UNITED STATES BANKRUPTCY COURT
DISTRICT OF NEW JERSEY

Caption in compliance with D.N.J. LBR 9004-1(b)

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Attorneys for UnitedHealthcare Insurance Company

In re:

Invitae Corporation, *et al*.[1]

Debtors.

Chapter 11

Case No. 24-11362 (MBK)

(Jointly Administered)

LIMITED OBJECTION TO DEBTORS' NOTICE TO CONTRACT PARTIES TO POTENTIALLY ASSUMED EXECUTORY CONTRACTS AND UNEXPIRED LEASES

UnitedHealthcare Insurance Company, on behalf of itself, its affiliates, parents, and subsidiaries (collectively, "United"), hereby submits this limited objection to the *Notice to*

[1] The last four digits of Debtor Invitae Corporation's tax identification number are 1898. A complete list of the Debtors in these chapter 11 cases and each such Debtor's tax identification number may be obtained on the website of the Debtors' proposed claims and noticing agent at www.kccllc.net/invitae.

24113622405010000000000014

Contract Parties to Potentially Assumed Executory Contracts and Unexpired Leases [Docket. No. 365] (the "Assumption Notice"), filed by Invitae Corporation ("Invitae") and its affiliated debtors (collectively, the "Debtors"). In particular, United objects to the $0 cure amount listed on the Assumption Notice for the PPA (as defined below). Rather, as described below, the correct cure amount under 11 U.S.C. § 365(b) should be at least $36,780,598.87, if not significantly higher.

In support of its objection, United states as follows:

I. BACKGROUND

A. United's Health Insurance Plans and Contracts with Providers

1. United provides health insurance benefits to members insured under its, or its affiliates', fully insured group medical policies through a network of providers who contract with United to render medical services to members. United also provides health insurance benefits to members under Medicare Advantage plans, as well as to members under managed Medicaid programs in certain states.

2. United also administers self-insured health plans of third parties, by which the members of those self-insured plans may also access medical care through United's network of providers.[2] United's contracts with such third parties to administer self-funded insurance plans expressly authorize United to pursue any and all overpayments administered by United and paid by such third parties.

3. United's network providers agree to provide services to United's members, to accept reimbursement at specific fixed rates for those services, and to not bill United's members for any other amounts (except under limited circumstances). United's network providers are also

[2] United's fully insured plans and the third party self-insured plans administered by United (together and separately) are referred to herein as being United health insurance plans, with their members referred to as being United's members.

required to refer United's members only to other in-network providers or to use reasonable commercial efforts to direct United members only to other in-network providers. In exchange, United's network providers receive certain benefits, including access to members of United's health insurance plans as a source of patients.

4. Out-of-network (or "non-network") providers have not entered into any provider agreement with United. United has not agreed to pay out-of-network providers any predetermined amounts for services provided to United's members, and out-of-network providers have not agreed to refrain from charging United members for the balance of whatever portion of the provider's charges United does not pay. Out-of-network providers must either bill the member directly for services rendered or obtain an assignment of the member's health plan and bill United directly for its services standing in the shoes of the member. Generally, out-of-network providers charge and bill United and plan members at rates set by the providers, which are almost always higher than the contractual rates agreed to between United and its network providers. United members are also subject to being billed by their out-of-network providers for the difference between the provider's charges and the amount of reimbursement paid by United. This is in addition to the cost-sharing amounts United members must pay under their plan.

5. United's health insurance plans typically require United members to pay for some portion or all of the charges submitted by medical providers for the services such members receive, typically until a certain out-of-pocket maximum has been met. These member payment responsibilities (also called cost-sharing obligations) generally consist of a combination of a deductible (the amount of money a member must pay for services before his or her insurance benefits are triggered), coinsurance (the percentage of a provider's charges the member must pay for services received after his or her deductible has been met), and copays (a flat amount per visit).

6. United's members must pay the cost-sharing amounts required under their health insurance plan for the services rendered to them to be covered and eligible for benefits paid by United. United reserves the right under its health plans to recover payments made to providers where member payment responsibilities were not paid or not required to be paid.

