STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
FRAUD DIVISION
2400 DEL PASO ROAD, SUITE 250
SACRAMENTO, CA 95834
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Dave Jones, *Insurance Commissioner*
George Mueller, *Deputy Commissioner*

November 6, 2018

Stephen Rusconi
Business Manager
Fresno County District Attorney's Office
2220 Tulare Street, Suite 1000
Fresno, CA 93721

RE: Executed Original of the Fiscal Year 2018-19 Grant Award Agreement for the Workers' Compensation Insurance Fraud Program

Dear Stephen Rusconi:

Fresno County was awarded $1,184,988 for the Fiscal Year 2018-19 Workers' Compensation Insurance Fraud Program.

Please find the following three documents enclosed:

- Executed Original of the Fiscal Year 2018-19 Grant Award Agreement
- Summary of Important Deadlines
- After Award Administrative Requirements

Sincerely,

Jan Perschler

Janis Perschler
Manager, Local Assistance Unit

Enclosures

cc: Manuel C. Jimenez, Jr., Deputy District Attorney

INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

GRANT AWARD AGREEMENT

Fiscal Year 2018-19

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, 2018** through **June 30, 2019.**

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 **$1,184,988.** 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	**DAVE JONES** Insurance Commissioner
Lisa Smittcamp	George Mueller
Name: Lisa A. Smittcamp Title: District Attorney	Name: **George Mueller** Title: Deputy Commissioner
Address: 2220 Tulare Street, Suite 1000 Fresno, CA 93721	
Date: 9/20/18	Date: 10-22-18

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

Crista Hill — 11/5/18

Crista Hill, Budget Officer, CDI — Date

CALIFORNIA DEPARTMENT OF INSURANCE
FRAUD DIVISION

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM

REQUEST FOR APPLICATION
FISCAL YEAR 2018-2019

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FISCAL YEAR 2018-2019

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GRANT APPLICATION CHECKLIST and SEQUENCE
FISCAL YEAR 2018-2019

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?	☒	☐

GRANT APPLICATION TRANSMITTAL

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM

Grant Period: July 1, 2018 to June 30, 2019

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: $ 1,459,063

(2) Estimated Carryover Funds: $ 0

Traci Fritzler,
Assistant District Attorney
(3) *Program Director*

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

(5) *District Attorney's Signature*

Name: Lisa A. Smittcamp

Title: District Attorney

County: Fresno

Address: 2220 Tulare Street, Suite 1000

Fresno, CA 93721

Telephone: (559) 600-3141

Date: 4-19-18

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGRAM CONTACT FORM
FISCAL YEAR 2018-2019

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 #: (559) 600-2135 Fax #: (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 #: (559) 600-4447 Fax #: (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, Suite 1000

   d. Fresno, CA 93721

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

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

BOARD OF SUPERVISORS RESOLUTION
FISCAL YEAR 2018-2019

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, 2018.

COUNTY PLAN: QUALIFICATIONS
FISCAL YEAR 2018-2019

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 2016-2017 and 2017-2018 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 the 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 2016-2017

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

New Cases

Claimant Fraud

The Fraud Unit filed a claimant fraud case involving a farming company worker who sustained an on the job injury. 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, running, twisting and bending his neck all at 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.

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%.

In another claimant fraud case, a dairy worker suffered an 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' compensation 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 claim was submitted, 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 examination she said she could not reach or grasp at eye level or overhead, could not push or pull, could not grip, grasp, hold or manipulate with the right hand. She said she could not perform repetitive motions with the right hand and could not perform forceful activity with the right arm or hand. Investigation revealed that she was working at several employers during her workers' compensation case. One of those employers had her performing grape related harvesting including pruning, leafing, thinning, cluster thinning, and training vines.

In another case, 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, 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.

The final filed applicant fraud case 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' compensation claims in the past for the same body part but denied prior injuries at his deposition and to his PQME.

A new investigation was initiated 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 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 Central Valley Premium Fraud 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.

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 in wages to the insurance company which resulted in a premium loss of approximately $347,351.

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.

Medical Provider Fraud

The Fraud Unit focused on helping CDI and the Consortium set up a new Central Valley Workers' Compensation Fraud Task Force. This Task Force handles all types of workers' compensation fraud with an emphasis on provider fraud. The Fraud Unit worked with CDI to develop new provider fraud investigations. The FBI met with the Task Force to turn over several provider fraud cases that were connected to a larger provider fraud case that resulted in federal indictments of three providers.

In addition, the Department of Industrial Relations was contacted to streamline data mining for the development of new investigations. To further develop cases, the Fraud Unit attended a monthly Healthcare Fraud meeting that was hosted by the U.S. Attorney's Office. Information about providers and updates on investigations as well as prosecutions were shared.

