Zalma's Insurance Fraud Letter

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"A Vain Person Is Worse Than A Liar. A Liar Knows He Is Lying, Whereas Someone Who Is Absorbed In His Self-Image Of Greatness, Firmly Believes In His Delusions."

Rebbe Yehoshua of Ostrova


Arson-for-Profit Scheme Fails

Innocent Co-Insureds Have no Rights to Proceeds When Fraud Committed on Their Behalf

Plaintiffs Timeless Bar, Inc. and Horseshoe Club, LLC sued their insurer Illinois Casualty Company, claiming the latter breached the parties' insurance agreement. Specifically, the Plaintiffs allege that even though the fire that destroyed their property was intentionally set by an officer of the corporation and a member of the LLC, the insurer was obligated under the policy and Minnesota law to pay for the loss.

In *Timeless Bar, Inc., doing business as The Press Bar and Parlor, and Horseshoe Club, LLC v. Illinois Casualty Company*, No. 22-cv-1685 (KMM/LIB), United States District Court, D. Minnesota (May 21, 2024) the USDC, in a lengthy opinion resolved the issues of who was responsible for the fraud.

BACKGROUND

In April 2016, while still a married couple, Andrew Welsh and Jessie Welsh purchased a bar in St. Cloud, Minnesota. The couple opened the business as The Press Bar and Parlor and operated it through a corporation, Timeless Bar, Inc. ("Timeless Bar"). They also set up a real estate holding company, Horseshoe Club, LLC ("Horseshoe Club"), and arranged the building purchase through that company. On February 17, 2020, a fire that destroyed the bar. The Defendant and law enforcement later discovered that Andrew intentionally set the fire.

Illinois Casualty Company ("ICC") insured The Horseshoe Club against the risk of loss by fire and covered as an additional named insured – "building owner" – for certain losses associated with the building itself under the Policy.

The Arson and Plaintiffs' Insurance Claims

On February 17, 2020, Andrew Welsh burned down the bar. The following day, Andrew executed a Non-Waiver Agreement with ICC as the authorized representative of Timeless Bar as a named insured under the Policy. On February 26, 2020, Timeless Bar and the Horseshoe Club submitted the initial insurance claim to ICC via a "Proof of Loss" seeking approximately $1.4M in proceeds. The initial claim sought the policy limits for the building and other amounts. The claim states that the fire was of "unknown origin." Further, the sworn proof of loss states: That said loss did not originate by any act, design or procurement on the part of your insured, or as affiant; nothing has been done by or with the privity or consent of your insured or this affiant, to violate the conditions of the policy, or render it void. Andrew and Jessie both signed that proof of loss on behalf of the businesses. There is no dispute that in the proof of loss, Andrew falsely stated that the fire was of unknown origin and that the loss did not originate by any act, design, or procurement of his own. Nor is there any dispute that his submission of the false claim as an affiant on behalf of the insured was an effort to defraud ICC.

DISCUSSION

The crux of the dispute in this case is whether Andrew Welsh's conduct-burning down the bar and later lying about it in the insurance claims-allows ICC to deny coverage to Timeless Bar and Horseshoe Club. ICC argued that Andrew's conduct is imputable to the Plaintiffs for purposes of all three exclusions at issue: his submission of fraudulent insurance claims precludes coverage for the Plaintiffs under the Misrepresentation and Dishonesty Exclusions, and his arson precludes coverage under the Intentional Acts Exclusion.

As explained below, the Court found that there is no genuine dispute that Andrew filed fraudulent claims on behalf of both Timeless Bar and Horseshoe Club. Because he did so, no reasonable jury could find that ICC breached the Policy by denying coverage under either the Misrepresentation Exclusion or the Dishonesty Exclusion.

Misrepresentation and Dishonesty Exclusions

ICC is entitled to judgment as a matter of law because the Policy provides no coverage. He filed a fraudulent claim when he signed the original Proof of Loss on February 26, 2020, and the May 15, 2020, amended Proof of Loss. No reasonable jury could conclude otherwise based on this record.

"Innocent Insureds"

Minn. Stat. § 65A.01, subd. 3, provided that the entire policy was void if, either before or after a loss, "*the insured* has willfully and with intent to defraud, concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof or the interests of the insured therein." (emphasis in the original)

The Court found that, even viewed in the light most favorable to Plaintiffs, Andrew's false statements in the proofs of loss submitted to ICC were dishonest acts and were made with intent to defraud ICC, and his actions are properly imputed to Timeless Bar and Horseshoe Club for purposes of applying the Misrepresentation and Dishonesty Exclusions.

Andrew's actions are imputed to the Plaintiffs, the Misrepresentation Exclusion and the Dishonesty Exclusion preclude coverage as a matter of law, and ICC is entitled to summary judgment.

ZIFL OPINION

Arson-for-Profit is a serious crime. An arson fire is a specifically peril, the risk of loss of which, is insured by a fire policy. There is no "arson" exclusion in a fire insurance policy. The named insured may go to jail for the crime but that does not effect the insurance claim. Where Welsh went wrong was in signing under oath a false claim as a result of the fire. The fraud voided coverage and no one had the right to recover even his innocent wife and the innocent corporations who owned the building where the bar was located.

Wisdom

"Intelligence once meant more than what any artificial intelligence does. It used to include sensibility, sensitivity, awareness, discernment, reason, acumen, and wit." — **Sherry Turkle**
"Enlightened statesmen will not always be at the helm." — **James Madison**
"To me it was strange that we had worked and had come all the way to the moon to study the moon, and what we really discovered was the Earth. – **William Anders**
"To be a person of truth, be swayed neither by approval nor disapproval. Work at not needing approval from anyone and you will be free to be who you really are." — **Rebbe Nachman**
"A complete fool is better than a half-sage." — **Jewish saying**
"They that can give up essential liberty to purchase a little temporary safety, deserve neither liberty nor safety." — **Benjamin Franklin**
"This was the object of the Declaration of Independence. Not to find out new principles, or new arguments, never before thought of, not merely to say things which had never been said before; but to place before mankind the common sense of the subject, in terms so plain and firm as to command their assent, and to justify ourselves in the independent stand we are compelled to take." —**Thomas Jefferson**
"Lust is easy. Love is hard. Like is most important." — **Carl Reiner**
"The sacred rights of mankind are not to be rummaged for, among old parchments, or musty records. They are written, as with a sun beam, in the whole volume of human nature, by the hand of the divinity itself; and can never be erased or obscured by mortal power." —**Alexander Hamilton**

More McClenny Moseley & Associates Issues

This is ZIFL's twenty ninth 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.

June 6, 2024

Seeking Information in the McClenny Moseley & Associates Investigation

The FBI's New Orleans Division is seeking to identify potential victims of the law firm McClenny Moseley & Associates (MMA). The FBI believes MMA primarily targeted Southeastern Louisiana homeowners after Hurricane Ida and may have been assisted by Apex Roofing & Restoration.

If you believe were victimized by MMA or have information relevant to this investigation, please fill out this short form.

If you know of someone else who has possibly been victimized by MMA, please encourage them to complete the form themselves.

The FBI is legally mandated to identify victims of federal crimes it investigates. Victims may be eligible for certain services, restitution, and rights under federal and/or state law. Your responses are voluntary but may be useful in the federal investigation and to identify you as a potential victim. Based on the responses provided, you may be contacted by the FBI and asked to provide additional information. All identities of victims will be kept confidential.

The FBI seeks the following from potential victims:

1. Were you a victim of McClenny Moseley & Associates?
   a. Yes
   b. No

c. Unsure

2. Did McClenny Moseley & Associates receive money from your insurance company on your behalf?
   a. Yes
   b. No
   c. Unsure

3. If McClenny Moseley & Associates received money on your behalf, did they send any money to you?
   a. Yes
   b. No
   c. Unsure

Litigation Financing on the Verge of Regulation

Third-party litigation financing has become a controversial issue in the U.S. court system over the past decade. Litigation financing has a history dating back to medieval England. The practice was once prohibited by doctrines in common law known as "champerty" or "maintenance," which barred strangers to a lawsuit from providing funding in exchange for a financial interest in the outcome of the case.

James Whittle, vice president and counsel for the Washington-based American Property Casualty Insurance Association, said third-party litigation funding as we know it began roughly 30 years ago in Australia before moving to other countries that practice common law, such as the U.S. and the United Kingdom.

Without regulatory change and as long as litigation funders are satisfied with their return on investment, they will continue to fund litigation, he said. Louisiana, still suffering from the fact of litigation funding of hurricane based insurance litigation that resulted in hundreds of potentially false claims and litigation and suits against the Texas law firm, McClenny, Moseley & Associates that have many suits dismissed.

The Louisiana legislature has sent (SB 355) to the Governor for signature to regulate the litigation finance. The measure was passed unanimously by the state Senate on Friday. It would bar outside funders from controlling cases in which they invest. The bill also would require parties in lawsuits to disclose funding from "countries of concern" to the state attorney general.

Landry, a Republican, has not publicly said whether he intends to sign the bill. His predecessor, Democrat John Bel Edwards, last year vetoed more expansive legislation that would have generally required third-party funding disclosures in civil cases.

The new bill is part of a push in several states to force disclosure of litigation funding arrangements, in which investors pay for the cost of lawsuits in return for a piece of the proceeds in successful cases.

The Louisiana bill would generally ban funders from directing lawyers and parties on how to pursue suits, including whether to settle, a concern often voiced by detractors of the industry. It would also make litigation financing contracts subject to discovery in civil cases.

