UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA

BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA, INC.

Plaintiff

v.

HALOMD, INC.; HOSPITALIST MEDICINE PHYSICIANS OF GEORGIA - TCG, PC; and SOUND PHYSICIANS EMERGENCY MEDICINE OF GEORGIA, PC

Defendants

CASE NO. 1:25-CV-02919-TWT

MOTION TO DISMISS THE AMENDED COMPLAINT BY DEFENDANTS SOUND PHYSICIANS EMERGENCY MEDICINE OF GEORGIA, PC AND HOSPITALIST MEDICINE PHYSICIANS OF GEORGIA - TCG, PC

Defendants Sound Physicians Emergency Medicine of Georgia, PC and Hospitalist Medicine Physicians of Georgia - TCG, PC (together, "Sound Physicians") respectfully move to dismiss plaintiff Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.'s ("Blue Cross") amended complaint (Docket No. 43) under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6). This motion is accompanied by a memorandum of law, which sets out its grounds in detail. In short:

1. The Court lacks subject-matter jurisdiction. Blue Cross asks the Court to vacate thousands of arbitrations conducted under the No Surprises Act, 42 U.S.C. § 300gg-111. But Congress expressly stripped the Court of jurisdiction to

review these arbitrations, except where there are grounds for vacatur under the Federal Arbitration Act. However, Blue Cross has failed to comply with the procedure for vacatur and has failed to show a substantive basis for vacatur.

2. Blue Cross cannot use other causes of action—such as its RICO and state-law claims—as an alternative to the vacatur rules or to evade the bar on judicial review that Congress enacted.

3. Furthermore, each of Blue Cross's causes of action fails to state a claim on which relief can be granted, for the reasons set out in Sound Physicians' brief.

Accordingly, Sound Physicians respectfully requests that the Court dismiss the amended complaint.

Dated: September 19, 2025

Respectfully submitted,

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA

BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA, INC. *Plaintiff* v. **HALOMD, INC.; HOSPITALIST MEDICINE PHYSICIANS OF GEORGIA - TCG, PC; and SOUND PHYSICIANS EMERGENCY MEDICINE OF GEORGIA, PC** *Defendants*	CASE NO. 1:25-CV-02919-TWT

MEMORANDUM IN SUPPORT OF
SOUND PHYSICIANS' MOTION TO DISMISS

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September 19, 2025

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I. INTRODUCTION

Congress passed the No Surprises Act, 42 U.S.C. § 300gg-111 ("NSA") to protect patients from large out-of-network medical bills. The NSA requires insurance companies (like plaintiff Blue Cross[1]) and medical providers (like defendant Sound Physicians) to negotiate about how much the insurer will pay the provider for a patient's medical care. If negotiations fail, either side can invoke binding arbitration (known as Independent Dispute Resolution or "IDR") where an arbitrator will determine a reasonable payment.

But Blue Cross does not like the arbitration system that Congress established, and particularly does not like that Sound Physicians frequently prevails in arbitration. It now asks this Court to vacate *thousands* of arbitrations where Blue Cross disagrees with the arbitrators' rulings, and to find Sound Physicians liable for damages as to arbitrations where Sound Physicians was the prevailing party. It even invokes the RICO statute, arguing that Sound Physicians' arbitration submissions—again including those where the arbitrator ruled in Sound Physicians' favor—amount to wire fraud and obstruction of justice. This theory is just as weak as it sounds.

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[1] This brief refers to defendants Sound Physicians Emergency Medicine of Georgia, PC and Hospitalist Medicine Physicians of Georgia-TCG, PC together as "Sound Physicians." It refers to co-defendant HaloMD, Inc. as "HaloMD," and plaintiff Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. as "Blue Cross." "Am. Compl." citations refer to Blue Cross's amended complaint, Docket No. 43. "Initial Compl." citations refer to Blue Cross's original complaint, Docket No. 1.

Stripped of its rhetoric, the following is Blue Cross's argument why Sound Physicians violated RICO and why the Court should vacate thousands of arbitration rulings and award damages to the losing party:

- In some instances, the parties dispute whether the claim is eligible for arbitration, a technical question that the NSA empowers arbitrators to decide (and which largely turns on the specific kind of Blue Cross health insurance plan the patient has). Each side submits its position on this technical issue, and the arbitrator rules on it. Am. Compl. ¶¶ 64-65. But Blue Cross now asserts that Sound Physicians' arbitration submissions explaining why a particular claim is eligible for IDR constitute *wire fraud* – even where the arbitrator agreed with Sound Physicians and ruled against Blue Cross. Am. Compl. ¶ 177.
- Blue Cross is a massive insurance company, and Sound Physicians is comprised of "over 4,000 physicians [at] more than 400 hospitals." Am. Compl. ¶ 15. Thus, it is no surprise that these parties participate in thousands of IDRs each year. *Id*. ¶ 8. But Blue Cross now asserts that Sound Physicians violated RICO by sending too many dispute to arbitration—even though the law gives providers the right to invoke the IDR process and does not limit the number of requests. Am. Compl. ¶ 180.
- Finally, Blue Cross asserts that Sound Physicians violated the law because it sometimes asked arbitrators to award higher payments for medical care

than Blue Cross thinks is fair—even though the law does not limit either side's bid or ask, and even where the arbitrator ruled that Sound Physicians' offer was the more reasonable one. Am. Compl. ¶¶ 66-67.

These theories are meritless, and the Court should dismiss Blue Cross's complaint for at least six reasons:

First, Congress expressly prohibited judicial review of IDR rulings, except where there are grounds for vacatur under the Federal Arbitration Act ("FAA"). 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). Vacatur review is "among the narrowest known to the law," and requires circumstances such as corruption equal in gravity to bribery or a physical threat to an arbitrator. *See AIG Baker Sterling Heights, LLC v. American Multi-Cinema, Inc.*, 508 F.3d 995, 1001 (11th Cir. 2007); *Guardian Flight, L.L.C. v. Med. Evaluators of Texas ASO, L.L.C.*, 140 F.4th 613, 621-622 (5th Cir. 2025). Blue Cross relies on only two of the potential grounds for vacatur under the FAA: that Sound Physicians' favorable results were procured by "undue means" or "fraud," and that the arbitrators "exceeded their powers" when they rejected Blue Cross's arguments that certain arbitrations should not move forward. *See* Am. Compl. ¶¶ 253, 254. For the reasons below, its allegations here are not nearly enough to reverse an arbitration award, let alone thousands of them. The losing party in an arbitration does not get a do-over in federal court merely because it disagrees with the other side's arguments and believes the arbitrator erred by agreeing with them. This is jurisdictional and outcome dispositive.

Second, Blue Cross has not submitted a proper request to vacate any of the thousands of arbitration awards in question. For good reason, the Eleventh Circuit requires more than a complaint analyzed under notice-pleading standards to vacate an arbitration ruling. Instead, the law requires an application (i.e., a motion) supported by clear and convincing evidence, filed within three months of the award. *Bonar v. Dean Witter Reynolds, Inc.*, 835 F.2d 1378, 1383 (11th Cir. 1988); 9 U.S.C. § 12. If it were otherwise, the losing side could easily force discovery in federal court to re-litigate its arbitration losses from years prior. Here, Blue Cross references only six arbitrations by docket number, does not plead the date of the final awards, attaches no evidence or other support, and asks the Court to vacate thousands of arbitrations going back years. This is insufficient as a matter of law.

Third, Blue Cross's claims under RICO, ERISA, and various state-law theories are prohibited by NSA's bar on judicial review. A plaintiff cannot thwart Congress's bar on judicial review by simply invoking a different cause of action. Likewise, well-established law bars plaintiffs from using a different claim (like RICO) to challenge the outcome of an arbitration, rather than complying with the procedural and substantive rules for vacatur. *See Decker v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 205 F.3d 906, 910 (6th Cir. 2000); *see also Freeman v. Citibank, N.A.*, No. 3:14-cv-00067-TCB-RGV, 2015 WL 13777266, at *24 (N.D. Ga. 2015).

Fourth, Blue Cross has not pleaded a viable RICO claim. Nearly every litigation or arbitration involves the parties submitting opposing factual and legal

positions to a tribunal. The losing side cannot relitigate the case by suing again and claiming that the other side's briefs in the first case were wire fraud.

Ironically, as discussed below on page 40, Blue Cross's initial complaint in *this* case made exactly the sort of error that it claims is wire fraud. Blue Cross's theory of the case is that incorrect statements of fact submitted to a tribunal are wire fraud and thus support RICO liability. Here, Sound Physicians' arbitration filings stated that it had completed a required negotiation period before seeking arbitration. But those statements were *wire fraud,* Blue Cross argued to this Court, because Sound Physicians supposedly had not requested to negotiate before filing.

