



NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

March 15, 2013

Dear Governor Cuomo, Comptroller DiNapoli, Attorney General Schneiderman, President Pro Tem Skelos, Majority Coalition Leader Klein, Speaker Silver, Chairman DeFrancisco, Chairman Hannon, Chairman Farrell, and Chairman Gottfried:

On behalf of the Department of Financial Services, I hereby submit this report required by Section 409(c) of the Financial Services Law summarizing the Department's activities to investigate and combat health insurance fraud.

Like last year's report, this report highlights the importance of fighting no-fault fraud, which costs New Yorkers hundreds of millions of dollars in insurance costs. The number of suspected no-fault fraud reports received by the Department increased by 16 percent from 2011 to 2012. Reports of no-fault fraud totaled 90 percent of health insurance fraud reports, up from 85 percent in 2011, and more than half of reports of fraud of all types, making no-fault fraud again the biggest single fraud issue faced by the Department.

DFS has been carrying out Governor Cuomo's statewide initiative to stop deceptive doctors and shut down medical mills that plague New York's no-fault insurance payment system in three phases, with each phase consisting of a particular group of providers. The first phase consists of downstate providers, the second phase consists of providers who have been found guilty of professional misconduct and/or convicted of a crime in connection with services provided under the no-fault law, and the third phase consists of upstate providers. Details about the three phases are set forth in this report.

This report also highlights some of the major investigations undertaken during 2012, including many investigations conducted jointly with fellow law enforcement agencies. These investigations resulted in the arrests and prosecutions of individuals whose schemes were responsible for millions of dollars of fraudulent claims to insurance companies. Overall, investigations by the Department led to 195 arrests for health care fraud in 2012.

The Department and its Financial Frauds and Consumer Protection Division (FFCPD) will continue to aggressively combat health care fraud in the coming year.

Respectfully submitted,

Benjamin M. Lawsky
Superintendent of Financial Services



Annual Report on the Activities of the Department to Investigate and Combat Health Insurance Fraud

As required by § 409(c) of the Financial Services Law

March 15, 2013

Benjamin M. Lawskey
Superintendent
New York State Department of Financial Services

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Introduction

Through the enactment of the Financial Services Law, the Banking and Insurance Departments were merged into a single Department of Financial Services (DFS) which began operating on October 3, 2011. The merger was proposed as a way to establish a single regulatory agency with a broad overview of the entire range of financial services, as well as to capitalize on efficiencies through government restructuring. To that end, DFS is tasked with consolidating regulatory and non-regulatory functions and working to identify ways to become a more efficient and effective regulator.

This report, required under Section 409(c) of the Financial Services Law, summarizes the activities of the Department in combating health insurance fraud during 2012.

Fin. Serv. L. § 409(c) provides: No later than March fifteenth of each year, beginning in two thousand twelve, the superintendent shall furnish to the governor, the state comptroller, the attorney general, the temporary president of the senate, the speaker of the assembly, the chairpersons of the senate finance and health committees, and the assembly ways and means and health committees, a report summarizing the department's activities to investigate and combat health insurance fraud including information regarding referrals received, investigations initiated, investigations completed, and any other material necessary or desirable to evaluate the department's efforts.

2012 Highlights

The Department's Insurance Frauds Bureau investigates and combats health care fraud, which includes three major types of insurance: accident and health, private disability and no-fault.

- A total of 88 health care fraud investigations were opened in 2012. In addition, investigators recorded 195 arrests during the past year.
- The Department received 15,475 reports of suspected health care fraud, including 13,944 involving no-fault, 1,389 involving accident and health insurance and 142 involving disability insurance.
- Reports of suspected no-fault fraud accounted for 58 % of the 24,038 reports of all types of fraud received during 2012, versus 51% during 2011.
- The combined Upstate/Downstate Office of the Drug Enforcement Administration Tactical Diversion Task Force, of which the Insurance Frauds Bureau is a member, made 70 arrests during the year. The Task Force investigates organized drug diversion schemes, "doctor shopping" and forgery of controlled-substance subscriptions.

This report, required under Section 409(c) of the Financial Services Law, summarizes the activities of the Department in investigating and combating health insurance fraud during 2012. The Financial Frauds and Consumer Protection Division is headquartered in New York City, with an office in Mineola and five offices across the upstate region: Albany, Syracuse, Rochester, Buffalo and Oneonta. The Bureau has a longstanding commitment to combating

insurance fraud and strives to serve the people of New York State with dedication, professionalism and distinction.