The measure would require lawyers to disclose the names of certain foreign entities from countries of concern financing suits in Louisiana—and provide a copy of the funding agreements—to the state's attorney general. That includes entities in Russia, China, and Iran.

The bill is similar to legislation introduced at the federal level last year by Sen. John Kennedy (R-La.) and House Speaker Mike Johnson (R-La.). The federal legislation has not moved and is considered a long shot in a deeply divided Congress.

Bloods Gang Member Took Over Fire Restoration Industry in New York Sentenced to 12 Years

Jatiek Smith, a gang leader who recruited other gang members and used violence, threats of violence, and extortion to take over the fire restoration business in New York City and defraud insurance companies was sentenced to 12 years in prison.

Smith was sentenced by U.S. District Judge Jed S. Rakoff after being convicted following a bench trial in December 2023 of racketeering and extortion conspiracies. In addition to the prison term, Smith, of Staten Island, New York, was sentenced to three years of supervised release and ordered to forfeit $354,546.44. Restitution will be determined at a later date, according to prosecutors.

In 2019, Smith joined the fire mitigation company First Response, which was involved the practice of "chasing fires," which refers to soliciting repair, mitigation, demolition, and construction business from the owners of fire-damaged properties. Insurers pay for the services.

Prosecutors showed how Smith, a member of the Bloods, a violent street gang, quickly assumed control over the operations of First Response. He recruited other gang members and associates to join him at First Response and then used violence and extortion to terrorize and dominate the fire restoration industry in New York City.

The use of violence and extortion to dominate an industry places the New York case in a category of its own. But experts say often-aggressive, sometimes-violent tactics have been seen across the country as fire restoration, paid for by insurance carriers, attracts illegitimate contractors seeking quick profits. In many cases, contractors or adjusters show up at fire victims' homes, sometimes even before firefighters have extinguished the blaze. Read more.

Smith asserted control over the industry by first ousting First Response's main competitor, American Emergency Services (AES), through violence, threats, and extortion. Once Smith and his crew had established control over the industry, they imposed rules that allocated a preferential share of fires to First Response. These rules were backed by threats — including a demand that AES pay $100,000 to continue in the business and threats to kill children — and violence.

Industry participants who solicited fires in violation of Smith's rules were assaulted in broad daylight, prosecutors found. Smith and his crew also extorted hundreds of thousands of dollars from other industry participants.

According to prosecutors, Smith maximized his profits from this scheme by concealing illegal conditions in properties and defrauding insurance companies.

In his defense, Smith claimed that the competitor he ousted was the aggressor in the industry and he worked to reduce the conflicts and violence by standing up to that firm and setting up a rotation system to assure that all chasers got a minimum number of fires each month. He maintained the system was not extortionate.

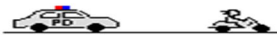
Judge Rakoff found that Smith's defense was undermined by the government's proof of Smith's use of violence and extortion to enforce the rotation. The judge found that overall, the government proved beyond a reasonable doubt that Smith and his co-conspirators agreed to extort AES, ServPro, EFS and an individual.

Prosecutors' evidence included recordings of Smith threatening to kill competitors and ordering an attack on a rival firm's employee and videos recovered from his cellphone showing his crew members assaulting employees of rival emergency mitigation services firms.

The judge also found that there was ample proof of the actual existence of a racketeering enterprise, of Smith's participation in it, and of the commission of extortion and mail and/or wire fraud.

Smith was wrong that the insurance fraud was unrelated to the purpose of dominating the fire restoration industry. First Response primarily operated in Brooklyn, Queens, and Staten Island but also did business in the Bronx and Manhattan.

Insurers must be professional, and its claims personnel must be effective and knowledgeable to avoid this type of fraud when it has become so easy that a Bloods Gang member can take over and effectively defraud them.



The Compact Book of Adjusting Property Claims Fourth Edition

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.

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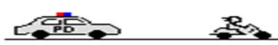


RICO Suit Against Chiropractors

Allstate Effectively Alleges RICO Conspiracy

In *Allstate Insurance Co. et al. v. Lint Chiropractic PC et al.,* No. 2:23-cv-10904, United States District Court, E.D. Michigan, Southern Division (May 30, 2024) Allstate brought a RICO case against chiropractors and conspiracies to defraud Allstate.

BACKGROUND

Robert Super, exercises "dominion and control" over all units of a medical device called the Nervomatrix. Super proliferated the fraudulent use of Nervomatrix machines at numerous medical clinics in Michigan. Super implemented a "predetermined protocol" mandating the use of Nervomatrix machines-regardless of medical necessity.

ANALYSIS

Plaintiffs allege violations of two provisions of the RICO statute. Plaintiffs have plausibly alleged claims under both provisions.

THE RICO ENTERPRISE

A RICO "enterprise" may include any legal entity and any group of individuals associated in fact although not a legal entity. [18 U.S.C. § 1961(4)].

THE PARTICIPANTS

1. Lint Chiropractic Enterprise. Super owned and managed Lint Chiropractic and directed its staff's conduct. He installed Nervomatrix machines there and developed a predetermined protocol to direct patients toward unnecessary treatments, resulting in fraudulent billing.

2. MI Medical Enterprise. Super also owned and managed MI Medical, implementing the same fraudulent protocol.

3. Supplies Plus Enterprise. Super managed Supplies Plus, deciding to write prescriptions for unnecessary DME.

Pattern of Racketeering Activity

To establish a pattern of racketeering activity, Plaintiffs demonstrated that Defendants committed at least two predicate acts of racketeering. Plaintiffs allege that all the predicate acts of mail and wire fraud served the common purpose of inducing Plaintiffs to pay large sums for bogus medical bills. These allegations sufficiently demonstrate the necessary relationship among the acts.

Predicate Acts and Civil Rule 9(b)

The Allstate plaintiffs adequately alleged the fraudulent scheme.

Plaintiffs' Motion to Dismiss, was GRANTED.

ZALMA OPINION

The type of Fraud that Allstate used to base its RICO action is rampant as detailed in hundreds of health insurance fraud convictions reported in Zalma's Insurance Fraud Letter twice a month. The Allstate entities, as the victim of the fraud, is proactively fighting the frauds perpetrated against it by this RICO case that, when tried successfully, will take the profit out of the crime.

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.

Health Insurance Fraud Convictions

Pharmacy Owner Sentenced to Two Years in Prison for $1M Health Care Fraud Scheme

Paul Mansour, 56, of Sierra Madre, California was a pharmacist who co-owned **Mansour Partners Inc.,** doing business as **Best Buy Drugs** (Best Buy), was sentenced to two years in prison for submitting more than $1 million in false and fraudulent claims to Medicare for prescription drugs that were never dispensed to beneficiaries.

According to court documents, From January 2017 to July 2022, Mansour created fake patient profiles in the Best Buy pharmacy's digital filing system using fictitious names, dates of birth, and addresses. Mansour added fraudulent prescriptions to the fake patient profiles and then submitted false and fraudulent claims to Medicare for those prescriptions in the name of actual Best Buy patients. In doing so, Mansour billed Medicare for fraudulent prescriptions that were never dispensed to beneficiaries. Mansour pleaded guilty on April 5, 2023, to one count of health care fraud.

United States Reaches $1.2 Million Civil Settlement with Festus Pain Management Doctor Over Allegations of False Claims to Federal Health Care Programs

Dr. Nehal Modh the president and sole owner of **Progressive Pain Management** (PPM) in Festus, Missouri knowingly submitted false claims to Medicare and Missouri Medicaid. The United States Attorney's Office for the Eastern District of Missouri announced June

11, 2024, that the United States reached a civil settlement to resolve allegations that Dr. Modh & PPM falsely indicated to both Medicare and Missouri Medicaid that ultrasound guidance was used on certain pain management injections, submitted false claims for payment for facet joint injections that did not meet billing substantiation requirements, and improperly coded claims for payment to receive excess reimbursement.

As part of the settlement, Dr. Modh and PPM will repay the United States $1.2 million, consisting of $600,000 in restitution doubled under the False Claims Act (FCA).

The settlement resolves allegations brought under the qui tam or whistleblower provisions of the FCA by Donna Chronister, a former employee of PPM.

Two Individuals Plead Guilty to Health Care Fraud Conspiracy

Francene Aretha Gayle, 50, of Apopka, Florida, pleaded guilty before U.S. District. Judge Liles Burke to five counts of unlawful drug distribution, one count of health care fraud conspiracy, and one count of wire fraud conspiracy. Gayle's wife, Schara Monique Davis, 48, also of Apopka, pleaded guilty to one count of health care fraud conspiracy and one count of wire fraud conspiracy.

Gayle, a former doctor and her wife pleaded guilty June 10, 2024, to crimes involving the medical practice they ran in north Alabama for many years. According to the defendants' plea agreements, between about 2014 and early 2020, Gayle was a doctor who operated a multi-clinic practice in Huntsville, Athens, and Killen. Davis owned the practice and served as business manager. In 2019, the Killen clinic shut down. In March 2020, the Alabama Medical Licensure Commission revoked Gayle's license, and the other two clinics closed shortly after that.

Gayle admitted that she had unlawfully distributed drugs, including oxycodone, hydrocodone, and methadone.

