Zalma's Insurance Fraud Letter

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Volume 25, Issue 14 – July 15, 2021
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Quote of the Issue

"It is a happy talent to know how to play."

Ralph Waldo Emerson

Three Types of Insurance Fraud

Post-dating a Loss

This fraud technique involves a loss at a time when an individual has no or inadequate insurance. Following the loss, the individual applies for insurance or increases the limits of existing coverage. After a period of time (usually several days or weeks), a fraudulent claim is submitted for a loss reported to have happened after the new policy came into effect. Failure of the insurer, or its agent, to see the property (especially if the insurer has included the items on its schedules) before issuance of a policy is an invitation to this type of fraud. There is an unwritten exclusion in every insurance policy that requires that every covered loss must be fortuitous, that is, be the result of a contingent or unknown event. Attempting to post-date an auto loss is often difficult and if there is a police report, impossible.

Insurance policies typically come into effect at 12:01 a.m., standard time on the day the policy is purchased. If a person has an auto accident, fire or theft at 10:00 a.m. he may go to an insurance agent, purchase a policy that goes into effect at 12:01 a.m. that day, and make claim on the new policy.

Because the insurance fraud perpetrator will report that the loss occurred the day after the policy date, this type of scheme usually fails. When there is evidence that the insured knew about the incident before the policy was acquired or that there exists evidence when it actually happened, like a police or fire report, this type of fraud will fail.

Paper Property

This sort of fraud involves property that never existed or was never owned by the insured. It can be the most difficult type of staged loss to defeat. Paper property can appear in a staged loss or in a legitimate claim, where paper property is used to inflate the claim amount. In the presentation of the claim, the insured produces a receipt (original or duplicate) or an appraisal. The document is either fraudulent (examples include the use of computers or even white-out paint and a photocopier to change the name of the owner) or represent the value of an item owned by another individual.

For example, an insured who purchased jewelry at a department store on a credit card, took the jewelry to an appraiser, returned the jewelry for full credit and then reported it stolen. The jewelry (no longer in her possession) was then insured by means of the appraisal and a loss was reported shortly thereafter. The receipt presented to the insurer was legitimate and if the receipt was not verified with the vendor the fact that it was returned and is still in inventory at the vendor will never be discovered.

In one of my cases my investigator went to the vendor to verify the sales receipt. It was verified and then the vendor asked the investigator: "would you like to see it?" He then pulled the item out of a showcase and provided the investigator with the receipt showing he refunded the insured the purchase price when it was returned.

Health Insurance Fraud

The nation's bill for health care fraud is enormous — as large as $300 billion or more every year. Fraud takes place at many points in the health care system, in hospitals, nursing homes, and diagnostic facilities, by doctors, attorneys, health care providers, durable equipment providers, and patients.

One large area prone to fraud is the Medicare system. This system processes more than 800 million claims a year with 70 different contractors handling the claims that come from hundreds of thousands of doctors, laboratories, and other health practitioners and facilities.

In 2012 Medicare paid out over $817 billion dollars. If only five percent went to fraud, they took over $40 billion and if ten percent went to fraud more than $81 billion was paid to fraud perpetrators. I have heard estimates up to 30 percent of payouts are fraudulent. The numbers, regardless of the percentage, are excessive.

Surveys show that it is usually the claimant who perpetrates the fraud, as opposed to health care providers, employers, or attorneys. The most common fraudulent activity is a false statement or omission of information, *i.e.*, lying about the severity of an injury or failing to mention a pre-existing condition then profiting by obtaining a portion of the amounts billed from the provider.

Some naïve physicians whose practices are not burdened by a group of patients out to fool them or cheat the patients' employers or insurers, will always assume that their patients are telling the truth. It is difficult for a physician to believe a patient would seek his or her assistance if the patient was not injured or ill. As a result, they will find themselves unwitting participants in a fraud. Most physicians operate on the assumption that each person is a normal patient with a real problem that will get better in the average amount of time. The physician diagnoses, treats, and moves on to the next patient, never questioning what the patient said or even considering the fact that a patient would intentionally try to deceive. Medical schools do not teach interview or interrogation techniques. Most physicians take history by asking questions on a pre-printed form and seldom detect inconsistencies because of the need to fill out the form as quickly as possible and get on to the next patient.

Honest physicians may experience a gut feeling that something is not right. However, because of the precarious state of medical economics, the highly competitive environment in which most physicians practice, the unique character of fee-for-service medicine, and the impact that word-of-mouth can have on a practice, they choose not to confront the patient with their suspicions. Physicians are aware that angry patients with extensive contacts in the community can destroy a medical practice with innuendo, exaggerated stories of dissatisfaction, and rumors that are impossible to counter with reasonable facts. The physician will often back down, go along with the unexplainable symptoms described by the patient and, while protecting his or her practice, unwittingly become a party to fraud or abuse.

There are also cases of "staged" fraud in medical insurance, such as the non-existent trip-and-fall, where an uninjured person reports slipping and falling on debris in a business establishment. The fraudulent trip and fall victim will either obtain medical reports from an honest physician by providing a false history and symptoms. Others obtain a report from a dishonest doctor or chiropractor who prepares a false report for a fee. In the former, the physician is duped to join in the fraud; in the latter, the physician is an active participant in the fraud.

Staged accidents are often detected because of the willingness of the claimant to settle for a reasonable sum rather than involve counsel or because the reports produced by the dishonest physician are often identical for multiple claimants. It is not unusual for an unscrupulous physician to issue identical reports of injury and treatment to multiple claimants with the only change being the name and description of the patient. SIU investigators collect such bills from suspected physicians. If they are identical, or almost identical, evidence exists for increased fraud investigation and reports of suspected fraud to the authorities.

When discussing fraudulent disability claims or fraudulent claims of bodily injury, it is important that basic terminology be defined. Malingering, obtaining benefits under false pretenses, abuse of benefits, and providing a physician with a false history to support a claimed injury are all types of fraud. The frauds differ (for the purposes of medical evaluation) on the basis of how diligently the person claiming the injury researched the medical condition and how effective the claimant is in deceiving an honest physician.

A study conducted by an insurer in Southern California compared auto accidents with resulting objective injuries with those that produced only subjective "whiplash" or soft tissue injuries. For the objective injuries, it was found that 50% were suffered by occupants of the at-fault vehicle and 50% by occupants of the not-at-fault vehicle. For soft tissue injuries, however, only 8% were suffered by occupants of the at-fault vehicle. What this suggests, of course, is that a substantial number of the soft tissue injury claims are suspicious. It is also interesting to note the results of a study in Bulgaria where there was no right to sue for injuries resulting from automobile injuries at that time no claims of soft tissue injuries have been reported to the state health insurance system. This does not mean that people do not suffer actual soft-tissue injuries, it means that such claims of injury require a thorough investigation and the reported pain and suffering may only be relieved by an application of cash rather than medicine.

