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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

JAMES AVELLINI MEDICAL P.C., JRA MEDICAL P.C., and JAMES AVELLINI, M.D.,

Defendants.

----------X

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 James Avellini Medical P.C., JRA Medical P.C., and James Avellini, M.D. (collectively, the "Defendants"), hereby allege as follows:

NATURE OF THE ACTION

1. GEICO brings this action to recover more than $174,000.00 Defendants have wrongfully obtained from GEICO by submitting, and causing to be submitted, thousands of

fraudulent no-fault insurance charges relating to medically unnecessary, illusory, and otherwise non-reimbursable healthcare services, including examinations, electrodiagnostic testing, and spinal ultrasounds (collectively the "Fraudulent Services"), that allegedly were provided to individuals who claimed to have been involved in automobile accidents and eligible for coverage under GEICO no-fault policies ("Insureds").

2. Additionally, GEICO seeks a declaration that it is not legally obligated to pay reimbursement of more than $908,000.00 in pending no-fault insurance claims that have been submitted by or on behalf of Defendants James Avellini Medical P.C. and JRA Medical P.C. because:

(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; and

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

3. The Defendants fall into the following categories:

(i) Defendants James Avellini Medical P.C. ("JA Medical") and JRA Medical P.C. ("JRA Medical") (collectively, the "Providers") are New York professional corporations through which the Fraudulent Services purportedly were performed and billed to New York automobile insurance companies, including GEICO.

(ii) Defendant James Avellini, M.D. ("Avellini") is a physician licensed to practice medicine in New York that purported to own JA Medical and JRA Medical.

4. 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; and

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

5. As such, Defendants do not now have – and never had – any right to be compensated for the Fraudulent Services that were billed to GEICO through the Providers.

6. 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 submitted, or caused to be submitted, to GEICO.

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

8. As a result of the Defendants' fraudulent scheme, GEICO has incurred damages of more than $174,000.00.

THE PARTIES

I. Plaintiffs

9. 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.

II. Defendants

10. Defendant JA Medical is a New York professional medical corporation with its principal place of business in New York. JA Medical was formed in New York on January 25, 2022. JA Medical is purportedly owned by Avellini and was used as a vehicle to submit fraudulent billing to GEICO and other New York automobile insurers.

11. Defendant JRA Medical is a New York professional medical corporation with its principal place of business in New York. JA Medical was formed in New York on December 12, 2022. JRA Medical is purportedly owned by Avellini and was used as a vehicle to submit fraudulent billing to GEICO and other New York automobile insurers.

12. Defendant Avellini resides in and is a citizen of New Jersey. Avellini became licensed to practice medicine in New York on October 30, 1981. Avellini purported to own JA Medical and JRA Medical.

13. Avellini was previously charged with Fraudulent Practice and disciplined by the New York State Board for Professional Medical Conduct in 2011 in connection with a false representation that he was a board-certified physician and/or a board-certified cosmetic surgeon. Avellini did not contest the charge of Fraudulent Practice and consented to a censure and reprimand, to pursue a course of continuing education in the area of medical ethics, and to pay a monetary fine of $10,000.00.

JURISDICTION AND VENUE

14. 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.

15. Pursuant to 28 U.S.C. § 1331, this Court also has jurisdiction over the claims brought under 18 U.S.C. §§ 1961 et seq. (the Racketeer Influenced and Corrupt Organizations ["RICO"] Act) because they arise under the laws of the United States.

16. 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 this is the District where a substantial amount of the activities forming the basis of the Complaint occurred.

ALLEGATIONS COMMON TO ALL CLAIMS

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

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

19. 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.

20. 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 to Insureds.

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

22. 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.

23. 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").

24. 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").

25. 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.

26. 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).

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; 6531.

28. New York law prohibits licensed healthcare services providers, including 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.

29. What is more, with limited exceptions that are not applicable here, New York law prohibits licensed healthcare services providers, including physicians, from referring patients for electrodiagnostic 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.

30. 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.

31. 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.

32. 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 …

33. 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.

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

35. 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.

36. 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.

II. The Defendants' Fraudulent Scheme

37. Beginning in late 2021, and continuing through the present day, the Defendants masterminded and implemented a complex fraudulent scheme in which they billed GEICO and other New York automobile insurers millions of dollars for medically unnecessary, illusory, and otherwise non-reimbursable services.

38. J.A. Medical was the first of the Providers to begin billing GEICO in early 2022. Based on issues identified by GEICO in its analysis of the billing and the locations from which the services were being performed, GEICO began requesting that JA Medical and Avellini appear for an examination under oath ("EUO") with respect to claims submitted seeking payment.

39. JA Medical never responded to the EUO requests and shortly after GEICO began making the requests, and on or about January 5, 2023, JA Medical stopped billing GEICO. As noted above, JRA Medical was incorporated on December 12, 2022, and began submitting billing to GEICO for the same services that JA Medical had billed, beginning on January 10, 2023, i.e., five days after JA Medical stopped billing GEICO. The morphing of the "practices" was simply part of the fraudulent scheme, and Avellini never notified GEICO that he had elected to transition his "practice" from JA Medical to JRA Medical or that the successor professional corporation from an operational perspective was simply a mirror image of the original and operated from the same Clinics (as defined below) in the New York metropolitan area.

A. The Multidisciplinary Clinics and Kickbacks

40. Avellini and the Providers did not advertise or market the Providers' services to the public, did not maintain stand-alone practices, and were not the owners of or leaseholders of the real property from which the Providers purported to provide the Fraudulent Services.

