

This Page Was
Intentionally
Left Blank





Special Report:

Effective Strategies for Investigating Complex Insurance Fraud Cases

by John J. Smith

While it is probably true that the greatest number of insurance fraud-related crimes or civil insurance fraud violations¹ are “single incident insurance fraud matters” involving a single false claim submitted by an individual insured person, some insurance fraud crimes involve complex fraud schemes and multi-person conspiracies resulting in thefts of large sums of money. The most complex criminal cases investigated and prosecuted by the Office of the Insurance Fraud Prosecutor (OIFP) frequently involve:

- I. Staged Automobile Accident Conspiracies;
- II. Medical Service Provider Health Insurance Fraud; and
- III. Insurance Agent Theft.

This article discusses investigative strategies for these three types of complex cases.

In large part, the investigative strategies are governed by the different financial incentives presented by the underlying kinds of insurance coverages, the different kinds of fraudulent conduct committed by the targets involved in each kind of case, and related investigative and legal issues. It is especially important that law enforcement understands the financial incentives provided by each type of insurance policy which drives the conduct of the wrongdoers.

The underpinnings for all of the investigative strategies in this article are succinctly summarized in the following principles:

1. All complex insurance fraud investigations require a careful review and painstaking analysis of the records which constitute the particular insurance claim(s), and other records, in order to identify misrepresentations contained in the claims and to uncover other investigative leads.
2. In addition to a careful review of records, complex insurance fraud investigations require comprehensive field investigations to gather evidence, including interviews of targets and witnesses, and sometimes expert witness assistance.
3. Frequently, complex insurance fraud investigations require proof beyond a reasonable doubt that an event did not occur. Examples include staged accident conspiracies where the State must prove beyond a reasonable doubt that the accident did not occur; investigations of medical service providers, where the State must prove that a service was not rendered, or not rendered as described in the medical billing code or that a patient does not exist; and investigations of certain insurance agent frauds, where the State must prove that insurance premium financing was not sought or that an

1. See The Insurance Fraud Prevention Act, [N.J.S.A. 17:33A-1 et seq.](#), (hereinafter the “Fraud Act”) specifically [N.J.S.A. 17:33A-4](#) which enumerates civil insurance fraud violations. Criminal violations include Insurance Fraud, [N.J.S.A. 2C:21-4.6](#), Health Care Claims Fraud, [N.J.S.A. 2C:21-4.3](#), and Theft by Deception, [N.J.S.A. 2C:20-4](#), among others.

insurance customer for whom financing was arranged does not exist.²

4. Frequently, during the early stages of these complex investigations, the investigative effort is best directed at developing probable cause in support of a search warrant. The execution of a search warrant at the business location(s) of a target medical service provider or an insurance agent greatly increases the likelihood of obtaining evidence necessary for successful prosecution of complex cases.
5. Complex insurance fraud investigations require a close working relationship between law enforcement, insurance carrier claims personnel, and insurance carrier Special Investigations Unit (SIU) personnel to obtain all of the necessary claims documents, checks, and other records in order to gather the evidence and identify investigative leads.

Staged Automobile Accident Conspiracies

The investigation of staged automobile accidents³ will involve an examination of both property damage claims and Personal Injury Protection (PIP)⁴ claims planned and submitted by multiple persons playing different roles, most often in loosely knit conspiracies or rings.⁵ These

conspirators (or groups of conspirators) will engage in different kinds of fraudulent conduct enticed by the different economic incentives provided by the automobile insurance policy, as well as by other financial incentives. Not every investigation will target all of these conspirators, but all of these conspirators should be considered potential targets until the facts and evidence dictate otherwise.

The Conspirators and the Financial Incentives Which Control Their Conduct

The conspirators can include the insured person (hereinafter the insured) as well as the driver(s) and any passengers in the vehicle(s) (collectively called claimants); police officers or other police personnel, for example, police dispatchers; persons who act as “runners;” insurance claims adjusters (both independent contractors utilized by insurance carriers on a claim-by-claim basis and adjusters employed by the insurance company); the medical service providers;⁶ and plaintiffs’ personal injury lawyers.

Each of these persons plays a different role in a PIP fraud conspiracy. The role each plays is defined by the different financial incentives provided by the underlying automobile insurance policy, as well as by financial incentives provided from sources other than the insurance policy.

The underlying automobile insurance policy provides insurance coverages and corresponding claims money based on the different components of an auto insurance claim. The different components of the claim consist of PIP insurance claims for medical bills for insureds and claimants, claims for lost wages, and claims for essential services; a potential claim for “non-economic losses,”⁷ also known as pain and suffering, if the applicable threshold is met; and property damage claim(s) to the insured vehicle and to other vehicles.

A zero threshold auto insurance policy provides the greatest financial incentive for the conspirators in a staged accident PIP conspiracy. This is because it permits recovery of money for non-economic losses, i.e. “pain and suffering” even though no “objective” injuries such as broken bones and obvious lacerations or injuries are sustained by the claimant. See generally N.J.S.A. 39:6A-8.

In contrast, insurance policies which have a verbal threshold (or limitation on lawsuit option) require that the claimant sustain and prove certain kinds of objective injuries (death; dismemberment; significant disfigurement; fracture; loss of a fetus; permanent loss of a body organ, member, function or system; and so on)



2. Proving a negative is far more difficult than proving that an event did occur or that a specific person does exist, which frequently adds to the complexity of these investigations. Because these types of investigations frequently require proof that an event did not occur, the investigative effort is often best directed towards obtaining admissions from at least some of the targets that the event did not occur. Admissions that the event did not occur are more readily obtained in these cases when the targets are confronted by well prepared investigators who have analyzed the claims records and have identified the misrepresentations or inconsistencies in them.

3. The term “staged accident” is difficult to define and is frequently used to describe differing factual scenarios. It can include such conduct as “controlled crashes” where the participants in the vehicles intentionally “crash” or bump vehicles together and claim an accident occurred and injuries resulted; a “paper accident” where no accident occurs but a false or partially false police report is procured which describes an accident, sometimes supplemented by phony auto damage appraiser reports and medical records; a real accident where persons who were not involved in the accident claim that they were; and even intentionally

Deputy Attorney General Jacqueline Smith and Analyst Paula Carter work on an auto insurance fraud case.

Netmap for Claims Search Data Mining Software



NetMap for ClaimSearch and ViewLink Manager are data mining software tools. This computer screen shot depicts lines containing information which visually represents the relationships between claimants, addresses, providers, and claims.

in order to sue for non-economic losses (pain and suffering). These types of specific injuries are usually obvious and therefore difficult to “fake.” That is why zero threshold auto insurance policies are favored by the conspirators in staged accident fraud schemes. It is easy to fake complaints of back pain and soft tissue injuries, such as muscle sprains and spasms, and to submit claims for them. Insurance policies with a zero threshold permit suit for non-economic losses without requiring the claimant, their medical service providers, or their lawyers to offer concrete and objective proof of injuries.

Other financial incentives beyond the insurance policy can include cash payments, often provided to “runners” and to claimants, by medical service providers and lawyers. Typically, “runners” pay claimants to participate in staged accidents and to seek the professional services of a

particular medical service provider and/or lawyer. Sometimes, claimants are further enticed by the prospect of collecting lost wages and, most importantly, by collecting money for non-economic losses (pain and suffering).

The automobile insurance policy provides its own incentives to medical service providers to participate in phony accident conspiracies, or, at the very least, to pay “runners” to bring in patients. First, the PIP component of the policy virtually guarantees that the provider’s medical billings will be paid. Assuming the provider’s fee is sufficient to include a profit, increasing the number of PIP patients who are seen or treated increases the total profit. Second, soft tissue injuries, the type generally claimed by these patients, lend themselves to sustained courses of certain treatments, which also increases the amount of billing and hence profit.

colliding with other, innocent automobiles selected at random on public streets and highways.

4. While it is not the purpose of this article to detail the legal requirements for maintaining automobile insurance, suffice it to say that every owner of an automobile registered in New Jersey is required to maintain liability insurance against loss from bodily injury, death, and property damages arising out of use of the automobile. N.J.S.A. 39:6A-3 and 39:6A-3.1. Except for the lower-cost “basic,” N.J.S.A. 39:6A-3.1, and “special,” N.J.S.A. 39:6A-3.3, policies, all standard automobile liability insurance policies provide Personal Injury Protection (PIP) benefits, which are paid without regard to negligence or fault. N.J.S.A. 39:6A-4. PIP coverage includes: 1) payment of medical expense benefits for reasonable, necessary, and appropriate treatment and services to persons covered by the policy who were injured in the accident; 2) income continuation benefits for the loss of income as a result of bodily injury; 3) essential services benefits to reimburse necessary and reasonable expenses incurred for essential services ordinarily performed by the injured person for himself or his family; 4) death benefits limited to the maximum income continuation benefit that would have been paid

but for the death; and 5) funeral expense benefits, limited to \$1,000 per person. N.J.S.A. 39:6A-4. A “basic” policy includes a PIP medical expense benefit with a lower maximum benefit amount than the standard policy. It does not include the four other PIP benefits. N.J.S.A. 39:6A-3.1. The “special” policy includes PIP coverage for emergency medical care only, and a death benefit. N.J.S.A. 39:6A-3.3.

5. In a strict legal sense, a conspiracy involves an express or implied agreement among persons to commit acts to further a criminal purpose(s). N.J.S.A. 2C:5-2. While this article will utilize the terms “conspiracy” and “conspirator” when describing the conduct of all role players in a staged accident conspiracy, there have been few, if any, cases where the evidence was sufficient to prove that all of these players agreed with one another to engage in insurance fraud based on staged or fraudulent automobile accidents. In common parlance, staged accident conspiracies are often described as “rings” or “PIP mills” and it is commonly thought or implied that claimants, “runners,” doctors, and lawyers have met and either expressly or implicitly agreed to submit false auto insurance claims. The reality is that it is rare to obtain evidence proving that

claimants, “runners,” doctors, and lawyers have all met and expressly or implicitly agreed to submit false automobile insurance claims. Rather, these rings or associations exist most often as loosely connected groups of persons. It is probably true that if there is a common link among them, it is generally the “runner” who brings these parties together on an ad hoc basis operating in a loosely knit association to submit false insurance claims. This is not to say that there are not some cases where evidence will establish that some or all of the claimants, “runners,” doctors, and lawyers have agreed with each other to submit false claims.

6. For purposes of this article, the term “medical service providers” includes, but is not limited to, chiropractors, dentists, nurses, doctors, pharmacists, physical therapists, psychologists, and the employees and technicians associated with these professional practices.

7. Non-economic losses are losses for pain and suffering as contrasted with economic losses which include medical expenses, income continuation, essential services, and funeral benefits. See N.J.S.A. 39:6A-2. Non-economic losses are frequently recovered by claimants through a civil lawsuit.

Third, because these claimants have not suffered any real injury, the medical service provider is able to skimp on the amount of time and care expended on each patient. This frees the provider to see even more claimants and bill accordingly. Further, the greediest providers will pad their billings by conduct ranging from upcoding to billing for services or equipment which was never provided.

As for the lawyers, most plaintiffs' personal injury lawyers represent clients on a contingency fee basis. In a lawsuit seeking damages for pain and suffering from soft tissue injuries, the settlement the insurance carrier will approve is often based on the medical billings. The higher the billings, the higher the settlement, and thus, the higher the attorney's contingency fee. Thus, the attorney has his own financial incentive to encourage the client to seek medical treatment to drive up the billings.

These economic incentives motivate the provider to increase medical billings in order to increase his profit. The claimant is motivated to increase medical billings to increase the bodily injury settlement he hopes to collect. The lawyer is motivated to increase medical billings to increase the bodily injury settlement and hence his contingency fee. From an investigator's point of view, this creates the difficult situation

in which all the participants in a scheme share similar financial incentives, first, to have high medical billings and, second, to swear that those high billings are accurate.