But the amended complaint confirms that it was Blue Cross that was wrong on the facts; Sound Physicians *did* request to negotiate before filing for arbitration. *Compare, e.g.,* Initial Compl. ¶ 122 with Am. Compl. ¶ 148. Blue Cross had to amend to correct its own errors of fact in its submission to this Court. If Blue Cross's theory were right—that an error of fact in a submission to a tribunal were actionable as wire fraud—then Blue Cross itself would be liable for wire fraud. Of course, this isn't the law. But Blue Cross's factual errors illustrate Sound Physicians' point: Blue Cross is flatly wrong on the law.

Fifth, Blue Cross's ERISA claim fails because it has not pleaded facts to show ERISA standing. Blue Cross has carefully avoided pleading that it is an ERISA fiduciary—a condition precedent for its claim here. In other cases, cited below, various Blue Cross entities have expressly argued that they are not an ERISA

fiduciary.

Sixth, Blue Cross's state-law fraud claims fail because Blue Cross has not pleaded the elements required for fraud under Georgia law. In particular, Blue Cross has not shown that it was defrauded or that it relied on the supposedly false statements. Just the opposite: Blue Cross alleges that it disagreed with Sound Physicians' positions, and that it failed at convincing the arbitrators that it was right. This describes losing an arbitration, not being defrauded.

The bottom line is that Congress has expressly precluded the judicial review that Blue Cross seeks. That is true no matter what cause of action Blue Cross invokes. The Fifth Circuit recently resolved a similar case, rejecting judicial review of an IDR ruling and noting that Congress instead empowered a government agency to address alleged non-compliance with IDR rules. *Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 277 (5th Cir. 2025).[2] In short, the Court is the wrong forum for this complaint, and it should dismiss this case.

II. BACKGROUND AND PROCEDURAL HISTORY

A. The parties

Blue Cross is a large healthcare insurance carrier operating in Georgia. Am. Compl. ¶¶ 11, 19. Blue Cross has sued defendants Sound Physicians and HaloMD

[2] Similar issues are now pending before the Eleventh Circuit, which is reviewing a decision from the Middle District of Florida dismissing another request for vacatur of IDR rulings. *See REACH Air Medical Services LLC v. Kaiser Foundation Health Plan Inc., et al.*, No. 24-10135 (11th Cir. argued June 3, 2025).

in this case. *See* Am. Compl. ¶ 2. Sound Physicians is comprised of "over 4,000 physicians, advanced practice providers, CRNAs, and nurses." Am. Compl. ¶ 15. HaloMD administers the IDR process on behalf of healthcare organizations, including Sound Physicians. Am. Compl. ¶ 121. Blue Cross alleges that HaloMD submitted and administered some, but not all, of the IDR claims at issue here. Am. Compl. ¶ 131.

B. The NSA and the IDR process

Congress enacted the NSA to address the practice of "surprise billing" to patients for out-of-network items and services. Am. Compl. ¶ 32. The NSA created a process for resolving disputes about payment for out-of-network medical services with the goal of taking the consumer out of billing disputes between insurers and providers. Am. Compl. ¶ 32. This process involves three steps: open negotiations, IDR submissions, and then a binding payment determination by arbitrators known as Independent Dispute Resolution Entities ("IDREs"). *See* 42 U.S.C. § 300gg-111(c); Am. Compl. ¶ 32.

When a dispute arises over the payment amount for an out-of-network service covered by the NSA, either the medical provider or insurer first initiates open negotiations with the other side. *See* 42 U.S.C. § 300gg-111(c)(1)(B); Am. Compl. ¶ 32. If they are unable to agree on a payment amount within thirty days, either party can then initiate the IDR arbitration process. *See* 42 U.S.C. § 300gg-111(c)(1)(B); 45 C.F.R. § 149.510(b)(2)(i).

Not every medical service and not every insurance plan is eligible for IDR. Am. Compl. ¶ 37. As Blue Cross's amended complaint shows, the criteria are technical. Paragraphs 19-24 describe the difference between "fully insured" and "self-funded" plans, plans that Blue Cross administers for the government, and plans where Blue Cross acts as a "Host Plan" for other Blue Cross entities. Am. Compl. ¶¶ 19-24. According to Blue Cross, certain Blue Cross plans are not eligible for NSA IDR, as they are instead controlled by Georgia's surprise billing laws or federal rules setting rates for plans that Blue Cross administers for the government. *See* Am. Compl. ¶¶ 38, 40. While Blue Cross knows with certainty what kind of insurance it provides to each of its insured, the best it can offer as to Sound Physicians' knowledge is that "[w]hile BCBSGA administers different types of health plans, providers generally know what type of health care coverage the patient has" because patients presumably present their insurance cards when receiving medical care. Am. Compl. ¶ 25.

A provider or insurance company initiates the IDR process through an online portal. Am. Compl. ¶ 44. At the end of the process, the provider or insurance company must attest that "the item(s) and/or service(s) at issue are qualified … within the scope of the Federal IDR process." Am. Compl. ¶ 55. After a party initiates IDR, the parties select an IDRE (i.e., arbitrator)—or if they cannot agree, a government agency appoints one. *See* 42 U.S.C. § 300gg-111(c)(4)(F). The complaint acknowledges that the first step of the IDR process is for the arbitrator

to determine whether the claim is eligible for IDR. Am. Compl. ¶ 64 ("First, the IDRE is required by regulation to determine whether the Federal IDR process applies." (quotations omitted)). The arbitrators are expressly authorized and indeed required to make this determination. Am. Compl. ¶ 64; *see also* 45 C.F.R. § 149.510(c)(1)(v). A dispute only moves forward—and there can only be an award—if the IDRE determines that it is eligible. *Id.* Thus, as to each of the IDRs as to which Blue Cross alleges it suffered "damages," *see* Am. Compl. ¶ 10, the IDRE must have determined that the claim was eligible for IDR.

If the IDRE determines the dispute is eligible, each party proposes a payment amount for the medical care at issue. The IDRE then selects the offer it finds to be most reasonable, which is thus the amount the insurer must pay the provider. *See* 42 U.S.C. § 300gg-111(c)(5)(B). This is a "baseball" style arbitration, where the IDRE must select between the two sides' offers and pick the one that is most reasonable under specified statutory factors. Am. Compl. ¶¶ 66-67. In selecting the most reasonable offer, the IDRE considers the "qualifying payment amount" which is usually the insurer's median in-network rate for the item or service, the provider's training, experience, quality, and market share, and the patient's acuity. *See* 42 U.S.C. § 300gg-111(c)(5)(C)(i)(I); Am. Compl. ¶¶ 54, 67. However, the IDRE is prohibited from considering the medical provider's usual or customary rates. 42 U.S.C. § 300gg-111(c)(5)(D).

C. Section 300gg-111(c)(5)(E) limits judicial review.

The NSA specifies that the arbitrator's ruling is generally binding on the parties, and further bars judicial review. Specifically, § 300gg-111(c)(5)(E)(i) first provides that the award is binding absent narrow exceptions, and then goes on to bar judicial review except under even more narrow circumstances:

> A determination of a certified IDR entity …
>
> (I) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and
>
> (II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9.

Id. The reference at the end to § 10(a) of title 9 refers to circumstances for vacatur under the FAA. *See* Am. Compl. ¶ 71 (citing 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II)).

D. The original and amended complaints

Blue Cross filed its original complaint on May 27, 2025. Dkt. No. 1. Prior to the deadline for the defendants' responses to the original complaint, Blue Cross filed its amended complaint on August 29, 2025. Dkt. No. 43. Section III.E.1 (on page 40) of this brief discusses the material changes between the original and amended complaints.

III. ARGUMENT

A. Legal standard

Sound Physicians moves to dismiss the amended complaint under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6).

Under Rule 12(b)(1), a court must dismiss a case where it lacks subject-matter jurisdiction. "[B]ecause a federal court is powerless to act beyond its statutory grant of subject matter jurisdiction, a court must zealously ensure that jurisdiction exists over a case[.]" *Lara Santiago v. Mayorkas*, 554 F. Supp. 3d 1340, 1345 (N.D. Ga. 2021) (cleaned up). "[O]nce a federal court determines that it is without subject matter jurisdiction, the court is powerless to continue." *Bochese v. Town of Ponce Inlet*, 405 F.3d 964, 974–75 (11th Cir. 2005). Here, the burden is on the plaintiff: "it is presumed that a federal court lacks jurisdiction in a case until the plaintiff shows the court has jurisdiction over the subject matter." *Lara Santiago*, 554 F. Supp. at 1345; *see also Bochese*, 405 F. 3d at 975.[3]

Under Rule 12(b)(6), a court must dismiss a complaint that "fails to state a claim on which relief may be granted." *Id*. To survive, a complaint must state a "plausible claim for relief." *Simpson v. Sanderson Farms, Inc.*, 744 F.3d 702, 708 (11th Cir. 2014); *see also Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). A claim is plausible only when it contains sufficient factual allegations for the court "to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 678. The plausibility standard demands "more than a sheer possibility that a

[3] A challenge to subject-matter jurisdiction under Rule 12(b)(1) "may be based on a facial or factual challenge to the complaint." *Taylor v. Mystery Ship, LLC*, 649 F. Supp. 3d 1291, 1294–95 (N.D. Ga. 2022). In this case, the absence of subject-matter jurisdiction in apparent on the face of the complaint.

defendant has acted unlawfully." *Id.* Thus, "[w]here a complaint pleads facts that are 'merely consistent with' a defendant's liability, it 'stops short of the line between possibility and plausibility.'" *Id.* (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 557 (2007)). Though courts take the facts alleged in the light most favorable to the plaintiff, legal conclusions and recitations of claim elements are not enough. *Iqbal*, 556 U.S. at 678 ("Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice.").

