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FI-00136
UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

21st CENTURY CENTENNIAL INSURANCE COMPANY,
BRISTOL WEST INSURANCE COMPANY,
ECONOMY PREFERRED INSURANCE COMPANY,
ECONOMY PREMIER ASSURANCE COMPANY,
FARMERS CASUALTY INSURANCE COMPANY,
FARMERS GROUP PROPERTY AND CASUALTY INSURANCE COMPANY,
FARMERS INSURANCE EXCHANGE,
FARMERS NEW CENTURY INSURANCE COMPANY,
FARMERS PROPERTY AND CASUALTY INSURANCE COMPANY,
FOREMOST INSURANCE COMPANY GRAND RAPIDS MICHIGAN,
FOREMOST SIGNATURE INSURANCE COMPANY,
MID-CENTURY INSURANCE COMPANY,
SECURITY NATIONAL INSURANCE COMPANY,
TRUCK INSURANCE EXCHANGE,

Plaintiffs,

-against-

JONATHAN LANDOW M.D.,
VIVIANE ETIENNE M.D.,
KAMRUNNAHAR KANNY a/k/a KANNY KAMRUNNAHAR,
MACINTOSH MEDICAL P.C.,
ATLANTIC MEDICAL & DIAGNOSTIC, P.C.,
WEI HONG XU, N.P.
CHADAE HAFFENDEN MORISSON, N.P.
NICOLA HOUSLIN, N.P.
NATASHA JAGGA, N.P.
ALEKSANDR KOPACH, P.A.
MARIO LEON, P.A.
IDY LIANG, N.P.
HIRAM LUIGI MARTINEZ, M.D.
JOSEPH MARTONE, P.A.
AJIN MATHEW, P.A.,
AMIRA NASSER, P.A.
SONIA SIKAND, P.A.,
JOHN DOES 1-10,

Defendants.

Docket No.:
1:26-cv-3074

COMPLAINT

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Plaintiffs, 21st Century Centennial Insurance Company, Bristol West Insurance Company, Economy Preferred Insurance Company, Economy Premier Assurance Company, Farmers Casualty Insurance Company, Farmers Group Property and Casualty Insurance Company, Farmers Insurance Exchange, Farmers New Century Insurance Company, Farmers Property and Casualty Insurance Company, Foremost Insurance Company Grand Rapids, Michigan, Foremost Signature Insurance Company, Mid-Century Insurance Company, Security National Insurance Company, Truck Insurance Exchange, (hereinafter referred to as "Plaintiffs"), as and for their Complaint against the Defendants in this action, hereby allege as follows upon information and belief:

I. INTRODUCTION

1. This action seeks to recover more than $1,655,000 that Defendants have obtained from Plaintiffs by submitting, and causing to be submitted, thousands of fraudulent charges for medically unnecessary medical treatment and testing, through Defendants Macintosh Medical, P.C. ("Macintosh") and Atlantic Medical & Diagnostic, P.C. ("Atlantic"), which were purportedly administered to New York No-Fault claimants who were injured in automobile accidents and are eligible for insurance coverage under Plaintiffs' policies of insurance. In addition, Plaintiffs seek a declaration that the Defendants have no right to receive payment for any pending claims that have been asserted by Macintosh and Atlantic totaling at least $3,700,000.

2. Macintosh and Atlantic purport to be valid medical professional corporations. Macintosh is listed as solely owned and operated by Jonathan Landow, MD ("Landow"). Atlantic is listed as owned 95% by Landow and 5% owned by Defendant Viviane Etienne, MD and she is the purported Medical Director of Atlantic. In fact, Macintosh and Atlantic are controlled illegally by layperson Kamrunnahar Kanny ("Kanny") and John Does 1-10 ("John Does"). At the direction of Kanny and these other parties, Macintosh and Atlantic operate as hubs of a scheme

to defraud Plaintiffs by billing for services based on pre-determined protocols that are designed to maximize financial gain by billing for services that were not rendered in good faith and referring patients for medically unnecessary and excessive services. These fraudulent bills include, but are not limited to, claims for boilerplate initial and follow-up examinations, referred extracorporeal shockwave therapy ("ESWT"), referred transcranial doppler testing ("TCD"), injection therapy including steroids, nerve block and trigger point allegedly utilizing ultrasonic guidance for needle placement, outcome assessment testing, referred durable medical equipment ("DME"), referred MRIs, referred videonystagmography testing ("VNG"), referred oral pain killers including opioids, and referred compounding creams and ointments.

3. Plaintiffs seeks to recover the monies paid to Defendants under false pretenses and a declaration that it is not obligated to pay more than $3,700,000 in pending claims submitted by Macintosh and Atlantic because:

a. The claims submitted were not medically necessary and, to the extent that they were accurately billed, they were done pursuant to a pre-determined fraudulent protocol designed with the sole goal of financial gain and not for the benefit of patients;

b. Defendants were and are in violation of New York statutes and regulation regarding healthcare practice and licensing because Defendants were and are engaging in an illegal financial agreement to obtain and refer patients based on kickbacks and self-referrals that effectively ceded control of the professional corporations to unlicensed individuals;

c. Defendants used billing codes to exaggerate and misrepresent the nature and extent of treatment, to the extent that it was even rendered, to inflate charges to maximize billing;

d. Landow, though listed as the owner of Macintosh and primary owner of Atlantic, does not render any treatment, is not qualified to administer or monitor much of the alleged treatment billed, and is not ever physically in New York State to oversee operations. Etienne also does not manage or direct Atlantic or monitor the alleged claims submitted.

e. Macintosh and Atlantic have submitted and continue to submit claims representing that services were provided by employees, when any treatments, to the extent

rendered, were improperly rendered by independent contractors, primarily nurse practitioners ("NPs") and physician assistants ("PAs"), in violation of No-Fault regulations.

4. Defendants fall into the following categories:

a. Macintosh and Atlantic are the professional corporations that have submitted to and collected claims from Plaintiffs;

b. Landow is the paper owner of Macintosh and he and Etienne are the paper owners of Atlantic;

c. Kanny and John Does are the true parties that control Macintosh and Atlantic in violation of New York law and who have conspired with Landow and Etienne to manufacture fraudulent claims;

d. Defendants Wei Hong Xu NP, Chadae Haffenden Morrison, NP, Nicola Houslin, NP, Aleksander Kopach, PA, Mario Leon, PA, Idy Liang, NP, Hiram Luigi Martinez, MD, Joseph Martone, PA, Ajin Mathew, PA, Amira Nasser, PA, and Sonia Sikand, PA (collectively, "Treating Professional Defendants") are independent contractors whom Macintosh and Atlantic falsely represent as employees and who provide the fraudulent services for Macintosh and Atlantic in furtherance of the scheme. Each one of these parties has submitted over 400 claims to Plaintiffs and is aware of the falsity of the claims submitted.

5. The Defendants' scheme continues uninterrupted to the present and is ongoing. The Defendants have known that: (a) the claims submitted to Plaintiffs by Macintosh and Atlantic were not medically necessary, but were administered based on a pre-determined protocol designed to enrich the Defendants, rather than to treat patients in good faith; (b) the Defendants were not in compliance with laws and regulations relating to healthcare practice and licensing, including but not limited those that relate to control of medical professional corporations and improper referral arrangements; and (c) treatment was falsely billed and/or exaggerated and, to the extent it was even provided, was administered by independent contractors, for whom Macintosh and Atlantic are not permitted to bill.

6. The scheme required coordination between Landow, Etienne, Kanny, the Treating Professional Defendants, and John Does. In carrying out this scheme, Defendants transmitted through the United States Mail claim forms, medical reports, and other documents that falsely represented that treatment was necessary and accurately represented by the codes and reports; that any alleged treatment was rendered by bona fide employees; and that Macintosh and Atlantic were controlled by licensed professionals.

7. Defendants do not have now, and have never had, any right to be compensated for their fraudulent services billed to Plaintiffs.

8. Annexed hereto as **Exhibit 1** is spreadsheet list of claims submitted by Defendants over the last six years, which Plaintiff believes contain misrepresentations as described herein. (The Exhibit is not intended to be exhaustive or limiting, but is extensive. All rights are reserved.)

9. The spreadsheet shown as **Exhibit 1** lists what are believed to be 26,515 instances of fraudulent billing submissions from Macintosh and Atlantic as providers submitting No-Fault billings. The list includes the "Billing Provider Group Name" (Macintosh or Atlantic); the claim number, date received, type of claim form received, the Current Procedural Terminology ("CPT") code and the charged amount, in columns appropriately labeled to same.

10. **Exhibit 2** is a collection of about 25 sample claim submissions (appropriately redacted) demonstrating the typical fraudulent submission that would comprise those incidents listed in Exhibit 1. **Exhibit 2** is merely a small representative sample and is in no way intended as exhaustive or limiting.

11. Defendants' fraudulent scheme continues uninterrupted through the commencement of this action and seeks to collect on pending fraudulent claims. As a result of

the Defendants' conspiracy, to date, Plaintiffs have incurred damage exceeding $5,300,000 comprised of over $1,655,000 in claims paid and more than $3,700,000 in pending claims asserted.

THE PARTIES

12. Plaintiff, 21st Century Centennial Insurance Company, at all pertinent times herein, is a corporation organized and existing under the laws of the Commonwealth of Pennsylvania, with a principal place of business located at 6301 Owensmouth Avenue, Woodland Hills, CA 91367 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

13. Plaintiff, Bristol West Insurance Company, at all pertinent times herein, is a corporation organized and existing under the laws of the State of Ohio, with a principal place of business located at 5990 West Creek Road, Independence, OH 44131 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

14. Plaintiff, Economy Preferred Insurance Company, at all pertinent times herein, is a corporation organized and existing under the laws of the State of Illinois, with a principal place of business located at 700 Quaker Lane, Warwick, RI 02887 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

15. Plaintiff, Economy Premier Assurance Company, at all pertinent times herein, is a corporation organized and existing under the laws of the State of Illinois, with a principal place of business located at 700 Quaker Lane, Warwick, RI 02887 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

16. Plaintiff, Farmers Casualty Insurance Company, at all pertinent times herein, is a corporation organized and existing under the laws of the State of Rhode Island, with a principal

place of business located at 1300 Woodland Avenue West, Des Moines, IA 50265 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

17. Plaintiff, Farmers Group Property and Casualty Insurance Company, at all pertinent times herein, is a corporation organized and existing under the laws of the State of Rhode Island, with a principal place of business located at 700 Quaker Lane, Warwick, RI 02887 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

18. Plaintiff, Farmers Insurance Exchange, at all pertinent times herein, is a corporation organized and existing under the laws of the State of California, with a principal place of business located at 6301 Owensmouth Avenue, Woodland Hills, CA 91367 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