7. The cost-share obligations of United's members are generally lower for services they receive from network providers than for services from non-network providers, and members are protected from being billed by network providers for the difference between their plan's reimbursement to the network provider and the provider's billed charge. This structure allows United's members to obtain medical services from in-network providers with minimal financial risk or out-of-pocket expenses.

8. United aims to provide the individuals covered by the benefit plans it insures and administers with comprehensive healthcare coverage at affordable costs, from well-qualified medical professionals, at professionally staffed and accredited medical facilities.

9. The cost-sharing obligations of United's members are an important check on fraud, waste, and abuse. Since it is members, not their plans, who control the services they receive, members' payment responsibilities sensitize members to unnecessary or overpriced services, resulting in more affordable healthcare for all members (as well as healthcare consumers, generally).

B. United's Relationship with Invitae

10. Invitae is a provider of clinical laboratory testing services.

11. United and Invitae are parties to a National Ancillary Provider Participation Agreement with an effective date of January 1, 2017, which has been amended from time to time (the "PPA").[3]

12. Pursuant to the PPA, Invitae agreed to provide certain covered services to United's members, in exchange for certain fees.

13. Prior to 2017, Invitae was not among the network of providers contracted with United. Thus, if a United member sought medical services from Invitae prior to the effective date of the PPA, such services were considered to be "out-of-network," and subject to higher co-pays and deductibles.

14. Pursuant to the PPA, United agreed to pay claims for covered services in accordance with the Payment Policies (as defined in the PPA), and according to the lesser of (i) the fee for health care services charged by Invitae that does not exceed the fee Invitae would ordinarily charge another person regardless of whether the person is one of United's members (the "Customary Charge"), and (ii) the applicable fee schedule.

15. Under the PPA, Invitae must submit claims to United as described in the Protocols (as defined in the PPA), and using current, correct, and applicable coding. In particular, all claims submitted under the PPA must use Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS") procedure codes, with modifiers where

[3] The PPA contains United's highly confidential and sensitive commercial information. While the Debtors should have a copy of the PPA, other parties in interest may request copies of the PPA by written request to United's counsel and upon the entry into either an acceptable confidentiality agreement or the entry of an appropriate protective order. If requested by the Court, United will provide a copy of the PPA to it for *in camera* review.

appropriate,[4] ICD-10-CM codes[5] or its successor, and other codes in compliance with the Health Insurance Portability and Accountability Act's ("HIPAA") standard data set requirements.

16. Under the PPA and the Protocols, certain procedure codes have prior authorization requirements, which allow United to verify if services are medically necessary and covered, or prior notification requirements.

17. In addition, differing diagnoses and/or services have varying member cost-sharing obligations under United's health insurance plans.

18. Under the PPA, a claim may be denied for, among other reasons, not following the Protocols, lack of prior notification or prior authorization when required, untimely filing, lack of coverage under the member's health plan, lack of medical necessity, or submission not in compliance with HIPAA standard data set requirements.

19. Misrepresenting the diagnoses and/or services provided to obtain higher payment or payment for noncovered services is a violation of the PPA; *see, e.g.*, 2023 UnitedHealthcare Care Provider Administrative Guide for Commercial and Medicare Advantage, at 24, 156; and may be fraud; *see, e.g.*, 18 U.S.C. §§ 1035, 1341, 1343, 1347; 31 U.S.C. § 3729(a)(1); 42 U.S.C. §§ 1320a-7a(a)(1) (A)–(B), (E).

[4] HCPCS is a standardized code system for submitting claims to the Centers for Medicare & Medicaid Services ("CMS"), and is comprised of two principal subsystems: HCPCS Level I consists of the CPT code set developed and maintained by the American Medical Association to describe medical, surgical, radiology, laboratory, anesthesiology, and evaluation/management services of health care providers; and HCPCS Level II is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT code set, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office.

