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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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

Docket No.: _____ ()

Plaintiffs,

-against-

**Plaintiff Demands a Trial
by Jury**

STANLEY-SANGWOOK KIM, D.O.,
STANLEY-SANGWOOK KIM, D.O., P.C., and
JOHN DOE DEFENDANTS “1”-“10,”

Defendants.

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COMPLAINT

Plaintiffs, Government Employees Insurance Company, GEICO Indemnity Company, GEICO General Insurance Company and GEICO Casualty Company (collectively “GEICO” or “Plaintiffs”), as and for their Complaint against Stanley-Sangwook Kim, D.O. (“Kim”), Kim Stanley-Sangwook Kim, D.O, P.C. (“Kim PC”), and John Doe Defendants 1-10 (collectively, the “Defendants”), hereby allege as follows:

NATURE OF THE ACTION

1. GEICO brings this action to recover more than \$450,000.00 that the Defendants wrongfully obtained from GEICO by submitting, and causing to be submitted, hundreds of fraudulent no-fault insurance charges relating to medically unnecessary, excessive, illusory, and otherwise non-reimbursable healthcare services, including sham patient examinations, putative outcome assessment testing, and trigger point injections (collectively, the “Fraudulent Services”). The Fraudulent Services were allegedly provided to New York automobile accident victims insured by GEICO (“Insureds”) through Kim and Kim PC. The fraudulent scheme committed in this case involves a physician’s participation in an illegal referral and kickback arrangement that permitted him and his professional corporation access to a steady stream of automobile accident victims, and in turn, fraudulently bill GEICO for thousands of dollars of Fraudulent Services by exploiting Insureds for financial gain without regard to genuine patient care.

2. GEICO seeks to recover the monies stolen from it and, further, seeks a declaration that it is not legally obligated to pay reimbursement of more than \$250,000.00 in pending no-fault insurance claims that have been submitted by or on behalf of Kim PC because:

- (i) the Fraudulent Services were not medically necessary and were provided – to the extent provided at all – pursuant to pre-determined fraudulent protocols designed solely to financially enrich the Defendants, rather than to treat or otherwise benefit the Insureds;
- (ii) 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;
- (iii) the Fraudulent Services were provided – to the extent provided at all – through the use of illegal kickback arrangements;
- (iv) the Fraudulent Services were provided – to the extent provided at all – by independent contractors rather than by employees of Kim PC; and

- (v) in many instances, the Fraudulent Services were never legitimately provided at all.

3. The Defendants fall into the following categories:

- (i) Defendant Kim is a physician licensed to practice medicine in the State of New York, who owned and controlled Kim PC, and who purported to perform many of the Fraudulent Services on behalf of Kim PC;
- (ii) Defendant Kim PC is a New York medical professional corporation through which the Fraudulent Services supposedly were provided and billed to insurance companies, including GEICO; and
- (iii) John Doe Defendants “1”-“10” (the “John Doe Defendants”) are individuals and/or entities who participated in the fraudulent scheme perpetrated against GEICO by, among other things, assisting with the operation of Kim PC and the provision of medically unnecessary services, “brokering” or “controlling” access to patients in exchange for illegal kickback payments, and/or spearheading the pre-determined fraudulent protocols used to maximize profits without regard to genuine patient care.

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

- (i) the Fraudulent Services were not medically necessary and were provided – to the extent provided at all – pursuant to pre-determined fraudulent protocols designed solely to financially enrich the Defendants, rather than to treat or otherwise benefit the Insureds;
- (ii) 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;
- (iii) the Fraudulent Services were provided – to the extent provided at all – through the use of illegal kickback arrangements;
- (iv) the Fraudulent Services were provided – to the extent provided at all – by independent contractors rather than by employees of Kim PC; and
- (v) in many instances, the Fraudulent Services were never legitimately provided at all.

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

6. The chart annexed hereto as Exhibit “1” sets forth a representative sample of the fraudulent claims that have been identified to-date that Defendants submitted, or caused to be submitted, to GEICO through Kim PC.

7. The Defendants’ fraudulent scheme began as early as 2020 and has continued uninterrupted through the present day, as Kim PC continues to seek collection on pending charges for the Fraudulent Services.

8. As a result of Defendants’ fraudulent scheme, GEICO has incurred damages of more than \$450,000.00.

THE PARTIES

I. Plaintiffs

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

II. Defendants

10. Defendant Kim resides in and is a citizen of New York. Kim became licensed to practice medicine in New York on November 25, 2005. Kim owned and controlled Kim PC, purported to personally perform many of the Fraudulent Services on behalf of Kim PC, and used Kim PC as a vehicle to submit fraudulent billing to GEICO and other insurers.

11. Kim, though currently a licensed physician, is a convicted felon, and is no stranger to insurance fraud. Kim was previously convicted of Insurance Fraud in the Third Degree (N.Y. Penal Law § 176.20), a Class D felony, in Queens County Supreme Court.

12. Following Kim’s criminal conviction, Kim entered into a consent order with the New York State Department of Health Board for Professional Medical Conduct, through which: (i) Kim’s license to practice medicine in the State of New York was suspended for a period of six months; (ii) Kim was placed on probation by the State Board for Professional Medical Conduct for a period of three years; and (iii) Kim was required to pay a fine of \$12,000.00.

13. Kim completed his probation on August 18, 2020, and in October 2020, began regularly submitting bills for the Fraudulent Services through Kim PC to GEICO.

14. Upon information and belief, Kim’s history as a convicted felon and the resulting discipline against his license – which can be located by prospective employers, patients, and referral sources using a simple internet search – has made it virtually impossible for Kim to obtain legitimate employment and contributed to his motive to carry out the fraudulent scheme outlined in this Complaint.

15. Defendant Kim PC is a New York medical professional corporation with its principal place of business in New York. Kim PC was incorporated on or about March 24, 2009, was owned and controlled by Kim, and was used by Kim as a vehicle to submit fraudulent no-fault insurance billing to GEICO and other insurers.

16. Upon information and belief, the John Doe Defendants reside in and are citizens of New York. The John Doe Defendants are individuals and entities, presently not identifiable, who knowingly participated in the fraudulent scheme by, among other things, assisting with the operation of Kim PC and the provision of medically unnecessary services, “brokering” or “controlling” access to patients in exchange for illegal kickback payments, and/or spearheading the pre-determined fraudulent protocols used to maximize profits without regard to genuine patient care.

JURISDICTION AND VENUE

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

18. Pursuant to 28 U.S.C. § 1331, this Court also has jurisdiction over 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.

19. 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.

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

ALLEGATIONS COMMON TO ALL CLAIMS

21. GEICO underwrites automobile insurance in New York.

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

22. New York’s no-fault laws are designed to ensure that injured victims of motor vehicle accidents have an efficient mechanism to pay for and receive the health care services that they need. Under New York’s Comprehensive Motor Vehicle Insurance Reparations Act (N.Y. Ins. Law §§ 5101, et seq.) and the regulations promulgated pursuant thereto (11 N.Y.C.R.R. §§ 65, et seq.) (collectively referred to as the “No-Fault Laws”), automobile insurers are required to provide Personal Injury Protection Benefits (“No-Fault Benefits”) to Insureds.

23. No-Fault Benefits include up to \$50,000.00 per Insured for necessary expenses incurred for health care goods and services, including medical services.

24. An Insured can assign his/her right to No-Fault Benefits to health care goods and services providers in exchange for those services.

25. 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”). In the alternative, a health care provider may submit claims using the Health Care Financing Administration insurance claim form (known as the “HCFA-1500 form”).

26. Pursuant to the No-Fault Laws, professional corporations are not eligible to bill for or to collect No-Fault Benefits if they fail to meet any New York State or local licensing requirements necessary to provide the underlying services.

27. 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 (Emphasis added).