The Insurance Frauds Bureau

Role in Investigating Health Care Fraud

The Financial Services Law created a new Financial Frauds and Consumer Protection Division (FFCPD). The Insurance Frauds Bureau is part of FFCPD's Criminal Investigations Unit.

Health Care Fraud

The Department investigates insurance fraud, including health care fraud, throughout New York State. Health care fraud involves three major types of insurance: accident and health, private disability and no-fault.

Types of Health Care Fraud

Department 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 insurance premiums for all consumers.

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

- Pharmaceutical fraud.
- Billing for services that were never rendered.
- Billing for more expensive procedures than were actually provided, commonly known as upcoding.
- Performing medically unnecessary treatments and expensive diagnostic tests for the purpose of generating insurance payments.
- Misrepresenting non-covered treatments as medically necessary covered treatments, e.g., cosmetic nose surgery billed as deviated septum repair.
- Unbundling – billing as if each step of a procedure were a separate procedure.
- Staging or causing auto accidents.
- Filing no-fault claims for nonexistent injuries.
- Filing false or exaggerated medical disability claims.
- Staging fake slip-and-fall accidents.
- Accepting kickbacks for patient referrals.

A review of health care fraud reports received by the Department in 2012 showed that the Bureau continued to receive numerous allegations of pharmaceutical fraud and/or diversion of controlled substances. In addition, reports of medically unnecessary treatments and expensive diagnostic tests increased.

The High Cost of Health Care Fraud

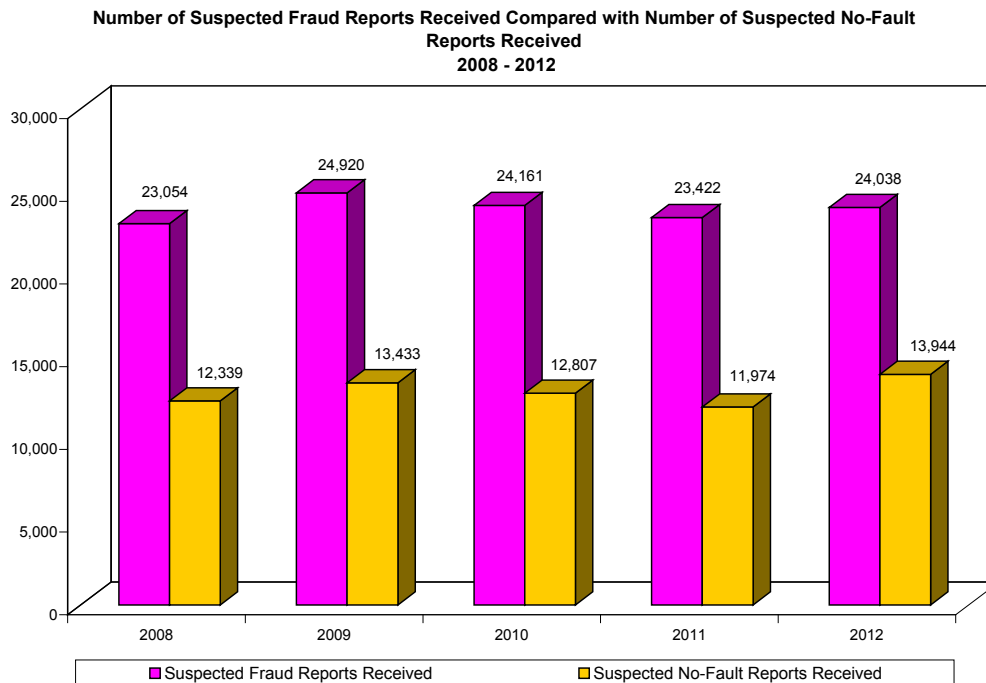
Health care fraud is a costly and pervasive drain on the national health care system. Though experts vary in their estimates, all agree that the costs of health care fraud are exorbitant. The U.S. spends more than \$2 trillion on health care annually and the National Health Care Anti-Fraud Association (NHCAA) has estimated that at least 3 percent of that spending – or \$68 billion – is lost to fraud each year. Combating fraud and abuse helps rein in the escalating costs of health care in the United States.

