Zalma's Insurance Fraud Letter

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Quote of the Issue

"Socialism of any type leads to a total destruction of the human spirit."

Aleksandr Solzhenitsyn

Prosecution Proper for Accident in Missouri and Fraud in Kansas

Crossing a State Line to Present a Fraudulent Claim Doesn't Work

Under K.S.A. 2020 Supp. 21-5106(a)(1) and (b)(3), a Kansas court has jurisdiction over a crime partly committed in Kansas by a criminal actor who commits either (1) an act that constitutes a constituent and material element of the offense or (2) an act that is a substantial and integral part of an overall continuing criminal plan and the act causes an effect or consequence in Kansas close enough in time or cause to be a proximate result. Two courts found no jurisdiction but the Supreme Court read the whole statute and found jurisdiction in *State of Kansas v. Ivan Rozell,* No. 121, 094, Supreme Court of Kansas (April 22, 2022)

PRELIMINARY HEARING

The State's burden of proof at a preliminary hearing is not proof beyond a reasonable doubt, only probable cause. Probable cause at a preliminary examination signifies evidence sufficient to cause a person of ordinary prudence and caution to conscientiously entertain a reasonable belief of the accused's guilt. To determine whether the State has met this burden, a preliminary hearing judge does not pass on credibility, and, when evidence conflicts, the judge must accept the version of the testimony most favorable to the State.

FACTS

Rozell committed no acts related to the insurance fraud charges while physically in Kansas. Given that, Rozell argues the Wyandotte County District Court lacked jurisdiction to prosecute him because Kansas laws have no extraterritorial effect.

Crimes sometimes involve multistate conduct. And the United States Supreme Court has recognized that "[a]cts done outside a jurisdiction, but intended to produce and producing detrimental effects within it, justify a state in punishing the cause of the harm as if [the defendant] had been present at the effect." [*Strassheim v. Daily*, 221 U.S. 280, 285, 31 S.Ct. 558, 55 L.Ed. 735 (1911).] Both the district court and the Court of Appeals disagreed with the State.

Rozell was in a minor vehicle collision with Saul Lopez at an intersection in Kansas City, Missouri. Lopez did not obey the right of way and hit Rozell's vehicle, but any contact between the vehicles was minimal. Lopez gave Rozell insurance information. Rozell told Lopez he was fine and declined Lopez' offer to call police.

Lopez' father held title to and insured the vehicle Lopez was driving at the time of the accident. His father lived in Kansas City, Kansas, and was insured under a Kansas insurance policy issued by State Farm Insurance through an agent based in Kansas. Lopez also lived in Kansas City, Kansas.

Rozell faxed a copy of a hospital bill to State Farm. The bill was for services received at Research Medical Center in Missouri. The State Farm representative thought the amount of the bill-around $52,000- was disproportionate to the severity of the collision. He contacted Rozell and asked whether Rozell had submitted the correct document. Rozell confirmed he had. The representative transferred the claim to a special investigations department at State Farm.

The special investigator, Michael Haire, was based out of a State Farm office in Kansas. Haire reviewed the original medical bill Rozell had submitted to State Farm and a second one Rozell sent after his initial claim. Haire determined the first bill was for medical expenses incurred two days before the vehicle collision.

A records custodian for Research Medical Center also reviewed the original bill and noticed its discharge date did not match the hospital records. State Farm declined to pay Rozell's claim and submitted a fraud report to the Kansas Insurance Department. The State then charged Rozell with insurance fraud and making a false information.

The preliminary hearing judge found probable cause to bind over Rozell for trial for insurance fraud and making a false information.

A different judge than the one who heard the preliminary hearing conducted a hearing on Rozell's second motion. The judge granted the motion to dismiss based on lack of jurisdiction.

The State appealed arguing Kansas courts had jurisdiction. Rozell did not file briefs or appear during the appeal. The Court of Appeals affirmed the dismissal, holding the State had not established jurisdiction. The State timely petitioned for review, which the Supreme Court granted.

ANALYSIS

The issue presented to the district court was whether the State presented sufficient evidence at the preliminary hearing to establish probable cause that Kansas had jurisdiction. Resolving this issue required the Supreme Court to interpret the statutes.

Legal Framework for Proximate Cause Jurisdiction

Rozell focused on constitutional and statutory provisions about a defendant's right to have a trial in the county or district where the crime, or one or more elements of the crime, were committed. Consistent with *Strassheim*, 221 U.S. at 285, the United States Supreme Court has held that this Sixth Amendment provision does not defeat a state's territorial jurisdiction over a crime partly committed in multiple states. The Court considered *United States v. Rodriguez-Moreno*, 526 U.S. 275, 281, 119 S.Ct. 1239, 143 L.Ed.2d 388 (1999) which held that "'[W]here a crime consists of distinct parts which have different localities the whole may be tried where any part can be proved to have been done.'").

For a Kansas court to have jurisdiction under K.S.A. 2020 Supp. 21-5106(b)(3), there must be a direct connection or nexus between the defendant's act or acts outside Kansas and the result in Kansas.

The State charged Rozell with crimes that do not necessarily require someone, or something, to suffer harm. Rozell can be found guilty of both charged crimes even though the insurance company denied his claim.

Under K.S.A. 2020 Supp. 21-5106(a)(1) and (b)(3), a Kansas court has jurisdiction over a crime partly committed in Kansas by a criminal actor who commits either (1) an act that is a constituent and material element of the offense or (2) an act that is a substantial and integral part of an overall continuing criminal plan and that act causes an effect or consequence in Kansas close enough in time or cause to be a proximate result.

Insurance Fraud

The crime requires that a person:

1. communicates information to an insurer, here communications about medical records and bills alleged to be related to treatment for injuries incurred in the automobile accident;
2. knows the communication contains materially false information, here, for example, the alleged alteration of the date on which Rozell received medical care;
3. submits the false information in support of an insurance claim or benefit or insurance application, here Rozell's claim against Lopez' father's insurance; and
4. acts with the intent to defraud, which a reasonable person might infer from Rozell's submission of the allegedly altered bill.

The State argues that "it is indisputable that the insurance company that issued the policy is harmed when it is subject to a fraudulent claim." State Farm's investigator in Kansas, testified to steps he took in Kansas to investigate the claim, which included interviews with Lopez and Lopez' father and taking photographs of the damage to the car Lopez drove. The referral of the fraud investigation to the Kansas investigator and the follow-up appointment with the Kansas insured both occurred within one month of the accident and directly flowed from Rozell's submission of paperwork documenting his claim. And these actions were integral to State Farm's review of Rozell's claim. A reasonable inference may be drawn in the light most favorable to the State that Rozell's submission of an allegedly fraudulent claim was an act that caused proximate results in Kansas.

Making A False Information

The evidence at the preliminary hearing was sufficient to establish the allegedly altered paper made its way to Kansas where the investigating agent drew conclusions about whether State Farm should pay or deny Rozell's claim. This evidence is sufficient to cause a person of ordinary prudence and caution to conscientiously entertain a reasonable belief Rozell's actions led to the consequence or result in Kansas of attempting to influence Haire to approve Rozell's claim.

Jurisdiction

The Supreme Court concluded that the State presented sufficient evidence to establish probable cause that Rozell's actions of submitting an allegedly false claim, which he supported with allegedly altered documents, with the alleged intent to defraud State Farm caused a consequence or effect in Kansas close enough in time or cause to the alleged criminal acts of insurance fraud and making a false information to qualify as a proximate result that allows Kansas to exercise jurisdiction.

ZIFL OPINION

The Supreme Court of Kansas found that the two lower courts allowed a technicality – an activity in the sister-city of Kansas City, Missouri to Kansas City, Kansas defeated criminal jurisdiction although the investigation and expenses incurred by State Farm happened in Kansas, was an act of form over substance. Rozell will be tried for insurance fraud in Kansas and should be convicted since the medical bills submitted were obviously fraudulent and for services provided before the accident.

Wisdom

"So long as the people do not care to exercise their freedom, those who wish to tyrannize will do so; for tyrants are active and ardent, and will devote themselves in the name of any number of gods, religious and otherwise, to put shackles upon sleeping men." —**Voltaire**
"The man who moves a mountain begins by carrying away small stones." – **Confucius**
"The simplest acts of kindness are by far more powerful than a thousand heads bowing in prayer." **— Mahatma Gandhi**
"[Judges'] minds should not be distracted with jarring interests; they should not be dependent upon any man, or body of men." —**John Adams**
"The ultimate authority ... resides in the people alone. ... The advantage of being armed, which the Americans possess over the people of almost every other nation ... forms a barrier against the enterprises of ambition, more insurmountable than any..." — **James Madison**
"One of the most pathetic — and dangerous — signs of our times is the growing number of individuals and groups who believe that no one can possibly disagree with them for any honest reason." —**Thomas Sowell**
"No loss by flood and lightning, no destruction of cities and temples by hostile forces of nature, has deprived man of so many noble lives and impulses as those which his intolerance has destroyed." — **Helen Keller**
"To curtail free expression strikes twice at intellectual freedom, for whoever deprives another of the right to state unpopular views necessarily deprives others of the right to listen to those views." — **C. Van Woodward**
"From the saintly and single-minded idealist to the fanatic is often but a step." —**Friedrich August von Hayek**
"Only in Congress do people adjust to economic adversity and growing deficits by spending more money." —**Thomas Sowell**
"The censor's sword pierces deeply into the heart of free expression." —**Earl Warren**
"The natural cure for an ill-administration, in a popular or representative constitution, is a change of men." —**Alexander Hamilton**

Doctor Who Defrauded Health Insurers Tried TO Back Out OF Plea Deal

In *State Of New Jersey Amgad A. Hessein,* No. A-0983-20, Superior Court of New Jersey, Appellate Division (April 26, 2022) Dr. Amgad A. Hessein, a physician facing a thirty-eight-count indictment alleging billing fraud related to his medical practice, was on the verge starting his trial after completion of jury selection when he pled guilty to second-degree theft by deception, N.J.S.A. 2C:20-4(a), and second-degree health care insurance claims fraud, N.J.S.A. 2C:21-4.3(a).

As part of the plea agreement, the prosecutor gave a gift to Dr. Hessein by dismissing the remaining thirty-six counts because defendant entered into a consent order requiring forfeiture of $2,000,000 and directing that he pay restitution in the amount $235,093.75.

Prior to sentencing defendant to an aggregate eight-year prison term and ordering forfeiture of funds and restitution, Judge John M. Deitch denied defendant's motion to withdraw his guilty pleas.

