossi's. The investigation ultimately led to all seven ring members.

One of the ring members, Michael Winberg of Levittown, Pennsylvania, pled guilty to second degree aggravated arson for setting the fire at the Country Barrel Inn. The Court sentenced Winberg to five years in State prison. Winberg was also a former licensed public insurance adjuster who had been employed by Rossi Adjustment Services. He had previously been convicted of theft related to his insurance business as a public adjuster. The Court sentenced Winberg on the theft charge to three years probation and ordered him to pay $15,337 in restitution.

***Lewis Korngut*** *is a Supervising Deputy Attorney General in charge of OIFP's Property and Casualty Section. He was a Mercer County Assistant Prosecutor where he tried capital cases including State v. Timmendequas.*


*OIFP receives the Outstanding Achievement in Arson Investigations Award from the International Association of Arson Investigators, Inc. for OIFP's prosecution of the State v. Rossi "arson for profit" ring. Pictured from left to right: Supervising Deputy Attorney General Lewis Korngut, Chief State Investigator Anne Kriegner, Insurance Fraud Prosecutor Greta Gooden Brown, State Investigator Robert Stemmer, Civil Investigator Joseph Salvatore, and NJ Division of Criminal Justice Director Vaughn McKoy.*

# Indicators of Financial Abuse Against the Elderly

- A recent acquaintance expresses an interest in finances, promises to provide care, or ingratiates him- or herself with the elder
- A relative or caregiver has no visible means of support and is overly interested in the elder's financial affairs
- A relative or caregiver expresses concern over the cost of caring for the elder, or is reluctant to spend money for needed medical care
- The utility and other bills are unpaid
- The elder's placement, care, or possessions are inconsistent with the size of his or her estate
- A relative or caregiver isolates the elder, makes excuses when friends or family call or visit, and does not give the elder messages
- A relative or caregiver gives implausible explanations about finances, and the elder is unaware of or unable to explain the arrangements
- Checking account and credit card statements are sent to a relative or caregiver and are not accessible to the elder
- At the bank, the elder is accompanied by a relative or caregiver who refuses to let the elder speak for him- or herself, and/or the elder appears nervous and afraid of the person
- The elder is concerned or confused about "missing" money
- There are suspicious signatures on the elder's checks, or the elder signs checks and another third party fills in the payee and amount
- There is an unusual amount of banking activity, particularly after joint accounts are set up or someone begins helping the elder with finances
- A will, power of attorney, or other legal document is drafted, but the elder does not understand the implications

# GlaxoSmithKline to Pay $2.1 Million to New Jersey's Medicaid Program

# GlaxoSmithKline to Pay $2.1 Million to NJ's Medicaid Program in National Settlement and $850,608 in State Settlement

by John Krayniak

New Jersey's Medicaid Program will receive more than $2.1 million as a result of a national settlement reached in 2004 that requires pharmaceutical giant GlaxoSmithKline to pay $87 million in damages and penalties to federal and state Medicaid programs. The Office of the Insurance Fraud Prosecutor's Medicaid Fraud Section separately negotiated an additional $850,608 to reimburse New Jersey's state-operated prescription drug programs. Using a national stage to also fight fraud locally showcases New Jersey's current ability to fight Medicaid fraud, which is in stark contrast to the first decade after Medicaid was created when the program operated with few controls against fraud.

Federal attorneys alleged in the national litigation that GlaxoSmithKline sold pharmaceutical products to privately-operated health management organizations (HMOs) at deeply discounted prices, concealed the transactions, and then underreported "best price" information to the Center for Medicaid and Medicare Services (CMS). This had the effect of artificially deflating the price of the pharmaceuticals and, therefore, diminished the amount of money the company was required to pay federal and state Medicaid programs — thus allegedly cheating the states out of significant funding for prescription drug programs.

In order to receive Medicaid reimbursement for drugs, pharmaceutical manufacturers enter into a contract under the Medicaid Drug Rebate Statute that requires the return of monies to state and federal Medicaid programs in the form of rebates. In order to calculate the amount of the rebate, pharmaceutical companies must provide "best price" information to CMS. "Best price" is the lowest price that a manufacturer offers a product for sale to commercial purchasers. As with Medicaid, state-sponsored programs require pharmaceutical manufacturers to follow "best price" rules in order to participate in state-funded pharmaceutical assistance programs. As a result of providing inaccurate "best price" information, GlaxoSmithKline allegedly effectively discounted the amount of rebate monies owed to New Jersey's two state-funded pharmaceutical assistance programs, Pharmaceutical Assistance to the Aged and Disabled (PAAD) and Senior Gold (SG).

GlaxoSmithKline avoided higher rebate payments by allegedly relabeling or repackaging certain drugs under private HMO labels. For example, under a private labeling agreement with California-based HMO Kaiser Permanente, GlaxoSmithKline allegedly manufactured, packed, and shipped Flonase to Kaiser, substituting Kaiser's identification number for the GlaxoSmithKline identification

# GlaxoSmithKline to Pay $2.1 Million to New Jersey's Medicaid Program

number. The result of the private labeling arrangement was allegedly to allow Kaiser additional price discounts on Flonase without having to report the discounted price asGlaxoSmithKline's "best price," thus allowing GlaxoSmithKline to avoid paying higher rebates to the state Medicaid programs. Similarly, GlaxoSmithKline allegedly provided Kaiser discount prices on Paxil without reporting the discounted price to CMS in order to avoid paying higher Medicaid rebates.

The state Medicaid programs collectively are one of the biggest purchasers of pharmaceutical products. Prescription drug expenditures are a significant portion of every state's Medicaid budget. The budget constraints felt by many states and the financial recoveries received through state participation in federal cases have caused many states to take a hard look at prescription drug costs. In state fiscal year 2004, the State of New Jersey spent $531,000,000 for PAAD and $19,500,000 for SG. These are significant programs whose costs are rising dramatically. Our Medicaid Fraud Control Unit (MFCU) has applied techniques successful in Medicaid investigations to PAAD and SG.

Since the inception of the Medicare-Medicaid anti-fraud and abuse legislation that established the state MFCUs, the MFCUs have successfully prosecuted over 9,000 corrupt medical providers and vendors — convictions that would not have occurred without this enabling legislation. The MFCUs police most of the nation's Medicaid expenditures with a combined staff of approximately 1,275 and a total federal budget of approximately $100,000,000. This amount represents a small fraction of the total Medicaid budget that the units are responsible for policing. MFCU size varies state by state and is dictated to some extent by the size of the state's Medicaid program. In New Jersey, the Medicaid budget is over $992,000,000 (fiscal year 2004), representing a significant portion of the State budget, and the MFCU has 36 full-time staff. New York is the largest MFCU with over 300 staff persons and Wyoming is the smallest with only four staff members.

Joint federal-state investigations that result in national settlements, such as the GlaxoSmithKline settlement, generally arise with the filing of a federal false claims action, also called a *qui tam* case. The Federal False Claims Act includes provisions that provide the authority and financial incentive to private individuals, called relators, to enforce the Act on behalf of the Federal Government. These relators, sometimes known as whistleblowers, are generally current or former employees of a health care provider and are protected from retaliatory actions by the Act. A *qui tam* complaint is filed under seal in Federal District Court and remains under seal for at least 60 days to allow the government time to conduct an adequate investigation. Often the 60-day period is extended, sometimes for years. The state MFCUs are notified that a *qui tam* has been filed and an investigation has commenced when the Department of Justice (DOJ) contacts the National Association of Medicaid Fraud Control Units (NAMFCU) and requests the assistance of the MFCUs. The NAMFCU president, with the assistance of counsel, appoints a negotiating team to work in conjunction with DOJ attorneys. Selection of team members is based on varying criteria, but includes experience, availability, and the extent to which a state's Medicaid program has been damaged. Each state team meets with federal attorneys and attempts to set a framework for negotiations. The issues generally are restitution, civil damages, exclusion or non-exclusion from the Medicaid and Medi-

care programs, as well as criminal charges. The teams consider the strength of the case and other factors in negotiating a settlement. These include the defendants' economic liability, whether a settlement would push them into bankruptcy, the impact it would have on innocent shareholders or employees, and the effect that exclusion of the provider from the Medicaid and Medicare programs would have on the programs' abilities to provide needed medical care to their beneficiaries. All settlements require the defendant to enter into a Corporate Integrity Agreement which sets forth specific conduct that the provider will or will not engage in.

All recoveries and damages are generally allocated based upon a state's actual damages. Participating MFCUs are asked to supply their states' specific Medicaid billing data. When the defendant's conduct has been long running, billing data is not easily obtainable and negotiations produce an agreed-upon extrapolation formula. State and federal attorneys bargain and negotiate for the best possible settlement for the government. Because the Federal Government subsidizes each state's Medicaid program in differing amounts, damages are allocated based on the funding formulas. When the government team feels it has negotiated its best settlement, the proposed settlement agreement and release is distributed to each MFCU. These are reviewed at the state level by the MFCU and the Medicaid agency. A critical element in reaching a settlement is to obtain the agreement of the Medicaid agency to not exclude the provider as a Medicaid provider or to refuse to place a manufacturer's drug on the state formulary. When appropriate, state agencies have agreed to the settlement and signed the agreement. The signed agreement is then returned to the NAMFCU team. Authorized representatives of the defendant execute the agreement and transfer the agreed-upon amount of money to a designated escrow account. The money is then distributed to the Federal Government and then to each individual state.

All MFCUs are members of the NAMFCU, which is based in Washington, D.C. NAMFCU employs a full-time counsel and paralegal and, because the majority of the units are in state Attorneys General Offices, shares office space and works very closely with the National Association of Attorneys General (NAAG). Since 1994, NAMFCU members have worked closely with DOJ in investigating, prosecuting, and negotiating settlements with providers whose business is national in scope and affects the Medicare, Medicaid, and other health care programs.

Cooperative efforts between state and federal authorities are effective in protecting Medicaid and Medicare from health care providers or vendors whose unscrupulous activities involve both programs and cross state lines. All participants in these cases recognize that while there is one Medicare program, there are essentially 50 Medicaid programs. A coordinating point is necessary because settlement of these cases would be impossible if defendants sought to obtain settlements from individual states and negotiate separate terms with each state. NAMFCU provides the coordination nationally, allowing New Jersey's MFCU to also focus on effecting remedies for state-funded programs.

***John Krayniak*** *is a 17 year veteran of the Division of Criminal Justice and has been the Supervising Deputy Attorney General of OIFP's Medicaid Fraud Section for 11 years. He previously served for eight years as a Deputy District Attorney in the Los Angeles County District Attorney's Office.*

# Best Practices Guide for Insurance Company Referrals to OIFP

*Joseph Scrimo, Special Investigations Manager, Allstate New Jersey, accepts OIFP's Second Annual Excellence in Investigation Award from Insurance Fraud Prosecutor Greta Gooden Brown at the Seventh Annual Insurance Fraud Summit.*

# Best Practices Guide for Insurance Company Referrals to OIFP

by Scott Patterson and John J. Smith

The Insurance Fraud Prevention Act requires insurance companies to report suspicious insurance fraud claims to OIFP. Insurance company Special Investigation Units (SIUs) should ensure that their referrals result in an OIFP investigation. What are the keys to a successful referral?

## Identify the Lies

Conduct which forms the basis of criminal and civil insurance fraud, in most cases, involves presenting or causing to be presented any written or oral false statement in support of an insurance application for coverage, an insurance claim for money, or an insurance benefit pursuant to an insurance policy. The most commonly prosecuted insurance fraud crimes require the identification of specific false statements or omissions made by criminal defendants during the course of submitting insurance policy applications and claims. Therefore, it is important for insurance company SIUs to identify false statements or omissions submitted to their insurance companies in connection with insurance applications or claims. The key to a successful referral lies in the ability of the insurance company and law enforcement to identify the false statements submitted to the insurance company.

All insurance fraud investigations must begin with the insurance company's underwriters and claims examiners and continue with the SIU. It is important for insurance company personnel to carefully review the applications and claims records, identify false statements or omissions, and assist law enforcement with the development of creative investigative strategies to prove the statements are false and were submitted to steal insurance coverage or claims money. Insurance companies' underwriting, claims, and SIU personnel are trained to review insurance applications and claims and, therefore, are uniquely poised to identify the false statements and omissions which the insurance company relies upon in deciding whether to extend coverage or pay a claim. False statements or omissions frequently are difficult for law enforcement to identify because not only are they buried in large volumes of claims documents, affidavits, insurance carrier adjuster notes, examinations under oath, medical records, recorded statements, and other documents, but also because law enforcement is not sufficiently familiar with the specific information carrier underwriters and claims personnel consider critical when extending coverage or paying claims. Both insurance companies and law enforcement investigators must painstakingly review each and every document contained in the insurance companies' files to identify potential misrepresentations, false statements, and omissions.



For example, insurance company personnel have greater expertise than law enforcement in the interpretation of, or application of, CPT Codes to particular medical diagnostic tests, treatment, and procedures in connection with the adjustment of medical insurance claims and in connection with the adjustment of auto insurance Personal Injury Protection (PIP) claims. Referrals to law enforcement by insurance companies regarding service providers who are suspected of misusing a CPT Code must include identifying the CPT Code(s) in dispute, identifying all claims in which that code was misused by the provider, identifying the amount of money the provider billed through misuse of the CPT Code, and the amount paid by the insurance company. The insurance company should also explain why each claim was paid or settled. The referral should explain the insurance company's reason for concluding the use of the CPT Code is fraudulent and include an expert's report if necessary to clarify the facts. If the medical provider's claims violate State health care licensing regulations or other regulations, such as fee schedules promulgated in connection with the No-Fault insurance law, then insurance companies should so advise law enforcement.

## Gathering and Obtaining Evidence

After identifying the false statements and omissions, it is important for insurance company personnel to gather and obtain all of the evidence in the possession, custody, and control of the insurance carrier to prove that the statements are false. Insurance companies should identify the corroborating proof which was obtained during the detailed underwriting or claims review processes or through the SIU investigation.
After the insurance company gathers and obtains all of the information in its possession in connection with the referral, OIFP can utilize its powerful investigative tools, such as search warrants, electronic surveillance, subpoenas (both civil and criminal), Court Orders authorizing seizure of assets, and arrests, to gather all of the additional evidence necessary to prove both civil and criminal cases in court.

For example, medical service providers may be criminally charged when they bill for diagnostic tests and medical services which they have not rendered, among other conduct. These cases are aggressively investigated and prosecuted, particularly when the referral reflects a pattern of fraudulent conduct which can be corroborated by the provider's employees and by patient testimony. A good referral for this type of case includes:

- evidence of fraudulent billings, i.e. the claims forms and claims payment information;
- any patient interviews that attest to the fact that services were not provided (law enforcement can and will obtain additional patient interviews as part of its field investigation following carrier referral);
- any sworn statements from the provider's employees and/or former employees attesting to the fact that this was part of the provider's billing practice (experience teaches that often former employees report the improper billing practices).

Other kinds of insurance fraud cases require referrals that include different information and require a different investigative focus. For example, the criminal investigation of PIP rings, involving automobile accidents staged by "runners" and claimants to obtain PIP payments and bodily injury settlements for non-economic losses, present complex challenges for law enforcement. These cases require careful analysis by insurance company personnel of the interpretation

*New Jersey Attorney General Peter C. Harvey welcomes Seventh Annual Insurance Fraud Summit Keynote Speaker Anthony Dixon, President and CEO of New Jersey Manufacturers Insurance Company.*

and application of CPT Codes for medical diagnostic tests and treatments rendered to the claimants, as well as complex field investigations conducted by law enforcement which target the claimants who participate in a suspect accident and the involvement of "runners," medical service providers, and sometimes corrupt police officers and lawyers.

The investigation of staged accident rings is frequently best begun with a review of the police report to determine whether the accident actually occurred. Insurance company personnel should consider "walk-in" police reports by claimants, which by definition do not include a police officer as witness, as particularly suspect. No auto PIP fraud matter should be referred to OIFP unless insurance company personnel first obtain and analyze the police reports. Insurance company personnel should be aware that some of OIFP's criminal and civil prosecutions have included police reports which were wholly fictitious or obtained as a result of bribes paid to the police officer in order to support an automobile insurance claim.

Insurance companies should identify the claimants and any evidence which suggests the participation of "runners." If during Examinations Under Oath (EUOs) or depositions, claimants have not been confronted with inconsistencies surrounding the alleged occurrence of the accident and their medical treatment records, carrier personnel should specifically include this information in the referral so that law enforcement can question such inconsistencies in the course of the field investigation. Law enforcement has successfully located and confronted the claimants in order to obtain admissions and confessions which constitute powerful evidence in court.

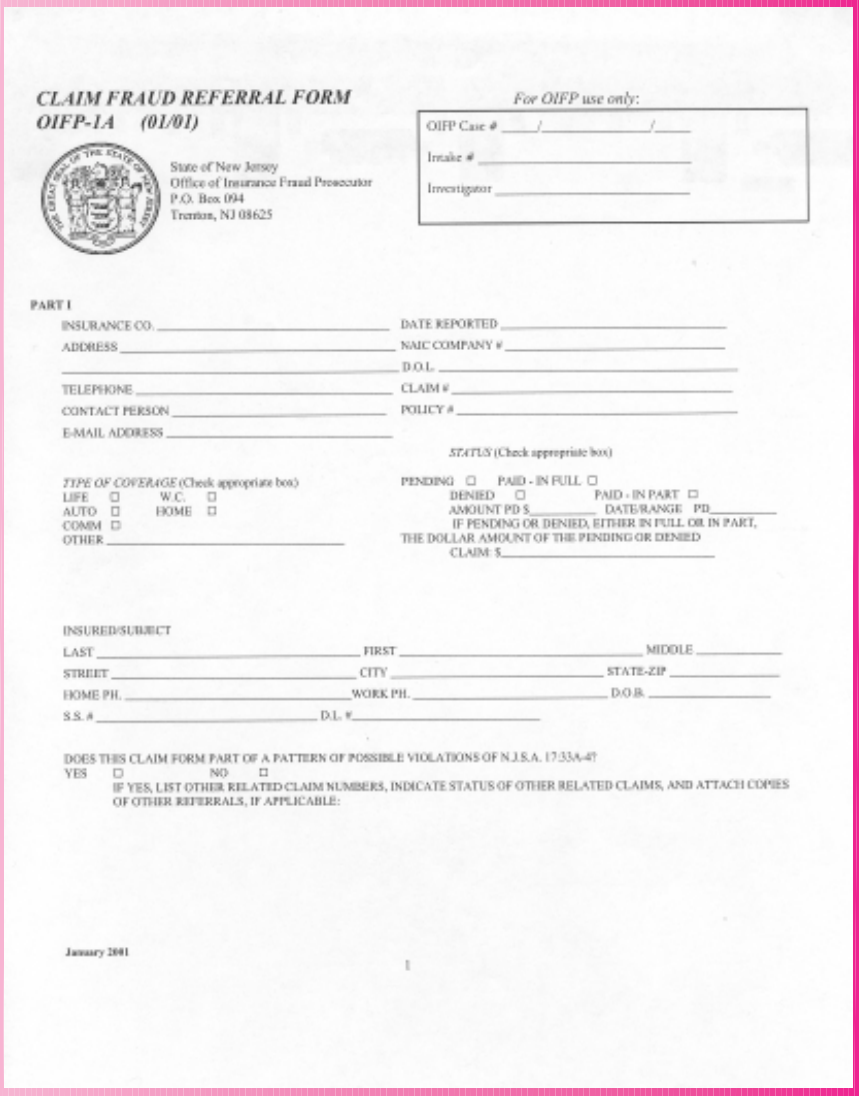
The SIU investigation should include efforts to determine whether the claimants attended all of the medical treatments billed and whether the providers billed for tests and treatments not rendered to the claimants.

The more difficult issue of whether the diagnostic tests and treatments provided to the PIP claimant were "medically necessary" is frequently a matter of subjective medical opinion and is the most challenging issue for OIFP to prove as fraud. In all such cases involving medical service providers, it is advisable for the insurance carrier to have an expert review the diagnostic tests and medical protocols employed by the suspect medical service provider and render a report. The expert's report should be included as part of the referral to OIFP.

Although the ensuing field investigation conducted by law enforcement will always attempt to obtain evidence that the medical service provider submitted insurance PIP claims knowing the accident was staged and the claimant was not injured, such evidence has frequently proved to be difficult to obtain. As a result, insurance carrier personnel and law enforcement should first focus on whether the medical service provider submitted claims for tests and treatments not rendered and also seek evidence or any investigative leads which will prove that the medical service provider knew the accident was staged and the purported patients not injured.

## Communicate the Fraud Theory and Evidence

It is important that the insurance company referral combine the information obtained through its investigation of the alleged fraud with the reasons it believes the fraud occurred (i.e. the fraud theory) and effectively communicate all of this information as well as any investigative leads to law enforcement. The OIFP referral forms were designed to promote effective communication by requiring insurance carriers to focus on the specific omissions or false statements found in the investigation. The forms enable the insurance company to identify the false statements or omissions and the corroborating proofs or investigative leads it obtained during its investigation and present that information clearly. Careful utilization of these referral forms by insurance company personnel will provide law enforcement with clear investigative leads to develop evidence during field investigations to sustain the cases in court.



CLAIM FRAUD REFERRAL FORM
OIFP-1A (01/01)

For OIFP use only:
OIFP Case # ____/____/____
Intake # ____
Investigator ____

State of New Jersey
Office of Insurance Fraud Prosecutor
P.O. Box 094
Trenton, NJ 08625

PART I

INSURANCE CO. ____ DATE REPORTED ____
ADDRESS ____ NAIC COMPANY # ____
____ D.O.L. ____
TELEPHONE ____ CLAIM # ____
CONTACT PERSON ____ POLICY # ____
E-MAIL ADDRESS ____

TYPE OF COVERAGE (Check appropriate box)
LIFE ☐ W.C. ☐
AUTO ☐ HOME ☐
COMM ☐
OTHER ____

STATUS (Check appropriate box)
PENDING ☐ PAID - IN FULL ☐
DENIED ☐ PAID - IN PART ☐
AMOUNT PD $____ DATE/RANGE PD____
IF PENDING OR DENIED, EITHER IN FULL OR IN PART,
THE DOLLAR AMOUNT OF THE PENDING OR DENIED
CLAIM: $____

INSURED/SUBJECT
LAST ____ FIRST ____ MIDDLE ____
STREET ____ CITY ____ STATE-ZIP ____
HOME PH. ____ WORK PH. ____ D.O.B. ____
S.S. # ____ D.L. #____

DOES THIS CLAIM FORM PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. 17:33A-4?
YES ☐ NO ☐
IF YES, LIST OTHER RELATED CLAIM NUMBERS, INDICATE STATUS OF OTHER RELATED CLAIMS, AND ATTACH COPIES OF OTHER REFERRALS, IF APPLICABLE:

January 2001

As should be obvious from the above discussion, fraud referrals from insurance companies are not ready for court upon receipt by law enforcement. All referrals require further investigation. To prepare a case for prosecution, OIFP conducts an investigation which includes review and analysis of underwriting or claims records as well as a field investigation to identify witnesses and to produce admissible evidence. OIFP can issue subpoenas, execute search warrants, conduct undercover investigations, identify and interview witnesses, conduct electronic surveillance, and develop other evidence necessary to prosecute to conviction, impose civil insurance fraud penalties, and impose licensing sanctions. In addition, when a carrier refers a matter to OIFP involving suspected false claims, OIFP, as part of a comprehensive investigation, routinely canvasses other insurance companies and databases to determine whether the person submitting the suspected claim has submitted similar suspect claims to other carriers. Canvassing other insurance companies for additional information and evidence is often a key investigative step which, for a variety of reasons, insurance companies frequently cannot accomplish.

## Successful Referrals

The Act mandates that all suspicious claims be reported to OIFP. This means that approximately 10,000 cases are reported annually. Although all cases are carefully reviewed, insurance companies and law enforcement can work together as partners to insure that referrals develop into good cases. A good referral is clearly written, is objective, identifies the false statement or omission, and communicates to law enforcement the fraud theory as well as the relevant facts and corroborative evidence and investigative leads. Finally, it is important to remember that quality referrals should be made as soon as possible to permit law enforcement to conduct the type of complex and time-consuming investigation these cases require so that cases can be filed in court prior to the expiration of the Statute of Limitations.

***Scott R. Patterson*** *is a 15 year veteran with New Jersey's Division of Criminal Justice and currently serves as the Supervising Deputy Attorney General in charge of OIFP's Case Screening and Litigation Support Section. He previously served as an Assistant Prosecutor in Passaic County.*

*Joanne Roberts, Assistant Vice President, Selective Insurance Company, receives OIFP's Annual Appreciation Award at the Seventh Annual Insurance Fraud Summit.*

# OIFP Offers Rewards for Reporting Insurance Fraud

# OIFP Offers Rewards for Reporting Insurance Fraud

by Melaine B. Campbell

The public plays a significant role in the detection of insurance fraud and now New Jersey offers incentives to encourage people to join in that effort through the Insurance Fraud Detection Reward Program. Following a recommendation by the Office of the Insurance Fraud Prosecutor (OIFP), the New Jersey State Legislature enacted legislation creating the Insurance Fraud Detection Reward Program. The implementation of this program in 2004 by OIFP makes New Jersey one of only a few states in the nation to offer such a reward. Under the terms of the program, a person providing information in accordance with certain guidelines is eligible to receive up to $25,000 when the information leads to the conviction of a person or entity for Health Care Claims Fraud, Insurance Fraud, or any other criminal offense related to an insurance transaction.

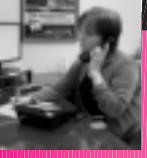
The Insurance Fraud Detection Reward Program is part of a package of anti-fraud reforms enacted in 2003 that enhances the State's ability to detect insurance fraud and to punish offenders. As part of the anti-fraud reforms, the New Jersey State Legislature created the new crime of "Insurance Fraud" which is part of the New Jersey Criminal Code. The crime of "Insurance Fraud," N.J.S.A. 2C:21-4.5 and 4.6, makes any false representation with respect to any insurance claim, application, payment, or document used in any insurance or premium finance transaction, illegal.

Under the provisions of the new law, OIFP has promulgated regulations to administer the reward program. The regulations pursuant to N.J.A.C. 13:88-3 provide a mechanism for individuals to report suspected insurance fraud to OIFP and to apply for a reward under the Insurance Fraud Detection Reward Program.

## Making a Referral

In order to be eligible for the reward program, individuals may report suspected fraud cases using one of the following methods:

- Call the OIFP toll-free hotline at 877-55-FRAUD (877-553-7283) during regular business hours (Monday through Friday 9:00 a.m. to 5:00 p.m.) and speak to a hotline operator;
- Call the OIFP toll-free hotline number at 877-55-FRAUD (877-553-7283) after regular business hours and leave a detailed message, including a name and phone number at which the caller can be reached;
- Log onto the OIFP website, ***www.njInsuranceFraud.org***, and submit an online report;



# OIFP Offers Rewards for Reporting Insurance Fraud

- Send an electronic mail message to OIFP at njinsurancefraud@njdcj.org;
- Write directly to OIFP at the following address: Office of the Insurance Fraud Prosecutor, P.O. Box 094,Trenton, New Jersey 08625-0094, Attention: CLASS.

## Reward Application Procedure

A person seeking a reward for information submitted to OIFP under this law must fully complete a reward application form provided by OIFP. The form may be obtained by requesting one in writing from OIFP, calling the OIFP toll-free hotline and requesting one, or logging onto the OIFP website and downloading the form. The form must be signed and notarized and mailed to the Office of the Insurance Fraud Prosecutor, P.O. Box 094, Trenton, New Jersey 08625-0094.

An applicant may be required to submit to an OIFP interview regarding the provided information. An applicant may also be required to give a verbal statement under oath and sign a written memorialization of the statement. The applicant may also be called to testify before the Grand Jury or at a trial or other related hearings.

A person seeking a reward must either simultaneously file a reward application with the fraud referral or file an application no later than 30 days from the date the person initially provided information to OIFP.

## Criteria for Evaluating a Reward Application

OIFP may pay a reward following the conviction of a person or entity for Health Care Claims Fraud, Insurance Fraud, or any other criminal offense involving or related to an insurance transaction. A person who provides such information to OIFP and submits a timely reward application shall be eligible for a reward only if the information:

- leads to the conviction of a specific individual(s) or entity(ies) for specified conduct occurring during a particular time period, as detailed in the reward program application submitted by the informant pursuant to N.J.A.C. 13:88-3.5; or
- directly leads to the conviction of other individuals or other entities for specified conduct occurring during a particular time period as detailed in the reward program application submitted by the informant pursuant to N.J.A.C. 13:88-3.5.


OIFP shall not grant a reward for information relating to an individual or entity that, at the time the information is provided, is already the subject of a referral to OIFP; is already the subject of an investigation by OIFP; or is already the subject of an insurance fraud investigation by the New Jersey Department of Human Services, the New Jersey Department of Health and Senior Services, the Health Care Financing Agency, the Office of the Inspector General, the New Jersey Department of Banking and Insurance, the New Jersey Department of Consumer Affairs and its licensing boards, or any other federal, state, county or municipal agency.

## Determination and Notification of Eligibility for Reward

OIFP will notify a reward applicant whether that applicant is eligible for the reward within 90 days of the conviction of the person(s) or entity(ies) who committed Health Care Claims Fraud, Insurance Fraud, or other criminal offenses related to an insurance transaction. Rewards will be made as promptly as possible, but will not be made until all direct appeals of the conviction have been exhausted.

## Persons Ineligible for a Reward

Although everyone is encouraged to report instances of insurance fraud to OIFP, certain individuals are not eligible to receive a reward for their information. These individuals include present or past officers or employees of any of the federal, state, county, or municipal agencies listed in N.J.A.C. 13:88-3.8(c), as well as immediate family members of these officers and employees and present and past individuals working on behalf of the agencies or entities, or immediate family members of these individuals, at the time they came into possession of or divulged information leading to an arrest, prosecution, and conviction.

Additionally, government employees, contractors, or grantees who came into possession of or divulged information in the course of their official duties; present or past employees of insurance companies or individuals working on behalf of an insurance company; or the immediate family members of such individuals at the time they came into possession of or divulged information leading to an arrest, prosecution, and conviction, are ineligible for a reward. Obviously, individuals or entities that participated in or facilitated the reported offense and individuals providing false information are ineligible for a reward. Individuals or entities who are eligible for a reward under any state, federal, or other reward program based on a report of substantially the same information reported to OIFP, are also ineligible for a reward.

## Rules and Regulations Under N.J.A.C. 13:88-3

N.J.A.C. 13:88-3, adopted in 36 N.J.R. 3297(b) on July 6, 2004, sets forth the complete rules for the implementation of the Insurance Fraud Detection Reward Program. Individuals interested in participating in the reward program should refer to these provisions for complete requirements and other information on the program.

# Leveling the Playing Field –
## *OIFP Targets Workers' Compensation Premium Fraud*

# Leveling the Playing Field

## *OIFP Targets Workers' Compensation Premium Fraud*

by Melaine B. Campbell

Lurking beneath the smoldering surface of fraudulent workers' compensation claims lies a hotbed of corporate application and premium fraud. Although some businesses struggle to keep up with costs, others renege on their responsibility to protect injured workers. In New Jersey, the Office of the Insurance Fraud Prosecutor (OIFP), the insurance industry, the Compensation Rating and Inspection Bureau (CRIB), and producers are joining forces to combat workers' compensation application and premium fraud.

Throughout 2004, OIFP and insurance carriers have intensified their effort to detect, deter, and eradicate workers' compensation application fraud on all levels through investigation, prosecution, education, and research. OIFP has been identifying common fraud schemes and fraud indicators in workers' compensation applications and from premium fraud referrals. OIFP has participated in training for law enforcement and the industry to identify these fraud schemes and indicators, and has allocated resources to address the rising tide of application and premium fraud.

### The Workers' Compensation System in New Jersey

Employers generally obtain workers' compensation insurance through the voluntary market, the residual or involuntary market otherwise known as assigned risk, and through approved self-insurance.

CRIB defines the residual market process as employers who are ineligible for the voluntary market, purchasing workers' compensation insurance through CRIB. Employers in the residual market complete an application for designation of an insurance company. The application requires the employer to disclose the name and location of the employer's operations, taxpayer identification number, legal status, location of payroll records, ownership interests, prior insurance record, voluntary market rejections, description of operations, general eligibility information, classification of operations, including the number of employees and payroll, as well as other information designed to calculate the appropriate premium.

After review and approval by CRIB, a servicing carrier is designated to provide workers' compensation insurance to the employer. Under the residual market, an assigned carrier must accept an employer's application and issue a policy for at least one year. After one year, the carrier may request relief from CRIB and the employer may be assigned to another carrier.

According to CRIB, premium rates in the involuntary market are based on two basic factors: an annual premium level that will assess the total amount of money needed to pay the antici-

pated incurred indemnity/medical obligations and the allowable items of overhead expenses, and apportionment of this total amount among all employers in a fair manner in relation to their contributions to the total claims cost. Cost apportionment is accomplished by a classification system that divides the industry in the State into approximately 600 business classifications. The realized hazards of each group are catalogued by compiling the payroll, premium, and incurred loss experience.

According to CRIB, this system provides a level playing field in terms of premium contribution, subject to statutorily required application of experience rating. Experience rating compares the loss history of a given employer with the expected losses of other employers of like size and kind assigned to the same classification. By comparing similar employers, CRIB produces a credit experience modification and extends premium savings to the employer enjoying fewer losses than average. Conversely, greater losses than average result in a debit modification and increased premium cost. The system provides each group of employers the opportunity to influence their own premium rate, thereby offering an economic incentive to control the frequency and severity of work-related injuries.

Industry for purposes of workers' compensation insurance is divided into three categories: manufacturing, construction/erection, and all other. These categories are further subdivided to form the basis for approximately 600 business classifications. Classification rates are based upon the losses that occur and the payrolls expended in a given business. Classification rates represent an average rate intended to encompass both the hazardous and non-hazardous work performed within the business at risk. Less hazardous operations within a given business reduce the overall rate for the class.

The premium is based primarily on a payroll estimate for the initial policy term. The final premium is determined by a final audit at the expiration of a policy. The final audit includes premium adjustment to the actual payroll expenditures made during the policy term through review of original payroll records, disbursement books, general ledgers, and payroll tax reports. The audit allows the carrier to review and amend classifications and rates that apply to the business and work covered by the policy. The premium is basically calculated by the following equation:

*Payroll/100 x Classification(Rate) x Experience Modification Factor + Expense Constant + Surcharges = Premium*

*New Jersey Manufacturers Insurance Company Special Investigations Unit Director Loni Hand discusses workers' compensation premium fraud issues with John Kuller, Esq., at the Seventh Annual Insurance Fraud Summit. Hand is co-chair of OIFP's Workers' Compensation Working Group.*

## Premium Fraud Scams

Some employers attempt to lower their premiums by lying on workers' compensation insurance applications and lying during or avoiding audits. Premium fraud, however, generally involves lies concerning payroll, classification (type of work done), and experience modification factor (claims history).

Although the employer may provide an estimated payroll to obtain workers' compensation insurance, a failure to disclose a significant amount of payroll is a fraud indicator and one of the most common types of premium fraud. Sometimes the scheme is more elaborate with employers paying employees "off the books" or misrepresenting the employees as "independent contractors." Some employers even hide payroll by creating bogus employee-leasing firms. Fraud may sometimes be detected when employees are on the payroll of "subcontractors" or "vendors" with common management or ownership. Other payroll fraud indicators may include a disproportionate amount of claims for the stated payroll, claimants who are not listed as employees in the audit, discrepancies in payroll reported to the insurer versus government agencies, and discrepancies in the size and type of operation versus payroll.

Employers may attempt to lower rates by lying about the business classification and locations of operation. Employers may represent that their employees work at lower-risk tasks: for example, a construction company may fraudulently place more payroll in clerical or sales jobs and less payroll in roofing classifications. Red flags should immediately go up when industrial and construction operations report only low-risk classifications for workers. Another fraud scheme involves lying about the number or location of operations by setting up storefront headquarters to hide high-risk or higher-rated job sites.

Employers may fraudulently reduce their premiums by lying about their loss and claims history. A business with a poor claims history might form a shell company that is essentially the same operation to handle ongoing jobs.

Insurance carriers have become increasingly concerned about audit fraud. In some instances, an employer may repeatedly delay or impede a carrier's audit or it may provide false documents to avoid a premium increase. In other cases, scheming businesses might refuse to provide adequate records to a carrier. The State may, however, subpoena records or execute a search warrant if necessary to investigate misstatements of audit information or concealment of risk in order to commit fraud.

## Workers' Compensation Fraud Statutes

The new Insurance Fraud Statute, N.J.S.A. 2C:21-4.5, 4.6, makes it a second degree crime to commit five or more acts of insurance fraud in an amount of $1,000 or more, and a third degree crime for fewer than five acts or less than $1,000. Prosecutors can charge other crimes, such as theft, under other criminal statutes in appropriate cases. Underwriting fraud is addressed in several workers' compensation statutes: N.J.S.A. 34:15-70 requires many employers to procure workers' compensation insurance for their employees; N.J.S.A. 34:15-57.4 renders providing a false statement or misrepresentation in connection with a workers' compensation application a fourth degree crime; and N.J.S.A. 34:15-79 renders failing to provide workers' compensation insurance a fourth degree crime. Of course, the New Jersey Insurance Fraud Prevention Act, N.J.S.A.17:33A, provides civil penalties for workers' compensation application and premium fraud.

## Closing the Loopholes

During 2004, a working group comprised of members of OIFP, the insurance industry, CRIB, and producer groups addressed issues relative to this type of fraud. The working group will continue to seek ways to uncover and deter schemes designed to conceal records, payroll, classification, and experience modification factor information.

## Leveling the Playing Field

Premium fraud is destructive to the corporate sector and small businesses. Premium fraud not only drives up the cost of insurance, it also gives the fraudsters an unfair competitive advantage. This year's workers' compensation anti-fraud initiative provides the means to level the playing field.

***Ron Brazda**, Director-Underwriting, Compensation Rating and Inspection Bureau, contributed to this article.*

*(top left) Susan Aiani, Workers' Compensation Special Investigator, Chubb Insurance Group, instructs OIFP investigators on the detection of workers' compensation fraud. (top right) Neil Johnson, Vice President, Liberty Mutual Insurance Company and co-chair of OIFP's Workers' Compensation Working Group, reports to the Seventh Annual Insurance Fraud Summit on the Group's 2004 application fraud initiative.*

# Demystifying the HIPAA Privacy Rule

## *Disclosing Protected Health Information (PHI) to Law Enforcement*

by Diane Ibrahim and Melaine B. Campbell

### Enactment of HIPAA

Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) in 1996 to "improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes."[1] HIPAA went into effect on April 14, 2001. Most covered entities were given until April 14, 2003, to comply with the Privacy Rule and smaller entities were given until April 14, 2004, to comply.

Part of HIPAA's main focus is health care fraud, one of the main sources of excessive health care costs. When Congress enacted HIPAA, the House Committee on Government Reform and Oversight issued a report stating that in 1995 alone, approximately $1 trillion was spent on health care, divided among Medicare, Medicaid, and various state and private programs.[2] Estimates indicated that as much as ten percent, or $100 billion ($274 million a day), was lost to fraud and abuse.[3]

HIPAA includes regulations pertaining to privacy, known as the "Standards for Privacy of Individuals' Identifiable Health Information," or the "Privacy Rule." (45 C.F.R. § 160 and 164). HIPAA's Privacy Rule is also intended to protect an individual's privacy while allowing law enforcement to investigate and prosecute crimes, including health care fraud. Nonetheless, questions often arise from insurance carriers, doctors, hospitals, pharmacies, and others when they are asked to disclose patient information to law enforcement officials. The concerns center around HIPAA's Privacy Rule and a misunderstanding of its provisions and exceptions regarding disclosures of protected health information (hereinafter referred to as PHI).

It is important for law enforcement and covered entities to understand that, under certain circumstances, covered entities are permitted to disclose PHI to law enforcement officials without the individual's written authorization pursuant to the law enforcement exception. Furthermore, when PHI is requested through a grand jury subpoena or a Court Order, disclosure is required. HIPAA does not protect the

1 Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996). 2 H.R. Rep. No. 104-747 (1996). 3 Ibid.



confidentiality of the information requested by a grand jury subpoena and should not be cited as a basis to resist complying with the subpoena.

## The Privacy Rule

The Privacy Rule creates national standards to keep medical records and PHI confidential. It restricts the ability of covered entities to divulge an individual's medical records to unauthorized persons. The Code of Federal Regulations (C.F.R. Parts 160-164) governs the ability of "covered entities" to use and disclose "individually identifiable health (medical) information concerning a person, called protected health information (PHI)." The regulations specifically identify three types of covered entities under HIPAA: (1) health plans: group and individual health insurance, HMOs, Medicare, Medicaid, and other government health plans; (2) health care clearing houses: billing services and providers; and (3) health care providers: doctors, nurses, paramedics and other emergency services personnel; hospitals and clinics; pharmacies (45 C.F.R. 160.103).

The regulations define PHI as "individually identifiable health information" that is transmitted by electronic media, or maintained in any electronic medium (45 C.F.R. § 162.103) or transmitted or maintained in any other form or medium. PHI is essentially all health records identifiable by a patient name or other personal identifiers such as a Social Security number. Covered entities may not use or disclose PHI unless permitted by a provision of these rules. PHI may be most readily disclosed by written authorization from the patient. Under certain circumstances, however, HIPAA does not require such written authorization. The Privacy Rule generally allows covered entities to use or disclose PHI without written authorization for treatment, payment, and health care operations. Uses and disclosures between covered entities that are sometimes allowed include the detection of health care fraud and abuse, or compliance with HIPAA.

