INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

GRANT AWARD AGREEMENT

Fiscal Year 2019-20

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, 2019** through **June 30, 2020.**

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 **$1,275,026.** 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	**RICARDO LARA** Insurance Commissioner
Lisa A. 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: 9/12/19	Date: 10/17/19

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

Crista Hill
Crista Hill, Budget Officer, CDI

10/21/19
Date

CALIFORNIA DEPARTMENT OF INSURANCE
FRAUD DIVISION

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM

REQUEST FOR APPLICATION
FISCAL YEAR 2019-2020

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FISCAL YEAR 2019-2020

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FORM 01

GRANT APPLICATION CHECKLIST and SEQUENCE
FISCAL YEAR 2019-2020

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, 2019 to June 30, 2020

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 93727

Telephone: (559) 600-2135

(1) New Funds Being Requested: $ 1,429,879

(2) Estimated Carryover Funds: $ 110,000

Traci Fritzler,
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: (559) 600-3141

Date: 4/12/19

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGRAM CONTACT FORM
FISCAL YEAR 2019-2020

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

      Fresno, CA 93721

   d. E-mail address: mcjimenez@fresnocountyca.gov

   e. 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

      Fresno, CA 93721

   d. E-mail address: srusconi@fresnocountyca.gov

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

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

   a. Name: Manuel C. Jimenez Jr.

   b. Title: Sr. Deputy District Attorney

   c. Address: 2220 Tulare Street, Suite 1000

      Fresno, CA 93721

   d. E-mail address: mcjimenez@fresnocountyca.gov

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

FORM 04

BOARD OF SUPERVISORS RESOLUTION
FISCAL YEAR 2019 – 2020

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, 2019.

COUNTY PLAN: QUALIFICATIONS
FISCAL YEAR 2019-2020

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 05 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.
- Information concerning investigations should be general and are subject to disclosure under a PRA request or subpoena. Investigation details that are confidential should be provided only in Attachment B, Part 1, FORM 05.

1. What areas of your workers' compensation insurance fraud operation were successful and why?
    - Detail your program's successes for the 2017-2018 and 2018-2019 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 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 a sworn deposition, 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.

Another 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 check 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. This investigation resulted in a new claimant fraud case filed in FY 2018-2019.

Premium Fraud

The Central Valley Workers' Compensation Fraud Task Force (hereinafter referred to as 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 $629,829.91 and the other a loss of $323,115. The business owner was convicted of Insurance Code Section 11880(a) and sentenced to 2 years state prison stipulation to restitution in full in the amounts previously stated.

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 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 Employment Development Department (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.

Janelle Perez and Sarah Waddell of CDI, along with Charles Almaraz and Steve Hatch, both Senior Investigators of the Fraud Unit, are assigned full–time 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 (FTB), and EDD. 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 interagency 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 execution of search warrants and arrest details. When evidence in these types of cases, can be collected in 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 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 areas in which they 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 centered on 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 that there was no legal issue of treatment raised by either the employee or the employer to create the need for 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 District Attorney's Office has uncovered billings for ML 102 reports of $193,060, and the psychologist has received $109,369 in payments.

The Task Force investigated 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 involved 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

The Fraud Unit collected $43,388 in restitution in FY 2017-2018.

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. 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. In addition, 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.

Fiscal Year 2018-2019

The Fraud Unit filed six claimant fraud cases, two premium fraud cases, and twenty–one uninsured employer fraud cases.

New Cases

Claimant Fraud

In one claimant fraud case, the claimant was packing and lifting grapes in a cold storage facility when she reported a back injury. Surveillance video was obtained of the claimant cleaning her car. The observed actions were inconsistent with her reported limitations. This surveillance video was examined by the claimant's primary care physician, neurologists, and physical therapist who all concluded that the claimant misrepresented her injury, condition, and limitations during the examinations. Claimant was immediately released back to work without any restriction.