Ongoing Case Activity

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 was collected in restitution.

In one case, an auto repair mechanic was convicted of a felony and sentenced to felony probation and a stipulation to pay $70,073 in restitution.

In another claimant fraud case, the Fraud Unit obtained a misdemeanor conviction and a stipulation to pay $28,043 in restitution. Both of these convictions required the restitution stipulation to be pursuant to Penal Code Section 1214 to better protect the victims. It allows the restitution to be perfected by the victim as a civil judgement.

Open Investigations

The Fraud Unit had 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, in a premium fraud case. The defendants are pending sentencing.

The Fraud Unit had 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 was investigated. The last investigation also involves unreported payroll. The assigned investigator is waiting for an audit to be completed.

The Fraud Unit had 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.

A second provider fraud investigation involved a Durable Medical Equipment provider. Initial investigation found that expensive wrist and knee braces were billed

by the provider, but patients never received these expensive items. Instead, they received a very inexpensive sleeve or support. The investigation progressed with additional insurance companies being contacted to run data analysis.

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

Another investigation was initiated 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.

Fiscal Year 2017-2018

The Fraud Unit filed six claimant fraud cases, four premium fraud cases, and thirty-seven uninsured employer fraud cases.

New Cases

Claimant Fraud

In one claimant fraud case, the employee made material misrepresentations in sworn deposition testimony concerning a prior motor vehicle accident in which the employee suffered a back injury. The applicant exaggerated his physical condition to the PQME. The defendant's self-described medical condition and pain level were contradicted by video surveillance.

In another claimant fraud case, the applicant claimed an injury to his neck and chest after being pinned between a walnut bin and an air machine for thirty seconds. The employer's security camera system did not corroborate the applicant's account that he was pinned, and also confirmed that immediately after the alleged injury, the employee was seen moving around the warehouse without manifesting any apparent physical restrictions or limitations. The defendant's initial treating physician returned him to full duties, although when the defendant did not agree, he sought treatment with his family physician who declared the defendant temporarily partially disabled. The applicant was seen by another doctor who placed him on modified work status and recommended a series of chiropractic treatments for the cervical and thoracic spine. The employer's security video was sent to this doctor. After reviewing the videotape, the doctor stated in a supplemental report: "The videotape showed what actually happened during the period of time the alleged injury occurred... it is obvious that the employee was not pinned or pushed for 30 seconds as described to me. At the most, he might be only lightly contacted by the bin as he quickly moved away from the bin. He quickly resumed his work without showing any

signs of impairment."

In another case, a forklift driver reported an injury to his left side when he lifted four boxes of berries off of the warehouse floor. At a medical appointment, the employee was given work restrictions of no bending, stooping, kneeling, or squatting, and no lifting objects weighing more than 15 pounds. Sub rosa was conducted the same day as this medical appointment. The defendant was observed working on a fence requiring physical activity beyond his work restrictions. The doctor discharged claimant to regular work duties.

The Fraud Unit filed another claimant fraud case in which the defendant made multiple material misrepresentations. Sub rosa was conducted. The statements and video surveillance was provided to medical personnel treating the employee. After review, the doctor's office opined that the claimant failed to accurately represent her subjective complaints, physical abilities, physical limitations, and work status. As a result, the medical finding was made that the defendant could have been returned to full duty at work and deemed at maximum medical improvement as of the date of the sub rosa.

In another claimant case filed in FY 2017-2018, the employee was hired as a seasonal laborer working in vineyards. Several months after being hired the employee reported that his right hand was caught and smashed between metal and a log. His primary treating physician changed his work status to modified duty with no use of his right hand. Shortly after this appointment, sub rosa was taken of the employee building a fence in front of his residence using his right hand without any observed limitations. The sub rosa was shared with his treating physician. After reviewing the surveillance, the claimant's doctor released him back to work with no restrictions.

The final claimant fraud case filed by the Fraud Unit involved a farming employee who alleged an injury while he was standing on a ladder. He fell off the ladder causing him to bump his chest against a tree branch. The employee misrepresented to the AME that he had not worked for more than four years prior to the AME appointment. Sub rosa of the defendant was given to the AME. Based upon the review of the surveillance, the AME changed the employee's impairment ratings, his entitlement to a "pain add-on," his need for future surgery to both shoulders, and his status as a qualified injured worker (which would have entitled the claimant to $12,000 for two supplemental job displacement vouchers).

The Fraud Unit initiated a new claimant fraud investigation involving an employee of an animal center. The claimant stated she injured her knee while cleaning the dog play area. The claimant had previously told several co-workers and supervisors that she injured the knee at a trampoline facility and that she had an old injury from cheerleading. Sub rosa shows claimant only using crutches at her medical appointments and otherwise engaging in normal activities after claiming that she used crutches to go everywhere.

