FRAUD

DETECTION AND PROSECUTION

COMBATTING THE "FRAUD TAX"

SCOTT HARSHBARGER
ATTORNEY GENERAL
Commonwealth of Massachusetts

February 9, 1993

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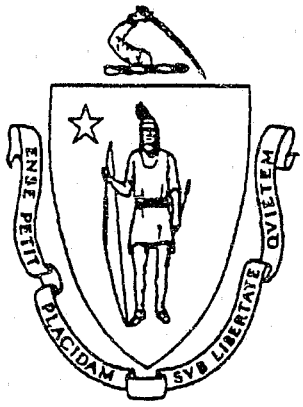

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The Commonwealth of Massachusetts
Office of the Attorney General
One Ashburton Place,
Boston, MA 02108-1698

SCOTT HARSHBARGER
ATTORNEY GENERAL
(617) 727-2200

February 9, 1993

To the Citizens and Taxpayers of Massachusetts:

As citizens of Massachusetts, we are all paying, in addition to our taxes, our high automobile insurance premiums and the billions of dollars spent on health insurance, an expensive "FRAUD TAX." The "FRAUD TAX" is the hidden, extra amount that we pay in insurance premiums, in taxes, for health care and for goods and services that is added to cover the cost of fraud and corruption.

Medicaid fraud, automobile insurance fraud, consumer scams, embezzlements, workers' compensation fraud, unemployment compensation fraud and white collar crime are among the many types of fraud that contribute to the "FRAUD TAX." Having studied these issues for several years, I am absolutely convinced that the amount of fraud in the public sector pales in comparison to what I have seen in the private sector.

Regardless of where or how the fraud occurs, it is costing Massachusetts working men and women hundreds of millions of dollars annually. Fraud is not a victimless crime. It is crippling small businesses, costing us jobs and diminishing the impact of important government programs. It is making Massachusetts an expensive place in which to do business and to live.

In this, the first in a series of reports I will issue regarding fraud, I concentrate on three types of fraud that my office has been fighting:

* MEDICAID FRAUD -- My Medicaid Fraud Control Unit is fighting fraud by investigating and prosecuting providers of health-related services that are cheating the system. In 1992, that Unit set records for the number of cases brought, convictions obtained and money recovered.

* UNEMPLOYMENT COMPENSATION FRAUD -- The Attorney General's Division of Employment and Training prosecutes employers and individuals who try to defraud the unemployment insurance system by failing to pay into the Unemployment Compensation Fund or by collecting unemployment benefits while working.

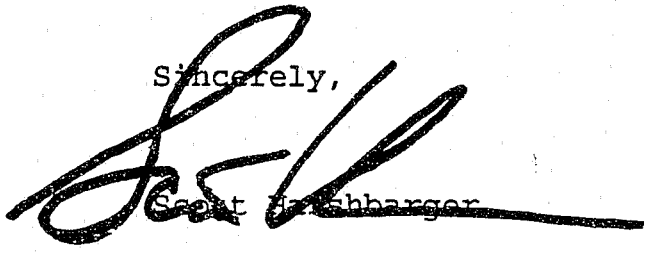
* INSURANCE FRAUD -- Experts estimate that from five to 25 percent of the cost of the workers' compensation system is the result of waste, fraud and abuse. My Insurance Fraud Division, working with members of the insurance industry, is combatting automobile and homeowners' insurance fraud and workers' compensation fraud through reforms in the system and prosecution of those defrauding the system.

The Attorney General's office, working with private businesses, the insurance industry and state agencies such as the Department of Employment and Training, the Department of Public Welfare and the Department of Industrial Accidents, has been making inroads into the problem of fraud. We are establishing a public-private partnership that is effectively fighting the abuse that costs us all.

With the help of the Legislature, which has provided seed money to finance our prosecutorial efforts, and through the help of hundreds of individual citizens, who can no longer afford to subsidize this waste and abuse and who are willing to assist in our investigations, this office is sending the message that fraud will no longer be tolerated. Whether it is occurring in corporate boardrooms, doctors' offices, insurance agencies, or the public sector, or whether it is being committed by laborers, employers, professionals or public officials, the law applies equally to all and offenders commit fraud at their peril.

This is the first of a series of reports on fraud in our state, its many faces, and what steps are being taken to combat it. Future reports will focus on other areas of fraud and will offer recommendations on how best to prevent it. It is my hope that these reports will focus debate and attention on this major problem that affects each and every one of us. I appreciate any comments that you may have and any assistance that you can provide in reducing the "FRAUD TAX" in the Commonwealth.

Sincerely,



Scott Harshbarger

MEDICAID FRAUD

MEDICAID FRAUD CONTROL UNIT

PROFILE

Attorney General Scott Harshbarger's Medicaid Fraud Control Unit (MFCU) surpassed totals of the previous 14 years in virtually every statistical category during calendar year 1992. MFCU prosecutors maintained a balanced enforcement approach to combatting fraud, waste and abuse in the Medicaid system by prosecuting providers of health-related services and, where appropriate, exercised civil enforcement authority. The Unit reported a record number (4) of providers who were sentenced to Massachusetts jails in 1992. In addition to returning $14,394,271.48 to the state's Medicaid Program, MFCU also recorded 79 criminal indictments, 30 individual convictions, four corporate convictions and 17 convictions of other entities.

Pursuant to the provisions of M.G.L. c. 118E, §21A et seq., the Unit negotiated a number of civil settlements and, for the first time, filed consent judgments in Suffolk Superior Court. Total 1992 civil and criminal recoveries amounted to $2.394 million - a 14-year high. The previous highest amount recovered was $2.287 million in 1990. In addition to incarceration and monetary recoveries, the Unit also negotiated a $12 million settlement with the Franciscan Children's Hospital and Rehabilitation Center - the single largest recovery ever in Massachusetts.

MFCU conducted 91 preliminary investigations which resulted in the opening of 26 formal investigations. The Unit received 476 telephone calls/complaints during this 12-month period. Fifty new cases were opened while 63 investigations were terminated and closed.

The Unit received one-third of its referrals from the Department of Public Health - most of which were related to patient abuse and neglect of nursing home residents. Twenty-two percent of the total investigations were generated internally, while 20 percent came from citizen complaints. A comparison of referrals shows that 1992 had the most balanced referral sources of the previous five years, including 1989, when 79 percent of all referrals were generated internally.

Patient abuse prosecutions also increased in 1992. In addition to the convictions reported below, abuse and neglect prosecutions increased significantly from previous years, with most of the 1992 investigative work to result in applications for criminal complaints after January 1, 1993. A total of 14

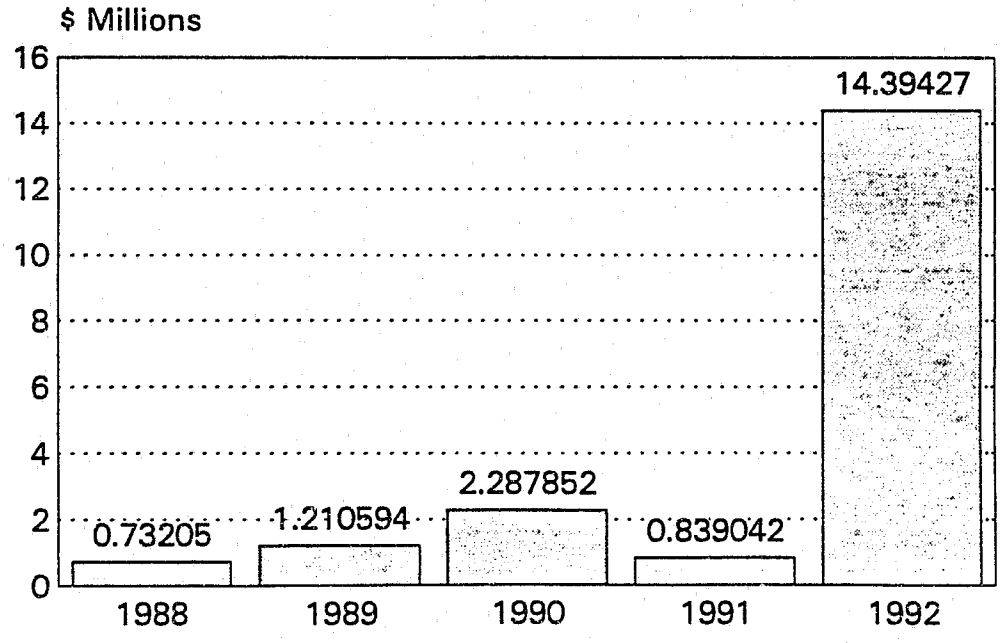
abuse prosecutions were undertaken against various individuals in the state's long-term care nursing facilities. As stated, that number is expected to increase dramatically during calendar year 1993.

