

N E W J E R S E Y

INSURANCE **Fraud**

***Exposing
Disability
Scam
Artists***

**Targeting Excessive
Ambulatory Surgical Center Fees**

**Protecting New Jersey's
Elderly Population**



2006 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor

Annual Report of

The New Jersey Office of the Insurance Fraud Prosecutor

for Calendar Year 2006

Submitted March 1, 2007 (Pursuant to N.J.S.A. 17:33A-24d)

Stuart Rabner, 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

Editor

Greta Gooden Brown
Insurance Fraud Prosecutor

Co-Editor

John J. Smith
First Assistant Insurance Fraud Prosecutor

Co-Editor/Copy Editor

Joan Enright
Administrative Analyst

Feature Writers

Frank P. Brennan, Esq.

John Butchko
Special Assistant

John Grady
Deputy Attorney General, DOL

William Hoyman
Deputy Attorney General

John Kennedy
Assistant Attorney General

Lewis Korngut
Supervising Deputy Attorney General

John Krayniak
Assistant Attorney General

Scott Patterson
Supervising Deputy Attorney General

Ray Shaffer
Administrative Liaison

John J. Smith
Assistant Attorney General

Sherry L. Wilson
Deputy Attorney General

Contributors

Michelle Apgar
Supervising Civil Investigator

Paula Carter
Supervising Analyst

Norma Evans
Supervising Deputy Attorney General

Jennifer Fradel
Deputy Attorney General, DOL

Charles Janousek
Special Assistant

Pat Miller
Administrative Assistant

Photographers

Carlton Cooper, *Civil Investigator*
Susan Cedar, *Administrative Assistant*

Production

Paul Kraml, *Art Director*
Enrique Pinas, *Graphic Designer*
Sina Adl, *Graphic Designer*

Administrative and Technical Support

Susan Cedar, *Administrative Assistant*
Cynthia Ronan, *Administrative Assistant*
Gina Lemanowicz, *Civil Investigator*



Table of Contents

About the Cover

The cover of the 2006 Annual Report of the Office of the Insurance Fraud Prosecutor (OIFP) features “Dancing Susan.”

Susan represents that category of insurance fraud cheat who claims that she is disabled and unable to perform the duties of her occupation or of her daily life, but still is able to “live it up” on the money obtained from phony insurance disability claims. Cases prosecuted by OIFP demonstrate that insurance cheats who submit phony disability claims include licensed professionals such as doctors, lawyers, podiatrists, State employees, as well as persons from many other walks of life.

Phony disability insurance claims can take the form of false submissions to workers’ compensation insurance plans, to Social Security disability, and to other insurance companies to replace lost wages, lost income from a professional business or practice, or to pay off loans and other debts that the claimant claims he can no longer pay because he is purportedly “disabled.” If a person elects to engage in phony disability insurance fraud, he or she can be criminally prosecuted and sent to jail. A person can also be sued for a civil insurance fraud violation and ordered to pay civil penalties and restitution. If the person is a professional licensee, he or she may also suffer loss of his or her professional license.

A description of these cases can be found on page 12 of the 2006 Annual Report, and on pages 92 to 93, 110, 113, and 115.

Table of Contents

Message from the Insurance Fraud Prosecutor: "Where Do We Go From Here?"	4	OIFP Scores Supreme Court Victory	40
OIFP Table of Organization	8	The Growing Problem of Rate Evasion	44
OIFP Year in Review: OIFP Maintains Steady Gains in Criminal and Civil Sanctions	10	NJ Insurance Industry's Perspective on Ambulatory Surgical Centers	48
2006 Licensing Sanctions Imposed on Insurance Professionals by DOBI	21	NJ Legislature Takes Aim at Fraud and Abuse in the Medicaid Program	52
2006 Sanctions Imposed on Licensed Professionals by Professional Boards	21	Closing the Loopholes on Insurance Fraud: OIFP's 2006 Recommendation for Legislative Reform... Extending Immunity for AntiFraud Information Sharing	58
OIFP Criminal Investigations and Prosecutions Statistics	22	Insurance Fraud Prosecutor Case Notes	66
OIFP Civil Investigations and Litigation Statistics	22	Case Index	68
OIFP Criminal and Civil Monetary Sanctions and Restitution Summary 2001-2006	23	OIFP Criminal Case Notes	70
OIFP Criminal Charges Summary 2001-2006	23	Putting the Brakes on Unscrupulous Insurance Licensees	99
Criminal Cases Investigated in 2006 by Fraud or Provider Type	24	Protecting the Elderly Population	106
OIFP and County Prosecutors' Offices Total Defendants Sentenced to Jail 2002-2006	25	OIFP Civil Case Notes	108
New Jersey Observes First Annual Insurance Fraud Awareness Month	26	DOL Civil Litigation Case Notes	112
OIFP Funds County Prosecutors' Insurance Fraud Fighting Efforts	30	Professional Licensing Proceedings	114
County Prosecutors' Offices Case Notes ...	32	OIFP/Government/Industry Contacts	116
OIFP Budget for FY2006	38	County Prosecutor Contacts	117
OIFP Expenditure Report for FY2006	39		

A Message from the Insurance Fraud Prosecutor





A Message from the Insurance Fraud Prosecutor

Where Do We Go From Here?

I am pleased to present the 8th Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor (OIFP). In addition to reporting to the Governor and the Legislature on the accomplishments of OIFP and the effectiveness of its operations and programs during 2006 as required by N.J.S.A. 17:33A-24d, this year's Annual Report contains articles of interest to the public, the insurance industry, the judiciary, law enforcement, and other government officials. Having exceeded our 2006 goals, the Report begins with the question, "Where Do We Go From Here?" In order to answer that question, I must begin by first recounting OIFP's accomplishments in aggressively confronting insurance fraud since its inception in 1999.

Since its creation, OIFP's award winning fraud fighting bureau has charged 1,553 defendants with insurance fraud related crimes and obtained 838 years in state prison sentences. In addition, OIFP has imposed 14,325 civil sanctions for violations of the civil fraud act, a feat that has earned OIFP world renowned acclaim for leading the nation in fighting insurance fraud. OIFP has also obtained court ordered restitution awards for victimized entities and individuals totaling over \$168.3 million and imposed over \$38.3 million in criminal and civil fines.

In 2006 alone, OIFP prosecutors and investigators charged 220 defendants with crimes related to insurance fraud and sent defendants to jail for a combined total of approximately 81 years. In so doing, OIFP increased the number of Indictments and Accusations filed from last year by 30% and 25%, respectively. OIFP also obtained restitution orders totaling nearly \$35 million, thereby exceeding OIFP's insurance industry supported budget by approximately \$5 million.

OIFP's war on insurance fraud is a war fought on three fronts. Consequently, in addition to OIFP's criminal enforcement efforts, in 2006, OIFP imposed 1,263 civil sanctions on insurance fraud cheats representing a 4% increase over last year's figure. The dollar value of the 2006 civil consent orders issued to fraud doers by OIFP's civil investigators for civil fraud penalties increased by 20% over last year's total to \$6.8 million. If an insurance fraudster refused to execute a civil consent order and admit wrongdoing, civil litigation to obtain a civil settlement or judgment, with its attendant civil penalty, was instituted by civil State attorneys representing OIFP. In 2006, these civil settlements increased to 50 and judgments increased to 167, representing a combined percentage increase of 14% over last year's figure.

On the third front, professional licensing sanctions, OIFP's 2006 accomplishments demonstrate that OIFP has continued to keep the heat on licensed professionals who choose to abuse their licensing privileges and commit insurance fraud. To this end, 29 licensees were sanctioned by courts and various professional licensing boards for insurance fraud related conduct, representing a 4% increase over 2005 figures. An additional 22 licensees, consisting of insurance producers, were sanctioned by the Department of Banking and Insurance in conjunction with OIFP's prosecutions, representing a 175% increase from 2005.

Since its creation, OIFP's award winning fraud fighting bureau has charged 1,553 defendants with insurance fraud related crimes and obtained 838 years in state prison sentences.

A Message from the Insurance Fraud Prosecutor

In vouching for OIFP's sustained success, the most recent report of the Coalition Against Insurance Fraud, a Washington based public policy and advocacy organization for consumer groups and professionals in the public and private sectors, once again ranks OIFP as a national leader in fighting insurance fraud.

In 2006, OIFP prosecuted individuals and entities for committing auto, medical, disability, property, and Medicaid fraud in hundreds of cases, some of which bear highlighting. For example, OIFP dismantled several large-scale auto theft rings, some of which operated out of car dealerships and solicited, among other things, owner initiated false auto theft claims or “give ups.” These cases also involved the illegal duplication of ignition keys through fraudulent locksmithing, the involvement of employees working at the car dealerships, and the fencing of stolen cars across the country on the internet through eBay. OIFP’s prosecution recovered over 150 stolen high-end vehicles from the tri-state area valued at over \$3 million.

OIFP also prosecuted a racketeering case involving two lawyers, their law firm, several “runners,” and approximately 28 phony claimants, all of whom were allegedly engaged in a scheme to submit phony automobile accident insurance claims in excess of \$5 million, as part of a corrupt personal injury legal practice. Additionally, the owner of a body shop, two police officers, and seven others were indicted for allegedly staging accidents to obtain over \$100,000 in fraudulent auto damage claims, and a licensed chiropractor was convicted by OIFP, along with seven others, for staging accidents in order to submit phony Personal Injury Protection (PIP) claims to five insurance carriers for over 300 bogus chiropractic treatments.

In a sophisticated life insurance fraud scheme, OIFP prosecuted a woman who pled guilty to falsifying nine life insurance claims valued at over \$1 million by providing false death certificates purporting to establish her own death and posing as her daughter, who was the designated beneficiary on the policies, in order to collect the proceeds. She collected over \$700,000 on the false claims before her scheme was detected by the defrauded carriers. An insurance agent was also charged by OIFP and pled guilty in 2006 to falsifying insurance policy applications in order to collect a quarter of a million dollars in up-front life insurance sales commissions. In another life insurance scam, OIFP charged an individual for falsifying a life insurance application in order to obtain \$1 million in life insurance benefits on the life of his brother who had perished in the September 11 attack on the World Trade Center.

OIFP also convicted a Board Certified plastic surgeon who defrauded four insurance companies out of approximately \$1 million by claiming that he was totally disabled and unable to practice plastic surgery when, in fact, he performed dozens of surgical procedures. On the eve of trial, the surgeon entered a guilty plea and was sentenced to prison for three years. Following an 11-week-long jury trial, OIFP obtained a conviction of a businessman who had been indicted in connection with his submission of fraudulent insurance claims totaling almost \$400,000 arising out of an arson fire at his commercial property. The defendant was convicted of conspiracy, attempted theft by deception, and witness tampering. The jury found that the defendant had, among other things, padded his contents claim by alleging that articles inside his premises had been damaged by the fire when, in fact, no such articles had been in the premises at the time of the fire. The defendant was sentenced to 11 years in state prison and is appealing his conviction.

In another OIFP trial victory, a Camden police officer was convicted for conspiracy, official misconduct, bribery, and Criminal Use of Runners for his role in selling police accident reports to a retired Camden police officer so that “runners” could illegally solicit individuals listed in the reports for treatment at a chiropractic facility with which he was affiliated. He was sentenced to four years in state prison. In yet another 2006 trial victory, the manager of a pharmacy, the pharmacy technician, and the pharmacy itself were convicted for billing the Medicaid program for prescription medications that were never dispensed and providing illegal kickbacks to Medicaid beneficiaries. The kickback scheme targeted HIV/AIDS patients and induced them to sell their AIDS medications back to the pharmacy. The individual defendants were sentenced to five years and six and one-half years in state prison, respectively.

Equally noteworthy are OIFP's 2006 accomplishments in its civil enforcement efforts. OIFP scored a monumental victory in a New Jersey Supreme Court decision that reversed the lower courts and held that the burden of proof in civil insurance fraud actions is the preponderance of the evidence standard, rather than the higher clear and convincing standard urged by our adversaries. In 2006, OIFP also imposed civil fines on a doctor and his office manager in the amount of \$4.5 million for, among other things, operating an unlicensed MRI facility for approximately ten years. In another case, OIFP fined an MRI facility \$1 million for operating without a license for two years.

In vouching for OIFP's sustained success, the most recent report of the Coalition Against Insurance Fraud, a Washington based public policy and advocacy organization for consumer groups and professionals in the public and private sectors, once again ranks OIFP as a national leader in fighting insurance fraud. According to the Coalition report, out of 47 state fraud bureaus, OIFP ranked fourth in the number of fraud convictions, second in the amount of restitution, and first in the number of civil sanctions. The Coalition's report also revealed that while OIFP received the fifth largest number of referrals, OIFP opened more cases than any other state.

These results represent the culmination of OIFP's successful partnerships with the insurance industry and County Prosecutors' Offices throughout the State. This 2006 Annual Report, like the seven reports that preceded it, gives testament to the close cooperation and collaboration which form the bedrock of OIFP's partnerships. Our collective eight years of experience teaches that to answer the question "where do we go from here," we must acknowledge that fraud schemes are far more complex and sophisticated than they have been in the past. Fraud fighters must now target licensed medical service providers who manipulate federal and State regulations, as well as diagnostic and procedure codes, in ever more sophisticated ways in order to exploit and defraud our insurance system. Simultaneously, fraud fighters must also target more clever and devious fraudsters from every profession and walk of life, including both career criminals and opportunistic swindlers.

Whereas in the past, we have had the luxury of focusing on single incident theft cases, OIFP and its partners must now focus our shrinking resources on complex organized theft schemes that systematically and repeatedly loot large sums of insurance dollars. These are the types of cases that will have the greatest impact in combating insurance fraud in New Jersey, will aid in eliminating fraud costs from the insurance marketplace, and will restore tax dollars to our government sponsored health programs. However, by choosing to follow this path, we must also adopt new benchmarks for success. Indeed, focusing on "impact" cases means foregoing the numerical measures of success that we have come to expect.

Therefore, OIFP, with the help of our allies, will build on our eight-year record of success, including the exceptional results obtained in 2006, to target the most complex and highest impact cases which threaten the insurance industry and the insurance purchasing public in New Jersey. While this focus may result in fewer overall cases being prosecuted in the future, the quality of the prosecutions which are brought, as measured by the impact those prosecutions have on deterring the most egregious insurance fraud cheats, will inure to the benefit of New Jersey citizens and businesses and will serve to take OIFP and its partners to the next level. I am honored to be a part of this effort and I am grateful for the continued support of our allies in the insurance industry, law enforcement, and other government agencies as we set our sights onward and upward.

OIFP, with the help of our allies, will build on our eight-year record of success, including the exceptional results obtained in 2006, to target the most complex and highest impact cases which threaten the insurance industry and the insurance purchasing public in New Jersey.

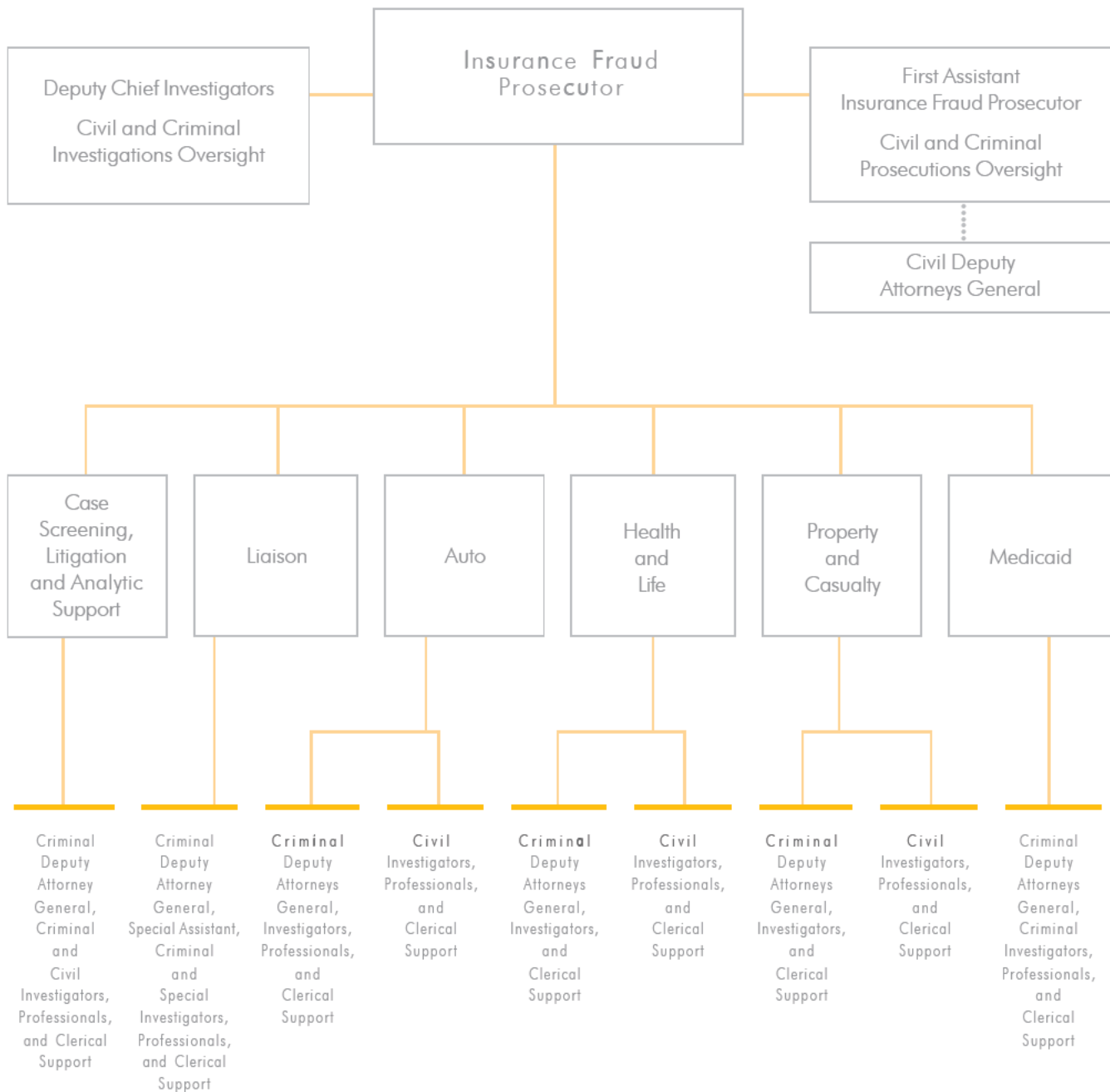
Respectfully submitted,

Greta Gooden Brown

New Jersey Insurance Fraud Prosecutor

Table of Organization

Office of the Insurance Fraud Prosecutor









The Year in Review:

OIFP Maintains Steady Gains in Criminal and Civil Sanctions

by John J. Smith

Background

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

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

As a law enforcement agency, OIFP's primary focus is criminal prosecution. AICRA also required, however, that to ensure the most effective coordination of public and private anti-fraud efforts, certain civil enforcement functions of the Division of Insurance Fraud Prevention, Department of Banking and Insurance, would be transferred to OIFP pursuant to a plan of reorganization which became effective on August 24, 1998. (Reorganization Plan 0007-98).

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

This report constitutes the 8th Annual Report submitted by OIFP pursuant to N.J.S.A. 17:33A-24d, which requires OIFP to annually provide a report of activities conducted during the prior calendar year to the Governor and the Legislature.

OIFP-Criminal

OIFP-Criminal investigates and prosecutes all types of insurance fraud, most of which involve health, disability, auto, homeowners, life, or commercial insurance coverages, including both claims and application underwriting fraud. During 2006, OIFP-Criminal maintained a configuration comprised of four substantive sections, namely, Health and Life; Auto; Property and Casualty; and Medicaid Fraud.

Health and Life Section

Health care insurance fraud accounts for as much as ten percent of our national health care costs according to the United States Accounting Office. While these losses

are initially borne by health care insurers and HMOs, they are ultimately passed on to the health care consumer in the forms of increased premiums and deductibles, and may also result in a reduction in the number of eligible insureds and a narrowing of the scope of coverage provided under health insurance policies.

Health care claims fraud can be committed by health care practitioners, such as doctors, chiropractors, and dentists; by those providing health care related services, such as invalid transportation and medical billing businesses; or by patients themselves. Health care claims fraud is committed when a business or individual makes a misrepresentation in the course of submitting a claim for benefits under a health insurance policy. *N.J.S.A. 2C:21-4.2*. A patient may commit health care claims fraud, for example, by submitting a claim for treatment expenses for feigned injuries, or by submitting altered medical receipts for reimbursement of legitimate claims. A physician may commit health care claims fraud by knowingly submitting a bill for services that were either unnecessary or not rendered at all. Several examples of health care claims fraud cases prosecuted by OIFP are reported in OIFP's criminal case notes.

OIFP's Health and Life Section also prosecutes disability and life insurance

fraud. Disability fraud occurs when an individual misrepresents the disabling condition or the employment status of the individual in order to obtain benefits under a disability insurance policy. The disability policies involved in these cases are sometimes purchased by licensed professionals and provide substantial disability benefits. Life insurance fraud can take the form of misrepresentations submitted in connection with a claim for the proceeds of a life insurance policy. These types of cases may or may not include the actual death of the insured. Actual case examples of both types of fraud are included in OIFP's criminal case notes.

Auto Section

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

those treatments. Cases involving medical service providers committing PIP insurance fraud are routinely assigned to the Auto Section.

Uninjured occupants of vehicles involved in collisions are sometimes contacted by "runners" and encouraged to pursue claims for purported "soft tissue" injuries, such as back sprains, also known as "whiplash." Such soft tissue injuries are frequently claimed because they often are not verifiable by the use of common diagnostic visualization techniques such as x-rays and Magnetic Resonance Imaging (MRI). Instead, proof that a claimant has sustained soft tissue injuries is usually dependent upon subjective factors, such as "limitation of motion" and the claimant's subjective complaints, which can be easily fabricated by unscrupulous claimants seeking to exploit the system. These are among the most difficult and complex cases investigated and prosecuted by OIFP's Auto Section.

"Runners" typically receive an illegal fee or commission for recruiting potential claimants and referring them to unscrupulous medical providers and/or attorneys who, in turn, benefit by providing unnecessary medical services or pursuing unwarranted claims for monetary damages. See *N.J.S.A. 2C:21-22.1*. Some "runners" resort to planning and staging auto accidents to insure a steady flow of phony injury claimants. Staged accidents typically involve one of several common scenarios, such as the passing of an unsuspecting motorist and abruptly stopping, thereby causing a "rear ender" in which the innocent driver appears to be at fault. Another common scenario involves encouraging an unsuspecting motorist to proceed through a stop sign, or from a parking space, and quickly accelerating to cause a crash, again making it appear that the unsuspecting motorist is at fault.

In other cases, a "runner" or conspirator may claim to have been in an accident where there was no collision at all, such as where a previously damaged vehicle is placed at a public location and it is falsely reported that the vehicle and its occupants were the victims of a crash with a phantom



*First Assistant Prosecutor
John J. Smith reviews prosecution recommendations.*



Recognizing the exemplary performance of DAG Lewis Korngut and SI Robert Stemmer in the field of Fire/Arson Investigation, the Camden County Fire Marshal's Office bestowed upon them the Edward Garrity award. DAG Korngut and SI Stemmer displayed a high level of professionalism and investigative skill during the investigation and subsequent trial of Samuel Siligato. Siligato was found guilty in July 2006 of attempted theft by deception, conspiracy, and witness tampering. The charges were related to a 1998 fire at a property which Siligato owned.

“hit-and-run” vehicle. Persons who claim to be in auto accidents when they were not are sometimes called “jump-in claimants.” Several examples of cases involving “runners” and “jump-in claimants” are included in OIFP’s criminal case notes.

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

Another type of automobile insurance fraud prosecuted by OIFP’s Auto Section involves the staged thefts of automobiles, also known as “give ups,” or owner-initiated fraudulent auto theft claims. In these cases, the owner or lessee of a vehicle abandons the vehicle or turns it over (the “give up”) to a person who agrees to dispose of the vehicle on behalf of the owner or lessee. Sometimes, the vehicle “given up” is not disposed of, but is simply given a different Vehicle Identification Number (VIN). This is known as “re-tagging” and prevents law enforcement from identifying the vehicle as stolen. Once the vehicle has been disposed of or re-tagged, the owner or lessee typically files a fraudulent police

report and insurance claim alleging the vehicle has been stolen in order to collect claim money.

“Give ups” are most often perpetrated where the lessee has exceeded the permitted mileage under a lease and is facing a substantial lease end “penalty” payment to the vehicle leasing company, or where an unscrupulous owner seeks to exploit the difference between the apparent “book value” of a worn or damaged vehicle and its true fair market value. The middleman in a “give up” scheme usually removes the vehicle to a secluded location and attempts to completely destroy it in order to preclude its return to the owner, usually by dousing the vehicle with an accelerant, such as gasoline, and burning it.

Sometimes, a vehicle’s owner or lessee turns the vehicle over to members of a stolen car ring who have established relationships with unscrupulous auto body repair shops, also known as “chop shops,” which disassemble vehicles and sell the parts on the black market. Stolen car rings may also smuggle vehicles out of the country for resale at prices significantly below fair market value. Re-tagged vehicles are often sold to unsuspecting buyers. Sometimes, these sales occur in person. Other times, these sales are made through advertisements in trade newspapers or on eBay.

OIFP’s Auto Section also prosecutes a large number of cases involving fictitious insurance identification cards. Fictitious insurance identification cards enable persons to skirt mandatory insurance laws and drive without auto insurance. Undoubtedly spawned by high auto

insurance premiums, there exists a considerable black market in New Jersey for fictitious insurance identification cards. Motorists who drive uninsured expose the law abiding motoring public to substantial losses resulting from inadequate insurance coverage.

Property and Casualty Section

OIFP's Property and Casualty Section investigates and prosecutes cases involving property insurance claims. These typically include cases where homeowners falsely claim damage to their property or falsely claim a property loss in order to submit an insurance claim.

The Property and Casualty Section also investigates allegations of fictitious certificates of insurance provided by contractors, as well as cases involving licensed insurance agents who commit theft of premiums or engage in a variety of fraudulent premium financing schemes. These latter cases are often complex, involve many insurance purchasing victims and/or insurance premium finance companies, and often result in theft of large sums of money. Examples of all of these cases are included in OIFP's criminal case notes.

Medicaid Fraud Section

OIFP's Medicaid Fraud Section investigates and prosecutes all categories of Medicaid provider fraud, elder abuse and neglect, and fraud in the administration of the Medicaid program. Medicaid is a state and federally funded health insurance program that provides reimbursement for the health care expenses of the disabled, economically disadvantaged, and, more recently, those who work, but whose income and health benefits fall below certain levels. In New Jersey, the cost of the program is shared equally by the State and federal government. The State's share of Medicaid expenditures represents approximately 15 percent of its annual budget.

The New Jersey Legislature has recognized that billions of dollars are spent each year on health care in New Jersey and approximately 10 percent of these costs can be attributed to fraud. Medicaid fraud is a serious problem with far ranging consequences, not only for taxpayers, but for those who depend on these programs for their health care. In order to preserve the financial integrity of the Medicaid health care system in New Jersey, the Attorney General deems it

essential to maintain, within the Office of the Insurance Fraud Prosecutor, a unit designed to investigate and prosecute Medicaid fraud cases.

The Medicaid Fraud Section receives 75% of its operational funding from the federal government. Since the Medicaid Fraud Section typically recovers more money in restitution and penalties than the 25% State matched portion of its budget, the Medicaid Fraud Section constitutes an extremely cost effective means of combating fraud and abuse in the administration of the Medicaid program.

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

Changes to federal law authorize the Medicaid Fraud Section to also prosecute health care fraud in any federally funded health care programs, including Medicare, when the case involves a connection to Medicaid fraud and the appropriate Inspector General of the involved federal agency consents. Moreover, changes in guidelines issued by the federal government encourage the Medicaid Fraud Section to negotiate civil settlements in appropriate cases, such as when the evidence may be insufficient to satisfy the higher burden of proof required at a criminal trial but there is sufficient evidence to make the determination that an overpayment has been made to a provider.

The Medicaid Fraud Section's ability to settle civil cases has proven to be very



Supervising Deputy Attorney General Scott Patterson provides legal advice to law enforcement.



Deputy Chief Investigator Richard Falcone discusses investigative strategies with Manager Ronald Dellanno.

effective in protecting the Medicaid program from overpayments that would not otherwise be recovered. In addition, by collaborating with the Medicaid Fraud Units in 47 other states and the District of Columbia, as well as federal authorities, OIFP's Medicaid Fraud Section has been aggressive in utilizing settlement authority to recover monies from providers whose business is national in scope. Most of these cases, which have dramatically increased over the past several years, are initially filed under the Federal False Claims Act. All monetary recoveries and penalties are generally allocated based upon a state's actual Medicaid damages. State and federal prosecutors work as a team on each case, negotiating the best possible settlement for their respective governmental entities. In addition to restitution and possible civil or administrative penalties, all settlements require a corporate integrity agreement and, where appropriate, criminal action against the offending parties. Examples of these civil settlements are reported in the case notes.

Medicaid fraud increases commensurately with an increase in program benefits. One provider group in particular, non-emergency transportation providers, continues to generate significant criminal investigations and prosecutions in the Medicaid Fraud Section. The New Jersey Medicaid program reimburses providers of non-emergency transportation who transport Medicaid recipients between their homes and the place where a Medicaid covered service is rendered. The Medicaid program provides different modes of transportation based on the recipient's ability to ambulate without physical assistance. Livery transportation is provided to those who can freely ambu-

late and do not need assistance. Mobility assisted vehicles, formerly referred to as invalid coach transportation services, are provided to those who are wheelchair bound or not able to ambulate on their own due to an existing medical or mental condition.

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

On another front, the Medicaid Fraud Section continues to focus significant resources on pharmacy cases. Several Medicaid investigations and prosecutions target pharmacists involved in illegal kickback schemes, fraudulent billings for prescription medications that were never dispensed, and illicit drug diversion. Various investigative techniques are utilized to combat these criminals whose sole purpose is to defraud the Medicaid

program. The Medicaid Fraud Section has adopted a more aggressive use of undercover infiltration, search warrants, and arrest warrants. These law enforcement tools are used to gain the advantage of secrecy and surprise.

Organizational and Operational Structure

State Investigators in the Division of Criminal Justice, Department of Law and Public Safety, who are assigned to OIFP are responsible for conducting OIFP's criminal investigations. OIFP's criminal cases are prosecuted by Deputy Attorneys General within the Division of Criminal Justice, who are similarly assigned to OIFP. These State Investigators and Deputy Attorneys General are assigned to the specialized Health and Life, Auto, Property and Casualty, and Medicaid Fraud Sections in OIFP-Criminal.

The Deputy Attorneys General in each section are supervised by a Supervising Deputy Attorney General, while the State Investigators in each section are supervised by a Supervising State Investigator. The Supervising Deputy Attorneys General report directly to the Insurance Fraud Prosecutor. Supervising State Investigators report to the Deputy Chief Investigator in charge of criminal investigations.

A team of analysts, technical assistants, paralegals, and other professional support staff provides support and assistance to the investigators and prosecuting attorneys in OIFP-Criminal. Support staff assist in organization and analysis of documents, records, and related data compiled in the course of conducting criminal investigations. They also perform case and financial analysis, legal research, case tracking, and other administrative functions. OIFP-Criminal operates utilizing a strike force model whereby the Deputy Attorneys General, Investigators, and professional and clerical support staff work together to investigate and prosecute insurance fraud and Medicaid fraud throughout the State.

OIFP - Civil

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

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

Civil Health Care Fraud

As indicated previously, the problem of health care related fraud, within the context of both health insurance and automobile insurance, is among the greatest challenges faced by OIFP and others engaged in the battle against insurance fraud in New Jersey. While OIFP places a premium on the criminal prosecution of medical service providers and others who defraud the insurance delivery system by submitting claims for services not rendered, for non-existent injuries, and for medical treatments which are not necessary, there are some medical fraud cases which pose subjective questions of medical judgment which are not always best resolved in the criminal forum where the standards of proof are the highest and the rules of evidence are the most exacting.

For cases where criminal prosecution is not the appropriate remedy, the OIFP-Civil Health and Life squads investigate with a view towards imposing monetary penalties for fraudulent conduct. Additionally, the squads closely coordinate with the professional licensing boards to impose licensing sanctions where



Acting Team Leader Douglas Graham reviews an investigation report.

1. Civil violations in relation to the Medicaid program do not fall under the purview of the Fraud Act. Such violations are cognizable pursuant to N.J.S.A. 30:4D-17e.



Division of Law Deputy Attorney General Barbara Zimmerman prepares a brief for civil litigation.

appropriate. Among the cases falling within the purview of Civil Health and Life squads are fraudulent billings submitted by medical providers for unnecessary medical procedures, overstated medical procedures (upcoding), or procedures and services not rendered as billed to insurance companies and plans. By consolidating resources in a specialized area, OIFP obtains the benefit of specialization in this complex area of insurance fraud and assures optimum coordination with interested entities and agencies, such as the Division of Consumer Affairs' Enforcement Bureau and referring insurance carriers.

Civil Auto, Property and Casualty Fraud

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

A "give up" is one of the most common scenarios giving rise to a fraudulent auto theft claim, wherein the owner or lessee "gives up" the vehicle to an intermediary for disposal as a predicate to the filing of a fraudulent auto theft insurance claim. These false claims are also sometimes known as owner-initiated fraudulent automobile insurance claims. Within OIFP, both the Criminal and Civil Auto Sections investigate auto insurance fraud, to include automobile "give ups."

As noted, OIFP's Criminal Auto Section routinely files criminal cases charging

theft or insurance fraud in cases in which there is evidence to prove that the owner of the automobile falsely reported his vehicle stolen to the police and to the insurance company to steal insurance claim money. Typically, this evidence is obtained when the insured confesses or when, unbeknownst to the insured, law enforcement has the automobile in its possession prior to the date and time the insured reported he last saw the purportedly stolen car. In other cases where the evidence of a false report of theft is circumstantial and the Insurance Fraud Prosecutor, in a sound exercise of prosecutorial discretion, believes that the case cannot be proved in a criminal court beyond a reasonable doubt, OIFP's Civil Auto squads will investigate and impose civil fraud penalties in appropriate cases.

OIFP Investigators receive specialized training in auto theft forensics and are tasked with, among other things, developing working relationships with other government agencies, including fire marshals and other fire officials, who may be helpful in assisting investigators develop leads on new cases. That coordination typically entails a combination of activities, including training by OIFP staff in the identification and investigation of auto theft fraud, review by OIFP staff of local charges relating to the filing of false police reports, and the joint investigation of individuals, suspected rings, or locations reputed to be the last resting place of possible "give ups," to include lakes, rivers, and secluded areas.

Organizational and Operational Structure

OIFP-Civil's staff are assigned to squads which are housed in OIFP's three regional offices located in Cherry Hill

*In recognition of their heroic efforts in apprehending auto theft suspects, on February 23, 2006, State Investigators **Toni Petreski, Jarek Pyrzanowski, and Jeffrey Lorman** received a Senate and General Assembly Citation from the State of New Jersey.*

These OIFP State Investigators exemplified extraordinary service with The Auto Theft Task Force of Essex and Union Counties.

On March 31, 2006, additional commendations were extended by the Director of the Division of Criminal Justice, Gregory Paw, and Chief State Investigator Michael Tarantino.

(South Jersey), Whippany (North Jersey), and Lawrenceville (Central Jersey). Supervising Managers oversee the regional squads, which are each assigned line supervisors and legal overseers. The Supervising Managers for each region report to the Deputy Chief Investigator for civil investigations.

At the conclusion of a civil investigation, if the assigned Civil Investigator determines that the fraud allegation is supported by the evidence, the investigator prepares and serves the subject with an administrative consent order for execution providing for an appropriate civil fine under authority of the Fraud Act. The proposed consent order includes a description of the violation, an admission of facts which establish the fraud, and the amount of the fine. In addition, if the subject is a licensed person or entity, for example, a physician, nurse, attorney, or auto body shop, the consent order also states that the subject's licensing authority will be notified that the subject entered into a consent order in an insurance fraud matter.

If the subject refuses to sign the proposed civil consent order, then the case is referred to the Division of Law for further action, to include litigation. Civil litigation by the Division of Law's Insurance Fraud Unit Deputy Attorneys General is typically pursued where evidence

strongly indicates that the subject of the investigation has violated the Fraud Act and the subject has refused to execute a consent order or agreement requiring payment of an appropriate insurance fraud fine. Civil litigation is also pursued to enforce the provisions of a prior fraud settlement where the fine is delinquent. As with most litigation, a significant percentage of cases are settled before trial. Regardless of how the Division of Law attorneys resolve a matter, the resolution usually entails admissions which establish the fraud, fines, attorney fees, costs, and restitution. Matters are referred for licensing sanctions in appropriate cases. If the fraud allegation involves automobile insurance, and is adjudicated by court order, the order may also require the suspension of driving privileges for one year. *N.J.S.A. 39:6A-15.*

Case Screening, Litigation and Analytical Support Section (CLASS)

Most cases investigated by OIFP are the result of referrals from the Special Investigation Units of insurance companies which are required by law to refer matters of suspected insurance fraud to OIFP. *N.J.S.A. 17:33A-9.* OIFP's well publicized hotline and interactive Web site also generate a significant number of referrals to OIFP, as do other law

enforcement, regulatory, and administrative agencies. In addition, referrals are made pursuant to the provisions of *N.J.S.A. 2C:21-4.7* and *N.J.A.C. 13:88-3* providing a reward for information leading to the arrest, prosecution, and conviction of an insurance fraudster.

The reporting of targets and defendants under investigation by County Prosecutors' Offices generates a substantial number of civil insurance fraud investigations for OIFP. CLASS assists in monitoring these cases and assigning them for civil fraud action by OIFP. In order to ensure effective coordination between OIFP and County Prosecutors' Offices, OIFP maintains a monthly reporting system pursuant to which all subjects under investigation by County Prosecutors' Offices are reported to OIFP on a monthly basis. Regardless of whether those subjects are ultimately prosecuted by the reporting County Prosecutor's Office, the reported subjects are investigated by OIFP-Civil whenever the allegations appear to constitute a civil violation of the Fraud Act.

Upon receipt, all referrals of suspected insurance fraud are date stamped, classified by OIFP region and type of insurance fraud, and subjected to an initial screening by CLASS to determine whether a crime and/or potential civil violation has occurred. If the referral is deemed appropriate for a criminal investigation, the case is assigned to the appropriate section and becomes the responsibility of an OIFP Criminal Investigator and Deputy Attorney General. If the referral is deemed appropriate for a civil investigation, the case is assigned accordingly, and initially, becomes the responsibility of an OIFP Civil Investigator, with legal guidance provided by a Deputy Attorney General.

Of the referrals to OIFP in 2006, CLASS identified 3,030 as warranting further investigation following initial review and screening. Referrals not warranting assignment after initial screening are entered into OIFP's database for future reference should additional information come to light. Many referrals identified for investigative follow-up are



Administrative Assistant Lynn Wasserman, CLASS Unit, screens incoming cases.



Supervising Analyst Paula Carter compiles statistics for OIFP's Annual Report.

assigned initially to OIFP-Civil. However, as noted, some referrals may be assigned directly for criminal investigation immediately following initial screening. Civil investigations are continually monitored and evaluated with respect to their potential for possible referral for criminal prosecution. Most of the cases prosecuted criminally by OIFP have both civil and criminal components. Many of the criminal prosecutions handled by OIFP-Criminal were, in fact, initiated as civil insurance fraud investigations. This procedure ensures the most efficient allocation of OIFP resources and preserves the confidentiality of privileged law enforcement files.

OIFP Liaison and Coordination Functions

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

Section of OIFP includes a County Prosecutor Liaison, a Law Enforcement Liaison, an Insurance Industry Liaison, and a Professional Boards Liaison.

County Prosecutors' Offices

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

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

During 2006, the Attorney General, through OIFP, provided \$3.3 million in funding to 17 of the 21 County Prosecutors' Offices. County Prosecutors have relied upon the funds to fund fraud-fighting personnel, including Assistant Prosecutors and Investigators, and to purchase equipment for combating insurance fraud. OIFP also continued its training program for County Prosecutor investigative and prosecutorial personnel by conducting a full day seminar at the Dempster Training Academy in

Lawrenceville on May 26, 2006. In addition, OIFP personnel conducted ten site visits to County Prosecutors' Offices in 2006 to review their fraud-fighting programs and provide guidance and assistance in investigating and prosecuting insurance fraud cases, as well as identifying new initiatives.

OIFP liaison personnel are also responsible for the coordination of insurance fraud case referrals, investigations, and prosecutions between OIFP and County Prosecutors' Offices, as well as other law enforcement agencies. In order to coordinate investigations and prosecutions, avoid duplication of effort among law enforcement agencies, and ensure that OIFP identifies appropriate cases for the imposition of civil penalties, County Prosecutors' Offices provide OIFP with a monthly update as to the status of all insurance fraud related matters pending within each County Prosecutor's Office. Information provided by County Prosecutors' Offices is entered and maintained in OIFP's broader investigative and case tracking database.

Law Enforcement

AICRA recognized that coordination among law enforcement agencies at every level is crucial to ensuring the effectiveness of a broad-based program to reduce the incidence of insurance fraud. Aggressive enforcement requires the sharing of information and resources among law enforcement professionals, from the local police officer checking a drivers license, insurance identification card, and registration, to State and federal investigators probing sophisticated insurance scams. OIFP's Law Enforcement Liaison maintains open lines of communication with municipal, county, State, and federal law enforcement officials to meet these objectives.

The Law Enforcement Liaison also provides assistance to local law enforcement agencies in the identification, investigation, and charging of insurance fraud offenses by developing and coordinating insurance fraud training for the law enforcement community. Except in a relative handful of urban areas which have served as hubs for auto insurance fraud over the years, most local law enforcement agencies are not trained to

deal with the challenges presented by the subtleties and complexities of insurance fraud. To address the need for insurance fraud training in the local law enforcement community, and to enlist the participation of local law enforcement agencies in the battle against insurance fraud, the OIFP Law Enforcement Liaison has coordinated periodic fraud training programs for law enforcement personnel throughout the State.

In 2006, the Law Enforcement Liaison also conducted periodic regional coordination meetings of municipal, county, and federal law enforcement officials. These meetings afford the attendees the opportunity to meet counterparts in other participating agencies, to establish ongoing channels of communication with one another, and to share information and resources, as appropriate. OIFP's regional coordination meetings have also featured speakers on insurance fraud related topics, such as organized insurance crime rings, sophisticated identity theft scams, and forensic investigative techniques.

Insurance Industry

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

As the primary point of contact, the Insurance Industry Liaison routinely provides advice, guidance, and technical assistance to members of the insurance industry. As a charter member of the New Jersey Special Investigators Association

(NJSIA), the Insurance Industry Liaison has also been instrumental in organizing and promoting the two-day Annual NJSIA Conference, which has served over the years to offer valuable training and networking opportunities for insurance fraud professionals from both the public and private sectors. The Annual NJSIA Conference is the most highly attended conference of its kind in the United States and provides some of the most valuable educational and training opportunities available today for insurance fraud professionals.

The OIFP Insurance Industry Liaison also played a prominent role in the planning and organization of the Annual Insurance Fraud Summit sponsored jointly by NJSIA and the Insurance Council of New Jersey (ICNJ). At the October 5, 2006, Summit, executives from the insurance industry, as well as senior level staff from the Attorney General's Office, DOBI, and OIFP, presented over 200 attendees with information about OIFP's cases, programs, and initiatives, as well as new fraud trends and schemes.

In addition, during 2006, OIFP's Insurance Industry Liaison hosted or participated in numerous meetings with various industry and trade groups dedicated to combating insurance fraud. These meetings included ongoing working group meetings with industry professionals focusing on areas of shared concern, such as workers' compensation premium insurance fraud.

The Insurance Industry Liaison is also responsible for referring and tracking insurance fraud related matters involving businesses and individuals licensed by DOBI. The Insurance Industry Liaison serves as OIFP's primary contact person for DOBI. In this capacity, the Insurance Industry Liaison served as a key member in the periodic meetings of the DOBI/OIFP Interface Group. Those meetings were attended by representatives of DOBI's Enforcement Division, which oversees the tracking and coordination of case dispositions involving licensed producers, public adjusters, and real estate agents.

Professional and Occupational Boards

Committing civil or criminal insurance fraud can result in professional license suspension, revocation, or other disciplinary actions. Coordination is necessary to ensure that professional licensing boards within the Division of Consumer Affairs, Department of Law and Public Safety, are alerted promptly when a licensee is the subject of an OIFP investigation.

Responsibility for coordinating OIFP's activities with those of the professional and occupational boards is assigned to OIFP's Professional Boards Liaison who, prior to joining OIFP in 1998, served as an Executive Director of the New Jersey State Medical Board. Procedures implemented by the Professional Boards Liaison provide for prompt notification to the professional licensing boards by OIFP when licensees are the subject of OIFP investigations. These procedures also provide for reciprocal notification of OIFP by the professional licensing boards so that OIFP can initiate a civil or criminal investigation, as warranted.

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



tion of insurance fraud committed by professional licensees.

During 2006, the Liaison and Continuing Communications Group continued to monitor 555 active insurance fraud related cases. Since its establishment in October 1998 through the end of 2006, the Group reviewed and resolved 1,191 cases through administrative closure, civil or criminal disposition by OIFP, or licensing sanctions by the appropriate professional board. Through this collaborative effort, professional and occupational boards within the Division of Consumer Affairs took disciplinary action against 29 professionally licensed individuals in 2006.

2006 Licensing Sanctions Imposed on Insurance Professionals by the Dept. of Banking and Insurance

	Suspension	Revocation	Surrender	Other	TOTAL
Public Adjusters	0	0	0	0	0
Real Estate Agents	0	0	0	0	0
Insurance Producers	1	20	1	0	22
TOTAL	1	20	1	0	22

2006 Sanctions Imposed on Licensed Professionals by Professional Licensing Boards

	Suspension	Revocation	Voluntary Surrender	Reprimand	TOTAL
Bureau of Securities	0	1	0	0	1
Chiropractic	3	1	1	1	6
Cosmetology	1	0	0	0	1
Dental	2	0	0	1	3
Dept. of Health - EMT	0	1	0	0	1
Medical	4	0	4	1	9
Professional Counselors	0	0	1	0	1
Nursing	1	1	0	0	2
Pharmacy	1	2	0	0	3
Marriage Therapy	0	1	1	0	2
TOTAL	12	7	7	3	29

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.

