



State of New Jersey

OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF LAW AND PUBLIC SAFETY
OFFICE OF THE INSURANCE FRAUD PROSECUTOR

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VIA HAND DELIVERY

Honorable Philip D. Murphy, Governor
Office of the Governor
State of New Jersey
125 West State Street
Trenton, New Jersey 08625

Dear Governor Murphy:

I am pleased to submit the Annual Report of the Office of the Insurance Fraud Prosecutor (OIFP) for the calendar year 2017, pursuant to N.J.S.A. 17:33A-24. Under the leadership of former Acting Insurance Fraud Prosecutor Christopher Iu, OIFP continued its efforts to combat insurance fraud across the state.

OIFP has two units that are responsible for litigation¹: the Private Insurance Section and the Medicaid Fraud Control Unit (MFCU). The Private Insurance Section investigates and prosecutes crimes against private insurance carriers; any governmental program, such as the State Health Benefits Program and any other insurance related person or entity. MFCU

¹ A third unit, CLASS (the Case Intake, Litigation and Analytical Support Section) screens case referrals, provides analytic support and acts as liaison to the insurance industry and the Department of Banking and Insurance, Bureau of Fraud Deterrence.



investigates and prosecutes defendants who have defrauded the Medicaid Program as well as those who have defrauded or harmed the elderly, when there is a nexus to the Medicaid program. The MFCU is also responsible for False Claims Act cases, which are civil cases against defendants who have defrauded the Medicaid Program.

Collaboration

We in OIFP understand that our efforts to prevent insurance fraud and abuse can be greatly enhanced by collaboration with other entities. For example, the Insurance Section participates in the Division of Criminal Justice Commercial Bribery Task Force (CBTF). The CBTF is comprised of Deputy Attorneys General, detectives and analysts from the Financial & Computer Crimes Bureau and OIFP. The main goal of the CBTF is to thwart the kickback culture that is seen throughout medical offices in the State of New Jersey.¹

MFCU hosts quarterly meetings of the Elder Abuse Working Group (EAWG) to discuss any projects or initiatives each of the member organizations are working on and to share ideas on the prevention, investigation, and prosecution of elder abuse. The EAWG's member organizations include the Office of the Long Term Care Ombudsman, Adult Protective Services, the Division of Consumer Affairs and the Department of Human Services Office of the Public Guardian for the Elderly. Elder abuse cases can be quite complex and might involve a number of different agencies, and procedures and actions such as facility inspections, licensing actions, civil lawsuits, as well as criminal referrals.

¹ Due to their complex and long-term nature, CBTF cases that were initiated in 2017 were not resolved until 2018. They will be captured in the 2018 Annual Report.

An overview of significant cases for each unit follows.

A. SIGNIFICANT CASES – PRIVATE INSURANCE

State v. Hector Marquez, et al.

On March 22, 2017, Hector Marquez, 44, of West New York was sentenced to ten years in state prison for first-degree money laundering and second-degree misconduct by a corporate official; and ordered to repay \$110,370 in restitution. This sentencing brings to a conclusion an extensive investigation into a fraudulent bank financing scam through a company named D.I.B. Leasing of Teterboro, of which Marquez was the general manager. During the course of its operations, D.I.B. Leasing obtained approximately \$1.4 million in fraudulent loans for luxury cars in a scheme involving the use of personal identifying information of otherwise legitimate and unsuspecting customers whose income would not have qualified them for such high-end loans. Using their information, Marquez and others created fake employment records, inflated incomes and supplied phony pay stubs and fictitious employee verifications in order to dupe banks into providing the loans.