Fraud claims require a higher pleading standard. *Am. Dental Ass'n v. Cigna Corp.*, 605 F.3d 1283, 1291 (11th Cir. 2010). This requires that '[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake.'" *Id.* Under Rule 9(b), plaintiffs must allege: "(1) the precise statements, documents, or misrepresentations made; (2) the time, place, and person responsible for the statement; (3) the content and manner in which these statements misled the Plaintiffs; and (4) what the defendants gained by the alleged fraud." *Id.* (quoting *Brooks v. Blue Cross & Blue Shield of Fla., Inc.*, 116 F.3d 1364, 1380–81 (11th Cir.1997)). Moreover, a plaintiff must also allege facts with respect to each defendant's participation in the fraud, and cannot simply make generic allegations against the defendants together. *Id.*

As to a request for vacatur, the rules of notice pleading do not apply. *O.R. Sec., Inc. v. Pro. Plan. Assocs., Inc.*, 857 F.2d 742, 748 (11th Cir. 1988). Instead, for the reasons set out in § III.C.2, below, the party seeking vacatur must make an

application or motion supported by clear and convincing evidence. *Id.*

B. Congress prohibited judicial review of IDR rulings, unless the requirements for vacatur under the FAA are met.

Congress has expressly prohibited judicial review of IDR rulings—unless certain narrow exceptions are met—and this bar is jurisdictional. Specifically, the NSA states that a "determination of a certified IDR entity … shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a)" of the FAA. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). Paragraphs 1 through 4 of § 10(a) of the FAA set out the grounds for vacatur. *Id.* ("In any of the following cases the United States court in and for the district wherein the award was made may make an order vacating the award upon the application of any party to the arbitration."). As discussed below (in § C.3 on page 28) none of these grounds exist here.

Where Congress makes a clear statement restricting judicial review, it is limiting the subject-matter jurisdiction of the courts. *See Arbaugh v. Y&H Corp.*, 546 U.S. 500, 515-516 (2006); *see also Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 153-154 (2013). The Constitution empowers Congress to limit the jurisdiction of federal courts. *United States v. Hudson*, 11 U.S. 32, 33 (1812). To do so, it must enact a statute that provides "clear and convincing evidence that Congress intended to deny" access to judicial review. *Bd. of Governors of Fed. Reserve Sys. v. MCorp Fin., Inc.*, 502 U.S. 32, 44 (1991).

For example, where—as here—Congress states that a determination is not subject to judicial review, the bar is jurisdictional. That was the Ninth Circuit's holding in *Biological Diversity v. Bernhardt*, 946 F.3d 553, 563 (9th Cir. 2019), which analyzed a statute providing that no determination under a certain law "shall be subject to judicial review." *Id.; see also Montanans For Multiple Use v. Barbouletos*, 568 F.3d 225, 228 (D.C. Cir. 2009) (same as to a statute providing that "no determination" under a certain process "shall be subject to judicial review"); *see also See Acker v. Tarr,* 486 F.2d 654, 656 (7th Cir. 1973) (finding no jurisdiction to review a deferment classification, where the statute provides for "no judicial review" except in limited circumstances).

C. Blue Cross has not met the requirements for vacatur under the FAA.

The exclusive means to challenge an IDR award is to seek vacatur under the FAA. *Guardian Flight, L.L.C. v. Med. Evaluators of Texas ASO, L.L.C.*, 140 F.4th 613, 620 (5th Cir. 2025). There is no path for judicial review in the NSA itself, nor another path elsewhere in federal law. Thus, Blue Cross's complaint (including its request for "vacatur" in count 10) must be analyzed as a request for vacatur under § 10(a)(1)-(4) of the FAA—there is no other source of jurisdiction, and that is all it could be. But vacatur requires clear and convincing evidence that:

- "the award was procured by corruption, fraud, or undue means"
- "there was evident partiality or corruption in the arbitrators"
- "the arbitrators were guilty of misconduct in refusing to postpone the

hearing, upon sufficient cause shown, or in refusing to hear evidence," or

- "the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made"

9 U.S.C. § 10(a); Am. Compl. ¶ 71. For the reasons below, Blue Cross has failed to meet the standard for vacatur under the FAA, and this is not a close call.

1. The demanding standard for vacatur

Judicial review of an arbitration award under the FAA is "among the narrowest known to the law." *AIG Baker Sterling Heights, LLC v. American Multi-Cinema, Inc.*, 508 F.3d 995, 1001 (11th Cir. 2007). Vacatur "is not a mechanism to appeal or otherwise challenge the merits" of an arbitration award. *Floridians for Solar Choice, Inc. v. PCI Consultants, Inc.*, 314 F. Supp. 3d 1346, 1354 (S.D. Fla. 2018), *aff'd sub nom. Floridians for Solar Choice, Inc. v. Paparella*, 802 F. App'x 519 (11th Cir. 2020). Congress established "narrow and exclusive grounds for vacatur to prevent arbitration from becoming merely a prelude to a more cumbersome and time-consuming judicial review process." *Id.* (cleaned up).

The court adjudicating a motion for vacatur may "revisit neither the legal merits of the award nor the factual determinations upon which it relies." *Wiand v. Schneiderman*, 778 F.3d 917, 926 (11th Cir. 2015); *see also Walden v. Doctor's Assocs., Inc.*, No. 1:14-CV-2806-LMM, 2015 WL 11504572 at *5 (N.D. Ga. June 11, 2015) ("Courts are generally prohibited from vacating an arbitration award on the basis of errors of law or interpretation"). The Eleventh Circuit recognizes that arbitrators

are not "junior varsity trial courts where subsequent appellate review is readily available to the losing party," and that "arbitration losers who resort to the courts continue to lose in all but the most unusual circumstances." *Cat Charter, LLC v. Schurtenberger*, 646 F.3d 836, 843 (11th Cir. 2011); *Wiregrass Metal Trades Council AFL-CIO v. Shaw Env't & Infrastructure, Inc.*, 837 F.3d 1083, 1086 (11th Cir. 2016).

2. Vacatur requires a timely motion supported by clear and convincing evidence, not merely allegations in a complaint.

The FAA "imposes strict procedural requirements on parties seeking to vacate arbitration awards." *Johnson v. Directory Assistants Inc.*, 797 F.3d 1294, 1299 (11th Cir. 2015). Under the FAA, "[a]ny application to the court" challenging an arbitration award "shall be made and heard in the manner provided by law for the making and hearing of *motions*, except as otherwise herein expressly provided." 9 U.S.C. § 6 (emphasis added). Controlling Eleventh Circuit precedent confirms this: to challenge an arbitration ruling under the FAA, the required procedure is to file an application or motion to vacate in the district court, supported by clear and convincing evidence. *See O.R. Sec., Inc. v. Pro. Plan. Assocs., Inc.*, 857 F.2d 742, 748 (11th Cir. 1988); *Johnson v. Directory Assistants Inc.*, 797 F.3d 1294, 1299 (11th Cir. 2015). By law, a motion for vacatur must be filed within three months of the award. 9 U.S.C. § 12.

If as here, a plaintiff errs and titles its document as a complaint rather than motion, the court may still consider it because "[t]he Federal Rules are liberal, such

that an erroneous nomenclature does not prevent the court from recognizing the true nature of a motion." *See Johnson*, 797 F. 3d at 1299; *see O.R. Sec.* 857 F. 2d at 748. But the document—no matter what is called—must meet the evidentiary and substantive requirements for a motion to vacate under the FAA. *Id.; see also GPS of New Jersey MD, P.C. v. Aetna, Inc.,* No. CV2205487ESJSA, 2024 WL 414042, at *2 (D.N.J. Feb. 5, 2024) (construing complaint filed under the NSA as a motion for vacatur, and finding that the plaintiff failed to sufficiently demonstrate that it was entitled to vacatur).

