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

DEFENDANTS' REPLY IN SUPPORT OF THEIR 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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I. INTRODUCTION

HCSC's[1] opposition pivots to rhetoric because its legal arguments fail. But repeating the labels "kickbacks" and "fraud" is not enough to show standing or state a valid claim.

To start, HCSC agrees that its fraud theories related to NSA arbitration are pleaded only for preservation. They must be dismissed. And HCSC's new vacatur claim is a carbon copy of those filed by other Blue Cross entities across the country. *Every* court to reach this theory has rejected it.[2] HCSC cannot relitigate the parties' arbitration positions on IDR eligibility by labeling the Defendants' arguments "fraud." Nor can it cite three arbitration rulings it disagrees with and then use this case to take discovery on and relitigate *thousands* of arbitrations.

That leaves the Practice-Acquisition and Credentialing Theories. The Court lacks subject-matter jurisdiction over these theories because HCSC has not suffered concrete harm from the alleged regulatory violations. HCSC's standing argument is circular: it seeks to manufacture standing for *any* regulatory violation by declaring that it would not have paid for the IOM services at issue if it knew of the supposed violation, and that it was thus harmed because it did pay. But as explained below, Fifth Circuit precedent directly rejects this argument for self-declared standing.

Even if jurisdiction existed, HCSC's claim would still fail as a matter of law. Its complaint asserts that the Defendants committed fraud by submitting CMS-1500 claim forms that supposedly certified compliance with the Texas laws in question. *See* AC ¶ 30. But the CMS-1500 form—which is properly before the Court now because HCSC does not oppose Defendants' request for judicial notice—plainly does not include any such representation. Facing this reality, HCSC's

[1] This reply uses the same defined terms as Defendants' motion to dismiss (Dkt. No. 53). "Opp." citations refer to HCSC's opposition (Dkt. No. 54).

[2] *See Anthem Blue Cross Life & Health Ins. Co. v. HaloMD LLC*, 2026 WL 982629, at *7–9 (C.D. Cal. Apr. 9, 2026); *Blue Cross Blue Shield Healthcare Plan of Ga., Inc. v. HaloMD, Inc.*, 2026 WL 2017291, at *20–24 (N.D. Ga. July 10, 2026); *Aetna Health Inc. v. Radiology Partners, Inc.*, 2026 WL 1556164, at *3 (M.D. Fla. Apr. 16, 2026).

opposition pivots to a new theory, which is also circular. HCSC declares that it has decided that the claims are not "payable," so the Defendants committed fraud merely by billing for them. But this is directly foreclosed by Supreme Court precedent holding that there can be fraud absent an express false statement only where "the claim does not merely request payment, but also makes specific representations about the goods or services provided" *and* the defendant's failure to disclose noncompliance with them makes the claim misleading. *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 190 (2016). This forecloses HCSC's theory.

II. ARGUMENT

A. Counts and arguments that are pleaded only for preservation must be dismissed.

HCSC's opposition confirms that Counts II, IV, VI, VIII, and X and its arguments about supposed fraud in the IDR process (other than its vacatur claim) are pleaded only to preserve them for appellate review, and the Court need not address them here. Opp. 5–6.[3]

B. The vacatur count fails as a matter of law.

1. HCSC sued under § 10(a) without filing the "application" that § 10(a) requires.

What is the cause of action here? The answer is found on page 72 of HCSC's AC:

> **COUNT XI**
> **VACATUR OF NSA IDR AWARDS UNDER 9 U.S.C. § 10**
> **(Against Physician Oversight and Monitoring Associates)**

HCSC expressly pleads Count XI under 9 U.S.C. § 10, part of the FAA. The plain language of *this* section requires an "application" to be filed by a "party to the arbitration." *Id.* § 10(a). As a matter of federal law, an "application" under § 10(a) "shall be made and heard in the manner provided by law for the making and hearing of motions." 9 U.S.C. § 6. This requires evidence, not allegations.

