Zalma's Insurance Fraud Letter

A ClaimSchool™ Publication © 2024	Volume 28, Issue 10 – May15, 2024
Barry Zalma & ClaimSchool, Inc.	Subscribe to the e-mail Version of ZIFL, it's Free!
Go to my blog & Videos at: *Zalma on Insurance*	Read the last two issues of ZIFL here.
And at https://zalma.com/blog	Go to the Barry Zalma, Inc. web site here
Go to the Insurance Claims Library	Videos from "Barry Zalma on YouTube"
"Zalma on Insurance" at https://zalmaoninsurance.locals.com/subscribe	Go to Barry Zalma videos at Rumble.com
Listen to the Podcast: *Zalma on Insurance*	Mr. Zalma on Twitter/X @bzalma
Videos from Zalma on Insurance	@Zalma on Truth Social;
Subscribe to Barry Zalma on Substack.com	Follow me on LinkedIn here
Go to Newsbreak.com https://www.newsbreak.com/@c/1653419?s=01	Go to GTTR at https://gettr.com/@zalma

"If You Keep Saying Things Are Going To Be Bad, You Have A Good Chance Of Being A Prophet."

Isaac Bashevis Singer

Incompetent Insurance Fraud Claim Results in Conviction

Fraudster Pawns Jewelry & Then Claims it Stolen

The defendant, Vincent Chaney, appealed two orders from Superior Court denying his motions to suppress and for a new trial. In *State of New Hampshire v. Vincent Chaney,* No. 2022-0718, Supreme Court of New Hampshire (May 3, 2024) resolved the dispute over Chaney's conviction.

FACTS

In 2018, the defendant traveled to Florida and purchased three pieces of jewelry: (1) a necklace worth $63,138 (hereinafter, the large necklace); (2) a necklace worth $4,500 (hereinafter, the small necklace); and (3) a bracelet worth $16,050. Following the purchases, the defendant took out an insurance policy with Phoenix Insurance Company, also known as Travelers Insurance, on all three pieces of jewelry.

Chaney filed an insurance claim with Travelers Insurance for the small necklace and bracelet. Travelers Insurance paid the claim in March. In May, the defendant filed a second claim with Travelers Insurance alleging that the large necklace had been stolen during an armed robbery in Boston.

Travelers ultimately denied the second claim due to the defendant's non-cooperation and referred the case to the New Hampshire Insurance Department (Department), indicating that it believed the insurance claim to be suspicious. During the state's investigation, the investigator learned that Castro had twice pawned a bracelet identical to the one reported missing in the first insurance claim. At the time of the investigation, the bracelet remained at the pawn shop.

In December 2019, the investigator interviewed Ms. Castro who lived with Chaney after he obtained approval for a one-party intercept in order to record the interview. Castro described the three pieces of jewelry and alleged that they were all either missing or stolen. She stated that she had an older bracelet at her house similar to the one that went missing but that she had never insured the older bracelet due to its age. She also stated that she had never pawned the older bracelet.

Castro changed her story and stated that the bracelet at the pawn shop was the older bracelet that she previously claimed was at her house. The interview ended soon thereafter.

After obtaining a warrant the state's search discovered drugs, drug paraphernalia, multiple firearms, and one of the missing necklaces. The defendant was subsequently charged with possession of a controlled substance with intent to sell and numerous counts of being a felon in possession of a deadly weapon. The defendant was separately charged with three counts of insurance fraud in connection with the claims he made to Travelers Insurance.

ANALYSIS

To suppress evidence seized under a search warrant, the defendant must show that the misrepresentations in the supporting affidavit were material and were made intentionally or recklessly. Materiality is determined by whether, if the omitted statements were included, there would still be probable cause.

In its order on the defendant's motion to suppress, the trial court concluded that the affidavit supporting the search warrant did not contain any material misrepresentations or omissions that rendered the warrant invalid. Regarding the investigator's failure to mention the friend's corroboration, the court ruled any such omission was immaterial to a finding of probable cause.

Finally, the court found that, although the defendant's assertion that the investigator, rather than Castro, initiated the termination of the interview was "mostly accurate," The Supreme Court agreed with the trial court's well-reasoned and thorough order that the affidavit supporting the search warrant did not contain any material omissions or misrepresentations that rendered the warrant invalid.

The task of the issuing court is to make a practical, common-sense decision whether given all the circumstances set forth in the affidavit before it, including "veracity" and basis of knowledge of persons supplying hearsay information, there is a fair probability that contraband or evidence of a crime will be found in a particular place.

The reviewing court may consider only the information that the police brought to the issuing court's attention. Neither the issuing court nor the reviewing court could have considered the 2005 receipt when determining probable cause, and any alleged error in not attempting to introduce it at the suppression hearing did not prejudice the defendant's case. The order was affirmed and Mr. Chaney's conviction stood affirmed.

ZIFL OPINION

Mr. Chaney participated in an amateurish attempt at insurance fraud by reporting the theft of jewelry that he had pawned, a fact easy for a police agency to establish but difficult for an insurer to determine. Chaney was caught when the pawned jewelry was found, a search warrant was obtained and the police not only found in his residence one of the "stolen" items, plus drugs sufficient to arrest him as a drug dealer as well as a perpetrator of insurance fraud. He tried to claim the warrants were improper and the Supreme Court refused his claims.

Wisdom

"Music is life itself. What would this world be without good music?" – **Louis Armstrong**
"Life becomes easier and more beautiful when we can see the good in other people."—**Y. T. BENNETT**
"The absence of alternatives clears the mind marvelously." – **Henry Kissinger**
"Where wisdom enters, subtlety comes along." — **Talmud**
"Life is a great big canvas; throw all the paint you can at it." — **Danny Kaye**
"I am no longer as inspired by expertise as I once was. Perhaps the worth of any lifetime is measured more in kindness than in competency." — **Rachel Naomi Remen**
"Talking comes by nature, silence by wisdom." — **Yiddish proverb**
"Constitutions of civil government are not to be framed upon a calculation of existing exigencies, but upon a combination of these with the probable exigencies of ages, according to the natural and tried course of human affairs." — **Alexander Hamilton**
"Abstract art is a product of the untalented, sold by the unprincipled to the utterly bewildered. — **Al Capp**
"I am a proud Jew with 3,700 years of civilized history. ... Nobody came to our aid when we were dying in the gas chambers and ovens. Nobody came to our aid when we were striving to create our country. We paid for it. We fought for it. We died for it. We will stand by our principles. We will defend them. And, when necessary, we will die for them again, with or without your aid. ... I'm not a Jew with trembling knees." – **Menahem Begin to Joe Biden in June 1982**

More McClenny Moseley & Associates Issues

This is ZIFL's twentyeigth installment of the saga of McClenny, Moseley & Associates and its problems with the federal courts in the State of Louisiana and what appears to be an effort to profit from what some Magistrate and District judges indicate may be criminal conduct to profit from insurance claims relating to hurricane damage to the public of the state of Louisiana.

April 23, 2024

MMA Files Statement of Financial Affairs in its Bankruptcy

On April 23, 2023, MMA filed its Statement of Financial Affairs.

MMA Reported Gross Income as follows:

- 2024 - $803,956.63
- 2023 - $12,247,362.23
- 2022 - $22,596,895.00

MMA then lists monetary transfers made 90 days before filing bankruptcy and within 1 year before filing that benefited an insider. Part 3 (Pages 5-22) describes 98 lawsuits in which MMA was involved within 1 year of the bankruptcy filing.

Part 4 lists Certain Gifts and Charitable Contributions made within 2 years before filing bankruptcy. On Page 23, MMA admits that it donated $10,000 to the Louisiana First Fund, described as a donation to now Louisiana Governor Jeff Landry's election efforts. We already knew about the direct donation of $5,000 to Governor Landry's campaign by Zach Moseley.

Now we know the total amount could be as high as $15,000. I think that it would benefit the Office of Governor Jeff Landry to arrange for these donations to go to charity. Otherwise, people may get the impression that Louisiana Government does not fully reject this firm's behavior.

MMA then lists 9 different accountants or bookkeepers who maintained the books of MMA within 2 years of filing the bankruptcy.

The debtor also claims to hold property it does not own: "Personal items that belong to Zach Moseley that are located in the Debtor's office: Misc Baseball Hats, Koozies, Socks, Plastic Money Gun, Exercise Dice Game, Misc Legal Books, Misc Novels, Lounge Chair + Footrest, Framed Kanye West Tweets in Golden Frame, Cactus Jack Rug in Golden Frame, Cactus Jack Rug in Golden Frame, Framed Photos, Framed Certificates, Framed Diplomas, Misc. ties, shirts, slacks, and jackets, Garment Bags, Framed Photos, eating Pad, Golf Balls, Desk Name Plates Las Vegas BLVD Street Sign.

The last page warns: "Bankruptcy fraud is a serious crime. Making a false statement, concealing property, or obtaining money or property by fraud in connection with a bankruptcy case can result in fines up to $500,000 or imprisonment for up to 20 years, or both."

May 2, 2024

MMA filed an Emergency Motion to Authorize the Use of Cash Collateral

On May 2, 2024, MMA filed the attached Emergency Motion for Interim and Final Orders Authorizing the Debtor's Use of Cash Collateral.

MMA states "The Debtor currently has over 25,000 engagement agreements with clients regarding damage/insurance claims, and a fee interest in more than 5,000 mass tort claims."

MMA argues in part "If the Debtor is not authorized to spend cash collateral, the Debtor would face the real possibility of being forced to cease operations, thereby placing the Debtor's clients and creditors in great difficulty."

It is wonderful that MMA is expressing serious concern for its clients and argues that the best way to protect those clients is to give MMA access to more money. MMA's proposed payroll through May 31 is $68,444.44.

MMA also indicates "The Debtor has obtained authority and agreement from EAJF to process a limited payroll since the filing of this case and has continued to attempt to agree upon an interim order for use of cash collateral. No agreement was reached."

MMA also alleges that if the Debtor is not authorized to spend cash collateral, the Debtor would face the real possibility of being forced to cease operations, thereby placing the Debtor's clients and creditors in great difficulty.

MMA prays that:

> Pursuant to Bankruptcy Rule 4001(b)(2), the Debtor requests that this Court conduct a preliminary hearing on an emergency basis. As set forth in the attached budget, the Debtor requires use of cash collateral to maintain the operation of its business. The failure to timely pay the obligations associated with the operation of the business will result in immediate and irreparable harm to the clients, employees, and the Debtor's estate. The Debtor seeks the emergency use of cash collateral on a limited basis in accordance with Exhibit A pending a final hearing. Because the Debtor's request for interim authorization seeks the use of only that amount as is necessary to avoid immediate and irreparable harm to its estate pending a final hearing, its request complies with Bankruptcy Rule 4001(b)(2).

To me, the Petition is a remarkable example of Chutzpah – Yiddish for Unmitigated Gall – by begging to keep the business viable and allow it to continue in what appears to be its fraudulent and criminal conduct that caused the Louisiana Insurance Department to assess massive fines against it, multiple sanction orders from US District courts, and continue to act to the detriment of its clients, the defendants in the multiple frivolous suits it filed against insurers who did not even do business in Louisiana and its multiple creditors who helped it conduct what appears to be it fraudulent activities.

Hedge Funds Object to MMA's Proposed Bankruptcy Counsel

On May 2, 2024, Equal Access Justice Fund, LP and EAJF ESQ Fund, LP filed an "Objection to Application for Authority to Employ Walker & Patterson, P.C." Walker & Patterson is the law firm that is representing MMA in the bankruptcy filing. The funds argue in part as follows:

"On April 11, 2024, the Debtor filed its Application to Employ Walker & Patterson, P.C. ("WP"), seeking approval of a highly unusual fee agreement, including the payment and permanent retention by WP for a $60,000.00 flat fee ("Flat Fee") it apparently received from the Debtor pre-petition and on the eve of the Petition Date. The second highly unusual feature contemplated by the Application to Employ is a shocking request that WP be entitled to retain, on a contingency fee basis, forty percent (40%) of all funds received by the estate while WP is employed as counsel for the Debtor ("Contingency Fee")."

"The Flat Fee is questionable, but the proposed additional contingent fee is highly inappropriate. WP proposes that in addition to the improper Flat Fee, it should also be entitled to receive "a 40% contingency fee on all value obtained for the estate, including but not limited to money recovered and collected, sales of property, reduction of liability, and all other benefits obtained for the estate.""

