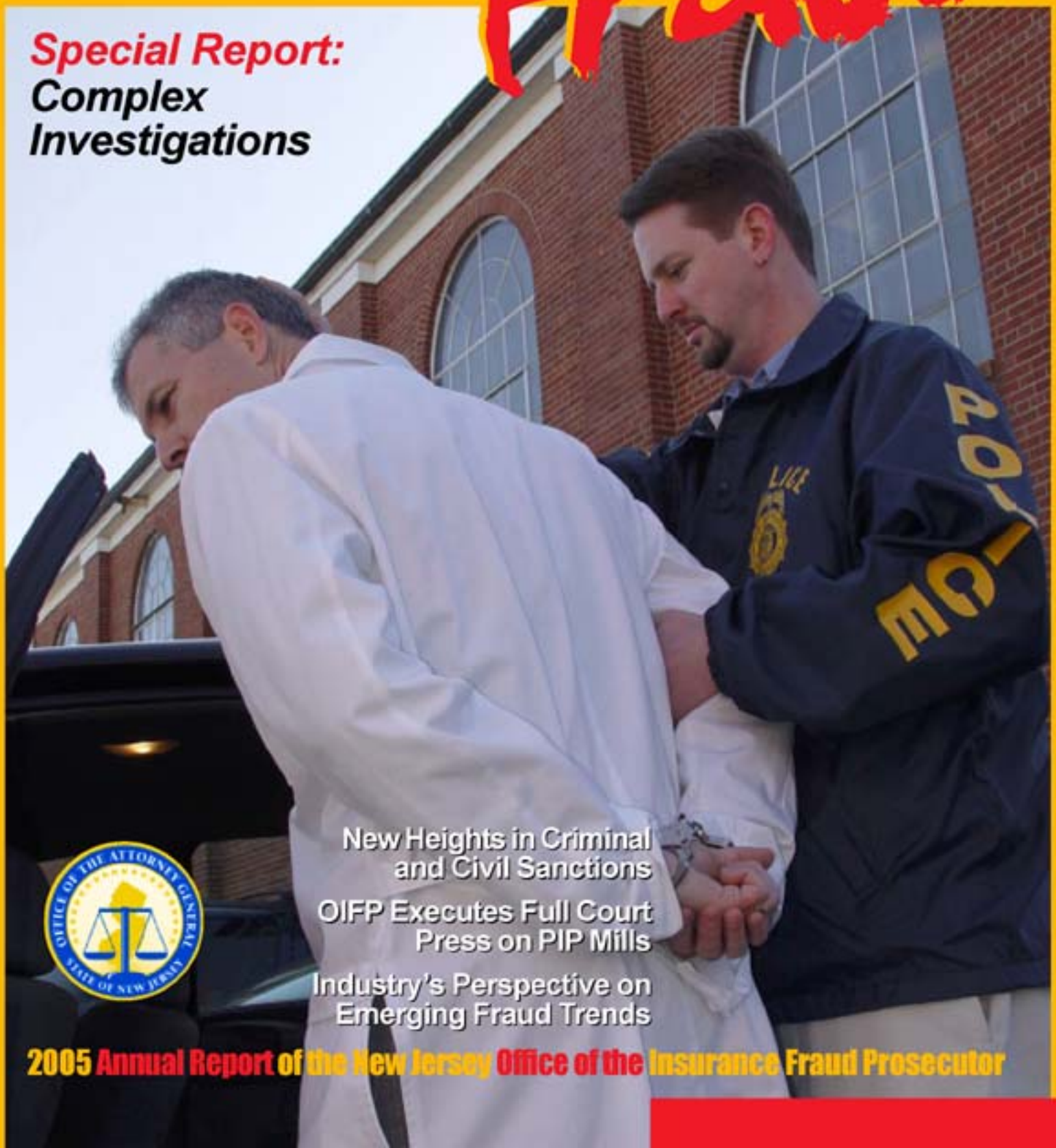
NEW JERSEY

INSURANCE Fraud

Special Report: Complex Investigations



New Heights in Criminal and Civil Sanctions

OIFP Executes Full Court Press on PIP Mills

Industry's Perspective on Emerging Fraud Trends

2005 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor

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Annual Report of

The New Jersey Office of the Insurance Fraud Prosecutor

for Calendar Year 2005

Submitted March 1, 2006 (Pursuant to N.J.S.A. 17:33A-24d)

Zulima V. Farber, *Attorney General*
Greta Gooden Brown, *Insurance Fraud Prosecutor*

Prepared by:
OFFICE OF THE ATTORNEY GENERAL
Department of Law & Public Safety

DIVISION OF CRIMINAL JUSTICE
OFFICE OF THE INSURANCE FRAUD PROSECUTOR
P.O. Box 094 • Trenton, NJ • 08625-0094
609.896.8888 • *www.njinsurancefraud.org*

ANNUAL REPORT STAFF

First Assistant Insurance Fraud Prosecutor
John J. Smith, *Assistant Attorney General*

Editor
Melaine B. Campbell
Supervising Deputy Attorney General

Co-Editors
John Kennedy
Assistant Attorney General
Marquis D. Jones, Jr.
Deputy Attorney General

Copy Editor
Joan Enright
Administrative Analyst

Feature Writers
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Assistant Supervising Deputy Attorney General
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Douglas Falduto
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Neil Johnson
John Butchko
Special Assistant
Jarek Pyrzanowski
State Investigator
Christina Runkle
Analyst
Ray Shaffer
Special Assistant
Peter Lee
Deputy Attorney General
John Krayniak
Assistant Attorney General
Wellington Gu
Intern

Contributors
Michelle Apgar
Supervising Civil Investigator
Jennifer Fradel
Deputy Attorney General, DOL
Charles Janousek
Special Assistant
Pat Miller
Administrative Assistant
Barry T. Riley
Supervising State Investigator
Brian Harshman
Supervising State Investigator
Charles Wells
State Investigator

Photographer
Carlton A. Cooper
Civil Investigator

Production
Paul Kraml, *Art Director*
Enrique Piñas, *Graphic Designer*

Administrative and Technical Support
Susan Cedar, *Administrative Assistant*
Cynthia Ronan, *Administrative Assistant*

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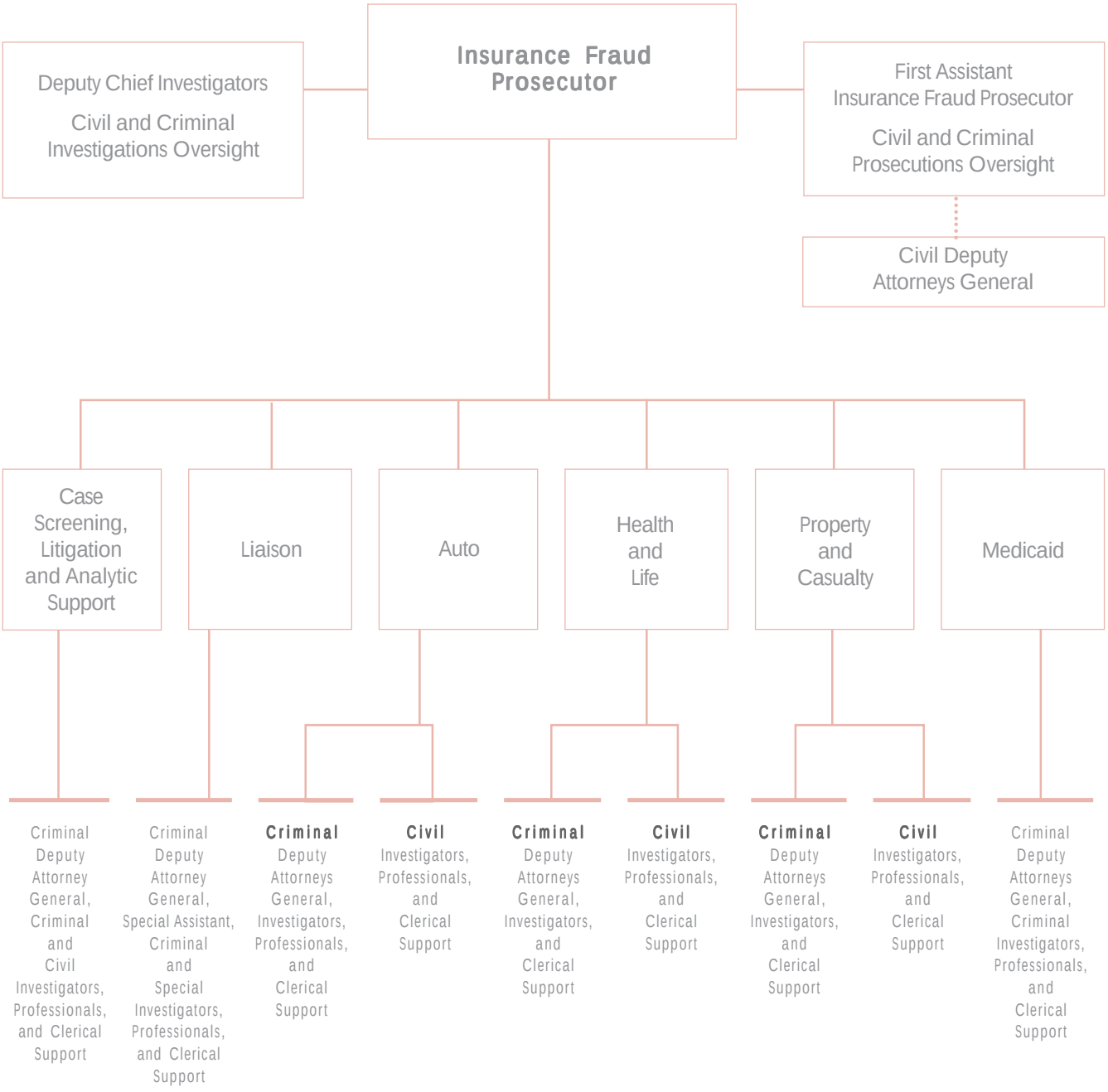
Office of the Insurance Fraud Prosecutor

Office of the Insurance Fraud Prosecutor



A Message from the Insurance Fraud Prosecutor

Making the Best Better

I am pleased to present the 7th Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor (OIFP). Throughout 2005, OIFP continued to wage war against fraud doers. Armed with some of the toughest fraud fighting legislation in the nation, OIFP has taken the lead, both in this State and in the nation, in putting a comprehensive fraud fighting plan into action that has achieved unparalleled results. Fighting side-by-side with our allies in the insurance industry and other law enforcement and government agencies, we are winning many pivotal battles.

Our goal for 2005 was to "Make the Best Better." I am proud to report that we have surpassed that goal. During 2005, OIFP built upon its past accomplishments, confronted and overcame obstacles, and conducted a comprehensive self-analysis to determine where we can improve our efforts to fight insurance fraud.

This year's Annual Report summarizes OIFP's 2005 accomplishments, provides statistical data, and describes OIFP's functions and programs in an article entitled *The Year in Review: OIFP Reaches New Heights in Criminal and Civil Sanctions*. In continuing to provide a library of reference materials offered to inform the insurance industry, law enforcement, the judiciary, government officials, and others interested in combating insurance fraud, this year's Report also contains articles on effective strategies for investigating insurance fraud, parallel prosecutions, emerging insurance fraud law, PIP mills, and fraud trends.

Notwithstanding our vast arsenal of enforcement weapons, criminal prosecution remains the most effective means to deter fraudsters. In 2005, OIFP increased the number of those convicted of committing insurance fraud. Together with County Prosecutor Insurance Fraud Units funded by OIFP, in 2005, we filed criminal insurance fraud related charges against 599 defendants, 175 of whom were convicted and sentenced to a total of 180 years in jail. OIFP alone accounted for over 65 percent of the jail time meted out to those convicted of insurance fraud.

In addition to an increase in convictions in 2005 for insurance fraud related offenses, at trial, OIFP again maintained its impressive 100 percent conviction rate. Most notably in 2005, however, OIFP achieved an unprecedented 448 percent increase in restitution orders imposed over last year, amounting to over $88 million dollars. Criminal fines and penalties also showed a 57 percent increase over last year totaling $624,691.

Civil enforcement actions brought by OIFP in 2005 under the Insurance Fraud Prevention Act were equally noteworthy. Administrative Consent Orders issued by OIFP nearly doubled over last year's figure to $5,725,808. Judgments and settlements obtained by OIFP in civil litigation netted a record-breaking $5,435,660. In addition, OIFP prevailed in significant legal battles, obtaining favorable legal precedents in the area of civil insurance fraud law.

The Division of Criminal Justice (DCJ) came under scrutiny in 2005 as a result of allegations that DCJ personnel, other than OIFP staff, were being improperly paid out of OIFP funds derived from assessments on the insurance industry. These allegations prompted the Attorney General, Peter C. Harvey, and the Director of the Division of Criminal Justice, Vaughn L. McKoy, among others, to request an audit of OIFP funds by the State Auditor.

The audit concluded that, given OIFP's statutory configuration in the Division of Criminal Justice, it was perfectly appropriate for DCJ personnel who provide various support services to OIFP to be paid out of OIFP funds. However, the audit also revealed that the Division of Criminal Justice had inadequate documentation to support those charges.

Turning this problem into an opportunity to "make the best better," staff from the Attorney General's Office, the Division of Criminal Justice, and OIFP developed a cost allocation plan designed to document and support all DCJ charges to OIFP. This cost allocation plan, fully described in a sidebar to our *Year in Review* article, precisely identifies all support services provided to OIFP and determines a fair methodology for assessing costs associated with those services. This comprehensive cost allocation plan is the first of its kind in the history of the Division of Criminal Justice and will undoubtedly become a model for other public/private partnerships in State government.

Under the leadership of Director McKoy, the Division of Criminal Justice also implemented a division-wide timekeeping system that will facilitate precise tracking of time spent by DCJ employees on OIFP activities, and vice versa. These changes will provide the type of documentation that the auditors found lacking during the audit period.

The auditors also recommended that the Insurance Fraud Prosecutor should exercise fiscal oversight over OIFP funds. With this mandate, I will ensure complete transparency and accountability with regard to the use of OIFP funds. OIFP's fiscal activities will now be posted periodically on our Web site, thus allowing the insurance industry and the public the opportunity to view OIFP expenditures and be assured that all expenditures are appropriate.

It has been reported that the public/private partnership approach to fighting fraud, pioneered here in New Jersey, is the "best" approach, providing the "best" overall results in the detection, investigation, and prosecution of insurance fraud. This accomplishment was publicly recognized in the most recent survey of the Coalition Against Insurance Fraud, a Washington based independent non-profit organization of consumers, government agencies, and insurers dedicated to combating insurance fraud through public information and advocacy.

Once again, the Coalition ranked New Jersey as the national leader in fighting insurance fraud. The Coalition reported that out of 44 State Fraud Bureaus, OIFP opened more cases than any other state and twice as many cases as the number two state in this category. The survey also revealed that New Jersey presented the second greatest number of cases for prosecution, logged in the third greatest number of fraud convictions and, by far, filed the greatest number of civil actions. New Jersey's civil cases alone represented 82 percent of all civil cases from all 44 states.

These results should come as no surprise since, in recent years, there have been record increases in the number of individuals charged, convicted, fined, and sent to prison for committing insurance fraud in New Jersey. Over the past seven years, OIFP has convicted over 1,000 fraudsters, over 400 of whom have been sent to jail for a total of 766 years. During the same time period, OIFP has imposed nearly 5,000 civil sanctions totaling nearly $27 million and obtained restitution orders totaling over $135 million.

OIFP, in partnership with the insurance industry, has undoubtedly had a profound and lasting impact on New Jersey's insurance marketplace. Maintaining a high level of successful criminal and civil prosecutions, however, is an ever-increasing challenge. At OIFP, we confront this challenge by recognizing that successful prosecutions begin with top notch investigations. This commitment to excellence in investigations was recognized in 2005 when OIFP was selected as one of 15 semi-finalists for the 2005 IACP/Motorola Webber Seavey Award for Quality in Law Enforcement. This award was presented to OIFP by the International Association of Chiefs of Police (IACP) to promote and recognize quality performance by law enforcement agencies around the globe. In being selected, OIFP out-performed 125 prestigious law enforcement agencies throughout the world.

While we take pride in all our accomplishments, like great athletes, we must, of necessity, have short memories. We cannot dwell on the fraudsters of the past, whom we have successfully prosecuted, but must focus instead on the fraudster of the present. To that end, we at OIFP recognize that there is always room for improvement. As these investigations become more labor intensive, more high-tech, and more challenging, we must constantly evaluate ourselves to find new and better ways to target sophisticated and organized insurance fraud rings and enterprises. We remain open to suggestions for improvement, and are quick to adopt and implement constructive changes as was evident in our prompt response to the findings of the State Auditor.

OIFP's improvements and achievements in 2005 would not have been possible without the support of our many allies in the insurance industry as well as in other law enforcement and government agencies. I am grateful for their support and commitment to making OIFP better and commend them for their fraud fighting efforts. Our collective efforts inure to the benefit of all New Jerseyans by enhancing the economic viability of New Jersey's insurance marketplace, maintaining the integrity of insurance dollars, and punishing those who choose to deprive New Jersey citizens of the safety net afforded by adequate insurance coverage.

Respectfully submitted,

Greta Gooden Brown

New Jersey Insurance Fraud Prosecutor

The Year in Review: OIFP Reaches New Heights in Criminal and Civil Sanctions

The Year in Review:

OIFP Reaches New Heights in Criminal and Civil Sanctions

by Melaine B. Campbell

The impact that insurance fraud prosecutions are having on fraudsters may be gleaned from this excerpt from an actual OIFP undercover conversation with a medical provider:

> Doctor: The insurance companies investigate everything. They spend a lot of money, the doctors examine every patient...But, you know, I tell the doctor whatever the patient says that's it. I try not to treat the patient anymore if he says there's nothing wrong with him. You know why? I don't want my name on the front page of *The Star Ledger* and that's what's gonna happen now. They call it fraud. Fraud is very serious and you know what, when the f__ing police come through the f__ing door, he'll be talking like a parrot about you and me. If somebody, if the police come through the door and they say, "Listen you're coming in here and saying there's nothing wrong with you, why are you treating?" There's no f__ing way! And I don't want it. I don't want them in my door. I can't treat someone if there is nothing wrong with them...We have to pretend everybody is an investigator that walks through the door.

News Reports Tout OIFP's Success

The success of OIFP's prosecutions has been prominently reported in news accounts throughout 2005. Here are just some of the OIFP cases highlighted in newspaper reports this year. In one of its most significant cases to date, OIFP prosecuted Vito Gruppuso, a licensed insurance agent, for the largest insurance fraud scheme ever prosecuted by the State of New Jersey. Gruppuso was sentenced to ten years in state prison and ordered to pay a $225,000 criminal fine. Gruppuso was further ordered to pay $78,836,258 in restitution. He also surrendered his insurance producer's license for life.

Gruppuso was the owner and former president of National Program Services (NPS), an insurance brokerage firm servicing the commercial community. In entering a guilty plea, Gruppuso 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. Gruppuso also admitted 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.

Another agent/producer who made news when he pled guilty in 2005 was Michael Chamberlain. A former Hunterdon County insurance broker and financial planner, Chamberlain stole over $300,000 from the retirement accounts of

a 78-year-old senior citizen. Chamberlain had been charged in an indictment with systematically looting the victim's annuity accounts, investing the monies for his own benefit, and ultimately purchasing a resort home valued at more than $400,000 in Florida. Chamberlain is pending sentencing.

OIFP's conviction of James Clark at trial in 2005 was also widely reported. Clark was the owner and operator of Home Health Care Center, Inc., a Hoboken-based business that delivered prescription medications from pharmacies to people's homes. Clark received payments totaling $343,000 from the State Health Benefits Program for fraudulent claims submitted by his company. Clark was sentenced to nine years in state prison. Likewise, in 2005, OIFP also tried and convicted Florence Acquaire, an electrologist, for falsely billing insurance carriers for nearly $900,000 in medical services. Acquaire was sentenced to seven years in state prison and ordered to pay restitution to the insurance carriers.

A State Grand Jury returned an indictment on December 16, 2005, charging Alan E. Ottenstein and Jean Woolman with conspiracy to commit racketeering, racketeering, attempted theft by deception, and Health Care Claims Fraud. Ottenstein was also charged with false swearing. According to the indictment, through medical practices Ottenstein owned, operated, and controlled, as well as a Las Vegas corporation, from October 1, 1990 through August 31, 2003, Ottenstein, a physician formerly licensed in New Jersey, and his former associate, Woolman, allegedly billed automobile insurance companies, particularly PIP insurance coverage, through a variety of fraudulent schemes.

The State alleged that Ottenstein wrongfully billed insurance companies for epidural injections in connection with pain management; wrongfully billed insurance companies for separate anaesthetic and steroid injections as well as for use of a contrast agent as part of an epidural procedure, billing practices known as "unbundling;" wrongfully billed insurance companies for use of medical supplies to include sterile trays when sterile trays were not used; wrongfully billed insurance companies for a separate "facility fee" when the separate fee was not lawfully charged; wrongfully altered Magnetic Resonance Imaging (MRI) reports so that patients, primarily injured in automobile accidents, would appear to have an auto-related injury when, in fact, they did not; and wrongfully billed mechanical disk recovery system treatments as surgical procedures.

Insurance Fraud Prosecutor Greta Gooden Brown challenges attendees at the 8th Annual Insurance Fraud Summit to "make the best better" in the fight against insurance fraud.

The State also alleged that Ottenstein, Woolman, and the medical practices unlawfully misrepresented treatments and services to various insurance companies. Among these insurance companies were New Jersey Manufacturers, Aetna, Allamerica, Allstate, AmeriHealth, Guardian, HealthNet, Horizon Blue Cross Blue Shield, Liberty Mutual, MetLife, New Jersey CURE, The Oxford Plan, Prudential, State Farm, and Zurich. The State alleged that as much as $2 million in fraudulent claims were submitted to the insurance companies by the defendants through the medical practices. This case represented a collaborative effort between numerous insurance companies, particularly New Jersey Manufacturers Insurance Company, and OIFP.[1]

In sum, OIFP secured jail terms for over 130 fraudsters during 2005. Notably, OIFP obtained a three-year state prison term in 2005 against Angel Lobo, a Paterson physician who committed Health Care Claims Fraud by falsifying treatment records and billing insurance companies for medical services not rendered. Lobo enlisted the services of a "runner" who referred automobile accident "victims" to his medical office. Dannie Campbell, a "runner" who orchestrated fictitious automobile accidents, was also sentenced in 2005 to three years in state prison. Likewise, a prosecution by OIFP's Medicaid Fraud Control Unit resulted in a three-year state prison sentence for Rammohan Pabbathi for using "runners" and paying kickbacks to medical providers to defraud Medicaid. In 2005, a court also sentenced LeClerc Adisson, a medical doctor, to probation conditioned upon 364 days in jail, for submitting fraudulent PIP claims for services he never provided.

Record-Breaking Statistics in 2005: Restitution up 448 Percent

OIFP's Criminal and Civil statistics for 2005 once again show a steady upward trend over its already impressive 2004 figures. Arrests for insurance fraud totaling

1. An indictment is merely an accusation. The defendants are presumed innocent of the charges unless and until proven guilty beyond a reasonable doubt in a court of law.

Insurance Fraud Prosecutor Greta Gooden Brown accepts the 2005 IACP/Motorola Webber Seavey Award for Quality in Law Enforcement from New Jersey Attorney General Peter C. Harvey.

213 were up 17 percent from 2004; accusations filed and defendants charged by accusation totaling 79 increased by 13 percent for the same period; 182 convictions in 2005 represents a 3 percent increase from 2004. OIFP fines, penalties, and restitution imposed showed substantial increases this year as well. OIFP saw a 57 percent increase over 2004 in criminal fines and penalties totaling $624,691. Most noteworthy for 2005 was a record-breaking 448 percent increase over 2004 figures in restitution imposed amounting to $88,910,527. In addition, OIFP again recorded an impressive 100 percent conviction rate in 2005.

On the civil side, in 2005, Administrative Consent Orders issued nearly doubled to $5,725,808. Additionally, OIFP saw a 178 percent increase in civil judgment and settlement amounts imposed against violators during 2005 which totaled an unprecedented $5,435,660. Nearly $4,000,000 of the judgments and settlements were entered against licensed medical professionals and medical providers. One such provider, Daniel Fontanella, a former Passaic County chiropractor, pled guilty to a single count of second degree theft by deception on charges filed by the Passaic County Prosecutor. Following civil litigation under the Insurance Fraud Prevention Act (the Fraud Act), Fontanella was ordered to pay a $935,610 civil penalty and $68,910 in attorneys' fees. OIFP also brought a civil enforcement action against Healthcare Integrated Systems, Inc. (HIS), resulting in a finding by the Honorable Charles E. Villanueva, J.S.C., that HIS and four related entities knowingly violated the Fraud Act. Judge Villaneuva imposed a $2.5 million civil fine on the defendants in this case. During 2005, OIFP was also successful in litigation against Medical Alliances, LLC; Mitchell Rubin, its owner; and a sister company, Neurological Testing Services, LLC. The defendants were found to have violated the Fraud Act and were ordered to pay $98,700 in civil penalties and attorneys' fees as a result of their billing for "professional" services rendered in connection with electro-diagnostic testing.

OIFP a Leader in the Insurance Fraud Fight

Indeed, OIFP has shown itself to be the premier insurance fraud office in the nation. In the most recent survey conducted by the Coalition Against Insurance Fraud (the Coalition), an independent Washington D.C.-based insurance fraud monitor, New Jersey was named the national leader. Out of 44 state fraud bureaus, OIFP opened more cases than any other state and twice as many cases as the number two state in this category. According to the Coalition survey, OIFP presented the second greatest number of cases for prosecution, logged in the third greatest number of fraud convictions, and, by far, had the greatest number of civil actions. New Jersey's civil cases alone represented 82 percent of all civil cases from all 44 states.

Over the past seven years, OIFP has reviewed and screened over 66,000 referrals of suspected or actual insurance fraud. OIFP has convicted over 1,000 fraudsters of insurance fraud or insurance fraud-related offenses, over 420 of whom have

been sent to jail for a total of 766 years. OIFP has obtained restitution for victims totaling over $135 million. In addition, OIFP has imposed nearly 5,000 civil sanctions totaling almost $27 million.

OIFP's Blueprint for Success[2]

The success achieved by OIFP can be attributed to its comprehensive, collaborative, and cohesive approach to fighting insurance fraud in New Jersey. OIFP was established on May 19,1998, when the New Jersey Legislature enacted the Automobile Insurance Cost Reduction Act of 1998 (AICRA). AICRA established OIFP as a law enforcement agency within the State's Division of Criminal Justice, the criminal arm of New Jersey's Attorney General's Office, with a primary objective of criminally prosecuting insurance fraud. OIFP has the authority and responsibility under AICRA not only to investigate every type of insurance fraud but also to conduct and coordinate criminal, civil, and administrative investigations and prosecutions of insurance and Medicaid fraud throughout the State. AICRA further empowered OIFP to oversee and coordinate the anti-fraud efforts of law enforcement and other public agencies in New Jersey with those of the insurance industry.

Within OIFP, there are specialized insurance fraud sections, mirroring classifications in the insurance industry, in both criminal and civil bureaus. Those sections consist of auto fraud, health and life fraud, and property and casualty fraud, as well as the Medicaid Fraud Section. Armed with some of the toughest insurance fraud crimes in the nation, OIFP-Criminal investigates and prosecutes cases related to an insurance transaction cognizable under Title 2C of the New Jersey Code of Criminal Justice. OIFP-Civil, on the other hand, investigates cases of fraud which constitute violations of the Insurance Fraud Prevention Act, N.J.S.A. 17:33A-1, et seq.

Often, OIFP-Civil can impose fines or obtain restitution in cases where the facts do not give rise to the level of proof required to sustain a criminal prosecution. In addition, civil actions have a ten-year Statute of Limitations which is substantially longer than the five-year Statute of Limitations applicable to criminal prosecutions. However, 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.

An important component of OIFP's structure is the Case Screening, Litigation, and Analytical Support Section (CLASS). CLASS receives, screens, assigns, and tracks approximately 10,000 referrals each year. The majority of the referrals emanate from insurance carriers which are statutorily mandated to report suspicious claims. OIFP also receives numerous referrals from OIFP's hotline and Web site, other law enforcement and public agencies, as well as citizen letters and walk-ins. These referrals are entered into OIFP's case tracking system, Law Manager. Initially, existing databases are searched for pertinent or relevant information. Cases are then screened by specially trained investigators to determine whether the referral contains sufficient information to launch an investigation.

Where an investigation is warranted, investigators work with analysts to develop evidence needed to prosecute the case. Analysts use a variety of software applications to analyze the complex relationships among individuals, businesses, and their financial relationships. In addition, OIFP maintains databases containing intelligence information through collaborative and cooperative arrangements with other law enforcement and governmental agencies.

In 2005, OIFP went online with its statutorily mandated "All Claims Database" (ACD). ACD encompasses comprehensive data submitted by insurance carriers regarding New Jersey automobile insurance claims involving a theft or an accident. The database's utility is enhanced with a software tool which is arguably the most powerful "data mining" application available. By "mining" such claims data, OIFP can identify fraudulent patterns and trends amidst an otherwise incomprehensible morass of data.

In addition to investigating and prosecuting insurance fraud, OIFP staff work throughout the year on various anti-fraud programs. Partnering with the insurance industry, other law enforcement and government agencies, OIFP coordinates and

Division of Criminal Justice Director Vaughn L. McKoy addresses attendees at the 8th Annual Insurance Fraud Summit.

2. See "OIFP Leads Nation's Insurance Fraud War," *2004 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor,* March 2005, at 8.

Ernst Csiszar, President of Property and Casualty Insurers of America, delivers the keynote address at the 8th Annual Insurance Fraud Summit.

conducts programs designed to foster public awareness of insurance fraud, provides resources to support the fraud-fighting efforts of other law enforcement agencies and engages in cross training between the insurance industry and law enforcement to advance technical expertise. OIFP accomplishes this mammoth task through a comprehensive liaison program.

There are four designated OIFP liaisons, namely, the County Prosecutor Liaison, the Law Enforcement Liaison, the Insurance Industry Liaison, and the Professional Boards Liaison. Through its County Prosecutor Liaison, OIFP supports the prosecution of insurance fraud cases at the county level and provides annual in-service instruction to personnel in the County Prosecutors' Offices throughout the State. In 2005, OIFP provided $2,970,764 in grants to County Prosecutors' Offices throughout the State to support insurance fraud units within the respective offices. OIFP's Law Enforcement Liaison conducts quarterly law enforcement coordination meetings in each of OIFP's three regional offices which provide opportunities to share information and intelligence among law enforcement agencies at every level in New Jersey and neighboring states.

Through its Insurance Industry Liaison, in 2005, OIFP instituted a joint training program with experienced insurance industry professionals and law enforcement officials to offer specialized training to investigative staff from both OIFP and insurance industry Special Investigations Units (SIUs). New Jersey Manufacturers Insurance Company sponsored comprehensive training in 2005 for OIFP investigators on the industry's perspective on workers' compensation fraud. Allstate Insurance Company also provided "hands-on" training on owner "give-up" fraud by Car Tech to OIFP investigators as part of its Fraud Awareness Month.

OIFP's Insurance Industry Liaison also routinely convenes working group meetings and attends meetings throughout the year with insurance industry executives and insurance industry trade association representatives, affording both OIFP and the insurance industry the opportunity for open and ongoing dialogue on issues of mutual interest. In 2005, OIFP's Insurance Industry Liaison was instrumental in orchestrating both the Annual New Jersey Insurance Fraud Summit and the Annual Conference of the New Jersey Special Investigators Association, the premier statewide networking and training events in the insurance fraud fighting arena.

OIFP's Insurance Industry Liaison also works closely with New Jersey's Department of Banking and Insurance, coordinating investigations and tracking OIFP cases involving professionals licensed by the Department, which includes public adjusters, real estate agents, and licensed insurance producers. In 2005, OIFP tracked 86 such cases in coordination with the Department. Through OIFP's Professional Boards Liaison, OIFP provides a mechanism to ensure effective coordination between OIFP and all other professional licensing authorities which have the power to impose such sanctions as license suspension, license revocation, and fines on professional licensees. OIFP's Professional Boards Liaison maintains a database of professional licensees who have been the

"NJM applauds the dogged effort of the Insurance Fraud Prosecutor to bring to justice those who not only steal premium dollars from policyholders, but also endanger lives through unnecessary and sometime dangerous medical procedures. I also credit the hard work of NJM's Special Investigations Unit, headed by a former prosecuting attorney and staffed with other former law enforcement officials and insurance specialists. This case is an example of how the criminal justice system and insurance company fraud investigators can work together to protect New Jersey drivers. There is nothing like the sound of a clanging jail cell door to make dishonest practitioners understand that New Jersey truly has zero tolerance for insurance fraud."

–Anthony G. Dickson,
President and CEO,
New Jersey Manufacturers
Insurance Company,
commenting on the
State v. Ottenstein, et al. indictment

subject of complaints to either OIFP, a County Prosecutor's Office, or one of New Jersey's many professional licensing boards.

Training

Throughout 2005, OIFP staff conducted training on insurance fraud to several groups and entities. Insurance Fraud Prosecutor (IFP) Greta Gooden Brown and First Assistant Insurance Fraud Prosecutor (FAP) John J. Smith hosted a workshop on *Insurance Fraud* at the New Jersey Institute for Continuing Legal Education's 2005 Criminal Law Institute. Supervising Deputy Attorney General John Krayniak lectured at Seton Hall Law School's Healthcare Compliance Certification Program. FAP Smith presented a lecture at the "Tools for Accountability in State Government" seminar sponsored by the Association of Government Accountants, Trenton Chapter. State Investigators Jarek Pyrzanowski and Jeffrey Lorman presented a training session on Innovative Auto Theft Schemes to NICB Special Agents in Gettysburg, Pennsylvania. In addition, the OIFP Liaison Section conducted numerous presentations to groups including Central Jersey Claim Representatives; the National Association of Insurance Women; Chubb Insurance; the Rotary Club; the 1752 Club, an insurance trade group; Independent Insurance Agents of New Jersey; Highpoint Insurance Company; the Insurance Council of New Jersey; Risk Insurance Managers of New Jersey; KMA Insurance; Palisades Safety Insurance; Chartered Property and Casualty Underwriters; Property Insurers of America; and NAS Brokerage.

Recognition in 2005

In 2005, OIFP was again recognized as a world leader in fighting insurance fraud. Among the honors received by OIFP in 2005 was its selection as one of 15 semi-finalists for the 2005 IACP/Motorola Webber Seavey Award for Quality in Law Enforcement. The IACP/Motorola Webber Seavey Award recognizes innovative projects in law enforcement. The Award judges quality and excellence with results that have been sustained for a minimum of one year. Since the award was introduced in 1992, over 1,600 municipal, county, state, and federal agencies and sheriff's departments have participated in this distinguished program. The International Association of Chiefs of Police selected OIFP for this honor over 125 other law enforcement contenders throughout the world, including the FBI Regional Computer Forensic Laboratory Program in Quantico, Virginia. IFP Brown's speech, given at the "Healthcare Cost Crisis Conference" sponsored by HealthSense, Inc., the Health Care Payers Coalition of New Jersey, and the New Jersey Association of Health Plans, was cited as a "MUST Read" by HealthSense, Inc., and reported in its weekly online publication "Symptoms & Cures." IFP Brown was also requested to assist the State of Washington with its efforts to create a fraud bureau through legislation. Likewise, the Insurance Bureau of Canada expressed a desire to implement many of OIFP's insurance fraud investigative and administrative procedures.

Making the Best Better

OIFP has had a significant impact on insurance fraud in New Jersey. The insurance industry works assiduously with OIFP to investigate and combat fraud on many levels, from underwriting, through SIU investigations, to OIFP prosecutions. Other law enforcement agencies continue to detect and fight insurance fraud at the local level and the public is showing a greater awareness of insurance fraud. Insurance carriers, impressed with a friendlier market as well as the State's tough stand in fighting fraud, are moving back into New Jersey. Yet, much needs to be done. Insurance fraud schemes are vast and complex. Investigating and prosecuting those involved in these large-scale crimes require the continuous financial support of the insurance industry. Fiscal constraints in recent years have resulted in program and staffing cutbacks. Although OIFP has managed to maintain a level of excellence in the quality of OIFP cases, we have seen an impact on our ability to staff investigations. In order to "make the best better," OIFP must continue its efforts to investigate and prosecute high quality cases and coordinate its efforts with the insurance industry, other law enforcement and government agencies, as well as the public. But OIFP's success also depends upon an appropriate level of funding that will support the staffing and resources needed to maintain its recognized level of excellence.

Melaine B. Campbell is a Supervising Deputy Attorney General and serves as Special Assistant to the Insurance Fraud Prosecutor. She has been a prosecuting attorney for over 25 years with the Division of Criminal Justice, the Hunterdon County Prosecutor's Office, and as Acting County Prosecutor in Somerset County.

OIFP's Cost Allocation Plan

by Ray Shaffer

The Division of Criminal Justice (DCJ) and the Office of the Insurance Fraud Prosecutor (OIFP) were challenged this year to respond to allegations that DCJ personnel, other than OIFP staff, were being improperly paid out of OIFP funds. These allegations prompted the Insurance Fraud Prosecutor (IFP), through the Attorney General and the Director of the Division of Criminal Justice, to request an audit of OIFP funds by the State Auditor. The audit concluded that, given OIFP's statutory configuration within the Division of Criminal Justice, it was appropriate for DCJ personnel who provide various support services to OIFP to be paid out of OIFP funds, such as personnel within DCJ's Human Resources, Budget, Facilities, and Information Technology Sections.

The audit noted that DCJ had inadequate documentation to support charges for services DCJ provided to OIFP. OIFP's original cost allocation plan, developed when OIFP was first formed, was created by a transition team comprised of Department of Law and Public Safety (DLPS) and DCJ personnel. OIFP personnel were dedicated solely to the programmatic and enforcement functions of the Office. The audit found that over the years, much of the supporting documentation for the original cost allocation plan was no longer available to support the cost methodology. The auditors' recommendation was that the IFP should exercise more direct fiscal oversight over OIFP funds. As a result of this recommendation, the IFP hired an Administrative Liaison to work with DCJ on administrative matters and formed a committee to redraft a comprehensive Cost Allocation Plan which precisely identifies all support services provided by DCJ to OIFP and documents a fair methodology for assessing costs associated with those services.

The Cost Allocation Plan details four different levels of support that DCJ provides to OIFP: Administrative Support, Criminal Support, Intermittent Support, and Non-Salary Expenses.

- **Administrative Support**
  Due to the nature of administrative work in such areas as Human Resources, Fiscal and Budget, Facilities, and IT Services, it is impossible to segregate those services provided to OIFP from those provided to other sections within DCJ. The Cost Allocation Plan provides that administrative salary costs are to be allocated based on the percentage size of OIFP to that of the entire DCJ. At the beginning of each fiscal year (July 1), this percentage will be determined and that percentage will be applied to the salaries and fringe benefits costs of all of those sections classified as providing administrative support to OIFP for that fiscal year.

- **Criminal Support**
  DCJ provides a number of services that are essential to enable the criminal component of OIFP to investigate and prosecute criminal insurance fraud. Evidence storage, State Grand Jury, and Records and Identification sections, among others, allow OIFP to use resources already in place rather than create its own separate entities. In order for OIFP to pay its fair share of those shared criminal resources, at the beginning of each fiscal year, the Cost Allocation Plan details a formula to determine the percentage size of the criminal component of OIFP to that of DCJ's. This percentage will then be used for the upcoming fiscal year to pay staff salaries and fringe benefits for sections under this classification.

- **Intermittent Support**
  DCJ also provides a host of resources to OIFP on an as-needed basis. Manpower for search warrants, forensic computer analysis, handwriting analysis, and the installation of electronic surveillance equipment are a few examples. Since these resources are used intermittently, DCJ has developed a new division-wide timekeeping system to enable OIFP to precisely track the amount of time spent by DCJ employees on OIFP activities. At the end of each fiscal quarter, time spent by non-OIFP staff on OIFP matters will be calculated and OIFP will reimburse DCJ for those costs.

  The new timekeeping system will also work in reverse, tracking the number of hours worked by OIFP staff on non-OIFP assignments. Given tight budget restrictions and limited resources, it is necessary for OIFP and DCJ to work together on priority matters. However, this does not mean that the insurance industry should foot the bill for these non-insurance fraud-related activities. The new tracking system will allow both OIFP and DCJ to determine the number of hours worked by each of the staffs and reconcile the manpower costs on a quarterly basis.

- **Non-Salary Costs**
  In order for OIFP to accomplish its mission, it must have facilities and equipment available for its use. Items that are used solely by OIFP will be purchased and maintained by OIFP. Items, such as buildings, computer networks, and phone systems, that OIFP shares with other sections within DCJ will be paid based on the percentage use of those resources by OIFP staff. Percentage size of OIFP as compared to DCJ in these areas will be determined at the beginning of each fiscal year and will be applied to those costs as they occur for the entire fiscal year.

The IFP is working hard to ensure that there is complete transparency and accountability in the use of industry monies for the operation of OIFP. Consequently, once the Cost Allocation Plan has been fully implemented, a summary of the plan and quarterly expense reports will be posted on OIFP's Web site so that the insurance industry, as well as the general public, will understand how industry monies are being used to support OIFP's nationally recognized insurance fraud program.

During the audit process, the IFP became acutely aware of a looming fiscal problem that will have serious repercussions in Fiscal Year '07 beginning on July 1, 2006. For the last five years, the OIFP budget of $29,771,000 has remained stagnant while the cost of operations has steadily increased. As a result, many successful programs, such as the State Police Fraudulent Insurance Card Unit, had to be disbanded for lack of funds. Other successful programs, such as the grant program to fund County Prosecutor Insurance Fraud Units, are also in danger of being discontinued. In order to further reduce expenses, OIFP has also been forced to reduce staffing levels in order to remain within budget. Currently, OIFP has approximately 50 unfilled vacancies which adversely affects OIFP's ability to investigate and prosecute cases. In the coming months, the IFP will be working assiduously to address the need for increased funding.

OIFP Criminal Investigations and Prosecutions Statistics
January 1, 2005 – December 31, 2005

New Cases Opened	493
Indictments/Accusations Filed	148
Number of Defendants Charged	222
Number of Defendants Convicted	182
Number of Defendants Sentenced	212
Number of Defendants Sentenced to State Prison	23
Total Number of Years	105
Number of Defendants Sentenced to County Jail	111
Total Number of Years	13
Total Criminal Fines Imposed	$587,816
Total Criminal Penalties Imposed	$36,875
Total Civil Penalties/Fines Imposed in Medicaid Cases	$2,513,920
Total Restitution Imposed	**$89,910,527[1]**

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

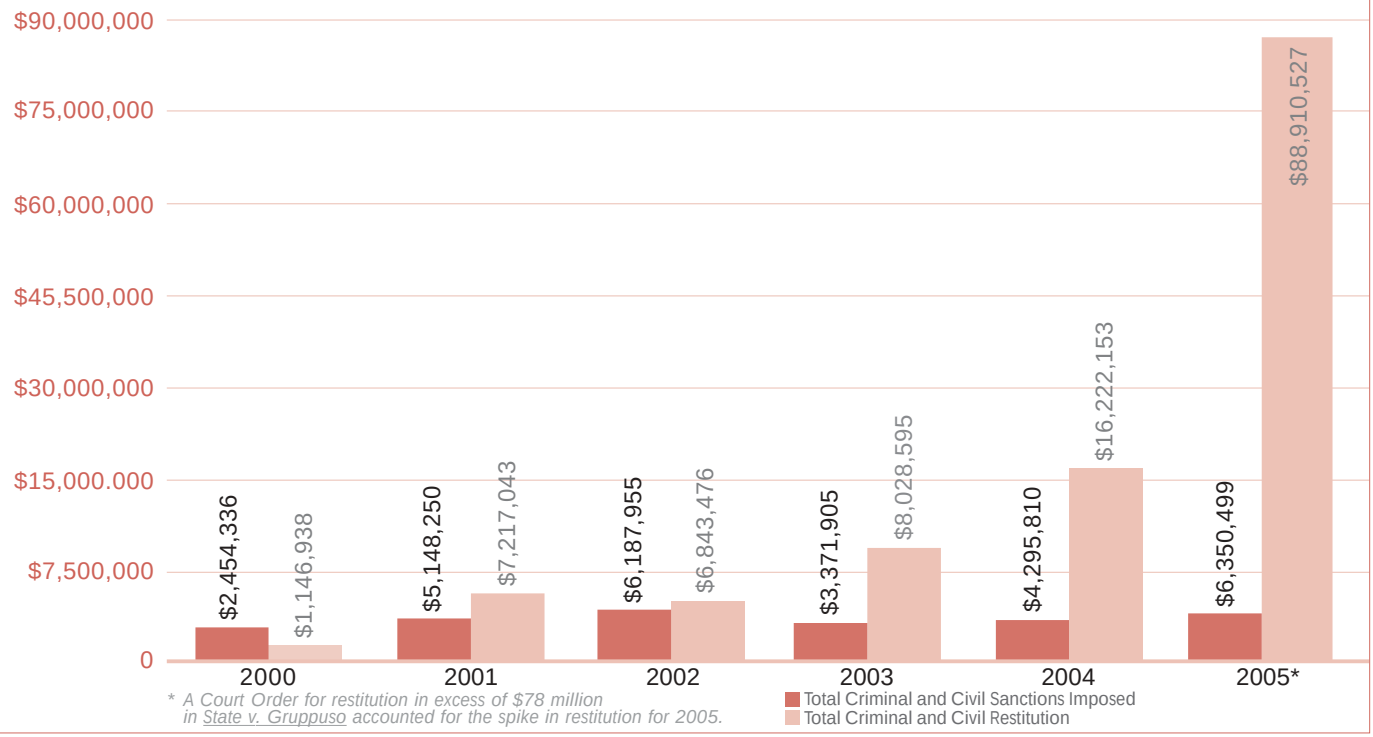
OIFP Civil Investigations and Litigation Statistics[2]
January 1, 2005 - December 31, 2005

	Number	Dollar Amount
Civil Investigations		
New Cases Opened	6,193	—
Number Forwarded for Investigation	2,977	—
No Investigation Warranted	3,216	—
Sanctions Imposed		
Insurance Fraud Letters of Admonition	536	—
Administrative Consent Orders Issued	397	$5,725,808
Administrative Consent Orders Executed	346	$1,375,384
Settlements Entered	49	$569,700
Judgments Entered	149	$4,865,960
Complaints Filed	140	—
Collections (Department of Banking and Insurance)[3]		
Number of OIFP Accounts Paid in Full	576	—
Total Amount Received		**$1,955,664**

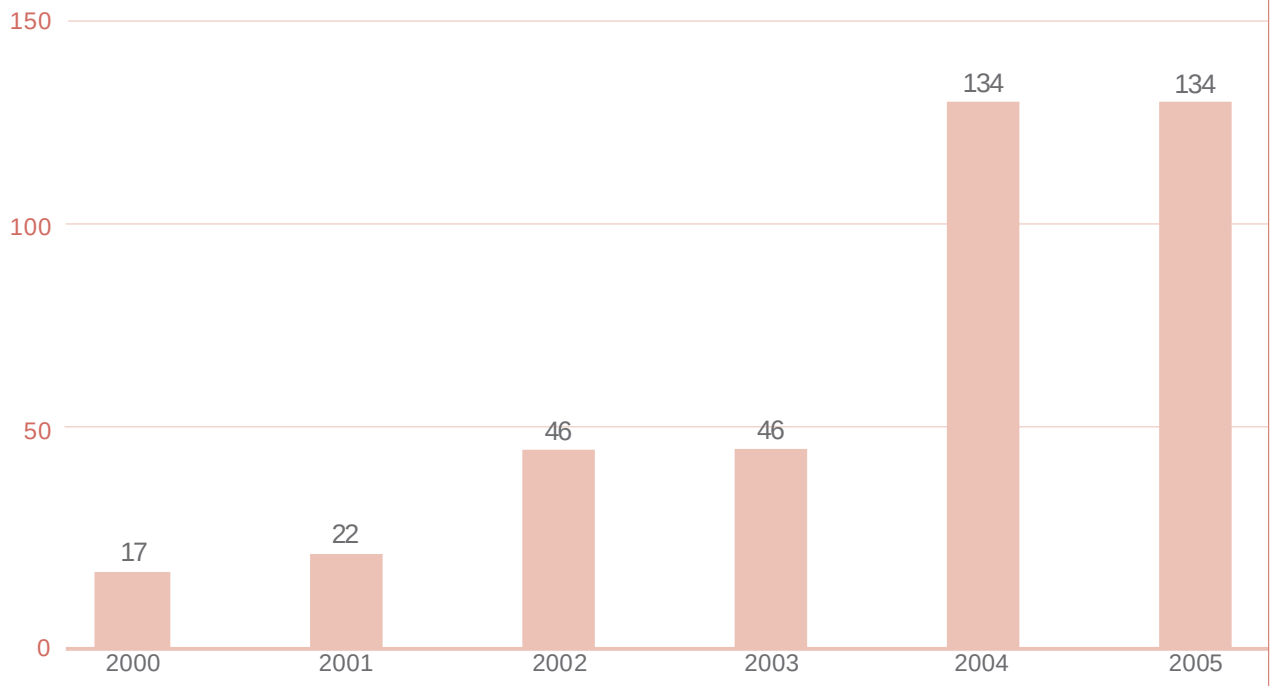
[2] *These statistics comprehensively reflect the number of discrete actions undertaken by the Office of Insurance Fraud Prosecutor in pursuing civil sanctions against insurance fraud violators. It should be noted that, in some instances, more than one action was taken against a single violator or for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

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

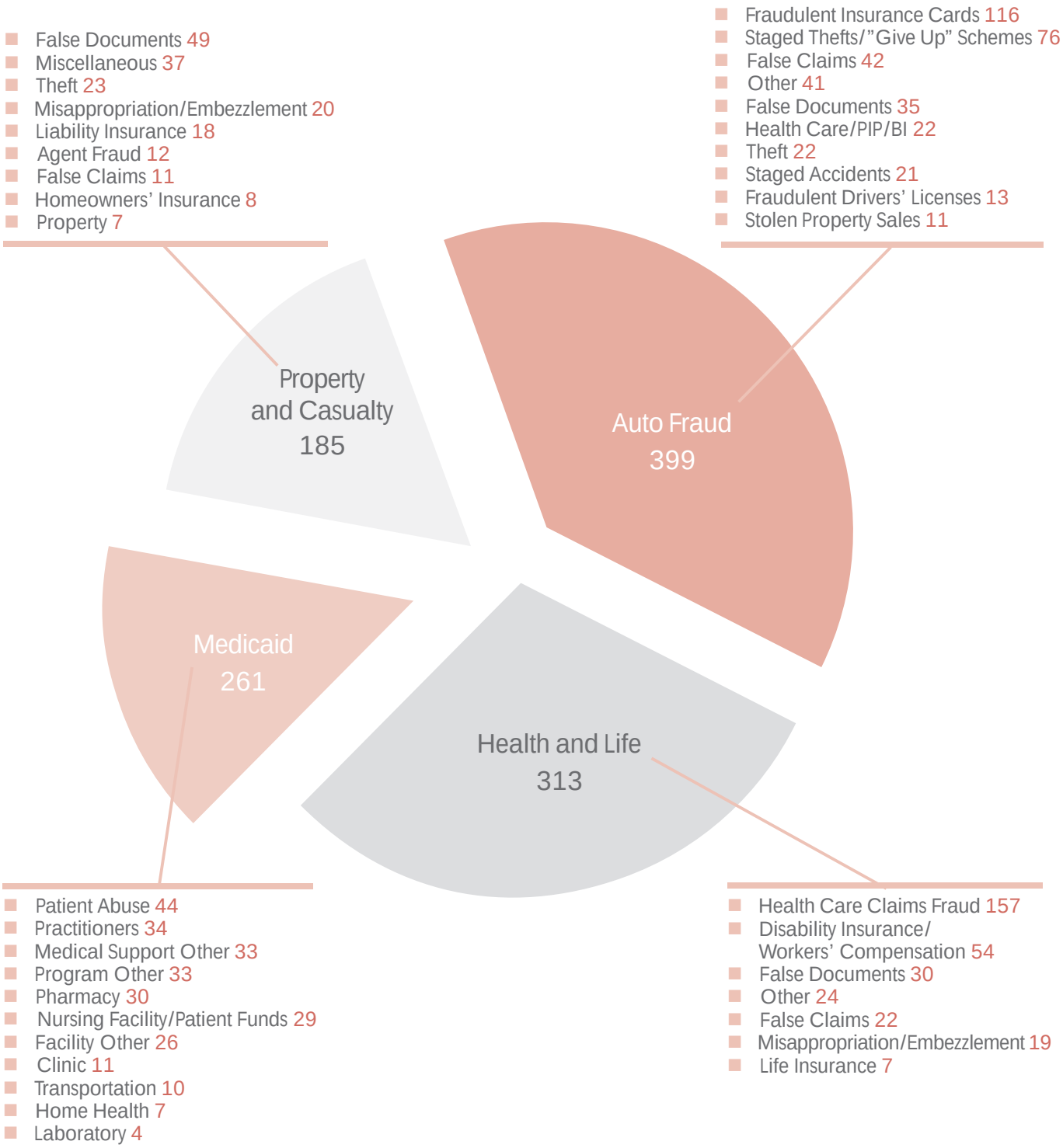
OIFP Criminal and Civil Monetary Sanctions and Restitution Summary **2000–2005**



OIFP Defendants Sentenced to Jail Time **2000–2005**



Criminal Cases Investigated in **2005** by Fraud or Provider Type



OIFP Expenditures for Fiscal Years 2001–2005

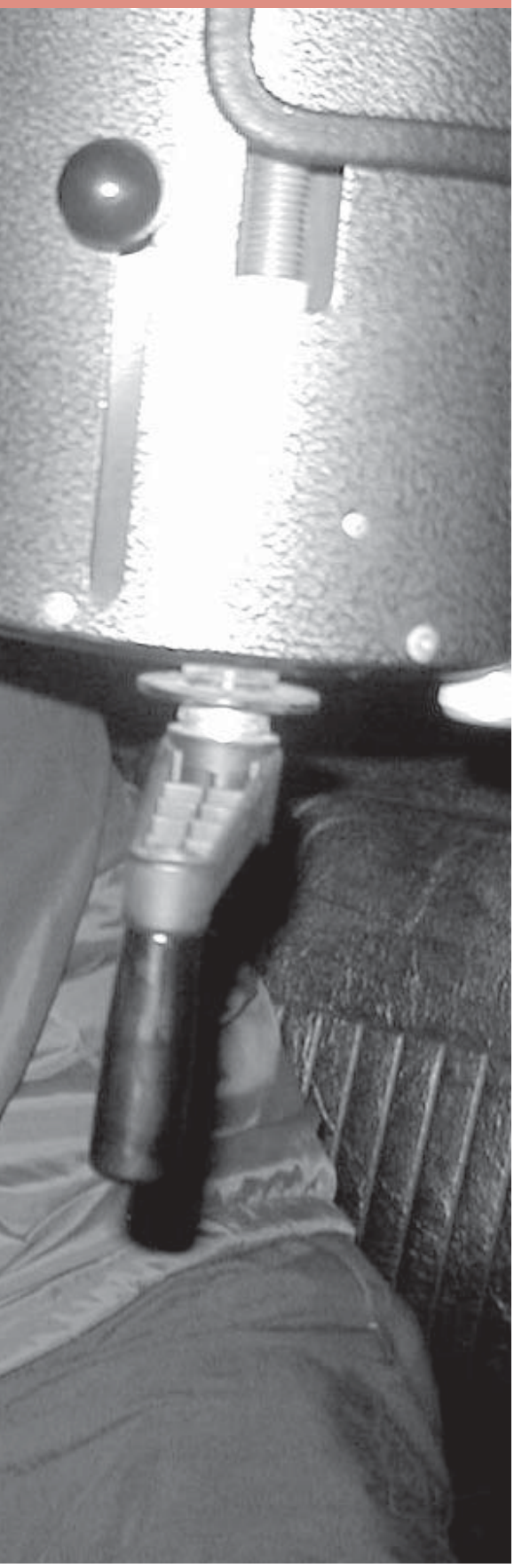
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Resources					
Resources	$29,771,000	$29,771,000	$29,771,000	$29,771,000	$31,497,231.20[1]
Carry Forward	$37,225	$282,960	$95,445	$189,600	$211,426.40
Total Resources Available	$29,808,225	$30,053,960	$29,866,445	$29,960,600	$31,708,657.60
	FY 2001	**FY 2002**	**FY 2003**	**FY 2004**	**FY 2005**
Expenditures					
Salaries	$14,998,761	$16,321,577	$16,689,972	$17,580,358	$16,924,285.00
Fringe Benefits	$3,659,287	$3,839,786	$3,971,668	$5,194,421	$5,682,338.00
Non-Salary	$4,760,995	$2,808,513	$2,594,686	$2,830,986	$1,624,305.00
Division of Law Payment	$1,294,544	$1,561,695	$1,711,597	$1,665,474	$1,543,240.00
Public Awareness	$2,197,970	$1,858,186	$1,900,000	$300,000	$1,200,000.00
County Prosecutor Program	$2,884,225	$3,024,438	$2,998,521	$2,389,361	$1,713,141.00
Total Expenditures	**$29,795,782**	**$29,414,195**	**$29,866,444**	**$29,960,600**	**$28,687,309.00**
Remaining at end of FY	**$12,443**	**$639,765**	**$1**	**$0**	**$3,021,348.60**[2]

Fiscal Year = July 1 through June 30

[1] This figure reflects an additional $1,726,231.20 from non-industry monies.

[2] This figure reflects OIFP funding absorbed by DCJ, rather than being charged to the industry, in order to reconcile salary charges questioned in the July 2005 Report issued by the State Auditor and pending completion and implementation of the Cost Allocation Plan recommended by the State Auditor to provide the necessary documentation to support all salary charges by DCJ to the OIFP budget.

POLICE



Special Report:

Effective Strategies for Investigating Complex Insurance Fraud Cases

by John J. Smith

While it is probably true that the greatest number of insurance fraud-related crimes or civil insurance fraud violations[1] are "single incident insurance fraud matters" involving a single false claim submitted by an individual insured person, some insurance fraud crimes involve complex fraud schemes and multi-person conspiracies resulting in thefts of large sums of money. The most complex criminal cases investigated and prosecuted by the Office of the Insurance Fraud Prosecutor (OIFP) frequently involve:

I. Staged Automobile Accident Conspiracies;

II. Medical Service Provider Health Insurance Fraud; and

III. Insurance Agent Theft.

This article discusses investigative strategies for these three types of complex cases.

In large part, the investigative strategies are governed by the different financial incentives presented by the underlying kinds of insurance coverages, the different kinds of fraudulent conduct committed by the targets involved in each kind of case, and related investigative and legal issues. It is especially important that law enforcement understands the financial incentives provided by each type of insurance policy which drives the conduct of the wrongdoers.

The underpinnings for all of the investigative strategies in this article are succinctly summarized in the following principles:

1. All complex insurance fraud investigations require a careful review and painstaking analysis of the records which constitute the particular insurance claim(s), and other records, in order to identify misrepresentations contained in the claims and to uncover other investigative leads.
2. In addition to a careful review of records, complex insurance fraud investigations require comprehensive field investigations to gather evidence, including interviews of targets and witnesses, and sometimes expert witness assistance.
3. Frequently, complex insurance fraud investigations require proof beyond a reasonable doubt that an event did not occur. Examples include staged accident conspiracies where the State must prove beyond a reasonable doubt that the accident did not occur; investigations of medical service providers, where the State must prove that a service was not rendered, or not rendered as described in the medical billing code or that a patient does not exist; and investigations of certain insurance agent frauds, where the State must prove that insurance premium financing was not sought or that an

1. See The Insurance Fraud Prevention Act, N.J.S.A. 17:33A-1 et seq., (hereinafter the "Fraud Act") specifically N.J.S.A. 17:33A-4 which enumerates civil insurance fraud violations. Criminal violations include Insurance Fraud, N.J.S.A. 2C:21-4.6, Health Care Claims Fraud, N.J.S.A. 2C:21-4.3, and Theft by Deception, N.J.S.A. 2C:20-4, among others.

insurance customer for whom financing was arranged does not exist.[2]

4. Frequently, during the early stages of these complex investigations, the investigative effort is best directed at developing probable cause in support of a search warrant. The execution of a search warrant at the business location(s) of a target medical service provider or an insurance agent greatly increases the likelihood of obtaining evidence necessary for successful prosecution of complex cases.
5. Complex insurance fraud investigations require a close working relationship between law enforcement, insurance carrier claims personnel, and insurance carrier Special Investigations Unit (SIU) personnel to obtain all of the necessary claims documents, checks, and other records in order to gather the evidence and identify investigative leads.

Staged Automobile Accident Conspiracies

The investigation of staged automobile accidents[3] will involve an examination of both property damage claims and Personal Injury Protection (PIP)[4] claims planned and submitted by multiple persons playing different roles, most often in loosely knit conspiracies or rings.[5] These conspirators (or groups of conspirators) will engage in different kinds of fraudulent conduct enticed by the different economic incentives provided by the automobile insurance policy, as well as by other financial incentives. Not every investigation will target all of these conspirators, but all of these conspirators should be considered potential targets until the facts and evidence dictate otherwise.

The Conspirators and the Financial Incentives Which Control Their Conduct

The conspirators can include the insured person (hereinafter the insured) as well as the driver(s) and any passengers in the vehicle(s) (collectively called claimants); police officers or other police personnel, for example, police dispatchers; persons who act as "runners;" insurance claims adjusters (both independent contractors utilized by insurance carriers on a claim-by-claim basis and adjusters employed by the insurance company); the medical service providers;[6] and plaintiffs' personal injury lawyers.

Each of these persons plays a different role in a PIP fraud conspiracy. The role each plays is defined by the different financial incentives provided by the underlying automobile insurance policy, as well as by financial incentives provided from sources other than the insurance policy.

The underlying automobile insurance policy provides insurance coverages and corresponding claims money based on the different components of an auto insurance claim. The different components of the claim consist of PIP insurance claims for medical bills for insureds and claimants, claims for lost wages, and claims for essential services; a potential claim for "non-economic losses,"[7] also known as pain and suffering, if the applicable threshold is met; and property damage claim(s) to the insured vehicle and to other vehicles.

A zero threshold auto insurance policy provides the greatest financial incentive for the conspirators in a staged accident PIP conspiracy. This is because it permits recovery of money for non-economic losses, i.e. "pain and suffering" even though no "objective" injuries such as broken bones and obvious lacerations or injuries are sustained by the claimant. See generally N.J.S.A. 39:6A-8.

In contrast, insurance policies which have a verbal threshold (or limitation on lawsuit option) require that the claimant sustain and prove certain kinds of objective injuries (death; dismemberment; significant disfigurement; fracture; loss of a fetus; permanent loss of a body organ, member, function or system; and so on)

Deputy Attorney General Jacqueline Smith and Analyst Paula Carter work on an auto insurance fraud case.

2. Proving a negative is far more difficult than proving that an event did occur or that a specific person does exist, which frequently adds to the complexity of these investigations. Because these types of investigations frequently require proof that an event did not occur, the investigative effort is often best directed towards obtaining admissions from at least some of the targets that the event did not occur. Admissions that the event did not occur are more readily obtained in these cases when the targets are confronted by well prepared investigators who have analyzed the claims records and have identified the misrepresentations or inconsistencies in them.

3. The term "staged accident" is difficult to define and is frequently used to describe differing factual scenarios. It can include such conduct as "controlled crashes" where the participants in the vehicles intentionally "crash" or bump vehicles together and claim an accident occurred and injuries resulted; a "paper accident" where no accident occurs but a false or partially false police report is procured which describes an accident, sometimes supplemented by phony auto damage appraiser reports and medical records; a real accident where persons who were not involved in the accident claim that they were; and even intentionally

NetMap for ClaimSearch and ViewLink Manager are data mining software tools. This computer screen shot depicts lines containing information which visually represents the relationships between claimants, addresses, providers, and claims.

in order to sue for non-economic losses (pain and suffering). These types of specific injuries are usually obvious and therefore difficult to "fake." That is why zero threshold auto insurance policies are favored by the conspirators in staged accident fraud schemes. It is easy to fake complaints of back pain and soft tissue injuries, such as muscle sprains and spasms, and to submit claims for them. Insurance policies with a zero threshold permit suit for non-economic losses without requiring the claimant, their medical service providers, or their lawyers to offer concrete and objective proof of injuries.

Other financial incentives beyond the insurance policy can include cash payments, often provided to "runners" and to claimants, by medical service providers and lawyers. Typically, "runners" pay claimants to participate in staged accidents and to seek the professional services of a particular medical service provider and/or lawyer. Sometimes, claimants are further enticed by the prospect of collecting lost wages and, most importantly, by collecting money for non-economic losses (pain and suffering).

The automobile insurance policy provides its own incentives to medical service providers to participate in phony accident conspiracies, or, at the very least, to pay "runners" to bring in patients. First, the PIP component of the policy virtually guarantees that the provider's medical billings will be paid. Assuming the provider's fee is sufficient to include a profit, increasing the number of PIP patients who are seen or treated increases the total profit. Second, soft tissue injuries, the type generally claimed by these patients, lend themselves to sustained courses of certain treatments, which also increases the amount of billing and hence profit.

colliding with other, innocent automobiles selected at random on public streets and highways.

4. While it is not the purpose of this article to detail the legal requirements for maintaining automobile insurance, suffice it to say that every owner of an automobile registered in New Jersey is required to maintain liability insurance against loss from bodily injury, death, and property damages arising out of use of the automobile. N.J.S.A. 39:6A-3 and 39:6A-3.1. Except for the lower-cost "basic," N.J.S.A. 39:6A-3.1, and "special," N.J.S.A. 39:6A-3.3, policies, all standard automobile liability insurance policies provide Personal Injury Protection (PIP) benefits, which are paid without regard to negligence or fault. N.J.S.A. 39:6A-4. PIP coverage includes: 1) payment of medical expense benefits for reasonable, necessary, and appropriate treatment and services to persons covered by the policy who were injured in the accident; 2) income continuation benefits for the loss of income as a result of bodily injury; 3) essential services benefits to reimburse necessary and reasonable expenses incurred for essential services ordinarily performed by the injured person for himself or his family; 4) death benefits limited to the maximum income continuation benefit that would have been paid but for the death; and 5) funeral expense benefits, limited to $1,000 per person. N.J.S.A. 39:6A-4. A "basic" policy includes a PIP medical expense benefit with a lower maximum benefit amount than the standard policy. It does not include the four other PIP benefits. N.J.S.A. 39:6A-3.1. The "special" policy includes PIP coverage for emergency medical care only, and a death benefit. N.J.S.A. 39:6A-3.3.

5. In a strict legal sense, a conspiracy involves an express or implied agreement among persons to commit acts to further a criminal purpose(s). N.J.S.A. 2C:5-2. While this article will utilize the terms "conspiracy" and "conspirator" when describing the conduct of all role players in a staged accident conspiracy, there have been few, if any, cases where the evidence was sufficient to prove that all of these players agreed with one another to engage in insurance fraud based on staged or fraudulent automobile accidents. In common parlance, staged accident conspiracies are often described as "rings" or "PIP mills" and it is commonly thought or implied that claimants, "runners," doctors, and lawyers have met and either expressly or implicitly agreed to submit false auto insurance claims. The reality is that it is rare to obtain evidence proving that claimants, "runners," doctors, and lawyers have all met and expressly or implicitly agreed to submit false automobile insurance claims. Rather, these rings or associations exist most often as loosely connected groups of persons. It is probably true that if there is a common link among them, it is generally the "runner" who brings these parties together on an ad hoc basis operating in a loosely knit association to submit false insurance claims. This is not to say that there are not some cases where evidence will establish that some or all of the claimants, "runners," doctors, and lawyers have agreed with each other to submit false claims.

6. For purposes of this article, the term "medical service providers" includes, but is not limited to, chiropractors, dentists, nurses, doctors, pharmacists, physical therapists, psychologists, and the employees and technicians associated with these professional practices.

