SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: IRA GAMMERMAN, Justice

PART 27

Oxford Health Plans (NY) Inc
v.
Better Care Health Care et al

INDEX NO. 112410-01

MOTION DATE

MOTION SEQ. NO. 02

MOTION CAL. NO.

The following papers, numbered 1 to ______ were read on this motion to/for ______

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	
Answering Affidavits — Exhibits	
Replying Affidavits	

Cross-Motion: ☐ Yes ☐ No

Upon the foregoing papers, it is ordered that this motion

FILED
SEP 13 2002
COUNTY CLERK'S OFFICE
NEW YORK

MOTION IS DECIDED IN ACCORDANCE WITH ACCOMPANYING MEMORANDUM DECISION

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE

Dated: SEP 9 - 2002

IRA GAMMERMAN, J.S.C.

Check one: ☐ FINAL DISPOSITION ☑ NON-FINAL DISPOSITION

17286

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK IAS PART 27
---X
OXFORD HEALTH PLANS (NY), INC. AND OXFORD HEALTH INSURANCE , INC.,

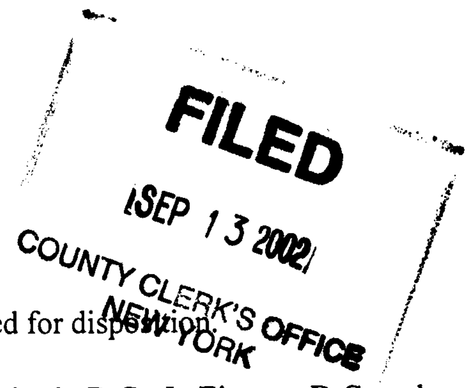
Plaintiffs,

Index # 112410/01
P. C. No. 17286

-against-

BETTER CARE HEALTH CARE PAIN MANAGEMENT & REHAB PC, et al,

Defendants.
---X



IRA GAMMERMAN, J:

Motion sequence numbers 002 and 003 are consolidated for disposition.

Motion sequence 002 is brought by defendants Ira Grushack, D.C., Jo Eisman, D.C. and East Park Chiropractic. Motion sequence 003 is brought by defendants Dr. David Bass, Dr. Jeffrey Siegel, Dr. Joseph Vitoulis, Dr. Sherry Morris, Dr. Brian Katz, Dr. Phillip Gura, Bass, Gura, Katz Chiropractic, Office Masters, Inc., EHMPC Healthcare Management, Inc., WPMPC Healthcare Management, Inc., FSMPC Healthcare Management, Inc., Mineola Medical Healthcare Management, Inc., TMPC Healthcare Management, Inc., LMPC Healthcare Management Inc., CMPC Healthcare Management, Inc., EMMPC Healthcare Management, Inc., Levit Management, Inc., MMPC Healthcare Management, Inc., General Medical Healthcare Management, Inc., EK Healthcare Management, Inc., JL Healthcare Management, Inc., MB Healthcare Management, Inc., TR Healthcare Management, Inc., TF Healthcare Management, Inc., Park Avenue Medical Wellness, PC, East Meadow Medical Healthcare, PC, Franklin Square Medical Healthcare, PC, East Rock Medical PC, Malverne Medical PC, Lyn N Medical PC, General Medical Healthcare PC, Jamahill Medical PC, Bettercare Healthcare Pain &

Management PC, Smith Medical PC, Mineola Medical Healthcare PC, a/k/a Levit Medical Healthcare PC, Bohemia Medical PC, Advanced Healthcare Wellness and Medical PC, Millenium Medical Wellness PC, White Plains Medical Healthcare PC, Tarrytown Medical Healthcare PC, Larchmont Medical Healthcare PC, Barry Wein, D.O., David Ashley, M.D., Dan Lewis, M.D., Morton Aizic, D.O., William Bailey, D.O., Patrick Murphy, D.O., Landis Barnes, D.O., Vicki Seidenberg, M.D., and Allen Sossan, D.O., Henry Cohen, D.C., Joseph A. DeNoia, D.C. and A. DeNoia Chiropractic Office, Gardiner Avenue Chiropractic, Thomas Flannigan, D.C., Eugene Z. Haller, D.C., Indelicato Chiropractic and Joseph Indelicato, D.C., Evan Karpf, D.C., James H. Lambert, D.C. and Connectquot Chiropractic, P.C., Ronald Michelli, D.C. and Malverne Chirporactic Office, Ronald Miller, Michael Paule, D.C. and Tarrytown Chiropractic Center, Albert Posillico, D.C. and Affordable Family Chiropractic, Tred Rissacher, D.C., Alan Siegel, D.C. and Forest Chiropractic, Bruce Todaro, D.C. and Todaro Chiropractic Office, David Wallman, D.C. and Smithtown Chiropractic, Estelle Farrell, D.O., Xiao Hong Tau and Martin Gluck, Affordable Family Chiropractic Center, Tarrytown Chiropractic Center, and Emma Stoylar, M..D. The motion of Vladimir Slutsker D.O., originally brought as a cross motion, will also be considered in conjunction with the motions of the above defendants.