[3] HCSC asserts (Opp. 8–9) that Defendants concede it can recover IDR awards as "consequential damages" without vacatur. Certainly not. Judge Schroeder rejected this exact argument in *HaloMD*. 2026 WL 1557492, at *5–6 (E.D. Tex. May 22, 2026). To prove these amounts as damages would require relitigating the arbitrations, which is not permitted.

See Garber v. Sir Speedy, Inc., 1996 WL 734947, at *4–5 (N.D. Tex. Dec. 11, 1996).

HCSC argues that other procedural requirements of the FAA, like those in § 12, do not apply here because the NSA did not expressly incorporate them. Whether or not that's so, applying the plain language of the very statute that HCSC invokes (and this section, § 10(a), is the one that the NSA incorporates), HCSC must file an application, supported by evidence—not a complaint under notice-pleading rules. *See* 9 U.S.C. §§ 10(a), 6. It has not. Instead, it asks the Court to allow it to conduct discovery about "thousands," AC ¶ 220, of arbitrations that it has not even identified.

The same conclusion follows under Rule 9(b). There is no dispute that Rule 9(b) applies to applications for vacatur based on supposed fraud. *See Guardian Flight II*, 140 F.4th 613, 619–22 (5th Cir. 2025); *Blue Cross Blue Shield Healthcare Plan of Ga. v. HaloMD, Inc.*, 2026 WL 2017291, at *21 (N.D. Ga. July 10, 2026) ("*Blue Cross of Georgia*"). To merely reference "thousands" of arbitrations and ask to proceed to discovery turns this rule on its head. What are the specific fraudulent statements in each? What is the basis for vacatur in each? HCSC's position violates a direct holding from the Fifth Circuit. *Guardian Flight II* says that where a party seeks to vacate an NSA arbitration based on fraud, it "must state with particularity the circumstances constituting fraud or mistake" and "must 'specify the statement contended to be fraudulent, identify the speaker, state when and where the statements were made, and explain why the statements were fraudulent.'" 140 F.4th at 619 (citation omitted).

And the same conclusion follows from a practical consideration of the rule that HCSC proposes. HCSC proposes that a holding company can cite *three* examples of purported fraud, then proceed to discovery on "thousands" of unidentified arbitrations its divisions conducted. This fails even under basic notice pleading rules. How are the Defendants on notice of which arbitrations are at issue? Likewise, extensive discovery on thousands of arbitrations does not

comport with FAA policy of "expedited judicial review." *See Garber*, 1996 WL 734947, at *4. In short, Congress's express intent of creating a streamlined process under the NSA, with limited judicial review, would be flipped on its head, and this Court would become a forum to relitigate any and every IDR loss where the losing party disagrees with the arbitrator's rulings about eligibility. HCSC has cited *no* precedent that allows blanket vacatur of thousands of unidentified arbitrations in one case, and this Court should not be the first to allow this.

2. **There is no basis to vacate on the grounds of fraud.**

Vacatur for fraud requires clear and convincing evidence of fraud that could not be discovered before or during arbitration, and that it materially related to an issue in the arbitration. *Morgan Keegan & Co. v. Garrett*, 495 F. App'x 443, 447 (5th Cir. 2012) (citation omitted).

As to the requirement of clear and convincing evidence of fraud in thousands of arbitrations, HCSC has no response except to point to general allegations about supposed fraud in three arbitrations. *Blue Cross of Georgia* rejected the same theory, holding that an insurer could not vacate "thousands of IDR determinations based on general allegations" that defendants made false eligibility attestations. *Blue Cross of Georgia*, 2026 WL 2017291, at *21. That reasoning applies here. Like the plaintiff in *Blue Cross of Georgia*, HCSC similarly attempts to "summarize thousands of misrepresentations" by merely "list[ing] several reasons why the items submitted for IDR could be ineligible." *See id.*; AC ¶ 172. But this is not enough without stating "what erroneous information was entered into the IDR Portal to mislead the IDRE." *Blue Cross of Georgia*, 2026 WL 2017291, at *21. HCSC also omitted the "when" required under Rule 9(b), as that rule "requires the time and place to be alleged *for each statement*." *Id*. at *22 (emphasis in original).

