IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TEXARKANA DIVISION

HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY, *Plaintiff*, v. NEUROMONITORING ASSOCIATES, LLC, PHYSICIAN OVERSIGHT, LLC, and MONITORING ASSOCIATES LLC, *Defendants*.	Case No. 5:26-cv-00022-RWS-JBB

PLAINTIFF'S RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS AND REQUEST FOR JUDICIAL NOTICE

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Defendants, related entities that provide intraoperative neuromonitoring ("IOM"), have carried out three separate fraud schemes, each layered on top of the others, that have caused millions of dollars in harm to HCSC. ***First***, Defendants covertly agreed to pay surgeons illegal kickbacks in exchange for express agreements to order IOM services from Defendants. ***Second***, Defendants lied about who performed those IOM services, handling the increase in orders by assigning unauthorized personnel to perform the services. ***Third***, Defendants fraudulently utilized the No Surprises Act ("NSA") by serially lying about the eligibility of their claims for the NSA's Independent Dispute Resolution ("IDR") process to take advantage of heightened award amounts resulting from the IDR process. This included efforts to launder claims not eligible for payment in the first place—because the claims were tainted by kickbacks or otherwise performed by unauthorized personnel—through the IDR process. HCSC footed the bill for Defendants' fraud: it paid Defendants' illegal, kickback-tainted claims, claims for services performed by unauthorized medical personnel, and it paid inflated IDR awards on Defendants' ineligible claims. HCSC would not have paid these amounts, totaling millions of dollars, absent Defendants' lies.

HCSC now stands before the Court seeking to recover the funds it lost because of Defendants' fraud. Defendants' Motion to Dismiss (D.E. 53, hereinafter "MTD") distorts or otherwise entirely ignores the actual allegations in HCSC's Amended Complaint and relies on legal arguments that do not bear scrutiny. It should be denied.[1]

BACKGROUND

I. Defendants Engage In Classic Forms of Healthcare Fraud Outside of the IDR Process.

Defendants are providers of IOM services—procedures used to monitor a patient's neural pathways during surgery. D.E. 40 ("FAC") ¶¶ 4–5, 14–16, 33. There are two components to IOM:

[1] Plaintiff does not oppose Defendants' request for judicial notice.

(a) a "technical" component, consisting of a technician in the operating room who monitors and tracks data; and (b) a "professional" component, consisting of a physician called a reader located offsite who reads, monitors, and interprets a patient's data during the operation in real-time. *Id.* ¶¶ 35–36. IOM services are ordered by surgeons on an as-needed basis. *Id.* ¶ 34.

The IOM market is saturated, and IOM services are only medically necessary in limited circumstances. *Id.* ¶¶ 34, 38. IOM providers have thus resorted to illegal practices to boost their sales and encourage surgeons to order IOM more frequently. One such practice involved using surgeon-owned entities to kick back a portion of IOM providers' profits to surgeons in exchange for IOM referrals. *Id.* ¶¶ 41–43. Surgeons would (1) create shell LLCs that entered into sham management agreements with IOM providers; (2) order IOM services from those LLCs, which would then be performed and billed by the IOM provider; and (3) receive a portion of the collections in the guise of distributions from the LLC. *Id.* ¶¶ 42–43. This practice largely came to a halt when the Office of Inspector General rendered an opinion[2] (the "OIG Opinion") explaining that it violated the federal anti-kickback statute. *Id.* ¶¶ 44–46.

Once it became known in the industry the OIG would be issuing its opinion, the LLCs were effectively defunct, and surgeons were left with useless shell companies and a lost revenue stream. *Id*. ¶ 51. Defendants saw this as a business opportunity: they could offer to pay the same kickbacks, but through different means. *Id.* ¶¶ 47–49. Defendants negotiated sham purchases of the surgeons' LLCs—which held no appreciable assets, employed nobody, served no legal purpose, and were effectively worthless after the OIG Opinion. *Id.* ¶¶ 50–51. Defendants nonetheless paid exorbitant prices for the LLCs. *Id.* ¶¶ 52–54. The purchase price was paid out in installments over several

[2] HCSC alleges that NMA itself may have solicited the OIG Opinion as part of a "monthslong campaign . . . to convince surgeons . . . their arrangements . . . were illegal" in order to cause the surgeons to work with NMA "using a slightly different (but still illegal) model." FAC ¶¶ 47–48.

years and was calibrated to equal or exceed the kickbacks the surgeons previously received, with a corresponding agreement by the surgeons to order a quota of IOM services from Defendants on an exclusive or near-exclusive basis during that period. *Id*. Put simply, Defendants bribed surgeons to order and refer IOM services at a specific volume over an extended period of time. *Id.*

This scheme was no less illegal than the one it replaced, and violated multiple Texas laws that prohibit paying physicians for referrals. *See id.* ¶¶ 23–28, 54–55. Even so, it worked: surgeons who rarely or never before used NMA for IOM services suddenly began doing so in large volumes. *Id.* ¶¶ 55–56, 64–66, 68–120. HCSC, like other health insurers, does not pay claims for services tainted by illegal kickbacks, which Defendants knew. *Id.* ¶¶ 23–28. Yet HCSC paid millions on these non-payable claims to Defendants before uncovering the truth. *Id.* ¶¶ 69–120.

Defendants further engaged in fraud in providing the professional component of IOM services. *Id.* ¶ 121. That component is performed remotely by a physician "reader" who monitors patient data in real time; they must be credentialed with the rendering facility and licensed in the state where the facility is located (here, Texas). *Id.* ¶¶ 36, 122–23. If those prerequisites are absent, HCSC will not pay for the service. *Id.* Defendants used readers who were neither properly credentialed or licensed while falsely representing to HCSC (and facilities) that a different licensed, credentialed reader performed the monitoring. *Id.* ¶¶ 124–25. This enabled Defendants to perform and bill for IOM services at facilities where they would not otherwise be able to do so because a properly licensed, credentialed reader was not available. *Id.* ¶¶ 126–29. Per a former NMA employee, NMA regularly engaged in this fraud, including (but not limited to) at Baptist Hospital in San Antonio, TX, and UT Tyler Hospital in Tyler, TX. *Id.* ¶¶ 128–29. Any such claims were non-payable by HCSC. Many of these claims also inevitably made their way through the IDR process, despite being non-payable. FAC ¶ 222.

II. Defendants' Fraudulently Initiate Thousands of IDR Proceedings.

Defendants' kickback scheme and IOM reader fraud are two classic forms of healthcare fraud, and HCSC seeks damages from Defendants equal to the amounts HCSC paid on any claims infected by either (or both) of those schemes, as the claims were non-payable in the first instance. However, on top of (though separate and apart from) those schemes, Defendants layered an ***additional*** scheme, using the NSA's IDR process to launder ineligible claims to supercharge their revenue. Defendants serially submitted ineligible claims to the IDR process, lied to HCSC and the IDRE about the eligibility of those claims, and improperly obtained millions in IDR awards.

The federal IDR process has strict eligibility requirements, including exclusions for claims governed by specified state law, claims outside the NSA's scope, claims previously decided in IDR, untimely claims, and improperly batched claims. *Id.* ¶¶ 141, 145–46. To initiate formal IDR, a provider must submit information through the HHS portal and attest that the items or services are qualified items or services. *Id.* ¶¶ 144–56. The Notice of IDR Initiation contains only the initiating provider's attestations and does not include input from the health plan. *Id.* ¶ 157.

NMA saw this as another opportunity for profit, calling it a "great boon to NMA" and "very fruitful." *Id.* ¶¶ 168–70. NMA used its affiliates, including Physician Oversight and Monitoring Associates, to initiate ***thousands*** of IDR disputes for ineligible services and items. *Id.* ¶ 171, 179–220. In doing so, Defendants intentionally made serial misrepresentations in their IDR submissions, lying about the plan type, service type, dates of service, whether open negotiation under the NSA occurred and when, whether the provider filed an appeal, and whether the items or services were even qualified IDR items or services within the scope of the federal IDR process. *Id.* ¶ 172. Defendants paired their misrepresentations with underhanded tactics to obscure and prevent HCSC from detecting Defendants' fraud until after the fact. *Id.* ¶¶ 9–10, 178, 220. By so

doing, Defendants ultimately procured thousands of fraudulent IDR awards. *Id.* ¶¶ 174–75, 220. This further caused HCSC to incur administrative fees, overhead costs, and staffing expenses, separate from any final award. *Id.* ¶¶ 10, 176–77, 247, 272, 333. All told, HCSC lost millions to this scheme, separate and apart from what it lost to Defendants' fraud outside the IDR process.

LEGAL STANDARD

A motion under Rule 12(b)(1) may be granted "only if it appears certain that the plaintiff cannot prove any set of facts in support of [its] claim that would entitle plaintiff to relief." *Novo Nordisk Inc. v. Axtell's Rite-Value Pharm., Inc.*, No. 4:25-cv-837, 2026 WL 1684178, at *2 (E.D. Tex. June 10, 2026). Because Defendants mount a facial attack on the Court's subject-matter jurisdiction, HCSC's "allegations are presumed to be true for purposes of deciding the motion." *Id.* With respect to Rule 12(b)(6), the court must "assume that all well-pleaded facts are true and view those facts in the light most favorable to the plaintiff." *Haley IP, LLC v. Harman Int'l Indus., Inc.*, No. 2:25-cv-00577, 2026 WL 873227, at *1 (E.D. Tex. Mar. 20, 2026).

ARGUMENT

I. The NSA Does Not Bar HCSC's Fraud Claims, And HCSC Has Pled Its Standalone IDR Fraud Claims To Preserve Them.

HCSC's FAC asserts claims related to (1) classic healthcare fraud that occurred outside the IDR process; and (2) fraudulent submissions made by Defendants while initiating the IDR process. Defendants do not and cannot argue that the NSA's judicial review provision bars the former fraud claims, even though HCSC's damages for those kickback and reader fraud claims include both the original amounts paid on the claims, plus any IDR award. *See, e.g.*, FAC ¶ 222. Instead, Defendants only argue that the NSA forecloses HCSC's claims arising from fraudulent eligibility statements made to IDREs. MTD at 13 (conceding the NSA arguments apply solely to "Counts II, IV, VI, VIII, and X"). The NSA thus provides no defense to most of HCSC's Complaint.

As for HCSC's claims regarding IDR eligibility submissions, Defendants argue they are foreclosed by this Court's decision in *HaloMD* and similar cases, which they argue "explicitly recognized [a] restriction" in the NSA on legal challenges to IDR awards outside of vacatur. *Id*. at 11; *see also Blue Cross Blue Shield of Texas v. HaloMD*, No. 5:25-CV-132, 2026 WL 1557492, at *7 (E.D. Tex. May 22, 2026). HCSC recognizes that—with the exception of vacatur—this Court's decision in *HaloMD* (if fully upheld by the Fifth Circuit on appeal) would foreclose claims regarding fraud in the IDR process based solely on eligibility attestations. Hence, HCSC noted as much in its Amended Complaint, explaining that it seeks to preserve these claims. FAC ¶ 38 n.24.[3]

II. HCSC Pleads A Valid Claim For Vacatur.

Defendants systematically lied to HCSC and IDREs regarding the eligibility of thousands of claims for the IDR process. *See* FAC ¶¶ 172, 180–219. The result is that Defendants repeatedly caused IDREs to issue IDR awards on ineligible claims in the absence of jurisdiction. *See id.* In addition, Defendants submitted claims that should never have been paid in the first place since they were procured by means of illegal kickbacks. *See id.* ¶¶ 225–30. This is precisely the type of exceptional scenario for which vacatur is designed.

A. Courts have uniformly rejected Defendants' procedural arguments.

Defendants first contend that, to the extent HCSC seeks vacatur, the FAA requires HCSC to file an "application" that is "supported by clear and convincing evidence" instead of a complaint.