One week earlier, on March 17, 2017, Paul Russo, 52, of Scotch Plains was sentenced to six years in State prison and ordered to repay \$150,267 in restitution for his role in the scheme as finance manager of D.I.B. Leasing. Russo had earlier pleaded guilty to second-degree money laundering and second-degree misconduct by a corporate official. Other co-conspirators who had been previously sentenced (in 2016) for their roles in the scheme included Patsy Galasso, 76, of Cliffside Park (owner of D.I.B. Leasing), who was sentenced to five years of probation following a plea of guilty to third-degree money laundering; Jennifer Perez, 31, of Union City (assisted with loan applications), who was admitted into the Pre-Trial Intervention (PTI) program; Michael Ricciardi, 54, of Wayne (bookkeeper for D.I.B. Leasing), who was sentenced

to four years of probation following a plea of guilty to third-degree trafficking in personal identifying information; and Lisa Ghobrial, 49, of Ridgefield (Title Manager for D.I.B. Leasing), who was sentenced to three years of probation following a plea of guilty to third-degree misconduct by a corporate official.

State v. Vikas Mehta

On March 17, 2017, Vikas Mehta, 43, of Cliffside Park, was indicted for first-degree money laundering and multiple counts of second-degree theft for allegedly stealing more than \$1,000,000 from his employer, including the draining of a \$600,000 insurance annuity belonging to the victim. In addition to the money laundering and theft charges, Mehta, a Passaic County hotel manager, was charged with identity theft and forgery in connection with the theft of four checks in the amounts of \$600,000; \$100,000; \$185,000; and \$205,385. All were stolen from his employer at the Fairbridge (formerly Ramada) Inn in Wayne.

While working in the Wayne hotel, Mehta learned that his boss owned a \$600,000 annuity with The Prudential Insurance Company. The investigation revealed that Mehta used his boss's personal information to arrange to have the annuity cashed out by telephone and have the check delivered via Fed Ex to a place where he could intercept it. He allegedly deposited the check into his own account and from there disbursed the proceeds into accounts which were closed a short time later.

During the course of the investigation, OIFP detectives discovered several other large sums of money Mehta appeared to have stolen from his employer including two payments – the first of \$100,000 and the second of \$185,000 – released from an IRA account the victim held with Securities America, Inc. Both withdrawals were effectuated through the use of forged IRA

Distribution Forms, and the wire transfers were made to a corporate account belonging to Mehta. Also allegedly stolen was a \$205,385 check issued by American Security Insurance Company in satisfaction of a claim by the victim for a rental home that was damaged by a fire. The victim's wife endorsed the check and had given it to Mehta, as a trusted employee, to obtain the endorsement of the mortgage company that held the lien on the property. Instead, Mehta allegedly forged the lienholder's endorsement and deposited the check into another of his corporate accounts.

This matter is pending a trial date in Bergen County.

State v. Kayson Allen

On March 24, 2017, Kayson Allen, 33, of Jersey City, was indicted for second-degree insurance fraud, third-degree theft by deception, identity theft, and the trafficking in stolen identities. The charges allege that Allen, a janitorial employee at the Trenton Processing and Distribution Center of the United States Postal Service, accessed personnel records at his place of employment. He then used the personal identifying information from those records to manufacture false identities and purchase policies from several insurance companies¹ under the identities of current and former postal employees. Allen then allegedly submitted false claims under those identities for thefts that never occurred. The purported thefts, of over \$14,000 in value, included jewelry, an iPhone, a gold chain and medallion, watches and cash.

The suspicious activity initially came to light when U.S. Customs and Border Protection Officers stopped Allen while he was re-entering the United States following a day trip to Canada.

¹ The victim insurance companies were American Banking Insurance Company of Florida; Ameriprise Auto & Home Insurance; Jewelers Mutual Insurance Company; and Assurant Specialty Property Renters Insurance.

In his possession at that time were more than 50 documents containing the personal identifying information of other people, including social security numbers, fake drivers' licenses, insurance applications, bills and bank account information.

On October 19, 2017, Allen pleaded guilty to second-degree trafficking in personal identifying information, and was sentenced to three years in prison.

