IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA *ex rel.* SW CHALLENGER, LLC, Plaintiffs, vs. EVICORE HEALTHCARE MSI, LLC, Defendant.	Case No. 1:19-cv-2501-VM

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANT EVICORE'S MOTION TO DISMISS RELATORS' SECOND AMENDED COMPLAINT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Rules

Regulations

PRELIMINARY STATEMENT

In their Second Amended Complaint ("SAC") Relators have laid out a comprehensive scheme within eviCore. The primary reason that Government intermediary managed care organizations ("MCOs") retain EviCore is to administer Medicare and Medicaid treatment requests by performing the medical review function to ensure that medically unnecessary services are not approved. All other ancillary tasks performed by eviCore are in service of this main function to act as a gatekeeper to ensure that only appropriate claims are approved. Relators' allege that eviCore abdicated that responsibility, and instituted auto-approval systems unbeknownst to these MCOs[1] which essentially eliminated eviCore's review function altogether. eviCore did this to lower its own expenses and meet contractual obligations to approve claims in a timely manner.

Faced with these allegations made on the personal knowledge of two of its employees, eviCore argues that the pleadings do not state a false claim as a matter of law. eviCore is simply wrong. Relators have more than satisfied the standard imposed at the pleading stage to identify the elements of the scheme, those involved, and support a conclusion that false claims were submitted – in this case, approvals of procedures where the contractually required vetting process was intentionally skipped without the knowledge of the MCO, resulting in payments by Medicare/Medicaid that would not have been made had the Government known of this conduct.

It is well settled that conduct like this can constitute worthless services, requiring the Defendant to return all of the payments it has received pursuant to a contract with the Government. Furthermore, as Relators demonstrate below, the SAC satisfies all of the particularity requirements of Rule 9(b) and alleges the elements of the violations alleged as a matter of law. To the extent certain details or documents are not included with specificity in the SAC, they reside in

[1] While some of these measures were agreed to by MCOs, many of them were not and were instituted solely to benefit eviCore's bottom-line.

Defendant's possession, and such documents can easily be identified in discovery. Courts routinely relax Rule 9(b) standards to accommodate the realities of litigation. Accordingly, the Court should deny eviCore's motion to dismiss.

STATEMENT OF FACTS

Relators hereby incorporate by reference the factual discussion set forth in their SAC.

LEGAL STANDARDS

A complaint need only "contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). First, "'a court must accept as true all of the allegations contained in a complaint,'" except legal conclusions and threadbare recitals of the elements of the cause of action. *Harris v. Mills*, 572 F.3d 66, 72 (2d Cir. 2009) (quoting *Iqbal*, 556 U.S. at 679). Second, a court determines "whether the 'well-pleaded factual allegations,' assumed to be true, 'plausibly give rise to an entitlement to relief.'" *Hayden v. Paterson*, 594 F.3d 150, 161 (2d Cir. 2010) (quoting *Iqbal*, 556 U.S. at 679).

Fed. R. Civ. P. 9(b) further provides that, "in alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake. Malice, intent, knowledge, and other conditions of a person's mind *may be alleged generally*." (Emphasis added). In the seminal *U.S. ex rel. Chorches as Tr. for the Bankr. Estate of Fabula v. Am. Med. Response, Inc.*, 865 F.3d 71, 81 (2d Cir. 2017), the Second Circuit held that a relator must "(1) specify the statements that the plaintiff contends were fraudulent, (2) identify the speaker, (3) state where and when the statements were made, and (4) explain why the statements were fraudulent." *Id.* at 81 (internal citation omitted). Whether particular allegations meet this threshold is a "case- and context-specific" inquiry. *Id.*; *accord U.S. ex rel. Bilotta v. Novartis Pharms. Corp.*, 50 F. Supp. 3d 497, 508 (S.D.N.Y. 2014) (Rule 9(b) requires "a fact-specific inquiry" that depends upon "the nature

of the case, the complexity or simplicity of the transaction or occurrence, the relationship of the parties and the determination of how much circumstantial detail is necessary to give notice to the adverse party and enable him to prepare a responsive pleading") (quoting *U.S. ex rel. Kester v. Novartis Pharm. Corp.*, 23 F. Supp. 3d 242, 258 (S.D.N.Y. 2014)) (internal quotation marks omitted). Most importantly, *Chorches* held that "Rule 9(b) does not require that every qui tam complaint provide details of actual bills or invoices submitted to the government, so long as the relator makes plausible allegations . . . that lead to a strong inference that specific claims were indeed submitted and that information about the claims submitted are peculiarly within the opposing party's knowledge." 865 F. 3d at 86; *see Rana v. Islam*, 305 F.R.D. 53, 58 (S.D.N.Y. 2015) ("[A] plaintiff need not plead dates, times, and places with absolute precision, so long as the complaint gives fair and reasonable notice to defendants . . . .") (citation and internal marks citations omitted).

ARGUMENT

I. FRAUD AGAINST A PRIVATE ENTITY STANDING IN THE GOVERNMENT'S SHOES AND ENTRUSTED WITH THE CARE AND DISTRIBUTION OF GOVERNMENT FUNDS IS FRAUD AGAINST THE GOVERNMENT FOR FALSE CLAIMS ACT PURPOSES.[2]

Relators allege that eviCore is providing worthless services (i.e., fraudulent "auto-approval" utilization management) to MCOs, who stand in the shoes of federal and state government and distribute healthcare funds. EviCore appears to argue that Relators are one step removed from alleging a fraud against the Government, even though the MCO is acting for the Government and distributing Government funds to, among others, Defendant eviCore. *See* ECF 22 at pp. 10-11. This is not the state of the law. Rather, submitting false claims to a private entity tasked with distributing Government funds is a violation of the FCA.

[2] This Section responds to Section I(A)(1) of Defendant's brief (ECF 22 at pp. 10-11).