[3] An order granting vacatur "nullifie[s] the decision of an arbitration panel." *Forsythe Int'l, S.A. v. Gibbs Oil Co. of Texas*, 915 F.2d 1017, 1020 (5th Cir. 1990). If HCSC obtains vacatur of the IDR awards at issue, there is no statutory or collateral attack bar, as there will be no judgment to be attacked. *See, e.g.*, *Dodrill v. Ludt*, 764 F.2d 442, 444 (6th Cir. 1985) (explaining "the general rule is that a judgment which is vacated, for whatever reason, is deprived of its conclusive effect as collateral estoppel" and listing cases). While not an issue for the Court to address now, should HCSC ultimately obtain vacatur, HCSC reserves the right to move to set aside the judgment on the dismissed claims, or otherwise seek to pursue these claims. HCSC will also pursue its IDR eligibility fraud-related claims if permitted after the Fifth Circuit's review of the *HaloMD* ruling.

MTD at 14. That argument, however, relies on procedural provisions of the FAA that have not been incorporated into the NSA. Courts analyzing the NSA have uniformly concluded that the procedural requirements of the FAA are inapplicable. This Court should do the same.

The NSA provides that an IDR award "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" of the FAA. 42 U.S.C.A. § 300gg-111(5)(E)(i)(II). Those provisions, in turn, contain the substantive grounds for vacatur set out in the FAA. But the ***procedural*** requirements NMA references are found in other sections of the statute: 9 U.S.C. §§ 6, 10, and 12. The NSA does not cross reference these sections.

As the Fifth Circuit and other courts have recognized, Congress "incorporated only parts of § 10." *Guardian Flight L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 276 (5th Cir. 2025) ("*Guardian Flight I*"). Courts have thus held the procedural requirements set out in other parts of the FAA do not apply to the NSA. *See, e.g.*, *Med-Trans Corp. v. Cap. Health Plan, Inc.*, 700 F. Supp. 3d 1076, 1083 (M.D. Fla. 2023) ("[T]he NSA does not invoke or discuss §§ 6, 9, 12, or any other sections of the FAA."); *Guardian Flight, LLC v. Aetna Health Inc.*, 711 F. Supp. 3d 662, 670 (S.D. Tex. 2024) (agreeing with *Med-Trans* as to how the "NSA and FAA intersect and the proper way to seek judicial review of IDR awards"); *Jeffrey Farkas, M.D., LLC v. 1199SEIU Nat'l Benefit Fund*, No. 25-CV-57, 2026 WL 891659, at *16 (E.D.N.Y. Apr. 1, 2026) (explaining "the NSA does not incorporate Section 12, the FAA's procedural rules for vacating an award"); *Mitchell F. Reiter MD PC v. Horizon Blue Cross Blue Shield of N.J.*, No. 2:25-cv-12526, 2025 WL 3514300, at *3 (D.N.J. Dec. 8, 2025) ("Congress unequivocally incorporated only § 10(a)(1)-(4) of the FAA into the NSA."). Congress knew how to incorporate sections of the FAA and chose to "invoke[] four paragraphs of the FAA to describe 'cases' where an IDR decision may be 'subject

to judicial review'—nothing more." *Med-Trans Corp.*, 700 F. Supp. 3d at 1083.[4]

Given the above, courts (including the Fifth Circuit) apply ordinary pleading standards to claims for vacatur under the NSA. *See Guardian Flight, L.L.C. v. Med. Evaluators of Tex. ASO, L.L.C.*, 140 F.4th 613, 619–20 (5th Cir. 2025) ("*Guardian Flight II*") (evaluating NSA vacatur claim under Rule 12(b)(6) and "accept[ing] factual allegations as true . . . in the light most favorable to the plaintiffs"). Contrary to Defendants' arguments (MTD at 15–16), HCSC need not meet the FAA's procedural requirements by filing a motion specifying each IDR award at issue, providing evidence at the outset, or beating the FAA's three-month motion deadline. And Defendants' assertion that HCSC cannot obtain vacatur because HCSC was not a party to the IDR proceedings (MTD at 15–16) is wrong. HCSC explains NMA's counterparty in the IDR proceedings was "HCSC's *division* Blue Cross Blue Shield of Texas," FAC ¶ 13 (emphasis added), which is part of HCSC. Defendants cannot claim HCSC is a "part[y]" bound by the IDR awards, 42 U.S.C.A. § 300gg-111(5)(E)(i), but not a party when it comes to challenging them.

B. HCSC's non-IDR fraud claims do not require vacatur to proceed in full.

HCSC need not obtain vacatur to recover the full amounts it lost due to Defendants' non-IDR fraud—including consequential damages attributable to IDR awards where kickback-tainted claims were laundered through the IDR process. Defendants do not argue otherwise. Indeed, they effectively concede the point, asserting their fraud outside the IDR process lacks "any connection

[4] Defendants also cite cases regarding discovery limitations, but those cases arose in the context of ordinary arbitrations, based on FAA provisions not incorporated into the NSA. *O.R. Secs., Inc. v. Prof'l Planning Assocs., Inc.*, 857 F.2d 742, 745–46 (noting discovery limits stem from "[t]he policy of expedited judicial action expressed in [§] 6"); *U.S. Ship Mgmt., Inc. v. Maersk Line, Ltd.*, 188 F. Supp. 2d 358, 362–63 (S.D.N.Y. 2002) (same). But even if the Court accepts Defendants' attempt to incorporate into the NSA certain FAA provisions that Congress excluded, HCSC's claims still survive. While Section 6 of the FAA "generally requires" a motion to vacate, courts have found complaints plus subsequent briefing satisfy that requirement. *Johnsson v. Directory Assistants Inc.*, 797 F.3d 1294, 1299 (11th Cir. 2015).

to the enumerated and exhaustive list of factors that IDREs consider." MTD at 18. That establishes HCSC's kickback and reader fraud claims do not "challenge a determination of a certified IDR entity" within the meaning of the NSA. 42 U.S.C. § 300gg-111(c)(5)(E)(i). Nor, for that matter, could Defendants raise this argument at the Rule 12 stage given that it goes solely to HCSC's damages on its non-IDR fraud claims.[5] In any event, even were it necessary, HCSC has plausibly alleged grounds for vacatur with respect to claims tainted by non-IDR fraud, as explained below.

C. HCSC's vacatur claim is properly pled.

The FAA sets out four distinct grounds for vacatur. *See* 9 U.S.C. § 10(a). Two are relevant here. First, an IDR award may be vacated where the award is procured by "corruption, fraud, or undue means." *Id.* § 10(a)(1). Here, the awards were procured by fraud or undue means in that Defendants lied about claims' eligibility for the IDR process and concealed their illegal practices that rendered the claims non-payable in the first instance. *See* FAC ¶¶ 338–42. Second, an IDR award may be vacated where IDREs "exceeded their powers." 9 U.S.C. § 10(a)(4). That occurred here insofar as IDREs rendered IDR awards on ineligible claims. *See* FAC ¶¶ 344–45.

1. Vacatur is appropriate under § 10(a)(1).

Vacatur under § 10(a)(1) based on fraud requires showing "(1) that the fraud occurred by clear and convincing evidence; (2) that the fraud was not discoverable by due diligence before or during the arbitration hearing; and (3) the fraud materially related to an issue in the arbitration." *Jackson v. Conifer Rev. Cycle Solutions, LLC*, No. 4:19-cv-256, 2019 WL 8755075, at *6 (E.D. Tex. Dec. 17, 2019). Defendants dispute only the first and second prongs.

[5] *See, e.g.*, *Texas v. Colony Ridge, Inc.*, No. CV 24-0941, 2024 WL 4553111, at *12 (S.D. Tex. Oct. 11, 2024) (holding the court could not address damages-related arguments at the Rule 12 stage); *Greathouse v. Cap. Plus Fin. LLC*, 690 F. Supp. 3d 610, 640 (N.D. Tex. 2023) (same); *Francis v. Nelson*, No. 24-CV-01130, 2025 WL 597092, at *3 (W.D. Tex. Feb. 24, 2025) (same).

On the first prong, "'willfully . . . withholding'" or "'knowingly concealing evidence' constitutes arbitration fraud" warranting vacatur. *Guardian Flight II*, 140 F.4th at 621 (citation omitted). Courts regularly grant vacatur where a party conceals or lies about facts or evidence relevant to arbitral proceedings. *See NuVasive, Inc. v. Absolute Med., LLC*, 71 F.4th 861, 878 (11th Cir. 2023) (granting vacatur where party distorted evidence by coaching a witness); *France v. Bernstein*, 43 F.4th 367, 378 (3d Cir. 2022) (granting vacatur where party withheld evidence); *Bonar v. Dean Witter Reynolds, Inc.*, 835 F.2d 1378, 1384 (11th Cir. 1988) (granting vacatur where party misrepresented an expert's qualifications). That occurred here in several respects.

Most simply, Defendants lied thousands of times about simple, binary facts to cause IDREs to render awards on ineligible claims. *See* FAC ¶ 172. It is hard to imagine a clearer case for vacatur than where a party lies to make a non-eligible dispute appear eligible. Defendants assert other courts have held this is insufficient, but the cases they cite say nothing of the sort. *See* MTD at 17. For example, in *Guardian Flight II*—which involved a handful of IDR disputes—the Court held only that the plaintiff had not pled facts "supporting an inference that the misstatement was intentional" where it speculated an insurer mischaracterized its "qualifying payment amount" ("QPA") in IDR proceedings. 140 F.4th at 621. But here, Defendants lied about simple, specific, binary facts ***thousands of times***, ***even after being put on notice***. FAC ¶¶ 172–220.[6]

With respect to the kickback and improper credentialing claims, "[t]he NSA applies to 'items or services . . . ***for which benefits are provided under the plan***.'" *Jeffrey Farkas, M.D.*, 2026 WL 891659, at *3 (quoting 42 U.S.C. § 300gg-132(a)) (emphasis added); *see also* 86 Fed.

[6] HCSC has explicitly identified specific eligibility misrepresentations, making this case different than *Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc.*, 160 F.4th 1110, 1121–23 (11th Cir. 2025). And *Anthem* is similarly unhelpful, as the court dismissed the plaintiff's claims on prong two, not prong one. *Anthem Blue Cross Life & Health Ins. Co. v. HaloMD LLC*, No. 8:25-CV-01467, 2026 WL 982629, at *7–9 (C.D. Cal. Apr. 9, 2026).

Reg. 36,872, 36,891 (July 13, 2021) (explaining NSA protections do not extend to non-covered items or services). HCSC (like other insurers and the federal government) does not pay or cover claims tainted by the types of fraud that occurred here. *See* FAC ¶¶ 23–28. This is not a policy regarding the IDR process but a coverage rule that (1) renders the claims at issue not covered and ineligible for the IDR process, and (2) sets HCSC's QPA for these claims to $0. *Id.* The NSA does not require insurers to pay illegal claims. And Defendants prevented HCSC from raising any arguments about this fraud in the IDR process by concealing their schemes. *Id.* ¶¶ 7, 341.

As for Defendants' assertion that they made no specific fraudulent statements, the fact that Defendants "'willfully . . . with[eld]'" or "'knowingly conceal[ed]'" their illegal scheme is sufficient for vacatur. *Guardian Flight II*, 140 F.4th at 621 (citation omitted). But even were that not the case, as discussed more fully below, deliberately submitting a claim knowing that the payor would not pay if fully informed "can be actionable misrepresentation" by itself. *Universal Health Services, Inc. v. United States*, 579 U.S. 176, 188–89 (2016).

Defendants' arguments related to prong two also fail. Defendants claim HCSC "pleads that it was aware of the supposed misstatements and argued to the arbitrator that the statements were wrong." MTD at 18 (emphasis omitted). That mischaracterizes HCSC's allegations. HCSC alleges that it was able to catch and object to Defendants' ineligible submissions in ***some*** cases. But Defendants submitted tens of thousands of claims to IDR, and not all of them are ineligible. Defendants paired their misrepresentations with underhanded tactics to obscure and prevent HCSC from detecting Defendants' fraud until after the fact. *Id.* ¶¶ 9–10, 178. 220. The fact that HCSC managed to object in some instances reflects only that it is acting diligently to catch fraud, even if it is not possible to do so every time. That is all vacatur requires. *See Jackson*, 2019 WL 8755075, at *6 (the FAA requires "the fraud was not discoverable *by due diligence*") (emphasis added).

