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

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

PLAINTIFF'S SUR-REPLY IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS AND REQUEST FOR JUDICIAL NOTICE

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INTRODUCTION

Repeating the same errors as their opening brief, Defendants' reply ignores or misconstrues HCSC's allegations, and abandons or fails to defend several previously raised arguments. The Court should deny Defendants' motion.

I. HaloMD is Irrelevant to HCSC's Kickback and Reader Fraud Claims.

In a footnote, Defendants claim the *HaloMD* decision precludes recovery of IDR awards that were issued on claims subject to kickbacks and/or reader fraud. *See* D.E. 55 ("Rep.") at 2 n.3. *HaloMD* did not hold that if a provider commits fraud outside of the NSA process, but then launders the claim through the IDR process, the NSA immunizes the provider from liability. There were no kickback claims in *HaloMD*. Here, HCSC's kickback and reader fraud claims (1) concern conduct that occurred outside of the IDR process; (2) rest on issues the IDREs did not and could not consider; and (3) seek damages consisting in part of amounts HCSC paid to Defendants separate from any IDR award. To that end, HCSC's kickback and reader fraud claims do not challenge a "determination of a certified IDR entity." 42 U.S.C. § 300gg-111(c)(5)(E)(i). Nor is vacatur required for HCSC to recover the full amounts HCSC lost to Defendants' billing fraud, including the portions of those consequential damages consisting of IDR awards. *See* D.E. 54 ("Opp.") at 8–9. And there is no collateral attack bar because "the link between the conduct complained of and the [IDR proceedings are] . . . attenuated" and "at least some of the resulting claims [are] based on harm independent of the arbitration award." *Gulf Petro Trading Co., Inc. v. Nigerian Nat. Petroleum Corp.*, 512 F.3d 742, 751 n.5 (5th Cir. 2008). In fact, Defendants do not dispute this issue is not properly before the Court on a 12(b)(6) motion. Opp. at 9.

II. HCSC Pleads a Claim For Vacatur.

A. Defendants' Procedural Arguments Lack Merit.

Every court that has addressed Defendants' procedural argument has rejected it. Defendants do not attempt to distinguish or rebut this authority. They instead claim that "[w]hether or not" they are wrong on the law, HCSC must follow the FAA's procedures for vacatur because HCSC cites 9 U.S.C. § 10 in its FAC. Rep. at 3. It is unclear how HCSC's citation to a statute could change the applicable law. In any event, the NSA provides an IDR award "shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of Title 9" of the FAA. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). As such, Count XI of the FAC seeks "vacatur of NSA IDR awards under 9 U.S.C. § 10." Neither the NSA nor the FAC incorporate the procedural provisions of the FAA.

B. Vacatur is Warranted Based on Fraud and Undue Means.

Fraud. Given the above, ordinary pleading standards apply to HCSC's claim for vacatur. *See Guardian Flight, L.L.C. v. Med. Evaluators of Tex. ASO, L.L.C.*, 140 F.4th 613, 619–20 (5th Cir. 2025). HCSC is therefore not required, as Defendants assert, to plead "the specific fraudulent statements in each" of the thousands of IDR submissions at issue. Rep. at 3. Rather, Fifth Circuit precedent holds that a plaintiff satisfies Rule 9(b) by pleading the parameters of a fraudulent scheme with one or more representative examples, which HCSC has done. *See El Paso Disposal, LP v. Ecube Labs Co.*, 766 F. Supp. 3d 692, 708 (W.D. Tex. 2025) (plaintiffs are not required "to itemize with particularity each and every action that formed a part of the fraudulent scheme"); *Griggs v. Credit Solutions of Am., Inc.*, No. 10-cv-1291, 2010 WL 2976209, at *3 (N.D. Tex. July 28, 2010) (plaintiff must provide "representative examples" of fraud but need not "allege specific details of *every* alleged fraudulent claim forming the basis of [the plaintiff's] complaint") (citations omitted). *Guardian Flight* does not purport to modify the Rule 9(b) analysis here.