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

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

30. Therefore, under the No-Fault Laws, a health care provider is not eligible to receive No-Fault Benefits if it is fraudulently licensed, if it pays or receives unlawful kickbacks in exchange for patient referrals, if it permits unlicensed laypersons to control or dictate the treatments, or allows unlicensed laypersons to share in the fees for the professional services.

31. In State Farm Mut. Auto. Ins. Co. v. Mallela, 4 N.Y.3d 313, 320 (2005), the New York Court of Appeals confirmed that health care providers that fail to comply with licensing requirements are ineligible to collect No-Fault Benefits, and that insurers may look beyond a facially-valid license to determine whether there was a failure to abide by state and/or local laws. Additionally, in Andrew Carothers, M.D., P.C. v. Progressive Ins. Co., 33 N.Y.3d 389, 393 (2019), the New York Court of Appeals reiterated that only licensed physicians may practice medicine in New York because of the concern that unlicensed individuals are “not bound by ethical rules that govern the quality of care delivered by a physician to a patient.”

32. Pursuant to the No-Fault Laws, only health care providers in possession of a direct assignment of benefits are entitled to bill for and collect No-Fault Benefits. There is both a statutory and regulatory prohibition against payment of No-Fault Benefits to anyone other than the patient or his/her health care 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 health care services as covered under section five thousand one hundred two (a)(1) of the Insurance Law ...

33. Accordingly, for a health care provider to be eligible to bill for and to collect charges from an insurer for health care services pursuant to Insurance Law § 5102(a), it must be the actual provider of the services. Under the No-Fault Laws, a professional corporation 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 professional corporation, such as independent contractors.

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

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

36. Pursuant to New York Insurance Law § 403, the NF-3s and HCFA-1500 forms submitted by a health care 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

A. Overview of the Scheme

37. Beginning in 2020 and continuing through the present day, the Defendants implemented a complex fraudulent scheme in which Kim PC was used to bill GEICO and other New York automobile insurers hundreds of thousands of dollars for medically unnecessary, excessive, illusory, and/or otherwise non-reimbursable healthcare services.

B. The Defendants' Unlawful Kickback and Referral Arrangements

38. The Defendants did not operate Kim PC from any single, fixed, location.

39. Instead, the Defendants operated Kim PC on an itinerant basis from various “No-Fault” medical clinics, primarily located in Queens and the Bronx.

40. As a result of illegal kickback and referral arrangements, the Defendants accessed patients and allegedly provided Fraudulent Services from the following No-Fault medical clinic locations, where Kim PC received steady volumes of patients through no legitimate efforts of their own, including at the following clinics (collectively, the “Clinics”):

- 153-01 Northern Boulevard, Flushing, New York (the “Northern Boulevard Clinic”);
- 1894 Eastchester Road, Bronx, New York (the “Eastchester Road Clinic”);
- 137-42 Guy R. Brewer Boulevard, Jamaica, New York (the “Guy R. Brewer Avenue Clinic”);
- 37-23 72nd Street, Jackson Heights, New York (the “72nd Street Clinic”); and
- 172-17 Jamaica Avenue, Jamaica, New York (the Jamaica Avenue Clinic”).

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

42. At many of the Clinics, unlicensed laypersons, rather than the healthcare professionals working in the Clinics, created and controlled the patient base and dictated fraudulent protocols used to maximize profits without regard to actual patient care.

43. The Clinics provided facilities for the Defendants, as well as a “revolving door” of medical professional corporations, chiropractic professional corporations, physical therapy

professional corporations and/or a multitude of other purported healthcare providers, all geared towards exploiting New York's no-fault insurance system.

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

45. For example:

- (i) GEICO received billing from at least 12 different providers that purported to operate out of the 72nd Street Clinic;
- (ii) GEICO received billing from at least 49 different healthcare providers that purported to operate out of the Eastchester Road Clinic;
- (iii) GEICO received billing from at least 30 different healthcare providers that purported to operate out of the Guy R. Brewer Avenue Clinic;
- (iv) GEICO received billing from at least 27 different healthcare providers that purported to operate out of the Jamaica Avenue Clinic; and
- (v) GEICO received billing from at least 24 different healthcare providers that purported to operate out of the Northern Boulevard Clinic.

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

47. For example, the Defendants paid the referral sources at the Clinics through payments typically disguised as "rent". They were, in reality, kickbacks for referrals, and the relationship was a "pay-to-play" arrangement. In connection with this arrangement, when an

Insured visited one of the Clinics, he or she was automatically referred by one of the Clinic's "representatives" for the performance of the Fraudulent Services.

48. In order to obtain access to the Clinics' patient base (i.e., Insureds) the Defendants entered into illegal kickback and referral arrangements with unlicensed persons and/or healthcare professionals, including John Doe Defendants, who "brokered" or "controlled" access to patients treated, or purported to be treated, at the Clinics.

49. Neither Kim, nor any other healthcare professional purportedly associated with Kim PC, had their own patients at the Clinics or did anything to create a patient base.

50. The Defendants did not market the existence of Kim PC or the Fraudulent Services to the general public.

51. The Defendants did not advertise for patients, did not maintain any website, and never sought to build name recognition or make any legitimate efforts of their own to attract patients on behalf of Kim PC.

52. Kim did not do virtually anything that would be expected of the owner of a legitimate medical professional corporation to develop its reputation and attract patients to the Clinics or to Kim PC.

53. The Defendants did not have any patients of their own at the Clinics, and the healthcare services that they could provide to the patients at the Clinics were limited and dictated by the unlicensed laypersons and/or healthcare professionals, including the John Doe Defendants, who controlled access to patients at the Clinics and were interested only in maximizing profits without regard to genuine patient care.

54. At bottom, neither Kim nor any other medical professional that may have rendered services under the name of Kim PC at the Clinics had a genuine doctor-patient relationship with the

Insureds that visited the Clinics, as the Insureds had no scheduled appointments with Kim or Kim PC specifically.

55. In fact, the Insureds were simply directed by the Clinics, and the unlicensed laypersons and/or healthcare professionals associated therewith, to subject themselves to treatment by whatever individual was working on behalf of Kim PC and the other medical providers on that given day, because of the illegal kickbacks paid by the Defendants.

C. The Defendants' Fraudulent Treatment and Billing Protocol

56. Regardless of the nature of the accidents or the actual medical needs of the Insureds, the Defendants purported to subject virtually every Insured to a pre-determined fraudulent treatment protocol without regard for the Insureds' individual symptoms or presentment.

57. 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.

58. The Defendants' fraudulent treatment and billing protocol resulted in hundreds of thousands of dollars in billing to GEICO for medically unnecessary, excessive, illusory, and/or bogus services, including patient examinations, putative outcome assessment testing, and trigger point injections under ultrasound guidance (*i.e.*, the "Fraudulent Services").

59. No legitimate physician or other licensed healthcare provider would permit the fraudulent treatment and billing protocol described below to proceed under his or her auspices. Rather, the Defendants permitted the fraudulent treatment and billing protocol described below to proceed under their auspices because they sought to profit from the fraudulent billing submitted to GEICO and other insurers.

1. The Fraudulent Charges for Initial Consultations

60. Upon receiving a referral pursuant to the kickbacks that the Defendants paid to the unlicensed laypersons and/or healthcare professionals associated with the Clinics, including John Doe Defendants, the Defendants purported to provide most of the Insureds in the claims identified in Exhibit “1” with an initial consultation.

61. In keeping with the fact that the initial consultations were performed pursuant to the kickbacks that the Defendants paid at the Clinics, Kim and Kim PC virtually always purported to perform the initial consultations at the Clinics where they obtained their initial referrals, rather than at any stand-alone practice.

