IN THE MATTER OF THE	*	**BEFORE THE MARYLAND**
	*	
MARYLAND INSURANCE ADMINISTRATION	*	**INSURANCE COMMISSIONER**
	*	
v.	*	
	*	**CASE NO. : MIA- 2018-01-011**
TRACY RENEE CACHO	*	
504 Pritchard Lane	*	**Fraud Division File No.: R-2017-3435A**
Upper Marlboro, Maryland 20774	*	
	*	

* *

ORDER

This Order is entered by the Maryland Insurance Administration ("MIA") against Tracy Renee Cacho ("Respondent") pursuant to §§ 2-108, 2-201, 2-204, and 2-405 of the Insurance Article, Md. Code Ann. (2017 Repl. Vol. & Supp.)("the Insurance Article").

I. Facts

1. Respondent's husband had an accident insurance policy with American Family Life Assurance Company of Columbus ("AFLAC"), an authorized insurer. The policy took effect on July 5, 2016, and provided coverage for the Respondent, her husband (policyholder) as well as Respondent's son.

2. Between July, 2016, and March, 2017, Respondent filed twenty-four (24) claims against the AFLAC policy for herself, her husband and their son for treatment purportedly received at MedStar Georgetown University Hospital ("Georgetown"), MedStar National Rehabilitation ("National"), MedStar Washington Hospital Center ("Washington"), Prince George's Hospital Center ("Prince George's"), Para-Med Medical Transport, Inc. ("Para-Med"), Johns Hopkins Medical Center ("Johns Hopkins"), Doctors Community Hospital ("Doctors"), Orthopaedic Medicine and Surgery ("OMS"), New York Presbyterian University Hospital ("NYPH"), New York Presbyterian EMS ("NYPEMS"), Children's National Medical Center

("Children's"), as well as Dental One Associates ("Dental One"). Relying on claim information provided by Respondent, AFLAC issued $16,770.00 in benefit payments.

3. Each claim form submitted identified Respondent's husband as the policyholder and the majority of the claims were accompanied by supporting documentation to ostensibly validate purported treatment by respective providers. Respondent was identified as the patient in eleven (11) claims and her husband was identified as the patient in eleven (11) claims. Respondent's son was identified as the patient in two (2) claims. AFLAC denied twelve of the twenty-four claims prior to issuing payment. Each claim form contained the following fraud warning immediately preceding the policyholder signature line:

> *Any Person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

4. On August 24, 2016, an AFLAC claims specialist contacted Children's to validate a claim submitted by Respondent for treatment her son purportedly received. A representative advised there were no records of Respondent's son ever being treated there.

5. On August 31, 2016, an AFLAC claims specialist contacted Dental One to validate a claim submitted by Respondent for treatment she purportedly received in 2016. A representative advised that Respondent was not seen at their office in 2016.

6. On September 12, 2016, an AFLAC claims specialist contacted Johns Hopkins to verify a claim submitted by Respondent for treatment her husband purportedly received. The Johns Hopkins representative was unable to locate records under Respondent's husband's name and date of birth.

7. On September 30, 2016, an AFLAC claims specialist contacted Prince George's to validate a claim submitted by Respondent for treatment she purportedly received in September, 2016. A representative advised there was no record of Respondent receiving treatment on September, 2016.

8. On November 19, 2016, an AFLAC claims specialist contacted Georgetown to validate a claim submitted by Respondent for treatment she purportedly received on September 12, 2016. A representative advised there was no record for treatment of Respondent on September 12, 2016.

9. On November 30, 2016, an AFLAC claims specialist contacted Doctors to validate a claim submitted by Respondent for treatment her husband purportedly received. A representative was unable to locate records for Respondent's husband by name, date of birth, or social security number. Further, the account number on the claim was for someone else.

10. On March 3, 2017, AFLAC referred Respondent's claims to its Special Investigations Unit ("SIU").

11. On April 7, 2017, an AFLAC investigator sent a letter to Respondent's husband requesting cooperation with AFLAC's investigation, and a reply within ten (10) days.