Defendants complain HCSC pled "only" three detailed examples. But HCSC has described at length the types of misrepresentations Defendants made, who made them, during what time, to whom, and in what forum. *See* FAC ¶¶ 172–220. While HCSC could plead additional examples if required to do so, Defendants' argument runs headlong into Fifth Circuit law, under which comparably detailed pleadings have regularly been deemed to satisfy Rule 9(b). *See, e.g.*, *United States ex rel. Gomez v. Koman Constr., LLC*, 796 F. Supp. 3d 353, 379 (W.D. Tex. 2025) (Rule 9(b) satisfied where the plaintiff pled two examples along with the general contours of a complex fraud).[1] Defendants fail to explain why the Court should apply Rule 9(b) differently in this case, arguing only that the Court should modify ordinary pleading standards due to the "FAA policy of 'expedited judicial review.'" Rep. at 3–4. But this argument depends on the proposition that the FAA's procedural provisions apply here, *see id.*, which—as discussed above—is incorrect.

Defendants further cite a lone, unpublished opinion by an out-of-circuit district court that eschewed ordinary pleading standards in dismissing a similar claim. Rep. at 4.[2] But Defendants make no effort to square that court's analysis with an unbroken line of Fifth Circuit authority holding similarly detailed allegations satisfy Rule 9(b). The opinion Defendants cite explicitly discounted the plaintiff's allegations and dismissed the complaint based in part on that court's own view it was "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." *Blue*

[1] *See also SC Shine PLLC v. Aetna Dental, Inc.*, No. 22-cv-0834, 2023 WL 4216989, at *20 (W.D. Tex. June 26, 2023) ("Even in circumstances when the alleged defrauded parties allege numerous instances of fraud, like here, a single example may suffice to avoid dismissal.").

[2] The only other case to address a similar claim is factually distinguishable in that the court understood the plaintiff to allege they objected to eligibility in every instance, whereas HCSC alleges that it was unable to do so. *See Anthem Blue Cross Life & Health Ins. Co. v. HaloMD LLC*, 2026 WL 982629, at *8 (C.D. Cal. Apr. 9, 2026). The facts in *Aetna Health Inc. v. Radiology Partners, Inc.*, 2026 WL 1556164, at *1–2 (M.D. Fla. Apr. 16, 2026) differed significantly, with different types of misrepresentations based on different conduct.

Cross Blue Shield Healthcare Plan of Georgia, Inc. v. HaloMD, Inc., No. 1:25-CV-2919, 2026 WL 2017291, at *23 (N.D. Ga. July 10, 2026). Defendants provide no reason for the Court to blindly adopt such reasoning in the face of voluminous contrary Fifth Circuit authority.

Defendants' assertion that HCSC does not plead the false statements at issue is simply wrong. The FAC explains the specific misrepresentations Defendants made in their submissions to the IDR process that support vacatur, including the knowingly false attestation in every instance that the item or service was "qualified." FAC ¶¶ 149–50, 152–56, 172. HCSC also alleges the time and place of specific representative examples of Defendants' misrepresentations. *Id.* ¶¶ 184–85, 197–99, 210–13. Defendants' assertion that HCSC must allege "each statement" remains flatly inconsistent with an unbroken line of Fifth Circuit authority explained above.

Defendants further repeat their argument that HCSC was required to plead examples where HCSC did not manage to notify Defendants of falsehoods and object. Rep. at 4–5. While HCSC could do so if required, Defendants do not engage with the substance of HCSC's opposition, which explains that the only purpose of representative examples is to give "sufficient particularized detail to . . . provide fair notice to Defendant[s] of the nature of the[ ] claims against [them]." *El Paso Disposal*, 766 F. Supp. 3d at 708. HCSC chose examples highlighting the willful nature of Defendants' conduct, which did not differ in any way when HCSC did not object. Defendants' argument is incompatible with Fifth Circuit precedent holding "[a] representative claim need not mirror every detail of the others; requiring as much would erode Rule 9(b)'s flexibility for pleading complex or long-running fraud schemes." *Gomez*, 796 F. Supp. 3d at 376.