62. The initial consultations were performed as a “gateway” in order to provide a false basis to justify the Defendants’ exploitation of the Insureds through: (i) Kim PC’s medically unnecessary, excessive, illusory, or otherwise non-compensable services; and (ii) a laundry-list of prescriptions for various other putative goods and services, including physical therapy, durable medical equipment, pharmaceuticals, and other medically unnecessary/illusory medical services.

63. In keeping with the fact that the initial consultations identified in Exhibit “1” were not genuine but simply a means to justify their ability to bill for additional services pursuant to a predetermined, fraudulent treatment protocol, the initial consultations resulted in virtually every Insured receiving at least one of the other Fraudulent Services on the same date of service, immediately following the initial consultation.

64. The Defendants then billed the examinations and consultations through Kim PC under CPT code 99244, virtually always resulting in a charge of \$324.69 for each purported consultation.

65. All of the Defendants' billing for initial consultations represented that the consultations had been personally performed by Kim.

66. The charges for the initial consultations were fraudulent in that the consultations were medically unnecessary and were performed – to the extent they were performed at all – pursuant to the kickbacks that the Defendants paid at the Clinics in coordination with John Doe Defendants, not to treat or otherwise benefit the Insureds.

67. Furthermore, Kim PC's charges for the initial consultations were fraudulent in that they misrepresented the nature and extent of the initial consultations.

68. For example, in the claims for initial consultations identified in Exhibit "1", the Defendants misrepresented and exaggerated the amount of face-to-face time that the examining healthcare professional spent with the Insureds or the Insureds' families.

69. The use of CPT code 99244 typically requires that a healthcare professional spend 60 minutes of face-to-face time with the Insured or the Insured's family.

70. Though the Defendants, Kim PC, and Kim billed their initial consultations under CPT code 99244, no healthcare professional associated with Kim PC spent 60 minutes on an initial consultation.

71. Rather the initial consultations in the claims identified in Exhibit "1" rarely lasted more than 10 to 15 minutes.

72. In keeping with the fact that the initial consultations rarely lasted more than 10 to 15 minutes, Kim PC's purported initial consultations were documented using pre-printed templated forms, that set forth a limited range of examination components.

73. The pre-printed template forms that Kim PC used in conducting the initial consultations set forth a limited range of potential patient complaints, examination/diagnostic testing options, potential diagnoses, and treatment recommendations.

74. All that was required to complete the pre-printed templated forms was a brief patient interview and a perfunctory physical examination of the Insureds.

75. These putative interviews and examinations did not require any healthcare professional associated with Kim PC to spend more than 10 to 15 minutes of face-to-face time with the Insureds during the putative initial consultations.

76. Pursuant to the Fee Schedule, when the Defendants submitted charges for initial consultations under CPT code 99244, or caused them to be submitted, they falsely represented that an associated healthcare professional: (i) took a “comprehensive” patient history; (ii) conducted a “comprehensive” physical examination; and (iii) engaged in medical decision-making of “moderate complexity.”

a. Misrepresentations Regarding the Performance of Consultations

77. Pursuant to the Fee Schedule, the use of CPT code 99244 to bill for an initial patient encounter represents that the examining physician performed a “consultation” at the request of another physician or other appropriate source.

78. However, Kim PC did not provide its purported “consultations” – to the extent provided at all – pursuant to a legitimate referral from any other physician or other appropriate source. Rather, to the extent that the putative “consultations” were performed in the first instance, they were performed as a result of the illegal kickback payments and pursuant to the Defendants’ fraudulent treatment protocol in order to generate billing to be submitted through Kim PC.

79. In keeping with the fact that the Defendants did not provide their purported “consultations” at the request of another physician or appropriate source, the supposed “results” of the putative “consultations” were neither transmitted back to any referring physicians or other appropriate sources, nor were the supposed “results” of the putative “consultations” incorporated into any of the Insureds’ treatment plans, or otherwise acted upon in any way.

80. Pursuant to the Fee Schedule, the use of CPT code 99244 to bill for a patient consultation represents that the physician who performed the consultation submitted a written consultation report to the physicians or other appropriate sources who purportedly requested the consultations in the first instance.

81. However – and, again, in keeping with the fact that the Defendants did not provide their purported “consultations” at the request of another physician or appropriate source – neither Kim nor any other healthcare professional associated with Kim PC ever submitted any written consultation report to any referring physician or other healthcare provider.

82. In the claims for purported “consultations” identified in Exhibit “1”, the Defendants misrepresented the underlying services to be consultations billable under CPT code 99244 because such consultations are reimbursable at a higher rate than commensurate patient examinations.

b. Misrepresentations Regarding “Comprehensive” and “Detailed” Patient Histories

83. Pursuant to the Fee Schedule, when the Defendants submitted charges for initial consultations through Kim PC under CPT code 99244, they represented that they took a “comprehensive” patient history.

84. Pursuant to the American Medical Association’s CPT Assistant (the “CPT Assistant”), which is incorporated by reference into the Fee Schedule, a patient history does not

qualify as “comprehensive” unless the physician has conducted a “complete” review of the patient’s systems.

85. Pursuant to the CPT Assistant, a physician has not conducted a “complete” review of a patient’s systems unless the physician has documented a review of the systems directly related to the history of the patient’s present illness, as well as at least 10 other organ systems.

86. The CPT Assistant recognizes the following organ systems with respect to a review of 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.

87. When the Defendants billed for the initial consultations under CPT code 99244 through Kim PC, they falsely represented that Kim took a “comprehensive” patient history from the Insureds they purported to treat during the initial consultations.

88. In fact, no healthcare professional associated with Kim PC ever took a legitimate “comprehensive” patient history from the Insureds they purported to treat during the initial consultations, because they did not document a review of the systems directly related to the history of the patients’ present illnesses or a review of 10 organ systems unrelated to the history of the patients’ present illnesses.

89. Furthermore, pursuant to the CPT Assistant, a “detailed” patient history requires – among other things – that the examining physician take a history of systems related to the patient’s presenting problems, as well as a review of a limited number of additional systems.

90. However, no healthcare professional associated with Kim PC ever took a “detailed” patient history from Insureds during its initial consultations, inasmuch as they did not review systems related to the patients’ presenting problems and did not conduct any review of a limited number of additional systems.

91. Rather, after purporting to provide the initial consultations, the Defendants simply prepared reports containing ersatz patient histories in order to justify the performance of the Fraudulent Services.

92. These patient histories did not genuinely reflect the Insureds’ actual circumstances, and instead were designed solely to support the: (i) purported diagnoses that did not correlate with the patient’s actual symptoms or concerns; (ii) Kim PC’s billing to GEICO, and other insurers, for the Fraudulent Services that they purported to provide; and (iii) the laundry-list of other purported goods and services prescribed to Insureds at the conclusion of the putative consultations.

c. Misrepresentations Regarding “Comprehensive” or “Detailed” Physical Examinations

93. Pursuant to the Fee Schedule, a physical examination does not qualify as “comprehensive” unless the healthcare provider either: (i) conducts a general examination of multiple patient organ systems; or (ii) conducts a complete examination of a single patient organ system.

94. Further, pursuant to the CPT Assistant, in the context of patient 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.

95. Pursuant to the CPT Assistant, in the context of patient 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; (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.

96. When the Defendants billed for the initial consultations through Kim PC under CPT code 99244, they falsely represented that Kim performed a “comprehensive” patient examination on the Insureds they purported to treat during the initial consultations.

97. In fact, no healthcare professional associated with Kim PC ever conducted a general examination of multiple patient organ systems or conduct a complete examination of a single patient organ system.

98. For instance, no healthcare professional associated with Kim PC 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.

99. Furthermore, although Kim PC often purported to provide a more in-depth examination of the Insureds’ musculoskeletal systems during their putative initial consultations, 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; (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.

d. Misrepresentations Regarding the Extent of Medical Decision-Making

100. Similarly, when the Defendants submitted charges for initial consultations under CPT code 99244 through Kim PC, Kim represented that he engaged in medical decision-making of “moderate complexity.”

