Zalma's Insurance Fraud Letter

A ClaimSchool™ Publication © 2022
Barry Zalma & ClaimSchool, Inc.
Go to my blog & Videos at: *Zalma on Insurance*
***And* at** https://zalma.com/blog
Go to the Insurance Claims Library
Listen to the Podcast: *Zalma on Insurance*
Videos from Zalma on Insurance
Subscribe to Barry Zalma on Substack.com

Volume 26, Issue 12 – June 15, 2022
Subscribe to e-mail Version of ZIFL, it's Free!
Read last two issues of ZIFL here.
Go to the Barry Zalma, Inc. web site here
Videos from "Barry Zalma on YouTube"
Go to Barry Zalma videos at Rumble.com at https://rumble.com/zalma
@zalma on Truth Social

Quote of the Issue

"There Are a Thousand Ways to Do Injustice Without Breaking a Single Law."

Mishle Yehoshua

Insurance Fraud & the States

State insurance departments near the turn of the century recognized that insurance fraud is a serious crime taking multiple billions of dollars from the insurance industry. Local police and prosecutors were not concerned, even after insurance fraud was made a felony, because no one suffered physical injury or death. Insurance fraud just cost a lot of money to insurers who were perceived as extremely wealthy and more victimizers than victim.

Since almost no one was being prosecuted for insurance fraud states, like California, enacted statutes that required insurers to thoroughly investigate all claims, institute a special fraud investigation unit whose only purpose was to detect, investigate, gather evidence, and present that evidence to prosecutors to prosecute the crime. The Special Investigation Units (SIU) did the work only to find most of their investigations ignored and their successes received little or no encouragement from the insurers and the state. Both wanted all claims settled quickly and fairly. The sales people could not explain why their fraud perpetrator clients were being placed under oath and asked to prove their loss rather than just receive a quick and unquestioned check.

State law made all insurers doing business in the state as the only entities required by law to investigate and help in the prosecution of criminals seeking to defraud the insurer. All other persons and entities, when they are the victim of a crime, report it to a police agency who investigates the crime. Reporting a crime, like a robbery, to police has no consequences to the person reporting the crime nor does that person have any obligation past reporting the crime, since they are immune from suit for doing the public service of reporting a crime.

Because insurers are compelled to investigate their customers who the insurer believes have committed a fraudulent act find, if they err, that they are charged with breach of the covenant of good faith and fair dealing. The suits for erroneously, even in good faith, reporting an insured to the state for fraud, exposes the insurer to tort damages and punitive or exemplary damages.

Although it is unusual to impose criminal punishment for the consequences of purely accidental conduct, it is not unusual to punish individuals for the unintended consequences of their unlawful acts. [*U.S. v. Stewart*, 590 F.3d 93 (2nd Cir. 2009)]

The privilege provided to protect those who report suspected crimes to police agencies is often ignored or sidestepped by the courts as the California Court of Appeal did in *Frommoethelydo v. Fire Insurance Exchange*, 42 Cal. 3d 208, 721 P.2d 41, 228 Cal. Rptr. 160 (Cal. 07/24/1986). In that case the insurer who denied a claims for fraud and saw its insured arrested and tried for insurance fraud, was made a defendant when the insured was acquitted.

Even if the insurer obtains a defense verdict, the cost of defending a bad faith lawsuit is often greater than paying the person the insurer believes had attempted to defraud it.

Anti-Fraud Statutes & Regulations

Anti-fraud statutes in my home state of California, and most other states, are also victims of the law of unintended consequences. Because insurance fraud has been estimated to take from the industry anywhere from $80 billion to $300 billion every year, states enacted statutes requiring insurers to create special fraud investigation units ("SIU") to pursue fraud investigations that would normally be performed by the police. Statutes require the SIU to do the investigation, collect the evidence and then report findings to state fraud investigators for prosecution.

For example, California, like almost every state, has enacted an Insurance Frauds Prevention Act. One provision of that act provides, in part:

> Any company licensed to write insurance in this state that believes that a fraudulent claim is being made shall within 60 days after determination by the insurer that the claim appears to be a fraudulent claim send to the Fraud Division ... the information requested ... and any additional information relative to the factual circumstances of the claim and the parties claiming loss or damages that the commissioner may require.

This is a mandatory statutory obligation on the part of insurers to report their "belief" that it "appears" to the insurer that a fraudulent claim is being made. Once sufficient facts are developed that supports the "appearance" of a fraudulent claim the insurer is obligated to report that "appearance" and/or "belief" to the state and thoroughly investigate the claim to help the state in its efforts to prove that a crime occurred. In addition, to encourage and require insurers to fulfill the requirement to report suspected fraudulent claims and to encourage and require insurers to train and maintain effective investigation of potential fraudulent claims, the California Department of Insurance ("CDOI"), like many other states, enacted a set of emergency regulations requiring all insurers who do business in the state of California to maintain or retain an SIU and a plan to defeat fraudulent insurance claims (the SIU Regulations). The California SIU Regulations were approved in their final form in October 2005.[1]

To encourage compliance the CDOI has audited dozens of insurers regarding the SIU Regulations and found that most insurers doing business in California that were audited were in violation of some portion of the SIU Regulations. Major fines, as much as $10,000 per violation, may be imposed on those insurers who refuse, or fail to, comply with the SIU Regulations.

For example, failure to train 100 employees can, therefore, result in a fine from $500,000 to $1 million. The potential fines were a great incentive to create – at least the appearance of – an effective SIU. The SIU regulations require insurers to train every claims employee in accordance with the requirements of the SIU Regulations no later than 30 days after the person is hired and annually thereafter. The intent of the SIU Regulations was to make it easier for an insurer to comply with the statutes and recognize fraud when it is being attempted so that insurance fraud can be prosecuted and fraud perpetrators deterred. A logical, important intent to protect the insurance industry and those it insures pursued with a great deal of good intentions.

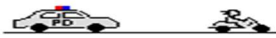
Unfortunately, the existence of a Fraud Division or Fraud Bureau in the Department of insurance deterred police, Sheriffs and prosecutors from investigating insurance fraud. The Fraud Division or Fraud Bureau was woefully underfunded where a large state like California would have only 220 fraud investigators and would receive from insurers about 1500 reports of suspected fraud every month. Investigation of, and prosecution of insurance fraud, shrunk like Alice after eating a mushroom.

The California Insurance Code attempts to protect the insurers who fulfil the requirements of the reporting statutes by providing that no insurer, or the employees or agents of any insurer, shall be subject to civil liability for libel, slander or any other relevant cause of action by virtue of providing information concerning a Suspected Fraudulent Claim to law enforcement, including the California Department of Insurance, Fraud Division. However, in *Frommoethelydo v. Fire Insurance Exchange*, 42 Cal. 3d 208, 721 P.2d 41, 228 Cal. Rptr. 160 (Cal. 07/24/1986) the California Supreme Court concluded that, although immune from suit for reporting the insured to the Fraud Division, it could still be charged with the tort of bad faith for not investigating further after the insured was acquitted of criminal charges of insurance fraud.

Unintended Consequences

Therefore, the good intentions of the SIU statutes and Regulations reduced the number of fraud arrests and convictions and cause insurers to be sued for bad faith for accusing an insured of fraud who was either never arrested or was, like Frommoethelydo, acquitted.

The law of unintended consequences found the good intentions of the state legislatures and departments of insurance to reduce insurance fraud had exactly the opposite result and also caused insurers to face multiple unwarranted and unnecessary bad faith lawsuits if they were not required to comply with the statute and SIU Regulations.



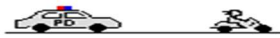
Wisdom

"There are a thousand ways to do injustice without breaking a single law." — **Mishle Yehoshua**
"It is the duty of parents to maintain their children decently, and according to their circumstances; to protect them according to the dictates of prudence; and to educate them according to the suggestions of a judicious and zealous regard for their usefulness, their respectability and happiness." —**James Wilson**
"Courage isn't the absence of fear --- it's being afraid but doing what you need to do anyway." — **Carol Krucoff**
"Dialogic is not to be identified with love. But love without dialogic, without real outgoing to the other, reaching to the other, the love remaining with itself --- this is called Lucifer." — **Martin Buber**
"Inflation is in effect a hidden tax. The money that people have saved is robbed of part of its purchasing power, which is quietly transferred to the government that issues new money." —**Thomas Sowell**
"Were we directed from Washington when to sow, and when to reap, we should soon want bread." —**Thomas Jefferson**

---

[1] Adapted from my book *It's Time to Abolish The Tort of Bad Faith* Available as a paperback here. Available as a Kindle book here. And See my book, *California SIU Regulations 2020* available as a Kindle book here and as a paperback here. Also available by searching at amazon.com.

"It is the madness of folly, to expect mercy from those who have refused to do justice; and even mercy, where conquest is the object, is only a trick of war; the cunning of the fox is as murderous as the violence of the wolf." —**Thomas Paine**
"Only those who risk going too far can find out how far one can go." — **T.S. Eliot**
"Wealth consists not in having great possessions, but in having few wants." — **Epictetus**
"That from these honored dead we take increased devotion to that cause for which they gave the last full measure of devotion — that we here highly resolve that these dead shall not have died in vain — that this nation, under God, shall have a new birth of freedom — and that government of the people, by the people, for the people, shall not perish from the earth. — **Abraham Lincoln**
"Every day above earth is a good day." — **Ernest Hemingway**
"Rule number one is, don't sweat the small stuff. Rule number two is, it's all small stuff."— **Robert Eliot**
"I don't care too much for money, money can't buy me love" – **The Beatles**



Reporting On an Accusation of Insurance Fraud Results in Defamation Suit

Fair Report Privilege Protects Reports of Insurance Fraud

Fox Television Stations, LLC (Fox), William Melugin, Daniel Leighton, and Kris Knutsen (collectively, the Fox defendants) appealed from orders denying their special motions to strike (Code Civ. Proc., § 425.16; anti-SLAPP statute) the complaint filed by Dr. Jay W. Calvert, a nationally recognized plastic surgeon, and Jay Calvert, M.D., Professional Corporation (the professional corporation) (collectively, the Calvert plaintiffs). In J*ay W. Calvert et al. v. Fox Television Stations, LLC et al*., B310772, California Court of Appeals, (May 25, 2022) the Court of Appeal reversed the trial court's decision.

FACTS

This case arises from the Fox defendants broadcasting and publishing news reports about a civil lawsuit filed against Dr. Calvert by his former patient Natalie West alleging insurance fraud and medical battery. In response, the Calvert plaintiffs sued the Fox defendants and Houston for defamation. The trial court found that although the defamation claims arose from protected activity, the Calvert plaintiffs had shown a probability of prevailing on their claims.

On appeal, the Fox defendants and Houston contend Fox's reporting, including its interview with Houston, is absolutely privileged under Civil Code section 47, subdivision (d), as a fair and true report of a judicial proceeding. Further, the Calvert plaintiffs failed to plead and prove actual malice. The Fox defendants also argue several of the statements at issue do not constitute actionable defamation.

On May 31, 2018 West filed a lawsuit against Dr. Calvert, the professional corporation, the University of Southern California (USC), and others, alleging causes of action for fraud, medical battery, breach of contract, and forcible sexual penetration of an unconscious person with a foreign object. West alleged in her second amended complaint that in 2013 Dr. Calvert performed a cosmetic nasal surgery to reconstruct West's nose after a failed reconstructive surgery by another doctor. West paid for the surgery in full, but Dr. Calvert fraudulently billed West's medical insurer for the procedure by falsely characterizing the surgery as a medically necessary correction of a nasal airway obstruction.