It is critically important for law enforcement personnel investigating staged accident PIP fraud to understand these various financial incentives. Understanding the financial incentives provided by the different insurance claims emanating from a staged accident PIP fraud conspiracy allows the investigation to target each of the conspirators based on the role each plays and the financial incentives which entice each conspirator.

The Medical-Related Claims

Medical bills can include bills for diagnostic testing, as well as for medical treatments rendered to the insurance claimants, any medical supplies provided, and sometimes transportation to and from the medical service provider's office(s). These different categories of medical bills are all possible avenues for further investigation.

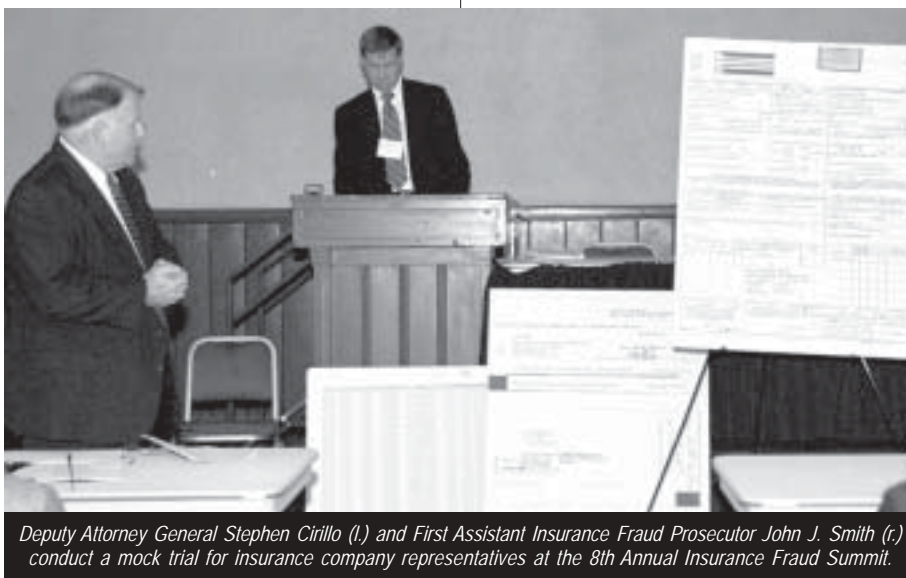
It is extremely rare to be able to prove that a medical service provider assisted with the planning or execution of staged accidents. In other words, it is difficult to obtain evidence to prove that the medical service provider knows that the accident is staged and that the claimants/patients are not actually hurt but are merely submit-

ting to treatment, or appearing to submit to treatment, so that false insurance claims can be submitted and a lawsuit for non-economic losses can be filed. As a result, medical service providers are rarely prosecuted for knowingly treating patients known to be faking injuries purportedly obtained in a staged accident.⁸

Experience teaches that it is best to investigate a medical service provider for complicity in a staged accident PIP fraud ring by seeking evidence that the provider billed for diagnostic testing or medical services and treatments not actually rendered to the patient, not rendered properly, not billed properly, or provided without medical necessity, rather than seeking evidence that the medical service provider knew that the accident was staged and that the claimants were not hurt. Should any information be produced that the provider treated claimants knowing that the accident was faked and that the claimant was not injured, however, such information should be aggressively investigated.

It is not uncommon to obtain evidence that medical service providers submitted bills for fraudulent medical testing and for services not rendered. In some cases, evidence can be obtained that the medical service provider billed for dates when the claimant did not appear for treatment, or if the claimant did, in fact, appear, billed for treatments not rendered to the claimant.

This type of medical fraud is facilitated by the fact that, frequently, persons willing to participate in staged accidents as claimants/patients in order to submit false insurance claims are not willing to attend the typically protracted medical treatment protocol associated with soft tissue auto accident injuries. This protocol generally requires



8. Medical service providers do not have to expressly agree to treat persons whom the providers know were in staged accidents and are not actually hurt in order to attract PIP patients. With the aid of others, usually "runners," there is a steady stream of claimants willing to serve as PIP patients and willing to falsely claim they were injured in an auto accident. Claimants are willing to claim injury and seek treatment because of financial incentives to include the fact that "runners" pay them to do so, usually between \$200 to \$500, and because the claimants, with the aid



Supervising Deputy Attorney General Tina Polites (l.) and Deputy Attorney General Phillip Mogavero (r.) draft a Motion for court.

claimants to appear for treatment several days per week for many successive weeks. Instead, claimants will simply fail to appear for treatment. If they do show up for treatment, they frequently do not stay at the medical office long enough to meet with the doctor, undergo any necessary follow-up examination, undergo additional diagnostic testing or x-rays, and undergo the physical therapy associated with the treatment plan. Nevertheless, medical service providers frequently will continue to bill for a claimant whether or not the claimant appears for treatment, or, if the claimant does appear, whether or not the claimant remains long enough to undergo the full panoply of diagnostic tests and treatments.

A careful review of the medical documents and records submitted with the insurance claim, together with other information, may provide law enforcement with evidence or leads to obtain evidence that bills were submitted for tests and treatments not rendered. If the investigation of this aspect of the automobile accident PIP ring is historical,⁹ the investigation should be directed at obtaining all of the treatment records for particular claimants, to include the medical service provider's appointment records and sign-in sheets,¹⁰ to confront the purported claimant/patient with these records and

question the claimant about dates on which he supposedly appeared for medical treatment and the treatment he actually received. Work records, time cards, travel and vacation records, and credit card receipts, as well as reports relating to incarceration in jail, have all been used to confront claimants to seek admissions that the claimant did not appear at the provider's office on a given date, even though the provider billed the insurance company seeking PIP insurance coverage for treatment allegedly provided to those claimants on those dates. Confronted with this type of evidence, some claimants will admit that on certain dates they did not appear at the medical practice for treatment despite insurance billing records to the contrary. In other cases, claimants will admit that even though they did, in fact, appear for treatment, not all of the services billed to the insurance company by the medical service provider were actually received by the claimant. In yet other cases, the investigation should obtain records pertaining to the availability of the medical service provider, to include the medical service provider's vacation schedule, credit card bills, travel agency records, and other such records, to develop evidence that the medical service provider was not present to treat the claimant on all the dates for which the insurance company was billed.¹¹

of personal injury lawyers, hope to also obtain a bodily injury settlement in the future.

9. The term "historical investigation" means an investigation that is directed to insurance claims submitted in the past. It does not include an investigation in which undercover investigators are currently attempting to infiltrate or have infiltrated the medical practice as patients or "runners," or where law enforcement surveillance of the medical practice is being conducted.

10. HIPAA privacy issues should not prohibit law enforcement from obtaining these records. See "Demystifying the HIPAA Privacy Rule," 2004 An-

nual Report of the New Jersey Office of the Insurance Fraud Prosecutor, March 2005, at 68.

11. The investigation should determine whether or not the absent medical service provider arranged for a substitute medical service provider to treat during vacations, or whether or not the nature and type of treatments prescribed for the patient could be "monitored" by the vacationing medical service provider. For an example of such a case, in a context other than PIP fraud, see *United States v. Siddiqi*, 959 F.2d 1167 (2d Cir.1992) and *Siddiqi v. United States*, 98 F.3d 1427 (2d Cir.1996).



Enlisting the aid of a medical expert can greatly assist law enforcement with the review of the medical records and can produce information about which the claimants can be questioned. With the assistance of an expert, claimants can be questioned about the manner in which the purported treatments were rendered, the equipment used, the length of time tests and treatments were administered, and so on. Evidence gleaned from this type of information can be used to build a case against a medical service provider despite recalcitrance on the part of the claimants.

A major objective at this stage of the investigation of a PIP fraud conspiracy should be to establish probable cause for a search warrant to search the medical service provider's office for additional evidence and seize treatment and insurance billing records.¹² To achieve this goal, the investigation should focus on identifying a number of claimants who can provide credible evidence that the medical service provider billed for services on dates when the claimant did not appear for treatment or other information to support the fact that claims submitted by the provider are false. However, the investigator should anticipate that some claimants will not remember and will not have records of the exact dates on which they appeared for treatment, nor in all likelihood, will all of them be inclined to cooperate.

Claimants are reluctant to cooperate because of the financial incentive PIP claims offer them, specifically a settlement or lawsuit which includes compensation for non-economic losses. While many claimants will provide admissions which are evidential of fraud, some claimants participating in a PIP fraud conspiracy are sufficiently sophisticated to understand that the greater the amount of medical treatments billed to the insurance company, the greater the potential bodily injury settlement they will likely receive for non-economic losses. Such claimants are less likely to cooperate. Other obstacles that impede the cooperation of claimants are the use of false identities, rendering it difficult to identify some claimants; the cohesiveness of ethnic groups and suspicion of law enforcement; the use of foreign languages; and issues relating to illegal immigration.

Complex Medical PIP Fraud

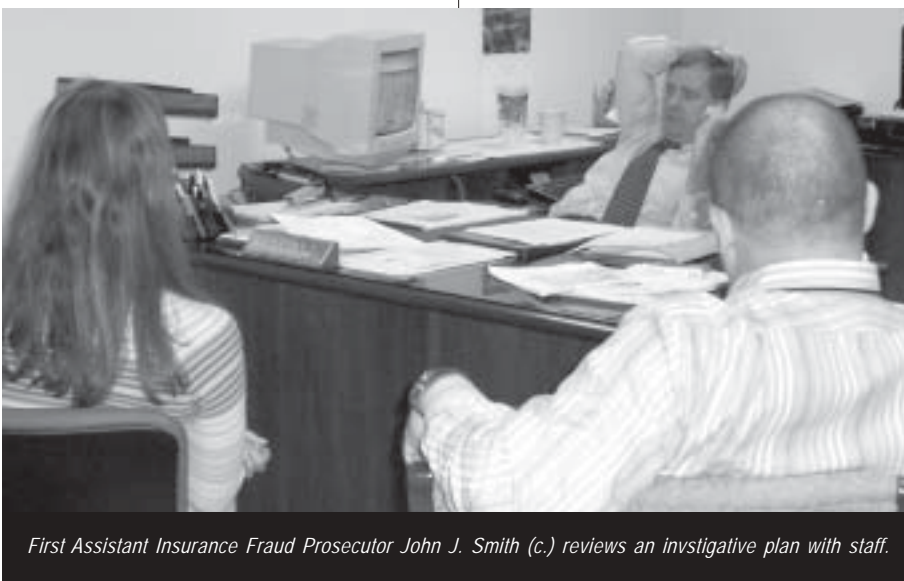
Heretofore, the description of the investigation of a medical service provider's participation in a fraudulent PIP conspiracy has been directed at the more obvious types of medical billing fraud committed by medical service providers. It should be noted that these investigations are nonetheless complicated, frequently require undercover investigative work, nu-

merous interviews, surveillances, preparation of an affidavit in support of a search warrant, as well as an extensive review of claims documents.

Law enforcement must also be aware of the financial incentives the PIP statute directly provides to medical service providers, and indirectly to PIP claimants and plaintiffs' attorneys, to fraudulently create the appearance that PIP claimants were injured in order to meet the threshold required by the PIP statute¹³ to file a lawsuit. These incentives lead to frauds more complex than billing for services not rendered.

Throughout the development of PIP law and the statutory verbal threshold, PIP insurance claimants, their attorneys, and medical service providers who treat claimants pursuant to PIP insurance coverage have sought to identify and articulate injury in order to meet the verbal threshold which enables them to file a lawsuit, and recover claims money for non-economic losses (pain and suffering). This provides a major financial incentive for medical service providers, plaintiffs' attorneys, and claimants.

