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UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF NEW YORK

-----X  
LIBERTY MUTUAL INSURANCE COMPANY, LIBERTY  
MUTUAL FIRE INSURANCE COMPANY, LIBERTY INSURANCE  
CORPORATION, THE FIRST LIBERTY INSURANCE CORPORATION,  
LM INSURANCE CORPORATION, LIBERTY MUTUAL MID-  
ATLANTIC INSURANCE COMPANY, LIBERTY COUNTY MUTUAL  
INSURANCE COMPANY, LM PROPERTY and CASUALTY  
INSURANCE COMPANY, SAFECO COMPANY OF INDIANA, and  
AMERICAN STATES INSURANCE COMPANY,

Docket  
No.: \_\_\_\_\_ ( )

Plaintiffs,

**Plaintiff Demands  
a Trial by Jury**

-against-

RHS CHIROPRACTIC, P.C., RICHARD STERNBERG, D.C.,  
TERRA CHIROPRACTIC, P.C., MARIO DUQUE, D.C., PIVOTAL  
CARE PHYSICAL THERAPY, P.C., MUHAMMAD USMAN, P.T.,  
INNA LEVTSENKO NURSE PRACTITIONER IN ADULT HEALTH,  
P.C., INNA LEVTSENKO, N.P., 406 MEDICAL, P.C., EASTERN  
PARKWAY MEDICAL HEALTH SERVICES, P.C., CATHY DELERME-  
PAGAN, M.D., REGINA SHAKAROVA, ALEKSANDER GULKAROV,  
PETER KHAIMOV, ANTHONY DIPIETRO, CLARISSA FELIX a/k/a  
CLARISSA TAVARES, ROMAN ISRAILOV a/k/a ROMAN  
SHAKAROVA, ILONA FRATKIS, and JOHN DOE DEFENDANTS “1” –  
“10”,

Defendants.

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## **COMPLAINT**

Plaintiffs Liberty Mutual Insurance Company, Liberty Mutual Fire Insurance Company, Liberty Insurance Corporation, The First Liberty Insurance Corporation, LM Insurance Corporation, Liberty Mutual Mid-Atlantic Insurance Company, Liberty County Mutual Insurance Company, LM Property and Casualty Insurance Company, Safeco Company of Indiana, and American States Insurance Company (collectively “Liberty Mutual” or “Plaintiffs”), as and for their Complaint against Defendants, hereby allege as follows:

### **NATURE OF THE ACTION**

1. This action seeks to recover more than \$375,000.00 that Defendants have wrongfully obtained from Liberty Mutual by submitting and/or causing to be submitted, thousands of fraudulent no-fault insurance charges relating to medically unnecessary, illusory, and otherwise unreimbursable healthcare services, including initial and follow-up examinations, electrodiagnostic testing, outcome assessment testing, physical therapy services, chiropractic services, extracorporeal shockwave therapy (“ESWT”), disability examinations, and referrals for durable medical equipment (“DME”) and pharmaceuticals (collectively, the “Fraudulent Services”), allegedly provided to New York automobile accident victims covered by policies of insurance issued by Liberty Mutual (“Insureds”).

2. The Fraudulent Services are the byproduct of a scheme perpetrated by the Defendants at two purported medical “clinics”, the first of which is located at 160-59 Rockaway Boulevard, Queens, New York (the “160-59 Rockaway Clinic”) and the second of which is located at 409 Rockaway Boulevard, Queens, New York (the “409 Rockaway Clinic”) (collectively, the “Clinics”), and both of which are illegally owned and controlled by unlicensed laypersons. To effectuate the scheme, the unlicensed laypersons illegally controlled various healthcare

professional corporations and the Clinics, and then used their control of the professional corporations to implement a fraudulent, predetermined treatment protocol in order to enrich themselves by exploiting the Insureds' "no-fault" insurance benefits.

3. As part of the fraudulent scheme, Defendants billed Liberty Mutual and the New York automobile industry for a laundry-list of unnecessary treatments. In fact, Liberty Mutual has received billing for alleged treatments rendered to Insureds at the Clinics during the past five (5) years from a "revolving door" of more than forty (40) separately named healthcare providers at the 409 Rockaway Clinic and more than fifty-five (55) separately named healthcare providers at the 160-59 Rockaway Clinic, including Defendants RHS Chiropractic, P.C. ("RHS Chiropractic"), Terra Chiropractic, P.C. ("Terra Chiropractic"), Pivotal Care Physical Therapy, P.C. ("Pivotal Care"), Inna Levtsenko Nurse Practitioner in Adult Health, P.C. ("Levtsenko P.C."), 406 Medical, P.C. ("406 Medical"), and Eastern Parkway Medical Health Services, P.C. ("Eastern Parkway") (collectively, the "Provider Defendants").

4. Liberty Mutual brings this action to recover more than \$375,00.000 that has been wrongfully obtained from it along with a declaration that it is not legally obligated to pay reimbursement of more than \$345,000.00 in pending No-Fault insurance claims that have been submitted by or on behalf of the Provider Defendants because they were ineligible for payment for one or more of the following reasons:

- (i) the Provider Defendants were fraudulently and unlawfully controlled and/or operated by unlicensed laypersons;
- (ii) the Provider Defendants submitted claims for Fraudulent Services that were not medically necessary and were provided – to the extent that they were 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;

- (iii) the Provider Defendants submitted claims for Fraudulent Services using billing codes that misrepresented and exaggerated the level of services that purportedly were provided in order to inflate the charges submitted to Liberty Mutual;
- (iv) in many cases, the Fraudulent Services were unlawfully provided – to the extent that they were provided at all – by independent contractors rather than by the Provider Defendants or their employees; and
- (v) Terra Chiropractic engaged in illegal kickback and referral arrangements with unlicensed individuals and entities as part of a scheme to defraud New York automobile insurers.

5. The Defendants fall into the following categories:

- (i) The Provider Defendants were medical, chiropractic, and physical therapy, professional corporations through which the Fraudulent Services purportedly were performed and billed to New York automobile insurance companies, including Liberty Mutual.
- (ii) Richard Sternberg, D.C. (“Sternberg”), Mario Duque, D.C. (“Duque”), Muhammad Usman, P.T. (“Usman”), Inna Levtsenko, N.P. (“Levtsenko”), and Cathy Delerme-Pagan, M.D. (“Delerme Pagan”) (collectively, the “Nominal Owner Defendants”) are all licensed healthcare professionals who falsely purport to own and control the Provider Defendants.
- (iii) Defendants Regina Shakarova (“Regina”), Aleksander Gulkarov (“Gulkarov”), Peter Khaimov (“Khaimov”), Anthony DiPietro (“DiPietro”), Clarrisa Felix a/k/a Clarissa Tavares (“Clarissa”), Roman Israilov a/k/a/ Roman Shakarova (“Roman”), Ilona Fratkis (“Fratkis”) along with the John Doe Defendants “1” through “10” (the “John Doe Defendants”)(collectively, the “Management Defendants”) secretly and unlawfully control and/or derive economic benefit from the Provider Defendants in contravention of New York law. Through their illegal ownership and/or control of the Provider Defendants, the Management Defendants engaged in collusive referral and financial arrangements and caused Insureds to be referred by and amongst the Provider Defendants for the sole purpose of exploiting the Insureds’ No-Fault benefits. The Management Defendants are persons who are not and never have been licensed healthcare professionals.
- (iv) John Doe Defendants “1” – “10” are unlicensed persons and entities who are presently not identifiable, but who are associated with the Management Defendants to illegally control the Provider Defendants, and who have been involved in the fraudulent scheme committed against Liberty Mutual and

other New York automobile insurers, along with the other Management Defendants named herein.

6. As discussed below, Defendants at all relevant times have known that: (i) the Provider Defendants were unlawfully controlled by unlicensed laypersons; (ii) the Fraudulent Services were not medically necessary and provided – to the extent provided at all – pursuant to predetermined fraudulent protocols designed solely to financially enrich Defendants, rather than to treat or otherwise benefit the Insureds who purportedly are subjected to them; (iii) the billing codes the Defendants used for purposes of billing the Fraudulent Services misrepresented and exaggerated the level of services that are purportedly provided in order to inflate the charges submitted to Liberty Mutual; (iv) in many instances, the Fraudulent Services were unlawfully provided – to the extent provided at all – by independent contractors, rather than by employees of the Provider Defendants; and (v) Terra Chiropractic engaged in illegal kickback payments and referrals with the Management Defendants, as part of a scheme to defraud New York automobile insurers.

7. As such, Defendants do not have any right to be compensated for the Fraudulent Services that have been billed to Liberty Mutual through the Provider Defendants.

8. The charts annexed hereto as Exhibits “1” – “6” set forth the fraudulent claims that have been identified to-date that Defendants have submitted, or caused to be submitted, to Liberty Mutual.

9. The Defendants’ fraudulent scheme began as early as 2020 and continues uninterrupted through the present day. As a result of Defendants’ scheme, Liberty Mutual has incurred damages of more than \$375,000.00.

## **THE PARTIES**

### **I. Plaintiffs**

10. Plaintiffs Liberty Mutual Insurance Company and Liberty Mutual Mid-Atlantic Insurance Company are Massachusetts corporations with their principal place of business in Boston, Massachusetts. Liberty Mutual Insurance Company and Liberty Mutual Mid-Atlantic Insurance Company are authorized to conduct business and to issue policies of automobile insurance in the State of New York.

11. Plaintiffs Liberty Insurance Corporation, The First Liberty Insurance Corporation and LM Insurance Corporation are Illinois corporations with their principal place of business in Boston, Massachusetts. Liberty Insurance Corporation, The First Liberty Insurance Corporation and LM Insurance Corporation are authorized to conduct business and to issue policies of automobile insurance in the State of New York.

12. Plaintiff Liberty Mutual Fire Insurance Company is a Wisconsin corporation with its principal place of business in Boston, Massachusetts. Liberty Mutual Fire Insurance Company is authorized to conduct business and to issue policies of automobile insurance in the State of New York.

13. Plaintiff Liberty County Mutual Insurance Company is a Texas corporation with its principal place of business in Boston, Massachusetts. Liberty County Mutual Insurance Company is authorized to conduct business and to issue policies of automobile insurance in the State of New York.

14. Plaintiffs LM Property and Casualty Insurance Company, Safeco Company of Indiana, and American States Insurance Company are Indiana corporations with its principal place of business in Boston, Massachusetts. LM Property and Casualty Insurance Company, Safeco

Company of Indiana, and American States Insurance Company are authorized to conduct business and to issue policies of automobile insurance in the State of New York.

## **II. Defendants**

15. Defendant RHS Chiropractic is a New York chiropractic professional corporation, incorporated on or about October 16, 2019, with its principal place of business in New York. RHS operated from the 160-59 Rockaway Clinic and was used by Defendants to submit billing for the Fraudulent Services to automobile insurance companies, including Liberty Mutual.

16. Defendant Sternberg resides in and is a citizen of New York. Sternberg became a licensed chiropractor in New York on or about January 13, 1998, and purports to own RHS Chiropractic.

17. Defendant Terra Chiropractic is a New York chiropractic professional corporation incorporated on or about March 16, 2021, with its principal place of business in New York. Terra Chiropractic operated from the 160-59 Rockaway Clinic and was used by Defendants to submit billing for the Fraudulent Services to automobile insurance companies, including Liberty Mutual.

18. Defendant Duque resides in and is a citizen of New York. Duque became a licensed chiropractor in New York on or about September 18, 1998, and purports to own Terra Chiropractic.

19. Defendant Pivotal Care is a New York physical therapy professional corporation incorporated on or about December 21, 2021, with its principal place of business in New York. Pivotal Care operated out of both Clinics and was used by Defendants to submit billing for the Fraudulent Services to automobile insurance companies, including Liberty Mutual.

20. Defendant Usman resides in and is a citizen of New York. Usman became a licensed physical therapist in New York on or about March 2, 2016, and purports to own Pivotal Care.

21. Defendant Levtsenko P.C. is a New York medical professional corporation incorporated on or about August 30, 2017, with its principal place of business in New York. Levtsenko P.C. operated out of the 160-59 Rockaway Clinic and was used by Defendants to submit billing for the Fraudulent Services to automobile insurance companies, including Liberty Mutual.

22. Defendant Levtsenko resides in and is a citizen of New York. Levtsenko became a licensed nurse practitioner in New York on or about March 11, 2015, and purports to own Levtsenko P.C.

23. Defendant 406 Medical is a New York medical professional corporation incorporated on or about September 16, 2016, with its principal place of business in New York. 406 Medical operated out of the 409 Rockaway Clinic and was used by Defendants to submit billing for the Fraudulent Services to automobile insurance companies, including Liberty Mutual.

24. Defendant Eastern Parkway is a New York medical professional corporation incorporated on or about April 22, 2019, with its principal place of business in New York. Eastern Parkway operated out of the 409 Rockaway Clinic and was used by Defendants to submit billing for the Fraudulent Services to automobile insurance companies, including Liberty Mutual.

25. Defendant Delerme-Pagan resides in and is a citizen of New York. Delerme-Pagan became a licensed physician in New York on or about April 12, 1995, and purports to own 406 Medical and Eastern Parkway.

26. Defendant Regina resides in and is a citizen of New York. Regina is a non-physician who, at all times, conspired and participated in the fraudulent scheme outlined in this Complaint, including: (i) illegally controlling the Clinics and the Provider Defendants with others, including the Management Defendants, (ii) engaging in illegal referral arrangements, and (iii)

establishing and implementing a predetermined fraudulent treatment and billing protocol to support the excessive rendering and billing of the medically unnecessary Fraudulent Services.

27. Defendant Gulkarov resides in and is a citizen of New York. Gulkarov is a non-physician who, at all times, conspired and participated in the fraudulent scheme outlined in this Complaint, including: (i) illegally controlling the Clinics and the Provider Defendants with others, including the Management Defendants, (ii) engaging in illegal referral arrangements, and (iii) establishing and implementing a predetermined fraudulent treatment and billing protocol to support the excessive rendering and billing of the medically unnecessary Fraudulent Services.

28. Defendant Khaimov resides in and is a citizen of New York. Khaimov is the owner of A&P Rockaway, L.L.C. (“A&P Rockaway”), which is the company that leases space at the 409 Rockaway Clinic. Khaimov is a non-physician who, at all times, conspired and participated in in the fraudulent scheme outlined in this Complaint, including: (i) illegally controlling the Clinics and the Provider Defendants with others, including the Management Defendants, (ii) engaging in illegal referral arrangements, and (iii) establishing and implementing a predetermined fraudulent treatment and billing protocol to support the excessive rendering and billing of the medically unnecessary Fraudulent Services.

29. Defendant DiPietro resides in and is a citizen of New York. DiPietro is a non-physician who, at all times, conspired and participated in the fraudulent scheme outlined in this Complaint, including: (i) illegally controlling the Clinics and the Provider Defendants with others, including the Management Defendants, (ii) engaging in illegal referral arrangements, and (iii) establishing and implementing a predetermined fraudulent treatment and billing protocol to support the excessive rendering and billing of the medically unnecessary Fraudulent Services.

30. Defendant Clarissa resides in and is a citizen of New York. Clarissa is a non-physician who, at all times, conspired and participated in the fraudulent scheme outlined in this Complaint, including: (i) illegally controlling the Clinics and the Provider Defendants with others, including the Management Defendants, (ii) engaging in illegal referral arrangements, and (iii) establishing and implementing a predetermined fraudulent treatment and billing protocol to support the excessive rendering and billing of the medically unnecessary Fraudulent Services.

31. Defendant Roman resides in and is a citizen of New York. Roman is a non-physician who, at all times, conspired and participated in the fraudulent scheme outlined in this Complaint, including: (i) illegally controlling the Clinics and the Provider Defendants with others, including the Management Defendants, (ii) engaging in illegal referral arrangements, and (iii) establishing and implementing a predetermined fraudulent treatment and billing protocol to support the excessive rendering and billing of the medically unnecessary Fraudulent Services.

32. Defendant Fratkis resides in and is a citizen of New York. Fratkis is a non-physician who, at all times, , conspired and participated in the fraudulent scheme outlined in this Complaint, including: (i) illegally controlling the Clinics and the Provider Defendants with others, including the Management Defendants, (ii) engaging in illegal referral arrangements, and (iii) establishing and implementing a predetermined fraudulent treatment and billing protocol to support the excessive rendering and billing of the medically unnecessary Fraudulent Services.

33. The John Doe Defendants reside in and are citizens of New York. The John Doe Defendants are individuals and entities, presently not identifiable, who are not and never have been licensed healthcare professionals, yet illegally control, and derive economic benefit from the operation of the Clinics and the Provider Defendants in contravention of New York law, and engaged

in illegal referral arrangements with the Provider Defendants and directed the fraudulent, predetermined treatment and billing protocol at the Clinics.

### **JURISDICTION AND VENUE**

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

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

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

### **ALLEGATIONS COMMON TO ALL CLAIMS**

#### **I. An Overview of the No-Fault Laws and Licensing Statutes**

37. Liberty Mutual underwrites automobile insurance in New York.

38. New York’s “No-Fault” laws are designed to ensure that injured victims of motor vehicle accidents have an efficient mechanism to pay for and receive the healthcare services that they need. Under New York’s Comprehensive Motor Vehicle Insurance Reparations Act (N.Y. Ins. Law §§ 5101, et seq.) and the regulations promulgated pursuant thereto (11 N.Y.C.R.R. §§

65, et seq.) (collectively, referred to as the “No-Fault Laws”), automobile insurers are required to provide Personal Injury Protection Benefits (“No-Fault Benefits”) to Insureds.

