



**New York State Department 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

Report to the Governor, the Comptroller, the Attorney General, the President Pro Tem of the Senate, the Speaker of the Assembly, and the Chairpersons of the Senate Finance and Health Committees and the Assembly Ways and Means and Health Committees

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March 15, 2012

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



NEW YORK STATE  
DEPARTMENT *of*  
FINANCIAL SERVICES

Andrew M. Cuomo  
Governor

Benjamin M. Lawsky  
Superintendent

March 15, 2012

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

On behalf of the Department of Financial Services ("the Department"), 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.

As you will see, this report highlights the importance of fighting no-fault fraud. Reports of no-fault fraud totaled 85 percent of health insurance fraud reports and more than half of reports of fraud of all types. In sum, it is the biggest single fraud issue faced by the Department.

That is why Governor Cuomo directed the Department to launch a statewide initiative to stop deceptive doctors and shut down medical mills that plague New York's no-fault insurance payment system and cost New Yorkers hundreds of millions of dollars in insurance costs.

The Department has also sent demands for information to 135 medical providers whose billing practices have raised concerns regarding possible no-fault fraud.

This report highlights some of the major investigations undertaken during 2011, including a number of 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 210 arrests for health care fraud in 2011.

In the coming year, the Department and its Financial Frauds and Consumer Protection Division (FFCPD) look forward to continuing to work closely with all our partners to aggressively combat health care fraud.

Respectfully submitted,

Benjamin M. Lawsky  
Superintendent of Financial Services

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## EXECUTIVE SUMMARY

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. The Financial Services Law created a new Financial Frauds and Consumer Protection Division, which includes the Insurance Frauds Bureau of the former Insurance Department.

This report, required under Section 409(c) of the Financial Services Law, summarizes the activities of the Department in combating health insurance fraud during 2011.

## PURPOSE OF THIS REPORT

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.

## **Health Care Fraud 2011 Highlights**

- Effective October 3, 2011, the New York State Insurance Department and the New York State Banking Department merged into a new agency – the Department of Financial Services (DFS).
- DFS's Financial Frauds and Consumer Protection Division's (FFCPD) Criminal Investigations Unit includes what was the Insurance Frauds Bureau, which had been part of the Insurance Department.
- The Department's FFCPD investigates and combats health care fraud, which includes three major types of insurance: accident and health, private disability and no-fault.
- Health care fraud investigations conducted by the Department resulted in 210 arrests, up 32 percent from the 159 arrests in 2010.
- The Department received 14,033 reports of suspected health care fraud including 1,915 involving accident and health insurance, 144 involving disability insurance and 11,974 involving no-fault.
- Reports of suspected no-fault fraud accounted for 51% of a total of 23,422 reports of all types of fraud received during the year.
- The Department's FFCPD and other members of the Drug Enforcement Administration Tactical Diversion Task Force made 47 arrests in 18 investigations.

## **I. Insurance Frauds and the Departmental of Financial Services**

### **A. Merger of the Insurance and Banking Departments**

Governor Andrew Cuomo announced his plan to create the Department of Financial Services (DFS) by merging the New York State Insurance Department and the New York State Banking Department in his 2011 State of the State address. The new Department is designed to better regulate modern financial services organizations. By combining the Insurance and Banking Departments into a unified financial regulator, the new Department of Financial Services will be a more efficient, modern, and comprehensive regulator of the financial sector.

Superintendent of Financial Services Benjamin M. Lawsky set the mission and announced the structure for the Department. He summarized the three main goals of the DFS to be “keeping New York on the cutting edge as the financial capital of the world, protecting consumers better than ever before, and serving as a model of efficient government.” Superintendent Lawsky described the structure of the new Department’s five main divisions: The Insurance Division; the Banking Division; the Financial Frauds and Consumer Protection Division; the Real Estate Division; and the Capital Markets Division.



The Department’s new 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 Department has a longstanding commitment to combating insurance fraud. That commitment will continue and the Department will strive to serve the people of New York State with dedication, professionalism and distinction.

### **B. Health Care Fraud<sup>1</sup>**

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.

#### **1. 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.

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<sup>1</sup> The other areas of insurance fraud that the Department investigates are discussed in a separate report entitled “The New York State Department of Financial Services Report on the Activities of the Financial Frauds and Consumer Protection Division” as required by Section 409(b) of the Financial Services Law.

