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February 27, 2009

To: the Governor, the State Comptroller, the Attorney General, the President Pro Tem of the Senate, the Speaker of the Assembly, the Chair of the Senate Finance Committee, the Chair of the Senate Health Committee, the Chair of the Assembly Ways & Means Committee, and the Chair of the Assembly Health Committee

I am pleased to submit the Annual Report of the Superintendent of Insurance on the efforts of the Insurance Frauds Bureau to investigate and combat health care fraud during 2008. Over the past year, the Frauds Bureau worked closely with law enforcement agencies throughout New York State to investigate and prosecute fraud in the health care sector.

Frauds Bureau investigations led to 171 arrests for health care fraud in 2008. This report highlights a number of major investigations undertaken this past year, including a 19-month investigation of a staged accident ring and an affiliated medical clinic in Manhattan. The investigation led to the indictment of 62 individuals and two corporations.

In an era of fiscal austerity, the Frauds Bureau recouped more than \$9 million in overpayments and \$78,551 in fines from five health care providers who improperly billed United Healthcare, which administers the Empire Plan, the primary health insurance plan for state employees.

In the coming year, the Frauds Bureau looks forward to continuing its longstanding tradition of collaborating with law enforcement agencies throughout the state to aggressively combat health care fraud.

Sincerely,

Eric R. Dinallo
Superintendent of Insurance

The Annual Report
of the Superintendent of Insurance
on the Activities of the
Insurance Department
to Investigate and Combat
Health Insurance Fraud
in Accordance with Section 410
of the New York State
Insurance Law

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2.	Number of Health Care Fraud Cases Opened - 2008	4

I. Health Care Fraud 2008 Highlights

- **The Frauds Bureau investigates and combats health care fraud, which includes three major types of insurance: health, private disability and no-fault.**
- **Health care fraud investigations conducted by the Frauds Bureau resulted in 171 arrests in 2008.**
- **Estimates by the National Health Care Anti-Fraud Association (NHCAA) put the cost of health care fraud at 3% of all health care spending, for a total of \$68 billion.**
- **The Frauds Bureau is a member of the FBI New York Health Care Fraud Task Force, a multi-agency group established in 2007 to address health care fraud in the New York metropolitan area.**
- **There were 14,142 reports of suspected health care fraud received by the Frauds Bureau during 2008 – 1,421 involved accident & health insurance, 382 involved disability insurance and 12,339 involved no-fault.**
- **New York State has received more than \$9 million in refunds and \$78,551 in fines from five health care providers who inappropriately billed United HealthCare, administrator of the Empire Plan. The bills did not reflect the fact that the out-of-network providers were systematically waiving co-insurance payments that were required to be paid by patients.**
- **A 19-month investigation led to the indictment of 62 individuals and two businesses, accused of staging more than 40 auto accidents over a three-year period and submitting fraudulent claims under no-fault. The investigation was conducted by the Frauds Bureau and other members of the FBI New York Health Care Fraud Task Force.**
- **An investigation by the Frauds Bureau resulted in the arrest of a suspect accused of stealing the identity of another person and purchasing disability income insurance in that person's name. He subsequently filed a claim and collected a total of \$141,620 in benefit checks issued to the person whose identity he had assumed.**

II. The Insurance Frauds Bureau

A. Health Care Fraud

The Frauds Bureau investigates insurance fraud, including health care fraud, throughout New York State. The Bureau is headquartered in New York City, with five offices across the upstate region: Albany, Syracuse, Rochester, Buffalo and Oneonta. A full list of office locations, including addresses and telephone/fax numbers, appears on the last page of this Report.

For the purpose of this Report, we will use the term health care to include investigations of health, private disability and no-fault fraud. The State's no-fault system provides for the payment of benefits to victims of motor vehicle accidents.

B. Types of Health Care Fraud

Frauds Bureau investigators work closely with the insurance industry and law enforcement agencies on the federal, state and local levels to combat health care fraud schemes. Such schemes increase health insurance premiums for all consumers.

The following are some of the more common types of health care fraud.