FACTS

In March 2020, defendant filed a motion to withdraw his guilty pleas and vacate his sentence. Before the motion was heard, defendant filed a verified petition for post-conviction relief (PCR) alleging trial counsel was ineffective by permitting him to enter guilty pleas including "an illegal civil consent order . . . forfeit[ing] property and money without . . . a restitution hearing," and by allowing him to plead guilty "to second [-] degree health [] care insurance fraud instead of proceeding on a theory third[-]degree reckless health[ ]care insurance fraud."

Defendant also made claims against appellate counsel, contending ineffective assistance of counsel by not challenging: the legality of the forfeiture consent order and the lack of a restitution hearing; and the factual basis of the guilty plea to second-degree health care insurance fraud. Judge Deitch issued an order denying defendant's motion and his PCR petition without an evidentiary hearing.

DISCUSSION

To withdraw a guilty plea after sentencing a defendant, to establish vacation, it is necessary to correct a manifest injustice. In considering whether relief is appropriate, the motion judge must weigh the four factors identified in *State v. Slater*, 198 N.J. 145, 157-58 (2009):

1. whether the defendant has asserted a colorable claim of innocence;

2. the nature and strength of defendant's reasons for withdrawal;
3. the existence of a plea bargain; and
4. whether withdrawal would result in unfair prejudice to the State or unfair advantage to the accused.

Applying *Slater*, Judge Deitch properly exercised his discretion in determining that these factors did not weigh in defendant's favor and thus denied defendant's motion because there was no showing of a manifest injustice.

As for the first factor, the judge held that defendant – as the judge did in denying defendant's previous motion to withdraw guilty pleas affirmed by this court on direct appeal – failed to set forth any colorable claim of innocence.

As for the second factor, the judge rejected defendant's argument that there was a strong reason for plea withdrawal and that the court's forfeiture order was illegal because it was based on a "civil consent judgment" used by the State to gain an unfair upper hand in criminal plea negotiations. Defendant's consent order addressed both restitution and forfeiture of defendant's property in the context of criminal proceedings, and there was no reference in the order to a civil judgment or any judgment being entered against the defendant.

As for the third factor, the judge noted that defendant reached a plea agreement, which typically isn't "given great weight in the balancing process," and highlighted that defendant had the "heavier burden in seeking to withdraw pleas entered as a part of a plea bargain." The factor therefore weighed against defendant.

As for the fourth factor the judge explained that when there are colorable reasons for withdrawal, coupled with an appropriate assertion of innocence, arguments against permitting withdrawal of a plea prior to sentencing weaken considerably absent unfair prejudice or advantage. The judge held that as defendant did not offer proof of the other three factors to support withdrawal of his plea, and the State showed it would be prejudiced if a withdrawal was granted because "many of [its] witnesses [were] elderly or infirm and could no longer be available at trial." Hence, the factor weighed against defendant.

To succeed on a PCR claim, a defendant must demonstrate: (1) counsel's performance was deficient, and (2) the deficient performance actually prejudiced the accused's defense. *Strickland v. Washington*, 466 U.S. 668, 687 (1984); *see also State v. Fritz*, 105 N.J. 42, 58 (1987) (adopting the two-part *Strickland* test in New Jersey).

There was no deficient performance by trial counsel which prejudiced defendant, therefore appellant counsel was not ineffective for failing to raise an issue that would not have constituted reversible error on direct appeal. Defendant's criminal consent order requiring the forfeiture of money was legal. The judge aptly reasoned that since "there was no illegal plea bargain to warn [d]efendant against accepting," trial counsel was not ineffective, and thus "there was no issue for appellate counsel to raise."

Regarding appellate counsel's alleged failure to argue that trial counsel erred in permitting defendant to plead guilty to second-degree health care insurance fraud rather than advancing a theory of third-degree reckless health care insurance fraud, the judge properly noted defendant "knowingly and intelligently pled guilty to second[-]degree health care [insurance] claims fraud," as evidenced in the trial record. The judge further commented that the factual sufficiency of defendant's plea was raised and rejected on direct appeal.

The trial judge properly found that defendant failed to demonstrate there was any evidence supporting a third-degree reckless health care insurance claim fraud instead of a second-degree offense.

Finally, Judge Deitch did not abuse his discretion in not conducting an evidentiary hearing. There were no disputed facts regarding entitlement to PCR that could not be resolved based on the existing record and defendant failed to set forth a *prima facie* case of ineffective assistance of counsel.

ZIFL OPINION

Insurance criminals have no honor. Dr. Hessein was facing a great deal of jail time, fines and restitution orders and a trial charging him with thirty two counts of major fraud. He pleaded guilty to one count and agreed to restitution. After he was sentenced to jail on the plea, he changed his mind and wanted to withdraw his plea and go to jail after most of the witnesses against him were dead or infirm. It wasn't even a good try and he obviously used the fraudulent money he gained that were not taken by the court to fund this stupid, second appeal, trying to withdraw his plea. Hopefully he will be able to help the health of his fellow prisoners.

Drivers Admit Lying When They Apply for Auto Insurance Coverage

How Much Americans Think They Save By Lying on Auto Insurance Applications

In an article at https://www.propertycasualty360.com/2022/05/10/how-many-americans-lie-on-auto-insurance-applications/ the authors report about a survey that showed that the primary reason Americans lie to car insurance companies is to save money. About a third of survey participants said they lie because they're a high risk and know they'd pay higher premiums telling the truth.

The fibbing survey participants estimated they'd save an average of $362 per month or $4,342 per year. While it's difficult to know how that matches up to any actual savings, it's a significant amount. Even honest people can be tempted to lie with such savings, especially now with inflation adding to everything that a person in the U.S. may need to buy.

How Gender Affects Lying on Auto Insurance Applications

Finder.com's study found that men (19.8% or 23.9 million) lie more often than women (8.9% or 11.9 million) on car insurance applications. The high discrepancy may be because young men pay some of the highest auto premiums.

How Age Affects Lying on Auto Insurance Applications

According to the collected data it was concluded that Millennials are the most likely to lie when applying for car insurance. Here's more data on the age of those who lie on applications:

- 17.9% of Gen Z
- 22.5% of Millennials
- 18.1% of Gen X
- 4.0% of Baby Boomers
- 3.4% of the Silent Generation

Since younger drivers typically pay higher rates than older drivers, they may have more incentive to lie on applications to save money.

The following shows the estimated monthly median auto insurance savings for those who lie on applications:

- Gen Z — $113
- Millennials — $100
- Gen X — $104
- Baby Boomers — $50
- Silent Generation — $37

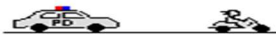
How Location Affects Lying on Auto Insurance Applications

The study by Finder.com at https://www.finder.com/lying-on-insurance also analyzed the location of those who lie on car insurance applications. Drivers in the West (16.3%) were most likely to lie, and those in the Midwest (11.1%) were the least likely.

The Downside to Lying on Auto Insurance Applications

It may be tempting to lie when applying for auto insurance, especially if you think it will save a significant amount of money on premiums. However, the downside is that if an insurer discovers you fraudulently obtained coverage by lying on an application, they can deny your claim and, in states like California or New York, rescind your policy from its inception or in other states they can cancel your coverage.

Therefore, it's wise for insurers to communicate the financial dangers of not being truthful to potential policyholders. They should encourage consumers to consider legitimate ways to cut the cost of coverage by taking advantage of available car insurance discounts, shopping around, and comparing multiple quotes to find affordable coverage that meets their needs.



Free Insurance Videos

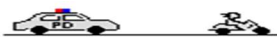
Barry Zalma, Esq., CFE has published five days a week videos on insurance claims, insurance claims law, insurance fraud and insurance coverage matters at https://www.rumble.com/zalma.

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

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

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

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



Convicted Fraudster Frivolously Keeps Trying to Avoid Jail

Those Who Commit Insurance Fraud Have Funds to Issue Interminable Motions & Appeals

Insurance fraud convictions are unreasonably rare and when the perpetrator is convicted the convicted defendant seems to have unlimited funds to appeal the convictions. Imtiaz Shareef, after his conviction, unsuccessful in his first appeal filed a new appeal claiming his lawyers failed him.

In *Imtiaz Shareef v. United States of America,* Nos. 3:22-cv-001144-RJC, 3:18-cr-00157-RJC-DCK-3, United States District Court, W.D. North Carolina, Charlotte Division (May 4, 2022) the USDC put a stop to Shareef's appeals.

BACKGROUND

On April 19, 2018, a federal grand jury indicted Petitioner Imtiaz Shareef, along with three coconspirators, on one count of wire fraud and bank fraud conspiracy in violation of 18 U.S.C. § 1349 (Count One) and one count of money laundering conspiracy in violation of 18 U.S.C. § 1956(h) (Count Two). As to Count One, the Indictment charged that, "[f]rom in or about April 2009 through in or about April 2018, … [Petitioner and the coconspirators] did knowingly … conspire … to commit offenses against the United States, including violations of Title 18, United States Code, Sections 1343 (wire fraud) and 1344 (bank fraud)."

Title 18, Section 1349 provides:

> Any person who attempts or conspires to commit any offense under this chapter shall be subject to the same penalties as those prescribed for the offense, the commission of which was the object of the attempt or conspiracy. [18 U.S.C. § 1349].

Petitioner proceeded to trial and the jury convicted him on both counts. On Count One, the jury specifically found that "wire fraud, in violation of 18 U.S.C. § 1343" and "bank fraud, in violation of 18 U.S.C. § 1344" were objects of the conspiracy. Petitioner was sentenced to a term of imprisonment of 57 months on each count to be served concurrently.

On appeal, Petitioner argued that "the insurance fraud scheme supporting the wire fraud object of the conspiracy concluded prior to the running of the statute of limitations and, even if the charge was timely, insufficient evidence supported the jury's verdict." *United States v. Shareef,* 852 Fed. App'x 92, 93 (4th Cir. 2021). The Fourth Circuit affirmed the USDC's judgment. He also unsuccessfully argued that prior acts evidence was inappropriately admitted against him and that his trial counsel was ineffective for failing to request a "reliance-on-expert" jury instruction.

Not deterred by his failure at the Fourth Circuit, on March 30, 2022, Petitioner filed a new motion in the USDC and made two claims:

1. prosecutorial misconduct for the Government submitting 18 U.S.C. §§ 1343 and 1344 to support Petitioner's conviction without submitting such statutes to the grand jury; and
2. ineffective assistance of trial and appellate counsel for failing to adequately introduce into the record evidence showing that Petitioner was indicted only for violations of 18 U.S.C. § 1349 and 18 U.S.C. § 1956 (h), and allowing the Government to convict or maintain a conviction for Title 18 U.S.C. 1343 and 18 U.S.C. 1344 unconstitutionally.