No-Fault Fraud

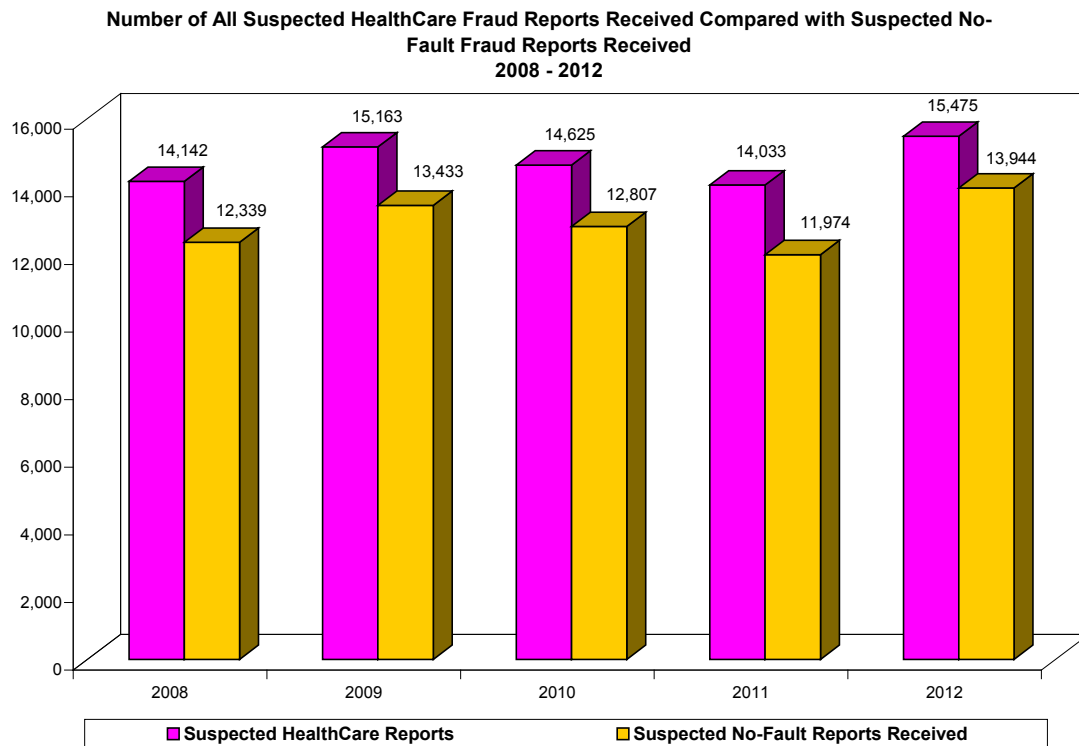
The number of suspected no-fault fraud reports received by the Department increased by 16% from 2011 to 2012. Suspected no-fault fraud reports accounted for 58% of all fraud reports received by the Department in 2012, versus 51% in 2011.

The number of suspected no-fault fraud reports made up 90% of all health care fraud reports in 2012 and have accounted for approximately 85% of total health care fraud reports since at least 2008.

Suspected Fraud Reports Compared to Suspected No-Fault Fraud Reports



Suspected Healthcare Fraud Compared to Suspected No Fault Fraud Reports Received



Combating no-fault fraud is one of the Department's highest priorities. In early March 2012, Governor Cuomo announced a statewide initiative to stop deceptive health care providers and shut down medical mills that plague New York's no-fault payment system and cost New Yorkers hundreds of millions of dollars in insurance costs.

DFS has carried out the initiative in three phases, with each phase consisting of a particular group of providers.

DFS will continue to utilize the procedures contained in Section 5109 and Regulation 68-E to deauthorize providers who engage in unlawful conduct. Toward that end, each provider that violates Section 5109 will be subject to a Departmental hearing to determine whether or not the provider should be barred from the no-fault system.

Collaborative Efforts to Combat Health Care Fraud

The Insurance Frauds Bureau is a member of several task forces and working groups designed to foster cooperation and communication among the many law enforcement agencies involved in combating health care fraud. Participation provides the opportunity to plan joint investigations, share information and hone investigative skills. Toward that end, several of the Bureau's investigators have been assigned to these groups and partner with other members in investigating cases involving health care fraud:

Drug Enforcement Administration Tactical Diversion Task Force

The Task Force investigates organized drug diversion schemes, “doctor shopping” and forgery of controlled-substance prescriptions. Successful investigations conducted by the combined Upstate/Downstate Task Force resulted in 70 arrests in 2012. A Bureau investigator is assigned full time to each office of the Task Force to work side-by-side with other members. An investigation conducted by the Downstate Office of the Task Force led to the arrest in May of 14 defendants charged with participating in the distribution of illegally diverted prescription drugs oxycodone and oxymorphone. Summaries of this case and several others conducted by the Task Force are detailed later in this Report.

