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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.:_____ ( )

Plaintiffs,

-against-

Plaintiff Demands a Trial by Jury

BV PHYSICAL THERAPY, P.C., BV NASSAU COUNTY PHYSICAL THERAPY, P.C., BORIS VASSERMAN, 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, BV Physical Therapy, P.C. ("BV PT"), BV Nassau County Physical Therapy, P.C. ("BV Nassau") (collectively, the "Vasserman PCs"), Boris Vasserman ("Vasserman"), and John Doe Defendants "1" through "10" (collectively, the "Defendants"), hereby allege as follows:

NATURE OF THE ACTION

1. GEICO brings this action to recover more than $300,000.00 that Defendants wrongfully obtained from GEICO by submitting, and causing to be submitted, hundreds of fraudulent no-fault insurance charges relating to medically unnecessary, illusory, and otherwise unreimbursable healthcare services, including computerized range of motion and muscle strength testing services ("ROM/MT") and activity limitation measurement tests ("ALM Tests") (collectively the "Fraudulent Services"), which were allegedly provided to individuals who claimed to have been involved in automobile accidents and were eligible for coverage under New York no-fault insurance policies issued by GEICO ("Insureds") and to terminate on ongoing fraudulent scheme committed against GEICO by the Defendants.

2. As discussed in more detail below, Vasserman is a physical therapist licensed to practice in New York who falsely posed as the purported "owner" of 2 professional corporations, known as BV PT and BV Nassau. Vasserman was nothing more than a nominal owner who, at all relevant times, was never the true owner, controller, or operator of the Vasserman PCs. Nor did Vasserman actually provide virtually any of the purported "services" billed through the Vasserman PCs. In reality, Vasserman, who at all relevant times, was a resident and citizen of Florida, acted to conceal the unlawful ownership, control, and/or operation of the Vasserman PCs and the provision of the Fraudulent Services by a series of unlicensed individuals and entities, including John Doe Defendants "1" through "10", who together with the Vasserman PCs, carried out the scheme utilizing illegal kickback and referral arrangements that allowed the Vasserman PCs to access a steady stream of motor vehicle accident victims.

3. The Defendants, to conceal the fraudulent nature of their billing, submitted billing for the Fraudulent Services in the name of the two (2) separate professional corporations. Though

they were supposedly separate entities, the Vasserman PCs operated serially and on an itinerant basis from a virtually-identical collection of "No-Fault" medical clinics, primarily located in Brooklyn, New York City, Queens, the Bronx and Nassau County (the "No-Fault Clinics").

4. GEICO seeks to recover the monies wrongfully obtained from it and, further, seeks a declaration that it is not legally required to pay reimbursement of more than $2,000,000.00 in pending no-fault insurance claims that have been submitted by or on behalf of the Vasserman PCs, because:

(i) the Fraudulent Services were not medically necessary and were provided, to the extent provided at all, pursuant to pre-determined fraudulent protocols designed solely to financially enrich the Defendants, rather than provide genuine patient care;

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

(iii) the Fraudulent Services were provided – to the extent provided at all – at the direction of unlicensed laypersons and through the use of illegal kickback arrangements with those unlicensed laypersons;

(iv) the Fraudulent Services were not eligible for reimbursement because the majority, if not all, were performed by independent contractors; and

(v) the Vasserman PCs were fraudulently incorporated and/or owned, controlled, and operated by laypersons.

5. The Defendants fall into the following categories:

(i) Defendant Vasserman is a physical therapist licensed in the State of New York, who falsely purported to own, control, and operate the Vasserman PCs, and who purported to perform the Fraudulent Services;

(ii) Defendant BV PT is a New York professional corporation through which the Fraudulent Services allegedly were provided and were billed to New York automobile insurance companies, including GEICO;

(iii) Defendant BV Nassau is a New York professional corporation through which the Fraudulent Services allegedly were provided and were billed to New York automobile insurance companies, including GEICO;

(iv) John Doe Defendants "1"-"5" (hereinafter the "Management Defendants") are individuals and entities who secretly owned, operated, and/or controlled the Vasserman PCs in violation of New York law, but who were never licensed healthcare professionals or entities; and

(v) John Doe Defendants "6"-"10" are individuals and/or entities who participated in the fraudulent scheme perpetrated against GEICO by, among other things, assisting with the performance of the medically unnecessary services, "brokering" or "controlling" access to patients in exchange for illegal kickback payments, and/or spearheading the pre-determined fraudulent protocols used to maximize profits without regard to genuine patient care.

6. As discussed herein, the Defendants, at all relevant times, knew that (i) the Vasserman PCs were unlawfully incorporated and owned, controlled, and operated by laypersons (ii) the Fraudulent Services, to the extent provided at all, were provided as a result of illegal kickbacks paid to access patients; (iii) the Fraudulent Services were not medically necessary and provided, to the extent provided at all, pursuant to pre-determined fraudulent protocols designed solely for the financial gain of the Defendants, with no regard for the actual treatment of the Insureds who purportedly received the Fraudulent Services; (iv) the billing codes used for the Fraudulent Services misrepresented the level of services that were allegedly provided in order to inflate and maximize billing to GEICO; and (v) in many cases, the Fraudulent Services, to the extent provided at all, were provided by independent contractors, rather than by Vasserman or any employee of the Vasserman PCs.

7. The Defendants do not have, nor have they ever had, the right to be compensated for the Fraudulent Services that they billed to GEICO.

8. The charts annexed hereto as Exhibits "1" and "2" set forth a representative sample of the fraudulent claims that have been identified to date that the Defendants have submitted to GEICO.

9. The Defendants' fraudulent scheme began as early as 2020 and has continued uninterrupted to the present day, as the Vasserman PCs continue to seek collection on payment for the Fraudulent Services.

10. As a result of the Defendants' fraudulent scheme, GEICO has incurred damages more than $300,000.00.

THE PARTIES

I. Plaintiffs

11. Plaintiffs, Government Employees Insurance Company, GEICO Indemnity Company, GEICO General Insurance Company, and GEICO Casualty Company, are Maryland corporations with their principal places of business in Chevy Chase, Maryland. GEICO is authorized to conduct business and to issue automobile policies in New York.

II. Defendants

12. Vasserman resides in and is a citizen of Florida. Vasserman became licensed to practice physical therapy in New York on January 3, 1996, and in Florida on March 9, 2009. Vasserman served as the nominal owner of the Vasserman PCs and was falsely listed on virtually all of the Vasserman PCs' billing as the purported "Treating Provider" who rendered the Fraudulent Services. Vasserman's name and license number were used to conceal the unlawful ownership and control of the Vasserman PCs by the John Doe Defendants.

13. BV PT is a New York professional corporation with its principal place of business located in New York. BV PT was incorporated on or about April 29, 2020, and used by the Defendants to submit fraudulent billing to GEICO and other New York automobile insurers.

14. BV Nassau is a New York professional corporation with its principal place of business located in New York. BV Nassau was incorporated on or about May 18, 2022, and used by the Defendants to submit fraudulent billing to GEICO and other New York automobile insurers.

15. John Doe Defendants "1"-"10" reside in and are citizens of New York. John Doe Defendants "1"-"10" are individuals and entities, presently not identifiable, who knowingly participated in the fraudulent scheme by, among other things, unlawfully owning and controlling the Vasserman PCs, assisting with the performance of medically unnecessary services, "brokering" or "controlling" access to patients in exchange for illegal kickback payments, and/or spearheading the pre-determined fraudulent protocols used to maximize profits without regard to genuine patient care.

JURISDICTION AND VENUE

16. 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. This Court also has original jurisdiction pursuant to 28 U.S.C. § 1331 over claims brought under 18 U.S.C. §§ 1961 et seq. (the Racketeer Influenced and Corrupt Organizations ("RICO") Act). 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.