The Year in Review: OIFP Maintains Steady Gains in Criminal and Civil Sanctions

OIFP Criminal Investigations and Prosecutions Statistics January 1, 2006 – December 31, 2006

New Cases Opened	489
Indictments/Accusations Filed	189
Number of Defendants Charged	220
Number of Defendants Convicted	175
Number of Defendants Sentenced	187
Number of Defendants Sentenced to State Prison	18
Total Number of Years	76
Number of Defendants Sentenced to County Jail	91
Total Number of Years	5
Total Criminal Fines Imposed	\$94,555
Total Criminal Penalties Imposed	\$29,490
Total Civil Penalties/Fines Imposed in Medicaid Cases	\$848,500
Total Restitution Imposed	\$34,704,461 ¹

¹ This total includes restitution imposed in criminal and civil actions

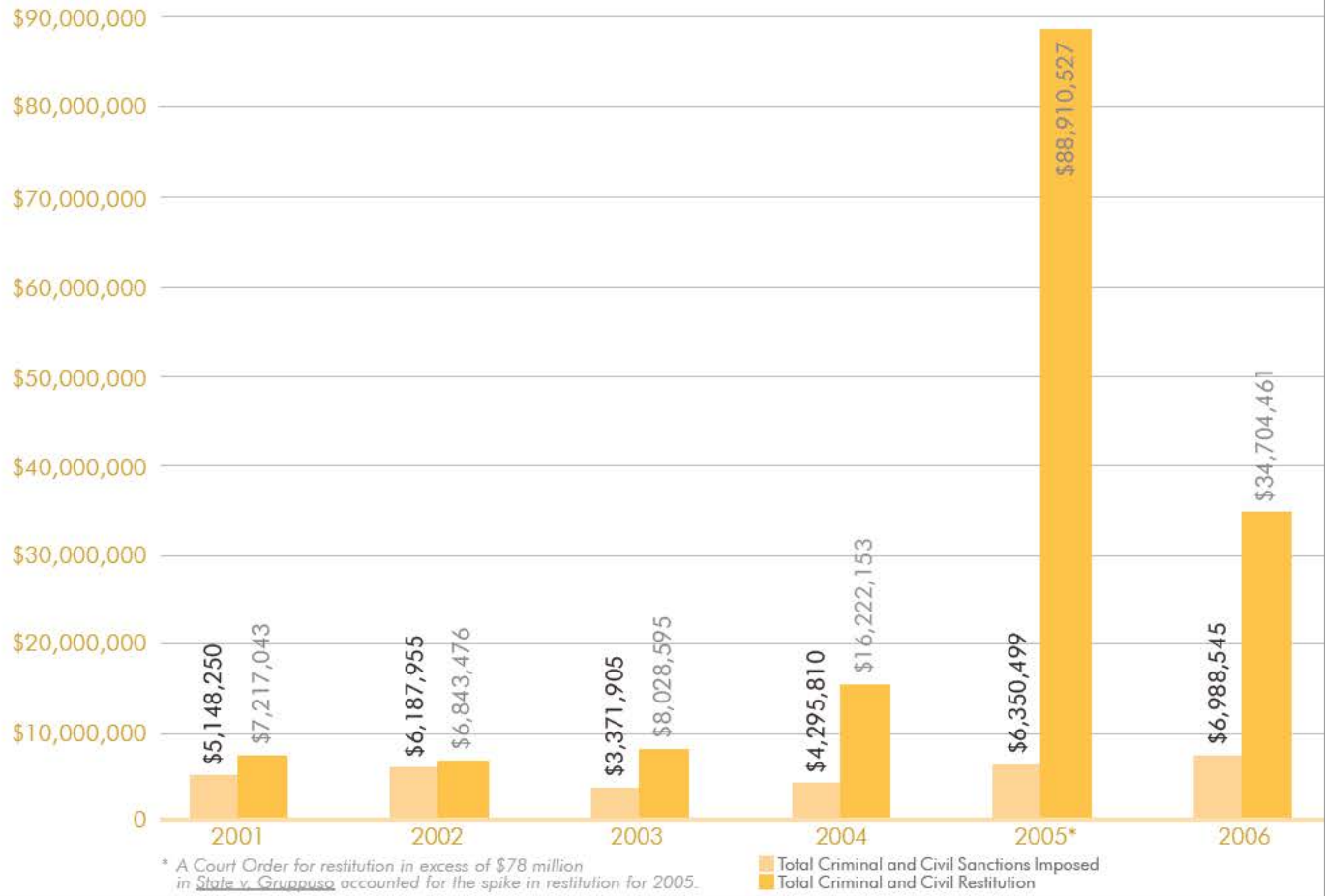
OIFP Civil Investigations and Litigation Statistics² January 1, 2006 - December 31, 2006

	Number	Dollar Amount
Civil Investigations		
New Cases Opened	5,859	—
Number Forwarded for Investigation	3,030	—
No Investigation Warranted	2,829	—
Sanctions Imposed		
Insurance Fraud Letters of Admonition	722	—
Administrative Consent Orders Issued	280	\$6,864,500
Administrative Consent Orders Executed	224	\$984,500
Settlements Entered	50	\$308,114
Judgments Entered	167	\$1,182,552
Complaints Filed	100	—
Collections (Department of Banking and Insurance)³		
Number of OIFP Accounts Paid in Full	450	—
Total Monies Collected	—	\$1,809,373

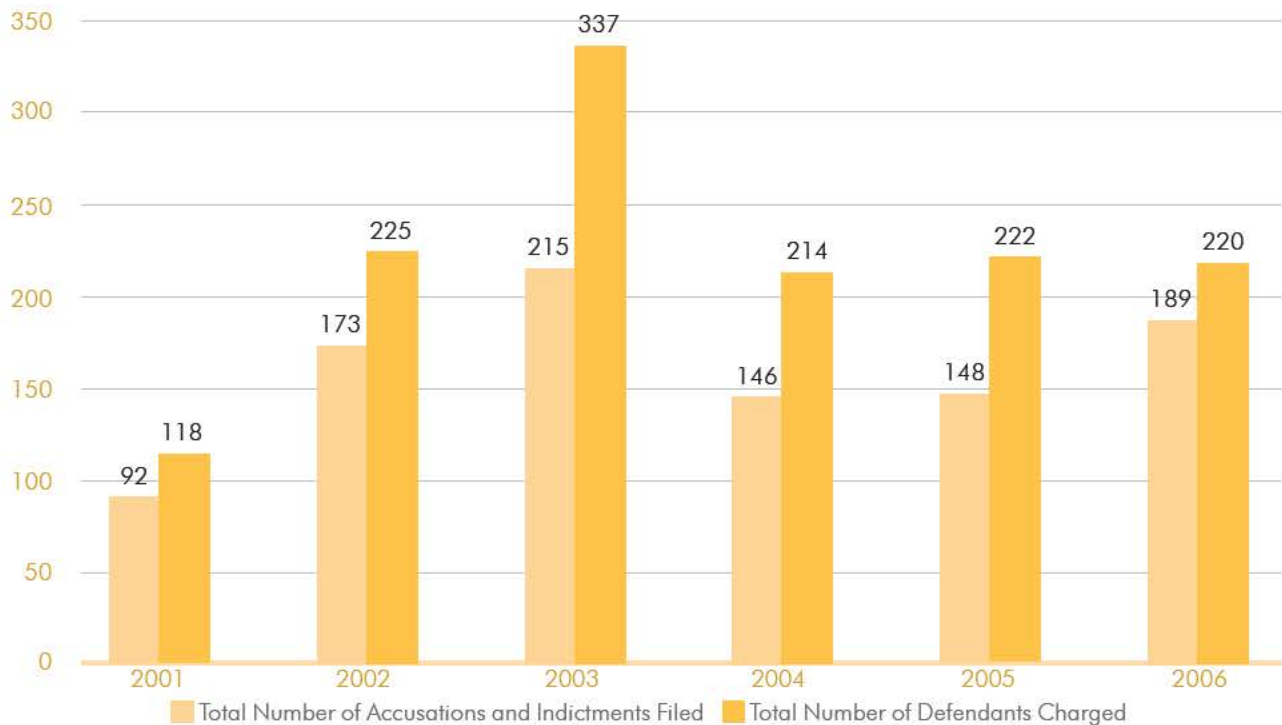
² These statistics comprehensively reflect the number of discrete actions undertaken by the Office of Insurance Fraud Prosecutor in pursuing civil sanctions against insurance fraud violators. It should be noted that, in some instances, more than one action was taken against a single violator or for a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

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

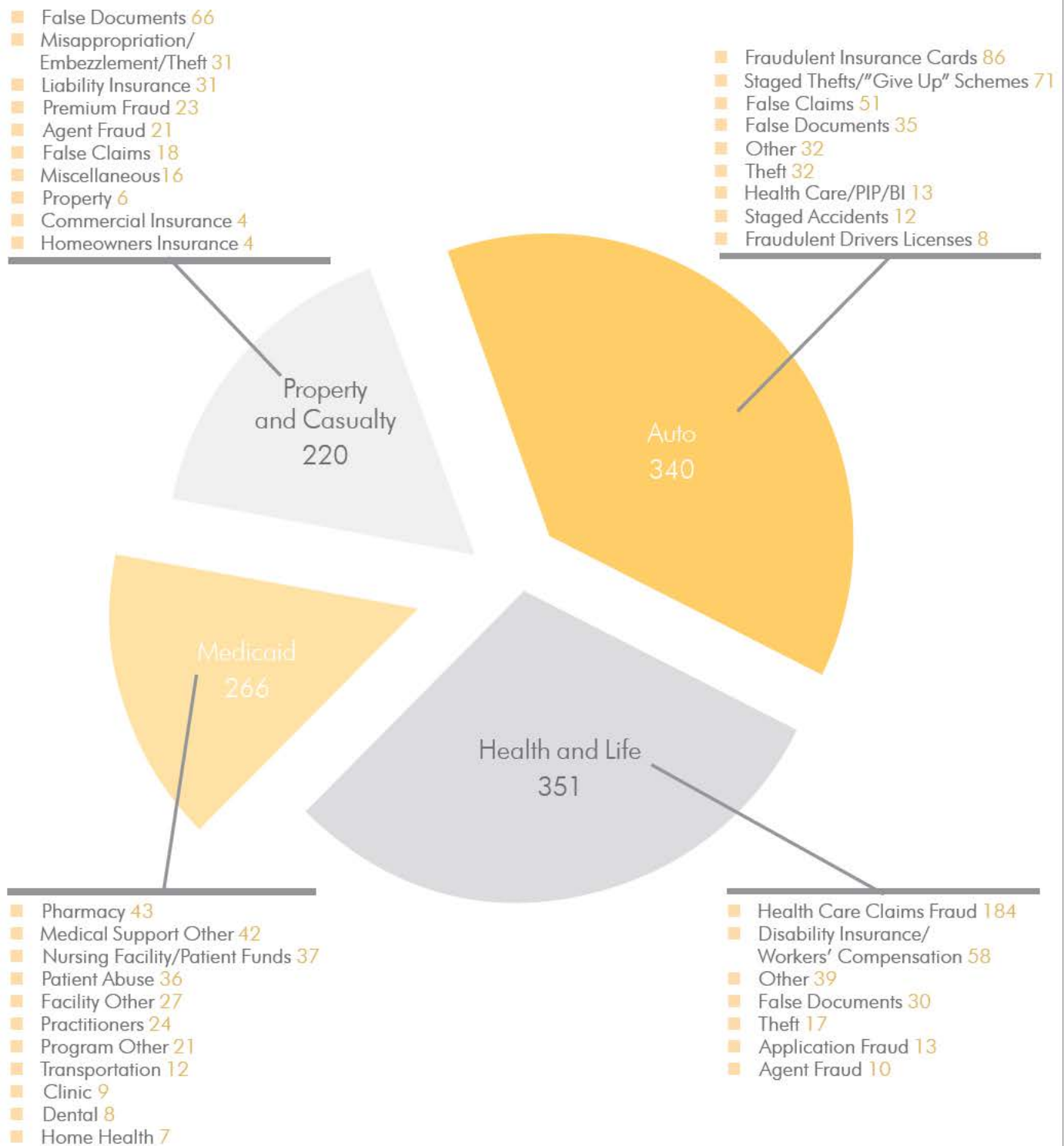
OIFP Criminal and Civil Monetary Sanctions and Restitution Summary 2001–2006

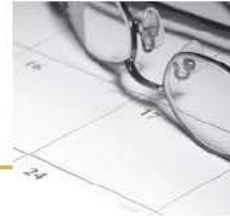


OIFP 2001-2006 Criminal Charges Summary

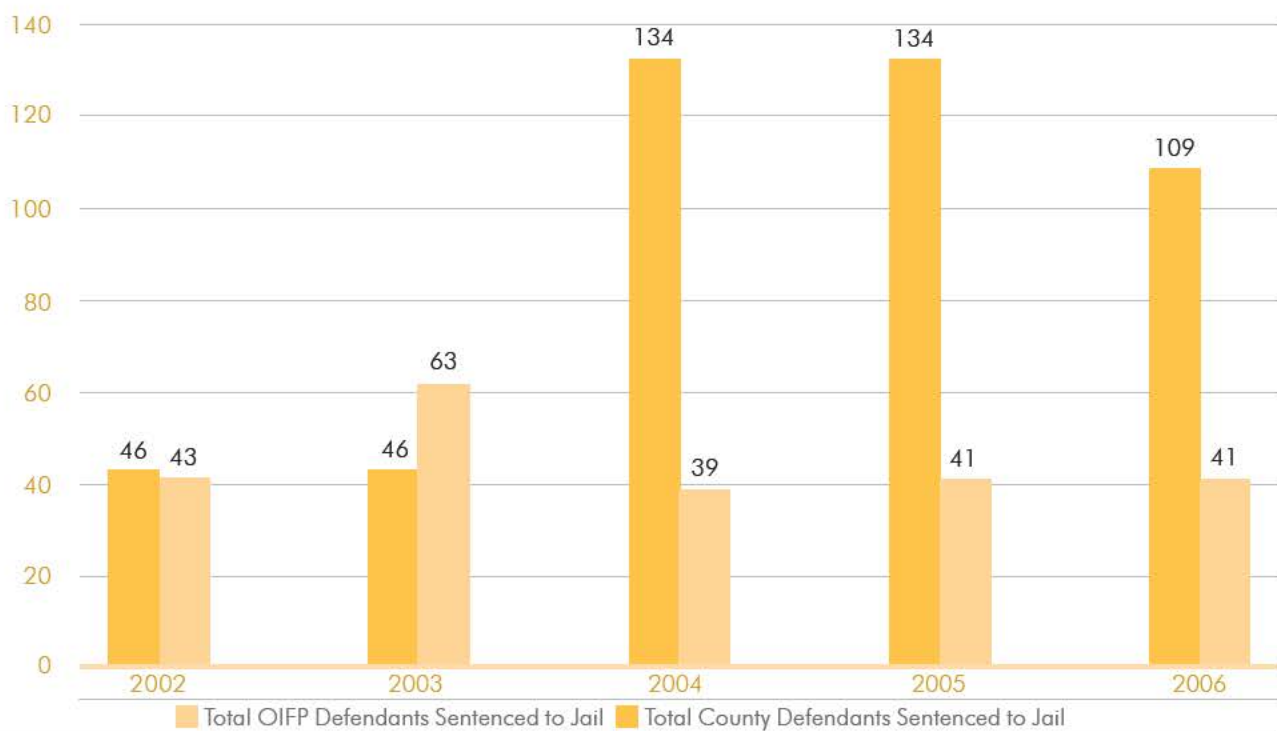


Criminal Cases Investigated in 2006 by Fraud or Provider Type





OIFP & County Prosecutors' Offices – Total Defendants Sentenced to Jail 2002–2006



New Jersey Observes First Annual Insurance Fraud Awareness Month by John Butchko

In October 2006, the Office of the Insurance Fraud Prosecutor (OIFP), working in conjunction with the Insurance Council of New Jersey (ICNJ) and the New Jersey Special Investigators Association (NJSIA), celebrated the first annual "Insurance Fraud Awareness Month." In addition to the anti-insurance fraud events traditionally sponsored by OIFP and various industry trade organizations during the month of October, in 2006, a concerted effort was made to coordinate these functions and develop new events and programs to heighten public awareness concerning the impact of insurance fraud on New Jersey's residents and to spotlight New Jersey's nationally recognized anti-insurance fraud efforts. Some of the special events commemorating Insurance Fraud Awareness Month included the Ninth Annual New Jersey Insurance Fraud Summit, the First Annual Anti-Fraud Awareness Essay Contest for High School Seniors, the 16th Annual New Jersey Special Investigators Training Seminar, OIFP and Industry Working Group Meetings, and the publication of the Fifth Edition of OIFP's Uninsured Motorists Identification Directory (UMID).

Ninth Annual New Jersey Insurance Fraud Summit - October 5, 2006

Since its creation in 1998, OIFP has hosted a statewide Insurance Fraud Summit during the month of October, which is jointly

sponsored by ICNJ and NJSIA. For the ninth consecutive year, executive level representatives from the State's insurance industry, government officials, and members of the law enforcement community committed to the detection, investigation, and prosecution of insurance fraud gathered to collectively review yearly accomplishments, discuss programmatic and policy issues, and suggest legislative and regulatory changes to enhance New Jersey's ability to effectively combat insurance fraud. William Ballinger, President of Allstate Insurance Company New Jersey, provided the opening keynote address, which was followed by breakout sessions covering specific topics of interest for the 250+ attendees. During the Summit, OIFP also recognized individuals and Special Investigative Units who have made significant contributions to its anti-fraud efforts. The 2006 Prosecutor's Excellence in Investigation Award was presented to Horizon Blue Cross Blue Shield. In addition, Richard Stokes of the Property Casualty Insurers Association received the 2006 OIFP Recognition Award.

First Annual Anti-Fraud Awareness Essay Contest for High School Seniors

In a proactive effort to educate future insurance consumers concerning the significant burden insurance fraud places

on our society, OIFP, ICNJ, and NJSIA sponsored the First Annual Anti-Fraud Awareness Essay Contest for High School Seniors. In mid-August, notices were mailed to more than 480 public and private high schools throughout New Jersey, inviting seniors to compete for \$2,000 in scholarship funds that were donated by ICNJ and NJSIA. Participants were required to write a short essay consisting of 500 words or less on the topic: "How Does Insurance Fraud Affect the Residents of New Jersey?" In response, OIFP received more than 100 essays from high school seniors throughout the State. Following pre-established criteria, which included areas such as written expression, creativity, and language mechanics, a panel of representatives from OIFP, ICNJ, and NJSIA, read and graded all submitted essays and identified 15 finalists for the final round of judging. Using the same criteria, New Jersey Insurance Fraud Prosecutor Greta Gooden Brown, NJSIA President Paul Gallo, and ICNJ President Magdalena Padilla reviewed the finalists' essays and selected the contest winners. On October 30, 2006, an awards ceremony took place at the New Jersey State House recognizing the winners. Stephanie Pankiw of Hasbrook Heights High School was awarded first place and received a \$1,000 scholarship. Alexander Powell of Hamilton High West was awarded second place and received a \$750 scholarship. Michelle Ann Rauh of Camden County Technical High School was awarded third place and received a \$250 scholarship. The winning essays are reproduced below:

1st Place

Stephanie Pankiw
Hasbrook Heights High School

What Is the Impact of Insurance Fraud on the Residents of New Jersey?

The impact of insurance fraud on the residents of New Jersey is similar to the effect that a pickpocket has on an individual. Insurance fraud is caused by people who try to trick insurance companies by exaggeration or an outright lie. People and companies who ignore the problem indirectly make others think that



William P. Ballinger, President of Allstate New Jersey, delivers the Keynote Address at the 2006 Insurance Fraud Summit.



Winners of the First Annual Insurance Fraud Awareness Essay Contest for High School Seniors with Insurance Industry sponsors: Paul Gallo, President, New Jersey Special Investigators Association; Alexander Powell, Hamilton High School West, 2nd place; Stephanie Pankiw, Hasbrook Heights High School, 1st place; Michelle Rauh, Camden County Technical Schools, 3rd place; and Magdalena Padilla, President, Insurance Council of New Jersey.

fraud is a crime that is “not dangerous.” However, each year, insurance fraud causes loss of life, occupation and property.

Insurance fraud can happen in many different ways. The money that people receive through fraudulent insurance claims is money that they should not have received. This money comes from the pockets of others as their premiums rise. The two types of fraud are hard fraud and soft fraud. Hard fraud involves a planned accident, theft or some other incident in which the person involved makes off with a lot of money. Soft fraud involves a smaller lie, but the payment is still felt as those insured under the same plan pay higher premiums.

Fraud is often unnoticed and when it is, some insurers choose to ignore the incident and not waste their time or money bringing the case to court. This is often true because simply paying the small claim would be less costly than becoming involved in a legal battle. The medical and health care system is often an easy target. The system is very large and with doctors and hospitals so busy, it is easy to miss fraudulent claims. Many people prey on immigrants who, because of their language and customs barrier, often don't realize they are being deceived. Individuals are also a huge part of the problem. Many people defraud the system and go unnoticed; this encourages others. This type of crime, compared to other more violent ones, is not heavily prosecuted. Also, it is almost socially accepted and people generally tolerate it.

Insurance fraud has an effect on everyone. People with low income can lose

all of their savings due to rising premiums. Those who can't afford insurance or buy into fraudulent plans are put at a health risk. Companies who are not trying to defraud the system lose money, and sometimes their entire company due to rising premiums. This drives up the cost of goods that people buy in the stores. People who work for companies that must pay rising premiums are at risk to lose their jobs. In extreme cases, people are even killed to get insurance money.

Either directly or indirectly, everyone is affected by insurance fraud and everyone must pay for it. The only way to stop it is to crackdown on those who are responsible, even the small cases. Insurance fraud causes families tragedy and financial insecurity. For something that is supposed to make you feel safe and protected, it seems to leave many feeling unsure and worried about their future.

2nd Place

**Alexander Powell
Hamilton High West**

What Is the Impact of Insurance Fraud on the Residents of New Jersey?

Insurance Fraud is a growing problem that needs to be stopped now. Insurance fraud happens when people trick their insurance companies to collect money that they are not entitled to. It is not just customers of the companies who can commit this act, but also the agents themselves can also be involved. These are criminal acts which impact everyone. Negative effects impact all insurance costs. People lose money, premiums and consumer

goods stay high, and honest and loyal companies lose money. Additionally, people's health can be endangered. This crime has greatly hurt the State of New Jersey as well as the rest of the country and needs to be stopped.

When criminals cheat insurance companies, these businesses must then inflate the cost of policies to help cover for the large costs of this insurance fraud. This is detrimental to everyone, not just the culprits who commit this theft. Companies lose billions of income each year as costs of employee health coverage and business insurance increase because of fraud.

Due to rising insurance costs, companies have to raise the prices of consumer goods to compensate for the cost of health and commercial insurance for workers. By stealing money from insurance agencies, felons are raising the prices of not just insurance, but of regular goods such as food and clothes. Besides being unfair, it makes it harder for people who do not have a lot of money to begin with. With insurance prices increased as well as other commodities, people less fortunate will have a great deal of trouble managing money and being able to buy necessary items.

Most importantly, innocent people are getting injured and killed because of the acts people set up to cheat insurance companies. People can die from insurance schemes such as staged auto accidents and arson. These people include whole families, many with young children. Innocent humans should not have to worry about being injured because of insurance fraud. This problem needs to stop now!

To stop this crime, fraud bureaus need to be expanded in order to investigate and hunt down criminals. Stricter fraud laws must be implemented to stop fraud before it starts. By having tougher laws, people will be less likely to commit these acts in fear of being harshly punished. If New Jersey continues to fight against insurance fraud, we are on our way to becoming a safer and better State.

3rd Place

Michelle Ann Rauh

Camden County Technical Schools

What Is the Impact of Insurance Fraud on the Residents of New Jersey?

Most American citizens are distraught about the price of insurance, whether it be in the form of car, life, health or home owners insurance. One of the main reasons is fraud. It comes in many forms when relating to insurance. It comes in the form of doctors submitting false claims, faked injuries in automobile accidents, those not disabled receiving disability and the employed receiving unemployment. These are just a few examples that lead to the high costs of insurance that the citizens of New Jersey pay. In New Jersey and nationwide, investigators and organizations are taking the necessary steps to cut down the roots of insurance fraud. So, what more can we do?

One of the largest dilemmas with insurance fraud is the people who commit it. Most of these people would not commit a robbery or steal a car. However, they find themselves in a circle of lies and deception because they have committed insurance fraud. Why is this so? It's because most people are unaware of the consequences and those who do, believe they won't be caught. I believe the greatest

step that can be taken in the fight against insurance fraud is more public awareness. There should be public speakers at schools throughout all grades, even on a college level. Although internet and news media help spread awareness, most students are unaware of the serious consequences involved. By teaching the generations to come, we can help eliminate the perpetual problem of insurance fraud.

There are affordable ways to spread familiarity with insurance fraud through schools that benefit the community. One way is to have an Insurance Fraud Awareness Chapter at schools. The chapter would consist of advisors and students interested in becoming conscious about insurance fraud. These particular students could be trained and taught on all there is to know about insurance fraud. The students can in turn teach students within their school and others. Like most chapters or organizations in a school, they could participate in community service. Students teaching students on insurance fraud will benefit both parties through social interaction. It's important for students to have the opportunity to take an important part in the State by contributing to the rise in awareness of this plaguing problem. This program or chapter would create leaders in the State of New Jersey who would

eventually move on to promote more programs in their future endeavors.

Furthermore, the spread of awareness can be done by any individual interested in lowering the premiums of insurance. In short, by spreading information, we are lowering the rate in which insurance fraud will be committed. In turn, premiums will lower. The largest step towards this is the above solutions; a chapter of students spreading the awareness. As long as there are people with low morals in New Jersey, insurance fraud will never be stopped. In contrast, we can dramatically lower it by reaching out to the consumers of future generations.

16th Annual New Jersey Special Investigators Training Seminar

The NJSIA is a nonprofit organization formed to unite insurance fraud investigators in the public and private sectors for their mutual benefit. NJSIA monitors trends affecting the industry and shares technical information with the insurance companies' Special Investigations Units (SIUs), law enforcement, and regulatory agencies. Through their educational arm, the NJSIA Educational Foundation, Inc., NJSIA has undertaken the mission of educating insurance fraud investigators and law enforcement personnel in fraud awareness, investigative techniques, fraud trends, and recent developments in the laws relating to insurance fraud. In October, the NJSIA Educational Foundation sponsors an annual day-and-a-half fraud training seminar that is attended by more than 700 representatives of insurance companies, regulatory bodies, and law enforcement agencies from the northeastern United States. This training event is regarded as one of the premier insurance fraud training seminars in the country.

OIFP supports NJSIA's mission and participates in its annual training seminar. This year's seminar was held on October 16 to 17, 2006, and featured special programs to further New Jersey's First Annual Insurance Fraud Awareness Month. Insurance Fraud Prosecutor Greta Gooden Brown opened the conference and addressed the conference's 700+



At the 16th Annual NJSIA Training Seminar, representatives from Allstate New Jersey demonstrate how auto "chop shops" strip cars for parts in less than 10 minutes.



On behalf of Horizon Blue Cross Blue Shield, Douglas Falduto accepts the Annual Prosecutors' Excellence in Investigations Award from Insurance Fraud Prosecutor Greta Gooden Brown.

attendees. Further, in addition to 26 workshops sponsored by NJSIA, which provide nine hours of State mandated training for SIU personnel, OIFP conducted workshops on the proper submission of suspected insurance fraud cases and instructions on the criteria for completing the newly revised referral form. In addition, Allstate Insurance Company conducted a demonstration showing how professional auto thieves can dismantle a vehicle of its major components in less than ten minutes, a scheme often employed by individuals looking to "give-up" their vehicles.

OIFP Meets with Working Groups, Industry Representatives, and Industry Trade Groups

Other significant events undertaken as part of Insurance Fraud Awareness Month included special meetings conducted with the insurance industry's SIU community and trade groups, as well as meetings of Working Groups that were established as a result of the first statewide Insurance Fraud Summit in 1998. Working Groups, comprised of key SIU executives and the OIFP Industry Liaison, meet regularly throughout the year to identify and articulate industry concerns with respect to insurance fraud in the areas of life and health, auto, property/casualty, and workers' compensation. Working Groups provide progress reports at quarterly meetings with OIFP executive staff, Department of Banking and Insurance executive staff, and trade group

members. As part of Insurance Fraud Awareness Month, results of the Working Groups' efforts were recognized at the Insurance Fraud Summit.

Since 1998, Working Groups have formed the foundation for several new initiatives undertaken by OIFP, including specific recommendations incorporated in OIFP's prior Annual Reports. The recent formation of a Working Group focused on concerns of insurance producers represented one such initiative. In June 2006, the Producers Working Group conducted a comprehensive half-day training session on insurance agencies, brokers, policies, and fraud. This invaluable training was also attended by OIFP Civil Investigators, State Investigators, and Deputy Attorneys General.

Publication of the Fifth Edition of OIFP's "Uninsured Motorists Identification Directory" (UMID)

During Insurance Fraud Awareness Month, OIFP disseminated the Fifth Edition of the Uninsured Motorists Identification Directory (UMID) to all local, county, and State police agencies throughout New Jersey. The UMID is produced by OIFP to provide law enforcement officers with a hands-on tool designed to assist the officer on the scene. The UMID contains contact telephone numbers and other information of insurance carriers and self-insured entities for verification of automobile insurance coverage.

One of the types of insurance fraud most commonly encountered by law enforcement agencies is the presentation of a fictitious or counterfeit automobile insurance identification card to a police officer making a motor vehicle stop. By providing law enforcement with the direct contact telephone number of insurance carriers, where verification of insurance coverage can be obtained, the Directory enables the officer to quickly ascertain the validity of the presented insurance identification card in order to take the appropriate enforcement action.

Incorporated into this year's edition of the UMID was a description of the anti-counterfeiting measures utilized by insurance carriers on the insurance identification cards issued to policyholders. By providing law enforcement with these descriptions, the Directory serves as an invaluable source of intelligence information in conducting these investigations. Since this edition of the UMID contained this proprietary commercial information which is not subject to public access pursuant to N.J.S.A. 47:1A-1, et seq., or public disclosure pursuant to N.J.A.C. 11:3-6.4, the information contained in the Directory is highly confidential, must be safeguarded, and cannot be made available to the general public.

John Butchko is a 28-year veteran of State government and currently serves as OIFP's Liaison Section Chief as well as a Special Assistant to the Insurance Fraud Prosecutor. He also acts as the Liaison to the insurance industry, the New Jersey Department of Banking and Insurance (DOBI), and the New Jersey Motor Vehicle Commission. Prior to joining OIFP in 1998, he served as DOBI's Chief Investigator and Deputy Director of the Division of Insurance Fraud Prevention.

OIFP Funds County Prosecutors' Insurance Fraud Fighting Efforts by Joan Enright

Aided by funding provided by the Office of the Insurance Fraud Prosecutor (OIFP), New Jersey's County Prosecutors continued in 2006 to do their part in the State's war on insurance fraud. By conducting criminal investigations and prosecutions at the county level, County Prosecutors have used OIFP funding to launch or augment programs to catch and punish insurance cheats.

Pursuant to the Automobile Insurance Cost Reduction Act of 1998 (AICRA), the Attorney General is authorized to reimburse County Prosecutors for their efforts in combating insurance fraud. Since its inception in 1999, the New Jersey County Prosecutor Insurance Fraud Reimbursement Program, administered by OIFP on behalf of the Attorney General, has funded fraud fighting personnel and equipment in most of the State's 21 County Prosecutors' Offices.

The funding of County Prosecutors' Offices to enhance their ability to investigate and prosecute insurance fraud is an integral part of New Jersey's comprehensive war on insurance fraud because County Prosecutors are often able to detect, investigate, and prosecute insur-

ance scams which might otherwise "fly below the radar screen" of the broader statewide criminal justice system. Through their cultivation of local informants, their ability to tap local law enforcement resources, and their unique familiarity with local crime demographics, County Prosecutors are often able to identify and develop promising leads which culminate in successful criminal prosecutions.

With financial and technical support from OIFP, County Prosecutors continued in 2006 to implement new and innovative initiatives uniquely tailored to investigate and prosecute insurance cheats within their respective jurisdictions. These programs ran the gamut in terms of their focus and operational methods. The common element in all of these programs, however, is that without funding from OIFP, local law enforcement authorities would have lacked sufficient resources to adequately investigate and prosecute most of these cases.

In Essex County, New Jersey's most urban county, the Essex County Prosecutor used OIFP funding to continue an Essex County Vehicle Fire Initiative. Recognizing that motor vehicle fires

motivated by insurance fraud were responsible for a large number of fraudulent insurance claims in Essex County, the Essex County Prosecutor implemented protocols for processing, reviewing, and screening all vehicles burned in the county. The Initiative operates as a separate program within the Essex County Arson Task Force. Staff assigned to the Initiative work closely with insurance company investigators and local police department detectives and fire department personnel to ensure that every motor vehicle fire in the county is investigated by qualified personnel as expeditiously and efficiently as possible. The program has proven to be a unique and effective weapon in the fight against insurance fraud.

Responding to another type of insurance problem that is pervasive in urban counties, the Hudson County Prosecutor's Office Insurance Fraud Unit utilized its OIFP funding to target commuter vans operating without insurance coverage. Hudson County witnessed a major increase in the use of these commuter vans as an alternative to traditional mass transit. These vehicles, which are commonly referred to as "dollar vans," provide a less expensive means of public transportation. Working with the Bus Enforcement Unit of the Motor Vehicle Commission, as well as municipal, county, and bi-state police agencies, the county Insurance Fraud Unit participated in random roadside inspections of these vehicles. These inspections invariably uncovered irregularities in the insurance documents provided, which led to criminal investigations and prosecutions. This program provided the added benefit of removing unsafe vehicles from the roadways.

At the other end of New Jersey, in Salem County, OIFP funding enabled the Salem County Prosecutor's Office to implement an Insurance Fraud Ride Along Program. Under this Program, the county's OIFP funded insurance fraud Investigator rides along with municipal police officers in patrol cars which have been specifically



Agent Robert Larsen, Vehicle Fire Case Specialist Doris Stoeckel, Assistant Prosecutor Michael Morris, and Detective Marlin Bullock of the Essex County Vehicle Fire Initiative.



assigned to make motor vehicle stops to perform document checks, which include verifying the authenticity of motor vehicle insurance identification cards. In order to verify whether a card is fictitious, or whether the underlying insurance was canceled for non-payment of premium, the Program relies, in large part, upon the Uninsured Motorists Identification Directory (UMID) issued by OIFP to all County Prosecutors' Offices and local police departments.

The UMID, a directory of insurance company "hotline" numbers, was specifically compiled, published, and distributed by OIFP to law enforcement agencies throughout New Jersey in order to provide them with an efficient and effective tool to directly contact insurance companies to verify insurance coverage. Salem's Ride Along Program has proven effective in identifying and deterring the use of fraudulent motor vehicle insurance identification cards as well as identifying undisclosed drivers and cancelled policies. The Program sends a strong message to drivers in Salem County that using a counterfeit insurance card in lieu of properly insuring one's vehicle is a crime in New Jersey.

In a similar vein, the OIFP funded Insurance Fraud Unit in the Morris County Prosecutor's Office launched a large scale investigation of a criminal enterprise suspected of transporting individuals out of state to obtain fraudulent automobile registrations and fictitious motor vehicle insurance identification cards. This investigation followed the Unit's observation of a significant increase in rate evasion cases in Morris County whereby individuals were using false out-of-state addresses to insure their vehicles in order to obtain cheaper rates.

The Union County Prosecutor's Office restructured its insurance fraud investigative unit with funding provided through OIFP and developed a close working relationship with the highly successful Essex/Union Auto Theft Task Force. This relationship yielded great dividends in 2006 as the Unit developed several

confidential informants through its Task Force activities, which ultimately led to arrests arising from owner-initiated auto thefts or "give ups."

As a long-standing participant of OIFP's County Prosecutor Reimbursement Program, the Atlantic County Prosecutor's Office Insurance Fraud Unit launched a training initiative in 2006 and, among other things, provided document fraud training to casino personnel. The training led to referrals from the casinos involving casino employees receiving health and medical benefits under fictitious names. The county Insurance Fraud Unit investigated these cases and arrests were made.

Other County Prosecutors' Offices that participated in OIFP's County Prosecutor Insurance Fraud Reimbursement Program concentrated their enforcement efforts in all areas of insurance fraud rather than focusing on a particular program or initiative. Funding provided by OIFP to the County Prosecutors' Offices throughout the State totaled over \$3.3 million in 2006 and supported or contributed to the salaries of 31 detectives and investigators, 8 assistant prosecutors, and 6 technical and administrative support staff assigned to investigate and prosecute insurance fraud.

Pursuant to the requirements of AICRA and the County Prosecutor Insurance Fraud Reimbursement Program, county Insurance Fraud Units work closely and coordinate their activities with OIFP on an ongoing basis. All County Prosecutors' Offices submit periodic reports to OIFP, which include names, addresses, and other pertinent identifying information regarding any subjects under investigation for insurance fraud within their offices. The status of all matters under investigation are updated in monthly reports which provide OIFP with information which is added to its own database of cases to ensure that its own investigations do not duplicate or overlap those undertaken by the counties.

The information reported by county Insurance Fraud Units also enables OIFP, in most cases, to open corresponding civil cases whenever it appears that OIFP may have authority to impose a civil fine pursuant to the provisions of the Insurance Fraud Prevention Act. In 2006, the reporting of subjects under investigation by County Prosecutors' Offices resulted in OIFP opening 580 civil investigations, most of which would not have come to OIFP's attention but for the reports submitted by the counties. Many of the substantial civil cases opened by OIFP-Civil have resulted from these county referrals.

County Prosecutors' Insurance Fraud Units contribute greatly to OIFP's overall success in its enforcement efforts. In 2006, these county units charged a total of 333 defendants and obtained 188 convictions by guilty plea or trial. These convictions resulted in aggregate jail terms of more than 73 years. Some of the most notable criminal cases handled by the County Prosecutors' Insurance Fraud Units in 2006 are summarized in this Section of OIFP's Annual Report.

Joan Enright is an Administrative Analyst who oversees the administration of the County Prosecutor Insurance Fraud Reimbursement Program. She has been with the Division of Criminal Justice for over 13 years.

County Prosecutors' Offices Case Notes

Atlantic County Prosecutor's Office

State v. Miguel Pacheco

Miguel Pacheco was arrested on July 20, 2006, and charged with manufacturing and sale of false government documents. At the time of his arrest, a search warrant was executed resulting in the seizure of equipment allegedly utilized in the manufacture of counterfeit documents. On December 21, 2006, Pacheco pled guilty to an indictment that charged him with sale of false government documents.

The Insurance Fraud Unit, with the assistance of the Hammonton Police Department, NJ Motor Vehicle Commission Security Investigation Unit, US Department of Labor, and the FBI, conducted a six-month undercover investigation, which resulted in the purchase of alleged counterfeit documents, including vehicle registrations, vehicle insurance identification cards, and Social Security cards. Pacheco will be sentenced in 2007.

State v. Blanca Buritica

On June 2, 2006, Blanca Buritica was sentenced to three years probation following her guilty plea to an indictment that charged her with knowingly exhibiting a document that falsely purported to be issued by a government agency and possession of a false government document.

The Atlantic County Prosecutor's Office Insurance Fraud Unit initiated an investigation after receiving information that a patient of a local doctor had been receiving medical insurance benefits for several years under an assumed name. The investigation revealed that Buritica was in the United States illegally. While here, she obtained a fictitious Social Security card and eventually obtained a New Jersey identification card under her assumed name. Buritica then used the counterfeit documents to obtain employment in an Atlantic City casino where she then received health insurance benefits through a union that covers casino workers.

Between March 2001 and September 2005, Blanca Buritica, using an assumed name and counterfeit identification, allegedly submitted 28 claims for medical

treatment through Horizon Healthcare totaling in excess of \$1,000. Additionally, Buritica allegedly filled 24 prescriptions through the Enbrel Enrollment Program.

Bergen County Prosecutor's Office

State v. Catherine Xerri, et al.

On May 12, 2006, Catherine Xerri was sentenced to four years state prison for conspiracy to commit Insurance Fraud and eight years state prison for attempted murder. Xerri purchased a 2004 Dodge Ram and fraudulently reported on a motor vehicle insurance application that she was the primary operator of the vehicle and that it would be parked at her residence in Westwood.

Franklin Baez, who allegedly utilized the vehicle for his construction business, was allegedly the sole driver of the vehicle and kept it parked at his residence in Hackensack. Xerri failed to disclose this information on her insurance application. It is alleged that Baez' driving privileges were suspended at the time, resulting in his ineligibility to obtain a motor vehicle insurance policy in his name. As a result of this investigation, Baez was charged with Insurance Fraud and conspiracy to commit Insurance Fraud.

Subsequent to this investigation, Xerri and Baez were arrested and charged with attempted murder. Baez remains in county jail pending disposition of the matters.

State v. Thomas Iwanicki, et al.

On October 20, 2006, Thomas Iwanicki was arrested and charged with Insurance Fraud. Iwanicki filed a report with the Hoboken Police Department claiming that his 2001 Mercedes-Benz SL500 had been stolen in Hoboken. He also filed a claim in excess of \$25,000 with Allstate Insurance Company for the loss of the vehicle. Subsequently, the vehicle was discovered partially burned in Englewood. A forensic examination conducted on behalf of the insurance company concluded that the car had not been stolen and that the fire was caused by a flammable liquid poured on the interior surfaces of the car.

Following his arrest, Iwanicki implicated Adam Nelag as the individual who was utilizing the vehicle during the time when it had been burned. On October 20, 2006, a warrant was issued for Nelag's arrest. Nelag was extradited from Florida and charged with Insurance Fraud. The matter is pending.

Burlington County Prosecutor's Office

State v. Colleen Sacca

Colleen Sacca, a former nurse, pled guilty to Health Care Claims Fraud and was sentenced on September 22, 2006, to three years probation, conditioned upon serving 364 days in county jail at the conclusion of probation. Sacca allegedly presented a fraudulent prescription for hydrocodone at a pharmacy in Cinnaminson Township, which was then submitted to her prescription insurance plan.

State v. William Schobert

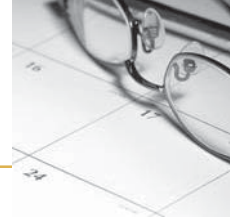
In a cooperative investigation with Medford Township, William Schobert was arrested on July 11, 2006, and charged with Health Care Claims Fraud, theft by deception, and forgery. The State alleges that, between March 2002 and March 2004, Schobert, a pharmacist employed at a Medford pharmacy, falsely created prescriptions in his name and in the names of others, printed receipts for the fraudulent prescriptions, subsequently deleted the records from the store's computer, and then allegedly submitted the receipts as claims for reimbursement from his insurance company for over \$80,000. The matter is pending Grand Jury.

State v. Patrick Peterson

Patrick Peterson pled guilty to an indictment charging him with simulating a motor vehicle insurance identification card. On October 20, 2006, he was sentenced to 12 months state prison.

State v. Shirley Gismondi, et al.

On December 1, 2006, Lori Martellacci, Gina Naticcione, and Richard Naticcione were each sentenced to two years probation following their guilty pleas to charges of conspiracy to commit theft by deception. In addition, they were each ordered to pay a \$1,000 criminal fine and joint and several



restitution in the amount of \$1,911 to the Burlington Township Fire Department. On September 29, 2006, Eric Schleinkofer was sentenced to three years state prison and ordered to pay restitution to the Burlington Township Fire Department in the amount of \$1,911. Schleinkofer previously pled guilty to charges of conspiracy to commit arson. On the same date, the court sentenced Shirley Gismondi to two years probation. Gismondi previously pled guilty to conspiracy to commit theft by deception.

Lori Martellacci, with the assistance of Gina Naticcione and Richard Naticcione, arranged to "give up" her vehicle when she found herself unable to make the car payments. Richard Naticcione contacted Eric Schleinkofer, who agreed to "get rid" of the car for \$200. Richard Naticcione gave the keys to Schleinkofer. Subsequently, Schleinkofer and his girlfriend, Shirley Gismondi, picked up the vehicle at a local mall and set it on fire in Burlington Township.

Camden County Prosecutor's Office

State v. Bryan Sharp

Following a three-week jury trial, Bryan Sharp was convicted of arson for insurance on December 20, 2006. Sharp, Chief of the Camden County Fire Police, set fire to his house in order to benefit from the proceeds of a false insurance claim. An investigation by the Fire Marshal determined the fire to be arson. High Point Insurance Company paid Sharp \$200,000 on the fraudulent claim. Sentencing is scheduled for early 2007.

State v. Catherine Fee, et al.

Catherine Fee, a licensed pharmacist, pled guilty to an Accusation charging her with conspiracy to distribute CDS by forging doctors' signatures on prescription phone-in logs. The incidents occurred without the doctors' knowledge. On February 10, 2006, Fee was sentenced to three years probation, ordered to pay \$1,229 in restitution to CVS Pharmacy, and surrendered her pharmacist's license for three years. Eckerd Pharmacy was repaid \$1,250 in a separate agreement.



Warren County Detective Clement Mezzanotte prepares an investigation report.

Brian Weimer was also charged for his alleged role in picking up the fraudulently obtained prescriptions. Weimer is currently a fugitive; a bench warrant has been issued for his arrest.

State v. Robert Chisholm

On October 23, 2006, Robert Chisholm was sentenced to five years and 72 days in state prison. Chisholm previously pled guilty to an indictment that charged him with forgery, criminal attempt to obtain CDS by fraud, theft of property, and Health Care Claims Fraud. Chisholm stole a blank prescription pad from his treating physician, and, on various occasions, entered a pharmacy and submitted fraudulent prescriptions for Xanax. Chisholm usually paid for the prescriptions with cash, however, in one incident, he used his Medicaid plan as payment. Pharmacy employees became suspicious and notified law enforcement when they noticed that the prescription amounts had been altered.

Essex County Prosecutor's Office

State v. Keith Roberts

Keith Roberts pled guilty to Insurance Fraud on February 27, 2006. On April 21, 2006, he was sentenced to three years in state prison. Roberts had reported his vehicle stolen from Vineland, but could not explain to investigators how his transponder equipped 2001 Mitsubishi Galant arrived in Newark, to be burned, without one of the keys that he surrendered after the fire.

State v. Carlos Torres

On September 25, 2006, Carlos Torres pled guilty to Insurance Fraud and theft by deception for arranging to have his 2003 Chevy Trailblazer disposed of in Newark. Torres was sentenced to two years probation.

State v. Vincent DeVito

Vincent DeVito was indicted on March 6, 2006, and charged with Insurance Fraud and arson. DeVito allegedly arranged to have his 1996 Mercedes-Benz G320 burned in Belleville. The matter is pending trial.

Gloucester County Prosecutor's Office

State v. Dana Balbian

In September 2006, Dana Balbian entered the Pretrial Intervention (PTI)¹ Program after pleading guilty to an Accusation charging her with obtaining CDS by fraud and Health Care Claims Fraud. Balbian, a pharmacy employee, allegedly received and filled 28 fraudulent prescriptions. She alleged the prescriptions were in the names of two individuals who were her friends. Four of the 28 fraudulent prescriptions were submitted to Horizon of New Jersey for payment.

State v. Wendell E. Frazier

On September 14, 2006, Wendell E. Frazier was sentenced to three years probation. Frazier previously pled guilty to an Accusation charging him with attempting to commit Insurance Fraud. Frazier reported to the Glassboro Police Department that he had been carjacked. Frazier later admitted that he filed a false police report and made false statements to the insurance company on his claim.

Hudson County Prosecutor's Office

Hudson County Initiative

In 2004, the Hudson County Prosecutor's Office Insurance Fraud Unit became aware of abuses that existed in the commuter "Dollar" van business operating within Hudson County, in which the insurance premium money was being diverted and fictitious insurance identification cards were being provided to independent owner operators by franchised carrier management. As part of a proactive response to this type of illegal activity, the New Jersey Motor Vehicle Commercial Bus Inspection Unit, various Municipal Police Departments, and the Port Authority Police Department were contacted. Arrangements were made to conduct eight joint safety inspections of these vehicles, three during 2005 and five during 2006, in various Hudson County locations utilizing the Uninsured Motorists Identification Directory (UMID) issued each year by OIFP.

As a result of these joint operations, the NJMV Commercial Bus Unit's, as well as the various Municipal Police Departments', ability to recognize valid insurance

cards has increased and fictitious insurance identification cards are more readily detected. In addition, various Investigators have made direct contacts with the insurance companies involved and have obtained up-to-date information on the vehicles that are currently insured. As an added benefit, the NJMV Inspectors utilize the information in the UMID in their daily inspections throughout the State of New Jersey. As a result of the above initiative, the owners of J & T Transit and Sphinx Transportation have been successfully prosecuted.

State v. Mike Murtana

Mike Murtana, the owner of Sphinx Transportation, pled guilty to an indictment that charged him with Insurance Fraud. On September 15, 2006, he was sentenced to four years probation and ordered to pay restitution in the amount of \$67,850. Sphinx Transportation was targeted in a Hudson County initiative designed to address the diversion of auto insurance premium money and uninsured motorists.

State v. Ernest Baptista, et al.

On October 19, 2006, Ernest Baptista pled guilty to Insurance Fraud for his part in the arson of a 2005 Chevrolet Equinox. Baptista, in his position as credit manager at the dealership where the vehicle had been purchased, had also arranged for its disposal when the buyers, Sandra Hernandez and Oscar Mendoza, allegedly could not make the monthly payments on the vehicle. Hernandez and Mendoza, as cooperating witnesses, also pled guilty to Insurance Fraud in this matter and are to be

admitted into the PTI Program. As part of the plea agreement, the defendants agreed to pay restitution in the amount of \$27,500, with Baptista responsible for \$15,000 of that sum.

Hunterdon County Prosecutor's Office

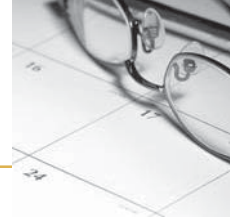
State v. Bruce Keller, et al.

Bruce and Irlene Keller were indicted and charged with aggravated arson, arson, attempted theft by deception, and conspiracy. On June 20, 2006, following a two-and-a-half week jury trial, they were convicted on all charges. The Kellers are pending sentencing in this matter.

The charges arose from circumstances surrounding a residential fire at a home the Kellers owned in Hunterdon County. Months prior to the fire, they had purchased a residence in Virginia. However, Bruce and Irlene Keller were in New Jersey and staying at the Hunterdon County home at the time of the fire. Both escaped from the burning residence uninjured.

Bruce and Irlene Keller subsequently submitted a claim to Chubb Insurance Company claiming approximately \$2.5 million in losses from both the residence and the contents of the residence. An investigation conducted by the New Jersey State Police Arson/Bomb Unit determined the fire to be arson, for which the Kellers were charged. The investigation also revealed the absence of furnishings and clothing at the fire scene, as well as other circumstantial evidence. It was alleged that the Kellers had moved the majority of their belongings to their Virginia

1. Pretrial Intervention (PTI) is a diversionary program created by statute and court rule. The Legislature established that it is the public policy of the State to divert certain defendants from the criminal justice system when, among other factors, diversion will serve to remove cases from the criminal court in order to focus resources on more serious matters or more dangerous defendants, or PTI supervision will suffice to deter that particular defendant from future criminality. N.J.S.A. 2C:43-12a. A defendant is admitted to PTI upon the recommendation of the PTI program director and the consent of the prosecutor. The program director and the prosecutor are required to consider, and base their decisions on, the defendant's amenability to correction, responsiveness to rehabilitation, and the nature of the offense. Id. at -12b,e; PTI Guideline 3. If a defendant is admitted to PTI, the criminal prosecution is suspended while the defendant undergoes the supervision or rehabilitation required by the PTI program staff. The judge may order restitution as part of the PTI program. If the defendant successfully completes the program, the criminal charge is dismissed. If the defendant fails to complete the program, the criminal prosecution resumes. N.J.S.A. 2C:43-13; R. 3:28.



residence prior to the fire, and, therefore, fabricated the loss of contents insurance claim.

Mercer County Prosecutor's Office

State v. Justin Crowe

Justin Crowe was indicted and charged with presenting a fictitious insurance identification card to a police officer. He was admitted into the PTI Program on December 2, 2006.

State v. Sherayla Hill

Sherayla Hill was indicted and charged with tampering with public records (a temporary registration tag) and uttering a fraudulent insurance identification card for allegedly presenting a fake insurance identification card to a New Jersey State Trooper. She was admitted into the PTI Program on February 16, 2006.

State v. Jennifer Radigan

Jennifer Radigan pled guilty to filing a false police report and attempted theft for falsely reporting her car stolen. Radigan was sentenced to five years probation on January 9, 2006.

State v. Calvin Riggins

On May 26, 2006, Calvin Riggins pled guilty to an indictment charging him with tampering with public records after presenting a fraudulent insurance identification card to a police officer. He was given a probationary sentence.

State v. Sonia Styles

On August 7, 2006, Sonia Styles pled guilty to an indictment charging her with eluding and theft by receiving stolen property. On September 29, 2006, she was sentenced to seven years state prison with a three-year period of parole ineligibility. Styles was eluding police while driving a car that had been stolen from South Carolina as part of a sophisticated auto theft ring that stole from auto dealerships in and around the South Carolina area. The *modus operandi* employed by the thieves was to test drive a car and switch keys after the test drive; then the thieves would drive the car off the lot (utilizing the stolen key) after the dealership closed for the night.

State v. Kenneth Swick

Kenneth Swick pled guilty to uttering a fraudulent government document and uttering a fraudulent insurance identification card. He was sentenced to probation on April 21, 2006. Swick presented a Pennsylvania drivers license, to avoid using his suspended New Jersey drivers license, and a fraudulent insurance card to a police officer during a motor vehicle stop.

Morris County Prosecutor's Office

State v. Delmiro Dacuna

On January 11, 2006, Delmiro Dacuna was charged with Insurance Fraud resulting from his alleged inclusion of false information on his company's application for workers' compensation insurance. Dacuna was admitted into the PTI Program and fined \$500.

State v. Kimberly (Stark) McCauley, et al.

David McCauley pled guilty to Health Care Claims Fraud, and, on October 6, 2006, he was sentenced to four concurrent five-year state prison terms. On June 16,

2006, Kimberly Stark (formerly McCauley), having previously pled guilty to theft by deception, was sentenced to three years probation and ordered to pay restitution in the amount of \$8,895 to five insurance companies. In March 2006, Kimberly Stark McCauley executed a \$5,000 civil Consent Order.

David McCauley and his former wife Kimberly (Stark) McCauley were indicted and charged with numerous crimes arising out of their engagement in a pattern of conduct that involved the submission of false or inflated claims to various health insurance companies. David McCauley operated a licensed substance abuse treatment center for adolescents. Kimberly McCauley conducted her chiropractic practice at a location that was adjacent to her husband's rehabilitation center. David McCauley sent more than 30 of his patients to his wife for chiropractic services that were either not necessary or not performed. Kimberly McCauley subsequently agreed to cooperate with the investigation.



Detective Douglas Porter, Secretary Tracy Zandarski, and Assistant Prosecutor Rachelle Jones review a Sussex County insurance fraud case.

State v. Tina Hadjissa, et al.

On September 6, 2006, Tina Hadjissa and Tampe Hadjissa, a married couple, were indicted and charged with conspiracy to commit Insurance Fraud, Insurance Fraud, and theft. The Hadjissas allegedly submitted fraudulent information in connection with their application for Medicaid and public assistance and allegedly received money and benefits to which they were not entitled. Both defendants were admitted into the PTI Program in November 2006, conditioned upon making full restitution in the amount of \$7,000.

State v. Rony Hernandez, et al.

On October 11, 2006, Rony Hernandez, his wife, Ligia Canelas, and his brother, Denis Hernandez, were indicted and charged with receiving stolen property (namely, cars and motorcycles), operating a "chop shop," fencing, altering motor vehicle identification numbers, and other crimes. Rony Hernandez and Denis Hernandez were also charged with leading a stolen car ring. The matter is pending trial.

Ocean County Prosecutor's Office

State v. Brian Stout

On September 28, 2006, Brian Stout was sentenced to three years state prison after pleading guilty to Health Care Claims Fraud, forgery, obtaining a controlled dangerous substance by fraud, and theft. Stout obtained stolen prescription blanks and proceeded to have a series of prescriptions filled for OxyContin, using his health care benefits. An alert pharmacist checked on a prescription submitted by Stout and found that it had not been authorized. Pharmacy records indicated that there had been ten additional prescriptions that had been filled by Stout.

State v. Carolyn Therrien

On June 19, 2006, Carolyn Therrien was sentenced to three years probation after pleading guilty to Insurance Fraud. Therrien reported to a store manager that she slipped and fell on an icy parking lot at a local supermarket. Subsequently, Therrien filed an insurance claim with the Travelers Property and Casualty Insur-

ance Company seeking compensation for injuries sustained in the alleged fall. Video surveillance of the parking lot recorded Therrien's actions at the time of the claimed incident. The video demonstrated that the claimed "slip and fall" did not occur.

Passaic County Prosecutor's Office

State v. Isabel Tavares a/k/a Isabel Rodriguez

On June 30, 2006, Isabel Tavares, a/k/a Isabel Rodriguez, was sentenced to five years probation after pleading guilty to theft by deception. Tavares was also ordered to pay over \$50,000 in restitution. Tavares submitted a fraudulent workers' compensation claim to Chubb Insurance. Tavares failed to disclose several prior and subsequent injuries for which she also submitted claims. Furthermore, she used false personal identifiers including a false Social Security number and date of birth, in an effort to conceal those additional claims from Chubb.

State v. Tamara Issac

On April 24, 2006, Tamara Issac was admitted into the PTI Program for a period of three years and was ordered to pay \$3,000 in fines. Issac allegedly claimed that her vehicle was struck from behind by another vehicle. A subsequent investigation by AAA Mid-Atlantic Insurance Group and the Insurance Fraud Unit revealed that Issac had actually backed up into the opposing vehicle.

