The Essential Resource for The Insurance Fraud Professional

Zalma's Insurance Fraud Letter

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Quote of the Issue

"Happiness is not a goal, it's a by-product."

Eleanor Roosevelt

October 1, 1979 - 2021 – Another Anniversary – Thank You

Forty-one years ago today I left the world of the employed and became an entrepreneur by opening my own law firm. The law practice was incorporated shortly thereafter as Barry Zalma, Inc. When I opened for business on October 1, 1979, I had no clients and no certainty that I would have any in the future. I had borrowed money from the bank to carry me through the first six months and was concerned about my ability to pay the loan with my third child about to be born.

Much to my surprise and pleasure, on October 1, 1979, at 8:10 a.m., the best claims handler in the London market, Alan Warboys, called from London and provided me with my first case as an independent lawyer to represent Certain Underwriters at Lloyd's, London. He, and the Lloyd's Underwriters he represented, showed faith in me as a lawyer and insurance expert. Alan is now, and will forever be, my law firm's first client and is still and always will be a good friend. He is retired from the market now as I am retired from the practice of law.

Me Dreaming About Being a Writer

Although I retired from the practice of law, I still work an eight hour day, five days a week as a consultant, author, blogger, and videoblogger.

I was admitted to the California Bar on January 2, 1972. I practiced law in California full time until I retired from the practice of law in 2015. To those of you, in addition to Alan, who have honored me by retaining me as your lawyer, thank you for a long, productive and successful legal career.

In 2015 I asked that the California Bar render my license to practice law inactive and it agreed. I will limit my work to acting as an insurance claims handling, insurance fraud and insurance bad faith consultant, expert witness, educator and author.

I Am Not Retired. I am Only Retired from the Practice of Law

I am fully recovered from open heart surgery and continue to work five days a week. I am only slowing from my time as a lawyer by limiting my work to consulting and testifying as an expert. I am now 79-years-old.

I used that expertise last year when I testified in an Idaho trial court for a policyholder who was not treated well by his insurer and received a favorable verdict. I keep busy helping lawyers – both for insurers and policyholders – deal with difficult insurance issues. Most of the cases for which I am retained as a consultant or expert are resolved by settlement – often shortly after my report to the court is published and I am rarely required to testify at trial.

I expect to continue working, using my 54 years of experience in the insurance claims industry, forever, or, at least, until I reach the century mark my mother reached before she passed away.

I will continue to publish, twice a month, *Zalma's Insurance Fraud Letter* and will publish daily articles at https://zalma.substack.com, to my blog, *Zalma on Insurance,* digests of recent cases. I have now made available for anyone interested in being a claims professional a complete Insurance Claims Library available as paperbacks or Kindle books at Amazon.com where I have already published *Zalma on Insurance Claims, Construction Defects and Insurance*, *Zalma's Mold & Fungi Handbook, The Homeowners Insurance Policy, The Law of Unintended Consequences and the Tort of Bad Faith, Insurance Fraud, The Compact Book of Adjusting Property Claims Second Edition, The Compact Book of Adjusting Liability Claims Second Edition* and dozens of

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I will continue to serve you as a claims handling and bad faith consultant, expert witness, author, educator, arbitrator or mediator. Since my firm has been reduced to only me, I will always answer the phone or respond to your inquiries by telephone, e-mail, or even via the U.S. Postal Service.

Thank you again for your faith in me and my firm, Barry Zalma, Inc. If you need assistance, insurance claims consulting or the services of an expert witness, please call at 310-390-4455. I'm the only one here so I answer the phone and have no one from whose person I need to socially distance.

Wisdom

"We live in an age of science and of abounding accumulation of material things. These did not create our Declaration. Our Declaration created them. The things of the spirit come first. Unless we cling to that, all our material prosperity, overwhelming though it may appear, will turn to a barren scepter in our grasp." – **Calvin Coolidge**

"Many people never grow up. They stay all their lives with a passionate need for external authority and guidance, pretending not to trust their own judgment." —**Alan Watts**

"When you meet someone better than yourself, turn your thoughts to becoming his equal. When you meet someone not as good as you are, look within and examine your own self." – **Confucius**

"Love all, trust a few, do wrong to none." – **William Shakespeare**

"Truth is proper and beautiful in all times and in all places." – **Frederick Douglass**

"If you are serious about wanting to improve education, do not vote more money for the education establishment that has been dumbing down the schools for years. Vote for vouchers, tax credits, or anything else that will transfer decision-making power to parents." —**Thomas Sowell**

"Love your country, but never trust its government." —**Robert A. Heinlein**

"Never trust governments absolutely and always do what you can to prevent them from doing too much harm." —**John Arthur Passmore**

"A lie doesn't become truth, wrong doesn't become right and evil doesn't become good just because it's accepted by a majority." — **Booker T. Washington**

"We find few historians who have been diligent enough in their search for truth; it is their common method to take on trust what they help distribute to the public; by which means a falsehood once received from a famed writer becomes traditional to posterity." —**John Dryden**

"The first principle of solid wisdom is discretion; without it all the erudition of life is merely bagatelle." – **Norm Macdonald**

"Socialism means equality of income or nothing... Under socialism you would not be allowed to be poor. You would be forcibly fed, clothed, lodged, taught, and employed whether you like it or not. If it were discovered that you had not character enough to be worth all this trouble, you might possibly be executed in a kindly manner; but whilst you were permitted to live you would have to live well." —**George Bernard Shaw**

The EUO As a Tool

The EUO Is a Serious and Important Part of the Insurer's Investigation

The attorney, insurance claims professional or investigator who conducts the EUO can take a role similar to the role of a prosecutor without the usual constitutional restraints controlling testimony at a deposition or trial. [*Hickman v. London Assurance Corporation,* 184 Cal. 524, 195 P. 45 (1920)] A false statement as to any material fact during the EUO can cause the policy to be declared void, even if the fact has no relationship to the loss.

In *Claflin* the false testimony concerned a witness that would not affect the amount payable under the policy but to protect his reputation for veracity. The U. S. Supreme Court found that the witness of the injury was material to the investigation and declared the policy void for fraud because he made false statements under oath.

Contrary to the Belief of Lawyers for the Insured, the EUO Is Not an Adversary Proceeding like a Deposition in a Lawsuit.

The EUO is an investigative tool made available to the insurer. It allows the insurer to delve deeply and under oath into all aspects of the policy and the loss. The testimony to be elicited is not constrained by rules of discovery or the Codes of Civil Procedure.

The only restraint on the EUO is reasonableness. Unlimited questions are allowed. Only totally irrelevant and unreasonable questions dealing with facts completely outside the policy, its acquisition or the loss are not favored.

Irrelevant questions need to be tolerated if there is any possibility the question may lead to an inquiry about facts relevant to the policy or claim. In fact, there are no questions that are irrelevant in an EUO since each question may lead to more important information that could never have been learned about had not a foundation been laid by questions that appear, on their face, to be irrelevant. Since there are no rules for the taking of the EUO any question asked is important and must be answered. There is no judge to rule on objections and no court has the ability to enter into the taking of an EUO.

In *Ram v. Infinity Select Ins*., 807 F.Supp.2d 843 (2011), during the investigation of the insured's claim, the plaintiff produced limited records. Where an insurer has reason to suspect fraud in relation to a theft claim, inquiries into the insured's financial status are relevant and material, and a refusal to answer questions on that subject constitutes a material breach of the insurance contract. Plaintiff refused to discuss his 2008 income at his EUO and much of the income and employment information that he was willing to provide throughout the investigation of his claim was admittedly false. The Court concluded that Plaintiff's failure to answer income questions constituted a breach of the duty to cooperate, and the court concluded that no reasonable juror could find otherwise.

In *Powell v. United States Fid. & Guar. Co.,* 88 F.3d 271 (4th Cir.1996), the insureds' home was destroyed by fire. Under their homeowners' insurance policy, the insureds were required to "submit to questions under oath and sign and swear to them." During the EUO, the insureds refused to answer several questions and "to turn over financial and other documents," claiming that an EUO did not permit the insurer to "delve into financial or other information relating to the [insureds'] possible motives to intentionally set the fire ... but ... [was] instead limited ... to an examination relating to the existence and extent of loss under the policy." The United States Court of Appeals for the Fourth Circuit disagreed, stating that an EUO "encompasses investigation into possible motives for suspected fraud." Concluding that the EUO "is not restricted to amount of loss, but the insurer has the right to examine the insured and his witnesses as to any matter material to the insurer's liability and the extent thereof."

Therefore, in *Phillips v. Allstate Indemn. Co*., 156 Md.App. 729, 848 A.2d 681 (2004) and *Lindsey v. State Farm Fire and Cas. Co.,* Not Reported in F.Supp.2d, 2000 WL 1597763 (D.Md., 2000) under the facts and circumstances of the case, the refusal to answer questions about his financial circumstances during the EUO violated the terms of the policy and constituted a failure to cooperate.

In Michigan, in the context of a homeowner's insurance policy, that the remedy for failing to comply with a requirement to submit to an EUO is dismissal of the insured's action. *Thomson v. State Farm Ins. Co.,* 232 Mich.App. 38, 45, 592 N.W.2d 82 (1998); *Yeo v. State Farm Ins. Co.,* 219 Mich.App. 254, 257, 555 N.W.2d 893 (1996). The court saw no reason to distinguish between a valid EUO in a homeowner's insurance policy and a valid EUO in a policy providing uninsured motorist benefits. An insurance policy is much the same as any other contract; it is an agreement between the parties. Because the no-fault statute does not require uninsured motorist benefits, there is no public policy against enforcing the EUO provision in this context, and we must honor the intent of the parties' contract. [*Cruz v. State Farm Mut. Auto. Ins. Co*., 241 Mich.App. 159, 614 N.W.2d 689 (2000)].

The EUO Should Be Required by an Insurer:

- When the insured has insufficient documentary evidence to prove his loss.
- When the insured refuses to cooperate in the investigation of the insurer.
- When the insured is unable to present documentary evidence in support of his or her claim.
- When the Insured needs help proving his or her loss.
- When the insurer has no other means of "cross examining" the proof of loss submitted by the insured.
- When the insurer witnesses a fraudulent claim is being attempted.