In the seminal *U.S. ex rel. Marcus v. Hess*, 317 U.S. 537, 544 (1943),[3] the Court held that federal funds granted to third parties for distribution "are as much in need of protection from fraudulent claims as any other federal money." *See also U.S. v. Lagerbusch*, 361 F.2d 449, 449-50 (3d Cir. 1966) (affirming an FCA decision against a defendant who made false representations to a private corporation, where the Government paid the corporation's operating costs, including the sums improperly obtained by the defendant); *U.S. ex rel. Luther v. Consol. Indus., Inc.*, 720 F. Supp. 919, 921-22 (N.D. Ala. 1989) (FCA applies when a claim is presented not to the Government, but to a government-contractor, so long as "payment of the claim would ultimately result in a loss to the United States."); *U.S. ex rel. Wilkins v. Ohio*, 885 F. Supp. 1055, 1060 (S.D. Ohio 1995) (claim against the U.S. includes requests or demands made to a contractor, grantee, or other recipient of Government funds, where the Government provides any portion of the money that is requested or demanded); *U.S. ex rel. Sequoia Orange Co. v. Oxnard Lemon Co.*, CV-F-91-194 OWW, 1992 WL 795477, at *5 (E.D. Cal. May 4, 1992) ("[A]false claim is actionable although the claims or false statements were made to a party other than the Government, if the payment thereon *would ultimately result in a loss to the United States*.") (emphasis added); *but see Am. Textile Mfrs. Inst., Inc. v. The Limited, Inc.*, 190 F.3d 729 (6th Cir. 1999) (rejecting *Sequoia*).

The weight of authority is clear. If a private entity is entrusted with the maintenance and distribution of Government funds, fraud against that entity is actionable under the FCA. Relators have provided specific factual allegations of how eviCore defrauded the MCOs it serves through its "auto-approval" process of skipping contracted-for clinical review in favor of simply approving all treatment requests. *See, e.g.*, SAC ¶¶ 20-25, 26 (eviCore, without MCO knowledge or approval,

[3] *Hess* was superseded by statute, but only with respect to its conclusions regarding the public disclosure doctrine.

established auto-approve protocols beginning Labor Day 2018 and continued for 126 dates, when queue volumes were high until July 22, 2019), 29-30 (detailing October 2019 directive from eviCore, which stated that BlueCross BlueShield of Texas' ("BCBS TX") submissions would be auto-approved without proper clinical review because "it was decided to not increase the touches on our end" since the health plan was terminating eviCore's contract and management wanted to limit resources spent handling BCBS TX cases), 90-98, 102 (in October 2017, eviCore initiated auto-approvals without BCBS TX approval), 103 (BCBS TX agreed to allow auto-approvals for six-month period, but at the expiration of the agreed-upon six-month term and without BCBS TX's knowledge, eviCore refused to re-implement full medical necessity review), 105 (internal eviCore document discussing auto-approvals, which are "not health plan directed approvals"), 108 (example of eviCore using auto-approvals during time of staff shortage without MCO knowledge), 111 (auto-approval of 200 physical therapy visits for an ankle sprain), 122-23, 125-26 (evidence of knowledge of wrongdoing – internal eviCore directive to "update our resources and remove any language of 'auto-approval'"), 127-28 (2019 incident, where eviCore misrepresented to Texas Medicaid and BCBS TX that a review decision granting full approval (made because of eviCore's auto-approval policy) was based on an appropriate medical necessity review, and post-hoc efforts by eviCore to craft a plausible medical necessity explanation for the auto-approval review decision).

II. THE SAC IDENTIFIES SPECIFIC FACTS NECESSARY TO MEET RULE 9(B)'S HEIGHTENED PLEADING STANDARD.[4]

Setting aside that eviCore's worthless auto-approval process, by which it provided no clinical review for thousands of claims, calls into question all claims that have passed through

[4] This Section relates to Section I(A)(2) of Defendant's brief (ECF 22 at 11-12).

eviCore, the SAC makes specific factual references, which "lead to a strong inference that specific claims were indeed submitted." *Chorches*, 865 F.3d at 86. Those are the following:

1. Jaimie Clodfelter, D.O., an eviCore Medical Reviewer, is frequently asked to review surgical requests even though she is not a surgeon (SAC ¶ 29). Evidence of such reviews conducted by Dr. Clodfelter could be located in discovery and "are peculiarly within the opposing party's knowledge" for purposes of Rule 9(b). *Chorches*, 865 F.3d at 82.

2. From October 30, 2019, until contract terminated, BCBS TX submissions were auto-approved because eviCore wanted to limit its resources spent on BCBS TX (SAC ¶ 30). Given that Relators provide a specific date range, these unauthorized auto-approved BCBS TX submissions could be easily located and are peculiarly within eviCore's knowledge.

3. On October 27, 2017, eviCore directed the auto-approval for BCBS TX of pediatric treatment requests. At the time, BCBS TX expected full medical necessity review of requests. It was not until approximately one month later that BCBS TX granted eviCore permission to proceed with auto-approvals on a limited time basis, after eviCore had already been doing so without BCBS TX's knowledge. (SAC ¶¶ 102-03). Given the specific and limited date range provided – and the limitation to pediatric treatment requests – such unauthorized auto-approvals are easily locatable and peculiarly within eviCore's knowledge.

4. The auto-approvals discussed in the previous paragraph were to last for only six months, and then eviCore was required to re-implement full clinical review. Instead, eviCore kept the auto-approval process in place, without BCBS TX knowledge and in violation of the parties' express agreement. (SAC ¶ 103). Given the specific date range (i.e., six months after the agreement with BCBS TX), specific exemplars of unauthorized auto-approvals for BCBS TX insureds should be locatable, and are once again peculiarly in eviCore's knowledge.

5. An October 28, 2017 eviCore email stated that "any Passport cases with a start date of 11/1/17 or later requires medical necessity review. A start date of 10/31/17 or before remains auto approval." (SAC ¶ 109). Such date range would make it easy in discovery for eviCore to track Passport claims post-October 31, 2017, that were subject to auto-approval.

6. In a November 8, 2017 email, an eviCore manager described auto-approvals that allowed "significantly more visits" than would normally occur and requested "examples of egregious requests" to use in a meeting, specifically referencing a case in which a reviewer had "to auto approve 200 visits for an ankle sprain …." (SAC ¶ 111). The responses that the eviCore manager received to her email, and the presentation she gave at the meeting regarding these examples, would be discoverable and are solely within the knowledge of eviCore.

7. Relators pled misrepresentations that eviCore made to Texas Medicaid and BCBS TX during an October 3, 2019 call. (SAC ¶¶ 127-28). That specific claim is easily discoverable and provides the requisite notice under R.9(b).