- Billing for services that were not rendered;
- Billing for more expensive procedures than were actually provided, a practice known as upcoding;
- Performing medically unnecessary treatments;
- Filing claims for nonexistent injuries;
- Filing false or exaggerated medical disability claims;
- Misrepresenting noncovered treatments as medically necessary covered treatments; and
- Unbundling, i.e., billing as if each step of a procedure were a separate procedure.

A review of health care fraud reports received by the Bureau in 2008 showed an increase in upcoding, billing for services not provided, and billing for unnecessary medical testing such as electromyographies (EMGs).

C. The Costs of Health Care Fraud

According to the National Health Care Anti-Fraud Association (NHCAA), \$2.26 trillion was spent on health care and more than 4 billion health insurance claims were processed in the United States during 2007. NHCAA estimates "conservatively" that 3% of all health care spending – \$68 billion – is lost to health care fraud. No matter what the source of your health care coverage, whether it is employer provided or purchased individually, health care fraud results in higher premiums, increased out-of-pocket costs and reduced benefits or coverage.

III. Attacking the Problem of Health Care Crime

A. FBI New York Health Care Fraud Task Force

The Frauds Bureau is a member of the FBI New York Health Care Fraud Task Force, a multi-agency group established in 2007 to address health care fraud in the New York metropolitan area. The mission of the Task Force is to identify, investigate and prosecute health care fraud. The FBI is the lead agency for the Task Force, whose members include agents and detectives from the FBI, the NYPD, investigators from the Frauds Bureau, and other federal, state and local law enforcement agencies, as well as the insurance industry. (A summary of a major no-fault insurance fraud scheme investigated by the Frauds Bureau and other members of the FBI New York Health Care Fraud Task Force appears on p. 6.)

B. Other Group Participation

The Frauds Bureau actively participates in several other task forces and working groups designed to foster cooperation among the many agencies involved in fighting health care fraud. Participation provides the opportunity to share information and hone investigative skills. Among those groups whose members investigate health care fraud are the Central New York Health Care Fraud Working Group and the Western New York Health Care Fraud Task Force. (A case involving felony health care fraud investigated by the Western New York Health Care Fraud Task Force is summarized on p. 7.)

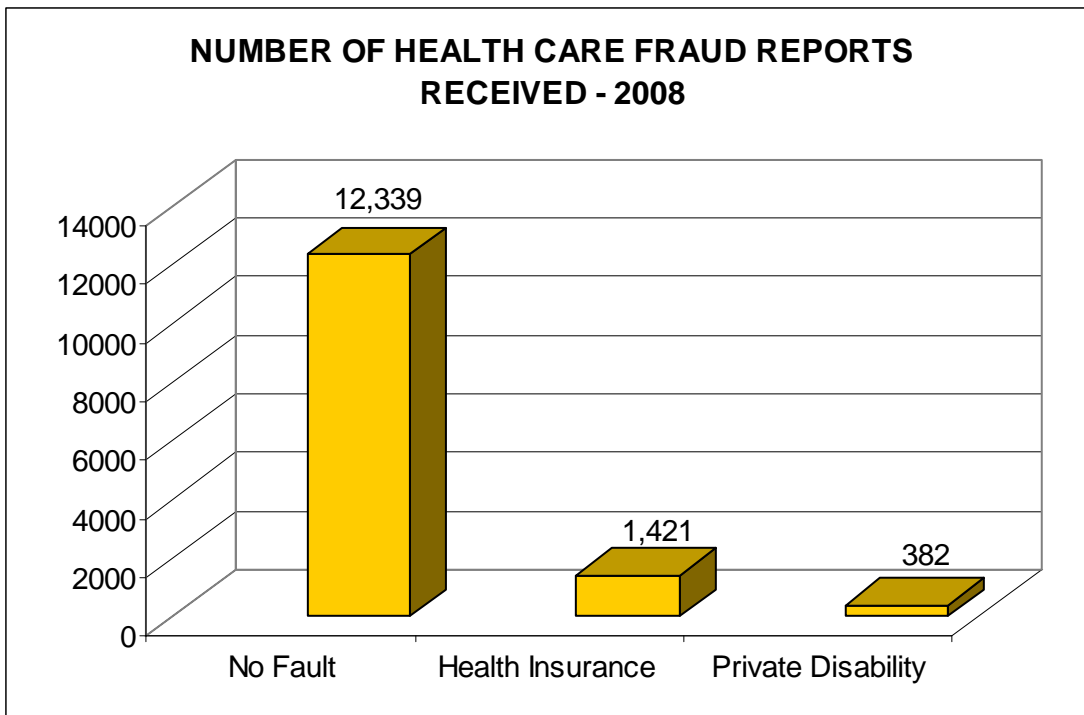
IV. Reporting and Preventing Insurance Fraud