Indeed, "[r]easonable diligence does not require parties to assume the other side is lying," and a party is "entitled to rely upon [the opposing party's] representations without launching a separate fact-checking investigation." *France*, 43 F.4th at 379–80; *see also Allstate Ins. Co. v. Lyons*, 843 F. Supp. 2d 358, 375 (E.D.N.Y. 2012) ("emphatically reject[ing]" the notion that "sophisticated insurer[s]" can inherently to detect "complex fraudulent schemes"). One party cannot avoid vacatur by claiming the other should have caught their fraud. And whether HCSC's diligence was sufficient cannot be resolved on a motion to dismiss. *In re Commonwealth Oil/Tesoro Petroleum Corp. Sec. Litig.*, 467 F. Supp. 227, 260–61 (W.D. Tex. 1979).

Defendants further note the specific examples of fraud HCSC provides in its complaint are instances in which HCSC caught Defendants. MTD at 18–19. But HCSC selected these examples because they demonstrate the intentional nature of Defendants' conduct: they lied even after being put on notice. *See* FAC ¶¶ 172–73; 180–219. Providing representative examples in complex fraud cases gives "sufficient particularized detail to . . . provide fair notice to Defendant[s] of the nature of the[ ] claims against [them]." *El Paso Disposal, LP v. Ecube Labs Co.*, 766 F. Supp. 3d 692, 708 (W.D. Tex. 2025). Defendants cannot claim that their conduct differed between the instances where they were caught in a lie, and those where they were not.[7] "[T]he purpose of Rule 9 is not to reintroduce formalities to pleading, but is instead to provide defendants with a more specific form of notice as to the particulars of their alleged misconduct." *U.S. ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 503 (6th Cir. 2007). Defendants cannot feign lack of notice.

The foregoing distinguishes this case from the authority Defendants rely upon, in which the courts understood the plaintiffs to "alleg[e] that [they] knew about the false eligibility attestations and objected" without exception. *Anthem Blue Cross Life & Health Ins. Co. v.*

[7] If needed, HCSC can amend to provide examples where it failed to detect the ineligibility.

HaloMD LLC, No. 8:25-CV-01467, 2026 WL 982629, at *8 (C.D. Cal. Apr. 9, 2026); *Aetna Health Inc. et al. v. Radiology Partners, Inc. et al.*, No. 3:24-cv-1343, 2026 WL 1556164, at *3 (M.D. Fla. Apr. 16, 2026). It cannot be that, by catching and objecting to eligibility in ***some*** instances, a party to IDR proceedings is forever foreclosed from seeking vacatur.[8] Indeed, systematic fraud in the IDR process like Defendants' can only be distinguished from inadvertence where, as here, an undeniable pattern of false statements emerges. Defendants' theory would hold that, by the time fraud can be confirmed, it is too late to seek vacatur.

Moreover, even when HCSC objected, often ***the IDRE did not review the objection***. *See* FAC ¶¶ 142(g), 157. The NSA itself is silent on what an IDRE must review to determine eligibility. Until recently, the regulations stated that the IDRE need only "review the information submitted in the ***notice of IDR initiation***" by Defendants, as opposed HCSC's objections, "to determine whether the Federal IDR process applies." 45 C.F.R. § 149.510(c)(1)(v) (emphasis added). The lack of a requirement to review objections to eligibility exacerbated a conflict of interest: an IDRE only gets paid if it determines a claim or service is eligible. *See* 42 U.S.C. § 300gg-111(c)(5)(F); *see also Peabody v. Rotan Mosle, Inc.*, 677 F. Supp. 1135, 1138 (M.D. Fla. 1987) (explaining "a conflict of interest raises arbitral impartiality issues and, as such, requires this Court to take a broader and more intrusive review of the award"). IDREs have thus regularly ignored or failed to account for objections in determining eligibility. *See* FAC ¶¶ 189–219.

Reinforcing the fact that IDREs did not have to consider HCSC's objections, the relevant regulation was recently amended—and will go into effect August 3, 2026—to ***remove*** the language directing IDREs to review only the "notice of IDR initiation" and replace it with language requiring review of "information in the notice of IDR initiation, notice of IDR initiation response,

[8] That is particularly true where there is no allegation that all submissions were fraudulent.

and any additional information [provided in response to a request by an IDRE.]" *See* Federal Independent Dispute Resolution Operations, 91 Fed. Reg. 33900, 33943, 34075 (June 4, 2026). Had IDREs previously reviewed objections to eligibility, this change would not have been needed.

This change also further distinguishes the cases Defendants rely upon, in which fraud was "brought to the attention of the arbitrator, who addressed it." *Barahona v. Dillard's, Inc.*, 376 F. App'x 395, 398 (5th Cir. 2010). Even as Congress imported a few specific provisions of the FAA into the NSA, the reality is that "differences pervade the IDR and arbitration processes," and the IDR process "is not an arbitration." *Mod. Orthopaedics of NJ v. Premera Blue Cross*, No. 2:25-CV-01087, 2025 WL 3063648, at *5–7 (D.N.J. Nov. 3, 2025). It lacks the element of consent to specific processes and procedures to resolve disputes. As a result, the IDR process does not provide a reliable way to raise and address this type of fraud—a fact Defendants deliberately exploited. *See* FAC ¶¶ 142, 144–57. No authority under the FAA holds that vacatur is unavailable in instances where fraud was discovered, but there was no mechanism to raise it.

If nothing else, lying to IDREs knowing that any objection HCSC lodged would fall on deaf ears constitutes procuring an award by "undue means." 9 U.S.C. § 10(a)(1). This is separate grounds for vacatur that "describes underhanded or conniving ways of procuring an award that are similar to corruption or fraud, but do not precisely constitute either." *Nat'l Cas. Co. v. First State Ins. Grp.*, 430 F.3d 492, 499 (1st Cir. 2005). This catchall exists for situations in which bad conduct may not squarely fit a particular mold. The only argument Defendants raise on this point is that undue means requires "intentional conduct," and HCSC has not sufficiently alleged that their actions were intentional. MTD at 19–20. Defendants are wrong. HCSC alleges that Defendants systematically lied thousands of times about simple, binary facts—even after being put on notice of their falsity—intending to secure IDR awards on ineligible claims, knowing that HCSC would

not be able to catch every lie and that the IDRE would not review HCSC's objections even when it did. *See* FAC ¶¶ 172–78. If this deliberate misconduct is not "undue means," nothing would be.

In any event, the Court need not reach these latter issues at this stage of the case. The allegation that in many cases Defendants' fraud went undetected despite HCSC's substantial diligence satisfies the second prong of the vacatur analysis at the Rule 12 stage. And that is sufficient to resolve the inquiry as to HCSC's vacatur claim as a whole on a Rule 12(b)(6) motion, as "a motion to dismiss under Rule 12(b)(6) doesn't permit piecemeal dismissals of parts of claims." *Signal Funding, LLC v. Sugar Felsenthal Grais & Helsinger LLP*, 136 F.4th 718, 724 (7th Cir. 2025); *see also* Wright & Miller, 5B Fed. Prac. & Proc. Civ. § 1358 (4th ed.) (explaining "a Rule 12(b)(6) motion may not be used to dismiss only part of a claim").

2. Vacatur is also appropriate under § 10(a)(4).

Vacatur is further warranted under § 10(a)(4) because the IDREs exceeded their authority by rendering IDR awards in the absence of jurisdiction. Review under § 10(a)(4) "is quasi-jurisdictional: a check to make sure that the arbitration agreement granted the arbitrator authority to reach the issues it resolved." *Gherardi v. Citigroup Glob. Markets Inc.*, 975 F.3d 1232, 1238 (11th Cir. 2020). In the arbitration context, "[t]he powers of an arbitrator are 'dependent on the provisions under which the arbitrators were appointed.'" *Apache Bohai Corp. LDC v. Texaco China BV*, 480 F.3d 397, 401 (5th Cir. 2007) (citation omitted). "Where arbitrators act 'contrary to express contractual provisions,' they have exceeded their powers" and the court "will vacate an award that ignores the limitation." *Id.* (citation omitted). And "where the arbitrator exceeds the express limitations of his contractual mandate, judicial deference is at an end." *PoolRe Ins. Corp. v. Organizational Strategies, Inc.*, 783 F.3d 256, 262 (5th Cir. 2015) (citation omitted).

The NSA process works differently than traditional arbitration in that "the IDR entities'

powers are derived from the language of the NSA and its related guidance," rather than an arbitration agreement. *Guardian Flight, LLC*, 711 F. Supp. 3d at 674. But the same principles apply—an IDRE exceeds its powers when it acts contrary to "a plain limitation" in the NSA. *Apache*, 480 F.3d at 401. Congress authorized IDREs to resolve only disputes involving "qualified IDR items and services" and prescribed specific eligibility requirements that must be satisfied before a dispute may proceed through the IDR process. *See* 42 U.S.C. § 300gg-111(c); 45 C.F.R. § 149.510; FAC ¶ 141. Indeed, "certified IDR entities are ***statutorily prohibited*** from making payment determinations for items and services that are not subject to the [NSA.]" 91 Fed. Reg. 33900, 33933 (June 4, 2026) (emphasis added). These requirements are "plain and unambiguous," and generally relate to simple, binary facts. *Apache*, 480 F.3d at 404. Nor is eligibility discretionary; it is a threshold condition that defines the limits of an IDRE's authority. Where that condition is absent, an IDRE is barred from adjudicating a dispute. *Cf. Allstate Ins. Co. v. N.J. Mfrs. Ins. Co.*, 325 A.3d 343, 348 (Del. Ch. Ct. 2024) (vacatur granted under similar state statute where arbitrator "had no authority" under the statute, was "wrong in accepting jurisdiction of the case," and, as a result, "exceeded his authority" in issuing an award).

Defendants' cited cases miss the mark. For example, in *BNSF R.R. Co. v. Alstrom Transp., Inc.*, 777 F.3d 785, 788–89 (5th Cir. 2015), the plaintiff argued that the arbitrators simply "botched" the legal merits of an arbitrable dispute. That is plainly different from whether an IDRE ignored simple, binary facts that statutorily deprived it of both jurisdiction and authority to address the dispute, but still issued an award. For example, claims to Medicare plans are not subject to the NSA, and whether a plan falls under Medicare does not require analysis—it is typically apparent from the name of the plan itself. But IDREs nonetheless regularly rendered IDR awards on Defendants' claims to HCSC's Medicare plans. *See* FAC ¶¶ 192–205. This is not a disputed issue;

it is simply a fact that exists and constrains the IDRE's authority. "'[A]rbitrators wield only the authority they are given.'" *Parrott v. Int'l Bancshares Corp.*, 167 F.4th 728, 735 (5th Cir. 2026) (citation omitted). Congress narrowly constrained the powers of IDREs to certain types of disputes. Defendants' position that IDREs are empowered to simply ignore those constraints with impunity and order private parties like HCSC to pay millions of dollars with virtually no legal process, on pain of an enforcement action by the federal government, simply cannot be right.

Defendants' catastrophizing about the policy implications of such a holding is neither relevant nor persuasive. Even in the context of ordinary arbitration, "where the arbitrator exceeds the express limitations of his contractual mandate, judicial deference is at an end." *PoolRe*, 783 F.3d at 262; *see, e.g.*, *Allstate Ins. Co.*, 325 A.3d at 348. This principle applies with equal or greater force here, where the element of consent is lacking and the limits are set by regulation. And it is hard to see how this could be inconsistent with the policies underlying the NSA. "Congress designed the IDR process to create an 'efficient' and streamlined vehicle for a certain category of disputes." *Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc.*, 160 F.4th 1110, 1119 (11th Cir. 2025). There is nothing inconsistent with that goal in policing the boundaries set by Congress to ensure the IDR process remains properly limited.

Indeed, substantial differences between arbitration and the IDR process counsel applying these limitations diligently here. "Arbitration 'is a matter of consent, not coercion, and parties are generally free to structure their arbitration agreements as they see fit.'" *PoolRe*, 783 F.3d at 262. That is why arbitration under the FAA typically does not implicate constitutional due process—it is a matter of private contract, enforced by private actors, and so lacks the element of state action. *See Yonir Techs., Inc. v. Duration Sys. (1992) Ltd.*, 244 F. Supp. 2d 195, 208 (S.D.N.Y. 2002).