7. Non-economic losses are losses for pain and suffering as contrasted with economic losses which include medical expenses, income continuation, essential services, and funeral benefits. See N.J.S.A. 39:6A-2. Non-economic losses are frequently recovered by claimants through a civil lawsuit.

Third, because these claimants have not suffered any real injury, the medical service provider is able to skimp on the amount of time and care expended on each patient. This frees the provider to see even more claimants and bill accordingly. Further, the greediest providers will pad their billings by conduct ranging from upcoding to billing for services or equipment which was never provided.

As for the lawyers, most plaintiffs' personal injury lawyers represent clients on a contingency fee basis. In a lawsuit seeking damages for pain and suffering from soft tissue injuries, the settlement the insurance carrier will approve is often based on the medical billings. The higher the billings, the higher the settlement, and thus, the higher the attorney's contingency fee. Thus, the attorney has his own financial incentive to encourage the client to seek medical treatment to drive up the billings.

These economic incentives motivate the provider to increase medical billings in order to increase his profit. The claimant is motivated to increase medical billings to increase the bodily injury settlement he hopes to collect. The lawyer is motivated to increase medical billings to increase the bodily injury settlement and hence his contingency fee. From an investigator's point of view, this creates the difficult situation in which all the participants in a scheme share similar financial incentives, first, to have high medical billings and, second, to swear that those high billings are accurate.

It is critically important for law enforcement personnel investigating staged accident PIP fraud to understand these various financial incentives. Understanding the financial incentives provided by the different insurance claims emanating from a staged accident PIP fraud conspiracy allows the investigation to target each of the conspirators based on the role each plays and the financial incentives which entice each conspirator.

The Medical-Related Claims

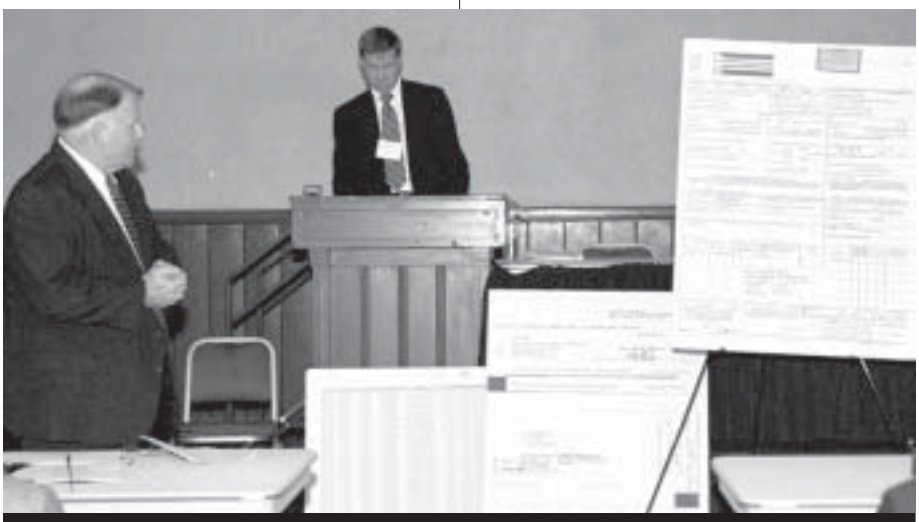
Medical bills can include bills for diagnostic testing, as well as for medical treatments rendered to the insurance claimants, any medical supplies provided, and sometimes transportation to and from the medical service provider's office(s). These different categories of medical bills are all possible avenues for further investigation.

It is extremely rare to be able to prove that a medical service provider assisted with the planning or execution of staged accidents. In other words, it is difficult to obtain evidence to prove that the medical service provider knows that the accident is staged and that the claimants/patients are not actually hurt but are merely submitting to treatment, or appearing to submit to treatment, so that false insurance claims can be submitted and a lawsuit for non-economic losses can be filed. As a result, medical service providers are rarely prosecuted for knowingly treating patients known to be faking injuries purportedly obtained in a staged accident.[8]

Experience teaches that it is best to investigate a medical service provider for complicity in a staged accident PIP fraud ring by seeking evidence that the provider billed for diagnostic testing or medical services and treatments not actually rendered to the patient, not rendered properly, not billed properly, or provided without medical necessity, rather than seeking evidence that the medical service provider knew that the accident was staged and that the claimants were not hurt. Should any information be produced that the provider treated claimants knowing that the accident was faked and that the claimant was not injured, however, such information should be aggressively investigated.

It is not uncommon to obtain evidence that medical service providers submitted bills for fraudulent medical testing and for services not rendered. In some cases, evidence can be obtained that the medical service provider billed for dates when the claimant did not appear for treatment, or if the claimant did, in fact, appear, billed for treatments not rendered to the claimant.

This type of medical fraud is facilitated by the fact that, frequently, persons willing to participate in staged accidents as claimants/patients in order to submit false insurance claims are not willing to attend the typically protracted medical treatment protocol associated with soft tissue auto accident injuries. This protocol generally requires



Deputy Attorney General Stephen Cirillo (l.) and First Assistant Insurance Fraud Prosecutor John J. Smith (r.) conduct a mock trial for insurance company representatives at the 8th Annual Insurance Fraud Summit.

8. Medical service providers do not have to expressly agree to treat persons whom the providers know were in staged accidents and are not actually hurt in order to attract PIP patients. With the aid of others, usually "runners," there is a steady stream of claimants willing to serve as PIP patients and willing to falsely claim they were injured in an auto accident. Claimants are willing to claim injury and seek treatment because of financial incentives to include the fact that "runners" pay them to do so, usually between $200 to $500, and because the claimants, with the aid

Supervising Deputy Attorney General Tina Polites (l.) and Deputy Attorney General Phillip Mogavero (r.) draft a Motion for court.

claimants to appear for treatment several days per week for many successive weeks. Instead, claimants will simply fail to appear for treatment. If they do show up for treatment, they frequently do not stay at the medical office long enough to meet with the doctor, undergo any necessary follow-up examination, undergo additional diagnostic testing or x-rays, and undergo the physical therapy associated with the treatment plan. Nevertheless, medical service providers frequently will continue to bill for a claimant whether or not the claimant appears for treatment, or, if the claimant does appear, whether or not the claimant remains long enough to undergo the full panoply of diagnostic tests and treatments.

A careful review of the medical documents and records submitted with the insurance claim, together with other information, may provide law enforcement with evidence or leads to obtain evidence that bills were submitted for tests and treatments not rendered. If the investigation of this aspect of the automobile accident PIP ring is historical,[9] the investigation should be directed at obtaining all of the treatment records for particular claimants, to include the medical service provider's appointment records and sign-in sheets,[10] to confront the purported claimant/patient with these records and question the claimant about dates on which he supposedly appeared for medical treatment and the treatment he actually received. Work records, time cards, travel and vacation records, and credit card receipts, as well as reports relating to incarceration in jail, have all been used to confront claimants to seek admissions that the claimant did not appear at the provider's office on a given date, even though the provider billed the insurance company seeking PIP insurance coverage for treatment allegedly provided to those claimants on those dates. Confronted with this type of evidence, some claimants will admit that on certain dates they did not appear at the medical practice for treatment despite insurance billing records to the contrary. In other cases, claimants will admit that even though they did, in fact, appear for treatment, not all of the services billed to the insurance company by the medical service provider were actually received by the claimant. In yet other cases, the investigation should obtain records pertaining to the availability of the medical service provider, to include the medical service provider's vacation schedule, credit card bills, travel agency records, and other such records, to develop evidence that the medical service provider was not present to treat the claimant on all the dates for which the insurance company was billed.[11]

of personal injury lawyers, hope to also obtain a bodily injury settlement in the future.

9. The term "historical investigation" means an investigation that is directed to insurance claims submitted in the past. It does not include an investigation in which undercover investigators are currently attempting to infiltrate or have infiltrated the medical practice as patients or "runners," or where law enforcement surveillance of the medical practice is being conducted.

10. HIPAA privacy issues should not prohibit law enforcement from obtaining these records. See "Demystifying the HIPAA Privacy Rule," *2004 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor,* March 2005, at 68.

11. The investigation should determine whether or not the absent medical service provider arranged for a substitute medical service provider to treat during vacations, or whether or not the nature and type of treatments prescribed for the patient could be "monitored" by the vacationing medical service provider. For an example of such a case, in a context other than PIP fraud, see United States v. Siddiqi, 959 F.2d 1167 (2d Cir.1992) and Siddiqi v. United States, 98 F.3d 1427 (2d Cir.1996).

Enlisting the aid of a medical expert can greatly assist law enforcement with the review of the medical records and can produce information about which the claimants can be questioned. With the assistance of an expert, claimants can be questioned about the manner in which the purported treatments were rendered, the equipment used, the length of time tests and treatments were administered, and so on. Evidence gleaned from this type of information can be used to build a case against a medical service provider despite recalcitrance on the part of the claimants.

A major objective at this stage of the investigation of a PIP fraud conspiracy should be to establish probable cause for a search warrant to search the medical service provider's office for additional evidence and seize treatment and insurance billing records.[12] To achieve this goal, the investigation should focus on identifying a number of claimants who can provide credible evidence that the medical service provider billed for services on dates when the claimant did not appear for treatment or other information to support the fact that claims submitted by the provider are false. However, the investigator should anticipate that some claimants will not remember and will not have records of the exact dates on which they appeared for treatment, nor in all likelihood, will all of them be inclined to cooperate.

Claimants are reluctant to cooperate because of the financial incentive PIP claims offer them, specifically a settlement or lawsuit which includes compensation for non-economic losses. While many claimants will provide admissions which are evidential of fraud, some claimants participating in a PIP fraud conspiracy are sufficiently sophisticated to understand that the greater the amount of medical treatments billed to the insurance company, the greater the potential bodily injury settlement they will likely receive for non-economic losses. Such claimants are less likely to cooperate. Other obstacles that impede the cooperation of claimants are the use of false identities, rendering it difficult to identify some claimants; the cohesiveness of ethnic groups and suspicion of law enforcement; the use of foreign languages; and issues relating to illegal immigration.

Complex Medical PIP Fraud

Heretofore, the description of the investigation of a medical service provider's participation in a fraudulent PIP conspiracy has been directed at the more obvious types of medical billing fraud committed by medical service providers. It should be noted that these investigations are nonetheless complicated, frequently require undercover investigative work, numerous interviews, surveillances, preparation of an affidavit in support of a search warrant, as well as an extensive review of claims documents.

Law enforcement must also be aware of the financial incentives the PIP statute directly provides to medical service providers, and indirectly to PIP claimants and plaintiffs' attorneys, to fraudulently create the appearance that PIP claimants were injured in order to meet the threshold required by the PIP statute[13] to file a lawsuit. These incentives lead to frauds more complex than billing for services not rendered.

Throughout the development of PIP law and the statutory verbal threshold, PIP insurance claimants, their attorneys, and medical service providers who treat claimants pursuant to PIP insurance coverage have sought to identify and articulate injury in order to meet the verbal threshold which enables them to file a lawsuit, and recover claims money for non-economic losses (pain and suffering). This provides a major financial incentive for medical service providers, plaintiffs' attorneys, and claimants.

Particularly troubling from an insurance fraud perspective is the long series of diagnostic tests which has evolved so that medical service providers, with the support and assistance of plaintiffs' attorneys and claimants, can increase medical bills and demonstrate that claimants sustained injuries. In connection with "soft tissue" injuries, diagnostic testing not only increases the costs which automobile insurance companies must pay the medical service provider, but those tests are used to

First Assistant Insurance Fraud Prosecutor John J. Smith (c.) reviews an invstigative plan with staff.

12. One of the underlying premises for this article is that the investigation must obtain the documents and records related to the insurance claim. While documents and records can be obtained from the insurance company, it is more important that the documents and records be obtained from the target medical service provider. The preferable way to obtain such records and documents is to develop probable cause for a search warrant as opposed to issuing a grand jury subpoena or an administrative subpoena under the Insurance Fraud Prevention Act. A search warrant provides law enforcement with the advantage of surprise and experience teaches that the execution of a search warrant will generally produce more evidence than the issuance of a subpoena. Sometimes, interviews conducted simultaneously with the search

OIFP civil investigator Lisa Yildiz confers with an insurance carrier SIU about a fraud referral.

demonstrate that claimants were, in fact, injured and justify even more tests and more treatments. As a result, auto insurance companies must pay more money for medical services, and ultimately more money to settle cases or to pay judgments following a lawsuit, thereby paying more money to claimants and their lawyers.

The most difficult, challenging, and complex investigations of medical service providers are those that do not focus only on relatively straightforward fraudulent conduct, such as billing for services not rendered. The most difficult and complex investigations focus on whether or not the medical service provider billed appropriately for the diagnostic testing and medical services he/she actually rendered by utilizing the appropriate CPT Code,[14] and whether or not the diagnostic testing and treatments given were medically necessary and properly delivered and not merely rendered to generate insurance claim revenue.

As stated, with respect to the medical billing, it is the medical service providers who have the primary financial incentive provided by the PIP coverage included in the standard auto insurance policy to bill insurance companies as much as possible for medical expenses, including diagnostic testing and treatment. Since medical service providers, who are paid for diagnostic testing and medical services provided by PIP coverage, have few limits on their medical discretion and judgment,[15] there is little to impede them from prescribing diagnostic tests and treatments to inflate the medical expense component of PIP claims.[16] In order to maximize medical bills, some unscrupulous medical service providers may bill for more expensive services than are actually rendered or actually needed in order to maximize revenues to the medical practice.

Medical Service Provider Self-Referral

Law enforcement should be aware that unscrupulous medical service providers will refer patients to diagnostic testing facilities or medical supply companies in which they have an ownership interest to produce more insurance claims money for the medical service provider. Frequently, medical service providers have financial interest(s) in medical corporations which own diagnostic testing equipment, such as MRI machines,

will prompt witnesses in the provider's office to cooperate with the investigators.

13. N.J.S.A. 39:6A-1 et seq.

14. CPT Code, Current Procedural Terminology, is a nomenclature used to describe and report medical services and procedures. It is intended to be a uniform language which accurately describes medical, diagnostic, surgical, and related services. It is commonly used with respect to medical bills and claims submitted to insurance companies for payment.

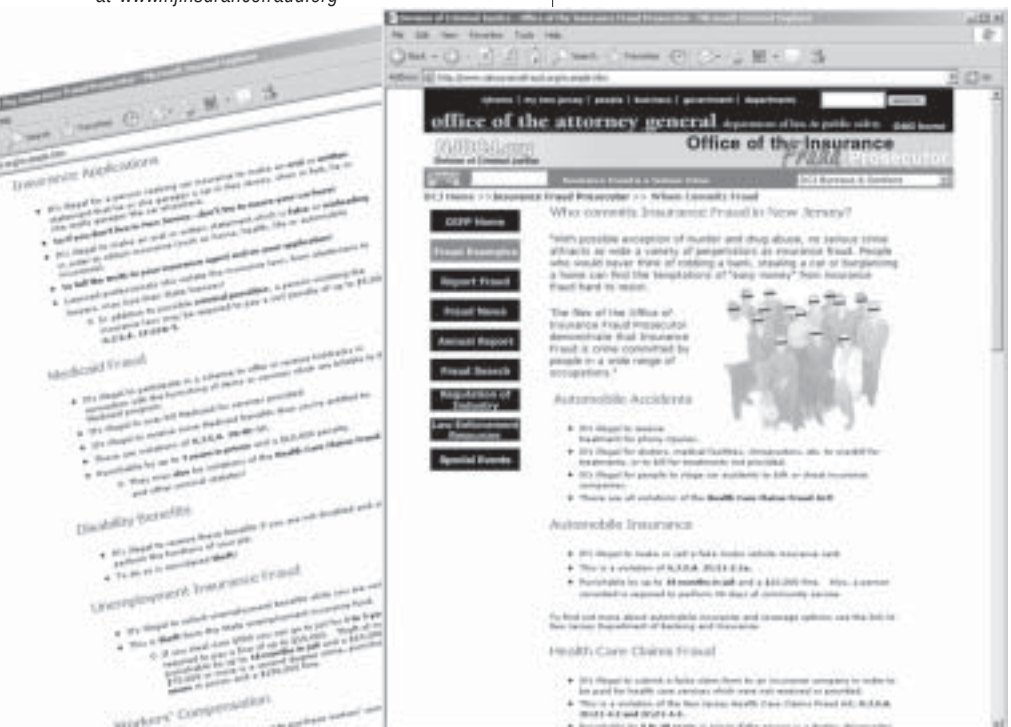
15. Legislative attempts to deter medical service providers from overprescribing diagnostic tests and treatments include publishing PIP fee schedules and requiring pre-certification of certain diagnostic tests and treatments.

16. One mechanism to deter medical service providers from overprescribing unnecessary diagnostic testing and treatment utilized by insurance companies is the concept of Peer Review. Frequently, insurance companies will procure the services of a Peer Review doctor who will then review the diagnostic testing and treatments rendered by the target medical service provider. The reports of Peer Review doctors can be valuable to law enforcement to assess the alleged fraudulent conduct of the target medical service provider and can sometimes contribute to the effort to articulate probable cause for a search warrant. Law enforcement investigations of medical service providers suspected of engaging in PIP fraud should obtain and carefully review any available medical reports by Peer Review doctors.

or in corporations which include ambulatory surgical centers,[17] or in corporations that provide medical supplies. These providers may refer claimants to these related corporations so that the medical service provider can bill the PIP insurance carrier for services, supplies, and equipment provided by the related corporations in order to maximize revenues to the medical service provider. This practice is known as self-referring.

Medical service providers utilize different artifices to conceal their ownership interest in these related corporations. Sometimes, these entities are incorporated in the names of persons related to or employed by the medical service provider. Bills are then submitted to insurance companies utilizing different Taxpayer Identification Numbers (TIN)[18] in order to create the illusion that the payments are going to separate providers even though, in reality, the revenues are ultimately flowing to the target medical service provider. Law enforcement must be aware of such practices utilized by medical service providers who submit medical bills under the PIP component of an automobile insurance claim.

OIFP maintains a comprehensive Web Site at www.njinsurancefraud.org



Other Complex Medical Service Provider Frauds

In addition to inflated and unnecessary diagnostic testing and self-referrals, complex PIP medical provider fraud includes billing for services which are more expensive than the services actually rendered. This is sometimes referred to as "upcoding." Another type of PIP medical provider fraud involves billing separately for components of a procedure in order to improperly inflate billings, also known as "unbundling."

Pain management techniques have recently emerged as an area where medical service providers can bill for more expensive services than those actually rendered. For example, trigger point nerve stimulation has been billed as more invasive epidural injections. Medical service providers have also been prosecuted for falsifying reports of diagnostic testing related to Nerve Conduction Velocity studies.[19] In these cases, medical service providers have either "cut and pasted" the names of patients with normal reports onto diagnostic reports of other patients who had abnormal Nerve Conduction Velocity studies, duplicated wave length lines either within a report or across several reports to make the reports appear abnormal, inserted false numeric values which could not physically be reported by the diagnostic machine utilized,[20] and other related frauds and schemes.

In addition to the more complex and difficult-to-prove schemes discussed above, law enforcement has encountered several diagnostic tests and treatments which provide medical service providers with a purported medical basis upon which to justify continued medical treatment and further increase the amount of the medical bills submitted to the insurance companies. These tests and treatments include, but are not limited to, use of an activator;[21] Computerized Tomography/CAT Scan;[22] Electromyography; Needle EMGs and Surface EMGs;[23] Evoked Potentials;[24] hot and cold packs;[25] Kinematic MRI;[26] Magnetic Resonance Imaging (MRI);[27] Nerve Conduction Velocity Studies (NCVs);[28] Surface Electromyography (SEMG);[29] Transcutaneous Electrical Nerve Stimulation (TENs);[30] Traction-Mechanical;[31] Vertebral Axial Decompression (VAX-D);[32] and X-rays.

Such diagnostic tests and treatments also provide plaintiffs' attorneys and insured claimants with a basis to allege that an injury was suffered within the meaning of the PIP statute so that lawsuits can be filed for non-economic losses. Law enforcement must develop innovative investigative strategies to detect, investigate, prosecute, and deter insurance fraud based on these tests and treatments, as well as other complex and ever-evolving PIP medical frauds.

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17. Ambulatory Surgical Centers (ASCs) were authorized by federal regulations to provide facilities for surgical, diagnostic, and related procedures which are too complicated to be performed in a doctor's office yet do not require the full facilities of a hospital. Medical service providers can own, operate, and control ASCs to provide and bill for increasingly complicated diagnostic procedures and surgeries. Under these circumstances, additional charges, to include facility fees, can be charged by the medical service provider. ASCs appear to be emerging as providing additional avenues and financial incentives for fraud. See generally 42 C.F.R. 416.2.

18. The Taxpayer Identification Number (TIN) is the number assigned by the Internal Revenue Service to businesses which have tax obligations. Insurance companies use the TIN to track payments made to medical service providers and their corporations.

19. State v. Barry Vogel, Indictment No. SGJ479-03-5, Union County 2003; See also *2003 Annual Report of the New Jersey Office of the*

OIFP civil investigators review documents in a health care fraud case. Pictured, l. to r. civil investigators Bonnie Apone, Shawn Stewart, and Joseph Lombardo.

A commonly encountered related allegation is that some of these tests are provided by persons, often employees of the target medical service provider, who are not licensed or certificated to perform these diagnostic tests and treatments. Law enforcement must determine the licensing status, training, and education of persons who perform these tests and treatments.

Auto Property Damage Claims

Besides paying for medical billings, the automobile insurance policy also provides coverage for property damage. This provides another financial incentive for fraud. Property damage claims include damage to the insured vehicle (collision), as well as damage to other vehicles (liability). Some staged accidents are designed primarily, if not exclusively, to file insurance claims for automobile (property) damage only, as opposed to filing bodily injury-related claims, including PIP and non-economic losses.[33]

From the standpoint of the conspirators, particularly claimants whose cars sustained damage attributable to the insured vehicle, property damage claims have advantages. Auto insurance carriers will pay property damage claims, usually based on a police automobile accident report and/or an auto damage appraisal report,[34] with much less scrutiny than is given to bodily injury claims. For example, in a large-scale insurance fraud case prosecuted by the Division of Criminal Justice, more than $1 million in property damage claim money was stolen from a large auto insurance carrier with few, if any, related bodily injury claims. Typically, these fake property damage claims were based on a report that a driver of the insured vehicle lost control of the insured vehicle, then struck two

Insurance Fraud Prosecutor, March 2004, at 118.

20. Cadwell machine.

21. An activator is a chiropractic manipulative treatment used in connection with chiropractic adjustments to decrease muscle spasms.

22. CAT Scans are a specialized type of X-ray sometimes used to better visualize soft tissue injuries.

23. Needle EMGs and Surface EMGs are used to determine how muscles respond to electrical stimulation in order to determine whether or not an injury exists. Surface EMGs use electrodes attached to the skin by "sticky pads" and Needle EMGs use needles inserted directly into muscles to record muscle responses to electrical stimulation.

24. Evoked Potentials/Somatosensory Evoked Potentials are used to assess peripheral sensory function to determine whether or not there is neurological injury.

25. Hot and cold packs are used to treat pain and muscle spasms and to reduce swelling. A common allegation is that medical service providers bill for hot and cold packs but do not always provide them to claimants.

26. Kinematic MRI is a magnetic resonance imaging scan of a body part in motion.

27. Magnetic Resonance Imaging (MRI) is an in-depth radiological study. Recent investigations have focused on the question of whether or not a three-dimensional image was produced at higher cost to the insurance company than a standard image.

28. Nerve Conduction Velocity studies utilize electrodes attached to the skin by "sticky pads" to deliver electrical stimulation and record nerve responses to that stimulation. Frauds related to NCVs have previously been described.

29. Surface Electromyography purportedly measures the effect of electrical stimulation on muscles.

30. Transcutaneous Electrical Nerve Stimulation is a hand-held device used to relieve chronic pain and is frequently prescribed to patients for home use.

31. There are various mechanical traction devices, including cervical traction and lumbar traction. Mechanical traction is used to relieve muscle spasms. There have been allegations that medical service providers fraudulently bill mechanical traction as a surgical procedure.

32. Vertebral Axial Decompression is used to "decompress" the lumbar spine and is purportedly a non-surgical treatment for herniated discs.

33. State v. William McLaughlin, 310 N.J. Super. 242, 263-65 (App. Div.), certif. den., 156 N.J. 381 (1998).

34. Investigators should begin every staged accident investigation by verifying that the police accident report(s) is genuine. The police officer who wrote the report, while he/she likely will not remember the particular accident, should be identified and interviewed and the validity of the report confirmed.

other parked luxury cars. Fictitious police reports were used to document the accident and included such "excuses" as: "dropped lit cigarette in lap and lost control;" "dog ran out in front of the car;" "reaching for radio and lost control of car;" and so on.

In essence, this case consisted of many property damage claims involving three cars for a total amount of just under $30,000 for each phony claim. Few, if any, bodily injury claims were submitted. None of the purported accidents actually occurred, and none were staged. They were all paper accidents supported by police accident reports. The defendant who was the "ringleader" was an independent auto insurance appraiser.[35] He masterminded the conspiracy by preparing fictitious police accident reports to support the claims from a pad of blank police reports in his possession or, in other cases, by paying bribes to police officers to write fictitious reports to support the claims.

As an independent auto insurance claims appraiser, the mastermind also had in his possession a box of photographs of many different makes and models of damaged cars which he would append to the damage appraisal reports submitted to the insurance company to further support the insurance claims. Each claim was submitted at less than $10,000 per car which, at that time, was the limit below which no additional insurance company review was required.

The case was successfully cracked when the investigative focus was directed towards a careful examination of the documents and records. Specifically, it was only after the investigation uncovered evidence proving that the police reports, the appraisal reports prepared by the mastermind which detailed the damages to the three cars, and the photographs of damaged cars submitted in support of the claims were fictitious that the scheme was unraveled.

An interesting investigative sidelight to this case was uncovering how the insurance policies were procured for the claimants. The investigation revealed that, in many cases, the mastermind recruited persons to act as insured claimants and assisted them in obtaining insurance policies from the insurance company which ultimately paid the phony claims. Fictitious identities were used in some cases. Eventually, all of the conspirators were identified by tracing the insurance policies back to the insurance agency that sold many of the policies against which the fictitious property damage claims were made.

Investigating automobile property damage claims ordinarily requires reviewing fewer documents than investigating claims involving bodily injuries.[36] Property damage claim records available from the insurance company typically include an ACORD form, which provides first notice of the claim either to the insurance agent or directly to the insurance company, the police report, an auto damage appraisal report, sometimes a tow truck bill, and oftentimes photographs of the damaged vehicles. The investigation of a property damage claim should focus on obtaining these documents, reviewing them to extract investigative leads, confronting the claimants with suspect statements or omissions, and questioning them in order to obtain admissions and confessions.

Investigators should obtain a copy of the police report directly from the police department, and compare it to the copy submitted to the carrier. First, investigators should confirm whether the accident report was, in fact, written by a police officer, or whether the accident report is wholly fictitious. Second, investigators should compare the report on file with the police department with the copy submitted to the carrier to see if any information has been altered or added.[37]

One other avenue of investigation that may produce a useful investigative lead is to further check the insurance claim file to determine whether or not a bill from a towing company was submitted. Fraudsters submitting false auto damage claims frequently report that the car was so badly damaged that it was not possible to drive it away. In such cases, there should also be a tow truck bill. While insurance cheats are frequently clever enough to concoct fictitious accidents with fraudulent police reports, insurance appraisals, and photographs, they frequently overlook the tow truck bill. Accident claims which reflect substantial damage to automobiles should also include a tow bill, and the absence of a tow bill is an investigative lead which should be pursued to determine whether the accident is fictitious.

35. An independent appraiser is an appraiser who is not an employee of the auto insurance company but rather is contracted on a case-by-case basis by the auto insurance company.

36. All insurance claims consist of documents and records. Persons commit insurance fraud by including false information on the claims documents and records in order to deceive the insurance company into paying them money to which they are not entitled. All insurance fraud investigations of whatever type must focus on the claims documents and records, particularly the misrepresentations or omissions reflected therein, and must obtain proof that the information reflected is false. This review is best conducted by law enforcement working in partnership with insurance carrier claims and SIU personnel.

37. The mere fact that the accident report is on file with the police department does not guarantee its accuracy. Unfortunately, investigators must be alert to the possibility that the officer who prepared the report is involved in the fraudulent scheme. See *2004 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor*, March 2005, at 104.

38. Fictitious claims frequently require the prosecutor to prove that something did not happen. Requiring proof that an event did not occur is extremely difficult. It is much more difficult than proving that something did happen. To be successful, such investigations require that the investigator obtain admissions from some, or at least one, of the conspirators that the underlying auto accident was staged. In order to obtain such an admission, the investigator must obtain the documents and records which comprise the insurance claim, review same, note possible inconsistencies and misrepresentations, and then confront the conspirators with other facts obtained during the investigation in order to obtain admissions that the accident did not occur.

Additional aspects of property damage claims which may produce investigative leads include claimants submitting for ancillary expenses to include rental cars and damage claims for the contents of the vehicles involved in purported accidents. Investigators should obtain and review records of these ancillary claims and question claimants about the claims submitted for these expenses. Frequently, evidence or investigative leads can be developed through this line of questioning.

The review of claims submitted to insurance companies for car rentals has produced valuable evidence to prove that claimants submitted false claims based on the fact that the underlying automobile accident never occurred. Similarly, false claims have been submitted for damage to property contained in the car included in the purported accident even though evidence indicates that the accident was fictitious. By obtaining the documentary evidence associated with claims for rental cars and contents claims, the investigator can confront the suspect claimant with additional evidence and pursue additional lines of questioning which may lead to statements, admissions, or confessions both about the auto property damage claim and about the PIP and bodily injury aspects of the claim, if any.[38]

Lost Wage Claims

Law enforcement should be aware that in addition to phony bodily injury claims for non-economic losses, the lost wage portion of a PIP insurance claim provides claimants with another economic incentive to falsify a claim. Sometimes auto insur-

Experience teaches that when the appropriate documentary evidence is obtained and used to confront the suspect claimant or passenger, one or more of these persons may admit that the accident did not occur. This serves as the basic predicate for the entire case and these admissions, coupled with the documentary evidence and other evidence gathered during the course of the investigation, can be used to obtain convictions of those persons who refuse to cooperate and elect to go to trial.

John J. Smith (l.). NJSIA President Paul Gallo (r).

First Assistant Insurance Fraud Prosecutor John J. Smith Receives NJSIA President's Award

First Assistant Insurance Fraud Prosecutor (FAP) John J. Smith received the New Jersey Special Investigators Association (NJSIA) President's Award for Outstanding Service to the NJSIA in 2005. This award recognized the expertise and level of achievement reached by FAP Smith throughout his career in fighting insurance fraud.

FAP Smith is an Assistant Attorney General with the New Jersey Division of Criminal Justice (DCJ) where he has been employed since 1985. As the First Assistant Insurance Fraud Prosecutor, AAG Smith oversees all criminal insurance fraud investigations and prosecutions as well as investigations of civil violations of the Insurance Fraud Prevention Act in the Office of the Insurance Fraud Prosecutor. FAP Smith, who has been with the Office since its inception, served as Acting New Jersey Insurance Fraud Prosecutor for approximately six months.

FAP Smith was instrumental in drafting legislation critical to the creation of the Office of the Insurance Fraud Prosecutor as well as policies and procedures to define the function of the Office. An expert in the field of Insurance Fraud law, FAP Smith has also drafted provisions of the criminal laws in New Jersey utilized to prosecute insurance fraud. He has personally tried numerous criminal cases, including insurance fraud, to verdict before juries.

FAP Smith's expertise in the field has long been recognized throughout the insurance industry as well as the legal and investigative communities. He has been an instructor for the New Jersey Institute for Continuing Legal Education on the topics of insurance fraud and health care fraud. He regularly teaches DCJ Academy courses for New Jersey criminal and civil state investigators. He received a Certificate of Appreciation for his anti-fraud presentation at a joint seminar sponsored by the Private Detectives Association of New Jersey and The Association of Certified Fraud Examiners.

FAP Smith has received awards from the New Jersey Attorney General, recognizing his dedication, direction, service, and productivity within the Office. He also received a DCJ Director's Award for his work in the prosecution of State v. Carl Lichtman, et al., one of the largest insurance fraud cases ever litigated in the State of New Jersey.

FAP Smith previously served as Chief of DCJ's Casino Prosecutions Section before transferring to DCJ's Economics Crime Bureau where he served as a Supervising Deputy Attorney General (SDAG). As SDAG, FAP Smith had oversight responsibility for the Insurance Fraud Unit, the Medicaid Fraud Unit, and the Major Fraud Unit, which included Tax and Securities Fraud, and general "major fraud" cases involving public money and other crimes.

FAP Smith is active in the United States Army Reserve, Judge Advocate General's Corps, where he holds the rank of Colonel. From 1982 to1985, FAP Smith served on active duty in the United States Army as a Captain in the Judge Advocate General's Corps where he prosecuted criminal cases as a military trial counsel. He was also appointed Special Assistant United States Attorney at Fort Dix, New Jersey, where he prosecuted cases before the U.S. Magistrate.

FAP Smith received a Bachelor of Arts degree from Pennsylvania State University. He earned his law degree at Duquesne University and a Master of Laws in Taxation from Temple University.

ance claimants will submit claims for lost wages that are greatly inflated. Claimants who were unemployed at the time of the purported accident may also submit claims for lost wages from a non-existent job. With respect to any lost wage claim, investigators should obtain the documents submitted to the PIP insurance carrier in an effort to determine whether or not the insured claimant actually lost the wages claimed as a result of the purported auto accident. The Department of Labor can provide quarterly wage reporting records to confirm whether or not insured claimants were working prior to the purported accident.

Essential Services Claims

Another component of a personal injury auto insurance claim is the claim for essential services. Essential services are meant to compensate the insured claimant for personal services which he is no longer able to provide for himself as a result of injuries sustained in the auto accident. Law enforcement should recognize essential services as another financial incentive for a claimant to commit fraud. On occasion, insured claimants will submit essential services claims to insurance companies for essential services which were never rendered on behalf of the claimant. This is sometimes done by falsifying receipts paid to maids and housekeepers, or by claiming that persons who are friends or relatives of the insured claimant provided essential services when, in fact, they did not. Interviews of these persons to confront them with documents, such as receipts, bills, checks or money orders, related to the suspicious essential services claim will sometimes produce valuable evidence, not only about the false essential services claim, but also of the entire auto accident insurance claim.

Investigative Techniques

Some of the underlying premises of this article are that all documents related to the claim must be obtained and analyzed, and that damaging admissions are more apt to be obtained when fraud participants are confronted with inconsistencies and other leads gathered through a careful analysis of those records. This section describes some of the records relevant to staged accident frauds, as well as the usefulness of undercover operations and expert medical assistance.

Police Reports

Evidence that an automobile accident did not occur can be developed by focusing investigative effort on the police report. Fraudulent automobile insurance claims have been based on police reports written by officers who were bribed to write false police reports, or on police reports that were wholly fictitious and were written by conspirators using pads of blank form police reports. Wholly fictitious police reports submitted to support insurance claims will not be officially "on file" in the police department, which is why any investigation of a suspected staged accident must begin with verifying that the police report submitted to the carrier is identical to a genuine report on file with the department.

If a police report can be proved to be false or fictitious, all of the insurance claims which flow from the accident described in the police report can more readily be proved to be fraudulent. Insurance companies rely heavily on the police report when deciding whether or not to pay insurance claims, particularly auto property damage claims. The investigation should, therefore, first focus on attempting to prove that the police report is not genuine in whole or in part.

However, it is not always possible for the investigator to obtain proof that the police report was fraudulent. Many police reports are "walk-in" police reports. A "walk-in" police report is generated when purported claimants go to the police station and report that an automobile accident occurred. In such cases, no police officer "investigates" the accident, observes the accident scene, or the fact that an accident actually occurred. The occurrence of the accident is based solely on the report given by the potential "walk-in" claimant. While the "walk-in" report appears genuine, the index of suspicion for these reports should be very high.

Even if a police officer is called to the scene of an accident and views what appears to be the aftermath of an auto accident, the accident may nonetheless be staged. Investigative experience has demonstrated that claimants will sometimes "stage" accidents in the streets by crashing cars together to create an accident scene.[39] Thus, a police officer who is called to the scene of such a "staged" accident may write a police report which, from the police officer's perspective, is genuine, but actually depicts a fraudulent staged accident. Law enforcement investigating PIP fraud must view all police accident reports with skepticism.

PIP Applications

Another important record that should be obtained during the investigation is the PIP application. The PIP application is used by each claimant to initiate an automobile PIP claim. PIP applications require that the claimant state that he/she

39. See State v. Anhuar Bandy, Indictment No. SGJ456-02-8(9), Union County, 2002; State v. John Groff, Indictment No. SGJ444-01-6(1), Camden County, 2001.

40. See N.J.S.A. 2C:21-4.3f(2), Health Care Claims Fraud, which provides: "the falsity, fictitiousness, fraudulence, or misleading nature of a statement may be inferred by the trier of fact in the case of a person who attempts to submit, submits, causes to be submitted or attempts to cause to be submitted any record, bill, claim or other document for more treatments or procedures than can be performed during the time in which the treatments or procedures were represented to have been performed."

41. In order to insert investigators in an undercover capacity as patients of the medical service provider, law enforcement may wish to make use of pretext insurance policies and coordinate with local law enforcement in order to have a police report on file with respect to a fictitious auto accident. Pretext insurance policies have been successfully used in criminal investigations of insurance fraud. See also Commonwealth v. Shuman, 462 N.E.2d 80 (Mass. 1984).

42. Investigators have successfully infiltrated PIP fraud conspiracies and served in an undercover capacity as "runners" and have directly dealt with both lawyers and medical service providers, accepting money to procure clients and patients to serve as PIP claimants.

was, in fact, in an auto accident and suffered injuries. The PIP application generally requests information about medical treatments, lost wages, and requires the claimant's signature.

When attempting to seek admissions or confessions from persons who are claimants suspected of participating in staged automobile accidents, the PIP application is an important document to use to confront the purported claimant. While it may seem that claimants would rarely admit that an accident did not occur, investigative experience teaches that sometimes claimants who are confronted with inconsistencies about the accident gleaned from police reports, PIP applications, and other insurance claims records will admit that the accident did not occur.

Claim Checks

The investigation should also obtain all insurance claim checks paid as a result of the purported staged accident claim. Claim checks for property damage, medical expenses paid pursuant to the PIP coverage, as well as checks used to reimburse insured claimants for rental cars, lost wages, and essential services are important to developing the facts, particularly the amount of money paid. As part of the investigation, bank accounts and any money which may be available for restitution or subject to forfeiture should be identified by tracing the claim checks into bank accounts owned by the conspirators.

Undercover Investigations

If the investigation of the medical service provider's office is not historical, in that it is not focused on past claims, and law enforcement is investigating a presently operating practice, other investigative techniques should be considered. In addition to the aforementioned search warrant, successful investigative techniques utilized include conducting surveillance of claimants entering the medical service provider's office and recording the amount of time the claimant remained in the office;[40] inserting investigators in an undercover capacity posing as claimants to record statements made by the medical service provider or persons assisting him;[41] and gaining the confidence of the medical service provider or lawyer and serving as a "runner"[42] who is willing to refer other claimants to the medical practice in return for payment.

Following some or all of the investigative techniques described above, a search warrant can be prepared and executed to accumulate additional evidence and identify additional claimants of the medical service provider so that the field investigation can continue to develop the full scope of the fraud.

Expert Assistance to Guide the Investigation

While medical and other experts have been commonly used at trials to explain medical issues to triers of fact, including petit juries, judges, and various administrative boards, law enforcement investigating medical service providers who commit fraud related to medical diagnostic tests and treatments will frequently require the assistance of a medical expert during the investigation to review medical records, to render opinions about the nature of the services rendered and billed to the insurance company, and to assist with developing questions to ask the claimants and/or the target medical service provider. This information, together with the other facts and evidence gathered during the investigation through patient interviews, interviews of employees of the medical service provider, and from claim and patient file review, will augment an affidavit of probable cause to obtain to a search warrant.[43]

43. Although there have been few criminal prosecutions based on unnecessary medical testing which was actually rendered to insured claimants, with the assistance of expert witnesses, law enforcement has begun to mount investigations and prosecutions based on allegations that treatments were not necessary in the context of automobile insurance PIP fraud.

Staged Accident PIP Fraud Conspirators

Claimants

During the early stages of an investigation into a PIP fraud conspiracy, the investigative focus should be on the police report, the PIP application, and other claims documents. Following a painstaking review and analysis of those documents, a field investigation that includes questioning claimants should be conducted in order to obtain evidence that the accident did not occur. Generally, questioning of claimants should include three basic areas: whether or not the accident occurred; whether or not all medical treatments were received; and whether or not a "runner" was used to recruit the claimant, as well as the identity of the "runner."

As previously noted, while it is difficult to obtain direct evidence that the medical service providers and/or the lawyers participated in the submission of PIP claims and the filing of bodily injury suits knowing that the underlying accidents were staged and the claimants are faking injuries, on the other hand, claimants and "runners" do participate in the actual staging of phony accidents, and this fact can be exploited to the advantage of law enforcement. The initial investigative focus with respect to the purported claimants should, therefore, be to obtain admissions that the underlying accident(s) was staged by confronting them with details from the police report and PIP application(s) and any other evidence which tends to show that the accident was staged.

Whether or not the claimants admit that the accidents were phony, the questioning of the claimants should then shift and they should be questioned about the medical treatment records. They should be asked whether or not they appeared for all the treatments the medical service providers billed the insurance companies, and whether or not they received all the medical tests, treatments, and medical supplies billed by the medical service providers, in order to develop evidence that the medical service providers billed insurance companies for treatments not rendered or even for unnecessary medical tests.

The claimants should also be questioned about the "runner" who recruited them for the staged accident. This line of questioning should attempt to elicit the identity of the person for whom the "runner" works, to include medical service providers, lawyers, or even other "runners;" whether the claimant was paid, how much and from what source the "runner" obtained money to pay the claimant to participate in the accident; and whether the claimant was present when the "runner" spoke with the medical service provider, the doctor's office manager, or the lawyer, as well as what was said.

It should be noted that identity fraud is common in auto insurance PIP fraud. Claimants have been known to simultaneously participate in multiple staged accidents and seek medical treatments using different identities. Frequently, the identity of claimants becomes an investigative issue. Investigative efforts must be made to verify the identity of the claimants.

"Runners"

Investigative experience teaches that many staged automobile accident conspiracies are initiated by "runners."[44] Although acting as a "runner" or utilizing a "runner" is a crime in New Jersey, it has been argued that conduct which is limited to merely identifying persons who were involved in legitimate automobile accidents and soliciting them to obtain services from a particular medical service provider or lawyer is not only benign, but is useful to society so that persons obtain appropriate medical care and are fully informed of their rights pursuant to the PIP law. However, investigative experience teaches that, far too often, "running" is not limited to legitimate accidents and is seldom benign.

"Runners" frequently are responsible for recruiting persons to stage and participate in automobile accidents and to seek treatment and file lawsuits for non-existent injuries. "Runners" are probably the driving force behind PIP fraud conspiracies in that they connect claimants to medical service providers and lawyers to take advantage of the financial incentives provided by the PIP statute. If "runner" involvement is suspected, the investigation should focus on the "runner." The purported claimants should be questioned about the "runner." Some claimants will admit to receiving payments from a "runner," as one incentive for participating in a staged accident.

"Runners" sometimes identify persons who were involved in legitimate automobile accidents by obtaining information from police departments, hospitals, and other sources. Some "runners" simply recruit persons "from the street" to participate in staged accidents. Police reports are obtained either after a crash is staged on the street and a police officer responds, or simply by walking into the police station and falsely reporting an accident as a "walk in." The claimants created by the accident are then directed by the "runner" to particular medical service providers and/or lawyers to begin the process of instituting PIP claims and sometimes bodily injury claims for non-economic losses.

Some "runners" will identify legitimate automobile accidents with legitimate claimants, and then encourage people to "jump in" to the legitimate accident by having the "jump in" claimant falsely add his or her name to the police report. Some "runners" completely stage auto accidents or create wholly fictitious paper accidents by falsifying police reports as previously described. These are all reasons why law enforcement should begin investigations by focusing on the police report.

Investigations conducted by OIFP have involved "runners" who were disbarred lawyers; "investigators" hired by law firms; licensed private investigators; ambulance drivers and emergency medical technicians; chiropractors, doctors and relatives of doctors; police officers and

44. New Jersey passed a Criminal Use of Runners statute, effective July 12, 1999. The statutory definition of a "runner" is a person who, for 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

other police department personnel, including police dispatchers; law students; medical and law office managers; and other persons who have no other identifiable occupation.

In some investigations of lawyers who are suspected of utilizing the services of "runners," it is alleged that some lawyers will employ "runners" but cloak them with the title of "investigator."[45] These "investigators" are frequently not licensed private investigators and are not assigned to investigate matters for which the lawyer has previously been retained by a client. Rather, these "investigators" identify persons involved in auto accidents, or fraudulently create potential insurance claimants by staging accidents, and soliciting those persons to become clients of the lawyer. Frequently, the investigation will uncover the fact that money is provided by the lawyer (or the medical service provider) to pay the "runner," and to pay persons procured by the "runner" to serve as claimants. Frequently, that money is treated by law firms as "investigative fees" and deducted for tax purposes. This fact may present a basis for a state or federal tax fraud investigation.

OIFP investigations have developed evidence that the business of "running" has become even more sophisticated. "Runners" have initiated medical "marketing" businesses which are cloaked with the indicia of legitimacy. These businesses contact medical service providers for the sole purpose of soliciting PIP claimants for the medical practice under the guise of "marketing" for the medical practice.

One of the most effective investigative techniques for law enforcement to employ when investigating an ongoing automobile insurance PIP conspiracy in which a medical service provider or lawyer is utilizing a "runner" is to attempt to infiltrate the conspiracy by having an investigator work undercover and pose as a "runner." In several OIFP investigations, law enforcement has been able to gain the confidence of persons who are already "runners," have those "runners" introduce undercover investigators to medical service providers or lawyers, gain the confidence of the doctor or lawyer, and become employed as a "runner." By working undercover as a "runner" and using pretext insurance policies,[46] other law enforcement officers working in undercover capacities can pose as claimants, infiltrate the professional practices, and gather powerful evidence with which to prosecute the medical service providers, lawyers, claimants, and "runners."[47]

The investigation should also focus on determining who is providing money to the "runner." Typically, "runners" are paid by medical service providers and/or lawyers. Oftentimes, "runners" are self-employed, servicing multiple medical service providers and lawyers simultaneously, and creating separate and distinct conspiracies. Investigations have produced evidence that the doctor, the doctor's office manager, and/or the lawyer have all "fronted" money to "runners" to be used to provide an initial financial incentive to entice purported claimants. Such payments may include money paid to the "runner" for the "runner's" personal benefit, as well as money given to the "runner" to entice the claimants.

The investigation should also determine what records, if any, are maintained by the doctors and/or lawyers who are utilizing the services of the "runner;" whether or not consensual recording equipment can be successfully

an insured or an insurance carrier for providing services to the client, patient, or customer. See N.J.S.A. 2C:21-22.1a. See also "OIFP's Prosecutions Prove Corrupting Influence of 'Runners' on Health Care System," *2003 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor,* March 2004, at 16.

45. For example see State v. Irwin Seligsohn, et al., Indictment No. SGJ506-05-8, Essex County, 2005.

46. A pretext insurance policy is an auto insurance policy provided by an insurance company for investigative use by law enforcement. See footnote 41.

47. State v. Anhuar Bandy, Indictment No. SGJ 456-02-8(9), Union County, 2002.

employed; and the methods used by the "runner" to procure claimants, insurance policies, and automobiles. Finally, investigators should attempt to enlist the "runner's" cooperation in reviewing other suspected insurance claim records obtained by law enforcement to identify evidence and investigative leads about other staged accidents.

Lawyers

Probably the most insulated participant in an automobile insurance PIP conspiracy is the plaintiff's lawyer. Investigative experience teaches that it is difficult to obtain evidence that lawyers represent claimants knowing that the underlying accidents are staged or even knowing that the claimants did not appear for all the medical services for which the medical service providers billed the insurance company.

The lawyer relies on the claimant's representation that he was involved in an automobile accident, examines the police report and the insurance policy, and awaits the medical reports and medical records from the medical service provider before submitting claims and making demands to the insurance company, all of which serve to provide the lawyer with a basis to deny that he knew the claim involved fraud. Lawyers have no financial incentive, nor any legal requirement, to pointedly question the client about the automobile accident or the medical service provider about the medical bills submitted to the insurance company or the medical reports which detail the claimant's purported injuries. The lawyer, therefore, has plausible deniability because he relies upon the reports and statements of others, including those of the police officer, his client, and his client's medical service provider.

Frequently, the "runner" and/or the claimant are the only persons who have direct contact with the lawyer. While prosecutions of lawyers for conduct related to the submission of fraudulent PIP and bodily injury claims to insurance companies are relatively rare, the best avenues of investigation may be to utilize the "runner" or the claimant, who agrees to cooperate with law enforcement, to target the lawyer or mount a successful undercover operation to infiltrate the law firm with undercover operatives.

Medical Service Provider Health Insurance Fraud

The investigation of medical service providers who submit fraudulent insurance claims to health insurance companies or self-funded health insurance plans in some ways parallels the investigation of medical service providers who submit fraudulent medical bills pursuant to the PIP component of auto insurance policies. Nonetheless, investigations of medical service providers who submit false health insurance claims frequently require a different investigative focus.

Comparison of PIP Fraud and Health Care Fraud

The two types of investigations are similar in that both require obtaining and reviewing medical records; frequently require the interpretation of CPT Codes; frequently require a parallel financial investigation to determine whether a civil forfeiture action or restitution is appropriate and feasible; usually require consideration be given to obtaining a search warrant; and oftentimes require a comparison of dates of treatment and nature of treatment as shown in billing records with information obtained from field interviews of patients concerning the dates the patients appeared for treatment and the type of treatment received.

There are differences, however, in the investigative approaches to medical service providers who submit fraudulent PIP claims pursuant to auto insurance policies and medical service providers who submit fraudulent claims pursuant to health insurance policies. One major difference is that, unlike an automobile insurance policy which provides financial incentives to commit fraud to each of the different persons involved in such claims, health insurance usually provides a financial incentive to commit fraud only to the medical service provider, and only occasionally to the patient. Thus, health insurance fraud usually involves fewer targets than those often found in PIP fraud conspiracies. Despite this limit, large amounts of money can be stolen through fraudulent health insurance claims.

Another difference is apparent in the initial referral information submitted to OIFP involving these two types of allegations. Most PIP fraud referrals to OIFP begin with information about several underlying suspicious auto accidents. For example, frequently, PIP fraud investigations will be initiated based on information by an anonymous source that accidents are staged and that "runners" are soliciting claimants for various providers; or on information about several specific staged accidents; or on information that several of the underlying police reports were fraudulent in some way; or on information that a claimant(s) admitted that he/she was solicited by a "runner" to participate in a staged accident. Law enforcement will then begin to develop that information, usually focusing on a smaller and finite number of related claims. Once the evidence begins to develop, typically, law enforcement will then focus the investigation on a smaller number of claimants/patients treated by suspect medical service providers.

Because PIP referrals frequently begin with information about specific staged accidents, "runners," claimants, or the medical service providers who treat them, the investigations tend to be more focused initially and usually involve a smaller number of claims. On rare occasions, however, a PIP fraud conspiracy is referred alleging that a medical service provider is "excessively billing" PIP carriers on a large and not clearly defined scale.

On the other hand, referrals to OIFP involving medical service providers who falsely bill health insurance or self-insured plans usually consist of allegations of fraud with respect to a few patients but with indications that fraud is suspected to be more widespread. The scope and parameters of the fraud are generally less well identified at the time of initial referral.

Frequently, such referrals include allegations that the medical service provider is misusing or abusing a specific CPT Code. Several patients are usually identified as examples of the alleged fraud in these types of referrals but the total number of instances of the suspect billings is unknown. In addition, TIN runs will evidence payment of large sums of money, sometimes over several years, but the number of specific patients for which allegedly fraudulent claims were submitted is not clear. Likewise, any issues regarding the medical validity of the specific CPT Code or Codes used or abused by the provider are equally unclear.[48]

Initial Analysis of the Referral

Among the initial objectives of a law enforcement investigation of a medical service provider who is alleged to have fraudulently submitted claims to health insurance carriers is to conduct a preliminary review and ascertain the potential scope of the alleged fraud. In order to make this assessment, the investigation must determine the number of patients and health insurance companies involved, the period of time during which the alleged fraudulent conduct occurred, and, to the extent possible, whether or not the allegation of fraud is a matter about which reasonable medical opinions can differ or a matter which can be proved to be fraud by either the civil or criminal standard of proof.[49] Frequently, these steps can be accomplished by canvassing health insurance carriers, inquiring about any internal investigations into allegations of fraud, requesting claims information and payment information (TIN runs) for the years in question, and consulting with experts to help guide the investigation.

Crime, Civil Fraud, or Difference of Medical Opinion

It is extremely important that law enforcement determine at the earliest possible time whether or not the alleged fraud is susceptible of proof by either the civil or criminal standard of proof. If this issue is not determined early in the investigation, a great deal of law enforcement time and resources can be wasted developing information and evidence about a medical billing issue that may not be best litigated in either a criminal or civil court because the underlying predicate cannot be proved by either the criminal or civil standard of proof. Such determinations are particularly difficult to make because these issues frequently involve subjective medical judgments which may not be susceptible of proof beyond a reasonable doubt nor even by the lower civil preponderance of evidence standard.

The determination of whether or not the performance of a medical procedure or use of a billing code can be proved to be fraudulent by either applicable standard of proof is the most difficult determination confronting law enforcement when investigating these allegations in either PIP fraud cases or in health care fraud cases. Nonetheless, law enforcement must determine early in the investi-

48. N.J.S.A. 17:33A-9 requires insurance companies to refer suspicious claims to OIFP. Frequently, health insurance companies referring matters to OIFP will allege that a medical service provider committed fraud or violated the Fraud Act by submitting a bill which is alleged to be fraudulent for any one of a variety of reasons. Typically, the referral will allege fraud in connection with one or more patients but the precise details are generally scarce. In other cases, OIFP will receive notice from health insurance companies of fraud allegedly committed by medical service providers after the insurance company has conducted a more comprehensive investigation and has elected to file a civil lawsuit. N.J.S.A. 17:33A-7d requires carriers who file civil lawsuits under the Fraud Act, including against medical service providers, to provide notice to OIFP. Typically, the statutory notice requirement is met by providing OIFP with a copy of the civil complaint filed. These cases are known as "7d" cases. In these cases, the insurance company generally alleges fraud by a medical service provider on grounds to include billing for medical diagnostic tests or treatments not rendered or not necessary; the use or misuse of a CPT Code; or billing for services when the proper licenses and certificates have not been obtained by the medical service provider or his employees. In these cases, the carrier's internal investigation has progressed to the point where the scope of the alleged fraud, at least with respect to that particular referring health insurance carrier, has been more fully identified prior to the filing of the lawsuit. However, oftentimes, the extent to which the medical service provider's alleged fraudulent conduct has impacted other carriers remains to be investigated.

49. In Liberty Mutual Insurance Company v. Rose Land, Frank Land and Steven Budge, (New Jersey Supreme Court docket A-124-04), the Supreme Court heard oral argument on October 24, 2005, on the issue of the State's burden of proof in civil insurance fraud actions brought pursuant to the Fraud Act. The State's position is that the appropriate standard is the preponderance of evidence standard. See also "A Comprehensive Guide to New Jersey Insurance Fraud Law," *2004 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor*, March 2005, at 28-29. The criminal burden of proof is beyond a reasonable doubt.

gation whether or not such a case can be proved in court by either the civil or criminal standard of proof before investigative resources are expended on a case that cannot be successfully litigated in civil or criminal court.

Other similar questions which frequently confront law enforcement at the onset of a health care provider investigation are allegations that a medical service provider is excessively billing. Allegations of excessive billing on the part of a medical service provider from the perspective of the insurance company may mean that the medical service provider is billing for unnecessary tests or charging excessively. Nonetheless, such allegations involve difficult issues to litigate in that they can constitute issues about which medical judgments can reasonably differ or disputes about the appropriate billing code to use. However, law enforcement should consider the possibility that an allegation of "excessive billing" may mean that the medical service provider is billing for treatments not rendered, an allegation which frequently does provide a solid basis for a law enforcement investigation.

Common Types of Health Care Fraud

Investigative experience teaches that criminal cases targeting medical service providers who submit fraudulent claims to health insurance companies run the gamut. They include billing for services not rendered; providing one service but billing for a higher level service (upcoding); billing medical services as separate components rather than a single service as prescribed by the CPT Code either expressly or implicitly (unbundling); billing for more services than can be completed in the time available;[50] and billing for services when the medical service provider or his staff do not possess the specific certification or license that permits billing for that particular service. Other allegations of health insurance fraud by medical service providers include allegations of self-referral;[51] allegations of cosmetic procedures, such as plastic surgery, falsely represented as medically necessary;[52] and allegations that non-medical procedures are falsely represented as medical procedures.

Generally, cases involving dissecting medical procedures and testing in order to uncover fraud require the assistance of medical experts. Cases which involve an interpretation of CPT Codes are difficult and may require the assistance of a coding expert. For those investigations in which a determination is made that the fraud cannot be proved by either the civil or criminal standard of proof, the allegations should be referred to the appropriate professional board for licensing action.

Determining the Scope and Parameters of the Fraud

A systematic approach employed by law enforcement to ascertain the scope and parameters of an investigation of a medical service provider who is allegedly submitting fraudulent bills to health insurance companies should include the following investigative steps:

1. Searching of OIFP's database for previous referrals about the suspect medical service provider, whether or not they led to the filing of a complaint alleging civil fraud or were referenced without investigation for intelligence purposes;
2. Contacting the appropriate professional licensing board, through the Enforcement Bureau in the Division of Consumer Affairs, to determine whether it has received referrals of fraud about the suspect medical service provider or whether or not it is conducting an investigation;[53]
3. Canvassing other major health insurance carriers to ascertain whether any other carrier has received suspicious or fraudulent claims from the suspect medical service provider or has referred such matters to the carrier's Special Investigations Unit;
4. Requesting Taxpayer Identification Number (TIN) runs to determine the amount of money paid to the suspect medical service provider each year.[54]

These inquiries will permit law enforcement to establish the parameters of the alleged fraud.

As in the case of medical service providers who submit PIP claims to auto insurance carriers, frequently, the initial objective of the investigation into a medical service provider who is submitting false claims to health insurance companies is to obtain probable cause for a search warrant. In many cases, probable cause for a search warrant will consist of an expert's analysis of the alleged fraud from records and bills of some of the provider's patients, information obtained through select patient

50. See the permissive inference in N.J.S.A. 2C:21-4.3f(2), The Health Care Claims Fraud statute.

51. The concern with self-referral is that the treatments may be unnecessary and the doctor may be referring the patient to the other medical corporations which he owns or in which he has a financial interest, in order to submit additional bills to the insurance companies in order to increase revenue. Generally speaking, doctors may refer patients to corporations which they own or in which they have a financial interest if their ownership interest in the related corporations is conspicuously displayed in their medical practice and patients are aware of same.

52. Ordinarily, plastic surgery is not compensable pursuant to most health insurance plans because it is not "medically necessary." Criminal cases have been based on the allegation that a medical service provider will perform cosmetic plastic surgery and falsely allege that the surgery was medically necessary.

53. See N.J.S.A. 45:9-19.3 and N.J.S.A. 17:33A-25.

54. A Taxpayer Identification Number (TIN) is a number used by the tax authority to determine the amount of income a taxpayer receives during the course of a year. Insurance companies are required to report such information to the tax authority. Frequently, medical service providers will have several TINs which render this investigative step more difficult. A medical service provider may obtain one TIN for his medical practice and a different TIN for any related corporations, such as a medical supply corporation, a corporation which owns diagnostic testing machines such as an MRI, or a separate medical practice. Unless all TINs are identified, a TIN run will not reflect the total amount of money insurance carriers are paying to the medical service provider. There are legitimate tax and business reasons to have separate TINs. However, investigative experience teaches that some medical service providers obtain separate TINs to disguise or con-

interviews, information obtained from select interviews of current and past employees of the medical service provider, results of TIN runs, and any general information provided by the insurance company(ies). This information may be sufficient to articulate probable cause for a search warrant to search the suspect medical service provider's office(s).

Insurance Agent Fraud

The investigation and prosecution of insurance producers[55] suspected of engaging in fraudulent conduct presents a different investigative focus than the investigation and prosecution of staged accident auto insurance PIP mills and medical service providers. While staged accident and health care provider investigations and prosecutions are directed primarily at false insurance claims, insurance agent fraud usually does not involve false claims but often simply involves theft of insurance premium money, which thefts are concealed through a variety of schemes. Insurance agent fraud also can include false and fraudulent premium financing schemes[56] and, in some cases, various forms of underwriting fraud.[57]

Theft of Premium Money

Most complex insurance agent investigations and prosecutions involve investigations into thefts of insurance premiums and related money paid by insurance customers. Insurance agents conceal the theft of insurance premium money by several different artifices.

One method of concealing theft of premium money occurs when persons pay insurance agents for insurance coverage and the agent purports to provide the insured with valid indicia of insurance coverage, such as an automobile insurance identification card,[58] a Certificate of Insurance, an insurance policy declaration page, or the mere representation by the insurance agent that the insured customer now possesses valid insurance coverage. The insurance customer has no way of knowing that he does not have the benefit of the underlying coverage unless he verifies same with the insurance company purportedly providing the coverage.

Insurance agents accept insurance premium payments from insured customers. Insurance agents are required to deposit the premium money in a premium trust account or otherwise refrain from co-mingling the funds with other business operating funds or personal money or from converting the funds for any other use.[59] Some agents fail to remit the insurance premiums to the insurance company providing coverage and instead steal the insurance premium money and use it for their own personal benefit.

Since insurance coverage is not a physical object that the insured customer can readily determine he possesses, it is relatively easy for insurance agents to conceal thefts of insurance premium money. Frequently, the insured customer does not think about insurance coverage unless and until there is a claim. More often than not, there are no claims made against the purported policy and so the missing insurance coverage goes undetected by the customer.[60] The fact that insurance coverage is not verified until a claim is presented serves to facilitate concealment of this type of theft.

ceal the exact amount of money they are receiving from insurance companies.

55. The term "insurance producer" is a statutory term and refers to what is more commonly known as an insurance agent. See N.J.S.A. 17:22A-28. Insurance producers are licensed by the State of New Jersey through the Department of Banking and Insurance (DOBI). An independent agent may represent more than one insurance company, while an exclusive agent represents only one insurance company or a group of related companies.

56. Premium financing occurs when the insured, most often a small commercial business, borrows money from a third party lender to pay for insurance premiums.

57. Underwriting fraud usually involves falsifying an application submitted to an insurance company so as to conceal some aspect of the risk being insured to obtain a lower premium rate for the insured. This practice sometimes permits the agent to attract and retain insurance clients.

58. See N.J.S.A. 39:3-29 and 39:3-29.1.

59. See generally, N.J.A.C. 11:17C-2.1(a) and N.J.A.C. 11:17C-2.2(a).

60. With respect to automobile insurance, frequently, the only physical evidence of insurance is the auto insurance identification card. Auto insurance agents who are committing thefts of auto insurance premiums will frequently issue phony auto insurance identification cards which appear to evidence valid insurance coverage but, in fact, do not. The insured customer is required to present an insurance identification card to police officers, motor vehicle inspectors, or other persons from time to time. On occasion, a police officer or other person will investigate the bona fides of the insurance identification card presented by the insured customer and determine that it is not valid.

With respect to automobile insurance in particular, one red flag which points to the agent's theft of insurance premiums is the insurance agent's direction to insured customers to contact the agent directly, rather than the insurance company, if the insured has an auto insurance claim. In some cases, the defalcating insurance agent will directly pay the auto insurance claim, for example by paying to fix a dented fender, rather than have the insured customer contact the insurance company, only to learn that insurance coverage was never bound or was cancelled because insurance premium money was never remitted by the agent to the insurance company.[61] In such cases, the insurance agent, in effect, acts as the insurance company by covering the insured customer's losses in order to conceal the theft of auto insurance premium money.

If there is a catastrophic automobile insurance claim in an amount greater than the amount which the defalcating insurance agent can practically cover, the agent will often attempt to pass the loss to the insurance company by claiming that the premiums were not remitted sooner due to clerical error in the office. This conduct is sometimes referred to as "back dating" the insurance coverage.

Theft of insurance premiums may be more common with respect to commercial liability insurance. Though commercial liability insurance is frequently required for various reasons, claims are infrequent enough that insurance agents can conceal insurance premium defalcations because the insured business customer often has no reason to contact the insurance company since the customer has experienced no losses. Thus, the agent is able to accept insurance premiums, divert the money to his or her own purposes, and not remit the premiums to the insurance company.

Complex insurance agent theft schemes can sometimes involve reinsurance and excess risk insurance. Since reinsurance and excess risk insurance are not called upon except in cases of catastrophic loss, the insured does not miss it and the opportunity for the agent to steal premiums is even greater. Other related insurance agent theft schemes include stealing insurance premium money by selling insurance policies for insurance companies that do not exist, particularly "offshore" insurance companies, or for foreign companies not authorized to do business in the State of New Jersey.[62]

Another theft of insurance premium money occurs when an insurance policy is properly sold (coverage bound) and the insurance agent remits the full year's premium for that policy, but the insurance policy is cancelled during the period of coverage. Reasons for cancellation can vary and include the fact that a commercial business ceased to do business or the insurance purchased was no longer needed for valid reasons. In such cases, part of the premium is required to be returned to the insured customer.[63] Consequently, the insurance company will return the unearned premium to the insurance agent to be rebated to the insurance customer. However, insurance agents bent on committing theft will retain and steal the insurance premium rebate, instead of forwarding it to the customer, and use the money for his/her own purposes. Frequently, customers who have had insurance cancelled for valid reasons do not anticipate a premium rebate. Thus, the agent's theft of these rebates goes undetected.

Law enforcement should be alert to yet another issue sometimes encountered in connection with insurance agent thefts. On occasion, especially during periods of business downturns, insurance agents and agencies will become cash starved and may divert the insurance premiums from insurance carriers, not so much for personal enrichment, but simply to keep the insurance agency afloat by paying rent, salaries, and other operating expenses. Although this conduct clearly represents a misuse of the insurance premium money which should be held in trust and remitted to the insurance company, cases where the insurance agent is not personally enriched by the diversion of the insurance premium money may have somewhat less criminal trial jury appeal. Investigators and prosecutors should distinguish between cases in which insurance premium money was diverted to keep a business afloat and those cases where insurance premium money was diverted for personal enrichment of the insurance agent. Assessing this question early in the investigation will enable law enforcement to select those cases which will best support criminal prosecution. Those cases which do not support a criminal prosecution may be best referred to the Department of Banking and Insurance (DOBI) for insurance agent licensing action.

Premium Financing Fraud

Investigative experience teaches that an agent who engages in one of the schemes described above will frequently engage in others as well. Investigations of insurance agents who are committing insurance premium theft must, therefore, consider whether or not the insurance agent is committing premium financing fraud in addition to theft of insurance premiums. Investigative experience indicates that theft of premiums and premium financing fraud are often related. Premium financing is frequently arranged by insurance agents to service their customers, typically small business commercial customers, who cannot afford to pay the full premiums for required insurance coverage. The agent will obtain the necessary insurance coverage and contemporaneously arrange for financing with a premium financing company.

Typically, the transaction involves the completion and submission of a premium financing loan application which is completed by both the insured and his insurance agent and submitted to the premium financing company so that the premium financing company will loan the in-

61. The insurance company may nonetheless be required to provide coverage because it may be bound by the actions of its agent.