Wisdom

"The man who falls in love with himself will have no rivals." — **Morris Mandel**
"Who looks outside, dreams; who looks inside, awakes." – **Carl Jung**
"Chance favors only the prepared mind." – **Louis Pasteur**
"You know you're in love when you can't fall asleep because reality is finally better than your dreams." — **Theodor Seuss Geisel**
"The simplest toy, one which even the youngest child can operate, is called a grandparent." — **Sam Levenson**
"There are those who will say that the liberation of humanity, the freedom of man and mind, is nothing but a dream. They are right. It is the American Dream." —**Archibald MacLeish**
"Republicans did win the Civil War. That's why there is no more slavery. It was a Republican president who issued the Emancipation Proclamation. It was a Republican-controlled Congress that voted for the 13th Amendment, outlawing slavery." – **Thomas Sowell**
"What the eyes see and the ears hear, the mind believes." – **Harry Houdini**
"If a problem has no solution. it may not be a problem, but a fact – not too be solved, but to be coped with over time." — **Shimon Peres**

"Those who expect to reap the blessings of freedom, must, like men, undergo the fatigues of supporting it." —**Thomas Paine**

The Public Adjuster & Fraud

EVERY PROFESSION HAS THE OCCASIONAL CROOK

When a public insurance adjuster exceeds his or her authority and attempts to defraud an insurer on behalf of the adjuster's client, the standard "Concealment or Fraud" provision precludes the insureds from obtaining any recovery under their policies as the claims submitted by Berson, their public insurance adjuster, in his capacity as their agent, were fraudulent. [*Astoria Quality Drugs, Inc. v. United Pacific Ins. Co. Of NY,* 163 A.D.2d 82, 557 N.Y.S.2d 339).] "Chubb, therefore, is entitled to full recovery of the claims paid." [*Chubb & Son v. Consoli,* 283 A.D.2d 297, 726 N.Y.S.2d 398, 2001 N.Y. Slip Op. 04550 (2001).]

The Texas legislature has statutorily made a contract that is void for illegality under the common law enforceable or voidable at the option of the least culpable party—the insured—when a person contracts with the insured to perform services as a public insurance adjuster but does not have a public insurance adjuster's license. [*Lon Smith & Assocs., Inc. v. Key*, 527 S.W.3d 604 (Tex. App. 2017

In *U.S. v. Saada*, 212 F.3d 210 (3rd Cir., 1999) the government's evidence at trial showed that:

> [i]n 1990, appellants contacted Ezra Rishty, Isaac's cousin, for help in an insurance fraud scheme. Rishty was a public insurance adjuster in New York City who had conspired with various clients in over 200 fraudulent insurance schemes in the past.

Rishty agreed to assist Isaac in filing a fraudulent insurance claim, and enlisted the help of Morris Beyda, a former employee who by then owned his own business. Rishty also enlisted the help of Sal Marchello, a general adjuster for the Chubb Insurance Group ("Chubb"), which was Scrimshaw's insurer. Marchello assured Rishty that Chubb would assign him to handle the future Scrimshaw claim.

In *U.S. v. Lemm*, 680 F.2d 1193 (8th Cir. 1982) a scheme to defraud insurers was defeated with the testimony of a putative PA. He explained to the trial court that the arson and insurance fraud activities underlying the convictions of various defendants resulted from fire to fire, but a general scenario was summarized by Eugene P. Gamst, the government's chief witness, who was a public insurance adjuster licensed in Minnesota. The government's case showed that at some point in the early 1970's Gamst began mixing his legitimate adjustment activities with arson, eventually becoming the center of an arson ring alleged to have existed from April 1, 1975 to September 1, 1978.

The basic mode of operation was that Gamst, or occasionally another coconspirator, would recruit an individual to start an arson fire for insurance proceeds. Gamst would instruct the individual how to start the fire, how to act, and what to tell the authorities. After the fire, Gamst would pose as a legitimate public adjuster of an accidental fire. Occasionally, Gamst would also act as a private contractor and repair the fire damage in order to obtain a larger portion of the insurance proceeds. The roles of the other conspirators included providing seed money for the purchases of property, locating property for burning, providing property to be burned, preparing and torching the property, and recruiting others to the scheme resulted in convictions.

In *Everett Cash Mutual vs. Bonnie Sue Gibble,* the Court of Common Pleas of Lycoming County, Pennsylvania, NO. 01-01,640 was faced with a motion to exclude expert Testimony of Patrick Cassidy, Defendants' proposed expert witness.

When Ms. Gibble's furnace emitted soot into her home and the claim made with her homeowner's insurance company, was not handled to Ms. Gibble's satisfaction. Ms. Gibble sought the assistance of Mr. Cassidy, a public adjuster, and signed a "Public Adjustor Contract", retaining Cassidy Public Adjustment "to advise and assist in the adjustment of the insurance claim", agreeing to pay a contingent fee comprising a certain percentage "of the amount paid by the insurance companies in settlement of [the] loss and necessary expenses."

After making several payments, including one which it offered as payment in full satisfaction of the claim, which payment Defendants refused to accept, Plaintiff filed the instant action, seeking a declaratory judgment that it had fulfilled all of its obligations under the insurance contract. Defendants counter-claimed for breach of contract, negligence, intentional infliction of emotional distress, unfair trade practices act violations and bad faith, and also joined the adjusters brought in by the insurance company as additional defendants. In support of their claims, Defendants plan to introduce the testimony of Mr. Cassidy as an expert witness, and in that regard have provided Plaintiff with a copy of his report, in which he opines, *inter alia*, that Plaintiff and Additional Defendants "did not follow proper claims practice."

Gibble, in response, argue that Mr. Cassidy is acting as an expert in his role as a consultant, at the rate of $75 per hour, and only his work as a public adjuster is subject to the contingent fee agreement.

The long established rule of law that a special contract to pay more than the regular witness fees in ordinary cases is void for want of consideration and as being against public policy. Section 552 of the Restatement of Contracts, which provides, in subsection (2): "[a] bargain to pay an expert witness for testifying to his opinion a larger sum than the legal fees provided for other witnesses is illegal only if the agreed compensation is contingent on the outcome of the controversy."

In *In Re Mushroom Transportation Co., Inc., Debtor*, 70 B.R. 416 (E.D. Pa. 1987), the court precluded an expert witness from testifying at trial because of a contingent fee arrangement whereby the expert had been hired to assist the debtor in a bankruptcy

proceeding in collecting monies allegedly due the debtor from a certain party. Public adjusters, when acting as an expert witness, must be paid a reasonable fee. They may not share in the recovery.

The testimony of interested lay witnesses about historical facts generally does not pose a risk of the same proportion as that of an expert with a contingent financial interest. The concealment of a contingent financial arrangement with a witness would be unconscionable. With the disclosure of such an arrangement, an opinion proffered by an expert would likely be so undermined as to be deprived of any substantial value.

Defendants' attempt to segregate Mr. Cassidy's work as an expert witness from his work as a public adjuster claiming it was "merely one of form" failed. It was also of no consequence that the public adjuster contract was entered into prior to the commencement of litigation.

Mr. Cassidy's preparation of the expert report followed the commencement of litigation and, as Defendants admit, Mr. Cassidy will be entitled under the contingent fee agreement to a percentage of any damages awarded for their loss. The Court concluded, therefore, that the opinion rendered in the report is "so undermined as to be deprived of any substantial value". While he may testify as a fact witness with respect to his adjuster role, Mr. Cassidy must be precluded from giving any opinion as an expert witness.

A contingent fee can bring the expert much more than an hourly rate would provide. Because of the opportunity of a windfall public adjusters and lawyers are willing to gamble they will get nothing for their efforts in exchange for the opportunity of a windfall. That opportunity colors the testimony a public adjuster, who will profit from a verdict, as an expert and such testimony must be precluded.