A. Insurance Company Reporting

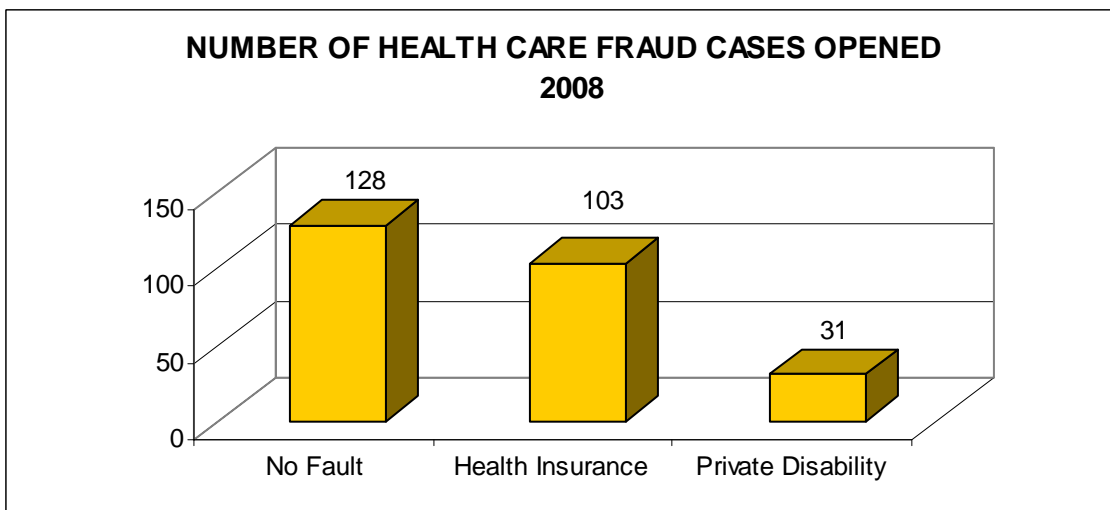
Insurers are required by Section 405 of the Insurance Law to report suspected fraud to the Frauds Bureau. The Bureau has a Web-Based Case Management System, known as FCMS, that allows insurers to submit reports of suspected fraud electronically via the Web site. The system has been fully operational since the first quarter of 2007. In 2008, approximately 90% of the 23,054 fraud reports received by the Bureau were transmitted electronically and received remotely from insurers. Insurers have access to FCMS through the Department portal using secure accounts.

There were 14,142 reports of suspected health care fraud received by the Frauds Bureau during 2008 – 1,421 involved accident and health insurance, 382 involved disability insurance and 12,339 involved no-fault. A total of 262 new health care fraud cases were opened for investigation in 2008. (It should be noted that frequently one case can be linked to multiple fraud reports.) At the same time, investigations continued in numerous cases that were opened in prior years. All told, Frauds Bureau health care fraud investigations resulted in 171 arrests in 2008.

Graph 1



Graph 2



B. Compliance with Section 409 of the Insurance Law

Section 409 of the New York Insurance Law requires insurers that write at least 3,000 policies of auto, workers' compensation or accident and health insurance in New York State to submit to the Department a Fraud Prevention Plan for the detection, investigation and prevention of insurance fraud. The Plans must provide for a full-time Special Investigations Unit (SIU) as well as specific staffing levels within the SIU.

There were 68 approved insurer SIUs dedicated to investigating health care fraud in New York State in 2007 (the latest year for which data are available). These insurers comprised accident and health insurers, HMOs, life insurers and nonprofit medical and dental indemnity or health service corporations. In addition, there were nine approved SIUs of property and casualty insurers writing accident and health insurance during 2007.