Shareef asked that his conviction be vacated for what he alleged were many due -process violations.

DISCUSSION

Prosecutorial Misconduct

The Verdict Form submitted to the jury mirrored the charges set forth in the Indictment. And, consistent with the Indictment, the jury found that "wire fraud, in violation of 18 U.S.C. § 1343" and "bank fraud, in violation of 18 U.S.C. § 1344" were objects of the conspiracy. There was, therefore, no prosecutorial misconduct relative to the sufficiency of the Indictment or the way the charges were presented to the jury.

Ineffective Assistance of Counsel

The Sixth Amendment to the U.S. Constitution guarantees that in all criminal prosecutions, the accused has the right to the assistance of counsel for his defense. To show ineffective assistance of counsel, Petitioner must first establish a deficient performance by counsel and, second, that the deficient performance prejudiced him. In making this determination, there is a strong presumption that counsel's conduct falls within the wide range of reasonable professional assistance. Furthermore, in considering the prejudice prong of the analysis, the Court can only grant relief if the result of the proceeding was fundamentally unfair or unreliable. Under these circumstances, the petitioner bears the burden of affirmatively proving prejudice. [*Bowie v. Branker,* 512 F.3d 112, 120 (4th Cir. 2008)].

If the petitioner fails, as did Shareef, to meet this burden, a reviewing court need not even consider the performance prong.

Appellate counsel is not required to assert all non-frivolous issues on appeal. Rather, it is the hallmark of effective appellate advocacy to winnow out weaker arguments and to focus on more promising issues.

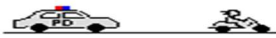
A decision with respect to an appeal is entitled to the same presumption that protects sound trial strategy. Additionally, the petitioner still bears the burden of showing that there is a reasonable probability that but for counsel's failure to raise an issue on appeal, the result of the proceeding would have been different; i.e., that he would have prevailed on appeal.

The Indictment plainly set forth that the objects of the conspiracy were the violation of 18 U.S.C. §§ 1343 and 1344 and Petitioner was convicted accordingly. There was no deficient performance by Petitioner's trial or appellate counsel for their failure to raise or attempt to support a frivolous argument.

Petitioner's Motion to Vacate, Set Aside or Correct Sentence under 28 U.S.C. § 2255 [Doc. 1] was denied and the USDC refused to allow further appeal.

ZIFL OPINION

The USDC refused to properly allow Shareef to abuse the judicial process a second time and kept him jailed in accordance with his conviction. The court, in addition, to ruling on this frivolous motion should have sanctioned Shareef and his lawyers for wasting the time of the court with a frivolous appeal.



Good News From the

An NBA assistant coach filched $350,000 from the league's health plan for retired players, federal officials allege in New York City. Kenyon Dooling was a former NBA player, Utah Jazz assistant coach and VP of the player's association. Dooling is among the latest of 19 people charged with billing the plan $5 million for fake med and dental services. *Here are the federal allegations:* The suspected scheme allegedly was led by former New Jersey Nets and Houston Rockets shooting guard Terrence Williams. Dooling recruited others to join in and made false claims himself. He pocketed $350,000 in the process. One alleged *Twitter feed:* **Dooling:** Let's make this thing grow sir. Dentist Aamir Wahab: Lol I'm down bro[.] Get me the whole NBA. **Dooling:** Yes we will[.] *Dooling contacts another suspect:* "Hey bro, here's the breakdown: 5600 for you and me. Then 10800 for the guy. I fronted him 4300$ so you can put it with my 5600=9800 to My [bank account] … That way everything is under 10k." Dooling is now suspended as Jazz assistant coach.. He also spent parts of 13 seasons as a player with seven NBA teams.

An agent ambushed clients, looting them for her own gain. Koreasa M. Williams persuaded her client to cash in several life policies to invest the proceeds in annuities the Tucson, Ariz. agent said she'd procure. Over six months in 2019, Williams convinced her client to give her $1.2 million. She used nearly $900,000 to pay victims of a prior unrelated annuity scheme in an attempt to avoid criminal charges. Williams later pleaded guilty in the unrelated con and was sentenced to 51 months. She used the remaining $300,000 to pay her attorney fees for the unrelated scheme, and to settle a civil suit brought by another client. Williams pled federally guilty to the recent life scheme. Sentencing comes later.

Thousands of homeowners lost everything when the Tubbs wildfire barreled through Sonoma County, Calif in 2017. Then along came contractor **Salvador Chiaromonte**. He took more than $1 million of victims' money and left them unrepaired homes. The fire wrecked 4,600 homes. Victims signed about 40 construction contracts with Chiaramonte. He took money for work that was shoddily performed or not done at all. Chiaramonte missed deadlines, and broke promises on construction start dates. Victims saw their rebuilds drag on with no progress. One victim was D.M. Kelley, who lost his house. He met with Chiaramonte who repeatedly mentioned his Christian values. Chiaramonte took over $100,000 from Kelley and did almost no work. Kelley demanded his money back. Chiaramonte said he needed the money to save his own home. "I said, 'What about us? We have no houses!" Kelley retorted. Chiaramonte pled no contest and faces a six-year jail term, including 18 months of probation. Meanwhile, some of Chiaramonte's victims still haven't rebuilt their homes with their insurance money stolen. "A lot of them are still very emotionally raw," says attorney Rich Freeman, who represents 14 homeowners in a lawsuit. "The horror of what they went through, losing everything in the fires, the emotional trauma of that, coupled with battling with their insurance companies to find out what their coverage was, only to have this guy run off with or squander their money and leave them scrambling — there's almost nothing that could make them whole again."

We'll unveil a new and larger fraud estimate at the Coalition's Midyear Meeting, June 6-7 in Orlando. For years, the Coalition's familiar $80-billion loss estimate has been a benchmark. We now think fraudsters have been stealing much more. You'll learn the definitive new fraud estimate — for each line — after a year-long study by a Coalition task force of your peers. Register today to

attend the unveiling in person. You'll also network with fellow decisionmakers, learn the newest fraud trends, plus updates on court decisions that directly affect your work — and much more.

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

A crash ring that has terrorized truckers in New Orleans continues being rolled up. *Here's the latest:* A 2014 Dodge Avenger owned and driven by Doneisha Gibson maneuvered a collision with Hotard bus on I-10 in New Orleans. Ishais Price also was in the Avenger. Gibson recruited Chandrika Brown and Price as passengers for a crash ring that ram commercial vehicles to exploit their robust insurance coverage. The Avenger's driver switched seats with Gibson after the crash. Gibson and the other passengers lied that the bus illegally changed lanes and caused the crash. Brown, Gibson, Price and the driver hired lawyers and falsely received $677,500 of injury payouts. *Another recent ring crash:* Aisha Thompson lied she was a passenger in Erica Lee's 2015 RAV4. They intentionally crashed into a tractor-trailer owned by Averitt Express. The driver exited the RAV4 and Lee got behind the wheel to make it appear she drove. Passenger "A" also lied to the insurer that she was Thompson. The passengers got medical care and hired a lawyer to pressure the trucking firm and its insurer. Thompson's insurance settlement was $30,000. She was handed 18 months in federal prison, and Brown three years of probation. They were convicted, along with Keishira Richardson in yet another setup crash. This trio must repay $5.5 million in *Operation Sideswipe*, which has earned 36 federal convictions so far.

Clad only in shorts, Timothy Brooks' lifeless body sat in his orange lounge chair with a gunshot wound to his stomach. A 12-gauge shotgun with the muzzle pointed upward lay between the Duncan, Okla. man's legs. Brooks' son killed his father for $500,000 of life insurance and disguised the murder to look like suicide, prosecutors contend. *Here's allegedly why:* James Kyle Brooks was estranged from his father. He secretly took out the life policy without his father's knowledge. Brooks said he went to Tim's home the day before to talk. They cleaned the shotgun together, then his father began "talking crazy talk" while reloading the weapon and threatening to shoot himself, Brooks claimed. His father then lifted the gun and said "watch this" and then shot himself, Brooks claimed. A spent shell rested on the floor to the left of Tim. Yet the shell exit port is on the right side of the gun. And because the gun is a pump action, it would've been hard to manipulate it with enough force to eject the spent shell from his father's position. Nor was there evidence of anyone cleaning the shotgun; there were no "soiled cloth patches in the gun cleaning kit or in the trash. And Timothy could've shot himself only after moving his body in an unusual way. His son also called the life insurer almost daily about getting the payout.

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A chiro stole the IDs of toddlers and children then billed for treating them as adults in a $2.2-million billing con. Susan H. Poon attended health fairs for employees of UPS warehouses and Costco locations in the Santa Ana, Calif. area. She gathered their personal info, including the IDs of the kids. Poon never even met the patients, yet billed for diagnosing and treating them and their parents. She also sent fraudulent durable medical equipment prescriptions — based on the ghost patient visits — to a DME manufacturer. And she fabricated medical documentation containing the IDs of the fake patients to mislead an auditor. Poon received 70 months in federal prison.

Illegal kickbacks and patient referrals earned medical sales rep Steven Monaco a federal fraud conviction. The Sewell, N.J. man led two related schemes that resulted in $4.6 million of losses to public health plans. *First scheme:* Monaco was a sales rep for a medical diagnostic lab. He launched a kickback scheme with a doc, Daniel Oswari. Monaco arranged for Oswari's medical assistant to be placed on the lab's payroll laboratory while continuing to work as a medical assistant for Oswari's practice. In exchange, Oswari referred all his lab work to the laboratory for testing. The lab paid Monaco $36,000. *Second scheme:* Monaco and pharma sales rep Richard Zappala received a percentage of the insurance payouts for compound med scripts they arranged. Monaco and Zappala paid docs to sign medically unneeded prescriptions for the compound meds. Monaco bribed Oswari and his staff to prescribe the compound meds to Oswari's patients insurance plans without examining the patients. Monaco also arranged for other medical providers to sign

medically unneeded prescriptions for Monaco's family members and others without exams. Monaco paid the providers cash and tickets to sporting events — he earned $350,000 in illicit payouts in return. Monaco will be federally sentenced later.

Fraudster's Fake £1.1m Claim Defeated by Surveillance

Anthony Hawkins, a retired scrap metal dealer's £1.1 million insurance claim dismissed in full after an investigation carried out by Admiral Insurance and Horwich Farrelly found the claimant to be a liar who fabricated evidence to fraudulently inflate the value of his claim of loss of earnings.