What follows is a case-by-case analysis of criminal and civil matters which have been completed. This report also contains a comparative analysis of the Unit's activities with previous years dating back to 1988.

CIVIL AND CRIMINAL MONEY RECOVERED
YEARS 1988 THROUGH 1992

	1988	1989	1990	1991	1992
OVERPAYMENTS RECOVERED	$365,188.00	$369,923.51	$961,771.37	$557,207.72	$11,040,987.02
FINE, PENALTIES, COSTS	$233,408.00	$544,440.66	$243,605.20	$144,309.00	$162,535.20
CIVIL DAMAGES ASSESSED	$25,000.00	$255,000.00	$117,715.00	$67,068.14	$459,750.00
PNA RECOVERIES	$32,176.60	$13,730.00	$201,408.09	$30,457.35	$55,999.26
OTHER RECOVERIES	$76,277.57	$27,500.00	$763,352.09	$40,000.00	$2,675,000.00
TOTALS	$732,050.17	$1,210,594.17	$2,287,851.75	$839,042.21	$14,394,271.48

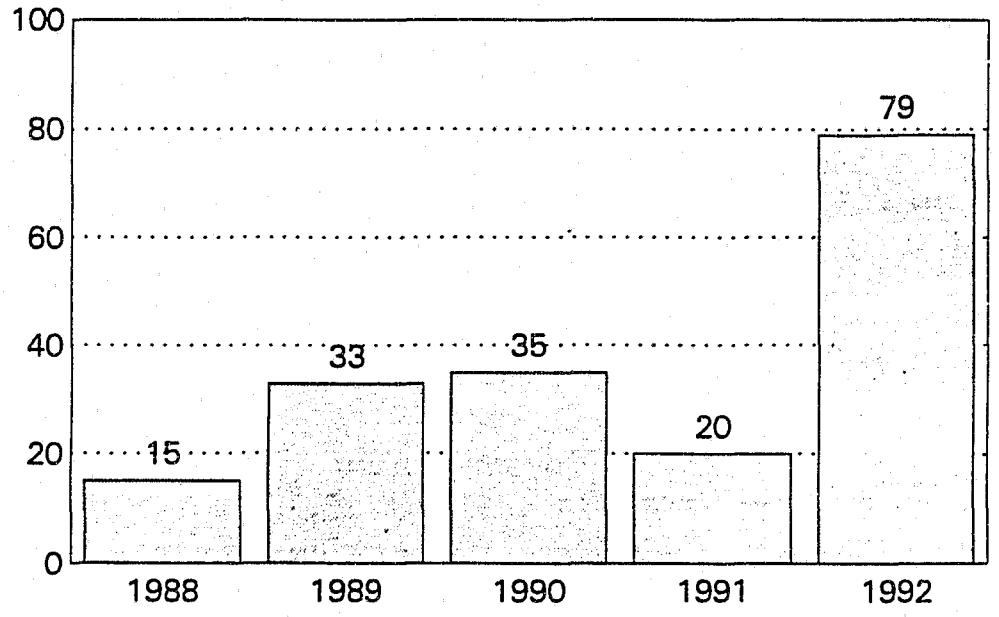
TOTAL DOLLARS RECOVERED
YEARS 1988 THROUGH 1992