FBI New York Health Care Fraud Task Force

The New York Task Force was part of a takedown conducted by a nationwide strike force that resulted in charges against 92 suspects in schemes to defraud the Medicare and Medicaid programs of \$432 million in fraudulent claims. Of those arrested, 15 were suspects in three New York Task Force cases. In one case, nine people, including the manager and medical director of a medical facility in Brooklyn, were charged with conspiring to defraud the Medicare and Medicaid programs of more than \$13 million by submitting fraudulent claims for physical therapy that was not provided or was medically unnecessary. In another case, four licensed chiropractors allegedly failed to provide chiropractic services to patients residing in assisted-living facilities, yet billed Medicare for \$6.4 million. In the third case, the office manager of a Queens medical clinic and the owner of an ambulette service received \$3 million from Medicare after claiming to provide physical therapy and diagnostic tests to patients who were paid cash kickbacks to use those two defendants’ medical and ambulette services. The arrests took place in October and charges brought against the suspects included health care fraud, wire fraud, violations of the kickback statutes and money laundering.

Other Group Participation

The Insurance Frauds Bureau also actively participates in the Western New York Health Care Fraud Task Force, the FBI/U.S. Attorney Health Care Fraud Working Group and the Medicare Fraud Strike Force, among others. Participation provides the opportunity for studying trends, planning strategies and conducting joint investigations.

Reporting and Preventing Insurance Fraud

Insurance Company Reporting

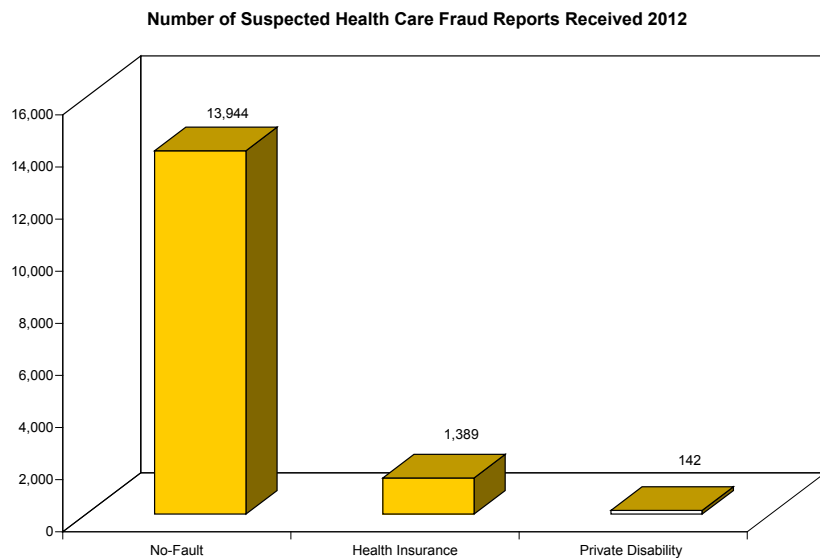
Insurers are required by Section 405 of the Insurance Law to report suspected fraud to the Department. The Department has a Web-based Case Management System, known as FCMS, that allows insurers to submit reports of suspected fraud electronically. The system has been fully operational since the first quarter of 2007. In 2012, approximately 95% of the 24,038 fraud reports received by the Bureau were transmitted electronically and received remotely from insurers. Insurers have access to FCMS through the Department’s portal using secure accounts.

The benefits of FCMS to insurers include automatic acknowledgment of receipt of fraud reports, and automatic notification of case assignments and eventual case disposition. Insurers also

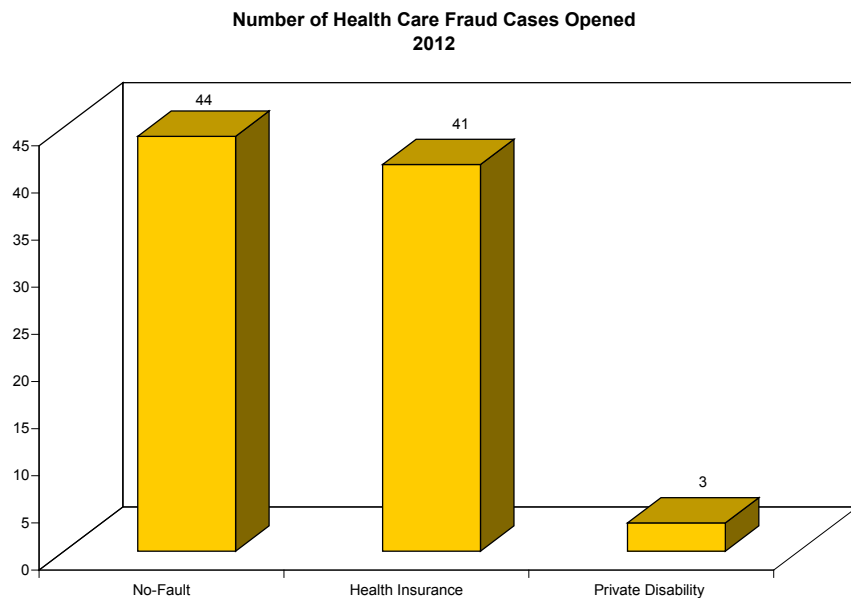
benefit from on-line help screens and an on-line manual of operations, as well as search and cross-reference features. Department staff members regularly monitor the system and make improvements and changes as necessary.