19. Plaintiff, Farmers New Century Insurance Company, at all pertinent times herein, is a corporation organized and existing under the laws of the State of Illinois, with a principal place of business located at 6301 Owensmouth Avenue, Woodland Hills, CA 91367 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

20. Plaintiff, Farmers Property and Casualty Insurance Company, at all pertinent times herein, is a corporation organized and existing under the laws of the State of Rhode Island, with a principal place of business located at 1440 Yankee Park Place, Suite C, Dayton, OH 45458 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

21. Plaintiff, Foremost Insurance Company Grand Rapids, Michigan, at all pertinent times herein, is a corporation organized and existing under the laws of the State of Michigan, with a principal place of business located at 5600 Beech Tree Lane, Caledonia, MI 49316 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

22. Plaintiff, Foremost Signature Insurance Company, at all pertinent times herein, is a corporation organized and existing under the laws of the State of Michigan, with a principal place of business located at 6301 Owensmouth Avenue, Woodland Hills, CA 91367 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

23. Plaintiff, Mid-Century Insurance Company, at all pertinent times herein, is a corporation organized and existing under the laws of the State of California, with a principal place of business located at 6301 Owensmouth Avenue, Woodland Hills, CA 91367 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

24. Plaintiff, Security National Insurance Company, at all pertinent times herein, is a corporation organized and existing under the laws of the State of Florida, with a principal place of business located at 900 S. Pine Island Road, Ft. Lauderdale, FL 33324 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

25. Plaintiff, Truck Insurance Exchange, at all pertinent times herein, is a corporation organized and existing under the laws of the State of California, with a principal place of business located at 6301 Owensmouth Avenue, Woodland Hills, CA 91367 and which, at all times material hereto, was engaged in the business of issuing policies of insurance.

26. Landow is a resident of the State of Florida. He became licensed to practice medicine in New York State in 1988 and is trained in internal medicine. He is listed owner of Macintosh and Atlantic, but does not practice medicine, and has caused fraudulent billing to be submitted to Plaintiffs.

27. Etienne is a resident of the State of New York. She became licensed to practice medicine in New York State in 1991 and is the listed Medical Director and 5% owner of Atlantic. She has been named as a defendant in several lawsuits that alleged that she participated in schemes

to defraud No-Fault insurers. *See Allstate Insurance Company v. Etienne,* 2009CV03582 (E.D.N.Y. 2009) (alleging participation in scheme to order unnecessary diagnostic testing); *Government Employees Insurance Company et al v. Dublin*, 2011CV04018 (E.D.N.Y. 2011) (alleging participation in scheme to order unnecessary diagnostic testing); *Government Employees Insurance v. Wellmart RX, Inc.,* 2019CV04414 (E.D.N.Y. 2019)(alleging participation in scheme to dispense unnecessary prescription medication).

28. Kanny is a resident of the State of New York and is not licensed to practice medicine. She is listed as "Director of Operations" for Macintosh and Atlantic but truly controls the administration of treatment and billing for fraudulent services.

29. Xu is a resident of the State of New York. She became licensed as a nurse practitioner in New York State in 2013 and purportedly renders treatment for Macintosh and Atlantic.

30. Morrison is a resident of the State of New York. She became licensed as a nurse practitioner in New York State in 2018 and purportedly renders treatment for Macintosh and Atlantic.

31. Houslin is a resident of the State of New York. She became licensed as a nurse practitioner in New York State in 2015 and purportedly renders treatment for Macintosh and Atlantic.

32. Jagga is a resident of the State of New Jersey. She became licensed as a nurse practitioner in New York State in 2022 and purportedly renders treatment for Macintosh and Atlantic.

33. Kopach is a resident of the State of New York. He became licensed as a physician assistant in New York State in 2015 and purportedly renders treatment for Macintosh and Atlantic.

34. Leon is a resident of the State of New York. He became licensed as a physician assistant in New York State in 2007 and purportedly renders treatment for Macintosh and Atlantic.

35. Liang is a resident of the State of New York. She became licensed as a nurse practitioner in New York State in 2014 and purportedly renders treatment for Macintosh and Atlantic.

36. Martinez is a resident of the State of New York. He became licensed to practice medicine in New York State in 2018 and is an alleged employee of Macintosh and Atlantic and is claimed to oversee and approve the claims allegedly rendered by their NPs and PAs.

37. Martone is a resident of the State of New York. He became licensed as a physician assistant in New York State in 2020 and purportedly renders treatment for Macintosh and Atlantic.

38. Mathew is a resident of the State of Connecticut. He was licensed as a physician assistant in New York State in 2018 and purportedly renders treatment for Macintosh and Atlantic.

39. Nasser is a resident of the State of New York. She was licensed as a physician assistant in New York State in 2017 and purportedly renders treatment for Macintosh and Atlantic.

40. Sikand is a resident of the State of New York. He was licensed as a physician assistant in New York State in 2018 and purportedly renders treatment for Macintosh and Atlantic.

41. Macintosh is New York State professional corporation registered in New York County in 1998 and lists Landow as the CEO with an address of 3530 Mystic Pointe Dr., Suite 1402, Aventura, Florida 33180.

42. Atlantic is New York State professional corporation registered in Albany County in 2002 and lists Landow as the CEO with an address of 3530 Mystic Pointe Dr., Suite 1402, Aventura, Florida 33180.

43. John Does are laypersons that control and are the primary beneficiaries of the profits of Macintosh and Atlantic.

JURISDICTION AND VENUE

44. Pursuant to 28 U.S.C. 1331, this Court has jurisdiction over the claims brought under 18 U.S.C. 1961, et seq, because they arise under the law of the United States of America.

45. In addition, this Court has supplemental jurisdiction over the subject matter of the New York State law claims asserted in this action pursuant to 28 U.S.C. 1367.

46. Venue in this district is proper pursuant to 28 U.S.C. 1391(b)(1), one or more of the Defendants reside in the Eastern District of New York.

47. Venue in this district is proper pursuant to 28 U.S.C. 1391(b)(2), this is the district where a substantial amount of the activities forming the basis of the Complaint occurred.

AN OVERVIEW OF NEW YORK'S NO-FAULT INSURANCE SYSTEM

48. In 1974, New York State enacted No-Fault insurance laws designed to ensure that persons injured in motor vehicle accidents are reimbursed promptly.

49. Under New York's Comprehensive Motor Vehicle Insurance Reparations Act, N.Y. Ins. Law §§ 5101, et seq., and the regulations promulgated thereunder, 11 N.Y.C.R.R. 65-1.1, et seq, automobile insurers are required to provide No-Fault insurance benefits ("Personal Injury Protection" benefits or "PIP Benefits") to claimants injured arising out the use or operation of motor vehicle.

50. Mandatory PIP Benefits include a minimum of $50,000 per claimant for necessary expenses that are incurred for healthcare goods and services.

51. The regulation and resulting case law has established that, with limited exceptions, an insurer must pay or deny claims within 30 days of receipt, or the insurer is liable for the claim, as well as 24% interest and attorney's fees.

52. Typically, a claimant will assign his/her right to PIP Benefits to the medical provider rendering services and that medical provider will receive payment directly from the insurer or contest any denials of claim in expedited arbitration or by bringing small civil court actions.

53. In these expedited proceedings, a medical provider makes a prima facie case for entitlement for benefits by proving mail of a claim form to an insurer and alleging that it was not paid timely. The claim is presumed to be medically necessary and causally related to a covered accident and the insurer has the burden of disproving these presumptions.

54. The contours of the No-Fault system, unfortunately, encourage some bad actors to exploit these rules to manufacture claims on a large scale that are not rendered in good faith and are financed by laypersons who have no concern for patient care.

55. To combat this problem, in 2002, the No-Fault regulations were amended to bar medical providers from being eligible to collect PIP Benefits if they fail to meet any New York State or local licensing requirements necessary to provide the underlying services, or if they fail to meet the applicable licensing requirements in any other state in which such services are performed.

56. Under 11 NYCRR 65-3.16(a)(12), only a licensed healthcare professional may: (i) practice the pertinent healthcare profession; (ii) own and control a professional corporation authorized to operate a professional healthcare practice; (iii) employ and supervise other healthcare professionals; and (iv) absent statutory exceptions not applicable in this case, derive economic

benefit from healthcare professional services. Unlicensed individuals may ***not***: (a) practice the pertinent healthcare profession; (b) own or control a professional corporation authorized to operate a professional healthcare practice; (c) employ or supervise healthcare professionals; or (d) absent statutory exceptions not applicable, derive economic benefit from professional healthcare services.

57. Therefore, under the No-Fault Laws, a healthcare provider is not eligible to receive PIP Benefits if it is fraudulently incorporated, fraudulently licensed, if it engages in unlawful fee-splitting with unlicensed non-professionals, or if it pays or receives unlawful compensation in exchange for patient referrals.

58. In that same vein, 11 NYCRR 65-3.11(a) bars a medical provider from billing for the services of independent contractors, who are not controlled or properly supervised by the billing medical provider.

59. Moreover, 11 NYCRR 65-3.8(g)(1) bars a medical provider from billing for services not rendered and for seeking amounts in excess of the proper fee schedule for the relevant service rendered.

60. Where a medical provider violates these regulations, an insurer may refuse payment or disgorge payments already made in reliance on a medical provider representation that its treatment complied with these provisions.

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

62. The NF-3 claims forms submitted by medical providers to insurers must be verified by the medical provider subject to the following warning:

> Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

II. DEFENDANTS' FRAUDULENT SCHEME

A. Overview

63. In the early 2000s, Landow submitted large amounts of questionable claims through Macintosh and Atlantic and, at least 11 other professional corporations including: Birch Medical and Diagnostic PC, Eastern Medical Practice PC, Empire Medical Services PC, Paramount Medical Services PC, Preferred Medical PC, Sovereign Medical Services PC, Spruce Medical and Diagnostic PC, Summit Medical Services PC, Urban Medical PC, New York Medical Inc., and Sound Medical PC. These companies seemingly stopped billing insurers for No-Fault claims a few years later.

64. Over the past 15 years, several creditors, including tax authorities, lending companies, and physicians who claimed that they were not paid for services rendered, filed actions against Landow and exposed him to significant liability. For example, in 2011, a tax court found that he had tax deficiencies of over $1,730,000 and, in 2015, he gave a confession of judgment exceeding $570,000 on a loan that was issued at an interest rate of 16.95%. *See e.g., Landow v. Commissioner of Internal Revenue*, 2011 T.C. Memo 177 (U.S. Tax Court, 2011); *Landow v. Wachovia Securities,* 966 F. Supp.2d 166 (E.D.N.Y. 2013); *Bronte SPV, LLC. v. Landow, et al.*, 601591/2017 (Sup. Ct. Nassau Co. 2017).