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 repairs;
- Unbundling, i.e., billing as if each step of a procedure were a separate procedure;
- Staging/causing auto accidents;
- Filing no-fault claims for nonexistent injuries;
- Filing false or exaggerated medical disability claims;
- Staging fake slip-and-fall accidents; and
- Accepting kickbacks for patient referrals.

A review of health care fraud reports received by the Department in 2011 showed a year-to-year increase in allegations of pharmaceutical fraud and/or diversion of controlled substances, as did the incidence of medically unnecessary treatments and expensive diagnostic tests. 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 abundant, remained steady during 2011.

## **2. The Costs of Health Care Fraud**

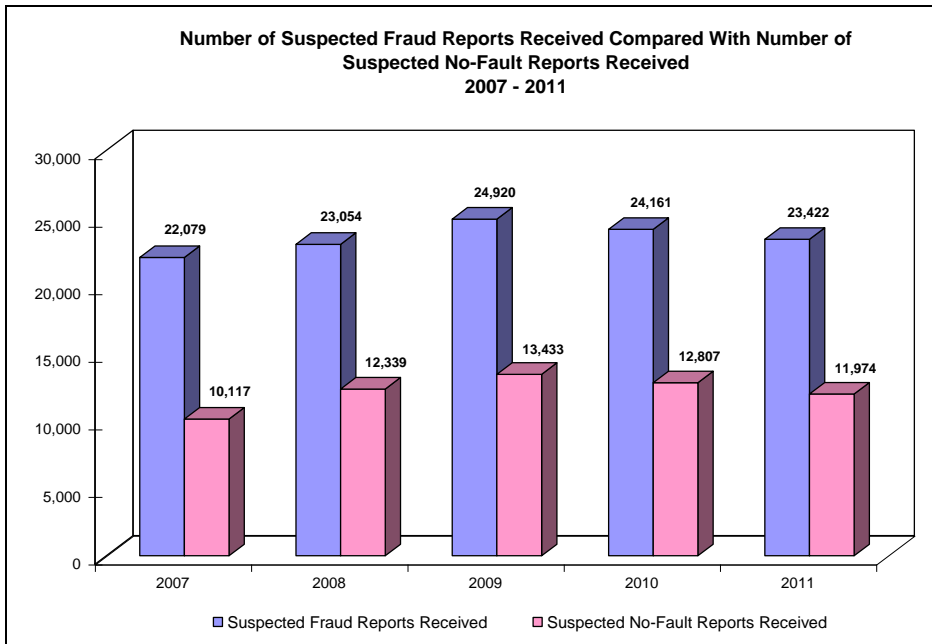
Health care fraud is a costly and pervasive drain on the national health care system. Though experts vary in their estimates, all agree that the costs of health care fraud are exorbitant. According to the National Health Care Anti-Fraud Association (NHCAA), fraud wastes at least 3 percent of all health care spending each year and may waste as much as 10 percent. The NHCAA estimates that the financial losses due to health care fraud are in the tens of billions of dollars annually. Combating fraud and abuse helps rein in the escalating costs of health care in the United States.

## **3. No-Fault Fraud**

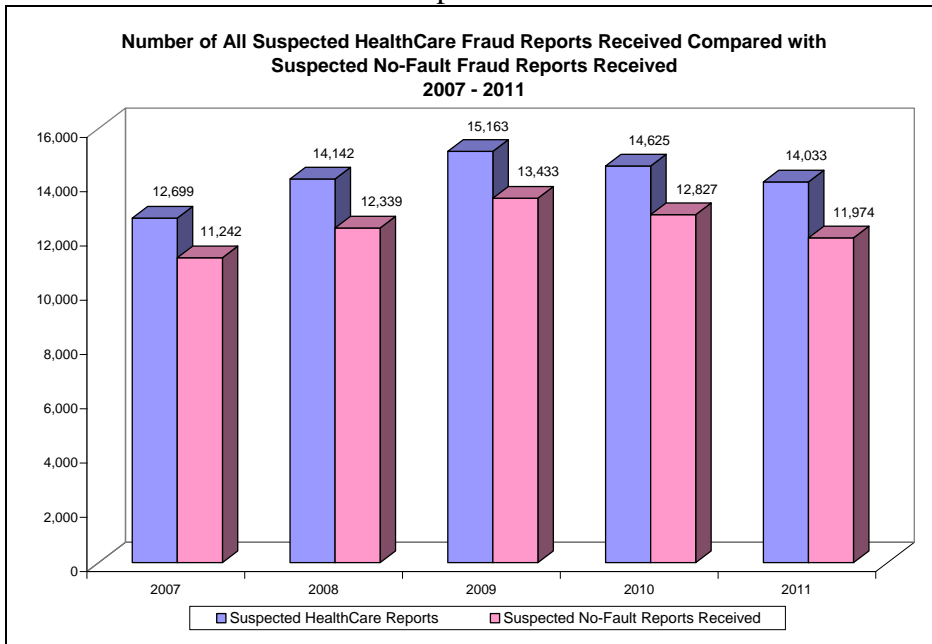
The number of suspected no-fault fraud reports received by the Department began to rise in 2007 and there were small year-to-year increases through 2009. Such reports declined in both 2010 and 2011, totaling 11,974 in the most recent year reported. In 2011, suspected no-fault fraud reports accounted for 51% of all fraud reports received by the Bureau.