17. Venue in this District is appropriate pursuant to 28 U.S.C. § 1391, as the Eastern District of New York is the District where one or more of the Defendants reside and because this is the District where a substantial amount of the activities forming the basis of the Complaint occurred.

ALLEGATIONS COMMON TO ALL CLAIMS

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

18. GEICO underwrites automobile insurance in New York.

19. New York's "No-Fault" laws are designed to ensure that injured victims of motor vehicle accidents have an efficient mechanism to pay for and receive the healthcare services that they need. 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 Personal Injury Protection Benefits ("PIP Benefits") to Insureds.

20. 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 medical services.

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

22. In New York, pursuant to a duly executed assignment, a healthcare 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"). In the alternative, in New York, a healthcare services provider may submit claims using the Health Care Financing Administration claim form (known as the "HCFA-1500 form").

23. 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.

24. 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 healthcare 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.

25. Medical professional entities incorporated in New York must both be owned by a licensed professional authorized by law to practice in New York and who is actually engaged in the practice of medicine in such corporation. N.Y. Bus. Corp. Law §1507.

26. In New York, only a licensed physician may practice medicine, may own and control a professional corporation authorized to practice medicine and, absent statutory exceptions not applicable in this case, may derive economic benefit from medical services. Unlicensed individuals in New York may not practice medicine, may not own or control a professional corporation authorized to practice medicine, may not employ or supervise physicians, and, absent statutory exceptions not applicable in this case, may not derive economic benefit from medical services.

27. New York law prohibits licensed healthcare services providers, including physicians, from paying or accepting kickbacks in exchange for patient referrals. See, e.g., New York Education Law §§ 6509-a; 6530(18); and 6531.

28. New York law prohibits unlicensed persons not authorized to practice a profession, like medicine, from practicing the profession and from sharing in the fees for professional services. See e.g., New York Education Law §6512, §6530 (11), and (19).

29. 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, if it permits unlicensed laypersons to control or dictate the treatments rendered, or allows unlicensed laypersons to share in the fees for the professional services.

30. In State Farm Mut. Auto. Ins. Co. v. Mallela, 4 N.Y.3d 313, 320 (2005), the New York Court of Appeals confirmed that healthcare services providers that fail to comply with licensing requirements are ineligible to collect PIP 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. In Andrew Carothers, M.D., P.C. v. Progressive Ins. Co., 33 N.Y.3d 389, 393 (2019), the New York Court of Appeals reiterated that only licensed physicians may practice medicine in New York because of the concern that unlicensed individuals are "not bound by ethical rules that govern the quality of care delivered by a physician to a patient."

31. 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 …

32. 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.

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

34. 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.

35. 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 healthcare 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.

II. The Defendants' Fraudulent Scheme

A. Overview of the Scheme

36. Beginning in 2020 and continuing through the present day, the Defendants masterminded and implemented a complex fraudulent scheme in which the Vasserman PCs were used to illegally bill GEICO and other New York automobile insurers millions of dollars for medically unnecessary, excessive, illusory, and/or otherwise un reimbursable healthcare services.

B. The Fraudulent Incorporation, Ownership, and Operations of the Vasserman PCs

1. BV PT

37. From at least 2017 to the present, Vasserman has resided in and was a citizen of the State of Florida, residing in Boca Raton.

38. In or about June of 2020, the Management Defendants recruited Vasserman, who was willing to "sell" the use of his physical therapy license so that the Management Defendants could fraudulently use BV PT as the ROM/ALM "testing" provider at the various No-Fault Clinics in New York.

39. Between June 2020 and October 2022, the Management Defendants used BV PT as a vehicle to submit fraudulent billing to GEICO and other insurers. In that time period, the Management Defendants used BV PT to submit more than $1,500,000.00 in fraudulent billing to GEICO.

40. To circumvent New York law and to induce the New York State Education Department to issue a certificate of authority authorizing BV PT to operate as a healthcare professional corporation or to permit it to operate as legitimately controlled professional practices, the Management Defendants entered into secret schemes with BV PT. Specifically, in exchange for a designated salary or other form of compensation from the Management Defendants, Vasserman agreed to falsely represent in the Certificate of Incorporation and related filings with New York State that he was the true shareholder, director, officer, or owner of BV PT, and that he truly owned and controlled the professional corporation.

41. Vasserman falsely represented in the Certificate of Incorporation and related filings with New York State that he was the true shareholder, director, officer, and owner of the BV PT,

and that he owned and controlled the professional corporation and professional practice, knowing that the BV PT would be used to submit fraudulent billing to insurers, including GEICO.

42. Although Vasserman was listed as the record owner of BV PT on the Certificate of Incorporation, or otherwise identified as the licensed professional controlling the professional practice, Vasserman exercised no genuine ownership or control over BV PT or the profits that were generated from it.

43. Vasserman was not the true shareholder, director, officer, or owner of the BV PT, and did not have any true ownership interest in or control over the respective professional corporation and practice.

44. Vasserman ceded true beneficial ownership and control over BV PT to the Management Defendants.

45. True ownership and control over BV PT rested entirely with the Management Defendants, who used the facade of BV PT to do indirectly what they are forbidden from doing directly, namely: (i) employ healthcare professionals; (ii) control those healthcare professionals' practices; and (iii) charge for and derive an economic benefit from their services.

46. At all relevant times, Vasserman has been nothing more than a nominal or "paper" owner of BV PT and has had no genuine ownership or control over the healthcare services provided by, or the profits generated from, the medical professional service corporation.

47. At all relevant times, Vasserman was never in control of the healthcare services that were provided under BV PT's name.

48. Vasserman had no genuine physician-patient relationship with the Insureds that visited the No-Fault Clinics, as the patients were simply directed by the Management Defendants to subject themselves to treatment by whatever healthcare providers were on duty that day.

49. Once Insureds arrived at the No-Fault Clinics for treatment, the Management Defendants coordinated with the other John Doe Defendants to direct the medical services that each patient received from BV PT, regardless of the actual medical needs of the individual Insureds.

50. The Management Defendants in coordination with the other John Doe Defendants established predetermined treatment protocols in order to bill for voluminous, unnecessary, and excessive treatments that were provided (or purported to be provided) regardless of the actual medical needs of each individual Insured.

51. At all relevant times, Vasserman was never in control of the billings submitted to insurance companies under BV PT's name.

52. At all relevant times, Vasserman has never been in control of the collections derived from the billings submitted to insurance companies under BV PT's name.

53. Throughout the course of Vasserman's relationship with the Management Defendants and the other John Doe Defendants, all decision-making authority relating to the operation and management of BV PT has been vested entirely with the Management Defendants.

54. The Management Defendants' decision-making authority relating to the operation and management of the No-Fault Clinics and BV PT included control, in coordination with the other John Doe Defendants, over the treatment protocols, including what treatments, testing, and other services the Insureds received, what referrals and prescriptions the Insureds received, and what healthcare providers or professional corporations would render those services.

55. The Management Defendants' decision-making authority also included the hiring and firing of all employees, including the administrative employees and the healthcare

professionals and technicians who allegedly performed the Fraudulent Services on behalf of the BV PT.

56. The Management Defendants' decision-making authority, in coordination with the other John Doe Defendants, also included control over how the Fraudulent Services were billed to insurers, including GEICO, who performed the billing services on behalf of the No-Fault Clinics, and how the BV PT's profits were dispersed.

57. In reality, Vasserman was no more than a de facto employee of the Management Defendants who, at all relevant times, remained firmly in control of all entities, healthcare services, patients, and profits generated at the No-Fault Clinics.

58. The Management Defendants at all relevant times maintained complete control over BV PT's billing, collections, and ultimately all revenues realized by the professional corporation, which they siphoned to themselves.

59. To conceal the illegal fee-splitting and siphoning away of the revenues to the Management Defendants, while simultaneously effectuating pervasive, total control over BV PT's operation and management, the Management Defendants arranged to have BV PT enter into various "billing", "marketing", "transportation" and/or other financial agreements, which called for exorbitant payments regardless of the actual value of any services provided.

