Barry I. Levy, Esq.
Michael A. Sirignano, Esq.
Joshua D. Smith, Esq.
RIVKIN RADLER LLP
926 RXR Plaza
Uniondale, New York 11556
(516) 357-3000

Counsel for Plaintiffs, Government Employees Insurance Company, GEICO Indemnity Company, GEICO General Insurance Company and GEICO Casualty Company

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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GOVERNMENT EMPLOYEES INSURANCE COMPANY, GEICO INDEMNITY COMPANY, GEICO GENERAL INSURANCE COMPANY and GEICO CASUALTY COMPANY,

Docket No.:
1:24-cv-01576-RPK-JAM

Plaintiffs,

-against-

Plaintiff Demands a Trial by Jury

ALL BORO MEDICAL SERVICES, P.C., SENECA MEDICAL P.C., PALMETTO MEDICAL P.C., DAVID CARMILI, M.D., and JOHN DOE DEFENDANTS 1-10,

Defendants.

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COMPLAINT

Plaintiffs Government Employees Insurance Company, GEICO Indemnity Company, GEICO General Insurance Company, and GEICO Casualty Company (collectively "GEICO" or "Plaintiffs"), as and for their Complaint against defendants, All Boro Medical Services, P.C., Seneca Medical P.C., Palmetto Medical P.C., David Carmili, M.D., and John Doe Defendants 1-10 (collectively, the "Defendants"), hereby allege as follows:

NATURE OF THE ACTION

1. GEICO brings this action to terminate an ongoing fraudulent scheme perpetrated by the Defendants through the submission of hundreds of fraudulent no-fault insurance charges relating to medically unnecessary, illusory, and otherwise non-reimbursable healthcare services, including outcome assessment testing, pain management injections, videonystagmography, and transcranial doppler studies (collectively the "Fraudulent Services") that allegedly were provided to New York automobile accident victims ("Insureds"). The Fraudulent Services were billed through three professional corporations known as All Boro Medical Services, P.C., Seneca Medical P.C., and Palmetto Medical P.C., despite the fact that the nominal owner of the professional corporations, David Carmili, M.D., is a pediatrician by training and not qualified to perform or supervise the healthcare services purportedly being provided. As part and parcel of the fraudulent scheme, the Defendants paid kickbacks to other healthcare services providers and unlicensed laypersons that controlled various multidisciplinary no-fault clinics, including John Doe Defendants 1-10, in order to obtain access to patients with no-fault insurance.

2. This action seeks to recover more than $549,000.00 that the Defendants wrongfully have obtained from GEICO by submitting and causing to be submitted, hundreds of fraudulent no-fault insurance charges relating to the Fraudulent Services that allegedly were provided to New York automobile accident victims.

3. In addition, GEICO seeks a declaration that it is not legally obligated to pay reimbursement of more than $1,000,000.00 in pending no-fault insurance claims that have been submitted by or on behalf of Defendants All Boro Medical Services, P.C., Seneca Medical P.C., and Palmetto Medical P.C. (collectively the "Provider Defendants") because:

(i) the Fraudulent Services were not medically necessary and were provided – to the extent that provided at all – pursuant to predetermined fraudulent protocols designed solely to financially enrich the Defendants, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to them;

(ii) in many cases, the Fraudulent Services never were provided in the first instance;

(iii) the billing codes used for the Fraudulent Services misrepresented and exaggerated the level and type of services that purportedly were provided in order to inflate the charges submitted to GEICO;

(iv) the Fraudulent Services were provided – to the extent provided at all – pursuant to illegal kickback and referral arrangements amongst the Defendants and others; and

(v) the Provider Defendants were not lawfully licensed as they were nominally owned by a licensed healthcare provider who did not actually practice medicine through the professional corporations as required by law.

4. The Defendants fall into the following categories:

(i) Defendant All Boro Medical Services, P.C. ("All Boro Medical"), Seneca Medical P.C. ("Seneca Medical"), and Palmetto Medical P.C. ("Palmetto Medical") are New York professional medical corporations through which the Fraudulent Services purportedly were performed and were billed to New York automobile insurance companies, including GEICO.

(ii) Defendant David Carmili, M.D. ("Carmili") is a physician licensed to practice medicine in New York who purported to own All Boro Medical, Seneca Medical, and Palmetto Medical and purported to perform many of the Fraudulent Services submitted through All Boro Medical, Seneca Medical, and Palmetto Medical.

(i) John Doe Defendants 1-10 (the "John Doe Defendants") are individuals and/or entities who participated in the fraudulent scheme perpetrated against GEICO by, among other things, assisting with the operation of the Provider Defendants and the provision of medically unnecessary services, "brokering" or "controlling" access to patients in exchange for illegal kickback payments, and/or spearheading the predetermined fraudulent protocols used to maximize profits without regard to genuine patient care.

5. As discussed herein, the Defendants at all relevant times have known that:

(i) the Fraudulent Services were not medically necessary and were provided –

to the extent provided at all – pursuant to predetermined fraudulent protocols designed solely to financially enrich the Defendants, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to them;

(ii) in many cases, the Fraudulent Services never were provided in the first instance;

(iii) the billing codes used for the Fraudulent Services misrepresented and exaggerated the level and type of services that purportedly were provided in order to inflate the charges submitted to GEICO;

(iv) the Fraudulent Services were provided – to the extent provided at all – pursuant to illegal kickback and referral arrangements amongst the Defendants and others; and

(v) the Provider Defendants were not lawfully licensed as they were nominally owned by a licensed healthcare provider who did not actually practice medicine through the professional corporations as required by law.

6. As such, the Defendants do not now have – and never had – any right to be compensated for the Fraudulent Services that were billed to GEICO through All Boro Medical, Seneca Medical, and Palmetto Medical.

7. The charts annexed hereto as Exhibits "1" through "3" set forth a representative sample of the fraudulent claims that have been identified to-date that the Defendants submitted, or caused to be submitted, to GEICO.

8. The Defendants' fraudulent scheme began as early as 2021 and has continued uninterrupted since that time.

9. As a result of the Defendants' fraudulent scheme, GEICO has incurred damages of more than $549,000.00.

THE PARTIES

I. Plaintiffs

10. Plaintiffs Government Employees Insurance Co., GEICO Indemnity Co., GEICO General Insurance Company and GEICO Casualty Co. are Nebraska corporations with their

principal places of business in Chevy Chase, Maryland. GEICO is authorized to conduct business and to issue automobile insurance policies in New York and New Jersey.

II. Defendants

11. Defendant All Boro Medical is a New York professional medical corporation with its principal place of business in New York. All Boro Medical was formed in New York on June 5, 1989. All Boro Medical is purportedly owned by Carmili and was used, along with Seneca Medical and Palmetto Medical, as a vehicle to submit fraudulent billing to GEICO and other insurers.

12. Defendant Seneca Medical is a New York professional medical corporation with its principal place of business in New York. Seneca Medical was formed in New York on April 26, 2001. Seneca Medical is purportedly owned by Carmili and was used, along with All Boro Medical and Palmetto Medical, as a vehicle to submit fraudulent billing to GEICO and other insurers.

13. Defendant Palmetto Medical is a New York professional medical corporation with its principal place of business in New York. Palmetto Medical was formed in New York on October 27, 2022. Palmetto Medical is purportedly owned by Carmili and was used, along with All Boro Medical and Seneca Medical, as a vehicle to submit fraudulent billing to GEICO and other insurers.

14. Defendant Carmili resides in and is a citizen of New York. Carmili was licensed to practice medicine in New York on July 27, 1987, purported to own All Boro Medical, Seneca Medical, and Palmetto Medical.

15. Carmili is a pediatrician by training, and was, at all relevant times, not qualified to perform or to supervise the various Fraudulent Services purportedly provided to Insureds and billed to GEICO through All Boro Medical, Seneca Medical, and Palmetto Medical.

16. Upon information and belief, John Doe Defendants reside in and are citizens of New York. John Doe Defendants are individuals and entities, presently not identifiable, who knowingly participated in the fraudulent scheme by, among other things, assisting with the operation of the Provider Defendants and the provision of medically unnecessary services; facilitating the illegal kickback arrangements by establishing relationships with healthcare providers or individuals who had access to patients at the Clinics; "brokering" or "controlling" access to patients in exchange for illegal kickback payments; and/or helping to design and/or implement the predetermined fraudulent protocols carried out through the Provider Defendants for the purpose of maximizing the Defendants' profits without regard to genuine patient care.

JURISDICTION AND VENUE

17. This Court has jurisdiction over the subject matter of this action under 28 U.S.C. § 1332(a)(1) because the matter in controversy exceeds the sum or value of $75,000.00, exclusive of interest and costs, and is between citizens of different states.

18. In addition, this Court has supplemental jurisdiction over the subject matter of the claims asserted in this action pursuant to 28 U.S.C. § 1367.

19. Venue in this District is appropriate pursuant to 28 U.S.C. § 1391, as this is the District where a substantial amount of the activities forming the basis of the Complaint occurred.

ALLEGATIONS COMMON TO ALL CLAIMS

20. GEICO underwrites automobile insurance in New York and New Jersey.

III. Pertinent New York Law Governing No-Fault Insurance Reimbursement

21. New York's no-fault insurance laws are designed to ensure that injured victims of motor vehicle accidents have an efficient mechanism to pay for and receive the health care services that they need.

22. Under New York's Comprehensive Motor Vehicle Insurance Reparations Act (N.Y. Ins. Law §§ 5101, et seq.) and the regulations promulgated pursuant thereto (11 N.Y.C.R.R. §§ 65, et seq.), automobile insurers are required to provide no-fault insurance ("Personal Injury Protection" or "PIP") benefits ("PIP Benefits") to Insureds.

23. In New York, PIP Benefits include up to $50,000.00 per Insured for necessary expenses that are incurred for healthcare goods and services, including chiropractic services.

24. In New York, an Insured can assign his/her right to PIP Benefits to health care goods and services providers in exchange for those services.

25. In New York, pursuant to a duly executed assignment, a health care provider may submit claims directly to an insurance company and receive payment for medically necessary services, using the claim form required by the New York State Department of Insurance (known as "Verification of Treatment by Attending Physician or Other Provider of Health Service" or, more commonly, as an "NF-3").

26. In the alternative, in New York a healthcare services provider may submit claims using the Health Care Financing Administration insurance claim form (known as the "HCFA-1500 form").

27. Pursuant to the New York no-fault insurance laws, healthcare services providers are not eligible to bill for or to collect PIP Benefits if they fail to meet any New York State or local licensing requirements necessary to provide the underlying services.

28. For instance, the implementing regulation adopted by the Superintendent of Insurance, 11 N.Y.C.R.R. § 65-3.16(a)(12) states, in pertinent part, as follows:

> A provider of health care services is not eligible for reimbursement under section 5102(a)(1) of the Insurance Law if the provider fails to meet any applicable New York State or local licensing requirement necessary to perform such service in New York or meet any applicable licensing requirement necessary to perform such

service in any other state in which such service is performed.

(Emphasis added).

29. New York law prohibits licensed healthcare services providers, including chiropractors and physicians, from paying or accepting kickbacks in exchange for patient referrals. See, e.g., New York Education Law §§ 6509-a; 6531.

30. New York law prohibits licensed healthcare services providers, including chiropractors and physicians, from referring patients to healthcare practices in which they have an ownership or investment interest unless: (i) the ownership or investment interest is disclosed to the patient; and (ii) the disclosure informs the patient of his or her "right to utilize a specifically identified alternative health care provider if any such alternative is reasonably available". See New York Public Health Law § 238-d.

31. What is more, with limited exceptions that are not applicable here, New York law prohibits licensed healthcare services providers, including chiropractors and physicians, from referring patients for diagnostic testing to healthcare practices in which they have an ownership interest, whether or not the healthcare services providers disclose their ownership interest to the patient. See New York Public Health Law § 238-a.

32. Therefore, under the New York no-fault insurance laws, a healthcare services provider is not eligible to receive PIP Benefits if it is fraudulently licensed, if it pays or receives unlawful kickbacks in exchange for patient referrals, or if it engages in illegal self-referrals.

33. In State Farm Mut. Auto. Ins. Co. v. Mallela, 4 N.Y.3d 313, 320 (2005), In State Farm Mut. Auto. Ins. Co. v. Mallela, 4 N.Y.3d 313, 320 (2005) and Andrew Carothers, M.D., P.C. v. Progressive Ins. Co., 33 N.Y.3d 389 (2019), the New York Court of Appeals made clear that healthcare providers that fail to comply with material licensing requirements are ineligible to collect No-Fault Benefits, and that insurers may look beyond a facially-valid license to determine

whether there was a failure to abide by state and local law.