In another claimant fraud case, the claimant reported suffering an injury while pulling up irrigation lines. The claimant was working too close to a trailer when he slipped and fell. The trailer struck his leg and foot. The claim was accepted. The defendant malingered by misrepresenting his limitations in several PQME appointments. Furthermore, the defendant was observed on surveillance video working at another place of employment exceeding his limitations represented to the doctors. The defendant committed perjury at a deposition when asked about his concurrent employment while receiving total temporary disability payments.

The Fraud Unit filed a claimant fraud case in which the defendant failed to disclose prior medical treatment. The defendant claimed to have injured his left pinky by a frozen chicken making contact with his left hand while handling the product. Eight months earlier the defendant received treatment at a hospital after a pipe fell on his left hand. The defendant received treatment for his work injury, which was determined to be a left pinky dislocation, and the noted objective finding was a left finger deformity. The defendant claimed to have no past medical history to multiple medical providers. The AME initially provided 100% apportionment to the defendant for his industrial injury but later reduced that to 50% after reviewing prior medical records.

Another claimant fraud case involved a dog park associate of an animal center in Fresno. She claimed that she injured her right knee while stepping down from a cement platform. She was retrieving a Frisbee that had become lodged in a fence. Prior to the reporting of this injury, the defendant told multiple coworkers that she had recently re-injured an old high knee at a trampoline park with her

boyfriend. She was observed by the coworkers visibly limping prior to the date of the reported industrial injury. The defendant appeared to present differently when attending medical visits and at work when observed in surveillance video.

The Fraud Unit filed an AOE/COE claimant fraud case in which a farm laborer sustained injuries at a job site: facial injuries, including nasal fracture, lacerations, and contusions resulting in a six-day hospitalization. The defendant claimed he tripped and fell while carrying a box of fruit. However, several witnesses saw the defendant involved in a physical altercation with another employee. The defendant initiated the physical contact, and the coworker punched the defendant in the face. The defendant lied to several medical practitioners about the circumstances surrounding his injuries.

In another claimant fraud case, the defendant reported an on-the-job injury to her right foot due to repetitive use at work. Investigation uncovered the defendant visiting the emergency room at another hospital reporting an injury to the same foot due to use of her treadmill at home.

The Fraud Unit has initiated an investigation into a case in which a farm laborer injured his back while picking up brush from pruned trees. The claimant was off work for an extended period and reported an extremely high pain level. Surveillance video captured the claimant running errands without limitation and only using a cane when seeing a doctor.

The Fraud Unit has begun several other claimant fraud investigations that appear promising.

Premium Fraud

The Fraud Unit has been a member of the Task Force since its inception on August 2, 2017. Staff coordinates with other attorneys and investigators from the Department of Insurance, Kern County, Tulare County, Kings County, Madera County, and Merced County on high-impact premium fraud cases. The EDD and the FTB are also members of the Task Force.

For FY 2018–2019, the Task Force served 10 search warrants, made six arrests, and obtained eight convictions. The restitution ordered on those convictions was $2,240,899.

The Fraud Unit filed a premium fraud case against the owner of a masonry company. The investigation started when an employee suffered an injury. The adjusting of the claim revealed wages, number of employees, and potential misclassification to falsely reduce premium. The defendant misrepresented a higher classification of employee to achieve a lower premium. In addition, the defendant underreported payroll.

The second premium fraud case started out with an anonymous phone call that the owner of a company was committing workers' compensation fraud. The caller stated that the defendant was not listing all his employees and was classifying them at the lowest classification. The caller further stated that he knew that three of the employees were receiving 1099s when they were actually employees. This issuing of the 1099s was done to help the employees avoid child support payments. The defendant misrepresented payroll and misclassified his employees.

The Task Force has started several new premium fraud investigations involving underreporting of payroll, cash pay, and x-mod evasion. The Task Force is currently assessing for viability the investigation of several PEO companies for piggybacking client policies without the approval of the insurer.