The rules of notice pleading do not apply. *O.R. Sec., Inc. v. Pro. Plan. Assocs., Inc.*, 857 F.2d 742, 748 (11th Cir. 1988). This is because the "manner in which an action to vacate an arbitration award is made is obviously important, for the nature of the proceeding affects the burdens of the various parties as well as the rule of decision to be applied by the district court." *Id. at* 745–46. If the party challenging the arbitration decision could rely on mere allegations, then "the burden … would be on the party defending the arbitration award. The defending party would be forced to show that the movant could not prove any facts that would entitle him to relief from the arbitration award." *Id.* And if "the defending party did not prevail on its motion to dismiss, the proceeding to vacate the arbitration award would develop into full scale litigation, with the attendant discovery, motions, and perhaps trial." *Id.* This is not the law, and for good reason. *Id.; see also Hall St. Assocs., L.L.C. v. Mattel, Inc.*, 552 U.S. 576, 588 (2008) ("If parties could take full-

bore legal and evidentiary appeals, arbitration would become merely a prelude to a more cumbersome and time-consuming judicial review process.").

Indeed, as Blue Cross's complaint emphasizes, there are tens of thousands of arbitrations each year under the NSA. Am. Compl. ¶ 93. The federal courts should not be the forum to relitigate each arbitration where the losing side merely pleads that the other side and the arbitrator got the facts wrong.

3. Blue Cross's unsupported complaint falls far short of the requirements for vacatur.

Blue Cross's complaint is not supported by exhibits, declarations, or evidence of any kind. It merely *alleges* that thousands of arbitration results are wrong. It asserts that "*most* of the disputes on which Defendants received an IDR payment determination were clearly ineligible for the process," Am. Compl. ¶ 8 (emphasis added), but does not identify nearly any of them or say why they were ineligible. Of these thousands of cases, it references six by docket number, notes that the arbitrator ruled against Blue Cross on various substantive and factual questions, and simply pleads that the arbitrator got it wrong. And Blue Cross has not pleaded the date of the award as to *any* of the arbitrations discussed in the complaint, and thus has failed to show that any of its request are timely (i.e., filed within three months of the ruling). In short, what it has filed is not nearly enough for vacatur under the FAA.

And even if Blue Cross's unsupported allegations were enough from a

procedural perspective (they are not), its allegations fall far short of showing a substantive basis for vacatur. Every court that has considered the NSA's incorporation of the FAA has agreed that the meaning and established understanding of paragraphs (1) through (4) of the FAA apply when analyzing a challenge to an NSA IDR ruling. *See Guardian Flight, L.L.C. v. Med. Evaluators of Texas ASO, L.L.C.*, 140 F.4th 613, 620 (5th Cir. 2025); *see Med-Trans Corp. v. Cap. Health Plan, Inc.*, 700 F. Supp. 3d 1076, 1084 (M.D. Fla. 2023), *consolidated appeal pending, see REACH Air Medical Services LLC v. Kaiser Foundation Health Plan Inc., et al,* No. 24-10135 (11th Cir. argued June 3, 2025), *see also GPS of New Jersey MD, P.C. v. Aetna, Inc.,* No. CV2205487ESJSA, 2024 WL 414042, at *3 (D.N.J. Feb. 5, 2024).

Blue Cross seeks vacatur of thousands of arbitration awards (which it does not even list) on the grounds that they were "procured by undue means and fraud" (i.e., ¶ 1 of § 10(a)) and because the arbitrators exceeded their "powers by issuing payment determinations on items and services that are not qualified IDR items and services within the scope of the NSA's IDR process" (i.e., ¶ 4 of § 10(a)). Am. Compl. ¶¶ 252, 253. In other words, it relies on only two of the four potential grounds for vacatur under the FAA.[4] In any event, each of these arguments fails

[4] Blue Cross does not rely on or plead facts to support an argument under §§ 10(a)(2) or (3). Section 10(a)(2) requires "evident partiality or corruption in the arbitrators." *Id.* Section 10(a)(3) applies "where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or

under the FAA.

a) No grounds for vacatur under § 10(a)(1)

Blue Cross has failed to show that any arbitration award was procured by, fraud, corruption, or undue means as required under §10(a)(1).

(1) No fraud

"Under the FAA, [f]raud requires a showing of bad faith during the arbitration proceedings, such as bribery, undisclosed bias of an arbitrator, or willfully destroying or withholding evidence." *Guardian Flight,* 140 F.4th 613 at 621. In the Eleventh Circuit, a party moving for vacatur under § 10(a)(1) must establish: (1) fraud, by clear and convincing evidence, (2) which was not discoverable upon the exercise of due diligence prior to or during the arbitration, and (3) which was materially related to an issue in the arbitration. *Floridians for Solar Choice, Inc. v. Paparella*, 802 F. App'x 519, 523 (11th Cir. 2020); *see also Bonar*, 835 F.2d at 1383.

The first element requires the movant to establish fraud by clear and convincing evidence. Blue Cross fails at this step, as it merely alleges that Sound Physicians misrepresented that claims were eligible for IDR arbitration under the NSA, that Blue Cross contested this eligibility at the arbitrations, and the arbitrator ruled in Sound Physicians' favor and against Blue Cross. *See, e.g.,* Am. Compl. ¶¶

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in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced." *Id.*

97-101, 139, 142-43, 145-46.

This is not fraud under the FAA. For example, in a published opinion, the Fifth Circuit recently upheld the dismissal of a complaint seeking to overturn IDR arbitrations on the grounds that one party misrepresented key information during the proceedings. *Guardian Flight,* 140 F.4th 613 at 621-622. Similarly, the United States District Court for the Middle District of Florida recently held that allegations of misrepresentations of fact in an IDR arbitration, without more, are not sufficient to sustain a claim without meeting the requirements of 10(a). *Med-Trans Corp. v. Cap. Health Plan, Inc.*, 700 F. Supp. 3d 1076, 1086 (M.D. Fla. 2023), *consolidated appeal pending, REACH Air Medical Services LLC v. Kaiser Foundation Health Plan Inc., et al,* No. 24-10135 (11th Cir. argued June 3, 2025).

Even if the alleged misrepresentations were somehow clear and convincing evidence of fraud (they are not), Blue Cross fails to meet the second requirement for vacatur under § 10(a)(1): that the fraud "must not have been discoverable upon the exercise of due diligence prior to or during the arbitration." *NuVasive, Inc. v. Absolute Med.*, 71 F.4th 861, 878 (2023). **Here, Blue Cross pleads the opposite: that it was aware of the supposed misstatements, argued to the arbitrator that the statements were wrong, but it still lost**. Am. Compl. ¶¶ 135-160. Blue Cross has pleaded itself out of court. It alleges that it knew about this "fraud" during the IDR process and that it presented this information to the arbitrators. For example, as to each of the awards that Blue Cross references in its complaint, it alleges that it

"timely responded to the IDR initiation to assert that IDR was not applicable to the dispute," sent a letter to the IDRE "stating that the services were ineligible," or "objected to the disputes' eligibility." *See, e.g.,* Am. Compl. ¶¶ 142, 145, 149, 155, and 159. Still, the arbitrators subsequently ruled against Blue Cross. *Id.*

By establishing that it contested the eligibility of the claims at the time of the arbitration, Blue Cross defeats its own argument that "fraud" occurred that was not discoverable by due diligence prior to or during the arbitration process. Blue Cross does not establish the required elements under the FAA's vacatur provision, but instead asks the Court to "revisit… the legal merits of the award [or] the factual determinations upon which it relies." *Wiand v. Schneiderman*, 778 F.3d 917, 926 (11th Cir. 2015). But controlling precedent forbids that.

(2) No undue means

"Undue means" in the context of § 10(a) refers to conduct that is immoral if not illegal. "[U]ndue means, warranting a vacatur of award, include measures equal in gravity to bribery ... or physical threat to an arbitrator." *Freeman v. Citibank, N.A.*, No. 314CV00067TCBRGV, 2015 WL 13777266, at *13 (N.D. Ga. Jan. 20, 2015), *report and recommendation adopted*, No. 3:14-CV-67-TCB, 2015 WL 13777347 (N.D. Ga. Feb. 10, 2015); *see also Med-Trans Corp.*, 700 F. Supp. 3d at 1085; *see also Am. Postal Workers Union, AFL–CIO v. U.S. Postal Serv.*, 52 F.3d 359, 362 (D.C. Cir. 1995); *PaineWebber Grp., Inc. v. Zinsmeyer Trusts P'ship,* 187 F.3d 988, 991 (8th Cir. 1999) ("[C]ircuits have uniformly construed the term undue means as

requiring proof of intentional misconduct.").

No evidence (or even allegation) of intentional conduct "equal in gravity to bribery ... or physical threat to an arbitrator" is present here, or anything remotely close to it. At most, Blue Cross argues that Sound Physicians submitted a large number of arbitrations, and that its settlement demands were larger than Blue Cross thinks they should have been.