The opposite is true of the IDR process, which is both state-mandated and state-enforced.

See Guardian Flight II, 140 F.4th at 620; *see also Nat'l Collegiate Athletic Ass'n v. Tarkanian*, 488 U.S. 179, 192 (1988) (state action exists where the government "creates the legal framework governing the conduct"); *Connecticut v. Doehr*, 501 U.S. 1, 10–11 (1991) (explaining Due Process applies where a law "enable[s] one of the parties to 'make use of state procedures with the overt, significant assistance of state officials'") (citation omitted). The IDR process simply "is not an arbitration." *Mod. Orthopaedics of NJ*, 2025 WL 3063648, at *5–7. When Congress transplanted the substantive grounds for vacatur from the FAA into the NSA, it took them from a context of consent to one of coercion. This new context comes with new constraints.

The awards at issue were rendered on ineligible claims with virtually no legal process on the front end—HCSC's objections generally were not even reviewed. If, as Defendants claim, there is no vacatur available on the back end under such circumstances, the statute raises significant due process concerns. The Court can and should interpret the statute to avoid that result. *Zadvydas v. Davis*, 533 U.S. 678, 699 (2001) (construing a statute to include limitations sufficient to meet constitutional due process). And there is no constraint on doing so, as the imported FAA provisions on vacatur are being applied in an entirely new context, with different procedural rules.

III. HCSC Has Article III Standing To Pursue Its Kickback And Reader Fraud Claims.

Defendants contend that a health insurer defrauded out of millions of dollars lacks ordinary Article III standing to recoup its losses from the responsible party. Not so. Defendants defrauded HCSC into paying millions of dollars on non-payable claims. That injury is traceable to Defendants because they procured the claims through illegal kickbacks and submitted them to HCSC. And that injury would be redressed by a judgment making HCSC whole for what it lost and prohibiting Defendants from continuing their scheme.

Injury. First, Defendants mischaracterize HCSC's allegations. "Kickbacks are designed to

influence providers' independent medical judgment" and induce them to order items or services regardless of medical necessity. *U.S. ex rel. Westmoreland v. Amgen, Inc.*, 812 F. Supp. 2d 39, 53 (D. Mass. 2011). Here, the ordering surgeons agreed to maintain an inflated volume of referrals to Defendants, regardless of patient need. FAC ¶ 54. And Defendants' reader fraud allowed them to take on more illicit referrals. *See id.* ¶ 126. Even under Defendants' incorrect view of the law, HCSC paid more than it should have. "If a defendant has caused . . . monetary injury to the plaintiff, the plaintiff has suffered a concrete injury in fact under Article III." *TransUnion LLC v. Ramirez*, 594 U.S. 413, 425 (2021). That is sufficient to dispose of Defendants' argument on this point.

In any event, Defendants' framing of HCSC's injury badly misses the mark. In contrast to the authority on which Defendants rely, HCSC neither chose to purchase anything, nor received anything for what it paid. That is not how insurance works. When Defendants perform IOM services and bill an insurer, the insurer has no say in that decision and "derives no benefit from those services; indeed, what the insurer gets is a ripened obligation to pay money to the insured—which hardly can be called a benefit." *Travelers Indemnity Co. of Conn. v. Losco Group, Inc.*, 150 F. Supp. 2d 556, 563 (S.D.N.Y. 2001). HCSC is obligated to pay some of the claims it receives and is not obligated to pay others. It covers services in some circumstances and does not in others. When Defendants deceived HCSC into covering millions of dollars in non-payable claims, HCSC did not receive a benefit for which it paid—it assumed a needless liability. *See* FAC ¶¶ 23–28, 121, 229. That is why, in cases of insurance fraud, the insurer's damages are typically deemed to be the full amount paid on fraudulent claims, regardless of any value provided to the insured.[9]

[9] *See, e.g.*, *Aetna Cas. Sur. Co. v. P & B Autobody*, 43 F.3d 1546, 1568 (1st Cir. 1994) ("Aetna is entitled to damages equal to the entire amount of its payments on fraudulent claims, regardless of any portion of the claims that might have been shown to be supportable if no fraudulent enlargement of the claims had occurred."); *Gov't Emps. Ins. Co. v. Galperin*, No. 23-cv-9241, 2025 WL 1029433, at *10 (E.D.N.Y. Feb. 24, 2025) ("[W]here each bill constitutes a fraudulent

In short, this is not a product defect case reflecting nothing more than a bare legal injury, where HCSC received something of value and is "likely better off financially" due to Defendants' fraud. *Earl v. Boeing Co.*, 53 F.4th 897, 903 (5th Cir. 2022). But for Defendants' fraudulent concealment of its kickbacks and reader fraud tainting the at-issue claims, HCSC would not have paid on said claims ***at all***. In other words, HCSC "lost money that wouldn't have been lost in a counterfactual world without [Defendants'] fraudulent scheme." *Id.* "Monetary harm is a classic form of injury-in-fact," such as where, as here, the plaintiff has been "forced to pay money it otherwise would have kept for itself" (and, in this case, would have used to pay other, valid claims). *Danvers Motor Co. v. Ford Motor Co.*, 432 F.3d 286, 293 (3d Cir. 2005).

Even beyond this straightforward monetary injury, courts around the country have held that health insurers "have a concrete and particularized interest in paying only valid claims," both based on their "business interest in only paying out valid claims" and because they expend their own "time and resources in investigating" problematic claims. *Cigna Health & Life Ins. Co. v. BioHealth Lab'ys, Inc.*, No. 3:19-CV-01324, 2025 WL 1450727, at *6–7 (D. Conn. May 20, 2025) (citations omitted). Even in the absence of a direct monetary injury, harm to these interests through payment of fraudulent claims is a sufficient injury to support a health insurer's standing.[10]

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claim, GEICO is entitled to damages in the entire amount it paid to the Defendants.").

[10] *See, e.g.*, *Aetna Inc. v. People's Choice Hosp., LLC*, No. SA-18-CV-00323, 2019 WL 12536916, at *5–6 (W.D. Tex. Mar. 28, 2019) (holding health insurer had standing to pursue claims for both self-funded and fully funded plans based on allegations that defendants submitted claims tainted by fraud, kickbacks, and misrepresentations); *Tri State Advanced Surgery Ctr., LLC v. Health Choice, LLC*, 112 F. Supp. 3d 809, 813 (E.D. Ark. 2015) (holding health insurer had standing for both self-funded and fully funded plans because it "sufficiently alleged an injury in the form of payment of fraudulent claim submissions that resulted in overpayments to [defendant provider]"); *Blue Cross of Cal., Inc. v. Insys Therapeutics Inc.*, 390 F. Supp. 3d 996, 1006 (D. Ariz. 2019) (finding direct injury and Article III standing for health insurer that alleged that defendants' "misrepresentations induced [insurer] to pay claims . . . that were not reimbursable, and that no such payments would have been made absent that conduct"); *Connecticut Gen. Life Ins. Co. v. La*

Traceability. Defendants' traceability argument falls even further afield. HCSC paid Defendants millions of dollars on non-payable claims procured through illegal kickbacks and performed by physicians who were not properly licensed and credentialed. *See* FAC ¶¶ 121–29; 223–32. Defendants caused that injury by (1) paying illegal kickbacks in exchange for referrals; (2) having physicians perform services without proper licensure or credentialing; and (3) billing the resulting non-payable claims to HCSC. *Id.* Cause and effect do not get much simpler than that. Despite Defendants' list of events recounted in the passive voice, MTD at 24, it is unclear what "unfettered choices" by third parties Defendants blame for HCSC's injury instead of their own actions—particularly given Defendants' express agreements with surgeons to order services from Defendants in exchange for kickbacks. FAC ¶¶ 54–55, 77–78, 90–91, 103–04, 116–17.

Even if the line was not so direct, it is enough for traceability that a defendant's conduct was "one of multiple contributing causes," and "uncertain or indirect causal connection may suffice at the pleading stage." *Est. of Parker v. Mississippi Dep't of Pub. Safety*, 140 F.4th 226, 236–37 (5th Cir. 2025) (cleaned up). Defendants' actions at least ***contributed*** *to* HCSC paying Defendants on the non-payable claims they submitted. Indeed, obtaining these payments from HCSC was the whole point of Defendants' scheme. *See also Insys*, 390 F. Supp. 3d at 1008 (rejecting a similar causation argument where doctors "were not exercising independent medical judgment" but "prescribing Subsys in exchange for kickbacks").

Redressability. Defendants' redressability argument is largely based on the circular contention that HCSC "has no injury for which to seek damages in the first place." MTD at 24.

Peer Surgery Ctr. LLC, No. 2:13-CV-03726, 2014 WL 961806, at *4 (C.D. Cal. Mar. 12, 2014) (same); *In re SmithKline Beecham Clinical Lab'ys, Inc. Lab'y Test Billing Pracs. Litig.*, 108 F. Supp. 2d 84, 105 (D. Conn. 1999) (same); *UnitedHealthcare Services, Inc. v. Team Health Holdings, Inc.*, No. 3:21-CV-00364, 2022 WL 1481171, at *8 (E.D. Tenn. May 10, 2022) (same).

That is wrong for the reasons discussed above—HCSC has lost millions to Defendants' scheme and risks losing more. FAC ¶¶ 69–120. Even ***nominal*** damages satisfy the redressability requirement because they are "damages paid to the plaintiff[ ] [that] 'affec[t] the behavior of the defendant towards the plaintiff' and thus independently provide redress" to the extent required by Article III. *Uzuegbunam v. Preczewski*, 592 U.S. 279, 291 (2021). And an award of injunctive or declaratory relief would head off further interference with HCSC's business from Defendants' scheme would plainly "lessen" HCSC's injury. *Inclusive Communities Project, Inc. v. Dep't of Treasury*, 946 F.3d 649, 655 (5th Cir. 2019). That is all that is required to satisfy redressability.

IV. Defendants' Attacks on HCSC's Kickback and Reader Fraud Claims Fail.

The submission of a claim for payment to a health insurer is a representation that the claim is payable. Where a party submits a claim to a health insurer knowing that it is ***not*** payable—for example, due to illegal kickbacks—and fails to disclose as much, that party has made a fraudulent misrepresentation. *See, e.g.*, *People's Choice Hosp.*, 2019 WL 12536916, at *10 (fraud adequately alleged where the defendants "omitted numerous material facts" when submitting claims "including that physicians, labs, and other individuals and entities had been paid for specimens"); *United Healthcare Servs., Inc. v. Next Health, LLC*, No. 3:17-CV-00243, 2021 WL 764035, at *5–6 (N.D. Tex. Feb. 26, 2021) (fraud adequately alleged based on "claims submitted . . . for lab services and prescriptions without disclosure that the services and prescriptions were induced by paying kickbacks to physicians").[11] That is what occurred here.

[11] *See also Connecticut Gen. Life Ins. Co. v. True View Surgery Ctr. One, LP*, 128 F. Supp. 3d 501, 514 (D. Conn. 2015) (fraud adequately alleged based on defendants' "practice of submitting claims to Cigna without disclosing a waiver of cost-share requirements"); *Connecticut Gen. Life Ins. Co. v. Advanced Surgery Ctr. of Bethesda, LLC*, No. CIV.A. DKC 14-2376, 2015 WL 4394408, at *22 (D. Md. July 15, 2015) (fraud adequately alleged based on fee waiver and dual-pricing scheme because the defendants "had a duty not to conceal or suppress material information that was necessary to qualify the true nature of their charges or billing practices").

Defendants' rejoinder is simply to invoke Rule 9(b) as a hyper-technical pleading standard. But "Rule 9(b) does not 'reflect a subscription to fact pleading' and requires only 'simple, concise, and direct' allegations of the 'circumstances constituting fraud,' which after *Twombly* must make relief plausible, not merely conceivable, when taken as true." *U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 186 (5th Cir. 2009) (citation omitted). It does not require "that a plaintiff plead the level of detail required to prevail at trial," *id.* at 189, nor plead "facts relating to the alleged fraud are peculiarly within the perpetrator's knowledge," *U.S. ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899, 903 (5th Cir. 1997). Rule 9(b) requires only "sufficient particularized detail to . . . provide fair notice to Defendant[s] of the nature of the[ ] claims against [them]." *El Paso Disposal*, 766 F. Supp. 3d at 708. Defendants cannot feign lack of notice here.