60. The Management Defendants also arranged for BV PT to issue checks to a series of individuals and entities, including various non-existent shell companies, purportedly for marketing or other services; however, these monies were paid solely as kickbacks in exchange for the referral of automobile accident victims to BV PT and the No-Fault Clinics.

61. The Management Defendants used their financial control over BV PT to permit them to: (i) control the day-to-day operations, exercise supervisory authority over, and illegally

own BV PT; and (ii) siphon to themselves all of the profits that were generated by the billings submitted to GEICO and other insurers through BV PT.

62. In reality, Vasserman has never been in control of BV PT's practice. At best, Vasserman has been nothing more than a de facto employee of the Management Defendants.

2. BV Nassau

63. By 2022, the Defendants' use of BV PT had begun to attract attention from special investigative units of New York automobile insurers.

64. Despite this, the Defendants wanted to continue their fraudulent scheme to continue to maximize their ill-gotten gains.

65. Toward that end, in May 2022, Vasserman, at the Management Defendants' direction, caused BV Nassau to be incorporated in New York as a physical therapy professional corporation.

66. BV Nassau began billing GEICO in June of 2022 and engaged in similar fraudulent practices and patterns. The Management Defendants and Vasserman established BV Nassau in order to continue the same systematic and fraudulent procedures, to the extent they were even performed, that were being undertaken using BV PT once BV PT stopped billing GEICO just a few months later in October of 2022.

67. In keeping with the fact that BV Nassau simply served as a replacement entity for BV PT, BV Nassau submitted billing to GEICO under many of the same claim numbers as BV PT had previously had.

68. Between June 2022 through October 2023, the Management Defendants used BV Nassau as a vehicle in order to submit more than $700,000 in fraudulent billing to GEICO.

69. Vasserman ceded true beneficial ownership and control over BV Nassau to the Management Defendants, as he did with BV PT.

70. At all relevant times, Vasserman was never in control of BV Nassau's patient base.

71. At all relevant times, Vasserman was never in control of the healthcare services that were provided under BV Nassau's name.

72. At all relevant times, Vasserman was never in control of the billings submitted to insurance companies under BV Nassau's name.

73. At all relevant times, Vasserman has never been in control of the collections derived from the billings submitted to insurance companies under BV Nassau's name.

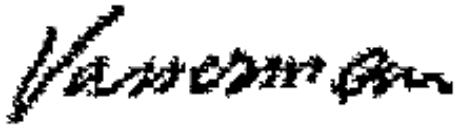
74. As with BV PT, the true ownership, management, and control of BV Nassau rested entirely and at all relevant times, with the Management Defendants, who have used the façade of BV Nassau to do indirectly what they are forbidden from doing directly, namely, to: (i) employ physicians and other licensed healthcare professionals; (ii) control their practices; and (iii) charge for and derive an economic benefit from their services.

75. Again, Vasserman has been nothing more than a nominal or "paper" owner of BV Nassau and has never had no genuine ownership or control over the healthcare services provided by, or the profits generated from, the medical professional service corporation.

76. The Management Defendants at all relevant times maintained complete control over BV Nassau billing, collections, and ultimately all revenues realized by the professional corporation, which they continued to siphon to themselves.

77. In reality, and similarly to BV PT, Vasserman has never been in control of BV Nassau's practice and has been nothing more than a de facto employee of the Management Defendants.

78. In keeping with the fact that the Vasserman PCs were formed to continue the fraudulent scheme that was controlled by the Management Defendants, Vasserman permitted the Management Defendants access to the following facsimile stamp of his signature, which was used by both Vasserman PCs on various reports, bills, and other documents:



C. The Defendants' Unlawful Kickback and Referral Arrangements

79. The Defendants did not operate the Vasserman PCs from fixed locations.

80. The Defendants did not engage in any legitimate marketing or advertising efforts to advertise the existence of the Vasserman PCs to the public.

81. Instead, the Defendants operated the Vasserman PCs on an itinerant basis from the various No-Fault Clinics.

82. Both of the Vasserman PCs operated sequentially out of the following No-Fault Clinics (the "No-Fault Clinics"):

- 3910 Church Avenue, Brooklyn, New York
- 1120 Morris Park Avenue, Bronx, New York
- 1655 Richmond Avenue, Bronx, New York
- 513 Church Avenue, Brooklyn, New York
- 3910 Church Avenue, Brooklyn, New York
- 30 S Central Avenue, Valley Stream, New York
- 558 Neptune Avenue, Brooklyn, New York
- 262 Avenue X, Brooklyn, New York

- 652 East Fordham Road, Brooklyn, New York
- 3041 Avenue U, Brooklyn, New York

83. As a result of illegal kickbacks and referral arrangements, Defendants accessed patients and allegedly provided Fraudulent Services from the No-Fault Clinic locations, where the Vasserman PCs received steady volumes of patients through no legitimate efforts of their own.

84. Though ostensibly organized to provide a range of healthcare services to Insureds at a single location, virtually all of the No-Fault Clinics in actuality were organized to supply "one-stop" shops for no-fault insurance fraud.

85. At many of the No-Fault Clinics, unlicensed laypersons, rather than healthcare professionals, created and controlled the patient base and dictated fraudulent treatment and billing protocols used to maximize profits without regard to actual patient care.

86. The No-Fault Clinics provided facilities for the Defendants, as well as a "revolving door" of medical professional corporations, chiropractic professional corporations, physical therapy professional corporations, and/or a multitude of other purported healthcare providers, all geared towards exploiting New York's no-fault insurance system.

87. In fact, at many of the No-Fault Clinics, GEICO received billing from an ever-changing number of fraudulent healthcare providers, starting and stopping operations without any purchase or sale of a "practice"; without any legitimate transfer of patient care from one professional to another; and without any legitimate reason for the change in provider name beyond circumventing insurance company investigations and continuing the fraudulent exploitation of New York's no-fault insurance system.

88. In keeping with the fact that unlicensed laypersons controlled many of the No-Fault Clinics and that Vasserman, the Vasserman PCs, and the Management Defendants paid illegal

kickbacks in exchange for patient referrals, at least one of the clinics was identified in United States of America v. Anthony Rose, et al., 19-cr-00789 (PGG) (S.D.N.Y.) ("USA v. Rose") as being controlled by laypersons and as receiving patients as a result of illegal kickback and referral arrangements.

89. In USA v. Rose, numerous individuals were indicted in November 2019 for paying bribes to 911 operators, medical personnel, NYPD officers, and others in exchange for confidential patient information. To exploit the patient information, Anthony Rose ("Rose"), the ringleader of the scheme, set up a fully staffed call center in order to contact the patients and to steer them to a preferred network of medical clinics (and lawyers) in New York and New Jersey. Specifically, the medical clinics, including at least one of the Clinics where the Vasserman PCs operated, were deemed preferred because the clinic controllers paid Rose kickbacks in exchange for the referrals.

90. A series of Government affidavits filed in support of surveillance warrants, including wiretaps, were unsealed in USA v. Rose. These affidavits detail the massive scope of the patient brokering scheme, reveal the identity of numerous layperson controllers and fraudulent clinic locations, and expressly implicate at least one of the Clinics where the Vasserman PCs operated. See USA v. Rose, ECF No. 398.

91. In particular, the Government affidavits unsealed in USA v. Rose include excerpts of wiretaps and other evidence indicating that, among dozens of other locations, patients were steered to the Clinic located at 3910 Church Avenue – a No-Fault Clinic location from which both of the Vasserman PCs operated.

92. In fact, GEICO received billing from an ever-changing number of fraudulent healthcare providers at many of the No-Fault Clinics, starting and stopping operations without any purchase or sale of a "practice", without any legitimate transfer of patient care from one

professional to another, and without any legitimate reason for the change in provider name beyond circumventing insurance company investigations and continuing the fraudulent exploitation of New York's no-fault insurance system.