65. Faced with a large debt to the government and private lenders, in or around 2015, Landow reactivated some of these old professional corporations, including Macintosh, and began submitting large amounts of mirrored and elaborate claims. In 2020, Landow abruptly stopped billing from all these companies, except Macintosh.

66. Landow also was referenced prominently in a criminal case *United States of America v. Rose*, 19CR00789 (S.D.N.Y.) where laypersons were charged with illegally owning and controlling No-Fault clinics, as part of a scheme to defraud insurers with fraudulent and unnecessary treatment claims. On June 14, 2021, the government filed an affidavit of an FBI Agent Scheenloch who described the contents of a wiretap that recorded Landow working to coordinate treatment with one of the defendants, who was the reported illegal lay owner of several clinics at which Macintosh had subleases. The affidavit provides in relevant part:

36. At approximately 10:38 a.m., Coles (using the Coles 5 telephone) sent a text to telephone number 212-996-2201, which stated "Good morning sir how you doing this I'd [*sic*] Nat give me a call when you get a chance[.]"[38]

37. About an hour later, at approximately 11:32 a.m., Coles (using the Coles 5 telephone) spoke with an unknown male, believed to be Dr. Landow (using telephone number 212-996-2201, and hereafter referred to as Dr. Landow and/or Landow).[39] [40] Coles told the doctor that he was ready to have him start. Dr. Landow responded that he needed a week or two so he could get people to respond and put them on the schedule. The doctor asked if Coles could wait, and Coles responded "no problem." Landow asked if they were going to be doing internal medicine and the pain, or just one or the other, and Coles explained that they were doing internal medicine and pain "in the office," and confirmed that they had someone who would take "these people (patients) to the surgery center." Landow informed Coles that they (possibly meaning the doctor's office) had different levels of involvement, sometimes they just did office space and sometimes they did "the whole enchilada." Landow said he would get working on it, and told Coles that he (Landow) had other new offices that he was involved with, but that he would get back to Coles sometime next week. Landow asked about the PA (presumably referring to Micah Katz) and asked if he was still there and Coles told him no, he (Micah) wasn't there anymore.[41] The doctor said he would call Coles back sometime next week.

[38] Coles 5 Telephone (0163V), Reference # 1,038
[39] Dr. Landow is possibly Dr. Jonathan Seth Landow. See for e.g.: http://www.troysflorist.com/florists-locust-valley-ny-ct8756/zip-code-11560-zp16271/
According NYSED.gov, Dr. Jonathan Seth Landow is a registered physician (License No. 176016).
[40] Coles 5 Telephone (0163V), Reference # 1,046
[41] Apparently the doctor had not had a good experience with the PA, and Micah Katz did not think he was a good

67. In July 2022, Landow closed Macintosh and began billing under Atlantic, which had been dormant since 2001. Atlantic used the same professionals and treated patients at the same affiliated clinics. Landow stated in an examination under oath that he closed Macintosh based on the advice of counsel. While Landow did not explain specifically why he closed Macintosh, another insurer has alleged that the reason for closing arose because Macintosh had made referrals for various treatments, including Shock Wave, Transcranial Doppler, and VNG tests, that were forged by laypersons at various clinics at which Macintosh operated. See complaint, paragraph 94, *United Services Auto. Assoc. v. Landow,* 24CV03471 (E.D.N.Y. 2024).

68. Atlantic operates in much the same manner as Macintosh and treats the same patients with the same professionals. Notably, Atlantic continued treating patients at clinics that had allegedly forged prescriptions in the name of Macintosh.

69. In light of these troubling facts, Plaintiffs did a review of a sample of claims and found that it was likely that the claims were based on a pre-determined protocol and not rendered in good faith as follows:

a. In virtually all claims, Macintosh and Atlantic billed CPT code 99204 for prolonged face-to-face evaluation of a patient (the fee schedule states that this service takes 45 minutes) for initial evaluations but the records indicate cursory checklists without written reports to establish how this evaluation truly was comprehensive.

b. In virtually all claims, Macintosh and Atlantic billed CPT code 99358 for prolonged face-to-face evaluation of a patient (the fee schedule states that this service takes 60 minutes) for outcome assessment testing but the records indicate cursory checklists without written reports explaining how this testing was designed to aid in patient care.

c. Over 80% of patients who received initial exams also received multiple trigger point injections under CPT code 20553 and the trigger point was almost always paired with ultra-sonic guidance for needle placement under CPT code 76942. The frequency of trigger point injections administered on initial exams deviates from generally accepted medical standards. In addition, ultra sonic guidance greatly increases cost and is not typically used unless there is a documented need. Macintosh and Atlantic did not provide documentation of any such need.

70. In further investigation of Macintosh and Atlantic, Plaintiffs also found that:

a. In 2018, an insurer sued Landow, Urban Medical, P.C., and Empire Medical Services, P.C. alleging that they conspired with various clinics to bill and refer for fraudulent services, illegal kickbacks and layperson control, and participating in a criminal enterprise designed to defraud No-Fault insurers. *Government Employees Ins. Co. v. Urban Medical, P.C.,* 18CV02956 (E.D.N.Y. 2018).

b. In 2019, a billing company sued Landow and three other medical professional corporations for which he was listed owner, Paramount Medical Services, P.C., Preferred Medical, P.C., and Sovereign Medical Services, P.C. See *Qwil PBC v. Landow*, 654605/2019 (Sup. Ct. N.Y. Co.). The action alleged that the billing company had loaned Landow and his entities over $2,000,000 in exchange for a security interest in the receivables for the entities, which generated revenue by

submitting No-Fault claims. The billing company alleged that Landow moved money around via various shell companies to avoid attachment of proceeds and paying debts.

c. In 2021, Landow was sued by two insurers that both alleged that he was deeply in debt and engaged in a shell game of submitting large amounts of boilerplate claims from various professional companies that he would operate concurrently and interchangeably that were the products of kickbacks with laypersons. Landow resided in Florida and did not monitor and control his New York clinics, which were comprised of a group of independent contractors who were paid per patient and encouraged to treat a high volume of patients and disregard their primary duty of patient care. None of the treatment was supervised by Landow and he was not qualified to provide or supervise most of the treatment that was billed. Landow's clinics would pay rent to various clinics as a sublease, when, in fact, the rent was not fair market value and were disguised payments for access to patients. *Government Employees Ins. Co. v. Landow,* 2021CV01440 (E.D.N.Y. 2021);1 *Travelers Personal Ins. Co. v. Landow,* 656567/2021 (Sup. Ct. N.Y. Co. 2021).

71. Considering these issues, Plaintiffs duly requested EUOs of Macintosh and Atlantic to determine the legitimacy of their claims. Landow submitted to EUOs requested by Plaintiffs, but his testimony raised further questions as to the legitimacy of those companies, in part, confirmed Landow's lack of supervision of treatment and that his companies exclusively found patients through large scale patient brokering.

72. In fact, Defendants engaged in a pervasive scheme to enrich themselves by excessively and falsely billing based on pre-determined protocols and not based on legitimate clinical findings for each individual patient. Defendants further justified these protocols with false reports. Finally, Defendants are engaged in an illegal and improper kickback scheme that was so extensive that Landow ceded control of Macintosh and Atlantic to Kanny and John Does, who are the true owners of Macintosh and Atlantic.

1 In the cited case, the Landow and other defendants moved to dismiss the claims for RICO and other claims, and the motion was denied by an order dated March 29, 2022.

73. As noted above, Exhibit 1 hereto lists over 26,000 alleged instances of submissions of fraudulent bills to the Plaintiffs by Atlantic and Macintosh.

74. As noted above, Exhibit 2 hereto is an illustrative sample of redacted claim forms from 25 typical fraudulent claims demonstrating the general appearance and nature of the fraudulent submissions.

B. Illegal Kickbacks

75. Macintosh and Atlantic are itinerant providers, who do not have their own offices to treat patients. Landow does no marketing or advertisement to solicit patients and Macintosh and Atlantic have no apparent patient base of their own.

76. Instead, patients are exclusively the result of referrals from over 70 medical clinics that treat No-Fault claimants, including but not limited to the following:

Clinic Location	Rendering City
1 CROSS ISLAND PLAZA, SUITE 113 and Suite 323	ROSEDALE
107 48 GUY R BREWER BLVD	JAMAICA
108 KENILWORTH PL	BROOKLYN
11 E HAWTHORNE AVE 3RD FLR	VALLEY STREAM
1120 MORRIS PARK AVE	BRONX
115 MEACHAM AVE	ELMONT
1320 LOUIS NINE BLVD	BRONX
137-42 GUY R BREWER BOULEVARD SUITE 11 & 12	JAMAICA
14 BRUCKNER BLVD	BRONX

148-43 HILLSIDE AVE	JAMAICA
1500 Astor Ave, suite 1A	BRONX
1647 MACOMBS ROAD	BRONX
170 W 233RD ST SUITE 3	BRONX
172 17 JAMAICA AVE	JAMAICA
175 20 HILLSIDE AVE 2ND FLR	JAMAICA
175 FULTON AVE	HEMPSTEAD
179 A School	Westbury
180-09 JAMAICA AVE	JAMAICA
1877 WEBSTER AVE	YONKERS
1894 EASTCHESTER SUITE 201	BRONX
2118 CONEY ISLAND AVE 3RD FLOOR	BROOKLYN
2184 FLATBUSH AVE	BROOKLYN
219 HEMPSTEAD TURNPIKE	WEST HEMPSTEAD
2270 GRAND AVE	BALDWIN
2386 JEROME AVE 2ND FLR	BRONX
275 W 231st Street	BRONX
2940 Grand Concourse	BRONX
30-55 3RD AVE SUIT B	BRONX
3125 TIBBETT AVENUE GROUND LEVEL	BRONX
3140B E TREMONT AVE	BRONX
318 WARREN ST	BROOKLYN

319 E 149TH STREET	BRONX
3209 FULTON ST	BROOKLYN
3407 WHITE PLAINS RD	BRONX
35 01 QUEENS BLVD	LONG ISLAND CITY
3626 BAILEY AVE	BRONX
3805 CHURCH AVE	BROOKLYN
391 E 149TH STREET ROOM 614	BRONX
3910 CHURCH AVE	BROOKLYN
399 LAKE AVE	STATEN ISLAND
400 ROCKAWAY AVE	BROOKLYN
4250 WHITE PLAINS RD	BRONX
430 W MERRICK ROAD	VALLEY STREAM
441 Willis Ave, 2nd Floor	BRONX
480 E JERICHO TPK	HUNTINGTON STATION
486 MCDONALD AVE	BROOKLYN
488 LAFAYETTE AVE	BROOKLYN
49 N FRANKLIN	HEMPSTEAD
51-27 QUEENS BLVD, 2ND FLOOR 2C	WOODSIDE
513 CHURCH AVE	BROOKLYN
5205 CHURCH AVE GROUND FLR	BROOKLYN
55 E 115TH STREET	NEW YORK
550 REMSEN AVE	BROOKLYN