State v. Felipe Zapata, et al.

On February 9, 2006, Felipe Zapata was arrested and charged with Health Care Claims Fraud. It is alleged that Felipe and his brother, Manuel Zapata, were "jump in" passengers in a motor vehicle accident. Felipe and Manuel Zapata allegedly claimed to be injured in the accident and were allegedly transported from the scene via ambulance. Subsequently, they allegedly began treatment with a local chiropractor and claims for such treatment were submitted to Palisades Insurance Company. The State alleges that neither Felipe nor Manuel Zapata were passengers in the vehicle at the time of the accident. A warrant has been issued for Manuel Zapata's arrest.

State v. Adalberto Matias

On October 17, 2006, Adalberto Matias was indicted and charged with attempted theft by deception. Matias allegedly filed a fraudulent motor vehicle theft claim with Clarendon National Insurance Company stating that he had last driven his car and parked it on March 11, 2003, when, in fact, the vehicle was recovered burned in Connecticut on March 10, 2003. The matter is pending trial.

State v. Yuri Guillen

An Accusation was filed charging Yuri Guillen with attempted theft by deception. On November 17, 2006, Guillen was admitted into the PTI Program for a period of three years. Guillen allegedly submitted a fraudulent auto theft claim to First Trenton Indemnity Company. A joint investigation by the Insurance Fraud Unit and Paterson Fire Department determined that the alleged theft and subsequent burning of Guillen's 2004 Dodge Caravan were fraudulent.

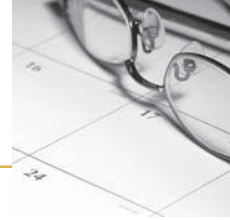
Salem County Prosecutor's Office

State v. Debora Karpinski

On April 3, 2006, Debora Karpinski pled guilty to an Accusation charging her with Insurance Fraud and was ordered to pay restitution in the amount of \$36,000. Between May 2004 and July 2005, Karpinski fraudulently obtained prescription blanks from her previous employer, a doctor, and submitted the prescriptions through Aetna Insurance Company.

State v. Liza Hern

On August 23, 2006, Liza Hern, a nurse, was indicted and charged with Insurance Fraud. On four separate occasions, Hern allegedly submitted fraudulent prescriptions to a pharmacy to obtain 120 tablets of Oxycodone and then submitted claims for the illegally obtained drugs to Express Scripts, which paid \$452 for the fraudulent prescriptions. The matter is pending trial.



State v. Arnetia Kidd

On July 19, 2006, Arnetia Kidd was indicted on charges of Insurance Fraud. Kidd allegedly failed to report an additional driver on her auto insurance policy. As a result, Allstate Insurance Company was allegedly defrauded approximately \$900 in premium payments. The matter is pending trial.

State v. Thias Thompson

On August 2, 2006, Thias Thompson was indicted and charged with Insurance Fraud. Thompson allegedly failed to report an additional driver on her auto insurance policy. As a result, Allstate Insurance Company was allegedly defrauded approximately \$1,300 in premium payments. The matter is pending trial.

Somerset County Prosecutor's Office

State v. Johnny Shi

On May 4, 2006, Johnny Shi was arrested and charged with theft by deception. Shi, who was a salesman at his brother's communications store, allegedly fraudulently filed approximately 30 insurance claims on cellular telephones that he had allegedly recently sold to customers. As a result of those claims, Shi allegedly received new replacement cellular telephones by mail, which he allegedly either kept for himself or resold as inventory at another store located in New York. The Green Brook Police Department and Insurance Fraud Unit were assisted by fraud investigators from Cingular Wireless and Asurion Insurance during this investigation.

State v. Anthony Doyle

On September 1, 2006, Anthony "Tad" Doyle was arrested and charged with Insurance Fraud. Doyle, a public adjuster, was hired by a Somerset couple to evaluate damage to their counter top resulting from a small kitchen fire in their home and to file a claim with New Jersey Manufacturers Insurance Company on their behalf. Doyle allegedly filed an inflated claim for approximately \$15,600 in damages. However, the State alleges that an investigation by the insurance company revealed the fire caused approximately \$700 in damages

to the claimants' home. Doyle's alleged misleading statements were allegedly intended to induce the insurance company into paying a grossly exaggerated claim. The case is pending trial.

Sussex County Prosecutor's Office

State v. Clayton Erven

On December 6, 2006, Clayton Erven was sentenced to one year probation, ten days in the SLAP program, and ordered to pay criminal fines after pleading guilty to exhibiting an altered or simulated motor vehicle insurance identification card. Erven produced an expired insurance card from Selective Insurance Company during a motor vehicle stop. The following day he stopped at the Sheriff's Department and produced an altered insurance card to get his car released from the impound yard.

Union County Prosecutor's Office

State v. Terrance J. Barfield

On August 25, 2006, Terrance J. Barfield was sentenced to three years state prison after previously pleading guilty to Insurance Fraud. Barfield assisted in dismantling a car knowing it would be reported stolen for insurance purposes. The owner of the car ultimately made a fraudulent claim to Rutgers Casualty Insurance Company.

State v. Andre Manning, et al.

On August 3, 2006, Andre Manning was sentenced to probation, conditioned upon serving 270 days in county jail, on charges of Insurance Fraud. Manning allegedly arranged to have his girlfriend's car disassembled at a "chop shop," knowing she would report it stolen to Clarendon Insurance Company. Manning allegedly admitted to participating in the destruction of two additional cars, knowing that they would be reported stolen for insurance purposes. The two insurance companies involved were High Point and Proformance Insurance. Manning's girlfriend, Josezetta Hill, was admitted into the PTI Program.

State v. Ruthie Walker

On September 14, 2006, Ruthie Walker was charged with Insurance Fraud for allegedly falsely reporting to New Jersey Manufacturers Insurance Company that her car had been stolen in New Jersey several weeks after it actually had been parked in an airport parking garage in Detroit, Michigan.

State v. Reveca Vigier

Reveca Vigier was charged with simulating a motor vehicle insurance identification card. On May 5, 2006, she was accepted into the PTI Program. Vigier allegedly presented a fraudulent Liberty Mutual insurance identification card to an Elizabeth police officer prior to leaving the scene of an accident.

State v. Marco Tranco

On August 2, 2006, Marco Tranco was accepted into the PTI Program. Tranco was charged with Insurance Fraud for allegedly inflating the value of the accessories in his stolen car claim submitted to Allstate Insurance Company.

Warren County Prosecutor's Office

State v. Georgeann Pludowski

On October 16, 2006, Georgeann Pludowski pled guilty to conspiracy and theft by failure to make required disposition of property received in connection with allegedly converting the proceeds of an estate, which included a \$30,000 life insurance benefit, for her and her husband's personal use. She was admitted into the PTI Program and ordered to pay \$36,865 in restitution.

State v. Steven Lee Wilson

On September 22, 2006, Steven Lee Wilson pled guilty to falsifying or tampering with public records and failure to register as a contractor. He was sentenced to 18 months probation, and ordered to pay \$2,000 in restitution and \$280 in criminal fines. Wilson, trading as Stevcon Renovations, allegedly presented an altered Certificate of Liability Insurance to a homeowner who had hired him to perform home renovations.

OIFP's Budget for Fiscal Year 2006 by Ray Shaffer

In accordance with N.J.S.A. 17:33A-30, OIFP operations are funded through an assessment on the insurance industry. It should be noted that although the Medicaid Fraud Section is a part of OIFP, monies derived from the assessment on the insurance industry do not fund the Medicaid Fraud Section. Rather, the Medicaid Fraud Section is funded by a federal grant that provides 75% federal funding and requires the State to provide a 25% State match from Direct State Services (DSS) funds.

OIFP operating costs consist of expenses incurred directly by OIFP staff, as well as expenses for services, facilities, and equipment shared jointly with the Division of Criminal Justice (DCJ) and the Department of Law and Public Safety, but benefitting OIFP staff and OIFP operations. By sharing these common services with DCJ and the Department of Law and Public Safety, OIFP is able to take advantage of economies of scale and thereby reduce its overall operating budget.

In order to ensure that there is transparency, accountability, and fiscal integrity in all expenditures of industry monies, the Insurance Fraud Prosecutor has implemented a 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 expenses. A summary of the Cost Allocation Plan and quarterly expense reports are posted on OIFP's Web site so that the insurance industry, as well as the general public, will have continuous access to OIFP's fiscal reports.

In accordance with the 2005 State Auditor Report, it is appropriate for DCJ personnel who provide various support services to OIFP to be paid out of OIFP funds. See

State Auditor Report for the Department of Law and Public Safety, Division of Criminal Justice, Office of the Insurance Fraud Prosecutor, issued July 15, 2005. Such services include administrative, legal, and investigative support. The Annual Cost Allocation Plan details the following four levels of support provided by DCJ to OIFP: Administrative Support, Professional Support, Intermittent Support, and Non-Salary Costs.

■ Administrative Support

Due to the nature of administrative work in such areas as Human Resources, Fiscal and Budget, Facilities, and IT Services, it is difficult to differentiate between those services provided to OIFP and those services provided to other sections within DCJ. The Cost Allocation Plan provides that administrative salary costs are to be allocated based on a ratio of the number of OIFP staff to the number of DCJ staff. At the beginning of each fiscal year (July 1), this percentage is determined and applied to the salaries and fringe benefits costs of those sections classified as providing administrative support to OIFP for that fiscal year.

■ Professional Support

DCJ provides a number of services that are needed to allow the criminal component of OIFP to better investigate and prosecute 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 resource providers. In order for OIFP to pay for 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. This percentage is then used for the upcoming fiscal year to pay the corresponding portion of staff salaries and fringe benefits costs for staff assigned to DCJ sections under this classification.

■ Intermittent Support

DCJ also provides a host of resources to OIFP on an as-needed basis. Extra manpower for search warrants, forensic computer analysis, handwriting analysis, and the installation of electronic surveillance equipment are a few examples of investigative support provided by DCJ to OIFP. In addition, OIFP relies on designated DCJ legal staff to handle its appeals, ethics inquiries, and forfeiture actions, among other legal tasks. 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 is calculated and OIFP reimburses DCJ for those costs.

The new timekeeping system also works in reverse, tracking the number of hours worked by OIFP staff on non-OIFP assignments. Given tight budget restrictions in the State and the increasing demands on statewide law enforcement, it is sometimes necessary for OIFP staff to provide support in implementing statewide DCJ initiatives. However, this does not mean that the insurance industry should pay for these non-insurance fraud related activities. The new tracking system allows both OIFP and DCJ to determine the number of hours worked by the respective staff members 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 are purchased and maintained by OIFP. Items, such as buildings, computer networks, and phone systems, that OIFP shares with other sections within DCJ, are paid based on the percentage use of those resources by OIFP staff. The percentage size of OIFP as compared to DCJ is determined at the beginning of each fiscal year and that percentage is applied to those costs as they are incurred through the fiscal year.

Ray Shaffer is the OIFP Administrative Liaison and assists the Insurance Fraud Prosecutor in the day-to-day administrative management of OIFP by working closely with the Division of Criminal Justice's Administrative Bureau. He had been part of the DCJ Administrative Bureau for 27 years before coming to OIFP in 2005.



OIFP Expenditure Report for Fiscal Year 2006

Personnel (Salaries and Fringe Benefits)		\$21,800,327.35
OIFP Staff Salaries and Fringe Benefits ¹	\$19,887,273.26	
DCJ Support Staff Salaries and Fringe Benefits ²	\$1,913,054.09	

Outside and Professional Services		\$4,894,587.83
County Prosecutor Reimbursement Program ³	\$2,905,699.84	
DOL Professional Support ⁴	\$1,600,000.00	
Expert Witness and Other Professional Services	\$146,152.30	
Transcription and Other Expenses	\$242,735.69	

Training, Trial and Investigative Travel Expenses⁵	\$20,904.71
--	--------------------

Vehicles and Vehicle Maintenance		\$703,460.68
Fuel and Oil for OIFP Undercover Vehicles	\$79,734.80	
Undercover Vehicle Lease and Maintenance	\$122,821.52	
State's Central Motor Pool Vehicle Lease, Maintenance & Fuel ⁶	\$500,904.36	

Office Supplies, Services, Equipment and Maintenance		\$984,399.68
Household and Janitorial Supplies	\$10,413.55	
Maintenance of Equipment	\$42,665.63	
Office Equipment Purchases	\$80,172.30	
Other Supplies	\$198.34	
Printing and Office	\$90,039.35	
Postage	\$31,113.76	
Telephone	\$215,881.99	
Database Licensing Purchases and Maintenance	\$178,432.51	
State Mainframe Charges	\$36,924.14	
IT and Telephone Equipment Purchases and Maintenance	\$298,558.11	

Building Rent and Maintenance⁷		-\$1,121.88
Maintenance - Building	\$141.12	
Rent - Buildings	\$1,263.00	

Total OIFP Expenditures for Fiscal Year 2006	\$28,402,558.37
Less Prior Year Repayment of Non-OIFP Hours	-\$475,059.58

Total Net OIFP Expenditures for Fiscal Year 2006	\$27,927,498.79
---	------------------------

¹ Includes Attorney, Investigator, Professional and Clerical staff working directly for OIFP.

² Cost of Shared Administrative and Criminal Support provided by DCJ per the FY2006 Cost Allocation Plan.

³ Funds provided to County Prosecutors' Offices as reimbursement for activities undertaken by those offices in connection with investigating and prosecuting insurance fraud. See N.J.S.A. 17:33A-28.

⁴ Civil Attorney Staff and Services provided by the Division of Law to litigate OIFP civil cases under the NJ Insurance Fraud Prevention Act. See N.J.S.A. 17:33A-1, et seq.


⁵ Includes witness transportation to and from trial.

⁶ Vehicle lease, fuel and maintenance for vehicles used by OIFP Investigators and Prosecutors to do field work and attend court appearances.

⁷ Includes rental of undercover facilities but does not include cost of building rent for OIFP's three regional offices which are billed separately by Treasury.

Fiscal Year = July 1 through June 30





OIFP Scores Supreme Court Victory

by John Grady

As reported in the 2005 Annual Report, on October 24, 2005, OIFP argued before the New Jersey Supreme Court as amicus curiae in the matter of Liberty Mutual Insurance Co. v. Land on the question of the appropriate burden of proof under the Insurance Fraud Prevention Act, N.J.S.A. 17:33A-1 et seq. (the IFPA). In the 22 years in which the IFPA has been in effect, the courts had not definitively resolved the burden of proof issue. A single trial court opinion, later refuted by its author, Harleysville Insurance Co. v. Diamond, 359 N.J. Super. 34 (2002), applied a clear and convincing standard in a matter involving an insurance carrier's cause of action for a violation of the IFPA. N.J.S.A. 17:33A-7. Although the judge who wrote the Harleysville opinion held in later opinions that the preponderance of the evidence 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 the Harleysville decision as the standard to be applied.

OIFP joined Liberty Mutual as amicus in the appeal to the Supreme Court to advocate that the preponderance standard was the appropriate standard under the IFPA and most accurately reflected the Legislative intent. OIFP's position was that a preponderance 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 in 1983 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. Indeed, the Legislature, and the Supreme Court in Merin v. Maglacki, 126 N.J. 430 (1992), identified insurance fraud as being of "massive proportions" and recognized the need to combat insurance fraud aggressively. In Merin, the Court held that the Commissioner's interpretation of the IFPA was entitled to deference, as it reasonably and substantially effectuated the legislative intent to combat insurance fraud. Likewise, with the authority to enforce the IFPA having been transferred to OIFP, it was argued that the Insurance Fraud Prosecutor's interpretation of the IFPA in this instance was 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 IFPA.

OIFP articulated for the Court the legislative purpose of the IFPA and the absence of any provision imposing a higher burden, as well as other persuasive reasons for imposing a preponderance standard. OIFP asserted that 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 a preponderance standard in similar legislation addressing the need to protect consumers from fraudulent conduct, such as the Consumer Fraud Act, N.J.S.A. 56:8-1 to -20, and its federal counterpart the False Claims Act, 31 U.S.C. §3729(a)(2), and the existence of a preponderance standard for affirmative defenses to an insurance claim were all additional factors in favor of a preponderance standard.

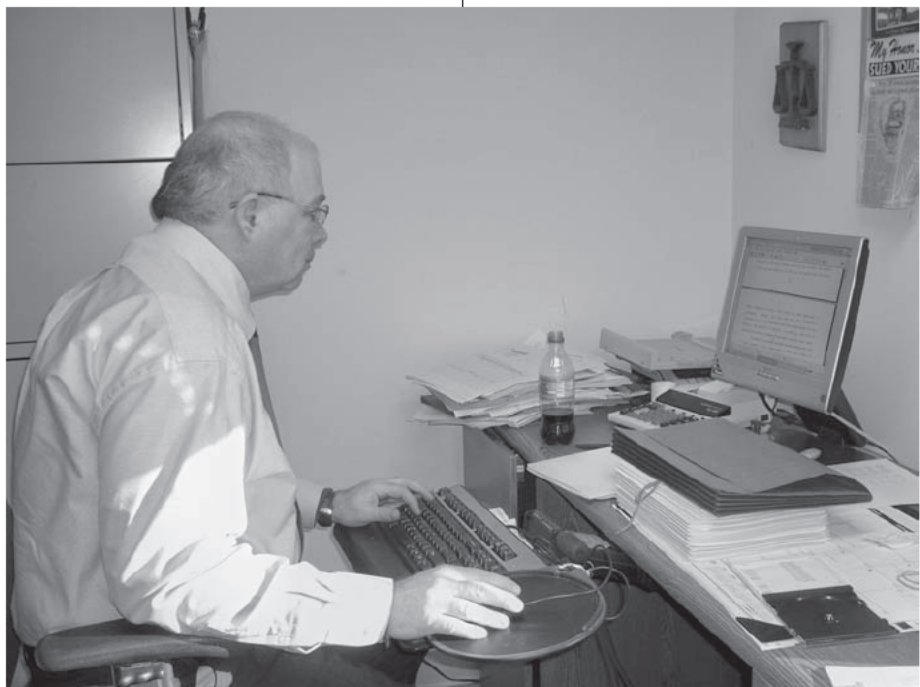
The New Jersey Supreme Court agreed with OIFP and, on March 14, 2006, ruled that the appropriate burden of proof under the Act is a preponderance of the evidence. In a 5-2 decision in Liberty Mutual Insurance Co. v. Land, 186 N.J. 163 (2006), authored by then Justice Zazzali,¹ the high court held that although the plain language of the Act and its legislative history are silent concerning the applicable standard of proof, a review of analogous fraud statutes, rules of statutory construction and related considerations persuaded the majority of the Supreme Court that the Legislature intended a preponderance of the evidence standard to apply to the Act. The Court reasoned that its ruling would effectuate the Legislature's intent to "confront aggressively the problem of insurance fraud in New Jersey." "The Legislature in enacting the IFPA did not codify common law fraud but rather supplemented that action because,

standing alone, it had proven to be insufficient in combating and deterring insurance fraud." Land, 186 N.J. at 174.

The closest statutory analogue to the IFPA in New Jersey is the Consumer Fraud Act (CFA) which is also remedial legislation, warranting liberal construction. Consumer fraud actions permit the imposition of treble damages and attorney fees to "compensate the victim for his or her actual loss; to punish the wrongdoer through the award of treble damages; and by way of the counsel fee provision, to attract competent counsel to counteract the community scourge of fraud." Land, 186 N.J. at 176 citing Lettenmaier v. Lube Connection, 162 N.J. 134, 139 (1999). In discussing the burden of proof under the CFA, the Appellate Division in Gennari v. Weichert Co. Realtors, 288 N.J. Super. 504, 541 (App. Div. 1996) aff'd 148 N.J. 582 (1997) had come to the conclusion that there was no indication that the Legislature intended to impose any greater burden of proof than that usually required in a civil action.

The CFA's federal counterpart, the False Claims Act (FCA) similarly requires proof by a preponderance of the evidence. 31 U.S.C. §3731(c). As with the IFPA, the FCA provides for civil penalties, and, in some cases, treble damages, against "any person who knowingly makes, uses or causes to be made or used a false record or statement to get a false claim paid or approved by the Government." 31 U.S.C. §3729(a)(2). Land, supra at 176. Congress overruled judicial interpretations of the FCA which imposed the higher clear and convincing standard by amending the FCA to explicitly provide for a preponderance standard, 31 U.S.C. §3731(c). Id. at 177. The Supreme Court noted that anti-fraud provisions of federal securities laws also rely upon a preponderance standard. Ibid.

These and other persuasive considerations, combined with the potential for inconsistent results when IFPA actions are coupled with an insurance carrier's affirmative defense of arson, fraud, or false swearing, which are all subject to a



Division of Law Deputy Attorney General John Grady drafts a motion for oral argument.

1. Justice Zazzali has since been appointed Chief Justice of the New Jersey Supreme Court to replace the retiring Chief Justice Deborah Poritz.



preponderance standard, assisted the Court in ruling that a preponderance standard was appropriate. Justice Zazzali observed that “it is doubtful that the Legislature envisioned that an affirmative defense of fraud would be governed by a preponderance of the evidence but that a counterclaim based on the same fraudulent conduct would require a higher standard of proof.” Land at 178. Finally, the Court observed that the Legislature is well aware of its ability to impose a higher standard of proof when it desires and had not done so in the context of the IFPA.

Justices Albin and Long dissented expressing, among other concerns, that pursuant to the majority’s opinion, the revocation of an individual’s driving privileges for a violation of the IFPA under a preponderance standard was less stringent than the standard applicable to other Title 39 violations which may result in revocation of driving privileges. Land dissenting opinion at 187; N.J.S.A. 39:6a-15. In a footnote, the majority left open the question of whether a higher standard should apply in automobile insurance cases where a mandatory revocation of driving privileges presents a set of interests not at stake in Land. Land, supra n.4 at p. 180.

Automobile insurance fraud and its impact upon automobile insurance rates were motivating forces behind the IFPA and the creation of OIFP. The use of the IFPA to address the activities of fraud rings, PIP mills, and opportunistic fraudsters has been an important part of restoring balance to the automobile insurance market. OIFP will, therefore, respond aggressively to any challenge to the application of the preponderance standard in automobile insurance cases and will assert that the very same reasons addressed by the Supreme Court in Land in determining that a preponderance standard for actions under the IFPA was both sensible and fair apply with all of the same force and vigor in automobile insurance cases.

John Grady, a Deputy Attorney General, is a 13-year veteran of the Division of Law and is the Lead Deputy for the Insurance Fraud Section. He is a certified civil trial attorney and spent eleven years in private practice before joining the Division of Law.





The Growing Problem of Rate Evasion

by Scott Patterson

Three types of insurance fraud are becoming more and more prevalent in this State due to the increasing costs of automobile insurance. They are insurance application fraud, rate evasion, and reverse rate evasion.

Application fraud occurs when false or fraudulent information is provided on an application in order to obtain insurance at a lower premium rate. The fraudulent information on the application may pertain to anything that is material to the policy and that would affect the premium to be charged for the prospective policy. Examples of information which might affect a rate premium would include the number of drivers in the household, driver history, type of car, use of car, or the location where the car is principally garaged.

Rate evasion is a specific type of application fraud, wherein a resident of one state fraudulently registers and insures his or her vehicle in a neighboring or some other state in order to avoid higher premiums that would be incurred had he or she insured the vehicle in the resident state. The effects of rate evasion include higher premiums for those who properly register their vehicle, loss of substantial revenues to the resident state, and reduced insurance company and stockholder profits. Examples of typical rate evaders who are prosecuted in New Jersey by the Office of the Insurance Fraud Prosecutor (OIFP) under the Insurance Fraud Prevention Act (Fraud Act) include persons who reside outside the State of New Jersey in Philadelphia, New York City, or elsewhere but illegally

register and insure their vehicles in New Jersey by falsifying their address, location where the vehicle is principally garaged, or other similar information on the vehicle registration and insurance application forms in order to avoid higher premiums. See N.J.S.A. 17:33A-4.

“Reverse rate evasion,” as it is commonly referred to in New Jersey, occurs when New Jersey residents fraudulently use out-of-state addresses to register and insure vehicles which they garage at their full-time residences in New Jersey. In some cases, this is done to obtain less expensive insurance policies than would otherwise be available to persons who principally garage their vehicles in New Jersey. In other cases, individuals avail themselves of “one stop shopping” in neighboring urban centers, such as Philadelphia, where they are able to obtain their vehicle’s title, registration, and insurance from a single dealer¹ for a low flat fee. The individuals involved may or may not even be aware that they are not complying with New Jersey motor vehicle insurance regulations.²

1. It should be noted that the Pennsylvania authorities have taken significant steps to make it more difficult for an individual to register a vehicle in Pennsylvania without proper identification.

2. In this regard, some local police departments have addressed this issue by distributing educational flyers to drivers of cars routinely parked in a New Jersey municipality but displaying out-of-state license plates. These flyers emphasize the car owner’s obligation to comply with New Jersey registration and insurance laws.

During this past year, OIFP has seen an influx of reverse rate evasion cases involving individuals who are registering their vehicles in North Carolina. This is in part due to the fact that North Carolina, which is ranked number five among the country's lowest insurance rates, does not require a North Carolina drivers license or proof of address to register vehicles and obtain license plates.³ Anecdotal data also suggests that the growth of reverse rate evasion may be linked to the issue of illegal immigration, particularly if the owner or operator of the vehicle is an undocumented New Jersey resident who is unable to meet the New Jersey Motor Vehicle Commission's six points of identification requirement to legally obtain a drivers license and automobile registration here in New Jersey. Such persons may be legally able to register their cars in other states, such as North Carolina, where there are less stringent licensing requirements.

Unfortunately, this growing practice of reverse rate evasion negatively impacts insurance carriers in New Jersey by depriving them of the higher premiums they might have charged had the insurance been properly obtained. The practice also deprives the State of New Jersey from collecting registration fees on the vehicles that would have been received had they been properly registered in New Jersey. Most significantly, New Jersey residents

suffer from the practice of reverse rate evasion when they become involved in a motor vehicle accident, suffer bodily injury, or incur property damage resulting from an accident with a reverse rate evader because many out-of-state policies provide lesser coverage than would otherwise be mandated under a policy in New Jersey. In addition, the rate evader's policy may be voided altogether in the event of a claim on the basis of the misrepresentations made by the policyholder in falsely claiming to reside or garage the insured vehicle in the "other" state.

Rate evasion and its counterpart, reverse rate evasion, are not only serious problems in this State but in others as well. As a result, rate evasion is being addressed by our neighboring states of New York and Pennsylvania as well as others throughout the country. On March 30, 2006, the Pennsylvania Insurance Fraud Prevention Authority (IFPA) and the Pennsylvania Insurance Department (PID) jointly hosted a meeting on the subject of rate evasion for over 140 representatives of the insurance industry, insurer and producer trade groups, the Pennsylvania Assigned Risk Plan (the Plan), the Pennsylvania Department of Transportation (PennDOT) Bureau of Motor Vehicles, and law enforcement officials from New York, New Jersey, and Pennsylvania. Following the meeting, the

Pennsylvania authorities issued a lengthy report outlining the crucial issues involved in reverse rate evasion.⁴ Likewise, in December 2006, after conducting an exhaustive investigation, the New York State Commission of Investigation produced a preliminary report of their investigation into rate evasion through the use of out-of-state license plates.⁵

As the agency charged by statute to serve as the focal point for all insurance fraud related problems, OIFP has long realized the seriousness of the problems surrounding rate evasion and reverse rate evasion.⁶ Although State statutes and regulations have allowed State officials to prosecute the non-resident rate evader in this State, jurisdictional issues, illegal immigration issues, legal issues pertaining to multiple residences, and law enforcement resource issues greatly complicate reverse rate evasion investigations for local law enforcement, County Prosecutors, and OIFP. Indeed, these factors have limited criminal prosecutions of reverse rate evaders.

N.J.S.A. 17:33A-24 requires OIFP to make appropriate legislative and regulatory recommendations to fight fraud. To this end, OIFP has made numerous recommendations over the years to amend the Fraud Act to create a violation which includes the practice of reverse rate evasion. Under these proposals, a New Jersey resident who fraudulently reports an out-of-state address as the address where he/she registers and garages his/her vehicle, when, in fact, the vehicle is garaged and primarily driven in New Jersey, would violate the Fraud Act.⁷

In addition, current motor vehicle laws provide little help in prosecuting reverse rate evaders. Unlike the statutory requirement for a resident of New Jersey to obtain a valid drivers license within a specified period of time, typically 60 days, there is no companion statutory requirement regarding registration of a motor vehicle in this State, if that motor vehicle is validly registered in some other jurisdiction.⁸ Since the requirement for insurance is intertwined with the registration requirement, a prosecution for insurance fraud in these circumstances would be difficult.



OIFP staff work with local police in conducting joint rate evasion investigations.



Rate evasion cases require in-depth investigations to establish residency.

However, Senate Bill No. 2087, sponsored by State Senators Stephen M. Sweeney (Salem, Cumberland, and Gloucester) and Shirley K. Turner (Mercer), would require new State residents to register their vehicles in New Jersey. The bill, which was introduced on June 26, 2006, passed the Senate on December 4, 2006, and was pending before the Assembly Committee on Transportation and Public Works.

The bill as proposed would essentially require a person who becomes a resident of this State, and who immediately prior thereto was authorized to operate and drive a motor vehicle in this State as a non-resident, to register his vehicle or vehicles within 60 days of becoming a resident. Those who fail to properly register their vehicles would be subject to a fine of up to

\$250 for the first violation, up to \$500 for a second violation, and impoundment for a third or subsequent violation.

Although the bill makes no mention of requiring that the newly registered vehicle be insured, current motor vehicle laws require that every owner or registered owner of a motor vehicle registered or principally garaged in this State shall maintain motor vehicle liability coverage.⁹ With the passage of this bill, law enforcement will finally have a necessary tool to combat these unique yet ever growing types of fraudsters who plague our streets, cause legitimate policyholders higher premiums, lower insurance company and stockholder profits, reduce State income in the form of registration and other fees, and put legitimate New Jersey residents and policyholders at risk.

Scott Patterson is a 17-year veteran of the Division of Criminal Justice and currently serves as the Supervising Deputy Attorney General in charge of OIFP's Case Screening, Litigation and Analytical Support Section (CLASS). He previously served as an Assistant Prosecutor in Passaic County.

3. *The Charlotte Observer*, Sunday, October 29, 2006.

4. "Challenges of Non-Resident Rate Evasion," joint report of the Pennsylvania Insurance Department and the Pennsylvania Insurance Fraud Prevention Authority, dated March 30, 2006.

5. "Preliminary Report of an Investigation into Rate Evasion Through the Use of Out-of-State License Plates," New York State Commission of Investigation, December 2006.

6. Over the years, OIFP has received correspondence from concerned citizens, in municipalities such as Riverside, Trenton, and Delran, complaining about the overwhelming presence of cars with out-of-state license plates parked overnight on a consistent and continuous basis in their communities. From the presence of those vehicles, these concerned citizens inferred that the vehicle owners and operators were, in fact, engaging in the illegal practice of reverse rate evasion. While this inference may be accurate in some cases, it would be ill advised for law enforcement to take any type of enforcement action without an in-depth investigation. Such investigations generally entail automobile traffic stops conducted by local patrol officers to check the vehicle registration and insurance documents presented by the operator of the vehicle, followed by exhaustive investigations by County Prosecutors' Offices or OIFP to substantiate any allegations of criminality arising from the initial "police roadside stop."

7. See 2005 OIFP Annual Report, p.91; 2003 OIFP Annual Report, p.181; 2002 OIFP Annual Report, p.90.

8. See N.J.S.A.39:3-17.1.

9. See N.J.S.A.39:6B-1.



NJ Insurance Industry's Perspective on Ambulatory Surgical Centers

by Frank P. Brennan, Esq.

If you ask New Jersey PIP insurers what is the most significant issue they face today in terms of potential fraud, you will often be told it is the problem arising from Ambulatory Surgical Centers (ASCs). Unlike many of the schemes that carriers have faced previously, ASCs present problems because of the complexity of the regulations which control the services provided and the individuals entitled to provide those services. In other contexts, insurers are accustomed to tackling issues created by the lack of regulation. Here, the perpetrators of these schemes are using the regulations and the confusion caused by their complexity to abuse the Personal Injury Protection (PIP) system to their advantage.

How It Was Supposed to Be

As we all know, the rising cost of health care has been a central issue for many regulatory agencies for years. In an effort to facilitate health care cost containment, the federal government issued regulations creating an opportunity for intermediate care settings to be used for certain services to eliminate the high cost associated with hospital care. These intermediate care settings were created to reduce costs by permitting lower cost settings for procedures too complex for doctors' offices but not so complex that a hospital setting is needed.

These intermediate care settings or ASCs are supposed to provide a legitimate incentive for surgeons to perform surgery in non-hospital settings. Although both the federal government and many states have specific regulations in

place to prevent self-referrals in most situations,¹ Medicare regulations created what is termed a "safe harbor" from self-referral prohibitions to accomplish the cost containment objective that ASCs can provide. Under the regulations, the "safe harbor" allows a surgeon to own an ASC and legally self-refer patients to that ASC. However, many providers are using these new regulations designed for cost containment as a method to "get around" the roadblocks that have prevented their abuses. The new abuses have taken the concept of cost containment and turned it on its head.

How It Is Today

An actual case scenario will demonstrate the abuses being seen today. An individual involved in an automobile accident, who had received much of the standard care provided in many PIP cases, was recommended for and provided a relatively new procedure known as Manipulation Under Anesthesia (MUA). MUA is a legitimate procedure that is provided when there is a very specific diagnosis and under very controlled circumstances. The procedure is usually performed in a hospital or ASC setting. It requires three procedures performed on three consecutive days. There are many potential fraud issues involved with an MUA but, for these purposes, the concern here is limited to the abuse of the ASC facility.

In this case, the procedure is performed by a chiropractor who bills \$11,550 for his services. The carrier also receives a bill for \$10,800 from a second chiropractor serving

as an "assistant surgeon." The procedure is performed at an ASC because anesthesia is required. The anesthesiologist bills the carrier \$2,670 for his services. Then, the ASC sends a bill to the carrier for \$41,550 as a "facility fee." In the span of three days, the carrier was billed a total of \$66,570 for procedures lasting 52 minutes in total. Clearly, in this scenario, rather than limiting health care costs, the use of an ASC has increased them exponentially. In some cases, carriers are receiving bills in excess of \$75,000 for single day procedures.

The original regulations for ASCs were created in the Medicare system. Some of the highlights of those regulations are that an ASC in which the provider performs the surgical procedure must be a Medicare Qualified and Certified ASC. 42 C.F.R. 416.2. In addition, the surgical procedure for which the facility fee is billed must be listed as a covered surgical procedure in the ASC Base Eligibility file. 42 C.F.R. 416.65. Also, the ASC must comply with state licensing requirements, must have a governing body, and must have all duly licensed medical staff qualified for their positions. Furthermore, the procedure must be performed in a safe manner by a qualified physician granted privileges by the ASC and the physician must evaluate

1. The application of the anti-self referral and anti-kickback statutes has been used by insurers for years as a method to contain abuses by medical providers attempting to maximize revenues by taking advantage of the PIP payment statutes.

the patient for proper anesthesia recovery before discharge.

In order to qualify for the “safe harbor,” the ASC must meet several requirements. The ASC must be a Medicare certified ASC and must have operating and recovery room space dedicated exclusively to the ASC. The patients referred to the ASC by an investor must be fully informed of that investment. Furthermore, the investment terms cannot be related to the expected volume of referrals. In addition, the ASC and other investors cannot loan funds or guarantee a loan to any investor. Also, at least one-third of the physician owner's medical income for the last 12 months must be from ASC procedures. Finally, any ancillary services may not be separately billed.

Under the regulations, the ASC must fall within one of the following four categories:

- a. Surgeon-owned ASC;
- b. Single-specialty ASC
- c. Multi-specialty ASC;
- d. Hospital/physician-owned ASC.

There are very specific regulations for each of these categories. The most common and most troublesome for PIP carriers is the multi-specialty ASC. For multi-specialty ASCs, all investors must either be physicians in a position to refer patients to the entity and perform procedures on those patients, or investors not employed by the ASC. In addition, at least one-third of the procedures performed by physician investors in the previous 12 months must have been performed at an owned ASC.

Where the Fraud Begins

The New Jersey Board of Medical Examiners (BME) recognizes the federal “safe harbor” for physician owners in New Jersey and has taken additional steps to regulate ASCs. However, the ASC itself is regulated by the Department of Health and Senior Services (DHSS) rather than the BME. Therefore, under the current system, DHSS regulates the facility while the BME regulates the practitioners.

Under this regulatory scheme, several potential issues may develop. These issues may be divided into different compliance parameters. The first is who is required to have a license, and how does one determine whether the individual or the entity is improperly operating without a license? DHSS licenses ASCs under the Health Care Facilities Planning Act, N.J.S.A. 26:2H-1, et seq. However, this licensure requirement does not apply to a surgeon's private practice.

A private surgical practice is defined at N.J.A.C. 8:43A-1.3 which states that to be exempt from DHSS licensure requirements, a surgical practice must be “established by a physician or physician professional association surgical practice solely for his/her/their private medical practice.” N.J.A.C. 8:43A-1.3. Also, a private practice must have only one dedicated operating room. If the operating room is not used “solely” for the practice of the owners, it is not a surgical practice, and it must be licensed.

This leads to the issue of charging facility fees for unlicensed ASCs operating as a private surgical practice. If the surgical practice is not subject to the licensing jurisdiction of DHSS, then the BME regulation limiting facility fees arguably applies. But, as will be seen later, this regulation is ambiguous. Also, under the federal “safe harbor” provisions, the provider must be a Medicare registered surgeon. Since Medicare only allows certain listed surgical procedures to be performed at ASCs, the same should apply in the PIP context.

There are also several other issues that arise in this context. For example, the physician must be privileged to perform “that surgery” or special procedure by a hospital, or, if not by a hospital, then directly by the BME. N.J.A.C. 13:35-4A.6(a). The BME regulations at N.J.A.C. 13:35-4A.1, et seq. also impose requirements on physicians who perform “surgery” or “special procedures” in an “office setting.” In that provision, each term is defined and “minor surgery” is specifically excluded. Finally, there are also extensive regulations that control

other factors, such as patient safety, written instructions, written surgical policies, written quality assurance programs, and existence and maintenance of emergency equipment.

The potential for insurance fraud in ASCs begins where the regulations end. At the present time, there are no regulations controlling the fees charged by the ASC and the associated providers. Medicare fees essentially do not apply in the PIP context. This determination was made by the Board based on its interpretation of the Medicare regulations and the Board's regulations.

One could argue that the fee issue should be controlled by the Board's regulation found at N.J.A.C. 13:35-6.17(h)(5) which reads:

A licensee who owns or practices in premises used for the performance of personal medical services including, but not limited to, ambulatory surgery services but not holding a Certificate of Need (License) from the State Department of Health, shall not charge, or permit or condone a charge or “facility fee” separate from the fee for professional services. A facility fee may, however, be charged by a licensee who is a registered Medicare provider of surgical services, who is billing pursuant to criteria for such fee established by rules of the United States Department of Health and Human Services.

The common understanding of this provision is that no facility fee is allowed unless the facility and provider qualify under the federal “safe harbor” provisions. More importantly, one could clearly argue that under this BME regulation, the Medicare fee schedule should apply. However, there is also a Board decision that is widely circulated that specifically speaks to the above underlined language as follows:

The Committee advises that the emphasized phrase should be understood to mean that the facility/medical office is, in fact, staffed and equipped to meet Medicare standards.



However, that rule does not purport to limit the charge by such a facility for a non-Medicare patient.

What has developed as a result of this BME opinion is that ASCs are charging excessive fees with no available controls other than the “Usual and Customary Standard” used in other PIP matters. Anyone familiar with PIP benefits would agree that this standard does not provide extensive controls. The Automobile Insurance Cost Reduction Act (AICRA) charged the Department of Banking and Insurance (DOBI) with the duty of regulating medical fees charged to PIP carriers. The stated goals were to ensure that fees are not excessive and to ensure that fees are uniform in order to limit disputes, to reduce inefficiency in billing, and to prevent fraud.

Armed with that statutory responsibility, DOBI is attempting to establish and periodically review the fees that auto insurers pay for the treatment of auto accident injuries. As of this writing, rules were proposed providing that these fees must be on a regional basis because expenses and fees vary by region. In addition, under the proposed regulation, fees must be based on the type of service provided (e.g., by CPT code) and fees must be “reasonable and prevailing.” Unfortunately, at the present time, ASC fees and many of the procedures performed at ASCs are not on the fee schedule.

DOBI’s proposed regulation and fee schedule will define certain terms as they apply in the PIP context and also provide fee schedule amounts for many of the services. For example, a surgical facility is defined as a facility licensed as an ASC in New Jersey in accordance with N.J.A.C. 8:43A-1; or a physician-owned single operating room in an office setting that is certified by Medicare. An appropriate procedure is defined as a procedure that is not defined as minor surgery by N.J.A.C. 13:35-4A.3.

In the insurance industry, the common perception is that the fees are still extremely high and possibly excessive. But, at the very least, the proposed regulations will provide some limits. The

good news for the industry is that the new regulations will provide some guidance where there was none. Also, there will be clearer definitions of key terms and concepts. However, the fraud and abuse will in all likelihood continue, especially in the area of self-referrals and ownership. Additionally, many of the fraud schemes that will remain are the same schemes currently being uncovered in medical fraud cases.

For example, a common type of fraud scheme in the medical arena is upcoding of procedures to reflect a higher reimbursed service than that which was provided. As in the MUA example, the services performed were billed utilizing surgical codes but they were, in fact, performed by chiropractors. This constitutes fraud on several levels. We have seen many providers charge for open procedures when percutaneous procedures are being performed. The important factor will always be that the procedure must be justified and supported by the medical documentation.

Another common fraud scheme is unbundling of services to create the appearance that what is inherently one procedure is billed as many to maximize profits. Common in the ASC cases is the separation of charges for “supplies” or billing for “co-surgeons” or “assistants,” as in our example, and also billing for certain procedures by segment or level as opposed to regions. Of particular significance is the fact that in many cases where the billing of the facility fee is not warranted, the billings will improperly include billings for supplies, personnel, and time involved in the procedure.

Currently, in a facility fee, the following are included and should not be billed separately:

1. nursing, technician, and related services;
2. use of the facilities where the surgical procedures are performed;
3. drugs, biological, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of surgical procedures;

4. diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
5. administrative recordkeeping and housekeeping items and services;
6. materials for anesthesia.

Yet, in many cases, separate charges for the above items are billed to the carriers.

Finally, in several cases, carriers are finding material misrepresentations being made by providers in medical records, diagnostic testing, and examination results in an effort to justify the referral to the ASC for procedures. This is by far the most egregious of violations in that a patient’s health is put at risk for the sake of submitting inflated bills for a procedure.

Currently, Ambulatory Surgical Centers are a “hot topic” in insurance fraud. The complexity and confusion between agencies and companies allow individuals to refer patients to ASC facilities and bill inappropriately for services and procedures. As a result, an entire industry is developing in the form of “medical management” to coordinate and perpetuate the fraud. Whole groups of providers are acting in concert to facilitate and maximize their take in these schemes. In addition to the new areas of fraud, they continue to utilize the old standbys to increase the profits by upcoding, unbundling, and false billing. The new regulations are welcome and will provide some relief, but they will not be the answer to the problem. All of those dedicated to fighting insurance fraud will have to remain vigilant, educate themselves on the potential abuses, and establish systems to detect the schemes as they occur.

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.





New Jersey Legislature Takes Aim at Fraud and Abuse in the Medicaid Program

by John Krayniak and Sherry L. Wilson

Medicaid is a state-administered health care program funded jointly by the state and federal governments. In our state, the costs are shared almost equally by the state and federal government. Medicaid provides health care to the indigent, elderly, and disabled. Significant legislation has recently been proposed by the New Jersey Legislature to help combat fraud in the \$9 billion Medicaid program. In particular, the New Jersey False Claims Act¹ and the Medicaid Program Integrity and Protection Act² were both introduced in 2006 to create new fraud fighting weapons.

While the proposed False Claims Act applies to fraud in all State programs, history suggests that many of these actions will undoubtedly allege fraud against the Medicaid program. The proposed Medicaid Program Integrity and Protection Act will be the first significant restructuring of State resources combating Medicaid fraud since the federal certification of our State's Medicaid Fraud Control Unit (MFCU) in 1978. The Act would establish an Office of the Medicaid Inspector General whose staff would be drawn from the Department of Human Services and the Department of Health and Senior Services (DHSS).

This article outlines the major provisions of both pieces of legislation. It is uncertain which, if any, of these bills will become law and in what precise form. What is certain is that the

Medicaid program consumes a significant portion of our State budget. Every dollar lost to fraud, waste, or abuse is one less dollar available to provide health care services, medications, and equipment to those in our society who need it the most. Efforts to prevent waste, abuse, and fraud and to recover funds lost through these means will aid our indigent, elderly, and disabled and maintain the integrity of the Medicaid program.

1. New Jersey False Claims Act

The New Jersey False Claims Act (NJFCA) could prove to be an effective tool in recovering funds stolen from State funded programs each year. Its federal counterpart and similar legislation in other states have been used to redress fraudulent schemes, such as billing for goods and services that were never delivered or rendered; performing unnecessary medical procedures in order to increase Medicare reimbursement; billing for tests not performed and phantom employees; and doctoring time slips. Under the proposed NJFCA, which essentially mirrors the federal False Claims Act, 31 U.S.C. §3729, *et seq.*, a person violates the NJFCA if he knowingly submits, or causes another person or entity to submit, false claims for payment of

1. Assembly Bill No. 3428, introduced July 4, 2006.

2. Assembly Bill No. 1852, introduced May 11, 2006.

State government funds.³ The NJFCA encompasses claims made for any government funded contract or program. Violators may be liable for three times the State's damages, plus civil penalties of \$5,000 to \$10,000 per false claim, which is the amount currently allowed under the federal False Claims Act, plus any adjustments for inflation.⁴

A civil action may be brought by the Attorney General or a private person for violations of the NJFCA.

Civil Action by the Attorney General

The Attorney General is charged with investigating violations of the NJFCA. If the Attorney General finds that a violation of the NJFCA has occurred, the Attorney General may file a civil action.

Civil Action by Private Persons (qui tams)

In order to recover stolen funds, the qui tam or whistle bower provisions of the NJFCA allow private persons with evidence of fraud against State funded contracts and programs to sue on behalf of the person and the State. However, the action must be brought in the name of the State of New Jersey. The person must immediately serve the complaint and a written disclosure of substantially all material evidence and information the person possesses upon the Attorney General. The complaint will be sealed for up to 60 days and will not be served on the defendant until service on the defendant is ordered by the court.

The Attorney General may, for good cause shown, request that the court extend the time during which the complaint remains under seal. The extension motions must be supported by affidavits or other submissions in camera. Under A3428, the Attorney General is limited to three motions of no more than a 90-day period for each extension, in effect maxing out any extensions at 270 days in total. However, the federal False Claims Act does not contain a time limit on extensions, but requires that good cause be shown for an extension of the seal. Senate bills S360 and S1829 mirror the federal False Claims Act.

The time limit on extensions is an important distinction between the Assembly and the Senate bills. Although the proposed legislation allows for civil suits, in reality, many of these cases filed under seal will be referred to the criminal division of the Attorney General's Office, the Division of Criminal Justice (DCJ), for criminal investigations. It is vitally important for DCJ to have the flexibility to conduct thorough investigations. Often times, such investigations are long term investigations which may be adversely impacted by a time limit.

The person bringing the action may voluntarily dismiss the action, with (1) the written consent of the Attorney General explaining why the Attorney General consented, and (2) the approval of the court. If a person brings an action under

the NJFCA and the action is based upon the facts underlying a pending Attorney General investigation, upon 30 days written notice to the person bringing the lawsuit, the Attorney General may take over the action on behalf of the State.

Once the Attorney General receives the complaint, the Attorney General has 60 days, plus any extensions granted, to file a pleading with the court indicating the Attorney General's intention to either proceed with the action or decline to proceed with the action. If the Attorney General proceeds with the action, the Attorney General will have primary responsibility for prosecuting the action, but the person bringing the action will have the right to continue as a party to the action. If the Attorney General declines to proceed with the action, the seal will be lifted and the person bringing the action may proceed with the action. After the complaint is unsealed and served on the defendant, the defendant shall file an answer to the complaint in accordance with the rules of the court.

With notice to the person bringing the action and an opportunity for that person to have a hearing, the Attorney General may move to dismiss the action for good cause shown. No other person may intervene in the private person's action brought under the NJFCA, except the State, and no other person may bring a related action based on the facts underlying the pending NJFCA action.

3. More specifically, the proposed NJFCA provides that a person violates the NJFCA if he:

- a. Knowingly presents or causes to be presented to an employee, officer or agent of the State, or to any contractor, grantee, or other recipient of State funds, a false claim for payment or approval;
- b. Knowingly makes, uses, or causes to be made or used a false record or statement to get a false claim paid or approved by the State;
- c. Conspires to defraud the State by getting a false claim allowed or paid by the State;
- d. Has possession, custody, or control of public property or money used or to be used by the State and knowingly delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt;
- e. Is authorized to make or deliver a document certifying receipt of property used or to be used by the State and knowingly makes or delivers a receipt that falsely represents the property used or to be used;
- f. Knowingly buys, or receives as a pledge of an obligation or debt, public property from any person who lawfully may not sell or pledge the property; or
- g. Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the State.

4. Under certain circumstances, where the defendant cooperates before he is aware of an existing investigation, the court may reduce the treble damages to not less than twice the amount of damages which the State sustains and may waive the civil penalty.



Assistant Attorney General John Krayniak provides input on pending Medicaid legislation.



Allocation of Recovery

If the Attorney General is successful, the person bringing the action is entitled to between 15% and 25% of the recovery. Where the action is based primarily on disclosures of specific information, other than that by the person bringing the action, the court will award no more than 10% of the recovery. The Attorney General would receive 10% of the recovery to be used for the investigation and prosecution of false claims under the Act. If the Attorney General does not proceed with an action, the person bringing the action shall receive a reasonable amount, between 15% and 30% of the proceeds of the action or settlement of the claim under the NJFCA.

Following distributions to the party bringing the action and the Attorney General, the injured State entity would be entitled to an award not to exceed its compensatory damages. Any remaining proceeds, including civil penalties awarded under the NJFCA, shall be deposited in the General Fund. Payments made to the person bringing the action shall be paid only out of the proceeds recovered from the defendant.

If the person bringing the action knowingly planned and initiated the violation of the NJFCA, the court may reduce the proceeds that the person bringing the action receives. The court is required to dismiss the private person from the civil action and preclude the private person from receiving any of the proceeds of the action if the person bringing the action is convicted of criminal conduct arising from his role in the violation of the NJFCA.

Attorneys Fees, Expenses, and Costs

The Attorney General is entitled to reasonable attorneys fees, expenses, and costs, if the Attorney General initiates an action under the Act or assumes control of the action. The person bringing the action is also entitled to attorneys fees, expenses, and costs. The court may even award the defendant attorneys fees, expenses, and costs, if the Attorney General does not proceed with an action and the court finds that the claim brought by the private person was "clearly frivolous, clearly vexatious, or brought primarily for the purposes of harassment."

Limitations on the Basis of Actions

A civil action against a member of the Legislature, member of the Judiciary, senior executive branch official, or member of a county or municipal governing body may not be based on "evidence or information known to the State when the action was brought." The NJFCA would also proscribe actions based on allegations or transactions that are the subject of a pending action or administrative proceeding in the State, as well as actions based upon allegations or transactions publicly disclosed in a criminal, civil, or administrative hearing; in an investigation, report, hearing, or audit conducted by or at the request of the Legislature; or by the news media, unless the action is brought by the Attorney General, or unless the person bringing the action is the original source of the information.

Employment Policies and Discrimination

The NJFCA would prohibit an employer from establishing policies to prevent an employee from disclosing information on false claims and discriminating against employees who disclose false claims information. Under certain circumstances, the NJFCA would make the employer liable for damages to the employee if the employer discriminates against the employee who disclosed the false claims information.

Period of Limitations

A civil action must be brought under the NJFCA within (1) six years of the date on which the violation was committed or (2) three years after "the date when facts material to the right of action are known or reasonably should have been known by the State official charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last."

