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 ORAL ARGUMENT REQUESTED

DEFENDANTS' MOTION TO DISMISS THE AMENDED COMPLAINT AND REQUEST FOR JUDICIAL NOTICE

John M. Pickett
Texas Bar No. 15980320
LAW OFFICES OF JOHN M. PICKETT
4122 Texas Blvd.
Texarkana, TX 75503
Telephone: (903) 794-1303
Fax: (903) 792-5098
jpickett@jpickettlaw.com

Matthew L. Knowles (*pro hac vice*) (Lead attorney)
Asseret Frausto (*pro hac vice*)
Carolyn Zaccaro (*pro hac vice*)
MCDERMOTT WILL & SCHULTE LLP
200 Clarendon Street
Boston, MA 02116
Telephone: (617) 535-4000
Fax: (617) 535-3800
mknowles@mcdermottlaw.com
afrausto@mcdermottlaw.com
czaccaro@mcdermottlaw.com

R. Bray McDonnell (*pro hac vice*)
MCDERMOTT WILL & SCHULTE LLP
500 N Capitol Street NW
Washington, D.C. 20001
Telephone: (202) 756-8000
Fax: (202) 756-8087
rmcdonnell@mcdermottlaw.com

Attorneys for Defendants

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MOTION TO DISMISS AND REQUEST FOR JUDICIAL NOTICE

Defendants Neuromonitoring Associates, LLC ("NMA"); Monitoring Associates, LLC; and Physician Oversight, LLC (together, "Defendants") move to dismiss Plaintiff Health Care Service Corporation ("HCSC")'s amended complaint (Dkt. No. 40) ("AC") under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6). The Defendants also request that the Court take judicial notice of the undisputed contents of the government forms and documents attached as Ex. 1–5.

I. INTRODUCTION AND SUMMARY OF THE ARGUMENT

In this case, HCSC offers three fraud theories, but each fails at the pleading stage. Bundling three deficient theories together in one complaint does not bolster any of them. This case should be dismissed with prejudice under Rules 12(b)(1) and 12(b)(6).

The first theory (the "NSA Theory") is foreclosed by Judge Schroeder's ruling in *HaloMD*. *Blue Cross Blue Shield of Texas v. HaloMD, LLC*, No. 5:25-CV-132-RWS, 2026 WL 1557492 (E.D. Tex. May 22, 2026) ("*HaloMD*"). This theory invokes RICO and state-law claims to seek review of No Surprises Act ("NSA") arbitration awards. But this is precisely the theory that the Court rejected in *HaloMD*. In light of that ruling, HCSC concedes it pleads these claims only to preserve them for appellate review. *See* AC at 38 n.24.

Indeed, in *HaloMD*, the Court held that the "NSA forecloses judicial review." 2026 WL 1557492, at *3. And *HaloMD* is indistinguishable: in both cases, the same affiliated plaintiff entities advanced the same theory through the same counsel, and both cases fail for the same reasons. In holding that the NSA bars judicial review, the Court reasoned that "inherent in the NSA's bar of judicial review of payment determinations is a limitation on the review of eligibility decisions" and that Blue Cross's claims were "an impermissible collateral attack on the [independent dispute resolution ("IDR")] awards." *Id.* at *4. The Court's decision was unequivocal and dismissed the case with prejudice for lack of subject-matter jurisdiction. Absent an intervening

decision from the Fifth Circuit, the same outcome should follow here.[1]

The only addition to the NSA Theory here is a count seeking vacatur under the Federal Arbitration Act ("FAA"), 9 U.S.C. § 10. *See* AC at Count XI, p. 72 ("VACATUR OF NSA AWARDS UNDER 9 U.S.C. § 10"). HCSC asks the Court to vacate "thousands" (AC ¶ 220) of arbitration awards. It does not list or identify the thousands of arbitrations in question, state who the parties were, plead when they happened, or offer the required facts and evidence to show why they must be vacated. This fails both procedurally and substantively. The statute that HCSC invokes (9 U.S.C. § 10) expressly requires an "application" (not merely a complaint) filed by a "party to the arbitration" (which HCSC is not) and it must be supported by "clear and convincing evidence" (of which HCSC offers none). 9 U.S.C. § 10; *Morgan Keegan & Co. v. Garrett*, 495 F. App'x 443, 447 (5th Cir. 2012); *Garber v. Sir Speedy, Inc.*, 1996 WL 734947, at *4–5 (N.D. Tex. Dec. 11, 1996) ("The requirement to present such applications by motion rather than in the form

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[1] Indeed, while HCSC and its affiliates have been filing these cases across the country, each court to rule on the theory to date has rejected it. *See Anthem Blue Cross Life & Health Ins. Co. v. HaloMD LLC*, 2026 WL 982629, at *7–10 (C.D. Cal. Apr. 9, 2026) (holding that Blue Cross plaintiffs failed to satisfy vacatur under the FAA where, as here, they "objected to eligibility for all the sample determinations identified in the" complaint but lost on this issue at arbitration, essentially "plead[ing] itself out of court"); *Aetna Health Inc. v. Radiology Partners, Inc.*, 2026 WL 1556164, at *3–4 (M.D. Fla. Apr. 16, 2026) (rejecting an insurance company's request to relitigate IDR arbitration awards that it called "fraud" based on arguments that it raised or could have raised during the arbitration and rejecting the insurance company's effort to use other statutes and causes of action "to end-around the NSA and FAA strictures," and held that use of state law to do so is preempted); *United HealthCare of Pa., Inc. v. Northstar Anesthesia of Pa., LLC*, 2026 WL 1145885, at *12–14 (E.D. Pa. Apr. 28, 2026) (holding that the court lacked jurisdiction over the insurer's common-law fraud claim where it sought equitable relief, recognizing that the insurer made "essentially the same arguments" as "rejected in *Anthem,*" *supra*, and reasoning that the insurer was "trying to evade Congress's policy choices in limiting judicial review because UnitedHealthcare believes the [NSA] leaves it with an inadequate remedy"); Order at 7–11, *Guardian Flight LLC v. Aetna Life Ins. Co.*, No. 3:24-cv-00680 (D. Conn. June 16, 2026), Dkt. 389 ("*Guardian Flight III*") (granting motion to dismiss claims premised on eligibility for IDR because the NSA provides for an "exclusive procedure" to challenge awards and allowing the claims would "permit a workaround to the barrier to plenary judicial review Congress imposed").

of a complaint is founded upon the fundamental policy of the FAA to provide for expedited judicial review by preventing the losing party from relitigating the matter by means of filing a new suit in federal court." (citations omitted)). This procedural requirement has an important policy rationale: a party cannot file a notice-pleading complaint and then use discovery to investigate thousands of unidentified arbitrations in hopes of gathering the evidence needed to make its "application" later. *See Baylor Health Care Sys. v. Equitable Plan Servs., Inc.*, 955 F. Supp. 2d 678, 688 n.1 (N.D. Tex. 2013); *Garber*, 1996 WL 734947, at *4–5. And the FAA requires that such applications be filed within three months of the arbitration, which HCSC fails to do here. 9 U.S.C. § 12. Put simply, seeking blanket and summary vacatur of thousands of unidentified arbitrations flunks every requirement of the statute that Count XI invokes.

Nor does HCSC meet the substantive test for showing fraud that could not have been raised during the arbitration, or that any particular arbitrator exceeded its powers. *See* 9 U.S.C. § 10(a). In fact, not only does HCSC fail to plead facts to meet any of these four scenarios for review under the FAA, it includes allegations that categorically rule them out. It is a brightline rule under the NSA and FAA that the losing side in an arbitration cannot relitigate the matter in court simply by alleging that the other side's arguments were fraudulent, particularly where the losing side knew about and raised the same objections in the arbitration. *See Guardian Flight, L.L.C. v. Med. Evaluators of Tex. ASO, L.L.C.*, 140 F.4th 613, 620–21 (5th Cir. 2025) ("*Guardian Flight II*"); *Barahona v. Dillard's, Inc.*, 376 F. App'x 395, 397–98 (5th Cir. 2010); *Anthem*, 2026 WL 982629, at *8. Likewise, that the arbitrator reached a decision that HCSC disagrees with does not mean that the arbitrator exceeded its powers; the losing side in any arbitration could try that argument, which is why precedent squarely rejects it.

* * *

HCSC's second theory (the "Practice-Acquisition Theory") relies on rhetoric to disguise why it fails as a matter of law. The following is HCSC's theory: years prior, NMA's *competitors* had arrangements to provide intraoperative neuromonitoring ("IOM") services where the surgeons owned the IOM companies to which they referred work. AC ¶¶ 42–43. A government agency opined that the competitors' approach could violate federal law as to claims submitted to the federal government. AC ¶¶ 44–46. After that, some surgeons sold their IOM companies to the Defendants, AC ¶¶ 49, and some did not switch to new providers, AC ¶¶ 78, 91, 104, 117. HCSC labels these corporate acquisitions as "kickbacks" and says they violate Texas law. AC ¶¶ 54, 65.

To be clear, HCSC does not allege a single instance where it claims IOM was not medically necessary, where HCSC was charged at a different price, or any other way in which the practice acquisitions affected it or harmed it, or that HCSC would be situated differently if those acquisitions had not happened or the surgeons' or the Defendants' businesses were structured differently. Instead, HCSC argues that the structure of the practice acquisitions violates Texas law. But HCSC does not have standing to litigate this: it has not suffered a concrete injury that is traceable to the challenged conduct. *See Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992); *Earl v. Boeing Co.*, 53 F.4th 897, 903 (5th Cir. 2022) (no injury and no standing where passengers alleged they would not have bought tickets on an airplane that did not satisfy regulatory standards).

And there is another problem: the Texas laws that HCSC cites do not provide a private right of action. HCSC cannot sue under them directly, and has not attempted to do so here. Instead, it relies on a multi-step fraud theory: "The submission of a claim for reimbursement to HCSC also ***constitutes*** a certification and representation of compliance" with certain HCSC "Kickback Policies" which in turn supposedly require compliance with Texas law. AC ¶ 224 (emphasis added). The word "constitutes" does too much work in this sentence. Fraud is a lie, and there are

no facts alleged to show a lie here. HCSC has not pleaded what the Defendants actually said that was false. It references "representations made on a claim form," AC ¶ 32, but never says what they are, notwithstanding its obligation under Rule 9(b) to plead with specificity. As HCSC notes, NMA submits claims using "standard healthcare 'claims forms'" (an example of this government form is attached as Exhibit 4). AC ¶¶ 29–32. For example, these forms make no representation about NMA's corporate structure or compliance with HCSC's policies. In short, its fraud count fails for lack of fraud.

* * *

Last, HCSC adds a third theory (the "Credentialing Theory") that amounts to no more than a vague rumor. According to an unnamed source, "some" IOM services were performed by providers who were either not licensed in the right state or not credentialed at the right hospital. It says that the Defendants use a "primary" and "secondary" reader for each IOM case. AC ¶ 124. While HCSC does not dispute that the primary reader was always licensed and credentialed, it says that sometimes the secondary reader was not credentialed or licensed in the relevant hospital or geography. *Id.* But only one reader is required, and HCSC has not pleaded a single case where either the secondary reader was not licensed or credentialed, or the primary reader did not in fact perform the reading. HCSC lacks standing here too. And it has pleaded no facts or details whatsoever, despite the requirements of Rule 9(b). This claim amounts to nothing more than a rumor based on anonymous sources. *See* AC ¶ 128. This unsupported addition, haphazardly grafted onto the amended complaint, does not even satisfy the lower bar of Rule 8.

II. BACKGROUND AND PROCEDURAL HISTORY

A. NMA and IOM services

IOM services are procedures that monitor neural pathway integrity (i.e., nerve and brain function) in real time during certain neurosurgical, orthopedic, and vascular surgeries. AC ¶ 33.

This involves off-site neurologists monitoring nerve function during surgeries. AC ¶ 36. There is no allegation or dispute about the medical necessity of these services, or that they were performed safely to proper standards.

NMA provides IOM services to independent surgeons nationwide. AC ¶ 39. To that end, NMA operates through several entities that furnish IOM services to doctors and file claims for reimbursement from insurance companies for their work. AC ¶¶ 14–16. Defendants Physician Oversight, LLC and Monitoring Associates, LLC are two such entities. AC ¶¶ 15–16.

Rather than using an outside company like NMA, some surgeons refer IOM work to companies that they own. But in 2023, the federal Department of Health and Human Services ("HHS") Office of the Inspector General ("OIG") issued Advisory Opinion No. 23-05, finding that self-referral to *surgeon-owned* IOM providers might violate the federal anti-kickback statute (which applies to claims for reimbursement submitted to the federal government, 42 U.S.C. § 1320a-7b) because the doctors own the companies to which they refer work. AC ¶¶ 42–44. After the OIG opinion,[2] NMA expanded its business by acquiring IOM companies that were previously owned by surgeons, so that they could be operated in compliance with the opinion. AC ¶¶ 47–49.

B. The NSA and IDR process

Congress enacted the NSA to address surprise "balance bills" for out-of-network medical services. AC ¶¶ 137–138. The NSA included IDR, an arbitration process for "resolving payment disputes on claims between out-of-network providers and health plans." AC ¶ 140. There are three primary steps in IDR: open negotiations between the provider and the health insurer, IDR submissions, and then a binding payment determination by arbitrators known as Independent

[2] HCSC asserts that NMA requested that OIG issue the opinion. AC ¶ 47. This assertion is both false (and indeed, is pleaded without a good-faith basis under Rule 11(a)) and irrelevant to this motion.

Dispute Resolution Entities ("IDREs"). 42 U.S.C. § 300gg-111(c); AC ¶ 142.

When a dispute arises over the payment amount for an out-of-network service covered by the NSA, either the medical provider or insurer initiates negotiations with the other side. 42 U.S.C. § 300gg-111(c)(1)(A); AC ¶ 141.d n.12. If they cannot agree on a payment amount within thirty days, either party can then initiate the IDR arbitration process. *See* 42 U.S.C. § 300gg-111(c)(1)(B); 45 C.F.R. § 149.510(b)(2)(i). A provider or insurance company initiates the IDR process through an online portal. AC ¶ 147. After a party initiates IDR, the parties select an IDRE (i.e., an arbitrator). AC ¶ 142.d. If they cannot agree on an IDRE, one will be appointed by HHS, a government agency. *Id.*; *see also* 42 U.S.C. § 300gg-111(c)(4)(F).

The amended complaint acknowledges that the first step of the IDR process is for the arbitrator to determine whether the claim is eligible for IDR. AC ¶¶ 142.f, 142.g, 142.h. The arbitrators are expressly authorized and indeed required to make this determination. AC ¶¶ 142.f, 142.g; *see also* 45 C.F.R. § 149.510(c)(1)(v). If the non-initiating party disagrees that a dispute is eligible, it can submit an objection to HHS, the Department of Labor, the Department of the Treasury, and the IDRE. *Anthem*, 2026 WL 982629, at *7. The IDRE reviews both the initiating party's notification of IDR initiation and the non-initiating party's objection before deciding eligibility. Ex. 1, *Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties*, CMS.gov § 5.5 (2023); *see also* Ex. 2, *Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities*, CMS.gov 10–11 (2022). A dispute only moves forward—and there can only be an award—if the IDRE determines that it is eligible.

If the IDRE determines that the dispute is eligible, each party proposes a payment amount. AC ¶ 142.h. The IDRE then selects an offer it finds to be most reasonable, which is the amount the insurer must pay, based on criteria laid out in the NSA. *See* 42 U.S.C. § 300gg-111(c)(5)(B),

(c)(5)(C). This is "baseball" style arbitration, where the IDRE must select between the two sides' offers and pick the one that is most reasonable under specified statutory factors. *See* H. Rep. 116-615, at 56–57 (2020). The IDRE may not consider the medical provider's usual or customary rates in determining the most reasonable offer. 42 U.S.C. § 300gg-111(c)(5)(D). Instead, the *only* factors that an IDRE may consider are the qualifying payment amounts ("QPAs"), information requested by the IDRE relating to the offers made, information provided by the parties relating to the offers, the provider's background and market share, the patient's acuity, the scope of services offered by the provider, and demonstrations of good faith efforts between the provider and insurer to enter into network agreements. *Id.* § 300gg-111(c)(5)(C).

The remedy for violating IDR rules is government enforcement, not private RICO litigation. As the Fifth Circuit has held, "HHS has the authority to enforce provider and payor non-compliance with the NSA's provisions." *Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271, 274 (5th Cir. 2025) ("*Guardian Flight I*") (citing 42 U.S.C. § 300gg-22(b)(2)(A) and stating that the statute "provid[es] for HHS enforcement against some payors for NSA non-compliance," and citing 42 U.S.C. § 300gg-134(b) and stating that the statute "provid[es] for HHS enforcement against providers for NSA non-compliance").

C. HCSC's efforts to use litigation to re-write the NSA

HCSC is a large mutual legal reserve company that provides health insurance plans and administrative services for groups such as employers and governmental entities in five states. AC ¶ 13. Unhappy with its results during the IDR process, HCSC and its related Blue Cross entities have begun to flood the courts with collateral attacks on these rulings in federal district courts. This present case is part of HCSC's litigation campaign.

Here, HCSC filed its original complaint on February 19, 2026, and the Defendants moved to dismiss on April 21, 2026. As the motion to dismiss was pending, the Defendants moved to stay

discovery given the weakness of HCSC's claims and the strength of the dispositive motion. Dkt. 32. This Court also decided *HaloMD* during this period. Two days before it was set to respond to the Defendants' motion to dismiss, HCSC filed the amended complaint rather than respond in opposition to the motion to dismiss. Dkt. 45, at 2. The next day, the Court granted the motion to stay discovery and held that the original motion to dismiss was moot. *Id*. at 5; Dkt. 42.

III. LEGAL STANDARD

The Defendants move to dismiss the amended complaint under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6). Under Rule 12(b)(1) a court must dismiss a case where it lacks subject-matter jurisdiction. "It is to be presumed that a cause lies outside [a federal court's] limited jurisdiction, and the burden of establishing the contrary rests upon the party asserting jurisdiction." *Pershing, L.L.C. v. Kiebach*, 819 F.3d 179, 181 (5th Cir. 2016) (alteration in original) (quoting *Kokkonen v. Guardian Life Ins. Co. of Am.*, 511 U.S. 375, 377 (1994)). "There are two types of attacks against a court's subject-matter jurisdiction: 'facial' and 'factual.'" *Reardon v. Am. Airlines, Inc.*, 167 F.4th 294, 299 (5th Cir. 2026) (citation omitted). Here, the absence of subject-matter jurisdiction is apparent on the face of the amended complaint. *See id.*

Under Rule 12(b)(6), a court must dismiss a complaint that "fails to state a claim upon which relief can be granted." *Polnac v. City of Sulphur Springs*, 555 F. Supp. 3d 309, 321 (E.D. Tex. 2021). A complaint must be "plausible on its face." *Phillips v. Collin Cmty. Coll. Dist.*, 630 F. Supp. 3d 828, 833 (E.D. Tex. 2022). "A claim has facial plausibility when the plaintiff pleads factual content that allows the Court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id*. (citation omitted); *see also Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). Though courts take the facts alleged in the light most favorable to the plaintiff, legal conclusions and recitations of claim elements are not enough. *Iqbal*, 556 U.S. at 678.