101. Pursuant to the CPT Assistant, 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.

102. Though the Defendants routinely falsely represented that initial consultations involved medical decision-making of “moderate complexity”, in actuality the initial consultations did not involve any medical decision-making at all, and, in the unlikely event that an Insured did present with injuries or symptoms with any degree of complexity, the deficient initial consultations were incapable of assessing and/or diagnosing them as such.

103. First, there was no risk of significant complications or morbidity – much less mortality – from the Insureds’ relatively minor complaints to the extent that they ever had any complaints arising from automobile accidents at all.

104. Nor, by extension, was there any risk of significant complications, morbidity, or mortality from the diagnostic procedures or treatment options provided by initial examinations and consultations – to the extent that the Defendants provided any such diagnostic procedures or treatment options in the first instance.

105. In almost every instance, any diagnostic procedures and “treatments” that the Defendant actually provided were limited to either a series of medically unnecessary trigger point injections, durable medical equipment, pharmaceuticals, and/or diagnostic tests or experimental and investigational “services”, none of which were health or life-threatening if properly provided or administered.

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

107. In fact, no healthcare professional associated with the Defendants engaged in any medical decision-making at all. Rather, the outcome of the initial consultations were pre-determined for virtually every Insured to result in boilerplate “diagnoses” that merely: (i) matched the patients’ subjective complaints; and (ii) added diagnoses that would justify performance of the particular Defendants’ fraudulent services as well as their purported prescriptions for other unnecessary goods and services.

108. In keeping with the fact that the purported initial consultations did not involve any legitimate medical decision making at all, the putative initial consultation “reports” virtually

always included a minimum of physical therapy, MRIs and “chiropractic/acupuncture” as a treatment “plan”, which was simply a checklist:

Treatment Plan:		X-Ray:
<input checked="" type="checkbox"/> Physical Therapy		MRI: C/S . L/S
<input type="checkbox"/> Pain Consultation		ROM:
<input type="checkbox"/> Neurology Consultation		Mantle Muscle Test
<input type="checkbox"/> Orthopedic Consultation		Functional Capacity Test
<input checked="" type="checkbox"/> Psychology Consultation		
<input checked="" type="checkbox"/> Chiropractic / Acupuncture		
Follow Up: L/S		

109. There are a substantial number of variables that can affect whether, how, and to what extent an individual is injured in a given automobile accident.

110. An individual’s age, height, weight, general physical condition, location within the vehicle, and the location of the impact all will affect whether, how, and to what extent an individual is injured in a given automobile accident.

111. It is extremely improbable that any Insureds involved in the automobile accidents underlying the claims identified in Exhibit “1” would suffer substantially identical injuries as the result of their accidents or require a substantially identical course of treatment.

112. It is even more improbable – to the point of impossibility – that this would occur repeatedly, often with the Insureds presenting at NY Orthopedics and Spine Health with substantially identical injuries on or about the exact same dates days, weeks, or even months after their accidents.

113. Even so, in keeping with the fact that the Defendants’ putative diagnoses were phony, and in keeping with the fact that the putative initial consultations involved not actual medical decision-making at all, the Defendants frequently issued substantially identical, phony “diagnoses”, on or about the same date, to more than one Insured involved in a single accident, and recommended a substantially identical course of medically unnecessary “treatment” to the Insureds, despite the fact that they were differently situated.

114. For example:

- (i) On February 16, 2021, two Insureds – TO and JV – were involved in the same automobile accident. Thereafter, on February 18, 2021, TO and JV both presented to Kim and Kim PC for purported initial examinations. TO and JV were different ages, in different physical conditions, and experienced the automobile accident in different ways. Even so, at the conclusion of the purported initial examinations, Kim and Kim PC provided TO and JV with substantially identical putative “diagnoses”, and recommended substantially the same course of treatment for both of them;
- (ii) On April 23, 2021, two Insureds – CB and JM – were involved in the same automobile accident. Thereafter, on April 29, 2021, CB and JM both presented to Kim and Kim PC for purported initial examinations. CB and JM were different ages, in different physical conditions, and experienced the automobile accident in different ways. Even so, at the conclusion of the purported initial examinations, Kim and Kim PC provided CB and JM with substantially identical putative “diagnoses”, and recommended substantially the same course of treatment for both of them;
- (iii) On March 9, 2022, seven Insureds – SK, MK, YK, BS, JC, KK, and SK – were all involved in the same automobile accident. Between October 3, 2022 and October 7, 2022 – nearly seven months after the accident – SK, MK, YK, BS, JC, KK, and SK all presented to Kim and Kim PC for purported initial examinations. SK, MK, YK, BS, JC, KK, and SK were different ages, in different physical conditions, and experienced the automobile accident in different ways. Even so, at the conclusion of the purported initial examinations, Kim and Kim PC provided SK, MK, YK, BS, JC, KK, and SK with substantially identical putative “diagnoses”, and recommended substantially the same course of treatment for all seven of them.
- (iv) On April 20, 2022, two Insureds – LC and JP – were involved in the same automobile accident. Thereafter, on May 12, 2022, both LC and JP presented to Kim and Kim PC for purported initial examinations. LC and JP were different ages, in different physical conditions, and experienced the automobile accident in different ways. Even so, at the conclusion of the purported initial examinations, Kim and Kim PC provided LC and JP with substantially identical putative “diagnoses”, and recommended substantially the same course of treatment for both of them.
- (v) On September 25, 2022, two Insureds – HK and NP – were involved in the same automobile accident. Thereafter, on September 27, 2022, both HK and NP presented to Kim and Kim PC for purported initial examinations. HK and NP were different ages, in different physical conditions, and experienced the automobile accident in different ways. Even so, at the

conclusion of the purported initial examinations, Kim and Kim PC provided HK and NP with substantially identical putative “diagnoses”, and recommended substantially the same course of treatment for both of them.

115. These are only representative examples.

116. In sum, the initial consultations did not genuinely reflect the Insureds’ actual circumstances, and instead were designed solely to support the particular Fraudulent Services that the respective Defendants purported to perform and then billed to GEICO and other insurers.

2. The Fraudulent Charges for Follow-Up Examinations

117. In addition to their fraudulent initial examinations, the Defendants 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.

118. The Defendants billed the follow-up examinations through Kim PC under CPT code 99214, most often resulting in a charge of \$127.41.

119. All of the billing submitted to GEICO by the Defendants for the putative follow-up examinations represented that each and every “exam” was performed by Kim.

120. Like the Defendants’ charges for the initial examinations, the charges for the follow-up examinations were fraudulent in that the follow-up examinations were medically unnecessary and were performed – to the extent they were performed at all – pursuant to the illegal kickback and financial arraignments, referral schemes and fraudulent treatment protocol.

a. The Defendants’ Misrepresentations Concerning the Nature and Extent of the Follow-Up Examinations

121. The charges for the follow-up examinations also were fraudulent in that they misrepresented the nature, extent, and results of the follow-up examinations.

122. In keeping with the fact that the follow-up examinations were fraudulent, the purported “reports” generated by the Defendants in connection with the putative follow-up

examinations virtually always: (i) merely reiterated the phony, pre-determined “diagnoses” provided by the Defendants at the conclusion of their initial consultations; (ii) included a blank “specialist referral form”, which was purportedly used by the John Doe Defendants to refer patients to other providers at the respective Clinic; and (iii) directed the Insureds to continue receiving the laundry list of unnecessary services provided to them at the Clinics.

