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# Hot on Their Paper Trail:

## *OIFP Prosecutes Health Insurance Cheats*

by Peter Lee

How do you prove your case when some of your best witnesses are either dead, incompetent to testify, or nowhere to be found? This question was one of many questions that were successfully answered by the Office of the Insurance Fraud Prosecutor (OIFP) in health care claims fraud cases during 2005. In recent years, as much as \$85 billion - or 5 percent of total U.S. annual health care spending - was estimated to have been lost to health insurance fraud.<sup>1</sup> While the financial rewards are obvious, the attraction of health care claims fraud for many criminals is based on the myth that these rewards can be obtained with little effort and with few consequences. Health insurance fraud criminals believe they can hide from prosecution behind a thicket of paperwork. Convictions obtained by OIFP in 2005, however, go a long way toward turning this notion on its head for would-be criminals.

Health care claims fraud cases present unique challenges for investigators and prosecutors. With literally little more than the stroke of a pen, criminals can steal millions from unsuspecting victims. Unlike many other crimes, these cases rarely involve the types of evidence that constitute a “smoking gun” in the eyes of a jury. Proving health care fraud charges at trial brings another set of challenges. Maintaining

“jury appeal,” for example, can be a daunting task when the prosecution is faced with explaining complex medical and insurance issues.

The ability to navigate the paper trail is frequently the key to unlocking the mysteries of health care claims fraud investigations. In practical terms this means spending the time and effort to track down and analyze the necessary documentation. Building on the available documentation, investigators and prosecutors can then assemble an intricate chain of proofs using a variety of evidence. Even before charges are filed, investigating health care claims fraud often means wading through a mountain of insurance claim forms, medical files, financial records, and interviewing many witnesses. In the process, investigators and prosecutors must master the complex terminology and practices of the health care and insurance industries. Assistance from expert witnesses in the relevant field also can be a prerequisite to bringing charges. At trial, such meticulous investigation must be distilled into a thoughtful presentation of evidence in order to obtain convictions.

### *State v. Clark*

In 2005, nothing better illustrated the rewards of such efforts than OIFP’s successful prosecution of *State v. James Clark*. Clark was the owner and operator of Home Health Care Center, Inc. (HHC), a Hoboken-based business that

1. Estimate for 2003 by the Blue Cross Blue Shield Association.

delivered prescription medications from pharmacies to people's homes. Clark's fraud focused on people who required daily medications to treat chronic illnesses, such as asthma. Clark offered to fill the prescriptions of his customers and to have the medications delivered to their homes at no charge. All of the patients targeted by Clark were insured under the State Health Benefits Plan that was administered by Horizon Blue Cross Blue Shield of New Jersey. Clark would fill the prescriptions at a local pharmacy or through a mail order prescription service by paying for the medications himself at full cost. By paying the costs himself, Clark prevented the patients or pharmacies from submitting claims to the insurance carrier for the costs of the medications. Clark, however, would submit claims to the insurance carrier seeking reimbursement as the "supplier" of the medications under provisions of the State Health Benefits Plan. The claims submitted by Clark were enormously inflated over what he actually paid for the medications. Although Clark falsely represented that he was licensed in order to get payment from the insurer, neither he nor HHC was ever licensed to dispense or sell prescription medications.

When the *Clark* case went to trial, the State's prosecutor faced a considerable evidentiary challenge in finding patients who were able to testify. Many patients whose prescriptions were used by Clark in the fraud were either dead, suffering from Alzheimer's disease, or could not be found. Only three patients actually testified against Clark at trial. Despite this difficulty, the State's prosecutor presented overwhelming evidence, including testimony from available patients, the State's primary investigator, pharmacists, an insurance claims analyst, a billing agency representative, an expert witness on procedures for filing health insurance claims, and records from the insurance carrier and pharmacies.

The State presented evidence at trial that Clark had submitted 400 fraudulent claims to Horizon, including approximately 330 claims for medications that were never dispensed or delivered to patients. Clark received payments worth \$343,000 from the State Health Benefits Program for the fraudulent claims. The primary case investigator uncovered these fraudulent claims through a painstaking analysis of the pharmacies' records and HHC's claim forms. His analysis revealed not only that the

prescriptions had not been filled by the pharmacies, but also that they *would not have been filled* by the pharmacies because subsequent claims for the same medications had been submitted before the medications were due to be refilled.

The jury returned a verdict, finding Clark guilty of all three charges in the indictment: two counts of second degree theft by deception and one count of second degree Health Care Claims Fraud. On April 1, 2005, Clark was sentenced in the Essex County Superior Court to nine years in state prison and ordered to pay a \$5,000 fine in addition to other penalties.