Plaintiffs Oxford Health Plans (NY), Inc. and Oxford Health Insurance, Inc. ("Oxford") bring this action against over one hundred and twenty named defendants seeking damages based on claims of fraudulent billing schemes. Oxford is one of the largest health plans in the New York Metropolitan area. Plaintiffs allege that the physicians, chiropractors, and lay people named in the complaint have intentionally circumvented New York's corporate and professional regulatory framework to defraud plaintiffs and induce them to overpay for certain services.

Oxford maintains that physicians knowingly sold the use of their names and medical licenses to non-physicians thus facilitating the formation of medical corporations that could be owned by lay persons. Oxford alleges that this scheme allowed non-physicians to charge for services on a physician or medical fee schedule and that the defendant medical corporations, physicians, chiropractors, and lay people engaged in fraudulent billing practices in connection with the alleged "vast fraudulent scheme." Five claims for relief are asserted, based on allegations of common law fraud, violation of New York General Business Law § 349, unjust enrichment/restitution, intentional interference with contract; additionally they seek declaratory relief.

Defendants move pursuant to CPLR §§ 3016(b) and 3211 (a)(7) and essentially advance seven arguments: (1) plaintiffs' claims are preempted by the Employee Retirement Insurance Security Act ("ERISA"), 29 U.S.C. § 1001, et seq., (2) plaintiffs have failed to plead fraud with sufficient particularity in accordance with CPLR § 3016(b), (3) plaintiffs have failed to state a cause of action for violation of G.B.L. § 349, (4) plaintiffs fail to state a claim for unjust enrichment, (5) plaintiffs fail to state a cause of action for intentional interference with contract, (6) plaintiffs do not set forth a basis to pierce the corporate veil, and (7) plaintiffs fail to allege facts sufficient to support a claim for punitive damages.

ERISA Preemption:

Defendants assert that each and every state law cause of action is preempted by federal law. Specifically, defendants claim that this dispute is governed by the provisions of the federal ERISA statute, 29 U.S.C. § 1001 et seq. It is true, as the defendants contend, that the ERISA

statute was designed to regulate the administration of employee benefit plans. As the statute itself states:

> It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries. . . .

29 U.S.C. § 1001 (b). The statute further defines employee benefit plans as:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds or prepaid legal services. . . .

29 U.S.C. § 1002. The statute contains a broad preemption provision that states in relevant part:

> the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . .

29 U.S.C. § 1144(a). While the Supreme Court has, in the past, liberally construed the term "relate to" it has since recognized, "if 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for really, universally, relations stop nowhere," New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645 (1995). To the extent that the interpretation of "relate to" has been narrowed, the Supreme Court recognizes that "some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law relates to the plan", Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983).

In enacting the ERISA statute Congress did not intend to supplant state law. An analysis of Congressional intent is paramount when considering whether a federal statute, such as ERISA, preempts state law, Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985). Federal Courts, interpreting Supreme Court decisions, have defined Congress' intent in enacting ERISA's preemption provision as designed to "protect employee benefit plans from conflicting state regulatory requirements and thereby promote efficiency through the establishment of uniform administrative schemes for processing claims and disbursing benefits," Beth Israel Medical Center v. Sciuto, 1993 U.S. Dist. Lexis 9145 (S.D.N.Y. 1993). The presumption against preemption is thus considerable, and "state laws of general application that merely impose some burdens on the administration of ERISA plans but are not 'so acute' as to force an ERISA plan to adopt certain coverage or to restrict its choice of insurers should not be disturbed," Plumbing Industry Board, Plumbing Local Union No. 1 v. E.W. Howell Company, Inc., 126 F.3d 61 (1997).