The list of reasons for requiring an EUO are not the only reasons but a small list of potential reasons for an EUO. When an insurance professional, whether an adjuster or a lawyer, finds a claim poses questions that cannot be answered by the usual and common methods of investigating a claim, it is important to consider the use of the EUO to get the answers not available anywhere else

The EUO is A Duty Owed by the Insured to the Insurer

Every fire insurance policy issued in the U.S., like the New York Standard Fire Insurance Policy provides that, in the event of a loss, the insurance company can require the insured to produce documents and testify at an EUO. By statute in those states like New York that have a standard fire insurance policy, also require that all risk or direct risk of physical loss policies that do not exclude fire, must provide the coverages or better than the coverages stated in the standard fire policy.

In *Ransom v. Selective Ins. Co.,* 229 N.J. Super. 43, 46, 550 A.2d 1006 (Law Div.1988) the court reviewed the examination under oath provision in a policy and concluded that the insured was required to submit to the EUO and produce requested documents in accordance with the written demand of counsel "because the circumstances surrounding the loss arouse[d] a *justified suspicion* of arson and because the *requests are specific, relevant, material and reasonable.*" (Emphasis added).

Applying the principles articulated in *Ransom,* and finding a reasonable basis to suspect that his claim of a theft loss was fraudulent, the court determined that the insured's failure to produce the requested documents constituted a material breach of the conditions of his policy. Recognizing that the insurer's rights may be "materially diluted by the delay between the loss and [the] resolution of the issue [,]" the court held:

> [A]n insured in these circumstances *must promptly file a declaratory judgment action seeking a determination of its obligation* to produce the records demanded by its insurer under an insurance policy when the insured objects to their production. The insured may not wait to assert his rights until the eve of the expiration of the statute of limitations for filing suit to compel coverage. Such delay works too great a hardship to the insurer who must be able to promptly investigate the legitimacy of claims. [*DeMasi v. Lexington Ins. Co*., Not Reported in A.2d, 2010 WL 3075674 (N.J.Super.A.D., 2010)]

Reversing a trial court ruling compelling appraisal (arbitration) under an insurance policy, the Eleventh Circuit court, in *Jacobs v. Nationwide Mutual Fire Insurance Co*., 236 F. 3d 1282 (11th Cir. 2001), applied Florida law in holding that the insured could not prove that he had fully complied with the EUO and document production requirements of the policy. Similarly, applying Florida law, the court in *Galindo v. ARI Mutual Insurance Co*., 203 F. 3d 771 (11th Cir. 2000), refused to allow appraisal to go forward until the insureds had submitted to EUO, and stated that:

> insureds must comply with post-loss terms of their respective homeowner's policies, which enabled the insurance companies to investigate the insureds' claims and to disagree with the loss amount before the appraisal term becomes effective. 203 F. 3d at 771.The failure to appear at EUO was held to be an absolute defense in *Lentini Brothers Moving & Storage Co. v. New York Property Insurance Underwriting Association*, 76 App. Div. 2d 759, 428 N.Y.S. 2d 684 (1980), aff'd, 51 N.Y. 2d 740, 53 N.Y. 2d 835, 440 N.Y.S. 2d 174 (1981). The intermediate appellate court stated: 'compliance with the policy provisions is a condition precedent to recovery. No compliance with the provisions as to written proof of loss or sworn examination occurred. Thus, recovery is barred.' 428 N.Y.S. 2d at 687. In *Allstate Insurance Co. v. Longwell*, 735 F. Supp. 1187 (S.D.N.Y. 1990), the court held that failure to appear for EUO is a breach of the cooperation clause even if the insured offers to cure the breach by answering the questions after denial of his claim.

The purpose of examinations under oath that was first described in *Claflin v. Commonwealth Insurance Co*., 110 U.S. 81, 94-95 (1884) made clear that every question that was relevant and pertinent in such an examination was material to the investigation of the insurer must be answered. It also clarified that a question is material when, "a true answer to it was of the substance of the obligation of the assured."

The position taken by the Court in *Claflin* has been upheld by every court that has considered it to date. For example, in *Gipps Brewing Corp v. Central Manufacturers Mutual Insurance Co*., 147 F. 2d 6, 13 (7th Cir. 1945), the court stated:

> We think there is no escape from the conclusion that these witnesses purposely refused to answer questions which were material to the inquiry. We see no basis for refusal to answer upon the ground that they were controversial or that the answers thereto might have been used for the purpose of impeachment. Such a limitation would seriously impair and perhaps destroy defendants' right under this provision of the policy. . .. We would think that defendants had a right to examine as to any matter material to their liability, as well as its extent.

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- Preparing a captioned report to insurance company management.
- Preparing a statement of loss.
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- Negotiating a third party claim with a claimant or lawyer.
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Man Bites Dog Story: State Farm Sues Chiropractors for Fraudulent Claims

Insurers Frustrated by Lack of Prosecution for Insurance Fraud Proactively Sue Chiropractors They Claim Defrauded the Insurers

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Insurers, victims of insurance fraud, see little or no prosecution of those who defraud them. State Farm, not willing to wait, proactively sued defendants James Marshall, D.C. and Marshall Chiropractic, LLC (collectively "Defendants") for fraud. After discovery was completed, the Chiropractors moved for summary judgment seeking dismissal of State Farm's suit. In *State Farm Guaranty Insurance Company, and State Farm Indemnity Company v. Marshall Chiropractic, LLC and James Marshall, D.C.,* Civil Action No. 20-1918 (MAH), United States District Court, D. New Jersey (September 17, 2021) the USDC was asked to dismiss because State Farm failed to file an affidavit of Merit asserted against the chiropractors required of malpractice suits against health care providers. State Farm did not allege malpractice.

BACKGROUND

Plaintiffs are auto insurers who provide personal injury payment ("PIP") coverage to their insureds. Defendant Marshall is a chiropractor licensed in the State of New Jersey and the owner of Defendant Marshall Chiropractic.

Plaintiffs sued the chiropractors asserting four causes of action: common law fraud; breach of the New Jersey Insurance Fraud Prevention Act; unjust enrichment; and declaratory relief. According to the Complaint, Defendants fraudulently acquired PIP payments from Plaintiffs by imposing a predetermined treatment protocol and subjecting State Farm-insured patients to "virtually the same laundry list of services on nearly every visit, "rather than conducting an individualized assessment and creating a personalized treatment plan. Plaintiffs demanded reimbursement for PIP-benefit payments totaling "approximately $850,000." They also sought treble damages, costs, and declaratory relief as redress for Defendants' alleged misconduct.

Fifteen months after the initiation of the suit and over twelve months after filing their Answer, Defendants moved for summary judgment. They assert for the first time that Plaintiffs were required to file an affidavit of merit under New Jersey statutes.

DISCUSSION

Application of the New Jersey Affidavit of Merit Statute

Defendants argued that Plaintiffs were required to comply with the New Jersey Affidavit of Merit Statute because the Complaint contains allegations that Defendants "breach[ed] the applicable standard of care owed . . . to their patients in providing medical services." Plaintiffs responded that their claims are outside the statute's scope because they are not pursuing personal injury, wrongful death, or property damages, and they have not filed an action for malpractice or negligence.

The failure to provide an appropriate affidavit or a statement in lieu thereof shall be deemed a failure to state a cause of action and ordinarily requires dismissal of the complaint with prejudice. However, plaintiffs have not filed an action for malpractice or negligence. The USDC concluded that claims seeking to recoup a finite sum previously paid, does not fall within the Affidavit of Merit Statute.

In this case, Plaintiffs sought to recover a sum that is substantially certain. Specifically, Plaintiffs seek the return of "more than $850,000 in PIP benefits" paid because of Defendants' alleged scheme. Although Plaintiffs relatedly seek treble damages, declaratory relief, and costs, those potential damages do not change the Court's analysis. The demands for repayment do not hinge upon a showing that Defendants committed professional malpractice. Accordingly, Plaintiffs' allegations do not trigger the Affidavit of Merit Statute.

Defendants' motion for summary judgment was denied.

ZIFL OPINION

State Farm, and other insurers, that proactively sue the persons and entities they believe are defrauding them have found that taking money from fraudsters is more effective than the rare prosecution by the state of the fraud perpetrators. As victims of fraud any insurer has the right to be indemnified from the fraudsters and, more importantly, take the profit out of the crime. Waiting for a state prosecutor – especially with some state prosecutors who are averse to even prosecuting serious criminal activities like assault, battery, and murder, it is time that all insurers – if their SIU develops evidence that they are being defrauded – should proactively file for damages under the state fraud statutes and the federal RICO statutes.

Good News From the

Viola Bowman came home from shopping to find her husband Albert "Rusty" Bowman dead. He was covered in blood, slumped in his recliner. Someone broke in and shot Rusty in his head and chest, the Warsaw, Mo. woman frantically told 9-1-1. "Hurry, there's blood everywhere," she told the operator. Viola shot Rusty herself and made the scene look like a burglary. Her motive was life insurance money. Bowman told first responders that she was at Walmart buying desert during the shooting. When she arrived home, she encountered the most "traumatic, terrifying event of her lifetime," Bowman claimed. Yet items like a laptop, car keys and wallet weren't stolen. And officials described her reaction as "odd," and her statements were rife with inconsistencies. Bowman rejected a plea deal that would've sent her home with time served — she insisted she didn't shoot Rusty. So, Bowman went to trial, and a jury convicted her of murder and weapons charges. Sentencing comes later.

Several life insurers employed Brian Bartz — to their clients' ultimate dismay. The Rochester, N.Y. couple stole more than $1M from insurers and clients — including taking nearly $330K from a widow. Bartz made 105 false policy applications for people, without their knowledge. He received more than $380K in commissions and bonuses as a result. The widow handed Bartz $330K from her late husband's life insurance payout to invest. He spent all but $10K. He also stole $70K from victims' bank accounts to pay for premiums on the life policies he secretly took out. And Bartz lied to clients and prospects that he was an investment advisor. He misused their investment money to gamble and pay back other investors. Bartz provided clients with fake statements to hide his deception. He got five years in prison, and must repay his victims in full.