Medical Provider Fraud

The Task Force prioritized working the cases opened in FY 2017–2018. The Fraud Unit anticipates charging in this fiscal year the provider investigation involving a PQME committing billing fraud regarding med–legal reports. The provider manipulated complexity factors to increase the amount billed to the insurance companies. In addition, the med–legal reports were being billed before a dispute in treatment had arisen. As a result these reports are not valid med–legal reports.

The Fraud Unit is also close to the end of the investigation regarding the licensed clinical psychologist fraudulently billing QME reports.

The Fraud Unit closed the third medical provider fraud investigation involving questionable chiropractor billings. The closure was due to evidentiary issues resulting from written direction from the Department of Industrial Relations to the chiropractor regarding limitations on his status as a QME once his certification lapsed.

Ongoing Case Activity

Convictions

$36,746.53 was collected by the Fraud Unit in restitution this fiscal year.

The Fraud Unit obtained two premium fraud convictions, one claimant fraud conviction and fourteen convictions in uninsured employer cases.

On one of the premium fraud convictions the defendant was sentenced to two years prison and ordered to pay $629,829.10 to State Compensation Fund and $323,115 to AIG.

Open Investigations

The Task Force has opened two voucher fraud investigations and has recently received information that may lead to the opening of several more voucher fraud investigations. Fresno County and Kern County are investigating these two cases. The essence of these investigations is vocational rehabilitation schools enrolling students through cappers in a fraudulent scheme involving kickbacks to cappers and attorneys. Often services billed by the school are not performed. In certain instances, the students are enrolled without their knowledge. In other situations, the students do not meet the minimum qualifications to receive the vocational rehabilitation.

The Task Force closed out two medical provider fraud investigations due to insufficient evidence.

2. Specify any unfunded contributions and support (i.e., financial, equipment, personnel, and technology) 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 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. Due to retirements and office needs, the Fraud Unit has experienced unusual turnover during FY 2018-2019. The Fraud Unit is prioritizing training within the unit and training offered by the Central Valley Regional Office at CDI to accelerate the learning curve for its new members.

Chief Gerald (Jerry) A. Stanley has supervised the Fraud Unit since 2018. He took over for Edith Treviso who retired. In this position, he supervises the Fraud Unit as

well as the other Department of Insurance Grant units. He is 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 Melanie Taylor, after Charlotte Zylka retired in October 2018, was assigned to the Fraud Unit in April 2019. She is an experienced attorney with over twenty–three years experience as a prosecutor in the Fresno County District Attorney's Office.

Senior Investigator Charles Almaraz has been working in the Fraud Unit since May 2013. Investigator Almaraz has seventeen years of law enforcement. 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, who was assigned to the Fraud Unit in 2016, was transferred in November 2018. Senior Investigator Kelly Mayfield has been working in the Fraud Unit since December 2018.

Senior Investigator Colin Spence who was assigned to the Fraud Unit since 2015 was transferred out of the Fraud Unit at the beginning of FY 2018–2019. Senior Investigator Jesus Perez was assigned to the Fraud Unit from July to November. Senior Investigator Terrence Holly has been working in the Fraud Unit since December 2018. He has over twenty–five years of experience as a Senior Investigator in the Fresno County District Attorney's Office. He has more than ten years of fraud experience working in the Real Estate Fraud, Identity Theft, and Welfare Fraud units.

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, FTB, and EDD. 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 (DOL)

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

Workers' Compensation Appeals Board (WCAB)

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 that are filed.

United States Postal Service (USPS)

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 Risk Management Department at the County of Fresno. Claimant fraud referrals are the forwarded to the Fraud Unit.

City of Parlier

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

Department of Homeland Security Investigations (DHS)

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 identities of claimant fraud suspects.

Federal Bureau of Investigations (FBI)

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.