As to the second prong, HCSC's theory is contrary to its own complaint. HCSC cannot circumvent the fact that in *every* example it included, it objected to the dispute's eligibility. AC ¶¶ 180–219; *see Anthem Blue Cross Life & Health Ins. Co. v. HaloMD LLC*, 2026 WL 982629, at

*8 (C.D. Cal. Apr. 9, 2026) (denying vacatur based on fraud where "[p]laintiffs objected to eligibility for all the sample determinations identified in the [amended complaint]"). And despite already amending its complaint *after* reviewing the Defendants' first motion to dismiss, HCSC has "not identified even one example of an IDR determination for which they could amend and allege that a defendant made a false eligibility attestation based on facts that Plaintiffs did not know, and could not reasonably have known, before or during the IDR process." *See id.*

HCSC offers no explanation why it *could not* raise these objections during arbitration. After all, the "fraud" at issue is about whether each HCSC insured patient had a type of insurance that is eligible for NSA IDR, when the arbitration was requested, and whether 'open negotiations' occurred between the parties first. AC ¶¶ 172, 181, 193, 212. Surely HCSC knows better than anyone what kind of insurance each of its insureds had, when the Defendants requested negotiations, and when the arbitration was filed. HCSC pleads no facts to explain why it could not raise any objections in this regard at the arbitrations. HCSC ignores this issue and instead falls back on rhetoric: that Defendants used "underhanded tactics" to escape HCSC's detection. Opp. 4, 11; AC ¶ 178. There is no clear and convincing evidence here, just labels. It does not explain what these underhanded tactics were, or why they made it impossible for HCSC to determine what kind of insurance it provided to its own insureds.

3. **There is no basis to vacate on the grounds of undue means.**

HCSC has not shown undue means because its allegations do not demonstrate conduct "equivalent in gravity to corruption or fraud, such as a physical threat to an arbitrator," or anything remotely close to it. *Guardian Flight II*, 140 F.4th at 621. Instead, this is a mill-run NSA dispute about whether certain claims were eligible for arbitration under the NSA. HCSC argues half-heartedly that "lying to IDREs" is "deliberate misconduct" that constitutes undue means. Opp. 14–15. It cites no authority for this proposition, and all of the courts to consider this issue have rejected

it. This is the same thing it says under the fraud prong, and it fails for the same reason. As the court held in *Blue Cross of Georgia*, where Blue Cross made the same argument that large providers initiate a large number of arbitrations and win a large number of them:

> [T]he Plaintiff argues that it loses a lot of IDR arbitrations … It is *highly improbable* to infer from these facts that there is a vast conspiracy of providers and IDREs that have conspired to defraud the Plaintiff of millions of dollars in thousands of NSA IDR proceedings over many years. It is *highly plausible* to infer that the Plaintiff engages in a consistent practice of submitting lowball offers to out-of-network providers in an effort to maximize its profits. This conclusion is reinforced by the generality and conclusory nature of the Plaintiff's fraud claims and failure to comply with Rule 9(b) as noted above.

2026 WL 2017291, at *23 (emphasis added).

4. **The NSA arbitrators did not exceed their authority.**

HCSC misunderstands the test for vacatur where arbitrators exceed their powers. *See* Opp. 15–18. HCSC argues that the arbitrators exceeded their authority by ordering it to pay for medical care after deciding the dispute was eligible, on the grounds that the initial ruling was supposedly an error. *See id.* In practice, this would mean that any time an arbitrator decides a threshold issue, a federal court would then be allowed to review each of its subsequent decisions.

Not so. The § 10(a)(4) inquiry asks only whether the arbitrator had authority to decide the threshold issue (here, eligibility), not whether it decided correctly. *See BNSF R.R. Co. v. Alstom Transp., Inc.*, 777 F.3d 785, 787 (5th Cir. 2015). The statute and regulations promulgated under it expressly authorized IDREs to decide eligibility, as HCSC concedes. *See* AC ¶¶ 142.g, 142.h; *see also* 42 U.S.C. § 300gg-111(c)(5); 45 C.F.R. § 149.510(c)(1)(v).