Delaware's governor signed two anti-fraud bills into law this week. One law makes the manufacture, sale and installing of counterfeit airbags a specific crime. The bill was backed by the Coalition and our partner American Honda Motor Company. Another important new law restricts access to traffic accident reports. They are no longer subject to disclosure as a public record. The law permits access to reports only by state and local law enforcement, insurers, fraud fighters and other officials connected to the incident. The law prevents outsiders from accessing the reports, then badgering crash victims to get fraudulent "injury" treatment and inflated vehicle repairs.

A Hawaii-based soldier beat his wife with a baseball bat then stabbed her the day after their anniversary in a rage-filled bid for $100K of life insurance. Army Spc. Raul Hernandez Perez and Selena Roth were divorcing. They lived in separate homes on Schofield Barracks, on Oahu. He searched online for how many swings it took to kill someone with a bat. Hernandez Perez then bought the $100K life policy on Dec. 15. He retrieved a baseball bat from the garage and hit Selena on the head four times as she lay face down early the morning of Jan. 10. When Hernandez Perez saw that Selena's chest was still rising and falling, he plunged a kitchen knife into her back four times. Selena's body was found on Jan. 13, stuffed in an outdoor trash bin, which he moved just inside Roth's house. Hernandez Perez pled guilty in military court, and will receive up to 65 years in prison when sentenced Sept. 21.

Blinded by greed, an eye doc grossly over-billed for minor procedures, charged for phantom tests and procedures and sent patients to collections if they refused to pay his bogus charges. Ameet Goyal (Rye, N.Y.) kept the scheme going for seven years. For example, he removed small bumps on patients' eyelids, a 15-minute procedure. He then billed for complex surgeries to remove eye tumors and do grafts to repair eyelids. The scheme involved numerous CPT codes for procedures and exams he never performed, and upcoded — stealing at least $3.6M. Goyal also stole more than $630K of federal loans intended to help small businesses during the pandemic. He filed for two separate businesses, despite running just one. Goyal also lied he didn't face criminal charges on the loan applications. He then used loan money for personal expenses such as country club dues. Goyal pleaded guilty and could spend decades in federal prison when sentenced Jan. 6.

Michael McNew bilked insurers as a crop agent and later as an adjuster in a $23M tobacco scam in Kentucky. The Mt. Sterling man teamed with farmers to inflate or invent crop damage, and falsify their acreage when adjusting damage claims against federal crop coverage. McNew then kept inflating and falsifying acreage and damage as an agent with ARMtech Insurance Services. He produced generic photos of losses that falsely showed damage to a specific producer's farm. McNew also submitted insurance applications for relatives and friends of his farmer co-conspirators — even though the "applicants" weren't farmers. That helped McNew spread out losses and obtain better guarantees. Roger Wilson owned Clay's Tobacco Warehouse in Mt. Sterling. Wilson arranged for farmers to buy poor-quality tobacco so they could use this tobacco to get fake grades that helped inflate their loss claims. He also produced fake sales receipts, shipping reports and bale tags. Wilson was responsible for over $9M of losses to the feds.

McNew received 86 months in federal prison, and Wilson a year. The feds and Kentucky fraud bureau teamed in the successful investigation and conviction.

Cancellation Rule Requires Contradictory Evidence to be Ignored

It's Not Nice to Lie to Your Insurer

An insurance company sought a judgment that an automobile insurance policy issued to a mechanic does not provide coverage for an accident involving the mechanic. After examining the mechanic under oath, the insurance company moved for summary judgment, arguing that the policy contained a business purpose exclusion for accidents occurring while road testing a vehicle, which the mechanic stated he was doing at the time the accident occurred. In *Tennessee Farmers Mutual Insurance Co. v. John A. Simmons et al.,* No. E2020-00791-COA-R3-CV, Court of Appeals of Tennessee, Knoxville (September 14, 2021) the insurer asked that the Court of Appeal reverse based on the cancellation rule.

FACTUAL BACKGROUND

John Arthur Simmons ("Simmons") worked as a diesel mechanic specializing in repairing vehicles and farming equipment that run on diesel engines. Jeremy Shipley ("Shipley") brought his 2005 Ford F-250 diesel pick-up truck to Simmons for repairs after the truck's oil pressure warning light came on. Three days later, on June 2, 2017, Simmons was involved in an automobile accident while driving Shipley's truck ("the Accident").

Celeste Miller and her husband, Robert Miller, sued Simmons, Shipley, and Shipley's wife, Stephanie Shipley, seeking compensation for personal injuries and property damage, alleging that Simmons negligently rear-ended the vehicle driven by Mrs. Miller while operating the truck for the purpose of "mechanical evaluation" with permission from the Shipleys.

Tennessee Farmers Mutual Insurance Company ("Farmers") had issued an automobile insurance policy to Simmons that was in effect on the date of the Accident. The policy contained a "business purpose" exclusion, which states: "**We** do not provide liability coverage . . . for any person or entity while employed or otherwise engaged in the business or occupation of selling, repairing, servicing, storing or parking vehicles designed for use mainly on public highways, including road testing and delivery."

On March 16, 2018, after receiving notice of the lawsuit filed by the Millers, Farmers conducted an examination under oath ("EUO") of Simmons as part of its investigation of the facts alleged by the Millers concerning the Accident. At the EUO Simmons and his wife both testified he was test driving the pickup to help in its repair.

Farmers filed a Complaint for Declaratory Judgment in the trial court, seeking a declaration that the policy it had issued to Simmons did not provide coverage for the Accident pursuant to the policy's business purpose exclusion. Farmers asserted that Simmons' statements during the EUO indicated that he was operating Shipley's truck "while engaged in his business and/or occupation of repairing and/or servicing vehicles." Simmons responded denying that he was road testing the truck at the time of the Accident. He asserted that he was "simply running personal errands" and that he had permission to use Shipley's truck until "Shipley got back in town and could arrange to pick up his vehicle."

The case was tried by a jury on March 9, 2020. Farmers called Shipley and Simmons to the witness stand; Simmons did not call any witnesses. Shipley testified he had taken his diesel truck to Simmons' Diesel at least twice before the Accident because he "trusted him more than [he] would a dealership." Shipley acknowledged that he would not have had a problem with Simmons driving the truck as part of repairing the vehicle. Simmons testified that Simmons' Diesel has been a licensed business in Loudon County for over ten years. He testified that Shipley was a repeat customer and that he had Shipley's truck on the date of the Accident only because Shipley had "brought it to be repaired." Simmons disputed that Shipley did not give him permission to use the truck for personal errands. He said Shipley told him that the truck "had a full tank of fuel, if I needed to drive it or wanted to drive it, I could."

Simmons admitted that when he was asked during the EUO if he was "test driving [the truck] or road testing it on June 2nd," he answered in the affirmative. He also acknowledged that when Shipley said to drive the truck, Shipley was "wanting to see if there's anything else wrong with it."

The case was considered by the jury, which found that the policy's automobile business exclusion did not exclude coverage for the Accident. On March 20, 2020, the trial court entered its judgment on the jury's verdict and ordered Farmers to provide Simmons with coverage for the Accident.

Farmers moved for judgment in its favor notwithstanding the jury's verdict because:

1. that the trial court erred in failing to apply the cancellation rule and allowing Simmons to contradict his own prior sworn testimony;
2. that the weight of the evidence preponderated against the jury's verdict that the automobile business exclusion did not apply; and
3. that the trial court erred in allowing Simmons to introduce evidence of an insurance agent's potential fault when comparative fault had not been alleged as an affirmative defense.

The trial court denied Farmers' motion. The trial court found that the weight of the evidence supported the verdict.

DISCUSSION

Under the cancellation rule, when a witness makes contradictory statements on the same question of fact, the statements cancel each other and, therefore, do not amount to evidence of the fact. The Tennessee Court of Appeal has observed that no sensible decision holds that a witness's testimony on a fact is automatically discounted simply because the witness contradicted himself or herself on that fact. Rather, the court assesses whether there is an explanation for the inconsistency and whether either version is corroborated by other evidence.

The question is not one of the credibility of a witness or of the weight of evidence; but it is whether there is any evidence at all to prove the fact. If the proof of a fact lies wholly with one witness, and he both affirms and denies it, and there is no explanation, it cannot stand otherwise than unproven. It would be mere caprice in a jury upon such evidence to decide it either way.

Upon a careful review of the record, we find that Simmons' statements are both contradictory and mutually exclusive. Simmons' assertions at trial directly contradict his prior sworn statements during the EUO that he was "test driving [the truck] or road testing it to see if there were any other problems that might need to be addressed" because Shipley "wanted to make sure it was fixed."

Before Farmers filed this declaratory action, Simmons had stated during the EUO that he was test driving the truck because Shipley wanted him to make certain it was fixed, and he never made any mention of running personal errands. At trial, Simmons added that the repair was completed on May 30, 2017, and that he was driving the truck at the time of the Accident to run personal errands. Given the circumstances and statements surrounding Simmons' contradictory statements, the Court of Appeal concluded that Simmons' competing accounts of the reason for using Shipley's truck at the time of the Accident cannot be reconciled.

Therefore, the Court of Appeal concluded that the trial court should have applied the cancellation rule to Simmons' testimony. When the rule is applied, the only remaining evidence supports but one conclusion: that Simmons was driving the truck for business purposes.

After applying the cancellation rule, the evidence in the record only supports the conclusion that Simmons was test driving the truck. Consequently, the trial court should have directed a verdict declaring that the automobile insurance policy Farmers issued to Simmons provides no coverage for the Accident pursuant to the policy's business purpose exclusion. As a result, the Court of Appeal remanded the case to the trial court for the entry of a verdict in favor of Tennessee Farmers Mutual Insurance Company.

ZIFL OPINION

The covenant of good faith and fair dealing requires that neither party do anything to deprive the other of the benefits of the contract. Simmons attempted to deprive Farmers of its right to exclude coverage while he was test driving the vehicle involved in the accident by changing his sworn testimony at trial from the sworn testimony at EUO. Since the two statements were contradictory they fell afoul of the cancellation rule and should have been ignored by the trial court and the jury. They were not and the judgment was reversed in favor of the insurer. What the court did not consider was that one of his sworn statements was false, sufficient grounds to deny the claim and void the policy.