Gayle and Davis both admitted to having conspired to commit health care fraud for several years by billing insurers for office visits under Gayle's name even when she did not see the patients, was not in the same building, and sometimes was not in the same town. The defendants knew that the billing scheme was fraudulent. In 2015, Blue Cross Blue Shield of Alabama audited the practice and discovered that Gayle was absent, other staff were seeing patients, and yet all office visits were being billed under Gayle's name. Blue Cross flagged the issue, and Gayle promised it would stop. Instead, the practice continued fraudulently billing insurers for office visits for the next four years. In total, between 2015 and 2020, Medicare, Medicaid, and Blue Cross paid more than $2.3 million for office visits billed under Gayle's name.

Gayle and Davis both also admitted to having conspired to commit wire fraud. In March 2020, based on concerns about her prescribing and billing practices, Gayle's Alabama medical license was revoked. Months later, Gayle and Davis applied for and obtained more than $450,000 in COVID-19 disaster relief funds through the Paycheck Protection Program (PPP) and Economic Injury Disaster Loan (EIDL) program. Those funds were designed to stabilize businesses struggling because of the pandemic. In their funding applications, Gayle and Davis certified that their medical practice needed the money because of economic uncertainty or injury caused by the pandemic. In reality, Gayle and Davis's practice had closed, and they used COVID-19 funds they received on other things.

The maximum penalty for unlawful drug distribution is twenty years in prison. The maximum penalty for health care fraud conspiracy is ten years in prison. The maximum penalty for wire fraud conspiracy is twenty years in prison.

Pharmacist Convicted of Unlawfully Dispensing Controlled Substances at Retrial

Hieu "Tom" Truong, 60, of Houston, was convicted by a federal jury in the Southern District of Texas. Truong, a Texas pharmacist was convicted after a retrial for unlawfully distributing and dispensing controlled substances at a now closed pharmacy.

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

The jury convicted Truong of two counts of unlawfully distributing and dispensing controlled substances. Truong was originally convicted at trial in May 2022 and was granted a new trial due to a change in the law following the Supreme Court's decision in *United States v. Ruan*.

He is scheduled to be sentenced on Sept. 23 and faces a maximum penalty of 20 years in prison on each count. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Massachusetts Psychiatrist Sentenced to Over Eight Years in Prison for $19 Million Insurance Fraud Scheme

Defendant used proceeds to finance multi-million-dollar homes in Wellesley and Nantucket and to purchase over $600,000 in jewelry from Cartier, Van Cleef and Tiffany's

Gustavo Kinrys, 53, of Wellesley, Massachusetts, a psychiatrist was sentenced for billing Medicare and private insurance companies for over $19 million in treatments he did not provide and obstructing justice in an attempt to conceal his crimes.

Kinrys was sentenced by U.S. District Court Judge Denise J. Casper to 99 months in prison, followed by three years of supervised release. Kinrys was also ordered to pay restitution and forfeiture in an amount to be determined at a later hearing. In October 2023, following a jury trial, Kinrys was convicted of seven counts of wire fraud, six counts of false statements relating to health care matters, and one count of obstructing a criminal health care investigation.

Kinrys was a licensed psychiatrist who owned and operated **Advanced TMS Associates**, located in Natick, Mass. Among other services, Kinrys offered transcranial magnetic stimulation (TMS) therapy and psychotherapy to patients suffering from depression. TMS therapy

is a noninvasive method of brain stimulation that uses rapidly alternating or pulsed magnetic fields to induce electrical currents directed at a patient's cerebral cortex.

Between January 2015 and December 2018, Kinrys engaged in a variety of fraudulent billing schemes in which he sought and received reimbursement for $19 million in services he did not render. For example, Kinrys billed Medicare and private insurers $10.6 million for thousands of TMS sessions he never provided, including over 8,000 sessions he claimed were provided to 74 patients who, in fact, never received a single session of the therapy. Kinrys also billed Medicare and private insurers for millions of dollars' worth of psychotherapy sessions he never provided, including over 900 face-to-face sessions he falsely claimed he provided while he was on vacation in locations like the Bahamas, the Dominican Republic, and the Czech Republic.

On 382 days, Kinrys billed Medicare and private insurers for having provided more than 24 hours' worth of psychotherapy services in a single day, including one day in July 2017 when he claimed he had provided hour-long psychotherapy sessions to 70 different patients – all while outside the United States on vacation. With the proceeds of his fraud, Kinrys paid off a $1.8 million home in Wellesley, purchased over $600,000 in jewelry from Cartier, Van Cleef, and Tiffany's and purchased a $2.1 million vacation home in Nantucket.

To further his fraudulent billing scheme, Kinrys made numerous false statements to his patients, the billing company he worked with, and the insurers to whom he submitted claims seeking reimbursement. When Medicare and private insurers sought records from Kinrys to justify his exorbitant claims, he took steps to conceal his fraud by creating, and forcing his employee to create, fake patient records to send to Medicare and private insurers. Kinrys continued his obstructive behavior when, in response to a July 2018 subpoena from the Department of Health and Human Services Office of Inspector General, he created and produced additional fake patient records purporting to show patients had received dozens of treatments that never happened, and which falsely represented that the condition of those patients was improving.

ZIFL can only wonder what took the federal government and insurers to detect Dr. Kinrys' fraud since it was so obvious.

CityMD Agrees to Pay Over $12M for Alleged False Claims to the COVID-19 Uninsured Program

City Medical of the Upper East Side, PLLC, Summit Medical Group, P.A., Summit Health Management, LLC, and **Village Practice Management Company, LLC**, which collectively do business as **CityMD**, and manage and operate approximately 177 urgent care practices in New Jersey and New York, agreed to pay $12,037,109 to resolve allegations that they violated the False Claims Act by submitting or causing the submission of false claims for payment for COVID-19 testing to a Health Resources and Services Administration (HRSA) program for uninsured patients.

HRSA's COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program (the Uninsured Program) provided claims reimbursement to health care providers, generally at Medicare rates, for testing uninsured individuals for COVID-19, treating uninsured individuals with a COVID-19 diagnoses, and administering COVID-19 vaccines to uninsured individuals.

The Justice Department alleges that, from Feb. 4, 2020, through April 5, 2022, CityMD knowingly submitted or caused to be submitted false claims for payment for COVID-19 testing to the Uninsured Program for individuals who had health insurance coverage when CityMD administered those tests. The United States contends that CityMD did not adequately confirm whether those individuals had health insurance coverage before submitting their claims to the Uninsured Program, including but not limited to certain individuals for whom CityMD had health insurance cards on file. The Justice Department further contends that CityMD caused outside laboratories to submit false claims for COVID-19 testing to the Uninsured Program in connection with individuals who had health insurance coverage by issuing requisition forms erroneously indicating that patients were uninsured.

CityMD received credit in the settlement under the department's guidelines for taking voluntary disclosure, cooperation, and remediation into account in False Claims Act cases. CityMD cooperated with the United States' investigation by, among other things, voluntarily contracting with a third party to assist the United States in determining the amount of the losses the United States contends were caused by claims submitted by CityMD to the Uninsured Program for patients who had health insurance as described above.

This civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Stephen Kitzinger, a patient of CityMD. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. The *qui tam* case is captioned *United States ex rel. Kitzinger v. City Practice Group of New York LLC d/b/a CityMD*, Civ. No. 2:20-cv-20111-SRC-CLW (D.N.J.). Mr. Kitzinger will receive $2,046,308 as his share of the recovery.

Former Fresno Sleep Clinic Owner Sentenced to 46 Months in Prison for Submitting Over $1.5 Million in Fraudulent Claims for Sleep Studies to Medicare and Medi-Cal

Jeremy Gober, 43, of Hanford, was sentenced to 46 months in prison for committing health care fraud and aggravated identity theft.

According to court documents, Gober co-owned and co-operated **Got Sleep Inc**., which operated sleep clinics in Fresno and Orange Counties. Sleep clinics perform diagnostic sleep studies to identify disorders like sleep apnea and narcolepsy.

From August 2016 through July 2020, Jeremy Gober caused Got Sleep to submit thousands of claims to Medicare and Medi-Cal for sleep studies that were not actually performed on patients. The claims also falsely stated that the patients had been referred for the sleep studies by physicians with whom Jeremy Gober had previously worked. This was done because Medicare and Medi-Cal will not pay for a sleep study unless the patient was referred by a physician. Gober caused more than $1.5 million in fraudulent claims to be submitted and $587,000 to be paid out by Medicare and Medi-Cal.

On March 11, 2024, Jeremy Gober's brother, **Travis Gober**, was sentenced to 19 months in prison for his conviction in a similar health care fraud and aggravated identity theft scheme related to other sleep clinics in the Central Valley.

Queens and Brooklyn-Based Eye Doctor Settles Health Care Fraud Claims for More Than $2.4 Million

Dr. Sheldon Rabin and his practice billed Medicare and Medicaid for services that were medically unnecessary or could not have been performed created a settlement agreement with Rabin, a New York-based ophthalmologist, his ophthalmology practice and related entities which allegedly provided ophthalmological health care services to Brooklyn and Queens residents, many of whom were elderly or non-native English speakers.

The settlement agreement requires the defendants to pay more than $2.4 million to resolve claims that they billed or caused to be billed false claims for payment to Medicare and Medicaid for certain procedures, tests, and other ophthalmological services that were either unnecessary or could not have been performed because the ophthalmologist was not in his office. Under the terms of the agreement, these providers, including **Sheldon Rabin, Sheldon Rabin, M.D., Sheldon Rabin, M.D., P.C. d/b/a New York Eye Care**, will pay $2,426,144.93 to the United States to resolve claims under the False Claims Act. The defendants have also separately agreed to pay $73,855.07 to New York State to resolve claims under New York State's False Claims Act, for a total payment of $2.5 million.