93. For example, GEICO received billing from more than 200 different healthcare providers who operated from the No-Fault Clinic located at 3910 Church Avenue in Brooklyn, New York (the "Church Avenue No-Fault Clinic"). These healthcare providers have included, but are not limited to, multiple medical practices, diagnostic testing practices, chiropractic practices, acupuncture practices, physical therapy practices, and psychology practices. At times, several providers of the same specialty simultaneously submitted billing to GEICO for services rendered to Insureds treating at the Church Avenue No-Fault Clinic.

94. The No-Fault Clinics willingly provided access to the Defendants in exchange for kickbacks and other financial incentives because the No-Fault Clinics were facilities that sought to profit from the "treatment" of individuals covered by no-fault insurance and, therefore, catered to high volumes of Insureds at the locations.

95. In general, the Defendants paid the referral sources at the No-Fault Clinics through payments typically disguised as "rent". They were, in reality, kickbacks for referrals, and the relationship was a "pay-to-play" arrangement. In connection with this arrangement, when an Insured visited one of the No-Fault Clinics, he or she was automatically referred by one of the No-Fault Clinic's "representatives" for the performance of the Fraudulent Services.

96. In order to obtain access to the No-Fault Clinics' patient base (i.e., Insureds), the Defendants entered into illegal kickback and referral arrangements with unlicensed persons and/or healthcare professionals who "brokered" or "controlled" access to patients treated, or purported to be treated, at the No-Fault Clinics.

97. None of the Vasserman PCs had their own patients at the No-Fault Clinics or did anything to create a patient base.

98. The Management Defendants did not legitimately advertise for patients, did not maintain any website, and never sought to build name recognition or make any legitimate efforts of their own to attract patients on behalf of the Vasserman PCs.

99. Vasserman did not do virtually anything that would be expected of the owner or owners of legitimate medical professional corporations to develop their reputation and attract patients to the No-Fault Clinics or to Vasserman PCs.

100. The Defendants did not have any patients of their own at the No-Fault Clinics, and the healthcare services that they could provide to the patients at the No-Fault Clinics were limited and dictated by the unlicensed laypersons and/or healthcare professionals who controlled access to patients at the No-Fault Clinics and were interested only in maximizing profits without regard to genuine patient care.

101. At bottom, neither Vasserman nor any other medical professional that may have rendered services under the name of the Vasserman PCs at the No-Fault Clinics had a genuine doctor-patient relationship with the Insureds that visited the No-Fault Clinics, as the Insureds had no scheduled appointments with Vasserman or the Vasserman PCs specifically.

102. In fact, the Insureds were simply directed by the No-Fault Clinics, and the unlicensed laypersons and/or healthcare professionals associated therewith, to subject themselves to treatment by whatever individual was working on behalf of the Vasserman PCs and the other medical providers on that given day, because of the illegal kickbacks paid by the Defendants.

D. The Defendants' Fraudulent Treatment and Billing Protocol

103. Regardless of the nature of the accidents or the actual medical needs of the Insureds, the Defendants purported to treat virtually every Insured to the same pre-determined fraudulent treatment protocols without regard for the Insureds' individual symptoms or alleged injuries.

104. Each step in 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 Defendants to generate and falsely justify the maximum amount of fraudulent no-fault billing for each Insured.

105. 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.

1. The Fraudulent Charges for Range of Motion/Muscle Testing

106. Upon receiving a referral pursuant to the kickbacks that the Defendants paid to the unlicensed laypersons and/or healthcare professionals associated with the No-Fault Clinics, the Defendants purported to provide the Insureds in the claims identified in Exhibits "1" and "2" with one or more sessions of medically unnecessary range of motion/muscle testing.

107. The Defendants billed the ROM/MT through BV PT to GEICO under multiple units of CPT codes 95851, 95831, and 95833, generally resulting in hundreds of dollars in charges for each session of ROM/MT "testing."

108. The charges for the ROM/MT were fraudulent in that: (i) the ROM/MT was medically unnecessary; (ii) BV PC unbundled the charges for the ROM/MT to artificially increase the amount they could charge GEICO; and (iii) the ROM/MT were performed pursuant to the

kickbacks that the BV PC paid at the Clinics in coordination with the Management Defendants not to treat or otherwise benefit the Insureds.

a. Traditional Tests to Evaluate the Human Body's Range of Motion and Muscle Strength

109. The adult human body is made up of 206 bones joined together at various joints that are either of the fixed, hinged or ball-and-socket variety. The body's hinged joints and ball-and-socket joints facilitate movement, allowing a person to – for example – bend a knee, rotate a shoulder, or move the neck to one side.

110. The measurement of the capacity of a particular joint to perform its full and proper function represents the joint's "range of motion." Simply, range of motion is the amount of movement around the joint.

111. A traditional, or manual, range of motion test consists of a non-electronic measurement of the movement at the joint in comparison with an unimpaired or "ideal" joint. In a traditional range of motion test, the limb actively or passively is moved around the joints. The physician then evaluates the patient's range of motion either by sight or through the use of a manual inclinometer or a goniometer (i.e., a device used to measure angles).

112. Similarly, a traditional muscle strength test consists of a non-electronic measurement of muscle strength, which is accomplished by having the patient move his/her body or extremity in a given direction against resistance applied by the examiner. For example, if an examiner wanted to measure muscle strength in the muscles controlling movement at a patient's knee, he or she would apply resistance against the patient's leg while having him/her move the leg up, then apply resistance against the patient's leg while having him/her move the leg down.

113. Physical evaluations performed on patients with soft-tissue trauma include range of motion and muscle strength tests, inasmuch as these tests provide a baseline for injury assessment

and treatment planning. Unless an examiner knows the extent of a given patient's joint or muscle strength impairment, it may substantially limit the ability to properly diagnose or treat the patient's injuries. Evaluation of range of motion and muscle strength is an essential component of the "hands-on" evaluation of a trauma patient.

114. Since range of motion and muscle strength tests are conducted as an element of a soft-tissue trauma patient's initial examination, as well as during any follow-up examinations, the Fee Schedule provides that range of motion and muscle strength tests are to be reimbursed as an element of the initial and follow-up examinations.

115. In other words, healthcare providers cannot conduct and bill for initial examinations and follow-up examinations, then bill separately for contemporaneously provided range of motion and muscle strength tests.

b. The Defendants' ROM/MT was Duplicative and Medically Unnecessary

116. As part of the purported "treatment" at the No-Fault Clinics, the Insureds received manual range of motion and manual muscle tests during initial and follow-up examinations.

117. The Defendants knew, prior to performing ROM/MT, that the Insureds had already received initial and/or follow-up examinations from other purported healthcare providers at the No-Fault Clinics that included manual range of motion and manual muscle tests, as those initial and follow-up examinations served to justify the subsequent performance of the Fraudulent Services by the Defendants.

118. Despite the fact that the Defendants knew that Insureds already had undergone manual range of motion and muscle testing during their initial and follow-up examinations, Defendants systemically billed for, and purported to perform, ROM/MT on Insureds.

119. The Defendants purported to provide the computerized range of motion tests by placing a digital inclinometer or goniometer on various parts of the Insured's body while the Insured was asked to attempt various motions and movements. The test is virtually identical to the manual range of motion testing that is described above and that purportedly was performed during the initial and follow-up examinations, except that a digital printout was obtained rather than the provider manually documenting the Insured's range of motion.

120. The Defendants purported to provide the computerized muscle strength tests by placing a strain gauge-type measurement apparatus against a stationary object, against which the Insured is asked to press multiple times using various muscle groups. As with the computerized range of motion tests, this computerized muscle strength test was virtually identical to the manual muscle strength testing that is described above and that purportedly was performed during the initial and follow-up examinations – except that a digital printout was obtained.