123. For example, the putative follow-up examination “reports” virtually always included the following identical directive for the Insureds to receive additional physical therapy and acupuncture/chiropractic services:

Treatment Plan:

Continue Physical Therapy	X-Ray :
Pain Consultation	MRI:
Neurology Consultation	ROM:
Orthopedic Consultation	Manuel Muscle Test
Psychology Consultation	Functional Capacity Test
Chiropractic / Acupuncture	
Follow Up: <i>cpw</i>	

124. These identical notations and “recommendation” appeared in virtually all of the Defendants’ putative follow-up examination reports.

b. The Defendants’ Misrepresentations That the Follow-Up Examinations Were Ever Provided in the First Instance

125. In addition to the misrepresentations regarding the nature and extent of the purported follow-up examinations, the Defendants routinely falsely represented that the putative follow-up examinations were conducted in the first instance.

126. In fact, the Defendants routinely manufactured phony examinations reports to create the false appearance that legitimate follow-up examinations had been performed, when, in fact, they had not been performed.

127. In particular, the Defendants routinely submitted purported examination “reports” that represented that Kim had, among other things: (i) documented the patient’s subjective

complaints; and (ii) conducted and documented a physical examination of the patient, complete with manual range of motion measurements.

128. In reality, the Defendants simply duplicated phony follow-up examination reports to create the false appearance that Kim had, among other things: (i) documented the patient’s subjective strength complaints; and (ii) conducted and documented a physical examination of the patient, complete with manual range of motion measurements, when, in fact, he had not.

129. For example, the following two pages are from what the Defendants falsely represented were two separate follow-up examinations of an Insured named CT – despite the fact that the notations on the second report were simply copied from the first report, down to identical pen markings and range of motion “measurements”:

The image shows two identical medical examination forms side-by-side. Each form is titled 'Review of Systems: 0 Normal 0 Other' and contains sections for Cervical Spine, Thoracic Spine, and Lumbar Spine. The forms include tables for Range of Motion (ROM) and Patient's ROM (approximately) for Flexion, Extension, Rotation, and Lateral Flexion. Handwritten notations in blue ink are present throughout, including '50', '60', '70', '45', '30', '20', '15', and '11'. The forms also include sections for Spurling Test, DTR, Sensation, Muscle strength, Straight Leg Raising test, and Shoulders. The forms are dated October 17, 2022 and November 17, 2022.

October 17, 2022 Follow-Up Exam

November 17, 2022 Follow-Up Exam

130. This is only a representative example.

131. In the claims identified in Exhibit “1”, the Defendants routinely fabricated the “results” of purported follow-up examinations in order to create the false appearance that those examinations were ever legitimately provided in the first instance, including, solely by way of example, for the following Insureds on the following supposed dates of service:

- (i) DT, on October 24, 2022 and December 1, 2022;
- (ii) KC, on October 25, 2022 and December 2, 2022;
- (iii) DS, on February 13, 2023 and March 21, 2023;
- (iv) HA, on February 17, 2023 and March 24, 2023; and
- (v) XC, on March 7, 2023 and April 11, 2023.

132. In the claims identified in Exhibit “1”, the Defendants routinely falsely represented that the purported follow-up examinations had legitimately been performed when, in fact, they had not been.

3. The Fraudulent Charges for Outcome Assessment Testing

133. Pursuant to their fraudulent billing and treatment protocol, illegal kickback and financial arrangements, and referral scheme, the Defendants caused bills to be submitted through Kim PC to GEICO for medically useless or otherwise illusory “outcome assessment tests” purportedly performed on or about the same dates the Defendants purported to subject the Insureds to initial or follow-up examinations.

134. The Defendants then billed the “outcome assessment tests” to GEICO through Kim PC using CPT code 99358, generally resulting in a charge of \$280.12 for each round of “testing.”

135. Like the Defendants’ charges for the other Fraudulent Services, the charges for the “outcome assessment tests” were fraudulent in that the tests were medically unnecessary and were

performed, to the extent they were performed at all, pursuant to the illegal kickback and referral schemes and fraudulent treatment protocol.

136. The “outcome assessment tests” that the Defendants purportedly provided to Insureds – to the extent provided at all – were simply pre-printed, multiple-choice questionnaires on which the Insureds were invited to report the symptoms they purportedly were experiencing, and the impact of those symptoms on their daily lives.

137. Since a patient history and physical examination must be conducted as an element of a soft-tissue trauma patient’s initial and follow-up examinations, and since the “outcome assessment tests” that the Defendants purportedly provided were nothing more than a questionnaire regarding the Insureds’ history and physical condition, the Fee Schedule provides that the “outcome assessment tests” should have been reimbursed as an element of the initial and follow-up examinations.

138. In other words, healthcare providers cannot conduct and bill for an initial examination or follow-up examination and then bill separately, or additionally, for contemporaneously-provided “outcome assessment testing” either using CPT code 99358 or by submitting charges for examinations in excess of the Fee Schedule.

139. Even so, the Defendants routinely billed GEICO for patient examinations and supposedly-contemporaneously-provided “outcome assessment testing” for a single Insured on a single date of service including, for example, for the following Insureds on the following dates:

- (i) KA, on October 29, 2020;
- (ii) NA, on November 5, 2020;
- (iii) SB, on January 21, 2021;
- (iv) JR, on April 29, 2021;

- (v) DS, on February 1, 2022;
- (vi) MA, on May 4, 2022;
- (vii) JB, on May 6, 2022;
- (viii) SC, on November 18, 2022;
- (ix) ML, on January 31, 2023; and
- (x) CL, on February 27, 2023.

140. These are only representative examples.

141. In the claims for purported outcome assessment testing identified in Exhibit “1”, the Defendants routinely and fraudulently billed GEICO for patient examinations and supposedly-contemporaneously-provided “outcome assessment testing” for a single Insured on a single date of service.

142. Even if the Defendants did perform the “outcome assessment tests” for which GEICO was billed, the information gained through the use of the tests would not have been significantly different from the information that the Defendants purported to obtain during virtually every Insured’s initial and follow-up patient history and examinations. In fact, the Defendants, in billing for fraudulent initial and follow-up examinations, represented that Kim took at least a “detailed” if not “comprehensive” patient history and performed at least a “detailed” if not “comprehensive” physical examination.

143. The “outcome assessment tests” represented purposeful and unnecessary duplication of the patient histories and examinations purportedly conducted during the Insureds’ initial examinations and follow-up examinations. The “outcome assessment tests” were part and parcel of the Defendants’ fraudulent scheme, inasmuch as the “service” was rendered – to the

extent rendered at all – pursuant to a predetermined protocol that was designed solely to financially enrich the Defendants and in no way aided in the assessment and treatment of the Insureds.

144. The Defendants’ use of CPT code 99358 to bill for the “outcome assessment tests” also constituted a deliberate misrepresentation of the extent of the service that was provided. Pursuant to the Fee Schedule, the use of CPT code 99358 represents – among other things – that the physician actually spent at least one hour performing some prolonged service, such as a review of extensive records and tests, or communication with the Insured and the Insured’s family.

145. Though the Defendants routinely submitted billing under CPT code 99358 for “outcome assessment tests”, no physician associated with Kim PC spent an hour reviewing or administering the tests or communicating with the Insureds or their families.

146. Indeed, the “outcome assessment tests” did not require any physician involvement at all, inasmuch as the “tests” simply were questionnaires that were completed by the Insureds.

147. Neither Kim nor any other physician supposedly associated with Kim PC had any meaningful involvement in the provision of the purported “outcome assessment tests”.

148. As the “outcome assessment tests” were medically unnecessary and were performed pursuant to the Defendants’ pre-determined fraudulent treatment protocol and illegal kickback scheme, the results of the “outcome assessment tests” like the other Fraudulent Services, were not incorporated into the Insureds’ respective treatment plans.

149. Moreover, the Defendants’ billing for putative outcome assessment testing was fraudulent inasmuch as it represented that any legitimate service was performed at all.

150. In fact, in many instances, the Defendants simply created duplicate purported “questionnaires” using previous notations – and even photocopied signatures – from Insureds to create the false appearance that subsequent “testing” had been performed.

