Fraud Bureau Intensifies Fight Against Violators

By Keith J. Roberts

In the fall of 2010, amendments to the New Jersey Insurance Fraud Prevention Act were implemented, separating the criminal and civil divisions of the Office of the Insurance Fraud Prosecutor (OIFP). The Bureau of Fraud Deterrence (Fraud Bureau) was created with the New Jersey Department of Banking and Insurance (DOBI) (N.J.S.A. 17:33A-8). The criminal division of OIFP remained with the attorney general in the Division of Criminal Justice (N.J.S.A. 17:33A-16).

According to DOBI, the reorganization was designed to strengthen the state’s ability to confront and deter civil insurance fraud. In addition, DOBI emphasized that the new Fraud Bureau would make a focused effort to investigate suspicious claims arising from medical providers treating auto accident victims receiving personal injury protection (PIP) benefits.

The focus on auto insurance resulted in a Fraud Bureau effort to develop a unit dedicated to investigating PIP claims. According to DOBI, the cost of providing consumers with PIP coverage has been inflated by a 40 percent margin since 2004, and is now among the highest in the nation.

As a direct result of targeting fraud rings for staged accidents, and medical providers who bill excessively or perform unnecessary treatment and diagnostic testing, the department has substantially increased the number of civil investigations.

Further, as a result of the creation of the Fraud Bureau, the department is reporting a 7 percent increase in the number of consent orders entered for civil fraud violations, along with a 13 percent increase for assessed civil penalties, amounting to just over $6 million. In addition, more than 3,700 new civil cases were opened. DOBI reported these numbers at the conclusion of its first 12 months operating the Fraud Bureau, from Nov. 1, 2010, through Oct. 31, 2011.

It is apparent that the push continues. DOBI has taken its message public, as indicated by a recent column published at South Brunswick Patch.com, by Acting Insurance Commissioner Ken Kobylowski. Kobylowski warned that insurance fraud results in losses to insurance companies in millions of dollars each year, which are passed on to consumers by way of increased premiums. He further indicated, however, that if consumers exercise caution, they can avoid losses associated with fraud by following these key steps:

• Only visit health-care providers and attorneys you know and trust.
• Avoid offers that are too good to be true. Be wary of any solicitations offering civil settlements or advance payments either by mail or in person.
• Keep organized records of all medical treatments, including the dates, treatments given and diagnoses.
• Report the accident to the police even if the damage to the cars involved was minor.
• Take photos of the damage if it is safe to do so.
• Count the number of passengers in the other vehicle. It is important to get all of the names, phone numbers and driver’s licenses to prevent people who were not in the car from filing claims later.

Private companies must join the fight. The insurance industry in New Jersey is required by law to file a plan with DOBI for the detection and prevention of fraudulent claims (N.J.S.A. 17:33A-15). The failure to comply with this provision of the act subjects a carrier to a penalty of up to $25,000 per violation.

There has been a push on the legislative front as well. In 2012, bills were introduced in the New Jersey legislature to expand the scope of the Insurance Fraud Prevention Act. Medical practitioners that impermissibly waive deductibles and co-pays would be subject
to conviction of a fourth-degree crime if amendments are passed into law.

Generally, insurance fraud in New Jersey constitutes a crime of the second degree (N.J.S. 2C:21-4.6(b)). Civil penalties under the act are also stiff.

Violators are subject to civil actions initiated by an insurance carrier, or the Department, which may result in fines or civil penalties of not more than $5,000 for a first violation, $10,000 for a second violation and $15,000 for each subsequent violation.

The math is simple. In the event a person is found to have submitted false claims to an insurance carrier, he would be subject to $60,000 in penalties. Further, since five violations under the act would constitute a pattern, treble damages would also apply, including counsel fees.

Against this backdrop, the state is pushing up against 5,000 newly opened insurance-fraud-related cases each year. Although the majority of cases will be civil investigations, crimes are not being overlooked.

The OIFP is aggressively prosecuting violators and, in many instances, securing jail sentences. The results are not a secret and are published monthly on the OIFP website.

The efforts of the state’s insurance fraud prosecutor are nationally recognized and have resulted in collaborations with law enforcement agencies throughout the country. In July, collaborating with other states and the federal government, the OIFP secured a settlement against a major pharmaceutical company that engaged in various unlawful practices for the marketing and prices of drugs. The state recovered $22.1 million in the largest health-care fraud settlement in history.