The plausibility standard demands "more than a sheer possibility that a defendant has acted

unlawfully." *Peacock v. AARP, Inc.*, 181 F. Supp. 3d 430, 433 (S.D. Tex. 2016) (quoting *Iqbal*, 556 U.S. at 678). "[F]actual allegations that are 'merely consistent with a defendant's liability, stop short of the line between possibility and plausibility of entitlement to relief,' and are thus inadequate." *Walker v. Beaumont Indep. Sch. Dist.*, 938 F.3d 724, 735 (5th Cir. 2019) (citation omitted). **Rather, the plausibility standard "requires" that the plaintiff plead facts demonstrating "that there is no 'obvious alternative explanation' for the decision" that is lawful.** *Pickett v. Tex. Tech Univ. Health Scis. Ctr.*, 37 F.4th 1013, 1034 (5th Cir. 2022) (quoting *Iqbal*, 556 U.S. at 682); *see also Guardian Flight II*, 140 F.4th at 622 ("A claim is merely conceivable and not plausible if the facts pleaded are consistent with both the claimed misconduct and a legal and obvious alternative explanation." (citation omitted)); *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 567 (2007).

Fraud claims must meet a higher pleading standard. Rule 9(b) requires that "a party must state with particularity the circumstances constituting fraud." Fed. R. Civ. P. 9(b). "At a minimum, Rule 9(b) requires that a plaintiff set forth the 'who, what, when, where, and how' of the alleged fraud." *U.S. ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899, 903 (5th Cir. 1997) (citation omitted); *accord Allstate Indem. Co. v. Bhagat*, 164 F.4th 426, 434 (5th Cir. 2026). Moreover, a plaintiff must also allege facts with respect to each defendant's participation in the fraud, and cannot simply make generic allegations against multiple defendants together. *Cypress/Spanish Ft. I, L.P. v. Pro. Serv. Indus., Inc.*, 814 F. Supp. 2d 698, 711 (N.D. Tex. 2011); *Saeed v. Bennett-Fouch Assocs., LLC*, 2012 WL 13026741, at *4 (N.D. Tex. Aug. 28, 2012).

IV. ARGUMENT

A. Federal law and Fifth Circuit precedent bar the judicial review that HCSC seeks under its NSA Theory.

Congress created IDR as a non-judicial system "for resolving payment disputes." AC

¶ 140. In doing so, it restricted judicial review of IDREs' determinations, except in very narrow circumstances. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). Though HCSC attempts to avoid this bar, this Court has explicitly recognized the restriction and rejected HCSC's theory in *HaloMD*. *See* 2026 WL 1557492, at *3 ("The Court agrees with Defendants that the NSA forecloses judicial review."). In fact, every court to consider the same or a closely related issue has adopted Defendants' position: the NSA does not allow for judicial review under this theory. *See Anthem*, 2026 WL 982629, at *7–10; Order at 7–11, *Guardian Flight III*, No. 3:24-cv-00680; *Aetna, Inc.*, 2026 WL 1556164, at *3–4; *UnitedHealthCare of Pa., Inc.* 2026 WL 1145885, at *12–14. HCSC recognizes this reality, and concedes that this Court's ruling in *HaloMD* "forecloses some of Plaintiff's claims based on" its IDR theory allegations. AC at 38 n.24.

The NSA states that a "determination of a certified IDR entity under subparagraph (A) . . . shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a)" of the FAA. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). Section 10(a) of the FAA sets out the grounds for vacatur, which are based on whether the award was procured as a result of "corruption, fraud, or undue means," 9 U.S.C. § 10(a)(1), or where the arbitrator was at fault either by corruption, misconduct, or exceeding their powers, *id.* § 10(a)(2)–(4). And "Subparagraph A" refers to a previous section of the NSA that contains all the IDRE's work. 42 U.S.C. § 300gg-111(c)(5)(A), (E)(i)(II); *HaloMD*, 2026 WL 1557492, at *3–4 ("[I]nherent in the NSA's bar of judicial review of payment determinations is a limitation on the review of eligibility decisions."); *Anthem*, 2026 WL 982629, at *9 ("[S]ubparagraph (A) refers to 'a determination for a qualified IDR item or service.' An IDRE's payment determination necessarily includes a determination of eligibility." (internal citations omitted)).

This is jurisdictional. Where Congress makes a clear statement restricting judicial review,

it limits the subject-matter jurisdiction of the courts. *See Arbaugh v. Y&H Corp.*, 546 U.S. 500, 515–16 (2006); *see also Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 153–54 (2013). Where—as here—Congress states a determination is not subject to judicial review, the bar is jurisdictional. *See Wilkinson-Okotie v. Gonzales*, 185 F. App'x 327, 328 (5th Cir. 2006) (describing a provision precluding judicial review as a "jurisdictional bar"); *see also Ctr. for Biological Diversity v. Bernhardt*, 946 F.3d 553, 563 (9th Cir. 2019) (analyzing statute providing that no determination under a certain law "shall be subject to judicial review"); *Montanans For Multiple Use v. Barbouletos*, 568 F.3d 225, 229 (D.C. Cir. 2009) (same as to a statute providing that "no determination" under a certain process "shall be subject to judicial review"); *Acker v. Tarr*, 486 F.2d 654, 656 (7th Cir. 1973) (finding no jurisdiction where the statute provides for "[n]o judicial review" except in limited circumstances).

The only plausible reading of § 300gg-111(c)(5)(E)(i)(II) of the NSA is that it bars judicial review of the IDRE's rulings, no matter what cause of action a plaintiff might invoke to challenge them. This Court agrees, having held that "the NSA prevents this Court from reviewing the . . . IDR awards at issue in [p]laintiff's suit." *HaloMD*, 2026 WL 1557492, at *3. It also rejected HCSC's argument that the statute bars only IDRE's payment determinations, not eligibility determinations, reasoning that "inherent in the NSA's bar of judicial review of payment determinations is a limitation on the review of eligibility determinations" because "[i]f the Court were to conclude that the items and services submitted for payment by Defendants were ineligible under the NSA, then the ultimate payment awards would necessarily be called into question." *Id.* at *4; *see also Anthem*, 2026 WL 982629, at *7; Order at 9, *Guardian Flight III*, No. 3:24-cv-00680 (acknowledging that counterclaims premised on fraudulent attestations of eligibility "would require judicial review of multiple IDR determinations" because the conduct "is inextricably tied

to those determinations"). The same reasoning applies to HCSC's claims.

Even outside the NSA's strict limitations on judicial review, courts nationwide, including the Fifth Circuit, make clear that the losing side of an arbitration cannot invoke other claims—like RICO or state-law fraud—to challenge the arbitration ruling where the "relationship between the alleged wrongdoing, purported harm, and arbitration award" underscores that a plaintiff seeks "to remedy wrongdoing that [FAA] Section 10 was meant to address." *Tex. Brine Co., L.L.C. v. Am. Arb. Ass'n, Inc.*, 955 F.3d 482, 488–89 (5th Cir. 2020); *Gulf Petro Trading Co. v. Nigerian Nat'l Petroleum Corp.*, 512 F.3d 742, 751 (5th Cir. 2008); *HaloMD*, 2026 WL 1557492, at *2; *cf. Aetna*, 2026 WL 1556164, at *4 ("The FAA preempts state law claims that would otherwise frustrate its purpose." (citing *Marmet Health Care Ctr., Inc. v. Brown*, 565 U.S. 530, 533 (2012))).

HaloMD answers the question here. There, this Court held that Blue Cross of Texas' claims for common-law fraud, negligent misrepresentation, fraudulent inducement, money had and received, RICO, and declaratory and injunctive relief were "impermissible collateral attacks" even where the Blue Cross plaintiff sought administrative fees, costs, expenses, and equitable relief alongside its request for damages, which the court noted were "largely co-extensive with the losses it generally sustained in the form of IDR awards decided against it." *Id.* at *5. This Court also recognized that the alleged harm—"economic harms as a result of the fees, costs, and time that must be (wrongly) allocated to the IDR process for [] ineligible submissions"—is intertwined with the ultimate award. *Id.* at *6.

Thus, the Court's inquiry should end here, and it should dismiss Counts II, IV, VI, VIII, and X because (1) the Court lacks subject-matter jurisdiction under the NSA, and (2) even if it had jurisdiction, the claims constitute prohibited collateral attacks on the IDR awards.

B. HCSC's claim for vacatur under the FAA fails.

Count XI attempts to invoke the only exception to the NSA's bar on judicial review. It

seeks vacatur under the FAA, expressly invoking 9 U.S.C. § 10. *See* AC ¶¶ 335–349. But Count XI fails both the procedural and substantive requirements of the FAA.

1. **HCSC fails the procedural requirements for vacatur.**

The statute that HCSC invokes, 9 U.S.C. § 10, states that in certain circumstances, "the United States court in and for the district wherein the award was made may make an order vacating the award ***upon the application*** of any party to the arbitration[.]" *Id.* (emphasis added). Thus, this statute expressly requires an "application," not a complaint. *Id.*; *see also O.R. Secs., Inc. v. Professional Plan. Assocs., Inc.*, 857 F.2d 742, 745 (11th Cir. 1988); *Baylor Health Care Sys.*, 955 F. Supp. 2d at 688 n.1; *Garber v. Sir Speedy, Inc.*, 1996 WL 734947, at *4–5. Federal Rule of Civil Procedure 7(b) makes clear that such an application must be in the form of a "motion which . . . shall state with particularity the grounds therefor, and shall set forth the relief or order sought." *O.R. Secs.*, 857 F.2d at 745.[3] And the FAA (again, the statute that HCSC expressly invokes in Count XI) says the same: "Any application to the court hereunder shall be made and heard in the manner provided by law for the making and hearing of motions, except as otherwise herein expressly provided." 9 U.S.C. § 6. And such an application must be made within three months of the award. 9 U.S.C. § 12; *see also Corey v. N.Y. Stock Exch.*, 691 F.2d 1205, 1213 (6th Cir. 1982) ("The three month notice . . . is meaningless if a party to the arbitration proceedings may bring an independent direct action asserting such claims outside of the statutory time period . . . ."). Finally, where the movant seeks to vacate for fraud (as HCSC does here), it must be supported by clear and convincing evidence. *Morgan Keegan & Co.*, 495 F. App'x at 447.

[3] The 2007 Amendments to Rule 7 changed the word "application" to "request," but made clear that this change was "stylistic only" and did not change the meaning. *See* Fed. R. Civ. P. 7(b) advisory committee's note to 2007 amendment.

The rules of notice pleading do not apply. A party cannot rely on mere allegations; otherwise, "the burden . . . would be on the party defending the arbitration award," and, absent a successful motion to dismiss, the proceeding "would develop into full scale litigation." *O.R. Secs.*, 857 F.2d at 745; *see also Legion Ins. Co. v. Ins. Gen. Agency, Inc.*, 822 F.2d 541, 543 (5th Cir. 1987) ("To permit time-consuming, costly discovery simply to replicate the substance of the arbitration would thwart its goal. The statutory bases for overturning an arbitral tribunal are precisely and narrowly drawn to prohibit such complete de novo review of the substance of the award . . . ."); *U.S. Ship Mgmt., Inc. v. Maersk Line, Ltd.*, 188 F. Supp. 2d 358, 363 (S.D.N.Y. 2002), *aff'd*, 51 F. App'x 66 (2d Cir. 2002) ("[T]he FAA and Federal Rules of Civil Procedure do not contemplate full-blown litigation for the purposes of contesting an arbitration award with which a party may disagree."). If parties could take "full-bore legal and evidentiary appeals," arbitration would become "merely a prelude to a more cumbersome and time-consuming judicial review process." *Hall St. Assocs., L.L.C. v. Mattel, Inc.*, 552 U.S. 576, 588 (2008).

HCSC's amended complaint falls short of the requirements for vacatur. It lacks exhibits, declarations, or evidence of any kind. At most, it *alleges* that the Defendants initiated myriad IDR disputes and prevailed in many of them. *E.g.*, AC ¶¶ 10, 219. Of these, HCSC identifies only *three* by docket number and raises various substantive issues it already argued (and lost) in these IDR proceedings. AC ¶¶ 180–219. Nor does it plead the date of the award as to any of the arbitrations discussed in the amended complaint, *see* AC ¶¶ 188, 202, 216, and thus has failed to show that any of its requests are timely (*i.e.*, filed within the three months of the ruling). *See* 9 U.S.C. § 12. Nor has HCSC even said that it (rather than an unnamed affiliate) was a party to the arbitrations in question. 9 U.S.C. § 10 (allowing "any party to the arbitration" to move to vacate an arbitration award). HCSC carefully avoids pleading that it is a party, because it is not—only its affiliates, who

are not parties to this case, were. This too is fatal. Nothing in the FAA allows a parent company to aggregate and then seek vacatur for myriad arbitrations that its subsidiaries lost. At bottom, what HCSC filed is not nearly sufficient for vacatur.

2. **HCSC fails the substantive standard for vacatur.**

HCSC's vacatur claim also fails the demanding standard for vacatur. In the Fifth Circuit, "judicial review of an arbitration award is extraordinarily narrow." *U.S. Trinity Energy Servs., L.L.C. v. Se. Directional Drilling, L.L.C.*, 135 F.4th 303, 307 (5th Cir. 2025) (quotation omitted). A federal court's review of an arbitration decision is "exceedingly deferential." *Id*. (quotation omitted). "Doubts or uncertainties must be resolved in favor of upholding an arbitration award." *Id*. (cleaned up). And courts "are not authorized to reconsider the merits of an award even though the parties may allege that the award rests on errors of fact or on misinterpretation of the contract . . . ." *Morgan Keegan & Co.*, 495 F. App'x at 449 (quoting *United Paperworkers Int'l Union, AFL-CIO v. Misco, Inc.*, 484 U.S. 29, 36 (1987)); accord *Guardian Flight II*, 140 F.4th at 621 n.4 ("[J]udicial review of an arbitration award under the FAA is extraordinarily narrow . . . [and] focuses on misconduct rather than mistake." (quotations omitted)).

Every court to address the NSA's incorporation of the FAA has applied the established meaning of paragraphs (1) through (4) of the FAA (§ 10(a)(1)–(4)) when evaluating challenges to NSA IDR determinations. *See Guardian Flight II*, 140 F.4th at 620; *Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc.*, 160 F.4th 1110, 1119 (11th Cir. 2025); *Anthem,* 2026 WL 982629, *at* *7; *Aetna*, 2026 WL 1556164, at *3. A plaintiff seeking to vacate an IDR award must therefore satisfy one of the four exceptions enumerated in paragraphs (1) through (4) of the FAA. HCSC seeks vacatur of thousands of arbitration awards on the grounds that they were "procured by corruption, fraud, or undue means" (§ 10(a)(1)) and that the IDREs "exceed[ed] their powers" (§ 10(a)(4)). AC ¶¶ 335–349. But as described below, the AC does not satisfy either test.

a. No grounds for vacatur under 9 U.S.C. § 10(a)(1)

No fraud. A party moving for vacatur under 9 U.S.C. § 10(a)(1) for fraud must demonstrate: "(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." *Morgan Keegan & Co.*, 495 F. App'x at 447 (quotation omitted and emphasis added).

First, HCSC fails to establish fraud by clear and convincing evidence. It merely alleges that Defendants misrepresented that claims were eligible for IDR arbitration under the NSA, that HCSC contested this eligibility at (at least some of) the arbitrations, and the arbitrator ruled in Defendants' favor in "many thousands" of disputes. *See, e.g.*, AC ¶¶ 172, 173, 187, 201, 215. But the Fifth Circuit has—like all other Courts considering this same issue—made clear that this is not fraud under the FAA. *Guardian Flight II*, 140 F.4th at 621–22; *Anthem*, 2026 WL 982629, at *7–9; *Reach Air Med. Servs. LLC*, 160 F.4th at 1121–23.

HCSC also alleges that the Defendants committed fraud by seeking arbitration for claims that supposedly violate HCSC's "policies" (based on the Practice-Acquisition and Credentialing Theories). This theory goes nowhere. **The NSA does not permit an insurance company to unilaterally enact a "policy" about which claims can go to IDR, and then sue for fraud if a provider seeks arbitration for a claim that supposedly does not meet the insurance company's restrictive policy**. Furthermore, fraud requires a fraudulent statement, but no such fraudulent statement is alleged here (let alone with specificity). There are statutory and regulatory factors that define what is a "qualified" service and are relied on by IDREs to determine eligibility. *See* 42 U.S.C. § 300gg-111(c)(5)(C), (D); 45 C.F.R. § 149.510(a)(2)(xi), (a)(4)(iii). But compliance with a payor's "policies" is not one of those factors. Thus, the Defendants' alleged silence on this issue is not a misrepresentation. Nor does HCSC's Practice-Acquisition Theory or

Credentialing Theory have any connection to the enumerated and exhaustive list of factors that IDREs consider. *See* 42 U.S.C. § 300gg-111(c)(5)(C) (authorizing the IDREs to consider the QPAs, information requested by or provided to the IDRE relating to the offers made, the provider's background and market share, the patient's acuity, the scope of services offered by the provider, and demonstrations of good faith efforts between the provider and insurer to enter into network agreements).

Second, even if the alleged misrepresentations were somehow clear and convincing evidence of fraud (they are not), HCSC fails to meet the second requirement for vacatur under § 10(a)(1): that the fraud must not have been "discoverable by due diligence before or during the arbitration hearing." *Morgan Keegan & Co.*, 495 F. App'x at 447 (quotation omitted); *accord Barahona*, 376 F. App'x at 397 (noting a party fails "its burden of proof where the grounds for fraud . . . is not only discoverable, but discovered and brought to the attention of the arbitrators; in such a case, courts will not give a disappointed party . . . a second bite at the apple." (cleaned up)).