39. No-Fault Benefits include up to \$50,000.00 per Insured for medically necessary expenses that are incurred for healthcare goods and services.

40. An Insured can assign his or her right to No-Fault Benefits to the provider of healthcare services in exchange for those services.

41. Pursuant to an executed assignment, a healthcare provider may submit claims directly to an insurance company and receive payment for medically necessary services, using the claim form required by the New York State Department of Insurance (known as “Verification of Treatment by Attending Physician or Other Provider of Health Service,” or more commonly, as an “NF-3”). Alternatively, a healthcare provider may a claim using the Health Care Financing Administration insurance claim form (known as the “HCFA-1500 Form”).

42. Under the No-Fault Laws, healthcare providers are not eligible to bill for or collect No-Fault Benefits if they fail to meet any New York State or local licensing requirement necessary to perform the underlying services.

43. Even more, the No-Fault Laws make clear that healthcare service providers are not eligible to receive No-Fault Benefits if they are privy to improper financial relationships associated with their patient referrals, conduct which is prohibited by, inter alia the New York Education Law.

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

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

46. Pursuant to 8 N.Y.C.R.R. § 29.1(b)(3), a licensee is precluded from “directly or indirectly” offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services.

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

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

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

49. In New York, only a licensed healthcare professional may: (i) practice the pertinent healthcare profession; (ii) own and control a professional entity authorized to operate a professional healthcare practice; (iii) employ and supervise other healthcare professionals; and (iv) absent statutory exemptions not applicable in this case, derive economic benefit from healthcare professional services.

50. Unlicensed individuals may not: (i) practice the pertinent healthcare profession; (ii) own or control a professional corporation authorized to operate a professional healthcare practice; (iii) employ or supervise healthcare professionals; or (iv) absent statutory exceptions not applicable in this case, derive economic benefit from professional healthcare services.

51. New York law also prohibits anyone from engaging in for profit, any business or service, which in whole or in part, includes the referring or recommending of persons to a physician, hospital, health related facility, or dispensary for any form of medical care or treatment. See, New York Public Health Law §4501. Similarly, no facility delivering healthcare services shall in any manner engage in financial arrangements with a medical referral service. See, New York Public Health Law §2811.

52. Therefore, under the New York No-Fault Laws, a healthcare service 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 rendered, or if it allows unlicensed laypersons to share in the fees for the professional services.

53. In State Farm Mut. Auto. Ins. Co. v. Mallela, 4 N.Y.3d 313 320, (2005) and Andrew Carothers, M.D., P.C. v. Progressive Ins. Co., 33 N.Y.3d 389 (2019), the New York Court of Appeals made clear that (i) healthcare providers that fail to comply with material licensing requirements are ineligible to collect No-Fault Benefits, and (ii) only licensed providers may practice medicine in New York because of the concern that unlicensed persons are “not bound by ethical rules that govern the quality of care delivered by a physician to a patient.”

54. Pursuant to the No-Fault Laws, only healthcare 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 patients or their healthcare providers. The implementing regulation adopted by the Superintendent of Insurance, 11 N.Y.C.R.R. §65-3.11, states – in pertinent part – as follows:

An insurer shall pay benefits for any element of loss ... directly to the applicant or ... upon assignment by the applicant ... shall pay benefits

directly to providers of healthcare services as covered under section five thousand one hundred two (a)(1) of the Insurance Law ... (emphasis added).

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

56. In New York, claims for No-Fault Benefits are governed by the New York Workers' Compensation Fee Schedule (the "NY Fee Schedule").

57. When a healthcare services provider submits a claim for No-Fault 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.

58. Pursuant to New York Insurance Law § 403, the NF-3 and HCFA-1500 forms submitted by a healthcare provider to Liberty Mutual, and to all other automobile insurers, must be verified by the healthcare provider subject to the following warning:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for instance 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**

59. Beginning in 2020, and continuing through the present day, the Defendants masterminded and implemented a complex fraudulent scheme in which the Provider Defendants – owned on paper by the Nominal Owner Defendants, but actually illegally controlled by the Management Defendants – were used to bill Liberty Mutual and the New York automobile insurance industry for millions of dollars in No-Fault insurance benefits they were never entitled to receive.

60. The Defendants used the Clinics, which were controlled by the Management Defendants, to perpetuate their fraudulent scheme. At these locations, the Provider Defendants were given access to No-Fault patients on behalf of whom the Defendants were able to bill automobile insurers, including Liberty Mutual, for the Fraudulent Services using various corporations.

61. To effectuate the scheme, the Management Defendants colluded with the Nominal Owner Defendants to use the Provider Defendants to implement a fraudulent, pre-determined, billing and treatment protocol that was established by the Management Defendants at the Clinics and designed solely to maximize profits without regard to genuine patient care.

62. Using the Clinics, the Management Defendants' fraudulent scheme included: (i) illegally controlling the Provider Defendants; (ii) engaging with the Nominal Owner Defendants to siphon off the profits from the provider Defendants; (iii) implementing a fraudulent billing and treatment protocol designed solely to maximize profits that the Management Defendants received through the Provider Defendants; and (iv) using the Provider Defendants as vehicles to submit

fraudulent No-Fault billing to Liberty Mutual and other New York automobile insurers pursuant to the pre-determined fraudulent treatment protocol.

63. The Nominal Owner Defendants did not establish their own practices but rather “entered” into Clinics where there were pre-existing patient bases, which were generated and controlled by the Management Defendants.

64. The Nominal Owner Defendants did virtually nothing to advertise or market their association with the Clinics to the general public or otherwise advertise or market their services to the general public. In fact, the Nominal Owner Defendants did virtually nothing to attract patients or create a patient base for their alleged professional “practices” at the Clinics.

65. For example, Delorme-Pagan testified during an examination under oath (“EUO”) of 406 Medical that she does not conduct any advertising or marketing for 406 Medical and does not maintain a website to attract new patients to her practice.

66. Despite failing to publicly market their services, the Provider Defendants each had a steady flow of patients from the moment they began rendering the Fraudulent Services due to the improper financial and referral arrangement with the Management Defendants.

67. The Management Defendants, rather than the Nominal Owner Defendants, created and controlled the Clinics, and controlled the Provider Defendants and the patient base, while concealing themselves as, among other things, purported office managers of the Clinics, in order to avoid detection of the illegal scheme by Liberty Mutual and other automobile insurers.

68. Patients at the Clinics were initially subjected to sham examinations at the direction of the Management Defendants, and, as a result of the phony diagnoses and recommendations listed in the examination reports, were then systematically directed to undergo a course of unnecessary and excessive treatment – including physical therapy, electrodiagnostic testing, and

chiropractic therapy (i.e., the Fraudulent Services) – with various healthcare providers operating from the Clinics, including the Provider Defendants.

69. The Defendants also directed Insureds to treat, or purport to treat with a variety of transient providers, such as Terra Chiropractic, who paid kickbacks to the Management Defendants, generally disguised as rent, in order to access the Clinics' patient base so as to subject Insureds to a host of illusory and unnecessary diagnostic tests and evaluations. These diagnostic tests and evaluations were performed, to the extent performed at all, to allow the Management Defendants to realize additional revenue from the operation of the Clinics, and to justify continued treatment of Insureds with the Provider Defendants so that Defendants could maximize the billing submitted to Liberty Mutual and exploit Insureds' No-Fault Benefits.

70. The Clinics, though ostensibly organized to provide a range of health care services to Insureds at each location, have at all times been under the control of the Management Defendants who organized and created them to be convenient one-stop shops for No-Fault insurance fraud.

71. The Management Defendants used the Provider Defendants at both Clinics simultaneously to maximize their likelihood of getting paid by New York automobile insurers.

**B. The Fraudulent Control and Operation of the Clinics by the Management Defendants**

72. At all relevant times herein, the Management Defendants controlled the Clinics, and unlawfully controlled the healthcare providers operating within the Clinics, including the Provider Defendants.

73. The Nominal Owner Defendants falsely represented in the certificates of incorporation and related filings with New York State that they were the true shareholders, directors, officers, and owners of the Provider Defendants, and that they truly owned, controlled,

and practiced through the professional corporations, knowing that the Provider Defendants would be used to submit fraudulent billing to Liberty Mutual and other New York automobile insurers.

74. Although the Nominal Owner Defendants were listed as the record owners of the Provider Defendants on the certificates of incorporation and billing submissions sent to Liberty Mutual, the Nominal Owner Defendants exercised no genuine ownership or control over the Provider Defendants or the profits that were generated from them.

75. The Nominal Owner Defendants have never been the true shareholders, directors, officers, or owners of the Provider Defendants, and never had any true ownership interest in, or control over their respective professional corporations and practices.

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

77. The Nominal Owner Defendants and the Provider Defendants relied on the Management Defendants for access to patients at the Clinics.

78. The Provider Defendants merely inserted themselves into an existing fraudulent operation at the Clinics and immediately began treating or purporting to treat, patients under the direction and control of the Management Defendants. The Management Defendants ensured that patients would be cultivated and would be waiting to be "treated" by the Provider Defendants, without any effort by the Nominal Owner Defendants.

79. The Nominal Owner Defendants had no genuine doctor-patient relationship with the Insureds that visited the Clinics, as the patients were simply directed by the Management

Defendants to subject themselves to a variety of unnecessary medical treatment by whatever healthcare providers were present that day at the Clinics, regardless of the actual healthcare needs of the patients themselves.

80. Once an Insured arrived at the Clinics for medical treatment, the Management Defendants dictated the scope of the medical and other healthcare services that each patient received from the Provider Defendants, regardless of the true medical needs of the Insured.

81. The Management Defendants established fraudulent pre-determined treatment protocols in order to bill for voluminous, unnecessary, and excessive medical treatments that were provided (or purported to be provided) regardless of the true medical needs of the Insureds.

82. Throughout the course of the Nominal Owner Defendants' relationships with the Management Defendants, all decision-making authority relating to the operation and management of the Provider Defendants rested entirely with the Management Defendants.

83. The Management Defendants' decision-making authority relating to the operating and management of the Clinics and the Provider Defendants, included control over the treatment protocol, including what treatment, testing, and other services Insureds received, the scope of the referrals and prescriptions for goods (such as medication and DME), and/or services the Insureds received, and which healthcare provider would render those services.

84. The Management Defendants' decision-making authority also included control over how the Fraudulent Services were billed to insurers, including Liberty Mutual, who performed the billing services on behalf of the Clinics, and how the profits of the Provider Defendants were to be divided and dispersed.

85. The Management Defendants dictated all of the financial arrangements with the Provider Defendants and concealed the arrangements through individual “sham” agreements with each of the Provider Defendants.

86. The individual agreements and financial arrangements with the Provider Defendants were not reflective of fair market value or the actual value of the services provided, if any, and when totaled among all of the Provider Defendants, reflected a scheme to use each of the Provider Defendants as a vehicle to illegally profit from professional medical services, unlawfully siphon off profits, and funnel large sums of money to themselves in contravention of New York law.

87. As discussed above, the Management Defendants caused the following Defendants to be established at the Clinics during the following years:

	<b>160-59 Rockaway Clinic</b>	<b>409 Rockaway Clinic</b>
2020	<ul style="list-style-type: none"> <li>• RHS Chiropractic (Sternberg)</li> </ul>	
2021	<ul style="list-style-type: none"> <li>• Terra Chiropractic (Duque)</li> </ul>	
2022	<ul style="list-style-type: none"> <li>• Levtsenko, P.C. (Levtsenko)</li> <li>• Pivotal Care (Usman)</li> </ul>	<ul style="list-style-type: none"> <li>• Eastern Parkway (Deleme-Pagan)</li> <li>• 406 Medical (Deleme-Pagan)</li> <li>• Pivotal Care (Usman)</li> </ul>

i. The Fraudulent Ownership and Operation of Eastern Parkway and 406 Medical

92. As an initial step in the fraudulent scheme, the Management Defendants commenced a search for a licensed medical professional who would be willing to sell the use of his or her medical license to the Management Defendants so that the Management Defendants could illegally operate and control medical professional corporations for the purpose of submitting

fraudulent no-fault billing to New York no-fault insurers as well as referring patients for Fraudulent Services allegedly provided by the other Provider Defendants operating at the Clinics.

93. In or about 2022, the Management Defendants recruited Delorme-Pagan, who was a licensed physician who was willing to “sell” them the use of her medical license so that the Management Defendants could fraudulently operate Eastern Parkway and subsequently 406 Medical and use those entities as the main or “gateway” medical practices at the 409 Rockaway Clinic.

94. Although Delorme-Pagan was listed as owner of record of Eastern Parkway and 406 Medical on the certifications of incorporation, Delorme-Pagan exercised no bona-fide ownership or control over the treatments rendered or the profits that were generated from Eastern Parkway or 406 Medical. Rather, the day-to-day operations, supervisory control, and true ownership of Eastern Parkway and 406 Medical rested in the hands of the Management Defendants.

95. In order to circumvent New York law and to induce the New York State Education Department (“Education Department”) to issue certificates of authority authorizing Delorme-Pagan to operate a medical practice, the Management Defendants entered into a secret arrangement with Delorme-Pagan. The Management Defendants used Eastern Parkway and 406 Medical to submit billing for the Fraudulent Services to Liberty Mutual and as a cover to control the 409 Rockaway Clinic through Eastern Parkway’s and subsequently, 406 Medical’s position as the primary leaseholder for the location.

96. In exchange for a designated salary or other form of compensation from the Management Defendants, Delorme-Pagan, agreed to falsely represent in the certificates of incorporation and related filings with New York State, that she was the true shareholder, director,

and officer of Eastern Parkway and 406 Medical and that she truly owned, controlled, and practiced through the professional corporations.

97. Delerme-Pagan agreed to falsely represent in the certificates of incorporation and related filings with New York State that she was the true shareholder, director, and officer of Eastern Parkway and 406 Medical and that she truly owned, controlled, and practiced through the professional corporations, knowing that the professional corporations would be used to submit fraudulent billing to insurers.

98. Delerme-Pagan ceded true beneficial ownership and control over the professional corporations to the Management Defendants.

99. The Management Defendants – rather than Delerme-Pagan – provided all start-up costs and investments in Eastern Parkway and 406 Medical.

100. Delerme-Pagan did not incur any costs to establish the Eastern Parkway or 406 Medical practices, nor did she invest any money in the professional corporations she purportedly owned.

101. The Management Defendants caused Eastern Parkway and 406 Medical to operate from the 409 Rockaway Clinic – a location the Management Defendants controlled – alongside other professional corporations they controlled or would come to control.

102. True ownership and control over Eastern Parkway and 406 Medical always rested entirely with the Management Defendants, who used the facade of Eastern Parkway and 406 Medical to do indirectly what they were forbidden from doing directly, namely: (i) employ healthcare professionals; (ii) control their practices; and (iii) charge for and derive an economic benefit from their services.

103. All decision-making authority relating to the operation and management of Eastern Medical and 406 Medical was vested entirely with the Management Defendants.

104. In addition, Delorme-Pagan never controlled or maintained any of Eastern Parkway or 406 Medical's books or records, including their bank accounts; never selected, directed, and/or controlled any of the individuals or entities responsible for handling any aspect of Eastern Parkway or 406 Medical's financial affairs; never hired or supervised any of Eastern Parkway or 406 Medical's employees; and was completely unaware of the most fundamental aspects of Eastern Parkway and 406 Medical operated.

105. Delorme-Pagan had no genuine involvement in managing the purported "practices" operating from the 409 Rockaway Clinic.

106. By contrast, the extent to which the Management Defendants managed and controlled Eastern Parkway and 406 Medical allowed them to maintain total control over both medical practices, the accounts receivable, and any revenues that might be generated therefrom, all while concealing their illegal ownership and control of Eastern Parkway and 406 Medical.

107. Pursuant to the Management Defendants directive, Eastern Parkway and 406 Medical purportedly performed initial examinations, which they performed as a "gateway" simply to: (i) prescribe unnecessary and expensive pharmaceuticals and DME, as well as (ii) make referrals and recommendations for the other healthcare services provided at the 409 Rockaway Clinic by other transient healthcare providers.

108. The prescriptions and referrals were made regardless of the Insureds' individual symptoms, presentation or even total absence of any medical problems arising from any automobile accident. The Management Defendants benefitted from this unlawful relationship because of: (i) the financial benefit that they realized from the payments made by the Provider

Defendants; and (ii) the fraudulent treatment reports and test results generated by the Provider Defendants, which they then used to support the continuation of the other medically unnecessary services purportedly provided to the Insureds at the Clinics (i.e., chiropractic, physical therapy, etc.) and billed to New York automobile insurers such as Liberty Mutual.

109. Eastern Parkway and 406 Medical were used as vehicles by which the Management Defendants unlawfully siphoned off profits and funneled large sums of money to themselves in contravention of New York law.

ii. The Fraudulent Ownership and Operation of Levtsenko, P.C.

110. Similarly, as an initial step in the fraudulent scheme conducted out of the 160-59 Rockaway Clinic, the Management Defendants commenced a search for a licensed medical professional who would be willing to sell the use of his or her medical license to the Management Defendants so that the Management Defendants could illegally operate and control medical professional corporations for the purpose of submitting fraudulent no-fault billing to New York no-fault insurers as well as referring patients for Fraudulent Services allegedly provided by the other Provider Defendants operating at the 160-59 Rockaway Clinic.