When I was an adjuster, I dealt with one PA who had a methodology to increase the value of every fire claim he had contracted: his insureds would always lose 10 cans of Libby's Peas and a Lalique perfume bottle.

When the insured was questioned about the list of claimed losses, she testified that she always bought Green Giant peas, never more than two cans at a time, and had never even heard of Lalique perfume – a brand that does not exist although Rene Lalique made beautiful crystal perfume bottles.

It is incumbent on an adjuster, when dealing with a claim presented by a public adjuster to compel the PA to produce some evidence to support the claim or review the claim in detail with the insured who probably never saw the proof of loss and proof of claim prepared by the PA.

NOT CROSS POLICE LINE DO NOT CROSS POLICE LINE

Good News From the

Clients took a fall when agent Alan Amir Yousefi spent more than $105K of their workers comp premiums on gambling, sports equipment and designer clothes. The Irvine, Calif. man issued bogus insurance certificates to contractors and small businesses, including a minority-owned firm. Without valid policies in place, Yousefi's clients were exposed to potentially catastrophic losses from claims. A construction company discovered it didn't have comp coverage after an injured employee filed a claim. The business suffered an uncovered loss and negotiated a costly settlement with the injured employee's attorney. Other victims faced premium hikes after having gaps in coverage through no fault of their own. A victimized contracting firm was suspended by the Contractors State License Board because Yousefi failed to secure a comp policy. Yousefi received 270 hours of community service and must repay more than $95K.

Workers comp policies were rented out to help shady contracting firms illegally avoid paying state-required premiums. Dennis Alexander Barahona created a shell company that purported to be involved in the construction industry. The Chelsea, Mass. man bought a small, basic workers comp policy in the name of his shell company. It covered a minimal payroll for a few purported employees. Barahona then "rented" the policy to dozens of work crews that had subcontracts with builders on projects in Florida. He sent the contractors an insurance certificate as false "proof" that the work crews had state-required coverage. By sending the certificate, Barahona lied that the work crews worked for his company. Barahona's tiny rented comp policy avoided the higher cost of obtaining adequate coverage for the numerous workers on the work crews. His policy covered a $91K payroll. The comp premiums cost just $15.K. The premium for the actual $4.3M payroll would've cost $728K. To hide the subterfuge, the contractors issued payroll checks for the workers' wages to Barahona's shell company. He cashed the checks, then gave the money to the work crews after deducting their fee — about 6% of the payroll. Barahona and the colluding contractors also avoided $1.1M of payroll taxes. He was handed 18 months in federal prison.

Flurries of bribes and kickbacks fueled a medical imaging firm's plot to milk California's workers comp system out of more than $250M. Sam Sarkis Solakyan ran Vital Imaging and San Diego MRI Institute, a network of firms throughout California. Solakyan bribed docs and a chiro to refer comp patients to his firms. He paid the providers cash or referred patients to their practices in a form of illegal cross-referring. They hid the bribes as sham fees for "marketing," "administrative services" and "scheduling." In fact, the money Solakyan paid them was a volume-based deal. Solakyan required the docs to refer to him a minimum number of patients for him to cross-refer patients to them. The referrals stopped if the docs missed their quotas. Solakyan hid his cash payouts to chiro Steven Rigler for patient referrals by calling the referrals "reports." Once he asked Rigler if Solakyan could "send my driver with your reports," then said, "I'll have him contact you then I'll just send him with your reports, buddy." Solakyan paid his recruiters more than $8.6M for obtaining MRI referrals. Solakyan was federally convicted and will receive up to 240 years in federal prison when sentenced Oct. 4. Rigler earlier received six months, and other key ring members also were previously sentenced.

A UK soccer player scored all the way from midfield — then not-so-brightly posted the feat (not to mention feet) on social media despite telling his insurer he was disabled. Callum Saunders played for the Horsham Football Club. He told his insurer Aviva that he hurt his foot in a car crash. Saunders couldn't play soccer or work as a self-employed plasterer, he lied. He claimed £17.3K. Then Saunders' wild midfield goal went viral. It was featured on TV, and Saunders posted the footage on his social media accounts. His team also posted the miracle shot on *YouTube*. Faced with the evidence, Saunders withdrew his injury claim, avoided jail, and will simply pay £5K in legal costs.

A woman who confessed to having her former NBA star hubby Lorenzen Wright shot wants her 30-year prison term thrown out because she claimed she was bullied. His $1M life policy reportedly was a driving motive; he and Sherra had spent most of the $55M salary the 6'-10" Wright earned during his 13-year NBA career before retiring. His decomposing, bullet-ridden body was found buried in a field in Memphis in 2010. A hired church pastor did the shooting. Sherra blew through the life policy money in just 10 months — including a mansion, investment properties, cars, and expensive trips to New York. She later pled guilty. Sherra now wants her sentence tossed. She claims, among other things, that female prison guards bullied her into a mental breakdown that led to her confession.

Japan's newest Black Widow murderer lost her death row appeal and will hang for poisoning four elderly partners with cyanide to collect their life insurance and other assets. Chisako Kakehi left a trail of damning evidence. The clues included her dating service applications, which said potential matches had to be elderly, ill or childless. Investigators also found medical books in Kakehi's home, with earmarked pages on poisoning, traces of cyanide. And she stored paraphernalia she used to hide the lethal drug in her partners' food and drink. Kakehi amassed more than U.S. $9M of insurance payouts and inheritance, then blew most of it on bad stock trading. Black Widows who murder for life insurance also have a history in the U.S. Olga Rutterschmidt and Helen Golay befriended two homeless men in the Los Angeles area, secretly took out eight life policies in their names worth millions, making them the beneficiaries. Rutterschmidt and Golay then ran down the men with their cars, making their deaths seem like hit-and-runs. The deadly duo received life in state prison.

Arsonist With "Chutzpah" Tries to Get Out of Jail Because Of Covid-19

Go Directly to Jail & Stay for The Full 60 Months

After being convicted of arson and sentenced to sixty months in federal prison asked for compassionate release even though he was in good health claiming fear of Covid 19. In *United States of America v. D-1 Ehab Sitto*, Case No. 17-20838, United States District Court Eastern District of Michigan Southern Division (July 7, 2021) the USDC looked at the evidence presented and determined that the request was not for compassion but was a pleading that defined the Yiddish word "chutzpah" or unmitigated gall.

Ehab Sitto is serving a 60-month sentence after pleading guilty to two counts of Malicious Use of Fire, 18 USC 844(i) based on his hiring of person experiencing homelessness to commit arson for the purpose of insurance fraud. The Court sentenced Defendant on May 23, 2019 and a Judgment was entered June 7, 2019. Defendant moved for compassionate release.

FACTS

Defendant has not asserted any medical conditions that are CDC risk factors, but instead offers family history, and current coronavirus infections by family members as well as a generalized concern regarding the possibility that he will contract the coronavirus at Federal Correction Institution Morgantown ("FCI Morgantown" or "Morgantown").

LEGAL ANALYSIS

A defendant may move for compassionate release under 18 U.S.C. § 3582(c)(1)(A) only after "fully exhaust[ing] all administrative rights to appeal a failure of the Bureau of Prisons to bring a motion on the defendant's behalf" or "the lapse of 30 days from the receipt of such a request by the warden of the defendant's facility, whichever is earlier." 18 U.S.C. § 3582(c)(1)(A).