Hawkins, claimed that he suffered multiple and serious injuries in a road traffic accident on 23 August 2014. As a result of his injuries Hawkins spent 26 days as an inpatient. Hawkins also claimed that he suffered recurrent infections around the metalwork in the injured right forearm. Central to his claim for lost earnings was a handwritten, undated letter that alleged to offer the claimant employment at the same scrap yard he had previously sold for a salary plus weekly bonuses.

The letter was later exhibited to the claimant's witness statement to support his claim for past and future lost earnings totalling £1.1m.

Admiral Insurance was concerned about the letter and the authenticity of the claimant's self-reporting at several medicolegal assessments and several periods of surveillance were commissioned between 2016 and 2020. Despite telling medical and care experts that he would only drive in emergencies and could only sit for 10 minutes due to back pain; surveillance captured the claimant driving on several and consecutive days, running errands and undertaking journeys far in excess of 10 minutes. He was also seen walking without any walking aid and switching the walking stick between his left and right hands, despite telling the defendant's care expert he could not grip or hold anything in his right hand.

Following a seven day trial the Judge concluded that Hawkins lied about how and when the letter offering employment came into being and referenced the numerous inconsistencies in the claimant's written and oral evidence when delivering his judgment, specifically his exaggeration of symptoms and the creation of evidence to inflate the value of the claim. The defendant's expert medical evidence was preferred across the board and the claim was dismissed in full with an order to pay the defendant's costs on an indemnity basis and for repayment of an interim payment. The Judge's assessment of damages to the defendant, under UK rules that loser pays, exceeded £120,000, was understood to be the highest assessment of damages to date in a claim involving serious injuries where fundamental dishonesty arguments were successful

Admiral Insurance noted that "insurance fraud is insidious" and affects all motorists through higher premiums. It promised that Admiral is fully committed to paying out on genuine injury claims quickly and fairly but it will exercise the law to its full extent to help it defend and discourage fraudulent and dishonest claims.

In the opinion of ZIFL all insurers across the world must emulate Admiral's commitment to use its investigators and lawyers to defend, deter and defeat fraudulent and dishonest claims.

Strems Law Firm Settle Fraud Claims With Citizens Property Insurance For $1 Million

Strems Law Firm Settles Fraud Suit with Insurers

The Strems Law Firm, a Miami-based law firm and its co-defendants agreed to a $1 million settlement with Citizens Property Insurance Corporation (Citizens) after the state-created insurer filed a lawsuit that alleged fraudulent claims involving the firm in collusion with a public adjusting firm and a water mitigation company.

The settlement was announced today at a press conference in Tampa, Florida hosted by Florida Chief Financial Officer Jimmy Patronis. Mr. Patronis commended Citizens' efforts and urged other insurance companies to take an aggressive stance against property insurance fraud.

Citizens Special Investigations Unit (SIU) initiated its investigation of the Strems Law Firm in 2016 after detecting suspicious patterns linking the law firm to the public adjusting and water mitigation companies. Investigators combed through more than 5,000 claims and sent more than 400 cases to the state which initiated its own criminal investigation.

Following investigations by Citizens' SIU and the state Citizens filed suit in 2020 against the Strems Law Firm, public adjusting firm Contender Claims Consultants (CCC), and All Insurance Restoration Services (AIRS) arguing that the law firm engaged the public adjusters to create, or fraudulently increase, the severity of claims – mostly nonweather water loss claims – submitted on behalf of policyholders. Four individuals – Scot Strems (Strems), Guillermo Saavedra (CCC), Cesar Guerrero and Derek Parsons (AIRS) – were also named in the lawsuit.

The complaint alleged the defendants created false invoices and took other steps to inflate the cost of claims submitted to Citizens and other insurance companies. In Citizens' case, the alleged fraud dates back to 2014.

Under the settlement finalized March 21, 2022, Citizens is to be paid $1 million and will dismiss the case against the defendants and all parties agreed to pay their own legal costs. Strems and the fellow defendants continue to deny wrongdoing in the settlement agreement, while Citizens stands behind the allegations in its complaint.

The Florida Bar in 2020 initiated disciplinary action against Scot Strems, the firm's principal. Strems was suspended for two years by the Florida Supreme Court, and additional sanctions are pending. The firm was restructured and is now doing business as The Property Advocates, P.A.

Health Insurance Fraud Convictions

Clinic Owner Sentenced To Federal Prison For Laundering Money For 'Pill Mill'

Defendant Also Bought Mercedes And Hummer With Profits

Jamesetta Whipple-Duncan, 59, of Savannah, a former Garden City, Georgia, clinic owner and CEO was sentenced to federal prison for 60 months after admitting she laundered money in connection with a notorious "pill mill" doctor who illegally dispensed massive amounts of drugs. She pleaded guilty to Money Laundering. U.S. District Court Judge Lisa Godbey Wood also ordered Whipple-Duncan to pay $86,074 in restitution and to serve three years of supervised release after completion of her prison sentence. There is no parole in the federal system.

As described in the plea agreement and other court documents, Whipple, as owner of the now-closed **Georgia Laboratory Diagnostics LLC**, in Garden City, Ga., was an employer of **Dr. Frank Bynes Jr**., 69, of Savannah. Bynes was sentenced in February 2020 to 240 months in prison and ordered to pay $615,145 in restitution to Medicare, Medicaid and Tricare after being found guilty by a federal jury on 13 counts of Unlawful Dispensation of Controlled Substances and three counts of Health Care Fraud.

For Whipple-Duncan's role, she owned and operated the clinic, hired Dr. Bynes, and then profited as her clinic provided Bynes with a base of operation from which he illegally distributed controlled substances, including highly addictive opioids and drug cocktails favored by addicts. Whipple-Duncan controlled the finances of the clinic, which largely consisted of cash from the clinic's patients. Whipple-Duncan used that cash to continue operations of the clinic, and to finance expenditures for herself, including a Mercedes-Benz sedan, a Hummer H2, a Can-Am Spyder, and a Polaris Slingshot.

Managers Of Arizona Telemedicine Company Admit Roles In $64 Million Fraud Schemes

Stephen Luke, 54, of Phoenix, Arizona, and **David Laughlin**, 48, of Buckeye, Arizona, each pleaded guilty before U.S. District Judge Esther Salas in Newark, New Jersey, federal court to informations charging them with one count of conspiracy to violate the federal Anti-Kickback statute and one count of conspiracy to commit health care fraud.

Luke and Laughlin owned and operated **RediDoc LLC**, a purported telemedicine company based in Phoenix. From September 2017 through December 2019, Luke and Laughlin conspired together and with others to unlawfully enrich themselves by submitting and causing to be submitted false and fraudulent claims to federal health care benefit programs. They did so through a circular scheme of kickbacks and bribes paid to doctors and solicited from marketing companies, pharmacies, and providers of durable medical equipment (DME).

Pharmacies and DME providers agreed to pay bribes and kickbacks to marketing companies in exchange for drug prescriptions and doctor's orders for DME. The marketing companies obtained the personal information of Medicare and TRICARE beneficiaries, which they sent to RediDoc, along with pre-filled prescriptions and DME orders. RediDoc then gave the beneficiary information and pre-marked prescriptions and DME orders to doctors to whom it paid bribes and kickbacks. The doctors often approved the prescriptions and DME orders without having had any contact with the beneficiary and without making a bona fide assessment that the medications or DME were medically necessary. Participants in the scheme selected particular drugs largely based on the reimbursement amounts that Medicare and TRICARE would pay, and not the medical needs of the beneficiaries.

Once RediDoc's doctors had signed the prescriptions and orders regardless of medical necessity, RediDoc then transmitted them to pharmacies and DME providers around the country for fulfillment and billing. When the pharmacies filled the prescriptions and orders and were reimbursed by health care benefit programs, they sent a portion of the reimbursement amount to the marketing companies, who further shared those funds with Luke, Laughlin, and RediDoc to purchase additional prescriptions and DME orders.

Through RediDoc, Luke and Laughlin received approximately $32 million from marketing companies. RediDoc paid several million dollars in kickbacks to doctors who were located in dozens of states around the country, including New Jersey. As part of their guilty pleas, Luke and Laughlin admitted that they and their conspirators caused the submission of false and fraudulent claims to health care

benefit programs totaling more than $64 million. Those claims were ineligible for federal health care benefit program reimbursement, in part, because they were procured through the payment of kickbacks and bribes.

The charges of kickback conspiracy are punishable by a maximum of five years in prison; the health care fraud conspiracy counts are punishable by a maximum of 10 years in prison, along with fines, restitution, and forfeiture penalties as to both counts. Sentencing for both defendants is scheduled for Oct. 11, 2022.

Goody Bag" Pill Mill Doctor Sentenced To 20 Years in Prison

Andrew Berkowitz, 62, of Huntington Valley, PA was sentenced to 20 years in prison, five years supervised release, and was ordered to pay a $40,000 fine and almost $4 million in restitution by United States District Judge Paul Diamond for running a prescription "pill mill" from his medical practice which he operated in Philadelphia under the name **A+ Pain Management**. Judge Diamond also ordered that the defendant shall forfeit fraud proceeds of approximately $3.4 million and four real properties.

In January 2020, Berkowitz pleaded guilty to 19 counts of health care fraud, and 23 counts of distributing oxycodone outside the course of professional practice and without a legitimate medical purpose, charges for which he was indicted in June 2019. The defendant fraudulently billed insurers for medically unnecessary physical therapy, acupuncture, chiropractic adjustments, and prescription drugs, and for treatments not provided at all. Regardless of their complaint, at every visit patients received a "goodie bag" which was a tote bag filled with prescription drugs for which Berkowitz submitted pharmacy claims through his company, **Bucks Philadelphia Medical Care Group**. The "goodie bags" typically included a combination of drugs including topical analgesics such as Relyyt and/or Lidocaine; muscle relaxers such as Chloroxazon and/or Cyclobenzaprine; anti-inflammatories such as Celecoxib and/or Nalfon; and Schedule IV controlled substances such as Tramadol for pain; and/or Eszopiclone and Quazepam for insomnia and anxiety. The defendant obtained payments from insurers of more than $4,000 for each bag by falsely asserting that the drugs were for the benefit of the patient when, in reality, Berkowitz was the real beneficiary.

As part of the fraud scheme, Berkowitz also prescribed oxycodone to "pill-seeking" patients in exchange for their tacit approval that he would submit excessive claims to the patient's insurer for the "goodie bag" and other medically unnecessary services. From 2015 through 2018, Berkowitz obtained more than an estimated $4 million in fraudulent proceeds from his scheme.