111. In or about 2022, the Management Defendants recruited Levtsenko, a licensed nurse practitioner, who was willing to “sell” them the use of her medical license so that the Management Defendants could fraudulently operate Levtsenko P.C. and use that entity as the main medical practice at the 160-59 Rockaway Clinic.

112. Although Levtsenko was listed as owner of record of Levtsenko P.C., on the certificate of incorporation, Levtsenko exercised no bona-fide ownership or control over the treatments rendered or the profits that were generated from Levtsenko P.C. Rather, the day-to-day

operations, supervisory control, and true ownership of Levtsenko P.C., rested in the hands of the Management Defendants.

113. In order to circumvent New York law and to induce the Education Department to issue certificates of authority authorizing Levtsenko to operate a medical practice, the Management Defendants entered into a secret arrangement with Levtsenko.

114. In exchange for a designated salary or other form of compensation from the Management Defendants, Levtsenko agreed to falsely represent in the certificate of incorporation and related filings with New York State, that she was the true shareholder, director, and officer of Levtsenko P.C. and that she truly owned, controlled, and practiced through the professional corporation.

115. Levtsenko agreed to falsely represent in the certificate of incorporation and related filings with New York State that she was the true shareholder, director, and officer of Levtsenko P.C. and that she truly owned, controlled, and practiced through the professional corporation, knowing that the professional corporation would be used to submit fraudulent billing to insurers.

116. Levtsenko ceded true beneficial ownership and control over the professional corporation to the Management Defendants.

117. The Management Defendants – rather than Levtsenko – provided all start-up costs and investments in Levtsenko P.C.

118. Levtsenko did not incur any costs to establish the Levtsenko P.C. practice, nor did she invest any money in the professional corporation she purportedly owned.

119. The Management Defendants caused Levtsenko P.C. to operate from the 160-59 Rockaway Clinic – a location the Management Defendants controlled – alongside other professional corporations they controlled or would come to control.

120. True ownership and control over Levtsenko P.C. always rested entirely with the Management Defendants, who used the façade of Levtsenko P.C. to do indirectly what they were forbidden from doing directly, namely: (i) employ licensed professionals; (ii) control their practices; and (iii) charge for and derive an economic benefit from their services.

121. All decision-making authority relating to the operation and management of Levtsenko P.C. was vested entirely with the Management Defendants.

122. In addition, Levtsenko never controlled or maintained any of Levtsenko P.C.s books or records, including their bank accounts; never selected, directed, and/or controlled any of the individuals or entities responsible for handling any aspect of Levtsenko P.C.s financial affairs; never hired or supervised any of Levtsenko P.C.s employees; and was completely unaware of the most fundamental aspects of how Levtsenko P.C. operated.

123. Levtsenko had no genuine involvement in managing the purported “practice” operating from the 160-59 Rockaway Clinic.

124. By contrast, the extent to which the Management Defendants managed and controlled Levtsenko P.C., allowed them to maintain total control over the medical practice, the accounts receivable, and any revenues that might be generated therefrom, all while concealing their illegal ownership and control of Levtsenko P.C.

125. Pursuant to the Management Defendants directive, Levtsenko P.C. purportedly performed initial examinations, which they performed as a “gateway” simply to: (i) prescribe unnecessary and expensive pharmaceuticals and DME; as well as (ii) make referrals and recommendations for the other healthcare services provided at the 160-59 Rockaway Clinic by the other Provider Defendants.

126. The prescriptions and referrals were made regardless of the Insureds' individual symptoms, presentation or even total absence of any medical problems arising from any automobile accident. The Management Defendants benefitted from this unlawful relationship because of: (i) the financial benefit that they realized from the payments made by the Provider Defendants; and (ii) the fraudulent treatment reports and test results generated by the Provider Defendants, which they then used to support the continuation of the other medically necessary services purportedly provided to the Insureds at the 160-59 Rockaway Clinic (i.e., chiropractic, physical therapy, etc.) and billed to automobile insurers such as Liberty Mutual.

127. Levtsenko P.C. was used as a vehicle by which the Management Defendants unlawfully siphoned off profits and funneled large sums of money to themselves in contravention of New York law.

iii. The Fraudulent Ownership and Operation of Pivotal Care

128. The same year the Management Defendants enlisted the participation of Levtsenko and Delerme-Pagan in the fraudulent scheme, the Management Defendants commenced a search for licensed physical therapists who would be willing to sell the use of their professional licenses to the Management Defendants so that the Management Defendants could fraudulently incorporate and/or control a physical therapy corporation under the physical therapist's professional's name.

129. Beginning in 2022, the Management Defendants recruited Usman, who was a licensed physical therapist who was willing to sell the Management Defendants the use of his professional license, so that they could fraudulently incorporate and/or control Pivotal Care.

130. Specifically, in 2022, the Management Defendants recruited Usman, a licensed physical therapist who was willing to sell them the use of his physical therapy license so that they

could fraudulently operate Pivotal Care from both the 409 Rockaway Clinic and 160-59 Rockaway Clinic.

131. In order to circumvent New York law preventing non-physical therapy professionals from owning and controlling physical therapy professional corporations, the Management Defendants entered into a secret scheme with Usman, wherein, in exchange for a designated salary or other form of compensation, Usman agreed to falsely represent in the certificates of incorporation and related filings with New York State, that he was the true shareholders, directors, and officers of Pivotal Care and that he truly owned, controlled, and practiced through the professional corporation, knowing that the professional corporation would be used to submit fraudulent billing to insurers.

132. As part of the Management Defendants' arrangement with Usman – the Management Defendants rather than Usman – provided all costs associated with setting up Pivotal Care at the Clinics, Usman did not invest any money in the professional corporation that he allegedly owned after ceding control over the professional corporation to the Management Defendants.

133. As a result, Usman was not the true shareholder, director, or officer of Pivotal Care and had no true ownership interest in or control over the professional corporation. In fact, true ownership, and control over Pivotal Care always rested entirely with the Management Defendants, who used the facade of Pivotal Care to do indirectly what they were forbidden from doing directly, namely: (i) employ physical therapy professionals; (ii) control their practices; and (iii) charge for and derive an economic benefit from their services.

134. Following Usman's decision to cede control of his professional corporation, (i) he exercised absolutely no control over or ownership interest in Pivotal Care, and (ii) all decision-

making authority relating to the operating and management of Pivotal Care was vested entirely with the Management Defendants.

135. In addition, subsequent to the purchase of his physical therapy license by the Management Defendants, Usman did not control or maintain Pivotal Care's or records, including their bank accounts; never selected, directed, and/or controlled any of the individuals or entities responsible for handling any aspect of Pivotal Care's financial affairs; never hired or supervised any of Pivotal Care's employees; and were unaware of fundamental aspects of how Pivotal Care operated.

136. In reality, Usman was never anything more than de facto employees of the Management Defendants.

137. Pivotal Care was used as a vehicle by which the Management Defendants unlawfully siphon off profits and funnel large sums of money to themselves in contravention of New York law.

138. Defendants' scheme not only unlawfully enriched the Management Defendants, but compromised patient care as Pivotal Care was subject to the pecuniary interests of non-physical therapists as opposed to the independent medical judgment of true physical therapist-owners.

v. The Fraudulent Incorporation of RHS Chiropractic

139. Prior to the Management Defendants enlisting the participation of the other Provider Defendants at the 160-59 Clinic, the Management Defendants had commenced a search for a licensed chiropractic professional who would be willing to sell the use of his or her professional license to the Management Defendants so that the Management Defendants could fraudulently incorporate and and/or control a chiropractic professional corporation under the chiropractic professional's name.

140. In or about 2020, the Management Defendants recruited Sternberg, who was a licensed chiropractor willing to “sell” them the use of his professional license so that the Management Defendants could fraudulently incorporate RHS Chiropractic and use that entity as the chiropractic practice at the 160-59 Rockaway Clinic.

141. Although Sternberg was listed as the owner of record of RHS Chiropractic on the certificate of incorporation, Sternberg exercised no ownership or control over the treatments rendered or the profits that were generated from RHS Chiropractic. Rather, the day-to-day operations, supervisory control, and true ownership of RHS Chiropractic rested in the hands of the Management Defendants.

142. In order to circumvent New York law, preventing non-chiropractic professionals from owning or controlling chiropractic professional corporations, the Management Defendants entered into a secret arrangement with Sternberg, wherein, in exchange for a designated salary or other form of compensation, Sternberg agreed to falsely represent in the certificate of incorporation and related filings with New York State, that he was the true shareholder, director, and officer of RHS Chiropractic and that he truly owned, controlled, and practiced through the professional corporation.

143. Sternberg agreed to falsely represent in the certificate of incorporation and related filings with New York State that he was the true shareholder, director, and officer of RHS Chiropractic and that he truly owned, controlled, and practiced through the professional corporation, knowing that the professional corporation would be used to submit fraudulent billing to insurers.

144. The Management Defendants – rather than Sternberg – provided all costs with setting up RHS Chiropractic and arranged for RHS Chiropractic to gain access to patients at the

160-59 Rockaway Clinic. Sternberg did not incur any costs to establish RHS Chiropractic's practice at the 160-59 Rockaway Clinic, nor did he invest any money in RHS Chiropractic after ceding control over it to the Management Defendants.

145. As a result, Sternberg was not the true shareholder, director, or officer of RHS Chiropractic and did not have any true ownership interest in or control over the professional corporation. In fact, true ownership and control over RHS Chiropractic always rested entirely with the Management Defendants, who used the facade of RHS Chiropractic to do indirectly what they were forbidden from doing directly, namely: (i) employ chiropractic professionals; (ii) control their practices; and (iii) charge for and derive an economic benefit from its services.

146. Following Sternberg's decision to cede control of the professional corporation: (i) he exercised absolutely no control or ownership interest in RHS Chiropractic; and (ii) all decision-making authority vested entirely with the Management Defendants.

147. In addition, subsequent to the purchase of his chiropractic license by the Management Defendants, Sternberg did not control or maintain RHS Chiropractic's books or records, including its bank accounts; never selected, directed, and/or controlled any of the individuals or entities responsible for handling any aspect of RHS Chiropractic's financial affairs; never hired or supervised any of RHS Chiropractic's employees; and was unaware of fundamental aspects of how RHS Chiropractic operated.

148. In reality, Sternberg was never anything more than a de facto employee of the Management Defendants.

149. RHS Chiropractic was used as a vehicle through which the Management Defendants unlawfully siphoned off profits, and funneled large sums of money to themselves in contravention of New York law.

150. Defendants' scheme not only unlawfully enriched the Management Defendants, but compromised patient care as RHS Chiropractic was subject to the pecuniary interests of non-chiropractors as opposed to the independent medical judgment of true chiropractor-owners.

**C. The Management Defendants' Efforts to Conceal Their Ownership and Control of the Provider Defendants Through Sham Financial Arrangements**

151. The Management Defendants used each of the Provider Defendants as "vessels" so that they could illegally profit from the Fraudulent Services, unlawfully siphon off profits, and funnel large sums of money to themselves in contravention of New York law.

152. To conceal their illegal arrangements and true ownership and control of the Provider Defendants, while simultaneously effectuating persuasive and total control over their operation and management, the Management Defendants arranged to have the Nominal Owner Defendants and the Provider Defendants enter into "management," "billing," "collection," "lease," and/or "marketing" agreements or other financial agreements.

153. These agreements or financial arrangements called for payments that were purportedly for the performance of certain designated services including management, marking, billing, collections, leasing, etc., but were in actuality: (i) sham agreements and arrangements; (ii) not reflective of the fair market value or the actual value of the services provided; and (iii) decoys to conceal the Management Defendants' illegal ownership and control over the Provider Defendants and/or unlawful financial arrangements.

154. In fact, the agreements and financial arrangements were created, dictated, and imposed by the Management Defendants upon the Provider Defendants to present the illusion that the Provider Defendants were paying legitimate fees for "management," "billing," "transportation," "collection," and "marketing" services, and/or for facility space and equipment, but they actually were used solely as a tool to permit the Management Defendants to (i) control

the day-to-day operations, exercise supervisory authority over, and illegally own the Provider Defendants; and (ii) to siphon all of the profits that were generated by the billings submitted to Liberty Mutual and other insurers through the Provider Defendants.

155. The net effect of these “management,” “billing,” “collection,” “marketing,” “transportation,” “lease,” and/or other financial arrangements, was to maintain the Provider Defendants in a constant state of debt to the Management Defendants, thereby enabling the Management Defendants to maintain total control over the professional corporations and healthcare practices, their accounts receivable, and all revenues generated therefrom.

156. Through all of these “billing,” “collection,” “management,” “transportation,” “marketing,” and/or “lease” agreements, the Management Defendants maintained complete control of all of the healthcare providers operating at the Clinics, their accounts receivable, and all revenues that generated therefrom.

157. The Management Defendants implemented a complex scheme to hide their illicit control of the Clinics and ill-gotten gains from exerting that control, that involved a variety of players across the two Clinics.

158. The Management Defendants, at all times, were unlicensed laypersons, rather than healthcare professionals, who are familiar to the No-Fault fraud arena, who illegally controlled the Provider Defendants and Clinics and directed fraudulent, pre-determined treatment and billing protocols.

159. For example, Liberty Mutual received pertinent information about the Clinics by a physician who actually operated out of both Clinics and averred that the Clinics were controlled by layperson managers and had pre-determined treatment protocols in place.

160. Prior to working at the Clinics, the physician was interviewed and hired by Roman, an unlicensed layperson, to work for a healthcare provider at the Clinics. The healthcare provider, and his respective practice, however, was truly owned and controlled by the Management Defendants.

161. The physician affirmed that both Clinics are controlled by the Management Defendants, including Larissa and DiPietro. During the time that the physician worked at the Clinics, they were instructed to follow a pre-determined treatment protocol that included prescribing certain medications to all patients regardless of whether they were medically necessary. If those medications were not prescribed, Larissa, DiPietro or another manager would attempt to have the physician prescribe the medication so that they could maximize their ill-gotten gains.

162. Further, the physician averred that upon their hiring, they were required to give their electronic prescription filing credentials to Regina and Larissa, who would use that information to submit prescriptions in the physician's name to the electronic prescription system without her knowledge or consent.

163. Many of these prescriptions were sent to Rego Park Pharmacy ("Rego Park"). In fact, over 90% of prescriptions received by Rego Park were from this physician while working at the 160-59 Rockaway Clinic and 409 Rockaway Clinic.

164. Further, Rego Park has paid approximately \$245,000.00 to Regina. These checks were described as "bonus" and "payroll" checks and were paid to Regina two to three times a month.

165. Furthermore, upon information and belief, Regina is married to Gulkarov. Gulkarov has also received "payroll" checks from Rego Park totaling approximately \$62,000.00.

Additionally, Rego Park has paid approximately \$379,000.00 to LL Consulting Group, Inc. doing business as Billing 4 You L.L.C., which is owned by Gulkarov.

166. Gulkarov is no stranger to No-Fault insurance fraud. In fact, Gulkarov was indicted and pled guilty in the Southern District of New York for paying kickbacks to 911 operators, hospital employees, and others for information regarding automobile accident victims in order to funnel the victims to professional corporations that he fraudulently owned and controlled by paying medical professionals to use their licenses to incorporate the medical practices. See USA v. Gulkarov, 1:22-cr-0020-PGG. DiPietro, Roman, and Khaimov were also named in this indictment and pled guilty based on similar allegations. Notably, one of the clinic locations that was part of the indictment was the 409 Rockaway Clinic.

167. During the pendency of the indictment, Gulkarov was represented by the Offices of Frederick P. Hafetz, LLC. Notably, Rego Park paid approximately \$25,000.00 to that office for legal fees related to Gulkarov's criminal representation.

168. The "payroll," "bonus," and legal representation fees paid by Rego Park to Gulkarov and Regina were described as such, to disguise what they really were, i.e., kickback payments for providing fraudulent prescriptions from the Clinics for DME and prescription medication to Rego Park.

169. Further, Khaimov, who was also named in the aforementioned indictment, is the owner of A&P Rockaway. A&P Rockaway leases space at that 409 Rockaway Clinic to Delerme-Pagan who initially operated out of the 409 Rockaway Clinic through Eastern Parkway Medical and later through 406 Medical. At the EUO of 406 Medical, Delerme-Pagan stated that her lease payments are paid to A&P Rockaway.

170. As described above, at all times, the Management Defendants exercised control over the Clinics and the Provider Defendants.

171. The unlawful kickback, referral payment and other financial arrangements were essential to the success of the Defendants' fraudulent scheme. The Defendants derived significant financial benefit from the relationship because without access to the Insureds, the Defendants would not have the ability to execute the fraudulent treatment and billing protocol and bill liberty Mutual and other insurers. At the same time, the voluminous list of healthcare services purportedly rendered to Insureds by the Provider Defendants at the Clinics in connection with the fraudulent claims listed in Exhibits "1" - "6" were enabled by the performance of the Fraudulent Services.

172. The Nominal Owner Defendants and Management Defendants at all times knew that the financial arrangements were illegal, and therefore, took affirmative steps to conceal the fraudulent scheme.

173. Furthermore, the Nominal Owner Defendants and Management Defendants at all times knew that the Management Defendants control over the Provider Defendants was illegal and therefore, took affirmative steps to conceal that they were the true controllers of the Provider Defendants.