As alleged by the Government, from 2013 through 2016, defendants improperly submitted claims to Medicare and Medicaid for treatments that were unnecessary by manipulating patient test readings to create an appearance of a need for certain eye care services, when in fact, the patients' test readings indicated no such need. Further, during this same time frame, the government alleged instances of services having been billed, but never actually rendered by Dr. Rabin, because he was out of the office or out of the country when the services were purportedly rendered.

The settlement includes the resolution of two civil actions brought under the *qui tam* or whistleblower provisions of the False Claims Act. Under the qui tam provisions of the False Claims Act, a private party can file an action on behalf of the United States and receive a portion of the settlement if the government takes over the case and reaches a monetary agreement with the defendant. As alleged in the *qui tam* actions, the defendants provided ophthalmological health care services to Brooklyn and Queens residents, many of whom were elderly or non-native English speakers.

Guilty to Obstructing Justice in Civil Investigation

Brenda Hicks, 58, of Macon, the owner of **Middle Georgia Family Rehab** has admitted in federal court to ordering two employees to illegally alter documents during a federal civil investigation into alleged improper healthcare billing by the business.

Hicks**,** pleaded guilty to one count of conspiracy to obstruct justice before Chief U.S. District Judge Marc Treadwell on June 5. Hicks faces a maximum of 20 years in prison to be followed by three years of supervised release and $250,000 fine. In addition, the plea agreement stipulates that Hicks will pay restitution to TRICARE, Medicare, Blue Cross Blue Shield, Medicaid and the U.S. Department of Veterans Affairs (VA). Sentencing is scheduled for Sept. 5. There is no parole in the federal system.

According to court documents, Middle Georgia Family Rehab, LLC (MGFR)—an outpatient rehabilitation facility owned by Hicks with locations in Byron and Macon—was served with a Civil Investigative Demand (CID) requesting various patient records on Oct. 7, 2019. After its receipt, Hicks set up a meeting about the CID with two MGFR employees. Hicks told them it was an "audit" and explained that MGFR did not have the records that were requested. She then instructed them to go into the system and pull any portions of the requested files, looking for hard copies of the records in MGFR's storage unit if needed.

Many of the requested records were either blank or missing. Hicks explained that if the records were not there or had not been signed, the employees were supposed to create or sign the records. For example, if the records were missing progress notes, Hicks instructed the employees to make them up by copying and pasting the narrative language from other progress notes to fill in the missing information. These narrative sections were supposed to contain unique information from each session, such as the patient's pain level and what exercises were performed at the visit.

One employee expressed concern to the other employee that what they were doing was illegal and quit. The other employee complied with Hicks' instructions and added notes and signatures to patient records as needed. These doctored patient records were then produced to the Civil Division of the U.S. Attorney's Office on Dec. 2, 2019, in response to the CID.

Hicks admitted that she conspired to corruptly alter patient records with the intent to impair the integrity of those records and their availability for use in a civil action. For more information about the civil action, please visit: https://www.justice.gov/usao-mdga/pr/judge-orders-middle-georgia-family-rehab-pay-96-million-damages-submitting-hundreds.

Chronic Disease Management Provider to Pay $14.9M to Resolve Alleged False Claims

Bluestone Physician Services of Florida LLC, Bluestone Physician Services, P.A. and **Bluestone National LLC**, operating in Florida, Minnesota and Wisconsin, respectively, have agreed to pay $14,902,000 to resolve allegations that they knowingly submitted claims for certain Evaluation and Management (E&M) codes for services related to the management of chronic care patients in assisted living and other care facilities that were not provided in conformity with applicable Medicare, Medicaid and TRICARE requirements.

The settlement resolves allegations that, during the period from Jan. 1, 2015, through Dec. 31, 2019, Bluestone knowingly submitted claims for two E&M codes, the domiciliary rest home visit code for established patients (99337) and the chronic care management code (99490), that did not support the level of service provided. The federal government's share of the settlement is $13,842,482 and $1,059,518 will be paid to the States of Florida and Minnesota.

In connection with the settlement, Bluestone has entered into a five-year Corporate Integrity Agreement (CIA) with HHS-OIG, which requires Bluestone, among other obligations, to establish and maintain a compliance program meeting certain requirements and to submit to an Independent Review Organization's review of Bluestone's Medicare claims to determine whether such claims were medically necessary, appropriately documented, and correctly coded.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Lisa Loscalzo, the former General Manager for Bluestone's Florida market. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. The *qui tam* case is captioned *U.S. ex rel. Loscalzo v. Bluestone Physician Services of Florida, Bluestone Physician Services, P.A., Bluestone National, LLC et al.*, 20-cv-295-FtM-38NPM (M.D. Fla). The civil settlement also includes the resolution of related allegations investigated by the U.S. Attorney's Office for the District of Minnesota. Ms. Loscalzo will receive $2,831,380 in connection with the settlement.

Massachusetts Surgeon to Pay $200,000 to Avoid Claims of Soliciting and Receiving Illegal Kickbacks

Dr. Tony Tannoury a Massachusetts doctor agreed to pay $200,000 to resolve allegations that he violated the Anti-Kickback Statute and the False Claims Act by soliciting and receiving free products from **DePuy Synthes, Inc**. and **DePuy Synthes Sales, Inc**. (collectively "DePuy"), in return for ordering DePuy products for use in his procedures. Doctor used these free products in surgeries he performed overseas in countries including the Kingdom of Saudi Arabia, Lebanon, and Qatar.

In January 2023, the U.S. Attorney's Office for the District of Massachusetts announced that DePuy had agreed to pay approximately $9.75 million to resolve allegations related to its role in this conduct. DePuy manufactures and distributes medical devices, including spinal implants, and has headquarters in Raynham, Mass.

According to the settlement agreement, Dr. Tannoury admits, acknowledges, and accepts responsibility for the facts underlying the government's allegations. From at least July 2016 through February 2018, Dr. Tannoury received products from DePuy for use in overseas surgeries, including cages, rods, screws, plates, and modular access and retraction systems. He performed at least five surgeries using these products in countries including the Kingdom of Saudi Arabia, Lebanon and Qatar. Dr. Tannoury never paid DePuy for these products that he used overseas and continued to use DePuy products in surgeries in Boston, including for Medicare and Medicaid beneficiaries.

The Anti-Kickback Statute ("AKS") prohibits offering, paying, soliciting, or receiving remuneration to induce referrals of items or services covered by Medicare and other federally funded programs. The 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 United States contends that Dr. Tannoury knowingly and willfully solicited and received free DePuy products, worth over $100,000, in return for Dr. Tannoury's ordering, arranging for, and recommending the purchase of DePuy's products in spine surgeries he performed on Medicare and Medicaid patients in Massachusetts in violation of the AKS.

Pharmacy Owner Sentenced for Paying Illegal Kickbacks and Money Laundering

Richard Hall, 53, of Fort Worth, a Texas pharmacy owner was sentenced to four years and four months in prison and ordered to pay over $59 million in restitution for paying illegal kickbacks and engaging in a money laundering conspiracy.

According to court documents and evidence presented at trial, Hall worked with others to create and market expensive compounded medications, which are intended to be custom-tailored to individual patient needs. Hall paid marketers to recruit area doctors to write prescriptions for these expensive compounded medications, including by creating so-called "investment opportunities" so that doctors who wrote prescriptions to the pharmacy could profit from the pharmacy operations. Hall paid illegal kickbacks to these marketers and engaged in a conspiracy to launder the unlawful proceeds.

A federal jury in the Northern District of Texas convicted Hall in July 2023 of four counts of paying and receiving unlawful kickbacks and one count of conspiring to launder money.

Florida Felon Sentenced to Prison for Role in Multi-Million Dollar Health Care Kickback Scheme After Pleading Guilty to COVID-19 Fraud and Unlawfully Possessing Firearm

Kareem Memon, 34, of Coral Springs, Florida, was sentenced to 96 months in federal prison, to be followed by three years of supervised release, by U.S. District Judge Raag Singhal, after admitting his role in a multimillion-dollar durable medical equipment (DME) kickback scheme and pleading guilty to carrying out a COVID-19 fraud scheme and being a felon in possession of firearms and ammunition.

On Feb. 8, 2024, Memon pled guilty to an information charging him with one count of conspiracy to commit health care fraud and one count of conspiracy to violate the federal Anti-Kickback Statute.

According to documents filed in the health care fraud case and statements made in court, Memon and his conspirators owned and operated marketing call centers and telemedicine companies through which they obtained doctors' orders for DME for Medicare beneficiaries without regard to medical necessity. Memon and his conspirators provided doctors' orders in exchange for bribes from DME companies that provided the braces to Medicare beneficiaries. Memon and his conspirators caused losses to Medicare in excess of $11 million.

On Sept. 21, 2023, Memon pled guilty to wire fraud, money laundering, and felon in possession charges in a separate case before Judge Singhal (Case No. 23-cr-80068). According to documents in the wire fraud case and statements made in court, Memon submitted fraudulent loan applications seeking more than $451,000 in forgivable Economic Injury Disaster Loans (EIDL) and Paycheck Protection Program (PPP) loans guaranteed by the Small Business Administration (SBA) under the Coronavirus Aid, Relief, and Economic Security (CARES) Act and used those funds for personal gains. Moreover, at the time of Memon's arrest he was a convicted felon and illegally possessed 12 firearms and ammunition.