[5] The International Classification of Diseases ("ICD") is published by the World Health Organization. As used herein, "ICD-10-CM" is the International Classification of Diseases, 10th Revision, Clinical Modification.

20. Pursuant to the PPA, Invitae must repay any overpayments within 30 days of written or electronic notice of the overpayment. Further, the PPA provides that recovery of overpayments may be accomplished by offsets against future payments.

21. The PPA's provisions governing the submission and the validity of claims are substantially the same as those set forth in United's health insurance plans, which would have been applicable during any time period in which Invitae was out-of-network with United.

C. United's Overpayments to Invitae

1. Overpayments Identified from Claims Review Using RAT-STATS Software

22. Prior to the Petition Date (defined below), United conducted a review of certain of Invitae's paid claims to verify consistency with coding and billing requirements and to ensure payment accuracy. Using RAT-STATS software developed by the Office of the Inspector General of the Department of Health and Human Services ("HHS OIG"),[6] United identified a statistically valid, random sample ("SVRS") of claims paying CPT codes 81162 and 81479, utilizing a 95% confidence rate, an anticipated rate of occurrence of 50%, and a desired precision rate of 10%, with dates of service from September 1, 2015 to February 6, 2023 (the "Review Period").[7] From the SVRS, United used RAT-STATS to identify two probe samples: a probe sample of 77 claim lines for CPT code 81162 (the "81162 Probe Sample"); and a probe sample of 52 claim lines for

[6] According to the HHS OIG website, "RAT-STATS is a free statistical software package that providers can download to assist in a claims review. The package, created by OIG in the late 1970s, is also the primary statistical tool for OIG's Office of Audit Services." OIG.com, RAT-STATS - Statistical Software, https://oig.hhs.gov/compliance/rat-stats/ (last visited April 30, 2024).

[7] *See Arizona Health Care Cost Containment Sys. v. Centers for Medicare & Medicaid Servs.*, No. CV-21-00952-PHX-DWL, 2023 WL 4661809, at *16 (D. Ariz. July 20, 2023) (finding a sampling approach utilizing RAT-STATS to be "well-supported by statistical literature").

CPT code 81479 (the "81479 Probe Sample" and together with the 81162 Probe Sample, the "Probe Sample Claims").[8]

23. United then requested medical records to review the propriety of the Probe Sample Claims.

24. United's review of the Probe Sample Claims and the associated medical records identified, among other things, that Invitae submitted claims to United seeking payment for genetic testing services performed on members using inaccurate, higher-paying CPT codes than the codes applicable to the services performed by Invitae. United's investigation also revealed that the prior authorization requests and the prior notifications that were being submitted to United misrepresented the laboratory test(s) that Invitae would be performing.

25. Within the Probe Sample Claims, an aggregate 60 claim lines were not supported based on misrepresentations of the services provided. Specifically, United found that 45.45% of the claim lines in the 81162 Probe Sample and 48.08% of the claim lines in the 81479 Probe Sample were unsupported by the underlying medical records, and, thus, were improperly paid.

26. The misrepresentations within the 81162 Probe Sample all concern Invitae performing and billing for a different test than was authorized. Specifically, prior authorization was often sought, or advance notification was often provided, for tests performed by Invitae that would be covered under United's health insurance plans, but the underlying medical records showed that Invitae performed a different test for which United did not grant prior authorization or Invitae did not provide advance notification. Further, in many of those instances, the underlying

[8] *See Duffy v. Lawrence Mem'l Hosp.*, No. 2:14-CV-2256-SAC-TJJ, 2017 WL 1277808, at *3 (D. Kan. Mar. 31, 2017) (directing defendant to utilize RAT-STATS, and noting the "software includes a Sample Size Determination feature to ensure that a statistically valid sample is drawn, which in turn allows for making a 'fair guess' and drawing conclusions from the sample to the universe").

medical records showed that the test that Invitae performed was a large panel test that United only covers if certain criteria are met.