West alleged that after the surgery, Dr. Calvert told her the surgery had been "a complete success" but he needed to do two "'tweaks'" in a second surgery. From 2013 through 2017, Dr. Calvert persuaded West to undergo 12 additional unnecessary and harmful nasal surgeries, in order to bill West's insurance carrier for additional procedures. West alleged Dr. Calvert "essentially treat[ed]" West's health insurance policies as "his own personal ATM machine."

Letters from Dr. Calvert's Counsel to Leighton and Melugin

On April 25, 2019 Dr. Calvert's attorney, Arthur H. Barens, in response to an inquiry regarding Fox-owned television station KTTV's intention to broadcast a report on West's allegations against Dr. Calvert, wrote to KTTV senior producer Leighton, requesting Leighton review West's medical files before airing the report.

KTTV published a written version of the report on its website.

The May 15, 2019 Report

On May 15, 2019 KTTV broadcast a second news report on West's allegations against Dr. Calvert. Melugin reported, "A lot of new details [are] coming out after our investigation into Dr. Jay Calvert first aired on Monday night." Melugin reported USC had "removed all affiliation with [Dr. Calvert] off of their plastic surgery website." Melugin stated Hakala held a press conference that day, in which she indicated more than 20 "new alleged victims" had contacted her to make similar allegations of insurance fraud and unnecessary surgeries. In footage of the press conference, Hakala opined USC would not have been in "a huge rush" to distance itself from Dr. Calvert if USC had full confidence in him.

Dr. Calvert's Demand for Retraction

On May 30, 2018 Neville L. Johnson, attorney for Dr. Calvert, sent a letter to Melugin, KTTV news director Kris Knutsen, and the Fox legal department demanding retraction of the May 13 and 15 reports and accompanying online articles.

The Fox defendants made no retraction.

Dr. Calvert's Complaint Against the Fox Defendants and Houston

On June 9, 2020 the Calvert plaintiffs sued the Fox defendants alleging a single cause of action for libel. The complaint alleged 60 statements made in the May 13 and 15 reports were "[f]alse [a]ccusations."

The Fox Defendants' and Houston's Special Motions to Strike

The Fox defendants separately filed special motions to strike the complaint.

Dr. Calvert submitted declarations in support of the Calvert plaintiffs' oppositions. He attached to his declaration in opposition to the Fox defendants' motion portions of West's and Houston's medical records, consent forms, insurance authorizations, and billing histories, which he asserted contradicted their allegations.

The trial court denied the special motions to strike. The trial court found the remaining 47 statements identified in the Calvert plaintiffs' complaint fell within the scope of Code of Civil Procedure section 425.16 because they "concerned a public figure and a matter of public interest." The court found the fair report privilege did not apply to any of the statements.

DISCUSSION

A cause of action arising from an act in furtherance of a defendant's constitutional right of petition or free speech in connection with a public issue is subject to a special motion to strike unless the plaintiff demonstrates a probability of prevailing on the claim.

If the evidence relied upon cannot be admitted at trial, because it is categorically barred or undisputed factual circumstances show inadmissibility, the court may not consider it in the face of an objection.

Defendants Carried Their Burden to Show Most of Their Claims Arose from Defendants' Protected Activity

The complaint's allegations of protected activity that provide only context for the Calvert plaintiffs' defamation claims must be disregarded for purposes of the anti-SLAPP analysis.

The Law of Defamation

The elements of a defamation claim are (a) a publication that is (b) false, (c) defamatory, and (d) unprivileged, and that (e) has a natural tendency to injure or that causes special damage. Additionally, a libel plaintiff who is a public figure must prove, by clear and convincing evidence, that the defendant made the libelous statement with actual malice that is, with knowledge that it was false or with reckless disregard of whether it was false or not.

The Professional Corporation Failed to Carry Its Burden to Show a Probability of Prevailing on Its Claims Because None of the Challenged Statements Concerned the Professional Corporation

The Fox defendants and Houston contend none of the allegedly defamatory statements concerned the professional corporation. The Calvert plaintiffs make no argument to the contrary.

The Trial Court Erred in Denying the Fox Defendants' Special Motion to Strike the Complaint as to Dr. Calvert's Claims

A plaintiff must prove the allegedly defamatory statements are not substantially true. Dr. Calvert submitted no evidence in opposition to the Fox defendants' special motion to strike to show Melugin's statements regarding USC were not substantially true. He has therefore failed to carry his burden to show a probability of success on his defamation claims based on these statements.

Civil Code section 47, subdivision (d) confers an absolute privilege on any fair and true report in, or a communication to, a public journal of a judicial proceeding, or anything said in the course thereof. When the fair report privilege applies, the reported statements are absolutely privileged regardless of the defendants' motive for reporting them. Fair and true in this context does not refer to the truth or accuracy of the matters asserted in the judicial proceedings, but rather to the accuracy of the challenged statements with respect to what occurred in the judicial proceedings.

A media defendant does not have to justify every word of the alleged defamatory material that is published. The reporter is not bound by the straitjacket of the testifier's exact words; a degree of flexibility is tolerated in deciding what is a "fair report."

The fair report privilege protects most of the challenged statements by West, Hakala, and Melugin regarding West's allegations against Dr. Calvert

Most of the statements made by Melugin, West, and Hakala pertaining to West's second amended complaint are privileged. The trial court, therefore, erred in failing to grant the Fox defendants' special motion to strike as to these statements in the complaint.

The extent Melugin's reporting of West's and Hakala's statements at the press conference-that more than 20 new alleged victims had contacted Hakala-exceeded the scope of West's second amended complaint, Dr. Calvert's claims based on these statements fail because he did not show the Fox defendants published the statements with actual malice.

DISPOSITION

The order denying the Fox defendants' special motion to strike is reversed. The cause is remanded to the trial court with directions to vacate the order denying the Fox defendants' special motion to strike and to enter a new order granting the motion. The Fox defendants are to recover their costs on appeal. Houston and the Calvert plaintiffs are to bear their own costs on appeal.

ZIFL OPINION

This case made clear the immunity created by Civil Code Section 47 since it applies to the press and to any SIU investigator who makes a report of a suspected insurance fraud to the state. People, like Dr. Calvert, who are accused of insurance fraud in a civil proceeding cannot stop publication of that information nor may he sue for defamation. The immunity is absolute.

Free Insurance Videos

Barry Zalma, Esq., CFE has published five days a week videos on insurance claims, insurance claims law, insurance fraud and insurance coverage matters at https://www.rumble.com/zalma.

Barry Zalma, Esq., CFE, now limits his practice to service as an insurance consultant specializing in insurance coverage, insurance claims handling, insurance bad faith and insurance fraud almost equally for insurers and policyholders. He also serves as an arbitrator or mediator for insurance related disputes. He practiced law in California for more than 44 years as an insurance coverage and claims handling lawyer and more than 54 years in the insurance business. He is available at http://www.zalma.com and zalma@zalma.com.

Mr. Zalma is the first recipient of the first annual Claims Magazine/ACE Legend Award.

Over the last 54 years Barry Zalma has dedicated his life to insurance, insurance claims and the need to defeat insurance fraud. He has created the following library of books and other materials to make it possible for insurers and their claims staff to become insurance claims professionals.

See the more than 400 videos at https://www.rumble.com/zalma

Person Accused of Fraud Failed to Promptly File Dispositive Motion

Provider To PIP Insured Not a Party to Contract

Plaintiffs Hartford Accident and Indemnity Company, Property & Casualty Ins. Company of Hartford, Trumbull Insurance Company, and Twin City Fire Insurance Company (together, "Hartford") claim that Defendant Greater Lakes Ambulatory Surgical Center LLC submitted fraudulent claims for no-fault benefits for treatment of individuals who were in auto accidents. Hartford asserts claims of fraud, silent fraud, and unjust enrichment.

In *Hartford Accident and Indemnity Company, et al. v. Greater Lakes Ambulatory Surgical Center LLC*, No. 18-cv-13579, United States District Court, E.D. Michigan, Southern Division (May 26, 2022) Greater Lakes moved for leave to file a motion for judgment on the pleadings under Federal Rule of Civil Procedure 12(c), arguing that Hartford's tort claims must be dismissed because the parties' relationship is governed by contract.

Analysis

The scheduling order, entered in July 2019, set a dispositive motion deadline of March 20, 2020. Hartford moved for summary judgment the day before that deadline, and a hearing on that motion was scheduled for September 24, 2020. But a week before the hearing-six months after the dispositive motion deadline-Greater Lakes moved for leave to file a motion for judgment on the pleadings.

The Court has the ability to modify the schedule to allow Greater Lakes to file a dispositive motion, but only for good cause. Fed.R.Civ.P. 16(b)(4). Although district courts enjoy wide discretion under Rule 16(b)(4), leave to amend a schedule should be denied when evidence of diligence is lacking. [*In re Nat'l Prescription Opiate Litig*., 956 F.3d 838, 843 (6th Cir. 2020).]

Greater Lakes showed neither that it could not have filed its dispositive motion despite its diligence nor that the delay was because of excusable neglect. Instead, it alleges that it retained new counsel in September 2020 who concluded that Hartford failed to state a claim. Attorney Shereef Akeel did first appear here in September 2020. But attorney Lukasz Wietrzynski represented Greater Lakes from the beginning of this litigation until October 2021.

Wietrzynski either made an intentional decision not file a dispositive motion by the deadline or he made an error in failing to do so. Either way, Wietrzynski's failure to timely file a dispositive motion does not provide Greater Lakes with good cause or excusable neglect.

The Court rejected Greater Lakes manifest injustice argument because its proposed motion for judgment on the pleadings lacks merit. In deciding whether a plaintiff has set forth a "plausible" claim, the Court must construe the complaint in the light most favorable to the plaintiff and accept as true all well-pleaded factual allegations.

Greater Lakes contends that Hartford's tort claims must be dismissed because the parties' relationship is governed by the no-fault policies. Greater Lakes maintains that those policies required it to provide proof of loss before Hartford became obligated to pay the

insurance claims. Thus, Greater Lakes argues that the allegation that it submitted fraudulent proof of loss relates to its performance under the policies and "sound[s] in contract" rather than tort law.

Under Michigan law, nonperformance of a contractual obligation gives rise to a breach of contract claim but generally not to tort liability. An exception to this "contract-only" rule is that tort liability may exist if the complaint alleges breach of a legal duty separate and distinct from a defendant's contractual obligations. For example, claims of fraud in the inducement and "fraud 'extraneous to the contract' are permissible, whereas 'fraud interwoven with the breach of contract' cannot support an independent claim."

Here, the complaint does not allege the existence of a contract between Hartford and Greater Lakes. Although Greater Lakes argues that the no-fault policies govern this dispute, it was not a party to those policies.

The contract-only rule does not bar tort claims when no contract exists. Greater Lakes insists, without supporting precedent, that the no-fault policies govern because healthcare providers can "step into the shoes" of insureds to obtain payment under the policies-meaning there is a contractual relationship between providers and insurers.

Even if there were a contract between Hartford and Greater Lakes, the Michigan Supreme Court has held that insureds may bring separate claims for fraud and recovery of no-fault benefits.