Defendants next contend that HCSC was required to plead it "*could not*" raise Defendants' fraud in the IDR process. Rep. at 5. The standard is not whether it was ***impossible*** for HCSC to raise objections; it is whether "the fraud was not discoverable ***by due diligence***." *See Jackson v.*

Conifer Rev. Cycle Sols., LLC, No. 4:19-cv-256, 2019 WL 8755075, at *6 (E.D. Tex. Dec. 17, 2019) (emphasis added). "Reasonable diligence does not require parties to assume the other side is lying," and a party is "entitled to rely upon [the opposing party's] representations without launching a separate fact-checking investigation." *France v. Bernstein*, 43 F.4th 367, 379–80 (3d 2022). Here, HCSC's allegations establish that it acted diligently, but was not able to catch every instance of fraud due to Defendants inundating HCSC with thousands upon thousands of fraudulent IDR submissions, with HCSC having just days to respond. FAC ¶¶ 142, 178, 220.

Finally, Defendants do not address or refute HCSC's allegation that IDREs regularly ignored or failed to account for HCSC's objections in determining eligibility. *See* FAC ¶¶ 180–219. Indeed, that is why the regulation was recently amended to remove the language directing IDREs to review only the "notice of IDR initiation." *See* Opp. at 13–14. Defendants' cases where fraud was "brought to the attention of the arbitrator, who addressed it" are thus inapplicable. *Barahona v. Dillard's, Inc.*, 376 F. App'x 395, 398 (5th Cir. 2010).

Undue Means. Vacatur is appropriate on the grounds of undue means where a party engaged in misconduct "equivalent in gravity to corruption or fraud." *Guardian Flight*, 140 F.4th at 622 (citations omitted). Defendants fail to explain how serial deception to obtain illegitimate awards under the NSA is not "equivalent in gravity" to fraud. They merely cite the portion of *Blue Cross of Georgia* in which the court improperly rejected the plaintiff's allegations in favor of its own "inferences." Rep. at 5–6. Even if not fraud, the conduct at issue is, "underhanded or conniving ways of procuring an award that are similar to corruption or fraud, but do not precisely constitute either." *Nat'l Cas. Co. v. First State Ins. Grp.*, 430 F.3d 492, 499 (1st Cir. 2005).

C. The IDREs Exceeded Their Authority.

"'[A]rbitrators wield only the authority they are given.'" *Parrott v. Int'l Bancshares Corp.*, 167 F.4th 728, 735 (5th Cir. 2026) (citation omitted). As relevant here, "certified IDR entities are

statutorily prohibited from making payment determinations for items and services that are not subject to the [NSA]." 91 Fed. Reg. 33900, 33933 (June 4, 2026) (emphasis added). This case concerns IDREs exceeding their powers by rendering IDR awards that are contrary to the plain and unambiguous eligibility requirements of the NSA.

Defendants are simply wrong when they argue the "§ 10(a)(4) inquiry asks only whether the arbitrator had authority to decide the threshold issue." Rep. at 6. The law distinguishes between instances in which an arbitrator "was arguably interpreting the contract" and thus entitled to deference, *BNSF R. Co. v. Alstom Transp., Inc.*, 777 F.3d 785, 788 (5th Cir. 2015), and where the arbitrator "exceeds the express limitations of his contractual mandate," in which case "judicial deference is at an end." *PoolRe Ins. Corp. v. Organizational Strategies, Inc.*, 783 F.3d 256, 262 (5th Cir. 2015) (citation omitted). Here, the statutory limits on IDRE authority rest on simple, binary facts. For example, no one would claim an IDRE could interpret the NSA to permit the IDRE to address and issue an award on a Medicare claim, yet that occurred here. *See* FAC ¶¶ 192–205. The issue before the Court is simply whether, at the Rule 12 stage, HCSC plausibly alleges that the IDREs disregarded the plain limits on their authority. It does. Two unpublished district court opinions from other circuits do not trump the controlling Fifth Circuit precedent above.

III. HCSC Has Article III Standing.

Defendants duped HCSC into paying tens of millions of dollars on non-payable claims. This is an Article III injury. Defendants cannot cite a single case holding otherwise.

