STATE OF NEW YORK
INSURANCE DEPARTMENT
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Andrew M. Cuomo
Governor

James J. Wrynn
Superintendent

March 1, 2011

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 2010. During the past year, the Frauds Bureau continued its longstanding tradition of working closely with federal, state, and local law enforcement agencies to investigate and prosecute fraud in the health care sector.

I am also pleased to announce that Frauds Bureau investigations led to 159 arrests for health care fraud in 2010. This report highlights some of the major investigations undertaken this past year, including a number of investigations conducted jointly with fellow law enforcement agencies as part of the Medicare Fraud Strike Force. This past July, one of those joint Strike Force investigations culminated in the arrest of eight defendants who were allegedly paying corrupt beneficiaries cash kickbacks inside a medical facility in return for receiving medically unnecessary medical treatment and procedures. The billings for those treatments were in excess of $20 million.

In the coming year, the Frauds Bureau looks forward to continuing to work closely with the law enforcement community and the insurance industry to aggressively combat health care fraud.

Sincerely,

James J. Wrynn
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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2010 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 159 arrests in 2010.**

- **The National Health Care Anti-Fraud Association "conservatively" estimates the cost of health care fraud to be about 3 percent of all health care spending, or $60 billion to $70 billion a year.**

- **The Frauds Bureau is a member of the Medicare Fraud Strike Force, a group of federal, state and local law enforcement agencies that investigates individuals and health care providers suspected of fraudulent billing.**

- **There were 14,625 reports of suspected health care fraud received by the Frauds Bureau during 2010 – 1,625 involved accident and health insurance, 193 involved disability insurance and 12,807 involved no-fault.**

- **Reports of suspected no-fault fraud accounted for 53% of all fraud reports received during 2010.**

- **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.**

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 an office in Mineola and 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 page 18 of this Report.

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;
- Staging/causing auto accidents;
- Performing medically unnecessary treatments and expensive diagnostic tests;
- Filing no-fault claims for nonexistent injuries;
- Filing false or exaggerated medical disability claims;
- Misrepresenting noncovered treatments as medically necessary covered treatments, e.g., cosmetic nose surgery billed as deviated septum repairs;
- Unbundling, i.e., billing as if each step of a procedure were a separate procedure;
- Staging fake slip-and-fall accidents; and
- Accepting kickbacks for patient referrals.

A review of health care fraud reports received by the Bureau in 2010 showed an increase in reporting of fake slip-and-fall accidents. Reports of other types of health care fraud, such as upcoding, billing for services not provided, and filing no-fault claims for nonexistent injuries, while plentiful, remained steady over the year.

C. The Costs of Health Care Fraud

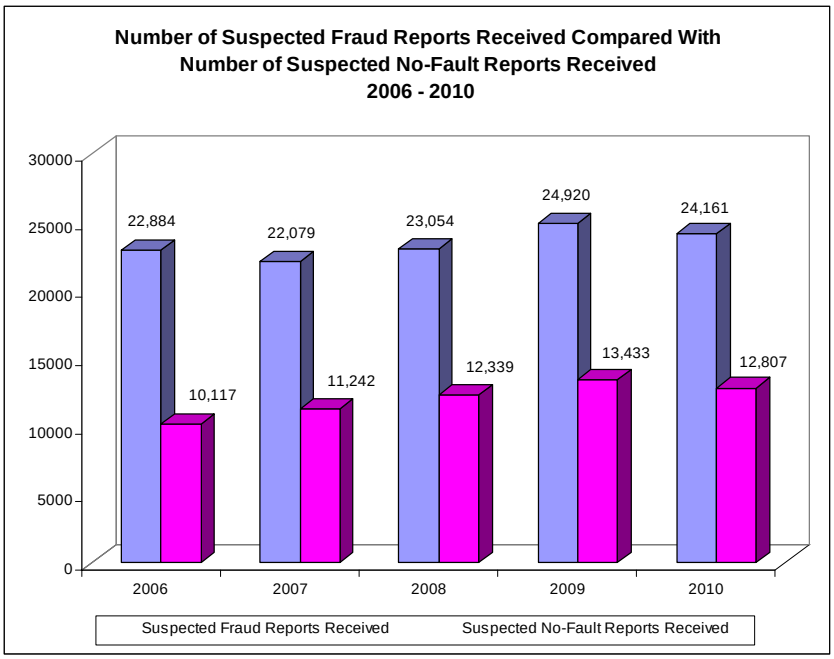
Health care fraud is a costly and pervasive drain on the national health care system. Though experts vary in their estimates of the cost of health care fraud, all agree it is in the billions of dollars. The National Health Care Anti-Fraud Association (NHCAA) “conservatively” estimates that fraud is about 3 percent of all health care spending. That estimate comes from NHCAA members, which include health insurers and federal, state and local agencies involved in investigating insurance fraud. Though the NHCAA admits the estimate is low, 3 percent amounts to a sizable $60 billion to $70 billion a year lost to fraud.

