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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

-----X
GOVERNMENT EMPLOYEES INSURANCE CO.,
GEICO INDEMNITY CO., GEICO GENERAL
INSURANCE COMPANY and GEICO CASUALTY CO.,

Docket No.:

Plaintiffs,

-against-

**Plaintiff Demands a Trial by
Jury**

NY INTERVENTIONAL PAIN MEDICINE PLLC
and JIGYNASA DESAI D.O.,

Defendants.

-----X

COMPLAINT

Plaintiffs Government Employees Insurance Co., GEICO Indemnity Co., GEICO General Insurance Company and GEICO Casualty Co. (collectively “GEICO” or “Plaintiffs”), as and for their Complaint against the Defendants, hereby allege as follows:

NATURE OF THE ACTION

1. This action seeks to recover more than \$223,000.00 that the Defendants 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 purported examinations, electrodiagnostic testing, and

pain management injections and procedures (collectively the “Fraudulent Services”), that allegedly were provided to New York automobile accident victims (“Insureds”).

2. In addition, GEICO seeks a declaration that it is not legally obligated to pay reimbursement of more than \$1,600,000.00 in pending no-fault insurance claims that have been submitted by or on behalf of Defendant NY Interventional Pain Medicine PLLC, because:

- (i) the Fraudulent Services were not medically necessary and were provided – to the extent that they were provided at all – pursuant to predetermined fraudulent protocols designed to financially enrich the Defendants, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to them;
- (ii) in many cases, the Fraudulent Services never were provided in the first instance;
- (iii) the billing codes used for the Fraudulent Services misrepresented and exaggerated the level and type of services that purportedly were provided in order to inflate the charges submitted to GEICO;
- (iv) the Fraudulent Services were provided – to the extent that they were provided at all – pursuant to illegal kickback and referral arrangements between the Defendants and others;
- (v) NY Interventional Practice, LLC failed to meet applicable New York licensing requirements necessary to provide the Fraudulent Services in New York.

3. The Defendants fall into the following categories:

- (i) Defendant NY Interventional Pain Medicine PLLC (“NY Interventional” or “Provider”) is a New corporate entity through which the Fraudulent Services purportedly were performed and were billed to automobile insurance companies, including GEICO.
- (ii) Defendant Jigynasa Desai, D.O. (“Desai”) is a physician licensed to practice medicine in New York and New Jersey, purported to own NY Interventional, and purported to perform many of the Fraudulent Services on behalf of NY Interventional.

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 that they were provided at all – pursuant to predetermined

fraudulent protocols designed to financially enrich the Defendants, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to them;

- (ii) in many cases, the Fraudulent Services never were provided in the first instance;
- (iii) the billing codes used for the Fraudulent Services misrepresented and exaggerated the level and type of services that purportedly were provided in order to inflate the charges submitted to GEICO;
- (iv) the Fraudulent Services were provided – to the extent that they were provided at all – pursuant to illegal kickback and referral arrangements between the Defendants and others; and
- (v) NY Interventional failed to meet applicable New York licensing requirements necessary to provide the Fraudulent Services in New York.

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

6. The chart annexed hereto as Exhibit “1” sets 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 2019 and has continued uninterrupted since that time.

8. As a result of the Defendants’ fraudulent scheme, GEICO has incurred damages of more than \$223,000.00.

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

A. Desai

10. Defendant Desai resides in and is a citizen of New York. Desai was licensed to practice medicine in New York on August 19, 2011, and in New Jersey on September 21, 2011, purported to own NY Interventional, and purported to perform many of the Fraudulent Services on behalf of NY Interventional.

11. By an Order effective October 14, 2024, the Administrative Review Board for the New York State Board for Professional Medical Conduct (“BPMC”) determined that Desai committed professional misconduct in the treatment of six patients.

12. BPMC determined that Desai committed gross negligence in her care of one patient and practiced the profession with negligence on multiple occasions with respect to two other patients. BPMC also found Desai’s documentation practices extremely deficient.

13. As a result of their findings, BPMC imposed a three-year suspension on Desai’s medical license, to be stayed while Desai serves a three-year term of probation requiring her, among other things, to utilize a “practice monitor” to review patient records, practice locations, prescribing records, and office records to confirm that Desai’s practice is conducted in accordance with generally accepted standards of professional medical care. Desai was also required to complete 40 hours of continuing medical education (“CME”) in recordkeeping and 40 hours of CME in the care of patients with substance abuse disorders.

14. On March 27, 2024, following the findings of the initial BPMC Committee reviewing Desai’s practices, the New York State Workers’ Compensation Board issued an Order temporarily suspending the authorization for Desai to treating injured workers within the New York State workers’ compensation system, effective March 26, 2024.

B. NY Interventional

15. Defendant NY Interventional is a New York professional limited liability company with its principal place of business in New York. NY Interventional was formed in New York on April 27, 2018. NY Interventional is nominally owned, at least in part, by Desai and was used as a vehicle to submit fraudulent billing to GEICO and other insurers.

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.

17. 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.

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

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

20. For example, and as set forth herein, Defendants submitted or caused to be submitted a substantial amount of fraudulent billing to GEICO under New York automobile insurance policies, for treatment that they purported to provide to GEICO’s New York-based Insureds. In reliance on the fraudulent claims, personnel at a GEICO office in the Eastern District of New York issued payment on the fraudulent claims.

21. Moreover, and as set forth herein, Defendants transacted substantial business in New York and derived a substantial amount of revenue based on their fraudulent and unlawful business activities in New York.

22. Furthermore, and as set forth herein, Defendants regularly committed tortious acts in New York, thereby causing GEICO to incur substantial damages.

ALLEGATIONS COMMON TO ALL CLAIMS

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

I. An Overview of the Pertinent Law Governing No-Fault Insurance Reimbursement

24. 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.

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

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

27. 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.

28. 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").

29. 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").

30. 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.

31. 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).

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

33. 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.

34. 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.

35. 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.

36. 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.

37. 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 ...

38. 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.

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

40. 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.

41. 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

42. Beginning in 2019, and continuing through the present day, the Defendants implemented a complex fraudulent scheme in which they billed GEICO and other automobile insurers millions of dollars for medically unnecessary, illusory, unlawful, and otherwise non-reimbursable services.

A. The Multidisciplinary Clinics and Kickbacks

43. Desai and NY Interventional did not advertise or market NY Interventional’s services to the general public, did not maintain stand-alone practices, and were not the owners of or leaseholders of the real property from which they purported to provide the Fraudulent Services.

44. Instead, NY Interventional operated on an itinerant basis from a large number of multidisciplinary clinics located throughout the New York metropolitan 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) 46 W Suffolk Avenue, Central Islip, New York (“Suffolk Avenue Clinic”);
- (ii) 35-18 150th Place, Flushing, New York (“150th Place Clinic”);
- (iii) 280 Broadway, Newburgh, New York (“Broadway Clinic”);
- (iv) 156 Dolson Street, Middletown, New York (“Dolson Street Clinic”); and
- (v) 1049 Yonkers Avenue, Yonkers, New York (“Yonkers Avenue Clinic”).

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

46. Desai and NY Interventional gained access to the Clinics by paying kickbacks to other healthcare services providers (the “Referring Providers”) that operated from the Clinics and/or individuals that owned or controlled the Clinics (the “Clinic Controllers”).

47. The kickbacks to the Clinics were disguised as ostensibly legitimate fees to “lease” space or personnel at the Clinics. In fact, these were “pay-to-play” arrangements that caused the Referring Providers and Clinic Controllers at the Clinics to provide access to Insureds and to refer the Insureds to the Defendants for the Fraudulent Services without regard for the medical necessity of any of the Fraudulent Services.

48. In keeping with the fact that the “rent” that Desai and NY Interventional paid to the Referring Providers and 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.

49. In exchange for these kickbacks from Desai and NY Interventional, the Referring Providers and Clinic Controllers automatically referred Insureds to the Defendants for the

medically unnecessary Fraudulent Services, regardless of the Insureds' individual circumstances or presentation.

B. The Defendants' Fraudulent Treatment and Billing Protocol

50. Virtually all of the Insureds whom the Defendants purported to treat were involved in relatively minor accidents, to the extent that they were involved in any actual accidents at all. 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.

51. Even so, the Defendants purported to subject virtually every Insured in the claims identified in Exhibit "1" to a substantially identical, medically unnecessary course of "treatment" that was provided pursuant to a predetermined, fraudulent protocol designed to maximize the billing that they could submit through NY Interventional and Desai Medical to insurers, including GEICO, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to it.

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

53. 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.

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

55. 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 Billing for Services Never Actually Performed

56. As part and parcel of Defendants' fraudulent scheme, NY Interventional routinely submitted billing not just for performing Fraudulent Services, but for services that were never performed at all.

57. For example, at an examination under oath ("EUO") of NY Interventional on February 22, 2024, Desai testified that she was out of the country for six weeks starting on October 7, 2022 and did not work at all during that time period.

58. Despite testifying that she was out of the country and not working during this time period, NY Interventional submitted billing to GEICO for services purportedly rendered by GEICO to numerous insureds between October 7, 2022 and November 11, 2022.