34. Pursuant to the New York no-fault insurance laws, only healthcare services providers in possession of a direct assignment of benefits are entitled to bill for and collect PIP Benefits. There is both a statutory and regulatory prohibition against payment of PIP Benefits to anyone other than the patient or his/her healthcare services provider. The implementing regulation adopted by the Superintendent of Insurance, 11 N.Y.C.R.R. § 65-3.11, states – in pertinent part – as follows:

> An insurer shall pay benefits for any element of loss … directly to the applicant or ... upon assignment by the applicant ... shall pay benefits directly to providers of healthcare services as covered under section five thousand one hundred two (a)(1) of the Insurance Law …

35. Accordingly, for a healthcare services provider to be eligible to bill for and to collect charges from an insurer for healthcare services pursuant to New York Insurance Law § 5102(a), it must be the actual provider of the services. Under the New York no-fault insurance laws, a healthcare services provider is not eligible to bill for services, or to collect for those services from an insurer, where the services were rendered by persons who were not employees of the healthcare services provider, such as independent contractors.

36. In New York, claims for PIP Benefits are governed by the New York Workers' Compensation Fee Schedule (the "NY Fee Schedule")

37. When a healthcare services provider submits a claim for PIP Benefits using the current procedural terminology ("CPT") codes set forth in the NY Fee Schedule, it represents that: (i) the service described by the specific CPT code that is used was performed in a competent manner in accordance with applicable laws and regulations; (ii) the service described by the specific CPT code that is used was reasonable and medically necessary; and (iii) the service and the attendant fee were not excessive.

38. Pursuant to New York Insurance Law § 403, the NF-3s and HCFA-1500 forms submitted by a healthcare services provider to GEICO, and to all other automobile insurers, must be verified by the health care provider subject to the following warning:

> 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.

III. The Defendants' Fraudulent Scheme

39. From early 2013 until late 2020, Carmili, All Boro Medical, and Seneca Medical submitted billing to GEICO for basic physical therapy services purportedly provided to patients involved in motor vehicle accidents from a single location in Ridgewood, New York. During that time period, the Defendants did not perform or bill for any of the Fraudulent Services discussed in detail below.

40. Beginning in 2021 and continuing through the present day, the Defendants masterminded and implemented a complex fraudulent scheme in which they billed GEICO and other automobile insurers hundreds of thousands of dollars for a litany of medically unnecessary, illusory, and otherwise non-reimbursable services, purportedly provided to Insureds on a transient basis at numerous locations throughout the New York area.

A. The Multidisciplinary Clinics and Kickbacks

41. Carmili, All Boro Medical, Seneca Medical, and Palmetto Medical did not advertise or market their services to the general public, did not generally maintain stand-alone practices, and were not generally the owners of or leaseholders of the real property from which they purported to provide the Fraudulent Services.

42. Instead, All Boro Medical, Seneca Medical, and Palmetto Medical largely operated

on an itinerant basis from several multidisciplinary clinics located throughout the New York area (the "Clinics") that purported to provide treatment to patients with no-fault insurance, including but not limited to Clinics at the following locations:

(i) 11118 Flatlands Avenue, Brooklyn, New York;

(ii) 1786 Flatbush Avenue, Brooklyn, New York;

(iii) 175-20 Hillside Avenue, Jamaica, New York;

(iv) 204-12 Hillside Avenue, Jamaica, New York;

(v) 22201 Hempstead Avenue, Jamaica, New York;

(vi) 3000 Eastchester Road, Bronx, New York;

(vii) 3432 E Tremont Avenue, Bronx, New York;

(viii) 381 Rockaway Avenue, Brooklyn, New York;

(ix) 4011 Warren Street, Elmhurst, New York;

(x) 409 Rockaway Avenue, Brooklyn, New York;

(xi) 69-37 Myrtle Avenue, Glendale, New York;

(xii) 714 Seneca Avenue, Ridgewood, New York; and

(xiii) 9709 Springfield Boulevard, Jamaica, New York

43. Though ostensibly organized to provide a range of healthcare services to Insureds at individual locations, these Clinics in actuality were organized to supply convenient, one-stop shops for no-fault insurance fraud.

44. Carmili, All Boro Medical, Seneca Medical, and Palmetto Medical gained access to the Clinics by paying kickbacks to other healthcare services providers (the "Referring Providers") and unlicensed laypersons (the "Clinic Controllers") who operated from the Clinics and controlled access to the Clinics.

45. The kickbacks to the Clinics were disguised as ostensibly legitimate fees to "lease" space or personnel at the Clinics. In fact, these were "pay-to-play" arrangements that caused the Referring Providers at the Clinics to provide access to Insureds and to refer the Insureds to the Defendants for the Fraudulent Services without regard for the medical necessity of any of the Fraudulent Services. To the extent that the Defendants attempted to disguise the payments as rent or for other services, the fact that the payments constituted kickbacks in exchange for patient referrals is demonstrated by the fact that the payments were far in excess of the fair market value of the putative leaseholds or other services allegedly provided.

46. In exchange for these kickbacks from Carmili, All Boro Medical, Seneca Medical, and Palmetto Medical, the Referring Providers and Clinic Controllers automatically referred Insureds to the Defendants for the medically unnecessary Fraudulent Services, regardless of the Insureds' individual circumstances or presentation.

B. The Defendants' Fraudulent Treatment and Billing Protocol

47. Virtually all the Insureds whom the Defendants purported to treat were involved in relatively minor, "fender-bender" accidents, to the extent that they were involved in any actual accidents at all. Concomitantly, virtually none of the Insureds whom the Defendants purported to treat suffered from any significant injuries or health problems as a result of the relatively minor accidents they experienced or purported to experience.

48. Even so, the Defendants purported to subject virtually every Insured to a substantially identical, medically unnecessary course of "treatment" that was provided pursuant to a predetermined, fraudulent protocol designed to maximize the billing that they could submit through All Boro Medical, Seneca Medical, and Palmetto Medical to insurers, including GEICO, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to it.

49. The Defendants purported to provide their predetermined fraudulent treatment protocol to Insureds without regard for the Insureds' individual symptoms, presentation, or – in most cases – the total absence of any actual medical problems arising from any actual automobile accidents.

50. Each step in the Defendants' fraudulent treatment protocol was designed to falsely reinforce the rationale for the previous step and provide a false justification for the subsequent step, and thereby permit the Defendants to generate and falsely justify the maximum amount of fraudulent no-fault billing for each Insured.

51. No legitimate physician or other licensed healthcare provider or professional corporation would permit the fraudulent treatment and billing protocol described below to proceed under his or her auspices.

52. The Defendants permitted the fraudulent treatment and billing protocol described below to proceed under their auspices because the Defendants sought to profit from the fraudulent billing submitted to GEICO and other insurers.

1. The Fraudulent Charges for Initial Examinations

53. Upon receiving an illegal referral from the Referring Providers and Clinic Controllers, All Boro Medical, Seneca Medical, and/or Palmetto Medical purported to provide the majority of Insureds in the claims identified in Exhibits "1" through "3" with an initial examination.

54. The initial examinations were performed as a "gateway" in order to provide Insureds with phony, predetermined "diagnoses" to allow the Defendants to then purport to provide medically unnecessary, diagnostic testing.

55. The initial examinations on behalf of All Boro Medical, Seneca Medical, and Palmetto Medical were typically performed by Moshtaq Ahmed, R.S.A. ("Ahmed")

56. Carmili never performed any initial examinations on behalf of All Boro Medical, Seneca Medical, or Palmetto Medical.

57. As set forth in Exhibits "1" through "3", the initial examinations were then typically billed to GEICO through All Boro Medical, Seneca Medical, and Palmetto Medical under CPT code 99204, typically resulting in a charge of $203.76 for each purported examination.

58. The charges for the initial examinations were fraudulent in that they misrepresented All Boro Medical, Seneca Medical, and Palmetto Medical's eligibility to collect No-Fault Benefits in the first instance and because they were medically unnecessary and were performed – to the extent that they were performed at all – pursuant to illegal referrals from the Referring Providers and Clinic Controllers, not to treat or otherwise benefit the Insureds.

59. Further, the Defendants also were not in compliance with relevant laws governing healthcare practice in New York and were not eligible to collect No-Fault Benefits in connection with any of the claims identified in Exhibits "1" through "3" inasmuch as: (i) Carmili, All Boro Medical, Seneca Medical, and Palmetto Medical gained access to Insureds at the Clinics by paying kickbacks to individuals who own and/or control the No-Fault Clinics, in violation of the No-Fault Laws; and (ii) All Boro Medical, Seneca Medical, and Palmetto Medical are nominally owned by a licensed healthcare provider who did not actually practice medicine through the professional corporate entities as required by law.

60. The charges for the initial examinations were also fraudulent in that they misrepresented the severity of the Insureds' presenting problems and the nature and extent of the examinations.

61. According to the NY Fee Schedule, the use of CPT code 99204 typically requires that the Insured present with problems of moderate-to-high severity.

62. Though the Defendants billed the purported initial examinations under CPT code 99204, the Insureds almost never presented with problems of moderate-to-high severity. By contrast, to the extent that the Insureds had any presenting problems at all as the result of their minor automobile accidents, the problems virtually always were low or minimal severity soft tissue injuries such as sprains and strains.

63. Even so, the Defendants routinely billed for the initial examinations under CPT code 99204, and thereby falsely represented that the Insureds presented with problems of moderate-to-high severity.

64. The Defendants routinely falsely represented that the Insureds presented with problems of moderate-to-high severity to create a false basis for their charges for the examinations under CPT code 99204, because examinations billable under that code are reimbursable at higher rates than examinations involving presenting problems of low severity, minimal severity, or no severity.

65. The Defendants also routinely falsely represented that the Insureds presented with problems of moderate-to-high severity to create a false basis for the other Fraudulent Services that the Defendants purported to provide to the Insureds, including diagnostic testing.

66. The Defendants also routinely falsely represented that the Insureds presented with problems of moderate-to-high severity in order to create a false basis for the referrals for continued medically unnecessary physical therapy, pursuant to the illegal "pay-to-play" arrangements that caused the owners/operators of the Clinics to provide the Defendants with access to Insureds.

67. Furthermore, the Defendants' charges for the initial examinations were fraudulent in that they misrepresented the nature and extent of the examinations.

68. The Defendants misrepresented and exaggerated the amount of face-to-face time

that the examining physician spent with the Insureds or the Insureds' families.

69. The use of CPT code 99204 to bill for an examination typically requires that that a physician spend 45 minutes of face-to-face time with the Insured or the Insured's family during the examination.

70. Although the Defendants billed for their putative examinations under CPT code 99204, neither Carmili, Ahmed, nor any healthcare practitioner associated with All Boro Medical, Seneca Medical, or Palmetto Medical ever spent 30 minutes, much less 45 minutes, on an initial examination. To the extent that the initial examinations were conducted, they lasted a fraction of the time represented by the billing.

71. In addition, pursuant to the Fee Schedule, when the Defendants submitted charges for initial examinations under CPT code 99204, or caused them to be submitted, they falsely represented that Carmili, Ahmed, or another healthcare practitioner associated with All Boro Medical, Seneca Medical, or Palmetto Medical: (i) took a "comprehensive" patient history; (ii) conducted a "comprehensive" physical examination; and (iii) engaged in medical decision-making of "moderate complexity."

72. Pursuant to the Fee Schedule, a "comprehensive" patient history requires that the physician take: (i) an extended history of the present illness; (ii) a review of all body systems, not only the body systems that are related to the patient's present complaint; and (iii) a complete past, family, and social history from the patient.

73. When the Defendants billed for the initial examinations under CPT code 99204, they falsely represented that they took a "comprehensive" patient history from the Insureds they purported to evaluate during the examinations.

74. In fact, with respect to the claims for initial examinations under CPT code 99204

that are identified in Exhibit "1", neither Carmili, Ahmed, nor any healthcare practitioner associated with the All Boro Medical, Seneca Medical, or Palmetto Medical ever recorded a "comprehensive" patient history.

75. For instance, in each of the claims under CPT code 99204 identified in Exhibit "1", neither Carmili, Ahmed, nor any healthcare practitioner associated with All Boro Medical, Seneca Medical, and Palmetto Medical ever recorded a history of all the Insured's body systems.

76. Rather, after purporting to provide the initial examinations, the Defendants simply prepared template fill-in-the blank reports containing phony or boilerplate patient histories that were designed solely to support the other Fraudulent Services that the Defendants purported to provide to the Insureds, including diagnostic testing, as well as referrals for medically unnecessary physical therapy.

77. In all of the claims for initial examinations under CPT code 99204 that are identified in Exhibit "1", the Defendants falsely represented that they had taken a "comprehensive" patient history, when in fact they had not taken a "comprehensive" patient history, because virtually all of the examination reports contain only a brief and cursory discussion of the Insureds' patient histories.

78. In the claims for initial examinations under CPT code 99204, the Defendants falsely represented that the initial examinations included a "comprehensive" patient history in order to provide a false basis to bill for the initial examinations under CPT code 99204, because that code is reimbursable at a higher rate than examination codes that do not require a "comprehensive" patient history.