## Law Enforcement Exception to the Privacy Rule

The Privacy Rule provides several specific exceptions under 45 C.F.R. 164.512 to permit disclosure of PHI by a covered entity to law enforcement without an individual's written authorization. Pursuant to the law enforcement exception, a covered entity may disclose PHI to a law enforcement official for a law enforcement purpose without the written authorization of the individual or the opportunity for the individual to agree or object, if certain conditions are met. These conditions include:

- information, such as certain wounds or injuries, required by law to be reported to a law enforcement agency;
- Court Order, warrant, subpoena, or summons issued by a judicial officer;
- grand jury subpoena;
- administrative subpoena or request where (1) the information sought is material to a legitimate law enforcement inquiry, (2) the request is specific and limited in scope to the purpose for which it is being sought, and (3) de-identified information[4] could not reasonably be used;
- information needed to locate or identify a suspect, fugitive, material witness, or a missing person;
- information about a victim of a crime;
- information about a crime occurring on the premises of the covered entity, such as a hospital or nursing home;
- reporting crime in emergencies;
- information pertaining to victims of abuse, neglect, or domestic violence;
- coroner's request;
- information needed to avert a serious threat to health/safety;
- other important miscellaneous exceptions, such as national security or intelligence and law enforcement custody.

There are three limitations under 45 C.F.R. § 164.512 to the law enforcement exception. First, the information sought must be relevant and material to a legitimate law enforcement inquiry. Second, the request must be specific and limited in scope to the extent reasonably practicable in light of the purpose for which law enforcement seeks the information. Finally, de-identified information cannot reasonably be used to fulfill the request.

## Minimum Necessary Requirement

The Privacy Rule requires that covered entities limit the use or disclosure of PHI to the minimum amount necessary to accomplish the intended lawful purpose.[5] Generally, the minimum necessary requirement does not apply to uses or disclosures that are required by law as described in 45 C.F.R. § 164.512(a),[6] which includes reports of victims of abuse, neglect, and domes-

4 "De-identified information" is a term used in 45 C.F.R. §164.512(f)(1)(ii)(C)(3) which is defined in 45 C.F.R. §164.514(a) as follows: Standard: de-identification of protected health information. Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information. 5 45 C.F.R § 164.502(b),164.514(d). 6 45 C.F.R § 164.502(b)(2)(v).

tic violence. When responding to a law enforcement subpoena or Court Order, and if reasonable to do so, a covered entity may rely on the representations of law enforcement that the requested information meets the minimum necessary requirement.[7]

## Specifically Protected Types of Medical Records

The Privacy Rule provides specified disclosure requirements for specially protected types of medical information. A covered entity must generally obtain an authorization for any use or disclosure of psychotherapy notes. There are exceptions, however, to the authorization requirement. No authorizations are needed for certain types of treatment, for payment of health care operations, for health oversight activities, to avert serious threats to health and safety, or as required by law.[8] The "required by law" exception includes disclosures for judicial and administrative proceedings and disclosures for law enforcement purposes. In instances where a law enforcement agency is seeking disclosure of specially protected types of medical information, such as confidential communications subject to the psychologist-patient privilege, information that a person has AIDS or HIV, or information about substance abuse diagnosis and treatment, it may seek a Court Order to obtain such records.

## Notification of Disclosure to Individuals

There is no requirement under current law for the covered entity to proactively notify an individual that it has disclosed PHI to law enforcement. Although an individual has a right to receive an accounting of the disclosure, the individual must request the accounting. Under the provisions of 45 C.F.R. §164.528(a)(2), however, the covered entity must temporarily suspend an individual's right to receive an accounting of disclosures to a law enforcement official for the time specified if such agency or official provides the covered entity with a written statement that the accounting would reasonably be likely to impede the agency's activities, and specifies the requested suspension time. If the law enforcement agency or official makes an oral request to suspend the accounting, the covered entity must document the request, including the identity of the agency or official making the request. The covered entity may then temporarily suspend the accounting of disclosures for no longer than 30 days from the date of the oral request, unless a written request is submitted during that time. In addition, a Court Order may affirmatively direct the covered entity not to disclose to the individual or to others that information has been provided under the law enforcement exception.

## Conclusion

HIPAA is an important law designed to reduce roadblocks in patient care, to fight health care fraud, and to protect PHI. In assisting to achieve these goals, covered entities with an understanding of the Privacy Rule and its law enforcement exceptions can be confident when responding to requests for PHI. This article is a brief overview of the law enforcement exception under HIPAA's Privacy Rule. In short, under the exception, a covered entity may disclose PHI to law enforcement pursuant to a Court Order or court-ordered warrant, a subpoena or summons issued by a judicial officer, a grand jury subpoena, or an administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law.[9] Covered entities must review specific code sections and regulatory text for a complete understanding of the requirements and exceptions regarding health information disclosures under HIPAA and the Privacy Rule.

***Diane Ibrahim*** *is a third year student at Temple University, Beasley School of Law. She was a 2004 intern with OIFP.*

7 45 C.F.R. § 164.514(d)(3)(iii)(a). 8 45 C.F.R. § 164.508(2). 9 45 C.F.R. § 164.512 (f)(1)(ii)(c).

# OIFP's Medicaid Fraud Unit Protects the Elderly

# OIFP's Medicaid Fraud Unit Protects the Elderly

by Marquis D. Jones, Jr.

*"I can only say, as all of us know, it takes more than a village to care for a senior."*

– Catherine Macchi,
*Office of Senior Affairs, Jersey City*

As the elderly population increases, so do the daily risks they face when they unfortunately do not have loving family members to care for them. To better protect the elderly from neglect, the New Jersey Medicaid Fraud Control Unit (MFCU) created a dedicated unit in 2004 to focus on the continuous concern of proper care for New Jersey's elderly population. In New Jersey, more than "70,000 elders are at risk of being physically, emotionally, or financially abused or neglected."[1] OIFP's Medicaid Fraud dedicated unit is working with the New Jersey Department of Health and Senior Services, Office of the Ombudsman for the Institutionalized Elderly, and the Division of Aging and Community Services to investigate allegations of elderly neglect at long-term care facilities, and to prosecute individuals and corporations responsible for egregious cases of elderly neglect.

The good news is that we are living longer than any time in our history. From 1920 to1965, the life expectancy in this country increased by approximately six years.[2] "The average American born today can expect to live more than 76 years, and life expectancy has risen dramatically for all age groups."[3] The increase in life expectancy results in an increase in America's elderly population. Some commentators project the increase in the 85 and older elderly population alone to double to seven million people by 2020, and further increase to between19 million and 27 million by 2050.[4]

As the elderly population increases, OIFP's MFCU remains vigilant of the number of elderly citizens living in long-term care institutions and residential facilities who may become victims of neglect. Some commentators estimate

1 Elder Abuse, New Jersey State Nursing Association, Elder Abuse Position Statement at *www.njsna.org*. 2 Statement of Tray Baroni, Director of Policy, Pharmaceutical Research and Manufacturers of America, Testimony Concerning Health Care and Caregiving for the Elderly at Public Hearing before the New Jersey Advisory Council on Elder Care, December 9,1998. 3 Ibid. 4 Statement of Assemblywoman Carol J. Murphy, Chair, New Jersey Advisory Council on Elder Care, Public Hearing before the New Jersey Advisory Council on Elder Care, December 9,1998.



## Reporting Elder Abuse

***Elder abuse is generally defined as follows:***[1]

**Physical Abuse:**
A caregiver or someone who has custody of an elderly person willfully inflicts physical pain or injury on the elderly person in the form of direct beatings, sexual assault, or physical restraints.

**Emotional Abuse:**
A caregiver or someone in a position of trust willfully inflicts emotional or psychological abuse on an elderly person with verbal assaults, threat, fear, humiliation, intimidation, or isolation.

**Neglect and Mistreatment:**
A caregiver or someone in a position of trust or who has a duty to care for an elderly person fails to provide care at a level that a reasonable person would provide to the elderly person, or in a competent fashion. The care may involve poor personal hygiene and unsanitary conditions, clothing, medical care, supervision, and protection from health and safety hazards. Often neglect leads to the development of pressure sores or decubitus ulcers, which are also known as bed sores.

**Financial Exploitation:**
A caregiver or someone in a position of trust who steals or mismanages money, illegally or improperly uses the elderly person's financial resources, or forces the elderly person to sign over assets to the abuser.

**Family and friends of elderly citizens with evidence of elder abuse are encouraged to call (in confidence) the insurance fraud hotline at 1-877-55 FRAUD or log onto *www.njInsuranceFraud.org.***

1 Elder Abuse, New Jersey State Nursing Association, Elder Abuse Position Statement at www.njsna.org.; Statistics, New Jersey Department of Health and Human Services, Aging and Community Services, Office of the Ombudsman for the Institutionalized Elderly, last modified July 1, 2003.

that nationally there are approximately 1.6 million people living in approximately 17,000 licensed nursing homes with another 900,000 to one million living in approximately 45,000 residential care facilities that include assisted living facilities and homes for the aged.[5]

New Jersey is home to approximately 1.4 million older adults.[6] As of December 2004, there were approximately 370 nursing home long-term care facilities that provide approximately 52,045 available beds.[7] Approximately 195 assisted living facilities provide another 16,356 possible beds.[8] New Jersey's elderly citizens also reside in residential health care facilities and boarding homes; however, the exact number of elderly residents residing in such facilities is unknown.

"The elderly in residential long-term care settings are particularly vulnerable to abuse and neglect, and the scant evidence available suggests abuse and neglect are serious and widespread."[9] In New Jersey, the number of nursing home complaints increased each year between 1999 and 2002. Significantly, most complaints regarded neglect and care issues.[10]

In addition to prosecuting cases of Medicaid fraud by medical service providers, OIFP's MFCU's legislative mandate includes prosecuting the various forms of elder abuse. Abuse of the elderly generally falls into one of several categories including physical abuse, sexual abuse, emotional abuse, neglect and mistreatment, and financial exploitation. The MFCU's statewide prosecution jurisdiction includes the review of complaints of abuse and neglect against patients in health care facilities receiving Medicaid funding. The MFCU also reviews complaints of theft of patients' private funds in these facilities.[11]

The MFCU maintains the authority to prosecute matters involving elder abuse under New Jersey's criminal statutes, the Health Care Claims

Fraud Act, and the Medicaid fraud statutes. Many matters involving physical abuse and other crimes against the person are also referred to various County Prosecutors. To enhance the protections afforded against elder abuse, the MFCU focuses on elderly neglect involving corporate entities and caregivers. By focusing on the neglect cases, OIFP's MFCU will continue to develop the expertise and experience to prosecute neglect cases centered on care issues.

If appropriate, OIFP's MFCU will prosecute corporations and caregivers in neglect cases for Health Care Claims Fraud and Medicaid fraud under a theory that they failed to deliver services for which they were paid by Medicaid.[12] Abusers may also be prosecuted under a New Jersey statute that makes it a third degree crime to abandon an elderly person or disabled adult or to unreasonably neglect to do, or fail to permit, any act necessary for the physical or mental health of the elderly person or disabled adult.[13] The statute applies when a person has a legal duty or the person assumes a continuing responsibility for the care of a person 60 or older or a disabled adult.[14] In addition to earlier cases, the MFCU is currently investigating cases of elderly neglect opened since September 2004. The cases involve allegations of care issues ranging from physical and sexual abuse, to economic exploitation, stolen property, and forgery.

Armed with a legislative mandate and the necessary tools, OIFP's MFCU looks forward to protecting New Jersey's growing elderly population.

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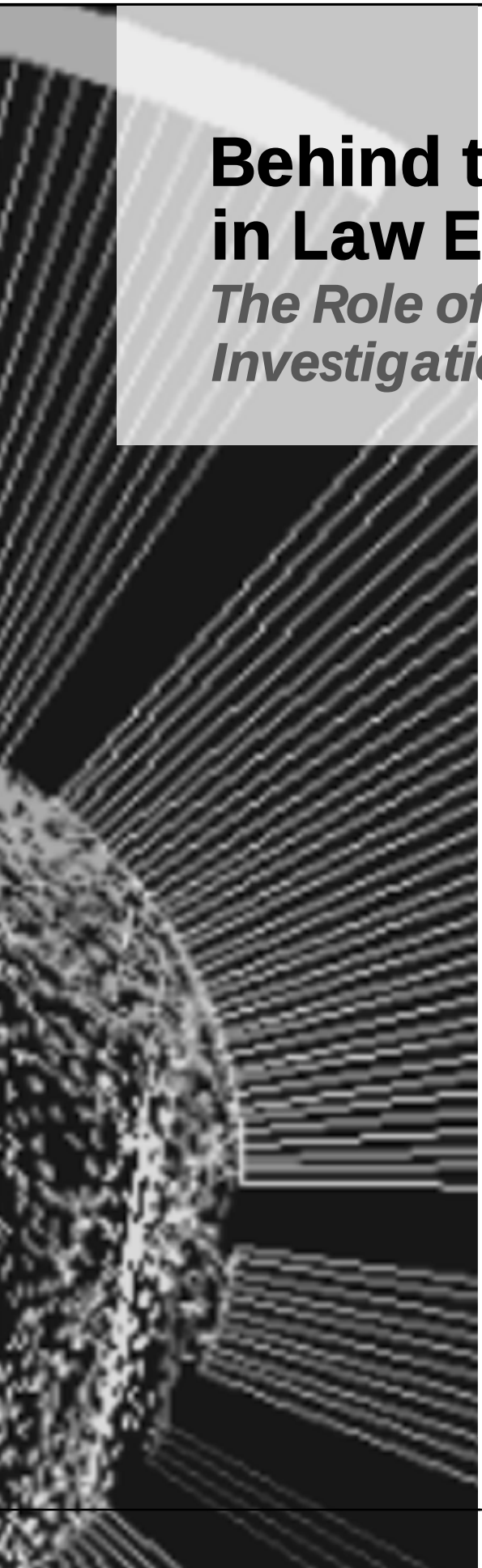
5 Statement of Catherine Hawes, Professor and Director, Texas A&M University System Health Science Center, Elder Abuse in Residential Long-Term Care Facilities, Testimony before the U.S. Senate Committee on Finance, June 18, 2002. 6 Susan C. Reinhard and Charles J. Fahey, Rebalancing Long-Term Care in New Jersey: From Institutional Toward Home and Community Care (March 2003). 7 Interview with Noreen D'Angelo, Executive Assistant, Office of Commissioner, Department of Health and Senior Services in Lawrenceville, NJ (January 11, 2005). 8 Ibid. 9 Ibid. 10 Statistics, New Jersey Department of Health and Human Services, Aging and Community Services, Office of the Ombudsman for the Institutionalized Elderly, last modified July 1, 2003. 11 *See* 42 U.S.C. §1396(b)(q)(40)(A). Other State agencies may seek to develop protective programs under the Programs for Older Americans Act that provides allotments for agencies that develop and enhance programs for the prevention of elder abuse, neglect, and exploitation. *See* 42 U.S.C. §3058i (West 2004). 12 *See* N.J.S.A. 2C:21-4.3 (Gain 2004); N.J.S.A. 30:4D-17 (West 2004). 13 *See* N.J.S.A. 2C:24-8 (West 2004). 14 Ibid.

# Behind the Scenes in Law Enforcement

*NetMap for ClaimSearch and ViewLink Manager are data mining software tools which visually represent the relationships between claimants, addresses, providers, and claims.*



# Behind the Scenes in Law Enforcement

## *The Role of Analysts in Criminal Investigations and Prosecutions*

by Christina Runkle, Paula Carter, and Annie Meredith

While the roles of prosecutors and investigators are well understood in the development and successful prosecution of a case, the law enforcement analyst's function is generally less recognized due to its background nature. Analysts can assist attorneys and investigators at all stages of a case as they manage, organize, and derive meaning from mountains of investigative data.

Generally, analysts help to marshal evidence gained from investigations by examining source and undercover information as well as witness interviews, physical and electronic surveillance, the execution of search and arrest warrants, and detailed review of insurance, patient, business, and financial records.

OIFP has had an analytical component since its establishment in 1998. Analysts are specially trained professionals who gather, organize, analyze, and derive meaning from data.[1] The majority of OIFP analysts have college degrees and have received law enforcement-related training in such areas as tactical and strategic intelligence analysis, criminal investigations, financial records examination and investigative analysis, computerized analytic methods, money laundering, organized criminal groups, and the New Jersey racketeering statute. Additional training in various software applications include Internet research, *Corel WordPerfect, Microsoft Access* and *Excel*, and *Analyst's Notebook*. Although analysts use a variety of tools to assist prosecutors and investigators, some of the main tools include extensive use of databases, investigative analysis, software, visual exhibits, and charts.

### Databases

Analysts create and use databases that are critical to developing meaningful information at the beginning of a case. OIFP analysts can take an extensive flat file database[2] of relevant information and create a relational database[3] to facilitate the identification of pertinent files. Organization of information at the beginning of a matter is important in the identification of fraud schemes.

Other information gathered at the inception of a case such as telephone toll data may be helpful in defining the scope of a conspiracy if records show

1 Wayne J. Forrest and Marilyn B. Peterson, "Analytic Support for Prosecuting Attorneys," The Prosecutor September/October 1998:33. 2 A flat file database specifies data attributes (columns, data types, etc.) one table at a time. 3 A relational database takes the flat file approach several logical steps further. It allows for the specification of information in multiple tables and the relationships between those tables. This allows for more flexibility in queries and reports.

a particular pattern of calls between or among certain numbers, or a significant volume of calls on or around certain significant dates. The OIFP investigative team recognizes that the prompt analysis of the toll data may be critical to the further development of the case. The OIFP analysts utilize custom *Microsoft Access* database applications to expedite the entry of toll data and prepare call pattern and frequency analyses.

An analyst may then export the data from the existing program into another *Microsoft Access* database. This type of changeover permits analysts to query the information in a manner that facilitates the identification of criminal conspirators.

Seized evidence, including patient files, billing records, check registers, corporate papers, disbursement journals, and tax records, is important. Analysts may develop *Microsoft Access* databases specific to patient information which capture the following fields: file origination date, policy number, claim number, patient name, date of loss, insurance company, payments by the carrier, and source information, including voucher and item numbers. Multiple queries and reports are created to assist investigative staff in the prompt location of pertinent patient files within such databases.

As the investigation progresses, this same type of database permits analysts to isolate information, such as staged accidents and "runners" responsible for each, and to quantify the billings generated and payments made by insurance carriers for suspect collisions. Additional fields permit further distillation of the data. Data distillation allows for the generation of reports that isolate fraudulent events based on specified individuals and providers involved in a fraud.

Additionally, OIFP analysts create custom databases that establish the cash flow between and among various co-conspirators, track corporate ownership, and profile individuals employed by various entities such as doctors, accountants, and clerical staff.

After categorizing information and defining fields, analysts build tables, queries, and data entry forms. The completed database gives an investigative team the ability to track financial transactions by individual and corporate entity. Analysts may also create profiles of pertinent individuals and

## OIFP Reporting Requirements

***Insurance carriers must provide their ISO Assigned Code and ISO Universal Field Name as well as submitting the following information:***

| | | | | |
|---|---|---|---|---|
| Policy Number | City | Business Name (Choose from ISO Appendix C) | VIN | Role in Claim |
| Policy Type | State | Address Information | Date of Recovery (Theft) | Role in Claim (if service providers reported with claim, their names, address required) |
| Claim Number | First Name (Role CL) | City | Vehicle Make | Individual/Business Indicator |
| Date of Loss | Last Name (Role CL) | State | Recovery Agency | Business Name (if a business) |
| Location of Loss Address (incl. State) | Address Information | Coverage Type | Condition of Recovered Vehicle (Theft) | Last Name |
| First Name (Choose either Role IN, CL) | City | Loss Type | VIN | First Name |
| Last Name (Choose either Role IN, CL) | State | Alleged Injuries/ Property Damage | Owner Retaining Salvage Indicator | City |
| Business Name (Choose either Role IN, CL) -Required if a Business | First Name (Choose from ISO Appendix C) | Vehicle Year | Date of Salvage | State |
| Address Information | Last Name (Choose from ISO Appendix C) | Vehicle Make (Abbrev.) | Buyer's Business Name OR Last and First Name (if owner did not retain salvage) | |

businesses via the collection of addresses, phone numbers, other identifying numbers, company/individual affiliations, and the source of their connection. Analysts also use databases to capture events or other relevant evidence specific to the profiled entity. Such databases provide voucher and item number references for each piece of information so the supporting documentation may be retrieved for review, or for use at trial. Analysis of database information pertaining to one defendant may even reveal additional criminal acts.

After analysts compile information for use through creation of databases, they can add to the financial database and use corporate profiles to prepare a link chart in a visualization program called *Analyst's Notebook*. Use of *Analyst's Notebook* may begin the focused preparation of a case for a grand jury presentation. Using *Analyst's Notebook*, analysts create charts that can show such information as all defendant-owned or controlled clinics and management companies, all corporate officers, and connections to other clinics and management companies owned or operated by relatives, or associated physicians. Charts also provide incorporation dates and can depict name changes for certain clinics. Charts serve as quick reference guides to the numerous business entities and players affiliated with each.

Often the complexity and volume of information a prosecutor can present to the grand jury or trial jury prompts a request for preparation of charts that can simplify the presentation of the evidence by facilitating a visual analysis of demonstrative evidence.

Analysts assist in the effort of the State to recover restitution. Analysts organize personal and corporate tax information into *Excel* spreadsheets and add tax return information seized from defendants. Detailed review of tax documents and careful organization of corroborative financial evidence are beneficial when analysts are tasked with determining a defendant's worth for criminal restitution purposes. It also provides a valuable benchmark as to the accuracy of the financial picture from a review of seized business and subpoenaed bank records. Flow charts are prepared in anticipation of a net worth analysis or asset forfeiture question.

## Future Analytical Tools

To provide even more support to prosecutors and investigators, analysts continue to consider tools in developing cases, such as the All Claims Database, an in-house data source; i2's *Analyst's Notebook Version 6*, an enhanced form of this visual analysis program; and *Sanction*, a trial presentation application.

## All Claims Database

The long-anticipated All Claims Database, mandated by the Automobile Insurance Cost Reduction Act (AICRA), became operational in 2004. AICRA tasked OIFP with developing a database containing all automobile claims paid by designated insurance companies conducting business in New Jersey. The database will include over 130,000 in automobile bodily injury claims and 500,000 in automobile property claims estimated to be paid annually by the insurance industry. The New Jersey Legislature determined that such a database would be an invaluable investigative tool and source of statistical data for the identification of fraudulent patterns and trends in filed insurance claims. Analysts will examine information in the database for patterns of fraudulent activity. OIFP analysts may then share the information with County Prosecutors, local law enforcement officials, and the New Jersey State Police.

The All Claims Database Unit is staffed with a Supervising Special In-

vestigator and three analysts. The Unit responds to requests for investigative assistance on open cases. The Unit also actively seeks to identify fraud schemes. For instance, analysts have searched the database for geographic areas exhibiting high accident rates, and for physicians whose patients' claims have been reported as suspicious to the National Insurance Crime Bureau (NICB). In addition to developing leads for OIFP investigators, the Unit can identify suspected fraudulent activity that impacts another state and forward the information to the prosecuting authority for investigation.

OIFP has also entered into an agreement with Insurance Services Office, Inc., (ISO) of Jersey City to data mine[4] claims information from its national database. ISO is an information services provider to the property and casualty insurance industry. The majority of New Jersey carriers already provide ISO with data, and the ISO database already contains suspicious claims information.

OIFP has also purchased two data mining applications to assist in the detection of fraudulent claims patterns: *NetMap for ClaimSearch* and *ViewLink Manager*. *NetMap for ClaimSearch* analyzes claims data from *ISO ClaimSearch*, the most comprehensive claims database available for property, casualty, and auto insurance.[5] It facilitates the analysis of multiple claims, by permitting analysts to view various connections across time, claims, and physical distance, instead of searching claim by claim. *View Link Manager (VLM)* is an automated visual link analysis tool that sorts through data to reveal connected items and the nature of their relationship.

*NetMap* and *VLM* draw lines that connect individuals, addresses, and claims. For example, Subject A is found to have been in an auto accident in early May 2004. Subject A also is found to share an address and telephone number with Subject B. Subject B is found to have had an auto accident, while driving Subject A's car, in late May 2004. Subjects A and B are both found to have been receiving medical treatment from Doctors C, D, and E. This scenario gives the analyst a nexus for a potential insurance fraud case. If connections indicate that a certain subject is more integral to the case, the focus of the investigation can be quickly shifted to limit extraneous investigative effort.

The All Claims Database Regulations were developed and promulgated in the N.J. Register in 2004, fulfilling the statutory mandate under AICRA.

## *Analyst's Notebook Version 6*

OIFP analysts continue to use the industry standard for investigative analysis software among law enforcement agencies, *Analyst's Notebook*. The program enables analysts to present complex scenarios in simple intuitive charts that have been used as aids in case development and for grand jury and trial exhibits.

In 2003, the manufacturer significantly enhanced the capabilities of *Analyst's Notebook* with the release of *Version 6*. OIFP analysts have begun to integrate the new, improved documentation and data import features into their investigative support efforts. *Analyst's Notebook* now allows for the combination of time line and network

4 According to WordNet ® 2.0, © 2003 Princeton University, data mining "is data processing using sophisticated data search capabilities and statistical algorithms to discover patterns and correlations in large preexisting databases; a way to discover new meaning in data." 5 In 1997, ISO acquired the Index System, a database of bodily injury claims, and the Property Insurance Loss Register (PILR), a list kept by the American Insurance Association of all fire losses over $500,000. In 1998, the National Insurance Crime Bureau (NICB) transferred its auto (VIN history, salvage records, etc.) and claims databases to ISO. Under the ISO umbrella, the bodily injury, property, and auto and claims databases were merged to form ISO ClaimSearch.

views of investigative data and it permits analysts to automatically switch from one to the other. It further allows for the conversion of chart information to a spreadsheet format. This facilitates sorting, evaluating, and duplicating data into *Microsoft Excel* and other similar applications. Finally, *Analyst's Notebook Online iLink* enables analysts to pull information from online sources, such as *LexisNexis*, and drag-and-drop the information directly into an existing *Analyst's Notebook* chart. *iLink* automatically merges the data from the online sources with existing data sources. Further, the online source items maintain ties to their underlying source so analysts can automatically update charts.

## Sanction

The *Sanction* program is a trial organization and presentation software program purchased in 2004 by OIFP. *Sanction* was adopted by the U.S. Department of Justice as the standard for federal prosecutors. OIFP analysts will use *Sanction* to assemble case exhibits, design video and audio clips, and to edit and annotate transcripts and documents. Using *Sanction*, analysts will provide technical support to prosecutors whose cases benefit from a digital court presentation by operating the program during trials.

## Conclusion

Law enforcement analysts assist investigators and prosecutors at virtually every phase of a major insurance fraud probe. In prosecutions and investigations, analysts assist in the management, organization, and evaluation of thousands of pieces of evidence, including data collected from carrier files, toll and DNR records, seized patient files, and seized and subpoenaed financial and corporate records. By developing and using databases and support products, analysts develop and refine visual aids for use before the grand jury and at trial. Any case can benefit from analysts' critical thinking and the application of one or more analytical techniques to help organize, evaluate, and make sense of any volume or type of evidence used by investigators and prosecutors to successfully prosecute their case.

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***Paula Carter*** *has been with New Jersey's Division of Criminal Justice for seven years and currently serves as a Supervising Administrative Analyst with the OIFP Case Screening and Litigation Support Section. She has been a law enforcement analyst for the State of New Jersey for more than 23 years, serving previously with the State Commission of Investigation and the State Police Intelligence Bureau. She is a Certified Criminal Analyst and a member of the International Association of Law Enforcement Intelligence Analysts (IALEIA).*

***Annie Meredith*** *is a Special Investigator with OIFP where she heads the All Claims Database Unit. She previously worked with the N.J. Division of Consumer Affairs in both the Enforcement Bureau for the Professional Boards and the Office of Consumer Protection, Cyberfraud Unit. She also served with the Camden County Prosecutor's Office.*

# Dennis Jay, Executive Director of the Coalition Against Insurance Fraud, Speaks Out

# Dennis Jay, Executive Director of the Coalition Against Insurance Fraud, Speaks Out

by Stephen D. Moore

***What is the Coalition Against Insurance Fraud and how would you describe its mission?***

The Coalition is a national alliance of insurers, government agencies, and consumers — all of whom are dedicated to combating all forms of insurance fraud. Our mission is threefold: to advocate passage of strong state anti-fraud laws and regulations, promote public awareness of fraud, and seek a greater understanding of this national crime problem through objective research.

***What was your background prior to leading the Coalition Against Insurance Fraud and how did you personally become involved in the war on insurance fraud?***

Before the Coalition, I was vice president of communications for the National Association of Professional Insurance Agents, where part of my role was to coordinate strategic alliances between the insurance industry and national consumer groups. When the idea of the coalition surfaced, the founding insurers' members wanted someone with an insurance background and the consumer groups wanted someone who had experience working for the consumer interest. I fit that bill.

***Just how big of a problem is insurance fraud?***

With the hidden nature of insurance fraud, we likely will never have accurate estimates of the extent of insurance fraud in the United States. Current estimates vary widely, from 3 to 25 percent of claims, depending on line of insurance and region. Studies by the coalition and others strongly suggest fraud is a huge problem, costing society tens of billions of dollars each year. We estimate it is at least $80 billion per year for both public and private insurance. It's either the number one, or two, most expensive economic crime in America. It's a problem that touches all Americans — individuals and businesses. It causes a drag on our economy, puts people in financial ruin, and even kills and injures people.

***As you know, our Insurance Fraud Prosecutor, Greta Gooden Brown, was a keynote speaker at the Asia-Pacific Fraud Conference held in Australia. To what extent do you consider insurance fraud to be a problem in other countries, as well as in the United States?***

With a global economy, it's nearly impossible to contain a problem like insurance fraud to a single country or continent. Ideas for committing finan-

# Dennis Jay, Executive Director of the Coalition Against Insurance Fraud, Speaks Out

cial fraud are spreading as fast as it takes to send an e-mail message around the globe. We are hearing from other countries much more frequently the last few years. The United States is more advanced in combating fraud than most other countries, and they seem to want to learn from our expertise.

***As Executive Director of the Coalition, what has been your greatest challenge?***

As an alliance of divergent interests – insurers, government agencies, and consumer leaders – it can be challenging sometimes to find common ground on the details of legislative initiatives or public outreach campaigns. We are fortunate in that we work with dedicated individuals, but they all come from different perspectives.

***What, would you say, has been the Coalition's greatest accomplishment?***

Overall, our greatest accomplishment has been helping to advance insurance fraud as an important issue nationally. Our work has helped our key constituents – legislators, insurers, and consumers – understand the importance of combating this crime. And the results of that include passage of anti-fraud legislation in 18 states, greater deterrence, and more effective anti-fraud initiatives by insurers.

***What, if any, are the greatest changes you have seen in the war against insurance fraud since joining the Coalition as its Executive Director?***

There have been many changes since the early 1990s, including the enactment of fraud laws in 28 states, the creation of 25 state fraud bureaus, and probably a doubling of the number of SIUs. On the negative side, the level of organized criminal enterprises involved in fraud scams has exploded. Their schemes have become more sophisticated and, sadly, more violent in some cases.

***New Jersey has established a state-level Insurance Fraud Prosecutor appointed by the Governor with both criminal and civil investigators and prosecutors whose sole responsibility is the investigation and prosecution of insurance fraud. In your opinion, how does this compare to the approach of insurance fraud agencies in other states?***

New Jersey — with its severe fraud problem — took a bold step in creating the Office of the Insurance Fraud Prosecutor. It has become a model that we encourage other states to consider. There are four aspects of this operation that we think are essential ingredients for success:

- Its place and high level within government give it excellent visibility and stature;
- With its prosecutorial arm, the agency doesn't have to worry about getting cases prosecuted, unlike other state fraud bureaus;
- It appears to be adequately funded;
- The mix of criminal prosecutions and civil actions gives the agency potent tools to make a difference.

***Is public awareness an important part of your anti-fraud efforts to change public attitudes towards insurance fraud? How so?***

Public awareness is essential to successfully fighting fraud. Our goal is to help people understand (1) what fraud is, (2) how severe it is, (3) who really ends up paying for it, and (4) how people can avoid being victimized. Good public awareness also creates

deterrence and a stigma because people begin to perceive there's a likelihood that you will be caught if you commit fraud, and punishment can be severe. It also encourages people to report fraud.

***What, in your opinion, are the most effective means of deterring insurance fraud?***

Different people are motivated by different things. Knowing that there are good detection methods by government and insurers will deter some people. The stigma of getting caught is one of their biggest fears. Others are deterred by the prospects of a stiff jail term and fines. And then there's a small percentage of criminals who are not deterred by anything.

***What do you see as emerging trends in the realm of insurance fraud?***

Some of the trends we see include the increasing level of sophistication by organized frauds, new twists on old scams, such as fraud involving air bags, glass repair, and street racers. The number of insurance agents committing insurance fraud also is a concern.

***What would you say is the greatest threat the insurance industry faces in 2005 in the area of insurance fraud?***

The greatest threat is taking their eye off the fraud ball. In some respects, insurers have not kept up with the growing level of sophistication of organized fraud. The industry needs to work more cohesively in all lines of the business to become smarter in combating fraud. That includes technology and providing greater support to their fraud units and to government as partners in this battle.

***What advice would you give to everyone in New Jersey joined in the battle against insurance fraud?***

First off, be proud of your success as leaders in combating fraud. Yours is an honorable business, fighting for an honorable cause. Fraud fighters are saving consumers millions of dollars in the State. But you need to keep challenging yourselves on how, as leaders, you take this fight to the next level. Resist fighting this battle one fraud at a time, and create a system and a culture that discourage people from committing this crime. The real savings in combating fraud is not detecting the crime or arresting people or putting them in jail. It is preventing them from committing fraud in the first place.

***What should we expect to see from the Coalition Against Insurance Fraud in the coming months and years?***

The Coalition will continue its core mandate to enact anti-fraud legislation, create greater public awareness, and to conduct research on the fraud issue. For this next year, we are developing some new information programs to aid the fraud-fighting community, sponsoring an aggressive outreach program, and will begin a multi-year research project to understand trends in how the courts are punishing fraudsters. There's still much work to be done.

# New Jersey
# Insurance Fraud Case Notes

# New Jersey Insurance Fraud Case Notes

OIFP has the authority and responsibility to investigate all types of insurance fraud and for conducting and coordinating criminal, civil, and administrative investigations and prosecutions of insurance and Medicaid fraud throughout New Jersey. The most formidable way to take action against insurance cheats is through criminal prosecutions. Criminal prosecutions may result in penalties ranging from the imposition of State prison or county jail sentences to probationary or diversionary dispositions. These sentences may also include criminal fines and restitution. Summaries of some of the most significant criminal cases brought by OIFP and County Prosecutors in 2004 are set forth in this section of the Report.

Those who defraud the Medicaid Program are subject to the same criminal sanctions as those who defraud private insurance carriers. In addition to the imposition of criminal penalties, however, other sanctions may be imposed upon Medicaid defendants, such as debarment from participation in the Medicaid Program as a Medicaid provider. Where a criminal prosecution is not viable, Medicaid providers may also be sued under civil Federal or State false claims statutes. Oftentimes, these cases result in settlements involving restitution and the imposition of civil fines. Highlights of such cases are included herein.

The Insurance Fraud Prevention Act (Fraud Act), N.J.S.A.17:33A-1, et seq., specifically provides OIFP with authority to impose civil fines on insurance fraud violators in addition to, or as an alternative to, criminal prosecution. Summaries of cases in which OIFP entered into Consent Orders providing for the voluntary payment of such fines, as well as cases in which OIFP's civil attorneys pursued such violators through civil litigation, are also included.

When persons who are licensed by the State commit insurance fraud, action may be taken by the appropriate licensing board against the person's license. Such actions may include the suspension or revocation of the license, or provide for a voluntary surrender of the license. Summaries of cases in which licensing authorities and OIFP coordinate their efforts in order to effect a licensing sanction are also included in this Report.

The following tables summarize OIFP's 2004 statistics in criminal and civil actions. Also included is a table of licensing actions taken by the licensing authorities against professional licensees who committed insurance fraud.

As reflected in the criminal table, in 2004, OIFP opened 464 new criminal investigations and filed criminal charges by Accusation or indictment against 214 defendants. OIFP prosecutions during the year resulted in the

# OIFP Criminal Investigations and Prosecutions Statistics

## January 1, 2004 - December 31, 2004

| | |
|---|---|
| New Cases Opened | 464 |
| Indictments/Accusations Filed | 146 |
| Number of Defendants Charged | 214 |
| Number of Defendants Convicted | 177 |
| Number of Defendants Sentenced | 223 |
| Number of Defendants Sentenced to State Prison<br>**Total Number of Years** | 34<br>**189** |
| Number of Defendants Sentenced to County Jail<br>**Total Number of Years** | 100<br>**10** |
| Total Criminal Fines Imposed | $361,300 |
| Total Criminal Penalties Imposed | $37,010 |
| Total Civil Penalties/Fines Imposed in Medicaid Cases | $6,475,165 |
| Total Restitution Imposed | **$16,222,153**[1] |

[1] This total includes restitution imposed in criminal and civil actions

conviction of 177 defendants. Of the 223 defendants sentenced in 2004, 134 received jail terms totaling 199 years. Further, a total of over $16 million in restitution was ordered, including restitution imposed in civil actions.

As indicated in the civil table, OIFP opened 8,236 new civil insurance fraud cases in 2004 and assigned 4,646 for further investigation. OIFP issued 427 Administrative Consent Orders totaling $3,897,500 during 2004. OIFP obtained 325 Executed Consent Orders totaling $1,684,230 in which subjects voluntarily admitted

# OIFP Civil Investigations and Litigation Statistics[1]

## January 1, 2004 - December 31, 2004

| CIVIL Investigations | Number | Dollar Amount |
|---|---|---|
| New Cases Opened | 8,236 | |
| Number Forwarded for Investigation | 4,646 | |
| No Investigation Warranted | 3,590 | |
| **Sanctions Imposed** | | |
| Insurance Fraud Letters of Admonition | 1,029 | |
| Administrative Consent Orders Issued | 427 | $3,897,500 |
| Administrative Consent Orders Executed | 325 | $1,684,230 |
| Settlements Entered | 103 | $361,630 |
| Judgments Entered | 234 | $1,593,345 |
| Complaints Filed | 139 | |
| **Collections (Department of Banking and Insurance)[2]** | | |
| Number of OIFP Accounts Paid in Full | 577 | |
| Total Amount Received | | $1,815,039 |

[1] These statistics comprehensively reflect the number of discrete actions undertaken by the Office of Insurance Fraud Prosecutor in pursuing civil sanctions against insurance fraud violators. It should be noted that, in some instances, more than one action was taken against a single violator or for a single violation.

[2] These figures were reported by the Department of Banking and Insurance which is responsible for the Collections function.

committing insurance fraud and agreed to pay the civil fine imposed. In addition, OIFP effected 103 settlements totaling $361,630 and obtained 234 judgments totaling $1,593,345. Further, OIFP civil attorneys filed 139 lawsuits against Fraud Act violators in 2004.

***Note:*** *An indictment, complaint, or other charge is merely an accusation. A defendant is presumed to be innocent of the charges unless and until proven guilty beyond a reasonable doubt.*

## *Auto Insurance Fraud*

### Altering of Vehicle Identification

***State v.***
***Rafael "Bugzy" Ramos,***
***Ceaser Labrego, Neil Arruda,***
***Hernando Cordoso, Richard***
***Pina, Manuel Pinto and***
***Denise Braga Simao***
***State v.***
***Michael Garafalo***
***State v.***
***John Faria***

A State Grand Jury returned an indictment charging Rafael "Bugzy" Ramos, Ceaser Labrego, Neil Arruda, Hernando Cardoso, Richard Pina, Manuel Pinto, and Denise Braga Simao with participation in a scheme to sell re-tagged vehicles, including high-end luxury vehicles, by sometimes using fraudulently generated automobile documentation. A re-tagged vehicle has it's Vehicle Identification Number (VIN) altered to conceal the identity of the rightful owner.

Ramos pled guilty to conspiracy and on March 29, 2004, and the Court sentenced him to four years probation and 75 hours of community service. Labrego pled guilty to certain alterations of motor vehicle trademarks and identification numbers and on March 19, 2004, the Court sentenced him to two years probation and 100 hours of community service. Arruda pled guilty to conspiracy and the Court sentenced him on April 16, 2004, to four years probation conditioned upon serving 364 days in county jail, performing 75 hours of community service, and paying a $60,000 civil insurance fraud fine. The Court admitted Cardoso into the PTI Program on February 20, 2004, conditioned upon forfeiture of a re-tagged van he had in his possession. Pina pled guilty to theft by deception and was admitted into the PTI Program conditioned upon performing 50 hours of community service and payment of restitution in an amount to be determined on a later date. Pinto pled guilty to theft by deception on February 26, 2004, and the Court sentenced him to five years probation conditioned upon paying a $5,000 civil insurance fraud fine. Braga Simao pled guilty to theft by deception and the Court sentenced her on April 2, 2004, to 364 days probation.