As an initial matter, Defendants are wrong to argue that the "quality" or "medical necessity" of the IOM services at issue somehow undermines HCSC's standing. HCSC pleads Defendants secured commitments from surgeons to meet inflated quotas for IOM referrals at "roughly the same volume as they referred" when the surgeons were being paid kickbacks on a per-order basis, regardless of medical necessity. FAC ¶¶ 26, 54; *id.* ¶ 34 (IOM services are only

sometimes medically necessary).[3] HCSC further alleges Defendants' reader fraud allowed them to take on more illicit referrals. *See id.* ¶ 126. Defendants' response (in a footnote) is to claim that HCSC is attempting to "amend its pleading" through briefing. Rep. at 7. That is plainly not so. Whatever broader legal issues are presented here, Defendants' argument is based on a clear misreading of HCSC's FAC and Defendants have waived any substantive response on this point.

Defendants also continue to rely on inapposite case law that concerns instances where a consumer buys a product that presents undisclosed risks but works as advertised, and thus the consumer receives "the benefit of her bargain." *Rivera v. Wyeth-Ayerst Lab'ys*, 283 F.3d 315, 320 (5th Cir. 2002); *Earl v. Boeing Co.*, 53 F.4th 897, 902 (5th Cir. 2022) (airline passengers who purchased tickets on an allegedly defective jet suffered no injury where risk failed to materialize). When Defendants perform IOM services and bill HCSC, HCSC has no say in that decision and HCSC "derives no benefit from those services," receiving only "a ripened obligation to pay money[,] . . . which hardly can be called a benefit." *Travelers Indemnity Co. of Conn. v. Losco Group, Inc.*, 150 F. Supp. 2d 556, 563 (S.D.N.Y. 2001). Indeed, Texas federal courts have already held as much for HCSC specifically, even in cases involving the NSA. *See Angelina Emerg. Med. Assoc.'s PA v. HCSC*, 506 F. Supp. 3d 425, 432 (N.D. Tex. 2020) (holding HCSC received no benefit from care to its insureds because as "saddling [HCSC] with a debt to repay hardly qualifies

[3] HCSC (like all payors) will not reimburse claims tainted by illegal kickbacks because, by their nature, kickbacks "cloud" a doctor's medical judgment with "improper financial considerations," *United States v. Patel*, 778 F.3d 607, 612 (7th Cir. 2015), and give them "an incentive to overrefer, thereby increasing utilization and costs," J.F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 Am. J. Law & Med. 205, 207 (1996); *see also U.S. ex rel. Westmoreland v. Amgen, Inc.*, 812 F. Supp. 2d 39, 53 (D. Mass. 2011) (noting kickbacks are "designed to influence providers' independent medical judgment"); *Blue Cross of Cal., Inc. v. Insys Therapeutics Inc.*, 390 F. Supp. 3d 996, 1006 (D. Ariz. 2019) (same). There is no basis to infer here, in Defendants' favor, that the alleged kickbacks ***did not*** function to encourage physicians to order more IOM than was necessary.

as a benefit"); *Guardian Flight LLC v. HCSC*, 735 F. Supp. 3d 742, 754 (N.D. Tex. 2024) (noting the NSA did not change that care provided to insureds does not confer a benefit on HCSC).

As a result, while Defendants emphasize that they performed the services for which they billed, that is irrelevant to HCSC's injury. Under Defendants' argument, an insurer could *never* have a claim for overpayment for any reason so long as a medical service was rendered. That is false. *See, e.g.*, Opp. at 19 n. 9 & 20 n.10. When Defendants deceived HCSC into paying claims that not only violated HCSC's policies, but also ***violated*** Texas law, *see* Opp. at 30–34, HCSC suffered an absolute economic loss and got nothing in return. Nor can Defendants distinguish a mountain of authority holding this satisfies Article III. See Opp. at 19 n.9 & 20 n.10. And while Defendants reiterate their claim that the laws they violated are "about protecting patients," they continue to fail to explain (1) from where they divine this alleged policy or (2) on what basis the policy skews the analysis in their favor. Rep. at 8.