79. Pursuant to the CPT Assistant, a physical examination does not qualify as "comprehensive" unless the examining physician either: (i) conducts a general examination of

multiple patient organ systems; or (ii) conducts a complete examination of a single patient organ system.

80. Pursuant to the CPT Assistant, in the context of patient examinations and examinations, a physician has not conducted a general examination of multiple patient organ systems unless the physician has documented findings with respect to at least eight organ systems.

81. The CPT Assistant recognizes the following organ systems:

(i) constitutional symptoms (e.g., fever, weight loss);

(ii) eyes;

(iii) ears, nose, mouth, throat;

(iv) cardiovascular;

(v) respiratory;

(vi) gastrointestinal;

(vii) genitourinary;

(viii) musculoskeletal;

(ix) integumentary (skin and/or breast);

(x) neurological;

(xi) psychiatric;

(xii) endocrine;

(xiii) hematologic/lymphatic; and

(xiv) allergic/immunologic.

82. Pursuant to the CPT Assistant, in the context of patient examinations and examinations, a physician has not conducted a complete examination of a patient's musculoskeletal organ system unless the physician has documented findings with respect to:

(i) at least three of the following: (a) standing or sitting blood pressure; (b) supine blood pressure; (c) pulse rate and regularity; (d) respiration; (e) temperature; (f) height; or (g) weight;

(ii) the general appearance of the patient – e.g., development, nutrition, body habits, deformities, and attention to grooming;

(iii) examination of the peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness);

(iv) palpation of lymph nodes in neck, axillae, groin, and/or other location;

(v) examination of gait and station;

(vi) examination of joints, bones, muscles, and tendons in at least four of the following areas: (a) head and neck; (b) spine, ribs, and pelvis; (c) right upper extremity; (d) left upper extremity; (e) right lower extremity; and/or (f) left lower extremity;

(vii) inspection and palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café-au-lait spots, ulcers) in at least four of the following areas: (a) head and neck; (b) trunk; (c) right upper extremity; (d) left upper extremity; (e) right lower extremity; and/or (f) left lower extremity;

(viii) coordination, deep tendon reflexes, and sensation; and

(ix) mental status, including orientation to time, place and person, as well as mood and affect.

83. In fact, with respect to the claims for initial examinations under CPT code 99204 that are identified in Exhibits "1" through "3", neither Carmili, Ahmed, nor any healthcare practitioner associated with All Boro Medical, Seneca Medical, or Palmetto Medical ever conducted or recorded a "comprehensive" physical examination.

84. With respect to the claims for initial examinations under CPT code 99204 that are identified in Exhibits "1" through "3", neither Carmili, Ahmed, nor any healthcare practitioner associated with All Boro Medical, Seneca Medical, or Palmetto Medical ever conducted a general examination of multiple patient organ systems or conducted a complete examination of a single

patient organ system.

85. For instance, in each of the claims under CPT code 99204 identified in Exhibit "1", neither Carmili, Ahmed, nor any healthcare practitioner associated with All Boro Medical, Seneca Medical, or Palmetto Medical ever conducted any general examination of multiple patient organ systems, inasmuch as they did not document findings with respect to at least eight organ systems.

86. Furthermore, although the Defendants often purported to provide a more in-depth examination of the Insureds' musculoskeletal systems in the claims for initial examinations identified in Exhibits "1", the musculoskeletal examinations did not qualify as "complete", because they failed to document:

(i) at least three of the following: (a) standing or sitting blood pressure; (b) supine blood pressure; (c) pulse rate and regularity; (d) respiration; (e) temperature; (f) height; or (g) weight;

(ii) the general appearance of the patient – e.g., development, nutrition, body habits, deformities, and attention to grooming;

(iii) examination of the peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness);

(iv) palpation of lymph nodes in neck, axillae, groin, and/or other location;

(v) examination of gait and station;

(vi) examination of joints, bones, muscles, and tendons in at least four of the following areas: (a) head and neck; (b) spine, ribs, and pelvis; (c) right upper extremity; (d) left upper extremity; (e) right lower extremity; and/or (f) left lower extremity;

(vii) inspection and palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café-au-lait spots, ulcers) in at least four of the following areas: (a) head and neck; (b) trunk; (c) right upper extremity; (d) left upper extremity; (e) right lower extremity; and/or (f) left lower extremity;

(viii) coordination, deep tendon reflexes, and sensation; and/or

(ix) mental status, including orientation to time, place and person, as well as mood and affect.

87. In keeping with the fact that the initial examinations purportedly provided by the Defendants did not satisfy the requirements of examinations billed using CPT 99204, the cursory initial examination reports submitted by the Defendants were simple template, fill-in-the blank reports that contained minimal narrative discussion or meaningful analysis of a patients history and condition, and routinely failed to record even the most basic requirements of a "comprehensive" physical examination. Rather, the "treating" provider simply placed a check mark next to each system that was purportedly examined.

88. To the extent that the initial examinations reports submitted by the Defendants purported to contain any narrative discussion of a patient's condition, they contained verbatim language that was simply copy-and-pasted from one examination report to another.

89. For example, numerous examination reports contained the following findings that could not plausibly apply to large volume Insureds whose reports to whom the Defendants purported to apply them:

- "Radiation: R/L shoulder and arm. R/L leg and foot with tingling and sensation in the foot."
- "Factor aggravating pain: Standing, Sitting or Reaching overhead."
- "CERVICAL SPINE: On examination, mild tenderness along with muscle spasm is noted in the para cervical musculature. There is tenderness to percussion at the C1, C2, C3, C4, C5, C6, C7 vertebral levels."
- "LUMBAR SPINE: On examination, there is spasm of lumbar erector spinae. There is tenderness to percussion at the L1, L2, L3, L4, L5 vertebral levels."
- "SHOULDERS EXAM: Examination revealed decreased range of motion in all planes."
- "LEFT / RIGHT KNEE EXAM: Tenderness is present, range of motion is restricted and painful."

90. The specific findings above appeared in virtually all examinations reported

submitted to GEICO through All Boro Medical, Seneca Medical, and Palmetto Medical, regardless of whether the Insured even complained of an injury with respect to the relevant body part.

91. In the claims identified in Exhibits "1" through "3", when the Defendants billed for the initial examinations under CPT code 99204, they falsely represented that they performed "comprehensive" patient examinations on the Insureds during the initial examinations.

92. In fact, the Defendants had not provided "comprehensive" examinations because they had not documented findings with respect to at least eight of the Insureds' organ systems, nor had they documented "complete" examinations of the Insureds' musculoskeletal systems or any of the Insureds' other organ systems.

93. The Defendants falsely represented that the initial examinations included "comprehensive" physical examinations in order to provide a false basis to bill for the initial examinations under CPT codes 99204, because those CPT codes are reimbursable at a higher rate than examinations that do not require "comprehensive" physical examinations.

94. Pursuant to the Fee Schedule, the complexity of medical decision-making is measured by: (i) the number of diagnoses and/or the number of management options to be considered; (ii) the amount and/or complexity of medical records, diagnostic tests, and other information that must be retrieved, reviewed, and analyzed; and (iii) the risk of significant complications, morbidity, mortality, as well as co-morbidities associated with the patient's presenting problems, the diagnostic procedures, and/or the possible management options.

95. Although the Defendants routinely falsely represented that their initial examinations involved medical decision-making of "moderate complexity" when billing under CPT code 99204, in actuality the examinations did not involve any medical decision-making at all.

96. In the claims for initial examinations under CPT code 99204, the Defendants falsely represented that the initial examinations involved medical decision-making of high complexity or moderate complexity in order to provide a false basis to bill for the initial examinations under CPT code 99204, because those CPT codes are reimbursable at a higher rate than examinations that do not require high complexity or moderate complexity medical decision-making.

97. First, the initial examinations did not involve the retrieval, review, and analysis of any medical records, diagnostic tests, or other information. When the Insureds presented to the Defendants for treatment, they typically did not arrive with any medical records. Furthermore, prior to the initial examinations, the Defendants neither requested any medical records from any other providers, nor reviewed any diagnostic test results.

98. Second, there was no risk of significant complications or morbidity – much less mortality – from the Insureds' relatively minor complaints. Nor, by extension, was there any risk of significant complications, morbidity, or mortality from the diagnostic procedures or treatment options provided by the Defendants. In virtually every instance, the Defendants provided a substantially identical treatment plan to the Insureds, consisting of referrals for medically unnecessary physical therapy and pain management injections, none of which were threatening to an Insured's health or life if properly administered.

99. Third, the Defendants did not genuinely consider any significant number of diagnoses or treatment options for Insureds during the initial examinations.

100. Rather, to the extent that the initial examinations were conducted in the first instance, the Defendants made a boilerplate, predetermined "diagnosis" for the Insureds, upon which the Defendants directed the Insureds to receive a predetermined pattern of treatment, a recommendation for pain management injections and to return to All Boro Medical, Seneca

Medical, and Palmetto Medical for additional pain management services, and to the providers from which All Boro Medical, Seneca Medical, and Palmetto Medical leased office space from for medically unnecessary physical therapy.

101. In keeping with the fact that the initial examinations were part and parcel of a predetermined fraudulent treatment protocol, virtually every initial examination report resulted in a recommendation to continue physical therapy at the Clinics and a diagnosis of cervical and/or lumbar sprain.

102. The cervical and/or lumbar sprain diagnoses appeared in the examination report of virtually every patient seen by All Boro Medical, Seneca Medical, and Palmetto Medical, regardless of the patient's specific condition, including whether or not the patient purported to suffer any injuries to the body parts identified.

103. To the extent that the initial examinations were conducted in the first instance, the Defendants made a boilerplate, predetermined "diagnosis" for the Insureds, upon which the Defendants directed the Insureds to receive a predetermined pattern of treatment, including diagnostic testing, a recommendation to return to the providers from which All Boro Medical, Seneca Medical, and Palmetto Medical leased office space from for medically unnecessary physical therapy.

104. In keeping with the fact that the initial examinations were performed as part of a predetermined, fraudulent treatment protocol and not to genuinely treat Insureds, the Defendants often billed GEICO for two initial examinations purportedly provided to a single Insured but submitted through two of the Provider Defendants. For example, the following Insureds purportedly received initial examinations performed by Ahmed under the auspices of both All Boro Medical and Palmetto Medical: (i) RE; (ii) JG; (iii) RM; (iv) AP; (v) TP; (vi) AR; (vii) GR;

(viii) AR; and (ix) RT.

2. The Fraudulent Charges for Follow-up Examinations

105. In addition to their fraudulent initial examinations, All Boro Medical, Seneca Medical, and Palmetto Medical purported to subject many of the Insureds in the claims identified in Exhibits "1" through "3" to one or more fraudulent follow-up examinations during the course of their fraudulent treatment protocol.

106. The Defendants typically billed for the follow-up examinations under CPT code 99214, typically resulting in a charge of $127.41.

107. Like the Defendants' charges for the initial examinations, the charges for the follow-up examinations were fraudulent in that the follow-up examinations were medically unnecessary and were performed – to the extent they were performed at all – pursuant to the kickbacks that Carmili, All Boro Medical, Seneca Medical, and Palmetto Medical paid at the Clinics not to treat or otherwise benefit the Insureds.

3. The Fraudulent Charges for Outcome Assessment Testing

108. In addition to the initial and follow-up examinations, All Boro Medical and Palmetto Medical, in many of the claims listed in Exhibits "1" and "3", also subjected Insureds to medically unnecessary outcome assessment tests ("OAT"), often on or about the same dates it purportedly subjected Insureds to an initial or follow-up examination.

109. All Boro Medical and Palmetto Medical billed the OAT submitted to GEICO using CPT code 99358, typically resulting in charges of $280.12 for each session of OAT.

110. Like the Defendants' charges for the other Fraudulent Services, the charges for OAT were fraudulent in that the tests were medically unnecessary and were performed, to the extent they were performed at all, pursuant to Defendants' illegal kickback and referral arrangements as well as their fraudulent treatment and billing protocols.

111. Since a patient history and physical examination must be conducted as an element of a soft-tissue trauma patient's initial and follow-up examinations, and since the OAT that All Boro Medical and Palmetto Medical purportedly provided was nothing more than a questionnaire regarding each Insured's history and physical condition, the Fee Schedule provides that the OAT should have been reimbursed as an element of the patient's initial and follow-up examinations.

112. In other words, healthcare providers cannot conduct and bill for patient examinations and then bill separately for contemporaneously provided OAT.

113. In the event All Boro Medical or Palmetto Medical did actually perform the OAT that it billed to GEICO, the information gained using the OAT would not have been significantly different from the information that the Defendants purported to obtain during the patient history and physical examinations it purported to perform as part of virtually every Insured's initial and/or follow-up examination. In fact, All Boro Medical and Palmetto Medical, in their billing for fraudulent initial and follow-up examinations, represented that they took at least a "detailed" patient history and performed a "detailed" physical examination.