27. Meanwhile, as set forth in Exhibit A, there were a variety of misrepresentations within the 81479 Probe Sample, including, but not limited to, performing and billing for a different test than was authorized. By way of illustration, for at least nine of the unsupported claims, Invitae identified a single gene test that United automatically approved under an advance notification process based on the representation of the nature of the test, but the actual test run and billed was a much larger multi-gene panel test (often testing dozens of genes) that would have required prior authorization with a review of medical criteria to justify such a test.

28. There were a variety of additional bases for the unsupported claims within the 81479 Probe Sample, including billing under an inaccurate code based on the test performed, the test was not registered with United, unbundling services, the underlying test was unproven and not covered under the PPA and the Protocols, lack of test order for the test performed, and lack of a medical record establishing that the test was actually performed.

29. Extrapolating the 45.54% aberrancy rate across the Review Period's universe of paid claim lines for CPT code 81162, excluding United's Community & State line of business (which includes Medicaid programs, discussed below), United overpaid Invitae by $20,074,172.19 for claim lines for CPT code 81162 with dates of service within the Review Period. This overpayment was calculated as follows:

Number of Claim Lines in 81162 Probe Sample that Are Not Supported	35	a
Number of Claim Lines in 81162 Probe Sample that Are Supported	42	b
Aberrancy Rate*	45.45%	c
Aggregate Payments within 81162 Probe Sample	$97,326.46	d
Unsupported Payments within 81162 Probe Sample	$48,260.80	e
Aggregate Payments in Review Period	$34,228,259.84	f

(excluding Community & State line of business)		
Number of Paid Claim Lines within Review Period	33,600	g
Overpayments Attributable to Community & State line of business within Review Period	$985,085.99	h
Extrapolated Overpayment Amount	**$20,074,172.19**	=(e/a)*c*g-h

30. Extrapolating the 48.08% aberrancy rate across the Review Period's universe of paid claim lines for CPT code 81479, excluding United's Community & State line of business (which includes Medicaid programs, discussed below), United overpaid Invitae by $16,619,432.90 for claim lines for CPT code 81479 with dates of service within the Review Period. This overpayment was calculated as follows:

Number of Claim Lines in 81479 Probe Sample that Are Not Supported	25	a
Number of Claim Lines in 81479 Probe Sample that Are Supported	27	b
Aberrancy Rate*	48.08%	c
Aggregate Payments within 81479 Probe Sample	$72,010.79	d
Unsupported Payments within 81479 Probe Sample	$37,447.31	e
Aggregate Payments in Review Period (excluding Community & State line of business)	$23,413,462.12	f
Number of Paid Claim Lines within Review Period	24,237	g
Overpayments Attributable to Community & State line of business within Review Period	$834,614.26	h
Extrapolated Overpayment Amount	**$16,619,432.90**	=(e/a)*c*g-h

31. Overpayments attributable to United's Community & State line of business (which includes Medicaid programs) initially were subtracted from the foregoing extrapolated overpayment calculations pending the receipt of appropriate regulatory approval for United to pursue them on behalf of individual state Medicaid programs. Thus far, United has received appropriate state regulatory approval to pursue overpayments attributable to United's Community & State line of business in the aggregate amount of $1,360,738.90 for claim lines for CPT Code

81162 and CPT Code 81479 with dates of service within the Review Period.[9] United intends to amend its Proof of Claim (as defined below) to include these additional amounts.

32. In sum, United overpaid Invitae no less than an aggregate $38,054,343.99 (the "Review Overpayments") for claim lines for CPT codes 81162 and 81479 with dates of service within the Review Period. United's payments to Invitae were based on Invitae's specific representations about the accuracy and completeness of its claim submissions.

2. Additional Overpayments Identified in the Ordinary Course

33. In addition to the Review Overpayments, United will periodically overpay a claim for a variety of ordinary course reasons that arise in the day-to-day operations of United and Invitae under the PPA. Examples of "ordinary course" reasons giving rise to such overpayments include, but are not limited to, the following: (i) the member's benefit package did not cover the services provided; (ii) the claim did not meet Medicare National Coverage Determinations and/or Local Coverage Determinations criteria; (iii) the member had primary coverage through another insurance carrier; (iv) the service(s) were provided after the member's insurance coverage was terminated; (v) the claim was allowed in an incorrect amount under the contract; (vi) the service(s) are not covered when billed with an invalid diagnosis code; or (vii) a corrected bill was submitted.