Defendants further fail to grapple with the additional, independently sufficient grounds for HCSC's standing: the nature of HCSC's business is such that it has "a concrete and particularized interest in paying only valid claims," both based on its "business interest in only paying out valid claims" and because it is forced to expend "time and resources in investigating" problematic claims. *Cigna Health & Life Ins. Co. v. BioHealth Lab'ys, Inc.*, No. 3:19-CV-01324, 2025 WL 1450727, at *6–7 (D. Conn. May 20, 2025) (citations omitted). Rather than address the unbroken line of authority holding this is sufficient for HCSC's standing, *see* Opp. at 20 n.10, Defendants try to recharacterize this as HCSC complaining of a self-inflicted injury incurred "by expending resources to investigate the Defendants." Rep. at 10. But this ignores that HCSC's business depends on paying only valid claims, such that it suffers an Article III injury even absent a loss of "its own money." *Cigna*, 2025 WL 1450727, at *5. And HCSC did not voluntarily "spend" its way

to an injury by advocating against Defendants;[4] it was harmed (above and beyond paying tainted claims) by incurring costs to uncover Defendants' kickback and reader fraud scheme.

Defendants' efforts to resuscitate their traceability arguments fare no better. They again argue that the surgeons are "independent actors" that sever traceability. Rep. at 9. But again, they completely ignore HCSC's allegations that Defendants paid the surgeons at issue illegal kickbacks to induce them to agree to Defendants' scheme. FAC ¶¶ 54–55, 64. The entire point of Defendants paying kickbacks was to illegally influence the judgment of referring providers. *See id*. The referring surgeons thus were not "independent actors" making "unfettered choices"; they were scheme participants, pushed by Defendants' actions which "produce[d] a determinative or coercive effect upon the action of [the surgeons], resulting in [HCSC's] injury." *Inclusive Communities Project, Inc. v. Dep't of Treasury*, 946 F.3d 649, 655–56 (5th Cir. 2019) (citation omitted).

IV. HCSC Pleads its Kickback and Reader Fraud Claims with Sufficient Particularity.

Defendants submitted claims for payment to HCSC barred by Texas law, knowing they were illegal and that HCSC would not pay them if it knew the truth. FAC ¶¶ 23–28; 226–28. Further, Defendants' claim that HCSC's allegations are limited to the express contents of standard claim forms[5] is Defendants' own invention and a misreading of HCSC's claims. Rep. at 10.

It is hornbook law that "[a] representation stating the truth so far as it goes but which the maker knows or believes to be materially misleading because of his failure to state additional or qualifying matter is a fraudulent misrepresentation." Restatement (Second) of Torts § 529 (1977). Courts applying this principle have routinely held that a provider that submits a claim they know

[4] Defendants' reliance on *FDA v. Alliance for Hippocratic Medicine*, 602 U.S. 367 (2024) is inapposite. That case rejected Article III standing for unregulated entities that spend money *advocating* against—but who were not harmed by—changes in federal regulations. *Id.* at 394–95.
[5] The form warns not to submit "false, incomplete or misleading information." D.E. 53-5 at 3.

to be non-payable to an insurer, intending that the insurer's ignorance will lead the insurer to pay that claim, has committed fraud—even in the absence of an affirmative misrepresentation on a claim form. *See* Opp. at 24–26. Defendants' halfhearted efforts to distinguish this long line of authority in their reply is unavailing.[6] That they did not write "we did not commit fraud" on the claim form does not render them immune from liability. And while HCSC cites authority supporting its position, Defendants fail to cite a single case.

For example, the court in *People's Choice Hospital* expressly found actionable fraud because the defendants' claims "omitted numerous material facts, including that physicians, labs, and other individuals and entities had been paid for specimens." *Aetna Inc. v. People's Choice Hosp., LLC*, No. 18-CV-00323, 2019 WL 12536916, at *10 (W.D. Tex. Mar. 28, 2019). In short, the court found fraud based on ***the very same conduct at issue here***, even as it found the defendants had also committed ***additional*** fraud based on other misrepresentations. *Id.* And while Defendants strain to characterize *Liberty Mutual* as turning on affirmative misrepresentations, the Court's holding—the submission of a CMS-1500 form is a representation that the claims "were eligible for reimbursement"—rests ***solely*** on a provider's obligation to "say enough in order to prevent his