"As stated, the Prepetition Secured Lenders have a security interest in proceeds from the Debtor's business which include mass tort litigation dockets involving products liability claims. In its Schedule A/B, Debtor estimates that recovery to be approximately $77,440,000.00. To allow WP to have any interest, much less a 40% interest, in the recoveries of mass tort cases that it did not generate, has no existing referral agreements, and has no involvement in would be unconscionable. "

The Hedge Funds also alleged:

> Prior to the Petition Date, Prepetition Secured Lenders brought suit against the Debtor (and others) in Harris County District Court, in Cause No. 2023-59211 ("Suit"). Therein, Prepetition Secured Lenders, the Debtor, and the Debtor's

principal John Zachary Moseley ("Moseley"), agreed to entry of an Agreed Temporary Injunction, which was made an order of the court. In pertinent part, the Agreed Temporary Injunction forbade the Debtor from "transferring, assigning, pledging, hypothecating, disposing, spending, wasting, or otherwise disposing of any and all money and/or property that comprises the Collateral" of the Prepetition Secured Lenders.

* * *

However, the Fifth Circuit has determined that once a flat fee for debtor's counsel is approved by the Bankruptcy Court, the review process as to reasonableness of that fee is restricted. "We have repeatedly interpreted § 328 as meaning precisely what it says [...] once those terms have been approved pursuant to § 328(a), the court may not stray from them at the end of the engagement unless developments subsequent to the original approval that were incapable of being anticipated render the terms improvident."

* * *

As a result, if the Court approves the Flat Fee, it is virtually impossible for the Court to review the propriety of that Flat Fee in the future.

* * *

The proposed contingency fee is also improper because it is not subject to certain calculation. Importantly under this contingency fee agreement, WP would be paid a 40% fee based upon vague notions of "value obtained for the estate", and "other benefits obtained for the estate." Those concepts are not defined by WP and the idea that WP would reap, for example, a 40% commission on real estate sold by the Debtor is astounding, unreasonable, and brazen. Further, a 40% fee in favor of WP based upon "reduction of liability" is puzzling as that is the purpose of most debtors filing a bankruptcy case in the first place.

May 6, 2024

Kevin M. Epstein, the United States Trustee for Region 7 (the "U.S. Trustee"), by and through the undersigned counsel, files this Objection to Debtor's Application for Authority to Employ Walker & Patterson, P.C. (the "Application") in the bankruptcy proceeding denoted "IN RE MMA LAW FIRM, PLLC, Case No. 24-31596, Chapter 11.

The Secured Creditors in this case —Equal Access Justice Fund, LP, and EAJF ESQ Fund, LP— also filed an objection to the Application. (See Docket No. 28). The U.S. Trustee notes that on April 30, 2024, an Official Committee of Unsecured Creditors (the "Committee") was appointed in this case. (Docket No. 23).

MMA sought authority to employ the law firm of Walker & Patterson under a fee arrangement consisting of a $60,000 flat fee for prosecuting the chapter 11 proceeding, and a contingency fee of 40% for "all value obtained for the estate, including but not limited to money recovered and collected, sales of property, reduction of liability, and all other benefit obtained for the estate."

The Trustee argued that:

12. The Debtor seeks approval of WP's hybrid fee as general bankruptcy counsel under section 328(a) of the Bankruptcy Code.

13. Section 328(a) of the Bankruptcy Code provides as follows:

"The trustee, or a committee appointed under section 1102 of this title, with the court's approval, may employ or authorize the employment of a professional person under section 327 or 1103 of this title, as the case may be, on any reasonable terms and conditions of employment, including on a retainer, on an hourly basis, on a fixed or percentage fee basis, or on a contingent fee basis. Notwithstanding such terms and conditions, the court may allow compensation different from the compensation provided under such terms and conditions after the conclusion of such employment, if such terms and conditions prove to have been improvident in light of developments not capable of being anticipated at the time of the fixing of such terms and conditions." 11 U.S.C. § 328(a).

14. Section 328(a) is generally used to establish the compensation of a special counsel. It is unusual to approve the compensation of a debtor's bankruptcy counsel under section 328(a). A debtor's bankruptcy counsel is generally employed under section 327(a) of the Bankruptcy Case 24-31596 Document 32 Filed in TXSB on 05/06/24 Page 3 of 74 Code, and the amount of reasonable compensation is determined by the court under section 330 by evaluating if the services were reasonable at the time they were made. In re Woerner, 783 F.3d 266, 274 (5th Cir. 2015) ("The statute permits a court to compensate an attorney not only for activities that were "necessary," but also for good gambles—that is, services that were objectively reasonable at the time they were made…").

15. In this case, the compensation of Debtor's bankruptcy counsel should not be approved under section 328(a). The $60,000.00 flat fee paid pre-petition by the Debtor is for services to be performed post-petition.1 Thus, there is no legal or factual basis for the flat fee to be approved under section 328(a). WP, as a professional employed by the estate, should be required to show that such fee is reasonable under section 330 of the Bankruptcy Code.

16. If the Court approves the flat fee under section 328(a), parties in interest will not have the ability to later test the reasonableness of the fee under section 330.

17. Similarly, the 40 percent contingency fee south by WP is not reasonable under the proposed terms and conditions. The contingency fee is overly broad and excessive when applied to the specific categories defined in the Contract2 and the Application.

> * * *
>
> The U.S. Trustee objects to the Application on the basis that it seeks to approve the compensation of the Debtor's bankruptcy counsel —a hybrid fee consisting of a $60,000.00 fee and a contingency fee of 40%— under section 328(a) of the Bankruptcy Code. Approval of the Application under such terms will prevent this Court and interested parties from later evaluating the reasonableness of the fees under section 330. Moreover, the terms of the contingency fee excessive and vague. The scope of the contingency fee includes categories of potential compensation that are impossible to quantify or measure under clearly defined parameters, which will lead to confusion and possibly create conflict between the bankruptcy estate and the professional. For the reasons stated in this Objection, the U.S. Trustee respectfully requests the Court to deny the Application.

A contingency fee is unusual in bankruptcy, and I am curious to see whether the Court will approve MMA's choice of counsel and, if so, under what terms.

Now Available New Book

The Compact Book of Adjusting Property Claims – Fourth Edition

On January 2, 2024, in Kindle, paperback and hardback formats, *The Compact Book of Adjusting Property Claims, Fourth Edition is now available for purchase here* and here. The Fourth Edition contains updates and clarifications from the first three editions plus additional material for the working adjuster and the insurance coverage lawyer.

A Primer for the First Party Property Adjuster The insurance adjuster is seldom, if ever, mentioned in a policy of insurance. The strict wording of the first party property policy sets the obligation to investigate and prove a claim on the insured.

Standard first party property insurance policies, based upon the more than a century old New York Standard Fire Insurance policy, contain conditions that require the insured to, within sixty days of the loss, submit a sworn proof of loss to prove to the insurer the facts and amount of loss.

In general, failure to file the proof within the time limited by the policy is fatal to an action upon it (*White v. Home Mutual Ins. Co*., 128 Cal. 131, 60 P. 666 (1900); *Beasley v. Pacific Indem. Co.,* 200 Cal.App.2d 207, 19 Cal.Rptr. 299 (Cal. App. 1962).

The California Supreme Court in 1900, when it decided White v. Home Mutual concluded that the requirement of proof of loss by the insured within the 60-day limit provided by the standard form of policy is a condition precedent to the right of the insured to maintain suit.

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

Help, My House Is Falling Into The Sea

Normally Honest People Will Try Insurance Fraud

> **"I present blogs and 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 to better understand insurance fraud and weapons that can be used to deter or defeat a fraudulent insurance claim."**

The Honest Real Estate Lawyer Tempted to Commit Fraud

Career criminals are not the only people who perpetrate insurance fraud. The temptation has become so great that almost anyone who is given the opportunity, will try. Those who do not premeditate insurance fraud are called perpetrators of soft frauds. Most are small. Some are not. The story that follows is a not a soft fraud but one that was premeditated for a great deal of money by a person who should have known better.

Some years ago, residents of a hillside community of multi-million dollar homes received a letter from the county engineer informing them that their houses sat on an active landslide. The engineers concluded that an unusual amount of irrigation water, water from septic systems, and rainfall lubricated an ancient landslide under their homes and that the slide was moving. The engineers were concerned because it was moving at the rate of three inches a year. The houses sitting on the landslide were also moving a few inches a month. Within ten years the houses would be torn apart by the movement if nothing was done to stabilize the hillside.

Homeowners, living on the hill, noticed cracks in the plaster walls. Concrete block walls split at the mortar seams. Cracks formed in the foundation systems. Since the homes on the hill were all valued from $1,500,000 and $8,500,000, the monetary value of the potential loss of 300 homes on the landslide was enormous. Many of the homeowners gathered and hired counsel to pursue persons responsible for their damage.

On advice of counsel, the homeowners reported claims to their insurers. Most of the insurers denied the claims because of clear and unambiguous exclusions for earth movement or subsidence. The insurers concluded that the predominant cause of the damage was the

excluded peril of earth movement. The claims were fairly and reasonably rejected. Some of the homeowners accepted the decision of their insurers. Some of the homeowners sued their insurers. The imaginative homeowners, like the insured, found a better way.

The insured was a real estate lawyer. He had experience in dealing with insurers for commercial developers he represented. He knew that, in addition to the basic retail insurance market, there was a surplus and excess lines insurance market that would insure almost anything.

ASK ME NO QUESTIONS I'LL TELL YOU NO LIES

Without informing his broker of the landslide situation on the hillside he asked the broker to seek a specialty insurance policy for his home. He wanted insurance that covered him for both earthquake and earth movement, landslide, mudslide, or other types of earth movement normally excluded by homeowner's policies. He explained to the broker a concern that the wild fires that often devastate hillside communities remove vegetation from the hillsides and increase the hazard of mudflow and landslide. He had invested a great deal of money in his home and wanted to protect against that risk.

The broker found a policy offered by a surplus line insurer. The policy insured dwellings only for the perils of earthquake and earth movement. The premium was a reasonable 3.75 percent of the value of the dwelling with a deductible equal to only 5 percent of the total amount at risk. To obtain the policy all the insurer required, by way of application, was the name of the insured, the address of the property to be insured, and the amount of insurance requested. It asked no questions about the potential risks of loss and the insured – since he was not asked – provided no information nor did he advise the insurer of the report from the county engineer.

After receiving a signed application from the insured the insurer agreed to insure any property because it did not fall within certain specified earthquake fault areas. The insured obtained a $2,500,000 policy for a premium of only $9,375.00.

Before the insured bought the policy, he had received and read the letter from the County. He knew there was a landslide actively affecting his house. At the time he bought the policy the insured had already seen cracks in his plaster walls. When he bought the policy, the insured applied the old maxim "ask me no questions – I'll tell you no lies."

His experience as a real estate attorney convinced the insured that if he told his prospective insurer his house was sitting on an active landslide it would not insure him. The insurer did not ask. The insured did not offer the information.

After the policy had been in effect for three months and the cracks in the plaster had grown to a size that he could place his index finger inside the crack he reported a loss to the earth movement insurer. He presented a claim for the total loss of the house. He demanded payment of policy limits less the deductible.

The insurer sent its adjuster to meet with the insured. They retained a geologist to inspect the property and determine the cause of the damage. The geologist learned of the active landslide from the public records kept by the city and County. He informed the insurer that thirteen months before it issued the policy the county had sent notice to all homeowners, including the insured, advising the homeowners of the active landslide.

After completing its investigation, with the advice of counsel, the insurer did the following:

1. It advised the insured that the policy was rescinded from its inception because of the concealment of a material fact. 1 The insured had concealed the fact of the landslide.
2. With the notice the insurer returned the $9,375.00 premium.
3. It advised the insured that even if it had not rescinded the policy, it would have denied his claim as one that was not fortuitous.
4. The investigation showed that the landslide had started before the inception of the policy.
5. The insurer further advised the insured that the loss in progress rule barred any recovery.
6. The insurer recommended that the insured present his claim, if he still wished to pursue it, to the insurer who insured him against earth movement at the time of the loss.

The insurer reasonably concluded that although the loss was progressive and continuous it was fairly certain that a loss had occurred on or before the insured learned of the landslide.

Of course, the insured did not have earth movement insurance at the time of the notice and bought the insurance from the surplus line insurer in an attempt to recover for the loss that had already occurred.

The insured, if asked, would testify that he had no intent to defraud his insurer. He would testify that the insurer, if it had asked him, would have been told the truth. All he was doing was taking an economic advantage over a lazy insurer who did not bother to ask.

What the lawyer/insured would have said, on its face, sounded reasonable. It wasn't true. He knew of a material fact that would affect the decision of his insurer to insure him. He concealed that fact from the insurer. He intended to conceal the fact from the insurer. Had the insurer known the truth it would not have issued a policy for a loss that was in progress since, by definition, insurance only reacts to a contingent or unknown event.

The insured, in fact, attempted a fraud. His action in fraudulently getting an earth movement policy was reprehensible. His actions in buying the earth movement policy were no less a fraud than if he set the house aflame and made claim on his fire insurance.