Unlike a no-fault claim, a fraud claim does not arise from an insurer's mere omission to perform a contractual or statutory obligation, such as its failure to pay all the PIP benefits to which its insureds are entitled. Rather, it arises from the insurer's breach of its separate and independent duty not to deceive the insureds, which duty is imposed by law as a function of the relationship of the parties.

The court also rejected the theory that the no-fault act preempted the fraud claim. The court acknowledged the contract-only rule, noting that "where, as here, the breach of separate and independent duties [is] alleged, [the insureds] should be allowed an opportunity to prove" their tort claims. Since "misrepresenting material facts and deceiving their insureds" involved the breach of an independent duty, the fraud claim survived.

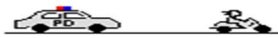
Greater Lakes argued that whether the no-fault act preempted the tort claims but not whether the plaintiffs could assert concurrent breach-of-contract and fraud claims. Greater Lakes is wrong on both counts. Since actions for payment of no-fault benefits are often asserted as breach-of-contract claims,

Conclusion

Greater Lakes showed neither good cause nor excusable neglect for its motion for leave to file a dispositive motion six months after the deadline, and its claim of manifest injustice lacked merit. The Court denied Greater Lakes' motion for leave to file a motion for judgment on the pleadings.

ZIFL OPINION

Hartford, probably frustrated by the failure of the state to prosecute fraud perpetrators, acted proactively sued the providers of health care for insureds that it claimed were fraudulent. Greater Lakes, faced with a motion for summary judgment it thought it would lose, filed a belated motion for a Judgment on the Pleadings and lost its request to file a late dispositive motion that the USDC's Magistrate Judge found was impotent. It is an act of "chutzpah" or unmitigated gall to bring this motion but it did succeed in slowing the opportunity of Hartford to obtain a summary judgment.



Good News From the

Coalition Against Insurance Fraud

$308.6 billion! Coalition Executive Director Matthew Smith introduced J. Michael Skiba, MBA, PhD, Dr. Fraud, Program Director-Criminal Justice, Colorado State University Global who took the audience on a journey of how his PhD team came together to formulate the number that will become the talking point for next few decades. The Coalition believes that the new number may have been quite higher if our associations had not pulled together as we have these many years. A great experience was had by all and we look forward to our Annual Meeting this December in Washington, D.C. The Coalition in partnership with Protiviti has launched a confidential survey that was sent out to our members on June 9. The online survey was developed to gather specific questions in a format that is simple and direct. It will take only a few minutes to complete. The Coalition and Protiviti encourage those who have received the survey to pass the link along to their co-workers, friends and family. Understanding that using data science to analyze consumers' personal data can be helpful to fight fraud, many are deeply concerned because it can unfairly discriminate against some consumers, including racial and ethnic minorities along with privacy concerns about insurers' use of personal data. Thus, legislators and regulators are debating whether to restrict insurers' use of personal data, including to fight fraud. Your opinions and those whom you have shared the survey link with will be helpful to those decisions. We encourage everyone to have their digital voices heard!

A German man created a fake Covid-19 testing center and took in nearly €6 million in payments from health insurers. The guy realized that Covid testing centers were a lucrative business. So, he set up a fraudulent test center in Freiburg im Breisgau, near the French border. While his outfit never administered any tests, a German health insurer still approved his invoices. In four months, the man billed nearly 500,000 tests and received €5.7 million. The sudden and large sums of money in his bank account caught the eye of a suspicious bank employee, who contacted law enforcement. After investigation, his bank account was frozen and the money was donated to the doctors association contracted by health insurers. He also received a year of probation.

Robin Row was convicted of burning her husband and two kids alive after setting their two-story Idaho duplex afire in 1992 to collect life insurance money. She's still the only woman on death row in Idaho. Row federally appealed after exhausting her state appeals. She claimed ineffective counsel because evidence of brain damage causing an intellectual disability allegedly wasn't presented to the state courts. Yet Row's fate remains in doubt after a recent U.S. Supreme Court decision involving two Arizona death row inmates. *Shinn vs. Ramirez* (6-3 decision) holds that evidence of ineffective counsel can't be used in a federal appeal unless it's first presented at the state level. Row stayed with a friend the night before the early-morning fire. Her whereabouts during the fire and new life policies for her husband and two kids also were red flags during her state trial. Investigators later found a storage unit where Row moved furniture and important documents before the fire. An arson investigator testified that Row was "incredibly smart" and "manipulative." Yet brain scans weren't introduced at her state trial, she contends. Filings from the state and Row's attorneys are due to Idaho's federal district court within 60 days after the Supreme Court's Ramirez decision.

Crippled by PTSD and combat wounds, Army vet Zachary Barton said he couldn't even lift 10 pounds. The Port St. Lucie, Fla. man collected more than $245,000 of federal disability payments, claiming he needed a cane to walk. Barton claimed "limited motion of the arm at the shoulder level and painful movement of the arm." He could only go to the gym about twice a week, and could barely lift a minimal amount of weight, he said. All the while he brightly posted social media photos of himself competing on-stage in body-building contests and doing other strenuous activities. Barton belonged to the Palm Beach Sports Club. He visited almost daily, routinely leg-pressing 650 pounds and chest-pressing over 300 pounds. Video also showed Barton also moved furniture out of his house during a move to Colorado Springs. And he drove, walked his pet and shopped with no difficulty. He pled guilty and will be sentenced in August.

Two more new anti-fraud laws are on the books.

Louisiana: A new law mandates the commissioner of insurance promulgate rules and regulations to create a new catastrophe claims process disclosure form to help consumers. The form must include such things as an explanation of how the claim process works, subject to the insurance policy's terms and conditions — including supplemental claims, differences between actual cash valuation and replacement cost valuation — and policyholder rights under state law. The form also must explain how consumers may file a complaint with the department if they are not satisfied with the claim process or settlement.

Oklahoma: Roofing claims drew the attention of legislators with a new law requiring insurance policies specifying a time limit covering roof damage due to wind or hail must include a provision allowing the filing of claims after the first anniversary of the loss but no later than 24 months after the loss date — if the damage is evident only with an inspection. Both bills were signed into law by their governors.

Painful and crippling, postal worker George Utley lied about the back sprain he said flashed over him when he stood up in the break room of a postal facility in Pennsylvania. Utley faked the injury, falsely inhaling nearly $732,560 of federal disability payments over 10 years. Investigators tracked him traveling, deep-sea fishing and weightlifting. They also recorded video of Utley doing yard work at his Florida home; repeatedly lifting and carrying heavy items; working on a race car; and hitching a flatbed car carrier, box trailer and fifth-wheel RV to his truck. Utley also indicted himself — posting social-media photos showing him weightlifting, bicycling in the mountains, catching a three-foot kingfish and visiting the Grand Canyon. *And a glaring red flag:* Despite claiming severe back pain, Utley only received $14 of prescription pain meds during his 10-year benefit period. He also ran several businesses while banking the disability money. Utley received 2 1/2 years in federal prison and must repay the stolen federal disability money.

Led away in handcuffs, psychiatrist Mark Agresti escaped more-serious punishment with a white-collar gift — eight years in federal prison instead of the minimum potential 15 1/2 years for a $31.3-million scheme. The Palm Beach County, Fla. doc ordered hundreds of expensive urine tests for insured residents of a sober home Bailynson. It operated in a rundown apartment complex in West Palm Beach. Instead of simple urine tests, Agresti ordered labs to screen the samples for 80 different drugs — most of which weren't even addictive. He knew that instead of receiving about $300 for each test, insurers would pay at least $1,500. Insurance money piled up as Agresti tested residents at least five times a week for drugs that weren't likely to be in their systems. Agresti also ordered similar tests at other sober homes in the county. He spent years building his career as a caring psychiatrist. Former patients credited him with pulling them out of devastating depression and saving their lives. But Agresti joined forces with mastermind and sober home owner Kenneth Bailynson — who testified against him. Bailynson bragged about his business smarts. If the FBI hadn't raided his sober home during a crackdown on the county's illicit drug treatment industry, he said he would've made $2 billion from the added homes and labs he planned to open around Florida.

A former Kentucky state legislator knew his pharmacy was fleecing insurers yet let the $2.7-million scam continue. Then-state Rep. Robert Goforth owned Hometown Pharmacy in Clay County. The normal procedure if a customer didn't pick up a prescription should've been to credit the charge back to the insurer. Instead, Goforth's pharmacy insurers for prescriptions that patients didn't pick up. Employees then put the meds back on the shelf and resold them. The pharmacy multiplied profits by buying doses of meds once and then effectively selling them multiple times. Even when a fraud investigator pointed out the scams, Goforth ignored the warnings and let the improper billing continue for several months. Goforth, a Republican, represented Jackson County and parts of Laurel and Madison counties in the state House before resigning in August 2021. Goforth faces up to 10 years in prison when sentenced.

Health Insurance Fraud Convictions

Osteopathic Physician Admits Illegally Prescribing Drug

Matthew Steven Miller, 43, pleaded guilty in front of U.S. District Judge Ronnie L. White to one count of obtaining a controlled substance by fraud and one count of making a false statement concerning a health care matter.

Miller, an osteopathic physician from Collinsville, Illinois pleaded guilty in U.S. District Court and admitted illegally prescribing an anti-anxiety drug.

Miller admitted illegally writing prescriptions for the anti-anxiety drug Xanax for six people between 2016 and 2018. He did not have a doctor-patient relationship with them, had not examined them, had not determined that they needed the drug and did not document the prescriptions, his plea agreement says. On some occasions, they sold the drugs and split the money with Miller, his plea says.

Miller wrote the prescriptions despite not being licensed by Missouri's Bureau of Narcotics and Dangerous Drugs and lacking a Drug Enforcement Administration registration number necessary to do so.

Miller was licensed to practice medicine in Missouri, Michigan and New Jersey.

Pleads Guilty to Fraud and Kickback Scheme Involving Covid-19 And Cancer Genetic Testing

Erik Santos, 52, of Braselton, Georgia pleaded guilty to a two-count Information charging him with, in count one, conspiracy to violate the Federal Anti-Kickback statute, and, in count two, conspiracy to commit health care fraud, before U.S. District Judge Kevin McNulty in Newark federal court.

Santos pleaded guilty June 7, 2022 for his role in a conspiracy to commit health care fraud and receive kickbacks in connection with fraudulent testing claims for COVID-19 and cancer genetic screenings.

According to documents filed in this case and statements made in court:

> Santos owned and operated a company that conducted business with medical testing companies. From September 2019 through March 2020, Santos and others agreed to engage in a scheme to provide medical testing companies with qualified patient leads and tests for medically unnecessary cancer genetic screening tests for Medicare beneficiaries in exchange for kickbacks of approximately $1,000 to $1,500 for each test that resulted in a reimbursement from Medicare. Santos entered into a sham contract and utilized sham invoices to make it appear that he was being paid for legitimate services and to conceal his fraudulent kickback scheme. During the course of the scheme, Santos received kickbacks of approximately $33,250 for cancer genetic screening tests. Santos's scheme aimed to submit more than $1.1 million in fraudulent claims to Medicare.