41. Instead, the Providers operated on an itinerant basis from numerous 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) 3626 Bailey Avenue, Brooklyn, New York;

(ii) 1975 Linden Boulevard, Elmont, New York;

(iii) 14 Bruckner Boulevard, Bronx, New York;

(iv) 60 Belmont Avenue, Brooklyn, New York;

(v) 3209 Fulton Street, Brooklyn, New York;

(vi) 719 Southern Boulevard, Bronx, New York; and

(vii) 3910 Church Avenue, Brooklyn, New York.

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

43. The Providers gained access to the Clinics by paying kickbacks or other forms of financial incentives to individuals that own and/or control the Clinics or other healthcare services providers that operated from the Clinics and controlled access to the Clinics (the "Clinic Controllers").

44. 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 Clinic Controllers 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.

45. In keeping with the fact that the "rent" that Avellini and the Providers paid to the Clinic Controllers constituted kickbacks in exchange for patient referrals, the purported "rent" was far in excess of the fair market value of the putative leaseholds.

46. In exchange for these kickbacks from Avellini and the Providers, the Clinic Controllers automatically and systematically referred Insureds to the Defendants for the medically useless Fraudulent Services, regardless of the Insureds' individual circumstances or presentation.

47. In keeping with the fact that the Clinic Controllers automatically and systematically referred Insureds to the Defendants, without genuine regard for patient care, the billing submitted for services purportedly provided to Insureds by the Clinic Controllers virtually never indicated that patients were being referred to the Providers.

B. The Defendants' Fraudulent Treatment and Billing Protocol

48. 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. 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.

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

50. The Defendants purported to provide their predetermined fraudulent 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.

51. 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.

52. 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.

53. 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

54. Upon receiving an unlawful referral from the Clinic Controllers, the Providers purported to provide virtually every Insured in the claims identified in Exhibits "1" and "2" with an initial examination.

55. 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, electrodiagnostic testing.

56. The initial examinations were typically performed by Avellini as well as Michael Alleyne, M.D. ("Alleyne"), Lubov Klimova, M.D. ("Klimova"), and Yekaterina Slukhinsky, M.D. ("Slukhinsky") (collectively, the "Treating Individuals") on behalf of the Providers.

57. As set forth in Exhibits "1" and "2", the initial examinations were then billed to GEICO through the Providers under CPT code 99203, typically resulting in a charge of $142.62 for each purported examination.

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

59. Furthermore, the Defendants 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" and "2" inasmuch as Avellini and the Providers gained access to Insureds at the Clinics by paying kickbacks and other financial incentives to individuals who own and/or control the No-Fault Clinics, in violation of the No-Fault Laws.

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 99203 typically requires that the Insured present with problems of moderate severity.

62. Though the Defendants billed the purported initial examinations under CPT code 99203, the Insureds almost never presented with problems of moderate 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 99203, and thereby falsely represented that the Insureds presented with problems of moderate severity.

64. The Defendants routinely falsely represented that the Insureds presented with problems of moderate severity in order to create a false basis for their charges for the examinations under CPT code 99203, 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 severity in order to create a false basis for the other Fraudulent Services that the Defendants purported to provide to the Insureds, specifically, medically unnecessary electrodiagnostic testing.

66. The Defendants also routinely falsely represented that the Insureds presented with problems of moderate severity in order to create a false basis for the referrals for continued medically unnecessary physical therapy, additional pain management and/or orthopedic consultations pursuant to the illegal "pay-to-play" arrangements that caused the Clinic Controllers to provide the Defendants with access to Insureds in the first instance.

67. The CPT Assistant provides various clinical examples of the types of presenting problems that qualify as moderately severe, and thereby justify the use of CPT code 99203 to bill for an initial patient examination.

68. For example, according to the CPT Assistant, the following clinical examples of presenting problems might support the use of CPT code 99203 to bill for an initial patient examination:

(i) Office visit for initial evaluation of a 48-year-old man with recurrent low back pain radiating to the leg. (General Surgery)

(ii) Initial office evaluation of 49-year-old male with nasal obstruction. Detailed exam with topical anesthesia. (Plastic Surgery)

(iii) Initial office evaluation for diagnosis and management of painless gross hematuria in new patient, without cystoscopy. (Internal Medicine)

(iv) Initial office visit for evaluation of 13-year-old female with progressive scoliosis. (Physical Medicine and Rehabilitation)

(v) Initial office visit with couple for counseling concerning voluntary vasectomy for sterility. Spent 30 minutes discussing procedure, risks and benefits, and answering questions. (Urology)

69. Pursuant to the CPT Assistant, the moderately severe presenting problems that could support the use of CPT code 99203 to bill for an initial patient examination typically are either chronic and relatively serious problems, acute problems requiring immediate invasive treatment, or issues that legitimately require physician counseling.

70. By contrast, to the extent that the Insureds in the claims identified in Exhibits "1" and "2" had any presenting problems at all as the result of their relatively minor automobile accidents, the problems virtually always were low or minimal severity soft tissue injuries such as sprains and strains.

71. For instance, and in keeping with the fact that the Insureds in the claims identified in Exhibits "1" and "2", either had no presenting problems at all as the result of their relatively minor automobile accidents, or else problems of low or minimal severity, in many of the claims identified in Jams "1" and "2", the Insureds did not seek treatment at any hospital as the result of their accidents.

72. 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, strain, or similar soft tissue injury diagnosis.

73. Furthermore, in many of the cases, contemporaneous police reports indicated that the underlying accidents involved relatively 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.

74. Even so, in the claims for initial examinations identified in Exhibits "1" and "2", Avellini and the Providers routinely billed for their putative initial examinations using CPT code 99203, and thereby falsely represented that the Insureds presented with problems of moderate severity.

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

76. The Defendants misrepresented and exaggerated the amount of face-to-face time that the examining physician spent with the Insureds or the Insureds' families.