The *Clark* case was by no means the only one in 2005 where dogged investigation and resourcefulness by OIFP resulted in convictions for health care fraud crimes. As reflected in the cases prosecuted by OIFP during the past year, financial incentives have drawn an increasingly diverse array of criminals to health care claims fraud. Defendants convicted of health insurance fraud through the efforts of OIFP in 2005 include health care providers, the owners and executives of health care facilities, patients, and beneficiaries of the Medicaid Program.

### *2005 OIFP Prosecutions*

Regardless of who the perpetrator is, the most common form of health care insurance fraud remains the submission of claims for services that were not provided. OIFP's prosecutions in 2005 show the enduring popularity of this method for committing health care fraud. For example, in *State v. Lobo*, a Passaic County doctor pled guilty to submitting nearly \$10,000 in phony health care claims to insurance companies for medical services that were never provided to patients. Dr. Angel R. Lobo operated the Pain Management Clinic in Paterson.

As part of his guilty plea, Lobo admitted that he had prepared false patient records to indicate that health care services were administered to patients when no such services were provided.



*Deputy Attorneys General Joan Burke, Tanya Justice, and Peter Lee conduct a case review.*



*Investigating provider fraud cases requires analyzing substantial amounts of documentary evidence.*

Lobo even instructed patients to sign in at his clinic on dates when they did not appear for treatment. This fraud was just one component of a larger scheme to file false Personal Injury Protection (PIP) claims for treating patients purportedly injured in automobile accidents.

On February 15, 2005, Dr. Lobo was sentenced to a three-year term in state prison and ordered to pay a \$100,000 fine for violating provisions of the civil Insurance Fraud Prevention Act. Lobo's office manager, a co-defendant, also admitted to assisting Lobo in obtaining, using, and paying "runners" to secure patients for the medical practice. The term "runner" refers to a person paid by an attorney, a health care service provider, or a health care facility operator to procure patients for a health care facility so that insurance claims can be submitted for providing treatment. "Running" was made illegal in New Jersey in 1999 with the enactment of the Criminal Use of Runners law.

Not all OIFP prosecutions in 2005 involved licensed health care services providers. As the case of *State v. Florence Acquire* shows, where greed is involved, criminals will dispense with niceties, such as following state licensing requirements. Florence Acquire, an electrologist, operated a Wayne, New Jersey, business called High Mountain Medical Center. She was indicted by a State Grand Jury on charges that she falsely billed insurance carriers for performing ordinary electrolysis - more commonly known as hair removal - by falsely identifying it as a medically necessary procedure for the removal of dead skin. Acquire, however, was not a licensed medical service provider and

was not, in fact, qualified to perform any type of surgical procedure. Nevertheless, over almost three years, and while actually performing common hair removal, she billed two insurance companies for the more expensive surgical procedure. Acquire received nearly \$900,000 in payments from the insurance carriers for the fraudulent claims. Following a ten-day trial before the Passaic County Superior Court, Acquire was convicted of second degree Health Care Claims Fraud and the third degree crimes of theft by deception and attempted theft by deception. She was sentenced to seven years in state prison and ordered to pay restitution to the two insurance carriers.

Patients also have gotten into the health insurance fraud act. In February 2005, Carol Severe, a Hunterdon County resident, admitted to committing health care claims fraud by submitting fraudulent health insurance claims of almost \$14,000 to Horizon Blue Cross Blue Shield of New Jersey. Over a four-and-a-half-year period, Severe submitted more than 40 insurance claims, indicating that her provider had treated her on 192 different dates. OIFP investigators discovered that the alleged services had not been provided and that Severe had forged the provider's name on the claim forms. As part of her sentence, Severe was ordered to pay restitution of \$13,947, as well as a \$5,000 fine for civil insurance fraud violations.

Cases prosecuted by OIFP in 2005 also show that health care fraud is not limited to health care professionals, operators of health care facilities, or their patients. Criminals from all walks

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of life are attracted to the possible financial rewards available in health care fraud and have tried to cash in. For example, in the case of *State v. Tricarico*, a former municipal official was convicted for embezzling public funds intended to pay for public employee health care costs. Joanne Tricarico, a former Personnel Director for Bloomfield Township, Essex County, was responsible for managing a health insurance benefit account for township employees. The account, publicly funded by tax dollars, was designed to reimburse township employees for pharmacy costs and prescription drugs. OIFP's investigation resulted in Tricarico's guilty plea to charges of official misconduct and theft by deception. Tricarico admitted that between January 17, 1997 and March 13, 2004, she wrote checks for her personal use from the pharmacy account and attempted to cover up the thefts by making fraudulent entries in the transaction journals used to record withdrawals from the pharmacy account. Tricarico was sentenced on July 7, 2005, to five years in state prison and ordered to pay restitution in the amount of \$482,578.