In a separate indictment, Michael Garafalo was charged with receiving stolen property. Garafalo pled guilty to the charge and was admitted into the PTI Program conditioned upon performing 50 hours of community service.

John Faria pled guilty to an Accusation charging him with theft by deception, and on March 5, 2004, the Court admitted him into the PTI Program conditioned upon paying fines and restitution totaling $28,889.

### Criminal Use of Runners

***State v.***
***Dannie Campbell, et al.***

The Court continued sentencing defendants in 2004 who were named in three State Grand Jury indictments charging Dannie Campbell and ten other defendants with conspiracy, health care claims fraud, and attempted theft by deception. Between July of 1997 and March of 1999, Dannie Campbell allegedly masterminded two fictitious automobile accidents. Co-conspirators allegedly treated for injuries purportedly sustained in the fictitious accidents and submitted Personal Injury Protection (PIP) insurance claims to an insurance company. The first phony automobile accident Campbell allegedly planned occurred on July 24, 1997, in Hillside, New Jersey, and involved co-defendants George Holly, Jr., Shaheed Johnson, Nathaniel Jones, and Rashonda Harris. All defendants allegedly claimed to have sustained injuries that required medical treatment. The defendants allegedly submitted false PIP insurance claims under Holly's automobile insurance policy for approximately $47,700 to Keystone Insurance Company/AAA Mid-Atlantic Insurance Company. The second phony accident Campbell allegedly planned occurred on September 16, 1998, in Newark and involved co-defendants Robert Paul Mitchner a/k/a "Shaboor," Chad Watson, Ramil Robinson, Duane Smith, Monesha Gray, and Deborah Mathis. These defendants allegedly submitted fictitious PIP insurance claims to Keystone Insurance Company/AAA Mid-Atlantic Insurance Company for approximately $42,950. In both cases, Keystone Insurance Company/AAA Mid-Atlantic Insurance Company became suspicious of the claims, denied payment, and referred the matters to OIFP.

Campbell pled guilty on October 7, 2004, to health care claims fraud and is scheduled to be sentenced in 2005. Johnson pled guilty on February 27, 2004, to conspiracy and on June 25, 2004, was sentenced to three years probation and ordered to pay a $2,500 civil insurance fraud fine. On January 30, 2004, Jones pled guilty to health care claims fraud, and on August 2, 2004, he failed to appear at his sentencing and the Court issued a bench warrant for his arrest. Mitchner pled guilty on January 26, 2004, to health care claims fraud and was sentenced to two years probation with 11 days of jail credit. Mathis pled guilty to health care claims fraud and on January 12, 2004, was sentenced to three years probation and ordered to pay a $2,500 civil insurance fraud fine.

The cases as to the other defendants are pending trial.

### *State v. James Lee Campbell*

On June 18, 2004, James Lee Campbell was found guilty of violation of probation and the Court sentenced him to a new three-year term of probation. Campbell had pled guilty to a State Grand Jury indictment charging him with conspiracy and bribery. Campbell, a "runner" for health care providers, admitted paying undercover police officers more than $1,000 to obtain police accident reports. He then recruited victims in the reports to file insurance claims. Campbell's earlier sentence was five years probation conditioned upon serving 180 days in jail.

## Fraudulent PIP Insurance Claims by Doctors, Chiropractors, and Other Health Care Providers

### *State v. Anhuar Bandy, Alejandro Ventura, Elvin Castillo, Raynaldo Cuevas, Cesar Caba and Victor Almonte, et al.*

OIFP realized significant success this year in the prosecution of a 2002 indictment for a large-scale staged accident ring. On October 15, 2004, following a six-week jury trial, Anhuar Bandy and Elvis Castillo were convicted of racketeering, conspiracy, health care claims fraud, and theft by deception. On December 3, 2004, the Court sentenced Bandy to 29 years State prison, ordered him to pay a $100,000 criminal fine and restitution in the amounts of $3,483 to Sentry Insurance, $14,106 to Allstate Insurance, and $472 to Prudential Insurance. The Court sentenced Castillo to 13 years State prison and ordered him to pay $27,800 in restitution and a $50,000 criminal fine.

Anhuar Bandy and Elvis Castillo are two of 28 persons named in ten separate 2002 State Grand Jury indictments that charged defendants with racketeering, conspiracy, health care claims fraud, attempted theft, theft by deception, use of a 17-year-old or younger to commit a criminal offense, and possession of a weapon without a permit. All of the charges stem from the defendants' alleged participation in phony automobile accidents in and around Union County for which they submitted false insurance claims.

The State Grand Jury's main indictment charged Anhuar Bandy with racketeering and related crimes. The State alleged Anhuar Bandy owned, controlled, or operated, as the chief corporate officer, six North Jersey chiropractic clinics, and that Alejandro Ventura, Elvin Castillo, Raynaldo Cuevas, Cesar Caba, and Victor Almonte were associated with Bandy, or the clinics, as "runners" who fabricated eight phony automobile accidents. The State alleged that defendants used information from the eight phony automobile accidents to submit PIP insurance claims in excess of $331,000 to several insurance companies. Additionally, the State alleged in the indictment that defendants submitted insurance claims in excess of $2 million for more than 90 other phony accidents, and that the accidents were constructed by obtaining cars, drivers and passengers, faking accidents, and then sending the occupants of the cars to treat at Bandy's chiropractic clinics so he could submit the PIP insurance claims. The State alleged that insurance claims for more than 90 phony automobile accidents were submitted to 16 other insurance carriers including Bayside Casualty, Clarendon National, Continental Insurance, Farm Family Insurance Company, Liberty Mutual Insurance Company, Maryland Insurance Company, The Moxon Company, National Continental Progressive, National General Insurance Company, NJ CURE, Ohio Casualty Insurance Company, Parkway Insurance, Progressive Casualty, Red Oak Insurance Company, United States Automobile Association (USAA), and New Jersey Manufacturers Insurance Company. The State alleged that most of the claim money was paid to Bandy owned, operated, or controlled chiropractic clinics.

Six of the 28 defendants, Anhuar Bandy, Alejandro Ventura, Elvin Castillo, Raynaldo Cuevas, Victor Almonte, and Cesar Caba who is currently incarcerated at a federal prison in Bridgeton, New Jersey, were charged with conspiracy to commit racketeering, racketeering, conspiracy, health care claims fraud, use of a 17-year-old or younger to commit a criminal offense, theft or attempted theft by deception, and possession of a weapon without a permit. Cesar Caba pled guilty to conspiracy to commit racketeering and theft by deception and was sentenced on December 3, 2004, to 15 years State prison. Raynaldo Cuevas pled guilty to conspiracy to commit racketeering and was sentenced on December 3, 2004, to six years State prison, ordered to pay $6,474 in restitution to State Farm Insurance Company, pay a $2,000 criminal fine as well as a $5,000 civil insurance fraud fine. Almonte pled guilty to conspiracy to commit racketeering and was sentenced on December 3, 2004, to five years State prison and ordered to pay $162 in restitution to Prudential Insurance Company.

Twenty-two other defendants were charged in eight separate indictments (a separate indictment for each accident) for allegedly submitting or caus-



ing to be submitted fraudulent PIP insurance claims for chiropractic treatments rendered by the Bandy or other clinics to treat them for injuries purportedly sustained in the phony automobile accidents. The eight Grand Jury indictments charged the 22 defendants with conspiracy, health care claims fraud, and theft or attempted theft for their participation in the eight phony accidents as passengers, vehicle operators, and insurance claimants. The defendants allegedly treated at various chiropractic clinics in order to submit insurance claims as part of the conspiracies involving these phony automobile accidents. The State alleged that defendants submitted insurance claims in excess of $331,000 for these eight phony automobile accidents to at least eight different insurance companies including Allstate Insurance Company, Kemper Insurance Company, MDA/Newark Insurance Company, Prudential Insurance Company, Republic Western Insurance Company (U-Haul of Arizona), Selective Insurance Company, Sentry Insurance Company, and State Farm Insurance Company.

Three of the first six racketeers who were indicted have pled guilty to conspiracy to commit racketeering and face prison sentences. Another defendant has pled guilty to health care claims fraud and also faces a prison sentence. On June 25, 2004, the Court sentenced Joel Cuevas, who previously pled guilty to conspiracy to commit health care claims fraud, to nine years State prison to run concurrent with a previously imposed unrelated sentence.

### *Elvin Castillo (Tax and Mortgage Fraud Cases)*

Elvin Castillo was sentenced on December 3, 2004, to six years State prison to run concurrent to the 13-year prison sentence on the ABP racketeering charges, ordered to pay $17,200 for taxes due and pay $19,040 in penalties for a total of approximately $36,240 due to the New Jersey Division of Taxation. Castillo pled guilty on November 30, 2004, to theft by deception involving a fraudulent mortgage application. He also pled guilty to failure to file a New Jersey State income tax return and failure to pay New Jersey gross income tax with intent to evade. According to the first indictment, Castillo submitted a fraudulent residential mortgage application and fictitious documentation in support of the mortgage loan application. The State alleged that Castillo submitted fraudulent information on the loan application, the tax returns submitted with the loan application, and two letters submitted in support of the loan application. The State also alleged that Castillo's primary source of income was the Spinal Health Center of Elizabeth. The Spinal Health Center was a chiropractic clinic targeted as part of the ABP investigation. Castillo allegedly claimed he worked at the health center although it was not an operating business at the time Castillo applied for the residential loan. The State also alleged in the indictment that the 1998 income tax returns Castillo submitted for purposes of calculating his monthly income were not filed with the New Jersey Division of Taxation. The State charged Castillo in the second indictment with filing a false or fraudulent New Jersey income tax return, failure to file a New Jersey income tax return, and failure to pay New Jersey gross income tax. The State alleged that Castillo failed to pay State income taxes for 1997, 1998, 1999, and 2000.

### *State v. Michael Baer*

Michael Baer was sentenced on January 30, 2004, to three years in State prison. Baer pled guilty to health care claims fraud and criminal use of runners. A State Grand Jury charged Baer with health care claims fraud, criminal use of runners, and theft by deception. Baer, a chiropractor, owned and operated a chiropractic practice. He was charged with submitting false PIP insurance claims on behalf of patients who were undercover OIFP State Investigators to Hanover Insurance Company and Parkway Insurance Company for approximately $20,153. The State also alleged that Baer knowingly used, solicited, or employed "runners" to procure patients for his chiropractic practice. OIFP will also refer the matter to the Board of Chiropractic Examiners for licensing action.

### *State v. Franca DiLisio, et al.*

A State Grand Jury returned two indictments that charged a licensed chiropractic physician and seven other people with health care claims fraud, criminal use of runners, theft, and attempted theft by deception. The State charged one defendant with misconduct by a corporate official. All the charges arise from allegations that the defendants staged accidents for the purpose of submitting fictitious PIP insurance claims to five insurance carriers, or that automobile insurance companies were billed for bogus chiropractic treatments.

The State alleged in the first indictment that, between May 1, 1998, and October 4, 2000, Franca DiLisio, a licensed chiropractor, arranged staged accidents with the assistance of "runners" Gerard Blanc and Rolando Pierre. A "runner" is a person who gets paid to procure patients or clients for licensed professional service providers so that insurance claims can be submitted for fake injuries. The State alleged that the accidents were staged so DiLisio could treat the occupants of the vehicles for injuries they purport-

*State Investigator Jose Vendes describes OIFP's "Give and Go" auto-theft ring investigation at the New Jersey Vehicle Theft Investigators' Association Annual Training Seminar.*

edly sustained, and then bill insurance carriers for PIP insurance claims even though the patients sustained no injuries. The defendants allegedly submitted a dozen false claims to Allstate Insurance Company, Selective Insurance Company, G.U.F.A.C. Insurance Company, and Colonial Penn Insurance Company for false chiropractic treatments on 302 separate dates for "patients" who had not appeared for the treatments. The claims totaled approximately $36,380, of which $3,435 was paid by insurance carriers. Gerard Blanc pled guilty to theft by deception and on October 1, 2004, the Court sentenced him to two years probation pending his continued cooperation with the State's investigation.

In the second indictment, the State charged Marie Amay, Mimose Pierre, and Joane Amay with health care claims fraud and attempted theft by deception for acting as passengers in staged accidents and generating fictitious medical treatment claims. DiLisio allegedly submitted 16 PIP insurance claims for the women to Allstate Insurance Company, Selective Insurance Company, Colonial Penn Insurance Company, Crawford Insurance Company, and Ohio Casualty for $65,153. The insurance companies failed to pay any of the 16 PIP claims and some of these cases are pending in civil court and/or arbitration.

DiLisio is scheduled to go to trial in early 2005. The remaining seven defendants are awaiting trial.

### *State v. Richard Herbert, Melisa Caraballo, and Monique Hernandez*

Trial is pending for Richard Herbert, Melisa Caraballo, and Monique Hernandez after a State Grand Jury returned an indictment that charged them with conspiracy, health care claims fraud, and attempted theft by deception. On October 1, 2004, the State also charged Herbert in a second indictment with attempting to obtain CDS by fraud. The first indictment alleged that between October of 1998 and November of 1999, Herbert and his office employees, Caraballo and Hernandez, conspired to submit bills for diagnostic tests and chiropractic treatments that were not rendered to a patient. The alleged patient was an undercover OIFP investigator, looking into fraudulent automobile insurance PIP claims. The State alleged that automobile insurance PIP claims totaling $2,219 were submitted to GSA Insurance Company even though the professional diagnostic tests and treatments were never done on the patient. Herbert, a licensed chiropractor, owned Rehab Associates located in East Orange. In the second indictment, the State charged Herbert with allegedly attempting to obtain Tylenol with codeine, Diazepam, Lortab, and Acetaminophen with codeine by misrepresentation, fraud, forgery, deception, or subterfuge.

## Fraudulent Automobile "Give-Up" and Theft Claims

### *State v. Jorge A. Salamanca*

Jorge A. Salamanca was admitted into the Pre-trial Intervention Program (PTI) on February 20, 2004, conditioned upon paying full restitution to an auto leasing company, a $5,000 civil insurance fraud fine, and his performing 60 hours of community service. Salamanca pled guilty to an Accusation charging him with tampering with public records or information. Salamanca admitted that he falsely reported to the Elizabeth Police Department that his 1996 Acura had been stolen. He also admitted he filed a fraudulent stolen car insurance claim with Allstate Insurance. Salamanca told Allstate he last saw his vehicle at 5:30 p.m. on June 9, 2002, in Elizabeth, New Jersey. The vehicle was found at 1:30 a.m. on June 10, 2002, in Miami, Florida, making it impossible for him to have seen his car at 5:30

p.m. on June 9 in Elizabeth. Allstate denied the claim and referred the matter to OIFP.

### *Operation "Give and Go"*

OIFP initiated a complex undercover investigation to address the increasing problem of automobile theft and automobile insurance "give-ups" in North Jersey. The investigation led to 22 criminal indictments against 38 persons on charges that they allegedly planned or participated in actual thefts of the vehicles or owner-involved automobile thefts, known as automobile "give-ups," in order to collect more than $790,000 in insurance claims. Several defendants pled guilty and were sentenced during 2004.

An automobile "give-up" is the voluntary transfer of an automobile by the owner to another person who then disposes of the vehicle, often for a cash payment, for the purpose of allowing the owner to file a false auto insurance theft claim with his automobile insurance carrier and collect insurance money for the phony theft. The owner may also have the car loan or lease paid off by the insurance carrier.

OIFP undercover State Investigators leased a garage on Tonnele Avenue in Jersey City and, posing as an auto repair garage, let it be known that anybody who owned or leased a car and who wanted to get rid of it to avoid further car payments or lease payments, or because the car was damaged or needed expensive repairs, could "give-it-up." After the owners "gave-up" the cars, they reported them stolen to the police, allegedly submitted false insurance auto theft claims, and the insurance company paid the claims.

As the result of the complex undercover investigation of auto theft and phony "owner-initiated" automobile "give-up" insurance claims, 28 people were charged in 18 indictments with conspiracy, theft by deception, receiving stolen property, tampering with public records and information, and false swearing. In four of the indictments, the State charged an additional ten people with conspiracy, receiving stolen property, tampering with public records, alteration of motor vehicle identification numbers, and simulating a motor vehicle insurance identification card.

State Investigators recovered 46 cars and SUVs from several persons who allegedly either stole the vehicle or acted as "middlemen" and received the "give-up" automobiles from car owners who filed false stolen car reports. Undercover State Investigators also received some vehicles directly from the owners.

The total market value of all the vehicles recovered exceeded $1 million. More than 32 automobile theft insurance claims were submitted to the 21 insurance companies. Insurance companies paid approximately $791,094 for the auto insurance theft claims. Claims for $48,056 were not paid either because the insurance company became suspicious of the claim, or the OIFP investigation interrupted the claims process. Most of the cars were turned over to the insurance carriers because they owned the cars after the auto theft claims were paid. The companies may seek restitution for the amount of money paid for claims.

In total, phony automobile insurance theft claims were submitted to 21 insurance carriers including: AIG Insurance Company, Allstate Insurance Company, Erie Insurance Company, First Trenton Indemnity, Hanover Insurance Company, Liberty Mutual Insurance Company, Manufacturers Insurance Company, Metropolitan Property and Casualty, Motors Insurance Company, Ohio Casualty Insurance Company, Penn National Insurance Company, Progressive Insurance Company, Prudential Insurance Company, Rutgers Casualty Insurance Company, Selective Insurance Company, Sompo Japan Insurance Company of America, State and Country Fire Insurance Company, State Farm Insurance Company, Travelers Insurance Company, Universal Underwriters Insurance Company, and USAA Insurance Company.

OIFP investigators arrested Ryan December and Jason December. The State charged Ryan December with conspiracy and receiving stolen property, and Jason December with conspiracy. Arrest warrants were issued for Richard Ruiz, Carmen Marchitello, Gilberto Pascual, Rafael Padilla, Juan Naut, and "Junior" (last name unknown). The remaining 19 defendants were issued summonses.

On March 1, 2004, Ryan December pled guilty to receiving stolen property and the Court sentenced him to three years State prison and a $500 criminal fine. On the same date, Jason December pled guilty to conspiracy and the Court sentenced him to three years probation. Padilla pled guilty to receiving stolen property and on December 10, 2004, he was sentenced to four years in State prison with 14 days jail credit and ordered to pay a $500 criminal fine. Angel Vasquez pled guilty to an Accusation on March 25, 2004, charging him with theft by unlawful taking for the theft of a 1999 Isuzu Rodeo, and the Court sentenced him to two years probation conditioned upon performing 50 hours of community service. Anthony Guiliano, Jr., pled guilty to theft by deception, and on June 4, 2004, the Court admitted him into the PTI Program for two years, and ordered him to pay $7,500 restitution to Hanover Insurance, a $5,000 civil insurance fraud fine, and to perform 50 hours of community service.

As part of OIFP's continuing investigation into automobile theft and automobile "give-up" schemes, OIFP obtained additional indictments that charged ten people with crimes related

*OIFP Administrative Assistant Pat Miller receives a Director's Award from DCJ . Director Vaughn McKoy congratulated Mrs. Miller for her dedicated service to OIFP.*

to phony automobile insurance "give-up" claims. Two of these additional indictments charged eight persons with conspiracy, alteration of motor vehicle trademarks and identification numbers, receiving stolen property, theft by deception, and tampering with public records or information. The State alleged in the two indictments that, between November of 2001 and August of 2002, three automobiles were allegedly "re-tagged" by several of the eight defendants. A "re-tagged" car's VIN has been altered in order to conceal the true identity of the car and its owner, and hide that it has been "given-up" to facilitate filing fraudulent auto theft insurance claims. Two of the defendants were allegedly involved in the automobile "re-tagging" scam. Rafael "Bugzy" Ramos and Ceaser Labrego were arrested by OIFP investigators and charged with conspiracy to commit altering motor vehicle trademarks and conspiracy to commit possession of altered property. As part of this investigation, two additional people were named in two other State Grand Jury indictments charging them with receiving stolen property and simulating a motor vehicle insurance identification card.

According to one of the indictments, Joaquin Martinez was allegedly driving a stolen Cadillac Escalade and the indictment also alleged that Martinez produced a fictitious Fidelity and Guaranty Insurance Underwriters insurance identification card when police stopped him. Martinez pled guilty to receiving stolen property and the Court admitted him into the PTI Program conditioned upon his performing 60 hours of community service. Gilberto Pasqual pled guilty to receiving stolen property and the Court sentenced him on January 16, 2004, to three years in State prison and ordered him to pay a $500 motor vehicle theft penalty.

In the second indictment, the State charged Edward G. Whyte with possession of a stolen 2003 Mercedes Benz that he had stolen from a Mercedes Benz dealership located in Plumstead, Pennsylvania, by means of a "key swap." A "key swap" theft occurs when a person posing as a customer enters an automobile dealership and takes a test drive. During the test drive, the genuine ignition key is "swapped" for a fake key. The car is stolen later by using the genuine ignition key. Whyte pled guilty to receiving stolen property and the Court admitted him into the PTI Program conditioned upon his performing 60 hours of community service.

Of the nine persons for whom arrest warrants were issued for "re-tagged" cars, six were arrested by OIFP investigators. Guillermo Guzman pled guilty to attempted theft by deception. Guzman also pled guilty to an unrelated Accusation that charged him with attempted theft by deception. Guzman admitted that he reported his 1984 Oldsmobile Cutlass stolen in Secaucus and that he submitted a theft claim to Prudential Insurance Company with various fraudulent invoices indicating that he had a $1,000 stereo system and $850 worth of rims and tires recently installed in the car. Guzman admitted the invoices were phony. The Court sentenced Guzman to two years probation and ordered him to pay a $200 criminal fine. Ceasar Labrego pled guilty to certain alterations of motor vehicle trademarks and identification numbers, and on March 19, 2004, the Court sentenced him to two years probation and ordered him to perform 100 hours of community service. Carmen Marchitello pled guilty to conspiracy and on March 19, 2004, the Court sentenced him to three years probation, ordered him to pay full restitution in an amount to be determined, and a $500 criminal fine. Juan Naut pled guilty to receiving stolen property. In an unrelated matter, on the same day, Naut also pled guilty to an Accusation filed by the Division of Criminal Justice's Major Narcotics Unit that charged him with distribution of a controlled and dangerous substance (Ecstasy) . The Court sentenced Naut to four years in State prison to run concurrent with an unrelated five-year State prison sentence for narcotics. The Court also ordered him to pay $156,654 in restitution and a Narcotics Unit-related criminal fine of $2,000. Richard Ruiz pled guilty to theft by deception. He also pled guilty to an Accusation that charged him with retaliation against a witness or informant. Ruiz admitted that on March 24, 2004, he caused or threatened bodily injury to an undercover informant for OIFP who was assisting the State in its continuing investigation of the "Give and Go" matter. The Court sentenced Ruiz on September 3, 2004, to three years probation conditioned upon his serving 180 days in county jail and payment of a $3,000 civil fine.

Noel Ortiz pled guilty to an Accusation that charged him with theft of moveable property, and the Court sentenced him on August 13, 2004, to three years in State prison. Ortiz admitted he



was paid between $400 to $800 for stealing six automobiles. The automobiles were left running and unattended for Ortiz to steal so the owners could submit phony automobile theft claims.

### *State v. Paulo Dasilva-Cristelo*

OIFP filed an Accusation that charged Paulo Dasilva-Cristelo with theft by deception. The Court admitted Dasilva-Cristelo into the PTI Program on May 25, 2004, conditioned upon paying restitution in the amount of $23,407 and performing 100 hours of community service. The State alleged that on August 10, 2001, Dasilva-Cristelo falsely reported to the Wildwood Crest Police Department that his 1999 Chevrolet pick-up truck had been stolen. He subsequently allegedly submitted a stolen car insurance claim with the Camden Fire Insurance Association. OIFP's investigation revealed that the FBI and Philadelphia Police Department seized Dasilva-Cristelo's pick-up truck in a sting operation on August 9, 2001, which was one day prior to the day he last reported seeing the vehicle.

### *State v. Joseph Gavin*

As part of the Dasilva-Cristelo investigation, on October 5, 2004, a Cape May County Grand Jury returned an indictment that charged Joseph Gavin with conspiracy and theft by deception. According to the indictment, Gavin, who was also known as Joseph Abadie, allegedly conspired with Paulo Dasilva-Cristelo to submit a phony automobile insurance claim to the Camden Fire Insurance Association. The State also alleged in the indictment that Dasilva-Cristelo "gave-up" his 1999 Chevrolet pick-up truck to Gavin so that Dasilva-Cristelo could file a false stolen vehicle report with the Camden Fire Insurance Association. Camden Fire Insurance Association paid approximately $23,407 for the phony automobile insurance theft claim for Dasilva-Cristelo. Gavin's case is pending trial.

### *State v. Johnny Figueroa*

On February 3, 2004, the Court admitted Johnny Figueroa into the PTI Program conditioned upon his performing 75 hours of community service and ordered him to pay a $5,000 civil insurance fraud penalty. Figueroa pled guilty to an Accusation that charged him with attempted theft by deception. Figueroa admitted he reported to the Paterson Police Department that his 1993 Lexus SC400 had been stolen and he subsequently submitted a stolen vehicle theft claim to NJ CURE. Figueroa admitted that he registered and insured the vehicle in his own name as a favor to a friend who owned the car and he knew that the car had not been stolen.

### *State v. Thomas Bright*

Thomas Bright was admitted into the PTI Program on April 8, 2004, conditioned upon payment of $13,465 in restitution to Colonial Penn Insurance Company and performing 100 hours of community service. A Cape May County Grand Jury returned an indictment that charged Bright with theft by deception, tampering with public records or information, and falsifying records. The State alleged in the indictment that Bright submitted a phony automobile theft claim to Colonial Penn Insurance Company for $13,465 to be paid to the finance company. Colonial Penn doubted Bright's auto theft claim because the Philadelphia Police Department possessed Bright's 1995 Nissan Pathfinder before Bright last reported seeing his vehicle.

### *State v. Adam E. Turco*

The Court admitted Adam E. Turco into the PTI Program on March 26, 2004, for 36 months conditioned upon his paying a $5,000 civil insurance fraud fine. Turco previously pled guilty to an Accusation that charged him with attempted theft by deception. Turco admitted he falsely reported to the East Brunswick Police Department that his 1996 BMW had been stolen from the East Brunswick train station. Turco had hidden the car in Brooklyn, New York, and filed a fraudulent auto theft insurance claim with New Jersey Manufacturers Insurance Company.

### *State v. Richard A. Brown*

Richard A. Brown pled guilty on September 27, 2004, to tampering with public records or information, and the Court admitted him into the PTI Program for three years conditioned upon payment of $13,280 in restitution to Liberty Mutual Insurance Company and a $5,000 civil insurance fraud fine. A Passaic County Grand Jury returned an indictment that charged Brown with tampering with public records or information. The State charged in the indictment that Brown falsely reported to the Paterson Police Department that his 1998 Honda Accord had been stolen for the purpose of submitting a fraudulent stolen vehicle theft claim to Liberty Mutual Insurance Company. Liberty Mutual denied the claim and referred the matter to OIFP for investigation.

### *State v. Geraldine Battista*

Geraldine Battista pled guilty on February 18, 2004, to an Accusation that charged her with theft by deception. The Court admitted Geraldine Battista into the PTI Program condi-

tioned upon her paying a $2,500 civil insurance fraud fine and performing 25 hours of community service. Battista admitted she falsely reported to the Elizabeth Police Department that her 1995 Mitsubishi Galant had been stolen from the parking lot of the Saxony Motel in Elizabeth. Battista lent the car to her boyfriend and knew it had not been stolen. Battista admitted she submitted a fraudulent vehicle theft insurance claim to New Jersey Manufacturers Insurance Company. New Jersey Manufacturers paid her $1,732 for the loss.

### *State v. Alberto Morales*

On September 23, 2004, Alberto Morales pled guilty to falsifying records. The Court admitted him into the PTI Program conditioned upon his paying a $2,500 civil insurance fraud fine. A State Grand Jury returned an indictment that charged Morales with attempted theft by deception, tampering with public records or information, and falsifying records. According to the indictment, Morales reported to the Union City Police Department on January 26, 2002, that his 1997 Acura had been stolen. The State also alleged in the indictment that on February 4, 2003, Morales submitted a fraudulent vehicle theft insurance claim to Clarendon National Insurance Company. OIFP's investigation revealed that on January 25, 2002, the day before Morales claimed he had last seen his car, the Philadelphia Police Department responded to a car fire. The police ultimately identified the burned car as Morales' Acura.

### *State v. Donald T. Holley, Jr.*

The Court admitted Donald T. Holley, Jr., into the PTI Program on April 19, 2004, conditioned upon paying $17,538 in restitution to Sentry Insurance Company and performing 50 hours of community service. On February 25, 2004, Holley pled guilty to an Accusation that charged him with tampering with public records or information. At the time of his guilty plea, Holley paid a $5,000 civil insurance fraud fine. Holley admitted that on December 17, 2001, he reported to the Newark Police Department that his leased 1999 Dodge Durango SUV had been stolen from a residential street in Newark. Holley also admitted that he submitted a fraudulent vehicle theft insurance claim to Sentry Insurance Company. OIFP's investigation revealed that on December 13, 2001, four days prior to the purported theft, Holley's vehicle had been involved in an automobile accident in the Bronx, New York, and had been towed to a salvage yard in the Bronx where it remained for two months. Sentry paid the lessor $17,575, plus $2,318 in towing, vehicle storage, and salvage fees.

### *State v. Modesta Vendittoli*

Modesta Vendittoli pled guilty to attempted theft by deception and on April 30, 2004, the Court admitted her into the PTI Program for one year conditioned upon performing 225 hours of community service. A State Grand Jury previously returned an indictment that charged Vendittoli with attempted theft by deception and tampering with public records or information. According to the indictment, on January 28, 2002, Vendittoli falsely reported to the Secaucus Police Department that, while she was inside shopping, her 1999 Acura was stolen from the Harmon Meadow Plaza parking lot in Secaucus. Vendittoli also allegedly reported the false theft to her insurance carrier First Trenton Indemnity Company. OIFP's investigation revealed that the Jersey City Police Department impounded Vendittoli's Acura on January 19, 2002, nine days prior to the reported theft in Secaucus.

### *State v. Sakinah Banks*

Sakinah Banks pled guilty to theft by deception and on May 10, 2004, the Court admitted her into the PTI Program conditioned upon payment of a $5,000 civil insurance fraud fine. An Essex County Grand Jury returned an indictment that charged Banks with theft by deception and tampering with public records or information. According to the indictment, Banks falsely reported to the Newark Police Department that her 1996 Honda Accord was stolen from outside her home. She also allegedly falsely reported the theft to Clarendon National Insurance Company. Clarendon paid Banks $817 for personal property in the car, and it paid off the car loan for $10,157.

A Hunterdon County police officer pulled Banks over driving the Honda Accord she previously reported stolen to the Newark Police. The Hunterdon County police officer noted the car showed no signs of theft or that it had been tampered with, and Banks used a key to operate the car. Furthermore, the police officer's inspection revealed the car's security system was still operational.

### *State v. Elias Retamar*

Elias Retamar was sentenced to three years probation on June 18, 2004, for submitting a false insurance claim and receiving stolen property. The Court will determine restitution at a later date. Retamar pled guilty to an Accusation that charged him with attempted theft by deception and receiving stolen property. Retamar admitted he falsely reported a 2000 Lexus as being stolen to the North Bergen Police Department. He also submitted a



false automobile insurance claim for the Lexus to the NJ CURE Insurance Company. Retamar admitted that the Lexus was not stolen, but that he had hidden it in a Weehawken garage. Retamar also pled guilty to three counts of receiving stolen property. He admitted to knowingly receiving a stolen 2003 Acura, a stolen 2002 Toyota Camry, and a stolen 2001 Ford Mustang GT convertible. Retamar admitted he conspired with several individuals who received stolen cars and replaced VINs to conceal the true identity and ownership of the stolen cars.

### *State v. James Good*

James Good pled guilty on December 3, 2004, to falsifying records. He is scheduled to be sentenced in early 2005. An Essex County Grand Jury charged Good with falsifying records. Good allegedly filed a false stolen vehicle claim with Liberty Mutual Insurance Company stating that his 1989 Subaru had been stolen, even though he knew he was not entitled to any insurance money. OIFP's investigation revealed that on October 12, 2001, Good's 1989 Subaru was involved in a Newark automobile accident where the driver and passenger fled the scene. The State alleged that Good submitted the false claim with Liberty Mutual in order to cover up for the person driving the car because she had wrongfully left the scene of the accident.

### *State v. Francisco Caba*

Francisco Caba pled guilty to conspiracy to commit theft by deception and on October 29, 2004, the Court sentenced him to five years probation and ordered him to pay $15,000 in restitution. The State charged his co-conspirator, Geuris Valdez-Fernandez in connection with an automobile insurance "give-up" conspiracy. Valdez-Fernandez previously pled guilty and entered the PTI Program conditioned upon his paying $10,154 in restitution and a $4,000 civil insurance fraud fine. A Middlesex County Grand Jury returned an indictment that charged Caba with conspiracy and theft by deception. According to the indictment, Caba conspired with Valdez-Fernandez to submit a phony automobile insurance claim to Newark Insurance Company–The Robert Plan of New Jersey Corporation. The State alleged in the indictment that Valdez-Fernandez turned over his 1998 Toyota Camry to Caba so Valdez-Fernandez could submit a phony automobile theft claim to Newark Insurance Company. The State alleged that Caba gave the car to an individual who was working undercover for investigators from OIFP. The individual turned the Toyota over to OIFP investigators and Valdez-Fernandez allegedly reported the car stolen to the New York City Police Department. Valdez-Fernandez also allegedly submitted a sworn Affidavit of Automobile Theft to Newark Insurance Company. Newark Insurance Company paid $14,234 to Toyota Financial Services, the company that financed Valdez-Fernandez' car loan.

### *State v. Omar K. Gordon*

Omar K. Gordon pled guilty to attempted theft by deception and the Court admitted him into the PTI Program on July 8, 2004, conditioned upon performing 50 hours of community service. A Hudson County Grand Jury charged Gordon with attempted theft by deception, tampering with public records or information, and falsifying records. Gordon allegedly reported to the Jersey City Police Department that his 1996 Nissan Maxima had been stolen from a Jersey City Pep Boys parking lot on August 24, 2001. Gordon allegedly submitted an Affidavit of Vehicle Theft to State Farm Insurance Company on September 24, 2001, stating he last saw his vehicle on August 23, 2001, in the Pep Boys parking lot and that he reported it missing to the police. OIFP's investigation revealed that New York City Police Department Detective Kenneth DeStefano recovered Gordon's vehicle in the Bronx, New York, on August 23, 2001. Accordingly, it could not have been in the Pep Boys parking lot as reported by Gordon.

### *State v. Larnardo R. Pittman*

A State Grand Jury returned an indictment on April 29, 2004, that charged Larnardo R. Pittman with theft by deception, tampering with public records or information, and false swearing. According to the indictment, Pittman allegedly reported to the Newark Police Department that his 2000 Ford F-350 pick-up truck was stolen on June 9, 2002, in Newark. The State also alleged in the indictment that Pittman reported the theft to Empire Insurance Company, a subsidiary of Zurich North American Insurance Company. Based on OIFP's investigation, the State alleged in the indictment that the statements about the truck being stolen on June 9, 2002, in Newark were false, and that Pittman knew that the truck had not been stolen because he knew where it was located at all relevant times. Empire Insurance Company paid Pittman in June of 2002 approximately $29,000 based on the allegedly fraudulent stolen truck insurance claim. His case is pending trial.

### *State v. Antoinette Campbell*

Antoinette Campbell pled guilty on September 28, 2004, to an Accusation that charged her with attempted theft by deception and the Court admitted

her into the PTI Program conditioned upon performing 50 hours of community service. Campbell admitted she fraudulently reported to the Newark Police Department that her 1991 Acura Legend had been stolen. Campbell submitted a fraudulent stolen vehicle claim to Clarendon Insurance Company. She later admitted her car had not been stolen, but rather partially stripped and parked in her friend's yard where Newark Police recovered it.

### *State v. Sixto Payano*
### *State v. Maria Rivera and Jose Garcia (a/k/a Antonio Garcia)*
### *State v. Henry Rodriguez*
### *State v. Steven Collier and Carlos Ortiz*

A Hudson County Grand Jury returned three indictments on May 18, 2004, that charged three Union City men, a Jersey City woman, and a Lakeworth, Florida, man with conspiracy, theft by deception, receiving stolen property, and tampering with public records or information.

The first indictment charged Sixto Payano with conspiracy and theft by deception. The second indictment charged Maria Rivera with conspiracy, theft by deception, and tampering with public records or information, and Jose Garcia, a/k/a Antonio Garcia, with conspiracy and theft by deception. The third indictment charged Henry Rodriguez with receiving stolen property.

The State alleged in the first indictment that Payano falsely claimed that a 1994 Chevrolet van was stolen so an automobile insurance theft claim could be submitted to the Progressive Insurance Company. The vehicle was reported stolen to the Hialeah, Florida Police Department. Progressive paid the automobile theft insurance claim for $8,547 to Onyx Acceptance Corp., which had a lien on the vehicle. Payano pled guilty to theft by deception and was admitted into the PTI Program on November 15, 2004, and ordered to pay a $5,000 civil insurance fraud fine.

The State alleged in the second indictment that Maria Rivera and Jose Garcia conspired to falsely claim that a 1994 Mitsubishi Eclipse was stolen so an automobile insurance theft claim could be submitted to First Trenton Insurance Company. Maria Rivera allegedly reported the car stolen to the Jersey City Police Department and she filed an Affidavit of Vehicle Theft with First Trenton Insurance Company. First Trenton Insurance Company paid $3,925 on the claim. Rivera pled guilty on October 4, 2004, to theft by deception and the Court sentenced her on November 19, 2004, to three years probation, ordered her to pay $3,926 in restitution, and to perform 150 hours of community service.

The State alleged in the third indictment that Henry Rodriguez possessed a 1998 Toyota that had been reported stolen. Rodriguez was charged with possession of stolen property. The 1998 Toyota had been previously reported stolen by its owner and GEICO Insurance Company paid a theft claim in the amount of $18,750 to the lien holder and to the owner of the vehicle.

A Hudson County Grand Jury returned an indictment on September 1, 2004, charging Steven Collier, a Jersey City police officer, and Carlos Ortiz with conspiracy and theft by deception. According to the indictment, on June 4, 1999, Collier allegedly "gave-up" his 1999 Acura Integra to Ortiz, Collier's auto mechanic. The State alleged in the indictment that Collier submitted a fraudulent vehicle theft claim to New Jersey Manufacturers Insurance Company on June 7, 1999. New Jersey Manufacturers paid $7,291 on the claim. Ortiz pled guilty on December 8, 2004, to conspiracy to commit theft by deception and on the same day he was admitted into the PTI Program for three years conditioned upon performing 50 hours of community service and paying $6,631 in restitution to New Jersey Manufacturers Insurance Company.

The cases as to the remaining defendants are pending trial.

### *State v. Jose Alvarez*

Jose Alvarez pled guilty to theft by deception on May 27, 2004, and was admitted into the PTI Program conditioned upon paying $8,005 in restitution to New Jersey Manufacturers Insurance Company. Alvarez, a former West New York police officer, had been charged with arranging the "give-up" of his 1997 Toyota Camry with co-conspirator, Alen Hernandez, for the purpose of submitting a fraudulent theft claim to his insurance carrier. Alvarez allegedly turned the vehicle over to Hernandez and reported to the Jersey City Police Department that the vehicle had been stolen. Alvarez allegedly submitted a fraudulent Affidavit of Vehicle Theft to New Jersey Manufacturers Insurance Company resulting in a payment to Alvarez of $15,665 to settle his claim.

### *State v. George T. Guden, Michael T. Guden, John E. Gassert and Angela Guden*

A Middlesex County Grand Jury returned an indictment on June 17, 2004, that charged George T. Guden, Michael T. Guden, John E. Gassert, and Angela Guden with conspiracy and theft by deception. Angela Guden was also charged in the indictment with tampering with public records or



information and false swearing. According to the indictment, between January of 2002 and March of 2002, George T. Guden and Michael Guden allegedly "gave-up" Angela Guden's 1995 Lincoln Mark VIII car to John Gassert so it could be falsely reported stolen to the police and an automobile insurance theft claim submitted to Liberty Mutual Insurance Company. George T. Guden is married to Angela Guden and Michael Guden is their son. The State alleged that Angela Guden reported to the Woodbridge Police Department that the Lincoln was stolen from the Woodbridge Shopping Mall. The Lincoln was later recovered in the possession of John Gassert, who is alleged to be an acquaintance of the Gudens. A fraudulent stolen car insurance claim was allegedly submitted to Liberty Mutual. Liberty Mutual paid approximately $12,330 to Angela Guden for the reported theft of her Lincoln.

John Gassert pled guilty to conspiracy to commit theft by deception, and the Court sentenced him on September 30, 2004, to three years suspended sentence conditioned on his full cooperation with the State's investigation. The Court admitted Michael Guden into the PTI Program on September 30, 2004, for 36 months conditioned upon his paying $4,185 in restitution to Liberty Mutual Insurance Company. The cases as to defendants George T. Guden and Angela Guden are pending trial.