The number of suspected no-fault fraud reports made up 85% of all health care fraud reports in 2011 and have accounted for upwards of 85% of total health care fraud reports since at least 2007.

**Graph 1**



**Graph 2**



New Yorkers pay 53% more than the national average for auto insurance premiums, making the State the fourth most expensive for such costs. Combating no-fault fraud is an essential component in mitigating these significant costs, and the Department is committed to rooting out and preventing no-fault fraud and all other types of health insurance fraud.

The Department will continue to take an aggressive proactive approach with regard to its efforts to combat no-fault insurance fraud. No-fault fraud is often perpetrated by complex



enterprises that consist of corrupt medical providers and attorneys. Earlier this month, Governor Cuomo announced a statewide initiative to stop deceptive medical providers and shut down medical mills that plague New York's no-fault insurance payment system and cost New Yorkers hundreds of millions of dollars in insurance costs. The initiative has two parts: 1) the Department issued a new regulation that will enable it to ban medical providers who engage in fraudulent and deceptive practices as part of the no-fault system. The regulation implements a 2005 law that gives DFS the power to regulate medical provider participation in the no-fault system, and 2) as part of an ongoing investigation, the Department is sending letters to 135 medical providers, identified through audits as well as information from law enforcement and insurance companies, whose billing practices have raised concerns regarding possible no-fault fraud and demanding information regarding their corporate structures, payment requests, and their direct participation in the practice. Any provider who refuses to respond to the Department's letters may be banned from participating in the no-fault system.

## **II. Collaborative Efforts to Combat Health Care Fraud**

The FFCPD's 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. To 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. Among the groups of which the Bureau is a member are the following:

- Western New York Health Care Fraud Task Force
- Central New York Health Care Fraud Working Group
- FBI/U.S. Attorney Health Care Fraud Working Group
- FBI New York Health Care Fraud Task Force
- National Insurance Crime Bureau Medical Working Groups
- Medicare Fraud Strike Force
- Drug Enforcement Administration Tactical Diversion Task Force (Upstate/Downstate)

### **A. Drug Enforcement Administration Tactical Diversion Task Force**

The FFCPD's Insurance Frauds Bureau has been a member of the Albany-based Drug Enforcement Administration Tactical Diversion Task Force (UTDTF) since February 2011 when an investigator was assigned to work side-by-side with the Task Force's other members. The Task Force investigates organized drug diversion schemes, "doctor shopping" and forgery of controlled substance prescriptions. The Task Force made 47 arrests as a result of the successful investigation of 18 cases in 2011. Due to the success of the UTDTF, Frauds Bureau recently joined a similar task force in the downstate area that is focused on the same problem.

## **B. Medicare Fraud Strike Force**

The Medicare Fraud Strike Force, coordinated jointly by the Department of Justice and the Department of Health and Human Services, is a multi-agency team of federal, state and local law enforcement agencies that combats fraud by analyzing data and putting an increased focus on community policing. The Strike Force is part of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), created in May 2009 to prevent and deter fraud and enforce current anti-fraud laws.

Since the inception of operations in March 2007, Strike Force operations in nine cities, including New York, have charged more than 1,140 defendants who collectively fraudulently billed the Medicare program for more than \$2.9 billion. Moreover, the HHS Centers for Medicare and Medicaid Services, working in conjunction with its Office of the Inspector General, are taking steps to increase accountability and decrease the presence of fraudulent providers.