12. On April 21, 2017, an AFLAC investigator received a phone call from Respondent. She admitted to submitting claims under her husband's policy and would obtain necessary documents from the providers to validate those claims, which she failed to do.

13. On May 10, 2017, an AFLAC investigator contacted Doctors to validate a claim submitted by Respondent for treatment she purportedly received on July 15, 2016. The representative was unable to verify the treatment.

14. On May 11, 2017, an AFLAC investigator contacted NYPH to validate a claim submitted by Respondent for treatment she purportedly received. The representative advised that Respondent was never a patient there.

15. On May 11, 2017, an AFLAC investigator contacted OMS to validate a claim submitted by Respondent for treatment she purportedly received on July 9, 2016. The representative advised that Respondent was not a patient at OMS.

16. AFLAC sent a letter to Respondent's husband on May 11, 2017, advising that they were unable to validate information submitted in the claim(s) and requesting reimbursement in the amount of $16, 770.00.

17. Section 27-802(a)(1) of the Maryland Insurance Article states,

> An authorized insurer, its employees, fund producers, or insurance producers, ... who in good faith has cause to believe that insurance fraud has been or is being committed shall report the suspected insurance fraud in writing to the Commissioner, the Fraud Division, or the appropriate federal, State, or local law enforcement authorities.

AFLAC, having a good faith belief that Respondent committed insurance fraud, referred the matter to the MIA, Fraud Division.

18. During the course of its investigation, the MIA contacted AFLAC and confirmed its handling of Respondent's claims.

19. On September 6, 2017, after examining the claim files submitted by Respondent to AFLAC, an MIA investigator noted that Respondent had submitted a Maryland State Police accident report in support of her November 21, 2016, claim that her husband was treated at Doctors following a motor vehicle accident. An MIA investigator interviewed the Maryland State trooper identified as the author of the accident report, he examined the report and advised it was altered. Further, he provided a copy of the actual report, which revealed Respondent's

husband was not involved in the accident but another person who resided at Respondent's address was.

20. On September 12, 2017, an MIA investigator went to Prince George's and interviewed the Director of Medical Billing, to validate the claim submitted by Respondent to AFLAC for treatment her husband purportedly received on August 7, 2016. The Director confirmed the documents submitted by Respondent were not used by the hospital during the course of regular business and they have no records of Respondent's husband ever being treated at Prince George's.

21. On September 12, 2017, an MIA investigator went to Doctors and interviewed the Director, Patient Financial Services, to validate a claim Respondent submitted to AFLAC for treatment her husband purportedly received on November 21, 2016. She advised the documents submitted by Respondent were fraudulent. She examined records on file under the patient identification number typewritten on the claim form. She identified the actual patient and found a copy of that patient's driver's license in the file, which identified a female who resided at Respondent's address.

22. On September 19, 2017, an MIA investigator interviewed a billing specialist for Georgetown. She examined documents for two claims Respondent submitted to AFLAC for treatment her husband purportedly received at Georgetown on August 3 and 4, 2016. The billing specialist advised the two claims were fraudulent, and referred the investigator to Georgetown's compliance officer.

23. On September 20, 2017, an MIA investigator contacted Para-Med and interviewed the owner, to validate a claim submitted by the Respondent to AFLAC for a medical transport of Respondent to Doctors on July 15, 2016. The owner examined the claim document

and concluded it was fraudulent. Respondent was never transported to Doctors on July 15, 2016, by Para-Med.

24. On September 20, 2017, an MIA investigator contacted Doctors and interviewed the Director, Patient Financial Service. She examined the claim documents Respondent submitted to AFLAC for treatment she purportedly received on July 15, 2016. The Director advised that the documents were fraudulent and Respondent was not a patient at Doctors on July 15, 2016.

25. On September 20, 2017, an MIA investigator contacted OMS and interviewed the billing coordinator. She examined the claim documents Respondent submitted to AFLAC for treatment Respondent purportedly received on July 9, 2016. She advised Respondent did not receive medical services at OMS on July 9, 2016.