121. The information gained through the use of the ROM/MT was not significantly different from the information obtained through the manual testing that was part and parcel of the Insured's initial and follow-up examinations. In the relatively minor soft-tissue injuries allegedly sustained by the Insureds, the difference of a few percentage points in the Insured's range of motion reading or pounds of resistance in the Insured's muscle strength testing is insignificant.

122. While ROM/MT can be a medically useful tool as part of a research project, under the circumstances employed by BV PT, it unnecessarily duplicated the manual range of motion and muscle strength testing purportedly conducted during the Insureds' initial and follow-up examinations.

123. In short, the ROM/MT was rendered pursuant to a pre-determined treatment protocol that: (i) did not aid in the assessment and treatment of the Insureds; and (ii) was designed solely to financially enrich the Defendants.

c. The Defendants' Fraudulent Unbundling of Charges for the Computerized Range of Motion and Muscle Tests

124. Not only did the Defendants deliberately purport to provide duplicative, medically unnecessary computerized range of motion and muscle tests; they also unbundled their billing for the tests, which maximized the fraudulent charges that they could submit to GEICO.

125. Pursuant to the Fee Schedule, when computerized range of motion testing and muscle testing are performed on the same date, all of the testing should be reported and billed using CPT code 97750.

126. CPT code 97750, described as "Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes", identifies a number of multi-varied tests and measurements of physical performance of a select area or number of areas. These tests include services such as extremity testing for strength, dexterity, or stamina, and muscle strength testing with torque curves during isometric and isokinetic exercise, whether by mechanized evaluation or computerized evaluation. They also include creation of a written report.

127. CPT code 97750 is a "time-based" code that – in the New York metropolitan area – allows for a single charge of $45.71 for every 15 minutes of testing. Thus, if a provider performed 15 minutes of computerized range of motion and muscle testing, it would be permitted a single charge of $45.71 under CPT code 97750. If the provider performed 30 minutes of computerized range of motion and muscle testing, it would be permitted to submit two charges of $45.71 under CPT code 97750, resulting in total charges of $91.42, and so forth.

128. The Defendants virtually always purported to provide computerized range of motion and muscle tests to Insureds on the same dates of service.

129. The computerized range of motion and muscle tests – together – usually did not take more than 15 minutes to perform. Thus, even if the computerized range of motion and muscle tests that the Defendants purported to perform were medically necessary, Defendants would usually be limited to a single, time-based charge of $45.71 under CPT code 97750, for each date of service on which they performed computerized range of motion and muscle tests on an Insured.

130. Nonetheless, to maximize their fraudulent billing for the computerized range of motion and muscle tests, the Defendants unbundled what should be a single charge of $45.71 under CPT code 97750 for both computerized range of motion and muscle testing into: (i) multiple charges of $39.73 under CPT code 95831, up to $476.76 under CPT code 95833 (for the muscle tests); and (ii) multiple charges of $41.66 under CPT code 95851 (for the range of motion tests).

131. For example, the following are examples of fraudulently unbundled muscle testing and range of motion testing charges for a single Insured on a single date of service:

Date of Service	Place of Service Including Zip Code	Description of Treatment or Health Service Rendered	Unit	Fee Schedule Treatment Code	Charges
08/20/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	MMT Neck Flexion	1	95831	$ 39 73
08/20/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	MMT Neck Extension	1	95831	$ 39 73
08/20/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	MMT Neck Rotation	1	95831	$ 39.73
08/20/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	MMT Trunk Flexion	1	95831	$ 39.73
08/20/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	MMT Shoulder Flexion (L)	1	95831	$ 39.73
08/20/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	MMT Shoulder Flexion (R)	1	95831	$ 39.73
08/20/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	MMT Shoulder Extension (L)	1	95831	$ 39.73
08/20/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	MMT Shoulder Extension (R)	1	95831	$ 39.73
08/20/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	MMT Shoulder Abduction (L)	1	95831	$ 39.73
08/20/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	MMT Shoulder Abduction (R)	1	95831	$ 39 73
08/20/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	MMT Knee Extension (L)	1	95831	$ 39.73
08/20/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	MMT Knee Extension (R)	1	95831	$ 39 73

TOTAL CHARGES TO DATE $ 476 76

Date of Service	Place of Service Including Zip Code	Description of Treatment or Health Service Rendered	Unit	Fee Schedule Treatment Code	Charges
09/24/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	ROM Cervical Flexion	1	95851	$ 41 66
09/24/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	ROM Cervical Extension	1	95851	$ 41.66
09/24/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	ROM Cervical Lateral	1	95851	$ 41 66
09/24/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	ROM Thoracic Lateral	1	95851	$ 41 66
09/24/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	ROM Lumbar Flexion	1	95851	$ 41 66
09/24/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	ROM Lumbar Extension	1	95851	$ 41 66
09/24/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	ROM Shoulder Flexion	1	95851	$ 41 66
09/24/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	ROM Shoulder Extension	1	95851	$ 41 66
09/24/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	ROM Shoulder Abduction	1	95851	$ 41 66
09/24/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	ROM Shoulder Adduction	1	95851	$ 41 66
09/24/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	ROM Knee Flexion	1	95851	$ 41 66
09/24/2020	79-45 Metropolitan Ave, Flushing, NY, 11379	ROM Hip Flexion/Extension	1	95851	$ 41 66

TOTAL CHARGES TO DATE $ 499 92

132. By unbundling what should be a single $45.71 charge, under CPT code 97750, into multiple charges, under CPT codes 95831, 95833, and 95851, the Defendants increased, by significant orders of magnitude, the charges for the ROM/MT that they submitted, or caused to be submitted, to GEICO.

d. The Defendants' Fraudulent Misrepresentations as to the Existence of Written, Interpretive Reports Regarding the ROM/MT

133. Not only were the Defendants' charges for the ROM/MT through BV PT fraudulent because the tests were duplicative, medically unnecessary, and because the billing was fraudulently unbundled, but the charges also were fraudulent because they falsely represented that the Defendants prepared written reports interpreting the test data.

134. Pursuant to the Fee Schedule, when a healthcare provider submits a charge for computerized range of motion testing using CPT code 95851 or for computerized muscle testing using CPT code 95831 or 95833, the provider represents that it has prepared a written report interpreting the data obtained from the test.

135. The CPT Assistant states that "Interpretation of the results with preparation of a separate, distinctly identifiable, signed written report is required when reporting codes 95851 and 95852".

136. The CPT Assistant also states that "[t]he language included in the code descriptor for use of these codes indicates, the preparation of a separate written report of the findings as a necessary component of the procedure" when using CPT code 95831 or 95833 to charge for muscle testing.

137. Though the Defendants routinely submitted billing for the computerized range of motion and muscle strength tests using CPT codes 95851, 95831, and 95833, to the extent they prepared any documentation at all as part for the purported "testing", the Defendants did not prepare written reports that actually interpreted the data obtained from the tests.

138. Instead, the Defendants simply generated a printout report devoid of any true interpretation or a treatment plan for the Insured who was supposedly "tested".

139. Therefore, even if the Defendants had satisfied the other requirements to submit their billing for ROM/MT under CPT codes 95851, 95831, and 95833 – and they did not – the Defendants' billing still did not comply with the Fee Schedule due to their failure to generate a separate, distinctly identifiable, and signed written report interpreting the results of the purported ROM/MT for any Insured.

140. The Defendants did not prepare written reports interpreting the data obtained from the tests because the tests were not meant to impact any Insureds' course of treatment. Rather, the tests were performed as part of the Defendants' pre-determined fraudulent billing and treatment protocols, which enriched Defendants at the expense of GEICO, and as part of the Defendants' improper financial and kickback arrangements.