### *State v. Katrina Johnson*

The Court admitted Katrina Johnson into the PTI Program on June 21, 2004, conditioned upon paying $15,845 in restitution to New Jersey Manufacturers Insurance Company and a $5,000 civil insurance fraud fine. A Mercer County Grand Jury returned an indictment that charged Johnson with theft by deception, tampering with public records or information, and false swearing. According to the indictment, Johnson allegedly reported that her 1999 Ford Expedition was stolen while parked on East State Street outside of a laundromat. Later, she allegedly reported to New Jersey Manufacturers Insurance Company that her car was stolen at 5:30 p.m. on March 23, 2003, from East State Street. OIFP's investigation revealed, however, that the car had been parked in a parking garage located at 29th Street and 6th Avenue in Manhattan since earlier in the day on March 23, 2003. Based on its investigation, OIFP doubted Johnson's claim that someone had stolen the Ford Expedition. New Jersey Manufacturers paid $21,324 for the stolen auto insurance claim.

### *State v. Juan J. Garay*

The Court admitted Juan J. Garay into the PTI Program on August 13, 2004, conditioned upon his paying a $5,000 civil insurance fraud fine. Garay pled guilty to an Accusation that charged him with attempted theft by deception. Garay admitted he submitted a fraudulent stolen automobile insurance claim to New Jersey Manufacturers Insurance Company on October 30, 2002. Garay falsely claimed he last saw his 1989 Ford Bronco at approximately 12:30 a.m. on October 25, 2002, parked at his residence in Newark. The vehicle had been towed away by the Newark Police Department on October 24, 2002. New Jersey Manufacturers Insurance Company suspected Garay's fraud and denied the claim.

### *State v. Natasha M. Rivera*

The Court admitted Natasha M. Rivera into the PTI Program on October 22, 2004, conditioned upon her paying a $5,000 civil insurance fraud fine. Rivera pled guilty to an Accusation that charged her with insurance fraud. Rivera admitted she fraudulently reported to First Trenton Indemnity Company that her 1996 Honda Accord had been stolen when, in fact, she was involved in an automobile accident and did not have collision insurance coverage for the vehicle.

### *State v. Ysirdo Paulino*

A Hudson County Grand Jury returned an indictment on June 30, 2004, that charged Ysirdo Paulino with attempted theft by deception, tampering with public records or information, and false swearing. According to the indictment, Paulino allegedly falsely reported to the Jersey City Police Department on March 12, 2003, that his 1999 Ford Windstar had been stolen. Paulino also allegedly submitted a fraudulent vehicle theft insurance claim to Allstate Insurance Company. OIFP's investigation revealed that the Newark Police Department towed Paulino's vehicle to its impound lot on March 10, 2003. Allstate suspected Paulino's fraudulent claim and denied the claim. Paulino's case is pending trial.

### *State v. Wildor Jeannot*

Wildor Jeannot pled guilty to theft by deception and on November 29, 2004, he was admitted into the PTI Program and ordered to pay $9,595 in restitution to Liberty Mutual Insurance Company. A Hudson County Grand Jury returned an indictment that charged Jeannot with theft by deception, tampering with public records, and false swearing. According to the indictment, Jeannot falsely reported to the Jersey City Police Department on February 5, 2003, that his 1997 Nissan Pathfinder had been stolen. Jeannot allegedly filed a stolen vehicle insurance claim with Liberty Mutual Insurance Company. OIFP's investiga-

tion revealed that the Pathfinder was recovered burning in an orange grove outside of Orlando, Florida, on the same date it was reported stolen, making it impossible to have been stolen in New Jersey nine hours earlier. Liberty Mutual paid $9,595 to the lien holder for the loss. Jeannot's case is pending trial.

### *State v. Maria M. Alicea*

The Court sentenced Maria M. Alicea on July 30, 2004, to five years probation conditioned upon her paying $14,210 in restitution to Liberty Mutual Insurance Company, a $3,500 civil insurance fraud fine, and a $100 criminal fine. Alicea pled guilty to an Accusation that charged her with arson of property for purpose of collecting insurance proceeds, theft by deception, and tampering with public records or information. Alicea admitted that she and other unidentified persons agreed to set fire to her 2001 Mitsubishi Galant. Later, Alicea falsely reported to Liberty Mutual Insurance Company that her car had been stolen and she submitted an automobile insurance theft claim to Liberty Mutual for $13,209. Liberty Mutual paid Alicea's car loan balance to Household Finance Company.

### *State v. Steven Garcia*

Steven Garcia pled guilty on November 16, 2004, to attempted theft by deception. He is scheduled to be sentenced in 2005. A Union County Grand Jury returned an indictment that charged Garcia with attempted theft by deception, tampering with public records or information, and false swearing. According to the indictment, Garcia submitted a fraudulent stolen vehicle insurance claim to First Trenton Indemnity Insurance Company. Garcia allegedly claimed his 1999 Ford F-150 pick-up truck had been stolen. The truck was subsequently recovered in a garage in Lebanon, Pennsylvania. OIFP's investigation revealed that allegedly Garcia had been paying storage to keep the truck in Pennsylvania. First Trenton, suspecting fraud, denied the claim and referred the matter to OIFP.

### *State v. Amalia Vanlaparra*

The Court admitted Amalia Vanlaparra into the PTI Program on October 27, 2004, conditioned upon her paying $500 in restitution and a $1,000 criminal fine. Vanlaparra pled guilty to an Accusation that charged her with insurance fraud. Vanlaparra admitted that she filed a fraudulent stolen vehicle claim with GEICO for her 2001 Toyota RAV 4. Vanlaparra knew that the car had not been stolen, but rather she "gave-up" the car to a person to whom she paid $1,500 to dispose of the Toyota. Vanlaparra wanted to avoid paying the $469 monthly car lease payments.

### *State v. Sean D. Walker*

The Court sentenced Sean D. Walker on November 12, 2004, to two years probation and ordered her to pay a $5,000 civil insurance fraud fine. Walker pled guilty to an Accusation that charged her with attempted theft by deception. Walker admitted she falsely reported a 2002 Toyota Corolla she rented from Enterprise Rent-a-Car as stolen to the Plainfield Police Department. She subsequently submitted a vehicle theft claim to Liberty Mutual Insurance Company. Walker admitted that the car was not stolen and she had lent it to a friend who had been involved in an accident. The Plainfield Police recovered the vehicle at the scene of the accident.

### *State v. Latoya Fisher*

Latoya Fisher pled guilty to an Accusation on November 4, 2004, that charged her with insurance fraud. Fisher admitted she reported to the New York City Police Department that her 2001 Mitsubishi Montero had been stolen. Fisher also allegedly reported the fraudulent theft of the vehicle to her insurer, First Trenton Indemnity Company. Fisher admitted the car had not been stolen, but rather she gave the keys to an unidentified person who took the car. Fisher wanted to make a phony stolen vehicle theft insurance claim with her insurer and no longer make payments on the vehicle. She is scheduled to be sentenced in early 2005.

### *State v. James Walker*

The Court admitted James Walker into the PTI Program on October 29, 2004, conditioned upon his paying $8,869 in restitution to GMAC and ordered him to perform 60 hours of community service. Walker pled guilty to an Accusation that charged him with theft by deception. Walker admitted he falsely claimed to GMAC Insurance Company that his 1998 Chevrolet Blazer had been stolen when he knew he had parked the car in Jersey City. He falsely reported the car stolen to the Roselle Police Department. Walker admitted making the false stolen car reports in order to submit a phony automobile insurance theft claim to GMAC. Believing that Walker's car had been stolen, GMAC paid Walker $1,968 on the auto insurance claim, and it paid Walker's Federal Credit Union $8,844, the balance due on his car loan.



### *State v. Lim Y. Bances*

A Union County Grand Jury returned an indictment on October 29, 2004, that charged Lim Y. Bances with attempted theft by deception and tampering with public records or information. According to the indictment, Bances allegedly knowingly falsely reported to the Elizabeth Police Department that her 2002 Nissan Altima had been stolen in order to collect insurance claim money from her insurance carrier, Metropolitan Property and Casualty Insurance Company. Bances' case is pending trial.

### *State v. Raiza Y. Delossantos*

Raiza Y. Delossantos pled guilty to an Accusation on November 8, 2004, that charged her with tampering with public records or information. Delossantos admitted she falsely reported to the Jersey City Police Department that her brother's 1997 Chevrolet Blazer in her possession had been stolen in order to collect insurance money from Selective Insurance Company of America. She is scheduled to be sentenced early in 2005.

### *State v. Esther Mazara*

Esther Mazara pled guilty to an Accusation on December 14, 2004, that charged her with insurance fraud and arson. Mazara admitted that she falsely reported to Metropolitan Property and Casualty Insurance Company (MetLife) that her 1999 Jeep Cherokee had been stolen. She also admitted she assisted an unidentified person with setting fire to her 1999 Jeep Cherokee in order to collect the insurance claim money. Mazara's car was found completely burned in Philadelphia prior to the time she reported the car stolen to MetLife. MetLife paid off Mazara's car loan to Sovereign Bank for approximately $9,118 and it reimbursed Mazara $660 for her car rental cost. In total, MetLife paid approximately $10,243 on this phony automobile theft claim. She is scheduled to be sentenced in 2005.

### *State v. Israel Rivera*

Israel Rivera pled guilty to an Accusation on November 8, 2004, that charged him with insurance fraud. Rivera admitted he falsely reported to the Liberty Mutual Insurance Company that his 2001 Honda Civic had been stolen. Rivera submitted an automobile insurance theft claim for approximately $10,398. Liberty Mutual paid the insurance claim to satisfy the car loan and towing and storage charges. Liberty Mutual became suspicious of the claim and referred the matter to OIFP. OIFP's investigation revealed that Rivera's car was found burning in Philadelphia prior to the date he reported the fraudulent theft to Liberty Mutual. Rivera is scheduled to be sentenced early in 2005.

## False Automobile Related Insurance Claims

### *State v. Ronald K. Smith*

The Court sentenced Ronald K. Smith to two years probation on April 16, 2004, and ordered him to perform 40 hours of community service. Smith pled guilty to an Accusation that charged him with attempted theft by deception. Smith admitted that, between April 30, 2001, and September 24, 2001, he submitted a fictitious Proof of Purchase Agreement from National Auto Sales reflecting he purchased a 1991 Acura for approximately $18,018. Smith, in fact, purchased the car from a relative for $100. The relative had purchased the car at an automobile auction for approximately $5,000. Smith admitted falsifying the National Auto Sales purchase agreement to inflate the amount of the theft claim and collect insurance claim money from the Allstate Insurance Company.

### *State v. Romonde Lominy Laguerre*

A Somerset County Grand Jury returned an indictment on July 14, 2004, that charged Romonde Lominy Laguerre with attempted theft by deception, uttering forged writings, and falsifying records. The State alleged in the indictment that, between September 15, 2000, and October 17, 2000, Laguerre submitted false automobile insurance claims to Liberty Mutual Insurance Company following the theft of a 1991 Ford Explorer which had been recovered. Laguerre also allegedly submitted a false automobile repair invoice by altering the invoice amount from $310 to $3,995. Laguerre allegedly submitted false receipts indicating that she paid for limousine transportation to and from her place of employment on 41 dates for $2,460, when she only used limousine transportation on 28 dates for $1,680.

### *State v. Juana Perez*

The Court admitted Juana Perez into the PTI Program on April 30, 2004, conditioned upon her performing 250 hours of community service. Perez pled guilty to an Accusation that charged her with attempted theft by deception. Perez was involved in a minor traffic accident in which her 1998 Hyundai Elantra sustained minor scratches. Perez subsequently filed a vehicle damage insurance claim with Liberty Mutual Insurance Company for $3,044. Perez admitted she enhanced the damage to her car in order to inflate the cost of the repair and damages.

### *State v. John Callery*

John Callery was admitted into the PTI Program on December 17, 2004, conditioned upon performing 75 hours of community service. Callery pled guilty to an Accusation that charged him with attempted theft by deception. Callery admitted he was involved in an automobile accident while driving his 1992 Dodge Caravan. In order to support his claim for a larger settlement, Callery submitted fraudulent repair receipts supplied by another person to Liberty Mutual Insurance Company. Liberty Mutual provided insurance coverage for the other vehicle involved in the accident.

### *State v. Zia Ghahary*

Zia Ghahary pled guilty to an Accusation on December 14, 2004, that charged him with insurance fraud. Ghahary admitted he submitted a phony automobile insurance property damage claim to The Hartford Insurance Company. Ghahary claimed the rear of his vehicle was damaged in a automobile accident when the damage was preexisting and he was not entitled to payment for the damage. He is scheduled to be sentenced in early 2005.

### *State v. Mark Perillo*

Mark Perillo pled guilty to an Accusation that charged him with insurance fraud, and on September 10, 2004, the Court sentenced him to three years probation and ordered payment of a $250 criminal fine and a $2,500 civil insurance fraud fine. Perillo's 2003 Mitsubishi was stolen in New York City on October 6, 2003. Perillo admitted he submitted phony invoices to Merchant's Insurance Company to fraudulently inflate his claim. Perillo included receipts for an expensive sound system, wheels, and tires with his stolen vehicle claim. The phony invoices totaled approximately $8,560. Merchant's Insurance Company, suspecting fraud, denied the claim and referred the matter to OIFP for investigation.

### *State v. Yaw Boaten*

Yaw Boaten pled guilty to an Accusation that charged him with insurance fraud, and on October 13, 2004, the Court admitted him into the PTI Program. Boaten admitted he was involved in an automobile accident when he had no automobile insurance. Boaten also admitted he reinstated his automobile insurance with State Farm Insurance Company, and he falsely claimed the accident occurred after his insurance policy was reinstated. He then submitted altered receipts for repairs to his car to State Farm.

### *State v. Anthony Dunlock*

Anthony Dunlock pled guilty on December 7, 2004, to an Accusation that charged him with theft by deception. Dunlock admitted he used a fictitious police report when he submitted an automobile insurance PIP claim to First Trenton Indemnity Insurance Company. He admitted he falsified the police report to reflect he was injured in an automobile accident that allegedly occurred on April 8, 2000. He then allegedly went to medical professionals to seek treatment for injuries and caused bills to be submitted to First Trenton for approximately $15,900. The insurance company that supposedly insured the other driver in the false police accident report, Pacesetter Adjustment Company of Baton Rouge, Louisiana, suspected fraud and contacted First Trenton. First Trenton referred the matter to OIFP for investigation and prosecution. Dunlock is scheduled to be sentenced in 2005.

### *State v. Maximilia Scheuerer*

Maximilia Scheuerer was admitted into the PTI Program on December 10, 2004, conditioned upon performing 50 hours of community service and paying a $2,500 civil insurance fraud fine. Scheuerer pled guilty to an Accusation that charged him with attempted theft by deception. Scheuerer admitted he submitted a falsely inflated claim to Colonial Penn Insurance Company for a Worthington trailer purchased for $10,000. In fact, the trailer had been purchased for only $5,300. When the trailer was allegedly stolen, Scheuerer admitted he submitted a false claim for $10,000. Colonial Penn denied the claim and referred the matter to OIFP for investigation.

### *State v. Jason Senf*

A Mercer County Grand Jury returned an indictment on November 19, 2004, that charged Jason Senf with insurance fraud and attempted theft by deception. According to the indictment, Senf allegedly submitted an insurance claim to Foremost Insurance Company for damage done to his all-terrain vehicle (ATV). The State alleged that Senf claimed he damaged his ATV on June 22, 2003, when he struck a tree. Senf allegedly attempted to make a collision claim for damages to his ATV. The State alleged that Senf's friend actually damaged the ATV earlier on April 18, 2003, when he struck a tree with the ATV. At that time, however, the ATV was not covered with collision insurance by Foremost Insurance Company. The State alleged that after the ATV was damaged, Senf at-

tempted to obtain insurance with collision coverage. Foremost investigated Senf's June 22, 2003, claim and then referred the matter to OIFP for further investigation and prosecution. His case is pending trial.

## Insurance Claims Involving Identity Fraud

### *State v. David Scott, Nicole Barker and Charles Gladney*

A State Grand Jury returned an indictment on March 2, 2004, that charged David Scott with conspiracy to commit health care claims fraud, theft by deception, and falsification of records. Nicole Barker and Charles Gladney were each charged in the indictment with conspiracy to commit health care claims fraud. According to the indictment, Barker had an auto accident in Philadelphia. She allegedly conspired with Scott and Gladney to make it appear to the police and to the insurance company that Barker was the driver and Scott was the passenger in Barker's car when the accident occurred. Gladney was a tow truck driver who allegedly supported Barker's and Scott's false claim.

Scott pled guilty to conspiracy and health care claims fraud and the Court sentenced him on December 3, 2004, to 364 days in county jail as a condition of three years probation. Barker pled guilty to conspiracy on September 27, 2004. She is scheduled to be sentenced in 2005. Gladney's case is pending trial.

## Insurance Fraud Committed by Police Officers

### *State v. Lt. Jerome F. Bollettieri, Sgt. Thomas G. DiPatri (ret.) and Charles Warrington, II*

Charles Warrington II, a registered agent for American Spinal Care, Inc. (ASC), a Collingswood chiropractic facility that submitted PIP automobile insurance claims to insurance companies, pled guilty to criminal use of runners; and the Court sentenced him to three years in State prison on November 1, 2004. A State Grand Jury indictment charged Warrington with conspiracy, bribery in official matters, and criminal use of runners. According to the indictment, Warrington requested and paid for illegally obtained police accident reports in order to solicit prospective patients for treatment at ASC. A State Grand Jury returned an indictment that charged former Camden Police Department Lt. Jerome F. Bollettieri and Sgt. Thomas G. DiPatri (ret.) with conspiracy, official misconduct, bribery, and criminal use of runners. At the time of the conduct alleged in the indictment, Bollettieri was the officer in charge of the Camden Police Department's Traffic Records Bureau. According to the indictment, DiPatri, a retired Camden police officer, allegedly bribed Bollettieri to illegally obtain police accident reports. The State also alleged in the indictment that DiPatri obtained the police accident reports to identify automobile accident victims in order to solicit prospective patients for treatment at ASC.

Following a bench trial, the Court found DiPatri guilty of conspiracy, bribery, official misconduct, and criminal use of runners. The Court sentenced DiPatri to three years State prison. The case as to Bollettieri is pending appeal and trial.

### *State v. Philip Major, et al.*

A State Grand Jury returned four separate indictments on September 24, 2004, that charged 39 persons, primarily from Essex County, with conspiracy to commit theft by deception and official misconduct relating to automobile insurance PIP fraud. Philip Major, an East Orange police officer and the central figure in the conspiracy, was charged in a separate Accusation. Major pled guilty to conspiracy and official misconduct for writing 16 false police automobile accident reports so that approximately 60 insurance claims could be submitted to insurance companies for PIP, property damage, and non-economic losses arising from bodily injuries purportedly sustained in automobile accidents. Major admitted that he was a "runner" and accepted bribe payments from two chiropractors for providing information from police accident reports to the chiropractors who used that information to recruit patients who submitted insurance claims. A "runner" is a person who gets paid to recruit people for licensed medical professionals or lawyers so that insurance claims can be submitted. Furthermore, Major admitted he had a financial interest in Metro Medical Services, a medical facility that specialized in treating persons for insurance claims, and he also admitted he attempted to bribe another police officer for additional police accident report information in order to recruit patients to submit insurance claims. He is scheduled to be sentenced in 2005.

The 39 defendants allegedly agreed to be identified as having been involved in phony automobile accidents in police reports written by former East Orange Police Officer Philip Major. The State alleged that the conspiracy to create phony accidents occurred be-

tween June of 1995 and October of 1999. Five of the 39 defendants (Jose Frias, Cordell Vaxter, Lawrence Hannah, Rafael Torres, and Brunilda Blanco) pled guilty on December 6, 2004, to conspiracy to commit official misconduct and theft by deception. They are scheduled to be sentenced in 2005.

Mark Bendet, a now-disbarred Passaic County attorney, pled guilty to conspiracy, bribery, and theft by deception and the Court sentenced him to 13 years in State prison and ordered him to pay fines and restitution based on charges that he committed conspiracy and official bribery. Bendet admitted that he, his former wife Imelda Toquero, and former East Orange Police Officer Philip Major paid bribe money for police automobile accident reports. Automobile insurance PIP claims were allegedly submitted for claimants by Metro Medical Services. Imelda Toquero pled guilty to a State Grand Jury indictment that charged her as a co-conspirator with her husband, Bendet. She admitted she paid a former East Orange police officer for police reports as part of her role in Metro Medical Services' criminal scheme. The Court sentenced Toquero to one year probation and 364 days in county jail. The Court sentenced "runner" Eddie Boyd of Carteret for his role in the fraud. The State charged Boyd as a co-defendant with Bendet and Toquero for bribes paid to a fictitious person they believed was an Irvington police officer. The Court sentenced Boyd to 364 days in county jail and ordered him to pay $11,975 in restitution to the Robert Plan Insurance Company. Boyd worked as a "runner" for Bendet, Toquero, Major, and Metro Medical Services. Boyd allegedly intended to use some of the police reports to solicit the people named in the reports to become insurance claimants.

## Receiving Stolen Property

### *"Operation VIN Swap"*
### *State v.*
### *Antonio Rodriguez-Baez*

OIFP investigators arrested Antonio Rodriguez-Baez pursuant to complaint warrants that charged him with receiving stolen property. Rodriguez-Baez allegedly bought and sold stolen and re-tagged cars at several garages located in Jersey City and North Bergen. Re-tagging of automobiles is done by altering the VIN to conceal the identities of the cars and facilitate fraudulent insurance claims. A State Grand Jury returned an indictment on August 19, 2004, charging Rodriguez-Baez with conspiracy, receiving stolen property, and alterations of motor vehicle trademarks and identification numbers. Rodriguez-Baez is allegedly the leader of an auto theft trafficking network. According to the indictment, Rodriguez-Baez a/k/a "Tony," Eladio Reyes, and/or Jaime Rodriguez allegedly bought and sold stolen automobiles; and Rodriguez-Baez allegedly conspired with others to organize, supervise, finance, and manage the stolen automobile ring that operated out of the Jersey City area. According to the indictment, Rodriguez-Baez allegedly possessed numerous stolen vehicles, including a 2000 Mercedes-Benz, a 2001 Mercedes-Benz, a 2004 Cadillac Escalade, and two 2002 Mercedes-Benzes. The State alleged that Rodriguez-Baez also ran the automobile re-tagging operation in order to resell or transport the vehicles out of state. This case is pending trial.

### *"Operation Car Swap"*
### *State v.*
### *Terron Session*

An Essex County Grand Jury returned an indictment on June 16, 2004, that charged Terron Session with receiving stolen property. According to the indictment, Session allegedly was in possession of a stolen 1992 Lexus SC300, a 2002 Cadillac DeVille, and a 2000 Honda VTR motorcycle on February 15, 2002; the alleged stolen vehicles were worth approximately $74,000. OIFP's investigation revealed that the vehicles were stolen from a Port Authority storage facility utilized by Conrail. Session's case is pending trial.

## Staged and Fictitious Accidents

### *State v.*
### *Owen Tracy*

Owen Tracy pled guilty to health care claims fraud, and the Court sentenced him on May 14, 2004, to three years probation conditioned upon serving four days in jail and payment of $40 in restitution and a $5,000 civil insurance fraud fine. A Middlesex County Grand Jury returned an indictment that charged Tracy with health care claims fraud, attempted theft by deception, and false swearing. According to the indictment, Tracy's girlfriend was involved in a motor vehicle accident in Perth Amboy and she was the only occupant of the car at the time of the accident. Tracy allegedly claimed he was a passenger in the car and wrongfully filed a PIP insurance claim for $1,672 with his girlfriend's auto insurance carrier, Rutgers Casualty. The State also alleged that Tracy filed a sworn affidavit claiming he did not have insurance coverage and was, therefore, entitled to insurance benefits under his

girlfriend's policy. Rutgers Casualty suspected a "jump in" false claim (an insurance fraud where a person claims to be injured in a car accident when he is not a passenger in the car). It denied the claim and referred the matter to OIFP for investigation.

***State v.***
***Wanda R. Middleton***

Wanda R. Middleton pled guilty to health care claims fraud and the Court sentenced her on May 14, 2004, to three years probation and ordered her to pay a $5,000 civil insurance fraud fine. A Middlesex County Grand Jury returned an indictment that charged Middleton with health care claims fraud and attempted theft by deception. According to the indictment, a motor vehicle accident took place in Edison, New Jersey, on September 8, 2001. A driver and two passengers occupied one of the vehicles involved in the accident. Only a driver occupied the other vehicle, which was insured by NJ CURE. The State alleged in the indictment that Middleton, who was not in either vehicle and was not involved in the accident, submitted false PIP insurance claims with NJ CURE. She allegedly claimed she was an injured passenger in the insured's car. NJ CURE denied the PIP claims that totaled $16,000 for medial treatment purportedly provided to Middleton. NJ CURE referred the matter to OIFP for investigation and prosecution.

***State v.***
***Eric Boyer, et al.***
***State v.***
***Shaquan McClaurin,***
***Kirk McNeill, Alnicsa Franklin,***
***Otis Christopher, Rodney***
***Mayes and Raynelle Hamilton***
***State v.***
***Tamika Sutton, Sakinah Hill,***
***Shinaka Hill, Vanessa Miller,***
***Louis McKenzie, Emilio***
***Mayes, Raphael McCray***
***and Kevin Douglas***
***State v.***
***Tamika Sutton,***
***Shonique Carney,***
***Sheri Brown,***
***Sareesah Houston a/k/a***
***Jareeseah Houston,***
***Ona Jones, Robert Henderson***
***and Ali Sawab***
***a/k/a Abdul Sawab***

Sentencing continued in 2004 for individuals caught in a staged accident ring masterminded by Eric Boyer. Boyer pled guilty to health care claims fraud, and the Court sentenced him on June 11, 2004, to four years in State prison. The State named 22 people in four State Grand Jury indictments that charged them with conspiracy, health care claims fraud, and attempted theft by deception. Boyer masterminded the three staged accidents involving 21 alleged co-conspirators that resulted in the submission of multiple fictitious PIP insurance claims to several insurance companies. OIFP alleged in the indictments that Boyer planned and orchestrated the three phony automobile accidents between October of 1998 and October of 1999. The other defendants allegedly posed as passengers in the accidents. The three phony accidents resulted in defendants allegedly submitting over $204,378 in fraudulent PIP insurance claims to Progressive Insurance Company, State Farm Insurance Company, and Alamo-National Union Fire Insurance Company.

Boyer allegedly recruited Shaquan McLaurin, Kirk McNeil, Alnicsa Franklin, Otis Christopher, Rodney Mayes, and Raynelle Hamilton to claim that on October 5, 1998, they were passengers in a van driven by Boyer and that they were injured in a phony accident. The defendants were allegedly treated for their purported injuries and allegedly submitted approximately $66,052 in PIP insurance claims to Progressive Insurance. Progressive denied the claims. McNeil pled guilty to attempted theft by deception. The Court sentenced him on February 27, 2004, to two years probation conditioned upon his performing 50 hours of community service and paying a $3,000 civil insurance fraud fine. Hamilton, McClaurin, and Rodney Mayes pled guilty to attempted theft by deception. The Court sentenced Mayes to three years probation on February 27, 2004, conditioned upon performing 75 hours of community service and paying a $3,000 civil insurance fraud fine. On the same day, the Court admitted McClaurin into the PTI Program for one year conditioned upon performing 50 hours of community service. The Court admitted Hamilton into the PTI Program on March 5, 2004, for one year, conditioned upon his continued cooperation with the State's investigation.

Boyer also orchestrated a staged accident on November 1, 1998, in West Orange. Tamika Sutton allegedly drove a van in this phony accident that collided with a vehicle driven by Valentino White. Defendants allegedly claimed that the passengers in Sutton's van were Sakinah Hill, Shinaka Hill, Louis McKenzie, Kevin Douglas, and Emilio Mayes. The passengers allegedly in White's vehicle were Vanessa Miller, Raphael McCray,

and another person not identified in the indictment. The occupants of both vehicles were allegedly treated for purported injuries sustained in the staged accident. They allegedly submitted PIP insurance claims to Progressive Insurance and State Farm Mutual Insurance Company for approximately $62,865, of which the carriers paid $5,389. McCray pled guilty to attempted theft by deception and the Court sentenced him on February 27, 2004, to five years probation conditioned upon performing 125 hours of community service and paying a $3,000 civil insurance fraud fine. McKenzie pled guilty to attempted theft by deception and the Court sentenced him on March 26, 2004, to three years probation conditioned upon performing 50 hours of community service. The Court admitted Miller into the PTI Program on May 17, 2004, for one year. Douglas and Shinaka Hill pled guilty on December 9, 2004, to attempted theft by deception. Both are scheduled for sentencing in 2005.

Boyer allegedly arranged yet another staged accident on December 1, 1998, in Irvington. In this accident, Boyer allegedly arranged for Tamika Sutton to report that a hit-and-run vehicle struck her rented van. The defendants allegedly claimed that the passengers in Sutton's van were Sheri Brown, Robert Henderson, Ona Jones, Ali Sawab, Shonique Carney, and Sareesah Houston. As with the other phony accidents, the occupants in the rented van allegedly claimed they sustained injuries that required treatment, and they allegedly submitted PIP insurance claims totaling $75,460 to Alamo-National Union Fire Insurance Company. Brown pled guilty to attempted theft by deception, and the Court admitted her into the PTI Program on June 7, 2004, for one year conditioned upon performing 50 hours of community service. Henderson and Jones pled guilty to attempted theft by deception and the Court sentenced Jones to three years probation with credit for 67 days of time served. On November 5, 2004, Henderson was sentenced to two years probation with credit for 74 days of time served.

The charges as to the remaining defendants are pending trial.

### *State v. Mark Christopher*

The Court sentenced Mark Christopher on March 19, 2004, to six years in State prison and ordered him to pay restitution in the amounts of $4,254 to Fast Track Auto Claims, $12,705 to Republic Western Insurance Company, and $3,324 to Specialty National Insurance Company. Christopher, a/k/a Mark Valentine, Mark Palmerri, Mark Alexander, and Eric Self, pled guilty on January 21, 2004, to an Accusation charging him with health care claims fraud and theft by deception. Christopher admitted that, with his girlfriend's assistance, he used a variety of aliases to orchestrate and participate in eight staged accidents in the Camden County and Burlington County areas between December 11,1997, and April 14, 2001. Christopher submitted over $17,000 in fraudulent property damage claims and, in one instance, a $4,000 fraudulent bodily injury PIP claim.

In several of the staged accidents, Christopher allegedly operated a rented truck to hit other vehicles and subsequently filed fraudulent insurance claims. To stage one accident, Christopher rented a truck from U-Haul in the name of "Mark Valentine" and allegedly placed his girlfriend in another car he owned under the name "Mark Palmerri." They allegedly falsely claimed to Republic Western Insurance that the U-Haul truck struck the car in which Christopher's girlfriend was riding. Republic Western paid $4,181 for the claim. For another staged accident, Christopher's girlfriend allegedly leased a truck from Penske Trucks under the fictitious name of "Lisa Palmerri." Penske Trucks' insurance carrier, Fast Track Auto, paid a $4,254 insurance claim to "Mark Alexander," another alias used by Mark Christopher. For yet another staged accident, Christopher allegedly used the alias "Mark Palmerri," and claimed his car was struck by a truck rented from Ryder Rent-a-Truck, operated by "Mark Valentine," still another alias of Christopher. In this case, Specialty National Insurance Company paid Christopher's $2,550 insurance claim under his "Mark Palmerri" alias. Similar claims for $2,931 and $773 were paid by Republic Western Insurance Company for accidents purportedly involving rented U-Haul trucks for which Christopher allegedly submitted insurance claims under various aliases. Republic Western Insurance also paid $4,089 to various health care providers for treatment of injuries Christopher allegedly claimed to have sustained in one of the purported auto accidents.

Christopher also admitted to a charge of credit card fraud. Christopher allegedly retrieved receipts and credit card information from the trash at the U-Haul offices and wrongfully used the credit card information to purchase various items over the internet.

### *State v. Abdullah "Wali" Islam, Leon Harris, Glenn Johnson and Rodney Hammock*

A State Grand Jury returned an indictment on January 6, 2004, that charged Abdullah Islam, Leon Harris, Glenn Johnson, and Rodney Hammock with conspiracy, health care claims fraud, and attempted theft. According to the indictment, Islam alleg-

edly masterminded a scheme in which he and the other defendants created the impression that an automobile accident occurred on July 25, 1998, in Newark. The defendants allegedly claimed the accident involved a 1984 Ford Bronco and a 1994 Hyundai. Defendants allegedly submitted PIP insurance claims for approximately $60,250 to GSA Insurance Company. GSA denied the claims because it suspected fraud and referred the matter to OIFP for investigation. Islam and Hammock pled guilty on March 22, 2004, to attempted theft by deception. The Court sentenced Hammock on July 6, 2004, to two years probation; and on September 13, 2004, Islam was sentenced to four years probation and ordered to pay a $200 criminal fine. The Court issued bench warrants for the arrest of Johnson and Harris. Both are currently fugitives with cases pending trial.

### *State v. Iris Salkauski, et al.*

The Court handed down another sentence for a defendant caught in a staged accident ring that involved 48 defendants. Omar Montes pled guilty to conspiracy, and on May 14, 2004, he was sentenced to three years in State prison and ordered to pay a $1,500 civil insurance fraud fine and restitution in an amount to be determined at a later date.

A State Grand Jury returned ten separate indictments against 48 people. The defendants were charged with conspiracy, theft by deception, and attempted theft by deception for their participation in a staged accident ring. The State alleged that the 48 defendants planned or participated in at least ten staged automobile accidents over a two- and-a-half year period, most frequently in the City of Camden and Pennsauken Township. At least one staged accident involved undercover law enforcement officers posing as participants in the illegal scheme. Allstate Insurance Company received PIP claims totaling $567,940 from the staged accident scheme. OIFP's investigation revealed that the defendants would allegedly stage the fake automobile accidents by purposely crashing cars into one another or into fixed objects. The defendants allegedly reported the motor vehicle accidents to area police departments, principally the Camden and Pennsauken Police Departments. The "victims" then allegedly sought and obtained treatment for the reported injures sustained as a result of the staged accidents. Ultimately, defendants allegedly filed fraudulent PIP claims with the Allstate Insurance Company for payment or reimbursement of medical expenses and "pain and suffering" costs.

The principal indictment identified Iris Salkauski as the leader of the conspiracy and the coordinator of each of the ten staged accidents. Salkauski allegedly orchestrated the staged accidents, recruited the participants or "victims" for each of the staged accidents, paid the "victims" for their participation in the staged accidents, and directed the "injured victims" to obtain medical care and legal services. The State charged Salkauski with conspiracy and attempted theft by deception. Salkauski remained a fugitive from the time of the indictment until her arrest on March 5, 2003. Police arrested Salkauski cowering in a bedroom closet inside a residence in Kissimmee, Florida. Police held Salkauski in the Osceola County jail without bail until her extradition to New Jersey. Salkauski ultimately pled guilty to conspiracy and was sentenced to five years State prison and ordered to pay a $235,000 civil insurance fraud fine.

The State Grand Jury indictments charged the remaining 47 defendants with conspiracy and theft by deception or attempted theft by deception. Hector Bonilla pled guilty to conspiracy and the Court sentenced him to four years in State prison to run concurrent with a county jail sentence stemming from an unrelated matter, in addition to payment of restitution and civil insurance fines. David Gonzalez pled guilty to conspiracy and the Court sentenced him to three years probation conditioned upon performing 150 hours of community service and paying a $1,500 civil insurance fraud fine. Ileana Gonzalez pled guilty to conspiracy and was sentenced to two years probation conditioned upon performing 100 hours of community service. Miguel Roman and Elba Soto pled guilty to conspiracy. The Court sentenced Roman to three years probation conditioned upon performing 150 hours of community service and paying a $1,500 civil insurance fraud fine. Soto was sentenced to two years probation conditioned upon paying a $1,500 civil insurance fraud fine. Many of the other defendants received similar sentences and any remaining defendants await trial.

### *State v. Neil Arruda and Simone Fernandes*

A State Grand Jury returned two separate indictments against Neil Arruda and his girlfriend, Simone Fernandes. The first indictment charged Arruda with conspiracy, theft by deception, and one count of false incrimination. The State charged Fernandes in the second indictment with conspiracy, theft by deception, and hindering apprehension or prosecution. The State alleged in the indictments that Arruda orchestrated five staged accidents between March of 1998 and February of 2000 with the help of nine alleged co-conspirators. The defendants allegedly submitted fraudulent automobile insurance claims

that led to payment of over $80,000 by numerous insurance companies.

Fernandes pled guilty to theft by deception, and on February 20, 2004, the Court sentenced her to three years in State prison and ordered her to pay restitution in the amount of $45,316. On January 8, 2004, Arruda pled guilty to conspiracy, and on April 12, 2004, he was sentenced to four years probation conditioned upon serving 364 days in county jail, performing 75 hours of community service, and paying $74,905 in restitution and a $60,000 civil insurance fraud fine. OIFP already charged seven of the co-conspirators in three separate indictments returned by Essex County and Union County Grand Juries. An eighth co-conspirator was previously charged by a State Grand Jury.

### *State v. Erik Bula*

Erik Bula pled guilty on July 21, 2004, to an Accusation that charged him with health care claims fraud and theft by deception. Bula admitted that he staged an automobile accident on October 13, 1998, in Union City, New Jersey, involving two cars and five other persons. Bula and the people involved in the accident allegedly received treatment for injuries they alleged were sustained as a result of the accident. The defendants also allegedly sought bodily injury settlements from Liberty Mutual Insurance Company. Bula admitted that, as a result of the staged accident, Liberty Mutual paid approximately $5,437 to him or on his behalf. In total, Liberty Mutual paid approximately $28,500 in PIP benefits and bodily injury settlements in claims from this staged automobile accident. Bula is scheduled to be sentenced early in 2005.

### *State v. Gladys Roman, Manuel Hernandez, Yaneris Diaz, Hernando Nhar and Claudia Quiroz Mazo*

In connection with the Bula investigation, a Passaic County Grand Jury returned an indictment on December 13, 2004, charging Gladys Roman, Manuel Hernandez, Yaneris Diaz, Hernando Nhar, and Claudia Quiroz Mazo with conspiracy. Diaz, Quiroz Mazo, and Nhar were also charged with theft by deception. Mazo allegedly drove a car that rear-ended Roman's car on October 13, 1998. Nhar and Bula were alleged passengers in Mazo's car; Hernandez and Diaz were alleged passengers in Roman's car. The State alleged in the indictment that the defendants staged the accident in order to submit fictitious PIP claims and bodily injury claims to Liberty Mutual Insurance Company and ELCO Administrative Service. Claims were paid in the following amounts:
Gladys Roman - $2,619 (PIP)
Manuel Hernandez - $6,323 (PIP)
Yaneris Diaz - $3,571 (PIP);
$1,200 (bodily injury)
Claudia Quiroz Mazo - $967 (PIP);
$7,000 (bodily injury)
Hernando Nhar - $572 (PIP);
$3,275 (bodily injury)
Erik Bula - $712 (PIP);
$4,725 (bodily injury)

The defendants await trial.

### *State v. Ali Harvey, Roy Bailey and Irene Smith*

An Essex County Grand Jury returned an indictment charging Roy Bailey and Irene Smith with conspiracy to commit theft by deception and attempted theft by deception. According to the indictment, Ali Harvey, Bailey, and Smith reported to the Newark Police Department that they were passengers in a car struck by a hit-and-run vehicle that ran a stop sign. The State alleged in the indictment that the accident never occurred and that the defendants treated at an East Orange chiropractic clinic for injuries they falsely claimed to have sustained in the phony accident so they could submit bodily injury and PIP claims to State Farm Insurance. State Farm denied the claims and referred the case to OIFP for investigation.

Bailey pled guilty to attempted theft by deception, and on October 22, 2004, the Court sentenced him to three years probation with credit for 87 days served in county jail and ordered him to perform 150 hours of community service. Harvey pled guilty to an Accusation charging him with conspiracy and was admitted into the PTI Program conditioned upon performing 50 hours of community service. Smith pled guilty to conspiracy and attempted theft by deception and was sentenced to two years probation conditioned upon completing 100 hours of community service.

### *State v. John Groff, et al.*

John Groff pled guilty to attempted theft by deception admitting that he conspired with 28 other defendants to stage phony accidents and on September 19, 2003, was sentenced to seven years in State prison with three-and-a-half years parole ineligibility. Following an appeal of his sentence, Groff was resentenced on November 3, 2004, to five years probation after he served 414 days in jail as part of his original sentence.

A State Grand Jury returned the indictment that charged Groff and Luis Ruiz with conspiracy and attempted theft by deception. Groff and Ruiz, who acted as "runners," allegedly conspired with 27 other defendants to stage a total of seven automobile accidents in

and around Camden County. As a result of these phony accidents, fictitious PIP claims for nearly $97,000 were allegedly submitted to Allstate Insurance Company, State Farm Insurance Company, Liberty Mutual Insurance Company, Prudential Insurance Company, and Material Damage Adjustment Corp. False police reports were allegedly submitted to the police departments of Pennsauken, Voorhees, Cherry Hill, Bellmawr, Camden, and Gloucester Township. The carriers refused payment of the claims because of their suspicions and referred the case to OIFP for further investigation. Ruiz pled guilty to conspiracy to commit theft by deception and was sentenced to three years in State prison with one year of parole ineligibility and ordered to pay a $20,000 civil insurance fraud fine. The other defendants were admitted into the PTI Program conditioned upon their paying a $1,000 civil insurance fraud fine and their continued cooperation with the State.