Accident and Health insurers reported \$77.0 million in savings resulting from SIU investigations in 2007. In addition, the nine Property and Casualty insurers writing accident and health insurance reported \$1.5 million in savings.

The Frauds Bureau monitors insurer compliance with Section 409 via the analysis of data included in the Annual SIU Reports, which are required by Section 409(g). A new law passed last year changed the SIU reporting date from January 15 to March 15 of each year. In addition, the Bureau conducts market conduct examinations of insurer SIUs to ensure compliance with Section 409.

C. Fraud Prevention Plan Requirements

The Frauds Bureau has established very specific requirements for the type of information that must be included in Fraud Prevention Plans. The most critical is the requirement for insurers to incorporate into their Plans an assessment of their vulnerability to fraud and to detail the methods by which they intend to reduce that vulnerability.

Among the other provisions in the Plans, insurers are required to:

- Provide for a full-time Special Investigations Unit separate from the underwriting and claims function;
- Describe the organization of the Special Investigations Unit, such as titles and job descriptions of investigative staff, minimum qualifications for employment, and the geographical location and assigned territory of each investigator.
- Provide the rationale for the level of staffing and resources devoted to the Special Investigations Unit based on objective criteria;
- Provide for in-service training for investigative, underwriting and claims personnel in identifying and evaluating instances of suspected fraud; and
- Develop a public awareness program focused on the cost and frequency of insurance fraud and the methods by which the public can assist in preventing fraud.

D. Public Awareness Programs

Insurer Public Awareness Programs must be geared to reach a wider audience than an insurer's policyholders and applicants. Toward that end, the New York Alliance Against Insurance Fraud and the National Health Care Anti-Fraud Association carry out advertising campaigns using newspapers, radio and television to target insurance consumers. The New York Alliance Against Insurance Fraud, a coalition of insurers that write property/casualty, life, and health insurance in New York State, performed the public awareness programs for more than 90 insurers with fraud prevention plans on file with the New York State Insurance Department. Further, the National Health Care Anti-Fraud Association performed the public awareness programs for an additional 19 health insurers with fraud prevention plans on file with the Department. In addition, several individual insurance companies have ongoing programs to heighten awareness and reduce public tolerance for insurance fraud. As a result, these anti-fraud messages reach millions of New Yorkers during the course of the year.

E. Consumer Reporting

Consumers are encouraged to report suspected fraud to the Bureau. To facilitate reporting, the Bureau maintains a toll-free hotline (1-888-FRAUDNY) for consumers to report their suspicions. Once a report is received, a Bureau investigator will contact the caller for details and the matter will be kept confidential. Such calls averaged about 37 a week during 2008. The Web site also includes a link to a fraud report form and instructions for consumers to report fraud by mail or fax.

V. *The Year in Review*

A. Major Cases

Numerous health care fraud investigations were conducted during the past year. Below are summaries of some of these cases.

Operation Direct Hit

- A 19-month investigation led to the indictment on 10/29/08 of 62 individuals and two businesses, accused of staging more than 40 auto accidents over a three-year period. The ring targeted unsuspecting Asian drivers who, while backing out of a driveway or a parking lot, would be deliberately hit by a car full of passengers, all of whom were participants in the fraud. Occupants of the cars involved were then sent to the same Upper Manhattan medical clinic whose operators were knowing accomplices in the scheme. In fact, these operators allegedly paid "runners" up to \$2,500 for each person referred to the clinic. The "patients" were also paid. The scheme defrauded insurers of \$1.6 million. The investigation was conducted jointly by the Frauds Bureau, the Queens DA's Office, NYPD's Fraudulent Accident Investigation Squad, other members of the FBI New York Health Care Fraud Task Force, and several insurance companies.

Forged Disability Checks

- The defendant in this case allegedly cashed disability benefit checks issued to her husband for more than five years after his death. An investigation by the Frauds Bureau revealed that from March 2002 through December 2007, she forged her husband's signature to a total of \$75,900 in benefit checks from Northwestern Mutual Life Insurance Company, while filing reports intended to mislead the insurer into thinking her husband was still alive.