77. The use of CPT code 99203 to bill for an examination typically requires that that a physician spend 30 minutes of face-to-face time with the Insured or the Insured's family during the examination.

78. Although the Defendants billed for their putative examinations under CPT code 99203, neither Avellini, Alleyne, Klimova, Slukhinsky, nor any healthcare practitioner associated with the Providers ever spent 30 minutes in performing an initial examination. To the extent that the initial examinations were actually conducted, they lasted a fraction of the time represented by the billing.

79. Pursuant to the CPT Assistant, at all relevant times the use of CPT code 99203 to bill for a patient examination represented that the physician or other healthcare practitioner who performed the examination conducted a "detailed" physical examination.

80. Pursuant to the CPT Assistant, a "detailed" physical examination requires – among other things – that the physician or other healthcare practitioner performing the examination

conduct an extended examination of the affected body areas and other symptomatic or related organ systems.

81. To the extent that the Insureds in the claims identified in Exhibits "1" and "2" had any actual complaints at all as the result of their relatively minor automobile accidents, the complaints were limited to minor musculoskeletal complaints, such as sprains and strains.

82. Pursuant to the CPT Assistant, in the context of patient examinations, a physician or other healthcare practitioner has not conducted an extended examination of a patient's musculoskeletal organ system unless the practitioner has documented findings with respect to the following:

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

(ii) general appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming);

(iii) examination of 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) brief assessment of mental status;

(vi) examination of gait and station;

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

(viii) coordination;

(ix) examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes; and

(x) examination of sensation.

83. In the claims for initial examinations identified in Exhibits "1" and "2", when Avellini and the Providers billed for the initial examinations under CPT code 99203, they falsely represented that the physician or other healthcare practitioner who purported to perform the examinations performed "detailed" patient examinations on the Insureds they purported to treat during the initial examinations.

84. In fact, with respect to the claims for initial examinations under CPT code 99203 that are identified in Exhibits "1" and "2", neither Avellini, Alleyne, Klimova, Slukhinsky, nor any other healthcare practitioner associated with the Providers conducted extended examinations of the Insureds' musculoskeletal systems.

85. For instance, neither Avellini, Alleyne, Klimova, Slukhinsky, nor any other healthcare practitioner associated with the Providers conducted extended examinations of the Insureds' musculoskeletal systems, inasmuch as they did not document findings with respect to the following:

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

(ii) general appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming);

(iii) examination of 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) brief assessment of mental status;

(vi) examination of gait and station;

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

(viii) coordination;

(ix) examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes; and/or

(x) examination of sensation.

86. In fact, with respect to the claims for initial examinations under CPT code 99203 that are identified in Exhibits "1" and "2", neither Avellini, Alleyne, Klimova, Slukhinsky, nor any healthcare practitioner associated with the Providers ever conducted or recorded a "detailed" physical examination.

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 99203, the cursory initial examination reports submitted by the Defendants were simple template, fill-in-the blank reports that contained no narrative discussion or meaningful analysis of a patients' medical history or condition, and routinely failed to record even the most basic requirements of a "detailed" physical examination. Rather, the "treating" provider simply placed a check mark next to each system that was purportedly examined.

88. In the claims identified in Exhibits "1" and "2", when the Defendants billed for the initial examinations under CPT code 99203, they falsely represented that they performed "detailed" patient examinations on the Insureds during the initial examinations.

89. Rather, to the extent that the initial examinations were conducted in the first instance, the Defendants utilized template examination forms that required minimal input from the Treating Individual and resulted in boilerplate, predetermined "recommendations" that directed Insureds to submit to electrodiagnostic testing, continue physical therapy, and receive additional pain management and/or orthopedic consultations at the Clinic.

90. In keeping with the fact that the initial examinations were part and parcel of a predetermined fraudulent treatment protocol and involved only the completion of basic template examination forms, virtually every initial examination reported contained the following verbatim language regarding "recommendations" for electrodiagnostic testing, including the same idiosyncratic grammar, misspellings, punctuation, and capitalization:

> "Based on the description of the injury, the patient's complaints, current physical findings and working diagnosis, the following recommendations are essential and medically necessary in order to stabilize and expedite recovery of His / Her injuries:
>
> 1.EMG / NCV studies of Upper and Lower Extremities to rule out Radiculopathy, Sensory nerve impairment / peripheral neuropathy in view of the patient's complaints, physical findings and working diagnosis.
> *** Better predict prognosis for recovery and possible residual Neurological deficit.
> ***Administer appropriate therapy.
> ***If Electro diagnostic study is Positive for neurogenic injury, treatment can be extended to tens for Neck, Back, Cervical and Lumbar traction and paravertebral nerve block."

91. The above "recommendations" appeared in the examination report of virtually every patient that was seen by the Providers, regardless of the patient's history, the nature of the accident and/or the specific condition.

92. For example, the above "recommendations" appeared in the purported initial examination reports for the following patients treated at both JA Medical and JRA Medical, regardless of which Treating Individual purported to actually perform the examination:

(i) TA, performed by Alleyne at JA Medical;

(ii) KC, performed by Slukhinsky at JA Medical;

(iii) WG, performed by Klimova at JA Medical;

(iv) DB, performed by Slukhinsky at JA Medical;

(v) YM, performed by Slukhinsky at JA Medical;

(vi) EF, performed by Avellini at JA Medical;

(vii) AS, performed by Slukhinsky at JA Medical;

(viii) MB, performed by Slukhinsky at JA Medical;

(ix) TE, performed by Alleyne at JA Medical;

(x) IR, performed by Klimova at JA Medical;

(xi) AH, performed by Slukhinsky at JRA Medical;

(xii) FE, performed by Slukhinsky at JRA Medical;

(xiii) JD, performed by Slukhinsky at JRA Medical;

(xiv) AF, performed by Slukhinsky at JRA Medical;

(xv) MB, performed by Slukhinsky at JRA Medical;

(xvi) JV, performed by Slukhinsky at JRA Medical;

(xvii) KS, performed by Avellini at JRA Medical;

(xviii) AB, performed by Avellini at JRA Medical;

(xix) GJ, performed by Avellini at JRA Medical; and

(xx) LT, performed by Alleyene at JRA Medical.