## **C. Western New York Health Care Fraud Task Force**

The Western New York Health Care Fraud Task Force works closely with state and local law enforcement agencies and the insurance industry to combat widespread fraud in the health care industry. In addition to the FFCPD's Insurance Frauds Bureau, Task Force members include the FBI, the U.S. Department of Health and Human Services' Office of the Inspector General, the IRS, and the U.S. Postal Service, among others. Investigations by the Task Force led to convictions and sentencing in two cases in 2011. In one case, a Buffalo podiatrist was sentenced to six months in federal prison, one year of supervised release and restitution of \$36,869 after pleading guilty to one count of theft in connection with health care fraud. In the second case, an Orleans County pediatrician was sentenced to five years' probation, 200 hours of community service and \$260,877 in restitution. He received free vaccines meant for Medicaid patients, dispensed them to non-Medicaid patients and billed their private insurers. Both cases are summarized in Section IV. A of this Report.

## **D. Other Group Participation**

The Bureau also actively participates in the FBI New York Health Care Fraud Task Force, the National Insurance Crime Bureau Medical Working Group and the Central New York Health Care Fraud Working Group. Participation provides the opportunity for studying trends, planning strategies and conducting joint investigations.

# **III. Reporting and Preventing Insurance Fraud**

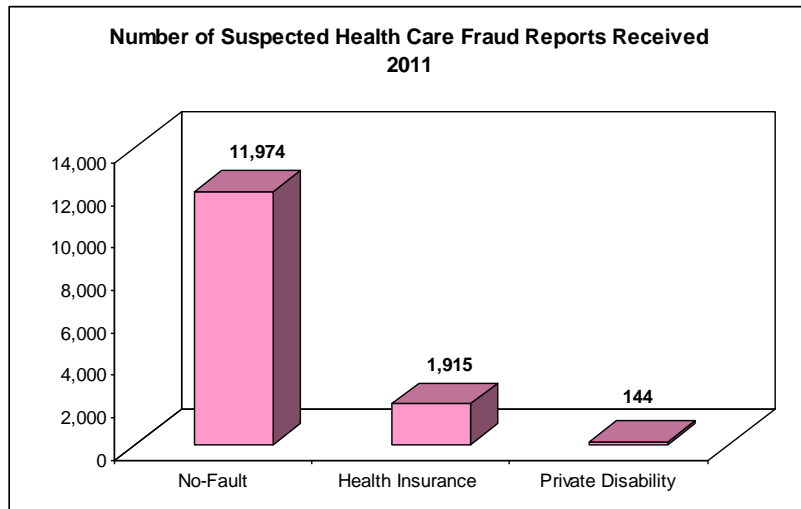
## **A. Insurance Company Reporting**

Insurers are required by Section 405 of the Insurance Law to report suspected fraud to the 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 2011, approximately 93 percent of the 23,422 fraud

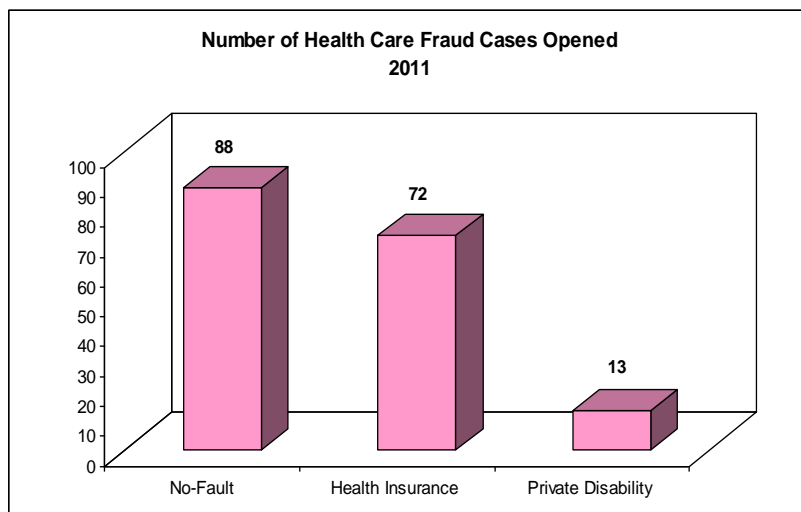
reports received by the Department were transmitted electronically and received remotely from insurers. Insurers have access to FCMS through the Department’s portal using secure accounts.