Insurance is, as the lawyer should have known at the time, a contract where one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event.

As a lawyer the intentional concealment of a material fact with the intent to deceive an insurer to its detriment is fraud, a criminal act, and if convicted, grounds for disbarment. For that reason, the insured accepted the denial and did nothing further about the claim.

Had the insurer not done the minimum investigation and retained the services of a competent engineer it would have paid the $2,500,000.00 claim. Had the insured's fraud been presented to a prosecutor he could have been arrested, tried, and convicted of attempted insurance fraud and would have been disbarred.

He was lucky that the insurer agreed to a mutual rescission of the policy, a return of the premium, and to forget what was attempted.

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.https://rumble.com/c/c-262921.

He 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 he practiced law in California for more than 44 years as an insurance coverage and claims handling lawyer and more than 55 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 55 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 500 videos at https://www.rumble.com/zalma.

Lies on Insurance Application Expensive

False Statement on Application Requires Rescission

Kimberli Orr obtained no-fault automobile insurance from defendant USA Underwriters and was involved in an automobile collision. Defendant denied plaintiff's claim for benefits because it discovered that plaintiff made material misrepresentations on her application for insurance. Defendant argued that it was entitled to rescind and void plaintiff's insurance policy, and the trial court granted defendant summary disposition.

In *Kimberli Orr v. USA Underwriters*, No. 363452, Court of Appeals of Michigan (April 25, 2024) the Court of Appeals resolved the dispute.

THE APPLICATION

In plaintiff's application for no-fault insurance from defendant, plaintiff Misrepresented that all drivers who might operate her vehicle, including residents of her household, were listed on the application, and that her driver's license had been suspended or revoked anytime in the three-year period before she applied for the insurance. Defendant issued the policy and, unfortunately, on the next day, plaintiff was involved in an automobile collision.

THE INVESTIGATION

Plaintiff made a claim for insurance benefits for the damages she sustained in the collision. During defendant's investigation of plaintiff's claim, defendant discovered that plaintiff's grandmother lived with her, but she was not listed on the insurance application. Thus, defendant refused to pay plaintiff any benefits, voided plaintiff's policy, and sent her a check for the premiums she had paid. Plaintiff cashed the check essentially accepting the insurer's rescission then changed her mind and sued defendant. During discovery, defendant learned that plaintiff's license had been suspended for three-days within the three years before plaintiff sought insurance from defendant.

THE MOTION FOR SUMMARY JUDGMENT

Defendant moved for summary disposition because, it argued, plaintiff made material misrepresentations on her insurance application that entitled defendant to rescind and void her insurance policy. In addition to evidence of the grandmother's residence, defendant also submitted plaintiff's driving record confirming that her license had been suspended for three-days within the three-year period before she applied for the insurance. Defendant further submitted affidavits from its underwriters that confirmed that it would not have issued plaintiff an insurance policy if it had known of the misrepresentations.

The trial court found that plaintiff made a reckless and material misrepresentation on her insurance application regarding her license, and that defendant relied upon that misrepresentation when it issued plaintiff the insurance policy. The trial court granted defendant summary disposition.

ANALYSIS

Summary disposition is appropriate if there is no genuine issue regarding any material fact and the moving party is entitled to judgment as a matter of law. The trial court focused on plaintiff's driving record, rather than the grandmother's residence, and the Court of Appeals did the same. As a result, an insurance policy is subject to common law contract defenses, including fraud, because the no-fault act does not prohibit an insurer from such defenses. Generally, fraud in the inducement to enter a contract renders the contract *voidable* at the option of the insurer. To establish fraudulent action, an insurer showed:

1. that plaintiff made a material representation;
2. that it was false;

3. that when plaintiff made it, she knew it was false, or made it recklessly, without any knowledge of its truth and as a positive assertion;
4. that she made it with the intention that it should be acted on by defendant;
5. that defendant acted in reliance upon it; and
6. that defendant thereby suffered injury.

A misrepresentation is material when an insurer would not have issued a policy if the misrepresentation had been known to the insurer. Plaintiff argued that her misrepresentation with regard to her driving record was not made knowingly or recklessly because she did not receive notice of the license suspension. Plaintiff's argument is misplaced, however, because the law requires her to know her driving status, i.e., whether or not she is a licensed driver, because only a licensed driver may drive.

Rescission is justified without regard to the intentional nature of the misrepresentation, as long as it is relied upon by the insurer. In this case, defendant provided affidavits that demonstrated that it relied on plaintiff's misrepresentations because it would have offered plaintiff's policy at a different price, or not at all, if it had known that plaintiff's license had recently been suspended.

Rescission is an equitable remedy. An insurer is not precluded from availing itself of traditional legal and equitable remedies to avoid liability under an insurance policy on the ground of fraud in the application for insurance, even when the fraud was easily ascertainable, and the claimant is a third party.

Fraud in the procurement of an insurance policy essentially taints the entire policy and all claims submitted under it, thereby invalidating the policy in a manner that suggests no policy ever existed.

ZIFL OPINION

Although an accident the day after a policy comes into effect is a classic red flag of fraud there was no need to prove the accident was less than honest since it was easily established the insured lied on her application for insurance. A material misrepresentation on an application even if unintentional is a basis for rescission in most states and specifically in Michigan. Whatever Ms. Orr would have collected from her no-fault insurer was lost because she lied.

From the

Congrats to the Coalition Against Insurance Fraud on its 30th anniversary! Howard Goldblatt started a close partnership between the Coalition & NCOIL that continues today under Matthew Smith's watch fighting fraud & protecting consumers. Here's to many more!

Paul Hicks wore a wig and custom-made rubber mask to look like his girlfriend, so his home security cameras seemed to record her burning down his house in Clermont County, Ohio.

In fact, Hicks torched the place for $400,000 of insurance payouts. Two masked intruders carrying gas cans entered his house and removed two large TVs, his security cams showed. Then they poured gasoline throughout the place and set the home ablaze. One person looked strikingly like his girlfriend. Hicks wore the rubber mask custom-ordered from a company called That's My Face. He then tried to convince investigators that she did the fiery deed. Hicks also kept his home surveillance cam locked in a fireproof safe inside the home to preserve the footage during the fire. And he maneuvered two years of his girlfriend's phone calls to him, making it appear she had a motive to start the fire. Hicks made a damage claim of more than $180,000 with Allstate. Yet given his income, he had only $11,000-$33,000 of property. His girlfriend was cleared. Hicks pled no contest. He'll serve no jail time though must repay the $400,000.

Health Insurance Fraud Convictions

NBA STAR 'BIG BABY' IS GOING TO JAIL FOR INSURANCE FRAUD

Ex-Boston Celtics player Glen 'Big Baby' Davis has been sentenced to 40 months in prison for defrauding the NBA healthcare plan. Davis, alongside several others, participated in a scheme that involved submitting false or inflated claims for medical and dental services that were never provided. Davis personally submitted $132,000 in fraudulent claims, which were uncovered through geolocation data and travel records. Overall, the group defrauded the plan of over $5 million. Davis will also be on supervised release for 3 years and must pay $80,000 in restitution. Nevada Attorney General Ford Announces Conviction Of Health Care Company And Its Owner

Ashley Bunton-Dodson, 36, of Las Vegas, and **Remedy Wellness and Resource Center, LLC** ("Remedy Wellness"), were sentenced May 7, 2024 in a Medicaid fraud case involving billing for services that were not provided to Medicaid recipients.

Remedy Wellness was sentenced for a category D felony offense of Submitting False Claims, Medicaid Fraud and Bunton-Dodson was sentenced for a Gross Misdemeanor offense of Intentional Failure to Maintain Adequate Records by District Court Judge Susan Johnson. Judge Johnson sentenced Bunton-Dodson to 364 days in jail, suspended, and placed her on probation for one year. As part of the sentence, Remedy Wellness was also ordered to pay $54,000 in restitution. The fraud occurred between August 2020 and March 2021. Individuals or businesses convicted of Medicaid fraud may also be administratively excluded from future Medicaid and Medicare participation.

Physician and Practice Agree to Pay Over $2 Million to Settle False Claims Act Allegations

James Aronovitz, D.O., and **Michigan Ear Care PLLC** agreed to pay over $2 million to resolve allegations that they violated the False Claims Act by charging the Medicare and Medicaid programs for services purportedly provided by Aronovitz, but actually rendered by physician assistants who Aronovitz did not properly supervise.

Under the settlement, Aronovitz and Michigan Ear Care will pay $2,003,800.91 to resolve allegations that Aronovitz submitted claims to Medicare and Medicaid under his National Provider Identifier for ear care services provided by physician assistants in nursing facilities and home health settings, without Aronovitz providing the required supervision of the physician assistants. The State of Michigan will receive $65,993.20 of the settlement amount based on its share of alleged damages to the Medicaid program.

Behavioral Health Company Employee Sentenced

Maurice Andrews, 38, of Las Vegas, was sentenced in a Medicaid fraud case involving fraudulently billing for healthcare services to Medicaid recipients. The fraud occurred between March 2018 and April 2019.

District Court Judge Mary Kay Holthius sentenced Andrews for Submitting False Claims, a category "D" felony. Andrews was sentenced to 19 to 48 months in prison, suspended, and placed on probation for two years. As part of the sentence, Andrews was ordered to pay $346,059 for restitution. Individuals or businesses convicted of Medicaid fraud may also be administratively excluded from future Medicaid and Medicare participation.

The investigation began after the Medicaid Fraud Control Unit (MFCU) received a referral from Silver Summit Healthplan (Silver Summit), a Managed Care Entity contracted with Medicaid, that a behavioral health company had billed excessively high levels of care for various patients and done so without prior authorizations. The investigation revealed that Andrews was the biller for the healthcare company and fraudulently billed services that were not provided. The providers at the healthcare company denied providing the services that Andrews claimed in the billings to Medicaid. Andrews caused the payments from Medicaid for these fraudulent billings to be paid into his personal bank account thereby further hiding his fraudulent conduct from the company.

Man Pleads Guilty to Elder Exploitation

Lawrence Montgomery, Jr. pleaded guilty to one felony count of Exploitation of an Elder Person in Hart County Superior Court. Judge Jeffery Malcom accepted the plea on April 2, 2024, and sentenced the defendant to 10 years of probation. The Court also ordered Mr. Montgomery to pay restitution to the victim, and he barred the defendant from serving as a guardian or power of attorney for another person for the duration of his sentence.

Montgomery placed his mother, Ruth Montgomery, under the care of Hartwell Health & Rehabilitation, becoming her personal representative, after she was diagnosed with Alzheimer's disease in 2019. Mr. Montgomery was thus obligated to use his mother's monthly social security checks to pay for her room and board at the facility. Instead, over the course of five months from October 2019 to February 2020, Mr. Montgomery gained sole access to her bank account and diverted his mother's funds to himself, putting the 77-year-old woman at risk of being discharged from the facility. Hartwell Health & Rehabilitation reported his conduct to the Georgia Department of Community Health (DCH), and the Attorney General's Medicaid Fraud Division launched an investigation in 2020.

Chicago Health Care Company and Its Owner To Pay $1 Million To Settle False Claims Act Lawsuit

Brian J. Weinstein and **Apollo Health Inc**. violated the False Claims Act by submitting claims to Medicare for care plan oversight services that were not actually performed, according to a consent judgment and settlement agreement filed in U.S. District Court in Chicago. Care plan oversight services ("CPO") involve a physician's supervision of a patient receiving complex or multidisciplinary medical care. At Weinstein's direction, Apollo's billers submitted 12,592 claims for CPO services on behalf of 25 providers purportedly employed by Apollo. Weinstein knew that the providers had not actually provided CPO services to Medicare patients and that CPO services had not been documented in the patients' medical records.

As a result, the Chicago health care company and its owner will pay $1 million to the United States to resolve a civil lawsuit arising from the submission of false claims to Medicare.

As part of the consent judgment and settlement agreement entered in the first week of May 2024, by U.S. District Judge Sharon Johnson Coleman, Weinstein and Apollo agreed to pay $1 million to the United States. The consent judgment and settlement agreement resolve a civil lawsuit 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 lawsuit prior to the settlement.

In a separate criminal prosecution, Weinstein pleaded guilty last year to a federal health care fraud charge and was sentenced to three years of probation.

Opioid Manufacturer Endo Health Solutions Inc. Ordered to Pay $1.536B In Criminal Fines and Forfeiture for Distributing Misbranded Opioid Medication

Endo Health Solutions Inc. (EHSI) was ordered May 3, 2024, to pay $1.086 billion in criminal fines and an additional $450 million in criminal forfeiture — the second-largest set of criminal financial penalties ever levied against a pharmaceutical company —for violations of the Federal Food, Drug and Cosmetic Act related to the distribution of the opioid medication Opana ER with INTAC (Opana ER).