93. These are only representative examples.

94. In the examination claims identified in Exhibits "1" and "2", Avellini, JA Medical, and JRA Medical submitted purported examination reports that virtually always contained the above verbatim "recommendations" regardless of Insureds' actual symptoms or presentation.

95. In further keeping with the fact that the initial examinations were part and parcel of a predetermined fraudulent treatment protocol and involved only the completion of basic template examination forms, virtually every initial examination report contained the following verbatim

language regarding patients' prognoses, including the same idiosyncratic grammar, misspellings, punctuation, and capitalization:

> "*At this time. [sic] patient's [sic] condition prognosis is guarded but favorable with treatment.*
> The possibility of this condition becoming permanent cannot be ruled out at this time. This deficit can persist for an indefinite period of time affection [sic] the patient's mobility and quality of life. The prognosis of this patient's condition in regards to a full and complete recovery is favorable with treatment but guarded at this time. Based on the slow process in the patient's recovery despite physical therapy intervention additional Neurological [sic] diagnostic tests were ordered to determine the full extent of the injury and the results of the testing will provide necessary information for final decision regarding this patient's prognosis."

96. The above prognosis appeared in the examination report of virtually every patient seen by the Providers, regardless of the patient's specific condition.

97. For example, the above "prognosis" appeared in the purported initial examination reports for the following patients treated at JA Medical and JRA Medical, regardless of which Treating Individual purported to actually perform the examination:

(i) TA, performed by Alleyne at JA Medical;

(ii) KC, performed by Slukhinsky at JA Medical;

(iii) WG, performed by Klimova at JA Medical;

(iv) DG, performed by Slukhinsky at JA Medical;

(v) YM, performed by Slukhinsky at JA Medical;

(vi) EF, performed by Avellini at JA Medical;

(vii) AS, performed by Slukhinsky at JA Medical;

(viii) MB, performed by Slukhinsky at JA Medical;

(ix) TE, performed by Alleyne at JA Medical;

(x) IR, performed by Klimova at JA Medical;

(xi) AH, performed by Slukhinsky at JRA Medical;

(xii) FE, performed by Slukhinsky at JRA Medical;

(xiii) JD, performed by Slukhinsky at JRA Medical;

(xiv) AF, performed by Slukhinsky at JRA Medical;

(xv) MB, performed by Slukhinsky at JRA Medical;

(xvi) JV, performed by Slukhinsky at JRA Medical;

(xvii) KS, performed by Avellini at JRA Medical;

(xviii) AB, performed by Avellini at JRA Medical;

(xix) GJ, performed by Avellini at JRA Medical; and

(xx) LT, performed by Alleyene at JRA Medical.

98. These are only representative examples.

99. In the examination claims identified in Exhibits "1" and "2", Avellini, JA Medical, and JRA Medical submitted purported examination reports that virtually always contained the above verbatim "prognoses" regardless of Insureds' actual symptoms or presentation.

2. The Fraudulent Charges for Electrodiagnostic Testing

100. Based upon the fraudulent, predetermined findings and "diagnoses" provided as a result of the initial examinations, Avellini, JA Medical, JRA Medical, and the Treating Individuals systemically subjected Insureds to a series of medically unnecessary nerve conduction velocity ("NCV") tests and electromyography ("EMG") tests (collectively the "electrodiagnostic" or "EDX" tests).

101. The EDX tests were typically performed by Avellini, Alleyne, Klimova, or Slukhinsky and were billed through JA Medical or JRA Medical to GEICO.

102. In keeping with the fact that the EDX tests were performed solely for profit and not to genuinely benefit the patients that were purportedly subjected to them, neither Avellini, Alleyne, Klimova, nor Slukhinsky are board-certified in either neurology or physiatry.

103. As discussed above, Avellini is not board-certified in any specialty and was previously disciplined by the New York State Board for Professional Medical Conduct for falsely holding himself out as a board-certified physician and/or board-certified cosmetic surgeon.

104. In keeping with Avellini's lack of relevant training, at an EUO of JRA Medical that was conducted by GEICO on November 16, 2023, Avellini misstated basic facts about EDX testing, e.g., Avellini incorrectly asserted that NCV testing is only used to test a patient's sensory nerves. In fact, NCV studies are performed on both sensory and motor nerves. Furthermore, both JA Medical and JRA Medical submitted significant billing to GEICO for NCV studies conducted of motor nerves purportedly performed by Avellini personally.

105. As set forth in Exhibits "1" and "2", Avellini, JA Medical, and JRA Medical then billed the EDX tests to GEICO primarily under CPT codes 95886, 95905, 95911, and 95913 typically resulting in charges between $2,405.20 and $2,548.22 for each Insured purportedly subjected to the testing.

106. In the claims for EDX tests identified in Exhibits "1" and "2", the charges for the EDX tests were fraudulent in that they were medically unnecessary and were performed – to the extent performed at all – pursuant to the fraudulent boilerplate "recommendations" and "prognoses" that Avellini, JA Medical, JRA Medical, and the Treating Individuals purported to provide during their phony initial examinations and the Defendants' unlawful referral scheme.