Health Insurance Fraud Convictions

Health Plan Intermediaries Holdings, LLC To Pay $2 Million After Allegedly Misleading Customers About Health Insurance Coverage

Health Plan Intermediaries Holdings, LLC (HPIH) has agreed to pay $2 million to resolve allegations that HPIH and its third-party agents knowingly marketed and sold insurance policies that were being misrepresented as Affordable Care Act (ACA)-compliant to consumers, misleading consumers with limited coverage and large out-of-pocket costs. The Settlement also resolves allegations that HPIH illegally increased the cost of the coverage to policyholders to cover their broker fees, among other fees.

The Department alleged that HPIH, and HPIH agents with HPIH's knowledge, misrepresented to consumers the nature of coverages or benefits provided by the policy and other services that it packaged and sold. The Department further alleges that HPIH knowingly misrepresented policies to consumers to create the impression that the policies purchased were either a robust ACA-compliant policy or were as comprehensive as an ACA-compliant policy.

According to the Department's Order to Show Cause, one consumer was sold a policy represented to her as ACA-compliant and included coverage for hospitalization, when in fact she was sold a policy that included only limited medical benefits. When the consumer was later hospitalized, she incurred more than $26,000 in charges and received only $300 in policy benefits, leaving her personally responsible for the remainder of the bill.

Another consumer purchased what he believed to be a broad supplementary health insurance plan when in fact he was sold a limited insurance benefit with benefit caps of $250 a day and a surgery benefit of only $1,000. The consumer required surgery and incurred uncovered out-of- pocket medical expenses exceeding $85,000.

The Order further alleges that several other consumers signed up for coverage believing that they had an expansive network of physicians to choose from, prescription drug coverage, access to preventative care, and coverage for pre-existing conditions -- none of which were true -- leaving consumers with substantial uncovered out-of-pocket costs.

In addition to the $2 million settlement payment paid to the state's General Fund to benefit consumers, taxpayers, and residents, HPIH also agreed to reform several of its business practices, including a change in its sales and marketing practices.

The company does not admit wrongdoing in this settlement.

Bristol, Tennessee Man Sentenced for Healthcare Kickback Scheme

John Paul Linke, 58, conspired to receive and pay kickbacks to encourage urine drug screen testing performed by a lab in Florida. Some of the testing referred to the lab was paid for by Medicare, Virginia Medicaid, and TennCare. Co-conspirator **Michael Olshavasky**, of Miami, Florida, will be sentenced on September 22, 2021.

Linke, a Bristol, Tennessee man was sentenced September 16, 2021 to three months of home confinement for conspiring with another man to pay and receive kickbacks. In addition to home confinement, he will pay $56,000 in monetary penalties and will be permanently excluded from participating in federal healthcare programs.

According to court documents: "The defendant's diversion of critical federal and state funds that were needed to target the opioid crisis for his own greed is unconscionable,"

Healthcare providers who use kickback schemes like this one are not only defrauding the healthcare system, but they're also stealing from Virginia taxpayers just to line their own pockets. Virginians trust their healthcare providers to make the best decisions for their patients without monetary gain or outside influence. Those who seek to profit off the opioid crisis through illegal schemes make the problem worse. The authorities promised to investigate and bring to justice those who, through their dishonesty, jeopardize the public health.

Between November 30, 2015, and May 30, 2016, Linke was employed at an office-based opioid treatment program that used medication-assisted treatment for patients suffering from substance use disorder. In exchange for being paid $5,000 per month, Linke arranged for the clinic to send urine drug screen samples to the laboratory in Florida where Olshavasky worked. These payments were disguised as commissions paid to Linke as an "independent sales representative" for Olshavsky's company, Encore Holdings LLC. Olshavasky paid Linke at least $16,000 through Encore Holdings to direct WRC's drug screening business to the Florida lab, although Linke was not actually an independent sales representative for Encore, and he did not act as such.

Treatment Facility Owner Sentenced to Federal Prison for Health Care Fraud

Marcus Lloyd Anderson (36, St. Petersburg, Florida) was sentenced by U.S. District Judge Mary S. Scriven to one year and a day in federal prison for health care fraud. As part of his sentence, the court also entered a money judgment in of $323,248, which were the proceeds of the offense.

Anderson had pleaded guilty on April 30, 2020.

According to court documents, Anderson submitted bogus claims to the Florida Medicaid program and related managed care organizations for services that were never provided to patients. Anderson falsely claimed that patients had received counseling at his treatment facility when, as he knew, they were not there. In fact, some patients were hospitalized or placed in assisted living facilities elsewhere when Anderson lied, claiming they were in his care. Anderson also stole and misused the billing credentials of multiple doctors by billing for services he claimed they had rendered to patients at his facility, when those doctors had left his employment many months before. By lying about the services rendered and misusing billing credentials, Anderson stole more than $300,000 from these programs.

Georgia Genetic Testing Laboratory to Pay Up To $200,000 To Resolve Anti-Kickback Statute Claims

Alpha Genomix Laboratories, Inc. admitted it paid unlawful kickbacks to **Aiken Counseling Group, LLC** to induce genetic testing referrals, from April 2015 through December 2016**.**

The United States alleges that during this time period, Alpha Genomix disguised its kickbacks by paying the salary of an individual who primarily worked for Aiken Counseling Group. Further, the United States alleged most of the referrals were not legitimately ordered by a physician and were medically unnecessary. Medicare and South Carolina Medicaid paid for these fraudulent claims, which violated the Anti-Kickback Statute and the False Claims Act. Alpha Genomix Laboratories, Inc. will pay a $35,000 settlement upfront and a percentage of gross annual revenues up to a total of $200,000 to resolve the claims.

The allegations settled arose from a lawsuit filed by a psychiatrist formerly employed by Aiken Counseling Group, under the whistleblower provisions of the False Claims Act. Under the act, private citizens can bring suit on behalf of the government for false claims and share between 15 and 30% of the recovery.

The owner of the Aiken Counseling Group, **Lain Bradford**, was sentenced in February 2020 to three years of probation and ordered to pay restitution, after pleading guilty to health care fraud and drug offenses in a related case. Aiken Counseling Group filed for Chapter 7 Bankruptcy in January 2018 and is no longer in business.

Since the allegations, Alpha Genomix Laboratories was sold to new ownership.

Companies that seek unmerited payment for unnecessary and illegitimate services abuse the programs and divert funds meant to improve the health and prolong the lives of beneficiaries.

South Hills Pharmacist Pleads to Health Care Fraud Conspiracy, Fraudulently Obtaining Controlled Substances and Misbranding Drugs

Timothy W. Forester, 46, of Venetia, PA pleaded guilty to three counts before Senior United States District Judge David S. Cercone. Forester, a South Hills pharmacist pleaded guilty in federal court to charges of obtaining controlled substances by fraud, misbranding of drugs, and health care fraud conspiracy.

In connection with the guilty plea, the court was advised that Forester was a licensed pharmacist who owned four pharmacies – **Century Square Pharmacy** in West Mifflin, PA and **Prescription Center Plus** with locations in South Park, PA, McMurray, PA and Eight Four, PA. From on or about November 14, 2018, to on or about February 14, 2019, Forester admitted he knowingly, intentionally and unlawfully obtained oxycodone and hydrocodone, Schedule II controlled substances, by misrepresentations, fraud, and deception. Forester admitted he did not place the controlled substances into the inventories of the four pharmacies and did not maintain records to show the controlled substances were dispensed. In addition, Forester admitted he relabeled generic drugs as name brand medications and then sold them as if they were the more expensive drugs. Finally, Forester admitted filling prescriptions with generic drugs, but billing Medicare and Medicaid for the more expensive name brand drugs, thereby committing health care fraud and causing a loss to Medicare and Medicaid of approximately $680,000.

Judge Cercone scheduled sentencing for February 8, 2020 at 11:30 a.m. As to Count 1, the law provides for a maximum sentence of four years in prison, a fine of $250,000 or both. As to Count 11, the law provides for a maximum sentence of three years in prison, a fine of $250,000 or both. As to Count 12, the law provides for a maximum sentence of 10 years in prison, a fine of $250,000 or both. Under the Federal Sentencing Guidelines, the actual sentence imposed is based upon the seriousness of the offenses and the prior criminal history, if any, of the defendant.

Carterville Nurse Sentenced on Felony Drug and Health Care Fraud Charges

Joseph M. Mattingly, 42, according to court documents, diverted Schedule II controlled substance (Hydrocodone) pills from a patient and defrauded the Medicare program of the cost of the pills.

In 2018, Mattingly was employed as a nurse with Progress Port, a center for adults with intellectual disabilities in Williamson County. Between August 20, 2018 and October 30, 2018, Mattingly obtained possession of 25 Hydrocodone pills he falsely claimed he dispended to a Progress Port resident, which he diverted for his own personal use.

Mattingly took three Hydrocodone pills intended for the same Progress Port resident and replaced those pills with Tylenol, an over-the-counter medication at three separate locations.

Local Providers Agree to Settle Allegations of Improper Billing for Electro-Acupuncture Devices

Align Health and Holistic Medical Center, Inc. and **Align Health Management, Inc.,** (collectively "Align"), **Eric Anderson, P.A. d/b/a Anderson Chiropractic Clinic** ("**Anderson Chiropractic**"), their owners and a former employee have agreed to pay $163,400 to resolve allegations that they knowingly and improperly billed Medicare for electro-acupuncture using peri-auricular stimulation devices in violation of the False Claims Act ("FCA").

Align and Anderson Chiropractic are outpatient clinics located in Maryville, Tennessee that offer medical and chiropractic services for the treatment of pain. According to the contentions of the United States contained in the settlement agreement, between September 2016 and March 2019 Align and Anderson Chiropractic routinely presented, or caused to be presented, to Medicare false claims for payment for the placement of electro-acupuncture devices on patients. The placement of these devices was improperly billed under code L8679, which resulted in the clinics receiving payments from Medicare to which they were not entitled.