EHSI pleaded guilty on April 18 to one misdemeanor count of introducing misbranded drugs into interstate commerce. In pleading guilty, EHSI admitted that from April 2012 through May 2013, certain EHSI sales representatives marketed Opana ER to prescribers by touting the drug's purported abuse deterrence, tamper resistance and/or crush resistance, despite a lack of clinical data supporting those claims.

EHSI's corporate affiliates emerged from bankruptcy on April 23. EHSI will cease to operate in its current form and will not emerge from bankruptcy. Payment of the criminal fine imposed at sentencing is addressed as a component of the broader resolution resolving all monetary claims held by the United States against the corporate entities. In addition, as part of the confirmed bankruptcy plan, the new company has funded voluntary trusts in settlement of opioid-relating claims, including public trusts that will pay over $450 million to state, municipal and Tribal entities to help fund programs to abate the opioid crisis. The department is crediting up to $450 million of such payments against the agreed forfeiture amount. The EHSI affiliates that have emerged from bankruptcy are subject to an injunction restraining future opioid sales and marketing and requiring the publication of millions of documents relating to its role in the opioid crisis.

In pleading guilty, EHSI admitted that certain sales managers were aware that the sales representatives were making claims of purported abuse deterrence, tamper resistance and/or crush resistance when marketing Opana ER to prescribers, and that certain sales representatives were striking non-medicated sample pills with hammers and conducting other demonstrations to convey the message that Opana ER was, in fact, crush proof and tamper resistant. The approved labeling for Opana ER did not provide adequate information for healthcare providers to safely prescribe Opana ER for use as an opioid that is abuse deterrent. According to the plea agreement, EHSI was responsible for the misbranding of Opana ER by marketing the drug with a label that failed to include adequate directions for its claimed abuse deterrence use, in violation of the FDCA.

EHSI withdrew Opana ER from the market in 2017.

Western Pennsylvania Nurse Sentenced to Consecutive Life Sentences After Pleading Guilty to Killing and Attempting to Kill Patients

Heather Pressdee, of Natrona Heights, pleaded guilty to three counts of first-degree murder, and 19 counts of criminal attempt to commit murder.

Pressdee, a western Pennsylvania nurse will spend the rest of her life in prison, without the possibility of parole, for intentionally administering lethal doses of insulin to patients at numerous skilled nursing facilities.

The guilty pleas regard Pressdee administering lethal and potentially lethal doses of insulin to 22 patients at facilities in Allegheny, Armstrong, Butler, and Westmoreland counties, beginning in 2020. Most of the patients died very soon after the insulin dose, or some time later.

In accordance with a plea agreement, a Butler County Judge sentenced Pressdee to three consecutive life sentences regarding three counts of first degree murder, plus 380 to 760 years of consecutive incarceration for the 19 counts of criminal attempt to commit murder.

Numerous relatives of the victims spoke during the hearing this week in Butler County Court. In victim impact statements, they disclosed pain and anguish caused by learning their loved one's death was not natural but was caused by a criminal act.

Charges were filed in May and November 2023. Pressdee has been incarcerated since her arrest in May 2023.

Pain Management Physician Sentenced for Unlawfully Distributing Opioids

Thomas Romano, 74, of Wheeling, West Virginia, n Ohio physician was sentenced to seven years in prison for unlawfully distributing opioids from his clinic.

According to court documents and evidence presented at trial, Romano owned and operated a self-named pain management clinic in Martin's Ferry, Ohio, to which individuals traveled hundreds of miles to obtain prescriptions for opioids and other controlled substances. The prescriptions Romano issued for opioids and other controlled substances greatly exceeded recommended dosages and were in dangerous, life-threatening combinations that fueled the addiction of the individuals to whom he prescribed. Between October 2014 and September 2019, Romano prescribed over 137,000 pills, including opioids, benzodiazepines, and muscle relaxants, to nine individuals.

A federal jury convicted Romano in September 2023 of 24 counts of unlawfully distributing controlled substances in violation of the Controlled Substances Act. According to court documents and evidence presented at trial, Romano issued prescriptions for opioids and other controlled substances greatly exceeded recommended dosages and were in dangerous, life-threatening combinations that fueled the addiction of the individuals to whom he prescribed. Between October 2014 and September 2019, Romano prescribed over 137,000 pills, including opioids, benzodiazepines, and muscle relaxants, to nine individuals.

The jury convicted Romano of 24 counts of unlawful distribution of a controlled substance, outside the usual course of professional practice, and not for a legitimate medical purpose to nine individuals. He faces a maximum penalty of 20 years in prison for each charge. A sentencing date has not yet been set.

Former VA Psychologist Sentenced to Prison for Submitting False Medical Documents, Health Care Fraud

Theresa A. Kelly, 57, pleaded guilty in October 2023 to one count of concealing a material fact by trick, scheme, or device; three counts of making or using a false writing or document; one count of obstruction of justice and one count of health care fraud. Kelly's conduct involved a multi-faceted scheme that impacted her employment at the VA, fraudulent billing to Medicare, and the obstruction of a federal civil lawsuit in the Southern District of Illinois.

A district judge sentenced a Kelly, a Herrin, Illinois woman, formerly employed in southern Illinois as a psychologist with the Department of Veterans Affairs, to 10 months imprisonment after she admitted to submitting false medical documents, obstructing justice, and committing Medicare fraud.

Kelly, a licensed clinical psychologist, was employed by the Marion VA Medical Center. According to court documents, between November 2016 and August 2020, Kelly submitted fraudulent medical documentation in the name of real and fake medical providers as part of the approval process for reasonable accommodations and medical leave, including FMLA leave. Kelly admitted to submitting false medical documents with forged signatures of two legitimate medical providers, one of whom is local to the southern Illinois area.

In addition to her submission of fraudulent medical documents, Kelly engaged in a scheme to defraud Medicare and obtain payment for psychiatric services that she did not provide to residents of a Southern Illinois nursing home between May 2016 and January 2018. In addition to her full-time job at the VA, Kelly owned a company by the name of TS Onsite Mental Health through which she claimed to provide psychotherapy sessions to patients at Shawnee Christian Nursing Center in Herrin, Illinois. Kelly billed Medicare for more than 400 claims—worth more than $54,000—for services that she did not provide. Kelly billed for at least some of the services on days she was on approved medical leave from the VA. In addition, her term of imprisonment, Kelly was ordered to repay $35,795.94 in restitution to the Centers for Medicare & Medicaid Services as repayment for her fraudulent claims.

Kelly also admitted to obstructing justice in a civil proceeding in federal court by submitting fraudulent medical documentation to her attorney—the contents of which were used to seek a continuance of the judicial proceeding. In April 2020, Kelly filed a discrimination complaint in U.S. District Court against the Secretary of Veterans Affairs. Rather than proceeding with the case, Kelly submitted a letter impersonating a real physician who had practiced in Anna, IL but had never treated Kelly. Kelly's lawsuit was ultimately dismissed by the judge.

Man Pleads Guilty to Defrauding COVID-19 Relief Programs and Commercial Equipment Lenders

Andra Shirone Thompson, 47, of Silver Spring, Maryland pleaded guilty May 2, 2024, to conspiring to defraud Coronavirus Aid, Relief, and Economic Security (CARES) Act loan programs and to his role in a years-long scheme to defraud commercial equipment financing companies.

According to court documents, Thompson, 47 joined a conspiracy to submit fraudulent applications for Economic Injury Disaster Loans (EIDLs) and Paycheck Protection Program (PPP) loans on behalf of companies he controlled, including A**lpha Bravo Tango LLC., Senergy Consulting Group Inc.**, and **Novus Ordo Seclorum LLC**. As a result of the deceitful loan applications, Thompson fraudulently obtained $716,375. Thompson spent a portion of the proceeds on vehicles, including a 2014 Lamborghini Aventador, and on renovations to a home in North Carolina.

Thompson also joined a conspiracy to defraud equipment financing companies by submitting fraudulent invoices that falsely showed the sale of substantial quantities of computer servers and related equipment. Thompson and his co-conspirators caused borrowers to submit these invoices to lenders to support their applications for loans to purchase the items shown on the invoices. Once approved, the loan proceeds were deposited into accounts controlled by Thompson and his co-conspirators. Unbeknownst to the lenders, the sales evidenced by the invoices never occurred. Thompson and his co-conspirators typically "kicked back" a portion of the proceeds to the borrower who submitted the application and kept the rest for themselves. Thompson personally participated in three executions of this scheme that caused approximately $813,362 in fraudulently induced lending.

Thompson pleaded guilty to two counts of conspiracy to commit wire fraud. He faces a maximum penalty of five years in prison on each count. A sentencing date has not yet been set. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Elara Caring Agrees to Pay $4.2 Million to Settle False Claims Act Allegations That It Billed for Ineligible Hospice Patients

Elara Caring, and its wholly owned subsidiaries **JHH/CIMA Holdings Inc., CIMA Healthcare Management Inc., CIMA Hospice of Texarkana L.L.C., CIMA Hospice of East Texas L.L.C.** and **CIMA Hospice of El Paso L.P**., have agreed to pay $4.2 million to resolve allegations that they violated the False Claims Act by knowingly submitting false claims and knowingly retaining overpayments for the care of hospice patients in Texas who were ineligible for the Medicare hospice benefit because they were not terminally ill.

The settlement resolves allegations that Elara Caring's Texarkana, Texas, location, which previously operated as CIMA Hospice, knowingly submitted false claims for hospice services provided to patients who were ineligible for the hospice benefit because they were not terminally ill. The patients at issue in the settlement were at the Texarkana location between 2014 and 2019 and in 2020. The settlement also resolves allegations regarding two patients at other Texas locations between 2015 and 2021. The settlement further resolves allegations that Elara Caring knowingly and improperly concealed or avoided obligations to repay overpayments for these patients.

The civil settlement resolved a lawsuit filed under the *qui tam* or whistleblower provision of the False Claims Act, which permits private parties to file suit on behalf of the United States for false claims and share in a portion of the Government's recovery. The *qui tam* lawsuit was filed by Aneko Jackson, a former Elara Caring employee, and is captioned *United States ex rel. Jackson v. CIMA Healthcare Management, Inc., et al*., Case No. 1:20-cv-00368 (W.D. Tex.). Ms. Jackson will receive $672,000 in connection with the settlement.

Justice Department Recovers Fraudulent Transfer of Proceeds Arising from Kickback Scheme

Floyd Calhoun Dent, III agreed to a settlement with the Justice Department worth over $16 million arising from a health care fraud judgment against Dent as well as fraudulent transfer claims against Dent, certain members of his family, his family trust and several corporations owned or controlled by Dent that received millions in assets that were the proceeds of the fraud.

Dent, 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 Dent and the other two individual defendants jointly for $114 million. The judgment was affirmed by the Fourth Circuit Court of Appeals in 2021.

Prior to the judgment, but after Dent's company, **BlueWave Healthcare Consultants Inc.,** which he owned jointly with co-defendant **Brad Johnson**, had been served with a Department of Health and Human Services Inspector General subpoena (IG subpoena), Dent transferred tens of millions of dollars in assets, which were the proceeds of his health care fraud scheme, to his spouse, his parents, his in-laws, a family trust and 10 corporations owned and/or operated by Dent. These transfers started within a few months of service of the IG subpoena and continued through 2015. In 2016, the District Court froze 12 parcels of real property that were owned by Dent and his spouse and certain of the Dent corporations.

In 2019, the United States filed an action under the Federal Debt Collection Procedures Act (FDCPA) against Dent and his spouse, the Dent children and the family trust, Dent's parents, and in-laws, the 10 Dent corporations, Dent's sister, Dent's long-time friend, two of Dent's long-term employees and the spouse of one such employee. The 2019 lawsuit sought to recover amounts transferred by Dent to these entities and individuals.

As part of the settlement announced April 29, 2024, Dent, his spouse and his family, the family trust and the 10 Dent corporations are surrendering nearly all of their assets, which are valued at over $33.6 million, including 22 parcels of real property worth approximately $19 million, $5 million in gold and silver coins, $8 million in cash and $1 million in vehicles, boats, farm equipment and other personal property. The settlement requires the assets be surrendered to the Justice Department and the Liquidating Trustee for now bankrupt **Health Diagnostic Laboratories Inc.** (HDL), a blood testing laboratory that participated in the health care fraud with Dent and his co-defendants. The HDL Liquidating Trustee will split these assets between the United States and other creditors of HDL pursuant to a bankruptcy court agreement. The United States' share of the recovered assets is expected to exceed $16 million.

Previously, in 2022, the United States resolved claims against a long-time friend of Dent and a long-term employee of Dent and the employee's wife. These claims settled for a combined total of $2.4 million, which was split between the United States and the HDL Liquidating Trustee.