Stolen Premiums

- An investigation by the Frauds Bureau, the Cobleskill Police Department and the Schoharie County DA's Office led to the arrest on 6/17/08 of a hardware store owner amid allegations that from November 2007 to April 2008, he collected health insurance premiums from an employee that were supposed to provide coverage for the employee and his family. However, investigators learned that the store owner never applied the payments to the employee's health insurance plan. A family member, unaware that he was without coverage, incurred \$11,000 in medical bills before the fraud was discovered. The suspect was charged with grand larceny and scheme to defraud.

Medical Mill Take-Down

- On 3/11/08, eleven persons, including three doctors, a chiropractor, two acupuncturists, other employees of a medical clinic, and ten corporations were charged in an 84-count indictment with operating a medical mill that cheated insurers of more than \$6.2 million over a five-year period. Two other suspects who allegedly assisted in the criminal affairs of the enterprise were charged in separate indictments. The enterprise used "runners" to stage accidents and bring "patients" to the clinic where medical providers prescribed unnecessary treatments and procedures, falsified medical records and submitted fraudulent claims to insurers. Four management and realty companies and six professional corporations were used to conceal parts of the operation and to launder the proceeds. The Frauds Bureau, the Manhattan DA's Office, NYPD's Fraudulent Accident Investigation Squad, GEICO and MetLife Insurance Companies and the National Insurance Crime Bureau pooled resources in the investigation that led to the take-down. The DA's Office has also begun a civil forfeiture action against the 11 individuals and ten corporations to recover the more than \$6.2 million stolen from insurers while the medical mill was in operation.

Felony Health Care Fraud

- A licensed clinical social worker was arrested on 2/20/08 and pleaded guilty to felony health care fraud for billing several insurers for more than \$500,000 for services he never provided. In July 2008, he was sentenced to serve one year in federal prison and ordered to pay restitution of \$100,000. In addition, he was

ined \$90,000 and agreed to forfeit a Florida home valued at \$400,000. A search warrant was executed at his home in Tonawanda, NY, where federal agents and Frauds Bureau investigators seized records and documents as evidence in the case. The case was investigated by the Western New York Health Care Fraud Task Force, of which the Frauds Bureau is a member.

Identity Theft

- An investigation by the Frauds Bureau uncovered evidence that the defendant assumed the identity of another person about 20 years ago. Then in 1990, using the stolen identity, he purchased disability income insurance from UNUM Provident Insurance Company. In 1999, he filed a claim under his policy coverage and from March 1999 through April 2007, he collected \$1,460 a month, a total of \$141,620, in benefit checks issued to the person whose identity he had assumed. That person presently resides in a Connecticut nursing home. The investigation further revealed that the defendant had two felony convictions prior to 1980. However, on his application for the disability income benefits, he answered “no” when asked if he had ever been arrested or convicted of a crime. The policy would not have been issued if UNUM had been aware of his criminal record. He was arrested on 12/9/08 and charged with identity theft in the 1st degree.

Two Caused Accidents

- A Brooklyn laborer was charged with conspiring with others to intentionally cause two auto accidents. The first, which occurred on 1/28/04, caused Statewide Insurance Company to be fraudulently billed \$23,000 in no-fault medical benefits and Liberty Mutual Insurance Company to be fraudulently billed \$35,000 in no-fault benefits. Following the second accident, which took place on 10/13/07, GEICO Insurance Company was fraudulently billed \$4,000 in no-fault benefits. The Frauds Bureau and the NYPD conducted the investigation that led to the defendant’s arrest on 5/28/08.

Forged

- A Schenectady woman submitted a medical request form for disability benefits to CIGNA Insurance Company. The insurer suspected that the doctor’s signature on the form was forged and reported their suspicions to the Frauds Bureau. Investigators conducted interviews with the doctor and his staff and were able to verify that the signature was indeed forged. The investigation led to her arrest on 11/19/08.

Collecting While Working

- Following an investigation by the Frauds Bureau and the Niagara County DA’s Office, an upstate man was arrested on 7/9/08 on charges that from 8/13/03 to 6/28/07, he illegally collected \$54,500 in disability benefits from Hartford Insurance Company. He submitted an application to Hartford for long-term

disability benefits, together with other supporting documents, in which he stated that he was unable to work. However, the investigation revealed that during the benefits period, he had been employed at a number of jobs, including work at a hospital and a gambling casino.