[6] These cases involved more than express misrepresentations. *See United Healthcare Servs., Inc. v. Next Health, LLC*, No. 3:17-cv-00243, 2021 WL 764035, at *5 (N.D. Tex. Feb. 26, 2021) (holding claims submitted "***without disclosure*** that the services . . . were induced by paying kickbacks to physicians and, in cases, not medically necessary" constituted a valid fraud claim, in addition to separate misrepresentations (emphasis added)); *Conn. Gen. Life Ins. Co. v. True View Surgery Ctr. One LP*, 128 F. Supp. 3d 501, 514 (D. Conn. 2015) (noting fraud claim was based on "practice of submitting claims to Cigna ***without disclosing*** a waiver of cost-share requirements" (emphasis added)); *Conn. Gen. Life Ins. Co. v. Adv. Surg. Ctr. Of Bethesda, LLC*, No. 14-cv-2376, 2015 WL 4394408, at *22 (D. Md. July 15, 2015) ("[W]hen submitting claims forms that included representations about their charges, the [Defendants] ***had a duty not to conceal or suppress material information*** that was necessary to qualify the true nature of their charges or billing practices" (emphasis added)); *see also Sky Toxicology, Ltd. v. UnitedHealthcare Ins. Co.*, No. 5:16-cv-01094-FB-RBF, 2018 WL 4211742, at *2, *9 (W.D. Tex. Sept. 4, 2018) (denying dismissal of fraud claims alleging kickback scheme for lab testing, where defendant induced lab tests via undisclosed kickbacks and concealed kickbacks as "investments").

words from misleading" a payor. *Liberty Mut. Fire Ins. Co. v. Acute Care Chiropractic Clinic P.A.*, 88 F. Supp. 3d 985, 1013–14 (D. Minn. 2015).[7]

Defendants' arguments regarding claims arising under the FCA similarly miss the mark. Defendants argue *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176 (2016), held that, for HCSC's implied certification theory to be valid, a claim must have both requested payment and made other specific misrepresentations. Rep. at 2, 12. Not so. In *Escobar*, the Supreme Court expressly declined to resolve whether "all claims for payment implicitly represent that the billing party is legally entitled to payment" because the claims in that case did "more" than demand payment. *Id.* at 188. The decision Defendants cite notes that fact, and also declined to reach the issue. *U.S. ex rel. Campbell v. KIC Dev., LLC*, No. 18-cv-193, 2019 WL 6884485, at *7 n.9 (W.D. Tex. Dec. 10, 2019). Still, other courts have held that an implied false certification theory based solely on a demand for payment is not barred by *Escobar*.[8] This confirms Defendants' demands for payment to HCSC, while hiding that the claims were induced by kickbacks, gives rise to a valid fraud claim.

Defendants attempt to frame this as HCSC trying to turn arbitration preferences into claims for fraud. But to be clear, not only is the specific conduct at issue disallowed under HCSC's

[7] HCSC has alleged both direct and implied misrepresentations. Whether it will be able to prove them "is a question for summary judgment, not a 12(b)(6) motion." *Kersh v. UnitedHealthcare Ins. Co.*, 946 F. Supp. 2d 621, 641 (W.D. Tex. 2013).

[8] *Josephs v. Amentum Servs., Inc.*, No. SAG-25-01477, 2025 WL 3223772, at *6 (D. Md. Nov. 19, 2025) (holding implied certification theory based on "request for payment under a contract without disclosing noncompliance with material contractual requirements" was, without specific representations, "one way" to plead fraud post-*Escobar*); *U.S. ex rel. Laporte v. Premiere Educ. Grp., L.P.*, No. 11-3523, 2017 WL 3471163, at *3 (D.N.J. Aug. 11, 2017) (finding falsity met where defendants' alleged noncompliance with federal regulations rendered them ineligible for funding, because defendants' mere representations of eligibility for payment were sufficiently "specific" to be "misleading half-truths"); *U.S. ex rel. Simpsons v. Bayer Corp.*, 376 F. Supp. 3d 392, 408–09 (D.N.J. 2019) (collecting cases, holding case law did not bar Relator from proving "submission of false claims . . . under either an express or implied false certification theory").

payment policies, it is also widely recognized as healthcare fraud, *see* Opp. at 28–31, and again it is ***expressly prohibited under Texas law***. *See* Tex. Health & Safety Code § 311.0025 (barring providers from "submit[ting] to a patient or a third party payor a bill for a treatment that the [provider] . . . knows was improper"); Tex. Occ. Code § 102.001 *et seq.* (expressly barring the payment of kickbacks for referrals like those at issue here); Tex. Penal Code § 32.43 (criminalizing the payment of kickbacks for referrals). Defendants' attempt to analogize their conduct to an anodyne misunderstanding falls flat.

