INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

GRANT AWARD AGREEMENT

Fiscal Year 2017-18

Workers' Compensation Insurance Fraud Program

The Insurance Commissioner of the State of California hereby makes an award of funds to **Fresno County,** Office of the District Attorney, in the amount and for the purpose and duration set forth in this grant award.

This grant award consists of this agreement and the application for the grant and made a part hereof. By acceptance of the grant award, the grant award recipient agrees to administer the grant program in accordance with all applicable statutes, regulations, and Request-for-Application (RFA).

Duration of Grant: The grant award is for the program period **July 1, 2017** through **June 30, 2018.**

Purpose of Grant: This grant award is made pursuant to the provisions of California Insurance Code Section 1872.83 and shall be used solely for the purposes of enhanced investigation and prosecution of workers' compensation insurance fraud cases.

Amount of Grant: The grant award agreed to herein is in the amount of **$1,135,400.** This amount has been determined by the Insurance Commissioner with the advice and consent of the Fraud Assessment Commission based on the estimated funds collected pursuant to Section 62.6 of the Labor Code. However, the actual total award amount for the county is contingent on the collection of assessments and the authorization for expenditure pursuant to Government Code Section 13000 et seq. The grant award shall be distributed pursuant to Section 1872.83 of the Insurance Code and the California Code of Regulations Subchapter 9, Article 3, Sections 2698.53, 2698.54, and 2698.57.

Official Authorized to Sign for Applicant/Grant Recipient _____ Name: **Lisa A. Smittcamp** Title: District Attorney Address: 2220 Tulare Street, Suite 1000 Fresno, CA 93721 Date: _____	**DAVE JONES** Insurance Commissioner _____ Name: **George Mueller** Title: Deputy Commissioner Date: _____

I hereby certify upon my own personal knowledge that budgeted funds are available for the period and purposes of this expenditure.

_____ _____

Crista Hill, Budget Officer, CDI Date

CALIFORNIA DEPARTMENT OF INSURANCE
FRAUD DIVISION

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM

APPLICATION
FISCAL YEAR 2017-2018

APPLICATION TABLE OF CONTENTS

Each Application must include a Table of Contents

TABLE OF CONTENTS
FISCAL YEAR 2017-2018

GRANT APPLICATION CHECKLIST and SEQUENCE
FISCAL YEAR 2017-2018

THE APPLICATION MUST INCLUDE THE FOLLOWING:

	YES	NO
1. **GRANT APPLICATION TRANSMITTAL (FORM 02)** completed and signed by the district attorney?	☒	☐
2. **PROGRAM CONTACT FORM (FORM 03)** completed?	☒	☐
3. Original or certified copy of the **BOARD RESOLUTION (FORM 04)** included? If NOT, the cover letter must indicate the submission date.	☐	☒
4. **TABLE OF CONTENTS**	☒	☐
5. The County Plan includes:		
a) **COUNTY PLAN QUALIFICATIONS (FORM 05)**	☒	☐
b) **STAFF QUALIFICATIONS (FORM 06(A))**	☒	☐
c) **ORGANIZATIONAL CHART (FORM 06(B))**	☒	☐
d) **PROGRAM REPORT (DAR OR FORM 07)**	☒	☐
e) **COUNTY PLAN PROBLEM STATEMENT (FORM 08)**	☒	☐
f) **COUNTY PLAN PROGRAM STRATEGY (FORM 09)**	☒	☐
6. Projected **BUDGET (FORMS 10-12)** included?	☒	☐
a) **LINE-ITEM TOTALS VERIFIED**?	☒	☐
b) **PROGRAM BUDGET TOTAL (FORM 12)** matches the amount requested on FORM 02?	☒	☐
7. **EQUIPMENT LOG (FORM 13)** completed and signed?	☒	☐
8. **JOINT PLAN (Attachment A)** completed and signed?	☒	☐
9. **CONFIDENTIAL CASE DESCRIPTIONS (Attachment B)** Is all content readable? A partial narrative is not acceptable.	☒	☐
10. **ELECTRONIC VERSION** (CD/DVD) included?	☒	☐

FORM 02

GRANT APPLICATION TRANSMITTAL

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM

Grant Period: July 1, 2017 to June 30, 2018

Office of the District Attorney, County of Fresno,
hereby makes application for funds under the Workers' Compensation Insurance Fraud Program pursuant to Section 1872.83 of the California Insurance Code.

Contact: Manuel C. Jimenez, Jr Sr.Deputy District Attorney

Address: 2220 Tulare Street, Suite 1000

Fresno, CA 93721

Telephone: (559) 600-2135

(1) New Funds Being Requested: $ 1,274,411

(2) Estimated Carryover Funds: $ 0

Jeff Dupras,
Assistant District Attorney
(3) *Program Director*

Stephen Rusconi,
District Attorney Business Manager
(4) *Financial Officer*

Lisa Smittcamp
(5) *District Attorney's Signature*

Name: Lisa A. Smittcamp

Title: District Attorney

County: Fresno

Address: 2220 Tulare Street, Suite 1000

Fresno, CA 93721

Telephone: (600) 600-3141

Date: 4/17/17

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGRAM CONTACT FORM
FISCAL YEAR 2017-2018

1. Provide contact information for the person with day-to-day operational responsibility for the program, who can be contacted for questions regarding the program.

   a. Name: Manuel C. Jimenez, Jr

   b. Title: Sr Deputy District Attorney

   c. Address: 2220 Tulare Street, Suite 1000

   d. Fresno, CA 93721

   e. E-mail address: mcjimenez@co.fresno.ca.us

   f. Telephone Number: (559) 600-2135 Fax Number: (559) 600-2144

2. Provide contact information for the District Attorney's Financial Officer.

   a. Name: Stephen Rusconi

   b. Title: District Attorney Business Manager

   c. Address: 2220 Tulare Street, Suite 1000

   d. Fresno, CA 93721

   e. E-mail address: SRusconi@co.fresno.ca.us

   f. Telephone Number: (559) 600-4447 Fax Number: (559) 600-4441

3. Provide contact information for questions regarding data collection/reporting.

   a. Name: Louis Ulrich

   b. Title: Program Technician

   c. Address: 2220 Tulare Street

   d. Fresno, CA 93721

   e. E-mail address: LUlrich@co.fresno.ca.us

   f. Telephone Number: (559) 600-6710 Fax Number: (559) 600-2144

BOARD OF SUPERVISORS RESOLUTION
FISCAL YEAR 2017-2018

Please be advised that a Resolution from the Board of Supervisors authorizing Fresno County to enter into a Grant Award Agreement with the California Department of Insurance will be forwarded no later than December 1, 2017.

COUNTY PLAN: QUALIFICATIONS
FISCAL YEAR 2017-2018

QUESTIONS

Answer the following questions to describe your experience in investigating and prosecuting workers' compensation insurance fraud cases during the last two (2) fiscal years, as specified in the California Code of Regulations, Title 10, Section 2698.55.

- The outcomes reported in Form 5 shall represent activities funded by this grant program.
- If a case is being reported in more than one insurance fraud grant program, clearly identify the component(s) that apply to this program.

1. What areas of your workers' compensation insurance fraud operation were successful and why?
   - Detail your program's successes for the 2015-2016 and 2016-2017 fiscal years ONLY. Include information you believe made your program successful.
   - It is not necessary to list every case that was worked during this time. A description of your significant cases for this period will suffice.

Since its inception in 1992, the Fresno County Workers' Compensation Fraud Unit (hereafter referred to as Fraud Unit) has developed expertise in the investigation and prosecution of fraud cases. The Fraud Unit has a proven record in the investigation and prosecution of workers' compensation fraud.

Fiscal Year 2015-2016

The Fraud Unit filed three claimant cases, two premium fraud cases, and twenty uninsured employer cases (two of which were felony cases for fraudulently using another person's business license).

New Cases

Claimant Fraud

One filed claimant fraud case involved a defendant who allegedly slipped and fell on a wet lunchroom floor hitting her head and shoulder on a bench and striking the floor, resulting in injuries to her shoulders, neck and back. She claimed that she could not walk without a cane and could not care for her grandchildren due to pain in her back, neck, and upper extremities.

Sub rosa video showed the defendant walking in her front yard taking out the trash without a cane or walker. Additional video showed defendant walking in her front yard unassisted and several adults picking up children at her residence. Subsequent to the surveillance, the defendant denied at a deposition walking without a cane and stated that she could not care for her grandchildren due to her pain. Interviews of neighbors revealed that the defendant was babysitting for several children while receiving total temporary disability payments.

Another case was filed against a dairy milker, who alleged an injury to his thoracic and lumbar spine that occurred during a slip and fall incident while chasing a cow. After receiving continued medical treatment, the defendant was released to return to modified duties. Although numerous attempts were made by the employer to contact the defendant and advise him that modified work was available, the defendant did not respond. The defendant retained counsel, changed medical providers and continued to receive medical treatment with little to no improvement and claimed a 10/10 pain level. At a QME exam the defendant claimed moderate to severe pain level, use of a cane, and a lifting maximum of five pounds. Video surveillance captured the defendant lifting and carrying his young child. Additional surveillance caught the defendant playing soccer, moving his upper and lower extremities without any apparent physical limitation or restriction. After reviewing the surveillance, the QME stated that all future medical care should be carried out on a non-industrial basis.

The third filed claimant case arose from a specific injury workers' compensation claim and a cumulative trauma claim. The defendant claimed he suffered an injury when he was hit on the right shoulder by an adult cow while working at a dairy. The employer saw the defendant working without any apparent physical restrictions. The primary treating physician reported discrepancies in objective findings. Video surveillance was conducted and shown to the QME who changed his whole person impairment rating based upon review of the surveillance.