34. Prior to the Petition Date, Invitae received additional overpayments as a result of "ordinary course" reasons in the aggregate amount of $86,993.78 (the "Ordinary Course Overpayments" and together with the Review Overpayments, the "Overpayments"), which remain due and owing to United.

[9] Other state Medicaid programs have not yet provided regulatory approval for United to pursue overpayments on their behalf. These additional overpayments may amount to as much as $381,182.94. If appropriate regulatory approval is received, such amounts should be considered to be part of the cure as set forth herein, and upon receipt of such approval, United will supplement this objection. United also will amend its Proof of Claim to include such amounts.

3. Potential Additional Overpayments for Charges Exceeding the Customary Charge

35. United is investigating additional overpayments arising from the Invitae's practice of submitting claims well in excess of the Customary Charge in violation of Section 2.1(vi) of the PPA and certain payment appendices. For example, United has learned that, while Invitae was billing it thousands of dollars per test (often between $1,500 to $7,500 per test), Invitae was offering those very same tests to patients at a "cash price" that was a fraction of the amount billed to United (often $250 and in some cases even less). By charging United in excess of the Customary Charge in this manner, it gives rise to additional breaches of the PPA. United is actively investigating this conduct and will supplement this objection upon a determination of the full scope of damages it has suffered.[10]

D. The Debtors' Bankruptcy Case

36. On February 14, 2024 (the "Petition Date"), the Debtors each filed a voluntary petition under Chapter 11 of Title 11 of the United States Code (the "Bankruptcy Code") in this Court.

37. In connection with the Overpayments (but excluding overpayments attributable to United's Community & State line of business[11]), on April 12, 2024, United timely filed a proof of claim against Invitae for pre-petition amounts due and owing under the PPA in the amount of $36,780,598.87 (the "Proof of Claim"). (Case No. 24-11362, Claims Reg., Claim No. 849.) A true and correct copy of the current operative Proof of Claim is attached hereto as **Exhibit A**. Because claims for pre-petition services rendered to United's members are likely continuing to be submitted under the PPA, United anticipates that the overpayment amounts for pre-petition dates

[10] Similarly, United will be amending its Proof of Claim in the near future once these damages have been quantified.

[11] *See* Part I.C.1 above.

of service will change over time. In addition, United intends to amend its Proof of Claim to include overpayments attributable to United's Community & State line of business for which United has received appropriate state regulatory approval to pursue (which, thus far, amount to an additional $1,360,738.90 in overpayments). Moreover, as noted above, United anticipates that additional overpaid claims will be identified for (among other things) Invitae's pattern and practice of charging United in excess of the Customary Charge; *see* Part I.C.3 above.

38. In addition, since the Petition Date, Invitae has continued to submit claims to United for services rendered to United's members on or after the Petition Date. In the ordinary course of business of paying claims under the PPA, post-petition overpayments are potentially accruing and may continue to accrue up to the closing date of the Sale Transaction,[12] and such amounts will be due and owing under the PPA.

39. On April 25, 2024, the Debtors filed the Assumption Notice, which identifies contracts that could potentially be assumed and assigned to the Successful Bidder (the "Potential Assumed Contracts"), and the amounts, if any, that the Debtors believe are owed to each counterparty to such Potential Assumed Contracts due to any defaults that exist under such contracts. (Dkt. No. 365.)

40. In Exhibit A to the Assumption Notice, the Debtors list numerous purported executory contracts between Invitae and United among the Potential Assumed Contracts that the Debtors may assume and assign as part of the Sale Transaction. (*Id.* at 245, 288, 341–42.)

