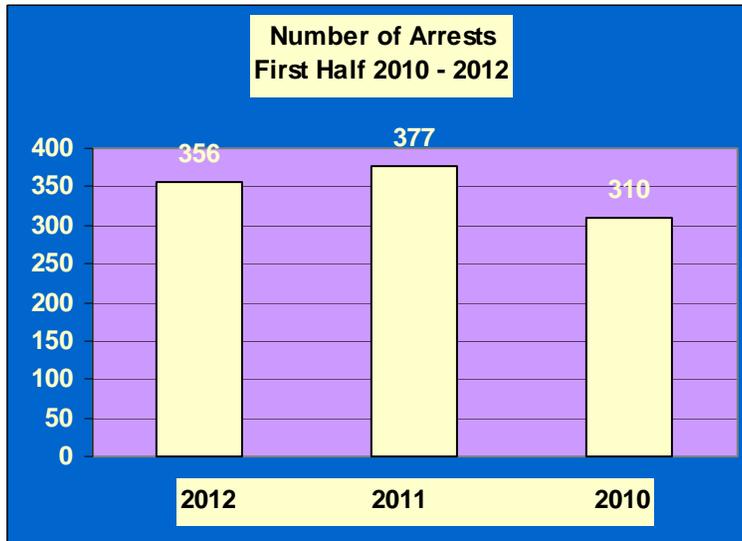


Arrests/Convictions/IFBs

First Half 2010 – 2012

- The Frauds Bureau recorded 356 arrests for the first half of 2012.



The following case summaries are among those that resulted in arrests during the January-June 2012 period:

- The 65th suspect in this long-term, no-fault fraud investigation was allegedly a “jump-in” to a car involved in an accident. He subsequently altered a Police Accident Report to make it appear that he was an injured passenger. New York Central Mutual Insurance Company was billed more than \$9,000 for this suspect’s nonexistent injuries. His 1/20/12 arrest was As the result of the collaborative efforts of the Insurance Frauds Bureau and the NYPD’s Fraudulent Accident Investigations Squad, he was arrested on 1/20/12 and charged with insurance fraud, larceny and forgery.
- An investigation by the Insurance Frauds Bureau and the State Insurance Fund led to the arrest on 1/9/12 of a Suffolk County contractor who had applied for and was issued a workers’ compensation insurance policy by the State Fund. On the application, he reported that his company had a payroll of \$10,000 and no employees with the exception of himself as a part-time worker. However, an audit of another State Fund policyholder revealed a payment of \$190,350 to the defendant’s business. In addition, sign-in documents at a Long Island business at which the contractor had done roofing work showed the signatures of three workers from the contractor’s

company on one occasion and “a crew” on another occasion. As a result of the fraud, the contractor avoided paying the State Fund \$37,753 in premiums owed.

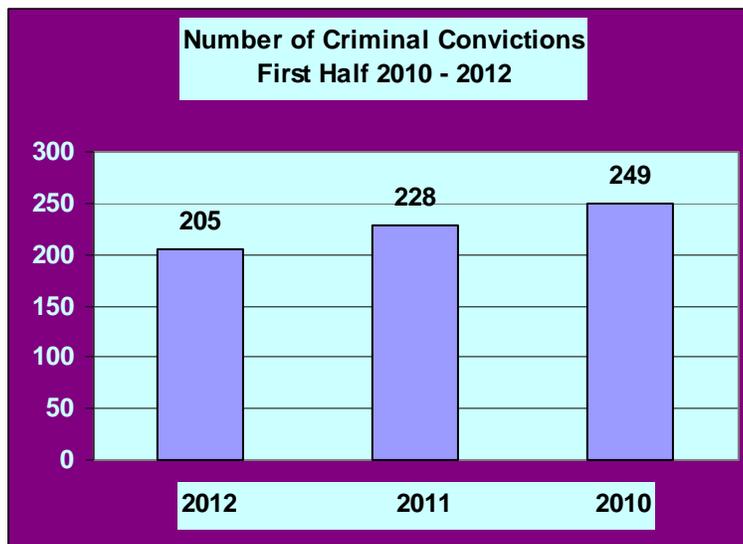
- In a follow-up to a November 2011 workers’ compensation fraud sweep in ten upstate counties, two suspects were arrested on 3/15/12, bringing the total number of arrests in this case to 21. The two most recent suspects were charged with offering a false instrument for filing for allegedly submitting false reports regarding an incident involving a co-worker arrested in the November sweep. The previously arrested suspect, a teacher aide, claimed she broke her ankle on the job when the accident actually occurred at her home. The Incident Report stating that the injury happened at work was completed and signed by the suspects arrested on 3/15/12. The arrests were the result of an investigation by the Insurance Frauds Bureau and the Workers’ Compensation Board’s Office of the Fraud Inspector General with the assistance of the State Insurance Fund.
- A Monroe County resident reported to Liberty Mutual Insurance Company that his 2011 Mustang had been stolen, that he had subsequently recovered it and was then involved in an accident while driving it. He filed a \$10,639 claim for the loss. However, an investigation by the Insurance Frauds Bureau, the Rochester and Webster Police Departments and the Monroe County DA’s Office as members of the Monroe County Auto Crime Task Force revealed that he had lent the car out to repay a drug debt and the person to whom he had lent it was actually driving when the accident occurred. When interviewed, the suspect admitted that he had falsely reported the car stolen and fabricated the rest of the story in order to collect the insurance payout.
- An investigation by the Insurance Frauds Bureau and the U.S. Attorney’s Office resulted in the arrest of the defendant in this case for allegedly submitting 14 forged Variable Annuity Surrender Request forms in the name of his deceased grandmother in order to withdraw \$37,175 from her annuity account. He had the money electronically transferred to his Internet bank account where he could easily make withdrawals. When interviewed during the investigation, the defendant admitted the fraud, stating that he did it in order to pay for his drug habit.
- An investigation by the Insurance Frauds Bureau and the Manhattan DA’s Office resulted in the arrest of three suspects for allegedly submitting hundreds of fraudulent claims for mental health treatments they never received. Two of the defendants were policyholders of a mental health insurer – OptumHealth Behavioral Solutions (OHBS) – that requires claimants who receive treatment from out-of-network providers to pay for those treatments and then file claims with OHBS for reimbursement. From June 2009 to September 2011, Defendant #1 in this case, a practicing psychiatrist, filed 206 claims for treatments she never received. In addition, she filed 19 legitimate claims for treatments but inflated the amounts she paid to her doctors. She was reimbursed a total of \$32,428 based on the fraudulent and inflated claims. Defendant #2 was accused of submitting more than 1,000 claims to OHBS from July 2010 to November 2011 seeking reimbursement for \$257,000 in mental