The Fraud Unit initiated a claimant fraud investigation into a claim involving a worker who sustained an injury to his left leg, foot, hip and testicles. The claimant filed the initial claim under a false name. Investigation revealed the claimant's true name. He misrepresented his physical capacity to his QME and also filed several different injury claims using false names to avoid suspicion about the amount of claims he has submitted.

Another claimant fraud investigation involved a claimant alleging injury while driving her private vehicle on company property. Her vehicle was struck by another vehicle. She alleged injuries to her neck, right upper extremity and chest. In 2014 she alleged so much pain that her AME could not finish the exam. Sub rosa video captured claimant using her right upper extremity by reaching, grasping overhead, pushing, pulling and gripping with no pain or discomfort.

The Fraud Unit started a claimant fraud investigation with elements of medical provider fraud. The claimant, a former employee of the insured labor contractor, filed a post-termination workers' compensation claim. According to his crew boss, the claimant never reported any work injury prior to leaving the employment of the insured. The claimant testified during his deposition that he was too injured to work and he has never helped his wife with her landscaping business in the Bay Area.

However, a few months before the deposition, he was captured on surveillance video performing landscaping work, e.g. mowing lawns, leaf blowing, dispensing hand-held fertilizer and raking leaves, at six residential locations in Santa Clara County. With respect to the medical fraud angle on this investigation, the claimant was steered towards a treating physician outside of the Member Provider Network and received legal representation from a Southern California attorney. The treating physician prescribed a plethora of medical treatment, pharmaceuticals and diagnostics including magnetic resonance imaging, extracorporeal shockwave therapy, voltage-actuated sensory nerve conduction threshold tests, topical creams for pain meds, and prescriptions for durable medical equipment. The insurance company was then barraged with liens associated with this claim.

Another claimant fraud investigation was initiated regarding a claim that an employee injured his right knee when he stepped on a rock using a jackhammer. Claimant denied prior injuries to his knee in his AME exam. Medical records revealed that the claimant injured his knee playing soccer twice within the two years prior to the alleged work injury.

In one claimant case involving a City of Fresno employee, the Fraud Unit obtained a conviction and collected $4,404.00 in restitution for the City of Fresno. In a claimant fraud case filed in FY 2014-2105 involving an auto repair mechanic, the defendant was convicted of a felony and stipulated to restitution in the amount of $70,073.56.

The Fraud Unit continued working a claimant fraud investigation in which the claimant is using two identities while working for two companies. She filed two different workers' compensation claims, one with each company. The focus of the investigation will be proving that the person using each name is the same person, and that this person was working without reporting income while receiving temporary disability payments.

Premium Fraud

The Central Valley Premium Fraud Consortium (hereinafter referred to as Consortium) served eleven search warrants, made two arrests, and obtained three convictions during Fiscal Year 2015-2016. The restitution ordered on these convictions was $1,591,462.00.

With the assistance of the Consortium, the Fraud Unit investigated and filed a premium fraud case against an owner of a carpet cleaning company for underreporting payroll. The company historically reported zero employees. A customer service representative provided a tip to the Special Investigative Unit for the insurance company that the company was requesting a certificate of insurance for a job. A review of the company's file showed zero employees but a history of requesting a large number of certificates.

Further investigation uncovered a company website advertising that the company has emergency crews that are available 24 hours a day, 7 days a week. The website had a link to a video showing the owner speaking about trucks and crews that were available in several towns. Additionally, an employee was injured and reported working as an employee two years prior to the company reporting the employee to the insurance company.

A second premium fraud case was filed against owners of a labor contracting company for underreporting payroll. The owners underreported payroll in the amount of $4,889,772.00 over two fiscal years. The amount of premium owed is approximately $346,000.00.

This premium fraud was discovered by comparing payroll audits to payroll reported to the EDD.

The Fraud Unit, with assistance from the Consortium, started a complex premium fraud investigation. The three owners of a trucking company reported different payroll amounts to EDD and to their workers' compensation insurance company. The owners are claiming their drivers are independent contractors. An audit was started in which the business turned over a limited amount of bank statements. During the review of the statements, auditors discovered about 5 million dollars in deposits with about 4 million dollars being transferred to another bank. A search warrant of the owner's bank was submitted to a forensic auditor to determine if money from the numerous bank accounts was being laundered to conceal the existence of another business and to avoid paying workers' compensation insurance premiums.

The Fraud Unit coordinated an investigation with the California Department of Insurance on an investigation of employer fraud in which the employer forced the employee to use his private health insurance to cover the work-related injury.

The Fraud Unit obtained a premium fraud conviction and collected $50,000.00 in restitution which was paid directly to the victim insurance company. In another premium fraud case, $545,000.00 was collected in restitution.

Unisured Employer

The Fraud Unit worked closely with the Contractors State Licensing Board and the Department of Industrial Relations in addressing the uninsured employer problem in Fresno County. The Fraud Unit filed twenty uninsured employer cases FY 2015-2016. Two of these cases were felony cases in which the defendants were using another person's business license without their permission.

Medical Provider Fraud

The Fraud Unit initiated three provider fraud investigations. The first investigation started with a referral from an insurance company regarding red flags on the medical billing forms. The Fraud Unit worked closely with the assigned federal investigator to coordinate and streamline the investigation.

The second provider fraud investigation involved a provider suspected of fraudulent billing for services not rendered. Data analytics showed a pattern of billing a specific CPT (Current Procedural Terminology) code section that raised red flags.

The third provider fraud investigation was a Durable Medical Equipment provider fraud investigation. Bill review ran data analytics, and random patients were interviewed to confirm services rendered.

The Fraud Unit continued the investigation started in FY 2013-14 in which a local business owner received billings from medical providers in Southern California for "employees" that did not in fact work for him. The Fraud Unit coordinated with the FBI on this investigation. A number of workers were interviewed. It was discovered that they were not getting better

and in fact were being treated for injuries that never occurred. The following commonalities were discovered:

1) They either found or were given business cards that promised immediate payment, legal services and the enticement of future larger settlements.

2) Upon calling the toll free number listed on the business card an attorney representative ("capper") was immediately dispatched to the calling party to sign them up with legal representation in Southern California. Through their attorney, the claimant would be directed to a specific medical clinic either in Bakersfield, Visalia or Fresno to begin treatment.

3) The treatment was clearly geared toward generating billing. In all cases the people were provided durable medical equipment, topical creams, Dual Electrical Stimulator (TENS-EMS) and accompanying electrodes, batteries and lead wires.

The investigation identified a Southern California based organization responsible for creating hundreds of millions of dollars of medical bills. Federal investigators were brought into the investigation to assist in conducting the financial/money laundering aspect and ultimately the decision was made to prosecute using federal health care statutes. The case was ultimately turned over to the Office of the United States Attorney for the preparation of grand jury indictments.

The Fraud Unit continued to investigate a growing provider fraud scheme referred by the Department of Industrial Relations. A local Fresno business contracted with numerous Qualified Medical Examiners throughout the State of California purportedly to handle the non-medical business functions of the QME practice. A 50/50 split or a special 60/40 split was advertised by the business. This business handled scheduling, transcription, billing and collections, and provided the office location for the exams. A review of the medical reports being generated by the business revealed patterns of overbilling. One of the patterns was misrepresenting the complexity factors that allow for the QME to bill the report at a higher monetary rate. These misrepresentations included billing for the evaluation of prior injuries that did not exist; unreasonable inflation of hours of record review time and/or medical research time; and the reporting of symptoms without positive subjective or objective findings.

Convictions/Restitution

Six claimants were convicted by the Fraud Unit during FY 2015-2016. One defendant was convicted in a premium fraud case. Restitution in the amount of $50,000 was paid to the insurance company in this case. The Fraud Unit obtained seven convictions in uninsured employer cases. $667,309.00 was collected in restitution during FY 2015-2016.

Ongoing Open Cases with No Activity

The Fraud Unit conducted a warrant sweep after a review of all open filed cases. A special arrest detail yielded eleven arrests of defendants who had previously failed to appear in court or who had outstanding arrest warrants. Due diligence reports were completed on all warrants to aid future warrant sweeps.

Fiscal Year 2016-2017

The Fraud Unit filed nine claimant cases, two premium fraud cases, and twenty-three uninsured employer cases (two of which are felony cases for fraudulently using another person's business license).

New Cases

Claimant Fraud

The Fraud Unit filed a claimant fraud case involving a worker who sustained an on the job injury for a farming company. The applicant suffered an injury to his lower back, left leg, and left testicle. It is alleged that he misrepresented the extent and severity of his injury during a QME appointment. The applicant is seen on sub rosa video walking with no cane, bending, stooping, walking, running, twisting and bending his neck all at about the same time he was presenting himself at medical appointments showing exaggerated injuries. This case started as an investigation in FY 2015-2016.

In another filed claimant fraud case, a milker was injured when one cow pushed him against a pole when he was walking between a group of cows. His complaints were pain in his rib area that limited deep breathing, raising of his arms, reaching with his arms, and sleeping on his right side. At his PQME examination the applicant claimed that he could not walk more than one quarter of a mile and that he could not stand for more than ten minutes. Sub rosa video after the PQME appointment showed the defendant jogging across a four lane roadway while quickly turning his head and neck checking traffic. The video also depicted the defendant pushing and pulling a wheeled laundry basket to a nearby laundromat where he proceeded to wash and fold laundry while standing for an extended period of time. At no time on the video did the defendant appear to be in any pain. This case started as an investigation in FY 2015-2016.