Mandatory Referral to Licensing Authority

The NJFCA requires the Attorney General to notify the appropriate licensing authority if a licensed professional, an owner, administrator, or employee of a licensed professional or any other person licensed or certified by a licensing authority of this state, or an agent representative or employee of any of them is found to have violated any provision of the NJFCA.

Amendment to the Medicaid Fraud Statute

The NJFCA would amend the Medicaid fraud statute so that the civil penalties for Medicaid fraud committed under that Medicaid fraud statute are consistent with those under the NJFCA and are supplemental to the penalties under the NJFCA. The civil penalty amount in the Medicaid fraud statute would increase from \$2,000 to not less than \$5,000 and not more than \$10,000, with adjustments for inflation.

Financial Incentive to the State

In the Deficit Reduction Act of 2005 (DRA), Congress gave the states a financial incentive to pass a state false claims act. Section 6031 of the DRA provides the state a 10% increase in the state share of any recovery. Medicaid is a state administered health insurance program funded by both the state and federal government. If, for example, the state and federal government each pay 50% of the cost of the program, under the DRA provision, the state would receive 60% and the federal government 40% of any recovery. The state would pay the relator, the person filing the suit on behalf of the state, between 10% to 15% of the recovery, thus negating the differential provided by the financial incentive. The state will benefit from the DRA provision if the law results in cases that would have otherwise gone undetected. Nonetheless, if the Attorney General brings the suit on behalf of the State, Section 6031 of the DRA does provide an increased recovery to our Medicaid program.

II. Medicaid Program Integrity and Protection Act

The Medicaid Program Integrity and Protection Act (MPIPA) would centralize fraud recovery efforts by establishing an independent Office of Medicaid Inspector General (OMIG). The OMIG would be responsible for preventing, detecting, and investigating fraud and abuse and coordi-

nating the anti-fraud efforts of all Medicaid funded state agencies. These efforts are currently divided amongst various divisions and sections in the Department of Human Services (DHS) and the Department of Health and Senior Services (DHSS). Under the MPIPA, these efforts would be consolidated in the OMIG.

Location

Although the Office of the Medicaid Inspector General will be located within the Department of Human Services (DHS), the office will be independent of any supervision or control by DHS.⁵ Once established, the OMIG will be the single State office responsible for Medicaid program integrity. DHS will continue to operate as the single State agency responsible for the general administration, setting of policies, and oversight of the Medicaid program.

Areas of Responsibility

The MPIPA sets forth various areas of responsibility for the OMIG including:

1. general functions, duties, powers, and responsibilities;
2. ensuring compliance with applicable Medicaid standards and requirements, identifying and reducing fraud and abuse, and improving efficiency and effectiveness of Medicaid;
3. investigating allegations of Medicaid fraud and abuse and enforcing applicable laws, rules, regulations, and standards; and
4. recovering improperly expended Medicaid funds, imposing administrative sanctions, damages or penalties, negotiating settlements, and developing an effective third party liability program.

Reporting

Under the Act, the Medicaid Inspector General (Inspector General) shall report the findings of audits, investigations, and reviews performed by the office and issue recommendations for corrective or remedial action to the Governor, the President of the Senate, the Speaker of the General Assembly, and the entity at issue. The Inspector General shall also monitor the implementation of those recommendations. The Inspector General would be required to provide periodic reports to the Governor and to issue an annual report to the Governor and to the Legislature.

Non-Lapsing Revolving Fund

The MPIPA would establish a "Medicaid Fraud Control Fund" as a non-lapsing revolving fund in the Department of Treasury. The fund shall be comprised of an annual \$3 million appropriation and monies recovered under the MPIPA. Funds from the Medicaid Fraud Control Fund must be used by the Inspector General and the Medicaid Fraud Control Unit for the exclusive purpose of investigating and prosecuting Medicaid fraud claims.

5. The MPIPA was partially vetoed by the Governor and returned to the Legislature with revisions, the most significant being the removal of the OMIG from DHS to the Office of the Inspector General.

John Krayniak, an Assistant Attorney General, is an 18-year veteran of the Division of Criminal Justice and has been the Chief of OIGP's Medicaid Fraud Control Unit for 13 years. He previously served for eight years as a Deputy District Attorney in the Los Angeles County District Attorney's Office.

Sherry L. Wilson is a Deputy Attorney General in OIGP's Medicaid Fraud Control Unit. She previously represented the State of New Jersey in criminal appeals and has over ten years of litigation experience.





Closing the Loopholes on Insurance Fraud:

OIFP's 2006 Recommendation for Legislative Reform... Extending Immunity for Anti-Fraud Information Sharing

by John Kennedy

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. The following article constitutes OIFP's 2006 recommendation for legislative reform.

Extending Immunity for Anti-Fraud Information Sharing

The Insurance Fraud Prevention Act (IFPA)¹ provides broad immunity from civil liability for carriers filing reports or furnishing information to OIFP. But, on its face, the Act does not provide immunity from civil liability for carriers who provide information directly to other carriers about possible fraudulent conduct. Therefore, some carriers have been reluctant to share information about suspected fraud schemes or suspected fraud perpetrators directly with each other. Nonetheless, such information sharing would greatly assist both OIFP and the insurance industry in their joint efforts to

aggressively confront insurance fraud as required by the IFPA.²

This article outlines the elements of the torts of defamation, trade libel, and tortious interference with economic advantage, as a framework for understanding the risks which have caused some carriers to be reluctant to share anti-fraud information directly with other carriers. The article then surveys the existing common law and statutory immunity provisions which are available to carriers. Finally, the article proposes that the immunity provision in the IFPA be broadened to mirror that found in the National Association of Insurance Commissioners' Insurance Fraud Prevention Model Act.

Elements of Intentional Torts

The elements of a claim of defamation are, first, a false and defamatory statement concerning another; second, an unprivileged publication to a third party; third, fault amounting at least to negligence on the part of the publisher; and, fourth, either a statement constituting libel without regard for damages, or the existence of actual damages caused by the publication.³

Of course, only false statements can constitute defamation. True statements

1. N.J.S.A. 17:33A-1, *et seq.*

2. N.J.S.A. 17:33A-2.

3. See DeAngelis v. Hill, 180 N.J. 1, 13 (2004); Restatement (Second) of Torts sec. 558 (1997).

of fact are absolutely protected.⁴ Whether a false statement is one which could constitute defamation is a question of law which is decided by the judge, not a jury. In making this determination, courts consider three factors. First, courts consider the fair and natural meaning of the statement. Generally, words that accuse a person of committing a crime (except those in connection with litigation) and words that subject a person to contempt or disparage the person's reputation are considered defamatory.⁵ Second, courts consider whether the statement is one of fact or opinion. Statements of pure opinion, as a matter of constitutional law, cannot constitute defamation, while opinion statements that imply the existence of underlying "facts" which are false and defamatory may be actionable.⁶ Third, the courts consider the listener's reasonable interpretation of the statement in the context in which it was made to determine whether the statement was capable of a defamatory meaning.⁷

With respect to the element of fault which the plaintiff must establish, New Jersey has imposed the "actual malice" standard when a statement is made by a member of the media and concerns either a business which affects the public's health and safety or a business which is subject to substantial government regulation.⁸ To satisfy the actual malice standard, the plaintiff must establish by clear and convincing evidence that the defendant published the statement knowing that it was false, or with reckless disregard for whether it was false.⁹ It appears to be an open question whether the courts would require the plaintiff to show actual malice when a statement about such a business is made by a private entity rather than by the media. Also, while there are good arguments that a health care provider's business both affects public health and safety and is subject to substantial regulation, it might be more difficult to argue that other types of businesses which might be the subject of possibly defamatory anti-fraud statements are similarly matters of public importance. If not, then the mere negligence standard

might be all that is required of a plaintiff.

Trade libel is similar to defamation. Trade libel exists when a false statement casts aspersions on one's business operation, even if it does not defame an individual's character. Nonetheless, one statement can form the basis for both tort claims, and in the context of statements concerning potentially fraudulent conduct in a commercial setting, that would likely be the case. To prove trade libel, the plaintiff needs to prove that defendant made a false statement derogatory to plaintiff's business, of a kind calculated to interfere with his relations with others; that defendant communicated the statement to a third party; that the statement played a material and substantial part in leading others not to deal with the plaintiff; that defendant knew the statement was false or made it with reckless disregard for whether it was false; and that the statement caused plaintiff pecuniary damages. Damages are not presumed in trade libel cases, as they can be in defamation cases involving statements deemed libelous as a matter of law.¹⁰

Finally, an action for tortious interference with existing contractual relations or with reasonably anticipated business relations could be brought in response to the sharing of information about potential fraud among carriers who have or may have business relations with the subject.

To prove its claim, plaintiff must show that it had a reasonable expectation of economic advantage that was lost as a direct result of defendants' malicious interference, and that it suffered losses thereby. Causation is demonstrated where there is 'proof

that if there had been no interference there was a reasonable probability that the victim of the interference would have received the anticipated economic benefit.'... Malice... means that harm was inflicted intentionally and without justification or excuse.... The conduct must be both 'injurious and transgressive of generally accepted standards of common morality or of law.'¹¹

A hypothetical illustrates how these tort claims, or other similar claims, might be applicable in the fraud information sharing context. As a result of facts gathered in an investigation, a carrier suspects that a doctor may be committing health care claims fraud. In an effort to further the investigation, the carrier shares with other carriers a summary version of some of the underlying facts and its conclusion that the facts indicate that the doctor may be committing claims fraud. This information sharing could well be beneficial to all companies. The referring carrier may be seeking information to help confirm or refute its suspicions. For example, the other carriers may have claims information which would help establish a pattern of suspect behavior. Or, the other carriers may have conducted interviews with patients that would help establish or dispel the referring carrier's suspicions. The information sharing may be beneficial to the other carriers as well, as they would be alerted to the possibility that the doctor is submitting fraudulent claims to them. As a result, those carriers would begin to scrutinize claims from that doctor, and send them to their Special Investigations Unit (SIU) rather than processing them for payment in the normal course.

4. *Ward v. Zelkovsky*, 136 N.J. 516, 530 (1994).

5. *DeAngelis*, *supra*, 180 N.J. at 13.

6. *Id.* at 14; *Ward*, *supra*, 136 N.J. at 531.

7. *DeAngelis*, *supra*, 180 N.J. at 15.

8. *Turf Lawnmower Repair v. Bergen Record Corp.*, 139 N.J. 392, 413 (1995), *cert. den.* 516 U.S. 1066 (1996).

9. *DeAngelis*, *supra*, 180 N.J. at 13.

10. *Patel v. Soriano*, 369 N.J. Super. 192, 248 (App. Div.), *certif. den.* 182 N.J. 141 (2004).

11. *Lamorte Burns & Co. v. Walters*, 167 N.J. 285, 305-06 (2001) (internal citations omitted).



The doctor in question may then experience certain consequences as a result of this information sharing, such as an interruption or diminution of his or her cash flow, a delay in being approved as a provider by a carrier, or other consequences. In addition, the increase in the number of claims being scrutinized by various SIUs would result in additional patients or other associates being contacted and interviewed about potentially fraudulent claims. In response, the doctor may sue the referring carrier for making the statements to the other carriers, alleging that the statements were false and defamatory, constituted trade libel, or tortiously interfered with existing or potential economic relations with his associates and his patients. This list is not meant to be exhaustive, and the doctor's lawyers may well pursue additional legal theories. But it is sufficient to illustrate the risks which have caused some carriers to refrain from sharing information about potentially fraudulent conduct directly with other carriers.¹²

Because such information sharing serves the public good by furthering the fight against insurance fraud, the law provides, in various places, immunities from civil liability for statements made in the course of reporting fraud to government agencies or sharing information about potential fraud with other industry actors. Nonetheless, as discussed below, each of these immunities has its own limitations which must be kept in mind.

Existing Immunity Provisions

The free flow of information and the expression of opinions, even harsh and critical ones, play crucial roles in advancing important societal interests. Balancing the value of free communication with the need for the State to provide redress to its citizens whose reputations have been falsely tarnished, the New Jersey Supreme Court has recognized both an absolute privilege and a qualified privilege in defamation-related actions.

Although defamatory, a statement will not be actionable if it is subject to an absolute or qualified privilege. A statement made in the course of judicial, [quasi-judicial,] administrative, or legislative proceedings is absolutely privileged and wholly immune from liability.¹³

The absolute privilege applies to any communication made in judicial, quasi-judicial, or administrative proceedings, by litigants or other authorized participants, to achieve the objects of the litigation, and that have some connection or logical relation to the action.¹⁴ The absolute privilege is not limited to statements made in the courtroom or during the actual administrative proceeding itself. It extends to all statements or communications which have some connection or logical relation to the proceeding. Whether the privilege applies is a question of law to be decided by the judge.¹⁵

The requirement that the statement has some connection or logical relation to a judicial, quasi-judicial, or administrative proceeding has particular relevance in the context of anti-fraud information sharing.

12. See e.g., *Yourman v. People's Security Life Ins. Co.*, 992 F. Supp. 696 (D.N.J. 1998) (plaintiff sued insurer for defamation when insurer wrote to the Department of Banking and Insurance (DOBI) responding to plaintiff's complaint. The letter recounted the facts of plaintiff's application for coverage, and expressed the opinion that the facts could support an insurance fraud referral); *Felt v. Horizon Blue Cross Blue Shield of New Jersey*, 385 N.J. Super. 470 (App. Div. 2006) (plaintiff sued for defamation, malicious prosecution, and tortious interference with economic relations when insurer terminated plaintiff's participating provider agreement and reported the termination to the Board of Medical Examiners); *Binkewitz v. Allstate Ins. Co.*, 222 N.J. Super. 501 (App. Div.), cert. den. 113 N.J. 378 (1988) (plaintiff sued for defamation and tortious interference over statement insurer made in rejecting plaintiff as an adjuster for a fire loss claim).

13. *Erickson v. Marsh & McLennan Co.*, 117 N.J. 539, 563 (1990) (citing *Rainier's Dairies v. Raritan Valley Farms*, 19 N.J. 552, 558 (1955)).

14. *Hawkins v. Harris*, 141 N.J. 207, 216 (1995).

15. *Ibid.*

In *Hawkins v. Harris*,¹⁶ the Supreme Court ruled that the absolute privilege can apply to allegedly defamatory statements made by an insurance company's investigators investigating the circumstances of a motor vehicle accident which is in litigation, provided the other requirements of the privilege are met. However, the court ruled that it was unclear whether the investigators' statements to witnesses, alleging that the claimant was an unfaithful spouse, bore any logical relation to the litigation. The Supreme Court remanded the matter to the trial court to decide that issue.¹⁷

In *Devlin v. Greiner*,¹⁸ a husband hired a private investigator to follow his wife. The investigator gave the husband a report saying the wife regularly met with another man in compromising circumstances. Two months later, the husband sued for divorce. The wife sued the investigator for defamation. The court ruled that there was a factual question whether an investigative report issued two months before litigation commenced was sufficiently connected to a judicial proceeding to be absolutely privileged. The court therefore denied a motion to dismiss, and stated the immunity claim could be revisited following discovery.¹⁹ Therefore, the absolute privilege would not apply to anti-fraud information sharing among carriers when that information sharing is not sufficiently connected to an existing or reasonably contemplated judicial, quasi-judicial, or administrative proceeding. Even when the privilege does apply, insurance carriers may need to undertake discovery efforts and incur litigation expenses to demonstrate the applicability of the privilege in cases where the connection is not obvious.

When the absolute privilege does apply, it bars all civil liability theories with the sole exception of malicious prosecution.²⁰ The Supreme Court has reasoned that "[i]f the policy, which in defamation actions affords an absolute privilege or immunity to statements made in judicial or quasi-judicial proceedings, is really to mean anything then we must not permit its circumvention by affording an almost

equally unrestricted action under a different label."²¹ The Court, however, ruled that the privilege does not bar a malicious prosecution action because the exacting pleading and proof requirements for that type of action provide adequate protection to the interest in free access to the courts and administrative agencies, while allowing redress to the innocent defendant subjected to a lawsuit which is itself wrongful.²²

Even if a defamatory statement is not protected by the absolute privilege, it may be protected by the qualified privilege. The New Jersey Supreme Court has defined the qualified privilege as follows:

A communication 'made *bona fide* upon any subject matter in which the party communicating has an interest, or in reference to which he has a duty, is privileged if made to a person having a corresponding interest or duty, although it contains crimimatory matter which, without this privilege, would be slanderous and actionable[.]'²³

The qualified privilege provides less protection than the absolute privilege because the qualified privilege can be overcome if the plaintiff can prove by clear and convincing evidence that the speaker knew the defamatory statement was false or acted in reckless disregard of its falsity.²⁴ If the qualified privilege applies, it protects against all tort theories with the exception of malicious prosecution.²⁵

It would seem clear that statements made in a good faith effort to share

information about potential fraud schemes would be protected by the qualified privilege even if the statements turn out to be false. All insurance carriers share an interest in detecting and preventing insurance fraud. Indeed, auto and health carriers are required by law to implement State-approved fraud detection plans and to maintain full-time SIUs to investigate possible fraud.²⁶ Statements made between fraud investigators for the purpose of sharing or soliciting information relevant to a potential fraud would be appropriate communications made to further the legitimate interests of all concerned. Therefore, such good faith statements would be privileged from tort suits. Nonetheless, plaintiffs can seek to defeat the privilege by showing that the statement was made with knowledge that it was false or in reckless disregard to its falsity. While the plaintiff bears a heavy burden of proof on this issue, still, carriers would be required to incur litigation expenses in responding to such a claim.

The Insurance Fraud Prevention Act and the Motor Vehicle Theft and Motor Vehicle Insurance Fraud Reporting Immunity Act

The Insurance Fraud Prevention Act provides:

No person shall be subject to civil liability for libel, violation of privacy or otherwise by virtue of the filing of reports or furnishing of other information, in good faith and without malice, required by this

16. 141 N.J. 207 (1995).

17. *Id.* at 219, 222.

18. 147 N.J. Super. 446 (Law Div. 1977).

19. *Id.* at 460. The court did state that if the absolute immunity did not apply, the qualified privilege, discussed next, would apply. *Ibid.*

20. *Peterson v. Ballard*, 292 N.J. Super. 575, 582 (App. Div.), cert. denied 147 N.J. 260 (1996); *Ruberton v. Gabage*, 280 N.J. Super. 125, 134 (App. Div.), cert. denied 142 N.J. 451 (1995).

21. *Ranier's Dairies*, *supra*, 19 N.J. at 564.

22. *Ibid.*

23. *Marsh & McLennan Co.*, *supra*, 117 N.J. at 563 (internal citation omitted).

24. *Id.* at 565.

25. *Binkewitz v. Allstate Ins. Co.*, *supra*, 222 N.J. Super. at 516.



section or required by [OIFP] as a result of the authority conferred upon it by law.²⁷

Thus, carriers enjoy an absolute immunity from civil liability under any theory for good faith statements made to OIFP in the course of a referral or in response to any requirement by OIFP. Similarly, under the Motor Vehicle Theft and Motor Vehicle Insurance Fraud Reporting Immunity Act,²⁸ insurers, their agents and employees are absolutely immune from “any civil liability in a cause of action of any kind” for releasing information about automobile theft or automobile insurance fraud to a government agency.²⁹ Nonetheless, these statutory immunities do not on their face extend to information sharing from one carrier directly to another.

The Insurance Information Practices Act

The Insurance Information Practices Act³⁰ regulates insurance companies’ collection, use, and disclosure of information in connection with life, health, disability, and property-casualty insurance. The act authorizes insurers to share information about individual, natural persons for anti-fraud purposes with other insurers and with insurance support organizations. It provides:

An insurance institution, agent or insurance-support organization³¹ shall not disclose any personal or privileged information about an individual collected or received in

connection with an insurance transaction unless the disclosure is:

....

c. To an insurance institution, agent, insurance-support organization or self-insurer, if the information disclosed is limited to that which is reasonably necessary:

(1) To detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with insurance transactions[.]³²

Information disclosure is also permitted to a law enforcement or other government agency to prevent or prosecute an illegal act; in response to an administrative or judicial subpoena or order; or as otherwise permitted by law.³³

Under the act, immunity from civil causes of action arising from disclosures made in accordance with the act is provided thusly:

No cause of action in the nature of defamation, invasion of privacy or negligence shall arise against any person for disclosing personal or privileged information in accordance with this act, nor shall such a cause of action arise against any person for furnishing personal or privileged information to an insurance institution, agent or insurance-support organization; except this section shall provide no immunity for disclosing or furnishing false information with malice or willful intent to injure any person.³⁴

26. N.J.S.A. 17:33A-15; N.J.A.C. 11:16-6.4.

27. N.J.S.A. 17:33A-9b.

28. N.J.S.A. 17:23-8 et seq.

29. N.J.S.A. 17:23-15.

30. N.J.S.A. 17:23A-1, et seq.

31. “Insurance-support organization” is defined as an entity which regularly collects information about natural persons to provide to carriers for the purpose of detecting or preventing fraud, misrepresentation, or nondisclosure. N.J.S.A. 17:23A-2m.

32. N.J.S.A. 17:23A-13c.

33. N.J.S.A. 17:23A-13f, g, h.

34. N.J.S.A. 17:23A-21.

The most significant limitations on this existing statutory immunity concern the causes of action which are precluded, and the definitions of the statutory terms “individual,” “personal information,” and “privileged information.” The immunity precludes actions “in the nature of” defamation, invasion of privacy, or negligence. This wording raises the question of whether some causes of action are not precluded because they are not in the nature of defamation, invasion of privacy, or negligence. It could certainly be argued, following *Binkewitz v. Allstate Ins. Co.* and similar cases discussed above, that if the immunity is to serve its purpose, it must bar all theories of recovery except malicious prosecution. But, on the other hand, courts do not lightly extend absolute privileges.³⁵ This section of the statute has not been cited in a reported court decision, and so its applicability to theories arguably different from defamation, invasion of privacy, and negligence remains an open question.

The act applies to carriers writing insurance that is “primarily for personal, family or household needs rather than business or professional needs[.]”³⁶ It regulates the disclosure of information about an “individual,” which is defined to mean a natural person who is an insured, an applicant, or a claimant.³⁷ At least on its face, it is questionable whether the statute provides immunity for sharing information about persons who are not themselves insureds, applicants, or claimants, such as medical providers asserting rights as assignees of the insured.

The statute provides immunity for sharing “personal information” and “privileged information.” “Personal information” is defined as information from which judgments can be made about an individual’s character or characteristics.³⁸ That definition seems to contemplate underwriting information, and therefore would be relevant in application fraud cases. “Privileged information” is defined as information which relates to a claim for benefits or to civil or criminal proceedings involving an individual, and which was gathered in connection with or in reason-

able anticipation of such a claim for benefits or civil or criminal proceedings.³⁹

These definitions, and the wording of Section 13’s authorization to disclose information “about an individual” do not expressly authorize an insurance company to share information about corporate entities suspected of committing fraud. Nonetheless, the act does provide immunity for sharing anti-fraud information about individuals. Thus, while not perfect, the existing law provides an immunity which carriers can use to share anti-fraud information about individuals among themselves, until a more comprehensive provision is adopted.

National Insurance Crime Bureau

Under N.J.S.A. 17:23-19a and its implementing regulations, every insurer transacting automobile insurance must report thefts of motor vehicles or their major components and losses involving motor vehicle salvage to the National Insurance Crime Bureau (NICB).⁴⁰ The insurer, NICB, and law enforcement are authorized to cooperate and exchange information. The statute also provides:

An insurer, a law enforcement agency, or the [NICB], or their agents or employees, shall not be subject to civil liability in a cause of action of any kind for conducting an investigation or providing or receiving any information which is required to be reported under subsection a. of this section.⁴¹

While providing broad immunity for information shared in cooperation with NICB, this immunity provision does not address information sharing directly between carriers without NICB’s involvement.

Proposed Amendment to the Insurance Fraud Prevention Act

As discussed above, New Jersey common law and statutory law currently provide a patchwork of immunity provisions shielding some but not all anti-fraud information sharing from potential civil lawsuits. Perhaps as a result of the gaps in protection from potentially

expensive civil litigation, some carriers have been reluctant to share anti-fraud information directly with other carriers. Therefore, the immunity provision in the Insurance Fraud Prevention Act should be amended to eliminate the gaps in protection.

The Insurance Fraud Prevention Act currently provides immunity from civil liability in N.J.S.A. 17:33A-9b. That section was adopted as part of the original Insurance Fraud Prevention Act in 1983 and has not been updated since.⁴² It was based on the National Association of Insurance Commissioners’ (NAIC) Insurance Fraud Prevention Model Act as it existed at that time. Nonetheless, the NAIC Insurance Fraud Prevention Model Act has been updated several times since then. In particular, in 1995, the NAIC model act was amended to specifically provide immunity for exchanges of information between insurers.⁴³ The immunity section of the NAIC Insurance Fraud Prevention Model Act currently reads as follows:

A. There shall be no civil liability imposed on and no cause of action shall arise from a person’s furnishing information concerning suspected, anticipated or completed fraudulent insurance acts, if the information is provided to or received from:

- (1) The commissioner or the commissioner’s employees, agents or representatives;
- (2) Federal, state, or local law enforcement or regulatory officials or their employees, agents or representatives;
- (3) A person involved in the prevention and detection of fraudulent insurance acts or that person’s agents, employees or representatives; or
- (4) The NAIC or its employees, agents or representatives.

B. Subsection A of this section shall not apply to statements made with actual malice. In an action brought



against a person for filing a report or furnishing other information concerning a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that Subsection A of this section does not apply because the person filing the report or furnishing the information did so with actual malice.

C. This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in Subsection A of this section.⁴⁴

The immunity provision in New Jersey's IFPA has not been updated to address the shortcomings in the existing version which the National Association of Insurance Commissioners has identified over the past 23 years. As a result, the State's announced public policy to "confront aggressively the problem of insurance fraud"⁴⁵ suffers when anti-fraud information sharing is restricted. The Legislature should update the immunity provision in the IFPA to incorporate the recommendations of the NAIC and, in that way, encourage the free yet responsible flow of information directly between and among persons engaged in the detection and prevention of fraud. Accordingly, OIFP proposes that N.J.S.A. 17:33A-9 be amended to read as follows:

a. [no change.]

b. There shall be no civil liability imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated or completed fraudulent insurance acts, if the information is provided to or received from:

(1) The Office of the Insurance Fraud Prosecutor, the commissioner or their employees, agents or representatives;

(2) Federal, state, or local law enforcement or regulatory officials or their employees, agents or representatives;

(3) A person involved in the prevention and detection of fraudulent insurance acts or that person's agents, employees or representatives; or

(4) The National Association of Insurance Commissioners, the National Insurance Crime Bureau, an insurance support organization as defined in N.J.S.A. 17:23A-2, or their employees, agents or representatives.

c. Subsection b. of this section shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that subsection b. of this section does not apply because the person filing the report or furnishing the information did so with actual malice.

d. This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in subsection b. of this section.

e. [existing subsection c. redesignated as subsection e.]

John Kennedy is an Assistant Attorney General serving as a 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.

35. See Devlin v. Greiner, *supra*, 147 N.J. Super. at 456.

36. N.J.S.A. 17:23A-1, -2n (defining "insurance transaction").

37. N.J.S.A. 17:23A-2j, -13.

38. N.J.S.A. 17:23A-2l.

39. N.J.S.A. 17:23A-2w.

40. N.J.S.A. 17:23-19; N.J.A.C. 11:16-2.1, *et seq.*

41. N.J.S.A. 17:23-19d.

42. L. 1983, c. 320, sec. 9.

43. 1995-1 NAIC Proceedings 50, 89-90. The model act was also amended at that time to require the plaintiff to plead with specificity any allegations that a false statement was made with actual malice, which is necessary to overcome the immunity. This was done so that the use of notice pleading would not deprive persons reporting fraud of the benefit of immunity by forcing them to engage in discovery to refute an allegation of actual malice. *Ibid.*

44. NAIC Insurance Fraud Prevention Model Act at sec. 7.

45. N.J.S.A. 17:33A-2.





Insurance Fraud Prosecutor Case Notes

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. N.J.S.A. 17:33A-16 et seq. Under this statutory authority, OIFP conducts or coordinates all criminal, civil, and administrative investigations and prosecutions of insurance and Medicaid fraud in New Jersey.

Criminal prosecutions remain the most effective 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.¹ Most criminal dispositions also include

criminal fines and restitution. Medicaid providers are also subject to debarment from the Medicaid program. This section of the Annual Report includes summaries of significant criminal prosecutions undertaken by OIFP in 2006.

The Insurance Fraud Prevention Act (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. These summaries describe cases in which OIFP entered into Consent Orders for the

1. Pretrial Intervention (PTI) is a diversionary program created by statute and court rule. The Legislature established that it is the public policy of the State to divert certain defendants from the criminal justice system when, among other factors, diversion will serve to remove cases from the criminal court in order to focus resources on more serious matters or more dangerous defendants, or PTI supervision will suffice to deter that particular defendant from future criminality. N.J.S.A. 2C:43-12a. A defendant is admitted to PTI upon the recommendation of the PTI program director and the consent of the prosecutor. The program director and the prosecutor are required to consider, and base their decisions on, the defendant's amenability to correction, responsiveness to rehabilitation, and the nature of the offense. Id. at -12b,e; PTI Guideline 3. If a defendant is admitted to PTI, the criminal prosecution is suspended while the defendant undergoes the supervision or rehabilitation required by the PTI program staff. The judge may order restitution as part of the PTI program. If the defendant successfully completes the program, the criminal charge is dismissed. If the defendant fails to complete the program, the criminal prosecution resumes. N.J.S.A. 2C:43-13; R. 3:28.

voluntary payment of fines, and cases in which OIFP's civil attorneys successfully sued violators through civil litigation.

In addition, actions taken against licensed professionals who committed insurance fraud by the appropriate licensing board are included 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 licenses.

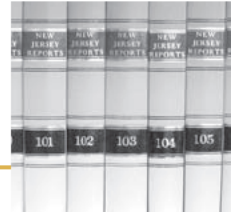
In 2006, OIFP opened 489 new criminal investigations. Two hundred and twenty defendants were prosecuted by Accusations or indictments.² In addition, OIFP convicted 175 defendants in 2006. Of the defendants convicted, 109 received jail terms totaling 81 years. Furthermore, court ordered restitution totaled over \$34,704,461, including restitution imposed in civil actions.

OIFP opened 5,859 civil insurance fraud cases in 2006, and conducted 3,030 investigations. The number of Administrative Consent Orders issued totaled 280 and amounted to \$6,864,500. OIFP also obtained 224 executed Consent Orders totaling \$984,500 where subjects admitted committing insurance fraud and agreed to pay civil fines. OIFP obtained 50 civil settlements totaling \$308,114 and 167 civil judgments totaling \$1,182,552. In addition, OIFP's civil attorneys filed 100 lawsuits against Fraud Act violators in 2006.

². An indictment, Accusation, or complaint is merely an accusation. All defendants and subjects are presumed innocent of any charges unless and until proven guilty beyond a reasonable doubt.

Case Index

OIFP Criminal Case Notes	70
Auto Insurance Fraud	70
Criminal Use of "Runners"	70
Fraudulent PIP Insurance Claims by Health Care Providers	72
Fraudulent Automobile "GiveUp" and Theft Claims	72
Organized Car Theft Rings	74
False AutomobileRelated Insurance Claims	78
Insurance Claims Involving Identity Fraud	80
Insurance Fraud Committed by Police Officers	81
Receiving Stolen Property	82
Staged and Fictitious Accidents	82
Fictitious Insurance Identification Cards and Motor Vehicle Documents	84
Motor Vehicle Commission (MVC) Investigations	84
Fictitious Insurance Identification Card Cases	85
Vehicle Theft	88
Health, Life and Disability Fraud	89
Fraudulent Health and Disability Claims by Health Care Providers	89
Fraudulent Billing by Health Care Providers	90
False Health Care Claims	91
Fraudulent Disability Claims	92
Health Insurance Underwriting/Application Fraud	93
Life Insurance Fraud	94
Drug Diversion	95
Property and Casualty Fraud	95
False Homeowners Insurance Claims	95
Fraudulent Stolen/Damaged Property Claims	96
Phony Certificates of Insurance	97
Insurance Professional Fraud	99
Insurance Carrier Employee Fraud	99
Insurance Premium Fraud	100
Insurance Sales Fraud	100
Department of Banking and Insurance (DOBI) Licensees	100
InsuranceRelated Theft/Attempted Theft	101
Medicaid Fraud	101
Provider Fraud	101
Patient and Elder Abuse	104



OIFP Civil Case Notes	108
Auto Fraud	108
Automobile Application Fraud	108
Automobile “GiveUp” and Theft Claims	108
Body Shop Fraud	109
Criminal Use of “Runners”	109
False Automobile Related Claims	109
Staged and Fictitious Accidents	110
Health, Life and Disability Fraud	110
False Health Care Claims	110
False Disability Claims	110
Life Insurance Fraud	110
Provider Fraud	110
Property and Casualty Fraud	111
False Homeowners Claims	111
False Property Damage Claims	111
Insurance Professional Fraud	111
Medicaid Civil Case Settlements	111
DOL Civil Litigation Case Notes	112
Professional Licensing Proceedings	114
Medical	114
Dental	114
Professional Counselors	114
Chiropractic	114
Pharmacy	114
Marriage Therapy	115
Nursing	115
Cosmetology/Hairstyling	115
Bureau of Securities	115
Department of Health and Senior Services/Office of EMS	115

AUTO INSURANCE FRAUD

Criminal Use of "Runners"

State v. Irwin B. Seligsohn, et al.

Racketeering and conspiracy charges were filed 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 (OIFP) 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 charged Irwin B. 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. was charged with conspiracy and filing or preparing a false or fraudulent New Jersey tax return. The superseding State Grand Jury 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 related actions.

The indictment alleges that, between October 30, 1993 and September 15, 2005, Irwin B. Seligsohn, and the law firm of Goldberger, Seligsohn & Shinrod, P.A., 735 Northfield Avenue, West Orange, Essex County, conspired with others to pay "runners" to solicit other individuals to participate in staged automobile accidents so that Personal Injury Protection (PIP) and other insurance claims could be submitted to insurance companies. Additionally, the indictment alleges that the defendants 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" by soliciting clients, with violating 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 were alleged to be the purported insurance claimants. They 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, P.A., 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 from engaging in theft by deception, Health Care Claims Fraud, Criminal Use of Runners, and tax fraud.

Among the persons charged were:

The Lawyers

- Irwin B. Seligsohn, Esq., was charged with conspiracy to commit racketeering, racketeering, conspiracy to commit Health Care Claims Fraud, theft by deception, conspiracy, Criminal Use of Runners, and filing or preparing a false or fraudulent New Jersey tax return;

- The law firm of Goldberger, Seligsohn & Shinrod, P.A., was charged with conspiracy to commit racketeering, racketeering, conspiracy, theft by deception, Criminal Use of Runners, Health Care Claims Fraud, and filing or preparing a false or fraudulent New Jersey tax return.

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 were charged with conspiracy to commit racketeering, racketeering, conspiracy, Health Care Claims Fraud, theft by deception, and Criminal Use of Runners. Edward Campbell was additionally charged with failure to pay or turn over taxes.

To date, 12 defendants have entered guilty pleas in connection with this alleged illegal scheme. The remaining defendants' cases are pending trial. Among the developments in this case during 2006 were:

On September 19, 2006, Louis Campbell was arrested by OIFP investigators and charged with tampering with a witness and

informant. The case is pending.

On September 8, 2006, Kasim Nash pled guilty to conspiracy and Health Care Claims Fraud. Sentencing is pending.

On August 1, 2006, Sharon Blanding was arrested on a bench warrant and bail was set at \$10,000. On September 8, 2006, Blanding pled guilty to conspiracy and Health Care Claims Fraud. She will be sentenced in 2007.

On July 27, 2006, Damon Brown pled guilty to conspiracy to commit racketeering and Health Care Claims Fraud. Brown is pending sentencing in 2007.

On June 30, 2006, Alonzo Goulbourne pled guilty to Health Care Claims Fraud. On August 1, 2006, the court sentenced him to three years in state prison.

On May 5, 2006, Bobbie Campbell surrendered himself to the court and the judge set bail at \$35,000. Bobbie Campbell's case is pending trial.

On April 19, 2006, Janelle Wilson, Iesha Harris, and Javiena McDonald pled guilty to conspiracy and Health Care Claims Fraud. On June 30, 2006, the court sentenced Wilson, Harris, and McDonald to two years probation, ordered them each to pay a \$1,500 civil insurance fraud fine and ordered them to perform 50 hours of community service.

On April 19, 2006, Pamela Rogers pled guilty to conspiracy and Health Care Claims Fraud. On June 19, 2006, the court sentenced her to two years probation and ordered her to pay a \$1,500 civil insurance fraud fine.

On April 12, 2006, Patrice Woodson, Rhonda Evans, and Angelique Pickett pled guilty to conspiracy and Health Care Claims Fraud. On June 30, 2006, the court sentenced Woodson and Pickett to two years probation and ordered them each to pay a \$1,500 civil insurance fraud fine and perform 50 hours of community service. On July 12, 2006, the court sentenced Evans to two years probation and ordered her to pay \$2,000 in restitution and a \$1,500 civil insurance fraud fine.

On February 6, 2006, OIFP investigators arrested Edward Campbell, Sr., a/k/a Reverend Campbell. The arrest was predicated on the fact that the court issued a bench warrant on January 17, 2006, for Campbell's failure to appear at a pre-arraignment conference on the racketeering indictment. Campbell was arrested at the office of his probation officer. Campbell had been



Acting Team Leader Jack Schull reviews his squad's pending caseload.

placed on probation in connection with an unrelated indictment previously returned by OIFP charging him with bribery.

On February 3, 2006, the court sentenced Al-Quide Rivers to three years probation and ordered him to pay \$2,915 in restitution and a \$1,500 civil insurance fraud fine. Rivers pled guilty to conspiracy and Health Care Claims Fraud.

On November 15, 2005, 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.

Also on November 15, 2005, Antoine Amons, Chandra Vaughan, Janelle Wilson, Javiena McDonald, Pamela Rogers, Lawrence Freeman, Alonzo Goulbourne, Sharon Blanding, Patrice Woodson, Rhonda Evans, Chris Russell, Phyllis Jackson, Tia Pullin, Edith Pullin, Eugenia Acey, James Bearfield, Angelique Pickett, Iesha Harris, and Wade Brown were charged with Health Care Claims Fraud, conspiracy, and theft by deception.

State v. Orlando Rolon, et al.

A State Grand Jury returned an indictment 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 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 in and around Camden providing treatment,

medical supplies, and transportation to patients, primarily automobile accident patients covered by automobile insurance policies.

The State alleged that Rolon illegally 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 alleged that some of the patients solicited by the "runners" were sent to JOL&M Medical Supply Company for medical supplies, including TENS Units which are used to treat soft tissue injuries of persons injured in auto accidents, and are billed to auto insurance carriers. The State also alleged that OR Medical Transport was used to transport some of the patients to and from Brotherhood Rehabilitation and other locations so that Rolon could bill auto insurance companies more money.

The State further alleged 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. It was also alleged that the defendants created the false impression 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, in fact, both corporations were owned, operated, and controlled by Rolon.

In addition, it was alleged that Rolon and others acted as "runners" by offering payments to patients of between \$200 to \$300 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 alleged that Rolon and Ramos committed Health Care Claims Fraud by submitting false claims to Liberty Mutual and AIG Insurance Companies for medical services provided by Brotherhood Rehabilitation and their related companies. It was also alleged 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 claim forms submitted to the insurance companies, including Liberty Mutual, when, in fact, Dr. Michael Marek was deceased.

On October 30, 2006, Rolon pled guilty to Criminal Use of Runners. On November 1, 2006, Ramos pled guilty to uttering a forged document. Both are scheduled to be sentenced in 2007.

State v. Monir Dawoud

On September 15, 2006, Dr. Monir Dawoud pled guilty to an Accusation charging him with Criminal Use of Runners. Dawoud admitted that, between January 5, 2000 and September 5, 2001, he was engaged in a conspiracy with another medical doctor and a chiropractor to utilize a "runner" who facilitated the payment between the doctors of "referral fees" in connection with the referral and treatment of patients. Charges against the other medical doctor and chiropractor are pending and the investigation is continuing.

Specifically, an OIFP undercover investigator acting as a "runner," met with Dawoud who agreed to refer purported patients from his (Dawoud's) medical practice to another medical practice. These referrals were made so that Magnetic Resonance Imaging (MRI) scans could be billed to auto insurance companies, primarily automobile insurance companies which provide PIP coverage. The MRIs were part of the medical testing conducted on patients who were purportedly injured in auto accidents. Dawoud agreed to refer the patients to the second doctor in return for payment of \$150 per patient.

Additionally, with respect to the patients who were referred to the other medical doctor's practice for treatments, several insurance companies were billed for treatments which were never rendered to the patients. Dawoud is scheduled to be sentenced in early 2007.

Fraudulent PIP Insurance Claims by Health Care Providers

State v. Franca DiLisio, et al.

A State Grand Jury returned two indictments charging Dr. Franca DiLisio, a licensed chiropractic physician, and seven others with Health Care Claims Fraud, Criminal Use of Runners, theft, and attempted theft by deception. DiLisio was also charged with misconduct by a corporate official. All the charges arise from allegations that the defendants staged accidents for the purpose of submitting phony PIP insurance claims to five insurance carriers, or that automobile insurance companies were billed for bogus chiropractic treatments.

The State alleged in the first indictment that, between May 1, 1998 and October 4, 2000, Franca DiLisio arranged staged accidents with the assistance of “runners” Gerard Blanc and Rolando Pierre. A “runner” is a person who is paid to procure patients or clients for licensed professional service providers so that insurance claims can be submitted. The State alleged that the accidents were staged so DiLisio could treat the occupants of the vehicles for injuries they never sustained, and then bill insurance carriers for PIP insurance claims. The defendants submitted claims to Allstate Insurance Company, Selective Insurance Company, G.U.F.A.C. Insurance Company, and Colonial Penn Insurance Company for chiropractic treatments on 302 separate dates when the “patients” had not even appeared for the treatments. The claims totaled approximately \$36,380, of which \$3,435 was paid by insurance carriers.

In the second indictment, the State charged Marie Amay, Mimose Pierre, and [redacted] with Health Care Claims Fraud and attempted theft by deception for acting as passengers in staged accidents and generating phony medical treatment claims. DiLisio allegedly submitted 16 PIP insurance claims for these defendants to Allstate Insurance Company, Selective Insurance Company, Colonial Penn Insurance Company, Crawford

Insurance Company, and Ohio Casualty Insurance Company totaling \$65,153. The insurance companies did not pay any of the 16 PIP claims and some of the cases are pending in civil court and/or arbitration. Marie Amay and [redacted] were previously admitted into the Pretrial (PTI) Program¹ and ordered to each perform 50 hours of community service. A bench warrant was issued for Pierre’s arrest. He is currently a fugitive.

On June 14, 2006, DiLisio pled guilty to theft. On July 27, 2006, the court sentenced her to two years probation and ordered her to pay \$3,400 in restitution to Allstate Insurance Company. The criminal cases as to the remaining defendants are pending trial.

State v. Eugene Williams a/k/a Carroll Williams

On August 21, 2006, an Essex County Grand Jury returned an indictment charging Eugene Williams, a/k/a Carroll Williams, with Health Care Claims Fraud and conspiracy. According to the indictment, on February 10, 2000 and September 5, 2001, Williams conspired with others to commit health care claims fraud. The State alleged that Williams, a chiropractic physician licensed in the State of New Jersey, practiced chiropractic medicine at the LaGuardia Primary Health Care Center in East Orange, and submitted health care insurance claims on behalf of four purported patients. The purported patients were undercover Newark police officers and undercover OIFP investigators. The State alleged that Williams caused PIP bills to be submitted to Parkway Insurance Company for chiropractic and other services not rendered to the purported patients in the approximate amount of \$21,481. Parkway paid approximately \$19,494 of those PIP insurance bills.

LaGuardia Primary Health Care Center was a chiropractic medical facility owned and operated by Dr. LeClerc Addison. Addison previously was sentenced to five years probation conditioned on serving 364 days in county jail as part of OIFP’s investigation of PIP fraud.

Fraudulent Automobile “Give Up” and Theft Claims

State v. Harry J. Torella

On January 6, 2006, the court admitted Harry J. Torella into the Pretrial Intervention (PTI) Program conditioned upon him paying \$1,166 in restitution and paying a \$5,000 civil insurance fraud fine. Torella pled guilty to an Accusation charging him with Insurance Fraud. Torella allegedly knowingly reported to the Island Heights Police Department and Prudential Insurance Company that someone stole his 1997 Chrysler Sebring, knowing that the car was not stolen. Torella allegedly reported the false theft so that he could file a fraudulent auto theft insurance claim.

State v. Sandra Rodriguez, et al.

On November 6, 2006, Jonathan Rodriguez pled guilty to arson. On December 8, 2006, the court sentenced him to 120 days in county jail and ordered him to pay a \$5,000 civil insurance fraud fine. On January 13, 2006, the court sentenced Sandra Rodriguez to one year probation and ordered her to pay a \$5,000 civil insurance fraud fine. Sandra Rodriguez pled guilty to arson with purpose to collect insurance proceeds.

A Cumberland County Grand Jury returned an indictment charging 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, Sandra Rodriguez and Jonathan Rodriguez allegedly conspired to dispose of a 2002 Chevrolet Cavalier and submit a false automobile insurance theft claim.

The State alleged that Sandra Rodriguez falsely reported to the Vineland Police Department that someone stole her Chevrolet Cavalier. She also allegedly reported the theft to Rutgers Casualty Insurance Company. The State further alleged that Jonathan Rodriguez took the Chevrolet Cavalier from Sandra Rodriguez and set it on fire in Buena

1. Pretrial Intervention (PTI) is a diversionary program created by statute and court rule. The Legislature established that it is the public policy of the State to divert certain defendants from the criminal justice system when, among other factors, diversion will serve to remove cases from the criminal court in order to focus resources on more serious matters or more dangerous defendants, or PTI supervision will suffice to deter that particular defendant from future criminality. N.J.S.A. 2C:43-12a. A defendant is admitted to PTI upon the recommendation of the PTI program director and the consent of the prosecutor. The program director and the prosecutor are required to consider, and base their decisions on, the defendant’s amenability to correction, responsiveness to rehabilitation, and the nature of the offense. Id. at -12b,e; PTI Guideline 3. If a defendant is admitted to PTI, the criminal prosecution is suspended while the defendant undergoes the supervision or rehabilitation required by the PTI program staff. The judge may order restitution as part of the PTI program. If the defendant successfully completes the program, the criminal charge is dismissed. If the defendant fails to complete the program, the criminal prosecution resumes. N.J.S.A. 2C:43-13; R. 3:28.



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.

State v. Monique S. Everett, et al.

A Passaic County Grand Jury returned an indictment charging 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, 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 subsequently arrested in possession of the 2000 Mitsubishi Mirage by the Montville Police Department.

Everett previously pled guilty to conspiracy to commit theft by deception. The court admitted her into the PTI Program conditioned upon her paying \$1,018 in restitution to Encompass Insurance Company and performing 75 hours of community service. Williams also pled guilty to conspiracy. On February 28, 2006, the court sentenced him to three years in state prison and ordered him to pay \$1,018 in restitution to Encompass Insurance Company. On January 17, 2006, Javin Ward pled guilty to conspiracy. On May 9, 2006, the court sentenced him to probation for one year and ordered him to pay \$1,018 in restitution. On January 17, 2006, James Westfield also pled guilty to conspiracy. On the same day, the court admitted him into the PTI Program conditioned upon him paying \$1,143 in restitution and performing 75 hours of community service.

State v. Manuel Molina

On March 9, 2006, the court sentenced Manuel Molina to three years probation and ordered him to pay a \$5,000 civil insurance fraud fine. On January 25, 2006, Molina pled guilty to an Accusation charging him with Insurance Fraud. Molina admitted that he falsely reported to the Newark Police Department and Allstate Insurance Company that his 1997 Dodge Caravan had been stolen in order to file a false insurance theft claim. In fact, Molina knew that his Dodge Caravan had not been stolen.

State v. Maria Kernizan, et al.

On March 8, 2006, the court admitted Maria Kernizan into the PTI Program conditioned upon her performing 60 hours of community service and paying a \$5,000 civil insurance fraud fine. On February 22, 2006, the court admitted her son, Loubert Barthelemy, into the PTI Program conditioned upon him paying a \$5,000 civil insurance fraud fine and performing 60 hours of community service. Kernizan and Barthelemy pled guilty on January 9, 2006, to conspiracy to commit theft by deception.

A Union County Grand Jury returned an indictment charging Kernizan and 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 claim to Clarendon National Insurance Company. The State alleged that Kernizan submitted an Affidavit of Theft to 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 City Police Department that someone stole the car on that date. 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 alleged claim that the vehicle was last seen and stolen on or after December 31, 2002. Clarendon National denied the claim and referred the matter to OIFP for investigation and prosecution.

State v. Carlos Manuel Patela, et al.

On March 9, 2006, an Essex County Grand Jury returned an indictment charging

Carlos Manuel Patela and Rui Alberto Dias with conspiracy to commit theft by deception. According to the indictment, Patela and Dias took possession of a 1985 Chevrolet Corvette knowing that the owner of the Corvette had reported the car stolen to his insurance company.

The car was reported stolen to the insurance company in order that a phony automobile theft insurance claim could be filed by the owner of the vehicle. Sentry Insurance Company paid the owner \$7,083 as reimbursement for the purportedly stolen car. The owner of the car was not charged in the indictment because he had previously been prosecuted in Essex County for the phony automobile insurance theft claim.

On July 31, 2006, Dias pled guilty to conspiracy. On October 16, 2006, the court sentenced him to three years probation and ordered him to perform 100 hours of community service. On October 23, 2006, Patela pled guilty to conspiracy. On December 11, 2006, the court sentenced him to two years probation and ordered him to pay \$7,083 in restitution to Sentry Insurance Company. Patela was also ordered to perform 50 hours of community service.

State v. Steven Garcia

Following a probation violation, the court terminated Steven Garcia's probation and sentenced him on February 10, 2006, to four years in state prison. The court had sentenced Garcia 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 had 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 that someone stole his 1999 Ford F-150 pickup truck. The truck was subsequently recovered in a garage in Lebanon, Pennsylvania. An investigation revealed that Garcia had been paying rent to keep the truck in Pennsylvania. First Trenton, suspecting fraud, denied the claim and referred the matter to OIFP for investigation.

State v. Raymond Delgaudio

On May 26, 2006, the court admitted Raymond Delgaudio into the PTI Program. On March 27, 2006, Delgaudio pled guilty to an Accusation charging him with Insurance

Fraud. Delgaudio allegedly admitted that he filed a fraudulent stolen vehicle report with the Demarest Police Department, claiming that his 2002 Jeep Grand Cherokee had been stolen out of his driveway. He subsequently allegedly submitted a fraudulent stolen vehicle claim to First Trenton Indemnity Company, knowing that his vehicle had not been stolen. First Trenton, suspecting fraud, denied the claim and referred the matter to OIFP for investigation.

State v. Luisa Escobar-Echeverry, et al.

On May 10, 2006, the court admitted Luisa Escobar-Echeverry into the PTI Program and ordered her to pay a \$3,000 civil insurance fraud fine. Escobar-Echeverry previously pled guilty to an Accusation charging her with Insurance Fraud. On May 9, 2006, the court admitted Escobar-Echeverry's boyfriend, Alex Angel, a/k/a Jans Londano, into the PTI Program and ordered him to pay a \$2,500 civil insurance fraud fine. Angel previously pled guilty to a separate Accusation charging him with conspiracy. The State alleged that Escobar-Echeverry falsely reported her 2003 Toyota stolen to the Union City Police Department and that she had arranged with Angel to dispose of the vehicle because she could no longer afford the car payments and the insurance payments. She also allegedly submitted a phony vehicle theft claim to Allstate Insurance Company. On the same day the vehicle was reported stolen, it was found on fire in Pennsylvania. Angel allegedly paid \$400 to another person to dispose of the car.