114. The OAT represented purposeful and unnecessary duplication of the patient histories purportedly conducted during the Insureds' initial and follow-up examinations. In that regard, the OAT were part and parcel of the Defendants' overall fraudulent scheme, inasmuch as the "service" was rendered – to the extent rendered at all – pursuant to a predetermined protocol that was designed solely to financially enrich Defendants and in no way aided in the assessment and treatment of the Insureds.

115. The Defendants' use of CPT code 99358 to bill for the OAT also constituted a deliberate misrepresentation of the extent of the service that was provided. Pursuant to the Fee Schedule, the use of CPT code 99358 represents – among other things – that the physician actually

spent at least one hour performing some prolonged service, such as a review of extensive records and tests, or communication with the Insured and the Insured's family.

116. Though All Boro Medical and Palmetto Medical routinely submitted billing under CPT code 99358 for OAT, neither Carmili, Ahmed, nor any healthcare professional associated with All Boro Medical or Palmetto Medical spent an hour reviewing or administering the tests or communicating with the Insureds or their families.

117. Indeed, the OAT did not require any physician involvement at all, because the "tests" simply were questionnaires that were completed by the Insureds.

118. In fact, the Defendants did not even bother to prepare a narrative report summarizing the test results. Instead, All Boro Medical and Palmetto submitted the questionnaires to GEICO with no indication that Carmili, Ahmed, or any healthcare professional associated with the Defendants performed any services whatsoever in connection with the OAT, let alone an hour of prolonged services.

119. Unsurprisingly, since the OAT was medically unnecessary and performed pursuant to the Defendants' predetermined fraudulent treatment protocols and illegal kickback and referral arrangements, the results of the OAT, like the other Fraudulent Services, was not incorporated into the Insureds' respective treatment plans.

4. The Fraudulent Charges for Videonystagmography and Computerized Dynamic Posturography

120. The Defendants purported to subject many Insureds to medically unnecessary videonystagmography ("VNG") tests and computerized dynamic posturography ("CDP") tests.

121. The charges for the VNG and CDP tests (collectively "VNG/CDP") were fraudulent in that the VNG/CDP tests were medically unnecessary and were performed – to the extent that they were performed at all – pursuant to the kickbacks the Defendants paid that allowed

the Defendants access to the Clinics' patients.

122. Seneca Medical billed the VNG/CDP to GEICO using CPT codes 92537, 92540, 92546, 92547, and 92548 generally resulting in charges of $421.13 for each VNG/CDP test it purported to provide.

a. Legitimate Uses for VNG/CDP Tests

123. VNG/CDP tests consist of tests that can be used to determine the cause of a patient's vertigo or balance disorder in cases where there are no readily recognizable contributing factors to the patient's condition.

124. In other words, VNG/CDP tests are not used to confirm the existence of dizziness or a balance disorder, but rather to identify the origin of the condition in the relatively rare cases where it cannot be determined through an ENT or neurological medical examination. Generally, VNG/CDP tests are employed to determine the source of the generation of vertigo, i.e., the inner ear or brain.

125. VNG tests record involuntary eye movements, called nystagmus, using video imaging technology. The nystagmus is recorded and analyzed using sophisticated video goggles which are equipped with infrared video cameras. The patient wears these goggles while being subjected to various stimuli, which duplicates the extraocular movement portion of the physical examination.

126. There are four main components to VNG testing: (i) the saccade test, which evaluates rapid eye movements between fixation points; (ii) the tracking test, which evaluates movement of the eyes as they pursue a visual target; (iii) the positional test, which measures eye movements associated with positions of the head; and (iv) the caloric test, which measures responses to warm or cold water or air circulated through the ear canal. The cameras record the

eye movements and display them on a video/computer screen. This allows the physician to see how the eyes move, which helps the physician assess the patient's vertigo, which in turn helps the physician assess the source of imbalance.

127. To properly administer a VNG test, the patient must be prepared appropriately. This preparation typically requires 72 hours of abstention from medication (with the exception of heart, high blood pressure and anticonvulsant medications); 24 hours of abstention from stimulants such as caffeine, as well as alcohol; and three hours of food abstention. In addition, patients must be provided with a pre-test history and examination, to determine – among other things – the nature of the problematic symptoms and the patient's eye movements.

128. VNG/CDP tests should not be used as a first-line diagnostic procedure when a patient reports dizziness as the result of automobile accident trauma. A legitimate diagnostic process for a patient reporting dizziness following an automobile accident should begin with a physical examination, including an ENT and neurological examination, followed by conservative care absent evidence of a more serious condition, e.g., a brain tumor. If the patient does not respond to conservative care, an MRI of the brain may be ordered. If a patient does not respond to conservative care, and the brain MRI is negative, the patient may be evaluated by an ENT or neurologist to determine if VNG/CDP is warranted. Virtually none of the Insureds were referred to the Provider Defendants by an ENT or a neurologist, the vast majority did not undergo conservative care prior to undergoing VNG/CDP testing with the Provider Defendants, and virtually none received a brain MRI prior to undergoing the VNG/CDP testing with the Provider Defendants.

b. The Defendants' Fraudulent VNG/CDP Testing Charges

129. Seneca Medical did not perform independent evaluations on Insureds to determine

if the VNG/CDP testing was medically necessary.

130. Instead, the Defendants performed the VNG/CDP testing pursuant to referrals issued by the Referring Providers as part of a predetermined protocol.

131. To the extent the Referring Providers conducted medical examinations that assessed the Insureds' neurological symptoms, virtually none of the Insureds who received VNG/CDP testing from the Provider Defendants reported experiencing dizziness, imbalance, or vertigo in the examination reports that preceded the VNG/CDP testing.

132. In even more egregious cases, the patent histories and examinations documented in the Referring Providers' examination reports directly contradicted the need for the VNG/CDP tests, nevertheless the Defendants subjected the Insureds to multiple rounds of testing.

133. For example:

(i) On December 8, 2021, an Insured named MA was purportedly involved in a motor vehicle accident. On December 15, 2021, MA sought treatment with Hasanuzzaman Medical Care P.C. and Mohammad Hasanuzzaman, M.D. ("Hasanuzzaman") at the Clinic located at 4011 Warren Street, Elmhurst, New York. At that visit, Hasanuzzaman did not document any dizziness, vertigo, or tinnitus. Nevertheless, on December 20, 2021, MA underwent VNG/CDP testing by Seneca Medical pursuant to a referral purportedly from Hasanuzzaman.

(ii) On July 9, 2021, and Insured named CR was purportedly involved in a motor vehicle accident. On December 9, 2021, CR sought treatment with Syed Asim Maqsood Medical P.C. and Syed Maqsood, D.O. ("Maqsood") at the Clinic located at 9709 Spingfield Boulevard, Jamaica, New York. At that visit, Maqsood did not document any vertigo and tinnitus and explicitly reported that patient denied any dizziness. Nevertheless, on January 5, 2022, CR underwent VNG/CDP testing by Seneca Medical.

(iii) On October 13, 2021, and Insured named CB was purportedly involved in a motor vehicle accident. On November 23, 2021, CB sought treatment with Syed Asim Maqsood Medical P.C. and Maqsood at the Clinic located at 9709 Spingfield Boulevard, Jamaica, New York. At that visit, Maqsood did not document any vertigo and tinnitus and explicitly reported that patient denied any dizziness. Nevertheless, on January 5, 2022, CB underwent VNG/CDP testing by Seneca Medical.

(iv) On July 28, 2021, and Insured named JP was purportedly involved in a motor vehicle accident. On August 23, 2021, JP sought treatment with Tri-Borough NY Medical Practice P.C. and Patricia Kelly, M.D. ("Kelly") at the Clinic located at 409 Rockaway Avenue, Brooklyn, New York. At that visit, Kelly did not document any dizziness, vertigo, or tinnitus. Nevertheless, on December 16, 2021, JP underwent VNG/CDP testing by Seneca Medical.

(v) On November 17, 2021, and Insured named KC was purportedly involved in a motor vehicle accident. On November 24, 2021, KC sought treatment with Quazi R Medical Services P.C. and Quazi Rahman, M.D. ("Rahman") at the Clinic located at 13721 220th Place, Laurelton, New York. At that visit, Rahman did not document any dizziness, vertigo, or tinnitus. Nevertheless, on November 30, 2021, KC underwent VNG/CDP testing by Seneca Medical.

(vi) On August 31, 2021, and Insured named KM was purportedly involved in a motor vehicle accident. On September 23, 2021, KM sought treatment with Tri-Borough NY Medical Practice P.C. and Kelly at the Clinic located at 203-12 Hillside Avenue, Hollis, New York. At that visit, Kelly did not document any dizziness, vertigo, or tinnitus. Nevertheless, on December 2, 2021, KM underwent VNG/CDP testing by Seneca Medical.

(vii) On March 27, 2021, and Insured named DH was purportedly involved in a motor vehicle accident. On January 11, 2022, DH sought treatment with WeCare Medical Services P.C. and Paul Brown, M.D. ("Brown") at the Clinic located at 381 Rockaway Avenue, Brooklyn, New York. At that visit, Brown did not document any dizziness, vertigo, or tinnitus. Nevertheless, on January 19, 2022, DH underwent VNG/CDP testing by Seneca Medical.

134. These are only representative examples.

135. In virtually all the claims identified in Exhibit "2", the Insureds who received VNG/CDP testing with Seneca Medical did so despite exhibiting no dizziness, vertigo, tinnitus, or gait abnormalities.

136. Although virtually none of the Insureds who received VNG/CDP displayed symptoms warranting the testing, the Defendants submitted, or caused to be submitted, thousands of dollars in bills for VNG/CDP testing to GEICO, as part of the Fraudulent Services.

137. Moreover, there are a substantial number of variables that can affect whether, how,

and to what extent an individual is injured in an automobile accident. These variables include, but are not limited to, an individual's age, height, weight, general physical condition, location within the vehicle, and the location of the impact.

138. It is extremely improbable – to the point of impossibility – that multiple Insureds involved in the same automobile accident would routinely require VNG/CDP testing at or about the same time.

139. Even so, and in keeping with the fact that the VNG/CDP testing purportedly performed by the Defendants was not medically necessary and was performed pursuant to predetermined protocols to maximize profits, the Defendants routinely provided VNG/CDP testing to multiple Insureds involved in the same accident at or about the same time.

140. Seneca Medical routinely provided VNG/CDP testing to multiple Insureds involved in the same accident at or about the same time as follows:

(i) On September 18, 2021, two insureds – ZK and TK - were involved in the same automobile accident. Thereafter, ZK and TK both - incredibly – were purportedly subjected to VNG/CDP testing by Seneca Medical on January 26, 2022.

(ii) On October 24, 2021, two insureds – BJ and CP - were involved in the same automobile accident. Thereafter, BJ and CP both - incredibly – were purportedly subjected to VNG/CDP testing by Seneca Medical on January 3, 2022 and January 13, 2023, respectively.

(iii) On December 12, 2021, two insureds – AP and SP - were involved in the same automobile accident. Thereafter, AP and SP both - incredibly – were purportedly subjected to VNG/CDP testing by Seneca Medical on January 3, 2022.

(iv) On December 8, 2021, two insureds – GK and PK - were involved in the same automobile accident. Thereafter, GK and PK both - incredibly – were purportedly subjected to VNG/CDP testing by Seneca Medical on January 18, 2022 and January 10, 2022, respectively.

(v) On August 28, 2021, two insureds – ZS and BA - were involved in the same automobile accident. Thereafter, ZS and BA both - incredibly – were

purportedly subjected to VNG/CDP testing by Seneca Medical on December 6, 2021.

(vi) On August 31, 2021, two insureds – KM and JW - were involved in the same automobile accident. Thereafter, KM and JW both - incredibly – were purportedly subjected to VNG/CDP testing by Seneca Medical on December 2, 2021.

(vii) On December 28, 2021, two insureds – BG and TY - were involved in the same automobile accident. Thereafter, BG and TY both - incredibly – were purportedly subjected to VNG/CDP testing by Seneca Medical on January 13, 2022.

(viii) On June 6, 2021, two insureds – SH and JR - were involved in the same automobile accident. Thereafter, SH and JR both - incredibly – were purportedly subjected to VNG/CDP testing by Seneca Medical on November 15, 2021.

(ix) On January 10, 2022, two insureds – MP and JP - were involved in the same automobile accident. Thereafter, MP and JP both - incredibly – were purportedly subjected to VNG/CDP testing by Seneca Medical on January 13, 2022.

(x) On August 1, 2021, two insureds MH and NJ - were involved in the same automobile accident. Thereafter, MH and NJ both - incredibly – were purportedly subjected to VNG/CDP testing by Seneca Medical on December 14, 2021.