The settlement announced today resolves the 2018 judgment against Dent in favor of the United States under the False Claims Act. It also resolves the United States' allegations under the FDCPA that Dent's transfer to certain family members, family corporations and the family trust were fraudulent transfers.

The settlement was the result of a coordinated effort between the Civil Division's Fraud and Corporate/Financial Litigation Sections.

The cases are *United States ex rel. Lutz, et al. v. BlueWave Healthcare Consultants, Inc., et al.* (D.S.C. Case No. 9:14-cv-00230-RMG) (False Claims Act judgment) and *United States v. AROC Enterprises, LLC, et al.* (D.S.C. Case No. 9:19-cv-234 RMG) (Federal Debt Collection Procedures action).

Laboratory Marketer and North Carolina Physicians Agree to Pay Over $1.3M to Settle Kickback Allegations

Thomas Anthony Carnaggio, of Irmo, South Carolina, and his marketing company, as well as three physicians in Charlotte, North Carolina, **Steven Bauer, M.D., Larry Berman, M.D.** and **Alireza Nami, M.D.,** and their medical practices, have agreed to pay a total of $1,373,400 to resolve alleged False Claims Act violations arising from their involvement in laboratory kickback schemes. The parties have agreed to cooperate with the Justice Department's investigations of other participants in the alleged schemes.

The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving remuneration to induce referrals of items or services covered by Medicare, TRICARE, and other federally funded healthcare programs. The Anti-Kickback Statute is intended to ensure that medical providers' judgments are not compromised by improper financial incentives and are instead based on the best interests of their patients.

The settlement announced April 29, 2024, resolves allegations that a marketer and his marketing company offered kickbacks to doctors on behalf of a laboratory in Anderson, South Carolina, and that doctors and their medical practices received kickbacks from the laboratory in return for laboratory referrals. The alleged kickbacks resulted in the submission of false or fraudulent laboratory testing claims to Medicare and TRICARE in violation of the False Claims Act.

- **Thomas Anthony Carnaggio and South Ventures LLC.** Carnaggio and his marketing company agreed to pay $400,000 to resolve allegations that from January 2017 to January 2020, Carnaggio, and his company, on behalf of the laboratory, offered to doctors in North Carolina and South Carolina thousands of dollars in kickbacks disguised as purported office space rental and phlebotomy payments to induce the doctors to order laboratory testing. In addition, Carnaggio and his marketing company allegedly received commissions from the laboratory as independent contractors based on the volume and/or value of the Medicare and TRICARE referrals that they arranged for and/or recommended, in violation of the Anti-Kickback Statute.
- **Steven Bauer and Ballantyne Medical Associates PLLC.** Dr. Bauer and his medical practice agreed to pay $205,000 to resolve allegations that from May 2016 to December 2021, they received thousands of dollars in kickbacks in the form of purported office space rental and phlebotomy payments from the laboratory, in return for ordering testing. Dr. Bauer and his

practice provided information that assisted the government's investigation and received credit under the Department of Justice's guidelines for taking cooperation into account in False Claims Act matters.

- **Larry Berman and Larry F. Berman, M.D., P.C.** Berman, and his medical practice agreed to pay $385,000 to resolve allegations that from July 2017 to November 2021, they received thousands of dollars in remuneration disguised as purported office space rental and phlebotomy payments from the laboratory in return for ordering testing.
- **Alireza Nami and Joint and Muscle Medical Care, P.C.** Nami and his medical practice agreed to pay $383,400 to resolve allegations that from November 2016 to November 2021, they received thousands of dollars in kickbacks from the laboratory disguised as the purchase price for used laboratory equipment, office space rental, and phlebotomy payments, in return for ordering testing.

The settlement was the result of a coordinated effort between the Civil Division's Commercial Litigation Branch, Fraud Section, and the U.S. Attorney's Office for the District of South Carolina, with assistance from HHS-OIG, DCIS and the FBI.

San Gabriel Valley-Based Nursing Home Chain to Pay Over $7 Million to Settle COVID-Related False Claims Allegations

ReNew Health Group LLC, ReNew Health Consulting Services LLC agreed with the United States and the State of California have reached a $7,084,000 civil settlement with Monrovia-based ReNew Health Group LLC, ReNew Health Consulting Services LLC, and two corporate executives for knowingly submitting false Medicare Part A claims for nursing home residents.

During the COVID-19 pandemic, to conserve hospital beds, the Centers for Medicare and Medicaid Services waived the requirement that a person must have had a hospital stay of at least three days (signaling an acute illness or injury) before reimbursing for skilled care in a nursing home.

The United States and the State of California alleged that the defendants knowingly misused this waiver by routinely submitting claims for nursing home residents when they did not have COVID-19 or any other acute illness or injury, but merely had been near other people who had COVID-19. Under the settlement, the defendants will pay $6,841,727 to the United States and $242,273 to the State of California, plus interest.

This investigation was prompted by a lawsuit filed under the whistleblower provisions of the False Claims Act, which permit private parties to sue on behalf of the government to redress false claims for government funds and to receive a share of any recovery. The settlement agreement in this case provides for the whistleblower, **Bay Area Whistleblower Partners**, to receive $1,204,280, plus interest, as its share of the settlement. The case is captioned *United States and State of California ex rel. Bay Area Whistleblower Partners v. ReNew Health Group LLC et al.*, No. 2:20-cv-09472 (C.D. Cal.).

Troy Woman Pleads Guilty to Yearslong Fraud to Obtain Benefits

Christie Mitchell, a Troy woman pleaded guilty in U.S. District Court in Bangor to Social Security fraud, health care fraud, and theft of public money and lied about income to appear eligible for SSI, MaineCare & SNAP benefits. According to court records, from about October 2013 to February 2020, Mitchell, 49, lied to the Social Security Administration (SSA) about her husband's presence in her household and his income to fraudulently appear eligible for Supplemental Security Income (SSI) payments. Mitchell also concealed her husband's presence and income from the Maine Department of Health and Human Services (ME/DHHS) from about October 2013 to December 2019 during which time she received MaineCare benefits and Supplemental Nutrition Assistance Program (SNAP) benefits.

In multiple benefit eligibility reviews, Mitchell falsely represented to the SSA and ME/DHHS that she and her husband lived separately. She failed to disclose her husband's presence and income despite knowing that she was required to and that it would affect her eligibility to receive benefits.

Mitchell faces up to five years in prison and a maximum fine of $250,000 followed by up to three years of supervised release on each of the Social Security fraud and health card fraud charges. She faces up to 10 years and a maximum fine of $250,000 followed by up to three years of supervised release on the theft of public money charge. The Court may also order Mitchell to pay restitution to SSA for the Social Security fraud charge and must order her to pay restitution to ME/DHHS for the health care fraud and theft of public money charges.

Four People Plead Guilty, Sentenced for Multi-Million-Dollar Medicaid Fraud Scheme that Involved Inflated Transportation Costs, Other Phantom Services

Jason Alexandre, Rex Barr, Earlson Satine, and **Natasha Hudson** and a non-medical transportation service, **Rides Your Way** conspired to defraud Medicaid of nearly $9 million pleaded guilty and were sentenced for their roles in the scheme.

The scheme involved overcharging Medicaid for non-medical transportation plans that were scarcely used and medically unnecessary. The scheme revolved around three Philadelphia-based service coordination agencies: **Brighter Care Services, Pennsylvania Service Coordination Agency**, and **Pennsylvania Development Agency**, who were charged in 2021 with Medicaid fraud, theft by deception, and related offenses, and ultimately pleaded guilty.

Most recently, Alexandre, owner of Brighter Care, was sentenced to one to three years in prison, seven years of probation, and to pay $1.63 million restitution.

Barr, owner of Rides Your Way, was sentenced to five years of probation and 100 hours of community service. Barr previously repaid $2 million and will repay an additional $1 million, as a condition of his sentence.

The Office of Attorney General investigation revealed that the service coordination agencies owned by the defendants utilized a non-medical transportation service provider called Rides Your Way, owned by Barr. The service coordination agencies enrolled their participants in Rides Your Way's expensive non-medical transportation subscription plans, without regard to whether those services were appropriate.

The defendants split the millions of dollars in Medicaid reimbursement while providing minimal services.

Between 2017 and 2019, the service coordination agencies received over $7.9 million from Medicaid, supposedly for reimbursement for services provided by Rides Your Way. However, during that same time period, Rides Your Way only provided a total of 1,712 rides to Medicaid consumers. Most participants enrolled with Rides Your Way never used the service.

Additionally, Alexandre and Satine overbilled Medicaid in excess of $2 million in other services they did not provide.

The 45th Statewide Investigating Grand Jury recommended charges against all four individuals. In February, Satine pleaded guilty to felony Medicaid fraud and theft by deception and was sentenced to 1½ to 5 years in state prison. He is required to pay $2.8 million dollars in restitution and previously repaid about $1.47 million to the Pennsylvania Department of Human Services in connection to this case. Hudson pleaded guilty in 2022 to two misdemeanor counts of theft and was sentenced to four years' supervision, with the first 11 ½ months on house arrest.

Physician and Owner of Bellflower Medical Clinic Pleads Guilty to Defrauding Medi-Cal Family Program Out of More Than $2.5 Million

Robert Eyzaguirre, 77, of Torrance, California pleaded guilty to one count of health care fraud, a felony that carries a statutory maximum sentence of 10 years in federal prison.

Eyzaguirre, the owner, and sole physician at a Bellflower medical clinic has pleaded guilty to submitting millions of dollars' worth of false claims to a Medi-Cal health care program that provides family planning services to low-income and uninsured patients, causing more than $2.5 million in losses, the Justice Department announced today.

According to his plea agreement, Eyzaguirre owned and operated **Dr. Robert's Medical Center**, a Bellflower-based medical clinic enrolled as a Family Planning, Access, Care and Treatment (Family PACT) provider run through the Medi-Cal public health program that California administered under Medicaid. At this clinic, Eyzaguirre employed and supervised **Gary Lee Didio**, 54, of Huntington Beach, and **Sandra Rios**, 51, of South Los Angeles.

From at least December 2013 through January 2020, Eyzaguirre conspired with Didio and Rios to submit more than $4.6 million in fraudulent claims to the Family PACT program for family planning services that were never provided. Specifically, Rios picked random names from an online phone-and-address directory and created fake patient files, including inserting fake vital signs and patient notes.

Eyzaguirre signed the fake patient files, falsely representing that he had provided family planning services to those patients. Eyzaguirre sometimes signed blank patient forms before the false vital signs and notes had been added. The fake patient files were then submitted to the Family PACT program for reimbursement. The Medi-Cal program paid more than $2.5 million on the fraudulent claims submitted by Dr. Robert's Medical Center.

Eyzaguirre also falsely certified in the fake patient files that laboratory tests were medically necessary. Didio and Rios then referred the names of fake patients to a laboratory in Northern California, which then paid an illegal kickback of $30 cash for each referral. In total, the laboratory paid more than $372,000 in illegal kickbacks for the referrals of fake Family PACT patients from Dr. Robert's Medical Center. The Medi-Cal program paid more than $1 million on the fraudulent claims submitted by the laboratory related to the scheme.

When Eyzaguirre learned that law enforcement was investigating the fraudulent scheme, he attempted to conceal the criminal activity by instructing Didio to remove the fake patient files from Dr. Robert's Medical Center and hide them offsite. Once the files had been moved, Eyzaguirre attempted to shred the fake patient files to prevent law enforcement from discovering them.

Eyzaguirre admitted in his plea agreement to abusing his position of trust as a physician and obstructing justice.

Rios and Didio have pleaded guilty to conspiring to receive illegal remunerations for healthcare referrals. They are expected to be sentenced in the coming months.

Florida Man Sentenced to 10 Years in Prison and Ordered to Pay More Than $97 Million in Restitution for Participation in Multiple Health Care Fraud and Kickback Schemes

Daniel Hurt, 59, a resident of Fort Lauderdale, Florida, was sentenced in federal court to 120 months of imprisonment, to be followed by three years of supervised release, and was ordered to pay more than $97 million in restitution and to forfeit more than $30 million and the proceeds from the sale of a yacht for conspiring to commit health care fraud and conspiring to pay and receive unlawful kickbacks.

United States District Judge W. Scott Hardy imposed the sentence.

According to information presented to the Court, Hurt engaged in three separate health care fraud and illegal kickback schemes.

First, he and his co-conspirators victimized both TRICARE—a program that provides civilian health care benefits for military personnel, military retirees, and military dependents—and CHAMPVA—a health care benefit program run by the Department of Veterans Affairs—through a scheme that involved the payment of illegal kickbacks. In all, that scheme caused a loss to TRICARE of more than $18 million and to CHAMPVA of more than $450,000. Hurt was initially indicted in the Southern District of Florida for his participation in that scheme, before his case was transferred to the Western District of Pennsylvania for sentencing.