State v. Evan, Frank & Janice Pescatore

On April 25, 2017, Evan Pescatore, 35, of Highlands, and his parents, Frank Pescatore, 70, and Janice Pescatore, 64, both of Asbury Park, were indicted for first-degree conspiracy to commit money laundering, and two counts of second-degree money laundering. Evan was charged individually with first-degree money laundering; and he and his father Frank were also each charged with insurance fraud, theft by deception, conspiracy to commit insurance fraud, and conspiracy to commit theft by deception, all in the second degree.

The indictment alleges that the Pescatores acted together to provide fraudulent, free high value life insurance policies to various applicants in central New Jersey only in order to generate substantial commission for themselves. Through a process known as "rebating," whereby something of value is offered as an inducement to applicants for them to open life insurance policies, the Pescatores opened 18 policies for various individuals through eight different insurance companies for a total face value of \$61.5 million. Rebating is prohibited by state law and by the insurance industry.

In generating the policies, the Pescatores approached various individuals and offered "free" life insurance. In reality, they arranged for a third party financing company to make the initial premium payment. The financing company would receive steep interest on its investment.

The money would be channeled through the insureds' bank accounts on its way to the insurer in order to maintain the illusion that the insureds were themselves paying. The Pescatores, meanwhile, provided false answers on the insurance applications, or directed the applicants to answer falsely to questions regarding source of payment.

Once the policies were placed, a significant commission was paid to the Pescatores (customarily, and per industry practice, such commission takes the form of most or all of the initial premium payment, *plus* a second payment over and above the initial premium payment, calculated differently by each company). From this, the initial loan would be paid, with interest, leaving the excess for the Pescatores as profit on the fraudulent policies. Subsequently, each policy lapsed when the second premium invariably went unpaid. Among the companies targeted by the Pescatores were the following: AXA Equitable Life Insurance Company, Minnesota Life Insurance Company, Lincoln Benefit Life Insurance Company, Allianz Life Insurance Company of North America, Zurich American Life Insurance Company, Genworth Life Insurance Company, Royal Neighbors of America, and Banner Life Insurance Company.

Ultimately, for the 18 fraudulent policies, the Pescatores realized over \$4 million in commission. Once the financiers were repaid with interest, the total profit to the Pescatores was greater than half a million dollars.

The defendants' Motion to Dismiss the Indictment was granted; the State intends to appeal that decision.

On May 2, 2017, Tomas Alicea, 54, of Union Township and David Roscos, 38, of Elizabeth were indicted for second-degree theft by deception, second-degree money laundering, and second-degree misconduct by a corporate official.

The indictment charges that Alicea and Roscos used their shell company, Tracks Unlimited, to bill their employer, Union GMC, approximately \$264,090 for upgrades on about 100 vehicles purchased from the dealership between 2013 and 2015. Using the personal identifying information of the unsuspecting purchasers of those vehicles, it is alleged that the defendants submitted bogus invoices on behalf of Tracks Unlimited for significant upgrades that were never performed, such as the installation of leather seats and televisions. The invoices were paid by Union GMC into a Tracks Unlimited bank account which the defendants then used as if it were a personal account.

On December 1, 2017, Roscos pleaded guilty to third-degree theft by deception and was sentenced to three years of probation and \$12,000 restitution. Alicia pleaded guilty to second-degree theft by deception and on April 2, 2018, he was sentenced to special probation for five years.

B. SIGNIFICANT CASES – MEDICAID FRAUD CONTROL UNIT

State v. Ibilola Ighama-Amegor

On May 31, 2017, Dr. Ibilola Ighama-Amegor was convicted after a three-week trial for the submission of fraudulent claims to the Medicaid Program. Ighama-Amegor, 55, whose practice, Quality Pediatrix, located in Newark, was found guilty by an Essex County jury of 48 counts of third-degree health care claims fraud and one count of third-degree Medicaid fraud. Testimony and documents presented at trial included evidence that Ighama-Amegor submitted

bills for 24 hours or more of work in a single day on 48 separate dates between April 30, 2008 and May 16, 2011. During the State's investigation detectives determined that Ighama-Amegor's practice was open for approximately eight hours per day, three days per week, making the time period and services billed for an impossibility.