174. The Management Defendants used the Provider Defendants as vehicles so that they could illegally profit from professional healthcare services, unlawfully siphon off profits, and funnel large sums of money to themselves in contravention of New York law.

**D. The Illegal Kickback/Referral Relationships**

175. In addition to illegally owning and controlling the Provider Defendants, the Management Defendants entered into secret agreements with transient providers, like Terra

Chiropractic and others not presently identifiable (the “Kickback Providers”) to give them access to the Clinics’ patient base on a rotating basis in exchange for kickback payments.

176. Once the Management Defendants received the kickback payments, they instructed the Provider Defendants to issue referrals for the Kickback Providers’ services. After that, the Kickback Providers were able to provide services at the Clinics without regard for their medical necessity. Rather, similar to the Fraudulent Services, the services provided by the Kickback Providers were provided – to the extent they were provided at all – solely for financial gain, not to treat or otherwise benefit the Insured.

177. The kickbacks paid by the Kickback Providers in exchange for those prescriptions and/or referrals at the Clinics were oftentimes disguised as rent payments to the primary leaseholders of the Clinics that were also illegally owned and/or controlled by the Management Defendants. This allowed the Management Defendants to conceal their identities and attempt to insulate themselves from exposure. Further the “rent” payments from the Kickback Providers gave the Clinics and providers operating therefrom, an appearance of legitimacy.

178. In keeping with that appearance of legitimacy, the Management Defendants implemented a predetermined treatment protocol pursuant to which the Kickback Providers would be required to issue certain referrals or recommendations in addition to paying rent in order to access the Clinics’ patient base. In particular, the Kickback Providers would be required to issue referrals for the Fraudulent Services, which would then be given to the Provider Defendants. In turn, the Provider Defendants would refer or recommend Insureds received services and/or testing performed by the Kickback Providers, including Terra Chiropractic.

179. Once the Management Defendants had access to those referrals, they purportedly had the Provider Defendants provide the Fraudulent Services, which were then billed to Liberty

Mutual and other New York automobile insurers. This arrangement permitted the Management Defendants to collect hundreds of thousands of dollars for medical services they were not otherwise legally eligible to collect.

180. The Kickback Providers have no control over the care and treatment of the patients, as the patients were “passed around” among different providers operating at the Clinics pursuant to the predetermined treatment protocol implemented by the Management Defendants.

181. The Kickback Providers exercised no control over the profits that were generated in connection with their operations at the Clinics, as the Kickback Providers ability to provide services and produce profit was dependent on the Management Defendants’ cultivation of the patient based and operation of the Provider Defendants at the Clinics.

**E. The Defendants’ Fraudulent Treatment and Billing Protocol**

182. The Defendants, using a fraudulent treatment and billing protocol, executed a complex fraudulent scheme designed to bill Liberty Mutual and the New York automobile insurance industry for the performance of the Fraudulent Services.

183. The Provider Defendants, in accordance with the Management Defendants’ pre-determined fraudulent treatment and billing protocol subjected the Insureds to a myriad of illusory and medically unnecessary healthcare services.

184. Defendants purported to subject virtually every Insured to a medically unnecessary course of “treatment” - regardless of the severity of the accident or the nature of the Insureds’ injuries (or lack thereof) – that was provided pursuant to a pre-determined, fraudulent protocol designed to maximize the billing that Defendants could submit to insurers, including Liberty Mutual, rather than to treat or otherwise benefit the Insureds who were subjected to it.

185. As part of the scheme, Defendants purported to subject the Insureds to medically unnecessary “tests” provided pursuant to a pre-determined, fraudulent protocol, which was applied without regard for the Insureds’ individual symptoms or presentment, or absence of any actual medical problems arising from any actual automobile accidents.

186. Each step in the fraudulent testing and 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.

187. Patients purportedly underwent an initial examination, and as a result, each patient was diagnosed with conditions that varied little, with the examining provider consistently concluding that the same pre-determined, excessive, and unnecessary treatment was medically necessary for each patient. The examinations invariably led to voluminous physical therapy treatments, chiropractic services, electrodiagnostic testing, outcome assessment testing, disability examinations and extracorporeal shockwave therapy.

188. No legitimate physician would have permitted the fraudulent treatment and billing protocol described below to proceed under his or her auspices.

i. The Fraudulent Charges for Initial Examinations

189. The Defendants purported to provide virtually every Insured with an initial examination.

190. The initial examinations were performed – to the extent performed at all – to provide Insureds with pre-determined diagnoses to allow the Defendants to then provide a host of medically unnecessary or illusory services.

191. Typically, Levtsenko P.C., 406 Medical and Eastern Parkway purported to provide the initial examinations at the Clinics. Levtsenko P.C. purportedly provided services out of the 160-59 Rockaway Clinic, while 406 Medical and Eastern Parkway purportedly provided services out of the 409 Rockaway Clinic.

192. Levtsenko P.C., 406 Medical and Eastern Parkway (collectively with the Management Defendants, the “Examination Defendants”) typically billed the initial examinations to Liberty Mutual under CPT codes: (i) 99203, typically resulting in a charge of \$114.10 or \$142.62, and (ii) 99204, typically resulting in a charge of \$163.01 or \$203.76.

193. The charges for the initial examinations were fraudulent in that the examinations were medically unnecessary and were performed – to the extent performed at all – pursuant to the fraudulent treatment protocol established by the Management Defendants and their illegal control of the Clinics and illegal financial arrangements.

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

195. According to the Fee Schedule, when the Examination Defendants submitted charges for initial examinations under CPT code 99203, they represented that: (i) they took a “detailed” patient history; (ii) they conducted a “detailed” physical examination; and (iii) they engaged in medical decision-making of “low complexity.”

196. Moreover, according to the Fee Schedule, when the Examination Defendants submitted charges for initial examinations under CPT code 99204, they represented that: (i) they took a “comprehensive” patient history; (ii) they conducted a “comprehensive” physical examination; and (iii) they engaged in medical decision-making of “moderate complexity.”

(i) Misrepresentations Regarding “Comprehensive” and “Detailed” Patient Histories

197. 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.

198. 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.

199. 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.

200. When the Examination Defendants billed for the examinations under CPT code 99204, they falsely represented that a nurse practitioner or physician associated with the Examination Defendants took a “comprehensive” patient history from the Insureds they purported to treat during the initial examinations.

201. In fact, no healthcare provider associated with the Examination Defendants took a “comprehensive” patient history from the Insureds they purported to treat during the initial examinations, because they did not properly document a review of ten organ systems unrelated to the history of the patients’ present illnesses.

202. In addition, according to the Fee Schedule, when the Examination Defendants billed for examinations under CPT code 99203, they represented that they took a “detailed” patient history.

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

204. However, the Examination Defendants did not take a “detailed” patient history from Insureds during the examinations, 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.

205. Rather, after purporting to provide the examinations, the Examination Defendants simply prepared reports containing ersatz patient histories which falsely contended that the Insureds continued to suffer from injuries they sustained in automobile accidents. Even in the

unlikely event that an Insured continued to suffer from injuries, there was no adequate history and examination performed to create a foundation for the Fraudulent Services.

206. These phony patient histories did not genuinely reflect the Insureds' actual circumstances, and instead were designed solely to support the Fraudulent Services that Defendants purported to provide and then billed to Liberty Mutual and other insurers.

(ii) Misrepresentations Regarding "Comprehensive" and "Detailed" Physical Examinations

207. Moreover, pursuant to the CPT Assistant 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.

208. 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.

209. Pursuant to the CPT Assistant, in the context of patient examinations, a physician has not conducted a general 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.

210. Furthermore, although the Examination Defendants often purported to provide a more in-depth examination of the Insureds' musculoskeletal system during their putative examinations, 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
- (ix) mental status, including orientation to time, place and person, as well as mood and affect.

211. Though the Examination Defendants billed for the examinations under CPT code 99204 and thereby falsely represented that they conducted a “comprehensive” physical examination of Insureds during the initial examinations, they did not conduct a general examination of multiple organ systems, inasmuch as they did not document findings with respect to multiple organ systems.

212. Pursuant to the Fee Schedule, a “detailed” physical examination requires – among other things – that the healthcare services provider conduct an extended examination of the affected body areas and other symptomatic or related organ systems.

213. Pursuant to the CPT Assistant, in the context of patient examinations, a physician has not conducted an extended examination of a patient’s musculoskeletal organ system unless the physician has documented findings with respect to:

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

- (vi) examination of gait and station;
- (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 six areas: (a) head and neck; (b) trunk; (c) right upper extremity; (d) left upper extremity; (e) right lower extremity; and (f) left lower extremity;
- (viii) coordination;
- (ix) examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes; and
- (x) examination of sensation.

214. When the Examination Defendants billed for the examinations under CPT code 99203, they falsely represented that they performed a “detailed” patient examination on the Insureds they purported to treat during the initial examinations.

215. In fact, the Examination Defendants did not conduct a detailed patient examination of Insureds, inasmuch as they did not conduct an extended examination of the affected body areas and other symptomatic or related organ systems.

(iii) Misrepresentations Regarding the Extent of Medical Decision-Making

216. In addition, when the Examination Defendants submitted charges for examinations under CPT code 99204, they represented that a nurse practitioner or physician associated with the Examination Defendants engaged in medical decision-making of “moderate complexity.”

217. Similarly, when the Examination Defendants submitted charges for examinations under CPT code 99203, they represented that a nurse practitioner or physician associated with the Examination Defendants engaged in medical decision-making of “low complexity”.

218. Pursuant to the Fee Schedule, the complexity of medical decision-making is measured by: (i) the number of diagnoses and/or the number 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.

219. Though the Examination Defendants routinely falsely represented that their initial examinations involved medical decision-making of "moderate complexity" (when billed under CPT code 99204) or "low complexity" (when billed under CPT code 99203), in actuality the initial examinations did not involve any medical decision-making at all, and, in the unlikely event that an Insured did present with such injuries or symptoms, the deficient initial examinations and consultations were incapable of assessing and/or diagnosing them as such.

220. First, the initial examinations did not involve the retrieval, review, or analysis of any medical records, diagnostic tests, or other information. When the Insureds presented to the Examination Defendants for "treatment" at the Clinics, pursuant to Defendants pre-determined fraudulent protocol, they did not arrive with any medical records. Furthermore, prior to the initial examinations, the Examination Defendants neither requested any medical records from any other providers, nor conducted any diagnostic tests.

221. Second, 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.

222. Nor, by extension, was there any risk of significant complications, morbidity, or mortality from the diagnostic procedures or treatment options provided by the Examination Defendants, to the extent that the Examination Defendants provided any such diagnostic procedures or treatment options in the first instance. In the unlikely event that such risks did exist, the deficient initial examinations were incapable of identifying such risks.

223. In almost every instance, any diagnostic procedures and “treatments” that the Examination Defendants actually provided were limited to a series of medically unnecessary diagnostic tests, none of which were health or life-threatening if properly administered.

224. Third, the Examination Defendants did not consider any significant number of diagnoses or treatment options for Insureds during the examinations. Rather, to the extent that the initial examinations were conducted in the first instance, the Examination Defendants provided a nearly identical, pre-determined “diagnosis” for the Insureds, and prescribed a similar course of treatment for each Insured.

225. In fact, no nurse practitioner or physician associated with the Examination Defendants engaged in any medical decision-making at all. Rather, the outcome of the examinations was predetermined for virtually every Insured to result in phony boilerplate “diagnoses” of sprains and strains.

226. The putative results of the initial examinations did not genuinely reflect the Insureds’ actual circumstances, and instead were designed solely to support the laundry-list of Fraudulent Services the Defendants purport to perform and then bill to Liberty Mutual and other insurers.

(iv) Misrepresentations Regarding the Amount of Time Spent on the Examinations

227. What is more, in every claim for purported examinations under CPT codes 99203 and 99204, the Examination Defendants misrepresented and exaggerated the amount of face-to-face time that the examining physicians spend with the Insureds or the Insureds’ families.

228. According to the Fee Schedule, the use of CPT code 99203 typically requires that the physician spend at least 30 minutes of face-to-face time with the Insured or the Insured’s family.

229. Similarly, the use of CPT code 99204, typically requires that the physician spend at least 45 minutes of face-to-face time with the Insured or the Insured's family.

230. Though the Examination Defendants routinely billed for the initial examinations under CPT codes 99203 and 99204, no nurse practitioner or physician associated with the Examination Defendants ever spent 30 minutes of face-to-face time with the Insureds or their families during the initial examinations, much less 45 minutes. Rather the initial examinations rarely lasted more than 10-15 minutes, to the extent that they were conducted at all.

231. In keeping with the fact that the initial examinations rarely lasted more than 10-15 minutes, much less 30 or 45 minutes, the Examination Defendants used boilerplate forms in documenting the initial examinations, setting forth a very limited range of potential patient complaints, examination/diagnostic testing options, potential diagnoses, and treatment recommendations.

232. All that was required to complete the boilerplate forms was a brief patient interview and cursory physical examination of the Insureds, consisting of a check of some of the Insureds' vital signs, basic range of motion and muscle strength testing, and basic neurological testing.

233. These interviews and examinations did not require any nurse practitioner or physician associated with the Examination Defendants to spend more than 10-15 minutes of face-to-face time with the Insureds let alone 30-45 minutes.

234. In the claims for initial examinations, the Examination Defendants falsely represented that the putative examinations involved at least 30 or 45 minutes of face-to-face time with the Insureds or their families, because consultations that entail at least 30 or 45 minutes of face-to-face time with the Insureds or their families are reimbursable at higher rates than examinations that require less time to perform.

(v) Misrepresentations Regarding the Severity of the Insureds' Presenting Problems

235. What is more, in the claims for examinations under CPT codes 99203 and 99204, the Examination Defendants misrepresented the severity of the Insureds' presenting problems.

236. Pursuant to the CPT Assistant, the use of CPT Codes 99203 and 99204, typically requires that the Insured presented with problems of moderate-to-high severity.

237. The CPT Assistant provides various clinical examples of the types of presenting problems that qualify as moderate to highly severe, and thereby justify the use of CPT codes 99203 and 99204 to bill for an examination.

238. Pursuant to the CPT Assistant, the moderate-to-high severe presenting problems that could support the use of CPT codes 99203, and 99204 to bill for an examination typically are severe problems.

239. By contrast, to the extent that the Insureds had any presenting problems at all as the result of their minor automobile accidents, the problems virtually always were low severity soft tissue injuries such as sprains and strains.

240. For instance, and in keeping with the fact that the Insureds either had no presenting problems at all as the result of their minor automobile accidents, or else problems of low severity, the Insureds did not seek treatment at any hospital as the result of their accidents.

241. To the limited extent that the Insureds did seek treatment at a hospital as the result of their accidents, they virtually always were briefly observed on an outpatient basis and released after a few hours with, at most, a minor sprain or strain diagnosis.

242. To the limited extent that the Insureds experienced any injuries at all as the result of their automobile accidents, the injuries were garden-variety soft tissue injuries such as sprains and strains.

243. The vast majority of soft tissue injuries such as sprains and strains resolve after a short course of conservative treatment, or no treatment at all.

244. Even so, in the claims for their purported examinations, the Examination Defendants virtually always billed for the putative examinations using CPT codes 99203 and 99204, thereby falsely representing that the Insureds presented with problems of moderate-to-high severity.

245. In the claims for the purported examinations, the Examination Defendants falsely represented that the Insureds presented with problems of moderate-to-high severity to create a false basis for their charges for the putative examinations under CPT codes 99203 and 99204, because evaluations billable under these CPT codes are reimbursable at higher rates than examinations involving presenting problems of low severity, minimal severity, or no severity.

## **2. The Fraudulent Charges for Follow-Up Examinations**

246. In addition to the fraudulent initial examinations, the Examination Defendants typically purported to subject Insureds to one or more fraudulent follow-up examinations during the course of the fraudulent treatment protocol.

247. The Examination Defendants virtually always billed the follow-up examinations to Liberty Mutual under CPT code 99213, typically resulting in a charge of \$70.24 or \$87.80, or CPT code 99214, typically resulting in a charge of \$101.93 or \$127.41.

248. Like the Examination 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 fraudulent treatment protocol established by the Management Defendants.

249. Pursuant to the Fee Schedule, the use of CPT code 99213 typically requires that the Insured present with problems of low-to-moderate severity.

250. Though the Examination Defendants routinely billed for the follow-up examinations under CPT code 99213, the Insureds did not present with problems of low-to-moderate severity. Rather the Insureds did not have any medical problems at all as the result of any automobile accident.

251. The charges for the follow-up examinations also were fraudulent in that they misrepresented the extent of the follow-up examinations.

252. The use of CPT code 99213 typically requires that the physician spend 15 minutes of face-to-face time with the Insured or the Insured's family.

253. Along similar lines, the use of CPT code 99214 typically requires that the physician spend 25 minutes of face-to-face time with the Insured or the Insured's family.

254. Though the Examination Defendants routinely billed for the follow-up examinations under CPT codes 99213 or 99214, the Examination Defendants did not spend 15 minutes of face-to-face time with the Insureds or their families during the follow-up examinations, much less 25 minutes. Rather, the follow-up examinations rarely lasted more than 10 minutes, to the extent that they were conducted at all.

255. In most cases, the Examination Defendants did not actually provide any legitimate follow-up examination but instead issued bogus, boilerplate "follow-up examination" reports to further support the laundry-list of Fraudulent Services that Defendants purported to perform and then billed to Liberty Mutual and other insurers.