62. DOBI can verify which insurance companies are authorized to do business in New Jersey.

63. Returned premiums are sometimes referred to as unearned premiums.

64. See N.J.S.A. 2C:21-4.6.

sured the amount of money necessary to pay the premium for the insurance policy. The principal amount of the loan is an amount approximately equal to one year's insurance premium. Insurance premium financing loans are considered risky and have a higher rate of interest than other loans. The insurance company receives the proceeds from the loan, issues the insurance coverage to the insured, and the insured makes periodic payments throughout the year to the financing company to repay the loan.

Because there appears to be little review of the loan application submitted by the insurance agent to the premium financing company, there is ample opportunity for fraud. Investigative experience teaches that, in some cases, the insurance agents themselves have the authority to consummate the loan on behalf of the premium financing company and, in some cases, even have the authority to issue the check to the insurance company and sign the check as an authorized representative of the premium financing company. This invites theft by some insurance agents.

The most common fraudulent conduct associated with insurance premium financing involves insurance agents who submit loan applications for fictitious insureds which enables the insurance agent to obtain the premium financing loan proceeds and divert them for his own use. Also, insurance agents sometimes submit loan applications for insurance customers who paid for insurance without the need to borrow insurance premium financing money. In those cases, the agent nonetheless submits a loan application purportedly on behalf of the insurance customer so that the agent can steal the insurance premium financing loan proceeds.

Experience also teaches that in periods of economic downturn, when commercial businesses, including insurance companies, are struggling, insurance premium financing fraud tends to accelerate. Insurance premium loan fraud operates much like a pyramid scheme. The insurance agent submits the first fraudulent loan application and receives the loan proceeds. When the payment is due on the first fraudulent loan, the agent submits two additional fraudulent loan applications in order to make the payment on the first fraudulent loan and to have additional cash. Later, four fraudulent loan applications are submitted, and the scheme continues to mushroom. After a time, so many fictitious loan applications have been submitted and so many payments become due to the premium financing company that the loans default.

Premium financing companies with defaulting loans rarely consider the possibility that such loans are fraudulent. Law enforcement must be aware that, from the perspective of insurance premium financing companies, loans in default are not necessarily indicators that fraudulent loan applications may have been submitted by the agent. Rarely, if ever, have premium financing companies reported defaulted loans to law enforcement. It is more likely that the loans will be treated as a business loss and "written off."

Another commonly occurring pattern is that an insurance agent whose fictitious loans have defaulted with a particular premium financing company will often begin to then obtain phony loans with a second premium financing company, and then a third, and even a fourth. Developing a time line will often illustrate the thefts from successive premium financing companies over a period of time. The point is that once an investigation of an insurance agent has begun and evidence of fraudulent insurance premium financing is identified, investigators and prosecutors should contact insurance premium financing companies in an effort to determine whether other loans in default have been issued through the insurance agent under investigation. Law enforcement cannot rely on premium financing companies to report such thefts. Additionally, as is the case with other unearned insurance premiums which are returned by the insurance company, any legitimate insurance premium money which is returned by the insurance company to the insurance agent because an underlying insurance policy

was cancelled early is frequently also stolen by the insurance agent under investigation and not returned to either the insured or the premium financing company.

Other Insurance Agent Thefts and Frauds

Other fraudulent conduct encountered when conducting investigations of insurance agents includes selling insurance policies to small employers and facilitating the inclusion of ineligible non-employees on the small employer group health insurance plan; selling or purporting to sell insurance policies to family, friends, or even fictitious people and then cancelling those policies after a short period of time so that the insurance agent can collect and retain the sales commission; selling insurance that may be unnecessary, sometimes called "churning;" and charging unauthorized "administrative fees" of various types in addition to the policy premium, which fees are ordinarily not permitted by statute.

Another commonly alleged insurance agent underwriting/application fraud is the sale of an auto insurance policy where it is alleged that the insurance agent conspired with the auto insurance customer to conceal adverse information in his or her driving record so as to secure a lower automobile insurance premium. Frequently, these cases are investigated as civil violations of the Fraud Act. It should be noted, however, that the recently enacted Insurance Fraud criminal statute provides a basis to charge a crime for this conduct in appropriate cases.[64] This conduct may or may not be found in connection with the type of large-scale insurance agent thefts described above.[65]

Investigative Techniques

The investigation of an insurance agent theft case is always best facilitated by obtaining all of the insurance agent's and the insurance agency's bank records by means of a subpoena. These records may consist of the premium trust account records, the insurance agency business operating bank account records, as well as any and all personal bank account records of the agent. Additionally, all available evidence of personal expenditures made by the agent, such as checks written to pay credit card bills, mortgages, car leases, and so on, should be identified utilizing the bank records. The agent's contract with the insurance companies he represents[66] should be obtained and reviewed and any provisions in the contract which provide for the establishment of a premium trust account and the time period within which the agent must remit premiums should be noted. The agent's book of business (customer list) and related records should be obtained and carefully reviewed. As with auto PIP insurance fraud conspiracies and medical service provider investigations, an early investigative objective should be obtaining a search warrant to search the insurance agency for this evidence and for evidence which will identify all of the bank accounts owned and controlled by the insurance agent.

Obtaining probable cause for an affidavit in support of a search warrant begins with a review of the initial complaints from insurance customers, coupled with interviews of those customers. Those complaints are typically received by DOBI's Division of Enforcement and Consumer Protection. Those complaints, together with interviews of other customers of the agent and information obtained by canvassing insurance carriers represented by the agent, often will provide probable cause for a search warrant.

Insurance agents are licensed by DOBI. Insurance agent theft cases are frequently referred to OIFP by DOBI. Some cases gain media coverage because insurance customers publicly complain that they paid insurance premium money to a particular insurance agent but later learned that they had no insurance coverage. During the course of an insurance agent investigation, law enforcement should periodically contact DOBI for updated information and complaints which may have been sent to DOBI after the investigation began.

Bank Records

During the criminal investigation, the insurance premium money should be traced using the bank account records. The money should be traced for the specific period of time the thefts are alleged to have occurred. The tracing should begin with payment by the insurance customer to the insurance agent. The tracing should then continue to determine whether the insurance premium payment was deposited into the insurance premium trust account, the insurance agent's business and operating accounts, or the insurance agent's personal accounts, or any combination thereof. The objective of tracing the insurance premium money is to determine the ultimate disposition of the money. Determining the total amount of money that the insurance agent diverted to business and operating expenses, the total amount the agent diverted to personal expenses, and the total amount of money that was properly remitted to the insurance company, if any, are the end objectives of the investigation and will provide compelling evidence of theft.

Insurance agent theft investigations heavily depend upon bank records. Experience teaches that banks are often slow to

65. Insurance agents frequently play a role in workers' compensation application insurance fraud which results in underpaying premiums or premium avoidance. Some workers' compensation application insurance fraud can result in theft of large amounts of money. A more detailed discussion of workers' compensation application fraud is beyond the scope of this article. See "Leveling the Playing Field--OIFP Targets Workers' Compensation Premium Fraud," *2004 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor,* March 2005, at 64.

66. DOBI can sometimes assist law enforcement in obtaining information identifying the companies that the insurance agent represents.

67. Similar to investigating allegations of fraudulent billing by medical service providers in connection with PIP fraud conspiracies or health insurance frauds, the investigation of an insurance agency for theft of insurance premiums must develop evidence of who within the agency was responsible for the thefts and who was not. Insurance agencies frequently employ other persons, besides the suspect insurance agent, to include secretaries, billing clerks, office managers, and a host of other persons. Sorting out which persons are responsible for thefts and which persons are not is a major challenge encountered by law enforcement. Frequently, interviews of insurance agency customers will provide some evidence of which persons were responsible for theft and which persons may not be.

produce bank records. Subpoenas for bank records should be issued early in the investigation as soon as the bank accounts used by the insurance agent are identified. As law enforcement identifies additional bank accounts, the records should likewise be subpoenaed. Investigative efforts should be expended on monitoring the progress of the banks in responding to the subpoenas and supplying the requested bank records.

Questionnaires to Customers

Following the execution of a search warrant, the investigative objective should be to contact insurance customers to continue to determine the amount of insurance premium money paid to the insurance agent, to identify any and all persons in the agency with whom the customers dealt,[67] and to obtain evidence that money was paid to the agent or others by obtaining cancelled checks or receipts for cash or money orders. Information about any claims which were submitted and the identity of the persons employed by the insurance agency who assisted with the processing of those claims is also useful investigative information.

Although second degree crimes can now be prosecuted for amounts as low as $1,000,[68] it is important to contact all or as many of the insurance customers as possible because restitution to these insurance customers or to the insurance carriers who were required to extend coverage despite the theft of the premiums is likely to be an issue.[69] An amount of restitution can be determined with reasonable certainty only after all, or as many as possible, of the customers and thefts are identified.

Contacting all the insurance customers of an insurance agency is labor intensive and requires a tremendous amount of law enforcement resources. It is sometimes useful to identify a customer list from the materials seized in a search warrant or obtained through other investigative steps and send a questionnaire to the insurance customers by mail. Such questionnaires facilitate the field investigation and can be drafted to fit the specific facts of the case.

Generally, the questionnaire will include such questions as the name of the insured; whether or not the insured paid cash for insurance or gave the agent a check or money order; whether or not the insured has a receipt from the insurance agent; whether or not the insured has a cancelled check negotiated by the insurance agent and from which a bank account belonging to the agent can be identified; whether the insured requested insurance premium financing in connection with the purchase of insurance; the identity of persons within the insurance agency with whom the insurance customer dealt; and other relevant information. The customers who respond to the questionnaire can then be interviewed and formal statements taken. The customers who do not respond may be left for later investigation if time, resources, and practicalities permit.

Premium Financing Investigative Steps

In addition to canvassing insurance premium financing companies to identify loans in default issued through the insurance agent under investigation, the investigation of fraudulent insurance premium financing should focus on the documents and records evidencing the loans and insured customers. Specific investigative attention should be directed to the loan applications and checks.

It is not uncommon to identify insurance premium loan applications that contain fictitious commercial businesses and post office boxes as addresses for the purported insured borrowers. While it is not uncommon for commercial businesses to utilize a post office box as a business address, law enforcement should be aware that post office boxes are also frequently used by insurance agents as the addresses of fictitious insurance borrowers to facilitate insurance premium fraud theft schemes. Field investigations should be conducted to determine whether or not the insured borrowers exist and reside at the addresses or subscribe to the post office boxes reflected on the loan applications.

Since the loan applications typically require an insurance policy number or other information to identify the insurance policy for which the loan is being issued, fictitious policy numbers are frequently reflected on the loan applications. All purported insurance policies should be verified with the insurance companies. Checks representing loan proceeds should be obtained and analyzed to determine who negotiated the checks and into what accounts the proceeds were deposited.

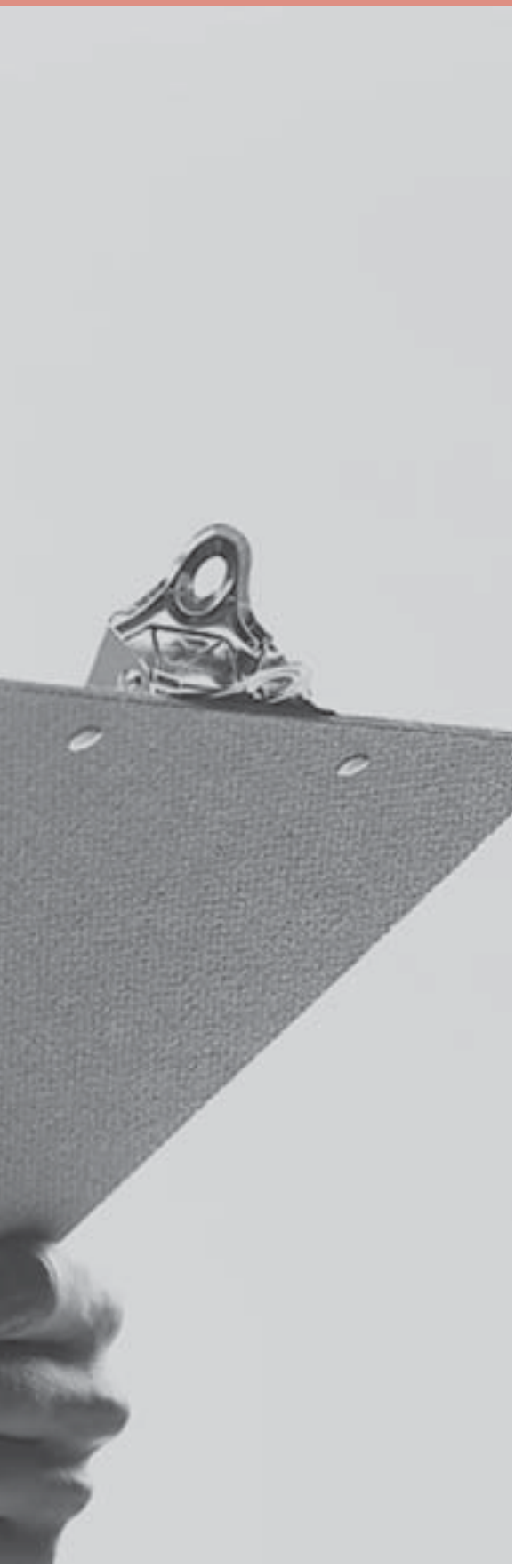
Conclusion

Investigations of complex insurance fraud schemes require a careful review of the records which constitute each claim or transaction, as well as a comprehensive field investigation to gather additional evidence. Frequently, execution of a search warrant and/or insertion of undercover operatives will be invaluable. While such investigations are complex and can be time consuming, they can be accomplished with a proper understanding of the document analysis needed, the roles of the various players in the scheme, and the financial incentives which motivate them.

68. The Insurance Fraud Statute, N.J.S.A. 2C:21-4.6, reduced the monetary threshold for second degree insurance-related crimes from $75,000 to $1,000.

69. See generally "A Comprehensive Guide to New Jersey Insurance Fraud Law," *2004 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor*, March 2005, at 35.

John J. Smith, an Assistant Attorney General, is the First Assistant Insurance Fraud Prosecutor and assists the Insurance Fraud Prosecutor with all facets of the Office's operations including its investigations, criminal prosecutions, and civil litigation. He has been with the Division of Criminal Justice for over 20 years.



OIFP Executes Full Court Press on PIP Mills

by Michael A. Monahan

During 2005, the Office of the Insurance Fraud Prosecutor (OIFP) significantly broadened its investigation and prosecution of Personal Injury Protection (PIP) fraud by breaking up major PIP mills, targeting "runners," and ferreting out "players." While OIFP continues to prosecute owner "give ups," false theft claims, inflated property damage claims, and rate evasion, the office has concentrated significant effort on the more insidious, complex, and costly types of automobile insurance fraud directed at PIP benefits.

The Insurance Research Council (IRC) estimated in a 2005 report that "fraud and buildup added between $4.3 and $5.8 billion to auto injury settlements in 2002, which represents between 11 and 15 percent of all dollars paid for private passenger auto injury insurance claims in that year." The IRC report noted that "the appearance of fraud was found in almost one in ten paid bodily injury liability (BI) claims and one in twenty paid Personal Injury Protection (PIP) claims. Buildup (the intentional inflation of an otherwise legitimate claim) was more common; nearly one in five paid BI claims and one in eight paid PIP claims involved the appearance of buildup."[1]

Personal Injury Protection, or PIP, as it is more commonly known, is a component of all automobile insurance policies under New Jersey's "no-fault" automobile insurance law. PIP insurance covers medical expenses incurred by the occupants of a motor vehicle injured in an accident, without regard to fault. Depending on the policy limits chosen, PIP coverage may be from as low as $15,000 per person or per accident to as high as $250,000 or more. The objective behind the law is obvious--to give legitimate auto accident victims a certain level of comfort knowing that their reasonable medical costs will be paid. Regrettably, schemers and crooks have taken advantage of the salutary purpose of the PIP law, treating it as an open invitation to commit fraud against automobile insurance carriers.

PIP fraud takes on several forms and may be committed by persons acting alone or in conspiracy with others (including health care professionals or attorneys). The most egregious examples of PIP fraud involve organized "rings" or medical care "mills." In a typical PIP fraud ring, corrupt health care providers (medical doctors or other health care professionals) employ "runners"[2] whose sole purpose is to solicit auto accident victims to

1. Insurance Research Council January 21, 2005 news release, "IRC Study Finds Fraud and Buildup Add Approximately $5 Billion to Auto Injury Insurance Claims."

2. Runners are known as "cappers," "steerers," "chasers," or "recruiters" in other jurisdictions. Acting as a "runner," or using, enlisting, or hiring someone to be a "runner," is a third degree crime in New Jersey. N.J.S.A. 2C:21-22.1.

become patients of the health care provider. For this service, "runners" are paid up to several hundred dollars *or more* for each patient referral. To assure a steady stream of patient referrals to the provider (and a steady stream of income for themselves), "runners" commonly choreograph staged[3] or fictitious[4] auto accidents and recruit others to act as "passengers" allegedly injured in those accidents. In both scenarios, "runners" instruct the passengers on how they should act and what they should say if questioned by law enforcement or insurance investigators. In most cases, the staging of auto accidents is done with the cooperation or complicity of the health care provider, his office staff, or both. When the "passengers" become patients of the provider, they assign to the provider their right to PIP benefits, thereby allowing the provider to collect payment of PIP benefits directly from the insurance carrier. Once the PIP benefits are assigned to the provider, the real theft begins. Often, providers bill the PIP carrier thousands of dollars for fictitious treatments and diagnostic tests never rendered, submitting false or fraudulent medical records in support of the contrived claims. In an accident claim involving four, five, or more allegedly injured passengers, fictitious claims for PIP benefits can easily exceed $20,000. For their part in the fraud, the "passengers" are paid a few hundred dollars by the "runner" and use the fictitious injuries and treatment history as the basis to file bodily injury claims for their alleged "pain and suffering." In some cases, lawyers are also active participants by assisting in the orchestration and planning of the fraud.

OIFP PIP Fraud Prosecutions

Perhaps the most notorious staged accident PIP fraud ring prosecuted by OIFP was *State v. Anhuar Bandy, et al.*[5] Following the receipt of an anonymous letter, OIFP conducted a lengthy investigation of five chiropractic clinics located in Elizabeth, Newark, Perth Amboy, and Plainfield. The investigation, which included use of wiretaps and undercover State Investigators, revealed that the Bandy-owned clinics were being operated as a vast criminal enterprise. Bandy, known to the conspirators as "El Jefe," or "The Chief," orchestrated dozens of staged accidents and directed the filing of hundreds of fraudulent PIP claims that caused millions of dollars of losses for the automobile insurance industry. Indeed, the investigation revealed a pattern of fraud of such vast proportions that Bandy and his lieutenant, Elvin Castillo, were indicted for racketeering, representing the first time the New Jersey racketeering law was used to prosecute an insurance fraud conspiracy. Following a six-week trial in 2004, Bandy and Castillo were convicted of all charges, including conspiracy, racketeering, Health Care Claims Fraud, and theft by deception. Bandy, the mastermind behind the scheme, was later sentenced to 29 years in state prison while Castillo received a 13-year state prison term.

In *State v. Philip Major, et al.*, over 30 individuals entered guilty pleas and were sentenced for their roles as fictitious automobile accident "victims" in a massive PIP fraud conspiracy. Major, a former police officer, committed official misconduct by accepting bribes from "runners" over a two-year period for his preparation of more than a dozen fictitious motor vehicle accident reports. With the fictitious accident reports in hand, the "runners" then referred the phony accident "victims" to medical providers who submitted claims to various insurance carriers for PIP benefits totaling more than $900,000. All the phony accident "victims" pled guilty to conspiracy to commit official misconduct and were sentenced to probation.[6]

PIP Fraud continued as costly crime in 2005. Carl Love pled guilty and was sentenced in April 2005 to three years probation for his role in a $1.2 million conspiracy to commit Health Care Claims Fraud and theft by deception as part of a broad-based chiropractic and automobile insurance fraud scheme. Love and four other defendants were charged in a State Grand Jury indictment with devising an insurance fraud scam geared to steer patients to a chiropractic business. The State charged Love in the indictment with using

3. Examples of staged auto accidents include the very low impact collision of two autos or taking two previously damaged vehicles and positioning them in such a way as to give the appearance of an accident.

4. These accidents are known as "paper accidents." In this scenario, the conspirators do not even bother to stage the accident but, rather, create phony accident reports and supplemental documentation which are submitted to the insurance carrier. A common fact pattern is an

OIFP analysts Christina Runkle (l.) and Paula Carter (r.) prepare a chart for trial.

a transportation company he owned to funnel patients to the chiropractic office. In so doing, the chiropractic practice increased the number of patients and the amount of PIP claims submitted to insurance companies for payment of various medical, diagnostic, and chiropractic treatments. Love's corporations ceased operation following the execution of search warrants by OIFP. Additionally, Love's corporate bank accounts were frozen and forfeited to the state. A lien was also filed on Love's home. Love subsequently filed for bankruptcy

A State Grand Jury returned an indictment on December 16, 2005, charging Alan E. Ottenstein and Jean Woolman with conspiracy to commit racketeering, racketeering, attempted theft by deception, and Health Care Claims Fraud. Ottenstein was also charged with false swearing. According to the indictment, from October 1, 1990 through August 31, 2003, Ottenstein, a physician formerly licensed in New Jersey, and his former associate, Woolman, through medical practices Ottenstein owned, operated, and controlled, as well as a Las Vegas corporation, allegedly fraudulently billed automobile insurance companies, particularly PIP insurance coverage, through a variety of schemes.

The State alleges that Ottenstein wrongfully billed insurance companies for epidural injections in connection with pain management; wrongfully billed insurance companies for separate anaesthetic and steroid injections as part of epidurals when those procedures should not have been billed separately, and wrongfully separately billed insurance companies for use of a contrast agent as part of an epidural procedure when the procedure should not have been separately billed, both billing practices known as "unbundling;" wrongfully billed insurance companies for use of medical supplies to include sterile trays when sterile trays were not used; wrongfully billed insurance companies for a separate "facility fee" when the separate fee was not lawfully charged; wrongfully altered Magnetic Resonance Imaging (MRI) reports so that patients, primarily patients injured in automobile accidents, would appear to have an auto-related injury when, in fact, they did not; and wrongfully billed mechanical disk recovery system treatments as surgical procedures when, in fact, they were not surgical procedures.

The State also alleges that Ottenstein, Woolman, and the medical practices unlawfully misrepresented treatments and services to various insurance companies. Among these insurance companies were New Jersey Manufacturers, Aetna, Allamerica, Allstate, AmeriHealth, Guardian, HealthNet, Horizon Blue Cross Blue Shield, Liberty Mutual, MetLife, New Jersey CURE, The Oxford Plan, Prudential, State Farm, and Zurich.

allegation of an impact by a hit-and-run, or "phantom," vehicle.

5. For a comprehensive accounting of the investigation, prosecution, and disposition of this case, see "OIFP Takes on One of State's Largest Racketeering Rings," by SDAG Melaine B. Campbell, *2004 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor*, pp. 38-43.

6. Major, who had previously plead guilty to official misconduct, awaits sentencing.

The State alleges that perhaps as much as $2 million in fraudulent claims were submitted to the insurance companies by the defendants through the medical practices.[7]

OIFP obtained an indictment in *State v. Ayana D. Torres, et al.*, in 2005 charging three individuals with Insurance Fraud for their roles in an alleged PIP fraud scam. The indictment alleges that the individuals conspired to submit false PIP claims by falsely claiming two of them were present in a vehicle when it lurched forward and struck another vehicle.

OIFP obtained a three-year state prison term in 2005 against Angel Lobo, a Paterson physician who committed Health Care Claims Fraud by falsifying treatment records and billing insurance companies for medical services not rendered. Lobo, whose medical practice was known as "Pain Management Clinic," enlisted the services of a "runner" who referred automobile accident "victims" to the medical office. Unknown to Lobo, the "patients" referred to his office were undercover OIFP State Investigators. In each instance, Lobo provided no medical services to the undercover State Investigator, but he submitted claims for PIP benefits to the insurance carrier for dozens of fictitious treatments. Lobo's office manager, who assisted in the preparation and submission of numerous fictitious treatment records, pled guilty to Health Care Claims Fraud and received a probationary sentence.

In *State v. Dannie Campbell, et al.*, Campbell was a "runner" who orchestrated two fictitious automobile accidents and solicited nine individuals to act as "passengers" allegedly injured in the accidents. The court sentenced Campbell on April 1, 2005, to three years in state prison and ordered him to pay a $3,000 fine. Campbell persuaded others to fraudulently obtain medical treatment from a health care practitioner of Campbell's choice for their non-existent injuries. The health care services, encompassing dozens of treatments and diagnostic tests over a two-year period, resulted in over $90,000 in fraudulent PIP claims submitted to an automobile insurance carrier.[8] For their roles in the scheme, the "passengers" all pled guilty and were sentenced to probation.

On April 19, 2005, the court sentenced LeClerc Adisson, a medical doctor, to probation, with the condition that he serve 364 days in jail, for submitting fraudulent PIP claims for services he never provided. Adisson, the former owner of Laguardia Health Care in East Orange, also admitted to paying a "runner" to procure additional patients for his practice. In addition to the jail sentence, Adisson was ordered to pay $26,000 in restitution to the nine insurance companies he defrauded and to surrender his medical license.

In *State v. Gladys Roman, et al.*, four individuals who pled guilty to conspiracy were sentenced in July 2005 to probation for their role in staging an automobile accident and treating for fictitious injuries that resulted in the payment of approximately $20,000 in PIP benefits. As conditions of probation, the defendants were ordered to pay restitution of $17,561, and each to pay a civil insurance fraud penalty of $2,500.

PIP Mill Activity Flow Chart

Accident occurs that may or may not have been staged or is otherwise phony in some aspect. Enough damage is done to the vehicle so that the driver and/or passenger(s) may be injured.

"Runner" associated with a doctor and/or attorney solicits car passenger to seek treatment at alleged "PIP Mill." Patients are instructed what to say if questioned by authorities or the insurance carrier.

"Runner" brings patient to doctor usually for injuries that do not exist or are over-inflated in order to collect more money from the carrier under PIP.

With these and a multitude of other prosecutions and investigations, OIFP continues its vigilant assault against those who commit PIP fraud. Indeed, in November 2005, OIFP obtained a 20-count State Grand Jury indictment, *State v. Irwin Seligsohn, et al.*, charging two lawyers, their law firm, five "runners," and 23 phony accident "victims" in a racketeering conspiracy that alleges Health Care Claims Fraud, Criminal Use of Runners, theft by deception, and tax fraud. The matter is pending.

State Investigators continue to act in undercover capacities, infiltrating the offices of corrupt health care providers, and otherwise obtaining the evidence that will support future PIP fraud prosecutions and convictions. According to Insurance Fraud Prosecutor Greta Gooden Brown, staged automobile accidents threaten lives and the resulting fraudulent claims drive automobile insurance rates up. To be sure, OIFP's proactive efforts in the fight against PIP fraud will not stop so long as there are those who are determined to commit this most insidious and costly crime.

Michael A. Monahan is an Assistant Supervising Deputy Attorney General in the Office of the Insurance Fraud Prosecutor where he has served as the Assistant Section Chief of the Auto Fraud Section since 1999. He previously served as an Assistant Prosecutor with the Union County Prosecutor's Office.

7. An indictment is merely an accusation. Defendants are presumed innocent of the charges unless and until proven guilty beyond a reasonable doubt in a court of law.

8. All PIP claims were denied, and no money was paid to the treating health care providers, following an investigation by the carrier's Special Investigations Unit (SIU).

Attorney also associated with the doctor and/or "runner" represents the injured party or parties in order to seek the maximum allowed under PIP regardless of whether the patient was actually injured or treated by the doctor.

Patients are paid more money by insurance companies for their "pain and suffering," based on the inflated medical bills.

As a result of these conspiracies, insurance companies pay out millions of dollars for fraudulent PIP claims.

OIFP's Civil Litigation Yields a Record $5.4 Million in Penalties and Restitution

OIFP's Civil Litigation Yields a Record $5.4 Million in Penalties and Restitution

by John Grady

OIFP's attorneys in the Division of Law (DOL) Insurance Fraud Section obtained an unprecedented $5,435,660 in settlements and judgments in 2005, including nearly $4,000,000 against medical providers. DOL also obtained significant legal rulings in several cases, building a strong foundation upon which future case law interpreting the Insurance Fraud Prevention Act (the Fraud Act)[1] will be based.

In 2005, DOL:

- won a judgment against a diagnostic imaging facility in a ruling that the medical facility violated the Fraud Act by submitting claims while it was not licensed by the Department of Health and Senior Services;
- won a judgment against a national neurodiagnostic testing corporation in a ruling that the general business corporation violated the Fraud Act by submitting claims when it was not owned by licensed physicians, in violation of applicable law;
- defeated motions in the trial court alleging that OIFP's cooperation with insurance carrier victims and its funding mechanism violated equal protection, due process, fundamental fairness, and unlawful delegation of authority provisions of the federal and state constitutions; and
- argued in the State Supreme Court that the preponderance of the evidence is the correct standard of proof for violations of the Fraud Act.[2]

1. N.J.S.A. 17:33A-1 et seq.
2. A decision in that matter is pending.

State v. Fontanella

In a case that required DOL to pursue the violator through state and federal court, DOL obtained a $935,610 civil penalty and $68,910 in attorney fees against Daniel Fontanella, a former Passaic County chiropractor. Fontanella had pled guilty to a single count of second degree theft by deception in a case brought by the Passaic County Prosecutor. In entering his guilty plea, Fontanella admitted that 45 percent of the bills he submitted to insurance carriers during 1996 and 1997 were fraudulent. However, Fontanella resisted the imposition of a civil penalty, and his case was referred to DOL to litigate.

DOL analyzed 441 patient records and prepared a database covering more than 24,000 office visits over a two-year period. The State's analysis disclosed that, on average, Fontanella billed for 57 visits for each patient. His admission that 45 percent, or 11,035 patient visits, had been falsified meant he had received $955,505 in ill-gotten gains, none of which had been recovered by the carriers. Using a PowerPoint presentation, DOL convinced the court of the full extent of Fontanella's fraud, leading to the imposition of an appropriate penalty under the Fraud Act.

Fontanella raised various arguments to avoid imposition of the civil penalty. Fontanella asserted that only the Commissioner of Banking and Insurance, and not OIFP, had standing to bring a civil action in the name of the State. Fontanella further claimed that any civil penalties imposed would not be paid to the benefit

of the State. The Honorable Christine L. Miniman, J.S.C., rejected Fontanella's position, finding that the legislative mandate of the Automobile Insurance Cost Reduction Act of 1998 (AICRA), as well as Governor Whitman's Reorganization Plan which implemented AICRA, effectively transferred the Commissioner's authority to the Insurance Fraud Prosecutor. Judge Miniman also found that since June 30, 2003, all revenues generated by insurance fraud penalties were properly allocated to the General Fund as state revenue rather than for the reduction of debt incurred by the New Jersey Full Insurance Underwriting Association (JUA) and Market Transition Facility (MTF).

Judge Miniman also rejected Fontanella's defense that the civil penalties imposed upon him would constitute an undue penalty in light of the prior criminal prosecution. Civil penalties can be settled in the context of a criminal plea negotiation; but if an agreement cannot be reached, they must be imposed in a separate civil proceeding. The Supreme Court has already determined that this does not constitute "double punishment" under the state or federal constitutions because the civil penalties imposed under the Fraud Act are remedial in nature. *Merin v. Maglacki*, 126 N.J. 430, 440 (1992).

Fontanella also claimed that the $500,000 in restitution that he agreed to pay as part of his criminal sentence, but never paid, was discharged in a Chapter 7 bankruptcy proceeding and that making him pay a civil penalty which would benefit the carriers he defrauded would circumvent that discharge. Judge Miniman found his argument unpersuasive. Fontanella sought to avoid paying both restitution and the civil penalty by filing Chapter 7 and Chapter 13 bankruptcy petitions. The State opposed the Chapter 13 filing and prevailed. The Honorable Morris Stern, Judge, U.S. Bankruptcy Court, ruled that Fontanella's $500,000 restitution obligation was not discharged under Chapter 7, and that the inclusion of that $500,000 debt made him ineligible for protection under Chapter 13. Thus, the court dismissed the Chapter 13 proceeding. As a result, Fontanella is responsible for the $500,000 restitution obligation as well as the $1,004,520 in civil penalties and attorney fees ordered by Judge Miniman.

State v. Prata

DOL Deputy Attorneys General entered into a settlement agreement with Carl Prata who admitted to 57 violations of the Fraud Act and agreed to pay $204,000 in civil insurance fraud penalties. Prata, while employed by Allmerica Insurance Company and St. Paul Insurance Company, issued 57 fraudulent benefits checks to 45 co-conspirators. The face amount of the checks totaled $570,000. Prata was convicted of criminal charges by way of a plea agreement. He was sentenced to five years state prison and ordered to pay $50,000 restitution. Restitution will be paid prior to the payment of the Fraud Act penalty. Forty-two other co-defendants of Prata were prosecuted and entered plea agreements or were admitted into the PTI program. Each of those defendants agreed to pay restitution and signed Consent Orders for civil penalties ranging from $2,500 to $22,500.

State v. Healthcare Integrated Systems, Inc.

DOL Deputy Attorneys General also obtained a significant ruling in the ongoing civil enforcement action against Healthcare Integrated Systems, Inc. (HIS). This matter includes allegations against multiple professional practices, physicians, and corporate officers and board members of this now bankrupt diagnostic imaging entity. On March 18, 2005, the Honorable Charles E. Villanueva, J.S.C., granted OIFP partial summary judgment, ruling that HIS and four related entities had knowingly violated the Fraud Act by making false and misleading statements in bills for medical services submitted to Liberty Mutual Insurance Company. These particular HIS facilities were not licensed as required by the Department of Health and Senior Services. Judge Villanueva ruled that the claims represented that HIS was legally entitled to render health care services and to receive reimbursement for them, and were thus false and misleading statements.[3]

HIS has challenged OIFP's partnership with the insurance carriers who were vic-

Division of Law Deputy Attorney General Steven Smith pours over deposition transcripts in preparation for a court hearing.

3. Allegations that HIS and several other licensed entities billed for services that were not rendered remain to be litigated. A detailed analysis of years of billing records for eight diagnostic radiology facilities and interviews of the employees at each facility are ongoing. Partially completed discovery in this matter has already involved the production of more than 22,000 records.

timized by the fraudulent activity and the coordination of criminal and civil investigations. In response, OIFP has pointed to the legislative mandate underlying the creation of OIFP, namely, to coordinate an aggressive criminal and civil enforcement effort against insurance fraud. To that end, AICRA empowered OIFP to bring together all of the public and private resources available to address the pervasive problem of insurance fraud. This type of case reflects those efforts and fulfills OIFP's statutory mandate. HIS has also challenged the funding of OIFP and the standard of proof under the Fraud Act, claiming that a clear and convincing standard should apply. OIFP prevailed in the trial court on all of these issues.

State v. Medical Alliances, LLC

During 2005, DOL successfully obtained a judgment against Medical Alliances, LLC, a national company headquartered in Illinois; its principal owner, Mitchell Rubin; and a sister company, Neurological Testing Services, LLC. The defendants were ordered to pay $98,700 in civil penalties and attorney fees as a result of their billing for "professional" services rendered in regard to electro-diagnostic testing. The court ruled that these general business corporations violated the "corporate practice of medicine doctrine" and, consequently, violated the Fraud Act when they submitted claims for reimbursement. Organized for general business purposes and not owned by a licensed professional, these entities billed for interpreting neurological testing, much of which may have never been properly performed. They solicited chiropractors in New Jersey, who were not permitted to perform electro-diagnostic testing, with a representation that they could improve their cash flow by "leasing" equipment and technicians, and billing for the "technical" component, in order to share in the insurance proceeds available for such testing. The Illinois Attorney General's Office, equipped with information from a corporate whistleblower, also brought charges against these defendants addressing the widespread fraud they engaged in and the improper control asserted over medical practices by the defendants. DOL joined in the legal action in Illinois which put the defendants out of business and placed multi-millionaire Rubin in involuntary bankruptcy.

Burden of Proof

On October 24, 2005, DOL argued before the New Jersey Supreme Court as *amicus curiae* in the matter of *Liberty Mutual Insurance Co. v. Land* on the issue of the appropriate burden of proof under the Fraud Act. In the 22 years in which the Fraud Act has been in effect, the courts have not definitively resolved the burden of proof issue. Judge Villanueva opined in *Harleysville Insurance Co. v. Diamond*, 359 N.J. Super. 34 (2002), that the clear and convincing standard should apply when a carrier seeks to prove fraud under the Fraud Act. Although Judge Villanueva held in later opinions that the preponderance standard was more consistent with the Legislature's intent and the statutory scheme, the Appellate Division in remanding the *Liberty Mutual v. Land* matter for retrial adopted his *Harleysville* decision as the standard.

According to Insurance Fraud Prosecutor Greta Gooden Brown, the preponderance of evidence standard is the appropriate burden of proof under the Fraud Act. OIFP argued in *Land* that a prepon-

derance of the evidence standard is consistent with the Legislature's purpose to remedy the problem of insurance fraud with tools beyond those available in 1983. It was clear that the ability of an insurance carrier to rescind an insurance policy upon proof of fraud was not enough to address the problem of insurance fraud. The Legislature, and the Supreme Court in *Merin v. Maglacki*, 126 N.J. 430 (1992), identified insurance fraud as being of "massive proportions" and they recognized the need to combat insurance fraud aggressively. In *Merin*, the court held that the Commissioner's interpretation of the Fraud Act was entitled to deference, as it reasonably and substantially effectuated the legislative intent to combat insurance fraud. With the authority to enforce the Fraud Act having been transferred to OIFP, the Insurance Fraud Prosecutor's interpretation of the Fraud Act in this instance is a reasonable and effective means of carrying out the legislative purpose and should also be entitled to the substantial deference accorded to the agency charged with enforcing the Fraud Act.

The application of the preponderance standard is appropriate given the legislative purpose, the absence of any provision imposing a higher burden, the use of the preponderance standard in administrative proceedings, the use of the preponderance standard for the recovery of statutory penalties elsewhere, the use of the preponderance standard in similar legislation addressing the need to protect consumers from fraudulent conduct such as the Consumer Fraud Act, and the existence of the preponderance standard for affirmative defenses to an insurance claim. Liberty Mutual agreed with the State's position that, in the absence of specific language within the Fraud Act calling for a higher standard of proof, the preponderance standard is most consistent with the legislative intent, the purpose of the Fraud Act, and the statutory context.

The New Jersey State Bar Association, also appearing as *amicus*, argued for a clear and convincing standard. Acknowledging that the Fraud Act does not call for a higher standard, the Bar Association nevertheless advocated a higher standard to address its own perception that there is a potential for abuse of the Fraud Act by OIFP and insurance carriers -- although it offered no evidence of such abuse -- and to address the aggressive use, by some carriers, of extrapolation and statistical analysis to estimate the extent of fraudulent conduct. The Bar Association, in a point also disputed by OIFP, claimed that the Fraud Act did not take into account the billing practices of modern medical providers. OIFP's response was that medical providers need to reconcile their practices with the Fraud Act, which has been in place for 22 years. OIFP anticipates an early 2006 ruling from the Supreme Court on this important issue.

DOL achieved success in numerous other cases, including litigation against Scott Schemanski, a former Camden County chiropractor, who was ordered to pay civil penalties and attorney fees totaling $96,060 for continuing to practice after his license lapsed, billing for services not rendered, and other violations. In addition, former Monmouth County podiatrists Lee Frankel and Jonathan Siegel agreed to pay civil penalties and attorney fees of $32,500 and $50,000, respectively, for violating the Fraud Act by billing for services not rendered and submitting false operative reports for podiatric surgery procedures.

DOL's successful civil litigation efforts in 2005 on behalf of OIFP reflect OIFP's commitment to use all weapons available to the State to aggressively confront the problem of insurance fraud, identify fraudulent activity, and sanction the violators.

NOTE: Check the OIFP Web site ***www.njinsurancefraud.org*** for updates on pending court decisions discussed in this article.

John Grady is a Deputy Attorney General in the Division of Law where he serves as the Lead Deputy for the Insurance Fraud Section. A certified civil trial attorney, he was in private practice before joining the Attorney General's Office in 1993.

PETER C. HARVEY
Attorney General o
Attorney for Plain
R. J. Hughes Justi
P. O. Box 083
Trenton, New Jers
By: John C. Grad
Deputy Atto
(609) 896-8
SELECTIVE INSU
OF AMERICA,
and
PETER C. HARVEY
Attorney General of New J
Attorney for Plaintiff
R. J. Hughes Justice Com
P. O. Box 083
Trenton, New Jersey 08
By: John C. Grady
Deputy Attorney G
(609)896-8825
STATE OF NEW JERSEY
Plaintiff,
v.
DANIEL FONTANELLA

ENTERED ON ACMS

FILED
JUN 14 2005
Hon. Charles E. Villanueva

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION -MORRIS COUNTY
DOCKET NO. MRS-L-3571-02

FILED
JUL - 8 2005
CHRISTINE L. MINIMAN
JUDGE, SUPERIOR COURT

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION-PASSAIC COUNTY
DOCKET NO. PAS-L-5181-02

Civil Action

ORDER

Office of the Superior Court Clerk
By Deputy Clerk of the Superior Court
JAN 10 2006

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION
ESSEX VICINAGE

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION- ESSEX COUNTY
DOCKET NO. ESX-L-6216-04

Civil Action

STIPULATION OF SETTLEMENT
IFD#01-00866-25

The New Jersey Insurance Industry's Perspective on Emerging Fraud Trends

Introduction by John Butchko

Insurance fraud schemes are constantly evolving as insurance cheats develop new scams to avoid detection. Traditionally, the anti-fraud community has been "fighting the last war," striving to keep pace with these cheats who quickly alter or move on to a new scheme. Identifying new trends as soon as possible has become an essential element of New Jersey's comprehensive fraud detection strategy. Once new fraud schemes and trends are identified, this information must be shared with all entities responsible for combating insurance fraud, both public and private, so that the entire anti-fraud community can take the proper steps to confront these new challenges.

The insurance industry, on the front lines of this war, has become adept at identifying new and emerging fraud trends before they inflict significant economic damage. The Office of the Insurance Fraud Prosecutor (OIFP), through its philosophy of collaboration and cooperation, continues to work together with the industry to recognize and defeat the scams. In this article, recognized insurance fraud experts report on the newest trends and schemes which they see impacting New Jersey's insurance marketplace. Their insights and continuing efforts to combat insurance fraud are invaluable.

PIP/Ambulatory Care Facilities

by Kenneth Pringle

Ambulatory Surgery Centers (ASCs) are increasingly being used as a conduit through which some unscrupulous medical providers are exploiting automobile insurers' obligations to PIP claimants, while the attorneys that refer those PIP claimants are increasing the value of their casualty claims. Ironically, ASCs were authorized by the Legislature under the theory that such out-patient facilities would provide a less costly alternative to hospitals. Unfortunately, in the hands of greedy owners, ASCs can be a tool to exploit and overbill insurance companies.

New Jersey recognizes two categories of ASCs: centers that have two or more operating rooms and, therefore, must be licensed by the Department of Health and Senior Services (DHSS); and ASCs with one operating room, which are not required to be licensed and are not regulated by DHSS. Licensed ASCs are required to be certified by Medicare and to comply with applicable Medicare guidelines. As in the case of DHSS-licensed MRI facilities, licensed ASCs need not be owned by a plenary licensed physician, but must have a medical director. Although one-room operating facilities are exempt from DHSS' regulations, the exemption in N.J.A.C. 8:33-6.1(d) permits one-room operating room facilities only where services are provided by a physician in his or her private practice. The theory underlying this exemption is that the operating room is an extension of the physician's private practice. The reality, however, is that the original owners of these one-room unlicensed ASCs sometimes open these facilities to non-owners for the purpose of performing pain management and other

procedures under anesthesia. These procedures are sometimes billed at excessive rates by the medical provider. The ASC in turn bills a "facility fee" for each service provided. Where the owner of the facility, i.e. the professional for whose practice the operating room is supposed to be an extension, is not a participant in the procedures, neither the professional nor the facility fee is permitted.

For example, insurance companies are seeing two significant abuses in licensed and unlicensed ASCs. One of the more common scenarios involves Manipulations of the Spine Under Anesthesia, commonly referred to as MUA. These services are performed by a chiropractor with the assistance of an anesthesiologist. The chiropractors typically charge $450 for the procedure, while the anesthesiologist charges one to two times that amount. Some of these chiropractors have loose associations with pain management physicians, who administer an epidural injection or nerve block and trigger point injections while the patient is under anesthesia. The total duration of the combined procedures typically does not exceed 10 to 15 minutes. Yet, because of the involvement of multiple providers, and separate charges for facility fees, insurance companies are often billed in excess of $5,000 to $6,000 for what appears to be a series of services which occur in the space of 15 minutes. In addition to unbundling services, some providers submit bills using higher-value CPT codes that are reserved for more complex procedures, misleading insurers as to the value of the services the provider actually performed.

Another increasingly frequent scenario involves the licensed ASCs. In addition to overbilling schemes used in some one-room centers, some licensed ASCs have begun performing more invasive procedures on no fault claimants, including endoscopic disc spinal procedures. The owners of these facilities are typically anesthesiologists, orthopedists, and neurologists who refer their own patients to the facility for these invasive procedures. Typically, the primary physician invites a co-surgeon to participate in the procedure under the guise that another physician is necessary. Sometimes this surgeon is the same physician who provided a "second opinion" on the need for the surgery. Because these procedures are performed under anesthesia, there is an additional charge for anesthesia. The facility also typically adds a facility fee equal to 120 percent of the corresponding charges billed by the physicians. By unbundling and upcoding their bills for the services they perform, such ASCs will bill as much as $30,000 to $40,000 for a procedure that lasts 20 to 30 minutes.

Kenneth Pringle, Esq., is Managing Partner in the law firm of Pringle, Quinn, and Anzano, Esqs., in Belmar, NJ, and General Counsel to the New Jersey Special Investigators Association.

Insurance Fraud Prosecutor Greta Gooden Brown (c.) presents OIFP's Annual Excellence in Investigation Award to Skyland Insurance Company's Special Investigations Unit.

Health Insurance Application/Enrollment Fraud - The Silent Fraud

by Douglas Falduto

Traditionally, health care fraud has been primarily defined as physicians or medical professionals/facilities billing for services that were never provided, billing for a level of service higher than what was provided, or billing for services that were never needed. Conferences on health care fraud focus predominantly on the few bad apples in the medical profession who commit this economic crime.

However, there is another type of fraud committed against the health care system that does not carry the sensationalism of medical fraud: application and enrollment fraud. Application/enrollment fraud is a significant problem that costs New Jersey insurance companies, and subsequently subscribers, millions of dollars each and every year. The overall impact of health care fraud and abuse is not just in the expenditure of an insurance company's dollars to pay these claims. These costs are passed on to covered groups and individuals in the form of higher premiums.

Individuals are being asked to make substantial contributions to the cost of their health care. In an effort to obtain reasonably priced insurance that covers a

NJSIA President Paul Gallo, N.J. Insurance Council of New Jersey President Magdalena Padilla, Insurance Fraud Prosecutor Greta Gooden Brown, and OIFP Liaison Section Chief John Butchko participate in the 8th Annual Insurance Fraud Summit.

broad range of services, some individuals resort to committing application fraud. Application fraud takes on several different forms: it can be the small employer group owner who covers a relative or close friend who does not actually work for the group or an individual consumer who falsifies his primary residence in order to maintain coverage in New Jersey.

Enrollment or application fraud can be prosecuted criminally. In addition, the New Jersey Insurance Fraud Prevention Act, N.J.S.A. 17:33A et seq., defines this type of fraud as an "act by any person who makes or prepares any written or oral statement, intended to be presented to any insurance company or producer for the purpose of obtaining an insurance policy, knowing that the statement contains any false or misleading information concerning any fact or thing material to an insurance application or contract." "Any person" can include a broker who secures coverage with a carrier for a group or individual, the group manager who supplies the information to the insurance company, or the consumer who submits an application for coverage and fails to make accurate disclosures.

Some examples of the types of frauds that fall into this category are:

- Individuals who obtain or maintain a Direct Enrollment Consumer policy while not residing in New Jersey a majority of the year;
- Individuals who are placed on a Direct Enrollment Consumer policy by their Corporate and/or Administrative Services Only (ASO) employer in order to avoid responsibility for anticipated significant medical expenses;
- Individuals who place an ineligible party on the policy as a dependent;
- Enrollment of an individual who is not employed by the business;
- Creation of a fictitious business in order to obtain a Small Employer Health Plan for otherwise unrelated and ineligible parties;
- Selective enrollment of "family members" with no offer of enrollment to the bona fide employee population.

The ease with which application and enrollment fraud can be committed and the growing number of uninsured individuals throughout the State and the country are a high-risk combination, which should not be overlooked by the fraud-fighting community. Experience has proven that the primary reason this fraud is perpetrated is to secure health care coverage for someone who needs it but otherwise could not afford or procure it legitimately. The advances in technology and the ability to purchase insurance coverage over the internet have also made this a crime of opportunity and much more difficult to detect. Aggressive training, monitoring, investigating, and communication with the broker community will assist in minimizing the risk; however, until there is some relief in the skyrocketing costs associated with health care coverage, this will always be a crime that New Jersey and this country will have to tackle.

Douglas Falduto is the Director of the Special Investigations Unit, Horizon Blue Cross Blue Shield of New Jersey, Newark, NJ, and serves on the Board of Directors of the National Health Care Anti-Fraud Association.

Life Insurance Fraud Trends

by Michael M. McFarland & Daniel T. Marsano

Historical life insurance fraud continues to evolve, aided by new markets, the growth of technology, and greater globalization. Material misrepresentation at the time of application and forged or phony death certificates, medical records, and other documentation, all play their customary roles in various insurance fraud schemes. While life insurance fraud once was more of an individual endeavor, insurers now face organized groups who are educated in insurance law and savvy in their determination and execution. While the schemes remain basically the same in these arenas, the sophistication is much greater and insurers are challenged to keep up by continually developing new and better strategies to combat them.

With the emergence of the recent concepts of Stranger Owned Life Insurance (SOLI) and Investor Owned Life Insurance (IOLI), the industry now finds itself faced with a new area of concern. These concepts by themselves are not fraudulent but they do present a greater risk for fraudulent behaviors due to the potential financial benefits for multiple participants in the transaction.

With SOLI and IOLI, the intent from the point of sale is to invest in the life (or death) of the individual being insured. The four players in this type of transaction are an agent, a secondary market organization that purchases in-force life insurance contracts (settlement company), a lender making funding available to the settlement company, and the owner of the contract to be written. This is typically a legal vehicle, such as an LLC or a trust.

The agent solicits the sale of life insurance to an individual whose life is insurable and who has a reasonable need for insurance. The life insurance is free to the insured for a period of two years. This "free insurance" is accomplished by the settlement company using non-recourse funding from the lender to pay the premiums. There may be some financial inducement to the individual to convince him/her to participate as the insured.

If the individual dies during that two-year period, then his/her beneficiary will be paid the death proceeds minus the costs. Costs consist of the loan principal amount, any and all compounded and accrued interest, and administrative fees. If the individual does not die during the two-year period, then he/she is given a choice to keep the insurance by repaying the costs and assuming premium-paying responsibility or to sell the insurance to the settlement company and be done with it. The sale price at that time would be the present value of the death benefit minus the present value of the future premiums the settlement company will have to pay until the insured's death, minus the settlement company's commission and other costs, and the amount of money needed by the settlement company to achieve its target investment return. Once the settlement company owns the contract, it may hold it for its own investment purposes or pool it with other contracts, securitize the pool, and sell shares to investors.

The financial reward to the agent is more lucrative than the simple life insurance sale itself. A commission will compensate the agent; and then at the end of the two-year period, the agent will broker the sale of the contract to the settlement company, receiving another commission of up to 5 percent of the face amount. In many cases the agent will then sell another life insurance contract to the insured person and is compensated a third time. If both policies continue in force, the agent will also receive renewal commissions on both policies.

The overwhelming majority of agents and consumers are honest. However, the potential for large financial rewards for both the agent and the consumer increase the likelihood that some will engage in fraudulent activity. Unscrupulous agents may misrepresent, withhold, or manipulate specific details of the sale and ownership in order to avoid the underwriter's scrutiny and declination of the application. By hiding the actual intent to make it a SOLI/IOLI contract, the agent may acquire the policy as a term contract. Then, at a future point within the two-year period, the agent will convert it to a permanent contract and collect an additional commission.

Fraud involving SOLI/IOLI may be compounded by another fraudulent activity known as "Clean Sheeting," a scheme where the individual being insured conspires with the agent to deliberately withhold or misrepresent pertinent information about the insured's medical history that would have a direct impact on the pricing of the contract. Without the benefit of this medical information, the underwriter will unknowingly underprice the policy, significantly improving the investment returns of the ultimate owner.

The larger the contract, the higher the compensation throughout the various sales involved in the end-to-end transaction. The more underpriced the policy at issue, the higher the ultimate investment returns. This is a powerful combination that can result in medical and financial records being entirely fabricated by the agent and/or others. Medically impaired individuals suddenly have no medical history at all. Healthy stand-ins are examined to fool the underwriter. Word processors and spread sheets are utilized to create entirely false financial documents that appear to be CPA statements attesting to the multi-million dollar net worth of the individual being insured. The agent is compensated as noted above. The individual being insured receives a financial inducement for participating in the scheme, and the settlement company will ultimately receive an investment return much larger than it should have since the contract face amount is both inflated and underpriced.

This newest scheme has been the most daunting to the life insurance industry. Complicated by its blend of marketing ingenuity with great financial profit-

ability, it can be very difficult to detect without an increased sentinel approach. The onus upon the insurer to conduct a thorough verification of the information provided at the time of application is greater than ever. Preventing the fraud at point of inception and prosecuting it whenever possible is essential to stopping this newest trend to hit the industry.

Michael M. McFarland is Vice President of Life Underwriting for The Prudential Insurance Company of America, Newark, NJ.

Daniel T. Marsano is Vice President of Special Investigations for The Prudential Insurance Company of America, Newark, NJ.

Emerging Trends in Property Fraud

by Frank P. Brennan

Emerging trends in property insurance fraud can best be categorized as a re-emergence or resurgence of some of the classic forms of individual opportunistic frauds. For example, insurance carriers are experiencing a significant increase in insureds providing fictitious and oftentimes constructed proofs for losses to increase reimbursements for otherwise legitimate losses.

Insurance companies have seen instances of insureds who fall outside the parameters of the typical fraudster and who would not be expected to raise red flags in the course of adjustment of a property claim. Whether by design or encouragement, the unscrupulous insureds are creating claims and documentation in support of claims that rise in some instances to the level of the absurd.

Claims denied and disclaimed due to material misrepresentation are increasing, especially in claims for otherwise legitimate losses. Some cases involve assistance from third-party vendors who may have "encouraged" insureds to exaggerate their content, building, and even Additional Living Expense (ALE) claims. Other times insureds have attempted to increase their reimbursement based solely on the opportunity presented when a proof of loss is requested by the carrier.

These frauds are often more difficult to detect due to the nature of the underlying loss and the existence of an atypical offender. These are insureds who are not in dire financial straits, are not facing a significant impending crisis, and are not being driven to commit an act otherwise "out of character."

Insureds' claims have been denied when they produced receipts for content replacement purchases made overseas that were proven to be forged, as well as for "creating" ALE expenses with the aid of other professional friends or aides willing to provide false documentation. Although the incidence of manufactured losses in the form of staged burglaries, arson, and auto "give ups" has not ceased, it has not been as prevalent as padded losses.

The arrogance of the "someone owes me" attitude is eclipsed only by the "prove I'm lying" response that is becoming commonplace in many of these claims. Nowhere is this more evident than when an insured completes a sworn proof of loss for items lost in a theft that were not available on the market at the time of the loss, or when an insured claims ownership of personal effects in excess of $300,000 which are all brand new, purchased with cash, and for which not a single receipt is available or produced.

The combined efforts of company SIU and law enforcement investigators, as well as thorough questioning of these questionable claims stems the tide of these frauds. Carriers are pursuing investigations and completing the ground work, including demanding sworn statements and other proofs, prior to making appropriate referrals to OIFP. Demanding that the claimant prove his/her ownership and possession is critical to defending these claims and pursuing the appropriate corrective action as opposed to capitulating to the old school wisdom that you cannot "prove a negative" which allowed these claims to be paid in times past. As with all aspects of insurance fraud today, an aggressive stance and treatment is critical to the fight against fraud.

Frank P. Brennan, Esq., is Chairman of the SIU Litigation Section for the law firm of Marshall, Dennehey, Warner, Coleman & Goggi, Esqs., Cherry Hill, NJ.

Workers' Compensation Application Fraud

by Neil Johnson

During the past decade, insurers, law enforcement officials, state and local governments, and industry groups have marshaled their resources to identify and combat fraud, trying to keep pace with what some call "the fraud amoeba," or the new and old scams that threaten the insurance industry. Today, premium fraud is a growing segment of the insurance fraud problem. Within the premium fraud segment, workers' compensation (WC) premium fraud is most frequently committed. WC premium fraud occurs when companies alter one or more component of the WC formula in an effort to lower their premium costs. To understand how this might work, let's take a look at the way in which WC premiums are calculated.

Premiums are determined by the following variables:

- Classification - Each industry varies as to its risks and practices. Employers within the same industry are grouped into the workers' compensation classification that best describes the overall business.
- Rates - Each classification possesses a rate of "loss cost," which reflects the amount of premium that must be collected to cover future expected losses within that classification as a whole. Rates are determined by using historical data collected for each state by a rating organization. Rates vary by state, just as benefits vary by state.
- Payroll - The employer's anticipated payroll for the period of coverage is used as the basis for calculating the employer's initial premium. The payroll is allocated to the appropriate classification code and the rate for that classification code is applied per $100 of payroll. At the inception of the policy, the initial payroll is estimated. Actual payroll amounts are determined upon expiration of the policy. The employer is required to maintain books and records that allow the insurer to determine the actual payroll during the policy period. The employer is also required to make such books and records available for audit.
- Experience Rating - Experience rating adjusts the cost of workers' compensation insurance to match the claims history of the individual employer.

While policyholders have no influence over rates, they are in full control of the reporting of exposure units, for example, the number of employees in a location or vehicles in a fleet. It is by altering exposure units that WC premium fraud is perpetrated. Some of the deceits used by insureds include misclassifying employees, understating payrolls, making payments off the books, setting up separate companies to pay employees, reincorporating in states with lower workers' compensation rates, or coding employees as independent contractors. In addition, some employers achieve a lower experience modification factor by paying small workers' compensation claims to exclude these claims from their experience. This artificially lowers their loss experience, illegally lowering the ultimate premium.

While the impact of such dishonesty may seem limited to insurers, premium fraud has a trickledown effect on insureds, for whom fraud can have financial and competitive implications. The frontline of defense for insureds should be their insurance carriers. As part of their due diligence in purchasing WC or other coverages, insureds should learn about the organization, practices, and reputation of their carriers' fraud-fighting activities. Together we can help fight the fraud that raises costs for honest policyholders.

Neil Johnson is Assistant Vice President and Manager, Special Investigations Unit-Involuntary Market Services, Business Market, Liberty Mutual, Boston, MA.

Who Commits Insurance Fraud in New Jersey?

With possible exception of murder and drug abuse, no serious crime attracts as wide a variety of perpetrators as insurance fraud. People who would never think of robbing a bank, stealing a car or burglarizing a home can find the temptations of "easy money" from insurance fraud hard to resist.

The files of the Office of Insurance Fraud Prosecutor demonstrate that Insurance Fraud is crime committed by people in a wide range of occupations.

Insurance Fraud

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The insurance industry, on the front lines of this war, has become adept at identifying new and emerging fraud trends before they inflict significant economic damage. The Office of the Insurance Fraud Prosecutor (OIFP), through its philosophy of collaboration and cooperation, continues to work together with the industry to recognize and defeat the scams.

LOCK
UN
LOCK

OIFP Foils Innovative Auto Theft Schemes

by Jarek Pyrzanowski and Christina Runkle

According to the New Jersey Uniform Crime Report for 2004, vehicle theft decreased 3 percent nationally and 13 percent in New Jersey last year.[1] Although total thefts were down, insurance fraud investigative agencies at all levels witnessed a significant increase in organized auto theft rings specializing in Vehicle Identification Number (VIN) cloning, or motor vehicle identity theft.

This scheme can best be explained in terms of the crime of personal identity theft, where a criminal steals the name and numerical identifiers (e.g. Social Security number or date of birth) of an individual, enabling the criminal to appear to be someone else and exploit the situation for profit.

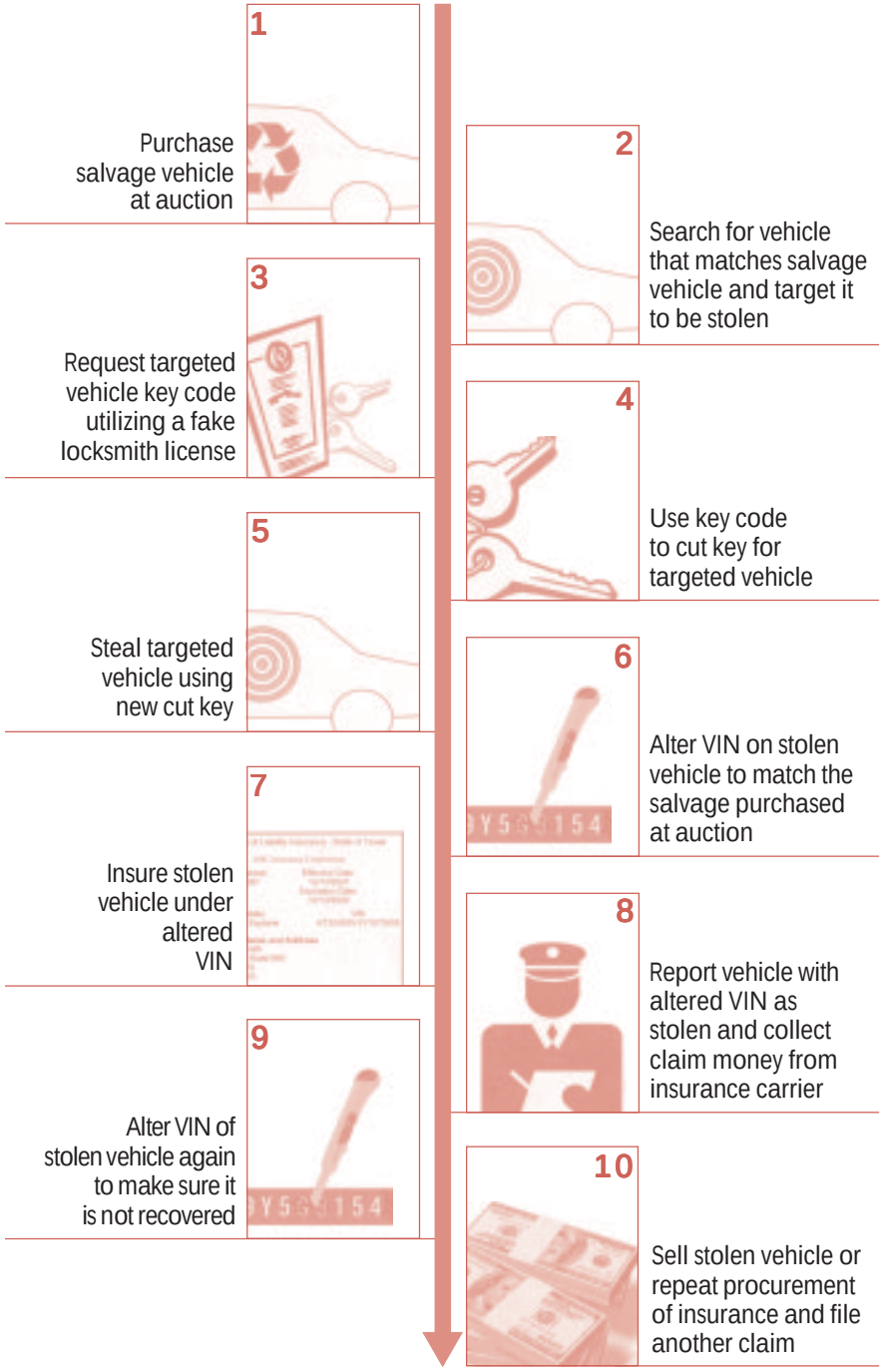
In a typical motor vehicle identity theft case, or cloning, a criminal steals the VIN of a dealership-owned vehicle or a privately owned vehicle parked in a dealership, mall, or commuter lot. The criminal steals the VIN identity by copying the actual digits of the VIN from the vehicle itself or, in the case of a dealership-owned vehicle, by accessing the dealership Web site and copying the VIN from the dealership vehicle listing. Next, the criminal steals a similar vehicle and replaces the VIN of the stolen vehicle with a copy of the VIN taken from the dealership or privately owned vehicle, thus creating a clone VIN. This switch results in two vehicles with the same VIN. Essentially, the stolen vehicle disappears because its VIN identity marker has been replaced with a VIN from a non-stolen vehicle. The criminal operatives then finish the transformation process by obtaining fake ownership documents, or authentic documents using falsified information. The stolen cloned vehicle is then sold to an unsuspecting buyer, either through a used car dealership, a newspaper advertisement, or an online auction.

In fact, the National Insurance Crime Bureau (NICB) deemed the growth of the practice and associated costs critical enough to institute a bureau-wide vehicle cloning initiative in 2004, which tactically and strategically dissected the phenomenon. According to NICB, criminals profit over $12 million each year through vehicle cloning and average a net profit of $30,000 for each vehicle they clone.

Recent New Jersey Office of the Insurance Fraud Prosecutor (OIFP) investigations have revealed VIN cloning operations, with slight variations from the norm. In one case, auto thieves stole two similar high-end vehicles and replaced the VIN of the less expensive vehicle with the VIN of the more expensive one. With both vehicles appearing to have the same identity, the least expensive vehicle was parked on the street to facilitate its recovery by local police. The police were tipped to the abandoned vehicle by an "anony-

1. The FBI's Uniform Crime Report (UCR) estimated the total value of vehicles stolen in the United States at $7.6 billion in 2004. New Jersey UCR statistics placed the total value of motor vehicles stolen in the state at $251.2 million. (UCR 2004).

Key Code/Vehicle Theft Activity Flow Chart



mous" caller, who was later revealed to be a co-conspirator. By recovering the less valuable vehicle and removing the stolen VIN from the National Crime Information Center (NCIC) database that tracks stolen vehicles, the police inadvertently helped to disguise the stolen cloned, more expensive vehicle for the theft ring. The police action effectively cleared the more valuable of the stolen vehicles for resale. In this particular case, the vehicle was slated to be shipped to the Dominican Republic.

In another twist on the scheme, OIFP investigators uncovered the use of VIN numbers from Canadian vehicles to re-tag vehicles stolen in this state. Criminals are well aware that an integrated registration system does not exist to link the vehicle registration databases among the 50 states, Canada, and Mexico. They use law enforcement's limited ability to match stolen vehicle VINs and other identifiers over multiple jurisdictions to their advantage.[2]

In 2005, OIFP completed Operation VINSwap, the investigation and prosecution of vehicle cloning ringleader Antonio Rodriguez-Baez. In August 2004, he was indicted by a State Grand Jury and charged with leading an automobile theft trafficking network, conspiracy, receiving stolen property, and making alterations to motor vehicle trademarks and/or identification numbers. The indictment detailed Rodriguez-Baez's (a/k/a "Tony" Eladio Reyes, and/or Jaime Rodriguez) alleged purchase and resale of stolen automobiles and how he conspired with others to organize, supervise, finance, and manage his Jersey City-based auto theft ring.

On April 22, 2005, Rodriguez-Baez admitted in court that he had served as the leader of an automobile theft trafficking network, a second degree offense. Two of his co-conspirators, Elias Retamar[3] and Lim Y. Bances[4] also pled guilty and were sentenced for their role in this operation. In September 2005, Rodriguez-Baez was sentenced to four years state prison and ordered to pay in excess of $123,500 in restitution to three insurance carriers: State Farm, AAA Mid-Atlantic, and Motors Insurance.