Under the statute, a court may reduce a defendant's term of imprisonment:

- if it finds that extraordinary and compelling reasons warrant such a reduction;
- if it finds that a reduction is consistent with applicable statements issued by the Sentencing Commission; and
- after considering the factors set forth in 18 U.S.C. Section 3553(a) to the extent they are applicable.

The defendant bears the burden of proving that "extraordinary and compelling reasons" exist to justify release under the statute.

The Government did not dispute that Defendant has now properly exhausted all administrative remedies. The Government disputed, however, whether Defendant's health and family circumstances constitutes an extraordinary circumstance warranting his release.

Defendant admitted that he is not suffering from any serious illnesses but instead, asserts that having A+ blood type, a familial background of heart disease, and the type of care available at Morgantown makes him more susceptible to a coronavirus infection. At the time of his presentence interview in 2019, Defendant informed the Probation Department that he was good health, had no chronic illnesses, and was not taking any prescribed medication. Since July 23, 2019, Defendant has not been prescribed any medicine nor required significant medical treatment for any illness, including heart related illnesses.

None of the Defendant's concerns are on the CDC list of underlying medical conditions for which people are at increased risk for severe illness from the coronavirus. Additionally, Defendant points to the Bureau of Prisons website as proof that Morgantown is not taking the proper coronavirus precautions because the number of cases increased from 74 to 121 over three days in December. As of January 2021, the cases at Morgantown have significantly decreased. Out of 442 inmates, Morgantown has eight active cases, two inmates and six officers.

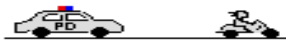
Defendant has not shown that he is at a heightened risk of severe complications should he contract COVID-19 or that the prison medical staff is incapable of treating his conditions.

CONCLUSION

For the reasons stated above, the Court concluded that Defendant has not established any extraordinary and compelling reasons for a reduction in his 60-month sentence. Defendant's Motion for Compassionate Release was denied.

ZIFL OPINION

There is no type of insurance fraud that is more evil than arson-for-profit. Firefighters are injured and die putting out such fires, neighbors are injured or die by the spread of intentionally set and accelerated fires. For a man in good health to claim compassionate release because of fear of contracting Covid-19 is an amazing act of unmitigated gall. His act of chutzpah was rejected and he will serve all 60 months of his reservation at the grey bar hotel.



Health Insurance Fraud Convictions

Justice Department Reaches Settlement Agreement with Physicians Group In El Paso Over Allegations of Violating the False Claims Act

El Paso Ear, Nose & Throat Associates (EPENT) has agreed to pay $750,000 to settle allegations that they violated the False Claims Act by billing Medicaid, Medicare and other federal healthcare programs by upcoding evaluation and management codes.

The government alleged that EPENT knowingly caused false claims to be submitted to federal healthcare programs by billing for services at a higher rate of reimbursement than they would be entitled to for the service actually provided. This scheme is commonly referred to as "upcoding."

The Defense Health Agency (DHA) supports the delivery of TRICARE, the program that provides integrated, affordable, high-quality healthcare services to more than 9.6 million uniformed service members, retirees and their families. TRICARE was one of the government health programs that was defrauded in this case.

The matter was investigated by the FBI, U.S. Department of Health and Human Services Office of Inspector General, Defense Criminal Investigative Service and the Texas Attorney General's Office Civil Medicaid Fraud Division.

Operator Of Residential Nursing Facility Sentenced for Health Care Fraud

Lopez Scott, 47, a Portsmouth, Virginia man was sentenced July 1, 2021 to two years in prison for defrauding the Virginia Medicaid program by submitting over $188,000 in false claims for a residential nursing facility.

According to court documents, Scott operated **Turning Points Residential Care,** a business authorized to provide residential support services and skilled nursing services to recipients of Medicaid. Between October 2016 and October 2019, Scott submitted numerous false and fraudulent claims to Virginia Medicaid, known as the Virginia Medical Assistance Program (VMAP), which misrepresented that 5,847.75 hours of skilled nursing services had been provided to a Medicaid recipient. As a result, Scott received approximately $188,297.39 in health care payments to which he was not entitled.

According to court documents, in order to conceal and cover up the fact that no skilled nursing services had been provided to the Medicaid recipient, Scott created fraudulent entries of nursing notes in the electronic office records of Turning Points, including the forged signature of a nurse, which falsely indicated that such services had been provided. Scott also asked this nurse to falsely state to investigators that she had continued to work for the company even after her employment had ceased.

Northern Ohio Health System Agrees to Pay Over $21 Million To Resolve False Claims Act Allegations for Improper Payments to Referring Physicians

Akron General Health System (AGHS), a regional hospital system based in Akron, Ohio, will pay $21.25 million to resolve allegations under the False Claims Act of improper relationships with certain referring physicians, resulting in the submission of false claims to the Medicare program. AGHS was acquired at the end of 2015 by the Cleveland Clinic Foundation (Clinic) through a full member substitution agreement.

This settlement resolves allegations that between August 2010 and March 2016, AGHS paid compensation substantially in excess of fair market value to area physician groups to secure their referrals of patients, in violation of the Anti-Kickback Statute and the Physician Self-Referral Law, and then submitted claims for services provided to these illegally referred patients, in violation of the False Claims Act. The Anti-Kickback Statute prohibits offering, paying, soliciting or receiving remuneration to induce referrals of items or services covered by Medicare, Medicaid and other federally funded programs.

The Physician Self-Referral Law, commonly known as the Stark Law, prohibits a hospital from billing Medicare for certain services referred by physicians with whom the hospital has an improper financial arrangement, including the payment of compensation that exceeds the fair market value of the services actually provided by the physician. The Clinic voluntarily disclosed to the government its concerns with these compensation arrangements, which were put in place by AGHS's prior leadership, and received credit for its cooperation in the resolution reached by the parties.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Beverly Brouse, the former Director of Internal Audit at AGHS, and Ethical Solutions LLC. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. The *qui tam* case is captioned *United States ex rel. Brouse et al. v. Akron General Health System, Inc. et al.*, No. 5:15-cv-2720 (N.D. Ohio).

Contract Rehabilitation Therapy Providers Agree to Pay $8.4 Million To Resolve False Claims Act Allegations Relating to The Provision of Medically Unnecessary Therapy Services

Select Medical Corporation and **Encore GC Acquisition LLC** agreed to pay $8.4 million to resolve allegations that **Select Medical Rehabilitation Services Inc.** (SMRS) violated the False Claims Act by knowingly causing 12 skilled nursing facilities (SNFs) in New York and New Jersey to submit false claims to Medicare for rehabilitation therapy services that were not reasonable, necessary or skilled. Select Medical Corporation was the prior parent company of SMRS, while Encore GC Acquisition LLC is the successor-in-interest to SMRS. The alleged conduct occurred prior to Encore's acquisition of SMRS.

From 1997 through March 31, 2016, SMRS offered contract rehabilitation therapy services to SNFs across the country. The United States alleged that, at various times between Jan. 1, 2010, through March 31, 2016, SMRS contracted with 12 SNFs in New York and New Jersey to provide rehabilitation therapy services. The United States alleged that SMRS' corporate policies and practices encouraged and resulted in the provision of medically unnecessary, unreasonable and unskilled therapy services being provided to patients at the 12 SNFs.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Melissa Vail, a former SMRS employee. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. The *qui tam* case is captioned *U.S. ex rel. Doe v. Select Medical Corporation et al.*, No. 2:16-cv-03569 (D.N.J.).