A. HCSC has pled actionable misrepresentations made by Defendants with respect to their surgeon LLC kickback scheme.

Defendants first argue[12] that HCSC has not adequately pled facts showing that Defendants made a misrepresentation or lied to HCSC regarding the kickback scheme. MTD at 26–28. Not so.

[12] Defendants do not attack HCSC's negligent misrepresentation at all, other than to say that because HCSC uses the same general factual allegations for both claims, Rule 9(b) should apply. MTD at 25 n.5. That is false. As Defendants' own case law states, "[n]egligent misrepresentation claims . . . do not become subject to heightened pleading simply because they are based on the same set of operative facts as corresponding fraud claims." *Am. Realty Tr., Inc. v. Travelers Cas. & Sur. Co. of Am.*, 362 F. Supp. 2d 744, 749 (N.D. Tex. 2005). Rather, a plaintiff must waive Rule 8's pleading standard for the claim (which HCSC does not do) or the two claims must be "so intertwined" the court cannot use a "simple redaction" to remove the former while keeping the latter. *Id.* Here, the Court could easily do so. The "primary difference" between fraud and negligent misrepresentation is that the former requires "actual intent to defraud" while the later requires only that the party making the false statement "acted negligently in doing so." *N. Cypress Med. Ctr. Op. Co. v. Aetna Life Ins. Co.*, 898 F.3d 461, 474 (5th Cir. 2018). The Court could "simp[ly] redact" any allegations of Defendants' intentional misconduct and address the allegations under the Rule 8 standard as a result. *Am. Realty Tr., Inc.*, 362 F. Supp. at 749. Regardless, as described herein, the distinction is meaningless and "essentially dissolves when the pleading satisfies Rule 9(b) in any event." *SC Shine PLLC v. Aetna Dental, Inc.*, No. SA-22-CV-0834, 2023 WL 4216989, at *21 (W.D. Tex. June 26, 2023).

HCSC alleges Defendants submitted claims for payment to HCSC, asserting they were medically necessary, appropriate, and payable, despite knowing they were non-payable and intending that HCSC would pay them anyhow out of ignorance. FAC ¶¶ 30–32. That is sufficient.

"A representation stating the truth so far as it goes but which the maker knows or believes to be materially misleading because of his failure to state additional or qualifying matter is a fraudulent misrepresentation." Restatement (Second) of Torts § 529 (1977). Indeed, one example from the Restatement is where a seller makes a nominally true statement to a buyer but fails to also disclose legal issues that may be material to the buyer's decision to pay. *Id.* at Illustration 2; *United States ex rel. Campbell v. KIC Dev., LLC*, No. EP-18-CV-193, 2019 WL 6884485, at *7 (W.D. Tex. Dec. 10, 2019) (applying "common-law meaning of fraud" under Restatement § 529 and finding actionable fraud where a contractor invoiced the government for services performed under a contract procured through illegal kickbacks absent disclosure of kickbacks). Relatedly, fraud may also occur when a party has a "duty to disclose facts" but "fails to do so." *Muhammad v. Ocwen Loan Servicing, Inc.*, No. 3:15-cv-3805, 2016 WL 2857509, at *4 (N.D. Tex. Apr. 14, 2016). That duty may arise where "one voluntarily discloses partial information, but fails to disclose the whole truth" or "one makes a partial disclosure and conveys a false impression." *Id.*

Here, Defendants submitted claims for payment and certified, via their submission, that they were payable. Indeed, the CMS-1500 form that Defendants admit they used contains an express prohibition on supplying "false, incomplete or misleading information." *See* D.E. 53-5 at 2. Defendants miss the point by effectively positing that they could only commit fraud by scrawling "this claim was not procured by illegal kickbacks" in the margin of a claim form. By submitting claims to HCSC for reimbursement, Defendants represented at minimum that ***compensable*** IOM services were rendered for the identified patients, and that Defendants were entitled to payment for

those services. That is the very meaning and purpose of submitting a claim in the first place. Defendants thus conveyed "a false impression" that the claims were eligible for payment. *Muhammad*, 2016 WL 2857509, at *4; *see also* FAC ¶¶ 23–28, 47–56, 64–66, 68–120.

Put differently, Defendants' kickback scheme negated their entitlement to payment, which Defendants knew when submitting claims for payment, rendering Defendants' representation false. *See Universal Health Servs.*, 579 U.S. at 188 (noting healthcare claims fall "squarely within the rule that half-truths—representations that state the truth only so far as it goes, while omitting critical qualifying information—can be actionable misrepresentations"). *Liberty Mut. Fire Ins. Co. v. Acute Care Chiropractic Clinic P.A.*, 88 F. Supp. 3d 985 (D. Minn. 2015) is instructive. In *Liberty*, the Court denied a motion seeking to dismiss healthcare fraud claims (including RICO and negligent misrepresentation claims) that rested on allegations that providers had submitted claims while failing to disclose that they were providing medical services in violation of state law. *Id.* at 993–995. As the court explained:

> Here, by allegedly falsely representing to Plaintiffs, through the submission of HCFA–1500 forms, that Defendants were eligible for reimbursement under the No–Fault Act, Defendants surely failed to say enough to prevent their words from misleading Plaintiffs. In fact, Defendants likely had a duty to *not* complete and submit the HCFA–1500 forms because two notices on the form expressly warned that health care providers that filed claims that contained "any misrepresentation or any false, incomplete or *misleading* information," may be subject to fines or imprisonment.

Id. at 1014 (also noting Defendants had "special knowledge . . . to which Plaintiffs did not have access"). That is what HCSC alleges.[13] FAC ¶¶ 30 (providers must "represent that the treatment provided was medically necessary and appropriate and certify that they followed all applicable

[13] HCSC also has a policy in place of not paying claims for services that violate state or federal law, including anti-kickback laws, or that otherwise amount to fraudulent billing practices. FAC ¶ 28. Defendants claim ignorance of any such policies, *see* MTD at 27, which is tantamount to claiming ignorance of applicable rules and regulations (which is not an excuse for not following them). Regardless, Defendants do not contest that HCSC is permitted to not pay fraudulent claims.

laws and regulations, have not violated applicable laws, and that their claim forms are accurate"), 31–32 (HCSC relies on providers' representations); 223–224 (submitting a claim form constitutes a representation that, among other things, the claim form is "true, accurate, and complete" and that the provider did not "knowingly or recklessly disregard or misrepresent or conceal material facts" including violations of applicable laws). Cases arising in this very context confirm this is fraud. *See, e.g.*, *People's Choice Hosp.*, 2019 WL 12536916, at *10 (holding "misleading claim forms can be basis for fraud claims"); *Next Health*, 2021 WL 764035, at *5–6 (Rule 9(b) satisfied based on allegations claims were submitted "without disclosure that the services and prescriptions were induced by paying kickbacks to physicians and, in cases, not medically necessary"); *supra* n. 11.

Defendants further assert HCSC does not plead that Defendants were aware HCSC would not pay claims tainted by kickbacks, but HCSC alleges precisely that. *See, e.g.*, FAC ¶¶ 66, 226–29. Indeed, Defendants were ***prohibited by law*** from submitting kickback-tainted claims to HCSC. *See* Texas Occupations Code § 102.001(a) (kickbacks illegal under Texas law); Tex. Health & Safety Code § 311.0025 (providers prohibited from submitting claims tainted by illegal activity to insurers); *see also* FAC ¶¶ 24–28. That is why Defendants concealed their scheme. *Id.* ¶¶ 47–58.

HCSC's Amended Complaint also supplies more than sufficient detail of the "who, what, when, where, and how" of the false representations:

Who: HCSC pleads each Defendant's respective role in the scheme and the specific individuals within Defendants that coordinated the scheme—NMA, directed by Nick Luekenga, Rommy Foteh, and Josh Smith, as the entity providing IOM services, and Physician Oversight and Monitoring Associates, among others, assisting as NMA-affiliated billing entities. FAC ¶¶ 4, 14–16, 57, 60. HCSC also provides specific examples of the individual surgeons to whom Defendants paid kickbacks—Drs. Slabisak, Subramanian, Peterson, and Kushwaha. *Id.* ¶¶ 69–120.

What and How: HCSC explains the kickback scheme in detail and why it was illegal—purchasing surgeon-owned LLCs for exorbitant prices in "sham" sales as a kickback to induce IOM referrals to NMA, in violation of Texas law. *Id.* ¶¶ 23–28, 41–67. HCSC explains that Defendants hid and did not disclose their scheme when submitting claims, *see id.* ¶¶ 7, 223, 225, and provides more than a dozen examples of fraudulent claims for the surgeons noted above, and identifies which of the two named billing entity defendants (Physician Oversight and Monitoring Associates) submitted which claim, *see id.* ¶¶ 47–58, 69–120.

When and where: HCSC gives the timeframe, location, and specific dates of numerous fraudulent claims. *Id.* ¶¶ 76–80 (August 2023 for Defendants' sham purchase of Dr. Slabisak's LLC in the Plano area, and subsequent kickback-induced claims, submitted by Physician Oversight and Monitoring Associates), 89–93 (August 2023 for Defendants' sham purchase of Dr. Subramanian's LLC in the Houston area, and subsequent kickback-induced claims, submitted by Physician Oversight and Monitoring Associates), 102–106 (June 2023 for Defendants' sham purchase of Dr. Peterson's LLC in the Austin area, and subsequent kickback-induced claims, submitted by Physician Oversight and Monitoring Associates), 115–119 (2023 for Defendants' sham purchase of Dr. Kushwaha's LLC in the Houston area, and subsequent kickback-induced claims, submitted by Physician Oversight and Monitoring Associates).

Defendants claim that HCSC only provides a dozen specific examples of fraudulent claims when it should provide hundreds. MTD at 28. But it would be "absurd" to require HCSC to "itemize with particularity each and every action that formed a part of the fraudulent scheme"; rather, HCSC "need only provide some representative examples," which it has done. *El Paso Disposal*, 766 F. Supp. 3d at 708. And while Defendants fault HCSC for not catching on to Defendants' scheme sooner, Defendants "concealed [their] illicit financial arrangement with

surgeons from HCSC and others" resulting in HCSC "unwittingly pa[ying] reimbursements to Defendants on claims tainted by kickbacks." FAC ¶ 7. Regardless, HCSC's claims are not barred simply because it did not detect the hidden scheme sooner; "regardless of the strength of [its] investigatory capabilities, [HCSC] is not barred from asserting fraud claims solely for failing to detect . . . [Defendants'] complex fraudulent schemes[.]" *Allstate Ins. Co.*, 843 F. Supp. 2d at 375.

B. HCSC's allegations plausibly allege violations of Texas state law.

Defendants next argue that their actions did not violate Texas law. Defendants' argument is two-fold: first that as a factual matter, their innocence can be inferred based on "obvious alternative and lawful explanations," and second that even if HCSC's allegations are addressed as pleaded, Defendants' conduct does not violate Texas state law. MTD at 29–34.

HCSC alleges in detail that Defendants entered into illegal kickback agreements. HCSC's allegations are not based on circumstantial evidence permitting of multiple inferences but on information received from "individuals with knowledge from their work within NMA." FAC ¶ 50. Defendants thus simply ask the Court to ***disbelieve*** HCSC's allegations. But "Rule 12(b)(6) does not countenance [] dismissals based on a judge's disbelief of a complaint's factual allegations." *Coll v. Abaco Operating LLC*, No. 2:09-CV-345, 2010 WL 11469933, at *1 (E.D. Tex. Mar. 19, 2010) (quoting *Neitzke v. Williams*, 490 U.S. 319, 327 (1989)).