The Department received 14,033 reports of suspected health care fraud during 2011 – 1,915 involving accident and health insurance, 144 involving disability insurance and 11,974 involving no-fault. A total of 173 new health care fraud cases were opened for investigation. Of these, 72 involved accident and health, 13 involved disability and 88 involved no-fault. In contrast, of a total 170 new health care fraud cases opened in the prior year, 72 involved no-fault. (It should be noted that frequently multiple fraud reports 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 210 arrests in 2011 compared to 159 arrests in 2010 - an increase of 32%.

**Graph 3**



**Graph 4**



## B. 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 will contact the caller for details maintained on a confidential basis. The Department recorded an average of 21 calls per week during 2011. The “Consumers” section on the Department’s website also includes a link to a fraud report form and instructions for consumers to report fraud to the Department by mail or fax. The section is designed to help consumers recognize, report and combat insurance fraud.

## IV. The Year in Review

### A. Major Cases in 2011

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

- **No Treatment:** In February, a Manhattan podiatrist was charged with stealing more than \$100,000 from a health insurer by submitting claims for treatment that never occurred and asking patients to lie to investigators. He is accused of using patient information of at least five persons to submit claims to CIGNA Insurance Company. In two instances, the defendant allegedly accepted payment for claims he filed on behalf of patients, one of whom was in Europe and the other at Disney World when the treatment purportedly was provided. CIGNA paid out a total of \$100,671 on the fraudulent claims. An investigation by the Department led to the arrest.
- **Probation and Restitution:** In March, an upstate resident was sentenced to three years’ probation and ordered to pay \$33,000 in restitution. Following an auto accident, he received prescriptions for medications through his no-fault insurance coverage. He submitted the receipts to Selective Insurance Company for reimbursement with an altered bill indicating that he had paid the entire cost of the medications. An investigation uncovered evidence that Medicaid had paid for the prescriptions, with the exception of his co-payments that ranged from \$.50 to \$6, the only out-of-pocket expenses the defendant incurred.
- **Forged Prescriptions:** An investigation resulted in the arrest in March of a registered nurse in Nassau County for insurance fraud. The defendant had 17 prescriptions for controlled substances filled at various local pharmacies under her health insurance plan. Records from three of the pharmacies showed that the defendant had picked up the prescriptions. Numerous physicians purportedly wrote the prescriptions, however, the physicians in question informed investigators that the prescriptions were forged. As a result of the fraud, the defendant’s insurance plan paid the pharmacies \$10,679 for forged prescriptions.
- **Fraudulent Billing:** A Yonkers medical billing clerk was employed by a doctor who also treated her as a patient. The investigation found that, during the first half of 2008, the

clerk had submitted 20 claims totaling \$52,200 for services that were not provided to her and for visits that never took place. As a result, Nippon Life Insurance Company paid out \$28,326 on the fraudulent claims. The clerk was arrested in June on a charge of insurance fraud.

- **Phony Claims:** A pharmacist and his roommate were arrested in July and charged with insurance fraud as a result of an investigation. The pharmacist allegedly used the computer system at the Brooklyn drug store where he was employed to generate phony claims in the name of his roommate as if actual prescriptions had been written and filled. The roommate then submitted the phony claims to Medco Health Solutions, a pharmacy benefits management program, and obtained reimbursements of more than \$1 million.
- **Unqualified Participants:** A New York-licensed broker was charged with enrolling small business owners in Healthy New York, a state-sponsored health insurance plan, which they were not qualified to participate in. The broker allegedly helped the small business owners file applications to MVP Healthcare and charged them fees ranging from \$250 to \$1,000. The fraudulently obtained coverage resulted in MVP's payment of an estimated \$491,000 in medical and prescription drug claims and \$7,800 in commissions to the broker. The broker was arrested in July as a result of the investigation.
- **Stolen Prescription Pads:** A fourth suspect was charged with health care fraud in a continuing investigation led by the Department with the assistance of the U.S. Department of Health and Human Services' Office of the Inspector General. Evidence indicated that the suspect had stolen prescription pads from medical facilities, sold some of the pads and filled prescriptions for controlled substances with the remaining pads. He then sold the medications he had obtained illegally. A search warrant executed at his Bronx residence in September led to his arrest. Three other suspects in the case had previously been arrested in connection with a scheme to steal blank prescription pads, write prescriptions for controlled substances (*i.e.*, oxycodone), and have them filled. Search warrants were executed at the residences of those suspects in August based on evidence gathered during the investigation. The suspects were arrested in August and September for allegedly running a fraudulent prescription drug ring from their homes.
- **Claims-Handling Complaint:** A New York City man was arrested in September and charged with filing nine fraudulent claims for \$22,570 with Aetna Insurance Company for medical treatment he allegedly had not received. The investigation disclosed that a doctor who the man claimed had performed medical services in January 2010 had died in August 2009. Several other claims indicated treatment by another doctor at NYU Langone emergency room but investigators found that there was no such doctor associated with NYU and the State Education Department Office of the Professions had no record of a health care provider with the name provided on the suspect's claims. After filing the claims and before the investigation was initiated, the suspect wrote to the Superintendent of Insurance twice and spoke with him on one occasion to complain about Aetna's handling of his claims. Aetna paid \$11,256 on the nine claims.