According to information from the U.S. Department of Health and Human Services, Americans spent $2.34 trillion dollars on health care in 2008 and of those trillions of dollars, the FBI estimates that health care fraud depleted the system of between 3 and 10 percent – a staggering $70 billion to $234 billion. Combating fraud and abuse would go a long way toward reigning in the country's ever-escalating cost of health care.

D. No-Fault Fraud

After several years of decline, the number of suspected no-fault fraud reports began to rise in 2007, evening off in 2010. Suspected no-fault claims totaled 12,807 in 2010, accounting for 53 percent of all fraud reports received during the year.

Graph 1



Combating no-fault fraud remains an important part of mitigating the increase in auto insurance costs. The Frauds Bureau's No-Fault/Medical Unit is dedicated to rooting out no-fault fraud as well as other forms of health insurance fraud.

E. Proposed Revisions to Department Regulation 68

Following extensive consultation with insurers, medical providers and trial attorneys, the Department issued a working draft of an amendment to Regulation 68 to help reduce fraud and abuse associated with no-fault claims, while making the no-fault system more user-friendly to injured parties and to health care providers. The Department posted the working draft on its Web site and has received an array of comments from all interested parties. The Department is reviewing the comments and is conducting further discussions with the stakeholders in order to ensure that the new rules eventually

promulgated will effectively address the issues that are driving automobile insurance loss costs in a manner that is fair and equitable to all.

F. Health Care Reform 2010

The Patient Protection and Affordable Care Act, signed into law by President Obama on March 23, 2010, will put in place comprehensive reforms to the health care system in the United States. Each state will be required to implement its provisions as outlined in the law. Although the Act is a federal law, the regulation of insurance, including health insurance, remains the responsibility of the states.

After the U.S. Department of Health and Human Services noted an increase in health care-related crime only weeks after enactment of the legislation, the New York State Insurance Department issued a warning to consumers to be aware of bogus health insurance plans. The fake insurance plans are being peddled by scammers hoping to take advantage of public confusion over the new health care provisions. The Department urged consumers to keep in mind certain red flags to recognize health insurance fraud, such as high-pressure sales tactics, door-to-door sales and TV ads with toll-free numbers, adding that what seems too good to be true often is.

In addition, the Department advised senior citizens to be on the lookout for fraud as they began to receive their $250 rebates for Medicare Part D prescription drug costs under the new federal reforms. The one-time, tax-free rebate is being sent to eligible senior citizens to help them pay for the gap above the initial prescription drug coverage limit but below the point where catastrophic coverage begins, known as the “doughnut hole.” There have been some reports of seniors being contacted and told they must disclose personal information in order to receive their rebates or that rebates must be transferred to a third party. This is simply not true but these tactics can be confusing and intimidating.

The Frauds Bureau is monitoring reports of suspected fraud in these areas to ensure that any potential fraud schemes are promptly investigated and handled appropriately.

III. Combating Health Care Fraud – Collaborative Efforts

The Frauds Bureau is a member of several task forces and working groups designed to foster cooperation and communication among the many agencies involved in combating health care fraud. To ensure that the Bureau remains an active participant, several investigators have been assigned to these groups and partner with other members in investigating cases involving health care fraud. Some of the cases that were under investigation during 2010 are summarized in Section *V.* A of this Report.

A. Medicare Fraud Strike Force

The Medicare Fraud Strike Force supplements the health care fraud enforcement activities of the U.S. Attorneys' Offices by targeting chronic fraud, as well as emerging or migrating schemes perpetrated by criminals operating as health care providers or suppliers. In addition to the Frauds Bureau, Strike Force members include the Department of Justice Criminal Division's Fraud Section, law enforcement partners in the Department of Health and Human Services (HHS), and state and local law enforcement agencies.

The Department of Justice announced on 9/22/10 that from the inception of operations in March 2007, the Strike Force has obtained indictments of more than 810 individuals and organizations that falsely billed the Medicare program for more than $1.85 billion. Moreover, the HHS Centers for Medicare & Medicaid Services is working together with its Office of the Inspector General to take steps to increase accountability and decrease the presence of fraudulent providers. Several investigations conducted by the Medicare Fraud Strike Force are summarized in Section *V.* A of this Report.