St. Jude Medical, Inc. Agrees to Pay $27 Million For Allegedly Selling Defective Heart Devices

St. Jude Medical Inc. (St. Jude) has agreed to pay $27 million to settle allegations under the False Claims Act that, between November 2014 and October 2016, it knowingly sold defective heart devices to health care facilities that, in turn, implanted the devices into patients insured by federal health care programs. St. Jude was acquired by Abbott Laboratories in January 2017.

The government alleged that St. Jude failed to disclose serious adverse health events in connection with the premature depletion of the battery in certain models of its Fortify, Fortify Assura, Quadra and Unify devices, which are implantable defibrillators used in patients at risk of cardiac arrest due to an irregular heartbeat. The devices are surgically implanted into patients' chests, and when the devices detect an irregular heartbeat, they send an electrical pulse to the heart to "shock" it back to its normal rhythm. The government alleged that, by 2013, St. Jude knew that lithium clusters formed on the batteries of the devices, causing some of the batteries to short and, in turn, suffer a premature power drain.

The government alleged that, in late 2014, St. Jude submitted a request to the FDA to approve a change to prevent lithium clusters from draining the battery and told the FDA, "no serious injury, permanent harm or deaths have been reported associated with this" issue. However, according to the government's allegations, St. Jude was aware at that time of two reported serious injuries and one death associated with premature battery depletion (PBD) induced by lithium clusters.

St. Jude continued to distribute devices that had been manufactured without the new design. In August 2016, St. Jude contacted the FDA and informed it that the number of PBD events had increased to 729, including two deaths and 29 events associated with loss of pacing. On Oct. 10, 2016, St. Jude issued a medical advisory regarding the PBD caused by lithium cluster shorts, which FDA classified as a Class I recall. A Class I recall is where there is a reasonable probability that "violative" products "will cause serious adverse health consequences, including death." After the recall, St. Jude no longer sold the older devices, but thousands of them had been implanted into patients between Nov. 20, 2014, and Oct. 10, 2016.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Debbie Burke, a patient who received one of the devices that was subject to recall. The *qui tam* case is captioned *United States ex rel. Debbie Burke v. St. Jude Medical, Inc.*, No. 16-cv-3611 (D. Md.).

Medical Device Companies Alere Inc. And Alere San Diego Inc. Agree to Pay $38.75 Million To Settle False Claims Act Allegations

Alere Entities Allegedly Sold Diagnostic Devices They Knew Had a Materially Defective Algorithm

Alere Inc. and **Alere San Diego Inc.** (collectively, Alere), medical device manufacturers agreed to pay $38.75 million to resolve allegations that the companies violated the False Claims Act by billing, and causing others to bill, the Medicare program for defective rapid point-of-care testing devices.

The settlement announced today resolves allegations that, from 2008 to 2016, Alere knowingly sold defective INRatio blood coagulation monitors used by Medicare beneficiaries taking anticoagulant drugs, such as warfarin. For those patients, blood coagulation monitoring is essential to determining a clinically appropriate and safe dosage for their medications. Too much of an anticoagulant drug can cause major bleeding, and too little of the drug can cause blood clots and strokes.

Since at least 2008, Alere allegedly knew that the software algorithm used in each version of its INRatio monitors contained a material defect. Based on its own internal research, as well as external complaints and warnings, Alere allegedly was aware that INRatio devices had a "system limitation" that produced inaccurate and unreliable results for some patients. The United States alleged that, despite awareness that INRatio systems were linked to over a dozen deaths and hundreds of injuries, including intra-cerebral hemorrhaging and cardiovascular events following bleeding episodes, Alere concealed the defect for years and billed Medicare for the use of defective INRatio devices. Alere allegedly failed to take appropriate corrective actions until 2016, when the devices were removed from the market following a nationwide Class I product recall undertaken at the request of the U.S. Food and Drug Administration (FDA).

ZIFL wonders what took the government 13 years to catch on to this crime and why no one is going to jail.

Manhattan Doctor Sentenced to More Than 17 Years in Prison for Bribery and Kickback Scheme, And for Distributing Oxycodone and Fentanyl for No Legitimate Medical Purpose

GORDON FREEDMAN, a doctor who practiced in New York, New York, was sentenced July 8, 2021 in Manhattan federal court to 121 months in prison for participating in a scheme to receive bribes and kickbacks in the form of fees for sham educational programs ("Speaker Programs") from pharmaceutical company Insys Therapeutics in exchange for prescribing millions of dollars' worth of Subsys, a potent fentanyl-based spray manufactured by Insys, among other offenses (the "Insys Bribery Offenses"). FREEDMAN was convicted of the Insys Bribery Offenses following a jury trial. FREEDMAN was also sentenced to 210 months in prison, to run concurrently to the other sentence, for distributing oxycodone and fentanyl to a patient for no legitimate medical purpose (the "Diversion Offense"). That patient ultimately died of a fentanyl overdose from drugs FREEDMAN illegally prescribed him. FREEDMAN pled guilty to the Diversion Offense in December 2019.

FREEDMAN was sentenced by United States District Judge Kimba M. Wood.

According to the allegations contained in the Indictments against FREEDMAN, the evidence presented in Court during the trial related to the Insys Bribery Offenses, and filings in related proceedings:

Insys manufactured Subsys, a powerful painkiller approximately 50 to 100 times more potent than morphine. The U.S. Food and Drug Administration ("FDA") approved Subsys only for the management of breakthrough pain in cancer patients. Prescriptions of Subsys typically cost thousands of dollars each month, and Medicare and Medicaid, as well as commercial insurers, reimbursed prescriptions written by the defendants. In or about August 2012, Insys launched a "Speakers Bureau," purportedly aimed at educating practitioners about Subsys. In reality, however, Insys used its Speakers Bureau to induce doctors to prescribe large volumes of Subsys by paying them Speaker Program fees. At each Speaker Program, speakers were supposed to conduct a slide presentation for other health care practitioners regarding Subsys. However, many of the Speaker Programs led by the speakers paid by Insys were predominantly social affairs where no educational presentation occurred. Attendance sign-in sheets for the Speaker Programs were frequently forged by adding the names and signatures of health care practitioners who had not actually been present.

FREEDMAN, a doctor certified in pain management and anesthesiology, owned a private pain management office on Manhattan's Upper East Side and was an associate clinical professor at a large hospital in Manhattan ("Hospital-1"). FREEDMAN received approximately $308,600 in Speaker Program fees from Insys in exchange for prescribing large volumes of Subsys.

In March 2013, a Regional Sales Manager for Insys sent an email to FREEDMAN informing him that he would receive more Speaker Programs in the coming months because Insys wanted prescriptions of Subsys to increase, and urging FREEDMAN to put more patients on Subsys. FREEDMAN responded, in part, "Got it," and significantly increased his Subsys prescriptions in the following months, during which he received approximately $33,600 in Speaker Program fees.