- **Upcoding:** After pleading guilty to federal health care fraud in May, a chiropractor was sentenced in November to five years' probation and was ordered to pay \$199,999 in restitution to Excellus BlueCross BlueShield. From 2005 through 2009, he submitted more than \$200,000 in fraudulent claims to Excellus. In numerous instances he provided routine services but submitted claims for more expensive treatments, a practice known as upcoding. In other instances, he billed for services that he never provided and for visits that never occurred. His arrest was the result of an investigation conducted by Department investigators and the FBI.
- **Participation for Members Only:** A senior official of the Otsego County Chamber of Commerce was arrested for his participation in a fraudulent health insurance scheme. He enrolled New York City residents in the Chamber's health plan by maintaining that they were Chamber members and offering them lower rates than they would have paid for coverage in the New York City area. He enrolled other individuals outside of Otsego County in the Chamber's legitimate health plan after creating a nonexistent "associate member" designation for them. The enrollees were unaware that they had been fraudulently listed as Chamber members. The Department began its investigation after being contacted by MVP Health Care, which had noticed an unusual spike in new enrollments with many enrollees residing outside of Otsego County. After the scheme was discovered, the 400 New York City enrollees and 120 legitimate Otsego County enrollees lost their coverage. Coverage for the Otsego County enrollees subsequently was reinstated under a new plan. MVP lost more than \$135,000 in premiums, and paid more than \$654,000 in claims for medical treatments, plus \$285,000 for prescription drugs for the fraudulently enrolled members.
- **Operation Eye In The Sky:** Three drivers and five passengers were arrested in March for staging an accident in the Bronx in June 2010 and subsequently filing no-fault claims for nonexistent injuries. A video surveillance camera caught them circling the block and then setting up the three-car collision. After assessing the damage, the drivers returned to their cars and repeated the "accident" to cause more damage. They were treated for their alleged injuries at local Bronx medical clinics that billed insurers up to \$39,000. The three men told investigators that one of them stopped short, leaving no time for the other two to avoid hitting the stopped car. Evidence gathered during an investigation by the Department and the NYPD's Fraudulent Accident Investigations Squad indicated that the eight defendants were friends prior to the accident.
- **Prescribed For Herself:** A Rochester pharmacist was accused of prescribing medications for herself by calling prescriptions in to local pharmacies using the Drug Enforcement Administration numbers of two doctors, one of whom was her former husband. The prescriptions were then submitted electronically to Excellus Health Plan which paid out \$1,200 in reimbursements for the illegally prescribed drugs. The Rochester Office of the FBI requested the assistance of the Department in the investigation that led to the pharmacist's arrest in March.
- **Illegally Obtained Medications:** In March, agents from the FBI and the IRS asked the Department for assistance in an investigation that revealed that a Rochester attorney was

receiving large quantities of prescription pain killers from a local doctor, although his medical records did not support the need for those medications. Over a five-year period, Excellus Health Plan paid out \$398,793 for the illegally obtained medications. Following a sealed federal grand jury indictment, a warrant was issued and the attorney was arrested in May and charged with health care fraud and related crimes.