L8679 is a billing code for "implantable neurostimulator, pulse generator" devices that are surgically implanted into the central nervous system or targeted peripheral nerves through procedures that are typically performed by a surgeon in an operating room. However, the United States contends that Align and Anderson Chiropractic falsely billed Medicare under L8679 for electro-acupuncture devices they knew were not surgically implanted into their patients and for procedures that did not involve anesthesia or take place in an operating room. The underlying services for which Align and Anderson Chiropractic submitted the L8679 claims involved application of a device used for electro-acupuncture. Common brand names for this device include P-Stim, Stivax, NeuroStim, ANSiStim, E-Pulse, and NSS-2 Bridge. The electro-acupuncture devices were applied by inserting needles into patients' ears and by taping the devices behind their ears with an adhesive. Medicare does not reimburse for electro-acupuncture devices billed as neurostimulators and did not reimburse for acupuncture at all during the period of the covered conduct.

In addition to paying the civil settlement, which was based on the parties' ability to pay, Align, Anderson Chiropractic, and their owners have agreed to enter into an Integrity Agreement ("IA") with the Office of Inspector General of the Department of Health and Human Services ("OIG-HHS"). The IA requires, among other things, that Align, Anderson Chiropractic, and their owners implement specific measures intended to prevent future health care fraud and to address evolving compliance risks. These measures include training for staff on applicable health care fraud laws and submitting to a claims review conducted by an Independent Review Organization to ensure compliance with Medicare billing requirements.

Worcester Dental Office Manager Pleads Guilty to Role in Medicare Fraud Scheme

Robin Cronin, 58, of Worcester, Mass. pleaded guilty to one count of conspiracy to commit health care fraud and one count of health care fraud. U.S. District Court Judge Timothy S. Hillman scheduled sentencing for Jan. 21, 2022.

Cronin, pleaded guilty September 21, 2021 to her participation in a scheme to defraud the Massachusetts Medicaid program, commonly known as MassHealth.

Cronin was indicted along with **Dr. Anthony DiStefano III** and **Dr. Scott Cale**, dentists practicing in Worcester, for their roles in the Medicaid Fraud scheme.

According to the indictment, from 2014 to 2018, dental services that DiStefano personally delivered were billed to MassHealth using Cale's provider identification credentials. The purpose of this arrangement was to deceive MassHealth into paying for dental services that were not reimbursable as DiStefano had previously been terminated from the MassHealth provider program over concerns regarding the quality of care he provided to patients. Cale then allegedly paid DiStefano a share of the money that MassHealth paid Cale. Cronin, DiStefano's office manager, was aware of the arrangement and personally billed MassHealth for services that were not reimbursable, knowing that the claims were false.

DiStefano and Cale have pleaded not guilty and are considered innocent until proven guilty.

The charges of health care fraud and conspiracy to commit health care fraud provide for a sentence of up to 10 years in prison, three years of supervised release and a fine of up to $250,000. Sentences are imposed by a federal district court judge based upon the U.S. Sentencing Guidelines and other statutory factors.

Orlando Cardiologist Pays $6.75 Million To Resolve Allegations False Claims Act

Dr. Ashish Pal, a cardiologist based in Orlando, Florida, paid $6.75 million to resolve allegations that he violated the False Claims Act by performing medically unnecessary ablations and vein stent procedures.

The settlement resolves allegations that, from Jan. 1, 2013 to Dec. 31, 2019, Dr. Pal knowingly submitted false claims to federal health care programs for medically unnecessary ablations and vein stent procedures. The government alleged that Dr. Pal performed the ablations and stent procedures on veins that did not qualify for treatment under accepted standards of medical practice. Additionally, the government alleged that Dr. Pal made misrepresentations in patient medical records to justify the procedures, including overstating the degree of reflux and diameter of veins, and falsely documenting patient symptoms. The United States also alleged that, in many instances, the ablations were performed either exclusively or primarily by one or more ultrasound technicians outside their scope of practice.

To help ensure the alleged abuses outlined in this case do not reoccur, Dr. Pal and **Interventional Cardiology & Vascular Consultants, PLC** entered a detailed, multi-year integrity agreement with HHS-OIG. This integrity agreement contains training and reporting requirements as well as a quarterly claims review conducted by an Independent Review Organization, with the requirement that the review team includes at least one interventional cardiologist who is board certified. It also contains provisions for stipulated penalties and, possibly, the exclusion from federal health programs such as Medicare and Medicaid in the event of a breach of its terms.

The resolution obtained in this matter was the result of a coordinated effort between the Civil Division's Commercial Litigation Branch, Fraud Section and the U.S. Attorney's Office for the Middle District of Florida, with assistance from the Department of Defense Office of Inspector General, the FBI, the U.S. Department of Health & Human Services Office of Inspector General and the Office of Personnel Management Office of Inspector General.

Ophthalmologist Pleads Guilty to Seven-Year Healthcare Fraud Scheme and To Defrauding SBA Program Intended to Help Small Businesses During Covid-19 Pandemic

AMEET GOYAL, an ophthalmologist in Rye, New York, pled guilty September 13, 2021 to perpetrating a seven-year healthcare fraud scheme by falsely billing for millions of dollars of procedures he did not perform, and also to fraudulently obtaining two Government-guaranteed loans intended to help small businesses during the COVID-19 pandemic while facing charges on pretrial release for the healthcare fraud scheme. GOYAL pled guilty before U.S. District Judge Cathy Seibel to all charges in a six-count superseding Indictment.

According to the allegations contained in the Indictment, court filings, and statements made during court proceedings:

> At all relevant times, GOYAL owned and operated the ophthalmology practice **Ameet Goyal M.D. P.C**., doing business as **Rye Eye Associates**, with offices in Rye, Mt. Kisco, and Wappingers Falls, New York, and Greenwich, Connecticut (the "Practice"). Between 2010 and 2017, GOYAL engaged in widespread healthcare fraud by consistently "upcoding" simpler, lower-paying surgical procedures and examinations as complex, higher-paying major operations in fraudulent billings submitted to Medicare, private insurance companies, and patients. As a result, GOYAL fraudulently obtained at least $3.6 million in payments for procedures he did not perform. As part of the scheme, GOYAL routinely falsified patient medical records, authoring fictitious templated operative reports that matched the complex operation he billed rather than the different minor procedure he actually

performed. GOYAL also pressured other employees in the Practice to engage in the scheme, and threatened the livelihood of employees who refused to comply. GOYAL caused patients to pay thousands of dollars out of pocket for fraudulently billed charges, and initiated debt collection proceedings against patients who did not pay the full amounts of those false charges.

For example, GOYAL and others at the Practice routinely treated patients for an excision of a chalazion, a small bump on an eyelid, typically removed in less than 15 minutes. An excision of chalazion, when billed truthfully under its associated code, paid the Practice approximately $200 on average from patients and insurance programs. However, GOYAL systematically billed an excision of chalazion and other similar superficial eyelid procedures as if he had performed an orbitotomy together with a conjunctivoplasty, which are complex surgeries into the orbit of the eye, often to remove an orbital tumor together with grafting to close the resulting wound, that typically take an hour or more to perform. These substantial surgeries, as billed, paid the Practice approximately $1,400 on average from a combination of insurance and patient out-of-pocket payments. GOYAL also upcoded certain superficial procedures as an excision and repair of eyelid, a type of higher-paying eyelid surgery involving reconstruction or removal of certain lesions other than chalazions. During the relevant time period, GOYAL billed less than 40 chalazions under the billing code designated for excision of chalazion, while billing over 1,400 orbitotomies, over 700 bundled conjunctivoplasties, and over 1,600 excision and repair of eyelid surgeries, all of which he claimed to have personally performed. The scheme involved numerous other CPT codes for procedures and examinations not performed or upcoded, resulting in at least $3.6 million of ill-gotten gains for GOYAL.

The Coronavirus Aid, Relief, and Economic Security ("CARES") Act is a federal law enacted on March 29, 2020, designed to provide emergency financial assistance to the millions of Americans who are suffering the economic effects caused by the COVID-19 pandemic. One source of relief provided by the CARES Act was the authorization of hundreds of billions of dollars in forgivable loans to small businesses for job retention and certain other expenses through the Small Business Administration's ("SBA") Paycheck Protection Program ("PPP"). Applicants with pending criminal charges are ineligible for PPP loans. The PPP also limits each eligible borrower to one loan, and a maximum loan amount calculated based on a business's average monthly payroll expenses.

In or about April 2020, GOYAL applied to the SBA and Bank-1, a federally insured institution, for over $630,000 in Government-guaranteed loans through the SBA's PPP Program. Specifically, on or about April 21, 2020, GOYAL applied for a loan in the amount of $358,700 for the business "Ameet Goyal," with his own social security number and email address. On or about April 29, 2020, GOYAL applied for a second loan in the amount of $278,500, with a business name "Rye eye associates," using the Employer Identification Number for Ameet Goyal M.D. P.C and a different email address controlled by GOYAL. To substantiate each loan, however, GOYAL submitted the exact same underlying payroll expense report, showing the same employees and payroll costs.

On both applications, GOYAL falsely answered that he was not facing any pending criminal charges, and electronically placed his initials "AG" directly under his "No" response. GOYAL also falsely certified, among other things, that his business would not receive another PPP loan until the end of the year. After obtaining approval from Bank-1 and the SBA through his fraudulent misrepresentations, GOYAL executed loan notes for two loans. On May 4, 2020, GOYAL received the first loan of $358,700, and on May 11, 2021, GOYAL received the second loan of $278,500. GOYAL used the business checking account into which these funds were deposited to pay business and personal expenses, including by making a $1,800 payment to a country club in Westchester, New York, within days of receiving the first loan.

GOYAL, 58, of Rye, New York, pled guilty to all six counts in the Superseding Indictment. The first count charged healthcare fraud, which carries a maximum sentence of 10 years in prison; the second count charged wire fraud, which carries a maximum sentence of 20 years in prison; and the third count charged making false statements relating to health care matters, which carries a maximum sentence of five years in prison. Counts four, five, and six charged that while on pretrial release, the defendant committed the following offenses, respectively: bank fraud, which carries a maximum sentence of 30 years in prison; making false statements on a loan application, which carries a maximum sentence of 30 years in prison; and making false statements in a matter within the jurisdiction of the executive branch of the Government of the United States, which carries a maximum sentence of five years in prison. Additionally, a conviction under counts four, five, and six, if committed while on pretrial release, provides for an additional maximum sentence of 10 years in prison consecutive to any other sentence of imprisonment.