An additional claimant fraud case was filed by the Fraud Unit based upon a failure to disclose prior injuries. An employee claimed that he injured his right knee when he stepped on a rock while using a jackhammer. The defendant denied prior injuries to his knee in his AME exam. Medical records revealed that the defendant injured his knee playing soccer twice within the two years prior to the work injury. This case started as an investigation in FY 2015-2016.

Another filed claimant fraud case involved a machine operator who was working alone on an evening shift checking on a machine that was on a raised platform about three feet in height. While walking on the platform, he slipped on an onion causing him to fall with his full weight on his left foot. His initial physician treated a left foot injury. His PQME gave him a 23 % disability rating. Sub rosa video showed the defendant walking with a limp to the doctor but then later walking with no limp in his neighborhood after the doctor visit. The PQME after viewing the surveillance changed his disability rating to 5 %. This case started as an investigation from FY 2015-2016.

In another claimant fraud case, a dairy worker suffered injury from falling on the dairy parlor floor. She was treated and returned back to work. Three months later she was fired for being involved in a physical altercation at work. Three months after her termination, a workers'

compensation claim was filed reporting an injury sustained one month prior to the fight. She claimed injuries to her neck, right hand, right arm, right shoulder, both elbows, and back. This claim was denied. One year later, defendant filed a workers' comp claim for the initial fall on the parlor floor. This claim was accepted. Her AME doctor observed unusual behavior at the appointment. Surveillance was conducted. After reviewing the surveillance, the AME doctor found that the defendant's representations at the initial appointment were inconsistent with the video and found no impairment, rating her 0%.

The Fraud Unit filed a claimant fraud case in which the claimant was injured when her vehicle collided with a tractor on farm property. On the DWC-1 filed by the claimant she alleged only a "chest contusion," but later claimed injury to her neck, right upper extremity and chest. After the claimant submitted her claim for injury, she was seen on sub rosa video smiling, reaching, grasping overhead, pushing, pulling, gripping, grasping with the right upper extremity, pushing a gate, and pushing up and pulling down a large garage door among many other significant activities even though she presented extreme pain behavior in several doctor appointments. At an AME she said she cannot reach or grasp at eye level or overhead, cannot push or pull, cannot grip, grasp, hold or manipulate with the right hand. She said she could not perform repetitive motions with the right hand and cannot perform forceful activity with the right arm or hand. Investigation revealed that she was working at several employers during her workers' comp case. One of the employers had her performing grape related harvesting including pruning, leafing, thinning, cluster thinning, and training vines. This case started as an investigation from FY 2015-2016.

In another case started as an investigation in FY 2015-2016, the claimant, a former employee of the insured labor contractor, filed a post-termination workers' comp claim. According to his crew boss, the claimant never reported any work injury prior to leaving the employment of the insured. The claimant testified during his deposition that he was too injured to work and he has never helped his wife with her landscaping business in the Bay Area. However, a few months before the deposition, he was captured on surveillance video performing landscaping work, (e.g. mowing lawns, leaf blowing, dispensing hand-held fertilizer, raking leaves), at six residential locations in Santa Clara County.

The Fraud Unit filed another claimant fraud case involving an employee who claimed injury to his hip and spine while pushing cows from the corrals in a dairy operation. At his PQME, the defendant is observed in the waiting room to be walking with a normal gait without a limp. He was smiling and joking and his movements were fluid and without restriction. When the defendant walked into the examination room several minutes later, he was limping and moaning and groaning. This case started out as an investigation in FY 2015-2016.

The final applicant fraud case that the Fraud Unit filed involved an employee whose duties included mechanical repair, supervision, and driving a truck. The defendant was run over by a trailer that was being backed up by another employee. The trailer tires knocked down the defendant causing injuries to his ankles, both knees, and hips. The defendant used crutches at his medical appointments. Sub rosa video showed the defendant not using crutches at his residence or in public. This video was shown to his treating physician who released him back to work. The defendant's fraudulent misrepresentations to his treating physician resulted in an overpayment of TTD.

The Fraud Unit initiated a new applicant fraud investigation on an employee of a farm labor contractor and irrigator. While at work, a tractor tire rolled over the employee's foot and ankle causing lumbar strain. The claimant's supervisor saw him walking with a selective limp. The claimant has filed several workers' comp claims in the past for the same body part but denied these prior injuries at his deposition and to his PQME.

Another new applicant fraud investigation involves an applicant that allegedly received EDD benefits at the same time that he was receiving TTD benefits.

A new investigation was opened involving an employee claiming a work related injury, but information was received to contradict the initial report. The applicant's supervisor reports that the claimant did not let him know that the claimant had injured her ankle at work but told him that she injured the ankle at a Zumba class.

The Fraud Unit opened another claimant fraud investigation after an employee reported injuries to his neck and chest after allegedly being pinned between a walnut bin and another machine. The applicant has received medical treatment. The employer's security video does not corroborate the applicant's account of how he got injured. This video was shown to the applicant's treating physician who opined that "it is obvious that the applicant was not pinned or pushed for thirty seconds as he represented initially. At the most he was lightly contacted by the bin as he quickly moved away from the bin. He quickly resumed his work without showing any signs of impairment."

Premium Fraud

The Fraud Unit has been a member of the Central Valley Premium Fraud Consortium since its inception in 2005. Staff coordinates with other attorneys and investigators from the Department of Insurance, Kern County, Tulare County, Kings County and Merced County on high-impact premium fraud cases. The Employment Development Department (EDD) and the Franchise Tax Board are also members of the Consortium. The Consortium served eleven search warrants, made nine arrests, and obtained six convictions during Fiscal Year 2016-2017. The restitution ordered on these convictions was $6,047,814.00.

The Fraud Unit filed a premium fraud case centered around a trucking company underreporting payroll to its workers' compensation insurance carrier. EDD records showed payroll of large amounts reported during policy periods that the trucking company was reporting no payroll.

Search warrants were served on bank accounts to trace the money of the owners. Large sums of money were found to be transferred to one account that was the payroll and expense account for the trucking company. The owners claimed that the truck drivers were independent contractors. Further investigation showed that the trucking company leased the trucks to the drivers, but the drivers did not have independent authority to operate in California.

A forensic audit was conducted by the insurance company. The auditor determined that the trucking company failed to report a total of $1,626,935.00 in wages to the insurance company which resulted in a premium loss of approximately $347,351.28.

Another premium fraud case filed by the Fraud Unit involved State Compensation Insurance Fund. The defendant intentionally misrepresented his business, payroll and number of employees to State Fund. The underreporting of payroll and employees was discovered when the defendant was reported to be performing plumbing work on a prevailing wage job at a local jail.

There are three ongoing premium fraud investigations that are being worked as part of the Consortium. CDI and the Consortium members are converting the Consortium to a Central Valley Workers' Compensation Fraud Task Force.

The Central Valley Workers' Compensation Fraud Task Force has thirty open investigations. Dennis Reed of CDI and Charles Almaraz, Senior Investigator for the Fraud Unit, are assigned fulltime to the Task Force. The other Consortium members participate to the degree that their budget and proximity to Fresno allows.

Medical Provider Fraud

The Fraud Unit did not initiate any new provider fraud investigations this fiscal year. The Fraud Unit focused on helping CDI and the Consortium set up the new Central Valley Workers' Compensation Fraud Task Force. This Task Force will handle all types of workers' compensation fraud with an emphasis on provider fraud. The Fraud Unit is working with CDI to develop new provider fraud investigations. The FBI will be meeting with the Task Force at the end of April to turn over several provider fraud cases that are connected to a larger provider fraud case that resulted in federal indictments of three providers. The Department of Industrial Relations will be contacted to streamline data mining for the development of new investigations. The Fraud Unit attends a monthly Healthcare Fraud meeting that is hosted by the U.S. Attorney's Office. Information about providers and updates on investigations as well as prosecutions are shared.

Ongoing Case Activity for FY 2015-2016 and Outcomes from FY 2014-2015

Convictions

The Fraud Unit obtained three claimant fraud convictions during FY 2016-2017. Two defendants were convicted in a premium fraud case. The Fraud Unit obtained twelve convictions in uninsured employer cases. $48,000.00 was collected in restitution this fiscal year.

In one case, an auto repair mechanic was convicted of a felony and sentenced to felony probation and ordered to pay $70,073.56 in restitution.

In another claimant fraud case, the Fraud Unit obtained a misdemeanor conviction and a stipulation to pay $28,043.00 of restitution. Both of these convictions required the restitution stipulation to be pursuant to Penal Code Section 1214 to better protect the victims by having the restitution order be recognized as a civil judgment.

Open Investigations

The Fraud Unit has an ongoing claimant fraud investigation involving an employee who was

off work receiving TTD for several years when surveillance captured him working for another employer. The activities observed exceeded his representations to his doctors. The activities were unreported. The video shows the claimant picking plums while wearing a box strapped to his upper torso. The video also shows the claimant carrying a 12 foot ladder and climbing up and down the ladder and bending at the waist.

The Fraud Unit obtained two felony convictions and a stipulated restitution order for $346,601.78, in a premium fraud case. The defendants are pending sentencing.

The Fraud Unit has three ongoing premium fraud investigations as part of the Consortium. In one of these investigations, a property maintenance company is being investigated for not reporting all of its employees to the insurance company. In the second investigation, an auditor discovered unreported payroll. The corresponding suspected fraudulent claim is being investigated. The last investigation also involves unreported payroll. The assigned investigator is waiting for an audit to be completed.