In March 2020, at a time when many individuals reported difficulty obtaining Covid-19 tests, Santos and others agreed to extend their scheme to also incorporate those tests, along with significantly more expensive and medically unnecessary respiratory pathogen panel tests. Specifically, Santos and his co-conspirators agreed that Santos would be paid kickbacks for each Covid-19 test submitted to a laboratory, provided that those tests were bundled with significantly more expense respiratory pathogen panel tests, which did not treat or identify Covid-19, and regardless of the medical necessity of either test. Santos agreed to use sham contracts and sham invoices to conceal this portion of the scheme as well.

The count of conspiracy to commit health care fraud carries a maximum potential punishment of 10 years in prison. The count of conspiracy to violate the Anti-Kickback Statute carries a maximum potential penalty of five years in prison. Both offenses are also punishable by a fine of $250,000 or twice the gross gain or loss from the offense.

Doctor Pleads Guilty to Billing for Office Visits She Never Performed and Settle Civil Claims for Half a Million Dollars

Soaries Maxine Peterson, M.D., 68, a Muskegon, Michigan physician pleaded guilty on May 25, 2022, to a felony information charging her with one count of health care fraud. According to court documents, Peterson billed Medicare, Medicaid, and Blue Cross Blue Shield for services that she did not perform. Dr. Peterson admitted that she billed for office visits for patients who came to her office, often to obtain monthly prescriptions for controlled substances, when she was on vacation out of state or when she was outside of the office performing other services. During these encounters, patients met only with unlicensed office staff and no qualified health professional.

As part of a global settlement, Dr. Peterson also agreed to pay the United States and the State of Michigan $500,000 to resolve her civil liability under the False Claims Act for the alleged fraudulent claims she billed to Medicare and Medicaid, as well to resolve her federal liability under the Controlled Substances Act related to her prescribing of controlled substances. More specifically, the United States alleges that Dr. Peterson wrote prescriptions for controlled substances to her patients without a legitimate medical purpose and outside the usual course of professional practice. As part of the investigation, Dr. Peterson surrendered her Drug Enforcement Administration ("DEA") registration for cause, and she has agreed to never reapply for a new registration, preventing her from ever prescribing opioids and other controlled substances in the future.

Dr. Peterson pleaded guilty to one count of health care fraud (18 U.S.C. § 1347). She is scheduled to be sentenced on Wednesday, September 7, 2022, and faces a maximum sentence of 10 years in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

A Year in Federal Prison for Billing Medicare for Non-Existent Treatment

Henry Smilie, the former owner of a Chicago home health care company was sentenced to a year in federal prison for fraudulently obtaining $1.2 million from Medicare through a phony billing scheme.

Smilie was the owner and Chief Executive Officer of Home Physician Services LLC, which arranged in-home health care services for patients who were purportedly elderly and homebound. From 2012 to 2014, Smilie participated in a scheme to defraud Medicare by submitting approximately $1.97 million in false claims, causing the federally funded program to pay Smilie's company at least $1.2 million. The false claims pertained to "care plan oversight" services that were either not rendered or involved treatment that was far less intricate than portrayed in the claims submitted by Smilie's company to Medicare.

Smilie, 61, of Lake Zurich, Ill., pleaded guilty to a federal health care fraud charge. U.S. District Judge Jorge L. Alonso imposed the year-and-a-day sentence June 7, 2022 and also ordered Smilie to pay $1.2 million in restitution to Medicare.

Guilty To Making False Statements Concerning Her Daughter's Medical Care

Shelley Noreika, age 48, of Newville, PA, pleaded guilty June 8, 2022 before U.S. District Court Judge Sylvia H. Rambo for false statements relating to health care matters.

Noreika admitted that on or about February 4, 2020, she made false statements concerning her 5-year-old daughter to medical providers. Noreika told her daughter to pretend having a seizure while Noreika videotaped her. Noreika then emailed the video clip of the fake seizure to her daughter's pediatric neurologist, along with false statements concerning the minor child's medical condition. On multiple other occasions, Noreika also falsely reported to medical providers that her daughter experienced seizures, when in fact no such seizures occurred. Noreika never witnessed her daughter have an actual seizure on February 4, 2020, or on any other date. Noreika misled medical providers concerning the health and condition of her daughter knowing they would rely on her false statements in their diagnosis and treatment decisions.

Pursuant to the terms of a written plea agreement, the parties agreed the offense involved a loss amount exceeding $95,000 but less than $150,000, which includes costs borne by insurers and the government for the daughter's unnecessary medical treatment and visits.

Noreika no longer cares for the minor child, and she also faces related state charges which are pending.

Former CEO of Defunct Medical Testing Laboratory Sentenced to Prison for Medical Kickback Scheme

Signed Phony Agreements to Market Other Testing Labs; Payments Were Actually Kickbacks for Referring Government Business

Jae Lee, 51, of Bellevue, Washington, the former Chief Executive Officer of **Northwest Physicians Laboratory** (NWPL) was sentenced May 27, 2022 in U.S. District Court in Seattle to two years in prison and $7.6 million in restitution for conspiracy to solicit kickbacks. Jae Lee served as the CEO of NWPL. Between 2013 and 2015, Lee conspired with others to get kickbacks from medical testing labs in exchange for government testing business referred to the labs. In pronouncing sentence, U.S. District Judge John C. Coughenour noted, the scheme was large and clearly illegal.

The activities of Bellevue-based NWPL have been the subject of extensive civil and criminal litigation. CEO Lee helped NWPL obtain more than $3.7 million in kickback payments by steering urine drug test specimens to two labs that could bill the government for testing. This resulted in government payments to those two labs of more than $6.5 million.

According to records filed in the case between January 2013 and July 2015, two labs, that were not physician owned, made payments to NWPL in exchange for referrals of Medicare and TRICARE program business, in violation of the Anti-Kickback Statute. Paying remuneration to medical providers or provider-owned laboratories in exchange for referrals encourages providers to order medically unnecessary services. The Anti-Kickback Statute functions, in part, to discourage such behavior. NWPL was physician-owned, and for that reason could not test urine samples for patients covered by government health programs such as Medicare, Medicaid, and TRICARE. In order to conceal the payment of the kickbacks, Lee and other co-conspirators involved described the fees as being for marketing services; however, no marketing services were performed.

The kickback payments to NWPL were commingled with other company revenue. Over the course of the scheme, Lee received more than $800,000 in distributions from NWPL's commingled funds. As prosecutors wrote in their sentencing memo, the crime was based purely on Mr. Lee and the others' greed. The NWPL business model was profitable. It could afford to pay doctors thousands of dollars a month in dividends. It could afford to pay healthy distributions to its owners. This did not satisfy Mr. Lee. He was determined to maximize profits even if it meant breaking the law.

The company, NWPL, pleaded guilty in February 2021 and was sentenced to pay $8,114,417 in restitution joint and several with the other criminal defendants. NWPL has dissolved. To date, the labs and individuals involved in this investigation have agreed to pay more than $14 million to settle related civil allegations.

In addition to Lee, two other defendants await sentencing. **Kevin Puls**, 57, the former Executive Director of NWPL, is scheduled for sentencing September 6, 2022. **Richard Reid**, 53, was convicted following a six-day jury trial. He is scheduled for sentencing on October 11, 2022.

Pharmacist Convicted of Unlawfully Distributing Controlled Substances

Hieu "Tom" Truong, 58, of Houston, Texas, was convicted by a federal jury in the Southern District of Texas. Truong was a Texas pharmacist on May 27 for unlawfully distributing controlled substances from a now-shuttered Houston pharmacy.

According to court documents and evidence presented at trial, Truong was the pharmacist-in-charge of S**&S Pharmacy** in Houston. In just 18 months, Truong and his co-conspirators unlawfully distributed over 750,000 doses of controlled substances, including over 500,000 oxycodone and hydrocodone pills. Trial evidence showed that S&S Pharmacy unlawfully dispensed controlled substances in bulk for cash, based on forged or stolen prescriptions brought in by street-level drug dealers.

Truong was convicted of three counts of unlawfully distributing and dispensing controlled substances. He faces a maximum penalty of up to 20 years in prison on each count. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors. Sentencing is scheduled for October 3, 2022.

To date, seven other co-conspirators, including the owner and manager of the pharmacy, have pleaded guilty to unlawfully distributing controlled substances.

Physician To Pay More Than $600,000 To Resolve Claim He Fraudulently Billed Medicare and Medicaid

James A. Sakr, M.D., has agreed to pay $602,661.61 to resolve allegations, arising under the False Claims Act, that he fraudulently billed Medicare and Medicaid for procedures that were not medically necessary or that he did not perform.

From at least January 1, 2014, to December 31, 2019, Dr. Sakr, an ear, nose, and throat (ENT) doctor based in Dansville, NY, billed Medicare and Medicaid for procedures not performed at all or were not documented in patient medical records.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Lee M. Mandel, M.D., FACS. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. The qui tam case is captioned *United States ex rel. Mandel v. Sakr,* 17-cv-907 (W.D.N.Y.). Dr. Mandel will receive a share of the settlement.

Home Sleep Testing Company to Pay $3.5 Million To Settle Federal Health Care Fraud Suit

Snap Diagnostics LLC, a nationwide provider of home sleep testing diagnostic services based in Wheeling, Ill.; its founder, **Gil Raviv**; and its vice president, **Stephen Burton**, violated the False Claims Act and the Anti-Kickback Statute by fraudulently billing Medicare and four other federal health care programs for medically unnecessary services and for services that were occasioned by kickbacks.

Snap, a suburban Chicago diagnostics company that provides home sleep testing will pay $3.5 million to the United States to settle a civil lawsuit accusing the company of defrauding Medicare and four other federal health care programs through kickbacks and unnecessary home sleep testing.

The suit in U.S. District Court in Chicago alleged Raviv directed Snap to submit claims for patients' second and third nights of home sleep testing when, in fact, the company knew that only a single night of testing was needed to effectively diagnose obstructive sleep apnea and that it routinely tested and claimed only one night for patients with private health insurance. As a result, the suit alleged that, in addition to defrauding five federal agencies, SNAP unlawfully multiplied the copays it received from senior citizens who were Medicare beneficiaries. The suit also alleged that SNAP's business model relied on several unlawful kickback schemes, which incentivized physicians and their staffs to refer all of their home sleep testing services to SNAP.

As part of a settlement agreement approved Friday by U.S. District Judge Mary M. Rowland, SNAP agreed to pay the United States $3.5 million, while Raviv will pay $300,000, and Burton $125,000, for a total settlement amount of $3.925 million. These payments represent amounts the United States is willing to accept due solely to Snap's, Raviv's, and Burton's respective financial conditions, as shown by sworn financial disclosures. Snap and Raviv also entered into a corporate integrity agreement with the Office of Inspector General of the U.S. Department of Health and Human Services, requiring Snap to, among other things, retain an independent review organization to perform annual reviews of claims and submit reports to the OIG-HHS.

The settlement resolves two civil lawsuits filed under the *qui tam*, or whistleblower, provisions of the False Claims Act. The Act permits private citizens to bring lawsuits on behalf of the United States for false claims, and to share in any recovery. The United States intervened in the two lawsuits and filed a complaint in intervention prior to the settlement. The settlement agreement is neither an admission of liability by SNAP, Raviv, or Burton, nor a concession by the United States that its claims are not well founded.

Justice Department Recovers Fraudulent Transfer of Proceeds Arising from Medical Kickback Scheme

Alex Hart Raley Jr., who received millions from an individual subsequently found liable for violating the False Claims Act by paying kickbacks, has agreed to pay $2.3 million to resolve a civil lawsuit alleging that the transfer violated the Federal Debt Collection Procedures Act. Raley was not involved in the kickback violations.