TOTAL FOR PERIOD = $19,463,809.78

CRIMINAL INDICTMENTS

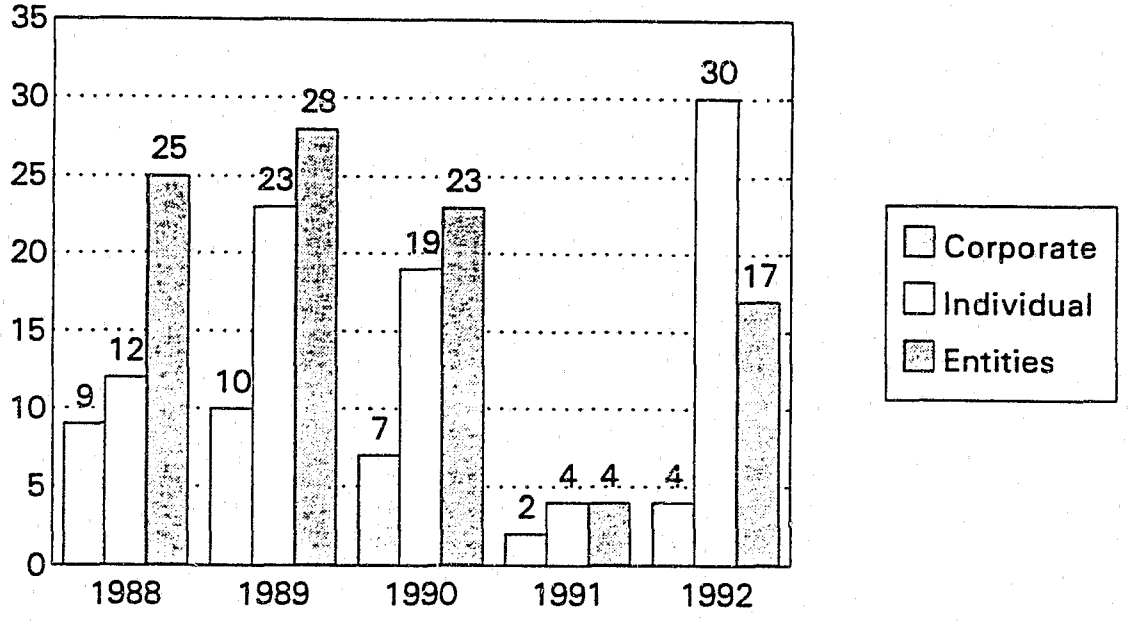
YEARS 1988 THROUGH 1992



TOTAL FOR TIME PERIOD = 182

TOTAL CONVICTIONS

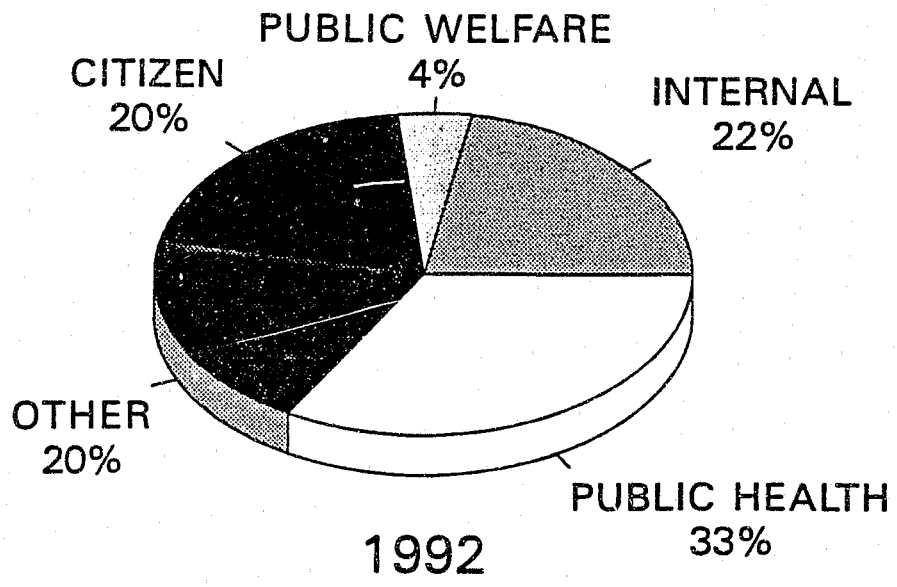
YEARS 1988 THROUGH 1992



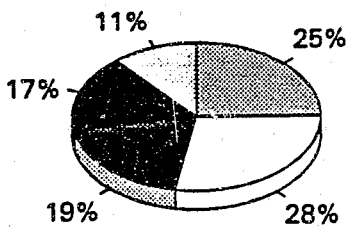
TOTAL FOR TIME PERIOD = 217

SOURCE OF INVESTIGATIONS

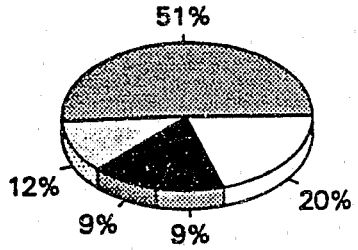
YEARS 1988 THROUGH 1992



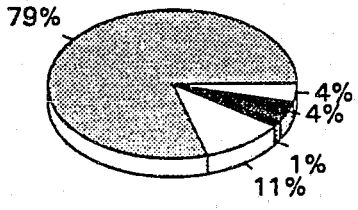
1992



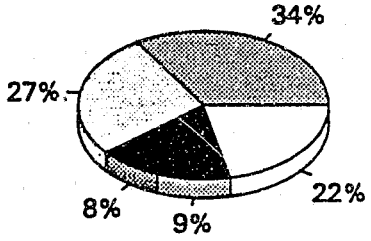
1991



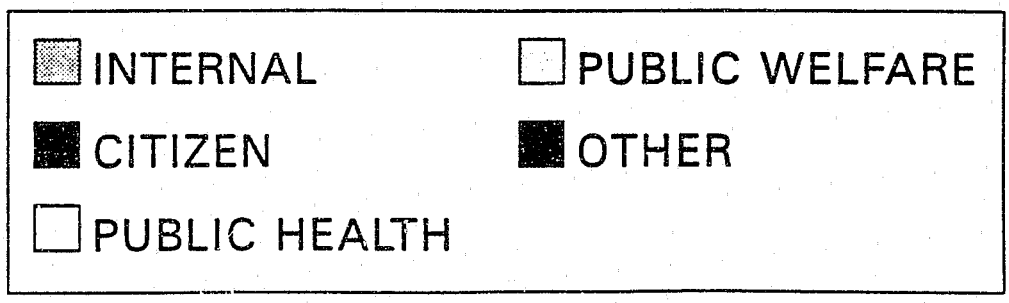
1990



1989



1988



CONVICTIONS

1. ANDOVER PHYSICIAN PLEADS GUILTY

A North Andover physician and his professional corporation, Merrimack Valley Walk-In Clinic, Inc., were indicted on 136 counts each of submitting false Medicaid claims. In November, he pled guilty to charges of Medicaid fraud and larceny from the state's Medicaid program, involving approximately $25,000. He was sentenced to two years in the Middleton House of Correction, one year to serve and the balance suspended for five years. In addition, he relinquished his right to $98,000 in unpaid claims which the Medicaid program had withheld prior to the indictments.

2. WALTHAM PEDIATRICIAN CONVICTED

A Waltham pediatrician was convicted of Medicaid Fraud and was ordered to serve six (6) months in the House of Correction and pay $11,000 in restitution to the state's Medicaid Program. A Suffolk Superior Court Jury found the 61-year old pediatrician guilty of larceny and submitting false Medicaid bills to the Department of Public Welfare from July through October 1988. He was ordered to serve two years probation, and make full restitution upon his release from jail.

3. BROCKTON PHARMACIST PLEADS GUILTY

A Brockton pharmacist pled guilty in Suffolk Superior Court to a single count of larceny over $250 and filing false Medicaid claims.

The owner and operator of the pharmacy was sentenced to a two-year suspended sentence in the House of Correction and ordered to pay $3,750 in fines. He was ordered to pay $2,000 in restitution to the Department of Public Welfare, and was also ordered to pay $1,000 to the Attorney General's Medicaid Fraud Unit for costs of its investigation.

4. TAXI CAB OWNER PLEADS GUILTY

The owner of a Methuen taxi company pled guilty in Suffolk Superior Court to a multi-count indictment for larceny and Medicaid fraud, involving $58,500. He was sentenced to one year in Suffolk County House of Correction. He served 60 days of that sentence and was placed on probation for 18 months. He pled guilty to filing false Medicaid claims which enabled him to embezzle money from the Department of Public Welfare.

The defendant was also ordered to pay $58,500 in restitution. In addition, he was fined $6,250 and ordered to pay $3,750 to the Attorney General's Office for investigation costs.

5. WEST SPRINGFIELD PHARMACIST SENTENCED

A West Springfield pharmacist was sentenced in Suffolk Superior Court to serve 30 days of a six-month term in the House of Correction for filing false Medicaid claims. He was also ordered to pay $18,000 in restitution. His corporation was ordered to pay $6,500 in fines. The guilty plea was the result of the filing of false claims for services which were not rendered.

6. FRANKLIN TAXI CAB OWNERS CONVICTED

The former owners of a Franklin taxi company were convicted on charges of larceny and Medicaid fraud involving $10,000. The defendants overbilled the Department of Public Welfare for more expensive individual trips provided to Medicaid recipients when they were actually sharing rides. One of the owners was sentenced to probation and 1,000 hours of community service.

7. ROXBURY PHARMACIST PLEADS GUILTY

A Roxbury pharmacy owner was indicted on 22 counts of larceny and 23 counts of submitting false Medicaid claims. The charges relate to the defendant allegedly submitting $86,700 in false Medicaid claims.

On July 22, 1992, the owner and operator of the pharmacy pled guilty and admitted to submitting bills for payment to the Department of Public Welfare for prescriptions not actually dispensed. He was sentenced to a three-to-five-year suspended term to Cedar Junction and was also ordered to contribute 100 hours of community service and will serve a two-year probation term.

The defendant also pled guilty to larceny and was fined $12,500 and was ordered to pay restitution in the amount of $87,000 to the Department of Public Welfare.

8. SPRINGFIELD NURSING HOME EMPLOYEE CONVICTED

A former employee of a Springfield nursing home was convicted of patient abuse and assault and battery in Springfield District Court. The victim of the assault was a 75-year-old resident of the facility.

A nurse's aide was sentenced to concurrent six-month suspended jail terms in the House of Correction, and was placed on probation for a period of one year with the special condition that she neither seek nor accept any employment within the health care field during her period of probation.

9. TWO NURSE'S AIDES ADMIT ABUSE

Two former nurse's aides at the Great Barrington Health Care Nursing Home in Great Barrington admitted to facts sufficient to warrant findings of guilty on a number of abuse charges. The two were placed on probation until July 26, 1993, with the condition that they not work at nursing home facilities and that each perform 100 hours of community service.

10. WORCESTER NURSE'S AIDE PLEADS GUILTY

A former nurse's aide at Spring Valley Convalescent Home in Worcester pleaded guilty to a single count of patient abuse and was ordered to pay a $500 fine and serve three years probation. He was also sentenced to 100 hours of community service. He was also ordered to supervised probation and will undergo psychiatric counseling during his probation.

PENDING CRIMINAL PROSECUTIONS

1. SPRINGFIELD HOMECARE AGENCY AND OWNER INDICTED

A Springfield home health care agency and its owner were indicted on charges that they filed false Medicaid claims that bilked the state Department of Public Welfare of $5,250.

The defendants were each charged by a Suffolk County Grand Jury with 13 counts of filing false claims and a single charge of larceny in excess of $250. The charges are pending in Suffolk Superior Court and are expected to be tried in February, 1993.

2. FORMER NURSING HOME OWNER INDICTED

Norfolk and Suffolk County Grand Juries returned multiple indictments charging the former owner and administrator of a Dorchester nursing home with embezzlement, larceny, welfare fraud and unemployment compensation fraud involving more than $30,000. The former owner of the nursing home was indicted on

four counts of larceny, one count of perjury, three counts of making false representation and 15 counts of false statements to obtain unemployment benefits. The indictments are pending in both counties and are expected to be tried in early 1993.