Common law tort claims that do not impact on the administration of employee benefit plans are not preempted by ERISA. Congress did not intend to "foreclose every state cause of action with a conceivable effect upon ERISA plans, but to maintain exclusive federal control over the regulation of such plans," Geller v. County Line Auto Sales, Inc., 86 F.3d 18 (1996).

The heart of the plaintiff's complaint in this case sounds in fraud. The state law causes of action asserted here in no way affect the administration of employee benefit plans or upset the federal government's exclusive control over such plans. The ERISA statute is not intended to be read so broadly as to prevent tort claims, such as those asserted here, from being adjudicated by a state court.

Defendants argue that any mention of an employee benefit plan is enough to invoke ERISA preemption. However, the cases defendants rely upon do not support their argument. The moving defendants cite Parnello v. Time Ins. Co, No. 91 C 20160, 1992 WL 184291 (N.D. Ill 1992) for the proposition that "vague references to 'health plans' in complaints have been found to qualify as ERISA plans for the purposes of pre-answer motions to dismiss." In Parnello, the plaintiff sued her employer and its insurers for their failure to provide insurance and fully cover medical expenses. In its determination that the plan at issue was an employee benefit plan covered by ERISA, the court found that "there are allegations of a promise to provide health insurance to Rosemary Parnello by her employer." Similarly, in Henry v. Robey-Barber Ins. Services Corp., 777 F.Supp. 1554 (M.D. Fla. 1991), the plaintiff sued her insurers pursuant to an insurance contract. In Henry, the court relied on factual allegations contained in the plaintiff's amended complaint to establish that "the coverage was provided by her employer, and not acquired individually by plaintiff" and ultimately held that the plan in question was an employee benefits plan covered by ERISA.

Here, the moving defendants have not offered any evidence that Oxford's insureds were receiving treatment under employee benefit plans. Defendants contend that because Oxford refers to itself as "one of the largest health plans in the New York metropolitan area" it must be concluded that the patients treated by the various defendants were covered under employee benefit plans administered by Oxford. In a similar vein, the moving defendants claim that because Oxford asserts that it "had a valid contractual relationship under which [Oxford] was responsible to pay for certain portions of the insureds' medical coverage, and the insureds were obligated to pay other amounts," that is an indication that these relationships existed pursuant to

employee benefit plans. But these allegations are not evidence that these services were obtained as part of an employee benefit plan.

In fact, this action does not involve an employee and employer, the classic parties in an action under ERISA. The sheer size of this action requires that hundreds, if not thousands, of patients were treated by the moving defendants over the period of time in question. However, how these patients may have been covered, i.e. as individuals or as part of an employee benefit plan, is not relevant.

There is simply no demonstration here that the plans at issue are covered by the ERISA statute, and thus there can be no basis to conclude that the relevant provisions of that statute preempt the state law causes of action.

Common Law Fraud Claims:

Defendants move to dismiss the fraud claims alleged in the complaint on two grounds. First, defendants claim that the plaintiffs cannot base a cause of action for fraud on improper corporate structure. Second, defendants seek to dismiss the common law fraud claims pursuant to CPLR § 3016(b) for failure to plead fraud with sufficient particularity.

Improper Corporate Structure:

The plaintiffs allege that the named defendants engaged in a broad-based and well organized scheme designed to defraud the insurers and to induce payment for unwarranted claims. In essence, plaintiffs contend that professional service corporations were formed in violation of §§ 1503, 1507, and 1508 of the Business Corporation Law and allowed non-physicians to control and own professional corporations and collect fees on a medical fee schedule. Plaintiffs assert that these arrangements were not only in violation of the statute but

also served as the foundation by which the defendants could perpetuate their fraudulent activities. In furtherance of the alleged scheme plaintiffs allege that physicians sold their names and licenses in order to become "paper owners" of the defendant medical corporations. Plaintiffs further contend that the physicians had no real financial interest or professional involvement in the medical services offered at the medical facilities and that "laypersons or chiropractors were in fact undisclosed principles, shareholders, officers, and de facto owners of the corporations." Plaintiffs also claim that the physicians agreed to transfer paper ownership to another chiropractor or layperson after a period of time. Defendants argue that no cause of action is created by the alleged improper corporate form utilized by the defendant professional corporations.