Blue Cross and Sound Physicians are both large entities, so a large volume of claims is the expected outcome, not a surprise. There is no cap on the number of claims eligible for IDR. The same is true of Blue Cross's theory that Sound Physicians' monetary demands were too high. As Blue Cross explains, the arbitrator's job is to select the most appropriate option between the two that are submitted (one by each side). If Sound Physicians' offer is too high, why would the arbitrator select it—and what are the undue means? Certainly, Blue Cross points to no statutory or other constraints limiting the amount that a provider can request in the IDR process. It objects that Sound Physicians' demands were sometimes higher than the billed charges, but then notes that Congress expressly prohibited consideration of the billed charges in the IDR process. Am. Compl. ¶ 67, citing 42 U.S.C. § 300gg-111(c)(5)(D) (IDREs "shall not consider … the amount that would have been billed by such provider or facility . . ."). In any event, if the provider's offer is unreasonably high, then the arbitrator will select the insurance company's number instead. But there are no undue means shown here.

b) No grounds for vacatur under § 10(a)(4)

Vacatur is permitted under 9 U.S.C. § 10(a)(4) only if the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made. **"[T]he test for whether an arbitrator exceeds his authority is whether the arbitrator had the power, based on the parties' submissions or the arbitration agreement, to reach a certain issue, not whether the arbitrator correctly decided that issue.**" *Gherardi v. Citigroup Glob. Markets Inc.*, 975 F.3d 1232, 1238 (11th Cir. 2020) (citations and quotations omitted; emphasis added).

Blue Cross's position here is a non-starter. The arbitrators are plainly authorized to decide eligibility and to decide between the parties' proposed awards for compensating the medical provider. *See* Am. Compl. ¶ 100; *see also* 45 C.F.R. § 149.510(c)(1)(v). This precludes Blue Cross's § 10(a)(4) argument. Again, the question is whether the arbitrators were authorized to decide, not whether they made the wrong decision. While reviewing an arbitration award under this provision of the FAA, "the sole question for [the court] is whether the arbitrator (even arguably) interpreted the parties' contract, not whether he got its meaning right or wrong." *Hidroelectrica Santa Rita S.A. v. Corporacion AIC, SA*, 119 F.4th 920, 925 (11th Cir. 2024), quoting *Oxford Health Plans LLC v. Sutter*, 569 U.S. 564, 569 (2013). "[I]t is not enough to show that the arbitral authority committed even a serious error." *Hidroelectrica Santa Rita* at 925.

Blue Cross merely alleges that the arbitrators sometimes made errors in some eligibility determinations, and that they sometimes picked the wrong offer (because Blue Cross would prefer that the arbitrator selected its offer instead). Blue Cross has failed to allege facts showing that the arbitrators exceeded their powers.

In *Wiregrass Metal Trades Council AFL-CIO v. Shaw Env't & Infrastructure, Inc.*, the Eleventh Circuit recognized that '[t]he refusal of courts to review the merits of an arbitration award is the proper approach… because '[t]he federal policy of settling… disputes by arbitration would be undermined if courts had the final say on the merits of the awards.'" 837 F.3d 1083, 1091 (11th Cir. 2016) (citing *United Steelworkers of Am. v. Enter. Wheel & Car Corp.*, 363 U.S. 593, 595-98 (1960)). That is precisely the problem with Blue Cross's request here. Allowing judicial review of every IDRE's decision on eligibility or the proper award would—in practice—replace the IDREs with federal judges. And that is precisely what Eleventh Circuit precedent rejects. *See Cat Charter, LLC v. Schurtenberger*, 646 F.3d 836, 843 (11th Cir. 2011) ("The Eleventh Circuit recognizes that arbitrators are not junior varsity trial courts where subsequent appellate review is readily available to the losing party." (cleaned up)).

D. Blue Cross cannot use other claims and theories to circumvent the jurisdictional bar on judicial review or the strict requirements for vacatur.

The only plausible reading of § 300gg-111(c)(5)(E)(i)(II) of the NSA is that it bars judicial review of IDR rulings, no matter what cause of action a plaintiff might

invoke to challenge them: it says these rulings "shall not be subject to judicial review, except" under the vacatur provision of the FAA. *Id.* Any other reading would be atextual—and flatly contrary to the law.

Similarly, caselaw from other contexts make clear that the losing side of an arbitration cannot invoke other claims—like RICO or state-law fraud—to challenge the arbitration ruling while ignoring the strict limits and procedures under the FAA. When a plaintiff's objective in a suit brought under other causes of action is "to rectify the alleged harm she suffered by receiving a smaller arbitration award… [the plaintiff] should have filed a motion to vacate the arbitration award under the FAA." *Decker v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 205 F.3d 906, 910 (6th Cir. 2000); *see also Freeman v. Citibank, N.A.*, No. 3:14-cv-00067-TCB-RG,V 2015 WL 13777266, at *24 (N.D. Ga. 2015). When a plaintiff seeks damages "for an alleged wrongdoing that compromised an arbitration award" outside of the vacatur process, that suit is "no more, in substance, than an impermissible collateral attack on the award itself." *Freeman*, 2015 WL at *24 (dismissing claims under Fair Debt Collection Practices Act "to the extent [they] are based on any alleged injury arising from the [arbitration] award itself").

Blue Cross's attempts to bring RICO, ERISA, and state-law claims despite the NSA's jurisdiction-stripping provision are nothing more than an "impermissible collateral attack" on the arbitration awards. *Id*. Therefore, the Court's inquiry should end here, and it should dismiss the case.

E. The RICO claims fail as a matter of law.

For the reasons set out above, Congress has precluded the judicial review that Blue Cross seeks, no matter which legal theory it invokes—including RICO. Furthermore, Blue Cross's RICO theory also fails as a matter of law for several additional and independent reasons:

1. Arbitration submissions cannot be wire or mail fraud.

To survive a motion to dismiss, a RICO claim must set out two or more predicate acts. *Cisneros v. Petland, Inc.*, 972 F.3d 1204, 1208 (11th Cir. 2020). Here, Blue Cross has failed to do so. It appears to rely on five supposed predicate acts constituting wire or mail fraud:

(1) Submitting arbitration filings that include incorrect facts about eligibility;
(2) Collecting on judgments from favorable IDR determinations;
(3) Initiating large numbers IDR disputes;
(4) Demanding "outrageous" payments far exceeding the actual charges; and
(5) Engaging in the IDR process "in bad faith."

See Am. Compl. ¶ 171.[5] These theories fail for two reasons: first, as a matter of law, none of them constitutes wire or mail fraud, and second, Blue Cross has not provided the details required under Rule 9(b).

[5] For clarity, the allegations from Paragraph 171 have been reordered to align with the sequence in which they are addressed in this Brief.

a) Neither arbitration submissions nor collecting judgments from successful arbitrations constitute wire or mail fraud.

As the Eleventh Circuit has made clear, the "mailing of litigation documents, even perjurious ones, [does] not violate the mail-fraud statute." *United States v. Pendergraft*, 297 F.3d 1198, 1209 (11th Cir. 2002)).[6] Likewise, courts have repeatedly held that litigation activity generally cannot give rise to racketeering liability. *Nero v. Mayan Mainstreet Inv 1, LLC*, 645 F. App'x 864, 868 (11th Cir. 2016) ("[F]ederal fraud charges cannot be based on the filing of court documents."); *Pendergraft*, 297 F.3d at 1208 ("A number of courts have considered whether serving litigation documents by mail can constitute mail fraud, and all have rejected that possibility.") (collecting cases); *Kim v. Kimm*, 884 F.3d 98, 104 (2d Cir. 2018) (holding that mere litigation activity cannot serve as a RICO predicate offense and "conclud[ing] that allegations of frivolous, fraudulent, or baseless litigation activities—without more—cannot constitute a RICO predicate act") (collecting cases). This rule applies to actions taken in furtherance of litigation more broadly. *Thakkar v. Good*, No. 6:20-cv-2005-RBD-EJK, 2021 WL 1830410 at *3 (M.D. Fla. Feb. 5, 2021) ("[L]itigation activity, including filing lawsuits and court documents or fabrication of evidence, cannot support a RICO claim based on mail or wire fraud."); *see also Club Exploria, LLC v. Aaronson, Austin, P.A.*, No: 6:18-cv-

[6] This applies equally to electronic transmissions, as mail and wire fraud are treated interchangeably for RICO purposes. *United States v. Ward*, 486 F.3d 1212, 1221 (11th Cir. 2007).

576-Orl-28DCI, 2019 WL 1297964, at *4 (M.D. Fla. Mar. 21, 2019) ("[T]he sending of prelitigation letters—even if those letters contain falsehoods—does not amount to 'mail fraud.'").

These principles extend to arbitration proceedings as well, as courts have held that arbitration activities cannot form the basis for mail or wire fraud. *Republic of Kazakhstan v. Stati*, 380 F. Supp. 3d 55, 60-61 (D.D.C. 2019) (holding that litigation materials transmitted during a prior arbitration could not constitute wire or mail fraud); *Diamond Resorts Int'l, Inc. v. Aaronson*, No. 6:17-cv-1394-Orl-37DCI, 2018 WL 735627, at *5 (M.D. Fla. Jan. 26, 2018) (holding that false statements in arbitration demands were not grounds for mail or wire fraud).