State v. Randi Fleischman

On November 29, 2006, the New Jersey Supreme Court heard oral argument in this case. On May 11, 2006, the New Jersey Supreme Court granted the State's Petition for Certification on the issue of whether five or more false statements made by a claimant in a single document submitted in support of one insurance claim can constitute the most serious form of the crime of Insurance Fraud, a second degree offense. The case is pending decision by the Supreme Court. Previously, the Appellate Division upheld the Middlesex County trial court's dismissal of the charge of Insurance Fraud as to Randi Fleischman on the basis that Fleischman's alleged conduct did not constitute second degree Insurance Fraud.

A Middlesex County Grand Jury returned an indictment on March 22, 2005, that

charged 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 alleged 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 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 ground that the State did not or could not offer evidence of five or more acts of insurance fraud within the meaning of the statute in order to elevate the charge to a second degree Insurance Fraud offense. Thus, according to the trial judge, the count was not properly charged as a second degree crime. On March 20, 2006, the State petitioned the Supreme Court to review the case.

Organized Car Theft Rings

OIFP initiated several investigations into gangs of car thieves and others who engaged in a series of automobile insurance theft claims and organized auto theft rings. These investigations originated from separate investigative sources developed by OIFP through analysis of investigative data and intelligence information. Through additional investigation, 33 criminal targets were identified, which targets were common to these otherwise apparently unrelated theft conspiracies.

Through criminal conspiracies described below, the targets would traffic in automobile "give ups" by automobile owners, or would otherwise steal automobiles. These "given up" stolen cars as well as the actual

stolen cars would be re-tagged and sold for far below market value. Many of the cars were sold through use of the internet on eBay to innocent purchasers located nationwide after they were stolen and re-tagged. These innocent purchasers face the risk of losing the cars they purchased.

An automobile "give up" claim, also known as an owner-initiated phony insurance theft claim, occurs when the owner of an automobile voluntarily "gives up" the car to another for disposal and then submits a false automobile insurance theft claim as if the car had been stolen. The owner is paid for the purported theft by his insurance company and the car can be re-tagged and sold.

A car is re-tagged when the Vehicle Identification Number (VIN) plates are removed from the car so that the VIN can be changed to a VIN that does not correspond to a stolen car. In that way, the true identity of the car and the fact that it had been reported stolen can be concealed, and the car can be sold to an innocent purchaser, or otherwise disposed of.

Through investigation, which included coordination with law enforcement in Pennsylvania and New York, OIFP uncovered evidence that automobile owners had "given up" their cars so that they could be falsely reported stolen to insurance companies and insurance claims could be submitted, as well as evidence that members of a gang stole cars from a large auto mall (auto dealership), as well as from other car dealerships and locations. OIFP's investigation involved an extensive covert infiltration of the several conspiracies, employment of electronic surveillance and physical surveillance, as well as the execution of search and arrest warrants. Working in an undercover capacity, OIFP investigators purchased 35 cars from several of the defendants. These recovered cars have a total approximate value of \$1.5 million. These criminal initiatives are described below:

Operation Steal-A-Deal/Sansone Motors

In total, 12 cars valued at over \$600,000 were stolen from the Sansone Route 1 Auto Mall located on Route 1, Avenel, New Jersey. These cars were allegedly stolen by Sansone employees, including Esmerdo Pena and Aneudy "Elvis" Ruiz, by taking keys from the dealership and giving those keys to car thieves so the automobiles could be driven off the lot after hours and sold. In addition to Pena and Ruiz, several individu-



als were charged in this investigation for their roles in “giving up” vehicles in order to file phony auto insurance theft claims. The following developments occurred in this operation in 2006:

On August 11, 2006, Esmerdo Pena pled guilty to an Accusation charging him with leader of an auto theft trafficking network. Pena admitted that, between June 13, 2004 and November 18, 2004, as an organizer or supervisor of an automobile theft trafficking network, he conspired with several others to steal automobiles from an automobile dealership and to accept automobiles that were “given up” by their owners so that phony automobile insurance theft claims could be submitted to automobile insurance carriers. During the time period in question, Pena was an employee of Sansone Route 1 Auto Mall and assisted in the theft of cars from his employer. He also participated in automobile “give ups” with persons who wanted to “give up” their car, in order to submit a phony insurance theft claim, and, in some cases, purchase a new car. Pena is scheduled to be sentenced early in 2007.

On September 1, 2006, the court sentenced Aneudy “Elvis” Ruiz to four years in state prison and ordered him to pay \$10,500 in restitution to OIFP and a \$3,500 civil insurance fraud fine. On June 29, 2006, Ruiz pled guilty to an Accusation charging him with receiving stolen property and conspiracy. Ruiz admitted that, between October 2004 and January 2006, he was involved in a conspiracy with others to steal cars and accept owner initiated “give up” vehicles so that auto insurance claims could be submitted. Ruiz admitted that at the time in question, he was employed as a salesman at Lincoln Mercury/Mazda of the Sansone Route 1 Auto Mall. Ruiz admitted that he stole the spare ignition keys for automobiles to be sold at Sansone and used them to steal vehicles from the auto dealership. Additionally, Ruiz admitted to being involved in three owner “give up” auto thefts whereby he took cars from their owners so the owners could report them stolen and submit phony insurance theft claims. Ruiz admitted to selling seven cars stolen from the auto dealership for a total of \$18,000 and also admitted to selling the three “give up” cars for a total of \$1,500. On April 10, 2006, OIFP investigators arrested Ruiz and charged him with being a leader of an auto theft trafficking network, conspiracy, receiving stolen property, and theft by unlawful taking. The judge set bail at \$100,000.

On August 4, 2006, the court sentenced Ruben More to three years probation and ordered him to pay up to \$25,000 in restitution to Liberty Mutual Insurance Company, \$700 in restitution to OIFP, and a \$3,000 civil insurance fraud fine. On June 15, 2006, More pled guilty to an Accusation charging him with conspiracy and Insurance Fraud. More admitted that he falsely reported to the Elizabeth Police Department and to Liberty Mutual that his 2002 Buick had been stolen when, in fact, he knew that it had not been stolen. More also admitted that he conspired with Marisa Mercuri to confirm Mercuri’s false claim that her 2003 Nissan Xterra had been stolen in Hillside. Mercuri is More’s girlfriend.

On August 4, 2006, the court admitted Jose Diaz into the PTI Program conditioned upon him paying up to \$29,865 in restitution to GEICO Insurance Company, \$1,000 in restitution to OIFP, a \$3,000 civil insurance fraud fine, and performing 60 hours of community service. On June 28, 2006, Diaz pled guilty to Insurance Fraud. Diaz allegedly fraudulently reported his 2004 Acura TL stolen to the Elizabeth Police Department and also allegedly fraudulently reported the theft to GEICO.

On October 12, 2006, Grzegorz Miekina pled guilty to an Accusation charging him with Insurance Fraud. Miekina admitted that he fraudulently reported his 2002 Infiniti QX4 stolen to the Linden Police Department and also fraudulently reported the theft to Liberty Mutual Insurance Company. He is scheduled to be sentenced in 2007.

On October 11, 2006, the court admitted Gregory Urena-Disla into the PTI Program conditioned upon him paying \$450 in restitution and a \$3,000 civil insurance fraud fine. On June 29, 2006, Urena-Disla pled guilty to an Accusation charging him with Insurance Fraud. Urena-Disla allegedly fraudulently reported his 2002 Acura CL stolen to the Perth Amboy Police Department and also

allegedly fraudulently reported the theft to Auto One Insurance Company.

On August 25, 2006, the court admitted Wilimi Ruiz-Duran into the PTI Program conditioned upon him paying a \$3,000 civil insurance fraud fine. The court also ordered him to pay \$12,763 in restitution to GEICO Insurance Company and \$500 in restitution to OIFP. On June 15, 2006, Ruiz-Duran pled guilty to an Accusation charging him with Insurance Fraud. Ruiz-Duran allegedly fraudulently reported his 2000 Honda Accord stolen to the Perth Amboy Police Department and also allegedly fraudulently reported the theft to GEICO Insurance Company.

On April 10, 2006, OIFP investigators arrested Jerinardo Fernandez and charged him with conspiracy to commit Insurance Fraud, Insurance Fraud, theft by deception, tampering with a witness, and terroristic threats. He was released on \$100,000 bail. On November 30, 2006, Fernandez pled guilty to an Accusation charging him with Insurance Fraud and tampering with witnesses and informants. Fernandez admitted that he gave his 2002 Honda Civic to Esmerdo Pena so that he (Fernandez) could report the vehicle stolen and collect the insurance money. Fernandez also admitted that he reported the vehicle stolen to First Trenton Indemnity Company. Finally, Fernandez admitted that once he was notified he was a target of an investigation, he threatened Pena and his family. Fernandez is scheduled to be sentenced in 2007.

Operation Big Stash

OIFP’s investigation revealed that members of an auto theft gang frequently met at a restaurant parking lot to discuss thefts of other vehicles, exchange stolen cars so that they could be picked up, re-tagged, and sold, and otherwise plan car thefts. The following developments occurred in this operation in 2006:

On October 4, 2006, Artur Czubek pled guilty to an Accusation charging him with leader of an auto trafficking network. Czubek is scheduled to be sentenced in early 2007. Czubek admitted that, between November 22, 2004 and October 22, 2005, he was involved in a conspiracy with others to either steal cars or accept owner-initiated “give up” vehicles so that auto insurance claims could be submitted. Czubek was involved with the theft and resale of 13 cars. Nine of the cars were stolen, including some

from automobile dealerships. Four of the cars were owner "give ups." OIFP undercover investigators purchased nine stolen cars from Czubek for a total of \$26,000. The nine stolen vehicles have a total value of approximately \$562,000. OIFP undercover investigators bought four owner "give ups" from Czubek for a total of \$4,300. These four owner "give ups" have a total value of approximately \$133,000. OIFP investigators arrested Artur Czubek and charged him with conspiracy to commit receiving stolen property, receiving stolen property, leader of an auto trafficking network, and conspiracy to commit Insurance Fraud.

On July 26, 2006, a Union County Grand Jury returned an indictment charging Krzysztof Sprysak, a/k/a Krzysztof Rumor, a/k/a Andrzej Komar, with conspiracy, receiving stolen property, and fencing. According to the indictment, Sprysak, also known as Rumor, conspired with others to knowingly receive stolen property and fence stolen cars. The State alleged that Sprysak possessed a stolen 2003 BMW 330I. It is alleged that he sold the car to an OIFP undercover investigator. Although a 2003 BMW 330I has an approximate value of \$38,000, it was alleged that Sprysak agreed to sell the car for much less. Sprysak failed to appear at his arraignment on September 11, 2006. The judge issued a bench warrant for his arrest.

On October 25, 2006, a Middlesex County Grand Jury returned an indictment charging Artur Lapinski with conspiracy, receiving stolen property, and fencing. According to the indictment, Lapinski conspired with persons, who were not further identified in the indictment, to commit receiving stolen property and trafficking in stolen property. Specifically, it is alleged that Lapinski knowingly possessed a stolen 2005 BMW M3. It is further alleged that Lapinski sold the stolen BMW to another person who was acting in an undercover role on behalf of OIFP. It is also alleged that the 2005 BMW M3 had been stolen from an auto dealership in Warwick, Rhode Island. The indictment also charges Lapinski in a separate conspiracy. In that conspiracy, it is alleged that Lapinski agreed with other persons, who were not identified in the indictment, to commit Insurance Fraud. At trial, the State intends to prove that Lapinski committed Insurance Fraud in that he agreed with another person to sell an Infiniti QX4 so that the owner of the Infiniti QX4 could falsely report it stolen to the insurance company.

On July 14, 2006, the court sentenced Monika Fijalkowska to two years probation conditioned upon her performing 75 hours of community service. The court also ordered her to pay \$4,000 in restitution to OIFP, \$48,437 in restitution to Allstate Insurance Company, and a \$6,000 civil insurance fraud fine. On May 31, 2006, Fijalkowska pled guilty to Insurance Fraud. Fijalkowska admitted that she submitted phony insurance claims for two separate phony automobile thefts.

With respect to the first theft, Fijalkowska reported her 2001 BMW X5 as having been stolen to the New York City Police Department. She admitted that she then submitted a claim to Allstate Insurance Company falsely claiming that her car had been stolen. As part of the claim, she alleged that a camera and a Panasonic Home Surround System were also stolen with an additional value of approximately \$1,200. Allstate paid her claim in the approximate amount of \$11,861.

With respect to the second phony insurance claim, Fijalkowska admitted that she reported a 2003 Audi A4 as having been stolen to the New York City Police Department. She submitted a phony automobile theft claim to Allstate Insurance Company alleging that her car had been stolen. Allstate paid Fijalkowska approximately \$25,772 in settlement of her auto insurance claim. In both cases, Fijalkowska admitted that she "gave up" her car to another person who was not further identified.

On August 30, 2006, the court admitted Janina Komsta into the PTI Program. On May 31, 2006, Komsta pled guilty to an Accusation filed in Union County charging her with conspiracy to commit Insurance Fraud. Komsta allegedly conspired with Monika Fijalkowska to report Fijalkowska's 2003 Audi A4 stolen to the New York City Police Department.

On September 27, 2006, the court admitted Desiree Gan into the PTI Program conditioned upon her paying \$16,119 in restitution to Liberty Mutual Insurance Company and a \$3,000 civil insurance fraud fine, and performing 60 hours of community service. On August 18, 2006, Gan pled guilty to an Accusation charging her with Insurance Fraud. Gan allegedly falsely reported to the New York City Police Department that her 1999 Mercedes Benz ML430 had been stolen. Gan also allegedly falsely submitted a stolen vehicle claim to Liberty Mutual Insurance Company, knowing her vehicle had not been stolen.

OIFP investigators previously arrested Rodamir Drozdil and charged him with receiving stolen property, stolen license plates, and possession of burglary tools. OIFP investigators also previously arrested Daniel Sokolski and charged him with receiving stolen property, stolen license plates, and possession of burglary tools. Both cases remain pending.

Operation Jellystone

On December 12, 2006, OIFP investigators arrested Jose Torres and charged him with leader of auto theft trafficking network, certain persons not to have weapons, unlawful possession of a weapon, and violation of the regulatory provisions relating to firearms. The case is pending Grand Jury.

State v. Erica Lee Silverstein

On November 9, 2006, the court admitted Erica Lee Silverstein into the PTI Program. Silverstein pled guilty to an Accusation charging her with attempted theft by deception. Silverstein allegedly falsely reported her 2002 Nissan Sentra stolen to the North Brunswick Police Department and subsequently allegedly filed a false vehicle theft claim with Liberty Mutual Insurance Company. It is also alleged that Silverstein's vehicle was not stolen but that she had given the keys to another person to dispose of the car so that a false insurance claim could be submitted.

State v. Kathleen Natale Hughes

On December 1, 2006, the court admitted Kathleen Natale Hughes into the PTI Program conditioned upon her paying a \$2,000 civil insurance fraud fine and performing 50 hours of community service. On October 2, 2006, Hughes pled guilty to an Accusation charging her with attempted theft by unlawful taking. Hughes allegedly falsely reported to Liberty Mutual Insurance Company that her 2004 Nissan Quest had been stolen in Camden.



State v. Walter Francis, et al.

On September 8, 2006, the court admitted Walter Francis into the PTI Program conditioned upon him paying \$6,896 in restitution to New Jersey CURE Insurance Company and a \$1,000 criminal fine. He had previously paid a \$3,000 civil insurance fraud fine. On July 11, 2006, Francis pled guilty to an Accusation charging him with conspiracy and theft by deception. Francis allegedly falsely reported to the Jersey City Police Department and New Jersey CURE that his 1998 Chevrolet Cavalier had been stolen, when, he had allegedly given the vehicle to Michael Steele so that Steele could dispose of the car.

On September 15, 2006, the court sentenced Michael Steele to two years probation and ordered him to pay a \$1,000 criminal fine as well as a \$2,000 civil insurance fraud fine. On July 21, 2006, Steele pled guilty to an Accusation charging him with conspiracy and arson. Steele admitted that he took possession of Francis' 1998 Chevrolet Cavalier and set it on fire so that Francis could falsely report that the vehicle had been stolen.

State v. Eduardo Pagan, Jr.

On August 17, 2006, a Somerset County Grand Jury returned an indictment charging Eduardo Pagan, Jr., with Insurance Fraud, falsifying records, and tampering with public records or information. According to the indictment, Pagan falsely reported to the Belleville Police Department that his leased 2001 Jaguar had been stolen. It is also alleged that Pagan submitted a false vehicle theft claim to Parkway Insurance Company, knowing that the vehicle had not been stolen. The case is pending.

State v. Deland Docsol

On December 11, 2006, Deland Docsol pled guilty to attempted theft by deception. On the same day, the court admitted him into the PTI Program. An Essex County Grand Jury returned an indictment on August 8, 2006, charging Docsol with attempted theft by deception and tampering with public records or information. According to the indictment, on November 16, 2002, Docsol allegedly fraudulently reported to the Irvington Police Department that his 1995 Mercedes Benz E420 had been stolen on that day even though the vehicle had been in the possession of the Atlanta, Georgia, Police Department since November 13, 2002. The State alleged that Docsol submitted a fraudulent Affidavit of

Vehicle Theft to Prudential Property and Casualty Insurance Company, falsely stating that he last saw the vehicle on November 16, 2002. Prudential, suspecting fraud, denied the claim and referred the matter to OIFP for investigation.

State v. Victor Shulou

On December 21, 2006, Victor Shulou pled guilty to an Accusation charging him with Insurance Fraud. Shulou admitted that he falsely reported that his car had been stolen in New York City, knowing that it had not been stolen. He subsequently filed a false stolen vehicle insurance claim with Allstate Insurance Company. Shulou will be sentenced in 2007.

State v. Michael J. Jolas

On August 21, 2006, an Essex County Grand Jury returned an indictment charging Michael J. Jolas with theft by deception. According to the indictment, Jolas reported to the Belleville Police Department that his 2001 Kia Sephia had been stolen, knowing that it had not been stolen. It is also alleged that Jolas falsely submitted a vehicle theft insurance claim to One Beacon Insurance/New Jersey Skylands Insurance Company. The insurance company paid \$9,039 on the claim.

State v. Paulette Foti-McMullen, et al.

On October 11, 2006, Hank McMullen pled guilty to an Accusation charging him with Insurance Fraud. He admitted that he and his wife, Paulette Foti-McMullen, falsely reported that her 2003 Ford Expedition was stolen and filed a false stolen vehicle police report with the Hamilton Township Police Department in support of the phony auto insurance theft claim. Hank McMullen further admitted that he assisted his wife in filing a false auto theft insurance claim with State Farm Insurance Company by concealing the fact that the Ford Expedition was set on fire in New York so that the McMullens could falsely claim the Expedition had been stolen. Hank McMullen is scheduled to be sentenced in early 2007. The McMullens were also prosecuted by the Hamilton Township Municipal Court and by law enforcement authorities in New York for conduct related to this false insurance claim.

State v. Mary Maldonado, et al.

On November 30, 2006, a Somerset County Grand Jury returned an indictment charging Mary Maldonado and her son, Alan Maldonado, Jr., with conspiracy, Insurance

Fraud, attempted theft by deception, tampering with public records, and false swearing. According to the indictment, Mary Maldonado fraudulently reported to the Old Bridge Township Police Department that her 2002 Acura RSX, which her son Alan had been driving, had been stolen. The State further alleges that Mary Maldonado submitted a fraudulent stolen vehicle claim to Allstate Insurance Company, even though the vehicle had not been stolen but had, in fact, been involved in an accident. Allstate, suspecting fraud, denied the claim and referred the matter to OIFP for investigation.

State v. Cindy Cassagne-Centeno

On November 9, 2006, Cindy Cassagne-Centeno pled guilty to an Accusation charging her with Insurance Fraud. Cassagne-Centeno admitted that she falsely reported to the Jersey City Police Department and Selective Insurance Company that her 2002 Honda Accord was stolen from outside her residence when, in fact, the vehicle had been found burning in New York City the day before she reported she had last seen the car. Cassagne-Centeno is scheduled to be sentenced in 2007.

State v. Juan Saldivar

On December 7, 2006, Juan Saldivar pled guilty to an Accusation charging him with Insurance Fraud. Saldivar admitted that he falsely reported to Encompass Insurance Company that his Ford Expedition had been stolen, even though he knew the person who had the vehicle and that the vehicle had subsequently been returned to him. He is scheduled to be sentenced in 2007.

State v. Rosa Cuellar

On November 9, 2006, an Essex County Grand Jury returned an indictment charging Rosa Cuellar with Insurance Fraud, attempted theft by deception, and tampering with public records. According to the indictment, Cuellar falsely reported to Newark Police Department and Progressive Insurance Company that her 2004 Hyundai had been stolen, when she had allegedly given the vehicle to another person to dispose of so that she could file a false auto theft claim with her insurance company and receive the claim money for the vehicle. The case is pending.

State v. Joseph Gavin

Joseph Gavin, who had an outstanding warrant for his arrest, was arrested in Pennsylvania by OIFP investigators on November 2, 2006, and was transported to Cape May

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

State v. Keith R. Turpin

On November 28, 2006, Keith R. Turpin pled guilty to an Accusation charging him with Insurance Fraud. Turpin admitted that on April 19, 2006, he falsely reported to the Asbury Park Police Department that his 2004 Volkswagen had been stolen when, in fact, it had not been stolen. He later submitted a vehicle theft insurance claim to Rutgers Casualty Insurance Company, which paid \$28,050 on the claim. Turpin is scheduled to be sentenced in 2007.

State v. Alexander Schaefer

On December 12, 2006, Alexander Schaefer pled guilty to an Accusation charging him with Insurance Fraud. Schaefer admitted that he submitted a false insurance claim to State Farm Insurance Company claiming that his ten-day-old 2003 Yamaha motorcycle was stolen while parked in Wayne, when, in fact, it was damaged while he was operating it. Schaefer's scheme came to light when it was discovered that he was cited for careless driving by the Pequannock Police Department while riding the motorcycle that he previously reported as being stolen in Wayne. State Farm denied Schaefer's claim and the matter was referred to OIFP for investigation. He is scheduled to be sentenced in 2007.

False Automobile-Related Insurance Claims

State v. Thomas Liu

On August 28, 2006, the court admitted Thomas Liu into the PTI Program conditioned upon him paying a \$1,500 civil insurance fraud fine. The court also ordered him to perform 75 hours of community service. A Monmouth County Grand Jury returned

an indictment on February 23, 2006, charging Liu with conspiracy and attempted theft by deception. According to the indictment, Liu, the owner of Long Branch Service Center, allegedly provided phony repair receipts totaling \$2,532 to John Callery. Callery, who was involved in an automobile accident, allegedly used the phony repair receipts in order to inflate his insurance claim to Liberty Mutual Insurance Company. Callery pled guilty to attempted theft by deception and was admitted into the PTI Program.

State v. Misty Megill

On January 26, 2006, OIFP investigators and members of the New Jersey State Police arrested Misty Megill and charged her with Insurance Fraud and tampering with public records. The State alleges that Megill and perhaps others purchased used cars, often salvage cars. In registering the vehicles with the Motor Vehicle Commission (MVC), Megill allegedly falsely indicated that the cars were covered with an auto insurance policy when, in fact, they were not. The cars were then allegedly sold or leased to others. Megill was arraigned in Monmouth County and bail was set at \$170,000/10%. This matter is pending presentation to a Grand Jury. The investigation is continuing and additional arrests and charges are anticipated.

State v. Louis Rivadeneira

On December 15, 2006, the court sentenced Louis Rivadeneira to a one-year probationary term and ordered him to pay \$9,800 in restitution. On October 19, 2006, Rivadeneira had pled guilty to attempted theft by deception. A Hudson County Grand Jury returned an indictment on May 2, 2006, charging Rivadeneira, who owned and operated an automobile body repair business known as Louis & Sons Auto Body, with conspiracy and attempted theft by deception. According to the indictment, between May 4, 2000 and August 15, 2003, Rivadeneira inflated automobile body repair claims submitted to Allstate Insurance Company and United Services Automobile Association (USAA). The State alleged that Rivadeneira was responsible for submitting several inflated automobile repair claims by causing additional damage to be inflicted on cars he was to repair and by charging the insurance companies for repairs that were not necessary or were never made as billed.

State v. Sylvia Morales

On July 11, 2006, the court admitted Sylvia Morales into the PTI Program follow-

ing her May 24, 2006, guilty plea to Insurance Fraud. A Bergen County Grand Jury returned an indictment charging Morales with Insurance Fraud. According to the indictment, Morales allegedly submitted a fraudulent damage and theft of property claim to Consumer First Insurance Company for her 2001 BMW. The indictment alleged that Morales reported that she was the driver of the vehicle when it was damaged and that parts had been stolen when, in fact, her son, who had a suspended drivers license and was not insured to drive Morales' vehicle, was the alleged driver of the vehicle when it was damaged and the parts were stolen.

State v. Robinson Rodriguez

On September 18, 2006, a Bergen County Grand Jury returned an indictment charging Robinson Rodriguez with Insurance Fraud and attempted theft by deception. According to the indictment, Rodriguez allegedly submitted phony receipts totaling \$2,500 to Liberty Mutual Insurance Company in support of his claim that four rims and tires were stolen from his 1999 Lincoln Navigator. The indictment alleges that the rims and tires were already on the Navigator when Rodriguez purchased the vehicle despite Rodriguez' claim that he purchased the rims and tires separately. Rodriguez failed to appear at his arraignment on October 16, 2006, and the court issued a bench warrant for his arrest.

State v. Jason Senf

In May 2006, the trial court stayed the prosecution of Jason Senf pending the outcome of the Supreme Court's decision addressing the application of the Insurance Fraud statute in State v. Randi Fleischman. The Appellate Division had reversed the trial court's order admitting Senf into the Mercer County PTI Program and returned the case to the trial court for trial. Over the State's objection, on July 25, 2005, the trial court stayed the prosecution and admitted Senf into the PTI Program, conditioned upon him paying a \$5,000 civil insurance fraud fine and



performing 100 hours of community service. The State objected to Senf's participation in the PTI Program because he was charged with a serious second degree crime.

A Mercer County Grand Jury previously returned an indictment that charged Senf with Insurance Fraud and attempted theft by deception. According to the indictment, Senf allegedly submitted a fraudulent insurance claim to Foremost Insurance Company for damage to his all-terrain vehicle (ATV). The State alleged that Senf falsely claimed that he damaged his ATV on June 22, 2003, when he struck a tree and 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 and concealed the fact that the ATV had been damaged. Suspecting fraud, Foremost investigated Senf's June 22, 2003, claim and referred the matter to OIFP for further investigation and prosecution.

State v. Virginia B. Kinion , et al.

On April 13, 2006, Virginia B. Kinion pled guilty to Health Care Claims Fraud. The court sentenced her on August 18, 2006, to three years probation and ordered her to pay a \$10,000 civil insurance fraud fine. On

March 24, 2006, John Knight pled guilty to falsifying records. The court sentenced him on August 18, 2006, to two years probation and ordered him to pay a \$5,000 civil insurance fraud fine. A Passaic County Grand Jury returned an indictment 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, Kinion and Knight allegedly submitted a false automobile insurance policy application and false PIP claims to Clarendon National Insurance Company. The State alleged 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 alleged 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 further alleged that Kinion and Knight caused fraudulent PIP insurance claims for \$9,917 and \$13,231 to be submitted to Clarendon for the automobile accident. Clarendon denied the claims and referred the matter to OIFP for investigation.

State v. Jay Gorzkowski

On November 27, 2006, Jay Gorzkowski pled guilty to an Accusation charging him with Insurance Fraud. Gorzkowski admitted that he reported to the Elmwood Police Department that his 1999 Mercedes Benz had been stolen. Gorzkowski admitted that he grossly inflated the value of the vehicle when he submitted the stolen automobile insurance claim to Consumer First Insurance Company in order to obtain a larger insurance payoff for the vehicle. Consumer First, suspecting fraud, denied the claim and referred the matter to OIFP for investigation. Gorzkowski is scheduled to be sentenced in early 2007.

State v. Frances Bowie, et al.

On September 9, 2006, the court admitted Monique Bowie into the PTI Program

conditioned upon her paying \$123 in restitution to Amica Insurance Company and a \$2,000 civil insurance fraud fine. On July 28, 2006, the court sentenced Frances Bowie to two years probation and ordered her to pay a \$4,000 civil insurance fraud fine. On June 12, 2006, Frances Bowie pled guilty to an Accusation charging her with Health Care Claims Fraud. Bowie's daughter, Monique Bowie, was charged in a separate Accusation with attempted theft by deception. Frances Bowie admitted that, between May 13, 2002 and May 28, 2003, she submitted a false automobile insurance claim to an insurance company. Specifically, she admitted that she falsely claimed to Amica Mutual Insurance Company that, following an automobile accident, she was required to hire another person to perform "essential services" for her because of the injuries she sustained in the automobile accident. Frances Bowie admitted that, in total, she submitted approximately \$1,500 in phony essential services claims to Amica Mutual Insurance Company. Suspecting fraud, Amica denied both claims and referred the matter to OIFP for investigation.

State v. Nicholas A. DiMeglio

On October 4, 2006, a Union County Grand Jury returned an indictment charging Nicholas A. DiMeglio with theft by deception, uttering forged writing, and falsifying records. According to the indictment, DiMeglio allegedly submitted an altered invoice in the amount of \$8,745 in order to support the amount of damage he claimed his 2002 Kawasaki motorcycle sustained in a collision with a truck. The State alleges that DiMeglio submitted the altered invoice to Rider Insurance Company to make it appear that, prior to the accident, the insured motorcycle had had extensive repairs and renovations, even though the repairs and renovations had never been made. DiMeglio failed to appear at his arraignment on November 13, 2006, and the court issued a bench warrant for his arrest.

State v. Judith E. Hoffman

On September 19, 2006, the court admitted Judith E. Hoffman into the PTI Program conditioned upon her performing 50 hours of community service. Hoffman previously pled guilty to an Accusation charging her with Insurance Fraud. Hoffman allegedly was involved in a motor vehicle accident. At the time of the accident, her automobile insurance policy with Allstate Insurance Company allegedly had been terminated for failure to pay the premium. Hoffman allegedly

reinstated the insurance policy with Allstate following the accident and allegedly changed the time on the police accident report so that it reflected that she had insurance coverage at the time of the accident.

State v. Alexis Figueroa

On August 15, 2006, a Hudson County Grand Jury returned an indictment charging Alexis Figueroa with attempted theft by deception. According to the indictment, Figueroa allegedly obtained medical services from the Jersey City Medical Center, valued in excess of \$500, by falsely claiming to be injured in an automobile accident in which a taxicab was allegedly struck by another vehicle. The State alleged that Figueroa was not in the taxicab when it was struck and, therefore, did not suffer injuries. The alleged motive for Figueroa's seeking treatment from the Jersey City Medical Center was to submit a false PIP claim to Amica Mutual Insurance Company in an effort to obtain insurance claim money. The insurance company's investigation of the incident prevented Figueroa from going forward with his alleged attempt to defraud Amica Mutual Insurance Company. The case is pending trial.

State v. Hanif Bethea, et al.

On August 24, 2006, an Essex County Grand Jury returned an indictment charging Hanif Bethea and Thomas Merritt with conspiracy, Health Care Claims Fraud, attempted theft by deception, and tampering with public records. According to the indictment, between May 16, 2001 and April 9, 2002, Bethea and Merritt conspired to commit Health Care Claims Fraud and theft by deception by allegedly claiming that they had been injured in an automobile accident which purportedly occurred on May 16, 2001, in Newark. The State alleges that the accident did not occur and neither Bethea nor Merritt were injured. The State also alleges that Bethea and Merritt caused the East Orange Chiropractic Association to bill Metropolitan Property and Casualty Insurance Company a total of approximately \$9,861 for diagnostic and chiropractic treatments related to the purported auto accident. East Orange Chiropractic billed approximately \$5,173 for treatments rendered to Bethea and \$4,688 for treatments rendered to Merritt. Bethea failed to appear at his arraignment on October 2, 2006, and the court issued a bench warrant for his arrest.

Additionally, two other claimants, William Ebron and Suzette Tanner, were also treated for alleged injuries arising from the pur-

ported accident in a total amount of approximately \$11,215. Ebron and Tanner previously pled guilty and both were sentenced to four years probation, ordered to pay \$14,690 in restitution and to each pay a \$5,000 civil insurance fraud fine.

State v. Evelia Toledo

On November 29, 2006, Evelia Toledo pled guilty to an Accusation charging her with Insurance Fraud. On the same day, she was admitted into the PTI Program conditioned upon her performing 100 hours of community service. Toledo allegedly submitted an altered receipt for towing of her 1999 Ford Crown Victoria to the Iservco Insurance Company, following an accident she was involved in on the New Jersey Turnpike.

State v. Town & Country Auto Body, et al.

On December 6, 2006, the court admitted Town & Country Auto Body and Vincent Iuffredo into the PTI Program conditioned upon them paying \$6,757 in restitution to Liberty Mutual Insurance Company and paying a \$7,500 civil insurance fraud fine. On the same day, Town & Country Auto Body located on East Main Street in Mendham, pled guilty to an Accusation charging it with theft by deception. Town & Country's owner/operator, Vincent Iuffredo, was also charged by way of an Accusation with theft by deception. The corporate defendant, Town & Country Auto Body, allegedly stole insurance company claims money from Liberty Mutual by inflating automobile damage repair claims.

State v. Noemi Romero, et al.

On November 17, 2006, a Mercer County Grand Jury returned an indictment charging Noemi Romero, Argelia Romero, and Maria Romero with conspiracy, Health Care Claims Fraud, attempted theft by deception, and tampering with public records. According to the indictment, following an allegedly minor automobile accident which occurred in West Orange, Noemi Romero, the driver of one of the vehicles involved in the purported accident, conspired with Maria Romero and Argelia Romero to claim to the West Orange Police Department that Maria and Argelia were passengers in the car and were injured, when, in fact, they were not passengers in the car at the time of the accident and were not injured. The State alleges that following the claim of injuries, Noemi, Maria, and Argelia Romero submitted claims for medical treatment to New Jersey Manufacturers Insurance Company based on the automobile

insurance policy's PIP coverage. The State alleges that approximately \$20,000 in PIP claims were submitted as a result of the purported accident.

Insurance Claims Involving Identity Fraud

State v. Vianey Vincent

On December 18, 2006, Vianey Vincent pled guilty to Health Care Claims Fraud. He will be sentenced in 2007. A State Grand Jury returned an indictment charging Vianey Vincent, a/k/a Steven Vincent, a/k/a Vincent Steven, a former State employee of the Irvington Branch of the Motor Vehicle Commission, with Health Care Claims Fraud, theft of identity, and attempted theft by deception. The indictment alleged that, between January 1, 1998 and August 31, 2002, Vincent used the fictitious identities of Steven Vincent and Vincent Steven to obtain an automobile insurance policy, a home mortgage, an automobile loan, and other credit card purchases with a value in excess of \$75,000. The indictment also alleged that Vincent submitted false PIP insurance claims to State Farm Insurance Company and attempted to collect uninsured motorist insurance benefits by claiming that "Steven Vincent" was insured with State Farm and that he (Vianey Vincent) was entitled to insurance benefits as a member of "Steven Vincent's" household. OIFP investigators arrested Vincent pursuant to an arrest warrant. Vincent was released on \$50,000 bail.

State v. Solanji Severino Chavez

On September 22, 2006, the court sentenced Solanji Severino Chavez to a one-year probationary term and ordered her to perform 25 hours of community service. Severino Chavez previously pled guilty to an Accusation charging her with uttering a simulated document. Severino Chavez admitted that she possessed a fictitious New Jersey drivers license bearing the name Marisol Garcia, knowing she was not Marisol Garcia.

State v. Oscar Garcia Guillen a/k/a Rafael Feliciano

On July 12, 2006, a Union County Grand Jury returned an indictment charging Oscar Garcia Guillen with Insurance Fraud and theft of identity. According to the indictment, Garcia Guillen allegedly stole the identity of a Trenton man, using the man's drivers license and personal information to obtain an auto insurance policy from First Trenton Indemnity Company. The State al-



leges that later, following an automobile accident in Hamilton, Garcia Guillen allegedly presented police with a fraudulent insurance card in the Trenton man's name and submitted a claim in the man's name for \$3,127 to State Farm Insurance Company, the other driver's insurance company. Garcia Guillen failed to appear at his pre-arraignment conference on August 4, 2006. The judge issued a bench warrant for his arrest.

State v. Alif James, et al.

On December 21, 2006, Michelle Chappell pled guilty to conspiracy. She is scheduled to be sentenced in 2007. A Hudson County Grand Jury returned an indictment on October 17, 2006, charging Alif James and Michelle Chappell with conspiracy, theft of identity, and theft by deception. According to the indictment, James and Chappell conspired to commit identity theft and theft of a car. James allegedly obtained a 1998 Honda Accord from an auto dealership utilizing the identity of another person, which James wrongfully obtained. The State further alleged that Chappell co-signed certain records in connection with the purchase of the Honda knowing that James was using a fictitious identity. The case as to James is pending trial.

Insurance Fraud Committed by Police Officers

State v. Jerome F. Bollettieri, et al.

On August 11, 2006, following a six-day bench trial, the trial judge convicted Jerome F. Bollettieri of conspiracy, official misconduct, bribery, and Criminal Use of Runners. He will be sentenced in 2007. Bollettieri, who was the Lieutenant in charge of the Camden County Police Department's Automobile Accident Report Records Room at the time he was charged in an indictment previously returned by the State Grand Jury, was also charged, along with Thomas DiPatri, Charles Warrington, and Ettore C. Carchia with providing Camden Police auto accident reports to DiPatri so they could, in turn, be provided to Warrington, a "runner," to solicit patients for a chiropractic practice known as American Spinal. Specifically, the State Grand Jury indictment charged Bollettieri and DiPatri with conspiracy, official misconduct, bribery, and Criminal Use of Runners. Warrington was charged with conspiracy, bribery in official matters, and Criminal Use of Runners.

Previously, the court sentenced Carchia to three years probation and ordered him to sur-

render his chiropractic license following his guilty plea to an Accusation charging him with Health Care Claims Fraud in connection with this investigation. In addition, following a six-day bench trial, DiPatri was convicted of conspiracy, bribery, official misconduct, and Criminal Use of Runners. The court sentenced him to three years state prison.

Bollettieri's trial was stayed pending an appeal to the State Supreme Court in which Bollettieri alleged that the State intended to improperly use immunized testimony against him in his trial. The State Supreme Court returned Bollettieri's case to the trial court for a *Kastigar* hearing; and on January 23, 2006, the trial judge ruled that Bollettieri's prior statement could, in fact, be admitted into evidence against him at his trial.

State v. Philip Major, et al.

The court meted out sentences or issued arrest warrants in 2006 for two additional persons who were among 39 defendants, 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 defendants 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 2006:

Cari Blanco and Nieves Carasco had 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. The court sentenced them on February 24, 2006, to three years probation and ordered them each to pay a \$1,500 civil insurance fraud fine. Blanco was also ordered to pay \$3,895 in restitution to Prudential Insurance Company.

On September 15, 2006, the court sentenced former East Orange Police Officer Philip Major to 364 days in county jail. 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 dam-

age, 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 a medical facility that specialized in treating persons with 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.

State v. Jeffrey Nemes

As part of a continuing investigation into a series of arson fires in Mercer County and elsewhere, a State Grand Jury previously returned three separate indictments that charged Jeffrey Nemes, a former Hamilton Township police officer, with bribes allegedly offered to local district fire chiefs, bribes allegedly offered to the Executive Vice President of the East Windsor Police Athletic League (PAL), and the alleged theft of insurance claim money in connection with a construction and home repair business which was owned and operated by Nemes, known as Nemes Enterprises, Inc.

With respect to the third indictment involving the alleged theft of insurance claim money, on May 19, 2005, the Appellate Division of the New Jersey Superior Court reversed Nemes' conviction for theft by failure to make proper disposition of property. The Appellate Court returned the case to the trial court for a new trial. A 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., for the purpose of making repairs but 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. Nemes appealed his conviction

which was reversed by the Appellate Division and remanded for a new trial. The case is pending re-trial.

The trial on the charges that Nemes allegedly 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 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 June 13, 2006, the Appellate Division denied Nemes' request to dismiss the indictment on the ground that double jeopardy attached as a result of the declaration of the mistrial, and ordered the case returned to the trial court for trial. The trial is scheduled for early 2007. Likewise, the third indictment alleging that Nemes allegedly offered bribes to the Vice President of the East Windsor PAL is pending trial.

Receiving Stolen Property

State v. Anthony Josephs, et al.

The court previously sentenced Anthony Josephs to five years in state prison. Josephs pled guilty to receiving stolen property. 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 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 key to the cars with a fake key so they could return and use the real ignition key to steal the cars. The defendants stole cars from dealerships located in Oakhurst and Lawrence.

On October 20, 2006, the court sentenced Sasha Andre Brown to a five-year probationary term. On January 19, 2006, Brown pled

guilty to an Accusation charging him with receiving stolen property. Brown admitted that he possessed a bag of approximately 24 stolen automobile ignition keys used to steal expensive new cars from dealers. Brown admitted that he did so by using a similar scheme as Anthony Josephs.

State v. Julio Cid-Peralta

On January 13, 2006, a Union County Grand Jury returned an indictment charging Julio Cid-Peralta with receiving stolen property, alterations of motor vehicle trademark identifications, and obstructing administration of law or other governmental function. According to the indictment, Cid-Peralta was allegedly in possession of a stolen 1993 Mazda RX7. The State alleged that the stolen Mazda had an altered Vehicle Identification Number (VIN). The State also alleged that when Cid-Peralta was stopped while driving the allegedly stolen car, he exited the vehicle and ran. Cid-Peralta failed to appear at his arraignment on March 6, 2006, and the court issued a bench warrant for his arrest.

State v. Giovanni Muscia

On May 15, 2006, Giovanni Muscia pled guilty to theft by deception. He is scheduled to be sentenced in early 2007. A Passaic County Grand Jury returned an indictment charging 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. Anhuar Bandy, Elvin Castillo, et al.

Following a six-week jury trial, Anhuar Bandy and Elvin Castillo were convicted of racketeering, conspiracy, Health Care Claims Fraud, and theft by deception. The Court sentenced Bandy to 29 years state prison, ordered him to pay a \$100,000 criminal fine and restitution in the amounts of \$3,483 to Sentry Insurance Company, \$14,106 to Allstate Insurance Company, and \$472 to Prudential Insurance Company. The Court sentenced Castillo to 13 years state prison and ordered him to pay \$27,800 in restitution and a \$50,000 criminal fine.

Anhuar Bandy and Elvin Castillo are two of 28 persons named in ten separate 2002 State Grand Jury indictments that charged defendants with racketeering, conspiracy, Health Care Claims Fraud, attempted theft,

theft by deception, use of a 17-year-old or younger to commit a criminal offense, and possession of a weapon without a permit. All of the charges stem from the defendants' alleged participation in phony automobile accidents in and around Union County for which they submitted false insurance claims.

The State Grand Jury's main indictment charged Bandy with racketeering and related crimes. The State alleged Anhuar Bandy owned, controlled, or operated, as the chief corporate officer, six North Jersey chiropractic clinics, and that Alejandro Ventura, Elvin Castillo, Raynaldo Cuevas, Cesar Caba, and Victor Almonte were associated with Bandy, or the clinics, as "runners" who fabricated eight phony automobile accidents. The State alleged that defendants used information from the eight phony automobile accidents to submit PIP insurance claims in excess of \$331,000 to several insurance companies. Additionally, the State alleged in the indictment that defendants submitted insurance claims in excess of \$2 million for more than 90 other phony accidents, and that the accidents were constructed by obtaining cars, drivers and passengers, faking accidents, and then sending the occupants of the cars to treat at Bandy's chiropractic clinics so he could submit the PIP insurance claims.

The State alleged that insurance claims for these phony automobile accidents were submitted to 16 other insurance carriers, including Bayside Casualty, Clarendon National, Continental Insurance, Farm Family Insurance Company, Liberty Mutual Insurance Company, Maryland Insurance Company, The Moxon Company, National Continental Progressive, National General Insurance Company, NJ CURE, Ohio Casualty Insurance Company, Parkway Insurance, Progressive Casualty, Red Oak Insurance Company, United States Automobile Association (USAA), and New Jersey Manufacturers Insurance Company. The State alleged that most of the claim money was paid to Bandy owned, operated, or controlled chiropractic clinics.

Pursuant to *State v. Natale*, a New Jersey Supreme Court decision which mandated re-sentencing in certain cases, the *Bandy* case was remanded to the trial court for re-sentencing. On August 7, 2006, Judge Triarsi of Union County held a re-sentencing hearing for Bandy. Bandy appeared in court, publically admitted his guilt for the record, agreed to waive all further appeals of his conviction, and agreed to pay \$2 million in civil insurance fraud fines and restitution to



insurance companies. Judge Triarsi re-sentenced Bandy to 17 years in state prison.

While in court, Bandy tendered \$1 million representing a \$170,000 civil insurance fraud fine, and \$830,000 in partial payment of a total of \$1,830,000 in restitution to 21 insurance companies identified as victims of insurance fraud during the OIFP investigation. Bandy also provided the State with two mortgages on homes pledged to secure the remaining \$1 million of restitution to be paid to the 21 insurance companies over the next five years.

State v. Dannie Campbell, et al.

Dannie Campbell and ten other defendants were previously implicated in three indictments which charged them 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 PIP insurance claims to an insurance company. The fictitious accidents occurred in Hillside and Newark.

Ramil Robinson, pled guilty to Health Care Claims Fraud on June 30, 2006. Robinson failed to appear at his sentencing on August 21, 2006, resulting in the issuance of a bench warrant for his arrest.

Campbell previously pled guilty to Health Care Claims Fraud and was sentenced to three years in state prison and ordered to pay a \$3,000 criminal fine. Nathaniel Jones, Duane Smith, Shaheed Johnson also previously pled guilty to Health Care Claims Fraud. Jones was sentenced to two years probation and ordered to pay a \$2,500 civil insurance fraud fine, Smith was sentenced to three years probation and ordered to pay a \$2,500 civil insurance fraud fine, and Johnson was also sentenced to three years probation and ordered to pay a \$2,500 civil insurance fraud fine. The charges as to the remaining defendants are pending trial.

State v. Eric Boyer, et al.

State v. Shaquan McClaurin, et al.

State v. Louis McKenzie, et al.

State v. Tamika Sutton, et al.

The court sentenced three defendants in 2006 who were previously named in four State Grand Jury indictments charging conspiracy, Health Care Claims Fraud, and at-

tempted theft by deception. The defendants allegedly conspired with Eric Boyer, the alleged mastermind of three staged accidents which purportedly occurred between October 1998 and October 1999, and 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 as a result of this alleged illicit scheme.

On January 27, 2006, the court sentenced Alnisca Franklin to a three-year probationary term with credit for 72 days served in county jail. She was also ordered to perform 30 hours of community service and pay a \$3,000 civil insurance fraud fine. Franklin pled guilty to attempted theft by deception.

On March 20, 2006, Shonique Carney pled guilty to attempted theft by deception. The court sentenced her on May 12, 2006, to a two-year probationary term and ordered her to perform 25 hours of community service.

On June 19, 2006, OIFP investigators arrested Ali Sawab, a/k/a Abdul Sawab, in Philadelphia on a bench warrant. He waived extradition and was incarcerated in the Essex County Jail. The judge set bail at \$50,000. On August 8, 2006, Sawab pled guilty to attempted theft by deception. On October 16, 2006, the court sentenced him to a two-year probationary term with credit for 86 days served in county jail. The charges as to the remaining defendants are pending trial.

State v. Iris Ojeda, et al.

On January 13, 2006, a State Grand Jury returned an indictment charging Iris Ojeda, her daughter, Sacha Ojeda, and Felix Nieves with conspiracy, Health Care Claims Fraud, and attempted theft by deception. According to the indictment, between February 2, 2000 and May 9, 2001, Iris Ojeda, Sacha Ojeda, and Nieves allegedly agreed to stage an automobile accident for the purpose of submitting phony PIP and bodily injury insurance claims. The State further alleged that the three staged an accident in Paterson and claimed to have suffered bodily injuries as a result of the accident. The State further alleged that PIP applications were submitted to the Robert Plan/GSA Insurance Company and the three began to treat for their purported injuries. The Robert Plan paid out more than \$25,000 including \$10,907 for injuries purportedly sustained by Iris Ojeda, \$5,006 for injuries purportedly sustained by Sacha Ojeda, and \$10,847 for injuries purportedly sustained by Nieves.

State v. Samantha Demetro, et al.

On January 27, 2006, Bobby Eley pled guilty to conspiracy. On March 27, 2006, the court admitted him into the PTI Program conditioned upon him paying a \$2,500 civil insurance fraud fine. On February 1, 2006, Steven "David" Thompson surrendered on an arrest warrant and was arraigned in Bergen County Superior Court. On March 27, 2006, Thompson pled guilty to conspiracy. On May 5, 2006, the court admitted him into the PTI Program and ordered him to pay \$1,000 in restitution to State Farm Insurance Company and a \$2,500 civil insurance fraud fine.

A State Grand Jury returned an indictment charging Samantha Demetro, Bobby Eley, and Steven "David" Thompson with conspiracy. Demetro was also charged with theft by deception. According to the indictment, Demetro, Eley, and Thompson allegedly conspired to submit automobile insurance property damage and bodily injury insurance claims relating to nine automobile accidents which purportedly occurred between November 1998 through March 1999. The State alleged that all nine purported automobile accidents allegedly occurred on the same Route 21 exit ramp located in Passaic. The State also alleged that all nine automobile accidents involved the same cars, namely a 1995 Ford Crown Victoria and a 1983 Porsche 928.

The State further alleged that insurance claims for these purported accidents were submitted to the following insurance companies: American Family Mutual Insurance Company, CGU/United Security Insurance Company, Prudential Insurance Company, Pekin Insurance Company, Allstate Insurance Company, State Farm Insurance Company, Selective Insurance Company, and the St. Paul Fire and Marine Insurance Company. More than \$63,000 was allegedly obtained from the insurance companies for these alleged automobile accidents representing both property damage and bodily injury insurance claims. Approximately \$4,711 in claims were allegedly denied.

State v. Abdullah "Wali" Islam, et al.

On February 6, 2006, Leon Harris, who was arrested on a bench warrant, pled guilty to theft by deception. On April 17, 2006, the court sentenced him to three years probation with credit for 53 days served in county jail. The Court issued a bench warrant for the arrest of Glenn Johnson. He is currently a fugitive.

A State Grand Jury returned an indictment charging Abdullah Islam, Leon Harris, Glenn Johnson, and Rodney Hammock with conspiracy, Health Care Claims Fraud, and attempted theft. According to the indictment, Islam allegedly masterminded a scheme in which he and the other defendants falsely claimed that an automobile accident had occurred on July 25, 1998, in Newark. The defendants allegedly claimed the accident involved a 1984 Ford Bronco and a 1994 Hyundai. Defendants allegedly submitted PIP insurance claims for approximately \$60,250 to GSA Insurance Company. GSA allegedly denied the claims because it suspected fraud and referred the matter to OIFP for investigation. Islam and Hammock previously pled guilty to attempted theft by deception. The court sentenced Hammock to two years probation, and Islam was sentenced to four years probation and ordered to pay a \$200 criminal fine.

State v. Creative Auto Body, et al.

On December 6, 2006, a State Grand Jury returned a superseding indictment charging seven individuals, as well as two police officers. John A. Smith, who is currently a police officer with the Borough of Roselle, was charged with conspiracy, official misconduct, and theft by deception. Samad Abdel, who is currently a police detective with the City of Plainfield, was charged with conspiracy, official misconduct, attempted theft by deception, and theft by deception. On December 18, 2006, Abdel pled guilty to two counts of official misconduct. He is scheduled to be sentenced in 2007.