Ighama-Amegor was sentenced to a three-year term in state prison.

State v. Steven Beukas (New Jersey Mobile Dental)

On September 15, 2017, defendant Stephen Beukas pled guilty to second-degree misconduct by a corporate official. This plea was a result of an extensive MFCU criminal investigation into his practice, New Jersey Mobile Dental, P.A. (NJ Mobile). NJ Mobile was comprised of dentists that traveled to various nursing homes and assisted living facilities throughout New Jersey in order to provide on-site dental treatment. Beukas, a licensed dentist, owned NJ Mobile.

The investigation revealed that Beukas, through the operation of NJ Mobile, defrauded the New Jersey Medicaid Program in an ongoing common scheme, which involved the following: 1) billing for services that his employee dentists could not have possibly rendered; 2) instructing the dentists to perform procedures on Medicaid patients in a manner that did not constitute a billable dental procedure; 3) systematically billing almost every Medicaid patient at least one unit of Behavior Management regardless of whether the patient required the additional treatment time that would warrant the claim; and 4) systematically billing a trip charge for nearly every Medicaid patient a dentist purported to see in a day, even if they all resided in the same facility.

On December 15, 2017, Defendant Beukas was sentenced to eight years in New Jersey State Prison. He also agreed to perform 450 hours of community service. In addition, he agreed to execute a Consent Order under which he would be permanently debarred from participation in Medicaid or any other state or federally funded health insurance or prescription assistance program. Under the Consent Order, he also agreed to pay restitution and a civil penalty, which totaled \$7,082,724.00.

State v. Labre Hodge

Labre Hodge, a Certified Nursing Assistant (CNA), admitted that she made purchases in excess of \$500 with an American Express credit card issued to an elderly female victim, C.D., who was under her care. Hodge pleaded guilty to an accusation charging her with one count of third-degree theft by deception. On July 28, 2017, in Camden County, pursuant to a global resolution of this matter with another case being prosecuted by the OIFP- Private Insurance Bureau, the defendant was sentenced to 270 days in county jail to be served via electronic monitoring and three years of probation. Hodge's CNA license had previously been revoked.

State v. Angela Liriano

Angela Liriano, a Hudson County certified homemaker-home health aide, admitted to submitting fraudulent time sheets to various home health agencies and obtaining wages for services not rendered in excess of \$10,000. On October 3, 2017, Liriano pleaded guilty to an accusation charging her with one count of third-degree health care claims fraud. Pursuant to her plea agreement, she signed a consent order with the New Jersey Board of Nursing for permanent

revocation of her certificate to practice as a certified homemaker-home health aide in the State of New Jersey. Liriano was sentenced to three years of probation on November 3, 2017.

State v. Elswheetta Perry and State v. Natesha Allen

On June 26, 2017, in Hunterdon County, two Certified Nursing Assistants, defendants Elswheetta Perry and Natesha Allen were each charged with third-degree neglect of elderly or disabled persons and fourth-degree falsifying or tampering with records. Those charges stemmed from an MFCU criminal investigation into an incident involving a fall by a 92 year-old nursing home resident with dementia. The investigation revealed that the resident was under the defendants' care when she fell. Perry and Allen attempted to cover up the incident.

As a result of their misrepresentation, the resident was not physically assessed for injuries or treated for at least an hour despite showing signs of pain and discomfort. Subsequently, medical staff discovered that the resident suffered a fractured hip from the fall. The investigation also revealed that Perry and Allen falsified reports relating to the incident.

Perry and Allen were admitted into the PTI program. As a condition of their admission to PTI, they were both required to permanently forfeit their CNA licenses and to complete 180 hours of community service.