The Fraud Unit has several ongoing provider fraud investigations. The first investigation involves a provider suspected of fraudulent billing for services not rendered. Data analytics show a pattern of billing a specific CPT(Current Procedural Terminology) code that raises red flags. Investigation will focus on the number of face-to-face patient meetings billed daily under CPT code 99215 at the same address. This face-to-face meeting requires a long visit with the doctor due to the serious nature of the medical condition of the patient. This investigation has been assigned to the Central Valley Workers' Compensation Fraud Task Force.

The second provider fraud investigation assigned to the Task Force is a Durable Medical Equipment provider fraud investigation. Initial investigation has found that expensive wrist and knee braces are billed by the provider, but patients never receive these expensive items. Instead, they receive a very inexpensive sleeve or support. The investigation is progressing with additional insurance companies being contacted to run data analysis.

The third investigation involves suspected providers upcoding QME reports and AME reports by manipulating complexity factors. This manipulation inflates the bill to the insurance company. This investigation has also been assigned to Central Valley Workers' Compensation Fraud Task Force.

Another investigation started with a referral from one insurance company regarding red flags on the medical billing forms. The Fraud Unit contacted a second insurance company and has received similar questionable medical billing forms. The medical treatment appears to be focused on generating billing as opposed to treating the patient.

At a monthly meeting the Fraud Unit attends at the U.S. Attorney's Office, it was discovered that federal investigators were independently investigating the same medical company. Both agencies will work together to streamline the investigation.

Ongoing Open Cases with No Activity

In FY 2017-2018 the Fraud Unit will do a review of the cases that have outstanding warrants. If appropriate, a warrant sweep will be organized or the cases will be handled

individually.

2. Specify any unfunded contributions (i.e., financial, equipment, personnel, and technology) and support your county provided to the workers' compensation insurance fraud program.

The Fresno County District Attorney's Office assigns a Budget Analyst, Chief Deputy District Attorney and a Commander of the Bureau of Investigations to oversee the Fraud Unit. The Bureau of Investigations provides additional investigative staff for search warrant and arrest warrant service when needed for officer safety.

The Fraud Unit is housed in the same building as members from the other Department of Insurance grants. Investigators and prosecutors roundtable cases and share ideas for the most effective ways to investigate and prosecute these cases.

3. Detail and explain the turnover or continuity of personnel assigned to your workers' compensation insurance fraud program. Include any rotational policies your county may have.

The prosecution of workers' compensation insurance fraud involves lengthy investigations and complicated issues. The Fresno County District Attorney's Office is committed to maintaining continuity of staff to allow the expertise necessary to prosecute these cases.

Chief Edith Treviso has supervised the Fraud Unit since 1995. In February 2015, she was promoted to Chief of the Financial Crimes Division. In this position, she supervises the Fraud Unit as well as the other Department of Insurance Grant units. She is still actively involved in reviewing cases for the Fraud Unit.

Senior Deputy District Attorney Manuel C. Jimenez, Jr. was assigned to the Fraud Unit in August 2012. In December 2016, Mr. Jimenez was promoted to a Senior Deputy District Attorney. He is an experienced attorney, who was previously assigned to the Auto Insurance Fraud Unit from August 2007 to August 2012.

Deputy District Attorney Charlotte Zylka was assigned to the Fraud Unit in April 2015. She is an experienced attorney who has been with the District Attorney's Office since 1999. She requested to be assigned to the Fraud Unit. She has prior financial crimes experience in the welfare fraud unit, and her familiarity with paper cases is an asset.

Senior Investigator Charles Almaraz has been working in the Fraud Unit since May 2013. Investigator Almaraz has sixteen years of law enforcement experience. He has worked for the Welfare Fraud and Felony Trial Teams. Investigator Almaraz was a Deputy Sheriff for eight years prior to being hired by the Fresno County District Attorney's Office. He is also fluent in Spanish.

Senior Investigator Steve Hatch rejoined the Fraud Unit in January 2016. He was last assigned to the Fraud Unit in August 2011 and focused on medical provider fraud. He has been a district attorney investigator for seventeen years. He has worked in identity theft,

welfare fraud, IHSS fraud, and real estate fraud. He is a forensic computer expert and can use this expertise in complex premium fraud and provider fraud investigations. Before he became a district attorney investigator, he was assigned to the Fraud Unit as a paralegal for five years.

Senior Investigator Colin Spence was assigned to the Fraud Unit in November of 2015. He has a Bachelor of Science in Criminology with a Law Enforcement Option. He has worked in law enforcement since 1995. Prior to working for the Fresno County District Attorney's Office, he worked for the Fresno County Sheriff's Department for two years and the Ventura Police Department for nine years. He has worked as a Senior Investigator for the Fresno County District Attorney's Office for the past ten years in a wide variety of assignments, including the following fraud related assignments: financial crimes (with experience investigating identity theft, forgery, fraud, and embezzlement), public integrity (with experience investigating corruption and theft of public funds), and real estate fraud.

4. List the governmental agencies you have worked with to develop potential workers' compensation insurance fraud cases.

California Department of Industrial Relations, Division of Workers' Compensation

The Department of Industrial Relations, Division of Workers' Compensation provides guidance, education, and information about the Workers' Compensation system of laws, rules, and court decisions. DWC provides information and documentation related to Qualified Medical Evaluators and Qualified Medical Evaluations. DWC also refers medical provider fraud cases to the Fraud Unit.

Central Valley Premium Fraud Consortium

The Fraud Unit has been a member of the Consortium since its inception in 2005. The counties in the Central Valley (Merced, Kings, Tulare, Kern and Fresno) and the Fraud Division assist each other in investigating and prosecuting premium fraud cases. The Consortium meets on a quarterly basis and coordinates the service of search warrants in multiple counties.

Employment Development Department

EDD is a member of the Consortium and provides valuable information regarding employer payroll. EDD investigators assist the Fraud Unit in analyzing Unemployment Insurance Code violations.

Contractors State License Board (CSLB)

CSLB's Statewide Investigative Fraud Team (SWIFT) conducts undercover sting operations in Fresno County throughout the year in an effort to deter the number of uninsured contractors. Fraud Unit investigators participate in these stings and staff attorneys prosecute the cases. CSLB investigators also refer cases to the Fraud Unit when they are out in the field and identify a contractor working with employees and no insurance. CSLB periodically conducts enforcement actions in Fresno County and refers uninsured employers to the Fraud

Unit.

Department of Labor

Department of Labor investigators refer uninsured employers, wage theft and premium fraud cases to the Fraud Unit for prosecution.

Workers' Compensation Appeals Board

The Workers' Compensation Appeals Board refers claimants to the Fraud Unit when there is a question of employer fraud. Transcripts from the hearings are often used to prove cases which are filed.

United States Postal Service

Staff also work with investigators from the United States Postal Service Office of Inspector General on cases involving postal employees committing workers' compensation insurance fraud.

Fresno Unified School District

The Fraud Unit works with the claims adjusters at the Fresno Unified School District (FUSD) on claimant fraud cases. FUSD is self-insured and adjusts their workers' compensation fraud cases in-house. Staff has provided training to FUSD on numerous occasions.

County of Fresno

The Fraud Unit also works directly with the Risk Management department at the County of Fresno. Claimant fraud referrals are forwarded to the Fraud Unit.

City of Parlier

The City of Parlier refers claimant cases to the Fraud Unit and has contacted the unit for advice regarding potential claimant fraud by city employees.

Department of Homeland Security Investigations

Many of the suspects investigated by the Fraud Unit are foreign born nationals from an assortment of countries. The Department of Homeland Security Investigations, Enforcement Removal Operations and Citizenship Immigration Services have assisted the Fraud Unit in determining the true identity of claimant fraud suspects.

Federal Bureau of Investigations

The Fraud Unit and the special agent assigned to investigate medical fraud out of the Fresno office of the Federal Bureau of Investigations have partnered with the Department of Insurance Fraud Division to investigate large scale organized provider fraud.

California Medical Board

The Fraud Unit contacts the Medical Board when they are working cases involving allegations of provider fraud.

Drug Enforcement Administration

Fraud Unit investigators and DEA diversion investigators partner on cases where it is believed a medical practitioner or patient is diverting controlled prescription medications (i.e. patients or doctors misusing or selling controlled substances). The DEA assists the Fraud Unit by providing controlled substance prescription information that may lead to evidence of criminal activity by medical providers or claimants.

Franchise Tax Board

Suspects willing to commit premium and medical fraud are often willing to defraud other entities, including the State of California. When the Fraud Unit suspects an individual or business entity is committing tax evasion, a referral is made to the Franchise Tax Board.

California Department of Corrections, Office of Internal Affairs

Investigators from the Department of Corrections and Rehabilitation, Office of Internal Affairs and the Fraud Unit partner on claimant fraud cases when the claimant is a Department of Corrections employee working in Fresno County.

Fresno Police Department

The Fresno Police Department has contacted the Fraud Unit for training in workers' compensation investigations regarding potential claimant fraud by employees.

5. Were any frozen assets distributed in the current reporting period? (Assets may have been frozen in previous years.) If yes, please describe. If no, state none.

None.