The defendant is also subject to a civil judgement in which he is obligated to pay approximately $1.8 million as a result of civil False Claims Act liability for false claims submitted to Medicare, and subject to a permanent prohibition on Berkowitz ever prescribing, distributing or dispensing controlled substances ever again.

3 Found Guilty of Participating in Scheme to Submit Millions of Dollars in Fraudulent Bills for Substance Abuse Treatment for Teens

The three defendants convicted today of health care fraud charges are: **Gregory Hearns**, 66, of Compton, California, the billing supervisor for ARS who compiled the monthly billing and arranged for its submission to Medi-Cal (guilty of one count and acquitted on 10 others); **LaLonnie Egans,** 64, of Bellflower, California a former manager at ARS (guilty of three counts); and **Tina Lynn St. Julian**, 58, of Inglewood, California, a former counselor at ARS (guilty of four counts).

The three were convicted by a federal jury on May 9, 2022 as participants in an $18.5 million scheme that submitted fraudulent claims to California's Drug Medi-Cal program for alcohol and drug treatment services for high school and middle school students.

With the three guilty verdicts, a total of 19 people have been convicted of federal criminal charges stemming from fraudulent bills submitted by a Long Beach company – the non-profit **Atlantic Recovery Services** (ARS), later called **Atlantic Health Services** – that provided substance use disorder treatment services to students at local high schools and middle schools through Medi-Cal and its Drug Medi-Cal program.

According to court documents and the evidence presented at a 12-day trial, the participants in the ARS scheme defrauded the Drug Medi-Cal program by submitting bills for services to students who did not medically need alcohol or drug treatment. ARS also billed Drug Medi-Cal for group and individual counseling sessions that were not provided or did not meet the requirements for reimbursement as to size, length, or setting. To support the false billings, ARS employees falsified numerous documents.

The former president and chief executive officer of ARS – **Richard Mark Ciampa**, 68, of Commerce – pleaded guilty last year and was sentenced in September to seven years in federal prison.

In March 2009, Drug Medi-Cal ordered ARS to repay an overpayment, which caused a significant amount of financial pressure on Ciampa and ARS. Ciampa, in turn, passed along this financial pressure to his employees and threatened the employees that they would lose their jobs with ARS or have their hours reduced to part-time if they did not generate significant billings. In response to Ciampa's threats, ARS employees generated false and fraudulent claims for submission to Drug Medi-Cal.

Hearns also pressured ARS employees to increase billings. The pressure from ARS management prompted Egans and St. Julian to commit specific actions, including enrolling students in ARS's substance abuse treatment program even if the students had used drugs or alcohol only one time or just occasionally, exaggerating documentation to falsely show that enrolled students had a medically diagnosed substance use disorder, falsifying documents to make it look like group and individual counseling sessions had taken place, collecting student signatures on sign-in sheets for group counseling sessions that the students did not attend or that were not conducted, and forging signatures on sign-in sheets and other documents that were used to support claims for reimbursement.

During the four-year period that ended in March 2013, ARS submitted false and fraudulent claims of just over $18.5 million, and Drug Medi-Cal paid approximately $17,635,100 on those claims.

Southern California Center for Autistic Children Pays $650,000 To Resolve Allegations of Fraudulent Billing

Prism Behavioral Solutions has paid $650,000 to resolve allegations that it billed the state's Medicaid Program, known as Medi-Cal, for services to autistic children without actually providing care to the children, according to a settlement agreement signed by Prism Behavioral Solutions, the United States, and the State of California.

Prism Behavioral Solutions provides treatment to children diagnosed with autism and other related disorders through therapy called Applied Behavioral Analysis. Prism Behavioral Solutions maintains a corporate address in Woodland Hills, California, and provides medical services to patients in Southern California. The United States and the State of California alleged that Prism Behavioral Solutions violated the federal False Claims Act and the California False Claims Act by knowingly submitting false claims to Medi-Cal for medical services that Prism Behavioral Solutions did not perform from September 2016 through December 2019. According to a whistleblower's complaint, this included Prism Behavioral Solutions billing Medi-Cal for cancelled appointments.

This settlement resolves the allegations in a former Prism Behavioral Solutions employee's whistleblower lawsuit filed under the *qui tam* provisions of the False Claims Act, which permit private individuals to sue for false claims on behalf of the government and to share in a recovery. The civil lawsuit was filed in the Southern District of California and is captioned *United States and the State of California, ex rel. Mason v. Prism Autism Foundation*, 19-CV-0043-W (BLM). As part of this settlement, the whistleblower will receive $130,000.

Home Health Company Operating in Florida Pays $2.1 Million To Resolve False Claims Allegations

SHC Home Health Services of Florida, LLC and its related entities (collectively "**Signature HomeNow**") have paid $2.1 million to the United States government to settle claims of improperly billing the Medicare Program for home health services provided to beneficiaries living in Florida.

Signature HomeNow operated home healthcare services in Florida and its corporate headquarters are located in Louisville, Kentucky.

According to a complaint filed in the United States District Court for the Southern District of Florida against Signature HomeNow and the subsequent settlement agreement, it was alleged that between 2013 and 2017 Signature HomeNow knowingly submitted false or fraudulent claims seeking payment from the Medicare Program for home health services to Medicare beneficiaries who: (i) were not homebound; (ii) did not require certain skilled care; (iii) did not have a valid or otherwise appropriate plans of care in place; and/or (iv) did not have appropriate face-to-face encounters needed in order to be appropriately certified to receive home health services.

This matter arose from a complaint to the Department of Health and Human Services, Office of Inspector General (HHS-OIG) complaint hotline (https://oig.hhs.gov/fraud/report-fraud/) and from a complaint for monetary damages under the *qui tam* provisions of the federal False Claims Act. *See United States ex rel. Barbara Mellott-Yezman and Patricia Rench v. SHC Home Health Services-Ocala, LLC et al.,* Case No. 15-cv-24713 (S.D. Fla.).

Dentist Pleads Guilty to Unlawfully Obtaining Medicaid Funds and Paying Recruiters to Refer Medicaid Beneficiaries to His Dental Office in Exchange for Kickbacks

Edward T. Buford III, age 70, of Silver Spring, Maryland, pleaded guilty on May 4, 2022, to conspiracy to commit mail fraud and healthcare fraud. As part of his guilty plea, Buford will be required to pay $1,267,630 in restitution.

According to his guilty plea, from January 2013 to May 2018, Buford and others devised and executed a scheme to defraud Medicaid for the District of Columbia by filing fraudulent Medicaid claims for dental services to Medicaid beneficiaries, receiving the fraudulently obtained funds from Medicaid, and recruiting Medicaid beneficiaries to fuel the scheme through the payment of kickbacks and bribes.

Buford was a licensed dentist in Washington, D.C. and the owner and Chief Executive Officer of **International Dental Associates, Inc.** (IDA), a dental clinic located in Washington, D.C. Before 2015, Buford was enrolled as a Medicaid provider, however, in April 2015, Medicaid suspended payments to Buford under his provider number.

After Buford's provider number was suspended in 2015, Buford and his business partner/IDA manager (Co-conspirator 1) continued to submit claims to Medicaid through IDA's provider number. In April 2016, Buford and Co-conspirator 1 re-enrolled IDA as a provider in Medicaid. Within IDA's application, Buford and Co-conspirator 1 failed to disclose Buford's suspension from Medicaid.

Buford and his co-conspirators caused the submission of Medicaid claims by Buford and IDA for a variety of dental services, including dentures. As part of the conspiracy, Buford and Co-conspirator 1 offered and paid kickbacks to Co-conspirator 2 and other patient recruiters in exchange for referring Medicaid beneficiaries to IDA for dental services, even though Medicaid would not pay claims had it known they were procured through kickbacks. Medicaid paid substantially more for dentures than for many other dental services, including dental cleanings, and Buford and Co-conspirator 1 paid Co-conspirator 2 larger cash kickbacks for beneficiaries that agreed to be fitted for dentures—approximately $50 per beneficiary—than for beneficiaries who only agreed to receive dental cleanings.

At Buford and Co-conspirator 1's direction, Co-conspirator 2 offered Medicaid beneficiaries cash bribes to induce them to visit and accept dental services from IDA. Buford and his co-conspirators typically paid higher amounts to beneficiaries who agreed to be fitted for dentures than those who only agreed to receive cleanings. Even though dentures required multiple visits to fit and deliver, Buford and his co-conspirators paid the beneficiaries only for the initial visit—after which Buford and his co-conspirators could bill Medicaid for the dentures—and numerous beneficiaries never returned to IDA after receiving the cash bribe. Accordingly, Buford and his co-conspirators stored hundreds of undelivered dentures on IDA's premises, many of which had been billed to and paid for by Medicaid.

As part of the scheme to defraud, Buford maintained a Post Office box in Silver Spring, Maryland as IDA's billing address and received the fraudulently obtained funds at that location. For example, on September 21, 2017, Buford caused Medicaid to mail a check for $17,397 to the Maryland P.O. box for services purportedly provided to 11 Medicaid beneficiaries.

Based on the amount that Medicaid paid to Buford and IDA for dentures that were not delivered, the actual loss to Medicaid was at least approximately $1,267,630.

Buford faces a maximum sentence of 20 years in federal prison followed by 3 years of supervised release for conspiracy to commit mail fraud and healthcare fraud. U.S. District Judge Theodore D. Chuang has scheduled sentencing for August 3, 2022, at 9:00 a.m.

ZIFL can only wonder what took the government five years to catch on to this fraud.

Couple Convicted Of $1 Million Medicare Fraud Scheme

Lindell King and **Ynedra Diggs,** were convicted by a federal jury for a $1 million Medicare fraud scheme. The husband and wife owned and operated group homes in which Medicare beneficiaries lived. King and Diggs had an agreement with **Behavioral Medicine of Houston** (BMH) to send patients to their mental health center in return for kickbacks paid under the guise of transportation or other fabricated service fees. BMH paid Diggs and King an amount totaling nearly $1 million, all of which was billed to Medicare.

Diggs and King were both convicted of conspiracy to defraud the United States, conspiracy to pay and receive health care kickbacks, and numerous violations of the Anti-Kickback Statute. Each face 15 to 20 years in prison, once sentencing is decided.

Major William Marlowe of the Texas Attorney General's Medicaid Fraud Control Unit, in collaboration with other agencies, investigated the case and made the announcement. Trial Attorneys Monica Cooper and Brynn Schiess of the Criminal Division's Fraud Section prosecuted the case.