The seven other defendants were charged as follows:

- Marco Rebelo, of Avenel, the owner and operator of Creative Auto Body on 409 East First Avenue in Roselle, was charged with conspiracy, misconduct by a corporate official, and tampering with public records or information;
- Eli Vasquez, currently incarcerated at Bayside State Prison, was charged with conspiracy, theft, and attempted theft by deception;
- Danny DaCosta, of Elizabeth, was charged with conspiracy, theft, and attempted theft by deception;
- Rogerio Neves, of Elizabeth, was charged with conspiracy, theft, and attempted theft by deception;
- Rui Correia, of Elizabeth, was charged

with conspiracy, theft, and attempted theft by deception;

- Charles T. Smith, of Willingboro, was charged with theft and attempted theft by deception; and

The indictment alleges that the defendants reported seven staged or fictitious car accidents between March 2001 and March 2003 and filed more than \$117,800 in fraudulent automobile insurance property damage claims based on those phony accidents. The defendants, including the police officers, allegedly provided false information for police accident reports from the Roselle and Plainfield Police Departments that were used to substantiate the auto accident claims. Claims were allegedly filed with Progressive Insurance Company, Great American Insurance Company, Clarendon National Insurance Company, State Farm Insurance Company and Liberty Mutual Insurance Company. Approximately \$94,200 was allegedly paid by the insurance companies.

In connection with this OIFP investigation, on December 1, 2006, the court admitted Scot L. Frasier into the PTI Program conditioned upon him paying \$17,747 in restitution and performing 60 hours of community service. On May 18, 2006, Frasier pled guilty to theft by deception. Frasier allegedly submitted two separate auto property damage insurance claims based on two accidents which never occurred.

In the first purported accident, Frasier allegedly claimed that his 1997 Nissan Maxima collided with a Mercedes Benz driven by another driver in Plainfield. It is alleged that this accident never occurred. Liberty Mutual paid approximately \$4,911 to Frasier for damage to his 1997 Nissan and Liberty Mutual paid approximately \$25,000 for damage to the Mercedes Benz. The second accident purportedly occurred in Linden. Frasier allegedly submitted a false insurance claim to State Farm claiming that his 1997 Nissan collided with a 1989 Honda Civic. State Farm paid approximately \$11,747 to Frasier on the claim because the Nissan was supposedly totaled.

Fictitious Insurance Identification Cards and Motor Vehicle Documents

Motor Vehicle Commission (MVC) Investigations

In 2006, OIFP continued to make strides

in the disposition of defendants prosecuted as part of its investigation of misconduct on the part of some Motor Vehicle Commission (MVC) employees. As reported earlier, this investigation was part of OIFP's continuing investigation into official misconduct and fraud on the part of some State employees at the MVC, as well as the procurement of fictitious identification to include drivers licenses, commercial drivers licenses, and other MVC-related documents. Many people file false insurance claims utilizing several different false identities. Phony drivers licenses and other false identification facilitate this illegal conduct.

State v. Rita Okolo, et al.

A State Grand Jury returned an indictment charging 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 indictments, Okolo allegedly accepted a \$500 bribe from Capellan to provide him with a fictitious commercial drivers license in the name of Josefina Martinez. The State alleged in the indictment that Martinez was issued a commercial drivers license without taking the commercial drivers license exam.

Okolo pled guilty to official misconduct. On February 17, 2006, the court sentenced her to 364 days in county jail as a condition of four years probation. Martinez pled guilty to conspiracy to commit official misconduct. On February 17, 2006, the court sentenced her to three years probation. Capellan pled guilty to conspiracy. On February 24, 2006, the court sentenced him to three years probation and ordered him to perform 100 hours of community service.

State v. Esterlina Marin, et al.

On February 10, 2006, the court admitted Esterlina Marin into the PTI Program conditioned upon her performing 25 hours of community service and paying a \$4,000 criminal fine. Esterlina Marin pled guilty to an Accusation charging her with official misconduct. The State alleged that Esterlina Marin, a clerk at the Lodi branch of the MVC, at the request of her brother, Ivan Marin, assisted in obtaining four drivers licenses for individuals by allegedly falsifying official MVC documents. Specifically, she allegedly claimed that she had reviewed the birth certificates of four applicants when, in



fact, she had not reviewed birth certificates for those applicants.

On January 27, 2006, Ivan Marin pled guilty to an Accusation charging him with official misconduct. On March 17, 2006, the court sentenced him to one year probation and ordered him to pay a \$4,000 criminal fine.

State v. Stacey Chestnut

On March 10, 2006, the court sentenced Stacey Chestnut to one year probation. Chestnut previously pled guilty after 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, created two fictitious motor vehicle forms for two people who were not named in the indictment. Chestnut created and processed an application for a duplicate non-photo drivers license and an application for a drivers examination permit for a commercial drivers license (CDL).

Fictitious Insurance Identification Card Cases

State v. Wilberta Johnson

On February 17, 2006, the court sentenced Wilberta Johnson to three years probation. Johnson pled guilty to presenting a false insurance identification card. A State Grand Jury returned an indictment charging Johnson 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 she was having her 2002 Kia inspected at the Plainfield MVC Inspection Station. Suspecting the card was fraudulent, MVC personnel contacted OIFP.

State v. Lisa Johnson

On May 5, 2006, the court sentenced Lisa Johnson to three years probation. On March 13, 2006, Johnson pled guilty to simulating a motor vehicle insurance identification card. A Union County Grand Jury returned an indictment on January 25, 2006, charging Johnson with simulating a motor vehicle insurance identification card. According to the indictment, Johnson allegedly exhibited a counterfeit Prudential Property and Casualty Insurance Company auto insurance identification card when she was having her 1991 GEO inspected at the Plainfield MVC Inspection Station. Suspecting the card was

fraudulent, MVC personnel referred the matter to OIFP. Johnson had failed to appear at her arraignment on February 21, 2006, and the court issued a bench warrant for her arrest.

State v. Mario Bonillo

On April 26, 2006, Mario Bonillo pled guilty to simulating a motor vehicle insurance identification card. On the same day, the court admitted him into the PTI Program conditioned upon him performing 60 hours of community service. A Union County Grand Jury returned an indictment on January 25, 2006, charging Bonillo with simulating a motor vehicle insurance identification card. According to the indictment, Bonillo allegedly exhibited a counterfeit Allstate Insurance Company auto insurance identification card when he was having his 1987 Mazda inspected at the Plainfield MVC Inspection Station. Suspecting the card was fraudulent, MVC personnel referred the matter to OIFP. Bonillo had failed to appear at his arraignment on February 21, 2006, and the court issued a bench warrant for his arrest.

State v. John W. Noone

On April 17, 2006, John W. Noone pled guilty to an indictment charging him with simulating a motor vehicle insurance identification card. On June 23, 2006, the court sentenced him to one year probation. According to the indictment, Noone presented a counterfeit Liberty Mutual Insurance Company auto insurance identification card to an Edison Township police officer.

State v. Fernando Nunez

On June 1, 2006, Fernando Nunez pled guilty to an indictment charging him with simulating a motor vehicle insurance identification card. On August 11, 2006, the court sentenced him to three years probation. According to the indictment, Nunez presented a counterfeit Liberty Mutual Insurance Company auto insurance identification card to a New Jersey State Trooper.

State v. Mauro Sandoval-Pujois

On July 26, 2006, the court admitted Mauro Sandoval-Pujois into the PTI Program. On February 16, 2006, a Middlesex County Grand Jury returned an indictment charging Sandoval-Pujois with simulating a motor vehicle insurance identification card. According to the indictment, Sandoval-Pujois allegedly presented a counterfeit State Farm Indemnity Company auto insurance

identification card to a Perth Amboy City police officer.

State v. Vernard K. Carter, Jr.

On May 12, 2006, the court sentenced Vernard K. Carter, Jr., to three years probation. On March 13, 2006, Carter pled guilty to and indictment charging him with simulating a motor vehicle insurance identification card. According to the indictment, Carter allegedly exhibited a counterfeit Prudential Insurance Company auto insurance identification card when he was having his 1990 Honda Accord inspected at the Plainfield MVC Inspection Station. Suspecting the card was fraudulent, MVC personnel referred the matter to OIFP.

State v. Edith Munoz

On March 24, 2006, the court ordered Edith Munoz to pay a \$200 criminal fine after he pled guilty to a disorderly persons offense of simulating a motor vehicle insurance identification card. Munoz admitted that he presented a counterfeit Allstate Insurance Company motor vehicle insurance identification card to a Perth Amboy police officer during a traffic stop for a motor vehicle violation.

State v. Timothy D. Jones

On February 10, 2006, the court ordered Timothy D. Jones to pay a \$155 criminal fine. On the same day, Jones pled guilty to a disorderly persons offense of simulating a motor vehicle insurance identification card. Jones admitted that he presented a counterfeit Prudential Insurance Company auto insurance identification card to a State Trooper during a traffic stop for a motor vehicle violation.

State v. Zyvritic Penn

On May 12, 2006, the court admitted Zyvritic Penn into the PTI Program conditioned upon her performing 50 hours of community service. On March 29, 2006, Penn pled guilty to an Accusation charging her with simulating a motor vehicle insurance identification card. Penn allegedly presented a counterfeit Prudential Commercial Insurance Company auto insurance identification card when she was having her car inspected at the Eatontown MVC Inspection Station. Suspecting the card was fraudulent, MVC personnel referred the matter to OIFP.

State v. Kareem H. Ross

On April 13, 2006, the court sentenced Kareem H. Ross to three years probation with credit for eight days spent in county

jail. On February 24, 2006, Ross pled guilty to an Accusation charging him with simulating a motor vehicle insurance identification card. Ross admitted that he displayed a fraudulent Liberty Mutual Insurance Company auto insurance identification card to an Orange police officer.

State v. Andres Zapata-Quisqueya

On March 10, 2006, the court sentenced Andres Zapata-Quisqueya to two years probation. Zapata-Quisqueya pled guilty to an indictment charging him with simulating a motor vehicle insurance identification card. According to the indictment, Zapata-Quisqueya allegedly presented a counterfeit New Jersey Manufacturers Insurance Company auto insurance identification card to an inspector at the Plainfield MVC Inspection Station.

State v. Natasha V. Crisp

On April 28, 2006, the court sentenced Natasha V. Crisp to two years probation. Crisp pled guilty on February 14, 2006, to an indictment charging her 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.

State v. Jeffrey Ferrer, et al.

On May 22, 2006, Bernardo Santiago pled guilty to an Accusation charging him with producing a phony motor vehicle insurance identification card. On July 17, 2006, the court admitted Santiago into the PTI Program. Santiago allegedly sold fraudulent motor vehicle identification cards to a co-worker, Nelson Ferrer.

The court previously admitted Jeffrey Ferrer into the PTI Program. The court sentenced Nelson Ferrer to one year probation. Jeffrey Ferrer and his father, Nelson Ferrer, pled guilty to separate Accusations charging them with simulating a motor vehicle insurance identification card. Jeffrey Ferrer allegedly assisted in obtaining and selling a phony Countryway Insurance Company auto insurance identification card. An undercover OIFP investigator allegedly 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. Patricia Wilson

On June 20, 2006, a Burlington County Grand Jury returned an indictment charging Patricia Wilson with simulating a motor vehicle insurance identification card. According to the indictment, Wilson allegedly presented a phony Allstate Insurance Company auto insurance identification card to a Beverly City police officer during a traffic stop.

State v. Angela Caruso

On October 13, 2006, the court admitted Angela Caruso into the PTI Program. On August 7, 2006, Caruso pled guilty to an Accusation charging her with simulating a motor vehicle insurance identification card. Caruso allegedly presented a phony Proformance Insurance Company auto insurance identification card to a Beverly City police officer during a traffic stop.

State v. Jessica M. Lee

On September 26, 2006, Jessica M. Lee pled guilty to an indictment charging her with simulating a motor vehicle insurance identification card. She is scheduled to be sentenced early in 2007. According to the indictment, Lee allegedly presented a counterfeit Allstate Insurance Company auto insurance identification card to an inspector at the Eatontown MVC Inspection Station.

State v. Roscoe Henderson

On June 9, 2006, the court sentenced Roscoe Henderson to three years in state prison. On April 10, 2006, Henderson pled guilty to an Accusation charging him with sale of a simulated document. Henderson admitted that he sold a fictitious drivers license to a New Jersey State Police Detective who was operating in an undercover capacity as part of an OIFP investigation into the unlawful manufacture and sale of fictitious drivers licenses, motor vehicle inspection stickers, and other related MVC documents. During the course of the investigation, Henderson sold a fictitious drivers license and a fictitious automobile insurance identification card. Henderson was previously arrested after selling the phony insurance card for \$75 at a restaurant located in Rahway. Evidence was seized, including a computer believed to be used in unlawfully manufacturing fictitious documents.

State v. Daniel Rosa

On October 24, 2006, Daniel Rosa pled guilty to an Accusation charging him with simulating a motor vehicle insurance identification card. Rosa admitted that, following a motor vehicle accident in which he was involved, he presented a phony Public Service Mutual Insurance Company auto insurance identification card to a Passaic police officer. He will be sentenced in early 2007.

State v. Latosha R. Smith

On December 18, 2006, Latosha R. Smith pled guilty to an indictment charging her with simulating a motor vehicle insurance identification card. On the same day, she was sentenced to one year probation. According to the indictment, Smith presented a phony Proformance Insurance Company auto insurance identification card to a Burlington City police officer during a routine traffic stop.

State v. Salvatore L. Vitale

On June 12, 2006, a Monmouth County Grand Jury returned an indictment charging Salvatore L. Vitale with simulating a motor vehicle insurance identification card. According to the indictment, on August 19 and August 20, 2004, Vitale allegedly created a phony motor vehicle insurance identification card and also allegedly exhibited or displayed a different phony insurance identification card to an Englishtown police officer.

With respect to the insurance identification card which the indictment alleges was produced, it purportedly represented that Vitale was insured by the New Jersey Exchange Insurance Company and that a valid policy of automobile insurance was in effect from October 29, 2003, to October 29, 2004. The insurance policy purportedly covered a 1996 Chevrolet. The State alleges that the card was phony.

The State also alleges that Vitale displayed a different counterfeit automobile insurance identification card to an Englishtown police officer. That card allegedly indicated that a 2001 Mercedes Benz automobile was covered with a policy of automobile insurance issued by Allstate Insurance Company for the period August 19, 2004, to August 19, 2005.

State v. John Musso

On September 18, 2006, John Musso pled guilty to tampering with public records and information. On November 17, 2006, the court sentenced him to one year probation and ordered him to forfeit his public employment. A Cumberland County Grand Jury re-



turned an indictment on June 7, 2006, charging Musso with tampering with public records or information and simulating a motor vehicle insurance identification card. According to the indictment, between December 28, 2004 and January 8, 2005, Musso allegedly presented a fictitious insurance identification card to the MVC Inspection Stations at Millville and Bridgeton. The alleged false insurance identification card reflected that Selective Insurance Company provided insurance for Musso's automobile when, in fact, Musso had no insurance. The State further alleged that Musso falsely registered a 1990 Dodge Caravan by representing that it was covered by a Liberty Mutual Insurance group policy when, in fact, it was not.

State v. Larry Murphy, et al.

On September 6, 2006, a Mercer County Grand Jury returned an indictment charging Larry Murphy and his wife Charlotte Murphy with conspiracy, simulating a motor vehicle insurance identification card, tampering with public records, and falsifying records. According to the indictment, between July 1, 2005 and September 30, 2005, Larry and Charlotte Murphy allegedly produced and sold phony automobile insurance identification cards. Specifically, the State alleged that they conspired to produce a phony Liberty Mutual Insurance Company auto insurance identification card and a phony State Farm Insurance Company auto insurance identification card in the name of Kai A. Harris. On October 15, 2005, Charlotte Murphy was arrested by the New Jersey State Police in connection with allegedly registering a car using a phony Prudential Insurance Company auto insurance identification card. On September 29, 2005, Larry Murphy was arrested and charged in connection with the alleged phony insurance identification card scam.

The arrests were the result of an undercover investigation conducted by OIFP investigators into the production and sale of phony insurance identification cards. 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. Juan Diaz-Mata

On October 31, 2006, a Passaic County Grand Jury returned an indictment charging Juan Diaz-Mata with simulating a motor ve-

hicle insurance identification card. According to the indictment, Diaz-Mata was involved in a motor vehicle accident and allegedly provided a phony New Jersey Re-Insurance Company auto insurance identification card to a police officer at the scene of the accident.

State v. Cecilio Casablanca

On November 29, 2006, an Essex County Grand Jury returned an indictment charging Cecilio Casablanca with simulating a motor vehicle insurance identification card. According to the indictment, Casablanca was involved in a motor vehicle accident and allegedly provided a phony New Jersey Manufacturers Insurance Company auto insurance identification card to a Belleville police officer at the scene of the accident.

State v. Maria D. Colon Cifuentes

On November 3, 2006, a Union County Grand Jury returned an indictment charging Maria D. Colon Cifuentes with simulating a motor vehicle insurance identification card. According to the indictment, Colon Cifuentes presented a fictitious Amica Insurance Company auto insurance identification card to a motor vehicle inspector at the Plainfield MVC Inspection Station.

State v. Rafael Ottenwalder

On October 12, 2006, Rafael Ottenwalder pled guilty to an Accusation charging him with sale of a simulated New Jersey drivers license and sale of a simulated motor vehicle insurance identification card. Ottenwalder admitted that in May and June of 2005, he knowingly sold a fictitious New Jersey drivers license and a fictitious New Jersey auto insurance identification card to an undercover OIFP investigator in Union City. Ottenwalder is scheduled to be sentenced in early 2007.

State v. Miguel Torres

On December 6, 2006, Miguel Torres pled guilty to an Accusation charging him with simulating a motor vehicle insurance identification card. Torres admitted that he presented a counterfeit American National Fire Insurance Company auto insurance identification card to a West New York police officer following an automobile accident in which he was involved. He is scheduled to be sentenced in 2007.

State v. Francerly Padilla

On September 8, 2006, a Union County Grand Jury returned an indictment charging

Francerly Padilla with simulating a motor vehicle insurance identification card. According to the indictment, Padilla allegedly presented a fraudulent Allstate Insurance Company auto insurance identification card to an inspector at the Rahway MVC Inspection Station.

State v. Charles R. Bright

On August 21, 2006, a Monmouth County Grand Jury returned an indictment charging Charles R. Bright with simulating a motor vehicle insurance identification card. According to the indictment, Bright allegedly presented a fraudulent Prudential Insurance Company auto insurance identification card to an inspector at the Eatontown MVC Inspection Station.

State v. Tinyetta Watkins

On October 2, 2006, the court admitted Tinyetta Watkins into the PTI Program conditioned upon her performing 50 hours of community service. On July 12, 2006, a Mercer County Grand Jury returned an indictment charging Watkins with simulating a motor vehicle insurance identification card. According to the indictment, Watkins was involved in a motor vehicle accident. Watkins allegedly presented a fraudulent First Trenton Indemnity Company auto insurance identification card to the police officer who responded to the scene of the accident.

State v. Dante M. Fox

On November 28, 2006, a Burlington County Grand Jury returned an indictment charging Dante M. Fox with simulating a motor vehicle insurance identification card. According to the indictment, Fox presented a fraudulent CAN Insurance Company auto insurance identification card to a Burlington City police officer during a routine traffic stop.

State v. Marta L. Sanaallah

On September 8, 2006, a Union County Grand Jury returned an indictment charging Marta Sanaallah with simulating a motor vehicle insurance identification card. According to the indictment, Sanaallah allegedly presented a fraudulent Allstate Insurance Company auto insurance identification card to an inspector at the Rahway MVC Inspection Station.

State v. Leonna Brown

On September 22, 2006, the court admitted Leonna Brown into the PTI Program. On July 17, 2006, Brown pled guilty to an Accusation charging her with attempted theft by deception. Brown allegedly was in-

involved in a motor vehicle accident in Philadelphia in which she struck a parked car. She also allegedly presented a phony State Farm Indemnity Company auto insurance identification card to the owner of the vehicle she struck. When the owner of the struck vehicle submitted a claim to State Farm, State Farm determined that the card was fraudulent and referred the matter to OIFP for investigation.

State v. Karen Y. Schenck-Heuston

On September 27, 2006, a Somerset County Grand Jury returned an indictment charging Karen Y. Schenck-Heuston with simulating a motor vehicle insurance identification card. According to the indictment, Schenck-Heuston presented a counterfeit Maryland Casualty Insurance Company auto insurance identification card to the State Police while attempting to obtain her vehicle from a State Police impound lot.

State v. Alfred R. Cole

On November 27, 2006, an Essex County Grand Jury returned an indictment charging Alfred R. Cole with simulating a motor vehicle insurance identification card. According to the indictment, on April 7, 2006, Cole presented a counterfeit New Jersey Manufacturers auto insurance identification card to a Verona police officer while attempting to get his 1994 Lexis released from the police department impound lot.

Vehicle Theft

Operation Ninja I

State v. Torray A. Murphy, et al.

OIFP and the State Police conducted a joint investigation of a conspiracy to steal motorcycles, to alter the Vehicle Identification Number (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 materials. As a 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 J. Bunn, Ronald R. Crosland, Gregory Haygood, Jamar L. Doggett, and John White, who were each charged with theft by unlaw-

ful taking, receiving stolen property, and fencing. The State alleged that the defendants conspired to steal 16 motorcycles valued at approximately \$97,225 in Burlington County. The State further charged defendants with 23 separate instances of allegedly receiving stolen motorcycles valued at approximately \$153,557, and 12 separate instances of allegedly fencing stolen motorcycles valued at approximately \$83,857.

The investigation is continuing and further charges are anticipated. The following dispositions occurred in 2006:

On August 7, 2006, Janine Barnes pled guilty to an Accusation charging her with receiving stolen property. On November 3, 2006, the court sentenced her to a one-year probationary sentence and ordered her to pay \$1,592 in restitution to GEICO Insurance Company and \$675 in restitution to Rider Insurance Company.

Randolph Brolo pled guilty to an Accusation charging him with receiving stolen property. On January 6, 2006, the court sentenced him to two years probation.

Rodney Butler pled guilty to an Accusation charging him with receiving stolen property. On January 27, 2006, the court sentenced him to a one-year probationary sentence and ordered him to pay \$1,861 in restitution.

On January 27, 2006, Rodney West pled guilty to an Accusation charging him with Insurance Fraud. On March 17, 2006, the court sentenced him to a two-year probationary sentence and ordered him to pay \$2,350 in restitution to Rider Insurance Company.

On June 5, 2006, David Schall pled guilty to an Accusation charging him with alteration of motor vehicle identification numbers. On December 12, 2006, the court admitted him into the PTI Program conditioned upon him paying \$2,500 in restitution.

On June 12, 2006, Alan Barbosa pled guilty to an Accusation charging him with receiving stolen property. On the same day, the court sentenced him to a one-year probationary sentence.

Operation Ninja II

State v. Ian Boyington, et al.

In this continuing joint State Police and OIFP investigation, the following defendants were issued summonses or were arrested in 2006:

Ian Boyington - On October 12, 2006, a summons was issued and Boyington was charged with possession of a motor vehicle with an altered vehicle identification number (VIN), and a motor vehicle title offense;

Neil Moyer - On November 8, 2006, a summons was issued and Moyer was charged with receiving stolen property and fencing;

Steven Capers was arrested on November 30, 2006, and charged with receiving stolen property, unlawful taking, possession of a motor vehicle with an altered vehicle identification number (VIN), a motor vehicle title offense, and tampering with public records or information;

Gabriel Allen Evans was arrested on December 6, 2006, and charged with theft by unlawful taking, receiving stolen property, and alteration of a motor vehicle identification number (VIN);

Jeffrey Morgan was arrested on December 6, 2006, and charged with theft by unlawful taking, receiving stolen property, alteration of a motor vehicle identification number (VIN), and fencing;

Gregory Kellum - On December 12, 2006, a summons was issued and Kellum was charged with theft by unlawful taking and receiving stolen property.

Operation Wire Harness

State v. Reyniz Moran, et al.

The Fort Lee Police Department arrested Reyniz Moran, Edward Peralta, and Wilson Burgos during a traffic stop. All were charged with possession of burglary tools, possession of motor vehicle master keys, and receiving stolen property. Fort Lee Police contacted OIFP because they obtained evidence consistent with theft of cars and motorcycles. Additional charges against Moran and Peralta were filed including receiving stolen property, alteration of VINs, and possession with intent to distribute. The case is pending Grand Jury action.

State v. Krzysztof Walentynowicz, et al.

On October 16, 2006, Krzysztof Walentynowicz pled guilty to receiving stolen property. On December 11, 2006, the court sentenced him to three years probation and ordered him to perform 60 hours of community service. On July 26, 2006, a Union County Grand Jury returned an indictment charging Walentynowicz with receiving stolen property and prohibited alteration of motor vehicle trademark or identifi-



cation number. According to the indictment, in Cranford, Walentynowicz allegedly possessed a 2001 BMW 330, a 2001 Audi S4, a 2002 Jeep Grand Cherokee, a 2002 Jeep Limited, a 2002 GMC Denali, and two 2002 Cadillac Escalades, knowing they were stolen. The State alleged that Walentynowicz possessed these automobiles in order to re-tag them or chop them into parts.

On August 16, 2006, Lukasz Zalewski pled guilty to an Accusation charging him with receiving stolen property. Zalewski admitted that he had possession of a 2002 Jeep Limited, a 2001 BMW 330, a 2001 Audi S4, a 2002 Jeep Grand Cherokee, a 2002 GMC Denali, and two 2002 Cadillac Escalades, knowing they were stolen. Zalewski admitted that he possessed these automobiles in order to re-tag them or chop them into parts. He is scheduled to be sentenced in 2007.

State v. Jaguar Kevin Reed

On August 8, 2006, an Essex County Grand Jury returned an indictment charging Jaguar Kevin Reed with receiving stolen property. According to the indictment, on July 18, 2005, Reed allegedly knowingly possessed and sold a re-tagged Cadillac Escalade. A re-tagged automobile is an automobile in which the VIN is removed so that another VIN can be inserted. By changing the VIN plates, thieves are able to conceal the true identity of the car and the fact that it has been reported stolen. This facilitates resale of the car.

Operation Rice Burners

State v. Michael Campo, et al.

On November 1, 2006, OIFP investigators obtained arrest warrants for nine targets, Michael Campo, Ramon Carrillo, Reginald Lee, Ronald Bennett a/k/a "Fat Man," Frazier Gibson, Eddie Lee, Ajon Rodgers, James Campbell, and an unidentified person known only as "T." Also, search warrants were executed at a residence and a garage. The defendants were charged with receiving stolen property and bail was set at

amounts ranging from \$25,000 to \$100,000. These cases are pending presentation to the Grand Jury.

State v. Jose Suarez, et al.

On November 15, 2006, OIFP investigators obtained an arrest warrant for Jose Suarez. Suarez was charged with receiving stolen property and leader of an auto trafficking network. The State alleged that Suarez conspired with others to dispose of and transport stolen vehicles, including four motorcycles and at least ten stolen automobiles.

As part of the Suarez investigation, on November 15, 2006, OIFP investigators obtained arrest warrants for Janny Lopez and Joshua Provost. Provost and Lopez were charged with receiving stolen property, including an allegedly stolen Yamaha motorcycle and a Nissan 350Z automobile.

State v. Luis Marte

On December 8, 2006, a Union County Grand Jury returned an indictment charging Luis Marte with conspiracy, receiving stolen property, and attempted fencing. According to the indictment, between November 14, 2003 and January 4, 2006, Marte allegedly conspired with others, who were not further identified in the indictment, to take possession of a stolen 2004 Cadillac Escalade. The State alleges that Marte illegally obtained a Michigan title for the Cadillac Escalade, which was allegedly stolen from an auto dealership in Great Neck, New York. Frequently, persons who traffic in stolen cars obtain out-of-state automobile titles and re-tag or change the Vehicle Identification Numbers (VIN) on stolen cars to conceal the true identity of the car and the fact that it has been stolen.

HEALTH, LIFE, AND DISABILITY FRAUD

Fraudulent Health and Disability Claims by Health Care Providers

State v. Philip Potacco

On January 20, 2006, the court sentenced Philip Potacco to three years probation and ordered him to pay \$48,000 in restitution to New Jersey Manufacturers Insurance Company, First Trenton Insurance Company, and State Farm Insurance Company. Potacco pled guilty to theft by deception. A State Grand Jury previously returned an indictment charging Potacco with Health Care Claims Fraud and attempted theft by deception. According to the indictment, Potacco allegedly contin-

ued to practice chiropractic medicine for approximately four years in Little Falls Township in Passaic County and South Orange in 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 billed automobile insurance companies for treating automobile accident patients under their PIP insurance. Potacco billed approximately \$98,175 to multiple carriers. The insurance companies paid Potacco approximately \$48,022.

State v. William Burke, et al.

A State Grand Jury returned an indictment charging William Burke and licensed cardiologists, with conspiracy, Health Care Claims Fraud, and attempted theft by deception. According to the indictment, Burke practiced at Orange Mountain Medical Associates which had offices located in West Orange, Berkeley Heights, and Millburn. They allegedly submitted false insurance claims to insurance companies between January 1, 1997, and February 5, 2002. The State alleged that the doctors agreed to prescribe unnecessary cardiac diagnostic tests that were inconsistent with their patients' ailments. The State also alleged that although the patients had insufficient cardiac symptoms to justify the administration of stress tests and electrocardiograms, the doctors administered those procedures and allegedly provided questionable cardiac-related diagnoses in order to bill insurance companies for the cardiac-related medical tests at a higher specialist rate. The doctors allegedly submitted fraudulent bills to multiple insurance companies, including Prudential Insurance Company and Aetna Insurance Company. The insurance companies received at least \$35,000 in allegedly false bills. Burke and [redacted] are scheduled to go on trial in 2007.

State v. W. Lance Kollmer

On May 8, 2006, W. Lance Kollmer pled guilty to theft by deception. On September 7, 2006, the court sentenced Kollmer to three years in state prison and ordered him to pay \$925,171 in restitution and a \$100,000 civil insurance fraud fine.

A State Grand Jury previously returned three separate indictments against Kollmer. The third indictment charged Kollmer, a board certified plastic surgeon, with theft by deception and attempted theft by deception.

Kollmer submitted allegedly false insurance claims between August 2001 and March 2004, to U.S. Life/American General Insurance Company and the Hartford Insurance Company falsely claiming he was totally disabled, unable to practice medicine, and entitled to be reimbursed for office overhead expenses and other disability insurance claim payments. U.S. Life/American General Insurance Company and the Hartford Insurance Company paid approximately \$614,825 for these claims through January 2004.

The first indictment charged Kollmer with submitting false disability insurance claims to Sentry Insurance Company and American General Insurance Company. Kollmer allegedly obtained more than \$300,000 in fraudulent insurance claim money from Sentry Insurance Company and American General Insurance Company by falsely claiming he was totally disabled from practicing as a plastic surgeon. However, Kollmer allegedly performed dozens of surgical procedures during the claimed disability period. The second indictment charged Kollmer with theft by deception. Kollmer allegedly falsely claimed he was totally disabled, and, pursuant to a contract between himself and Unum Provident Corporation, entitled to a waiver of \$9,000 in life insurance premiums.

Fraudulent Billing by Health Care Providers

State v. Paul Anodide

On April 28, 2006, the court sentenced Paul Anodide to four years probation. He was also sentenced to 180 days in county jail, suspended on the condition that he serve 20 days in the SLAP program. The court ordered him to perform 100 hours of community service and pay a \$5,000 criminal fine. His dentist's license was suspended for life and he was barred from applying for reinstatement of his license. Anodide pled guilty to theft by deception. A State Grand Jury previously 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, submitted bills to three insurance carriers for 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 that were billed to the carriers were not rendered

to the patients. Anodide also submitted claims for Sunday dental services when the dental office was closed on Sundays. According to the indictment, Anodide also submitted claims for crowns and root canals that were allegedly performed twice on the same tooth. Anodide submitted fraudulent claims to several 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 Anodide's allegedly fraudulent dental insurance claims that were paid with State money.

State v. Craig W. Gordon

On May 9, 2006, Craig W. Gordon pled guilty to Health Care Claims Fraud and to the practice of medicine by an unlicensed person. On June 9, 2006, the court sentenced him to five years probation and ordered him to pay a \$1,100 criminal fine.

On January 4, 2006, a Morris County Grand Jury returned an indictment charging Gordon with Health Care Claims Fraud, theft by deception, and practice of medicine by an unlicensed person. According to the indictment, between January 26, 2000 and January 9, 2001, Gordon, a doctor who was licensed to practice medicine in the State of New York but whose license was revoked in March 1995, operated a business known as GFM Health Services which operated out of Gordon's residence in Chatham, New Jersey. Gordon caused fraudulent claims to be submitted to Horizon Blue Cross Blue Shield of New Jersey through the Medicare program for treatments to two patients. The State alleged that the claims created the false impression that health care services had been provided by Jaime Ligot, M.D., when, in fact, they were either provided by Gordon, who is not a licensed practitioner, or not provided at all. The State alleged that Horizon Blue Cross Blue Shield of New Jersey paid approximately \$10,966 in fraudulent claims submitted by Gordon.

State v. Mark Radowitz

On April 21, 2006, the court sentenced Mark Radowitz to three years in state prison and ordered him to pay \$16,700 in restitution. On January 30, 2006, Radowitz pled guilty to Health Care Claims Fraud. A State Grand Jury previously returned an indictment charging Radowitz with Health Care Claims Fraud, theft by deception, and falsify-

ing 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. The State alleged 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 further alleged that Radowitz billed on approximately 179 dates for approximately \$16,000 in chiropractic treatments never rendered to two patients.

State v. Eugene Ruta, et al.

On April 3, 2006, Eugene Ruta pled guilty to conspiracy and Health Care Claims Fraud. On the same day, Andrew Farro pled guilty to conspiracy to commit Health Care Claims Fraud and Criminal Use of Runners. On September 22, 2006, the court sentenced Ruta to 364 days in county jail as a condition of three years probation. Farro will be sentenced in 2007. A State Grand Jury previously returned an indictment charging Ruta and 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. 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 alleged 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" solicited, and another person to whom Farro paid money as a "runner," were all undercover OIFP investigators. Additionally, an undercover Newark police officer posed as a patient. The indictment charged that the defendants paid approximately \$2,000 to persons who posed as "runners."

The State further 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. The State also alleged that Ruta knew that Farro used a "runner" to solicit patients for Valley Total Health Center. In total, bills for approxi-



mately \$12,499 were allegedly submitted to Parkway Insurance Company for “runner” solicited patients and Parkway paid approximately \$5,945 on these claims to Valley Total Health Center.

State v. Juan Carlos Fischberg, et al.

On October 11, 2006, a State Grand Jury returned an indictment charging Juan Carlos Fischberg and his wife, Gezel Villanueva, with money laundering, conspiracy, Health Care Claims Fraud, theft by deception, falsifying medical records, and false swearing. According to the indictment, between January 1, 1998 and August 22, 2003, Fischberg, a board certified doctor, owner and operator of Hudson Rehabilitation and Medical Center, allegedly defrauded 17 insurance companies by falsely stating that his patients were injured and suffered from medical conditions, primarily as a result of automobile accidents. The State alleges that Fischberg falsely claimed that it was necessary for him to perform electro-diagnostic testing in order to diagnose and treat these medical conditions and bill auto insurance companies. The State also alleges that, between March 5, 2003 and December 31, 2003, Fischberg and his wife, Gezel Villanueva, conspired to commit money laundering by transferring over \$500,000, which was derived from theft and health care claims fraud committed against various auto insurance companies, to South America and to the Capital Trust Company of Delaware. It is further alleged that the money was transferred to conceal the nature, location, source, ownership, or control of the money and to hide the fact that it was money allegedly obtained through the submission of false insurance claims. Fischberg and Villanueva failed to appear at their arraignment on November 14, 2006. The court issued a bench warrant for their arrest.

State v. Evelyn Wilson

On November 14, 2006, Evelyn Wilson pled guilty to an Accusation charging her with theft by deception. Between August 20, 2001 and June 16, 2004, Wilson, a former clinical social worker and marriage and family therapist, submitted insurance claims to Horizon Blue Cross Blue Shield for social work, marriage counseling, and family therapist services which were never rendered to patients or clients. Specifically, Wilson admitted that she submitted claims for several hundred therapy sessions for which she rendered no service to any patient or client. She admitted that as a result of these phony sub-

missions, she stole approximately \$109,500 from Horizon Blue Cross Blue Shield. Wilson is scheduled to be sentenced in early 2007.

False Health Care Claims

State v. Olivette Henderson, et al.

On November 27, 2006, the court sentenced Olivette Henderson to three years probation and ordered her to pay \$3,000 in restitution. Henderson pled guilty to Health Care Claims Fraud and theft of identity. A State Grand Jury previously 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 utilized the insurance identification information of Quivier Richardson to obtain medical services. The medical services 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.

On October 13, 2006, Quivier Richardson pled guilty to Health Care Claims Fraud. On November 27, 2006, the court sentenced her to three years probation and ordered her to pay \$3,000 in restitution. On March 9, 2006, a State Grand Jury returned a separate indictment charging Richardson with conspiracy, Health Care Claims Fraud, and theft by deception for providing her health insurance identification card to Olivette Henderson.

State v. Thomas J. Lagno

On June 19, 2006, the court sentenced Thomas J. Lagno to three years probation and ordered him to pay \$5,893 in restitution and a \$5,000 civil insurance fraud fine. On April 6, 2006, Lagno pled guilty to an Accusation charging him with Health Care Claims Fraud. Lagno admitted that, between February 29 and August 30, 2004, he fraudulently caused claims for prescription drugs and medical treatment from physicians and other medical service providers to be sent to a former employer for payment. The former employer was Access Systems Integration (ASI) which is headquartered in Hazlet. Lagno had been an employee of ASI but had terminated his employment and was no longer entitled to prescription drug coverage nor other medical benefits as a result of that employment. The case was referred to OIFP when the benefits coordinator for ASI began receiving medical claims pertaining to Lagno even though he was no longer employed by the company.

State v. Carol Ann Benvenuto

On June 30, 2006, the court sentenced Carol Ann Benvenuto to three months probation and ordered her to pay a \$5,000 civil insurance fraud fine. On April 13, 2006, Benvenuto pled guilty to an Accusation charging her with theft by deception. Benvenuto admitted that, between August 7, 2001 and September 10, 2002, she submitted phony health insurance claims to her health insurance company. She admitted that she worked as a receptionist for a doctor's office. She further admitted that she submitted insurance claim forms to Horizon Blue

Cross Blue Shield seeking reimbursement for medical services which she neither received nor paid to her employer doctors. In total, she fraudulently obtained approximately \$1,935 for phony health insurance claims submitted to Horizon Blue Cross Blue Shield to which she was not entitled.

State v. Reginald Smithson

On May 8, 2006, Reginald Smithson pled guilty to theft by deception. On June 19, 2006, the court sentenced him to four years probation and ordered him to pay \$1,550 in restitution to State Farm Insurance Company. An Essex County Grand Jury previously returned an indictment charging Smithson with theft by deception, Insurance Fraud, and forgery. According to the indictment, Smithson allegedly submitted a phony receipt to State Farm showing he paid a hospital \$1,001 for medical treatment related to injuries sustained in an automobile accident. The State alleged that Smithson altered the receipt and that the hospital treated him for an unrelated illness.

State v. Harry Slough

On July 14, 2006, the court sentenced Harry Slough to two years probation and ordered him to pay \$5,757 in restitution to the State Health Benefits Plan. On May 24, 2006, Slough pled guilty to an Accusation charging him with theft by deception. Slough admitted that he wrongfully utilized the prescription insurance card coverage of his former wife to obtain prescription medicines. Slough and his former wife, a Department of Corrections sergeant, divorced on May 1, 1997. Nonetheless, Slough admitted that he obtained the prescription drug insurance card belonging to his former wife and utilized same to obtain prescription medicines even though he was no longer a dependent spouse entitled to her prescription insurance benefit coverage. In total, two insurance companies, Aetna and Horizon Blue Cross Blue Shield, paid a total of approximately \$5,756 for health insurance and prescription drug benefits to which Slough was not entitled.

State v. Florentina Mauricio

On October 17, 2006, Florentina Mauricio pled guilty to Health Care Claims Fraud. On November 17, 2006, the court sentenced her to two years probation and ordered her to pay a \$5,000 civil insurance fraud fine. On June 27, 2006, a Morris County Grand Jury returned an indictment charging Mauricio with Health Care Claims

Fraud and attempted theft by deception. According to the indictment, between November 22, 2003 and February 18, 2005, Mauricio claimed injury in an automobile accident in which her disabled vehicle was struck by another car. As a result of the collision, Mauricio allegedly sought medical treatment for her purported injuries. First Trenton Indemnity Company was allegedly billed approximately \$3,015 in connection with Mauricio's x-rays and approximately 23 visits to her chiropractor. The insurance company suspected fraud, denied the claim, and referred the matter to OIFP for investigation.

State v. Henry Robitaille, et al

On April 7, 2006, the court admitted Henry Robitaille into the PTI Program after Robitaille pled guilty on January 5, 2006, to an Accusation charging him with Health Care Claims Fraud. Robitaille allegedly appeared at a medical treatment center seeking medical treatment for Geraldine McKinney through fraud. Robitaille and McKinney misrepresented insurance information to personnel at the medical treatment center by claiming that McKinney was Robitaille's wife. The State alleged that Henry Robitaille and Geraldine McKinney were not married and that the insurance coverage of Robitaille's wife was improperly utilized to treat Geraldine McKinney who fraudulently pretended to be his wife. Charges against McKinney, who is currently in Ireland, are pending.

Fraudulent Disability Claims

State v. John Rhody

On May 19, 2006, the court sentenced John Rhody to three years probation. Rhody pled guilty to falsification of records. A State Grand Jury previously 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 wrongfully collected disability insurance benefits from the Standard Insurance Company by submitting a false disability claim. The State alleged that Rhody was actually working by buying and selling classic post cards on eBay and other locations while he was allegedly disabled and collecting disability insurance. The State also alleged that by submitting false records about his disability, occupation, and income, Rhody was 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. Richard Segal

On May 8, 2006, the court admitted Richard Segal into the PTI Program. An Accusation was filed charging Segal with falsifying records, theft by deception, and Insurance Fraud. The State alleged that Segal falsified a disability insurance claim form to indicate that he was fully disabled, as opposed to partially disabled. Segal's treating physician had allegedly determined that he was only partially disabled.

State v. Jonathan Siegel

On October 11, 2006, Jonathan Siegel pled guilty to attempted theft by deception. He is scheduled to be sentenced in early 2007. On March 6, 2006, a Monmouth County Grand Jury returned an indictment charging Siegel with attempted theft by deception and uttering a forged document. According to the indictment, between January 26, 1998 and September 7, 2001, Siegel committed disability insurance fraud by wrongfully accepting disability benefits from the Unum Life Insurance Company of North America. The State alleged that Siegel, who was at one time a licensed podiatrist in the State of New Jersey, worked for a large New Jersey and a New York law firm, but concealed the fact that he was working and the amount of money he was paid as an employee of the law firms, in order to collect greater disability benefits from Unum Life Insurance Company. Siegel had filed a disability claim with Unum alleging that he was injured and unable to work as a podiatrist, even though he was allegedly working and collecting a salary as an employee of the two law firms.

State v. Michelle Cannin

On April 28, 2006, the court sentenced Michelle Cannin to three years probation and ordered her to pay \$3,089 in restitution. Cannin pled guilty on March 6, 2006, to theft by deception. A State Grand Jury previously returned an indictment charging Cannin with Insurance Fraud, theft by deception, forgery, and unsworn falsification. According to the indictment, Cannin allegedly submitted fraudulent insurance disability claim forms to the New Jersey Department of Labor. The State alleged those forms falsely indicated that a physician had certified that Cannin was unable to work, was disabled, and, therefore, entitled to collect disability insurance payments, when, in fact, Cannin had forged records in the name of the physician to support her fraudulent disability claim. In total, Cannin allegedly stole approximately \$3,000 in disability claim benefits.



State v. Dennis Massimo

On November 3, 2006, the court sentenced Dennis Massimo to three years probation and ordered him to pay \$6,700 in restitution. On September 14, 2006, Massimo pled guilty to an Accusation charging him with theft by deception. Massimo, who was formerly employed by the New Jersey Department of Banking and Insurance (DOBI), admitted that, between June 21, 2003 and October 10, 2003, he wrongfully collected temporary disability benefits while absent from his employment with DOBI. Massimo admitted that while he was receiving temporary disability benefits from the State as a result of his absence from his position with DOBI based on a medical disability, he worked as a general contractor employed by an auto group. As a general contractor, Massimo admitted receipt of approximately \$123,704 in income from the auto group while he was collecting \$432 per week in temporary disability benefits from the State.

State v. Barbara Jean Potts

On December 22, 2006, the court sentenced Barbara Jean Potts to three years probation and ordered her to pay \$3,169 in restitution and a \$100 criminal fine. On November 9, 2006, Potts pled guilty to an Accusation charging her with theft by deception. Potts admitted that, between April 19 and June 19, 2005, she wrongfully collected workers' compensation temporary disability benefits. Potts allegedly collected temporary disability benefits from her employer due to a work-related injury while concealing the fact that she was employed elsewhere by another company.

State v. John Ponticello

On December 6, 2006, John Ponticello pled guilty to an Accusation charging him with theft by deception. Ponticello admitted that, between August 22, 2003 and November 7, 2005, he submitted false disability claims to the JMIC Life Insurance Company claiming that he was disabled so that JMIC Life would pay \$425 per month to the Ford Motor Company on his (Ponticello's) behalf in repayment of an automobile loan Ponticello incurred. The State alleged that, over a period of approximately 17 months, Ponticello submitted false disability claims with fraudulent doctors' signatures to JMIC Life in order for JMIC Life to pay \$10,563 to the Ford Motor Company for his auto loan. He is scheduled to be sentenced in 2007.

Health Insurance Underwriting/ Application Fraud

State v. Direct Home, Inc.

On April 13, 2006, Direct Home, Inc., pled guilty to theft by failure to make required disposition of property received. On June 30, 2006, the court sentenced Direct Home, Inc., to pay \$2,308 in restitution and pay a \$1,000 criminal fine. On January 26, 2006, a Somerset County Grand Jury returned an indictment charging Direct Home, Inc., a housewares distributor, with theft by deception. According to the indictment, between April 14, 2001 and May 8, 2001, Direct Home, Inc., wrongfully accepted approximately \$2,500 in health insurance premiums from an individual for the employer-sponsored group health insurance plan maintained by Direct Home, Inc. The State alleged that Aetna Insurance Company provided the insurance coverage for Direct Home, Inc.'s employees but was never forwarded the premiums paid to Direct Home, Inc., by the purported insured who later learned that his health insurance had been cancelled.

State v. John K. Hoover

On August 21, 2006, a State Grand Jury returned an indictment charging John K. Hoover with Health Care Claims Fraud and theft by deception. According to the indictment, Hoover, who was employed by Salem County as a Sheriff's Officer, allegedly falsified employer sponsored health insurance records concerning his marital and family status. The State alleges that Hoover falsified a health insurance benefits form reflecting that he was separated but still married to his wife and that his stepdaughter remained his dependent for employer-sponsored health insurance and related medical and prescription drug benefits. The State further alleges that this information was false and that Hoover was divorced and did not have dependents. The State also alleges that by falsifying the health insurance benefits forms and related records, Hoover wrongfully obtained in excess of \$17,641 in health care claims, prescription drug benefits, and insurance premiums paid by Salem County.

State v. Bernard Gelman

On March 10, 2006, the court sentenced Bernard Gelman to three years probation, and ordered him to pay \$80,088 in restitution and a \$5,000 civil insurance fraud fine. Gelman pled guilty to an Accusation charging him with theft by deception. Gelman admitted that he wrongfully caused the Director of Risk and Insurance Management at his place of employment located in Gloucester

City, to change the date that his son, Kevin Gelman, an attorney, left employment with the company which was a provider of administrative services. At the time of the alleged fraud, Bernard Gelman was a senior executive with his employer's parent corporation. Gelman's son, Kevin, allegedly ended his employment with the company on April 24, 1998, to start his own business. Shortly after leaving the company, Kevin Gelman was allegedly debilitated by illness and injuries caused by an accident. The State alleged that Bernard Gelman then 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 son's departure. Approximately \$80,087 was allegedly obtained from Prudential Insurance Company as a result of Bernard Gelman's fraud.

State v. Joseph Venziano

On November 21, 2006, a Cape May County Grand Jury returned an indictment charging Joseph Venziano with Health Care Claims Fraud, theft by deception, and falsifying or tampering with records. According to the indictment, between October 18, 2002 and December 30, 2003, Venziano allegedly falsely represented that he remained married to his former wife so that she would be eligible as a dependent spouse for health insurance benefits. The State alleges that health insurance benefits were provided through Venziano's employer by the Aetna Life Insurance Company under a policy which benefits ended if the marriage ended. The State further alleges that since Superior Court records indicate that Joseph Venziano was divorced on February 20, 1998, his former wife was no longer eligible for dependent spouse health insurance benefits under that policy.

State v. Carol Magnes

On December 19, 2006, Carol Magnes pled guilty to an Accusation charging her with theft by deception. Magnes admitted that, between July 28, 2003 and November 28, 2005, she stole health insurance claim money from Oxford Health Plans by falsely enrolling Maria Gutierrez and Jon Magnes as if they were employees of her husband's (Dr. Jeffrey Magnes) medical office when, in fact, they were not. She admitted that by enrolling them as employees, she was able to obtain lower cost small employer group health insurance for Gutierrez and Jon Magnes even though they were not employees of the medical practice. Furthermore,

she admitted that medical claims were submitted to Oxford for medical treatments for Gutierrez and Jon Magnes even though they were not entitled to the medical coverage. The State alleged that the medical claims totaled approximately \$81,000. She will be sentenced in 2007.

Life Insurance Fraud

State v. Atul K. Agarwala

On October 13, 2006, the court admitted Atul K. Agarwala, M.D., into the PTI Program and ordered him to pay a \$30,000 civil insurance fraud fine. On June 28, 2006, the State charged Agarwala by way of an Accusation with falsifying or tampering with records. According to the Accusation, between September 4, 2001 and October 4, 2001, Agarwala, together with a licensed insurance agent, Aziz Chaundhry, allegedly attempted to falsify an insurance application in order to obtain \$1 million worth of life insurance on the life of Agarwala's brother, Mukul Agarwala. The State alleged that the life insurance application was false because Agarwala did not disclose that Mukul Agarwala had been killed in the attack on the World Trade Center. Once Equitable Life Insurance Company determined that Mukul Agarwala had died in the attack on the World Trade Center, the case was referred to OIFP. Aziz Chaundhry previously entered into a consent agreement to pay a civil insurance fraud fine in the amount of \$5,000 for his alleged role in attempting to falsify the application.

State v. Mary Maschuci

On June 19, 2006, Mary Maschuci pled guilty to an Accusation charging her with Insurance Fraud, theft by deception, attempted theft by deception, and uttering a forged document. Maschuci admitted that, between June 9, 2003 and April 20, 2005, she submitted false life insurance claims to a variety of insurance companies. The claims were allegedly false in that Maschuci had applied for life insurance benefits on her own life, and, posing as her daughter, Maschuci then contacted the insurance companies indicating that Mary Maschuci had died. Maschuci then allegedly submitted false death certificates to the insurance companies and collected or attempted to collect life insurance claim money.

In total, Maschuci allegedly attempted to collect approximately \$1,083,155 in life insurance claim money and actually collected \$738,409. The State alleged that false life insurance claims were sent to nine insurance

companies, including Empire Indemnity Insurance Company, Individual Assurance Company, Protective Life Insurance Company, AIG Insurance Company, Hartford Life & Accident Insurance Company, USAA Life Insurance Company, Minnesota Life Insurance Company, Allstate Insurance Company, and Conesco Insurance Company. Maschuci will be sentenced in 2007.

State v. Kenneth Wilson

On September 7, 2006, the court sentenced Kenneth Wilson to five years in state prison following his guilty plea to Insurance Fraud. Wilson admitted that, between June 3, 2004 and October 30, 2004, he issued four worthless checks to Transamerica Occidental Life Insurance Company in connection with premium payments for his term life insurance policy which would have benefited his fiancé. The four worthless checks allegedly totaled \$10,390 and were drawn on Botree Investments, LLC; Web-Loan; Ogle, Liles & Upshaw, LLP; and Metabolex, Inc. The State alleged that Wilson also attempted to obtain a \$6,888 loan from the insurance policy, but that loan was denied by Transamerica. At the time of sentencing, Wilson was incarcerated in South Woods State Prison for unrelated charges filed by the Burlington County Prosecutor's Office.