Here, HCSC pleads that it was aware of the supposed misstatements and argued to the arbitrator that the statements were wrong. HCSC has "pleaded itself out of court." *Anthem,* 2026 WL 982629 at *8 ("[B]y alleging that Plaintiffs knew about the false eligibility attestations and objected, Anthem has pleaded itself out of court . . . because the fraud was known during the IDR and disclosed to the IDRE." (cleaned up)); *Aetna*, 2026 WL 1556164, at *3 ("[Plaintiff's] own admission that it knew [defendants] were engaged in" the alleged fraud prior to the IDR arbitration "is fatal to [plaintiff's] position."). In HCSC's initial complaint, HCSC pleaded that it was aware of Defendants' alleged misrepresentations and objected to them. *E.g.*, Compl. (Dkt. 1) ¶¶ 162, 176, 190, 216. Recognizing that it "pleaded itself out of court," *Anthem*, 2026 WL 982629, at *8, HCSC attempts to save its vacatur claim by amending it to say that "[i]n many instances,

HCSC [did] not discover Defendants' deception until after the fact" and therefore was "unable to object," AC ¶ 178. But this does not remedy the fatal flaw in its allegations that in *each example that HCSC references in its amended complaint*, it alleges that it objected to the dispute's eligibility, *including raising these objections to the IDRE*:

- **DISP-461040**: "HCSC also submitted an objection to the IDR Dispute: DISP-461040 Objection: State specified law applies to this item or service. As a result, the [NSA] IDR Process is not applicable for the following claims." AC ¶ 187.

- **DISP-1965465**: "HCSC submitted an objection to the IDRE explaining that the services being disputed were ineligible for the IDR process: . . . This dispute includes items or services under a coverage type not subject to the [NSA] . . . . Objection to the following items or service which are under a coverage type not subject to the [NSA] Charge exceeds Medicare's reasonable amount. Therefore, this submission is not eligible for the Federal IDR Process." AC ¶ 201.

- **DISP-1299633**: "HCSC submitted an objection to the IDRE explaining that the services being disputed were ineligible for the IDR Process: Objection to the following items and services. State specified law applies to this item or service. As a result, the [NSA] IDR Process is not applicable for the following claims." AC ¶ 215.

The court in *Anthem* refused to find fraud for vacatur on these same facts. *See* 2026 WL 982629, at *8 (holding that plaintiffs failed to allege fraud for FAA vacatur where "[p]laintiffs objected to eligibility for all the sample determinations identified in the [amended complaint]"). By alleging that it contested eligibility to the arbitrator during the IDR process, HCSC defeats its own argument that any "misrepresentation" was undiscoverable by due diligence before or during the arbitration. Controlling precedent squarely forecloses further review. *See Barahona*, 376 F. App'x at 397; *see also Anthem*, 2026 WL 982629, at *8.

No undue means. Under 9 U.S.C. § 10(a), "undue means" refers to "behavior that is immoral if not illegal." *Guardian Flight II*, 140 F.4th at 621 (quotation omitted). It warrants vacatur where behavior "is equivalent in gravity to corruption or fraud, such as a physical threat to an arbitrator." *Id.* at 622 (quoting *Am. Postal Workers Union, AFL–CIO v. U.S. Postal Serv.*, 52 F.3d 359, 362 (D.C. Cir. 1995)). "Circuits have uniformly construed the term undue means as

requiring proof of intentional misconduct." *Id.* (quotation omitted).

No evidence (or even allegation) of intentional conduct "equivalent in gravity to corruption or fraud, such as a physical threat to an arbitrator" is present here, or anything remotely close to it. At most, HCSC alleges Defendants submitted IDR claims that HCSC thinks were ineligible and made settlement demands that were larger than HCSC thinks were appropriate. AC ¶¶ 343, 172, 189, 203, 217. But as it alleges, HCSC objects to eligibility when it thinks a claim is ineligible for the IDR process, AC ¶¶ 187, 201, 215, and the IDRE is authorized, indeed required, to determine whether a claim is eligible for the IDR process. AC ¶¶ 142.f, 142.g, 142.h.

The same is true of HCSC's argument that Defendants' monetary demands were too high. As HCSC explains, the arbitrator's job is to select the most appropriate option between the two that are submitted (one by each side). AC ¶ 142.i. This decision is not subject to judicial review. Certainly, HCSC points to no statutory or other constraints limiting the amount that a provider can request in the IDR process. It objects that Defendants' demands were sometimes higher than reasonable market value for the services, but the NSA forbids IDREs from considering "usual and customary charges." 42 U.S.C. § 300gg-111(c)(5)(D). In any event, if the provider's offer is unreasonably high, then the arbitrator will select the insurance company's number instead.[4]

b. No grounds for vacatur under 9 U.S.C. § 10(a)(4)

Vacatur is permitted under § 10(a)(4) "where the arbitrators exceeded their powers, or so

[4] To the extent HCSC alleges undue means because IDREs are "incentivized not to scrutinize whether claims submitted to the IDR Process are eligible and to instead simply rubberstamp the provider's attestations of eligibility," AC ¶ 166, such argument fails where "this fee structure is part of the IDR rules established by Congress." *Anthem,* 2026 WL 982629, at *8. In *Anthem*, the court squarely rejected this argument, finding that "[s]uch financial incentives are not akin to bad faith or bribery." *Id*. Especially where, as here, the Complaint "does not allege that improper financial incentives motivated an IDRE's decision-making for any particular award." *Id*. In the end, this is rhetoric, not legal argument. That HCSC would prefer that Congress had written the law differently is not for this Court to resolve.

imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made." 9 U.S.C. § 10(a)(4). In other words, vacatur is proper under § 10(a)(4) "[o]nly when the arbitrator acts outside the scope of their [] delegated authority." *U.S. Trinity*, 135 F.4th at 308 (cleaned up) (quoting *Oxford Health Plans LLC v. Sutter*, 569 U.S. 564, 569 (2013)). And "merely 'convincing a court of an arbitrator's error—even his grave error—is not enough.'" *Id.* (quoting *Oxford Health Plans LLC*, 569 U.S. at 572). For this reason, when "determining whether the arbitrator exceeded his jurisdiction, [courts] resolve all doubts in favor of arbitration." *Valentine Sugars, Inc. v. Donau Corp.*, 981 F.2d 210, 213 (5th Cir. 1993) (citing *Moses H. Cone Mem'l Hosp. v. Mercury Constr.*, 460 U.S. 1, 24–25 (1983)).

HCSC merely alleges that the Defendants "induced the IDREs to 'exceed their powers' and render awards on services" not subject to the NSA. AC ¶ 347. Setting aside that this conclusory allegation does not satisfy pleading standards, HCSC's position is untenable. Congress and the implementing federal agencies expressly delegated authority to IDREs to decide both eligibility and between the parties' proposed awards for compensating the medical provider. *See* AC ¶¶ 142.f, 142.g, 142.h, 142.i; 42 U.S.C. § 300gg-111(c)(5); 45 C.F.R. § 149.510(c)(1)(v). And while reviewing an arbitration award under the FAA, courts are empowered to decide *only* whether the arbitrator has engaged in an authorized determination, not to second guess the accuracy of the decision. *See BNSF R.R. Co. v. Alstom Transp., Inc.*, 777 F.3d 785, 787 (5th Cir. 2015) (quoting *Oxford Health Plans LLC*, 569 U.S. at 569) ("[T]he sole question for us is whether the arbitrator (even arguably) interpreted the parties' contract, not whether he got its meaning right or wrong."); *Anthem,* 2026 WL 982629, at *9 ("Our sole question under § 10(a)(4) is whether the arbitrator (even arguably) performed the assigned task, not whether she got the outcome right or wrong." (quotation omitted)). But that is precisely what HCSC asks the Court to do here.

Put simply, because the NSA is clear that IDREs have the power to decide the arbitrability of the dispute, 45 C.F.R. § 149.510(c)(1)(v), and to resolve the dispute by choosing one of two offers, 42 U.S.C. § 300gg-111(c)(5)(A)(i), HCSC fails to allege facts showing the arbitrators exceeded their powers. *See Anthem,* 2026 WL 982629, at *9. To say otherwise would be to make this Court a court of appeals for *de novo* review of each IDR eligibility ruling and subsequent dispute resolution. That is not the system that Congress designed. *Id*. (finding such a position "would be inconsistent with the NSA's creation of a streamlined IDR process for resolving surprise billing disputes and its limitations on judicial review").

C. The Court lacks subject-matter jurisdiction as to HCSC's other theories too.

Under Fifth Circuit precedent, the Court also lacks subject-matter jurisdiction as to HCSC's Practice-Acquisition and Credentialing Theories, as HCSC lacks Article III standing. *See Earl*, 53 F.4th at 900–04. Standing is an "irreducible constitutional minimum" to bring a case in federal court, and HCSC has the burden to establish it. *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016). It must plead facts showing: (1) an injury in fact; (2) that is fairly traceable to the challenged conduct of the Defendants; and (3) likely to be redressed by a favorable judicial decision. *Id.*; *Lujan*, 504 U.S. at 560–61.

HCSC has not done so. *First*, HCSC fails to show an injury in fact. The Fifth Circuit has rejected fraud-based theories of injury where the plaintiff received the product or service purchased and failed to plausibly allege that it was economically worse off under a counterfactual without the alleged fraud. In *Earl*, passengers alleged that Boeing and Southwest Airlines fraudulently concealed safety defects in a Boeing plane and as a result they either bought tickets they otherwise would not have purchased or paid more than they otherwise would have. 53 F.4th at 900–03. The Fifth Circuit rejected both theories, finding a lack of subject-matter jurisdiction. It held that *Rivera v. Wyeth-Ayerst Lab'ys*, 283 F.3d 315 (5th Cir. 2002), foreclosed standing because the plaintiffs

had purchased airline tickets and received flights without injury—just as the *Rivera* plaintiffs "paid for an effective pain killer, and they received just that." *Earl*, 53 F.4th at 902 (quoting *Rivera*, 283 F.3d at 320–21).

The same defect exists here. HCSC does not allege that the IOM services were not performed, were medically unnecessary, or were charged at a different rate as a result of the Practice-Acquisition or Credentialing Theory. To be sure, HCSC argues that it would choose not to pay for the care its insureds received if it knew about these supposed facts that the Defendants did not disclose, but that is the same as what the plaintiffs said in *Earl*—and under Fifth Circuit precedent, this is not enough. Like the plaintiffs in *Rivera* and *Earl*, HCSC received the benefit of what it paid for—IOM services—and does not plausibly allege that it is financially worse off because of the alleged misconduct. See *Earl*, 53 F.4th at 902–03.

Indeed, HCSC's case for standing is even weaker than the plaintiffs in *Earl* as both of its theories turn on what are at most, patient-protection rules—not statutes created to protect the insurer-plaintiff that brought the case. HCSC cannot establish standing by pointing to an alleged violation of policies intended to protect patients. The patients were not injured either, but even if they were, Article III requires HCSC to plead its own concrete injury, not a legal violation or a hypothetical risk to others. See *TransUnion LLC v. Ramirez*, 594 U.S. 413, 426–27 (2021). And that these statutes were not written to protect insurers makes its case for standing weaker still. *See id.*

HCSC also fails the traceability test. Subject-matter jurisdiction demands a causal connection between the alleged injury and the challenged conduct; the injury must be fairly traceable to the defendant's conduct and not the result of independent actions by third parties. *Lujan*, 504 U.S. at 560–61. The Fifth Circuit recently reiterated that where the causal link depends

on independent decisions by third parties, standing is "substantially more difficult to establish," and that standing cannot rest on injuries caused by the "unfettered choices made by independent actors not before the court." *Reule v. Jackson*, 114 F.4th 360, 367 (5th Cir. 2024) (quotation omitted). HCSC's supposed injury (if there were one) is not fairly traceable to the conduct it challenges. The causal chain is too attenuated: NMA allegedly purchased certain practices; surgeons then selected NMA to perform IOM services; patients underwent procedures; IOM services were performed; HCSC received claims for reimbursement. HCSC has not pleaded facts showing that the supposed misconduct is traceable to any supposed injury. *See Reule*, 114 F.4th at 367–69. *Earl* rejects precisely that type of speculative counterfactual injury theory. 53 F.4th at 903.

Finally, HCSC fails to plead facts showing redressability. Assuming the facts it pleads are true, suppose that—under the injunction it seeks—it is only billed for claims for cases by physicians who did not sell their practices to NMA and all IOM readers are credentialed at all hospitals. HCSC would be in exactly the same position it is today: it would pay the same amount for the same care for its insureds. The same is true under its damages theory, as it has no injury for which to seek damages in the first place.

Because HCSC has not plausibly alleged a concrete injury that is traceable to the conduct at issue and redressable by the relief it seeks, the Practice-Acquisition and Credentialing Theories must be dismissed for lack of subject-matter jurisdiction.

D. HCSC's fraud claims fail.

For the reasons above, HCSC's fraud theory related to IDR arbitrations is barred by federal law. Even if it were not, it would fail because (for the reasons above) HCSC has not pleaded facts to show reliance, a required element of its fraud and negligent misrepresentation claims. *JPMorgan Chase Bank, N.A. v. Orca Assets G.P., L.L.C.*, 546 S.W.3d 648, 653 (Tex. 2018).

That leaves HCSC's Practice-Acquisition and Credentialing Theories. Each fails for two reasons: because they do not include the details or specifics required under Rule 9(b), and because those facts that are pleaded simply do not show fraud.

In Texas, a plaintiff alleging fraud must show: "(1) the defendant made a material representation that was false; (2) the defendant knew the representation was false or made it recklessly as a positive assertion without any knowledge of its truth; (3) the defendant intended to induce the plaintiff to act upon the representation; and (4) the plaintiff actually and justifiably relied upon the representation and suffered injury as a result." *Id.* (cleaned up). "The fourth element has two requirements: the plaintiff must show that it actually relied on the defendant's representation and, also, that such reliance was justifiable." *Id.* (citation omitted).[5]

Rule 9(b)'s heightened pleading standard applies to HCSC's RICO, fraud, and negligent misrepresentation claims. *Arruda v. Curves Int'l, Inc.*, 861 F. App'x 831, 833–34 (5th Cir. 2021) (Rule 9(b) applies to RICO); *Sec. Data Supply, LLC v. Nortek Sec. & Control LLC*, 2019 WL 3305628, at *7 (N.D. Tex. July 22, 2019) ("In general, courts . . . require a plaintiff to plead the offense of commercial bribery with specificity under Rule 9(b)." (citation omitted)); *Pace v. Cirrus Design Corp.*, 93 F.4th 879, 889 (5th Cir. 2024) ("Rule 9(b)'s heightened pleading requirements

[5] Similarly, to allege negligent misrepresentation, a plaintiff must show: "(1) a representation made by a defendant in the course of its business or in a transaction in which it has a pecuniary interest; (2) the representation conveyed false information for the guidance of others in their business; (3) the defendant did not exercise reasonable care or competence in obtaining or communicating the information; and (4) the plaintiff suffers pecuniary loss by justifiably relying on the representation." *Id.* at 653–54 (cleaned up). HCSC's negligent misrepresentation claims do not have a "separate focus" from its fraud claims. Instead, it relies on the same alleged misrepresentations, subjecting its negligent misrepresentation claims to Rule 9(b). *See Momentum Glob. FZ LLC v. Kairos Glob. Trade, LLC*, 2026 WL 807337, at *6–7 (S.D. Tex. Mar. 24, 2026) (applying Rule 9(b) and dismissing negligent misrepresentation claim where the court found that there was "no 'separate focus'" for the negligent misrepresentation claim where the plaintiff relied on the same set of alleged misrepresentations as its fraud count).

apply when a plaintiff's misrepresentation claim sounds in fraud." (cleaned up)); *Cypress Home Care, Inc. v. Qlarant Integrity Sols., LLC*, 2020 WL 10317439, at *3 (E.D. Tex. Mar. 18, 2020) (Schroeder, J.) ("The Fifth Circuit recognizes that Rule 9(b) can apply to a claim for negligent misrepresentation when the fraud and negligent misrepresentation claims are sufficiently intertwined." (citation omitted)).

As the Fifth Circuit has emphasized, Rule 9(b) serves an important "screening function, standing as a gatekeeper to discovery, a tool to weed out meritless fraud claims sooner than later." *U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 185 (5th Cir. 2009). Courts therefore apply this rule "with 'bite' and 'without apology,'" *id.* (citation omitted), requiring a complaint plausibly allege the "'who, what, when, where, and how' of the alleged fraud," *Thompson*, 125 F.3d at 903 (citation omitted). A plaintiff cannot rely on discovery to supplant the missing details. *See Webb v. Everhome Mortg.*, 704 F. App'x 327, 330 (5th Cir. 2017) (holding that "allowing [plaintiff's] insufficient fraud claim to proceed to discovery would defeat the purpose of Rule 9(b)'s heightened pleading standard"); *Preston L. Firm, L.L.P. v. Mariner Health Care Mgmt. Co.*, 2009 WL 10680007, at *3 (E.D. La. June 10, 2009) ("[T]he plaintiff cannot engage in discovery to fulfill the basic pleading requirements of Rule 9(b)."), *aff'd in part sub nom. Preston L. Firm, L.L.C. v. Mariner Health Care Mgmt. Co.*, 622 F.3d 384 (5th Cir. 2010).

a. The Practice-Acquisition Theory fails.

(i) No pleaded facts showing that any Defendant lied to HCSC.

The core failure of this theory is that it simply does not plead what the fraudulent statement—the lie—was. In other words, HCSC fails the requirements to plead facts with specificity showing that the defendant made a material misrepresentation and knew its representation was false. *See JPMorgan Chase Bank N.A.,* 546 S.W.3d at 653. The most HCSC says is that it has a policy of not paying claims that do not comport with the Texas statutes that it

cites, and that the "submission of a claim for reimbursement to HCSC also ***constitutes*** a certification and representation of compliance with the Kickback Laws and Policies." AC ¶ 224 (emphasis added). It notes that the Defendants' claims for reimbursement are submitted to HCSC using standard government-issued forms. AC ¶¶ 29–32. While HCSC has not attached the form in question, it describes, relies on, and integrates it into its amended complaint, *see, e.g.*, AC ¶ 32, and thus the Court may properly consider it here. *Allen v. Hays*, 812 F. App'x 185, 189 (5th Cir. 2020); *see also United States v. Tarango*, 396 F.3d 666, 668–69 n.1 (5th Cir. 2005) ("HCFA 1500 claim forms are the standardized forms used when physician claims are submitted to insurance companies."); *United States v. Rashan*, 2026 WL 962444, at *2 (S.D.N.Y. Apr. 9, 2026) ("Healthcare providers are responsible for submitting claims for reimbursement to payers after furnishing a medical procedure or service. Providers submit their claims via the CMS 1500 claim form, which is the standard uniform professional provider healthcare billing form." (internal citations omitted)). The form in question is attached as Exhibit 4.