COUNTY PLAN: STAFFING
FISCAL YEAR 2017-2018

COUNTY OF FRESNO

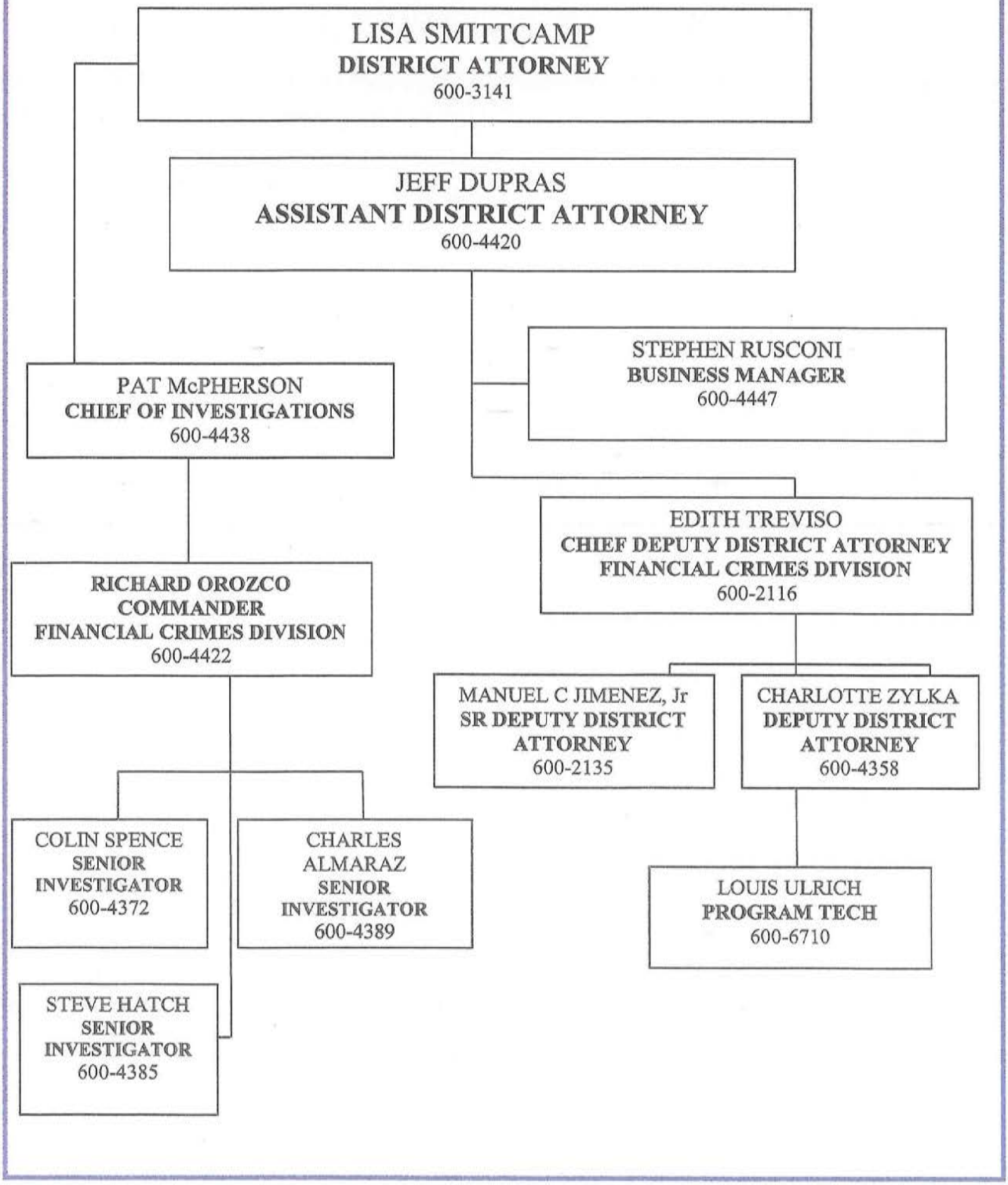
Prosecutors	% Time	Time With Program Start Date/End Date
Manuel C. Jimenez, Jr. – Sr. Deputy District Attorney	100	August 2012 - present
Charlotte Zylka – Deputy District Attorney	100	April 2015- present

COUNTY OF FRESNO

Investigators	% Time	Time With Program Start Date/End Date
Charles Almaraz – Senior Investigator	100	May 2013 - present
Colin Spence – Senior Investigator	100	August 2015 – present
Steve Hatch – Senior Investigator	100	January 2016 – present

COUNTY PLAN: ORGANIZATIONAL CHART
FISCAL YEAR 2017-2018

ORGANIZATIONAL CHART



COUNTY PLAN: DISTRICT ATTORNEY PROGRAM REPORT FISCAL YEAR 2017-2018

DAR (FORM 07) is submitted online

STATISTICAL INFORMATION WILL BE CAPTURED

FROM JULY 1, 2016 TO APRIL 15, 2017

To access the DAR webpage on the CDI website, click on the following link or copy the URL into your browser.

http://www.insurance.ca.gov/0300-fraud/0100-fraud-division-overview/10-anti-fraud-prog/dareporting.cfm

COUNTY PLAN: PROBLEM STATEMENT
FISCAL YEAR 2017-2018

PROBLEM STATEMENT

Describe the types and magnitude of workers' compensation insurance fraud (e.g., claimant, single/multiple medical/legal provider, premium/employer fraud, insider fraud, insurer fraud) relative to the extent of the problem specific to your county.

Use local data or other evidence to support your description.

Workers' compensation fraud continues to affect the citizens in Fresno County. The population is estimated to be 979,915 (U.S. Census Bureau) and the agricultural operations cover nearly half of the county. (Fresno County Farm Bureau 2014) Fresno County provides 1.88 million acres of the world's most productive farmland. Twenty percent of the jobs in the county are related to agriculture from farm workers to salespersons. (Fresno County Farm Bureau 2017) Fresno is the number one county in agricultural production in the United States. (2012 Census of Agriculture)

Fresno County is home to a diverse community. Hispanics and Latinos account for half of the population. 52.4 % of the households in Fresno County are Spanish-speaking. There are an estimated 539,299 people who are eighteen years or older. Of that amount 22.3 % of those people speak Spanish as their first language. Furthermore, 26.3 % speak minimal English, which contributes to a weaker understanding of their legal rights and obligations in the workers' compensation system.

In the last three years, Fresno County has been in the top fifteen counties for suspicious fraud claims and ranked 12th overall in those years. (Department of Insurance- Fraud Division, 2017)

Claimant Fraud

The agricultural industry lends itself to low wages and a transitory workforce. The jobs are seasonal and physically demanding. Gerawan Farms of Reedley, which is the largest stone-fruit and table grape grower in the nation, is located in Fresno County. The second largest (Wawona Packing), the seventh largest (Fowler Packing) and the fourteenth largest (Simonian Fruit) are also in Fresno County. At peak harvest, the number of employees at Gerawan approaches twelve thousand. Zacky Farms and Foster Farms are also large employers with plants in Fresno County. Zacky Farms employs eleven hundred workers and Foster Farms employs approximately twelve hundred employees. Harris Ranch, California's largest beef producer, is located in Coalinga (Fresno County) and has about four hundred workers.

The Fraud Unit works directly with the Human Resources departments of all of the above employers regarding potential fraudulent claims. The cases are complicated by the fact that

the majority of the claimant's attorneys are from the Los Angeles area. These attorneys often refer their clients to Southern California physicians. Temporary disability is often extended without a firm medical diagnosis.

Many of the claimant fraud referrals involve malingering. These cases can be difficult to prove, despite video surveillance which shows the employee active, if the doctor is unwilling to conclude that a misrepresentation was made.

The unemployment rate in Fresno County was 10.6 % in January 2017. (State of California, EDD, Labor Market Division) This percentage is almost twice the unemployment rate of California which is 5.1 %. Due to this high rate, workers will try to remain on temporary disability after their injury has resolved. The dim prospects of finding alternative work make the option of exaggerating their injury more attractive.

Premium Fraud

Cash pay is the number one method used by employers to cheat insurance companies out of their premiums. Employers are required to report their payroll less often and insurance companies do not learn of the underpaid premium until an audit. With smaller employers, audits are often waived and fraud is only discovered at the end of the policy, if at all. Employers can now report payroll electronically. This form of reporting makes it difficult to determine who is responsible for making misrepresentations. Also, many auditor positions have been eliminated as a result of the economy. Several years can go by before fraud is detected, making any investigation difficult when trying to locate witnesses.

The Fraud Unit has seen a rise in referrals for premium fraud where employers report zero payroll but request certificates of insurance.

Employers are finding creative ways to lower payroll. Employers classify employees as independent contractors and run payroll through other companies. They also misclassify their employees or fail to report claims by paying the medical expenses out of pocket.

Partnering with EDD has proven invaluable when attempting to prove premium fraud. Employers will often report payroll accurately to EDD. Comparing what is reported to EDD to what is reported to the insurance company can provide strong evidence of fraud. Employers often report a much smaller payroll to their workers' compensation carrier.

The Fraud Unit works with the Franchise Tax Board (FTB) on all types of workers' compensation fraud investigations. FTB offers assistance with bank search warrants and will bring their tax cases to the Fraud Unit for prosecution. FTB has joined the Consortium and one of their agents travels from Sacramento at least once per month for an office day at the CDI Fresno office.

Employment Fraud

In a slow economy employers try to reduce costs in any way possible. The Fraud Unit filed twenty-three uninsured employer cases this fiscal year. These cases are significant since injured workers are not getting the benefits to which they are entitled.

The majority of uninsured employer cases are filed with the assistance of CSLB. Staff participates in undercover stings with CSLB staff. Fraud Unit investigators are often called into the field by CSLB investigators who find uninsured contractors many of whom have employees working in the field.

Provider Fraud

Provider Fraud is a major problem in Fresno County. Many of the fraud schemes in Southern California and Kern County have made their way to Fresno.

The Fraud Unit has several ongoing provider fraud investigations. The first investigation involves a provider suspected of fraudulent billing for services not rendered. Data analytics show a pattern of billing a specific CPT (Current Procedural Terminology) code section that raises red flags. Investigation will focus on the number of face-to-face patient meetings billed daily under CPT code 99215 at the same address. This face-to-face meeting requires a much longer visit with the doctor by the patient due to the serious nature of the medical condition of the patient.