Another new investigation involves an employee of a farming company. He reported that while moving a ladder, a bucket of peaches fell on his head causing a head

injury. The claimant stated to doctors that he had no prior head injuries. Prior medical records contradict these representations.

In another investigation an employee of a farm reported an injury that occurred when he tripped and fell. He reported injuries to his left knee, right wrist, and lumbar. Sub rosa shows claimant exceeding stated limitations to medical professionals. Further misrepresentations at a deposition and at WCAB hearings are being investigated.

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. On August 2, 2017 the Consortium transitioned into the Central Valley Workers' Compensation Fraud Task Force (hereinafter referred to as Task Force). This Task Force served five search warrants, made nine arrests, and obtained five convictions during Fiscal Year 2017-2018. The restitution ordered on these convictions was $2,943,318.

In one premium fraud case, an owner of a property maintenance company failed to properly report payroll over several years. In addition, the business owner dissuaded an employee who suffered an on the job injury by telling the employee that his medical expenses would not be covered. This owner also told another injured employee not to report the industrial injury as a work injury, and the business would reimburse the employee if he used his own health insurance. The premium loss exceeds $100,000.

The Fraud Unit filed a premium fraud case that involved a conspiracy between two individuals to commit insurance fraud by running employee payroll through a separate business in order to reduce the rate of premium. The investigation revealed that a business owner underreported payroll by using a separate business to pay the insured business' employees thereby concealing payroll from two different insurance carriers over multiple policy years. One insurance company suffered loss of premium of $183,613 and the other a loss of $323,115. The second defendant was the controller for the first defendant's business. This controller handled the payroll and insurance related matters. The controller personally misrepresented employee payroll to the insurance carriers at the behest of the business owner.

The Fraud Unit filed another premium fraud case in which the defendant failed to report payroll and also underreported payroll to his insurance companies. CDI Investigative Auditor Christine Smith began the initial case evaluation. Further interviews were conducted. The interviews confirmed that the defendant paid his employees' wages in cash and failed to report these wages to his insurance company or the EDD. Bank records revealed that defendant deposited in excess of $1.4 million during the insurance policy years and declared no payroll for his

employees. The combined loss of premiums for the insurance companies is in excess of $87,000.

In the final premium fraud case filed by the Fraud Unit, a business owner underreported payroll to his insurance company to reduce the amount of premium owed. The business owner failed to report accurately the number of employees and failed to report accurately the classification of his employees. The total unpaid premium is in excess of $233,000.

The Fraud Unit as a member of the Task Force has initiated several premium fraud investigations. In one of the investigations, a company is alleged to be underreporting payroll by improperly representing employees as independent contractors. In another premium fraud investigation a farming company over multiple fiscal years underreported payroll to its insurance company. The company reported payroll to EDD that far exceeded the payroll numbers being reported to the insurance company for each fiscal year. This underreported payroll has generated a potential loss of $314,000.

The Task Force has twenty-two open investigations. Janelle Perez and Sarah Waddell of CDI along with Charles Almaraz and Steve Hatch, both Senior Investigators for the Fraud Unit are assigned fulltime to the Task Force. The other Task Force members participate to the degree that their budget and proximity to Fresno allow.

Medical Provider Fraud

The Task Force commenced on August 2, 2017. The Task Force's MOU establishes an agreement to operate an interagency Workers' Compensation anti-fraud partnership between CDI and the Fresno County District Attorney's Office, the Tulare County District Attorney's Office, the Kings County District Attorney's Office, the Kern County District Attorney's Office, the Merced County District Attorney's Office, the Madera County District Attorney's Office, the California Franchise Tax Board, and the California Employment Development Department. A separate "Memorandum of Understanding" governs the Task Force's operations.

Given the challenges of one investigator working alone in a county to make an impact on workers' compensation fraud in their community, and those that come with working a complex premium fraud or medical provider fraud case that affects multiple counties in the central California region, the idea was formed to work together as a task force to combine our existing resources to fight insurance fraud on a more effective scale with a more robust program through inter-agency cooperation. Smaller agencies and those with new personnel can benefit by shortening their learning curve in working with a task force of experienced personnel as well as ramp up and navigate a larger case much more quickly. Conversely they can participate(schedule permitting) with larger counties working in unison on complex and large scale cases and in enforcement operations such as the execution of search warrants and arrest details. When evidence in these types of cases can be collected in a coordinated effort and the cases completed in a shorter frame, the success of the case and its outcome are significantly improved.