health services purportedly provided to her and her family by a doctor in Brooklyn. Investigators learned that this defendant allegedly fabricated both the services and the doctor. From 2006 to 2011, Defendant #3 filed more than 1,700 claims with her employer for mental health treatments she never received and 38 legitimate claims in which she inflated the amounts paid to her doctor. She was paid \$353,958 on the false and inflated claims. Moreover, she tried to steal another \$33,000 by submitting several claims multiple times. Her employer fully funds its own employee health plan and was, therefore, liable for the financial loss.

- An investigation by the Drug Enforcement Administration Tactical Diversion Task Force led to the arrest of 14 defendants charged with participating in the distribution of illegally diverted prescription drugs oxycodone and oxymorphone. From April 2011 through at least May 2012, they worked together to sell tens of thousands of pills on the streets of Upper Manhattan. During the execution of search warrants at five locations in the Bronx and Upper Manhattan, approximately 9,000 of the prescription pills, \$24,000 in cash and hundreds of bottles of HIV medications were recovered. Of the 14 defendants, 13 are currently in custody and one remains at large. This ongoing investigation was conducted by the Downstate Office of the Task Force and is being handled jointly by Task Force members including the DEA, the U.S. Attorney for the Southern District, the NYPD and the Insurance Frauds Bureau.
- An investigation by the Insurance Frauds Bureau led to the arrest of a saleswoman for Oxford Health Care for her participation in a scheme to fraudulently obtain sales commissions. Investigators learned that during 2008 and 2009, the defendant filed claims for sales commissions by falsely stating that she had sold certain Oxford products when, in fact, those products had been sold by one of her co-workers. She was able to carry out this scheme by gaining access to a restricted Oxford database that provided detailed information about each salesperson's monthly sales. She used this information to file the false claims and over the two year period collected \$24,053 in commissions to which she was not entitled.
- Three individuals and a check-cashing business were charged in the Eastern District of New York for their alleged roles in a money-laundering scheme that violated the Bank Secrecy Act (BSA). The defendants allegedly failed to follow reporting and anti-money laundering requirements for transactions. According to the indictment, a check-cashing store in Flushing, NY; its owner; and two other persons were charged with using the store to file false currency transactions reports (CTRs). The store's owner allegedly caused the business to fail to have an effective anti-money laundering (AML) program. In addition, he was charged with conspiring to commit tax violations with respect to the fees the store received in connection with the scheme. As part of the scheme, which lasted from June 2009 through June 2011, the other two defendants presented to the store's manager and other employees checks to be cashed at the store. The checks were written on accounts of shell corporations that appeared to be health-care related but in fact did no legitimate business. The indictment alleges that the employees accepted these checks and provided cash to the defendants and never obtained any identification documents or information. The store

allegedly filed CTRs that falsely stated the checks were cashed by foreign nationals who set up the shell corporations. The two defendants cashed checks totaling more than \$19 million during the course of the scheme. Approximately \$32 million has been seized from the store's bank accounts in connection with this case. In addition to the Insurance Frauds Bureau, the following agencies collaborated in the investigation that led to the arrests: The U.S. Justice Department; the Office of the U.S. Attorney for the Eastern District; U.S. Immigration and Custom Enforcement; the FBI; IRS Criminal Investigation; and the U.S. Department of Health and Human Services.

- The number of criminal convictions obtained by prosecutors in Insurance Frauds Bureau cases totaled 205 for the first six months of 2012.



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- The Insurance Frauds Bureau received 12,634 reports of suspected fraud during the first half of 2012, up from 12,050 received in the same period the year earlier, an increase of 4.8 percent.

**Number of Suspected Fraud Reports
Received First Half 2010- 2012**