141. These are only representative examples.

142. In many of the claims identified in Exhibit "2", two or more Insureds involved in the same underlying accident received VNG/CDP testing from the Defendants at or about the same time, despite the fact that the Insureds were differently situated.

143. Even if an Insured reported the existence of some general form of dizziness or balance disorder, the VNG/CDP tests that supposedly were provided by the Defendants were medically unnecessary because the cause of the Insured's dizziness or imbalance could be identified through the physical examinations that the Referring Providers routinely purported to provide, and the patient histories and examinations that they purported to take, during every initial

examination/consultation and follow-up examination.

144. In keeping with the fact that the VNG/CDP tests that supposedly were provided by the Defendants were medically unnecessary, upon information and belief no physician or healthcare provider associated with the Defendants properly prepared the Insureds for the tests or conducted any sort of pre-test evaluation or screening. This, in turn, rendered the data that the Defendants purported to obtain from the tests unreliable and useless.

145. Because the Defendants knew the VNG/CDP tests were unreliable and useless, the results that the Defendants purported to obtain from the tests was not incorporated into any Insured's treatment plan. Even when the VNG/CDP tests returned a positive result, the Insureds rarely, if ever, underwent vestibular rehabilitation, balance retraining, or any other therapy to address their putative balance issues.

146. In further keeping with the fact that the VNG/CDP tests were unreliable and useless, in many instances when the VNG/CDP tests returned inconclusive results, the Insureds did not undergo additional testing to generate conclusive results.

147. In keeping with the fact that the VNG/CDP tests were medically unnecessary and administered pursuant to a predetermined fraudulent treatment protocol, virtually all the VNG/CDP reports contain pre-printed, boilerplate language, stating "patient c/o recurrent episodes of dizziness and headaches" even though virtually none of the patients who treated with the Defendants actually complained of recurrent episodes of dizziness.

148. In further keeping with the fact that the VNG/CDP tests were unreliable and useless, to the extent the Provider Defendants generated Infrared/Video ENG Reports as a result of the VNG tests, the Infrared/Video ENG Reports virtually always contained the following pre-printed boilerplate test results:

- "Summary and Impression: Of the test performed [sic], normal VNG evaluation. No peripheral or central vestibular disorders noted. The variable history and clinical findings can be impaired by unspecified posttraumatic or psychogenic vertiginous disorder."

- "Recommendations: Clinical correlation is suggested. Balance rehabilitation is recommended for symptomatic improvement is symptoms persist. The treatment plan may be designed for the pt to force the use of vestibular system input on demand with habituation exercises."

149. It is clear the VNG/CDP testing was purportedly rendered and then billed to GEICO pursuant to the Defendants' fraudulent treatment and billing protocols designed solely to financially enrich the Defendants, rather than to benefit any of the Insureds who supposedly were subjected to the tests.

5. The Fraudulent Charges for Transcranial Doppler Studies

150. The Defendants also purported to subject many Insureds to medically unnecessary transcranial doppler ("TCD") testing.

151. The charges for the TCD testing were fraudulent in that the transcranial doppler tests were medically unnecessary and were performed—to the extent they were performed at all—pursuant to fraudulent treatment protocols and illegal kickback and referral arrangements.

152. Carmili and Seneca Medical then billed the TCD to GEICO using CPT 93886, 93890, and 93892, typically resulting in charges of $486.55 for each session of TCD they purported to provide.

a. Legitimate Uses for TCD

153. TCD is an ultrasound technique that uses sound waves to evaluate blood flow (blood circulation) in and around the brain.

154. TCD typically uses a Doppler Transducer that enables recording of blood flow velocities from intracranial arteries through selected cranial foramina and thin regions of the skull.

Mapping of the sampled velocities as a color display of spectra locates the major brain arteries in three dimensions.

155. TCD obtains information about the physiology of blood flow through the intracranial cerebrovascular system.

156. Depending on the type of measurement needed, TCD studies can take at least 45 minutes, if not more.

157. TCD evaluation of the intracranial cerebrovascular system is generally used in connection with the following:

(i) Vasospasm, following a ruptured brain aneurysm;

(ii) Sickle cell anemia, to determine a patient's stroke risk;

(iii) Ischemic stroke;

(iv) Intracranial stenosis or blockage of the blood vessels;

(v) Cerebral microemboli; or

(vi) Patent Foramen Ovale, a hole in the heart that does not close properly after birth, which may provoke embolic stroke.

158. The symptomology of the above-named conditions includes sudden severe headache with no known cause; numbness, weakness, or paralysis of the face, arm, leg, or one side of the body; confusion; trouble speaking, seeing, or walking; and/or sudden dizziness, loss of balance, or loss of coordination.

159. Headaches or dizziness following head trauma are not indications for TCD studies of the intracranial cerebrovascular system.

160. Moreover, in the event the Insureds did suffer from any such symptoms, the onset of those symptoms was nether sudden nor unexplained but rather a purported result of the motor vehicle accidents that caused them to seek treatment at the No-Fault Clinics in the first instance.

161. In a legitimate setting, if a medical doctor needs to examine a patient's intracranial circulation he or she orders a magnetic resonance angiogram ("MR angiogram") or a computed tomography angiogram ("CT angiogram"), both of which measure and visualize intracranial blood flow with more accuracy than TCD.

162. Indeed, there are virtually no clinical indications for TCD in an outpatient setting.

b. The Defendants' Fraudulent TCD Charges

163. The Defendants did not perform independent evaluations on Insureds to determine if the TCD was medically necessary.

164. Instead, the Defendants performed the TCD pursuant to referrals from the Referring Providers.

165. In keeping with the fact that the TCD was performed pursuant to predetermined treatment protocols, the medical examinations performed by the Referring Providers often failed to screen for the symptoms that would warrant TCD.

166. To the extent the Referring Providers conducted medical examinations that assessed the Insureds' head pain and neurological symptoms, in virtually all cases where the Defendants purported to provide TCD, the Insureds did not suffer any sort of injury as the result of the automobile accident that would warrant the TCD.

167. Indeed, in keeping with the fact that that the TCD was medically useless and performed on a protocol basis rather than to benefit any of the Insureds, the diagnoses generated by the Referring Providers and listed on the Provider Defendants' billing to justify the TCD they administered to Insureds were often directly contradicted by the medical records generated by the Referring Providers.

168. Despite virtually none of the Insureds who received TCD displaying symptoms

warranting the testing, the Defendants submitted, or caused to be submitted, hundreds of thousands of dollars in bills for TCD to GEICO.

169. Specifically, virtually none of the Insureds who received TCD at Seneca Medical reported suffering sudden or unexplained severe headaches, numbness or weakness, confusion, trouble speaking, seeing, or walking, and/or sudden dizziness, loss of balance, and/or coordination.

170. Moreover, it is extremely improbable – to the point of impossibility – that multiple Insureds involved in the same automobile accident would routinely require TCD at or about the same time.

171. Even so, and in keeping with the fact that the TCD purportedly performed by the Defendants was not medically necessary and was performed pursuant to predetermined protocols to maximize profits, Carmili and Seneca Medical routinely provided TCD to multiple Insureds involved in the same accident at or about the same time.

172. For example:

(i) On September 18, 2021, two insureds – ZK and TK - were involved in the same automobile accident. Thereafter, ZK and TK both - incredibly - received TCD from Seneca Medical on January 26, 2022.

(ii) On October 24, 2021, two insureds – BJ and CP - were involved in the same automobile accident. Thereafter, BJ and CP both - incredibly - received TCD from Seneca Medical on January 3, 2022 and January 13, 2022, respectively.

(iii) On December 12, 2021, two insureds – AP and SP - were involved in the same automobile accident. Thereafter, AP and SP both - incredibly - received TCD from Seneca Medical on January 3, 2022.

(iv) On December 8, 2021, two insureds GK and PK - were involved in the same automobile accident. Thereafter GK and PK both - incredibly - received TCD from All Boro Medical on January 18, 2022 and January 10, 2022, respectively.

(v) On November 17, 2021, two insureds – KC and RH - were involved in the same automobile accident. Thereafter, KC and RH both - incredibly -

received TCD from Seneca Medical on November 30, 2021.

(vi) On August 28, 2021, two insureds – ZS and BA - were involved in the same automobile accident. Thereafter, ZS and BA both - incredibly - received TCD from Seneca Medical on December 6, 2021.

(vii) On August 31, 2021, two insureds – JW and KM - were involved in the same automobile accident. Thereafter, JW and KM both - incredibly - received TCD from Seneca Medical on December 2, 2021.

(viii) On December 28, 2021, two insureds – , BG and TY - were involved in the same automobile accident. Thereafter, BG and TY both - incredibly - received TCD from Seneca Medical on January 13, 2022.

(ix) On June 26, 2021, two insureds – SH and JR - were involved in the same automobile accident. Thereafter, SH and JR both - incredibly - received TCD from Seneca Medical on November 15, 2021.

(x) On January 10, 2022, two insureds – MP and JP - were involved in the same automobile accident. Thereafter, MP and JP both - incredibly - received TCD from Seneca Medical on December 14, 2021.

173. These are only representative examples.

174. In many of the claims identified in Exhibit "2", two or more Insureds involved in the same underlying accident received TCD from Seneca Medical at or about the same time, even though the Insureds were differently situated.

175. As with the other Fraudulent Services, the TCD was rendered and billed pursuant to the Defendants' fraudulent treatment and billing protocol designed solely to financially enrich the Defendants, rather than to benefit any of the Insureds who supposedly were subjected to the tests.

176. Indeed, even had the Insureds displayed symptoms warranting TCD, in a legitimate clinical setting the practitioner would initially administer a transcranial doppler study of the intracranial arteries, billed using CPT code 93886 or CPT code 93888, and would only proceed to perform a vasoreactivity test, billed using CPT code 93890 if the Insured displayed symptomology

warranting that additional testing. Nevertheless, the Provider Defendants routinely purported to provide vasoreactivity test billed using CPT code 93890 simultaneous with study of the intracranial arteries, billed using CPT code 93886.

177. In keeping with the fact that the Defendants performed TCD – to the extent performed at all – pursuant to a predetermined fraudulent protocol and not for the benefit of Insureds, in virtually every instance, the reports generated by the Provider Defendants as a result of the TCD failed to contain any actual data points or analysis regarding the TCD.

6. The Fraudulent Charges for Pain Management Injections

178. As part and parcel of the Defendants' fraudulent scheme, Carmili, All Boro Medical, and Palmetto Medical caused many of the Insureds in the claims identified in Exhibits "1" and "3" to be subjected to a series of medically unnecessary pain management injections including nerve block point injections, generally performed using ultrasound guidance.

179. Typically, Carmili and/or Ahmed purported to perform the injections.

180. As set forth in Exhibits "1" and "3", Carmili then: (i) billed the injections through All Boro Medical or Palmetto Medical to GEICO, typically under CPT codes 64510, 64520, and 76942.

181. As set forth below, the charges for the pain management injections were fraudulent because the pain management injections were medically unnecessary and were provided – to the extent that they were provided at all – pursuant to the Defendants' predetermined fraudulent treatment and billing protocol, and not to treat or otherwise benefit the Insureds who were subjected to it.

182. In addition, the charges for the pain management injections were fraudulent in that they misrepresented the services actually provided and failed to properly document the services provided.

a. The Defendants' Fraudulent Pain Management Injections

183. Generally, when a patient presents with a soft tissue injury such as a sprain or strain secondary to an automobile accident, the initial standard of care is conservative treatment comprised of rest, ice, compression, and – if applicable – elevation of the affected body part.

184. If that sort of conservative treatment does not resolve the patient's symptoms, the standard of care can include other conservative treatment modalities such as chiropractic treatment, physical therapy, and the use of pain management medication.

185. The substantial majority of soft tissue injuries such as sprains and strains will resolve over a period of weeks through this sort of conservative treatment, or no treatment at all.

186. In a legitimate clinical setting, pain management injections should not be administered until a patient has failed more conservative treatments, including chiropractic treatment, physical therapy, and pain management medication.

187. This is because the substantial majority of soft tissue injuries such as sprains and strains will resolve over a period of weeks through conservative treatment, or no treatment at all, and invasive interventional pain management procedures entail a degree of risk to the patient that is absent in conservative forms of treatment.

188. Nevertheless, the Defendants routinely purported to provide pain management injections less than thirty days after an Insureds' motor vehicle accident, and often less than a week after the Insured's accident, well before a patient could have possibly failed more conservative treatment.

189. For example:

(i) On April 18, 2023, an Insured named PH purportedly received a pain management injection from All Boro Medical at the Clinic located at 3432 Tremont Avenue, Bronx, New York only 1 day after being involved in a motor vehicle accident on April 17, 2023.

(ii) On April 15, 2022, an Insured named EW purportedly received a pain management injection from All Boro Medical at the Clinic located at 3000 Eastchester Road, Bronx, New York only 1 day after being involved in a motor vehicle accident on April 14, 2022.