Both *Anthem* and *Blue Cross of Georgia* rejected this argument, holding that IDREs have authority to determine their own jurisdiction. *Anthem*, 2026 WL 982629, at *9; *Blue Cross of Georgia*, 2026 WL 2017291, at *24. The only question is whether the IDREs performed the task assigned to them, not whether their ruling was right or wrong. Disagreement with the answer is

not a ground for vacatur; if it were, every IDR award would be relitigated where the losing side disagreed about eligibility.[4]

C. HCSC's circular argument for Article III standing violates Fifth Circuit precedent.

HCSC alleges that certain Defendants provided IOM services to HCSC's insureds; it does *not* allege any problem with the quality of these services, nor that any were medically unnecessary. *See generally* AC ¶¶ 60, 78, 91, 104, 117.[5] The price paid (if any) for these out-of-network services was either what HCSC decided to pay, or what the IDR arbitrator determined was fair—in other words, there is no connection between the supposed regulatory violation and the price. Instead, HCSC's grievance is that the financial structure of business acquisitions supposedly incentivized doctors to choose Defendants over other IOM providers. AC ¶¶ 53–54. The selection of IOM provider, of course, makes no difference to HCSC.

So why did this cause concrete harm to HCSC that is sufficient for Article III standing? HCSC's only response is 'because we say so.' It declares in its complaint that it has decided that it will not pay for services rendered to its insureds if the physicians ordering them (allegedly) have an incentive to select one IOM provider over another—and that it was harmed because it paid for services that it decided not to pay for. That's it. This argument is circular and contrary to Fifth Circuit precedent. Self-declared standing (*any* insurance plaintiff or consumer plaintiff could say this about any law or regulation) is not sufficient.

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[4] HCSC's passing due-process argument, Opp. 17–18, fails. It has not pleaded a constitutional challenge or due process claim, nor challenged the IDR regulations. Constitutional avoidance applies only where a statute is ambiguous, and the NSA is not. *See Iancu v. Brunetti*, 588 U.S. 388, 397 (2019). The Fifth Circuit already construed this provision narrowly and textually, and its holding controls here. *Guardian Flight II*, 140 F.4th at 620–21, n. 3 & n.4.

[5] HCSC says for the first time in its opposition that IOM services were provided "regardless of patient need." Opp. 19. The AC says no such thing and HCSC cannot amend its pleading through briefing. *See Roebuck v. Dothan Sec., Inc.*, 515 F. App'x 275, 280 (5th Cir. 2013). HCSC's attempt to slip this point into its opposition brief is a confession that the amended complaint is insufficient.

Earl v. Boeing Co. controls here, and HCSC has failed to distinguish it. 53 F.4th 897, 901–03 (5th Cir. 2022). There, Boeing allegedly violated safety regulations that led to airplane crashes that killed hundreds, and hid its violations. *Id.* at 900. Other passengers—i.e., the people these safety regulations are expressly designed to protect—sued, alleging they were defrauded. *Id.* They made the same argument that HCSC makes here: they would not knowingly pay for tickets on a plane that violated safety regulations, and were injured because they paid for tickets after Boeing concealed the regulatory violations. *Id.* at 902. Yet the passengers lacked standing because they had suffered neither physical nor economic injury. *Id*. at 902–03. As the Fifth Circuit held, "[e]veryone now agrees that [this] theory of injury cannot support Article III standing" under the Fifth Circuit's precedent in *Rivera v. Wyeth-Ayerst Laboratories. Id*. at 902; 283 F.3d 315, 320 (5th Cir. 2002). In other words, it is not sufficient for the passengers to declare in litigation that they would not knowingly buy tickets on a plane that violates regulatory standards, and thus they were defrauded and injured because they did so unknowingly.