59. For example, according to billing submitted to GEICO by NY Interventional:

- (i) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named BC at the Suffolk Avenue Clinic;
- (ii) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named VU at the Suffolk Avenue Clinic;
- (iii) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named RA at the Suffolk Avenue Clinic;
- (iv) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named EB at the Suffolk Avenue Clinic;

- (v) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named DC at the Suffolk Avenue Clinic;
- (vi) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named JC at the Suffolk Avenue Clinic;
- (vii) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named CF at the Suffolk Avenue Clinic;
- (viii) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named HBHU at the Suffolk Avenue Clinic;
- (ix) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named MK at the Suffolk Avenue Clinic;
- (x) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named NS at the Suffolk Avenue Clinic;
- (xi) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named PT at the Suffolk Avenue Clinic;
- (xii) On October 7, 2022, Desai purportedly performed a follow-up examination and pain management injection on an Insured named VU at the Suffolk Avenue Clinic;
- (xiii) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named CDME at a Clinic located at 17 Perlman Drive, Suite 201, Spring Valley, New York;
- (xiv) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named RW at the 150th Place Clinic;
- (xv) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named YC at the 150th Place Clinic;
- (xvi) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named JHC at the 150th Place Clinic;
- (xvii) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named IMC at the 150th Place Clinic;
- (xviii) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named YK at the 150th Place Clinic;
- (xix) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named EY at the 150th Place Clinic;

- (xx) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named RJJ at the 150th Place Clinic;
- (xxi) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named RS at the 150th Place Clinic;
- (xxii) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named SHS at the 150th Place Clinic;
- (xxiii) On October 7, 2022, Desai purportedly performed a follow-up examination and electrodiagnostic testing on an Insured named TS at the Suffolk Avenue Clinic;
- (xxiv) On October 7, 2022, Desai purportedly performed a follow-up examination and electrodiagnostic testing on an Insured named RGA at the Suffolk Avenue Clinic;
- (xxv) On October 7, 2022, Desai purportedly performed a follow-up examination and electrodiagnostic testing on an Insured named JQ at the Suffolk Avenue Clinic;
- (xxvi) On October 7, 2022, Desai purportedly performed a follow-up examination and electrodiagnostic testing on an Insured named EF at the Suffolk Avenue Clinic;
- (xxvii) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named JHP at the 150th Place Clinic;
- (xxviii) On October 7, 2022, Desai purportedly performed a follow-up examination on an Insured named JHP at the 150th Place Clinic;
- (xxix) On October 17, 2022, Desai purportedly performed a follow-up examination and pain management injection on an Insured named AFD at the 150th Place Clinic;
- (xxx) On October 17, 2022, Desai purportedly performed a follow-up examination and pain management injection on an Insured named KPC at the Suffolk Avenue Clinic;
- (xxxi) On October 17, 2022, Desai purportedly performed a follow-up examination and pain management injection on an Insured named JM at the Suffolk Avenue Clinic;

(xxxii) On November 5, 2022, Desai purportedly performed a follow-up examination and electrodiagnostic testing on an Insured named RW at the 150th Place Clinic;

60. These are only representative examples. In the claims identified in Exhibit “1”, Desai and NY Interventional submitted billing for services that were never actually performed.

61. In fact, NY Interventional submitted billing for at least 28 examinations purportedly performed by Desai at three separate Clinics on the very same day that Desai gave birth to her child in a different country.

2. The Fraudulent Charges for Initial Examinations at NY Interventional

62. Upon receiving an illegal referral from the Referring Providers and Clinic Controllers at the Clinics, NY Interventional purported to provide virtually every Insured in the claims identified in Exhibit “1” with an initial examination.

63. 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, illusory, or otherwise non-reimbursable electrodiagnostic testing, pain management injections, and follow-up examinations.

64. The initial examinations were typically performed by Desai on behalf of NY Interventional.

65. As set forth in Exhibit “1”, the initial examinations were then typically billed to GEICO through NY Interventional under CPT codes 99244 or 99203, typically resulting in charges ranging from \$142.62 to \$652.00 for each purported examination.

66. The charges for the initial examinations were fraudulent in that they misrepresented NY Interventional’s eligibility to collect No-Fault Benefits in the first instance and because they were medically unnecessary and were performed – to the extent that they were performed at all –

pursuant to illegal referrals from the Referring Providers and Clinic Controllers at the Clinics, not to treat or otherwise benefit the Insureds.

67. Further, the Defendants also were not in compliance with relevant laws governing healthcare practice in New York and were not eligible to collect No-Fault Benefits in connection with any of the claims identified in Exhibit “1” inasmuch as Desai and NY Interventional gained access to Insureds at the Clinics by paying kickbacks to individuals who own and/or control the No-Fault Clinics, in violation of the No-Fault Laws.

68. 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.

a. Misrepresentations Regarding Insureds’ Presenting Problems

69. According to the NY Fee Schedule, the use of CPT code 99244 typically requires that the Insured present with problems of moderate-to-high severity.

70. Similarly, the use of CPT code 99203 typically requires that the Insured present with problems of moderate severity.

71. Though the Defendants billed many of the purported initial examinations under CPT codes 99244 and 99203, the Insureds almost never presented with problems of moderate severity, much less moderate-to-high severity. By contrast, to the extent that the Insureds had any presenting problems at all as the result of their minor automobile accidents, the problems virtually always were low or minimal severity soft tissue injuries such as sprains and strains.

72. Even so, the Defendants routinely billed for the initial examinations under CPT codes 99244 and 99203, and thereby falsely represented that the Insureds presented with problems of moderate or moderate-to-high severity.

73. The Defendants routinely falsely represented that the Insureds presented with problems of moderate or moderate-to-high severity in order to create a false basis for their charges for the examinations under CPT codes 99244 and 99203, because examinations billable under those codes are reimbursable at higher rates than examinations involving presenting problems of low severity, minimal severity, or no severity.

74. The Defendants also routinely falsely represented that the Insureds presented with problems of moderate severity or moderate-to-high severity in order to create a false basis for the laundry list of other Fraudulent Services that the Defendants purported to provide to the Insureds, including electrodiagnostic testing and pain management injections.

75. The Defendants also routinely falsely represented that the Insureds presented with problems of moderate severity or moderate-to-high severity in order to create a false basis for the referrals for continued medically unnecessary chiropractic, physical therapy, and acupuncture services, pursuant to the illegal “pay-to-play” arrangements that caused the Referring Providers and Clinic Controllers to provide the Defendants with access to Insureds.

b. Misrepresentations Regarding the Nature and Extent of Examinations

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

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

78. Pursuant to the NY Fee Schedule and CPT Assistant, the use of CPT code 99244 to bill for an examination typically requires that a physician spend 60 minutes of face-to-face time with the Insured or the Insured’s family during the examination.

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

80. Although the Defendants billed for their putative examinations under CPT codes 99244 and 99203, neither Desai, nor any healthcare practitioner associated with NY Interventional ever spent 30 minutes, much less 60 minutes, on an initial examination. To the extent that the initial examinations were actually conducted, they lasted a fraction of the time represented by the billing.

81. In addition, pursuant to the Fee Schedule, when the Defendants submitted charges for initial examinations under CPT code 99244, or caused them to be submitted, they falsely represented that Desai or another healthcare practitioner associated with NY Interventional: (i) took a "comprehensive" patient history; (ii) conducted a "comprehensive" physical examination; and (iii) engaged in medical decision-making of "moderate complexity."

82. Similarly, when the Defendants submitted charges for initial examinations under CPT code 99203, or caused them to be submitted, they falsely represented that Desai or another healthcare practitioner associated with NY Interventional perform a "detailed" physical examination.

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

84. When the Defendants billed for the initial examinations under CPT codes 99244, they falsely represented that they took a “comprehensive” patient history from the Insureds they purported to evaluate during the examinations.

85. In fact, with respect to the claims for initial examinations under CPT codes 99244 that are identified in Exhibit “1”, neither Desai, nor any healthcare practitioner associated with the NY Interventional ever recorded a “comprehensive” patient history.

86. For instance, in each of the claims under CPT code 99244 identified in Exhibit “1”, neither Desai, nor any healthcare practitioner associated with NY Interventional ever recorded a history of all of the Insured’s body systems.

87. Rather, after purporting to provide the initial examinations, the Defendants simply prepared reports containing phony or boilerplate patient histories that were designed solely to support the laundry list of other Fraudulent Services that the Defendants purported to provide to the Insureds, including electrodiagnostic testing and pain management services, and referrals for continued medically unnecessary chiropractic, physical therapy, and acupuncture services.

88. In all of the claims for initial examinations under CPT codes 99244 that are identified in Exhibit “1”, the Defendants falsely represented that they had taken a “comprehensive” patient history, when in fact they had not taken a “comprehensive” patient history, because virtually all of the consultation reports contain only a brief and cursory discussion of the Insureds’ patient histories.

89. In the claims for initial examinations under CPT 99244, the Defendants falsely represented that the initial examinations included a “comprehensive” patient history in order to provide a false basis to bill for the initial examinations under CPT codes 99244, because those

codes reimbursable at a higher rate than examinations that do not require a “comprehensive” patient history.