- **Videotape Evidence:** A Bronx man who filed a no-fault application in September 2010 subsequently sought and received medical treatment for purported injuries. A review of a videotape of the accident scene, however, showed that the defendant was not involved in the accident and was not in proximity to any of the vehicles involved in the accident. As a result of the fraud, Liberty Mutual Insurance Company was billed more than \$20,000 for unnecessary medical treatment. Department investigators and the NYPD's Fraudulent Accident Investigations Squad conducted the investigation that led to the man's arrest in April.
- **Federal Prison Sentence and Restitution:** After pleading guilty to one misdemeanor count of theft in connection with health care fraud in January, a Buffalo podiatrist was sentenced in May to six months in federal prison and one year of supervised release, and was ordered to pay restitution of \$36,070 to Medicare and \$799 to Univera Healthcare. He had been charged with 28 counts of health care fraud in January 2009 and subsequently admitted that in April 2005 he submitted a claim to Medicare falsely stating that he had performed a procedure called a "wedge excision." He was originally charged with repeatedly billing Medicare and private insurers for expensive treatments when he was actually providing only routine foot care. The investigation that led to his arrest was conducted by the Western New York Health Care Fraud Task Force, of which the FFCPD's Frauds Bureau is a member.
- **Sting Operation Nets "Runner":** As a result of an undercover sting operation conducted by the Department and the Suffolk County Insurance Crime Bureau, a known "runner" was arrested in May and charged with computer trespass. The defendant allegedly paid two employees at a hospital in Bay Shore for patient file information. He then contacted the patients and steered them to specific attorneys and medical clinics in an insurance fraud scheme. The two hospital employees were arrested in February and also charged with computer trespass.
- **Podiatrist Sentenced:** After pleading guilty to grand larceny in March, an Orleans County pediatrician was sentenced in August to five years' probation and 200 hours of community service, and was ordered to pay \$260,877 in restitution (\$81,544 to insurers and \$179,333 to Medicaid). He had received free vaccines that were supposed to be dispensed to Medicaid patients; however, he used the vaccines for non-Medicaid patients and billed their private insurers. The investigation was conducted by the Western New York Health Care Fraud Task Force, of which the FFCPD's Insurance Frauds Bureau is a member.
- **No-Fault Fraud:** Twelve suspects were indicted for participating in a no-fault scheme. The indictment charged that they staged auto accidents to generate fraudulent billing for

unnecessary medical treatments and coached legitimate accident victims to exaggerate injuries. The suspects were accused of defrauding numerous insurers of more than \$45,000. The Department, the NYPD's Fraudulent Accident Investigations Squad, the Queens DA's Office and the SIUs of Progressive, GEICO and Safeco Insurance Companies collaborated on the investigation that led to the arrests.

- **No-Fault Fraud Mill:** Twenty-four defendants were charged with health care fraud for their participation in billing scams that defrauded insurers, Medicare and Medicaid out of millions of dollars. Twenty-two of the defendants were accused of causing no-fault insurers to pay out millions in reimbursements for medical treatment that was never provided or that was medically unnecessary. Two indictments charged doctors who allegedly faked ownership of medical clinics and concealed the fact that the true owners were not medical professionals. These "front" doctors, other health care providers and clinic employees caused fraudulent bills to be submitted to insurers. Charges were also brought against "runners" who were paid to recruit patients and patients who faked and exaggerated injuries from auto accidents. The patients allegedly were coached by clinic employees on how to describe their purported injuries to insurance companies. Another indictment named two operators of a medical supply company for allegedly forging doctors' signatures and prescriptions to support fraudulent billing to Medicare and Medicaid for durable medical equipment. The defendants each face a maximum sentence of 20 years in prison. Six search warrants were executed and ten accounts were frozen in connection with the investigation, which was conducted jointly by the Department, the Office of the U.S. Attorney for the Southern District, the FBI, the NYPD and U.S. Department of Health and Human Services.
- **Two Sentenced for Health Care Fraud:** An investigation by the Department investigators together with the FBI culminated in jail sentences and orders to pay restitution for two defendants for their parts in a scheme to defraud numerous medical insurance providers by submitting fraudulent claims. One woman was sentenced to six months and ordered to pay \$247,391 after having been arrested in 2003 and subsequently pleading guilty to one count of health care fraud. Her co-defendant in the scheme, who billed massages as physical therapy and billed for services not provided, was sentenced to 30 months and ordered to pay \$2.6 million. She had been arrested in 2003 and subsequently pled guilty to health care fraud and obstruction of justice.
- **60<sup>th</sup> Defendant Arrested:** An ongoing investigation into no-fault fraud led to the arrest of a Brooklyn man charged with larceny. He intentionally had crashed his vehicle into a bicycle to defraud Progressive Insurance Company. The defendant falsely reported the "accident" to Progressive, was treated for nonexistent injuries, and Progressive paid out more than \$2,000 for unnecessary medical treatment. The man is the 60<sup>th</sup> defendant to be arrested in connection with this long-term investigation conducted by the Department and the NYPD's Fraudulent Accident Investigations Squad.
- **Services Not Rendered:** A joint investigation conducted by the Department and the New York State Office of Medicaid Fraud led to the November arrest of a Rochester optometrist for allegedly billing for services that he did not provide. The optometrist



fraudulently obtained \$36,752 from Excellus Health Plan and \$3,946 from Medicaid. Investigators learned that he was a salaried employee at an eye-care center who was not authorized to submit bills to insurers. When interviewed, the defendant confessed to submitting the fraudulent claims.