FBI West Palm Beach and Newark Field Offices investigated the cases. Invaluable assistance was provided by the Bureau of Alcohol,

Medical Device Manufacturer Innovasis Inc. and Two Top Executives Agree to Pay $12M to Settle Allegations of Improper Payments to Physicians

Innovasis Inc. a Spinal device manufacturer and senior executives **Brent Felix** and **Garth Felix** agreed to pay a total of $12 million to resolve allegations that they violated the False Claims Act by paying kickbacks to spine surgeons to induce their use of Innovasis's spinal devices. Brent Felix is the founder, President and Chairman of the Board of Innovasis, which is headquartered in Utah. Garth Felix served in various leadership roles for Innovasis, including as the company's Chief Financial Officer.

The Federal Anti-Kickback Statute prohibits offering or paying anything of value to induce referrals of items or services covered by Medicare and other federally funded programs. The statute is intended to ensure that medical providers' judgments are not compromised by improper financial incentives.

The settlement resolves allegations that from January 1, 2014, through December 31, 2022, Innovasis provided improper remuneration to seventeen orthopedic surgeons and neurosurgeons to induce them to use Innovasis spinal implants, devices and other equipment in medical procedures the physicians performed on Medicare beneficiaries, in violation of the Anti-Kickback Statute. The improper remuneration was allegedly provided in the form of consulting fees, intellectual property acquisition and licensing fees, registry payments and performance shares in Innovasis, as well as travel to a luxury ski resort, lavish dinners and holiday parties for surgeons, their office staff and family members. For example, Innovasis allegedly paid physicians for consulting services at rates far in excess of fair market value or, in some cases, for work that was never actually performed. Similarly, the company allegedly paid physicians far in excess of fair market value to acquire or license purported intellectual property for which Innovasis never obtained any valuation prior to purchase and thereafter never used for meaningful product development. Innovasis also paid physicians to attend a company-sponsored conference held at a luxury resort in Deer Valley, Utah, which included the cost of travel, lodging and high-end meals, among other things. During the relevant period, Brent Felix, along with his brother Garth Felix, allegedly controlled or otherwise directed Innovasis's operations, strategic decisions, and the agreements with surgeons who allegedly received improper remuneration from Innovasis.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Robert Richardson, a former Regional Sales Director for Innovasis. Under those provisions, a private party can file an action for false claims on behalf of the United States and receive a portion of any recovery. Richardson will receive approximately $2.2 million as his share of the recovery in this case. The *qui tam* case is captioned *United States ex rel. Richardson v. Innovasis Inc., et al*., No. 3:19-CV-02440-X (N.D. Tex.).

Penn Highlands Healthcare to Pay $735,000 to Settle False Claims Act Allegations

Penn Highlands Healthcare — a Pennsylvania not-for-profit corporation operating a hospital system in north, central, and western Pennsylvania—and several of its hospitals—including **Penn Highlands DuBois**, formerly known as **DuBois Regional Medical Center** — (together "Penn Highlands") have agreed to pay the United States $735,000 to resolve a lawsuit alleging False Claims Act infringement through the submission of claims to Medicare and Medicaid resulting from violations of the Physician Self-Referral Law, United States Attorney Eric G. Olshan announced today.

The Physician Self-Referral Law, commonly known as the Stark Law, prohibits a medical provider from billing Medicare or Medicaid for certain services referred by physicians with whom the hospital has a financial relationship, unless that relationship satisfies one of the law's statutory or regulatory exceptions. The Stark Law is intended to ensure that medical decision-making is not compromised by improper financial incentives and is instead based on the best interests of the patient.

In this case, the United States alleged that, from July 1, 2009, through June 30, 2012, Penn Highlands DuBois violated the Stark Law by paying improper compensation to referring physician Gary Ott, M.D., and to a physician employed by Women's Care of Pennsylvania, Dr. Ott's practice, in the amount of $420,000 under a Consulting, Medical Director and Related Services Agreement for "employment services" allegedly performed before the agreement went into effect, during which time neither physician was employed by Penn Highlands DuBois.

The settlement stems from a whistleblower complaint filed in October 2016 by three medical providers formerly employed by Penn Highlands pursuant to the qui tam provisions of the False Claims Act, which permit private persons, also called relators, to bring a lawsuit on behalf of the government and to share in the proceeds of the suit. The Act also permits the government to intervene and take over the lawsuit, as the government did in this case in regard to some of the relators' allegations. The relators will receive $154,350 as part of the settlement.

Doctor Convicted of $70M Medicare Fraud Scheme

David M. Young, M.D., 61, of Fredericksburg, Texas, was convicted by a federal jury. The jury found Dr. Young for causing the submission of over $70 million in fraudulent claims to Medicare for medically unnecessary orthotic braces and genetic tests ordered through a telemarketing scheme.

According to court documents and evidence presented at trial, Young signed thousands of medical records and prescriptions for orthotic braces and genetic tests that falsely represented that the braces and tests were medically necessary and that he diagnosed the beneficiaries, had a plan of care for them, and recommended that they receive certain additional treatment. Young prescribed braces and genetic tests for over 13,000 Medicare beneficiaries, including undercover agents posing as different Medicare beneficiaries, many of whom he did not see, speak to, or otherwise treat. Young's false prescriptions were then used by brace supply companies and laboratories to bill Medicare more than $70 million. Young was paid approximately $475,000 in exchange for signing the fraudulent prescriptions.

The jury convicted Young of one count of conspiracy to commit health care fraud, which carries a maximum penalty of 10 years in prison, and three counts of false statements relating to health care matters, each of which carries a maximum penalty of five years in prison. He is scheduled to be sentenced at a later date. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Florida Businessman Daniel Hurt To Pay Over $27 Million For Medicare Fraud In Connection With Cancer Genomic Tests

Daniel Hurt, who owned and/or operated **Fountain Health Services LLC, Verify Health, Landmark Diagnostics LLC, First Choice Laboratory LLC** and **Sonoran Desert Pathology Associates LLC**, agreed to pay over $27 million to resolve allegations that he and his companies conspired with others to violate the False Claims Act (FCA) by submitting false claims to, and receiving payments from, Medicare for cancer genomic (CGx) tests that were not medically necessary and were procured through illegal kickbacks.

Hurt previously pleaded guilty to criminal healthcare fraud for these offenses. The civil settlement is based on Hurt's ability to pay.

Attorney General Ken Paxton Secures 84-Month Prison Sentence for Clinic Owner in $15 Million Medicare Fraud Scheme

Gwendolyn Gibbs, 72, owner of the Houston-area **Daybreak Rehabilitation Center**, was sentenced to 84 months in federal prison for orchestrating a $15 million health care fraud and kickback scheme. Gibbs was also ordered to pay $8,680,380 in restitution to government health care programs and will be subject to three years of supervised release following her prison term.

Gibbs falsified medical records and submitted false claims for patients, including individuals with intellectual disabilities, that were either never provided or not medically necessary. Gibbs also paid kickbacks to patient recruiters and owners of group homes in exchange for forcing residents to attend the clinic in exchange for transportation, supervision, and meals.

RiverSpring and ElderServe Collected Millions in Medicaid Payments for Services They Never Provided to Seniors in New York City and Surrounding Counties

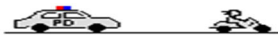
New York Attorney General Letitia James announced a $10.1 million settlement with health care companies *RiverSpring Living Holding Corp.* (RiverSpring) and ElderServe Health, Inc. d/b/a RiverSpring at Home (ElderServe) for failing to provide vulnerable New York seniors with personalized health care services while continuing to bill New York's Medicaid program for those services. For years, RiverSpring and ElderServe collected millions of dollars in Medicaid payments while members of the RiverSpring Managed Long Term Care Plan in New York City and Westchester, Nassau, and Suffolk counties did not receive the care they were promised. The settlement is the result of a joint investigation between the Attorney General's Medicaid Fraud Control Unit (MFCU), and the United States Attorney's Office for the Southern District of New York (USAO-SDNY). Under the settlement, approximately $6 million will be returned to the New York State Medicaid Program.

RiverSpring is a New York not-for-profit corporation that provides administrative support to **The Hebrew Home for the Aged at Riverdale** and affiliated organizations. ElderServe is a New York not-for-profit corporation that administers a Managed Long Term Care Plan (the RiverSpring MLTCP) for Medicaid beneficiaries. Services provided under the RiverSpring MLTCP are specific to each member's needs and can include home health aide services, nurse visits, social adult day care services, and other community-based services.

An investigation by MFCU found that from 2012 to 2017, the RiverSpring MLTCP collected Medicaid payments for services it never provided to its members. In many cases, RiverSpring either did not provide its members with qualifying services or did not adequately document that the services were provided. Despite this, RiverSpring received millions of dollars in Medicaid payments for these services.

As a result of the settlement, RiverSpring and ElderServe must pay $10,159,130 to federal and state Medicaid programs. $6,095,478 of the settlement funds will be returned to New York's Medicaid program.

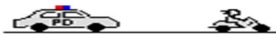
The case against RiverSpring was initiated by a former employee, who will receive a portion of the settlement because the former employee filed a whistleblower lawsuit under the qui tam provisions of the federal and New York False Claims Act. This Act allows people to file civil actions under seal on behalf of the government and share in any recovery.