(iii) On December 29, 2022, an Insured named CV purportedly received a pain management injection from All Boro Medical at the Clinic located at 69-37 Myrtle Avenue, Glendale, New York only 2 days after being involved in a motor vehicle accident on December 27, 2022.

(iv) On May 8, 2023, an Insured named KM purportedly received a pain management injection from All Boro Medical at the Clinic located at 160-59 Rockaway Boulevard, Jamaica, New York only 3 days after being involved in a motor vehicle accident on May 5, 2023.

(v) On June 3, 2022, an Insured named OB purportedly received a pain management injection from All Boro Medical at the Clinic located at 3000 Eastchester Road, Bronx, New York only 3 days after being involved in a motor vehicle accident on May 31, 2022.

(vi) On November 1, 2022, an Insured named VF purportedly received a pain management injection from All Boro Medical at the Clinic located at 3432 East Tremont Avenue, Bronx, New York only 3 days after being involved in a motor vehicle accident on October 29, 2022.

(vii) On January 12, 2023, an Insured named JMR purportedly received a pain management injection from All Boro Medical at the Clinic located at 69-37 Myrtle Avenue, Glendale, New York only 3 days after being involved in a motor vehicle accident on October 29, 2022.

(viii) On June 26, 2023, an Insured named KT purportedly received a pain management injection from Palmetto Medical at the Clinic located at 160-59 Rockaway Boulevard, Jamaica, New York only 4 days after being involved in a motor vehicle accident on June 22, 2023.

(ix) On November 29, 2022, an Insured named AC purportedly received a pain management injection from All Boro Medical at the Clinic located at 3432 East Tremont Avenue, Bronx, New York only 4 days after being involved in a motor vehicle accident on November 25, 2022.

(x) On February 10, 2023, an Insured named OA purportedly received a pain management injection from All Boro Medical at the Clinic located at 3000 Eastchester Road, Bronx, New York only 5 days after being involved in a motor vehicle accident on February 5, 2022.

190. There are only representative samples. The Defendants routinely purported to

provide medically unnecessary pain management injections well before a patient could have plausibly failed more conservative treatment.

191. In a legitimate clinical setting, pain management injections should not, absent certain clinical presentations not present here, be administered more than once every two months, and multiple varieties of pain management injections should not be administered simultaneously.

192. This is because: (i) properly administered pain management injections should generally provide pain relief lasting for at least two months; (ii) a proper interval between pain management injections, and different types of pain management injections, is necessary to determine whether or not the initial pain management injections were effective; and (iii) if a patient's pain is not relieved through the pain management injections, the pain may be caused by something more serious than a soft tissue injury secondary to an automobile accident, and the perpetuating factors of the pain must be identified and managed.

193. However, in the claims for pain management injections identified in Exhibit "1", Carmili and All Boro Medical routinely purported to administer multiple pain management injections to Insureds within a span of weeks, even though such a regimen was not only medically unnecessary, but also placed the Insureds at risk.

194. For example:

(i) On June 10, 2022, an Insured named MDD was involved in an automobile accident. Thereafter, on June 14, 2022, All Boro Medical and Carmili purported to provide a nerve block injection to MDD. Only a month later, on July 14, 2022, All Boro Medical and Carmili purported to provide a second nerve block injection to MDD. Barely a month after that, on August 16, 2022, All Boro Medical and Carmili purported to provide a third nerve block injection to MDD. Barely a month after that, on September 20, 2022, All Boro Medical and Carmili purported to provide a fourth nerve block injection to MDD. Only five weeks after that, All Boro Medical and Carmili, on October 27, 2022, purported to provide a fifth nerve block injection to MDD.

(ii) On October 20, 2022, an Insured named PW was involved in an automobile accident. Thereafter, on December 13, 2022, All Boro Medical and Carmili purported to provide a nerve block injection to PW. Barely a month later, on January 19, 2023, All Boro Medical and Carmili purported to provide a second nerve block injection to PW. Barely a month after that, on February 21, 2023, All Boro Medical and Carmili purported to provide a third nerve block injection to PW. Exactly one month after that, on March 21, 2023, All Boro Medical and Carmili purported to provide a fourth nerve block injection to PW.

(iii) On January 31, 2023, an Insured named DM was involved in an automobile accident. Thereafter, on February 3, 2023, All Boro Medical and Carmili purported to provide a nerve block injection to DM. Exactly one month later, on March 3, 2023, All Boro Medical and Carmili purported to provide a second nerve block injection to DM. Barely a month after that, on April 7, 2023, All Boro Medical and Carmili purported to provide a third nerve block injection to DM.

(iv) On September 14, 2022, an Insured named BD was involved in an automobile accident. Thereafter, on September 26, 2022, All Boro Medical and Carmili purported to provide a nerve block injection to BD. Only three weeks later, on October 17, 2022, All Boro Medical and Carmili purported to provide a second nerve block injection to BD.

(v) On May 29, 2022, an Insured named AB was involved in an automobile accident. Thereafter, on June 8, 2022, All Boro Medical and Carmili purported to provide a nerve block injection to AB. Barely a month after that, on July 13, 2022, All Boro Medical and Carmili purported to provide a second nerve block injection to AB. Barely a month after that, on August 17, 2022, All Boro Medical and Carmili purported to provide a third nerve block injection to AB. Barely a month after that, on September 21, 2022, All Boro Medical and Carmili purported to provide a fourth nerve block injection to AB. Less than a month after that, All Boro Medical and Carmili, on October 20, 2022, purported to provide a fifth nerve block injection to AB. Less than six weeks after that, All Boro Medical and Carmili, on December 1, 2022, purported to provide a sixth nerve block injection to AB.

(vi) On December 9, 2022, an Insured named FAP was involved in an automobile accident. Thereafter, on February 15, 2023, All Boro Medical and Carmili purported to provide a nerve block injection to FAP. Barely a month later, on March 16, 2023, All Boro Medical and Carmili purported to provide a second nerve block injection to FAP. Barely a month after that, on April 19, 2023, All Boro Medical and Carmili purported to provide a third nerve block injection to FAP.

(vii) On June 9, 2022, an Insured named DS was involved in an automobile

accident. Thereafter, on June 14, 2022, All Boro Medical and Carmili purported to provide a nerve block injection to DS. Exactly one month later, on July 14, 2022, All Boro Medical and Carmili purported to provide a second nerve block injection to DS. Only five weeks after that, on August 23, 2022, All Boro Medical and Carmili purported to provide a third nerve block injection to DS.

(viii) On March 18, 2022, an Insured named MG was involved in an automobile accident. Thereafter, on May 4, 2022, All Boro Medical and Carmili purported to provide a nerve block injection to MB. Barely a month after that, on June 8, 2022, All Boro Medical and Carmili purported to provide a second nerve block injection to MB. Less than five weeks after that, on July 13, 2022, All Boro Medical and Carmili purported to provide a third nerve block injection to MB. Less than five weeks after that, on August 17, 2022, All Boro Medical and Carmili purported to provide a fourth nerve block injection to MB.

(ix) On September 16, 2022, an Insured named SP was involved in an automobile accident. Thereafter, on September 26, 2022, All Boro Medical and Carmili purported to provide a nerve block injection to SP. Only two weeks later, on October 10, 2022, All Boro Medical and Carmili purported to provide a second nerve block injection to SP.

(x) On January 9, 2023, an Insured named JMR was involved in an automobile accident. Thereafter, on January 12, 2023, All Boro Medical and Carmili purported to provide a nerve block injection to JMR. Barely a month after that, on February 15, 2023, All Boro Medical and Carmili purported to provide a second nerve block injection to JMR. Exactly one month after that, on March 15, 2023, All Boro Medical and Carmili purported to provide a third nerve block injection to JMR. Less than five weeks after that, on April 19, 2023, All Boro Medical and Carmili purported to provide a fourth nerve block injection to JMR.

195. The Defendants' predetermined treatment protocol – including subjecting Insureds to a large amount of medically unnecessary pain management injections over the course of a few weeks, before the Insureds had failed any legitimate course of conservative treatment – was employed by Carmili and All Boro Medical solely to maximize the potential charges that they could submit, and cause to be submitted, to GEICO, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to them.

196. In keeping in the fact that the pain management injections were provided pursuant

to a predetermined protocol designed to maximize the billing that Carmili and the Provider Defendants could submit to GEICO, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to it, Carmili, All Boro Medical, and Palmetto Medical provided pain management injections to many Insureds despite the fact that the Insureds had suffered no injuries that legitimately would warrant any pain management injections at all.

197. As set forth above, virtually all of the Insureds in the claims identified in Exhibits "1" through "3" whom the Defendants purported to treat were involved in relatively minor accidents, to the extent that they were involved in any actual accidents at all.

198. In keeping with the fact that the Insureds' accidents were minor, most of the Insureds in the claims identified in Exhibits "1" through "3" did not visit any hospital emergency room following their accidents. To the limited extent that the Insureds did report to a hospital after their accidents, they virtually always were briefly observed on an outpatient basis and then sent on their way after a few hours with, at most, a minor sprain or strain diagnosis.

199. Furthermore – and again in keeping with the fact that the Insureds' accidents were minor – contemporaneous police reports regarding the claims identified in Exhibits "1" through "3" frequently indicated that the underlying accidents involved low-speed, low-impact collisions, that the Insureds' vehicles were drivable following the accidents, and that no one was seriously injured in the underlying accidents or injured at all.

200. Virtually none of the Insureds in the claims identified in Exhibits "1" through "3" suffered from any significant injuries or health problems as a result of the relatively minor accidents they experienced or purported to experience.

201. To the extent that the Insureds in the claims identified in Exhibits "1" through "3" suffered from any injuries or health problems at all as the result of their minor accidents, the

injuries virtually always were minor, garden-variety strains and sprains.

202. As set forth above, ordinary strains and sprains virtually always resolve after a short course of conservative treatment, or no treatment at all, which is why the standard of case generally require healthcare services providers to demonstrate by contemporaneous documentation why continued treatment is necessary beyond the four-week, eight-week, and 13-week marks.

203. Concomitantly, virtually none of the Insureds in the claims identified in Exhibits "1" and "3" required extensive pain management treatment, especially invasive pain management injections provided months or even more than a year after the underlying accidents.

204. Even so, in addition to billing for medically unnecessary pain management injections before the Insureds had tried and failed any legitimate course of more conservative treatment, Carmili and All Boro Medical also routinely provided medically unnecessary pain management injections to Insureds who had been involved in very minor accidents – and who had not suffered any injury more serious than a sprain or strain – many months or even more than a year after the underlying accidents, long after any legitimate injuries the Insureds had experienced would have resolved.

205. As set forth above, Carmili, All Boro Medical, and Palmetto Medical routinely submitted billing to GEICO for medically unnecessary pain management injections, in that the pain management injections: (i) were provided, to the extent that they were provided at all, primarily for the benefit of the Defendants, and not to treat or otherwise benefit the Insureds; and (ii) were not the most appropriate standard of level of service in accordance with standards of good practice and standard professional treatment protocols.

b. The Defendants' Misrepresentations Regarding Paravertebral Sympathetic Injections

206. As part and parcel of their fraudulent treatment protocol, the Defendants routinely

represented in the billing submitted to GEICO that they provided Insureds with cervical or lumbar paravertebral sympathetic injections under CPT codes 64510 or 64520.

207. A paravertebral sympathetic injection generally involves the insertion of a needle, under x-ray or fluoroscopic guidance, into the anterior region of the spine (i.e., front of the spine) and then into a specific nerve ganglion (i.e., cluster of nerve cells) in order to provide temporary pain relief.

208. Lumbar paravertebral sympathetic injections, like those purportedly provided to Insureds by the Defendants, are performed to provide temporary relief to an Insured's legs and feet.

209. A lumbar paravertebral sympathetic injection may be appropriate for patients with certain conditions affecting their lower extremities, including:

(i) Complex regional pain syndrome (CRPS);

(ii) Phantom limb pain;

(iii) Hyperhidrosis;

(iv) Critical limb ischemia;

(v) Diabetes-related neuropathy;

(vi) Postherpetic neuralgia due to shingles (herpes zoster);

(vii) Raynaud's disease;

(viii) Cancer pain; or

(ix) Vascular pain.

210. Nevertheless, the Defendants routinely purported to provide lumbar paravertebral sympathetic injections despite the fact that none of the Insureds identified in Exhibits "1" and "3" presented with any of the above conditions, much less as a result of their purported motor vehicle

accidents.

211. Similarly, cervical paravertebral sympathetic injections, like those purportedly provided to Insureds by the Defendants, are performed to diagnose sympathetically mediated pain (a chronic neuropathic pain condition) or to treat certain circulation problems or nerve injuries not applicable to motor vehicle accident patients.

