



NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

March 15, 2015

Dear Governor Cuomo, Comptroller DiNapoli, Attorney General Schneiderman, President Pro Tem Skelos, Majority Coalition Leader Klein, Speaker Heastie, 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.

The Department received 16,835 reports of suspected health care fraud during 2014, of which 1,234 involved accident and health insurance, 162 involved disability insurance and 15,439 involved no-fault. The Department opened 109 health care fraud cases for investigation, of which 34 involved accident and health, 10 involved disability and 65 involved no-fault. Like last year's numbers, these statistics highlight the importance of fighting no-fault fraud, which costs New Yorkers hundreds of millions of dollars in insurance costs. Reports of no-fault fraud totaled 62 percent of health insurance fraud reports and well over half of reports of fraud of all types, making no-fault fraud again the biggest single fraud issue faced by the Department.

This report also highlights some of the major investigations undertaken during 2014, including 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 77 arrests for health care fraud in 2014.

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:
Investigating and Combating
Health Insurance Fraud**

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

March 15, 2015
Benjamin M. Lawskey
Superintendent
New York State Department of Financial Services

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Introduction

This report, required under § 409(c) of the Financial Services Law, summarizes the 2014 activities of the Department of Financial Services in combating health insurance fraud.

2014 Highlights

- The Department’s Insurance Frauds Bureau (Bureau) investigates and combats health care fraud, which affects three major types of insurance: accident and health, private disability and no-fault. The Bureau is headquartered in New York City, with an office in Mineola and five offices across upstate New York: Albany, Syracuse, Rochester, Buffalo and Oneonta. It has a longstanding commitment to combating insurance fraud and strives to serve the people of New York State. Highlights of our efforts to combat health care fraud in 2014 include the following:
 - 109 health care fraud investigations in 2014 were opened, of those investigations, 77 arrests were made.
 - 16,835 reports of suspected health care fraud were received: 15,439 no-fault, 1,234 accident and health insurance and 162 disability insurance.
 - Reports of suspected no-fault fraud accounted for 62% of the total reports received.
 - The combined Upstate/Downstate Office of the Drug Enforcement Administration Tactical Diversion Task Force, of which the Department is a member, made 36 arrests. The Task Force investigates organized drug diversion schemes, “doctor shopping” and forgery of controlled-substance prescriptions.

Overview of Health Care Fraud in New York State

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. According to the National Health Care Anti-Fraud Association (NHCAA), the U.S. was projected to spend \$3.1 trillion on health care in 2014, with billions of health insurance claims processed. The NHCAA reports that financial losses due to health care fraud are estimated in the tens of billions of dollars each year. In turn, combating fraud and abuse helps rein in the escalating costs of health care in the United States.

2014 Health Care Fraud Reports Received and Arrests Made

The Department received 16,835 reports of suspected health care fraud during 2014 – 1,234 involved accident and health insurance, 162 involved disability insurance and 15,439 involved no-fault. The Department opened 109 health care fraud cases for investigation. Of those, 34 involved accident and health, 10 involved disability and 65 involved no-fault. (Note: multiple fraud reports frequently can be linked to one case.) Department investigations resulted in 77 arrests in 2014.

Types of Health Care Fraud

Health care fraud affects three major types of insurance: accident and health, private disability and no-fault. The more common types of health care fraud include:

- Prescription drug diversion and misuse.
- Medical identity fraud.
- Billing for services that were never rendered and products that were not provided.
- Billing for more expensive procedures or services than were actually provided, commonly known as upcoding.
- Performing medically unnecessary treatments and expensive diagnostic tests for the purpose of generating insurance payments.
- Misrepresenting noncovered treatments as medically necessary covered treatments, e.g., cosmetic nose surgery billed as deviated septum repair, for the purpose of obtaining insurance payments.
- 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 slip-and-fall accidents.
- Accepting kickbacks for patient referrals.

In 2014, the Department received health care fraud reports that included numerous allegations of medically unnecessary treatments and expensive diagnostic tests. Reports of prescription drug diversion and misuse remained steady.