Blue Cross's theories fail under this rule. Indeed, all of the alleged misrepresentations it points to are in submissions made attendant to the IDR process. Am. Compl. ¶¶ 79-88. Such arbitration conduct cannot support a wire fraud theory. *See Nero*, 645 F. App'x at 868; *Pendergraft*, 297 F.3d at 1208. And while Blue Cross claims that allegedly ineligible filings forced it into arbitrations it otherwise would have avoided, such alleged conduct is insufficient even where it "led to Plaintiffs engaging in subsequent arbitrations that might not have otherwise occurred." *See Diamond Resorts*, 2018 WL 735627, at *5.

Likewise, the collection of judgments secured through successful IDR arbitrations is simply an extension of the same litigation-related conduct, and it cannot support a mail or wire fraud claim. *See Pendergraft*, 297 F.3d at 1208

("Again, prosecuting litigation activities as federal crimes would undermine the policies of access and finality that animate our legal system"). Nor does Blue Cross plead any misrepresentation regarding collection of judgments obtained through successful arbitrations. After all, Blue Cross admits (as it must) that it lost the very arbitrations for which Sound Physicians procured payments. *Am. Dental Ass'n v. Cigna Corp.*, 605 F.3d 1283, 1292 (11th Cir. 2010) ("We have held that a plaintiff must allege that some kind of deceptive conduct occurred in order to plead a RICO violation predicated on mail fraud.").

(1) Blue Cross's factual errors disprove its legal theory.

Blue Cross's filings in this case prove the same point. Again, Blue Cross's theory of the case is that false statements of fact in arbitration filings amount to wire fraud. Blue Cross argues that if a party submits incorrect facts in an arbitration and wins, the losing side can sue in federal court for wire fraud.

But it was Blue Cross's original complaint in this case (Docket No. 1) that was riddled with factual errors, rather than Sound Physicians' arbitration filings. For example, as to arbitrations DISP-1318943 and DISP-1689761, Blue Cross pleaded that that Sound Physicians did not comply with a supposed prerequisite for IDR because "[n]either [Sound Physicians] nor HaloMD initiated open negotiations for this dispute" and yet they initiated IDR while attesting that they had completed negotiations. Initial Compl. ¶¶ 122, 125. Yet after Sound Physicians demonstrated that this is wrong, that it did request negotiations, Blue Cross was

forced to amend its complaint to withdraw the assertion. Blue Cross's original complaint also relied on an IDR dispute that did not even involve any of the parties in this case (DISP- 272256). Initial Compl. ¶126. Blue Cross amended its complaint to correct the error, but the mistakes went beyond a typo—the dispute in question apparently concerns a different set of patients and a different mix of insurance plans than Blue Cross originally alleged. *See* Initial Compl. ¶126; Am. Compl. ¶157. Blue Cross changed or withdrew the following allegations:

Docket No.	**Initial Complaint**	**Amended Complaint**
DISP-1318943	"Neither HMP nor HaloMD initiated open negotiations for this dispute." ¶122	"[O]n January 25, 2024, Sound Physicians sent a notice of open negotiations to BCBSGA." ¶148
DISP-1689761	"[N]o entity had initiated open negotiations for the service" ¶125	"[O]n January 19, 2023, Sound Physicians sent a notice of open negotiation to BCBSGA." ¶153
DISP-272256	DISP-**272256** "Of the **ten** patients whose services were disputed in this IDR, **four** were members of fully insured health plans subject to Georgia's surprise billing law, SBCPA, and **six** were members of various self-funded plans." ¶126	*Withdrawn* – this arbitration did not involve Sound Physicians or Blue Cross.

Under Blue Cross's theory, its own incorrect statements of fact in its complaint would be wire fraud, and Sound Physicians could file another case against Blue Cross based on its initial complaint here. Fortunately, this is not the law. Instead, Blue Cross's factual errors illustrate exactly why its legal theory

cannot be right. They show that nearly every arbitration or litigation involves fact disputes, and the proper way to challenge the other sides' facts is to raise them with the tribunal or fact-finder for resolution, not to file a new case under RICO.

b) Blue Cross's remaining theories fail to establish wire fraud.

Blue Cross's remaining theories are even weaker. Mail or wire fraud can only occur where "a person (1) intentionally participates in a scheme to defraud another of money or property and (2) uses the mails or wires in furtherance of that scheme." *Am. Dental Ass'n*, 605 F.3d at 1290. "Under the mail and wire fraud statutes, a plaintiff only can show a scheme to defraud if he proves that some type of deceptive conduct occurred." *Ayres v. Gen. Motors Corp.*, 234 F.3d 514, 521 (11th Cir. 2000) (quotations omitted); *accord Am. United Life Ins. Co. v. Martinez*, 480 F.3d 1043, 1065 (11th Cir. 2007) (affirming dismissal of plaintiff's substantive RICO claims where complaint did not allege that defendants made any affirmative misrepresentations in the mailings). Such deceptive conduct requires either "knowingly making false representations," "concealing material facts," or making statements "with reckless indifference to their truth or falsity." *United States v. Sawyer*, 799 F.2d 1494, 1502 (11th Cir. 1986) (citations omitted).

Blue Cross's remaining theories of wire fraud consist of its claims that Sound Physicians (1) "initiat[ed] hundreds of disputes at the same time," (2) demand[ed] outrageous payments far in excess of their charges," and (3) engag[ed] in the IDR process in bad faith." Am. Compl. ¶ 176. But none of these come close to

constituting wire or mail fraud because none allege deceptive conduct. *See Ayres*, 234 F.3d at 521; *Am. United Life Ins.*, 480 F.3d at 1065.

As to the first two theories, there is no limit on the number of IDRs a party may pursue nor the amount a party may seek. Even if Blue Cross had identified any such limits, the conduct still would not qualify as predicate acts under RICO, as there is no deception—no one is disguising, hiding, or lying about the number of arbitrations filed or the payment demanded. *See generally*, 18 U.S.C. § 1961(1) (listing the predicate acts capable of supporting RICO claims).

Blue Cross's final theory, that Sound Physicians engaged in the IDR process in bad faith, refutes itself: Bad faith alone does not constitute wire or mail fraud. *See Am. United Life Ins.*, 480 F.3d at 1065; *Ayres*, 234 F.3d at 521. Put differently, RICO does not provide a 'good-faith overlay' on all litigation and arbitration, such that one party can sue the other for racketeering if it thinks the other side did not litigate or arbitrate in good faith.

c) Blue Cross's claims are barred by the First Amendment under the *Noerr-Pennington* doctrine.

The right to petition the government for redress of grievances is within the protection of the First Amendment, and this extends to acts in and around litigation—such acts generally cannot be the basis for civil liability. *See BE & K Const. Co. v. N.L.R.B.*, 536 U.S. 516, 525 (2002); *see also McGuire Oil Co. v. Mapco, Inc.*, 958 F.2d 1552, 1562 (11th Cir.) (dismissing claims related to litigation activity

brought under Alabama's Unfair Trade Practices Act because "the right of access to the courts is an aspect of the First Amendment right to petition the Government for redress of grievances."). Thus, parties are generally immune from liability arising from litigation activity under the *Noerr-Pennington* doctrine. *Octane Fitness, LLC v. ICON Health & Fitness, Inc.*, 572 U.S. 545, 555-556 (2014). This rule extends to arbitration, at least where the arbitration involves a public or quasi-public arbitration forum or process. *See, e.g., USS-POSCO Indus. v. Contra Costa Cnty. Bldg. & Const. Trades Council, AFL-CIO,* 31 F.3d 800, 811 (9th Cir. 1994) (applying the *Noerr-Pennington* doctrine to "seven suits in federal court and eight arbitration actions"); *Eurotech, Inc. v. Cosmos Eur. Travels Aktiengesellschaft*, 189 F. Supp. 2d 385, 392-393 (E.D. Va. 2002) (the doctrine applies to a quasi-governmental arbitration process to resolve disputes about internet domain names). The IDR process that Congress established by statute plainly qualifies as a public or quasi-public arbitration process.

To overcome this constitutional immunity, a plaintiff must "allege facts sufficient to show that *Noerr-Pennington* immunity did not attach to [the] defendant's actions." *Vista Acquisitions, LLC v. W. Shore Walden LLC*, No. 1:22-CV-739-MLB, 2023 WL 2145515, at *3 (N.D. Ga. Feb. 21, 2023), *appeal dismissed sub nom. Vista Acquisition, LLC v. W. Shore Walden LLC,* No. 23-10970, 2023 WL 6160229 (11th Cir. July 13, 2023) (cleaned up) (dismissing RICO claims brought based on litigation conduct and imposing sanctions under Fed. R. Civ. P. 11). Blue Cross

has failed to allege any such facts here, as the Complaint is based entirely on arbitration conduct and statements made in as part of arbitrations. Thus, Blue Cross's claims should be dismissed because Sound Physicians' arbitration conduct is protected by the *Noerr-Pennington* doctrine.