Floyd Calhoun Dent III, along with two other individuals, was found liable by a South Carolina jury in 2018 for submitting false claims to Medicare and TRICARE, in violation of the Anti-Kickback Statute and the False Claims Act. A judgment was subsequently entered against these defendants jointly for $114 million. Prior to the judgment, but after Dent had been served with a Department of Health and Human Services Inspector General subpoena, Dent transferred several million dollars to Raley. Dent acknowledged that he received nothing in return for this payment, but contended that it was intended to fulfill a childhood promise.

The settlement announced June 6, 2022 resolves the United States' allegations that Dent's transfer to Raley was a fraudulent transfer. The settlement requires him to surrender any retained funds, as well as gold and silver coins that Raley purchased with a portion of the transferred funds, to the Department of Justice and the Liquidating Trustee for now bankrupt Health Diagnostic Laboratories Inc., which will split these assets pursuant to a bankruptcy court agreement.

The settlement was the result of a coordinated effort between the Civil Division's Fraud and Corporate/Financial Litigation Sections, and the U.S. Attorney's Office for the District of South Carolina. The matter was handled by Senior Trial Counsel Alicia J. Bentley and

Trial Attorney Andrew Warner of the Civil Division and Assistant U.S. Attorneys James Leventis, Johanna Valenzuela, and Joanna Stroud. [The case is *United States v. AROC Enterprises, LLC, et al* (D.S.C. Case No. 9:19-cv-234 RMG).]

Man To Pay $900,000 For Violations of The False Claims Act

Rodney L. Yentzer, of Cumberland County, has agreed to pay the United States $900,000 to resolve civil liability for alleged violations of the False Claims Act.

Between 2017 and 2019, Yentzer, through a group of pain clinics he controlled known as Pain Medicine of York (PMY), caused the submission of false claims for payment to Medicare. Those claims were for presumptive and definitive Urine Drug Tests (UDTs) that were not medically reasonable or necessary and were not used to aid in the diagnosis and treatment of patients.

Additionally, Yentzer agreed to be excluded from all Federal health care programs for 22 years. Yentzer's exclusion means that no Federal health care program payment may be made, either directly or indirectly, for any items or services furnished by Yentzer or at the direction or on the prescription of Yentzer.

In March of 2022, in a related matter, Yentzer pleaded guilty to Health Care Fraud, Money Laundering, and Theft of Public Money for defrauding Medicare, Medicaid, and the U.S. Department of Health and Human Services between 2016 and 2020. Yentzer is awaiting sentencing. The news release can be found here: https://www.justice.gov/usao-mdpa/pr/cumberland-county-man-pleads-guilty-health-care-fraud-money-laundering-and-theft-public

Medical Biller Sentenced for Healthcare Fraud, Aggravated Identity Theft, And Tax Offenses

Joshua Maywalt (42, Tampa) to five years and five months in federal prison for healthcare fraud, aggravated identity theft, filing a false income tax return, and failing to file an income tax return. As part of his sentence, the court also entered an order forfeiting $2,257,029.86 and real property located at 5346 Northdale Boulevard in Tampa, which are traceable to proceeds of the offense. Maywalt had pleaded guilty on December 1, 2021.

According to court documents, Maywalt worked as a medical biller at a company in Clearwater that provided credentialing and medical billing services for its medical provider clients. In this capacity, Maywalt had access to the company's financial, medical provider, and patient information. Maywalt was assigned to a Tampa Bay area physician's account ("Physician #1") and was responsible for submitting claims to Florida Medicaid Health Maintenance Organizations (HMO) for services rendered by Physician #1 to Medicaid recipients.

Maywalt abused his role as a medical biller by wrongfully accessing and utilizing the company's patient information and Physician #1's name and identification number to submit false and fraudulent claims to a Florida Medicaid HMO for medical services purportedly rendered by Physician #1, which were not actually rendered. Maywalt also altered the "pay to" information associated with the HMO's payment processor so that the payments for the non-rendered medical services were sent to bank accounts under Maywalt's control.

Maywalt knowingly signed and filed a false federal income tax return for tax year 2019 which substantially understated his income and reported only his employment wages, and not the substantial amount of money he was depositing into his bank accounts as a result of his fraudulent activities. In addition, Maywalt failed to file federal income tax returns for 2017 and 2018, as required by the Internal Revenue Service.

Middle Georgia Family Rehab to Pay $9.6 Million

In ***U.S. v. Middle Georgia Family Rehab*** *(MGFR)* on Tuesday, May 24, 2022 the District Court for the Middle District of Georgia found in favor of the United States and the State of Georgia in a civil case involving the fraudulent billing of hundreds of TRICARE and Medicaid claims by a Macon health care facility, ordering the defendants to pay $9,617,679.22 in damages and penalties.

U.S. District Judge Self initially granted partial summary judgment in this False Claims Act case on Wednesday, April 20. According to court documents, in that decision, the Court determined that approximately 800 false claims for services were improperly billed to Medicaid and TRICARE by MGFR and MGFR owner Brenda Hicks. Those improper services were billed under the names of a physical therapist and a speech therapist who were no longer employed by MGFR and therefore could not possibly have provided the services in question.

In analyzing the question of whether MGFR knowingly submitted the false claims, the Court found that MGFR's conduct "epitomizes 'reckless disregard' of the truth." Specifically, the Court found that MGFR's submission of almost 800 claims to Medicaid and TRICARE over an eight-month period following the resignation of one physical therapist and the submission of 41 claims following the resignation of a speech therapist could not be characterized as an "honest mistake."

Caris Life Sciences Pays Over $2.8 Million To Settle False Claims Act

Caris circumvented Medicare's "14-Day Rule" for Lab Tests Resulting in Added Medicare Expenses

Caris Life Sciences, Inc. (Caris) has agreed to pay $2,886,674.86 to resolve allegations that it violated the False Claims Act in an alleged nationwide scheme to improperly bill Medicare for laboratory tests known as "Caris Molecular Intelligence" and the "ADAPT Biotargeting System."

In this case, tests for cancer patients were delayed for no reason other than to circumvent a Medicare requirement and allow improper payment to Caris. The US Attorney expressed his gratitude for the support of the United States Department of Health and Human Services for their assistance in investigating these important claims.

Caris, a molecular science company headquartered in Texas, developed a series of laboratory tests primarily for cancer patients to detect the activity of certain genes within a breast cancer tumor to predict the risk of breast cancer recurrence in patients. These predictive

genetic marker tests are used by oncologists and other physicians to assist in determining appropriate treatment options for cancer patients.

During the time period covered by the settlement, Medicare's 14-Day Rule prohibited laboratories from separately billing Medicare for tests performed on specimens if a physician ordered the test within 14 days of the patient's discharge from a hospital stay either in an outpatient or inpatient setting. However, if the test was performed more than 14 days after discharge, then Medicare's 14-Day Rule permitted laboratories to bill Medicare directly for the test.

The United States contends that Caris perpetrated a scheme to evade Medicare regulations when submitting claims to the Centers for Medicare & Medicaid Services (CMS) for its predictive marker tests to circumvent Medicare's 14-Day Rule (which establishes who may bill Medicare for certain laboratory services) in three ways:

- Caris sought direct reimbursement from CMS for claims on behalf of Medicare beneficiaries, when tests were ordered and submitted for testing within 14 days after an inpatient discharge. For inpatient beneficiaries, hospitals receive a lump-sum payment CMS called the Diagnosis-Related Group ("DRG") payment. By submitting separate claims for the laboratory tests, Medicare paid twice for the same service, as part of the DRG and in a direct payment to Caris.
- Caris sought direct reimbursement from CMS for claims on behalf of Medicare beneficiaries, when Caris failed to discourage providers who ordered testing within 14 days after an inpatient or outpatient discharge from canceling the order and placing a new order for testing after the 14-day time period had elapsed; and
- Caris sought direct reimbursement from CMS for tests ordered within 14 days of a beneficiary's out-patient procedure.

The civil settlement includes the partial resolution of one action and final resolution of another brought under the *qui tam* or whistleblower provisions of the False Claims Act against Caris. Under the *qui tam* provisions of the False Claims Act, a private party can file an action on behalf of the United States and receive a portion of the settlement if the government takes over the case and reaches a monetary agreement with the defendant. The *qui tam* cases are captioned *United States ex rel. Doe v. (UNDER SEAL) and United States ex rel. Caughron v. CDx Holdings, Inc. f/k/a Caris Life Science, Civil Action No. 18-CV-0352 (E.D.N.Y).*

The claims resolved by the settlement are allegations only and there has been no determination of liability.

Healthkeeperz, Inc. To Pay $2.1 Million To Resolve False Claims Act Allegations

Healthkeeperz, Inc. (Healthkeeperz), has agreed to resolve allegations that the company violated the False Claims Act by billing claims to Medicaid programs that were not reimbursable under the applicable North Carolina Medical Clinical Coverage Policy. Healthkeeperz has agreed to pay $2.1 million to resolve the allegations.

Healthkeeperz provides case management services for Medicaid beneficiaries under the North Carolina **Medicaid Community Alternatives Program for Disabled Adults** (CAP/DA). The settlement resolves allegations that from January 1, 2016, through October 31, 2019, Healthkeeperz submitted reimbursement claims to North Carolina Medicaid and received payment based on those claims for services that were not covered by Medicaid.

The allegations arose from a lawsuit filed by a whistleblower under the *qui tam* provisions of the federal False Claims Act and the North Carolina False Claims Act. Under the False Claims Acts, private citizens can bring suit on behalf of the government for false claims and share in any recovery. The act also allows the government to intervene and take over the action. The government conducted the investigation and intervened in this action to effectuate the settlement.

The settlement is a result of a coordinated effort between the Department of Health and Human Services Office of the Inspector General, the North Carolina Attorney General's Medicaid Investigations Division, and the United States Attorney's Office for the Western District of North Carolina.

The lawsuit resolved by this settlement is *United States and the State of North Carolina ex rel. Ginger L. Hill v. Healthkeeperz, Inc.* (1:20CV32). The claims resolved by this settlement are allegations only and there has been no determination of liability.

Last of 15 Plead Guilty in Extensive Health Care Fraud Conspiracy to Defraud Medicaid

A Total of Fifteen Defendants Have Pleaded Guilty in Connection with the Conspiracy

Arlinda Moriarty, 53, of Cranberry, Pennsylvania, her sister **Daynelle Dickens,** 47, of Pittsburgh, and their uncle **Tony Brown**, 64, also of Pittsburgh, pleaded guilty to one count each of conspiracy to commit health care fraud and health care fraud before United States District Judge Cathy Bissoon. Moriarty also pleaded guilty to one count of engaging in a scheme to conceal material facts in a health care matter and one count of aggravated identity theft.

According to admissions made in connection with the defendants' guilty pleas, between January 2011 and April 2017, Moriarty, Dickens, and Brown were associated with four related entities controlled by Moriarty—**Moriarty Consultants, Inc.** (MCI), **Activity Daily Living Services, Inc**. (ADL**), Everyday People Staffing, Inc**. (EPS), and **Coordination Care, Inc**. (CCI). Dickens owned CCI, and Brown was an employee of MCI. MCI, ADL, and CCI were approved under the Pennsylvania Medicaid program to offer certain services to qualifying Medicaid recipients ("consumers"), including personal assistance services (PAS), service coordination, and non-medical transportation, among other services. EPS nominally performed back-office functions for MCI, ADL, and CCI.