Insurance providers make tempting targets for health care fraud criminals. In cases prosecuted by OIFP, it was not unusual to find that several insurance carriers were victimized by one criminal defendant. In *State v. Cohen*, at least six insurance carriers or third party health insurance claims administrators were targeted with fraudulent claims from Barry Cohen, a former certified public accountant. Cohen operated Headways, Inc., a family-owned business located in Bergen County that provided health care services and therapy to patients suffering from brain injuries. Over a three-year period, Cohen intentionally submitted dozens of claims to insurance companies and self-funded health benefit plans in which he added hours or dates for therapy that were never provided. OIFP investigators discovered that Cohen added more

than 4,000 hours of nonexistent services - worth more than \$350,000 - on dozens of bills submitted to the insurers for payment. After entering a plea of guilty to Health Care Claims Fraud, Cohen was ordered by the Bergen County Superior Court to pay \$328,000 in restitution and a \$105,000 civil fine. He also received a three-year term of probation.

### *2005 OIFP Medicaid Prosecutions*

In 2005, OIFP was active again in prosecuting criminals for abuses of the Medicaid program. The Medicaid program, which is funded by the state and federal governments, provides health care services and prescription drugs to persons who may not otherwise be able to afford such services and medicines. The scope and scale of criminal abuses of the Medicaid program are such that OIFP has a dedicated Medicaid Fraud Control Unit to investigate and prosecute these crimes.

OIFP's Medicaid Fraud Control Unit was kept busy in 2005 by the likes of Rammohan Pabbathi, the 58-year-old owner of a Monmouth County pharmacy. Pabbathi was involved in a scheme using "runners" and paying kickbacks to medical providers to defraud Medicaid. Based on the strength of the OIFP investigation, Pabbathi entered a guilty plea to the second degree crime of Health Care Claims Fraud. At his plea hearing, Pabbathi admitted that he, as the owner and operator of GLV Parke Warner Pharmacy in Neptune Township, Monmouth County, fraudulently billed Medicaid for prescriptions that his pharmacy did not dispense. During one undercover operation in the case, State Investigators obtained evidence of Pabbathi billing the Medicaid program \$1,130 for one HIV medication prescribed to a "runner," even though he had not dispensed it. The investigators even managed to record Pabbathi offering kickbacks to Medicaid recipients

to participate in his scheme. After entering his guilty plea, Pabbathi was sentenced by the Monmouth County Superior Court to three years in state prison and ordered to pay \$450,000 in restitution and fines to the Medicaid program.

A Warren County dentist who billed Medicaid for dental services that he never performed was another criminal snared by OIFP's Medicaid Fraud Control Unit. On May 27, 2005, Dr. Roger H. Brown pled guilty in Somerset County Superior Court to committing Health Care Claims Fraud. Between January 1993 and September 2004, Brown submitted hundreds of false claims to numerous health insurance providers for reimbursement of dental services, which he never provided. In addition to the Medicaid program, the victimized insurance providers included Delta Dental, MetLife, Horizon Blue Cross Blue Shield, CIGNA, and Aetna. OIFP's investigation uncovered \$95,182 in false claims submitted by Brown. Brown admitted to deliberately misrepresenting the dates on which services were rendered and to filing false claims for treating Temporomandibular Joint Dysfunction (TMJ) when he was, in fact, providing cosmetic dental services that are not covered by private dental insurance.

### *Catching Fugitives*

As busy as OIFP was during 2005, it still made time to meet up with some old acquaintances. Genady Chulak was originally convicted of theft by deception, corporate misconduct, and Medicaid fraud on December 14, 2000. Chulak owned GGE Impact Corporation, a company doing business under the name of Medicall that transported Medicaid patients for appointments with doctors and other health care providers. As part of his fraud, Chulak inflated mileage charges when billing the Medicaid program for his transportation services. He also was charged with paying kickbacks to Medicaid patients



for using Medicaid's services. Following his jury trial in December 2000, but before he could be sentenced, Chulak fled to Canada. Chulak was arrested by immigration officials in December 2004 while trying to re-enter the United States. In March 2005, Chulak finally was sentenced in the Middlesex County Superior Court, receiving a seven-year state prison sentence, and ordered to pay almost \$1 million in restitution and fines - a case of justice delayed, but not denied, for Mr. Chulak.

### *Bringing Criminals to Justice*

These cases represent just a small sampling of the health care fraud cases prosecuted by OIFP in 2005. Despite the inherent challenges of prosecuting such cases, OIFP met these challenges and successfully brought criminals to justice for a wide assortment of health care frauds. As the examples above show, while the paper trail may be a long and arduous one, detailed investigations and perseverance often lead to the reward of convictions in health insurance fraud cases. For health care fraud criminals, 2005 will be remembered as yet another year that OIFP was hot on their paper trail.

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