State v. Guy Cardinale

On November 29, 2006, Guy Cardinale entered a guilty plea to an Accusation charging him with issuing worthless checks. He admitted that, between July 25, 2006 and August 28, 2006, he issued a worthless check in the amount of \$66,488 to Transamerica in connection with the purchase of a life insurance policy. The check was dishonored by the bank. Cardinale is scheduled to be sentenced in 2007.

Cardinale also pled guilty on November 29, 2006, to theft by deception pursuant to an unrelated State Grand Jury indictment returned on July 28 2006. According to the indictment, between July and December 2002, Cardinale, who was employed as an agent for the Canada Life Assurance Company, allegedly submitted life insurance policy applications and supporting records to create the impression that customers had purchased various life insurance policies when, in fact, they had not purchased such policies. The State alleged that Cardinale submitted the fraudulent documents to the Canada Life Assurance Company in order to collect more than \$346,025 in up-front commissions for four fictitious sales of insurance policies.



Drug Diversion

State v. Dawn M. Nehring

On July 13, 2006, a Burlington County Grand Jury returned an indictment charging Dawn M. Nehring with theft by deception and obtaining controlled dangerous substances. According to the indictment, between January 17, 2001 and October 16, 2003, Nehring allegedly used the prescription drug insurance benefits of her grandmother, mother, and brother to illegally obtain narcotic drugs. The State alleged that the prescriptions were filled at numerous pharmacies and that Nehring wrongfully utilized the prescription drug benefit cards and related information to obtain the drugs. Several prescription drug insurance plans and labor union prescription drug plans were allegedly victimized, to include Independence Blue Cross Blue Shield, Aetna Insurance Company, and the Carpenters Pension and Annuity Fund of Philadelphia. The State alleged that approximately \$61,052 in phony claims for prescription drugs were submitted as a result of Nehring's conduct and approximately \$48,023 was paid by the insurance carriers or other prescription drug plans. On July 21, 2006, Nehring was arrested by OIFP investigators. Her case is pending trial.

State v. Gerald McGuigan

On March 8, 2006, Gerald McGuigan pled guilty to an Accusation charging him with theft by deception. McGuigan admitted that he submitted 82 phony prescription drug claims to Caremark Insurance Company and Medco Health Solutions and that \$11,220 was paid for the prescriptions. On April 28, 2006, the court sentenced McGuigan to 90 days in county jail as a condition of a three-

year probationary sentence and ordered him to pay \$11,220 in restitution. McGuigan was previously arrested by OIFP investigators and charged with Health Care Claims Fraud, theft by deception, obtaining controlled dangerous substances by fraud, and forgery. The State alleged 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 for payment.

State v. Annabelle Tulud

On June 7, 2006, the court sentenced Annabelle Tulud to four years probation and ordered her to pay \$14,129 in restitution. On April 11, 2006, Tulud pled guilty to an Accusation charging her with obtaining controlled dangerous substance by fraud. Tulud, a registered nurse who previously surrendered her nursing license, admitted that, between October 29, 2003 and April 1, 2005, she obtained prescription medication by submitting fraudulent prescriptions. She admitted that she obtained Actiq Fentanyl by submitting phony prescriptions to a pharmacy located in Livingston. She admitted that she had previously stolen blank prescription forms from her physician, filled them out as if her doctor had prescribed the medication, and illegally obtained the narcotic prescription drug. The State alleged that approximately \$14,129 in prescription drugs were obtained by fraud, and that MEDCO Insurance Company was fraudulently billed for these prescription claims.

PROPERTY AND CASUALTY FRAUD

False Homeowners Insurance Claims

State v. Richard Farber

On January 13, 2006, the court sentenced Richard Farber to four years in state prison and ordered him to pay \$2,069 in restitution and a \$2,500 civil insurance fraud fine. Farber pled guilty to an Accusation charging him with theft by deception. Farber admitted that he submitted a false homeowners insurance claim. Farber allegedly told Philadelphia Contributionship Insurance Company that a burglar stole his plasma television, digital camera, camcorder, notebook computer, and scanner, and supported his claim with receipts showing purchases of the items from an appliance store, but Farber had returned the items to the store for a refund.

State v. Rita Farmer

On February 6, 2006, the court admitted Rita Farmer into the PTI Program conditioned upon her performing 50 hours of community service and paying a \$2,500 civil insurance fraud fine. Farmer pled guilty to an Accusation charging her with forgery. Farmer allegedly submitted phony flooring company receipts to Hanover Insurance Company to support her homeowners insurance claim of water damage to her home.

State v. Michael Oteri

On March 10, 2006, the court sentenced Michael Oteri to four years probation. On January 23, 2006, Oteri pled guilty to forgery. A Camden County Grand Jury previously returned an indictment charging Oteri with forgery by uttering. According to the indictment, Oteri allegedly provided a phony boat dealership sales receipt to support his claim that certain items were stolen from his home, including fishing rods and other property related to boating.

State v. Joseph Connors

On October 25, 2006, the court admitted Joseph Connors into the PTI Program conditioned upon him paying a \$5,000 civil insurance fraud fine. On August 24, 2006, Connors pled guilty to an Accusation charging him with falsifying records. Connors allegedly submitted a false receipt which had been changed from \$683.22 to \$1,683.22. The State alleged that the receipt was purportedly issued by a residential services company which had repaired a home intercom and doorbell system at Connors' home. The intercom/doorbell system had allegedly been damaged by lightening, and Connors allegedly added \$1,000 to the receipt which was then submitted to Countryway Insurance Company for reimbursement on a homeowners insurance claim.

State v. Steven Budge, et al.

On June 6, 2006, the court admitted Steven Budge, John Budge, and Frank Land into the PTI Program and ordered each of them to pay a \$500 criminal fine. A State Grand Jury returned an indictment charging Steven Budge, a Public Insurance Claims Adjuster, his brother John Budge, and their uncle Frank Land with attempted theft by deception. According to the indictment, a house owned by Frank Land was allegedly damaged as a result of winds that caused a large tree limb to fall on the roof. The State further alleged that Steven Budge, John Budge, and Frank Land inflicted further

damage to the roof in order to inflate the homeowners insurance claim to Liberty Mutual Insurance Company. The State also alleged that Steven Budge submitted an appraisal to repair the roof to Liberty Mutual which was allegedly inflated by approximately \$60,000. Liberty Mutual, suspecting fraud, denied the claim and referred the case to OIFP for further investigation.

State v. Jill Ravitz

On or about October 13, 2006, Jill Ravitz was dismissed from the Bergen County PTI Program for failure to remain law abiding in that she was charged in another, unrelated case. The court had admitted Ravitz into the PTI Program for a period of one year following her guilty plea to an Accusation charging her with attempted theft by deception. Ravitz allegedly submitted a homeowners insurance claim falsely claiming that a \$10,000 diamond ring was missing. The State alleged that Ravitz submitted the claim after she received an appraisal for the diamond ring which she falsely claimed she purchased. The carrier denied the claim and referred the matter to OIFP for investigation. She will be sentenced in 2007.

State v. Sharon Knecht

On December 13, 2006, a Monmouth County Grand Jury returned an indictment charging Sharon Knecht with Insurance Fraud. According to the indictment, Knecht allegedly submitted an altered \$1,800 art gallery estimate to State Farm Insurance Company for a painting that was damaged from a water leak in her home. The State alleged that the art gallery estimate was actually \$800.

State v. Gilbert Noble

On December 11, 2006, Gilbert Noble pled guilty to an Accusation charging him with Insurance Fraud. Noble admitted that in June 2006, he submitted three altered receipts to AAA Mid-Atlantic Insurance Group in support of his homeowners claim in connection with an alleged residential burglary. Allegedly, Noble's insurance claim was for approximately \$20,748. AAA Mid-Atlantic, suspecting fraud, denied the claim and referred the matter to OIFP for investigation. He will be sentenced in 2007.

Fraudulent Stolen/Damaged Property Claims

State v. James Eifler

On February 1, 2006, the court sentenced James Eifler to one year probation and ordered him to pay \$780 in fines and penalties.

He had previously paid State Farm Insurance Company \$3,830 in restitution. Eifler pled guilty to Insurance Fraud and forgery. A State Grand Jury had 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 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.

State v. Soena Sahni

On February 24, 2006, the court admitted Soena Sahni into the PTI Program conditioned upon her performing 75 hours of community service. Sahni pled guilty to an Accusation charging her with Insurance Fraud. Between March 13, 2004 and August 31, 2004, Sahni allegedly submitted altered and fraudulent computer rental receipts to the Hartford Insurance Company to support her claim that rented computer equipment was allegedly stolen from her place of business during a burglary.

State v. David Guyton

On March 10, 2006, the court sentenced David Guyton to three years probation and ordered him to pay a \$2,500 civil insurance fraud fine. On January 5, 2006, Guyton pled guilty to a State Grand Jury indictment charging him 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. The State alleged that Guyton submitted a fraudulent \$7,004 claim to the New Jersey Insurance Underwriting Association for the loss of four gas ranges and four refrigerators resulting from a fire at an apartment building located at 22 Goodwin Avenue in Newark. Guyton allegedly falsified a number of records in support of the claim.

State v. Alan Rogoff

On July 25, 2006, the court admitted Alan Rogoff into the PTI Program conditioned upon him performing 50 hours of community service. On June 20, 2006, an Accusa-

tion was filed charging Rogoff with Insurance Fraud. According to the Accusation, Rogoff allegedly submitted a phony lost/theft claim to State Farm Insurance Company. The State alleges that Rogoff submitted a phony receipt for a diamond engagement ring in support of his claim that the ring had been stolen, when, in fact, he had returned the ring to the jeweler and exchanged it for a larger ring.

State v. Samuel Siligato

State v. Gary Dixon

State v. Francisco Diaz

State v. Michael Howell

Following an 11-week jury trial, Samuel Siligato was found guilty of attempted theft by deception, conspiracy, and witness tampering. On September 7, 2006, the court sentenced him to 11 years in state prison.

A State Grand Jury previously returned an indictment charging 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 allegedly paid a \$15,000 insurance claim for the building's contents and \$165,000 for the building itself. The State alleged that Siligato also fraudulently submitted a \$206,900 claim to Farmers Mutual Insurance Company for the contents of the building.

During the course of this investigation and prosecution, OIFP investigators arrested Gary Dixon and charged him with perjury. Prior to the date Siligato's trial was originally scheduled to begin, Siligato allegedly offered Dixon's testimony in his defense after Siligato allegedly threatened Dixon and his family to persuade Dixon to provide perjured testimony to exculpate him (Siligato). Siligato also offered the testimony of Francisco Diaz. OIFP investigators arrested Diaz and charged him with perjury. The State alleged that Siligato coerced Diaz for perjured testimony. An arrest warrant for terroristic threats was also issued for Michael Howell. The State alleged that Howell threatened the son of a cooperating witness who was then expected to testify at Siligato's trial. A State Grand Jury returned an additional indictment on August 29, 2005, charging Siligato with witness tampering based on the above conduct.

State v. Nalin Parmar

On December 21, 2006, an Accusation was filed charging Nalin Parmar with Insurance Fraud. According to the Accusation, on December 23, 2004, Parmar, who operates Sayreville Wine & Liquor, allegedly submitted an altered invoice to Great American Insurance Company in support of a property damage claim. The State alleged that, on December 2, 2004, several shelves on which liquor was stored, collapsed. The State further alleged that although the cost of replacing the shelves was \$1,570, Parmar allegedly altered the invoice to read \$7,570 and submitted the altered invoice to his insurance company. He is scheduled to be sentenced in 2007.

Phony Certificates of Insurance²

State v. Michael Fernandez

On March 17, 2006, the court admitted Michael Fernandez into the PTI Program conditioned upon him performing 75 hours of community service. Fernandez pled guilty to an Accusation charging him with forgery. Fernandez, the owner/operator of Michael's Carpentry & Construction, allegedly provided a phony York-Jersey Underwriters, Inc., Certificate of Insurance to a person at whose home Fernandez was contracted to do work.

State v. Robert Belisonzi

On January 5, 2006, the court admitted Robert Belisonzi into the PTI Program. An Accusation was previously filed charging Belisonzi with forgery. Belisonzi, the owner of the Mason Jar, a catering business, allegedly provided a phony Eastern Insurors, LLC, Certificate of Insurance to a business with which he had contracted to provide catering services.

State v. Dorothy McCausland

On June 26, 2006, the court admitted Dorothy McCausland into the PTI Program. On May 22, 2006, McCausland was charged by way of an Accusation with forgery. According to the Accusation, McCausland, in her capacity as office manager of Complete Masonry, allegedly submitted a phony New Jersey Manufacturers Insurance Company Certificate of Insurance to a waterproofing company. The State alleged that Complete Masonry was a subcontractor doing work for a waterproofing company.

State v. Joseph Greble

On March 13, 2006, the court admitted Joseph Greble into the PTI Program conditioned upon him performing 50 hours of community service. Greble pled guilty to

forgery. Greble, of Red Alert Security, LLC, on two occasions, allegedly presented counterfeit Certificates of Insurance to two companies with which he had contracted to supply security alarm work.

State v. Art Gallagher

On January 20, 2006, Art Gallagher failed to appear at his sentencing. The court issued a bench warrant for his arrest. Gallagher previously pled guilty to an Accusation charging him with forgery. Gallagher, the owner and operator of Tower Building Contractors, admitted providing a phony Atlantic Insurance Services Certificate of Insurance to a contracting firm for which he was doing subcontracting work.

State v. Wilson Aguirre

On June 30, 2006, the court admitted Wilson Aguirre into the PTI Program. On April 25, 2006, a Middlesex County Grand Jury returned an indictment charging Aguirre with forgery. According to the indictment, Aguirre allegedly submitted a phony Zurich Insurance Company Certificate of Insurance to a business with whom Aguirre had contracted to do landscaping work.

State v. Heriberto Quiroz

On August 22, 2006, the court admitted Heriberto Quiroz into the PTI Program. On May 2, 2006, a Hudson County Grand Jury returned an indictment charging Quiroz with forgery. According to the indictment, Quiroz, operator of Quiroz Trucking, Inc., allegedly submitted a phony NorthGuard Insurance Company Certificate of Insurance to a construction company relative to work Quiroz performed at a construction site.

State v. Joseph Fleres

Joseph Fleres failed to appear at his arraignment on January 23, 2006. The court issued a bench warrant for his arrest. A Bergen County Grand Jury previously returned an indictment charging Fleres with forgery. According to the indictment, Fleres, the owner of Fleres Construction, allegedly provided a forged Scottsdale Insurance Company Certificate of Insurance to a business for which Fleres was contracted to do construction work.

State v. Scott Rosanio

On February 17, 2006, the court sentenced Scott Rosanio to 18 months probation and ordered him to pay a \$1,000 criminal fine. The court previously admitted Rosanio into the PTI Program conditioned upon him performing 50 hours of community service. Rosanio was terminated from the program and, on the same day, pled guilty to an Ocean County Grand Jury indictment charging him with forgery. According to the indictment, Rosanio, a home repair contractor doing business as Creative Construction, allegedly forged a Certificate of Liability Insurance. The State alleged that the Certificate of Insurance purported that Mercer Mutual Insurance Company insured Rosanio's contracting business for liability, when, in fact, Rosanio had forged the Certificate of Insurance.

State v. Dennis Carey

On May 1, 2006, Dennis Carey failed to appear at his arraignment. The court issued a bench warrant for his arrest. On February 28, 2006, a Hudson County Grand Jury returned an indictment charging Carey with forgery by uttering. According to the indictment, Carey allegedly faxed a phony Preserver Insurance Company and New Jersey Re-Insurance Company Certificate of Liability Insurance to a home improvement company, which had allegedly hired Carey to do subcontracting work.

State v. William Jenkins

William Jenkins failed to appear at his arraignment on April 17, 2006. The court issued a bench warrant for his arrest. On March 9, 2006, a Burlington County Grand Jury returned an indictment charging Jenkins with forgery. According to the indictment, Jenkins allegedly filed a phony Mercer Insurance Company Certificate of Liability Insurance with the Township of Pemberton on behalf of a general contractor.

State v. Daliton Marcal

On August 22, 2006, Daliton Marcal failed to appear at a court hearing. The judge issued a bench warrant for his arrest. On May 2, 2006, a Hudson County Grand Jury

2. Frequently, contractors and other businesses are required to present proof of insurance when seeking construction work. Too often, the Certificates of Insurance offered as proof of insurance are phony, and the contractors or other businesses do not have the proper insurance to provide protection in the event of an insurable loss.

returned an indictment charging Marcal with forgery. According to the indictment, Marcal, who was doing business as First March Construction, allegedly submitted a phony Certificate of Liability Insurance in connection with construction work being done on Bergenline Avenue in Union City. The State alleged that the Certificate of Insurance was purportedly issued by Fleet Insurance Services of Newark, and also purports that Travelers Indemnity insured Marcal and his construction company for commercial general liability and workers' compensation insurance from November 5, 2004 to November 5, 2005.

State v. Mario Ramos

On June 21, 2006, the court admitted Mario Ramos into the PTI Program and ordered him to pay \$4,666 in restitution. On May 3, 2006, a Mercer County Grand Jury returned an indictment charging Ramos with theft by failure to make required disposition of property received and forgery. According to the indictment, between July 2, 2005 and July 26, 2005, Ramos, who operated Ramos Heating Co., allegedly provided a phony insurance binder to an individual in connection with restoration work being done on a building located at 114 Centre Street in Trenton. The insurance binder was allegedly provided to demonstrate that Ramos had the requisite insurance before beginning work on the building. The indictment also alleged that Ramos accepted \$4,666 from the individual as a down payment for the work to be performed on the building, but did not perform any work and never returned the money.

State v. William Van't Veer

On April 6, 2006, the court admitted William Van't Veer into the PTI Program conditioned upon him performing 50 hours of community service. A Somerset County Grand Jury previously returned an indictment charging Van't Veer with forgery. According to the indictment, Van't Veer, a construction contractor, allegedly submitted a phony Ohio Casualty Insurance Company Certificate of Insurance to obtain work at a bank.

State v. Steven Day

On August 4, 2006, the court admitted Steven Day into the PTI Program. On June 22, 2006, Day pled guilty to an Accusation charging him with forgery. Day, the operator of JPS Construction Company, allegedly submitted two phony Ohio Casualty Group Certificates of Insurance to a construction company which hired Day to do subcontracting work.

State v. Fernando Vasquez

On June 27, 2006, a Hudson County Grand Jury returned an indictment charging Fernando Vasquez with forgery. According to the indictment, on September 16, 2004, Vasquez, the owner/operator of First Rate Construction, allegedly provided a phony Ohio Casualty Group Certificate of Insurance to a contracting firm that had hired First Rate Construction to do subcontracting work.

State v. Lance Lally

On September 18, 2006, Lance Lally pled guilty to forgery. He is scheduled to be sentenced early in 2007. On July 31, 2006, a Monmouth County Grand Jury returned an indictment charging Lally with forgery. According to the indictment, on or about November 29, 2005, Lally, a contractor operating a company known as Lally Painting and Construction, issued a fictitious Certificate of Liability Insurance indicating that he had workers' compensation insurance when, in fact, he did not, in order to obtain work from a general contractor. The State further alleged that the Certificate of Liability Insurance falsely reflected that Lally's company was insured by Peerless Insurance Company and possessed the requisite liability insurance.

State v. Steven Roesch

On September 26, 2006, a Sussex County Grand Jury returned an indictment charging Steven Roesch with forgery. According to the indictment, on October 27, 2005, Roesch, the owner and operator of Steven Roesch Carpentry, presented a phony Quincy Mutual Fire Insurance Company Certificate of Liability Insurance to a person with whom he had contracted to build a deck. This case is pending trial.

State v. John Mullen

On September 27, 2006, the court admitted John Mullen into the PTI Program conditioned upon him performing 25 hours of community service. Mullen was charged with forgery by way of an Accusation. According to the Accusation, Mullen, who operated J. Mullen Roofing, LLC, allegedly provided false Jeanne Frey Insurance Agency Certificates of Liability Insurance to three different general contractors with which J. Mullen Roofing had contracted to do work.

State v. Prestige Homes Development Corporation

On December 22, 2006, the court sentenced Prestige Homes Development Corporation to pay \$5,000 in criminal fines. On October 11, 2006, the corporation pled

guilty to an Accusation charging false records. According to the Accusation, Prestige Homes Development Corp., which is in the business of residential home construction, submitted 17 fraudulent Certificates of Liability Insurance to the Hartford Insurance Company during the course of an audit that Hartford was conducting at Prestige Homes.

State v. Patrick Loftus

On November 16, 2006, Patrick Loftus pled guilty to an Accusation charging him with forgery. Loftus, the owner/operator of Computer Logix, admitted that he presented an altered Quincy Mutual Fire Insurance Certificate of Insurance to a department store in connection with a software consulting job contract. He is scheduled to be sentenced in 2007.

State v. William Luciano

On October 27, 2006, William Luciano pled guilty to an Accusation charging him with forgery. According to the Accusation, Luciano, the owner and operator of T&L Custom Tile and Marble, allegedly presented a forged Hartford Insurance Company Certificate of Liability Insurance to a construction company for which he had contracted to do work. He is scheduled to be sentenced in early 2007.

State v. Tadeusz Dobrzanski

On December 6, 2006, an Ocean County Grand Jury returned an indictment charging Tadeusz Dobrzanski with forgery. According to the indictment, on March 1, 2006, Dobrzanski, the owner and operator of TJD Construction, allegedly presented a phony Selective Insurance Company Certificate of Liability Insurance to a condominium complex which had contracted with TJD Construction to do repair work.

State v. Bruce Buccolo, et al.

On June 8, 2006, a Somerset County Grand Jury returned an indictment charging Bruce Buccolo, his wife, Lori Lapira, and the heavy equipment leasing company he owned, operated and controlled known as United Leasing, Inc., with theft of services and forgery. According to the indictment, between June 12, 2001 and November 20, 2001, Buccolo, Lapira, and United Leasing allegedly leased heavy construction equipment from an equipment rental company, incurring unpaid charges due under the equipment lease of approximately \$25,000. The State further alleged that Buccolo presented a phony Certificate of Liability Insurance in order to induce the company to rent the heavy equipment to him.



State v. Mark Little

On December 11, 2006, the court admitted Mark Little into the PTI Program. On November 1, 2006, Little was charged by way of an Accusation with forgery. According to the Accusation, Little allegedly submitted an altered State Farm flood insurance application and a forged letter on State Farm letterhead to a bank when applying for a home loan, in support of his claim that he had sufficient flood insurance to secure the loan.

INSURANCE PROFESSIONAL FRAUD

Insurance Carrier Employee Fraud

State v. Sharonda Ross, et al.

On September 25, 2006, Michelle Patterson pled guilty to conspiracy. On November 3, 2006, the court sentenced her to three years probation and ordered her to pay \$489 in restitution. A State Grand Jury had 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 further alleged that a total of approximately 18 checks were wrongfully diverted in this manner and the conspiracy netted the defendants approximately \$49,889.

Sharonda Ross previously pled guilty to theft by deception, and the court admitted her into the PTI Program 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 to three years probation and ordered him to pay \$22,258 in restitution to Prudential Insurance Company.

State v. Melita Bilali, et al.

On November 1, 2006, a State Grand Jury returned an indictment charging Melita Bilali, Greicy Rodriguez, Wilson Ruiz, and Guillermo Rosario with theft by deception and conspiracy. Bilali was also charged with uttering a forged document. According to the indictment, between March 18, 2002 and May 1, 2002, Bilali, Ruiz, Rodriguez, and Rosario allegedly stole claims money from Prudential Insurance Company when Bilali issued phony claims checks from the Prudential computer system. The State alleges that Bilali, who was employed at Prudential as a customer service representative in the Disability Management Service Division fraudulently diverted five claims checks totaling \$13,634 to Ruiz, Rodriguez, and Rosario. This case is pending trial.

State v. Lisa Fitzpatrick-Gordon, et al.

On October 30, 2006, a Monmouth County Grand Jury returned an indictment charging Lisa Fitzpatrick-Gordon, Brady Bell, and Robert Scatigna with conspiracy to commit theft by deception and theft by de-

Putting the Brakes on Unscrupulous Insurance Licensees

by Lewis Korngut

OIFP continued to see a growing trend in the area of insurance agent/producer fraud during 2006. OIFP received numerous referrals alleging that certain insurance producers had stolen insurance premium money from unsuspecting insureds, leaving many insureds without insurance. The investigations have shown that because of the accessibility to large amounts of premium money, some insurance producers/agents cannot avoid the temptation of converting this premium money for their own personal use. The State will continue to prosecute these cases, sending a strong message to these agents/producers that prosecution and jail time will be the result of such misconduct.

During 2006, numerous producers were convicted by OIFP for stealing premium money. Many of these convicted defendants received jail time. Michael Chamberlain, a licensed insurance broker formerly of Basking Ridge, was sentenced in February 2006 to five years state prison. He admitted to swindling a 78-year-old man of his life savings totaling

over \$300,000. Rodger Strandskov, a licensed insurance broker from the Eastern Insurance Agency in Kendall Park, was sentenced in February 2006 to three years state prison for stealing over half a million dollars from AMGRO Premium Finance Company. Stacy Bates, a Millville licensed insurance agent, was sentenced in March 2006 to three years state prison for stealing over \$105,000 from approximately 124 insurance customers seeking auto and homeowners insurance policies.

Another licensed agent, Louis Polite of Burlington Township, received five years probation for stealing \$57,657 from approximately 50 victims and an additional \$3,000 from New Jersey PAIP. Mercedes Lastra, a licensed bail bondsman, was sentenced in November 2006 to five years probation for stealing \$52,000 from individuals who gave her money to procure bail bonds. As part of their sentences, all of the aforementioned licensed producers have forfeited their licenses and have been ordered to pay full restitution.

In yet another producer scam, in November 2006, Guy Cardinale, a licensed insurance producer, pled guilty to second and

third degree theft by deception. Cardinale admitted to bilking Canada Life Assurance Company out of more than \$364,000 in fraudulently obtained insurance sales commissions. Cardinale admitted that he forged the names of several of his clients on certain documents in order to have policies issued and premiums electronically deducted from their bank accounts. Sentencing is scheduled for March 2007. Cardinale faces up to five years in state prison and the loss of his insurance producer's license.

OIFP is committed to aggressively pursuing licensed agents who break the law and violate their duty to their clients. These criminals victimize individuals and businesses and undermine the sterling reputations of countless law abiding agents and producers.

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

ception. According to the indictment, between June 25 and July 29, 2002, Gordon allegedly conspired with Bell and Scatigna to steal approximately \$21,393 from State Farm Insurance Company. The State alleges that Gordon, who was an employee of State Farm, fraudulently issued five claim checks to Bell, Scatigna, and a person who was not identified in the indictment. This case is pending trial.

Insurance Premium Fraud

State v. Ana Carmona, et al.

On June 20, 2006, Ana Carmona pled guilty to Insurance Fraud. On September 8, 2006, the court sentenced her to five years probation and ordered her to pay \$617 in restitution to Clarendon Insurance Company and a \$3,000 civil insurance fraud fine. On January 4, 2006, a State Grand Jury returned an indictment charging Carmona with Insurance Fraud. According to the indictment, on December 4, 2003, Carmona, a licensed real estate agent, allegedly committed application fraud by falsifying an automobile insurance application and submitting it to Clarendon National Insurance Company in order to save automobile insurance premiums.

The State alleged Carmona falsely stated in her automobile insurance application that there were no other licensed drivers residing in her household and made other misleading statements and/or omissions in her automobile policy application to Clarendon Insurance. The State also alleged that by concealing the fact that other licensed drivers resided in her house, Carmona was able to deceive Clarendon Insurance Company into charging her substantially less for automobile insurance.

Unrelated to the investigation of Carmona, her insurance agent, Herberto Zayas, was charged by the Passaic County Prosecutor's Office for the sale of fraudulent automobile insurance identification cards. On May 17, 2006, a Passaic County Grand Jury returned an indictment charging Zayas with theft by failure to make required disposition. According to that indictment, Zayas accepted insurance premium money from a corporation which operated a car wash in Plainfield, in order that general commercial liability and commercial property damage/loss insurance could be purchased, but failed to obtain the insurance and retained the insurance premium money for his own use. The indictment alleged that approximately \$6,795 in premium money was stolen by Zayas.

Insurance Sales Fraud

State v. Lisa Brown

On April 7, 2006, the court sentenced Lisa Brown to three years probation and ordered her to pay \$3,000 in restitution. On February 6, 2006, Brown pled guilty to a Union County Grand Jury indictment charging her 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, stole insurance premium money from three insurance customers with the promise that she could obtain auto insurance for them at a much lower rate. The State alleged 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 alleged that Brown stole the premium money and left the insurance customers without valid automobile insurance. Brown was neither licensed nor authorized to sell insurance or accept premiums as a licensed insurance agent.

State v. Joseph Caruso

On May 8, 2006, the court admitted Joseph Caruso into the PTI Program conditioned upon him paying \$5,000 in restitution. On April 3, 2006, Caruso pled guilty to an Accusation charging him with theft by deception and forgery. Caruso allegedly sold insurance policies and insurance-related investment products and services between August 9, 2001 and July 16, 2002, even though he did not have a valid license to sell insurance. The State alleged that Caruso collected approximately \$97,000 in insurance sales commissions during the relevant time period while employed as an insurance agent with a financial services firm in Point Pleasant. In New Jersey, insurance agents or insurance producers are required to have a State-issued insurance producers license.

Department of Banking and Insurance (DOBI) Licensees

State v. Rodger Strandskov

On February 17, 2006, the court sentenced Rodger Strandskov to three years in state prison and ordered him to pay \$305,658 in restitution to Lexington Insurance Company and \$305,190 in restitution to the Insurance Company of the State of Pennsylvania. Strandskov pled guilty to an Accusation charging him with theft by fail-

ure 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, borrows money from a lender to purchase the required commercial trucking insurance. Strandskov admitted that, in some cases, he stole insurance premium finance money and used it for his own purposes. Additionally, Strandskov admitted that he did not return insurance premium finance 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 AMGRO Premium Financing.

State v. Michael Chamberlain

On February 3, 2006, the court sentenced Michael Chamberlain to five years in state prison and ordered him to pay \$303,757 in restitution, following his guilty plea to theft by unlawful taking. A State Grand Jury previously returned an indictment charging Chamberlain with theft by unlawful taking, forgery, and misapplication of entrusted property. According to the indictment, Chamberlain, then a licensed securities dealer selling investments for American Skandia, which was later purchased by Prudential Insurance Company, allegedly stole \$300,000 from a 78-year-old victim by forging documents related to three annuity accounts maintained by the American Skandia/Prudential Company. The Prudential Insurance Company reported the matter to OIFP for further investigation.

State v. Louis Polite

On March 31, 2006, the court sentenced Louis Polite to five years probation, ordered him to pay \$3,277 in restitution to PAIP and \$57,461 to 50 victims, as well as ordering him to forfeit his producer's license. On August 25, 2006, the court suspended certain conditions of the sentence imposed on Polite. Polite agreed to increase the amount of payments he had been making in order to reconstitute the insurance companies and others.



On January 27, 2006, Polite pled guilty to an Accusation charging him with theft by failure to make required disposition of property received. Polite, a licensed insurance agent, admitted that, between January 1, 2003 and November 19, 2004, he accepted insurance premiums from 24 insurance customers, most of whom were purchasing automobile insurance, and did not remit the insurance premiums to the insurance companies to pay for the insurance coverage. He admitted that he stole the money and used it for his own purposes.

State v. Stacey Bates

On March 17, 2006, the court sentenced Stacey Bates to three years in state prison, ordered her to pay \$105,553 in restitution, and permanently revoked her insurance agent's license. On January 30, 2006, Bates pled guilty to an Accusation charging her with theft by failure to make required disposition. Bates, a licensed insurance agent and the owner and operator of Stacey Bates General Insurance Agency located at 319 North High Street in Millville, admitted that she accepted insurance premiums from insurance customers, primarily for automobile insurance, and did not remit the insurance premium money to the appropriate insurance carrier to obtain valid insurance for the insurance customers. Instead, Bates admitted taking the insurance premium money and spending it for her own purposes. OIFP's investigation identified approximately 104 insurance customers whose premium money was stolen by Bates totaling approximately \$99,058.

State v. Julio Fonseca

On November 15, 2006, a State Grand Jury returned an indictment charging Julio Fonseca, a licensed insurance agent who operated an insurance agency located at 377 Henry Street in Orange, with failure to make required disposition and simulating a motor vehicle insurance identification card. According to the indictment, between March 7 and December 9, 2003, Fonseca allegedly accepted insurance premium money as payment for insurance coverage from customers of his insurance agency but never turned the insurance premium money over to the insurance companies and instead stole the money to use it for his own purposes. The State also alleges that Fonseca issued simulated New Jersey PAIP auto insurance cards on June 20 and December 9, 2003, to an insurance customer. The total amount of theft is alleged to be several thousand dollars.

INSURANCE-RELATED THEFT/ ATTEMPTED THEFT

State v. E. Nkem Odinkemere

On January 13, 2006, following a five-day trial in Essex County before Judge John C. Kennedy, the jury was unable to reach a verdict. On March 27, 2006, the indictment against E. Nkem Odinkemere was dismissed. A State Grand Jury previously returned an indictment charging Odinkemere with misapplication of entrusted property. The State alleged 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 allegedly used the money for his own benefit.

State v. Monserrat Rodriguez

On March 1, 2006, the court sentenced Monserrat Rodriguez to one year probation. Rodriguez pled guilty to an Accusation charging her with issuing bad checks. Rodriguez admitted that, between April 26, 2005 and May 14, 2005, she wrote approximately 39 checks totaling \$7,803. The checks were drawn on a High Point Insurance Company bank account. Rodriguez knew the bank would not honor the checks.

State v. Angel C. Fontaina

On April 13, 2006, the court sentenced Angel C. Fontaina to four years in state prison and ordered him to pay \$4,000 in restitution. On March 16, 2006, Fontaina pled guilty to an Accusation charging him with theft by deception. Fontaina, who was incarcerated in the Hudson County jail based on his guilty plea to first degree armed robbery, admitted that he stole \$4,600 in connection with an annuity investment issued by the General Electric Capital Assurance Program. Fontaina admitted that he issued a check to the General Electric Capital Assurance Program to fund an annuity investment. The check was drawn in the amount of \$3,000. Later, Fontaina made two withdrawals of \$3,000 from the General Electric Capital Assurance annuity and used the cash for his own purposes. General Electric Capital Assurance later learned that Fontaina's initial \$3,000 check was worthless when it bounced.

State v. Mercedes Lastra

On November 14, 2006, the court sentenced Mercedes Lastra to five years probation and ordered her to pay \$52,930 restitution to a bail bond company. The court also revoked her bond agent license for a period

of five years. On September 21, 2006, Lastra pled guilty to an Accusation charging her with theft by failure to make required disposition of property received. Lastra, a bond agent licensed in the State of New Jersey and an employee of a bail bond company located in Perth Amboy, admitted that, between September 24, 2004 and January 26, 2005, she accepted bail money which represented premium surety bonds from various persons. She admitted that she took the bail bond money and issued phony bonds by taking blank bail bonds and completing them as if they had been paid for and properly issued. In total, Lastra admitted that she stole approximately \$52,930 in connection with phony bail bonds issued for 15 criminal defendants.

MEDICAID FRAUD

Provider Fraud

State v. William J. Adamshick

On February 10, 2006, the court sentenced William J. Adamshick to three years probation and ordered him to pay \$25,000 in restitution and \$25,000 in civil penalties. It also revoked his pharmacist's license and barred him from participating in the Medicaid program for five years. Adamshick pled guilty to Health Care Claims Fraud.

A State Grand Jury previously returned an indictment charging Adamshick with Health Care Claims Fraud and Medicaid fraud. According to the indictment, between May 15, 2000 and January 30, 2002, Adamshick, a licensed pharmacist, allegedly submitted fraudulent claims to the Medicaid program for a narcotic prescription drug known as Stadol. Adamshick allegedly billed the Medicaid program in excess of \$20,000 for approximately 238 phony Stadol prescriptions that were never dispensed to patients.

State v. Delphine Moore, et al.

Delphine Moore, owner and operator of M and M Rest Home located in Perrineville, Howard Beale, owner and operator of the Chelsea Rest Home located in Long Branch, and Kathryn McGlynn, owner and operator of the Atlantic House, all located in Monmouth County, were previously admitted into the Pre-Trial Intervention (PTI) Program. Moore's admission into PTI was conditioned upon her paying \$19,200 in restitution and paying a \$1,500 civil penalty. Beale's admission into PTI was conditioned upon him paying \$4,800 in restitution and paying a \$1,000 civil penalty. McGlynn's admission into PTI was condi-

tioned 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 their assisted living facilities at that pharmacy. The prescriptions were allegedly billed to the Medicaid program. The kickbacks allegedly took the form of cash and free of charge over-the-counter medications, which were also allegedly used by the residents of the nursing homes.

On February 17, 2006, the court sentenced Jacob Cohen to pay standard fines and penalties, which he did at the time of sentencing. Cohen pled guilty to Medicaid fraud in connection with this investigation. In addition, Michael Stavitski, former owner and operator of the Belmar Home Town Pharmacy, 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 previously pled guilty to Medicaid fraud and he was sentenced to three years probation.

State v. Azam Khan, et al.

On January 27, 2006, the court sentenced Azam Khan to three years in state prison. Khan pled guilty to an Accusation charging him with Health Care Claims Fraud. A State Grand Jury previously returned an indictment charging Shahid Khawaja, Milton Barasch, and Axat Jani with Health Care Claims Fraud, theft by deception, and Medicaid Fraud. All four defendants allegedly participated in an illegal scheme to bill 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.

Jani previously pled guilty to Health Care Claims Fraud. The court sentenced Jani 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, previously pled guilty to money laundering. The court sentenced Khawaja to five years in state

prison and ordered him to pay \$235,984 in restitution. Barasch, a licensed pharmacist, also pled guilty to Health Care Claims Fraud. The court sentenced Barasch to four years in state prison, suspended his Medicaid privileges for five years, and suspended his pharmacist's license for one year.

State v. Edward Acquaye

On June 30, 2006, Edward Acquaye pled guilty to Medicaid fraud. On September 1, 2006, the court sentenced him to three years probation and ordered him to pay \$1,500 in restitution and a \$1,000 civil fine. On January 24, 2006, a Middlesex County Grand Jury returned an indictment charging Acquaye with Medicaid fraud in connection with the Michael Stavitski investigation. According to the indictment, between November 20, 2001 and February 20, 2002, Acquaye, who did business as EDFAMAX, Inc., was the president and operator of the Lincoln Rest Home, which was licensed by the New Jersey Department of Health and Senior Services. It is alleged that Acquaye accepted kickbacks in the form of cash from Michael Stavitski, who owned, operated, and controlled the Belmar Home Town Pharmacy. In total, \$4,800 was paid by Stavitski to Acquaye so that he would direct residents of the Lincoln Rest Home to the Belmar Home Town Pharmacy to have prescriptions filled. The Medicaid program prohibits paying cash or offering anything of value to a Medicaid provider in exchange for directing business to providers, such as pharmacies, so that the Medicaid program can be billed for prescription or other claims. Stavitski was previously prosecuted by the OIFP Medicaid Fraud Control Unit and was convicted and sentenced to serve seven years in state prison. He was also ordered to pay \$1.1 million in restitution and penalties and relinquished his Medicaid provider license for a period of seven years.

State v. Edward Sigle

On July 25, 2006, Edward Sigle pled guilty to Medicaid fraud. On September 1, 2006, the court sentenced him to three years probation and ordered him to pay \$2,000 in restitution and a \$1,000 civil fine. On January 24, 2006, a Middlesex County Grand Jury returned an indictment charging Sigle with Medicaid fraud in connection with the Michael Stavitski investigation. According to the indictment, between March 1, 2001 and February 20, 2002, Sigle, who operated the Meadowview Rest Home/Country View

Care Center located in Monroe, violated the Medicaid kickback statute by accepting money in return for directing nursing home residents to use a specific pharmacy for obtaining drugs prescribed by their physicians. Sigle was paid to direct nursing home residents to utilize the Belmar Home Town Pharmacy which was owned and operated by Stavitski.

State v. Shirley Welch

On October 16, 2006, Shirley Welch pled guilty to theft by deception. She is scheduled to be sentenced in 2007. On February 14, 2006, a Monmouth County Grand Jury returned an indictment charging Welch with Medicaid fraud in connection with the Michael Stavitski investigation. According to the indictment, between January 1, 2000 and February 20, 2002, Welch, who was licensed by the New Jersey Department of Health and Senior Services, and who was the former administrator/vice-president of the Pineland Rest Home, allegedly accepted kickbacks in the form of cash from Michael Stavitski, who owned, operated, and controlled the Belmar Home Town Pharmacy. The cash kickbacks were allegedly paid to Welch so that she would direct residents of the Pineland Rest Home to the Belmar Home Town Pharmacy to have prescriptions filled. Laws that govern the Medicaid program prohibit paying cash or offering anything of value to a Medicaid provider in exchange for directing business to providers, such as pharmacies, so that the Medicaid program can be billed for prescription or other claims. Stavitski was previously prosecuted by the OIFP Medicaid Fraud Control Unit and was convicted and sentenced to serve seven years in state prison. He was also ordered to pay \$1.1 million in restitution and penalties and relinquished his Medicaid provider license for a period of seven years.

State v. Dwayne Smith, et al.

On February 3, 2006, OIFP Medicaid Fraud Control Unit investigators arrested Dwayne Smith on an outstanding warrant. He was transported to the Essex County Correctional Facility. A State Grand Jury previously returned an indictment charging Dwayne Smith and his corporation, Smith & Williams Transportation, Inc., with Health Care Claims Fraud and Medicaid fraud. According to the indictment, between March 21, 2003 and May 20, 2004, Smith, through Smith & Williams Transportation, Inc., allegedly fraudulently billed the Medicaid pro-



gram 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 alleged that Smith falsely billed the Medicaid program approximately \$12,600. Dwayne Smith and Smith & Williams Transportation are scheduled to go on trial in early 2007.

State v. Jean Edward LaGuerre

On June 29, 2006, Jean Edward LaGuerre pled guilty to an Accusation charging him with forgery. He will be sentenced in 2007. On March 10, 2006, OIFP Medicaid Fraud Control Unit investigators arrested LaGuerre and charged him with forgery. LaGuerre was allegedly posing as a licensed pharmacist and was employed by a pharmacy that specialized in providing medications to nursing home residents. The State alleged that LaGuerre was not a licensed pharmacist in New Jersey and, therefore, could not legally dispense prescription medicine.

State v. Ojah Pharmacy, et al.

On March 21, 2006, following a five-week jury trial, Ojah Pharmacy, Verona Boodram, and Alpha Bangoura were convicted of Health Care Claims Fraud and Medicaid fraud. Upon conviction, bail for both individual defendants was revoked and they were remanded to the Essex County Jail. On June 6, 2006, the court sentenced Bangoura to six-and-a-half years in state prison. Boodram was sentenced to five years in state prison and ordered to pay \$21,500 in restitution. On June 23, 2006, the court ordered Ojah Pharmacy to pay \$21,500 in restitution and \$69,000 in fines and penalties. It also ordered the corporation dissolved and revoked its permit to operate as a pharmacy.

A State Grand Jury previously returned an indictment against Ojah Pharmacy, its manager Verona Boodram, and the pharmacy technician, Alpha Bangoura, charging them with Health Care Claims Fraud and Medicaid fraud. According to the indictment, between June 1, 2002 and October 28, 2004, the defendants billed the Medicaid program for prescriptions that were neither filled nor dispensed to Medicaid patients. The State further alleged that certain Medicaid patients sold their legitimate prescriptions to the pharmacy so that the pharmacy could support the fraudulent Medicaid bills. The State also alleged that the Medicaid program was billed approximately \$57,000 for prescriptions that were not filled.

State v. Terry Gatto

On May 12, 2006, Terry Gatto pled guilty to an Accusation charging her with theft by deception. Gatto admitted that, between November 4, 2002 and November 19, 2004, she used her prescription drug plan, Advance PCS, to fill phony prescriptions for OxyContin and Hydrocodone, both addictive narcotics. She admitted that the prescriptions were false because either the doctors did not prescribe those medications or the patients did not actually exist. Some of the purported patients were Medicaid recipients. Gatto admitted that a pharmacist filled the phony prescriptions in exchange for a share of the proceeds. The drugs were sold for \$350, which Gatto admitted splitting with the pharmacist by paying her \$175 for each bottle of medication illegally sold. Gatto admitted that she paid the pharmacist between \$1,400 and \$1,500 for eight bottles of medications which were illegally sold. She is scheduled to be sentenced in 2007. This investigation is continuing and more charges are anticipated.

State v. Mark Szarszewski

On September 22, 2006, the court admitted Mark Szarszewski into the PTI Program, conditioned upon him paying \$1,644 in restitution and performing 60 hours of community service. He was previously suspended by the Board of Pharmacy. On the same date, Szarszewski was charged by way of an Accusation with Medicaid fraud. Szarszewski, formerly a licensed pharmacist, allegedly wrongfully obtained Ambien, a prescription medicine, by falsely utilizing Medicaid beneficiary information.

State v. Cory Davis

On May 25, 2006, the court sentenced Cory Davis to three years probation, conditioned upon him serving 30 days in county jail. The court suspended the jail sentence. On the same date, Davis pled guilty to an Accusation charging him with Medicaid fraud. Davis admitted that in the course of applying to become a Medicaid provider, he concealed his prior criminal record. Specifically, Davis stated that when submitting the Medicaid provider application to the Division of Medical Assistance and Health Services so that he could qualify to operate as a Medicaid provider, he responded in the negative to the question inquiring whether or not Davis had ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime or disorderly persons offense in New Jersey or anywhere else,

when, in fact, he had a prior criminal conviction for distribution of drugs and had served prison time.

State v. Mary Villone

On July 28, 2006, the court sentenced Mary Villone to three years probation, conditioned upon her serving 90 days in the SLAP program. She was also ordered to pay a \$1,000 criminal fine. On May 19, 2006, Villone pled guilty to Medicaid fraud. A State Grand Jury previously returned an indictment charging Villone with Health Care Claims Fraud and Medicaid fraud. According to the indictment, Villone, the administrator of PE Medical Transport, Inc., allegedly submitted false transportation claims to the Medicaid program between January 2002 and February 2004.

PE Medical Transport provided mobility assistance vehicles and transportation assistance to Medicaid patients who required transportation to and from health care providers. Villone allegedly falsified prior authorization requests, certificates of medical necessity, and transportation trip certifications which Villone submitted to Medicaid in support of claims for transportation services not rendered and for patients who did not require transportation. In total, Villone submitted approximately 2,080 false claims totaling \$51,500 in billings to the Medicaid program.

During the investigation, PE Medical Transport settled with the State by paying \$204,000 in restitution and \$204,000 in civil penalties. An additional \$42,000 was forfeited to the State. The Medicaid Fraud Section "froze" PE Medical Transport's bank accounts which totaled approximately \$400,000.

State v. Frances M. Colon-Torres

On November 13, 2006, Frances M. Colon-Torres pled guilty to a six-count indictment. On December 18, 2006, the court sentenced her to two years probation and ordered her to pay \$18,000 in fines and restitution. She was also barred from working in the health care field for two years. On September 8, 2006, an Essex County Grand Jury returned an indictment charging Colon-Torres with false government documents, theft by deception, and uttering a forged document. According to the indictment, between August 2004 and May 2005, Colon-Torres was allegedly employed by a nursing home located in Orange, New Jersey, under false pretenses. The State alleged that Colon-Torres was first employed as a Licensed Prac-

tical Nurse (LPN), and then as a Registered Nurse (RN). The State further alleged that the licensing certificates she provided to the nursing home, demonstrating that she was an LPN and then an RN, were both phony. Finally, the State alleged that Colon-Torres stole approximately \$37,518 in salary by presenting phony nursing licenses to the nursing home in order to gain employment when she was not qualified.

State v. Frederick Feit

On September 26, 2006, a State Grand Jury returned an indictment charging Frederick Feit, a licensed medical doctor, with Health Care Claims Fraud and theft by deception. According to the indictment, between January 1, 1996 and December 31, 2004, Feit operated a medical practice known as Modern Pain Therapy located at 42 Center Street in Freehold. The State alleged that Feit submitted false claims to a number of health insurers and government-sponsored health care insurance plans in the amount of \$589,851. The State also alleged that Feit billed for nerve block injections used to alleviate pain when, in fact, he simply administered less invasive intramuscular injections using narcotics such as Demerol or morphine, a practice sometimes referred to as "up-coding." In addition to the Medicare Program, Aetna Insurance Company, Horizon Blue Cross Blue Shield, and Empire Insurance Company were allegedly falsely billed for nerve blocks when patients merely received less invasive and less expensive intramuscular injections. It is also alleged that Feit submitted false claims to Horizon Blue Cross Blue Shield for medical services not rendered.

State v. Gayford Yaw

On November 2, 2006, Gayford Yaw pled guilty to an Accusation charging him with unlawful taking. Yaw, who was employed as a pharmacy technician at Atlantic Health Systems/Morristown Hospital and at Ojah Pharmacy located on Sussex Turnpike in East Orange, admitted that, between September 26, 2002 and June 9, 2004, he stole several drugs from the Morristown Hospital pharmaceutical inventory, including Zithromax, Combivir, Lipitor, Zocor, Accupril, Diovan, Celebrex, Augmentin, Zolof, Zyprexa, and others. He also admitted that he sold the stolen drugs to various persons who owned or operated pharmacies so that the drugs could be resold to customers of the pharmacies. In total, Yaw admitted to stealing approximately \$13,438 worth of drugs. He is scheduled to be sentenced in 2007.

State v. Ademola T. Salami, et al.

On November 8, 2006, a State Grand Jury returned an indictment charging Ademola T. Salami, a licensed pharmacist, and the pharmacy he owned and operated, Bethel Pharmacy, Inc., located at 301 Osborne Terrace in Newark, with Health Care Claims Fraud and Medicaid fraud. According to the indictment, between January 1 and April 10, 2004, Salami, through Bethel Pharmacy, allegedly submitted claims to the Medicaid program for false prescriptions. The State alleged that the prescriptions were false because at least 12 prescriptions were forged and backdated, and the remaining 80 were not prescribed by the doctor whose purported signature was, in fact, forged on the prescription form. In total, the State alleged that Salami and Bethel Pharmacy billed the Medicaid program approximately \$16,851 based on phony prescriptions.

State v. Julio Anthony Munoz, et al.

On October 19, 2006, TNT Medical Supply, Inc., pled guilty to Health Care Claims Fraud. On the same date, Julio Anthony Munoz was admitted into the PTI Program conditioned upon him paying \$67,728 in restitution and penalties. The court also debarred him from participating in the Medicaid program for a period of eight years. The corporation will be sentenced in early 2007. A State Grand Jury previously returned an indictment charging Munoz and TNT with Health Care Claims Fraud and Medicaid fraud. According to the indictment, Munoz, a Medicaid provider, owned, operated, and controlled TNT. The State alleged that, between January 2002 and August 2003, Munoz 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 alleged that Munoz falsely billed the Medicaid program approximately \$29,840.

State v. Abdelraow Ismaiel

On December 18, 2006, Abdelraow Ismaiel was charged by way of an Accusation charging him with Medicaid fraud. According to the Accusation, Ismaiel was the owner and operator of Careway Invalid Coach, a provider of transportation services to Medicaid patients to facilitate travel to medical appointments for treatments. Between May 1, 2004 and January 31, 2005, Ismaiel allegedly offered money as bribes to several medical facility employees so that those employees would recommend the utilization of Careway for patient transportation and Careway could then bill the Medicaid program for any transportation services provided. Ismaiel will be sentenced in 2007.

Patient and Elder Abuse³

State v. Donald Beckett

Following a three-day jury trial, on March 30, 2006, Donald Beckett was acquitted of aggravated assault. A Sussex County Grand Jury previously returned an indictment charging him with aggravated assault. According to the indictment, on October 11, 2003, Beckett, who was employed at a SubAcute Rehabilitation Center as a Certified Nursing Assistant, allegedly committed an assault on an elderly resident of the Rehab Center.