The second provider fraud investigation is a Durable Medical Equipment provider fraud investigation. Bill review ran data analytics, and random patients were interviewed to confirm services rendered. Initial investigation has found that expensive wrist and knee braces are billed by provider, and patients never receive these expensive items. Instead, they receive a very inexpensive sleeve or support

The third investigation involves suspected providers upcoding QME reports and AME reports by manipulating complexity factors. This manipulation inflates the bill to the insurance company.

Another investigation started with a referral from one insurance company regarding red flags on the medical billing forms. The Fraud Unit contacted a second insurance company and has received similar questionable medical billing forms. The medical treatment appears to be geared to generating billing as opposed to treating the patient. At a monthly meeting the Fraud Unit attends at the U.S. Attorney's Office, it was discovered that federal investigators were independently investigating the same medical company. The Fraud Unit is working closely with the assigned federal investigator to coordinate and streamline the investigation.

The Fraud Unit is involved in an ongoing investigation (as discussed earlier) in which a Southern California based organization was responsible for creating hundreds of millions of dollars of medical bills. Federal indictments have issued against three providers, and two more are expected in the near future. These indictments are the product of the hard work of the Fraud Unit, CDI, FBI, and the U.S. Attorney's Office. The Fraud Unit will be meeting with the FBI later this month to discuss several provider fraud cases that are linked to the indicted case.

Another fraudulent provider fraud scheme involves medical billing companies in Southern California billing and rebilling for services completed in Fresno County. Often the employee's injuries are not being thoroughly evaluated. Instead the trend is to have each injured worker undergo the same battery of tests, whether needed or not.

Another aspect of medical fraud in Fresno County is the fact that many injured workers are Spanish speaking and unable to take an active role in their treatment. Some of the workers interviewed complained that body parts are being treated which were never injured.

COUNTY PLAN: PROGRAM STRATEGY
FISCAL YEAR 2017-2018

PROGRAM STRATEGY

1. Explain how your county plans to resolve the problem described in your problem statement. Include improvements in your program.

Claimant Fraud

The Fraud Unit will continue to maintain open communication with our referral sources. Staff will educate employers on the red flags of claimant fraud and what documentation is needed for criminal prosecution.

The Fraud Unit will maintain close contact with Special Investigation Units and Third Party Administrators when FD-1's are received that warrant investigation. The Fraud Unit will continue working closely with the Fraud Division on joint investigations.

Employer Fraud

When tipster referrals are received on uninsured employers, an investigator will respond as quickly as possible. The Fraud Unit will work closely with the CSLB investigators and participate in sting operations when requested. Additionally, the Fraud Unit is working closely with the Labor Commissioner's Office to coordinate joint operations.

The Fraud Unit is exploring working with private companies that allow people to anonymously report information about workers' compensation fraud.

Premium Fraud

As members of the Consortium, the Fraud Unit coordinates with the Fraud Division and Central Valley counties to investigate and prosecute premium fraud. The Consortium prioritizes its resources and focuses on the most serious cases. The Consortium has been successful in streamlining the length of the investigations, while maintaining the integrity of the prosecution. Utilizing EDD and FTB records in conjunction with employee statements has eliminated the need for search warrants in some cases. The Fraud Unit has been working with CDI and Consortium members to convert the Consortium into the Central Valley Workers' Compensation Fraud Task Force. This Task Force will investigate all types of complex workers' compensation fraud with an emphasis on provider fraud. A Senior Investigator from the Fraud Unit is housed at CDI as part of this Task Force.

Provider Fraud

Medical provider cases are very complex and the investigations are often very lengthy. The Fraud Unit will focus on a narrow aspect of the fraud with the goal of completing an investigation and filing charges in a timely manner. The fraud will not be deterred unless charges are filed. It is imperative to focus the investigation rather than attempt to pursue every lead. This will accomplish the goal of preventing the providers from continuing to

commit fraud as well as send a message to other providers in the community that fraud will not be tolerated.

The Fraud Unit believes medical provider fraud (including fraud by billing companies, medical management companies, claimant attorneys, pharmacies, durable medical equipment sales companies, and assorted medical providers) is the largest cost driver in the Workers' Compensation industry. The steadily rising cost of fighting fraud is directly influenced by the large, organized criminal conspiracies at the core of provider fraud.

Due to the complexity and jurisdictional reach of these criminal enterprises, the Central Valley Workers' Compensation Fraud Task Force was created. It is comprised of prosecutors and investigators from the district attorney's offices of the Central Valley as well as members of state investigative and regulatory agencies. This Task Force would allow investigators to develop complex provider fraud investigations and create efficient sharing of information between agencies. Complex applicant fraud and premium fraud would also be investigated. In addition, this Task Force will have dedicated investigators housed at CDI to function as a true task force. As discussed earlier, the Fraud Unit has already housed one of its three senior investigators at the regional CDI office in Fresno. The Fraud Unit is committed to this task force concept and is willing to help CDI and the other Central Valley counties. Provider fraud affects the Central Valley as a whole. The Fraud Unit believes that the task force is the best way to help Central Valley prosecutors and investigators combat the organized crime groups responsible for the medical provider fraud.

2. What are your plans to meet the announced goals of the Insurance Commissioner and the Fraud Assessment Commission? Copies have been provided for your reference.
    - If these goals are not realistic for your county, please state why they are not, and what goals you can achieve. What is your strategic plan to accomplish the goals?

One goal of the Fraud Assessment Commission and the Insurance Commissioner is to focus resources on the fraud with the greatest negative consequences: medical provider fraud. The Fraud Unit is cognizant that in these economic times it is essential to focus our resources on the fraud with the greatest fiscal impact. With this goal in mind, the Fraud Unit changed its organizational structure to better use the resources the Fraud Unit has received. The Fraud Unit has two prosecutors instead of three, which gives the Unit the ability to keep three senior investigators. The result of this structure has allowed us to dedicate one of the three investigators fulltime to the Central Valley Workers' Compensation Fraud Task Force.

The Fraud Unit intends to use expert witnesses during the investigation process (e.g. billing experts and QME experts) to streamline investigations and prosecutions. The Fraud Unit is exploring alternatives to criminal prosecution such as pursuing civil cases against medical providers under IC 1871.7 (Runners and Cappers Statute) and BP 17200 (Unfair Business Practices Statute) in appropriate cases.

As discussed above, the Fraud Unit along with the other Consortium members is working with CDI to create the Central Valley Workers' Compensation Fraud Task Force. It is envisioned that this new task force would coordinate efforts with CDI and other Central

Valley counties to complete investigations on medical provider fraud cases as well as complex applicant fraud and premium fraud cases. Dedicated investigative staff would be housed at the CDI Fresno regional office. Coordinating Central Valley resources will help not only Fresno but the other Central Valley counties combat complex workers' compensation fraud more efficiently and effectively.

Staff will continue to focus on investigating and prosecuting every type of fraud in the workers' compensation system. It is essential to have a balanced caseload. Claimant fraud, medical provider fraud, premium fraud and the willfully uninsured affect the integrity of the system. Staff will pursue all referrals in a timely manner. We will work with SIU's and third party administrators to ensure they have the knowledge necessary to prepare referrals.

It is essential that the Fraud Unit and CDI have an effective working relationship. This requires regular communication which will streamline investigations and eliminate duplication of effort. (See Attachment A for a copy of our Joint Plan).

Outreach is a vital component of the Fraud Unit's workers' compensation anti-fraud program. During FY 2015-2016, the Fraud Unit targeted a new audience for outreach. The Fraud Unit gave a presentation on workers' compensation fraud to an organization named COOL-Coalition of Organized Labor. This organization is comprised of leaders of labor groups both private and public. The presentation focused on what the Fraud Unit is doing in the different areas of employer fraud as well as provider fraud. The goal of the presentation was to increase the number of referrals. The Fraud Unit continued an area of outreach started in FY 2014-2015. The Unit has partnered with individual professors at the Craig School of Business at Fresno State University to give presentations ranging from a half hour to two hours on workers' compensation fraud. The professors and graduate students have given the Fraud Unit great feedback. Both have expressed enthusiasm in learning more about workers' compensation laws and how to prevent and discover fraud. Given that these students will be either business owners or employees in the future, the Fraud Unit's goal of helping educate the future workforce and business owners and thereby prevent or deter future fraud is being accomplished.

In FY 2016-2017 the Fraud Unit conducted a joint outreach presentation with CDI to a large group of farm labor contractors. The presentation was well attended, and the attendees had a number of questions for the presenters.

In FY 2017-2018 the Fraud Unit will attempt develop new areas of outreach such as targeting the workers of large companies in Fresno. This outreach will focus on both English and Spanish speaking populations.

3. What goals do you have that require more than a single year to accomplish?

The more complicated medical provider fraud and premium fraud cases can take more than a year to investigate. These cases often require search warrants and forensic review of the evidence seized. The Fraud Unit and the Consortium are collaborating on finding ways to streamline the bigger investigations.

For example, the Fraud Unit has filed six premium fraud cases in the last four fiscal years without first obtaining search warrants. Staff has relied on EDD records and witness

statements to prove the crimes. These cases were investigated and filed in a timely fashion. In addition, the Central Valley Workers' Compensation Fraud Task Force has been created which will streamline complex applicant, premium, and medical fraud investigations.

4. Training and Outreach

- List the **training received** by each county staff member in the workers' compensation fraud unit **during Fiscal Years 2015-2016 and 2016-2017**.