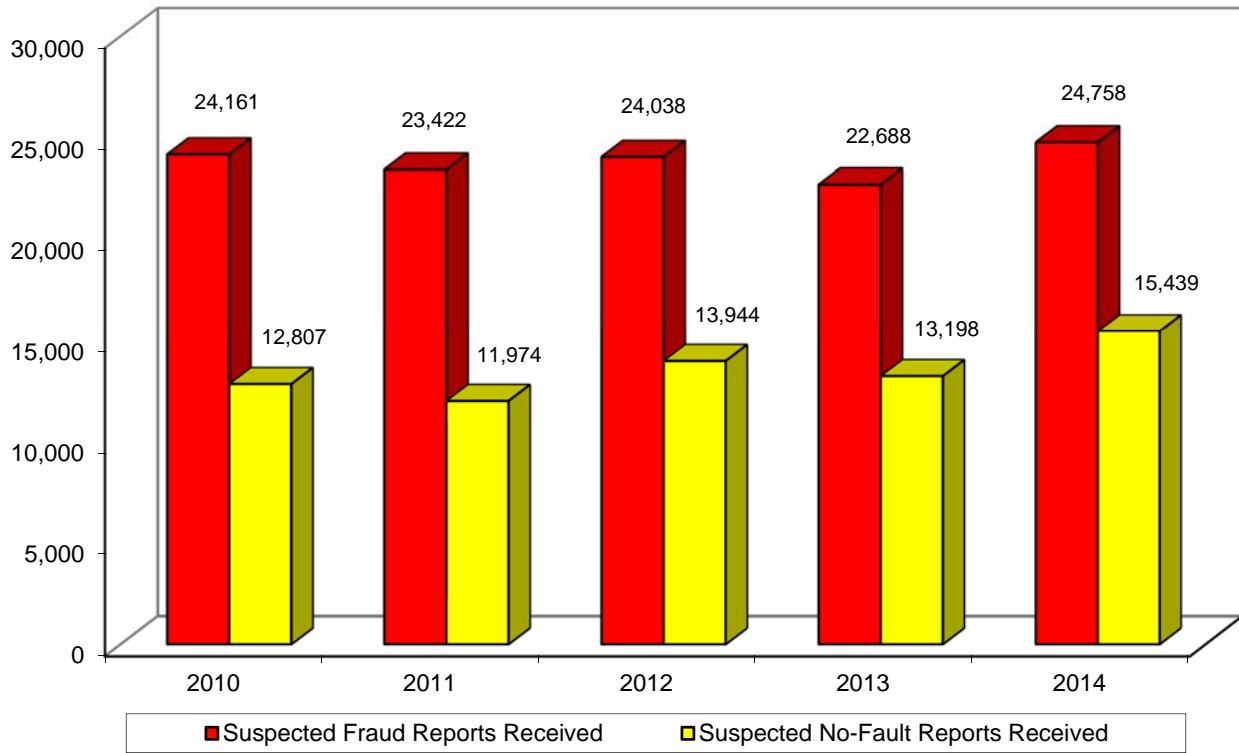
No-Fault Fraud

No-fault fraud accounts for the majority of health care fraud reported and combating no-fault fraud is one of the Department's highest priorities. To combat no-fault fraud, in 2012 the Department updated the regulation promulgated pursuant to New York Insurance Law § 51, which governs the no-fault system. In 2013, the Department's investigations led to the ban of 18 doctors and other health care providers from billing insurance companies under the no-fault system. The Department maintained its aggressive approach to combating this fraud throughout the year with investigations that are ongoing. The Department will continue to utilize the procedures set out in New York Insurance Law §5109 and Regulation 68-E to deauthorize unscrupulous providers and protect New York consumers from rising automobile insurance premiums inflated as a result of fraud.