Finally, Defendants claim that HCSC lacks specific examples of reader fraud claims and thus is effectively seeking to suspend Rule 9(b). Rep. at 12–13. That is false. HCSC is not asking this Court to suspend Rule 9(b). It merely asks the Court to take into account that Defendants have unique (and sole) access to the critical information that would allow HCSC to identify specific claims infected by this fraud (*e.g.*, surgery-level information not included on claim forms, such as real-time surgical IOM service chat logs and internal documents identifying which NMA readers actually performed a given service). Federal courts in Texas addressing fraud claims under Rule 9(b) consider a plaintiff's "limited access to crucial information" like this, because "[t]o conclude otherwise simply rewards hiding the ball, by demanding that Plaintiffs plead facts at the outset of the case that can only be readily ascertained through discovery." *System One Holdings LLC v. Campbell*, No. B:18-cv-54, 2018 WL 4290459, at *8 (S.D. Tex. Aug. 21, 2018). Based on information provided by a former NMA employee with knowledge, HCSC has alleged what it can: since at least May 2022, on numerous claims, Defendants misrepresented to HCSC that a properly licensed/credentialed reader performed the IOM service when in reality, a non-licensed or non-credentialed reader did it instead, for IOM services provided to patients of at least two facilities, Baptist Hospital in San Antonio, TX, and UT Tyler Hospital in Tyler, TX. FAC ¶¶ 123–29. The

precise information needed to identify the specific claims at issue for these misrepresentations lies in Defendants' possession alone. As such, dismissing HCSC's reader fraud theory would only "reward" Defendants for "hiding the ball." *Campbell*, 2018 WL 4290459, at *8.

V. HCSC Plausibly Alleges Defendants Violated RICO.

HCSC has RICO standing for the harms caused by Defendants. Defendants' reply again argues that HCSC cannot establish a RICO injury because its insureds received the IOM services HCSC paid for, and therefore HCSC suffered no cognizable harm. But, for the reasons explained above and in HCSC's opposition, that argument ignores HCSC's allegations. The FAC alleges that: (1) Defendants' kickback scheme caused surgeons to order IOM services regardless of patient need to meet express quotas, causing HCSC to pay claims it otherwise would not have paid; (2) HCSC suffers an absolute economic loss with no corresponding benefit every time it pays a fraudulent claim, regardless of any services rendered; and (3) HCSC was injured in its business by virtue of paying fraudulent claims and expending resources investigating and combating Defendants' scheme. Defendants never meaningfully address these allegations or harms.

Nor do Defendants engage with HCSC's authority, including *People's Choice Hospital*, 2019 WL 12536916, at *5–6, which held materially identical allegations sufficed for RICO standing. HCSC's business depends on paying only legitimate claims. When HCSC pays a non-payable claim, or is forced to expend resources combating fraud, it suffers an economic loss without a corresponding benefit and an injury to its business. *See id*. HCSC's injuries here satisfy RICO standing. Defendants cite no cases involving healthcare fraud because they cannot.

HCSC adequately pleads the predicate act of wire fraud. Defendants next argue that, unlike in *United States v. Luna*, 968 F.3d 922 (8th Cir. 2020), there are no "allegations of deceptive conduct here." Rep. at 14. But HCSC alleges that Defendants, much like the defendants in *Luna*, entered into illegal kickback arrangements and ***concealed*** them with sham transactions "to keep