### 3. The Fraudulent “Outcome Assessment Testing”

256. In addition to the other Fraudulent Services, Defendants, pursuant to their fraudulent billing and treatment protocol directed by the Management Defendants, routinely subjected the vast majority of Insureds to one or more sessions of medically useless “outcome assessment testing,” generally on the same dates they purported to subject the Insureds to initial or follow-up examinations.

257. Typically, Levtsenko and Adam purported to provide the “outcome assessment tests” at the 160-59 Rockaway Clinic, while Delorme-Pagan purported to provide the “outcome assessment tests” at the 409 Rockaway Clinic.

258. Levtsenko, Adam, Delorme-Pagan, and the Management Defendants billed the “outcome assessment tests” to Liberty Mutual through Levtsenko P.C., 406 Medical and Eastern Parkway (collectively with the Management Defendants, the “OAT Defendants”) under CPT code 99358, generally resulting in a charge of \$280.12 for each round of “testing.”

259. Like, 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 performed at all, pursuant to the fraudulent treatment protocol established by the Management Defendants.

260. The “outcome assessment tests” that the OAT Defendants purportedly provided to Insureds 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 lives.

261. 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 OAT Defendants purported to provide 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 patient’s history and initial examinations and follow-up examinations.

262. In other words, healthcare providers cannot conduct and bill for a patient’s history and initial examination or follow-up examination, then bill separately for contemporaneously provided “outcome assessment tests.”

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

264. Under the circumstances employed by the Management Defendants, the “outcome assessment tests” represented purposeful and unnecessary duplication of the patient histories and examinations purportedly conducted during the Insured’s initial examination and follow-up examinations.

265. The “outcome assessment tests” were part and parcel of Defendants’ fraudulent scheme, inasmuch as the “service” was rendered – to the extent rendered at all – pursuant to a pre-determined protocol that was designed solely to financially enrich Defendants and in no way aided in the assessment and treatment of the Insureds.

266. The OAT 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 a physician or medical provider actually spent at least one hour performing some prolonged service, such as review of extensive records and tests, or communication with the patient and his or her family.

267. Though the OAT Defendants routinely submitted billing for the "outcome assessment tests" under CPT code 99358, no physician or nurse associated with the OAT Defendants spent an hour reviewing or administering the tests or, any time at all reviewing or administering the tests.

268. 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.

269. Nevertheless, the OAT Defendants submitted billing to Liberty Mutual for billing under CPT code 99358.

270. In keeping with the fact that the outcome assessment tests were medically unnecessary and were performed pursuant to Defendants' pre-determined fraudulent treatment protocol, the results of the outcome assessment tests, like the other Fraudulent Services, were not incorporated into the Insureds' respective treatment plans.

#### **4. The Fraudulent Chiropractic Treatment**

271. In addition to the other Fraudulent Services that the Defendants purported to provide, RHS Chiropractic (collectively with the Management Defendants, the "Chiropractic Defendants") routinely purported to subject Insureds to chiropractic treatment at the 160-59 Rockaway Clinic.

272. As with the charges for the other Fraudulent Services, the charges for chiropractic treatment were fraudulent in that they were (i) medically unnecessary; and (ii) performed pursuant to the exaggerated diagnoses set forth in the fraudulent initial chiropractic examinations and as part and parcel to the improper referral and financial arrangements amongst the Defendants and others.

(i) The Chiropractic Initial and Follow-Up Examinations

273. In addition to the fraudulent initial and follow-up medical examinations conducted by the Examination Defendants, Insureds at the Clinics were also subjected to an initial chiropractic examination which served as “justification” to provide medically unnecessary, illusory, or otherwise un-reimbursable chiropractic treatment.

274. The Chiropractic Defendants, at the direction of the Management Defendants, routinely billed the initial chiropractic examinations to Liberty Mutual under CPT code 99203, typically resulting in a charge of \$75.00.

275. Similarly, the follow-up examinations were billed under CPT code 99212, typically resulting in a charge of \$36.19.

276. The Chiropractic Defendants’ charges for the initial chiropractic examinations were fraudulent in that they: (i) misrepresented the extent of the Insureds’ presenting problems; (ii) misrepresented the amount of time spent on the examinations; (iii) misrepresented the extent of the examinations allegedly performed; and (iv) misrepresented the extent of the medical decision-making during the examinations.

277. Specifically, the use of CPT code 99203 recommends that the practitioner typically spend 30 minutes of face-to-face time with the Insured or the Insured’s family.

278. Though the Chiropractic Defendants routinely billed for the initial examinations under CPT code 99203, the chiropractors associated with the Chiropractic Defendants did not spend 30 minutes of face-to-face time with the Insureds or their families during the initial examinations. Rather, the initial examinations rarely lasted more than 10 minutes to the extent they were conducted at all.

279. To the extent that the initial chiropractic examinations were conducted in the first instance, the Chiropractic Defendants provided a pre-determined laundry-list of phony “diagnoses” for every Insured and prescribed virtually identical courses of treatment. The Chiropractic Defendants used a boilerplate form designed for speed and convenience. The form sets forth a limited range of potential patient complaints, examination/diagnostic testing options, and treatment recommendations – many of which were incomplete, inaccurate or not performed in the first instance.

280. These unsubstantiated and exaggerated diagnoses and treatment plans bore no actual relationship to the conditions actually presented but were simply recited as a matter of course in order to justify the performance of the chiropractic services and other Fraudulent Services.

281. Clearly, the claims for initial chiropractic examinations were fraudulent in that the Chiropractic Defendants routinely falsely represented the extent of the examinations as well as the diagnoses and conditions of the Insureds for the sole purpose of justifying additional billing submitted by the Defendants for the Fraudulent Services.

(ii) The Fraudulent Chiropractic Treatment

282. Like the charges for the other Fraudulent Services, the chiropractic treatment was performed by the Chiropractic Defendants – to the extent that it was performed at all – pursuant to

the Management Defendants' directive and Defendants' illegal referral and kickback scheme, not to treat or otherwise benefit the Insureds.

283. Pursuant to Defendants' fraudulent pre-determined treatment and billing protocol, the Examination Defendants routinely referred patients to the Chiropractic Defendants for chiropractic services.

284. Initially, the Chiropractic Defendants diagnosed Insureds with sprains and strains and invariably concluded that Insureds required a treatment plan that included chiropractic adjustments of multiple regions several times per week, typically on the same day they received multiple physical therapy modalities, generally resulting in hundreds of dollars of charges for each Insured.

285. The Chiropractic Defendants purported to provide this identical chiropractic treatment plan to virtually every Insured, regardless of the Insureds' individual circumstances or unique presentment, to submit as much billing as possible for chiropractic services, without regard for medical necessity.

286. Based on the nature of the minor accidents, it is highly unlikely that nearly all of the Insureds who presented to the Chiropractic Defendants at the 160-59 Rockaway Clinic for treatment suffered injuries as the result of the accidents they purportedly experienced which required extended chiropractic services.

287. Nonetheless, following the initial examinations and follow-up examinations, Insureds were prescribed and given a medically unnecessary, extended course of chiropractic services. In fact, the Chiropractic Defendants purported to provide Insureds with weeks or months of chiropractic services, including chiropractic manipulation treatments that were billed under CPT code 99050 (1-2 regions), CPT code 98941 (3-4 regions), and CPT code 98942 (5 regions).

288. The purported results of the Defendants' other Fraudulent Services were used by Defendants as continued justification for the rounds of chiropractic treatments, despite the fact the Chiropractic Defendants did not incorporate the "findings" of the other Defendants or the results of the other Fraudulent Services into the chiropractic treatment, nor was there ever any assessment or modification of the chiropractic treatment. For example:

- (i) no details were provided to distinguish which vertebral levels were treated or the length or duration of the adjunctive therapies that were applied;
- (ii) there was no evidence that the purported muscle spasm/hypertonicity and range of motion restrictions were specifically documented for each patient;
- (iii) the treatment/progress notes provided no specifics as to how or where chiropractic manipulations were applied; and
- (iv) no ongoing assessment of the patient's condition or their progress was documented.

289. The weeks or months of continued, unchanging chiropractic treatments that were performed on virtually every Insured were not based on medical necessity and not intended to resolve the complaints/symptoms of the Insureds. Instead, the "protocol" approach to the performance of chiropractic treatments were designed solely to maximize the charges that Defendants could submit to Liberty Mutual, and other automobile insurers, and to maximize the revenues that could be generated from each Insured who was subjected to the protocol.

## **5. The Fraudulent Physical Therapy Treatment**

290. Consistent with the excessive and fraudulent provision of the healthcare services Defendants purported to provide to Insureds at the Clinics, Pivotal Care, at the direction of the Management Defendants, purported to subject many Insureds to a pre-determined physical therapy regimen.

291. Like Defendants' charges for the other Fraudulent Services, the charges for the physical therapy treatment were fraudulent in that the physical therapy treatment was performed – to the extent that it was performed at all – pursuant to the Management Defendants' directive, illegal financial arrangements, and pre-determined fraudulent treatment protocol.

292. The charges for the physical therapy that allegedly was provided through Pivotal Care also misrepresented its eligibility to bill for or to collect No-Fault Benefits in the first instance.

293. In most cases, Pivotal Care purported to subject each Insured to dozens of physical therapy treatments over an extended period of time, generally resulting in hundreds of dollars of charges for each Insured.

294. In most cases, the Insureds did not go to the hospital at all following their putative accidents and, to the extent that they did visit a hospital or other legitimate healthcare provider after their accidents, they virtually always were briefly observed on an outpatient basis and then sent on their way after an hour or two.

295. Nonetheless, pursuant to Defendants' fraudulent treatment and billing protocol, following their initial examination and follow-up examinations, virtually every Insured was prescribed a medically unnecessary, extended course of physical therapy.

296. Pivotal Care's charges for the physical therapy were predicated on the boilerplate "diagnoses" they provided to the Insureds following the initial and follow-up examinations, as well as the medically useless diagnostic tests.

297. But for these contrived "diagnoses" and diagnostic tests, Pivotal Care would not have been able to submit charges for the physical therapy because they would have no way to justify the performance of the physical therapy.

**6. The Fraudulent Charges for Disability Examinations**

298. Upon receiving a referral pursuant to the kickbacks that the Management Defendants paid to Terra Chiropractic, Terra Chiropractic purported to provide all of the Insureds in the claims identified in Exhibit “2” with a work related or medical disability examination (“disability examination”).

299. Terra Chiropractic’s purported disability examinations, which they billed under CPT code 99456, were medically unnecessary, performed solely to generate profits, and also performed pursuant to illegal kickback arrangements.

300. Terra Chiropractic purported to perform the medically unnecessary disability examinations, at the 160-59 Rockaway Clinic, which is also where they obtained their initial referrals, rather than at any stand-alone practice, in keeping with the fact that the disability examinations were performed pursuant to the kickbacks that the Management Defendants paid at the 160-59 Rockaway Clinic.

301. The disability examinations purportedly included a physical, range of motion, and muscle strength testing evaluations.

302. Terra Chiropractic purported to perform the disability examinations, which were billed to Liberty Mutual under CPT code 99456, resulting in a charge of \$670.00.

303. CPT code 99456 permits for a “[w]ork related or medical disability examination by other than the treating physician.” Such an examination must include the: (i) completion of a medical history commensurate with the patient’s condition; (ii) performance of an examination commensurate with the patient’s condition; (iii) formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; (iv) development of a future medical treatment plan; and (v) completion of necessary documentation/certificates and report.

304. Pursuant to the CPT Assistant, the use of CPT code 99456 is inappropriate where the underlying examination involves active management of the patient's presenting problems. Rather, use of CPT code 99456 is appropriate only in cases where the examination is performed to establish baseline information prior to the issuance of life or disability insurance certification, or else in work-related or other disability examinations.

305. In other words, the service described by CPT code 99456 is not for the purpose of treating any of the Insureds' injuries, but simply to establish a baseline for life or disability insurance purposes.

306. Accordingly, Terra Chiropractic's billing under CPT code 99456 is ineligible for no-fault reimbursement as a matter of law because, as defined by the CPT Assistant, CPT code 99456 cannot meet the no-fault law's basic requirement threshold that services be medically necessary to treat injuries arising out of a motor vehicle accident.

307. Despite routinely billing Liberty Mutual under CPT code 99456 for examinations characterized as "disability examinations," the examinations did not involve work-related or other disability claims, nor were they conducted to establish baseline information prior to the issuance of life or disability insurance certificates.

308. Moreover, none of the bills or reports submitted by the PC Defendants contain any information regarding any policy or claim relating to life insurance or disability insurance, let alone life insurance or disability insurance certificates.

309. Terra Chiropractic routinely misrepresented their examinations to be disability examinations under CPT code 99456 because it allowed them to both seek a higher rate of reimbursement than if they billed under the legitimate CPT codes for examinations, and to inflate

the total billing relating to the Insureds by concealing what would be obvious duplication of services if they billed for the same type of examination performed by other providers.

310. Further, the disability examinations were performed as a “gateway” in order to provide the Insureds with an excessive number of phony, pre-determined “diagnoses” to allow the Provider Defendants to then purport to provide medically unnecessary, illusory, or otherwise non-reimbursable electrodiagnostic tests at the 160-59 Rockaway Clinic.

311. Terra Chiropractic’s charges for the disability examinations were fraudulent in that: (i) the examinations were medically unnecessary and performed pursuant to the Defendants’ pre-determined treatment and billing protocols; (ii) the CPT code used to bill for the disability examinations misrepresented the extent, nature, and necessity of the examinations and the complexity of the Insureds’ injuries; and (iii) the examinations were performed pursuant to kickback arrangements.

312. The disability examinations purportedly performed by Terra Chiropractic were nothing more than form documents where an examining doctor would enter an Insureds’ response to questions into a computer that would generate a report, with minimal other information, comments, or narration beyond what was automatically generated.

## **7. The Fraudulent Charges for Extracorporeal Shockwave Therapy**

313. The Defendants’ also purported to subject many of the Insureds “treated” by Eastern Parkway and 406 Medical to medically unnecessary extracorporeal shockwave therapy “treatments.”

314. The charges for the ESWT were fraudulent in that the ESWT was medically unnecessary and was performed – to the extent performed at all – pursuant to the illegal financial

arrangements that the Defendants entered into that allowed the Provider Defendants access to the Clinics patients.

315. Eastern Parkway and 406 Medical (collectively with the Management Defendants, the “ESWT Defendants”) purported to provide the ESWT. Once the ESWT “treatment” was documented, the ESWT Defendants then billed Liberty Mutual \$700.39 for each “treatment” through Eastern Parkway or 406 Medical using CPT code 0101T.

**CATEGORY III CODES**  
**Medical Fee Schedule**

**0042T–0504T**  
**Effective April 1, 2019**

	Code	Description	Relative Value	FUD	PC/TC Split
■	0042T	Cerebral perfusion analysis using computed tomography with contrast administration, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time	15.44	XXX	
■ +	0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)	2.47	XXX	
■ +	0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	3.23	XXX	
	0058T	Cryopreservation; reproductive tissue, ovarian	BR	XXX	
	0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue	BR	XXX	
	0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue	BR	XXX	
■	0075T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel	18.68	XXX	
■ +	0076T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel (List separately in addition to code for primary procedure)	17.50	XXX	
	0085T	Breath test for heart transplant rejection	BR	XXX	
+	0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	BR	XXX	
+	0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	BR	XXX	
■	0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intra-ocular retinal electrode array, with vitrectomy	16.22	XXX	
■	0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified, high energy	2.78	XXX	

316. As noted, CPT code 0101T is listed in the Fee Schedule as a “temporary code” identifying emerging and experimental technology. Temporary codes may become permanent codes or deleted during updates of the code set. Additionally, and as noted in the Fee Schedule, the CPT code: (i) is scheduled to be paid using the conversion rate for surgical services, and (ii) does not distinguish between a professional component and technical component, thus confirming that the service need be performed by a licensed physician to be reimbursable.

317. In the first instance, the charges were fraudulent in that the “treatment” being performed on Insureds was not actually ESWT but was rather Radial Pressure Wave Therapy. Radial Pressure Wave Therapy involves the low energy delivery of compressed air and is incapable of generating a true shock wave. Radial Pressure Wave Therapy does not satisfy the requirements of CPT code 0101T, which requires “high energy” shockwave and, therefore was not reimbursable.

318. Second, the charges were fraudulent because the use of ESWT for the treatment of back, neck, and non-tendinopathy shoulder pain is experimental and investigational in nature. In fact, and in keeping with that characterization: (i) the use of ESWT has not been approved by the US Food and Drug Administration (“FDA”) for the treatment of back, neck, or non-tendinopathy shoulder pain, (ii) there are not legitimate peer reviewed studies that established the effectiveness of ESWT for the treatment of back, neck, or non-tendinopathy shoulder pain, and (iii) the Centers for Medicare and Medicaid Services has published coverage guidance for ESWT stating that further research is needed to establish the efficacy and safety of ESWT in the treatment of musculoskeletal conditions; that there is uncertainty associated with this intervention; and it is not reasonable and necessary for the treatment of musculoskeletal conditions and, therefore, not covered.

319. Notwithstanding the experimental nature, the ESWT Defendants purportedly provided ESWT through Eastern Parkway and 406 Medical as part of a pre-determined fraudulent protocol to many Insureds, without regard to each Insured’s individual complaints, symptoms, or presentation.