E. The Medically Unnecessary "Activity Limitation Measurements" Tests

141. In addition to the other Fraudulent Services, the Defendants also subjected most Insureds to medically unnecessary activity limitation measurement tests.

142. The Defendants billed the putative ALM Tests to GEICO using CPT code 97799 or 97800, typically resulting in a charge of: (i) $475.00 for each putative round of "testing" purportedly provided through BV PT; and (ii) $614.00 for each putative round of "testing" purportedly provided through BV Nassau.

143. Like their charges for the other Fraudulent Services, Defendants' charges for ALM Tests were fraudulent in that the tests were: (i) medically unnecessary; and (ii) performed pursuant to Defendants' fraudulent treatment protocol and improper kickback arrangements between the Defendants and others.

144. The Defendants purported to provide ALM Tests to Insureds despite their knowledge that the ALM Tests were medically unnecessary and duplicative of the manual range of motion and muscle strength tests that were performed during the examination/consultations, and/or the computerized ROM/MT that Defendants also purported to perform.

145. Much like the duplicative computerized ROM/MT, the ALM results were accompanied by a vague, and meaningless digital printout of an Insured's muscle strength with no true interpretation or treatment plan.

146. The muscle strength data obtained using ALM Tests was not significantly different from the information obtained through the manual testing that was part and parcel of the examinations purportedly provided by other healthcare "providers" at the No-Fault Clinics to the Insureds.

147. In addition, the muscle strength data obtained through the use of the ALM Tests was significantly different from the data that Defendants obtained through the computerized ROM/MT they purported to provide to Insureds.

148. Under the circumstances employed by the Defendants, the ALM Tests represented purposeful and unnecessary duplication of the manual range of motion and muscle strength testing purportedly conducted during the examination/consultations, and of the medically unnecessary computerized ROM/MT, all of which Defendants purportedly conducted in addition to the manual range of motion and muscle strength testing.

149. Not only did the Defendants purport to provide duplicative, medically unnecessary ALM Tests, they also billed in excess of what was allowable under the Fee Schedule for the ALM Tests, again which maximized the fraudulent charges that they could submit to GEICO.

150. CPT code 97799 – which the Defendants used to bill GEICO for the purported ALM Tests – is an "unlisted physical medicine/rehabilitation procedure" and is a by-report code.

151. However, pursuant to the Fee Schedule, ALM Tests should be billed under CPT code 97750, at a charge of $45.71 per unit, for every 15 minutes of testing.

152. CPT code 97750, which is described as "Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes," identifies a number of multi-varied tests and measurements of physical performance of a select area or number of areas (emphasis added). These tests include services such as extremity testing for strength, dexterity, or stamina, and muscle testing with torque curves during isometric and isokinetic exercise, whether by mechanized evaluation or computerized evaluation. They also include creation of a written report.

153. Instead of billing under the proper code, the Defendants submitted inflated charges for ALM Tests under CPT code 97799 at a charge of either $475.00 or $614.00 per date of service. Through this fraudulent billing protocol, the Defendants inflated the charges they submitted to GEICO for each distinct session of ALM Tests by as much as one-thousand percent (1000%) — submitting a bill for $475.00, for what should have been a single charge of $45.71 or, at most, two charges totaling $91.42.

154. Like the other tests discussed herein, the ALM Tests were not meant to impact any Insured's course of treatment. Rather, the ALM Tests were performed as part of Defendants' pre-determined fraudulent billing and treatment protocols, which financially enriched Defendants at the expense of GEICO, and as part of the improper financial and kickback arrangements between Defendants and others.

F. The Fraudulent Billing for Independent Contractor Services

155. The Defendants' fraudulent scheme also included the submission of claims to GEICO on behalf of the Vasserman PCs seeking payments for services provided by independent contractors.

156. Under the New York no-fault insurance laws, professional corporations are ineligible to bill for or receive payment for goods or services provided by independent contractors. Healthcare services must be provided by the professional corporations themselves, or by their employees.

157. Since 2001, the New York State Insurance Department consistently has reaffirmed its longstanding position that professional corporations are not entitled to receive reimbursement under the New York no-fault insurance laws for healthcare providers performing services as independent contractors. See DOI Opinion Letter, February 21, 2001 ("where the health services

are performed by a provider who is an independent contractor with the PC and is not an employee under the direct supervision of a PC owner, the PC is not authorized to bill under No-Fault as a licensed provider of those services"); DOI Opinion Letter, February 5, 2002 (refusing to modify position set forth in 2-21-01 Opinion letter despite a request from the New York State Medical Society); DOI Opinion Letter, March 11, 2002 ("If the physician has contracted with the PC as an independent contractor, and is not an employee or shareholder of the PC, such physician may not represent himself or herself as an employee of the PC eligible to bill for health services rendered on behalf of the PC, under the New York Comprehensive Motor Vehicle Insurance Reparations Act…"); DOI Opinion Letter, October 29, 2003 (extending the independent contractor rule to hospitals); DOI Opinion Letter, March 21, 2005 (DOI refused to modify its earlier opinions based upon interpretations of the Medicare statute issued by the CMS).

158. The Vasserman PCs routinely submitted charges to GEICO and other insurers for Fraudulent Services that were performed by healthcare professionals and/or technicians other than the Provider Defendants or the Vasserman PCs' employees.

159. To the extent the Fraudulent Services were performed in the first instance, they were performed by individuals other than Vasserman and by physicians/technicians that the Defendants treated as independent contractors.

160. For instance, upon information and belief, the Defendants:

(i) paid the healthcare providers, either in whole or in part, on a 1099 basis rather than a W-2 basis;

(ii) established an understanding with the healthcare providers that they were independent contractors, rather than employees;

(iii) paid no employee benefits to the healthcare providers;

(iv) failed to secure and maintain W-4 or I-9 forms for the healthcare providers;

(v) failed to withhold federal, state, or city taxes on behalf of the healthcare providers;

(vi) permitted the healthcare providers to set their own schedules and days on which they desired to perform services;

(vii) permitted the healthcare providers to maintain non-exclusive relationships and perform services for their own practices and/or on behalf of other practices; and

(viii) failed to cover the healthcare providers for either unemployment or workers' compensation benefits.

161. By electing to treat the technicians and other healthcare providers as independent contractors, the Defendants realized significant economic benefits – for instance:

(i) avoiding the obligation to collect and remit income tax as required by 26 U.S.C. § 3102;

(ii) avoiding payment of the FUTA excise tax required by 26 U.S.C. § 3301 (6.2 percent of all income paid);

(iii) avoiding payment of the FICA excise tax required by 26 U.S.C. § 3111 (7.65 percent of all income paid);

(iv) avoiding payment of workers' compensation insurance as required by New York Workers' Compensation Law § 10;

(v) avoiding the need to secure any malpractice insurance; and

(vi) avoiding claims of agency-based liability arising from work performed by the healthcare providers.

162. The Defendants were aware that, in order for them to receive reimbursement from GEICO and other no-fault insurers for the Fraudulent Services, those services needed to be, among other things, performed by employees of the Vasserman PCs, and not by independent contractors.

163. However, the Defendants wanted to realize, among other things, all of the financial benefits outlined above.

164. Therefore, and in furtherance of their fraudulent scheme, the Defendants misrepresented the identity of the individuals performing the Fraudulent Services.

165. Virtually all of the billing submitted by the Defendants through the Vasserman PCs falsely represented that Vasserman performed the billed-for-services on behalf of the Vasserman PCs.

166. In reality, Vasserman virtually never performed the Fraudulent Services on behalf of the Vasserman PCs.

167. Instead, virtually all of the Fraudulent Services were performed – to the extent they were performed at all – by independent contractors.

168. In keeping with the fact that Vasserman virtually never performed the Fraudulent Services on behalf of the Vasserman PCs, Vasserman, while simultaneously residing in Florida with a continuing an active physical therapy incorporation, often purported to perform a practically impossible amount of purported healthcare services for GEICO Insureds on individual dates, often at numerous No-Fault Clinics.