Drug Enforcement Administration (DEA)

The Fraud Unit investigators and DEA diversion investigators collaborate 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 (CDC)

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 (FPD)

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 2019-2020

COUNTY OF FRESNO

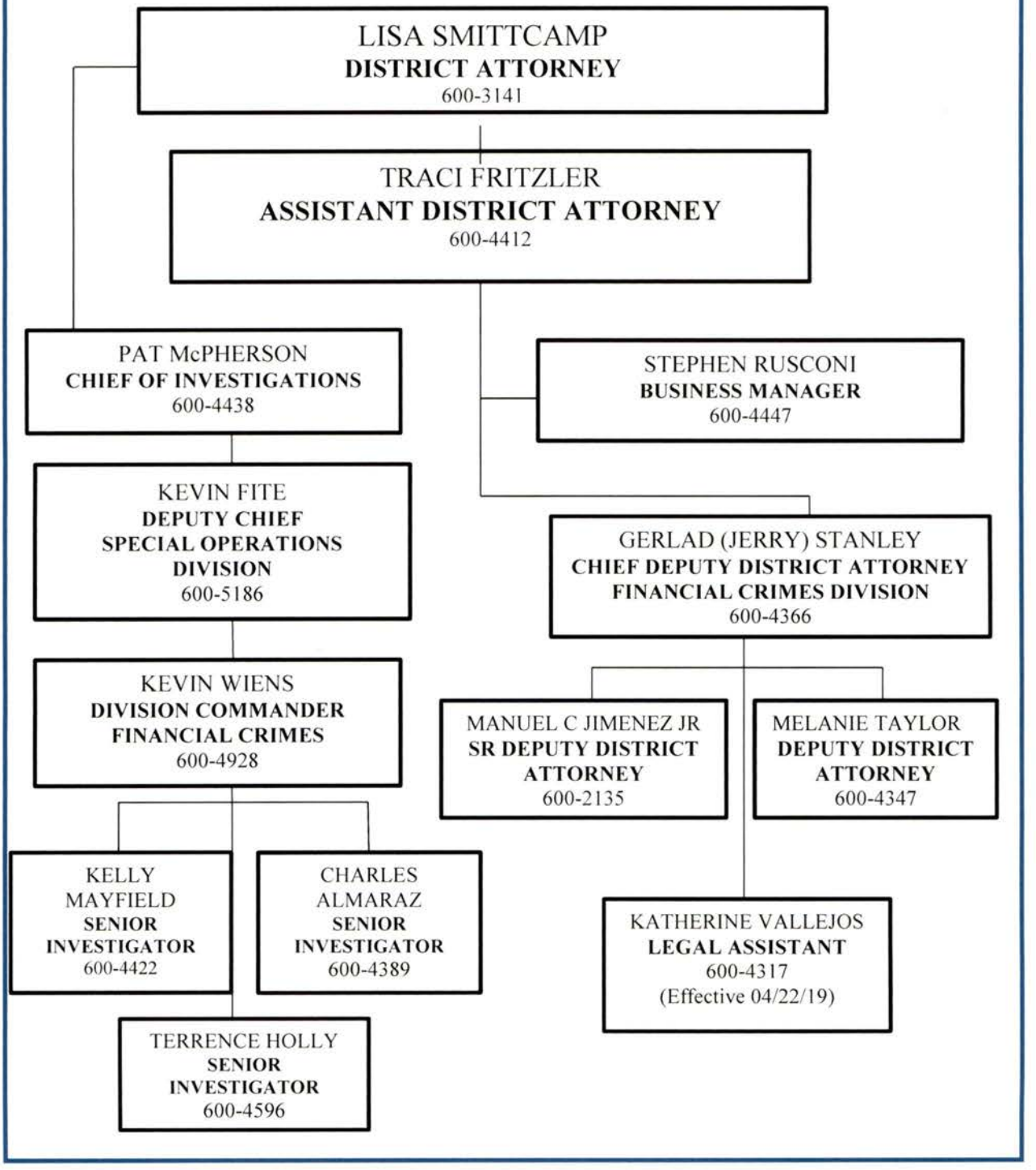
Prosecutors	% Time	Time With Program Start Date/End Date
Manuel C. Jimenez, Jr. – Sr. Deputy District Attorney	100	August 2012-present
Melanie Taylor – Deputy District Attorney	100	April 2019-present
Charlotte Zylka – Deputy District Attorney	100	July 2018-October 2018