151. For example, the following pages – which feature identical, duplicated notations – were submitted by the Defendants to GEICO in support of two separate outcome assessment tests supposedly provided to an Insured named CT on two separate dates – despite the fact that the notations on the second report were simply copied from the first report, down to identical pen markings:

Shoulder Pain and Disability Index Please circle the number that best describes the question being asked.

How severe is your pain? No pain at all = 0; Worst pain imaginable = 10

1. At its worst?
0 1 2 3 4 5 6 7 8 9 10
2. When lying on the involved side?
0 1 2 3 4 5 6 7 8 9 10
3. Reaching for something on a high shelf?
0 1 2 3 4 5 6 7 8 9 10
4. Pushing with the involved arm?
0 1 2 3 4 5 6 7 8 9 10
5. Touching the back of your neck?
0 1 2 3 4 5 6 7 8 9 10

How much difficulty do you have? No difficulty = 0; So difficult it requires help = 10

1. Washing your hair?
0 1 2 3 4 5 6 7 8 9 10
2. Washing your back?
0 1 2 3 4 5 6 7 8 9 10
3. Putting on an undershirt or pullover sweater?
0 1 2 3 4 5 6 7 8 9 10
4. Putting on a shirt that buttons down the front?
0 1 2 3 4 5 6 7 8 9 10
5. Putting on your pants?
0 1 2 3 4 5 6 7 8 9 10
6. Placing an object on a high shelf?
0 1 2 3 4 5 6 7 8 9 10
7. Carrying a heavy object of 10 pounds?
0 1 2 3 4 5 6 7 8 9 10
8. Removing something from your back pocket?
0 1 2 3 4 5 6 7 8 9 10

October 17, 2022 Outcome Assessment Test

Shoulder Pain and Disability Index Please circle the number that best describes the question being asked.

How severe is your pain? No pain at all = 0; Worst pain imaginable = 10

1. At its worst?
0 1 2 3 4 5 6 7 8 9 10
2. When lying on the involved side?
0 1 2 3 4 5 6 7 8 9 10
3. Reaching for something on a high shelf?
0 1 2 3 4 5 6 7 8 9 10
4. Pushing with the involved arm?
0 1 2 3 4 5 6 7 8 9 10
5. Touching the back of your neck?
0 1 2 3 4 5 6 7 8 9 10

How much difficulty do you have? No difficulty = 0; So difficult it requires help = 10

1. Washing your hair?
0 1 2 3 4 5 6 7 8 9 10
2. Washing your back?
0 1 2 3 4 5 6 7 8 9 10
3. Putting on an undershirt or pullover sweater?
0 1 2 3 4 5 6 7 8 9 10
4. Putting on a shirt that buttons down the front?
0 1 2 3 4 5 6 7 8 9 10
5. Putting on your pants?
0 1 2 3 4 5 6 7 8 9 10
6. Placing an object on a high shelf?
0 1 2 3 4 5 6 7 8 9 10
7. Carrying a heavy object of 10 pounds?
0 1 2 3 4 5 6 7 8 9 10
8. Removing something from your back pocket?
0 1 2 3 4 5 6 7 8 9 10

November 17, 2022 Outcome Assessment Test

152. This is only a representative example.

153. In the claims for outcome assessment testing identified in Exhibit “1”, the Defendants routinely fabricated the results of the purported “testing” in order to create the false appearance that the billed-for outcome assessment testing was legitimately provided in the first instance, when, in fact, it was not.

4. The Fraudulent Charges for Trigger Point Injections

154. Pursuant to their fraudulent billing and treatment protocol, illegal kickback and financial arrangements, and referral scheme, the Defendants caused bills to be submitted through Kim PC to GEICO for medically unnecessary trigger point injections, often purportedly provided by the Defendants on or about the same dates they purported to subject the Insureds to initial or follow-up examinations and putative “outcome assessment testing”.

155. The purpose of these medically unnecessary injections was to enrich the Defendants as the injections were performed regardless of the Insureds’ symptoms or complaints.

156. The Defendants then billed the trigger point injections to GEICO through Kim PC under CPT codes 20553 and 20550, generally resulting in charges of between \$110.85 and \$131.01 for each round of trigger point injections that they purported to provide.

157. All of the billing submitted to GEICO by the Defendants for the putative trigger point injections represented that Kim performed each and every billed-for injection.

158. Like the Defendants’ charges for the other Fraudulent Services, the charges for the trigger point injections were fraudulent in that the trigger point injections were medically unnecessary and were performed – to the extent they were performed at all – pursuant to illegal kickbacks and the fraudulent treatment protocol established by the Defendants.

(i) Legitimate Use of Trigger Point Injections

159. 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.

160. 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.

161. Any legitimate trigger point treatment should begin with conservative therapies such as bed rest, active exercises, physical therapy, heating or cooling modalities, massage, and basic, non-steroidal, anti-inflammatory analgesic, such as ibuprofen or naproxen sodium.

162. In a legitimate trigger point treatment, trigger point injections should not be administered until a patient has pain symptoms that have persisted for more than three months and has failed or been intolerant of conservative therapies for at least one month.

163. In a legitimate trigger point treatment, trigger point injections should not be administered more than once every two months, or more than six times in any given year. This is because: (i) properly administered trigger point injections should provide pain relief lasting for at least two months; and (ii) if a patient's pain is not relieved through the injections, the pain may be caused by something other than a trigger point, and the perpetuating factors of the pain must be identified and managed.

(ii) The Defendants' Medically Unnecessary Trigger Point Injections

164. The Defendants typically did not wait until any Insured failed conservative therapies before purporting to provide trigger point injections.

165. Instead, the Defendants frequently purported to provide trigger point injections to Insureds within the first week or two – and often within days – after the Insureds' automobile accidents, before the Insureds could have had pain symptoms that persisted for more than three months and before the Insureds could have failed or been intolerant of conservative therapies for at least one month.

166. For example:

- (i) On June 19, 2021, an Insured named HK was involved in an automobile accident. Just 10 days later, on June 29, 2021, the Defendants purported to provide a trigger point injection to HK, which they billed to GEICO through Kim PC, despite the fact that HK could not have – by that point – experienced “persistent” pain symptoms or failed a course of conservative therapy;
- (ii) On July 19, 2021, an Insured named MK was involved in an automobile accident. Just one week later, on July 26, 2021, the Defendants purported to provide a trigger point injection to MK, which they billed to GEICO through Kim PC, despite the fact that MK could not have – by that point – experienced “persistent” pain symptoms or a failed course of conservative therapy;
- (iii) On August 4, 2021, an Insured named RM were involved in an automobile accident. Just five days later, on August 9, 2021, the Defendants purported to provide a trigger point injection to RM which they billed to GEICO through Kim PC, despite the fact that RM could not have – by that point – experienced “persistent” pain symptoms or a failed course of conservative therapy;
- (iv) On August 11, 2021, an Insured named AB was involved in an automobile accident. Just five days later, on August 16, 2021, the Defendants purported to provide a trigger point injection to AB, which they billed to GEICO through Kim PC, despite the fact that AB could not have – by that point – experienced “persistent” pain symptoms or a failed course of conservative therapy;
- (v) On August 11, 2021, an Insured named ND was involved in an automobile accident. Just five days later, on August 16, 2021, the Defendants purported to provide a trigger point injection to ND, which they billed to GEICO through Kim PC, despite the fact that ND could not have – by that point – experienced “persistent” pain symptoms or a failed course of conservative therapy;
- (vi) On August 22, 2021, an Insured named MT was involved in an automobile accident. Just nine days later, on August 31, 2021, the Defendants purported to provide a trigger point injection to MT, which they billed to GEICO through Kim PC, despite the fact that MT could not have – by that point – experienced “persistent” pain symptoms or a failed course of conservative therapy;
- (vii) On December 20, 2022, an Insured named NM was involved in an automobile accident. The next day, December 21, 2021, the Defendants

purported to provide a trigger point injection to NM, which they billed to GEICO through Kim PC, despite the fact that NM could not have – by that point – experienced “persistent” pain symptoms or a failed course of conservative therapy;