B. 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 and the NYPD, investigators from the Frauds Bureau and other federal, state and local law enforcement agencies, as well as the insurance industry. Members of the Task Force meet on a regular basis to discuss joint investigations, study trends and plan strategies.

C. Other Group Participation

The Frauds Bureau also actively participates in the Central New York Health Care Fraud Working Group and the Western New York Health Care Fraud Task Force. Participation provides the opportunity for joint investigations, sharing information and honing investigative skills.

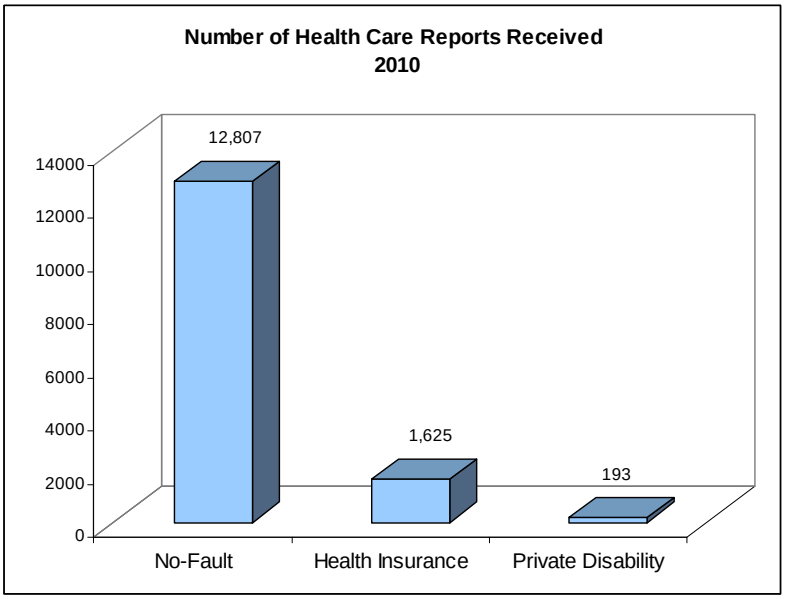
IV. Reporting and Preventing Insurance Fraud

A. Insurance Company Reporting

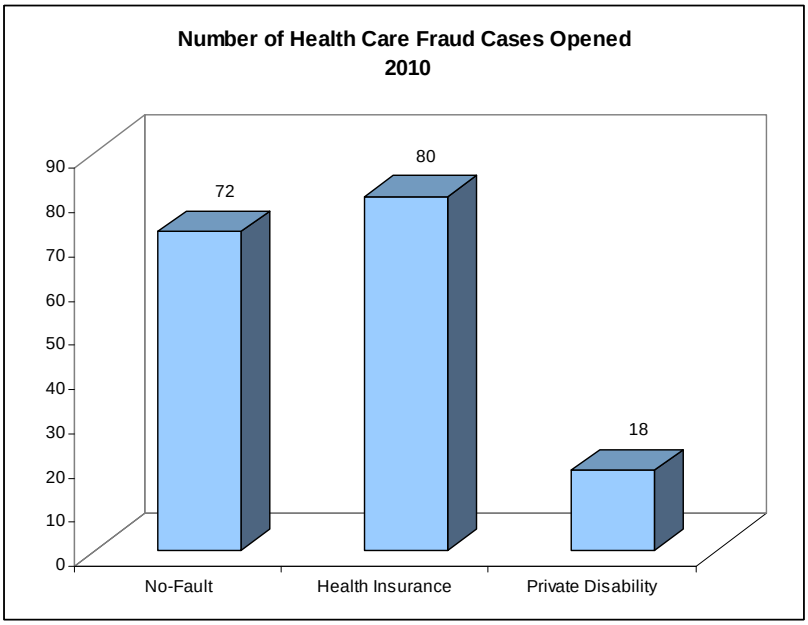
Insurers are required by Section 405 of the Insurance Law to report suspected fraud to the Frauds Bureau. The Bureau has a Web-Based Case Management System, known as FCMS, that allows insurers to submit reports of suspected fraud electronically. The system has been fully operational since the first quarter of 2007. In 2010, approximately 90% of the 24,161 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.