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/



Chutzpah From Convicted Dentist

Sentenced to 20 Years in Prison for Medicaid Fraud Yet Demands Return of his License to Practice Dentistry

THE LICENSE REVOCATION

The Board of Dental Examiners revoked Seth Lookhart's dental license after he was convicted of dozens of crimes perpetrated in furtherance of a fraudulent scheme of staggering proportions that jeopardized the health and safety of his patients. Lookhart appealed the Board's revocation of his license, arguing that his punishment was inconsistent with past Board decisions. On appeal, the superior court concluded that the Board properly exercised its discretion by revoking Lookhart's dental license.

In a case of Chutzpah (unmitigated gall) called Seth Lookhart v. State Of Alaska, Division Of Corporations, Business, & Professional Licensing, Board Of Dental Examiners, No. S-18466, No. 7702, Supreme Court of Alaska (May 24, 2024) he asked for his license to practice dentistry from jail, the time of the Supreme Court was wasted as it resolved the issues raised by Lookhart.

FACTS AND PROCEEDINGS

Seth Lookhart was issued an Alaska dental license in June 2014 and a parenteral sedation permit in May 2015. Between May 2016 and March 2017, Lookhart systematically and unnecessarily sedated his patients in a manner that allowed him to fraudulently bill the maximum amount covered by Alaska's Medicaid program, overcharging Medicaid by more than $1.6 million. Lookhart routinely billed Medicaid for sedation that was not performed, billed Medicaid at higher rates than other insurers, and created false dates of service to maximize his wrongful reimbursements. During this same period Lookhart also stole an additional $412,500 from a business partner.

In order to maximize his billings to Medicaid, Lookhart engaged in a series of standard-of-care violations: He sedated patients beyond the scope of his training and permit, sedated multiple patients simultaneously, billed Medicaid for sedation during routine cleanings, and sedated patients with underlying chronic diseases that made sedation dangerous. He allowed his unlicensed office manager to sedate patients, pressured patients into unwanted sedation, and left sedated patients to drive themselves home.

On two occasions, Lookhart's patients nearly lost their lives as a direct consequence of his reckless sedation practices. Lookhart also extracted one deeply sedated patient's tooth while riding a hoverboard, and then sent a video of the unsafe extraction to his friends and family members without the patient's consent.

After a six-week bench trial ending in January 2020, he was convicted on 46 charges, including 11 felony counts of medical assistance fraud, three felony counts of scheming to defraud, one count of felony theft. The trial court also issued an order finding that the State had proven 13 sentencing aggravators beyond a reasonable doubt. The trial court found that the evidence against Lookhart was "overwhelming." He was ultimately sentenced to 20 years in prison with eight years suspended.

Dental Board Proceedings

Following Lookhart's convictions, the Division of Corporations, Business and Professional Licensing filed a 17-count accusation seeking to revoke Lookhart's dental license. Lookhart stipulated to the facts contained in the accusation, leaving it to an administrative law judge (ALJ).

The ALJ concluded that Lookhart's "astonishing range of misconduct" was "more wide-ranging and severe" than in any prior case in which the Board imposed a lesser sanction. Taken as a whole, the ALJ concluded that revocation was the "clear and obvious sanction," adopting the Division's contention that, "[i]f this case does not require it, no future case will."

The Superior Court's Decision

The trial court noted that "no Alaska case is factually comparable to the sheer scale of malfeasance here," that the Board "painstakingly detailed" Lookhart's misconduct, and that it had "carefully considered and rejected any comparison with prior Board cases."

DISCUSSION

As relevant to this case the statute which provides for license revocation in cases of fraud and providing the same for standard-of-care violations, would be rendered meaningless.

No Prior Dental Board Decision Involves Similar Facts.

Lookhart stole millions of dollars from the state program that provides medical care for the indigent, while simultaneously defrauding a business partner of several hundred thousand more and committing an egregious string of standard-of-care violations that not only jeopardized the safety, privacy, and autonomy of his patients, but also brought the dental profession into disrepute.

Lookhart stole millions of dollars from Medicaid. In furtherance of this massive fraud, he repeatedly subjected his patients to great risk of harm. There are no cases in the Board's history comparable to Lookhart's.

The Supreme Court concluded that the Board did not abuse its discretion by revoking Lookhart's license. None of the Board's prior licensing cases involved misconduct of the scope and severity in this case, so there was no applicable precedent to limit the Board's exercise of its discretion.

ZIFL OPINION

"Chutzpah" is a Yiddish word for unmitigated gall usually explained as a person convicted of murdering his parents who asks for clemency because he is an orphan. Lookhart, a dentist about to serve 20 years in state prison had the chutzpah to demand his license to practice dentistry reinstated. The Supreme Court gave his claim short-shrift and by doing so protected his fellow prisoners from being treated by a vicious person who almost killed a patient while extracting a tooth balancing on a hoverboard and stealing from Medicaid.

Convictions of Other Than Health Insurance Fraud

To 10 Years In Prison For Leading One Of The Largest No-Fault Insurance Frauds In New York History

BRADLEY PIERRE was sentenced to 10 years in prison by U.S. District Judge Paul G. Gardephe for conspiracy to commit bribery and conspiracy to defraud the Internal Revenue Service ("IRS") in connection with his orchestration of a $60 million fraud targeting No-Fault automobile insurance companies. PIERRE pled guilty before Judge Gardephe on December 18, 2023.

According to the Indictment, the plea agreement, and statements made in court:

> New York and New Jersey No-Fault insurance laws require a driver's automobile insurance company to pay automobile insurance claims automatically for certain types of motor vehicle accidents, provided that the claim is legitimate and below a particular monetary threshold. Pursuant to these requirements, insurance companies will often pay medical service providers directly for the treatment they provide to automobile accident victims without the need to bill the victims themselves. This process resolves automobile claims without apportioning blame or fault for the accident, thereby avoiding protracted disputes and the costs associated with an extended investigation of the accident.
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> From at least in or about 2008 through in or about 2021, PIERRE agreed with others (the "Clinic Controllers") to unlawfully own and run medical clinics located in the New York area, including, among others, Veda Medical, Sky Medical, Sun Medical, and Rutland Medical (the "Clinics"). PIERRE knew that clinics are unable to bill insurance companies for No-Fault benefits if the medical facilities are controlled by non-physicians. PIERRE nonetheless agreed with others, including doctors, to submit bills to insurance companies falsely representing that the Clinics were owned and operated by licensed doctors and to direct doctors to lie under oath during Examinations under Oath ("EUOs") about the ownership, control, and finances of the Clinics. PIERRE personally coached doctors to lie under oath in these EUOs.
>
> PIERRE used his control of the Clinics for personal profit. Between 2008 and 2021, PIERRE took over $20,000,000 from the Clinics by either transferring the funds directly to bank accounts under his control or using the Clinics' bank accounts to pay his personal finances. PIERRE also used his control of the Clinics to steer prescriptions to pharmacies in return for over a million dollars in kickbacks and to steer patients to seek legal representation from his wife's law firm, the Law Firm of Nonna Shikh (the "Shikh Firm"). The Shikh Firm then filed lawsuits against insurance companies on these patients' behalf. PIERRE maintained an office at the Shikh Firm and was actively involved in the legal practice as a "manager." The Shikh Firm made millions of dollars from the scheme and transferred over $4 million of illegal proceeds to PIERRE through a "marketing" arrangement between PIERRE's shell companies and the Shikh Firm.
>
> PIERRE used his control of the Clinics and his managerial role at the Shikh Firm to also steer patients to seek MRIs at a medical facility over which he exercised substantial control (the "MRI Facility"). PIERRE also agreed with the purported sole owner of the MRI Facility, who was a doctor, that the doctor would falsely report injuries in MRI reports. These falsified injuries allowed the Clinics to bill insurance companies for additional, unnecessary medical services and allowed attorneys to falsely claim injuries in lawsuits against insurance companies. PIERRE and the doctor agreed that the doctor would lie to insurance companies during EUOs about PIERRE's role in the MRI Facility.
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> PIERRE hid his control over several of the Clinics and the MRI Facility using phony loan arrangements. These agreements claimed that PIERRE was making non-recourse loans to the Clinics and the MRI Facility, which would only have to be paid back if insurance companies paid the medical practices' claims. The agreements also set PIERRE's "fee" as twice the amount loaned to the practices. However, in reality, PIERRE took almost $10,000,000 in excess of what these purported loan agreements permitted.
>
> PIERRE further agreed to pay bribes to fill the Clinics and the MRI Facility with patients. From at least in or about 2015 up to and including 2021, PIERRE agreed with others to pay bribes to hospital employees, 911 dispatchers, and other individuals (collectively, "lead sources") for the confidential names and numbers of motor vehicle accident victims. PIERRE agreed that others, including Anthony Rose, a/k/a "Todd Chambers," would then call victims and lie to them to induce victims to receive medical treatment at the Clinics and legal representation from the Shikh Firm. PIERRE helped Rose expand his bribery operation to New Jersey by recommending clinics and attorneys in the state that would pay kickbacks for referrals. PIERRE also recommended that Rose open a shell company to hide the illegality of the payments, which Rose in fact did. PIERRE paid Rose over $800,000 as part of the bribery scheme.