3. FORMER FAIRHAVEN LAWYER INDICTED

A former Fairhaven lawyer and nursing home owner was indicted on larceny, perjury and the filing of false Medicaid claims as part of a scheme which allegedly totaled $75,000.

The defendant was indicted on two counts of larceny, 13 counts of filing false Medicaid claims and 13 counts of perjury. Also indicted were Center Green Rest Home, Inc., of Fairhaven, and Gardners Grove Nursing Home, Inc., of Swansea.

The former lawyer was also indicted on larceny, perjury and filing false claims in his role as Trustee of a realty trust. The 38-count indictment alleges a period of fraudulent activity from May 1987 to June of 1992.

A Bristol County Grand Jury also indicted him on forgery counts related to the Suffolk County indictments.

The defendant voluntarily suspended the practice of law in 1991 in lieu of disbarment proceedings by the state Board of Bar Overseers.

4. EAST BOSTON NURSING HOME AIDE CHARGED WITH ABUSE

A nursing home aide, while employed at an East Boston nursing home, allegedly pushed a resident of that facility. He has been charged with patient abuse and assault and battery as a result of the incident. The resident fell and struck his head. The trial was scheduled for December 21, 1992 in East Boston District Court.

5. PLYMOUTH WOMAN CHARGED WITH PATIENT ABUSE

A nursing home employee has been charged with abuse and neglect while manipulating the leg of an elderly resident and asking in a threatening tone, "Are you going to be good?". The resident's medical condition was such that the defendant's handling of the resident was very painful to her. The defendant was aware of the victim's condition. Trial is scheduled May 26, 1993, in Plymouth District Court.

6. NURSING HOME AIDE CHARGED WITH ABUSE

An aide formerly employed at a Brockton nursing home has been charged with striking a resident twice. Trial is scheduled February 12, 1993, at Brockton District Court.

7. NURSING HOME AIDE IN DEFAULT

A Brighton nursing home aide is in default in Concord District Court. He has been charged with abuse and indecent assault and battery. A warrant was issued for his arrest on November 19, 1992.

CIVIL SETTLEMENTS

1. BOSTON HOSPITAL ENTERS LARGEST SETTLEMENT EVER ($12 MILLION)

In June, Attorney General Scott Harshbarger's Medicaid Fraud Control Unit entered into the largest civil settlement in it's 14-year history when a Boston hospital and rehabilitation center agreed to an unprecedented $12 million dollar civil settlement.

The settlement with the Attorney General required the hospital to make a total of $9.5 million in monetary settlements and restitution to the Commonwealth over a five-years-period, including:

* cash repayments to the Medicaid program;

* reductions in future Medicaid reimbursements to the hospital; and

* relinquishing the right to $3 million in unpaid claims due from the state.

The settlement also contains a Community Care Initiative totalling more than $2.5 million, including:

* $1.5 million in free care to low-income families in need of pediatric medical services;

* a $1 million mobile medical van to provide medical and diagnostic services throughout the community; and

* an interpreter services program at the hospital to serve the increasing needs of the community.

The hospital also agreed to a series of management and board reforms that will allow for greater control and accountability over the fiscal affairs of the hospital.

2. SETTLEMENT REACHED WITH A NEW BEDFORD HOSPITAL ($499,500)

The Medicaid Fraud Control Unit reached a $499,500 civil settlement with a New Bedford hospital stemming from the alleged improper receipt of Medicaid funds. A related health care company entered into the agreement on behalf of the now-defunct hospital.

The investigation focused on the alleged improper receipt of Medicaid monies from 1984 to 1988. Allegations included billing for services performed by other medical entities which were not enrolled in the Medicaid program and, therefore, not entitled to receive fees for services provided to Medicaid recipients.

3. HOLYOKE DENTIST ENTERS CIVIL SETTLEMENT ($300,000)

The owner and operator of dental clinics at two malls in Holyoke and Chicopee agreed to pay a total of $300,000 as a result of an investigation of questionable billing practices. The investigation centered around the dentist allegedly being paid for services that were not reimbursable under the Medicaid program.

4. REVERE PHARMACY SETTLES OVERPAYMENT CASE ($300,000)

A Revere pharmacy entered into a civil agreement with the Attorney General's Medicaid Fraud Control Unit for violations of the Medicaid rules and regulations relating to pharmacy providers. As part of a consent judgment filed in Suffolk Superior Court, the pharmacy agreed to repay the Department of Public Welfare $300,000 in restitution.

5. SPRINGFIELD PHARMACY SETTLES MEDICAID CASE ($250,000)

A $250,000 civil settlement with a Longmeadow pharmacist and Springfield pharmacy for alleged violations of state Medicaid laws and regulations was filed in Suffolk Superior Court. The owner and operator of the pharmacy entered into a civil consent judgment whereby $250,000 was paid to the Department of Public Welfare for payments allegedly received as a result of false statements and misrepresentation to the Commonwealth.

6. BROOKLINE PHYSICIAN SIGNS CONSENT DECREE ($90,000)

A Brookline physician entered into a civil consent decree with the Attorney General whereby $75,000 was paid to the Department of Public Welfare as restitution for overpayments received from the Medicaid program. The doctor also agreed to pay $15,000 to the Attorney General's office for the cost of the investigation.

7. AGREEMENT REACHED WITH BROCKTON DENTIST ($60,000)

The Medicaid Fraud Control Unit reached a $60,000 civil agreement with a Westwood dentist who operates a dental center in the Westgate Mall in Brockton. The Medicaid investigation centered around allegations that the dentist upgraded service codes and received medical payments higher than that to which he was entitled.

8. TAXI COMPANY AGREES TO REPAY OVERPAYMENT ($60,000)

A Cambridge taxi company entered into a settlement agreement with the Attorney General's Medicaid Fraud Control Unit and paid $50,000 in damages and $10,000 for costs of investigation for violations of various rules and regulations of the Department of Public Welfare.

9. REST HOME OWNER PAYS RESTITUTION ($55,000)

The Medicaid Fraud Control Unit entered into a $55,000 civil settlement with the owner and operator of a Jamaica Plain rest home for alleged violations of state laws and regulations in maintaining patients' personal needs bank accounts. The civil agreement required the owner and the rest home to pay $50,000 directly to the residents for alleged mismanagement and misappropriation of the bank accounts. The owner also paid $5,000 to the Attorney General's office for costs of investigation.

10. LAWRENCE DOCTOR SETTLES CLAIMS (50,000)

A Lawrence doctor entered into a settlement agreement with the Attorney General's Medicaid Fraud Control Unit and agreed to repay the Department of Public Welfare $50,000 as a result of computer errors generated by his billing clerk for billing of medium consultations instead of medium office visits. The physician repaid a total of $50,000, including $5,000 for the cost of the Attorney General's investigation.

11. STOUGHTON OBSTETRICIAN MAKES RESTITUTION ($30,000)

The Medicaid Fraud Control Unit and a Stoughton obstetrician entered into a civil settlement involving $30,000 in restitution and investigation costs. The doctor allegedly overcharged the Medicaid program for the delivery of services. The settlement reached with the Attorney General consisted of $6,250 in overpayments received during the period of May 1990 to October 1991, and $19,750 in penalties. In addition, the Attorney General recovered $4,000 for the cost of the investigation.

12. TRANSPORTATION PROVIDER AGREES TO REPAYMENT OF OVERBILLING ($30,000)

A Lowell transportation provider entered into a civil settlement with the Attorney General and agreed to pay the Department of Public Welfare $30,000 in restitution. The transportation company, a wheelchair van provider, was transporting Medicaid recipients who were ambulatory and was billing trips for multiple rides as more expensive individual rides when recipients shared the ride.

13. MEDFORD CLINICS REIMBURSE MEDICAID PROGRAM ($21,000)

Two Medford clinics entered into civil settlements with the Attorney General's Medicaid Fraud Control Unit.