In 2014, FREEDMAN's prescriptions of Subsys rose even further, and he was the fourth-highest prescriber of Subsys nationally in the final quarter of 2014, accounting for approximately $1,132,287 in overall net sales of Subsys in that quarter. During 2014, FREEDMAN was the highest-paid Insys Speaker in the nation, receiving approximately $143,000.

During the period in which FREEDMAN was receiving kickbacks from Insys, he was also distributing powerfully addictive prescription drugs to a particular patient ("Patient-1") with no legitimate medical purpose. From in or about 2013 through in or about May 2017, FREEDMAN prescribed enormous quantities of oxycodone and fentanyl to Patient-1. For example, in 2013 alone, FREEDMAN prescribed Patient-1 approximately 85,427 oxycodone pills – an average of approximately 234 oxycodone pills per day – containing a total of approximately 2,422,435 mg of oxycodone. On or about April 13, 2017, FREEDMAN gave Patient-1 prescriptions for approximately 150 doses of a drug containing fentanyl, and for approximately 950 oxycodone pills containing approximately 30 mg of oxycodone per pill. On or about May 4, 2017, Patient-1 died of a fentanyl overdose after ingesting a quantity of the drug prescribed by FREEDMAN on or about April 13, 2017.

In addition to the prison sentence, FREEDMAN, 61, of New York, New York, was sentenced to three years of supervised release, ordered to forfeit $308,600 and ordered to pay a total fine across the two cases of $75,000.

FREEDMAN was one of five Manhattan doctors convicted for participating in the Subsys bribery conspiracy. **Todd Schlifstein** was convicted upon a guilty plea and sentenced by Judge Wood on October 28, 2019, principally to a term of two years in prison. **Alexandru Burducea** was convicted upon a guilty plea and sentenced by Judge Wood on January 27, 2020, principally to a term of 57 months in prison. **Dialecti Voudouris** was convicted upon a guilty plea and sentenced by Judge Wood on March 5, 2020, principally to time served. **Jeffrey Goldstein** was convicted upon a guilty plea and sentenced by Judge Wood on June 16, 2021, principally to a term of 57 months in prison.

JURY CONVICTS MEDICAL EQUIPMENT COMPANY OWNERS OF $27 MILLION FRAUD

Leah Hagen, 49, and **Michael Hagen,** 54, of Arlington, Texas, were owners and operators of two durable medical equipment (DME) companies: **Metro DME Supply LLC** (Metro) and **Ortho Pain Solutions LLC** (Ortho Pain), both operated out of the same location in Arlington. A federal jury convicted the Dallas area owners and operators of two durable medical equipment companies of one count of conspiracy to defraud the United States and to pay and receive health care kickbacks and one count of conspiracy to commit money laundering.

According to the evidence presented at trial, The defendants paid a fixed rate per DME item in exchange for prescriptions and paperwork completed by telemedicine doctors that were used to submit false claims to Medicare. The defendants paid illegal bribes and kickbacks and wired money to their co-conspirator's call center in the Philippines that provided signed doctor's orders for orthotic braces. The evidence at trial showed emails exchanged between Leah and Michael Hagen and their co-conspirators showing a per-product pricing structure for orthotic braces but disguising their agreement as one for marketing and other services.

Through this scheme, the defendants billed Medicare Parts B and C approximately $59 million and were paid approximately $27 million. The defendants wired millions of proceeds into their personal bank accounts, both in the U.S. and overseas. At sentencing, the Hagens each face a maximum sentence of 25 years in prison.

ZIFL can only wonder why the defendants were able to steal $27 million before they were caught.

Georgia Woman and Montgomery Man Plead Guilty to Their Part in Drug Distribution Conspiracy Involving Montgomery Physician

Shayla Denise Moorer, 39, of Suwanee, Georgia entered a guilty plea and last week, on June 30, 2021, **Naaman Rashad Jackson**, 33, from Montgomery, Alabama admitted his guilt in federal court.

Moorer's and Jackson's guilty pleas follow an April 2021 indictment charging them and thirteen others with conspiring to unlawfully distribute oxycodone, a Schedule II opioid controlled substance. The overall conspiracy began at an unknown date and continued through April 2020. Both Moorer and Jackson operated in the scheme with **Deandre Varnel Gross**, who previously pleaded guilty to his role in the conspiracy. According to court records, Moorer and Jackson entered into an agreement with associates of theirs to obtain prescriptions of oxycodone from Montgomery, Alabama physician, **D'livro Lemat Beauchamp**, despite there being no medical reason to do so. They would then fill those prescriptions at a pharmacy. Once they had the oxycodone tablets, Moorer and Jackson would sell some or all of them to others. Often, they would receive the prescriptions without actually seeing Beauchamp. Instead, Moorer and Jackson would obtain the prescriptions from other co-conspirators.

In Moorer's plea agreement, she admitted to first receiving a prescription as part of the scheme on or about April 18, 2014. Jackson's agreement states his first prescription was received on or about July 3, 2013. Thereafter, they both received prescriptions for either 60 or 90 30-milligram oxycodone tablets made out to them and signed by Beauchamp approximately once a month. Moorer continued in the scheme until March of 2020 and Jackson continued until April 2020. Over the course of Moorer's involvement, she admitted to receiving and filling 63 oxycodone prescriptions which resulted in approximately 5,100 illegally obtained tablets and a total of 153,000 milligrams of the highly addictive and abused drug. During Jackson's participation in the scheme, he obtained 47 prescriptions for 4,230 pills, equaling 126,900 milligrams of oxycodone.

Moorer's and Jackson's sentencing hearings will take place on September 28, 2021 and they are both facing a maximum of 20 years in prison. The cases against the other thirteen named in the indictment are still pending.

Virginia Diagnostic Testing Lab Agrees to Pay $1.4 Million To Resolve False Claims Act Allegations

Genetworx Laboratories, a Virginia diagnostic laboratory will pay $1.4 million to resolve allegations that it violated the False Claims Act by submitting or causing to be submitted claims for genetic tests to Medicare without valid physician oversight.

According to the contentions of the United States contained in the settlement agreement:

> From July 2014 to September 2015, **Genetworx Laboratories** utilized the services of **Seth Rehfuss** as a sales representative who persuaded groups of senior citizens in senior housing complexes to submit to genetic testing, despite applicable Medicare rules requiring proper orders from a treating physician for such tests. Genetworx, in turn, submitted claims for payment to Medicare for Rehfuss's genetic tests performed without valid physician oversight.

Rehfuss, of Somerset, New Jersey, previously pleaded guilty in Trenton federal court to a superseding information charging him with conspiracy to commit health care fraud and was sentenced in May 2019 to 50 months in prison.

Surgical Care Affiliates and Orlando Surgery Center Agree to Pay $3.4 Million To Settle False Claims Act Liability

Surgical Care Affiliates, LLC and **Orlando Center for Outpatient Surgery, LP** agreed June 28, 2021 to pay the United States $3.4 million to resolve allegations that both companies violated the False Claims Act by submitting claims for kidney stone procedures that were not medically justified and for engaging in an illegal kickback arrangement.

The United States previously intervened in a whistleblower lawsuit against SCA and the Orlando Center on October 15, 2019. The lawsuit and settlement relate to the submission of claims for extracorporeal shock wave lithotripsy, a procedure used to break up kidney stones. According to the lawsuit, Dr. Patrick Hunter was a urologist who performed lithotripsy procedures at the Orlando Center, a facility affiliated with SCA. According to the settlement agreement, between January 2010 and April of 2016, the Orlando Center submitted claims for lithotripsy procedures performed on Medicare and TRICARE patients by Dr. Hunter that were medically unnecessary because the procedures were not medically indicated or because the patients did not have kidney stones.