Between January 2011 and April 2017, MCI, ADL, and CCI, collectively, received more than $87,000,000 in Medicaid payments based on claims submitted for home health services, with PAS payments accounting for more than $80,000,000 of the total amount. During that time, Moriarty admitted orchestrating a wide-ranging conspiracy to defraud Medicaid for the purpose of obtaining millions of dollars

in illegal Medicaid payments through the submission of fraudulent claims for services that were never provided to the consumers identified on the claims, or for which there was insufficient or fabricated documentation to support the claims.

The defendants admitted that the conspiracy and fraud scheme were carried out in a variety of ways. For example, co-conspirators fabricated timesheets to reflect the provision of in-home PAS care that, in fact, they never provided to the consumers identified on timesheets. Members of the conspiracy also paid kickbacks to consumers in exchange for their participation in the scheme. Indeed, Brown admitted paying kickbacks to his then-son-in-law in connection with the submission of fraudulent Medicaid claims stating that Brown had provided in-home care for the son-in-law, when, in fact, he had not. As part of the conspiracy, co-conspirators also caused the submission of Medicaid claims in the name of "ghost" employees for PAS care that never occurred.

Moriarty and Dickens also admitted causing the periodic bulk submission of fraudulent Medicaid claims for so-called "unused" hours—i.e., excess hours of care that consumers had not needed and therefore should not have been billed. Finally, Moriarty admitted that during the course of audits of MCI, ADL, and CCI, she directed the fabrication of various documents for submission to state authorities in an effort to conceal the Medicaid fraud scheme. Among other things, co-conspirators fabricated PAS timesheets, criminal history checks for attendants, child-abuse clearance forms for attendants, and certain consumer affidavits to ensure that files requested as part of the audits appeared complete. During the conspiracy, Moriarty and Dickens received payments from the Moriarty-related companies totaling approximately $1,660,000 and $1,071,000, respectively.

In connection with their guilty pleas, Moriarty, Dickens, and Brown have agreed to pay restitution of $8,700,000, $1,000,000, and $43,113.02, respectively.

A total of 16 defendants were charged in connection with the health care fraud conspiracy and scheme, and 15 have now pleaded guilty. The remaining defendant died during the pendency of the case.

The conspiracy and health care fraud charges each carry a maximum total sentence of not more than 10 years in prison, a fine of $250,000, or both. The concealment of material facts in relation to a health care matter charge carries a maximum total sentence of not more than five years in prison, a fine of $250,000, or both. The aggravated identity theft charge carries a mandatory sentence of two years in prison to run consecutively with any sentence imposed on any other charge and a fine of no more than $250,000. Under the Federal Sentencing Guidelines, the actual sentence imposed would be based upon the seriousness of the offense and the prior criminal history, if any, of the defendants.

Judge Bissoon scheduled sentencing hearings for Moriarty, Dickens, and Brown on September 28, 2022.

Former CEO Of Defunct Medical Testing Laboratory Sentenced to Prison for Kickback Scheme

Signed Phony Agreements to Market Other Testing Labs; Payments Were Actually Kickbacks

Jae Lee, 51, of Bellevue, Washington, served as the CEO of **Northwest Physicians Laboratory** (NWPL). Lee, was sentenced May 27, 2022 in U.S. District Court in Seattle to two years in prison and $7.6 million in restitution for conspiracy to solicit kickbacks, announced U.S. Attorney Nick Brown. Jae Lee, 51, of Bellevue, Washington, served as the CEO of Northwest Physicians Laboratory (NWPL). Between 2013 and 2015, Lee conspired with others to get kickbacks from medical testing labs in exchange for government testing business referred to the labs. In pronouncing sentence, U.S. District Judge John C. Coughenour noted, the scheme was large and clearly illegal.

The activities of Bellevue-based NWPL have been the subject of extensive civil and criminal litigation. CEO Lee helped NWPL obtain more than $3.7 million in kickback payments by steering urine drug test specimens to two labs that could bill the government for testing. This resulted in government payments to those two labs of more than $6.5 million.

According to records filed in the case between January 2013 and July 2015, two labs, that were not physician owned, made payments to NWPL in exchange for referrals of Medicare and TRICARE program business, in violation of the Anti-Kickback Statute. Paying remuneration to medical providers or provider-owned laboratories in exchange for referrals encourages providers to order medically unnecessary services. The Anti-Kickback Statute functions, in part, to discourage such behavior. NWPL was physician-owned, and for that reason could not test urine samples for patients covered by government health programs such as Medicare, Medicaid, and TRICARE. In order to conceal the payment of the kickbacks, Lee and other co-conspirators involved described the fees as being for marketing services; however, no marketing services were performed.

The kickback payments to NWPL were commingled with other company revenue. Over the course of the scheme, Lee received more than $800,000 in distributions from NWPL's commingled funds. As prosecutors wrote in their sentencing memo, "The crime was based purely on Mr. Lee and the others' greed. The NWPL business model was profitable. It could afford to pay doctors thousands of dollars a month in dividends. It could afford to pay healthy distributions to its owners. This did not satisfy Mr. Lee. He was determined to maximize profits even if it meant breaking the law."

The company, NWPL, pleaded guilty in February 2021 and was sentenced to pay $8,114,417 in restitution joint and several with the other criminal defendants. NWPL has dissolved. To date, the labs and individuals involved in this investigation have agreed to pay more than $14 million to settle related civil allegations.

In addition to Lee, two other defendants await sentencing. **Kevin Puls**, 57, the former Executive Director of NWPL, is scheduled for sentencing September 6, 2022. **Richard Reid,** 53, was convicted following a six-day jury trial. He is scheduled for sentencing on October 11, 2022.

Sentenced To Jail for Defrauding Masshealth

Defendant Caused MassHealth to Pay Over $100,000 for Personal Care Attendant Services That Were Not Provided

Abdikadir Maow, 50, a Medford, Massachusetts man was found guilty and sentenced to one year in the Middlesex House of Correction for his role in a scheme to falsely submit claims to MassHealth for Personal Care Attendant (PCA) services that were not rendered, Attorney General Maura Healey announced today.

After a three-day trial, a Middlesex Superior Court jury found Maow guilty of Medicaid False Claims and Larceny by False Pretenses over $1200. Middlesex Superior Court Judge Christopher Barry-Smith sentenced Maow on Tuesday to one year in the Middlesex House of Correction, followed by three years of probation and ordered him to pay $112,000 in restitution. While on probation, Maow will be prohibited from having any role or responsibilities with the PCA program and will instead be required to receive services from a home health company.

Maow was indicted in October 2020 as part of a coordinated sweep charging seven individuals in PCA fraud cases. The AG's Office alleged that, from 2015 to May of 2020, Maow and his PCA participated in a scheme to falsely submit timesheets for PCA services that were not actually rendered to Maow. According to the AG's Office, Maow's PCA was billing and getting paid for PCA hours purportedly provided during times when the PCA was working at a secondary employer or while the PCA or Maow were traveling or residing out of the country separately for long periods of time. During Maow's trial, the AG's Office presented evidence that Maow caused more than $112,000 in fraudulent billing to MassHealth.

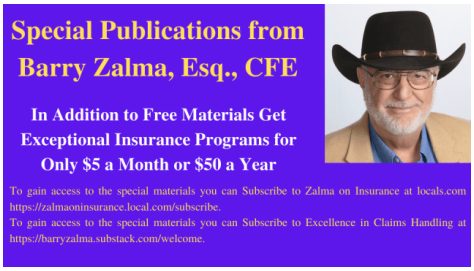
The conclusion of this trial follows years of efforts by AG Healey's Medicaid Fraud Division to combat fraud and misconduct in the PCA program. In March, the AG's Office secured indictments against four individuals in another PCA false billing scheme, and in July 2021, the Division indicted a New Bedford man who allegedly defrauded the program by falsely billing for services he did not receive.

The Medicaid Fraud Division receives 75 percent of its funding from the U.S. Department of Health and Human Services under a grant award. The remaining 25 percent is funded by the Commonwealth of Massachusetts.

Zalma on Substack & Locals.com

Special Publications from Barry Zalma, Esq., CFE

In Addition to Free Materials Get Exceptional Insurance Programs for Only $5 A Month Or $50 A Year



Barry Zalma has created at Locals.com and substack.com a series of insurance educational materials most of which are free to anyone. The free materials include more than 441 videos and more than 4200 digests of recent appellate court opinions and more than 81 videos dealing with true crime stories of insurance fraud.

In addition to the free materials, for a paid subscription to either Locals.com or substack.com, you can receive important, more detailed and informative information needed by everyone interested in insurance, insurance claims or insurance fraud.

The special materials include, at least, the following subjects in addition to the more than 415 videos and free materials:

- Liability Insurance.
- Property Insurance is a Personal Indemnity Contract.
- What is Insurance?
- Insurance Education Part I, a Video Training Program.
- Excellence in Claims Handling a Video Training Program.
- Ethics and the IME.
- Arson & Fraud by Husband Voids Entire Policy
- If an Insurer Wants to Defeat Coverage it Should Collect Convincing Evidence
- To Defeat Insurance Claim the Insurer Must Collect Convincing Evidence.
- A Postal Inspector Guilty of Insurance Fraud
- The Excellence in Claims Handling Program
- New Material added every month in text or video format.

How to Subscribe to Zalma on Insurance and Excellence in Claims Handling

To gain access to the special materials you can Subscribe to Zalma on Insurance at locals.com https://zalmaoninsurance.local.com/subscribe.

To gain access to the special materials you can Subscribe to Excellence in Claims Handling at https://barryzalma.substack.com/welcome.

Zalma on Insurance at Locals.com The Locals.com community is called **Zalma on Insurance** and is a community created by Barry Zalma, Esq., CFE and ClaimSchool, Inc. to help create a community of insurance professionals dedicated to excellence in claims handling.

Zalma on Insurance will provide materials on insurance, insurance claims, insurance law and insurance fraud. Some material presented will be free and there will be special publications for subscribers.

A source for the insurance claims person to become an insurance claims professional who can provide excellence in claims handling to the insurance buying public.

Become a Professional Claims Handler

In search of profit, insurers have decimated their professional claims staff. They laid off experienced personnel and replaced them with young, untrained, unprepared people. A virtual clerk replaced the old professional claims handler. Process and computers replaced hands-on human skill, empathy and judgment. Money was saved by paying lower salaries. Within three months of firing the experienced claims people gross profit increased.

The promises made by an insurance policy are kept by the professional claims person. Keeping a professional claims staff dedicated to excellence in claims handling is cost-effective over long periods of time. A professional and experienced adjuster will save the insurer millions by resolving disputes, paying claims owed promptly and fairly, and by so doing avoid litigation.

The professional claims person is an important part of the insurer's defense against litigation by insureds against insurers for breach of contract and the tort of bad faith. Claims professionals resolve more claims for less money without the need for either party to involve counsel. A happy insured or claimant satisfied with the results of his or her claim will never sue the insurer.

Incompetent or inadequate claims personnel force insureds and claimants to public insurance adjusters and lawyers. Every study performed on claims establishes that claims with an insured or claimant represented by counsel cost more to resolve than those where counsel is not involved. Prompt, effective, professional claims handling saves money for both the insured and the insurer and fulfills the promises made when the insurer sold the policy.