The maximum potential sentences are prescribed by Congress and are provided here for informational purposes only, as any sentencing of the defendant will be determined by the judge.

ZIFL can only wonder what took the US Attorney so long to charge this doctor who was not only violating the law but his oath to his patients to first do no harm.

Tennessee Doctor Pleads Guilty to Maintaining An Illegal Drug Premises

Dr. David Newman, 61, of Maryville, Tennessee pleaded guilty September 13, 2021 in the Eastern District of Tennessee to maintaining his Knoxville, Tennessee, pain clinic as an illegal drug premises.

According to court documents, Dr. Newman owned, operated, and was Medical Director of **Tennessee Valley Pain Specialists** (TVPS), a non-insurance, cash-equivalent pain clinic. Newman owned this clinic with **Dr. Steven Mynatt**. Newman continued to operate and serve as Medical Director of TVPS, despite knowing that Mynatt was prescribing opioids to patients outside professional

practice and for no legitimate medical purpose. Newman and Mynatt were charged with drug-related offenses as part of the April 2019 Appalachian Regional Prescription Opioid Strick Force Surge. Mynatt entered a guilty plea related to his distribution of controlled substances at TVPS in February 2020 and will be sentenced on Feb. 9, 2022.

Newman pleaded guilty to unlawfully maintaining a drug premises. He is scheduled to be sentenced on Feb. 9, 2022, and faces a maximum sentence of 20 years in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Ex-Owner of Virginia Assisted Living Facility Pleads Guilty to Fraud

Mable Jones, the former owner of a Richmond, Virginia, assisted living facility pleaded guilty to health care fraud after spending more than $800,000 meant for residents' care on travel, gambling expenses and personal debts, federal prosecutors said.

Jones owned and operated **Jones & Jones**, an assisted living facility for elderly and incapacitated adults, according to court documents. As a representative payee for residents who were legally incapable of managing their own funds, she regularly received state and federal benefit payments on their behalf.

Between December 2015 and the spring of 2019, when the facility closed, Jones spent more than $800,000 of residents' benefits on herself, leading to deficiencies that endangered residents' health and safety, court documents state. These conditions prompted state and federal audits and during those audits Jones made false statements, prosecutors said.

Jones faces a maximum of 10 years in prison at sentencing, which is set for Jan. 11.

Pain Doctor Convicted of Over $100 Million Health Care Fraud Scheme

Francisco Patino, 66, of Wayne County, excessively prescribed highly addictive opioids to his patients at his medical clinic in Livonia. In exchange for opioids, these patients would receive (or be billed as if they had received) facet joint or nerve block injections, both lucrative spinal injections. Although these spinal injections were purportedly intended to treat chronic pain, evidence at trial demonstrated that Patino injected patients without regard to medical necessity. Evidence also revealed that if patients refused to accept the injections, Patino would withhold their prescriptions for opioids. From January 2012 through July 2017, Patino billed Medicare for more of these injections than any provider in the country. The evidence at trial also showed that in 2016 and 2017, Patino prescribed more 30-milligram Oxycodone pills than every other provider in the state of Michigan.

A federal jury in the Eastern District of Michigan convicted Michigan doctor Patino September 22, 2021 for his role in masterminding and executing a complex scheme to defraud Medicare and other health insurance programs by administering medically unnecessary spinal injections in exchange for prescriptions of high doses of opioids to patients.

According to court documents and evidence presented at trial Patino also developed illegal kickback relationships with at least one diagnostic laboratory, under which he was paid in exchange for referring his patients' samples to that lab. The evidence showed that the labs funneled money into bank accounts held by others, who then distributed the money to Patino or spent it on his behalf. Patino also spent funds he derived from these various schemes on jewelry, cars, and vacations. A sizable portion of Patino's fraud proceeds were devoted toward the promotion of Patino's specialized diet program and lifestyle and wellness book. Patino paid Ultimate Fighting Championship and other mixed martial arts fighters to promote the Patino Diet.

Patino, who gained fame as an alligator-wrestling surgeon from Woodhaven, Michigan was convicted following a jury trial and after being accused of masterminding a more than $100 million health care fraud scheme — one of the largest in U.S. history.

The case against Patino drew wide interest because of the scope of the alleged crime and the doctor's outsized personality and appearance. Before spending three years in jail awaiting trial, Patino was frequently shirtless, posing next to bikini-clad women and flexing his muscles in social media posts and promotional photographs for his self-styled "Patino Diet." During a court hearing, Patino appeared dramatically thin, elderly and clothed — in an orange Livingston County Jail jumpsuit.

The surgeon has been detained amid allegations he hid millions of dollars in offshore bank accounts and concerns he would try to flee the United States if released on bond.

The Patino case is also linked to an investigation involving a $200 million scheme and businessman **Mashiyat Rashid**. Prosecutors say Rashid spent his share of the scheme on a $7 million Franklin mansion, courtside NBA tickets, a Lamborghini, Hermes clothes and rare watches.

Patino was convicted of one count of conspiracy to commit health care fraud and wire fraud, two counts of health care fraud, one count of conspiracy to defraud the United States and pay and receive health care kickbacks, one count of conspiracy to commit money laundering, and one count of money laundering. He is scheduled to be sentenced on Jan. 20, 2022, and faces a maximum total penalty of life in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Attorney General James Announces Conviction of Former Fugitive Dentist for Medicaid Fraud

Dawer Nadi Receives 4 and 1/3 to 10 Years Imprisonment Sentence and Ordered to Pay More Than $27,000 in Restitution After Second Conviction for Fraud and Related Crimes

Dawer Nadi, 63, of Long Island, was convicted for defrauding New York state by submitting false Medicaid claims for dental services after his dental license was revoked. Nadi was convicted last month of grand larceny, unauthorized practice of dentistry, and several counts of filing false Medicaid claims, and sentenced to 4 and 1/3 to 10 years imprisonment and ordered to pay $27,768.42 in restitution. Nadi's New York dental license was revoked in January 2011, following a previous conviction from the Office of the Attorney General (OAG) in March 2005 for fraudulently overbilling Medicaid for dental services. Sentencing concluded an investigation started by the OAG's Medicaid Fraud Control Unit (MFCU) in 2011 upon learning that Nadi continued to practice dentistry notwithstanding the revocation of his license. He was arrested last year after being a fugitive since 2012.

Following his first conviction in 2005, Nadi was barred from participating as a health care provider in the Medicaid program — a sanction known as "exclusion" — and was prohibited from receiving payment for treating Medicaid patients. At the time, Nadi agreed to pay the state restitution totaling $400,000 for the false claims he filed, but that debt remains unpaid. In January 2011, based on the 2005 conviction, Nadi's license to practice dentistry in New York state was revoked and he was prohibited from practicing dentistry altogether.

In early 2011, OAG detectives learned that Nadi was still practicing dentistry on Long Island and treating Medicaid patients. A subsequent investigation led to Nadi's arrest later that year and his indictment in 2012. After his arrest, Nadi fled to Afghanistan where he set up a dental practice. While an arrest warrant was issued for Nadi, the United States does not have an extradition treaty with Afghanistan and Nadi remained a fugitive until last year. In March 2020, as the COVID-19 pandemic spread worldwide, Nadi left Afghanistan and attempted to re-enter the United States. He was arrested on March 21, 2020 upon his arrival at JFK International Airport, and thereafter arraigned on the 2012 indictment.

The Honorable John B. Collins in Suffolk County Supreme Court, sentenced Nadi on his conviction after a jury trial of: Grand Larceny in the Third Degree, a class D felony; Unauthorized Practice of a Profession, a class E felony; and eight counts of Offering a False Instrument for Filing in the First Degree, all class E felonies. The court imposed a sentence of 4 and 1/3 to 10 years imprisonment and ordered the defendant to pay $27,768.42 in restitution.

Videos on YouTube and Zalma on Insurance from Barry Zalma

Over 320 Videos describing important insurance issues described by Barry Zalma and available to anyone who views or subscribes to the YouTube account. Issues include insurance fraud, definition of insurance, insurance as a contract of personal indemnity, millions for defense and not a dime for tribute and the tort of bad faith. Please subscribe. There are 62 Videos are at https://www.youtube.com/channel/UCFg7qxC0tVgKcMUqoUfnwPw/videos but I have had some difficulty posting new videos to my YouTube channel. I have posted about 320 videos on insurance, insurance claims, insurance law, and insurance fraud to this YouTube Channel my Rumble channel https://rumble.com/c/c-262921 and my blog, https://zalma.com/blog.

Other Insurance Fraud Convictions

Murder for Insurance Money

Adam Barness, 33, and **Manpreet Sidhu**, 42, were found guilty September 23, 2021 of first-degree murder and conspiracy.

The two men were convicted of murder in the death of a man whose body was in the front seat of an SUV pulled over by the California Highway Patrol in 2018. On Jan. 16, 2018, a CHP officer pulled over a speeding GMC Yukon near Highway 65 and James Road.

Barness and Sidhu were inside, as was the body of 49-year-old Evmir Miraflores Evangelista. There was "substantial trauma" to Miraflores' neck, and an autopsy confirmed he had been strangled, prosecutors said.

A search of the vehicle turned up gloves, metal wire, a large shovel and a full can of gas, according to prosecutors. Both Barness and Sidhu claimed to know nothing about Evangelista's death, but the investigation revealed Barness was the beneficiary of the slain man's life insurance policy.

Both defendants face 25 years to life in prison at a sentencing hearing scheduled Oct. 27.

Former New York Insurance Broker Sentenced to Prison For $1m Fraud Scheme

Brian Bartz of Rochester, New York, a former insurance broker is going to prison for defrauding insurance companies and individual investors out of more than $1 million.

Bartz was convicted of wire fraud and aggravated identity theft. He was sentenced to serve 70 months in prison by U.S. District Judge Charles J. Siragusa. Bartz was also been ordered to pay full restitution to the victims in this case.