The Business Corporation Law provisions at issue here do not expressly create a private cause of action. However, "a private cause of action is implied where it can be shown that the plaintiff belongs to the class of legislatively intended beneficiaries and that a right of action would be in furtherance of the legislative purpose," CPC International Inc. v. McKesson, 70 N.Y.2d 268 (1987). Included in the analysis of whether a statute creates a private cause of action is "what indications there are in the statute or its legislative history of an intent to create (or conversely deny) such remedy and, most importantly, the consistency with the purposes underlying the legislative scheme," Burns Jackson Miller Summit & Spitzer v. Lindner, 59 N.Y.2d 314 (1989). There is no indication that the legislature intended that these provisions grant a private cause of action to insurers against health care providers that violated the statute.

However, even when a statute does not create a private cause action, a plaintiff my seek to recover for damages that result from wrongs independent of the statutory scheme itself. I have

allowed common law fraud claims to proceed where fraudulent activity has been facilitated by improper corporate structure. Plaintiffs here do not seek recovery for the improper corporate structure alone, but rather maintain that the corporate structure served as a foundation by which defendants could readily engage in fraudulent activities. In Progressive Northeastern Insurance Co. v. Advanced Diagnostics and Treatment Medical, P.C., No. 601112/00 (Sup.Ct., July 25, 2001), I held that an insurer could raise issues relating to improper corporate form where the "plaintiffs seek to recover for fraudulent claims, which plaintiffs allege, were facilitated by the illegal corporate structure."

The parties have argued at length about recent federal court decisions that address this issue. The cases cited by the parties are in harmony with my ruling in Progressive. In State Farm v. Mallela, 175 F.Supp.2d 401 (E.D.N.Y. 2001), the plaintiff insurance company alleged that the defendant PCs had falsely represented in their certificates of incorporation that they were owned by licensed professionals when, in fact, these corporations were owned and controlled by non-licensed individuals. The plaintiff sought to enjoin the defendants from submitting any claims based on the alleged improper corporate form in violation of the relevant Business Corporation Law provisions. In its ruling the court took pains to distinguish the facts of the case from those decided in Progressive. As that court concluded, "Progressive Northeastern, relied on by plaintiff, supports this court's holding. . .the Progressive Northeastern court stated that the insurers are not seeking to deny claims as result of the corporate structure of the [service providers], rather plaintiffs seek to recover for fraudulent claims, which plaintiffs allege were facilitated by the illegal corporate structure," id.

Similarly, in Universal Acupuncture Pain Services, P.C. v. State Farm, 196 F.Supp.2d 378 (S.D.N.Y. 2002), the defendant PC was suing State Farm Insurance company for the payment of claims under New York's No-Fault Insurance Law. State Farm counterclaimed stating that the payment of claims was unwarranted due to the plaintiffs improper corporate structure. In ruling that § 1503 of the Business Corporation Law did not create a private cause of action the federal court interpreted state law stating, "courts have permitted a common law fraud claim premised on the same set of facts to which a statute applies, despite the fact that there is no private cause of action in the statute, the claim was premised on a substantive injury or loss independent of the statutory violation." Thus, as stated in Universal, where damage or injury can be established independent of the statutory violations, claims relating to improper corporate structure should not be dismissed.

Here, plaintiffs assert that the improper corporate form utilized by the defendants allowed them to facilitate their various fraudulent billing schemes. Plaintiffs may not assert a cause of action for the violation of Business Corporations Law §§ 1503, 1507, and 1508 alone. However, plaintiff's complaint does not rely on the violation of these provisions as the sole basis for the fraud and resultant injury claims. Plaintiff's complaint alleges that the improper corporate form utilized by defendants was a mechanism by which the fraudulent activities could be carried out and perpetuated. Plaintiffs seek to recover damages for the submission of fraudulent claims, not for the alleged statutory violation. As such, plaintiffs should not be precluded from basing portions of their fraud claim on the alleged improper corporate structure of the defendant corporations. Accordingly, defendants motion to dismiss based on failure to state a cause of action based on improper corporate form should be denied.

Fraud Pleadings:

Defendants move to dismiss plaintiffs common law fraud claims pursuant to CPLR § 3016 (b) for failure to plead fraud with particularity. The essential elements of a claim for fraud are representation of material fact, falsity, scienter, reasonable reliance and damages, Small v. Lorillard Tobacco Company, Inc, 94 N.Y.2d 43 (1st Dept 1998) . In addition, these elements must be supported by factual allegations sufficient to satisfy the requirement of CPLR § 3016(b), Williams v. Upjohn Health Care Services, Inc., 119 A.D.2d 817 (2nd Dept 1986). CPLR § 3016 (b) mandates that where a cause of action is based upon "misrepresentation, fraud. . .the circumstances constituting the wrong shall be stated in detail."