What is missing are any specifics describing how the Defendants lied to HCSC. In Texas, a plaintiff alleging fraud must show that "the defendant 'made a material representation that was false'" and did so knowingly or recklessly. *JPMorgan Chase Bank, N.A.*, 546 S.W.3d at 653 (citation omitted). HCSC has not done so. ***First***, while it vaguely references its "policy" of not paying certain claims, it does not allege facts showing that it ever told any Defendant of this policy, that any Defendant knew about it, that any Defendant agreed to it, or that any Defendant falsely told HCSC that it had complied with it. Not only are there no *specifics* here (i.e., who, what, when, where, and how), there are no facts at all. ***Second***, while HCSC says vaguely that submitting a claim "constitutes" a certification of compliance with these policies, it does not plead any *specifics* about any false statement. In other words, it does not say who lied to HCSC, what they said, when

they said it, where they said it, or how it is false. HCSC does not and cannot plead that the claim form contains a certification of compliance with these Texas laws or with HCSC's supposed policy. Even if the Court does not take judicial notice of the form, the claim fails for this reason—it is HCSC's job, as the plaintiff, to plead facts to make its case. But the Court can and should look at the form, Exhibit 4, and it will see that there is no certification of compliance with HCSC's policies or the laws in question.[6]

There is no other contract that was breached or that could serve as the basis for a fraud claim. These claims were all out-of-network—there is no contract between the Defendants and HCSC which could form the basis of an obligation to certify such compliance. *Cf. N. Cypress Med. Ctr. Operating Co., Ltd. v. Aetna Life Ins. Co.*, 898 F.3d 461, 469 (5th Cir. 2018) ("Out-of-network providers . . . have no contract with [the insurer] . . . ."). HCSC makes no allegation to support such a requirement.

And HCSC again failed to give the "when" or "where" of any supposed misrepresentation, instead providing only the date IOM services were provided. AC ¶¶ 80, 93, 106, 119. It variously lumps all the Defendants together, *see* AC ¶¶ 67, 77–78, 90–91, 103–04, 117–118, or claims NMA was the sole culprit, *see* AC ¶¶ 54, 75, 88, 101, 114. And with respect to the supposedly tainted claims, HCSC again fails to allege "who" submitted them for all but 12 of the 475 claims HCSC states were "tainted." AC ¶¶ 80, 93, 106, 119. Nor does it plead facts to explain why it did not know about the Defendants' business arrangements at the time it paid the claim, but does know about them now.

[6] The only representations on the form even close to what HCSC describes are expressly limited to claims *to the government* "for payment from federal funds" under Medicare; there is no reference to HCSC's policies or Texas law at all. *See* Exhibit 4 at 2.

(ii) No facts to show a violation of the Texas laws that underpin HCSC's theory.

HCSC's theory is that the Defendants lied about complying with the Texas laws. The section above shows that the Defendants did not certify compliance with these laws. Moreover, the facts pleaded in the Complaint do not show a violation of those laws in the first place. HCSC has failed to plead facts that rule out obvious alternative and lawful explanations for the transactions at issue. HCSC continues to advance its utterly unsupported conclusion that the former surgeon-owned entities NMA (or a related entity) purchased "were and are essentially worthless," AC ¶ 51, and so NMA *must* have paid a price "that far exceeded[] fair market value" for the entities, AC ¶ 52. It does not plead any facts about what the price was, and why it was unreasonable. And the facts HCSC pleaded are consistent with a straightforward alternative: NMA paid valuable consideration for ownership of these entities (including accounts receivable, intangible value, and existing business relationships reflected in HCSC's own allegations). HCSC has not pleaded facts to rule out these alternative lawful explanations, and its claim thus fails under Rules 8(a) and 9(b). *See Twombly*, 550 U.S. at 567.

HCSC likewise alleges that the surgeons set up the subject entities to help them order and provide IOM services for their patients. AC ¶¶ 71, 84, 97, 110. After NMA or a related entity bought the entities, the doctors did not switch to different, unrelated companies for IOM. HCSC claims the *only* explanation for that behavior is that NMA paid them a kickback. AC ¶ 54. But again, the conclusory nature of HCSC's allegation illustrates how it failed to rule out the same obvious alternative explanation: the doctors did not want to change to an entirely new provider. There are plenty of reasons a surgeon would do so, including to ensure the same quality of service or avoid costs associated with switching. In other words, HCSC's theory fails because it relies on an assumption that the only reason the surgeons would not change IOM providers is that they

received kickbacks. The flaw in this logic speaks for itself.

There is likewise an obvious alternative lawful explanation for HCSC's new claim that the only supposed kickback paid was the purchase price for the former surgeon-owned entities, "paid in installments." AC ¶ 53. Businesses and individuals alike regularly choose to pay a debt or purchase price, or to receive payment, in installments, and for a variety of reasons. One particularly salient reason here is liquidity: NMA, amid a strategic business expansion, *see* AC ¶ 48, needed to keep its liquid capital base as free as it could so that it could continue to make advantageous acquisitions. HCSC thus failed to rule out several "obvious alternative explanation[s] for the decision[s]" that it claims were illicit. *See Pickett*, 37 F.4th at 1034 (cleaned up). That failure is fatal to its claim.

HCSC's attempt to impute guilt through allegations in *other* lawsuits from years prior likewise fail. *See* AC ¶¶ 61–63 (citing complaint filed against NMA in federal court in Illinois in 2018 by a competing IOM provider). To start, a competitor's unverified claims in a complaint are not facts pleaded in this case and therefore do not move the needle on plausibility. *See Word of Faith World Outreach Ctr. Church, Inc. v. Sawyer*, 90 F.3d 118, 123–24 (5th Cir. 1996); *cf. Taylor v. Charter Med. Corp.*, 162 F.3d 827, 830 (5th Cir. 1998). HCSC has not pleaded—it has not certified under Rule 11(a)—that these things are true to its knowledge, merely that another plaintiff alleged them. This is especially problematic where the case was dismissed by stipulation of the parties, without the court ruling on several motions to dismiss. *See* Minute Entry, Dkt. No. 56, *Nuvasive Clinical Servs., Inc. v. Neuromonitoring Assocs., LLC*, No. 1:18-cv-4304 (N.D. Ill. Mar. 15, 2019).

HCSC also misunderstands the statutes it cites. HCSC cites the Texas commercial bribery statute, Tex. Penal Code § 32.43, which makes it an offense for a fiduciary to solicit or accept a

benefit—without the beneficiary's consent—on an understanding that the benefit will influence the fiduciary's conduct in the beneficiary's affairs. *Id.* § 32.43(b). This statute has five elements HCSC must prove: "1) intentionally or knowingly; 2) offering, conferring, or agreeing to confer a benefit; 3) to a fiduciary; 4) without the consent of the fiduciary's beneficiary; and 5) acceptance of that benefit would be a violation of Subsection (b)." *In re: DuPuy Orthopaedics, Inc.*, 2016 WL 6271465, at *6 (N.D. Tex. Jan. 5, 2016) (citing Tex. Penal Code § 32.43(c)). Here, even if the allegations were true (they are not), HCSC cannot show a violation of § 32.43.

First, HCSC cannot establish the essential knowledge element. As a matter of law, the purported offeror of the illegal bribe (in this case the Defendants) must know that the doctor would violate a fiduciary duty owed to his patient to prove a violation of § 32.43. 6 Tex. Prac. Texas Criminal Law § 19.9 (2d ed. Apr. 2025 update) ("An essential element is that the offeror must know that the offeree is a fiduciary and that the offeree would violate a duty owed to a beneficiary by accepting the offer."). But here, the IOM services provided were necessary—there is no evidence that the patients, in fact, did not need such monitoring. So what fiduciary duty was violated? HCSC does not say. And without an underlying fiduciary violation, HCSC cannot show that NMA "knowingly" engaged in commercial bribery because it could not have known its "conduct [was] reasonably certain" to cause the doctors to violate a fiduciary duty owed to their patients. Tex. Penal Code § 6.03(b) (defining culpable mental states).

Nor can HCSC show that the acceptance of the alleged bribes by the surgeons "influence[d] the conduct of the fiduciary in relation to the affairs of his beneficiary." *Id.* § 32.43(b). As noted above, the facts as pleaded by HCSC show the opposite. It alleges that the referring surgeons set up the subject entities from which they ordered IOM services. *See* AC ¶¶ 71, 73, 84, 86, 97, 99, 110, 112. And after the acquisition of these entities, the surgeons *continued to order IOM services*

from entities affiliated with NMA. *See* AC ¶¶ 78, 91, 104, 117. HCSC claims the only explanation for this conduct was bribery. *See* AC ¶¶ 79, 92, 105, 118. For the reasons given above, there are obvious alternative explanations for that alleged conduct. In any event, the amended complaint's allegations show the purchase of the entities did *not* "influence the conduct" of the doctors "in relation to the affairs of" their patients because they did not switch to an unrelated provider. *See* Tex. Penal Code § 32.43(b). Even if that were not true, the commentary to § 32.43 makes clear the statute "does not reach a simple breach of fiduciary duty; it covers only corrupt breaches that involve a bribe." *Jackson v. Radcliffe,* 795 F. Supp. 197, 206 (S.D. Tex. 1992). HCSC failed to adequately allege any illicit payment to the surgeons. It has therefore failed to adequately plead the elements of commercial bribery—let alone based on supposed claims to HCSC for payment in which any Defendant failed to disclose the same.

Second, HCSC references—again, only in passing—supposed violations of the Texas Patient Solicitation Act, Tex. Occ. Code § 102.001 *et seq*. AC ¶ 24. That statute prohibits knowingly "offer[ing] to pay or agree[ing] to accept . . . any remuneration . . . or any benefit or commission to or from another for securing or soliciting a patient or patronage for or from a person" licensed by a state healthcare regulatory agency. Tex. Occ. Code § 102.001(a). But here, HCSC fails to do anything but quote the statute, let alone allege any of the required elements.

Even if it had, however, this statute does not reach the alleged conduct. An adjacent section of the Act provides that this provision "permits any payment, business arrangement, or payment practice permitted by 42 U.S.C. Section 1320a-7b(b) or any regulation adopted under that law." *Id.* § 102.003. But 42 U.S.C. § 1320a-7b(b) only proscribes remuneration arrangements that implicate a *federal* healthcare program. *See id.* (prohibiting kickbacks, bribes, or rebates in return for providing or arranging to provide a service "for which payment may be made in whole or in

part under a Federal health care program"). Payment structures that do *not* implicate a federal healthcare program are permitted by the federal statute. Since such arrangements are permitted by the federal statute, they are permitted by § 102.001. Here, HCSC is not a federal health care program. Its claims under § 102.001 therefore fail as a matter of law since the federal statute does not reach such claims.

Third, HCSC again resorts to another provision of the Texas Patient Solicitation Act, Tex. Occ. Code § 101.203, AC ¶ 26, which prohibits healthcare professionals from violating Tex. Health & Safety Code § 311.0025. The latter section in turn prevents such professionals from submitting to a patient or third-party payor a bill for treatment which that professional "knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary." Tex. Health & Safety Code § 311.0025(a). HCSC's claims under this statute still fail as a matter of law.

Once again, HCSC fails to allege anything beyond quoting this statute's language. HCSC does not allege that the services billed for were not provided, were medically unnecessary, or were unreasonable—or that the Defendants made false representations about any of these things. At most, HCSC attempts to claim that the IOM services provided were "illicit" because they "are tainted by kickbacks." *See, e.g.*, AC ¶¶ 93–94. "Illicit" means "[i]llegal or improper." *Illicit*, Black's Law Dictionary (12th ed. 2024). But HCSC fails to show that these services were illegal (as it has not shown violations of the statutes on which it relies). Nor can it show these services were improper—its own amended complaint draws a clear distinction between the doctor-owned structure the HHS's OIG found could be illegal and the structure HCSC claims exists here. *Compare* AC ¶¶ 44–46, *with id.* ¶¶ 75, 88, 101, 114.

Fourth, to the extent the statutes are ambiguous as to their application to the conduct HCSC alleges, this Court should not interpret them more broadly than their intended purposes. Texas law

explicitly requires judges to interpret criminal statutes "according to the fair import of their terms, to promote justice and effect the objectives" of the criminal law. Tex. Penal Code § 1.05(a). Here, the fair import of each statute evinces a distinct, limited purpose: prohibiting direct bribes and other explicit *quid pro quo* arrangements that harm beneficiaries. But that purpose would not be served by broadening the reach of these statutes to prohibit arrangements which HCSC does not allege harm the beneficiaries: here, the patients.[7]

b. The Credentialing Theory fails.

The amended complaint also asserts that the Defendants committed fraud because an unnamed source supposedly told HCSC that sometimes the Defendants use two physicians to read IOM results, and that in some instances one of the two readers is either not credentialed at the hospital in question or licensed in the state in question. AC ¶¶ 226, 254. The source told HCSC that two IOM readers are always assigned to a particular operation; one is "credentialed at the rendering facility and licensed in the state where the procedure is taking place," while one "*typically* is not." AC ¶ 124 (emphasis added). HCSC asserts this is "an additional reason" why the claims are not payable. AC ¶ 121. To be clear, HCSC does not allege that more than one physician needs to perform the IOM reading in the first place (i.e., it is not that two licensed and credentialed physicians are required).

[7] HCSC also asserts an impliedly alternative claim: that the same conduct alleged to constitute fraud also constitutes negligent misrepresentation. But that claim fails for the same reasons as given above—HCSC has failed to sufficiently plead a violation of the kickback laws that underlie both claims. Indeed, HCSC relies on the same allegations to support its claim for negligent misrepresentation. Thus, the fraud claim is "so intertwined with the negligent misrepresentation claim that it is not possible to describe a simple redaction that removes the fraud claim while leaving behind a viable negligent misrepresentation claim." *Am. Realty Trust, Inc. v. Travelers Cas. & Sur. Co. of Am.*, 362 F. Supp. 2d 744, 749 (N.D. Tex. 2005). The necessity for this Court to "engage in line-by-line redaction in order to excise inadequate averments of fraud from accompanying claims of negligent misrepresentation" thus counsels in favor of dismissal. *See id.* at 752.

This theory fails under Rule 9(b) because the facts in the amended complaint do not show fraud—i.e., a lie. Perhaps most importantly, HCSC *never identifies* the law, rule, or policy requiring both readers to be licensed and credentialed. Whether a non-physician IOM reader must be *state-licensed* rather than certified under facility policy is generally state- and role-dependent; CMS's cited hospital telemedicine language does not, by itself, create a universal licensure rule for all states or roles. *See* Ex. 5, CMS, Memorandum, *Telemedicine Services in Hospitals and Critical Access Hospitals* (Jul. 15, 2011), https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/scletter11_32.pdf.

And HCSC does not list any claims where this supposedly happened. It does not list any doctors supposedly involved. It does not list any entities other than NMA, though in another part of the complaint it says NMA does not do such work itself, but "through its related and commonly owned entities," none of which is named with respect to credentialing. AC ¶ 60. HCSC names two hospitals but implies there are more. *See* AC ¶ 128. Indeed, HCSC does not even say the "primary" did not have access to the IOM data during procedures, which would be an obvious prerequisite for the "secondary" "perform[ing] the IOM reading." AC ¶ 125. HCSC also does not say why or how "the ordering surgeon has no way of knowing that this is occurring"—even though, for the service to be effective, they *must* be able to communicate somehow. *Id.*

And yet, despite providing *nothing* beyond general accusations and conjecture, HCSC posits that it is "highly likely" such activity occurred. AC ¶ 129. But it also cannot say whether this occurred with respect to any claim mentioned in the amended complaint. All it *can* say is that "some or all of these claims" *may* have been performed this way, asserting that is "highly likely." *Id.* But all HCSC offers is wild conjecture that NMA "acknowledge[s] and encourage[s]" this practice "companywide," AC ¶ 127, irrelevant speculation on why NMA is supposedly doing this,

AC ¶ 126, and rumors from an unnamed "former employee" who, quite conveniently, *only* alleges that this practice included two Texas hospitals—nothing else, AC ¶ 128. That's not highly likely. That's implausible, let alone plausible and specific enough to satisfy Rule 9(b).

E. HCSC's RICO claims fail.

HCSC offers two RICO claims, one premised on its NSA Theory (Count X) and the other on its Practice-Acquisition Theory (Count IX).

1. **The RICO claim based on the NSA Theory fails.**

The RICO claim based on the NSA Theory fails for reasons already established, and which are incorporated here by reference: the Court lacks subject-matter jurisdiction to apply RICO as a collateral attack on arbitration awards. *See HaloMD*, 2026 WL 1557492, at *3, *Anthem*, 2026 WL 982629, at *9–10, AC at 38 n. 24; *supra* § IV.A.

The theory also fails because it is based on the incorrect premise that submitting requests for arbitration and arbitration documents via wire amounts to wire fraud. As a matter of law, the "mailing of litigation documents, even perjurious ones, [does] not violate the mail-fraud statute." *United States v. Pendergraft*, 297 F.3d 1198, 1209 (11th Cir. 2002); *see also Snow Ingredients, Inc. v. SnoWizard, Inc.*, 833 F.3d 512, 524–25 (5th Cir. 2016) (citing *Pendergraft* and noting that "we agree with our sister circuit that 'prosecuting litigation activities as federal crimes would undermine the policies of access and finality that animate our legal system'").[8] Likewise, courts have repeatedly held that litigation activity generally cannot give rise to racketeering liability. *See Snow Ingredients*, 833 F.3d at 524–25; *Pendergraft*, 297 F.3d at 1208 (collecting cases); *Kim v. Kimm*, 884 F.3d 98, 104 (2d Cir. 2018) (collecting cases). This rule applies to actions taken in furtherance of litigation more broadly. *See CADG Erwin Farms, LLC v. Ipour*, 2024 WL 1394501,

[8] This applies to electronic transmissions, as mail and wire fraud are treated interchangeably for RICO purposes. *United States v. Bruno*, 809 F.2d 1097, 1104 (5th Cir. 1987).

at *5–7 (N.D. Tex. Mar. 31, 2024) (holding that mailing notices of default or termination, and filing lawsuits and notices were insufficient predicate acts under RICO because "the Fifth Circuit has expressly held that, in the absence of other criminal acts, such litigation activity, even if in bad faith, cannot serve as the basis for a civil RICO claim"); *Snow Ingredients, Inc.*, 833 F.3d at 524–25. This is the case even where the plaintiff alleges the lawsuits were malicious. *See Raney v. Allstate Ins. Co.*, 370 F.3d 1086, 1087–88 (11th Cir. 2004) (holding that an "alleged conspiracy to extort money through the filing of malicious lawsuits" are not predicate acts of extortion or mail fraud under RICO); *see also CADG Erwin Farms*, 2024 WL 1394501, at *7 ("The Complaint contains no allegations of any criminal activity in connection with the lawsuits and *lis pendens*, such as witness tampering or other corruption, which could trigger RICO's applicability.").