The mission of this Task Force is to successfully investigate and prosecute all areas of workers' compensation fraud in the participating counties in the Central Valley focusing our combined resources on complex medical fraud cases. The Task Force also works on premium fraud and applicant fraud cases as directed by the Insurance Commissioner's goals and objectives. This task force approach will include all areas of workers' compensation fraud, but will be committed to focusing on those cases which have the highest impact in our communities as well as cases that cross county lines.

The Fraud Unit through the Task Force has initiated three new medical provider fraud investigations.

The first provider fraud investigation centers around a licensed clinical psychologist fraudulently billing QME reports. The crux of this investigation is that the med-legal reports are fraudulent in their entirety. The reason for this illegal billing is because there was no legal issue of treatment raised by either the employee or the employer to cause a panel to be formed to choose a qualified medical examiner to render a report. A joint investigation between the Federal Bureau of Investigation, California Department of Insurance and the Fresno District Attorney's Office has uncovered billings for ML102 reports of $193,060, and the psychologist has received $109,369 in payments.

The Task Force is also investigating a PQME who is committing billing fraud regarding med-legal reports. Complexity factors are being manipulated, and med-legal reports are being billed before a dispute in treatment has arisen, which makes the entire billing fraudulent.

The third medical provider fraud investigation involves questions arising from a chiropractor's billings. The chiropractor, after losing his QME certification, billed for two ML-106 supplemental reports and appeared at a deposition. The assigned investigator is following up with the Department of Industrial Relations as part of the investigation.

Ongoing Case Activity

Convictions

$43,388 was collected by the Fraud Unit in restitution this fiscal year.

The Fraud Unit obtained three claimant fraud convictions during FY 2017-2018. $50,683 was ordered in restitution payable to the insurance companies as part of these convictions. These stipulations are all pursuant to Penal Code Section 1214 which enables the insurance company to perfect a civil judgment.

We have several premium fraud cases in court and anticipate convictions in the next few months. The Fraud Unit obtained twenty-six convictions in uninsured employer cases. In one of these uninsured cases, the defendant pled to a felony for fraudulently using a business license without authorization.

Open Investigations

The Task Force has an ongoing medical provider fraud investigation focusing on a doctor billing a specific CPT code in a questionable manner. Data analytics revealed outlier statistics. The analytics show a number of billings per day of appointments requiring 45 minutes face to face with the doctor that exceeded 24 hours. Also kickbacks for food prescriptions in the form of checks for portions of the dispensing fee from the food medication company are being investigated.

The Fraud Unit has a durable medical equipment investigation that is still ongoing pending information from other insurance carriers being received.

A medical provider fraud investigation regarding a billing service has been closed due to evidentiary problems.

The Fraud Unit has an ongoing investigation that identified a Southern California based organization responsible for creating hundreds of millions of dollars of medical bills. The investigation started with a referral from an insurance company regarding questionable med-legal report billing. 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. This case is pending an August 2018 trial date with the US Attorney's Office.

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 Fresno County District Attorney's Office is providing approximately $140,000 from the general budget at a net county cost to supplement the funding received for FY 2017-2018. The Fresno County District Attorney's Office is committed to keeping its current staffing level which allows two senior investigators to remain housed at CDI as part of the Task Force.

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 (DWC)

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 Workers' Compensation Fraud Task Force (Task Force)

The Fraud Unit has been a member of the Central Valley Premium Fraud 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 met on a quarterly basis and coordinates the service of search warrants in multiple counties. This Consortium has been converted into the Task Force.

The Task Force commenced on August 2, 2017. The Task Force's MOU establishes an agreement to operate an interagency Workers' Compensation anti-fraud partnership between CDI and the Fresno County District Attorney's Office, the Tulare County District Attorney's Office, the Kings County District Attorney's Office, the Kern County District Attorney's Office, the Merced County District Attorney's Office, the Madera County District Attorney's Office, the California Franchise Tax Board, and the California Employment Development Department. A separate "Memorandum of Understanding" governs the Task Force's operations.

The mission of this Task Force is to successfully investigate and prosecute all areas of workers' compensation fraud in the participating counties in the Central Valley focusing our combined resources on complex medical fraud cases. The Task Force will also work on premium fraud and applicant fraud cases as directed by the Insurance Commissioner's goals and objectives. This task force approach will include all areas of workers' compensation fraud, but will be committed to focusing on those cases which have the highest impact in our communities as well as cases that cross county lines.

Employment Development Department (EDD)

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 works 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 (FUSD)

The Fraud Unit works with the claims adjusters at 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 (DEA)

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 (FTB)

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.