There were 14,625 reports of suspected health care fraud received by the Frauds Bureau during 2010 – 1,625 involved accident and health insurance, 193 involved disability insurance and 12,807 involved no-fault. A total of 170 new health care fraud cases were opened for investigation in 2010. (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 159 arrests in 2010.

Graph 2



Graph 3



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 (or individuals if written on a group business) 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 62 approved insurer SIUs dedicated to investigating health care fraud in New York State in 2010. These SIUs comprised accident and health insurers, HMOs, life insurers and nonprofit medical and dental indemnity or health service corporations. In addition, there were 17 property and casualty insurers with approved SIUs writing accident and health insurance during 2010.

Accident and health insurers reported $105 million in savings resulting from SIU investigations in 2009 (the most recent year for which data are available). In addition, two property and casualty insurers writing accident and health insurance reported $33,000 in savings. Accident and health insurers also reported $29.8 million in recoveries resulting from SIU investigations in 2009.

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). Annual SIU Reports are due to the Department by March 15 of each year and must be filed electronically using the Department's Portal Web site. In addition, the Bureau may perform market conduct field examinations of insurer SIUs to ensure compliance with Section 409.

C. Fraud Prevention Plan Requirements

Section 409 has established specific requirements for the type of information that must be included in the 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 require the following additional provisions to be included in all Fraud Prevention Plans:

- Interface of SIU personnel with law enforcement and prosecutorial agencies including the State Insurance Department Frauds Bureau;
- 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 identifying and evaluating instances of insurance fraud; and
- 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.

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 National Health Care Anti-Fraud Association conducted the public awareness programs for 26 health insurers or health insurer groups in 2010. (A group is an organization comprising affiliated insurers.) The New York Alliance Against Insurance Fraud, a coalition of New York insurers, performed public awareness programs on behalf of its members. Namely, 28 health insurers or health insurer groups participated in the Alliance's program during the past year. In addition, several individual insurance companies have ongoing programs to heighten awareness and reduce public tolerance for insurance fraud. As a result of these programs, the anti-fraud messages reach millions of New Yorkers each year.

E. Consumer Reporting

Consumers are encouraged to report suspected fraud to the Frauds 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. The Bureau recorded on average 21 calls a week during 2010. 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. Some of these cases are summarized below.

HE'S NO DOC

- A no-fault fraud investigation conducted by the State Police with the assistance of the Frauds Bureau resulted in the 2/23/10 arrest of a suspect charged with falsely representing himself as a doctor and telephoning a prescription for pain medication in to a local Wal-Mart pharmacy. When he attempted to have the

prescription filled, the pharmacy contacted the State Police. At his arrest, the suspect admitted to misrepresenting himself as the doctor and was charged with criminal impersonation. The prescription was not filled.

NO JOB, NO WAGES

- A Schenectady man was arrested on 3/22/10 and charged with insurance fraud following an unsuccessful attempt to defraud Nationwide Insurance Company of $20,500. In March 2009, after being involved in an auto accident, he submitted a no-fault claim for lost-wage benefits. In support of his claim, he included documentation stating that he was employed as a landscaper. But an investigation by the Frauds Bureau revealed that he was in fact unemployed at the time of his accident.

NOT LEGALLY MARRIED

- In May 2007, an employee at the Rochester Psychiatric Center listed her ex-husband on her employer-sponsored health insurance contract as her legal husband, although they had been divorced since the 1980s. On 4/1/10, she met with investigators from the Frauds Bureau and the Rochester Police Department and admitted that she had named her ex-husband as her spouse though they were not legally married because he needed medical care and did not have health insurance. As a result of the fraud, Excellus Health Plan paid out $162,126 in medical benefits to which the defendant's ex-husband was not entitled. On 4/28/10, she surrendered herself at the Rochester Police Department and was charged with insurance fraud in the 2nd degree.

182 BOGUS CLAIMS

- An investigation by the Frauds Bureau resulted in the arrest on 5/20/10 of a Queens woman charged with filing fraudulent health insurance claims. While working as a medical billing clerk in a doctor's office from 2005 to 2010, she filed 182 claims totaling $82,625 with an Oxford health insurance plan for medical treatments she purportedly received from the doctor who employed her. On occasion, she sent the insurer as many as four or five claims a week. Oxford paid $61,545 on the claims directly to the suspect who used the money for personal gain.

NOT HIS WIFE

- A Rochester man was arrested on 1/25/10 for falsely naming his live-in girlfriend as his wife on the Excellus Health Plan he received through his employer. The woman, who was not arrested, used the insurance to pay for $37,000 in medical, dental and prescription drug benefits she was not entitled to receive.