320. In keeping with the fact that Eastern Parkway and 406 Medical rendered the ESWT “treatments” pursuant to a fraudulent pre-determined treatment protocol, the ESWT “treatments” that Eastern Parkway and 406 Medical allegedly performed were not tailored to any individual

Insured's particular circumstances, and virtually none of the medical records submitted by Eastern Parkway or 406 Medical contain any patient-specific assessment of the Insureds' response to such "treatments."

321. While the Radial Pressure Wavey Therapy machines used by Eastern Parkway and 406 Medical had a range of pressure, intensity, pulse, and frequency settings, the "Radial Pressure Wave Treatment Plan" form that Eastern Parkway and 406 Medical submitted for the majority of the Insureds showed that the settings were almost always identical:

PROCEDURES AND PARAMETERS (technician use):  
Pulse Intensity 1.3 BAR (1.0-2.6)  
Pulses 2000 (1500-4000)  
Frequency 10 Hz (3-16)

322. Further, the form contained no details regarding whether the Insured responded to conservative treatment or not.

323. Further, the ESWT Defendants performed ESWT for the treatment of back, neck, and non-tendinopathy shoulder pain without a specific diagnosis. ESWT must be performed pursuant to a diagnosis. Such specific diagnoses include tendinopathies, lateral epicondylitis, and patellar tendinopathy. Eastern Parkway and 406 Medical, however, failed to provide ESWT pursuant to a specific diagnosis.

324. In fact, all of the Insureds subjected to ESWT "treatments" by Eastern Parkway and 406 Medical, identified in Exhibits "5" and "6" received a general diagnosis of sprain of ligaments of the cervical spine, lumbar spine, or thoracic spine.

325. In all of the claims in Exhibits "5" and "6" the ESWT Defendants falsely represented that ESWT was medically necessary, when in fact, it was not medically necessary for

each Insured and was instead provided pursuant to predetermined fraudulent protocols. As a result, the ESWT Defendants were not eligible to collect No-Fault benefits in the first instance.

#### **8. The Fraudulent Pain Fiber Nerve Conduction Studies**

326. As part of the Management Defendants fraudulent treatment protocol, many Insureds were subjected to medically unnecessary pain fiber nerve conduction studies, which are alternative known as voltage-actuated sensory nerve conduction threshold tests, current perception threshold tests, and sensory nerve conduction threshold tests (collectively, the “PfNCS studies”) through RHS Chiropractic (collectively with the Management Defendants, the “PfNCS Defendants”).

327. The charges for the PfNCS studies were fraudulent in that the PfNCS studies were medically unnecessary and performed not to treat or otherwise benefit the Insureds, but instead pursuant to the PfNCS Defendants’ predetermined treatment protocol and improper financial and referral arrangements between the PfNCS Defendants and others.

##### **a. The Human Nervous System and Electrodiagnostic Testing**

328. The human nervous system is composed of the brain, spinal cord, and peripheral nerves that extend throughout the body, including through the arms and legs and into the hands and feet.

329. Two primary functions of the nervous system are to collect and relay sensory information through the nerve pathways into the spinal cord and up to the brain, and to transmit signals from the brain into the spinal cord and through the peripheral nerves to initiate muscle activity throughout the body.

330. The nerves responsible for collecting and relaying sensory information to the brain are called sensory nerves, and the nerves responsible for transmitting signals from the brain to initiate muscle activity throughout the body are called motor nerves.

331. Peripheral nerves consist of both sensory and motor fibers. They carry electrical impulses throughout the body, originating from the spinal cord and extending, for example, into the hands and feet through the arms and legs.

332. The segments of nerves closest to the spine and through which impulses travel between the peripheral nerves and the spinal cord are called the nerve roots. A disease or dysfunction of the peripheral nerves is called a neuropathy, and can cause various symptoms and signs including pain, numbness, weakness, and reflex changes. A “pinched” nerve root is called a radiculopathy, and can cause various symptoms and signs, including pain, altered sensation, loss of muscle control, and alteration of reflexes.

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

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

335. The Recommended Policy does not identify PfNCS studies as having any documented usefulness in diagnosing radiculopathies. In fact, PfNCS studies are not recognized as having any value in the diagnosis of any medical condition.

b. Legitimate Tools for Neuropathy Diagnosis

336. The PfNCS Defendants supposedly provided the PfNCS studies to Insureds in order to diagnose abnormalities in the Insureds' peripheral nerves or nerve roots.

337. There are three primary diagnostic tools that are well-established in the medical, neurological, and radiological communities for diagnosing the existence, nature, extent, and specific location of abnormalities (i.e., neuropathies) in the peripheral nerves and in the nerve roots (i.e., radiculopathies). These diagnostic tests are nerve conduction velocity ("NCV") tests, electromyography ("EMG") tests, and magnetic resonance imaging tests ("MRIs").

338. Except in very limited circumstances, for diagnostic purposes NCV tests and EMG tests are performed together if: (i) nerve damage is suspected following an auto accident; (ii) the damage cannot be fully evaluated through a physical examination or other generally accepted diagnostic technique; and (iii) the tests are necessary to determine an appropriate treatment plan.

339. If NCV tests and EMG tests are necessary to diagnose nerve damage, they should be performed no fewer than 14-21 days following an auto accident because it typically takes at least that long for axonal damage to appear following a trauma.

340. MRI testing is an imaging technique that can produce high quality images of the muscle, bone, tissue, and nerves inside the human body. MRIs often are used following auto accidents to diagnose abnormalities in the nerve roots through images of the nerves, nerve roots, and surrounding areas.

c. PfNCS Studies Are Not a Legitimate Tool for Neuropathy Diagnosis

341. The PfNCS study is a type of sensory perception threshold study that purports to diagnose abnormalities only in the sensory nerves and sensory nerve roots. It does not, and cannot, provide any diagnostic information regarding the motor nerves and motor nerve roots.

342. Unlike NCV testing, PfNCS studies do not measure velocity, amplitude, or latency. Defendants did not measure an amplitude of the sensory neural action potential (SNAP), nor do they measure the latency or nerve conduction velocity.

343. The PfNCS studies are performed by administering electricity through specific skin sites to stimulate sensory nerves in the arms, legs, hands, feet, and/or face. The voltage is increased until the patient states that he or she perceives a sensation from the stimulus caused by the voltage. “Findings” then are made by comparing the minimum voltage stimulus required for the patient to announce that he or she perceives some sensation from it with purported normal ranges.

344. If the patient’s sensation threshold is greater than the purported “normal range” of voltage required to evoke a sensation, it allegedly indicates that the patient has a hypoesthetic condition (i.e., that the patient’s sensory nerves have decreased function). If the voltage required for the patient to announce that he perceives a sensation is less than the supposed normal range of intensity to evoke a sensation, it allegedly indicates that the patient has a hyperesthetic condition (i.e., that the patient’s sensory nerves are in a hypersensitive state).

345. In actuality, however, there are no reliable, peer-reviewed data that establish normal response ranges in PfNCS studies.

346. Specifically, there is no reliable evidence of the existence of normal ranges of intensity or voltage required to evoke a sensation using a PfNCS device. Given the lack of evidence

of normal ranges of intensity required to evoke a sensation, it is impossible to determine whether any given Insured's personal PfNCS study results are normal or abnormal.

347. Even if there was some evidence of the existence of normal ranges of intensity required to evoke a sensation using a PfNCS device, there is no reliable evidence to prove that a sensation threshold greater than the normal range would indicate a hypoesthetic condition or that sensation threshold less than the normal range would indicate a hyperesthetic condition.

348. Similarly, even if an abnormal sensation threshold indicated either a hypoesthetic or hyperesthetic condition, there is no reliable evidence to prove that the extent or cause of any such conditions could be identified from PfNCS studies. Indeed, numerous pathological and physiological conditions other than peripheral nerve damage can cause hyperesthesia and hypoesthesia.

349. Furthermore, even if PfNCS studies could produce any valid diagnostic information regarding the sensory nerve fibers:

- (i) no reliable evidence proves that any such information would have any value beyond that which could be gleaned from a routine history and physical examination of the patient;
- (ii) no reliable evidence proves that any such information would indicate the nature or extent of any abnormality in the sensory nerves or sensory nerve roots;
- (iii) no reliable evidence proves that any such information would indicate the specific location of the abnormality along the sensory nerve pathways;
- (iv) PfNCS studies do not provide any information regarding the motor nerves or motor nerve roots, which are as likely as the sensory nerves or sensory nerve roots to be injured in an auto accident; and
- (v) there would be no legitimate diagnostic advantage to using PfNCS studies to obtain information regarding the sensory nerve fibers where, as here, the PfNCS studies were duplicative of provided NCV tests, EMG tests, and/or MRIs.

350. Simply put, no legitimate medical evidence supports the conclusion that PfNCS studies are in any way useful, let alone medically necessary, to diagnose neuropathies in general or radiculopathies in particular.

351. Notably, the Centers for Medicare & Medicaid Services (“CMS”) have determined that PfNCS studies are not medically reasonable and necessary for diagnosing sensory neuropathies (i.e., abnormalities in the sensory nerves) and radiculopathies and therefore are not compensable.

352. In keeping with the fact that the PfNCS Defendants’ putative PfNCS studies were medically unnecessary, the CPT handbook, which establishes thousands of CPT codes for healthcare providers to use in describing their services for billing purposes, does not recognize a CPT code for PfNCS studies.

353. Finally, in keeping with the fact that the PfNCS Defendants’ purported PfNCS studies were medically useless, the putative “results” of Defendants’ PfNCS studies were not incorporated into any Insured’s treatment plan, and the PfNCS studies played no genuine role in the treatment or care of Insureds.

d. Each of the Two Main PfNCS Devices Manufacturers Claims the Other is a Fraud

354. Until 2004, about the same time that CMS was considering the medical benefits of PfNCS studies before ultimately issuing its National Coverage Determination denying Medicare coverage of PfNCS studies, the two primary manufacturers of sensory nerve conduction threshold devices were Neurotron, Inc., and Neuro Diagnostic Associates, Inc.

355. Neurotron, Inc. manufactured a device called the “Neurometer.” Neuro Diagnostic Associates, Inc. manufactured a device called the “Medi-Dx 7000.” While the physics and

engineering behind the Neurometer and the Medi-Dx 7000 differ, each of the devices purported to provide quantitative data on sensory nerve conduction threshold.

356. In or about 2004, following the issuance of the CMS National Coverage Determination, Neuro Diagnostic Associates, Inc. renamed and/or reorganized itself as PainDx, Inc., and re-branded its Medi-Dx 7000 device as the “Axon-II.”

357. Neuro Diagnostic Associates, Inc.’s last known business address and telephone number is identical to that currently used by PainDx, Inc. Moreover, the technical specifications of the Medi-Dx 7000 are virtually identical to the Axon-II.

358. Upon information and belief, the PfNCS studies were provided to Insureds using an Axon-II or re-branded Medi-Dx 7000 device.

359. Neuro Diagnostic Associates, Inc. claims that the Neurometer does not produce valid data or results, and has been fraudulently marketed. For its part, Neurotron Inc. has asserted the same claims regarding Neuro Diagnostic Associates, Inc.’s Medi-Dx 7000/Axon-II.

360. Among the charges made by Neurotron, Inc. against the Medi-Dx 7000 are that: (i) there is no reliable evidence that the type of electrical wave forms (asymmetrical wave forms) used by the Medi DX 7000 stimulate or provide any useful diagnostic information regarding any specific kind of sensory nerve fiber; (ii) the alternating output of electrical current used by the Medi-Dx 7000 is “severely distorted by skin impedance” (e.g., texture, thickness, temperature of the skin etc.) making it “impossible” to determine the true intensity levels of the electrical current being delivered by the Medi-Dx 7000; (iii) the Medi-Dx 7000 protocols are “incapable of measuring the thresholds in the sensory nerves”; and (iv) there are no peer-reviewed studies that validate the tests performed using the Medi-Dx 7000.

361. Because the Axon-II is virtually identical to the Medi-Dx 7000, any and all of Neurotron, Inc.'s criticisms of the Medi-Dx 7000 also apply to the Axon-II/Medi-DX 7000 that is used by the PfNCS Defendants.

e. The PfNCS Defendants' Medically Unnecessary PfNCS Studies

362. Pursuant to their pre-determined treatment protocol and improper financial and referral arrangements with the Management Defendants, the PfNCS Defendants, purported to subject many Insureds to a series of medically unnecessary PfNCS studies.

363. The PfNCS Defendants billed the PfNCS studies to Liberty Mutual as charges under CPT code codes 95904 and 95937, frequently, resulting in charges of more than \$1,000.00 for each Insured on whom the PfNCS studies were purportedly performed.

364. The PfNCS Defendants purported to subject many Insureds to PfNCS studies, supposedly to diagnose neuropathies or radiculopathies.

365. As a threshold matter, the PfNCS studies were medically unnecessary because, for all the reasons discussed at length above, there is no legitimate medical evidence that PfNCS studies are useful in diagnosing any medical condition, let alone neuropathies or radiculopathies.

366. The PfNCS studies were also medically unnecessary because virtually every Insured who purportedly was subjected to the Defendants' PfNCS studies also received NCVs, EMGs, and/or MRIs, services which are performed to properly diagnose neuropathies or radiculopathies.

367. Even if the PfNCS studies purportedly provided by the PfNCS Defendants had any legitimate value in the diagnosis of neuropathies or radiculopathies, they were duplicative of the NCV tests, EMG tests, and/or MRIs that the Insureds received and that, in any case, provided far

more specific, sensitive, and reliable diagnostic information than the PfNCS studies that the PfNCS Defendants purported to provide.

368. Even assuming that there was some diagnostic value for PfNCS studies, which there is not, the PfNCS studies in these circumstances could not possibly have provided any diagnostic information of any value beyond that which was produced through NCVs, EMGs and/or MRIs.

369. In keeping with the fact that the PfNCS Defendants' purported PfNCS studies were medically unnecessary and could not possibly have provided any additional diagnostic value, the putative "results" of the PfNCS Defendants' PfNCS studies were not incorporated into any Insured's treatment plan, nor did the PfNCS studies play any genuine role in the treatment or care of the Insureds.

**F. The Fraudulent Billing for Independent Contractor Services**

370. The Defendants' fraudulent scheme also included submission of claims to Liberty Mutual on behalf of the Provider Defendants seeking payments for services provided by independent contractors.

371. 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.

372. Since 2001, the New York 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 these 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).

373. The Defendants routinely submitted charges to Liberty Mutual and other insurers for Fraudulent Services that purportedly were performed by chiropractors, physical therapists, and physicians who were: (i) not legitimately employed by the Provider Defendants; and (ii) never supervised by the Nominal Owner Defendants. In fact, the chiropractors, physical therapists, and physicians who actually performed the Fraudulent Services that were ultimately billed in the name of the Provider Defendants: (a) set their own work schedules or had them set by one of the Management Defendants; and/or (b) performed services for multiple healthcare providers at the same time. Additionally, the Defendants:

- (i) paid the chiropractors, physical therapists, and physicians, either in whole, or in part, on a 1099 basis rather than a W-2 basis;
- (ii) established an understanding with the chiropractors, physical therapists, and physicians that they were independent contractors, rather than employees;
- (iii) paid no employee benefits to the chiropractors, physical therapists, and physicians;

- (iv) failed to secure and maintain W-4 or I-9 forms for the chiropractors, physical therapists, and physicians;
- (v) failed to withhold federal, state, or city taxes on behalf of the chiropractors, physical therapists, and physicians;
- (vi) compelled the chiropractors, physical therapists, and physicians to pay for their own malpractice insurance at their own expense;
- (vii) permitted the chiropractors, physical therapists, and physicians to set their own schedules and days on which they desired to perform services;
- (viii) permitted the chiropractors, physical therapists, and physicians to maintain non-exclusive relationships and perform services for their own practices and/or on behalf of other practices;
- (ix) failed to cover the chiropractors, physical therapists, and physicians 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) that represented to the IRS and to the New York State Department of Taxation that the chiropractors, physical therapists, and physicians were independent contractors.

374. By electing to treat the chiropractors, physical therapists, and physicians 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 as 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 physicians.

375. Because the chiropractors, physical therapists, and physicians were independent contractors and performed the Fraudulent Services, the Defendants never had any right to bill or collect No-Fault Benefits in connection with those services.

376. The Defendants billed for the Fraudulent Services as if they were provided by actual employees of the Provider Defendants to make it appear as if the services were eligible for reimbursement.

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

**G. The Fraudulent Billing Defendants Submitted or Caused to be Submitted to Liberty Mutual**

378. To support their fraudulent charges, Defendants systematically submitted or caused to be submitted thousands of NF-3 form, HCFA-1500 forms, and/or treatment reports through the Provider Defendants to Liberty Mutual seeking payment for services for which Defendants were not entitled to receive payment.

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

- (i) The NF-3 forms, HCFA-1500 forms, and/or treatment reports uniformly misrepresented to Liberty Mutual that the Provider Defendants were lawfully licensed and, therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 N.Y.C.R.R. § 65-3.16(a)(12). In fact, the Provider Defendants were not properly licensed in that they were professional healthcare entities that were unlawfully owned and controlled by, engaged in illegal financial arrangements or paid kickbacks to the Management Defendants and others who are not licensed medical professionals.