COUNTY OF FRESNO

Investigators	% Time	Time With Program Start Date/End Date
Charles Almaraz – Senior Investigator	100	May 2013-present
Terrence Holly – Senior Investigator	100	December 2018-present
Kelly Mayfield – Senior Investigator	100	December 2018-present
Jesus Perez – Senior Investigator	100	July 2018–November 2018
Steve Hatch – Senior Investigator	100	January 2016–November 2018

COUNTY PLAN: ORGANIZATIONAL CHART
FISCAL YEAR 2019-2020

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, 2018 TO APRIL 15, 2019

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 2019-2020

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 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 salesperson. (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. 53.2% of the households in Fresno County are Spanish–speaking. 25.4 % of the population live below the poverty line. There are an estimated 539,299 people who are eighteen years or older. Of that amount, 22.3%, 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.

Fresno County's high unemployment rate provides additional incentive to injured workers to misrepresent a non–industrial injury as industrial or to malinger. The dim prospects of finding alternative work make the option of fraudulently receiving workers' compensation benefits 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. In addition, many auditor positions have been eliminated because 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 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 twenty–two 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.

Medical Provider Fraud

Medical 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 for the last two fiscal years made medical provider fraud investigation a priority. The Task Force anticipates filing a medical provider fraud case before the end of this fiscal year. This investigation focuses on PQME fraudulently billing med–legal reports.

COUNTY PLAN: PROGRAM STRATEGY
FISCAL YEAR 2019-2020

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 continue maintain close contact with Special Investigation Units and Third Party Administrations when FD-1's are received that warrant investigation. The Fraud Unit will continue to work 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 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 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, theTask 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 2019-2020 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 of these goals 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 prioritize the prosecution of 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 California State University, Fresno 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 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 Deputy 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 has continued to expand its outreach. The Fraud Unit, along with CDI presented to a California Farm Labor Contractor association forum on "Managing and Preventing Potential Fraud in Work Injury Claims." The presentation was well received and has yielded referrals to CDI.

In FY 2019–2020, The Fraud Unit will continue to expand its outreach. The priority will be reaching out to the Spanish speaking community and the labor force. Social media, print media, radio, and television opportunities will be explored. The Fraud Unit will also make contact with individual employers' human resource departments

to schedule outreach. Additionally, any significant convictions by the Fraud Unit will be highlighted with press release.

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 **insurance fraud training received** by each county staff member in the workers' compensation fraud unit **during Fiscal Years 2017-2018 and 2018-2019**.

- Describe what kind of training/outreach **you provided in Fiscal Year 2018-2019** 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. Do not include presentation materials (e.g., fliers, power points, sign in sheets).

- Describe what kind of training/outreach **you plan to provide in Fiscal Year 2019-2020**.

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

- October 2017 – CDAA Fraud Symposium
- April 2018 – NCFIA Anti–Fraud Conference
- April 2017 – NCFIA Anti-Fraud Conference
- July 2018 – Labor Commissioner Julie A. Su Training Re LC 238.5 and 1423–1429
- September 2018 – Essential Strategies to Combat Voucher Fraud
- October 2018 – CDAA Fraud Symposium
- April 2019 – NCFIA Anti–Fraud Alliance

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

- April 2018 – NCFIA Anti–Fraud Conference

Colin Spence, Senior Investigator, attended the following training:

- October 2017 – CDAA Fraud Symposium
- February 2018 – Premium Fraud Training

Jesus Perez, Senior Investigator, attended the following training:

- August 2018 – CDI Applicant and Premium Fraud Training
- October 2018 – CDAA Fraud Symposium

Steve Hatch, Senior Investigator, attended the following training:

- September 2018 – Essential Strategies to Combat Voucher Fraud

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.