FRAUDULENT DOCUMENTS

- After being involved in an auto accident, a Schenectady man filed a claim for wage-replacement benefits under the no-fault portion of his auto insurance policy with Nationwide Insurance Company. However, an investigation by the State Police, with the assistance of the Frauds Bureau, revealed that the documents he submitted in support of his claim were fraudulent. As a result, he collected $5,300 in benefits to which he was not entitled. He was arrested on 6/30/10 and charged with insurance fraud and falsifying business records.

MAJOR HEALTH CARE FRAUD/MONEY LAUNDERING SCHEMES

- An investigation by the Frauds Bureau, the Office of the U.S. Attorney for the Eastern District and the NYPD led to the 6/15/10 arrest of 17 defendants (and an 18th defendant who had fled to Florida and was arrested on 6/17) for their participation in health care fraud and money laundering schemes. Agents from Immigration and Customs Enforcement, the IRS and the FBI executed search warrants at the offices of 12 durable medical equipment retail companies that were operated by the defendants in Brooklyn and seized bank account assets. The defendants allegedly used their companies to submit fraudulent invoices to private no-fault insurers for reimbursable expenses for durable medical equipment at prices much higher than the price paid by the defendants, as well as for durable medical equipment that was never obtained. They laundered the proceeds by issuing checks to their companies which were cashed at various check-cashing facilities and the cash was delivered back to the defendants.

CHIROPRACTOR SENTENCED

- Dr. Anthony LaTona, a Queens chiropractor, was sentenced on 7/14/10 to a conditional discharge and waived his rights to future claims totaling $8.5 million. He was convicted on 6/3/10 of insurance fraud in the 3rd degree after investigators found that he convinced a "patient" to fabricate injuries and then billed Empire Blue Cross and Blue Shield more than $26,000 for medical treatments over a three-month period. He paid a $1,000 kickback to the "patient" who was actually a Frauds Bureau undercover investigator. At a meeting on 9/16/08, LaTona instructed the undercover to fake back and knee injuries in order to obtain insurance payments. The undercover operation commenced as a result of information received that Dr. LaTona had paid kickbacks to Verizon employees in order to use their medical information to bill insurance companies.

$40,622 IN COURT-ORDERED RESTITUTION

- After pleading guilty to grand larceny, Jacqueline Jacob of Brooklyn, NY, was ordered on 7/14/10 to pay $40,622 in restitution to United HealthCare Insurance Company. While working in a doctor's office, she used her husband's medical insurance card to submit 82 fraudulent claims to the insurer for medical

treatments purportedly provided to her children. However, no such services were ever rendered.

STRIKE FORCE STRIKES

- In a continuing Medicare Fraud Strike Force operation, 11 defendants, including medical professionals, were charged with conspiracy to commit health care fraud under Section 1349 of Title 18 of the U.S. Code. Three suspects, arrested on 7/14, were charged for their involvement in a $3.5 million scheme in which they submitted fraudulent claims for durable medical equipment. Those involved included the owner of an oxygen equipment services company and two others who served as patient recruiters. Some recruiters targeted local churches for beneficiaries whose personal information the defendants used for fraudulent billings. A search warrant was executed at the oxygen equipment services company at the time of the arrests.

  Eight other defendants were arrested on 7/16 at a separate location for submitting allegedly fraudulent claims for physical therapy and other medical services that were medically unnecessary or were not provided to beneficiaries at all. The Strike Force's investigation included the use of a court-ordered camera and microphone hidden in a room at the clinic, identified in the complaint as the "Kickback Room," in which the conspirators allegedly paid cash kickbacks to corrupt beneficiaries. The purpose of the kickbacks was to induce the beneficiaries to receive unnecessary medical services or to remain silent when services not provided were billed to various insurance carriers. The conspirators obtained the money for the kickbacks by cashing checks drawn on clinic accounts that had been made payable to a nonexistent corporation. A search warrant was executed at the clinic at the time of the arrests. Together, the 11 defendants defrauded the insurers of more than $25 million.

REPAYMENT ORDERED

- Brian Finley of Monroe County was convicted of insurance fraud and sentenced on 8/9/10 to a year's probation and ordered to repay $6,200 to the Excellus Health Plan. He was arrested on 5/10/10 for naming his ex-wife as his spouse on an application for employer-sponsored health insurance although they were no longer married. He told investigators his ex-wife needed medical coverage. As a result of the fraud, Excellus paid more than $29,000 in medical benefits to which the ex-wife was not entitled. The Frauds Bureau conducted the investigation that resulted in his arrest.