Particularly troubling from an insurance fraud perspective is the long series of diagnostic tests which has evolved so that medical service providers, with the support and assistance of plaintiffs' attorneys and claimants, can increase medical bills and demonstrate that claimants sustained injuries. In connection with "soft tissue" injuries, diagnostic testing not only increases the costs which automobile insurance companies must pay the medical service provider, but those tests are used to



First Assistant Insurance Fraud Prosecutor John J. Smith (c.) reviews an investigative plan with staff.

12. One of the underlying premises for this article is that the investigation must obtain the documents and records related to the insurance claim. While documents and records can be obtained from the insurance company, it is more important that the documents and records be obtained from the target medical service provider. The preferable way to obtain such records and documents is to develop probable cause for a search warrant as opposed to issuing a grand jury subpoena or an administrative subpoena under the Insurance Fraud Prevention Act. A search warrant provides law enforcement with the advantage of surprise and experience teaches that the execution of a search warrant will generally produce more evidence than the issuance of a subpoena. Sometimes, interviews conducted simultaneously with the search



OIFP civil investigator Lisa Yildiz confers with an insurance carrier SIU about a fraud referral.

demonstrate that claimants were, in fact, injured and justify even more tests and more treatments. As a result, auto insurance companies must pay more money for medical services, and ultimately more money to settle cases or to pay judgments following a lawsuit, thereby paying more money to claimants and their lawyers.

The most difficult, challenging, and complex investigations of medical service providers are those that do not focus only on relatively straightforward fraudulent conduct, such as billing for services not rendered. The most difficult and complex investigations focus on whether or not the medical service provider billed appropriately for the diagnostic testing and medical services he/she actually rendered by utilizing the appropriate CPT Code,¹⁴ and whether or not the diagnostic testing and treatments given were medically necessary and properly delivered and not merely rendered to generate insurance claim revenue.

As stated, with respect to the medical billing, it is the medical service providers who have the primary financial incentive provided by the PIP coverage included in the standard auto insurance policy to bill

insurance companies as much as possible for medical expenses, including diagnostic testing and treatment. Since medical service providers, who are paid for diagnostic testing and medical services provided by PIP coverage, have few limits on their medical discretion and judgment,¹⁵ there is little to impede them from prescribing diagnostic tests and treatments to inflate the medical expense component of PIP claims.¹⁶ In order to maximize medical bills, some unscrupulous medical service providers may bill for more expensive services than are actually rendered or actually needed in order to maximize revenues to the medical practice.

Medical Service Provider Self-Referral

Law enforcement should be aware that unscrupulous medical service providers will refer patients to diagnostic testing facilities or medical supply companies in which they have an ownership interest to produce more insurance claims money for the medical service provider. Frequently, medical service providers have financial interest(s) in medical corporations which own diagnostic testing equipment, such as MRI machines,

will prompt witnesses in the provider's office to cooperate with the investigators.

13. *N.J.S.A. 39:6A-1 et seq.*

14. CPT Code, Current Procedural Terminology, is a nomenclature used to describe and report medical services and procedures. It is intended to be a uniform language which accurately describes medical, diagnostic, surgical, and related services. It is commonly used with respect to medical bills and claims submitted to insurance companies for payment.

15. Legislative attempts to deter medical service providers from overprescribing diagnostic tests and treatments include publishing PIP fee schedules and requiring pre-certification of certain diagnostic tests and treatments.

16. One mechanism to deter medical service providers from overprescribing unnecessary diagnostic testing and treatment utilized by insurance companies is the concept of Peer Review. Frequently, insurance companies will procure the services of a Peer Review doctor who will then review the diagnostic testing and treatments rendered by the target medical service provider. The reports of Peer Review doctors can be valuable to law enforcement to assess the alleged fraudulent conduct of the target medical service provider and can sometimes contribute to the effort to articulate probable cause for a search warrant. Law enforcement investigations of medical service providers suspected of engaging in PIP fraud should obtain and carefully review any available medical reports by Peer Review doctors.



or in corporations which include ambulatory surgical centers,¹⁷ or in corporations that provide medical supplies. These providers may refer claimants to these related corporations so that the medical service provider can bill the PIP insurance carrier for services, supplies, and equipment provided by the related corporations in order to maximize revenues to the medical service provider. This practice is known as self-referring.

Medical service providers utilize different artifices to conceal their ownership interest in these related corporations. Sometimes, these entities are incorporated in the names of persons related to or employed by the medical service provider. Bills are then submitted to insurance companies utilizing different Taxpayer Identification Numbers (TIN)¹⁸ in order to create the illusion that the payments are going to separate providers even though, in reality, the revenues are ultimately flowing to the target medical service provider. Law enforcement must be aware of such practices utilized by medical service providers who submit medical bills under the PIP component of an automobile insurance claim.

OIFP maintains a comprehensive Web Site at www.njinsurancefraud.org

Other Complex Medical Service Provider Frauds

In addition to inflated and unnecessary diagnostic testing and self-referrals, complex PIP medical provider fraud includes billing for services which are more expensive than the services actually rendered. This is sometimes referred to as "upcoding." Another type of PIP medical provider fraud involves billing separately for components of a procedure in order to improperly inflate billings, also known as "unbundling."

Pain management techniques have recently emerged as an area where medical service providers can bill for more expensive services than those actually rendered. For example, trigger point nerve stimulation has been billed as more invasive epidural injections. Medical service providers have also been prosecuted for falsifying reports of diagnostic testing related to Nerve Conduction Velocity studies.¹⁹ In these cases, medical service providers have either "cut and pasted" the names of patients with normal reports onto diagnostic reports of other patients who had abnormal Nerve Conduction Velocity studies, duplicated wave length lines either within a report or across several reports to make the reports appear abnormal, inserted false numeric values which could not physically be reported by the diagnostic machine utilized,²⁰ and other related frauds and schemes.

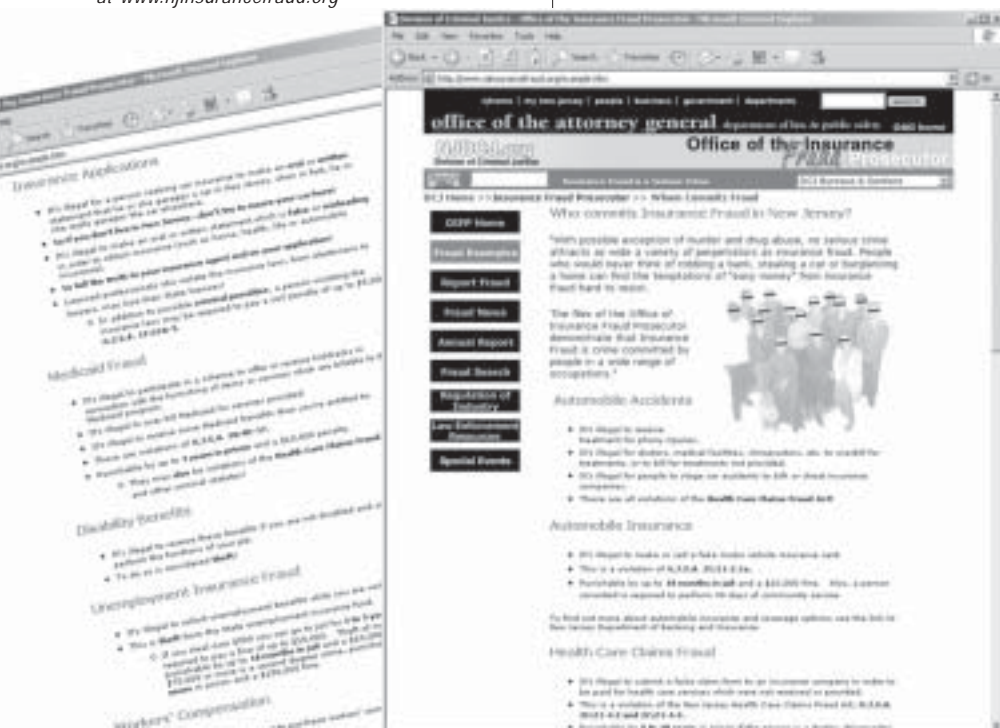
In addition to the more complex and difficult-to-prove schemes discussed above, law enforcement has encountered several diagnostic tests and treatments which provide medical service providers with a purported medical basis upon which to justify continued medical treatment and further increase the amount of the medical bills submitted to the insurance companies. These tests and treatments include, but are not limited to, use of an activator;²¹ Computerized Tomography/CAT Scan;²² Electromyography; Needle EMGs and Surface EMGs;²³ Evoked Potentials;²⁴ hot and cold packs;²⁵ Kinematic MRI;²⁶ Magnetic Resonance Imaging (MRI);²⁷ Nerve Conduction Velocity Studies (NCVs);²⁸ Surface Electromyography (SEMG);²⁹ Transcutaneous Electrical Nerve Stimulation (TENS);³⁰ Traction-Mechanical;³¹ Vertebral Axial Decompression (VAX-D);³² and X-rays.

Such diagnostic tests and treatments also provide plaintiffs' attorneys and insured claimants with a basis to allege that an injury was suffered within the meaning of the PIP statute so that lawsuits can be filed for non-economic losses. Law enforcement must develop innovative investigative strategies to detect, investigate, prosecute, and deter insurance fraud based on these tests and treatments, as well as other complex and ever-evolving PIP medical frauds.

17. Ambulatory Surgical Centers (ASCs) were authorized by federal regulations to provide facilities for surgical, diagnostic, and related procedures which are too complicated to be performed in a doctor's office yet do not require the full facilities of a hospital. Medical service providers can own, operate, and control ASCs to provide and bill for increasingly complicated diagnostic procedures and surgeries. Under these circumstances, additional charges, to include facility fees, can be charged by the medical service provider. ASCs appear to be emerging as providing additional avenues and financial incentives for fraud. See generally 42 C.F.R. 416.2.

18. The Taxpayer Identification Number (TIN) is the number assigned by the Internal Revenue Service to businesses which have tax obligations. Insurance companies use the TIN to track payments made to medical service providers and their corporations.

19. *State v. Barry Vogel*, Indictment No. SGJ479-03-5, Union County 2003; See also 2003 Annual Report of the New Jersey Office of the





OIFP civil investigators review documents in a health care fraud case. Pictured, l. to r. civil investigators Bonnie Apone, Shawn Stewart, and Joseph Lombardo.

A commonly encountered related allegation is that some of these tests are provided by persons, often employees of the target medical service provider, who are not licensed or certificated to perform these diagnostic tests and treatments. Law enforcement must determine the licensing status, training, and education of persons who perform these tests and treatments.

Auto Property Damage Claims

Besides paying for medical billings, the automobile insurance policy also provides coverage for property damage. This provides another financial incentive for fraud. Property damage claims include damage to the insured vehicle (collision), as well as damage to other vehicles (liability). Some staged accidents are designed primarily, if not exclusively, to file insurance claims for automobile (property) damage only, as opposed to filing bodily

injury-related claims, including PIP and non-economic losses.³³

From the standpoint of the conspirators, particularly claimants whose cars sustained damage attributable to the insured vehicle, property damage claims have advantages. Auto insurance carriers will pay property damage claims, usually based on a police automobile accident report and/or an auto damage appraisal report,³⁴ with much less scrutiny than is given to bodily injury claims. For example, in a large-scale insurance fraud case prosecuted by the Division of Criminal Justice, more than \$1 million in property damage claim money was stolen from a large auto insurance carrier with few, if any, related bodily injury claims. Typically, these fake property damage claims were based on a report that a driver of the insured vehicle lost control of the insured vehicle, then struck two

Insurance Fraud Prosecutor, March 2004, at 118.
20. Cadwell machine.

21. An activator is a chiropractic manipulative treatment used in connection with chiropractic adjustments to decrease muscle spasms.