## Uninsured Motorists (Fictitious Insurance Identification Cards and Motor Vehicle Documents)

### *State v. Jose Ramon Bouson*

Jose Ramon Bouson was sentenced on February 20, 2004, to three years probation conditioned upon his serving 180 days in county jail. Bouson pled guilty to an Accusation that charged him with simulating a motor vehicle insurance identification card. Bouson admitted that, while on probation for an unrelated conviction, he manufactured and sold a counterfeit motor vehicle insurance identification card to a person acting in an undercover capacity for OIFP.

### *State v. Waddell A. Tidwell*

Waddell A. Tidwell was sentenced on March 12, 2004, to probation for one year. Tidwell pled guilty to an Accusation that charged him with simulating a motor vehicle insurance identification card. Tidwell admitted that on three different occasions he sold fictitious insurance identification cards to an undercover New Jersey State Trooper.

### *State v. Boyd Robinson*

Boyd Robinson pled guilty to the sale of a simulated document and on January 23, 2004, the Court sentenced him to five years probation conditioned upon serving 364 days in county jail. A State Grand Jury returned an indictment that charged Robinson with simulating a motor vehicle insurance identification card, sale of a simulated document, and forgery. According to the indictment, between July of 2001 and August of 2001, Robinson allegedly sold a fictitious State Farm Indemnity Company automobile insurance identification card, a fictitious New Jersey driver's license, and three fictitious motor vehicle inspection stickers to an undercover OIFP investigator.

### *State v. Darren Ragin*

A Camden County Grand Jury returned an indictment on January 8, 2004, that charged Darren Ragin with simulating a motor vehicle insurance identification card for a 1988 Ford Taurus. According to the indictment, Ragin allegedly presented a fictitious Allstate insurance identification card to a Motor Vehicle Commission (MVC) inspector at the Cherry Hill MVC inspection station. Ragin's case is pending trial.

### *State v. Jorge Luis Velasquez*

Jorge Luis Velasquez was admitted into the PTI Program on February 20, 2004. Velasquez pled guilty to an Accusation that charged him with simulating a motor vehicle insurance identification card. Velasquez admitted that, during a traffic stop in South Plainfield, he knowingly presented a South Plainfield police officer with a counterfeit Liberty Mutual motor vehicle insurance identification card.

### *State v. Lakisha L. Williams*

On April 27, 2004, Lakisha L. Williams was admitted into the PTI Program, conditioned upon performing 40 hours of community service. Williams pled guilty to an Accusation that charged her with simulating a motor vehicle insurance identification card. Williams admitted that while having her vehicle inspected at a Cumberland County MVC inspection facility, she presented a counterfeit Camden Fire Insurance Company motor vehicle insurance identification card to a MVC inspector.

### *State v. Tyshon Phipps*

Tyshon Phipps pled guilty to simulating a motor vehicle insurance identification card and on April 30, 2004, the Court sentenced him to two years probation. An Essex County Grand Jury returned an indictment charging Phipps with simulating a motor vehicle insurance identification card. Phipps allegedly presented a fraudulent Progressive Insurance Company automobile insurance identification card to a police officer during a traffic stop.

### *State v. Mike Dinari*

Mike Dinari pled guilty to simulating a motor vehicle insurance identification card and was sentenced on October 22, 2004, to two years probation and ordered to pay a $500 criminal fine. A Bergen County Grand Jury returned an indictment that charged Dinari with simulating a motor vehicle insurance identification card. Following a motor vehicle stop in Ridgefield Park, Dinari allegedly presented a police officer with a fraudulent First Trenton Insurance Company motor vehicle insurance identification card knowing that the insurance identification card was counterfeit.

### *State v. Angel L. Miranda*

The Court sentenced Angel L. Miranda on March 26, 2004, to one year probation. Miranda pled guilty to an Accusation that charged him with simulating a motor vehicle insurance identification card. Miranda admitted that, to prevent having his parked, unregistered vehicle towed for a parking violation, he presented a fictitious Liberty Mutual insurance identification card to a New Jersey State Trooper.

### *State v. Nimer Elsamna*

Nimer Elsamna pled guilty to forgery and was sentenced on March 12, 2004, to one year probation. An Essex County Grand Jury returned an indictment charging Elsamna with forgery. According to the indictment, Elsamna allegedly sold a fictitious MVC temporary registration tag to an undercover OIFP investigator.

### *State v. Lamar Sturdivant*

The Court admitted Lamar Sturdivant into the PTI Program on March 22, 2004. Sturdivant pled guilty to an Accusation that charged him with simulating a motor vehicle insurance identification card. Sturdivant admitted that he presented a counterfeit Camden Fire Insurance Company motor vehicle insurance identification card to a MVC inspector.

### *State v. Clarence Shambry, Sr.*

Clarence Shambry, Sr., pled guilty to simulating a motor vehicle insurance identification card and was sentenced on March 26, 2004, to five years probation and ordered to perform 100 hours of community service. A Camden County Grand Jury returned an indictment that charged Shambry with simulating a motor vehicle insurance identification card. According to the indictment, Shambry sold a counterfeit Allstate Insurance Company motor vehicle insurance identification card to a New Jersey State Trooper.

### *State v. Kasandra Hall*

The Court admitted Kasandra Hall into the PTI Program on June 25, 2004, for a period of one year conditioned upon her performing 60 hours of community service. A Union County Grand Jury returned an indictment that charged Hall with simulating a motor vehicle insurance identification card. According to the indictment, Hall allegedly presented a false Liberty Mutual insurance identification card to a MVC inspector while having her 1999 KIA Sephia inspected at the Rahway MVC inspection station.

### *State v. Rafael Gadea*

The Court sentenced Rafael Gadea on April 2, 2004, to three years probation. Gadea pled guilty to an Accusation that charged him with simulating a motor vehicle insurance identification card. Gadea admitted that he presented a counterfeit Allstate automobile insurance identification card to a New Jersey State Trooper after being stopped for a motor vehicle violation in Camden. Gadea admitted that he bought the card “on the street,” that the card was counterfeit, and that he did not possess automobile insurance.

### *State v. Belinda Weedon*

On April 23, 2004, OIFP filed an Accusation that charged Belinda Weedon with forgery; and on the same date, the Court accepted her into the PTI Program for one year. The State alleged that while entering into a lease contract with Somerset Auto for a 2001 Dodge Stratus, Weedon presented Somerset Auto with a fictitious Liberty Mutual insurance declaration.

### *State v. Angel M. Leon*

The Court admitted Angel M. Leon into the PTI Program on July 12, 2004. The State charged Leon in an Accusation with simulating a motor vehicle insurance identification card and falsifying records. Leon, who operated a taxicab company in the Camden area, admitted that he knowingly presented a counterfeit New Hampshire Insurance Company motor vehicle insurance identification card for one of his taxicabs to a police officer. Leon also admitted that he falsified a State of New Jersey vehicle registration application by falsely providing New Hampshire Insurance Company as the insurer of a taxicab.

# OIFP Criminal Case Notes – *Insurance Fraud*

### *State v. Emiled R. Herrera*

The Court admitted Emiled R. Herrera into the PTI Program on May 14, 2004, for one year conditioned upon his performing 60 hours of community service. A Union County Grand Jury returned an indictment charging Herrera with simulating a motor vehicle insurance identification card. According to the indictment, Herrera allegedly presented a fictitious New Jersey Manufacturers Insurance Company automobile insurance identification card to a motor vehicle inspector while having his 1995 Toyota pick-up truck inspected at the Plainfield MVC facility.

### *State v. Elexis N. Dantzler*

The Court admitted Elexis N. Dantzler into the PTI Program on July 6, 2004. Dantzler pled guilty to an Accusation that charged her with the sale of a simulated motor vehicle insurance identification card and tampering with public records. Dantzler admitted that she sold a fictitious State Farm Indemnity motor vehicle insurance identification card to an undercover New Jersey State Trooper. She also admitted presenting a fictitious motor vehicle insurance identification card to the NJ MVC.

### *State v. Denar R. Sandoval*

On October 29, 2004, the Court admitted Denar R. Sandoval into the PTI Program conditioned upon performing 60 hours of community service. A Union County Grand Jury returned an indictment that charged Sandoval with simulating a motor vehicle insurance identification card. According to the indictment, Sandoval allegedly presented a counterfeit automobile State Farm Insurance Company insurance identification card to a MVC inspector while having his 1995 Nissan truck inspected at the Rahway MVC inspection station.

### *State v. Yvette R. Williams*

Yvette R. Williams pled guilty to simulating a motor vehicle insurance identification card and was sentenced on July 23, 2004, to probation for one year. A Cumberland County Grand Jury charged Williams with simulating a motor vehicle insurance identification card. According to the indictment, Williams allegedly presented a fictitious Liberty Mutual Insurance Company motor vehicle insurance identification card to a MVC inspector while having her vehicle inspected at the Millville inspection station.

### *State v. Raul Garcia*

Raul Garcia was admitted into the PTI Program on November 15, 2004, following his guilty plea on the same date to simulating a motor vehicle insurance identification card. A Mercer County Grand Jury returned an indictment that charged Garcia with falsifying records and simulating a motor vehicle insurance identification card. According to the indictment, Garcia allegedly presented a counterfeit Allstate Insurance Company motor vehicle insurance identification card to a MVC inspector while having his 1990 Honda Prelude inspected at the Lawrenceville MVC inspection facility.

### *State v. Taleatha L. Thomas*

A Mercer County Grand Jury returned an indictment on November 19, 2004, that charged Taleatha L. Thomas with simulating a motor vehicle insurance identification card. According to the indictment, Thomas allegedly presented a counterfeit Liberty Mutual Insurance Company motor vehicle insurance identification card to a MVC inspector while having her 1997 Geo Prism inspected at the Lawrenceville MVC inspection facility. Thomas' case is pending trial.

### *State v. Jorge Fonseca and Joe Abel Hojas-Bravo*

Joe Abel Hojas-Bravo pled guilty to official misconduct and the Court sentenced him on December 3, 2004, to 180 days in county jail as a condition of 30 months probation. Jorge Fonseca pled guilty on October 18, 2004, to conspiracy and is scheduled to be sentenced in early 2005.

A State Grand Jury returned an indictment that charged Fonseca with conspiracy, forgery, and sale of simulated documents. The State Grand Jury also returned a second indictment that charged Hojas-Bravo with conspiracy, official misconduct, and transfer of a simulated document. According to the first indictment, between June 28, 2002, and July 9, 2002, Fonseca allegedly conspired with an employee of the Irvington MVC to make fictitious drivers' licenses, driving permits, and automobile titles. The second indictment alleged that Hojas-Bravo, an employee of the Rahway MVC facility, conspired with another person to create and transfer a fictitious New Jersey motor vehicle driver's license.

***Note:*** *The following two cases are municipal court matters. Offenses prosecuted in municipal court are not crimes and these defendants were not charged with any crime in these matters.*

### *State v. Emilio Lebron*

Emilio Lebron pled guilty on May 17, 2004, in Upper Deerfield Township Municipal Court to a disorderly persons offense for possession of a fictitious motor vehicle insurance identification card. The Court sentenced him to a fine of $300 and court costs.

### *State v. Jose Sandoval*

Jose Sandoval pled guilty on December 1, 2004, to a disorderly persons charge for possession of a false motor vehicle insurance identification card. He was ordered to pay a $250 fine.

## Motor Vehicle Commission Initiative

### *"FIX-DMV"*

"FIX-DMV" is OIFP's continuing investigation into official misconduct and fraud at the State's Motor Vehicle Commission (MVC), as well as the procurement of fictitious identification to include drivers' licenses, commercial drivers' licenses, and other MVC-related documents. OIFP has learned by investigating and prosecuting insurance fraud that false identification, including fictitious drivers' licenses, is frequently used by persons to commit insurance fraud. For example, false identification is used in staged accidents for submitting false PIP automobile insurance claims. Many people file false insurance claims utilizing several different false identities. Fictitious drivers' licenses facilitate this illegal conduct.

### *"FIX-DMV-1" State v. Rita Okolo, Josefina Martinez and Fermin Capellan*

A State Grand Jury returned an indictment that charged Rita Okolo, a MVC employee, with multiple counts of conspiracy, official misconduct, and bribery in official matters. The State also charged her with one count of sale of a simulated document. A second indictment charged Josefina Martinez and Fermin Capellan each with conspiracy and bribery in official matters.

According to the first indictment, Okolo, in her official capacity as an Exam Technician at the Wayne MVC office located on Route 23, allegedly sold fictitious commercial drivers' licenses for $300 to undercover OIFP investigators between November of 2002 and January of 2003. According to the second indictment, between February of 2003 and May of 2003, Okolo allegedly accepted a $500 bribe from Capellan to provide him with a fictitious commercial driver's license in the name of Josefina Martinez. The State alleged in the indictment that Martinez was issued a commercial driver's license without taking the commercial driver's license exam. The Okolo, Martinez, and Capellan cases are pending trial.

### *"FIX-DMV-2" State v. Tiffany Swinney*

Tiffany Swinney pled guilty on November 30, 2004, to tampering with public records or information and is scheduled to be sentenced in early 2005. A State Grand Jury charged Swinney with tampering with public records or information and sale of a simulated document. A Wayne police officer stopped Swinney for a motor vehicle violation. According to the indictment, Swinney, an employee of the Wayne MVC office located on Route 23, allegedly presented a fictitious driver's license to the police officer. A MVC lookup revealed that MVC had suspended Swinney's driver's license.

### *"Fix-DMV-13" State v. Stacey Chestnut*

A State Grand Jury returned an indictment on March 4, 2004, that charged Stacey Chestnut with official misconduct. According to the indictment, Chestnut, in her capacity as an employee of the Wayne MVC facility located on Route 23, allegedly created two fictitious motor vehicle forms for two people who were not named in the indictment. The State alleged that Chestnut created and processed an application for a duplicate non-photo driver's license and an application for a driver's examination permit for a commercial driver's license (CDL). Chestnut's case is pending trial.

### *"Fix-MVC-16" State v. Karina Noelia Vallego, Monica Morelli, Luis Lagos and Betty E. Doering*

OIFP investigators arrested and charged Karina Noelia Vallego, her mother Monica Morelli, Luis Lagos, and Betty E. Doering with conspiracy to commit a sale of a simulated document and tampering with public records related to obtaining false identification documents. A State Grand Jury returned an indictment on May 24, 2004, that charged the defendants with conspiracy and tampering with public records.

The State alleged that Vallego, Morelli, Lagos, and Doering assisted

another person to identify people involved in the sale of fictitious MVC documents including drivers' licenses, registrations, and other related public records. Additionally, the State alleged that Morelli, Lagos, and Doering provided an undercover OIFP investigator with a fictitious birth certificate, paycheck stub, and Union County identification card in order to facilitate obtaining a fictitious New Jersey driver's license. Doering, Morelli, and Lagos pled guilty to conspiracy on October 6, 2004, and are scheduled to be sentenced in 2005. Vallejo's case is pending trial.

### *State v. Kamillah Ali and Julia Ali*

Following the arrests of Kamillah Ali and Julia Ali, a State Grand Jury returned an indictment on October 15, 2004, that charged Kamillah Ali with simulating a motor vehicle insurance identification card, conspiracy, and sale of simulated documents. The Grand Jury also charged Ali's mother, Julia Ali, in the indictment with sale of a simulated document. According to the indictment, Kamillah and Julia Ali allegedly sold fictitious motor vehicle-related documents including drivers' licenses, automobile titles, a temporary registration tag, a fictitious insurance identification card, a phony birth certificate, and a phony Social Security card. The State alleged that the documents were sold to an OIFP undercover investigator as part of an investigation into the source of fictitious documents. The case is pending trial.

### *State v. Michael Delgato*

An Essex County Grand Jury returned an indictment on November 12, 2004, that charged Michael Delgato with simulating a motor vehicle insurance identification card. According to the indictment, on four occasions Delgato allegedly sold fictitious Liberty Mutual Insurance Company, Prudential Insurance Company, and State Farm Insurance Company motor vehicle insurance identification cards. Delgato awaits trial.

### *State v. Wesley M. Jordan*

Wesley M. Jordan pled guilty on November 29, 2004, to an Accusation that charged him with exhibiting and/or displaying a simulated motor vehicle insurance identification card to a law enforcement officer. Jordan, a former Cumberland County corrections officer, admitted that he presented a fictitious New Jersey Skylands automobile insurance identification card to an inspector while having his car inspected at the Millville MVC inspection facility. He later presented the same fictitious card to a State Trooper. Jordan is scheduled to be sentenced in early 2005.

### *State v. Jazzmia Green*

The Court admitted Jazzmia Green into the PTI Program on December 15, 2004, conditioned upon performing 50 hours of community service. A Mercer County Grand Jury returned an indictment that charged Green with simulating a motor vehicle insurance identification card. According to the indictment, Green allegedly presented a counterfeit State Farm automobile insurance identification card to an inspector at the Lawrenceville MVC inspection station.

### *State v. Florine Vereen*

The Court admitted Florine Vereen into the PTI Program on December 15, 2004, conditioned upon performing 50 hours of community service. A Mercer County Grand Jury returned an indictment that charged Vereen with simulating a motor vehicle insurance identification card. According to the indictment, Green allegedly presented a counterfeit Liberty Mutual automobile insurance identification card to an inspector at the Lawrenceville MVC inspection station.

## *Health and Disability Fraud*

### Fraudulent Health and Disability Claims by Doctors, Chiropractors, and Other Health Care Providers

### *State v. Richard Finder*

On January 22, 2004, the Court sentenced Richard Finder to three years probation conditioned upon his serving 180 days in county jail, ordered him to perform 350 hours of community service, and to pay restitution in the amount of $201 and a $15,000 civil insurance fraud fine. Finder, a former licensed chiropractor, pled guilty to an Accusation that charged him with health care claims fraud. Finder admitted that, from January of 2000 through August of 2000, he submitted over $1,260 in fraudulent bills to the Cigna Insurance Company for chiropractic treatments that were never rendered to patients. Finder formerly operated The Family Chiropractic Clinic located in Fort Lee.

### *State v. Paul Anodide*

A State Grand Jury returned an indictment on January 22, 2004, that charged Paul Anodide with health care claims fraud, theft by deception, and falsifying records. According to the indictment, Anodide, a licensed dentist with an office in Trenton, allegedly submitted bills to three insurance carriers

regarding approximately 28 patients with more than 75 allegedly fraudulent dental insurance claims. The claims allegedly totaled approximately $85,914 and the carriers paid approximately $62,846 on the claims. The allegedly fraudulent claims included claims for root canals, crowns, and fillings. All of the services were billed to the carriers, but allegedly were not rendered to the patients. The State also alleged that Anodide submitted claims for Sunday dental services when the dental office was closed. According to the indictment, Anodide also allegedly submitted claims for crowns and root canals that were performed twice on the same tooth. Anodide allegedly submitted fraudulent claims to insurance carriers including Prudential Health Care of New Jersey, Aetna US Healthcare, and Delta Dental Insurance Company. Prudential was the third party claims administrator for the New Jersey State Health Dental Plan that provides dental services to State employees. Prudential processed dental insurance claims that were paid with State money. Anodide awaits trial.

### *State v. William Burke and*

A State Grand Jury returned an indictment on December 6, 2004, charging William Burke and , both licensed cardiologists, with conspiracy, health care claims fraud, and attempted theft by deception. According to the indictment, Burke and practiced at Orange Mountain Medical Associates which had offices located in West Orange, Berkeley Heights, and Millburn. They allegedly submitted false insurance claims to insurance companies between January 1, 1997, and February 5, 2002. The State alleged that the doctors agreed to prescribe unnecessary cardiac diagnostic tests that were inconsistent with their patients' ailments. The State also alleged that although the patients had insufficient cardiac symptoms to justify the administration of stress tests and electrocardiograms, the doctors administered stress tests and electrocardiograms; and they allegedly gave questionable cardiac-related diagnoses in order to bill insurance companies for the cardiac-related medical tests at a higher specialist rate. The doctors allegedly submitted fraudulent bills to multiple insurance companies including Prudential Insurance Company and Aetna Insurance Company. The insurance companies received at least $35,000 in allegedly false bills. This case is pending trial.

### *State v. Andrew Rosenfarb*

The Court sentenced Andrew Rosenfarb on September 10, 2004, to three years probation conditioned upon his paying $1,530 in restitution to State Farm Insurance Company and a $10,000 civil insurance fraud fine. In addition, Rosenfarb's professional license was suspended for a period of one year. Rosenfarb pled guilty to an Accusation that charged him with health care claims fraud. Rosenfarb admitted that he submitted health insurance claims pertaining to two patients for acupuncture services purportedly rendered on approximately 36 different dates when he provided no acupuncture services. Rosenfarb submitted the insurance claims to Encompass Insurance Company and State Farm Insurance Company. The claims submitted to State Farm Insurance Company related to an automobile insurance PIP claim.

### *State v. David M. Fink*

David M. Fink pled guilty to health care claims fraud and the Court sentenced him on October 15, 2004, to five years probation. A Middlesex County Grand Jury returned an indictment that charged Fink with health care claims fraud. According to the indictment, the Court previously placed Fink on probation and ordered him not to practice psychology as part of a sentence imposed on August 13, 2002, for health care claims fraud. Despite the previous Court Order, and in violation of his probation, Fink allegedly continued to render psychological counseling. He allegedly billed three insurance companies, Oxford Health Plan, New Jersey Manufacturers, and United Health Group Insurance, for treating 34 patients. Fink's 2002 sentence required him to pay approximately $6,000 in civil fines and penalties. A licensing action has been taken against Fink by the New Jersey Board of Psychological Examiners regarding his continued practice, and he has been ordered to pay $39,409 in penalties.

### *State v. Nicola Amato*

The Court sentenced Nicola Amato on July 9, 2004, to three years probation conditioned upon payment of a $20,000 civil insurance fraud fine. Amato, a licensed chiropractor, pled guilty to an Accusation that charged him with theft by deception. Amato admitted that while operating a chiropractic practice in Waretown, he submitted fictitious insurance bills pertaining to approximately 28 patients between April of 1997 and October of 1999. Amato also admitted that the chiropractic insurance claims were fraudulent because he performed three or four chiropractic area manipulations, but billed the insurance companies for five chiropractic area manipulations. By overbilling, Amato stole approximately $27,348 based on the approximately 1,784 bills submitted for five chiropractic area manipulations when he performed less than five manipulations.

# OIFP Criminal Case Notes – *Insurance Fraud*

### *State v. Alphonso Smith and Daniel Catanzaro*

Alphonso Smith and Daniel Catanzaro pled guilty to reckless health care claims fraud and on August 6, 2004, they were both sentenced to one year probation and ordered to pay restitution in the amount of $9,400 each. The Court also ordered Catanzaro to perform 200 hours of community service. A State Grand Jury returned an indictment that charged Smith and Catanzaro with reckless health care claims fraud, attempted theft by deception, and theft by deception. Smith, a licensed medical doctor, and Catanzaro, a licensed chiropractor, operated a medical practice in Wayne known as Quality Care Physicians, or Physicians Plus. The doctors allegedly submitted bills between July of 1997 and March of 1999 in the amount of $36,000 for anesthesia administered by needle injection when they provided electrical stimulation therapy that did not involve injected anesthesia. Ordinarily, licensed medical service providers can bill more money for needle injected anesthesia than electrical stimulation. The false claims were allegedly submitted to several insurance companies for both health and automobile insurance including Oxford Health Care, New Jersey Manufacturers Insurance Company, United Health Care, and Allstate Insurance Company.

### *State v. Patrick Manze and Michelle Maglione*

Patrick Manze, a medical doctor, and Michelle Maglione, Manze's fiancé and office manager, pled guilty to two separate Accusations charging them with health care claims fraud. The Court sentenced Manze on July 16, 2004, to two years probation conditioned upon his paying a $5,000 civil insurance fraud fine. Manze's medical license was also suspended for a period of one year. The Court admitted Maglione into the PTI Program conditioned upon her performing 50 hours of community service and paying a $5,000 civil insurance fraud fine.

Maglione admitted that she solicited health insurance information from a friend so insurance claims could be submitted under the pretense that the friend planned to become a patient of Manze at a later date. The friend, who was not charged, provided the information, but indicated that she presently had no reason to see the doctor. Manze admitted that he utilized the health insurance information solicited by Maglione to submit two fraudulent health insurance claims to Horizon Blue Cross Blue Shield for approximately $2,625. Manze allegedly submitted false bills for an office examination and diagnostic tests including a cystoscopy, a cystometrogram, and for two ultrasound studies. The bills were denied by the insurance company because it suspected the bills were fraudulent. The friend detected the alleged fraudulent scheme when she received an Explanation of Benefits Form for tests she knew were not performed by the doctor. She immediately contacted Horizon to report the fraudulent bills.

### *State v. Roben Brookhim*

The State charged Roben Brookhim with health care claims fraud, and on November 19, 2004, the Court admitted him into the Union County PTI Program conditioned upon paying a $90,000 civil insurance fraud fine and a penalty in the amount of $20,000 to the Board of Dentistry representing fines and costs. Brookhim also surrendered his dental license which has been deemed to be a revocation. The charge stemmed from Brookhim's alleged continued practice of dentistry although he was previously suspended from the practice of dentistry by the Board of Dentistry, which regulates licensed dentists in New Jersey. Brookhim also allegedly continued to bill insurance companies for dental treatments even though he had no license to practice at the time. OIFP alleged that Brookhim concealed his continued practice of dentistry by having his nephew's name, Rony Elyahouzadeh, who was also a licensed dentist, appear on various records relating to Brookhim's treatment of dental patients, including insurance bills and claim forms. Elyahouzadeh was also jointly and severally liable for the civil insurance fraud fines and professional licensing fines. Elyahouzadeh was not criminally prosecuted; however, he received a six-month active suspension of his dental license with an additional 30-month suspension to be stayed.

### *State v. W. Lance Kollmer*

A State Grand Jury returned a third indictment on October 12, 2004, that charged W. Lance Kollmer, a board-certified plastic surgeon, with theft by deception and attempted theft by deception. The State alleged that Kollmer submitted false claims between August of 2001 and March 2, 2004, to U.S. Life/American General Insurance Company and the Hartford Insurance Company claiming he was totally disabled, unable to practice medicine, and entitled to be reimbursed for office overhead expenses and other disability insurance claims payments. The State alleged that U.S. Life/American General Insurance Company and the Hartford Insurance Company paid approximately $614,825 for these claims through January of 2004.

The first indictment charged Kollmer with submitting false disability insurance claims to Sentry Insurance Company and American General Insurance Company. The State alleged that Kollmer obtained more than $300,000 in fraudulent insurance claim money from Sentry Insurance Company and American General Insurance Company by falsely claiming he was totally disabled from practicing as a plastic surgeon. Kollmer allegedly performed, however, dozens of surgical procedures during the claimed disability period. The second indictment charged Kollmer with theft by deception. The State alleged that Kollmer falsely claimed he was totally disabled; and, pursuant to a contract between himself and Unum Provident Corporation, he was entitled to $9,000 in life insurance without having to pay any insurance premiums. Kollmer's cases are pending trial.

### *State v. Barry Vogel*

Barry Vogel pled guilty to health care claims fraud, and on October 22, 2004, the Court sentenced him to five years probation, conditioned upon serving 180 days in county jail. His medical license was also permanently revoked. A State Grand Jury returned an indictment that charged Vogel, a neurologist, with health care claims fraud and theft by deception. According to the indictment, Vogel allegedly submitted fraudulent bills for more than $54,000 to Prudential Property and Casualty Insurance Company of New Jersey for diagnostic services he failed to render or failed to render properly. The State alleged that Vogel submitted fraudulent health insurance claims for electro-diagnostic tests, known as nerve conduction velocity (NCV) tests, he allegedly performed on victims in automobile accidents. The State also alleged that Vogel fraudulently submitted the same diagnostic test results for multiple patients.

## Fraudulent Billing by Health Care Providers

### *State v. John Marrone*

The Court admitted John Marrone into the PTI Program on November 3, 2004. An Accusation charged Marrone with falsifying or tampering with records. Marrone, a licensed family therapist, allegedly fraudulently billed insurance carriers for therapy and counseling treatments by misrepresenting that the treatments were performed by licensed doctors.

## False Health Care Claims

### *State v. Paul Scrudato*

Paul Scrudato pled guilty to theft by deception and the Court sentenced him on July 23, 2004, to two years probation conditioned upon paying $7,047 in restitution to Hunterdon Regional High School, Delta Dental, Horizon Blue Cross Blue Shield, and the New Jersey Division of Pensions and Benefits; a $1,500 civil insurance fraud fine; and a $5,000 criminal fine.

A State Grand Jury returned an indictment that charged Scrudato with health care claims fraud and theft by deception. According to the indictment, McManus Middle School, located in Linden, employed Scrudato as an Information Systems Administrator. Although he was entitled to enrollment in the State Health Benefits Program, Scrudato allegedly caused fraudulent health insurance claims to be submitted to Delta Dental and Horizon Blue Cross Blue Shield in the approximate amount of $21,916. The State alleged that the claims were fraudulent because Scrudato claimed a woman he lived with and her children from a previous marriage were entitled to health and dental benefits as his lawful dependants under the State Health Benefits Program. The State alleged that they were not entitled to the benefits because neither the woman nor her children were the lawful dependants of Scrudato. More than $11,000 was paid for health insurance-related claims.

Delta Dental and Horizon Blue Cross Blue Shield administer dental

and health insurance claims as third party administrators for the New Jersey State Health Benefits Program. State tax dollars pay the health and dental claims for State employees and their dependants as a benefit of employment with the State of New Jersey.

### *State v. Barry Cohen*

A State Grand Jury returned an indictment on September 8, 2004, that charged Barry Cohen with health care claims fraud, theft by deception, and misconduct by a corporate official. Cohen, a Certified Public Accountant, operated a family-owned corporation known as Headways, Inc. The corporation provided health care services, including therapy, to patients who had suffered brain injuries. According to the indictment, Cohen allegedly caused Headways to submit more than $350,000 in fraudulent health insurance claims to several insurance companies and self-funded health benefits plans. Among the insurance companies and health benefits plans that allegedly received the false claims were Allstate Insurance Company, Horizon Blue Cross Blue Shield of New Jersey, State Farm Insurance Company, Proformance Mutual Insurance Company, the New Jersey Automobile Full Insurance Underwriting Association, and Key Benefit Administrators, a third party claims administration company that administered health insurance for the Teamsters Union Local 560 Benefit Fund. The State alleged in the indictment the claims were for services that were not rendered by Cohen. Cohen's case is pending trial.

## Fraud Committed by Pharmacists

### *State v. John D. Wylie*

The Court sentenced John D. Wylie to two years probation on March 26, 2004, and ordered him to pay $1,050 in restitution to Horizon Blue Cross Blue Shield, $17,477 in restitution to Aetna Insurance Company, and a $135,000 civil insurance fraud fine. Wylie pled guilty to an Accusation that charged him with theft by deception. Wylie admitted he submitted approximately 136 false claims to Horizon Blue Cross Blue Shield of New Jersey and Aetna Life Insurance Company. Wylie, a licensed pharmacist, practiced holistic medicine at the Center for Health Education Research, Inc., (CHER) in Cherry Hill. Wylie was licensed to perform various non-reimbursable, non-medical treatments to include electric stimulation, neuromuscular reeducation, manual manipulation, and body fluid analysis including blood, saliva, and urine. He admitted that, by submitting the claims to insurance carriers on behalf of insured patients, he wrongfully represented that these procedures were covered medical procedures done pursuant to doctor's orders. The investigation revealed that Wylie fraudulently billed Aetna for $16,426, and Horizon Blue Cross Blue Shield for $1,051.

## Fraudulent Disability Claims

### *State v. Barbara D. Dickens*

Barbara D. Dickens pled guilty on January 12, 2004, to theft by deception. The Court sentenced her to three years in State prison and ordered her to pay $25,308 in restitution to CIGNA Insurance Company. A State Grand Jury returned an indictment that charged Dickens with theft by deception and falsifying records. According to the indictment, Dickens allegedly represented to CIGNA Insurance Company that she did not maintain employment because she was totally disabled between April of 1997 and January of 1999. CIGNA Insurance paid Dickens a total of $25,305 in disability insurance benefits. OIFP's investigation showed that Dickens was continuously employed and ineligible to receive disability insurance benefits.

### *State v. Suzanne Shenk*

Suzanne Shenk pled guilty to theft by deception and was sentenced on April 2, 2004, to five years probation and ordered to pay $1,247 in restitution to Aetna Insurance Company and a $5,000 civil insurance fraud fine. A Passaic County Grand Jury returned an indictment that charged Shenk with theft by deception, forgery, and falsifying documents. According to the indictment, Shenk allegedly wrongfully collected disability insurance payments from Aetna Insurance Company by concealing she worked at a physician's office. The State alleged in the indictment that Shenk forged a letter and falsified another letter to support her disability claims to Aetna Insurance.

### *State v. Jasmine Gomez*

On September 13, 2004, a State Grand Jury returned an indictment that charged Jasmine Gomez with theft by deception and uttering a forged document. According to the indictment, Gomez allegedly wrongfully collected approximately $5,100 in disability insurance claims from Trustmark Insurance Company. The State alleged that Gomez began to receive disability insurance claims money from Trustmark

after a November of 2001 automobile accident. The State further alleged Gomez forged physician statements to falsely indicate that she was still injured and unable to return to work in order to continue receiving the disability insurance payments. Gomez' case is pending trial.

### Health Insurance Underwriting/Application Fraud

#### *State v. Barry W. Kallenberg*

The Court sentenced Barry W. Kallenberg on March 26, 2004, to180 days in county jail as a condition of one year probation and ordered him to pay Horizon Blue Cross Blue Shield $64,980 in restitution. Kallenberg pled guilty to an Accusation that charged him with theft by deception. Kallenberg admitted that he created a fictitious real estate management business in order to purchase group health insurance and that he applied to Horizon Blue Cross Blue Shield of New Jersey for a small employer health benefits policy in order to provide health coverage at a lower premium employee group rate for five people who were not entitled to the coverage because they were not bona fide employees of a bona fide business. OIFP's investigation revealed that Kallenberg submitted employee health insurance claims totaling approximately $111,500 to Horizon Blue Cross Blue Shield.

#### *State v. Robert Bloch*

As part of the Barry Kallenberg case, Robert Bloch pled guilty on May 10, 2004, to an Accusation that charged him with theft by deception, and the Court admitted him into the PTI Program conditioned upon performing 40 hours of community service. Bloch admitted he falsely obtained employer-sponsored group health insurance by falsely representing he was an employee of a real estate management company known as Hill Parking.

#### *State v. Michael S. Sorbello*

Michael Sorbello was sentenced on December 2, 2004, to five years probation, ordered to pay $18,000 in restitution and a $2,500 civil insurance fraud fine. Sorbello pled guilty to an Accusation that charged him with theft by deception. Sorbello admitted he stole $38,299 from New Jersey Manufacturers Insurance Company. Sorbello falsely represented to New Jersey Manufacturers that he was enrolled as a full-time student at Gloucester County Community College and, therefore, entitled to collect approximately $568 per week in workers' compensation insurance benefits. The insurance benefits were provided pursuant to a workers' compensation insurance policy that provided coverage for Sorbello based on the death of this father. The policy permitted Sorbello to collect the $568 per week as long as he was enrolled as a full-time student. New Jersey Manufacturers' investigation revealed that Sorbello was not enrolled anywhere as a full-time student. New Jersey Manufacturers referred the matter to OIFP for further investigation and prosecution.

## *Insurance Professional Fraud*

### Insurance Agent Fraud

#### *State v. Joseph Binczak*

Joseph Binczak pled guilty to theft by deception, and on January 7, 2004, the Court sentenced him to three years in State prison and ordered payment of $573,700 in restitution. A State Grand Jury indicted Binczak for theft by deception and falsifying records. The Ukranian National Association (UNA) employed Binczak as an insurance sales manager responsible for maintaining life insurance annuity accounts for UNA members. He allegedly wrongfully withdrew over $600,000 from the annuity accounts of seven members of UNA, deposited the money into his own bank accounts, and used the money for his own purposes. Binczak also allegedly falsified a letter authorizing him to withdraw $30,000 from an insured's annuity account held at UNA, and he falsified another document authorizing him to withdraw $45,000 from another insured's annuity account held at UNA.

#### *State v. Vito Gruppuso*

Vito Gruppuso pled guilty on January 30, 2004, to an Accusation that charged him with theft by failure to make required disposition of property received. OIFP investigators arrested Gruppuso, a licensed insurance agent and charged him with three counts of theft by failure to make required disposition of insurance premiums obtained from various insurance customers. The State alleged that Gruppuso wrongfully engaged in insurance premium financing transactions and he embezzled insurance premiums entrusted to him by insureds. Gruppuso is pending sentencing.

#### *State v. Kirti S. Shah*

On May 17, 2004, Kirti S. Shah pled guilty to uttering a forged writing. The Court admitted him into the PTI Program for one year conditioned upon paying a civil insurance fraud fine in the amount of $5,000 and performing 50 hours of community service. An

Essex County Grand Jury returned an indictment that charged Shah with attempted theft by deception, uttering a forged writing, and falsifying records. According to the indictment, Shah, a licensed insurance agent who worked for Prudential Insurance Company, allegedly falsified receipts in connection with an automobile property damage insurance claim, and he submitted the falsified receipts to Prudential Insurance Company in order to wrongfully inflate the amount of the insurance claim for damage to a 1997 BMW.

### *State v. Peter Clark*

On August 6, 2004, the Court sentenced Peter Clark to four years in State prison and ordered him to pay $385,944 in restitution. He also forfeited his insurance agent's license. Clark, an independent licensed insurance agent, purchased several fictitious insurance-based annuities for himself and family members in order to collect commissions for the sales. OIFP's investigation revealed that premium payment checks were returned for insufficient funds, while Clark collected over $100,000 in commissions for the sale of fictitious annuities.

Clark pled guilty to an Accusation that charged him with theft by failure to make required disposition of property received and theft by deception. Clark admitted he purchased several annuity policies for himself and family members in order to receive the commissions for the sales. Clark admitted stealing commissions from the following insurance companies:

American National Insurance Company - $56,034;
Allianz Life Insurance Company - $36,125;
Conseco Services LLC - $38,500;
American Equity Investment Life Insurance Company - $9,400,
American Investors Life - $6,717;
ING USA Annuity & Life Insurance Company - $44,603;
Midland National Life-Annuity Division - $15,961
North American Company Life & Health Insurance - $9,948

Clark also admitted that he defrauded approximately ten persons by convincing them to invest a lump sum of money in a fictitious investment he promised would pay the investor 12 percent interest. Clark repaid six of the victims but owes four victims approximately $169,000.

### *State v. Joseph Birnie and Michael Delisi*

A State Grand Jury returned an indictment on April 30, 2004, that charged Joseph Birnie and Michael Delisi with conspiracy and theft by failure to make required disposition of property received. The State also charged Birnie with a separate count of theft by failure to make required disposition of property received. According to the indictment, Birnie allegedly received residential insurance property damage claim money from insureds who suffered either fire losses or who were building modular homes. He allegedly stole the money and used it for his own purposes. The State alleged that Birnie did very little or no work for the insureds, but he retained all the insurance claim and other money. The State alleged in a separate count of the indictment that Birnie conspired with co-defendant Delisi, a licensed public insurance adjuster who did business as Anton Adjustment, Inc., and a building contractor. The State alleged in the indictment that Birnie and Delisi obtained insurance claim money from an insured for restoration of a home damaged by fire. They allegedly stole over $185,000 from the victim insureds and used the money for their own purposes. The case is pending trial.

### *State v. Jeffrey Hall*

A Union County Grand Jury returned an indictment on May 19, 2004, that charged Jeffrey Hall with theft by failure to make required disposition. According to the indictment, Hall allegedly accepted insurance premiums from four insurance customers but failed to obtain their insurance coverage. The State alleged that Hall stole the insurance premium money and used it for his own purposes. The State further alleged that the Valvano Insurance Agency in Linden employed Hall as an insurance agent. While employed at Valvano, Hall allegedly accepted insurance premiums of approximately $6,963 from Congruent Machine, Inc.; $4,200 from John and Elaine Rafanello; $1,800 from VSI Distributors, Inc.; and $3,664 from PAC Tool & Supply Company. The State alleged that none of these customers received insurance coverage. Hall's case is pending trial.

### *State v. Robert Stone*

Robert Stone, a licensed insurance agent in the State of New Jersey who was the owner/operator of Stone Insurance Company located in Camden, pled guilty on November 15, 2004, to failure to make required disposition of property received. He is scheduled to be sentenced in early 2005. A State Grand Jury returned an indictment that charged Stone with failure to make required disposition of property received. According to the indictment, Stone allegedly stole approximately $22,585 in premium money from insurance customers or from the Standard Funding Corporation (SFC), a company in the business of lending insurance premium money to people for the purchase of insurance policies. The State alleged that Stone,

rather than using the insurance customers' money or SFC's money to purchase insurance policies, stole the money and used it for his own benefit.

### *State v. Stanley Span and Paul Kaplan*

Paul Kaplan pled guilty on August 2, 2004, to theft by deception and theft by failure to make required disposition of property received. The Court sentenced him to three years probation conditioned upon paying restitution in the amount of $7,740. Stanley Span pled guilty to theft by deception and was sentenced to three years probation and ordered to pay $6,740 in restitution. Both defendants are licensed insurance agents and officers of the now defunct Span Associates Insurance Agency located in Springfield. Span and Kaplan were charged in a State Grand Jury indictment with stealing approximately $20,000. They allegedly sold fictitious insurance policies, collected insurance premium monies from the purchasers, and failed to remit the monies to the insurance companies. Span also allegedly distributed fictitious New Jersey Personal Automobile Insurance Plan (NJPAIP) automobile insurance identification cards. Kaplan also allegedly knowingly cashed a $4,000 check drawn on a closed account in November of 2000.