41. United interprets the following set of purported executory contracts in Exhibit A to the Assumption Notice as designating the PPA as a whole for potential assumption and assignment (the "PPA Contract List"):

[12] Capitalized terms not defined herein shall have the meaning ascribed to them in the Assumption Notice.

Debtor Entity	Contract Counterparty	Document Title	Effective Date
Invitae Corporation	UnitedHealthcare Insurance Company	National Ancillary Provider Participation Agreement	1/1/17
Invitae Corporation	UnitedHealthcare Insurance Company	Amendment to the Facility Participation Agreement	4/1/21
Invitae Corporation	UnitedHealthcare Insurance Company	Amendment Four to the Ancillary Provider Participation Agreement	11/1/22
Invitae Corporation	UnitedHealthcare of New York, Inc., Oxford Health Plans (NY), Inc., and UnitedHealthcare Insurance Company	Ancillary Provider Participation Agreement	1/1/17
Invitae Corporation	UnitedHealthcare Insurance Company	Amendment	7/1/22
Invitae Corporation	UnitedHealthcare Insurance Company	Appendix 2 Commercial Networks Disclosure Addendum	
Invitae Corporation	UnitedHealthcare Insurance Company	Ohio State Program Regulatory Requirements Appendix	10/11/16
Invitae Corporation	UnitedHealthcare Insurance Company	Amendment to the National Ancillary Provider Participation Agreement	5/1/18
Invitae Corporation	UnitedHealthcare Insurance Company	Amendment	6/1/18
Invitae Corporation	UnitedHealthcare Community Plan	Notification of Welcome to UnitedHealthcare Community Plan of Virginia Network and Regulatory Requirements Appendix	8/1/18
Invitae Corporation	UnitedHealthcare Insurance Company	Amendment	8/1/18
Invitae Corporation	UnitedHealthcare Insurance Company	Minnesota Regulatory Requirements Appendix	9/1/18
Invitae Corporation	UnitedHealthcare	Florida Lab Benefit Management Program Transition	6/4/19
Invitae Corporation	UnitedHealthcare Insurance Company	Amendment Number Two to the National Ancillary Provider Participation Agreement	7/1/19
Invitae Corporation	UnitedHealthcare Insurance Company	Amendment to the Ancillary Provider Participation Agreement	2/1/20
Invitae Corporation	UnitedHealthcare Insurance Company	Amendment	7/1/20

Invitae Corporation	UnitedHealthcare Insurance Company	Amendment to Participation Agreement for Veterans Affairs Community Care Program	8/1/20
Invitae Corporation	UnitedHealthcare of River Valley, Inc.	UnitedHealthcare Community Plan Amendment	1/1/21
Invitae Corporation	UnitedHealthcare Insurance Company	Amendment	7/1/21
Invitae Corporation	UnitedHealthcare	Massachusetts Government Programs Regulatory Requirements Appendix	1/1/22
Invitae Corporation	UnitedHealthcare	Minnesota State Program Regulatory Requirements Appendix	1/1/22
Invitae Corporation	UnitedHealthcare	Notice of UnitedHealthcare Participation Agreement Including Rocky Mountain Health Plans	7/1/23
Invitae Corporation	UnitedHealthcare Insurance Company	Participation Agreement between UnitedHealthcare Insurance Company and Invitae Corporation	7/1/23
Invitae Corporation	UnitedHealthcare of North Carolina, Inc. (UnitedHealthcare Insurance Company)	North Carolina Regulatory Requirements Appendix	

(*Id.* at 341–42.)

42. The cure designation for each of the purported executory contracts on the PPA Contract List is $0.00. (*Id.*)

II. LIMITED OBJECTION

Sections 365(b) and 365(f) of the Bankruptcy Code require that the Debtors cure, or provide adequate assurance that they will promptly cure, all defaults under any executory contracts that they seek to assume and assign to the Successful Bidder.

United hereby submits this limited objection to the cure amounts listed in the Assumption Notice because (i) the Assumption Notice fails to properly reflect the pre-petition amounts owed to United under the PPA, and (ii) the Assumption Notice fails to include in the cure amounts any overpayment liabilities that may arise between the Petition Date and the closing of the Sale Transaction.