FORM 06(a)

COUNTY PLAN: STAFFING
FISCAL YEAR 2018-2019

COUNTY OF FRESNO

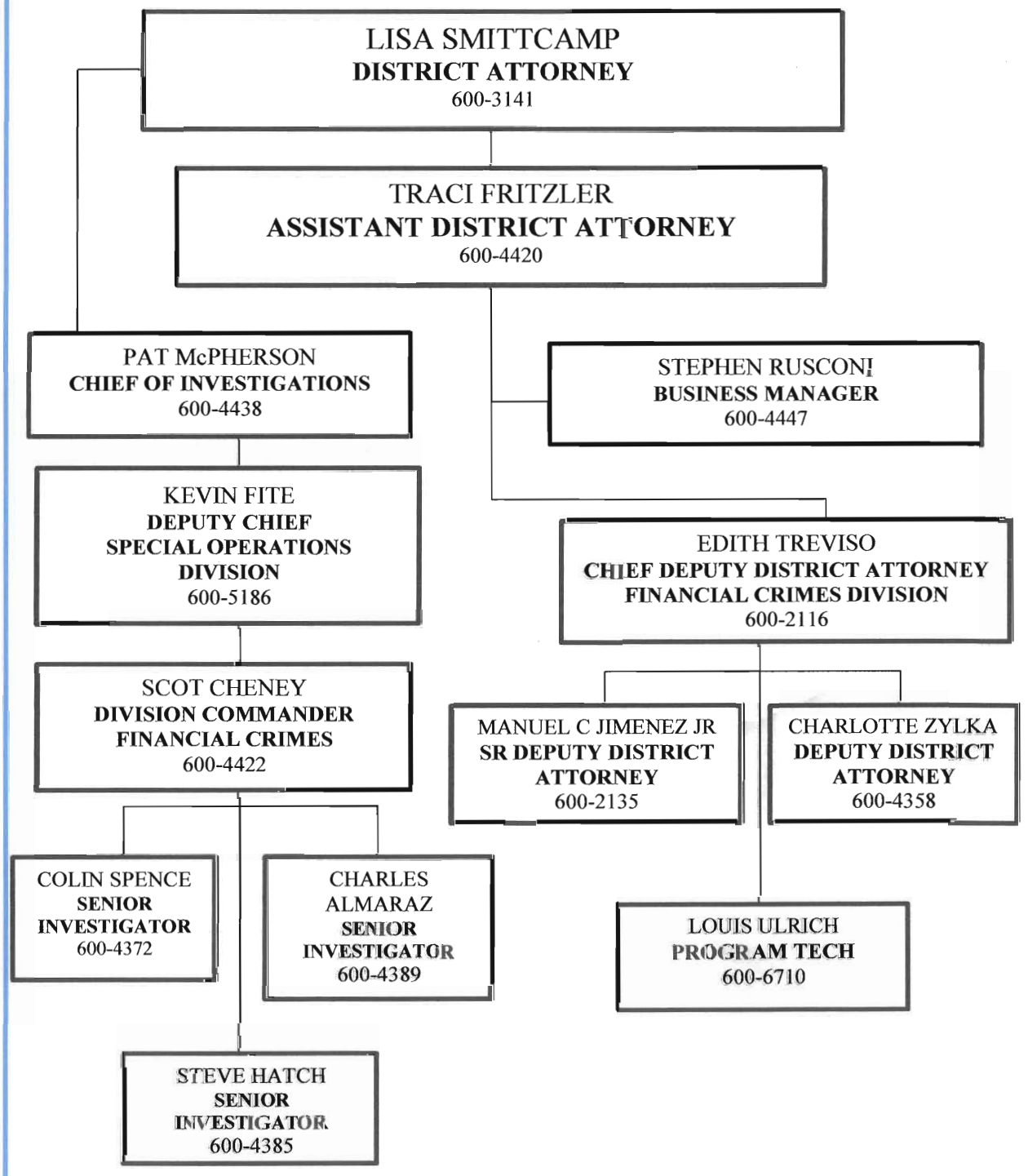
Prosecutors	% Time	Time With Program Start Date/End Date
Manuel C. Jimenez, Jr. – Sr. Deputy District Attorney	100	August 2012 - present
Charlotte Zylka – Deputy District Attorney	100	April 2015 - present

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 2018-2019

ORGANIZATIONAL CHART



COUNTY PLAN: DISTRICT ATTORNEY PROGRAM REPORT
FISCAL YEAR 2018-2019

DAR (FORM 07) is submitted online

STATISTICAL INFORMATION WILL BE CAPTURED

FROM JULY 1, 2017 TO APRIL 15, 2018

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 2018-2019

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 three county in agricultural production in California. (2017 Crop Report) Fresno County is ranked 48th out of all California counties with an unemployment rate of 8.1%. (EDD Monthly Labor Force Report December 2017)

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, 2018)

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 Task Force and one of their agents travels from Sacramento at least once per month for an office day at the CDI Central Valley Regional Office.