- (viii) On December 22, 2022, an Insured named SP was involved in an automobile accident. Just six days later, on December 28, 2022, the Defendants purported to provide a trigger point injection to SP, which they billed to GEICO through Kim PC, despite the fact that SP could not have – by that point – experienced “persistent” pain symptoms or a failed course of conservative therapy;
- (ix) On January 5, 2023, an Insured named JM was involved in an automobile accident. That same day, the Defendants purported to provide a trigger point injection to JM, which they billed to GEICO through Kim PC, despite the fact that JM could not have – by that point – experienced “persistent” pain symptoms or a failed course of conservative therapy; and
- (x) On February 4, 2023, an Insured named HP was involved in an automobile accident. Just two days later, on February 6, 2023, the Defendants purported to provide a trigger point injection to HP, which they billed to GEICO through Kim PC, despite the fact that HP could not have – by that point – experienced “persistent” pain symptoms or a failed course of conservative therapy.

167. These are only representative examples.

168. In the claims for trigger point injections identified in Exhibit “1”, the Defendants routinely purported to provide trigger point injections to Insureds within the first week or two – and often within days – after the Insureds’ automobile accidents, before the Insureds could have had pain symptoms that persisted for more than three months and before the Insureds could have failed or been intolerant of conservative therapies for at least one month.

D. The Fraudulent Billing for Independent Contractor Services

169. The Defendants’ fraudulent scheme also included the submission of claims to GEICO on behalf of Kim PC seeking payment for services provided by independent contractors.

170. Under the New York no-fault insurance laws, professional corporations are ineligible to bill for or receive payment for goods or services provided by independent contractors

– the healthcare services must be provided by the professional corporations, themselves, or by their employees.

171. Since 2001, the New York State Insurance Department consistently has reaffirmed its longstanding position that professional corporations are not entitled to receive reimbursement under the New York no-fault insurance laws for healthcare providers performing services as independent contractors. See DOI Opinion Letter, February 21, 2001 (“where the health services are performed by a provider who is an independent contractor with the PC and is not an employee under the direct supervision of a PC owner, the PC is not authorized to bill under No-Fault as a licensed provider of those services”); DOI Opinion Letter, February 5, 2002 (refusing to modify position set forth in 2-21-01 Opinion letter despite a request from the New York State Medical Society); DOI Opinion Letter, March 11, 2002 (“If the physician has contracted with the PC as an independent contractor, and is not an employee or shareholder of the PC, such physician may not represent himself or herself as an employee of the PC eligible to bill for health services rendered on behalf of the PC, under the New York Comprehensive Motor Vehicle Insurance Reparations Act...”); DOI Opinion Letter, October 29, 2003 (extending the independent contractor rule to hospitals); DOI Opinion Letter, March 21, 2005 (DOI refused to modify its earlier opinions based upon interpretations of the Medicare statute issued by the CMS).

172. The healthcare professionals and/or technicians working on behalf of Kim PC worked without any legitimate supervision by Kim.

173. The healthcare professionals and/or technicians working on behalf of Kim PC did not exclusively provide services for Kim PC.

174. To the extent that they were performed in the first instance, all of the Fraudulent Services performed by healthcare services providers other than Kim were performed by healthcare professionals and/or technicians whom the Defendants treated as independent contractors.

175. For instance, the Defendants:

- (i) paid the health care professionals and/or technicians, either in whole or in part, on a 1099 basis rather than a W-2 basis;
- (ii) established an understanding with the health care professionals and/or technicians that they were independent contractors, rather than employees;
- (iii) paid no employee benefits to the health care professionals and/or technicians;
- (iv) failed to secure and maintain W-4 or I-9 forms for the health care professionals and/or technicians;
- (v) failed to withhold federal, state, or city taxes on behalf of the health care professionals and/or technicians;
- (vi) compelled the health care professionals to pay for their own malpractice insurance at their own expense;
- (vii) permitted the health care professionals and/or technicians to set their own schedules and days on which they desired to perform services;
- (viii) permitted the health care professionals and/or technicians to maintain non-exclusive relationships and perform services for their own practices and/or on behalf of other practices;
- (ix) failed to cover the health care professionals and/or technicians for either unemployment or workers' compensation benefits; and
- (x) "filed corporate and payroll tax returns (e.g., Internal Revenue Service ("IRS") forms 1120 and 941 and New York State NYS-45 WEB Forms) that did not report: (i) all of the monies they paid for the services of the healthcare professionals and/or technicians; and/or (ii) the identity of each healthcare professional and/or technician who performed the Fraudulent Services, to the extent Defendants included a list of "employees" with their filings.

176. By electing to treat the healthcare professionals as independent contractors, the Defendants realized significant economic benefits – for instance:

- (i) avoiding the obligation to collect and remit income tax as required by 26 U.S.C. § 3102;
- (ii) avoiding payment of the FUTA excise tax required by 26 U.S.C. § 3301 (6.2 percent of all income paid);
- (iii) avoiding payment of the FICA excise tax required by 26 U.S.C. § 3111 (7.65 percent of all income paid);
- (iv) avoiding payment of workers' compensation insurance as required by New York Workers' Compensation Law § 10;
- (v) avoiding the need to secure any malpractice insurance; and
- (vi) avoiding claims of agency-based liability arising from work performed by the health care professionals.

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

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

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

180. All of the billing submitted by the Defendants through Kim PC to GEICO represented that Kim performed the billed-for services on behalf of Kim PC.

181. In reality, many of the Fraudulent Services were performed – to the extent they were performed at all – by independent contractors.

182. In keeping with the fact that many of the Fraudulent Services were performed by independent contractors, rather than by Kim or an employee of Kim PC, the Defendants frequently billed GEICO for services purportedly performed by Kim at multiple locations in a single day.

183. However, during a July 19, 2023 examination under oath, Kim testified that he never treated patients on behalf of Kim PC at more than one location in a single day.

184. Even so, the Defendants frequently submitted billing to GEICO that falsely represented that Kim had performed services at multiple locations in a single day, including, for example:

- (i) On January 29, 2021, the Defendants submitted 12 separate charges to GEICO for services purportedly provided through Kim PC at two separate locations. All of the Defendants' billing on this date falsely represented that Kim had personally performed the billed-for services, despite the fact that Kim testified that he never treated patients at more than one location in a single day;
- (ii) On September 8, 2021, the Defendants submitted 20 separate charges to GEICO for services purportedly provided through Kim PC at two separate locations. All of the Defendants' billing on this date falsely represented that Kim had personally performed the billed-for services, despite the fact that Kim testified that he never treated patients at more than one location in a single day;
- (iii) On May 5, 2022, the Defendants submitted 14 separate charges to GEICO for services purportedly provided through Kim PC at two separate locations. All of the Defendants' billing on this date falsely represented that Kim had personally performed the billed-for services, despite the fact that Kim testified that he never treated patients at more than one location in a single day;
- (iv) On June 27, 2022, the Defendants submitted six separate charges to GEICO for services purportedly provided through Kim PC at two separate locations. All of the Defendants' billing on this date falsely represented that Kim had personally performed the billed-for services, despite the fact that Kim testified that he never treated patients at more than one location in a single day; and
- (v) On September 6, 2022, the Defendants submitted 47 separate charges to GEICO for services purported provided through Kim PC at two separate

locations. All of the Defendants' billing on this date falsely represented that Kim had personally performed the billed-for services, despite the fact that Kim testified that he never treated patients at more than one location in a single day.