To be clear, United does not object to the assumption of the PPA and assignment to the Successful Bidder, but it objects to the $0.00 proposed cure amounts by the Debtors for each of the purported executory contracts in the PPA Contract List. United contends that the actual cure amounts owed to United must be paid pursuant to 11 U.S.C. § 365 for the PPA to be assumed and assigned.

As of the Petition Date, an aggregate amount of $38,141,337.77 is owed to United under the PPA. As noted above, it is expected that this amount may change over time as additional overpayments are identified, given the timing of the submission and payment of medical claims for pre-petition dates of service, as well as arising from the receipt of additional states' regulatory approval to seek recovery of overpayments for Medicaid members, and the completion of the investigation into (among other things) the pattern and practice of charging United in excess of the Customary Charge. In addition, through the ongoing operation of Invitae's business, additional overpayments may become due and owing post-petition through the closing date of the Sale Transaction.

Accordingly, if the Debtors desire to have the PPA assumed and assigned, then proper arrangements must be made to ensure that all outstanding amounts currently owed to United under the PPA are paid. Specifically, in accordance with 11 U.S.C. § 365, the order approving the Sale Transaction must require payment in full of the pre-petition and post-petition amounts due to United under the PPA as set forth herein.

United will work in good faith with the Debtors and Successful Bidder to resolve the issues raised herein.

III. RESERVATION OF RIGHTS

United hereby reserves its right to make such other and further objections as may be appropriate, including modifying the cure amount if additional amounts accrue or are determined to be owing under the PPA before the effective date of assumption.[13]

IV. CONCLUSION

United respectfully requests that the Court enter an order (i) requiring the payment of the amounts outstanding under the PPA as described herein as part of the cure of defaults under 11 U.S.C. §§ 365 (b) and (f), and (ii) granting such other and further relief as the Court deems appropriate.

Dated: May 1, 2024

Respectfully submitted,

By: /s/ Joseph C. Barsalona II

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[13] United also reserves its right to compel arbitration of any disputes under the PPA.

EXHIBIT A

Fill in this information to identify the case:

Debtor Invitae Corporation

United States Bankruptcy Court for the: _____ District of New Jersey (State)

Case number 24-11362

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. **Who is the current creditor?**
   See summary page
   Name of the current creditor (the person or entity to be paid for this claim)
   Other names the creditor used with the debtor _____

2. **Has this claim been acquired from someone else?**
   ☑ No
   ☐ Yes. From whom? _____

3. **Where should notices and payments to the creditor be sent?**
   Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

Where should notices to the creditor be sent?	**Where should payments to the creditor be sent?** (if different)
See summary page	
Contact phone 860-251-5000	Contact phone _____
Contact email egoldstein@goodwin.com	Contact email _____

   Uniform claim identifier for electronic payments in chapter 13 (if you use one):
   _

4. **Does this claim amend one already filed?**
   ☐ No
   ☑ Yes. Claim number on court claims registry (if known) _____ Filed on 4/12/2024 MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**
   ☑ No
   ☐ Yes. Who made the earlier filing? _____

24113622404120000000000049

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**
   - ☑ No
   - ☐ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ___ ___ ___ ___

7. **How much is the claim?** $ 36,780,598.87 . **Does this amount include interest or other charges?**
   - ☑ No
   - ☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**
   Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
   Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
   Limit disclosing information that is entitled to privacy, such as health care information.
   See attachment

9. **Is all or part of the claim secured?**
   - ☑ No
   - ☐ Yes. The claim is secured by a lien on property.

   Nature or property:
   - ☐ Real estate: If the claim is secured by the debtor's principle residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*.
   - ☐ Motor vehicle
   - ☐ Other. Describe: _____

   Basis for perfection: _____
   Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

   Value of property: $_____
   Amount of the claim that is secured: $_____
   Amount of the claim that is unsecured: $_____ (The sum of the secured and unsecured amount should match the amount in line 7.)