90. Pursuant to the CPT Assistant, a physical examination does not qualify as “comprehensive” unless the examining physician either: (i) conducts a general examination of multiple patient organ systems; or (ii) conducts a complete examination of a single patient organ system.

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

92. The CPT Assistant recognizes the following organ systems:

- (i) constitutional symptoms (e.g., fever, weight loss);
- (ii) eyes;
- (iii) ears, nose, mouth, throat;
- (iv) cardiovascular;
- (v) respiratory;
- (vi) gastrointestinal;
- (vii) genitourinary;
- (viii) musculoskeletal;
- (ix) integumentary (skin and/or breast);
- (x) neurological;
- (xi) psychiatric;
- (xii) endocrine;
- (xiii) hematologic/lymphatic; and

(xiv) allergic/immunologic.

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

- (i) at least three of the following: (a) standing or sitting blood pressure; (b) supine blood pressure; (c) pulse rate and regularity; (d) respiration; (e) temperature; (f) height; or (g) weight;
- (ii) the general appearance of the patient – e.g., development, nutrition, body habits, deformities, and attention to grooming;
- (iii) examination of the peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness);
- (iv) palpation of lymph nodes in neck, axillae, groin, and/or other location;
- (v) examination of gait and station;
- (vi) examination of joints, bones, muscles, and tendons in at least four of the following areas: (a) head and neck; (b) spine, ribs, and pelvis; (c) right upper extremity; (d) left upper extremity; (e) right lower extremity; and/or (f) left lower extremity;
- (vii) inspection and palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café-au-lait spots, ulcers) in at least four of the following areas: (a) head and neck; (b) trunk; (c) right upper extremity; (d) left upper extremity; (e) right lower extremity; and/or (f) left lower extremity;
- (viii) coordination, deep tendon reflexes, and sensation; and
- (ix) mental status, including orientation to time, place and person, as well as mood and affect.

94. In fact, with respect to the claims for initial examinations under CPT codes 99244 that are identified in Exhibit “1”, neither Desai, nor any healthcare practitioner associated with NY Interventional ever conducted or recorded a “comprehensive” physical examination.

95. With respect to the claims for initial examinations under CPT codes 99244 that are identified in Exhibit “1”, neither Desai, nor any healthcare practitioner associated with NY

Interventional ever conducted a general examination of multiple patient organ systems, or conducted a complete examination of a single patient organ system.

96. For instance, in each of the claims under CPT codes 99244 identified in Exhibit “1”, neither Desai, nor any healthcare practitioner associated with NY Interventional ever conducted any general examination of multiple patient organ systems, inasmuch as they did not document findings with respect to at least eight organ systems.

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

- (i) at least three of the following: (a) standing or sitting blood pressure; (b) supine blood pressure; (c) pulse rate and regularity; (d) respiration; (e) temperature; (f) height; or (g) weight;
- (ii) the general appearance of the patient – e.g., development, nutrition, body habits, deformities, and attention to grooming;
- (iii) examination of the peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness);
- (iv) palpation of lymph nodes in neck, axillae, groin, and/or other location;
- (v) examination of gait and station;
- (vi) examination of joints, bones, muscles, and tendons in at least four of the following areas: (a) head and neck; (b) spine, ribs, and pelvis; (c) right upper extremity; (d) left upper extremity; (e) right lower extremity; and/or (f) left lower extremity;
- (vii) inspection and palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café-au-lait spots, ulcers) in at least four of the following areas: (a) head and neck; (b) trunk; (c) right upper extremity; (d) left upper extremity; (e) right lower extremity; and/or (f) left lower extremity;
- (viii) coordination, deep tendon reflexes, and sensation; and/or

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

98. Pursuant to the CPT Assistant, a “detailed” physical examination requires – among other things – that the physician, chiropractor, or other healthcare practitioner performing the examination conduct an extended examination of the affected body areas and other symptomatic or related organ systems.

99. To the extent that the Insureds in the claims identified in Exhibit “1” 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.

100. Pursuant to the CPT Assistant, in the context of patient examinations, a physician, chiropractor, 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.

101. In the claims for initial examinations identified in Exhibit “1”, when Desai and NY Interventional 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.

102. In fact, with respect to the claims for initial examinations under CPT code 99203 that are identified in Exhibit “1”, Desai, nor any other healthcare practitioner associated with NY Interventional conducted extended examinations of the Insureds’ musculoskeletal systems.

103. For instance, neither Desai, nor any other healthcare practitioner associated with NY Interventional 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.

104. In fact, with respect to the claims for initial examinations under CPT code 99203 that are identified in Exhibit “1”, neither Desai, nor any healthcare practitioner associated with NY Interventional ever conducted or recorded a “detailed” physical examination.

105. Moreover, and in further keeping with the fact that the Defendants did not conduct any “comprehensive” or “detailed” physical examinations, the examination reported contained verbatim language that was copied-and-pasted across numerous reports for numerous different Insureds.

106. Specifically, numerous examination reports contained the following language regarding the purported review of systems and physical examination, including the same idiosyncratic grammar, misspellings, punctuation, and capitalization, appeared in the purported examination reports of numerous Insureds:

“Constitutional: No loss of appetite, no fever, no Weakness, no Fatigue. ENT: no Change in vision. no Double vision. Pulmonary: no Shortness of breath. no Productive Cough. Cardiology: no Chest Pain. no Palpitations. no Lightheadedness. Gastroenterology: no Abdominal pain. no Constipation. no Diarrhea. no Change in bowel habits. Hematology/Lymph [sic] no Abnormal bleeding/bruising. no Abnormal bruising. Neurology. no Headache no Dizziness. Psychology. no Depression. no Anxiety. Endocrinology. no Fatigue with stress evenings [sic]. no Cold sensitivity. Allergy: no Runny nose. no Sinus congestion. Dermatology: no Rash. no Hives.”

“Constitutional: Vital Signs: Within normal limits. General Appearance: Well developed, well-nourished, appears of stated Age. Patient is awake, alert, and oriented x 3 with a full and bright effect. Cooperative through-out the exam. pleasant. Distress: Patient was in moderate distress due to pain and discomfort. EENT: Within normal limits. Head: Normocephalic, atraumatic. Extremities: no deformities, cyanosis, edema, or clubbing. Psychiatric Awareness: alert and responsive. Cognitive Function: normal mentation. Judgment and Insight: no deficits. Mood and Affect: Cooperate, pleasant.”

“Neurological/Psychiatric: Mental Status. Alert, oriented in place, time, person. Insight was normal. Understands commands well. Follows one-two step commands without mistakes. Concentration and attention span were both normal. Speech fluent. Repetition, naming volume are all normal. Cranial Nerves: II-XII grossly intact.”

107. The above “Physical Exam” findings appeared in the examination reports of numerous patients seen by the Provider, regardless of the patient’s specific condition.

108. For example, the above language appeared in the purported initial examination reports for the following patients treated at NY Interventional:

- (i) GW;
- (ii) RG;
- (iii) MMP;
- (iv) NC;
- (v) JO;
- (vi) VS;
- (vii) LP;
- (viii) PP;
- (ix) DC; and
- (x) EH.

109. These are only representative examples. In the examination claims identified in Exhibit “1”, Desai and NY Interventional submitted purported examination reports that routinely contained the above verbatim “review of systems” and “physical exam” regardless of Insureds’ actual symptoms or presentation.

110. Moreover, and in further keeping with the fraudulent nature of the examination reports submitted to GEICO, Desai and NY Interventional routinely purported to provide numerous insureds with the same exact ranges of spinal ranges of motion.

111. Specifically, the following language regarding Insureds’ purported ranges of motion routinely appeared in the examination reports of numerous Insureds:

“Spine = Cervical Spine: ROM: Flexion 35/45. Extension 30/45, Right Lateral 35/45, Left Lateral 35/45, Right Rotation 70/80, Left Rotation 70/80”

112. The above “Range of Motion” findings appeared in the examination reports of numerous patient seen by the Provider, regardless of the patient’s specific condition.

113. For example, the above language appeared in the purported initial examination reports for the following patients treated at NY Interventional:

- (i) GW;
- (ii) RG;
- (iii) MMP;
- (iv) NC;
- (v) JO;
- (vi) VS;
- (vii) LP;
- (viii) PP;
- (ix) DC; and

(x) EH.

114. These are only representative examples.

115. In the examination claims identified in Exhibit “1”, Desai and NY Interventional submitted purported examination reports that routinely contained the above verbatim language and purported ranges of motion, regardless of Insureds’ actual symptoms or presentation.

116. The Defendants falsely represented that the initial examinations included “comprehensive” physical examinations, when billed under CPT code 99244, or “detailed” physical examinations, when billed under CPT code 99203, in order to provide a false basis to bill for the initial examinations under CPT codes 99244 and 99203, because those codes are reimbursable at a higher rate than examinations that do not require “comprehensive” or “detailed” physical examinations.

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

118. Although the Defendants routinely falsely represented that their initial examinations involved medical decision-making of “moderate complexity” when billing under CPT code 99244, in actuality the examinations did not involve any medical decision-making at all.

119. First, the initial examinations did not involve the retrieval, review, and analysis of any medical records, diagnostic tests, or other information. When the Insureds presented to the

Defendants for treatment, they typically did not arrive with any medical records. Furthermore, prior to the initial examinations, the Defendants neither requested any medical records from any other providers, nor conducted any diagnostic tests.