HCSC's argument for standing is even weaker than the one that failed in *Boeing* and *Rivera*—the laws in question here are about protecting patients, not insurers, and there are no safety or medical-necessity issues in play here. Its argument must fail under this precedent. HCSC's opposition offers no answer to this fatal defect in its claim, and simply repeats that it was injured because it would not have paid if it had known of the supposed regulatory violation. *See* Opp. 20. But this is the same thing the passengers said in *Boeing* and the patients said in *Rivera*. The *Boeing* plaintiffs argued that the Fifth Circuit's rule would "imperil all sorts of fraud litigation." 53 F.4th at 903. That may well be so, and this rule is why this case must be dismissed.

The out-of-district cases HCSC cites are not precedent, do not change the Fifth Circuit's strict rule, and in any event, do not support HCSC's argument on these facts. Each case it cites

involves clear lies that caused harm, such as billing for unnecessary services or lying about where care was delivered in order to secure higher rates.[6] In any case, none changes the controlling Fifth Circuit rule in *Boeing* and *Rivera*, which requires dismissal here.

The same holds for HCSC's new theory about credentialing. It cannot merely declare that it was injured because it would not have paid for the services if it knew about the credentialing issue—it must plead facts showing a concrete harm.

Second, even if it had alleged an injury, HCSC failed to show that it is fairly traceable to NMA's conduct. Stripped of its legal conclusions, HCSC alleges only this: NMA bought certain IOM providers; surgeons later chose NMA for IOM services; patients received those services; and HCSC received reimbursement claims. HCSC claims ignorance as to which "unfettered choices" by non-parties suffice to break the causal chain, Opp. 21, but it is clear from the case caption who the non-parties are: the surgeons. They are "independent actors not before the court." *Reule v. Jackson*, 114 F.4th 360, 367 (5th Cir. 2024). At most, HCSC alleges only that the surgeons had a choice, and they chose NMA for IOM services. The Fifth Circuit has expressed its disapproval of

[6] *See Blue Cross of Cal., Inc. v. Insys Therapeutics Inc.*, 390 F. Supp. 3d 996, 1002–03 (D. Ariz. 2019) (claims for cancer drugs for patients not diagnosed with cancer); *Cigna Health & Life Ins. Co. v. BioHealth Lab'ys, Inc.*, 2025 WL 1450727, at *2 (D. Conn. May 20, 2025) ("billing for medically unnecessary tests"); *Aetna Inc. v. People's Choice Hosp., LLC*, 2019 WL 12536916, at *3 (W.D. Tex. Mar. 28, 2019) (misrepresenting location of services to obtain higher rates). HCSC's remaining cases likewise involved concrete payment injuries absent here: overpayments or services not rendered. *Tri State Advance Surgery Ctr., LLC v. Health Choice, LLC*, 112 F. Supp. 3d 809, 812 (E.D. Ark. 2015) (charging patient one rate and insurer a higher rate, while misrepresenting "there is a single, fixed price billed both to it and to the patient"); *Conn. Gen. Life Ins. Co. v. La Peer Surgery Ctr., LLC*, 2014 WL 961806, at *2 (C.D. Cal. Mar. 12, 2014) (reducing or waiving co-pay obligations for patients while billing insurer the full cost of treatments); *In re SmithKline Beecham Clinical Lab'ys, Inc. Lab'y Test Billing Pracs. Litig.*, 108 F. Supp. 2d 84, 91 (D. Conn. 1999) (billing insurers "for tests that physicians did not order or intend to order" or for "more expensive tests than were ordered"); *Unitedhealthcare Servs., Inc. v. Team Health Holds., Inc.*, 2022 WL 1481171, at *2 (E.D. Tenn. May 10, 2022) (upcoding, i.e., billing for "a higher level of medical care than was provided").

such attenuated arguments to establish Article III standing. *See id.* 367–69; *Earl*, 53 F.4th at 903.