The clinics paid $19,529 in restitution to the Department of Public Welfare. The monies represent overpayments made to the clinics for medical services performed but incorrectly billed by the clinics. The clinics also paid $2,000 to the Office of the Attorney General for cost of investigation.

14. TWO DOCTORS AGREE TO PAY RESTITUTION ($20,000)

Two Allston doctors paid $17,000 to the Department of Public Welfare in restitution based on their billing of routine physical therapy services to Medicaid recipients by an employee who was not a licensed physical or occupational therapist. In addition, the two agreed to pay the Attorney General's office $3,000 for the cost of investigation.

15. CAB OWNER SETTLES BILLING CASE ($17,500)

A Sharon taxi owner entered into a settlement agreement with the Medicaid Fraud Control Unit for improper Medicaid billing practices. In addition to the $15,000 in restitution to the Department of Public Welfare, the owner also paid $2,500 for the cost of the Attorney General's investigation.

16. NORTHAMPTON PHYSICIAN SIGNS CONSENT JUDGMENT ($17,500)

The Medicaid Fraud Control Unit obtained a $17,500 consent judgment with a Northampton physician for alleged violations of state Medicaid laws and regulations. The terms of the agreement require the doctor to pay $10,000 in civil penalties, in addition to the $5,000 payment to the Department of Public Welfare, as well as a payment of $2,500 to the Attorney General's office for the cost of the investigation.

17. QUINCY CONVALESCENT HOME PAYS $16,745

The Medicaid Fraud Control Unit and a Quincy nursing home entered into a civil settlement involving misappropriation of Medicaid funds from patients' accounts into the facility's business operating account. As part of the agreement, the convalescent home returned approximately $6,000 to the patients' accounts. The nursing home was also fined $4,745 for failure to have proper authorization forms on file to manage the patients' funds. In addition, the MFCU recovered $6,000 to cover the cost of its investigation.

18. LAWRENCE DENTIST SETTLES, PAYS $15,000

A Lawrence dentist entered into a settlement agreement with the Attorney General's Medicaid Fraud Control Unit and paid $11,000 to the Department of Public Welfare for billings for an incorrect service code. He also agreed to pay $4,000 for cost of the investigation.

19. ATTLEBORO CAB COMPANY RETURNS $10,000

An Attleboro cab company entered into a settlement agreement with the Attorney General's Medicaid Fraud Control Unit. The discrepancies found totalled roughly $5,000. Under the agreement, the cab company paid $10,000 in restitution to the Department of Public Welfare.

20. HULL PHARMACY ENTERS SETTLEMENT, PAYS $10,000

The Attorney General's Medicaid Fraud Control Unit entered into a settlement agreement with a Hull pharmacy. The pharmacy agreed to pay the Department of Public Welfare $8,500 for errors in billing and $1,500 for cost of the Attorney General's investigation.

21. SPRINGFIELD TRANSPORTATION SERVICE SIGNS AGREEMENT, PAYS $7,500

A transportation service in Springfield, a wheelchair van provider, entered into a civil agreement with the Attorney General's Medicaid Fraud Control Unit and paid the Department of Public Welfare $7,500 in restitution. The provider was found to be transporting recipients who were ambulatory and also billed multiple riders as more expensive individual rides. The service also agreed to voluntarily and permanently withdraw as a provider of transportation services in the Medicaid program.

22. LOWELL VAN COMPANY SETTLES, $6,000 RECOVERED

A Lowell-area wheelchair van provider was found to be transporting recipients who were ambulatory. The company entered into a civil settlement agreement with the Attorney General and paid the Department of Public Welfare $6,000 in restitution.

23. CAPE VAN CHAIR COMPANY PAYS BACK $5,000

A Mattapoisett wheelchair van provider was transporting recipients who were ambulatory and was cited by Attorney General Scott Harshbarger's Medicaid Fraud Control Unit for discrepancies in the mileage billed to Medicaid. The provider entered into a civil settlement and paid the Department of Public Welfare $5,000 in restitution.

24. OPTOMETRIST PAYS $2,000 TO SETTLE CLAIMS

A Brockton optometrist entered into a settlement agreement with the Attorney General's Medicaid Fraud Control Unit. The optometrist agreed to repay the Department of Public Welfare $2,000 in restitution.

OTHER RECOVERIES

1. MEDICAL LAB PAYS BACK $499,000

The Medicaid Fraud Control Unit assisted in a joint Federal-State inquiry into the billing practices of a Randolph medical laboratory company. As a result of the inquiry, the U.S. Department of Justice and U.S. Department of Health and Human Services reached a $499,000 civil settlement with the medical laboratory company. The investigation concerned an alleged kickback scheme with physicians to provide holter monitoring services to Medicare and Medicaid recipients during January, 1985 through December, 1988.

2. MAC (MAXIMUM ALLOWABLE COST) PHARMACY RECOVERY ($1.7 MILLION)

Attorney General Scott Harshbarger's Medicaid Fraud Control Unit identified a Medicaid billing error within the state's Medicaid Pharmacy Program which, upon correction, will result in a $1.7 million recoupment by the Department of Public Welfare's Medicaid Program. Medicaid payments to providers such as pharmacies are based upon a computer billing claims process. Due to a computer billing error, pharmacies across the state were paid a higher amount than allowed during a six-month period. MFCU pharmacy investigators identified the error and reported it to DPW, which began recoupment proceedings.

UNEMPLOYMENT COMPENSATION FRAUD

DIVISION OF EMPLOYMENT AND TRAINING

PROFILE

The Division of Employment and Training in the Criminal Bureau provides the Department of Employment and Training (DET) with legal assistance and representation necessary to enforce the Massachusetts employment law. The Division manages appellate matters arising from decisions granting or denying employment compensation benefits to individual claimants.

The Division prosecutes employers who fail to comply with the law that requires them to pay a quarterly contribution to the Unemployment Compensation Fund and individuals who collect unemployment benefits while gainfully employed and earning wages or who otherwise collected benefits when it was apparent they were ineligible. The Division also represents the Commissioner of DET in cases brought against him and also on his behalf.

Within the unemployment system, fraud takes many shapes, from illegal immigrants to fictitious companies, from multiple false names and social security numbers to persons registering in multiple states, to companies who underpay or don't pay at all into the fund. Checks are collected under persons' names who have been imprisoned or are deceased, persons who have found employment and decide not to report it. Theft of the checks and kickbacks for those within the system who help others process false claims are all part of the problem.

The Attorney General's task, through its DET Unit, is to weed out fraud within the system. At present, the office is staffed with five Assistant Attorneys General and three investigators.

Under Attorney General Harshbarger, this Division has taken a proactive stance. In hopes of deterring others from committing fraud against the system, arrests are commonly made at a persons' place of employment. Also, with the assistance of the DET Fraud Hotline, persons fraudulently collecting unemployment checks are more commonly being arrested at the DET satellite office when they go to pick up the checks.

As of June 30, 1992, the office had a total cases of 1,882 and in the fiscal year had recovered $746,619.66 in restitution, made 173 arrests and indicted seven individuals.

AMNESTY PROGRAM

On September 18, 1991, Attorney General Harshbarger and DET Commissioner Nils L. Nordberg announced an amnesty program for approximately 1,000 employers who have failed to pay their unemployment contributions, and employees who collected unemployment compensation benefits for which they were not eligible. The program was developed to clear a backlog of cases that began to accumulate in the late 1960's, grew dramatically during the 1980's and was not the subject of any attention until Attorney General Harshbarger and Commissioner Nordberg focused on it.

The amnesty program was a 90-day program that is being followed up by an intense effort to arrest and prosecute individuals who have not removed the outstanding default warrants against them.

Based on the outstanding principal, an employer in default who participated in the amnesty program received a minimum of a 50 percent reduction and a maximum of a 90 percent reduction in accrued interest, in addition to a recommendation from the Attorney General's office to the court that the criminal proceedings be suspended. The amnesty program ended December 20, 1991, and is not anticipated to be repeated.