Hurt admitted during his plea hearing that, through this scheme, he and his co-conspirators billed TRICARE, CHAMPVA, and other insurance providers for expensive compounded medications that were not medically necessary. Hurt and his co-conspirators worked with patient recruiters to solicit patients who had health insurance, with the patient recruiters then generating prescriptions containing the patients' information and a limited selection of expensive compounded medications. These prescriptions, which used formulations created or altered to obtain the maximum possible reimbursement from the insurance companies, were then referred to a telemedicine service and sent to a pharmacy owned by Hurt and his co-conspirators.

During the conspiracy, patient recruiters and the telemedicine service sent thousands of medically unnecessary prescriptions to this pharmacy, which, after filling the prescriptions, would bill patients' insurance plans thousands of dollars for the compounded medications. Once the pharmacy received payment for the prescriptions, the pharmacy would then pay a kickback to Hurt and his co-conspirators, who would, in turn, pay kickbacks to the patient recruiters. As part of his plea, Hurt admitted to personally receiving more than $4.2 million from this scheme.

Second, Hurt engaged in a scheme that involved the payment of illegal kickbacks related to cancer genomic (CGx) testing, which was billed as if the testing were done in the Western District of Pennsylvania. In all, Medicare suffered a loss of more than $25 million from that scheme. CGx testing uses DNA sequencing to detect mutations in genes that could indicate a higher risk of developing certain types of cancers in the future.

Hurt admitted that, beginning in late 2018 and continuing through approximately October 2019, he, and his co-conspirators, including individuals associated with so-called marketing entities, acquired thousands of CGx testing samples from Medicare beneficiaries located throughout the United States. Marketers used targeted campaigns to induce beneficiaries to submit CGx specimens by means of cheek swabs sent to their homes or provided to them at purported "health fairs" held throughout the United States.

Hurt directed these CGx specimens to be sent to Ellwood City Medical Center (ECMC), a hospital located in Ellwood City, Pennsylvania. Hurt further used ECMC as the billing entity for Medicare purposes despite the fact that the facility did not possess properly validated equipment to conduct any CGx testing on-site and, as such, ECMC staff were required, at Hurt's direction, to repackage the samples and send them to third-party reference laboratories that were capable of completing the testing. In order to justify Medicare reimbursement for the CGx testing, Hurt and his co-conspirators obtained CGx prescriptions from telemedicine physicians without regard to the fact that the doctors did not conduct proper telemedicine visits, were not treating the Medicare beneficiaries for cancer or symptoms of cancer, and did not use the test results in the treatment of the beneficiaries.

During this time, Hurt directed ECMC staff to transfer millions of dollars from ECMC-related accounts to bank accounts that Hurt controlled. In turn, Hurt admitted using funds he obtained from ECMC to pay millions of dollars in kickbacks to the marketers, among others, in exchange for their efforts to obtain CGx samples. To disguise such kickbacks, Hurt entered into sham contracts with the marketers to make it appear that they were engaged in, and being paid for, legitimate marketing and referral services. Likewise, Hurt, acting through entities he controlled, entered into similar agreements and business arrangements with ECMC that disguised the payments he obtained from the facility as purportedly legitimate payments, including payments related to management services at ECMC's laboratory. Payments, in fact, were based on the volume of CGx tests and the amount of resulting Medicare reimbursements. Hurt also admitted that he and others used a portion of Medicare reimbursements obtained through the fraudulent submission of CGx claims to engage in monetary transactions in excess of $10,000, including approximately $3 million in payments toward the purchase of a luxury watercraft in Florida called "In My DNA."

Hurt's third scheme involved illegal kickback payments and cancer genomic testing that caused an additional loss to Medicare of at least $53.3 million. Hurt was initially charged for his participation in that scheme in the District of New Jersey, before his case was transferred to the Western District of Pennsylvania for sentencing.

In that scheme, Hurt admitted that he owned several clinical laboratories that conducted or arranged for a variety of medical tests, and that he paid kickbacks and bribes to various entities who supplied referrals and orders for CGx for Medicare and other health care benefit program beneficiaries, without regard to medical necessity. These laboratories submitted claims for payment to Medicare for these CGx tests, and Medicare reimbursed the laboratories without knowing that the services were not medically necessary or were procured through the payment of kickbacks. Hurt admitted paying kickbacks to entities who supplied referrals for each CGx test that was billed to Medicare and other health care benefit programs.

To conceal the payments of bribes, Hurt and the suppliers entered into sham contracts to make it appear that the suppliers were engaged in, and being paid for, legitimate marketing and referral services. Hurt received at least $26.9 million from the $53.3 million reimbursed by Medicare.

DOJ Resolves Allegations Tacoma Spine Surgeon Billed For Unnecessary Surgeries

CHI Franciscan Health and **St. Joseph Medical Center** will pay $745,654 to resolve the matter and former Orthopedic Surgeon **Kevin Schoenfelder** will pay $197,054 to resolve the case.

Both the hospital group and the doctor will pay double the amount the government alleges was fraudulently billed to government health plans to resolve a False Claims Act *qui tam* matter alleging the Tacoma, Washington physician billed government insurance programs for medically unnecessary spinal surgeries.

According to the settlement agreement, on May 21, 2018, Dr. Daniel Nehls filed a *qui tam* lawsuit alleging Dr. Schoenfelder had been performing medically unnecessary spinal surgeries, among other allegations. CHI resolved claims that the hospital billed for Dr. Schoenfelder's performance of spinal surgery at more spinal levels than necessary and medically unnecessary spinal fusions at Tacoma's St. Joseph Hospital. Dr. Scheonfelder resolved claims pertaining to his performance of allegedly medically unnecessary spinal surgeries.

Between January 1, 2013, and June 30, 2018, these surgeries were billed to government health programs when they were not medically necessary. The surgeries were billed to Medicare, TRICARE, and Veterans Affairs.

In resolving the case, neither the doctor nor the hospital and CHI Franciscan are admitting wrongdoing. Each is paying the government health programs the amount that was improperly billed and additional penalties. Additionally, Dr. Nehls, as the relator who reported the false claims, will receive 22% of the payments to the government health programs.

Dr. Schoenfelder retired in 2018 and surrendered his physician license in 2019.

Connecticut Dentists Pay $498K to Settle False Claims Allegations

BOHUN CHOI, DDS and **MICHONG SON, DDS,** and their businesses, **C&S FAMILY DENTAL NEW BRITAIN, LLC**, **and C&S FAMILY DENTAL WATERBURY, LLC,** have entered into a civil settlement agreement with the federal and state governments and will pay more than $498,000 to resolve allegations that they violated the federal and state False Claims Acts.

Choi and Son are both licensed to practice dentistry in Connecticut. Choi, Son, C&S Family Dental New Britain ("C&S New Britain") and C&S Family Dental Waterbury ("C&S Waterbury") are enrolled as dental providers in the Connecticut Medical Assistance Program ("CTMAP"), which includes the state's Medicaid program.

It is alleged that, in violation of their CTMAP provider agreements and the federal Anti-Kickback Statute, C&S New Britain, C&S Waterbury, Choi, and Son submitted claims to the CTMAP related to dental services rendered to Connecticut Medicaid patients referred to C&S New Britain and C&S Waterbury by a third-party "patient recruiting" company. Specifically, the federal and state governments alleged that C&S New Britain, C&S Waterbury, Choi, or Son paid a patient recruiter $110 for each Connecticut Medicaid patient the recruiter referred to them whenever the patient received services over and above routine preventative care, such as dental cleanings and exams, and submitted claims for dental services rendered to those patients. With each submitted claim, they impliedly certified that the conditions of receiving payment were met, including, but not limited to, that they did not pay kickbacks or violate any terms or provisions of the Connecticut Dental Health Partnership ("CTDHP") provider manual concerning the submitted claim.

The CTDHP provider manual, which is an addendum to both the CTMAP provider agreement and the CTMAP provider manual, expressly prohibits per-patient compensation for individuals referred to CMAP providers.

To resolve the allegations under the federal and state False Claims Acts, C&S New Britain, C&S Waterbury, Choi, and Son agreed to pay $498,310 to reimburse the Medicaid program for conduct occurring from April 1, 2018, through January 12, 2020.

Under the False Claims Act, the government can recover up to three times its actual damages, plus penalties of $13,946 to $27,894 for each false claim.

This case stems from a larger investigation into fraudulent activity by health care providers who submit kickback-tainted claims to the CTMAP for services rendered to Connecticut Medicaid patients referred by third-party patient recruiting companies.

Florida Hospital System Agrees to Pay $1.5 Million to Resolve Liability Relating to Self-Disclosure of Improper Discounts

Baptist Health System Inc. (Baptist Health), located in Florida, has agreed to pay $1.5 million to resolve allegations that it violated the False Claims Act by knowingly causing its subsidiaries to offer discounts to patients to induce them to purchase or refer Baptist Health services reimbursed by federal health care programs. In connection with the settlement, the United States acknowledged that Baptist Health took significant steps entitling it to credit for cooperating with the government's investigation.

The Anti-Kickback Statute prohibits parties who participate in federal healthcare programs from knowingly and willfully paying or receiving any remuneration in return for referring an individual to, or arranging for the furnishing of, any item or services for which payment is made by the federal healthcare programs. The United States alleged that Baptist Health subsidiaries provided discounts of up to 50% or more on patient cost sharing obligation balances for certain categories of Medicare beneficiaries, chosen by Baptist Health, without regard to any financial need consideration, during the period from Jan. 1, 2016, through Aug. 15, 2022. The United States contends that Baptist Health subsidiaries provided these discounts in exchange for the beneficiaries' purchase or referral of services by certain categories of Medicare beneficiaries from Baptist Health subsidiaries.

Baptist Health voluntarily self-disclosed this conduct to the United States. In addition, Baptist Health cooperated with the government's investigation and took remedial measures, including discontinuing its discount policy, conducting an internal compliance review, and providing the United States with a detailed disclosure statement and other supplemental information to assist the United States in its investigation.

Three Admit Half-Million Dollar Health Care Fraud Conspiracy

Doriann Morgan, 58, of St. Louis County, **Thalisa Walton,** 46, of Hazelwood, and **Barbara Jackson**, 59, of St. Louis, pleaded guilty to a felony charge of conspiracy to commit health care fraud in three separate hearings in U.S. District Court in St. Louis.

The former owner, office manager, and business manager of a St. Louis County, Missouri-based home health care company pleaded guilty to a federal charge Monday and admitted involvement in a health care fraud conspiracy that fraudulently billed the Missouri Medicaid program more than $552,000.

They each admitted that from roughly January 2018 to August 2021, they conspired to submit fraudulent reimbursement claims to Missouri's Medicaid program for personal care services that were never provided. They admitted receiving $552,659.

Jackson was business manager of **A Mother's Touch In-Home Care LLC**, responsible for recruiting clients and assigning employees to provide care. Morgan owned the company and submitted Medicaid claims. Walton was office manager.

Morgan, Walton and Jackson are no longer affiliated in any way with A Mother's Touch In-Home Care LLC, which continues to do business under new ownership.

The three submitted fraudulent claims for personal care services purportedly provided by Jackson for a woman who did not live in Missouri and received no services, their plea agreements say. They also submitted claims for providing services for clients at times when their own social media posts showed them doing something else.

In a separate civil settlement, Morgan, Walton and Jackson agreed to pay $910,000 to resolve allegations that they violated the False Claims Act by billing Missouri Medicaid using false timesheets and payroll records for in home services that were never provided. The civil settlement resolves claims brought under the qui tam or whistleblower provisions of the False Claims Act by Michele Bickley. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. Ms. Bickley will receive $90,090 of the proceeds from the settlement.

"HHS-OIG is committed to protecting our communities and taxpayer funds from schemes targeting Missouri's Medicaid program, which provides necessary services to vulnerable populations," said Special Agent in Charge Linda Hanley of the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG). "Working proudly with the Missouri Attorney General's Medicaid Fraud Control Unit and our other law enforcement partners, our agency will continue to investigate those who threaten the integrity of federal and state health care programs and the people served by them."

The three are scheduled to be sentenced August 26. The charge is punishable by up to 10 years in prison, a $250,000 fine, or both prison and a fine.

Glastonbury Psychologist Sentenced to Prison for Defrauding Medicaid of More Than $1.6 Million

MICHAEL B. PINES, 75, of Avon, Connecticut was sentenced by U.S. District Judge Sarala V. Nagala in Hartford to 27 months of imprisonment, followed by 3 years of supervised release, for defrauding Medicaid of more than $1.6 million.

According to court documents and statements made in court, Pines is a psychologist who owned and operated Michael B. Pines, Ph.D., P.C., located in Glastonbury. Pines provided psychotherapy to young children, adolescents, and adults, and he was enrolled individually as a Behavioral Health Clinician provider in the Connecticut Medicaid Program ("Medicaid").