HCSC alleges that Defendants paid kickbacks by purchasing worthless LLCs owned by surgeons for exorbitant sums in exchange for the surgeon's agreement to order IOM services from Defendants exclusively, at or above a certain volume, with payments from Defendants structured over time to ensure continued ordering of IOM services. *See* FAC ¶¶ 47–58. This is a classic method of paying kickbacks. *See, e.g.*, *Kuzma v. N. Ariz. Healthcare Corp.*, 607 F. Supp. 3d 942, 947 (D. Ariz. 2022) (finding a hospital paid illegal kickbacks where it acquired assets of a medical

group for more than fair market value and explaining "a court may 'infer that any excess over fair value is intended to induce referrals'"); *United States ex rel. Riedel v. Bos. Heart Diagnostics Corp.*, 332 F. Supp. 3d 48, 68 (D.D.C. 2018) (defendant paid an illegal kickback when it "paid more than the fair market value" for supplies from doctors to induce referrals).

Defendants assert the allegation that the LLCs were worthless is "utterly unsupported," and HCSC "does not plead any facts about what the price was, and why it was unreasonable." MTD at 29. But HCSC explains the LLCs existed only on paper as conduits for illegal kickbacks, lacked ordinary business activities or assets other than the kickback payments, and as soon as it became known in the industry that the OIG would be issuing an opinion regarding the LLC's business structure, they were effectively defunct. FAC ¶¶ 51–52. Yet Defendants agreed to pay hundreds of thousands of dollars for each of the LLCs—far beyond their accounts receivable or fair market value—in exchange for an agreement for referrals from physician owners. *Id*. ¶¶ 52–55.

Defendants claim that this does not "rule out . . . alternative lawful explanations," such as Defendants simply wanting to purchase these LLCs for their own mysterious reasons. MTD at 29. It is unclear where Defendants see that wiggle room. Regardless, courts "are not authorized or required to determine whether the plaintiff's plausible inference . . . is equally or more plausible than other competing inferences." *Lormand v. US Unwired, Inc.*, 565 F.3d 228, 267 (5th Cir. 2009). Factual arguments like those Defendants raise here must await a later stage of the case.

Similarly, Defendants argue HCSC "alleges that the surgeons set up the subject entities to help them order and provide IOM services for their patients" and "the doctors did not switch to different, unrelated companies for IOM" for various reasons. MTD at 29. But HCSC alleges, with examples, the exact opposite: the ordering surgeons created the LLCs solely as a conduit for illegal kickbacks and the LLCs served no role in providing IOM services before they were shut down by

the OIG opinion, FAC ¶¶ 41–46, and that the surgeons switched to ordering IOM services from Defendants specifically because Defendants paid them to do so, *id.* ¶¶ 54–55.

Finally, Defendants try to explain away the installment payments for the sham LLCs as NMA trying to remain "liquid" so it could make more acquisitions. MTD at 30. While creative, it is hard to see how the Amended Complaint permits this inference. HCSC specifically alleges that the installments were "calibrated to constitute kickbacks paid out for a period into the future" under the "guise of installment payments," and that NMA's additional LLC acquisitions was a direct result of surgeons "flock[ing] to NMA" because they could "continue to receive kickbacks in exchange for referrals" under the arrangement. FAC ¶¶ 53–56.[14]

Defendants' arguments that their conduct, as alleged, does not violate Texas law similarly fail. HCSC alleges that Defendants violated both the Texas Commercial Bribery Statute (Tex. Penal Code § 32.43) and Texas Patient Solicitation Act (Tex. Occ. Code § 102.001 *et. seq.*). With respect to the Texas Commercial Bribery statute, Defendants claim that HCSC "must prove" but "cannot establish" the "essential knowledge element" of the statute because Defendants did not know that the surgeons to whom they were paying kickbacks in exchange for referrals would "violate a fiduciary duty" to their patients, or that acceptance by the surgeons of the alleged bribes actually "influenced" their conduct towards their patients. MTD at 31.

That is false. Starting with the surgeons' fiduciary duty, the act of accepting kickbacks in exchange for referrals is generally held to be a violation of the fiduciary duty owed by physicians to patients. *See United States v. Shah*, 95 F.4th 328, 358 (5th Cir. 2024) (noting that whether or

[14] Defendants take issue with HCSC citing another lawsuit brought against it. MTD at 30. HCSC referenced that lawsuit because it disclosed internal NMA information relevant to the claims at issue here (NMA's own tracking of the kickbacks paid to surgeons), and such information (as opposed to the lawsuit on its own) renders HCSC's claims more plausible. FAC ¶¶ 60–63.

not a physician accepts a bribe under the statute is irrelevant, because even offering such a bribe constitutes a violation "regardless of whether any physician accept[s] it").[15] The American Medical Association has made clear "[p]hysicians may not accept . . . [p]ayment for services relating to the care of a patient from any health care facility/organization to which the physician has referred the patient" consistent with their fiduciary duty.[16] Defendants cannot seriously claim ignorance of a physicians' fiduciary obligation to not accept bribes to send their patients to specific providers.

As for Defendants' "knowledge" argument and claim that HCSC cannot show that kickbacks influenced physician behavior towards patients, the physicians at issue expressly agreed to (1) switch and begin ordering IOM services from Defendants, having never done so previously, and (2) to order IOM services from Defendants at or above a certain volume, regardless of patient need. FAC ¶¶ 54–56, 70, 74–80, 83, 87–93, 96, 100–106, 109, 113–119, 321. Defendants thus ***knew and intended*** that the bribes would "influence the conduct of the fiduciary [i.e., the surgeon] in relation to the affairs of his beneficiary" in the form of IOM service referrals. Tex. Penal Code § 32.43(b)–(c); Tex. Penal Code § 6.03 (noting a person acts "knowingly, or with knowledge" when they are "aware that [their] conduct is reasonably certain to cause the result"). That is the violation, as Defendants' own case law points out. *Jackson v. Radcliffe*, 795 F. Supp. 197, 206 (S.D. Tex. 1992). And where an offer to a fiduciary is at issue, "there need be no allegation of agreement or understanding that the alleged benefit will influence the fiduciary" and "[t]he offense is complete once the offer is made." 6 Tex. Prac., Texas Criminal Law § 19.9, n.4 (2d ed.).

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[15] *See, e.g.*, *Lilly v. Comm'r*, 188 F.2d 269, 271 (4th Cir. 1951), *rev'd on other grounds*, 343 U.S. 90 (1952) (explaining "receipt by the physician of secret profits through dealings with his patients" breaches the physician's fiduciary duty to patients); *Forziati v. Bd. of Registration in Med.*, 333 Mass. 125, 127–28 (Mass. 1955) ("The fee splitting operations of the plaintiff were in plain conflict with his moral obligations as a physician.").

[16] American Medical Association, AMA Code of Medical Ethics Opinion 11.3.4 (Fee Splitting) (last visited June 30, 2026), tinyurl.com/4yme2k27

Defendants next attempt to distance themselves from their alleged violations of the Texas Patient Solicitation Act (Tex. Occ. Code § 102.001 *et. seq.*) by arguing HCSC's allegations as to the statute are insufficient and that the incorporation of related federal law renders the TPSA inapplicable to this action. MTD at 32–33. The TPSA bars anyone from "offer[ing] to pay . . . directly or indirectly, overtly or covertly any remuneration in cash or in kind to . . . another for securing or soliciting a patient or patronage . . . from a person licensed, certified, or registered by a state health care regulatory agency." FAC ¶ 24. HCSC lays out, with examples, how NMA covertly paid surgeons (persons licensed by a state health care agency) bribes in the form of kickbacks (remuneration) to secure referrals (patronage) from the surgeon. *Id.* ¶¶ 47–56, 68–120.

Defendants claim that the Act's inclusion of a safe harbor for any arrangement allowed by the federal Anti-Kickback Statute means, effectively, that the TPSA only applies to federal claims. Not so. Texas courts have consistently read the TPSA to mean what it says: that it reaches kickback-tainted claims, regardless of the payor. *See, e.g.*, *DAC Surgical Partners P.A. v. United Healthcare Servs.*, Inc., No. 4:11-CV-1355, 2016 WL 7177881, at *14 (S.D. Tex. Dec. 8, 2016) (TPSA applies "to referrals for services paid . . . by private insurers"); *Aetna Life Ins. Co. v. Humble Surgical Hosp.*, LLC, No. CV H-12-1206, 2016 WL 7496743, at *2 (S.D. Tex. Dec. 31, 2016) (explaining "Texas prohibits hospitals from paying doctors to refer patients" and holding the law was violated where kickback-tainted claims were billed to private payor); *Cf. In re Little River Healthcare Holdings, LLC*, No. 18-60526, 2024 WL 4613586, at *5 (Bankr. W.D. Tex. Oct. 29, 2024) (the TSPA, by its plain terms, "appears to apply to commercial healthcare benefits").[17]

[17] The leading scholarly article on the TPSA explains why Defendants' argument is wrong based on the statute's text, legislative history, and judicial interpretations. Trenton Brown, *Health Care Referrals Out of the Shadows: Recognizing the Looming Threat of the Texas Patient Solicitation Act and Other Illegal Remuneration Statutes*, 49 St. Mary's L.J. 749, 787 (2018)

In any event, Defendants misread the safe harbor provision. Section 102.003 excludes from the TPSA only those payments, business arrangements, or payment practices that are "permitted" by 42 U.S.C. § 1320a-7b(b). Tex. Occ. Code § 102.003. That federal statute prohibits kickbacks and bribery in connection with items or services for which payment may be made under a federal healthcare program. 42 U.S.C. § 1320a-7b(b). It does not affirmatively authorize kickbacks or bribery in transactions involving private payors. Defendants nevertheless argue that because the federal statute says nothing about private-payor arrangements, those arrangements are somehow necessarily "permitted" by the statute and therefore fall within the TPSA's safe harbor. MTD at 32–33. But that argument conflates the absence of a federal prohibition with an affirmative federal authorization. Section 102.003 says no such thing; it protects only conduct explicitly "permitted" by the federal statute—*i.e.*, conduct specifically permitted by the safe harbor.

Defendants next take issue with HCSC's allegations regarding Defendants' violations of Texas's Health and Safety Codes, specifically, Tex. Occ. Code § 101.203, which incorporates Tex. Health & Safety Code § 311.0025. Defendants argue—in circular fashion—that HCSC "failed to show" that the IOM services were improper under the law because HCSC has not shown how the alleged kickbacks are illegal, illicit, or improper, and that Defendants' purchase of the surgeon's LLCs eliminated the concerns raised by the OIG. MTD at 33.[18] Not so.

Section 101.203 of Texas's Occupation Code bars a health care professional from violating Section 311.0025 of Texas' Health & Safety Code, which in turn bars a "health care professional" from submitting "to a patient or a third party payor a bill for a treatment that the . . . professional

[18] Defendants incorrectly refer to these as "another provision of the Texas Patient Solicitation Act." Tex. Occ. Code § 102.001 *et seq.* is the Patient Solicitation Act. Tex. Occ. Code § 101.203 relates to physician license revocation or denial. The provision it incorporates, Tex. Health & Safety Code § 311.0025, relates to billing practices by hospitals, facilities, or health care professionals.

knows . . . was improper, unreasonable, or medically or clinically unnecessary." That is what HCSC alleges—Defendants submitted claims for reimbursement for IOM services that Defendants knew were improper[19] because they were induced by kickbacks paid to surgeons, in violation of kickback and patient solicitation laws. FAC ¶¶ 26–27, 47–56, 68–120, 225–28 (noting Defendants "intended that their financial arrangements with referring providers remain hidden from HCSC" to induce reimbursement on otherwise non-payable claims). Defendants' assertion that the prior "doctor-owned structure" is different from the new NMA-owned structure also changes nothing, because HCSC alleges that the purchase of the LLC—and the payments made to surgeons for the purchases—***is the scheme*** for paying kickbacks inducing the IOM referrals to Defendants, tainting the whole claim with fraud. FAC ¶¶ 23–28, 47–56, 64–66, 68–120.