Insurers who believe they can handle first or third party claims with young, inexpensive, inexperienced and untrained claims handlers should be accosted by angry stockholders whose dividends have plummeted or will plummet as a result. When an insurer compromises on staff, profits, thin as they may have been previously, will move rapidly into negative territory. Tort and punitive damages will deplete reserves. Insurers will quickly question why they are writing insurance. Those who stay in the business of insurance will either adopt a program requiring excellence in claims handling from every member of their claims staff, or they will fail.

Insurance is a business. It must change—this time for the better—if it is to survive. It must rethink the firing of experienced claims staff and reductions in training to save "expense." Insurers should, if they wish to succeed, adopt a program to promote excellence in claims handling that can help insurers keep the promises made by the insurance policy and avoid charges of breach of contract and the tort bad faith in both first and third party claims.

Insurers must understand that they cannot adequately fulfill the promises they make to their insureds and their obligations under fair claims practices acts without a professional, well trained and experienced claims staff. An insurer must work vigorously and intelligently to create a professional claims department or recognize it will lose its market and any hope of profit.

An insurer whose claims staff is made up of people who are less than professional will find itself the subject of multiple instances of expensive, counterproductive litigation.

Excellence in Claims Handling at substack.com

A Program to Create the Insurance Claims Professional including one hour video training programs, insurance law text materials, and insurance claims law commentary.

Other Insurance Fraud Convictions

Jacksonville Contractor Pleads Guilty to Felony Home Repair Fraud

Clint A. Stevens, 45, the owner of a Jacksonville construction company pleaded guilty to home repair fraud May 24, 2022 in Morgan County Court.

Stevens, the owner of C&A Construction, pleaded guilty to home repair fraud, a Class 4 felony. The single charge stems from an arrest by Jacksonville Police on April 12th, 2021 after an investigation.

According to the charges, Stevens misrepresented material facts relating to terms of a contract or promised performance, saying September 28, 2020 that he would start repairs on a home on Pintail Court by October 2020 and then didn't initiate the work.

Stevens has settled tort damages, small claims, and breach of contract cases on 9 separate occasions dating back to 2013. The settlements include restitution totaling nearly $100,000. One small claims case remains open dating from February of last year.

According to the Better Business Bureau, Stevens' construction business has received 7 complaints over the last 3 years.

Stevens was sentenced to 1 year of probation, a $500 county fine plus probation fees and court costs. Turner says that Stevens must pay restitution to a local business in a separate investigation initiated by the Jacksonville Police.

C & A Construction is not listed as a licensed roofing contractor in the State of Illinois. Currently, general contracting businesses do not have to be licensed by the state. However, local governments can require contractors to possess a surety bond and insurance to operate in their locality.

ZIFL can only wonder why this person was only given probation.

NJ Used Car Dealer Pleads Guilty To $45 Million NYC Covid Mask Fraud

3M Had Previously Sued Ron Romano's Company, Saying It Falsely Represented Itself to Be an Authorized Vendor

Ronald Romano of Manalapan, a New Jersey used car dealer pled guilty May 31, 2022 to a $45 million scheme to sell personal protective equipment in the darkest days of the pandemic to New York City at a massive markup.

Romano pled guilty in federal court in Manhattan to conspiracy to violate the Defense Production Act. Prosecutors alleged Romano tried to sell 3M-brand face masks to NYC officials at a 400 percent markup over list price – even though he was not an authorized distributor and did not actually have the masks.

The city did not pursue the purchase, after contacting 3M and verifying Romano's company was not a certified reseller.

Zalma on Insurance Blog Posting

- Explaining Reasonable Conduct of Insurer June 8, 2022
- Reporting on an Accusation of Insurance Fraud Results in Defamation Suit June 8, 2022
- The Effect of the Tort of Bad Faith on the USA June 7, 2022
- A Reefer Trailer is a Vehicle June 7, 2022
- Fairly Debatable or Genuine Dispute Defenses to Bad Faith June 6, 2022
- Denial of Liability is not a Denial of Insurance Coverage June 6, 2022
- The Law of Unintended Consequences and The Tort of Bad Faith June 3, 2022
- Unambiguous Contract Must Be Interpreted as Written June 3, 2022
- Bad Faith & Damages June 2, 2022
- Pennsylvania Requires Court to Announce a Convicted Defendant's Recidivism Risk Reduction Incentive June 2, 2022
- Damages for Breach of an Insurance Policy June 1, 2022
- An Occurrence Can Include The Unintended Physical Damage Caused By Intentional Development Activity June 1, 2022
- Zalma's Insurance Fraud Letter – June 1, 2022 May 31, 2022
- INSURANCE AS A NECESSITY May 30, 2022
- ERISA Preempts State Law May 30, 2022
- The Law of Unintended Consequences & Insurance May 27, 2022
- No Good Deed Goes Unpunished: Insurance Coverage Cannot be Created by Estoppel May 27, 2022
- True Crime of Insurance Fraud Video Number 81 May 26, 2022
- Health Insurance Fraud Convict Appeals Again May 26, 2022

True Crime Stories of Insurance Fraud

There are now available at https://rumble.com/zalma more than more than 81Video True Crime Stories of insurance fraud.

Barry Zalma, Esq., CFE presents videos so you can learn how insurance fraud is perpetrated and what is necessary to deter or defeat insurance fraud. This Video Blog of True Crime Stories of Insurance Fraud with the names and places changed to protect the guilty are all based upon investigations conducted by me and fictionalized to create a learning environment for claims personnel, SIU investigators, insurers, police, and lawyers better understand insurance fraud and weapons that can be used to deter or defeat a fraudulent insurance claim. You can see all the True Crime Stories of Insurance Fraud and insurance law with a total of more than 420 videos at https://rumble.com/zalma.

Underwriting & Rescission

Rescission as a Weapon Against Insurance Fraud

Since the turn of the century the plaintiffs' bar has attempted to defeat the remedy of rescission and allow their clients more access to courts of law assessing damages against insurers and avoid equity courts who, if rescission was established, would have no right to damages at law. The plaintiff's bar created the concept of "post loss underwriting" (an oxymoron) to convince a court that the insurer did not use the remedy of rescission properly and force the insurer to pay a claim on a policy issued by deception even when the attempts to get damages from an insurer that has established all of the elements needed to prove the right to rescission.

Consider *Nieto v. Blue Shield of California Life & Health Insurance Co*.[2] where the California Court of Appeal dealt with one of the first of the so-called "post-loss underwriting" cases only to have the Court of Appeal found that plaintiff Julie Nieto failed to disclose information about her medical condition and treatment on a health insurance application she submitted to Blue Shield of California Life & Health Insurance Company (Blue Shield). The court concluded that the application was a "concealment" as defined by California Insurance Code § 331 and a misrepresentation as defined by California Insurance Code § 359. Based on the material misrepresentation and concealment of material fact Blue Shield rescinded the policy it issued to Nieto.

In response, Nieto filed an action against Blue Shield claiming the rescission was post claim underwriting and an act of bad faith. The trial court, following the law, granted Blue Shield's motion for summary judgment, ruling that it was entitled to rescission as a matter of law in view of the undisputed evidence that Nieto made material misrepresentations and omissions regarding her medical history.

The Court of Appeal affirmed the trial court because it agreed that undisputed evidence established that the information Nieto provided to Blue Shield was false.

Noting that the underwriting of Nieto's policy was proper based on the facts she provided by the application, Blue Shield was deceived when it agreed to insure her and was, as a result, entitled to rescind the policy.

The court, exercising its mandate as an appellate court recognized that the covenant of good faith and fair dealing, that applies to all parties to an insurance contract equally, allows an insurer to reasonably rely upon the statements made by an applicant on an application for insurance. If the insurer is deceived by the application, it has the right to void the contract and put the parties back in the position they were in before the contract was made.

The Court of Appeal noted that in 2005 Blue Shield offered several health insurance plans to individuals. As part of the determination whether to issue coverage, Blue Shield provided an application to each individual seeking coverage that requested detailed information of past and current health problems, treating physicians, prescribed medications and recommended treatment. Using proprietary written guidelines, Blue Shield evaluated the responses provided by each applicant to determine eligibility for health insurance and, if so, at what premium rate.

Blue Shield, like all insurers, relied on the information provided by the applicant when it received the signed application. Blue Shield did not assume the applicant was untruthful nor did it do any investigation to prove she was untruthful at the time it made the decision to insure Nieto.

Rather, Blue Shield, believing in and applying the covenant of good faith and fair dealing, only sought to review medical or pharmacy records when the applicant disclosed a condition or treatment that warranted further assessment. When no such condition or treatment was disclosed by the proposed insured, Blue Shield would have no reason to review medical or pharmacy records for the purpose of ascertaining the truthfulness of the applicant's responses.

If the application was incomplete, Blue Shield would contact the applicant to provide additional information. This overall review process is called "underwriting" by the insurance industry.

Nieto, like applicants for almost every type of insurance policy, signed and dated the application directly below the following attestation:

> I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. I understand and agree to each of them. I alone am responsible for the accuracy and completeness of the information provided on this application. I understand that neither I, nor any family members, will be eligible for coverage if any information is false or incomplete. I also understand that if coverage is issued, it may be cancelled or rescinded upon such a finding.

Nieto confirmed in her deposition that she took responsibility for the accuracy and completeness of the information provided in the application. The trial court expressly rejected Nieto's assertion that Blue Shield had engaged in post loss underwriting in violation of a section of the California Insurance Code explaining that before issuing the policy Blue Shield properly completed its underwriting process and resolved all reasonable questions arising from the information provided by Nieto. It further found the evidence showed that Blue Shield was not required to do more, as there was nothing in the application to alert Blue Shield that Nieto's responses were false.

The court reasoned that even if Blue Shield had been required to investigate further, there was no evidence to suggest that it would have learned of Nieto's undisclosed condition and treatment.

The undisputed evidence presented to the court established that Nieto made material misrepresentations and omissions on the application regarding her medical condition and treatment. Nieto responded negatively to the inquiries in the "Medical History" portion of the application, when in fact she had suffered from chronic back problems throughout 2005 and previously. Nieto represented that her last

[2] . *Nieto v. Blue Shield of California Life & Health Ins. Co.* (2010) 181 Cal.App.4th 60.

doctor's visit had occurred three years earlier, when in fact she had seen and received significant treatment from two doctors regularly and one at least 17 times between February and May 2005, including the day she signed the application.

Finally, Nieto represented that she had not taken or been directed to take any prescription medications in the past year, when in fact she had filled at least 10 prescriptions for four different medications and had received two steroid injections as well as an oral steroid.

The undisputed evidence further established that Nieto's misrepresentations and omissions were material to the decision of Blue Shield to insure or not insure Nieto.

Even if Blue Shield had not pleaded the issue of its insured's fraud as an affirmative defense, the Court in *Cruey v. Gannett Co*. (1998) 64 Cal.App.4th 356, 367 found that an affirmative defense may be raised for the first time in a summary judgment motion absent a showing of prejudice. Addressing the issue of privilege, the Court stated:

> Given the long-standing California court policy of exercising liberality in permitting amendments to pleadings at any stage of the proceedings [citation] and of disregarding errors or defects in pleadings unless substantial rights are affected [citation], we believe that a party should be permitted to introduce the defense of privilege in a summary judgment procedure so long as the opposing party has adequate notice and opportunity to respond.