22. CAT Scans are a specialized type of X-ray sometimes used to better visualize soft tissue injuries.

23. Needle EMGs and Surface EMGs are used to determine how muscles respond to electrical stimulation in order to determine whether or not an injury exists. Surface EMGs use electrodes attached to the skin by "sticky pads" and Needle EMGs use needles inserted directly into muscles to record muscle responses to electrical stimulation.

24. Evoked Potentials/Somatosensory Evoked Potentials are used to assess peripheral sensory function to determine whether or not there is neurological injury.

25. Hot and cold packs are used to treat pain

and muscle spasms and to reduce swelling. A common allegation is that medical service providers bill for hot and cold packs but do not always provide them to claimants.

26. Kinematic MRI is a magnetic resonance imaging scan of a body part in motion.

27. Magnetic Resonance Imaging (MRI) is an in-depth radiological study. Recent investigations have focused on the question of whether or not a three-dimensional image was produced at higher cost to the insurance company than a standard image.

28. Nerve Conduction Velocity studies utilize electrodes attached to the skin by "sticky pads" to deliver electrical stimulation and record nerve responses to that stimulation. Frauds related to NCVs have previously been described.

29. Surface Electromyography purportedly measures the effect of electrical stimulation on muscles.

30. Transcutaneous Electrical Nerve Stimula-

tion is a hand-held device used to relieve chronic pain and is frequently prescribed to patients for home use.

31. There are various mechanical traction devices, including cervical traction and lumbar traction. Mechanical traction is used to relieve muscle spasms. There have been allegations that medical service providers fraudulently bill mechanical traction as a surgical procedure.

32. Vertebral Axial Decompression is used to "decompress" the lumbar spine and is purportedly a non-surgical treatment for herniated discs.

33. *State v. William McLaughlin*, 310 N.J. Super. 242, 263-65 (App. Div.), cert. den., 156 N.J. 381 (1998).

34. Investigators should begin every staged accident investigation by verifying that the police accident report(s) is genuine. The police officer who wrote the report, while he/she likely will not remember the particular accident, should be identified and interviewed and the validity of the report confirmed.

other parked luxury cars. Fictitious police reports were used to document the accident and included such “excuses” as: “dropped lit cigarette in lap and lost control;” “dog ran out in front of the car;” “reaching for radio and lost control of car;” and so on.

In essence, this case consisted of many property damage claims involving three cars for a total amount of just under \$30,000 for each phony claim. Few, if any, bodily injury claims were submitted. None of the purported accidents actually occurred, and none were staged. They were all paper accidents supported by police accident reports. The defendant who was the “ringleader” was an independent auto insurance appraiser.³⁵ He masterminded the conspiracy by preparing fictitious police accident reports to support the claims from a pad of blank police reports in his possession or, in other cases, by paying bribes to police officers to write fictitious reports to support the claims.

As an independent auto insurance claims appraiser, the mastermind also had in his possession a box of photographs of many different makes and models of damaged cars which he would append to the damage appraisal reports submitted to the insurance company to further support the insurance claims. Each claim was submitted at less than \$10,000 per car which, at that time, was the limit below which no additional insurance company review was required.

The case was successfully cracked when the investigative focus was directed towards a careful examination of the docu-

ments and records. Specifically, it was only after the investigation uncovered evidence proving that the police reports, the appraisal reports prepared by the mastermind which detailed the damages to the three cars, and the photographs of damaged cars submitted in support of the claims were fictitious that the scheme was unraveled.

An interesting investigative sidelight to this case was uncovering how the insurance policies were procured for the claimants. The investigation revealed that, in many cases, the mastermind recruited persons to act as insured claimants and assisted them in obtaining insurance policies from the insurance company which ultimately paid the phony claims. Fictitious identities were used in some cases. Eventually, all of the conspirators were identified by tracing the insurance policies back to the insurance agency that sold many of the policies against which the fictitious property damage claims were made.

Investigating automobile property damage claims ordinarily requires reviewing fewer documents than investigating claims involving bodily injuries.³⁶ Property damage claim records available from the insurance company typically include an ACORD form, which provides first notice of the claim either to the insurance agent or directly to the insurance company, the police report, an auto damage appraisal report, sometimes a tow truck bill, and oftentimes photographs of the damaged vehicles. The investigation of a property damage claim should focus on

obtaining these documents, reviewing them to extract investigative leads, confronting the claimants with suspect statements or omissions, and questioning them in order to obtain admissions and confessions.

Investigators should obtain a copy of the police report directly from the police department, and compare it to the copy submitted to the carrier. First, investigators should confirm whether the accident report was, in fact, written by a police officer, or whether the accident report is wholly fictitious. Second, investigators should compare the report on file with the police department with the copy submitted to the carrier to see if any information has been altered or added.³⁷

One other avenue of investigation that may produce a useful investigative lead is to further check the insurance claim file to determine whether or not a bill from a towing company was submitted. Fraudsters submitting false auto damage claims frequently report that the car was so badly damaged that it was not possible to drive it away. In such cases, there should also be a tow truck bill. While insurance cheats are frequently clever enough to concoct fictitious accidents with fraudulent police reports, insurance appraisals, and photographs, they frequently overlook the tow truck bill. Accident claims which reflect substantial damage to automobiles should also include a tow bill, and the absence of a tow bill is an investigative lead which should be pursued to determine whether the accident is fictitious.

35. An independent appraiser is an appraiser who is not an employee of the auto insurance company but rather is contracted on a case-by-case basis by the auto insurance company.

36. All insurance claims consist of documents and records. Persons commit insurance fraud by including false information on the claims documents and records in order to deceive the insurance company into paying them money to which they are not entitled. All insurance fraud investigations of whatever type must focus on the claims documents and records, particularly the misrepresentations or omissions reflected therein, and must obtain proof that the information reflected

is false. This review is best conducted by law enforcement working in partnership with insurance carrier claims and SIU personnel.

37. The mere fact that the accident report is on file with the police department does not guarantee its accuracy. Unfortunately, investigators must be alert to the possibility that the officer who prepared the report is involved in the fraudulent scheme. See *2004 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor*, March 2005, at 104.

38. Fictitious claims frequently require the prosecutor to prove that something did not happen.

Requiring proof that an event did not occur is extremely difficult. It is much more difficult than proving that something did happen. To be successful, such investigations require that the investigator obtain admissions from some, or at least one, of the conspirators that the underlying auto accident was staged. In order to obtain such an admission, the investigator must obtain the documents and records which comprise the insurance claim, review same, note possible inconsistencies and misrepresentations, and then confront the conspirators with other facts obtained during the investigation in order to obtain admissions that the accident did not occur.



John J. Smith (l.). NJSIA President Paul Gallo (r).

*First Assistant Insurance
Fraud Prosecutor John J. Smith
Receives NJSIA
President's Award*

Additional aspects of property damage claims which may produce investigative leads include claimants submitting for ancillary expenses to include rental cars and damage claims for the contents of the vehicles involved in purported accidents. Investigators should obtain and review records of these ancillary claims and question claimants about the claims submitted for these expenses. Frequently, evidence or investigative leads can be developed through this line of questioning.

The review of claims submitted to insurance companies for car rentals has produced valuable evidence to prove that claimants submitted false claims based on the fact that the underlying automobile accident never occurred. Similarly, false claims have been submitted for damage to property contained in the car included in the purported accident even though evidence indicates that the accident was fictitious. By obtaining the documentary evidence associated with claims for rental cars and contents claims, the investigator can confront the suspect claimant with additional evidence and pursue additional lines of questioning which may lead to statements, admissions, or confessions both about the auto property damage claim and about the PIP and bodily injury aspects of the claim, if any.³⁸

Lost Wage Claims

Law enforcement should be aware that in addition to phony bodily injury claims for non-economic losses, the lost wage portion of a PIP insurance claim provides claimants with another economic incentive to falsify a claim. Sometimes auto insur-

Experience teaches that when the appropriate documentary evidence is obtained and used to confront the suspect claimant or passenger, one or more of these persons may admit that the accident did not occur. This serves as the basic predicate for the entire case and these admissions, coupled with the documentary evidence and other evidence gathered during the course of the investigation, can be used to obtain convictions of those persons who refuse to cooperate and elect to go to trial.

First Assistant Insurance Fraud Prosecutor (FAP) John J. Smith received the New Jersey Special Investigators Association (NJSIA) President's Award for Outstanding Service to the NJSIA in 2005. This award recognized the expertise and level of achievement reached by FAP Smith throughout his career in fighting insurance fraud.

FAP Smith is an Assistant Attorney General with the New Jersey Division of Criminal Justice (DCJ) where he has been employed since 1985. As the First Assistant Insurance Fraud Prosecutor, AAG Smith oversees all criminal insurance fraud investigations and prosecutions as well as investigations of civil violations of the Insurance Fraud Prevention Act in the Office of the Insurance Fraud Prosecutor. FAP Smith, who has been with the Office since its inception, served as Acting New Jersey Insurance Fraud Prosecutor for approximately six months.

FAP Smith was instrumental in drafting legislation critical to the creation of the Office of the Insurance Fraud Prosecutor as well as policies and procedures to define the function of the Office. An expert in the field of Insurance Fraud law, FAP Smith has also drafted provisions of the criminal laws in New Jersey utilized to prosecute insurance fraud. He has personally tried numerous criminal cases, including insurance fraud, to verdict before juries.

FAP Smith's expertise in the field has long been recognized throughout the insurance industry as well as the legal and investigative communities. He has been an instructor for the New Jersey Institute for Continuing Legal Education on the topics of insurance fraud and health care fraud. He regularly teaches DCJ Academy courses for New Jersey criminal and civil state investigators. He received a Certificate of Appreciation for his anti-fraud presentation at a joint seminar sponsored by the Private Detectives Association of New Jersey and The Association of Certified Fraud Examiners.

FAP Smith has received awards from the New Jersey Attorney General, recognizing his dedication, direction, service, and productivity within the Office. He also received a DCJ Director's Award for his work in the prosecution of *State v. Carl Lichtman, et al.*, one of the largest insurance fraud cases ever litigated in the State of New Jersey.

FAP Smith previously served as Chief of DCJ's Casino Prosecutions Section before transferring to DCJ's Economics Crime Bureau where he served as a Supervising Deputy Attorney General (SDAG). As SDAG, FAP Smith had oversight responsibility for the Insurance Fraud Unit, the Medicaid Fraud Unit, and the Major Fraud Unit, which included Tax and Securities Fraud, and general "major fraud" cases involving public money and other crimes.

FAP Smith is active in the United States Army Reserve, Judge Advocate General's Corps, where he holds the rank of Colonel. From 1982 to 1985, FAP Smith served on active duty in the United States Army as a Captain in the Judge Advocate General's Corps where he prosecuted criminal cases as a military trial counsel. He was also appointed Special Assistant United States Attorney at Fort Dix, New Jersey, where he prosecuted cases before the U.S. Magistrate.

FAP Smith received a Bachelor of Arts degree from Pennsylvania State University. He earned his law degree at Duquesne University and a Master of Laws in Taxation from Temple University.

ance claimants will submit claims for lost wages that are greatly inflated. Claimants who were unemployed at the time of the purported accident may also submit claims for lost wages from a non-existent job. With respect to any lost wage claim, investigators should obtain the documents submitted to the PIP insurance carrier in an effort to determine whether or not the insured claimant actually lost the wages claimed as a result of the purported auto accident. The Department of Labor can provide quarterly wage reporting records to confirm whether or not insured claimants were working prior to the purported accident.

Essential Services Claims

Another component of a personal injury auto insurance claim is the claim for essential services. Essential services are meant to compensate the insured claimant for personal services which he is no longer able to provide for himself as a result of injuries sustained in the auto accident. Law enforcement should recognize essential services as another financial incentive for a claimant to commit fraud. On occasion, insured claimants will submit essential services claims to insurance companies for essential services which were never rendered on behalf of the claimant. This is sometimes done by falsifying receipts paid to maids and housekeepers, or by claiming that persons who are friends or relatives of the insured claimant provided essential services when, in fact, they did not. Interviews of these persons to confront them with documents, such as receipts, bills, checks or money orders, related to the suspicious essential services claim will sometimes produce valuable evidence, not only about the false essential services claim, but also

of the entire auto accident insurance claim.