Between January 2015 and January 2020, the defendant was employed as an insurance broker at several different life insurance companies, selling and servicing policies and receiving commissions and bonuses for selling such policies. In connection with his employment, Bartz submitted approximately 105 fraudulent policy applications in various individuals' names without their knowledge, utilizing actual names, social security numbers and dates of birth. As a result, life insurance policies were issued, and the defendant was paid a total of $382,740.63 in commissions and bonuses to which he was not entitled.

Bartz also used approximately $70,579.83 that he fraudulently withdrew from various bank accounts of unsuspecting clients in order to pay policy premiums on the fraudulent life insurance policies he obtained.

In addition, Bartz defrauded his insurance clients and potential clients by falsely claiming to also be an investment advisor, persuading individuals to invest funds that he never invested nor intended to invest. Rather than investing such funds on behalf of his clients, Bartz used them to gamble or to pay back prior investors.

To prevent victims from inquiring about their investments, Bartz issued fake account statements. The victims included a widow who "invested" a $332,500 payout from her deceased husband's life insurance policy with the defendant. Bratz stole all but $10,000 of that widow's investment. In total, the loss amount for Bartz's schemes was approximately $1,026,668.46.

Three Men Jailed in the U.K. Following Dangerous 50mph "Crash for Cash" Collision

Three Londoners have been jailed after deliberately causing a collision on a busy A-road which resulted in an innocent driver crashing into the back of their car at 50mph.

The group had attempted to claim £49,869.50 from motor insurers. However, CCTV footage and inconsistencies in the accounts of the men raised alarm bells with the insurer, who referred the case to City of London Police's Insurance Fraud Enforcement Department and the IFB.

The group were sentenced at Inner London Crown Court on Friday 17 September 2021 as follows:

- **Kudrat Azizi**, 34, of Poppy Court, Headstone Drive, Harrow, 20 months imprisonment.
- **Ghulem Haider**, 33, of Tadworth Road, Brent, 12 months imprisonment.
- **Miatullah Marufkhail**, 29, of Railway Approach, Harrow, 9 months imprisonment.

Stephen Dalton, Head of Intelligence and Investigations at the IFB, said:

> "These calculating 'Crash for Cash' fraudsters fueled by their selfish greed, clearly had no care for the pain and distress they caused their victim to suffer. I'm pleased that this gang has been brought to justice and that innocent road users in Hertfordshire are protected from the harm they posed. 'Crash for Cash' fraud will never be tolerated, and we are working closely with IFED and the insurance industry to put a stop to these appalling car crash scams."

The scam which took place in Hertfordshire saw the three fraudsters using two vehicles in a convoy, where the one in front would act as a decoy to divert suspicion by slamming the brakes so the innocent driver at the back of the queue of cars would crash into the second vehicle.

Crash for Cash scams are a serious problem in the UK. Recent analysis by the IFB shows that over 170,000 motor insurance claims made over a 15-month period were suspected of being potentially linked to the dangerous scam.

Guilty of Insurance Fraud

Christopher Katsikaris of Nampa, Idaho, was given mercy and was sentenced to two years of supervised probation and a $500 fine after being convicted of one count of insurance fraud.

Katsikaris plead guilty to the offense on June 21 after it was determined that damage he listed on a vehicle theft claim was present before the reported disappearance.

On April 16, 2018, Katsikaris reportedly filed a police report with the Nampa Police Department alleging that his vehicle had been stolen and submitted a claim for vehicle theft to his insurance company. When asked by the company whether the vehicle had any damage present prior to the theft, Katsikaris stated there were only minor dings. Five days later, the Owyhee County Sheriff's Office located the vehicle. The car had been partially stripped and was badly damaged.

While investigating the claim, Katsikaris' insurance company received photographs of his vehicle that were taken by his dealership on April 9, 2018, just a week before Katsikaris submitted a vehicle theft claim.

The pictures reportedly showed that much of the damage on the car was present before it was reported as stolen, and that items which Katsikaris had claimed were missing from the recovered vehicle, such as a roof rack, were not present. His claim was then denied.

When questioned by investigators at the Idaho Department of Insurance, Katsikaris admitted that he knowingly failed to inform his insurance company about the damage that was present on his vehicle before the reported theft, and that he had hoped that making the claim would lead his insurance company to pay to fix the damage.

In addition to probation and a fine, the court also imposed 150 days of suspended discretionary jail time which Katsikaris' probation officer may utilize as deemed necessary. Katsikaris must also pay $514.97 in restitution to the Idaho Department of Insurance and $2,528.22 to his insurance company.

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

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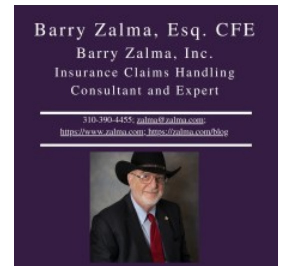
Barry Zalma, Esq., CFE, now limits his practice to service as an insurance consultant specializing in insurance coverage, insurance claims handling, insurance bad faith and insurance fraud almost equally for insurers and policyholders. He also serves as an arbitrator or mediator for insurance related disputes. He practiced law in California for more than 44 years as an insurance coverage and claims handling lawyer and more than 52 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.

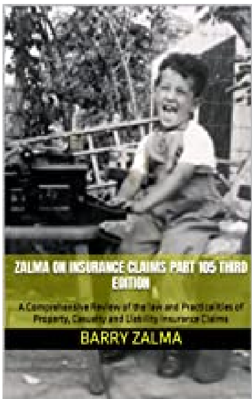


Over the last 53 years Barry Zalma has dedicated his life to insurance, insurance claims and the need to defeat insurance fraud. He has created the following library of books and other materials to make it possible for insurers and their claims staff to become insurance claims professionals.

Go to the podcast Zalma On Insurance at https://anchor.fm/barry-zalma; Follow Mr. Zalma on Twitter at https://twitter.com/bzalma; Go to Barry Zalma videos at Rumble.com at https://rumble.com/c/c-262921; Go to Barry Zalma on YouTube- https://www.youtube.com/channel/UCysiZklEtxZsSF9DfC0Expg; Go to the Insurance Claims Library – https://zalma.com/blog/insurance-claims-library/ Read posts from Barry Zalma at https://parler.com/profile/Zalma/posts; and the last two issues of ZIFL at https://zalma.com/zalmas-insurance-fraud-letter-2/ podcast now available at https://podcasts.apple.com/us/podcast/zalma-on-insurance/id1509583809?uo=4

New Books for the Insurance Claims Professionals

Zalma on Insurance Claims Part 105 Third Edition: A Comprehensive Review of the law and Practicalities of Property, Casualty and Liability Insurance Claims



by Barry Zalma | Sep 2, 2021

Kindle $9.95 Available instantly

Hardcover , $35.95

Paperback , $25.95

This is the fifth part of a Treatise on Insurance Claims consisting of a series of ten books, of which this is the latest addition to Barry Zalma's insurance claims Treatise that will form the most thorough, up-to-date, expert-authored insurance claims guide available today.

Written by nationally-renowned insurance coverage expert Barry Zalma, a semi-retired insurance coverage attorney, consultant, expert witness and blogger, Zalma on Insurance Claims provides in-depth explanations, analysis, examples, and detailed discussion of Property insurance claims; Third-party liability claims; Casualty claims; and Insurance Fraud.

Thorough, yet practical, this fifth part of the ten-part treatise form the ideal guide for any professional who works in, or frequently interacts with, the insurance industry. Claims professionals, risk managers, producers, underwriters, attorneys (both plaintiff and defense), and business owners will benefit greatly from the ten volume Treatise. It is also the perfect resource for insurance educators, trainers, and students whose role requires an understanding of insurance law.

As you read through the various volumes of Zalma on Insurance Claims, you will find comprehensive—yet comprehensible—coverage of key topics, dealing with all property, casualty and liability insurance.

Table of Contents

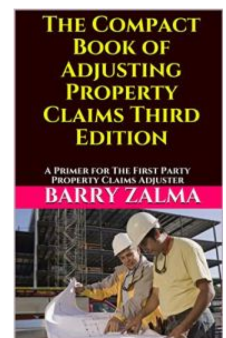
Chapter 1 Investigation of Liability Claims.
Chapter 2 Errors & Omissions & the Claims Made & Reported Policies
Chapter 3 The Notice-Prejudice Rule.
Chapter 4 Types of Torts.
Chapter 5 The Liability Claim File.
Chapter 6 Duty to Defend.
Chapter 7 Tests for Determining Duty to Defend:
Chapter 8 Scope of The Duty to Defend.
Chapter 9 Grounds to Reject Coverage for Defense or Indemnity.
Appendix 1 Form Letter to Expert
Appendix 2 Form Letter to Independent Medical Examiner
Appendix 3 Non Waiver Agreements
Appendix 4 Form Letter: Rescinding Automobile Policy.
Appendix 5 Form Letter: Rescission and Denial Letter
Appendix 6 Form Letter: Advising of Right to Appraisal
Appendix 7 Form Letter: Reservation of Rights Letter to Insured.
Appendix 8 Form Letter: Reservation of Rights Letter B.
Appendix 9 Authorization Forms
Appendix 10 California Actual Cash Value Statute.

The Compact Book of Adjusting Property Insurance Claims – Third Edition

A Manual for the First Party Property Insurance Adjuster Newly Updated and Edited

The insurance adjuster is not mentioned in a policy of insurance. The obligation to investigate and prove a claim falls on the insured. Standard first party property insurance policies, based upon the 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.

The policy allows the insurer to then, and only then, respond to the insured's proof of loss. The insurer can then either accept or reject the proof submitted by the insured.



Technically, if the wording of the policy was followed literally the insurer could sit back, do nothing, and wait for the proof. If the insured was late in submitting the proof the insurer could reject the claim. If the insured submits a timely proof of loss the insurer could either accept or reject the proof of loss. If the insurer rejected the proof of loss the insured could either send a new one or give up and gain nothing from the claim. Suit on the policy would be difficult because the policy contract limited the right to sue to times when the proof of loss condition had been met.