C. MFCU FALSE CLAIMS ACT (FCA) RECOVERIES¹

In calendar year 2017, in partnership with the National Association of Medicaid Fraud Control Units (NAMFCU), the State recouped a total of \$11,480,260.89 for the Medicaid

¹ The False Claims Act allows private individuals – Relators - to bring suit on behalf of the government for the recovery of fraudulent payments. That suit is referred to as a “*qui tam*” proceeding.

Program, which includes payment for both the federal and State portions of Medicaid. For this period, the State recovered a net amount (State portion only after adding interest and deducting the federal portion and Relators' shares) of \$5,325,205.53.

The State participated in 13 NAMFCU FCA settlements. The following three cases yielded the most significant recoveries.

Mylan, Inc.

Mylan, Inc. is a Pennsylvania corporation with its principal offices in Canonsburg, Pennsylvania. Mylan, Inc., through its subsidiaries, manufactures, markets, and sells pharmaceuticals. In 2007, Mylan, Inc. acquired Dey Pharma, L.P. (Dey) which held the exclusive rights to sell EpiPen, and, in 2012, changed Dey's name to Mylan Specialty, L.P. The Mylan settlement resolved allegations asserted in two *qui tam* actions. The Relators alleged that Mylan incorrectly classified EpiPen as a "non-innovator multiple source" drug, rather than a "single source" or "innovator multiple source" drug, for Medicaid Drug Rebate Program purposes and underpaid rebates owed to the Medicaid Program for EpiPen as a result of this misclassification. Mylan's settlement with the United States also resolved allegations that Mylan Specialty overcharged certain entities that participated in the 340B Drug Pricing Program.

The total amount of the settlement was \$465 million, of which \$445.7 million will be paid to the Medicaid Program, with the remaining amount to be paid to the 340B Program participants. New Jersey's total share (State and federal) of the settlement amount was \$14,420,570.48. After payment of the federal share and the Relators' shares, the State's net recovery was \$6,129,845.42.

Templin & Banigan v. Organon USA/ Corsi and Ezzie v. Omnicare, Inc.

The settlement in Templin & Banigan v. Organon USA resolved civil liability against Omnicare stemming from allegations that it submitted or caused the submission of false claims to the Medicaid program for Remeron (an antidepressant medication) by entering into purchase agreements with Organon, and by agreeing to recommend the prescription of Remeron to Medicaid patients in return for monetary payments disguised as rebates or discounts, in violation of the federal and State Anti-Kickback statutes.

Omnicare's total settlement amount across all government programs was \$23,000,000, plus accrued interest. New Jersey received a total (State and federal) of \$943,545.10, with a net recovery of \$461,066.94 (after payment of the federal share).

In Corsi and Ezzie v. Omnicare, Inc., Relators alleged that Omnicare knowingly implemented a prescription verification system that resulted in false claims to Medicare Part D and Medicaid in connection with prescription drug services performed at its hub pharmacy in King of Prussia, Pennsylvania, and at Omnicare's other hub pharmacy locations throughout the United States. Relators alleged that Omnicare's automated label verification system was designed and implemented in such a fashion that it allowed certain generic prescriptions (1) to be filled and dispensed with drugs with a different National Drug Code (NDC) than that identified by the pharmacist and billed to the government; and (2) to be dispensed with patient-specific labels containing incorrect NDCs and manufacturer information.

The total monetary value for the Corsi settlement across all government programs was \$8,000,000.00, plus interest. New Jersey received a total (State and federal) of \$30,147.77, with a net recovery of \$12,870.65 (after payment of the Relators' share and the federal share).