Investigative Techniques

Some of the underlying premises of this article are that all documents related to the claim must be obtained and analyzed, and that damaging admissions are more apt to be obtained when fraud participants are confronted with inconsistencies and other leads gathered through a careful analysis of those records. This section describes some of the records relevant to staged accident frauds, as well as the usefulness of undercover operations and expert medical assistance.

Police Reports

Evidence that an automobile accident did not occur can be developed by focusing investigative effort on the police report. Fraudulent automobile insurance claims have been based on police reports written by officers who were bribed to write false police reports, or on police reports that were wholly fictitious and were written by conspirators using pads of blank form police reports. Wholly fictitious police reports submitted to support insurance claims will not be officially “on file” in the police department, which is why any investigation of a suspected staged accident must begin with verifying that the police report submitted to the carrier is identical to a genuine report on file with the department.

If a police report can be proved to be false or fictitious, all of the insurance claims which flow from the accident described in the police report can more readily be proved to be fraudulent. Insurance companies rely heavily on the police report when deciding whether or not to pay insurance claims, particularly auto property damage claims. The investiga-

tion should, therefore, first focus on attempting to prove that the police report is not genuine in whole or in part.

However, it is not always possible for the investigator to obtain proof that the police report was fraudulent. Many police reports are “walk-in” police reports. A “walk-in” police report is generated when purported claimants go to the police station and report that an automobile accident occurred. In such cases, no police officer “investigates” the accident, observes the accident scene, or the fact that an accident actually occurred. The occurrence of the accident is based solely on the report given by the potential “walk-in” claimant. While the “walk-in” report appears genuine, the index of suspicion for these reports should be very high.

Even if a police officer is called to the scene of an accident and views what appears to be the aftermath of an auto accident, the accident may nonetheless be staged. Investigative experience has demonstrated that claimants will sometimes “stage” accidents in the streets by crashing cars together to create an accident scene.³⁹ Thus, a police officer who is called to the scene of such a “staged” accident may write a police report which, from the police officer’s perspective, is genuine, but actually depicts a fraudulent staged accident. Law enforcement investigating PIP fraud must view all police accident reports with skepticism.

PIP Applications

Another important record that should be obtained during the investigation is the PIP application. The PIP application is used by each claimant to initiate an automobile PIP claim. PIP applications require that the claimant state that he/she

39. See *State v. Anhuar Bandy*, Indictment No. SGJ456-02-8(9), Union County, 2002; *State v. John Groff*, Indictment No. SGJ444-01-6(1), Camden County, 2001.

40. See *N.J.S.A. 2C:21-4.3f(2)*, Health Care Claims Fraud, which provides: “the falsity, fictitiousness, fraudulence, or misleading nature of a statement may be inferred by the trier of fact in the case of a person who attempts to submit, submits, causes to be submitted or attempts to

cause to be submitted any record, bill, claim or other document for more treatments or procedures than can be performed during the time in which the treatments or procedures were represented to have been performed.”

41. In order to insert investigators in an undercover capacity as patients of the medical service provider, law enforcement may wish to make use of pretext insurance policies and coordinate with local law enforcement in order to have a po-

lice report on file with respect to a fictitious auto accident. Pretext insurance policies have been successfully used in criminal investigations of insurance fraud. See also *Commonwealth v. Shuman*, 462 N.E.2d 80 (Mass. 1984).

42. Investigators have successfully infiltrated PIP fraud conspiracies and served in an undercover capacity as “runners” and have directly dealt with both lawyers and medical service providers, accepting money to procure clients and patients to serve as PIP claimants.



was, in fact, in an auto accident and suffered injuries. The PIP application generally requests information about medical treatments, lost wages, and requires the claimant's signature.

When attempting to seek admissions or confessions from persons who are claimants suspected of participating in staged automobile accidents, the PIP application is an important document to use to confront the purported claimant. While it may seem that claimants would rarely admit that an accident did not occur, investigative experience teaches that sometimes claimants who are confronted with inconsistencies about the accident gleaned from police reports, PIP applications, and other insurance claims records will admit that the accident did not occur.

Claim Checks

The investigation should also obtain all insurance claim checks paid as a result of the purported staged accident claim. Claim checks for property damage, medical expenses paid pursuant to the PIP coverage, as well as checks used to reimburse insured claimants for rental cars, lost wages, and essential services are important to developing the facts, particularly the amount of money paid. As part of the investigation, bank accounts and any money which may be available for restitution or subject to forfeiture should be identified by tracing the claim checks into bank accounts owned by the conspirators.

Undercover Investigations

If the investigation of the medical service provider's office is not historical, in that it is not focused on past claims, and law enforcement is investigating a presently operating practice, other investigative

techniques should be considered. In addition to the aforementioned search warrant, successful investigative techniques utilized include conducting surveillance of claimants entering the medical service provider's office and recording the amount of time the claimant remained in the office;⁴⁰ inserting investigators in an undercover capacity posing as claimants to record statements made by the medical service provider or persons assisting him;⁴¹ and gaining the confidence of the medical service provider or lawyer and serving as a "runner"⁴² who is willing to refer other claimants to the medical practice in return for payment.

Following some or all of the investigative techniques described above, a search warrant can be prepared and executed to accumulate additional evidence and identify additional claimants of the medical service provider so that the field investigation can continue to develop the full scope of the fraud.

Expert Assistance to Guide the Investigation

While medical and other experts have been commonly used at trials to explain medical issues to triers of fact, including petit juries, judges, and various administrative boards, law enforcement investigating medical service providers who commit fraud related to medical diagnostic tests and treatments will frequently require the assistance of a medical expert during the investigation to review medical records, to render opinions about the nature of the services rendered and billed to the insurance company, and to assist with developing questions to ask the claimants and/or the target medical service provider. This information, together with the other facts and evidence gathered during the investigation through patient interviews, interviews of employees of the medical service provider, and from claim and patient file review, will augment an affidavit of probable cause to obtain a search warrant.⁴³

43. Although there have been few criminal prosecutions based on unnecessary medical testing which was actually rendered to insured claimants, with the assistance of expert witnesses, law enforcement has begun to mount investigations and prosecutions based on allegations that treatments were not necessary in the context of automobile insurance PIP fraud.

Staged Accident PIP Fraud Conspirators

Claimants

During the early stages of an investigation into a PIP fraud conspiracy, the investigative focus should be on the police report, the PIP application, and other claims documents. Following a painstaking review and analysis of those documents, a field investigation that includes questioning claimants should be conducted in order to obtain evidence that the accident did not occur. Generally, questioning of claimants should include three basic areas: whether or not the accident occurred; whether or not all medical treatments were received; and whether or not a “runner” was used to recruit the claimant, as well as the identity of the “runner.”

As previously noted, while it is difficult to obtain direct evidence that the medical service providers and/or the lawyers participated in the submission of PIP claims and the filing of bodily injury suits knowing that the underlying accidents were staged and the claimants are faking injuries, on the other hand, claimants and “runners” do participate in the actual staging of phony accidents, and this fact can be exploited to the advantage of law enforcement. The initial investigative focus with respect to the purported claimants should, therefore, be to obtain admissions that the underlying accident(s) was staged by confronting them with details from the police report and PIP application(s) and any other evidence which tends to show that the accident was staged.

Whether or not the claimants admit that the accidents were phony, the questioning of the claimants should then shift and they should be questioned about the medical treatment records. They should be asked whether or not they appeared for all the treatments the medical service providers billed the insurance companies, and whether or not they received all the medical tests, treatments, and medical supplies billed by the medical service providers, in order to develop evidence that the medical service providers billed insurance companies for treatments not rendered or even for unnecessary medical tests.

The claimants should also be questioned about the “runner” who recruited them for the staged accident. This line of questioning should attempt to elicit the identity of the person for whom the “runner” works, to include medical service providers, lawyers, or even other “runners;” whether the claimant was paid, how much and from what source the “runner” obtained money to pay the claimant to participate in the accident; and whether the claimant was present when the “runner” spoke with the medical service provider, the doctor’s office manager, or the lawyer, as well as what was said.

It should be noted that identity fraud is common in auto insurance PIP fraud. Claimants have been known to simultaneously participate in multiple staged accidents and seek medical treatments using different identities. Frequently, the identity of claimants becomes an investigative issue. Investigative efforts must be made to verify the identity of the claimants.

“Runners”

Investigative experience teaches that many staged automobile accident conspiracies are initiated by “runners.”⁴⁴ Although acting as a “runner” or utilizing a “runner” is a crime in New Jersey, it has been argued that conduct which is limited to merely identifying persons who were involved in legitimate automobile accidents and soliciting them to obtain services from a particular medical service provider or lawyer is not only benign, but is useful to society so that persons obtain appropriate medical care and are fully informed of their rights pursuant to the PIP law. However, investigative experience teaches that, far too often, “running” is not limited to legitimate accidents and is seldom benign.

“Runners” frequently are responsible for recruiting persons to stage and participate in automobile accidents and to seek treatment and file lawsuits for non-existent injuries. “Runners” are probably the driving force behind PIP fraud conspiracies in that they connect claimants to medical service providers and lawyers to take advantage of the financial incentives provided by the PIP statute. If “runner”

involvement is suspected, the investigation should focus on the “runner.” The purported claimants should be questioned about the “runner.” Some claimants will admit to receiving payments from a “runner,” as one incentive for participating in a staged accident.

“Runners” sometimes identify persons who were involved in legitimate automobile accidents by obtaining information from police departments, hospitals, and other sources. Some “runners” simply recruit persons “from the street” to participate in staged accidents. Police reports are obtained either after a crash is staged on the street and a police officer responds, or simply by walking into the police station and falsely reporting an accident as a “walk in.” The claimants created by the accident are then directed by the “runner” to particular medical service providers and/or lawyers to begin the process of instituting PIP claims and sometimes bodily injury claims for non-economic losses.

Some “runners” will identify legitimate automobile accidents with legitimate claimants, and then encourage people to “jump in” to the legitimate accident by having the “jump in” claimant falsely add his or her name to the police report. Some “runners” completely stage auto accidents or create wholly fictitious paper accidents by falsifying police reports as previously described. These are all reasons why law enforcement should begin investigations by focusing on the police report.

Investigations conducted by OIFP have involved “runners” who were disbarred lawyers; “investigators” hired by law firms; licensed private investigators; ambulance drivers and emergency medical technicians; chiropractors, doctors and relatives of doctors; police officers and

44. New Jersey passed a Criminal Use of Runners statute, effective July 12, 1999. The statutory definition of a “runner” is a person who, for pecuniary benefit, procures or attempts to procure a client, patient, or customer at the direction of, request of, or in cooperation with a provider whose purpose is to seek to obtain benefits under a contract of insurance or assert a claim against



other police department personnel, including police dispatchers; law students; medical and law office managers; and other persons who have no other identifiable occupation.

In some investigations of lawyers who are suspected of utilizing the services of “runners,” it is alleged that some lawyers will employ “runners” but cloak them with the title of “investigator.”⁴⁵ These “investigators” are frequently not licensed private investigators and are not assigned to investigate matters for which the lawyer has previously been retained by a client. Rather, these “investigators” identify persons involved in auto accidents, or fraudulently create potential insurance claimants by staging accidents, and soliciting those persons to become clients of the lawyer. Frequently, the investigation will uncover the fact that money is provided by the lawyer (or the medical service provider) to pay the “runner,” and to pay persons procured by the “runner” to serve as claimants. Frequently, that money is treated by law firms as “investigative fees” and deducted for tax purposes. This fact may present a basis for a state or federal tax fraud investigation.