Between January 2017 and October 2023, Pines submitted and caused to be submitted fraudulent claims to Medicaid for psychotherapy services that were purportedly provided to his Medicaid clients. Specifically, Pines submitted claims for dates of service when no services of any kind had been provided to the Medicaid clients identified in the claims, including when he was traveling, on vacation, recovering from surgery, or otherwise not working. He also submitted claims when an appointment had been canceled, when the claimed client was in the hospital, when he had stopped treating the claimed client, and when the claimed client had never been his client. In addition, when Pines treated multiple Medicaid clients in the same family at the same time, he billed Medicaid for the group visit as multiple individual claims, a practice that he knew was not permitted by Medicaid.

The investigation revealed that Pines used his business bank account for numerous personal expenditures.

Through this scheme, Pines defrauded Medicaid of $1,617,679. Judge Nagala ordered Pines to make full restitution. Pines also forfeited 16 pieces of jewelry, which he paid for using his business bank account, with an appraised replacement value of $67,685.

On January 31, 2024, Pines pleaded guilty to health care fraud.

Pines who was released on a $250,000 bond, is required to report to prison on June 24.

How to Avoid Insurance Fraud from the Louisiana Department of Insurance

LDI and St. Tammany Parish Sheriff's Office to Help Consumers Avoid Storm-Related Insurance Fraud

I usually write everything in ZIFL, but this notice is useful wherever you work or live and as you read just change "Louisiana" to your state's name.

> As residents begin to recover from the destructive tornadoes and severe weather that swept through Louisiana on April 10, the Louisiana Department of Insurance (LDI) and St. Tammany Parish Sheriff's Office (STPSO) are jointly reminding consumers to remain alert for potential fraud and other scams.
>
> Investigators from the LDI Office of Insurance Fraud and detectives from the STPSO Property Crimes and Public Affairs divisions met in Covington to outline a plan of action for combatting insurance fraud and educating consumers in the area. The LDI is already investigating potential cases of insurance fraud in the parish, and both the LDI and STPSO are committed to working to prevent additional insurance crime.
>
> * * *
>
> Scammers and other criminals may attempt to take advantage of storm victims as they recover and rebuild. Some of these fraudulent practices include scammers posing as contractors or housing inspectors, fake solicitations for disaster donations, and false offers of state or federal aid. These scam attempts can be made over the phone, by email or mail, text or even door-to-door.

The LDI and STPSO urge all residents to take the following steps to safeguard themselves against insurance fraud:

- Contact your insurance carrier immediately if you believe your property sustained damage.
- If you need repairs after a disaster, request a list of reputable contractors from your insurance carrier, the Better Business Bureau, or a specialized organization. Ask for a copy of the contractor's Louisiana license and proof of insurance.
- Contact multiple contractors and obtain more than one estimate. Get estimates in writing including all materials, labor payment requirements and timetables for completion. If sub-contractors are required, they should also be listed on the estimate.
- Be wary of any contractor who uses high pressure sales tactics or discourages you from contacting your insurance company.
- Do not allow a contractor to inspect your property when you are not home. If you give a contractor permission to inspect your property, watch them conduct the inspection.
- Request references that include contact information and ask the reference about the contractor's work schedules, pricing and the quality of the finished product.
- Read all documents provided by a contractor before signing. If you feel unsure about a contractor, do not sign the contract. If the contractor seems in a hurry to have you sign an agreement and pay the deposit, take additional time to review the scope of the work needing to be performed.
- Do not give a contractor Power of Attorney over your affairs or permit them to negotiate or settle your insurance claim. Generally, work directly with your insurer on the claim and pay the contractor rather than permitting the contractor to collect from the insurer.
- Do not pay a contractor the full amount up front, and do not sign a completion certificate until all work is completed as indicated in your contract or written estimate. Always pay contractors by check or credit card so you have a record of all payments issued.

Policyholders who believe they may be a victim of insurance fraud or notice suspicious activity related to their insurance claim are encouraged to contact the LDI Office of Insurance Fraud at 225-342-4956 or online at www.ldi.la.gov/reportfraud.

About the Louisiana Department of Insurance: *The Louisiana Department of Insurance works to improve competition in the state's insurance market while assisting individuals and businesses with the information and resources they need to be informed consumers of insurance. As a regulator, the LDI enforces the laws that provide a fair and stable marketplace and makes certain that insurers comply with the laws in place to protect policyholders. You can contact the LDI by calling 1-800-259-5300 or visiting www.ldi.la.gov.*

New Book Now Available from Barry Zalma

Property Investigation Checklists: Uncovering Insurance Fraud, 14th Edition

Property Investigation Checklists: Uncovering Insurance Fraud, 14th Edition provides detailed guidance and practical information on the four primary areas of any investigation of suspicious claims. The book also examines recent developments in areas such as arson investigation procedures, bad faith, extracontractual damages, The fake burglary, and Lawyers Deceiving Insurers, Courts & Their Clients During, Catastrophes—A New Type Of Fraud and the appendices includes the NAIC Insurance Information and Privacy Protection Model Act and usable forms for everyone involved in claims and will provide necessary information to the claims adjuster, SIU fraud investigator, claims manager, or coverage lawyer so he or she can be capable of excellence.

The newest book joins other insurance, insurance claims, insurance fraud, and insurance law books by Barry Zalma all available at the Insurance Claims Library – https://zalma.com/blog/insurance-claims-library/

Other Insurance Fraud Convictions

Former Desert Sun VP Sentenced For Ordering His Son To Shoot Him In Legs To Delay Prison

Shannon Egeland's insurance scheme and concocted shooting, which led to the amputation of his left leg, "an unthinkable kind of situation," and tacked on three years and 10 months to his 10-year sentence for mortgage fraud. He was sentenced in U.S. District Court

in Portland. England, a convicted white-collar criminal was sentenced Wednesday for persuading his son to shoot him in the leg as part of a staged insurance scam a day before he was to set to start serving a decade-long federal prison term from a high-profile mortgage fraud case.

U.S. District Judge Anna J. Brown called Shannon Egeland's insurance scheme and concocted shooting, which led to the amputation of his left leg, “an unthinkable kind of situation," and tacked on three years and 10 months to his 10-year sentence for mortgage fraud.

The additional time resulted from Egeland's guilty plea in May to conspiracy to commit wire fraud in the elaborate insurance scam, and for interstate failure to pay child support.

Egeland, who stood on a prosthetic leg before the judge in U.S. District Court in Portland, said he's spent time reflecting the past 3 ½ years he's been in custody, and has realized he's in need of mental health counseling and treatment. He's now taking three mental health-related medications.

"What bothers me the most is my son - the pain is on him," Egeland said. "The pain that he has shouldn't be there...I've had 3 ½ years to recognize I am broken...If I could take it all back, I would, but I can't...That will haunt me the rest of my life."

On July 31, 2014, Egeland directed his son Rylan Egeland, then 17, to shoot him in the leg with a shotgun along a roadside in Caldwell, Idaho, hoping to delay his prison sentence and benefit from a bogus disability insurance policy that he had applied for seven days earlier.

The son shot Egeland in his lower legs and then left the scene. Egeland called 911 and claimed he was a victim of assault when he stopped to help a pregnant motorist. He told authorities he was suddenly hit in the head and shot along the side of the road.

Egeland previously had pleaded guilty to fraud charges for his role in the Desert Sun housing scandal that rocked Central Oregon in 2009. Egeland was a co-owner of Desert Sun, which raised millions from local banks through a series of phony business plans and falsified loan applications.

Guilty of Unemployment Insurance Fraud

Jamaine Myers, 46, of Troy, New York pleaded guilty to unemployment insurance fraud, illegally obtaining $1.6M in unemployment insurance benefits.

According to the Department of Justice (DOJ), Myers obtained these benefits using another person’s name. These benefits included benefits funded by the federal government’s response to the COVID-19 pandemic.

The DOJ also says Myers gave **Carl DiVeglia III** the personal information of a different person, which DiVeglia used to file a false claim with the New York State Department of Labor website. DiVeglia pleaded guilty previously in the same scheme, per the DOJ.

Myers faces a term of supervised release of up to three years when he is sentenced in September, and a fine of up to $250,000.

Sentenced For Felony Insurance Fraud After Boise Hit-And-Run Incident

Jeri Ann Kipper of Meridian, Idaho, formerly of Nampa, was sentenced on one count of felony insurance fraud in Canyon County on April 30, 2024. On August 11, 2022, Kipper's vehicle participated in a collision in Boise, sustaining front-end damage. The vehicle fled the scene without stopping. However, a witness photographed it leaving the scene and captured its license plate number. Kipper obtained new license plates for her vehicle the following day.

On Aug. 18, 2022, the Nampa Police Department conducted a routine traffic stop on Kipper's vehicle. She was identified as the driver and received a traffic citation for not having insurance.

The officer's bodycam video also captured the damage to the front of the vehicle during the stop. Kipper purchased insurance for her vehicle from Progressive Insurance shortly after the traffic stop.

On September 9, 2022, Kipper made a claim on her policy from Canyon County stating her vehicle was hit by an unknown vehicle at a rest stop near New Plymouth. Kipper claimed the date of loss was Sept. 8, 2022. She submitted photographs to Progressive Insurance of the damage.

The damage was identical to what was captured during the Nampa Police Department's traffic stop, revealing the damage was present on the vehicle before her policy was purchased.

Kipper pled guilty to one felony count of insurance fraud. On April 30, she was sentenced to four years of prison, two years fixed and two years indeterminate, which was suspended for four years of supervised probation. She was ordered to serve 30 days in jail, complete 16 hours of a Healthy Thinking class and pay restitution to DOI.

Kipper was also ordered to pay the public defender $350. The Judge ordered an additional 50 days of discretionary jail time, which her probation officer can impose should she have any problems while on probation.

Defendant Sentenced for Workers’ Comp Fraud, Ordered to Pay Restitution

Christopher Dangelo Green pled no contest to felony insurance fraud. The Honorable Satnam Rattu sentenced Green to 180 days county jail and 2 years formal probation and ordered $133,291.79 in restitution to the victim.

In 2021, Green reported he was injured while working as part of a road crew that repaved roadways. There were no witnesses to the alleged accident. Green gave conflicting reports about the incident and his injuries to his employer, medical providers, and insurance company. Green’s co-workers reported he recently told them he needed money, and Green hoped he was involved in a “freak

accident" at work so he could get paid out. Two co-workers also reported Green asked them to hit him with a vehicle while at work so he could get money to help pay his debts, which they declined.

An investigation determined Green's account of the accident was not true and he lied about being in constant pain and unable to work. It was also discovered Green was working as a barber during this time. Surveillance of Green showed he was not being truthful to doctors about his physical activities and limitations. Green's fraudulent workers' compensation claim cost the employer and insurance company more than $130,000.

Sentenced For Defrauding $1M

Adrian Fluellen, 29, was sentenced to 51 months in prison and ordered to pay more than $900,000 in restitution in the sentence handed down by United States District Judge Matthew F. Leitman.

The Pennsylvania man was sentenced in May 2024 for defrauding multiple states and the federal government for pandemic insurance fraud in Michigan, Pennsylvania and Maryland.

Court records established that Fluellen and a co-defendant defrauded the federal government, Michigan, Pennsylvania and Maryland of roughly $1 million in funds intended to help individuals who had lost their jobs during the COVID-19 pandemic.

The pair committed their crimes through the use of interstate wires and obtaining unauthorized social security numbers and other means of identification belonging to other individuals.

Fluellen pleaded guilty to wire fraud and conspiracy to commit wire fraud in February.

Fluellen and his co-defendant used stolen personal identification to file hundreds of false unemployment claims with state unemployment insurance agencies in Michigan, Pennsylvania and Maryland in the names of other individuals without their knowledge or consent.

The defendants received hundreds of Bank of America prepaid debit cards in the names of those individuals loaded with roughly $1 million in Pandemic Unemployment Assistance funds at addresses in Michigan and Pennsylvania.

Fluellen, his co-defendant, and their accomplices then successfully unloaded more than $930,000 from the cards via cash withdrawals and purchases that included jewelry, drugs, at least one vehicle, and at least one firearm.

Attorney Sentenced for Lying to Clients About Civil Case Outcomes

James Conaboy, of Clarks Summit, Pennsylvania, a former Scranton attorney has been sentenced to prison for lying to clients who filed civil cases and for forging corresponding documents — including a judge's signature.

Pennsylvania Attorney General Michelle Henry reported that Conaboy previously pleaded guilty to misdemeanor forgery and tampering with records. A Luzerne County judge sentenced Conaboy to 30 days to a year in prison, followed by four years of probation.