185. These are only representative examples.

186. In the claims identified in Exhibit "1", the Defendants frequently submitted billing to GEICO that falsely represented that Kim had performed services at multiple locations in a single day, despite the fact that Kim testified that he never treated patients at more than one location in a single day.

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

187. To support their fraudulent charges, the Defendants systematically submitted or caused to be submitted hundreds of NF-3, HCFA-1500 forms, and/or treatment reports through Kim PC to GEICO seeking payment for the Fraudulent Services for which the Defendants were not entitled to receive payment.

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

- (i) The HCFA-1500 forms and supporting documentation submitted by and on behalf of the Defendants uniformly misrepresented to GEICO that the Fraudulent Services were medically necessary. In fact, the Fraudulent Services, to the extent provided at all, were not medically necessary and were provided pursuant to pre-determined fraudulent protocols designed solely to financially enrich Defendants, rather than to treat or otherwise benefit the Insureds;
- (ii) The HCFA-1500 forms and supporting documentation submitted to GEICO by and on behalf of Defendants uniformly misrepresented and exaggerated the level of the Fraudulent Services and the nature of the Fraudulent Services that purportedly were provided;
- (iii) The HCFA-1500 forms, and treatment reports submitted by and on behalf of the Defendants uniformly fraudulently concealed the fact that the Fraudulent Services were provided – to the extent provided at all – pursuant to illegal kickback arrangements amongst the Defendants and others;

- (iv) The HCFA-1500 forms and supporting documentation submitted to GEICO by and on behalf of Defendants fraudulently concealed that the Fraudulent Services were performed – to the extent performed at all – by independent contractors rather than employees of Kim PC; and
- (v) The HCFA-1500 forms, and treatment reports submitted by, and on behalf of, the Defendants uniformly misrepresented to GEICO that the Defendants were eligible to receive PIP Benefits pursuant to Insurance Law § 5102(a)(1) and 11 N.Y.C.R.R. § 65-3.11 for the services that supposedly were performed. In fact, the Defendants were not eligible to seek or pursue collection of PIP Benefits for the services that supposedly were performed.

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

189. 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.

190. To induce GEICO to promptly pay the fraudulent charges for the Fraudulent Services, Defendants systematically concealed their fraud and went to great lengths to accomplish this concealment.

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

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

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

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

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

196. 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 \$450,000.00 based upon the fraudulent charges.

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

FIRST CAUSE OF ACTION

Kim PC

(Declaratory Judgment – 28 U.S.C. §§ 2201 and 2202)

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

199. There is an actual case in controversy between GEICO and Kim PC regarding more than \$250,000.00 in fraudulent billing for the Fraudulent Services that has been submitted to GEICO.

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

201. Kim PC has no right to receive payment for any pending bills submitted to GEICO because the billing codes used for the Fraudulent Services – to the extent they were provided at all – misrepresented and exaggerated the level of services that purportedly were provided in order to inflate the charges submitted to GEICO.

202. Kim PC has no right to receive payment for any pending bills submitted to GEICO because the Fraudulent Services were provided – to the extent they were provided at all – pursuant to illegal kickback payments made in exchange for patient referrals.

203. Kim PC has no right to receive payments for any pending bills submitted to GEICO because the Fraudulent Services were provided – to the extent they were provided at all – by independent contractors rather than employees of Kim PC.

204. Kim PC has no right to receive payments for its pending bills submitted to GEICO because, in many instances, the Fraudulent Services were never legitimately provided in the first place.

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

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

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

207. Kim PC is an ongoing “enterprise,” as that term is defined in 18 U.S.C. § 1961(4), that engages in activities which affect interstate commerce.

208. Kim knowingly has conducted and/or participated, directly or indirectly, in the conduct of Kim PC’s affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, based upon the use of the United States mails to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments that Kim PC was not eligible to receive under the No-Fault Laws because: (i) the billed-for-services were not medically necessary; (ii) the billed-for-services were performed and billed pursuant to a pre-determined, fraudulent treatment and billing protocol designed solely to enrich Defendants; (iii) the billing codes used for the services misrepresented and exaggerated the level of services that purportedly were provided in order to inflate the charges that could be submitted; (iv) in many instances, the Fraudulent Services were never legitimately provided in the first place; (v) Kim PC obtained its patients through the Defendants’ illegal

kickback scheme; and (vi) the billed-for services were performed, to the extent they were provided at all, by independent contractors rather than Kim PC's employees. The fraudulent billings and corresponding mailings submitted to GEICO that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit "1."

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

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

211. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$450,000.00 pursuant to the fraudulent bills submitted by the Defendants through Kim PC.

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

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

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

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

215. Kim PC is an ongoing “enterprise,” as that term is defined in 18 U.S.C. § 1961(4), that engaged in activities which affected interstate commerce.

216. Kim and the John Doe Defendants are employed by and/or associated with the Kim PC enterprise.

217. Kim and the John Doe Defendants knowingly have agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of Kim PC’s affairs through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, based upon the use of the United States mails to submit or cause to be submitted hundreds of fraudulent charges on a continuous basis for over two years seeking payments that Kim PC was not eligible to receive under the No-Fault Laws because: (i) the billed-for-services were not medically necessary; (ii) the billed-for-services were performed and billed pursuant to a pre-determined, fraudulent treatment and billing protocol designed solely to enrich Defendants; (iii) the billing codes used for the services misrepresented and exaggerated the level of services that purportedly were provided in order to inflate the charges that could be submitted; (iv) in many instances, the Fraudulent Services were never legitimately provided in the first place; (v) Kim PC obtained its patients through the Defendants’ illegal kickback scheme; and (vi) the billed-for services were performed, to the extent they were provided at all, by independent contractors rather

than Kim PC's employees. The fraudulent bills and corresponding mailings submitted to GEICO that comprise the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as Exhibit "1".

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

219. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$450,000.00 pursuant to the fraudulent bills submitted by Defendants through Kim PC.

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

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

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

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

223. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that the billed-for services were medically necessary, when in fact the billed-for services were not medically necessary and were performed and billed pursuant to a pre-determined, fraudulent protocol designed solely to enrich the Defendants;

(ii) in every claim, the representation that the billed-for services were properly billed in accordance with the Fee Schedule, when in fact the billing codes used for the billed-for services misrepresented and exaggerated the level and type of services that purportedly were provided in order to inflate the charges submitted to GEICO; (iii) in every claim, the representation that the billed-for services were performed by Kim when, in fact, they were performed - to the extent they were performed at all - by independent contractors; and (iv) in many claims, the representation that the billed-for services were legitimately provided in the first place, when, in fact, they were not.

224. The Defendants intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induce GEICO to pay charges submitted through Kim PC that were not compensable under the No-Fault Laws.

225. GEICO has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$450,000.00 pursuant to the fraudulent bills submitted by Defendants through Kim PC.

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

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

FIFTH CAUSE OF ACTION
Against All Defendants
(Unjust Enrichment)

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

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

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

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

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

233. By reason of the above, the Defendants have been unjustly enriched in an amount to be determined at trial, but in no event less than \$450,000.00.

JURY DEMAND

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

WHEREFORE, Plaintiffs Government Employees Insurance Company, GEICO Indemnity Company, GEICO General Insurance Company and GEICO Casualty Company demand that a Judgment be entered in their favor:

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

B. On the Second Cause of Action against Kim, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$450,000.00, 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 Kim and the John Doe Defendants, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$450,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

D. On the Fourth Cause of Action against the Defendants, compensatory damages in favor of GEICO in an amount to be determined at trial but in excess of \$450,000.00, together with punitive damages, costs, interest, and such other and further relief as this Court deems just and proper; and

E. On the Fifth Cause of Action against the Defendants, more than \$450,000.00 in compensatory damages, plus costs and interest and such other and further relief as this Court deems just and proper.

Dated: February 12, 2024

RIVKIN RADLER LLP

By: /s/ Barry I. Levy

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