OIFP investigations have developed evidence that the business of “running” has become even more sophisticated. “Runners” have initiated medical “marketing” businesses which are cloaked with the indicia of legitimacy. These businesses contact medical service providers for the sole purpose of soliciting PIP claimants for the medical practice under the guise of “marketing” for the medical practice.

One of the most effective investigative techniques for law enforcement to employ when investigating an ongoing automobile insurance PIP conspiracy in which a

medical service provider or lawyer is utilizing a “runner” is to attempt to infiltrate the conspiracy by having an investigator work undercover and pose as a “runner.” In several OIFP investigations, law enforcement has been able to gain the confidence of persons who are already “runners,” have those “runners” introduce undercover investigators to medical service providers or lawyers, gain the confidence of the doctor or lawyer, and become employed as a “runner.” By working undercover as a “runner” and using pretext insurance policies,⁴⁶ other law enforcement officers working in undercover capacities can pose as claimants, infiltrate the professional practices, and gather powerful evidence with which to prosecute the medical service providers, lawyers, claimants, and “runners.”⁴⁷

The investigation should also focus on determining who is providing money to the “runner.” Typically, “runners” are paid by medical service providers and/or lawyers. Oftentimes, “runners” are self-employed, servicing multiple medical service providers and lawyers simultaneously, and creating separate and distinct conspiracies. Investigations have produced evidence that the doctor, the doctor’s office manager, and/or the lawyer have all “fronted” money to “runners” to be used to provide an initial financial incentive to entice purported claimants. Such payments may include money paid to the “runner” for the “runner’s” personal benefit, as well as money given to the “runner” to entice the claimants.

The investigation should also determine what records, if any, are maintained by the doctors and/or lawyers who are utilizing the services of the “runner;” whether or not consensual recording equipment can be successfully

an insured or an insurance carrier for providing services to the client, patient, or customer. See *N.J.S.A. 2C:21-22.1a*. See also “OIFP’s Prosecutions Prove Corrupting Influence of ‘Runners’ on Health Care System,” *2003 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor*, March 2004, at 16.

45. For example see *State v. Irwin Seligsohn, et al.*, Indictment No. SGJ506-05-8, Essex County, 2005.

46. A pretext insurance policy is an auto insurance policy provided by an insurance company for investigative use by law enforcement. See footnote 41.

47. *State v. Anhuar Bandy*, Indictment No. SGJ 456-02-8(9), Union County, 2002.

employed; and the methods used by the “runner” to procure claimants, insurance policies, and automobiles. Finally, investigators should attempt to enlist the “runner’s” cooperation in reviewing other suspected insurance claim records obtained by law enforcement to identify evidence and investigative leads about other staged accidents.

Lawyers

Probably the most insulated participant in an automobile insurance PIP conspiracy is the plaintiff’s lawyer. Investigative experience teaches that it is difficult to obtain evidence that lawyers represent claimants knowing that the underlying accidents are staged or even knowing that the claimants did not appear for all the medical services for which the medical service providers billed the insurance company.

The lawyer relies on the claimant’s representation that he was involved in an automobile accident, examines the police report and the insurance policy, and awaits the medical reports and medical records from the medical service provider before submitting claims and making demands to the insurance company, all of which serve to provide the lawyer with a basis to deny that he knew the claim involved fraud. Lawyers have no financial incentive, nor any legal requirement, to pointedly question the client about the automobile accident or the medical service provider about the medical bills submitted to the insurance company or the medical reports which detail the claimant’s purported injuries. The lawyer, therefore, has plausible deniability because he relies upon the reports and statements of others, including those of the police officer, his client, and his client’s medical service provider.

Frequently, the “runner” and/or the claimant are the only persons who have direct contact with the lawyer. While prosecutions of lawyers for conduct related to the submission of fraudulent PIP and bodily injury claims to insurance companies are relatively rare, the best avenues of investigation may be to utilize the “runner” or the claimant, who agrees to coop-

erate with law enforcement, to target the lawyer or mount a successful undercover operation to infiltrate the law firm with undercover operatives.

Medical Service Provider Health Insurance Fraud

The investigation of medical service providers who submit fraudulent insurance claims to health insurance companies or self-funded health insurance plans in some ways parallels the investigation of medical service providers who submit fraudulent medical bills pursuant to the PIP component of auto insurance policies. Nonetheless, investigations of medical service providers who submit false health insurance claims frequently require a different investigative focus.

Comparison of PIP Fraud and Health Care Fraud

The two types of investigations are similar in that both require obtaining and reviewing medical records; frequently require the interpretation of CPT Codes; frequently require a parallel financial investigation to determine whether a civil forfeiture action or restitution is appropriate and feasible; usually require consideration be given to obtaining a search warrant; and oftentimes require a comparison of dates of treatment and nature of treatment as shown in billing records with information obtained from field interviews of patients concerning the dates the patients appeared for treatment and the type of treatment received.

There are differences, however, in the investigative approaches to medical service providers who submit fraudulent PIP claims pursuant to auto insurance policies and medical service providers who submit fraudulent claims pursuant to health insurance policies. One major difference is that, unlike an automobile insurance policy which provides financial incentives to commit fraud to each of the different persons involved in such claims, health insurance usually provides a financial incentive to commit fraud only to the medical service provider, and only occasionally to the patient. Thus, health insurance

fraud usually involves fewer targets than those often found in PIP fraud conspiracies. Despite this limit, large amounts of money can be stolen through fraudulent health insurance claims.

Another difference is apparent in the initial referral information submitted to OIFP involving these two types of allegations. Most PIP fraud referrals to OIFP begin with information about several underlying suspicious auto accidents. For example, frequently, PIP fraud investigations will be initiated based on information by an anonymous source that accidents are staged and that “runners” are soliciting claimants for various providers; or on information about several specific staged accidents; or on information that several of the underlying police reports were fraudulent in some way; or on information that a claimant(s) admitted that he/she was solicited by a “runner” to participate in a staged accident. Law enforcement will then begin to develop that information, usually focusing on a smaller and finite number of related claims. Once the evidence begins to develop, typically, law enforcement will then focus the investigation on a smaller number of claimants/patients treated by suspect medical service providers.

Because PIP referrals frequently begin with information about specific staged accidents, “runners,” claimants, or the medical service providers who treat them, the investigations tend to be more focused initially and usually involve a smaller number of claims. On rare occasions, however, a PIP fraud conspiracy is referred alleging that a medical service provider is “excessively billing” PIP carriers on a large and not clearly defined scale.

On the other hand, referrals to OIFP involving medical service providers who falsely bill health insurance or self-insured plans usually consist of allegations of fraud with respect to a few patients but with indications that fraud is suspected to be more widespread. The scope and parameters of the fraud are generally less well identified at the time of initial referral.



Frequently, such referrals include allegations that the medical service provider is misusing or abusing a specific CPT Code. Several patients are usually identified as examples of the alleged fraud in these types of referrals but the total number of instances of the suspect billings is unknown. In addition, TIN runs will evidence payment of large sums of money, sometimes over several years, but the number of specific patients for which allegedly fraudulent claims were submitted is not clear. Likewise, any issues regarding the medical validity of the specific CPT Code or Codes used or abused by the provider are equally unclear.⁴⁸

Initial Analysis of the Referral

Among the initial objectives of a law enforcement investigation of a medical service provider who is alleged to have fraudulently submitted claims to health insurance carriers is to conduct a preliminary review and ascertain the potential scope of the alleged fraud. In order to make this assessment, the investigation must determine the number of patients and health insurance companies involved, the period of time during which the alleged fraudulent conduct occurred, and, to the extent possible, whether or not the allegation of fraud is a matter about which reasonable medical opinions can differ or a matter which can be proved to be fraud by either the civil or criminal standard of proof.⁴⁹ Frequently, these steps can be accomplished by canvassing health insurance carriers, inquiring about any internal

investigations into allegations of fraud, requesting claims information and payment information (TIN runs) for the years in question, and consulting with experts to help guide the investigation.

Crime, Civil Fraud, or Difference of Medical Opinion

It is extremely important that law enforcement determine at the earliest possible time whether or not the alleged fraud is susceptible of proof by either the civil or criminal standard of proof. If this issue is not determined early in the investigation, a great deal of law enforcement time and resources can be wasted developing information and evidence about a medical billing issue that may not be best litigated in either a criminal or civil court because the underlying predicate cannot be proved by either the criminal or civil standard of proof. Such determinations are particularly difficult to make because these issues frequently involve subjective medical judgments which may not be susceptible of proof beyond a reasonable doubt nor even by the lower civil preponderance of evidence standard.

The determination of whether or not the performance of a medical procedure or use of a billing code can be proved to be fraudulent by either applicable standard of proof is the most difficult determination confronting law enforcement when investigating these allegations in either PIP fraud cases or in health care fraud cases. Nonetheless, law enforcement must determine early in the investi-

48. N.J.S.A. 17:33A-9 requires insurance companies to refer suspicious claims to OIFP. Frequently, health insurance companies referring matters to OIFP will allege that a medical service provider committed fraud or violated the Fraud Act by submitting a bill which is alleged to be fraudulent for any one of a variety of reasons. Typically, the referral will allege fraud in connection with one or more patients but the precise details are generally scarce. In other cases, OIFP will receive notice from health insurance companies of fraud allegedly committed by medical service providers after the insurance company has conducted a more comprehensive investigation and has elected to file a civil lawsuit. N.J.S.A. 17:33A-7d requires carriers who file civil lawsuits under the Fraud Act, including against medical service providers, to provide

notice to OIFP. Typically, the statutory notice requirement is met by providing OIFP with a copy of the civil complaint filed. These cases are known as "7d" cases. In these cases, the insurance company generally alleges fraud by a medical service provider on grounds to include billing for medical diagnostic tests or treatments not rendered or not necessary; the use or misuse of a CPT Code; or billing for services when the proper licenses and certificates have not been obtained by the medical service provider or his employees. In these cases, the carrier's internal investigation has progressed to the point where the scope of the alleged fraud, at least with respect to that particular referring health insurance carrier, has been more fully identified prior to the filing of the lawsuit. However, oftentimes, the extent to which the medical

service provider's alleged fraudulent conduct has impacted other carriers remains to be investigated.

49. In Liberty Mutual Insurance Company v. Rose Land, Frank Land and Steven Budge, (New Jersey Supreme Court docket A-124-04), the Supreme Court heard oral argument on October 24, 2005, on the issue of the State's burden of proof in civil insurance fraud actions brought pursuant to the Fraud Act. The State's position is that the appropriate standard is the preponderance of evidence standard. See also "A Comprehensive Guide to New Jersey Insurance Fraud Law," *2004 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor*, March 2005, at 28-29. The criminal burden of proof is beyond a reasonable doubt.

gation whether or not such a case can be proved in court by either the civil or criminal standard of proof before investigative resources are expended on a case that cannot be successfully litigated in civil or criminal court.

Other similar questions which frequently confront law enforcement at the onset of a health care provider investigation are allegations that a medical service provider is excessively billing. Allegations of excessive billing on the part of a medical service provider from the perspective of the insurance company may mean that the medical service provider is billing for unnecessary tests or charging excessively. Nonetheless, such allegations involve difficult issues to litigate in that they can constitute issues about which medical judgments can reasonably differ or disputes about the appropriate billing code to use. However, law enforcement should consider the possibility that an allegation of “excessive billing” may mean that the medical service provider is billing for treatments not rendered, an allegation which frequently does provide a solid basis for a law enforcement investigation.