The attorney general office's investigation revealed that Conaboy lied to numerous clients about their cases, including making promises of settlements that never actually were reached. Two cases involved Conaboy making representations about alleged six-figure settlement payouts, according to officials. In 2021, Conaboy told clients they had won a $700,000 settlement in a medical malpractice case — in reality, the case was terminated by the court because Conaboy did not serve the lawsuit. Prosecutors also said that Conaboy forged a judge's signature on documents that showed the clients were successful.

The couple who brought that medical malpractice case sued Conaboy, as did others.

In another case, an employment suit, Conaboy told a client a $517,000 settlement had been negotiated whereas, in reality, the suit had been dismissed.

In a third case, another medical malpractice suit, Conaboy withdrew the suit, but told his client a $50,000 settlement was negotiated.

Conaboy was with the Scranton law firm Abrahamsen, Conaboy, and Abrahamsen. Conaboy consented to his disbarment In April 2023, after the Pennsylvania Disciplinary Board of the State Supreme Court initiated action. He is no longer listed as a member of the law firm. There was no comment why the sentence was so light except for his voluntarily giving up his license to practice law.

Sixth Nigerian National Pleads Guilty to International Fraud Scheme that Defrauded Elderly U.S. Victims

Amos Prince Okey Ezemma, 50, a sixth Nigerian national pleaded guilty to operating a transnational inheritance fraud scheme that defrauded elderly and vulnerable consumers across the United States.

According to court documents, Ezemma was a member of a group of fraudsters that sent personalized letters to elderly victims in the United States over the course of several years. The letters falsely claimed that the sender was a representative of a bank in Spain and that the recipient was entitled to receive a multimillion-dollar inheritance left for the recipient by a family member who had died overseas years before. Ezemma and his co-conspirators told a series of lies to victims, including that, before they could receive their purported inheritance, they were required to send money for delivery fees, taxes, and other payments to avoid questioning from government authorities. Ezemma and his co-conspirators collected money victims sent in response to the fraudulent letters through a complex web of U.S.-based former victims, whom the defendants convinced to receive money and forward to the defendants or persons associated with them. Victims who sent money never received any purported inheritance funds. In pleading guilty, Ezemma admitted to defrauding over $6 million from more than 400 victims, many of whom were elderly or otherwise vulnerable.

On May 2, Ezemma pleaded guilty to conspiracy to commit mail and wire fraud. Ezemma is scheduled to be sentenced by U.S. District Judge Kathleen M. Williams on July 22. Ezemma faces a maximum penalty of 20 years in prison. With Ezemma's guilty plea today, all six defendants charged in the indictment have now been convicted for participating in this scheme.

Five other defendants have already been convicted and sentenced by Judge Williams in connection with this scheme. On Nov. 1, 2023, the court sentenced **Ezennia Peter Neboh**, who was extradited from Spain to 128 months in prison. On Oct. 20, 2023, **Kennedy Ikponmwosa** was sentenced to 97 months in prison. Three other defendants who were extradited from the United Kingdom also received prison sentences. **Emmanuel Samuel**, **Jerry Chucks Ozor** and **Iheanyichukwu Jonathan Abraham** were sentenced to 82 months, 87 months, and 90 months in prison, respectively, for their roles in the scheme.

If you or someone you know is age 60 or older and has been a victim of financial fraud, help is standing by at the National Elder Fraud Hotline at 1-833-FRAUD-11 (1-833-372-8311). The hotline is open Monday through Friday from 10:00 a.m. to 6:00 p.m. ET. English, Spanish, and other languages are available.

Defendant Ordered to Pay $687,560.96 in Restitution for Workers' Comp Insurance Fraud

Jorge Maldonado was convicted of felony workers' compensation insurance fraud on April 18, 2023. At a restitution hearing on April 25, 2024, the Honorable Tami Bogert ordered Maldonado to pay $687,560.96 in restitution to the victims.

Maldonado is the owner of **Pro-Care Building Maintenance**. The California Department of Insurance (CDI) received a suspected fraud referral on Maldonado. An investigation by CDI determined that between 2015 and 2017, Maldonado significantly under-reported the number of employees working for Pro-Care Building Maintenance to three insurance carriers – Employers Preferred Insurance Company, Markel Corporation and Atlas General Insurance Services. This resulted in the insurance companies losing a total of $687,560.96 in workers' compensation insurance premiums for the under-reported number of employees.

Insurance fraud of this nature puts employees of the company at risk if they are injured on the job. It also illegally reduces costs for the fraudster, allowing them to undercut honest employers on job bids. This results in unfair competition and hurts not only other companies within the industry, but also consumers who have fewer choices and less reputable companies to choose from.

California Contractor Pleads Guilty to Insurance Fraud After Underreporting Nearly $1M in Payroll

Kent Bo Fridolfsson, 67, of Benicia, California, pleaded guilty to six charges of insurance fraud and grand theft after a joint investigation with the California Department of Insurance, Solano County District Attorney's Office and the Employment Development Department reportedly revealed he underreported payroll by nearly $1 million to save on workers' compensation insurance and taxes.

Fridolfsson was placed on formal probation, ordered to pay more than $725,000 in restitution, and ordered to surrender his contractor's license.

The joint investigation began after one of Fridolfsson's employees reportedly sustained a work-related injury and contacted State Compensation Insurance Fund, which provided insurance coverage to Fridolfsson's business. Fridolfsson was the former president and owner of the construction company Diversified Specialists and had been a licensed contractor in California since 1986.

Fridolfsson had insurance coverage with State Fund from 2010 to 2021 and was required to report payroll during each policy period. From 2010 to 2019, Fridolfsson reported zero payroll to State Fund. In January 2019, one of his employees contacted State Fund after sustaining a work-related injury. After being contacted by State Fund, the Contractors State License Board conducted a site inspection of Fridolfsson's business and interviewed a number of his employees.

The joint investigation reportedly found that Fridolfsson underreported his payroll by $989,823. The failure to report employee payroll resulted in the illegal reduction of workers' comp insurance premiums, leading to roughly $382,104 in premium owed to State Fund. The underreported payroll also resulted in an unpaid payroll tax to EDD of roughly $347,520.

Fridolfsson was convicted on April 5. The case was prosecuted by the Solano County District Attorney's Office.

Businessman Jose Uribe Pleads GUILTY To Trying To Bribe Senator Bob Menendez In A Corruption Case Involving Bribes Of Cash, Cars And Gold Bars

Jose Uribe admitted to seven counts, including conspiracy to commit bribery, honest services wire fraud, obstruction of justice, tax evasion and other charges. Uribe, a New Jersey businessman has pleaded guilty to trying to bribe Democratic Senator Bob Menendez in a corruption case.

The New Jersey Democrat Senator has been under investigation for allegedly accepting bribes of cash, gold bars and a luxury car over the last five years to carry out favors for three businessmen - including Uribe - who are also charged in the case.

Uribe, a former New Jersey insurance broker, has been accused of providing Menendez a Mercedes-Benz in exchange for the senator's help in a New Jersey insurance fraud case. He is the first in the case to plead guilty, and he is now expected to begin cooperating with prosecutors.

The senator, his wife and the two other co-defendants have pleaded not guilty.

Uribe admitted to seven counts, including conspiracy to commit bribery, honest services wire fraud, obstruction of justice, tax evasion and other charges. The senator, his wife and the three other co-defendants have pleaded not guilty

The Department of Justice first announced its investigation into Menendez in September 2023, alleging he received over $400,000 in cash and gold as bribes.

The corruption scandal led Menendez to step down from his influential post as chairman of the Senate Foreign Relations Committee.

The other businessmen indicted in the case alongside Uribe are **Wael Hanna** and **Fred Diabes**.

Prosecutors said in a February filing that Wael Hana, an Egyptian-American halal tycoon, allegedly worked with Menendez and bribed the senator to receive favors for his company.

Allegedly Hana shortchanged the Menendez couple by providing them a diamond ring he said was worth $35,000, though a jeweler later told Nadine the band was worth $12,000. Hana worked with the jeweler to get a receipt that falsely claimed the ring was worth more, according to prosecutors.

Diabes, meanwhile, is responsible for bribing Menendez with the gold bars, according to the FBI. The 70-year-old embattled Democrat and wife Nadine are charged with accepting bribes of cash, gold bars and a luxury car over the last five years to carry out favors for three businessmen who are also charged. New Jersey Senator Bob Menendez claims gold bars and cash at the center of his bribery indictment were found during an illegal search of his home - and he wants a New York judge to toss out the evidence.

Stashes of cash were found in jackets bearing the senator's name during a search of his home.

Prosecutors In The Southern District Of New York Claim Menendez Had Ties To Egyptian Officials

Diabes allegedly gave the senator gold in exchange for Menendez applying pressure the state's U.S. attorney's office to not aggressively prosecute him in a bank fraud case. In 2013, Diabes' penthouse was broken into, and he had gold bars, cash and other items stolen.

The perpetrators were caught and confessed, and Daibes signed official police documentation certifying that the gold bars were his, identifiable thanks to serial numbers and markings. Daibes had the stolen gold bars returned to him.

The Menendez couple, however, claimed that the gold bars at the center of their scandal were actually family heirlooms, according to the February court filing. A Menendez staffer and a jeweler were told by the senator and his wife that the gold came from Nadine's deceased mother. Prosecutors allege that Nadine told her jeweler a false cover story about where the gold came from.

In January, Nadine asked for separate trials so their marriage secrets would not be spilled in court

It's Time to Subscribe to My Substack

For Subscribers Only I Have Published Special Insurance Articles and Videos

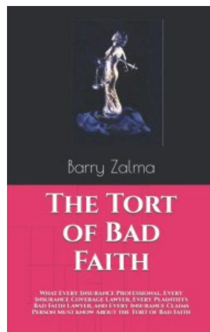
I published on Locals.com more than 25 videos and two webinars of the Excellence in Claims Handling program. I also published on Substack.com videos and webinars of the Excellence in Claims Handling Program available only to Subscribers. The subscribers have access to all the videos and a webinar on "The Examination Under Oath A Tool Available to Insurers to Thoroughly Investigate Claims and Work to Defeat Fraud" among others.

The videos start with the history of insurance and work their way through various types of insurance and how to obtain and deal with insurance claims. Subscribe and receive videos and articles available only to subscribers to the Excellence in Claims Handling at locals.com and to articles and videos also available to subscribers at Substack.com for a small fee of only $50 a year. You can Subscribe to "Zalma on Insurance" at https://zalmaoninsurance.locals.com/subscribe and to "Excellence in Claims Handling" at https://barryzalma.substack.com/welcome.

The Tort of Bad Faith

Read the full article at https://www.linkedin.com/pulse/new-book-from-barry-zalma-tort-bad-faith-barry-zalma-esq-cfe and at https://zalma.com/blog plus more than 4300 posts.

What Every Insurance Professional, Every Insurance Coverage Lawyer, Every Plaintiffs Bad Faith Lawyer, and Every Insurance Claims Person Must know About the Tort of Bad Faith



A Book Needed by Every Insurance Claims Professional

The implied covenant of good faith and fair dealing is a concept of insurance law at least three centuries old. It first appeared in British jurisprudence in a case decided by Lord Mansfield sitting in the House of Lords as the highest court in Britain. In Carter v. Boehm. 3Burrow, 1905, Lord Mansfield explained that insurance is a contract upon speculation; the special facts upon which the contingent chance is to be computed, lie, most commonly, in the knowledge of the insured only. The underwriter trusts to his representation and proceeds upon confidence that he does not keep back any circumstance in his knowledge, to mislead the underwriter into a belief that the circumstance does not exist, and to induce him to estimate the risk as if it did not exist. The keeping back such circumstance is a fraud, and therefore the policy is void.

Lord Mansfield stated the rule still followed to this day: "Good faith forbids either party by concealing what he privately knows, to draw the other into a bargain, from his ignorance of that fact, and his believing the contrary.

The implied covenant explains that no party to a contract of insurance should do anything to deprive the other of the benefits of the contract."

Available as a Hardcover Available as a paperback Available as a Kindle Book

Barry 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 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 55 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. Go to the podcast Zalma On Insurance at https://podcasters.spotify.com/pod/show/barry-zalma/support Write to Mr. Zalma at zalma@zalma.com; http://www.zalma.com; http://zalma.com/blog.

He publishes daily articles at https://zalma.substack.com, 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 the Insurance Claims Library – https://zalma.com/blog/insurance-claims-library/ to consider more than 50 volumes written by Barry Zalma on insurance and insurance claims handling.

Go to Zalma's Insurance Fraud Letter at https://zalma.com/zalmas-insurance-fraud-letter-2/ ; Go to X @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/UCysiZklEtxZsSF9DfC0Expg; Go to the Insurance Claims Library – https://zalma.com/blog/insurance-claims-library/** and GTTR at https://gettr.com/@zalma