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

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

122. Rather, to the extent that the initial examinations were conducted in the first instance, the Defendants made a boilerplate, predetermined “diagnosis” for the Insureds, upon which the Defendants directed the Insureds to receive a predetermined pattern of treatment, including a recommendation to return to NY Interventional for electrodiagnostic testing and pain management services and to the providers from which NY Interventional leased office space from for medically unnecessary chiropractic, physical therapy, and acupuncture services.

123. In keeping with the fact that the initial examinations were part and parcel of a predetermined fraudulent treatment protocol and performed pursuant to illegal referral arrangements with the Clinic Controllers, the Defendants’ initial examination reports routinely

contained the following verbatim language regarding an Insureds' purported "Care Plan", including the same idiosyncratic grammar, misspellings, punctuation, and capitalization:

"1. Continue Conservative Care: Chiropractic / Physical therapy for the neck and low back pain 2-3/week for 6 weeks. 2. Acupuncture 2-3/week for 4 weeks. 3. Consider NSAIDs with persisting symptoms. 4. Correct biomechanics of movements and position."

"NDX (EMG/NCV) of the [UPPER/LOWER/UPPER and LOWER] extremity to rule out of [sic] radiculopathy. Treatment Plan: As a result of the patients [sic] subjective complaints following a thorough physical exam. [sic] I have recommended a comprehensive treatment plan which includes, but not limited to conservative treatment as pharmacological therapy, physical therapy, chiropractor modalities, epidural steroid injection evaluation, surgical evaluation, in order to rule out any nerves, joints, ligaments, tendons, and/or muscles [sic] pathological damage and determine if cervical and lumbar radiculopathies exist to threat the patient properly and accordingly. As you well know the EDX is and [sic] extension of the history and physical examination. It's goal is to help in distinguishing among the variety of causes for numbness, weakness, and a pain [sic]."

124. The above "Care Plan" routinely appeared in the examination reports of Insureds seen by the Provider, regardless of the patient's specific condition.

125. For example, the above language appeared in the purported initial examination reports for the following patients treated at NY Interventional:

- (i) GW;
- (ii) RG;
- (iii) MMP;
- (iv) NC;
- (v) JO;
- (vi) VS;
- (vii) LP;
- (viii) PP;

(ix) DC; and

(x) EH.

126. These are only representative examples.

127. In the examination claims identified in Exhibit “1”, Desai and NY Interventional submitted purported examination reports that routinely contained the above verbatim language and purported “Care Plan”, regardless of Insureds’ actual symptoms or presentation.

128. In the claims for initial examinations under CPT code 99244, the Defendants falsely represented that the initial examinations involved medical decision-making of high complexity or moderate complexity in order to provide a false basis to bill for the initial examinations under CPT code 99244, because that CPT code is reimbursable at a higher rate than examinations that do not require moderate complexity medical decision-making.

129. Furthermore, according to the Fee Schedule, the use of CPT code 99244 requires that the performing physician who performed a consultation at the request of another physician or other appropriate source: (i) document the necessity for the consultation; (ii) include the name of the requesting physician or other referral source on the bill for the consultation; and (iii) report the opinion rendered and services ordered or performed as a result of the consultation to the referring entity.

130. The initial consultations purportedly provided by the Defendants, however, did not comply with these requirements. Instead, the Defendants – to the extent that they performed the consultations in the first instance – virtually always failed to (i) document the necessity for the consultation; (ii) include the name of the requesting physician or other referral source on the bill for the consultation; and (iii) document and report the opinion rendered and services ordered or performed as a result of the consultation to the referring entity.

131. The consultation reports and treatment notes submitted by the Defendants for initial consultations using CPT codes 99244 virtually always failed to indicate why the consultation was necessary.

132. Furthermore, the bills submitted by the Defendants for initial consultations using CPT code 99244 virtually always failed to include the name of the requesting physician or other referral source on the bill for the consultation.

133. The Defendants routinely failed to identify the Referring Provider so as to conceal the true sources of the referrals for the purported examinations, as well as the identities of the owners/operators of the No-Fault Clinics to whom Desai and NY Interventional paid kickbacks in exchange for access to Insureds, and back to whom the Defendants referred the Insureds for continued medically unnecessary chiropractic, physical therapy, and acupuncture services, pursuant to their illegal kickback and referral scheme.

134. In addition, the treatment notes submitted by the Defendants for initial consultations using CPT codes 99244 virtually always failed to include any indication that Desai and NY Interventional communicated any report to the referring physician regarding the opinion rendered and services ordered or performed as a result of the consultation.

3. The Fraudulent Charges for Follow-up Examinations at NY Interventional

135. In addition to their fraudulent initial examinations, Desai and NY Interventional often purported to subject the Insureds in the claims identified in Exhibit “1” to multiple fraudulent follow-up examinations during the course of the Defendants’ fraudulent treatment and billing protocol.

136. Desai purported to perform most of the putative follow-up examinations at the Clinics, which were then billed to GEICO through NY Interventional, typically under CPT code 99213, resulting in charge between \$87.80 and of \$416.00 for each putative follow-up examination.

137. Like the charges for the initial examinations, the charges for the follow-up examinations were fraudulent in that the follow-up examinations were medically unnecessary and were performed – to the extent that they were performed at all – pursuant to the kickbacks that Desai and NY Interventional paid to the Referring Providers and Clinic Controllers at the Clinics, not to treat or otherwise benefit the Insureds.

138. The charges for the follow-up examination also were fraudulent in that they misrepresented NY Interventional's eligibility to receive PIP Benefits in the first instance. In fact, NY Interventional was never eligible to receive PIP Benefits in the first instance, because of the fraudulent and unlawful conduct described herein.

139. In addition, the charges for the follow-up examinations were fraudulent in that they misrepresented the nature, extent, and results of the purported examinations.

140. Pursuant to the CPT Assistant, the use of CPT code 99213 to bill for a follow-up examination typically requires that the patient present with problems of low to moderate severity.

141. The CPT Assistant provides various clinical examples of the types of presenting problems that might qualify as problems of low to moderate severity, and thereby justify the use of CPT code 99213 to bill for a follow-up patient examination, specifically:

- (i) Follow-up visit with 55-year-old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen. (Family Medicine/Internal Medicine)
- (ii) Follow-up office visit for an established patient with stable cirrhosis of the liver. (Gastroenterology)
- (iii) Outpatient visit with 37-year-old male, established patient, who is 3 years post total colectomy for chronic ulcerative colitis, presents for increased irritation at his stoma. (General Surgery)
- (iv) Routine, follow-up office evaluation at a three-month interval for a 77-year-old female with nodular small cleaved-cell lymphoma. (Hematology/Oncology)

- (v) Follow-up visit for a 70-year-old diabetic hypertensive patient with recent change in insulin requirement. (Internal Medicine/Nephrology)
- (vi) Quarterly follow-up office visit for a 45-year-old male, with stable chronic asthma, on steroid and bronchodilator therapy. (Pulmonary Medicine)
- (vii) Office visit with 80-year-old female established patient, for follow-up osteoporosis, status-post compression fractures. (Rheumatology)

142. Accordingly, pursuant to the CPT Assistant, even the low-to-moderate severity presenting problems that could support the use of CPT code 99213 to bill for a follow-up patient examination typically are problems that pose some ongoing, real threat to the patient's health.

143. By contrast, and as set forth above, to the extent that the Insureds in the claims identified in Exhibit "1" suffered any injuries at all in their minor automobile accidents, the injuries virtually always were ordinary soft tissue injuries such as sprains and strains, which were not severe at all.

144. Ordinary soft tissue injuries such as strains and sprains virtually always resolve after a short course of conservative treatment such as rest, ice, compression, and elevation, or no treatment at all.

145. By the time the Insureds in the claims identified in Exhibit "1" to NY Interventional for the putative follow-up examinations, the Insureds either did not have any genuine presenting problems at all as the result of their minor automobile accidents, or their presenting problems were minimal.

146. Even so, in the claims for follow-up examinations identified in Exhibit "1", Desai and NY Interventional routinely billed for their putative follow-up examinations under CPT code 99213, and thereby falsely represented that the Insureds continued to suffer from presenting problems of low to moderate severity at the time of the purported follow-up examinations.

147. In the claims for follow-up examinations identified in Exhibit “1”, Desai and NY Interventional routinely falsely represented that the Insureds presented with problems of low-to-moderate severity or moderate in order to create a false basis for their charges for the examinations under CPT code 99213, because follow-up examinations billable under CPT code 99213 are reimbursable at higher rates than examinations involving presenting problems of minimal severity, or no severity.

148. In the claims for follow-up examinations identified in Exhibit “1”, Desai and NY Interventional also routinely falsely represented that the Insureds presented with problems of either low to moderate severity or moderate to high severity in order to create a false basis for the other Fraudulent Services that the Defendants purported to provide to the Insureds, as described herein.

149. Furthermore, and pursuant to the NY Fee Schedule, when Desai and NY Interventional submitted charges for the follow-up examinations under CPT code 99213, they represented that they performed at least two of the following three components: (i) took an “expanded problem focused” patient history; (ii) conducted an “expanded problem focused physical examination”; and (iii) engaged in medical decision-making of “low complexity”.