These principles extend to arbitration proceedings as well, as courts have held that arbitration activities cannot form the basis for mail or wire fraud. *Republic of Kazakhstan v. Stati*, 380 F. Supp. 3d 55, 60–61 (D.D.C. 2019) (holding that litigation materials transmitted during a prior arbitration could not constitute wire or mail fraud); *Diamond Resorts Int'l, Inc. v. Aaronson*, 2018 WL 735627, at *5 (M.D. Fla. Jan. 26, 2018) (holding that false statements in arbitration demands were not grounds for mail or wire fraud). HCSC's supposed predicate acts therefore fail under this rule because all the alleged misrepresentations it points to pertaining to the IDR theory are in submissions made attendant to the IDR process. *See* AC ¶¶ 3, 9, 172, 175, 184, 191, 196, 205, 210, 219, 332. Such arbitration conduct cannot support a wire fraud theory. *See Snow Ingredients, Inc.*, 833 F.3d at 524–25; *Pendergraft*, 297 F.3d at 1208. And while HCSC claims that allegedly ineligible filings forced it into arbitrations it otherwise would have avoided, such alleged conduct is insufficient even where it "led to Plaintiffs engaging in subsequent arbitrations that might not have otherwise occurred." *See Diamond Resorts Int'l*, 2018 WL 735627, at *5.

Likewise, procuring payments secured through successful IDR arbitrations is simply an extension of the same litigation-related conduct, and it cannot support a mail or wire fraud claim. *See Snow Ingredients*, 833 F.3d at 524–25 (5th Cir. 2016); *Pendergraft*, 297 F.3d at 1208. Nor does HCSC plead any misrepresentation regarding collection of judgments obtained through successful arbitrations. That dooms its claim, as proof of deceptive conduct is required for wire fraud. *See CADG Erwin Farms*, 2024 WL 1394501, at *5; *see also Am. Dental Ass'n v. Cigna Corp.*, 605 F.3d 1283, 1292 (11th Cir. 2010) ("[A] plaintiff must allege that some kind of deceptive conduct occurred in order to plead a RICO violation predicated on mail fraud." (citation omitted)).

2. **The RICO claim based on the Practice-Acquisition Theory fails.**

To state a civil RICO claim under 18 U.S.C. § 1962(c), HCSC must allege three common elements: "(1) a person who engages in (2) a pattern of racketeering activity, (3) connected to the acquisition, establishment, conduct, or control of an enterprise." *Snow Ingredients, Inc.*, 833 F.3d at 523–24 (internal quotation omitted). Additionally, a plaintiff lacks RICO standing if it fails to demonstrate an injury to its "business or property ***by reason of*** a violation of § 1962." *HCB Fin. Corp. v. McPherson*, 8 F.4th 335, 338–39 (5th Cir. 2021) (emphasis added).[9]

a. Failure to plead RICO injury

A "plaintiff only has standing if, and can only recover to the extent that, he has been injured in his business or property by the conduct constituting the violation." *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479 (1985). And a "defendant who violates section 1962 is not liable for treble damages to everyone he might have injured by other conduct, nor is the defendant liable to those who have not been injured." *Id.* (quoting approvingly from *Haroco, Inc. v. Am. Nat'l Bank & Tr.*

[9] These arguments also apply to the RICO claim based on the NSA Theory, although that theory first fails for jurisdictional reasons. To the extent the theory survives, these arguments are incorporated by reference as to the NSA Theory.

Co. of Chicago, 747 F.2d 384, 398 (7th Cir. 1984)). HCSC has not pleaded facts to show that it was injured in any way by the supposed violation of § 1962.

Specifically, HCSC has not pleaded facts to show that it paid for medical care that was unnecessary, or that cost more than it would have had the practice acquisitions not been structured in the form to which HCSC objects. In fact, HCSC does not dispute that it must pay for IOM services that its insureds receive and does not allege any instance where IOM services were not medically necessary. But a plaintiff lacks RICO standing if it fails to demonstrate an injury to its "business or property ***by reason of*** a violation of § 1962." *HCB Fin. Corp.*, 8 F.4th at 338–39 (emphasis added). *See generally* 18 U.S.C. § 1964(c). This requires a showing of "concrete financial loss." *Patterson v. Mobil Oil Corp.*, 335 F.3d 476, 492 n.16 (5th Cir. 2003). A plaintiff fails to allege an injury when its allegations do not demonstrate it paid more than it would have absent the racketeering activity, as HCSC fails to do here. *See Price v. Pinnacle Brands, Inc.*, 138 F.3d 602, 607 (5th Cir. 1998) (affirming the dismissal of RICO claim where plaintiffs did not allege "they received something different than precisely what they bargained for" or "that the value of the cards that they did receive is less than the consideration paid"); *Earl*, 53 F.4th at 903 (holding that plaintiffs did not allege an injury where they did not allege "that they're any worse off financially because [of] defendants' fraud," reasoning that "[i]n an ordinary fraud lawsuit—a pyramid scheme, for example—there are identifiable victims who lost money that wouldn't have been lost in a counterfactual world without the fraudulent scheme").

Indeed, HCSC fails to allege RICO standing for three main reasons. ***First***, there are no allegations that it paid more for IOM services than it would have absent the alleged referral agreement. *See Earl*, 53 F.4th at 903 (rejecting an "overcharge-by-fraud" theory of injury). ***Second***, HCSC does not allege that the IOM services were never performed; its insureds received

the service for which HCSC paid. *See Price*, 138 F.3d at 607. ***Finally***, it does not allege that it paid for IOM services that were not necessary. Indeed, HCSC does not allege that its insureds did not need IOM, meaning that it would have paid for the IOM services regardless. Put simply, HCSC did not "los[e] money that wouldn't have been lost in a counterfactual world without the fraudulent scheme." *See Earl*, 53 F.4th at 903 (finding no RICO injury where passengers alleged they would not have bought tickets on an airplane that did not satisfy regulatory certifications); *see also Rivera*, 283 F.3d at 320–21 (no injury where plaintiffs paid for and received an effective painkiller, despite regulatory and safety risks). And awarding damages to HCSC without any consideration for the fact that these medical services were indisputably provided would reward HCSC with a windfall: it would effectively not have to pay for treatments its insureds needed and actually received, and for which it has an obligation to pay.

At most, HCSC objects to Defendants' corporate structure. *See, e.g.*, AC ¶ 321. But this dissatisfaction is not itself a concrete injury to business or property. After all, the Texas state statutes to which HCSC cites as prohibiting kickbacks—Tex. Occ. Code § 102.001, Tex. Penal Code § 32.43, and Tex. Occ. Code § 101.203—are meant to protect patients, not insurers. The Texas anti-bribery statute criminalizes corrupt benefits accepted by a "fiduciary" which influences his conduct in relation to a "beneficiary." In other words, its purpose is to protect beneficiaries from corrupt arrangements involving those who have a duty to put the beneficiary's best interests first. *See* Tex. Penal Code § 32.43. But here, it is undisputed that HCSC is not a beneficiary; the patients are the beneficiaries, and they received their necessary medical services.

Put simply, HCSC must plead that the alleged racketeering conduct directly caused it to pay money it otherwise would not have paid. Because the amended complaint does not do so, HCSC lacks civil RICO standing. *See* 18 U.S.C. § 1964(c); *HCB Fin. Corp.*, 8 F.4th at 338–39.

b. Failure to plead predicate acts

A RICO claim must include at least "two or more predicate criminal acts that are (1) related and (2) amount to or pose a threat of continued criminal activity." *Snow Ingredients, Inc.*, 833 F.3d at 524 (citation omitted). Here, HCSC relies on two theories: wire fraud (the submission of claims to HCSC, and transmission of the associated payments, etc.) and violations of the Texas commercial bribery statute, Tex. Penal Code § 32.43. *See* AC ¶¶ 308–22, 332. Each fail.

(i) Wire fraud

HCSC argues that NMA's submission of claims for payment constitutes wire fraud because those claims were allegedly "tainted" by kickbacks. AC ¶ 309. As noted above, pleading a fraudulent scheme under RICO requires allegations of deceptive conduct. And to show deceptive conduct, a plaintiff must allege a fraudulent statement or other violation of the wire fraud statute. HCSC has not. *See supra* § IV.D.a. For the reasons in the sections above, which are incorporated by reference here, HCSC has not alleged with specificity a fraudulent statement that any Defendant made to HCSC. In short, it has not shown fraud—without fraud, there is no wire fraud.

(ii) Commercial bribery

HCSC also points to supposed violations of the Texas commercial bribery statute, Tex. Penal Code § 32.43, as predicate acts to support its RICO claim; this theory fares no better than the others. For the reasons given above, *see supra* § IV.D.a.ii, which are incorporated by reference here, the Texas commercial bribery statute has no private right of action and does not reach the conduct HCSC alleges. But even if it did, HCSC has not pleaded facts supporting each required element of the offense. *See id.* Where a RICO plaintiff "seeks to allege racketeering activity through the commission of state statutory offenses," that plaintiff must "allege facts plausibly showing the commission of those offenses—that is, *each* element of *each* identified state statutory offense." *In re EpiPen Direct Purchaser Litig.*, 2023 WL 2860858, *4 (D. Minn. Apr. 10, 2023).

Finally, as shown above, HCSC has not shown that it was injured "by reason of" the supposed violation. *See* 18 U.S.C. § 1964(c); *supra* § IV.D.2.a.

c. Failure to plead the existence of a RICO enterprise

HCSC also fails to adequately plead the existence of a RICO enterprise. To avoid dismissal under Rule 12(b)(6), HCSC "must plead specific facts, not mere conclusory allegations, which establish the existence of an enterprise." *Elliott v. Foufas*, 867 F.2d 877, 881 (5th Cir. 1989). An enterprise is "any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity." 18 U.S.C. § 1961(4).

HCSC's RICO claims rely on an "associated-in-fact" enterprise theory. AC ¶ 292. *See generally* 18 U.S.C. § 1961(4). It alleges that the Defendants and "the surgeons who made referrals to NMA and Physician Oversight"—who HCSC calls the "Ordering Surgeons"—formed the associated-in-fact enterprise. AC ¶ 292. The Supreme Court has held that an association-in-fact enterprise must possess three qualities: "a purpose, relationships among those associated with the enterprise, and longevity sufficient to permit these associates to pursue the enterprise's purpose." *Boyle v. United States*, 556 U.S. 938, 946 (2009) (citation omitted). In other words, it must be "a continuing unit that functions with a common purpose." *Id.* at 948. Ultimately, the court "must be wary of transforming business-contract or fraud disputes into federal RICO claims." *See Arruda*, 861 F. App'x at 836; *accord Bible v. United Student Aid Funds, Inc.*, 799 F.3d 633, 655–56 (7th Cir. 2015) (noting that courts distinguish between "run-of-the-mill commercial relationship[s] where each entity acts in its individual capacity to pursue its individual self-interest, versus a truly joint enterprise where each individual entity acts in concert with the others to pursue a common interest" and highlighting that "[t]his distinction is important"); *United Food & Com. Workers Unions & Emps. Midwest Health Benefits Fund v. Walgreen Co.*, 719 F.3d 849, 855–56 (7th Cir. 2013) (concluding that the allegations were insufficient to plead an association-in-fact enterprise

where the allegations demonstrated only that "defendants had a commercial relationship, not that they had joined together to create a distinct entity" for engaging in fraud).

HCSC fails to allege a relationship among "those associated with the enterprise," e.g., among Defendants and the Ordering Surgeons. *Boyle*, 556 U.S. at 946. As to the IOM Referral Enterprise, HCSC alleges parallel, bilateral conduct between the Defendants and ordering surgeons (e.g., the surgeons ordered IOM services which the Defendants provided). What it fails to allege is any collaboration among the Ordering Surgeons and NMA entities beyond parallel conduct that, at most, is indicative only of reasonable commercial activity (ordering and provision of IOM services) conducted in parallel. But failure to "plausibly imply anything more than parallel conduct" cannot support that the Defendants and the ordering surgeons "associated together for a common purpose." *See In re Insurance Brokerage Antitrust Litig.*, 618 F.3d 300, 374 (3d Cir. 2010) (quoting *Boyle*, 556 U.S. at 946); *Brunig v. Clark*, 560 F.3d 292, 297 (5th Cir. 2009) (dismissing RICO claim where plaintiff alleged only "a conclusory statement, a recitation of the elements masquerading as facts [that] does not make it any more or less probable that the listed parties have an existence separate and apart from the pattern of racketeering"). Especially where HCSC fails to plead facts to "plausibly imply concerted action" it did not allege any "collaboration among the [ordering surgeons]" to further the purported scheme. *See In re Insurance Brokerage Antitrust Litig.*, 618 F.3d at 374.

F. The Court should dismiss HCSC's claims for money had and received.

After dismissing the federal claims, the Court should not exercise its supplemental jurisdiction to hear these state-law equitable claims. However, even if the Court did reach it, it should still dismiss the claims for money had and received.

In Texas, money had and received is an equitable claim, where "a plaintiff must show that a defendant holds money which in equity and good conscience belongs to [the plaintiff]." *Baylor*

Scott & White v. Project Rose MSO, LLC, 633 S.W.3d 263, 293 (Tex. Ct. App. 2021) (citation omitted). But a plaintiff cannot "survive the motion to dismiss stage by pleading only legal conclusions." *Partners & Friends Holding Corp. v. Cottonwood Minerals L.L.C.*, 653 F. Supp. 3d 344, 349 (N.D. Tex. 2023).

As to the Practice-Acquisition Theory, HCSC does not dispute that the IOM services were medically necessary or that they were actually provided, nor does it plead that it paid more than it would have from another provider. If it invokes equity to receive these services for its insureds for free, its request must fail. As to its Credentialing Theory, HCSC has not identified or pleaded with specificity facts about a single patient who did not receive care from at least one licensed and credentialed IOM reader; why, in these circumstances, would the result be that HCSC should not have had to pay for them? HCSC thus cannot show that Defendants hold money that "in equity and good conscience" belongs to it. *Baylor Scott & White*, 633 S.W.3d at 293. The Court should dismiss these claims, if it reaches them at all.

G. HCSC's declaratory judgment counts and requests for injunctive relief fail.

The Declaratory Judgment Act is discretionary; courts "*may*" declare such rights but are not required to do so. 28 U.S.C. § 2201(a) (emphasis added); *MedImmune, Inc. v. Genentech, Inc.*, 549 U.S. 118, 136 (2007). When exercising its discretion to consider "a declaratory judgment action, a district court must engage in a three-step inquiry." *Orix Credit Alliance, Inc. v. Wolfe*, 212 F.3d 891, 895 (5th Cir. 2000). "The court must ask (1) whether an actual controversy exists between the parties in the case; (2) whether it has authority to grant declaratory relief; and (3) whether to exercise its broad discretion to decide or dismiss a declaratory judgment action." *Frye v. Anadarko Petroleum Corp.*, 953 F.3d 285, 294 (5th Cir. 2019) (cleaned up).

HCSC's request for declaratory judgment fails as to its IDR claims because the Court lacks subject-matter jurisdiction to review these arbitration awards, for the reasons set out above. The

Court likewise lacks authority to grant declaratory judgment as to HCSC's claims based on its Practice-Acquisition Theory. The Declaratory Judgment Act "does not provide . . . jurisdiction." *California v. Texas*, 593 U.S. 659, 672 (2021). Rather, as with "every other type of remedy," the plaintiff must satisfy the basic standing and jurisdictional requirements of Article III. *Id.* Likewise, as to the Texas statutes HCSC cites for its Practice-Acquisition Theory, none provides a private right of action. *Spurlock v. Johnson*, 94 S.W.3d 655, 658 (Tex. Ct. App. 2002); *Conn. Gen. Life Ins. Co. v. Elite Ctr. for Minimally Invasive Surgery LLC*, 2017 WL 607130, at *15 (S.D. Tex. Feb. 15, 2017), *amended and superseded in part*, 2017 WL 1807681 (S.D. Tex. May 5, 2017). It is well established by courts within the Fifth Circuit that "declaratory judgment under 28 U.S.C. § 2201 is not available where the substantive statute at issue does not provide a private right of action." *See, e.g.*, *DAC Surgical Partners P.A. v. United Healthcare Servs., Inc.*, 2016 WL 7177881, at *13 (S.D. Tex. Dec. 8, 2016) (internal quotation omitted and collecting cases).

A similar outcome must follow as to HCSC's request for injunctive relief. Injunctions are an equitable remedy and are not awarded as "a matter of right." *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312 (1982) (citation omitted). HCSC's claim for equitable relief still suffers from a fatal flaw: the only harm HCSC claims to have suffered is a monetary one. *See* AC ¶¶ 10, 81, 94, 107, 120, 143, 175–176, 188–190, 202–204, 216–218, 227, 232, 242, 247, 257, 260, 267, 272, 275–278, 327, 344. Alleged injuries involving only the loss of money are not irreparable. *Sampson v. Murray*, 415 U.S. 61, 90 (1974) ("The key word in this consideration is *irreparable*. Mere injuries, however substantial, in terms of money . . . are not enough.").

V. CONCLUSION

For the above reasons, the Court should dismiss the amended complaint with prejudice.

Respectfully submitted,

Dated: June 18, 2026

/s/ *Matthew L. Knowles*
Matthew L. Knowles (*pro hac vice*) (Lead attorney)
Asseret Frausto (*pro hac vice*)
Carolyn Zaccaro (*pro hac vice*)
MCDERMOTT WILL & SCHULTE LLP
200 Clarendon Street
Boston, MA 02116
Telephone: (617) 535-4000
Fax: (617) 535-3800
mknowles@mcdermottlaw.com
afrausto@mcdermottlaw.com
czaccaro@mcdermottlaw.com

R. Bray McDonnell (*pro hac vice*)
MCDERMOTT WILL & SCHULTE LLP
500 N Capitol Street NW
Washington, D.C. 20001
Telephone: (202) 756-8000
Fax: (202) 756-8087
rmcdonnell@mcdermottlaw.com

John M. Pickett
Texas Bar No. 15980320
LAW OFFICES OF JOHN M. PICKETT
4122 Texas Blvd.
Texarkana, TX 75503
Telephone: (903) 794-1303
Fax: (903) 792-5098
jpickett@jpickettlaw.com

Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that the foregoing document was electronically filed with the Clerk of the Court using the CM/ECF filing system, which will generate and send an e-mail notification of said filing to all counsel of record on June 18, 2026.

/s/ Matthew L. Knowles
Matthew L. Knowles

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

DECLARATION OF MATTHEW L. KNOWLES IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS AND REQUEST FOR JUDICIAL NOTICE

I, Matthew L. Knowles, pursuant to 28 U.S.C. § 1746 and Eastern District of Texas Local Rule CV-7(b), declare as follows:

1. I am an attorney at McDermott Will & Schulte LLP, which represents Defendants Neuromonitoring Associates, LLC; Physician Oversight, LLC; and Monitoring Associates, LLC ("Defendants") in the above-captioned case. I am admitted *pro hac vice* in the U.S. District Court for the Eastern District of Texas. I am over 21 years of age, and I am competent to make this Declaration. The statements in this Declaration are true and made of my personal knowledge.

2. I submit this Declaration in support of Defendants' Motion to Dismiss the Amended Complaint and Request for Judicial Notice (the "Motion"), dated June 18, 2026, and filed concurrently with this Declaration.