Common Types of Health Care Fraud

Investigative experience teaches that criminal cases targeting medical service providers who submit fraudulent claims to health insurance companies run the gamut. They include billing for services not rendered; providing one service but billing for a higher level service (upcoding); billing medical services as separate components rather than a single service as prescribed by the CPT Code ei-

ther expressly or implicitly (unbundling); billing for more services than can be completed in the time available;⁵⁰ and billing for services when the medical service provider or his staff do not possess the specific certification or license that permits billing for that particular service. Other allegations of health insurance fraud by medical service providers include allegations of self-referral;⁵¹ allegations of cosmetic procedures, such as plastic surgery, falsely represented as medically necessary;⁵² and allegations that non-medical procedures are falsely represented as medical procedures.

Generally, cases involving dissecting medical procedures and testing in order to uncover fraud require the assistance of medical experts. Cases which involve an interpretation of CPT Codes are difficult and may require the assistance of a coding expert. For those investigations in which a determination is made that the fraud cannot be proved by either the civil or criminal standard of proof, the allegations should be referred to the appropriate professional board for licensing action.

Determining the Scope and Parameters of the Fraud

A systematic approach employed by law enforcement to ascertain the scope and parameters of an investigation of a medical service provider who is allegedly submitting fraudulent bills to health insurance companies should include the following investigative steps:

1. Searching of OIFP's database for previous referrals about the suspect medical service provider, whether or

not they led to the filing of a complaint alleging civil fraud or were referenced without investigation for intelligence purposes;

2. Contacting the appropriate professional licensing board, through the Enforcement Bureau in the Division of Consumer Affairs, to determine whether it has received referrals of fraud about the suspect medical service provider or whether or not it is conducting an investigation;⁵³
3. Canvassing other major health insurance carriers to ascertain whether any other carrier has received suspicious or fraudulent claims from the suspect medical service provider or has referred such matters to the carrier's Special Investigations Unit;
4. Requesting Taxpayer Identification Number (TIN) runs to determine the amount of money paid to the suspect medical service provider each year.⁵⁴

These inquiries will permit law enforcement to establish the parameters of the alleged fraud.

As in the case of medical service providers who submit PIP claims to auto insurance carriers, frequently, the initial objective of the investigation into a medical service provider who is submitting false claims to health insurance companies is to obtain probable cause for a search warrant. In many cases, probable cause for a search warrant will consist of an expert's analysis of the alleged fraud from records and bills of some of the provider's patients, information obtained through select patient

50. See the permissive inference in N.J.S.A. 2C:21-4.3f(2), The Health Care Claims Fraud statute.

51. The concern with self-referral is that the treatments may be unnecessary and the doctor may be referring the patient to the other medical corporations which he owns or in which he has a financial interest, in order to submit additional bills to the insurance companies in order to increase revenue. Generally speaking, doctors may refer patients to corporations which they own or in which they have a financial interest if their ownership interest in the related corporations is conspicuously displayed in their medical practice and patients are aware of same.

52. Ordinarily, plastic surgery is not compensable pursuant to most health insurance plans because it is not “medically necessary.” Criminal cases have been based on the allegation that a medical service provider will perform cosmetic plastic surgery and falsely allege that the surgery was medically necessary.

53. See N.J.S.A. 45:9-19.3 and N.J.S.A. 17:33A-25.

54. A Taxpayer Identification Number (TIN) is a number used by the tax authority to determine the amount of income a taxpayer receives during the course of a year. Insurance companies are required to report such information to the tax authority.

Frequently, medical service providers will have several TINs which render this investigative step more difficult. A medical service provider may obtain one TIN for his medical practice and a different TIN for any related corporations, such as a medical supply corporation, a corporation which owns diagnostic testing machines such as an MRI, or a separate medical practice. Unless all TINs are identified, a TIN run will not reflect the total amount of money insurance carriers are paying to the medical service provider. There are legitimate tax and business reasons to have separate TINs. However, investigative experience teaches that some medical service providers obtain separate TINs to disguise or con-



interviews, information obtained from select interviews of current and past employees of the medical service provider, results of TIN runs, and any general information provided by the insurance company(ies). This information may be sufficient to articulate probable cause for a search warrant to search the suspect medical service provider's office(s).

Insurance Agent Fraud

The investigation and prosecution of insurance producers⁵⁵ suspected of engaging in fraudulent conduct presents a different investigative focus than the investigation and prosecution of staged accident auto insurance PIP mills and medical service providers. While staged accident and health care provider investigations and prosecutions are directed primarily at false insurance claims, insurance agent fraud usually does not involve false claims but often simply involves theft of insurance premium money, which thefts are concealed through a variety of schemes. Insurance agent fraud also can include false and fraudulent premium financing schemes⁵⁶ and, in some cases, various forms of underwriting fraud.⁵⁷

Theft of Premium Money

Most complex insurance agent investigations and prosecutions involve investigations into thefts of insurance premiums and related money paid by insurance customers. Insurance agents conceal the theft of insurance premium money by several different artifices.

One method of concealing theft of premium money occurs when persons pay insurance agents for insurance coverage

and the agent purports to provide the insured with valid indicia of insurance coverage, such as an automobile insurance identification card,⁵⁸ a Certificate of Insurance, an insurance policy declaration page, or the mere representation by the insurance agent that the insured customer now possesses valid insurance coverage. The insurance customer has no way of knowing that he does not have the benefit of the underlying coverage unless he verifies same with the insurance company purportedly providing the coverage.

Insurance agents accept insurance premium payments from insured customers. Insurance agents are required to deposit the premium money in a premium trust account or otherwise refrain from commingling the funds with other business operating funds or personal money or from converting the funds for any other use.⁵⁹ Some agents fail to remit the insurance premiums to the insurance company providing coverage and instead steal the insurance premium money and use it for their own personal benefit.

Since insurance coverage is not a physical object that the insured customer can readily determine he possesses, it is relatively easy for insurance agents to conceal thefts of insurance premium money. Frequently, the insured customer does not think about insurance coverage unless and until there is a claim. More often than not, there are no claims made against the purported policy and so the missing insurance coverage goes undetected by the customer.⁶⁰ The fact that insurance coverage is not verified until a claim is presented serves to facilitate concealment of this type of theft.

ceal the exact amount of money they are receiving from insurance companies.

55. The term "insurance producer" is a statutory term and refers to what is more commonly known as an insurance agent. See *N.J.S.A.* 17:22A-28. Insurance producers are licensed by the State of New Jersey through the Department of Banking and Insurance (DOBI). An independent agent may represent more than one insurance company, while an exclusive agent represents only one insurance company or a group of related companies.

56. Premium financing occurs when the insured, most often a small commercial business, borrows

money from a third party lender to pay for insurance premiums.

57. Underwriting fraud usually involves falsifying an application submitted to an insurance company so as to conceal some aspect of the risk being insured to obtain a lower premium rate for the insured. This practice sometimes permits the agent to attract and retain insurance clients.

58. See *N.J.S.A.* 39:3-29 and 39:3-29.1.

59. See generally, *N.J.A.C.* 11:17C-2.1(a) and *N.J.A.C.* 11:17C-2.2(a).

60. With respect to automobile insurance, frequently, the only physical evidence of insurance is the auto insurance identification card. Auto insurance agents who are committing thefts of auto insurance premiums will frequently issue phony auto insurance identification cards which appear to evidence valid insurance coverage but, in fact, do not. The insured customer is required to present an insurance identification card to police officers, motor vehicle inspectors, or other persons from time to time. On occasion, a police officer or other person will investigate the bona fides of the insurance identification card presented by the insured customer and determine that it is not valid.

With respect to automobile insurance in particular, one red flag which points to the agent's theft of insurance premiums is the insurance agent's direction to insured customers to contact the agent directly, rather than the insurance company, if the insured has an auto insurance claim. In some cases, the defalcating insurance agent will directly pay the auto insurance claim, for example by paying to fix a dented fender, rather than have the insured customer contact the insurance company, only to learn that insurance coverage was never bound or was cancelled because insurance premium money was never remitted by the agent to the insurance company.⁶¹ In such cases, the insurance agent, in effect, acts as the insurance company by covering the insured customer's losses in order to conceal the theft of auto insurance premium money.

If there is a catastrophic automobile insurance claim in an amount greater than the amount which the defalcating insurance agent can practically cover, the agent will often attempt to pass the loss to the insurance company by claiming that the premiums were not remitted sooner due to clerical error in the office. This conduct is sometimes referred to as "back dating" the insurance coverage.

Theft of insurance premiums may be more common with respect to commercial liability insurance. Though commercial liability insurance is frequently required for various reasons, claims are infrequent enough that insurance agents can conceal insurance premium defalcations because the insured business customer often has no reason to contact the insurance company since the customer has experienced no losses. Thus, the agent is able to accept insurance premi-

ums, divert the money to his or her own purposes, and not remit the premiums to the insurance company.

Complex insurance agent theft schemes can sometimes involve reinsurance and excess risk insurance. Since reinsurance and excess risk insurance are not called upon except in cases of catastrophic loss, the insured does not miss it and the opportunity for the agent to steal premiums is even greater. Other related insurance agent theft schemes include stealing insurance premium money by selling insurance policies for insurance companies that do not exist, particularly "offshore" insurance companies, or for foreign companies not authorized to do business in the State of New Jersey.⁶²

Another theft of insurance premium money occurs when an insurance policy is properly sold (coverage bound) and the insurance agent remits the full year's premium for that policy, but the insurance policy is cancelled during the period of coverage. Reasons for cancellation can vary and include the fact that a commercial business ceased to do business or the insurance purchased was no longer needed for valid reasons. In such cases, part of the premium is required to be returned to the insured customer.⁶³ Consequently, the insurance company will return the unearned premium to the insurance agent to be rebated to the insurance customer. However, insurance agents bent on committing theft will retain and steal the insurance premium rebate, instead of forwarding it to the customer, and use the money for his/her own purposes. Frequently, customers who have had insurance cancelled for valid reasons do not anticipate a premium rebate. Thus, the agent's theft of these rebates goes undetected.

Law enforcement should be alert to yet another issue sometimes encountered in connection with insurance agent thefts. On occasion, especially during periods of business downturns, insurance agents and agencies will become cash starved and may divert the insurance premiums from insurance carriers, not so much for personal enrichment, but simply to keep the

insurance agency afloat by paying rent, salaries, and other operating expenses. Although this conduct clearly represents a misuse of the insurance premium money which should be held in trust and remitted to the insurance company, cases where the insurance agent is not personally enriched by the diversion of the insurance premium money may have somewhat less criminal trial jury appeal. Investigators and prosecutors should distinguish between cases in which insurance premium money was diverted to keep a business afloat and those cases where insurance premium money was diverted for personal enrichment of the insurance agent. Assessing this question early in the investigation will enable law enforcement to select those cases which will best support criminal prosecution. Those cases which do not support a criminal prosecution may be best referred to the Department of Banking and Insurance (DOBI) for insurance agent licensing action.

Premium Financing Fraud

Investigative experience teaches that an agent who engages in one of the schemes described above will frequently engage in others as well. Investigations of insurance agents who are committing insurance premium theft must, therefore, consider whether or not the insurance agent is committing premium financing fraud in addition to theft of insurance premiums. Investigative experience indicates that theft of premiums and premium financing fraud are often related. Premium financing is frequently arranged by insurance agents to service their customers, typically small business commercial customers, who cannot afford to pay the full premiums for required insurance coverage. The agent will obtain the necessary insurance coverage and contemporaneously arrange for financing with a premium financing company.

Typically, the transaction involves the completion and submission of a premium financing loan application which is completed by both the insured and his insurance agent and submitted to the premium financing company so that the premium financing company will loan the in-

61. The insurance company may nonetheless be required to provide coverage because it may be bound by the actions of its agent.