150. In actuality, however, in the claims for follow-up examinations identified in Exhibit “1”, Desai did not take any legitimate patient histories, conduct any legitimate physical examinations, or engage in any legitimate medical decision-making at all.

151. Rather, following their purported follow-up examinations, Desai simply reiterated the false, boilerplate “diagnoses” that they provided to the Insureds following their purported initial examinations, and recommended that the Insureds continue to return to NY Interventional for additional medically unnecessary Fraudulent Services.

152. In keeping with the fact that the putative “results” of the follow-up examinations were phony, and were falsified to support continued, medically unnecessary Fraudulent Services by the Defendants, Desai and NY Interventional routinely falsely reported that the Insureds continued to suffer from the effects of soft tissue injuries secondary to minor automobile accidents, long after the minor underlying automobile accidents occurred, and long after any attendant soft tissue injury pain or other symptoms attendant to the minor automobile accidents would have resolved.

153. In further keeping with the fact that the Defendants did not conduct any “comprehensive” physical examinations, the follow-up examination reports contained the same verbatim language found in the initial examination reports that was copied-and-pasted across numerous reports for numerous different Insureds.

154. For example, the following language, including the same idiosyncratic grammar, misspellings, punctuation, and capitalization, appeared in the purported follow-up examination reports of numerous Insureds:

“Constitutional: No loss of appetite, no fever, no Weakness, no Fatigue. ENT: no Change in vision. no Double vision. Pulmonary: no Shortness of breath. no Productive Cough. Cardiology: no Chest Pain. no Palpitations. no Lightheadedness. Gastroenterology: no Abdominal pain. no Constipation. no Diarrhea. no Change in bowel habits. Hematology/Lymph [sic] no Abnormal bleeding/bruising. no Abnormal bruising. Neurology. no Headache no Dizziness. Psychology. no Depression. no Anxiety. Endocrinology. no Fatigue with stress evenings [sic]. no Cold sensitivity. Allergy: no Runny nose. no Sinus congestion. Dermatology: no Rash. no Hives.”

“Constitutional: Vital Signs: Within normal limits. General Appearance: Well developed, well-nourished, appears of stated Age. Patient is awake, alert, and oriented x 3 with a full and bright effect. Cooperative through-out the exam. pleasant. Distress: Patient was in moderate distress due to pain and discomfort. EENT: Within normal limits. Head: Normocephalic, atraumatic. Extremities: no deformities, cyanosis, edema, or clubbing. Psychiatric Awareness: alert and responsive. Cognitive Function: normal

mentation. Judgment and Insight: no deficits. Mood and Affect: Cooperate, pleasant.”

“Neurological/Psychiatric: Mental Status. Alert, oriented in place, time, person. Insight was normal. Understands commands well. Follows one-two step commands without mistakes. Concentration and attention span were both normal. Speech fluent. Repetition, naming volume are all normal. Cranial Nerves: II-XII grossly intact.”

155. In the claims for follow-up examinations identified in Exhibit “1”, Desai and NY Interventional routinely falsely represented that the Insureds continued to suffer pain and other symptoms as the result of minor soft tissue injuries, long after the underlying accidents occurred, because these phony diagnoses provided a false basis for the other Fraudulent Services that the Defendants and the Referring Providers purported to provide to the Insureds.

156. Accordingly, the Defendants’ follow-up examination reports routinely contained the following verbatim language regarding an Insureds’ purported “Care Plan”, including the same idiosyncratic grammar, misspellings, punctuation, and capitalization:

“1. Continue Conservative Care: Chiropractic / Physical therapy for the neck and low back pain 2-3/week for 6 weeks. 2. Acupuncture 2-3/week for 4 weeks. 3. Consider NSAIDs with persisting symptoms. 4. Correct biomechanics of movements and position.”

157. The above “Care Plan” routinely appeared in the follow-up examination reports of Insureds seen by the Provider, regardless of the patient’s specific condition.

158. In addition to performing fraudulent follow-up examinations at the Clinics, Desai also frequently purported to perform medically unnecessary follow-up examinations on the same day as surgical procedures at the ambulatory surgical centers utilized by NY Interventional. In order to induce GEICO to pay these charges, the Defendants appended modifier 25 next to the charges for these follow-up examinations, indicating that Desai performed a significant, separately identifiable evaluation and management services on the same day as the procedure.

159. Modifier 25 is generally appropriate to use in two scenarios: (i) when a problem-oriented evaluation and management service is performed at the same time as a preventive medicine evaluation and management service, e.g., when an ear infection presents during the course of a child’s wellness visit; or (ii) when a minor surgical procedure is provided at the same time as a significant and distinct problem-oriented evaluation and management procedures, e.g., when a patient presents with a head laceration and the physician separately performs a neurological examination.

160. When Desai and NY Interventional utilized modifier 25 to bill for their follow-up examinations performed at the surgical centers, the examinations—to the extent they were performed at all—were always provided in connection with a preplanned surgical procedure, failed to present any significant or distinct issues, and were performed despite the fact that the Defendants’ had purportedly provided (and billed for) follow-up examinations at the Clinics in advance of the procedures.

161. Rather Desai and NY Interventional routinely billed for follow-up examinations performed at the surgical centers and fraudulently utilized modifier 25 solely to increase the amount of fraudulent billing they could submit to GEICO and other insurers.

4. The Fraudulent Charges for Electrodiagnostic Testing at NY Interventional

162. Based upon the fraudulent, predetermined findings and “diagnoses” provided during the initial examinations, Desai and NY Interventional subjected Insureds to a series of medically unnecessary nerve conduction velocity (“NCV”) tests and electromyography (“EMG”) tests (collectively the “electrodiagnostic” or “EDX” tests).

163. The EDX tests were typically performed by Desai and billed through NY Interventional to GEICO.

164. As set forth in Exhibit “1”, Desai and NY Interventional then billed the EDX tests to GEICO primarily under CPT codes 95886, 95905, and 95911 typically resulting in charges between \$629.31 and \$6525.00 for each Insured purportedly subjected to the testing.

165. In the claims for EDX tests identified in Exhibit “1”, the charges for the EDX tests were fraudulent in that they were medically unnecessary and were performed – to the extent they were performed at all – pursuant to the fraudulent boilerplate “care plans” and diagnoses that Desai and NY Interventional purported to provide during their phony initial examinations and the Defendants’ unlawful referral scheme.

166. Moreover, in the claims for EDX tests identified in Exhibit “1”, the charges for the EDX tests were fraudulent in that they misrepresented the Providers’ eligibility to collect PIP Benefits in the first instance.

167. In fact, the Provider was never eligible to collect PIP benefits in connection with the claims identified in Exhibit “1” because – as a result of the fraudulent and unlawful conduct described herein – the Provider 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

168. 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.

169. 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.

170. 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.

171. EMG and NCV tests are forms of electrodiagnostic tests, and purportedly were provided by NY Interventional because they were medically necessary to determine whether the Insureds had radiculopathies.

172. 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.

173. 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

174. 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”).

175. 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.

176. 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.

177. F-wave and H-reflex studies are additional types of NCV tests that may be conducted 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.

178. 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.

179. In an attempt to extract the maximum billing out of each Insured who supposedly received NCV tests, Desai and NY Interventional 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.

180. Desai and NY Interventional 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 to determine whether the Insureds had radiculopathies.

181. 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.

182. 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.

183. 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.

184. 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.”

185. Desai and NY Interventional did not tailor the NCVs they purported to perform and/or provide to the unique circumstances of each individual Insured.

186. Instead, Desai and NY Interventional applied a fraudulent “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 Exhibit “1”.

187. Specifically, in virtually every claim for NCV testing identified in Exhibit “1”, Desai and NY Interventional 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 ulnar motor nerves;
- (iii) left and right median sensory nerves;
- (iv) left and right radial sensory nerves; and
- (v) left and right ulnar sensory nerves.

188. The cookie-cutter approach to the NCVs that Desai and NY Interventional 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 the Defendants could submit to GEICO and other insurers, and to maximize their ill-gotten profits.

c. The Fraudulent Unbundling of F-Wave Tests

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

190. 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.

191. Nevertheless, Desai and NY Interventional routinely 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.

192. This charge is entirely duplicative of the charges submitted under CPT Code 95911 and submitted by Desai and NY Interventional solely to increase the amount of fraudulent billing that they could submit to GEICO and other insurers.

193. 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.

194. However, there is no indication in the electrodiagnostic reports accompanying the Providers’ billing submissions that would suggest that Desai ever used any “preconfigured electrode array” when providing the EDX services identified in Exhibit “1”.

195. Rather, Desai and NY Interventional simply utilized CPT code 95905 to inflate the amount of fraudulent billing they could submit to GEICO and other insurers.

196. For example, Desai and NY Interventional unlawfully unbundled the NCV studies and submitted billing under CPT code 95905 with respect to the following Insureds:

- (i) CC;
- (ii) GW;
- (iii) SS;

- (iv) JU;
- (v) RMK;
- (vi) RG;
- (vii) AS;
- (viii) DB;
- (ix) LH;
- (x) OB;
- (xi) NC;
- (xii) JO;
- (xiii) VS;
- (xiv) SL;
- (xv) MP;
- (xvi) JP;
- (xvii) JC;
- (xviii) CD;
- (xix) TF; and
- (xx) SR.