5506 AVENUE N	BROOKLYN
552 EAST 180th STREET	BRONX
560 PROSPECT AVE	BRONX
599 SOUTHERN BLVD	BRONX
60-40 82nd STREET	MIDDLE VILLAGE
611 EAST 76TH STREET	BROOKLYN
632 UTICA AVE	BROOKLYN
647 BRYANT AVE 2	BRONX
65-03 GRAND AVE	MASPETH
6506 ROOSEVELT AVE	WOODSIDE
681 THWAITES PL	BRONX
71 SOUTH CENTRAL AVE	VALLEY STREAM
717 SOUTHERN BLVD	BRONX
787 MEACHAM AVE	ELMONT
788 SOUTHERN BLVD	BRONX
79-45 METROPOLITAN AVE	MIDDLE VILLAGE
800 St Ann's Avenue	Bronx
82 11 37TH AVE 602	JACKSON HEIGHTS
89 40 56TH AVE	ELMHURST
8925 130TH STREET	RICHMOND HILL
903 SHERIDAN AVE SUITE E	BRONX
92 05 ROCKAWAY BLVD	OZONE PARK

92 12 165TH ST	JAMAICA
951 BROOK AVE 203	BRONX
975 KELLY ST	BRONX

77. The clinics purport to provide a multi-disciplinary treatment approach but, in fact, are hubs for kickbacks, whereby professional medical corporations can obtain access to the clinics' patient base in exchange for payments that are falsely characterized as sub-leases.

78. Many of the clinic locations have been sued multiple times for participating in other schemes to manufacture illegitimate No-Fault claims. See, e.g., *Government Employees Insurance Co., et al., v. East Flatbush Medical, P.C., et al*., 20-CV-1695 (E.D.N.Y.). Moreover, since Plaintiffs began investigations of Defendants, several other insurers have sued Landow, Atlantic, and several other Defendants, alleging substantially the same fraudulent treatment protocols. *See American States Ins. Co. v. Atlantic Medical & Diagnostic, P.C.,* 606333/2023 (Sup. Ct. Nass. Co. 2023); *Nationwide Affinity Ins. Co. of America v. Atlantic Medical & Diagnostic, P.C.,* 620109/2023 (Sup. Ct. Nass. Co. 2023); *Allstate Ins. Co. v. Landow,* 24CV02010 (E.D.N.Y. 2024); *United Services Automobile Association v. Landow*, 24CV03471 (E.D.N.Y. 2024).

79. Macintosh and Atlantic had no bona fide relationship with the patients and treated them solely based on the payment for access. Macintosh and Atlantic entered into illegal kickbacks with licensed and unlicensed persons, including John Does, who bartered No-Fault claimants as assets to generate revenue by defrauding insurance companies with illegitimate claims.

80. Macintosh and Atlantic had no ability to schedule patients for procedures and they were directed to the providers by the clinics' layperson staff. The clinics had no legitimate reason to refer the No-Fault claimants to Defendants and the treatment offered by Defendant was not necessary or proper.

81. The payments made by Defendants for access to clinic patients are characterized falsely as legitimate fees to sublease space at the clinics.

82. Although the Defendants entered into purported, boilerplate "leases" relating to the

83. clinics, the lease arrangements called for payments that were not reflective of the fair market value for leasing a tiny portion of space and/or non-exclusive space that was shared with numerous other healthcare providers in the clinics.

84. These kickbacks for access to patients were Defendants sole business model and were so extensive as to essentially cede control of Macintosh and Atlantic to the layperson John Does who referred patients.

C. Fraudulent Billing

85. Defendants' claims were pre-determined fraudulent protocols designed solely to financially enrich the Defendants, rather than to treat or otherwise benefit the patients. The treatment was provided pursuant to the directives of Kanny and other unlicensed laypersons at the clinics, none of whom are permitted by law to render or control the provision of healthcare services.

86. Macintosh and Atlantic have created a pay structure for their itinerant professionals that determines compensation on a "fee-for-service" schedule, meaning the employee was paid the greater of an hourly rate or the "fee-for-service" which would be based on the amount the individual generated in billing for Defendants. This type of agreement results in services

performed based on financial incentive, rather than true medical decision making or need. This fraudulent treatment scheme manifested itself in several manners.

D. Fraudulent Initial Examinations

87. Pursuant to the Defendants' pre-determined treatment and billing protocols, Macintosh and Atlantic purported to perform initial medical examinations on the vast majority of the No-Fault claimants they treated.

88. The initial examinations essentially were performed as gatekeepers in order to provide No-Fault claimants with pre-determined diagnoses to allow the Defendants to bill for the laundry list of other fraudulent services and as a springboard for other medical providers' services.

89. Defendants created a boilerplate, pre-determined "diagnosis" for the No-Fault claimant, wherein Defendants steered patients into receiving a pre-determined pattern of treatment, referrals, and recommendations to return for services at the clinics from which Macintosh or Atlantic leased office space.

90. Defendants billed the initial examinations to Plaintiffs under current CPT code 99204, which requires 45 minutes of face-to-face time with the patient and results in a charge of $203.76.

91. None of the Defendants provided 45-minute examinations and, in fact, Plaintiffs' investigation yielded that initial exams lasted about 10-15 minutes and, in some cases, were not provided at all.

92. Furthermore, the charges for the initial examinations were fraudulent in that they misrepresented the severity of the No-Fault claimants presenting problems and the nature and extent of the initial examinations.

93. 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. These forms were simplified and allowed for a brief interview, a check of vital signs, and range of motion.

94. These interviews and examinations, even if performed, did not require any medical professional employed by Macintosh and Atlantic to spend 45 minutes of face-to-face time with the Insureds.

95. According to the Fee Schedule, the use of CPT code 99204 typically requires that the patient presents with problems of moderate or moderate-to-high severity.

96. Though Defendants routinely billed for the initial examinations under CPT code 99204, the vast majority of the No-Fault claimants did not present with problems of moderate or moderate-to-high severity as the result of an auto accident. Rather, to the extent that they had any health problems as the result of auto accidents, the problems were usually of low severity, and the deficient initial examinations were incapable of assessing and/or diagnosing problems of higher severity.

97. According to the Fee Schedule, when Macintosh and Atlantic submitted charges for initial examinations under CPT code 99204, they represented that they: (i) took a "comprehensive" patient history; (ii) conducted a "comprehensive" physical examination; and (iii) engaged in medical decision-making of "moderate complexity."

1. Falsehoods Regarding "Comprehensive" and "Detailed" Patient Histories

98. 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.

99. 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.

100. The CPT Assistant recognizes the following fourteen (14) organ systems with respect to a review of systems: (i) constitutional symptoms (i.e. 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.

101. When Defendants billed for the initial examinations under CPT code 99204, they falsely represented that they took a "comprehensive" patient history from the Insureds they purported to treat during the initial examinations.

102. No Defendant ever took a "comprehensive" patient history from the patients they purported to treat during the initial examinations, because they did not document a review of the systems directly related to the history of the patients' present illnesses or a review of 10 organ systems unrelated to the history of the patients' present illnesses.

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

104. These sham patient histories did not genuinely reflect the patients' actual circumstances and instead were designed solely to support the laundry-list of fraudulent services that Defendants purported to provide and then billed to Plaintiffs and other insurers.

105. Pursuant to the CPT Assistant, a "detailed" patient history requires – among other things – that the examining physician take a history of systems related to the patient's presenting problems, as well as a review of a limited number of additional systems.

106. Pursuant to the Fee Schedule, a "detailed" patient history also requires that the healthcare provider take a past medical history, family, and social history from the patient to the extent that the patient's past medical history, family, and social history is relevant to the patient's presenting problems.

107. No Defendant ever took a "detailed" patient history during the initial examinations, as they did not review systems related to the patients' presenting problems, did not conduct any review of a limited number of additional systems, and did not take a past medical history, family, and social history from the patients to the extent that the patients' past medical history, family, and social history were relevant to the patients' presenting problems.

108. Rather, after purporting to provide the initial examinations, Defendants simply prepared reports containing false patient histories which inaccurately contended that the patients continued to suffer from injuries they sustained in automobile accidents.

109. These fake patient histories did not genuinely reflect the actual circumstances and instead were designed solely to support the fraudulent services that the Defendants purported to provide and then billed to Plaintiffs and other insurers.

2. Falsity Regarding "Comprehensive" and "Detailed" Physical Examinations

110. 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.

111. 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.

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

113. In addition the general appearance of the patient – *i.e.*, development, nutrition, body habits, deformities, and attention to grooming; examination of the peripheral vascular system by observation (*i.e.*, swelling, varicosities) and palpation (*i.e.,* pulses, temperature, edema, tenderness); palpation of lymph nodes in neck, axillae, groin, and/or other location; examination of gait and station; 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 inspection and palpation of skin and subcutaneous tissue (*i.e.,* scars, rashes, lesions, café-au-lait spots, ulcers) in at least four of the following areas: (i) head and neck; (ii) trunk; (iii) right upper extremity; (iv) left upper extremity; (v) right lower extremity; (vi) left lower extremity; (vii) coordination, deep tendon reflexes, and sensation; and (viii) mental status, including orientation to time, place and person, as well as mood and affect.

114. When Defendants billed for the initial examinations under CPT code 99204, they falsely represented that they performed a "comprehensive" patient examination on the Insureds they purported to treat during the initial examinations.

115. No Defendant ever conducted a general examination of multiple patient organ systems or conducted a complete examination of a single patient organ system, nor did they document findings with respect to at least eight organ systems.

116. Furthermore, although Defendants often claimed to provide a more in-depth examination of the patients' musculoskeletal systems during their supposed initial 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 – i.e., development, nutrition, body habits, deformities, and attention to grooming;

(iii) examination of the peripheral vascular system by observation (*i.e.*., swelling, varicosities) and palpation (i.e., 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 (*i.e.,* 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.

117. 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.

118. Pursuant to the CPT Assistant, in the context of patient examinations, a physician has not conducted a detailed 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 – *i.e.,* development, nutrition, body habits, deformities, and attention to grooming;

(iii) examination of the peripheral vascular system by observation (*i.e.,* swelling, varicosities) and palpation (*i.e.,* 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 (*i.e.,* 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.

119. The Defendants' motor examinations were clinically useless, and they did not routinely perform any sensory examinations regardless of patient's complaints or symptoms.