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

Outreach Provided in Fiscal Year 2018–2019

- October 2018 – PIWC – Revisiting Fraud in Workers' Comp
- November 2019 – CFLCA Ag Labor Forum–"Managing and Preventing Potential Fraud in Work Injury Claims"
- March 2019 – Fresno State University Craig School of Business Presentation

Training/Outreach Planned for Fiscal Year 2019–2020

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 the 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 California State University, Fresno. The Fraud Unit will look to target the labor force 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 this letter is unsuccessful, staff contacts the Probation Department and the defendant's attorney and calendars a Probation Violation hearing. The Fraud Unit has collected $36,746.53 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. Project a count you expect to **actively** investigate. Do not include cases that are open and assigned but have little or no expectation of being worked.

   Projection for FY 2019-2020:

   a. ___40___ new investigations will be opened and worked during FY 2019-2020

   b. ___25___ new prosecutions will be initiated during FY 2019-2020

   Prior year's projection from FY 2018-2019 submitted RFA:

   c. ___40___ new investigations will be initiated during FY 2018-2019

   d. ___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.

$ 1,429,879 FY 2019-2020 Grant REQUEST	$ 1,218,180 FY 2018-2019 Grant AWARD	$ 211,699 FY 2019-2020 Increase Requested

Utilization Plan:

The Fraud Unit is requesting additional funding for Fiscal Year 2019–2020 to maintain staffing and continue dedicating two full time senior investigators to the 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 employers' problem.

The Fraud Unit has a close relationship with CSLB. The Fraud Unit not only participates in sting operations but also answers questions regularly meets with investigators to receive the most up to date information on the uninsured employer problem in Fresno.

FORM 10

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
BUDGET: PERSONNEL SERVICES
FISCAL YEAR 2019-2020

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:	$144,168	$144,168
Benefits:		
Retirement: *($144,168 @ .6480)*	$93,421	
OASDI: *($144,168 *.0145) + ($128,400*.062)*	$10,051	
Health Ins- Annual:	$11,641	
Unemployment:	$98	
Workers Comp:	$672	
Admin Fee- Annual:	$111	$115,994
(1) DEPUTY DISTRICT ATTORNEY IV:		
This position devotes 100% of time to this program.		
Annual salary:	$133,936	$133,936
Benefits:		
Retirement: *($133,936 @ .6480)*	$86,791	
OASDI: *($133,936 *.0145) + ($128,400*.062)*	$9,903	
Health Ins-Annual: $8,643		
Unemployment:	$98	
Workers Comp:	$672	
Admin Fee- Annual:	$111	$106,218
(3) SENIOR DEPUTY DISTRICT ATTORNEY INVESTIGATORS:		
These positions devote 100% of their time to this program.		
Annual salary: *3 @ $100,336*	$301,008	$301,008
Overtime:	$5,000	$5,000
Benefits:		
Retirement: *3 @ ($100,336 @ .9218)*	$277,469	
OASDI: *3 @ ($100,336 *.0765)*	$23,027	
Health Ins-Annual: *3 @ $11,597*	$34,791	
Unemployment: Annual *3* $98*	$294	
Workers Comp: Annual *3* $672*	$2,016	
Admin Fee- Annual: *3* $111*	$333	$337,930

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
BUDGET: PERSONNEL SERVICES
FISCAL YEAR 2019-2020