197. These are only representative examples. In the NCV claims identified in Exhibit “1”, Desai and NY Interventional 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

198. EMGs 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.

199. There are many different muscles in the arms and legs that can be tested using EMGs. 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 EMGs 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 EMGs should vary from patient-to-patient.

200. 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.

201. To the extent they were performed at all, Desai and NY Interventional did not tailor the EMGs 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.

202. In addition, Desai and NY Interventional routinely submitted billing to GEICO for EMGs that were never actually performed.

203. In keeping with the fact that Desai and NY Interventional routinely submitted billing to GEICO for EMGs that were never actually performed, numerous Insureds denied ever having a procedure at NY Interventional that involved the use of a needle.

5. The Fraudulent Charges for Pain Management Injections and Disc Procedures at NY Interventional

204. As part and parcel of the Defendants' fraudulent scheme, Desai and NY Interventional caused most of the Insureds in the claims identified in Exhibit "1" to be subjected to a series of medically unnecessary pain management injections including, but not limited to, trigger point injections, epidurograms, epidural injections, lidocaine injections, facet injections, arthrocentesis injections, lumbar discectomy, and annuloplasties, which often purportedly were performed with fluoroscopic guidance or ultrasonic guidance and under anesthesia.

205. Typically, Desai purported to perform the injections and procedures.

206. As set forth in Exhibit "1", Desai then billed the injections through NY Interventional to GEICO, typically under CPT codes 20553, 20611, 22526, 22527, 62290, 62291, 62321, 62323, 64483, 64484, 64490, 64491, 64492, 64493, 64494, 64495, 64634, 72275, 72285, 72295, 76942, J1030, and J2001.

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

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

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

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

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

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

213. In a legitimate clinical setting, pain management injections should not be administered more than once every two months, and multiple varieties of pain management injections should not be administered simultaneously.

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

215. However, in the claims for pain management injections identified in Exhibit "1",
Desai and NY Interventional:

- (i) routinely referred the Insureds for pain management injections before the Insureds had tried and failed any course of legitimate, conservative treatment; and/or

- (ii) routinely purported to administer multiple pain management injections to Insureds within a span of weeks, despite the fact that such a regimen not only was medically unnecessary, but also placed the Insureds at risk.

216. For example:

- (i) On August 21, 2020, an Insured named JTK was involved in an automobile accident. Thereafter, on February 16, 2021, NY Interventional and Desai purported to provide multiple pain management injections to JTK. Less than a week later, on February 20, 2021, NY Interventional and Desai purported to provide multiple injections to JTK. Less than a month after that, on March 14, 2021, NY Interventional and Desai purported to provide multiple injections to JTK. Two weeks after that, on March 27, 2021, NY Interventional and Desai purported to provide multiple injections to JTK.
- (ii) On December 30, 2020, an Insured named JD was involved in an automobile accident. Thereafter, on April 23, 2021, NY Interventional and Desai purported to provide multiple pain management injections to JD. Barely a week later, on May 1, 2021, NY Interventional and Desai purported to provide multiple injections to JD. Less than a month after that, on May 28, 2021, NY Interventional and Desai purported to provide multiple injections to JD. Barely three weeks after that, on June 19, 2021, NY Interventional and Desai purported to provide multiple injections to JD.
- (iii) On August 21, 2020, an Insured named SK was involved in an automobile accident. Thereafter, on February 16, 2021, NY Interventional and Desai purported to provide multiple pain management injections to SK. Less than a month after that, on March 13, 2021, NY Interventional and Desai purported to provide multiple injections to SK. Six weeks after that, on April 24, 2021, NY Interventional and Desai purported to provide multiple injections to SK. Less than a month later, on May 21, 2021, NY Interventional and Desai purported to provide multiple injections to SK. Barely a month later, on June 25, 2021, NY Interventional and Desai purported to provide multiple injections to SK. Barely three weeks later, on July 17, 2021, NY Interventional and Desai purported to provide multiple injections to SK. Barely a month later, on August 20, 2021, NY Interventional and Desai purported to provide multiple injections to SK. Barely a week later, on August 28, 2021, NY Interventional and Desai purported to provide multiple injections to SK.

217. Desai and NY Interventional's predetermined treatment protocol – including subjecting Insureds to a large amount of medically unnecessary pain management injections over the course of a few weeks, before the Insureds had failed any legitimate course of conservative treatment – was designed and employed by NY Interventional and Desai solely to maximize the

potential charges that they could submit, and cause to be submitted, to GEICO, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to them.

218. In keeping in the fact that the pain management injections were provided pursuant to a predetermined protocol designed to maximize the billing that NY Interventional and Desai could submit to GEICO, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to it, NY Interventional and Desai provided pain management injections to many Insureds despite the fact that the Insureds had suffered no injuries that legitimately would warrant any pain management injections at all.

219. As set forth above, virtually all of the Insureds in the claims identified in Exhibit “1” whom the Defendants purported to treat were involved in relatively minor accidents, to the extent that they were involved in any actual accidents at all.

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

221. Furthermore – and again in keeping with the fact that the Insureds’ accidents were minor – contemporaneous police reports regarding the claims identified in Exhibit “1” frequently indicated that the underlying accidents involved low-speed, low-impact collisions, that the Insureds’ vehicles were drivable following the accidents, and that no one was seriously injured in the underlying accidents or injured at all.

222. Virtually none of the Insureds in the claims identified in Exhibit “1” suffered from any significant injuries or health problems as a result of the relatively minor accidents they experienced or purported to experience.

223. To the extent that the Insureds in the claims identified in Exhibit “1” suffered from any injuries or health problems at all as the result of their minor accidents, the injuries virtually always were minor, garden-variety strains and sprains.

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

225. Concomitantly, virtually none of the Insureds in the claims identified in Exhibit “1” required extensive pain management treatment, especially invasive pain management injections provided months or even more than a year after the underlying accidents.

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

227. As set forth above, NY Interventional and Desai routinely submitted billing to GEICO for medically unnecessary pain management injections, in that the pain management injections: (i) were provided, to the extent that they were provided at all, primarily for the benefit

of the Defendants, and not to treat or otherwise benefit the Insureds; and (ii) were not the most appropriate standard of level of service in accordance with standards of good practice and standard professional treatment protocols.

a. The Fraudulent Billing for Epidurograms

228. An epidurogram is a diagnostic radiographic imaging procedure that involves the injection of contrast into the epidural space in order to evaluate the structure of the epidural space and diagnose the source of a patient's pain.

229. In a legitimate clinical setting, epidurograms are rarely, if ever, medically necessary. In keeping with the fact that epidurograms are almost never performed in a legitimate clinical setting, in 2022 the American Medical Association, which is responsible for maintaining the CPT codes, deleted CPT code 72275, i.e., the code for epidurography.

230. To the extent an epidurogram were ever medically necessary, they are diagnostic in nature and theoretically performed in order to inform the treatment a patient receives. When performed, epidurograms involves a formal, recorded contrast study that describes the epidural space and includes images taken during the procedure.

231. The epidurograms billed to GEICO were typically performed by Desai on behalf of NY Interventional.

232. As set forth in Exhibit "1", the epidurograms were then typically billed to GEICO through NY Interventional under CPT code 72275, typically resulting in a charge between \$460.86 and \$1,900.00 for each purported epidurogram.

233. The charges for the epidurograms were fraudulent in that they were performed – to the extent that they were performed at all – solely in order to maximize the volume of fraudulent billing the Defendants could submit to GEICO and other insurers and to not genuinely benefit the Insureds purportedly subjected to the procedures.

234. In keeping with the fraudulent nature of the epidurograms, the Defendants virtually always: (i) failed to identify any diagnostic issue requiring the epidurogram in either the preceding examination report or procedure report; (ii) failed to indicate what or how much contrast material was supposedly utilized; (iii) failed to describe the epidural space; (iv) failed to indicate how the purported results of the epidurogram altered an Insured's treatment plan; and (v) failed to include any imaging from the epidurograms.

235. Desai and NY Interventional simply billed for epidurograms under CPT code 72275 as part of their predetermined fraudulent treatment and billing protocol to inflate the amount of fraudulent billing they could submit to GEICO and other insurers.

236. For example, Desai and NY Interventional submitted billing for fraudulent, epidurograms under CPT Code 72275 with respect to the following Insureds:

- (i) WM;
- (ii) SDS;
- (iii) YSA;
- (iv) EW;
- (v) RC;
- (vi) JD;
- (vii) ML;
- (viii) AP;
- (ix) AG;
- (x) DC;
- (xi) MRC;
- (xii) JC;

- (xiii) SH;
- (xiv) NS;
- (xv) RG;
- (xvi) EP;
- (xvii) JTK;
- (xviii) SK;
- (xix) YC; and
- (xx) SEC.