NO EXPENSES INCURRED

- Following an auto accident on 1/14/10, a self-employed resident of Saratoga County applied to Erie Insurance Company for reimbursement of $2,800 in expenses under the no-fault portion of his auto insurance coverage. On the

application, he stated that the expenses included day care for his children which was purportedly being provided by his live-in girlfriend, the children's mother. He also listed transportation expenses and included a receipt from a local taxi company. However, an investigation by the Frauds Bureau and Erie's SIU revealed that his girlfriend lived out of state and did not move to New York until March 2010. In addition, the taxi receipt had allegedly been written by the defendant. He was arrested on 8/19/10 and charged with insurance fraud and falsifying business records.

STRIKE FORCE SUCCESS

- An investigation by the Medicare Fraud Strike Force, of which the Frauds Bureau is a member, led to the 9/22/10 arrest of a surgeon on charges that from 2/09 to 1/10, he defrauded Medicare and numerous other health care benefit programs of at least $3.5 million. Investigators began reviewing the doctor's practice after receiving complaints from patients who said the doctor had submitted claims for services they had not received. He allegedly consistently filed claims for office visits, examinations and subsequent surgical procedures as if he were treating unrelated conditions, when in fact he was providing follow-up services related to an initial procedure. In addition, he often billed for working more than 24 hours in a day. A search warrant was executed at his office on the day of his arrest and bank records were seized.

695 COUNTS OF FORGERY

- A Queens accountant was arrested on 9/21/10 for filing 695 fraudulent health insurance claims totaling more than $115,000 with Aetna and United HealthCare Oxford from 11/09 through 5/10. She filed several apparently legitimate claims and then forged the health care providers' paperwork to file the bogus claims. In submitting the claims, she used the names of three out-of-network providers in order to be paid directly, rather than having the payments made to in-network providers. Of the total amount the defendant was paid, $65,000 was for a psychologist's care that was never provided. All but 54 of the claims were paid by Aetna. Her arrest was the result of an investigation conducted jointly by the Frauds Bureau and the Queens DA's Office. She was charged with insurance fraud, grand larceny and 695 counts each of forgery and possession of a forged instrument.

STAGED SLIP AND FALL

- Video surveillance images led to the arrest on 10/20/10 of an Auburn, NY, man accused of staging a slip-and-fall accident. The video showed the suspect deliberately pouring soda onto the floor of a convenience store and then lying on the floor until customers and store employees came to his aid. He subsequently filed a claim with the store's insurer, Travelers Property & Casualty Insurance Company, for a purported back injury but later withdrew it. The Frauds Bureau

and the Auburn Police Department pooled resources in the investigation that led to his arrest. He was charged with falsifying business records and insurance fraud.

PHANTOM MEDICAL CLINICS

- An ongoing investigation by the Medicare Fraud Strike Force, of which the Frauds Bureau is a member, led to the 10/13/10 arrest of nine suspects charged with conspiracy to commit health care fraud under Section 1349 of Title 18 of the U.S. Code. The arrests were part of a nationwide takedown of an Armenian health care fraud ring that led to 73 arrests. One of the defendants is reported to be the East Coast ringleader of the gang. The defendants were charged with submitting $163 million in fraudulent bills to Medicare and private insurers and operating 118 phantom medical clinics in 25 states. They allegedly stole identities of providers and thousands of Medicare recipients and submitted bills for treatment that was never provided, e.g., forensic pathologists charging for live office visits and obstetricians conducting allergy tests. Forty-four defendants were charged with racketeering conspiracy, conspiracy to commit health care fraud, identity theft and money laundering.

PAIN IN THE NECK

- An investigation conducted by the Frauds Bureau resulted in the arrest on 10/10/10 of a former rehabilitation specialist. After claiming that chronic neck pain caused by a job-related injury left her unable to work, she started collecting disability benefits. During the benefit period from March 2005 to 2009, she submitted allegedly fraudulent documents to her insurer stating that her disability prevented her from working. In fact, evidence indicated that she was employed as a family care provider while collecting nearly $46,870 in benefits to which she was not entitled. She was charged with insurance fraud and falsifying business records.