The Department received 15,475 reports of suspected health care fraud during 2012 –1,389 involving accident and health insurance, 142 involving disability insurance and 13,944 involving no-fault. A total of 88 new health care fraud cases were opened for investigation. Of these, 41 involved accident and health, 3 involved disability and 44 involved no-fault. (It should be noted that multiple fraud reports frequently can be linked to one case). At the same time, investigations continued in numerous cases that were opened in prior years. Health care fraud investigations by the Department resulted in 195 arrests in 2012.

Suspected Health Care Fraud - Reports Received 2012



Health Care Fraud – New Cases 2012



Consumer Reporting

Consumers are encouraged to report suspected fraud to the Department. The Bureau maintains a toll-free hotline to facilitate reporting. Once a report is received, an investigator contacts the caller for details maintained on a confidential basis. The Department recorded an average of 26 calls per week during 2012. The “Consumers” section on the Department’s website includes a link to a fraud report form and instructions that consumers can use to report fraud to the Department. The section is designed to help consumers recognize, report and combat insurance fraud.

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 (or individuals if written on a group basis) 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 Plan must provide for a full-time Special Investigations Unit (SIU), as well as specific staffing levels within the SIU.

In 2012, there were 64 approved insurer SIUs dedicated to investigating health care fraud in New York State. These SIUs included accident and health insurers, HMOs, life insurers, nonprofit medical and dental indemnity or health service corporations. In addition, 15 property and casualty insurers with approved SIUs reported writing accident and health insurance business during 2012.

Health and life insurers reported \$108.9 million in savings resulting from SIU investigations in 2011 (the latest year for which data are available). Health and life insurers reported \$28.8 million in recoveries from SIU investigations. In addition, four property and casualty insurers writing accident and health insurance reported \$4.2 million in savings.

The Insurance Frauds Bureau monitors insurer compliance with Section 409 via the analysis of data included in the annual SIU Reports. The Bureau may perform market conduct field examinations of insurer SIUs to ensure compliance with Section 409.

Fraud Prevention Plan Requirements

Section 409 sets out specific requirements for the type of information that must be included in Fraud Prevention Plans. For example, the Plans must provide for an SIU separate from claims and underwriting and must include details regarding the staffing and other resources dedicated to the SIU. In order to be designated an SIU investigator, individuals must meet certain educational and/or professional experience criteria as specified in Section 409 and Department Regulation 95.

Section 409 and Department Regulation 95 also require the following information and/or procedures to be included in all Fraud Prevention Plans:

- Interface of SIU personnel with law enforcement and prosecutorial agencies.

- Coordination with other units of the insurer for the investigation and initiation of civil actions based on information received by or through the SIU.
- Development of a fraud detection and procedures manual to assist in the detection and elimination of fraudulent activity.
- The rationale for the level of staffing and resources devoted to the SIU based on objective criteria.
- In-service training of investigative, claims and underwriting personnel in identification and evaluation of insurance fraud.
- Development of 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.

Electronic Submission of Fraud Prevention Plans

The Department has initiated a Web-based system for the submission of insurer Fraud Prevention Plans. Beginning in 2013, insurers will submit their Plans to the Department electronically via the portal application “Fraud Prevention Plans.” All Plans will be electronically stored and insurers will be able to access their Plans via the portal. Additionally, the Bureau will begin scanning prior Plans into the portal during the coming year.

Public Awareness Programs

The New York Alliance Against Insurance Fraud and the National Health Care Anti-Fraud Association carry out advertising campaigns via newspapers, radio, television and billboards to target insurance consumers. The National Health Care Anti-Fraud Association conducted the public awareness programs for 19 health insurers or health insurer groups with Fraud Prevention Plans on file. (A group is an organization comprising affiliated insurers.) There were 33 health insurers or health insurer groups with Fraud Prevention Plans on file that participated in the program. 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 each year.

The Year in Review

Major Cases in 2012

Numerous health care fraud investigations were conducted during the past year. Some of these cases are summarized below.