Laurel County Kentucky Woman for Medicaid Fraud

EyeDeal EyeCare, owned by licensed optometrist, **Caroline Hendy**, fraudulently billed Medicaid for duplicate frames, lenses, lens coatings, fittings, and repairs, which were offered to clients within 14 days of their initial glasses purchase. The investigation found that EyeDeal EyeCare fraudulently collected $68,907.20 from Medicaid.

On, March 28, 2022, Caroline Hendy, 53, of London, Kentucky, pleaded guilty to one count of Theft by Deception over $1,000 but less than $10,000 (a Class D Felony) and one count of Devising or Engaging in a Scheme to Defraud the Kentucky Medical Assistance Program of $1,000 or more (Class D felony).

On April 25, 2022, at a sentencing hearing, Hendy entered the supervised pre-trial diversion program, and her sentence was diverted for three years. She was also ordered to pay restitution to the Kentucky Medical Assistance Program in the amount of $68,907.20.

US Settles with Amazon Online Pharmacy for Overdispensing Insulin

Amazon Subsidiary PillPack Will Pay $5.79 Million and Admits Dispensing Insulin Pens that Exceeded Days-of-Supply Limits

PillPack, LLC ("PillPack"), a wholly-owned subsidiary of **Amazon.com, Inc**. agreed to a settlement that resolves allegations that PillPack improperly billed Government healthcare programs ("GHPs"), including Medicare and Medicaid, for more insulin pens than patients needed according to their prescriptions and falsely under-reported the days-of-supply of insulin dispensed. Under the settlement, PillPack agreed to pay approximately $5.79 million to the United States and various States that were fraudulently overbilled for insulin. As part of the settlement, PillPack also admitted and accepted responsibility for certain conduct the Government alleged in its Complaint, including that it dispensed insulin pens that exceeded days-of-supply limits imposed by GHPs.

Insulin pens (hard plastic pen-shaped cases containing syringes filled with insulin solution) are a common way for diabetic patients to self-administer insulin. Manufacturers most frequently distribute insulin pens in five-pen cartons with each pen containing 300 units (3 mL) of insulin solution. Pharmacies can dispense such pens to patients only with valid prescriptions from licensed prescribers. Valid insulin prescriptions must set forth the "directions for use," which typically designate both how much insulin to administer and the frequency and/or timing of when to administer it.

When PillPack sought reimbursement from GHPs for insulin pens, it was required to report, among other data, the quantity dispensed and the days-of-supply. The "quantity dispensed" specifies the amount of medication being dispensed to a patient when the pharmacy fills the prescription, and the "days-of-supply" refers to the number of days that the dispensed medication should last if the patient uses it according to the directions for use in the prescription. Typically, to calculate days-of-supply, a pharmacist divides the total quantity of medication being dispensed to a particular patient by that patient's "daily dose," *i.e.*, the amount of medication that the prescriber directs the patient to use each day.

GHPs impose dispensing limits for prescription drugs, including insulin pens, in terms of quantity and days-of-supply and will deny a claim if the reported days-of-supply exceeds those limits, unless an override is obtained. GHPs typically calculate the date on which a prescription refill would be needed (the "refill due date") based on the date when a patient last filled a prescription and the days-of-supply reported by the pharmacy for that prior fill. GHPs also typically establish automated processes to deny claims for reimbursement for refills that are submitted too far in advance of the refill due dates. The reliability of these processes depends on the accuracy of the days-of-supply reported by pharmacies.

As alleged in the Government's Complaint:

From April 2014 through November 2019 (the "Covered Period"), PillPack's general practice was to dispense insulin pens to patients using full cartons. PillPack would dispense and bill for the full carton, and falsely under report the days-of-supply to make it appear that the dispensing did not violate the program's days-of-supply limit.

The practice of under-reporting days-of-supply also led PillPack to dispense premature refills to program beneficiaries. Whenever PillPack recorded in its internal system the inaccurate lower days-of-supply that were submitted to conform with the GHP's days-of-supply limit, the system would generate a premature refill due date. As a result, PillPack pharmacists frequently dispensed insulin pen refills days or weeks before patients actually needed them according to their prescriptions.

The settlement requires PillPack to pay $5,616,136.85 to the United States, and PillPack has agreed separately to pay $175,522.55 to state governments, for a total of $5,791,659.40. Under the settlement, PillPack admitted, among other things, that:

- During the Covered Period, PillPack's insulin pen dispensing practice was to supply patients with a full carton of insulin pens. In many instances, this resulted in exceeding the GHP's applicable days-of-supply limit. Instead of accurately reporting the days-of-supply and contacting the GHP or its agent to attain the requisite override, in many instances PillPack would dispense and bill for the full carton, and reduce the days-of-supply reported to the GHP to conform to the GHP's days-of-supply limit. As a result, for those claims, PillPack reported days-of-supply data to GHPs that were different from, and lower than, the days-of-supply that should have been reported had PillPack calculated days-of-supply according to the typical pharmacy billing formula of dividing the quantity of insulin dispensed by the daily dose.
- Prior to April 2019, PillPack's prescription management and dispensing software determined refill dates based on the reported days-of-supply. Thus, during this time period, when PillPack pharmacists reported inaccurate lower days-of-supply data to GHPs and payors working on their behalf, the software used this inaccurate data to generate premature refill due dates, causing PillPack pharmacists to dispense insulin pen refills to patients days or weeks before the patients actually needed them according to their prescriptions.
- During the Covered Period, PillPack received audit reports from pharmacy benefit managers, acting on behalf of GHPs, requesting that PillPack repay the overpayments it had received for insulin pen prescription claims due to inaccurate days-of-supply reporting.
- GHPs and payors working on their behalf approved and paid claims submitted by PillPack for insulin pen refills that they would not have approved if PillPack had accurately reported the days-of-supply for previous fills according to the typical pharmacy billing formula of dividing the quantity dispensed by the daily dose. Specifically, PillPack's practice of dispensing and submitting reimbursement claims for insulin pen refills using inaccurate lower days-of-supply data prevented GHPs and payors working on their behalf from reliably calculating refill due dates and confirming that refills had not been prematurely dispensed before approving PillPack's claims for reimbursement.
- In certain instances, over time, patients accumulated multiple extra insulin pens that they did not need according to their prescriptions.

In connection with the filing of the lawsuit and settlement, the Government joined a private whistleblower lawsuit that had previously been filed under seal pursuant to the False Claims Act.

Doctor Sentenced in $12 Million Medicare Fraud and Device Adulteration Scheme

Donald Woo Lee, 55, of Temecula, California and a doctor was sentenced April 28, 2022 to 93 months in prison for defrauding Medicare, re-packaging single-use catheters for re-use on patients, and submitting false declarations in a bankruptcy proceeding.

According to court documents, Woo Lee recruited Medicare beneficiaries to his clinics, falsely diagnosed the beneficiaries, and provided the beneficiaries with medically unnecessary procedures. Lee billed these unnecessary procedures to Medicare using an inappropriate code in order to obtain a higher reimbursement, a practice known as "upcoding." In addition, the evidence showed that Lee re-packaged used, contaminated catheters for re-use on patients. These catheters had been cleared by the Food and Drug Administration (FDA) for marketing as single-use only and the re-use of these devices put patients at risk of infection and other bodily injury. Lee submitted claims of approximately $12 million to Medicare for the vein ablation procedures he performed, and received $4.5 million as a result.

In October 2019, Lee was convicted after a five-day trial, when a jury found him guilty of seven counts of health care fraud and one count of adulteration of a medical device. Lee also pleaded guilty on March 2, 2020, to one count of submitting false declarations in a bankruptcy proceeding. In addition to the term of imprisonment, Lee was sentenced to serve three years of supervised release and ordered to pay more than $4.5 million in restitution to Medicare.

Pharmacy Owner Pleads Guilty In Health Care Fraud And Kickback Scheme

Robert John Sabet, 46, of Brooklyn, New York pleaded guilty April 28, 2022 to conspiracy to commit health care fraud and unlawfully spending the proceeds of his $6.8 million fraud.

According to court documents, Sabet, the owner of two New York City pharmacies, conspired to bill Medicare and Medicaid for expensive prescription drugs that were not needed by patients, were dispensed in connection with kickbacks, or, in some cases, not dispensed at all. As part of the conspiracy, Sabet and others paid kickbacks and bribes to customers to convince them to fill prescriptions at his pharmacies, and paid customers cash in exchange for the ability to bill Medicare and Medicaid for over-the-counter health care-related products on their behalf. Sabet used proceeds of the scheme to purchase luxury items, such as a 2020 Porsche Taycan worth over $250,000.

Sabet pleaded guilty to conspiracy to commit health care fraud and committing unlawful financial transactions. He is scheduled to be sentenced on July 29 and faces a maximum penalty of 10 years in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Physician and Co-Conspirators Sentenced for Conspiring to Distribute Fentanyl Patches, Opioid Pills and Other Controlled Substances

Dr. Janet Sue Arnold, age 63, of Benton City, Washington, was sentenced to serve 48 months in federal prison for conspiring to distribute and possess with intent to distribute opioid pain medications and other controlled substances without a legitimate medical purpose and outside the usual course of professional practice. Senior Judge Shea also imposed a period of 3-years' federal supervised release.

In announcing the sentence, Senior Judge Shea emphasized the risks created by Defendant's offense, stating, that this "particular crime created the risk of so many others."

According to court documents, Arnold abused her position of trust as a medical doctor by participating in a prescription drug conspiracy with **Danielle Corine Mata, David Barnes Nay, Lisa Marie Cooper** and **Jennifer Cheri Prichard**. As part of their conspiracy, Dr. Arnold and her conspirators pushed thousands of pills on the street to be abused by addicts, and potentially caused others to become addicted to controlled substances. Mata and Prichard, who were both addicts, started out as patients but eventually started working at Dr. Arnold's Richland, Washington clinic – **Desert Wind Family Practice**. In approximately March 2016, Mata became the practice's office manager and one of Arnold's most trusted associates. During the conspiracy, Nay and Cooper also provided Mata with the names of fictitious patients for her to use on several of the blank, pre-signed prescriptions to obtain opioids.

The conspiracy operated primarily out of Dr. Arnold's clinic in Richland, Washington. On regular basis, the conspirators distributed highly addictive and dangerous controlled substances, including fentanyl, oxycodone, methadone, hydromorphone, methylphenidate, an amphetamine mixture, as well as carisoprodol and alprazolam. Dr. Arnold had a pattern and practice of providing office staff and patients with hundreds of blank, pre-signed prescriptions that, after logging into the clinic computer, allowed the conspirators to complete and print prescriptions for opioids and other controlled substances. Text messages recovered by investigators from Arnold's and Mata's phones demonstrated that Dr. Arnold had texted Mata asking if she needed more "signed paper." A conspirator acknowledged how important Dr. Arnold's signature was to the illegal prescription drug distribution conspiracy when she commented to another conspirator, "It's just a scribble, but it's important." Dr. Arnold also prescribed oxycodone pills to a DEA confidential informant without a legitimate medical reason and outside the usual course of medical practice. The confidential informant, posing as a patient, sought treatment from Dr. Arnold for a headache. The confidential informant's interactions with Arnold were covertly audio- and video-recorded.