The strict pleading requirements for fraud should not be construed to serve as a bar to a valid cause of action. The provision of CPLR § 3016(b) requires "only that the misconduct complained of be set forth in sufficient detail to clearly inform a defendant with respect to the incidents complained of and is not to be interpreted so strictly as to prevent an otherwise valid cause of action in situations where it may be impossible to state in detail the circumstances constituting a fraud," Lanzi v. Brooks, 43 N.Y.2d 778 (1977). Decisions denying motions to dismiss pursuant to CPLR 3016 (b) have been upheld where the complaint in question "sets forth the interlocking relationship of the various defendants" and those relationships are "read in the light most favorable to plaintiffs," Tomkins PLC v. Bangor Punta Consolidated Corp., 194 A.D.2d 493 (1st Dept 1993). This reflects a recognition that in fraud cases information is often "peculiarly within the knowledge" of one party making it impossible to state fraud claims in precise detail, Jered Contracting Corp. v. New York City Transit Authority, 22 N.Y.2d 187 (1968).

Here, plaintiffs have submitted a lengthy complaint alleging a vast fraudulent scheme perpetrated by over one-hundred and twenty defendants. Viewing the complaint in the light most favorable to the plaintiffs, plaintiffs have sufficiently alleged the mechanisms and methods by which the moving defendants allegedly established a system that would enable them to defraud the insurers. Furthermore, considering the size and scope of the alleged scheme, it seems self evident that further evidence relating to the alleged fraudulent schemes is within the exclusive control of the defendants and will be brought to light as discovery proceeds.

For the foregoing reasons defendants motion to dismiss for failure to plead fraud with sufficient particularity is denied.

General Business Law § 349:

Plaintiffs rely on General Business Law § 349 as the basis for their second claim for relief. General Business Law § 349 makes unlawful "deceptive acts and practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state," N.Y. Gen. Bus. Law § 349. Under section 349 a plaintiff must make a prima facie showing that "the acts complained of are consumer oriented in the sense that they affect similarly situated consumers... and that the defendant is engaging in an act or practice that is deceptive or misleading in a material way and that plaintiff has been injured by reason thereof. . .," Oswego Laborer's Local 214 Pension Fund v. Marine Midland Bank, 84 N.Y.2d 20 (1995).

General Business Law § 349 concerns consumer transactions. Article 22-A, of which § 349 is a part, is entitled "Consumer Protection from Deceptive Acts and Practices." This article has been found to relate to consumer oriented activities, and "the Practice Commentaries accompanying General Business Law article 22-A leave no doubt as to the statute's primary

concern with the consumer," Cruz v. NYNEX Information Services, 265 A.D.2d 285 (1st Dept 2000) (citing, Givens, Practice Commentaries, McKinney's Cons Laws of NY, Book 19, General Business Law § 349, at 566-576; Givens, Supp. Practice Commentaries, McKinney's Cons Laws of NY, Book 19, General Business Law art 22-A, 1999-2000 Pocket Part, at 214-256). The term consumer is understood to mean "associated with an individual or natural person who purchases goods, services or property primarily for personal, family or household purposes," id. While the statute is not viewed as precluding its application in business to business disputes *per se*, its application in such disputes "is severely limited," id. I have previously ruled on such claims brought by insurers against health care providers in Progressive and held that "plaintiff insurers, who were the sellers of policies, were clearly not 'consumers' as defined by the statute."

Here the plaintiff insurance companies cannot be considered consumers as contemplated by the statute. The present case presents circumstances nearly identical to Progressive where such claims were dismissed. The insurance companies in this action are not situated as consumers of physician services and should therefore not be afforded the protections intended for that class of individuals.

The cases cited by the plaintiffs to support their claim are not relevant. While it is true that businesses have been permitted to pursue claims based on violations of General Business Law § 349, those businesses were acting as the direct consumers of particular services, see Myers, Smith & Granady, Inc. v. New York Property Insurance Underwriting Ass'n, 85 N.Y.2d 832 (1995); Strutman v. Chemical Bank, 95 N.Y.2d 24 (2000); Scalp & Blade, Inc. v. Advest Inc., 281 A.D.2d. 882 (4th Dept 2001); Gaidon v. Guardian Life Insurance Co. of America, 94 N.Y.2d 330 (1999). Here, the plaintiffs are not the direct consumers of any of the services

provided by the defendants. These plaintiffs are the insurers of the customers, not the recipients of medical services.