- (ii) The NF-3 forms, HCFA-1500 forms, and/or treatment reports submitted by and on behalf of Defendants uniformly misrepresented to Liberty Mutual that the healthcare services were medically necessary and that the services actually were performed. In fact, many of the services were not medically necessary. To the extent that the healthcare services were performed, they were performed pursuant to predetermined fraudulent protocols designed solely to financially enrich Defendants, rather than to treat or otherwise benefit the Insureds who purportedly were subjected to them and were provided pursuant to the improper referral and financial arrangements between the Defendants.
- (iii) The NF-3 forms, HCFA-1500 forms, and/or treatment reports submitted by and on behalf of the Defendants misrepresented and exaggerated the nature and level of services that purportedly were provided.
- (iv) With the exception of NF-3 forms, HCFA-1500 forms, and treatment reports identifying services actually performed by the Nominal Owners, the NF-3 forms, HCFA-1500 forms, and treatment reports submitted by, and on behalf of, the Defendants uniformly misrepresented to Liberty Mutual that the Defendants were eligible to receive No-Fault 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 No-Fault Benefits for the services that supposedly were performed because the services were provided by independent contractors, to the extent they were provided at all.
- (v) The NF-3 forms, HCFA-1500 forms, and/or treatment reports uniformly misrepresented to Liberty Mutual that Terra Chiropractic was lawfully licensed and, therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 N.Y.C.R.R. § 65-3.16(a)(12). In fact, Terra Chiropractic was not properly licensed in that it was a professional healthcare corporation that paid kickbacks to the Management Defendants and others who are not licensed medical professionals.

**I. Defendants’ Fraudulent Concealment and Liberty Mutual’s Justifiable Reliance**

380. 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 Liberty Mutual.

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

382. Specifically, Defendants knowingly misrepresented and concealed facts related to the Provider Defendants in an effort to prevent discovery that the Provider Defendants were fraudulently controlled and engaged in unlawful financial arrangements with unlicensed persons, and therefore are ineligible to bill for or collect No-Fault Benefits.

383. For example, Defendants misrepresented control over the Provider Defendants in filings with the Education Department, so as to (i) induce the Education Department to issue the licenses required to permit the Provider Defendants to engage in the practice of a licensed profession; (ii) induce the Education Department to continue to recognize the Provider Defendants as being legally organized and authorized to practice their respective professions; and/or (iii) induce the Education Department to allow the licensed professionals to continue to lawfully practice their profession, despite the control of their licenses by unlicensed laypersons.

384. The Management Defendants also entered into various financial arrangements with the Provider Defendants that were designed to, and did, conceal their true control over the Provider Defendants, as well as their unlawful referral, kickback and other financial arrangements.

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

386. Nevertheless, Defendants knowingly misrepresented and concealed facts in order to prevent Liberty Mutual from discovering that the Fraudulent Services were medically unnecessary and performed pursuant to fraudulent predetermined protocols designed to maximize the charges that could be submitted rather than to benefit the Insureds who supposedly were subjected to them.

387. In every bill that Defendants submitted or caused to be submitted, Defendants uniformly concealed the fact that Defendants misrepresented and exaggerated the level and nature of the services purportedly provided, and inflated the billing to insurers.

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

389. Further, Terra Chiropractic and the Management Defendants engaged in an unlawful kickbacks and referral scheme, that allowed Terra Chiropractic access to the patient base at 160-59 Rockaway in exchange for providing compensation to the Management Defendants, who then instructed other providers at the 160-59 Rockaway Clinic to refer patients to Terra Chiropractic for the Fraudulent Services.

390. Additionally, many of the Fraudulent Services were provided – to the extent that they were provided at all – by independent contractors who were not legitimately employed by the Provider Defendants and were never supervised by the Nominal Owner Defendants, which allowed the Provider Defendants to realize significant gains by avoiding multiple tax requirements.

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

392. In accordance with the No-Fault Laws, and Liberty Mutual's standard office practices and procedures, Liberty Mutual either: (i) timely and appropriately denied the pending

claims for No-Fault Benefits submitted through the Provider Defendants; (ii) timely issued requests for additional verification with respect to all of the pending claims for No-Fault Benefits submitted through the Provider Defendants; (iii) timely issued payment with respect to the claims submitted through the Provider Defendants; or else (iv) the time in which to pay or deny the pending claims of No-Fault Benefits submitted through the Provider Defendants, or to request additional verification of those claims, has not expired.

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

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

395. Liberty Mutual is under statutory and contractual obligations to promptly and fairly process claims within 30 days. The facially-valid documents submitted to Liberty Mutual 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 Liberty Mutual to reply upon them. As a result, Liberty Mutual has incurred damages of more than \$375,000.00 based upon the fraudulent charges.

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

**FIRST CAUSE OF ACTION**  
**Against All Defendants**  
**(Declaratory Judgment – 28 U.S.C. §§ 2201 and 2202)**

397. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

398. There is an actual case in controversy between Liberty Mutual and Defendants regarding more than \$345,000.00 in fraudulent billing for the Fraudulent Services that have been submitted to Liberty Mutual under the names of the Provider Defendants.

399. Defendants have no right to receive payment for any pending bills submitted to Liberty Mutual under the names of the Provider Defendants because the Provider Defendants were secretly and/or unlawfully controlled by unlicensed individuals and entities, and illegally operating.

400. Defendants have no right to receive payment for any pending bills submitted to Liberty Mutual under the names of the Provider Defendants because the Provider Defendants engaged in unlawful kickback, referral, and/or other financial arrangements with unlicensed individuals and entities as part of a scheme to defraud New York automobile insurers and therefore, were ineligible to bill for or to collect No-Fault Benefits.

401. Defendants have no right to receive payment for any pending bills submitted to Liberty Mutual under the names of the Provider Defendants because the Fraudulent Services were not medically necessary and were provided – to the extent provided at all – pursuant to

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

402. Defendants have no right to receive payment for any pending bills submitted to Liberty Mutual under the names of the Provider Defendants because the billing codes used for the Fraudulent Services misrepresented and exaggerated the level of services that purportedly were provided in order to inflate the charges submitted to Liberty Mutual.

403. Defendants have no right to receive payment for any pending bills submitted to Liberty Mutual under the names of the Provider Defendants because the Fraudulent Services provided – to the extent provided at all – by independent contractors, rather than employees of the Provider Defendants.

404. Terra Chiropractic has no right to receive payment for any pending bills submitted to Liberty Mutual because Terra Chiropractic engaged in illegal kickback and referral arrangements with unlicensed individuals and entities as part of a scheme to defraud New York automobile insurers in contravention of New York law.

405. Accordingly, Liberty Mutual requests a judgment pursuant to the Declaratory Judgement Act, 28 U.S.C. §§2201 and 2202, declaring that:

- (i) the Provider Defendants have no right to receive payment for any pending bills submitted to Liberty Mutual because they were fraudulently, and illegally controlled by unlicensed laypersons and therefore, are ineligible to seek or recover No-Fault Benefits;
- (ii) the Provider Defendants have no right to receive payment for any pending bills submitted to Liberty Mutual because they engaged in a scheme to defraud through unlawful financial arrangements;
- (iii) the Provider Defendants have no right to receive payment for any pending bills submitted to Liberty Mutual because the Fraudulent Services were ordered and performed – to the extent performed at all – pursuant to fraudulent, predetermined protocols designed solely to maximize charges to Liberty Mutual, not because they were medically necessary or designed to

facilitate the treatment of or otherwise benefit the Insureds who purportedly have been subjected to them;

- (iv) the Provider Defendants have no right to receive payment for any pending bills submitted to Liberty Mutual because the CPT 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 Liberty Mutual;
- (v) the Provider Defendants have no right to receive payment for any pending bills submitted to Liberty Mutual because the Fraudulent Services were unlawfully provided – to the extent that they were provided at all – by independent contractors rather than by the Provider Defendants or their employees; and
- (vi) Terra Chiropractic has no right to receive payment for any pending bills submitted to Liberty Mutual because they engaged in a scheme to defraud through unlawful kickback and referral arrangements.

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

406. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

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

408. Sternberg and the Management Defendants knowingly have conducted and/or participated directly or indirectly, in the conduct of RHS Chiropractic’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 RHS Chiropractic was not eligible to receive under the No-Fault Laws because: (i) it was unlawfully controlled by unlicensed laypersons; (ii) it engaged in unlawful financial arrangements with unlicensed laypersons in contravention of New York law; (iii) the billed-for-services were not

medically necessary and not the result of professional judgment; (iv) the billed-for-services were performed and billed pursuant to a predetermined, fraudulent treatment and billing protocol designed solely to enrich Defendants; (v) the billed-for-services were performed pursuant to improper referral and financial arrangements between Defendants; (vi) 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; and (vi) in many cases, the billed-for-services were provided – to the extent that they were provided at all – by independent contractors rather than by RHS Chiropractic’s employees. The fraudulent bills and corresponding mailings submitted to Liberty Mutual that compromise the pattern of racketeering activity identified through the date of this Complaint are described, in part, in the chart annexed hereto as Exhibit “1”.

409. RHS Chiropractic’s business is racketeering activity, inasmuch as the enterprise exists for the purpose of submitted fraudulent charges to insurers. The predicate acts of mail fraud are the way in which Sternberg and the Management Defendants operated RHS Chiropractic, inasmuch as RHS Chiropractic never was eligible to bill for or collect No-Fault Benefits, and acts of mail fraud therefore were essential in order for RHS Chiropractic 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.

410. RHS Chiropractic is engaged in inherently unlawful acts, inasmuch as its very corporate existence is an unlawful act, considering that it is fraudulent controlled by non-physicians, and its existence therefore depends on continuing misrepresentations made to the New York State Department of Education and the New York Department of State. These inherently unlawful acts are taken by RHS Chiropractic in pursuit of inherently unlawful goals – namely, the theft of money from Liberty Mutual and other insurers through fraudulent No-Fault billing.

411. Liberty Mutual has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$138,000.00 pursuant to the fraudulent bills submitted by Defendants through RHS Chiropractic.

412. By reason of its injury, Liberty Mutual 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 Sternberg and the Management Defendants**  
**(Violation of RICO, 18 U.S.C. § 1962(d))**

413. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

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

415. Sternberg and the Management Defendants are employed by and/or associated with the RHS Chiropractic enterprise.

416. Sternberg and the Management Defendants knowingly have agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of RHS Chiropractic enterprise'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 seeking payments that RHS Chiropractic was not eligible to receive under the No-Fault Laws because: (i) it was unlawfully organized and/or owned and controlled by unlicensed laypersons; (ii) it engaged in unlawful financial arrangements with unlicensed laypersons in contravention of New York law; (iii) the billed-for-services were performed and billed pursuant to a predetermined, fraudulent treatment

and billing protocol designed solely to enrich Defendants; (iv) the billed-for-services were performed pursuant to improper referral and financial arrangement between Defendants; (v) 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; and (vi) in many cases, the billed-for-services were provided – to the extent that they were provided at all – by independent contractors, rather than by RHS Chiropractic’s employees.

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

418. Liberty Mutual has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$138,000.00 pursuant to the fraudulent bills submitted by Defendants through RHS Chiropractic.

419. By reason of its injury, Liberty Mutual 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 RHS Chiropractic, Sternberg and the Management Defendants**  
**(Common Law Fraud)**

420. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

421. RHS Chiropractic, Sternberg and the Management Defendants intentionally and knowingly made false and fraudulent statements of material fact to Liberty Mutual and concealed material facts from Liberty Mutual in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

422. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that RHS Chiropractic was properly licensed and therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 NYCRR § 65-3.16(a)(12), when in fact it was fraudulently controlled by unlicensed laypersons; (ii) in every claim, the representation that RHS was properly licensed and, therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) 11 NYCRR § 65-3.16(a)(12), when in fact the professional corporation engaged in illegal kickback, referral and other financial arrangements with unlicensed laypersons; (iii) in every claim, the representation that the billed-for services were the result of professional judgment and properly billed in accordance with the Fee Schedule, when in fact the billed-for services were performed and billed pursuant to a predetermined, fraudulent protocol designed solely to enrich Defendants; (iv) in every claim, the representation that the charges were appropriate and consistent with the service provided, when in fact the charges exaggerated the level of service and the nature of the service that purportedly was provided; and (v) in every claim, the representation that the services were provided by employees, when in fact the billed-for services were provided, in many cases, by independent contractors.

423. RHS Chiropractic, Sternberg and the Management Defendants intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induct Liberty Mutual to pay charges submitted through RHS Chiropractic that were not compensable under the No-Fault Laws.

424. Liberty Mutual has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$138,000.00 pursuant to the fraudulent bills submitted by Defendants through RHS Chiropractic.

425. Defendants' extensive fraudulent concealment demonstrates a high degree of moral turpitude and wanton dishonesty that entitles Liberty Mutual to recover punitive damages.

426. Accordingly, by virtue of the foregoing, Liberty Mutual 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 RHS Chiropractic, Sternberg and the Management Defendants**  
**(Unjust Enrichment)**

427. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

428. As set forth above, RHS Chiropractic, Sternberg and the Management Defendants have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of Liberty Mutual.

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

430. RHS Chiropractic, Sternberg and the Management Defendants have been enriched at Liberty Mutual's expense by Liberty Mutual's payments, which constituted a benefit that Defendants voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

431. Defendants' retention of Liberty Mutual's payments violates fundamental principles of justice, equity and good conscience.

432. By reason of the above, Defendants have been unjustly enriched in an amount to be determined at trial, but in no event less than \$138,000.00.

**SIXTH CAUSE OF ACTION**  
**Against Terra Chiropractic, Duque and the Management Defendants**  
**(Common Law Fraud)**

433. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

434. Terra Chiropractic, Duque, and the Management Defendants intentionally and knowingly made false and fraudulent statements of material fact to Liberty Mutual and concealed material facts from Liberty Mutual in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

435. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that Terra Chiropractic was properly licensed and, therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) 11 NYCRR § 65-3.16(a)(12), when in fact the professional corporation engaged in illegal kickback, and other financial arrangements with unlicensed laypersons; (ii) in every claim, the representation that the billed-for services were the result of professional judgment and properly billed in accordance with the Fee Schedule, when in fact the billed-for services were performed and billed pursuant to a predetermined, fraudulent protocol designed solely to enrich Defendants; (iii) in every claim, the representation that the charges were appropriate and consistent with the service provided, when in fact the charges exaggerated the level of service and the nature of the service that purportedly was provided; and (iv) in every claim, the representation that the services were provided by employees, when in fact the billed-for services were provided, in many cases, by independent contractors. The fraudulent bills and corresponding mailings submitted to Liberty Mutual identified through the date of this Complaint are described, in part, in the chart annexed hereto as Exhibit “2”.

436. Terra Chiropractic, Duque and the Management Defendants intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induct Liberty Mutual to pay charges submitted through Terra Chiropractic that were not compensable under the No-Fault Laws.

437. Liberty Mutual has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$37,000.00 pursuant to the fraudulent bills submitted by Defendants through Terra Chiropractic.

438. Defendants' extensive fraudulent concealment demonstrates a high degree of moral turpitude and wanton dishonesty that entitles Liberty Mutual to recover punitive damages.

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

**SEVENTH CAUSE OF ACTION**  
**Against Terra Chiropractic, Duque and the Management Defendants**  
**(Unjust Enrichment)**

440. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

441. As set forth above, Terra Chiropractic, Duque and the Management Defendants have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of Liberty Mutual.

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

443. Terra Chiropractic, Duque and the Management Defendants have been enriched at Liberty Mutual's expense by Liberty Mutual's payments, which constituted a benefit that Defendants voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

444. Defendants' retention of Liberty Mutual's payments violates fundamental principles of justice, equity and good conscience.

445. By reason of the above, Defendants have been unjustly enriched in an amount to be determined at trial, but in no event less than \$37,000.00.

**EIGHTH CAUSE OF ACTION**  
**Against Usman and the Management Defendants**  
**(Violation of RICO 18 U.S.C. § 1962(c))**

446. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

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

448. Usman and the Management Defendants knowingly have conducted and/or participated directly or indirectly, in the conduct of Pivotal Care'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 since its inception seeking payments that Pivotal Care was not eligible to receive under the No-Fault Laws because: (i) it was unlawfully controlled by unlicensed laypersons; (ii) it engaged in unlawful financial arrangements with unlicensed laypersons in contravention of New York law; (iii) the billed-for-services were not medically necessary and not the result of professional judgment; (iv) the billed-for-services were performed

and billed pursuant to a predetermined, fraudulent treatment and billing protocol designed solely to enrich Defendants; (v) the billed-for-services were performed pursuant to improper referral and financial arrangements between Defendants; (vi) 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; and (vi) in many cases, the billed-for-services were provided – to the extent that they were provided at all – by independent contractors rather than by Pivotal Care’s employees. The fraudulent bills and corresponding mailings submitted to Liberty Mutual that compromise the pattern of racketeering activity identified through the date of this Complaint are described, in part, in the chart annexed hereto as Exhibit “3”.

449. Pivotal Care’s business is racketeering activity, inasmuch as the enterprise exists for the purpose of submitted fraudulent charges to insurers. The predicate acts of mail fraud are the way in which Usman and the Management Defendants operated Pivotal Care, inasmuch as Pivotal Care never was eligible to bill for or collect No-Fault Benefits, and acts of mail fraud therefore were essential in order for Pivotal Care 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 Pivotal Care continues to attempt collection on the fraudulent billing submitted by Pivotal Care to the present day.

450. Pivotal Care is engaged in inherently unlawful acts, inasmuch as its very corporate existence is an unlawful act, considering that it is fraudulent controlled by non-physicians, and its existence therefore depends on continuing misrepresentations made to the New York State Department of Education and the New York Department of State. These inherently unlawful acts are taken by Pivotal Care in pursuit of inherently unlawful goals – namely, the theft of money from Liberty Mutual and other insurers through fraudulent No-Fault billing.