3. Attached to the Motion as **Exhibit 1** is a true and correct excerpted copy, with highlighting added to the relevant portions per Local Rule CV-7(b), of the public

document and website found at: Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties, CMS.gov (2023), https://www.cms.gov/files/document/federal-idr-guidance-disputing-parties-march-2023.pdf, in the form I downloaded it on April 7, 2026.

4. Attached to the Motion as **Exhibit 2** is a true and correct excerpted copy, with highlighting added to the relevant portions per Local Rule CV-7(b), of the public document and website found at: Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities (2022), https://www.cms.gov/files/document/ta-certified-independent-dispute-resolution-entities-august-2022.pdf, in the form I downloaded it on April 7, 2026.

5. Attached to the Motion as **Exhibit 3** is a true and correct excerpted copy, with highlighting added to the relevant portions per Local Rule CV-7(b), of the public document and website found at: Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties – Topic: Errors Identified After Dispute Closure, CMS.gov (2025), https://www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf, in the form I downloaded it on April 7, 2026.

6. Attached to the Motion as **Exhibit 4** is a true and correct copy of the public government form CMS-1500 found at: https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1500.pdf, in the form I downloaded it on June 18, 2026.

7. Attached to the Motion as **Exhibit 5** is a true and correct excerpted copy, with highlighting added to the relevant portions per Local Rule CV-7(b), of the public

document and website found at: CMS, Memorandum, *Telemedicine Services in Hospitals and Critical Access Hospitals* (Jul. 15, 2011), https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/scletter11_32.pdf, in the form I downloaded on June 15, 2026.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on the 18th day of June, 2026, in Boston, Massachusetts.

/s/ Matthew L. Knowles
Matthew L. Knowles

EXHIBIT 1

Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties

December 2023 Update to March 2023 Guidance

This guidance document is effective upon publication and is consistent with all relevant court cases and guidance **for items and services furnished on or after October 25, 2022 for plan years (in the individual market, policy years) beginning on or after January 1, 2022** by an out-of-network provider subject to the Requirements Related to Surprise Billing; Part II, 86 FR 55980, and Requirements Related to Surprise Billing; Final Rule, 87 FR 52618.

Items and services furnished before October 25, 2022 for plan years (in the individual market, policy years) beginning on or after January 1, 2022 are subject to a different guidance document, issued on October 7, 2022 and updated December 15, 2023 effective July 26, 2022**.**

Please visit www.cms.gov/nosurprises for the most current guidance documents related to the Federal IDR Process.

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- ✓ Written information, including an attestation, regarding the applicability of the Federal IDR process;
- ✓ Non-initiating party's information regarding the inapplicability of the Federal IDR Process, as necessary; and
- ✓ Signature of a representative of the initiating party, full name, and date.

If the non-initiating party fails to respond to the initiating party's selection of a certified IDR entity, the initiating party's preferred certified IDR entity will be selected, unless that certified IDR entity is ineligible for another reason.

5.4 Failure to Select a Certified IDR Entity: Random Selection by the Departments

When the parties cannot agree on the selection of a certified IDR entity, the Departments will randomly select a certified IDR entity **no later than 6 business days** after the date of initiation of the Federal IDR Process and will notify the parties of the selection.[17] The certified IDR entity selected by the Departments will be one that charges a fee within the allowed range that can be found here). If there is an insufficient number of certified IDR entities available that charge a fee within the allowed range, the Departments will randomly select a certified IDR entity that has approval to charge a fee outside of that range.

5.5 Instances When the Non-Initiating Party Believes the Federal IDR Process Does Not Apply

If the non-initiating party believes that the Federal IDR Process is not applicable, the non-initiating party must notify the Departments by submitting the relevant information through the Federal IDR portal as part of the certified IDR entity selection process. This information must be provided not later than **1 business day** after the end of the 3-business-day period for certified IDR entity selection (the same date that the notice of selection or of failure to select a certified IDR entity must be submitted). This notification must include information regarding the Federal IDR Process' inapplicability.

The certified IDR entity must determine whether the Federal IDR Process is applicable. The certified IDR entity must review the information submitted in the **Notice of IDR Initiation** and the notification from the non-initiating party claiming the Federal IDR Process is inapplicable, if one has been submitted, to determine whether the Federal IDR Process applies. If the Federal IDR Process does not apply, the certified IDR entity must notify the Departments and the parties within 3 business days of making that determination. While the matter is under review by the certified IDR entity, the timelines of the Federal IDR Process continue to apply, so the parties should continue to meet deadlines to the extent possible, as described in Section 9. Further, the Departments will maintain oversight of the applicability of the Federal IDR Process through their audit authority.

[17] A situation in which the non-initiating party does not object to the preferred certified IDR entity included in the initiating party's Notice of IDR Initiation, and the initiating party submits its preferred certified IDR entity on the Notice of Certified IDR Entity Selection, is not considered a failure to select a certified IDR entity.

Appendix C. Resources

Notices:

- Paperwork Reduction Act (PRA) notices and information collection requirements for the Federal Independent Dispute Resolution Process (Download Notices and Information Requirements)
- Standard notice & consent forms for nonparticipating providers & emergency facilities regarding consumer consent to waive surprise billing protections (Download Surprise Billing Protection Form) (PDF)
- Model disclosure notice on patient protections against surprise billing for providers, facilities, health plans, issuers and carriers (Download Patient Rights & Protections Against Surprise Medical Bills) (PDF)
- Rules and Fact Sheets
- Federal IDR Portal

Please see https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets for information on the applicable fees.

Independent Dispute Resolution Timeline for Claims

Where to go for help

CMS.Gov/NoSurprises

No Surprises Help Desk: 1-800-985-3059

Department of Health & Human Services
200 Independence Ave S.W.
Washington D.C. 20201
Toll Free Call Center: 1-877-696-6775
www.hhs.gov

Department of Labor
200 Constitution Ave N.W.
Washington, DC 20210
1-866-4-USA-DOL / 1-866-487-2365
www.dol.gov

Department of the Treasury
1500 Pennsylvania Ave N.W.
Washington, D.C. 20220
General Information: (202) 622-2000
www.treasury.gov

Federal Independent Dispute Resolution (IDR) Process
Guidance for Disputing Parties

December 2023 Update to March 2023 Guidance

EXHIBIT 2

Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities

August 2022

Provisions in this document related to the calculation of Qualifying Payment Amounts (QPAs) and disputes involving air ambulance services have not been amended to reflect the opinion and order in *Texas Medical Association, et al. v. U.S. Department of Health and Human Services, et al.,* Case No. 6:22-cv-450-JDK (*TMA III*). Information on provisions related to batched disputes also have not been amended to reflect the opinions and orders in *Texas Medical Association, et al. v. U.S. Department of Health and Human Services, et al.,* Case No. 6:23-cv-00059-JDK (*TMA IV*) and *TMA III*. Guidance issued by the Departments of the Treasury, Labor, Health and Human Services, and Office of Personnel Management on the calculation and use of QPAs, as well as their related exercise of enforcement discretion, can be found in "FAQs about Consolidated Appropriations Act Implementation, 2021 Part 62" (October 6, 2023) (available at: https://www.cms.gov/files/document/faqs-part-62.pdf).

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

the technical direction provided to certified IDR entities by the Departments. If the initiating party does not resubmit the qualified IDR items or services within four business days, the qualified IDR items and services cannot be considered for payment determinations. When re-submitting disputes involving previously inappropriately batched or bundled qualified IDR items or services in new batches, bundles, or as single disputes, the initiating party may not add additional items or services for consideration. Both parties must also pay the appropriate certified IDR entity fees for single or batched disputes and administrative fees for each of the re-submitted disputes, as applicable.

Currently, the Federal IDR portal is unable to accommodate separating inappropriately batched or bundled disputes into separate disputes (even when the qualified items and services meet all of the other applicable requirements) within the system. As a purely operational matter, the re-submission of qualified IDR items or services that have been inappropriately included in a batched or bundled dispute and acceptance of those qualified IDR items or services in properly batched or single disputes must be accomplished through resubmission by following the process for initiating the Federal IDR process in the Federal IDR portal. The Departments are working to update the Federal IDR portal system so that improperly batched or bundled qualified IDR items or services can be addressed by certified IDR entities within the Federal IDR portal without resubmission by the parties, streamlining the process for addressing inappropriately batched or bundled qualified IDR items or services.

Topic: Eligibility for the Federal IDR Process

9. **How should the certified IDR entity proceed if a non-initiating party that is a plan or issuer, states that it did not receive the open negotiation notice from an initiating party that is a provider, facility, or provider of air ambulance services[13]?**

Step 1: Confirm that the item or service included in the dispute is a qualified IDR item or service for the Federal IDR process

- **Have both parties attested that the Federal IDR process applies?**
    a. If ***yes***, move on to step 2.

    b. If ***no***, request documentation or an explanation to determine if the non-initiating party believes that the item or service included in the dispute is not subject to the Federal IDR process for any reason other than the non-initiating party's assertion that it did not receive the notice of open negotiation. If the documentation demonstrates that the item or service included in the dispute is **not subject** to the Federal IDR process for a reason other than the non-initiating party's non-receipt of the notice of open

[13] Throughout this section of the document, for simplicity of drafting, "provider" refers to a "provider", "facility", or "provider of air ambulance services", as applicable.

negotiation (i.e., the out-of-network payment amount for the item or service is determined subject to a specified state law), the certified IDR entity must close the dispute due to the inapplicability of the Federal IDR process. If the documentation demonstrates that the item or service included in the dispute is a qualified IDR item or service subject to the Federal IDR process, go to step 2.

Step 2: Determine whether the provider received an initial payment or notice of denial of payment

- **Did the provider receive an initial payment or notice of denial of payment from a group health plan or health insurance issuer for the qualified IDR item or service under dispute?**
  a. If ***yes*,** move to step 3.

  b. If ***no*,** the certified IDR entity must close the dispute and mark it as ineligible because a provider must receive an initial payment or notice of denial of payment from a plan or issuer in order for a party to initiate the open negotiation period and for the Federal IDR process to be initiated. The certified IDR entity may direct the provider to file a formal complaint for investigation by the appropriate Federal or state enforcement authority for the plan's or issuer's failure to timely issue an initial payment or notice of denial of payment. The provider may do so by contacting the No Surprises Help Desk. The certified IDR entity should also inform the provider that the period for open negotiation cannot be initiated until the initial payment or notice of denial of payment is received by the provider.

Step 3: Determine whether the required disclosures were included with the initial payment or notice of denial of payment

- **Request from both parties a copy of the provider remittance advice, explanation of benefits, or other documentation included with the initial payment or notice of denial of payment to determine if the initial payment or notice of denial of payment includes all of the required disclosures (see Appendix A)**
  a. If ***all required disclosures were provided,*** skip to step 4A.

  b. If ***any required disclosures were not provided***, the certified IDR entity should determine what required disclosure(s) are missing. If any disclosures described in Appendix A are missing (*e.g.*., email address or telephone number for the plan or issuer, QPA(s) for the qualified IDR item(s) or service(s) under dispute or additional information about the QPA that is required to be provided upon request), the certified IDR entity should place the dispute in the "outreach in progress" status in the Federal IDR portal and

Department of Health & Human Services200 Independence Avenue, S.W. Washington, D.C. 20201
Toll Free Call Center: 1-877-696-6775
www.hhs.gov

Department of Labor 200 Constitution Ave NW Washington, DC 20210
1-866-4-USA-DOL / 1-866-487-2365
www.dol.gov

Department of the Treasury 1500 Pennsylvania Ave., N.W.Washington, D.C. 20220
General Information: (202) 622-2000
www.treasury.gov

Federal Independent Dispute Resolution (IDR) Process

Technical Assistance for Certified IDR Entities

EXHIBIT 3

Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties
June 2025

Topic: Errors Identified After Dispute Closure

Purpose:
The Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) categorized three types of errors—clerical, jurisdictional, and procedural—that a certified Independent Dispute Resolution (IDR) entity may make, but is not identified until after a dispute is closed. These types of errors should be corrected by reopening a closed dispute to ensure the results of the Federal IDR process are aligned with the No Surprises Act (NSA) and that a certified IDR entity complies with the NSA and its implementing regulations. This Technical Assistance (TA) defines these types of errors and contains process guidelines to better ensure the efficient and logical correction of the certified IDR entity's errors, including when a closed dispute resulted in a payment determination.[1] It is intended only to provide clarity to the public regarding the Departments' process under their existing authority to establish an IDR process aligned with statutory and regulatory requirements. This TA is not intended to have the force of law or to impose substantive requirements on parties to the Federal IDR process or on certified IDR entities. It includes a general description of agency policy and sets forth operational guidance to the certified IDR entities.

Based on feedback from certified IDR entities and disputing parties, the Departments have determined that a process for reopening disputes to correct errors identified after dispute closure is needed to support disputing parties and certified IDR entities, and to ensure program integrity. This TA provides guidance to disputing parties and certified IDR entities on the error correction process and clarifies how certified IDR entities should treat three categories of errors identified after dispute closure. Specifically, this TA:

- Provides definitions and examples of the three categories of errors that may be corrected after dispute closure: (1) clerical, (2) jurisdictional, and (3) procedural;
- Includes instructions on correcting such errors;
- Clarifies the impact of a corrected error on the administrative and certified IDR entity fees; and
- Identifies types and examples of errors that may not be corrected after dispute closure.

To reduce errors, the Departments continue to strongly encourage certified IDR entities to have robust quality assurance (QA) programs to verify dispute eligibility and review payment determinations before transmitting determinations to disputing parties and/or closing disputes. A certified IDR entity that does not maintain an adequate QA process may be determined to not be

[1] Under section 9816(c)(5)(e) of the Internal Revenue Code (Code), section 716(c)(5)(E) of the Employee Retirement Income Security Act (ERISA), and section 2799A-1(c)(5)(E) of the Public Health Service Act (PHS Act), IDR payment determinations are generally binding, absent a claim of fraud or misrepresentation of facts, and are subject to judicial review only in limited circumstances described in 9 USC § 10(a).

fit or qualified to make determinations under the Federal IDR process.[2] The Departments will continue to monitor the volume of errors and emphasize that the certified IDR entities are responsible for ensuring that eligibility and payment determinations are accurate. This TA applies to requests to reopen closed disputes received by the Departments:

- On or after **June 6, 2025**; and
- Prior to **June 6, 2025**, but to which the Departments had not responded prior to **June 6, 2025**.

Eligible requests will be evaluated by the Departments in accordance with this TA document. Requests to reopen disputes that the Departments denied prior to **June 6, 2025** should not be resubmitted for reconsideration as they will not undergo additional review. This TA provides a streamlined approach to the requests to reopen closed disputes and ensures the process of correcting errors is uniform and consistent from publication of this TA onward.

Categories of Errors that Certified IDR Entities May Submit for Reopening and Correction After Dispute Closure:

Category 1: Clerical Error

The Departments define a clerical error as a typographical (typo), computational (user) error, or IT systems error impacting the operation or use of the Federal IDR portal made by the certified IDR entity while performing administrative tasks or functions that do not involve the certified IDR entity's discretion, judgment, or expertise.

Examples of clerical errors include, but are not limited to, the following:

1. Based on the documentation provided by the disputing parties, a certified IDR entity determines that the initiating party will be the prevailing party to a dispute. However, the certified IDR entity mistakenly selects the non-initiating party when identifying the prevailing party in the payment determination.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the original payment determination and issue a new one in favor of the initiating party, which will supersede the payment determination made in error.

2. When issuing a payment determination, the certified IDR entity mistakenly fails to upload the required documentation that one or both disputing parties submitted to the Federal IDR portal. The certified IDR entity appropriately considered the information included in this documentation when rendering the payment determination but did not upload the documentation to the Federal IDR portal.

[2] 26 CFR 54.9816–8T(e)(6)(ii)(G), 29 CFR 2590.716-8(e)(6)(ii)(G), 45 CFR 149.510(e)(6)(ii)(G).

If the Departments approve the request to reopen the dispute, the certified IDR entity should re-issue the payment determination that has been corrected to include the previously omitted documentation.

3. When issuing a payment determination, the certified IDR entity makes a typo in the summary section of the payment determination by misspelling a party's name.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should re-issue the payment determination reflecting the appropriate spelling.

4. When a disputing party receives a link from the Federal IDR portal to make an offer, the link is broken and cannot be accessed, and therefore an offer cannot be made in a timely manner.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should proceed with the Federal IDR process.

Category 2: Jurisdictional Error

The Departments define a jurisdictional error as a situation when the certified IDR entity incorrectly determines that an item or service either is or is not a qualified IDR item or service eligible for the Federal IDR process under the requirements of the NSA.

Examples of jurisdictional errors include, but are not limited to, situations where the eligibility of the item or service was incorrectly determined based on the following considerations:

1. Whether it relates to an item or service furnished during a plan year beginning prior to January 1, 2022;

2. Whether it is subject to an All-Payer Model Agreement under section 1115A of the Social Security Act or a specified State law;

3. Whether it relates to an item or service payable by Medicare, Medicaid, CHIP, or TRICARE, Indian Health Service, Veterans Affairs Health Care, short-term limited duration insurance, or excepted benefits;

4. Whether it is furnished by a participating provider, a participating facility, or a participating provider of air ambulance services; or

5. Whether it would not have been covered in-network by the health plan or issuer.

The Departments have determined that jurisdictional errors should be corrected by reopening a dispute to ensure compliance with the NSA's requirements. If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the payment determination, correct the eligibility determination (to reverse a determination of eligibility), communicate to the disputing parties the change to the eligibility determination, refund or invoice the certified

IDR entity fees as appropriate, and send the resulting eligibility determination to the disputing parties.

Category 3: Procedural Error

The Departments define a procedural error as a situation when the certified IDR entity incorrectly determines the eligibility of an item or service for the Federal IDR process or incorrectly makes a determination because a disputing party satisfied, or failed to satisfy, a required procedural step to engage in the Federal IDR process, such as submitting required documentation or timely completion of a step in the process.

Examples of procedural errors include, but are not limited to, the following:

1. The certified IDR entity renders a payment determination for a dispute in which the initiating party failed to timely furnish the notice of initiation to the non-initiating party.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the payment determination and update the eligibility determination to reflect that the dispute is ineligible for the Federal IDR process, close the dispute, and return the certified IDR entity fees, as applicable.

2. The certified IDR entity determines a dispute is ineligible for the Federal IDR process, believing the initiating party initiated the Federal IDR process before the open negotiation period expired when the party's initiation was, in fact, timely.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should update the eligibility determination to reflect that the dispute is eligible and proceed with the Federal IDR process.

3. The certified IDR entity renders a payment determination for a dispute but did not evaluate documentation received from a party that the dispute was subject to the 90-day cooling off period at the time of IDR initiation.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the payment determination and update the eligibility determination to reflect that the dispute is ineligible for the Federal IDR process, close the dispute, and return the certified IDR entity fees, as applicable. The initiating party may request an extension of time from the Departments to initiate the open negotiation period.