107. Moreover, in the claims for EDX tests identified in Exhibits "1" and "2", the charges for the EDX tests were fraudulent in that they misrepresented the Providers' eligibility to collected PIP Benefits in the first instance.

108. In fact, the Providers were never eligible to collect PIP benefits in connection with the claims identified in Exhibits "1" and "2" because – as a result of the fraudulent and unlawful conduct described herein – the Providers and the EDX tests were not in compliance with all significant laws and regulations governing healthcare practice in New York.

a. The Human Nervous System and Electrodiagnostic Testing

109. The human nervous system is composed of the brain, spinal cord, spinal nerve roots, and peripheral nerves that extend throughout the body, including through the arms and legs and into the hands and feet. Two primary functions of the nervous system are to collect and relay sensory information through the nerve pathways into the spinal cord and up to the brain, and to transmit signals from the brain into the spinal cord and through the peripheral nerves to initiate muscle activity throughout the body.

110. The nerves responsible for collecting and relaying sensory information to the brain are called sensory nerves, and the nerves responsible for transmitting signals from the brain to initiate muscle activity throughout the body are called motor nerves. The peripheral nervous system consists of both sensory and motor nerves. They carry electrical impulses throughout the body, from the spinal cord and extending, for example, into the hands and feet through the arms and legs.

111. The segments of nerves closest to the spine and through which impulses travel between the peripheral nerves and the spinal cord are called the nerve roots. A "pinched" nerve

root is called a radiculopathy, and can cause various symptoms and signs including pain, altered sensation, altered reflexes on examination, and loss of muscle control.

112. EMG and NCV tests are forms of electrodiagnostic tests, and purportedly were provided by JA Medical and JRA Medical because they were medically necessary to determine whether the Insureds had radiculopathies.

113. The American Association of Neuromuscular and Electrodiagnostic Medicine ("AANEM"), which consists of thousands of neurologists and physiatrists and is dedicated solely to the scientific advancement of neuromuscular medicine, has adopted a recommended policy (the "Recommended Policy") regarding the optimal use of electrodiagnostic medicine in the diagnosis of various forms of neuropathies, including radiculopathies.

114. The Recommended Policy accurately reflects the demonstrated utility of various forms of electrodiagnostic tests and has been endorsed by two other premier professional medical organizations, the American Academy of Neurology and the American Academy of Physical Medicine and Rehabilitation.

b. The Fraudulent NCV Tests

115. NCV tests are non-invasive tests in which peripheral nerves in the arms and legs are stimulated with an electrical impulse to cause the nerve to depolarize. The depolarization, or "firing," of the nerve is transmitted, measured, and recorded with electrodes attached to the surface of the skin. An EMG/NCV machine then documents the timing of the nerve response (the "latency"), the magnitude of the response (the "amplitude"), and the speed at which the nerve conducts the impulse over a measured distance from one stimulus location to another (the "conduction velocity").

116. In addition, the EMG/NCV machine displays the changes in amplitude over time as a "waveform." The amplitude, latency, velocity, and shape of the response then should be compared with well-defined normal values to identify the existence, nature, extent, and specific location of any abnormalities in the sensory and motor nerve fibers.

117. There are several motor and sensory peripheral nerves in the arms and legs that can be tested with NCV tests. Moreover, most of these peripheral nerves have both sensory and motor nerve fibers, either or both of which can be tested with NCV tests.

118. F-wave and H-reflex studies are additional types of NCV tests that may be performed in addition to the sensory and motor nerve NCV tests. F-wave and H-reflex studies generally are used to derive the time required for an electrical impulse to travel from a stimulus site on a nerve in the peripheral part of a limb, up to the spinal cord, and then back again. The motor and sensory NCV studies are designed to evaluate nerve conduction in nerves within a limb.

119. According to the Recommended Policy, the maximum number of NCV tests necessary to assist in the diagnose a radiculopathy in 90 percent of all patients is: (i) NCV tests of three motor nerves; (ii) NCV tests of two sensory nerves; and (iii) two H-reflex studies.

120. In an attempt to extract the maximum billing out of each Insured who supposedly received NCV tests, Avellini, the Providers, and the Treating Individuals often purported to test far more nerves than recommended by the Recommended Policy. Specifically, to maximize the fraudulent charges that they could submit to GEICO and other insurers, the Providers routinely purported to perform and/or provide: (i) NCV tests of at least eight motor nerves; (ii) NCV tests of at least ten sensory nerves; (iii) multiple F-wave studies; and (iv) multiple H-reflex studies.

121. Avellini, JA Medical, JRA Medical, and the Treating Individuals often purported to provide and/or perform NCVs on more nerves than recommended by the Recommended Policy

so as to maximize the fraudulent charges that they could submit to GEICO and other insurers, not because the NCVs were medically necessary or needed to determine whether the Insureds had radiculopathies.

122. What is more, the decision of which peripheral nerves to test in each limb and whether to test the sensory fibers, motor fibers, or both sensory and motor fibers in any such peripheral nerve must be tailored to each patient's unique circumstances.

123. In a legitimate clinical setting, this decision is determined based upon a history and physical examination of the individual patient, as well as the real-time results obtained as the NCV tests are performed on particular peripheral nerves and their sensory and/or motor fibers. As a result, the nature and number of the peripheral nerves and the type of nerve fibers tested with NCV tests should vary from patient-to-patient.

124. This concept is emphasized in the Recommended Policy, which states that:

> EDX studies [such as NCVs] are individually designed by the electrodiagnostic consultant for each patient. The examination design is dynamic and often changes during the course of the study in response to new information obtained.

125. This concept also is emphasized in the CPT Assistant, which states that "[p]re-set protocols automatically testing a large number of nerves are not appropriate."

