NorthAmerican TRAINING GROUP

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WEEKLY FRAUD NEWS & REVIEW

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FRAUD CONVICTIONS

A pharmacist stole a doctor's identity to bill insurers $1.7 million for a drug patients never received. Robert Kielar made more than 600 false claims for a medicine that stimulates production of red blood cells. The Chicago man stole the DEA number of a doctor who had been a friend for 40 years. Kielar also stole the identities of patients who did not need the drug. He forged prescriptions, patient receipts, and invoices to fool insurers. He used the money to pay his salary plus mortgages on his Illinois home and properties in Florida and Illinois. Kielar received 7 years in federal prison.

UK man Jagdeve Singh Rai slit a longtime friend's throat and threw his body into a river for a life-insurance payout. He had stolen Jasbir Singh Bain's identity and taken out a large life-insurance policy in Bain's name. Rai's kids were the named beneficiaries. Bains was a perfect victim: homeless and struggling with alcohol and drug addiction. Rai invited Bains to a park outside of London and changed the angle of outdoor security cameras to hide the gruesome murder. Cell records also linked the two around the time of the murder. Bains received life in prison.

FRAUD CHARGES

The owner of a tiny orthopedic hospital bribed a prominent California state legislator to help preserve a state law that kept the exec's $500-million workers' comp scheme going, state prosecutors charge. Sen. Ron Calderon allegedly took $30,000 in bribes from former hospital owner Michael Drobot to protect a loophole allowing Drobot to charge workers' comp insurers huge markups on spinal-implant devices. Drobot's Long Beach hospital was a major provider of spinal surgeries paid for by workers' comp insurers. He paid tens of millions of dollars in kickbacks to doctors, chiropractorss, recruiters, and others who referred spinal patients to his hospital. Drobot paid $15,000 in kickbacks for lumbar fusion surgery and $10,000 per cervical fusion surgery. He also owned a spinal-implant distributorship and required doctors who referred patients to use implants supplied by his company. He then charged insurers inflated rates for the devices. Drobot submitted more than $500 million in false bills for thousands of patients to at least 150 workers' comp insurers, making this the largest such case in California history, prosecutors say. Calderon was his alleged stooge, accepting lavish dinners, golf

excursions, and plane trips on Drobot's dime, prosecutors allege. Drobot also hired Calderon's college-age son Zachary for $10,000 a summer for three years for work in which he appeared for roughly 15 days. The bribe allegedly was disguised as payments to Zachary but the money went into an account controlled by his father. Drobot has agreed to plead guilty. He is cooperating and could receive up to 10 years in federal prison. Calderon is fighting the charges.

An adjuster helped fleece $230,000 from the New Jersey Turnpike Authority, prosecutors charged Wednesday. Robert Napolitano investigated crashes on the turnpike and determined how much repairs to the system would cost. He told insurers whose motorists caused damage to issue checks payable to his firm Dawn to Dusk. Napolitano split the money with Turnpike Authority claims manager Gerardo Blasi instead of sending the money to the Authority, prosecutors allege. Blasi already has pleaded guilty and awaits sentencing. Napolitano could serve up to 20 years in federal prison if convicted.

Kenneth Neil Price told police he awoke to the sound of a vehicle starting up. The Lumberton, North Carolina man said he went outside to find his black 2005 Chevy pickup gone, and two men trying to get into his wife's car. The men then got into another vehicle, which drove off along with an SUV, Price told his insurer. His burned truck was found 11 hours later. Despite the elaborate story, Price allegedly orchestrated the theft himself for a $13,475 insurance payout.

Victoria White filed a claim with Southern General Insurance for damage to her 2005 PT Cruiser from an auto accident, the North Carolina insurance department says. Southern General settled the repair claim with a check for $2,247 made out to the Kings Mountain woman and the lien holder, Darin Groom Auto Sales. The dealer repossessed the vehicle and contacted Southern General about the vehicle damage. The check was cashed after being endorsed by White and Darin Groom Auto Sales, the insurer told the dealer. The auto dealership says it neither endorsed the check nor received the money for the repairs. White allegedly stole the money for personal use, the insurance department says.

Police officer Michael Avila told his Crystal Lake, Illinois department that he hurt his wrist so badly he needed to be placed on light work detail. He then went off-duty for several months after supposedly reinjuring his wrist, the state insurance department says. The department's workers' comp fraud unit grew suspicious and surveilled him. Remarkably, footage showed Avila lifting weights at the police station's own workout facility. He also earned money as a personal trainer while supposedly being unable to work, prosecutors say.

Francis Rixford's timing was criminally off, Pennsylvania prosecutors say. The Scranton, Pennsylvania-area man bought comprehensive and collision coverage, then said his car struck a deer. He actually had no auto coverage at the time, prosecutors said Monday. His car was towed

to a nearby Walmart at 10:24 that morning and cell records allegedly show Rixford added the coverage at 10:37 a.m. He faces insurance-fraud charges.

The huge plot by firefighters, police officers, and prison guards to falsely retire with cushy federal disability pay took another leap with the bust of 28 more suspects in New York. The employees allegedly lied that they had such severe depression, post-traumatic stress disorder, or other psychological problems they were unable to work and had to retire early. Many linked their supposed symptoms to 9/11. Living cushy retirement lives, they are golfing, traveling, flying helicopters, and running a martial-arts studio, the feds say. Ringleaders coached employees how to fail memory tests with plausibility, how to dress, and how to behave. Nearly every disability retirement application included identical descriptions of daily living. They used phrases such as "I have the TV on to keep me company" and "I'm unable to perform any type of work activity in or out of the house." The descriptions also were written in the same handwriting. The suspected ringleaders allegedly collected one-time cash payments of about $20,000 to $50,000 from each retiree. Nearly 135 suspects have been charged for stealing $22 million in disability money. Hundreds of employees could have stolen up to $400 million in benefits, federal prosecutors say.