Finally, Defendants demand that the Court construe any ambiguities in these statutes against HCSC because they are supposedly intended to protect patients, not insurers. MTD at 33–34. Defendants cite no authority and offer no explanation as to why the Court should do so. But either way, these statutes are not ***solely*** about protecting patients. Indeed, anti-kickback laws are generally intended to guard against the inflated healthcare costs that flow from kickbacks. *See, e.g.*, *Westmoreland*, 812 F. Supp. 2d at 50 (explaining that the purpose of the federal anti-kickback statute is "[p]reservation of the public fisc"). The Commercial Bribery statute, for example, is placed in a title and chapter prescribing fraud involving "offenses against property." *See* Tex. Penal Code § 32.43. The Patient Solicitation Act obviously protects patients, but it also plainly regulates financial arrangements for obtaining patient referrals, and the Texas Legislature prohibited the

[19] While not defined by the statute, the term "improper" is defined in dictionaries and is "so well-known as to be understood by a person of ordinary intelligence"; it means "not in accord with propriety, modesty, good manners, or good taste" and "not in accord with fact, truth, or right procedure." *Ex parte Taff*, 710 S.W.3d 438, 443–44 (Tex. Ct. App. 2025).

payment practice itself, not merely patient injury. Tex. Occ. Code § 102.001. Likewise, Texas's prohibition on health care professionals sending improper bills to payors (which is designed to protect a payor like HCSC) is enshrined in statutory provisions related to managing physician's licenses. Tex. Occ. Code § 101.203; Tex. Health & Safety Code § 311.0025.

C. HCSC's IOM reader fraud allegations satisfy Rule 9(b).

Defendants' arguments against HCSC's IOM reader fraud theory also fail. In what appears to be a deliberate misreading of HCSC's allegations, Defendants call HCSC's IOM reader fraud theory an unfounded "rumor" and urge the Court to disbelieve it as "irrelevant speculation." MTD at 34–36. This is not a cognizable argument under Rule 12. *See Coll*, 2010 WL 11469933, at *1.

First, Defendants' assertion that HCSC has not alleged a misrepresentation is wrong. HCSC alleges Defendants misrepresented on claims that the ***primary*** reader for an IOM service (properly licensed and credentialed) performed the IOM reading services when, in reality, a ***secondary*** reader (not licensed or so credentialed) performed the service, hiding behind the primary reader's name. FAC ¶¶ 125, 129. Misrepresenting who performed a medical service, and their qualifications for doing so, is universally understood to render a claim fraudulent.[20]

Second, contrary to Defendants' argument, the fact that HCSC did not explicitly identify in its complaint the numerous Texas statutes and rules applicable to the provision of medical care in Texas does not render its IOM reader fraud theory deficient. HCSC alleges an IOM reader

[20] *See Waldmann v. Fulp*, 259 F. Supp. 3d 579, 594 (S.D. Tex. 2016) (noting that "intentionally provid[ing]" the wrong physician on a medical claim for reimbursement is "a false claim"); *United States v. Mackby*, 261 F.3d 821, 826 (9th Cir. 2001) (observing in the FCA context that "a claim may be false even if the services billed were actually provided, if the purported provider did not actually render or supervise the service"); *U.S. ex rel. Walthour v. Middle Ga. Family Rehab, LLC*, No. 18-cv-00378, 2022 WL 1182817, at *6 (M.D. Ga. Apr. 20, 2022) ("It has long been accepted that claims submitted for reimbursement under the name of a provider who did not actually render the services constitute false claims.").

"must . . . be credentialed with the rendering facility and licensed in the state where the facility is located to perform the reading" and that such requirements are "important safeguards of patient safety." FAC ¶ 123. That is all that is required; a plaintiff need not provide "exposition of [its] legal argument" in its complaint. *Skinner v. Switzer*, 562 U.S. 521, 530 (2011). In any event, Texas law requires remote IOM readers (which are physicians) to be licensed and credentialed at the facility where the patient receives care.[21] The Texas Medical Board explicitly states that "a physician ***may not*** provide telemedicine medical services to patients in Texas unless they hold a ***full*** Texas medical license, [unless they] held an out-of-state telemedicine license as of [9.1.22]." 22 Tex. Admin. Code § 175.1 (emphasis added). HCSC is only obligated to pay for remote services provided by licensed providers. Tex. Ins. Code § 1455.004(e) (requiring payment for telemedicine medical services by an out-of-state provider to a Texas patient ***if*** the provider is "licensed or otherwise authorized" in, and has an office in, Texas).

Third, HCSC alleges all the particulars necessary to satisfy Rule 9(b) in pleading its IOM reader fraud theory. Based on information from a former employee, HCSC alleges the who, what, when, where, how, and even the why, behind the fraud: since at least May 2022, on numerous claims, Defendants misrepresented to HCSC that a properly licensed/credentialed reader performed the IOM service when in reality, a non-licensed or non-credentialed reader did it instead, for IOM services provided to patients of at least two facilities, Baptist Hospital in San Antonio, TX, and UT Tyler Hospital in Tyler, TX. FAC ¶¶ 123–25. NMA made the

[21] *See* Tex. Occ. Code § 151.002(a)(13) (defining "practicing medicine" as the "diagnosis" of a disease or injury by "any system or method" by physicians or those who charge for their services); Tex. Occ. Code § 111.001(4) (defining "telemedicine medical service" as a health care service delivered by a physician "licensed in this state" or acting under a licensed physician's delegation/supervision, to a patient at a different physical location than the physician); Tex. Occ. Code § 155.001 (requiring any person practicing medicine to hold a Texas license); Tex. Health & Safety Code § 241.101 (noting hospitals may determine who may provide care to their patients).

misrepresentations so it could make more money by billing for IOM services at facilities it could not otherwise do so because a properly credentialed/licensed reader was unavailable. *Id.* ¶ 126. Beyond these allegations, the relevant information is "uniquely in the possession and . . . control of" Defendants, and it is "not necessarily the plaintiff's responsibility to provide that information in her complaint"; a court should "take into account [plaintiff's] limited access to crucial information" *System One Holdings LLC v. Campbell*, No. 1:18-cv-54, 2018 WL 4290459, at *8 (S.D. Tex. Aug. 21, 2018) (internal citation omitted), *rep. & rec. adopted*, 2018 WL 4283127 (S.D. Tex. Sept. 7, 2018). Defendants 9(b) arguments fail.

V. HCSC Plausibly Alleges Defendants Violated RICO.

HCSC alleges two separate violations of 18 U.S.C. § 1962(c). The first arises from an association-in-fact enterprise among Defendants, and referring surgeons ("Ordering Surgeons"), to pay illegal kickbacks in exchange for exclusive or near-exclusive referrals of IOM services—a coordinated and classic pattern of commercial bribery and wire fraud (the "IOM Referral Enterprise"). FAC ¶¶ 290–328. The second arises from a related, association-in-fact enterprise layered on top of this scheme, through which Defendants systematically submitted ineligible claims into the IDR process using false eligibility attestations to obtain inflated awards to which they were not entitled (the "IDR Submission Enterprise"). FAC ¶¶ 329–34. Both sets of claims require that the Defendants "engaged in (1) conduct (2) of an enterprise (3) through a pattern (4) of racketeering activity." *Molina-Aranda v. Black Magic Enterprises, L.L.C.*, 983 F.3d 779, 784 (5th Cir. 2020). The FAC readily satisfies each of these elements for both theories.

A. HCSC plausibly alleges a claim for the IOM referral enterprise.

1. HCSC adequately pleads a RICO injury.

Defendants first recycle their standing argument, asserting HCSC suffered no injury

because the IOM services were medically necessary and actually performed. MTD 38–40. This argument fails for the same reasons stated above as to Article III standing. *See supra* Arg. § III.

"[F]or a plaintiff to have standing to sue under RICO, the plaintiff must satisfy two elements—injury and causation." *Williams v. Steward Health Care Sys., LLC*, No. 5:20CV123, 2021 WL 7629734, at *27 (E.D. Tex. Dec. 16, 2021) (citation omitted). Those standards are readily satisfied here for the same reasons as above. *See supra* Arg. § III. *First*, "[k]ickbacks are designed to influence providers' independent medical judgment" and induce them to order items or services regardless of medical necessity. *Westmoreland*, 812 F. Supp. 2d 39, 53 (D. Mass. 2011). Here, ordering surgeons agreed to maintain an artificially inflated volume of referrals to Defendants, FAC ¶ 54, and Defendants' reader fraud allowed them to take on more illicit referrals, *see id.* ¶ 126, causing HCSC to pay more on claims it otherwise would not have paid. *Second*, contrary to Defendants' claim that "HCSC does not dispute that it must pay for IOM services that its insureds receive," MTD at 39, HCSC does ***not*** pay for IOM (or any other) services tainted by illegal kickbacks or performed by unauthorized providers, and receives no benefit when it does. FAC ¶¶ 23–28, 121–29; *supra* Arg. § III. *Third*, even apart from these losses, HCSC was injured in its business by virtue of having paid fraudulent claims and being forced to expend resources to combat Defendants' plot. *See supra* Arg. § III. Facing similar arguments, Courts found that is sufficient for RICO standing. *See People's Choice*, 2019 WL 12536916, at *6. Defendants' efforts to import standing arguments from different contexts continue to be a square peg meeting a round hole.

After rehashing their Article III standing argument, Defendants repeat their argument that the Court should ignore the text of the Texas statutes prohibiting its conduct because, Defendants contend, those statutes are intended to protect patients, not insurers. MTD at 40. This is the third time Defendants raise this point without explaining any legal basis for their argument or where

this alleged purpose or "policy" came from. In the end, Defendants concede that HCSC has RICO standing so long as Defendants' "conduct directly caused it to pay money it otherwise would not have paid." *Id.* at 40. For the reasons discussed above, HSCS alleges just that. *See supra* Arg. § III.

2. HCSC adequately pleads the predicate act of wire fraud.

Defendants offer a brief, citation-free argument regarding wire fraud: that HCSC "has not alleged with specificity a fraudulent statement that any Defendant made to HCSC." MTD at 41. That argument fails for the reasons discussed above. *See supra* Arg. § IV(A). But it also misapprehends the nature of wire fraud. While HCSC thoroughly alleges the false claims Defendants submitted, the statute does not even require this much. It only requires that they "devised or intend[ed] to devise any scheme or artifice to defraud" using mails or wires "for the purpose of executing" the scheme. 18 U.S.C. §§ 1341, 1343. A scheme to defraud can be shown where "(1) there was a 'deliberate plan of action' or 'course of conduct' to hide or misrepresent information; (2) the hidden or misrepresented information was material; and (3) the purpose was to get someone else to act on it." *United States v. Luna*, 968 F.3d 922, 926 (8th Cir. 2020). So much like in this case, courts have found a scheme to defraud where defendants concealed "paying kickbacks" so private payors would fail to realize they had "no obligation to pay" resulting claims, and so were deceived into paying tainted claims. *Id.* at 926–28 (upholding convictions for mail and wire fraud and conspiracy to defraud insurers based on recruitment/kickback scheme).

"Because '[t]he mail and wire fraud statutes are broader than a claim of common law fraud,' it is possible for a plaintiff to sufficiently plead mail or wire fraud while nevertheless failing to plead common law fraud," and "'the actual transmissions that use the mails and wires do not have to be false or contain misrepresentations—only the scheme must be fraudulent.'" *Evercrete Corp. v. H-Cap Ltd.*, 429 F. Supp. 2d 612, 623 (S.D.N.Y. 2006) (citations omitted). Defendants

used the wires in numerous ways in perpetrating the scheme—for example, in paying kickbacks, submitting claims, and receiving payment from HCSC. FAC ¶ 310. To be sure, Defendants' claims to HCSC were also fraudulent, and this independently supports a claim for wire fraud.[22] But even if Defendants' claims to HCSC were ***not*** independently fraudulent, they still committed wire fraud.