COUNTY NAME: FRESNO

A. PERSONNEL SERVICES: Salaries and Employee Benefits			*COST*
(1) SENIOR LEGAL ASSISTANT:			
This position devotes 100% of time to this program.			
Annual salary:		$49,893	$49,893
Benefits:			
Retirement: *($49,893 @ .6480)*		$32,331	
OASDI: *($49,893 *.0765)*		$3,817	
Health Ins-Annual:		$8,642	
Unemployment:		$98	
Workers Comp:		$672	
Admin Fee- Annual:		$111	$45,671
Membership Dues:			
California Bar Dues *2 @$380*		$760	$760
SUMMARY:			
Salaries	$629,005		
Overtime	$5,000		
Benefits	$605,813		
Dues	$760		
TOTAL	**$1,240,578**		
A. PERSONNEL SERVICES TOTAL			**$1,240,578**

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: OPERATING EXPENSES
FISCAL YEAR 2019-2020

COUNTY NAME: FRESNO

B. OPERATING EXPENSES	COST
MOBILE COMMUNICATIONS: *24/7 radio network access ($87.50*4 radios*12 mos.)*	$4,200
LIABILITY INSURANCE: *rates set by County Risk Management* $ 400	$400
MAINTENANCE-EQUIPMENT: *repairs and maintenance of office equipment* $ 2,700	$2,700
OFFICE EXPENSE: *routine office supplies* $ 3,500	$3,500
POSTAGE: *cost of mailing correspondence, legal documents, and subpoenas*	$600
DATA PROCESSING: *computer network access (connections, air cards, file storage), phone network and hardware, cellular voice and data, and software license renewals*	$37,500
PROFESSIONAL & SPECIALIZED SERVICES: *costs may include records management copies of vital records and court proceedings, and prorated cost of annual audit*	$6,000
PUBLICATIONS: *costs for required attorney publication materials*	$1,500
RENTS & LEASES - BUILDINGS: *prorated costs of office space and facility maintenance*	$42,500
TRANSPORTATION, TRAVEL, & EDUCATION: *transportation, mileage, meals, and registration fees for program related in-state travel/training*	$9,500
TRANSPORTATION & TRAVEL - FLEET: *program vehicle operation & maintenance costs*	$18,000
INDIRECT COSTS: *(10% * Salaries ($629,005))*	$62,901
B. OPERATING EXPENSE TOTAL	**$189,301**

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: EQUIPMENT
FISCAL YEAR 2019-2020

COUNTY NAME: FRESNO

C. EQUIPMENT	*COST*
C. EQUIPMENT TOTAL	**$ -**
D. PROGRAM BUDGET TOTAL	**$1,429,879**

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: EQUIPMENT LOG
PRIOR FISCAL YEAR 2018-2019

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 Title: Senior Deputy District Attorney

Signature: Manuel C. Jimenez Date: 4/15/19

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, the Fraud Unit will assign a prosecutor to the case to serve as a legal resource for CDI detectives. The assigned attorney and CDI detective will develop a litigation plan. This action is consistent with and supports the philosophy of vertical prosecution. 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.

Vertical prosecution shall be used for all cases investigated. Vertical prosecution means the case detective from CDI or the Fraud Unit will communicate with the assigned prosecutor when the case is assigned for investigation. The assigned prosecutor and detective will meet in person or via telephone prior to starting the investigation. They will discuss the viability of the case, the investigative plan, and schedule meetings and case updates throughout the investigation.

a. Pursuant to the above provision, and to maximize the efficient and effective expenditure of resources, it is expected that each party will conduct its investigations independently in most cases. However, it is understood and agreed that either party will provide assistance to the other upon request in any investigation where such assistance is needed. This could include serving search warrants, interviewing witnesses, making arrests, etc.

b. Joint investigation may be undertaken in cases where the parties determine it is beneficial to combine resources to achieve the most efficient and effective result. This will be determined on a case-by-case basis. The Fraud Division detective(s) and the assigned prosecutor shall communicate at regular intervals as necessary, but no less than one time a month, for the duration of a joint investigation and resulting prosecution.

c. It is the intent of this joint investigative plan to avoid duplication of investigative efforts by maintaining regular communication to discuss caseloads and share information concerning current investigations.