126. Avellini, JA Medical, JRA Medical, and the Treating Individuals did not tailor the NCVs they purported to perform and/or provide to the unique circumstances of each individual Insured.

127. Instead, Avellini, JA Medical, JRA Medical, and the Treating Individuals applied a fraudulent pre-established "protocol" and purported to perform and/or provide NCVs on the same peripheral nerves and nerve fibers in virtually all of the claims identified in Exhibits "1" and "2".

128. Specifically, in virtually every claim for NCV testing identified in Exhibits "1" and "2", Avellini, JA Medical, JRA Medical, and the Treating Individuals purported to test some combination of the following peripheral nerves and nerve fibers – and in many cases, all of them – in each Insured to whom they purported to provide NCV tests:

(i) left and right median motor nerves;

(ii) left and right peroneal motor nerves;

(iii) left and right tibial motor nerves;

(iv) left and right ulnar motor nerves;

(v) left and right median sensory nerves;

(vi) left and right radial sensory nerves;

(vii) left and right superficial peroneal sensory nerves;

(viii) left and right sural sensory nerves; and

(ix) left and right ulnar sensory nerves.

129. The cookie-cutter approach to the NCVs that Avellini, the Providers, and the Treating Individuals purported to provide to Insureds clearly was not based on medical necessity. Instead, the cookie-cutter approach to the NCVs was designed solely to maximize the charges that Avellini and the Providers could submit to GEICO and other insurers, and to maximize their ill-gotten profits.

c. The Fraudulent Unbundling of F-Wave Tests

130. To further inflate the volume of fraudulent billing the Providers could submit to GEICO and other insurers, Avellini and the Providers routinely unbundled the charges for the nerve conduction studies they purported to perform by simultaneously submitting charges under CPT code 95911 and 95905.

131. Pursuant to the NY Fee Schedule and the CPT Assistant, the use of CPT code 95911 indicates that the provider performed nerve conduction studies on 10-11 separate sensory nerves and/or motor nerves with or without F-wave studies, i.e., F-wave studies are included in CPT code 95911.

132. Nevertheless, for virtually every Insured, Avellini and the Providers submitted a second, separate charge under CPT code 95905 – simultaneously with a charge under CPT Code 95911 – purportedly for the performance of four separate F-wave studies.

133. This charge is entirely duplicative of the charges submitted under CPT Code 95911 and was submitted by Avellini and the Providers solely to increase the amount of fraudulent billing that they could submit to GEICO and other insurers.

134. Additionally, the use of CPT code 95905 requires the use of a "preconfigured electrode array" utilizing anatomically specific electrodes to perform motor and/or sensory nerve testing, such as the NC-stat® Device manufactured by NeuroMetrix, Inc.

135. However, there is no indication in the electrodiagnostic reports accompanying the Providers' billing submissions that would suggest that Avellini or the Treating Individuals used any "preconfigured electrode array" when providing the EDX services identified in Exhibits "1" and "2".

136. Rather, Avellini and the Providers simply utilized CPT code 95905 to inflate the amount of fraudulent billing they could submit to GEICO and other insurers.

137. For example, Avellini and the Providers unlawfully unbundled the NCV studies and submitted billing under CPT code 95905 with respect to the following Insureds:

(i) WG;

(ii) DB;

(iii) YM;

(iv) EF;

(v) TE;

(vi) IR;

(vii) OW;

(viii) AA;

(ix) YM;

(x) RP;

(xi) AJP;

(xii) CG;

(xiii) JV;

(xiv) NS;

(xv) VT;

(xvi) CB;

(xvii) VB;

(xviii) MA;

(xix) AB; and

(xx) YM.

138. These are only representative examples.

139. In the NCV claims identified in Exhibits "1" and "2", Avellini, JA Medical, and JRA Medical routinely unbundled their billing for NCV studies and fraudulent represented that they performed F-wave studies utilized preconfigured electrode arrays.

d. The Fraudulent EMG Tests

140. EMG tests involve insertion of a needle into various muscles in the spinal area ("paraspinal muscles") and in the arms and/or legs to measure electrical activity in each such muscle. The electrical activity in each muscle tested is compared with well-defined norms to identify the existence, nature, extent, and specific location of any abnormalities in the muscles, peripheral nerves, and nerve roots.

141. There are many different muscles in the arms and legs that can be tested using EMG tests. The decision of how many limbs and which muscles to test in each limb should be tailored to each patient's unique circumstances. In a legitimate clinical setting, this decision is based upon a history and physical examination of each individual patient, as well as the real-time results obtained from the EMG tests as they are performed on each specific muscle. As a result, the number of limbs as well as the nature and number of the muscles tested through EMG tests should vary from patient-to-patient.

142. According to the Recommended Policy, the maximum number of EMG tests necessary to diagnose a radiculopathy in 90 percent of all patients is EMG tests of two limbs.

143. To the extent they were performed at all, Avellini, JA Medical, JRA Medical, and the Treating Individuals did not tailor the EMG tests they purported to provide and/or perform to the unique circumstances of each patient. Instead, they often tested the same muscles in the same limbs repeatedly, without regard for individual patient presentation.

144. Even if there were any need for any of the EMG tests that Avellini, JA Medical, JRA Medical, and the Treating Individuals purported to provide, the nature and number of the EMG tests that Avellini, JA Medical, JRA Medical, and the Treating Individuals purported to provide frequently grossly exceeded the maximum number of such tests – i.e., EMG tests of two

limbs – that should have been necessary in at least 90 percent of all patients with a suspected diagnosis of radiculopathy.

145. Nevertheless, Avellini, JA Medical, JRA Medical, and the Treating Individuals routinely purported to subject Insureds in the claims identified in Exhibits "1" and "2" to four-limb EMG tests.