III. RELATORS ADEQUATELY ALLEGE THAT EVICORE SUBMITTED FALSE CLAIMS IN VIOLATION OF THE FCA

Defendant's argument that the SAC identifies "[n]o Statute or Regulation that eviCore Violated" is predicated on its misreading of the SAC. The SAC alleges that eviCore violated the FCA by causing fraudulent claims to be submitted to the Government, for services eviCore knew to be medically unnecessary and worthless. As detailed below, a worthless services claim made pursuant to the FCA stands for the unexceptional proposition that an entity may not cause the Government to pay for products or services that are so deficient that they have no value to the United States. *E.g.*, *U.S. ex rel. Mikes v. Strauss*, 274 F.3d 687, 703 (2d Cir. 2001) ("[A] worthless services claim asserts that the knowing request of federal reimbursement for a procedure with no

medical value violates the Act irrespective of any certification").[5] Causing the Government to pay for a product or service of no value, if done with the requisite knowledge, violates the FCA. *E.g.*, *Fisher v. U.S.*, 529 U.S. 667, 679 (2000) (Medicare payments are made "not simply to reimburse for treatment" but to "maintain a certain level of quality medical care").

EviCore is obligated to perform functions under the Medicare Integrity Program, 42 U.S.C. § 1395kk-1(a), which include any or all program integrity functions described in 42 C.F.R. § 421.304, such as "[c]onducting medical reviews, utilization reviews, and reviews of potential fraud related to activities of providers of services," and "[a]uditing, settling and determining cost report payments for providers of services, or other individuals or entities … as necessary to help ensure proper Medicare payment." *See also* 42 C.F.R. § 421.200 (specifying carrier contractor functions). Relators' claims are based not on eviCore's deficient prior authorization program but, rather, on the *fraudulent claims for reimbursement* that eviCore submitted to MCOs for worthless services in exchange for Government money. *E.g.*, SAC ¶ 133. Relators allege that eviCore fraudulently certified that worthless services were medically necessary in order to receive Government money, and the statute that eviCore caused to be violated is the FCA. *E.g.*, SAC ¶¶ 21, 32-35, 87, 131-33, 168-72.

IV. RELATORS ADEQUATELY PLEAD VIOLATIONS OF CONTRACTS

Relators allege in detail eviCore's contractual obligations, including:

1. "[E]viCore contracts with MCOs to provide utilization management services and review prior authorization requests." (SAC ¶ 10).

2. "[E]viCore knowingly accepted subcontracts from MCOs to take on the responsibility of providing CMS and Qui Tam States with prior authorization and

[5] *Accord U.S. ex rel. Lee v. Smithkline Beecham, Inc.*, 245 F.3d 1048, 1053 (9th Cir. 2001) ("In an appropriate case, knowingly billing for worthless services or recklessly doing so with deliberate ignorance may be actionable under § 3729, regardless of any false certification conduct."); *U.S. ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266 (9th Cir. 1996) (FCA actions "have also been sustained under theories of supplying substandard products or services").

utilization management for outpatient and home health services provided pursuant to Medicare Advantage and Medicaid Plans. As such, eviCore was required to turn the same square corners in their dealings with MCOs as if they were dealing with the Government itself." (SAC ¶ 14).

3. "eviCore's contracts with MCOs include a key timing provision that requires eviCore to approve, partially approve, or deny in a timely fashion each request for prior authorization to deem services to a given beneficiary as reimbursable (each request also referred to as a 'case'). In many instances, the turnaround time ("TAT") to process requests for prior authorizations is only 24 to 48 hours. Failure to meet its prescribed TAT will result in contractual penalties for eviCore." (SAC ¶ 18).

4. "eviCore, however, failed to hire sufficient staff to properly service its MCO subcontracts and meet the contractual timing requirements." (SAC ¶ 19).

5. "Like its predecessor CareCore, eviCore contracts with private healthcare insurance companies to provide prior authorization and utilization management services pertaining to home health and outpatient services ordered by treating providers for the insurers' patient-beneficiaries." (SAC ¶ 55).

6. "eviCore specifically contracts with third-party insurance companies, such as WellCare, to perform utilization management services by providing reimbursement determinations for services ordered by physicians and allied health professionals for hundreds of thousands of covered lives, including Medicare Advantage and Medicaid Plans." (SAC ¶ 85).

7. "Upon information and belief, eviCore's contracts with insurers include key timing provisions that require eviCore to approve, partially approve, or deny provider requests within a limited time-period or pay a penalty for the late response." (SAC ¶ 106).

Rule 9(b) does not require Relators to attach eviCore's contracts with MCOs to the SAC—which would be impossible here because eviCore alone has access to them. Determining whether allegations meet Rule 9(b) is a "case- and context-specific" inquiry. *Chorches*, 865 F.3d at 81. Particularly in the *qui tam* context, where a "third-party has been defrauded, it is likely the relators have limited knowledge of the specifics of the alleged fraud. Therefore, when facts are mostly within the perpetrator's knowledge, Rule 9(b) is relaxed." *U.S. ex rel. Stewart v. The Louisiana Clinic*, No. 99-1767, 2002 WL 257690, at *2 (E.D. La. Feb. 22, 2002) (citing *U.S. ex rel.*

Thompson v. Columbia/HCA Healthcare Corp., 125 F.3d 899, 903 (5th Cir. 1997)). To require unreasonable particularity of Relators "would frustrate the purpose of the FCA and inhibit the ability of the United States to uncover fraud through relators acting on its behalf." *Id.* Moreover, with this policy goal in mind, courts apply a "more flexible" standard in actions where the defendant induced a third party to file false claims – as Relators have alleged here. *See U.S. ex rel. Nargol v. DePuy Orthopedics, Inc.*, 865 F.3d 29, 39 (1st Cir. 2017) (quoting *U.S. ex rel. Duxbury v. Ortho Biotech Prods., L.P.*, 579 F.3d 13, 29 (1st Cir. 2009)); *Lawton ex rel. U.S. v. Takeda Pharm. Co.*, 842 F.3d 125, 130 (1st Cir. 2016).