### *State v. Michael Chamberlain*

A State Grand Jury returned an indictment on November 5, 2004, that charged Michael Chamberlain with theft by unlawful taking, forgery, and misapplication of entrusted property. Chamberlain was a licensed securities dealer selling investments for a company known as American Skandia. Prudential Insurance Company later purchased American Skandia. The State alleged that Chamberlain stole $300,000 from a 78-year-old victim by forging documents related to three annuity accounts in connection with the American Skandia/Prudential company. The Prudential Insurance Company reported the matter to OIFP for further investigation. At OIFP's request, the Marion County, Florida Sheriff's Department assisted in the arrest of Michael Chamberlain. OIFP extradited Chamberlain from Florida to New Jersey on August 4, 2004. Chamberlain's case is pending trial.

### *State v. Ralph Malek a/k/a Raafat Abdel Malek*

Ralph Malek was sentenced on December 17, 2004, to five years probation and ordered to pay restitution in the amount of $43,648. Malek, a licensed insurance agent, pled guilty to an Accusation that charged him with theft by deception. Malek, who was also known as Raafat Abdel Malek, admitted he stole $43,648 from Fidelity and Guaranty Life Insurance Company (Fidelity). Malek admitted he submitted an annuity insurance application using the name of a fictitious applicant to Fidelity. Malek also allegedly submitted to Fidelity a worthless check in the amount of $87,500 drawn on the bank account of a business he formerly owned known as Contaldo's Specialties. Fidelity advanced Malek his insurance agent commissions in the amount of $7,875, but the bank dishonored the premium check used to purchase the annuity insurance and Fidelity cancelled the policy. Malek also allegedly submitted an annuity application to Fidelity with a premium payment check in the amount of $436,487 using the name of a second fictitious applicant. The premium payment check and replacement check from a third business formerly operated by Malek turned out to be worthless. Fidelity advanced Malek his insurance agent sales commission of $35,773.

Malek allegedly stole approximately $43,648 from Fidelity and Guaranty Life Insurance Company by sending worthless insurance premium checks and insurance applications containing fraudulent information in order to receive unearned insurance sales commissions.

### *State v. Louis Polite (Polite Insurance Agency)*

OIFP investigators executed a search warrant on November 22, 2004, at the offices of the Polite Insurance Agency in Burlington County. Louis Polite, who owned and operated Polite Insurance Agency and who was an insurance agent licensed in the State of New Jersey at the time of the search warrant, was suspected of theft of insurance premiums. It is alleged that Polite accepted premium money but failed to forward the money to the insurance company which may have left the insurance customers of the Polite Insurance Agency without insurance coverage. OIFP and the Philadelphia Police Department arrested Polite on November 23, 2004, and charged him with theft by deception and issuing fraudulent motor vehicle insurance identification cards. Polite waived extradition from Pennsylvania and was returned to New Jersey on November 24, 2004. The investigation is continuing.

## Insurance Carrier Employee Fraud

### *State v. Rosemarie Padilla*

The Court sentenced Rosemarie Padilla to five years probation on October 15, 2004, conditioned upon serving 60 days in county jail and ordered her

to pay $12,000 in restitution to Prudential Insurance Company. Padilla pled guilty to an Accusation that charged her with theft by deception. Padilla admitted she used the identification and password of a co-worker to enter the Prudential Insurance employee overtime computer system and fraudulently entered overtime hours between January of 2001 and May of 2003. Based on her fraud over a three-year period, Padilla stole approximately $34,040 in overtime pay from the Prudential Insurance Company.

### *State v. Lola Ruth Byrd*

A State Grand Jury returned an indictment on March 31, 2004, that charged Lola Ruth Byrd with theft by deception. According to the indictment, Byrd allegedly used her position at State Farm Insurance to generate ten State Farm Insurance drafts payable to Sherman McNeil. The State alleged that Byrd used closed insurance claim files and generated insurance claim checks as if McNeil had sustained property losses and was entitled to insurance claim money. McNeil had no connection to any of the old property loss files that Byrd allegedly used to create the fictitious claims checks. State Farm became aware of the fraud when McNeil allegedly attempted to cash the fraudulently issued claims checks. It then conducted an internal investigation, contacted OIFP, and fully cooperated with the continuing criminal investigation. Byrd's case is pending trial.

### *State v. Wanda Reeves and Clifford T. Baskerville*

Wanda Reeves was sentenced on October 29, 2004, to three years in State prison and ordered to pay restitution in the amount of $25,000. Clifford T. Baskerville was sentenced on the same day to five years in State prison and ordered to pay $25,000 in restitution. Reeves and Baskerville had previously pled guilty to theft by deception. A State Grand Jury returned an indictment that charged Reeves and Baskerville with conspiracy and theft by deception. According to the indictment, the Robert Plan Corporation in Edison employed Reeves as a claims adjuster/processor. The Robert Plan Corporation owns several insurance companies that included Eagle Insurance Company, GSA Insurance Company, and Newark Insurance Company. The Robert Plan audited Reeves' claims processing work and determined that Reeves allegedly issued eight fraudulent insurance claims checks to either herself and/or Baskerville in the approximate amount of $25,000 so they could cash the checks and steal the money.

Additionally, a Morris County Grand Jury returned an indictment charging both Reeves and Baskerville with theft of approximately $120,000 from Cambridge Integrated Services located in Whippany. Cambridge also employed Reeves as a claims adjuster and, similar to her conduct at the Robert Plan Corporation, she allegedly issued fraudulent claims checks to Baskerville so they could cash the checks and steal the money.

### *State v. Rashonda Clark*

Rashonda Clark pled guilty to theft by deception, and the Court sentenced her on November 5, 2004, to two years probation and ordered her to pay restitution in the amount of $12,678. A Union County Grand Jury returned an indictment that charged Clark with theft by deception and forgery. According to the indictment, Clark allegedly falsely certified to Palisades Safety and Insurance Management Corporation that she had been called to active military duty by the United States Army. Clark allegedly submitted a forged copy of Army active duty military orders to support her claim. A joint investigation by OIFP and Palisades revealed, however, that Clark had commenced employment at AIG Insurance Company and her fraud enabled her to receive salaries from both companies. Clark stole approximately $12,678 from Palisades.

### *State v. Linda Clements-Wright, Neville L. Holder, Lisa Givens, George Givens, Bruce Alston, Neville Louis Holder, Marsha Alston Walker and Michael McCormick*

Following a three-week trial, a jury convicted Linda Clements-Wright on December 16, 2004, of conspiracy, theft by unlawful taking, and money laundering. She is scheduled to be sentenced in 2005.

According to a State Grand Jury indictment, for almost three-and-a-half years, Clements-Wright issued approximately 150 Allstate insurance claim checks totaling approximately $594,369 to 11 persons with whom she was acquainted, but who allegedly were not entitled to the insurance claim money. The State alleged that Clements-Wright conspired with her acquaintances to cash the checks, keep 10 percent for themselves, and return the remaining money to her. Clements-Wright worked for Allstate in Burlington County as a claims processing specialist. The State charged Clements-Wright with conspiracy, theft by unlawful taking, and money laundering.

### *State v. Bruce Baez and Eddie Perez*

A State Grand Jury returned an indictment on September 13, 2004, that

charged Bruce Baez and Eddie Perez with conspiracy and theft by deception. The State also charged Baez with uttering a forged document. According to the indictment, Perez and Baez allegedly conspired to steal six disability checks issued by New Jersey Manufacturers Insurance Company to Juan "Marcial" Perez, who died on March 15, 2000. Juan "Marcial" Perez had been receiving insurance disability checks pursuant to a workers' compensation insurance policy from New Jersey Manufacturers Insurance Company. New Jersey Manufacturers, unaware that Juan "Marcial" Perez died, continued to send checks to his Millville home. The State alleged the defendants stole the disability checks, forged them, and cashed them. The case is pending trial.

## Public Insurance Adjuster Fraud

### *State v. Marc Rossi*

The Court sentenced Marc Rossi on March 19, 2004, to eight years in State prison for his role in a conspiracy that involved arson and vandalism and enabled Rossi to earn commissions through his insurance adjusting business. The Court also ordered Rossi to pay restitution in the amount of $306,209 to Providence Washington; $90,318 to Zurich Insurance Company; $31,176 to Penn Millers Insurance Company; $2,054 to Farmers Mutual Insurance Company; $59,201 to NJUI; $48,895 to Liberty Mutual Insurance Company; and $5,000 to East Windsor PAL. Finally, the Court ordered Rossi to pay a $50,000 civil insurance fraud fine.

A State Grand Jury returned an indictment that charged Rossi, a licensed public insurance adjuster, with conspiracy, arson for hire, theft by deception, forgery, and falsifying records. Four other defendants were also charged in separate indictments. According to one indictment, Rossi, president of Rossi Adjustment Services, allegedly conspired with and paid several of his employees to commit arson fires or acts of vandalism causing property damage so he could obtain commissions through Rossi Adjustment Services by adjusting the arson and vandalism insurance claims. In some cases, the owners of the properties allegedly were aware of the fraudulent nature of the insurance claims. In other cases, the owners did not know the properties were purposely damaged. Rossi pled guilty to arson, conspiracy to commit arson, bribery, theft, and theft by deception.

### *State v. Fire Chief*

The Court admitted the fire chief of a Hamilton Township fire company, implicated in the Jeffrey Nemes/Marc Rossi investigation, into the Mercer County PTI Program conditioned upon his continued cooperation with the State. The fire chief pled guilty to a charge of obstructing the administration of law for giving false statements to law enforcement during the Nemes/Rossi investigation. Nemes and Rossi were allegedly paying bribes to and soliciting fire chiefs to allow fires to burn longer and do more damage. Nemes allegedly would benefit in that his home repair contracting business (Nemes Enterprises) would have the potential for bigger contracts and Rossi's public adjusting insurance business would be awarded bigger fees based on higher insurance claims. Nemes' case is pending trial.

### *State v. Samuel Siligato*

The Rossi investigation also led to a State Grand Jury charging Samuel Siligato on February 17, 2004, with theft by deception, attempted theft by deception, and conspiracy. According to the indictment, Siligato allegedly conspired to submit false insurance claims in connection with a suspicious arson fire at a commercial building he owned in Hammonton. The commercial building contained office space, retail space, and apartments. Siligato allegedly submitted several insurance claims as the result of the fire. First Trenton Insurance Company paid a $15,000 insurance claim for the building's contents and $165,000 for the building itself. The State alleged that Samuel Siligato also submitted a $206,900 claim to the Farmers Mutual Insurance Company for the contents of the building. Siligato allegedly retained Marc Rossi's Rossi Adjustment Services company to adjust the insurance claims. Siligato's case is pending trial.

### *State v. Jeffrey Nemes and John Fiore*

A State Grand Jury returned an indictment on June 9, 2004, that charged Jeffrey Nemes and John Fiore with conspiracy and bribery in official and political matters. Fiore, the Executive Vice President of the East Windsor Police Athletic League (PAL) and a former East Windsor police detective, was also charged with misapplication of entrusted property and official misconduct. The State named Marc Rossi as an unindicted co-conspirator in this case.

According to the indictment, Nemes and Fiore allegedly conspired with Rossi to defraud the East Windsor PAL. The State alleged in the indictment that Fiore used his position as Executive Vice President of the East Windsor PAL to contract with Nemes to build a concession stand/administration building in East Windsor. Nemes operated a construction com-

## Employee convicted of theft

pany known as Nemes Enterprises. The State alleged that the East Windsor PAL paid Nemes approximately $274,046 for construction of a building, which at most should have cost $224,900 to erect. The State also alleged that in return for Fiore's influencing the PAL Board of Directors to contract with Nemes for an inflated price to construct the building, Fiore received construction of a deck on his home free of charge. The State intends to show that Rossi received $5,000 for his role in arranging the alleged deal between Fiore and Nemes Enterprises. The case is pending trial.

### *State v. Oscar Medina*

The Court sentenced Oscar Medina on July 23, 2004, to three years probation and ordered him to perform 50 hours of community service. Medina was also required to surrender his insurance license. Medina previously pled guilty to theft by deception. A State Grand Jury returned an indictment that charged Medina with theft by deception and commercial bribery for accepting a $5,700 bribe to provide advice, services, and assistance in connection with the adjustment and settling of an automobile insurance claim. Medina was an insurance claims adjuster employed by Liberty Mutual Insurance Company. Medina allegedly contacted insurance claimants involved in automobile accidents and advised them that they would be able to obtain a larger claim settlement by paying him a fee rather than hiring an attorney. In one instance, Medina allegedly stole $5,700 by falsely creating the impression that he was entitled to 15 percent of the claimant's bodily injury insurance settlement money as a Liberty Mutual Group claims adjuster.

## Insurance Premiums Fraud

### *State v. Philip A. McKeaney*

Philip A. McKeaney pled guilty to theft by failure to make required disposition of property received and to a related but separate charge of misapplication of entrusted property. On May 21, 2004, the Court sentenced McKeaney to seven years in State prison and ordered him to pay a total of $1,163,831 in restitution to nine companies he deceived by stealing and laundering money. OIFP's investigation revealed that McKeaney allegedly defrauded the following companies:

1. Memorial Hospital of Salem County, $541,737;
2. Christiana Health Care Services, Wilmington, DE, $32,612;
3. Goodwill Industries of Southern New Jersey, $185,775;
4. New Jersey American, Inc. (NJA), Blackwood, NJ, $180,912;
5. Concord Engineering Group, Inc., Voorhees, NJ, $70,615;
6. Eagle Affiliates of Harrison, Harrison, NJ, $52,860;
7. King Limousine, King of Prussia, PA, $30,942;
8. Rodento Management, Wilmington, DE, $11,465; and
9. Young Volkswagen, Easton, PA, $20,289.

A State Grand Jury charged McKeaney with financial facilitation of criminal activity (money laundering), theft by failure to make required disposition of property received, and theft by deception. McKeaney operated Haddon National Companies, Inc. (HNC), a corporation that served as a third party health insurance administrator. Third party health insurance administrators receive money from employers, corporations, and sometimes government entities that self-fund and self-insure employee health insurance plans. HNC contracted with the companies to receive money for health insurance benefits, to deposit that money, and to pay the health insurance claims of its clients. HNC earned fees based on paid health insurance claims. HNC also received money from its clients to purchase special re-insurance policies to provide health insurance coverage.

According to the indictment, McKeaney allegedly stole in excess of $1 million from nine clients that should have been used to pay health insurance claims or purchase re-insurance policies. McKeaney allegedly used some of the stolen money to pay personal debts and expenses. He also allegedly transferred money to Cambria Corporation, a business in which McKeaney had an interest. McKeaney also allegedly laundered money earmarked for health care claims on policies by transferring approximately $494,188 from HNC to Cambria Corporation.

# Miscellaneous Insurance Fraud

## False Homeowners Insurance Claims

### *State v. Barsis Asaad*

Barsis Asaad pled guilty on March 8, 2004, to an Accusation that charged her with attempted theft by deception. The Court admitted her into the PTI Program for three years conditioned upon payment of a $5,000 civil insurance fraud fine. Asaad submitted a homeowners insurance claim for approximately $33,000 to New Jersey Manufacturers Insurance Company for flood damages at her condominium caused by her neighbor's pipe or hot water heater bursting. Asaad admitted that she inflated her claim by submitting fraudulent receipts to New Jersey Manufacturers Insurance Company.

### *State v. Crystal Sims*

Crystal Sims pled guilty on December 13, 2004, to insurance fraud. Sims admitted to submitting a false property damage claim to Germantown Insurance Company/The Philadelphia Contributionship Insurance Company for a damaged skylight after she had already been reimbursed by the insurance company for the damage. Sims is scheduled to be sentenced in 2005.

## Fraudulent Stolen/Damaged Property Claims

### *State v. Solomon Bouzaglou and Joseph Benlolo*

The Court sentenced Joseph Benlolo on January 16, 2004, to five years probation and ordered him to pay a $5,000 civil insurance fraud fine. The Court sentenced his co-conspirator Solomon Bouzaglou on February 6, 2004, to five years probation and ordered him to pay a $5,000 civil insurance fraud fine and perform 150 hours of community service. Bouzaglou and Benlolo previously pled guilty to separate Accusations that charged each of them with conspiracy and attempted theft by deception. Bouzaglou and Benlolo admitted they conspired with others, including a public insurance adjuster, to intentionally cause water damage to costume jewelry stored in an Irvington warehouse. Fireman's Fund Insurance Company insured the jewelry for $1 million. The defendants admitted they submitted an insurance claim to Fireman's Fund for approximately $973,638, knowing they intentionally damaged the jewelry. Fireman's Fund, suspecting the claim was fraudulent, denied the claim and referred the matter to OIFP for investigation.

### *State v. Sol Zaltz, Yehudah Berger, Sam Nisser and David Nisser*

As part of the Bouzaglou and Benlolo investigation, Sol Zaltz, Yehudah Berger, Sam Nisser, and David Nisser, who were charged in a State Grand Jury indictment with conspiracy and attempted theft by deception, pled guilty in 2004 to theft by deception. The defendants allegedly conspired to purchase 20,000 pieces of inexpensive costume jewelry, produce phony receipts, store the jewelry in a warehouse, and purposely damage the jewelry in order to collect on the insurance policy. a licensed public insurance adjuster, allegedly conspired with Bouzaglou and Benlolo and submitted an inflated insurance claim in the amount of $973,638 to Fireman's Fund. pled guilty to attempted theft by deception and the Court sentenced him on April 27, 2004, to five years probation conditioned upon serving 180 days in county jail and paying a $10,000 civil insurance fraud fine. was also required to permanently surrender his public adjuster's license in New Jersey and New York. Zaltz, Berger, Sam Nisser, and David Nisser all pled guilty to attempted theft by deception. The Court sentenced Zaltz and Berger on August 6, 2004, to three years probation and ordered each to pay a $2,500 criminal fine and a $5,000 civil insurance fraud fine. The Court sentenced Sam Nisser to three years probation on August 2, 2004, and ordered him to pay a criminal fine in the amount of $5,000 and a civil insurance fraud fine in the amount of $5,000. The Court admitted David Nisser into the PTI Program on August 2, 2004, conditioned upon his performing 50 hours of community service and ordered him to pay a $2,500 civil insurance fraud fine.

### *State v. Jill Ravitz*

The Court admitted Jill Ravitz into the PTI Program on February 6, 2004, for a period of one year. Ravitz pled guilty to an Accusation charging her with attempted theft by deception. Ravitz submitted a homeowners insurance claim falsely claiming a $10,000 diamond ring was missing. Ravitz submitted the claim after she received an appraisal for the diamond ring, which she falsely claimed she purchased. The carrier denied the claim and referred the matter to OIFP for investigation and prosecution.

### *State v. Lorraine DeMauro*

The Court admitted Lorraine DeMauro into the PTI Program on September 27, 2004, conditioned upon her paying a $3,000 civil insurance fraud

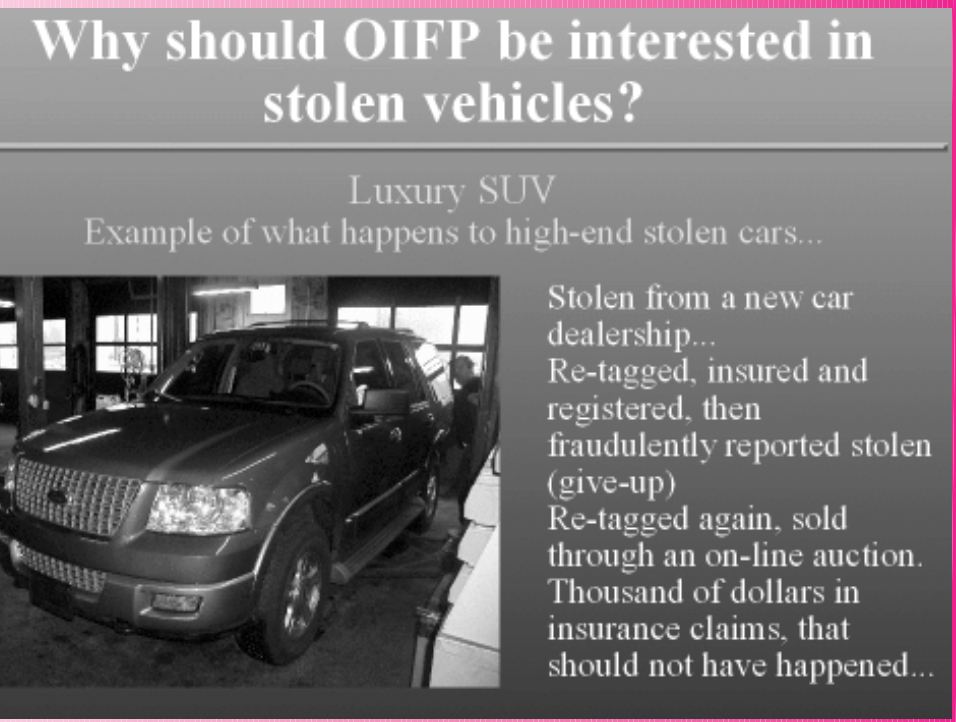
fine and performing 50 hours of community service. DeMauro pled guilty to an Accusation that charged her with forgery. DeMauro admitted she submitted a fraudulent receipt from Nationwide Computers & Electronics in support of her property damage insurance claim to Selective Insurance Company that her computer had been damaged by lightning.

### *State v. Jack DiCristofalo*

Jack DiCristofalo was charged in an Accusation on December 15, 2004, with attempted theft by deception. It is alleged that DiCristofalo, the owner of a security monitoring company known as IDS Security, submitted inflated and false invoices to Merchants Insurance Group in connection with an insurance claim for repairs to his company's computers, which had purportedly been damaged by lightning. DiCristofalo was pending admission in 2005 into the PTI Program.

### *State v. Dean Marletta*

Dean Marletta was admitted into the PTI Program on December 1, 2004, and ordered to pay a $15,000 civil insurance fraud fine. Marletta pled guilty to an Accusation charging him with attempted theft by deception. Marletta admitted that he submitted a fraudulent property loss claim to Harleysville Insurance Company. The claim Marletta submitted to Harleysville was for property loss consisting of approximately $24,000 to $27,000 worth of tools and equipment Marletta used in his business as a self-employed general contractor. Marletta traded as Master Craftsmen. Marletta admitted that, in support of his claim, he submitted false receipts reflecting the purchase of various tools and other equipment for which he sought reimbursement from Harleysville as the result of an alleged theft.




## Life Insurance Fraud

### *State v. Mary Ann McCue*

The Court sentenced Mary Ann McCue on March 18, 2004, to two years probation conditioned upon her paying $2,628 in restitution to Wachovia Bank, $312 in restitution to Kamy Dental, and a civil insurance fraud penalty in the amount of $1,500. McCue pled guilty to an Accusation that charged her with health care claims fraud, theft by deception, and uttering a forged instrument. McCue admitted she used a false identity, claiming to be the widow of a man who had died in February of 1999, to submit a fraudulent life insurance claim to Metropolitan Life Insurance. Metropolitan Life sent McCue a check in the amount of $2,628 to satisfy the life insurance claim. McCue admitted she forged the widow's name when she endorsed the claim check. McCue also admitted she used her roommate's name without permission on a patient information form and dental insurance card to have dental work done at Kamy Dental in Toms River. Kamy Dental submitted a bill in the amount of $312 to Horizon Blue Cross for payment of McCue's dental treatment.

### *State v. Michelle Kush*

Michelle Kush pled guilty to an Accusation on March 26, 2004, that charged her with theft by deception. The Court admitted her into the PTI Program. Kush admitted she fraudulently used her mother's name to collect her father's death benefits. Kush's mother was the legal beneficiary of her

father's death benefits that were to be terminated upon the death of her mother. Kush admitted that, in her capacity as Attorney-in-fact pursuant to a Power of Attorney, she endorsed and cashed the checks from CIGNA Insurance Company payable to her deceased mother. The checks totaled $7,921.

### *State v. Kofi Boakye, Irene Addai and "Jane Doe"*

Irene Addai pled guilty on August 31, 2004, to theft by deception and falsifying documents. The Court sentenced her to two years probation and ordered her to pay a $5,000 civil insurance fraud fine. A State Grand Jury returned an indictment that charged Kofi Boakye and Irene Addai with conspiracy, attempted theft by deception, theft of identity, theft by deception, hindering prosecution, and falsifying records. "Jane Doe" was charged with conspiracy, attempted theft by deception, theft of identity, and falsifying records. According to the indictment, Boakye who allegedly used the aliases Kofi Boachie and James Boachie, Irene Addai, and another woman identified simply as "Jane Doe," allegedly conspired to falsify a life insurance application to obtain a life insurance policy, submit a false death claim, and steal the claim money. The State also alleged that Boakye and Irene Addai falsified student loan applications in order to steal approximately $38,000 in student loan money from ITT Skills Company by falsely indicating that Irene Addai, Kofi Boakye, Alberta Addai, and James Addai were students at Bloomfield College. The State alleged that after the defendants obtained student loan money from ITT Skills Company, they used some of it to pay for $500,000 Massachusetts Mutual life insurance policies on the lives of Kofi Boakye and Irene Addai. The State further alleged the defendants obtained the life insurance policies for Kofi Boakye and Irene Addai by falsifying their identities, Social Security numbers, and income levels on the policy applications. The State also alleged that Boakye and "Jane Doe" submitted a false life insurance claim to Massachusetts Mutual misrepresenting that James Boachie, one of the persons whose life was insured, died in Ghana, Africa, on March 12, 2001. Boakye's case is pending trial.

## Phony Certificates of Insurance

### *State v. William Tompkins*

William Tompkins pled guilty to theft by deception and the Court sentenced him on November 8, 2004, to two years probation, ordered him to pay restitution in the amount of $6,000 to Monument Contractors, Inc., and $3,141 to Global Risk Management Services, Inc. An Essex County Grand Jury returned an indictment that charged Tompkins with theft by deception and theft of services. Tompkins, the owner of DMT Consultants, Inc., allegedly fraudulently obtained a surety insurance bond for Newark building contractor, Monument Contractors, by fraudulently representing himself as a licensed insurance broker to Global Risk Management, a retail surety bond agency. Monument Contractors contracted with Bernards Township to build park pavilions in Harry Dunham Park. Contractors, such as Monument, must provide a performance insurance bond in order to do construction work for local governments. Cumberland Casualty and Surety/The Saint Paul Company issued the surety bond to Global Risk Management. In addition to allegedly fraudulently representing himself as a licensed insurance broker, Tompkins allegedly overcharged Monument for the surety insurance bond and stole approximately $6,000 due to Cumberland Casualty and Surety that Monument paid Tompkins for the bond.

### *State v. George Shampanore*

George Shampanore pled guilty to an Accusation that charged him with forgery and on March 25, 2004, the Court admitted him into the PTI Program. Shampanore, who owns and operates a siding and roofing business, presented a forged Certificate of Insurance from The Hartford Insurance Company to a potential customer while bidding on a roofing job in Linden. Contractors often must present proof of insurance when bidding on projects. Shampanore's Certificate of Insurance had been cancelled in March 2001.

### *State v. Michael Serghides*

Michael Serghides pled guilty to forgery and the Court admitted him into the PTI Program on August 6, 2004, for one year conditioned upon performing 75 hours of community service. A Morris County Grand Jury returned an indictment that charged Serghides with forgery. According to the indictment, Serghides allegedly presented a forged Zurich North America Insurance Company Certificate of Insurance to Framan Mechanical, Inc., in an attempt to secure a subcontracting job through a contract with Lakeland High School. Contractors are frequently required to provide proof of insurance when working on public contracts.



### *State v. Keith Corliss*

The Court admitted Keith Corliss into the PTI Program on August 16, 2004, conditioned upon performing 50 hours of community service. In an Accusation filed charging him with forgery, the State alleged that Corliss presented a fraudulent Highlands Insurance Company Certificate of Insurance falsely showing he had insurance coverage for performing boat repairs at Lentze Marina in West Keansburg.

### *State v. Frank Costello*

A Camden County Grand Jury returned an indictment on July 29, 2004, that charged Frank Costello with forgery. According to the indictment, Costello, the owner of a roofing company, allegedly knowingly provided a fraudulent Northwestern Mutual Certificate of Insurance to a client for whom he was repairing a roof. Costello's case is pending trial.

### *State v. Troy McMahon*

Troy McMahon was sentenced on December 17, 2004, to one year probation and ordered to perform 50 hours of community service. McMahon pled guilty to an Accusation that charged him with forgery. McMahon, the owner of McMahon Sanitation, Inc., admitted he presented a forged Certificate of Insurance to Crown Hearth and Patio, Inc., who had hired McMahon for demolition and removal of debris on its property. Contractors are frequently required to present proof of insurance before starting contracting work.

### *State v. Rueben Stewart*

An Atlantic County Grand Jury returned an indictment on August 11, 2004, that charged Rueben Stewart with forgery. According to the indictment, Stewart allegedly issued an altered Certificate of Insurance to Contemporary Environmental Management of Bedford Hills, New York. Boyarin Hourigan Blundell Insurance Agency of Toms River properly issued the Certificate of Insurance, but Stewart allegedly altered it to show that he had insurance coverage provided by Ohio Casualty Insurance Company, which was no longer represented by Boyarin Hourigan Blundell. Stewart's case is pending trial.

### *State v. Robert Huber*

Robert Huber pled guilty on November 12, 2004, to forgery. He is scheduled to be sentenced in 2005. A Hunterdon County Grand Jury returned an indictment that charged Huber with forgery. According to the indictment, Huber allegedly provided a phony Certificate of Insurance in connection with the lease of rental property. Landlords sometimes require persons to offer proof of insurance before they rent property. In this case, the State alleged that Huber falsified a Vreeland Insurance Agency Certificate of Insurance that allegedly indicated it provided insurance to Huber by Selective Insurance Company.

### *State v. William Cheney*

The Court sentenced William Cheney on December 10, 2004, to 18 months probation and ordered him to pay a $1,000 criminal fine. Cheney pled guilty to an Accusation that charged him with forgery. Cheney, who operated Painting and Home Improvements, admitted he presented a phony Ohio Casualty and Legion Insurance Company Certificate of Insurance to Hometown Builders. Hometown Builders hired Cheney's company as a painting subcontractor.

### *State v. Nicholas Barbella*

An Essex County Grand Jury returned an indictment on November 15, 2004, that charged Nicholas Barbella with forgery. According to the indictment, Barbella, a roofing contractor who did business as Dr. Frank-n-Stein, Inc., allegedly issued a phony Cumberland Mutual Fire Insurance Company Certificate of Insurance. The State alleged that Barbella issued the phony Certificate of Insurance to the management of and mortgage holder of the Lawton Arms Apartments located in West Orange. Barbella's case is pending trial.

### *State v. Wayne Kellum*

A State Grand Jury returned an indictment on November 5, 2004, that charged Wayne Kellum with forgery. According to the indictment, Kellum, who owned and operated WK Trucking, a subcontractor, allegedly presented a fraudulent Certificate of Insurance to general contractor Marone Contracting. Frequently, subcontractors have to prove they have the appropriate insurance when working for general contractors. The State alleged that the fraudulent Certificate of Insurance

falsely indicated WK Trucking had general liability and automobile insurance from Selective Insurance Company. Kellum's case is pending trial.

### *State v. Joseph Curto*

The Court sentenced Joseph Curto on December 20, 2004, to an 18-month suspended sentence. Curto pled guilty on the same date to an Accusation that charged him with forgery. Curto admitted he presented Merit Developers with a phony Certificate of Insurance indicating he had purchased general liability and workers' compensation insurance. The Certificate of Insurance reflected Curto had commercial general liability insurance coverage from Freemont Insurance Company and workers' compensation insurance from Pawtucket Mutual Insurance Company. Both Pawtucket and Freemont Insurance Companies no longer do business in New Jersey. The case was referred to OIFP for investigation and prosecution after Abnet, Inc., Insurance Company of Piscataway was contacted by Travelers Insurance Company who was auditing insurance coverage for Merit Developers.

## Insurance-Related Tax Cases

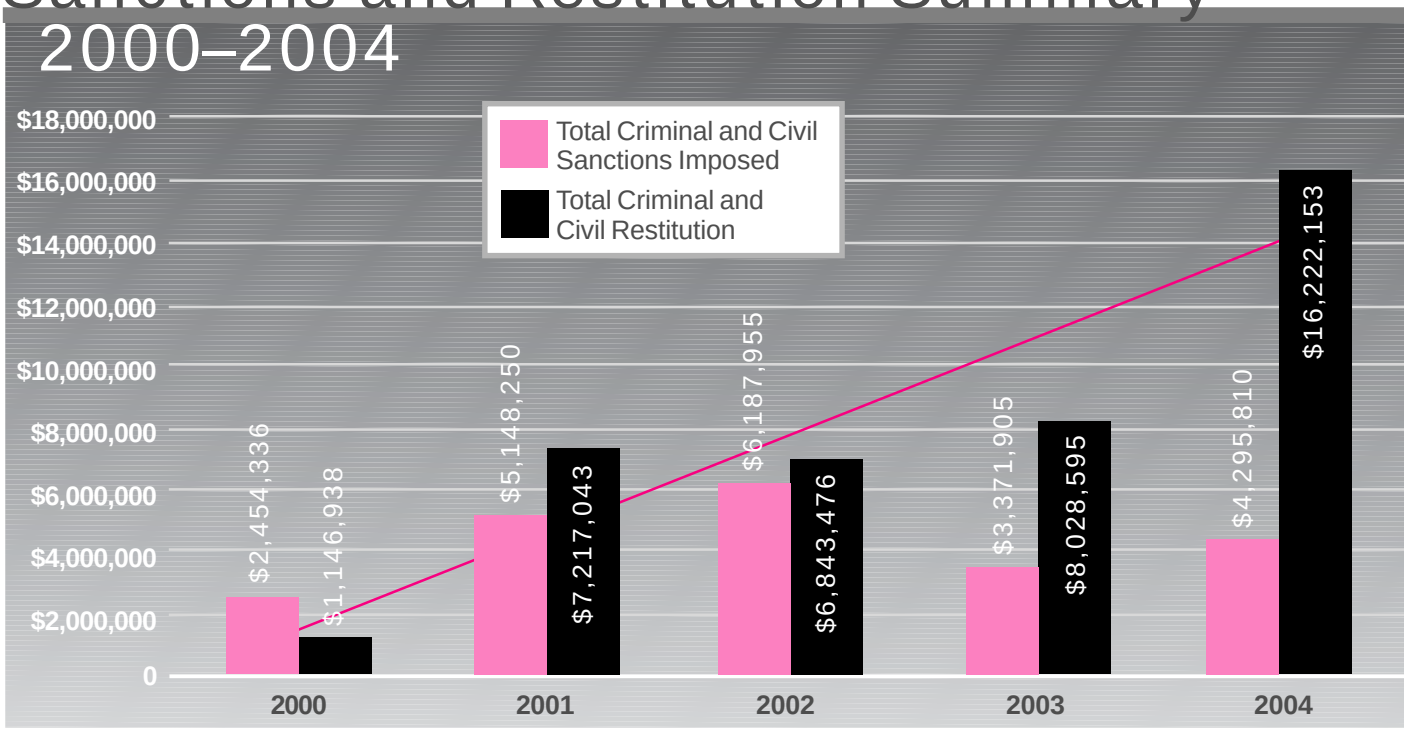
### *State v. Richard Nardone and Donna M. Januik*

Richard Nardone pled guilty on October 4, 2004, to filing false and fraudulent New Jersey Income Tax returns, failure to pay New Jersey Gross Income Tax with intent to evade, and misconduct by a corporate official. On the same date, Donna M. Januik pled guilty to filing false and fraudulent New Jersey Income Tax returns and failure to pay New Jersey Gross Income Tax with intent to evade. A State Grand Jury returned an indictment that charged Nardone and Januik, his sister, with conspiracy, filing false and fraudulent New Jersey Income Tax returns, filing false and fraudulent New Jersey Corporate Tax returns, and failure to pay New Jersey Gross Income Tax with intent to evade. The State also charged Nardone with misconduct by a corporate official.

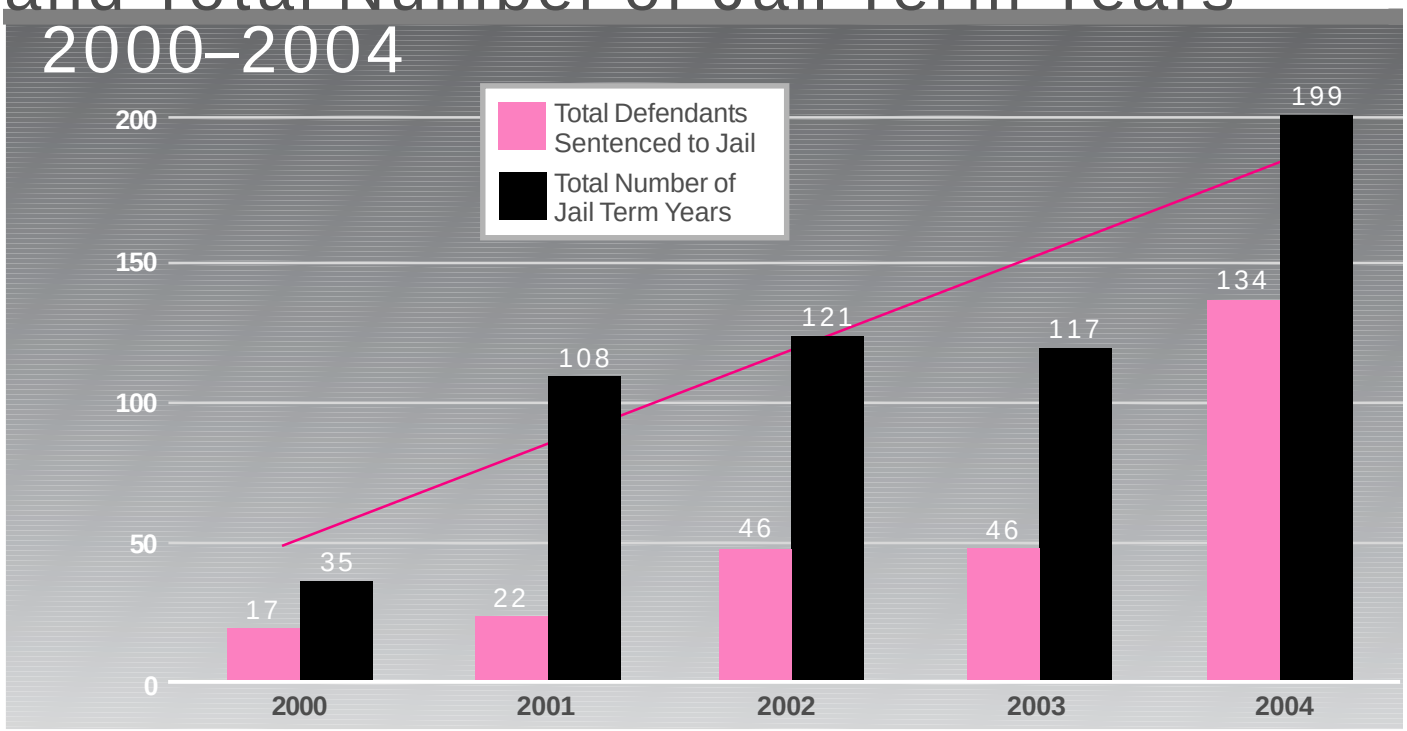
According to the indictment, to avoid paying New Jersey corporate business and income taxes, Nardone and Januik allegedly transferred and withdrew large sums of money from Nardone's chiropractic business and from related medical treatment, diagnostic, or rehabilitation facilities owned, operated, and controlled by Nardone. Furthermore, Nardone and Januik allegedly created three fictitious employees identified as Brian Taylor, Jeanne Pierre, and Mark Wallace for issuing at least 144 corporate checks exceeding $400,000. Nardone then allegedly instructed an employee to endorse and cash the checks at an unlicensed check cashing business in Irvington. The employee allegedly returned the cash to Nardone. Nardone and Januik also allegedly utilized corporate accounts to pay for more than $180,000 in personal expenses without reporting the funds as income.

Nardone's chiropractic office was located in Orange. Nardone's related businesses were identified as: Professional Medical Technologies, Inc. (PMT), located in Mountainside; Camino Rehabilitation, Inc., located in Springfield; Hermosa Medical Services, Inc., located in Mountainside; Advanced Diagnostic, Inc., located in Roselle Park; and Medical Diagnostic, Inc., located in Mountainside. Januik also operated a billing and collection agency known as ZNS Billing. The chiropractic practice and the related businesses ceased operations.