No-Fault Fraud by the Numbers

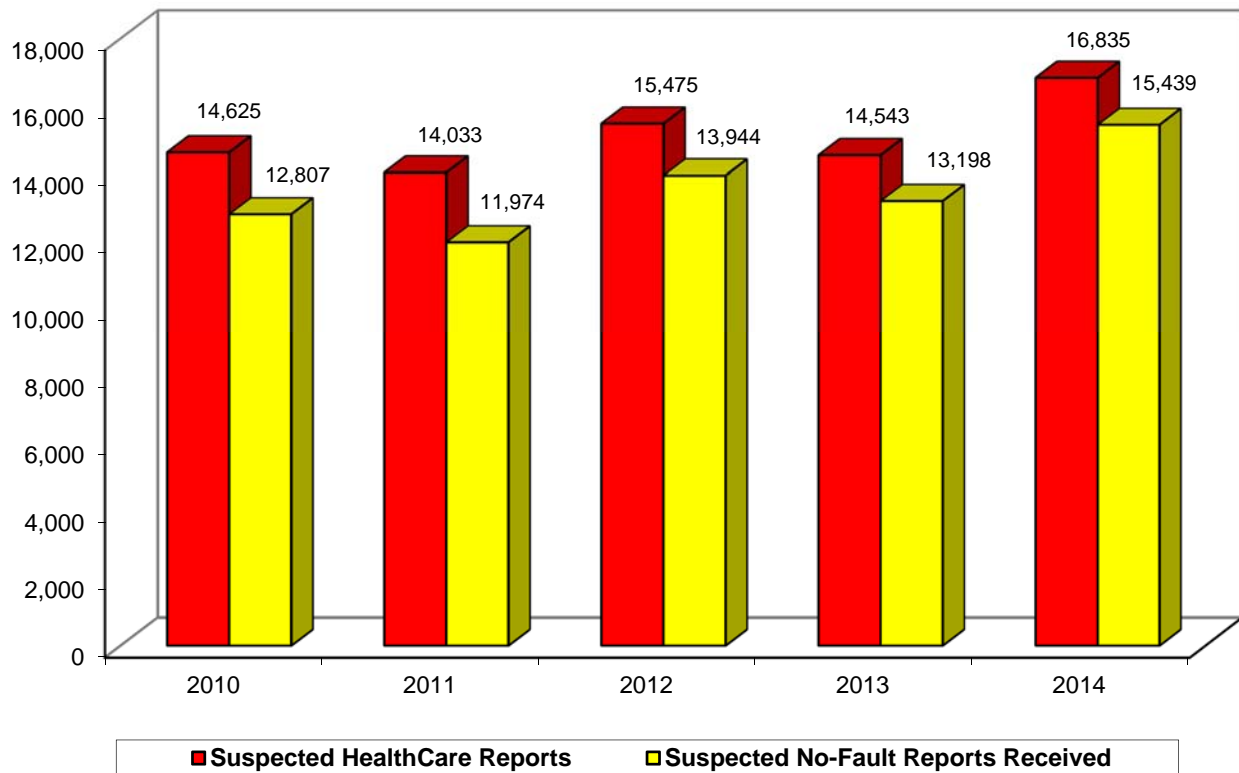
As shown in Figure 1 below, suspected no-fault fraud reports accounted for 62% of all fraud reports received by the Department in 2014. The number of suspected no-fault fraud reports received by the Department increased by approximately 17% during the year.

**Figure 1. Number of Suspected Fraud Reports Received Compared with
Number of Suspected No-Fault Reports Received
2010 - 2014**



As shown in Figure 2 below, the number of suspected no-fault fraud reports comprised 92% of all health care fraud reports in 2014 and have accounted for a minimum of 85% of total health care fraud reports since at least 2008.

Figure 2. Number of All Suspected Health Care Fraud Reports Received Compared with Suspected No-Fault Fraud Reports Received 2010 - 2014



Collaborative Efforts to Combat 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. The Department is a member of 12 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 for joint investigations, intelligence gathering, and effective use of state resources. Toward that end, several of the Department’s investigators have been assigned to those groups and partner with other members in investigating cases involving health care fraud. 2014 highlights from these collaborative efforts are below:

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 36 arrests in 2014. A Department 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 indictment in December of eleven defendants, including a New York State-licensed physician, for their participation in a widespread drug ring that involved the unlawful distribution of nearly 1.2 million oxycodone tablets intended for sale in New York.

Rochester Health Care Fraud Working Group

An investigation conducted jointly by the Department and other members of the Rochester Health Care Fraud Working Group led to the federal charge of health care fraud against the owner/operator of a medical imaging center in September. The owner/operator was accused of performing imaging procedures that had not been prescribed and fraudulently billing for them in the amount of more than \$1 million.

Other Group Participation

The Department actively participates in the Western New York Health Care Fraud Task Force, the Central New York 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 Health Care Fraud

Insurance Company Reporting

Under § 405 of the New York Insurance Law, insurers are required to report suspected fraud to the Department. The Department has a web-based case management system, known as the Fraud Case Management System (“FCMS”), which allows insurers to submit reports of suspected fraud electronically. In 2014, insurers electronically submitted approximately 95% of the 24,758 fraud reports received. Insurers have access to the FCMS through the Department’s portal using secure accounts.

The benefits of the FCMS to insurers include automatic acknowledgment of receipt of fraud reports, and 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.

Consumer Reporting

The Department encourages consumers to report suspected fraud to the Department and maintains a toll-free hotline to facilitate reporting. The Department recorded an average of 33 calls per week in 2014. The “Consumers” section of the Department’s website includes a link to a fraud report form and instructions for how to report fraud to the Department. The section is designed to help consumers recognize, report and combat insurance fraud.

Compliance with § 409 of the New York Insurance Law

§ 409 of the New York Insurance Law requires insurers that write at least 3,000 individual accident and health, workers' compensation or automobile policies (or group policies that cover at least 3,000 individuals) issued or issued for delivery annually in New York to submit to the Department a Fraud Prevention Plan for the detection, investigation and prevention of insurance fraud. Licensed health maintenance organizations (HMOs) with at least 60,000 enrollees also must submit a Fraud Prevention Plan. Plans must provide for a full-time Special Investigations Unit (SIU), as well as specific staffing levels within the SIU.