- Describe what kind of training/outreach **you provided in Fiscal Year 2016-2017** to local Special Investigative Units, as well as, public and private sectors to enhance the investigation and prosecution of workers' compensation insurance fraud. Also describe any coordination with the Fraud Division, insurers, or other entities.

- Describe what kind of training/outreach **you plan to provide in Fiscal Year 2017-2018**.

Manuel C. Jimenez, Jr., Sr. Deputy District Attorney, attended the following training:

- October 2015-CDAA Fraud Symposium
- February 2016-State Compensation Insurance Fund Presentation
- March 2016 -NCFIA Anti-Fraud Conference
- May 2016-Provider Fraud Training by Jim Fisher
- September 2016-CDAA Fraud Symposium
- April 2017-Workers' Comp Fraud Roundtable " An Investigator's Perspective on Provider Fraud" by Dan Harkness
- April 2017-NCFIA Anti-Fraud Conference

Charlotte Zylka, Deputy District Attorney, attended the following training:

- October 2015 –CDAA Fraud Symposium
- March 2016-NCFIA Anti-Fraud Conference
- May 2016-Provider Fraud Training by Jim Fisher
- September 2016-CDAA Fraud Symposium
- April 2017-Workers' Comp Fraud Roundtable-"An Investigator's Perspective on Provider Fraud" by Dan Harkness

Charles Almaraz, Senior Investigator, attended the following training:

- September 2015-CDAIA Annual Conference
- November 2015-CDI Healthcare Fraud 404 Investigations Training
- March 2016-NCFIA Anti-Fraud Conference
- May 2016-Provider Fraud Training by Jim Fisher
- September 2016-Fresno State University Leadership Conference
- April 2017-Workers' Comp Fraud Roundtable "An Investigator's Perspective on Provider Fraud" by Dan Harkness
- April 2017-NCFIA Anti-Fraud Conference

Charles Almaraz is a Peace Officer Standards and Training certified instructor in multiple disciplines and provide training for the Bureau of Investigations

Colin Spence, Senior Investigator, attended the following training:

- October 2015-CDAA Fraud Symposium
- November 2015- CDI Healthcare Fraud 404 Investigations Training
- February 2016-SCIF Workers' Compensation Fraud Investigations
- April 2016-PORAC Workers' Compensation & Industrial Disability Retirements for Public Safety Officers
- April 2016-San Diego District Attorney's Office Witness Protection Training
- May 2016-Provider Fraud Training by Jim Fisher
- June 2016-EDD "Employee or Independent Contractor" Training
- September 2016-Workers' Compensation Fraud Investigation Training by Carol Reed DDA Monterey County and Kathleen Harris Captain CDI at CDAIA Conference
- September 2016-CDAA Fraud Symposium
- October 2016-Provider Fraud Training by Dan Harkness at SIU Roundtable Meeting in Bakersfield
- October 2016-Fraud Training by Fresno PD at the California Financial Crimes Investigators' Association Meeting
- April 2017-Workers' Comp Fraud Roundtable "An Investigator's Perspective on Provider Fraud" by Dan Harkness

Steve Hatch, Senior Investigator, attended the following training:

- January 2016-Cell Phone Forensics
- May 2016-Provider Fraud Training by Jim Fisher
- September 2016-CDAA Fraud Symposium
- March 2016-NCFIA Anti-Fraud Conference
- May 2016-Provider Fraud Training by Jim Fisher.
- April 2017-Workers' Comp Fraud Roundtable "An Investigator's Perspective on Provider Fraud" by Dan Harkness

<u>Outreach Provided in Fiscal Year 2015-2016</u>

- October 2015 PIWC (Professionals in Workers' Compensation)-Workers' Compensation Fraud Trends
- January 2016-COOL(Coalition of Organized Labor)-Workers' Compensation Fraud Unit-Employer Fraud and Provider Fraud
- February 2016-Reedley High School Career & Technical Education/Electives and College Expo
- March 2016-Fresno State Human Resources Student Group Presentation
- March 2016-Fresno State Human Resources Craig School of Business Presentation
- April 2016-Fraud Roundtable Luncheon

<u>Outreach Provided in Fiscal Year 2016-2017</u>

- October 2016- PIWC-Workers' Compensation Fraud Trends
- November 2016- Fraud Unit Training with Zenith Insurance to Scelzi Enterprises
- February 2017-Reedley High School Career & Technical Education/Electives and College Expo

- February 2017-Fresno State University Criminology Fair
- March 2017-Farm Labor Contractors Presentation
- March 2017-Fresno State University Craig School of Business Presentation

Training/Outreach Planned for Fiscal Year 2017 – 2018

The Fraud Unit's outreach will include speaking to SIUs, self-insured and third party administrators to educate them on the elements necessary to prove criminal fraud. Staff will continue hosting fraud luncheons and network with other grant counties and SIUs in the Central Valley. The Fraud Unit will also provide outreach to the Hispanic community in an effort to educate them about their rights and responsibilities in the workers' compensation system. Staff will work with the Central Valley Legal Services to provide training for the attorneys and the employees they help.

The Fraud Unit will continue to reach out to employers to give training to both managers and employees.

The Fraud Unit will continue the successful outreach at Fresno State University. The Fraud Unit will look to target the working people by reaching out to employers of all sizes. In addition, the Unit will contact the Coalition of Organized Labor to coordinate more training for the members of the unions.

5. Describe the county's efforts and the district attorney's plan to obtain restitution and fines imposed by the court to the Workers' Compensation Fraud Account pursuant to California Insurance Code Section 1872.83(b)(4).

The Fraud Unit maintains a database of all restitution orders on criminal convictions. Payments are made directly to our Unit, which we document and then forward to the victim(s). If a payment is missed, staff immediately sends a notification letter to the defendant(s) reminding him/her of the obligation.

If the letter is unsuccessful, staff contacts the Probation Department and the defendant's attorney and calendars a Probation Violation hearing. The Fraud Unit has collected $48,000.00 in restitution this fiscal year. This sum has been paid directly to the victims of fraud.

The Fraud Unit is committed to collecting restitution for the victims of fraud.

6. Identify the performance objectives that the county would consider attainable and would have a significant impact in reducing workers' compensation insurance fraud.

   Projection:

   a. 50 new investigations will be initiated during FY 2017-2018

   b. 25 new prosecutions will be initiated during FY 2017-2018

7. If you are asking for an increase over the amount of grant funds awarded last fiscal year, please provide a brief description of how you plan to utilize the

additional funds.

$ 1,274,411 FY 2017-2018 Grant REQUEST	$ 1,236,000 FY 2016-2017 Grant AWARD	$ 38,411 FY 2017-2018 Increase Requested

Utilization Plan:

The Fraud Unit is requesting additional funding for Fiscal Year 2017 – 2018 to maintain staffing and continue dedicating a fulltime senior investigator to the Central Valley Workers' Compensation Fraud Task Force.

8. Local district attorneys have been authorized to utilize Workers' Compensation Insurance Fraud funds for the investigation and prosecution of an employer's willful failure to secure payment of workers' compensation as of January 2003. Describe the county's efforts to address the uninsured employer's problem.

The Fraud Unit is committed to investigating and prosecuting employers who willfully fail to secure workers' compensation insurance. Staff coordinates with the CSLB regarding uninsured employers in Fresno County. Enforcement actions are conducted periodically throughout the year. Investigators also respond to all phone tips and consumer complaints regarding uninsured employers.

The Fraud Unit is a member of the Roadside Vendor Task Force. The Fraud Unit has teamed up with local law enforcement to cite uninsured vendors. Staff also coordinates with ABC investigators to conduct business inspections and cite uninsured businesses.

Staff prosecutors are educating employees concerning the risks of being injured while working for an uninsured employer through outreach in the community. Twenty-three uninsured employer cases were filed this fiscal year and $14,160.00 has been collected for the Department of Insurance Workers' Compensation Fraud Account.

FORM 10

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
BUDGET: PERSONNEL SERVICES
FISCAL YEAR 2017-2018

COUNTY NAME: FRESNO

A. PERSONNEL SERVICES: Salaries and Employee Benefits		COST
(1) SENIOR DEPUTY DISTRICT ATTORNEY:		
This individual devotes 100% of time to this program.		
Annual salary:	$126,282	$126,282
Benefits:		
Retirement: ($126,282 @ .6583)	$83,131	
OASDI: ($126,282 *.0765)	$9,661	
Health Ins- Annual:	$7,386	
Unemployment: ($126,282 @ .00067)	$85	
Workers Comp: ($126,282 @ .010293)	$1,300	
Admin Fee- Annual:	$105	$101,668
(1) DEPUTY DISTRICT ATTORNEY IV:		
This individual devotes 100% of time to this program.		
Annual salary:	$117,364	$117,364
Benefits:		
Retirement: ($117,364 @ .6583)	$77,261	
OASDI: ($117,364 *.0765)	$8,978	
Health Ins-Annual:	$7,386	
Unemployment: ($117,364 @ .00067)	$79	
Workers Comp: ($117,364 @ .010293)	$1,208	
Admin Fee- Annual:	$105	$95,017
(3) SENIOR DEPUTY DISTRICT ATTORNEY INVESTIGATORS:		
This individual devotes 100% of time to this program.		
Annual salary: 3 @ $87,442	$262,326	$262,326
Overtime:	$5,000	$5000
Benefits:		
Retirement: 3 @ ($87,442 @ .8819)	$231,345	
OASDI: 3 @ ($87,442 *.0765)	$20,068	
Health Ins-Annual: 3 @ $7,386	$22,158	
Unemployment: 3@ ($87,442 @ .00067)	$176	
Workers Comp: 3@ ($87,442 @ .010293)	$2,700	
Admin Fee- Annual: 3* $105	$315	$276,762

(1) PROGRAM TECHNICIAN:
This individual devotes 100% of time to this program.