4. The certified IDR entity renders a payment determination on an item or service that has already received a payment determination through the Federal IDR process, either by the same or different certified IDR entity.

If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the second payment determination and update the eligibility determination to reflect that the dispute is ineligible for the Federal IDR process, close the dispute, and return the certified IDR entity fees for the second payment determination, as applicable.

5. Both parties requested to withdraw a dispute in a timely manner, but the certified IDR entity issued a payment determination before realizing the dispute was requested to be withdrawn.

   If the request to reopen the dispute is approved by the Departments, the certified IDR entity should complete the withdrawal of the dispute, retaining only half of the certified IDR entity fee from each party.[3]

6. The certified IDR entity does not realize it has received an offer and/or fees from one of the disputing parties in a timely manner and incorrectly issues a default judgment in favor of the other disputing party.

If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the default judgment and review the dispute, considering the offers and information submitted by both parties and issue a new, corrected payment determination, which will supersede the default judgment.

The Departments have determined that procedural errors should be corrected by reopening a dispute to ensure compliance with the NSA's requirements. If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the payment determination (if applicable), correct the eligibility determination (to reverse a determination of eligibility or ineligibility), communicate to the disputing parties the change to the eligibility determination, refund or invoice the certified IDR entity fees as appropriate, send the resulting eligibility determination to the disputing parties, and continue the Federal IDR process (if applicable).

Process of Reopening a Closed Dispute for Clerical, Jurisdictional, or Procedural Errors: A disputing party, the certified IDR entity, or the Departments may initiate the process for correcting a clerical, jurisdictional, or procedural error after dispute closure.

If a disputing party identifies an error after the certified IDR entity closes the dispute, one or both parties should report the error as soon as possible to the relevant certified IDR entity, which should validate the reported error by confirming its existence and that it falls into one of the three categories defined above. The certified IDR entity should then report the error to the Departments as soon as possible by submitting a request to reopen the closed dispute via the Federal IDR portal. If the Departments determine that the error is a clerical, jurisdictional, or procedural error, they will approve the reopening of the dispute in the Federal IDR portal, which will allow the certified IDR entity to make the appropriate adjustment to the dispute and/or

[3] 26 CFR 54.9816-8T(c)(2)(ii), 29 CFR 2590.716-8(c)(2)(ii), and 45 CFR 149.510(c)(2)(ii).

reissue the payment determination to both parties, as appropriate. Failure to promptly report errors to the Departments will result in processing delays. Disputing parties may lodge a complaint against the certified IDR entity if the certified IDR entity does not act on an error that falls into one of the three categories.[4]

If a certified IDR entity identifies an error after closing a dispute, it should submit a request to the Departments to reopen the closed dispute via the Federal IDR portal. If the Departments identify an error after a certified IDR entity closes a dispute, they will notify the certified IDR entity of the error, reopen the closed dispute, and instruct the certified IDR entity to correct the error.

The Departments recognize that the correction of an error could impact the amounts to be paid to the prevailing party or which party prevails in the dispute. Furthermore, the Departments recognize that the rescission of the original payment determination and issuance of a new payment determination impacts the deadline by which payments must be made under 26 CFR 54.9816–8T(c)(4)(ix), 29 CFR 2590.716-8(c)(4)(ix), and 45 CFR 149.510(c)(4)(ix), which is not later than 30-calendar days after a payment determination. If a payment determination is rescinded and reissued, the applicable party is no longer required to make a timely payment based on the withdrawn payment determination. Instead, a new 30-calendar-day period begins on the date the certified IDR entity issues a new binding payment determination following correction of a clerical, jurisdictional, or procedural error. The Departments will consider a party to be in compliance with 26 CFR 54.9816–8T(c)(4)(ix), 29 CFR 2590.716-8(c)(4)(ix), and 45 CFR 149.510(c)(4)(ix) if it makes the appropriate payment amount to the prevailing party within this time period.

Additionally, prior to the date on which the Departments reopen a closed dispute via the Federal IDR portal due to one of the categories of errors described in this TA, the applicable party remains subject to the requirement to pay the other party the applicable amount within 30 calendar days of the original payment determination, regardless of whether a request to reopen a closed dispute has been filed. If a payment determination is rescinded and is not replaced by a new payment determination, but rather, the dispute is closed as ineligible, the payment requirement associated with the rescinded determination is void.

The Departments expect that as soon as a dispute is closed following a correction, certified IDR entities will timely communicate any change to the dispute, such as a corrected payment or eligibility determination, and the appropriate next steps to both disputing parties and the Departments.

Administrative and Certified IDR Entity Fees:

The correction of an error does not change the requirement for both disputing parties to pay the administrative fee for all disputes for which a certified IDR entity is selected, including disputes where the certified IDR entity determines that the item(s) or service(s) under dispute are not

[4] Complaints against certified IDR entities may be submitted to the FederalIDRQuestions@cms.hhs.gov.

eligible for the Federal IDR process. With respect to the certified IDR entity fee, if the correction of an error reverses a determination that a dispute was or was not eligible for the Federal IDR process, the certified IDR entity must either refund or invoice the parties for the certified IDR entity fee as appropriate for the resulting eligibility determination.[5]

Denial of Request to Reopen a Closed Dispute:

The Departments will deny a request to reopen a dispute to correct an error identified after dispute closure if they determine that it is not a clerical, jurisdictional, or procedural error. In general, the Departments will deny a reopening request if the reopening would require the certified IDR entity to reconsider the factors described in 26 CFR 54.9816–8(c)(4)(iii), 29 CFR 2590.716-8(c)(4)(iii), and 45 CFR 149.510(c)(4)(iii). Additionally, the Departments will deny a request to reopen a dispute to correct a clerical, jurisdictional, or procedural error made by a disputing party, rather than the certified IDR entity.

Examples of a request to reopen a dispute that will be denied by the Departments include, but are not limited to, the following:

1. The certified IDR entity requests to reopen a closed dispute to reconsider its payment determination based on information it initially failed to consider, such as a document submitted by a disputing party containing information on the acuity of the participant receiving the qualified IDR item or service.

2. After a payment determination is issued, the certified IDR entity receives notification that the prevailing party made a typo in its offer, resulting in the party's actual offer amount differing from its intended offer amount. For example, the prevailing party submitted an offer of $1,000 but intended the offer amount to be $10,000.[6]

[5] As required by section 9816(c)(8)(A) of the Code, section 716(c)(8)(A) of ERISA, and section 2799A-1(c)(8)(A) of the PHS Act and 26 CFR 54.9816-8(d)(2), 29 CFR 2590.716-8(d)(2), and 45 CFR 149.510(d)(2), and as explained in the interim final rules titled, Requirements Related to Surprise Billing; Part II (published on October 7, 2021), each party to a determination for which a certified IDR entity is selected must, at the time the certified IDR entity is selected, pay to the certified IDR entity a non-refundable administrative fee due to the Secretary. Because the Departments expect that a large part of the expenditures in carrying out the Federal IDR process will come from the initiation of the Federal IDR process, the Departments will have incurred expenditures in instances in which the parties reach an agreement before the certified IDR entity makes a determination or in which the certified IDR entity determines that the dispute does not qualify for the Federal IDR process, and thus, it is appropriate that the parties should still be expected to pay the administrative fee for ineligible disputes. Therefore, if the correction of an error alters the eligibility determination of a dispute, both parties to a dispute must still pay an administrative fee.

[6] The Departments emphasize the importance of disputing parties ensuring accuracy in their Notice of Offer submissions to prevent such an error from occurring.

EXHIBIT 4

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEP... ...a Code) (

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. I... ...OLICY GROUP OR FECA NU...

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

INSURE... ...F BIRTH MM YY F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ...E (Stat...

...ER CLAI...

c. RESERVED FOR NUCC USE

c. OTHER ACC...NT?

...SURANCE PLAN ... ...ROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. C... ...signated b...

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE CO... & SIGNI... F...

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE ... ...ase of a... ...al ... ...rmation ne... to process this claim. I also request payment of governme... ...elf or ... ...rty ... ...assignme... below.

SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS ... ...PREGNANCY (LMP ... ...HER ... MM DD YY ... DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PRO... ...CE 1... 17b.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITI... CLAIM INFORMA... ...signated...

20. OUTSIDE LAB? YES NO $ CHARGES

...AGN... ...S OR NATURE OF IL... ...Y Relate... ...L to service line below (24E) ICD Ind.

B. C. D. F. G. H. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) O...CE From MM ... To DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

SAMPLE

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

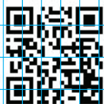
I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY

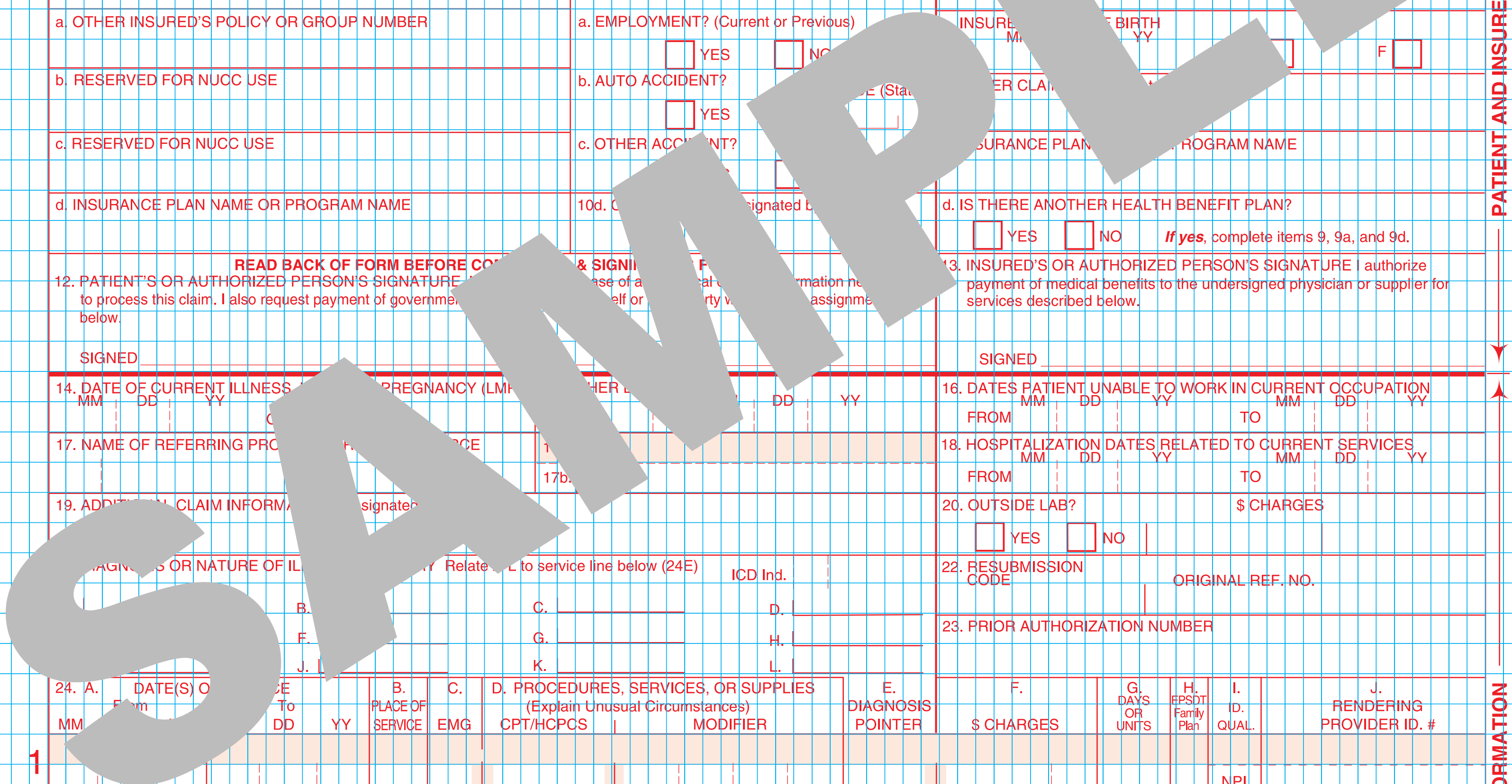
ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEP... (...a Code) (

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. I... ...OLICY GROUP OR FECA NU...



a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES N...

...INSURE... ...F BIRTH M... YY F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ...E (Sta...

...ER CLA...

c. RESERVED FOR NUCC USE

c. OTHER ACC...NT?

...SURANCE PLAN ...ROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. C... ...signated b...

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE CO... & SIGNI... F...

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE ...ase of a...al ...rmation ne... to process this claim. I also request payment of governme... ...elf or ...rty w... ...assignme... below.

SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS ... PREGNANCY (LMP) ...HER D... MM DD YY ... DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PRO... ...CE 17a. 17b.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDI... ...CLAIM INFORMA... ...signate...

20. OUTSIDE LAB? YES NO $ CHARGES

...AGN...S OR NATURE OF IL... ...Relate... ...L to service line below (24E) ICD Ind.

B. C. D. F. G. H. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM ... To DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

SAMPLE

1. MEDICARE X (Medicare#) MEDICAID X (Medicaid#) TRICARE X (ID#/DoD#) CHAMPVA X (Member ID#) GROUP HEALTH PLAN X (ID#) FECA BLK LUNG X (ID#) OTHER X (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

3. PATIENT'S BIRTH DATE MM DD YY SEX
XX XX XX M X F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

5. PATIENT'S ADDRESS (No., Street)
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

6. PATIENT RELATIONSHIP TO INSURED
Self X Spouse X Child X Other X

7. INSURED'S ADDRESS (No., Street)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

CITY STATE
XXXXXXXXXXXXXXXXXXXXXXXX XXX

8. RESERVED FOR NUCC USE
XXXXXXXXXXXXXXXXXXXX

CITY STATE
XXXXXXXXXXXXXXXXXXXXXX XXXXXX

ZIP CODE TELEPHONE (Include Area Code)
XXXXXXXXXXXX (XXX) XXXXXXXXXX

ZIP CODE TELEPHONE (Include Area Code)
XXXXXXXXXXXX (XXX) XXXXXXXXXXXX

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

a. OTHER INSURED'S POLICY OR GROUP NUMBER
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

a. EMPLOYMENT? (Current or Previous)
X YES X NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX
XX XX XXXX M X F X

b. RESERVED FOR NUCC USE
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

b. AUTO ACCIDENT? PLACE (State)
X YES X NO XXX

b. OTHER CLAIM ID (Designated by NUCC)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

c. RESERVED FOR NUCC USE
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

c. OTHER ACCIDENT?
X YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

d. INSURANCE PLAN NAME OR PROGRAM NAME
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

10d. CLAIM CODES (Designated by NUCC)
XXXXXXXXXXXXXXXXXXX

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
X YES X NO *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED XXXXXXXXXXXXXXXXXXXXXXXXXX DATE XXXXXXXXXXXXX

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
XXXXXXXXXXXXXXXXXXXXXXXXX

SIGNED XXXXXXXXXXXXXXXXXXXXXXXXX

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP) MM DD YY
XX XX XXXX QUAL. XXX

15. OTHER DATE QUAL. XXX MM DD YY
XXXX XXXX

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
FROM XX XX XXXX TO XX XX XXXX

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE XXX
XXXXXXXXXXXXXXXXXXXXXXXXXX

17b. NPI XXXXXXXXXXXXXXXXXXXX

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
FROM XX XX XXXX TO XX XX XXXX

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) XXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

20. OUTSIDE LAB? $ CHARGES
X YES X NO XXXXXXXXX XXXXXXXXX

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. X

A. XXXXXXX B. XXXXXXX C. XXXXXXX D. XXXXXXX
E. XXXXXXX F. XXXXXXX G. XXXXXXX H. XXXXXXX
I. XXXXXXX J. XXXXXXX K. XXXXXXX L. XXXXXXX

22. RESUBMISSION CODE ORIGINAL REF. NO.
XXXXXXXXXXX XXXXXXXXXXXXXXXXXXX

23. PRIOR AUTHORIZATION NUMBER
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	XX	XX	XX	XX	XX	XX	XX	XX	XXXXX	XX	XX	XX	XX	XXXX	XXXXXXXX	XXX	XX	NPI	XXXXXXXXXXX
2	XX	XX	XX	XX	XX	XX	XX	XX	XXXXX	XX	XX	XX	XX	XXXX	XXXXXXXX	XXX	XX	NPI	XXXXXXXXXXX
3	XX	XX	XX	XX	XX	XX	XX	XX	XXXXX	XX	XX	XX	XX	XXXX	XXXXXXXX	XXX	XX	NPI	XXXXXXXXXXX
4	XX	XX	XX	XX	XX	XX	XX	XX	XXXXX	XX	XX	XX	XX	XXXX	XXXXXXXX	XXX	XX	NPI	XXXXXXXXXXX
5	XX	XX	XX	XX	XX	XX	XX	XX	XXXXX	XX	XX	XX	XX	XXXX	XXXXXXXX	XXX	XX	NPI	XXXXXXXXXXX
6	XX	XX	XX	XX	XX	XX	XX	XX	XXXXX	XX	XX	XX	XX	XXXX	XXXXXXXX	XXX	XX	NPI	XXXXXXXXXXX

25. FEDERAL TAX I.D. NUMBER SSN EIN
XXXXXXXXXXXXXXX X X

26. PATIENT'S ACCOUNT NO.
XXXXXXXXXXXXXX

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
X YES X NO

28. TOTAL CHARGE
$XXXXXXX XX

29. AMOUNT PAID
$XXXXXXX XX

30. Rsvd for NUCC Use
XXXXXXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
XXXXXXXXXXXXXXXXX

SIGNED XXXXXXXXXX DATE XXXX

32. SERVICE FACILITY LOCATION INFORMATION XXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXX
a. XXXXXXXXXX b. XXXXXXXXXXXXXXXXXX

33. BILLING PROVIDER INFO & PH # (XXX) XXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
a. XXXXXXXXXX b. XXXXXXXXXXXXXXXXXXXX

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

EXHIBIT 5

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7000 Security Boulevard, Mail Stop 02-02-38
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C: 11-32- Hospital/CAH

DATE: **July 15, 2011**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Telemedicine Services in Hospitals and Critical Access Hospitals (CAHs)

Memorandum Summary

- ***Telemedicine Rules Adopted for Hospitals/CAHs:*** New and amended rules effective July 5, 2011 permit hospitals and CAHs to provide telemedicine services to their patients through written agreements with a distant-site hospital or a distant-site telemedicine entity
- ***Streamlined Credentialing & Privileging for Telemedicine Physicians & Practitioners.*** Hospitals and CAHs may rely, when granting telemedicine privileges, upon the privileging decisions of a distant-site hospital or telemedicine entity with which they have a written agreement that meets Medicare requirements.