- An upstate woman sought treatment at a Rochester medical facility in October 2011. During the course of the treatment, the woman was asked if she had previously been treated at the facility and answered that she had not. Investigators, however, examined medical records that indicated that someone using the woman’s name, insurance benefits card and workplace identification had received medical treatment on six prior occasions at the facility. When confronted with this information, the suspect signed a statement

admitting that she had given her documents to her cousin to use for medical treatment. As a result of the alleged fraud, Excellus Health Plan paid \$1,570 in benefits for someone not entitled to receive them. The Insurance Frauds Bureau played a lead role in the investigation assisted by the Rochester Police Department. The suspect was arrested in January on a charge of insurance fraud.

- Sixteen suspects were arrested in March for their roles in staging auto accidents to collect insurance payouts. They allegedly conspired to stage nine accidents in Brooklyn from September 2009 to May 2011. In some instances, one group of defendants drove or were passengers in U-Haul trucks they had rented, while another group of defendants hailed a livery cab, driven by an unsuspecting driver, into which the U-Haul driver would crash. In another type of staged accident, the defendants pretended to be pedestrians struck by other defendants or by vehicles driven by unsuspecting drivers. The defendants collected \$400,000 in insurance payouts as a result of fraudulent claims submitted to insurers. Most of the defendants allegedly agreed to participate in the accidents in exchange for money up-front and the promise of a bodily injury lawsuit settlement after they were treated at a medical clinic. Some of the defendants eventually received money from lawsuit settlements. Charges brought against the suspects included insurance fraud and grand larceny. An investigation conducted by the Insurance Frauds Bureau, the New York Attorney General's Office and the NYPD led to the arrests. The Bureau brought this case to the AG's Office based on referrals received from insurers alleging staged accidents involving U-Haul rental trucks and livery cars. IFB investigators obtained insurance company files, conducted interviews and secured copies of rental agreements from U-Haul.
- A long-term no-fault fraud investigation resulted to the arrest of two defendants in March, bringing the total number of arrests thus far in the case to 68. The first defendant, along with another suspect previously arrested, falsely reported to officers responding to his 911 call that a vehicle had hit his car and left the scene. He subsequently sought medical treatment for nonexistent injuries for which Permanent General Assurance Company was billed more than \$34,000. The second defendant, with others previously arrested, altered a Police Accident Report by adding his name as a passenger in a car that was involved in an accident. He applied for benefits under the no-fault portion of his auto insurance and was treated at a local medical facility for injuries purportedly received in the accident. Hartford Insurance Company was later billed in excess of \$3,000. The Bureau's investigators conducted surveillance, obtained claims data, issued subpoenas and participated in an undercover operation.
- In March 2012, the Insurance Frauds Bureau initiated an investigation involving Medicaid fraud. Records showed that in February 2012, the suspect had telephoned a pharmacy stating that she was a doctor and requested a prescription for Tramadol, a common pain medication. The suspect subsequently picked up the prescription and paid for it with her Medicaid card. The pharmacist later called the doctor whose name the suspect had used in ordering the prescription for additional information for the Medicaid claim. The doctor informed him that she had not authorized a prescription for the suspect and in fact had never provided any medical care to her. The pharmacist reported the incident to the Rochester Police Department. Investigators contacted the Office of the Medicaid Inspector General for a listing of all paid prescriptions for the suspect. The

listing showed a pattern of prescriptions for Tramadol and Percocet purportedly authorized by two doctors, both of whom provided statements that they had not prescribed any medications for the suspect. The pharmacist was able to identify the suspect from photos and she was called in for an interview. When questioned, she admitted misrepresenting herself as the two doctors to order several prescriptions during the prior year and using her Medicaid card to pay for them. She was arrested and charged with criminal impersonation as a result of the Bureau's investigation.