Annual salary:	$50,608	$50,608
Benefits:		
Retirement: ($50,608 @ .6583)	$33,315	
OASDI: ($50,608 *.0765)	$3,872	
Health Ins-Annual:	$7,386	
Unemployment: ($50,608 @ .00067)	$34	
Workers Comp: ($50,608 @ .010293)	$521	
Admin Fee- Annual:	$105	$45,233
Membership Dues:		
California Bar Dues 2 @$380	$760	
CDAIA 3 @ $25	$75	$835

SUMMARY:

Salaries	$556,580
Overtime	$5,000
Benefits	$518,680
Dues	$835
TOTAL	**$1,081,095**

A. PERSONNEL SERVICES TOTAL	$1,081,095

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: OPERATING EXPENSES
FISCAL YEAR 2017-2018

COUNTY NAME: FRESNO

B. OPERATING EXPENSES	COST
MOBILE COMMUNICATIONS:	$ 8,000
LIABILITY INSURANCE:	$208
MAINTENANCE-EQUIPMENT:	$2,500
OFFICE EXPENSE:	$4,000
POSTAGE:	$500
DATA PROCESSING:	$32,000
PROFESSIONAL & SPECIALIZED SERVICES:	$6,000
COMPUTER SERVICE SOFTWARE:	$2,500
PUBLICATIONS:	$600
RENTS & LEASES - BUILDINGS:	$45,000
FACILITY MAINTENANCE:	$4,000
SMALL TOOLS:	$5,000
MILEAGE:	$350
TRANSPORTATION, TRAVEL, & EDUCATION:	$10,000
TRANSPORTATION & TRAVEL - FLEET:	$17,000
INDIRECT COSTS: (10% * Salaries ($556,580))	$55,658
B. OPERATING EXPENSE TOTAL	$193,316

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM PROGRAM BUDGET: EQUIPMENT FISCAL YEAR 2017-2018	
COUNTY NAME: FRESNO	
C. EQUIPMENT	***COST***
C. EQUIPMENT TOTAL	
D. PROGRAM BUDGET TOTAL	$1,274,411

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: EQUIPMENT LOG
PRIOR FISCAL YEAR 2016-2017

COUNTY NAME: FRESNO

Equipment Ordered	Equipment Cost	Date Ordered	Date Received	Serial Number	Equipment Tag Number
Cellebrite 4PC	$4,800	3/1/2017	In process		

☐ **No equipment purchased.**

I certify this report is accurate and in accordance with the Grant guidelines.

Name: Manuel C. Jimenez, Jr Title: Sr. Deputy District Attorney
Signature: [signature] Date: 4/20/17

Attachment "A"

Joint Investigative Plan

JOINT INVESTIGATIVE PLAN

I. STATEMENT OF GOALS

The purpose of the Joint Plan is to create a framework by which the Fresno District Attorney's Office (hereinafter referred to as the Fraud Unit) and the CDI Regional Office (hereinafter referred to as CDI) will effectively work together to combat workers' compensation fraud. Given the limited resources available to investigate and prosecute fraud; it is imperative not to duplicate efforts. It is also essential to use the resources of both agencies to their fullest potential. For example, if a case crosses county lines, the Fraud Unit will turn to CDI for assistance.

The Fraud Unit and CDI are working with representatives of the Premium Fraud Consortium to create a Central Valley Workers' Compensation Fraud Task Force. This task force would be housed at the CDI office in Fresno and be comprised of CDI investigators and District Attorney investigators from the Central Valley offices. The purpose of the task force would be to marshal the resources of the Central Valley counties to investigate and prosecute medical provider fraud cases, premium fraud cases, and complex applicant fraud cases.

II. RECEIPT OF ASSIGNMENT OF CASE

CDI and the Fraud Unit will deconflict upon assignment of investigations to ensure there is no duplication of investigative efforts. If it is determined that CDI will conduct the investigation, both the attorney and CI detective will develop a litigation plan. They will work together to determine the charges to be filed and interviews to be conducted. During the initial meeting, timelines will be established for the completion of the investigation and priorities will also be set. The Fraud Unit will be apprised of all aspect of CDI's investigation.

III. INVESTIGATIONS

By working together at the outset of a case, and by sharing fraud referrals on a monthly basis, there will be no duplication of effort. Open communication will exist between both offices, which is the key to investigation the cases as expediently and efficiently as possible.

When CDI investigates a case, the detective and prosecutor will meet within 30 days of the case assignment to discuss their litigation plan. This 30-timeline may be extended on an as needed basis by agreement between the Fraud Unit and CDI. The detective will apprise the prosecutor of his/her progress on a monthly basis. The CDI detective will contact the deputy district attorney at any time in order to review the litigation plan and make changes if needed.

The CDI Captain, or his designee, and the Supervising Attorney will meet quarterly to discuss any issues or problems with the joint investigation of cases.

IV. UNDERCOVER OPERATIONS

In the event that an undercover operation occurs during this grant period, both the CDI Captain, or his designee and the Supervising Attorney will meet to develop a litigation plan which will identify the direction of the investigation, address relative investigative issues, define the responsibilities of both agencies and provide a method to resolve disagreements. When it becomes necessary, the Supervising Attorney or his/her designee will provide authorization to CDI to conduct surreptitious recordings pursuant to Penal Code Section 633.

V. CASE FILING REQUIREMENTS

Cases presented to the Fraud Unit for filing will contain sufficient evidence to prove guilt beyond a reasonable doubt. This will include verification that witnesses are available and willing to testify, and contain all available documentation needed to prove the fraud. Witnesses will be interviewed pursuant to Proposition 115.

If interpreters were used, they will be identified and interviewed if possible. It is difficult to state a more definitive list of requirements for filing, since each case is different. Ongoing discussions between the detective and deputy district attorney will determine what additional investigation is needed.

The Fraud Unit will provide CDI with a filing decision in writing within 30 days of the case submission. Ceritifed Court Minute Orders on all workers' compensation convictions in Fresno County will be provided to CDI as soon as possible.

VI. TRAINING

CDI Fresno Regional Office and the Fraud Unit will continue to work together to educate the community on ways to combat fraud. Any requests for training received by CDI will be communicated to the Fraud Unit and visa versa. In this way both office will conduct outreach together to employers, carriers and the public.

VII. PROBLEM RESOULTION

With CDI Regional Office and the Fraud Unit working in a "team concept" it will be easier to resolve problems in an expedient manner. This will also reduce any potential breakdown in communication between offices.

In the event a conflict develops between the agencies, using the open lines of communication established, the agencies will seek resolution at the lowest level possible. If a resolution cannot be achieved at this level, the immediate supervisors shall meet to seek resolution. It is anticipated that most, if not all, conflicts will be resolved by this step, If a conflict persists, then the Captain of the CDI Fresno Office, and the Chief Attorney for the District Attorney shall meet and confer.

VIII. PREMIUM FRAUD CONSORTIUM

Fresno County has joined together with CDI, the counties of the Central Valley, Employment Development Dept and FTO to investigate and prosecute premium fraud. The Premium Fraud Consortium's goal is to coordinate law enforcement activities by utilizing a team approach to effectively deal with the growing number of multi-jurisdictional premium fraud cases. A separate "Mutual Assistance Agreement and Operation Guidelines" governs the Consortium's operations.

IX. EMPLOYERS WHO ARE WILLFULLY UNINSURED

CDI and the Fraud Unit are committed to working together in investigate and prosecute employers in Fresno County who are willingly uninsured. A CDI detective will accompany a District Attorney investigator whenever possible when following up on a tip of an uninsured employer in the county. CDI will be the liaison with the WCIRB in determining if a particular employer carries Workers' Compensation Insurance.

X. Central Valley Workers' Compensation Fraud Task Force

Fresno County is working with CDI and the members of the Consortium to convert the Consortium into a regional Workers' Compensation Fraud Task Force comprised of prosecutors and investigators from the district attorney's offices of the Central Valley as well as members of state investigative and regulatory agencies. The mission of the Central Valley Workers' Compensation Fraud Task Force will be to successfully investigate and prosecute all areas of workers' compensation fraud in participating counties but focusing the combined resources on complex medical fraud cases. This Task Force would allow investigators to develop provider fraud investigation expertise and create efficient sharing of information between agencies. The Fraud Unit has already assigned one Senior Investigator to this Task Force. This investigator is housed at the CDI Regional Office in Fresno. A separate Memorandum of Understanding will govern the Task Force's operations.

XI. OTHER

Both CDI and the Fraud Unit will assist each other in the following ways:

1. Storing evidence.
2. Sharing specialized equipment.
3. The service of search warrants, arrest warrants and/or subpoenas, and
4. In any other way necessary to accomplish our common goal of deterring workers' compensation fraud.

XI. CONCLUSION

The Fraud Unit and CDI agree to work together to investigate and prosecute those who commit insurance fraud in Fresno County by working impact cases while at the same time maintaining a balanced case load. Both agencies agree that anti-fraud efforts must be conducted in a cost effective and efficient manner with professionalism, productivity and effectiveness being the overriding principles governing the relationship. Both agencies further agree that the ultimate goal is to reduce workers' compensation insurance fraud in Fresno County.

Date 4/5/17

Manuel Jimenez
Deputy District Attorney
Fresno County District Attorney's Office
Workers' Compensation Fraud Unit

Date 4/5/17

Eric Charlick
Captain
California Department of Insurance
Fraud Division, Fresno Regional Office