On May 5, 2011, the Centers for Medicare & Medicaid Services (CMS) published a final rule (76 FR 25550), effective July 5, 2011, governing the agreements under which a hospital or CAH may provide telemedicine services to its patients. "Telemedicine," as the term is used in this rule, means the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications. The distant-site telemedicine physician or practitioner provides clinical services to the hospital or CAH patient either simultaneously, for example, as in teleICU services, or non-simultaneously, as is the case with many teleradiology services.

Under the new and revised hospital and CAH regulations, located at 42 CFR. Part 482 and Part 485, Subpart F respectively, telemedicine services must be provided under a written agreement between the hospital or CAH and one or more:

- Distant-site hospitals that participate in Medicare; or
- Distant-site telemedicine entities. For the purposes of this rule, a distant-site telemedicine entity is defined as an entity that -- (1) provides telemedicine services; (2) is not a Medicare-participating hospital; and (3) provides contracted services in a manner that enables a hospital or CAH using its services to meet all applicable Conditions of Participation (CoPs), particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital or CAH.

The written agreement must contain provisions requiring the distant-site hospital or telemedicine entity to use a credentialing and privileging process that at least meets the Medicare standards that hospitals have traditionally been required to use (found at 42 CFR 482.12(a) and 42 CFR 482.22(a)). The written agreement must also ensure that the distant-site hospital or telemedicine entity has granted privileges to the individual telemedicine physicians and practitioners providing telemedicine services to hospital/CAH patients, and that the distant-site telemedicine physicians or practitioners hold a license issued or recognized by the State where the hospital or CAH is located. The distant-site hospital or telemedicine entity must provide a list of telemedicine physicians and practitioners who are privileged there and their current privileges at the distant-site hospital or entity to the hospital or CAH. In the case of an agreement with a distant-site telemedicine entity, the agreement must also state that the entity is a contractor of services to the hospital or CAH which furnishes contracted telemedicine services in a manner that permits the hospital or CAH to comply with all applicable CoPs. The hospital or CAH must, under the terms of the agreement, review the services provided to its patients by telemedicine physicians and practitioners covered by the agreement and provide written feedback to the distant-site hospital or telemedicine entity, addressing, at a minimum, all adverse events or complaints related to the telemedicine services provided at the hospital or CAH.

In addition, under the revised CAH regulations at 42 CFR 485.616(c)(1), an exception is made in the case of telemedicine services to the requirement that CAH agreements for clinical services may only be with a Medicare-participating provider or supplier, since telemedicine entities do not participate as such in Medicare. Further, under revised 42 CFR 485.641(b), concerning outside quality assurance reviews of care provided in the CAH by Medical Doctors and Doctors of Osteopathy (MDs/Dos), the distant-site hospital would be the outside entity conducting such reviews of distant-site telemedicine MDs/DOs providing telemedicine services to the CAH's patients under written agreement.

An advance copy of the revised guidance in State Operations Manual Appendix A (hospitals) and Appendix W (CAHs) is attached to this memorandum. The final version will be issued at a later date and may vary slightly from this advance copy.

Effective Date: Immediately. This policy should be communicated to all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

Training: This policy should be shared with all survey and certification staff and their managers.

/s/
Thomas E. Hamilton

Attachment

cc: Survey and Certification Regional Office Management

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal **(Advance Copy)** **Date:**

SUBJECT: Revised Appendix A, Interpretive Guidelines for Hospitals, and Revised Appendix W, Interpretive Guidelines for Critical Access Hospitals (CAHs)

I. SUMMARY OF CHANGES: New guidance is provided to reflect regulatory changes concerning the provision of telemedicine services in Hospitals and CAHs.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: Upon Issuance
IMPLEMENTATION DATE: Upon Issuance

The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix A/§482.12(a) Standard: Medical Staff
R	Appendix A/§482.22(a) Standard: Composition of the Medical Staff
R	Appendix A/§482.22(c) Standard: Medical Staff Bylaws
N	Appendix W/§485.616(c) Standard: Agreements for Credentialing and Privileging of Telemedicine Physicians and Practitioners
R	Appendix W/§485.635(c) Standard: Services Provided through Agreements or Arrangements
R	Appendix W/§485.641(b) Standard: Quality Assurance

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2011 operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

State Operations Manual

Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev.)

* * *

C-0196

[§485.616 Condition of Participation: Agreements]

(c) Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners.

(1) The governing body of the CAH must ensure that, when telemedicine services are furnished to the CAH's patients through an agreement with a distant-site hospital, the agreement is written and specifies that it is the responsibility of the governing body of the distant-site hospital to meet the following requirements with regard to its physicians or practitioners providing telemedicine services:

(i) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.

(ii) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.

(iii) Assure that the medical staff has bylaws.

(iv) Approve medical staff bylaws and other medical staff rules and regulations.

(v) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.

(vi) Ensure the criteria for selection are individual character, competence, training, experience, and judgment.

(vii) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society.

(2) When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site hospital, the CAH's governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site hospital regarding individual distant-site physicians or practitioners.

The CAH's governing body or responsible individual must ensure, through its written agreement with the distant-site hospital, that the following provisions are met:

(i) The distant-site hospital providing telemedicine services is a Medicare-participating hospital.

(ii) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges;

(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH is located; and

(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such information for use in the periodic appraisal of the individual distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH's patients and all complaints the CAH has received about the distant-site physician or practitioner.

Interpretive Guidelines §485.616(c)

"Telemedicine," as the term is used in this regulation, means the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications. The distant-site telemedicine physician or practitioner provides clinical services to the CAH patient either simultaneously, as is often the case with teleICU services, for example, or non-simultaneously, as may be the case with many teleradiology services. "Simultaneously" means that the clinical services (for example, assessment of the patient with a clinical plan for treatment, including any medical orders needed) are provided to the patient in "real time" by the telemedicine physician or practitioner, similar to the actions of an on-site practitioner when called in by a patient's attending physician to see the patient. "Non-simultaneously" means that, while the telemedicine physician or practitioner still provides clinical services to the patient, such services may involve after-the-fact interpretation of diagnostic tests in order to provide an assessment of the patient's condition and do not necessarily require the telemedicine practitioner to directly assess the patient in "real time." This would be similar to the services provided by an on-site radiologist who interprets a patient's x-ray or CT scan and then communicates his or her assessment to the patient's attending physician who then bases his or her diagnosis and treatment plan on these findings. . (See 76 FR 25552, May 5, 2011)

A CAH may make arrangements with a distant-site Medicare-participating hospital for the provision of telemedicine services to the CAH's patients by physicians or practitioners granted privileges by the distant-site hospital.

If a CAH enters into an agreement for telemedicine services with a distant-site hospital, the agreement must be in writing. Furthermore, the written agreement must specify that it is the responsibility of the distant-site hospital to conduct its credentialing and privileging process for those of its physicians and practitioners providing telemedicine services such that the distant-site hospital:

- *Determines, in accordance with State law, which categories of practitioners are eligible candidates for privileges or membership on the distant-site hospital's medical staff.*
- *Appoints members and grants medical staff privileges after considering the recommendations of the existing members of the distant-site hospital's medical staff.*
- *Assures that the distant-site hospital's medical staff has bylaws.*
- *Approves the distant-site hospital's medical staff bylaws and other medical staff rules and regulations.*
- *Ensures that the medical staff is accountable to the distant-site hospital's governing body for the quality of care provided to patients.*
- *Ensures the criteria for granting medical staff membership/privileges to an individual are the individual's character, competence, training, experience, and judgment.*
- *Ensures that under no circumstances is the accordance of distant-site hospital medical staff membership or privileges dependent solely upon certification, fellowship or membership in a specialty body or society.*

Since the distant-site hospital must also participate in Medicare, it has an independent obligation to comply with these same requirements for all of its medical staff under §§482.12(a)(1) through (a) (7). Nevertheless, the written telemedicine services agreement between the CAH and the distant-site hospital must explicitly include a provision addressing the distant-site hospital's obligation to comply with these provisions.

The CAH's governing body (or the individual responsible for the CAH if it has no governing body) has the option, when considering granting privileges to telemedicine physicians and practitioners, to rely upon the credentialing and privileging decisions of the distant-site hospital for these physicians and practitioners. In order to exercise this alternative credentialing and privileging option, the CAH's governing body must ensure that its written agreement with the distant-site hospital addresses all of the following:

- *That the distant-site hospital participates in the Medicare program. If the distant-site hospital's participation in Medicare is terminated, either voluntarily or involuntarily, at any time during the agreement, then as of the effective date of the termination, the CAH may no longer receive telemedicine services under the agreement;*

- *That the distant-site hospital provides a list to the CAH of all its physicians and practitioners covered by the agreement, including their privileges at the distant-site hospital. The list may not include any physician or practitioner who does not hold privileges at the distant-site hospital. The list must be current, so the agreement must address how the distant-site hospital will keep the list current;*

- *That each physician or practitioner who provides telemedicine services to the CAH's patients under the agreement holds a license issued or recognized by the State where the CAH is located. States may have varying requirements as to whether they will recognize an out-of-state license for purposes of practicing within their State, and they may also vary as to whether they establish different standards for telemedicine services. The licensure*

requirements governing in the State where the CAH whose patients are receiving the telemedicine services is located must be satisfied, whatever they may be; and

- *That the CAH has evidence that it reviews the telemedicine services provided to its patients and provides feedback based on this review to the distant-site hospital for the latter's use in its periodic appraisal of each physician and practitioner providing telemedicine services under the agreement. At a minimum, the CAH must review and send information to the distant-site hospital on all adverse events that result from a physician or practitioner's provision of telemedicine services and on all complaints the CAH has received about a telemedicine physician or practitioner.*

If the CAH's governing body or responsible individual does not rely on the privileging decisions of the distant-site hospital, then it must for each physician or practitioner providing telemedicine services under an agreement follow the CAH's standard process for review of credentials and granting of privileges to physicians and practitioners.

Survey Procedures §485.616(c)(1) & (2)

- *Ask the CAH's leadership whether it uses telemedicine services. If yes,*
    - *Ask to see a copy of the written agreement(s) with the distant-site hospital(s). Does each agreement include the required elements concerning credentialing and privileging of the telemedicine physicians and practitioners by the distant-site hospital?*
    - *Does the CAH have documentation indicating that it granted privileges to each telemedicine physician and practitioner?*
    - *Does the documentation indicate that the CAH's governing body or responsible individual made the privileging decision based on the privileging decisions of the distant-site hospital? If yes:*
        - *Does the agreement address the required elements concerning the distant-site hospital's Medicare participation, appropriate licensure of telemedicine physicians and practitioners, current list of telemedicine physicians and practitioners with privileges, and review by the CAH of the telemedicine physicians' and practitioners' services?*
        - *Ask to see the list provided by the distant-site hospital of the telemedicine physicians and practitioners, including their privileges and pertinent licensure information.*
        - *Ask for evidence that the CAH conducts the required review of the telemedicine services provided by the telemedicine physicians and practitioners, including any associated adverse events and complaints, and that it provides the required feedback to the distant-site hospital.*

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[(c) Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners.]

(3) The governing body of the CAH must ensure that when telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the agreement is written and specifies that the distant-site telemedicine entity is a contractor of services to the CAH and as such, in accordance with §485.635(c)(4)(ii), furnishes the contracted services in a manner that enables the CAH to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in this section with regard to its physicians and practitioners providing telemedicine services.

(4) When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the CAH's governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site telemedicine entity regarding individual distant-site physicians or practitioners. The CAH's governing body or responsible individual must ensure, through its written agreement with the distant-site telemedicine entity, that the following provisions are met:

(i) The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at (c)(1)(i) through (c)(1)(vii).

(ii) The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides a current list to the CAH of the distant-site physician's or practitioner's privileges at the distant-site telemedicine entity.

(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH whose patients are receiving the telemedicine services is located.

(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site telemedicine entity such information for use in periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH's patients and all complaints the CAH has received about the distant-site physician or practitioner.

Interpretive Guidelines §485.616(c)(3) & (4)

For the purposes of this rule, a distant-site telemedicine entity is defined as an entity that -- (1) provides telemedicine services; (2) is not a Medicare-participating hospital; and (3) provides contracted services in a manner that enables a CAH using its services to meet all applicable CoPs, particularly those requirements related to the credentialing and privileging of physicians and practitioners providing telemedicine services to the patients of a CAH. A distant-site

telemedicine entity would include a distant-site hospital that does not participate in the Medicare program that is providing telemedicine services to a Medicare-participating CAH. (See 76 FR 25553, May 5, 2011)

A CAH may have an agreement with a distant-site telemedicine entity for the provision of telemedicine services to the CAH's patients by physicians or practitioners granted privileges by the distant-site telemedicine entity.

If a CAH enters into an agreement for telemedicine services with a distant-site telemedicine entity, the agreement must be in writing. Furthermore, the written agreement must specify that under the agreement the distant-site telemedicine entity is a contractor providing services to the CAH, and that, in accordance with the requirements of §485.635(c)(4)(ii), the distant-site telemedicine entity furnishes its telemedicine services in a manner that enables the CAH to comply with all applicable CAH Conditions of Participation (CoPs), including, but not limited to, the specific requirements governing telemedicine services. Under §485.635(c)(4)(ii,) the CAH's governing body or responsible individual is obligated to ensure that all contractors of services furnish those services in a manner that enables the CAH to comply with all applicable CoPs.

The CAH's governing body (or the individual responsible for the CAH if it has no governing body) has the option, when considering granting privileges to telemedicine physicians and practitioners, to rely upon the credentialing and privileging decisions of the distant-site telemedicine entity for these physicians and practitioners. In order to exercise this alternative credentialing and privileging option, the CAH's governing body must ensure through its written agreement with the distant-site telemedicine entity that all of the following requirements are included in the agreement and that the contractor fulfills these requirements:

- *The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meets the standards at §485.616(c)(1)(i) through (c)(1)(vii). In other words, the distant-site telemedicine entity must at a minimum:*

  - *Determine, in accordance with State law, which categories of practitioners are eligible candidates for medical staff privileges or membership at the telemedicine entity;*
  - *Appoint members and grant medical staff privileges after considering the recommendations of the existing members of its medical staff;*
  - *Assure that its medical staff has bylaws;*
  - *Approve its medical staff's bylaws and other medical staff rules and regulations;*
  - *Ensure that the medical staff is accountable to the distant-site telemedicine entity's governing body for the quality of care provided to patients;*
  - *Ensure the criteria for granting distant-site telemedicine medical staff membership/privileges to an individual are the individual's character, competence, training, experience, and judgment; and*
  - *Ensure that under no circumstances is the accordance of medical staff membership or privileges dependent solely upon certification, fellowship or membership in a specialty body or society.*

- *The distant-site telemedicine entity provides to the CAH a list of all its physicians and practitioners covered by the agreement, including their privileges at the distant-site telemedicine entity. The list may not include any physician or practitioner who does not hold privileges at the distant-site telemedicine entity. The list must be current, so the agreement must address how the distant-site telemedicine entity will keep the list current;*

- *Each physician or practitioner who provides telemedicine services to the CAH's patients under the agreement holds a license issued or recognized by the State where the CAH is located. States may have varying requirements as to whether they will recognize an out-of-state license for purposes of practicing within their State, and they may also vary as to whether they establish different standards for telemedicine services. The licensure requirements governing in the State where the hospital whose patients are receiving the telemedicine services is located must be satisfied, whatever they may be; and*

- *The CAH reviews the performance of the physicians and practitioners providing telemedicine services to its patients and provides a written review to the distant-site telemedicine entity for the latter's use in its periodic appraisal of each physician and practitioner providing telemedicine services under the agreement. At a minimum, the CAH must review and send information to the distant-site telemedicine entity on all adverse events that result from a physician's or practitioner's provision of telemedicine services and on all complaints the CAH has received about a telemedicine physician or practitioner.*

If the CAH's governing body or responsible individual does not rely on the privileging decisions of the distant-site telemedicine entity, then it must for each practitioner providing telemedicine services under an agreement follow the CAH's standard process for review of credentials and granting of privileges to physicians and practitioners.

Survey Procedures §485.616(c)(3) & (4)

- *Ask the CAH's leadership whether it uses telemedicine services. If yes,*
    - *Ask to see a copy of the written agreement(s) with the distant-site telemedicine entity(ies). Does each agreement explicitly state that the distant-site telemedicine entity will provide telemedicine services in a manner that enables the CAH to comply with all applicable CoPs?*
    - *Does the CAH have documentation indicating that it granted privileges to each telemedicine physician and practitioner?*
    - *Does the documentation indicate that the CAH's governing body or responsible individual made the privileging decision based on the privileging decisions of the distant-site telemedicine entity? If yes:*
        - *Does the written agreement with the distant-site telemedicine entity address the required elements concerning the distant-site telemedicine entity's utilization of a medical staff credentialing and privileging process that meets the requirements of the*

hospital CoPs, licensure of telemedicine physicians and practitioners, current list of telemedicine physicians and practitioners with privileges at the distant-site telemedicine entity, and written review by the CAH of the telemedicine physicians' and practitioners' services?

- *Is there a list provided by the distant-site telemedicine entity of the telemedicine physicians and practitioners covered by the agreement, including their privileges and pertinent licensure information?*

- *Is there evidence that the CAH reviews the services provided by the telemedicine physicians and practitioners, including any adverse events and complaints, and provides written feedback to the distant-site telemedicine entity?*

- *Ask the CAH how it verifies that the telemedicine entity fulfills the terms of the agreement with respect to its credentialing and privileging process and otherwise assures that services are provided in a manner that enables the CAH to meet all applicable CAH requirements? (Surveyors do not attempt to independently verify whether or not the distant-site telemedicine entity's credentialing and privileging process fulfills the regulatory requirements. Surveyors focus only on what actions the CAH takes to ensure that the distant-site telemedicine entity complies with the terms of the agreement.)*

* * *

C-0285

§485.635(c) Standard: Services Provided Through Agreements or Arrangements

(1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including--

(5) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier.

Interpretive Guidelines §485.635(c)(1) ***& (c)(5)***

All agreements for providing health care services to the CAH's patients must be with a provider or supplier that participates in the Medicare program, except in the case of an agreement with a distant-site telemedicine entity for the provision of telemedicine services. The *agreements* should describe routine procedures (e.g., for obtaining outside laboratory tests); and there should be evidence in the agreement or arrangement that the governing body (or responsible individual)

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

Having considered Defendants Neuromonitoring Associates, LLC's, Physician Oversight, LLC's, and Monitoring Associates, LLC's Motion to Dismiss the Amended Complaint under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6) and Request for Judicial Notice (the "Motion") and any response thereto, the Court finds that the Motion should be GRANTED in its entirety.

IT IS HERBY ORDERED this __ day of ___________, 2026 that:

1. The Motion is GRANTED and Plaintiff Health Care Service Corporation's claims are DISMISSED WITH PREJUDICE.
2. The Court takes judicial notice of the documents cited in the Motion and separately attached to the Motion as Exhibits 1 to 5.

IT IS SO ORDERED.