In his plea allocution, Rodriguez-Baez acknowledged his involvement in the theft and/or VIN and title alteration of the ten vehicles listed in Chart #1. A comparison of the pairs of Mercedes Benz vehicles reveals that the VIN switch to clear the "background" of the more expensive vehicle in each pair would have permitted the auto thieves to resell vehicles with a combined value of $157,000.

Operation VINSwap and other ongoing OIFP investigations have revealed several other innovative auto theft methods currently being used by professional car thieves. These methods include key swaps, key code acquisitions, theft of valet keys, and vehicle theft via identity theft. These schemes, which are briefly discussed in the following sections, are significant in that they may enable thieves to thwart factory-installed anti-theft devices and transponder-equipped keys. They also compromise protections offered by some after-market security devices.

Key Swaps

A key swap occurs when an auto thief switches a dummy key with an original key at a dealership, without a salesperson's knowledge. In most cases, a thief will switch the real key for a fake one in the palm of his hand, while pretending to test radio or temperature system controls. With the real key in his possession, the thief can return at a later time to drive the vehicle off the lot personally, or hire someone to do it for him. Criminals benefit from the lapse of time between the theft of the vehicle and dealership quarterly inventories of their lots, and/or the discovery by law enforcement that the vehicle has been stolen.

Key swap specialists possess extensive knowledge of the vehicle brands and models that they want to steal, the location of dealerships with desirable vehicles in their inventory, and how these particular dealerships operate. These operatives use dealer Web sites to research stock information and the VINs of targeted vehicles. In some cases, they take advantage of "insider" information, or personally conduct a physical surveillance of targeted dealerships. In this manner, they learn where the keys are kept in the showroom and how they are secured. Key swaps usually involve high-end vehicles that are almost impossible to steal without a key. Thieves may disconnect the anti-theft devices and park vehicles suspected of being equipped with after-market security devices on the street for a "cooling off" period in order to avoid detection.

2. NICB has agreements with law enforcement agencies in Mexico. NICB recently dedicated additional personnel to its recovery and repatriation efforts with Mexico, various South American countries, Russia, and Italy as part of its Vehicle Cloning Initiative. (NICB 2004 Annual Report: The Road Less Taken)

3. In April 2004, Elias Retamar pled guilty to an accusation charging him with attempted theft by deception and receiving stolen property. In pleading guilty, Retamar admitted that he was in the business of "re-tagging" stolen vehicles for sale on the street. In June 2004, he was sentenced to three years probation.

4. In October 2004, a Union County Grand Jury indicted Lim Y. Bances and charged her with attempted theft by deception and tampering with public records or information. Allegedly she had falsely reported her 2002 Nissan Altima stolen to the Elizabeth Police Department and subsequently filed a fraudulent theft claim. In February 2005, she pled guilty to the tampering with public records or information charge. In July 2005, she was admitted to the Pre-trial Intervention (PTI) Program.

Key Code Acquisitions

High-end vehicles are also are stolen from new car dealerships through fraudulently obtained key codes. Manufacturers create key codes to correspond with VINs. The manufacturers and key code database companies contract with locksmiths to cut keys for customers who have lost their keys or have locked themselves out of their vehicles. As long as the key codes are provided to legitimate locksmiths and are used for their intended purpose, the system works fine. Unfortunately, criminals either pose as locksmiths or acquire locksmith equipment and fraudulently obtain key codes. They then simply cut keys for the vehicles they want to steal from dealerships.

Vehicles stolen in this manner can easily be re-tagged, insured, registered, fraudulently reported stolen, and/or resold several times over. OIFP investigators have seen a trend toward the sale of these vehicles on internet vehicle auction sites. Most internet auction Web sites have experienced security staff who cooperate with law enforcement and check the VINs of all vehicles put up for auction. However, these vehicles are not physically inspected, so stolen re-tagged vehicles can slip through the security net. Some auction sites provide fraud insurance protection.

Valet Key Thefts

Many high-end vehicles come with valet keys, which are provided by manufacturers as a convenience in the event a key is misplaced. Some manufacturers provide this spare key in the owner's manual. Many owners neglect to remove the spares from the glove compartment, which can turn an intended convenience into a disaster if the vehicle is targeted by thieves. Vehicles known to come with valet keys have become prime targets for auto thieves who break into these vehicles in commuter lots or shopping malls to search glove compartments for the keys. Vehicles found to contain valet keys can be stolen, re-tagged, shipped overseas, and resold at a substantial profit.

Vehicle Theft via Identity Theft

In cases of vehicle theft via identity theft, a criminal assumes another person's identity through the theft of personal information and the production of counterfeit forms of identification, such as drivers' licenses and Social Security cards. OIFP investigations have revealed auto rental firms to be a prime source for the theft of personal information from rental invoices or via associates working at the counters. The criminal then uses the fake identity to secure a vehicle loan, usually for a lease with high monthly payments. He or she makes the initial lease payment and drives the vehicle from a dealer's lot, as a seemingly legitimate lessee. Once in possession of the vehicle, the thief proceeds to sell the vehicle for profit, through re-tagging or cloning.

Conclusion

The increase in vehicle thefts through cloning, key swap, key code, valet key, and identity theft schemes has not been limited to New Jersey. The NICB vehicle cloning initiative of 2004 has helped focus national attention on a scheme that has cost consumers and insurance carriers millions. OIFP investigators have uncovered several auto theft networks in which cloning, re-tagging, and the various "key" schemes are commonplace. Internet auctions and online dealership inventory searches are also standard operating procedures for these car thieves. While inroads have been made through investigations and prosecutions completed during 2005, ongoing OIFP investigations offer the potential for the interdiction of even larger-scale criminal networks during 2006.

Law enforcement, motor vehicle manufacturers and retailers, anti-theft device developers, insurance carriers, and internet auction sites will continue to adjust their investigative strategies, vehicle and product designs, and operating and hiring procedures in an attempt to thwart the exploitation of their products and services by organized criminals for profit. While these changes may prevent or minimize the use of valet keys, key codes, key swaps, and similar schemes by auto theft rings, such adjustments offer only temporary solutions. Criminals can be counted upon to modify their tactics in response to law enforcement, insurance, and auto industry anti-theft inroads. Our challenge is to be more innovative and technologically savvy than the organized auto thieves, so that we can identify and promptly disrupt the next set of motor vehicle theft schemes.

Jarek Pryzanowski is a Division of Criminal Justice State Investigator with the Auto Fraud Unit of OIFP. He has been with the Division for six years. SI Pryzanowski is a member of the Essex and Union Auto Theft Task Force. He lectures on auto theft and auto insurance fraud issues.

Christina Runkle has been an Administrative Analyst with the Division of Criminal Justice OIFP's Case Screening, Litigation and Analytical Support Section for five years. She previously served 18 years as a Principal Intelligence Research Analyst with the New Jersey State Police. She is a Certified Criminal Analyst and a member of the International Association of Law Enforcement Intelligence Analysts (IALEIA).

Operation VinSwap Vehicle Histories

	Vehicle Make, Model and Values	Method of Theft	Location Stolen and Recovered	Altered VIN?	Notes
	2000 Mercedes Benz S430; **$46,600**	Burglary at Dealership	Queens, NY; Jersey City, NJ	Yes	Cloned to S500 recovered at the Port in Elizabeth
	2001 Mercedes Benz S500; **$67,500**	Key Swap	Long Island City, NY; Port Elizabeth, NJ	No – *Clone of 2000 Mercedes S430*	Attempted to ship to Dominican Republic
	2004 Cadillac Escalade EXT; **$60,000**	Key Code	Ewing Twp., NJ: Possession at time of arrest	No Counterfeit VIN and Title	Re-tagged for re-sale to unsuspecting buyer
	2002 Mercedes Benz S500; **$55,000**	Key Swap	Mercedes Benz of Cherry Hill, NJ; Jersey City, NJ	Yes – *to match 2002 Mercedes S55*	Vehicle returned to dealership
	2002 Mercedes Benz S55; **$90,000**	Theft from commuter lot	Greenwich, CT; Possession at time of arrest	No	Vehicle VIN matched that of less expensive MBS500 – *Slated to be shipped overseas for re-sale*
	2002 BMW; **$70,000**	Key Swap	New York, NY; North Bergen, NJ	No – *Counterfeit VIN and Title*	Re-tagged for re-sale to unsuspecting buyer
	2000 Lexus RX 300; **$38,500**	"Give up"	New York, NY; North Bergen, NJ	Yes	Re-tagged for re-sale to unsuspecting buyer
	2001 Ford Mustang GT Convertible; **$18,800**	Possible theft of valet key	Secaucus, NJ; North Bergen, NJ	Yes	Re-tagged for re-sale to unsuspecting buyer
	2002 Toyota Camry; **$19,500**	Possible theft of valet key	New York, NY; North Bergen, NJ	Yes	Re-tagged for re-sale to unsuspecting buyer
	2003 Acura 3.2TL; **$29,000**	Possible theft of valet key	New York, NY; North Bergen, NJ	Yes	Re-tagged for re-sale to unsuspecting buyer
Total Value:	**$494,900**				

Hot on Their Paper Trail: OIFP Prosecutes Health Insurance Cheats

Hot on Their Paper Trail:

OIFP Prosecutes Health Insurance Cheats

by Peter Lee

How do you prove your case when some of your best witnesses are either dead, incompetent to testify, or nowhere to be found? This question was one of many questions that were successfully answered by the Office of the Insurance Fraud Prosecutor (OIFP) in health care claims fraud cases during 2005. In recent years, as much as $85 billion - or 5 percent of total U.S. annual health care spending - was estimated to have been lost to health insurance fraud.[1] While the financial rewards are obvious, the attraction of health care claims fraud for many criminals is based on the myth that these rewards can be obtained with little effort and with few consequences. Health insurance fraud criminals believe they can hide from prosecution behind a thicket of paperwork. Convictions obtained by OIFP in 2005, however, go a long way toward turning this notion on its head for would-be criminals.

Health care claims fraud cases present unique challenges for investigators and prosecutors. With literally little more than the stroke of a pen, criminals can steal millions from unsuspecting victims. Unlike many other crimes, these cases rarely involve the types of evidence that constitute a "smoking gun" in the eyes of a jury. Proving health care fraud charges at trial brings another set of challenges. Maintaining "jury appeal," for example, can be a daunting task when the prosecution is faced with explaining complex medical and insurance issues.

The ability to navigate the paper trail is frequently the key to unlocking the mysteries of health care claims fraud investigations. In practical terms this means spending the time and effort to track down and analyze the necessary documentation. Building on the available documentation, investigators and prosecutors can then assemble an intricate chain of proofs using a variety of evidence. Even before charges are filed, investigating health care claims fraud often means wading through a mountain of insurance claim forms, medical files, financial records, and interviewing many witnesses. In the process, investigators and prosecutors must master the complex terminology and practices of the health care and insurance industries. Assistance from expert witnesses in the relevant field also can be a prerequisite to bringing charges. At trial, such meticulous investigation must be distilled into a thoughtful presentation of evidence in order to obtain convictions.

State v. Clark

In 2005, nothing better illustrated the rewards of such efforts than OIFP's successful prosecution of *State v. James Clark*. Clark was the owner and operator of Home Health Care Center, Inc. (HHC), a Hoboken-based business that

1. Estimate for 2003 by the Blue Cross Blue Shield Association.

delivered prescription medications from pharmacies to people's homes. Clark's fraud focused on people who required daily medications to treat chronic illnesses, such as asthma. Clark offered to fill the prescriptions of his customers and to have the medications delivered to their homes at no charge. All of the patients targeted by Clark were insured under the State Health Benefits Plan that was administered by Horizon Blue Cross Blue Shield of New Jersey. Clark would fill the prescriptions at a local pharmacy or through a mail order prescription service by paying for the medications himself at full cost. By paying the costs himself, Clark prevented the patients or pharmacies from submitting claims to the insurance carrier for the costs of the medications. Clark, however, would submit claims to the insurance carrier seeking reimbursement as the "supplier" of the medications under provisions of the State Health Benefits Plan. The claims submitted by Clark were enormously inflated over what he actually paid for the medications. Although Clark falsely represented that he was licensed in order to get payment from the insurer, neither he nor HHC was ever licensed to dispense or sell prescription medications.

When the *Clark* case went to trial, the State's prosecutor faced a considerable evidentiary challenge in finding patients who were able to testify. Many patients whose prescriptions were used by Clark in the fraud were either dead, suffering from Alzheimer's disease, or could not be found. Only three patients actually testified against Clark at trial. Despite this difficulty, the State's prosecutor presented overwhelming evidence, including testimony from available patients, the State's primary investigator, pharmacists, an insurance claims analyst, a billing agency representative, an expert witness on procedures for filing health insurance claims, and records from the insurance carrier and pharmacies.

The State presented evidence at trial that Clark had submitted 400 fraudulent claims to Horizon, including approximately 330 claims for medications that were never dispensed or delivered to patients. Clark received payments worth $343,000 from the State Health Benefits Program for the fraudulent claims. The primary case investigator uncovered these fraudulent claims through a painstaking analysis of the pharmacies' records and HHC's claim forms. His analysis revealed not only that the prescriptions had not been filled by the pharmacies, but also that they *would not have been filled* by the pharmacies because subsequent claims for the same medications had been submitted before the medications were due to be refilled.

The jury returned a verdict, finding Clark guilty of all three charges in the indictment: two counts of second degree theft by deception and one count of second degree Health Care Claims Fraud. On April 1, 2005, Clark was sentenced in the Essex County Superior Court to nine years in state prison and ordered to pay a $5,000 fine in addition to other penalties.

The *Clark* case was by no means the only one in 2005 where dogged investigation and resourcefulness by OIFP resulted in convictions for health care fraud crimes. As reflected in the cases prosecuted by OIFP during the past year, financial incentives have drawn an increasingly diverse array of criminals to health care claims fraud. Defendants convicted of health insurance fraud through the efforts of OIFP in 2005 include health care providers, the owners and executives of health care facilities, patients, and beneficiaries of the Medicaid Program.

Deputy Attorneys General Joan Burke, Tanya Justice, and Peter Lee conduct a case review.

2005 OIFP Prosecutions

Regardless of who the perpetrator is, the most common form of health care insurance fraud remains the submission of claims for services that were not provided. OIFP's prosecutions in 2005 show the enduring popularity of this method for committing health care fraud. For example, in *State v. Lobo*, a Passaic County doctor pled guilty to submitting nearly $10,000 in phony health care claims to insurance companies for medical services that were never provided to patients. Dr. Angel R. Lobo operated the Pain Management Clinic in Paterson.

As part of his guilty plea, Lobo admitted that he had prepared false patient records to indicate that health care services were administered to patients when no such services were provided.

Investigating provider fraud cases requires analyzing substantial amounts of documentary evidence.

Lobo even instructed patients to sign in at his clinic on dates when they did not appear for treatment. This fraud was just one component of a larger scheme to file false Personal Injury Protection (PIP) claims for treating patients purportedly injured in automobile accidents.

On February 15, 2005, Dr. Lobo was sentenced to a three-year term in state prison and ordered to pay a $100,000 fine for violating provisions of the civil Insurance Fraud Prevention Act. Lobo's office manager, a co-defendant, also admitted to assisting Lobo in obtaining, using, and paying "runners" to secure patients for the medical practice. The term "runner" refers to a person paid by an attorney, a health care service provider, or a health care facility operator to procure patients for a health care facility so that insurance claims can be submitted for providing treatment. "Running" was made illegal in New Jersey in 1999 with the enactment of the Criminal Use of Runners law.

Not all OIFP prosecutions in 2005 involved licensed health care services providers. As the case of *State v. Florence Acquaire* shows, where greed is involved, criminals will dispense with niceties, such as following state licensing requirements. Florence Acquaire, an electrologist, operated a Wayne, New Jersey, business called High Mountain Medical Center. She was indicted by a State Grand Jury on charges that she falsely billed insurance carriers for performing ordinary electrolysis - more commonly known as hair removal - by falsely identifying it as a medically necessary procedure for the removal of dead skin. Acquaire, however, was not a licensed medical service provider and was not, in fact, qualified to perform any type of surgical procedure. Nevertheless, over almost three years, and while actually performing common hair removal, she billed two insurance companies for the more expensive surgical procedure. Acquaire received nearly $900,000 in payments from the insurance carriers for the fraudulent claims. Following a ten-day trial before the Passaic County Superior Court, Acquaire was convicted of second degree Health Care Claims Fraud and the third degree crimes of theft by deception and attempted theft by deception. She was sentenced to seven years in state prison and ordered to pay restitution to the two insurance carriers.

Patients also have gotten into the heath insurance fraud act. In February 2005, Carol Severe, a Hunterdon County resident, admitted to committing health care claims fraud by submitting fraudulent health insurance claims of almost $14,000 to Horizon Blue Cross Blue Shield of New Jersey. Over a four-and-a-half-year period, Severe submitted more than 40 insurance claims, indicating that her provider had treated her on 192 different dates. OIFP investigators discovered that the alleged services had not been provided and that Severe had forged the provider's name on the claim forms. As part of her sentence, Severe was ordered to pay restitution of $13,947, as well as a $5,000 fine for civil insurance fraud violations.

Cases prosecuted by OIFP in 2005 also show that health care fraud is not limited to health care professionals, operators of health care facilities, or their patients. Criminals from all walks

Investigating health care claims fraud often means wading through a mountain of insurance claim forms, medical files, financial records, and interviewing many witnesses. In the process, investigators and prosecutors must master the complex terminology and practices of the health care and insurance industries. Assistance from expert witnesses in the relevant field also can be a prerequisite to bringing charges. At trial, such meticulous investigation must be distilled into a thoughtful presentation of evidence in order to obtain convictions.

of life are attracted to the possible financial rewards available in health care fraud and have tried to cash in. For example, in the case of *State v. Tricarico*, a former municipal official was convicted for embezzling public funds intended to pay for public employee health care costs. Joanne Tricarico, a former Personnel Director for Bloomfield Township, Essex County, was responsible for managing a health insurance benefit account for township employees. The account, publicly funded by tax dollars, was designed to reimburse township employees for pharmacy costs and prescription drugs. OIFP's investigation resulted in Tricarico's guilty plea to charges of official misconduct and theft by deception. Tricarico admitted that between January 17, 1997 and March 13, 2004, she wrote checks for her personal use from the pharmacy account and attempted to cover up the thefts by making fraudulent entries in the transaction journals used to record withdrawals from the pharmacy account. Tricarico was sentenced on July 7, 2005, to five years in state prison and ordered to pay restitution in the amount of $482,578.

Insurance providers make tempting targets for health care fraud criminals. In cases prosecuted by OIFP, it was not unusual to find that several insurance carriers were victimized by one criminal defendant. In *State v. Cohen*, at least six insurance carriers or third party health insurance claims administrators were targeted with fraudulent claims from Barry Cohen, a former certified public accountant. Cohen operated Headways, Inc., a family-owned business located in Bergen County that provided health care services and therapy to patients suffering from brain injuries. Over a three-year period, Cohen intentionally submitted dozens of claims to insurance companies and self-funded health benefit plans in which he added hours or dates for therapy that were never provided. OIFP investigators discovered that Cohen added more than 4,000 hours of nonexistent services - worth more than $350,000 - on dozens of bills submitted to the insurers for payment. After entering a plea of guilty to Health Care Claims Fraud, Cohen was ordered by the Bergen County Superior Court to pay $328,000 in restitution and a $105,000 civil fine. He also received a three-year term of probation.

2005 OIFP Medicaid Prosecutions

In 2005, OIFP was active again in prosecuting criminals for abuses of the Medicaid program. The Medicaid program, which is funded by the state and federal governments, provides health care services and prescription drugs to persons who may not otherwise be able to afford such services and medicines. The scope and scale of criminal abuses of the Medicaid program are such that OIFP has a dedicated Medicaid Fraud Control Unit to investigate and prosecute these crimes.

OIFP's Medicaid Fraud Control Unit was kept busy in 2005 by the likes of Rammohan Pabbathi, the 58-year-old owner of a Monmouth County pharmacy. Pabbathi was involved in a scheme using "runners" and paying kickbacks to medical providers to defraud Medicaid. Based on the strength of the OIFP investigation, Pabbathi entered a guilty plea to the second degree crime of Health Care Claims Fraud. At his plea hearing, Pabbathi admitted that he, as the owner and operator of GLV Parke Warner Pharmacy in Neptune Township, Monmouth County, fraudulently billed Medicaid for prescriptions that his pharmacy did not dispense. During one undercover operation in the case, State Investigators obtained evidence of Pabbathi billing the Medicaid program $1,130 for one HIV medication prescribed to a "runner," even though he had not dispensed it. The investigators even managed to record Pabbathi offering kickbacks to Medicaid recipients to participate in his scheme. After entering his guilty plea, Pabbathi was sentenced by the Monmouth County Superior Court to three years in state prison and ordered to pay $450,000 in restitution and fines to the Medicaid program.

A Warren County dentist who billed Medicaid for dental services that he never performed was another criminal snared by OIFP's Medicaid Fraud Control Unit. On May 27, 2005, Dr. Roger H. Brown pled guilty in Somerset County Superior Court to committing Health Care Claims Fraud. Between January 1993 and September 2004, Brown submitted hundreds of false claims to numerous health insurance providers for reimbursement of dental services, which he never provided. In addition to the Medicaid program, the victimized insurance providers included Delta Dental, MetLife, Horizon Blue Cross Blue Shield, CIGNA, and Aetna. OIFP's investigation uncovered $95,182 in false claims submitted by Brown. Brown admitted to deliberately misrepresenting the dates on which services were rendered and to filing false claims for treating Temporomandibular Joint Dysfunction (TMJ) when he was, in fact, providing cosmetic dental services that are not covered by private dental insurance.

Catching Fugitives

As busy as OIFP was during 2005, it still made time to meet up with some old acquaintances. Genady Chulak was originally convicted of theft by deception, corporate misconduct, and Medicaid fraud on December 14, 2000. Chulak owned GGE Impact Corporation, a company doing business under the name of Medicall that transported Medicaid patients for appointments with doctors and other health care providers. As part of his fraud, Chulak inflated mileage charges when billing the Medicaid program for his transportation services. He also was charged with paying kickbacks to Medicaid patients

for using Medicall's services. Following his jury trial in December 2000, but before he could be sentenced, Chulak fled to Canada. Chulak was arrested by immigration officials in December 2004 while trying to re-enter the United States. In March 2005, Chulak finally was sentenced in the Middlesex County Superior Court, receiving a seven-year state prison sentence, and ordered to pay almost $1 million in restitution and fines - a case of justice delayed, but not denied, for Mr. Chulak.

Bringing Criminals to Justice

These cases represent just a small sampling of the health care fraud cases prosecuted by OIFP in 2005. Despite the inherent challenges of prosecuting such cases, OIFP met these challenges and successfully brought criminals to justice for a wide assortment of health care frauds. As the examples above show, while the paper trail may be a long and arduous one, detailed investigations and perseverance often lead to the reward of convictions in health insurance fraud cases. For health care fraud criminals, 2005 will be remembered as yet another year that OIFP was hot on their paper trail.

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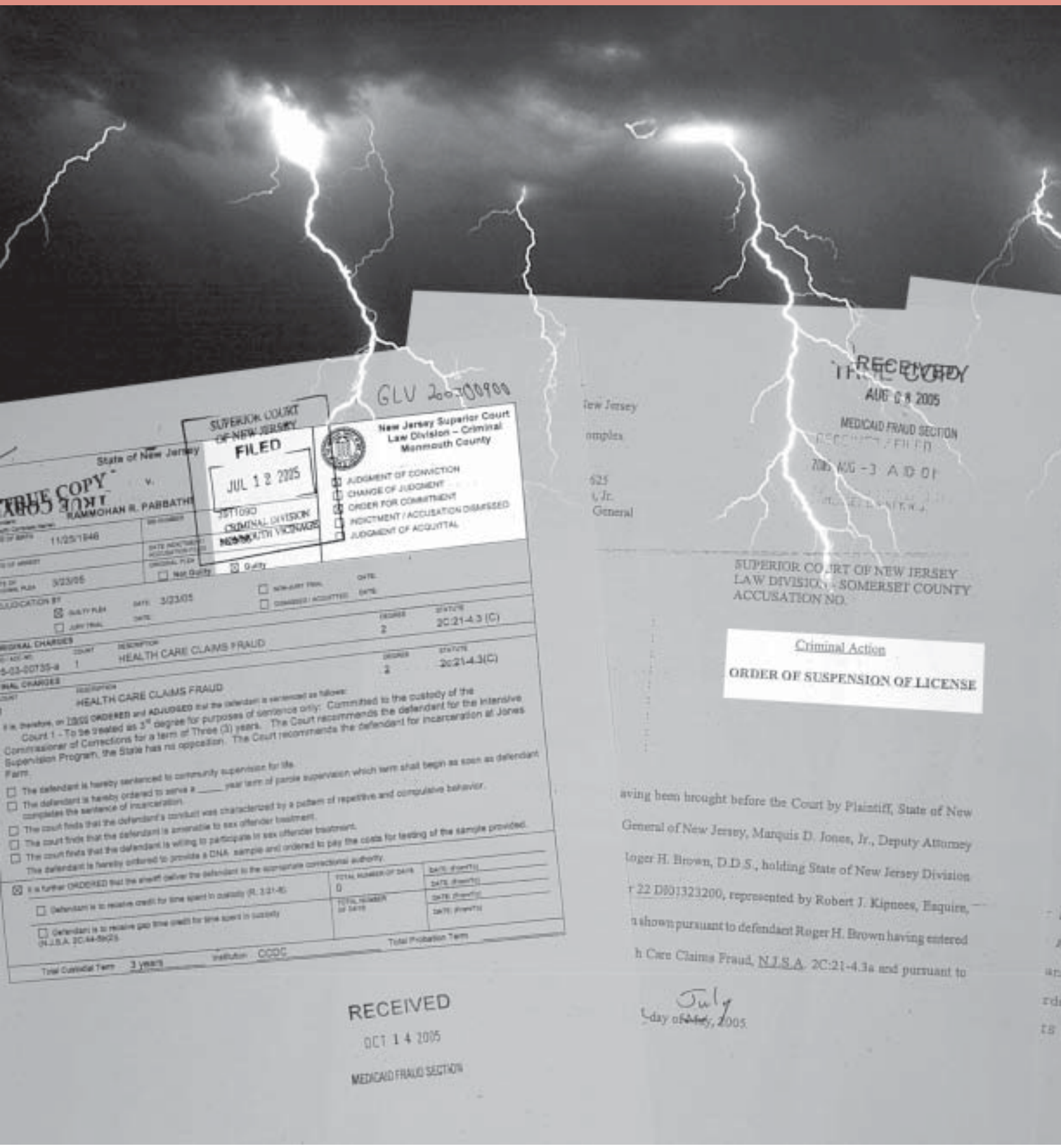
Peter Lee is a Deputy Attorney General assigned to the Health and Life Section of OIFP. He has been with the Division of Criminal Justice for seven years. Prior to joining the Division, he was in private practice.


State of New Jersey
v.
RAMMOHAN R. PABBATHI
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3/23/05
SUPERIOR COURT OF NEW JERSEY
FILED
JUL 12 2005
CRIMINAL DIVISION
New Jersey Superior Court
Law Division – Criminal
Monmouth County
JUDGMENT OF CONVICTION
CHANGE OF JUDGMENT
ORDER FOR COMMITMENT
INDICTMENT / ACCUSATION DISMISSED
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Total Custodial Term 3 years
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MEDICAID FRAUD SECTION
SUPERIOR COURT OF NEW JERSEY
LAW DIVISION - SOMERSET COUNTY
ACCUSATION NO.
Criminal Action
ORDER OF SUSPENSION OF LICENSE
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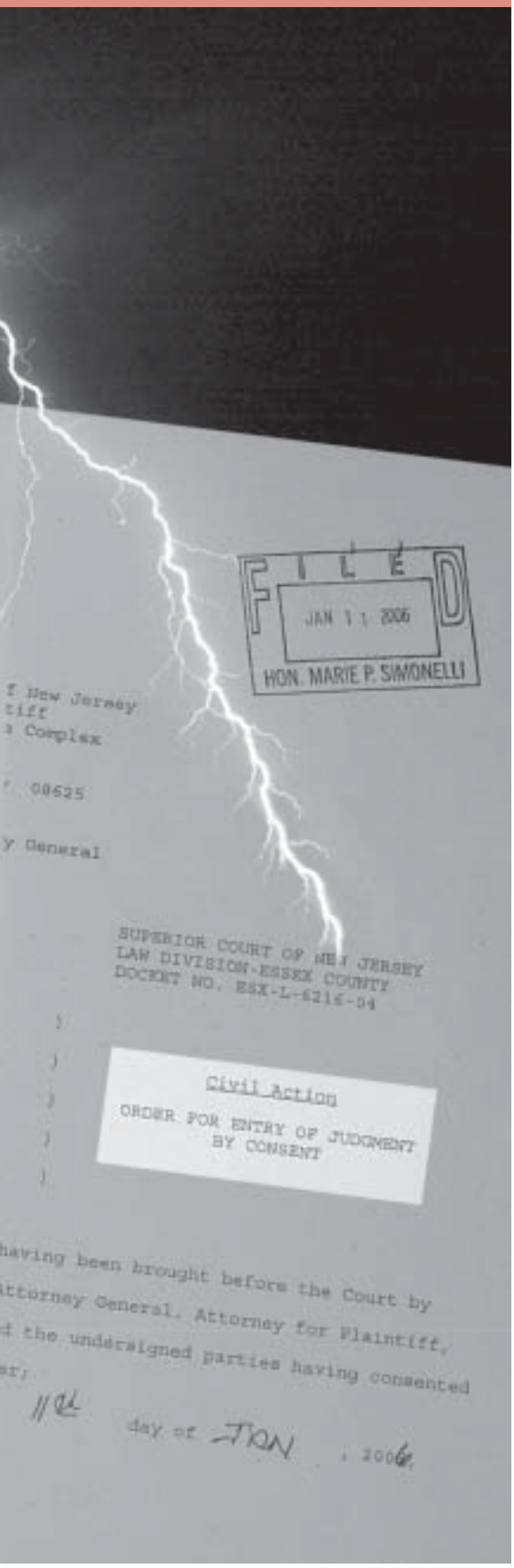


Parallel Proceedings:

OIFP's Triple Threat

by John Kennedy

When the New Jersey Legislature created the Office of the Insurance Fraud Prosecutor (OIFP) in 1998, it adopted a new model of law enforcement in which one office is expressly required to conduct both civil and criminal investigations and court proceedings. OIFP is also required to coordinate the civil, administrative, and criminal actions of other executive branch agencies to ensure that the taxpayers and policyholders of New Jersey receive the most efficient use of the State's various weapons against insurance fraud. Centralizing both the responsibility and the legal authority to conduct civil and criminal actions in one office has yielded impressive results in New Jersey's war against insurance fraud. As discussed in this article, although some legal issues are raised by this centralization, the Legislature acted well within its authority, and OIFP's procedures ensure that its often simultaneous civil and criminal proceedings are conducted in accordance with applicable law.

The purpose of the Insurance Fraud Prevention Act[1] (the Fraud Act) as amended by the Automobile Insurance Cost Reduction Act (AICRA)[2] 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.[3]

To accomplish this purpose, the Fraud Act requires OIFP to pursue "the most effective resolution of insurance fraud cases, whether by criminal, civil, or administrative enforcement action, or a combination thereof."[4] The Fraud Act grants OIFP the authority to "prosecute criminal cases [and] litigate civil cases as appropriate[.]"[5] OIFP is directed to refer fraudulent conduct by licensed professionals to the appropriate licensing board, which must report back to OIFP on the action it takes.[6] OIFP may also join in private civil litigation initiated by insurance carriers, for the purpose of seeking statutory civil penalties.[7] The Fraud Act requires OIFP to develop a coordinated statewide anti-fraud enforcement policy for all state and local agencies, including criminal law enforcement agencies and civil enforcement agencies, and to recommend regulatory and statutory changes needed to fulfill the purposes of the Fraud Act.[8]

1. L. 1983, c. 320 (codified at N.J.S.A. 17:33A-1 to -15).
2. L. 1998, c. 21, sections 32 through 46 (codified at N.J.S.A. 17:33A-16 to -30).
3. N.J.S.A. 17:33A-2.
4. Id. at -27.
5. Id. at -20.
6. Id. at -10c and -25.
7. Id. at -7d.
8. Id. at -20 and -24b.

In creating OIFP, the Legislature explicitly mandated a new model of law enforcement, in which administrative, civil, and criminal remedies are pursued by one agency, to ensure the most effective use of the State's resources for the benefit of its citizens who pay insurance premiums and who are victimized by insurance fraud. In doing so, the Legislature was well within its rights, as a substantial body of case law has developed over the last 30 years affirming not only the propriety of simultaneous civil and criminal investigative and enforcement activities, but also, in many cases, its desirability.

The Propriety of Simultaneous Civil and Criminal Actions

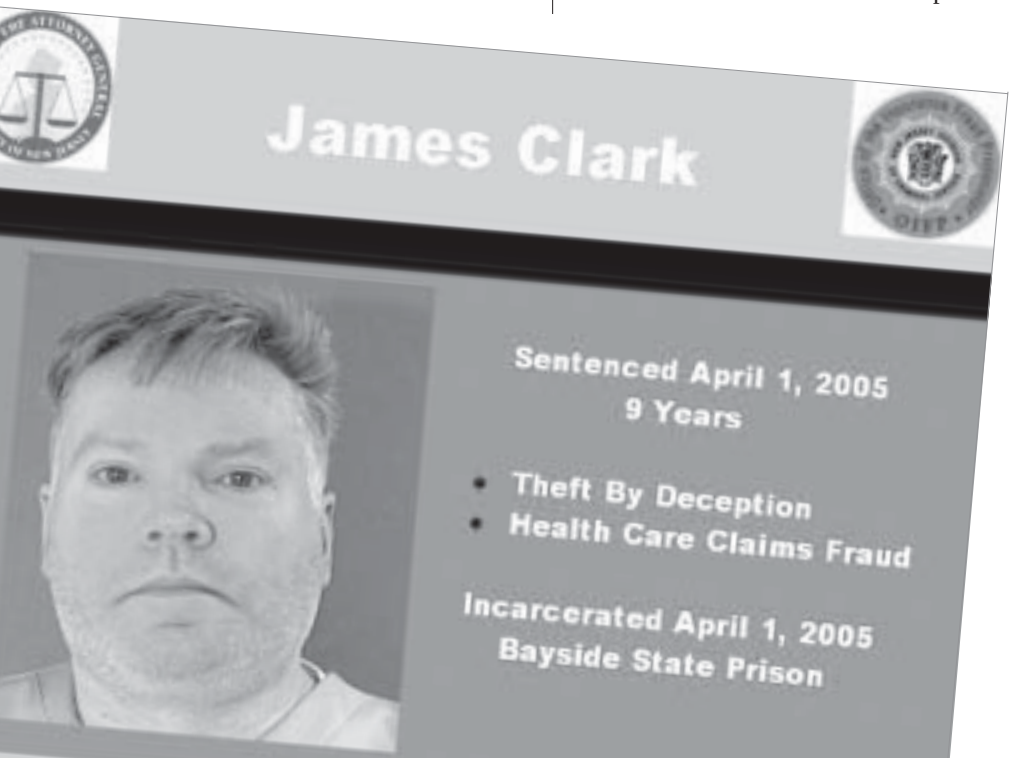
There is no general constitutional prohibition against the government's pursuing simultaneous civil and criminal litigation based on the same conduct, much less simultaneous civil and criminal investigations.

> The civil and regulatory laws of the United States frequently overlap with the criminal laws, creating the possibility of parallel civil and criminal proceedings, either successive or simultaneous. In the absence of substantial prejudice to the rights of the parties involved, such parallel proceedings are unobjectionable under our jurisprudence.[9]

In the seminal case of *United States v. Kordel*,[10] the Federal Food and Drug Administration (FDA) had filed a civil in rem action seeking the seizure of certain unsafe products. In the course of that civil litigation, the FDA served interrogatories, which a corporate officer answered without asserting his Fifth Amendment privilege. While the civil litigation was pending, a grand jury indicted the corporation and certain corporate officers for transactions which underlay the civil action. Following their criminal conviction, the defendants appealed, arguing that the use of the interrogatory answers in the criminal investigation violated the Fifth Amendment or the due process clause.[11] The Supreme Court rejected the Fifth Amendment argument because a corporation has no Fifth Amendment privilege, and because the corporate officer who answered the interrogatories neglected to assert his Fifth Amendment privilege, and therefore waived it.[12] The Court also rejected the defendants' argument that the use of the interrogatory answers "reflected such unfairness and want of consideration for justice as independently to require the reversal of their convictions. On the record before us we cannot agree that the respondents have made out either a violation of due process or a departure from proper standards in the administration of justice requiring the exercise of our supervisory power."[13] The Court further noted that prompt and efficient government action serves the public interest:

> It would stultify enforcement of federal law to require a governmental agency such as the FDA invariably to choose to either forgo recommendation of a criminal prosecution once it seeks civil relief, or to defer civil proceedings pending the ultimate outcome of criminal trial.[14]

New Jersey law is similar. In *State v. Kobrin Securities, Inc.*,[15] the State Bureau of Securities filed a civil complaint for securities fraud; and thereafter, a grand jury returned an indictment against the corporation and two of the individuals who were also named in the civil complaint. Following the return of the indictment, the trial court stayed the civil action on its own motion, reasoning that the case was "paralyzed by the Fifth Amendment issue."[16] The New Jersey Supreme Court reversed. The Court ruled that "whatever the difficulties of invoking the Fifth Amendment privilege, there is no constitutional inhibition that a defendant in a criminal case not be put to the difficult choice of having to assert the privilege in a related civil case[.]"[17] The Court reasoned as follows:



9. Securities and Exchange Commission v. Dresser Industries, Inc., 628 F.2d 1368, 1374 (D.C. Cir.)(footnote omitted), cert. den., 449 U.S. 993 (1980).

10. 397 U.S. 1 (1970).

11. 397 U.S. at 2-6.

12. Id. at 8-9.

13. Id. at 11. The defendant bears the burden of proving that the government's conduct was improper. Id. at 9. The defendant bears the burden of proof under state law as well. State v. Kobrin Securities, Inc., 111 N.J. 307, 316 (1988).

14. U.S. v. Kordel, supra, 397 U.S. at 11 (citation omitted).

15. 111 N.J. 307 (1988).

16. Id. at 310-12.

17. Id. at 313 (citations and internal quotation marks omitted).

18. Id. at 314 (quoting Gordon v. Federal Deposit Insurance Corporation, 427 F.2d 578, 580 (D.C. Cir. 1970) (other citations omitted).

Audiologists
Speech-language pathologists
Chiropractors
Dentists
Dental Assistants (registered and limited registered)
Dental Hygienists
Dental Teachers
Interns and Residents studying dentistry
Marriage and Family Therapists
Alcohol and Drug Counselors
Medical doctors
Doctors of Osteopathy
Podiatrists
Bio-analytical Laboratory Directors
Acupuncturists
Athletic Trainers
Nurse Midwives
Hearing Aid Dispensers
Physicians Assistants
Practical Nurses
Registered Nurses
Nurse Anesthetists
Nurse Practitioners
Homemaker—Home Health Aides
Occupational Therapists
Ophthalmic Dispensers
Ophthalmic Technicians
Ophthalmic Dispenser and Technician Apprentices
Optometrists
Orthotists
Prosthetists
Pharmacists
Physical Therapists
Physical Therapist Assistants
Psychologists
Respiratory Therapists

Loss of New Jersey License: A Major Penalty

About 600,000 New Jerseyans hold licenses to practice their profession in the state. Their activities are regulated by 38 boards. The Office of Insurance Fraud Prosecutor reports all persons in the 80 professions and occupations requiring a license suspected of committing insurance fraud to the appropriate board. The boards have some discretion in deciding whether to revoke their licenses, but their standards of proof are also lower than those required in a criminal court of law.

In short, anyone who commits Insurance Fraud in New Jersey faces the possibility of losing the right to practice their profession — in addition to any criminal and civil penalties that may be assessed. Moreover, this penalty may be assessed even if the fraud does not involve the profession itself.

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Cemetery Operators and Salespersons (non-religious)
Cosmetologists
Barbers
Beauticians
Manicurists
Beauty School Teachers and Students
Electrical Contractors
Fire and Burglar Alarm Installers
Master Plumbers
Funeral Directors
Funeral Director Trainees
Professional Engineers
Engineers in Training
Land Surveyors
Land Surveyors in Training
Home Inspectors
Professional Planners
Planners in Training
Home Movers
Warehousemen
Licensed Real Estate Appraisers
Residential Appraisers
Certified General Appraisers
Apprentice Appraisers
Certified Shorthand Reporters

There may be cases where the requirement that a criminal defendant participate in a civil action, at peril of being denied some portion of his worldly goods, violates concepts of elementary fairness in view of the defendant's position in an interrelated criminal prosecution. On the other hand, the fact that a man is indicted cannot give him a blank check to block all civil litigation on the same or related underlying subject matter. Justice is meted out in both civil and criminal litigation. The overall interest of the courts that justice be done may very well require that the compensation and remedy due a civil plaintiff should not be delayed (and possibly denied). The court, in its sound discretion, must assess and balance the nature and substantiality of the injustices claimed on either side.[18]

The New Jersey Legislature has clearly enunciated the public policy of this State as requiring the simultaneous and coordinated use of criminal, civil, and administrative powers to fight insurance fraud, not only in the AICRA amendments cited above but also more recently:

The Legislature finds and declares:

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 policyholders, 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.
>
> . . . .
>
> 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.[19]

To paraphrase *Kordel*, this public policy would be stultified if OIFP did not pursue appropriate administrative, civil, and criminal actions to achieve the most effective resolution of insurance fraud cases.

There are a number of legal issues that arise with some regularity in parallel civil and criminal investigations or parallel civil and criminal legal proceedings. These issues center on the Fifth Amendment right to be free from compelled self-incrimination, the possibility that either the government or the subject might abuse the typically broader discovery process available in the civil litigation for the purpose of benefitting the criminal litigation, the need to respect the requirements of grand jury secrecy, and questions of double jeopardy. These issues are discussed below.

The Privilege Against Compelled Self-Incrimination

The Fifth Amendment, made applicable to the states through the Fourteenth Amendment, provides that "no person... shall be compelled in any criminal case to be a witness against himself[.]"[20] A person may invoke the privilege against self-incrimination in any proceeding, civil or criminal, formal or informal, where the answers might tend to incriminate him in a future criminal proceeding. However, the privilege is not self-executing under either federal or state law and must be invoked by anyone who claims its protections, or else it is waived. Generally, when the privilege is not asserted and the person questioned chooses to answer, the choice to respond is considered voluntary.[21] In a civil matter, a party may assert the Fifth Amendment privilege if he believes his answer would incriminate him. Nonetheless, the trier of fact is entitled to draw an adverse inference against that party.[22] While the State cannot burden the exercise of the Fifth Amendment privilege by imposing sanctions or the automatic forfeiture of an important interest if the privilege is asserted,[23] that rule is not violated when the only consequence to an assertion of the Fifth Amendment is that the trier of fact in a civil proceeding may draw an adverse inference.[24] Similarly, an individual can refuse to answer questions asked by an insurer in an examination under oath conducted under the terms of an insurance policy if the insured believes the answers would incriminate him. However, the insured must bear the consequences of that choice, which would likely be a declination of coverage based on the insured's failure to cooperate with the carrier. [25]

Although the general rule is that the Fifth Amendment privilege is waived if the person fails to assert it, the Supreme Court created a well-known exception to this rule in *Miranda v. Arizona*[26] in which the Court held that custodial interrogation by law enforcement officers is inherently coercive, automatically triggering the Fifth Amendment privilege. The *Miranda* rule is designed to overcome "the singular problems associated with custodial interrogation after a defendant is arrested or otherwise confined."[27] The warnings are required only when the defendant is in custody and the interrogation is carried out by law enforcement.[28] Thus, in *State v. P.Z.*, the New Jersey Supreme Court ruled that a civil investigator from the Division

19. N.J.S.A. 2C: 21-4.4.

20. U.S. Const. amend. V; accord N.J.R.E. 503.

21. See State v. P.Z., 152 N.J. 86, 100-01 (1997).

22. Baxter v. Palmigiano, 425 U.S. 308 (1976).

23. State v. P.Z., supra, 152 N.J. at 106-07.

24. Id. at 107-08; Arthurs v. Stern, 560 F.2d 477, 478 (1st Cir. 1977) (finding the existence of indictments did not require the medical board to stay a license revocation proceeding against the doctor-defendant; the board was not constitutionally forbidden from drawing an adverse inference if the doctor refused to testify at the disciplinary hearing), cert. den., 434 U.S. 1034 (1978).

25. See State Farm Indemnity Company v. Warrington, 350 N.J. Super. 379 (App. Div. 2002).

26. 384 U.S. 436 (1966).

27. State v. P.Z., supra, 152 N.J. at 102.

28. Id. at 102.

29. Id. at 103.

30. See State v. Helewa, 223 N.J. Super. 40 (App. Div. 1988) and State v. Flower, 224 N.J. Super. 90 (App. Div. 1988).

31. The P.Z. Court also held that the Sixth Amendment right to counsel applies by its terms only to criminal prosecutions, and not to civil investigations. 152 N.J. at 109-11.

32. U.S. v. Stribling, 437 F.2d 765, 772-73 (6th Cir.) (civil IRS agent had no duty to advise taxpayer that he was under criminal investigation, and statements made by the taxpayer were admissible in the criminal trial) cert. den., 402 U.S. 973 (1971); U.S. v. Jaskiewicz, 433 F.2d 415, 421 (3rd Cir. 1970) cert. den., 400 U.S. 1021 (1971).

33. See Lewis v. U.S., 385 U.S. 206, 209 (1966) (holding use of undercover officer does not violate the Fourth Amendment); Hoffa v. U.S., 385 U.S. 293, 303 (1966) (holding use of undercover informant does not violate due process or the privilege against self-incrimination); See generally State v. Patton, 362 N.J. Super. 16, 29-32 (App. Div.) certif. den. 178 N.J. 35 (2003) (holding confessions obtained by verbal trickery or misrepresentations are admissible so long as the defendant's will was not overborne; however, manufacturing false physical evidence renders a resulting confession inadmissible).

34. Lewis v. U.S., supra, 385 U.S. at 209 n. 5 (internal quotation omitted).

35. 397 U.S. at 11.

36. Id. at 11-12.

37. Id. at 4 and n.5 (quoting section 305 of the Food, Drug and Cosmetic Act).

38. Ibid.

of Youth and Family Services (DYFS) was not required to give *Miranda* warnings before taking a statement from the subject of her civil investigation, who was not in custody, but who was simultaneously under criminal investigation for endangering the welfare of a child.[29] However, two Appellate Division opinions have equated DYFS workers with law enforcement officers when they questioned defendants who were incarcerated.[30] Thus, civil investigators are well advised to issue *Miranda* warnings if they question a subject who is incarcerated. However, civil investigators, like their criminal counterparts, are not required to give *Miranda* warnings to a subject who is not incarcerated.[31]

Similarly, the existence of parallel civil and criminal investigations does nothing to change the general rule of law that the State has no obligation to warn subjects of a criminal investigation that they are under investigation.[32] Criminal investigations of sophisticated fraud operations frequently involve the use of undercover investigators and other surreptitious investigative techniques. Undercover investigations, by their nature, require concealing the true identity of the undercover officer and misrepresenting his true intention, namely, to gather incriminating evidence against the subject. Nonetheless, these affirmative misrepresentations inherent in all undercover criminal investigations are perfectly lawful and do not violate either the due process clause, the Fifth Amendment, or the Fourth Amendment.[33] "Artifice and stratagem may be employed to catch those engaged in criminal enterprises.... The appropriate object of this permitted activity, frequently essential to the enforcement of the law, is to reveal the criminal design[.]"[34] A requirement that civil investigators must advise a suspect that he is under criminal investigation would have no basis in law, and would impose a duty on a civil investigation that does not exist in the criminal investigation itself.

Nonetheless, there is dictum in the Supreme Court opinion in *Kordel* which could be read as though it imposes such a duty. Doing so, however, would place the dictum on a collision course with established law. In *Kordel*, after it had rejected the defendants' argument that the use of civil interrogatory answers in the criminal investigation was a violation of due process,[35] the Court went on to note the issues that were not before it: "We do not deal here with the case where the government has...failed to advise the defendant in its civil proceeding that it contemplates his criminal prosecution[.]"[36] Not only is this statement unnecessary to the Court's holding, and therefore dictum, but the Court is also expressly stating that the issue of advising a defendant of a contemplated criminal prosecution was not before it; therefore, the Court did not create a rule that such advice is required. There are other reasons why this dictum should be read cautiously. The case in *Kordel* arose under the Federal Food, Drug and Cosmetic Act. As the Supreme Court noted earlier in its opinion, section 305 of the Food, Drug and Cosmetic Act required the FDA to serve a notice on the subject of its civil investigation, advising the subject that it was contemplating referring the matter to a U.S. Attorney for criminal proceedings, and granting the subject "appropriate notice and an opportunity to present his views, either orally or in writing, with regard to such contemplated proceeding."[37] In *Kordel*, the FDA had served the section 305 notice after it had served the interrogatories but before the corporation had answered them.[38] Thus, the Supreme Court's observation that it was not dealing with a case in which the government had failed to advise the defendant that it contemplated a criminal prosecution must be read in context, namely, in a case arising under a statutory scheme that mandated such notice.

Nonetheless, in its dictum, the Court did not cite section 305 of the Act, but rather cited three cases from lower courts, which, upon examination, certainly do not establish that such a duty exists.[39] However, in light of the fact that the *Kordel* statement was merely dictum, that it arose in the context of a statutory scheme which mandated such notice, and that it is based on weak precedent, it should not be read as contradicting the firmly established principle that approves the use of undercover operations in criminal investigations, and thus necessarily obviates any requirement that the State notify subjects that they are or may be under criminal investigation.

Disclosure of Information Gathered in the Civil Investigation

Information gathered through civil investigations may be shared with criminal prosecutors provided there was a good faith basis for undertaking that investigative step in the civil matter.[40] On the other hand, the State cannot use civil litigation solely to obtain evidence for a criminal prosecution or investigation.[41] Even if the civil agency has sought criminal enforcement in a case, that alone does not mean that civil investigative steps were conducted in bad faith.[42] The mere fact that a criminal prosecution could ultimately result from information the civil investigator legitimately obtains does not bar the subsequent turnover of that information to a prosecutor, or its admission in a criminal trial.[43]

Disclosure of Information Gathered in the Criminal Investigation

Prosecutors generally may share information gathered during criminal investigations with their civil counterparts unless the information is required to be kept confidential. The rule of grand jury secrecy is the most common confidentiality requirement to arise in parallel proceedings.[44] Prosecutors may not disclose grand jury materials to anyone, including civil attorneys handling a parallel civil case, absent a Court Order.[45] Grand jury materials include grand jury transcripts and documents obtained through a grand jury subpoena.[46] However, just because documents were subpoenaed in a criminal investigation does not insulate those documents from any civil investigation. While the prosecutor may not turn them over to the civil investigators, the civil investigators may obtain them from the source independently.[47]

To obtain grand jury materials from the prosecutors for use in a civil proceeding, a civil investigator must apply to the court for a disclosure order.[48] In *State v. Doliner*, the New Jersey Supreme Court required that government attorneys and agencies seeking disclosure of grand jury materials make a strong showing of particularized need that outweighs the interest of grand jury secrecy, just as civil litigants would.[49] In balancing the interests of grand jury secrecy with the request to disclose grand jury materials, a court must take into account the policy reasons for grand jury secrecy:

> (1) to prevent the escape of those whose indictment may be contemplated; (2) to insure the utmost freedom to the grand jury in its deliberations, and to prevent persons subject to indictment or their friends from importuning the grand jurors; (3) to prevent subornation of perjury or tampering with the witnesses who may testify before grand jury and later appear at the trial of those indicted by it; (4) to encourage free and untrammeled disclosures by persons who have information with respect to the commission of crimes; (5) to protect innocent accused who is exonerated from disclosure of the fact that he has been under investigation and from the expense of standing trial where there was no probability of guilt.[50]

When grand jury proceedings have concluded, "the first three factors will almost invariably disappear."[51] The fourth factor will ordinarily not constitute a bar to disclosure since in New Jersey every witness is on notice that his or her testimony will be disclosed to a defendant upon request.[52] The fifth factor, the need to protect the innocent, is not applicable when an indictment is returned against a defendant, but otherwise would be.[53] When the factors justifying secrecy become less significant, the burden on the party seeking disclosure of grand jury materials will similarly decrease.[54]

39. The Kordel Court cited the following three cases. In Smith v. Katzenbach, 351 F.2d 810 (D.C. Cir. 1965), a taxpayer, Smith, was interviewed by IRS agents in North Carolina who did not inform him he was under criminal investigation. Smith filed suit in the District of Columbia to enjoin the use of the information he provided, arguing that the agents' failure to advise him of his rights violated his privilege against self-incrimination and his right to counsel. The District Court dismissed the complaint for lack of jurisdiction, and the D.C. Circuit affirmed, without deciding the merits. Id. at 817. In U.S. v. Lipshitz, 132 F. Supp. 579 (E.D.N.Y. 1955), an IRS criminal investigator directed an IRS civil auditor to gather information from the taxpayer far in excess of what was needed for the civil audit. The taxpayer was not advised he was under criminal investigation. The District Court concluded the taxpayer's Fourth and Fifth Amendment rights were thereby violated. Id. at 523. That ruling was expressly disapproved by the Second Circuit in U.S. v. Sclafani, 265 F.2d 208, 414-15 (2d Cir.), cert. den., 360 U.S. 918 (1959), in which the court ruled that the government has no duty to advise a taxpayer that an audit has become a criminal investigation. Lastly, in U.S. v. Guerrina, 112 F. Supp. 126 (E.D. Pa. 1953), the District Court initially ruled that records turned over to the IRS by a taxpayer who did not know he was under criminal investigation were obtained by "stealth," which rendered the taxpayer's consent invalid. Id. at 129. Upon reconsideration, however, the court concluded that its decision was incorrect, and ruled that the IRS agent's failure to advise that criminal prosecution was being considered did not invalidate the consent. The court therefore reversed its earlier suppression order. U.S. v. Guerrina, 126 F. Supp. 609, 611 (E.D. Pa. 1955).

40. See U.S. v. Kordel, supra, 397 U.S. at 6; Securities and Exchange Commission v. Dresser Industries, Inc., supra, 628 F.2d at 1386-87.

41. See U.S. v. Kordel, supra, 397 U.S. at 6, 11-12, Securities and Exchange Commission v. Dresser Industries, Inc., supra, 628 F.2d at 1387.

42. U.S. v. Gel Spice Company, Inc., 773 F.2d 427, 432-433 (2d Cir. 1985) cert. den., 474 U.S. 1060 (1986); see U.S. v. Funaro, 253 F. Supp.2d 286, 297 (D. Conn. 2003); see also U.S. v. Kordel, supra, 397 U.S. at 11-12.

43. State v. P.Z., supra, 152 N.J. at 119-20 ("stating although the prosecutor anticipated being informed of the results of [the DYFS worker's] visit to P.Z., the visit had a legitimate independent purpose and was not pretextual."; see Securities and Exchange Commission v. Dresser Industries, Inc., supra, 628 F.2d at 1387.

When concerns for secrecy are not implicated, the most relevant factor for a court to consider will be whether or not there has been an abuse of the grand jury process.[55] That inquiry will focus on objective criteria, such as: (1) the stated purpose of the grand jury investigation; (2) whether an indictment was returned; (3) the degree of civil agency involvement in the grand jury investigation; (4) whether the agency is seeking access to evidence that it would not be entitled to under its own investigative powers; and (5) whether the grand jury investigation is instituted at the behest of the agency.[56]

The limitations that apply to the disclosure of grand jury materials generally do not apply to information gathered in other manners by criminal investigators and prosecutors.[57] For instance, prosecutors may share with civil investigators evidence obtained though interviews, surveillances, and search warrants.

Procedural Issues

Many of the cases discussing parallel proceedings issues arise when one party seeks to stay the civil case or some portion of it. A consensus has arisen as to the factors a court should consider in weighing such requests, as will be outlined below.

Preliminarily, however, it should be noted that such factors come into play only after formal litigation has been initiated, whether by the filing of a civil complaint, a criminal indictment, or both. Before the initiation of civil or criminal litigation, the mere existence of parallel investigations provides no basis for a court to enjoin either the civil or criminal investigation by the government: the subject may assert his Fifth Amendment privilege equally in either investigation, and the subpoena authority of the grand jury is at least as powerful as any available on the civil side. Thus, the criminal prosecutor could obtain directly, by use of a grand jury subpoena, any information he might seek to obtain indirectly from his civil colleagues. Accordingly, simultaneous civil and criminal investigations create little risk of "substantial prejudice to the rights" of the subject.[58]

Once civil litigation has commenced, it is not uncommon for either the defendant or the government to move to stay some aspect of civil discovery or, sometimes, the entire civil case. In determining whether to stay a civil proceeding pending the outcome of a related criminal case, courts will consider such factors as: (1) the status of the criminal case and, in particular, whether the defendant has been indicted; (2) whether the defendant's exercise of his Fifth Amendment privilege will expose him to unnecessary adverse consequences;[59] (3) whether the two actions are identical in scope; and (4) whether the civil action is designed to prevent continued injury to the public.[60] A court will generally refuse to grant a stay when there has been no

44. Information pertaining to electronic surveillance is also subject to confidentiality requirements. See 18 U.S.C. 2517; N.J.S.A. 2A:156A-15, 2A:156A-17.

45. State v. Doliner, 96 N.J. 236, 246 (1984); R. 3:6-6; R. 3:6-7.

46. In re Grand Jury Proceedings, 851 F.2d 860, 866-867 (6 Cir. 1988).

47. Securities and Exchange Commission v. Dresser Industries, supra, 628 F.2d at 1383; In re Grand Jury Investigation,748 F. Supp. 1188, 1208 (E.D. Mich. 1990).

48. State v. Doliner, supra, 96 N.J. at 246 (1985); see Doe v. Klein, 143 N.J. Super. 134 (App. Div. 1976).

49. State v. Doliner, supra, 96 N.J. at 246 (1985); see In the Matter of an Application for Disclosure of Grand Jury Testimony and Exhibits from a State Grand Jury Investigation, 124 N.J. 443 (1991); see also U.S. v. Sells Engineering, Inc., 463 U.S. 418, 479-80 (1983)(application under Fed. R. Crim. P. 6(e)(3)(C)(i)).

50. State v. Doliner, supra, 96 N.J. at 247.

51. Ibid.

52. Ibid.

53. Ibid.

54. In the Matter of an Application for Disclosure of Grand Jury Testimony and Exhibits from a State Grand Jury Investigation, supra, 124 N.J. at 453-54.

55. State v. Doliner, supra, 96 N.J. at 249; In the Matter of an Application for Disclosure of Grand Jury Testimony and Exhibits from a State Grand Jury Investigation, supra,124 N.J. at 453-54.

56. State v. Doliner, supra, 96 N.J. at 250.

57. See note 44 as to disclosure of electronic surveillance material.

58. See Securities and Exchange Commission v. Dresser Industries, supra, 628 F.2d at 1381.

59. "Ultimately, what is at risk is not their constitutional rights - for they cannot be forced to testify, and under Baxter [v. Palmigiano, supra,] any adverse consequence in the civil litigation is consistent with the constitutional guarantee - but their strategic position in the civil case." Sterling National Bank v. A-1 Hotels International, Inc., 175 F. Supp.2d 573, 578 n.4 (S.D.N.Y. 2001).

60. State v. Kobrin Securities, Inc., supra, 111 N.J. at 314; see Hicks v. City of New York, et al., 268 F. Supp.2d 238, 241-42 (E.D.N.Y. 2003).

indictment against the proponent of the stay.[61] However, if there has been an indictment, then the proponent of the stay has a somewhat easier task of showing that the balance of factors favors a stay.[62] Courts need not stay the entire civil proceeding, and have broad discretion to fashion orders which protect both the defendant's rights and the rights of the civil plaintiff. The court can require that discovery be conducted in a certain order; it can seal confidential material; and it can limit examinations.[63]

Civil and Criminal Sanctions

The Double Jeopardy Clause of the Fifth Amendment of the United States Constitution, applicable to the states through the Fourteenth Amendment, guarantees that no person shall "be subject for the same offense to be twice put in jeopardy of life or limb[.]"[64] The Double Jeopardy Clause protects against multiple prosecutions of a person for the same offense, and against multiple punishments for the same offense.[65] The Double Jeopardy Clause of the State Constitution is, on its face, significantly more narrow, prohibiting only successive prosecution after an acquittal.[66] Accordingly, the New Jersey Supreme Court has consistently held that the State constitutional protection is to be construed so that it is coextensive with the Federal Double Jeopardy Clause, and the court has consistently followed Federal Supreme Court Double Jeopardy jurisprudence.[67]

In *Hudson v. United States*,[68] the United States Supreme Court held that the Double Jeopardy Clause protects against the imposition of multiple *criminal* punishments for the same offense. The Court largely disavowed its holding in *United States v. Halper*,[69] in which it had ruled that Double Jeopardy restraints would be triggered by a civil sanction if the sanction was "punitive" rather than remedial in nature.[70] The Court's decision in *Hudson* returned the focus of the Double Jeopardy inquiry to the criminal character of the sanction.[71] This approach has been adopted by the New Jersey Supreme Court.[72]

Whether a particular sanction is criminal or civil is a matter of statutory construction.[73] The New Jersey Supreme Court has held that penalties under the Insurance Fraud Prevention Act are civil, not criminal, penalties.[74] Accordingly, the imposition of criminal punishment for insurance fraud conduct and the imposition of civil penalties under the Fraud Act for the same conduct do not violate the State or Federal Double Jeopardy Clauses.

Conclusion

Consolidating both the responsibility and the legal authority to conduct civil and criminal investigations and legal proceedings in OIFP has resulted in a more coordinated and productive use of the State's resources. Simultaneous civil and criminal proceedings can raise a variety of legal issues. Nonetheless, by having a proper understanding of these issues, and by conducting each investigation for its own legitimate purpose, OIFP is able to conduct these simultaneous investigations or prosecutions in a lawful and appropriate manner. By doing so, OIFP fulfills the public policy enunciated in its enabling legislation.

John Kennedy is an Assistant Attorney General, serving as Special Assistant to the Insurance Fraud Prosecutor, concentrating on civil matters involving licensed medical providers. Previously, he was Section Chief in OIFP's criminal division for three years, overseeing all criminal prosecutions except Medicaid cases. He has been with the Division of Criminal Justice since 1987.

61. Hicks v. City of New York, supra, 268 F. Supp.2d at 242; U.S. Commodity Futures Trading Commission v. A.S. Templeton Group, Inc., 297 F. Supp.2d 531 (E.D.N.Y. 2003).

62. See Hicks v. City of New York, supra, 268 F. Supp.2d at 242; State v. Kobrin Securities, Inc., supra, 111 N.J. at 314-17.

63. See generally "Parallel Civil and Criminal Proceedings," by Senior District Judge Milton Pollack, Southern District of New York, reprinted in 126 F.R.D. 201, 216 (1989).

64. U.S. Const. amend. V; Benton v. Maryland, 395 U.S. 784 (1969).

65. Brown v. Ohio, 432 U.S. 161, 165 (1977); see State v. Black, 153 N.J. 438, 443 (1998).

66. N.J. Const. (1947) art. 1, para. 11.

67. See State v. Widmaier, 157 N.J. 475, 490, 500 (1999) (finding protections against Double Jeopardy under the New Jersey Constitution consistently have been interpreted by the court to be co-extensive with the protections afforded by the federal clause).

68. 522 U.S. 93, 99 (1997).

69. 490 U.S. 435 (1989).

70. Hudson v. U.S., supra, 522 U.S. at 101.

71. Ibid.

72. See State v. Widmaier, supra, 157 N.J. at 492-93; State v. Black, supra, 153 N.J. at 445; Auge v. New Jersey Department of Corrections, 327 N.J. Super. 256, 263 (App. Div), certif. den.164 N.J. 559 (2000).

73. Hudson v. U.S., supra, 522 U.S. at 99.

74. Merin v. Maglaki, 126 N.J. 430 (1992).

2005 OIFP Licensing Board Statistics

	Suspension	Revocation	Voluntary Surrender	Reprimand	TOTAL
Chiropractic	7	1	0	0	8
Electrical Contractor	0	0	0	1	1
Medical	2	2	2	0	6
Speech Pathology	0	1	0	0	1
Nursing	1	0	0	0	1
Pharmacy	0	3	2	0	5
Physical Therapy	0	0	0	1	1
TOTAL	10	7	4	2	23

Kickbacks– Not Business as Usual to OIFP'S Medicaid Fraud Control Unit

by Marquis D. Jones, Jr.

High Medicare and Medicaid costs remain one of the hotbed issues in the United States. Both remain designated high risk programs partly due to their size.[1] The Government Accounting Office estimated fiscal year 2004 Medicare costs at $297 billion and Medicaid fiscal year 2003 costs at $274 billion.[2] The costs of fraud must be taken into consideration when evaluating the true costs of these programs. Medicaid and Medicare Fraud Control Units continue to discover fraudulent acts as corporations and individuals continue to push the ethics envelope in competitive business environments. Many corporations and individuals fail to realize that questionable business practices in private transactions are illegal if done in connection with government-sponsored programs. Agencies that police Medicare and Medicaid are combating these practices at the state and federal levels by prosecuting kickback arrangements that add to the cost of providing medical care.

The extent of the problem is visible at both federal and state levels. In a recently released Semi-Annual Report of the Office of Inspector General (OIG), OIG reported three matters in the significant investigative results section.[3] Each one involved illegal kickbacks. The cases produced at least $700 million in health care fraud settlements. Of this amount, more than $58 million may be directly attributable to penalties related to kickbacks. According to OIG reports, between 2001 and 2005, various states recovered approximately $8.8 million for various business arrangements that violated kickback laws.[4] In fact, the largest health care fraud investigation to date with total recoveries of $1.7 billion was partly a kickback case.[5] The kickback allegations in the case involved the company paying doctors in the form of free rent, free staff, vacations, recruiting bonuses, payments for unperformed consulting work, and phony partnership distributions.[6]

New Jersey's Medicaid Fraud Control Unit (MFCU) in the Office of the Insurance Fraud Prosecutor (OIFP) aggressively pursues those who engage in illegal kickback schemes. In 2005, MFCU prosecuted five

1. Government Accountability Office, Report to Congressional Committees, Health Care Fraud and Abuse Control Program, Results of Review of Annual Reports for Fiscal Years 2002 and 2003, GAO-05-134 (2005).

2. Ibid.

3. Office of the Inspector General, U.S. Dept. of Health and Human Services, Semiannual Report (October 1, 2004 to March 31, 2005).

4. Office of the Inspector General, OIG Fraud and Prevention Report (visited Dec. 6, 2005) <http://oig.hhs.gov/fraud/enforcement/administrative/cmp/cmpitems.html#3>.

5. House Budget Committee Hearing (July 9, 2003) (testimony of Dara Corrigan, Acting Principal Deputy Inspector General). The case involved HCA, Inc., and the government charged that the company submitted false hospital cost reports and paid kickbacks to physicians for the referral of beneficiaries.

6. Ibid.

cases for business behavior that violated New Jersey's anti-kickback laws. New Jersey recovered approximately a half million dollars in four of the five cases. In *State v. Pabbathi*, the court sentenced the owner of GLV Parke Warner Pharmacy to seven years in state prison in 2005 and ordered him to pay $450,000 in restitution. Undercover MFCU investigators posing as Medicaid beneficiaries busted Pabbathi when he paid them cash to use GLV Pharmacy. Pabbathi then billed Medicaid for filling prescriptions never dispensed to beneficiaries.

MFCU also charged four assisted living facility operators in a Medicaid kickback scheme in 2005. The State alleged that the owners of the assisted living facilities received kickbacks from the Belmar Home Town Pharmacy as an inducement to fill the prescriptions of the residents at the pharmacy. The prescriptions were billed to the Medicaid program. The kickbacks took the form of cash, free over-the-counter medications that were used by the residents of the facilities, and waiver of co-pays.