3. Misrepresentations Regarding the Extent of Medical Decision-Making

120. When Defendants submitted charges for initial examinations under CPT code 99204, they represented that they engaged in medical decision-making of "moderate complexity."

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

122. Though the Defendants routinely falsely represented that their initial examinations involved medical decision-making of "moderate complexity," 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 were incapable of assessing and/or diagnosing them as such.

123. First, the initial examinations did not involve the retrieval, review, or analysis of any medical records, diagnostic tests, or other information. When the patients presented to the Defendants for "treatment," they did not arrive with any medical records. Furthermore, prior to the initial examinations, the Defendants did not request any medical records from any other providers, nor conducted any diagnostic tests. As noted above, Landow did not consider the patients to be the Defendants' patients, but rather the patients of the respective clinics, as they did not arrive for treatment based on any marketing, advertising or outreach performed by Landow or any of the Defendants.

124. Second, there was no risk of significant complications or morbidity – much less mortality – from the relatively minor complaints of most patients.

125. Nor, by extension, was there any risk of significant complications, morbidity, or mortality from the diagnostic procedures or treatment options provided by the Defendants if

properly administered, to the extent that the 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 wholly insufficient in identifying such risks.

126. Third, the Defendants did not consider a significant number of diagnoses or treatment options for their nominal patients during the initial examinations.

127. Rather, to the extent that the initial examinations were conducted in the first instance, the Defendants provided a nearly identical, pre-determined "diagnosis" for the No-Fault Claimants, and prescribed a similar course of treatment for each.

128. The purported results of the initial examinations did not genuinely reflect the patients' actual circumstances and instead were designed solely to support the fraudulent services that Defendants purported to perform, as well as the other services provided at the clinics and then billed to Plaintiffs.

129. For example, the initial examination findings often did not support the supposed subjective complaints and rarely, if ever, was there any explanation as to why treatment plans were virtually identical, consisting of a routine set of services that were referred, recommended, and prescribed despite lack of clinical documentation in the initial examination reports. Typically, such a plan included (i) MRIs; (ii) trigger point and other injections; (iii) pharmaceuticals; and (iv) DME; (v) extensive physical therapy; (vi) chiropractic treatments (vii) Shockwave Therapy; (viii) a battery of experimental diagnostic sets discussed herein; and (ix) acupuncture, etc., are all ordered anyway despite a complete lack of clinical justification. Additionally, there was rarely, if ever, evidence of documentation showing any coordination of care with chiropractic or physical therapy providers at the clinics.

130. The Defendants prescribe various medically unnecessary pharmaceuticals and DME despite there being no legitimate symptoms for such prescriptions. These Provider Defendants wrote these prescriptions pursuant to the improper financial arrangements with the clinic owners/controllers and others at the various Clinics.

E. The Fraudulent Follow-Up Examinations

131. In addition to the fraudulent initial examinations, Macintosh and Atlantic typically purported to subject patients to one or more fraudulent follow-up examinations during their fraudulent treatment protocol.

132. Macintosh and Atlantic billed the follow-up examinations to Plaintiffs under CPT code 99213, resulting in a charge of $87.80 or CPT code 99214, resulting in a charge of $127.41.

133. The charges for the follow-up examinations were fraudulent in that the follow-up examinations were medically unnecessary and were performed pursuant to the illegal kickback and financial arrangements, referral schemes and fraudulent treatment protocol.

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

135. The use of CPT code 99213 typically requires that the physician spend 15 minutes of face-to-face time with the patient or the patient's family. Likewise, the use of CPT code 99214 typically requires that the physician spend 25 minutes of face-to-face time with the patient or the patient's family.

136. Though Macintosh and Atlantic routinely billed for the follow-up examinations under CPT codes 99213 or 99214, no physician ever spent 15 minutes of face-to-face time with patients or their families during the follow-up examinations, much less 25 minutes. Rather, the

follow-up examinations rarely occurred and, if they occurred, rarely lasted more than 5-10 minutes, to the extent that they were conducted at all – which is dubious at best as explained *supra*.

137. Macintosh and Atlantic issued fictional, boilerplate "follow-up examination" reports to further support the fraudulent services that Defendants purported to perform and then billed to Plaintiffs and other insurers, including interventional pain management injections and surgical procedures. The fictional, boilerplate results were also used to support the other medical services being performed at the clinics.

F. The Fraudulent "Outcome Assessment Testing"

138. Macintosh and Atlantic billed for medically useless "outcome assessment tests" on or within a few days of the same date they purported to subject the patients to examinations.[2]

139. Macintosh and Atlantic billed the "outcome assessment tests" using CPT code 99358, generally resulting in a charge of $280.12 for each round of "testing."

140. The charges for the "outcome assessment tests" were fraudulent in that the tests were medically unnecessary and were performed, to the extent they were performed at all, pursuant to the illegal kickback and referral schemes and fraudulent treatment protocol.

141. The "outcome assessment tests" purportedly provided were pre-printed, multiple-choice questionnaires on which the patients were summoned to report the symptoms they were experiencing, and the impact of those symptoms on their daily lives.

142. 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" purportedly provided were nothing more than a questionnaire regarding the

2 Atlantic appears to have ceased billing this procedure and this was primarily billed under the Macintosh iteration.

patient history and physical condition, the Fee Schedule provides that the "outcome assessment tests" should have been reimbursed as an element of the initial and follow-up examinations.

143. Healthcare providers cannot bill for an examination and then bill separately for contemporaneously provided "outcome assessment testing."

144. In the event the Defendants did perform the "outcome assessment tests" for which Plaintiffs was billed, the information gained through the use of the tests would not have been significantly different from the information obtained during virtually every Insured's examination. In fact, the Defendants, in billing for fraudulent initial and follow-up examinations, represented they took at least a "detailed" if not "comprehensive" patient history and performed at least a "detailed" if not "comprehensive" physical examination.

145. The "outcome assessment tests" represented purposeful duplication of the patient histories and examinations purportedly conducted during the Insureds' initial examinations and follow-up examinations.

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

147. Though the Provider Defendants routinely submitted billing under CPT code 99358 for "outcome assessment tests," no physician associated with Macintosh or Atlantic spent an hour reviewing or administering the tests or communicating with the Insureds or their families.

148. 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.

149. Nevertheless, Macintosh and Atlantic submitted billing to Plaintiffs under CPT code 99358.

150. Macintosh billed for outcome assessment testing on approximately 96% of its No-Fault claimants insured by Plaintiffs.

151. The results of the outcome assessment tests like the other fraudulent services, were not incorporated into the patients' respective treatment plans.

G. The Fraudulent Charges for Medically Unnecessary Trigger Point Injections

152. Based upon the fictitious, boilerplate "diagnoses" and "treatment plans" the Defendants documented, during their fraudulent initial examinations and follow-up examinations, need for a series of medically unnecessary pain management injections, including, but not limited to trigger point injections with ultrasound, which is the primary method in which Atlantic currently defrauds insurers.

153. The trigger point injections were billed to Plaintiffs by Defendants using CPT code 20553, representing trigger point injections in three or more muscles.

154. Like the charges for the other fraudulent services, the charges for the trigger point injections were medically unnecessary and were provided – to the extent that they were provided at all – pursuant to the fictitious, boilerplate "diagnoses" and "treatment plans" that the Defendants provided during their fraudulent initial consultations and follow-up examinations.

155. In fact, in almost every instance, patients were subject to trigger point injections on the same day they were subject to a sham initial or follow-up examination – in most cases the exams and injections occurred simultaneously.

156. Moreover, in the claims for trigger point injections (as for example, those identified in **Exhibit 1** by CPT Code 20553), the charges for the injections were fraudulent in that they

misrepresented the Defendants' eligibility to collect No-Fault Benefits in the first instance because – as a result of the illegal kickback, improper financial arrangements and referral scheme described herein – they were not in compliance with relevant laws and regulations governing healthcare practice in New York.

1. Standards for the Legitimate Use of Trigger Point Injections

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

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

159. In a legitimate clinical setting, trigger point treatment should begin with conservative therapies such as bed rest, active exercises, physical therapy, heating or cooling modalities, massage, and basic, non-steroidal, anti-inflammatory analgesic.

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

161. Furthermore, in a legitimate clinical setting, trigger point injections should not be administered more than once every two months, or more than six times in any given year.

162. This is because: (i) properly administered trigger point injections should provide pain relief lasting for at least two months; (ii) a proper interval between trigger point injections is necessary to determine whether or not the initial trigger point injections were effective; and (iii) if

a patient's pain is not relieved through the injections, the pain may be caused by something more serious than a soft tissue injury caused by an automobile accident, and the perpetuating factors of the pain must be identified and managed.

2. The Medically Unnecessary Trigger Point Injections

163. In the claims for trigger point injections, as, for example, those identified in **Exhibit 1,** the Defendants routinely purported to administer trigger point injections to the patients before the pain symptoms had persisted for more than three months, and/or before the patient had failed or been intolerant of more conservative therapies for at least one month.

164. Landow is not a pain management specialist or qualified to supervise such services.

165. Further non-physicians routinely perform the Defendants' trigger point injections. Despite physician assistants technically being able to perform such services, physicians must supervise physician assistants when performing services. Moreover, several No-Fault arbitrators have found that Atlantic's business practices were rendered pursuant to fraudulent pre-determined protocols and that the compensation agreements for the treating professional "incentivizes performance of the injection…Additionally, the practitioner will not be paid the [fee-for-service] rate if they don't use guidance for the injection, even if they don't believe it is medically necessary." *Atlantic Medical & Diagnostic PC v. Nationwide Ins. Co.*, AAA Case 17-23-1298-4992 (Arb. Bernadette Connor, July 30, 2025).

166. The non-physicians purportedly employed by the Defendants were not adequately supervised during the performance of pain management injections by Landow or any other medical doctor allegedly employed by Macintosh and Atlantic.

167. Macintosh and Atlantic routinely purported to provide trigger point injections within less than three months – and in some cases, the day of or a few days following –the auto

accidents, before the patients could possibly have failed any legitimate course of conservative treatment. Indeed, in at least 50 instances, Macintosh and Atlantic have billed for injections within one date of an accident. Representative samples from July 2021 and August 2025 are below, evidencing that this practice has been continuous:

MAURICE TELFER-0512-BD27183

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is not for verification of hospital treatment.)