237. These are only representative examples. In the claims for epidurograms identified in Exhibit “1”, Desai and NY Interventional routinely billed for medically unnecessary epidurograms solely to increase the amount of fraudulent billing they could submit to GEICO and other insurers.

b. The Fraudulent Billing for Discograms

238. A discogram is a diagnostic radiographic imaging procedure that involves the injection of contrast into the center of a spinal disc or discs that are suspected of causing pain. The physician then injects fluid to increase the pressure in the disc to see if it reproduces a patient’s pain.

239. In a legitimate clinical setting, discograms are diagnostic in nature and performed in order to inform the treatment or surgery a patient ultimately receives. Discograms are performed while the patient is awake, so that the patient may inform the physician whether or not the increased disc pressure has, in fact, reproduced the patient’s pain.

240. Additionally, in a legitimate clinical setting, discograms involve the insertion of a needle into an adjacent negative control disc, to establish whether a patient’s pain response is concordant or non-concordant, i.e., pain that is dissimilar to the patient’s usual pain.

241. The discograms billed to GEICO were typically performed by Desai on behalf of NY Interventional.

242. As set forth in Exhibit “1”, the discograms were then typically billed to GEICO through NY Interventional as multiple charges under CPT code 62290, 72285, or 72295, typically resulting in a charge between \$4,639.04 and \$15,600.00 for each purported discogram.

243. The charges for the discograms were fraudulent in that they were performed – to the extent that they were performed at all – solely in order to maximize the volume of fraudulent billing the Defendants could submit to GEICO and other insurers and to not genuinely benefit the Insureds purportedly subjected to the procedures.

244. In keeping with the fraudulent nature of the discograms, the Defendants routinely: (i) failed to identify any diagnostic issue requiring the discogram in either the preceding examination report or procedure report; (ii) purported to perform the discogram while the patient was sedated and impaired in their ability to participate in the procedure; (iii) failed to indicate the use of an adjacent negative control disc; and (iv) failed to indicate how the purported results of the discogram altered an Insured’s treatment plan.

245. Rather, Desai and NY Interventional billed for discograms solely to increase the amount of fraudulent billing they could submit to GEICO and other insurers.

c. The Fraudulent Billing for Ultrasonic Guidance

246. In addition to the fraudulent billing for pain management injections and disc procedures, Desai and NY Interventional routinely purported to perform – and separately bill for – ultrasonic guidance concomitantly with the other services purportedly provided.

247. For example, Desai and NY Interventional routinely purported to provide trigger point injections under CPT codes 20550, 20551, and 20553 while simultaneously billing for

ultrasonic guidance under CPT 76942, despite the fact that the use of ultrasonic guidance is medically unnecessary in order to treat trigger points.

248. Trigger points are irritable, painful, taut muscle bands or palpable knots in a muscle that can cause localized pain or referred pain that is felt in a part of the body other than that in which the applicable muscle is located. Trigger points can be caused by a variety of factors, including direct muscle injuries sustained in automobile accidents.

249. Trigger point injections typically involve injections of local anesthetic medication into a trigger point. Trigger point injections can relax the area of intense muscle spasm, improve blood flow to the affected area, and thereby permit the washout of irritating metabolites.

250. To increase the amount of fraudulent billing they could submit to GEICO and other insurers, Defendants routinely submitted a separate charge under CPT code 76942 for supposed “ultrasound guidance” used in the provision of the medically unnecessary trigger point injections.

251. The charges for “ultrasound guidance” of the injections were fraudulent inasmuch as, like the underlying trigger point injection itself, the ultrasound guidance was not medically necessary and was performed – to the extent that it was performed at all – pursuant to a predetermined fraudulent protocol designed to maximize the Defendants’ billing rather than to treat the Insureds who supposedly were subjected to it.

252. In a legitimate clinical setting, trigger point injections may be provided in an office setting, and rarely, if ever, require the use of ultrasound guidance or anesthesia.

253. In fact, because trigger points are generally identified by gently palpating the affected muscle and feeling for spots of tenderness or localized pain, performing trigger point injections using ultrasound guidance while a patient is sedated (and impaired in their ability to

communicate) will generally be a less effective and medically unnecessary way to treat an Insured's pain.

254. Even so, in order to maximize the amount of billing they could cause to be submitted to GEICO, Defendants routinely purported to provide trigger point injections, under anesthesia, using ultrasound guidance.

255. For example, Desai and NY Interventional routinely purported to provide trigger point injections under CPT codes 62321 and 62323 while simultaneously billing for ultrasonic guidance under CPT 76942, despite the fact that imaging guidance is part and parcel of any injection billed under CPT code 62321 or 62323.

256. Specifically, the Defendants purported to provide trigger point injections under CPT codes 20550, 20551, and 20553 concomitantly with ultrasonic guidance under CPT code 76942 with respect to the following Insureds:

- (i) YSA;
- (ii) DC;
- (iii) JC;
- (iv) JD;
- (v) JTK;
- (vi) SK;
- (vii) ML;
- (viii) MRC;
- (ix) NS; and
- (x) EW

257. These are only representative examples. In the claims identified in Exhibit “1”, Desai and NY Interventional routinely billed concomitantly for ultrasonic guidance and trigger point injections, solely to increase the amount of fraudulent billing they could submit to GEICO and other insurers.

d. The Fraudulent Billing for Non-Percutaneous Disc Surgeries

258. Dr. Desai is board-certified in physical medicine & rehabilitation. She is not board-certified in orthopedic surgery or neurosurgery, nor, upon information and belief, has she ever completed a residency or other training in orthopedic surgery or neurosurgery.

259. Nevertheless, on numerous occasions, Desai – through NY Interventional – purported to perform non-percutaneous (i.e., open) spinal surgeries that she was not qualified or capable of safely performing.

260. For example, in the claims identified in Exhibit “1”, Desai and NY Interventional submitted billing for the following procedures Desai was not qualified to perform: (i) transpedicular or costovertebral approach for posterolateral extradural exploration/decompression, lumbar, billed under CPT codes 63056 and 63057; and (ii) discectomy, anterior, with decompression of spinal cord and/or nerve root(s), billed under CPT codes 63075 and 63076.

261. To the extent that Desai actually performed any of these procedures, they were medically unnecessary and subjected Insureds to significant, unnecessary risk to their health and wellbeing.

262. The charges for procedures purportedly performed and billed under CPT codes 63056, 63057, 63075, and 63076 were fraudulent inasmuch as they were medically unnecessary and were performed – to the extent they were performed at all – despite the fact that Desai was incapable, by qualifications or training, of safely performing these procedures.

e. The Fraudulent Billing for Multiple Procedures Performed at Same Patient Visit

263. As part and parcel of their fraudulent treatment protocol, Desai and NY Interventional routinely purported to provide multiple spinal procedures on a single patient on a single day, solely to maximize the amount of fraudulent billing they could submit to GEICO and other insurers.

264. In a legitimate clinical setting, a physician would rarely perform multiple spinal procedures on a single patient on a single day, as doing so leaves the physician unable to discern which procedure helped (or potentially exacerbated) a patient's pain, thus significantly complicating a patient's future treatment plan.

265. Nevertheless, Desai and NY Interventional routinely purported to provide multiple spinal procedures on a single patient on a single day.

266. For example:

- (i) On February 27, 2021, Desai and NY Interventional purported to provide an Insured named YSA with multiple trigger point injections under CPT code 20553 and an epidural injection under CPT code 62321, with ultrasound guidance under CPT code 76942.
- (ii) On July 27, 2022, Desai and NY Interventional purported to provide an Insured named EP with multiple trigger point injections under CPT code 20553 and multiple transforaminal epidural injection under CPT codes 64483 and 64484, with ultrasound guidance under CPT code 76942.
- (iii) On April 24, 2021, Desai and NY Interventional purported to provide an Insured named EW with multiple trigger point injections under CPT code 20553 and an epidural injection under CPT code 62321, with ultrasound guidance under CPT code 76942.
- (iv) On March 12, 2022, Desai and NY Interventional purported to provide an Insured named JC with multiple trigger point injections under CPT code 20553 and multiple facet injections under CPT codes 64490, 64491, and 64492, with ultrasound guidance under CPT code 76942.
- (v) On February 20, 2021, Desai and NY Interventional purported to provide an Insured named JTK with multiple trigger point injections under CPT code 20553 and multiple epidural injections under CPT codes 64483 and 64484, with ultrasound guidance under CPT code 76942.

- (vi) On March 13, 2021, Desai and NY Interventional purported to provide an Insured named SK with multiple trigger point injections under CPT code 20553 and an epidural injection under CPT code 62321, with ultrasound guidance under CPT code 76942.
- (vii) On November 6, 2021, Desai and NY Interventional purported to provide an Insured named SH with multiple trigger point injections under CPT code 20553 and multiple epidural injections under CPT codes 64483 and 64484, with ultrasound guidance under CPT code 76942.
- (viii) On May 21, 2022, Desai and NY Interventional purported to provide an Insured named RG with multiple trigger point injections under CPT code 20553 and multiple epidural injections under CPT codes 64483 and 64484, with ultrasound guidance under CPT code 76942.
- (ix) On June 5, 2021, Desai and NY Interventional purported to provide an Insured named DC with multiple trigger point injections under CPT code 20553 and an epidural injection under CPT code 62321, with ultrasound guidance under CPT code 76942.
- (x) On April 2, 2022, Desai and NY Interventional purported to provide an Insured named NS with multiple trigger point injections under CPT code 20553 and an epidural injection under CPT code 62321, with ultrasound guidance under CPT code 76942.