146. For example, Avellini, JA Medical, JRA Medical, and the Treating Individuals purported to provide excessive, medically unnecessary four-limb EMG tests to the following Insureds:

(i) WG;

(ii) DB;

(iii) YM;

(iv) EF;

(v) TE;

(vi) IR;

(vii) OW;

(viii) AA;

(ix) YM;

(x) RP;

(xi) CG;

(xii) VT;

(xiii) CB;

(xiv) VB;

(xv) MA;

(xvi) AB;

(xvii) YM;

(xviii) VH;

(xix) KP; and

(xx) JSB.

147. These are only representative examples. In the EMG claims identified in Exhibits "1" and "2", Avellini, JA Medical, JRA Medical, and the Treating Individuals routinely purported to provide and/or perform EMG tests on muscles in all four limbs of the Insureds solely to maximize the profits that they could reap from each such Insured.

148. In addition, Avellini and the Providers routinely submitted billing to GEICO for EMG tests that were never actually performed.

149. In keeping with the fact that Avellini and the Providers routinely submitted billing to GEICO for EMG tests that were never actually performed, numerous Insureds denied ever having a procedure at JA Medical or JRA Medical that involved the use of a needle.

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

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

151. The NF-3, HCFA-1500 forms, and/or treatment reports submitted to GEICO by and on behalf of the Providers 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 Providers 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; and

(ii) The NF-3 forms, HCFA-1500 forms, and treatment reports submitted by and on behalf of the Providers 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.

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

152. 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.

153. 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.

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

155. Moreover, when GEICO attempted to investigate and verify the claims being submitted through JA Medical, rather than appear for an EUO, Avellini simply ceased billing through JA Medical but continued to perform and bill for the same Fraudulent Services through JRA Medical.

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

157. 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.

158. 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.

159. 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.

160. 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 $174,000.00 based upon the fraudulent charges.

161. 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 JA Medical and JRA Medical
(Declaratory Judgment – 28 U.S.C. §§ 2201 and 2202)

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

163. There is an actual case in controversy between GEICO and the Defendants regarding approximately $908,000.00 in fraudulent billing for the Fraudulent Services that has been submitted to GEICO using the names of the Providers.

164. Specifically, there is approximately $538,000.00 in pending fraudulent billing from JA Medical, and $369,000.00 in pending fraudulent billing from JRA Medical.

165. The Defendants 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 predetermined fraudulent protocols designed solely to financially enrich Defendants, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to them.

166. 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;

167. 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.

168. Accordingly, GEICO requests a judgment pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202, declaring that:

(i) The Defendants have no right to receive payment for any pending bills submitted to GEICO using the names of the Provider because 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 Defendants, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to them;

(ii) The Defendants have no right to receive payment for any pending bills submitted to GEICO using the names of the Provider because the

Fraudulent Services were provided – to the extent that they were provided at all – pursuant to illegal kickback arrangements between the Defendants and others; and

(iii) The Defendants have no right to receive payment for any pending bills submitted to GEICO because the in many cases, the Fraudulent Services 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.

AS AND FOR A SECOND CAUSE OF ACTION

Against Avellini, JA Medical, and JRA Medical
(Violation of RICO Statute - 18 U.S.C. § 1962(c))

169. GEICO incorporates, as though fully set forth herein, each and every allegation set forth above.

170. Avellini, JA Medical, and JRA Medical constitute an association-in-fact "enterprise" (the "EDX Enterprise"), as defined in 18 U.S.C. § 1961(4), which engages in activities that affect interstate commerce.

171. The members of the EDX Enterprise are and have been associated through time, joined in purpose, and organized in a manner amenable to hierarchal and consensual decision making, with each member fulfilling a specific and necessary role to carry out and facilitate its common purpose. Specifically, JA Medical and JRA Medical are ostensibly independent entities with different names and tax identification numbers that were created and/or operated as vehicles to achieve a common purpose – to facilitate the submission of fraudulent charges to GEICO and other insurers. The EDX Enterprise operated under multiple, separate corporate names in order to reduce the number of bills submitted under any individual name, in an attempt to avoid attracting the attention and scrutiny of GEICO and other insurers to the volume of billing and the pattern of fraudulent charges originating from any one company. Accordingly, the carrying out of this

scheme would be beyond the capacity of each member of the EDX Enterprise acting individually or without the aid of each other.

172. The EDX Enterprise is distinct from, and has an existence beyond, the pattern of racketeering that is described herein, namely by employing and coordinating many professionals and non-professionals who have been responsible for facilitating and performing a variety of administrative and professional functions beyond the acts of mail fraud and wire fraud (i.e., the submission of the fraudulent bills to GEICO); by preparing and filing fraudulent applications and documents in order to obtain licenses and registrations necessary to operate as medical professional corporations in New York State; by creating and maintaining patient files and other records; by maintaining the bookkeeping and accounting functions necessary to manage the receipt and distribution of insurance payments; by selecting and billing for services under specific CPT codes; by coordinating the fraudulent scheme with various Referring Providers and Clinic Controllers operating at multiple No-Fault Clinics, including obtaining prescriptions from them and delivering the Fraudulent Pharmaceuticals to them to dispense to Insureds; by facilitating payments stemming from the illegal kickback arrangements; and by retaining collection lawyers whose services also were used to generate payments from insurance companies to support all of the aforesaid functions.