62. DOBI can verify which insurance companies are authorized to do business in New Jersey.

63. Returned premiums are sometimes referred to as unearned premiums.

64. See *N.J.S.A.*, 2C:21-4.6.



sured the amount of money necessary to pay the premium for the insurance policy. The principal amount of the loan is an amount approximately equal to one year's insurance premium. Insurance premium financing loans are considered risky and have a higher rate of interest than other loans. The insurance company receives the proceeds from the loan, issues the insurance coverage to the insured, and the insured makes periodic payments throughout the year to the financing company to repay the loan.

Because there appears to be little review of the loan application submitted by the insurance agent to the premium financing company, there is ample opportunity for fraud. Investigative experience teaches that, in some cases, the insurance agents themselves have the authority to consummate the loan on behalf of the premium financing company and, in some cases, even have the authority to issue the check to the insurance company and sign the check as an authorized representative of the premium financing company. This invites theft by some insurance agents.

The most common fraudulent conduct associated with insurance premium financing involves insurance agents who submit loan applications for fictitious insureds which enables the insurance agent to obtain the premium financing loan proceeds and divert them for his own use. Also, insurance agents sometimes submit loan applications for insurance customers who paid for insurance without the need to borrow insurance premium financing money. In those cases, the agent nonetheless submits a loan application purportedly on behalf of the insurance customer so that the agent can steal the insurance premium financing loan proceeds.

Experience also teaches that in periods of economic downturn, when commercial businesses, including insurance companies, are struggling, insurance premium financing fraud tends to accelerate. Insurance premium loan fraud operates much like a pyramid scheme. The insurance agent submits the first fraudulent loan

application and receives the loan proceeds. When the payment is due on the first fraudulent loan, the agent submits two additional fraudulent loan applications in order to make the payment on the first fraudulent loan and to have additional cash. Later, four fraudulent loan applications are submitted, and the scheme continues to mushroom. After a time, so many fictitious loan applications have been submitted and so many payments become due to the premium financing company that the loans default.

Premium financing companies with defaulting loans rarely consider the possibility that such loans are fraudulent. Law enforcement must be aware that, from the perspective of insurance premium financing companies, loans in default are not necessarily indicators that fraudulent loan applications may have been submitted by the agent. Rarely, if ever, have premium financing companies reported defaulted loans to law enforcement. It is more likely that the loans will be treated as a business loss and "written off."

Another commonly occurring pattern is that an insurance agent whose fictitious loans have defaulted with a particular premium financing company will often begin to then obtain phony loans with a second premium financing company, and then a third, and even a fourth. Developing a time line will often illustrate the thefts from successive premium financing companies over a period of time. The point is that once an investigation of an insurance agent has begun and evidence of fraudulent insurance premium financing is identified, investigators and prosecutors should contact insurance premium financing companies in an effort to determine whether other loans in default have been issued through the insurance agent under investigation. Law enforcement cannot rely on premium financing companies to report such thefts. Additionally, as is the case with other unearned insurance premiums which are returned by the insurance company, any legitimate insurance premium money which is returned by the insurance company to the insurance agent because an underlying insurance policy

was cancelled early is frequently also stolen by the insurance agent under investigation and not returned to either the insured or the premium financing company.

Other Insurance Agent Thefts and Frauds

Other fraudulent conduct encountered when conducting investigations of insurance agents includes selling insurance policies to small employers and facilitating the inclusion of ineligible non-employees on the small employer group health insurance plan; selling or purporting to sell insurance policies to family, friends, or even fictitious people and then cancelling those policies after a short period of time so that the insurance agent can collect and retain the sales commission; selling insurance that may be unnecessary, sometimes called “churning;” and charging unauthorized “administrative fees” of various types in addition to the policy premium, which fees are ordinarily not permitted by statute.

Another commonly alleged insurance agent underwriting/application fraud is the sale of an auto insurance policy where it is alleged that the insurance agent conspired with the auto insurance customer to conceal adverse information in his or her driving record so as to secure a lower automobile insurance premium. Frequently, these cases are investigated as civil violations of the Fraud Act. It should be noted, however, that the recently enacted Insurance Fraud criminal statute provides a basis to charge a crime for this conduct in appropriate cases.⁶⁴ This conduct may or may not be found in connection with the type of large-scale insurance agent thefts described above.⁶⁵

Investigative Techniques

The investigation of an insurance agent theft case is always best facilitated by

obtaining all of the insurance agent's and the insurance agency's bank records by means of a subpoena. These records may consist of the premium trust account records, the insurance agency business operating bank account records, as well as any and all personal bank account records of the agent. Additionally, all available evidence of personal expenditures made by the agent, such as checks written to pay credit card bills, mortgages, car leases, and so on, should be identified utilizing the bank records. The agent's contract with the insurance companies he represents⁶⁶ should be obtained and reviewed and any provisions in the contract which provide for the establishment of a premium trust account and the time period within which the agent must remit premiums should be noted. The agent's book of business (customer list) and related records should be obtained and carefully reviewed. As with auto PIP insurance fraud conspiracies and medical service provider investigations, an early investigative objective should be obtaining a search warrant to search the insurance agency for this evidence and for evidence which will identify all of the bank accounts owned and controlled by the insurance agent.

Obtaining probable cause for an affidavit in support of a search warrant begins with a review of the initial complaints from insurance customers, coupled with interviews of those customers. Those complaints are typically received by DOBI's Division of Enforcement and Consumer Protection. Those complaints, together with interviews of other customers of the agent and information obtained by canvassing insurance carriers represented by the agent, often will provide probable cause for a search warrant.

Insurance agents are licensed by DOBI. Insurance agent theft cases are frequently referred to OIFP by DOBI. Some cases gain media coverage because insurance customers publicly complain that they paid insurance premium money to a particular insurance agent but later learned that they had no insurance coverage. During the course of an insurance agent investigation, law enforcement should periodically contact DOBI for updated information and complaints which may have been sent to DOBI after the investigation began.

Bank Records

During the criminal investigation, the insurance premium money should be traced using the bank account records. The money should be traced for the specific period of time the thefts are alleged to have occurred. The tracing should begin with payment by the insurance customer to the insurance agent. The tracing should then continue to determine whether the insurance premium payment was deposited into the insurance premium trust account, the insurance agent's business and operating accounts, or the insurance agent's personal accounts, or any combination thereof. The objective of tracing the insurance premium money is to determine the ultimate disposition of the money. Determining the total amount of money that the insurance agent diverted to business and operating expenses, the total amount the agent diverted to personal expenses, and the total amount of money that was properly remitted to the insurance company, if any, are the end objectives of the investigation and will provide compelling evidence of theft.

Insurance agent theft investigations heavily depend upon bank records. Experience teaches that banks are often slow to

65. Insurance agents frequently play a role in workers' compensation application insurance fraud which results in underpaying premiums or premium avoidance. Some workers' compensation application insurance fraud can result in theft of large amounts of money. A more detailed discussion of workers' compensation application fraud is beyond the scope of this article. See “Leveling the Playing Field--OIFP Targets Workers' Compensation Premium Fraud,” *2004 Annual Report of the New Jersey Office of the Insur-*

ance Fraud Prosecutor, March 2005, at 64.

66. DOBI can sometimes assist law enforcement in obtaining information identifying the companies that the insurance agent represents.

67. Similar to investigating allegations of fraudulent billing by medical service providers in connection with PIP fraud conspiracies or health insurance frauds, the investigation of an insurance agency for theft of insurance premiums must develop evidence of who within the agency was responsible for the

thefts and who was not. Insurance agencies frequently employ other persons, besides the suspect insurance agent, to include secretaries, billing clerks, office managers, and a host of other persons. Sorting out which persons are responsible for thefts and which persons are not is a major challenge encountered by law enforcement. Frequently, interviews of insurance agency customers will provide some evidence of which persons were responsible for theft and which persons may not be.



produce bank records. Subpoenas for bank records should be issued early in the investigation as soon as the bank accounts used by the insurance agent are identified. As law enforcement identifies additional bank accounts, the records should likewise be subpoenaed. Investigative efforts should be expended on monitoring the progress of the banks in responding to the subpoenas and supplying the requested bank records.

Questionnaires to Customers

Following the execution of a search warrant, the investigative objective should be to contact insurance customers to continue to determine the amount of insurance premium money paid to the insurance agent, to identify any and all persons in the agency with whom the customers dealt,⁶⁷ and to obtain evidence that money was paid to the agent or others by obtaining cancelled checks or receipts for cash or money orders. Information about any claims which were submitted and the identity of the persons employed by the insurance agency who assisted with the processing of those claims is also useful investigative information.

Although second degree crimes can now be prosecuted for amounts as low as \$1,000,⁶⁸ it is important to contact all or as many of the insurance customers as possible because restitution to these insurance customers or to the insurance carriers who were required to extend coverage despite the theft of the premiums is likely to be an issue.⁶⁹ An amount of restitution can be determined with reasonable certainty only after all, or as many as possible, of the customers and thefts are identified.

Contacting all the insurance customers of an insurance agency is labor intensive and requires a tremendous amount of law

enforcement resources. It is sometimes useful to identify a customer list from the materials seized in a search warrant or obtained through other investigative steps and send a questionnaire to the insurance customers by mail. Such questionnaires facilitate the field investigation and can be drafted to fit the specific facts of the case.

Generally, the questionnaire will include such questions as the name of the insured; whether or not the insured paid cash for insurance or gave the agent a check or money order; whether or not the insured has a receipt from the insurance agent; whether or not the insured has a cancelled check negotiated by the insurance agent and from which a bank account belonging to the agent can be identified; whether the insured requested insurance premium financing in connection with the purchase of insurance; the identity of persons within the insurance agency with whom the insurance customer dealt; and other relevant information. The customers who respond to the questionnaire can then be interviewed and formal statements taken. The customers who do not respond may be left for later investigation if time, resources, and practicalities permit.

Premium Financing Investigative Steps

In addition to canvassing insurance premium financing companies to identify loans in default issued through the insurance agent under investigation, the investigation of fraudulent insurance premium financing should focus on the documents and records evidencing the loans and insured customers. Specific investigative attention should be directed to the loan applications and checks.

It is not uncommon to identify insurance premium loan applications that contain fictitious commercial businesses and post office boxes as addresses for the purported insured borrowers. While it is not uncommon for commercial businesses to utilize a post office box as a business address, law enforcement should be aware that post office boxes are also frequently used by insurance agents as the addresses of fictitious insurance borrowers to facilitate insurance premium fraud theft

schemes. Field investigations should be conducted to determine whether or not the insured borrowers exist and reside at the addresses or subscribe to the post office boxes reflected on the loan applications.

Since the loan applications typically require an insurance policy number or other information to identify the insurance policy for which the loan is being issued, fictitious policy numbers are frequently reflected on the loan applications. All purported insurance policies should be verified with the insurance companies. Checks representing loan proceeds should be obtained and analyzed to determine who negotiated the checks and into what accounts the proceeds were deposited.

Conclusion

Investigations of complex insurance fraud schemes require a careful review of the records which constitute each claim or transaction, as well as a comprehensive field investigation to gather additional evidence. Frequently, execution of a search warrant and/or insertion of undercover operatives will be invaluable. While such investigations are complex and can be time consuming, they can be accomplished with a proper understanding of the document analysis needed, the roles of the various players in the scheme, and the financial incentives which motivate them.

68. The Insurance Fraud Statute, N.J.S.A. 2C:21-4.6, reduced the monetary threshold for second degree insurance-related crimes from \$75,000 to \$1,000.

69. See generally "A Comprehensive Guide to New Jersey Insurance Fraud Law," *2004 Annual Report of the New Jersey Office of the Insurance Fraud Prosecutor*, March 2005, at 35.

John J. Smith, an Assistant Attorney General, is the First Assistant Insurance Fraud Prosecutor and assists the Insurance Fraud Prosecutor with all facets of the Office's operations including its investigations, criminal prosecutions, and civil litigation. He has been with the Division of Criminal Justice for over 20 years.