d. Ongoing investigations will be discussed at each meeting or more often as the matter dictates. A prosecutor will be assigned to each investigation to assist in any legal issues and to ensure that all elements of the case are present to meet charging requirements. This teamwork will reduce unnecessary investigative work and ensure that an investigation is terminated at the earliest possible time if it becomes apparent that no further amount of work would result in a prosecution.

e. The Chief of the Fraud Unit or his designee will be available to meet with the Fraud Division detective at any time during the investigation of a case when so requested by the detective to discuss any aspect of the case.

f. It is the intent of the parties that by maintaining regular communication and adhering to agreed upon plans and procedures, the completed investigation will result in the filing of criminal charges and a successful prosecution. At the same time, however, it is understood that not every case that is investigated will result in a prosecution. This can happen when the evidence does not develop as expected, material witnesses are no longer available, the case lacks jury appeal, the reasonable likelihood of conviction is minimal, or other unforeseen circumstances develop. The parties will take all possible steps to avoid such situations, as it is not desirable to expend investigative resources on cases that are not prosecuted in court.

When it becomes necessary, the Supervising Attorney or his designee will provide authorization to CDI to conduct surreptitious recordings pursuant to Penal Code Section 633.

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 her 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.

Either party may decide to conduct an undercover operation in a particular case using its own personnel and resources. In a situation where the Fraud Division conducts its own independent undercover investigation in Fresno County, the detective will consult the assigned prosecutor on the case consistent with vertical prosecution.

In a case where there will be a "joint" undercover investigation, there will be a joint operational plan prepared prior to the start of the investigation, which outlines and specifies the goals and objectives of the investigation, as well as the duties and responsibilities, including personnel and financial responsibilities, of each of the parties in the investigation.

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 prosecutor will determine what additional investigation is needed. The prosecutor shall notify the case detective as soon as practical if additional follow up investigation is warranted on the case. Every effort shall be made by the parties to complete the investigation as soon as practical.

The assigned prosecutor shall file criminal charges only if all of the following requirements are satisfied:

a. Based upon a complete investigation and a thorough consideration of all pertinent information readily available, the prosecutor is satisfied that the evidence shows the accused is guilty of the crime to be charges; and

b. There is sufficient legally admissible evidence of a corpus delicti; and

c. There is sufficient legally admissible evidence of the identity of the perpetrator of the crime; and

d. The prosecutor has considered the probability of a conviction by an objective fact-finder hearing the admissible evidence and has considered the evidence necessary to satisfy the legal proof of a criminal case: and

e. The admissible evidence is of such convincing force that it would warrant conviction of the crime charged by a reasonable and objective fact-finder after hearing all the evidence available at the time of charging and after hearing the most plausible, reasonably foreseeable defenses that could be raised under the evidence presented.

The Fraud Unit will provide CDI with a filing decision in writing within 30 days of the case submission. If after a complete review of the case the prosecutor decides not to file criminal charges, the prosecutor will contact and consult with the Fraud Division to discuss the reasons for not filing the case. Both parties understand that not every case

may result in criminal prosecution. A case may be declined for prosecution when the evidence does not develop as expected, material witnesses are no longer available, the reasonable likelihood of a conviction is minimal and the case lacks jury appeal or other unforeseen circumstances develop. The parties will attempt to avoid such situations, so as not to expend investigative resources on cases that will not result in a criminal prosecution. If a case has been formally submitted for filing and the prosecutor declines to prosecute, a formal rejection notice either in letter format or via e-mail outlining the reasons why the case is being declined will be sent to the Central Valley Regional Office.

Certified Court Minute Orders on all workers' compensation convictions/sentencings 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 "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 tighter 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 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 caseload. 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 4/4/19

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

Date 4/4/19

Christine Diep
Captain
California Department of Insurance-Fraud Division
Central Valley Regional Office