26. On September 21, 2017, an MIA investigator contacted Children's and spoke to Legal Counsel for Risk and Litigation. She examined the claim documents and supporting documents Respondent submitted to AFLAC for treatment Respondent's son purportedly received on August 5, 2016. The Legal Counsel stated that the documents were not authentic and Children's did not bill for the services listed.

27. On September 28, 2017, an MIA investigator contacted NYPEMS and interviewed the supervisor for patient billing. He examined the claim documents Respondent submitted to AFLAC for treatment Respondent purportedly received on July 25, 2016. He advised Respondent was not a patient and further that NYPEMS did not transport her on July 25, 2016.

28. On October 2, 2017, an MIA investigator contacted MedStar Health, Inc. and spoke to assistant vice president of compliance operations. She examined the claim documents

Respondent submitted to AFLAC for treatment Respondent and her husband purportedly received between July, 2016, and February, 2017. She advised the documents submitted by Respondent reflecting she and her husband were treated at various Med-Star facilities (Georgetown, National, Washington) were not true and accurate reflections of services provided. Further, Med-Star National did not exist.

29. On October 3, 2017, an MIA investigator received an email from the billing manager of EMS confirming that the company did not issue a bill for ambulance transport for Respondent's son.

30. On October 5, 2017, an MIA investigator contacted Dental One and interviewed a billing specialist. She examined claim documents Respondent submitted to AFLAC for treatment Respondent purportedly received on August 26, 2016. She advised that while the Respondent was a patient, she was not seen and did not receive treatment on August 26, 2016.

31. On October 6, 2017, an MIA investigator contacted the Acting Compliance Officer for The John Hopkins Health System who verified that Respondent's husband did not receive any services from the hospital.

32. On October 11, 2017, an MIA investigator contacted NYPH and interviewed the supervisor of patient billing. She examined claim documents Respondent submitted to AFLAC for treatment she purportedly received on July 20, 2016. She advised Respondent was not a patient, and there was no record of her being treated on July 20, 2016.

33. On October 19, 2017, an NYPEMS privacy specialist contacted the MIA to reaffirm the information provided by the supervisor for patient billing on September 28, 2017. The privacy specialist confirmed Respondent was not a patient and there were no records of

emergency services provided to her between July 20 through 25, 2016. Additionally, the nursing manager identified in the claim was never employed by NYPEMS.

34. On October 24, 2017, an MIA investigator contacted the Prince George's County Police Department ("PGPD") to validate a police accident report Respondent submitted to AFLAC in support of her claim that her husband was treated at Prince George's on August 7, 2016, following a motor vehicle accident. A representative with the police department examined the accident report and advised, "This is definitely not a PGPD report."

35. On October 25, 2017, an MIA investigator contacted the New York City Police Department ("NYPD") to validate a police accident report Respondent submitted to AFLAC in support of her claim that she was treated on July 20, 2016, at NYPH, following a motor vehicle accident. A representative with the police department examined the accident report and advised; it was a fraudulent report and directed the MIA investigator to a web site where an actual NYPD accident report is available for comparison.

36. On November 8, 2017, an MIA investigator interviewed Respondent. She confessed that she submitted all twenty-four fraudulent claims to AFLAC and that she acted alone without her husband's knowledge or consent.

II. Violation(s)

In addition to all relevant sections of the Insurance Article, the Administration relies on the following pertinent sections in finding that Tracy Cacho violated Maryland's insurance laws:

37. § **27-403**

It is a fraudulent insurance act for a person:

(2) to present or cause to be presented to an insurer documentation or an oral or written statement made in support of a claim...with knowledge that the documentation or statement contains false or misleading information about a matter material to the claim.

38. § **27-408(c)**

(1) In addition to any criminal penalties that may be imposed under this section, on a showing by clear and convincing evidence that a violation of this subtitle has occurred, the Commissioner may:

(i) impose an administrative penalty not exceeding $25,000 for each act of insurance fraud; and

(ii) order restitution to an insurer or self–insured employer of any insurance proceeds paid relating to a fraudulent insurance claim[.]