2. The complaint does not comply with Rule 9(b).

Because Blue Cross's RICO claims rely on predicate acts of wire fraud, its substantive RICO allegations must satisfy Rule 9(b)'s heightened pleading standard. *Am. Dental Ass'n*, 605 F.3d at 1291. This requires that '[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake.'" *Id.* Under Rule 9(b), plaintiffs must allege: "(1) the precise statements, documents, or misrepresentations made; (2) the time, place, and person responsible for the statement; (3) the content and manner in which these statements misled the Plaintiffs; and (4) what the defendants gained by the alleged fraud." *Am. Dental Ass'n*, 605 F.3d at 1291 (quoting *Brooks v. Blue Cross & Blue Shield of Fla.*, Inc., 116 F.3d 1364, 1380–81 (11th Cir.1997)). Moreover, a plaintiff must also allege facts with respect to each defendant's participation in the fraud. *Id.*

Blue Cross's complaint is based on generalities and vague statements, not the specifics that Rule 9(b) requires, and impermissibly lumps the defendants together in violation of this circuit's shotgun-pleading ban. For example, it alleges:

- "Defendants have initiated thousands of knowingly ineligible disputes against BCBSGA. Indeed, ***most of the disputes on which Defendants received an IDR payment determination were on their face ineligible for the***

process." Am. Compl. ¶ 8.

- "Defendants strategically initiate hundreds of IDR process disputes against BCBSGA on the same day, most of which are fraudulent as do not involve qualified IDR items or services within the scope of the NSA's IDR process." Am. Compl. ¶ 96.

- "Defendants initiate the IDR process despite failing to initiate or pursue open negotiations. Open negotiation is a prerequisite to IDR; providers must attempt to negotiate a resolution with health plans before initiating the IDR process. Yet Defendants submitted numerous disputes for services ***where no open negotiation occurred***." Am. Compl. ¶ 85.

- "[M]ost of disputes from Defendants that reached a payment determination were ineligible for the IDR process, often despite objections from BCBSGA." Am. Compl. ¶ 102.

These general statements—which do not identify actors, dates, or actions—fail under Rule 9(b). *Henley v. Turner Broad. Sys., Inc.*, 267 F. Supp. 3d 1341, 1358-59 (N.D. Ga. 2017) (noting "conclusory, generalized and unsupported" allegations are insufficient even under the plausibility standard). Nor does Blue Cross identify which defendants were involved, instead resorting to impermissible "shotgun pleading" that lumps all defendants together—a practice the Eleventh Circuit has "roundly, repeatedly, and consistently condemn[ed] for years." *See Davis v. Coca-Cola Bottling Co. Consol.*, 516 F.3d 955, 979 (11th Cir. 2008) *abrogated on other grounds by Bell Atl. Corp. v. Twombly*, 550 U.S. 544 (2007). This precedent expressly prohibits the "sin of asserting multiple claims against multiple defendants without specifying which of the defendants are responsible for which acts or omissions, or which of the defendants the claim is brought against." *Weiland v. Palm Beach Cnty. Sheriff's Off.*, 792 F.3d 1313, 1323 (11th Cir. 2015).

3. Blue Cross's claims under 18 U.S.C. § 1962(c) should be dismissed because it has failed to identify an enterprise.

Blue Cross's RICO claims rely on an "associated in fact" enterprise theory. *See* Am. Compl. ¶ 164 and 18 U.S.C. § 1961(4) (defining "enterprise"). The Supreme Court has held that an association-in-fact enterprise must possess three qualities: "a purpose, relationships among those associated with the enterprise, and longevity sufficient to permit these associates to pursue the enterprise's purpose." *Boyle v. United States*, 556 U.S. 938, 946 (2009). It must be "a continuing unit that functions with a common purpose." *Id.* at 948. It is not enough for Blue Cross to merely allege that the purported enterprise shared a common purpose of making money; it must plead facts to show that the enterprise shared a *fraudulent* purpose. *Cisneros v. Petland, Inc.*, 972 F.3d 1204, 1212 (11th Cir. 2020). Specifically, the Eleventh Circuit has emphasized that "[a]n abstract common purpose, such as a generally shared interest in making money, will not suffice… Rather, where the participants' ultimate purpose is to make money for themselves, a RICO plaintiff must plausibly allege that the participants shared the purpose of enriching themselves *through a particular criminal course of conduct*." *Id.* at 1211 (emphasis added) (citations omitted).

Here, Blue Cross has failed to plausibly allege that the defendants share a qualifying, fraudulent purpose and that HaloMD is associated in fact. *See Ray v. Spirit Airlines, Inc.*, 836 F.3d 1340, 1355 (11th Cir. 2016) (explaining that "the

complaint [must] allege facts sufficient to give rise to a reasonable inference that the common purpose they shared included a scheme to . . . defraud."). Blue Cross has not alleged sufficient facts to plausibly support the inference that the defendants share a criminal purpose, as opposed to the obvious alternative explanation that the defendants simply interpret IDR eligibility differently than Blue Cross—or even that they erred on some subset of the thousands of IDR claims in question (which Sound Physicians does not concede)—and each sought to obtain profitable reimbursement using the IDR process. *See Lechter v. Aprio, LLP*, 565 F. Supp. 3d 1279, 1315 (N.D. Ga. 2021) ("The allegations in the Amended Complaint are just as consistent with each of the Defendants 'going about its own business.'") (quoting *United Food & Commercial Workers Unions & Emp'rs Midwest Health Benefits Fund v. Walgreen Co.*, 719 F.3d 849, 855 (7th Cir. 2013)). At a minimum, Blue Cross has failed to plead facts to rule out the "obvious alternative explanation," *Twombly*, 550 U.S. at 567, that the defendants simply interpreted IDR eligibility differently than it did, and sought to obtain profitable reimbursement to which they were legally entitled using the IDR process. *See Ray*, 836 F.3d at 1352-53; *see also Lechter*, 565 F. Supp. 3d at 1315 ("Plaintiffs also do not address the 'obvious alternative explanation' that instead of them each agreeing to perpetuate an elaborate conspiracy Defendants were each independently pursuing their own economic self-interest by providing financial services.") (quoting *Am. Dental Ass'n*, 605 F.3d at 1295). Under the strict pleading rules in Rule 9(b), this is not sufficient.

4. Blue Cross cannot show a § 1962(d) violation because there is no violation of § 1962(c).

Under 18 U.S.C. § 1962(d), it is "illegal for anyone to conspire to violate one of the substantive provisions of RICO, including § 1962(c)." *Am. Dental Ass'n*, 605 F.3d at 1293. The failure to state a claim for a primary RICO violation under § 1962(c) defeats a civil RICO conspiracy claim. *Douglas Asphalt Co. v. QORE, Inc.*, 657 F.3d 1146, 1153 (11th Cir. 2011). For the reasons above, Blue Cross failed to allege sufficient facts to support a finding that defendants engaged in a pattern of racketeering activity pursuant to § 1962(c), let alone that they knew about and agreed to facilitate the pattern of racketeering activity. Accordingly, Blue Cross fails to state a RICO claim under Section 1962(d).

F. The ERISA claims fail as a matter of law.

The ERISA equitable relief provision that Blue Cross relies on, 29 U.S.C. § 1132, is not applicable here because—for the reasons above—the NSA expressly prohibits judicial review in these circumstances. Indeed, the NSA expressly "modified portions of the Public Health Service Act, the Internal Revenue Code, and the *Employee Retirement Income Security Act*," removing judicial review except in specific cases governed by the FAA. *See Med-Trans Corp. v. Cap. Health Plan, Inc.*, 700 F. Supp. 3d 1076, 1079 (M.D. Fla. 2023).

Moreover, even if the Court had jurisdiction, Blue Cross's ERISA claim would still fail for two additional reasons:

a) No statutory standing under ERISA because Blue Cross has not pleaded facts to show that it is a fiduciary.

ERISA's cause of action for equitable relief only provides standing to sue for "a participant, beneficiary, or fiduciary." 29 U.S.C. § 1132(a)(3); *see also Sanctuary Surgical Ctr., Inc. v. Aetna Inc.*, 546 F. App'x 846, 851 (11th Cir. 2013). Blue Cross is not, of course, a participant or a beneficiary. Nor is it a fiduciary. Blue Cross is aware of this requirement, and the complaint attempts a sleight-of-hand to avoid it. In paragraph 257, it acknowledges that "ERISA authorizes a fiduciary of a health plan to bring a civil action" but Blue Cross never even asserts that it is one, let alone plead facts to show that it is an ERISA fiduciary.

This is not an inadvertent error, but an intentional choice. In other cases, Blue Cross and its affiliates routinely attempt to avoid liability in claims by plan members by arguing that they are *not* an ERISA fiduciary. *See, e.g.*, *Tiara Yachts, Inc. v. Blue Cross Blue Shield of Michigan*, 138 F.4th 457, 469 (6th Cir. 2025) (Blue Cross of Michigan argued that it was "insulate[d… from ERISA fiduciary duties"); *Technibilt Grp. Ins. Plan v. Blue Cross & Blue Shield of N. Carolina*, 438 F. Supp. 3d 599, 604 (W.D.N.C. 2020) ("Blue Cross' primary substantive argument is that, as a matter of law, it is not an ERISA fiduciary.").