State v. Sharmelanie L. Peppers

In cooperation with Delaware law enforcement, on January 30, 2006, OIFP Medicaid Fraud Control Unit investigators arrested Sharmelanie L. Peppers, a/k/a Charmelanie L. Peppers, a/k/a Larissa Moore, on a fugitive warrant based upon a Delaware complaint and warrant for Abuse, Mistreatment, or Neglect of a Patient. The patient subsequently died. Delaware requested OIFP's assistance as Peppers was then employed as a live-in assistant, caring for an elderly patient in New Jersey. Peppers also had numerous outstanding traffic warrants in New Jersey. Peppers was processed and transported to the Mercer County Correctional Facility where she was released into the custody of the Department of Corrections. The New Castle County, Delaware, Police Department was notified of the arrest and will be extraditing Peppers to Delaware.



State v. Madeline Petit

On September 28, 2006, Madeline Petit pled guilty to an indictment charging her with aggravated assault. On December 18, 2006, the court admitted her into the PTI Program. On February 22, 2006, a State Grand Jury returned an indictment charging Petit with assault upon an institutionalized elderly patient. According to the indictment, on January 15, 2004, Petit, a Certified Nursing Assistant employed at a patient care and rehabilitation center, allegedly committed an assault on an 80-year-old patient.

State v. Shirley Earnest

On April 13, 2006, Shirley Earnest was charged by way of Accusation with the crime of criminal restraint. She was admitted into the PTI Program and surrendered her Certified Nursing Assistant (CNA) license for a period of one year. According to the Accusation, Earnest, a licensed CNA, allegedly falsely imprisoned an elderly resident of a nursing home.

State v. Eldora McCall

On May 24, 2006, Eldora McCall pled guilty to uttering a forged instrument and theft of a motor vehicle. She is scheduled to be sentenced in early 2007. On February 22, 2006, a State Grand Jury returned an indictment charging McCall with uttering a forged document, attempted theft by deception, and theft by unlawful taking. According to the indictment, between March 31, 2004 and July 16, 2005, McCall, who was also known as Eldora Collins, forged two checks drawn on the account of an elderly nursing home patient in an effort to steal money belonging to the patient. Additionally, the indictment alleged that McCall stole the same patient's 2001 Buick LeSabre. The patient was a resident of a nursing home facility located in East Windsor Township, where McCall was employed as a Certified Nursing Assistant.

State v. Russell P. Smith, III

On May 30, 2006, Russell P. Smith, III, a Licensed Practical Nurse (LPN) in New Jersey, pled guilty to criminal sexual contact. On July 28, 2006, the court sentenced Smith to five years probation and ordered him to forfeit his LPN license. A Mercer County

Grand Jury previously returned an indictment charging Smith with aggravated assault and aggravated criminal sexual contact. According to the indictment, on July 1, 2004 and August 13, 2004, Smith allegedly assaulted various residents of a nursing and rehabilitation center located in Trenton. The State alleged that Smith committed an aggravated assault on four patients. The State also alleged that Smith committed an aggravated sexual assault on one of those patients. The alleged victims were patients were between 73 and 87 years old.

State v. Charlotte Moreland

On August 23, 2006, a Mercer County Grand Jury returned an indictment charging Charlotte Moreland with theft by unlawful taking. According to the indictment, between October 24 and 31, 2005, Moreland, a Certified Nursing Assistant employed as an aide for a 90-year-old resident of an assisted living facility located in East Windsor Township, allegedly used an ATM card without permission to steal approximately \$1,840 from the resident's bank account. OIFP investigators arrested Moreland on October 18, 2006. The case is pending trial.

State v. Antoinette Davis

On December 1, 2006, the court sentenced Antoinette Davis to one year probation. On September 18, 2006, Davis pled guilty to an Accusation charging her with uttering a forged document. Davis admitted that on or about August 18, 2005, she submitted a forged letter to the Department of Health and Senior Services. The letter was part of an application package so that Davis could obtain credentials as a Certified Nursing Assistant. Certified Nursing Assistants are

often employed in nursing homes to assist patients who are sometimes Medicaid beneficiaries. Davis admitted that the forged letter falsely advised the Department of Health and Senior Services that she had completed a period of criminal probation for theft from Burlington County when, in fact, she had not completed her probationary term and was still on probation.

State v. Helen Williamson

On October 25, 2006, an Ocean County Grand Jury returned an indictment charging Helen Williamson with neglect of the elderly and theft from the person. According to the indictment, between October 6 and 19, 2004, Williamson allegedly wrongfully neglected to care for a patient at a convalescent center located in Manahawkin. The State alleges that Williamson withheld pain medication from the patient. The State also alleges that Williamson stole a duragesic medication patch from the patient. A duragesic medication patch time releases pain medication to patients requiring such therapy. Pain medication patches are sometimes sought by persons who abuse narcotic substances. The case is pending trial.

3. Too frequently, Medicaid beneficiaries are subjected to neglect and abuse. The Office of the Insurance Fraud Prosecutor through its Elder Abuse and Neglect Unit in the Medicaid Fraud Section has begun an initiative to investigate and prosecute such allegations.

Protecting the Elderly Population

by John Krayniak and William Hoyman

Calendar year 2006 marked the second full year of operation for the Elder Abuse and Neglect Unit within the Medicaid Fraud Section. Created in 2004, the mission of this specialized unit is the detection, investigation, and prosecution of instances of alleged patient abuse and neglect that occur at any Medicaid provider facility. A provider facility is one that receives Medicaid dollars. The victim of abuse or neglect at such a facility need not be a Medicaid recipient.

Within the State of New Jersey, there are over 370 long term care facilities (nursing homes) where thousands of vulnerable elderly citizens reside. Combined with the elderly and disabled populations of numerous assisted living facilities and board and care homes, as well as those individuals who continue to reside at home but are reliant on home health aides, the potential for substantial harm being visited upon the elderly and disabled segments of our population is ever present.

In addition to the investigation and prosecution of cases, over the past two years, the Elder Abuse and Neglect Unit has successfully developed various sources of referrals for the reporting of cases of abuse and neglect. This outreach effort is ongoing. The wisdom of establishing an abuse and neglect unit with statewide prosecutorial authority has been confirmed by the enthusiastic response from other interested regulatory agencies that lack the authority to instigate criminal prosecutions and have, in years past, referred their investigative findings to the County Prosecutors' Offices when criminal prosecution was believed to be warranted. Both the Licensing and Certification Unit and the Assessment and Survey Unit within the Department of Health and Senior Services, Long Term Care Systems, have proven

to be invaluable allies contributing to the success of the Elder Abuse and Neglect Unit. A similar relationship is being developed with various offices within the Department of Human Services.

This past year, the Elder Abuse and Neglect Unit also became a member of the New Jersey State TRIAD Association. TRIAD is an organization devoted to addressing the safety concerns of the senior community. The goal of TRIAD is to reduce incidents of crime against the elderly population by the development of a statewide network of community based crime prevention programs, advocacy, and training conducted through a partnership of law enforcement, senior citizens, and community service organizations. The Elder Abuse and Neglect Unit will work to help advance the mission of this organization and thereby increase public awareness of the risks faced by the institutionalized elderly.

The individual County Prosecutors' Offices continue to be active partners in the prosecution of crimes involving the elderly. In addition to having concurrent jurisdiction with the Elder Abuse and Neglect Unit over incidents occurring within Medicaid provider facilities, the County Prosecutors are also responsible for all other cases involving elderly and disabled victims. Federal regulations require that dispositions in all cases involving offenses committed upon patients in Medicaid provider facilities be reported to the Office of the Inspector General of the federal Department of Health and Human Services. In order to assist the counties with this responsibility, the Elder Abuse and Neglect Unit monitors all county patient abuse and neglect prosecutions in order to gather information concerning dispositions and thereafter report those dispositions as required by federal law.

The Unit also stands ready to assist the local authorities by referring information concerning all dispositions to the various state occupational licensing agencies. The revocation or suspension of a professional license is a primary goal of a prosecution. This action

ensures a defendant will not be in a job or occupation that will allow ill advised access to the institutionalized elderly. Forms have been developed over the past year in order to streamline this process. In order to further cement the partnership between the Elder Abuse and Neglect Unit and the counties, a series of training programs addressing problems unique to the investigation and prosecution of abuse and neglect cases are also under development.

While the crimes of aggravated assault upon the institutionalized elderly and elderly neglect as defined in the code of criminal justice remain the primary tools of the Elder Abuse and Neglect Unit, experience has shown that the segment of the population served by the Unit is no less immune to other types of criminal behavior. In addition to the aforesaid assault and neglect offenses, calendar year 2006 also saw prosecutions of crimes for sex offenses, forgery, uttering forged instruments, criminal restraint, false imprisonment, and various types of theft, including motor vehicle theft, theft from the person, and theft by unlawful taking.

An unintended but not unwelcome consequence of the operation of the Elder Abuse and Neglect Unit has been its role as a clearing house not only for regulatory agencies seeking second opinions on difficult cases but also as an office of last resort for family members of victims not satisfied with conclusions reached in unrelated investigations. When circumstances warrant, the Unit has not been hesitant to request copies of all previous investigation reports in order to review them with a fresh perspective. While a previous conclusion is rarely challenged, a second review provides a concerned citizen with the satisfaction of knowing that his or her concerns have been given thoughtful consideration.

As it enters its third full year of existence, the Elder Abuse and Neglect Unit is maturing into an effective force against those who would take advantage of a vulnerable population. Abuse or neglect can be reported directly to the Elder Abuse and Neglect Unit at (609) 896-8772.

William Hoyman is a Deputy Attorney General assigned to OIFP's Medicaid Fraud Control Unit since 2000. For the past three years, he has concentrated on patient abuse cases. He previously served as both an Assistant County Prosecutor and Public Defender.



Investigators Gina Lemanowicz and Megan Flanagan confer on a case

During 2006, the following Consent Orders were executed in amounts of \$5,000 and above. Where appropriate, the criminal disposition of cases that were the subject of both criminal and civil enforcement actions are reported in the *OIFP Criminal Case Notes* section of this Annual Report.

AUTO FRAUD

Automobile Application Fraud

In the Matter of James Graves

James Graves executed a Consent Order for \$5,000 on July 19, 2006. Graves knowingly provided false and misleading information to Rutgers Casualty Insurance Company and the Great American Insurance Company. Graves applied for and obtained auto insurance using the identity of another individual.

In the Matter of Deena Perkins

Deena Perkins executed a Consent Order for \$5,000 on August 23, 2006. Following her involvement in an automobile accident, Perkins contacted GEICO Insurance Company to file a claim and learned that her GEICO policy had lapsed. Later that day, she applied for automobile insurance via the internet with E-Surance Insurance Company and was issued a policy subsequent to the accident. The following day, Perkins filed a claim with E-Surance for the damage to her vehicle that resulted from the accident that occurred prior to the effective date of the E-Surance policy.

In the Matter of Joel Serrano

Joel Serrano executed a Consent Order for \$5,000 on November 20, 2006. Serrano used another person's identity to obtain motorcycle insurance with Rider Insurance Company. Serrano subsequently filed a property damage claim with Rider, which was paid by the carrier.

Automobile "Give Up" and Theft Claims

In the Matter of Nora Termanini

Nora Termanini executed a Consent Order for \$5,000 on January 18, 2006. Termanini filed an auto theft claim with Hanover Insurance Company when, in fact, she willingly "gave up" the vehicle.

In the Matter of Suly Ayala

Suly Ayala executed a Consent Order for \$5,000 on January 18, 2006. Ayala submitted a fraudulent auto theft claim with Liberty Mutual Insurance Company when, in fact, she arranged for the vehicle's disposition.

In the Matter of Maria Amendolia

Maria Amendolia executed a Consent Order for \$5,000 on January 18, 2006. Amendolia's vehicle was purchased by the FBI Auto Theft Task Force as part of a "give up" sting operation. Following the vehicle's purchase, she reported it stolen to the Philadelphia Police Department and filed a fraudulent theft claim with State Farm Insurance Company.

In the Matter of William Vasquez

William Vasquez executed a Consent Order for \$5,000 on January 18, 2006. Vasquez was arrested by Newark Police for the arson of another individual's vehicle in an auto "give up" scheme. The matter was referred by First Trenton Indemnity Company.

In the Matter of Sandra Rodriguez

Sandra Rodriguez executed a Consent Order for \$5,000 on January 13, 2006. Rodriguez reported her vehicle stolen to the Vineland Police Department and to Rutgers Casualty Insurance Company. She subsequently admitted her involvement in the alleged theft and arson of the vehicle.

In the Matter of Martin Cardone

Martin Cardone executed a Consent Order for \$5,000 on February 15, 2006. Cardone filed an auto theft claim stating his vehicle had been stolen when, in fact, he was driving the vehicle in Florida. The case was referred by State Farm Insurance Company.

In the Matter of Jeannot Wildor

Jeannot Wildor executed a Consent Order for \$5,000 on February 15, 2006. Wildor filed an auto theft claim with Liberty Mutual Insurance Company when, in fact, she had "given up" the vehicle.

In the Matter of Ricardo Figueroa

Ricardo Figueroa executed a Consent Order for \$5,000 on February 15, 2006. Figueroa, a Bergen County police officer, filed an auto theft claim with State Farm Insurance Company stating that his vehicle had been stolen when, in fact, it had previously been sold to an undercover police officer.

In the Matter of Juan Negron

Juan Negron executed a Consent Order for \$5,000 on February 15, 2006. Negron had reported his vehicle stolen to the Lakewood Police Department. Prior to his filing the report, Negron's vehicle was found burning in New York City. Negron subsequently admitted that he "gave up" the vehicle because he could no longer afford the payments. The matter was referred by High Point Insurance Company.

In the Matter of Jennifer Clugh

Jennifer Clugh executed a Consent Order for \$5,000 on February 15, 2006. Clugh's vehicle was purchased by the FBI Auto Theft Task Force as part of a "give up" sting operation. Thereafter, she reported the vehicle stolen to the Philadelphia Police Department and filed a fraudulent theft claim with Allstate Insurance Company.

In the Matter of Andres Acevedo

Andres Acevedo executed a Consent Order for \$5,000 on February 15, 2006. Acevedo knowingly conspired with another to "give up" his insured vehicle and to submit a fraudulent automobile theft claim to Ohio Casualty Group.

In the Matter of Jose A. Vargas

Jose A. Vargas executed a Consent Order for \$5,000 on March 15, 2006. Vargas knowingly submitted a fraudulent auto theft insurance claim to Liberty Mutual Insurance Company.

In the Matter of Elsy G. Lazo

Elsy G. Lazo executed a Consent Order for \$5,000 on March 15, 2006. Lazo knowingly presented both written and oral false statements to MetLife Auto & Home Insurance Company and the Union City Police Department as part of a fraudulent auto theft claim.

In the Matter of Errold Lanier

Errold Lanier executed a Consent Order for \$5,000 on March 15, 2006. Lanier knowingly withheld and concealed information relevant to a fraudulent auto theft claim submitted by his wife to Clarendon Insurance Company. Lanier failed to inform his wife, who was the named insured, that the vehicle in question had been repossessed.

In the Matter of Manuel Molina

Manuel Molina executed a Consent Order for \$5,000 on April 19, 2006. Molina staged the theft of his vehicle and fraudulently reported it stolen to the Newark Police Department and Allstate Insurance Company.

In the Matter of James Patunas

James Patunas executed a Consent Order for \$5,000 on April 19, 2006. Patunas filed a fraudulent auto theft claim with State Farm Insurance Company.

In the Matter of Romont Thomas

Romont Thomas executed a Consent Order for \$5,000 on April 19, 2006. Thomas filed a fraudulent auto theft claim stating his vehicle was stolen when, in fact, he gave it to an undercover New York police officer for disposition. The matter was referred by First Trenton Indemnity Company.



Health and Life Civil Investigator Lucretia Davis prepares an investigation report.

In the Matter of Percy Melendez

Percy Melendez executed a Consent Order for \$5,000 on May 17, 2006. Melendez submitted a fraudulent auto theft claim to AIG Insurance Company.

In the Matter of Ramon Perez

Ramon Perez executed a Consent Order for \$5,000 on May 17, 2006. Perez filed a fraudulent auto theft claim with State Farm Insurance Company.

In the Matter of Hatidze Kalicaj

Hatidze Kalicaj executed a Consent Order for \$5,000 on May 17, 2006. Kalicaj fraudulently reported that her vehicle was stolen in Bloomfield. The vehicle, which was equipped with a transponder and for which all the keys were accounted, was recovered burned in Connecticut. The vehicle was purchased via Mitsubishi's "no payments for one year" promotion and the first payment was coming due. The matter was referred by Allstate Insurance Company.

In the Matter of Lim Y. Bances

Lim Y. Bances executed a Consent Order for \$5,000 on May 17, 2006. Bances fraudulently 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.

In the Matter of Steven Pisani

Steven Pisani executed a Consent Order for \$5,000 on July 19, 2006. Pisani provided false and misleading information regarding the theft of his vehicle. The matter was referred by High Point Insurance Company.

In the Matter of Tremonisha Falligan

Tremonisha Falligan executed a Consent Order for \$5,000 on July 19, 2006. Falligan filed a false vehicle theft claim with Liberty Mutual Insurance Company for the purpose of obtaining insurance money to which she was not entitled.

In the Matter of Paul Ackerman

Paul Ackerman executed a Consent Order for \$5,000 on July 19, 2006. Ackerman

staged the theft of his vehicle to obtain financial gain. The matter was referred by Liberty Mutual Insurance Company.

In the Matter of Francis Baccaro

Francis Baccaro executed a Consent Order for \$5,000 on July 19, 2006. Baccaro submitted a fraudulent auto theft claim to Liberty Mutual Insurance Company.

In the Matter of Tommaso Piccirillo

Tommaso Piccirillo executed a Consent Order for \$5,000 on July 19, 2006. Piccirillo filed a fraudulent auto theft claim with GE Auto Insurance Company.

In the Matter of Jason Jacoby

Jason Jacoby executed a Consent Order for \$5,000 on August 23, 2006. Jacoby filed a fraudulent vehicle theft claim with USF&G Insurance Company stating that his motorcycle had been stolen when, in fact, it had previously been sold.

In the Matter of Linda Mickens

Linda Mickens executed a Consent Order for \$5,000 on August 23, 2006. Mickens staged the theft of her vehicle to obtain a financial gain. The matter was referred by Liberty Mutual Insurance Company.

In the Matter of Bernard D. Cole

Bernard D. Cole executed a Consent Order for \$5,000 on August 23, 2006. Cole provided false and misleading statements to Chubb Insurance Company to support a fraudulent auto theft claim. He also submitted a fraudulent claim to High Point Insurance Company for the loss of items allegedly removed from the vehicle.

In the Matter of Randy Gemenden

Randy Gemenden executed a Consent Order for \$5,000 on September 20, 2006. Gemenden knowingly assisted another individual with submitting a fraudulent auto theft claim for the individual's vehicle. The matter was referred by State Farm Insurance Company.

In the Matter of Thomas Okuski, Jr., and Christopher Uffer

Thomas Okuski, Jr., and Christopher Uffer executed a Consent Order for \$5,000 each on October 18, 2006. Okuski, with Uffer's assistance, knowingly submitted a fraudulent auto theft insurance claim to State Farm Indemnity Company.

In the Matter of Angela M. Gruden

Angela M. Gruden executed a Consent Order for \$5,000 on October 18, 2006. Gruden conspired with others to dispose of her vehicle in an attempt to collect insurance proceeds. The matter was referred by the New York State Insurance Fraud Bureau.

In the Matter of Donna Bermudez

Donna Bermudez executed a Consent Order for \$5,000 on October 18, 2006. Bermudez submitted a fraudulent auto theft claim to First Trenton Indemnity Company when, in fact, her vehicle was in another's possession for repair work.

In the Matter of Jay Gorzkowski

Jay Gorzkowski executed a Consent Order for \$5,000 on December 20, 2006. Gorzkowski knowingly filed a fraudulent auto theft claim with Consumer First Insurance Company.

Body Shop Fraud

In the Matter of Town and Country Auto Body

Town and Country Auto Body executed a Consent Order for \$7,500 on December 20, 2006. Town and Country knowingly submitted claims for services that were not rendered as well as for parts that were not replaced. The matter was referred by Liberty Mutual Insurance Company.

Criminal Use of "Runners"

In the Matter of Andrew Farro

Andrew Farro executed a Consent Order for \$10,000 on December 20, 2006. In his role as a "runner," Farro provided a chiropractic physician with patients for medical treatment.

False Automobile-Related Claims

In the Matter of William Cuestas

William Cuestas executed a Consent Order for \$5,000 on August 23, 2006. Cuestas fraudulently submitted a claim to Utica National Insurance Company stating that his vehicle had been damaged in an accident. Cuestas previously filed a claim with Granada Insurance Company for the same damage stat-

ing the accident occurred three weeks prior to the date listed on the Utica claim.

In the Matter of Ellis Decresce

Ellis Decresce executed a Consent Order for \$5,000 on October 18, 2006. Decresce knowingly made a false and misleading statement to New Jersey Manufacturers Insurance Company in connection with his insurance claim for a motor vehicle accident in which his car was totaled. New Jersey Manufacturers paid \$48,633 on this claim. Decresce also failed to disclose that his vehicle was being used for business purposes and failed to disclose the location where the vehicle was garaged, which resulted in an annual premium savings of \$1,140.

In the Matter of Judith Hoffman

Judith Hoffman executed a Consent Order for \$5,000 on October 18, 2006. Hoffman knowingly altered a police report by changing the time of an accident in order to be eligible to pursue a property damage claim. The matter was referred by Allstate Insurance Company.

In the Matter of John L. Knight

John L. Knight executed a Consent Order for \$5,000 on November 20, 2006. Knight conspired with another individual to file a false police report that misrepresented the date of a motor vehicle accident. The fraudulent report was made in order to file a claim with Clarendon National Insurance Company, knowing that the individual's policy had lapsed at the time of the accident.

Staged and Fictitious Accidents

In the Matter of Anhuar Bandy

Anhuar Bandy executed a Final Judgment by Consent in the amount of \$2 million on August 7, 2006. Bandy committed insurance fraud by conspiring to stage automobile accidents and to submit false and misleading paperwork in support of fraudulent claims to numerous insurance companies in order to collect the proceeds.

In the Matter of Scot Frasier

Scot Frasier executed a Consent Order for \$5,000 on June 21, 2006. Frasier allegedly submitted two separate fraudulent auto property damage claims to Liberty Mutual Insurance Company and State Farm Insurance Company, respectively, with regard to

his 1997 Nissan. Frasier admitted that the claims were based on two accidents which never occurred.

HEALTH, LIFE, AND DISABILITY FRAUD

False Health Care Claims

In the Matter of John Huttenberger

John Huttenberger executed a Consent Order for \$5,000 on March 15, 2006. Huttenberger allegedly failed to disclose that he had consulted with a physician regarding a surgical procedure that was not performed prior to filling out his application for supplemental health insurance. The matter was referred by United Healthcare Company.

In the Matter of Steven L. Prosser

Steven L. Prosser executed a Consent Order for \$5,000 on March 15, 2006. Prosser submitted fraudulent receipts to Horizon Blue Cross Blue Shield for reimbursement for services that were not rendered to him.

In the Matter of Carol Ann Benvenuto

Carol Ann Benvenuto executed a Consent Order for \$5,000 on May 17, 2006. Benvenuto, while employed as a receptionist at a medical provider's office, submitted false medical claims to Horizon Blue Cross Blue Shield for reimbursement for services that were not rendered to her. She fraudulently obtained approximately \$1,935 for phony health insurance claims to which she was not entitled.

In the Matter of Stephanie Slavitt

Stephanie Slavitt executed a Consent Order for \$5,000 on August 23, 2006. Slavitt submitted Custodial Nursing Questionnaire Forms to John Hancock Life Insurance Company for services not rendered.

False Disability Claims

In the Matter of Bernard Gelman

Bernard Gelman executed a Consent Order for \$5,000 on January 18, 2006. Gelman provided an altered date for his son's resignation from a former employer in order for his son to obtain disability benefits under a policy to which he was not entitled. The matter was referred by Prudential Insurance Company (High Point).

In the Matter of Richard Serbin

Richard Serbin executed a Consent Order for \$50,000 on February 15, 2006. Serbin was working while collecting disability benefits. Serbin previously pled guilty to falsifying records, was admitted into the PTI Pro-

gram, and was ordered to pay \$170,869 in restitution to Reassure America Life Insurance Company.

In the Matter of Thomas Lagno

Thomas Lagno executed a Consent Order for \$5,000 on July 19, 2006. Lagno knowingly submitted false and misleading information to various health care facilities in pursuit of several workers' compensation claims.

In the Matter of Linda Van Pelt

Linda Van Pelt executed a Consent Order for \$5,000 on July 19, 2006. Van Pelt, a physician, failed to disclose the fact that she continued to treat patients while collecting total disability and business overhead expense benefits from UNUM Provident Corporation.

In the Matter of Willis Huggins

Willis Huggins executed a Consent Order for \$5,000 on November 20, 2006. Huggins knowingly failed to report that he had returned to work for a new employer while continuing to collect workers' compensation benefits. The matter was referred by New Jersey Manufacturers Insurance Company.

In the Matter of Brenda Hoffman

Brenda Hoffman executed a Consent Order for \$5,000 on November 17, 2006. Hoffman was working while collecting long-term disability benefits through her former employer. The matter was referred by The Hartford Life and Accident Company.

In the Matter of W. Lance Kollmer

W. Lance Kollmer executed a Consent Order for \$100,000 on December 20, 2006. Kollmer, a physician, knowingly misrepresented the extent of his physical limitations and continued to perform surgical procedures while receiving disability benefits. The matter was referred by US Life/American General Insurance Company.

Life Insurance Fraud

In the Matter of Atul Agarwala

Atul Agarwala executed a Consent Order for \$30,000 on August 23, 2006. Agarwala conspired with an agent working for Equitable Life Insurance Company to backdate a life insurance policy and increase the amount of death benefits in order to gain the proceeds. The policy was in the name of Agarwala's brother who perished in the World Trade Center disaster.

Provider Fraud



In the Matter of Martha Haldopoulos

Martha Haldopoulos executed a Consent Order for \$5,000 on March 15, 2006. Haldopoulos was an unlicensed provider who billed for services. The matter was referred by Oxford Health Insurance.

In the Matter of Gene Harnick

Gene Harnick executed a Consent Order for \$5,000 on August 23, 2006. Harnick, a dentist, submitted fraudulent dental claims to Aetna US Healthcare Insurance Company for dental procedures that were not rendered.

In the Matter of Kimberly McCauley

Kimberly McCauley executed a Consent Order for \$5,000 on March 15, 2006. McCauley, a chiropractor, knowingly billed Cigna Insurance Company for chiropractic services not rendered.

PROPERTY AND CASUALTY FRAUD

False Homeowners Claims

In the Matter of Susan Bonfiglio

Susan Bonfiglio executed a Consent Order for \$5,000 on January 18, 2006. Bonfiglio enhanced the extent of damage to her home on a claim she filed with Liberty Mutual Insurance Company.

In the Matter of Sharon H. Barrett

Sharon H. Barrett executed a Consent Order for \$5,000 on June 21, 2006. Barrett claimed that a video camera and equipment were damaged as the result of a fire at her residence and submitted fraudulent receipts to Cumberland Mutual Fire Insurance Company to receive compensation for these items.

In the Matter of Phyllis Manasseri

Phyllis Manasseri executed a Consent Order for \$5,000 on September 20, 2006. Manasseri filed a fraudulent property loss claim with Chubb Insurance Company stating that several items were stolen when, in fact, she had previously sold them.

In the Matter of Thomas Tizzio

Thomas Tizzio executed a Consent Order for \$5,000 on October 18, 2006. Tizzio presented false and misleading statements to AIG Personal Lines for a homeowners burglary claim for stolen watches knowing that the watches were not stolen.

False Property Damage Claims

In the Matter of Dave Bhavesh

Dave Bhavesh executed a Consent Order

for \$5,000 on March 15, 2006. Bhavesh submitted altered and fraudulent receipts to Selective Insurance Company in support of a property damage claim for his business.

Insurance Professional Fraud

In the Matter of Umberto Mazzone

Umberto Mazzone executed a Consent Order for \$5,000 on May 17, 2006. Mazzone, while employed as a claims adjuster at Preserver Insurance Company, knowingly diverted insurance claim checks to his own personal bank account.

MEDICAID CIVIL CASE SETTLEMENTS

OIFP's Medicaid Fraud Control Unit participates in state and federal global settlement cases where defendants are New Jersey Medicaid providers. These cases are generally coordinated through the National Association of Medicaid Fraud Control Units (NAMFCU). Most of these cases are federal qui tam filings. The settlement agreements generally require the corporate defendants to cooperate with federal and state law enforcement. Since the Medicaid program is funded jointly by the state and federal governments, settlement awards generally consist of both a federal and state share, representing the proportionate contribution of each governmental entity. The following Medicaid civil case settlements were entered into in 2006:

Serono, Inc., and Serono Laboratories, Inc.

Serono Laboratories, Inc., makers of Serostim, an AIDS treatment drug, entered into a settlement with the State of New Jersey on February 21, 2006. The joint state/federal investigation of Serono Laboratories showed manipulated computer software programs used to assist in the diagnosis and prognosis of AIDS patients, and illegal kick-backs paid to doctors to prescribe Serostim in order to increase its sales revenues. The New Jersey portion of the national settlement is \$24,825,800 in restitution and interest, \$11,855,746 of which represents the State share.

King Pharmaceuticals, Inc.

King Pharmaceuticals, Inc., entered into a settlement with the State of New Jersey on April 12, 2006, based upon the underpayment of its rebates for generic drugs under

the Medicaid and PAAD rebate program. The New Jersey portion of the settlement is \$4,446,449, of which \$981,732 represents the State share for the Medicaid program and \$2,566,475 for the PAAD program.

Glaxo, Inc., and SmithKline Beecham, Inc.

The State of New Jersey entered into a national settlement with Glaxo over the manipulation of the average wholesale price for Zofran and Kytril, which are prescribed to treat nausea. On August 30, 2006, the New Jersey Medicaid program received \$900,919, of which the State share was \$408,178, including \$204,089 in restitution and a \$204,089 penalty. This recovery was increased by \$19,204 in post-agreement interest.

Omnicare

On December 8, 2006, New Jersey received \$333,263 in a Medicaid settlement with Omnicare. The total New Jersey settlement, including both the federal and state share, was \$684,557. Omnicare is an institutional pharmacy provider. The settlement resolved allegations that Omnicare improperly switched prescriptions for fluoxetine, the generic form of Prozac, for Medicaid beneficiaries without their doctors' knowledge. By switching to tablets from the capsule form of the drug, Omnicare avoided the lower price allowed for the capsules under the federal upper payment limit.

State v. Clarence Coleman

On January 9, 2006, a Default Judgment, including civil penalties, attorney fees and costs, was obtained against Clarence Coleman in the amount of \$31,008. Coleman's drivers license was also suspended for one year. Coleman was convicted of attempted theft by deception after reporting that his 1998 Ford Explorer was stolen while parked in Newark.

State v. Frank Rose

In February 2006, the State obtained a Default Judgment against Frank Rose in the amount of \$32,479. Rose, who was employed by a Public Adjuster, was involved in an arson ring and was paid to set fires and submit claims for the resulting property damage.

State v. Clifton Baskerville, et al.

A Default Judgment was entered against Wanda Reeves for \$30,550 in February 2006. In March 2006, a Default Judgment was entered against Clifton Baskerville for \$15,500. Wanda Reeves, a/k/a Wanda Baskerville, using her position as a claims adjuster with the Robert Plan and Cambridge Integrated Services, caused the insurance carriers to issue claim checks payable to her and Clifton Baskerville. The checks, to which they were not entitled, totaled \$141,400. The defendants previously were criminally prosecuted and ordered to pay restitution to the defrauded carriers.

State v. John J. Graeber, D.M.D., et al.

OIFP intervened in this insurance fraud action brought by Delta Dental Plan of New Jersey, Inc., against John J. Graeber, D.M.D. On March 22, 2006, Graeber signed a Stipulation of Settlement and Consent Order for Entry of Judgment in the amount of \$100,000, to include a \$75,000 civil penalty and attorney fees for \$25,000. Graeber violated the Fraud Act by changing a patient's date of treatment and submitting the claim in the next policy year because the patient's coverage was exhausted.

State v. Nidia Munoz

In April 2006, the State obtained a Default Judgment against Nidia Munoz to include a \$15,000 civil penalty for two violations of the Fraud Act, attorney fees in the amount of \$1,269, and a \$54 service fee. Munoz fraudulently reported her 1998 Infiniti QX4 stolen to the Passaic Police Department and New Jersey Manufacturers Insurance Company, when, in fact, it was part of a sting operation in which individuals relinquished their vehicles in order to report them stolen for insurance benefits.

State v. Maria Perez

On April 11, 2006, a Default Judgment, including penalty, attorney fees, and costs, was obtained against Maria Perez for \$15,952. Perez had submitted an application to Rutgers Casualty Insurance Company to obtain automobile insurance for her 1996 Chevrolet Blazer using a North Plainfield, New Jersey, address when, in fact, she resided in Brooklyn, New York. Perez also submitted a

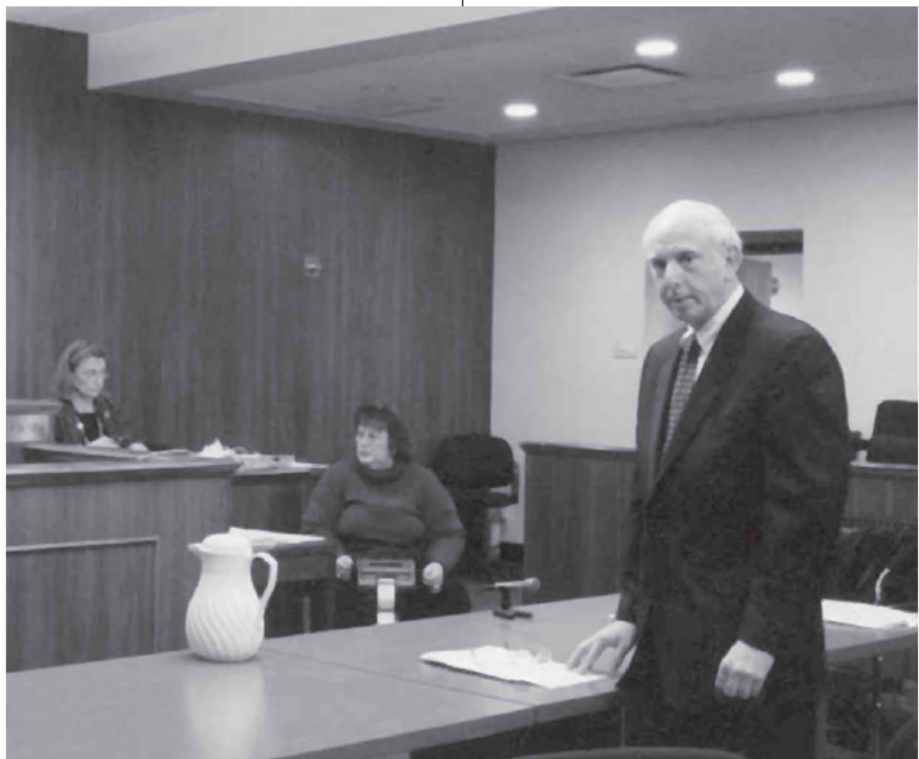
false lease agreement for a North Plainfield, New Jersey, address in support of her application for auto insurance.

State v. Ngan Hirai, D.D.S.

On May 9, 2006, Ngan Hirai, D.D.S., entered into a Stipulation of Settlement and Consent Order for Entry of Judgment wherein she agreed to pay a civil penalty of \$50,000 and attorney fees of \$21,000. Hirai had submitted fraudulent disability claim forms to General American Life Insurance Company stating that she was totally unable to practice as a dentist, when, in fact, she was doing so. As a result of a criminal action, Hirai was previously admitted into the PTI Program.

State v. Nicholas Lepore, Jr.

On May 26, 2006, a Default Judgment, including penalty, attorney fees and costs, was obtained against Nicholas Lepore for \$16,112. Lepore was also criminally prosecuted and pled guilty to arson charges. Lepore had staged the theft of his 1997 Mercedes Benz and filed a fraudulent auto theft claim with CGU Insurance Company.



Deputy Attorney General Frank Holstein argues a motion in Superior Court.



State v. Rajan Rihshinghani

In June 2006, the court entered a \$10,000 Stipulation of Settlement and Consent Judgment against Rajan Rihshinghani arising from a fraudulent credit disability claim case wherein Rihshinghani claimed to be disabled so that he could receive insurance payments to meet his home equity loan obligations. Rihshinghani, in fact, was gainfully employed when he received \$4,570 in credit disability benefits to which he was not entitled.

State v. Mitchell Collins

Mitchell Collins fraudulently obtained life insurance policies with Omaha Insurance Company in the names of his girlfriend's children by stating that he was their stepfather. In August 2006, the State was granted Summary Judgment in this matter to include \$10,000 in civil penalties for two violations of the Fraud Act and attorney fees in the amount of \$150.

State v. Timothy Hinchman

On August 4, 2006, a Default Judgment, including civil penalties, attorney fees and costs, in the amount of \$18,472 was obtained against Timothy Hinchman. Hinchman staged the theft of his vehicle and filed a fraudulent vehicle theft claim with his insurance carrier. Hinchman subsequently pled guilty to charges of attempted theft by deception.

State v. Charles Monge, et al.

In September 2006, a Default Judgment was obtained against Charles Monge in the amount of \$16,682 for his role in the staged theft and arson of a 1999 Honda Accord.

State v. Nguyet Thach, et al.

On September 8, 2006, Default Judgments, including civil penalties, attorney fees and costs, were obtained against Sang Son in the amount of \$17,226 and against Nguyet Thach in the amount of \$17,288. Son was the driver of a vehicle that was involved in an accident. According to the police report and the driver of the other vehicle, there were no passengers in Son's vehicle at the time of the accident. Thach subsequently filed a fraudulent PIP claim for injuries she allegedly sustained in this accident as a passenger. Thach and Son also provided false statements to the insurance carrier in support of this claim.

State v. Michael Harris

On September 22, 2006, a Default Judgment was obtained against Michael Harris in the amount of \$17,294. Harris falsely reported to the police and an insurance carrier that he was a passenger in a vehicle that was involved in an accident, when, in fact, he was a bystander to the incident. Harris subsequently treated with a medical provider for alleged injuries to his arm and neck and a PIP claim was submitted on his behalf. Harris was eventually arrested and pled guilty to Health Care Claims Fraud.

Medical

In the Matter of Axat Jani, M.D.

On January 19, 2006, to have been effective October 15, 2004, the State Board of Medical Examiners suspended the license of Axat Jani, M.D., for a period of five years with the first two years retroactive to October 15, 2004, and the remainder stayed to be a period of probation. The action was based on a guilty plea to Health Care Claims Fraud.

In the Matter of Myron Moskowitz, D.P.M.

On March 29, 2006, the State Board of Medical Examiners suspended the license of Myron Moskowitz, D.P.M., for a period of three years with the first year active and the remainder stayed to be a period of probation. The action was based on Moskowitz practicing podiatric medicine with an expired biennial registration and billing insurance carriers while suspended.

In the Matter of Michael Fizicki, M.D.

On July 13, 2006, the State Board of Medical Examiners accepted the voluntary surrender of the medical license of Michael Fizicki, M.D. The action was based on Fizicki engaging in the submission of allegedly fraudulent insurance claims resulting in an investigation and subsequent settlement with Horizon Blue Cross/Blue Shield.

In the Matter of Mark Freilich, M.D.

On September 14, 2006, the State Board of Medical Examiners suspended the medical license of Mark Freilich, M.D., for a period of two years with the first six months active effective October 1, 2006, and the remainder stayed to be a period of probation. The action was based on a *non vult* plea to complaints alleging false, negligent, and incompetent interpretations of MRI studies, providing medical services for an MRI facility not licensed by the Department of Health and Senior Services during the period of time when the services were rendered, and failing to hold a current biennial registration during the period in question.

In the Matter of Ronald Collins, M.D.

On November 14, 2006, the State Board of Medical Examiners accepted the surrender of the license of Ronald Collins, M.D., with prejudice. The action was based on Collins entering a plea of no contest to all of the allegations contained in the State's com-

plaint filed on May 22, 2006. Those allegations included, but were not limited to, Collins performing grossly inadequate clinical examinations and medical management of patients reporting personal injury; Collins directing, authorizing, ratifying or condoning the ordering and performance of unnecessary cervical and lumbar electrodiagnostic testing routinely on all patients involved in rear-end auto collisions; Collins directing, authorizing, ratifying or condoning the performance of electrodiagnostic testing on patients, some of whom he had never seen or examined and permitting tests to be performed by unlicensed and unsupervised persons; Collins engaging in an extended pattern of conduct to which he allowed himself to be employed by unlicensed persons to perform professional services in violation of N.J.A.C. 13:35-6.16(f); and Collins ordering, ratifying or condoning diagnostic testing performed by himself and others in a grossly incompetent or grossly negligent manner, preparing test reports containing fabricated data and unsupported diagnoses and billing at grossly inflated and excessive fees.

Dental

In the Matter of Rosemarie DiMeola, Registered Dental Hygienist

The State Board of Dentistry reprimanded Rosemarie DiMeola, R.D.H., for automobile application fraud.

In the Matter of Roger Brown, D.D.S.

On May, 17, 2006, the State Board of Dentistry suspended the license of Roger Brown, D.D.S., for a period of five years with the first 364 days active effective July 29, 2005, and with the remainder stayed to be a period of probation. The action was based upon Brown's guilty plea to Health Care Claims Fraud.

Professional Counselors

In the Matter of Anthony Panichella, P.C.

The Professional Counselor Examiners Committee accepted the voluntary surrender of the license of Anthony Panichella, P.C., with prejudice based upon Panichella's guilty plea to unauthorized practice of medicine. The scope of a professional counseling license does not permit the prescribing of medicine.

Chiropractic

In the Matter of Craig Klein, D.C.

On February 16, 2006, the State Board of Chiropractic Examiners suspended the license of Craig Klein, D.C., for a period of five years with the first two years active and the remainder stayed to be a period of probation. The action was based upon the resolution of an Accusation filed against Klein alleging the use of "runners" for referral of patients.

In the Matter of Mark Radowitz, D.C.

On May 8, 2006, the State Board of Chiropractic Examiners accepted the licensure surrender of Mark Radowitz, D.C., to be deemed a revocation effective April 21, 2006. The action was based on Radowitz' guilty plea to Health Care Claims Fraud.

In the Matter of Kimberly McCauley, D.C. (a/k/a Kimberly Stark, D.C.)

On July 12, 2006, the State Board of Chiropractic Board Examiners reprimanded the license of Kimberly McCauley, D.C., based upon McCauley billing an insurance carrier for chiropractic services not rendered to two patients for a total of ten visits.

Pharmacy

In the Matter of William Adamshick, R.P.

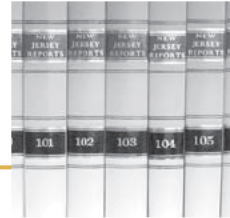
On March 9, 2006, the New Jersey Board of Pharmacy suspended the license of William Adamshick, R.P., for one year based upon Adamshick's criminal conviction for Health Care Claims Fraud.

In the Matter of Michael Stavitski, R.P.

On November 9, 2006, the New Jersey Board of Pharmacy revoked the license of Michael Stavitski, R.P., based upon his criminal conviction for Health Care Claims Fraud.

In the Matter of Ojah Pharmacy

On December 14, 2006, the State Board of Pharmacy revoked the permit of Ojah Pharmacy to operate as a pharmacy in the State of New Jersey based upon Ojah Pharmacy being convicted of Health Care Claims Fraud in that the corporation paid Medicaid recipients for their prescriptions for life-saving medications with the prescriptions being billed for but never dispensed to the actual patient.



Marriage Therapy

In the Matter of John Marron, Marriage Therapist

On April 4, 2006, the Board of Marriage and Family Therapy Examiners accepted the voluntary surrender of the license of John Marron, marriage therapist, with prejudice. The action was based upon Marron falsifying or uttering a billing statement to an insurance carrier for reimbursement of services provided, knowing that the bill contained false information with purpose to deceive and/or conceal wrongdoing.

In the Matter of Evelyn Wilson, Marriage Therapist/Licensed Certified Social Worker

On April 13, 2006, the Boards of Social Work Examiners and Marriage and Family Therapy Examiners revoked the licenses of Evelyn Wilson, licensed certified social worker and licensed marriage family therapist, with prejudice. The action by the two Boards was based upon findings that Wilson failed to keep adequate client progress notes and proper patient records, submitted bills containing inaccurate dates of services, and her failure to conform her record keeping to appropriate practices despite her claim to the contrary. Subsequently, Wilson pled guilty to theft by deception in that she submitted fraudulent health insurance claims to Horizon Blue Cross/Blue Shield for services that were never rendered.

Nursing

In the Matter of Kathryn McGlynn, R.N.

On April 18, 2006, the State Board of Nursing suspended the nursing license of Kathryn McGlynn, R.N., for a period of three years with the first six months active and the remainder stayed to be a period of probation. The action was based upon McGlynn steering Medicaid residents to a pharmacy for their prescription needs and receiving kickbacks.

In the Matter of Russell P. Smith, III, L.P.N.

On August 18, 2006, the State Board of Nursing accepted the permanent surrender of the nursing license of Russell P. Smith, III, to be deemed a revocation. The action was based upon Smith pleading guilty to one count of a Medicaid indictment charging criminal sexual contact involving a nursing home resident.

Cosmetology/Hairstyling

In the Matter of Linda Kaiser, Beautician

On June 29, 2006, the State Board of Cosmetology and Hairstyling suspended the license of Linda Kaiser, beautician, indefinitely, based upon Kaiser having entered into a Consent Order with OIFP based upon disability fraud.

Bureau of Securities

In the Matter of David Wiseman, Securities Dealer

The New Jersey Bureau of Securities summarily revoked the license of David Wiseman, security dealer, to function as a securities dealer in the State of New Jersey. The action was based on a Summary Judgment entered against Wiseman for knowingly making statements containing false or misleading information in pursuit of an insurance claim against an insurance carrier for theft of personal property.

Department of Health and Senior Services/Office of EMS

In the Matter of Kevin Lewandowski, E.M.T.

The Department of Health and Senior Services/Office of EMS revoked the EMT certification of Kevin Lewandowski, EMT. The action was based on Lewandowski pleading guilty in Middlesex County Superior Court to conspiracy to commit aggravated arson following his involvement in a fraudulent stolen automobile theft claim.

OIFP/Government/Industry Contacts

Office of the Insurance Fraud Prosecutor

<i>Insurance Fraud Prosecutor</i>	Greta Gooden Brown	609-896-8779	Lawrenceville
<i>First Assistant Prosecutor</i>	John J. Smith, Jr.	609-896-8767	Lawrenceville
<i>Deputy Chief Prosecutor</i>	Norma Evans	609-896-8888	Lawrenceville
<i>Civil Litigation Section Chief</i>	Jennifer Fradel	609-896-8872	Lawrenceville
<i>Deputy Chief Investigator (Criminal)</i>	Nancy Beiger	609-896-8701	Lawrenceville
<i>Deputy Chief Investigator (Civil)</i>	Richard Falcone	609-896-8868	Lawrenceville
<i>Liaison Section Chief</i>	John Butchko	609-896-8747	Lawrenceville

OIFP Liaison Section

<i>County Prosecutor Liaison (Cases)</i>	John Kennedy	609-896-8894	Lawrenceville
<i>County Prosecutor Liaison (Programmatic)</i>	Joan Enright	609-896-8752	Lawrenceville
<i>Law Enforcement Liaison</i>	Joseph Luccarelli	609-896-8859	Lawrenceville
<i>Industry Liaison</i>	John Butchko	609-896-8747	Lawrenceville
<i>Assistant Industry Liaison</i>	Carol Naar	609-896-8712	Lawrenceville
<i>Professional Boards Liaison</i>	Charles Janousek	609-896-8748	Lawrenceville

OIFP Case Screening, Litigation and Analytical Support Section (CLASS)

<i>Supervising AAG</i>	John Kennedy	609-896-8894	Lawrenceville
<i>Supervising Investigator</i>	Michelle Apgar	609-896-8745	Lawrenceville

State of New Jersey Department of Banking and Insurance

<i>Fraud Compliance and Annual Report Supervisor</i>	Virgil Dowtin	609-984-7310 Ext. 50402	Trenton
<i>Producer Investigations Manager</i>	William O'Byrne	609-292-5316 Ext. 50032	Trenton

State of New Jersey Motor Vehicle Commission

<i>Business Licensing (Auto Body Repair Facility) Manager</i>	Yvonne Dawkins	609-777-1691	Trenton
<i>Security, Investigations and Internal Audit Director</i>	Ken Shuey	609-984-5279	Trenton
<i>Business License Compliance Monitoring Manager</i>	Peter Curatolo	609-984-1122	Trenton

State of New Jersey Department of Human Services

<i>Director, Division of Medical Assistance and Health Services (Medicaid and NJ Family Care)</i>	Ann C. Kohler	609-588-2600	Trenton
---	---------------	--------------	---------

State of New Jersey Department of Health and Senior Services

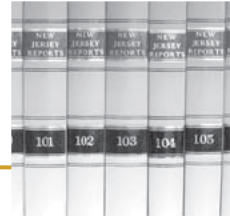
<i>Assistant Commissioner, Long-Term Care</i>	William Conroy	609-633-8977	Trenton
<i>Long-Term Care Licensing and Certification</i>	Barbara Goldman	609-633-9034	Trenton

State of New Jersey Division of Consumer Affairs

<i>Acting Director, Div. of Consumer Affairs (Professional Licensing Boards, etc.)</i>	Stephen B. Nolan	973-504-6200 800-242-5846	Newark (toll free NJ only)
--	------------------	------------------------------	-------------------------------

Industry Trade Groups

<i>Insurance Council of New Jersey</i>	Magdalena Padilla	609-882-4400	
<i>Property/Casualty Insurers of America</i>	Richard Stokes	609-396-9601	
<i>NJ Special Investigators Association</i>	Pete Vasquez	732-303-7857	
<i>NJ Vehicle Theft Investigators Association</i>	Brian Dimetrosky	973-534-9461	
<i>International Association of Special Investigative Units – Delaware Valley Chapter</i>	Thomas Donahue	610-276-3842	



County Prosecutor Insurance Fraud Contacts

Atlantic County	Chief Asst. Pros. James McClain Sgt. Samuel Cucciniello	609-909-7816 609-909-7866
Bergen County	Asst. Pros. Ralph Lilore Lt. Robert Dodd	201-226-5693 201-226-5538
Burlington County	Asst. Pros. Rose Marie Mesa Det. Wayne Raynor	609-265-5779 609-265-3147
Camden County	Sgt. Eric Rios Sr. Inv. Keith Sharper	856-225-8462 856-225-8448
Cape May County	Inv. George Hallett	609-465-1135
Cumberland County	1st Asst. Pros. Kenneth Pagliughi	856-453-0486
Essex County	Asst. Pros. Jeffrey Cartwright Asst. Pros. Michael Morris	973-266-7226 973-266-7232
Gloucester County	Asst. Pros. Margaret Cipparrone Det. William Perna	856-384-5648 856-384-5645
Hudson County	Asst. Pros. Michael Zevits Lt. James Hoppes	201-795-6529 201-533-2425
Hunterdon County	Det. Kristen Larsen	908-788-1580
Mercer County	Asst. Pros. Jeffrey Rubin Sgt. Frank LaBelle	609-278-8009 609-278-4863
Middlesex County	Exec. 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
Ocean County	Asst. Pros. Martin Anton Inv. Mark Malinowski	732-929-2027 732-929-2027 Ext. 4032
Passaic County	Asst. Pros. Robert Holmsen Lt. George Wall	973-837-7629 973-837-7631
Salem County	Inv. Matthew Clarke Inv. Jason Cobb	856-935-7510 Ext. 8525 856-935-7510 Ext. 8525
Somerset County	Det. John Fodor	908-575-3419
Sussex County	Asst. Pros. Rachelle Jones Det. Douglas Porter	973-383-1570 Ext. 4524 973-383-1570 Ext. 4403
Union County	Asst. Pros. James Tansey Sgt. Ana Zsak Det. Daniel Fay Det. James Russo	908-527-4570 908-527-4619 908-527-4723 908-527-4933
Warren County	Det. Clement Mezzanotte	908-475-6631