Without access to eviCore's contracts with MCOs, Relators have still adequately pled the "who, what, when and where" of the scheme. The "who" is eviCore, which adopted policies to ensure that unnecessary medical services were approved and ultimately paid by the Government (e.g., SAC ¶¶ 99-112). Relators complained repeatedly to eviCore's senior management from 2016 to 2020 about the scheme (e.g., SAC ¶¶ 145-48, 160). The "what" was that eviCore has engaged in fraudulent activities involving its role as the gatekeeper for determining whether requested services are reimbursable. To meet the high volume of prior authorization requests and to avoid contractual TAT penalties, eviCore instituted a scheme to "auto-approve" hundreds of cases daily, automatically deeming those services as reasonable and necessary, even though there had been no appropriate evaluation, and sometimes, no human evaluation of those cases at all (e.g., SAC, ¶¶ 20-21, 99-112). The "when" is that eviCore knowingly approved medically unnecessary services from at least 2016 and continuing through at least 2020. *Id.*

eviCore's cited cases are unavailing. (ECF 22 at p. 14). The plaintiffs in these cases did not allege, as Relators do here, specific factual allegations of a fraudulent scheme to submit false

claims.[6] In contrast, Relators allege the details of the fraudulent scheme supporting a strong inference of fraud. Allegations such as these satisfy Rule 9(b) "without necessarily providing details as to each false claim." *Duxbury*, 579 F.3d at 29; *see, e.g.*, *U.S. ex rel. Schumann v. AstraZeneca PLC*, No. 03–5423, 2010 WL 4025904, *10 (E.D. Pa. Oct. 13, 2010).

V. A DEFENDANT SEEKING PAYMENT FROM GOVERNMENT FUNDS FOR A DEFICIENTLY PERFORMED TASK MAY BE DEEMED A WORTHLESS SERVICE PROVIDER AND SUBJECT TO FALSE CLAIMS ACT LIABILITY.[7]

Next, eviCore argues that if it provides some services correctly and some fraudulently, then it has not performed "worthless services" because some of the services had, in fact, a measure of worth. Not only would that require a factual determination ill-suited for a pre-answer motion to dismiss, but it's not the law. In *U.S. ex rel. Scharber v. Golden Gate Nat'l Senior Care LLC*, 135 F. Supp. 3d 944 (D. Minn. 2015), the relator filed a *qui tam* claim against a nursing home. The relator alleged that the defendants' services "were wholly or partially worthless." *Id.* at 964. The defendants argued that the plaintiffs' worthless services allegations failed because a worthless services claim requires services that "[are] so deficient that for all practical purposes [they are] the equivalent of no performance at all." *Id.* The court rejected the defendants' argument, noting that "'[c]ourts have recognized that worthless services claims under the FCA are not, as a legal matter, limited to instances where no services at all are provided. A service can be worthless because of

[6] *See, e.g.*, *Ameti ex rel. U.S. v. Sikorsky Aircraft Corp.*, No. 3:14-cv-1223 (VLB), 2017 WL 2636037, *7 (D. Conn. June 19, 2017) (defense contractor's former employee did not allege facts that would support "a strong inference of fraud," such as allegations that relator had informed other employees of particular defects at issue or that he was personally aware of "fraudulent sale of a defective [product]" to the government); *U.S. ex rel. Youssef v. Tishman Constr. Corp.*, No. 12-cv-03862 (DLI) (RER), 2017 WL 1093190, *8 (E.D.N.Y. Mar. 23, 2017) (relator had "failed to provide any precise details about the supposedly fraudulent scheme," instead providing only "conclusory allegations that ha[d] no factual support"); *U.S. ex rel. Ladas v. Exelis, Inc.*, 824 F.3d 16, 26-27 (2d Cir. 2016) (relators alleged in conclusory fashion "that [the defendant] failed to perform required testing" on its products and failed to allege that "the devices themselves, or the equipment as a whole, were not tested in accordance with the [c]ontract").

[7] This Section relates to Section I(A)(4) of Defendant's brief (ECF No. 22 at 15-16).

its deficient nature even if the service was provided.'" *Id.* (quoting *U.S. ex rel. Academy Health Ctr. v. Hyperion Found., Inc.*, No. 10-552, 2014 WL 3385189, at *42-43 (S.D. Miss. 2014)). It added that "[g]iven the underlying purpose of the FCA to protect the federal fisc, it makes good sense that the statute would protect the government from paying for significantly deficient, even if not entirely non-existent, services." *Id.*

The Second Circuit has also upheld the validity of the "worthless services" theory of FCA liability. *See Mikes v.*, 274 F.3d at 703 (FCA liability based on "worthless services claim" is distinct from liability arising under "false certification" theory, and such claims may arise where service is so substandard that it is effectively equivalent to no service at all). In *Mikes*, the Second Circuit considered whether the defendants submitted false reimbursement requests for spirometry services. Because the defendants failed to calibrate the machines daily as recommended by published industry guidelines, the relators based their FCA theory on the contention that the spirometry results were unreliable – and thus worthless. The Second Circuit accepted the premise that a completely unreliable spirometry result could be "worthless" and therefore give rise to a false claim, and rejected the plaintiffs' theory only because the defendants had provided ample evidence of their good faith belief that their spirometry tests had medical value (e.g., the spirometers' instruction manual indicated that daily calibration was not required). *Id.* at 703-04. eviCore has not, and cannot, make such a "good faith" showing on its motion, such that eviCore's opposition to Relators' worthless service theory of liability must – at least for the time being – fail. *See also Chesbrough v. VPA. P.C.*, 655 F.3d 461, 465 (6th Cir. 2011) (radiology studies that had no diagnostic value were worthless for FCA purposes because they were of no medical value and, for all practical purposes, had not been provided).

VI. RELATORS HAVE SUFFICIENTLY ALLEGED EVICORE'S KNOWLEDGE OF WRONGDOING.[8]

eviCore contends that Relators offer no supporting facts that, if true, would show that it knew that, by utilizing auto-approvals, it would violate its contract requirements or any regulatory requirements, or that it would cause any plan to submit false claims. That is plainly incorrect. As detailed above, Relators have pled multiple instances of eviCore affirmatively misleading MCOs about its auto-approval practice, and also taking internal efforts to whitewash this fraud by removing the term "auto-approval" from its internal documents. *See, e.g.*, SAC ¶¶ 103 (after BCBS TX agreed to allow auto-approvals for limited six-month period, at the expiration of term and without BCBS TX's knowledge, eviCore refused to re-implement full medical necessity review), 125-26 (internal eviCore directive to "update our resources and remove any language of 'auto-approval'"), 127-28 (eviCore misrepresented to Texas Medicaid and BCBS TX that review decision granting full approval (made because of eviCore's auto-approval policy) was based on appropriate medical necessity review, and engaged in *post-hoc* efforts to craft plausible medical necessity explanation for auto-approval review decision). This was not simply fraud by omission. Rather, eviCore actively misled MCOs regarding its practices and then attempted to cover up its wrongdoing.