Miller v. CareCore National, LLC

This settlement resolved allegations that from June 1, 2005 through June 13, 2013, CareCore, in an effort to keep up with the volume of pre-authorization requests for diagnostic services and to avoid a contractual monetary penalty per case for untimely reviews, instituted a scheme to auto-approve hundreds of radiology service requests on a daily basis, deeming those diagnostic services as reasonable and medically necessary, even though there had been no evaluation of those cases by the appropriate medical personnel. This practice caused false or fraudulent claims to be submitted to and reimbursed by the State's Medicaid program, including its contracted Managed Care Organizations, for procedures that were not properly authorized as medically reasonable or necessary.

CareCore agreed to pay a total of \$54 million dollars to the federal government and states to resolve this matter. New Jersey's total Medicaid recovery (State and federal) was \$520,825.05. The net State share (after payment of the Relator's share and the federal share) was \$228,370.84.

In addition to the above-referenced matters, independent of NAMFCU, New Jersey's Medicaid Fraud Control Unit worked in conjunction with its federal counterpart and with Relator's counsel to secure a recovery in a State-only FCA case, Negron v. Progressive.

Negron v. Progressive

This settlement resolved claims that from March 19, 2009 through January 26, 2017, Progressive and its related entities in the State of New Jersey improperly permitted automobile insurance policyholders in New Jersey who were either Medicare and Medicaid beneficiaries at the time the policy was issued, or later became Medicare or Medicaid beneficiaries while their

Progressive policy was in force, to elect a “health first” automobile insurance policy in violation of the Medicare Secondary Payer Act and Medicaid regulations.

Under the Medicare Secondary Payer Act and Medicaid regulations, it is impermissible for policies to designate Medicare or Medicaid as the primary payor for automobile accident-related medical claims. Many of these Auto Policyholders in New Jersey and other claimants on their “health first” Progressive insurance policies later incurred medical claims in connection with an automobile accident that were billed to either Medicare or Medicaid. The case was resolved for a total of \$2,008,630.20, including interest. After the federal and Relator’s shares were deducted, the State of New Jersey’s recovery was \$435,872.78.

Goals for 2018

As we enter our 20th Anniversary Year, OIFP is positioned to vigorously pursue its mission. We are adopting an ambitious agenda for 2018. We are focusing on identifying and recruiting the experienced professionals needed to more effectively investigate, prosecute and litigate civil cases involving insurance fraud. As we move forward, we will be taking steps to expand and develop MFCU’s FCA practice as yet another avenue for fraud deterrence and recovery, in part by hiring a Deputy Attorney General whose primary responsibility will be FCA litigation. For all of our attorneys, detectives and investigators, we will increase training about financial fraud, especially money-laundering schemes, and provide training on how technology and social media are used to facilitate insurance fraud and related crimes. And, we will offer training about insurance fraud to other prosecutors and detectives throughout the state.

We are currently working to revamp our Anti-Insurance Fraud awareness campaign by publicizing our reward program, which incentivizes the public to report insurance fraud. We

have begun the process of establishing a truly statewide presence by taking steps to re-open a satellite office in South Jersey. We will also propose changes to legislation in order to broaden protections for elder victims of financial abuse, and to limit inappropriate access to personal information that can be gleaned from automobile accident reports.

I look forward to strengthening our relationship with the private insurance industry, our partners in the fight against insurance fraud. Indeed, since my appointment on March 26, 2018, I have met with representatives from several private insurance companies and I have scheduled future meetings with others. We have recently reinvigorated our relationship with members of the Elder Abuse Working Group by hosting our first World Elder Abuse Awareness Day Program on June 15, 2018. Finally, we will formally celebrate the 20th Anniversary of the Office of the Insurance Fraud Prosecutor at an event in October, which is Insurance Fraud Awareness Month.

Thank you for your attention to this Report.

Sincerely,

/S/ Tracy M. Thompson
Acting Insurance Fraud Prosecutor

Enclosure

C: Honorable Stephen M. Sweeney, President, New Jersey Senate
Honorable Craig J. Coughlin, Speaker, New Jersey Assembly
Honorable Gurbir S. Grewal, Attorney General