To determine ERISA fiduciary status, a court must evaluate whether the entity "exercised any discretionary authority or discretionary control respecting management of the plan, or had any discretionary authority or responsibility in

the administration of the plan… or, on the other hand, merely performed a ministerial and not discretionary function." *Fadely v. Blue Cross & Blue Shield of Georgia, Inc.*, No. 1:11-CV-1409-TWT, 2011 WL 4974857, at *5 (N.D. Ga. Oct. 18, 2011) (Thrash, J.) (cleaned up). Blue Cross has failed to plead any facts that would meet this test. In the complaint, it alleges that it administers fully insured plans, self-funded plans, government program claims, and acts as a "Host Plan." Am. Compl. ¶¶ 20-24. But an "insurance company does not become an ERISA 'fiduciary' simply by performing administrative functions and claims processing within a framework of rules established by an employer." *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288, 290 (11th Cir. 1989); *see also Oliver v. Coca Cola Co.*, 497 F.3d 1181, 1194 (11th Cir.), *reh'g granted, vacated in part on other grounds*, 506 F.3d 1316 (11th Cir. 2007) ("[T]he proper party defendant [fiduciary] in an action concerning ERISA benefits is the party that controls administration of the plan.").

G. The state-law claims fail as a matter of law.

For the reasons set out in section III.B, above, the Court lacks jurisdiction to review the IDR arbitrations at issue—no matter what cause of action Blue Cross invokes, including state-law claims. Furthermore, the state-law claims that Blue Cross asserts to challenge arbitrations conducted under the federal NSA fail for the following independent reasons:

1. No claim under Georgia's RICO statute (Count III)

The Georgia RICO statute is "modeled after the federal statute." *Williams*

Gen. Corp. v. Stone, 614 S.E.2d 758, 760 (Ga. 2005). The Eleventh Circuit has commented that the two are "essentially identical." *Feldman v. Am. Dawn, Inc.*, 849 F.3d 1333, 1342 (11th Cir. 2017) ("[F]ailure to state a claim under the federal act warrants dismissal under the Georgia Act."). For the reasons outlined above in section III.D, which we respectfully incorporate by reference here, Blue Cross's claims under O.C.G.A. §§ 16-14-4(b) and (c) also fail.

2. No claim for fraud, fraudulent misrepresentation, or negligent misrepresentation (Counts IV, V and VI)

Fraud, fraudulent misrepresentation, and negligent misrepresentation must be pleaded with particularity under Rule 9(b). *See Garfield v. NDC Health Corp.*, 466 F.3d 1255, 1262 (11th Cir. 2006); *see also Lechter v. Aprio, LLP*, 565 F. Supp. 3d 1279, 1333 (N.D. Ga. 2021). For the reasons set out above as to the RICO claim in § III.E.1.c), Blue Cross has failed to do so.

Blue Cross has also pleaded facts contrary to an essential element of each of these claims. To state a claim for fraud, fraudulent misrepresentation, or negligent misrepresentation, the plaintiff must plead that it relied on the alleged misrepresentation. *See Garfield,* 466 F.3d at 1262 (11th Cir. 2006) (to plead fraud with particularity, the complaint must state the allegedly fraudulent statements and "the manner in which they misled the plaintiff"); *Lechter*, 565 F. Supp at 1333 ("Liability for a negligent representation attaches when a defendant makes a false representation upon which the plaintiff relies."). Blue Cross has not done so. It

alleges, at most, that Sound Physicians made representations to the IDREs, Blue Cross disputed those representations, but the IDREs accepted Sound Physicians' position over Blue Cross's objections. Am. Compl. ¶¶ 135-160. The facts stated in the Complaint thus show that Blue Cross itself was not misled, and did not rely on any alleged misrepresentations. Accordingly, Blue Cross's claims under each of these theories fail as a matter of law, based on the allegations in the complaint.

3. No claim for theft by deception ("TBD") (Count VII)

TBD is a specific-intent crime under Georgia State Law. O.C.G.A. § 16–8–3; *McGee v. Sentinel Offender Servs., LLC*, 719 F.3d 1236, 1242 (11th Cir. 2013). To state a claim, a plaintiff must show that the defendant: (1) "obtain[ed] property;" (2) "by deceitful means or artful practice;" (3) "with the intention of depriving the owner of the property." *Avery v. Chrysler Motors Corp.*, 448 S.E.2d 737, 738 (Ga. Ct. App. 1994); *see also* O.C.G.A. § 16-8-3. To survive a motion to dismiss, Blue Cross would need to allege facts showing that Sound Physicians "acted with specific intent to commit theft by deception." *McGee*, 719 F.3d at 1244. It has not done so: Blue Cross does not even make a conclusory allegation about Sound Physicians' intent in this count, let alone plead facts (as required) that would show such intent.

Furthermore, like fraud, theft by deception requires reliance on the part of the plaintiff. *See King v. State*, 447 S.E.2d 645, 648 (Ct. App. Ga 1994) ("[T]he defendant's deceptive act or false representation must have induced the victim to part with his property.") As described above, Blue Cross does not allege that it

was misled during any IDR proceeding. Am. Compl. ¶¶ 135-160.

4. No claim under the Georgia Deceptive Trade Practices Act ("GUDTPA") (Count IX)

GUDTPA does not apply here. The statute prohibits a defined series of deceptive trade practices that arise in the course of a person's "business, vocation, or occupation." O.C.G.A. § 10-1-372. These practices include, for example, false advertising, § 10-1-372(a)(9), misrepresentation of goods as new when they are in fact used, § 10-1-372(a)(6), and making false representations regarding price reductions, § 10-1-372(a)(11). The statute is used to bring claims trademark infringement cases, *see, e.g. Top Tobacco, L.P. v. Star Importers & Wholesalers, Inc.*, 135 F.4th 1344, 1347 (11th Cir. 2025), as well as consumer complaints including data breaches and false advertising cases. *See, e.g., Miller v. NextGen Healthcare, Inc.*, 742 F. Supp. 3d 1304, 1320 (N.D. Ga. 2024), *Silverstein v. Proctor & Gamble Mfg. Co.*, No. CV 108-003, 2008 WL 11350000, at *3 (S.D. Ga. June 12, 2008).

Blue Cross alleges that in the course of submitting disputes to IDR, Sound Physicians misrepresented its services as being of a particular "standard, quality, or grade," or alternatively, misrepresented the services "sponsorship, approval, or characteristics," and created a likelihood of confusion within the meaning of GUDTPA. Am. Compl. ¶¶245-247. But these GUDTPA provisions are inapplicable to Blue Cross's allegations. The statute restricts conduct in trade or commerce, but does not provide relief related to conduct during litigation or arbitration. *See*

O.C.A. § 10-1-372 (statute applies to acts "in the course of [one's] business, vocation, or occupation")). Reading the statute as applying to conduct in a legal dispute would produce absurd results. Any loser in an arbitration or other legal dispute could invoke the statute to relitigate the earlier case on the grounds that a statement or claim during the case was misleading or deceptive.

Blue Cross does not cite any authority that suggests GUDTPA applies to statements made during a litigation or arbitration (as opposed to in business) and we have identified none. Thus, this claim also fails as a matter of law.

H. Blue Cross has violated the prohibition on shotgun pleadings.

Throughout its complaint, Blue Cross has committed the "sin of asserting multiple claims against multiple defendants without specifying which of the defendants are responsible for which acts or omissions, or which of the defendants the claim is brought against." *Weiland v. Palm Beach Cnty. Sheriff's Off.*, 792 F.3d 1313, 1323 (11th Cir. 2015). This style of "shotgun pleading" is not permissible in the Eleventh Circuit. *See Davis v. Coca-Cola Bottling Co. Consol.*, 516 F.3d 955, 979 (11th Cir. 2008) *abrogated on other grounds by Bell Atl. Corp. v. Twombly*, 550 U.S. 544 (2007). This is an additional basis on which to dismiss the complaint.

IV. CONCLUSION

For the reasons above, the Court should dismiss Blue Cross's complaint.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH LOCAL RULES 5.1 AND 7.1

Pursuant to Local Rules 5.1 and 7.1(D) of the United States District Court for the Northern District of Georgia, the undersigned certifies that this document has been prepared in accordance with the font and point size requirements set forth in Local Rule 5.1(C), as modified by the Court's July 29, 2025 Order (Docket No. 28 and 29) setting a limit of 45 pages exclusive of the caption, tables, and signature blocks. Specifically, this document has been prepared in 13-point Book Antiqua font on Microsoft Word for Mac OS X (v. 16.101).

September 19, 2025 */s/ Matthew L. Knowles*