- A Manhattan podiatrist was sentenced in November to one year in prison and was ordered to pay an unspecified amount in restitution to CIGNA Insurance Company. From 2008 to 2010, he filed hundreds of claims for treatments that he never provided and used patient information of at least five individuals to submit claims to CIGNA. In two instances, he accepted payment for claims he filed on behalf of patients, one of whom was in Europe and the other at Disney World when the treatments purportedly took place. In another instance, he contacted a CIGNA member and asked her to report that she had received treatment when she had not. CIGNA paid a total of \$100,671 on the fraudulent claims. Shulman was arrested in February 2011 as a result of the investigation conducted by the Insurance Frauds Bureau and subsequently pled guilty to grand larceny.
- An ongoing drug diversion investigation being conducted by the Insurance Frauds Bureau and the U.S. Department of Health and Human Services' Office of the Inspector General revealed that two suspects, previously arrested, were involved in stealing/filling prescriptions for controlled substances. Further investigation by the Bureau showed that many of these prescriptions were being filled at a particular pharmacy. Evidence was developed documenting the pharmacy owner's willful knowledge of the scheme. A search warrant was executed at the pharmacy in April and the defendant was arrested.
- In September 2011, the defendant arrived at a doctor's office to have a medical procedure performed. She presented a Medicaid Benefit ID card and completed the necessary forms providing patient medical history and other relevant information. During the visit, a nurse noticed a discrepancy in the medical chart and questioned the defendant who then admitted she was using the ID card and personal information of another person. She was denied services and left the office. During the investigation, the defendant was interviewed and admitted that she had used someone else's ID card to obtain medical treatment. Investigators also interviewed the owner of the ID card who submitted statements reporting that she had not authorized the defendant to use her ID card. The defendant was arrested in April and charged with identity theft, criminal possession of a forged instrument and falsifying business records. This case was referred by the Office of the Medicaid Inspector General and was investigated jointly by the Insurance Frauds Bureau and the Brighton Police Department. The Bureau took the lead in interviewing witnesses and suspects, obtaining statements and gathering evidence critical to the success of the investigation,
- An investigation by the Drug Enforcement Administration Tactical Diversion Task Force led to the arrest in May of 14 defendants involved in the distribution of illegally diverted prescription drugs on charges of conspiracy to violate the narcotics laws of the United States and distribution and possession with intent to distribute oxycodone and oxymorphone. From April 2011 through at least May 2012, the defendants worked

together to sell tens of thousands of pills in 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. The ongoing investigation is being conducted jointly by members of the Downstate Office of the Task Force, including the DEA, the U.S. Attorney for the Southern District of New York, the NYPD and the Insurance Frauds Bureau. The Bureau's investigator assigned to the Downstate Office of the DEA participated in search warrants and conducted numerous surveillances and interviews.

- An investigation by the Insurance Frauds Bureau and the Manhattan District Attorney's Office resulted in the May 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, the initial defendant, a practicing psychiatrist, filed 206 claims for treatments she never received. She also filed 19 claims for legitimate treatments but inflated the amounts she paid to her doctors. She was reimbursed a total of \$32,428 for the fraudulent and inflated claims. The second defendant 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. OHBS paid out more than \$114,000 on the fraudulent claims. In November, she pled guilty to grand larceny and was sentenced to 3-to-6 years in prison. From 2006-2011, the third defendant filed more than 1,700 claims with her employer for mental health treatments she never received and 38 claims in which she inflated the amounts paid to her doctor for treatments she did receive. She was paid \$353,958 on the false and inflated claims. Moreover, she tried to steal an additional \$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.
- Following an auto accident, the defendant began collecting lost-wage benefits. Beginning in May 2010 through mid-September 2011, he submitted 11 prescriptions for pain medication purportedly prescribed by his doctor. An investigation by the Insurance Frauds Bureau, the Niagara County District Attorney's Office and the Lockport Police Department revealed that the defendant was working while fraudulently collecting the benefits and had submitted forged or altered prescriptions and documentation stating that he was unable to work. State Farm paid him \$13,700 in lost-wage benefits and \$1,245 in prescription drug payments to which he was not entitled. The Bureau was the lead investigator in the investigation that resulted in the defendant's arrest in June on charges of grand larceny, insurance fraud, and criminal possession of a forged instrument.
- The suspect in this case went to a doctor's office for a medical procedure and presented a Blue Choice Option Medicaid Insurance Card in the name of another individual and completed paperwork using the personal information of the other person. After she left the doctor's office, the office manager found a social security card which, when checked, produced the name of a dependent child of the suspect. Several weeks later, an Insurance Frauds Bureau investigator met the suspect outside the doctor's office where she agreed

to be interviewed. She subsequently gave a voluntary statement admitting that she had used an insurance card that was not her own because her insurance did not cover the \$550 cost of the procedure she had received. The suspect was arrested in June and charged with falsifying business records and petit larceny. This case was referred by the Office of the Medicaid Inspector General. The Insurance Frauds Bureau was the lead investigator and worked on the investigation with the Rochester Police Department.