HCSC's fallback is that it was injured by expending resources to investigate the Defendants. This too is circular. And no facts are pleaded to support this in the AC. In any event, a plaintiff "cannot manufacture standing merely by inflicting harm on" itself. *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 416 (2013). Mitigation or investigation expenditures undertaken in anticipation of litigation are not independent injuries under the Supreme Court's concreteness requirement. *See FDA v. All. for Hippocratic Med.*, 602 U.S. 367, 395 (2024) ("[A]n organization that has not suffered a concrete injury . . . cannot spend its way into standing simply by expending money to gather information and advocate against the defendant's action.").

D. HCSC's fraud theories fail to show fraud.

HCSC's original and amended complaints assert a claim supposedly based on an express representation: the CMS-1500 claim forms that the Defendants submit supposedly stated that the Defendants "certify that they followed all applicable laws and regulations [and] have not violated applicable laws." AC ¶ 30. But the CMS-1500 form is now before the Court, as HCSC does not oppose the Defendants' request for judicial notice. Opp. 1, n.1. This language was invented from whole cloth. As the Court will see, the form simply does not state this, or make any applicable representation about compliance with laws. *See* Docket No. 53-5 at 2. As the form is properly the subject of undisputed judicial notice, it must control. *See Funk v. Stryker Corp.*, 631 F.3d 777, 783 (5th Cir. 2011). The express-representation theory fails.

In light of this, HCSC's opposition pivots to a new theory. It argues for the first time in its brief that the mere "submission of a claim for payment to a health insurer" is itself a representation by the provider that the provider thinks the insurer will pay it; if the insurer declares it will not pay the claim, that means the provider committed fraud by submitting the claim. Opp. 22. This is incongruous; out-of-network payors reject claims all the time, and providers do not commit fraud

by billing them for services rendered, even where they disagree about whether the claim is "payable." Here, this theory would mean that the CMS-1500 form amounts to a representation that the structure of the Defendants' business comports with the Texas laws they allegedly violate. *See* Opp. 22. The form simply does not say anything like this. No caselaw supports it. And this position would transform any claim dispute into a fraud claim, even where the provider is out-of-network and has no contract incorporating the insurer's internal rules.

Consider an example of the implications of HCSC's argument. Suppose HCSC declared that it would not pay for IOM performed by for-profit entities, and a for-profit entity submitted a claim for necessary IOM that it performed. Under HCSC's theory, this is fraud—even though the entity did not lie or misrepresent anything, and never agreed to HCSC's restriction.

None of the cases HCSC cites support this extreme result. For example, in *Aetna Inc. v. People's Choice Hospital, LLC*, there was actionable fraud because the plaintiff identified false statements on claim forms and additional misrepresentations by the defendant outside the forms, including details of each fraudulent communication. 2019 WL 12536916, at *10–11. The defendants there laundered claims through an in-network rural hospital with higher rates when they were really performed at out-of-network facilities with lower rates (i.e., they expressly lied about where the services were performed). *Id.* at *3. HCSC pleads no comparable facts here.[7] It identifies no misleading communication by NMA. This is also why HCSC's reliance, Opp. 25, on *Liberty Mutual v. Acute Care Chiropractic,* a district court opinion from Minnesota, is of no help.

[7] Similarly, the other cases HCSC cites involve express false representations. *See United Healthcare Svcs., Inc. v. Next Health, LLC*, 2021 WL 764035, at *2 (N.D. Tex. Feb. 26, 2021) (billing for "unnecessary" services); *Conn. Gen. Life Ins. Co. v. True View Surgery Ctr. One, LP*, 128 F. Supp. 3d 501, 506 (D. Conn. 2015) (provider "misrepresented the true cost of services provided"); *Conn. Gen. Life Ins. Co. v. Advanced Surgery Ctr. of Bethesda, LLC*, 2015 WL 4394408, at *2 (D. Md. Jul. 15, 2015) (defendants submitted "grossly inflated, phantom 'charges'" and misled plaintiffs into believing the patient and insurer were "charged . . . the same charge.").