Employment Fraud

In a slow economy employers try to reduce costs in any way possible. The Fraud Unit filed thirty-seven 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. 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.

The Fraud Unit through the Task Force has initiated three new medical provider fraud investigations.

One of the provider fraud investigations centers around a licensed clinical psychologist fraudulently billing QME reports. The crux of this investigation is that the med-legal reports are fraudulent in their entirety. The reason for this illegal billing is because there was no legal issue of treatment raised by either the employee or the employer to cause a panel to be formed to choose a qualified medical examiner to render a report.

The Task Force is investigating a PQME who is committing billing fraud regarding med-legal reports. Complexity factors are fraudulently being manipulated to increase billings. Additionally, med-legal reports are being billed before a dispute in treatment has arisen. Therefore, the entire billing is fraudulent.

The third medical provider fraud investigation that the Task Force is investigating involves questions arising from a chiropractor's billings. The chiropractor, after losing his QME certification, billed for tow ML-106 supplemental reports and appeared at a deposition. The assigned investigator is following up with the Department of Industrial Relations as part of the investigation.

The Fraud Unit through the Task Force has one ongoing provider fraud investigation. The 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 Fraud Unit has an ongoing investigation that identified a Southern California based organization responsible for creating hundreds of millions of dollars of medical bills. The investigation started with a referral from an insurance company regarding questionable med-legal report billing. 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. This case is pending an August 2018 trial date with the US Attorney's Office.

COUNTY PLAN: PROGRAM STRATEGY
FISCAL YEAR 2018-2019

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 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 Task Force, the Fraud Unit coordinates with the Fraud Division and Central Valley counties to investigate and prosecute premium fraud. The Task Force prioritizes its resources and focuses on the most serious cases. The Fraud Unit 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. This Task Force investigates all types of complex workers' compensation fraud with an emphasis on provider fraud. Two senior investigators from the Fraud Unit are 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 working with the Task Force 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.

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 will allow investigators to develop complex provider fraud investigations and create efficient sharing of information between agencies. Complex applicant fraud and premium fraud are being 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 two of its three senior investigators at the CDI Central Valley Regional Office. 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.

One of the goals of the Fraud Unit in FY 2018-2019 is to work with the Department of Industrial Relations on a Memorandum of Understanding to facilitate the sharing of data analytic information. This MOU will help streamline provider fraud investigations by the Fraud Unit and the Task Force.

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 impact: 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 our resources. The Fraud Unit has two prosecutors and three senior investigators. Keeping three senior investigators has allowed us to dedicate two of these investigators full time to the

Task Force.

As discussed above, the Task Force has been created. This new task force coordinates 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 are housed at the CDI Central Valley 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 all 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 SIUs 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. The Fraud Unit gave a presentation on workers' compensation fraud to an organization named COOL-Coalition of Organized Labor. The Fraud 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 in partnership with CDI presented another outreach to a group of farm labor contractors. In addition, the Senior District Attorney assigned to the Fraud Unit participated in a radio program focusing on the workers' compensation fraud problem in Fresno County.

In FY 2018-2019 the Fraud Unit will continue to expand its outreach. Staff is always available to speak to employer and employee groups.

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 Task Force are collaborating on finding ways to streamline the larger investigations.

4. Training and Outreach

- List the **training received** by each county staff member in the workers' compensation fraud unit **during Fiscal Years 2016-2017 and 2017-2018**.

- Describe what kind of training/outreach **you provided in Fiscal Year 2017-2018** 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 2018-2019**.

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

- September 2016-CDAA Fraud Symposium
- April 2017-Workers' Compensation Fraud Roundtable " An Investigator's Perspective on Provider Fraud" by Dan Harkness
- April 2017-NCFIA Anti-Fraud Conference
- October 2017-CDAA Fraud Symposium
- April 2018-NCFIA Anti-Fraud Conference

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

- September 2016-CDAA Fraud Symposium
- April 2017-Workers' Compensation Fraud Roundtable-"An Investigator's Perspective on Provider Fraud" by Dan Harkness
- April 2018-NCFIA Anti-Fraud Conference

Charles Almaraz, Senior Investigator, attended the following training:

- September 2016-Fresno State University Leadership Conference
- April 2017-Workers' Compensation Fraud Roundtable "An Investigator's Perspective on Provider Fraud" by Dan Harkness
- April 2017-NCFIA Anti-Fraud Conference
- April 2018-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:

- 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' Compensation Fraud Roundtable "An Investigator's Perspective on Provider Fraud" by Dan Harkness
- October 2017-CDAA Fraud Symposium
- February 2018-Premium Fraud Training

Steve Hatch, Senior Investigator, attended the following training:

- April 2017-Workers' Compensation Fraud Roundtable-"An Investigator's Perspective on Provider Fraud" by Dan Harkness

Outreach Provided in Fiscal Year 2016-2017

- 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

Outreach Provided in Fiscal Year 2017-2018

- August 2017-Workers' Compensation Presentation at Zenith Insurance
- October 2017-PIWC – Work Comp. Reality Check-Fraud Revisited
- February 2018-Farm Labor Contractors Presentation
- March 2018-Fresno State University Craig School of Business Presentation
- April 2018-KMJ 580 Radio Interview on Workers' Compensation Fraud

Training/Outreach Planned for Fiscal Year 2018-2019

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 attorneys and 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 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 $43,388 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. 40 new investigations will be initiated during FY 2018-2019

   b. 25 new prosecutions will be initiated during FY 2018-2019

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.

$ 1,459,063 FY 2018-2019 Grant REQUEST	$ 1,135,400 FY 2017-2018 Grant AWARD	$ 323,663 FY 2018-2019 Increase Requested

Utilization Plan:

The Fraud Unit is requesting additional funding for Fiscal Year 2018-2019 to maintain staffing and continue dedicating two full time senior investigators to the Task Force. In addition, the Fraud Unit is also requesting funding for two vehicles to replace grant vehicles purchased by the Fraud Unit more than a decade ago.

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: PERSONNEL SERVICES
FISCAL YEAR 2018-19

COUNTY NAME: FRESNO

A. PERSONNEL SERVICES: Salaries and Employee Benefits		COST
(1) SENIOR DEPUTY DISTRICT ATTORNEY:		
This position devotes 100% of time to this program.		
Annual salary:	$139,667	$ 139,667
Benefits:		
Retirement: ($139,667 @ .6583)	$91,943	
OASDI: ($139,667 *.0765)	$10,685	
Health Ins- Annual:	$7,647	
Unemployment: ($139,667 @ .00067)	$94	
Workers Comp: ($139,667 @ .010293)	$1,438	
Admin Fee- Annual:	$120	$ 111,927
(1) DEPUTY DISTRICT ATTORNEY IV:		
This position devotes 100% of time to this program.		
Annual salary:	$129,702	$ 129,702
Benefits:		
Retirement: ($129,702 @ .6583)	$85,383	
OASDI: ($129,702 *.0765)	$9,922	
Health Ins-Annual:	$7,647	
Unemployment: ($129,702 @ .00067)	$87	
Workers Comp: ($129,702 @ .010293)	$1,335	
Admin Fee- Annual:	$120	$ 104,494
(3) SENIOR DEPUTY DISTRICT ATTORNEY INVESTIGATORS:		
These positions devote 100% of their time to this program.		
Annual salary: 3 @ $96,665	$289,995	$ 289,995
Overtime:	$5,000	$ 5,000
Benefits:		
Retirement: 3 @ ($96,665 @ .8819)	$255,747	
OASDI: 3 @ ($96,665 *.0765)	$22,185	
Health Ins-Annual: 3 @ $7,647	$22,941	
Unemployment: 3@ ($96,665 @ .00067)	$194	
Workers Comp: 3@ ($96,665 @ .010293)	$2,985	
Admin Fee- Annual: 3* $120	$360	$ 304,412

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGAM BUDGET: PERSONNEL SERVICES
FISCAL YEAR 2018-19

COUNTY NAME: FRESNO

A. PERSONNEL SERVICES: Salaries and Employee Benefits		COST
(1) PROGRAM TECHNICIAN:		
This position devotes 100% of time to this program.		
Annual salary:	$53,326	$ 53,326
Benefits:		
Retirement: ($53,326 @ .6583)	$35,105	
OASDI: ($53,326 *.0765)	$4,079	
Health Ins-Annual:	$7,647	
Unemployment: ($53,326 @ .00067)	$36	
Workers Comp: ($53,326 @ .010293)	$549	
Admin Fee- Annual:	$120	$ 47,536
Membership Dues:		
California Bar Dues 2 @$380	$760	
CDAIA 3 @ $25	$75	$ 835
SUMMARY:		
Salaries	$612,690	
Overtime	$5,000	
Benefits	$568,369	
Dues	$835	
TOTAL	**$1,186,894**	
A. PERSONNEL SERVICES TOTAL		**$ 1,186,894**

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: OPERATING EXPENSES
FISCAL YEAR 2018-19