Arnold is the third of five defendants to be sentenced in this case. **David Barnes Nay**, age 43, of Kennewick, Washington, and **Lisa Marie Cooper**, age 55, of Prosser, Washington, were sentenced to 78-month and 24-month terms of imprisonment, respectively. **Danielle Corine Mata,** age 44, of Richland, Washington, and **Jennifer Cheri Prichard**, age 46, of Prosser, Washington, are scheduled to be sentenced in May 2022.

Radiology Business Owner Convicted at Trial Of $2 Million Health Care Fraud Scheme

Thomas G. O'Lear, 57, of North Canton, was found guilty by a federal jury following a five-day trial before Judge Dan Polster in Cleveland. O'Lear was convicted of defrauding Medicare and Medicaid out of approximately $2 million by billing for x-ray related services that his company, Portable Radiology Services, did not provide, for making false statements to cover up the fraud and for committing aggravated identity theft.

According to court documents and evidence presented at trial, O'Lear was President of **Portable Radiology Services** (PRS), a company that provided portable x-ray-related services to individuals residing in nursing homes, skilled nursing facilities and long-term care facilities.

Beginning in January 2013 through December 2017, O'Lear submitted false claims for reimbursement to Medicare, Medicaid and Medicaid Managed Care Organizations (MCOs) for services that he and his business did not provide, including for approximately 151 x-ray services purportedly provided to patients on dates after the patients had died.

Evidence also proved that O'Lear billed Medicare and Medicaid for purportedly having provided x-ray-related services to beneficiaries at nursing facilities on dates when the beneficiaries were hospitalized and not at the facilities; billed falsely claiming that x-ray services were performed on various dates, requiring separate reimbursement for transportation on each date; and billed one x-ray image as multiple images thereby requiring a greater reimbursement.

The jury also found that when O'Lear was audited by a Medicaid MCO, he covered up the scheme and committed aggravated identity theft by creating false medical records and forging the signatures of others, including a doctor.

As a result of the scheme, court documents state that O'Lear fraudulently billed Medicare, Medicaid and Medicaid MCOs approximately $3.7 million in claims, and received approximately $2 million in payments.

O'Lear is scheduled to be sentenced on August 2, 2022. Each of the health care fraud counts carries a maximum sentence of ten years in prison. The false statements relating to a health care matter counts carries a 5-year maximum sentence, and the aggravated identity theft counts carry a mandatory minimum of two years in prison, which must be served consecutive to any sentence imposed by the Court on the other charges.

Woman Awaiting Sentencing in Health Care Fraud Case Charged with Committing Health Care Fraud

Nicole Steiner, formerly known as **Nicole Balkas,** 32, of Stratford, Connecticut was arrested May 2, 2022 on a criminal complaint charging her with committing health care fraud after pleading guilty and while released on bond in another health care fraud case.

Following her arrest, Steiner appeared before U.S. Magistrate Judge S. Dave Vatti in Bridgeport and was released on a $250,000 bond into home detention and under electronic monitoring.

According to court documents and statements made in court, on April 28, 2021, Steiner pleaded guilty to one count of health care fraud related to her operation of **Helping Hands Academy, LLC**, in Bridgeport, which provided applied behavior analysis services to children diagnosed with Autism Spectrum Disorder (ASD), and was enrolled as a participating provider in the Connecticut Medicaid Program ("Medicaid"). From December 2018 to October 2020, Steiner submitted and caused to be submitted fraudulent claims to Medicaid for applied behavior analysis services that were purportedly provided to Medicaid clients. She submitted claims for dates of service when no applied behavior analysis services of any kind had been provided to the Medicaid clients identified in the claims, and she inflated the number of hours for certain claims even when applied behavior analysis had been provided to the Medicaid clients identified in the claims. Steiner also submitted false Medicaid claims in 2020 using a former employee's name and performing provider number.

After the Connecticut Department of Social Services (DSS), which administers the Medicaid program in Connecticut, terminated Helping Hands Academy as a provider, Steiner made several false statements and submitted an altered document to DSS in an effort to rescind the termination and to receive payment for previously submitted claims.

Medicaid suffered a loss of $551,311.85 as a result of Steiner's admitted conduct.

After her guilty plea, Steiner was released on a $50,000 bond pending sentencing.

It is alleged that, while she was awaiting sentencing in her case, Steiner was a silent partner in another company that provided applied behavior analysis services to children diagnosed with ASD called **New Beginnings Children's Behavioral Health LLC**. Steiner was responsible for billing claims to Medicaid, managing payroll, and recruiting and screening potential employees, and she and had access to and used her business partner's email and other online accounts to operate the company. Steiner and the company engaged in health care fraud by billing Medicaid for thousands of dollars in services not rendered and, in particular, billing for services not rendered by Steiner.

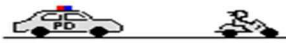
If convicted of the new charge, Steiner faces a maximum term of imprisonment of 10 years, which must be imposed consecutively to the sentence she receives in her initial health care fraud case.

Western Kansas Woman Sentenced for Insurance Fraud

Lace Morford, 41, of Sharon Springs, was sentenced in Thomas County District Court by Judge Kevin N. Berens on one count of insurance fraud, one count of unlawful use of a computer, one count of forgery and one count of theft. Berens sentenced Morford to make restitution in the amount of $17,942.50, pay a $500 fine and spend 15 days in the county jail as a condition of her probation.

Morford pleaded guilty to the charges in February. Investigators with the Kansas Insurance Department determined that Morford filed 15 invalid medical claims with her insurance carrier between June 2016 and May 2019. Morford used computers and a computer network at her place of work to falsify medical records to support her claims filed with the insurance carrier.

The case was prosecuted by Assistant Attorney General Brandon Hottman of the Fraud and Abuse Litigation Division in Schmidt's office.



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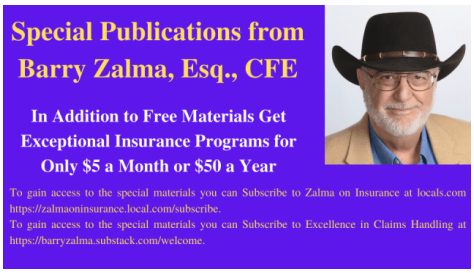

Barry Zalma has created at Locals.com and substack.com a series of insurance educational materials most of which are free to anyone. The free materials include more than 415 videos and more than 4150 digests of recent appellate court opinions and more than 59 videos dealing with true crime stories of insurance fraud.

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

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

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- Property Insurance is a Personal Indemnity Contract.
- What is Insurance?
- Insurance Education Part I, a Video Training Program.
- Excellence in Claims Handling a Video Training Program.
- Ethics and the IME.

- Arson & Fraud by Husband Voids Entire Policy
- If an Insurer Wants to Defeat Coverage it Should Collect Convincing Evidence
- To Defeat Insurance Claim the Insurer Must Collect Convincing Evidence.
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Zalma on Insurance at Locals.com The Locals.com community is called **Zalma on Insurance** and is a community created by Barry Zalma, Esq., CFE and ClaimSchool, Inc. to help create a community of insurance professionals dedicated to excellence in claims handling.

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

Become a Professional Claims Handler

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

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

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

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

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

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

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

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

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Other Insurance Fraud Convictions

Guilty of Murder-For-Hire & Insurance Fraud Case

Euri Jenkins heard a Florida jury return a guilty verdict saying he was the orchestrator of a 2017 plot to kill his pregnant wife.

Deliberations lasted less than a day before the jury reached a decision on the charge of first degree murder.

Jenkins, 35, now faces life in prison without parole.

Prosecutors told the jury that he plotted with another man, **Joevan Joseph,** then 19, to kill his wife, Makeva Jenkins.

Jenkins offered Joseph $1500 to kill Makeva in hopes of collecting on her life insurance policy.

Joseph shot her while she was asleep in her Lantana, Florida area home on June 29, 2017.

She was 33-years-old and pregnant at the time she was killed. She also had three other children.

Joseph, who confessed to killing her, faces up to 20 years in prison for the murder of Makeva and her unborn child.

Jenkins has been remanded to custody.

Iowa Man Pleads Guilty to Insurance Fraud & Serving Five Years

D'Alan Thurmond, age 41, of Waterloo, Iowa pled guilty on April 25, 2022, to one count of Presenting False Information, a class "D" Felony, following an investigation by the Iowa Insurance Division's Fraud Bureau.

The investigation began in December 2019 after the Iowa Insurance Division's Fraud Bureau received information indicating Thurmond had provided false information to an insurer following an automobile accident in Black Hawk County.

The investigation determined Thurmond had made false representations regarding the nature of the loss in an effort to secure benefits of the policy. He claimed that his vehicle was stolen when, in fact, it was involved in a single-car accident while he was the driver.

Following his guilty plea, Thurmond received a five year prison sentence, which he is serving concurrently to an unrelated crime. Financial penalties were suspended.

Fallout From the Infamous Strems Law Firm's Litigation Practices in Florida Continues

Gregory Saldamando, 39, represented a South Florida couple in a sinkhole damage claim against American Integrity Insurance Co., after a claims adjuster had the couple sign a retainer agreement with the Strems firm, the Bar explained.

Two years after Coral Gables plaintiffs' attorney Scot Strems was suspended from practice for filing thousands of unnecessary lawsuits against property insurers and violating other Bar rules, and two years after the Florida Bar filed a complaint against another attorney with the firm, the state Supreme Court has suspended the lawyer for 91 days.

"Saldamando did not adequately involve the clients in the settlement process and did not apprise them of the total settlement amount or the amount that Saldamando intended to take as the firm's fee, which was substantially higher than the amount the clients would obtain," reads a summary of the Bar's case against the attorney, posted this week.

Saldamando also did not provide the clients with any invoices or substantiation of the fees claimed by the firm. And although Saldamando withdrew as counsel before settling the case, the Strems firm took $30,000 from the final settlement obtained by new counsel, for fees and costs.