88 F. Supp. 3d 985 (D. Minn. 2015). There, the defendants made express misrepresentations to the insurance company about their ownership of their facilities, *id.* at 993, and provided medically unnecessary and sub-standard care while certifying that it was necessary, *id.* at 993–95. None of that happened here. HCSC relies on the CMS-1500 form alone.

The False Claims Act cases that HCSC cites prove Defendants' point instead. Under the FCA, there can be fraud through "implied false certification" of compliance with the government's conditions of payment only where the claim "does not merely request payment, but also makes specific representations about the goods or services provided," *and* these specific representations are misleading in that they fail to disclose breaches of other restrictions in the government's express conditions of payment. *U.S. ex rel. Campbell v. KIC Dev., LLC*, 2019 WL 6884485, at *7 (W.D. Tex. Dec. 10, 2019) (citing *Escobar*, 579 U.S. at 194). In *Campbell,* for example, there was a contract with the government in which the defendant promised not to pay gratuities and promised to comply with the federal Anti-Kickback Statute. *Id.* at *8. It made an implied false certification by submitting claims without telling the government that it was breaching those promises. There is no such contract here—the Defendants are out of network, and there is no other promise or representation about compliance with the Texas laws here.[8]

Finally, HCSC alleges that Defendants knew the claims were not payable under HCSC's supposed policy, but pleads no facts or specifics showing that it ever told the Defendants this, that they ever learned it elsewhere, or (most importantly) that they ever agreed to the restriction.

HCSC's nascent Credentialing Theory has additional flaws. It says one unidentified

[8] Nor does Texas law prohibit the Defendants from submitting the claims at issue, as HCSC represents on page 26 of its brief (citing Tex. Health & Safety Code § 311.0025 for the proposition that "providers [are] prohibited from submitting claims tainted by illegal activity to insurers"). The statute simply does not say what HCSC says it does.

person told HCSC of this practice at two Texas hospitals, AC ¶ 128, and that it is therefore "highly likely" that "some or all" claims were tainted, AC ¶ 129. **But HCSC does not identify a single claim—not one—where the named reader did not perform the service.** This vague set of theories, unsupported by any facts or specifics beyond the names of two hospitals, cannot satisfy Rule 8 or Rule 9(b) and thus should be dismissed. HCSC cannot avoid Rule 9(b) by saying the relevant facts are uniquely in the Defendants' possession (an argument HCSC pivots to just after claiming it has a source of information inside NMA). Any plaintiff could say that. HCSC cites only one case, a district court opinion from another district, to support this argument. Opp. 37 (citing *Sys. One Holdings LLC v. Campbell*, 2018 WL 4290459, at *8 (S.D. Tex. Aug. 21, 2018), *rep. & rec. adopted*, 2018 WL 4283127 (S.D. Tex. Sept. 7, 2018)). This case in turn cites a Fifth Circuit case (HCSC does not cite it), but that case does not have a fraud claim and does not reference Rule 9(b) at all. *See Innova Hosp. San Antonio, Ltd. P'ship v. Blue Cross & Blue Shield of Ga., Inc.*, 892 F.3d 719 (5th Cir. 2018). By failing to develop this argument and cite to on-point authority that would permit the Court to suspend a rule of civil procedure, HCSC has waived it.

In short, this theory is correctly described as a rumor. If a plaintiff could avoid Rule 9(b) by simply alleging that it lacks access to information, the rule would be a paper tiger. Instead, the Court must apply Rule 9(b) "with bite and without apology" as the Fifth Circuit requires. *U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 185 (5th Cir. 2009) (cleaned up).