- **Fraudulent Claims:** A Long Island business owner purchased a health plan from Oxford Insurance Company for himself and his sister, who was listed on documents submitted to Oxford as an employee of her brother's company. Oxford paid \$130,000 in medical bills for the sister; however, the sister admitted that she was not an employee when she was interviewed by the investigations from the Department and the Suffolk County DA's Office. The business owner was arrested and charged with insurance fraud.

## **B. Continuing Education/Training**

The Department's investigative staff members routinely attend career development seminars and training programs to increase their proficiency in investigative procedures, use of Department/industry/law enforcement databases as investigative tools, and problem-solving techniques in order to stay current with emerging developments in the area of health insurance fraud.

During 2011, Bureau staff took advantage of many of the educational opportunities offered by the New York Anti-Car Theft and Fraud Association, the New York Prosecutors Training Institute and the New York State Division of Criminal Justice Services, among others.

## **C. Outreach Program**

The Training Officer of the FFCPD's Frauds Buireau 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 31 groups that included 2,388 participants during 2011, as detailed in the following table:

**Insurance Frauds Bureau  
2011 Outreach Program  
Insurers, Law Enforcement and Community Groups**

<b>Date</b>	<b>Group</b>	<b>Location</b>	<b>Number of Attendees</b>
01/20/11	Office for the Aging (Caseworkers)	Hauppauge, NY	23
01/28/11	NYS Office of Fire Prevention & Control	Montour Falls, NY	12
02/24/11	Albany Police Department (Auto Unit)	Albany, NY	30
03/03/11	Preferred Mutual Insurance Company	New Berlin, NY	16
03/09/11	Nassau Cty. Dept. of Sr. Citizen Affairs	Merrick, NY	35
03/14/11	NYS Office of Fire Prevention & Control	Montour Falls, NY	25
03/22/11	Delaware Cty. Dept. of Emergency Svcs. (Fire Investigation Unit)	Delhi, NY	15
04/08/11	Co-op City Senior Center	Bronx, NY	50
04/26/11	NAIC International Fellows Program (Fellow)	New York, NY	1
04/28/11	NYS Special Investigations Unit	Saratoga, NY	100
05/06/11	Westchester County Police Academy (Recruits)	Valhalla, NY	68
05/05/11	NYS Assn. of Self-Insured Counties	Saratoga, NY	50
05/05/11	NY Prosecutor's Training Institute	Brooklyn, NY	100
05/06/11	Westchester County Police Academy (Recruits)	Valhalla, NY	15
05/11/11	Broome County Bank Security Officers	Binghamton, NY	9
06/04/11	Port Washington Senior Center	Port Washington, NY	26
06/06/11	New York State Insurance Department	New York, NY	28
06/13/11	NYS Office of Fire Prevention & Control	Montour Falls, NY	20
06/22/11	Liberty Mutual Insurance Company	Syracuse, NY	38
06/24/11	Delegation from Thailand	New York, NY	4
07/14/11	Port Washington Senior Center	Port Washington, NY	9
07/21/11	CCNS Bayside Senior Center	Bayside, NY	70
07/26/11	McNeil and Company	Cortland, NY	15
08/17/11	Hereford Insurance Company	Long Island City, NY	101
08/25/11	Young Israel of Midwood Senior Center	Brooklyn, NY	30
09/14/11	NYSID Examiner Trainees	New York, NY	27
12/08/11	Westchester County Police Academy (Recruits)	Valhalla, NY	31
12/13/11	NYPD Police Academy (Recruits)	New York, NY	640
12/15/11	NYPD Police Academy (Recruits)	New York, NY	240
12/19/11	NYPD Police Academy (Recruits)	New York, NY	200
12/21/11	NYPD Police Academy (Recruits)	New York, NY	360
<b>TOTALS</b>	<b>GROUPS 31</b>	<b>PARTICIPANTS</b>	<b>2,388</b>

**D. Insurance Frauds Bureau Offices**

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