The owner of the Belmar Pharmacy, Michael Stavitski, had pled guilty in 2004 to second degree Health Care Claims Fraud, pursuant to N.J.S.A. 2C: 21-4.3(a). The court sentenced him to seven years in prison and ordered payment of approximately $1,102,173 in restitution. Michael Stavitski and three of his four pharmacies submitted numerous claims to Medicaid for medications to beneficiaries and privately insured patients when, in fact, the medications were never provided to the individuals. Additionally, Stavitski billed Medicaid for medications that were never prescribed by physicians. Stavitski used his family members and employees to enter fraudulent prescriptions into his computers for billing purposes. The State alleged in the related assisted living facility kickback cases that Stavitski used many of the residents' names to fraudulently bill Medicaid.

In another case prosecuted by OIFP's MFCU with kickbacks at the heart of the fraudulent conduct, a court sentenced Genady Chulak in 2005 to seven years in prison and ordered him to pay $944,629 in fines and restitution. A jury convicted Chulak earlier for submitting false claims by inflating mileage charges on invalid coach transportation services rendered to Medicaid beneficiaries. At trial, New Jersey MFCU prosecutors introduced evidence that showed Chulak paid kickbacks to Medicaid patients for using his vans. Chulak used the beneficiaries' names to defraud Medicaid out of more than $472,000. He escaped to Canada after the guilty verdict. The Immigration and Naturalization Service arrested him in 2004 when he attempted to enter the United States from Canada.

What are Kickbacks?

These cases make clear the danger of kickbacks where the provider seeks to recover the cost of the kickbacks by fraudulent means. Kickbacks, however, may take a variety of forms, including cash, loans, gifts, free equipment, payment of rent on a provider's facility, speaker fees, grants, and payments to third parties for debts. Recognizing that kickbacks take many forms and involve sophisticated schemes, some federal courts utilize a very broadly defined anti-kickback law.[7] In the Third Circuit, which includes New Jersey, the law is violated if one knowingly solicits or receives any remuneration to induce the use of a service.[8] It is of no moment that part of the payment may be for legitimate services as long as one purpose of the payment is "to induce the ordering of services...."[9] The Third Circuit's view is among the broadest interpretations of the federal anti-kickback law in the country, and it is a view endorsed by OIG.[10] "The anti-kickback statute addresses not only the offer of payment of anything of value for patient referrals, but also the offer or payment of anything of value in return for purchasing, leasing, ordering, or arranging for or recommending the purchase, lease, or ordering of any item or service reimbursable in whole or part ...[by the government healthcare system]."[11] Furthermore, the term "kickback" is not narrowly construed to mean a return of a portion of funds. It is also defined as "a percentage payment for granting assistance by one in a position to open up or control a source or income."[12]

7. New Jersey's kickback law, as delineated under the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-17(c), provides in relevant part:

Any provider, or any person, firm, partnership, corporation or entity who solicits, offers, or receives any kickback, rebate or bribe in connection with:

(1) The furnishing of items or services for which payment is or may be made in whole or in part under this act; or

(2) The furnishing of items or services whose cost is or may be reported in whole or in part in order to obtain benefits or payments under this act; or

(3) The receipt of any benefit or payment under this act, is guilty of a high misdemeanor and, upon conviction thereof, shall be liable to a penalty of not more than $10,000.00 or to imprisonment for not more than 3 years or both.

The federal kickback law, 42 U.S.C.A. §1320a-7b(b), provides in relevant part:

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind -

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person-

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

8. See United States v. Greber, 760 F.2d 68, 72 (3d Cir. 1985) (adopting definition of kickback as defined in United States v. Hancock, 604 F.2d 999 (7th Cir. 1979)). New Jersey state courts have not

The Avon Pharmacy and its owner Michael Stavitski were convicted of Health Care Claims Fraud

It is highly likely that the New Jersey state courts will adopt the broad view of kickbacks enunciated by the Third Circuit. When New Jersey established its medical assistance program, it only penalized willfully obtaining benefits under the New Jersey Medical Assistance and Health Services Act (Act) to which a person was not entitled, or falsifying reports required under the Act.[13] Although amendments to the statute noted investigations that exposed abuses of the program, the amendments focused on increasing penalties in order to deter "unscrupulous health care providers" who sought to take advantage "of a system that was designed to provide much needed medical care for [New Jersey's] less fortunate citizens."[14]

The Legislature Acts Against Kickbacks

The New Jersey Legislature did not add the express prohibition against kickbacks until the 1979 amendments to the Act.[15] In doing so, the New Jersey Legislature noted that "fraud in and abuse of the Medicaid program by both providers and recipients [continued] to be a serious problem."[16] The Legislature intended to broaden prohibitions against willfully and fraudulently obtaining benefits and payments, and it added the specific prohibition against kickbacks without adding the term "willfully" as that term existed in every other section of the statute that prohibited conduct.[17] The failure to add an additional intent element to the newly enacted prohibition against kickbacks lends support to an argument that the New Jersey courts will broadly interpret New Jersey's anti-kickback statute to effectuate its purpose of deterring fraudulent conduct and abuse of the system.

The anti-kickback statutes' focus is on the inducement factor, which is the corruption sought to be curbed by the statutes.[18] It is the improper decision making that accompanies payments to refer business that adds to the costs of health care

defined the requisite standard under the state statute. Unlike the federal anti-kickback statute, New Jersey's statute does not include the terms "knowingly and willfully." Since there is no culpability standard explicitly stated in the statute, the court will be required to apply a knowingly level of culpability with regard to the nature of the conduct and the attendant circumstances. See N.J.S.A. 2C:2-2c(3).

9. United States v. Greber, supra, 760 F.2d at 71. Other courts have taken a more narrow view. While some courts require that "the prosecution show that the defendant knew of the anti-kickback prohibition and acted with the specific intent to violate that law," others require proof that the defendant acted with the general bad intent to knowingly disobey or intentionally disregard the law. Timothy J. Aspinwall, The Anti-Kickback Statute Standards of Intent: The Case for a Rule of Reason Analysis, 9 Ann. Health L. 155, 166 (2002) [hereinafter Standards of Intent].

10. OIG Compliance Program Guidance for Pharmaceutical Manufacturers, 68 Fed. Reg. 23731, 23734 (2003) [hereinafter OIG Compliance Program]; See also Standards of Intent, 9 Ann. Health L. at 166.

11. OIG Compliance Program, supra, 68 Fed. Reg. at 23734.

12. Hancock, 604 F.2d at 1002.

13. L. 1968, c. 365.

14. L. 1976, c. 89; Governor Brendan T. Bryne, Office of the Governor Press Release (Sep. 15, 1976).

15. L. 1979, c. 365.

16. Ibid.

17. Ibid.

18. Greber, supra, 760 F.2d at 71.

and compromises quality because medical decisions are no longer made based on the best interests of the patient, but on the financial interests of the kickback payers and recipients. In order not to stifle legitimate business arrangements, there are "safe harbors" carved out that are considered proper business conduct at the federal and state level.[19] Each element of an exception must be followed for the exception to apply.

In 1996, Governor Christine Todd Whitman recognized the potential drain on New Jersey's Medicaid program caused by kickbacks. In issuing an executive order to create a Health Care Fraud Task Force, Governor Whitman included kickbacks in the list of illegal practices that were draining the health care dollars of the state.[20] The task force issued a report in 1996 that recognized kickbacks as a growing area of fraud.[21] The task force noted kickback schemes where, in return for money, nursing homes would make their large patient population available to other health care providers who would bill Medicaid for unnecessary services or services not rendered.[22] The task force was also concerned with kickbacks taking the form of waived co-payments. [23] "The impact of this kind of fraud goes beyond the amount of the co-payment waived. By routinely waiving co-payments, a provider not only misrepresents his usual and customary charges, he also eliminates the financial incentive to patients to use medical care prudently."[24] Accordingly, there are added costs to Medicaid caused by improper provider and beneficiary conduct.

In addition to kickback schemes involving providers, New Jersey's MFCU will be especially vigilant in ferreting out schemes involving pharmaceutical companies. Focusing on pharmaceutical kickbacks will become increasingly important because the new Medicare prescription drug benefit that began January 2006 is expected to increase spending by $47 billion in 2006, with projected spending to reach $174 billion in 2015.[25] The increase is relevant to New Jersey because many Medicaid enrollees will also be eligible for the Medicaid prescription drug benefit. Commentators have noted that Medicaid faces heightened vulnerabilities in the prescription drug area because it reimburses for many more drugs than Medicare.[26] Accordingly, New Jersey will have to take steps to protect its prescription drug costs.[27]

In fact, two of the three cases reported by OIG in its Semi-Annual Report involved pharmaceutical companies and kickbacks.[28] Additionally, TAP Pharmaceutical Products, Inc., agreed in 2001 to pay $875 million to resolve criminal charges and civil liabilities in connection with its fraudulent drug pricing and marketing conduct with regard to Lupron, a drug for treatment of advanced prostate cancer in men.[29] New Jersey's portion of the settlement was more than $1.8 million. The government alleged that TAP provided free samples of Lupron for which providers billed Medicaid. The free samples were intended to be an inducement for the providers to order Lupron. The State also alleged that TAP gave providers improper inducements in the form of grants, debt forgiveness, expenses for travel and entertainment, VCRs and TVs. Furthermore, three pharmaceutical companies have paid $257 million, nearly $88 million, and $49 million, respectively, to resolve False Claims Act cases.[30] Given that pharmaceutical companies have been the culprits behind some of the biggest kickback and fraud schemes, it will be necessary to keep a constant watch on their activities.

Keeping Legitimate Business Arrangements

For Medicaid providers who wish to steer clear of complex business arrangements that may implicate state and federal kickback laws, information exists to safely navigate safe harbors and exceptions. For example, almost all of OIG's 2005 posted advisory opinions involve business arrangements that could potentially impli-

19. At the federal level, there are detailed and narrowly defined carve outs of permissive behavior called safe harbors pertaining to investment interests, space rental, equipment rental, personal services and management contracts, sale of practices, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary co-insurance and deductible amounts, increased coverage, reduced cost-sharing amounts, or reduced premium amounts offered by health plans, price reductions to health plans, practitioner recruitment, obstetrical malpractice insurance subsidies, investments in group practices, cooperative hospital service organizations, ambulatory surgical centers, referral arrangements for specialty services, price reductions offered to eligible managed care organizations, price reductions offered by contractors with substantial financial risk to managed care organizations, and gifts or transfer of drugs or medical supplies by a hospital or other receiving facility for ambulance replenishing. 42 C.F.R. §1001.952 (2005). Additionally, the federal anti-kickback statute excludes properly disclosed discounts from the definition of remuneration. 42 U.S.C.A. §1320a-7b(b)(3). The Office of the Inspector General has also proposed safe harbors for remuneration in the form of hardware, software, and other electronic technology necessary for electronic prescriptions pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and for donations of goods, items, services, and loans to qualified health centers that make medical services available to a medically underserved population. 70 Fed. Reg. 59015 (2005); 70 Fed. Reg. 38081 (2005). New Jersey's anti-kickback statute carves out properly disclosed discounts, reductions in price, and amounts paid to employees in a bona fide employment relationship. N.J.S.A. 30:4D-17(c).

20. Executive Order Number 50 (Whitman, 1996).

21. Governor's Task Force on Health Care Fraud, Initial Report p. 14 (1996).

22. Ibid.

23. Ibid.

24. Id. at 15.

25. Forums Institute for Public Policy, 2005 Hot Health Policy Issues for State Policymakers, February 9, 2005 (visited Dec. 1, 2005) <http://www.forumsinstitute.org>.

26. House Budget Committee Hearing, supra n.5, at 5 (testimony of Dara Corrigan).

27. Ibid.

28. Semiannual Report, supra n.3, at i.

29. See United States Attorney Press Release (visited November 28, 2005) <http://www.usdoj.gov/opa/pr/2001/October/513civ.htm>.

30. House Budget Committee Hearing, supra n. 5, at 6 (Testimony of Dara Corrigan). The companies

cate anti-kickback laws.[31] OIG states that "advisory opinions issued by the Office of Inspector General [will be] made available to the general public through [the] OIG website. One purpose of the advisory opinion process is to provide meaningful advice on the application of the anti-kickback statute and other OIG statutes for specific factual situations."[32]

Additionally, for very complicated businesses or for particularly problematic business areas, OIG may offer compliance guidance. In May 2003, OIG issued a compliance program guidance for pharmaceutical manufacturers.[33] The compliance guidance was issued to "assist companies that develop, manufacture, market, and sell pharmaceutical drugs or biological products..." to develop internal programs to assist them in following statutes, regulations, and requirements of federal health care programs.[34] OIG also noted that it has issued guidelines for hospitals, home health agencies, laboratories, third-party billing companies, and durable medical equipment companies.[35] Given that OIG follows the Third Circuit's view of kickbacks, it is likely that its opinions would be given the proper deference at the state level. Consequently, there is no lack of information for providers and companies who want to conduct business in an honest manner, and avoid potential prosecution under federal and state anti-kickback laws.

New Jersey's MFCU will continue to aggressively investigate and prosecute kickback schemes in 2006. As health care costs rise, additional costs to Medicaid caused by fraudulent behavior are an unacceptable drain on the system. As health care dollars become even more valuable, New Jersey must enforce a zero tolerance policy by demanding ethical business behavior by all its health care professionals.

Marquis D. Jones, Jr. is a Deputy Attorney General, serving in OIFP's Medicaid Fraud Section. He has been with the Division of Criminal Justice since 2003. He has over ten years of civil litigation experience.

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were, respectively, Bayer Corporation, GlaxoSmithKline, and Pfizer, Inc.

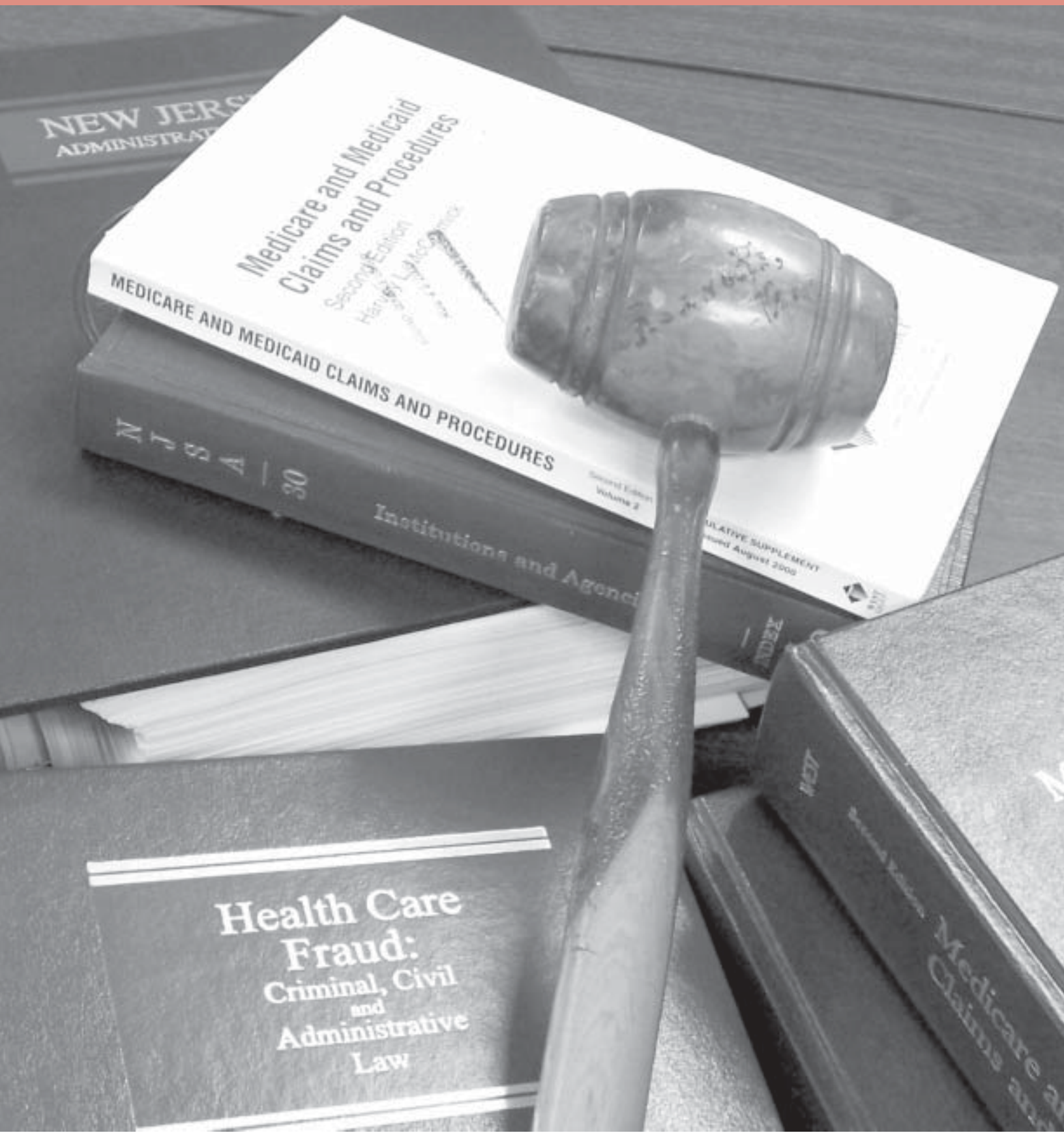
31. See Advisory Op. Ins. Gen. 05-01(January 28, 2005); Advisory Op. Ins. Gen. 05-02 (February 17, 2005); Advisory Op. Ins. Gen. 05-03 (February 17, 2005); Advisory Op. Ins. Gen. 05-04 (February 17, 2005); Advisory Op. Ins. Gen. 05-05 (February 18, 2005); Advisory Op. Ins. Gen. 05-06 (February 18, 2005); Advisory Op. Ins. Gen. 05-07 (February 18, 2005); Advisory Op. Ins. Gen. 05-08 (June 6, 2005); Advisory Op. Ins. Gen. 05-09 (June 6, 2005); Advisory Op. Ins. Gen. 05-11 (August 9, 2005); Advisory Op. Ins. Gen. 05-12 (October 31, 2005).

32. Office of Inspector General, Advisory Opinions (visited on November 23, 2005) <http://oig.hhs.gov/fraud/advisoryopinions.html>. OIG issues special Fraud Alerts as it did in 1994 regarding joint venture arrangements, routine waiver of Medicare Part B co-payments and deductibles, hospital incentives to referring physicians, prescription drug marketing practices, and arrangements for the provision of clinical laboratory services that could violate anti-kickback laws. It may also issue other guidance regarding the safe harbor regulations. See letter of D. McCarthy Thornton, Chief Counsel to the Inspector General, regarding up-front rebates, signing bonuses, and prebates that may implicate anti-kickback laws at <http://oig.hhs.gov/fraud/docs/safeharborregulations/prebate.htm>.

33. See OIG Compliance Program, supra, 68 Fed. Reg. at 23731.

34. Ibid.

35. Ibid.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MEDICARE AND MEDICAID CLAIMS AND PROCEDURES
Institutions and Agenci
Health Care Fraud: Criminal, Civil and Administrative Law

OIFP's Medicaid Fraud Control Unit:

Enforcement at Its Best

by John Krayniak

Medicaid was established by Congress in 1965 as part of the Great Society Program and is the primary government health care program for our poorest and disabled citizens. Medicaid is funded jointly by the state and federal governments and is administered by the State. New Jersey receives 50 percent of its Medicaid expenditures from the federal government. In State fiscal year 2005, the New Jersey Medicaid program spent almost $7.5 billion to provide care to approximately 800,000 beneficiaries.

For the first decade after Medicaid was created, the program operated with few controls against fraud. Inadequate safeguards combined with multi-billion dollar expenditure levels made a substantial amount of fraud inevitable. The result was an unprecedented theft of government dollars as local prosecutors struggled with the difficult task of prosecuting these highly sophisticated crimes.

After much media attention and congressional hearings highlighting the theft of taxpayer dollars and the harm suffered by Medicaid patients who were deprived of basic medical care in nursing homes, Congress recognized an urgent need to address the fraud and abuse that permeated the Medicaid program. The result was legislation to establish specialized state-based strike forces to police the Medicaid program and prosecute those who abuse or neglect nursing home residents.

The Advent of Medicaid Fraud Control Units

In 1977, Congress enacted legislation, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142, which established the state Medicaid Fraud Control Unit (MFCU) program and provided the states with incentive funding to investigate and prosecute Medicaid provider fraud. The enabling federal legislation emphasized the necessity of having an integrated multi-disciplinary team of attorneys, investigators, and auditors in one office in order to successfully prosecute these complex financial crimes. New Jersey was the first state to have a certified unit. The New Jersey Medicaid Fraud Control Unit was certified in March 1978.[1]

MFCUs are required to be separate and distinct from the state Medicaid programs to avoid institutional conflicts of interest. The units are generally located in the State Attorneys General Offices, although some MFCUs are located in other state agencies with law enforcement responsibilities. In New Jersey, the MFCU is designated as the Medicaid Fraud Section in the Office of the Insurance Fraud Prosecutor (OIFP) in the Division of Criminal Justice.

1. Federal regulations require MFCUs to be re-certified annually by the Secretary of the Department of Health and Human Services (DHHS), Office of Inspector General (OIG). New Jersey's Medicaid Fraud Control Unit has been re-certified every year since its inception in 1978.

In 2003, the Medicaid program was designated as an "at risk" program by the United States General Accounting Office. This was due to the size of the program, which now exceeds Medicare, and the vulnerabilities inherent in a program of this magnitude.[2] The State will spend approximately $8 billion in the upcoming state fiscal year to fund the Medicaid program. Since 50 percent of Medicaid program expenditures is directly funded by State taxpayer dollars, the Medicaid program is one of the largest expenditures in the State budget. In policing the program, the New Jersey MFCU, therefore, serves a vital role in the administration of the Medicaid program.

New Jersey's MFCU has also assumed responsibility for policing the Pharmaceutical Assistance to the Aged and Disabled (PAAD) and Senior Gold (SG) pharmaceutical assistance programs. These programs are funded entirely by State taxpayer dollars. In State fiscal year 2005, the State spent approximately $560 million on these programs. Beginning January 1, 2006, many PAAD and SG beneficiaries will be covered by Medicare Part D. On the surface, this will reduce program expenditures but the federal government will recoup some of its expenditures through the "claw back" provision of the Medicare Part D legislation. Therefore, State dollars continue to remain at risk.

Protecting Medicaid Beneficiaries and Resources

The protection of the Medicaid program and its beneficiaries from fraud, waste, and abuse is a vital and significant State interest from both a moral and fiscal view. The mission of law enforcement is to protect life and property. OIFP's Medicaid Fraud Section is unique in the Division of Criminal Justice in that its mission, which is "to protect the Medicaid program and its beneficiaries from fraud, waste and abuse," addresses both of these mandates.

In addition to investigating and prosecuting health care provider fraud, the Medicaid Fraud Section has direct responsibility for investigation of patient abuse and neglect in all facilities that receive Medicaid funds or house residents or patients who receive Medicaid benefits. The Section has a responsibility to protect tens of thousands of elderly and disabled residents residing in the State's 372 approved long-term care facilities and 84 hospitals. The Section also investigates abuse and neglect in hundreds of assisted living and board and care homes.

OIFP's Medicaid Fraud Section has 43 full-time positions. There are 11 Deputy Attorneys General (DAsG); 22 State Investigators; 7 professionals (consisting of two Auditors, one Management Assistant, one Attorney Assistant, one Analyst, one Technical Assistant and one Nurse); and three clericals. Two DAsG, two State Investigators and the Nurse are assigned to the Elder Abuse and Neglect Unit within the Medicaid Fraud Section.

During 2005, the Medicaid Fraud Section opened 119 cases and closed 100 cases. At the end of 2005, there were 161 cases pending, 39 of which were assigned to the Elder Abuse and Neglect Unit. Medicaid fraud cases are referred to the Section from several sources. The Division of Medical Assistance and Health Services (DMAHS) in the Department of Human Services refers provider fraud cases of all types to the Section. The Department of Health and Senior Services (DHSS) administers distinct parts of the Medicaid program and refers cases of suspected fraud in nursing homes and adult medical day care centers to the Section.

New Jersey's Medicaid program contracts with five private managed care organizations that provide program benefits to beneficiaries. The Medicaid Fraud Section meets with these carriers quarterly to discuss cases and program issues. These organizations have a contractual obligation to refer fraud cases to the Medicaid Fraud Section. Personnel in the Medicaid Fraud Section also generate cases. These cases come from cooperating witnesses, information received directly by the Medicaid Fraud Section, or analyzing Medicaid billing data.

OIFP's Medicaid Fraud Section is a member of the National Association of Medicaid Fraud Control Units (NAMFCU). NAMFCU also serves as a lucrative source of referrals of national cases to OIFP's Medicaid Fraud Section. NAMFCU employs a full-time counsel and paralegal and, since 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).

OIFP Medicaid Fraud Control Unit Chief, Assistant Attorney General John Krayniak, lectures students at the Seton Hall University School of Law Health Care Compliance Certification Program.

2. The Omnibus Reconciliation Act of 1993 required all states to have an MFCU by January 1995 unless a state could demonstrate to the Secretary of the Department of Health and Senior Services that it had a minimum amount of Medicaid fraud.

Medicaid Fraud Control Unit Deputy Attorneys General Marquis Jones (l.) and Alvina Seto (r.) confer on a case.

Since 1994, NAMFCU members, including New Jersey's MFCU, have worked closely with the United States Department of Justice (DOJ) in cases which affect the Medicare, Medicaid, and other health care programs. Cooperative efforts between state and federal authorities have proven effective in protecting Medicaid and Medicare from health care providers or vendors whose activities involve both programs and cross state lines. All recoveries and damages are generally predicated upon a state's actual damages. Since the federal government subsidizes each state's Medicaid program in differing amounts, damages are allocated based on the funding formulas.[3]

New Jersey's MFCU: An Example of Cost-Effective Enforcement

New Jersey's MFCU budget for federal fiscal year 2006 (October 1, 2005 to September 30, 2006) is $4,269,448. The federal government provides 75 percent of the operating costs of the Medicaid Fraud Section and the State provides the 25 percent state match. According to the breakdown for fiscal year 2006, the federal government will contribute $3,296,548 and the State will contribute $1,098,849 to the Section's budget.

Typically, the Medicaid Fraud Section recovers more in restitution and penalties than the state match of its federal grant. In addition to seeking restitution and criminal fines, the Medicaid Fraud Section has been very aggressive in utilizing the Medicaid civil false claims statute, N.J.S.A. 30:4D-17e, to punish offenders and return dollars to the State treasury.

Under New Jersey's statutory scheme, restitution that is collected in a Medicaid case is shared equally between the federal government and the state because the Medicaid program is funded in that manner. Penalty money collected through the Medicaid Fraud Section's efforts, however, is allocated in its entirety to the State. This makes New Jersey's MFCU a cost-effective mechanism to ensure that New Jersey's vital state interests are protected.

For example, in calendar year 2004, the Medicaid Fraud Section drew down $616,793 in State funds to match the federal grant contribution. During that time, the Medicaid Fraud Section recovered $8.4 million for the State in restitution and civil false claims penalties. This equates to $13.63 actually recovered for every one dollar of State money dedicated to OIFP's Medicaid Fraud Section. Additionally, the Medicaid Fraud Section recovered $43,658 for private insurance companies and provided $42,000 to the Attorney General's Law Enforcement Fund through forfeiture. As the State collects on judgments obtained during this period, this ratio increases.

In calendar year 2005, the Medicaid Fraud Section drew down $727,938 in State funds to match the federal contribution. During this time period, the Medicaid Fraud Section recovered $5.7 million for the State in restitution and civil penalties. This equates to $7.85 recovered for every State dollar dedicated to OIFP's Medicaid Fraud Section. This decrease is due in part to the timing of large settlements. Nonetheless, the Medicaid Fraud Section remains a cost-effective means of policing the Medicaid program.

The Medicaid Challenge

Medicaid fraud cases are among the most difficult cases a prosecutor, investigator, or auditor will encounter. There is frequently a massive amount of data which must be collected, analyzed, and categorized to determine if it is of evidential value. This is a time-consuming and labor- intensive task. Matters involving false claims always require the preparation of summary charts with attendant motions for admissibility and the drafting of appropriate jury charges for submission to the judge. These cases require intense scrutiny on issues of proof and a painstaking evaluation of evidence, often circumstantial, to prove criminal intent.

Because of the massive amount of data that is generally presented in these cases, Deputy Attorneys General must possess the ability to present information in a clear and concise manner. Deputy Attorneys General must be proficient in laying evidential foundations for the admission of summary charts and expert testimony concerning diverse areas, such as medical records, financial records, and program regulations. Moreover, managed care cases raise legal and factual issues distinct from the traditional fee-for-service cases.

The Medicaid Fraud Section is aggressive in its use of parallel proceedings and most cases involve related licensing and Medicaid provider issues. In all case settlements negotiated by Deputy Attorneys General in the Medicaid Fraud Section, defendants are required to settle not only criminal charges but also civil false claims penalties under New Jersey's Medicaid False Claims Act. The defendant must also agree to a period of debarment as a Medicaid provider. Lastly, for those defendants holding a professional license, a period of license suspension is also negotiated. This practice is cost effective, efficient, and eliminates the need for additional litigation after the criminal matter is concluded.

Conclusion

The achievements of New Jersey's MFCU highlights the success of federal and state government partnering in fighting fraud and returning much needed dollars to the State's Medicaid program. OIFP's Medicaid Fraud Section provides a stellar example of efficient and effective law enforcement.

John Krayniak, an Assistant Attorney General, is an 18-year veteran of the Division of Criminal Justice and has been the Chief of OIFP's Medicaid Fraud Control Unit for 12 years. He previously served for eight years as a Deputy District Attorney in the Los Angeles County District Attorney's Office.

3. Between 1994 and 2004, New Jersey recovered $18.3 million from national cases. Several recent cases resolved allegations against national health care companies that paid kickbacks to local medical providers to utilize their product or service. Following the execution of settlement agreements in some of these cases, OIFP's Medicaid Fraud Section is able to invoke the cooperation clause that is typically included in these agreements to commence investigation of local providers.

Closing the Loopholes on Insurance Fraud:

OIFP's Recommendations for Legislative and Regulatory Reform

by John J. Smith and Wellington Gu

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 prevention, detection, investigation, and prosecution. To fulfill that statutory mandate, since 1999 OIFP has recommended numerous legislative and administrative changes to the existing statutory and regulatory framework related to the prevention, detection, investigation, and prosecution of insurance fraud, as well as proposed new regulations and guidelines related to insurance fraud law enforcement and related matters.

Some major recommendations include (1) amendments to clarify and expand the scope of the Insurance Fraud Prevention Act (the Fraud Act), N.J.S.A. 17:33A-1 et seq.; (2) enhancement of legal penalties and new regulations addressing insurance fraud detection, investigation, and prosecution; (3) new legislative and administrative tools for the insurance industry to better protect itself against fraud; and (4) mechanisms to enhance cooperation among insurance companies, medical and automotive service providers, and State agencies.

In the past, OIFP recommendations have led to regulatory changes which enabled the insurance industry to better protect itself against persons who committed insurance fraud. For example, the following regulatory changes have been codified in the New Jersey Administrative Code at Chapter 11:3 and at N.J.S.A. 17:33B-1 et seq. to:

- Allow insurance companies to exclude coverage of drivers who have admitted violating or have been adjudicated to have violated the Fraud Act, and make these violators ineligible for insurance coverage in the voluntary automobile insurance market. See N.J.A.C. 11:3-34.4(a)(4) and (9); see also N.J.A.C. 11:3-8.5, amended in 2001, and see also N.J.S.A. 17:33B-13(h). Recommended in *OIFP Annual Report 2000*, p.52.
- Allow for mid-term policy cancellation where the insured has admitted violating or has been adjudicated to have violated the Fraud Act. See N.J.A.C. 11:35.4(g)(1). Recommended in *OIFP Annual Report 2000*, p.53.

With respect to persons who would circumvent the requirement to purchase automobile insurance coverage, a recommendation designed to protect the integrity of automobile insurance identification cards was also adopted in accordance with the following OIFP recomendation to:

- Require the use of anti-counterfeit technology, such as holographic imaging or other document security devices, for insurance identification cards. See N.J.A.C. 11:3-6.4, amended in 2004. Recommended in *OIFP Annual Report 1999*, p.48; *OIFP Annual Report 2001*, p.86.

This article highlights several OIFP recomendations. Some of these recomendations have been implemented through enactment of legislation or by adoption of regulation. Others are being proposed for consideration by the Governor, the Legislature, other government officials, and insurance industry executives

Proposed Legislative Amendments to the Insurance Fraud Prevention Act

The Fraud Act was passed in 1983 and substantially amended in 1998 when OIFP was established to combat insurance fraud and coordinate similar efforts in County Prosecutors' Offices. As the primary statutory authority for OIFP, the Fraud Act creates a framework for enforcement with respect to civil insurance frauds and insurance fraud-related crimes. OIFP undoubtely has a strong interest in clarifying any ambiguous language in the Fraud Act and ensuring the scope of the Fraud Act is adequate to combat all forms of insurance fraud. Thus, it is not surprising that a majority of OIFP's recommendations are aimed at achieving this goal.

Some of OIFP's recommended amendments to the Fraud Act are:

- Amend N.J.S.A. 17:33A-8 to insure that the Insurance Fraud Prosecutor has direct control over the statutory mechanism which provides for funding of OIFP operations. Currently, the statute sets forth responsibilities with respect to OIFP funding for the Attorney General, the Department of Banking and Insurance (DOBI), and the State Treasurer but provides no statutory mechanism for input from the Insurance Fraud Prosecutor. Amending the statutory funding provisions for OIFP is critical to its continued success.
- Amend N.J.S.A. 17:33A-3 to expand the definition of insurance companies to include entities such as HMOs, joint insurance funds, and self-insured entities, among other insurance-based arrangements. OIFP should be given civil insurance fraud enforcement authority to impose civil penalties on those who defraud these entities which provide similar indemnification or financial protection against insurable risks as licensed insurance companies. Recommended in *OIFP Annual Report 1999*, p.50; *OIFP Annual Report 2001*, p.85.
- Clarify the Fraud Act by making necessary technical corrections to replace, where appropriate, all references to the Commissioner of DOBI with references to the Insurance Fraud Prosecutor. Recommended in *OIFP Annual Report 2002*, p.91.
- Amend the Fraud Act to expressly establish a ten-year Statute of Limitations within which a civil lawsuit for a statutory civil fraud penalty must be filed, and expressly establish the burden of proof for such civil insurance fraud cases to be the preponderance of the evidence standard. Recommended in *OIFP Annual Report 2002*, p.91.
- Amend N.J.S.A. 17:33A-5 to permit the Attorney General's Office to authorize any person to pay a civil insurance penalty by the use of a credit card. Recommended in *OIFP Annual Report 1999*, p.51.
- Amend N.J.S.A. 17:33A-11 to expressly provide that in the interest of protecting confidential informants, investigative techniques, and other law enforcement matters requiring confidentiality, OIFP insurance fraud investigative files are confidential. Recommended in *OIFP Annual Report 1999*, p.51.
- Make the award of attorney fees mandatory in cases where the State successfully intervenes in a pending insurance company lawsuit in which fraud is alleged.
- Amend N.J.S.A. 17:33A-5 to grant OIFP the express authority to seek restitution on behalf of an insurance carrier or other insurer in connection with a lawsuit to impose civil insurance fraud fines against a violator. Recommended in *OIFP Annual Report 2001*, p.85.
- Amend N.J.S.A. 17:33A-4 to create a civil insurance fraud violation for practitioners who commit fraud through use of a business entity (corporation, partnership, or L.L.C..) they own, operate, or otherwise control. Recommended in *OIFP Annual Report 1999*, p.50.
- Amend N.J.S.A. 17:33A-4 so that the possession, display, distribution, or manufacture of a fictitious motor vehicle insurance identification card constitutes a violation of the Fraud Act.[1] Consideration should be given to also including other documents or records, such as certificates evidencing workers' compensation insurance or other certificates of insurance typically provided by contractors or subcontractors as part of any comprehensive amendment to the Fraud Act. Recommended in *OIFP Annual Report 2002*, p.88; *OIFP Annual Report 2004*, p.158.
- Amend the Fraud Act to create a violation which includes the practice of reverse rate evasion, in which a New Jersey resident fraudulently reports an out-of-state address as the address where the resident registers and garages his/her vehicles, when, in fact, those vehicles are garaged and are primarily driven in New Jersey. Recommended in *OIFP Annual Report 2003*, p.181; *OIFP Annual Report 2002*, p.90.[2]
- Require a practitioner, who has been found by a court to have committed a pattern of fraud violations in a civil or criminal case, to provide an accounting of claims money obtained through all such violations, and allow insurance companies to sue for compensatory damages which may be trebled. Recommended in *OIFP Annual Report 1999*, p.51.
- Clarify the extraterritorial application of the Fraud Act to include acts of insurance fraud which occur out-of-state but have a nexus to New Jersey.[3]

1. Although drafting language for each of the recommended statutory and regulatory changes recommended by OIFP is beyond the scope of this article, the following language is recommended as an amendment to N.J.S.A. 17:33A-4(a):

A person or practitioner violates the 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;

Proposed Enhancements of Legal Penalties and New Regulations

A major tool used by OIFP to combat insurance fraud is the authority to impose civil and criminal penalties against fraud perpetrators. However, OIFP has determined that current enforcement or regulatory authority is not sufficient to address some types of fraud, claims abuse, or similar conduct. Current laws have not fully addressed insurance fraud-related conduct within diagnostic imaging facilities and towing companies. Thus, OIFP recommends new regulations to plug potential loopholes or enhance enforcement efforts. OIFP's recommendations in this regard include:

- Require operators of MRI facilities and other diagnostic imaging facilities to undergo a comprehensive criminal background check, similar to checks made of operators of casinos, check cashing businesses, and bars. Persons who have been convicted of Insurance Fraud or other crimes of dishonesty should be disqualified from holding a license for, or exercising ownership or control over, any diagnostic imaging facility. Recommended in *OIFP Annual Report 2003*, p.182-183; *OIFP Annual Report 2000*, p.54; *OIFP Annual Report 2001*, p.87.
- Enact legislation which authorizes the Commissioner of DOBI to promulgate a schedule of appropriate towing and storage fees applicable to automobiles which have been damaged in accidents, or which have been recovered after being stolen. Such legislation should specifically describe the amount towing operators may charge not only municipalities, but also insurers and owners, as well as stronger penalties for those towing operators who violate the fee schedule. It should also require that towing or storage yard owners promptly take reasonable measures to identify and notify the owner and insurer of the vehicle of the location of its tow yard and any towing and storage fees that have accrued or are accruing, as well as any and all fees associated with towing, storing, and releasing vehicles. Recommended in *OIFP Annual Report 2003*, pp.178-179.

Proposals Concerning Accident and Related Police Reports

The role that automobile accident and related police reports play in the insurance claims process simply cannot be overstated. Police reports are crucial to the claims process. The accuracy and thoroughness of police reports, their release to insurance carrier representatives so that the process of detecting and investigating insurance fraud can begin, and preventing access to reports by "runners" promote anti-insurance fraud objectives. OIFP's recommendations in this area include:

- Articulate a reasonable standard for authorizing the release of accident reports to those with a legitimate need for the information within these reports, but which excludes "runners" seeking such reports to identify persons to solicit for medical or Personal Injury Protection (PIP) claims. Recommended in *OIFP Annual Report 2000*, pp.54-55.

b. Exhibits or displays to a law enforcement officer or a person conducting a motor vehicle inspection pursuant to Chapter 8 of 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.

It should be noted that the crime of selling forged insurance identification cards was amended pursuant to OIFP recommendations in 2001 (see N.J.S.A. 2C:21-2.3) and it is in the best interest of insurance fraud law enforcement to amend the civil fraud statute to parallel the criminal statute.

2. This change will necessitate a careful review of statutes within Title 39 to include financial responsibility and motor vehicle registration.

3. For analogous statutory guidance in the Criminal Code, see N.J.S.A. 2C:1-3.

- Amend N.J.S.A. 17:33A-29 to require law enforcement to release the results of sobriety tests to insurance company investigators conducting claims-related investigations. Recommended in *OIFP Annual Report 2002*, p.92.
- Amend statutory time frame for release of accident report information. While current law requires state and local law enforcement agencies, including the New Jersey State Police, to provide automobile accident report information (including incident reports or "walk-in" police reports, and reports related to auto accident fatalities) to insurance company investigators within 24 hours of the occurrence of the accident, depending on the complexity of the accident, the 24-hour time period is unrealistic. The statute should be amended to modify the time frame from 24 hours to 5 business days. Recommended in *OIFP Annual Report 2001*, p.86.

Proposed New Criminal Statutes

Persons who do not possess the requisite licenses nonetheless sometimes engage in insurance-related professional practice, such as selling insurance or insurance-related products without a license, or practicing chiropractic without being licensed. Unlicensed insurance sales often result in the theft of insurance sales commissions and premiums. The public is exposed to harm when regulated professions are practiced by those without the requisite licenses. Such unlicensed professional conduct should be prescribed by the New Jersey Criminal Code. OIFP's recommendations in this regard include:

- Repeal N.J.S.A. 17:17-12, an existing offense codified among the statutes pertaining to the licensing of insurance agents, and which does not appear in the New Jersey Criminal Code and which renders the conduct of selling insurance without a license a mere misdemeanor. Replace N.J.S.A. 17:17-12 with a criminal statute similar to N.J.S.A. 2C:21-20 (Practice of Medicine, Surgery or Podiatry by Unlicensed Persons); N.J.S.A. 2C:21-22 (Unauthorized Practice of Law); N.J.S.A. 2C:21-30 (Unlawful Practice of Dentistry); or N.J.S.A. 2C:21-31 (Unauthorized Practice of Immigration Law).
- Enact a criminal statute that makes it a third degree crime to practice chiropractic without a license in the same manner that the unlicensed practice of medicine, surgery, podiatry, dentistry, and law are crimes. Recommended in *OIFP Annual Report 2003*, p.179-180.
- Amend the Health Care Claims Fraud Act, the criminal Insurance Fraud statute, and other criminal theft statutes to provide that the theft of $500,000 or more constitutes a crime of the first degree. Recommended in *OIFP Annual Report 2002*, p.89.

Proposals Impacting "Runners"

"Runners" continue to be the driving force behind automobile insurance PIP fraud.[4] As the case descriptions in OIFP's Annual Reports from this year and past years clearly demonstrate, prosecutors have used the "Runners" statute to deter insurance fraud by "runners" and to prosecute those who continue to engage in the business of soliciting patients, clients, and insurance claimants for money. Still, refinements of the "Runners" statute are needed. OIFP recommendations in this area include:

- Enact remedial legislation to set forth explicit legislative findings and declarations which enumerate the public policy reasons which support the Criminal Use of Runners statute, N.J.S.A. 2C:21-22.1. A succinct statement of some of those policy reasons can be found within a previously published article in the *2003 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor*, "OIFP's Prosecutions Prove Corrupting Influences of 'Runners' on Health Care System," at p.16; see also the *2004 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor*, "A Comprehensive Guide to Insurance Law," at p.33.
- Amend N.J.S.A. 2C:21-22.1 so that it includes within its anti-"running" provisions government-sponsored health care plans to include Medicaid, Pharmaceutical Assistance to the Aged and Disabled Program (PAAD), and Senior Gold Prescription Discount Program (SG). Presently, because these programs are not "contracts of insurance" within the meaning of the "Runners" statute and because the Medicaid program is not an insurance carrier as defined in the statute, the "Runners" statute does not apply to these programs. Recommended in *OIFP Annual Report 2004*, p.157.
- Amend the definition of "provider" within N.J.S.A. 2C:21-22.1(a) to include "practitioner" as that term is defined by the Health Care Claims Fraud Act, N.J.S.A. 2C:21-4.2. By including practitioner within the definition of provider, the "Runners" statute will conform to the Health Care Claims Fraud statute. Recommended in *OIFP Annual Report 2004*, p.157-158.
- Amend N.J.S.A. 2C:21-22.1 to proscribe referrals by one provider to another provider for money, property, or other items of value, by specifically indicating that such referrals are not among those referrals "otherwise authorized by law" within the meaning of the statute. Recommended in *OIFP Annual Report 2002*, p.89.
- Amend N.J.S.A. 17:22B-13e to preclude public adjusters from contacting insureds within 48 hours after they sustain a loss compensable under a policy of insurance. Recommended in *OIFP Annual Report 2003*, p.178.[5]
- Create a system to enable the Motor Vehicle Commission (MVC), at the time a title to a motor vehicle is obtained through MVC, to determine whether the vehicle for which title has been requested has been reported stolen to any law enforcement authorities. This could be accomplished by providing limited access to the National Crime Information Center (NCIC) database,

4. See "OIFP's Prosecutions Prove Corrupting Influence of 'Runners' on Health Care System," *2003 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor*, March 2004, at 16.

or by extracting data from the NCIC database in such a manner as to make it readily accessible to MVC officials or by such other means as may be practicable.

- Redesign an anti-fraud uniform health care claims form so as to require clear and unambiguous information specifically identifying the type of procedures, medical services, and medical supplies provided and billed. Also, design the form to elicit information identifying any and all persons in the provider's office who provided, or assisted in providing, the services billed, including the professional license number and all Taxpayer Identification Numbers (TINs) associated with the licensed medical provider or related entities identified as having provided any of the services set forth in the claim form. The form should also incorporate a certification specifically affixing personal legal responsibility for the accuracy of the claim with the professional licensee in whose name and under whose supervision the services or supplies were provided. The certification should specify that the responsible provider reviewed the claim form and that it is accurate, complete, and truthful with respect to all information contained therein. Recommended in *OIFP Annual Report 2003*, p.182.
- Require insurance companies to send the patient a plain language statement of the services billed by the physician, so that patients can act as a check on potential fraudulent billing. Recommended in *OIFP Annual Report 1999*, p.49.

Proposed New Tools and Standards for the Insurance Industry

Licensed insurance companies in New Jersey are a major partner of OIFP in the fight against insurance fraud. As the first line of defense against fraud and a watchdog for suspicious insurance applications and claims, insurance companies should be provided with tools to better detect and deter insurance fraud crimes. In some cases, the industry should be encouraged to take certain steps to make it more difficult for criminals to commit insurance fraud in the first place. The ability of the insurance industry to protect itself enhances OIFP's ability to prosecute crimes and litigate fraud violations and secures the bottom line of every New Jersey insurance consumer. While some OIFP regulatory recommendations have been implemented, OIFP has proposed additional changes to assist insurance providers to better protect themselves against insurance fraud as follows:

- Reduce the notice period for cancellation of automobile insurance from a full policy cycle to 30 days, and add as grounds for cancellation the insured's failure to return a fully completed renewal questionnaire within 30 days of its due date. Recommended in *OIFP Annual Report 2000*, p.53.
- Promulgate appropriate regulations to require Insurance Services Office (ISO) and MVC records checks at the time an automobile insurance application is submitted in order to determine whether or not the applicant has undisclosed drivers residing in the household or motor vehicle violations so as to reduce the number of insurance application fraud cases that presently exist.
- Promulgate regulations that will facilitate the identification of undisclosed drivers residing in the insured's household by requiring not only the identity of each licensed driver but also the identity of any resident of the household who has reached his or her 17th birthday. Recommended in *OIFP Annual Report 2000*, p.53.

5. See N.J.S.A. 2C:40A-4 for an example of a criminal statute that prohibits physicians, chiropractors, or other health care professionals from contacting accident or disaster victims for 30 days.

Proposals to Facilitate Better Cooperation Among Insurance Companies, Service Providers, and State Agencies

In recent years, insurance fraud crimes have grown in complexity from simple "paper accidents" to intentional auto crashes and sophisticated PIP rings involving conspiracies which may include doctors, lawyers, "runners," and others. These crimes are solved only with extensive cooperation between insurance companies and OIFP. OIFP believes that it is important to promulgate regulations and guidelines that will enhance the cooperation and coordination among the insurance industry, the service providers, and various State agencies. Some of these proposals include:

- Update the MVC computer system to give insurers access to information identifying all drivers residing at the same address. MVC should also be given authority to charge insurance carriers the cost of programming changes. Recommended in *OIFP Annual Report 1999*, p.48.
- Allow the State Board of Medical Examiners to more readily share investigative information (N.J.S.A. 45:9-13) with OIFP and other State agencies investigating the conduct of licensed medical service providers and other licensees.[6] Recommended in *OIFP Annual Report 1999*, p.49.
- Amend various provisions governing the ethical conduct of licensed health care practitioners, such as physicians, chiropractors, dentists, and podiatrists, to require such health care practitioners to notify the appropriate licensing authority of potentially fraudulent activities, in a manner similar to the Rules of Professional Conduct 8.3 for attorneys. Recommended in *OIFP Annual Report 1999*, p.49.
- Empower the Director of MVC to sanction an auto body repair facility which violates the Fraud Act. Recommended in *OIFP Annual Report 2000*, p.52.
- Amend N.J.S.A. 17:33B-13 to clarify that a person who has admitted violating or who has been adjudicated to have violated the Fraud Act is excluded from automobile insurance eligibility in the voluntary market.
- Amend N.J.S.A. 39:10-20 and N.J.S.A. 39:13-4 to include as grounds for MVC to suspend or revoke the license of a motor vehicle dealer or auto body repair facility, the fact that a motor vehicle dealer or auto body repair facility has been convicted of a crime or offense related to insurance fraud, or that such business has admitted to or has been adjudicated as violating the Fraud Act.
- Amend N.J.S.A. 17:29C-7.1 so that automobile insurance policies can be cancelled if the insured has been determined to have made a material misrepresentation in the application for the current insurance policy, or that, during the current policy term, the insured has admitted to violating or has been adjudicated to have violated the Fraud Act.

Wellington Gu *was a summer intern with OIFP. He is a third-year law student at Washington and Lee University Law School.*

6. It should be noted that N.J.S.A. 17:33A-23 grants OIFP access to information in the possession of other State agencies.

To fulfill its statutory mandate, in its Annual Reports, OIFP recommends legislative and administrative changes to the existing statutory and regulatory framework related to the prevention, detection, investigation, and prosecution of insurance fraud, as well as proposed new regulations and guidelines related to insurance fraud law enforcement and related matters. OIFP's Annual Reports can be viewed at: www.njinsurancefraud.org.

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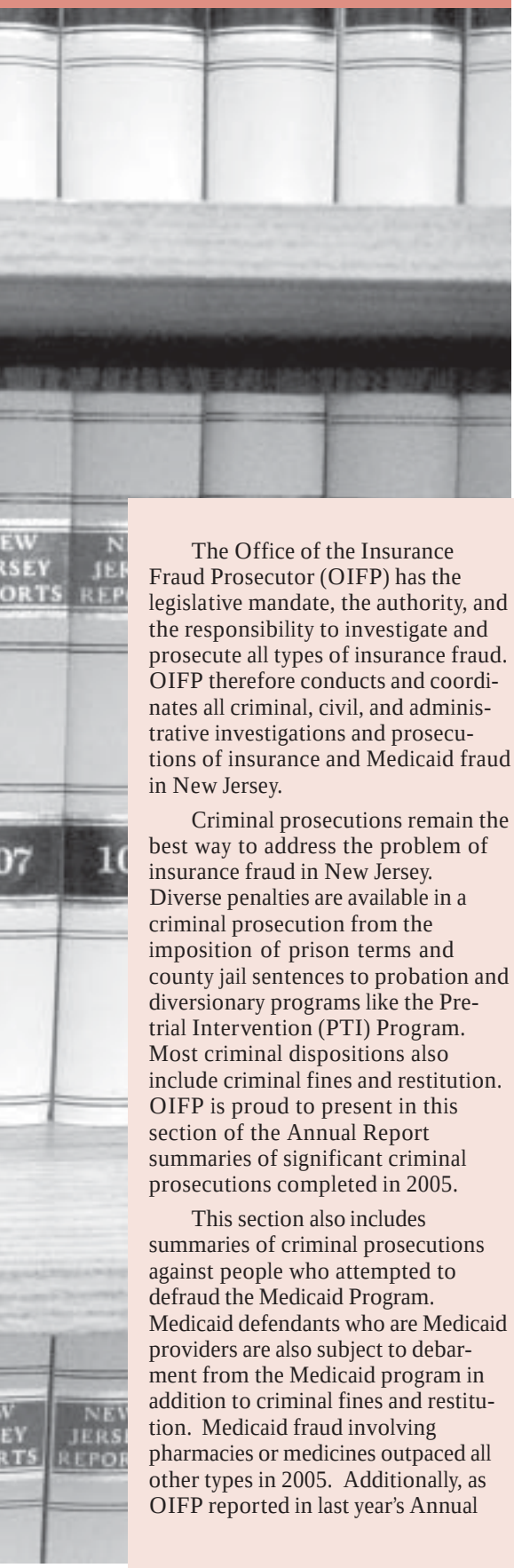

The Office of the Insurance Fraud Prosecutor (OIFP) has the legislative mandate, the authority, and the responsibility to investigate and prosecute all types of insurance fraud. OIFP therefore conducts and coordinates all criminal, civil, and administrative investigations and prosecutions of insurance and Medicaid fraud in New Jersey.

Criminal prosecutions remain the best way to address the problem of insurance fraud in New Jersey. Diverse penalties are available in a criminal prosecution from the imposition of prison terms and county jail sentences to probation and diversionary programs like the Pretrial Intervention (PTI) Program. Most criminal dispositions also include criminal fines and restitution. OIFP is proud to present in this section of the Annual Report summaries of significant criminal prosecutions completed in 2005.

This section also includes summaries of criminal prosecutions against people who attempted to defraud the Medicaid Program. Medicaid defendants who are Medicaid providers are also subject to debarment from the Medicaid program in addition to criminal fines and restitution. Medicaid fraud involving pharmacies or medicines outpaced all other types in 2005. Additionally, as OIFP reported in last year's Annual Report, it stepped up its protection of New Jersey's elderly population. Summaries of patient and elder abuse prosecutions are included in the case notes.

The New Jersey County Prosecutor Insurance Fraud Reimbursement Program, administered by the Attorney General through the Insurance Fraud Prosecutor, has provided funding for personnel in 19 of New Jersey's 21 counties. In 2005, these County Prosecutor Insurance Fraud Units charged 377 defendants and obtained 182 convictions by guilty plea or trial, resulting in jail terms totaling more than 62 years. The county units conduct proactive investigations as well as investigate referrals from various sources, including insurance carriers. The units also provide training to local police and fire departments. Some of the most notable cases handled by these units are summarized in this section.

The Insurance Fraud Prevention Act (the Fraud Act), N.J.S.A. 17:33A-1, et seq., specifically gives OIFP authority to impose civil fines on insurance cheats. The fines may be imposed as part of, or as an alternative to, criminal prosecutions. Summaries of cases that led to a banner year in settlements, judgments, and court rulings against violators of the Fraud Act are included in this section. The summaries are of cases where OIFP entered into Consent Orders for the voluntary payment of fines, and cases where OIFP's civil attorneys successfully sued violators through civil litigation.

OIFP also includes actions taken against licensed professionals who committed insurance fraud by the appropriate licensing board in this section. The summaries set forth the range of actions that may be taken in such cases, from suspension or revocation of licenses, to voluntary surrender of the licenses.

In 2005, OIFP opened 493 new criminal investigations. One hundred forty-eight defendants were prosecuted by accusations or indictments. In 2005, OIFP convicted 182 defendants. Of the defendants convicted in 2005, 134 received jail terms totaling 118 years. The court ordered more than $88,910,526 in restitution, including restitution imposed in civil actions.

OIFP opened 6,193 civil insurance fraud cases in 2005, and it assigned 2,977 for further investigation. Administrative Consent Orders numbered 397 and totaled $5,725,808. OIFP obtained 346 executed Consent Orders totaling $1,375,384 where subjects admitted committing insurance fraud and they agreed to pay the civil fine. OIFP obtained 49 settlements for $569,700 and 149 judgments for $4,865,960. OIFP's civil attorneys filed 140 lawsuits against Fraud Act violators in 2005.

NOTE: An indictment, complaint, or other charge is merely an accusation. All defendants and subjects are presumed innocent of any charges unless and until proven guilty beyond a reasonable doubt.

AUTO INSURANCE FRAUD

Criminal Use of Runners

State v. Dannie Campbell, et al.

Sentencing continued in 2005 for defendants implicated in three indictments that charged Dannie Campbell and ten other defendants with conspiracy, Health Care Claims Fraud, and attempted theft by deception. The State alleged in the indictments that Dannie Campbell masterminded fictitious automobile accidents in 1997 and 1998 that involved other co-conspirators so that the co-conspirators could treat for injuries purportedly sustained in the phony accidents and submit Personal Injury Protection (PIP) insurance claims to an insurance company. The fictitious accidents occurred in Hillside and Newark.

Campbell pled guilty to Health Care Claims Fraud, and on April 1, 2005, was sentenced to three years in state prison and ordered to pay a $3,000 criminal fine. Nathaniel Jones pled guilty to Health Care Claims Fraud and was sentenced on June 13, 2005, to two years probation with the condition that he pay a $2,500 civil insurance fraud fine. Duane Smith pled guilty on January 7, 2005, to Health Care Claims Fraud and was sentenced on April 1, 2005, to three years probation and ordered to pay a $2,500 civil insurance fraud fine. Shaheed Johnson pled guilty to conspiracy and was sentenced to three years probation and ordered to pay a $2,500 civil insurance fraud fine.

The charges as to the other defendants are pending trial.

In all cases, Keystone Insurance Company/AAA Mid-Atlantic Insurance Company referred the matters to OIFP.

State v. Irwin B. Seligsohn; Louis Campbell; Edward Campbell, Jr.; Richard Williams; Damon Brown; Goldberger, Seligsohn & Shinrod, PA; Ralph Campbell; Kasim Nash; Bobbie Campbell; Tamisha Campbell; Iesha Harris; Edward Campbell, Sr.; Antoine Amos; Chandra Vaughan; Janelle Wilson; Javiena McDonald; Pamela Rogers; Lawrence Freeman; Alonzo Goldbourne; Sharon Blanding; Patrice Woodson; Rhonda Evans; Chris Russell; Phyllis Jackson; Tia Pullin; Edith Pullin; Eugenia Acey; James Bearfield; Angelique Pickett; and Wade Brown

OIFP has filed racketeering and conspiracy charges against two Essex County lawyers, their law firm, and 28 other individuals as part of an ongoing insurance fraud investigation targeting Health Care Claims Fraud and the illegal use of "runners." The racketeering and conspiracy charges represent the first time the Division of Criminal Justice - Office of the Insurance Fraud Prosecutor has used New Jersey's Racketeering Influenced & Corrupt Organization (RICO) statute to prosecute an attorney and a law firm for Health Care Claims Fraud, Criminal Use of Runners, and related insurance fraud crimes.

The 20-count superseding State Grand Jury indictment was returned on November 15, 2005, charging Seligsohn, his Essex County law firm, five "runners," and 23 phony accident claimants variously with criminal racketeering, conspiracy to commit racketeering, auto insurance-related Health Care Claims Fraud, Criminal Use of Runners, theft by deception, and tax fraud.

The indictment alleges that the lawyers and their law firm engaged in a scheme of paying "runners" to solicit and obtain automobile accident clients for the law firm in order to substantially increase the amount of money obtained through insurance claims, lawsuits, and other legal actions.

The superseding State Grand Jury indictment alleges that between October 30, 1993 and September 15, 2005, Irwin B. Seligsohn and the law firm of Seligsohn, Goldberger & Shinrod, PA, 735 Northfield Ave., W. Orange, Essex County, conspired with others to pay "runners" to solicit other individuals to participate in staged automobile accidents so that automobile insurance Personal Injury Protection (PIP) and other insurance claims could be submitted to various insurance companies. Additionally, the indictment alleges that Seligsohn improperly accounted for the payments made to the "runners" and, as a result, it is charged that Seligsohn, and the law firm violated various New Jersey tax statutes.

The indictment charges the "runners" with illegally receiving payments for acting as "runners," violations of State income tax laws, and with assisting in the submission of phony insurance claims knowing that the accidents were staged and that no one was injured. The other defendants named in the State Grand Jury indictment, alleged to be insurance claimants, were charged with Health Care Claims Fraud for assisting in the submission of the phony insurance claims.

The indictment also seeks the forfeiture of an estimated $5 million in financial assets obtained by the law firm of Goldberger, Seligsohn & Shinrod, PA, as a result of the alleged illegal insurance fraud scheme. The indictment seeks proceeds such as investments, bank accounts, office equipment, real estate, and other assets obtained as proceeds from engaging in theft by deception, Health Care Claims Fraud, Criminal Use of Runners, and tax fraud.

The Lawyers

- Irwin B. Seligsohn, Esq., was charged with racketeering and conspiracy to commit racketeering. He was also charged with Health Care Claims Fraud, theft by deception, Criminal Use of Runners, filing or preparing a false or fraudulent New Jersey tax return, and conspiracy to commit the same.
- The law firm of Goldberger, Seligsohn & Shinrod, PA, was charged with racketeering and conspiracy to commit racketeering. It was also charged with theft by deception, Criminal Use of Runners, Health Care Claims Fraud, filing or preparing a false or fraudulent New Jersey tax return, and conspiracy to commit the same.

The "Runners," Claimants, and Others

- Louis Campbell; Edward Campbell, a/k/a Edward Campbell, Jr.; Edward Campbell, Sr., a/k/a Reverend Campbell; Richard Williams; and Damon Brown, alleged "runners," were charged with conspiracy to commit racketeering, racketeering, conspiracy, Health Care Claims Fraud, theft by deception, and Criminal Use of Runners. Edward Campbell, Jr., was additionally charged with failure to pay or turn over taxes.
- Ralph Campbell, Kasim Nash, Bobbie Campbell, and Tamesha Campbell, were charged with conspiracy to commit racketeering, racketeering, conspiracy, Health Care Claims Fraud, and theft by deception.
- Antoine Amons, Chandra Vaughan, Janelle Wilson, Javiena McDonald, Pamela Rogers, Lawrence Freeman, Alonzo Goldbourne, Sharon Blanding, Patrice Woodson, Rhonda Evans, Chris Russell, Phyllis Jackson, Tia Pullin, Edith Pullin, Eugenia Acey, James Bearfield, Angelique Pickett, and Wade Brown were charged with Health Care Claims Fraud, conspiracy, and theft by deception.

The defendants' cases are pending trial.

Administrative Assistants Cynthia Ronan, Susan Cedar, and Pat Miller work on distribution of the Annual Report.

State v. Orlando Rolon and Erika Ramos

A State Grand Jury returned an indictment on December 2, 2005, charging Orlando Rolon and Erika Ramos with conspiracy, Criminal Use of Runners, Health Care Claims Fraud, attempted theft by deception, and misconduct by a corporate official. The indictment also charged Ramos with uttering a forged document.

According to the indictment, between December 11, 1998 and February 13, 2002, Rolon and Ramos conspired to commit auto PIP insurance fraud. The State alleged that Rolon and Ramos owned, operated, or controlled several companies including Brotherhood Rehabilitation Associates, P.C., JOL&M Medical Supply Company, and OR Medical Transport. These companies did business providing treatment, medical supplies, and transportation to patients, primarily automobile accident patients covered by automobile PIP insurance in and around Camden.

The State alleges that Rolon used "runners" to solicit and pay patients so that Brotherhood Rehabilitation could provide medical services, including chiropractic, physical therapy and other related services, to patients who were injured in automobile accidents. The State alleges that some of the patients solicited by the "runners" were sent to JOL&M so that medical supplies, including TENS Units which are used to treat soft tissue injuries of persons injured in auto accidents, and that OR Medical Transport was used to transport some of the patients to and from Brotherhood Rehabilitation and other locations, all so that Rolon could bill auto insurance companies more money.

The State further alleges that Rolon, who had no medical or chiropractic license, owned, operated, and controlled Brotherhood Rehabilitation but created the appearance that a licensed chiropractor actually owned, operated, and controlled Brotherhood Rehabilitation so insurance claims were more likely to be paid. The State also alleges that a false impression was created that Ramos, who was an employee of Rolon's at Brotherhood Rehabilitation, owned, operated, and controlled JOL&M Medical Supply so that it would appear to insurance company claims personnel that JOL&M Medical Supply was independent from Brotherhood Rehabilitation, when both corporations were owned, operated, and controlled by Rolon.

The State also alleges that Rolon and others acted as "runners" to attract patients by offering payments of between $200 to $300 to patients to treat at Brotherhood Rehabilitation so that Brotherhood Rehabilitation, JOL&M Medical Supply, and OR Medical Transport would have a steady stream of patients for which automobile insurance PIP carriers and other insurance carriers could be billed.

In addition to Criminal Use of Runners, the State alleges that Rolon and Ramos committed Health Care Claims Fraud by submitting false claims to Liberty Mutual and AIG Insurance Companies related to medical services provided by Brotherhood Rehabilitation and related companies.

Finally, the State alleges that Rolon and Ramos committed theft and forgery by creating the impression that Dr. Michael Marek, a chiropractor, made medical decisions with respect to Brotherhood Rehabilitation patients and signed claims forms submitted to the insurance companies to include Liberty Mutual when, in fact, Marek was deceased.

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

State v. Angel Lobo and Mercy Lobo

Angel Lobo pled guilty to Health Care Claims Fraud and the court sentenced him on February 14, 2005, to three years in state prison and ordered him to pay $1,196 in restitution and a $100,000 civil insurance fraud fine. Mercy Lobo also pled guilty to Health Care Claims Fraud and the court sentenced her on February 14, 2005, to 15 months probation and ordered her to pay a $7,500 civil insurance fraud fine.

A State Grand Jury returned an indictment that charged Angel Lobo and Mercy Lobo with conspiracy, Health Care Claims Fraud, theft by deception, Criminal Use of Runners, and falsification of medical records. Angel Lobo, a licensed medical service provider, and his office manager, Mercy Lobo (no relation), operated the Pain Management Clinic located in Paterson. The State alleged in the indictment that Angel Lobo and Mercy Lobo paid persons to act as "runners" to procure patients for the purpose of submitting PIP insurance claims to Parkway Insurance Company and AIG Claims Services, Inc. The State also alleged that Angel Lobo and Mercy Lobo prepared false patient records in support of Angel Lobo's false billing for health care services.

All of the claims that formed the basis of the Health Care Claims Fraud charges were for services rendered to undercover OIFP State Investigators.

State v. Lisa Tsilionis, George Tsilionis, Carl Love, Jr., Rajauhn Sharrieff, and Rudolf Hora

Rajauhn Sharrieff previously pled guilty to official bribery, theft by deception, conspiracy, and misconduct by a corporate official. On March 24, 2005, the court sentenced him to three years probation conditioned upon serving 364 days in county jail. Carl Love, Jr., pled guilty on March 21, 2005, to conspiracy and possession of a weapon by a convicted felon. The court sentenced him on April 25, 2005, to three years probation.

A State Grand Jury previously returned an indictment charging Lisa Tsilionis and her former husband, George Tsilionis, chiropractors and the owners and operators of Allied Trauma and Health Care Center, Inc., with conspiracy, Health Care Claims Fraud, theft by deception, money laundering, and misconduct by a corporate official. The indictment also charged Carl Love, Jr., and Rajauhn Sharrieff, operators of medical transportation companies Essex Shuttle, Inc., and Love Courier, Inc., with conspiracy, Health Care Claims Fraud, theft by deception, and misconduct by a corporate official. Another defendant, Rudolf Hora, was charged with conspiracy.

Love was also separately charged with unlawful possession of a weapon. According to the indictment, between July 1996 and March 1999, Lisa Tsilionis and George Tsilionis allegedly fraudulently billed numerous insurance companies for chiropractic services and electro-diagnostic tests known as Somatosen-

sory Evoked Potentials (SSEP). The State also alleged that the Tsilionises, through Allied Trauma, fraudulently billed approximately 30 different insurance carriers over $1.2 million. The insurance carriers paid approximately $435,000 in claims.