NAME AND ADDRESS OF INSURER OR SELF-INSURER*	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
FARMERS INSURANCE COMPANY P O BOX 268994, OKLAHOMA CITY, OKLAHOMA, 73126	

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
07/21/2021		19691217D	12 Jul 2021	

PROVIDER'S NAME AND ADDRESS*
Macintosh Medical PC
C/o The Lostos Law Group, LLP, 591 Stewart Avenue, 4th Floor, Garden City, NY, 11530

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1 PATIENT'S NAME AND ADDRESS [redacted]

2 DATE OF BIRTH [redacted] | 3 SEX Male | 4 OCCUPATION (IF KNOWN)

5 [redacted] AND CONCURRENT CONDITIONS
M54.12 Radiculopathy, cervical region,M54.16 Radiculopathy, lumbar region,S13.0XXA Sprain of joints and ligaments of unspecified parts of neck, initial encounter,S23.0XXA Sprain of unspecified parts of thorax, initial encounter,S33.0XXA Sprain of ligaments of lumbar spine, initial encounter,

6 WHEN DID SYMPTOMS FIRST APPEAR? DATE 12 Jul 2021
7 WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE
8 HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES [ ] NO [X] IF YES, state when and describe
9 IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT? YES [X] NO [ ] IF "NO", explain
10 IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT? YES [ ] NO [X]
11 WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY? YES [ ] NO [ ] NOT DETERMINABLE AT THIS TIME [X] IF "YES", describe
12 PATIENT WAS DISABLED (UNABLE TO WORK) FROM _____ THROUGH _____
13 IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON _____ (DATE)

CONTINUE ON PAGE 2

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[redacted]512-BD27183

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?
YES [X] NO [ ] IF YES, describe your recommendation below: See Doctor's Report

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

Date of Service	Place of Service Including Zip Code	Description of Treatment or Health Service Rendered	Unit	Fee Schedule Treatment Code	Charges
07/13/2021	3010 CHURCH AVE, BROOKLYN, NY, 11203	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 45 minutes are spent face-to-face with the patient and/or family	1	99204	$ 353.76
07/13/2021	3010 CHURCH AVE, BROOKLYN, NY, 11203	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	4	76942 - 59	$ 1136.80
07/13/2021	3010 CHURCH AVE, BROOKLYN, NY, 11203	Injection(s), single or multiple trigger point(s), 3 or more muscles	4	20553 - 59	$ 624.96
07/13/2021	3010 CHURCH AVE, BROOKLYN, NY, 11203	Prolonged evaluation and management service before and/or after direct patient care, first hour	1	99358	$ 200.12
07/13/2021	3010 CHURCH AVE, BROOKLYN, NY, 11203	Injection, dexamethasone sodium phosphate, 1 mg	4	J1100	$ 23.60

TOTAL CHARGES TO DATE $ 2237.72

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

(This form is not for verification of hospital treatment.)

NAME AND ADDRESS OF INSURER OR SELF INSURER*	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
BRISTOL WEST INSURANCE P O BOX 258807, OKLAHOMA CITY NY 73125	

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
05/24/2025			12 May 2025	5036713694-1

PROVIDER'S NAME AND ADDRESS*
Atlantic Medical & Diagnostic P C
665 Hillside Avenue Suite 620, New Hyde Park, NY, 11040

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES

1 PATIENT'S NAME AND ADDRESS [redacted]

2 DATE OF BIRTH [redacted] | 3 SEX Female | 4 OCCUPATION (IF KNOWN)

5 DIAGNOSIS AND CONCURRENT CONDITIONS
S33 5XXA Sprain of ligaments of lumbar spine, initial encounter, S16 1XXA Strain of muscle, fascia and tendon at neck level, initial encounter, S40 011A CONTUSION, SHOULDER RIGHT INITIAL,

6 WHEN DID SYMPTOMS FIRST APPEAR? DATE 12 May 2025

7 WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE ______

8 HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES [ ] NO [X] IF YES, state when and describe

9 IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT? YES [X] NO [ ] IF "NO", explain

10 IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT? YES [ ] NO [X]

11 WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY? YES [ ] NO [ ] NOT DETERMINABLE AT THIS TIME [X]
IF "YES", describe

12 PATIENT WAS DISABLED (UNABLE TO WORK) FROM ______ THROUGH ______

13 IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON ______ (DATE)

CONTINUE ON PAGE 2

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Received by National Document Center 6/2/2025

[redacted]1636-BD190901

14 WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT*

YES [X] NO [ ] IF YES, describe your recommendation below See Doctor's Report

15 REPORT OF SERVICES RENDERED – ATTACH ADDITIONAL SHEETS IF NECESSARY

Date of Service	Place of Service Including Zip Code	Description of Treatment or Health Service Rendered	Unit	Fee Schedule Treatment Code	Charges
[illegible]	5506 Avenue N, Brooklyn, NY, 11234	[illegible]	1	99203 25,PA	$ 142 62
[illegible]	5506 Avenue N, Brooklyn, NY 11234	Injection, anesthetic agent, sciatic nerve, single	2	64445 59,50,PA	$ 297 28
[illegible]	5506 Avenue N, Brooklyn, NY, 11234	Injection anesthetic agent other peripheral nerve or branch	2	64450 59,50,58,PA	$ 136 36
[illegible]	5506 Avenue N, Brooklyn, NY, 11234	[illegible] single or multiple trigger point(s) 1 or 2 muscle(s)	1	20552 59,51,PA	$ 118 41
[illegible]	5506 Avenue N, Brooklyn, NY, 11234	Ultrasonic guidance for needle placement	1	76942 PA	$ 289 20
[illegible]	5506 Avenue N, Brooklyn, NY, 11234	Ultrasonic guidance for needle placement	1	76942 PA	$ 289 20
[illegible]	5506 Avenue N, Brooklyn, NY, 11234	Ultrasonic guidance for needle placement	1	76942 PA	$ 289 20
[illegible]	5506 Avenue N, Brooklyn, NY, 11234	Ultrasonic guidance for needle placement	1	76942 PA	$ 289 20
[illegible]	5506 Avenue N, Brooklyn, NY 11234	Ultrasonic guidance for needle placement	1	76942 PA	$ 289 20
[illegible]	5506 Avenue N, Brooklyn, NY, 11234	Ultrasonic guidance for needle placement	1	76942 PA	$ 289 20
[illegible]	5506 Avenue N, Brooklyn, NY, 11234	Injection dexamethasone sodium phosphate 1 mg	6	J1100	$ 159 30
[illegible]	5506 Avenue N, Brooklyn, NY, 11234	Injection bupivacaine, not otherwise specified 0 5 mg	15	J0665	$ 187 50
[illegible]	5506 Avenue N, Brooklyn, NY, 11234	Injection, Unclassified drug (Lidocaine), 1 mg	30	J3490	$ 247 50
[illegible]	5506 Avenue N, Brooklyn, NY, 11234	[illegible]	1	99358	$ 0 00

TOTAL CHARGES TO DATE $ [illegible]

168. Even when performed correctly, the injections that the Defendants purported to provide can cause significant adverse events including infection, nerve injury, hypotension, anesthetic toxicity, or even death. To the extent that the Defendants administered injections to patients with the frequency set forth in their billing, they increased these risks exponentially.

169. To further increase the fraudulent billing that they submitted for each round of medically unnecessary trigger point injections, the Defendants routinely submitted a separate charge under CPT code 76942 for "ultrasound guidance" of the trigger point injections, charging $289.20 per "unit" of guidance and routinely billing four to six units at a time for a total of $,1,156.80 or $1,735.20 for a wholly illusory service.

170. The charges for "ultrasound guidance" of the injections were fraudulent inasmuch as, like the underlying trigger point injection itself, the ultrasound guidance was not medically necessary and was performed – to the extent that it was performed at all which is dubious – pursuant to pre-determined fraudulent protocols and illegal kickback and financial arrangements, designed to maximize the Defendants' billing rather than to treat patients.

171. Ultrasound guidance is not required to properly administer a trigger point injection. Moreover, (i) the Defendants virtually never appropriately documented the use, need, or placement of the ultrasound guidance, (ii) nor were there any images included in the Defendants' records, or any notations that images were placed into the patients' charts, gravely calling into question whether ultrasound guidance was even performed in the first instance.

H. The Fraudulent Steroid Pain Management Injections

172. As part of the fraudulent scheme, in addition to the trigger point injections identified above, the Defendants also advised patients to receive multiple injections of the steroid "Dexamethasone Acetate" under CPT code J1094, resulting in charges that varied from $85.00 for

four units to $397.50 for six units, virtually always on the same day as the patients received trigger point injections and an initial or follow-up examination.

173. To the extent that the patients in the claims referred to in **Exhibit 1** (without limitation) experienced any injuries at all in their minor accidents, the injuries were minor soft tissue injuries.

174. For the claims for steroid injections (as for example those identified in **Exhibit 1** with CPT Code J1094), the Defendants: (i) routinely administered steroid pain management injections to patients who did not have any symptoms that legitimately would warrant the injections; and (ii) routinely purported to administer multiple steroid injections, and multiple varieties of pain management injections, to patients within a span of weeks, despite the fact that such an injection regimen not only was medically unnecessary, but also placed the patients at risk.

175. Dexamethasone injection is generally used to treat severe allergic reactions. It is also used: in the management of certain types of edemas (fluid retention and swelling; excess fluid held in body tissues,); gastrointestinal disease; and certain types of arthritis. Dexamethasone injection can also treat certain conditions that affect the blood, skin, eyes, thyroid, kidneys, lungs, and nervous system. It is sometimes used in combination with other medications to treat symptoms of low corticosteroid levels (lack of certain substances that are usually produced by the body and are needed for normal body functioning) and in the management of certain types of shock.

176. Dexamethasone injection is in a class of medications called corticosteroids. It works to treat people with low levels of corticosteroids by replacing steroids that are normally produced naturally by the body. It also works to treat other conditions by reducing swelling and redness and by changing the way the immune system works.

177. The Defendants recklessly and improperly used dexamethasone injection. There are adverse side effect from such injections including headache; slowed healing of cuts and bruises; thin, fragile, or dry skin; red or purple blotches or lines under the skin; skin depressions at the injection site; increased body fat or movement to different areas of your body; difficulty falling asleep or staying asleep; extreme changes in mood; changes in personality; depression; increased sweating; muscle weakness; joint pain; irregular or absent menstrual periods; hiccups; increased appetite; injection site pain or redness.

178. Some side effects can be serious requiring emergency medical treatment: infection; seizures; vision problems; swelling of the eyes, face, lips, tongue, throat, arms, hands, feet, ankles, or lower legs; difficulty breathing or swallowing; shortness of breath; sudden weight gain; rash; hives and itching.

I. Fraudulent Billing for Services of Independent Contractors

179. Defendants' fraudulent scheme also included submission of claims to Plaintiffs on behalf of Macintosh and Atlantic seeking payment for services provided by independent contractors.