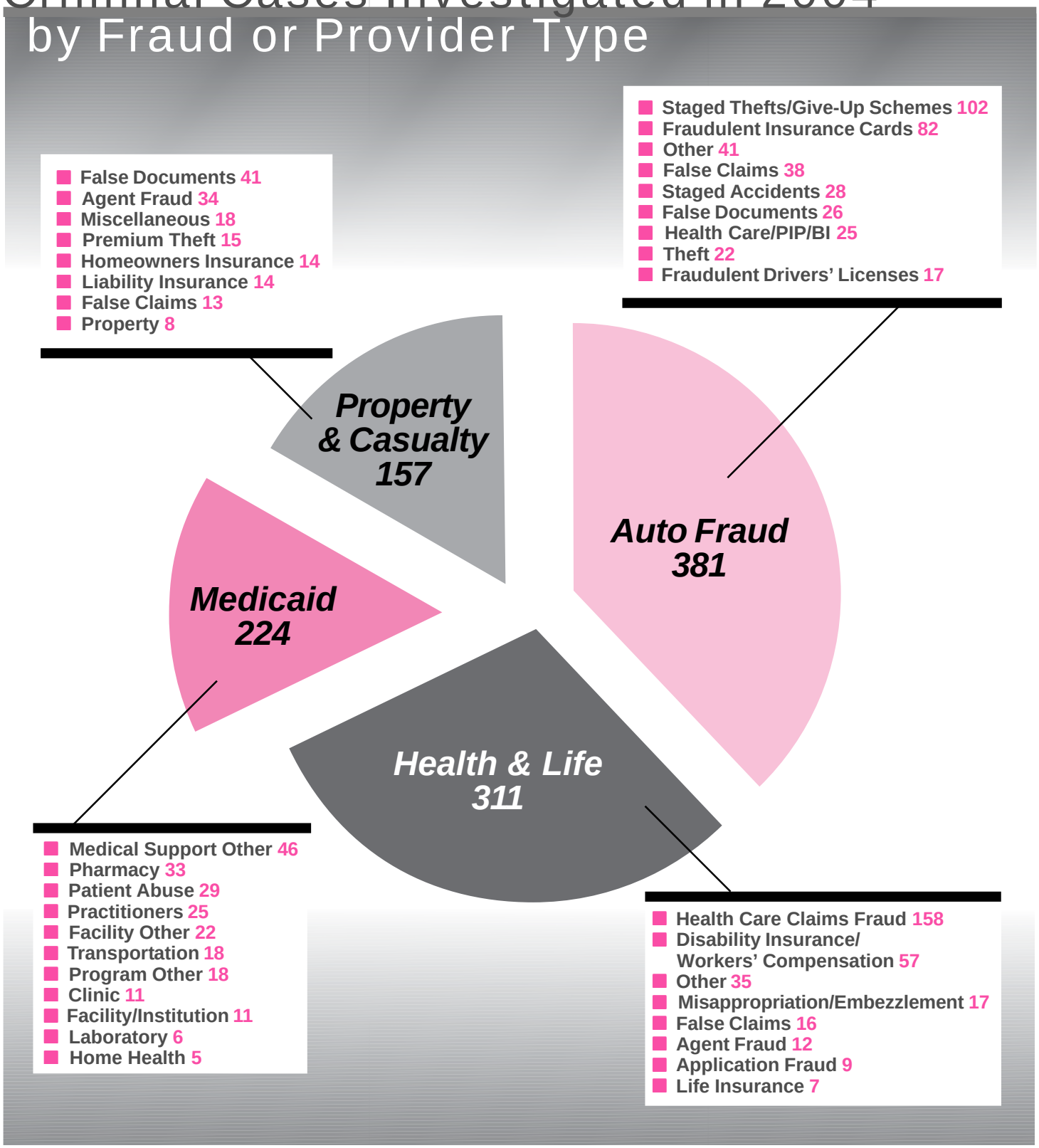
## OIFP Criminal and Civil Monetary Sanctions and Restitution Summary 2000–2004




## OIFP Defendants Sentenced to Jail Time and Total Number of Jail Term Years 2000–2004



# Criminal Cases Investigated in 2004 by Fraud or Provider Type



## *Criminal Case Summaries*

### *State v. Cristino Morales and Maria Carmen Cruz*

The Court sentenced Cristino Morales for health care claims fraud on January 23, 2004, to three years in State prison, ordered him to pay restitution in the amount of $10,000, and debarred him from participating in the Medicaid Program for a minimum period of five years. A State Grand Jury had charged Morales and Maria Carmen Cruz with health care claims fraud and Medicaid fraud. According to the indictment, Morales and Cruz, the owner/operators of a Camden clinic known as "New Hopes of New Jersey," allegedly billed the Medicaid Program, between May of 1999 and October of 1999, for mental health counseling and psychological services that were not rendered or not rendered as billed. The State alleged that more than $13,000 was stolen from the Medicaid Program based on fraudulent billings. Morales was the Executive Director of the clinic and Cruz served as the clinic's administrator.

Previously, Cruz pled guilty to Medicaid fraud and was sentenced to three years probation conditioned upon performing 150 hours of community service. In addition, she was debarred from participating in the Medicaid Program for a period of five years.

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

Imad Elbashir was sentenced on February 6, 2004, to three years in State prison, ordered to pay $103,000 in restitution and penalties, and debarred from participating in the Medicaid Program for a period of five years for health care claims fraud. Imadelin A. Khair and the corporation, I&I Invalid Coach, previously pled guilty to health care claims fraud. The Court sentenced Khair to three years in State prison. Khair and the corporation were ordered to pay $103,235 in restitution, and the corporation was dissolved and ordered to refrain from doing business in the State of New Jersey.

The State had charged Elbashir, Khair, and I&I Invalid Coach with conspiracy, health care claims fraud, theft by deception, Medicaid fraud, and corporate misconduct. I&I, Elbashir, and Khair owned an invalid coach provider that provided non-emergency medical transportation to Medicaid recipients. The State showed that I&I inflated mileage on claims submitted to the Medicaid Program. I&I received $90,000 in undeserved payments based on the false mileage claims.

### *State v. Manuprasad Parikh*

The Court sentenced Manuprasad Parikh on January 9, 2004, to three years probation. The Court also ordered $180,000 in restitution, $180,000 in civil fines, and 300 hours of community service. Parikh was also debarred from participating in the Medicaid Program for 12 years.

Parikh, the owner of Irving Pharmacy, pled guilty to an Accusation charging him with Medicaid fraud. Parikh, through Irving Pharmacy, fraudulently billed the Medicaid Program for expensive prescriptions (Serostim) used in HIV treatment valued at approximately $180,000 even though they were never dispensed to Medicaid recipients.

The Medicaid Fraud Section referred the matter to the Board of Pharmacy for appropriate licensing action.

### *State v. Michael Stavitski, Wall Pharmacy, Avon Pharmacy and Belmar Pharmacy*

Michael Stavitski was sentenced on June 18, 2004, to seven years State prison, ordered to pay restitution and penalties in the amount of $1.1 million, and received a seven-year suspension of his Medicaid privileges and suspension of his pharmacy license for one year.

A State Grand Jury charged Stavitski, a licensed pharmacist and the operator of four pharmacy corporations located in Monmouth County, with health care claims fraud, corporate misconduct, and Medicaid fraud. The grand jury charged three of the four pharmacy corporations with health care claims fraud and Medicaid fraud. Between May of 1996 and February of 2002, Stavitski and the three pharmacies allegedly submitted numerous claims for payment which reflected that medications or refills of medications were provided to Medicaid and privately insured patients when, in fact, such medications were never provided. Additionally, in many instances, Stavitski allegedly billed for providing medications that were never prescribed by physicians. Stavitski, Wall Pharmacy, Avon Pharmacy, and Belmar Pharmacy all pled guilty to health care claims fraud.

The Medicaid Fraud Section referred this case to the Board of Pharmacy; and in November of 2004, the Board revoked Stavitski's pharmacy license.

### *State v. Eliezer Martinez, et al.*

Following a five-week jury trial, on October 27, 2004, Eliezer Martinez, owner and operator of a drug and alcohol counseling center, was convicted of health care claims fraud and Medicaid fraud. He is scheduled to be sentenced in early 2005.

*Supervising Deputy Attorney General John Krayniak, Chief of OIFP's Medicaid Fraud Section discusses emerging Medicaid fraud issues.*

Previously, a State Grand Jury returned an indictment charging Eliezer Martinez, Olga Marquez, Olga Bonett, Juanita Melendez, Jose Jimenez, Bartolo Moreno, and Luz Senquiz with health care claims fraud and Medicaid fraud. Hispanic Counseling and Family Services of New Jersey, Inc., was a drug and alcohol counseling center owned and operated by Eliezer Martinez. According to the indictment, Martinez, Marquez, Bonett, Melendez, Jimenez, Moreno, and Senquiz, counselors employed at the center on behalf of Hispanic Counseling and Family Services of New Jersey, Inc., allegedly submitted fraudulent health care claims to the Medicaid Program seeking reimbursement for medical services provided to Medicaid recipients when, in fact, the health care services had not been provided.

Olga Marquez was accepted into the Camden County PTI Program conditioned upon completion of 50 hours of community service and her cooperation with the State. Bonett and Melendez pled guilty to health care claims fraud; and on October 5, 2004, the Court sentenced Melendez to one year probation conditioned upon her continued cooperation with OIFP's investigation. Jimenez pled guilty to health care claims fraud; and on October 7, 2004, the Court sentenced Jiminez to one year probation conditioned upon continued cooperation with OIFP's investigation. The Court sentenced Bonet on October 22, 2004, to one year probation also conditioned upon her cooperation with OIFP's investigation. Senquiz pled guilty to health care claims fraud and on October 22, 2004, the Court sentenced Senquiz to one year probation conditioned upon continued cooperation with OIFP's investigation. Bartolo Moreno was admitted into the PTI Program on December 23, 2004.

### *State v. Azam Khan, Shahid Khawaja, Milton Barasch and Axat Jani*

Axat Jani pled guilty to health care claims fraud. Jani was sentenced on October 15, 2004, to four years in State prison and ordered to pay a criminal fine of $10,000. Jani's Medicaid Program privileges were suspended for a period of five years and his medical license was suspended for one year. Milton Barasch, a licensed pharmacist, pled guilty to health care claims fraud. Shahud Khawaja, owner of S Brothers Pharmacy, pled guilty on February 17, 2004, to money laundering. Azam Khan pled guilty to health care claims fraud.

OIFP's Medicaid Fraud Unit uncovered that the defendants allegedly billed the Medicaid Program approximately $293,815 for medications either never dispensed or dispensed to persons using another person's Medicaid recipient number. Some bills were allegedly submitted to the Medicaid Program for medications prescribed for Medicaid recipients who had died years before.

These matters will also be referred to the respective professional licensing boards for action as may be appropriate.

### *State v. Steven Aberbach*

Steven Aberbach, a licensed pharmacist who pled guilty to health care claims fraud, was sentenced on March 12, 2004, to three years in State prison and ordered to pay a $10,000 fine. Before sentencing, he had paid $200,000 in restitution and fines. Aberbach, who was the owner/pharmacist of Springfield Pharmacy in Springfield, admitted that, between August of 2001 and June of 2003, he filled legitimate prescriptions for medicines on doctors' orders for a Medicaid patient, then added several false prescriptions for the same patient so that he could bill the Medicaid Program. This case was referred to the New Jersey Board of Pharmacy.

### *State v. Adebowale Oyenusi and Quick Script Pharmacy*

Adebowale Oyenusi was sentenced on January 26, 2004, to five years State prison, ordered to pay $152,215 in restitution, and a $75,000 fine. The corporate defendant, T&N Pharmaceutical Co., was sentenced on April 24, 2004, to pay a $75,000 fine. After an investigation by the Division of Criminal Justice's Major Narcotics Unit and the Medicaid Fraud Section of OIFP, a jury convicted Oyenusi and T&N Pharmaceutical Co.,

# OIFP Case Notes – *Medicaid Fraud*

trading as Quick Script Pharmacy, of conspiracy, Medicaid fraud, and theft by deception. Oyenusi, through Quick Script, submitted false claims for payment for fraudulent prescriptions.

### *State v. Recovery Services, Inc. State v. Bennie M. Martin*

After being extradited and returned to New Jersey from Texas by OIFP, Bennie M. Martin, a substance abuse counselor, pled guilty to health care claims fraud, Medicaid fraud, and misconduct by a corporate official. The Court sentenced Martin on April 8, 2004, to seven years State prison and ordered him to pay $587,290 in restitution to the Medicaid Program and to Passaic County. Martin also agreed to forfeit $333,754 which had been frozen in Recovery Services, Inc., bank accounts. This money will be applied toward restitution in addition to the $587,290 ordered by the Court.

According to a State Grand Jury indictment, between February of 2001 and September of 2002, Martin allegedly fraudulently obtained the names and Medicaid recipient numbers of Medicaid recipients who were not counseled at Recovery Services, Inc. Using the recipients' names and numbers, Martin allegedly falsely billed the Medicaid Program, falsely claiming he had provided the counseling services to those Medicaid recipients. Martin and Recovery Services, Inc., allegedly fraudulently submitted claims to Medicaid totaling over $900,000 for counseling sessions that never took place.

### *State v. Harvey Lee Bellamy and Bernice Bellamy*

Harvey Lee Bellamy, the owner of H&B Medical Transportation Services, Inc. (H&B), pled guilty to health care claims fraud; and Bernice Bellamy, who was in charge of billing, pled guilty to Medicaid fraud. Harvey Lee Bellamy was sentenced on June 11, 2004, to three years State prison and received a five-year debarment order from the Medicaid Program. Bernice Bellamy was sentenced on June 11, 2004, to five years probation and received a five-year debarment order from the Medicaid Program. Restitution for both will be ordered in an amount to be determined by the Court.

H&B was a mobility assistance patient transportation service located in Magnolia, Camden County, that provided transportation to Medicaid patients who require transportation to and from their medical treatment appointments. According to a State Grand Jury indictment, Harvey and Bernice Bellamy, through H&B, allegedly committed health care claims fraud and Medicaid fraud by billing the Medicaid Program for extra crew members who purportedly provided assistance to Medicaid recipients during the vehicle transports, even though extra crew members had not been provided during the transports. The Bellamys' false bills to Medicaid amounted to $22,860.

### *State v. Jacqueline McCaskill*

Jacqueline McCaskill was sentenced on May 20, 2004, to two years probation. McCaskill pled guilty to an Accusation charging her with Medicaid fraud. McCaskill worked as a clerk for the Passaic County Medicaid Assistance Center. She was responsible for assigning Medicaid numbers and cards to persons who qualified for the Medicaid Program and who were eligible for Medicaid health care and prescription benefits. McCaskill admitted that she fraudulently assigned herself and her four children Medicaid recipient numbers so that she and her children would qualify for Medicaid benefits they were not qualified for under the Program. Between July 1, 2000, and December 26, 2001, McCaskill and her children wrongfully received Medicaid benefits of approximately $33,215.

McCaskill also admitted that she sold fictitious Medicaid cards to friends who did not qualify for Medicaid in return for money and other gifts.

### *State v. Ashokkuma Patel*

Ashokkuma Patel pled guilty to an Accusation on October 25, 2004, charging him with health care claims fraud and Medicaid fraud. The Accusation charged that Patel's repurchase of drugs resulted in $7,717 being fraudulently billed to the Medicaid Program. Patel admitted that between July 8, 2003, and February 17, 2004, at the instruction of another, he bought prescription drugs from Medicaid recipients by paying them $20 to $50 per prescription. The prescriptions were then returned to the MLK Pharmacy inventory to be resold. Unbeknownst to Patel, the drugs were repurchased from OIFP investigators and cooperating witnesses acting in an undercover capacity posing as Medicaid recipients.

OIFP's investigation revealed that Patel filled prescriptions for Medicaid recipients, billed the Medicaid Program for the drugs, purchased the drugs back from the Medicaid recipients at greatly reduced prices, returned the drugs to the pharmacy's inventory, and billed Medicaid again for resold drugs. In essence, MLK Pharmacy created a "black market" by selling and repurchasing prescription drugs, while billing multiple claims to the Medicaid Program for the drugs.

Patel is scheduled to be sentenced early in 2005.

### *State v. Mary Villone*

A State Grand Jury returned an indictment on December 7, 2004, charging Mary Villone with health care claims fraud and Medicaid fraud. Mary Villone, the administrator of PE Medical Transport, Inc., allegedly submitted false transportation claims to the Medicaid Program between January of 2002 and February of 2004. PE Medical Transport provided mobility assistance vehicles and transportation assistance to Medicaid patients who required transportation to and from health care providers.

The State alleged that Villone falsified prior authorization requests, certificates of medical necessity, and transportation trip certifications which Villone submitted in support of claims for transportation services not rendered and for patients who did not require transportation. The State alleged that, in total, Villone submitted approximately 2,080 false claims totaling $51,500 to the Medicaid Program.

During the investigation, PE Medical Transport settled the case with the State by paying $204,000 in restitution and $204,000 in civil penalties. An additional $42,000 was forfeited to the State. The Medicaid Fraud Section "froze" PE Medical Transport's bank accounts which totaled approximately $400,000.

## *Medicaid Civil Case Settlements*

### *GlaxoSmithKline, Inc.*

The State of New Jersey Medicaid Program and the National Association of Medicaid Fraud Control Units reached a settlement agreement with GlaxoSmithKline, Inc., makers of Flonase, a nasal spray, and Paxil, an anti-depressant medication. GlaxoSmithKline allegedly violated the federal Medicaid drug rebate statute by failing to accurately report statutorily mandated "best price" information on the drugs. GlaxoSmithKline's actions allegedly decreased the rebate amount owed to the State. In addition to the Medicaid settlement, the Medicaid Fraud Section recovered $850,608 in restitution and penalties for the PAAD and Senior Gold State programs.

### *Bayer Corporation*

The New Jersey Medicaid Program has reached a settlement agreement, through the National Association of Medicaid Fraud Control Units, with Bayer Corporation, the maker of Cipro, an anti-infective, and Adalat, a calcium channel blocker. Bayer allegedly misreported the "best price" information on these drugs, thereby decreasing the rebate amount owed to the State of New Jersey. The amount of restitution and penalties for the Medicaid portion of these drugs is $6,797,685.

The Medicaid Fraud Section is investigating the impact of Bayer's conduct on New Jersey PAAD Program claims.

### *Rite Aid Pharmacies*

Rite Aid Pharmacies reached a national global settlement with the Medicaid Program through the National Association of Medicaid Fraud Control Units. Rite Aid has paid restitution to the State of New Jersey in the amount of $235,375. The Medicaid Fraud Control Unit alleged that Rite Aid failed to reverse payments for unfilled prescriptions.

### *Greater Trenton Behavioral Health*

Greater Trenton Behavior Health settled with the State of New Jersey's Medicaid Program for $16,245 in restitution. Greater Trenton, a mental health clinic, allegedly billed for two or more intake evaluations per year in violation of Medicaid regulations.

### *Schering Plough*

The New Jersey Medicaid Program reached a settlement agreement with Schering Plough through the National Association of Medicaid Fraud Control Units. Schering Plough makes Claritin, an allergy medication. A citizen's *qui tam* lawsuit alleged Schering Plough manipulated the average wholesale price to the detriment of the Medicaid Program. Schering Plough paid $6,265,819 in restitution and penalties.

### *Walmart Pharmacies*

The New Jersey Medicaid Program reached a settlement agreement with Walmart Pharmacies through the National Association of Medicaid Fraud Control Units. Walmart paid the State of New Jersey $8,773 in restitution and penalties for allegedly not refunding or crediting the Medicaid Program if a beneficiary failed to pick up a medication.

### *PE Medical Transport, Inc.*

PE Medical Transport, Inc., reached a settlement with the Medicaid Fraud Section and the Division of Medical Assistance and Health Services. The Medicaid Fraud Section alleged that PE Medical Transport submitted false claims for transportation services it failed to render. PE Medical Transport signed a Consent Order on December 21, 2004, and it paid $204,000 in restitution, $204,000 in penalties and/or fines, and forfeited $42,000 to the Civil Remedies and Forfeiture Bureau.



# Auto Fraud

## Criminal Use of "Runners"

### *In the Matter of Glenn Poller*

Glenn Poller executed a Consent Order on January 16, 2004, requiring him to pay a $5,000 civil penalty. Poller employed "runners" to refer individuals to his treatment facility. Poller pled guilty to employing a "runner" in a criminal case prosecuted by the Hudson County Prosecutor's Office.

### *In the Matter of Craig Klein*

Craig Klein executed a $25,000 Consent Order on October 13, 2004. Klein used a "runner" to have patients unlawfully referred to his medical facility enabling him to seek reimbursements for insurance claims to which he was not entitled. Klein pled guilty to criminal use of a runner.

## Fraudulent Automobile Claims

## "Give Up"

### *In the Matter of Constance White*

Constance White executed a Consent Order for $5,000 on January 14, 2004. White reported the theft of her motorcycle to the police and to Foremost Insurance Company. She initially accused her estranged boyfriend of the theft but later admitted filing a false police report. White pled guilty in municipal court. This offense was White's second violation of the New Jersey Insurance Fraud Prevention Act. She previously executed a $1,500 Consent Order for application fraud.

### *In the Matter of Carlos Grullon*

Carlos Grullon executed a Consent Order for $5,000 on January 14, 2004. Grullon conspired with others to report his vehicle was carjacked when it was actually "given up" to OIFP investigators in a sting operation. Grullon pled guilty to theft by deception and was sentenced to four years probation, ordered to pay $16,520 in restitution, and perform 200 hours of community service.

### *In the Matter of Katrina Johnson*

Katrina Johnson executed a Consent Order for $5,000 on July 23, 2004. Johnson submitted a false claim for the theft of her automobile. Johnson was prosecuted criminally by OIFP and was placed into the PTI Program and ordered to pay $15,845 in restitution. This case was referred by New Jersey Manufacturers Insurance Company.

### *In the Matter of Michael Ruggiero*

Michael Ruggiero executed a $5,000 Consent Order on August 18, 2004. Ruggiero falsely reported his vehicle stolen in an effort to obtain an insurance settlement from Liberty Mutual Insurance Company. However, the vehicle had been burned in Philadelphia prior to the time Ruggiero indicated he last saw it. Ruggiero was prosecuted by the Gloucester County Prosecutor's Office and was admitted into the PTI Program.

### *In the Matter of Santo Lamancusa*

Santo Lamancusa executed a $5,000 Consent Order on August 18, 2004. Lamancusa conspired with others to file a false insurance claim with State Farm Insurance Company for the theft of an automobile he operated. Lamancusa was also prosecuted for the fraudulent activity and sentenced to probation in Camden County.

## Staged Accidents

### *In the Matter of Iris Salkauski*

On January 8, 2004, Iris Salkauski executed a Consent Order for $235,000. Salkauski led a staged accident ring in Camden County. An investigation by OIFP and Allstate Insurance Company's SIU uncovered a conspiracy involving individuals who staged car accidents and filed fraudulent Personal Injury Protection (PIP) claims totaling $567,940 for fictitious injuries. Undercover law enforcement officers ultimately infiltrated the ring by posing as participants in one of the staged accidents. Salkauski has been sentenced to five years in State prison.

### *In the Matter of Sumara Ahmad and Vishwas Soni*

Sumara Ahmad and Vishwas Soni each executed $5,000 Consent Orders on October 13, 2004. Ahmad and Soni conspired to stage the theft of Ahmad's vehicle in order to file a false claim with First Trenton Indemnity Company.

## Application Fraud

### *In the Matter of Stanley Dubin*

Stanley Dubin executed a $5,000 Consent Order on October 13, 2004. Dubin obtained insurance coverage from Liberty Mutual Insurance Company for his vehicle under the name of his deceased mother. Dubin had an-

other individual pose as his mother and sign the insurance documents. Dubin was prosecuted by the Atlantic County Prosecutor's Office and was sentenced to probation and ordered to pay $1,141 in restitution.

## Licensed Insurance Provider Fraud

### In the Matter of Marc Rossi

Marc Rossi executed a $50,000 Consent Order on October 4, 2004. Rossi, a licensed Public Adjuster operating under Rossi Adjustment Services, operated an "arson-for-profit" and insurance fraud scheme responsible for at least six burned buildings. Rossi pled guilty to various charges and was sentenced to eight years in prison. He was also ordered to pay $537,673 in restitution to six insurance companies.

### In the Matter of Michael Winberg

Michael Winberg executed a $5,000 Consent Order on March 29, 2004. Winberg conspired with others to commit arson on the Country Barrel Inn in Mercer County. This case was referred by State Farm Insurance Company.

## Fraudulent Claim Checks

### In the Matter of George Givens

On August 18, 2004, George Givens executed a Consent Order for $15,000. Givens conspired with former Allstate Insurance Company employee Linda Clemens-Wright to wrongfully receive and cash 38 claim checks totaling $146,748.

### In the Matter of Lisa Givens

Lisa Givens executed a Consent Order for $15,000 on August 18, 2004. Givens conspired with former Allstate Insurance Company employee Linda Clemens-Wright to wrongfully receive and cash 32 claim checks totaling $112,980.

### In the Matter of Carol Cappuccio

Carol Cappuccio executed a Consent Order on January 14, 2004, for $8,000. Cappuccio knowingly received a fraudulent check from the Allmerica Insurance Company and solicited three others who also received fraudulent checks to participate in the fraud scheme.

## Health, Life, and Disability Fraud

### Provider Fraud

### In the Matter of John Douglas Wylie

John Douglas Wylie, a licensed pharmacist, executed a Consent Order in the amount of $135,000 on December 1, 2004. Wylie practiced holistic medicine at the Center for Health Education Research, Inc., in Cherry Hill. He admitted that he represented on health care claims that he was appropriately licensed to perform various non-reimbursable, non-medical treatments to include electric stimulation, neuromuscular reeducation, manual manipulation, and body fluid analysis. He submitted claims to insurance carriers on behalf of insured patients, misrepresenting that these procedures were covered medical procedures performed pursuant to doctor's orders. Wylie pled guilty to theft by deception and was sentenced to two years probation and ordered to pay $1,050 in restitution to Horizon Blue Cross Blue Shield and $17,477 in restitution to Aetna Insurance Company.

*Administrative Assistant Karen Chin opening OIFP civil investigation files.*

### In the Matter of Roben Brookhim and Rony Elyahouzadeh

Roben Brookhim and Rony Elyahouzadeh jointly executed a $90,000 Consent Order on November 29, 2004. Brookhim and Elyahouzadeh allegedly billed Aetna Insurance Company under the name of Elyahouzadeh for treatment rendered by Brookhim when Brookhim's dental license was suspended. Brookhim was charged with health care claims fraud and entered the PTI Program. Brookhim's dental license was surrendered and deemed a revocation by the Board of Dentistry. The Board of Dentistry suspended Elyahouzadeh's dental license for 36 months, with the first six months active and the remainder stayed to become a period of probation.

# OIFP Civil Case Notes


*Supervising State Investigator Joan Rudderow instructs OIFP civil investigators in fraud detection techniques.*

### *In the Matter of Roland Evans*

Roland Evans executed a $15,000 and a $5,000 Consent Order on March 17, 2004. Allegedly, Evans billed for services not rendered to the Guardian/PHS Health Plans and Aetna Insurance Companies and falsified information on an application for disability insurance with Berkshire Life Insurance Company of America.

### *In the Matter of Roberto Piccolo*

Roberto Piccolo executed a Consent Order requiring him to pay a $30,000 fine on March 10, 2004. Piccolo allegedly billed Delta Dental Insurance Company for services not rendered or for billing for the same services more than once.

### *In the Matter of Alphonso Smith*

Alphonso Smith executed a $10,000 Consent Order on June 22, 2004. Smith allegedly prepared statements on numerous insurance health care claims presented to insurance companies which contained false and misleading information. Smith's license was suspended for five years.

### *In the Matter of Patrick Manze and Michelle Maglione*

Patrick Manze and Michelle Maglione each executed Consent Orders requiring them to pay a $5,000 penalty on June 8, 2004. Manze allegedly conspired with Maglione, his office manager, to falsify records for two claims totaling $2,625 for a patient who was never treated in his office. The case was referred by Horizon Blue Cross Blue Shield of New Jersey.

### *In the Matter of Nicola Amato*

Nicola Amato executed a Consent Order in the amount of $20,000 on June 8, 2004. Amato, a licensed chiropractor, allegedly billed for services he did not perform, billing for "five" region chiropractic manipulations. An audit by Horizon Blue Cross Blue Shield uncovered the false billing. Amato pled guilty to theft by deception.

### *In the Matter of Andrew Rosenfarb*

Andrew Rosenfarb executed a $10,000 Consent Order on June 22, 2004. Rosenfarb allegedly submitted bills to Encompass Insurance Company for treatment of a patient while the patient was out of state on vacation.

### *In the Matter of Samuel Kaplowitz*

Samuel Kaplowitz executed a Consent Order on July 23, 2004, requiring him to pay a penalty of $30,250. Kaplowitz allegedly prepared statements on insurance health care claims forms presented to Horizon Blue Cross Blue Shield containing false and misleading information, specifically improper billing.

### *In the Matter of Daniel Cantanzaro*

Daniel Cantanzaro executed a $17,500 Consent Order on August 18, 2004. Cantanzaro allegedly prepared statements on health insurance claims forms presented to several carriers containing false and misleading information, specifically improper billing and manipulation of CPT codes. This case was referred to OIFP by the Division of Consumer Affairs Board of Medical Examiners.

### *In the Matter of Richard Finder*

Richard Finder executed a $15,000 Consent Order on September 22, 2004. Finder pursued a disability claim with Prudential Insurance Company when he was not disabled. He also submitted false bills to CIGNA Insurance Company for services not provided to a patient. Finder pled guilty to health care claims fraud.

## False Health Care Claims

### *In the Matter of Andrea Wahlig*

Andrea Wahlig executed a $5,000 Consent Order on April 26, 2004. Wahlig fraudulently inflated prescription receipts in a claim filed with New Jersey Manufacturers Insurance Company.

### *In the Matter of Owen Tracey*

Owen Tracey executed a Consent Order for $5,000 on July 23, 2004. Tracey filed a personal injury claim with Rutgers Casualty Insurance Company as a result of an automobile accident although he was not a passenger in the vehicle at the time of the accident.

### *In the Matter of Wanda Middleton*

Wanda Middleton executed a $5,000 Consent Order on October 13, 2004. Middleton filed a false health care claim for $15,000 with NJ CURE Insurance Company for personal injuries arising from an accident. Middleton was not a passenger in the vehicle. Middleton pled guilty to health care claims fraud.

## Fraudulent Disability Claims

### *In the Matter of Phillip Rello*

On January 14, 2004, Phillip Rello executed a $40,000 Consent Order. Rello paid $60,000 in restitution to UNUM Provident Insurance Company. Rello, a licensed electrician and owner of Rello Electric, was working while collecting workers' compensation benefits, performing tasks inconsistent with the physical limitations reported to the carrier.

### *In the Matter of Cindy J. Marco*

On February 18, 2004, Cindy J. Marco executed a Consent Order requiring her to pay a $5,000 penalty. Marco was collecting disability benefits after a work-related accident. However, Marco was employed as a receptionist while collecting the benefits and representing herself to be unable to return to work. This case was referred by New Jersey Manufacturers Insurance Company.

### *In the Matter of Suzanne Shenk*

Suzanne Shenk executed a $5,000 Consent Order on April 26, 2004. Shenk provided false information to Aetna Life Insurance Company in pursuit of a claim for disability benefits. She certified that she had no other income although she was working at another job.

### *In the Matter of Kumar Hathiramani*

Kumar Hathiramani executed a $15,000 Consent Order on May 13, 2004. Hathiramani pursued a claim with Northwestern Mutual Life Insurance Company for total disability although he was not disabled. Hathiramani also pled guilty to theft by deception and falsifying or tampering with records.

### *In the Matter of Jorge Santiago*

Jorge Santiago executed a $5,000 Consent Order on June 22, 2004. Santiago collected total permanent disability benefits while gainfully employed. Santiago used a different Social Security number to obtain employment.



### *In the Matter of Linda Rostron Kaiser*

Linda Rostron Kaiser executed a $5,000 Consent Order on July 23, 2004. Kaiser inflated the extent of her injuries received from a bicycle accident, claiming she was totally disabled and unable to continue her work as a hairdresser. An investigation uncovered that Kaiser was still employed at a different salon cutting and styling hair. Kaiser was prosecuted by the Monmouth County Prosecutor's Office and was admitted into the PTI Program.

### *In the Matter of Surinder Aggarwal*

Surinder Aggarwal executed a $15,000 Consent Order on July 23, 2004. Aggarwal pursued a claim with Northwestern Mutual Insurance Company, claiming he was totally disabled when he was not. Aggarwal was prosecuted by OIFP and pled guilty to theft by deception and falsifying or tampering with records.

## Life Insurance Fraud

### *In the Matter of Nada and Nasir Alharmoosh*

Nada and Nasir Alharmoosh each executed $5,000 Consent Orders on March 10, 2004. The Alharmooshes conspired to defraud Provident Mutual Life Insurance Company, Banner Life Insurance Company, Nacola Life Insurance Company, CNA Insurance Company, and Great American Life Insurance Company by providing false and misleading information relating to life insurance claims. Nada Alharmoosh falsely reported that Nasir Alharmoosh had died. OIFP prosecuted the case and the Alharmooshes pled guilty to theft by deception.

### *In the Matter of Daouda Traore*

Daouda Traore executed two $5,000 Consent Orders on June 8, 2004. Traore submitted a fraudulent claim to Mutual of Omaha Insurance Company for accidental death and life insurance benefits claiming his purported wife and child were fatally injured in a motor vehicle accident in Africa. He submitted an additional fraudulent claim for the same benefits to the American International Group (AIG) Life Insurance Company. He attempted to obtain $232,000 in benefits from the Mutual of Omaha Insurance Company and $175,000 in benefits from AIG. Traore also pled guilty to an Accusation charging him with theft by deception.

### *In the Matter of Patricia West*

Patricia West executed a $7,500 Consent Order on November 8, 2004. West submitted false statements to receive benefit checks on a Prudential life insurance policy.

# *Property and Casualty Fraud*

## False Homeowners Claims

### *In the Matter of Barsis Asaad*

Barsis Asaad executed a $5,000 Consent Order on March 10, 2004. Asaad had filed a false homeowners property damage claim totaling $32,495, providing $27,602 worth of false receipts.

### *In the Matter of Grigory Levyash*

Grigory Levyash executed a $5,000 Consent Order on August 18, 2004. Levyash submitted false receipts to State Farm Fire and Casualty Company in pursuit of a homeowners claim.

### *In the Matter of Dean Marletta*

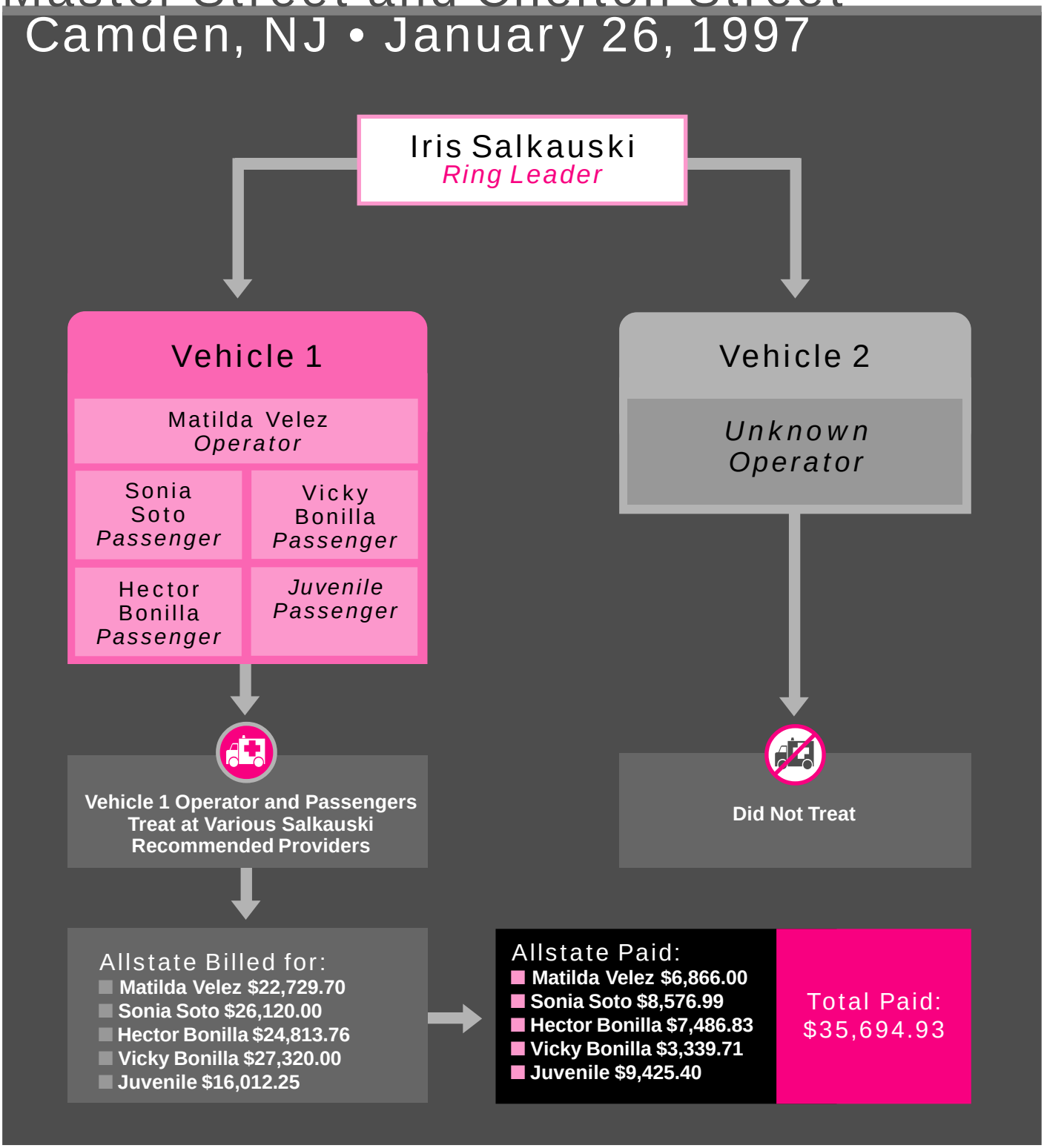
Dean Marletta executed a $15,000 Consent Order on December 15, 2004. Marletta submitted fictitious or altered receipts to Harleysville Insurance Company in support of a homeowners claim. Marletta was admitted into the PTI Program.

## False Commercial Claims

### *In the Matter of*

executed a $10,000 Consent Order on November 8, 2004. conspired with other individuals to purposely damage and destroy inventory in order to collect benefits from a Fireman's Fund Insurance Company commercial policy. pled guilty to attempted theft by deception.

# Intersection of Master Street and Chelton Street Camden, NJ • January 26, 1997



# DOL Civil Litigation Case Notes

### *State v. Kevin R. Milner*

On January 14, 2004, the Consent Order signed by Kevin Milner was fully executed in the amount of $10,000. Milner presented false and misleading information in support of a disability claim.

### *State v. Roberto Piccolo*

On January 28, 2004, Roberto Piccolo signed a Consent Order agreeing to pay a civil penalty of $30,000 for submitting statements in support of insurance claims which contained false information.

### *State v. David Harris*

On May 24, 2004, David Harris, a chiropractor, signed a Consent Order agreeing to pay a civil penalty of $15,000 for indirectly soliciting other persons to make claims for personal injury protection benefits.

### *State v. Charles H. Weatherby*

On October 18, 2004, summary judgment was entered against Charles H. Weatherby for a civil penalty of $7,500 and attorneys' fees of $3,765. Weatherby submitted false and misleading information in support of a property loss claim.

### *State v. Pamela Connant and Steven Hughes*

On October 28, 2004, the State was granted summary judgment and awarded civil penalties of $4,000 against Pamela Connant and $15,000 in civil penalties against Steven Hughes. The defendants were found to have violated the Fraud Act by providing false invoices and information in support of three claims for coverage submitted to Connant's auto insurer.

### *State v. Stacey Randolph*

On April 23, 2004, the Court entered a $10,000 Stipulation of Settlement and Consent Judgment against Stacey Randolph, a licensed insurance producer, for providing false information to State Farm Insurance Company regarding insurance policies and automobile theft claims. Civil penalties under the Fraud Act were also imposed against co-conspirators Maurice Jacobs, Betty Mure, and Tamara Biamby.

### *State v. Thomas Wickham, III*

On June 23, 2004, the Court entered a Stipulation of Settlement with Thomas Wickham, III. Wickham agreed to pay a $20,000 penalty and attorneys' fees in the amount of $7,500 for making false or misleading statements in support of claims for workers' compensation benefits. Wickham also made restitution to his employer, Clayton Block Company.

### *State v. Milton Milan and Joseph Darakshan*

On November 19, 2004, the Court entered summary judgment against former Camden Mayor Milton Milan. The Court ordered Milan to pay a $10,000 civil penalty and $2,176 in attorneys' fees and costs for violating the Fraud Act. Milan made a false property loss report on the day he was sworn in as Camden City Council President. Milan and co-defendant Joseph Darakshan reported computer equipment stolen in order to avoid paying an outstanding business equipment lease. Milan kept one of the computers and used it in his City Hall office. On October 1, 2004, Darakshan entered into a Stipulation of Settlement with the State and agreed to a $7,500 civil penalty. Darakshan also paid restitution to the Selective Insurance Company and leasing company.

### *State v. Peter Ladas*

On April 4, 2004, Peter Ladas, a licensed insurance producer, entered into a Stipulation of Settlement to pay a $15,000 civil Fraud Act penalty. Ladas made false or misleading statements to Prudential Life Insurance Company regarding the health status of an insured. The Department of Banking and Insurance filed a separate administrative action against Ladas, revoking his producer license. Ladas was also ordered to pay a $5,000 penalty and to make restitution to the Prudential Life Insurance Company.