insurance companies in the dark about their use of . . . kickbacks." *Luna*, 968 F.3d at 926. This type of "active concealment" through "deceptive actions intended *to avoid suspicion or prevent further inquiry*" is widely understood to establish a scheme to defraud. *United States v. Goss*, No. 6:19-CR-03048-1, 2022 WL 4109626, at *5 (W.D. Mo. Sept. 8, 2022) (emphasis in original); *see also id.* (scheme to defraud found where illicit kickbacks were disguised as legitimate payments); *United States v. Dobson*, No. 1:12-CR-42, 2013 WL 4049595, at *6 (E.D. Tenn. Aug. 8, 2013) ("A scheme to defraud need not involve a false statement, pretenses, promises, or representations."). Defendants further (1) lied to HCSC and hospitals about who performed what services and (2) submitted thousands of claims to HCSC for non-payable services, understanding that HCSC would not pay if it was aware of Defendants' illegal conduct. *See* FAC ¶¶ 121–29; 308–19. This is deceptive conduct of the type that courts routinely find sufficient.[9]

HCSC adequately pleads the predicate act of commercial bribery. Defendants also argue that HCSC cannot establish proximate causation under Texas's commercial bribery statute. Defendants' argument rests on the false assertion that HCSC pleads only that the claims at issue resulted from the "independent ordering decisions of non-party physicians." Rep. at 14–15. To the contrary, HCSC provided detailed allegations explaining that Defendants bribed physicians with illegal kickbacks, thus obtaining those physicians' express agreement to order a quota of IOM services exclusively from Defendants regardless of patient need, and that Defendants billed the resulting non-payable claims to HCSC. *See* FAC ¶¶ 47–55, 320–22. There is no step in this process

[9] *See, e.g.*, *Luna*, 968 F.3d at 926; *United States v. Bradley*, 644 F.3d 1213, 1241–42 (11th Cir. 2011) (scheme to defraud found where the defendants "induced" government payors "to reimburse for drugs . . . when the programs otherwise would have refused" based on their payment policies); *State Comp. Ins. Fund v. Capen*, No. SACV151279, 2015 WL 13298073, at *10 (C.D. Cal. Dec. 18, 2015) (scheme to defraud adequately alleged based in part on defendants entering into "contracts that allegedly served to cover up the kickbacks" that allowed them to bill a payor).

that Defendants did not deliberately induce or control outright.

HCSC adequately pleads the existence of an enterprise. Finally, Defendants argue that HCSC fails to allege an enterprise because there is "no allegation that the surgeons associated with each other." Rep. at 15. But "there is no need for a plaintiff to prove that each conspirator had contact with all other members." *Schwartz v. Lawyers Title Ins. Co.*, 970 F. Supp. 2d 395, 404 (E.D. Pa. 2013) (rejecting the same arguments based on the same authority). And "a party to a [RICO] conspiracy need not know the identity, or even the number, of his confederates." *United States v. Elliott*, 571 F.2d 880, 903 (5th Cir. 1978). HCSC alleges that Defendants and the Ordering Surgeons shared a common purpose of enriching themselves, maintained kickback arrangements between each other, and operated to obtain reimbursement from HCSC. FAC ¶¶ 293–97. Those allegations readily plead an association-in-fact enterprise under *Boyle*.

VI. HCSC Pleads Money Had and Received.

Defendants' supplemental-jurisdiction argument is beside the point, as this Court has diversity jurisdiction. FAC ¶ 17. Defendants also never address HCSC's authority recognizing that insurers may recover the full amount paid on fraudulent claims, even when the underlying services were actually performed. Opp. at 44. Nor must HCSC prove at the pleading stage that it "should pay nothing," as Defendants suggest. Rep. at 15 (emphasis omitted). A claim for money had and received is not all or nothing. HCSC need only allege that Defendants "hold[] money which in equity and good conscience belongs" to HCSC. *Bank of Saipan v. CNG Fin. Corp.*, 380 F.3d 836, 840 (5th Cir. 2004). It has done so here. FAC ¶¶ 274–78, 280–83.

CONCLUSION

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

Dated: July 24, 2026

By: */s/ John K. Harting*

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**Motion for *pro hac vice* admission forthcoming

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CERTIFICATE OF SERVICE

I, John K. Harting, hereby certify that on July 24, 2026, a true and correct copy of the above, with a proposed order, was served via e-mail through the Eastern District of Texas's CM/ECF system.

s/John K. Harting
John K. Harting