COUNTY NAME: FRESNO

B. OPERATING EXPENSES	COST
MOBILE COMMUNICATIONS:	$ 8,000
LIABILITY INSURANCE:	$ 250
MAINTENANCE-EQUIPMENT:	$ 2,700
OFFICE EXPENSE:	$ 4,000
POSTAGE:	$ 500
DATA PROCESSING:	$ 33,000
PROFESSIONAL & SPECIALIZED SERVICES:	$ 6,000
COMPUTER SERVICE SOFTWARE:	$ 2,500
PUBLICATIONS:	$ 600
RENTS & LEASES - BUILDINGS:	$ 45,000
FACILITY MAINTENANCE:	$ 2,500
SMALL TOOLS:	$ 5,000
MILEAGE:	$ 350
TRANSPORTATION, TRAVEL, & EDUCATION:	$ 7,500
TRANSPORTATION & TRAVEL - FLEET:	$ 17,000
INDIRECT COSTS: (10% * Salaries ($612,690))	$ 61,269
B. OPERATING EXPENSE TOTAL	**$ 196,169**

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: EQUIPMENT
FISCAL YEAR 2018-19

COUNTY NAME: FRESNO

B. EQUIPMENT	*COST*
(2) INVESTIGATOR VEHICLES: Vehicles will be used by the program investigators for Worker's Compensation Insurance Fraud activities. This cost includes equipment and installation.	$ 76,000
C. EQUIPMENT TOTAL	**$ 76,000**
D. PROGRAM BUDGET TOTAL	**$ 1,459,063**

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: EQUIPMENT LOG
PRIOR FISCAL YEAR 2017-2018

COUNTY NAME: FRESNO

Equipment Ordered	Equipment Cost	Date Ordered	Date Received	Serial Number	Equipment Tag Number

Rows can be inserted as needed.

☒ **No equipment purchased.**

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

Name: Manuel C. Jimenez Jr Title: Deputy District Attorney

Signature: Manuel C. Jimenez Jr Date: 4/23/18

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 Central Valley 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.

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 CDI 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 aspects 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 investigating 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 day 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 the Captain's 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. Certified Court Minute Orders on all workers' compensation convictions in Fresno County will be provided to CDI as soon as possible.

VI. TRAINING

CDI 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 vice versa. In this way both offices will conduct outreach together to employers, carriers and the public.

VII. PROBLEM RESOULTION

With CDI 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 CDI, and the Chief Attorney for the Fraud Unit shall meet and confer.

VIII. CENTRAL VALLEY WORKERS' COMPENSATION FRAUD TASK FORCE

The Central Valley Workers' Compensation Fraud Task Force(hereinafter referred to as "Taskforce") commenced on August 2, 2017. The Taskforce's MOU establishes an agreement to operate an interagency Workers' Compensation anti-fraud partnership between CDI and the Fresno County District Attorney's Office, the Tulare County District

Attorney's Office, the Kings County District attorney's Office, the Kern County District Attorney's Office, the Merced County District Attorney's Office, the Madera County District Attorney's Office, the California Franchise Tax Board, and the California Employment Development Department. A separate "Memorandum of Understanding" governs the Taskforce's operations.

Given the challenges of one investigator working alone in a county to make an impact on workers' compensation fraud in their community, and those that come with working a complex premium fraud or medical provider fraud case that affects multiple counties in the central California region, the idea was formed to work together as a task force to combine our existing resources to fight insurance fraud on a more effective scale with a more robust program through inter-agency cooperation. Smaller agencies and those with new personnel can benefit by shortening their learning curve in working with a task force of experienced personnel as well as ramp up and navigate a larger case much more quickly. Conversely they can participate(schedule permitting) with larger counties working in unison on complex and large scale cases and in enforcement operations such as the execution of search warrants and arrest details. When evidence in these types of cases can be collected in a coordinated effort and the cases completed in a tighter frame, the success of the case and its outcome are significantly improved.

The mission of this Taskforce is to successfully investigate and prosecute all areas of workers' compensation fraud in the participating counties in the Central Valley focusing our combined resources on complex medical fraud cases. The Task Force will also work on premium fraud and applicant fraud cases as directed by the Insurance Commissioner's goals and objectives. This task force approach will include all areas of workers' compensation fraud, but will be committed to focusing on those cases which have the highest impact in our communities as well as cases that cross county lines.

IX. EMPLOYERS WHO ARE WILLFULLY UNINSURED

CDI and the Fraud Unit are committed to working together to 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. 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 high 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 principals governing the relationship. Both agencies further agree that the ultimate goal is to reduce workers' compensation insurance fraud in Fresno County.

Date 4/19/18

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

Date April 12, 2018

Kathleen Rooney
Assistant Chief
California Department of Insurance
Fraud Division