Because Nieto had sufficient notice of, and an opportunity to respond to, Blue Shield's motion asserting that her fraud justified rescission of the policy, she suffered no prejudice by responding to the motion on the merits.

The trial court determined, as a matter of law, that Blue Shield was entitled to rescind coverage if the undisputed evidence showed that Nieto committed fraud by making material misrepresentations or omissions concerning her medical history or condition to Blue Shield before it issued the policy. Turning to the evidence submitted in connection with the motion, the trial court found "that the undisputed facts established each element of fraud and deceit under California law, with respect to [Nieto's] misrepresentations when applying for coverage with Blue Shield Life."

Therefore, the attempt to avoid rescission by claiming "post loss underwriting" failed and it was the fraud of Nieto not the insurer that resulted in her loss of coverage.

Nieto relied on the appellate court decision called *Hailey v. California Physicians' Service* (2007) 158 Cal.App.4th 452 (Hailey). She contended, unsuccessfully, that there were triable issues of fact as to whether Blue Shield reasonably completed the medical underwriting process in this case. The Court of Appeal concluded that *Hailey* is both legally and factually inapposite and agreed with the trial court that the undisputed evidence showed that Blue Shield conducted a reasonable investigation and its rescission was not due to any failure to resolve reasonable questions arising from the application. In simple language you cannot lie on an application and then complain that the insurance company did not catch the lies when they were made.

Hailey involved an interpretation of Health and Safety Code section 1389.3, which applies exclusively to health care service plans licensed and regulated by the Department of Managed Health Care. In *Hailey*, the insured completed a Blue Shield application, where Mrs. Hailey claimed she mistakenly believed the application sought information only about her – not her husband and son for whom she also sought coverage; she also claimed that she incorrectly underestimated her husband's weight.

After Blue Shield extended coverage to the insured and her family, the insured's husband was admitted to the hospital for stomach problems and later became completely disabled as the result of an automobile accident. Following the first hospitalization, a Blue Shield investigation revealed that the insured had misrepresented and omitted material information concerning her husband's medical condition.

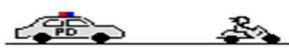
Blue Shield rescinded the policy. The trial court granted summary judgment in favor of Blue Shield on the insured's complaint for breach of contract and breach of the implied covenant of good faith and fair dealing and on Blue Shield's declaratory relief cross-complaint. The Hailey appellate court reversed, concluding that there were triable issues of fact as to whether Blue Shield engaged in post claims underwriting and whether the insured willfully misrepresented her husband's medical condition.

When the *Hailey* case, on remand, went to trial the Haileys' admitted that they intentionally misrepresented material facts to Blue Shield. Their suit was summarily dismissed mid-trial thereby putting a stake through the heart of the Haileys' post loss underwriting allegation. Blue Shield was required to try the case twice and take it through the litigation and appellate process just to have the Haileys' admit that they obtained the insurance by fraud.

Rescission, as the Court of Appeal found in *Nieto*, has nothing to do with claims.

Underwriting is a decision-making process based upon information submitted to the insurer by the proposed insured to convince the insurer to take a risk and insure the proposed insured. When, as did the Haileys and Nieto, the proposed insured lies to obtain the insurance the insurer may seek equity from the court and have the contract voided. To do otherwise would be unfair and allow a fraud to profit from wrongful conduct.

Rescission is an important equitable remedy hoary with age. It should not be limited by claims of bad faith claims handling. Once an insurer learns it was deceived into insuring someone it would not have insured, whether before or after the insurer was sued, it is still entitled to legitimately exercise the right to rescind. It was for that reason that the California Legislature provided both parties to an insurance contract by the California Insurance Code the right to declare a policy void and make both parties whole as if there was never a contract of insurance. [Adapted from my soon to be released book "The Equitable Remedy of Rescission of Insurance"]



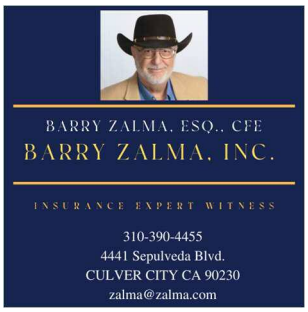
Become a Practioner of Excellence in Claims Handling

Insurance Law and Insurance Fraud Training at ZalmaonInsurance.locals.com/subscribe

Barry Zalma has created a special locals.com community called https://zalmaoninsurance.local.com/subscribe. For only $5.00 a month you can view insurance law materials and webinars on insurance claims handling sufficient to train your claims personnel as perpetrators of excellence in claims handling.

Barry Zalma, Esq., CFE

Barry Zalma, Esq., CFE, now limits his practice to service as an insurance consultant specializing in insurance coverage, insurance claims handling, insurance bad faith and insurance fraud almost equally for insurers and policyholders. He also serves as an arbitrator or mediator for insurance related disputes. He practiced law in California for more than 44 years as an insurance coverage and claims handling lawyer and more than 54 years in the insurance business. He is available at http://www.zalma.com and zalma@zalma.com.



Over the last 54 years Barry Zalma has dedicated his life to insurance, insurance claims and the need to defeat insurance fraud. He has created the following library of books and other materials to make it possible for insurers and their claims staff to become insurance claims professionals.

Barry Zalma, Inc., 4441 Sepulveda Boulevard, CULVER CITY CA 90230-4847, 310-390-4455; Subscribe to Zalma on Insurance at locals.com https://zalmaoninsurance.local.com/subscribe. Subscribe to Excellence in Claims Handling at https://barryzalma.substack.com/welcome. Write to Mr. Zalma at zalma@zalma.com; http://www.zalma.com; http://zalma.com/blog; I publish daily articles at https://zalma.substack.com, Go to the podcast Zalma On Insurance at https://anchor.fm/barry-zalma; Follow Mr. Zalma on Twitter at https://twitter.com/bzalma; Go to Barry Zalma videos at Rumble.com at https://rumble.com/c/c-262921; **Go to Barry Zalma on YouTube- https://www.youtube.com/channel/UCysiZklEtxZsSF9DfCoExpg; Go to the Insurance Claims Library – https://zalma.com/blog/insurance-claims-library/** Read posts from Barry Zalma at **Go to the Insurance Claims Library – https://zalma.com/blog/insurance-claims-library/**

New Book:

California Fair Claims Settlement Practices Regulations 2022

Now Available at Amazon.com

Minimum Standards for Adjusting Claims in California

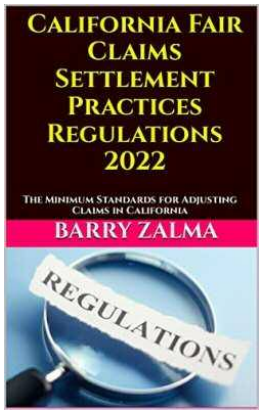
Every Claims Person in California Must Read, Understand, or be Trained About the California Fair Claims Settlement Practices Regulations by September 1 of Each Year

This book was designed to assist insurance personnel who do business in the state of California.

It will provide advice to:

- all insurance claims personnel,
- claims professionals,
- independent insurance adjusters,
- special fraud investigators,
- private investigators who work for the insurance industry,
- the management in the industry,
- the attorneys who serve the industry,

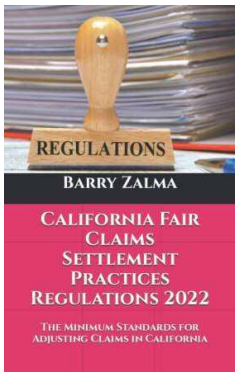
- public insurance adjusters,
- policyholders and
- counsel for policyholders working with insurers doing business in California



The information needed to properly, efficiently, and fairly resolve insurance claims in full compliance with the requirements of the Regulations so they can understand that the Regulations are merely minimum standards and every insurer requires that the service provided exceeds the requirements of the Regulations.

Since the California Regulations appear to be detailed, Draconian, and as or more extensive than similar regulations in other states, understanding and working under the Regulations should suffice in every state.

The insurer's lawyer will need to know, and establish, that the insurer fulfilled the requirements of the Regulations since it will show to a trier of fact that the insurer fulfilled the minimum standards required and required its claims personnel to comply with the Regulations. A knowledge of the Regulations can assist the lawyer in evaluating the exposure faced by an insurer and help the lawyer present an effective defense to an insurer sued for breach of the covenant of good faith and fair dealing.



Similarly, the lawyer representing a policyholder client needs complete knowledge of the Regulations to use them to prove that the insurer failed to fulfill the minimum standards set by the Regulations. Although not evidence of bad faith failure to fulfill the requirements of the Regulations can go a long way to convince a trier of fact (judge or jury) that the insurer did not act fairly and in good faith. Compliance with the Regulations is important to the evaluation of a claim for breach of the covenant of good faith and fair dealing and evaluation of a claim of damages resulting from the tort of bad faith.

Knowledge of the requirements of the Regulations is important to everyone involved in the business of insurance whether as an insurance adjuster, insurance claims management, public insurance adjuster, policyholder, defense lawyer, insurance coverage lawyer, and policyholder's lawyer.

For detail about this book and many more by Barry Zalma go to the Insurance Claims Library – https://zalma.com/blog/insurance-claims-library/ Available as a Kindle Book. Available as a Paper Back

New Book now Available at Amazon.com:

Insurance Fraudsters Deserve No Quarter

New Book That Explains How to Defeat or Deter Insurance Fraud

What every insurer should know about how it can be proactive in the efforts against insurance fraud by refusing to pay every fraudulent claim.

How Giving No Quarter Worked

Many years ago, a client I represented was offended that an insured tried to defraud him and the people who were names in the syndicate he represented at Lloyd's, London. I walked the Underwriter through the debris of the house that was burned, showed him some of the remains of the allegedly highly valuable fine arts, and then explained how he was deceived into issuing the policy. I was the attorney for Lloyd's underwriters for the fine arts and Imperial Casualty for the homeowners policy. Once it became clear to the Underwriter, I was given the following instruction: "Take No Prisoners!" The military instruction to give no mercy to the enemy.

Typically, if you give or grant no quarter, you treat someone—usually an opponent or foe of some kind—harshly. You don't take pity on them or give them any leeway or concession. That is what I did. The claim was denied, the policy was rescinded, and the bad faith suit that resulted was litigated without quarter or concession. It took more than five years, a motion for summary judgment, an appeal, and eventually a judgment in favor of the insurers that resulted in payment to the insurers of every dollar advanced and every dollar expended in investigation and defense of the bad faith suit. That was followed by suits against the claims adjuster, death threats and a bomb threat that took 15 years of my professional life. The appellate decision can be read at *Imperial Casualty & Indemnity Co. v. Sogomonian,* 243 Cal.Rptr. 639, 198 Cal.App.3d 169 (Cal. App. 1988).

After Mr. Sogomonian and his co-defendants were compelled to pay fraudulent claims against Imperial and the Lloyd's underwriters dropped precipitously. Giving no quarter to a fraud perpetrator not only defeated a fraudulent claim but deterred others from attempting fraud.

The *Imperial v. Sogomonian* case and many similar cases is why I am convinced that giving no quarter to a fraud perpetrator is the best way to deter and defeat insurance fraud and why I wrote this book to convince more insurance professionals to emulate the insurers that defeated the Sogomonian attempt at fraud.

Available as a paperback here. Available as a hardcover here. Available as a Kindle Book here.