The indictment stated that between June 1998 and December 1998, Love and Sharrieff allegedly created a patient transportation business called Essex Shuttle to disguise illegal patient referral fees (known as "'runners' fees") that Lisa and George Tsilionis made to Love, Sharrieff, and Hora as transportation costs. The indictment also charged that Love and Sharrieff, through Essex Shuttle, also fraudulently billed various insurance carriers approximately $5,400 for transportation services.

The State alleged that Love used his corporations to solicit patients for Allied Trauma, acting, in essence, as a "runner." The State alleged that while both of these businesses were purportedly incorporated to transport automobile accident insurance PIP claimants to and from treating medical service providers, Love actually used his corporations to solicit patients for Allied Trauma so that false automobile insurance PIP claims could be submitted to insurance companies. Most of Allied Trauma's patients were automobile accident insurance claimants who sought treatment at Allied Trauma under their automobile insurance PIP coverage. Essex Shuttle and Allied Trauma both ceased operations following the commencement of the State's investigation in approximately March 1999.

Working with OIFP, the Division of Criminal Justice's Civil Forfeiture Unit froze Love Courier and Essex Shuttle bank accounts containing approximately $2,800. The accounts are subject to possible forfeiture. Additionally, a lien was filed on Love's residence located on Northfield Avenue in West Orange. Love subsequently filed for bankruptcy.

The State also seized and forfeited the Tsilionises' home in Bergenfield and approximately $895,000 in their bank accounts.

State v. Richard Herbert, Melissa Caraballo, and Monique Hernandez

Melissa Caraballo pled guilty to attempted theft by deception, and the court admitted her into the Pre-trial Intervention (PTI) Program on May 20, 2005, conditioned upon her performing 50 hours of community service. Richard Herbert pled guilty to Health Care Claims Fraud and attempting to obtain controlled dangerous substances (CDS) by fraud. The court admitted him into the PTI Program on June 24, 2005, conditioned upon paying a $25,000 civil insurance fraud fine and performing 50 hours of community service. Monique Hernandez pled guilty to attempted theft by deception, and the court admitted her into the PTI Program on June 24, 2005, conditioned upon her performing 50 hours of community service.

A State Grand Jury returned an indictment that charged Monique Hernandez, Richard Herbert, and Melissa Caraballo with conspiracy, Health Care Claims Fraud, and attempted theft by deception. The State also charged Herbert in a second indictment with attempting to obtain CDS by fraud.

The State alleged in the first indictment that between October 1998 and November 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, but to an undercover OIFP investigator looking into fraudulent automobile insurance PIP claims. The State alleged that fraudulent automobile insurance PIP claims totaling $2,219 were submitted to GSA Insurance Company. 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.

State v. Alan E. Ottenstein and Jean Woolman

A State Grand Jury returned an indictment on December 16, 2005, charging Alan E. Ottenstein and Jean Woolman with conspiracy to commit racketeering, racketeering, attempted theft by deception, and Health Care Claims Fraud. Ottenstein was also charged with false swearing. According to the indictment, from October 1, 1990 through August 31, 2003, Ottenstein, a physician formerly licensed in New Jersey, and his former associate, Woolman, through medical practices Ottenstein owned, operated, and controlled, as well as a Las Vegas corporation, allegedly fraudulently billed automobile insurance companies, particularly PIP insurance coverage, through a variety of schemes.

The State alleges that Ottenstein wrongfully billed insurance companies for epidural injections in connection with pain management; wrongfully billed insurance companies for separate anaesthetic and steroid injections as part of epidurals when those procedures should not have been billed separately and wrongfully separately billed insurance companies for use of a contrast agent as part of an epidural procedure when the procedure should not have been separately billed, both billing practices known as "unbundling;" wrongfully billed insurance companies for use of medical supplies to include sterile trays when sterile trays were not used; wrongfully billed insurance companies for a separate "facility fee" when the separate fee was not lawfully charged; wrongfully altered Magnetic Resonance Imaging (MRI) reports so that patients, primarily patients injured in automobile accidents, would appear to have an auto-related injury when, in fact, they did not; and wrongfully billed mechanical disk recovery system treatments as surgical procedures when, in fact, they were not surgical procedures.

The State also alleges that Ottenstein, Woolman, and the medical practices unlawfully misrepresented treatments and services to various insurance companies. Among these insurance companies were New Jersey Manufacturers, Aetna, Allamerica, Allstate, AmeriHealth, Guardian, HealthNet, Horizon Blue Cross Blue Shield, Liberty Mutual, MetLife, New Jersey CURE, The Oxford Plan, Prudential, State Farm, and Zurich. The State alleges that perhaps as much as $2 million in fraudulent claims were submitted to the insurance companies by the defendants through the medical practices.

Fraudulent Automobile "Give Up" and Theft Claims

State v. Latoya Fisher

The court admitted Latoya Fisher into the PTI Program on January 7, 2005, conditioned upon her paying $657 in restitution to First Trenton Indemnity Company, a $5,000 civil insurance fraud fine, and performing 70 hours of community service. Fisher pled guilty to an accusation that charged her with Insurance Fraud. Fisher admitted that she reported to the New York City Police Department that her 2001 Mitsubishi Montero had been stolen. Fisher also allegedly reported the purported theft to her insurer, First Trenton Indemnity Company. Fisher admitted that the car had not been stolen, but that she gave the keys to an unidentified person who took the car so that Fisher could make a phony stolen vehicle theft insurance claim with her insurer and no longer make payments on the vehicle.

State v. Raiza Y. De Los Santos

The court admitted Raiza Y. De Los Santos into the PTI Program on January 14, 2005, conditioned upon her paying a $5,000 civil insurance fraud fine and performing 50 hours of community service. De Los Santos pled guilty to an accusation that charged her with tampering with public records or information. De Los Santos admitted that she falsely reported to the Jersey City Police Department that, while in her possession, someone stole her brother's 1997 Chevrolet Blazer. De Los Santos allegedly made the police report to collect insurance money from Selective Insurance Company of America.

State v. Israel Rivera

The court sentenced Israel Rivera on January 14, 2005, to five years probation and ordered him to pay $10,399 in restitution and a $5,000 civil insurance fraud fine. Rivera pled guilty to an accusation that charged him with Insurance Fraud. Rivera admitted that he falsely reported to the Liberty Mutual Insurance Company that someone stole his 2001 Honda Civic. Rivera allegedly submitted an automobile insurance theft claim for $10,398. Liberty Mutual paid the claim to satisfy the car loan, 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 to Liberty Mutual he last saw the Honda.

State v. Esther Mazara and Serapio Paez

Esther Mazara pled guilty to an accusation that charged her with Insurance Fraud and arson. Mazara admitted that she falsely reported to Metropolitan Property and Casualty Insurance Company (MetLife) that someone stole her 1999 Jeep Cherokee. She also admitted that she assisted another person, who was not identified in the accusation, with setting her vehicle ablaze so she could 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. The court sentenced Mazara on April 1, 2005, to two years probation and ordered her to pay $10,243 in restitution and perform 50 hours of community service.

A Hudson County Grand Jury returned an indictment that charged Serapio Paez with conspiracy, Insurance Fraud, theft by deception, and tampering with public records or information. The State alleges that Paez, who is currently incarcerated in the Passaic County jail awaiting sentencing on federal drug-related charges, conspired with Mazara to submit a phony auto insurance theft claim. The State further alleges that Paez took possession of a 1999 Jeep Cherokee with the purpose to destroy it so that Mazara could submit an auto theft claim.

State v. Steven Garcia

The court sentenced Steven Garcia on February 18, 2005, to three years probation and ordered him to pay a $1,000 criminal fine after he pled guilty to attempted theft by deception. 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 allegedly submitted a fraudulent stolen vehicle insurance claim to First Trenton Indemnity Company. Garcia allegedly reported someone stole his 1999 Ford F-150 pickup truck. The truck was subsequently recovered in a garage in Lebanon, PA. An investigation revealed that Garcia had been paying storage to keep the truck in Pennsylvania. First Trenton, suspecting fraud, denied the claim and referred the matter to OIFP for investigation.

State v. James Good

The court sentenced James Good on January 18, 2005, to one year probation conditioned upon his paying a $5,000 civil insurance fraud fine and performing 50 hours of community service. He previously pled guilty to falsifying records. According to a State Grand Jury indictment charging him with falsifying records, on January 10, 2002, Good allegedly falsely filed a stolen vehicle claim with Liberty Mutual Insurance Company, reporting someone stole his 1989 Subaru. Good allegedly knew that the vehicle had not been stolen and that he was not entitled to the insurance money. OIFP's investigation revealed that on October 12, 2001, Good's 1989 Subaru was involved in an automobile accident in Newark in which the driver and a passenger fled the scene. The State alleged that Good submitted the false claim with Liberty Mutual to cover up for the person driving the car who left the scene of the accident.

State v. Monique S. Everett, Javin Ward, James Westfield, and Robert Wayne Williams

Monique S. Everett pled guilty to conspiracy to commit theft by deception. The court admitted her into the PTI Program on October 28, 2005, conditioned upon her paying $1,018 in restitution to Encompass Insurance Company and performing 75 hours of community service. Robert Wayne Williams pled guilty to conspiracy on October 3, 2005. He is scheduled to be sentenced in 2006.

A Passaic County Grand Jury returned an indictment that charged Monique S. Everett, Javin Ward, James Westfield, and Robert Wayne Williams with conspiracy and theft by deception. The State also charged Everett with tampering with public records or information. According to the indictment, between November 8, 2001 and January 11, 2002, Westfield and Everett allegedly "gave up" a 2000 Mitsubishi Mirage valued at $10,149 to Williams and Ward. Westfield and Everett allegedly "gave up" the car to Williams so that it could be concealed from law enforcement and they could submit a false insurance claim. Later the car was allegedly reported stolen to Encompass Insurance Company and the phony auto theft claim was submitted. Williams was arrested in possession of the 2000 Mitsubishi Mirage by the Montville Police Department on November 25, 2001.

Ward's and Westfield's cases are pending in court.

State v. Ysirdo Paulino

The court admitted Ysirdo Paulino into the PTI Program on January 3, 2005, conditioned upon his performing 25 hours of community service. Paulino pled guilty on the same day to attempted theft by deception. A Hudson County Grand Jury returned an indictment that charged 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 ve-

hicle to its impound lot on March 10, 2003. Allstate suspected Paulino's claim was fraudulent and denied the claim.

State v. Roberto C. Ferreira

The court admitted Roberto C. Ferreira into the PTI Program on July 27, 2005, conditioned upon his paying a $5,000 civil insurance fraud fine and performing 50 hours of community service. Ferreira pled guilty to an accusation that charged him with Insurance Fraud. Ferreira admitted that on September 8, 2004, he falsely advised the Newark Police Department that he discovered his 2000 Land Rover stolen when he left a gym after a workout. Ferreira allegedly submitted a phony stolen automobile insurance claim to the Preserver Group Insurance Company. He allegedly claimed that the Land Rover contained approximately $2,300 worth of golf clubs. He filed an insurance claim for $27,000. An investigation revealed that the New York Sanitation Department impounded Ferreira's Land Rover almost two months earlier on July 12, 2004.

State v. Randi Fleischman

A Middlesex County Grand Jury returned an indictment on March 22, 2005, that charged Randi Fleischman with Insurance Fraud, attempted theft by deception, tampering with public records or information, and false swearing. According to the indictment, between November 1, 2003 and February 19, 2004, Fleischman allegedly submitted a phony auto insurance theft claim to Liberty Mutual Insurance Company. The State alleges that Fleischman advised Liberty Mutual and the Edison Police Department that someone stole her 2000 Chrysler Sebring while she was shopping at the Menlo Park Mall on December 5, 2003. An investigation revealed that the Bureau of Fire Investigations of the New York City Fire Department discovered the car burning in Brooklyn on November 27, 2003, casting doubt on Fleischman's alleged claim that her car had been stolen.

Fleischman allegedly submitted a phony auto insurance theft claim for $12,932. Liberty Mutual denied the claim and referred to the matter to OIFP for investigation.

This indictment is among the first in which the new crime of Insurance Fraud, which became effective June 9, 2003, was used to charge a person who submitted a false automobile theft claim.

The trial judge in Middlesex County dismissed the Insurance Fraud count on August 4, 2005, on the grounds that the State did not or could not offer evidence of five or more acts of insurance fraud within the meaning of the statute. On September 15, 2005, OIFP perfected an appeal of the trial judge's order dismissing the count to the Appellate Division. The case is scheduled for argument in early 2006.

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

A Middlesex County Grand Jury returned an indictment that charged George T. Guden, Michael T. Guden, John E. Gassert, and Angela Guden with conspiracy and theft by deception. The State also charged Angela Guden with tampering with public records or information and false swearing.

According to the indictment, between January 2002 and March 2002, George T. Guden and Michael T. Guden allegedly "gave up" Angela Guden's 1995 Lincoln Mark VIII. The State alleged that Angela Guden reported to the Woodbridge Police Department that someone stole the Lincoln from the Woodbridge Shopping Mall. The Lincoln was later recovered in the possession of John E. Gassert, who is alleged to be an acquaintance of the Gudens. An allegedly fraudulent stolen car insurance claim was submitted to Liberty Mutual. Liberty Mutual paid approximately $12,330 to Angela Guden for the reported theft of her Lincoln.

John E. Gassert previously pled guilty to conspiracy to commit theft by deception, and the court sentenced him to three years suspended sentence conditioned on his full cooperation with the State's investigation. The court admitted Michael T. Guden into the PTI Program, conditioned upon his paying $4,185 in restitution to Liberty Mutual Insurance Company.

In a continuing matter, George T. Guden and Angela Guden pled guilty on February 28, 2005, to conspiracy to commit theft by deception. The court sentenced George T. Guden on April 22, 2005, to 364 days in county jail as a condition of five years probation, and ordered him to pay $4,000 in restitution and a $5,000 civil insurance fraud fine. The court sentenced Angela Guden on the same day to four years probation and ordered her to pay $4,000 in restitution and a $5,000 civil insurance fraud fine.

State v. Lim Y. Bances

The court admitted Lim Y. Bances into the PTI Program on July 20, 2005, conditioned upon her performing 60 hours of community service. Bances pled guilty to tampering with public records or information. It was alleged in an indictment that Bances allegedly reported to the Elizabeth Police Department that her 2002 Nissan Altima had been stolen in order to collect insurance claim money from Metropolitan Property and Casualty Insurance Company.

State v. Larnardo R. Pittman

The court sentenced Larnardo R. Pittman on July 29, 2005, to three years probation. The court also ordered him to pay $19,000 in restitution and a $5,000 civil insurance fraud fine. Pittman pled guilty to theft by deception. A State Grand Jury returned an indictment charging Pittman with theft by deception, tampering with public records or information, and false swearing. According to the indictment, Pittman allegedly falsely reported to the Newark Police Department that his 2000 Ford F-350 pickup truck was stolen in Newark. The State also alleged in the indictment that Pittman allegedly reported the theft to Empire Insurance Company, a subsidiary of Zurich North American Insurance Company. Empire Insurance Company paid Pittman approximately $29,000 based on the fraudulent stolen truck insurance claim.

State v. Janelle Hall

The court admitted Janelle Hall into the PTI Program on August 1, 2005, conditioned upon her paying a $3,000 civil insurance fraud fine. Hall pled guilty to an accusation charging her with Insurance Fraud. Hall admitted that she falsely reported to the Allstate Insurance Company that someone stole her 1999 Nissan Maxima when it had not been stolen, but had been left in New York City. Hall admitted that she falsely reported the car stolen so she would no longer have to make payments on the vehicle. Allstate, suspecting fraud, denied the claim and reported the matter to OIFP for investigation.

State v. Sandra Rodriguez and Jonathan Rodriguez

A Cumberland County Grand Jury returned an indictment on July 20, 2005, that charged Sandra Rodriguez and her nephew, Jonathan Rodriguez, with conspiracy, aggravated arson, attempted theft by deception, tampering with public records or information, arson, and falsifying records. According to the indictment, between April 12, 2003 and July 5, 2003, Sandra Rodriguez and Jonathan Rodriguez allegedly conspired to dispose of a 2002 Chevrolet Cavalier and submit a false automobile insurance theft claim.

The State alleges that Sandra Rodriguez falsely reported to the Vineland Police Department and Rutgers Casualty Insurance Company that someone stole her Chevrolet Cavalier. The State further alleges that Jonathan Rodriguez took the Chevrolet Cavalier from Sandra Rodriguez and set it on fire in Buena Vista Township so that a claim could be sent to Rutgers Casualty. Rutgers Casualty denied the automobile theft insurance claim and referred the matter to OIFP for investigation.

Sandra Rodriguez pled guilty on November 28, 2005, to arson with purpose to collect insurance proceeds. She is scheduled to be sentenced in early 2006. Jonathan Rodriguez is a fugitive.

State v. Maria Kernizan and Loubert Barthelemy

A Union County Grand Jury returned an indictment on November 9, 2005, that charged Maria Kernizan and her son, Loubert Barthelemy, with conspiracy, attempted theft by deception, and Insurance Fraud. According to the indictment, Kernizan and Barthelemy allegedly conspired to submit a phony automobile theft loss claim to Clarendon National Insurance Company. The State alleges that Kernizan submitted an Affidavit of Theft to the Clarendon National Insurance Company claiming that she last saw her 1993 Toyota 4-Runner in Elizabeth on December 31, 2002. OIFP's investigation revealed that Kernizan and Barthelemy allegedly falsely reported to the New York Police Department that someone stole the car. Additional investigation revealed that the New York Department of Sanitation tagged the vehicle as a derelict or abandoned vehicle in the Bronx on December 25, 2002, casting doubt on Kernizan's and Barthelemy's claims that the vehicle was last seen and stolen on or after December 31, 2002.

The Clarendon Insurance Company denied the claim and referred the matter to OIFP for investigation and prosecution.

State v. Harry J. Torella

Harry J. Torella pled guilty to an accusation on October 11, 2005, that charged him with Insurance Fraud. Torella admitted that between June 27, 2003 and September 30, 2003, he knowingly falsely reported that someone stole his 1997 Chrysler Sebring to the Island Heights Police Department and to the Prudential Insurance Company. He is scheduled to be sentenced in early 2006.

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. OIFP's 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 in order to collect more than $790,000 in insurance claims.

Abraham Cepeda pled guilty to an accusation that charged him with receiving stolen property. Cepeda admitted that between December 9, 2002 and January 10, 2003, he assisted a co-conspirator, Juan E. Naut, and others to submit phony automobile theft "give up" insurance claims. Cepeda admitted that he assisted Naut and others by transporting purportedly stolen cars, to include three Honda Civics, a 1998 Infiniti QX4, a 2000 Dodge Stratus, a 2000 Toyota Celica, and a 2001 Mitsubishi Montero, to a garage located on Tonnele Avenue in Jersey City. The court sentenced Cepeda on December 2, 2005, to two years probation and ordered him to pay a $500 criminal fine.

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.

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

As the result of OIFP's 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 (VIN), and simulating a motor vehicle insurance identification card.

State Investigators recovered 46 cars and SUVs from several persons who allegedly either stole the vehicles 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 21 insurance companies. Claims for $48,056 were not paid either because the insurance company became suspicious of the claims, 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 the following 21 insurance carriers: 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.

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 to phony automobile insurance "give up" claims. Two of these additional indictments charged eight people 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 alleges in the two indictments that, between November 2001 and August 2002, three automobiles were alleg-

edly 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 the fact that it has been "given up" to facilitate filing fraudulent auto theft insurance claims.

State v. Donna L. Bermudez

The court admitted Donna L. Bermudez into the PTI Program on December 14, 2005, conditioned upon her performing 40 hours of community service. Bermudez pled guilty to an accusation that charged her with Insurance Fraud. Bermudez admitted that between September 21, 2004 and September 29, 2004, she falsely reported to the Little Ferry Police Department and the First Trenton Indemnity Company that her 2001 Mercedes SLK had been stolen.

False Automobile-Related Insurance Claims

State v. O'Neil J. Williams

The court admitted O'Neil J. Williams into the PTI Program on October 5, 2005, conditioned upon paying a $125 criminal fine. Williams pled guilty to an accusation that charged him with Insurance Fraud. Williams admitted that he falsely reported his Honda stolen as part of an insurance property damage claim. Williams admitted that he concocted the stolen car story to avoid admitting an accident with his car in which the vehicle suffered damage.

State v. Zia Ghahary

The court admitted Zia Ghahary into the PTI Program on February 14, 2005. Ghahary pled guilty to an accusation that charged him with Insurance Fraud. Ghahary admitted that he submitted a phony automobile insurance property damage claim to The Hartford Insurance Company. Ghahary allegedly claimed that the rear of his vehicle was damaged in a automobile accident when the damage was pre-existing, and he was not entitled to payment for the damage.

State v. Anthony Dunlock

The court sentenced Anthony Dunlock on December 16, 2005, to two years probation, conditioned upon serving 364 days in county jail, and ordered him to pay $15,900 in restitution. Dunlock pled guilty to an accusation that charged him with theft by deception. Dunlock admitted that he used a fictitious police report to submit an automobile insurance PIP claim to First Trenton Indemnity Company. He admitted that he falsified the police report to reflect that he was injured in an automobile accident that purportedly occurred on April 8, 2000. He allegedly sought medical treatment for purported injuries and caused bills to be submitted to First Trenton for approximately $15,900.

The insurance company that purportedly insured the other driver referred to in the false police accident report, Pacesetter Adjustment Company of Baton Rouge, Louisiana, suspected fraud and contacted First Trenton about the matter. First Trenton referred the matter to OIFP for investigation and prosecution.

State v. Heather Dorst

The court sentenced Heather Dorst on March 4, 2005, to three years probation conditioned upon her performing 100 hours of community service. Dorst pled guilty to charges of Insurance Fraud. Dorst admitted that on December 25, 2003, an individual allegedly drove her car in Magnolia, NJ, when it was struck in the rear by another vehicle. The individual, alone in the vehicle and driving with a suspended license, allegedly fled the scene of the accident. Later the same day, Dorst allegedly reported to the Magnolia Police Department that she was driving the car. She then allegedly submitted a PIP insurance claim to her insurance company, Farm Family Casualty Insurance Company, swearing that she was driving the car and that she suffered personal injuries as the result of the accident. Medical bills for approximately $2,364 were submitted for payment.

State v. Shirish M. Parikh and Bindu S. Parikh

The court admitted Shirish M. Parikh and his wife, Bindu S. Parikh, into the PTI Program on January 10, 2005, conditioned upon their performing 50 hours of community service. The State charged Shirish M. Parikh and Bindu S. Parikh with Insurance Fraud in complaints alleging that they falsely claimed that their Toyota Camry was damaged in a hit-and-run accident. They then allegedly submitted fraudulent repair bills to New Jersey Manufacturers Insurance Company, which denied the claim and referred the case to OIFP for investigation.

State v. Frank Catrambone

The court admitted Frank Catrambone into the PTI Program on May 18, 2005, conditioned upon his performing 20 hours of community service. Catrambone pled guilty to an accusation that charged him with Insurance Fraud. Catrambone admitted that on September 12, 2003, a car driven by his son was involved in an automobile accident. The car contained disc jockey sound equipment, allegedly valued at over $15,000, owned by Catrambone's disc jockey business. Catrambone admitted that he submitted phony receipts to support his claim to Palisades Insurance Company that the sound equipment was lost or damaged. Palisades Insurance Company, suspecting fraud, denied the claim.

State v. Virginia B. Kinion and John Knight

A Passaic County Grand Jury returned an indictment on June 29, 2005, that charged Virginia B. Kinion and her husband, John Knight, with conspiracy, Health Care Claims Fraud, and attempted theft by deception. The State also charged Kinion with theft by deception, tampering with public records or information, and falsifying records. The State charged Knight separately with falsifying records and false swearing.

According to the indictment, between June 6, 2002 and December 31, 2002, Kinion and Knight allegedly submitted a false automobile insurance policy application and false PIP claims to Clarendon National Insurance Company. The State alleges in the indictment that Kinion and Knight submitted an automobile insurance policy application that indicated they had no automobile insurance and no automobile accidents for the 36 months prior to the date of the application. The State alleges that Kinion and Knight had been involved in an automobile accident just hours before they submitted the insurance policy application, and that they allegedly attempted to represent to the insurance company that the automobile accident occurred after it agreed to provide automobile insurance. The State alleges that Kinion and Knight caused PIP insurance claims for $9,917 and $13,231 to be submitted to Clarendon National for the automobile accident. Clarendon denied the claims and referred the matter to OIFP for investigation.

Both defendants failed to appear at their pre-arraignment conference. The court issued a bench warrant for their arrests. OIFP investigators arrested Kinion on October 26, 2005. The charges are pending trial.

State v. Ayana Torres, Geraldo Torres, and Jose Rivera

A Union County Grand Jury returned an indictment on May 6, 2005, that charged Ayana Torres, Geraldo Torres, and Ayana Torres' brother, Jose Rivera, with conspiracy to commit Health Care Claims Fraud, Health Care Claims Fraud, and theft by deception.

According to the indictment, between March 10, 2000 and November 28, 2000, Ayana Torres, Geraldo Torres, and Jose Rivera allegedly conspired to submit false PIP claims to an insurance carrier.

The State alleged that Ayana Torres went to a garage in Elizabeth to pick up her car on March 10, 2000. The police had towed the car because it did not have a valid inspection sticker, and Rivera, who was allegedly driving the vehicle at the time, did not have a valid driver's license. When Ayana Torres started the vehicle, it allegedly lurched forward and struck another vehicle. The State alleges that Rivera and Geraldo Torres were not in the vehicle at the time it lurched forward. The State alleges that although Geraldo Torres and Rivera were not in the vehicle when it lurched forward, PIP claims were allegedly submitted to State Farm Insurance Company for them in excess of $1,000. State Farm referred the matter to OIFP for additional investigation and prosecution.

State v. Kevin O'Connor

The court admitted Kevin O'Connor into the PTI Program on November 2, 2005, conditioned upon his paying a $5,000 civil insurance fraud fine. O'Connor pled guilty to an accusation that charged him with attempted theft by deception. O'Connor admitted that he filed a false automobile accident claim with Rutgers Casualty Insurance Company claiming that his 2000 Ford van was involved in an automobile accident on March 4, 2003. The accident actually took place a month earlier when O'Connor had no insurance coverage for his van. Rutgers Casualty, suspecting fraud, denied the claim and referred the matter to OIFP for investigation.

State v. Romonde Lominy Laguerre

The court admitted Romonde Lominy Laguerre into the PTI Program on July 20, 2005, conditioned upon her paying a $5,000 civil insurance fraud fine. Laguerre pled guilty to attempted theft by deception. A Somerset County Grand Jury returned an indictment that charged Laguerre with attempted theft by deception, uttering forged writings, and falsifying records. The State alleged in the indictment that Laguerre submitted false automobile insurance claims between September 15, 2000 and October 17, 2000, to Liberty Mutual Insurance Company following the theft of a recovered 1991 Ford Explorer. Laguerre allegedly submitted a false automobile repair invoice by altering the invoice amount from $310 to $3,995. Laguerre also allegedly submitted false limousine transportation receipts for 41 dates for $2,460, when she only used limousine transportation on 28 dates for $1,680.

State v. Tommy Edwards

The court sentenced Tommy Edwards on August 24, 2005, to two years in state prison. On the same day, he pled guilty to an accusation that charged him with Insurance Fraud. Edwards admitted that in July 2003, he sought the advice of an attorney because he claimed that he had an automobile accident in June 2003. Edwards signed a PIP insurance application indicating that he was struck by a car on June 17, 2003, and he allegedly signed an affidavit stating that he had no car insurance. The documents enabled him to submit an insurance claim for medical bills in excess of $4,200, and perhaps also a legal claim for non-economic injuries to include pain and suffering. AIG Insurance Company denied the claim and referred the matter to OIFP.

State v. Jason Senf

The court admitted Jason Senf into the PTI Program on July 25, 2005, conditioned upon his paying a $5,000 civil insurance fraud fine and performing 100 hours of community service. A Mercer County Grand Jury returned an indictment that charged 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 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 attempted to obtain insurance with collision coverage. Foremost investigated Senf's June 22, 2003, claim and referred the matter to OIFP for further investigation and prosecution.

Senf's case is currently on appeal.

Insurance Claims Involving "Jump Ins"

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

A State Grand Jury previously returned an indictment that charged David Scott with conspiracy to commit Health Care Claims Fraud, 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, Nicole Barker allegedly had an automobile accident in Philadelphia between March 17 and May 1, 2002. She then allegedly conspired with Scott and Gladney to make it appear to the police and the insurance company that both Barker and Scott were passengers in the car. Gladney was a tow truck driver who allegedly supported the false claim Barker and Scott made about being injured in the automobile accident.

Scott pled guilty to conspiracy and Health Care Claims Fraud, and the court sentenced him to 364 days in county jail as a condition of three years probation. The court sentenced Barker on January 14, 2005, to three years probation after she pled guilty to conspiracy to commit Health Care Claims Fraud.

Insurance Fraud Involving Police Officers

State v. Philip Major, et al.

The court meted out sentences in 2005 for 31 of the 39 persons, primarily from Essex County, who were charged in four separate indictments with conspiracy to commit theft by deception and official misconduct relating to automobile insurance PIP fraud.

The 39 persons named in the indictments were allegedly involved in automobile accidents in police reports written by former East Orange Police Officer Philip Major between June 1995 and October 1999. The indictments returned by a State Grand Jury alleged that the automobile accident police reports were used to support fraudulent automobile insurance PIP and bodily injury claims.

The following dispositions occurred in 2005:

Jose Frias, Lawrence Hannah, Rafael Torres, and Brunilda Blanco were each sentenced on February 4, 2005, to one year probation and ordered to pay a $1,500 civil insur-

ance fraud fine. The court also ordered Blanco to pay $4,766 in restitution and Torres to pay $4,690 in restitution.

The court sentenced Cordell Vaxter on March 4, 2005, to one year probation and ordered him to pay $3,157 in restitution and a $1,500 civil insurance fraud fine.

Bienviendo Sanchez, Kenneth Kennedy, Barry Hill, Audrey Lopez, Katrina Campbell, Ronald Kelly, and Ron Bagley pled guilty to conspiracy to commit official misconduct and theft by deception. The court sentenced Sanchez, Kennedy, Lopez, and Campbell on February 28, 2005, to one year probation. The court ordered Sanchez, Kennedy, Lopez, and Campbell to each pay a $1,500 civil insurance fraud fine. The court also ordered Lopez to pay $5,975 in restitution, Sanchez to pay $6,537 in restitution, and Campbell to pay $5,709 in restitution. The court sentenced Kelly, Hill, and Bagley on March 4, 2005, to one year probation and ordered each to pay a $1,500 civil insurance fraud fine. Additionally, the court ordered Kelly to pay $2,371 in restitution.

Miguel Sanchez and Victor Medina pled guilty to conspiracy to commit official misconduct and theft by deception. The court sentenced Sanchez on March 4, 2005, to one year probation and ordered him to pay $8,340 in restitution and a $1,500 civil insurance fraud fine. Medina failed to appear at his sentencing on March 4, 2005; the court issued a bench warrant for his arrest.

Richard Morales pled guilty to conspiracy to commit official misconduct and theft by deception. The court sentenced him on March 11, 2005, to one year probation with credit for 17 days time served. As a condition of probation, the court ordered him to pay a $1,500 civil insurance fraud fine.

Investigators from OIFP arrested fugitive defendant, Ronald West, on January 26, 2005, pursuant to a bench warrant. West pled guilty to conspiracy to commit official misconduct and theft by deception. The court sentenced him on April 15, 2005, to one year probation and ordered him to pay a $1,500 civil insurance fraud fine.

Ana Baretto, Selena Brown, and Barbara Little pled guilty to conspiracy to commit official misconduct and theft by deception. On April 1, 2005, the court sentenced Baretto to two years probation and ordered her to pay $7,946 in restitution and a $1,500 civil insurance fraud fine. On the same day, the court sentenced Brown to two years probation and ordered her to pay $2,456 in restitution and a $1,500 civil insurance fraud fine; Little was sentenced to one year probation and ordered to pay a $1,500 civil insurance fraud fine.

Juan Frias, Romona Mora Silvero, Linc Palmer, and Felix Frias pled guilty to conspiracy to commit official misconduct and theft by deception. The court sentenced Juan Frias on April 1, 2005, to one year probation and ordered him to pay a $1,500 civil insurance fraud fine. The court sentenced Felix Frias on April 1, 2005, to two years probation and ordered him to pay $2,330 in restitution and a $1,500 civil insurance fraud fine. The court sentenced Silvero to two years probation and ordered her to pay $4,394 in restitution and a $1,500 civil insurance fraud fine. The court sentenced Palmer on April 15, 2005, to one year probation and ordered him to pay a $1,500 civil insurance fraud fine.

Enercida Noboa pled guilty to conspiracy to commit official misconduct and theft by deception. The court sentenced her on April 15, 2005, to three years probation and ordered her to pay $5,165 in restitution and a $1,500 civil insurance fraud fine.

Darrick Farmer and Mark Boyette pled guilty to conspiracy to commit official misconduct and theft by deception. The court sentenced Boyette on April 15, 2005, to one year probation and ordered him to pay a $1,500 civil insurance fraud fine. On the same day, the court sentenced Farmer to three years probation and ordered him to pay $10,770 in restitution and a $1,500 civil insurance fraud fine.

Jose Noboa pled guilty to conspiracy to commit official misconduct and theft by deception. The court sentenced him on May 6, 2005, to two years probation and ordered him to pay $2,710 in restitution and a $1,500 civil insurance fraud fine.

Janice Smart pled guilty to conspiracy to commit official misconduct and theft by deception, and on June 3, 2005, the court sentenced her to six months probation and ordered her to pay a $1,500 civil insurance fraud fine.

Davon Charisma, Jerry St. Louis, Guy Longechamp, and James Saint Jean pled guilty to conspiracy to commit official misconduct and theft by deception. The court sentenced them on July 15, 2005, to one year probation and ordered each to pay a $1,500 civil insurance fraud fine. The court also ordered Charisma and St. Louis each to pay $2,500 in restitution, Longechamp to pay $2,000 in restitution, and Saint Jean to pay $1,000 in restitution.

Cari Blanco and Nieves Carasco failed to appear at their arraignment and the court issued a bench warrant for their arrests. Both Blanco and Carasco surrendered on June 13, 2005, and each pled guilty to conspiracy to commit official misconduct. They are scheduled to be sentenced in early 2006.

Former East Orange Police Officer Philip Major previously pled guilty to conspiracy and two counts of official misconduct. Major pled guilty to 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. Many of the people posing as alleged accident victims filed insurance claims for personal injuries.

At his guilty plea hearing, Major admitted that he was a "runner" who accepted bribe payments from two chiropractors for the purpose of providing information from police accident reports to the chiropractors who used the information to recruit patients to submit insurance claims. A "runner" is a person who for money recruits persons for licensed medical professionals or lawyers so they can submit insurance claims. Furthermore, Major admitted he had a financial interest in Metro Medical Services, a medical facility that specialized in treating persons for insurance claims, and also admitted that he attempted to bribe another police officer for additional police accident report information in order to recruit patients to submit insurance claims.

Major is scheduled to be sentenced in early 2006.

State v. Jeffrey Nemes

As part of a continuing investigation into a series of arson fires in Mercer County and elsewhere, OIFP previously returned three indictments that charged Jeffrey Nemes, a former Hamilton Township police officer, with charges in one indictment relating to bribes allegedly offered to local fire district fire chiefs, in a second indictment with bribes allegedly offered to the Executive Vice President of the East Windsor Police Athletic League (PAL), and in a third indictment with the alleged theft of insurance claims money in connection with a construction and home repair business known as Nemes Enterprises, Inc., that was owned and operated by Nemes.

With respect to the third indictment, the Appellate Division of the New Jersey Superior Court reversed Nemes' conviction for theft by failure to make proper disposition of property on May 19, 2005. The Appellate Court returned the case to the trial court for a new trial. The jury had found Nemes guilty of theft by failure to make proper disposition of property. Nemes, while employed as a Hamilton Township police officer, allegedly took insurance claim money in the approximate amount of $130,000 from both commercial and residential property owners through Nemes Enterprises, Inc., but he allegedly failed to complete repairs to the properties. The court sentenced Nemes to seven years state prison and ordered him to pay a total of $130,833 in restitution and he appealed. The conviction was reversed.

The trial on the charges that Nemes offered bribes to fire chiefs in and around Hamilton Township, began on August 24, 2005. During the trial, the State alleged that Nemes offered a bribe on April 22, 1998, to the fire chief of the Rusling Hose Fire Company. A second bribe was alleged to have occurred during a conspiracy in which Nemes and Marc Rossi, the former owner of Rossi Adjustment Services, a public insurance claims adjusting business, agreed to offer a bribe to the fire chief of the Enterprise Fire Company in Hamilton Township. During the trial, the State alleged that bribes were offered to the fire chiefs so that they would allow fires to burn longer in order to cause additional damage. The State alleged that Nemes owned and operated a construction and home repair business during the period of time the alleged bribes were paid and was seeking additional construction work for his business. The trial ended in a mistrial on September 13, 2005, and is pending retrial.

Likewise, the indictment alleging that Nemes allegedly offered bribes to the Vice President of the East Windsor PAL is pending trial.

State v. Jeffrey Nemes and John Fiore

A State Grand Jury previously returned an indictment 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. Marc Rossi was named as an unindicted co-conspirator in this case. This case is pending trial.

Receiving Stolen Property

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

The court sentenced Antonio Rodriguez-Baez on September 16, 2005, to four years in state prison and ordered him to pay $19,838 in restitution to State Farm Insurance Company, $39,172 in restitution to AAA Mid-Atlantic Insurance Company, and $64,677 to Motors Insurance Company. Rodriguez-Baez pled guilty to being a leader of an automobile theft trafficking network. The network 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.

"Operation Car Swap"
State v. Terron Session

After he pled guilty to receiving stolen property, the court sentenced Terron Session on January 21, 2005, to five years probation with 364 days in county jail as a condition of probation. The court also ordered him to perform 200 hours of community service and pay a $500 criminal fine. An Essex County Grand Jury returned an indictment that charged 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 from a Port Authority storage facility.

State v. Jaroslaw Siurek

The court sentenced Jaroslaw Siurek on October 7, 2005, to three years probation. Siurek pled guilty to an accusation that charged him with receiving stolen property. Siurek admitted that on October 30, 2003, he knowingly possessed a stolen Porsche Boxster automobile. OIFP's investigation revealed that the Boxster was part of an alleged automobile insurance "give up" fraud. An automobile insurance "give up" occurs when the owner of an automobile "gives up" his car to another person so that the car can be hidden, chopped into parts, or re-tagged in order to permit the original owner to make a phony automobile insurance theft claim. In this case, an automobile theft claim was allegedly submitted to Chubb Insurance Company. Chubb paid a total of $73,943 to settle the theft claim.

OIFP began the investigation of Siurek following a report by the Linden Police Department who arrested Siurek on other charges. At the time of the arrest, Siurek possessed a bag containing automobile keys and automobile VIN plates. VIN plates are commonly used to identify automobiles. Sometimes people who steal or "give up" an automobile will change the VIN plates on the automobile to conceal its identity (re-tag) and to hide the fact that it has been reported as a stolen automobile.

State v. Anthony Josephs

Anthony Josephs pled guilty to receiving stolen property, and the court sentenced him on October 17, 2005, to five years in state prison. Josephs admitted that between December 2002 and January 2004, he knowingly possessed a stolen 2004 Cadillac Escalade, and between August 2003 and October 2003, he knowingly possessed a stolen 2000 Porsche Boxster. Josephs also admitted that he allegedly participated in stealing other cars from automobile dealerships. Josephs and others would allegedly appear at dealerships, test drive expensive cars, and switch the real ignition keys to the cars with fake keys so they could return and use the real ignition key to steal the cars. The defendant allegedly stole cars from dealerships located in Oakhurst and Lawrence.

State v. Giovanni Muscia

A Passaic County Grand Jury returned an indictment on September 21, 2005, that charged Giovanni Muscia with conspiracy and theft by deception. According to the indictment, Muscia owned and operated Rocky's Auto Body formerly located on Bloomfield Avenue in Paterson. Muscia allegedly received, stripped, and stored parts from automobiles that had been reported stolen, including a 1994 Mercedes Benz.

Staged and Fictitious Accidents

State v. Erik Bula

The court sentenced Erik Bula on March 11, 2005, to two years probation and ordered him to pay $5,438 in restitution and a $5,000 civil insurance fraud fine. Bula pled guilty to an accusation that charged him with Health Care Claims Fraud and theft by deception. Bula admitted that he staged an automobile accident in Union City that involved two cars and five other people. As the result of the staged accident, Bula and the people purportedly involved in the accident received treatment for injuries they alleged were sustained in the accident. They also allegedly sought bodily injury settlements from Liberty Mutual

Insurance Company. Bula admitted that as the 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 as the result the staged car accident.

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 in 2004 that charged 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 struck Roman's car on October 13, 1998. Nhar and Bula were passengers in Mazo's car. Hernandez and Diaz were 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).

Roman, Diaz, Hernandez, and Nhar pled guilty to conspiracy to commit Health Care Claims Fraud and theft by deception. The court sentenced them on June 24, 2005, to two years probation and ordered each to pay a $2,500 civil insurance fraud fine, and to pay restitution as follows: Roman, $2,619; Diaz, $4,771; Hernandez, $6,323; and Nhar, $3,848. Quiroz Mazo pled guilty to theft by deception, and the court sentenced her on July 22, 2005, to two years probation and ordered her to pay $7,967 in restitution and a $2,500 civil insurance fraud fine.

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

The court sentenced defendants in 2005 who were previously named in four State Grand Jury indictments variously charging conspiracy, Health Care Claims Fraud, and attempted theft by deception. The defendants allegedly conspired with Eric Boyer, the alleged mastermind of three staged accidents between October 1998 and October 1999 which resulted in the submission of multiple phony PIP insurance claims to several insurance companies. Over $204,378 in fraudulent claims were submitted to insurance companies.

Kevin Douglas and Shinaka Hill pled guilty to attempted theft by deception. The court sentenced Shinaka Hill on January 28, 2005, to five years probation. On the same day, the court sentenced Douglas to three years probation with credit for 84 days served in county jail, and ordered him to perform 75 hours of community service and to pay $3,009 in restitution.

Emilio Mayes was arrested in California on or about January 3, 2005, pursuant to a fugitive bench warrant. He waived extradition and was transported to New Jersey. Mayes pled guilty to attempted theft by deception, and the court sentenced him on May 20, 2005, to three years probation with credit for serving 52 days in county jail and ordered him to pay $1,935 in restitution and to perform 100 hours of community service.

Sakinah Hill was also arrested pursuant to a fugitive bench warrant. She pled guilty to attempted theft by deception, and the court admitted her into the PTI Program on June 6, 2005, conditioned upon her performing 50 hours of community service.

Tamika Sutton failed to appear at her arraignment and was arrested on a bench warrant on June 2, 2005. Sutton pled guilty to attempted theft by deception, and the court sentenced her on October 17, 2005, to two years probation with credit for 65 days served in county jail. The court also ordered Sutton to perform 50 hours of community service and to pay $445 in restitution.

Sareesah Houston pled guilty to attempted theft by deception. The court sentenced her on November 16, 2005, to two years probation with credit for nine days jail time.

The court admitted Vanessa Miller into the PTI Program on October 24, 2005.

Alnisca Franklin pled guilty on December 15, 2005, to attempted theft by deception. She is scheduled to be sentenced in 2006.

Charges as to the remaining defendants are pending trial.

State v. Iris Salkauski, et al.

The court handed down a sentence on September 23, 2005, for another defendant caught in a staged accident ring that involved 48 defendants. The court sentenced David Agosto to four years probation conditioned upon serving 180 days in county jail through the SLAP program. The court also ordered him to perform 100 hours of community service and to pay a $1,500 civil insurance fraud fine. Agosto pled guilty to conspiracy.

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 allegedly staged 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 injuries sustained as a result of the staged accidents. Ultimately, defendants allegedly filed fraudulent PIP claims with Allstate Insurance Company for payment or reimbursement of medical expenses and "pain and suffering" costs.

The principal indictment identified Iris Salkauski as the alleged 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. Salkauski ultimately pled guilty to conspiracy. The court sentenced her to five years state prison and ordered her to pay a $235,000 civil insurance fraud fine.

State of New York v. Alexander Karsheboym, Sergey Chizov, Ella Chisov, and Vlad Meisher

OIFP assisted the Westchester County New York District Attorney's Office on October 17, 2005 and October 18, 2005, with the arrests of Alexander Karsheboym, Sergey Chisov, Ella Chisov, and Vlad Meisher. The four, in addition to other defendants, were charged by the Westchester County New York District Attorney's Office variously with enterprise corruption, money laundering, and other related charges. It is alleged that the four defendants assisted in a staged accident/automobile PIP insurance fraud in which claims were submitted to numerous insurance companies, including GEICO, Nationwide Insurance Company, Liberty Mutual Insurance Company, Allstate Insurance Company, State Farm Insurance Company, Lyon Insurance Company, Royal Alliance Insurance Company, and Progressive Insurance Company arising from alleged staged accidents in and around the New York area.

Attorneys and investigators from OIFP assisted with the arrests and extraditions of the defendants to New York State to answer the above referenced charges. These cases are pending disposition in New York criminal court.

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

State v. Jorge Fonseca and Joe Abel Hojas-Bravo

The court sentenced Jorge Fonseca on January 5, 2005, to three years probation and ordered him to pay a $1,000 criminal fine following his guilty plea to conspiracy. Fonseca's charges stem from a Motor Vehicle Commission-related investigation into the sale of fraudulent motor vehicle documents.

According to the first indictment, between June 28, 2002 and July 9, 2002, Fonseca allegedly conspired with an employee of the Irvington Motor Vehicle Commission (MVC) facility to make fictitious drivers' licenses, driving permits, and automobile titles. The MVC employee was a confidential OIFP informant.

The State alleged in the second indictment that on July 9, 2002, Hojas-Bravo, in his capacity as an employee of the Rahway MVC office, conspired with a confidential OIFP informant to create and transfer a fictitious New Jersey motor vehicle driver's license. Hojas-Bravo pled guilty to official misconduct and the court sentenced him to 30 months probation conditioned upon his serving 180 days in county jail.

State v. Santa Vasquez

The court admitted Santa Vasquez into the PTI Program on July 19, 2005, conditioned upon her performing 60 hours of community service. OIFP filed an accusation that charged her with simulating a motor vehicle insurance identification card. Vasquez allegedly presented a counterfeit New Jersey Indemnity Insurance Company motor vehicle insurance identification card to an inspector at the Rahway MVC inspection facility.

State v. Taleatha L. Thomas

The court admitted Taleatha L. Thomas into the PTI Program on March 17, 2005. Thomas pled guilty to simulating a motor vehicle insurance identification card. A Mercer County Grand Jury returned an indictment that charged 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 motor vehicle inspector while having her 1997 Geo Prism inspected at the Lawrenceville MVC inspection facility.

State v. Wesley M. Jordan

The court admitted Wesley M. Jordan into the PTI Program on January 14, 2005, conditioned upon his performing 50 hours of community service. Jordan pled guilty 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.

State v. Sara Corcuera, Jose Vivanco, Pedro Roca Garcia, Julio Aviles, Geovani Geson Villeda-Fajardo, Joe J. Velez, and Cristian Y. Batres

A State Grand Jury returned seven indictments on February 28, 2005, against several defendants allegedly involved with creating false documents. One indictment charged Sara Corcuera with conspiracy, simulating a motor vehicle insurance identification card, and sale of simulated documents. Six other defendants were charged in separate indictments as follows:

- Jose Vivanco with simulating a motor vehicle insurance identification card and sale of a simulated document;
- Pedro Roca Garcia with simulating a motor vehicle insurance identification card and sale of a simulated document;
- Julio Aviles with conspiracy, simulating a motor vehicle insurance identification card, and sale of a simulated document;
- Geovani Geson Villeda-Fajardo with simulating a motor vehicle insurance identification card and sale of a simulated document;
- Joe J. Velez with simulating a motor vehicle insurance identification card; and
- Cristian Y. Batres with simulating a motor vehicle insurance identification card.

The State alleges in the indictments that between May 25, 2001 and July 19, 2002, Sara Corcuera created and sold counterfeit motor vehicle insurance identification cards, New Jersey State drivers' licenses, as well as other phony documents. The State also alleges that in at least one instance, Corcuera sold fictitious documents to an undercover OIFP investigator. Corcuera pled guilty to conspiracy, simulating a motor vehicle insurance identification card, and sale of simulated documents. The court sentenced her on September 9, 2005, to five years probation and ordered her to perform 150 hours of community service.

Joe J. Velez pled guilty on July 7, 2005, to simulating a motor vehicle insurance identification card. The court sentenced him on the same day to time served in county jail (47 days) and ordered him to pay a $250 criminal fine.

Julio Aviles pled guilty to simulating a motor vehicle insurance identification card. The court sentenced him on October 28, 2005, to two years probation conditioned upon his performing 50 hours of community service.

The remaining defendants' cases are pending trial.

State v. Hernando David

A Passaic County Grand Jury returned an indictment on March 28, 2005, that charged Hernando David with conspiracy and tampering with public records or information. The State alleges in the indictment that David used numerous aliases and conspired with two

other persons to obtain a driver's license using a fictitious name.

State v. Shanda Renee Coleman

The State admitted Shanda Renee Coleman into the PTI Program on April 4, 2005, conditioned upon her performing 50 hours of community service. She pled guilty on the same day to simulating a motor vehicle insurance identification card. A Monmouth County Grand Jury returned an indictment that charged Coleman with simulating a motor vehicle insurance identification card. According to the indictment, Coleman allegedly presented a phony motor vehicle insurance identification card to a New Jersey State Trooper during a traffic stop in Howell.

State v. Lunic Adisson

The court sentenced Lunic Adisson on April 18, 2005, to four years probation, ordered her to pay a $2,500 civil insurance fraud fine, and to perform 50 hours of community service. Adisson pled guilty to simulating a motor vehicle insurance identification card.

An Essex County Grand Jury returned an indictment that charged Adisson with simulating a motor vehicle insurance identification card. According to the indictment, Adisson allegedly presented the fictitious insurance identification card to an Irvington police officer to regain possession of her impounded car.

State v. Kamillah Ali and Julia Ali

Kamillah Ali pled guilty to sale of a simulated document and simulating a motor vehicle insurance identification card. The court sentenced her on September 12, 2005, to three years probation, conditioned upon paying $1,200 in restitution. Kamillah's mother, Julia Ali, pled guilty to a disorderly persons offense of creating a nuisance and was ordered to pay court fines.

A State Grand Jury returned an indictment that charged Kamillah Ali with simulating a motor vehicle insurance identification card, conspiracy, and sale of simulated documents. The Grand Jury also charged Julia Ali with sale of a simulated document. According to the indictment, Kamillah Ali 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.

State v. Darnell C. Kimbrough

The court sentenced Darnell C. Kimbrough on December 2, 2005, to three years probation and ordered him to perform 100 hours of community service. Kimbrough pled guilty to simulating a motor vehicle insurance identification card. A Somerset County Grand Jury returned an indictment that charged Kimbrough with simulating a motor vehicle insurance identification card and forgery. According to the indictment, on September 27, 2004, Kimbrough allegedly presented a phony National Consumer Insurance Company automobile insurance identification card to a State Trooper. At the time, National Consumer Insurance Company had not been doing business for six years. Kimbrough allegedly presented the phony card to retrieve his vehicle from the Somerville State Police impound. The State also alleged that in support of his claim that his vehicle was insured, Kimbrough allegedly presented the trooper with a phony National Consumer Insurance Company letter stating that a policy existed for Kimbrough and his vehicle.

State v. Jeffrey Ferrer and Nelson Ferrer

The court admitted Jeffrey Ferrer into the PTI Program on June 23, 2005. The court sentenced Nelson Ferrer on July 1, 2005, to one year probation.

Jeffrey Ferrer and his father, Nelson Ferrer, pled guilty to separate accusations that charged them with simulating a motor vehicle insurance identification card. Jeffrey Ferrer admitted that on June 24, 2004, he assisted in obtaining and selling a phony Countryway Insurance Company automobile insurance identification card. An undercover OIFP investigator approached Jeffrey Ferrer seeking to buy a phony auto insurance identification card. Jeffrey Ferrer allegedly indicated that he would be able to obtain the card from Nelson Ferrer. The undercover investigator paid $400 for the card. Jeffrey Ferrer allegedly retained $175 and gave the balance of the money to his father.

State v. Andres Zapata-Quisqueya

Andres Zapata-Quisqueya pled guilty on December 14, 2005, to simulating a motor vehicle insurance identification card. A Union County Grand Jury returned an indictment charging Zapata-Quisqueya with simulating a motor vehicle insurance identification card. According to the indictment, Zapata-Quisqueya allegedly presented a counterfeit New Jersey Manufacturers Insurance Company motor vehicle insurance identification card to an inspector at the Plainfield MVC Inspection Station. He is scheduled to be sentenced in 2006.

State v. Monique Singleton

The court admitted Monique Singleton into the PTI Program on December 14, 2005, conditioned upon her performing 60 hours of community service. Singleton pled guilty on the same day to simulating a motor vehicle insurance identification card. A Union County Grand Jury returned an indictment that charged Singleton with simulating a motor vehicle insurance identification card. According to the indictment Singleton allegedly presented a counterfeit Prudential Insurance Company motor vehicle insurance identification card to an inspector at the Plainfield MVC Inspection Station.

Motor Vehicle Commission Initiative

"FIX-MVC"

In 2005, OIFP continued to make strides in the disposition of defendants prosecuted as part of "FIX-MVC." "FIX-MVC" is OIFP's continuing investigation into official misconduct and fraud at the State Motor Vehicle Commission (MVC), as well as the procurement of fictitious identification to include drivers' licenses, commercial drivers' licenses, and other MVC-related documents. As OIFP has learned through successful prosecutions, many people file false insurance claims utilizing several different false identities. Phony drivers' licenses and other false identification facilitate this illegal conduct.

"FIX-MVC - 1"
State v. Rita Okolo, Josefina Martinez, and Fermin Capellan

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

According to the second indictment, between February 2003 and May 2003, Okolo allegedly accepted a 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 State alleged that Okolo permitted another individual, an OIFP undercover investigator, to take the commercial driver's license exam for Martinez.

Capellan pled guilty on April 25, 2005, to conspiracy; Martinez pled guilty on May 24, 2005, to conspiracy to commit official misconduct; and Okolo pled guilty to official misconduct on October 26, 2005. Sentencing is scheduled for early 2006.

"FIX-MVC - 2"
State v. Tiffany Swinney

Tiffany Swinney pled guilty to tampering with public records or information, and on May 27, 2005, the court sentenced her to three years probation and ordered her to perform 200 hours of community service. Swinney was previously charged by a State Grand Jury with tampering with public records or information and sale of a simulated document. Swinney, who was an employee of the Wayne MVC office located on Route 23, was stopped by a Wayne police officer for a motor vehicle violation. According to the indictment, Swinney allegedly presented a fictitious driver's license to the police officer. The investigation revealed that the State had suspended Swinney's driver's license.

"Fix-MVC - 6"
State v. Esterlina Marin

Esterlina Marin pled guilty on December 16, 2005, to an accusation charging her with official misconduct. Marin, a clerk at the Lodi branch of the MVC, admitted that she assisted in obtaining four drivers' licenses for individuals by falsifying official MVC documents. Specifically, she admitted that she allegedly reviewed the birth certificates of four applicants when she had not reviewed birth certificates for those applicants. Marin is scheduled to be sentenced in 2006.

"Fix-MVC - 13"
State v. Stacey Chestnut

On December 5, 2005, Stacey Chestnut pled guilty to official misconduct. A State Grand Jury returned an indictment charging her 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 alleges 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). She is scheduled to be sentenced in 2006.

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

After OIFP investigators arrested Karina Noelia Vallego, Vallego's mother Monica Morelli, Luis Lagos, and Betty E. Doering, the defendants were charged in a State Grand Jury indictment with conspiracy and tampering with public records. 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. Along with Vallego, the defendants allegedly sold various fictitious MVC documents.

Doering, Morelli, and Lagos pled guilty to conspiracy. On January 7, 2005, the court sentenced Doering to two years probation, Morelli to 30 months probation and ordered her to pay $2,310 in restitution, and Lagos to three years probation and ordered him to pay $2,310 in restitution. Vallego pled guilty to conspiracy to commit a sale of a simulated document, and on May 20, 2005, the court sentenced her to two years probation.

State v. Ghmaso Nyasanu Johnson, Delandras Markeith Williams, and Gentree Vanblake

A Union County Grand Jury returned an indictment that charged Ghmaso Nyasanu Johnson, Delandras Markeith Williams, and Gentree Vanblake with conspiracy and bribery. Johnson and Williams, both employees of the Plainfield MVC Inspection Station, were also charged with official misconduct.

According to the indictment, between January 20, 2004 and February 13, 2004, Johnson and Williams allegedly issued an automobile inspection sticker that falsely indicated that an automobile passed inspection. The indictment further sets forth that Vanblake, the owner of the automobile that failed inspection, allegedly bribed Johnson and Williams for $40 to issue a motor vehicle inspection sticker that falsely indicated that the car passed. The MVC fired Johnson and Williams.

Johnson and Williams pled guilty to conspiracy on August 3, 2005, and on the same day, the court admitted them into the PTI Program conditioned upon their performing 60 hours of community service. The court admitted Vanblake into the PTI Program on August 10, 2005, conditioned upon performing 60 hours of community service.

State v. Darren Ragin

The court sentenced Darren Ragin on July 22, 2005, to three years probation and ordered him to perform 75 hours of community service. Ragin pled guilty to a Camden County Grand Jury indictment charging him 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 an inspector at the Cherry Hill MVC Inspection Station.

State v. Jose E. Alvarez

A Camden County Grand Jury returned an indictment on October 6, 2005, that charged Jose E. Alvarez with simulating a motor vehicle insurance identification card. According to the indictment, Alvarez allegedly presented a fictitious State Farm motor vehicle insurance identification card to a Collingswood patrolman during a traffic stop.

State v. Michael Jeune

Michael Jeune pled guilty on June 2, 2005, to sale of simulated documents. A State Grand Jury returned an indictment charging him with sale of simulated documents. According to the indictment, between January 1, 2001 and March 23, 2001, Jeune allegedly purchased counterfeit U.S. Department of Defense DD214 Discharge forms from a co-conspirator. The State also alleged that Jeune used the DD214 Discharge forms to obtain drivers' licenses that were sold on the street for between $300 and $1,500. OIFP investigators arrested Jeune on March 23, 2001, for possessing the phony government documents. He is scheduled for sentencing in 2006.

State v. Larry Murphy and Charlotte Murphy

Larry Murphy and Charlotte Murphy were arrested by OIFP investigators on September 29, 2005, and charged with simulating a motor vehicle insurance identification card. The State alleges that the Murphys were producing fictitious insurance identification cards. Insurance identification cards are used to provide evidence that persons have the required automobile insurance. Fake insurance identification cards are sold on the street for prices ranging from $200 to $500. They are displayed to police officers and MVC officials so that it appears that the person showing a fake insurance identification card has the appropriate automobile insurance.

State v. Wilberta Johnson

Wilberta Johnson pled guilty on November 28, 2005, to presenting a false insurance card. A State Grand Jury returned an indictment charging her with simulating a motor vehicle insurance identification card and

manufacturing a false insurance card. According to the indictment, Johnson allegedly exhibited a phony Clarendon Insurance Company auto insurance identification card when having her 2002 Kia inspected at the Plainfield MVC Inspection Station. Suspecting the card was fraudulent, MVC personnel contacted OIFP. Johnson is scheduled to be sentenced in early 2006.

State v. Natasha V. Crisp

A Union County Grand Jury returned an indictment on November 9, 2005, that charged Natasha V. Crisp with simulating a motor vehicle insurance identification card. According to the indictment, Crisp allegedly exhibited a phony Prudential Insurance Company auto insurance identification card when she was having her 1997 Dodge Intrepid inspected at the Plainfield MVC Inspection Station. MVC personnel suspected the card was fraudulent and referred the matter to OIFP.

Vehicle Theft

Operation Ninja

State v. Torray A. Murphy, Kyle J. Bunn, Jamar L. Doggett, Ronald R. Crosland, Gregory Haygood, Rodney Butler, John White, Janine Barnes, Alan Barbosa, Arthur Outram, John Kennedy, Jaesen Hensely, Rodney West, Floyd Robertson, Anthony Angelone, Cory Carthan, Kevi Williamson, Quentin Durden, Michael Green, Anton Hall, Aaron Auten, Randy Brolo, David Schall, Jason Reed, and Jason Hobbs

OIFP and State Police conducted a joint investigation of a conspiracy to steal motorcycles, change the Vehicle Identification Numbers (VIN) of each motorcycle to conceal the true identity and ownership of the motorcycles in a process known as "stamping," and to otherwise obtain false title documents and registrations for the stolen vehicles.

As the result of the joint investigation, 23 persons were arrested on May 4, 2005, for their roles in a motorcycle theft ring that operated in Mercer and Burlington Counties. The defendants were variously charged with racketeering, conspiracy, Insurance Fraud, receiving stolen property, and fencing.

Among the 23 persons arrested were Kyle Bunn, Ronald Crosland, Gregory Haygood, Jamar Doggett, and John White, who were each charged with theft by unlawful taking, receiving stolen property, and fencing. The State alleges that the defendants conspired to steal 16 motorcycles in Burlington County valued at approximately $97,225, with 23 separate instances of receiving stolen motorcycles valued at approximately $153,557, and 12 separate instances of fencing stolen motorcycles valued at approximately $83,857.

The investigation is continuing and further charges are anticipated.

Previously, as part of the investigation, the Bensalem, PA, Police Department arrested Torray Murphy and Gregory Haygood on June 16, 2004, and charged them with attempted theft of an automobile. The defendants were placed in the Bucks County Correctional Facility. OIFP and the New Jersey State Police arrested Murphy on July 8, 2004, at the Bucks County Correctional Facility and charged him with eluding a police officer. Murphy was allegedly in the process of stealing a motorcycle on May 14, 2004, when he was spotted and fled the police in his van. He abandoned the van and continued to flee on foot. OIFP's subsequent investigation identified Murphy as the individual who allegedly fled on foot from the van. As a result, OIFP made the July 8, 2004, arrest of Murphy.

The arrest resulted from an undercover investigation in New Jersey of stolen motorcycles, and an automobile in Pennsylvania. OIFP, the New Jersey State Police, and other law enforcement agencies are continuing the investigation. Based on the investigation, the following dispositions occurred in 2005:

Anthony Angelone pled guilty to an accusation that charged him with receiving stolen property, and the court sentenced him on September 16, 2005, to two years probation and ordered him to pay $2,159 in restitution.

Floyd Robertson pled guilty on June 27, 2005, to a disorderly persons charge of fencing; the court sentenced him on the same day to one year probation conditioned upon his continued cooperation with the State's investigation into this matter.

Quentin Durden pled guilty to an accusation that charged him with receiving stolen property, and on July 19, 2005, the court admitted him into the PTI Program conditioned upon his paying $3,300 in restitution.

Aaron Auten pled guilty to an accusation that charged him with receiving stolen property, and the court admitted him into the PTI Program on August 11, 2005, conditioned upon his paying $2,169 in restitution.

Anton Hall pled guilty to an accusation that charged him with receiving stolen property, and the court sentenced him on October 28, 2005, to one year probation.

The court sentenced John Kennedy on September 12, 2005, to nine months in state prison after he pled guilty to an accusation that charged him with receiving stolen property.

Randolph Brolo, Rodney Butler, and Kevi Williamson pled guilty to accusations on October 31, 2005, that charged them with receiving stolen property. The court sentenced Williamson on December 23, 2005, to one year probation and ordered him to pay $2,159 in restitution. Brolo and Butler are scheduled to be sentenced early in 2006.

Torray Murphy pled guilty to an accusation on November 14, 2005, that charged him with eluding; he was sentenced on the same day to five years in state prison.

The other cases are pending.

State v. Arthur Chzubek, Edward Obszanski, Waldemar Kondzielewski, Dariusz Grabowski, Krzysztof Grabowski, Dominik Tabor, Patrick M. Gutorski, and Marcin D. Kisz (Operation Key Code Express)

OIFP Investigators arrested six people on November 1 and 2, 2005, and charged them as follows:

- Arthur Chzubek with conspiracy to commit receiving stolen property, receiving stolen property, leader of auto trafficking network, and conspiracy to commit Insurance Fraud;
- Edward Obszanski with receiving stolen property, conspiracy to commit receiving stolen property, certain alterations of motor vehicle trademarks and identification numbers, and conspiracy to commit Insurance Fraud;
- Dariusz Grabowski with conspiracy to receive stolen property, receiving stolen property, conspiracy to commit certain alterations of motor vehicle trademarks and identification numbers, certain alterations of motor vehicle trademarks and identification numbers, and leader of auto trafficking network;
- Waldemar Kondzielewski with receiving stolen property, conspiracy to commit receiving stolen property, conspiracy to commit certain alterations of motor vehicle trademarks and identification numbers, and certain alterations of motor vehicle trademarks and identification numbers;
- Krzysztof Grabowski with conspiracy to commit receiving stolen property, receiving stolen property, and leader of auto trafficking network;

- Patrick M. Gutorksi with conspiracy to commit receiving stolen property, receiving stolen property, and leader of auto trafficking network.

It is alleged that these defendants stole cars, purchased similar salvaged or wrecked cars in order to obtain the VINs, and replaced the original VINs in the stolen cars with the VINs from the salvaged cars to conceal the identity of the stolen cars. It is further alleged some of the stolen cars were sold on online auctions.

State v. Mariusz Mroczka and Kristina Kowalczyk

Mariusz Mroczka pled guilty to an accusation that charged him with receiving stolen property, and the court sentenced him on May 13, 2005, to four years in state prison and ordered him to pay $46,114 in restitution.

Mroczka admitted that between September 26 and October 2, 2003, he accepted stolen cars from another person. Specifically, Mroczka admitted that he took possession of a 2001 Lexus IS 300, a 2001 Lexus GS 430, a 2003 Lexus SC 430, and a Volkswagen Jetta. In total, the four cars were valued in excess of $170,000. Mroczka allegedly took possession of the stolen cars so that they could be re-tagged and resold. "Re-tagging" a vehicle means that the VIN is removed from the car and a different VIN is placed on the car so that it can be hidden from law enforcement and appear to be not stolen.

The alleged stolen cars were found on Mroczka's property in Linden when OIFP investigators executed a search warrant as part of an investigation into automobile thefts, automobile re-tagging, and insurance fraud. Investigators allegedly found various parts from other automobiles, mechanics' tools, and other evidence consistent with vehicle re-tagging during the search.

Kristina Kowalczyk pled guilty to an accusation that charged her with receiving stolen property, and the court admitted her into the PTI Program on September 28, 2005, conditioned upon her performing 60 hours of community service. Kowalczyk admitted that between September 26, 2003 and October 2, 2003, she knowingly possessed parts from a stolen 2001 Lexus IS 300. The owner of the 2001 Lexus reported the vehicle stolen on May 15, 2003, to the Clifton Police Department. New Jersey Manufacturers Insurance Company paid $26,225 to settle the automobile theft insurance claim. Kowalczyk pled guilty to the charge of receiving stolen property for her role in a scam in which automobiles were stolen and their VINs altered so that law enforcement could not trace the stolen vehicles to their legitimate owners.

OIFP's investigation revealed that automobile insurance theft claims were filed for these stolen cars with several insurance companies including New Jersey Manufacturers Insurance Company, AIG Insurance Company, Allstate Insurance Company, and the Peerless Insurance Company.

State v. Steven E. Williams

The court sentenced Steven E. Williams on May 11, 2005, to three years probation and ordered him to pay $3,555 in restitution and a $500 criminal fine. Williams pled guilty to an accusation that charged him with theft by unlawful taking. Williams admitted he stole a 2004 Cadillac Escalade from a dealership in Florham Park. Williams admitted that he went to the dealership to shop for a new Cadillac. When the salesman showed him a new Cadillac, Williams allegedly switched a blank key with the valet key for the new Cadillac. Williams admitted that he went back to the dealership the same day and utilized the valet key to steal the Cadillac Escalade. Later, Williams allegedly re-tagged the stolen Cadillac by changing the VIN in order to conceal its identity from law enforcement. The stolen Cadillac was valued at over $61,000.