The settlement agreement also resolves allegations that Dr. Hunter, SCA, and the Orlando Center engaged in an illegal kickback arrangement, where Dr. Hunter performed the lithotripsy procedures in exchange for per-procedure payments from the Orlando Center. Dr. Hunter allegedly agreed to perform his lithotripsy procedures at the Orlando Center in exchange for payments from the Orlando Center, in violation of the Anti-Kickback Statute. SCA vetted and approved the agreement. These procedures were then billed to and paid by Medicare and TRICARE in violation of the False Claims Act.

The settlement resulted from a lawsuit originally filed in the United States District Court for the Middle District of Florida by Scott Thompson. Mr. Thompson sued under the *qui tam*, or whistleblower, provisions of the False Claims Act permitting a private citizen to sue on behalf of the United States for false claims and to share in the recovery. The Act also allows the United States to intervene and prosecute the action. The United States intervened in this matter and litigated the case. Mr. Thompson will receive $748,000 of the proceeds from the settlement with SCA and the Orlando Center.

Dr. Hunter passed away in March of 2019. In November 2020, Dr. Hunter's estate paid the United States $1.75 million to resolve the government's claims arising from Dr. Hunter's alleged participation in the scheme.

The case is captioned *United States ex rel. Thompson v. Surgical Care Affiliates et al.*, Case No. 6:16-cv-2189-PGB-LRH. The settlement resolves the United States' claims against SCA and the Orlando Center in that case. The claims resolved by the settlement are allegations only, and there has been no determination of liability.

West Virginia Pharmacies Owner Fined in Prescription Probe

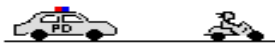
Beckley Pharmacy's two locations and **Bee Well Pharmacy** in South Charleston, West Virginia, filled prescriptions that were not for a legitimate medical purpose from 2015 to 2020.

The owner of the two West Virginia pharmacies agreed to pay $300,000 in civil penalties to settle allegations that they filled illegitimate prescriptions in violation of federal law.

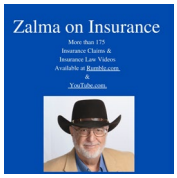
Federal prosecutors said:

> Under the settlement announced Monday, Bee Well Pharmacy will be unable to fill prescriptions for controlled substances after agreeing to surrender its Drug Enforcement Administration registration. The Beckley locations will retain their registrations but must adhere to more stringent regulatory and reporting obligations.

"Pharmacies must keep accurate records and maintain strong controls when handling controlled substances," acting U.S. Attorney Lisa G. Johnston said in a statement." Those that fail to do so open the door to the potential diversion of drugs, the illegal distribution, and abuse of these drugs.



Videos on YouTube and Zalma on Insurance from Barry Zalma



Over 320 Videos describing important insurance issues described by Barry Zalma and available to anyone who views or subscribes to the YouTube account. Issues include insurance fraud, definition of insurance, insurance as a contract of personal indemnity, millions for defense and not a dime for tribute and the tort of bad faith. Please subscribe. There are 62 Videos are at https://www.youtube.com/channel/UCFg7qxC0tVgKcMUqoUfnwPw/videos but I have had some difficulty

posting new videos to my YouTube channel. I have posted about 320 videos on insurance, insurance claims, insurance law, and insurance fraud to this YouTube Channel my Rumble channel https://rumble.com/c/c-262921 and my blog, https://zalma.com/blog.

Free Insurance Videos

Barry Zalma, Esq., CFE has published five days a week videos on insurance claims, insurance claims law, insurance fraud and insurance coverage matters at

Barry Zalma, Esq., CFE, now limits his practice to service as an insurance consultant specializing in insurance coverage, insurance claims handling, insurance bad faith and insurance fraud almost equally for insurers and policyholders. He also serves as an arbitrator or mediator for insurance related disputes. He practiced law in California for more than 44 years as an insurance coverage and claims handling lawyer and more than 52 years in the insurance business. He is available at http://www.zalma.com and zalma@zalma.com.

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

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

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

Other Insurance Fraud Convictions

"Con Man" Soaring Paws Animal Charity CEO Heads to Prison on Pet Insurance Fraud Charges

Albert Adams, the former CEO of the nonprofit organization Soaring Paws pleaded guilty to fraud. Adams will serve 15 months in prison followed by 10 years of probation for his latest scheme. He will also need to repay the nearly $13,000 he scammed.

In 2018, Hillsborough prosecutors convicted Adams of defrauding donors to his Soaring Paws charity after he used donations that were intended to help fly abused animals to new homes to instead pay for his own personal expenses. The new charges come not from false charity work, but from pet insurance fraud. An investigation found that Adams signed up for a pet insurance policy, which would reimburse him for his pets' medical expenses.

He proceeded to file claims and receive payment for nearly $13,000 worth of medical procedures that were never performed. The pet insurance provider discovered the deception and contacted law enforcement.

The investigation, which identified phony claims for nine nonexistent procedures supposedly performed on two dogs belonging to Adams. Initially, Adams was charged with six felonies, but prosecutors added four additional charges as the investigation continued.

The resulting charges were one count of Organized Fraud Less Than $20,000 and nine counts of False Statement in Support of an Insurance Claim Less Than $20,000. Each charge is a third-degree felony.

Before the truth was revealed, Adams received a total of $12,984.98 in ill-gotten payments from the pet insurance provider, Healthy Paws, between March 4 and April 8, 2020.

Adams was on probation from his Soaring Paws fraud conviction when he committed these new crimes, leading Judge Lyann Goudie to impose this new lengthy prison and probation term on Wednesday. Adams entered his guilty plea one day before his trial was set to begin. Before he heads to state prison, Adams will be taken south to the Lee County Jail, where he has another pending criminal case for attempting to fraudulently sell a woman a nonexistent dog for $575.

Former Insurance Broker Pleads Guilty to Defrauding Insurance Companies and Individual Investors Out of More Than $1-Million

Brian Bartz, 39, of Rochester, NY, pleaded guilty before U.S. District Judge Charles J. Siragusa to wire fraud and aggravated identity theft. The charges carry a mandatory minimum term of 2 years imprisonment and a maximum of 22 years imprisonment.

Between January 2015, and January 2020, the defendant was employed as an insurance broker at several different life insurance companies, selling and servicing policies and receiving commissions and bonuses for selling such policies. In connection with his employment, Bartz submitted approximately 105 fraudulent policy applications in various individuals' names without their knowledge, utilizing actual names, social security numbers, and dates of birth. As a result, life insurance policies were issued, and the defendant was paid a total of $382,740.63 in commissions and bonuses he was not entitled to receive. Bartz also used approximately $70,579.83 that he fraudulently withdrew from various bank accounts of unsuspecting clients in order to pay policy premiums on the fraudulent life insurance policies he obtained.

In addition, Bartz defrauded his insurance clients and potential clients by falsely claiming to also be an investment advisor, persuading individuals to invest funds that he never invested nor intended to invest. Rather than investing such funds on behalf of his clients, Bartz used them for himself, by gambling with them or paying back prior investors. To prevent victims from inquiring about their investments, Bartz issued fake account statements. The victims included a widow who "invested" a $332,500 payout from her deceased husband's life insurance policy with the defendant. Bratz stole all but $10,000 of that widow's investment.