*Division of Law Deputy Attorneys General discuss litigation issues. (l. to r.) Robert A. Storino, Steven Smith, Jeffrey Caccese, Jennifer M. Blum, John C. Grady, and Barbara C. Zimmerman.*



## Atlantic County Prosecutor's Office

### *State v. Ronald Rogers*

On July 2, 2004, Ronald Rogers was sentenced to three years in State prison after pleading guilty to receiving stolen property. An investigation by the Atlantic County Prosecutor's Office Insurance Fraud Task Force into the stripped and burned shell of a 1994 Cadillac Deville, with the assistance of the National Insurance Crime Bureau (NICB), located a valid VIN tracing the vehicle's ownership to Rogers. The execution of a search warrant found Rogers in possession of a stolen 1997 Cadillac Deville bearing the VIN plate from the torched vehicle and more than $1,000 in stolen goods in its trunk.

### *State v. Peter Quarelli and Debra Cornell*

On July 15, 2004, Peter Quarelli and Debra Cornell, his former wife, were indicted for insurance fraud, attempted theft by deception, conspiracy to commit theft by deception, unsworn falsification, and false swearing for allegedly filing a fraudulent insurance claim with First Trenton Insurance Company reporting the theft of $10,000 in jewelry from Quarelli's home. He also allegedly filed an official police report regarding the purported loss. An investigation by the Atlantic County Prosecutor's Office Insurance Fraud Task Force revealed alleged discrepancies in statements made by Quarelli to his insurance company and to the police. Cornell was admitted into the PTI Program on November 16, 2004. The charges against Quarelli are pending trial.

## Bergen County Prosecutor's Office

### *State v. Arcel Gaskin*

On January 30, 2004, Arcel Gaskin was sentenced to one year in State prison for exhibiting a fictitious motor vehicle insurance identification card following a joint investigation conducted by the Bergen County Prosecutor's Office and the Bergen County Police Department.

### *State v. Yerushah Gonzalez a/k/a Rosemary Suarez*

On May 29, 2004, Yerushah Gonzalez a/k/a Rosemary Suarez was sentenced to 110 days in county jail as a condition of three years probation. On April 19, 2004, Gonzalez pled guilty to hindering apprehension and possession of various fraudulent driving credentials following a cooperative investigation by the Bergen County Prosecutor's Office Insurance Fraud Squad and the North Arlington Police Department.

### *State v. Peter Sparta*

On February 24, 2004, Peter Sparta was admitted into the PTI Program, after pleading guilty to attempted theft by deception, on condition that he forfeit his public office pursuant to N.J.S.A. 2C:51-2 and be permanently barred from future employment in law enforcement. Sparta, a career Bergen County Sheriff's Officer, had reported his 2002 Audi stolen from the Garden State Plaza Mall. A joint investigation by the Bergen County Prosecutor's Office Insurance Fraud Task Force and the Bergen County Sheriff's Internal Affairs Division revealed that Sparta falsely reported to Liberty Mutual that his vehicle was stolen when, in fact, it had been abandoned in Jersey City.

## Burlington County Prosecutor's Office

### *State v. April Hines*

On July 2, 2004, April Hines was sentenced to two years probation and ordered to pay a $1,000 fine after pleading guilty to charges of attempted theft by deception. Hines falsely reported her 1999 Lexus RX300 stolen and filed a fraudulent insurance claim with Liberty Mutual. The fraud was discovered when the vehicle was stopped for a motor vehicle violation and the driver informed police that Hines had paid him to dispose of the vehicle. Hines admitted that she fraudulently attempted to collect on her insurance policy; however, no payment was made by Liberty Mutual on the fraudulent claim.

### *State v. Rene Lundborn*

On April 30, 2004, Rene Lundborn was sentenced to three years probation and ordered to pay a $250 fine after pleading guilty to health care claims fraud. Lundborn altered a prescription issued by her physician by changing the number of refills from zero to two and then used her Aetna U.S. Healthcare insurance card to pay for the two refills.


## Camden County Prosecutor's Office

### *State v. Santo Lamancusa*

On July 23, 2004, Santo Lamancusa was sentenced to four years probation conditioned on 90 days in the Sheriff's Labor Assistance Program (SLAP) after pleading guilty to one count of theft by deception. Lamancusa falsely reported his 1995 Ford Mustang stolen from the parking lot of a Cherry Hill restaurant when, in fact, the vehicle was found torched in Millville. An investigation revealed calls made from Lamancusa's cell phone from the Millville area though he claimed to be at the Cherry Hill restaurant where the alleged theft occurred. As part of his plea agreement, Lamancusa consented to pay a civil insurance fraud fine in the amount of $5,000; and his girlfriend, who allegedly corroborated his false statements, consented to a $3,000 civil insurance fraud fine.

### *State v. Lorena Lee*

On May 21, 2004, Lorena Lee was sentenced to three years probation, conditioned on serving 90 days in the Sheriff's Labor Assistance Program (SLAP), and ordered to pay restitution in the amount of $1,629 to Ben's Store following her guilty plea on charges of theft by deception. Lee's parked vehicle had been struck by a State Farm insured driver. State Farm settled the claim by issuing Lee a check in the amount of $1,629 to cover the replacement cost of her totaled vehicle. Lee did, in fact, receive this first check; however, she contacted State Farm advising that she did not receive it. Relying on Lee's representations, State Farm issued her a second check for $1,629 and cancelled payment on the first one. Although well aware that State Farm had stopped payment on the first check, Lorena Lee proceeded to cash the check at Ben's Store and then cashed the second check at another check cashing agency. Lee admitted to law enforcement authorities that she knew her vehicle was only worth $1,629 and that she was not entitled to the double payment.

### *State v. Vasilios Patouhas*

On April 12, 2004, Vasilios Patouhas was admitted into the PTI Program after being charged with attempted theft. Patouhas was alleged to have attempted to enlist a friend's assistance in a scheme to have Patouhas' boat "disappear" while Patouhas and his family were on vacation with the intent to thereafter report the boat stolen to law enforcement and his insurance company. Unbeknownst to Patouhas, his friend contacted the State Police which resulted in an undercover State Trooper proceeding to the Patouhas home, connecting the subject boat to his undercover vehicle, then removing it to State Police Headquarters for safekeeping. A summons was issued for Patouhas' arrest after he contacted his insurance company to report the boat stolen. Patouhas' insurance claim in the amount of $21,430 was denied and the Camden County Insurance Fraud Unit contacted the lien holder who then repossessed the boat.

## Cape May County Prosecutor's Office

### *State v. Michael Quinn*

On October 21, 2004, Michael Quinn, president of Quinn-Woodbine, Inc., was admitted into the PTI Program and ordered to make restitution in the approximate amount of $76,000. Quinn had been previously indicted on two counts of theft by deception for allegedly taking deductions from employees for health insurance and failing to remit those premiums to the employees' health insurer, thus leaving the employees without health insurance from August of 2000 to February of 2001.

### *State v. Claudia Delacruz*

On October 26, 2004, Claudia Delacruz was indicted on charges of attempted theft by deception and hindering apprehension. Delacruz allegedly falsely reported that her 2004 leased vehicle had been stolen in Wildwood Crest. The State intends to prove that the vehicle was not stolen as reported, but that Delacruz wanted to terminate her lease.

### *State v. Debra Williams and Laverne Williams*

On October 26, 2004, a Cape May County Grand Jury returned an indictment charging Debra Williams with uttering a forged instrument and Laverne Williams with forgery. Debra Williams filed a worker's compensation claim for an alleged injury suffered while employed by the County of Cape May.

# County Prosecutor Insurance Fraud Contacts

| | | |
|---|---|---|
| Atlantic County | Chief Asst. Pros. James McClain | 609-909-7816 |
| | Sgt. George Rochelle | 609-909-7800 |
| Bergen County | Asst. Pros. Liliana Silebi | 201-226-5750 |
| | Det. Sylvia Presto | 201-226-5537 |
| Burlington County | Asst. Pros. Rose Marie Mesa | 609-265-5779 |
| | Det. Jack Walker | 609-265-3147 |
| Camden County | Asst. Pros. Robin Hamett | 856-580-6069 |
| | Inv. David Baldino | 856-580-6068 |
| Cape May County | Inv. George Hallet | 609-465-1135 |
| Cumberland County | Det. Sandra Silvestri | 856-453-0486 Ext. 001 |
| Essex County | Asst. Pros. Jeffrey Cartwright | 973-266-7226 |
| | Robert Larsen, Vehicle Fire Coordinator | 973-266-7227 |
| Gloucester County | Asst. Pros. Margaret Cipparrone | 856-384-5684 |
| | Det. William Perna | 856-384-5645 |
| Hudson County | Asst. Pros. Michael Zevits | 201-795-6529 |
| | Det. John Bigger | 201-795-6959 |
| Hunterdon County | Det. Kristen Larsen | 908-788-1556 |
| Mercer County | Asst. Pros. Al Garcia | 609-278-4863 |
| Middlesex County | Asst. Pros. Ronald Abramowitz | 732-745-4108 |
| Monmouth County | Asst. Pros. Edward Quigley | 732-431-7160 |
| Morris County | Det. Daniel McNamara | 973-285-6271 |
| | Asst. Pros. Gerard Britton | 973-631-5193 |
| Ocean County | Asst. Pros. Martin Anton | 732-929-2027 |
| | Inv. Steven Budelman | 732-929-2027 Ext. 3446 |
| Passaic County | Asst. Pros. Robert Holmsen | 973-881-4966 |
| | Inv. George Wall | 973-881-4957 |
| Salem County | Inv. James Gillespie | 856-935-7510 Ext. 8521 |
| Somerset County | Det. Jorge Ramos | 908-575-3337 |
| Sussex County | Det. Doug Porter | 973-383-1570 |
| Union County | Asst. Pros. Eleanor Beaumont | 908-527-4670 |
| | Sgt. Steven Siegel | 908-527-4619 |
| Warren County | Det. Clement Mezzanotte | 908-475-6631 |

Subsequent to filing the claim, Debra Williams took time off from work and allegedly submitted fraudulent leave excuse slips to her supervisor, purportedly signed by physicians at Burdette Tomlin Memorial Hospital (BTMH), for medical treatment rendered for the alleged injury. The State intends to prove that Debra Williams did not receive medical treatment on the dates in question, that the hospital slips were fraudulent, and that Debra's mother, Laverne Williams, a cleaning service employee at BTMH, had stolen the hospital slips in question and forged the doctors' signatures.

## *Essex County Prosecutor's Office*

### *State v. Anthony Perkosky*

On March 26, 2004, Anthony Perkosky was sentenced to four years probation and ordered to pay $27,498 in restitution to State Farm Insurance Company for his role in having his 2002 Acura TL burned. He was also ordered to pay fines and perform 100 hours of community service.

*Union County Prosecutor Theodore Romankow joins Insurance Fraud Prosecutor Greta Gooden Brown and DAG Jennifer Fradel for a panel discussion of insurance fraud law enforcement efforts at the Annual Symposium of the Insurance Council of New Jersey.*

### *State v. Dennis Brown*

On June 7, 2004, Dennis Brown, a former Montclair firefighter, was admitted into the PTI Program after pleading guilty to an Accusation charging him with arson for his role in the burning of a 2002 Nissan Maxima. In addition to resigning from his position as a firefighter, Brown was fined and ordered by the Court to pay restitution.

### *State v. Yelitza Martinez*

On August 4, 2004, an Essex County Grand Jury indicted Yelitza Martinez, an employee of State Farm Insurance Company, on charges of aggravated arson, conspiracy, and attempted theft by deception. Martinez allegedly falsely reported her 1998 Toyota Camry stolen in West New York, New Jersey. The vehicle was subsequently found burning in Newark, New Jersey, at a time Martinez alleges she was driving the vehicle. The State intends to prove the vehicle was intentionally burned and that Martinez had a role in both its alleged theft and subsequent burning.

### *State v. Louis Trabucco*

On September 27, 2004, an Essex County Grand Jury returned an indictment charging Louis Trabucco with arson for hire, aggravated arson, conspiracy to commit aggravated arson, and theft by deception. Trabucco's 2002 Jeep Cherokee was found burning by the Newark Fire Department after he allegedly falsely reported it as having been stolen. The State intends to prove that Trabucco had a role in both the alleged theft and subsequent burning of the vehicle.

## *Gloucester County Prosecutor's Office*

### *State v. Nicole Pfund*

On July 8, 2004, Nicole Pfund was indicted by a Gloucester County Grand Jury for criminal attempt and theft by deception stemming from an allegedly staged "slip and fall" incident at a motel in West Deptford, New Jersey.

### *State v. Regina Toppi*

Regina Toppi, a nurse for Dr. Gottleib at Tenant Hospital, was indicted on March 24, 2004, for allegedly stealing a prescription pad and writing more than fifty prescriptions for Oxycodone and Percocet in the name of her mother.

### *Insurance Card Ride-Along Program*

The Gloucester County Prosecutor's Office Insurance Fraud Unit initiated an "Insurance Card Ride-Along Program" with various local police departments in Gloucester County. The program trains and assists local police officers in detecting fraudulent and counterfeit insurance cards. The Program resulted in 74 investigations in 2004.

On another front, the Gloucester County Prosecutor's Office Insurance Fraud Unit also initiated an investigation into a fraudulent contractor scheme allegedly perpetrated in four southern New Jersey counties. The contractor, Joel Gold, contracted with 52 homeowners for repairs to their homes, many of which were paid by their respective homeowners insurance companies. Gold was arrested by the Gloucester County Prosecutor's Office Insurance Fraud Unit on March 15, 2004, and was indicted in May of 2004. This case was consolidated with others and ultimately prosecuted by the Camden County Prosecutor's Office. Gold pled guilty and is currently in the Camden County Jail awaiting sentencing.

## *Hudson County Prosecutor's Office*

### *State v. Dora Barrueco and Anabela Jaco-Fuentes*

On August 16, 2004, Dora Barrueco and Anabela Jaco-Fuentes pled guilty to charges of insurance fraud and were admitted into the PTI Program. Barrueco, owner of Sandra's Car Service and New Way Car Service, admitted she did not pay the full premiums for her fleet auto insurance and that she provided fraudulent insurance documentation to her drivers, in addition to presenting fraudulent documentation to the City of West New York when applying for the licenses to operate her car services. Jaco-Fuentes admitted her complicity in providing Barrueco with the fraudulent insurance documents. As a result of the plea agreement, Barrueco agreed to cease operation of her two limousine car services.

### *State v. Victor Barrezueta and Anika Barrezueta*

On May 7, 2004, Victor Barrezueta was sentenced to three years probation and ordered to pay restitution in the amount of $28,006

# OIFP Industry Contacts

| | | | |
|---|---|---|---|
| Insurance Fraud Prosecutor | *Greta Gooden Brown* | 609-896-8779 | Lawrenceville |
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to AIG Insurance Company after pleading guilty to an Accusation charging him with arson. In pleading guilty, Barrezueta admitted sole responsibility for the burning of a 2001 Acura, owned by his mother Anika Barrezueta, for purposes of avoiding monthly car payments. Charges against Anika Barrenzueta were dismissed.

***State v. Cristian Mendoza Munoz, Federick Amor and Maria Torres***

On November 19, 2004, Cristian Mendoza Munoz was sentenced to two years probation and restitution of $12,336 for attempting to dispose of his 1997 Ford Expedition, insured by GEICO Insurance Company, and file a fraudulent theft claim. Previously, on June 15, 2004, Frederick Amor, owner of Two Brothers Auto Body, was indicted on charges of insurance fraud, conspiracy, theft by deception, and for his role as alleged leader of the auto theft trafficking network which Munoz attempted to use in "giving-up" his vehicle. Maria Torres was also indicted on June 15, 2004, for insurance fraud, conspiracy, and theft by deception for allegedly attempting to dispose of her 2003 Toyota Corolla, insured by IFA Insurance Company, through Amor. As a result of the investigation by the Jersey City Police Department, with the assistance of the Hudson County

Prosecutor's Office, both Munoz' and Torres' vehicles were recovered without sustaining any damages.

## Mercer County Prosecutor's Office

### State v. Al Elk

On January 30, 2004, Al Elk was sentenced to three years probation conditioned upon serving 180 days in county jail for his role in tampering with evidence in an auto "give-up" scheme. Upon presenting forged repossession paperwork, Elk retrieved a vehicle from the Trenton Police Department after that vehicle had been falsely reported stolen. Elk attempted to dispose of the vehicle before the police could link it to the "give-up" scheme.

### State v. Anne Marie Roberts

On January 30, 2004, Anne Marie Roberts was sentenced on charges of theft by deception to three years incarceration in State prison conditioned upon 10 months parole ineligibility. As a result of a childhood accident, Elizabeth Roberts, Anne Marie's daughter, was entitled to a settlement award with interest. At 20 years of age, Elizabeth attempted to claim the settlement award but was informed the money had already been disbursed. Anne Marie Roberts had fraudulently assumed her daughter's identity for the purpose of obtaining the $14,534 settlement check that had been issued for Elizabeth's benefit by the County Surrogate's Office. In July of 2001, a warrant of indictment was issued for Anne Marie Roberts. It was subsequently served upon her in 2003 when she attempted to enter Canada from the northwest United States.

## Monmouth County Prosecutor's Office

### State v. Lawrence Nowell

On December 10, 2004, Lawrence Nowell was sentenced to three years probation for conspiracy and simulating motor vehicle insurance identification cards. Based on information provided by a local insurance agency alleging fraudulent insurance identification cards were being presented for renewal, as well as information obtained from an individual attempting to renew an insurance policy, an investigation revealed that Nowell either rented vehicles to members of the Red Bank community and/or sold them fraudulent government-issued documents which were presented to law enforcement during motor vehicle stops. A search of the NJMVC database revealed that at one time Nowell had registered as many as 19 vehicles in his name and had provided fraudulent insurance company policy numbers on vehicle registration documents presented to NJMVC.

### State v. William Shomo

On or about December 17, 2004, William Shomo was sentenced to three years probation on charges of conspiracy and simulating motor vehicle insurance identification cards. A cooperative investigation by the Monmouth County Prosecutor's Office and Red Bank Police Department revealed Shomo was producing and/or selling fraudulent insurance identification cards, drivers' licenses, and other government-issued documents. As a result of this investigation, a search warrant was issued and executed on Shomo's Neptune, New Jersey, residence.

## Morris County Prosecutor's Office

### State v. Wanda Reeves and Clifton Baskerville

On October 29, 2004, Clifton Baskerville was sentenced to five years State prison, and his wife, Wanda Reeves, was sentenced to three years State prison with a recommendation for admission into the Intensive Supervision Program (ISP), on charges of theft by deception. Baskerville and Reeves admitted that they had stolen over $115,000 from an insurance brokerage firm where Reeves was employed.

### State v. Michael Fimognari

On February 18, 2004, Michael Fimognari pled guilty to insurance fraud and theft by deception. Fimognari was subsequently sentenced to 90 days S.L.A.P., three years probation, and ordered to pay $719 in restitution to State Farm Insurance. Fimognari, whose own license had been suspended, admitted that he had obtained a license and insurance by fraudulently assuming a false identity, and submitted an accident claim under the acquired policy for damage he caused to another vehicle.

### State v. Suzanne Elsmore

On January 13, 2004, Suzanne Elsmore pled guilty to one count of health care claims fraud and was sentenced to 100 hours community service, three years probation, and ordered to pay $3,500 in restitution to the Medicaid Program. Elsmore admitted to fraudulently obtaining Medicaid benefits in excess of $3,000.



### *State v. Christine Rotundo*

On January 27, 2004, Christine Rotundo pled guilty to health care claims fraud and was subsequently sentenced to 25 hours community service, five years probation, and agreed to pay $1,100 in restitution to U.S. Healthcare. Rotundo admitted that she had submitted fraudulent prescriptions for drugs under the name of another person insured by U.S. Healthcare.

### *State v. Lindsey Richmond*

On April 12, 2004, Lindsey Richmond pleaded guilty to health care claims fraud. Richmond was subsequently sentenced to three years of probation, restitution of $106 to Paid Prescription Plan, and agreed to participate in a drug rehabilitation program. Richmond admitted that she had submitted fraudulent prescriptions for prescription drugs.

### *State v. Kevin Briggs*

On June 4, 2004, Kevin Briggs pled guilty to simulating a motor vehicle insurance identification card. Briggs was facing up to 90 days jail and three years probation. Prior to sentencing, Briggs was arrested and charged with murder in Essex County.

## *Ocean County Prosecutor's Office*

### *State v. Xavier Blackwell*

On October 8, 2004, Xavier Blackwell pled guilty to charges of insurance fraud resulting from an auto "give-up" scheme and was sentenced to 180 days in county jail as a condition of probation, ordered to pay $23,538 in restitution to the Highpoint Insurance Company, as well as a civil insurance fraud fine in the amount of $5,000. In August of 2003, Blackwell reported the theft of his 1998 BMW from the Scores Gentlemen's Club, his place of employment, to the New York Police Department when, in fact, the vehicle had been recovered badly burned and submerged in a Manchester Township lake three days prior to the date it was reported stolen. During an extensive interview, Blackwell provided detailed information concerning the alleged theft. He also indicated that he leased the vehicle for $650 a month and it had approximately 68,000 miles on the odometer. When questioned about the discrepancy in dates of the reported theft and recovery of the vehicle, Blackwell terminated the interview; and he was subsequently charged with insurance fraud.

## *Passaic County Prosecutor's Office*

### *State v. Anthony Mancini and Lisbeth Delgado*

Anthony Mancini, owner of Total Care Chiropractic Center in Clifton, NJ, and Lisbeth Delgado, Total Care's office manager, each pled guilty to one count of criminal use of a "runner" in January of 2004 and were subsequently admitted into the PTI Program. An investigation by the Passaic County Prosecutor's Office revealed that, early in 2001, a confidential informant referred an undercover Prosecutor's Office detective to the Total Care Chiropractic Center; and, in return for the referral, Mancini paid the informant $1,300. After several months of treatment, the undercover detective referred a second undercover detective to Total Care. Delgado paid $1,100 for this second referral.

### *State v. Vernon Cannon*

On May 7, 2004, Vernon Cannon was sentenced to five years probation after pleading guilty to selling a simulated motor vehicle insurance identification card. In October of 2002, an undercover Prosecutor's Office detective purchased a fraudulent Hartford Insurance Company insurance identification card from Cannon for $120.

### *State v. Francis Baccaro*

On October 22, 2004, Francis Baccaro was sentenced to three years probation for committing insurance fraud by submitting a fraudulent auto theft claim to Liberty Mutual Insurance Company. On June 6, 2003, Baccaro reported to the Wayne Police Department that his 1999 Toyota 4-Runner had been stolen from the Willowbrook Mall; and, as a result of the alleged theft, in August of 2003, Liberty Mutual paid $24,876 to Toyota Motor Credit to satisfy the claim for the stolen vehicle. In November of 2003, the vehicle was recovered in a New York City parking garage. A review of the parking garage records revealed that Baccaro's vehicle had been parked there since June 5, 2003, the day prior to it being reported stolen.

## *Salem County Prosecutor's Office*

### *State v. Kim Sheehan*

On December 1, 2004, Kim Sheehan was indicted on charges of insurance fraud, theft by deception, and unsworn falsification to authorities for allegedly committing premium fraud

against her automobile insurer by intentionally misrepresenting the residency of her brother, who allegedly resided with her and was a driver of a vehicle insured under her policy.

## Somerset County Prosecutor's Office

### State v. Kodja Z. Zarlug

On September 13, 2004, Kodja Z. Zarlug pled guilty to possession of a fictitious insurance identification card.

## Union County Prosecutor's Office

### State v. David Pohida, Gerald Pohida and Cheri Jolley (URM Insurance Inc.)

In May of 2004, David Pohida and Gerald Pohida, principals of United Risk Management Insurance Agency, were indicted for theft by failure to make required disposition of property received, theft by deception, misapplication of entrusted property, and misconduct by a corporate official. Cheri Jolley, United Risk Management's office manager, was charged with theft by deception and theft by failure to make required disposition of property received. David and Gerald Pohida allegedly retained $84,000 in insurance premiums for their personal use while issuing and reissuing fictitious temporary insurance cards to at least 40 identified victims to conceal the thefts.

Additionally, David Pohida, Gerald Pohida, and Cheri Jolley were charged with insurance fraud for allegedly filing an application for insurance coverage for their livery company, Executive Transport, wherein they purported to list the vehicles as "medical transport" vehicles when, in fact, the vehicles were taxis. By doing so, the company allegedly avoided paying an additional $92,000 in insurance premiums.

On December 21, 2004, David and Gerald Pohida were charged by complaint with theft by deception for allegedly obtaining in excess of $150,000 in financing under the pretense of using the funds for financing an allegedly non-existent insurance policy.

### State v. Tulio Martins

On June 10, 2004, Tulio Martins was charged with theft by deception for allegedly falsely reporting his 2001 Toyota Camry stolen to the Elizabeth Police Department and Amica Insurance Co. when, in fact, he had arranged for another individual to dispose of the vehicle. Martins was accepted into the PTI Program on August 26, 2004, and required to pay restitution of $5,981 to Amica.

## Warren County Prosecutor's Office

### State v. Eben Campbell

On October 13, 2004, as the result of a cooperative investigation with the Warren County Prosecutor's Office Insurance Fraud Unit, the Lehigh County, Pennsylvania, Insurance Fraud Task Force obtained an arrest warrant for New Jersey resident Eben Campbell, charging him with application fraud. Pennsylvania authorities charged that Campbell registered and insured his light-duty tow truck in Pennsylvania, using his daughter's Pennsylvania address, to avoid paying a higher commercial liability coverage premium. Campbell, while operating his tow truck under the influence of alcohol, struck and killed a pedestrian. Because of the alleged application fraud, the victim's surviving widow and young children could only sue for the Pennsylvania minimum commercial liability coverage of $100,000, rather than the New Jersey minimum commercial tow truck liability coverage of $750,000, which would have pertained had the vehicle been legally insured in New Jersey. A detainer was placed on Campbell, who is presently incarcerated in the Warren County Correctional Center after pleading guilty to the vehicular homicide.

### State v. Georgeann Pludowski and Victor S. Pludowski, Sr.

On August 31, 2004, Georgeann Pludowski and Victor S. Pludowski, Sr., were charged by summons and complaint with theft by failure to make required disposition of property, theft by unlawful taking or disposition, and conspiracy. The complaint alleged that Georgeann Pludowski, as Executrix for the estate of her cousin, Frank Kozare, conspired with Victor S. Pludowski, Sr., to divert in excess of $70,000 from the estate, which included, among other items, more than $31,000 in death benefits from the New Jersey Teacher's Pension Fund and the New York Life Insurance Company.



## Medical

### *In the Matter of Juan Carlos Fischberg, M.D.*

On January 15, 2004, the State Board of Medical Examiners accepted the representation from Juan Carlos Fischberg, M.D., that he shall refrain from practicing medicine and surgery in New Jersey until further order of the Board. The Attorney General expects to allege negligent and/or fraudulent conduct involving physical examinations of patients; performance or subsequent reporting of electro-diagnostic testing; preparation of test reports containing data, diagnoses, and interpretations of said tests; and billing procedures.

### *In the Matter of Anne Kublin, M.D.*

On January 15, 2004, the State Board of Medical Examiners suspended the license of Anne Kublin, M.D., for three years, retroactive to January 2, 2003, with the first six months active and the remainder stayed as a period of probation, for alleged health care claims fraud, theft by deception, and forgery.

### *In the Matter of Erlinda Del Rosario, M.D.*

On February 1, 2004, the State Board of Medical Examiners revoked the license of Erlinda Del Rosario, M.D., based upon her having unlawfully been employed by a business which administered electro-diagnostic testing to patients. Del Rosario engaged in deceptive billing practices by allowing her name to be affixed to billing for medical procedures which she did not authorize or supervise. In addition, Del Rosario ordered or condoned medically unnecessary testing, said testing purportedly performed in a grossly incompetent and/or fraudulent manner.

### *In the Matter of Bububhaa Patel, M.D.*

On February 1, 2004, the State Board of Medical Examiners permitted the surrender, to be deemed a voluntary permanent retirement, of the medical license of Bububhaa Patel, M.D.

### *In the Matter of Martin Weinstein, D.P.M.*

On March 5, 2004, the State Board of Medical Examiners revoked the podiatric license of Martin Weinstein, D.P.M., for fraudulent insurance billing in excess of $56,000 as well as for fraudulently diverting more than $200,000 in insurance payments to his post office box by altering the mailing addresses of patients and policyholders.

### *In the Matter of Elliott Heller, M.D.*

On April 7, 2004, the State Board of Medical Examiners suspended the medical license of Elliott Heller, M.D., for six years retroactive to November 8, 2002, with the first five years active and the remainder stayed as a period of probation, based upon his guilty plea to theft by deception.

### *In the Matter of Patrick Manze, M.D.*

On May 1, 2004, the State Board of Medical Examners accepted the voluntary surrender of the medical license of Patrick Manze, M.D., to be deemed a revocation, following his guilty plea to health care claims fraud.

### *In the Matter of Alan Ottenstein, M.D.*

On June 25, 2004, the State Board of Medical Examiners accepted the surrender of the medical license of Alan Ottenstein, M.D., to be deemed a revocation, based upon allegations of repeated acts of negligence and gross negligent conduct involving the performance of a medical procedure as well as allegations of professional misconduct for possession of marijuana, loaded and illegal weapons, and for improperly maintained CDS in his medical office.

### *In the Matter of Robert L. Fink, D.P.M.*

On June 8, 2004, the State Board of Medical Examiners suspended the podiatric license of Robert L. Fink, D.P.M., said suspension stayed as a period of probation, following charges of fraudulent insurance billing for a procedure he never performed in addition to unbundling his fees for the procedure.

## Dental

### *In the Matter of Robert Poli, D.M.D.*

On December 17, 2003, the State Board of Dentistry reprimanded Robert Poli, D.M.D., based upon a Consent Order he executed for knowingly preparing and submitting a false and misleading insurance claim.

### *In the Matter of Terrance Stradford, D.D.S.*

On February 22, 2004, the State Board of Dentistry suspended the dental license of Terrance Stradford, D.D.S., for 90 days and pending a Board determination of his fitness to resume practice in compliance with a Board investigation based upon his failure to allow an inspection of his premises, failure to provide patient records, and failure to comply with a Board subpoena to appear and produce patient records.

*OIFP and representatives from the licensing boards meet to discuss pending cases. (l. to r.) OIFP First Assistant Prosecutor John J. Smith; DAG Paul Kenny, DOL Prosecutions Section Chief; OIFP Special Assistant Charles Janousek; Supervising State Investigator Brian Harshman.*

### *In the Matter of Francis O'Malley, D.D.S.*

On August 25, 2004, the State Board of Dentistry suspended the license of Francis O'Malley, D.D.S., for one year, with the first 30 days active and the remainder stayed as a period of probation, based upon his acknowledgment of submitting false and misleading insurance claims.

### *In the Matter of John Hunter, D.D.S.*

On September 10, 2004, the State Board of Dentistry reprimanded John Hunter, D.D.S., based upon a Consent Order he executed for knowingly billing for and receiving insurance payments for dental services he never provided.

### *In the Matter of Roberto Piccolo, D.M.D.*

On September 15, 2004, the State Board of Dentistry suspended the dental license of Roberto Piccolo, D.M.D., for two years, with the first 75 days active and the remainder stayed to be a period of probation, based upon a Consent Order he executed for knowingly submitting multiple claims to a dental insurance carrier containing misleading information.

### *In the Matter of Roben Brookhim, D.D.S.*

On December 2, 2004, the State Board of Dentistry accepted the surrender of the dental license of Roben Brookhim, D.D.S., to be deemed a revocation, based upon his having knowingly provided dental treatment and submitted bills to insurance companies for approximately 30 patients while his license was actively suspended.

### *In the Matter of Rony Elyahouzadeh, D.D.S.*

On December 2, 2004, the State Board of Dentistry suspended the license of Rony Elyahouzadeh, D.D.S., for a period of 36 months retroactive to November 24, 2004, with the first six months active and the remainder stayed as a period of probation, based upon his having knowingly aided and abetted the unlicensed practice of Roben Brookhim, D.D.S., while Brookhim's dental license was actively suspended.

## Chiropractic

### *In the Matter of William Ittner, D.C.*

On April 1, 2004, the Board of Chiropractic Examiners suspended the license of William Ittner, D.C., for five years, with the first 18 months active and the remainder stayed as a period of probation, based upon his use and payment of a "runner."

### *In the Matter of Michael Gardiner, D.C.*

On May 5, 2004, the Board of Chiropractic Examiners suspended the license of Michael Gardiner, D.C., for five years retroactive to July 24, 2003, with the first two years active and the remainder stayed as a period of probation, based upon his guilty plea to health care claims fraud and use of a "runner."

### *In the Matter of Scott Schemanski, D.C.*

On October 7, 2004, the Board of Chiropractic Examiners revoked the license of Scott Schemanski, D.C., for aiding and abetting the unlicensed practice of chiropractic and billing for those services as well as allowing unlicensed personnel to administer physical modalities without proper supervision.

## Pharmacy

### *In the Matter of Steven Aberbach, R.P.*

On December 31, 2003, the New Jersey Board of Pharmacy revoked the license of Steven Aberbach, R.P., based upon his guilty plea to health care claims fraud.

### *In the Matter of Jennifer Kim, R.P.*

On January 2, 2004, the New Jersey Board of Pharmacy revoked the license of Jennifer Kim, R.P., based upon her guilty plea to health care claims fraud.

# 2004 OIFP Licensing Board Statistics

| | Suspension | Revocation | Voluntary Surrender | Reprimand | TOTAL |
|---|---|---|---|---|---|
| **Chiropractic** | 3 | 1 | 0 | 0 | **4** |
| **Dental** | 4 | 1 | 0 | 2 | **7** |
| **Medical** | 4 | 4 | 2 | 0 | **10** |
| **Mortuary Science** | 0 | 1 | 0 | 0 | **1** |
| **Nursing** | 2 | 1 | 0 | 0 | **3** |
| **Pharmacy** | 0 | 5 | 0 | 0 | **5** |
| **Social Worker** | 2 | 0 | 0 | 1 | **3** |
| TOTAL | **15** | **13** | **2** | **3** | 33 |

***In the Matter of Kwadwo Agyemang, R.P.***

On January 14, 2004, the New Jersey Board of Pharmacy revoked the license of Kwadwo Agyemang, R.P., following his conviction for health care claims fraud.

***In the Matter of Michael Stavitski, R.P.***

On February 12, 2004, the New Jersey Board of Pharmacy revoked the pharmacy license of Michael Stavitski, R.P., based upon his conviction for health care claims fraud.

***In the Matter of Matthew Faenza, R.P.***

On February 12, 2004, the New Jersey Board of Pharmacy revoked the pharmacy license of Matthew Faenza, R.P., based upon his conviction for health care claims fraud.

## Nursing

***In the Matter of John C. Quinn, R.N., C.R.N.A.***

On May 17, 2004, the Board of Nursing suspended the license of John C. Quinn, R.N., C.R.N.A., for a period of five years based upon his having engaged in the use or employment of dishonesty, fraud, deception, misrepresentation, false promise or false pretense, and professional misconduct.

***In the Matter of Robert Cohen, R.N., C.R.N.A***

On May 21, 2004, the Board of Nursing suspended the license of Robert Cohen, R.N., C.R.N.A., for two years, with the first year active and the remainder stayed as a period of probation, based upon his guilty plea to conspiracy to commit theft by deception and theft by deception.

***In the Matter of Faith Penalver, R.N.***

On September 10, 2004, the Board of Nursing revoked the license of Faith Penalver, R.N., based upon her conviction for arson, conspiracy to commit aggravated arson, theft by deception, and conspiracy to commit theft by deception.

## Social Work

### *In the Matter of Tommi Murry, C.S.W.*

On November 20, 2003, the Board of Social Work Examiners suspended the license of Tommi Murry, C.S.W., for three years based upon his conviction for theft by deception.

### *In the Matter of Paul Steffens, C.S.W.*

On January 23, 2004, the Board of Social Work Examiners suspended the license of Paul Steffens, C.S.W., for three years based upon his guilty plea to Medicaid fraud.

### *In the Matter of Lisa Mulroony, C.S.W.*

On January 23, 2004, the Board of Social Work Examiners reprimanded Lisa Mulroony, C.S.W., based upon a Consent Order she executed for knowingly filing a false homeowners property damage claim.

## Mortuary Science

### *In the Matter of William Conyers, Funeral Director*

On June 1, 2004, the State Board of Mortuary Science of New Jersey revoked the funeral director license of William Conyers based upon his conviction for attempted theft by deception, witness tampering, falsifying records, and forgery.

# Closing the Loopholes on Fraud

## *OIFP's Recommendations for Legislative and Regulatory Reform*

Pursuant to N.J.S.A. 17:33A-24, the Office of the Insurance Fraud Prosecutor (OIFP) is required to evaluate and formulate proposals for legislative, administrative, and judicial initiatives to strengthen insurance fraud enforcement.

Some of the recommendations made by OIFP in prior Annual Reports have been implemented through the enactment of legislation, or by the adoption of regulations.

One important regulatory recommendation proposed by OIFP last year involved the regulation of towing companies.[1]

This proposal was directed toward unscrupulous towing companies which artificially inflate fees for the towing and storing of automobiles which have been involved in accidents or which have been towed and stored after retrieval as abandoned or stolen property. This conduct greatly impacts automobile insurance claims.

Two legislative initiatives are under review by the State Legislature.[2] These bills require the Department of Banking and Insurance to promulgate regional fee schedules addressing the recovery, towing, and storage of automobiles. Additional legislative action with respect to these bills is anticipated during calendar year 2005.

Other recommendations include:

### *Criminal Use of Runners Statute*

***Statement of the Problem:***

The Criminal Use of Runners statute, N.J.S.A. 2C:21-22.1, currently does not apply to schemes which target the Medicaid, Pharmaceutical Assistance to the Aged and Disabled Program (PAAD), and Senior Gold Prescription Discount Program (SG). These programs are not "contracts of insurance" and the Medicaid program is not an insurance carrier as defined in the "Runners" statute. The State spent approximately $1 billion in calendar year 2004 on these programs. In addition, the definition of "provider" does not currently include "practitioners" as defined in the Health Care Claims Fraud statute.

***Proposed Solution:***

Amend the definition of "provider" in N.J.S.A. 2C:21-22.1(a) to include "practitioner" as defined in N.J.S.A. 2C:21-24.2. The inclusion of "practitioner" within the definition of "provider" conforms this statute to our Health Care Claims Fraud statute, N.J.S.A. 2C:21-4.2. This inclusion is appropriate

1 *2003 Annual Report*, Office of the Insurance Fraud Prosecutor, p.178.
2 Assembly Bill 2829 and Senate Bill 1497.

because the "Runners" statute is designed to deter Health Care Claims Fraud schemes. Amend the definition of "runner" in N.J.S.A. 2C:21-22.1(a) to include any State or federally-funded health insurance or prescription assistance plan. Since the "Runners" statute carries a penalty of five years State prison with a presumption of imprisonment and a $15,000 fine, enforcement efforts would be enhanced by the passage of this amendment and greater protection would be given to taxpayer-funded programs.

## Fictitious Insurance Identification Cards

***Statement of the Problem:***

The conduct of issuing, selling, offering for sale, possession, creating, or displaying a fictitious insurance identification card is not expressly actionable pursuant to the Insurance Fraud Prevention Act. It is not actionable because this conduct does not involve a policy of insurance, but rather a purported policy of insurance.

***Proposed Solution:***

N.J.S.A. 17:33A-4a should be amended to include a section 4a(6) as follows:

A person or practitioner violates this Act if he:

A. Produces, sells, offers, or exposes for sale a document, printed form, or other writing which simulates a motor vehicle insurance identification card;

B. Exhibits or displays to a law enforcement officer or a person conducting a motor vehicle inspection pursuant to Chapter 8 or Title 39 of the Revised Statutes, a falsely made, forged, altered, counterfeited, or simulated motor vehicle insurance identification card, knowing that the insurance identification card was falsely made, forged, altered, counterfeited, or simulated.

C. Possesses a falsely made, forged, altered, counterfeited, or simulated motor vehicle insurance identification card, knowing that the insurance card was falsely made, forged, altered, counterfeited, or simulated.

OIFP intends to provide updates on these and other statutory and regulatory recommendations in the near future.

# OIFP Expenditures for Fiscal Year 2001 – 2004

| Resources | FY 2001 | FY 2002 | FY 2003 | FY 2004 |
|---|---|---|---|---|
| Resources | $29,771,000 | $29,771,000 | $29,771,000 | $29,771,000 |
| Carry Forward | $37,225 | $282,960 | $95,445 | $189,600 |
| Total Resources Available[1] | **$29,808,225** | **$30,053,960** | **$29,866,445** | **$29,960,600** |

| Expenditures | FY 2001 | FY 2002 | FY 2003 | FY 2004 |
|---|---|---|---|---|
| Salaries | $14,998,761 | $16,321,577 | $16,689,972 | $17,580,358 |
| Fringe Benefits | $3,659,287 | $3,839,786 | $3,971,668 | $5,194,421 |
| Non-Salary | $4,760,995 | $2,808,513 | $2,594,686 | $2,830,986 |
| Division of Law Payment | $1,294,544 | $1,561,695 | $1,711,597 | $1,665,474 |
| Public Awareness | $2,197,970 | $1,858,186 | $1,900,000 | $300,000 |
| County Prosecutor Program | $2,884,225 | $3,024,438 | $2,998,521 | $2,389,361 |
| Total Expenditures[2] | **$29,795,782** | **$29,414,195** | **$29,866,444** | **$29,960,600** |

1 These figures represent total funding available to support OIFP operations in a given fiscal year. Unencumbered funds are not billed to the insurance industry.
2 These figures represent the total expenditures for OIFP operations in the given fiscal year.

***Fiscal Year = July 1 through June 30***

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