3. HCSC adequately pleads the predicate act of commercial bribery.

HCSC also alleges that the IOM Referral Enterprise violated Texas Penal Code § 32.43 (Texas's prohibition on commercial bribery) by offering and paying funds to referring surgeons in exchange for referring their patients to Defendants for IOM services. FAC ¶¶ 320–22. Defendants first argue that Texas's commercial bribery statute "has no private right of action." MTD at 41. That is irrelevant; RICO provides the cause of action. *Aetna Life Ins. Co. v. Behar*, No. CV H-15-491, 2020 WL 2596803, at *2 n.9 (S.D. Tex. Apr. 27, 2020) (noting "[Section] 32.43 does not give rise to a private cause of action" but its "irrelevant" as "RICO gives rise to a private cause of action"); *Samsung Elecs. Am., Inc. v. Yang Kun Chung*, No. 3:15-CV-4108, 2017 WL 635031, at *6 (N.D. Tex. Feb. 16, 2017) (holding violations of [Section] 32.43 serve as RICO predicate acts).

Defendants next argue, without elaboration, that "HCSC has not pleaded facts supporting each required element of the offense." MTD at 41. That argument fails for the reasons set forth above. *See supra* Arg. § IV(B).

4. HCSC adequately pleads the existence of an enterprise.

Defendants conclude their RICO arguments by asserting that HCSC has failed to

[22] *See, e.g.*, *Aetna Life Ins. Co. v. Behar*, No. CV H-15-491, 2019 WL 4195355, at *16 (S.D. Tex. Aug. 5, 2019) (explaining "[f]or . . . mail-and-wire-fraud RICO allegations, the submissions of healthcare claims comprised the predicate acts"); *Allstate Indem. Co. v. Bhagat*, 164 F.4th 426, 434 (5th Cir. 2026) ("fraudulent billing" constituted wire fraud); *State Farm Mut. Auto. Ins. Co. v. Misra*, 658 F. Supp. 3d 362, 376 (W.D. Tex. 2023) ("prepar[ing] fraudulent bills and supporting medical documents" constituted "predicate act[s] of mail fraud").

adequately allege an association-in-fact enterprise between Defendants and the Ordering Surgeons. MTD at 42–43. Here again, Defendants' argument misrepresents HCSC's actual allegations.

A RICO enterprise may consist of either "a legal entity or an association-in-fact." *Allstate Ins. Co. v. Benhamou*, 190 F. Supp. 3d 631, 648 (S.D. Tex. 2016). An association-in-fact enterprise is simply "a group of persons associated together for a common purpose" and is established through evidence of "an ongoing organization, formal or informal," whose members "function as a continuing unit." *United States v. Turkette*, 452 U.S. 576, 583 (1981). An association-in-fact enterprise requires only "[1] a purpose, [2] relationships among those associated with the enterprise, and [3] longevity sufficient to permit these associates to pursue the enterprise's purpose." *Boyle v. United States*, 556 U.S. 938, 946 (2009).

HCSC plausibly alleges all three required characteristics. Defendants and the Ordering Surgeons shared the common "purpose" of enriching themselves through illegal kickbacks that generated exclusive or near-exclusive referrals of IOM services and, ultimately, reimbursement from HCSC. FAC ¶¶ 293–97. Their relationships were not ordinary vendor-customer relationships; the relationships included express agreements under which Defendants paid illegal remuneration to surgeons in exchange for referrals. *Id*. ¶¶ 295–306. And those coordinated relationships persisted for years, allowing the enterprise to repeatedly carry out its purpose through kickback payments, referrals, claim submissions, and reimbursements. *Id*. ¶¶ 296, 310–26.

Defendants attempt to recast these allegations as nothing more than "reasonable commercial activity" involving the ordering and provision of IOM services. MTD at 43. Ignoring HCSC's allegations will not make them go away. HCSC does not allege merely that surgeons referred patients to IOM providers or that Defendants submitted claims for reimbursement. It alleges that Defendants ***paid illegal kickbacks to induce those referrals, concealed those unlawful***

financial relationships, and submitted reimbursement claims to HCSC tainted by the resulting commercial bribery. FAC ¶¶ 47–66, 223–32, 295–326. Coordinated commercial bribery and fraudulent billing are not "ordinary commercial relationships"—they are coordinated criminal conduct. *See, e.g.*, *Unitedhealthcare Servs., Inc. v. Team Health Holdings, Inc.*, No. 3:21-CV-00364, 2022 WL 1481171, at *11 (E.D. Tenn. May 10, 2022) (RICO enterprise found where billing company coordinated with physicians to submit fraudulent claims to an insurer).

B. HCSC is preserving its claims regarding the IDR Submission Enterprise.

As discussed above, HCSC acknowledges that—apart from vacatur—its claims based on the IDR process are foreclosed by the Court's Order in *HaloMD*, to the extent it is upheld on appeal. *See supra* Arg. § I. HCSC has pled these claims to preserve them for appeal, or in the event vacatur is granted. HCSC nonetheless responds below to preserve its arguments on this score out of an abundance of caution.

Defendants principally argue that their transmission of false eligibility attestations and submissions through interstate wires cannot constitute wire fraud because those misrepresentations occurred as part of the IDR process. MTD at 36–38. But the authorities on which Defendants rely are inapposite. They address attempts to convert litigation conduct itself into predicate acts of mail or wire fraud. *See United States v. Pendergraft*, 297 F.3d 1198, 1206–09 (11th Cir. 2002); *Snow Ingredients, Inc. v. SnoWizard, Inc.*, 833 F.3d 512, 524–25 (5th Cir. 2016). They do not immunize parties who access statutory processes by making false certifications required to participate. For example, in *Bridge v. Phoenix Bond & Indemnity Co.*, bidders were held to have committed wire fraud where they falsely certified compliance with statutory bidding rules to obtain tax liens. 553 U.S. 639, 643 (2008). Courts have also sustained wire fraud convictions where defendants falsely certified eligibility for government contracting or grant programs. *See United States v. Maxwell*,

579 F.3d 1282, 1300 (11th Cir. 2009); *United States v. Pinson*, 860 F.3d 152, 170 (4th Cir. 2017).

Even where courts have recognized a litigation-activity doctrine, they have recognized an exception where there is a "multiplicity of wrongful suits." *Relevant Grp., LLC v. Nourmand*, No. 2:19-CV-05019, 2022 WL 2916860, at *11 (C.D. Cal. July 25, 2022) (citing cases); *see also Carroll v. U.S. Equities Corp.*, No. 1:18-CV-667, 2020 WL 11563716, at *9 (N.D.N.Y. Nov. 30, 2020) ("*Kim* leaves open the door for RICO claims premised on abusive litigation activities involving conduct beyond a single lawsuit."). And Defendants' reliance on this doctrine is further undermined by the fact that "The NSA is not an arbitration" or a litigation and the "differences pervade the IDR and arbitration processes." *Orthopaedics of NJ*, 2025 WL 3063648, at *5–7.[23]

VI. HCSC States a Claim For Money Had and Received.

Defendants first contend that "[a]fter dismissing the federal claims, the Court should not exercise its supplemental jurisdiction" over HCSC's state law claims. MTD at 43. Setting aside that HCSC's federal claims are adequately pled, the Court has diversity jurisdiction. FAC ¶ 17.

Beyond jurisdiction, to prevail on a claim for money had and received, "[a]ll [the] plaintiff need show is that defendant holds money which in equity and good conscience belongs to him," making the claim "less restricted and fettered by technical rules and formalities than any other form of action." *Bank of Saipan v. CNG Fin. Corp.*, 380 F.3d 836, 840 (5th Cir. 2004) (citation omitted). Rather, this claim "aims at the abstract justice of the case." *Id.* (citation omitted).

Defendants argue that HCSC cannot recover on this claim for their serial violations of the law, even if Defendants acted inequitably, because "the IOM services" stemming from referrals procured by kickbacks "were medically necessary [and] . . . actually provided." MTD at 44. It is

[23] Should vacatur be granted, or HCSC prevail on appeal, HCSC reserves the right to provide additional briefing on its IDR-based claims as appropriate.

unclear why that matters and Defendants make no effort to explain. Ultimately, as Defendants' own authority recognizes, a claim for money had and received will lie "by a defrauded party against the party who committed the fraud."[24] *Baylor Scott & White v. Project Rose MSO, LLC*, 633 S.W.3d 263, 293 (Tex. Ct. App. 2021). Insurers have thus recovered the full amounts of their loss where they paid fraudulent claims, even when the services underlying those claims were in fact performed. *RightCHOICE Managed Care, Inc. v. Hosp. Partners*, 109 F.4th 1054, 1064 (8th Cir. 2024) (affirming a jury verdict on money-had-and-received claim, awarding an insurer the full amount they paid on fraudulent insurance claims for testing the defendants in fact performed).

Nor, for that matter, do Defendants explain why their other malfeasance is immune to this claim. For example, insurers have recovered on a theory of money had and received where, as here, providers obtained their money through violations of Texas' anti-kickback laws. *See Humble*, 2016 WL 7496743, at *2 (awarding an insurer the amount they paid to a provider passed on as kickbacks). Given that money-had-and-received is not "restricted and fettered by technical rules and formalities," Defendants motion to dismiss should be denied. *Bank of Saipan*, 380 F.3d at 840.

VII. HCSC Is Entitled To Declaratory and Injunctive Relief.

Defendants conclude their brief with a cursory request that the Court dismiss HCSC's requests for declaratory and injunctive relief. This request is premature at the Rule 12 stage. While HCSC enumerates its request for injunctive and declaratory relief as separate counts, these are remedies HCSC may obtain through an underlying claim. *See HaloMD*, 2026 WL 1557492, at *7 (explaining "an injunction is a remedy rather than an independent cause of action" and dismissing the underlying cause of action). Standing alone, a "dispute over Plaintiff's request for relief is not

[24] Indeed, the court in *Baylor Scott & White* found that the plaintiff had adequately pled a claim for money had and received. *Baylor Scott & White*, 633 S.W.3d at 293–94.

a proper basis for dismissal under a Rule 12(b)(6) motion," because "[w]hether a claim for relief should be dismissed under Rule 12(b)(6) turns not on whether all of the relief asked for can be granted, but whether the plaintiff is entitled to *any* relief." *Mott's LLP v. Comercializadora Eloro, S.A.*, 507 F. Supp. 3d 780, 791 (W.D. Tex. 2020). Courts thus generally "decline to address whether a complaint has adequately pleaded facts supporting entitlement to a demanded form of relief," reserving that question for decision on a developed record. *Sec. & Exch. Comm'n v. Musk*, No. CV 25-105, 2026 WL 279790, at *66 (D.D.C. Feb. 3, 2026).

In any event, Defendants' substantive arguments miss the mark. With respect to declaratory relief, Defendants rehash their claim that HCSC lacks standing (which fails, *see supra* Arg. § III) and argue that HCSC's substantive claims fail (which, as described elsewhere in this brief, is wrong). As for injunctive relief, Defendants are incorrect that HCSC has only a monetary stake in stemming Defendants' ongoing fraud. Insurers have "a concrete and particularized interest in paying only valid claims" based on their "business interest" in doing so, and their expenditure of their own "time and resources in investigating" fraudulent claims. *BioHealth Lab'ys, Inc.*, 2025 WL 1450727, at *6–7. Courts have found health insurers to have standing to seek injunctive relief based on these interests when faced with similar schemes. *See, e.g.*, *People's Choice Hosp.*, 2019 WL 12536916, at *6, *23. Defendants will continue to cause harm to these interests so long as their fraud continues, and both declaratory and injunctive relief should ultimately be granted.

CONCLUSION

The Court should deny Defendants' motion as set forth above.

Dated: July 10, 2026

By: */s/ John K. Harting*

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CERTIFICATE OF SERVICE

I, John K. Harting, hereby certify that on July 10, 2026, a true and correct copy of the above, with a proposed order, was served via e-mail through the Eastern District of Texas's CM/ECF system.

s/John K. Harting
John K. Harting

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TEXARKANA DIVISION

HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY, *Plaintiff*, v. NEUROMONITORING ASSOCIATES, LLC, PHYSICIAN OVERSIGHT, LLC, and MONITORING ASSOCIATES LLC, *Defendants*.	Case No. 5:26-cv-00022-RWS-JBB **[PROPOSED] ORDER DENYING DEFENDANTS' MOTION TO DISMISS**

Pending before the Court is Defendants' motion to dismiss and request for judicial notice (D.E. 53). Having reviewed the briefing and based on the oral arguments of counsel, the Court makes the following rulings: Defendants' motion to dismiss is **DENIED**.