Rule 9(b)'s plain language requires knowledge, and other conditions of a person's mind, to be alleged only "generally." *U.S ex rel. Kane et al. v. Healthfirst, Inc.*, 120 F. Supp. 3d 370, 395 (S.D.N.Y. 2015) ("[T]he FCA's knowledge standard plainly encapsulates recklessness and deliberate ignorance."); *U.S ex rel. Hamilton v. Yavapai Cmty. Coll. Dist.*, No. 12 Civ. 08193 (PCT) (PGR), 2015 WL 1522174, at *3 (D. Ariz. Apr. 2, 2015) (the "'knowing' scienter needed for a violation of the FCA may be established not only though a showing of actual knowledge of

[8] This Section relates to Section I(A)(5) of Defendant's brief (ECF No. at 16).

the falsity of a claim, but also through a showing of deliberate indifference or reckless disregard of whether the claim is false"). Defendant's actions, including its deliberate misrepresentations to Texas Medicaid and BCBS TX, demonstrate actual knowledge of its wrongdoing, but at the very least its conduct is consistent with recklessness or deliberate ignorance, not merely negligence.

Indeed, Relators are required only to "'provide some minimal factual basis for conclusory allegations of scienter that give rise to a strong inference' of fraudulent intent." *Powers v. British Vita, P.L.C.*, 57 F.3d 176, 184 (2d Cir. 1995) (citation omitted). To meet this standard, a relator is required only to allege facts which demonstrate "a motive for committing fraud and a clear opportunity for doing so" or, alternatively, to "identify[] circumstances indicating conscious behavior by the defendant." *Id.* (citation omitted); *see U.S. ex rel. Taylor v. Gabelli*, 345 F. Supp. 2d 313, 326 (S.D.N.Y. 2004). Motive, in this context, "entail[s] concrete benefits that could be realized" by the fraudulent conduct, while opportunity "entail[s] the means and likely prospect of achieving concrete benefits by the means alleged." *Shields v. Citytrust Bancorp, Inc.*, 25 F.3d 1124, 1130 (2d Cir. 1994).

The SAC plainly alleges that eviCore had a motive for the swinging-gate utilization management scheme of auto-approvals – to reduce costs associated with staffing and thereby increase company profits. *E.g.*, SAC ¶¶ 19, 21, 26, 30, 98, 104, 107-08, 115. As concerns opportunity, the SAC alleges that eviCore had utilization management contracts with various MCOs and could achieve significant cost savings across the board by adopting the auto-approval process, which reduced its need for human clinical reviewers. eviCore had the means, motive, and opportunity to engage in fraud. Relators have sufficiently pled eviCore's scienter.

VII. RELATORS HAVE PLAUSIBLY ALLEGED THAT EVICORE MADE FALSE STATEMENTS TO MANAGED CARE PLANS AND THAT EVICORE'S STATEMENTS WERE MATERIAL TO FALSE CLAIMS.[9]

Relators identify specific false statements made by eviCore to both Texas Medicaid and Government-affiliated MCOs regarding eviCore's auto-approval process. *E.g.*, SAC ¶¶ 30, 102-03, 108, 127-28. Materiality here is obvious – if eviCore misrepresents that it is providing appropriate clinical review of claims when, in fact, it is not, then MCOs are (1) paying Government healthcare funds for potentially unnecessary medical services (SAC ¶ 111) (discussing auto-approval of 200 physical therapy sessions for a simple ankle sprain), and (2) paying Government healthcare funds to eviCore to provide utilization services that are not being rendered. The Government's healthcare funding is finite, as is the money it can provide to MCOs. False claims submitted to the MCOs for payment that have not been subject to proper clinical review have a real and significant impact on the public fisc. So does paying (albeit indirectly through MCOs) eviCore to provide utilization management services when, in fact, eviCore is simply auto-approving claims that come through its system. *See U.S ex rel. Escobar v. Univ. Health Servs., Inc.*, 842 F.3d 103 (1st Cir. 2016) (materiality threshold met because provider's misrepresentations were material, having gone to the "very essence of the bargain," and there was no evidence that the Government had actual knowledge of the violations).

VIII. RELATORS COMPLY WITH RULE 9(B) BY PROVIDING EXAMPLES OF SPECIFIC FALSE STATEMENTS MADE BY EVICORE.[10]

Relators identified false statements and misrepresentations made by eviCore to MCOs, as well as Texas Medicaid. *E.g.*, SAC ¶¶ 30, 102-03, 108, 127-28. Relators also provided various internal communications among eviCore employees, which demonstrate the type of misleading

[9] This Section relates to Section I(B)(1) of Defendant's brief (ECF No. 22 at 17).
[10] This Section relates to Section I(B)(2) of Defendant's brief (ECF No. 22, at 18).

statements that were being made to MCOs. *E.g.*, SAC ¶¶ 111, 125-26; *see, e.g.*, *Bilotta*, 50 F. Supp. 3d at 508 (Rule 9(b) requires "a fact-specific inquiry" that depends in part upon a determination of "how much circumstantial detail is necessary to give notice to the adverse party and enable him to prepare a responsive pleading"). That detail is provided in the SAC.

IX. RELATORS ADEQUATELY ALLEGE "REVERSE FALSE CLAIMS"

The SAC adequately alleges a "reverse false claim" predicated on eviCore's decision to retain, rather than return, Government funds it received from MCOs in connection with worthless services. The FCA prohibits not only fraudulent claims to receive Government money, but also the fraudulent avoidance or reduction of an obligation to pay the Government. 31 U.S.C. § 3729(a)(1)(G). Such an obligation, and attendant reverse false claims liability, arises where a defendant retains overpayments from the Government. *See* 31 U.S.C. § 3729(b)(3) ("an established duty, whether fixed or not, arising from ... the retention of any overpayment"); *see also U.S. v. Lakeshore Med. Clinic, Ltd.*, No. 14-CV-00892, 2013 WL 1307013, at *4 (E.D. Wis. Mar. 28, 2013) ("If the government overpaid defendant for E/M services and defendant intentionally refused to investigate the possibility that it was overpaid, it may have unlawfully avoided an obligation to pay money to the government."). As discussed above, a false claim submitted to a non-government entity violates the FCA in circumstances where "payment of the claim would ultimately result in a loss to the United States," as in the case of the MCOs. *Luther*, 720 F. Supp. at 921-22; *see supra* Section I (collecting cases).