* * *

In determining the amount of an administrative penalty, the Commissioner shall consider:

(i) the nature, circumstances, extent, gravity, and number of violations;
(ii) the degree of culpability of the violator;
(iii) prior offenses and repeated violations of the violator; and
(iv) any other matter that the Commissioner considers appropriate and relevant.

39. By the conduct described herein, the Respondent violated § 27-403 and is subject to administrative penalty.

III. Sanctions

40. Insurance fraud is a serious violation, which harms consumers in that the losses suffered by insurance companies are passed on to consumers in the form of higher premiums. The Commissioner may investigate any complaint that alleges a fraudulent claim has been submitted to an insurer, Insurance Article §§ 2-201(d)(1) and 2-405.

41. Respondent submitted twenty-four claims to AFLAC, accompanied by supporting documents, ostensibly verifying treatment at the respective treatment facility for herself, her husband, and son. All providers confirmed the documents were fraudulent and in most cases were completely manufactured. Having considered the factors set forth in § 27-408(c)(2), and COMAR 31.02.04.02, the MIA has determined that $7,200.00 is an appropriate penalty.

42. Additionally, Respondent is ordered to reimburse AFLAC $16,770.00, which is the amount she fraudulently obtained from AFLAC when submitting false claims.

43. Administrative penalties shall be made payable to the Maryland Insurance Administration and shall identify the case by number (R-2017-3435A) and name (Tracy Renee Cacho). Unpaid penalties will be referred to the Central Collections Unit for collection. Payment of the administrative penalty shall be sent to the attention of: Associate Commissioner, Insurance Fraud Division, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202.

44. Notification of reimbursement to AFLAC shall be made in writing to the Associate Commissioner, Insurance Fraud Division, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Such notification shall include a copy of the money order or cancelled check issued to AFLAC as proof of reimbursement and identify the case by number (R-2017-3435A) and name (Tracy Renee Cacho).

45. This Order does not preclude any potential or pending action by any other person, entity, or government authority, regarding any conduct by the Respondent including the conduct that is the subject of this Order.

WHEREFORE, for the reasons set forth above, and subject to the right to request a hearing, it is this 4th day of January 2018, **ORDERED** that:

(1) Tracy Renee Cacho shall pay an administrative penalty of seven thousand two hundred dollars ($7,200.00) within 30 days of the date of this Order.

(2) Tracy Renee Cacho shall pay restitution to AFLAC in the amount of sixteen thousand seven hundred and seventy dollars ($16,770.00) within 30 days of the date of this Order.

ALFRED W. REDMER, JR.
Insurance Commissioner

BY: signature on original
STEVE WRIGHT
Associate Commissioner
Insurance Fraud Division

RIGHT TO REQUEST A HEARING

Pursuant to § 2-210 of the Insurance Article and Code of Maryland Regulations ("COMAR") 31.02.01.03, an aggrieved person may request a hearing on this Order. This request must be in writing and received by the Commissioner within thirty (30) days of the date of the letter accompanying this Order. However, pursuant to § 2-212 of the Article, the Order shall be stayed pending a hearing only if a demand for hearing is received by the Commissioner within ten (10) days after the Order is served. The written request for hearing must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202, Attn: Hearings and Appeals Coordinator. The request shall include the following information: (1) the action or non-action of the Commissioner causing the person requesting the hearing to be aggrieved; (2) the facts related to the incident or incidents about which the person requests the Commissioner to act or not act; and (3) the ultimate relief requested. The failure to request a hearing timely or to appear at a scheduled hearing will result in a waiver of your rights to contest this Order and the Order shall be final on its effective date. Please note that if a hearing is requested on this initial Order, the Commissioner may affirm, modify, or nullify an action taken or impose any penalty or remedy authorized by the Insurance Article against the Respondent in a Final Order after hearing.