212. Specifically, a cervical paravertebral sympathetic injection may be appropriate for patients with certain conditions, including:

(i) Complex regional pain syndrome (CRPS);

(ii) Peripheral vascular disease;

(iii) Phantom limb pain;

(iv) Postherpetic neuralgia;

(v) Chronic post-surgical pain;

(vi) Hyperhidrosis;

(vii) Raynaud's syndrome;

(viii) Scleroderma;

(ix) Cluster headaches;

(x) Orofacial pain;

(xi) Atypical chest pain;

(xii) Ménière's disease;

(xiii) Intractable angina; or

(xiv) Refractory cardiac arrhythmias

213. Nevertheless, the Defendants routinely purported to provide cervical paravertebral sympathetic injections despite the fact that none of the Insureds identified in Exhibits "1" and "3"

presented with any of the above conditions, much less as a result of their purported motor vehicle accidents.

214. The Defendants falsely represented that they performed paravertebral sympathetic injections because those CPT codes are reimbursable at a higher rate than ordinary trigger point injections or diagnostic/therapeutic injections.

c. The Defendants' Failure to Properly Document Ultrasound Guidance

215. To further increase the fraudulent billing that they submitted for each round of medically unnecessary pain management injections, Defendants routinely submitted a separate charge under CPT code 76942 for ultrasound guidance.

216. The charges for ultrasound guidance of the injections were fraudulent inasmuch as, like the underlying injections, the ultrasound guidance was not medically necessary and was performed – to the extent that it was performed at all – pursuant to predetermined fraudulent protocols and illegal kickback and financial arrangements, designed to maximize the Defendants' billing rather than to treat the Insureds who supposedly were subjected to it.

217. In order to be reimbursable, ultrasound guidance procedures require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized.

218. The Defendants, however, virtually never appropriately documented the use, need, or placement of the ultrasound guidance. Nor were there any images included in the Defendants' records or any notations that images were placed into the Insureds' charts, calling into question whether ultrasound guidance was even performed in the first instance.

7. Carmili's Failure to Practice Through All Boro Medical, Seneca Medical, and Palmetto Medical

219. N.Y. Business Corporation Law § 1507 makes clear that a physician shareholder of

a medical professional corporation must be engaged in the practice of medicine through the professional corporation for it to be lawfully licensed. Section 1507 provides as follows:

> ***Issuance of shares***
>
> A professional service corporation may issue shares only to individuals who are authorized by law to practice in this state a profession which such corporation is authorized to practice and who are or have been engaged in the practice of such profession in such corporation…or who will engage in the practice of such profession in such corporation within thirty days of the date such shares are issued….All shares issued, agreements made, or proxies granted in violation of this section shall be void.

220. Legislative history confirms that a medical professional corporation's putative physician-owner not only must be licensed to practice medicine but must also be engaged in the practice of medicine through the medical professional corporation. For example, in commenting on the proposed amendment to Section 1507 in 1971, the State Education Department stated:

> This bill amends the Business Corporation Law in relation to the operation of professional service corporations. While this bill allows more flexibility in the ownership and transfer of professional service corporation stock, <u>it maintains the basic concept of restricting ownership to professionals working within the corporation</u>.

221. Similarly, the New York Department of State commented that:

> Section 1507 currently limits issuance of shares in such corporation to persons licensed by this State to practice the profession which the corporation is authorized to practice <u>and who so practice in such corporation or a predecessor entity</u>.
> The bill would add a third category of person eligible to receive stock, one who will practice such profession "within 30 days of the date such shares are issued."

222. New York's Department of Health was of the same opinion, commenting that:

> The bill would amend Article 15 of the Business Corporation Law pertaining to professional service corporations <u>to allow the issuance of shares of individuals who will engage in the practice of the profession within 30 days of the date such shares are issued, in addition to those presently so engaged</u>…. (emphasis added.)

Copies of the memoranda are annexed hereto as Exhibit "3".

223. With respect to the billing submitting to GEICO, Carmili has not legitimately

engaged in the practice of medicine through the Provider Defendants as required by New York law.

224. Specifically, Carmili does not supervise any of the treatment or services that allegedly are provided to patients of the Provider Defendants. Nor does Carmili train any of the medical professionals that allegedly provide medical services for the Provider Defendants.

225. Carmili does not work at any of the No-Fault Clinics where the Provider Defendants allegedly provide treatment and/or testing services.

226. Notably, Carmili has never been, and is, not qualified to provide and/or supervise any of the Fraudulent Services that are allegedly provided by the medical professionals associated with the Provider Defendants.

227. For example, Carmili is a physician specializing in pediatric medicine, and has neither the training nor the medical expertise to perform; (i) pain management injections; (ii) VNG/CDP; or (iii) TCD.

228. Critically, Carmili is not actually capable of: (i) performing these services that were purportedly conducted on GEICO Insureds; (ii) interpreting the results of the testing or treatment records; or (iii) supervising the services that were purportedly performed by the medical professionals working for the Provider Defendants.

229. Carmili's failure and inability to practice medicine through the Provider Defendants as well as his failure and inability to properly hire, train, or supervise the physicians who perform services billed using the name of the Provider Defendants, compromises patient care and leads to excessive and/or unnecessary testing.

III. The Fraudulent Billing Defendants Submitted or Caused to be Submitted to GEICO

230. To support their fraudulent charges, Defendants systematically submitted or caused to be submitted hundreds of NF-3, HCFA-1500 forms, and/or treatment reports through the

Provider Defendants to GEICO seeking payment for the Fraudulent Services for which the Defendants were not entitled to receive payment.

231. The NF-3, HCFA-1500 forms, and/or treatment reports submitted to GEICO by and on behalf of the Provider Defendants were false and misleading in the following material respects:

(i) The NF-3, HCFA-1500 forms and supporting documentation submitted by and on behalf of the Provider Defendants uniformly misrepresented to GEICO that the Fraudulent Services were medically necessary. In fact, the Fraudulent Services were not medically necessary and were provided pursuant to predetermined fraudulent protocols designed solely to financially enrich Defendants, rather than to treat or otherwise benefit the Insureds;

(ii) The NF-3, HCFA-1500 forms and supporting documentation submitted by and on behalf of the Provider Defendants uniformly misrepresented to GEICO that the Fraudulent Services were causally related to the Insureds' motor vehicle accidents. In fact, the Fraudulent Services were not causally related to the Insureds' motor vehicle accidents and were provided pursuant to predetermined fraudulent protocols designed solely to financially enrich Defendants, rather than to treat or otherwise benefit the Insureds;

(iii) The NF-3 forms, HCFA-1500 forms, and treatment reports submitted by and on behalf of the Provider Defendants uniformly fraudulently concealed the fact that the Fraudulent Services were provided – to the extent that they were provided at all – pursuant to illegal kickback and referral arrangements amongst the Defendants and others; and

(iv) The NF-3 forms, HCFA-1500 forms, and treatment reports submitted by and on behalf of the Provider Defendants uniformly fraudulently concealed the fact that the Provider Defendants are professional corporations operating in violation of material licensing laws in that they are medical professional corporations nominally owned by physicians who do not actually practice medicine through the professional corporations.

IV. Defendants' Fraudulent Concealment and GEICO's Justifiable Reliance

232. The Defendants legally and ethically were obligated to act honestly and with integrity in connection with the billing that they submitted, or caused to be submitted, to GEICO.

233. To induce GEICO to promptly pay the fraudulent charges for the Fraudulent Services, the Defendants systemically concealed their fraud and went to great lengths to accomplish

this concealment.

234. Specifically, the Defendants knowingly misrepresented and concealed facts related to the Provider Defendants in an effort to prevent discovery of the fact that the Provider Defendants unlawfully exchanged kickbacks for patient referrals.

235. Additionally, the Defendants entered into complex financial arrangements with one another that were designed to, and did, conceal the fact that the Provider Defendants unlawfully exchanged kickbacks for patient referrals.

236. Furthermore, the billing and supporting documentation submitted by the Provider Defendants for the Fraudulent Services, when viewed in isolation, did not reveal its fraudulent nature.

237. Nevertheless, Defendants knowingly misrepresented and concealed facts in order to prevent GEICO from discovering that the Fraudulent Services were medically unnecessary and performed – to the extent they were performed at all – pursuant to fraudulent predetermined protocols designed to maximize the charges that could be submitted, rather than to benefit the Insureds who supposedly were subjected to the Fraudulent Services.

238. In addition, the Defendants knowingly misrepresented and concealed facts related to the employment status of the health care professionals associated with the All Boro Medical in order to prevent GEICO from discovering that the health care professionals performing many of the Fraudulent Services were not employed by the Provider Defendants.

239. The Defendants also hired law firms to pursue collection of the fraudulent charges from GEICO and other insurers. These law firms routinely filed expensive and time-consuming litigation against GEICO and other insurers if the charges were not promptly paid in full.

240. The Defendants' collection efforts through numerous separate No-Fault collection

proceedings, which proceedings may continue for years, is an essential part of their fraudulent scheme since they know it is impractical for an arbitrator or civil court judge in a single No-Fault arbitration or civil court proceeding, typically involving a single bill, to uncover or address the Defendants' large scale-scale, complex fraud scheme involving numerous patients across numerous different clinics located throughout the metropolitan area.

241. GEICO is under statutory and contractual obligations to process claims promptly and fairly within 30 days. The facially valid documents submitted to GEICO in support of the fraudulent charges at issue, combined with the material misrepresentations and fraudulent litigation activity described above, were designed to and did cause GEICO to rely upon them. As a result, GEICO incurred damages of more than $549,000.00 based upon the fraudulent charges.

242. Based upon Defendants' material misrepresentations and other affirmative acts to conceal their fraud from GEICO, GEICO did not discover and could not reasonably have discovered that its damages were attributable to fraud until shortly before it filed this Complaint.

AS AND FOR A FIRST CAUSE OF ACTION
Against All Boro Medical Services, P.C., Seneca Medical P.C., and Palmetto Medical P.C.
(Declaratory Judgment – 28 U.S.C. §§ 2201 and 2202)

243. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

244. There is an actual case in controversy between GEICO and the Defendants regarding approximately $1,065,202.49 in fraudulent billing for the Fraudulent Services that has been submitted to GEICO using the names of the Provider Defendants.

245. Specifically, there is approximately $734,207.33 in pending fraudulent billing from All Boro Medical, approximately $88,427.89 in pending fraudulent billing from Seneca Medical and $242,567.27 in pending fraudulent billing from Palmetto Medical.

246. The Defendants have no right to receive payment for any pending bills submitted to GEICO because the Fraudulent Services were not medically necessary, not casually related to the Insured's motor vehicle accidents, and were provided – to the extent provided at all – pursuant to predetermined fraudulent protocols designed solely to financially enrich Defendants, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to them.

247. The Defendants have no right to receive payment for any pending bills submitted to GEICO because the Fraudulent Services in many cases, were never provided in the first instance, and the billing codes used for the Fraudulent Services misrepresented and exaggerated the level and type of services that purportedly were provided in order to inflate the charges submitted to GEICO;

248. The Defendants have no right to receive payment for any pending bills submitted to GEICO because the Fraudulent Services were provided – to the extent provided at all – pursuant to illegal kickback arrangements amongst the Defendants, and others.

249. The Defendants have no right to receive payment for any pending bills submitted to GEICO because the Provider Defendants are professional corporations operating in violation of material licensing laws in that they are medical professional corporations nominally owned by physicians who do not actually practice medicine through the professional corporations.

250. Accordingly, GEICO requests a judgment pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202, declaring that the Provider Defendants have no right to receive payment for any pending bills submitted to GEICO.

AS AND FOR A SECOND CAUSE OF ACTION

Against Carmili and All Boro Medical
(Common Law Fraud)

251. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

252. Carmili and All Boro Medical intentionally and knowingly made false and fraudulent

statements of material fact to GEICO and concealed material facts from GEICO in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

253. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that All Boro Medical was properly licensed, and therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 N.Y.C.R.R. § 65-3.16(a)(12), when in fact it was not properly licensed in that it obtained patients through an illegal kickback scheme; (ii) in every claim, the representation that the billed-for services were medically necessary, when in fact the billed-for services were not medically necessary and were performed and billed pursuant to a predetermined, fraudulent protocol designed solely to enrich Carmili and All Boro Medical; (iii) in many claims, the billed for services were provided to the Insured but were not actually provided in the first instance; and (iii) in every claim, the representation that All Boro Medical was in compliance with all material licensing laws when in fact All Boro Medical is nominally owned by a physician who does not actually practice medicine through the professional corporation. The fraudulent billings and corresponding mailings submitted to GEICO that comprise the fraudulent activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit "1".

254. Carmili and All Boro Medical intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induce GEICO to pay charges submitted through All Boro Medical that were not compensable under the No-Fault Laws.

255. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $414,000.00 pursuant to the fraudulent bills submitted by Carmili through All Boro Medical.