> PIERRE further recruited his own lead sources to participate in the bribery scheme. For instance, in or about 2017, PIERRE recruited Andrew Prime, knowing that Prime was bribing 911 operators and a hospital employee for confidential information. PIERRE paid Prime over $800,000 as part of the bribery scheme. PIERRE also personally recruited and bribed several of his own lead sources, including 911 operators and a source in 2019 that PIERRE codenamed the "Motherload" or "ML."
>
> PIERRE also agreed to bribe medical offices to send patients to the MRI Facility for MRIs. These medical offices included, among others, Epione Medical Center and Modern Brooklyn Medical. PIERRE facilitated these bribe payments through several intermediaries, including Anthony Rose, Jelani Wray, and others. PIERRE paid Jelani Wray over $800,000 in connection with these bribes.
>
> PIERRE then engaged in tax evasion. PIERRE utilized two companies in connection with the healthcare fraud and bribery schemes: Medical Reimbursement Consultants ("MRC") and Marketing 4 You ("M4Y"). PIERRE hid income from the IRS by concealing multiple bank accounts for MRC and using a series of check cashers for checks made out to MRC and M4Y. PIERRE also paid personal expenses from MRC and M4Y's bank accounts but improperly reported these payments as "business expenses." These included payments for his wedding, home renovations, jewelry, furniture, luxury clothing, travel, and gifts. In total, PIERRE underreported income, falsely reported expenses of over $4 million, and deprived the IRS of approximately $1.5 million in taxes due.

In addition to the prison term, PIERRE, 41, of Closter, New Jersey, was sentenced to three years of supervised release. PIERRE was also ordered to forfeit a money judgment of $3,500,000 and pay $1,500,000 in restitution.

Former Allianz Employee Pleads Guilty to Fraud Over $7-Billion Funds Collapse

Gregoire Tournant, 57, of Basalt, Colorado, admitted to two counts of investment adviser fraud at a hearing before Chief Judge Laura Taylor Swain of the federal court in Manhattan. Tournant, a former Allianz fund manager pleaded guilty over his role in a meltdown of private investment funds sparked by the pandemic that caused an estimated $7 billion of investor losses.

He faces up to 10 years in prison at his October 16 sentencing. Tournant also agreed to give up $17.5 million in he obtained from his fraud including bonuses.

The case stemmed from the March 2020 collapse of the German insurer's now-defunct Structured Alpha funds, which Tournant had created and oversaw as chief investment officer. In May 2022, Allianz agreed to pay more than $6 billion and its U.S. asset management unit pleaded guilty to securities fraud to resolve government probes into the collapse. Two other former Allianz fund managers pleaded guilty at the time.

The Structured Alpha funds had bet heavily on stock options, in a manner designed to limit losses in a market selloff, which Tournant likened to a form of insurance. Prosecutors said Tournant misled investors about the funds' risks by altering performance data and diverging from his promised hedging strategy and obstructed a U.S. Securities and Exchange Commission probe by directing a colleague to lie.

The funds once had more than $11 billion of assets under management but lost about $7 billion in February and March 2020 as the start of the pandemic set off a worldwide market panic. Before pleading guilty, Tournant admitted to providing deceptive information to investors.

Prosecutors said the fraud ran from 2014 through March 2020, with Tournant being paid more than $60 million over that time.

Tournant previously pleaded not guilty to five criminal counts including investment adviser fraud, securities fraud, conspiracy and obstruction. He had also accused the law firm Sullivan & Cromwell, which had represented him and Allianz, of making him a scapegoat after Allianz decided to cooperate with federal prosecutors.

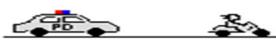
The case is U.S. v. Tournant, U.S. District Court, Southern District of New York, No. 22-cr-00276.

Kansas Man Sentenced to Probation for Auto Insurance Fraud

Robert Heidbreder, age 30, pleaded guilty in the District Court of Sedgwick County to one misdemeanor count of insurance fraud and one misdemeanor count of attempted theft after attempting to gain insurance coverage for an uninsured vehicle after that vehicle was reported stolen. He pleaded guilty and was sentenced on May 21 to six months of probation with six months underlying prison time if his probation is violated. Heidbreder was also assessed $1,000 in fines.

Kansas Insurance Commissioner Vicki Schmidt announced the sentence for insurance fraud.

The Kansas Department of Insurance investigated the case, which was prosecuted by the Kansas Attorney General's Office.



RICO Suit Against Chiropractors

Allstate Effectively Alleges RICO Conspiracy by Chiropractors to Defraud Allstate

In *Allstate Insurance Co. et al. v. Lint Chiropractic PC et al.*, No. 2:23-cv-10904, United States District Court, E.D. Michigan, Southern Division (May 30, 2024) Allstate brought a RICO case against chiropractors and conspiracies to defraud Allstate. Various Allstate

insurers accused several medical and chiropractic clinics, their suppliers, and their managers of orchestrating a racketeering scheme to exploit Michigan's no-fault insurance law by generating and submitting hundreds of fraudulent medical bills for reimbursement.

In response to dueling motions for summary judgement the USDC concluded that Plaintiffs have sufficiently alleged their claims, but Defendants' counterclaims fall short of providing a factual or legal basis distinct from the original allegations. Defendants' motion to dismiss was denied and Plaintiffs' motion to dismiss was granted.

BACKGROUND

Robert Super, a chiropractor from Florida, exercises "dominion and control" over all units of a medical device called the Nervomatrix. The Nervomatrix is used to treat "trigger points" – painful areas of knotting or tightness in muscles. To do so, the Nervomatrix first scans for trigger points (TPII) and then treats them with electrical stimulation ("LINT").

Super proliferated the fraudulent use of Nervomatrix machines at numerous medical clinics in Michigan. Super implemented a "predetermined protocol" mandating the use of Nervomatrix machines-regardless of medical necessity.

Defendants also billed for services not rendered-with Lint Chiropractic billing for treatments at some clinics before Nervomatrix machines were installed there, and Super billing during times that those clinics considered the machines abandoned because they had lost contact with him. Lint Chiropractic frequently used preprinted prescription forms with identical signatures, altering only the date and clinic address.

ANALYSIS

Plaintiffs allege violations of two provisions of the RICO statute. Plaintiffs have plausibly alleged claims under both provisions.

THE RICO ENTERPRISE

A RICO "enterprise" may include "any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity." [18 U.S.C. § 1961(4)]. This definition is intentionally broad, designed to stamp out corruption. Liability under 18 U.S.C. § 1962(c) requires that Defendants "participate" in the enterprise's conduct.

THE PARTICIPANTS

- **Lint Chiropractic Enterprise**. Super owned and managed Lint Chiropractic and directed its staff's conduct. He installed Nervomatrix machines there and developed a predetermined protocol to direct patients toward unnecessary treatments, resulting in fraudulent billing.
- **MI Medical Enterprise**. Super also owned and managed MI Medical, implementing the same fraudulent protocol used at Lint Chiropractic. Diagnostic conducted unnecessary tests on MI Medical patients to support these bills.
- **Supplies Plus Enterprise**. Super managed Supplies Plus, deciding to write prescriptions for unnecessary DME and generating fraudulent bills.
- **Diagnostic Chiropractic Enterprise**. Super managed Diagnostic Chiropractic, which billed for unnecessary tests arranged by Lint Chiropractic.

The USDC concluded that Plaintiffs sufficiently alleged the existence of each enterprise and how Defendants participated in the conduct of those enterprises.

Pattern of Racketeering Activity

To establish a pattern of racketeering activity, Plaintiffs must demonstrate that Defendants committed at least two predicate acts of racketeering within ten years. Plaintiffs allege that all the predicate acts of mail and wire fraud served the common purpose of inducing Plaintiffs to pay large sums for bogus medical bills. These allegations sufficiently demonstrate the necessary relationship among the acts.

Predicate Acts and Civil Rule 9(b)

Although fraud claims are subject to a heightened pleading standard, requiring plaintiffs to state with particularity the circumstances constituting fraud or mistake, the Allstate plaintiffs adequately alleged the fraudulent scheme, detailing how Defendants orchestrated a plan to defraud Plaintiffs with the Nervomatrix and fraudulent medical bills. Plaintiffs have pled their § 1962(c) fraud claims with sufficient particularity under Rule 9(b). Defendants' motion to dismiss on these grounds is denied.

RICO-Conspiracy Claim Under § 1962(d)

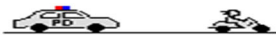
The key is not that each Defendant committed every act of fraud but that they conspired to achieve the fraudulent objectives of the enterprise.

MOTION TO DISMISS COUNTERCLAIMS

If Plaintiffs prevail on their fraud claims, it will necessarily mean that Counterclaimants are not entitled to the payments. Thus, the counterclaims serve no purpose. Accordingly, Defendants' Motion to Dismiss, was DENIED and it was ORDERED that Plaintiffs' Motion to Dismiss, was **GRANTED**.

ZIFL OPINION

The type of Fraud that Allstate used to base its RICO action is rampant as detailed in hundreds of health insurance fraud convictions reported in Zalma's Insurance Fraud Letter twice a month. The Allstate entities, as the victim of the fraud, is proactively fighting the frauds perpetrated against it by this RICO case that, when tried successfully, will take the profit out of the crime.



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Insurance Fraud Is Epidemic

Insurance fraud continually takes more money each year than it did the last from the insurance buying public. There is no certain number. Most attempts at insurance fraud succeed. Estimates of the extent of insurance fraud in the United States range from $87 billion to more than $308 billion every year.

Insurers and government backed pseudo-insurers can only estimate the extent they lose to fraudulent claims. Lack of sufficient investigation and prosecution of insurance criminals is endemic. Most insurance fraud criminals are not detected. Those that are detected do so because they became greedy, sloppy and unprofessional so that the attempted fraud becomes so obvious it cannot be ignored.