A judicial referee appointed to hear Saldamando's disciplinary case recommended in April 2021 only that he be publicly reprimanded and that he reimburse the Bar $8,100 for its investigative costs. Referee Dawn Denaro, who normally works as a children's court judge in Miami, said that Saldamando did not appear to have a selfish or dishonest motive and had taken steps to resolve the fee dispute with the clients.

But the Florida Supreme Court, as it has done several times in the last year, overruled the referee and imposed the 91-day suspension, plus the cost reimbursement. The court said in its March 31 order that Saldamando had violated three Bar rules of professional conduct.

The court said it "disapproves the referee's recommendation as to discipline, and instead imposes a ninety-one day suspension from the practice of law, effective thirty days from the date of this order so that respondent can close out his practice and protect the interests of existing clients," reads the order, endorsed by all seven justices.

Saldamando and his attorneys could not be reached for comment Tuesday evening. The Strems law firm was closed in late 2020, but several of its attorneys moved to another South Florida firm, Bar officials have said.

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The investigation determined Thurmond had made false representations regarding the nature of the loss in an effort to secure benefits of the policy. He claimed that his vehicle was stolen when, in fact, it was involved in a single-car accident while he was the driver.

"Insurance fraud is not a victimless crime. We all pay for insurance fraud in the form of higher insurance costs," Iowa Insurance Commissioner Doug Ommen said. "I appreciate the hard work of our Fraud Bureau and the Blackhawk County Attorney's Office in the prosecution of this case so Mr. Thurmond was held accountable for his actions."

Following his guilty plea, Thurmond received a five year prison sentence, which he is serving concurrently to an unrelated crime. Financial penalties were suspended.

Former Insurance Agent Pleads Guilty to Defrauding Client of More Than a Million Dollars

Koreasa M. Williams, 49, of Tucson, Arizona, pleaded guilty to defrauding an elderly annuity client of more than $1,300,000. Williams, formerly licensed in Arizona to sell life and health insurance, pleaded guilty to two counts of Wire Fraud, each of which carries a maximum penalty of 20 years in prison and a $250,000 fine. Sentencing is scheduled for July 5, 2022, before United States District Judge Jennifer G. Zipps.

Williams admitted she engaged in two separate schemes to defraud her client. In the first scheme, Williams admitted to inducing her client to cash in several life insurance policies in order to invest the proceeds in annuities to be procured by Williams. Williams admitted that over a period of six months in 2019, she fraudulently convinced her client to give her $1,200,000. Instead of investing that money for her client, Williams used almost $900,000 to pay victims of a prior unrelated annuity fraud scheme in an attempt to avoid criminal charges. Williams subsequently pleaded guilty to wire fraud in that unrelated fraud scheme and was sentenced to 51 months in prison in December 2021. Williams used the remaining $300,000 to pay her attorney's fees for the unrelated fraud scheme and to settle a civil suit brought by another client.

In the second scheme, Williams admitted to inducing her client to dissolve a charitable foundation and place more than $124,000 in an entity controlled by Williams. Williams was to hold the funds until a new entity could be established to receive the money that would then be used to care for her client's disabled adult daughter. However, Williams never established the new entity and instead diverted more than $118,00 to her own use and benefit.

Louisiana Man Becomes 37th Defendant Convicted in Operation Sideswipe

David Brown age 50, of Morgan City, Louisiana pled guilty on April 27, 2022 to Count One (1) of his indictment, charging him with Conspiracy to Commit Mail Fraud in violation of Title 18, United States Code, Section 371. By pleading guilty to Count 1, the defendant faces a maximum penalty of five (5) years' imprisonment; a term of supervised release of up to three (3) years; and a fine of up to $250,000.00, as well as a mandatory special assessment fee of $100.00.

The guilty plea brings the total number of defendants convicted in Operation Sideswipe to 37.

According to court documents, Brown falsely claimed that he was a passenger in a car that was struck by a tractor-trailer on May 11, 2017. In fact, the defendant conspired with Damian Labeaud ("Labeaud"), Mario Solomon ("Solomon"), and others to intentionally collide with a tractor-trailer in the area of Chef Menteur Highway and Downman Road in New Orleans.

After the intentional collision, Brown falsely informed NOPD officers at the scene that he had been driving the vehicle and that the tractor-trailer was at fault. Brown also filed a fraudulent lawsuit and lied in a deposition. This scheme caused the insurance company for the tractor-trailer to pay over $140,000.00 in settlement funds for the May 11, 2017 collision.

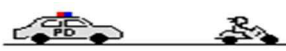
Guilty of Defrauding Insurer & Bank

Jay Wickey, age 64, of Sergeant Bluff, Iowa recently pled guilty to two counts of Forgery (Aggravated Misdemeanor) following an investigation by the Iowa Insurance Division's Fraud Bureau.

The investigation began in February 2019 after a complaint alleged Wickey had falsely endorsed the signature of a financial institution on multiple insurance checks. Wickey was arrested on December 21, 2019.

The investigation determined Wickey falsely endorsed the signature of his vehicle's lienholder, Regional Acceptance Bank, without their knowledge or consent, allowing him to collect proceeds for himself. Wickey's actions prevented Regional Acceptance Bank from protecting their financial interest by confirming the vehicle's repairs had been completed.

Following his guilty plea, Wickey received a two year suspended prison sentence, two years of probation, and was ordered to pay a fine of $625 as well as a probation enrollment fee of $300.



Zalma on Insurance Blog Posting

- True Crime of Insurance Fraud Video Number 73 May 13, 2022
- Never Settle a Proactive Suit Against Fraudsters May 13, 2022
- True Crime of Insurance Fraud Video Number 72 May 12, 2022
- Convicted Fraudster Frivolously Keeps Trying to Avoid Jail May 12, 2022
- True Crime of Insurance Fraud Video Number 71 May 11, 2022
- Homeowners Policy Provides no Cover for Killing Child by Leaving her in a Hot Car May 11, 2022
- True Crime of Insurance Fraud Video Number 70 May 10, 2022

- Liability Insurance Does not Continue Ad Infinitum May 10, 2022
- True Crime of Insurance Fraud Video Number 69 May 9, 2022
- Prosecution Proper for Accident in Missouri and Fraud in Kansas May 9, 2022
- True Crime of Insurance Fraud Video Number 68 May 6, 2022
- A Pox on Both Your Houses May 6, 2022
- How to Educate a Claims Staff of Insurance Professionals May 5, 2022
- True Crime of Insurance Fraud Video Number 67 May 5, 2022
- Doctor Attempts to Back out of Favorable Plea Deal When Sentenced to Jail May 5, 2022
- True Crime of Insurance Fraud Number 66 May 4, 2022
- Self-Insured-Retention Must be Fulfilled for Each Occurrence May 4, 2022
- True Crime of Insurance Fraud Video Number 65 May 3, 2022
- You Only Get the Insurance You Ask For May 3, 2022

New Book: Ethics For the Insurance Professional Third Edition

How The Covenant of Good Faith and Fair Dealing Requires Insurance Professionals to Act Ethically and With Utmost Good Faith and Fair Dealing

by Barry Zalma

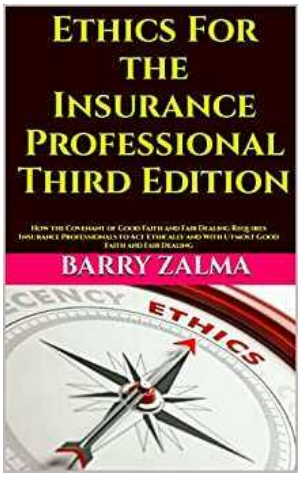
Ethics is Essential to the Insurance Professional

Insurance is, by definition, a business of the utmost good faith. This means that both parties to the contract of insurance must act fairly and in good faith to each other and do nothing that will deprive the other of the benefits the contract of insurance promised.

In essence the covenant requires that each party to the contract of insurance treat the other ethically, fairly and in good faith.

Without the covenant of good faith and fair dealing and without the people who work in the insurance industry applying and fulfilling the covenant ethically, insurance is impossible. One cannot act fairly and in good faith without being a person with a well-formed ethical compass.

In *Carter v. Boehm* S.C. 1 Bl. Burr 1906, 11th May 1766. 593, 3 Lord Mansfield in the British House of Lords stated: "Good faith forbids either party by concealing what he privately knows, to draw the other into a bargain, from his ignorance of that fact, and his believing the contrary."



Insurers, when making a decision to insure or not insure a risk, rely on the information provided to them by the insured. As Lord Mansfield instructed, the insured must provide the information requested honestly and in good faith. Failure to do so is unethical and breaches the covenant of good faith.

The implied covenant explains that no party to a contract of insurance should do anything to deprive the other of the benefits of the contract. By so doing an insurer must keep all the promises made by the policy fairly, promptly and in total accord with the promises made by the policy. Similarly, a person insured must treat the insurer ethically, fairly and in good faith when seeking the insurance. The implied covenant of good faith and fair dealing imposes obligations not only as to claims by a third party but also as to those claims made by the insured. When the insurer unreasonably, and in bad faith, withholds payment of the claim of its insured, it is subject to liability in tort. For the insurer to fulfill its obligation not to impair the right of the insured to receive the benefits of the agreement, it again must give at least as much consideration to the latter=s interests as it does to its own. Therefore, since, at the very least 1766, the business of insurance is a business of the utmost good faith. Each party to a contract of insurance must deal with each other ethically. The general duty of good faith and fair dealing incorporated by reference into every policy of insurance requires a complete understanding of ethics and ethical behavior.

In every insurance contract there is an implied covenant of good faith and fair dealing that neither party will do anything which will injure the right of the other to receive the benefits of the agreement. It was the decision of the California Supreme Court in *Gruenberg v. Aetna Insurance Co.,* 9 Cal.3d. 566, 108 Cal. Rptr. 480 (1973) that first stated that the tort of bad faith will apply to first party insurance in the state of California. Gruenberg was adopted in a majority of the states of the United States making the breach of an insurance contract unethically and in bad faith became a tort.

The covenant is mutual and the principles of good faith and fair dealing impose an affirmative obligation on the insured to cooperate as much as it requires the insurer to treat the insured fairly with regard to every claim presented.

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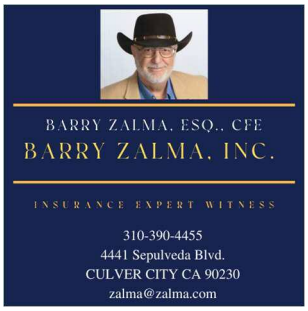
Barry Zalma, Esq., CFE

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



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

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Insurance Fraudsters Deserve No Quarter

New Book That Explains How to Defeat or Deter Insurance Fraud

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

How Giving No Quarter Worked

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

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

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

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

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