Courts have held that reverse false claims liability lies where the retention of Government funds was attributable to a lack of diligence or haste. *Kane*, 120 F. Supp. at 394 (S.D.N.Y. 2015) ("Defendants' argument that 'failure to act quickly enough' cannot constitute 'avoidance' is plainly at odds with the language and intentions of the FCA. . . ."). This reasoning is even more compelling here, where the violation is attendant to eviCore's fraud. *E.g.*, SAC ¶¶ 15-21.

X. THE STATE LAW CAUSES OF ACTION (COUNTS V-XX) ALLEGE PLAUSIBLE CLAIMS.[11]

Defendant's attempt to treat all state law claims as identical to their federal counterpart is wrong. For example, the Texas statute is broader than the FCA. *U.S. ex rel. Patel v. Catholic Health Initiatives*, 312 F. Supp. 3d 584, 607 (S.D. Tex. 2018) ("*The TMFPA's scope can be broader than the FCA's scope*. … [T]he TMFPA prohibits false or misrepresentative statements made to obtain payments under the Medicaid program, but it does not require the presentment of a particular false claim to be identified. On this reading, the law would penalize all conduct that violates the FCA *while also reaching a broader range of false or fraudulent conduct less closely tied to the Medicaid claim submission process*.") (emphasis added). Unlike the FCA, the TMFPA does not require the presentment of a "false claim" to incur liability. Rather, the TMFPA sets out several unlawful acts that each proscribe specific conduct generally involving misrepresentations made to the Medicaid program. Tex. Hum. Res. Code §§ 36.002(1)-(13).

A. Relators have stated plausible claims under the Texas statute.

In Count XIX of the SAC, Relators bring claims under the Texas Medicaid Fraud Prevention Act ("TMFPA"), Tex. Hum. Res. Code Ann. § 36.101 *et seq.* Although the TMFPA and FCA share similar objectives, the TMFPA differs from the FCA in two important ways: (1) the TMFPA defines "unlawful acts" that are actionable and (2) it permits the state to recover civil remedies and civil penalties rather than "damages." *See In re Xerox*, 555 S.W.3d 518, 526-35 (Tex. 2018) (discussing relevant provision under heading "The Remedies in section 36.052 Are Not Damages"). One is liable under the TMFPA if he commits certain unlawful acts, many of which are *not* conditioned on submission of a claim for payment to Texas Medicaid. Rather, one commits an unlawful act if he

[11] This Section relates to Section II of Defendant's brief (ECF No. 22 at 16).

> knowingly makes, causes to be made, induces, or seeks to induce the making of a *false statement or misrepresentation of material fact* concerning . . . information required to be provided by a federal or state law, rule, regulation, or provider agreement pertaining to the Medicaid program, or
>
> knowingly makes, uses, or causes the making or use of ***a*** *false record or statement material to an obligation* to pay or transmit money or property to this state under the Medicaid program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to this state under the Medicaid program.

Tex. Hum. Res. Code Ann. § 36.002(4)(B), (12) (emphasis added). In turn, one acts "knowingly" with respect to information if he (i) has knowledge of the information, and either (ii) acts with conscious indifference to the truth or falsity of the information, or (iii) acts in reckless disregard of the truth or falsity of the information. *Id.* § 36.0011(a)(1)-(3). The TMFPA does not require Relators to prove that eviCore acted with specific intent to commit an unlawful act in order to prove that it acted knowingly. *Id.* § 36.0011(b). An "obligation" is "a duty that arises from statute or regulation. *Id.* § 36.001(7-a), (7-a)(C). Facts or information are "material" if they have "a natural tendency to influence or [is] capable of influencing." *Id.* § 36.001(5-a).[12] Unlike the FCA, facts or information do not have to be tied to "the payment or receipt of money or property" in order to be material under and violate the TMFPA. *Compare* Tex. Hum. Res. Code Ann. § 36.001(5-a) *with* 31 U.S.C. § 3729(b)(4).

Also, unlike the FCA, the TMFPA allows recovery of civil remedies and penalties, not just "damages." *See Xerox*, 555 S.W.3d at 526-35 (remedies under section 36.052 are not damages because they are "fixed *without regard to any loss to the Medicaid program* and *without a direct benefit to the liable party*") (emphasis added). The State has no obligation to show that the

[12] In this respect, the TMFPA defines materiality differently than the FCA because the FCA defines "material" as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4).

payment or benefit is an overpayment or damages. The remedies include the amount of any payment or the value of any monetary or in-kind benefit provided under the Medicaid program, directly or indirectly, as a result of the unlawful act, including any payment made to a third party; two times the amount of the payment or the value of the benefit described above; interest on the amount of the payment or the value of the benefit described above; and a civil penalty. Tex. Hum. Res. Code Ann. § 36.052(a).

That the TMFPA does not require proof of submission of a false claim, and instead prohibits unlawful acts that are generally material false statements and misrepresentations affecting the Medicaid program, only strengthens Relators' Texas-specific allegations. Relators have provided Texas-specific examples of fairly egregious misrepresentations by eviCore to Texas Medicaid officials. *See* SAC ¶¶ 102-03, 127-28. At the pleadings stage, that suffices.[13]

B. Relators have made other state specific allegations such that they plausibly pled a nationwide scheme.

If a scheme is national in scope, the Court may allow individual state FCA-analog claims to proceed even if specific allegations have not been made in each state pled.[14]

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[13] Although defendants in other cases have relied on two to support their assertion that the FCA and TMFPA should be construed similarly, *see U.S. ex rel. Carroll v. Planned Parenthood Gulf Coast Inc.*, 21 F. Supp. 3d 825, 830 (S.D. Tex. 2014); *U.S. ex rel. Williams v. McKesson*, No. 3:12-CV-0371-B, 2014 WL 3353247 at *4, 6 (N.D. Tex. 2014), those cases are inapposite. In both, the parties *agreed*, without Texas' knowledge or participation, that the FCA and TMFPA would be construed similarly, and did not provide the courts with the relevant statutory language or law showing the statutes' substantive differences.