PODIATRIST SENTENCED TO $660,000 IN RESTITUTION

- Michael, Akyuz, a former podiatrist, was sentenced on 11/3/10 in U.S. District Court to serve two concurrent five-year terms of probation for falsely billing Medicare for services he did not provide. In addition, he was ordered to repay more than $660,000 in restitution, perform 100 hours of community service and undergo six months of electronic monitoring. He pleaded guilty in March 2010 to health care fraud and mail fraud. He billed Medicare for complicated procedures when he had only provided routine foot care to elderly patients at nursing homes and retirement homes. He has surrendered his license. His arrest was the result of an investigation by the Frauds Bureau, the FBI and the U.S. Attorney's Office.

POLICE OFFICER NABBED

- Following a two-and-a-half week trial, Matthew Romano was convicted on 11/4/10 of 17 counts of mail fraud for attempting to defraud the Village of Johnson City, the Public Employer Risk Management Association and the New York State Retirement System of salary and benefits. Romano claimed that on 12/30/06, while working as a police officer for the Village of Johnson City, he was assaulted and injured by two unknown persons in a local cemetery. However, an investigation revealed that no such assault occurred and Romano actually inflicted the injuries on himself. The Frauds Bureau teamed up with the State Police, the FBI, the Broome County Sheriff's Office and the Police Departments of Johnson City, Binghamton, Endicott and Vestal in the investigation the led to the arrest of this defendant.

IDENTITY THEFT

- An investigation by the Frauds Bureau and the NYPD's Identity Theft Unit resulted in the arrest on 11/3/10 of a Brooklyn woman accused of grand larceny. She admitted to investigators that she stole the identity, including medical insurance information, of a patient at the clinic where she was employed. She gave the information to another person who fraudulently caused Healthfirst Health Plans to be billed for medical treatment totaling $125,000. She was charged with grand larceny.

SENTENCED TO FINE AND RESTITUTION

- Steven Blackmon of Poughkeepsie, NY, pleaded guilty on 12/23/10 to insurance fraud in the 5th degree in full satisfaction of all charges. He was ordered to pay $23,432 in restitution within six months of sentencing and a fine of $750. He was arrested on 12/1/09 and charged with insurance fraud in the 3rd degree for collecting more than $10,000 in lost-wage benefits to which he was not entitled. After being injured in an auto accident, he filed for benefits under the no-fault portion of his auto insurance. He reported to New York Central Mutual Insurance Company that he was unable to work as a result of his injuries. However, an investigation by the Frauds Bureau found evidence that Blackman was working as a dance instructor at several local dance studios while fraudulently collecting benefits.

TWO-TIMER

- Heidi Laviolette was seriously injured in an automobile accident after she attempted to drive home from a party intoxicated. She was taken to an area hospital where she was treated for a broken ankle, a fractured rib and a collapsed lung. She was later charged with DWI (Driving While Intoxicated). Several months later, she was arrested and again charged with DWI in connection with another incident. As part of her plea bargain, she pleaded guilty to the second

DWI charge and the earlier charge was dismissed. Laviolette then filed a $62,000 insurance claim with GEICO Insurance Company for the medical bills associated with her initial accident, stating that she was not the driver but a passenger in the car when the accident occurred. Under New York's then-existing no-fault insurance law, which was applicable in this matter, drivers can be denied coverage for medical bills that result from injuries incurred in accidents that are caused by the fact that they are driving while intoxicated. GEICO referred the matter to the Frauds Bureau for investigation which revealed that Laviolette was in fact the intoxicated driver in the initial DWI charge. On 9/8/10, she was arrested and charged with insurance fraud. Under the Special Prosecutor Program, Laviolette admitted to driving intoxicated and pleaded guilty to felony insurance fraud on 12/6/10. She also agreed to enter an 18-month drug and alcohol treatment program. If she fails any part of the program, she will face seven years in prison.

HEALTH CARE FRAUD

- An Ulster County woman was arrested on 12/21/10 and charged with health care fraud when an investigation by the Frauds Bureau revealed that she listed as her husband a man who was not her husband on a family health insurance plan. As a result, MVP Health Care was fraudulently billed for $10,427 in medical treatment.

ONLY CO-PAYS PAID

- After sustaining injuries in an auto accident, the defendant in this case received prescriptions for medication under his no-fault benefits. He submitted receipts to Selective Insurance Company for reimbursement for the prescriptions, together with an altered bill falsely indicating that he had paid the entire cost of the medication – a total of $33,200. In fact, an investigation by the Frauds Bureau revealed that Medicaid had paid for the prescriptions except for co-payments that ranged from $.50 to $6. These co-pays were the only out-of-pocket expense the defendant incurred. He was arrested on 12/9/10 and charged with grand larceny, insurance fraud and falsifying business records.