False Claims

- The suspect in this case claimed that she was unable to work due to dizziness, allergies, a sore throat and heart palpitations. She filed a claim with State Farm Insurance Company under her disability insurance policy. In addition, she submitted numerous documents allegedly from her doctors confirming her disability status. However, an investigation by the Frauds Bureau uncovered evidence that her doctors had not prepared the disability forms that she submitted to her insurer. As a result of the fraud, from 9/9/04 to 9/20/06, she fraudulently collected \$37,750 in benefits. She was arrested on 12/4/08 on charges of grand larceny, possession of a forged instrument, insurance fraud and falsifying business records.

Treatments Not Covered

- The defendant in this case submitted claims to MVP Health Plan for office visits and laboratory tests that she stated had occurred after September 2007 when her health insurance coverage became effective. However, an investigation by the Frauds Bureau uncovered evidence that the defendant had altered the billing dates for the tests and visits which had actually taken place in July and August 2007, a time period that predated her coverage. She was arrested on 6/8/08 and charged with insurance fraud, falsifying business records and forgery.

Chiropractor Caught

- An investigation by the Frauds Bureau, the Workers' Compensation Board's Office of the Fraud Inspector General and the Suffolk County DA's Office led to the arrest on 11/20/08 of a chiropractor who allegedly continued to submit claims for treating a patient four years after the treatments ended. According to investigators, the suspect provided chiropractic treatments to the patient for ten years until 2004. However, he was charged with filing 96 fraudulent claims totaling \$3,201 with CNA Insurance Company from 2004 until May 2008 for services that were never rendered. The fraudulent claims were discovered when the insurer contacted the former patient to verify whether she was still being treated.

B. Waiver of Co-Insurance

New York State has received more than \$9 million in refunds and \$78,551 in fines from five health care providers that inappropriately billed United Health Care, which administers the Empire Plan, the primary health insurance plan for State employees. The bills submitted by the providers did not reflect the fact that the out-of-

network providers were systematically waiving co-insurance payments that were required to be paid by Empire Plan members. Because payments should reflect the actual charge, the bills were improperly inflated by the amount waived. Following reports by the New York State Comptroller that the providers were waiving the required co-insurance payments, the New York State Insurance Department conducted its own investigation and as a result received signed stipulations from four of the five providers. In those stipulations, the four providers agreed to pay civil fines to the Insurance Department and to reimburse United Health Care for the overpayment of the claims. The stipulations also state that the providers will discontinue the practice of waiving the co-insurance payments for Empire Plan members. These four providers are:

- Endoscopy Center of Long Island, which reimbursed the State \$3,135,834 and paid a civil penalty of \$31,358;
- Capital Region Ambulatory Surgery Center, Albany, which paid \$2,225,015 in reimbursement and \$22,250 in fines;
- Digestive Health Center of Huntington, Huntington, which repaid \$1,332,120 and paid \$13,321 in fines; and
- Day Op of North Nassau, Great Neck, which repaid \$1,162,232 and paid a fine of \$11,622.

The Department is negotiating fines and reimbursement with a number of other providers involved in this investigation.

C. 2008 Training

Frauds Bureau investigators participated in training seminars and continuing education courses during the year in order to keep current with emerging developments in fraud fighting.

L. David Covino, Director of the Special Investigations Unit at UNUM Insurance Company, conducted a training session on the subject of disability insurance fraud in October. His presentation focused on the types of disability fraud and ways to recognize this serious crime. He conducted the training from the Frauds Bureau's Albany Office, with a video conference hook-up to our New York City, Syracuse and Buffalo Offices. Approximately 50 investigators participated in the training.

In mid-April, several Bureau investigators attended a seminar on "Organized Groups in Health Care Fraud." A Special Agent from the FBI's Organized Crime Unit provided a detailed presentation on no-fault fraud rings.

In addition, the Bureau's Training Officer and other members of the investigative staff provided training for local police and fire units, prosecutors, insurers and others throughout the year. The Bureau provided training to 31 groups that included 2,396 participants during 2008.

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