HEALTH AND DISABILITY FRAUD

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

State v. Philip Potacco

Philip Potacco pled guilty on December 12, 2005, to theft by deception. A State Grand Jury returned an indictment that charged Potacco with Health Care Claims Fraud and attempted theft by deception. According to the indictment, Potacco allegedly continued to practice chiropractic medicine for approximately four years in Little Falls Township, Passaic County, and South Orange, Essex County, even though his license had been suspended by the Board of Chiropractic Examiners on several occasions.

Despite not having a valid license to practice chiropractic medicine, Potacco allegedly billed automobile insurance companies for treating automobile accident patients under their PIP insurance. Potacco allegedly billed approximately $98,175 to multiple companies including First Trenton Indemnity Company, New Jersey Manufacturers Insurance Company, and State Farm Insurance Company. The insurance companies allegedly paid Potacco approximately $48,022. Potacco is scheduled to be sentenced in 2006.

State v. Lev Natovich, Boris Natovich, and Joseph Matriss

A State Grand Jury returned a superseding indictment on January 10, 2005, that charged Lev Natovich with tampering with witnesses and informants. The new charge added by the superseding indictment alleges that between November 17, 2003 and November 19, 2003, Lev Natovich approached an individual and requested that he change or alter his anticipated testimony with respect to the charges alleged in the original indictment.

A State Grand Jury previously charged Lev Natovich with Health Care Claims Fraud, conspiracy to commit Health Care Claims Fraud, conspiracy to commit theft by deception, unlawful practice of dentistry, theft by deception, and conspiracy to commit unlawful practice of dentistry. Also named in the original indictment was Boris Natovich, Lev Natovich's father, who is the owner of United Dental Center. Boris Natovich was charged with one count of conspiracy to commit unlawful practice of dentistry. The final defendant named in the original indictment was Joseph P. Matriss, who is a dentist licensed to practice dentistry in New Jersey and who performed dental services at United Dental Center. Matriss was charged with Health Care Claims Fraud, conspiracy to commit Health Care Claims Fraud, conspiracy to commit theft by deception, and theft by deception.

The State alleged in the original indictment that, between September 1999 and March 2002, Boris Natovich and Matriss assisted Lev Natovich and another person who was previously charged, Vadim Lioubomoudrov, to provide dental treatment to United Dental Center patients, including children. Allegedly, neither Lev Natovich nor Lioubomoudrov were licensed in New Jersey to practice dentistry. It is believed that Lioubomoudrov held a Russian license to practice dentistry. The State also alleged that United Dental Center submitted fraudulent bills for dental services to a labor union and to Delta Dental Insurance patients for dental treatments performed by unlicensed dentists. The State alleged that the fraudulent bills were submitted to the insurance carriers reflecting Matriss, who was

licensed, as the treating dentist even though he had not treated some of the patients.

Joseph Matriss pled guilty to an accusation that charged him with falsifying or tampering with records. The court sentenced him on September 6, 2005, to one year probation and ordered him to pay $2,219 in restitution to Delta Dental, $9,781 in restitution to the labor union, and a $550 criminal fine. The court admitted Boris Natovich into the PTI Program on September 6, 2005, conditioned upon his paying $5,213 in restitution. Lev Natovich pled guilty to Health Care Claims Fraud, and the court sentenced him on October 7, 2005, to five years probation conditioned upon his spending at least six months in a drug rehabilitation center, and ordered him to pay $12,000 in restitution.

Fraudulent Billing by Health Care Providers

State v. LeClerc Adisson and Lunic Adisson

LeClerc Adisson and Lunic Adisson pled guilty to theft by deception, Health Care Claims Fraud, and Criminal Use of Runners. The charges were contained in an accusation and a State Grand Jury indictment. The court sentenced LeClerc Adisson on April 19, 2005, to 364 days in county jail as a condition of five years probation, and ordered him to pay approximately $26,000 in restitution to nine insurance companies and a $5,000 civil insurance fraud fine. LeClerc Adisson also surrendered his medical license. The court sentenced Lunic Adission to four years probation, ordered her to pay a $2,500 civil insurance fraud fine, and to perform 50 hours of community service.

A State Grand Jury returned an indictment against LeClerc Adisson and his niece Lunic Adisson, charging them with Health Care Claims Fraud, theft by deception, misconduct by a corporate official, and falsifying records. According to the indictment, between April 1997 and December 2000, LeClerc Adisson concealed that he owned and had a "beneficial interest" in two corporations, Dantor Medical Supply and Clara Medical Services. The State further alleged that, with the assistance of his niece, LeClerc Adisson submitted bills to various insurance companies for medical supplies and related services knowing the insurance companies would not pay the bills if they had known he owned Dantor Medical Supply and Clara Medical Services. The State alleged that some of the bills were fraudulent because they were inflated or for equipment never provided to patients. In total, the State alleged that LeClerc Adisson and Lunic Adisson fraudulently billed insurance carriers approximately $48,273, of which the Adissons were paid approximately $26,028.

Lunic Adisson was also named in a previous unrelated indictment that charged her with possession of a fictitious insurance identification card. The State alleged in the indictment that she presented the fictitious insurance identification card to an Irvington police officer to regain possession of her impounded car.

State v. Eugene Ruta and Andrew Farro

A State Grand Jury returned an indictment on May 12, 2005, charging Eugene Ruta and Andrew Farro with conspiracy, Health Care Claims Fraud, and Criminal Use of Runners. Ruta was a licensed chiropractor formerly employed at Valley Total Health Center in Orange, Essex County. Farro was also formerly employed as an office manager at Valley Total Health Center. According to the indictment, Farro allegedly agreed to pay a "runner" who was cooperating with OIFP $500 for every patient the "runner" could bring to Valley Total Health Center. The indictment further alleges that insurance claims were submitted to an insurance company for patients solicited for Valley Total Health Center in addition to claims for chiropractic services that were never rendered to patients. The patients the "runner" allegedly solicited, and another person to whom Farro allegedly paid money as a "runner," were all undercover OIFP investigators. Additionally, an undercover Newark police officer posed as a patient. The State alleged in the indictment that the defendants paid approximately $2,000 to persons who posed as "runner."

The State alleged in the indictment that Ruta committed Health Care Claims Fraud by permitting his office manager, Farro, to submit claims to insurance companies for services not rendered totaling approximately $5,945. The State also alleged that Ruta knew that Farro used a "runner" to solicit patients for Valley Total Health Center.

As part of the undercover investigation, in addition to sending investigators and police officers to Valley Total Health Center, investigators executed a search warrant to seize records and other evidence to support the charges. In total, bills for approximately $12,499 were allegedly submitted to Parkway Insurance for "runner" solicited patients. Parkway paid approximately $5,945 to Valley Total Health Center for insurance claims submitted.

The case against Ruta and Farro is pending trial.

State v. Ettore C. Carchia

Ettore C. Carchia pled guilty to an accusation charging him with Health Care Claims Fraud, and the court sentenced him on October 7, 2005, to three years probation. It also ordered him to surrender his chiropractic license. Carchia admitted that between January 1,1999 and October 20, 2000, he committed Health Care Claims Fraud by submitting PIP insurance claims to Allstate Insurance Company and Selective Insurance Company. The claims were false because they represented bills for chiropractic services not rendered, and chiropractic services that could not have been rendered given the time patients spent in the chiropractor's office.

Carchia was charged for his role in an insurance fraud and official corruption conspiracy that allegedly involved Camden Police Lieutenant Jerome Bollettieri, who was in charge of the Camden Police Department Records Room; retired Camden police officer, Thomas DiPatri; a person who acted as a "runner," Charles Warrington; and a now deceased man who owned, operated, or controlled a chiropractic clinic known as American Spinal Care, Inc., located in Collingswood.

The court sentenced Thomas DiPatri to three years in state prison pursuant to guilty verdicts returned for the crimes of conspiracy, bribery, official misconduct, and Criminal Use of Runners.

Jerome Bollettieri filed an appeal to the State Supreme Court seeking dismissal of the indictment. The Supreme Court recently dismissed his appeal and returned the case to Camden County Superior Court for trial.

The court sentenced Charles Warrington to three years in state prison.

State v. Mark Radowitz

A State Grand Jury returned an indictment on July 15, 2005, charging Mark Radowitz with Health Care Claims Fraud, theft by deception, and falsifying records. According to the indictment, between July 2, 1999 and September 5, 2000, Radowitz allegedly billed both Allstate Insurance Company and the California State Workers Compensation Insurance Fund for multiple chiropractic services allegedly provided to two patients. OIFP's investigation revealed that the chiropractic services billed to Allstate and the California State Workers Compensation Insurance Fund were not rendered even though Radowitz billed for them. The State alleges that Radowitz billed on approximately 179 dates for approximately $16,000 in chiropractic treatments never rendered to two patients.

State v. Paul Anodide

Paul Anodide pled guilty on November 14, 2005, to theft by deception. A State Grand Jury returned an indictment charging 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 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 is scheduled to be sentenced in 2006.

False Health Care Claims

State v. Reginald Smithson

The court issued a bench warrant on August 5, 2005, when Reginald Smithson failed to appear at his arraignment. An Essex County Grand Jury returned an indictment on June 9, 2005, charging Smithson with theft by deception, Insurance Fraud, and forgery. According to the indictment, Smithson allegedly submitted a phony receipt to State Farm Insurance Company showing he paid a hospital $1,001 for medical treatment related to injuries sustained in an automobile accident. The State alleges Smithson altered the receipt and the hospital treated him for an unrelated illness.

State v. James Clark

Following a 15-day jury trial, a jury found James Clark guilty of theft by deception and Health Care Claims Fraud. The court sentenced Clark on April 1, 2005, to nine years in state prison and ordered him to pay a $5,000 criminal fine.

A State Grand Jury returned an indictment charging Clark with theft by deception and Health Care Claims Fraud. Clark was president of Home Health Care Center, Inc. (HHC), located in Hoboken, and director of the now defunct Medical Care Management, Inc., d/b/a Mile Square Medical Group, formerly located in Weehawken. HHC is a business that delivers prescription medications from pharmacies to patients' homes and is not licensed to dispense or otherwise sell prescription medication. Mile Square Medical Group was a medical facility staffed by various physicians. Clark, himself, was neither a medical service provider nor a licensed pharmacist.

According to the indictment, between December 1, 1996 and September 11, 1998, Clark allegedly misrepresented to Horizon Blue Cross Blue Shield, which served as a third party claims administrator for the New Jersey State Health Benefits Program, that HHC was licensed to supply, dispense, and sell the prescription medications that were delivered to patients of Mile Square Medical Group. The State alleged that HHC grossly inflated the cost over the usual and customary price of the medicine for many prescriptions on claims it submitted to the State Health Benefits Program. The State also alleged that Clark submitted fraudulent health care reimbursement claims to Horizon Blue Cross Blue Shield and the State Health Benefits Program for prescription medications that were neither dispensed nor delivered to patients.

The State proved that Clark submitted nearly 400 fraudulent insurance claims for various medications. Approximately 330 claims were submitted for medications that were never dispensed and never delivered to the patients. The total amount of fraudulent billings allegedly submitted by Clark to Horizon Blue Cross Blue Shield and the State Health Benefits Program was in excess of $365,000, of which Horizon paid more than $343,000. The fraudulent prescription scheme allegedly involved at least eight different patients. The State Health Benefits Program is funded by tax dollars.

State v. Florence Acquaire

The court sentenced Florence Acquaire on September 30, 2005, to seven years in state prison and ordered her to pay $65,046 in restitution to Aetna Insurance Company and $4,428 in restitution to United Health Care. Following a ten-day bench trial, Acquaire was convicted of Health Care Claims Fraud, theft by deception, and attempted theft by deception.

A State Grand Jury previously returned an indictment charging Acquaire with two counts of Health Care Claims Fraud, two counts of attempted theft by deception, and two counts of theft by deception. According to the indictment, Acquaire allegedly rendered services as an electrologist, a person who removes unwanted hair. The State alleged that Acquaire, using the business name "High Mountain Medical Center," submitted fraudulent claims totaling $908,843 to United Health Group Insurance Company and Aetna Insurance Company. The State alleged the claims were fraudulent because Acquaire billed for hair removal by means of electrolysis as though it was a reimbursable medical surgical procedure known as a debridement, which can only be performed by or under the supervision of a properly licensed medical provider. The State alleged that Acquaire was not a licensed medical service provider, was not qualified to perform medical or surgical procedures, and would not have been authorized to bill the insurance companies for such procedures.

State v. Carol Severe

The court sentenced Carol Severe on June 10, 2005, to one year probation, ordered her to pay $13,947 in restitution and a $5,000 civil insurance fraud fine, and to perform 80 hours of community service. Severe pled guilty to an accusation charging her with Health Care Claims Fraud and uttering a forged document. Severe admitted that between January 5, 2000 and May 4, 2004, she obtained approximately $13,947 from Horizon Blue Cross Blue Shield by submitting false health insurance claims. An investigation revealed that Severe allegedly submitted 42 false claims for psychologist services on 192 dates. Severe allegedly submitted the false claims to Horizon Blue Cross Blue Shield by signing the psychologist's name to the claim forms.

State v. Barry Cohen

Barry Cohen pled guilty to Health Care Claims Fraud, and the court sentenced him on June 24, 2005, to three years probation and ordered him to pay $328,000 in restitution and a $105,000 civil insurance fraud fine. A State Grand Jury returned an indictment charging 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 to pa-

tients 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.

State v. Olivette Henderson

Olivette Henderson pled guilty on November 15, 2005, to Health Care Claims Fraud and theft of identity. A State Grand Jury returned an indictment charging Henderson with Health Care Claims Fraud and attempted theft by deception. According to the indictment, between December 11, 2000 and March 12, 2001, Henderson allegedly utilized the insurance identification information of another person to obtain medical services. The medical services allegedly included foot surgery and related medical bills for approximately $44,745. The bills were submitted to the CIGNA Property and Casualty Insurance Company and CIGNA paid approximately $7,550.

Henderson is scheduled for sentencing in 2006.

State v. Anthony Williams

A State Grand Jury returned an indictment on October 4, 2005, charging Anthony Williams with Health Care Claims Fraud and theft by deception. According to the indictment, between April 21, 2002 and April 28, 2005, Williams allegedly submitted a false New Jersey Transit automobile collision and personal injury claim to New Jersey Transit. The State alleges that Williams falsely claimed he was a passenger in a minivan that sustained relatively minor damage when a New Jersey Transit bus struck the side-view mirror of the minivan. The State also alleges that Williams claimed to be a passenger in the minivan even though the police investigation and OIFP's investigation revealed that he was not a passenger in the minivan. The State further alleges that Williams retained the services of an attorney and allegedly consulted with at least two physicians with respect to purported injuries. Williams failed to appear at his arraignment on November 18, 2005. The court issued a bench warrant for his arrest.

State v. Vera Maynard

The court admitted Vera Maynard into the PTI Program on October 26, 2005, conditioned upon her paying $6,066 in restitution and a $1,500 civil insurance fraud fine. An accusation was filed charging Maynard with theft by deception. According to the accusation, Maynard allegedly submitted fraudulent receipts to Horizon Blue Cross Blue Shield for reimbursement of medical bills for treatments never rendered to patients. The State alleges that Maynard was paid $6,066 by Horizon Blue Cross Blue Shield based on the fraudulent receipts.

Fraudulent Disability Claims

State v. John Rhody

John Rhody pled guilty on December 19, 2005, to falsification of records. He is scheduled to be sentenced in 2006. A State Grand Jury returned an indictment charging Rhody with theft by deception, falsifying or tampering with records, and contempt of court. According to the indictment, between May 31, 2001 and July 31, 2002, Rhody allegedly collected disability insurance benefits from the Standard Insurance Company by submitting a disability claim. The State further alleged that the evidence demonstrates that Rhody was actually working by buying and selling postcards on Ebay, and on other occasions and places, while he was allegedly disabled and collecting disability insurance.

The State also alleged that Rhody submitted false records about his disability, occupation, income, and was held in contempt of court in connection with a divorce action filed in Monmouth County Superior Court.

Rhody was formerly employed as an attorney by the Ocean-Monmouth Counties Legal Services Office.

State v. Jasmine Gomez

The court admitted Jasmine Gomez into the PTI Program on February 7, 2005, conditioned upon her paying $5,100 in restitution. A State Grand Jury returned an indictment charging 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 started receiving disability insurance claims money from Trustmark after a November 2001 automobile accident. The State further alleged Gomez forged physician statements to falsely indicate she was still injured and unable to return to work in order to continue receiving disability insurance payments.

State v. Douglas E. "David" Fittinger

The court sentenced Douglas E. "David" Fittinger on June 24, 2005, to five years probation, ordered him to pay $14,882 in restitution and a $5,000 civil insurance fraud fine, and to perform 325 hours of community service. Fittinger pled guilty to an accusation charging him with theft by deception. Fittinger admitted that between February 1, 2003 and June 10, 2003, he wrongfully obtained workers' compensation payments from his employer which is self-insured for workers' compensation insurance. The company administers its own workers' compensation insurance plan and makes workers' compensation payments. Fittinger admitted that he falsely claimed total disability in order to steal workers' compensation insurance money. An investigation revealed that Fittinger was allegedly dancing at a night club, training as a firefighter, working on a boat, and engaging in other conduct inconsistent with his claim of total disability. In total, Fittinger received approximately $14,882 in workers' compensation benefits from his employer.

State v. John Manto

The court admitted John Manto into the PTI Program on June 21, 2005, conditioned upon paying $20,366 in restitution and a $5,000 civil insurance fraud fine. Manto was

charged with theft by deception. Between August 22, 2002 and June 5, 2003, Manto allegedly collected temporary workers' compensation benefits by misrepresenting he was unable to return to work. Manto had been employed at a car repair business located in Manasquan. He allegedly claimed that he was injured while working and began to collect temporary workers' compensation benefits. He collected approximately $20,066 in temporary workers' compensation benefits from the workers' compensation carrier, New Jersey Manufacturers Insurance Company.

New Jersey Manufacturers terminated Manto's temporary workers' compensation benefits and referred the case to OIFP for investigation and prosecution. OIFP's investigation revealed that during the period of time Manto claimed to be injured and not working, he was allegedly working for a construction business owned by his brother.

State v. Michael Scherb

The court sentenced Michael Scherb on September 9, 2005, to three years probation, ordered him to pay $11,760 in restitution to Guard Insurance Group and a $3,000 civil insurance fraud fine. Scherb pled guilty to an accusation charging him with theft by deception and falsifying records. Scherb admitted that between April 18, 2003 and January 27, 2004, he committed theft of workers' compensation benefits. Scherb admitted that he advised the Guard Insurance Group, which provided workers' compensation insurance, that he was injured and unable to work. As a result, he collected approximately $11,760 in workers' compensation insurance benefits. Scherb also admitted that during the relevant time, he was able to work and was employed by a tree trimming service. The Guard Insurance Group became suspicious of the claim and referred the matter to OIFP for investigation.

State v. Richard Serbin

The court admitted Richard Serbin into the PTI Program on December 16, 2005, conditioned upon his paying $170,744 in restitution and a $50,000 civil insurance fraud fine. Serbin pled guilty to an accusation charging him with falsifying records. Serbin was licensed as both a pharmacist and an attorney-at-law in New Jersey. Serbin admitted that a claim statement he submitted in support of a disability claim to Reassure America Life Insurance Company contained a false statement. He admitted the claim statement falsely reported to Reassure America Life Insurance that he was not performing gainful work for a business entity. As a result of his plea, Serbin will repay Reassure America Life Insurance the $170,774 he received in disability payments.

State v. Lisa Kuhn

The court admitted Lisa Kuhn to the PTI Program on December 5, 2005. Kuhn admitted that she collected disability after becoming pregnant. She also admitted that when her temporary disability insurance claim expired, she submitted fraudulent disability claim forms to the Department of Labor on four occasions to extend her legitimate disability claim. The forms were fraudulent because she forged the name of her attending physician.

State v. Michelle Cannin

A State Grand Jury returned an indictment on December 14, 2005, charging Michelle Cannin with Insurance Fraud, theft by deception, forgery, and unsworn falsification. According to the indictment, Cannin submitted fraudulent insurance disability claim forms to the New Jersey Department of Labor. The State alleges those forms indicated a physician certified that Cannin was unable to work, was disabled, and therefore entitled to collect disability insurance payments. The State further alleges that Cannin forged records in the name of the physician to support her disability claim. In total, it is alleged that Cannin committed Insurance Fraud by stealing approximately $3,000 in disability claim benefits.

Health Insurance Underwriting/ Application Fraud

State v. and Marisol Perez

A State Grand Jury returned an indictment on June 6, 2005, charging and Marisol Perez with theft by deception and falsifying records. According to the indictment, was employed by the Camden County Department of Health in March 1990. During this time he allegedly falsified a "group enrollment application" listing "Marisol " as his wife. As a dependant wife, "Marisol " would have been entitled to health care benefits because of employment with Camden County.

Additionally, the State alleged that the fraud continued when was appointed as a Camden County Probation Officer. The State alleged that identified Marisol Perez as his wife when he enrolled her in family coverage as part of the State Prescription Drug Plan. The fraud against the state and county health and prescription benefits plans allegedly continued until approximately July 1, 2000, when deleted Perez from all insurance coverage on the grounds that they had separated. Later, in September 2001, allegedly indicated that he was widowed.

The State alleges that and Marisol Perez were never legally married, and as a result, Marisol Perez was not entitled to any insurance coverage as the wife of During the time allegedly represented that Marisol Perez was his wife, the State Health Benefits Plan was administered variously by Blue Cross Blue Shield of New Jersey, Aetna USHealthcare, Protective Dental Care (OraCare), and the New Jersey Division of Pensions and Benefits. The companies paid approximately $41,899 for health care and prescription coverage as the result of alleged representation that Marisol Perez was his wife.

and Perez's trials are scheduled for early 2006.

State v. Bernard Gelman

Bernard Gelman pled guilty on December 16, 2005, to an accusation charging him with theft by deception. Gelman admitted that he caused the Director of Risk and Insurance Management of an administrative services provider to change the date that his son left employment with the company. At the time of the fraud, Bernard Gelman was a senior executive with the corporation. Bernard Gelman allegedly intentionally instructed the company's employees to alter the date of his son's resignation from the company so that he could obtain disability insurance coverage under a new policy that went into effect after his departure. Approximately $80,087 was obtained from Prudential Insurance Company as the result of Bernard Gelman's fraud. He is scheduled to be sentenced in 2006.

Life Insurance Fraud

State v. Michelle Kush

The court sentenced Michelle Kush on June 24, 2005, to two years probation conditioned upon paying $5,184 in restitution. Kush pled guilty to an accusation charging her with theft by deception. 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 until the time of her death. Kush admitted that

pursuant to a Power of Attorney, she allegedly endorsed and cashed the checks from CIGNA Insurance Company payable to her deceased mother. The checks totaled $7,921.

State v. Regina Woods

The court sentenced Regina Woods on June 10, 2005, to nine months in county jail to run concurrent with a nine-month jail sentence she was serving for other unrelated charges. Woods pled guilty to an accusation charging her with forgery. Woods admitted that she sent a forged and phony City of Plainfield marriage certificate to Life Investors Insurance Company reflecting that she had been married to an individual who is now deceased. She told the court that she did so in order to obtain the benefits of a hospital income insurance policy that provided certain benefits to a surviving spouse. Woods and the decedent were never legally married. Life Investors Insurance Company of America learned of the phony marriage certificate and referred the case to OIFP for investigation and prosecution.

State v. Julieta Mangulabnan

The court admitted Julieta Mangulabnan into the PTI Program on October 5, 2005. The State charged Mangulabnan by way of an accusation with attempted theft by deception. According to the accusation, Mangulabnan allegedly forged a fraudulent affidavit and medical certificate to Fidelity Security Life Insurance Company in order to collect insurance benefits for the death of her husband. The Mangulabnans' homeowners insurance policy issued by Fidelity contained benefits for accidental death. Her husband died of natural causes. Julieta allegedly submitted false documentation to Fidelity in support of her claim that he died of injuries suffered in a fall. Fidelity denied the claim and referred the matter to OIFP for investigation.

Phony "Slip and Fall" Claims

State v. Robert P. Scott

The court sentenced Robert P. Scott on July 22, 2005, to three years probation and ordered him to pay $10,056 in restitution. Scott pled guilty to an accusation charging him with perjury and falsifying records. Scott admitted that he filed a false "slip and fall" law suit against the Asbury Park Press. In the lawsuit, Scott asserted that he allegedly slipped and fell as he attempted to retrieve a copy of the Asbury Park Press from his front porch. He claimed the Asbury Park Press newspaper delivery person "negligently" placed the newspaper on his front porch. In depositions and interrogatories submitted by Scott as part of his lawsuit, he allegedly falsely represented that he was injured picking up the newspaper.

Although the Honorable Ronald Lee Reisner, J.S.C., of Monmouth County dismissed the lawsuit, the Asbury Park Press spent in excess of $10,000 defending Scott's fraudulent claim.

Miscellaneous Medical-Related Fraud

State v. Julianne O'Brien

The court sentenced Julianne O'Brien on April 1, 2005, to 18 months probation and ordered her to pay $369 in restitution. O'Brien pled guilty to an accusation charging her with obtaining controlled dangerous substances. O'Brien admitted that while working for a dentist, she stole a pad of prescription blanks to write prescriptions for Vicodin and Vicoprofen. O'Brien admitted that she obtained the controlled dangerous prescription drugs Vicodin or Vicoprofen by filling the forged prescriptions at pharmacies located in Barnegat. O'Brien's health insurance company, Horizon Blue Cross Blue Shield, paid approximately $368 for the drugs O'Brien obtained from the pharmacies using the forged prescriptions.

State v. Gerald McGuigan

OIFP investigators arrested Gerald McGuigan on July 19, 2005, and charged him with Health Care Claims Fraud, theft by deception, obtaining controlled dangerous substances by fraud, and forgery. The State alleges that McGuigan obtained fraudulent prescriptions for Oxycontin, a controlled dangerous substance used primarily for treating chronic pain. The prescriptions were allegedly filled at a local pharmacy and issued to him in the name of his brother. Insurance claims were then sent to his brother's prescription plan, Caremark, Inc., for payment. The investigation is continuing into more than $11,000 alleged fraudulent prescription claims submitted to insurance carriers.

PROPERTY AND CASUALTY FRAUD

False Homeowners Insurance Claims

State v. Crystal Sims

The court admitted Crystal Sims into the PTI Program on March 28, 2005, conditioned upon her performing 75 hours of community service. Sims pled guilty to Insurance Fraud and admitted that she submitted a false property damage claim to Germantown Insurance Company/The Philadelphia Contributionship Insurance Company for a damaged skylight. Sims had already been reimbursed by the insurance company for the damage.

State v. Richard Farber

On November 17, 2005, Richard Farber pled guilty to an accusation charging him with theft by deception. Farber admitted that between October 23, 2003 and November 5, 2003, he submitted a false homeowners insurance claim to Philadelphia Contributionship Insurance Company alleging that a burglar stole his plasma television, digital camera, camcorder, notebook computer, and scanner. Farber supported his claim with receipts showing purchases of the items, but Farber returned the items to the store for a refund. He is scheduled to be sentenced in early 2006.

State v. Linda Hayes

The court sentenced Linda Hayes on March 18, 2005, to three years probation and ordered her to pay a $5,000 civil insurance fraud fine. Hayes pled guilty to falsifying records. Hayes admitted that she falsified certain receipts to support a homeowners insurance claim she submitted to USAA Casualty Insurance Company. Hayes allegedly submitted receipts to USAA Insurance Company claiming that certain property was stolen in a burglary. Hayes admitted that she inflated some receipts, and in other cases, the receipts were entirely fictitious.

Additionally, Hayes allegedly submitted a fraudulent Evesham Township Police Department Statement of Loss to USAA Insurance Company, as well as a burglary report or theft itemized statement of loss. USAA, suspecting fraud, questioned Hayes and referred the matter to OIFP for additional investigation and prosecution.

State v. David Feiner

The court admitted David Feiner into the PTI Program on June 22, 2005, conditioned upon his paying a $2,500 civil insurance fraud fine. Feiner was forced to find alternate housing following a flood in his home. He stayed at a hotel and his bills were paid by High Point Insurance Company. Feiner allegedly submitted a phony $438 hotel receipt for a night he never stayed in the hotel.

State v. Michael Oteri

A Camden County Grand Jury returned an indictment on September 26, 2005, charging Michael Oteri with forgery by uttering. According to the indictment, Oteri allegedly pro-

vided a phony sales receipt to support his claim that certain items were stolen from his home, including fishing rods and other property related to boating. The indictment further alleges that the receipts he submitted were phony.

State v. Rita Farmer

Rita Farmer pled guilty on November 29, 2005, to an accusation charging her with forgery. Farmer admitted that she submitted phony receipts to Hanover Insurance Company to support her homeowners insurance claim of water damage to her home. She is scheduled to be sentenced in 2006.

State v. JoAnn Gallagher

JoAnn Gallagher pled guilty on December 13, 2005, to an accusation charging her with attempted theft by deception. Gallagher admitted that she falsified a homeowners insurance claim with Allstate Insurance Company by claiming that water damage in her basement was caused by a broken washing machine hose. The damage was actually caused by heavy rain and poor drainage which was not covered under her homeowners policy. She will be sentenced in 2006.

Fraudulent Stolen/Damaged Property Claims

State v. Jack DiCristofalo

The court admitted Jack DiCristofalo into the PTI Program on February 16, 2005. The State charged DiCristofalo with attempted theft by deception. DiCristofalo owned a security monitoring company known as IDS Security. DiCristofalo admitted that he submitted inflated and false invoices to Merchants Insurance Group for an insurance claim for repairs to his company's computers, which had purportedly been damaged by lightning.

State v. David Guyton

A State Grand Jury returned an indictment on July 20, 2005, charging David Guyton with attempted theft by deception. According to the indictment, between October 13, 1999 and August 15, 2001, Guyton allegedly falsified receipts in order to inflate a property insurance claim. Guyton allegedly submitted the approximate $7,004 claim to the New Jersey Insurance Underwriting Association for the loss of four gas ranges and four refrigerators that resulted from a fire at an apartment building located at 22 Goodwin Avenue in Newark. The State alleges Guyton falsified a number of records in support of the claim.

State v. James Eifler

James Eifler pled guilty on October 31, 2005, to Insurance Fraud and forgery. A State Grand Jury returned an indictment charging Eifler with Insurance Fraud, attempted theft by deception, and forgery. According to the indictment, in November 2003, Eifler allegedly submitted a claim for approximately $6,017 to State Farm Insurance Company. Eifler alleged that someone stole certain plumbing tools from a shed on his property. State Farm settled Eifler's claim for approximately $3,830. In February 2004, Eifler allegedly submitted additional claim information to State Farm Insurance Company seeking an additional $6,000. In support of the second claim, Eifler allegedly submitted false receipts reflecting the purchase of some of the plumbing tools he sought reimbursement for from State Farm Insurance Company. He is scheduled to be sentenced in early 2006.

State v. Al Bernat and Lindsey Bernat

The court admitted Al Bernat and Lindsey Bernat into the PTI Program on April 25, 2005, conditioned upon their paying $3,489 in restitution and each performing 25 hours of community service. A Burlington County Grand Jury returned an indictment charging Al Bernat and his wife, Lindsey Bernat, with theft by deception. According to the indictment, the couple allegedly submitted a burglary insurance claim to an insurance company indicating the theft of automobile repair equipment including a scanner and a KV module that is used to diagnose engine trouble. The State alleged that the equipment was not stolen, but was concealed by Bernat. Bernat owned and operated A & F Auto Repair. The Ohio Casualty Insurance Company paid $12,516 for the Bernats' burglary claim. A portion of the claim money covered loss of the scanner and the KV module.

State v. Samuel Siligato

State v. Gary Dixon

State v. Francisco Diaz

State v. Michael Howell

A State Grand Jury charged Samuel Siligato 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. 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 Siligato also submitted a $206,900 claim to Farmers Mutual Insurance Company for the contents of the building.

OIFP investigators arrested Gary Dixon on May 25, 2005, and charged him with perjury. Prior to the date Siligato's trial was originally scheduled to begin, Siligato offered Dixon's testimony in his defense. An OIFP investigation determined that Siligato allegedly threatened Dixon and his family to offer perjured testimony to exculpate him with respect to the building and contents insurance claims.

Siligato also offered the testimony of Francisco Diaz. OIFP investigators arrested Diaz on June 9, 2005, and he was also charged with perjury. The State alleged that Siligato coerced Diaz for perjured testimony.

As part of the continuing investigation and prosecution of Siligato, an arrest warrant for terroristic threats was issued on July 21, 2005, for Michael Howell. The State alleges that Howell threatened the son of a cooperating witness who is expected to testify at Siligato's trial.

A State Grand Jury returned an additional indictment on August 29, 2005, charging Siligato with witness tampering.

State v. Dave Bhavesh

The court admitted Dave Bhavesh into the PTI Program on July 25, 2005, conditioned upon his performing 50 hours of community service. Bhavesh pled guilty to an accusation charging him with attempted theft by deception. Bhavesh, the owner and operator of The Gift Shop, allegedly submitted a property damage insurance claim to Selective Insurance Company when inventory at his shop sustained water damage from a broken pipe. Bhavesh admitted that he submitted altered and fraudulent receipts to Selective to support his $17,000 property damage claim. Selective, suspecting fraud, denied the claim and referred the matter to OIFP for investigation.

State v. Leona Darby

The court admitted Leona Darby into the PTI Program on December 1, 2005, conditioned upon paying a $3,500 civil insurance fraud fine. The State filed an accusation charging her with Insurance Fraud. Darby allegedly submitted a phony claim to Allstate Insurance Company for the loss of her engagement ring. An OIFP investigation revealed that Darby had previously submitted a claim and was paid $4,250 by New Jersey Manufacturers Insurance Company for the loss of the same engagement ring.

State v. Spiros Martini

A State Grand Jury returned an indictment on October 19, 2005, charging Spiros Martini with attempted theft by deception and forgery. According to the indictment, between September 11, 2002 and April 30, 2003, Martini allegedly falsified certain documents in connection with a commercial business fire loss insurance claim in order to inflate the claim submitted to Franklin Mutual Insurance Company.

Martini owned commercial property containing a computer business and a rubber business in South Amboy. After property was damaged by fire, and during the course of adjusting a commercial fire damage claim, the State alleges that Martini falsified an amendment to a lease indicating that he was due to be reimbursed property taxes from tenants at the commercial site. The State also alleges that Martini falsified these documents in order to wrongfully inflate the total amount of the insurance claim sought from Franklin Mutual Insurance Company.

State v. Soena Sahni

Soena Sahni pled guilty on December 12, 2005, to an accusation charging her with Insurance Fraud. Sahni admitted that between March 13, 2004 and August 31, 2004, she submitted altered and fraudulent receipts to The Hartford Insurance Company to support her claim that rented computer equipment was stolen from her place of business during a burglary. She is scheduled to be sentenced in 2006.

Phony Certificates of Insurance

State v. Robert Huber

Robert Huber pled guilty to forgery, and on March 4, 2005, the court sentenced him to two years probation. A Hunterdon County Grand Jury returned an indictment charging Huber with forgery. According to the indictment, on or about July 28, 2003, Huber allegedly committed forgery by providing 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. The State alleged that Huber forged a Certificate of Insurance that allegedly indicated insurance was provided to Huber by Selective Insurance Company.

State v. Matthew Hamilton

The court sentenced Matthew Hamilton on April 25, 2005, to one year probation following his guilty plea to forgery on the same day. A Burlington County Grand Jury returned an indictment charging him with forgery. According to the indictment, Hamilton operated a business known as TreeFellers, Inc. He allegedly presented a phony Penn Mutual/Harleysville Insurance Company insurance endorsement declaration page to a customer on whose property he was removing a tree.

State v. Scott Rosanio

The court admitted Scott Rosanio into the PTI Program on May 9, 2005, conditioned upon his performing 50 hours of community service. Rosanio was terminated from the program on November 14, 2005. He pled guilty on the same day to forgery and will be sentenced in early 2006.

An Ocean County Grand Jury returned an indictment charging Rosanio with forgery. According to the indictment, Rosanio was a home repair contractor doing business as Creative Construction. He allegedly forged a Certificate of Liability Insurance. The Certificate of Insurance purported that Mercer Mutual Insurance Company insured Rosanio's contracting business for liability. OIFP's investigation revealed that Rosanio forged the Certificate of Insurance.

State v. Wayne Kellum

The court admitted Wayne Kellum into the PTI Program on February 7, 2005, following his guilty plea to forgery. A State Grand Jury returned an indictment charging Kellum with forgery. According to the indictment, Kellum owned and operated WK Trucking, a subcontractor. Kellum allegedly presented a fraudulent Certificate of Insurance to a general contractor. 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.

State v. Nicholas Barbella

Nicholas Barbella pled guilty to forgery, and on May 6, 2005, the court sentenced him to two years probation conditioned upon his paying a $5,000 criminal fine and performing 75 hours of community service. An Essex County Grand Jury returned an indictment charging 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 and mortgage holder of an apartment building located in West Orange.

State v. William Scanlan

The court admitted William Scanlan into the PTI Program on September 22, 2005. A State Grand Jury returned an indictment charging Scanlan with forgery. The State alleged that William Scanlan, a contractor doing business as William C. Scanlan, Jr., and Son, issued a phony Zurich Insurance Company Certificate of Liability Insurance. The State alleged that Scanlan issued the phony Certificate of Insurance to a construction company to become a subcontractor for the company. The State also alleged that the phony Certificate of Insurance represented that William C. Scanlan, Jr., and Son were insured by Zurich Insurance Company for auto and general liability, but not for workers' compensation and excess liability.

State v. Todd Cifrodelli

The court admitted Todd Cifrodelli into the PTI Program on September 7, 2005, conditioned upon his performing 60 hours of community service. An accusation was filed charging Cifrodelli, who operated Chief Contracting, with forgery. Cifrodelli allegedly submitted a phony Travelers Insurance Company Certificate of Insurance to a construction company for subcontracting work.

State v. William Van't Veer

A Somerset County Grand Jury returned an indictment on May 19, 2005, charging William Van't Veer with forgery. Van't Veer, a construction contractor, allegedly submitted a phony Ohio Casualty Insurance Company Certificate of Insurance to obtain work at a bank. Van't Veer failed to appear at his arraignment on August 5, 2005. The court issued a bench warrant for his arrest.

State v. Rueben Stewart

Ruben Stewart pled guilty on March 31, 2005, to forgery. An Atlantic County Grand Jury returned an indictment charging Stewart with forgery. According to the indictment, Stewart allegedly issued an altered Certificate of Insurance to an environmental management company in New York. An insurance agency in 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 the insurance agency. The court issued a bench warrant for Stewart's arrest on May 13, 2005, when he failed to appear for sentencing.

State v. Anthony J. Phillips, Jr.

A State Grand Jury returned an indictment on October 19, 2005, charging Anthony J. Phillips, Jr., with forgery. According to the indictment, Phillips, a contractor and the owner of ACP General Contracting, had contracted to do work for a maintenance services company. The State alleged that Phillips submitted a phony Barclay Group Certificate of Liability Insurance to the company. The court issued a bench warrant for Phillips' arrest after he failed to appear for his arraignment on December 5, 2005.

State v. Thomas Schnepp

The court admitted Thomas Schnepp into the PTI Program on September 15, 2005. An accusation was filed charging Schnepp with forgery. The State alleged that Schnepp issued a phony Certificate of Liability Insurance on behalf of Lincoln General Insurance Company to a company.

State v. Dariusz (Darek) Krzak

The court admitted Dariusz Krzak into the PTI Program on December 6, 2005, conditioned upon his performing 50 hours of community service. A Mercer County Grand Jury returned an indictment charging Krzak with forgery. According to the indictment, Krzak, while doing subcontracting work for a roofing contractor, allegedly presented a phony Selective Insurance Company Certificate of Workers' Compensation Insurance to the company.

State v. Art Gallagher

Art Gallagher pled guilty to an accusation on October 7, 2005, charging him with forgery. Gallagher allegedly provided a phony Atlantic Insurance Services Certificate of Insurance to a contractor for whom he was doing sub-contracting work. Gallagher is the owner and operator of Tower Building Contractors. He is scheduled to be sentenced in 2006.

State v. Michael Fernandez

Michael Fernandez pled guilty on December 12, 2005, to an accusation charging him with forgery. Fernandez, the owner/operator of Michael's Carpentry & Construction, admitted that he provided a phony York-Jersey Underwriters, Inc., Certificate of Insurance to a person at whose home Fernandez was contracted to do work. Fernandez is scheduled to be sentenced in 2006.

State v. Robert Belisonzi

An accusation was filed on December 7, 2005, charging Robert Belisonzi with forgery. Belisonzi, owner of a catering business known as the Mason Jar, admitted that he provided a phony Eastern Insurors, LLC, Certificate of Insurance to a business for which he was contracted to provide catering services. Belisonzi is scheduled to be sentenced in 2006.

State v. Philip Boccadoro

The court admitted Philip Boccadoro into the PTI Program on December 19, 2005, conditioned upon his performing 50 hours of community service. Boccadoro pled guilty on the same day to an accusation charging him with forgery. Boccadoro, the owner of PMB Asphalt Construction, Inc., allegedly provided a phony Hartford Certificate of Insurance on two occasions to businesses for which Boccadoro contracted to do paving work.

State v. Joseph Fleres

A Bergen County Grand Jury returned an indictment on December 7, 2005, charging Joseph Fleres with forgery. According to the indictment, Fleres, the owner of Fleres Construction, allegedly provided a forged Scottsdale Insurance Co. Certificate of Insurance to a business for which Fleres was contracted to do construction work.

INSURANCE PROFESSIONAL FRAUD

Insurance Carrier Employee Fraud

State v. Linda Clements-Wright

The court sentenced Linda Clements-Wright on March 4, 2005, to seven years in state prison, and ordered her to pay a $40,000 criminal fine and restitution in the amount of $74,999.

Following a three-week trial, a jury convicted Clements-Wright of conspiracy, theft by unlawful taking, and money laundering. A State Grand Jury charged Clements-Wright, an Allstate Insurance Company Insurance Claims Process Specialist, with conspiracy, theft by unlawful taking, and money laundering. Clements-Wright worked out of Mount Laurel and Moorestown. According to the indictment, Clements-Wright issued approximately 150 Allstate insurance claim checks totaling approximately $614,344 to 11 persons with whom she was acquainted, but who were not entitled to the insurance claim money. It was alleged that Clements-Wright conspired with her acquaintances to cash the checks, keep 10 percent of the proceeds, and return the balance of the proceeds to her.

State v. Lola Ruth Byrd

The court sentenced Lola Ruth Byrd on September 2, 2005, to three years probation conditioned upon her serving 220 days in county jail. The court also ordered her to pay $2,500 restitution and to sign a $19,374 Consent Judgment. Byrd pled guilty to theft by deception.

A State Grand Jury returned an indictment charging 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 another individual. The State alleged that Byrd used closed insurance claims files and generated insurance claims checks as if the individual had sustained property losses and was entitled to insurance claim money. The individual 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 Byrd allegedly attempted to cash the fraudulent claims checks. It then conducted an internal investigation, contacted OIFP, and fully cooperated with the criminal investigation.

State v. Umberto Mazzone

The court admitted Umberto Mazzone into the PTI Program on May 13, 2005, conditioned upon his paying $7,252 in restitution to Preserver Group. Mazzone pled guilty to an accusation charging him with theft by deception. Mazzone, a claims adjuster for Preserver Group, Inc., admitted that he stole two Preserver Group insurance claims checks totaling $7,252, by wrongfully endorsing them and depositing them into his personal bank account. The checks were made payable to two legitimate Preserver Group insurance claimants.

State v. Bruce Baez and Eddie Perez

Bruce Baez pled guilty to theft by deception. Baez failed to appear at his sentencing, and on August 14, 2005, he was arrested on a bench warrant. The court sentenced him on September 16, 2005, to four years state prison and ordered him to pay $435 in restitution. Eddie Perez pled guilty to conspiracy to commit theft by deception. The court sentenced him on June 17, 2005, to two years probation and ordered him to pay $870 in restitution.

A State Grand Jury returned an indictment charging Baez and 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 an individual who died in March 2000. The decedent had been receiving insurance disability checks pursuant to a workers' compensation insurance policy from New Jersey Manufacturers Insurance Company. New Jersey Manufacturers, unaware that the individual had died, continued to send checks to his Millville home. The State alleged the defendants forged and cashed the disability checks.

State v. Sharonda Ross, Ivery Ross, and Michelle Patterson

A State Grand Jury returned an indictment charging Sharonda Ross, her husband Ivery Ross, and Ross's sister-in-law, Michelle Patterson, with conspiracy and theft by deception. Ivery Ross was also charged with theft of identity. According to the indictment, between October 8, 2002 and April 16, 2003, Sharonda Ross, who was employed as a Treasury Operations Associate for Prudential Insurance Company, allegedly conspired with Ivery Ross and Michelle Patterson to steal nearly $50,000 from Prudential. The State alleged that Sharonda Ross diverted insurance company checks to Ivery Ross and Michelle Patterson by using the identification codes of other Prudential employees to issue the checks. The State alleged that the conspiracy netted the defendants approximately $49,889, and a total of approximately 18 checks were wrongfully diverted in this manner.

Sharonda Ross pled guilty to theft by deception, and the court admitted her into the PTI Program on October 17, 2005, conditioned upon her paying $22,259 in restitution to Prudential Insurance Company. Ivery Ross also pled guilty to theft by deception and theft of identity. The court sentenced him on December 2, 2005, to three years probation and ordered him to pay $22,258 in restitution to Prudential Insurance Company. Patterson failed to appear at her arraignment on July 27, 2005. The court issued a bench warrant for her arrest.

State v. Lisa Brown

A Union County Grand Jury returned an indictment on November 2, 2005, charging Lisa Brown with theft by deception. According to the indictment, between November 12, 2001 and February 20, 2002, Brown, who was employed as a claims service representative by Fleet Insurance Services in Cranford, allegedly stole insurance premium money from three insurance customers with the promise that she could obtain auto insurance at a much lower rate. The State further alleges that Brown accepted approximately $3,600 in insurance premium money and issued fraudulent Chubb Insurance Company and First Trenton Indemnity Company documents, including policy binders. The State also alleges that Brown stole the premium money and left the insurance customers without valid automobile insurance. Brown was allegedly neither licensed nor authorized to sell insurance or accept premiums as a licensed insurance agent.

Persons Licensed by Department of Banking and Insurance: Insurance Agents, Real Estate Agents

State v. Robert Stone

The court sentenced Robert Stone on February 10, 2005, to two years probation with the condition that he pay $21,702 in restitution and perform 80 hours of community service. Stone pled guilty to a State Grand Jury indictment charging him with failure to make required disposition of property received. Stone, a licensed insurance agent, was the owner/operator of Stone Insurance Company. According to the indictment, Stone allegedly stole approximately $22,585. The State alleged that Stone obtained premium money from insurance customers or from the Standard Funding Corporation (SFC), a company that was in the business of lending insurance premium money to persons who needed to borrow money to buy insurance policies. The State further alleged that Stone stole the money and used it for his own benefit.

State v. Erica Nanne

The court admitted Erica Nanne into the PTI Program on April 22, 2005, conditioned upon her paying $4,863 in restitution and performing 50 hours of community service. A Somerset County Grand Jury charged Nanne with theft by failure to make required disposition. According to the indictment, Nanne allegedly stole approximately $4,863 in insurance premiums from insurance customers who had given her the money to purchase insurance. The State alleges that Nanne used the money for her personal benefit. The Mondaro Agency in Hillsborough employed Nanne as a licensed insurance agent.

State v. Vito Gruppuso

The court sentenced Vito Gruppuso on September 23, 2005, to ten years state prison, ordered him to pay a $225,000 criminal fine, and ordered him to pay the following in restitution: $3,746,524 to Wasaw Insurance; $6,320,056 to AIG Insurance Company; $15.8 million to Virginia Surety; $4.9 million to XL Insurance Company; and $48,069,678 to Kemper Insurance Company. The court also permanently revoked Gruppuso's insurance agent's license.

Gruppuso pled guilty to an accusation charging 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 that he embezzled insurance premiums entrusted to him by insureds.

State v. Melvin Smith

An Essex County Grand Jury returned an indictment on July 27, 2005, charging Melvin Smith with theft by failure to make required disposition. According to the indictment, Smith, a licensed insurance agent, allegedly failed to remit a $2,759 insurance premium check payable to North American Company for Life and Health Insurance on behalf of an insurance purchaser. The State also alleges that Smith deposited the check into his own personal bank account. Smith failed to appear at his pre-arraignment on August 22, 2005, and the court issued a bench warrant for his arrest.

State v. Joseph Birnie and Michael Delisi

Joseph Birnie pled guilty to theft by failure to make required disposition of property received. The court sentenced him on December 16, 2005, to three years probation, conditioned upon his serving 270 days in county jail, and ordered him to pay $145,870 in restitution. Michael Delisi also pled guilty to theft by failure to make required disposition of property received. The court sentenced him on December 16, 2005, to one year probation and ordered him to pay $10,000 in restitution, and to surrender his public adjuster's license.

A State Grand Jury returned an indictment charging Birnie and 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 insureds and used the money for their own purposes.

State v. Rodger Strandskov

On October 7, 2005, Rodger Strandskov pled guilty to an accusation charging him with theft by failure to make required disposition of property received. Strandskov, who was the president of Eastern Insurance Agency which operated in Kendall Park, admitted that he committed theft in two different ways.

Strandskov admitted that he did not remit premium finance money to insurance companies to pay for insurance policies sold through his agency. The premium finance money was provided by AMGRO Premium Financing. Insurance premium financing occurs when an insurance customer, in this case commercial trucking companies, borrow money from a lender to purchase the required commercial trucking insurance. Strandskov admitted that, in some cases, he stole borrowed insurance premium financing money and used it for his own purposes. Additionally, Strandskov admitted that he did not return borrowed insurance premium financing money for certain insurance policies that terminated earlier than the anticipated end date of the insurance coverage for approximately 14 insurance customers. Strandskov admitted that he stole approximately $474,289 from or due to AMGRO Premium Financing.

Strandskov is scheduled to be sentenced in early 2006.

State v. Michael Chamberlain

Michael Chamberlain pled guilty on December 5, 2005, to theft by unlawful taking. He is scheduled to be sentenced in 2006.

A State Grand Jury returned an indictment charging 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, Florida's Marion County Sheriff's Department assisted in the arrest of Michael Chamberlain. OIFP extradited Chamberlain from Florida to New Jersey in 2004.

MISCELLANEOUS INSURANCE FRAUD

Insurance-Related Tax Cases

State v. Richard Nardone and Donna M. Januik

The court sentenced Richard Nardone on June 17, 2005, to 30 months probation and ordered him to pay restitution in an amount to be determined by the court. Nardone pled guilty 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. The court sentenced Donna M. Januik on the same date to 30 months probation. 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 18-count indictment charging Richard Nardone and his sister, Donna M. Januik. Nardone, a New Jersey licensed chiropractor, was charged with conspiracy, filing false and fraudulent New Jersey Income Tax returns, filing false and fraudulent New Jersey Corporate Tax returns, failure to pay New Jersey Gross Income Tax with intent to evade, and misconduct by a corporate official. Januik was charged 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.

According to the State Grand Jury indictment, between January 1, 1998 and May 31, 1999, Nardone and Januik, in order to avoid paying New Jersey corporate business and income taxes, 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. The State alleged that Nardone and Januik created three fictitious employees. Nardone and Januik allegedly issued at least 144 corporate checks exceeding $400,000 to the fictitious employees. According to the indictment, 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. Additionally, the State alleged that Nardone and Januik utilized corporate accounts to pay for more than $180,000 in personal expenses without reporting the funds as income.

The investigation identified the location of Nardone's chiropractic office as 150 Main St., Orange, Essex County. Nardone's related businesses are identified as: Professional Medical Technologies, Inc. (PMT), located in Mountainside, Union County; Camino Rehabilitation, Inc., located in Springfield, Union County; Hermosa Medical Services, Inc., located in Mountainside; Advanced Diagnostic, Inc., located in Roselle Park, Union County; and Medical Diagnostic, Inc., located in Mountainside. The State alleged that Januik also operated a billing and collection agency known as ZNS Billing.

During the course of the investigation, OIFP and Division of Taxation investigators seized financial books and records relating to the case. Shortly thereafter, the chiropractic practice and the related businesses ceased operations.

State v. Paul LoPapa

The court sentenced Paul LoPapa on November 17, 2005, to five years probation with credit for 507 days served in the county jail. Consent Judgments were entered in favor of the following: $3.35 million to FSB Mortgage of Little Rock, AR; $9,248 to Alphonse Stoia; $20,000 to David Dubrow; $35,000 to XOZ Entertainment, S.A./Tyco Capital Ltd; and $20,000 to Patrick Pereira. LoPapa pled guilty to an indictment and a separate accusation charging him with theft by deception, attempted theft by deception, falsifying records, and forgery.

LoPapa admitted that between November 1, 1995 and February 1, 1996, through his real estate partnership known as Castle Rock Real Estate, he purchased residential real estate located in Saddle River, Bergen County. A mansion and a guest house are located on the property. LoPapa allegedly funded the purchase of the real estate by representing

that a fictitious person was willing to buy the real estate from LoPapa for $4.9 million. LoPapa admitted that he created the false impression that the fictitious person gave LoPapa $1 million cash and a promissory note for $3.9 million to buy the Saddle River property. LoPapa allegedly used the fictitious person's worthless promissory note and the purported $1 million cash to induce a mortgage lender to agree to advance the funds needed to purchase the property. LoPapa also admitted that he later transferred the worthless promissory note to the mortgage lender for $3.35 million to finance and to acquire the Saddle River property. The mortgage lender in turn, sold the worthless note through the banking system to FSB Mortgage of Little Rock, AR. Immediately after the bogus transaction, LoPapa allegedly transferred the property to his company, Castle Rock Real Estate, Inc.

LoPapa also admitted that between April 17, 1996 and January 7, 1997, he falsely inflated a homeowners contents insurance claim in the amount of $33,400. LoPapa allegedly submitted the inflated claim to the Great Northern Insurance Company alleging that water from a leaky roof damaged valuable artwork located at the Saddle River home. The artwork allegedly never existed.

LoPapa also allegedly falsified a receipt for a fictitious Certificate of Deposit that was purportedly given to Castle Rock Real Estate, Inc., in order to deceive an attorney about the financial position of Castle Rock Real Estate, Inc. Similarly, LoPapa admitted that he forged two letters and two affidavits purportedly issued by an attorney in order to deceive the credit agency about LoPapa's and Castle Rock Real Estate's financial conditions.

Finally, LoPapa pled guilty to a separate accusation and admitted that between April 20, 2000 and August 2, 2000, he stole mortgage loan application fees in the total approximate amount of $85,000 from four victims. LoPapa admitted that he falsely represented he was a real estate investor and mortgage broker representing the Citadel Group of Companies in order to induce persons looking for real estate loans to pay over to him mortgage application fees. LoPapa allegedly stole mortgage application fees, and provided no mortgage loan money for all four victims.

OIFP previously filed other criminal charges in connection with this investigation. Attorney Salvatore DeLello was charged on August 10, 1999, with criminal bribery, forgery, falsifying records, and false swearing for allegedly notarizing the signature of the fictitious individual on a deed in connection with the Saddle River real estate fraud. The court sentenced him to three years probation on October 1, 1999, and it ordered him to pay $30,000 in criminal fines.

Miscellaneous OIFP Investigations

State v. E. Nkem Odinkemere

A State Grand Jury returned an indictment on August 8, 2005, charging E. Nkem Odinkemere with misapplication of entrusted property. The State alleges that on September 1, 2000 and thereafter, Odinkemere, a licensed New Jersey attorney, misapplied money received from a client in connection with a real estate transaction, and he used the money for his own benefit. His case is pending trial in 2006.

Miscellaneous Theft/Attempted Theft

State v. Mercedes Lastra

OIFP investigators arrested Mercedes Lastra on March 11, 2005, and charged her with theft by unlawful taking. Lastra was a licensed bail bond agent who was charged with theft of approximately $60,000 from her employer, a bail bond company. The owner of the company reported to the Elizabeth Police Department that Lastra allegedly stole bail bonds from a company safe and posted the bail bonds on behalf of various persons who were charged with criminal offenses. In return for posting the bail bonds for the persons charged with criminal offenses, Lastra allegedly received money, and instead of turning the money over to the bail bond company, she kept the money for her own purposes. The State alleges that between September 24, 2004 and January 26, 2005, Lastra posted 15 stolen bail bonds and retained the money for the bail bonds.

OIFP is continuing the investigation into this matter.

Jay Phillips, Inc./John A. Phillips

The court sentenced John A. Phillips on December 21, 2005, in United States District Court to three years in prison followed by five years probation. It also ordered him to pay $4,278,055 in restitution.

Following an investigation by OIFP, and in coordination with the United States Attorney's Office, the United States Attorneys previously filed a Federal Information charging John A. Phillips with conduct related to wire fraud. Among other fraudulent conduct, Phillips was charged with and pled guilty to acting as a real property title agent and misappropriating approximately $98,468, which was earmarked to retire a mortgage.

State v. Monserrat Rodriguez

Monserrat Rodriguez pled guilty to an accusation on November 17, 2005, charging her with issuing bad checks. Rodriguez admitted that between April 26, 2005 and May 14, 2005, she allegedly wrote approximately 39 checks totaling $7,803. The checks were allegedly drawn on a bank account of High Point Insurance Company. Rodriguez allegedly knew the bank would not honor the checks. She is scheduled to be sentenced in 2006.

AUTO FRAUD

Automobile Claims "Give Ups"

In the Matter of Israel Rivera

Israel Rivera executed a Consent Order for $5,000 on January 12, 2005. Rivera reported his vehicle stolen to the Jersey City Police Department and his carrier, Liberty Mutual Insurance Company. However, the Philadelphia Fire Department found Rivera's 2001 Honda engulfed in flames 30 hours prior to the reported theft. Rivera pled guilty to falsely reporting his vehicle stolen. As a result of his plea, he was ordered to pay $10,400 in restitution and to serve five years probation.

In the Matter of Raiza De Los Santos

Raiza De Los Santos executed a Consent Order for $5,000 on January 24, 2005. De Los Santos supplied false and misleading information to Selective Insurance stating that a vehicle was stolen when, in fact, it was not. De Los Santos pled guilty to tampering with a public record or information.

In the Matter of Carmen Marchitello

Carmen Marchitello executed a Consent Order for $6,000 on February 23, 2005. Marchitello conspired with others to dispose of their vehicles knowing that insurance claims would be filed. Marchitello pled guilty to conspiracy.

In the Matter of Joao Faria

Joao Faria executed a Consent Order for $5,000 on February 23, 2005. Faria reported his father's car stolen when, in fact, Faria "gave up" the vehicle. Faria's father unwittingly pursued an auto theft claim with State Farm Insurance Company, without any knowledge of his son's actions. Faria pled guilty to theft by deception.

In the Matter of Cynthia Maresca

Cynthia Maresca executed a Consent Order for $5,000 on March 9, 2005. Maresca and another conspired to falsely report the theft of a vehicle. The case was referred by New Jersey Manufacturers Insurance Company.

In the Matter of Alicia Casal

Alicia Casal executed a Consent Order for $5,000 on March 9, 2005. Casal pursued an auto theft claim with One Beacon Insurance Company by falsely stating that her vehicle was stolen when, in fact, it had previously been burned and recovered.

In the Matter of Daniel Luciano

Daniel Luciano executed a Consent Order for $5,000 on March 9, 2005. Luciano pursued a claim with Liberty Mutual Insurance Company containing false and misleading information, specifically, reporting his vehicle stolen when, in fact, it had been abandoned after an accident.

In the Matter of Tulio Martins and Leslie Martins

Tulio Martins and Leslie Martins executed a Consent Order for $5,000 each on April 27, 2005. Leslie Martins provided false and misleading information to the Amica Mutual Insurance Company in pursuit of an automobile claim. Tulio Martins submitted a fraudulent automobile theft claim to Amica Mutual Insurance Company.

In the Matter of James Neal, Jr.

James Neal, Jr., executed a Consent Order for $5,000 on April 6, 2005. Neal submitted a fraudulent automobile theft claim to Allstate New Jersey Insurance Company.

In the Matter of Rene Irizarry

Rene Irizarry executed a Consent Order for $5,000 on April 6, 2005. Irizarry submitted a fraudulent automobile theft claim to State Farm Insurance Company.

In the Matter of Gregory Ciccone

Gregory Ciccone executed a Consent Order for $5,000 on April 6, 2005. Ciccone conspired with another to falsely report the theft of Ciccone's vehicle to New Jersey Manufacturers Insurance Company.

In the Matter of Gary Albanese

Gary Albanese executed a Consent Order for $5,000 on April 6, 2005. Albanese conspired with another to falsely report a vehicle stolen to the Bloomfield Police Department in pursuit of an auto theft claim.

In the Matter of James Walker

James Walker executed a Consent Order for $5,000 on April 27, 2005. Walker staged the April 12, 2003, theft of his vehicle in pursuit of a false claim with GMAC Insurance Company.

In the Matter of Marian Roberts

Marian Roberts executed a Consent Order for $5,000 on April 27, 2005. Roberts made false statements to State Farm Insurance Company regarding the theft of his vehicle.

In the Matter of Robert Hoyvald

Robert Hoyvald executed a Consent Order for $5,000 on April 27, 2005. Hoyvald made false statements about the facts surrounding the theft of his vehicle in pursuit of a claim with State Farm Insurance Company.

In the Matter of Robert Cappadona

Robert Cappadona executed a Consent Order for $5,000 on May 25, 2005. Cappadona submitted a false claim stating that his vehicle had been stolen when, in fact, he conspired with another to have the vehicle removed and dismantled.

In the Matter of Angela Estrella

Angela Estrella executed a Consent Order for $5,000 on May 25, 2005. Estrella falsely stated on an Affidavit of Theft that her vehicle was stolen. The claim was made to Clarendon Insurance Company.

In the Matter of Juan Cotto

Juan Cotto executed a Consent Order for $5,000 on May 25, 2005. Cotto pursued an auto theft claim with New Jersey CURE Insurance Company by falsely stating that his vehicle was stolen.

In the Matter of Heriberto Rodriguez

Heriberto Rodriguez executed a Consent Order for $5,000 on May 25, 2005. Rodriguez conspired with others to commit auto theft fraud by falsely reporting his vehicle stolen to Parkway Insurance Company.

In the Matter of Noel Lugo

Noel Lugo executed a Consent Order for $5,000 on May 25, 2005. Lugo conspired with others to commit auto theft fraud by reporting his vehicle stolen.

In the Matter of Dennis Brown

Dennis Brown executed a Consent Order for $5,000 on May 25, 2005. Brown, a former firefighter with the Montclair Fire Department, set fire to his 2002 Nissan Maxima and made a false vehicle theft claim to the Parkway Insurance Company. Brown pled guilty and subsequently resigned from the fire department.

In the Matter of Elliot Forti

Elliot Forti executed a Consent Order for $5,000 on June 22, 2005. Forti reported his vehicle stolen on May 30, 2004, and filed a claim with State Farm Insurance Company. The New York City Fire Department discovered the car burned one day earlier.

In the Matter of Luigi Andriano

Luigi Andriano executed a Consent Order for $5,000 on July 20, 2005. Andriano conspired with another to falsely report a vehicle

stolen to the Bloomfield Police Department in pursuit of an auto theft claim.

In the Matter of Thomas Stewart

Thomas Stewart executed a Consent Order for $5,000 on July 20, 2005. Stewart falsely reported the theft of his 2003 Nissan Altima.

In the Matter of Matilda Santana and Stephan Santana

Matilda Santana and Stephan Santana executed a Consent Order for $5,000 each on July 20, 2005. Matilda Santana filed a false claim stating her vehicle was stolen when she actually disposed of the vehicle with the help of Stephan Santana.

In the Matter of Bradley Brown

Bradley Brown executed a Consent Order for $5,000 on July 20, 2005. Brown filed a false claim with MetLife Home & Auto Insurance Company stating his vehicle was stolen when, in fact, he had disposed of it himself.

In the Matter of Debra Tower

Debra Tower executed a Consent Order for $5,000 on August 17, 2005. Tower reported her vehicle stolen to the Atlantic City Police Department and the Erie Insurance Group when, in fact, she gave the vehicle to an undercover law enforcement officer for disposal.

In the Matter of Micelle Zalta

Micelle Zalta executed a Consent Order for $5,000 on August, 17, 2005. Zalta falsely reported her vehicle stolen to State Farm Insurance Company.

In the Matter of Danny Duprey

Danny Duprey executed a Consent Order for $5,000 on October 19, 2005. Duprey submitted a fraudulent automobile insurance theft claim to American International Insurance Company.

In the Matter of Norma Villacis

Norma Villacis executed a Consent Order for $5,000 on October 19, 2005. Villacis filed a false vehicle theft report with Liberty Mutual Insurance Company.

In the Matter of Jose A. Alvarez

Jose A. Alvarez executed a Consent Order for $5,000 on October 19, 2005. Alvarez pursued a false auto theft claim with New Jersey Manufacturers Insurance Company.

In the Matter of Charles Avila

Charles Avila executed a Consent Order for $5,000 on November 16, 2005. Avila pursued an auto theft claim with Liberty Mutual Insurance Company when, in fact, he gave his vehicle to an undercover New York police officer for disposal.

In the Matter of Oscar Parra

Oscar Parra executed a Consent Order for $5,000 on November 16, 2005. Parra pursued an auto theft claim with New Jersey Manufacturers Insurance Company when, in fact, he arranged for an accomplice to dispose of the vehicle.

In the Matter of Xiemna Arcidiacono

Xiemna Arcidiacono executed a Consent Order for $5,000 on November 16, 2005. Arcidiacono filed a fraudulent automobile theft claim with State Farm Insurance Company.

In the Matter of Angelica Delapaz

Angelica Delapaz executed a Consent Order for $5,000 on November 16, 2005. Delapaz received a three-year conditional discharge by New York criminal court authorities following a Bronx New York District Attorney's Office "'give up' sting operation." The case was referred to OIFP by New Jersey Manufacturers Insurance Company.

In the Matter of Jane Kurtz

Jane Kurtz executed a Consent Order for $5,000 on December 22, 2005. Kurtz staged the theft of her vehicle in an effort to obtain an insurance settlement from Selective Insurance Company.

In the Matter of Adolfo J. Rosario

Adolfo J. Rosario executed a Consent Order for $5,000 on December 15, 2005. Rosario was involved in the "give up" of a vehicle in an effort to obtain an insurance settlement from GEICO Insurance Company.

In the Matter of Rafaelle Arcidiacono

Rafaelle Arcidiacono executed a Consent Order for $5,000 on December 15, 2005. Arcidiacono filed a fraudulent automobile theft claim with State Farm Insurance Company.

In the Matter of Elrees Broadnax

Elrees Broadnax executed a Consent Order for $5,000 on December 15, 2005. Broadnax pursued a false auto theft claim with Allstate Insurance Company.

In the Matter of Francisco Lopez

Francisco Lopez executed a $5,000 Consent Order on December 15, 2005. Lopez pursued an automobile theft claim with State Farm Insurance Company stating that his vehicle was stolen in Newark when, in fact, he had already sold it to an undercover New York police officer.

In the Matter of Jacqueline Perez

Jacqueline Perez executed a $5,000 Consent Order on December 15, 2005. Perez pursued a false auto theft claim with Selective Insurance Company when, in fact, she "gave up" her vehicle to another person.

In the Matter of Kevin Lewandowski

Kevin Lewandowski executed a Consent Order for $5,000 on September 19, 2005. Lewandowski conspired to submit a fraudulent auto theft claim with Selective Insurance Company.

In the Matter of Stephen Barr

Stephen Barr executed a Consent Order for $5,000 on September 14, 2005. Barr staged the loss of his vehicle and filed a claim with Allstate Insurance Company. Barr's vehicle had been sold as part of an FBI/Philadelphia police sting operation. Barr pled guilty in federal court to charges related to the auto "give up."