PROGRESS OF AMNESTY PROGRAM

On September 17 and 18, 1991, notices announcing the amnesty program were mailed to 1,000 individuals who were on the default list from as far back as 1967. A joint media announcement was made by Attorney General Harshbarger and Commissioner Nordberg. During the first 45 days of the program, 605 notices were returned. Additional investigative efforts resulted in 270 notices being mailed to a secondary address.

Out of 1,000 outstanding defaults, there was 509 successful contacts:

Employer cases	329	
Employee cases	180	
Amnesty Monies Collected		$156,173.28

(It was asserted that 33 individuals were deceased)

ENFORCEMENT AND FOLLOW UP

1. The Division is working with the 87 individuals who have expressed a willingness to remove their defaults and enter a payment program.

2. The Division will continue to monitor payments made by individuals under the umbrella of the amnesty program.

3. The Division will select 30 to 40 defaults per month that will be the focus of an intense enforcement campaign.

At the beginning of each month, cases are selected and criminal, registry, postal checks, etc., are conducted. An intense enforcement effort is then engaged to locate and apprehend the defaulters.

There are 310 cases that are 10 years or older in which less than $5,000.00 is owed to the Commonwealth. A plan has been approved to dispose of these old cases.

By the end of the program, it is expected that the remaining defaults will be less than 30 percent of the original 1,000.

ACTION TAKEN BY THE DIVISION OF EMPLOYMENT AND TRAINING FRAUD UNIT

1. DELINQUENT UNEMPLOYMENT TRUST FUND CONTRIBUTORS ARRESTED

Six employers or former employers were arrested on default warrants for criminal charges of failing to contribute to the state's Unemployment Trust Fund. The total amount owed by the individuals is nearly $248,000.

2. ATTORNEY GENERAL WARNS OF STOLEN CHECK CASHING SCHEME

The Attorney General warned Boston area retail businesses that cash checks that an undetermined number of unemployment checks stolen from DET were being cashed. Four individuals were arrested attempting to cash the stolen unemployment checks and several others are under investigation in connection with the stolen checks.

3. LAWRENCE WOMAN ARRAIGNED IN THEFT OF DET FUNDS

A complaint was brought against a Lawrence woman in connection with her alleged theft of approximately $4,000 in checks from the state DET office in Lawrence on July 5, 1991. The woman had worked there as a part-time clerk for approximately one year.

4. SIX INDIVIDUALS INDICTED ON 154 COUNTS OF STOLEN DET CHECKS

Six individuals were indicted by a Suffolk County Grand Jury for allegedly cashing checks stolen from DET and cashing them throughout the Commonwealth. The defendants were charged with 154 counts of larceny over $250, uttering and receiving stolen property involving more than $21,500.

5. NEW HAMPSHIRE MAN ARRESTED FOR ALLEGEDLY RECEIVING UNEMPLOYMENT CHECKS ISSUED TO MCI-BRIDGEWATER INMATE

A New Hampshire man was arraigned for allegedly receiving an unemployment check issued in the name of an MCI-Bridgewater inmate. The New Hampshire man was arrested by investigators from Attorney General Harshbarger's office and the Department of Employment and Training. The defendant allegedly signed for and received an unemployment check for $544 issued to an individual who was being held at MCI-Bridgewater.

6. TWO ARRESTED IN LEOMINSTER FOR ALLEGEDLY POSING AS UNEMPLOYMENT RECIPIENTS

Two individuals were arrested as a result of a joint effort by the Attorney General's office and the State Department of Employment and Training to crack down on individuals posing as claimants and fraudulently receiving and cashing unemployment checks.

7. SOUTH BOSTON MAN ARRESTED FOR COLLECTING UNEMPLOYMENT CHECK

A South Boston man was arrested for collecting unemployment checks that were not due him. The man was collecting checks under his brother's name, who has been at MCI- Concord since January 14, 1991. The defendant is alleged to have collected $10,000 in a 12-to-14 month period.

8. FAIRHAVEN MAN ARRESTED AND ARRAIGNED FOR COLLECTING UNEMPLOYMENT CHECKS UNDER FALSE NAME

A Fairhaven man was arrested and charged with larceny over $250 and forgery in connection with his alleged receipt of unemployment checks under the name of his brother. The brother had been incarcerated since December of 1991. The defendant allegedly collected $3,675 in unemployment checks that were not due him over a 15-month period.

9. LYNN MEN ARRESTED FOR UNEMPLOYMENT COMPENSATION FRAUD

Two Lynn men were arrested and arraigned in Lynn District Court on charges that they had each collected over $2,000 in unemployment compensation at the same time they were fully employed. One of the men was also arraigned on cocaine possession charges.

10. BOSTON WOMAN ARRESTED FOR COLLECTING UNEMPLOYMENT CHECKS UNDER FALSE NAME

A Boston woman was charged with larceny over $250 and forgery in connection with her alleged receipt of unemployment checks under an assumed name. The defendant allegedly collected $2,555 in unemployment checks that were not due her over a 36-week period.

11. THIRTEEN ARRAIGNED FOR FAILURE TO CONTRIBUTE TO UNEMPLOYMENT TRUST FUND

Thirteen employers and former employers voluntarily surrendered rather than face arrest on warrants for failure to

appear in court to face the criminal charges of failure to contribute to the state's Unemployment Trust Fund. The total amount allegedly owed by the individuals is nearly $63,000. None of the 13individuals involved took advantage of the amnesty program which ended in late 1991.

12. INCARCERATED MAN CHARGED WITH FRAUD

A South Boston man was arraigned on charges stemming from the alleged unlawful collection of unemployment compensation while he was incarcerated in the Suffolk House of Correction from November 1991 to April 1992. The man is charged with one count of larceny over $250 and one count of unemployment fraud. He allegedly received seven unemployment checks totalling $1,870 to which he was not entitled. These checks were allegedly picked up by an unidentified third party and then endorsed by the defendant.

13. FORMER STATE WORKER GUILTY OF STEALING DET CHECKS

A Quincy man who formerly worked for the state Department of Employment and Training was found guilty on charges stemming from the theft of $7,899 worth of unemployment checks from the Quincy DET office and threatening a witness in the case. The judge sentenced the man to two years in the House of Correction, one year to serve, and restitution in the amount of $7,899. He was sentenced to a concurrent six-month term for making threats. This case was a joint investigation between the Attorney General's office, the Department of Labor and Industries, and DET's Internal Control and Investigation Unit.

INSURANCE FRAUD

INSURANCE FRAUD DIVISION

PROFILE

The Attorney General's Insurance Fraud Division in the Criminal Bureau has been operational for 15 months. Privately funded by the insurance industry through the Insurance Fraud Bureau of Massachusetts (IFB), the division used its initial allocation of $100,000 to hire one assistant attorney general, a paralegal and a secretary, primarily for the prosecution of automobile insurance fraud cases. With the passage of the Workers' Compensation Reform Act in late December, 1991, an additional $100,000 was allocated to hire two assistant attorneys general exclusively for the prosecution of workers' compensation fraud. The Attorney General has committed additional resources, including supervisors, prosecutors and investigators to assist the division in the investigation and prosecution of automobile, homeowners' and workers' compensation insurance fraud, and fraud by claim adjusters, agents and other individuals employed in the insurance industry.

IFB, which also began operating in 1991, is a private non-profit investigative agency underwritten totally by members of the Massachusetts insurance industry. IFB is charged with investigating cases of insurance fraud in the Commonwealth and referring appropriate cases to the Attorney General's office for prosecution. For the first time in Massachusetts, this cooperative partnership brings together public and private resources to address this very serious problem of insurance fraud.

Commenting on the unique role of the IFB, its Executive Director, Daniel J. Johnston, said, "The creation and ongoing funding of the IFB is indeed an unprecedented insurance industry reaction to stepping up the fight against insurance fraud here in Massachusetts. Nowhere else in the United States has the insurance industry stepped in to voluntarily contribute millions of dollars to the battle against insurance fraud and it's clearly paying off, ultimately for the consumer. But it only works well here because of the unique relationship the IFB has with Attorney General Harshbarger's office. Without dedicated prosecution resources like we now have, the effort would go unfulfilled."