169. For example:

(i) On August 5, 2020, BV PT and Vasserman purported to provide ROM/MT and ALM Testing services to 33 different GEICO Insureds at six different No-Fault Clinic locations. All of the billing submitted by the Defendants through BV PT falsely represented that Vasserman had personally performed all of the billed-for services and sought reimbursement of $23,794.47 for 53 separate charges to GEICO, all supposedly performed by Vasserman on a single day.

(ii) On September 8, 2020, BV PT and Vasserman purported to provide ROM/MT and ALM Testing services to 35 different GEICO Insureds at five different No-Fault Clinic locations. All of the billing submitted by the Defendants through BV PT falsely represented that Vasserman had personally performed all of the billed-for services and sought reimbursement of $23,394.44 for 58 separate charges to GEICO, all supposedly performed by Vasserman on a single day.

(iii) On September 9, 2020, BV PT and Vasserman purported to provide ROM/MT and ALM Testing services to 43 different GEICO Insureds at seven different No-Fault Clinic locations. All of the billing submitted by the Defendants through BV PT falsely represented that Vasserman had personally performed all of the billed-for services and sought reimbursement of $28,276.97 for 63 separate charges to GEICO, all supposedly performed by Vasserman on a single day.

(iv) On September 24, 2020, BV PT and Vasserman purported to provide ROM/MT and ALM Testing services to 40 different GEICO Insureds at five different No-Fault Clinic locations. All of the billing submitted by the Defendants through BV PT falsely represented that Vasserman had personally performed all of the billed-for services and sought reimbursement of $26,415.40 for 60 separate charges to GEICO, all supposedly performed by Vasserman on a single day.

(v) On September 29, 2020, BV PT and Vasserman purported to provide ROM/MT and ALM Testing services to 40 different GEICO Insureds at five different No-Fault Clinic locations. All of the billing submitted by BV PT and Vasserman falsely represented that Vasserman had personally performed all of the billed-for services and sought reimbursement of $25,574.65 for 64 separate charges to GEICO, all supposedly performed by Vasserman on a single day.

(vi) On September 30, 2020, BV PT and Vasserman purported to provide ROM/MT and ALM Testing services to 36 different GEICO Insureds at six different No-Fault Clinic locations. All of the billing submitted by BV PT and Vasserman falsely represented that Vasserman had personally performed all of the billed-for services and sought reimbursement of $22,364.40 for 54 separate charges to GEICO, all supposedly performed by Vasserman on a single day.

(vii) On August 8, 2022, BV Nassau and Vasserman purported to provide ALM Testing services to 11 different GEICO Insureds at two different No-Fault Clinic locations. All of the billing submitted by the Defendants through BV Nassau falsely represented that Vasserman had personally performed all of the billed-for services and sought reimbursement of $6,754.00 for separate charges to GEICO, all supposedly performed by Vasserman on a single day.

(viii) On November 14, 2022, BV Nassau and Vasserman purported to provide ALM Testing services to 14 different GEICO Insureds at three different No-Fault Clinic locations. All of the billing submitted by the Defendants through BV Nassau falsely represented that Vasserman had personally performed all of the billed-for services and sought reimbursement of $8,596.00 for separate charges to GEICO, all supposedly performed by Vasserman on a single day.

(ix) On January 3, 2023, BV Nassau and Vasserman purported to provide ALM Testing services to 12 different GEICO Insureds at three different No-Fault Clinic locations. All of the billing submitted by the Defendants through BV Nassau falsely represented that Vasserman had personally performed all of the billed-for services and sought reimbursement of $7,368.00 for separate charges to GEICO, all supposedly performed by Vasserman on a single day.

(x) On August 24, 2022, BV Nassau and Vasserman purported to provide ALM Testing services to 5 different GEICO Insureds and BV PT purported to provide ALM Testing to 15 different GEICO Insureds at three different No-Fault Clinic locations. All of the billing submitted by BV Nassau, BV PT, and Vasserman falsely represented that Vasserman had personally performed all of the billed-for services and sought reimbursement of $12,280.00 for separate charges to GEICO, all supposedly performed by Vasserman, through both Vasserman PCs, on a single day.

170. These are only representative examples.

171. In the claims identified in Exhibits "1" and "2", the Defendants routinely falsely represented that the Fraudulent Services were performed by Vasserman when, in fact, the Fraudulent Services were performed – to the extent performed at all – by independent contractors.

172. Upon information and belief, the billing submitted by the Defendants through the Vasserman PCs to GEICO constituted only a fraction of the total fraudulent billing that the Defendants submitted through the Vasserman PCs to all of the automobile insurers in the New York automobile insurance market.

173. It is extremely improbable, to the point of impossible, that the Defendants only submitted fraudulent billing to GEICO, and that the Defendants did not simultaneously bill other automobile insurers.

174. The Defendants' misrepresentations were consciously designed to mislead GEICO into believing that it was obligated to pay for these services when, in fact, GEICO was not.

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

175. To support their fraudulent charges, the Defendants systematically submitted or caused to be submitted hundreds of NF-3 and/or treatment reports through the Vasserman PCs to GEICO seeking payment for the Fraudulent Services for which the Defendants were not entitled to receive payment.

176. The NF-3 and/or treatment reports submitted to GEICO by and on behalf of Defendants were false and misleading in the following material respects:

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

(ii) The NF-3 forms and supporting documentation submitted to GEICO by and on behalf of Defendants uniformly misrepresented and exaggerated the level of the Fraudulent Services and the nature of the Fraudulent Services that purportedly were provided;

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

(iv) The NF-3 forms and supporting documentation submitted to GEICO by and on behalf of Defendants fraudulently concealed that the Fraudulent Services were performed – to the extent performed at all – by independent contractors rather than employees of the Vasserman PCs; and

(v) The NF-3 forms and treatment reports submitted by, and on behalf of, the Defendants uniformly misrepresented to GEICO that the Defendants were eligible to receive PIP Benefits pursuant to Insurance Law § 5102(a)(1) and 11 N.Y.C.R.R. § 65-3.11 for the services that supposedly were performed. In fact, the Vasserman PCs were not eligible to seek or pursue collection of PIP Benefits for the services that supposedly were performed.

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

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

178. To induce GEICO to promptly pay the fraudulent charges for the Fraudulent Services, the Defendants systematically concealed their fraud through a complex scheme.

179. The Defendants knowingly misrepresented and concealed facts related to the Vasserman PCs in an effort to prevent GEICO from learning that the Defendants unlawfully exchanged kickbacks for patient referrals.

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

181. Furthermore, 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 pre-determined protocols designed to maximize the charges that could be submitted, rather than to benefit the Insureds who supposedly were subjected to the Fraudulent Services.

182. In addition, the Defendants knowingly misrepresented and concealed facts related to the employment status of the healthcare professionals associated with the Vasserman PCs in order to prevent GEICO from discovering that the healthcare professionals performing many of the Fraudulent Services were not employed by the Vasserman PCs.

183. Furthermore, in many cases, Defendants knowingly misrepresented that the Provider Defendants were the treating providers who rendered the Fraudulent Services, when, they were not.

184. The Defendants billed for the Fraudulent Services through multiple providers and entities using multiple tax identification numbers in order to reduce the amount of billing submitted through any single individual or entity or under any single tax identification number, thereby preventing GEICO from identifying the pattern of fraudulent charges submitted through any one entity.

185. Further, the Defendants employed a "quick hit" scheme where the Defendants would submit high amounts of fraudulent billing in a short period of time. In this case, BV Nassau opened only months before BV PT shut down in order to continue the scheme.

186. 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.

187. 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, complex fraud scheme involving numerous patients across numerous different clinics located throughout the metropolitan area.

188. GEICO is under statutory and contractual obligations to promptly and fairly process claims 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 $300,000.00 based upon the fraudulent charges.