[14] *E.g.*, *Duxbury*, 579 F.3d at 30–31 ("Although Duxbury does not identify specific claims, he has alleged the submission of false claims across a large cross-section of providers ... which further supports a strong inference that such claims were also filed nationwide."); *U.S. ex rel. Spay v. CVS Caremark Corp.*, 913 F. Supp. 2d 125, 174-75 (E.D. Pa. 2012) (collecting cases where "specific claims in one state or region satisfy Rule 9(b) requirements by establishing a nationwide inference of fraud"); *U.S. ex rel. Hudalla v. Walsh Constr. Co.*, 834 F. Supp. 2d 816, 823 (N.D. Ill. 2011) (defendant was on notice that relator was challenging its practices concerning projects beyond projects specifically named in complaint, as was "readily apparent from [relator's] detailed allegations regarding the nature of the alleged fraud; his contention that he had been told that defendant billed in the same way on other projects, his identification of several of those projects,

Relators have made plausible state-specific allegations supporting a finding of a nationwide fraudulent scheme, including allegations relevant to multiple states. *E.g.*, SAC ¶¶ 30, 102-03, 109, 122, 127-28. Factually, Relators have pled a national case, rendering the claims brought under each state statute viable at this pre-discovery stage.

XI. THE STATUTE OF LIMITATIONS DOES NOT BAR RELATORS' CLAIMS

Equally unavailing is eviCore's statute of limitations defense. It misstates the standard under Rule 15(c) in arguing that the SAC cannot relate back to Relators' initiation of this action.. *See* Def's Mem. at 23. Relation back is determined by the extent to which the allegations in the later pleading arise out of the same conduct set forth in the original pleading, and an amended pleading relates back where it asserts a claim "that arose out of the conduct transaction, or occurrence set out – or attempted to be set out – in the original pleading." Fed. R. Civ. P. 15(c)(1)(b).

Relators "brought" this action by serving their complaint on the Government on March 20, 2019. 31 U.S.C. § 3730(b)(2). The SAC's claims – like those in the original complaint – arise out of eviCore's illegal conduct in establishing an "automatic approval" system, in order to meet key timing provisions despite inadequate staffing and increase profits. Because the SAC's claims relate back to Relator's initial March 20, 2019 complaint to the Government, all claims arising on or after March 20, 2013 are timely within the six-year limitations period. That the initial complaint remains under seal does not change this analysis.

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and his statement that his claim 'includ[es], but [is] not limited to,' the named projects"); *U.S. ex rel. Schuhardt v. Wash. Univ.*, 228 F.Supp.2d 1018, 1034 (E.D. Mo. 2002) (plaintiffs not required "to provide specific allegation to substantiate each and every general allegation within the complaint"); *U.S. ex rel. Drennen v. Fresenius Med. Care Holdings, Inc.*, No. 09-10179, 2012 WL 8667597, at *1-2 (D. Mass. Mar. 6, 2012) (relator's allegation that "by reason of [defendant's] national billing practices, this billing likely occurred at [defendant's] other facilities throughout the country" was sufficient to allege nationwide false claims under Rule 9(b)).

XII. RELATORS HAVE ADEQUATELY ALLEGED THEIR RETALIATION CLAIMS

Relators adequately allege constructive termination attributable to their engagement in protected activities under 31 U.S.C. § 3730(h)(1). The pleading burden for retaliation under 31 U.S.C. § 3730(h)(1) is satisfied where a relator alleges that the defendant "'retaliated against [relator] for refusing to participate in activities that would result in a violation of State or Federal laws, rules, or regulations.' Nothing in federal pleading standards requires her to allege anything more than this to state a claim." *U.S. ex rel. Kennedy v. Aventis Pharm., Inc.*, No. 03 C 2750, 2008 WL 4371323, at *5 (N.D. Ill. Feb. 11, 2008). Courts have found constructive discharge where, for example, a relator's work environment is made intolerable through demands to engage in illegal conduct.[15]

Here, Relators allege clear engagement in protected behavior, and clear subsequent retaliation. Jane Doe 1 alleges that, after voicing concerns about eviCore's illegal policy, she was personally targeted with "unreasonable and uncommon productivity requirements, which in effect guaranteed her exclusion from future merit-based assignments to high-level projects." SAC ¶¶ 147-48. Jane Doe 2 similarly alleges that, after she voiced her concerns over eviCore's illegal conduct, she was passed over for promotions, SAC ¶¶ 153-55, and, like Jane Doe 1, targeted with unreasonable productivity requirements, SAC ¶¶ 161-62. Both Relators were forced to resign as a

[15] *See Flavel v. Svedala Indus., Inc.*, 868 F. Supp. 1422, 1468 (E.D. Wis. 1994) (denying defendants' summary judgment bid on constructive discharge claim where relator "concluded that [ ] management wanted him to participate in 'illegal and immoral'" activity); *Ward v. Cadbury Schweppes Bottling Grp.*, No. 09-03279 DMG (CWX), 2011 WL 13213887, at *13 (C.D. Cal. May 23, 2011) (triable issue raised on retaliation claim where plaintiff "reasonably believed he was being asked to 'participate in illegal acts that implicated 'fundamental policy concerns'") (citation omitted).

result of their refusal to engage in the illegal conduct that eviCore required, *e.g.*, SAC ¶ 128, and under the guise of individually targeted "productivity" requirements.

EviCore maintains that Relators have alleged no facts supporting anonymity. Def.'s Mem. at 23. But this was to protect Relators' identities because they are still working in healthcare and exposed to eviCore's influence within the industry. Anonymity does not prejudice eviCore because Relators have agreed to disclose their identities to eviCore pursuant to a protective order that would preserve eviCore's future right to seek public disclosure of Relators' identities. There is no basis to reveal Relators' identities on the public docket at this time, except as a tactical move by eviCore. As they allege, Relators have already suffered retaliation for voicing concerns about eviCore's conduct. *E.g.*, SAC ¶¶ 148, 155. Relators are often subjected to industry black-balling or other harassment after making allegations of wrongdoing.