The primary source of insurance fraud case referrals to the Attorney General's Insurance Fraud Division is the IFB. The Division also works closely with the Governor's Auto Theft Strike Force and insurance companies, including the Public Employees Retirement Administration which acts as the Commonwealth's workers' compensation insurer, to identify insurance fraud cases. In addition, the Insurance Fraud Division accepts complaints and referrals from other sources, including judges, law enforcement officials and private citizens.

THE WORKERS' COMPENSATION CRISIS

The workers' compensation system in most states, including Massachusetts, is in crisis. Costs have risen dramatically over the past decade and continue to soar. Insurance companies that write workers' compensation policies have experienced eight successive years of unprofitability and many are declining to offer such coverage. For Massachusetts employers, both large and small, ever-increasing premium costs erode profits or cause deficits resulting in downsizing, layoffs, relocation to other states, closure or the failure to offer workers' compensation coverage to employees, even though it is required by law. Employees, many of whom work at jobs where they face the risk of injury, are afraid of losing this benefit and facing financial hardship for themselves and their families, particularly in our current economy.

Many factors are cited as causes of this problem. Researchers estimate that from five to 25 percent of workers' compensation costs are attributed to fraud. Many solutions have been proposed, although none is all-encompassing or guaranteed to be successful. Many experts agree, however, that a crackdown on fraud is an important step in helping to stabilize the system. In Massachusetts, that crackdown will include the prosecution, where appropriate, of individual claimants, employers, insurers, health care providers and attorneys who individually or in "rings" defraud or attempt to defraud the workers' compensation system.

ATTORNEY GENERAL'S TASK FORCE

In October, 1991, Attorney General Harshbarger created the Attorney General's Task Force to Reduce Waste, Fraud and Abuse in the Workers' Compensation System. The Task Force members include executives from the insurance industry and Insurance Fraud Bureau, risk management firms, health care professionals, employers, union leaders, legislators, private investigators, attorneys and representatives from several state agencies.

Attorney General Harshbarger, who chairs the Task Force, requested that members review current statutes and the fraud provisions of the proposed reform legislation; establish protocols for referral to the Attorney General for swift prosecution of any appropriate fraud cases; and offer a series of recommendations to the Department of Industrial Accidents and others to reform or improve the system.

The first two mandates of the Task Force were accomplished with the passage of c. 398 of the Acts of 1991, which included stricter fraud provisions, and by the establishment of formal protocols for referral of suspected fraud cases to the Attorney General. The Task Force's mission is ongoing as members continue to offer recommendations to improve the system for the benefit of all parties.

What follows, in two sections, is a summary of cases which have been completed. The first section includes examples of automobile and other types of insurance fraud cases and prosecutions of individuals employed in the insurance industry. The second section includes examples of workers' compensation fraud prosecutions.

ACTION TAKEN BY THE INSURANCE FRAUD DIVISION

The following are examples of cases handled by the Attorney General's Insurance Fraud Division in cooperation with the Insurance Fraud Bureau:

1. SPRINGFIELD MAN INDICTED ON INSURANCE KICKBACK SCHEME

A former claims adjuster at Liberty Mutual Insurance Company was indicted by a Hampden County Grand Jury on four counts of commercial bribery and three counts of larceny over $250. The agent would allegedly gain increased workers' compensation settlements for claimants, if they paid him in return. If convicted, the agent faces a maximum of five years in prison or a fine of $25,000 for each charge of larceny. He also faces a maximum of five years in state prison and a fine of $10,000 for each charge of commercial bribery.

2. JUDGE ORDERS WORCESTER MAN TO REPAY INSURANCE COMPANY AFTER AUTO INSURANCE FRAUD TRIAL

A District Court judge ordered a Worcester man to repay the insurance company he defrauded by falsely reporting that his van was stolen. The sentence followed the first trial in the state resulting from an investigation by the new Insurance Fraud Bureau of Massachusetts.

3. 100-COUNT INDICTMENT RETURNED AGAINST FORMER INSURANCE AGENT FOR ALLEGEDLY STEALING $110,000 IN FRAUDULENT SURETY BOND SCHEME

A former Marshfield insurance agent was indicted by a Suffolk County Grand Jury for allegedly bilking numerous clients out of more than $110,000 in a fraudulent surety bond scheme. The agent was indicted on 16 counts of larceny over $250, and 42 counts each of forgery and uttering forged surety bonds. If convicted, the former agent faces a maximum sentence of five years on each larceny count and 10 years in state prison on the forgery and uttering counts.

4. GREENFIELD MAN ARRAIGNED ON AUTO INSURANCE FRAUD CHARGES

Attorney General Scott Harshbarger and Northwestern District Attorney Judd Carhart announced the arrest and arraignment of a Greenfield man in connection with the alleged arson of his automobile and the filing of false auto insurance claims.

The Greenfield man pled guilty to all charges and was sentenced to 30 days in the House of Correction, an additional two-year House of Correction sentence, suspended for two years, restitution of $9,753 to the insurance company and probation until March, 1994.

5. OXFORD MAN INDICTED FOR INSURANCE FRAUD AND LARCENY INVOLVING OVER $700,000

An Oxford man was indicted by a Worcester County Grand Jury on charges of insurance fraud and larceny involving more than $700,000. He was charged with 10 counts of larceny over $250 in connection with an alleged scheme that defrauded the Commerce Insurance Company of Webster. The man was associated with the company in his capacity as an insurance agent.

6. NEW HAMPSHIRE MAN INDICTED ON CHARGES OF INSURANCE FRAUD INVOLVED IN STAGED CHOKING ACCIDENTS

A New Hampshire man was indicted by a Suffolk County Grand Jury for allegedly staging a series of choking accidents in restaurants for the purpose of filing fraudulent insurance claims. Attorney General Harshbarger's office brought the charges following a joint investigation with the Insurance Fraud Bureau of Massachusetts. One of the restaurants referred the matter to the Insurance Fraud Bureau through a call to the bureau's hot line.

7. ALLEGED AUTO INSURANCE FRAUD RINGLEADER ARRESTED

The alleged leader of a major auto insurance fraud ring operating out of Cambridge and Somerville was arrested during a morning raid conducted by state police assigned to the Attorney General's Office. The defendant and other individuals are allegedly members of an auto insurance fraud ring which staged motor vehicle accidents for the purpose of collecting on fraudulent insurance claims. The charges include larceny, attempted larceny, insurance fraud and conspiracy.

8. SALEM MAN INDICTED FOR AUTO INSURANCE FRAUD

A Salem man was indicted on three counts of larceny over $250, four counts of insurance fraud and one count of attempted larceny. He allegedly told four insurance companies that his vehicle was involved in an accident in order to collect from each of them for the same damage. The defendant is alleged to have collected over $12,000 in fraudulent claims.

9. FORMER CLAIMS ADJUSTER PLEADS GUILTY CREATING FRAUDULENT CLAIMS: LARCENY

A former claims adjuster for Travelers Insurance Company pled guilty to creating false auto insurance claims and issuing more than $4,200 in payments to himself and to friends. The former Claims adjuster was indicted on six counts of making a fraudulent entry in a corporate record and six counts of larceny over $250. He was sentenced to 2 1/2 to 4 years in state prison, suspended for three years, and ordered to pay $4,242 in restitution.

10. SIX ARRAIGNED IN SOMERVILLE AUTO INSURANCE FRAUD RING CASE

Two men and two women were indicted in connection with an alleged multi-million dollar auto insurance fraud ring in Middlesex Superior Court. Two other defendants were arrested earlier. On June 30, a Middlesex County Grand Jury handed up 37 indictments against nine defendants alleged to have been involved in the ring, which allegedly staged accidents and filed false insurance claims of more than $3 million.

11. INSURANCE APPRAISER PLEADS GUILTY TO INSURANCE FRAUD

A Marlborough man, a former self-employed auto insurance appraiser, pled guilty to charges of insurance fraud and attempted larceny in the connection with the filing of falsified auto theft insurance claims. The guilty plea follows charges against the defendant in Dudley District Court.