In total, the loss amount for Bartz's schemes is approximately $1,026,668.46.

Arleta Insurance Agent Guilty After Stealing Insurance Payments From 26 Consumers

Angie Sosa, 33, of Arleta, California, a licensed insurance agent, pleaded no contest June 30, 2021 in Los Angeles Superior Court on one count of grand theft for stealing over $8,000 in auto insurance payments from 26 clients.

An investigation by the Department of Insurance revealed that between May 2018 and July 2018, Sosa, a licensed insurance agent doing business as **Sosa Insurance Services** in Panorama City, was stealing cash payments from her clients and keeping funds for her personal use. Sosa occasionally provided clients with a receipt for the payments, but did not deposit the cash into a trust bank account for payment to the insurance company. Sosa stole $8,171 in mostly cash payments from 26 clients.

The Department will be taking appropriate administrative action against Sosa's license and the business she managed.

This case is being prosecuted by the Los Angeles City Attorney's Office. Sosa is currently in Argentina, her attorney appeared on her behalf.

As a part of Sosa's plea, she will be sentenced to 12 months' probation, ordered to pay $8,172 to the insurance company and to serve 10 days of community labor or 100 hours of community service at an internationally recognized organization. She will also be ordered to not work or seek employment in the insurance field. Sosa is scheduled to return to court on January 30, 2022.

New Books for the Insurance Claims Professionals:

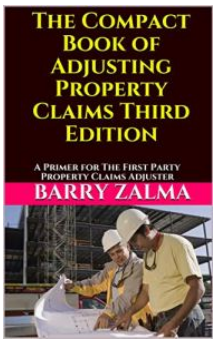
The Compact Book of Adjusting Property Insurance Claims – Third Edition

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

The insurance adjuster is not mentioned in a policy of insurance. The obligation to investigate and prove a claim falls on the insured. Standard first party property insurance policies, based upon the New York Standard Fire Insurance policy, contain conditions that require the insured to, within sixty days of the loss, submit a sworn proof of loss to prove to the insurer the facts and amount of loss.

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

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



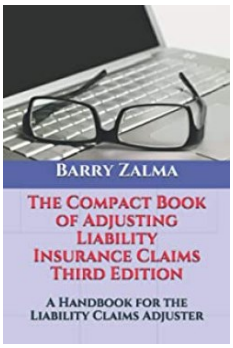
Insureds and insurers were not happy with that system. It made it too difficult for a lay person to successfully present a claim. The system, as written into the standard fire policy seemed to run counter to the covenant of good faith and fair dealing that had been the basis of the insurance contract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

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

Available as a Kindle book. Available as a paperback.

The Compact Book on Adjusting Liability Claims, Third Edition

A Manual for the Liability Claims Adjuster Newly Updated and Edited



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

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

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

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

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

Available as a Kindle book Available as a paperback.

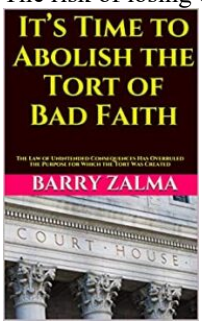
"It's Time to Abolish The Tort of Bad Faith"

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

INSURANCE AS A NECESSITY

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

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



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

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

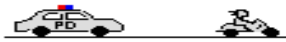
A simple insurance contract between two parties might say: "I insure you against the risk of loss of your engagement ring valued at $15,000 by all risks of direct physical loss except wear and tear for a premium paid by you of $15.00." Anyone who could read would understand that contract. If something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

The tort of bad faith was created because courts felt that insurers treated their insureds badly and defeated the purpose for which insurance is acquired. It has served its purpose. Fair Claims Settlement Practices laws and regulations are now available to control

insurers who do not act in good faith. Insurance fraud statutes and Regulations provide assistance to insurers who have been deceived by those they insure or who are victims of attempted insurance fraud.

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

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



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Consider Books to Show Your Appreciation to Your Insurer Clients or Claims Employees

Many insurers refuse to allow their employees to receive gifts from lawyers, independent adjusters or vendors.

If you wish to thank your insurance company clients for allowing you to represent their interest or if you wish to honor your claims personnel it is time to give them something that will be useful to them throughout the coming year and that will not offend insurer's rules to avoid attempts to extort clients for business from insurer employees.

The Insurance Claims Library

Over the last 51 years Barry Zalma has dedicated his life to insurance, insurance claims and the need to defeat insurance fraud. He has created the following library of books and other materials to make it for insurers and their claims staff to become insurance claims professionals.

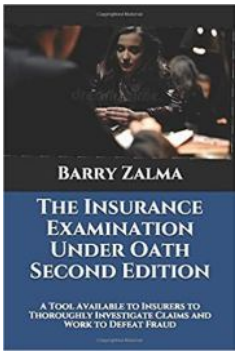
Consider the Insurance Claims Library where, for a small investment you can provide each claims office – rather than individual adjusters – a group of insurance books that will help them throughout the year.

By providing clients, claims departments, or claims personnel with any one or more of the books offered by the Insurance Claims Library. By so doing you can add to the insurance claims professionalism of your clients, employees and claims personnel. With delivery handled by Amazon.com any one or more of the following books, all available from amazon.com and http://zalma.com/blog/insurance-claims-library/, will gain the respect and gratitude from each recipient and their employers.

New and Now Available from the Zalma Insurance Claims Library

The Insurance Examination Under Oath Second Edition

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



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

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

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

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

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Zalma on Insurance Blog Posting

- Rescission of Insurance July 14, 2021
- Arsonist with "Chutzpah" Tries to Get Out of Jail Because of Covid-19 July 14, 2021
- Ethics and the Adjuster July 13, 2021
- Eighth Circuit Court of Appeals Finds No Physical Loss & No Coverage for Covid Shutdown July 13, 2021
- A Video About The Public Adjuster & Fraud July 12, 2021
- Zalma on Insurance Claims – Three New Third Edition Volumes July 12, 2021
- Third Party Insurance Fraud July 9, 2021
- Keeping Public Adjusters Professional July 9, 2021
- Tools Available to Insurers to Fight Fraud July 8, 2021
- Waiver of Punitive Damages Must be Clear, Unmistakeable and Unambiguous July 8, 2021
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- Lessee's Agreement to Self-Insure Lessor Treated Like Insurance July 7, 2021
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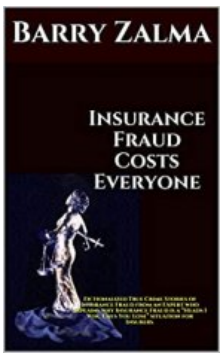
- Failure to Initial a Form Became Purchase of UM/UIM Coverage July 6, 2021
- Professional Conspiracies to Commit Insurance Fraud July 5, 2021
- Policy only Insures Members of Same Household July 5, 2021
- Catastrophe Fraud & Criminal Acts July 2, 2021
- Intentionally Harvesting Timber Without Right Not a Peril Insured Against July 2, 2021
- Zalma's Insurance Fraud Letter – July 1, 2021 June 30, 2021

Insurance Fraud Costs Everyone

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



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

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

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

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

Barry Zalma, Esq., CFE

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

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

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

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