For the foregoing reasons the defendants' motion to dismiss the second claim for relief is granted.

Unjust Enrichment:

Plaintiffs seek restitution for unjust enrichment in their third claim for relief. To state a claim for unjust enrichment a plaintiff must establish that: (1) the defendant was enriched (2) at plaintiff's expense, and (3) that it is against equity and good conscience to permit the defendant to retain what is sought to be recovered, Lake Minnewaska Mountain Houses, Inc. v. Rekis, 259 A.D.2d 797 (3rd Dept 1999).

The essence of the Oxford plaintiffs complaint is that the defendants created a fraudulent network whereby they could defraud the insurers out of millions of dollars. Plaintiffs contend that the creation of this network enabled defendants to engage in multiple forms of billing fraud, including:

> "improper multiple billings for the same service, billing chiropractor or lay person services as though they were physician services, billing the services of a physician at several different facilities at the same time, billing for services performed under the supervision of a physician when in fact there was no physician supervision, improperly waiving co-payments, co-insurance, and/or deductibles, providing unwarranted or medically unreliable testing, and circumventing the required pre-certification after eight chiropractic visits by billing additional visits as physician services thereafter."

Assuming these allegations to be true, there is a basis in equity and good conscience to recompense plaintiffs for monies that they paid as the result of unwarranted claims and improper

billing. Contrary to the position of the defendants, this is not a claim for unjust enrichment premised on improper corporate structure alone. Rather, plaintiffs seek to recover for services that were not provided or for which they were fraudulently billed. As such, the motion to dismiss the claim for unjust enrichment is denied.

Intentional Interference with Contract:

Plaintiffs' fourth claim seeks damages for intentional interference with contract. Specifically, plaintiffs allege that defendants tortiously interfered with the contractual relationship between them and their insureds by "waiving and/or reducing co-payments, co-insurance, and deductibles; giving free initial consultations; conspiring to defraud plaintiffs; and conspiring with the insureds to breach the insureds' implied covenant of good faith and fair dealing."

However, plaintiffs fail to establish the necessary requirements for a tortious interference with contract claim. Such a claim is established where it can be shown that there is the "existence of a valid contract between the plaintiff and a third party, defendant's knowledge of that contract, defendant's intentional procurement of the third party's breach of the contract without justification, actual breach of the contract, and damages resulting therefrom," Lama Holding Co. v. Smith Barney Inc., 88 N.Y.2d 413 (1996). In determining whether a breach of contract has occurred, " while it is unnecessary to set forth the contract in detail the provisions upon which the plaintiff's claim is based must, nevertheless, be set out," Berdych v. Bell Aerospace Corp, 19 A.D.2d 582 (4th Dept 1963). In considering claims for breach of contract it is also not for the court to "speculate as to the contractual duties, express or implied, which were

allegedly breached," Glassman v. Letchworth Village Development Center, 104 Misc.2d 755 (Ct Cl 1980).

The plaintiffs' complaint focuses on the structure and function of the scheme allegedly devised by the defendants to defraud the insurer. However, nowhere in the complaint do plaintiffs allege specific attempts by the defendants to incorporate plaintiff's insureds into their scheme. In order to properly state a claim for tortious interference with contract, plaintiffs would have to allege some form of interaction between the defendants and the insureds to show that defendants intentionally procured the insureds' breach of contract. Based on the allegations in the complaint I see no basis for the allegation that defendants tortiously interfered with contracts. Further, plaintiffs offer no evidence, in the form of the contracts themselves or the relevant provisions, to establish that a breach did occur.

For the foregoing reasons plaintiffs' fourth cause of action for intentional interference with contract is dismissed.

Piercing the Corporate Veil:

Defendants allege that plaintiffs'allegations are not sufficient to pierce the corporate veil allowing them to extend liability to the individual shareholders and managers of the defendant corporations. The essential elements necessary to pierce the corporate veil are a showing that (1) the owners exercised complete domination of the corporation in respect to the transaction attacked; and (2) that such domination was used to commit a fraud or wrong against the plaintiff which resulted in plaintiff's injury, Morris v. New York State Department of Taxation and Finance, 82 N.Y.2d 135 (1993). However, it has been observed that "because a decision whether to pierce the corporate veil in a given instance will necessarily depend on the attendant facts and

equities, the New York cases may not be reduced to definitive rules governing the varying circumstances when the power may be exercised," id.