451. Liberty Mutual has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$142,000.00 pursuant to the fraudulent bills submitted by Defendants through Pivotal Care.

452. By reason of its injury, Liberty Mutual 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.

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

453. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

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

455. Usman and the Management Defendants are employed by and/or associated with the Pivotal Care enterprise.

456. Usman and the Management Defendants knowingly have agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of Pivotal Care enterprise'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 seeking payments that Pivotal Care was not eligible to receive under the No-Fault Laws because: (i) it was unlawfully organized and/or owned and controlled by unlicensed laypersons; (ii) it engaged in unlawful financial arrangements with unlicensed laypersons in contravention of New York law; (iii) the billed-for-services were performed and billed pursuant to a predetermined, fraudulent treatment and billing protocol

designed solely to enrich Defendants; (iv) the billed-for-services were performed pursuant to improper referral and financial arrangement between Defendants; (v) 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; and (vi) in many cases, the billed-for-services were provided – to the extent that they were provided at all – by independent contractors, rather than by Pivotal Care’s employees.

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

458. Liberty Mutual has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$142,000.00 pursuant to the fraudulent bills submitted by Defendants through Pivotal Care.

459. By reason of its injury, Liberty Mutual 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.

**TENTH CAUSE OF ACTION**  
**Against Pivotal Care, Usman and the Management Defendants**  
**(Common Law Fraud)**

460. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

461. Pivotal Care, Usman and the Management Defendants intentionally and knowingly made false and fraudulent statements of material fact to Liberty Mutual and concealed material facts from Liberty Mutual in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

462. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that Pivotal Care was properly licensed and therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 NYCRR § 65-3.16(a)(12), when in fact it was fraudulently controlled by unlicensed laypersons; (ii) in every claim, the representation that Pivotal Care was properly licensed and, therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) 11 NYCRR § 65-3.16(a)(12), when in fact the professional corporation engaged in illegal financial arrangements with unlicensed laypersons; (iii) in every claim, the representation that the billed-for services were the result of professional judgment and properly billed in accordance with the Fee Schedule, when in fact the billed-for services were performed and billed pursuant to a predetermined, fraudulent protocol designed solely to enrich Defendants; (iv) in every claim, the representation that the charges were appropriate and consistent with the service provided, when in fact the charges exaggerated the level of service and the nature of the service that purportedly was provided; and (v) in every claim, the representation that the services were provided by employees, when in fact the billed-for services were provided, in many cases, by independent contractors.

463. Pivotal Care, Usman and the Management Defendants intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induce Liberty Mutual to pay charges submitted through Pivotal Care that were not compensable under the No-Fault Laws.

464. Liberty Mutual has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$142,000.00 pursuant to the fraudulent bills submitted by Defendants through Pivotal Care.

465. Defendants' extensive fraudulent concealment demonstrates a high degree of moral turpitude and wanton dishonesty that entitles Liberty Mutual to recover punitive damages.

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

**ELEVENTH CAUSE OF ACTION**  
**Against Pivotal Care, Usman and the Management Defendants**  
**(Unjust Enrichment)**

467. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

468. As set forth above, Pivotal Care, Usman and the Management Defendants have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of Liberty Mutual.

469. When Liberty Mutual paid the bills and charges submitted by or on behalf of Pivotal Care for No-Fault Benefits, it reasonable believed that it was legally obligated to make such payments based on Defendants' improper, unlawful, and/or unjust acts.

470. Pivotal Care, Usman and the Management Defendants have been enriched at Liberty Mutual's expense by Liberty Mutual's payments, which constituted a benefit that Defendants voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

471. Defendants' retention of Liberty Mutual's payments violates fundamental principles of justice, equity and good conscience.

472. By reason of the above, Defendants have been unjustly enriched in an amount to be determined at trial, but in no event less than \$142,000.00.

**TWELFTH CAUSE OF ACTION**  
**Against Levtsenko, P.C., Levtsenko and the Management Defendants**  
**(Common Law Fraud)**

473. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

474. Levtsenko, P.C., Levtsenko and the Management Defendants intentionally and knowingly made false and fraudulent statements of material fact to Liberty Mutual and concealed material facts from Liberty Mutual in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

475. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that Levtsenko, P.C. was properly licensed and therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 NYCRR § 65-3.16(a)(12), when in fact it was fraudulently controlled by unlicensed laypersons; (ii) in every claim, the representation that Levtsenko, P.C. was properly licensed and, therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) 11 NYCRR § 65-3.16(a)(12), when in fact the professional corporation engaged in illegal financial arrangements with unlicensed laypersons; (iii) in every claim, the representation that the billed-for services were the result of professional judgment and properly billed in accordance with the Fee Schedule, when in fact the billed-for services were performed and billed pursuant to a predetermined, fraudulent protocol designed solely to enrich Defendants; (iv) in every claim, the representation that the charges were appropriate and consistent with the service provided, when in fact the charges exaggerated the level of service and the nature of the service that purportedly was provided; and (v) in every claim, the representation that the services were provided by employees, when in fact the billed-for services were provided, in many cases, by

independent contractors. The fraudulent bills and corresponding mailings submitted to Liberty Mutual identified through the date of this Complaint are described, in part, in the chart annexed hereto as Exhibit “4”.

476. Levtsenko, P.C., Levtsenko and the Management Defendants intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induct Liberty Mutual to pay charges submitted through Levtsenko, P.C. that were not compensable under the No-Fault Laws.

477. Liberty Mutual has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$35,000.00 pursuant to the fraudulent bills submitted by Defendants through Levtsenko, P.C.

478. Defendants’ extensive fraudulent concealment demonstrates a high degree of moral turpitude and wanton dishonesty that entitles Liberty Mutual to recover punitive damages.

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

**THIRTEENTH CAUSE OF ACTION**  
**Against Levtsenko, P.C., Levtsenko and the Management Defendants**  
**(Unjust Enrichment)**

480. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

481. As set forth above, Levtsenko, P.C., Levtsenko and the Management Defendants have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of Liberty Mutual.

482. When Liberty Mutual paid the bills and charges submitted by or on behalf of Levtsenko, P.C. for No-Fault Benefits, it reasonably believed that it was legally obligated to make such payments based on Defendants' improper, unlawful, and/or unjust acts.

483. Levtsenko, P.C., Levtsenko, the Management Defendants, and John Doe Defendants have been enriched at Liberty Mutual's expense by Liberty Mutual's payments, which constituted a benefit that Defendants voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

484. Defendants' retention of Liberty Mutual's payments violates fundamental principles of justice, equity and good conscience.

485. By reason of the above, Defendants have been unjustly enriched in an amount to be determined at trial, but in no event less than \$35,000.00.

**FOURTEENTH CAUSE OF ACTION**  
**Against 406 Medical, Delerme-Pagan and the Management Defendants**  
**(Common Law Fraud)**

486. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

487. 406 Medical, Delerme-Pagan and the Management Defendants intentionally and knowingly made false and fraudulent statements of material fact to Liberty Mutual and concealed material facts from Liberty Mutual in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

488. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that 406 Medical was properly licensed and therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 NYCRR § 65-3.16(a)(12), when in fact it was fraudulently controlled by unlicensed laypersons;

(ii) in every claim, the representation that 406 Medical was properly licensed and, therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) 11 NYCRR § 65-3.16(a)(12), when in fact the professional corporation engaged in illegal financial arrangements with unlicensed laypersons; (iii) in every claim, the representation that the billed-for services were the result of professional judgment and properly billed in accordance with the Fee Schedule, when in fact the billed-for services were performed and billed pursuant to a predetermined, fraudulent protocol designed solely to enrich Defendants; (iv) in every claim, the representation that the charges were appropriate and consistent with the service provided, when in fact the charges exaggerated the level of service and the nature of the service that purportedly was provided; and (v) in every claim, the representation that the services were provided by employees, when in fact the billed-for services were provided, in many cases, by independent contractors. The fraudulent bills and corresponding mailings submitted to Liberty Mutual identified through the date of this Complaint are described, in part, in the chart annexed hereto as Exhibit “5”.

489. 406 Medical, Delorme-Pagan, the Management Defendants and John Doe Defendants intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induct Liberty Mutual to pay charges submitted through 406 Medical that were not compensable under the No-Fault Laws.

490. Liberty Mutual has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$8,000.00 pursuant to the fraudulent bills submitted by Defendants through 406 Medical.

491. Defendants’ extensive fraudulent concealment demonstrates a high degree of moral turpitude and wanton dishonesty that entitles Liberty Mutual to recover punitive damages.

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

**FIFTEENTH CAUSE OF ACTION**  
**Against 406 Medical, Delerme-Pagan and the Management Defendants**  
**(Unjust Enrichment)**

493. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

494. As set forth above, 406 Medical, Delerme-Pagan and the Management Defendants have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of Liberty Mutual.

495. When Liberty Mutual paid the bills and charges submitted by or on behalf of 406 Medical for No-Fault Benefits, it reasonably believed that it was legally obligated to make such payments based on Defendants' improper, unlawful, and/or unjust acts.

496. 406 Medical, Delerme-Pagan and the Management Defendants have been enriched at Liberty Mutual's expense by Liberty Mutual's payments, which constituted a benefit that Defendants voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

497. Defendants' retention of Liberty Mutual's payments violates fundamental principles of justice, equity and good conscience.

498. By reason of the above, Defendants have been unjustly enriched in an amount to be determined at trial, but in no event less than \$8,000.00.

**SIXTEENTH CAUSE OF ACTION**  
**Against Eastern Parkway, Delorme-Pagan and the Management Defendants**  
**(Common Law Fraud)**

499. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

500. Eastern Parkway, Delorme-Pagan and the Management Defendants intentionally and knowingly made false and fraudulent statements of material fact to Liberty Mutual and concealed material facts from Liberty Mutual in the course of their submission of hundreds of fraudulent bills seeking payment for the Fraudulent Services.

501. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) in every claim, the representation that Eastern Parkway was properly licensed and therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) and 11 NYCRR § 65-3.16(a)(12), when in fact it was fraudulently controlled by unlicensed laypersons; (ii) in every claim, the representation that Eastern Parkway was properly licensed and, therefore, eligible to receive No-Fault Benefits pursuant to Insurance Law § 5102(a)(1) 11 NYCRR § 65-3.16(a)(12), when in fact the professional corporation engaged in illegal financial arrangements with unlicensed laypersons; (iii) in every claim, the representation that the billed-for services were the result of professional judgment and properly billed in accordance with the Fee Schedule, when in fact the billed-for services were performed and billed pursuant to a predetermined, fraudulent protocol designed solely to enrich Defendants; (iv) in every claim, the representation that the charges were appropriate and consistent with the service provided, when in fact the charges exaggerated the level of service and the nature of the service that purportedly was provided; and (v) in every claim, the representation that the services were provided by employees, when in fact the billed-for services were provided, in many cases, by

independent contractors. The fraudulent bills and corresponding mailings submitted to Liberty Mutual identified through the date of this Complaint are described, in part, in the chart annexed hereto as Exhibit “6”.

502. Eastern Parkway, Delorme-Pagan and the Management Defendants intentionally made the above-described false and fraudulent statements and concealed material facts in a calculated effort to induct Liberty Mutual to pay charges submitted through Eastern Parkway that were not compensable under the No-Fault Laws.

503. Liberty Mutual has been injured in its business and property by reason of the above-described conduct in that it has paid at least \$15,000.00 pursuant to the fraudulent bills submitted by Defendants through Eastern Parkway.

504. Defendants’ extensive fraudulent concealment demonstrates a high degree of moral turpitude and wanton dishonesty that entitles Liberty Mutual to recover punitive damages.

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

**SEVENTEENTH CAUSE OF ACTION**  
**Against Eastern Parkway, Delorme-Pagan and the Management Defendants**  
**(Unjust Enrichment)**

506. Liberty Mutual incorporates, as though fully set forth herein, each and every allegation in the paragraphs set forth above.

507. As set forth above, Eastern Parkway, Delorme-Pagan and the Management Defendants have engaged in improper, unlawful, and/or unjust acts, all to the harm and detriment of Liberty Mutual.

508. When Liberty Mutual paid the bills and charges submitted by or on behalf of Eastern Parkway for No-Fault Benefits, it reasonable believed that it was legally obligated to make such payments based on Defendants' improper, unlawful, and/or unjust acts.

509. Eastern Parkway, Delerme-Pagan and the Management Defendants have been enriched at Liberty Mutual's expense by Liberty Mutual's payments, which constituted a benefit that Defendants voluntarily accepted notwithstanding their improper, unlawful, and unjust billing scheme.

510. Defendants' retention of Liberty Mutual's payments violates fundamental principles of justice, equity and good conscience.

511. By reason of the above, Defendants have been unjustly enriched in an amount to be determined at trial, but in no event less than \$15,000.00.

#### **JURY DEMAND**

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

**WHEREFORE**, Plaintiffs Liberty Mutual Insurance Company, Liberty Mutual Fire Insurance Company, Liberty Insurance Corporation, The First Liberty Insurance Corporation, LM Insurance Corporation, Liberty Mutual Mid-Atlantic Insurance Company, Liberty County Mutual Insurance Company, LM Property and Casualty Insurance Company, Safeco Company of Indiana, and American States Insurance Company demand that a judgment be entered in their favor.

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

B. On the Second Cause of Action against Sternberg and the Management Defendants, compensatory damages in favor of Liberty Mutual an amount to be determined at trial but in excess

of \$138,000.00, 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 Sternberg and the Management Defendants, compensatory damages in favor of Liberty Mutual an amount to be determined at trial but in excess of \$138,000.00, 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 RHS Chiropractic, Sternberg and the Management Defendants, compensatory damages in favor of Liberty Mutual an amount to be determined at trial but in excess of \$138,000.00, together with punitive damages, costs, interest and such other and further relief as this Court deems just and proper;

E. On the Fifth Cause of Action against RHS Chiropractic, Sternberg and the Management Defendants, more than \$138,000.00 for unjust enrichment, plus costs and interest and such other and further relief as this Court deems just and proper;

F. On the Sixth Cause of Action against Terra Chiropractic, Duque and the Management Defendants, compensatory damages in favor of Liberty Mutual an amount to be determined at trial but in excess of \$37,000.00, together with punitive damages, costs, interest and such other and further relief as this Court deems just and proper;

G. On the Seventh Cause of Action against Terra Chiropractic, Duque and the Management Defendants, more than \$37,000.00 for unjust enrichment, plus costs and interest and such other and further relief as this Court deems just and proper;

H. On the Eighth Cause of Action against Usman and the Management Defendants, compensatory damages in favor of Liberty Mutual an amount to be determined at trial but in excess

of \$142,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

I. On the Ninth Cause of Action against Usman and the Management Defendants, compensatory damages in favor of Liberty Mutual an amount to be determined at trial but in excess of \$142,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

J. On the Tenth Cause of Action against Pivotal Care, Usman and the Management Defendants, compensatory damages in favor of Liberty Mutual an amount to be determined at trial but in excess of \$142,000.00, together with punitive damages, costs, interest and such other and further relief as this Court deems just and proper;

K. On the Eleventh Cause of Action against Pivotal Care, Usman and the Management Defendants, more than \$142,000.00 for unjust enrichment, plus costs and interest and such other and further relief as this Court deems just and proper;

L. On the Twelfth Cause of Action against Levtsenko, P.C., Levtsenko and the Management Defendants, compensatory damages in favor of Liberty Mutual an amount to be determined at trial but in excess of \$35,000.00, together with punitive damages, costs, interest and such other and further relief as this Court deems just and proper;

M. On the Thirteenth Cause of Action against Levtsenko, P.C., Levtsenko and the Management Defendants, more than \$35,000.00 for unjust enrichment, plus costs and interest and such other and further relief as this Court deems just and proper;

N. On the Fourteenth Cause of Action against Delerme-Pagan and the Management Defendants, compensatory damages in favor of Liberty Mutual an amount to be determined at trial

but in excess of \$8,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

O. On the Fifteenth Cause of Action against Delerme-Pagan and the Management Defendants, and John Doe Defendants "1" – "10", compensatory damages in favor of Liberty Mutual an amount to be determined at trial but in excess of \$8,000.00, together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

P. On the Sixteenth Cause of Action against 406 Medical, Delerme-Pagan and the Management Defendants, compensatory damages in favor of Liberty Mutual an amount to be determined at trial but in excess of \$8,000.00, together with punitive damages, costs, interest and such other and further relief as this Court deems just and proper;

Q. On the Seventeenth Cause of Action against 406 Medical, Delerme-Pagan and the Management Defendants, more than \$8,000.00 for unjust enrichment, plus costs and interest and such other and further relief as this Court deems just and proper;

R. On the Eighteenth Cause of Action against Eastern Parkway, Delerme-Pagan and the Management Defendants, compensatory damages in favor of Liberty Mutual an amount to be determined at trial but in excess of \$15,000.00, together with punitive damages, costs, interest and such other and further relief as this Court deems just and proper; and

S. On the Nineteenth Cause of Action against Eastern Parkway, Delerme-Pagan and the Management Defendants, more than \$15,000.00 for unjust enrichment, plus costs and interest and such other and further relief as this Court deems just and proper.

Dated: March 25, 2024  
Uniondale, New York

RIVKIN RADLER LLP

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