In the Matter of Daniel Engravalle

Daniel Engravalle executed a Consent Order for $5,000 on September 14, 2005. Engravalle conspired with another to report a vehicle stolen to the Atlantic City Police Department and the Erie Insurance Group when, in fact, the vehicle was "given up" to an undercover law enforcement officer for disposal.

In the Matter of Roberto Ferreira

Roberto Ferreira executed a Consent Order for $5,000 on September 14, 2005. Ferreira pursued an auto theft claim with the Preserver Insurance Company falsely claiming that his vehicle was stolen.

Staged Accidents

In the Matter of Eric Bula

Eric Bula executed a Consent Order for $5,000 on February 23, 2005. Bula falsely reported to Liberty Mutual Insurance Company that he was involved in a motor vehicle accident when, in fact, the accident was staged. Bula pled guilty to an accusation charging Health Care Claims Fraud and theft by deception.

In the Matter of Ramon Reyes

Ramon Reyes executed a Consent Order for $5,000 on May 25, 2005. Reyes conspired

in the filing of false health care service claims for a staged accident.

In the Matter of Dignorah A. Flores

Dignorah A. Flores executed a Consent Order for $5,000 on June 22, 2005. Flores filed false health care service claims for personal injuries arising from a staged accident.

In the Matter of Neil M. Arruda

Neil M. Arruda executed a Consent Order for $60,000 on October 19, 2005. Arruda filed a false automobile theft claim and false health care service claims with Rider Insurance Company for personal injuries arising from thefts and accidents which he knew were staged for the purpose of collecting insurance money.

In the Matter of Anatilde Casiano

Anatilde Casiano executed a Consent Order for $5,000 on August 17, 2005. Casiano pursued a fraudulent injury claim with Ace USA Insurance by falsely stating that she fell while attempting to get onto a bus.

In the Matter of Raudi Arias

Raudi Arias executed a Consent Order for $5,000 on August 17, 2005. Arias filed false health care service claims with Allstate and State Farm Insurance Companies for personal injuries arising from a staged accident.

In the Matter of Luis Hernandez-Uzeta

Luis Hernandez-Uzeta executed a Consent Order for $5,000 on August 17, 2005. Hernandez-Uzeta filed false health care service claims with Prudential and Allstate Insurance Companies for personal injuries arising from a staged accident.

In the Matter of Ramon Arias

Ramon Arias executed a Consent Order for $5,000 on August 17, 2005. Arias filed false health care service claims with Allstate and State Farm Insurance Companies for personal injuries arising from a staged accident.

In the Matter of Kenia Gonzalez

Kenia Gonzalez executed a Consent Order for $5,000 on August 17, 2005. Gonzalez filed false health care service claims with Prudential and Allstate Insurance Companies for personal injuries arising from a staged accident.

In the Matter of Angelita Guerrero

Angelita Guerrero executed a Consent Order for $5,000 on April 27, 2005. Guerrero conspired to file false health care service claim forms with Allstate, Kemper, and Newark Insurance Companies for a staged accident.

In the Matter of Robin A. Ellison

Robin A. Ellison executed a Consent Order for $5,000 on December 15, 2005. Ellison and co-conspirators staged an accident in Philadelphia. An off-duty Philadelphia police officer witnessed the incident. Ellison pled guilty to conspiracy and Health Care Claims Fraud.

Body Shop Fraud

In the Matter of Brick Auto Body

Brick Auto Body executed a Consent Order for $5,000 on April 6, 2005. Brick Auto Body failed to make all the repairs to an insured's vehicle as specified in its inspection report and paid for by Liberty Mutual Insurance Company. Brick was paid $6,806 for repairs but failed to perform $2,069 worth of the repairs.

False Property Claim

In the Matter of Kirti S. Shah

Kirti S. Shah executed a Consent Order for $5,000 on February 23, 2005. Shah pursued a fraudulent auto property damage claim with Prudential Insurance Company by submitting altered receipts.

In the Matter of Harry Torella

Harry Torella executed a Consent Order for $5,000 on November 16, 2005. Torella submitted claims to Prudential Insurance Company for items stolen from his vehicle and reported his vehicle stolen twice. An OIFP investigation determined that Torella did, in fact, submit claims for items which were not stolen and submitted false receipts to support the claims. He also submitted two stolen vehicle claims for the same vehicle in a three-month period.

In the Matter of Frank Catrambone

Frank Catrambone executed a Consent Order for $5,000 on June 22, 2005. Catrambone submitted altered/false receipts in pursuit of his auto property claim filed with Palisades Insurance Company.

Property Damage

In the Matter of Zia Ghahary

Zia Ghahary executed a Consent Order for $5,000 on July 7, 2005. Ghahary provided false and misleading information to the Hartford Insurance Company by stating that his vehicle was struck by an unknown driver when, in fact, his car slipped out of gear and rolled into a ditch causing damage to the vehicle.

In the Matter of Ramonde Laguerre

Ramonde Laguerre executed a Consent Order for $5,000 on August 17, 2005. Laguerre submitted altered and fraudulent receipts to Liberty Mutual Insurance Company for repairs to his vehicle.

In the Matter of Kevin O'Connor

Kevin O'Connor executed a Consent Order for $5,000 on October 19, 2005. O'Connor attempted to file a false automobile loss claim with Rutgers Casualty.

HEALTH LIFE AND DISABILITY FRAUD

False Health Care Claims

In the Matter of Jesus Sanchez and Jacqueline Diaz

Jesus Sanchez executed a Consent Order for $10,000 on January 24, 2005. Jacqueline Diaz executed a $5,000 Consent Order on March 9, 2005. Sanchez listed his girlfriend, Jacqueline Diaz, as his spouse with Blue Cross Blue Shield of New Jersey and Delta Dental Insurance Company, enabling her to receive benefits to which she was not entitled.

In the Matter of Mohamed Attalla

Mohamed Attalla executed a Consent Order for $5,000 on January 25, 2005. Attalla conspired with another defendant to file a false health care service claim for personal injuries arising from a staged accident.

In the Matter of Carol Severe

Carol Severe executed a Consent Order for $5,000 on March 9, 2005. Severe submitted 42 false health care service claims for $13,947 to Horizon Blue Cross Blue Shield of New Jersey.

In the Matter of Carol Giannantonio

Carol Giannantonio executed a Consent Order for $5,000 on July 20, 2005. Giannantonio, while pursuing an injury claim, submitted fraudulent receipts for massage therapy services that were never provided to her.

In the Matter of Henry Gari

Henry Gari executed a Consent Order for $5,000 on July 20, 2005. Gari submitted false, misleading, and fictitious reports to Liberty Mutual Insurance to exacerbate his injuries and to enhance the value of his claim.

Provider Fraud

In the Matter of Michael Stavitski

Michael Stavitski executed a Consent Order for $15,000 on March 9, 2005. Stavitski allegedly billed prescription drug plans of various carriers for prescriptions he never provided to the patients.

In the Matter of Angel Lobo and Mercy Lobo

Mercy Lobo allegedly conspired with Angel Lobo to make fraudulent and misleading statements of material fact in the submission of fraudulent health claims. Mercy Lobo also allegedly conspired to bill for services not rendered to various patients. Mercy Lobo pled guilty to Health Care Claims Fraud and on April 27, 2005, executed a $7,500 Consent Order. Angel Lobo pled guilty to Health Care Claims Fraud and on April 27, 2005, executed a $100,000 Consent Order.

In the Matter of LeClerc Adisson

LeClerc Adisson executed a Consent Order for $5,000 on May 25, 2005. Adisson allegedly submitted false and misleading information to various insurance carriers. Adisson allegedly referred patients to a medical equipment company in which he has a significant financial interest and instructed his employees to bill insurance carriers for more expensive equipment than was actually supplied to the patients. Adisson pled guilty to Health Care Claims Fraud and Criminal Use of Runners.

In the Matter of Barry Cohen

Barry Cohen executed a Consent Order for $105,000 on July 20, 2005. Cohen, a Program Administrator for Headways, Inc., was allegedly double billing and billing for services not rendered.

In the Matter of Roger Brown

Roger Brown executed a Consent Order for $66,000 on June 22, 2005. Brown allegedly billed for TMJ nightguards when, in fact, he was performing bleaching.

In the Matter of Eric Leibowitz

Eric Leibowitz executed a Consent Order for $10,550 on September 14, 2005. Leibowitz, a licensed Clinical Social Worker, allegedly submitted claims to Horizon Blue Cross Blue Shield for payments to which he was not entitled. In addition, he allegedly improperly billed utilizing incorrect CPT Codes.

In the Matter of Richard Herbert

Richard Herbert executed a Consent Order for $25,000 on September 14, 2005. Herbert allegedly submitted false and misleading information on nine claims to GSA Insurance Company, specifically billing for services which were never rendered. Herbert pled guilty to conspiracy, Health Care Claims Fraud, and attempted theft by deception.

In the Matter of Monique Hernandez

Monique Hernandez executed a Consent Order for $5,000 on September 14, 2005. Hernandez allegedly conspired with and assisted Richard Herbert in submitting claims to GSA Insurance Company for services that were never rendered.

In the Matter of Joan Abrutyn

Joan Abrutyn executed a Consent Order for $5,000 on October 19, 2005. Abrutyn allegedly submitted psychotherapy medical bills to Oxford Health Plans while she was unlicensed to perform these services.

In the Matter of Barry Vogel

Barry Vogel executed a Consent Order for $60,000 on December 15, 2005. Vogel allegedly submitted fraudulent electro-diagnostic test results to several insurance carriers between August 1995 and May 1999. Specifically, Vogel allegedly submitted the exact test results for multiple patients.

PROPERTY AND CASUALTY FRAUD

False Homeowners Claims

In the Matter of Linda G. Hayes

Linda G. Hayes executed a Consent Order for $5,000 on April 6, 2005. Hayes pled guilty to criminal charges related to a false homeowners claim.

Life Insurance Fraud

In the Matter of Aziz Chaudhry

Aziz Chaudhry executed a Consent Order for $5,000 on April 6, 2005. Chaudhry provided false and misleading information to the Equitable Life Assurance Society of the United States in connection with an application for life insurance benefits.

In the Matter of Julieta Mangulabnan

Julieta Mangulabnan executed a Consent Order for $5,000 on June 22, 2005. Mangulabnan submitted false documentation to Fidelity Security & Life Insurance Company to support a claim that her husband died from injuries following a fall. This would have made the death a "covered loss." However, her husband's death was the result of a non-covered loss.

Fraudulent Disability Claims

In the Matter of Jasmine Gomez

Jasmine Gomez executed a Consent Order for $5,000 on May 25, 2005. Gomez submitted forged attending physician forms to Trustmark Insurance Company extending her disability period. Gomez pled guilty to an accusation charging Insurance Fraud.

In the Matter of Augustus Sielwonczuk

Augustus Sielwonczuk executed a Consent Order for $5,000 on June 22, 2005. Sielwonczuk allegedly made false and misleading statements while pursuing a workers' compensation claim with Garden State Reinsurance Association. Sielwonczuk exaggerated the extent and severity of his injuries to increase the amount of benefits to which he was entitled.

In the Matter of Thomas Thrower

Thomas Thrower executed a Consent Order for $5,000 on June 22, 2005. Thrower was working and performing activities inconsistent with his disability claim filed with Zurich Insurance Company.

In the Matter of Barbara Dickens

Barbara Dickens executed a Consent Order for $5,000 on June 22, 2005. Dickens was employed and performing duties inconsistent with her disability claim filed with Life Insurance Company in North America.

In the Matter of Mohammed Funna

Mohammed Funna executed a Consent Order for $5,000 on June 22, 2005. Funna, a car salesman, was injured and began collecting workers' compensation benefits. However, while receiving benefits, Funna worked as a salesman in real estate in violation of the terms of his policy.

In the Matter of Douglas Fittinger

Douglas Fittinger executed a Consent Order for $5,000 on August 17, 2005. Fittinger performed tasks inconsistent with his injuries while collecting workers' compensation benefits from the Crum & Forster Insurance Company. Fittinger pled guilty to an accusation charging Insurance Fraud. He was sentenced to 14 days in county jail, 325 hours of community service, and ordered to pay $14,000 in restitution to the insurance company.

In the Matter of Federico de la Cruz

Federico de la Cruz executed a Consent Order for $5,000 on August 17, 2005. De la Cruz, who claimed that he was unable to work, was, in fact, working while collecting workers' compensation benefits from Liberty Mutual Company.

In the Matter of Linda Casey

Linda Casey executed a Consent Order for $5,000 on January 7, 2005. Casey was working while collecting disability benefits from Liberty Mutual Insurance Company.

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

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, allegedly submitted fraudulent health care claims to the Medicaid program by seeking reimbursement for medical services never provided to Medicaid recipients.

Following a five-week trial, a jury convicted Eliezer Martinez of Health Care Claims Fraud. The court sentenced Martinez on January 21, 2005, to five years in state prison and ordered him to pay approximately $137,958 in restitution and a $275,916 criminal fine.

The court admitted Olga Marquez into the Camden County Pre-trial Intervention (PTI) Program conditioned upon completion of 50 hours of community service and her cooperation with the State in the continuing investigation into this matter.

Olga Bonett and Juanita Melendez pled guilty to Health Care Claims Fraud. The court sentenced Melendez to probation for one year conditioned upon her continued cooperation with OIFP's investigation. The court sentenced Bonett to probation for one year also conditioned upon her cooperation with OIFP's investigation.

Jose Jimenez also pled guilty to Health Care Claims Fraud and the court sentenced her to probation for one year conditioned upon her continued cooperation with OIFP's investigation.

Luz Senquiz pled guilty to Health Care Claims Fraud. The court sentenced her to probation for one year conditioned upon her continued cooperation with OIFP's investigation.

The court admitted Bartolo Moreno into the PTI Program in 2004.

Martinez is appealing his conviction.

State v. Douglas Tyer

The court sentenced Douglas Tyer on May 13, 2005, to five years probation and gave him credit for 586 days he spent in county jail.

Tyer previously pled guilty to two separate accusations. The State charged him in the first accusation with Medicaid fraud and in the second with receiving stolen property. Tyer admitted that he obtained stolen Medicaid recipient cards that entitled the named beneficiary to medical benefits to include prescription drugs. He also admitted that he obtained stolen written prescriptions, purportedly issued by doctors for various narcotic medicines, so that he could obtain narcotic drugs for personal use not related to medical treatment.

Tyer was previously arrested and convicted for similar conduct.

State v. Surbhi Tarkas and Progressive Health Care of Hudson County, Inc.

The court sentenced Surbhi Tarkas on June 23, 2005, to three years state prison. Progressive Health Care was also convicted and dissolved. At a restitution hearing on August 31, 2005, the court ordered Tarkas to pay $119,000 in restitution.

Tarkas and Progressive pled guilty on January 21, 2005, to theft by failure to make required disposition of property received.

A State Grand Jury returned an indictment that charged Tarkas and Progressive Health Care with theft by failure to make required disposition of property received. According to the indictment, between June 2000 and January 2001, Tarkas, in her capacity as the owner/operator of Meadowview Nursing Center, which was owned by Progressive Health Care of Hudson County, Inc., allegedly diverted over $100,000 from the trust account of nursing home residents and used it to pay corporate expenses. Meadowview Nursing Center was a Medicaid provider of long-term care services to Medicaid recipients. Meadowview received payments from the Medicaid program and Social Security on behalf of the nursing home residents. The nursing home was legally required to place $35 to $40 of these payments into a Personal Needs Account (PNA) each month for each resident's personal use. The State alleged in the indictment that Tarkas diverted over $100,000 from the PNA accounts and used it to pay the expenses of the nursing home, which was experiencing financial difficulties.

State v. Ashokkuma Patel (MLK Pharmacy)

The court sentenced Ashokkuma Patel on January 7, 2005, to three years probation. It also ordered him to pay $7,717 in restitution and to perform 100 hours of community service.

Patel pled guilty to an accusation that charged him with Health Care Claims Fraud and Medicaid fraud. According to the accusation, 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 undercover cooperating witnesses posing as Medicaid recipients.

OIFP's investigation of this matter 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. MLK Pharmacy created a "black market" by selling and repurchasing prescription drugs, while billing multiple claims to the Medicaid program for the drugs.

State v. Nino Paradiso

The court sentenced Nino Paradiso on April 1, 2005, to three years probation conditioned upon his serving 45 days in county jail, paying $17,506 in restitution and $52,518 in penalties, and performing 100 hours of community service. Paradiso is debarred from the Medicaid program for a period of five years. He pled guilty on January 14, 2005, to Medicaid fraud. Paradiso was a licensed pharmacist who owned Singac Pharmacy. The charges against the corporate defendant, Singac Pharmacy, were dismissed on January 14, 2005.

A State Grand Jury returned an indictment that charged Paradiso and Singac Pharmacy with Health Care Claims Fraud and Medicaid fraud. The State also charged Paradiso with misconduct by a corporate official. According to the indictment, between February 2001 and August 2001, Paradiso, through Singac Pharmacy, and Kenneth Horwitz, another licensed pharmacist, allegedly submitted approximately 103 fictitious prescription drug claims to the Medicaid program for eight Medicaid recipients.

Horwitz was employed as a licensed pharmacist at the Medical Treatment Center located in Clifton. The fictitious claims were allegedly submitted based upon prescriptions that Horwitz admitted he forged. The eight Medicaid recipients were unaware of the fictitious prescriptions and fraudulent claims. The Medicaid recipients received no medicine, but the defendant billed Medicaid approximately $35,012.

Horwitz pled guilty to an accusation that charged him with Medicaid fraud. The court sentenced him on April 28, 2005, to three years probation and ordered him to pay a $35,012 civil fine.

State v. Michael Pacheco and Matthew Faenza

Michael Pacheco pled guilty to violating probation on January 10, 2005. The court sentenced him to 60 days in the Sheriff's Labor Assistance Program (SLAP). An investigation by OIFP's Medicaid Fraud Control Unit (MFCU) revealed that Pacheco continued to be employed by McDermott Pharmacy, located in Paterson, as a pharmacy technician after a Medicaid fraud conviction for submitting false claims to the Medicaid program. Such employment violated the terms of his probation.

Pacheco pled guilty to an accusation that charged him with Medicaid fraud. Pacheco admitted that with his assistance between January 1998 and July 1999, Matthew Faenza, a licensed pharmacist who owned and operated the pharmacy, falsely billed the Medicaid program for drugs never dispensed to Medicaid patients. The drug most commonly involved in the phony Medicaid transactions was Serostim, an expensive drug used to treat persons infected with HIV. Pacheco also admitted that he paid "runners" for prescriptions. Faenza then billed Medicaid for those prescriptions.

The court sentenced Pacheco to three years probation and it suspended him from participating in the Medicaid program for five years.

Based on the same scheme, Faenza pled guilty to an accusation that charged him with Health Care Claims Fraud. Faenza admitted falsely billing the Medicaid program for drugs to Medicaid patients. The court sentenced Faenza to three years state prison. He paid $450,000 in restitution to the Medicaid program on the day of sentencing, and the court ordered him to pay a $15,000 criminal fine. The court also ordered his pharmacy license suspended for one year, and it barred him from participating in the Medicaid program for five years.

State v. Genady Chulak

The court sentenced Genady Chulak on February 28, 2005, to seven years in state prison. The court also ordered him to pay $944,629 in fines and restitution. Investigators from the Immigration and Naturalization Service arrested Chulak on December 30, 2004, when he attempted to enter the country from Canada. The court had issued a bench warrant after he failed to appear for his sentencing hearing in 2001.

A Middlesex County jury had found Chulak, an owner of GGE Impact Corporation t/a as Medicall, guilty of theft by deception, corporate misconduct, and Medicaid fraud for defrauding the Medicaid program of approximately $472,000. Following seven days of trial, the jury convicted Chulak of inflating the mileage charges for invalid coach transportation services provided to Medicaid patients. The Medicaid program pays transportation companies a set rate for mileage to transport patients to and from doctors' and other medical service providers' offices depending on the length of the trip, the number of people riding in the van, and other factors. The jury also convicted Chulak of paying kickbacks to Medicaid patients for choosing to utilize Medicall's vans.

State v. Azam Khan, Shahid Khawaja, Milton Barasch, and Axat Jani

Azam Khan, Shahid Khawaja, Milton Barasch, and Axat Jani 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 submission of the claims.

Jani pled guilty to Health Care Claims Fraud. The court sentenced him to four years in state prison and ordered him 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.

Khawaja, the owner of S Brothers Pharmacy, pled guilty to money laundering. The court sentenced him on July 22, 2005, to five years in state prison and ordered him to pay $235,984 in restitution.

Barasch, a licensed pharmacist, pled guilty to Health Care Claims Fraud. The court sentenced him on December 23, 2005, to four years in state prison, suspended his Medicaid privileges for eight years, and suspended his pharmacist's license for one year.

Khan pled guilty to Health Care Claims Fraud. He is scheduled to be sentenced in 2006.

These matters will also be referred to the respective professional licensing boards for action as may be appropriate.

State v. Rammohan Pabbathi and Abdul Hameed Anayoor

The court sentenced Rammohan Pabbathi on July 8, 2005, to three years in state prison and ordered him to pay $450,000 in restitution. Pabbathi pled guilty to an accusation that charged him with Health Care Claims Fraud. Pabbathi was the owner and operator of the GLV Parke Warner Pharmacy located in Neptune, New Jersey.

OIFP's MFCU received a tip that Pabbathi was paying kickbacks to Medicaid recipients. In order to investigate the allegation, MFCU investigators went undercover and posed as Medicaid recipients. They were paid cash by Pabbathi to refer other Medicaid patients to the pharmacy in violation of Medicaid anti-kickback laws. At the guilty plea hearing, Pabbathi admitted that he paid between $20 and $50 to Medicaid recipients in order to induce them to fill their prescriptions at the GLV Parke Warner Pharmacy.

Additionally, Pabbathi billed Medicaid for filling prescriptions that the pharmacy did not dispense. An undercover investigator from OIFP's MFCU posed as a Medicaid recipient and presented a prescription for an expensive HIV medicine. The undercover investigator was brought to the pharmacy after being solicited by another Medicaid recipient. The Medicaid recipient did not pick up her medication, but Pabbathi billed Medicaid as if he had properly dispensed the medication. The Medicaid program paid approximately $1,130 for the medicine. The investigation developed evidence of other fraudulent Medicaid transactions.

As part of this investigation, the State also charged Abdul Hameed Anayoor, a registered pharmacist employed at GLV Parke Warner Pharmacy. Anayoor pled guilty to Medicaid fraud and the court sentenced him August 26, 2005, to two years probation, ordered him to pay a $2,000 fine, and revoked his pharmacist's license. Anayoor admitted that on March 12, 2003, he offered to pay a kickback of $50 to all new Medicaid recipi-

ents who had their prescription drugs filled at GLV Parke Warner Pharmacy. He also admitted that he offered to pay a $20 kickback for all refilled prescriptions at GLV Parke Warner Pharmacy.

A Medicaid provider, such as a pharmacist or a doctor, who agrees to pay a Medicaid patient money or anything of value for medical services that the Medicaid provider can bill to the Medicaid program is in violation of the law. In this case, Anayoor offered the kickback money to an undercover OIFP investigator. The investigator posed as an HIV-positive Medicaid beneficiary who was seeking to have very expensive HIV drugs filled at GLV Parke Warner Pharmacy.

State v. Joanne Tricarico

The court sentenced Joanne Tricarico on July 7, 2005, to five years in state prison and ordered her to pay $482,578 in restitution. Tricarico pled guilty to an accusation that charged her with official misconduct and theft by deception. Tricarico admitted that she was the Personnel Director for the Township of Bloomfield and was responsible for managing a publicly funded health insurance benefit account for Bloomfield Township employees. The benefit account was designed to reimburse Bloomfield Township employees for pharmacy costs to include prescription drugs.

Tricarico admitted that between January 17, 1997 and March 13, 2004, she wrongfully wrote numerous checks for her own benefit drawn on the Township of Bloomfield's pharmacy account. Tricarico admitted she attempted to cover up the theft by making fraudulent entries in the corresponding transaction journals used to record the withdrawals from the pharmacy reimbursement account.

Tricarico stole $482,578 from the Township of Bloomfield's pharmacy reimbursement account. The investigation revealed that in 1997 Tricarico stole $2,945; in 1998 she stole $58,030; in 2000 she stole $106,000; in 2001 she stole $95,445; and between 2002 and 2004, she stole the balance of the $482,578 theft.

At the time of her plea, Tricarico entered into a Consent Order for restitution and a Consent Order for permanent forfeiture of public office.

State v. Delphine Moore, Howard Beale, Kathryn McGlynn, and Jacob Cohen

Delphine Moore, the owner and operator of M and M Rest Home located Perrineville; Howard Beale, the owner and operator of the Chelsea Rest Homes located in Long Branch; and Kathryn McGlynn, the owner and operator of the Atlantic House, all located in Monmouth County, were admitted into the PTI Program in March 2005. Moore's admission into PTI was conditioned upon paying $19,200 in restitution and paying a $1,500 civil penalty. Beale's admission was conditioned upon his paying $4,800 in restitution and paying a $1,000 civil penalty. McGlynn's admission was conditioned upon her paying $15,000 in restitution and paying a $1,000 civil fine.

Moore, Beale, and McGlynn allegedly received kickbacks from the Belmar Home Town Pharmacy as an inducement to fill the medical prescriptions of the residents living in the residential health care facilities at that pharmacy. The prescriptions were billed to the Medicaid program. The alleged kickbacks took the form of cash and free-of-charge over-the-counter medications, which were also used by the residents of the facilities.

Jacob Cohen, owner of DelMonte Rest Home, pled guilty on December 5, 2005, to Medicaid fraud for receiving kickbacks. He is scheduled to be sentenced in 2006.

As part of OIFP's investigation into this matter, Michael Stavitski was previously indicted by a State Grand Jury. He pled guilty to Health Care Claims Fraud and was sentenced to seven years in state prison and ordered to pay approximately $1.1 million in restitution and penalties.

Also, as part of the investigation, Stephen Poggioli pled guilty to Medicaid fraud and he was sentenced to three years probation.

State v. Mario Oliveira, Jr.

The court sentenced Mario Oliveira, Jr., on June 10, 2005, to four years probation, ordered him to pay $19,902 in restitution, and debarred him from participating in the Medicaid program for a period of five years. Oliveira pled guilty on April 28, 2005, to an accusation that charged him with Medicaid fraud. Oliveira admitted that between January 2001 and January 2003, he falsely billed the Medicaid program in connection with eyeglasses. He admitted that he altered his expired optician's license to make it appear that it was valid and current. He used the altered license to submit billings to the Medicaid program that would not have otherwise been paid. The State alleged that Oliveira billed the Medicaid program $19,902 in connection with phony Medicaid claims for eyeglasses.

State v. Andrew Stoveken

The court sentenced Andrew Stoveken on July 15, 2005, to one year probation, and ordered him to pay $3,000 in criminal restitution, $126,000 civil restitution, and a $7,000 criminal fine. Stoveken pled guilty to Health Care Claims Fraud. Stoveken admitted that between February 2001 and August 2003, he submitted false health care claims to the Medicaid program for 32 hearing aid batteries to Medicaid recipients in connection with hearing aids. Stoveken also admitted that he really provided only 16 batteries to Medicaid patients. Stoveken also admitted that he permitted a person who was not a Medicaid provider to bill the Medicaid program utilizing Stoveken's Medicaid provider number.

State v. Anthony Murphy

The court sentenced Anthony Murphy on September 9, 2005, to one year probation and ordered him to pay $16,119 in restitution to the Medicaid program and $9,474 to the Division of Taxation. Murphy pled guilty to an accusation charging him with Medicaid fraud and failure to pay income taxes. Murphy admitted that between May 30, 2001 and March 30, 2004, he wrongfully obtained health benefits from the Medicaid program. Murphy admitted that he applied for FamilyCare for himself, his wife, and his three children by falsely advising the Division of Medicaid Assistance and Health Services that he did not have health insurance by virtue of his employment and could otherwise not afford health coverage. He admitted that he falsely advised Medicaid that his income level qualified him to enroll in the FamilyCare program sponsored by Medicaid.

Murphy admitted that he is a self-employed contractor and the owner of A. Murphy Contracting and that income and profits he received from that business far exceeded the $25,071 per year income limit necessary to qualify for FamilyCare.

State v. John Cardillo

John Cardillo pled guilty to Health Care Claims Fraud, and the court sentenced him on December 2, 2005, to three years probation and ordered him to pay a $2,500 criminal fine. Cardillo admitted that between

May 1, 1999 and April 2003, he submitted false Medicaid cost reports to the Medicaid program. Cardillo was the Chief Financial Officer for Mt. Carmel Guild Hospital located at 1160 Raymond Boulevard, Newark. The Mt. Carmel Guild Hospital is associated with the Catholic Diocese of Newark.

The Medicaid program pays hospitals for health care services to Medicaid patients based on the number of Medicaid patients treated by the hospital. Typically, hospitals report the number of treated Medicaid patients over a given period of time to the Division of Medical Assistance and Health Services, which is the agency that administers the New Jersey Medicaid program. The Division of Medical Assistance and Health Services then reimburses the hospital for the health services from the Medicaid program. Cardillo, as Chief Financial Officer, submitted false cost reports to the Medicaid program in order to obtain more money from the Medicaid program for the Mt. Carmel Guild Hospital than the hospital was entitled to receive.

State v. Luz Senquiz

The court sentenced Luz Senquiz on May 27, 2005, to one year probation. Senquiz pled guilty to an accusation that charged her with Health Care Claims Fraud. Senquiz, who operated a psychological counseling center known as Latin American Community Services, admitted that between January 1, 2001 and June 1, 2001, she operated a psychological counseling practice for Medicaid and other patients. During the period of time charged, she admitted that even though she lacked the credentials to be a Medicaid provider, she provided psychological counseling to Medicaid patients for a variety of family, marital, and drug dependent psychological issues. Senquiz lacked the requisite Master's Degree in psychology or in a related discipline. She billed the Medicaid program approximately $9,445 for psychological services.

Senquiz previously pled guilty for her role in a separate Medicaid psychotherapy scam at a different psychology practice known as Hispanic Counseling and Family Services in Camden. In that case, she pled guilty to Health Care Claims Fraud for her role in fraudulently billing the Medicaid program by claiming that patients were provided psychotherapy services for one hour when patients were provided psychotherapy services for less time.

State v. Roger H. Brown

The court sentenced Roger H. Brown on July 29, 2005, to three years in state prison and ordered him to pay a $25,000 criminal fine. Brown's dental license was also suspended for a period of one year. Brown, a licensed dentist and the owner of Amwell Dental Associates, pled guilty to an accusation that charged him with Health Care Claims Fraud.

Brown admitted that between January 1993 and September 2004, he submitted false dental claims to the Medicaid program, Delta Dental, MetLife, Horizon Blue Cross Blue Shield, CIGNA Insurance, and Aetna Insurance. The false claims represented bills for dental services not rendered to patients. In other cases, Brown misrepresented the dates on which services were rendered; and he billed for providing Temporomandibular Joint Dysfunction (TMJ) Nightguards when he gave cosmetic teeth bleachings, which are cosmetic dental services generally not covered by private dental insurance.

The investigation revealed that he submitted approximately $95,182 in false claims. Brown agreed to pay $59,969 to the Medicaid program and $35,213 to private insurance companies in restitution, and $190,364 to the Medicaid program and the Department of Banking and Insurance in civil penalties.

State v. William J. Adamshick

William J. Adamshick pled guilty on November 28, 2005, to Health Care Claims Fraud. He is scheduled to be sentenced in early 2006. A State Grand Jury returned an indictment charging Adamshick with Health Care Claims Fraud and Medicaid fraud. The State alleged in the indictment that between May 15, 2000 and January 30, 2002, Adamshick, a pharmacist licensed in the State of New Jersey, submitted claims to the Medicaid program for a narcotic prescription drug known as Stadol.

Adamshick allegedly billed the Medicaid program for approximately 238 phony Stadol prescriptions. The State alleged that Adamshick wrongfully billed the Medicaid program in excess of $20,000 for Stadol prescriptions that were never dispensed to patients.

State v. Anthony Panichella

The court sentenced Anthony Panichella on August 18, 2005, to five years probation and 90 days in the Camden County Sheriff's Labor Assistance Program (SLAP). Panichella pled guilty to an accusation that charged him with the practice of medicine and surgery or podiatry by an unlicensed person. Panichella admitted that between January 1, 2004 and August 1, 2004, he prescribed medication for various patients for whom he was providing counseling services. As a licensed counselor, Panichella was able to counsel patients, but not prescribe medication. Panichella practiced as a licensed counselor and was owner/operator of Progressive Counseling Services in Audubon.

State v. Ojah Pharmacy, Alpha Bangoura, and Verona Boodram

A State Grand Jury returned an indictment against Ojah Pharmacy, it's manager Verona Boodram, and the pharmacy technician Alpha Bangoura on July 14, 2005, charging them with Health Care Claims Fraud and Medicaid fraud. According to the indictment between June 1, 2002 and October 28, 2004, the defendants allegedly billed the Medicaid program for prescriptions that were not filled and dispensed to Medicaid patients. The State further alleges that certain Medicaid patients sold prescriptions for medicines, written by doctors for the patients, to the pharmacy so that the pharmacy could support the fraudulent Medicaid bills. The State also alleges that the Medicaid program was billed approximately $57,000 for prescriptions not filled.

State v. Julio Anthony Munoz and TNT Medical Supply, Inc.

A State Grand Jury returned an indictment on October 5, 2005, that charged Julio Anthony Munoz and TNT Medical Supply, Inc., with Health Care Claims Fraud and Medicaid fraud. Munoz owned, operated, and controlled TNT. The State alleges that between January 2002 and August 2003, Munoz, a Medicaid provider, and his corporation falsely billed the Medicaid program for the most expensive surgical support stockings when the least expensive stocking was provided to the Medicaid patients. Surgical stockings are prescribed for patients for circulatory and related medical conditions. Surgical stockings may be billed in amounts ranging from $24 to $120.

The State alleges that Munoz falsely billed the Medicaid program approximately $29,840.

State v. Dwayne Smith and Smith and Williams Transportation, Inc.

A State Grand Jury returned an indictment on October 28, 2005, that charged Dwayne Smith and his corporation, Smith and Williams Transportation, Inc., with Health Care Claims Fraud and Medicaid fraud. The State alleges that between March 21, 2003 and May 20, 2004, Smith, through Smith and Williams Transportation, Inc., fraudulently billed the Medicaid program for transportation services in connection with medical treatments of Medicaid patients. The Medicaid program provides transportation to and from doctors' offices, hospitals, and other medical providers. In total, The State alleges that Smith falsely billed the Medicaid program approximately $12,600.

State v. Darryl Fisher

The court sentenced Darryl Fisher on December 23, 2005, to one year probation and ordered him to pay a $500 criminal fine. Fisher pled guilty to an accusation that charged him with forgery. Fisher admitted that between October 1, 2003 and November 31, 2003, he practiced as a physician's assistant without being properly licensed. Fisher was on staff at Wound Healing Associates (WHA), a Medicaid provider, which contracted with nursing homes to treat nursing home residents and patients for wounds to include bed sores and similar wounds. WHA operated in Camden County and the surrounding area. Following an effort by WHA to verify that Fisher was properly licensed, it was discovered that his physician assistant's license had been forged. The matter was referred to OIFP's MFCU for follow up investigation.

PATIENT AND ELDER ABUSE

State v. Chanel McRae

The court sentenced Chanel McRae on October 28, 2005, to five years probation. McRae pled guilty to aggravated assault. An Atlantic County Grand Jury returned an indictment that charged McRae with aggravated assault. The State alleged that on April 10, 2004, McRae, a Certified Nurse Assistant, assaulted a patient at the Absecon Manor Long Term Care and Rehabilitation Center.

State v. Donald Beckett

A Sussex County Grand Jury returned an indictment on May 5, 2005, that charged Donald Beckett with aggravated assault. According to the indictment, on October 11, 2003, Becket was employed at the Andover Subacute and Rehabilitation Center, Inc., located in Andover, Sussex County. The Center employed Beckett as a Certified Nurse Assistant. The State alleges that Becket committed an assault on an elderly resident of the Andover Rehabilitation Center. Beckett is scheduled for trial in 2006.

State v. Russell P. Smith, III

A Mercer County Grand Jury returned an indictment on September 30, 2005, that charged Russell P. Smith, III, with aggravated assault and aggravated criminal sexual contact. According to the indictment, on July 1, 2004 and August 13, 2004, Smith, a Licensed Practical Nurse in New Jersey, allegedly assaulted various residents of the Royal Healthgate Nursing and Rehabilitation Center located in Trenton. The State alleges that Smith committed an aggravated assault on four patients. The State also alleges that Smith committed an aggravated sexual assault on one of those patients. The alleged victims were patients in residence at the Royal Healthgate Nursing and Rehabilitation Center and are between 73 and 87 years old.

Atlantic County Prosecutor's Office

State v. Adrian Rodriquez

In July 2005, Adrian Rodriquez, a/k/a Adriano Sotomayor, was sentenced to seven years state prison and ordered to pay restitution in the amount of $280,059 to 32 victims. The Atlantic County indictment charged Rodriquez with theft by deception. An investigation by the Atlantic County Prosecutor's Office Insurance Fraud Task Force revealed that Rodriquez allegedly represented himself as an employee of Mutual Life Insurance Company while contacting families in Puerto Rico fraudulently requesting money to satisfy tax liens in order for the families to collect on large insurance policies of recently deceased family members.

State v. Miguel Angel Matos

As the result of an investigation by the Atlantic County Prosecutor's Office Insurance Fraud Task Force into the manufacture and sale of counterfeit motor vehicle insurance cards, on October 6, 2005, Miguel Angel Matos was indicted and charged with simulating a motor vehicle insurance card, conspiracy, tampering with public records, and possession of forgery devices. The investigation resulted in the execution of search warrants wherein materials allegedly used in manufacturing counterfeit insurance cards, as well as birth certificates and Social Security cards, were recovered. Matos is currently a fugitive.

Bergen County Prosecutor's Office

State v. Jesus Arroyo

Jesus Arroyo pled guilty to charges of Insurance Fraud and forgery; and on May 27, 2005, he was sentenced to serve 364 days in county jail and to five years probation, and ordered to pay $100,000 in restitution as a condition of probation. Arroyo, who allegedly assumed the identity of his deceased brother, provided a false statement under oath and collected an automobile accident settlement from Utica Mutual Insurance Company.

State v. Damon Brown

On August 19, 2005, Damon Brown was sentenced to two years probation and ordered to serve six months in county jail as a condition of probation. Brown was convicted of presenting a false and altered Allstate insurance identification card to a law enforcement officer.

Burlington County Prosecutor's Office

State v. John R. Okuszki, Randy Gemenden, and Christopher Uffer

In May 2005, John R. Okuszki, Randy Gemenden, and Christopher Uffer were charged with aggravated arson and conspiracy to commit arson. Gemenden and Uffer allegedly drove Okuszki's 2002 Subaru Impreza to a remote location in Tuckerton and set fire to the vehicle. Afterwards, Okuszki allegedly falsely reported the vehicle stolen to file a fraudulent insurance claim.

State v. Frank S. D'Amico

On October 25, 2005, Frank S. D'Amico was indicted for arson. D'Amico allegedly reported his 2001 Dodge pickup truck stolen from his New Castle, DE, home. The following day the vehicle was found burning in Mount Laurel, NJ; the cause of the fire was determined to be suspicious. The State intends to prove D'Amico drove his vehicle to Mount Laurel and set it on fire with the intention of collecting insurance money.

Camden County Prosecutor's Office

State v. Anita Trego

Anita Trego, a licensed pharmacist, pled guilty to an accusation charging her with Health Care Claims Fraud and on March 21, 2005, was sentenced to five years probation, ordered to successfully complete a Drug Court Program as a condition of probation, and ordered to pay $2,222 in restitution. The court also suspended Trego's pharmacy license for a period of five years. Trego was charged with possession of CDS and theft by unlawful taking after her employer, a local pharmacy, discovered she alegedly had stolen merchandise and pharmaceuticals from store inventory. Trego subsequently allegedly submitted fraudulent insurance claims to offset the loss of the stolen drugs.

State v. Brian Lang

Brian Lang, a licensed practical nurse, pled guilty to an accusation charging him with theft by unlawful taking and on March 11, 2005, was sentenced to five years probation, conditioned upon completion of a one-year in-patient drug program, and ordered to pay $297 in restitution to Health Net. The court also suspended Lang's nursing license for a period of two years. An investigation revealed that Lang, who was employed by a physician's group specializing in urology care, had allegedly stolen prescription blanks from his employer and forged the stolen blanks with various doctors' names in order to obtain Percocet and OxyContin.

Cape May County Prosecutor's Office

State v. Dawn Donovan

A Cape May County Grand Jury indicted Dawn Donovan on charges of exhibiting a fraudulent insurance identification card. On November 18, 2005, she pled guilty to the charge and was sentenced to three years probation.

Essex County Prosecutor's Office

State v. Bernard Cole

Bernard Cole pled guilty to charges of Insurance Fraud and conspiracy; and on December 14, 2005, he was sentenced to five years probation, ordered to pay $24,266 in restitution, and had his driver's license suspended for two years. Cole was employed by Chubb Insurance Company and also had his 2001 Mitsubishi Montero insured by Chubb. He allegedly submitted fraudulent claims to the insurance company regarding the theft of his vehicle.

State v. Nicola Popolizio

On November 29, 2005, Nicola Popolizio, a former Newark police officer, was indicted and charged with arson, attempted theft by deception, and Insurance Fraud for his alleged role in the arson of his 1993 Toyota Camry.

State v. Eric Barden

Eric Barden pled guilty to an indictment charging him with Insurance Fraud and attempted theft by deception; and on September 23, 2005, he was sentenced to three years probation. Barden allegedly reported the theft of his 2004 Jeep Grand Cherokee for the purpose of submitting a fraudulent insurance claim to Clarendon National Insurance Company.

State v. Michael A. Ruzzano

Michael A. Ruzzano pled guilty to theft by deception; and on August 26, 2005, he was sentenced to three years probation conditioned upon performing100 hours of community service. Ruzzano admitted to participating in the fraudulent theft of his vehicle for the purpose of defrauding Hanover Insurance Company.

State v. Michael DelPonte

Michael DelPonte was admitted into the PTI Program on June 10, 2005, and ordered to pay $32,469 in restitution to State Farm Insurance Company. DelPonte allegedly had an individual dispose of his leased 2001 Mercedes ML320, which had greatly exceeded its mileage allowance.

State v. Dorian Woodruff and Judy Brooks Woodruff

On October 25, 2005, Dorian Woodruff was indicted and charged with conspiracy to commit aggravated arson, aggravated arson, conspiracy to commit theft by deception, attempted theft by deception, conspiracy to commit Insurance Fraud, and Insurance Fraud for his alleged role in the theft and arson of his 2001 Ford Explorer. On the same date, Judy Brooks Woodruff was indicted for attempted theft by deception and Insurance Fraud.

OIFP Program Analyst Joan Enright instructs members of the County Prosecutors' Offices on grant application procedures.

State v. Carlos Torres

On November 29, 2005, Carlos Torres was indicted and charged with conspiracy to commit aggravated arson, aggravated arson, attempted theft by deception, and Insurance Fraud. Torres allegedly fraudulently reported his 2003 Chevy Trailblazer stolen. In addition, he claimed $5,000 in equipment upgrades for which he allegedly provided fraudulent receipts.

Gloucester County Prosecutor's Office

State v. George M. Halliday

On December 9, 2005, George M. Halliday was sentenced to three years probation and a one-year suspension of his driver's license. Halliday pled guilty to simulating a motor vehicle insurance identification card.

State v. Nicole Pfund

Nicole Pfund pled guilty to theft by deception for faking a slip-and-fall injury at a West Deptford Township hotel and on March 21, 2005, was sentenced to four years state prison and ordered to pay $4,323 in restitution. Pfund filed a $50,000 insurance claim with Selective Insurance Company after falsely reporting she had fallen in a flooded hotel bathroom.

State v. Margaret E. Moore

On April 29, 2005, Margaret E. Moore was sentenced to two years probation after pleading guilty to simulating a motor vehicle insurance identification card.

State v. Wendell E. Frazier

On July 21, 2005, Wendell E. Frazier was charged with making a false police report. A cooperative investigation by the Glassboro Police Department and the Gloucester County Prosecutor's Office revealed Frazier allegedly "gave up" a 2004 Chrysler Sebring, insured by New Jersey Manufacturers Insurance Company, and allegedly filed a fraudulent theft claim. The investigation is continuing.

State v. Sean C. Erickson

On September 16, 2005, Sean C. Erickson was sentenced to three years probation and ordered to pay $695 in fines and penalties after pleading guilty to simulating a motor vehicle insurance identification card.

State v. Cynthia A. Warner

On August 19, 2005, Cynthia A. Warner was sentenced to two years probation after pleading guilty to a charge of simulating a motor vehicle insurance identification card.

State v. Tanteepo K. Moulton

On October 21, 2005, Tanteepo K. Moulton was admitted into the PTI Program. Moulton was indicted for simulating a motor vehicle insurance identification card.

Hudson County Prosecutor's Office

State v. Ali Fouda and Samir Abdellatif

On July 7, 2005, Ali Fouda and Samir Abdellatif pled guilty to an accusation charging them with simulating a motor vehicle insurance identification card and were admitted into the PTI Program. Fouda and Abdellatif, owners of J&T Transit Corporation, Greenway Transit Corporation, and Rite Ride Transportation, all located in Fairview, admitted to illegally manufacturing insurance identification cards and providing the cards to their fleet drivers.

State v. Mariana Clark

On November 7, 2005, Mariana Clark was sentenced to three years probation and ordered to pay $28,000 in restitution after pleading guilty to an indictment charging her with theft by deception. Clark allegedly intercepted a life insurance check issued to her sister, forged the endorsement, and deposited the money into her personal account.

Mercer County Prosecutor's Office

State v. Enrique Chinchilla

On November 18, 2005, Enrique Chinchilla was sentenced to three years probation and ordered to forfeit approximately $600 to the State as part of his guilty plea. Chinchilla pled guilty to an accusation charging him with uttering a fraudulent government document.

State v. Oscar Diaz a/k/a Oscar Corrales

On November 17, 2005 , Oscar Diaz was arrested and charged with selling a fraudulent insurance identification card to an undercover police officer. The case is pending.

Monmouth County Prosecutor's Office

State v. Michael Frunzi

On January 12, 2005, Michael Frunzi, owner of Frunzi Investment Group, was admitted into the PTI Program conditioned upon paying $6,375 in restitution to Aurora Environmental, Inc. Frunzi was charged with theft by deception, misconduct of a corporate official, receiving deposits for a failing financial institution, and attempted theft by deception. Allegedly, Aurora Environmental paid Frunzi a $5,600 premium to insure the company's fleet vehicles; however, after a vehicle was involved in an accident, it was determined the insurance company never received the premium and had no listing of Aurora as a customer.

Morris County Prosecutor's Office

State v. Kimberly McCauley

On August 9, 2005, Kimberly McCauley pled guilty to an indictment charging her with theft by deception. An investigation revealed that Kimberly McCauley allegedly filed false insurance claims through her chiropractic office, New Life Chiropractic in Riverdale. She is awaiting sentencing.

State v. Joseph A. Tenaglia

Joseph Tenaglia pled guilty to an accusation charging him with exhibiting a fraudulent insurance identification card to a law enforcement officer; and on August 8, 2005, he was sentenced to 18 months state prison.

State v. Sydney A. Baker

Sydney A. Baker pled guilty to charges of exhibiting a fraudulent GEICO motor vehicle insurance identification card to a law enforcement officer; and on October 27, 2005, she was admitted into the PTI Program.

Ocean County Prosecutor's Office

State v. Jose Morales

On November 18, 2005, Jose Morales was sentenced to three years probation, conditioned upon serving 364 days in the county jail. Morales pled guilty to an indictment charging exhibition of a simulated motor vehicle identification card to a Lakewood Township police officer.

State v. Erin Larangiera

On May 2, 2005, Erin Larangiera pled guilty to an indictment charging her with Health Care Claims Fraud. She was sentenced to probation and ordered to pay $151 in restitution to Horizon Blue Cross Blue Shield. Allegedly, Larangiera, who worked in a physician's office, illegally accessed prescription blanks, forged prescriptions for her per-

sonal use, and utilized her Caremark prescription card to help pay for the prescriptions.

Passaic County Prosecutor's Office

State v. Shams Qureshi, M.D., Teresa Vargas, and Shkelzen Badivuku

Following a two-and-a-half year investigation into an alleged overbilling scheme at the Pain Center of North Jersey, on December 15, 2005, Shams Qureshi, his office manager Teresa Vargas, and office assistant Shkelzen Badivuku were indicted on charges of Health Care Claims Fraud and theft by deception. Badivuku was also charged with practicing medicine without a license. It is alleged that Qureshi generated and submitted fraudulent medical reports reflecting medical examinations when, in fact, no examinations were performed.

State v. Isabel Tavares

On August 23, 2005, Isabel Tavares was indicted on charges of theft by deception. Tavares allegedly submitted a fraudulent workers' compensation claim with Chubb Insurance and received in excess of $100,000 in disability payments before Chubb determined Tavares allegedly failed to disclose prior and subsequent injuries for which she received pain and suffering settlements from other insurance carriers.

State v. Andre Pascal, Pedro Pascal, Jose Pascal, Luis Pascal, Eduardo Abreu, Wilfredo Abreu, and Hector Abreu

On April 12, 2005, Andre Pascal, Pedro Pascal, Jose Pascal, Luis Pascal, Eduardo Abreu, Wilfredo Abreu, and Hector Abreu were indicted on charges of Health Care Claims Fraud, attempted theft by deception, and identity theft. It is alleged these individuals used multiple identities to file fraudulent claims for motor vehicle accidents and slip-and-fall claims.

State v. Adiel Brito

On June 14, 2005, Adiel Brito pled guilty to an accusation charging him with Insurance Fraud. Brito allegedly falsely reported his vehicle stolen to the Wayne Police Department and to New Jersey Manufacturers Insurance Company when, in fact, he had arranged to "give up" the vehicle. Brito was admitted into the PTI Program.

State v. Stephen Casey

Stephen Casey pled guilty to an accusation charging him with Insurance Fraud; and on July 22, 2005, he was sentenced to one year probation. Casey allegedly fraudulently reported his car stolen to the Fair Lawn Police Department and to Allstate Insurance Company in an attempt to collect insurance money when, in fact, he arranged to "give up" the vehicle.

State v. Michael Harris

Michael Harris pled guilty to an indictment charging him with Health Care Claims Fraud; and on June 10, 2005, he was sentenced to two years probation. Harris was initially listed as a passenger in a vehicle involved in an accident on a police accident report. A subsequent investigation by Liberty Mutual Insurance Company determined Harris was not a passenger in either vehicle at the time of the accident.

Salem County Prosecutor's Office

State v. Debora Karpinski

On August 12, 2005, Debora Karpinski was charged with Insurance Fraud. Karpinski previously worked in a physician's office; and during the period May 2004 through July 2005, she allegedly fraudulently obtained prescription blanks from her employer, illegally filled out and submitted prescriptions to a local pharmacy, and obtained medications for her personal use. Aetna Insurance Company paid $113,954 for the alleged fraudulent claims.

State v. Ruth Zane

On November 9, 2005, a Salem County Grand Jury indicted Ruth Zane on charges of Health Care Claims Fraud. Zane allegedly sold liquid morphine to an undercover police officer. Zane admitted that she illegally sold prescription drugs obtained through the Medicaid program for approximately $900 a month over a one-year period.

Somerset County Prosecutor's Office

State v. Eunice Rivers

On September 2, 2005, Eunice Rivers pled guilty to possession of a fictitious insurance identification card and was sentenced to three years probation and ordered to pay $180 in fines.

State v. Jaumar Ebram

On September 9, 2005, Jaumar Ebram pled guilty to possession of a fictitious insurance identification card and was sentenced to three years probation and ordered to pay $180 in fines.

Sussex County Prosecutor's Office

State v. Keith Tighe and Lenard Vandenhandel

On June 24, 2005, Keith Tighe pled guilty to attempted theft of a motor vehicle; he was sentenced to one year probation and ordered to pay $5,155 in fines. On the same date, Lenard Vandenhandel pled guilty to theft charges and was sentenced to one year probation and ordered to pay $625 in fines. Tighe and Vandenhandel allegedly participated in a conspiracy to conceal a 2000 Jeep Cherokee whose owners had reported it stolen to submit a false claim to New Jersey Manufacturers Insurance Company.

State v. James DeGrande

On October 11, 2005, James DeGrande pled guilty to an accusation charging him with altering a vehicle insurance identification card. DeGrande allegedly changed the dates on a First Trenton Indemnity Insurance Company card to make it appear the insurance policy was still in effect. He was admitted into the PTI Program and ordered to pay $202 in fines.

State v. Donna M. Miller

On November 1, 2005, Donna M. Miller pled guilty to an accusation charging her with altering a vehicle insurance identification card. Miller changed the dates on a First Trenton Indemnity Insurance Company card to make it appear the insurance policy was still in effect. Sentencing is scheduled for 2006.

Union County Prosecutor's Office

State v. George Cunha, Angel Melendez and Dennis Melendez

On October 25, 2005, George Cunha, Angel Melendez, and Dennis Melendez were indicted for Insurance Fraud and conspiracy to commit Insurance Fraud. Dennis Melendez was also indicted for official misconduct. Allegedly, Cunha falsely reported his car stolen to the Proformance Insurance Company after selling it to Dennis Melendez. With the help of Angel Melendez, Dennis Melendez allegedly disassembled and disposed of the car before notifying Cunha that he could report it stolen. The Proformance Insurance Company paid Cunha $14,000 on his claim.

State v. Rashad Jackson and Mary Jackson

On December 12, 2005, Rashad Jackson and Mary Jackson were indicted for insurance fraud for allegedly falsely reporting Rashad's car stolen to the High Point Insurance Company. High Point paid Mary Jackson $6,780 on the claim.

State v. Kelvin Ramos

On September 29, 2005 Kelvin Ramos pled to an accusation charging him with selling simulated motor vehicle insurance cards.

State v. Damian L. Washington

On November 10, 2005, Damian L. Washington was charged with selling a counterfeit Allstate motor vehicle insurance card. Allegedly, he was in possession of over 100 blank counterfeit insurance cards at the time of his arrest.

Warren County Prosecutor's Office

State v. Georgeann Pludowski

On June 15, 2005, Georgeann Pludowski was indicted and charged with theft by failure to make required disposition of property received. Pludowski allegedly illegally converted the proceeds of an estate, which included a $30,000 life insurance benefit, for her personal use. Trial is pending.

State v. Benjamin R. Noyes

On July 1, 2005, Benjamin R. Noyes was sentenced to seven years state prison and ordered to pay $980 in fines and restitution after pleading guilty to an accusation charging him with aggravated arson and criminal mischief. Noyes admitted to setting a fire which destroyed a partially constructed single family home, in addition to causing heat damage to two other structures and seven motor vehicles, with the intention of having Selective Insurance Company pay a $100,000 construction insurance policy to the builder, thus relieving Noyes of an anticipated mortgage responsibility upon completion of the single family home.

State v. Carl Prata

Carl Prata entered into a settlement agreement on December 22, 2005, admitting to 57 violations of the Fraud Act and agreeing to pay $204,000 in civil insurance fraud penalties. Prata, while employed by Allmerica Insurance Company and St. Paul Insurance Company, issued 57 fraudulent benefits checks to 45 co-conspirators. The face amount of the checks totaled $570,000. Prata was convicted of criminal charges by way of a plea agreement. He was sentenced to five years state prison and ordered to pay $50,000 in restitution. Restitution will be paid prior to the payment of the Fraud Act penalty. Forty-two other co-defendants of Prata were prosecuted and entered plea agreements or were admitted into the Pre-trial Intervention (PTI) Program. Each of those defendants agreed to pay restitution and signed Consent Orders for civil penalties ranging from $2,500 to $22,500.

State v. Richard D. Collins

In May 2005, Richard D. Collins, D.C., entered into a Consent Order with the Office of the Insurance Fraud Prosecutor. Collins agreed to pay a $1,500 penalty for the New Jersey Insurance Fraud Prevention Act (the Fraud Act) violation of billing for services not rendered in 1996.

State v. Faith Penalver and Stephen Penalver

Faith Sherak Penalver, a/k/a Faith Sherak, submitted a claim in the amount of $158,417 to First Trenton Indemnity Insurance Company in connection with a fire at her residence in Roosevelt, NJ. She and her son, Stephen I. Penalver, a/k/a Stephen I. Sherak, made numerous oral and written false statements to police and First Trenton investigators concerning the cause of the fire and the property claimed to have been lost as a result. On January 21, 2005, default judgments including penalty, attorney fees, and costs, were obtained against Faith Penalver for $106,437 and against Stephen Penalver for $76,437.

State v. Robert Fraser

On May 10, 2005, after a three-day trial, Robert Fraser, a licensed real estate agent, was found to have committed four violations of the Fraud Act. The Superior Court awarded a civil penalty of $9,500 and $6,510 in attorney fees. The civil penalty was assessed against Fraser for submitting multiple false statements in support of a false claim for damage to a motor vehicle. Fraser had been driving on the beach when his vehicle became stuck in the sand. He called a friend to tow him out but the friend's vehicle became mired as well. After both vehicles were damaged by the incoming surf, Fraser purchased his friend's vehicle but represented to the insurance carrier that the vehicle was undamaged when he bought and insured it. Fraser was prosecuted criminally as well and was convicted of all charges.

State v. Fredric Palmieri

Fredric Palmieri, a licensee of the Board of Accountancy, the Bureau of Securities, and the Department of Banking and Insurance admitted a violation of the Fraud Act for staging the theft of his 1997 Jaguar. He entered into a stipulation of settlement on May 19, 2005, and agreed to pay a $5,000 civil penalty and $1,000 in attorney fees. Palmieri of Medford, NJ, owned a 1997 Jaguar that was insured against damage or loss due to theft by Liberty Mutual Insurance Company. On November 20, 2001, Palmieri reported to the Philadelphia Police Department that his Jaguar had been stolen that afternoon. He also reported the theft to Liberty Mutual. On November 17, 2001, Palmieri's vehicle was recovered by the Gloucester Township Police Department burning in a sandpit. Prior to the vehicle being set on fire, all four doors, both front fenders, the hood, and the trunk had been removed.

State v. Richard Serbin

Richard Serbin executed a $50,000 Consent Order on December 16, 2005. Serbin provided false information to Reassure America Life Insurance Company in pursuit of a claim for disability benefits. Serbin pled guilty to falsifying records in a criminal case prosecuted by OIFP.

Medical

In the Matter of Paul Pevsner, M.D.

On April 14, 2005, to be effective July 1, 2005, the State Board of Medical Examiners suspended the license of Paul Pevsner, M.D., for a period of five years with the first two years active and the remainder stayed to be a period of probation. The offending conduct included issuing numerous exemplar MRI interpretation reports identified for corporate entities not licensed by the Department of Health and Senior Services.

In Matter of William Burke, M.D.

On May 25, 2005, the State Board of Medical Examiners revoked the license of William Burke, M.D., based on an Administrative Law Judge's finding that he engaged in acts of fraud and deception by repeatedly billing for radiological and other medical services not rendered; engaging in improper billing practices; and for professionally deceptive reporting.

In the Matter of Andrew Stoveken, H.A.D.

On June 6, 2005, the State Board of Medical Examiners revoked the hearing aide dispenser license of Andrew Stoveken, H.A.D., based on his guilty plea to Health Care Claims Fraud.

In the Matter of Leclerc Adisson, M.D.

On September 14, 2005, the State Board of Medical Examiners accepted the permanent surrender of the medical license of Leclerc Adisson, M.D., to be deemed a revocation based on his guilty plea to a criminal accusation and two separate indictments charging theft by deception.

In the Matter of Valery Rimerman, M.D.

On November 2, 2005, the State Board of Medical Examiners accepted the voluntary surrender of the license of Valery Rimerman, M.D., with prejudice to any re-application. Rimerman signed a Stipulation of Settlement wherein he admitted to submitting medical records and bills to two insurance companies containing false and misleading information.

Chiropractic

In the Matter of Michael Baer, D.C.

On February 7, 2005, the State Board of Chiropractic Examiners suspended the license of Michael Baer, D.C., for a period of five years with the first two years active commencing on January 16, 2004, with the remainder stayed as a period of probation based on his guilty plea to submitting phony health insurance claims for services not rendered.

In the Matter of Daniel Fontanella, D.C.

On March 3, 2005, the State Board of Chiropractic Examiners revoked the chiropractic license of Daniel Fontanella, D.C., based on his guilty plea to theft by deception in the creation or falsification of treatment and billing records for services never performed.

In Matter of Nicola (Nick) Amato, D.C.

On May 4, 2005, the State Board of Chiropractic Examiners suspended the chiropractic license of Nicola Amato, D.C., for a period of three years with the first six months active and the remainder stayed to be period of probation. Amato pled guilty to theft by deception.

In the Matter of Samuel Kaplowitz, D.C.

On September 21, 2005, the State Board of Chiropractic Examiners suspended the chiropractic license of Samuel Kaplowitz, D.C., for a period of three years with the suspension stayed to become a period of probation. Kaplowitz admitted in an OIFP civil Consent Order that he billed an insurance carrier for an incorrect CPT Code to obtain payment of fees to which he was not entitled.

In the Matter of Charles Nisivoccia, D.C.

On November 17, 2005, the State Board of Chiropractic Examiners suspended the chiropractic license of Charles Nisivoccia, D.C., for a period of five years with the first two years active effective December 17, 2005. Nisivoccia pled guilty to an accusation charging Criminal Use of Runners.

In the Matter of Richard J. Nardone, D.C.

On December 5, 2005, the State Board of Chiropractic Examiners suspended the chiropractic license of Richard J. Nardone, D.C., for an active period of five years based on his conviction for filing false and fraudulent New Jersey income tax returns, failure to pay New Jersey gross income tax with the intent to evade, and misconduct by a corporate official. The criminal case was prosecuted by OIFP.

Pharmacy

In the Matter of Abdul Anayoor, R.P.

On June 22, 2005, the New Jersey Board of Pharmacy accepted the surrender of the pharmacy license of Abdul Anayoor, R.P., to be deemed a revocation based on his guilty plea to Medicaid fraud.

In the Matter of Kenneth Horowitz, R.P.

On April 29, 2005, the New Jersey Board of Pharmacy revoked the pharmacy license of Kenneth Horowitz, R.P., based on his guilty plea to Medicaid fraud. Horowitz admitted submitting fictitious prescription drug claims to the Medicaid Program for payment or reimbursement.

In the Matter of John Wylie, R.P.

On February 4, 2005, the New Jersey Board of Pharmacy accepted the surrender of the pharmacy license of John Wylie, R.P., with prejudice based on his guilty plea to submitting fraudulent bills seeking insurance reimbursement and payment for performance of medical procedures he was not qualified or licensed to perform.

In the Matter of Nino Paradiso, R.P.

On July 6, 2005, the New Jersey Board of Pharmacy revoked the pharmacy license of Nino Paradiso, R.P., based on his guilty plea to Medicaid fraud.

Electrical Contractors

In the Matter of Phillip Rello, Electrical Contractor

On January 19, 2005, the Board of Examiners of Electrical Contractors reprimanded Phillip Rello, an electrical contractor, based on his execution of a civil Consent Order for disability fraud.

Physical Therapy

In the Matter of Lupe Amy Gonzalez, P.T.

On April 12, 2005, the New Jersey Board of Physical Therapy reprimanded Lupe Amy Gonzalez, P.T., based upon Gonzalez's involvement in the unauthorized practice of physical therapy, charging excessive fees, billing for services not rendered, and overutilizing services rendered.

OIFP Industry Contacts

Office of the Insurance Fraud Prosecutor

Insurance Fraud Prosecutor	Greta Gooden Brown	609-896-8779	Lawrenceville
First Assistant Prosecutor	John J. Smith, Jr.	609-896-8767	Lawrenceville
Deputy Chief Investigator – Civil	Sheila Brown	609-896-8725	Lawrenceville
Deputy Chief Investigator – Criminal	Richard Falcone	609-896-8718	Lawrenceville
Chief, Liaison Section	John Butchko	609 896-8747	Lawrenceville

OIFP Liaison Section

County Prosecutor Liaison (Cases)	Scott Patterson	609 896-8897	Lawrenceville
County Prosecutor (Grant Program)	Joan Enright	609 896-8752	Lawrenceville
Law Enforcement Liaison, SSI	Barry Riley	609-896-8854	Lawrenceville
Industry Liaison, Chief	John Butchko	609-896-8747	Lawrenceville
Assistant Industry Liaison	Carol Naar	609-896-8712	Lawrenceville
Professional Boards Liaison	Charles Janousek	609-896-8748	Lawrenceville

OIFP Case Screening, Litigation and Analytical Support Section (CLASS)

Supervising DAG	Scott Patterson	609 896-8897	Lawrenceville
Supervising State Investigator	Barry Riley	609 896-8854	Lawrenceville
Case Screening and Assignments	Michele Margiotta	609-896-8912	Lawrenceville

OIFP Investigative Sections

Criminal Prosecutions			
1st Assistant Prosecutor	John J. Smith, Jr.	609-896-8767	Lawrenceville
Criminal Investigations			
Deputy Chief Investigator	Richard Falcone	609-896-8718	Lawrenceville
Civil Investigations			
Deputy Chief Investigator	Sheila Brown	609-896-8725	Lawrenceville

State of New Jersey Department of Banking and Insurance

Fraud Compliance and Annual Reports			
Supervisor	Virgil Dowtin	609 984-7310 *Ext. 50402*	Trenton
Producer Investigations			
Manager	William O'Byrne	609-292-5316 *Ext.* 50032	Trenton

State of New Jersey Motor Vehicle Commission

Business Licensing (Auto Body Repair Facility)			
Manager	Yvonne Dawkins	609-777-1691	Trenton
Security, Investigations and Internal Audit			
Director	Ken Shuey	609-984-5279	Trenton
Business License Compliance Monitoring			
Manager	Peter Curatolo	609-984-1122	Trenton

Industry Trade Groups

New Jersey Special Investigators Association	Paul Gallo	631-547-4636
New Jersey Vehicle Theft Investigators Association	Foster Badgley	973-252-7390
International Association of Special Investigative Units – Delaware Valley Chapter	Thomas Donahue	610-276-3842

County Prosecutor Insurance Fraud Contacts

Atlantic County	Chief Asst. Pros. James McClain	609-909-7816
	Sgt. Samuel Cucciniello	609-909-7866
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. Mindy Mellits	856-225-8688
	Inv. David Baldino	856-580-6068
Cape May County	Inv. George Hallett	609-465-1135
Cumberland County	Det. Sandra Silvestri	856-433-0486 *Ext. 3001*
Essex County	Asst. Pros. Jeffrey Cartwright	973-266-7226
	Asst. Pros. Michael Morris	973-266-7232
Gloucester County	Asst. Pros. Margaret Cipparrone	856-384-5648
	Det. William Perna	856-384-5645
Hudson County	Asst. Pros. Michael Zevits	201-795-6529
	James Hoppes	201-533-2425
Hunterdon County	Det. Kristen Larsen	908-788-1580
Mercer County	Asst. Pros. Jeffrey Rubin	609-278-8009
	Sgt. Frank LaBelle	609-278-4863
Middlesex County	Asst. Pros. Ronald Abramowitz	732-745-4108
Monmouth County	Asst. Pros. John Loughrey	732-577-6618
Morris County	Asst. Pros. Lawrence Whipple	973-631-5193
	Lt. Daniel McNamara	973-285-6271
Ocean County	Asst. Pros. Martin Anton	732-929-2027
	Inv. Mark Malinowski	732-929-2027 *Ext. 4032*
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. John Fodor	908-575-3419
Sussex County	Det. Douglas Porter	973-383-1570 *Ext. 4403*
Union County	Asst. Pros. Eleanor Beaumont	908-527-4670
	Sgt. Steven Siegel	908-527-4658
Warren County	Det. Clement Mezzanotte	908-475-6631