A corporate veil can be pierced where a showing can be made that the directors and shareholders utilized the corporate form to facilitate personal gain. Broadly speaking, this doctrine is utilized in instances to "prevent fraud or to achieve equity," International Aircraft Trading Co. v. Manufacturers Trust Co., 297 N.Y. 285 (1948). Generally, corporate agents cannot incur liability unless they personally participate in, or have actual knowledge of, fraudulent activity or misrepresentations, Towjer Inc. v. Tarran, 236 A.D.2d 518 (2nd Dept 1997). However, the central question in an analysis is whether "the corporation is a dummy for its individual stockholders who are in reality carrying on the business in their personal capacities for purely personal rather than corporate ends," Port Chester Electrical Construction Corp. v. Atlas, 40 N.Y.2d 652 (1976).

The central theme of the plaintiffs' complaint is that several of the individual defendants created sham medical PCs in order to perpetrate fraudulent activities against the insurance company. Specifically, plaintiffs allege that defendants Bass and Siegel set up a network of medical practices, management companies, and a billing company that would allow them to augment their own personal revenues derived from the fraudulent activities of the various PCs. Furthermore, plaintiffs allege that various physicians sold their names and licenses to become nominal shareholders in the PCs. It is alleged that these physicians have nothing to do with the day-to-day operations of the facilities and collect fees for the use of their names and licenses only, and do not render any medical services.

Assuming the facts as alleged in the complaint to be true, the individual defendants did utilize the corporate form for their personal gain. Plaintiffs' complaint asserts that Bass and Siegel completely dominate the network of the medical corporations and management companies in such a way so as to maximize their personal profits. If the allegations concerning the physician owners are assumed to be true, they too must be viewed as having personally participated in the fraudulent activities and misrepresentations as the paper owners of the medical PCs. The doctrine of piercing the corporate veil is applied where it is shown that owners "abused the privilege of doing business in the corporate form to perpetrate a wrong or injustice against a party such that a court in equity will intervene," Morris v New York State Department of Taxation and Finance, et. al., 82 N.Y.2d 135 (1993). Viewing the complaint in the light most favorable to the plaintiff, I do not conclude that the individual defendants should not be held personally liable for the alleged fraudulent activity they allegedly perpetrated through the defendant corporations for their personal benefit.

Punitive Damages:

In conjunction with their first claim for relief plaintiffs seek an award of 20 million dollars in punitive damages. Punitive damages are appropriate in tort actions where the "wrongdoing is intentional or deliberate, has circumstances of aggravation or outrage, has a fraudulent or evil motive, or is in such conscious disregard of the rights of another that it is deemed willful and wanton," U.S. Trust Corp. v. Newbridge Partners, L.L.C., 278 A.D.2d 172 (1st Dept 2000).

Here, plaintiffs' complaint alleges conduct that, if true, is sufficiently egregious to warrant a claim for punitive damages. Defendants allegedly engaged in a scheme that was

designed to intentionally defraud the insurers, and can certainly be considered egregious tortious conduct. The claim for punitive damages is permitted to stand.

Motion Sequence 002:

In motion sequence 002 defendants Ira Grushack, D.C., Joe Eisman, D.C., and East Park Chiropractic request that plaintiffs be required to replead their complaint with separately numbered paragraphs and strike scandalous and irrelevant material. These defendants further request that the complaint be severed for discovery and trial.

The motion to require plaintiffs to replead is denied. The complaint does not allege scandalous or prejudicial material. The allegations contained in the complaint set forth the basic framework by which the defendants allegedly attempted to defraud plaintiffs. The claims are necessary and appropriate given the nature of the action.

Severance for discovery and trial is not appropriate. The complaint alleges a fraudulent scheme that was allegedly conducted with the aid and assistance of all the named defendants. Not only are the actions of the defendants interrelated, but the claims also raise common questions of law and fact. Further, given the number of defendants, severance will not facilitate judicial economy.

Conclusion:

The motions to dismiss plaintiff's second and fourth claims for relief based on violation of General Business Law § 349 and intentional interference with contract are granted. In all other regards the motions are denied.

This constitutes the decision and order of the court.

Dated: September 9, 2002

J.S.C.

IRA GAMMERMAN

FILED

SEP 13 2002

COUNTY CLERK'S OFFICE
NEW YORK