The National Insurance Crime Bureau (NICB) estimates that almost 25% of the bodily injury claims related to auto crashes are bogus. Property and casualty claims against auto insurance are not much better, coming in at around a 10% fraud rate.

A person commits the offense of insurance fraud by knowingly and with the intent to defraud any insurer presents or causes to be presented to any insurer any statement forming a part of, or in support of, a claim that contains any false, incomplete or misleading information concerning any fact or thing material to the claim. [18 Pa.C.S.A. § 4117(a)(2).] A person acts "knowingly" when he or she is aware that it is practically certain that his or her conduct will cause such a result. Likewise, a person acts "intentionally" when "it is his or her conscious object to engage in conduct of that nature or to cause such a result.

In Illinois insurance fraud is a creature of statute. Section 17-10.5(a)(1) of the Illinois Criminal Code of 2012 defines insurance fraud in the following manner:

> A person commits insurance fraud when he or she knowingly obtains, attempts to obtain, or causes to be obtained, by deception, control over the property of an insurance company or self-insured entity by the making of a false claim or by causing a false claim to be made on any policy of insurance issued by an insurance company or by the making of a false claim or by causing a false claim to be made to a self-insured entity, intending to deprive an insurance company or self-insured entity permanently of the use and benefit of that property." 720 ILCS 5/17-10.5(a)(1) (West 2016). [*Hale v. Travelers Indem. Co*., 2019 IL App (1st) 18-2707-U (Ill. App., 2019)]

The National Heath Care Anti-Fraud Association estimates conservatively that health care fraud costs the nation about $68 billion annually — about 3 percent of the nation's $2.26 trillion in health care spending. Other estimates range as high as 10 percent of annual health care expenditure, or $230 billion. Add that to the property and casualty fraud estimate and the total number becomes egregious.

No one will ever be able to place an exact number on the amount lost to insurance fraud. Everyone who has looked at the issue knows – whether based on their heart, their gut or empirical fact determined from convictions for the crime of insurance fraud – that the number is enormous.

When insurers and governments put on a serious effort to reduce the amount of insurance fraud the number of claims presented to insurers and the pseudo-government-based or funded insurers drops logarithmically.

Insurance fraud is not limited to the US. In Britain fraud costs the British economy amounts estimated in billions of British pounds. Since the amount of fraud actually detected is a small portion of what was actually found, the estimates published are little more than an educated guess.

As the industry attempts to keep pace with fraudsters' varied, ever-shifting tactics, it must deploy more innovative, effective anti-fraud technologies or risk dire losses. Vendors and organizations include the Coalition Against Insurance Fraud (CAIF), CSC, Detica NetReveal, Equifax, Experian, FICO, IBM, Innovation Group, Insurance Bureau of Canada (IBC), ISO/Verisk, KPMG, LexisNexis, Mattersight, Mitchell, the National Insurance Crime Bureau (NICB), SAP, SAS, and TransUnion.

Insurers must also generate a close relationship with the state insurance department's fraud division or fraud bureau, local police agencies, the FBI, the ATF, the Postal Investigation Service, the local fire department's arson unit, local prosecutors, and the local U.S. Attorneys if they are to have any chance to reduce the effect of insurance fraud. Insurers should also work to make the general public, state legislators, state governors, congress members and U.S. Senators, and the Attorney General of the United States aware of the effect insurance fraud has on the public at large and the insurance industry.

Wherever insurance is written insurance fraud exists. It is an equal opportunity fraud committed by people of every race, religion or national origin.

Insurers who do not exercise serious anti-fraud efforts often complain that the local district attorneys and police agencies give a low priority to the crime of insurance fraud. No matter how seriously the insurers work to prove fraud the authorities often ignore them. In response, police and prosecutors complain that the insurers do nothing that police and prosecutors can use to prosecute the crime of insurance fraud while insurers complain that prosecutors ignore them when they present evidence of a fraud. There is truth in both complaints. Insurers, although compelled by statute to investigate potential insurance fraud and to present the results of their investigations to prosecutors, they are not trained as police officers.

The logarithmic growth of fraud against insurers and government based programs like Medicare and Medicaid, will eat away any chance insurers – and their shareholders – can operate successfully. In addition, medical fraud perpetrated on federal and state agencies, will increase the tax burden of those who pay taxes to support Medicare, Medicaid and the so-called "Affordable Care Act" or Obamacare, will be insufferable.

In fact, insurers are almost universally ignored by police agencies when the insurer victim reports the crime. When insurance criminals are caught in the act they are seldom arrested, even less often prosecuted and almost never punished seriously. In addition to educating police and prosecutors insurers must work to educate the judiciary that the crime of insurance fraud is a serious crime that often causes injury or death to the innocents who are the conduit used by the fraud perpetrators to reach the deep pockets of the insurance companies or the state or federal governments.

Police and prosecutors must deal with insurers who are not equipped to perform an adequate criminal investigation. Insurer employees seldom have police or prosecutorial experience. They are in business to provide to those who buy insurance the benefits promised by the policy.

When faced with fraud employees of insurers are only qualified to conduct the investigation necessary to protect the insurer from civil litigation by a fraud perpetrator. In addition, the implied in law covenant of good faith and fair dealing and state fair claims settlement practices acts, impose on insurers an obligation to make every effort to pay claims fairly, promptly and without unnecessary delay.

If prosecution of insurance fraud is to be successful it is necessary that insurers, prosecutors and police agencies work together as a team dedicated to defeat the crime of insurance fraud. To do so the insurers must train their staff to recognize the elements of both the crime of insurance fraud and the elements of the civil tort of insurance fraud. If well trained, insurance personnel collecting information about a potential insurance fraud, will know the type and quality of information that either a prosecutor or a civil defense lawyer will need to prove fraud was attempted.

Some estimates indicate that more money goes out fighting fraud than is saved. Others show that every dollar spent by insurers to defeat fraud save the insurer as much as seven dollars in fraudulent claims. Although insurance fraud is a crime in almost every jurisdiction in the United States, it is the only crime where the victim is required to perform the investigation from its funds and to pay special taxes to support investigation and prosecution by public agencies of crimes committed against it. The Departments of Insurance across the country continue to add taxes on insurers and the insurance buying public to pay for the state's portion of the fight against insurance fraud.

Insurers are compelled by statute and Regulation to maintain Special Fraud Investigation Units, publish and fulfill a detailed anti-fraud program and train all of their anti-fraud personnel. Compliance by insurers is less than constant across the industry. Some have effective fraud units while others simply identify one employee as its anti-fraud director although his or her work is almost totally adjusting claims and not investigating fraud. The expense of staffing and pursuing the anti-fraud efforts required by statute and regulation reduces the profits earned by the insurer and is believed to be offset by the lack of payment to fraud perpetrators. Of course, these efforts are also made difficult by the imposition of fair claims settlement practices regulations that require quick, complete, thorough investigations and fair treatment and prompt payment of insureds even when fraud is suspected. The two opposing sets of laws create a Catch-22 from which insurers find difficulty complying with both.

The Departments of Insurance audit insurers regularly to be sure that each insurer works hard to train its people to investigate and seek prosecution of the crime of insurance fraud. Failure to do so sufficiently allows the state Department of Insurance to fine the insurer for not doing the work traditionally the duty of the state to investigate and prosecute crime.

In addition, adding insult to the injury, courts and juries assess tort and punitive and exemplary damages against insurers who under the compulsion of the Departments of Insurance to defeat fraudulent claims and, as required, accuse their insured's of fraud. If the insurer fails to prove the fraud and the police agencies, including the Departments of Insurance, fail to prosecute following the direction of the Departments of Insurance are dangerous.

Similar businesses in the financial sector, who are also regular victims of fraud and other crimes, are not taxed or compelled to investigate crimes committed against them. No state agency or person demands that a local or national bank pay for prosecuting embezzlers or armed robbers. No state agency or person demands that convenience store owners pay for prosecuting people who hold up 7-11 stores. No Regulator requires stockbrokers to investigate money laundering or fraudulent transactions.

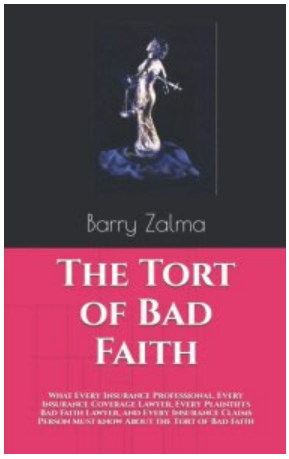
The imposition upon the insurance industry – and the attendant cost passed to the insurance consumer – is unique. Insurers are treated differently than all other businesses in the United States. George Orwell was right when, to paraphrase what he had a character in "Animal Farm" say, "all businesses are equal, some are more equal than others."

Clearly, insurers are less equal with regard to crimes perpetrated against them than are other businesses. They are the only business required to pay for special investigators and prosecutors to investigate crimes against them. They are the only business required, by statute, to investigate crimes against them and produce the evidence to the prosecutors. Without the power and immunity available to police agencies insurers are damned and fined if they don't comply and are damned with tort and punitive damages plus the cost of defending bad faith suits if they comply with the statutes and regulations. Adapted from my book, Insurance Fraud Second Edition, Volume I Available as a Kindle book; Available as a Hardcover; Available as a Paperback

The Tort of Bad Faith

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. Keeping back such circumstance is a fraud, and therefore the policy is void.

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.

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.

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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.

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He publishes daily articles at https://zalma.substack.com, 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.

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