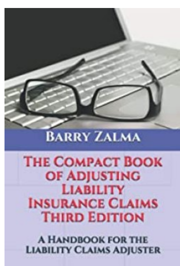
Insureds and insurers were not happy with that system. It made it too difficult for a lay person to successfully present a claim. The system, as written into the standard fire policy seemed to run counter to the covenant of good faith and fair dealing that had been the basis of the insurance contract for centuries. Most insurers understood that their insureds were mostly incapable of complying with the strict enforcement of the policy conditions. To fulfill the covenant of good faith and fair dealing insurers created the insurance adjuster to fulfill its obligation to deal fairly and in good faith with the insured.

The Third edition adds new material from 2018, 2019, and 2020 is easier to use and more compact than the original.

Available as a Kindle book. Available as a paperback.

The Compact Book on Adjusting Liability Claims – Third Edition

A Manual for the Liability Claims Adjuster Newly Updated and Edited



This *Compact Book of Adjusting Liability Claims* is designed to provide the new adjuster with a basic grounding in what is needed to become a competent and effective insurance adjuster. It is also available as a refresher for the experienced adjuster.

The liability claims adjuster quickly learns that there is little difficulty with a claimant (the person alleging bodily injury or property damage against a person insured) if the claim is paid as demanded. The insured may be unhappy if the claimant's claim is paid as presented since most do not believe they did anything wrong or fear an increase in premiums charged for subsequent policies.

The adjuster must be prepared to salve the insured's emotions, explain why in the law and the policy it was appropriate to pay the claimant and that the settlement is in the best interest of both the insured and the insurer the

adjuster represents.

The adjuster knows, and must be prepared to explain to an insured, that if a claim is resisted or denied the claimant will be unhappy, will probably file suit. If not promptly settled the claimant's lawyers will rake the insured over the coals to prove that the insured is liable for the claimant's injuries. The litigation will take time, effort, and money to establish the extent of the injuries and who is responsible for the injuries. Failure to settle promptly can cost the insured his or her reputation and will certainly cost the insurer much more than the claim could have been resolved for had it been resolved before the claimant retained a lawyer.

The Third edition adds new material from 2018, 2019, and 2020 is easier to use and more compact than the original.

Available as a Kindle book Available as a paperback.

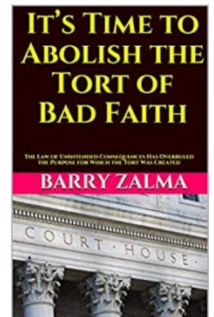
"It's Time to Abolish The Tort of Bad Faith"

The concept of unintended consequences is one of the building blocks of economics. Adam Smith's "invisible hand," the most famous metaphor in social science, is an example of a positive unintended consequence.

INSURANCE AS A NECESSITY

Neither the courts nor the governmental agencies seem to be aware that in a modern, capitalistic society, insurance is a necessity. No prudent person would take the risk of starting a business, buying a home, or driving a car without insurance.

The risk of losing everything would be too great. By using insurance to spread the risk, taking the risk to start a business, buy a home, or drive a car becomes possible.



Insurance has existed since a group of Sumerian farmers, more than 5,000 years ago, scratched an agreement on a clay tablet that if one of their number lost his crop to storms, the others would pay part of their earnings to the one damaged. Over the eons, insurance has become more sophisticated, but the deal is essentially the same. An insurer, whether an individual or a corporate entity, takes contributions (premiums) from many and holds the money to pay those few who lose their property from some calamity, like fire. The agreement, a written contract to pay indemnity to another in case a certain problem, calamity, or damage that is fortuitous, that is that occurs by accident, is called insurance.

In a modern industrial society, almost everyone is involved in or with the business of insurance. They insure against the risk of becoming ill, losing a car in an accident, losing business due to fire, becoming disabled, losing their life, losing a home due to flood or earthquake, or being sued for accidentally causing injury to another. The insurers, insureds, or people damaged by those insured are dependent on one another. In a country where human interactions are governed solely by the terms of written contracts, insurance would be a simple means of spreading risk and providing indemnity based on the promises made by the contract of insurance. But, in this the real world, insurance contracts are controlled by statutes enacted to ostensibly protect the consumer of insurance, regulations imposing obligations on the conduct of insurers and the decisions of trial and appellate courts interpreting insurance contracts.

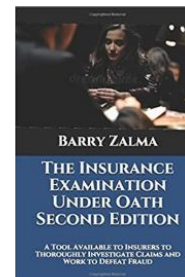
A simple insurance contract between two parties might say: "I insure you against the risk of loss of your engagement ring valued at $15,000 by all risks of direct physical loss except wear and tear for a premium paid by you of $15.00." Anyone who could read would understand that contract. If something happens to damage, destroy or lose the ring the insurer will pay you $15,000.00. However, insurers cannot write such a simple contract because the state requires many terms and conditions that complicate the policy wording and confuse the common person. The states and courts that did so had nothing but good intentions to protect the consumer against the insurer and control the actions of the insurer.

The tort of bad faith was created because courts felt that insurers treated their insureds badly and defeated the purpose for which insurance is acquired. It has served its purpose. Fair Claims Settlement Practices laws and regulations are now available to control insurers who do not act in good faith. Insurance fraud statutes and Regulations provide assistance to insurers who have been deceived by those they insure or who are victims of attempted insurance fraud.

It is time that all contracts, including insurance contracts, are treated like any other contract, and insureds who believe the insurer breached the contract of insurance can sue to recover the benefits promised by the policy.

Available as a paperback here. Available as a Kindle book here.

Legal Disclaimer



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New and Now Available from the Zalma Insurance Claims Library

The Insurance Examination Under Oath Second Edition

A Tool Available to Insurers to Thoroughly Investigate Claims and Work to Defeat Fraud

The insurance Examination Under Oath ("EUO") is a formal type of interview authorized by an insurance contract. It is taken under the authority provided by the agreement of the insurer, when he, she or it acquires a policy of insurance, to submit to a condition of the insurance contract that compels the insured to appear and give sworn testimony at the demand of the insurer. Failure to appear and testify is considered a breach of a material condition.

The EUO is conducted before a notary and a certified shorthand reporter who is present to give the oath to the person interviewed. The reporter will record the entire conversation and prepare a transcript to be read, reviewed, corrected and signed by the witness under penalty of perjury or by an oath taken before a notary or judge.

The EUO is a tool only sparingly used by insurers in the United States. A professional insurer will only require an insured to submit to an EUO when a thorough claims investigation raises questions: About the application of the coverage to the facts of the loss, the potentiality that a fraud is being attempted, or to assist the insured in the obligation to prove to the insurer the cause and amount of loss.

Although seldom used the EUO is an important tool needed by insurers when there is a question of coverage, destruction of evidence needed to prove a compensable loss or the amount of loss or evidence indicating the potential that a fraud is being attempted. The EUO and Legal Action provisions in an insurance policy are conditions precedent to an insured's ability to file suit, and that since the insured failed to substantially comply with the terms of those provisions, the appropriate remedy is dismissal without prejudice. The insured's failure to comply with these conditions does not bar his ability to bring suit to recover, but merely suspends his ability to bring suit until he has fully complied with those conditions.

Available as a paperback here or Available as a Kindle book here

Zalma on Insurance Blog Posting

- Requirements to Maintain Insurance as Part of a Construction Contract September 30, 2021
- Proactive Insurer Has to Fight to Renew Judgment Against Convicted Fraudster September 30, 2021
- Investigating the Extent of a Property Loss September 29, 2021
- Hospital Must Bill Primary Insurer Even if Medicare or Medicaid First Before Asserting a Lien September 29, 2021
- The Equitable Remedy of Subrogation September 28, 2021
- Investigation of Qui Tam Suit Not Covered by D&O Policy September 28, 2021
- How to Be a Whistleblower September 27, 2021
- Immediate Offer of Policy Limits Rejected by Plaintiff's Lawyer Seeking a Bad Faith Case September 27, 2021
- Evidence Needed to Prove Fraud September 24, 2021
- Even When Insured Fails to Defend Suit It is Difficult to Obtain Judgment September 24, 2021
- The False Claims Act and Qui Tam Actions September 23, 2021

- Insurers Beware: A Chink in the Armor of New York v. Sullivan September 23, 2021
- Retaining an Attorney by a Claims Person September 22, 2021
- Man Bites Dog Story: State Farm Sues Chiropractors for Fraudulent Claims September 22, 2021
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- Business Use Exclusion Is Reasonable and Common in a Homeowners Policy September 21, 2021
- Some Appellate Cases Establishing the Tort of Bad Faith September 20, 2021
- Cancellation Rule Requires Contradictory Evidence to be Ignored September 20, 2021
- How to Enforce Public Adjuster Ethics September 17, 2021

Insurance Fraud Costs Everyone

Fictionalized True Crime Stories of Insurance Fraud from an Expert who explains why Insurance Fraud is a "Heads I Win, Tails You Lose" situation for Insurers.

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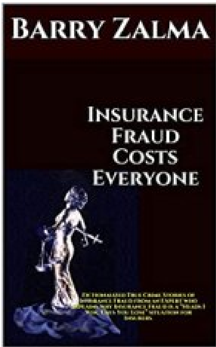


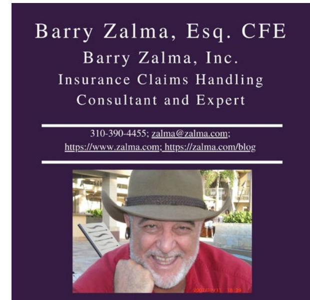
The stories help to Understand How Insurance Fraud in America is Costing Everyone who Buys Insurance Thousands of Dollars Every year and Why Insurance Fraud is Safer and More Profitable for the Perpetrators than any Other Crime.

This book started as a collection of columns I wrote and published in the magazines "Insurance Journal," "Insurance Week," and "The John Cooke Insurance Fraud Report" insurance trade publications serving the insurance community in the United States. Since the last edition I have added more stories that were published in my twice monthly newsletter, *Zalma's Insurance Fraud Letter* which is available free to anyone who clicks the links.

Available as a Kindle Book and Available as a Paperback from Amazon.com.

Barry Zalma, Esq., CFE

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



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