189. 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.

FIRST CAUSE OF ACTION
Against the Vasserman PCs
(Declaratory Judgment – 28 U.S.C. §§ 2201 and 2202)

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

191. There is an actual case in controversy between GEICO and the Vasserman PCs regarding more than $2,000,000.00 in fraudulent billing for the Fraudulent Services that has been submitted to GEICO.

192. The Vasserman PCs have no right to receive payment for any pending bills submitted to GEICO, because the Fraudulent Services were not medically necessary and were provided – to the extent provided at all – pursuant to pre-determined fraudulent protocols designed solely to financially enrich the Defendants, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to them.

193. The Vasserman PCs have no right to receive payment for any pending bills submitted to GEICO, because the billing codes used for the Fraudulent Services – to the extent provided at all – misrepresented and exaggerated the level of services that purportedly were provided in order to inflate the charges submitted to GEICO.

194. The Vasserman PCs 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 – by professional corporations that were unlawfully incorporated and operated and controlled by laypersons not licensed to render healthcare services.

195. The Vasserman PCs 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 payments made in exchange for patient referrals.

196. The Vasserman PCs have no right to receive payment for any pending bills submitted to GEICO because, in many cases, the Fraudulent Services – to the extent provided at all – were provided by independent contractors, rather than by employees of the Vasserman PCs.

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

SECOND CAUSE OF ACTION
Against Vasserman and the Management Defendants
(Violation of RICO, 18 U.S.C. § 1962(c))

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

199. BV PT is an ongoing "enterprise," as that term is defined in 18 U.S.C. § 1961(4), that engages in activities which affect interstate commerce.

200. Vasserman and the Management Defendants knowingly have conducted and/or participated, directly or indirectly, in the conduct of BV PT's affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, based upon the use of the United States mails to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments that BV PT was not eligible to receive under the No-Fault Laws because: (i) BV PT was unlawfully incorporated and owned and controlled by unlicensed individuals; (ii) the billed-for-services were not medically necessary; (iii) the billed-for-services were performed and billed pursuant to a pre-determined,

fraudulent treatment and billing protocol designed solely to enrich Defendants; (iv) the billing codes used for the services misrepresented and exaggerated the level of services that purportedly were provided in order to inflate the charges that could be submitted; (v) in many instances, the Fraudulent Services were never legitimately provided in the first place; (vi) BV PT obtained its patients through an illegal kickback scheme; and (vii) the billed-for services were performed, to the extent provided at all, by independent contractors rather than BV PT's employees. The fraudulent billings and corresponding mailings submitted to GEICO that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit "1."

201. BV PT's business is racketeering activity, inasmuch as the enterprise exists for the purpose of submitting fraudulent charges to insurers. The predicate acts of mail fraud are the regular ways in which Vasserman and the Management Defendants operated BV PT, inasmuch as BV PT never was eligible to bill for or collect No-Fault Benefits, and acts of mail fraud therefore were essential in order for BV PT to function. Furthermore, the intricate planning required to carry out and conceal the predicate acts of mail fraud implies a threat of continued criminal activity, as does the fact that Defendants continue to attempt collection on the fraudulent billing submitted through BV PT to the present day.

202. BV PT is engaged in inherently unlawful acts inasmuch as it continues to attempt collection on fraudulent billing submitted to GEICO and other insurers. These inherently unlawful acts are taken by BV PT in pursuit of inherently unlawful goals – namely, the theft of money from GEICO and other insurers through fraudulent no-fault billing.

203. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $300,000.00 pursuant to the fraudulent bills submitted

by the Defendants through BV PT.

204. By reason of its injury, GEICO is entitled to treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c), and any other relief the Court deems just and proper.

THIRD CAUSE OF ACTION
Against Vasserman and the Management Defendants
(Violation of RICO, 18 U.S.C. § 1962(d))

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

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

207. BV PT is an ongoing "enterprise," as that term is defined in 18 U.S.C. § 1961(4), that engaged in activities which affected interstate commerce.

208. Vasserman and the Management Defendants are employed by and/or associated with the BV PT enterprise.

209. Vasserman and the Management Defendants knowingly have agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of BV PT's affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, based upon the use of the United States mails to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments that BV PT was not eligible to receive under the No-Fault Laws because: (i) BV PT was unlawfully incorporated and owned and controlled by unlicensed individuals; (ii) the billed-for-services were not medically necessary; (iii) the billed-for-services were performed and billed pursuant to a pre-determined, fraudulent treatment and billing protocol designed solely to enrich

Defendants; (iv) the billing codes used for the services misrepresented and exaggerated the level of services that purportedly were provided in order to inflate the charges that could be submitted; (v) in many instances, the Fraudulent Services were never legitimately provided in the first place; (vi) BV PT obtained its patients through an illegal kickback scheme; and (vii) the billed-for services were performed, to the extent provided at all, by independent contractors rather than BV PT's employees. The fraudulent bills and corresponding mailings submitted to GEICO that comprise the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit "1".

210. Vasserman and the Management Defendants knew of, agreed to, and acted in furtherance of the common overall objective (i.e., to defraud GEICO and other insurers of money) by submitting or facilitating the submission of fraudulent charges to GEICO.

211. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $300,000.00 pursuant to the fraudulent bills submitted by Defendants through BV PT.

212. By reason of its injury, GEICO is entitled to treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c), and any other relief the Court deems just and proper.

FOURTH CAUSE OF ACTION
Against All Defendants
(Common Law Fraud)

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

214. Defendants 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.

215. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that Vasserman PCs were 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 they were not properly licensed in that the Vasserman PCs were unlawfully incorporated and/or owned, controlled, and operated by unlicensed laypersons; (ii) in every claim, the representation that the Vasserman PCs were 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; (iii) 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 pre-determined, fraudulent protocol designed solely to enrich the Defendants; (iv) in every claim, the representation that the billed-for services were properly billed in accordance with the Fee Schedule, when in fact the billing codes used for the billed-for services misrepresented and exaggerated the level and type of services that purportedly were provided in order to inflate the charges submitted to GEICO; and (v) in every claim, the representation that the billed-for services were performed by Vasserman when in fact they were performed, to the extent performed at all, by independent contractors.

216. Defendants 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 the Vasserman PCs that were not compensable under the No-Fault Laws.

217. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $300,000.00 pursuant to the fraudulent bills submitted

by the Defendants through the Vasserman PCs.

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

219. 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.

FIFTH CAUSE OF ACTION
Against All Defendants
(Unjust Enrichment)

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

221. As set forth above, Defendants have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of GEICO.

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

223. Defendants 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.

224. Defendants' retention of GEICO's payments violates fundamental principles of justice, equity, and good conscience.

225. By reason of the above, Defendants have been unjustly enriched in an amount to be determined at trial, but in no event less than $300,000.00.

JURY DEMAND

226. Pursuant to Federal Rule of Civil Procedure 38(b), GEICO demands a trial by jury.

WHEREFORE, Plaintiffs, Government Employees Insurance Company, GEICO Indemnity Company, GEICO General Insurance Company and GEICO Casualty Company, demand the entry of a judgment in their favor:

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

B. On the Second Cause of Action against the Vasserman and the Management Defendants, compensatory damages in favor of GEICO in an amount to be determined at trial but more than $300,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

C. On the Third Cause of Action against Vasserman and the Management Defendants, compensatory damages in favor of GEICO in an amount to be determined at trial but more than $300,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

D. On the Fourth Cause of Action against the Defendants, compensatory damages in favor of GEICO in an amount to be determined at trial but more than $300,000.00, together with punitive damages, costs, interest, and such other and further relief as this Court deems just and proper; and

E. On the Fifth Cause of Action against the Defendants, more than $300,000.00 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 7, 2024

RIVKIN RADLER LLP

By: /s/ Barry Levy

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