Cashier Jan Michelle Smith said her supervisor assaulted her while she was working at Harvey's Supermarket in Cordele, Georgia. Smith also said she was injured in the assault. She filed a claim with the store's comp carrier, and with the Georgia workers' comp board. But a police investigation determined the assault never happened, and no charges were filed. The board's own investigation agreed that the assault never happened and that the comp claim was bogus. She faces a variety of charges, with insurance-fraud charges pending.

Murder was a nice way to help out a cousin who needed the money, Elvira Rosa allegedly told an undercover cop she thought she had hired to rub out a friend for a mere $20,000 in life insurance. The Waterbury, Connecticut woman thought she had the plot all figured out, prosecutors say. Their allegations: Rosa was the beneficiary of the targeted man's policy. She needed the money to help her cousin's husband and two children because her cousin was in jail. Rosa gave the undercover officer the target's photo and spent nearly an hour discussing the hit. She would pay the guy $1,500, and gave him what she claimed was a $1,000 necklace as collateral until she received her pension check. Then they drove to New York, where Rosa pointed out the victim's home. He should be killed that night or the next night because impending bad weather would ensure he would be home. No word on how the victim was to be murdered.

RELATED NEWS

The Maryland Insurance Administration (MIA) reports two recent successes: Lashawn Lee had an accident insurance policy with AFLAC. Using her position as a patient account rep for a healthcare facility, the Oxon Hill woman created fake medical treatment documents and submitted them to AFLAC. She billed for medical treatments for herself and family members. AFLAC paid Lee $14,838 then uncovered the scam and referred it to the MIA. The agency investigated and issued a civil order requiring Lee to repay AFLAC and imposing a $20,000 fine; Veronique Myers was a Certified Nursing Assistant for the state of Maryland with a short-term group disability policy through Transamerica Life. The Baltimore woman was involved in a vehicle accident and applied for disability benefits, submitting false and altered medical and employment documents showing she returned to work later than she really did. The MIA's investigation confirmed the scam before any disability money was paid out. The state agency fined her $7,500.

Fire damaged Amelia Lester's home and the Tennessee woman filed a claim with Allstate. The insurer investigated, asking Lester and her husband to come in for an Examination Under Oath. Lester said she would answer questions only if Allstate first showed her its investigative files. The insurer refused, saying that could damage the probe. Lester never appeared for the EUO and sued for payment in federal court. The district court dismissed, so Lester appealed. The policy and Tennessee law both are clear that an insurer can deny a claim if the policyholder refuses an EUO, the court ruled. Nor does an insurer have to first share its claim file. "Why is it reasonable to expect an insurance company to share its investigative files with a policyholder before examining her?" the opinion says. "The point of an examination is to allow insurance companies to sort out fraudulent claims from honest ones, exorbitant claims from accurate ones. Telling the policyholder what the investigation has already uncovered undermines that purpose, as it would allow the policyholder to tailor her answers to the facts already discovered by the company."

Milton Lopez bought coverage for his single-family rental home in Fresno, California. On the application, he said the house was 1,600 square feet with eight rooms and had one resident. In fact, the house was over 3,000 square feet, with eight bedrooms and five bathrooms. Six of the bedrooms also were rented out. Fire destroyed the house and Allstate denied his claim based on material misrepresentation in the application. Lopez sued for breach of contract. The insurer asked specific questions on the application, and that is enough to establish materiality under California law, the appeals court ruled. Allstate thus was entitled to rescind the policy.

An Illinois hospice system was abruptly shuttered when its founder was charged with Medicare fraud. Seth Gillman allegedly billed Medicare for higher levels of service than Passages Hospice Illinois facilities rendered. Employee salaries remained unpaid for a month because Medicare froze payments to the company due to the federal investigation. The employees also

abruptly lost their prescription and health coverage. The job loss "is definitely making a huge impact on our family. There's also a lot of single parents who worked with Passages, a lot of people down to their last $5 or $10 now," said chaplain and employee Rev. Roger Carlson, of the firm's Sauk Valley unit. "It's left a lot of us in pretty rough shape." Nurses and mid-level managers at this unit quickly pitched in, working day and night to find other hospice providers for the patients. The tireless efforts landed the patients into other facilities. The hospice system's employees aren't so fortunate: All 330 were laid off.

LEGISLATION

Expanding the definition of insurance fraud will be on tap when Louisiana's legislature opens in early March. A proposal already in the works would make it a fraud if someone:

- impersonates an insurer or a rep such as an agent to steer a claimant into an insurance-fraud scheme;
- impersonates law enforcement or another official to direct a claimant to a specific healthcare treatment for a fraud scheme; or
- receives money or anything of value for soliciting a claimant to join a scheme.

The President signed a farm bill that adds $9 million to combat schemes by farmers who lie about losses covered by federal crop insurance. The new law also clarifies the existing prohibition on agents rebating money to induce farmers to purchase crop coverage. Agent groups strongly sought formal clarification from the USDA to clearly outline the illegal practice.

The West Virginia House rejected a bill creating a state false claims act. HB 4001 would have enabled whistleblowers to bring civil litigation. Opponents such as the state chamber of commerce thought the threat of whistleblower suits would harm West Virginia's business climate and deter needed business expansion. The bill cleared the committee hurdle but was defeated in a full House vote.