The Second Circuit and other courts have held that the likelihood that a plaintiff will suffer retaliation – including retaliation by third parties who discover the plaintiff's name in public court filings – supports a request to proceed anonymously. *See Sealed Plaintiff v. Sealed Defendant*, 537 F.3d 185, 190 (2d Cir. 2008) (one factor supporting anonymity is "whether identification poses a risk of retaliatory physical or mental harm"); *see also Does I thru XXIII v. Advanced Textile Corp.*, 214 F.3d 1058, 1069 (9th Cir. 2000) (district court abused its discretion in denying plaintiffs' motion to proceed anonymously where it failed to consider "evidence of threatened retaliation by parties not before the court" and by concluding that "risks of extraordinary economic injury are insufficient as a matter of law" to support request to maintain anonymity). In the specific context of an FCA qui tam action, courts permit relators to proceed anonymously to prevent them from suffering further harm. *See U.S. ex rel. Doe v. Boston Scientific Corp.*, No. 4:07-cv-2467 slip op. at 5 (S.D. Tex. July 2, 2009) (permitting relator to maintain anonymity during pendency of

unsealed qui tam action where relator's husband worked in same industry, giving rise to reasonable fear that he would suffer retaliation from his employer). Similarly here, not only have Relators already suffered retaliation by eviCore, but because they continue to work in the same industry, they reasonably fear being black-balled or harassed by third parties for having blown the whistle on their former employer. In light of this reasonable fear, and the fact that eviCore will suffer no prejudice (as Relators have agreed to provide their real names to eviCore), Relators should be permitted to proceed anonymously.

XIII. LEAVE TO FURTHER AMEND SHOULD BE GRANTED IF NECESSARY.

If the Court does order dismissal, Relators request leave to amend. "The Federal Rules provide that courts 'should freely give leave [to amend] when justice so requires.'" *Kroshnvi v. U.S. Pack Courier Servs.*, Inc., 771 F.3d 93, 109 (2d Cir. 2014) (quoting Fed. R. Civ. P. 15(a)(2)). Justice so requires absent factors "such as undue delay, bad faith or dilatory motive on the part of the movant...undue prejudice to the opposing party by virtue of allowance of the amendment, [or] futility of the amendment, etc.," which are wholly absent here. *Foman v. Davis*, 371 U.S. 178, 182 (1962). While decisions regarding leave to amend are left to the court's discretion, there must be good reason to deny leave. *Acito v. IMCERA Grp., Inc.*, 47 F.3d 47, 55 (2d Cir. 1995). This Circuit applies a "permissive standard" to such motions and have a "strong preference for resolving disputes on the merits," all of which favors granting leave to amend. *Williams v. Citigroup Inc.*, 659 F.3d 208, 212-13 (2d Cir. 2011) (quotation omitted).

Defendants must overcome this permissive standard and strong preference for resolving claims on their merits and meet their burden of demonstrating bad faith, prejudice, or futility. *See City of N.Y. v. Grp. Health Inc.*, 649 F.3d 151, 157 (2d Cir. 2011) ("The rule in our circuit is to allow a party to amend its complaint unless the nonmovant demonstrates prejudice or bad faith.")

Here, Defendant has not even filed an answer. *See, e.g., Am. Medical Ass'n v. United Healthcare Corp.*, No. 00-cv-2800, 2006 WL 3833440 (LMM), at *4 (S.D.N.Y. Dec. 29, 2006) (no undue delay when discovery was in its "early stages" and "[n]o scheduling order or deadline for filing motions to amend the pleading ha[d] expired"). Nor can Defendant demonstrate bad faith or dilatory motive on behalf of Relators. Relators have not yet had the benefit of an opinion from the Court applying the law to the facts alleged and setting forth factual deficiencies that must be addressed in order for Relators' complaint to be viable. *See, e.g., Ruotolo v. City of N.Y.*, 514 F.3d 184, 191 (2d Cir. 2008) ("Mere delay ... absent a showing of bad faith or undue prejudice, does not provide a basis for the district court to deny the right to amend.").

Furthermore, eviCore would not be prejudiced by the Court allowing another amendment to Relators' complaint, depending on this Court's ruling. Any amendment would not change Relators' core theory of their case and would present facts and circumstances substantially similar to those set forth in the SAC. *See Hanlin v. Mitchelson*, 794 F.2d 834, 841 (2d Cir. 1986) ("[T]he new claims are merely variations of the original theme...arising from the same set of operative facts as the original complaint...[and] were forecast by the original...allegations."); *Duling v. Gristede's Operating Corp.*, 265 F.R.D. 91, 103 (S.D.N.Y. 2010) ("defendants were on notice of the facts underlying [plaintiff's] claims prior to his motion [to amend] and cannot colorably claim prejudice due to unfair surprise") (same). Likewise, "[a]llegations that an amendment will require the expenditure of additional time, effort, or money do not constitute 'undue prejudice.'" *A.V. by Versace, Inc. v. Gianni Versace S.p.A.*, 87 F. Supp. 2d 281, 299 (S.D.N.Y. 2000).

In the absence of undue delay, bad faith, or undue prejudice, "the Second Circuit repeatedly has held that if the party moving for leave to amend its pleading 'has at least colorable grounds for relief, justice...require[s]'" permitting the amendment. *Intersource, Inc. v. Kidder Peabody & Co.*,

No. 90-cv-7389 (PKL), 1992 WL 369918, at *2 (S.D.N.Y. Nov. 20, 1992) (quoting *S.S. Silberblatt, Inc. v. East Harlem Pilot Block Bldg, 1. Hous. Dev. Fund. Co.*, 608 F.2d 28, 42 (2d Cir. 1979)). Although courts may deny leave to amend if the proposed amendment would be futile, they "should exercise caution ... in labeling a claim 'futile.'" *Gallegos v. Brandeis Sch.*, 189 F.R.D. 256, 258 (E.D.N.Y. 1999) (citation omitted). "A proposed claim may be labeled futile only where it is clearly frivolous or legally insufficient on its face." *Id.* at 259 (internal quotation and citation omitted). None of the issues raised by eviCore's motion to dismiss are insurmountable, such that an attempted amendment would be futile.

CONCLUSION

For the reasons set forth above, the Court should deny eviCore's motion to dismiss, or in the alternative, grant Relators leave to further amend.

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