- A Binghamton woman filed for no-fault benefits with the Progressive Insurance Company following an auto accident. As a result of injuries incurred in the accident, she was given prescriptions for pain medication. During the period from July 2009 to June 2010, she had filled the prescriptions at various pharmacies in the Binghamton area and submitted documentation provided by the pharmacies to Progressive for reimbursement. An investigation by the Insurance Frauds Bureau and the Broome County Sheriff's Department found evidence that she had altered the information on the documents to make it appear that she had paid cash, when in fact Medicaid had paid for the medications. She turned herself in to the Sheriff's Department in June and was charged with attempting to defraud her insurer of \$1,138. The Bureau played a lead role in interviewing witnesses and suspects and obtaining statements in the investigation that led to the arrest.
- The defendant was involved in an auto accident in February 2012 and filed a claim with GEICO Insurance Company for the damage. He reported a minor head injury at the time of the loss. He subsequently submitted a Notice of Proof of Loss Statement with two invoices claiming lost wages in the amount of \$2,000. He stated that he was a self-employed consultant and had missed ten hours of work for two clients due to headaches as a result of the head injury. One of the purported clients contacted the Department in April to report that the consultant had used her name and personal information on an insurance claim and had asked her to lie to the insurance company in exchange for \$100. Her boyfriend was a witness to this conversation and provided a written statement to investigators. In May, investigators interviewed the second purported client who stated that the defendant had not done any work for her either but declined to give a written statement. Investigators subsequently interviewed the defendant who admitted filing the claim and preparing and submitting the invoices claiming he had missed ten hours of work, but he could not provide any contracts, agreements or other documentation to demonstrate that he had worked for either of the purported clients. An investigation led by the Insurance Frauds Bureau with the assistance of the Rochester Police Department resulted in the defendant's arrest in July for insurance fraud.
- The Insurance Frauds Bureau worked closely with the FBI and the IRS in an investigation that led to the August arrest of an upstate resident, who pled guilty to health care fraud and mail fraud. Her plea is part of an ongoing investigation into a staged-accident scheme involving a U-Haul truck in Utica. She was sentenced in February to 27 months in prison and ordered to pay more than \$1.4 million in restitution to Progressive and Mutual of Omaha Insurance Companies.
- A Saratoga Springs man was sentenced in October to six months in jail followed by five years' probation and ordered to pay \$127,560 in restitution. In August, he pled guilty to grand larceny and attempted grand larceny. As part of his plea, he admitted that from

February 2008 to June 2011, he schemed to defraud HealthyNY, a state-sponsored program created to provide low-cost health insurance for small businesses that cannot afford traditional health plans, and MVP Health Care of Schenectady. He earned commissions by falsely reporting that certain businesses were qualified to obtain the HealthyNY benefits. He told the businesses that, in order to obtain the coverage, they would have to join his National Business Owner's Association for which he charged them a membership fee. At the time of his sentencing, He paid \$100,000 of the total restitution, all but \$5,700 of which will used to reimburse the eight businesses for the fees they paid for membership in the bogus association. The remainder will be paid to the State for fraudulent claims that were paid out. He also agreed to surrender his insurance broker's license and not engage in any insurance business during his probation. During the probation, He must make monthly payments on the nearly \$28,000 he will still owe the State. The Insurance Frauds Bureau was the lead agency in the investigation that led to the arrest, assisted by MVP's Special Investigations Unit and the Schenectady County District Attorney's Office.

- In October, the FBI New York Health Care Fraud Task Force, of which the Insurance Frauds Bureau is a member, was part of a takedown conducted by a nationwide strike force that resulted in charges against 92 suspects in schemes to defraud the Medicare and Medicaid programs of \$432 million. Of those arrested, 15 were suspects in three New York Task Force cases. In one New York case, nine people, including the manager and medical director of a medical facility in Brooklyn, were charged with conspiring to defraud the Medicare and Medicaid programs of more than \$13 million by submitting fraudulent claims for physical therapy that was not provided or was medically unnecessary. In another case, four licensed chiropractors allegedly failed to provide chiropractic services to patients residing in assisted-living facilities, yet billed Medicare for \$6.4 million. In a third case, the office manager of a Queens medical clinic and the owner of an ambulette service received \$3 million from Medicare after claiming to provide physical therapy and diagnostic tests to patients who were paid cash kickbacks to use the defendants' medical and ambulette services. Charges brought against the suspects included health care fraud, wire fraud, violations of the kickback statutes, and money laundering. The Bureau played a major role in the cases by participating in search warrants, conducting interviews with claimants, witnesses and medical providers, and analyzing numerous bank records and insurance claim files.
- In November, a man from Tonawanda, was convicted of insurance fraud and grand larceny. He admitted that, following an auto accident, he had filed with New York Central Mutual Insurance Company a fraudulent claim for lost wages in which he fabricated his employment and annual salary information. As a result of the fraud, he collected \$40,000 in no-fault benefits to which he was not entitled. He was arrested in May as a result of investigative work by the Insurance Frauds Bureau with the assistance of the Erie County District Attorney's Office.