180. Under the 11 NYCRR 65-3.11, 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 bona fide employees.

181. Since 2001, the New York State Department of Financial Services, formerly known as the Department of Insurance ("DFS"), 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 precisely

because it leads to confusion and risk to the patient. The DFS explained that "This Department has noticed that increasingly PCs are billing for No-Fault services provided through independent contractors. Such direct billing by the PC, due to the lack of supervisory control by the PC, may facilitate fraud, since the PC might bill under its own fee schedule as a specialist rather than the general practitioner fee schedule of the independent contractor, who actually provided the service. In addition, the patient may wrongfully believe the independent contractor's actions are under the supervision of the PC." See DFS Letter, February 21, 2001.

182. Defendants routinely submitted charges to Plaintiffs and other insurers for fraudulent services that purportedly were performed by physicians other than Landow through Macintosh and Atlantic.

183. Landow was not qualified to supervise or interpret much of the medical services being provided by Macintosh and Atlantic. Therefore, the Treating Professional Defendants, and other non-parties who were associated with Macintosh and Atlantic, worked without any truly meaningful medical supervision.

184. The professionals, including physicians, registered nurses, and physician assistants, as well as others utilized by Macintosh and Atlantic, worked part-time and/or followed irregular schedules, based on their own schedules, availability, and individual desires to performed services for them. The professionals and others often also only performed services at specific No-Fault clinics and not on behalf of Macintosh and Atlantic at the numerous clinics where one performed services.

185. Indeed, many of these professionals did not exclusively provide services for Macintosh and Atlantic, did not receive benefits, and had to procure their own malpractice insured.

These professionals also rendered services for various other professional corporations, as well as owned their own professional corporations which submitted billing to Plaintiffs.

186. The medical professionals who performed services for Macintosh and Atlantic were the listed owners of and/or submitted billing as treating providers through dozens of other professional corporations during the time they rendered services on behalf of Macintosh and Atlantic.

187. To the extent that healthcare services were provided by persons other than Landow, they were performed by physicians whom Defendants treated as independent contractors but falsely represented on claim forms as employees.

188. By electing to treat the professionals, and other rendering individuals as independent contractors, the Defendants falsely represented to patients that the Treating Professional Defendants were being monitored and supervised.

189. Defendants' misrepresentations were consciously designed to mislead Plaintiffs into believing that they were obligated to pay for these services, when in fact Macintosh and Atlantic had no standing to collect for such claims.

J. Landow Does Not Control Macintosh or Atlantic

190. N.Y. Business Corporation Law § 1507 makes clear that a physician shareholder of a medical professional corporation must be engaged in the practice of medicine through the professional corporation for it to be lawfully licensed.

191. A medical professional corporation's putative physician-owner not only must be licensed to practice medicine but must also be engaged in the practice of medicine through the medical professional corporation.

192. Landow has not and does not legitimately engage in the practice of medicine through Macintosh or Atlantic.

193. He is not physically present in New York State and does not supervise any of the treatment or services that allegedly are provided to patients or train any of the professionals that provide alleged services. As an internal medicine physician, he is not qualified to administer much of the services billed in any event.

194. Rather, Kanny, a layperson, and John Does, monitor and direct the professionals in what treatment should be administered, in violation of law.

195. Landow's failure and inability to practice medicine through Macintosh and Atlantic, as well as his failure and/or inability to properly hire, train, or supervise the physicians who perform services billed under the name of Macintosh and Atlantic, compromises patient care and leads to excessive and/or unnecessary testing.

III. FRAUDULENT BILLING DEFENDANTS SUBMITTED OR CAUSED TO BE SUBMITTED TO PLAINTIFFS

196. To support their fraudulent charges, the Defendants systematically submitted or caused to be submitted to Plaintiffs hundreds of NF-3 forms, assignment of benefits forms and medical reports/records using the name of Macintosh and Atlantic to seek payment for fraudulent services for which the Defendants were not entitled to receive payment.

197. The NF-3 forms, reports, assignment of benefits and other documents submitted to Plaintiffs by and on behalf of Defendants were false and misleading in the following material respects:

(i) The NF-3 forms, letters and other supporting documentation submitted to Plaintiffs by and on behalf of Macintosh and Atlantic uniformly misrepresented that Landow had performed, or at least supervised, the fraudulent services purportedly provided by Macintosh and Atlantic, and the Treating Professional Defendants, and that his name, license and the tax

identification numbers of Macintosh and Atlantic were being legitimately used to bill for the fraudulent services, making them eligible for payment pursuant to 11 N.Y.C.R.R. §65-3.16(a)(12) despite the fact that the Kanny and John Does unlawfully and secretly controlled, operated and managed Macintosh and Atlantic.

(ii) The NF-3 forms, letters and other supporting documentation submitted to Plaintiffs by and on behalf of Defendants uniformly misrepresented and exaggerated the level, nature, necessity, and results of the fraudulent services that purportedly were provided.

(iii) The NF-3 forms, letters and other supporting documentation submitted to Plaintiffs by and on behalf of the Defendants, uniformly concealed the fact that the fraudulent services were provided – to the extent provided at all – pursuant to illegal kickback and referral arrangements.

(iv) The NF-3 forms, letters and other supporting documentation submitted to Plaintiffs by and on behalf of the Defendants uniformly misrepresented that the fraudulent services were medically necessary when provided – to the extent provided at all – pursuant to the dictates of unlicensed laypersons, and not based upon legitimate decisions by licensed healthcare providers.

IV. DEFENDANTS' FRAUDULENT CONCEALMENT AND PLAINTIFFS' JUSTIFIABLE RELIANCE

198. 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 Plaintiffs.

199. To induce Plaintiffs to promptly pay the fraudulent charges for the fraudulent services, the Defendants systematically made material misrepresentations, concealed their fraud and the underlying fraudulent scheme, and went to great lengths to accomplish this concealment.

200. Specifically, the Defendants knowingly misrepresented and concealed facts related to the participation of Landow in the performance of fraudulent services and Landow's ownership, control and/or management of Macintosh and Atlantic. Additionally, the Defendants entered complex financial arrangements with one another that were designed to conceal the fact that the Defendants unlawfully exchanged kickbacks for patient referrals.

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

202. Plaintiffs take steps to timely respond to all claims and to 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. Plaintiffs are also under statutory and contractual obligations to process claims promptly and fairly within 30 days. The facially valid documents submitted to Plaintiffs in support of the fraudulent charges at issue, combined with the misrepresentations and fraudulent litigation activity described above, were designed to, and did cause Plaintiff to rely upon them. As a result, Plaintiffs incurred damages of approximately $5,300,000 based upon the fraudulent charges.

203. Based upon Defendants' material misrepresentations and other affirmative acts to conceal their fraud, Plaintiffs did not discover and could not reasonably have discovered that it was paying fraudulent claims at the time that they were submitted and due under the No-Fault regulations.

AS AND FOR A FIRST CAUSE OF ACTION

Against Landow and the Provider Defendants
(Declaratory Judgment – 28 U.S.C. §§ 2201 and 2202)

204. Plaintiffs incorporates, as fully set forth herein, each and every allegation in all the foregoing paragraphs of this Complaint as if fully set forth at length herein.

205. There is an actual case and controversy between Plaintiffs on the one hand and Landow and the Provider Defendants on the other hand regarding more than $3,700,000 in unpaid billing for the fraudulent services that has been submitted to Plaintiffs.

206. Landow, Macintosh, and Atlantic have no right to receive payment from Plaintiffs for the unpaid billing because the fraudulent services were not medically necessary and were provided – to the extent that they were provided at all – pursuant to illegal kickbacks and referral relationships between the Defendants and John Does and these referrals were so expansive as to effectively cede control of Macintosh and Atlantic to laypersons.

207. Landow, Macintosh, and Atlantic have no right to receive payment from Plaintiffs for the unpaid billing because the fraudulent services were not medically necessary and were provided – to the extent that they were provided at all – pursuant to pre-determined fraudulent protocols that serve to financially enrich the Defendants, rather than to treat or otherwise benefit the Insureds.

208. Landow, Macintosh, and Atlantic have no right to receive payment from Plaintiffs for the unpaid billing because the fraudulent services were not medically necessary and were provided – to the extent that they were provided at all – pursuant to the dictates of unlicensed laypersons, not based upon legitimate decisions by licensed healthcare providers.

209. Landow, Macintosh, and Atlantic have no right to receive payment from Plaintiffs for the unpaid billing because the Defendants' sham services – for which they submitted bills – fraudulently misrepresented and exaggerated the level of services that purportedly were provided in order to inflate the charges submitted to Plaintiff.

210. Landow, Macintosh, and Atlantic have no right to receive payment from Plaintiffs for the unpaid billing because the Defendants' sham services – for which they billed – fraudulently

misrepresented that they were at least supervised or controlled by Landow or other qualified physicians and were instead controlled by – to the extent that they were provided at all – by unlicensed individuals who were neither supervised nor controlled by Landow.

211. Accordingly, Plaintiffs requests a judgment pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202, declaring that Landow, Macintosh, and Atlantic have no right to receive payment for any pending bills submitted to Plaintiffs.

AS AND FOR A SECOND CAUSE OF ACTION

Against Landow and Macintosh
(Violation of RICO, 18 U.S.C. § 1962(c))

212. Plaintiffs incorporate, as fully set forth herein, each and every allegation in the foregoing paragraphs of this Complaint as if fully set forth at length herein.

213. Macintosh constitutes an ongoing "enterprise," as that term is defined in 18 U.S.C. § 1961(4), which engages in activities affecting interstate commerce.

214. Landow, Kanny, Etienne, the Treating Professionals Defendants were allegedly employed by Macintosh. Further, John Doe Defendants 1-10 knowingly have conducted and/or participated, directly or indirectly, in the conduct of the affairs of Macintosh through a pattern of racketeering activity consisting of repeated violations of the federal mail fraud statute, 18 U.S.C. § 1341, based upon the use of the United States mails to submit or cause to be submitted thousands of fraudulent charges seeking payments that Macintosh was not eligible to receive under the No-Fault Laws because: (i) the billed-for services were submitted through a medical practice not legitimately owned or controlled by a licensed physician, but which was being operated, managed, and controlled by John Doe Defendants for purposes of effectuating a large-scale insurance fraud scheme on Plaintiffs and other New York automobile insurers, (ii) the billed-for services were provided, to the extent provided at all, pursuant to the dictates of unlicensed laypersons, not based

upon legitimate decisions by licensed healthcare providers, and as a result of illegal financial arrangements between the Defendants and the clinics, (iii) the billed-for services were provided, to the extent provided at all, pursuant to pre-determined fraudulent treatment and billing protocols designed solely to financially enrich the Defendants, rather than to treat or otherwise benefit the Insureds, (iv) the claim submissions seeking payment for the billed-for services uniformly misrepresented and exaggerated the level, nature, necessity, and results of the fraudulent services that purportedly were provided.