12. GREENFIELD COUPLE INDICTED ON AUTO INSURANCE FRAUD CHARGES

Two Greenfield residents were arraigned in Franklin County Superior Court on larceny charges for their alleged involvement in an auto insurance fraud scheme involving more than $3,000. The two were indicted on 13 counts of larceny over $250 for allegedly accepting insurance premium payments from consumers and failing to pay these premiums to the insurance carriers.

13. FORMER SENIOR CLAIMS ADJUSTER INDICTED WITH TEN OTHERS

A former claims adjuster was indicted on 26 counts of making false entries into corporate books and 26 counts of larceny over $250. He allegedly arranged to have checks totalling more than $46,000 issued to fictitious claimants in automobile accident claims in order to obtain the proceeds of those checks for himself. Ten others were indicted for their alleged involvement with the scheme.

14. SIX DEFENDANTS INDICTED FOR FALSE AUTO INSURANCE CLAIMS

One individual was indicted on two counts of larceny over $250, five counts of insurance fraud and three counts of attempted larceny for his alleged involvement in a series of fraudulent automobile property damage claims involving more than $18,000. Five other individuals were indicted for their alleged criminal involvement in the scheme.

15. FOURTEEN MEN INDICTED FOR LARGE-SCALE AUTO AND CONSTRUCTION EQUIPMENT THEFT RING: OVER $1 MILLION IN PROPERTY INVOLVED

A total of 90 indictments were returned against 14 men in connection with the theft of trucks, automobiles and construction equipment and fraudulent insurance claims. The defendants were indicted on charges of larceny of motor vehicles and trailers, receiving stolen property, conspiracy, altering vehicle identification numbers and receiving stolen trailers. Four of the individuals were also indicted on filing of false theft reports and false theft claims against insurance policies. The alleged criminal activity occurred between 1987 and 1992.

16. BROCKTON MAN INDICTED ON INSURANCE FRAUD SCHEME

Three indictments were returned against a Brockton man relating to his alleged submission of fraudulent medical bills and wage information to an insurance company in support of a claim of bodily injuries suffered in a motor vehicle accident. The individual was indicted on one count of attempted larceny, one count of insurance fraud and one count of perjury.

17. TWO PEABODY RESIDENTS ARRAINGNED IN "JUMP-IN" INSURANCE FRAUD

Two Peabody residents were arraigned on criminal charges of larceny, insurance fraud and conspiracy relating to the alleged false filing of automobile insurance claims. The defendants allegedly participated in what is commonly referred to as a "jump-in" case, which is when individuals file automobile accident personal injury claims when, in fact, they were not passengers in the car.

18. HOLYOKE MAN INDICTED FOR AUTO INSURANCE FRAUD

A Holyoke man was indicted by a Hampden County Grand Jury for allegedly filing a fraudulent insurance claim. The defendant allegedly was involved in an auto accident on August 9, 1990. At

that time he did not have insurance on his vehicle. The man purchased auto insurance on August 10. He then allegedly filed an altered Holyoke Police Department accident report indicating that the accident occurred on August 12, 1990. As a result of the alleged false claim the insurance company paid the man and his passengers an amount exceeding $7,500.

19. FORMER INSURANCE AGENT ARRAIGNED ON LARCENY AND FORGERY CHARGES

A former Marshfield insurance agent was arraigned for allegedly bilking numerous clients out of more than $110,000 in a fraudulent surety bond case. The defendant allegedly sold fraudulent surety bonds to minority-owned and women-owned businesses, using three different schemes. Prosecutors allege that he: (1) sold surety bonds written by non-existent companies; (2) sold forged surety bonds of a legitimate company; and (3) required customers to post "collateral" for surety bonds, which was never returned. The amount of money allegedly stolen by the defendant from each victim ranged from $200 to more than $29,000.

WORKERS' COMPENSATION FRAUD CASES

1. A.G. OBTAINS INDICTMENT OF WORKERS' COMPENSATION CLAIMANT FOR PERJURY, ATTEMPTED LARCENY

A Cambridge man was indicted on one charge of attempted larceny and four counts of perjury in the course of filing a workers' compensation claim. The Cambridge man's claim was his seventh one in recent past. In each of these claims he alleged a back injury often within the first month of commencing his employment.

The defendant pled guilty and was sentenced to two years in the Suffolk County House of Correction. The sentence was suspended for three years, and the man placed on probation.

2. LEOMINSTER MAN CHARGED WITH WORKERS' COMPENSATION FRAUD, LARCENY

A Leominster man was indicted on charges of larceny and workers' compensation fraud for allegedly collecting workers' compensation while he was fully able to work, and for collecting unemployment benefits while he was working for several employers. The man is charged with larceny over $250 and filing a fraudulent insurance claim.

The man pled guilty and was sentenced to four-and-one-half months in the House of Correction, which had been previously served, and was remanded to the custody of immigration officials for deportation to Uruguay.

3. FORMER MDC WORKER INDICTED IN $10,000 WORKERS' COMPENSATION THEFT

A former Metropolitan District Commission employee was indicted for the alleged stealing of more than $10,000 in workers' compensation monies. The man was alleged to have continued cashing workers' compensation checks after having returned to full employment.

He pled guilty to one count of larceny over $250, and was sentenced to two years in the House of Correction, suspended for three years, and probation. In addition, he was ordered to make restitution to the Commonwealth in the amount of $12,206.

4. SPRINGFIELD MAN INDICTED ON INSURANCE KICKBACK SCHEME

A former claims adjuster at Liberty Mutual Insurance company was indicted on four counts of commercial bribery and three

counts of larceny over $250. He allegedly accepted kickbacks on six different occasions and received approximately $3,800 by gaining increased workers' compensation settlements for claimants.

He pled guilty in March, 1992, and was sentenced to two years probation. He was also ordered to make full restitution.

5. FORMER STATE HOUSE COURT OFFICER INDICTED ON LARCENY CHARGES

A former State House court officer was indicted on four counts of larceny in connection with an alleged no-show job scheme. An officer at the Massachusetts State House from 1977 to 1989, he claimed he was injured tripping over a television cable in the State House. He received workers' compensation for a nine-month period after the alleged incident and failed to return to work.

From 1985 to 1989, he received his full State House salary, amounting to over $120,000. While receiving workers' compensation for the State House accident, he was president of his own construction company. In 1989, he filed a claim for accidental disability retirement relating to his State House position. The claim was rejected.

For each of the five counts of larceny, he faces a maximum sentence of five years in the House of Correction and a maximum fine of $25,000.

6. CAMBRIDGE MAN INDICTED FOR PERJURY IN CONNECTION WITH WORKERS' COMPENSATION CASE

A Cambridge man was indicted on a perjury charge after he filed a workers' compensation claim alleging that he suffered an industrial accident at a worksite in Waltham and then testified under oath the he had not appeared before the Department of Industrial Accidents under any other name or for any other claim. The Chief Administrative Judge of the Department of Industrial Accidents recognized that the individual had in fact appeared before the Board previously under another name and was collecting benefits under both names. The Judge referred the case to the Insurance Fraud Bureau.

7. STATE EMPLOYEE INDICTED IN $66,000 WORKERS' COMPENSATION FRAUD

A state employee for the Department of Mental Retardation was indicted for allegedly filing false insurance and workers' compensation claims. He claimed to have been injured on October 1, 1989, while working at the Fernald School in Belmont. He made an insurance claim with the state's insurer for the alleged injuries sustained, and then made a second allegedly fraudulent claim for compensation from his second job at Human Services Personnel in Jamaica Plain and their insurer, with which he entered in to a lump sum agreement in September, 1990. The defendant allegedly collected a total of $66,240 on both claims.

WHERE TO REPORT FRAUD

James Bryant	Insurance Fraud Division	617-727-2200x2866
Brian Burke	Dept. Employment & Training	617-727-6824
Michael Kogut	Medicaid Fraud Control Unit	617-727-2200x3814
Carmen Russo	Civil Investigation Division	617-727-2200x2930
Insurance Fraud Bureau Hot Line		1-800-32FRAUD
Department of Employment & Training Hot Line		1-800-354-9927