256. Carmili and All Boro Medical's extensive fraudulent conduct demonstrates a high

degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

257. Accordingly, by virtue of the foregoing, GEICO is entitled to compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR A THIRD CAUSE OF ACTION

Against John Doe Defendants 1-10
(Aiding and Abetting Fraud)

258. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs above.

259. John Doe Defendants 1-10 knowingly aided and abetted the fraudulent scheme that was perpetrated on GEICO by All Boro Medical and Carmili.

260. The acts of John Doe Defendants 1-10 in furtherance of the fraudulent scheme included assisting with the operation of the Provider Defendant and the provision of medically unnecessary services, "brokering" or "controlling" access to patients in exchange for illegal kickback payments, and/or spearheading the predetermined fraudulent protocols used to maximize profits without regard to genuine patient care.

261. The conduct of John Doe Defendants 1-10 in furtherance of the fraudulent scheme was significant and material. The conduct of John Doe Defendants 1-10 was a necessary part of and was critical to the success of the fraudulent scheme because, without their actions, there would have been no opportunity for All Boro Medical or Carmili to obtain payment from GEICO and from other insurers.

262. John Doe Defendants 1-10 aided and abetted the fraudulent scheme in a calculated effort to induce GEICO into paying charges to All Boro Medical and Carmili for medically unnecessary, illusory, or otherwise non-reimbursable Fraudulent Services because they sought to

continue profiting through the fraudulent scheme.

263. The conduct of John Doe Defendants 1-10 caused GEICO to pay more than $414,000.00 pursuant to the fraudulent bills submitted through All Boro Medical.

264. The Defendants' extensive fraudulent conduct demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

265. Accordingly, by virtue of the foregoing, GEICO is entitled to compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR A FOURTH CAUSE OF ACTION

Against Carmili and All Boro Medical
(Unjust Enrichment)

266. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

267. As set forth above, Carmili and All Boro Medical have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of GEICO.

268. When GEICO paid the bills and charges submitted by or on behalf of All Boro Medical for No-Fault Benefits, it reasonably believed that it was legally obligated to make such payments based on the Defendants' improper, unlawful, and/or unjust acts.

269. Carmili and All Boro Medical have been enriched at GEICO's expense by GEICO's payments, which constituted a benefit that Defendants voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

270. Carmili and All Boro Medical's retention of GEICO's payments violates fundamental principles of justice, equity and good conscience.

271. By reason of the above, Carmili and All Boro Medical have been unjustly enriched in an amount to be determined at trial, but in no event less than $414,000.00.

AS AND FOR A FIFTH CAUSE OF ACTION

Against Carmili and Seneca Medical
(Common Law Fraud)

272. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

273. Carmili and Seneca Medical intentionally and knowingly made false and fraudulent statements of material fact to GEICO and concealed material facts from GEICO in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

274. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that Seneca Medical was properly licensed, and therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 N.Y.C.R.R. § 65-3.16(a)(12), when in fact it was not properly licensed in that it obtained patients through an illegal kickback scheme; (ii) in every claim, the representation that the billed-for services were medically necessary, when in fact the billed-for services were not medically necessary and were performed and billed pursuant to a predetermined, fraudulent protocol designed solely to enrich Carmili and Seneca Medical; (iii) in many claims, the billed for services were provided to the Insured but were not actually provided in the first instance; and (iv) in every claim, the representation that Seneca Medical was in compliance with all material licensing laws when in fact Seneca Medical is nominally owned by a physician who does not actually practice medicine through the professional corporation. The fraudulent billings and corresponding mailings submitted to GEICO that comprise the fraudulent activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit "2".

275. Carmili and Seneca Medical intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induce GEICO to pay charges submitted through Seneca Medical that were not compensable under the No-Fault Laws.

276. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $52,000.00 pursuant to the fraudulent bills submitted by Carmili through Seneca Medical.

277. Carmili and Seneca Medical's extensive fraudulent conduct demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

278. Accordingly, by virtue of the foregoing, GEICO is entitled to compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR A SIXTH CAUSE OF ACTION

Against John Doe Defendants 1-10
(Aiding and Abetting Fraud)

279. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs above.

280. John Doe Defendants 1-10 knowingly aided and abetted the fraudulent scheme that was perpetrated on GEICO by Seneca Medical and Carmili.

281. The acts of John Doe Defendants 1-10 in furtherance of the fraudulent scheme included assisting with the operation of the Provider Defendant and the provision of medically unnecessary services, "brokering" or "controlling" access to patients in exchange for illegal kickback payments, and/or spearheading the predetermined fraudulent protocols used to maximize profits without regard to genuine patient care.

282. The conduct of John Doe Defendants 1-10 in furtherance of the fraudulent scheme was significant and material. The conduct of John Doe Defendants 1-10 was a necessary part of and was critical to the success of the fraudulent scheme because, without their actions, there would have been no opportunity for Seneca Medical or Carmili to obtain payment from GEICO and from

other insurers.

283. John Doe Defendants 1-10 aided and abetted the fraudulent scheme in a calculated effort to induce GEICO into paying charges to Seneca Medical and Carmili for medically unnecessary, illusory, or otherwise non-reimbursable Fraudulent Services because they sought to continue profiting through the fraudulent scheme.

284. The conduct of John Doe Defendants 1-10 caused GEICO to pay more than $52,000.00 pursuant to the fraudulent bills submitted through Seneca Medical.

285. The Defendants' extensive fraudulent conduct demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

286. Accordingly, by virtue of the foregoing, GEICO is entitled to compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR A SEVENTH CAUSE OF ACTION

Against Carmili and Seneca Medical
(Unjust Enrichment)

287. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

288. As set forth above, Carmili and Seneca Medical have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of GEICO.

289. When GEICO paid the bills and charges submitted by or on behalf of Seneca Medical for No-Fault Benefits, it reasonably believed that it was legally obligated to make such payments based on the Defendants' improper, unlawful, and/or unjust acts.

290. Carmili and Seneca Medical have been enriched at GEICO's expense by GEICO's payments, which constituted a benefit that Defendants voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

291. Carmili and Seneca Medical's retention of GEICO's payments violates fundamental principles of justice, equity and good conscience.

292. By reason of the above, Carmili and Seneca Medical have been unjustly enriched in an amount to be determined at trial, but in no event less than $52,000.00.

AS AND FOR A EIGHTH CAUSE OF ACTION

Against Carmili and Palmetto Medical
(Common Law Fraud)

293. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

294. Carmili and Palmetto Medical intentionally and knowingly made false and fraudulent statements of material fact to GEICO and concealed material facts from GEICO in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

295. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that Palmetto Medical was properly licensed, and therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 N.Y.C.R.R. § 65-3.16(a)(12), when in fact it was not properly licensed in that it obtained patients through an illegal kickback scheme; (ii) in every claim, the representation that the billed-for services were medically necessary, when in fact the billed-for services were not medically necessary and were performed and billed pursuant to a predetermined, fraudulent protocol designed solely to enrich Carmili and Palmetto Medical; (iii) in many claims, the billed for services were provided to the Insured but were not actually provided in the first instance; and (iv) in every claim, the representation that Palmetto Medical was in compliance with all material licensing laws when in fact Palmetto Medical is nominally owned by a physician who does not actually practice medicine through the professional corporation. The fraudulent billings and corresponding mailings submitted to GEICO that comprise the fraudulent activity identified through the date of this Complaint are

described in the chart annexed hereto as Exhibit "3".

296. Carmili and Palmetto Medical intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induce GEICO to pay charges submitted through Palmetto Medical that were not compensable under the No-Fault Laws.

297. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $82,000,00 pursuant to the fraudulent bills submitted by Carmili through Palmetto Medical.

298. Carmili and Palmetto Medical's extensive fraudulent conduct demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

299. Accordingly, by virtue of the foregoing, GEICO is entitled to compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR A NINTH CAUSE OF ACTION

Against John Doe Defendants 1-10
(Aiding and Abetting Fraud)

300. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs above.

301. John Doe Defendants 1-10 knowingly aided and abetted the fraudulent scheme that was perpetrated on GEICO by Palmetto Medical and Carmili.

302. The acts of John Doe Defendants 1-10 in furtherance of the fraudulent scheme included assisting with the operation of the Provider Defendant and the provision of medically unnecessary services, "brokering" or "controlling" access to patients in exchange for illegal kickback payments, and/or spearheading the predetermined fraudulent protocols used to maximize profits without regard to genuine patient care.

303. The conduct of John Doe Defendants 1-10 in furtherance of the fraudulent scheme was significant and material. The conduct of John Doe Defendants 1-10 was a necessary part of and was critical to the success of the fraudulent scheme because, without their actions, there would have been no opportunity for Palmetto Medical or Carmili to obtain payment from GEICO and from other insurers.

304. John Doe Defendants 1-10 aided and abetted the fraudulent scheme in a calculated effort to induce GEICO into paying charges to Palmetto Medical and Carmili for medically unnecessary, illusory, or otherwise non-reimbursable Fraudulent Services because they sought to continue profiting through the fraudulent scheme.

305. The conduct of John Doe Defendants 1-10 caused GEICO to pay more than $82,000.00 pursuant to the fraudulent bills submitted through Palmetto Medical.

306. The Defendants' extensive fraudulent conduct demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

307. Accordingly, by virtue of the foregoing, GEICO is entitled to compensatory and punitive damages, together with interest and costs, and any other relief the Court deems just and proper.

AS AND FOR A TENTH CAUSE OF ACTION

Against Carmili and Palmetto Medical
(Unjust Enrichment)

308. GEICO incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

309. As set forth above, Carmili and Palmetto Medical have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of GEICO.

310. When GEICO paid the bills and charges submitted by or on behalf of Palmetto Medical for No-Fault Benefits, it reasonably believed that it was legally obligated to make such

payments based on the Defendants' improper, unlawful, and/or unjust acts.

311. Carmili and Palmetto Medical have been enriched at GEICO's expense by GEICO's payments, which constituted a benefit that Defendants voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

312. Carmili and Palmetto Medical's retention of GEICO's payments violates fundamental principles of justice, equity and good conscience.

313. By reason of the above, Carmili and Palmetto Medical have been unjustly enriched in an amount to be determined at trial, but in no event less than $82,000,00.

JURY DEMAND

314. Pursuant to Federal Rule of Civil Procedure 38(b), Plaintiffs demand a trial by jury.

WHEREFORE, Plaintiffs Government Employees Insurance Company, GEICO Indemnity Company, GEICO General Insurance Company and GEICO Casualty Company demand that a judgment be entered in their favor and against the Defendants, as follows:

A. On the First Cause of Action against Carmili, All Boro Medical, Seneca Medical, and Palmetto Medical, a declaration pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202, that Carmili, All Boro Medical, Seneca Medical, and Palmetto Medical have no right to receive payment for any pending bills submitted to GEICO; and

B. On the Second Cause of against All Boro Medical and Carmili, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $414,000.00, together with punitive damages, costs, interest and such other and further relief as this Court deems just and proper; and

C. On the Third Cause of Action against John Doe Defendants, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $414,000.00, together with

punitive damages, costs, interest and such other and further relief as this Court deems just and proper; and

D. On the Fourth Cause of Action against Carmili, more than $414,000.00 in compensatory damages, plus costs and interest, and such other and further relief as this Court deems just and proper; and

E. On the Fifth Cause of action against Carmili and Seneca Medical, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $52,000.00, together with punitive damages, costs, interest, and such other and further relief as this Court deems just and proper; and

F. On the Sixth Cause of Action against John Doe Defendants 1-10, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $52,000.00, together with punitive damages, costs, interest, and such other and further relief as this Court deems just and proper; and

G. On the Seventh Cause of Action against Carmili and Seneca Medical, more than $52,000.00 in compensatory damages, plus costs and interest and such other and further relief as this Court deems just and proper.

H. On the Eighth Cause of action against Carmili and Palmetto Medical, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $82,000,00, together with punitive damages, costs, interest, and such other and further relief as this Court deems just and proper; and

I. On the Ninth Cause of Action against John Doe Defendants 1-10, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $82,000,00, together with punitive damages, costs, interest, and such other and further relief as this Court deems

just and proper; and

J. On the Tenth Cause of Action against Carmili and Palmetto Medical, more than $82,000,00 in compensatory damages, plus costs and interest and such other and further relief as this Court deems just and proper.

Dated: Uniondale, New York
June 12, 2024

RIVKIN RADLER LLP

By: */s/ Barry I. Levy*
Barry I. Levy (BL 2190)
Michael A. Sirignano (MS 5263)
Joshua D. Smith (JS 3989)
926 RXR Plaza
Uniondale, New York 11556
(516) 357-3000

Counsel for Plaintiffs, Government Employees Insurance Company, GEICO Indemnity Company, GEICO General Insurance Company and GEICO Casualty Company

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