In 2014, there were 65 insurer SIUs dedicated to investigating health care fraud in New York State. Those SIUs were housed within accident and health insurers, HMOs, life insurers, nonprofit medical and dental indemnity and health service corporations. In addition, 15 property and casualty insurers with approved SIUs reported writing accident and health insurance business during 2014.

Health and life insurers reported \$273 million in savings resulting from SIU investigations in 2013 (the most recent year for which data are available). Health and life insurers reported \$38 million in recoveries from SIU investigations. In addition, three property and casualty insurers writing accident and health insurance reported \$293,000 in savings.

The Department monitors insurer compliance with § 409 through the analysis of data provided by insurers in annual SIU Reports. The Department may perform field examinations of insurer SIUs to assess compliance with § 409, Regulation 95 and other sections of Article 4 of the New York Insurance Law.

Fraud Prevention Plan Requirements

§ 409 of the Insurance Law sets out requirements for the type of information that must be included in Fraud Prevention Plans. For example, a Plan 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 § 409 and Department Regulation 95. § 409 and 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.
- Objective criteria for the level of staffing and resources devoted to the SIU.
- 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.
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The Year in Review

Some of the major health care fraud investigations conducted during the past year are summarized below.

- A man was arrested in March in connection with his participation in a money-laundering scheme. He was convicted of violation of U.S. Code Title 18 Section 1347 Health Care Fraud and was sentenced to three years' probation. He cashed checks from no-fault insurers for durable medical equipment purportedly provided to victims of auto accidents when, in fact, the equipment was never provided. The fraud was part of a larger scheme in which the owner of a multi-branch check-cashing company pleaded guilty in November for failing to follow reporting and anti-money laundering requirements for more than \$19 million in transactions. As part of the guilty plea, he will pay restitution of \$946,841 to the IRS and the company will forfeit \$3.3 million. The Department's investigation was conducted jointly by the Office of the U.S. Attorney for the Eastern District of New York, the Justice Department, the Department of Homeland Security, U.S. Immigration and Customs Enforcement and the Internal Revenue Service.
- An investigation conducted by the Medicare Fraud Task Force, of which the Department is a member, resulted in the arrest in May of the owner and operator of a durable medical supply company in Brooklyn. The defendant, whose practice is made up almost entirely of Medicare patients, had created numerous fictitious medical supply companies using the Tax Identification Number of his legitimate company. He then billed private health insurers and Medicare for approximately \$4 million of durable medical equipment for patients for whom the equipment was never provided. The owner's sister, who allegedly collaborated in the scheme, was also arrested.
- In an ongoing investigation being conducted by the Department and the Erie County District Attorney's Office, four defendants were arrested in October in connection with separate instances of attempted no-fault fraud involving the Niagara Frontier Transportation Authority, a self-insured public bus system. Following bus accidents, the defendants claimed various injuries and filed for benefits under New York's no-fault law. The investigation, however, aided by surveillance equipment on the buses, demonstrated that the injury claims were unsubstantiated. Each defendant was charged with offering a false instrument for filing in the 1st degree. A fifth defendant pleaded guilty to insurance fraud and offering a false instrument for filing in July and was sentenced to 18 months to 3 years in New York State prison.
- In September, the owner and operator of an upstate medical imaging center was charged with health care fraud, a federal charge, as part of a plea agreement with the Office of the U.S. Attorney for the Western District of New York. The owner/operator was accused of performing and billing for imaging procedures that had not been prescribed. The fraudulent billing amounted to more than \$1 million. The sentence and restitution is currently being negotiated. A joint investigation by the Department and the FBI as members of the Rochester Health Care Fraud Working Group led to the arrest.
- An investigation conducted by the Drug Enforcement Administration Tactical Diversion Task Force, of which the Department is a member, led to the indictment of eleven defendants in December for their participation in a drug distribution ring involving the prescription painkiller oxycodone. They were charged with conspiracy to distribute and

possession with intent to distribute oxycodone. The indictment alleges that from 2012 through 2014 the defendants operated at various medical clinics in Manhattan and the Bronx, including the office a New York State-licensed doctor who was at the center of the ring's activities and is charged with writing more than 13,000 medically unnecessary prescriptions for oxycodone. The indictment alleges that the doctor generally charged \$200 in cash for "patient visits" that involved few if any actual examinations but typically resulted in his issuing prescriptions for large quantities of oxycodone. Drug traffickers known as "crew chiefs" recruited and paid most of the "patients" to pose as patients for the purpose of obtaining the illegal prescriptions. The crew chiefs in turn arranged for the prescriptions to be filled at pharmacies with the drugs to be resold on the streets. Various clinic employees were charged with participating in the scheme by scheduling "patient visits" for which they charged the crew chiefs a cash fee. They also created fake documents such as MRI and urinalysis reports which the doctor at times requested to avoid attracting attention from law enforcement.