215. The fraudulent billings and corresponding mailings submitted to Plaintiffs that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as **Exhibit 1**, without limitation.

216. Macintosh constitutes a racketeering activity since the enterprise exists for the purpose of submitting fraudulent charges to insurers. The predicate acts of mail fraud are the regular ways in which the Defendants operated Macintosh, since Macintosh never operated as a legitimate medical practice, never was eligible to bill for or collect No-Fault Benefits and acts of mail fraud therefore were essential for Macintosh to function. Furthermore, the intricate planning required to conduct and conceal the predicate acts of mail fraud implies a threat of continued criminal activity, as does the fact that Defendants continue to attempt collection on the fraudulent billing submitted through Macintosh to the present day.

217. Macintosh are engaged in inherently unlawful acts since they continue to attempt collection on fraudulent billing submitted to Plaintiff and other New York automobile insurers. Macintosh conduct these inherently unlawful acts in pursuit of inherently unlawful goals – namely, the theft of money from Plaintiffs and other insurers through fraudulent No-Fault billing. Plaintiffs have been injured in its business and property by reason of the above-described conduct in that it

has paid at least $1,655,000 pursuant to the fraudulent bills submitted by the Defendants through Macintosh.

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

AS AND FOR A THIRD CAUSE OF ACTION

Against Landow and Atlantic
(Violation of RICO, 18 U.S.C. § 1962(d))

219. Plaintiffs incorporate, as though fully set forth herein, each and every allegation in the foregoing paragraphs of this Complaint as if fully set forth at length herein.

220. Atlantic is an ongoing "enterprise," as that term is defined in *18* U.S.C. § 1961(4), which engages in activities affecting interstate commerce.

221. Landow, Kanny, Etienne, the Treating Professional Defendants, and John Doe Defendants 1-10 are employed by and/or associated with Atlantic. Landow, Kanny, Etienne, the Treating Professional Defendants, and John Doe Defendants 1-10 knowingly have agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of their 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 fraudulent charges seeking payments that Macintosh was not eligible to receive under the No-Fault Laws because: (i) the billed-for services were submitted through a medical practice not legitimately owned or controlled by a licensed physician, but which was being operated, managed, and controlled by John Doe Defendants 1-10 for purposes of effectuating a large-scale insurance fraud scheme on Plaintiffs and other New York automobile insurers, (ii) the billed-for services were provided, to the extent provided at all, pursuant to the dictates of

unlicensed laypersons, not based upon legitimate decisions by licensed healthcare providers, and as a result of illegal financial arrangements between the Defendants and clinics, (iii) the billed-for services were provided, to the extent provided at all, pursuant to pre-determined fraudulent treatment and billing protocols designed solely to financially enrich the Defendants, rather than to treat or otherwise benefit the patients, and (iv) the claim submissions seeking payment for the billed-for services uniformly misrepresented and exaggerated the level, nature, necessity, and results of the fraudulent services that purportedly were provided.

222. The fraudulent billings and corresponding mailings submitted to Plaintiffs that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as **Exhibit 1**, without limitation.

223. Landow, Kanny, Etienne, the Treating Professional Defendants, and John Doe Defendants knew of, agreed to, and acted in furtherance of the common overall objective (i.e., to defraud Plaintiffs and other insurers of money) by submitting or facilitating the submission of fraudulent charges to Plaintiffs.

224. Plaintiffs have been injured in business and property by reason of the above-described conduct in that it has paid at least $1,655,000 pursuant to the fraudulent bills submitted by Defendants through Atlantic.

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

AS AND FOR A FOURTH CAUSE OF ACTION

Against All Defendants
(Violation of RICO, 18 U.S.C. § 1962(d))

226. Plaintiffs incorporate, as though fully set forth herein, each and every allegation in the foregoing paragraphs of this Complaint as if fully set forth at length herein.

227. The network of persons and entities acting in concert as described above constitutes an ongoing "enterprise," as that term is defined in 18 U.S.C. § 1961(4), which engages in activities affecting interstate commerce.

228. Landow, Kanny, Etienne, Macintosh, Atlantic, the Treating Professional Defendants, and John Doe Defendants 1-10 are employed by and/or associated with the enterprise. Landow, Kanny, Etienne, the Treating Professional Defendants, and John Doe Defendants 1-10 knowingly have agreed, combined and conspired to conduct and/or participate, directly or indirectly, in the conduct of their 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 fraudulent charges seeking payments that Macintosh and Atlantic were not eligible to receive under the No-Fault Laws because: (i) the billed-for services were submitted through a medical practice not legitimately owned or controlled by a licensed physician, but which was being operated, managed, and controlled by John Doe Defendants 1-10 for purposes of effectuating a large-scale insurance fraud scheme on Plaintiffs and other New York automobile insurers, (ii) the billed-for services were provided, to the extent provided at all, pursuant to the dictates of unlicensed laypersons, not based upon legitimate decisions by licensed healthcare providers, and as a result of illegal financial arrangements between the Defendants and clinics, (iii) the billed-for services were provided, to the extent provided at all, pursuant to pre-determined fraudulent treatment and billing protocols designed

solely to financially enrich the Defendants, rather than to treat or otherwise benefit the patients, and (iv) the claim submissions seeking payment for the billed-for services uniformly misrepresented and exaggerated the level, nature, necessity, and results of the fraudulent services that purportedly were provided.

229. The fraudulent billings and corresponding mailings submitted to Plaintiffs that comprise, in part, the pattern of racketeering activity identified through the date of this Complaint are described in the chart annexed hereto as **Exhibit 1**, without limitation,

230. Landow, Kanny, Etienne, Macintosh, Atlantic, the Treating Professional Defendants, and John Doe Defendants knew of, agreed to, and acted in furtherance of the common overall objective (i.e., to defraud Plaintiffs and other insurers of money) by submitting or facilitating the submission of fraudulent charges to Plaintiffs.

231. Plaintiffs have been injured in business and property by reason of the above-described conduct in that it has paid at least $1,655,000 pursuant to the fraudulent bills submitted by Defendants through Macintosh and Atlantic.

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

AS AND FOR A FIFTH CAUSE OF ACTION

Against All Defendants
(Common Law Fraud and Aiding and Abetting Fraud)

233. Plaintiffs incorporate, as though fully set forth herein, each and every allegation in the foregoing paragraphs of this Complaint as if fully set forth at length herein.

234. Defendants intentionally and knowingly made false and fraudulent statements of material fact to Plaintiffs and concealed material facts from Plaintiffs during their submission of thousands of fraudulent charges seeking payment for the Fraudulent Services.

235. Defendants intentionally and knowingly aided and abetted each other in the perpetration of fraud by creating, keeping and maintaining false business and medical records designed to further the frauds of those Defendants that actually submitted false statements to the Plaintiffs.

236. The false and fraudulent statements of material fact and acts of fraudulent concealment include: (i) the representation that Landow had performed, inasmuch as he purported to control, the fraudulent services and that his name, license and the tax identification number of Macintosh and Atlantic were being legitimately used to bill for the fraudulent services, making Macintosh and Atlantic eligible for payment pursuant to 11 N.Y.C.R.R. §65-3.16(a)(12*)* when in fact Landow never supervised nor controlled any of the services and Kanny and John Doe Defendants 1-10 unlawfully and secretly controlled, operated and managed Macintosh and Atlantic, (ii) the representation that the billed-for services had been rendered and were reimbursable, when in fact the claim submissions uniformly misrepresented and exaggerated the level, nature, necessity, and results of the services that purportedly were provided, (iii) the representations that the billed-for services submitted by all the Defendants named herein were eligible for reimbursement, when in fact the services were provided – to the extent provided at all – pursuant to illegal kickback and referral arrangements between the Defendants and clinics, and (iv) the representation that the billed-for services submitted by all of the Defendants named herein were medically necessary when they were provided – to the extent provided at all – pursuant to

the dictates of unlicensed laypersons, not based upon legitimate decisions by licensed healthcare providers.

237. Defendants intentionally made the above–described false and fraudulent statements and concealed material facts in a calculated effort to induce Plaintiffs to pay charges submitted through Macintosh and Atlantic, which were not compensable under New York no-fault insurance laws.

238. Plaintiffs justifiably relied on these false and fraudulent representations and acts of fraudulent concealment, and as a proximate result has been injured in its business and property by reason of the above–described conduct in that it has paid at least $1,655,000 for which Defendants are responsible – pursuant to the fraudulent bills submitted by the Defendants.

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

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

AS AND FOR A SIXTH CAUSE OF ACTION
Against All Defendants
(Unjust Enrichment)

241. Plaintiffs incorporate, as fully set forth herein, each and every allegation in the foregoing paragraphs of this Complaint as if fully set forth at length herein.

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

243. When Plaintiffs paid the bills and charges submitted by or on behalf of Macintosh and Atlantic for No-Fault Benefits, they reasonably believed that they were legally obligated to make such payments based on Defendants improper, unlawful, and/or unjust acts.

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

245. Defendants' retention of Plaintiffs' payments violates fundamental principles of justice, equity, and good conscience.

246. By reason of the above, Defendants have been unjustly enriched in an amount to be determined at trial, but in no event less than $1,655,000.

JURY DEMAND

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

WHEREFORE, Plaintiffs demand that a Judgment be entered in their favor and against the Defendants, as follows:

(i) On the First Cause of Action against Landow, Macintosh, and Atlantic, a declaration pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202, that Landow, Macintosh, and Atlantic have no right to receive payment for any pending bills submitted to Plaintiffs;

(ii) On the Second Cause of Action against Defendants, compensatory damages in favor of Plaintiffs in an amount to be determined at trial together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(c) plus interest;

(iii) On the Third Cause of Action against Defendants, compensatory damages in favor of Plaintiffs in an amount to be determined at trial together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(d) plus interest;

(iv) On the Fourth Cause of Action against Defendants, compensatory damages in favor of Plaintiffs in an amount to be determined at trial together with treble damages, costs, and reasonable attorneys' fees pursuant to 18 U.S.C. § 1964(d) plus interest;

(v) On the Fifth Cause of Action against Defendants, compensatory damages in favor of Plaintiffs in an amount to be determined at trial together with punitive damages, costs, interest, and such other and further relief as the Court deems just and proper;

(vi) On the Sixth Cause of Action against all Defendants, more than $1,655,000 in compensatory damages, plus costs and interest and such other and further relief as this Court deems just and proper.

Dated: New York, New York
May 21, 2026

GOLDBERG, MILLER & RUBIN, P.C.

By: _____

Harlan R. Schreiber
Attorneys for Plaintiffs
1501 Broadway, Suite 715
New York, New York 10036
(646) 503-5791
HSchreiber@gmrlawfirm.com