Additional examples of successful insurance fraud prosecutions include:

• A former Newark pharmacy owner pleaded guilty to charging Medicaid for medications he bought back from patients, and has agreed to pay $400,000 in restitution. A licensed pharmacy technician pleaded guilty to the charges, admitting that he bought back expensive prescription medication, generally from HIV/AIDS patients, at a discounted price after they were dispensed to Medicaid beneficiaries. He then sold the medications for profit. The defendant admitted that he billed Medicaid as if the patients had, in fact, received the medications.

Sentence is scheduled for Dec. 14.

• A North Jersey chiropractor was indicted for allegedly stealing more than $89,000 by submitting false claims to insurance carriers. The defendant was charged with 125 counts of second-degree health-care claims fraud and one count each of second-degree attempted theft by deception. Second-degree crimes carry a maximum sentence of 10 years in state prison and a criminal fine of up to $150,000.

• A former South Jersey licensed family and marriage therapist was sentenced to three years in state prison and ordered to pay over $22,000 in restitution arising from fraudulent claims submitted to Cigna Behavioral Health Insurance Company.

• A North Jersey physician was indicted for writing prescriptions while under suspension. The indictment alleges multiple counts of second-degree crimes, including conspiracy, distribution of controlled dangerous substances (CDS) and health-care claims fraud. The indictment further alleged the physician distributed CDS by providing fraudulent prescriptions in exchange for cash payments.

The state also continues to promote its Insurance Fraud Detection Reward Program, adopted in 2004. Individuals are strongly encouraged to report insurance fraud and receive a reward of 5 percent of the value of a recovery, or $25,000, whichever is less. See www.njinsurancefraud.org.

In the private sector, however, insurance carriers have faced a recent setback. In Selective Ins. Co. v. E. Hudson Pain Mgmt, 210 N.J. 597 (2012), the New Jersey Supreme Court decided a narrow legal question with adverse consequences for carriers attempting to rely upon the act in their efforts to litigate against medical providers treating auto accident victims.

It now appears that an automobile insurance carrier may not demand unduly broad discovery from medical providers receiving PIP benefits pursuant to the terms of an assignment of benefits from an insured.

In Selective, the carrier detected suspicious activity concerning treatments provided to its insureds, as well as the billing practices and corporate structure of medical provider defendants. As a consequence, Selective sought broad discovery to include documents relating to ownership, and compliance with certain regulations, asserting that the medical providers were subject to a “duty to cooperate” based upon the terms of the underlying policy.

The trial court agreed with Selective and ordered the discovery. In an emergent application to the Appellate Division for a stay, however, the trial court’s decision was reversed. Selective filed a petition for certification, which was granted, and the high court upheld the Appellate Division, but for reasons different from those stated in the opinion below.

Selective maintained that its request for discovery was based in part upon the mandate of the act. They argued that the conduct of the providers warranted further investigation, as clearly supported by the public interest in combating insurance fraud.

The Supreme Court was not persuaded. In the end, the court identified three important reasons why carriers were not entitled to relief. The court reasoned that the rights of an assignee can rise no higher than the rights of an assignor. Therefore, it logically follows that no greater duties of the assignor may be imposed upon the assignee.

It was clear that the insured’s duty to cooperate with Selective did not include the production of documents relating to the medical provider’s corporate structure or billing practices. Clearly, the medical provider would also not have the duty to produce such documents given that its obligations under the assignment could not be greater than the obligations of the insured.

The court next explained that the PIP statute was not ambiguous, and did not require a medical provider to produce the
discovery requested by Selective. Therefore, no relief could be supported by Selective’s interpretation of the no-fault discovery law (N.J.S.A. 39:6A-13b).

Finally, although recognizing the important public interest in combating insurance fraud, Selective could not rely upon the statute to expand the scope of permissible discovery in litigation with medical providers that specifically concerned the cooperation clause of the policy contract and the PIP discovery statute. In detail, the court noted the affirmative duties placed upon insurance carriers defined by the act, the remedies available, and the necessary elements that a carrier must plead to support a cause of action.

In closing, the court expressed the limited nature of the holding, given the narrow question presented, and a terse record that consisted almost entirely of initial pleadings filed by the parties. Insurance fraud remains a “high priority” for the state, as well as the private sector, and it is clear that enforcement litigation will only continue to expand.