E. The RICO claim fails as a matter of law.

No injury, causation, or deception. To bring a RICO claim, the plaintiff must have been injured in its business or property by reason of the Defendants' violation. *HCB Fin. Corp. v. McPherson*, 8 F.4th 335, 338–39 (5th Cir. 2021), and the racketeering conduct must be both the proximate and but-for cause of the injury, *Hemi Grp., LLC v. City of New York*, 559 U.S. 1, 9 (2010). For the same reasons discussed above as to standing, HCSC flunks this test. It does not

allege that its insureds did not receive the IOM services for which it paid or that it paid more for services than it would have had the acquisitions been structured in a way HCSC deems compliant. *See* Opp. 38. Nor can it seek to recover based on Defendants' contracts with and purported payments to physicians, as these were not the *proximate* cause of injury to HCSC. *See Hemi*, 559 U.S. at 9. HCSC's only response is its familiar refrain that it would not have paid for the IOM services if it knew about the Defendants' corporate structure. Opp. 38. But this argument is flatly contrary to Fifth Circuit precedent. *See Earl,* 53 F.4th at 903; *Rivera*, 283 F.3d at 320–21.

Relying on the Eighth Circuit's opinion in *United States v. Luna,* 968 F.3d 922 (8th Cir. 2020), HCSC argues that the Defendants committed wire fraud even if the claims they submitted for payment did not contain false statements. This misses the forest for the trees. A scheme to defraud requires deception. In *Luna,* the defendants made false or misleading statements to investigators, *id.* at 926–27, and told patients to lie to cover up their scheme, *id.* at 928. There are no such allegations of deceptive conduct here. For the reasons above, the submission of CMS-1500 forms was not deceptive. Nor was any of the other alleged conduct—certainly, none that caused proximate harm to HCSC.

To the extent that HCSC relies instead on the Texas commercial bribery statute as its predicate, this fails for lack of proximate causation. Stripped of labels, the causal chain HCSC alleges runs as follows: (1) NMA purchased entities owned by surgeons; (2) the surgeons (independent, licensed physicians, non-parties to this case) thereafter exercised their medical judgment to order IOM services for their patients and selected NMA to provide them; (3) NMA performed those services, which HCSC does not allege were medically unnecessary or deficient; and (4) HCSC reimbursed the claims at rates it agreed to pay or that IDR arbitrators determined. HCSC's asserted injury thus does not flow from the acquisitions at all. It flows—if it flows from

anything—from the intervening, independent ordering decisions of non-party physicians. That is precisely the kind of attenuated, multi-step theory Supreme Court precedent rejects. *See Anza v. Ideal Steel Supply Corp.*, 547 U.S. 451, 458–61 (2006); *Hemi*, 559 U.S. at 15 (no proximate cause where the theory of liability "rests on the independent actions of third and even fourth parties").

No enterprise. HCSC's opposition does not show that there is a RICO enterprise, or address the Defendants' challenge under *Boyle v. United States,* 556 U.S. 938 (2009). *See* Opp. 40–43. HCSC alleges separate bilateral acquisition agreements between Defendants and individual surgeons, but it has no allegation that the surgeons associated *with each other*, shared a common purpose among themselves, or even knew of one another. This is a textbook example of a rimless hub-and-spoke enterprise, and it fails under *Boyle. See In re Ins. Brokerage Antitrust Litig.*, 618 F.3d 300, 374 (3d Cir. 2010). An association-in-fact enterprise requires relationships *among* those associated with the enterprise and a common purpose they pursue together. *Boyle*, 556 U.S. at 946. Where a plaintiff alleges only that multiple parties (the non-party physicians) each entered separate, parallel, bilateral arrangements with a common hub (NMA)—but alleges no connection, coordination, or relationship among the spokes themselves—no enterprise exists. *Id.*

F. The money had and received claim fails.

Because the federal claims fail, the Court need not reach this state-law equitable claim. Even if it did, HCSC's opposition does not explain why it would be equitable to hold that HCSC should pay *nothing* for medically necessary and properly delivered IOM services that HCSC's insureds received. Instead, HCSC says only that it has determined that it will not pay, and thus equity demands that it be refunded. This fails as a matter of equity and common sense.

III. CONCLUSION

On all other issues, the Defendants rest on their earlier arguments and those made at the hearing on this motion. The Court should dismiss the amended complaint without leave to amend.

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Respectfully submitted,

/s/ Matthew L. Knowles

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

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 July 17, 2026.

/s/ Matthew L. Knowles
Matthew L. Knowles