STAGED ACCIDENTS

- An investigation by the Frauds Bureau and the NYPD's Fraudulent Accident Investigations Squad led to the 12/7/10 arrest of a Brooklyn man for his role in a no-fault fraud scheme. He is the 42nd suspect arrested in this long-term investigation. He participated in two staged accidents that were set up by a third party. He falsely reported that he had been injured in both accidents and sought and received medical treatment for nonexistent injuries. As a result, insurers were unjustly billed for more than $11,000 in no-fault benefits. He was charged with insurance fraud, grand larceny and falsifying business records.

B. 2010 Training

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

In September, Bureau investigators attended a workshop sponsored by the New York Anti-Car Theft and Fraud Association on the subject of no-fault fraud. The first presentation was titled "Acupuncture & No-Fault Fraud: A Practitioner's Perspective," in which an acupuncturist gave practical lessons on how to recognize fraud in billing by acupuncturists. In the second presentation – "How to Succeed in Automobile and Enhanced Damage Investigations" – a member of Liberty Mutual Insurance Company's Special Investigations Unit gave pointers on identifying enhanced damages in auto accident claims.

Bureau Director Frank Orlando attended the National Summit on Health Care Fraud at the Natcher Conference Center at the National Institutes of Health in Bethesda, MD, on January 28, 2010. The day-long Summit, sponsored by the U.S. Department of Health and Human Services and the U.S. Department of Justice, was the first national gathering on health care fraud between law enforcement and the public and private sectors.

In addition, Director Orlando, Deputy Superintendent Lafayette and Assistant to the Superintendent Joseph Placide participated in a public hearing sponsored by Nassau County Health and Human Services on 11/10/10. The three officials met with Nassau County residents to answer their questions about insurance fraud and discuss what consumers should know to avoid becoming victims of insurance fraud. Other issues on the agenda were federal health care reform, homeowners and renters insurance and what to consider when buying annuities.

C. Outreach Program

The Bureau's Training Officer and other members of the investigative staff provided training for local police and fire units, prosecutors, insurers and community groups throughout the year. The Bureau provided training to 26 groups that included 1,971 participants during 2010, as detailed in the following table:

Insurance Frauds Bureau
Training Program
Insurers, Law Enforcement and Community Groups
2010

Date	Group	Location	Number of Attendees
02/08/10	American Association of Retired People	Bronx, NY	175
02/12/10	NYS Office of Fire Prevention & Control	Montour Falls, NY	22
03/02/10	Eastern Claims Conference	New York, NY	93
03/15/10	NYS Office of Fire Prevention & Control	Montour Falls, NY	23
04/02/10	NYPD Police Academy (Recruits)	New York, NY	112
04/19/10	National Assn. of Insurance Commissioners (Intern)	New York, NY	1
05/06/10	National Assn. of Insurance Commissioners (Intern)	New York, NY	1
05/20/10	Westchester County Police Academy (Recruit)	Valhalla, NY	29
05/27/10	Public Employee Risk Mgmt. Assn.	Bolton Landing, NY	37
06/03/10	N.Y. Assn. of Independent Adjusters, Inc.	Watkins Glenn, NY	20
08/12/10	Inwood Senior Citizens Center	Lawrence, NY	9
08/13/10	Middle Village Older Adult Center	Middle Village, NY	75
08/21/10	Rego Park Senior Center	Rego Park, NY	30
09/01/10	Corsi Senior Center	New York, NY	60
09/10/10	Central Harlem Senior Center	New York, NY	80
09/13/10	General Insurance Association of Korea	South Korea	5
09/27/10	NYS Office of Fire Prevention & Control	Montour Falls, NY	33
10/25/10	National Assn. of Insurance Commissioners (Intern)	New York, NY	1
10/28/10	Albany Claims Assn. – Education Day	Albany, NY	25
11/04/10	NYS Office of Fire Prevention & Control	Montour Falls, NY	100
11/10/10	Nassau County Health & Human Svcs.	New York, NY	30
11/12/10	St. Charles Jubilee Senior Center	New York, NY	15
11/19/10	Chubb Insurance Company (claims, SIU)	New York, NY	15
12/10/10	Westchester County Police Academy (Recruits)	Valhalla, NY	27
12/20/10	NYPD Police Academy (Recruits)	New York, NY	560
12/21/10	NYPD Police Academy (Recruits)	Mew York, NY	430
TOTALS	**GROUPS 26**	**PARTICIPANTS**	**1,971**

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