173. Avellini was employed by and/or associated with the EDX Enterprise and knowingly conducted and/or participated, directly or indirectly, in the conduct of the EDX Enterprise's affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341 and federal wire fraud statute, 18 U.S.C. § 1343, based upon the use of the United States mails and/or interstate wires to submit or cause to be submitted thousands of fraudulent charges on a continuous basis for over two years, along with

continued efforts to collect on those charges, seeking payments Avellini, JA Medical, and JRA Medical were not eligible to receive under the No-Fault Laws. Specifically, the acts alleged herein constitute a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961, to wit, in violation of 18 U.S.C. §§ 1341:

(i) Avellini devised, executed, and/or knowingly assisted in carrying out a scheme to defraud GEICO of their money and property by means of false and fraudulent pretenses, representations and promises and by the concealment of material facts regarding the healthcare claims for payment;

(ii) Pursuant to the scheme, Avellini submitted, or caused to be submitted, to GEICO, through the EDX Enterprise, false and fraudulent claims and information in which they concealed that the charges submitted were for services provided pursuant to illegal, collusive agreements, kickbacks, fraudulent and counterfeit prescriptions, and for financial incentive rather than genuine patient care; and

(iii) Pursuant to the scheme, Avellini submitted, or caused to be submitted, to GEICO, through the EDX Enterprise, false and fraudulent claims and information in which they falsely represented that the Fraudulent Services the EDX Enterprise billed for were medically necessary when in fact they were not medically necessary and were instead provided and billed pursuant to predetermined treatment protocols solely to maximize profits.

For the purpose of executing this scheme and artifice to defraud, Avellini submitted, or caused to be submitted, false and fraudulent claims and information to GEICO by use of the mail and/or interstate wire that caused GEICO to make payments for said fraudulent claims. A representative sample of the fraudulent bills and corresponding mailings/wires submitted to GEICO through the EDX Enterprise that comprise the pattern of racketeering activity identified through the date of this Complaint are described, in part, in the charts annexed hereto as Exhibits "1" and "2".

174. The EDX Enterprise's business is racketeering activity, inasmuch as it exists for the purpose of submitting fraudulent charges to insurers and seeking to collect on the submitted fraudulent charges. The predicate acts of mail and wire fraud are the regular way in which Avellini operated the EDX Enterprise and acts of mail and wire fraud therefore are essential for the EDX

Enterprise to function. Furthermore, the intricate planning required to carry out and conceal the predicate acts of mail and wire fraud, the changing of TIN numbers and entities, implies a threat of continued criminal activity, as does the fact that Avellini continues to attempt collection on the fraudulent billing submitted through the EDX Enterprise to the present day.

175. The EDX Enterprise is engaged in inherently unlawful acts, inasmuch as it continues to attempt collection on fraudulent billing submitted to GEICO (and likely other automobile insurers). These inherently unlawful acts are taken by the EDX Enterprise in pursuit of inherently unlawful goals – namely, the theft of money from GEICO (and likely other automobile insurers) through fraudulent no-fault billing.

176. GEICO has been injured in their business and property by reason of the above-described conduct in that they have paid at least $174,000.00 pursuant to the fraudulent bills submitted in furtherance of the EDX Enterprise.

177. By reason of their injuries, Plaintiffs are 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.

AS AND FOR A THIRD CAUSE OF ACTION

Against Avellini and JA Medical
(Common Law Fraud)

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

179. Avellini and JA 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.

180. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that JA 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 Avellini and the Providers; and (iii) in many claims, the billed for services were provided to the Insured but were not actually provided in the first instance. 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".

181. Avellini and JA 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 JA Medical that were not compensable under the No-Fault Laws.

182. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $132,000.00 pursuant to the fraudulent bills submitted by Avellini through JA Medical.

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

184. 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 Avellini and JA Medical
(Unjust Enrichment)

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

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

187. When GEICO paid the bills and charges submitted by or on behalf of JA 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.

188. Avellini and JA 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.

189. Avellini and JA Medical's retention of GEICO's payments violates fundamental principles of justice, equity and good conscience.

190. By reason of the above, Avellini and JA Medical have been unjustly enriched in an amount to be determined at trial, but in no event less than $132,000.00.

AS AND FOR A FIFTH CAUSE OF ACTION

Against Avellini and JRA Medical
(Common Law Fraud)

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

192. Avellini and JRA 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.

193. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that JRA 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 Avellini and the Providers; and (iii) in many claims, the billed for services were provided to the Insured but were not actually provided in the first instance. 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".

194. Avellini and JRA 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 JRA Medical that were not compensable under the No-Fault Laws.

195. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least $41,000.00 pursuant to the fraudulent bills submitted by Avellini through JRA Medical.

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

197. 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 Avellini and JRA Medical
(Unjust Enrichment)

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

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

200. When GEICO paid the bills and charges submitted by or on behalf of JRA 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.

201. Avellini and JRA 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.

202. Avellini and JRA Medical's retention of GEICO's payments violates fundamental principles of justice, equity and good conscience.

203. By reason of the above, Avellini and JRA Medical have been unjustly enriched in an amount to be determined at trial, but in no event less than $41,000.00.

JURY DEMAND

204. 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 Avellini and JA Medical, a declaration pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202, that Avellini and JA Medical have no right to receive payment for any pending bills submitted to GEICO;

B. On the Second Cause of Action against Avellini, for compensatory damages in an amount to be determined at trial but in excess of $174,000.00, 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 Avellini and JA Medical, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $132,000.00,

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

D. On the Fourth Cause of Action against Avellini, more than $132,000.00 in compensatory damages, plus costs and interest, and such other and further relief as this Court deems just and proper.

E. On the Fifth Cause of Action against Avellini and JA Medical, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of $41,000.00, 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 Avellini, more than $41,000.00 in compensatory damages, plus costs and interest, and such other and further relief as this Court deems just and proper.

Dated: Uniondale, New York
August 6, 2024

RIVKIN RADLER LLP

By: /s/ ***Barry I. Levy***
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