267. These are only representative examples. In the claims identified in Exhibit “1”, Desai and NY Interventional routinely billed for multiple spinal injections and procedures purportedly performed on the same Insured on the same day, thus unnecessarily complicating the Insured’s treating plan, solely to increase the amount of fraudulent billing they could submit to GEICO and other insurers.

f. Misrepresentations Regarding the Reimbursable Amount for the Pain Management Injections and Disc Procedures

268. As set forth above, the No-Fault Laws prohibit healthcare services providers from charging for services in amounts exceeding the amounts set forth in the Fee Schedule.

269. Not only did NY Interventional and Desai routinely bill GEICO for medically unnecessary pain management injections and disc procedures, they also routinely misrepresented the reimbursable amount for the injections and disc procedures.

270. Specifically, and as set forth above and in Exhibit “1”, NY Interventional and Desai billed virtually all of their purported pain management injections under CPT codes 20553, 20611, 22526, 22527, 62290, 62291, 62321, 62323, 64483, 64484, 64490, 64491, 64492, 64493, 64494, 64495, 64634, 72275, 72285, 72295, 76942, J1030, and J2001.

271. NY Interventional and Desai knowingly submitted charges through NY Interventional in gross excess of the amounts allowed under the Fee Schedule in order to maximize the amount of fraudulent billing they could submit to GEICO.

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

272. To support their fraudulent charges, the Defendants systematically submitted or caused to be submitted thousands of NF-3 forms, HCFA-1500 forms, and treatment reports through NY Interventional and Desai Medical to GEICO seeking payment for the Fraudulent Services for which the Defendants were not entitled to receive payment.

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

- (i) The NF-3 forms, HCFA-1500 forms, and treatment reports submitted by and on behalf of NY Interventional and Desai Medical uniformly misrepresented to GEICO that the Fraudulent Services were medically necessary and, in many cases, misrepresented to GEICO that the Fraudulent Services actually were performed. In fact, the Fraudulent Services were not medically necessary, in many cases were not actually performed, and were performed – to the extent that they were performed 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) The NF-3 forms, HCFA-1500 forms, and treatment reports submitted by and on behalf of NY Interventional and Desai Medical 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, HCFA-1500 forms, and treatment reports submitted by and on behalf of NY Interventional and Desai Medical 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 self-referral arrangements amongst the Defendants and others; and
- (iv) The NF-3 forms, HCFA-1500 forms, bills, and treatment reports submitted or caused to be submitted by NY Interventional and Desai Medical uniformly misrepresented to GEICO that the Defendants were in compliance with all significant laws and regulations governing healthcare practice and/or licensing laws, and therefore were eligible to receive PIP reimbursement. In fact, as set forth herein, NY Interventional and Desai Medical were not in compliance with all significant laws and regulations governing healthcare practice and/or licensing laws, and therefore were not eligible to receive PIP reimbursement.

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

274. 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.

275. 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.

276. Specifically, they knowingly misrepresented and concealed facts related to NY Interventional and Desai Medical in an effort to prevent discovery of the fact that the Defendants unlawfully exchanged kickbacks for patient referrals and engaged in illegal self-referral arrangements.

277. Additionally, the Defendants entered into financial arrangements with the various Clinics that were designed to, and did, conceal that fact that the Defendants unlawfully exchanged kickbacks for patient referrals and engaged in illegal self-referral arrangements.

278. Furthermore, the Defendants knowingly misrepresented and concealed facts in order to prevent GEICO from discovering that the Fraudulent Services were medically unnecessary and performed 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.

279. GEICO maintains standard office practices and procedures that are designed to and do ensure that no-fault claim denial forms or requests for additional verification of no-fault claims are properly addressed and mailed in a timely manner in accordance with the No-Fault Laws.

280. For example, in accordance with the New York no-fault insurance laws, and GEICO's standard office practices and procedures, GEICO either: (i) timely and appropriately denied the pending New York claims for PIP Benefits submitted through the Defendants; or (ii) timely issued requests for additional verification with respect to all of the pending claims for PIP Benefits submitted through the defendants (yet GEICO failed to obtain compliance with the requests for additional verification), and, therefore, GEICO's time to pay or deny the claims has not yet expired.

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

282. 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 \$223,000.00 based upon the fraudulent charges.

283. Based upon the 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 NY Interventional
(Declaratory Judgment – 28 U.S.C. §§ 2201 and 2202)

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

285. There is an actual case and controversy between GEICO and the Provider Defendants regarding more than \$1,600,000.00 in unpaid billing for the Fraudulent Services that has been submitted to GEICO.

286. NY Interventional no right to receive payment from GEICO on the unpaid billing because the Fraudulent Services were not medically necessary and were provided – to the extent that they were provided at all – pursuant to pre-determined protocols that serve to financially enrich Defendants, rather than to treat or otherwise benefit the Insureds.

287. NY Interventional has no right to receive payment from GEICO on the unpaid billing because the billing codes used for the Fraudulent Services misrepresented and exaggerated the level of services that purportedly were provided in order to inflate the charges submitted to GEICO.

288. NY Interventional has no right to receive payment from GEICO on the unpaid billing because the Fraudulent Services were provided – to the extent that they were provided at all – pursuant to illegal kickback and self-referral arrangements amongst Defendants and others.

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

SECOND CAUSE OF ACTION
Against Desai
(Violation of RICO, 18 U.S.C. § 1962(c))

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

291. NY Interventional is an ongoing “enterprise” as that term is defined in 18 U.S.C. § 1961(4), that engages in activities that affected interstate commerce.

292. Desai knowingly has conducted and/or participated, directly or indirectly, in the conduct of NY Interventional’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 thousands of fraudulent charges on a continuous basis for over two years seeking payments that NY Interventional was not eligible to receive under the New York no-fault insurance law because of the fraudulent and unlawful conduct described herein. The fraudulent charges 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 part, in the chart annexed hereto as Exhibit “1”.

293. NY Interventional’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 way in which Desai operated NY Interventional, insofar as NY Interventional is not engaged in a legitimate medical practice, and acts of mail fraud therefore are essential in order for NY Interventional to function. Furthermore, the intricate planning required to carry out and

conceal the predicate acts of mail fraud implies a continued threat of criminal activity, as does the fact that Desai continues to attempt to collect on the fraudulent billing submitted through NY Interventional to the present day.

294. NY Interventional is engaged in inherently unlawful acts, inasmuch as it has been directed by Desai to continue to submit and attempt collection on fraudulent billing submitted to GEICO and other insurers, including the filing of lawsuits and arbitrations against GEICO seeking payment for the fraudulent billing. These inherently unlawful acts have been and continue to be taken by NY Interventional in pursuit of inherently unlawful goals – namely, the theft of money from GEICO and other automobile insurers through fraudulent no-fault billing.

295. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$223,000.00 pursuant to the fraudulent bills submitted through NY Interventional.

296. 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 NY Interventional and Desai
(Common Law Fraud)

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

298. NY Interventional and Desai 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 thousands of fraudulent charges seeking payment for the Fraudulent Services.

299. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that NY Interventional 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 Desai and NY Interventional; 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”.

300. NY Interventional and Desai 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 NY Interventional that were not compensable under New York no-fault insurance laws.

301. GEICO justifiably relied on these false and fraudulent representations and acts of fraudulent concealment, and as a proximate result has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$223,000.00 pursuant to the fraudulent bills submitted by NY Interventional and Desai through NY Interventional.

302. Desai and NY Interventional’s extensive fraudulent conduct demonstrates a high degree of moral turpitude and wanton dishonesty that entitles GEICO to recover punitive damages.

303. 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.

FOURTH CAUSE OF ACTION
Against NY Interventional and Desai
(Unjust Enrichment)

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

305. As set forth above, NY Interventional and Desai engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of GEICO.

306. When GEICO paid the bills and charges submitted by or on behalf of NY Interventional for PIP Benefits, it reasonably believed that it was legally obligated to make such payments based on Desai and NY Interventional's improper, unlawful, and/or unjust acts.

307. NY Interventional and Desai have been enriched at GEICO's expense by GEICO's payments which constituted a benefit that NY Interventional and Desai voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

308. Desai and NY Interventional's retention of GEICO's payments violates fundamental principles of justice, equity and good conscience.

309. By reason of the above, NY Interventional and Desai have been unjustly enriched in an amount to be determined at trial, but in no event less than \$223,000.00.

JURY DEMAND

310. 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:

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

B. On the Second Cause of Action against Desai, for compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$223,000.00, 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 NY Interventional and Desai, for compensatory damages in favor of GEICO an amount to be determined at trial but in excess of \$223,000.00, together with punitive damages, costs, interest, and such other relief as this Court deems just and proper; and

D. On the Fourth Cause of Action against NY Interventional and Desai, for more than \$223,000.00 in compensatory damages, plus costs, interest and such other and further relief as this Court deems just and proper.

Dated: Uniondale, New York
December 9, 2024

RIVKIN RADLER LLP

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