   Amount necessary to cure any default as of the date of the petition: $_____

   Annual Interest Rate (when case was filed)_____%
   - ☐ Fixed
   - ☐ Variable

10. **Is this claim based on a lease?**
    - ☑ No
    - ☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $_____

11. **Is this claim subject to a right of setoff?**
    - ☐ No
    - ☑ Yes. Identify the property: See attachment

24113622404120000000000049

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

		Amount entitled to priority
☑	No	
☐	Yes. *Check all that apply:*	
☐	Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$_____
☐	Up to $3,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$_____
☐	Wages, salaries, or commissions (up to $15,150*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$_____
☐	Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$_____
☐	Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$_____
☐	Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$_____

* Amounts are subject to adjustment on 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim entitled to administrative priority pursuant to 11 U.S.C. 503(b)(9)?**

☑ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☑ I am the creditor.

☐ I am the creditor's attorney or authorized agent.

☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.

☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have reasonable belief that the information is true and correct.

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

Executed on date 04/12/2024
MM / DD / YYYY

/s/Danielle Wilson
Signature

Print the name of the person who is completing and signing this claim:

Name: Danielle Wilson
First name Middle name Last name

Title: Director, SIU

Company: UnitedHealthcare Insurance Company
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: PO Box 9472, Minneapolis, MN, 55440-9472, USA

Contact phone 763-732-7060 Email danielle.wilson@uhc.com

KCC ePOC Electronic Claim Filing Summary

For phone assistance: Domestic (866) 967-0263 | International (310) 751-2663

Debtor:
24-11362 - Invitae Corporation

District:
District of New Jersey, Trenton Division

Creditor:
UnitedHealthcare Insurance Company, on behalf of itself, its parents, subsidiaries, and affiliates
Shipman and Goodwin LLP, c/o Eric Goldstein
One Constitution Plaza

Hartford, CT, 06103-1919
United States

Phone:
860-251-5000

Phone 2:

Fax:
860-251-5218

Email:
egoldstein@goodwin.com

Has Supporting Documentation:
Yes, supporting documentation successfully uploaded

Related Document Statement:

Has Related Claim:
No

Related Claim Filed By:

Filing Party:
Creditor

Other Names Used with Debtor:

Amends Claim:
Yes, 4/12/2024

Acquired Claim:
No

Basis of Claim:
See attachment

Last 4 Digits:
No

Uniform Claim Identifier:

Total Amount of Claim:
36,780,598.87

Includes Interest or Charges:
No

Has Priority Claim:
No

Priority Under:

Has Secured Claim:
No

Amount of 503(b)(9):
No

Based on Lease:
No

Subject to Right of Setoff:
Yes, See attachment

Nature of Secured Amount:

Value of Property:

Annual Interest Rate:

Arrearage Amount:

Basis for Perfection:

Amount Unsecured:

Submitted By:
Danielle Wilson on 12-Apr-2024 5:43:33 p.m. Eastern Time

Title:
Director, SIU

Company:
UnitedHealthcare Insurance Company

Optional Signature Address:
PO Box 9472

Minneapolis, MN, 55440-9472
USA

Telephone Number:
763-732-7060

Email:
danielle.wilson@uhc.com

UNITED STATES BANKRUPTCY COURT
DISTRICT OF NEW JERSEY

In re:	Chapter 11
Invitae Corporation,[1]	Case No. 24-11362 (MBK)
Debtor.	

ATTACHMENT TO PROOF OF CLAIM OF
UNITEDHEALTHCARE INSURANCE COMPANY

UnitedHealthcare Insurance Company, on behalf of itself and its parents, affiliates, and subsidiaries (collectively, "United"), is a creditor and party in interest in the above captioned bankruptcy case.

I. BACKGROUND

A. United's Health Insurance Plans and Contracts with Providers

1. United provides health insurance benefits to members insured under its, or its affiliates', fully insured group medical policies through a network of providers who contract with United to render medical services to members. United also administers self-insured health plans of third parties, by which the members of those self-insured plans may also access medical care through United's network of providers.[2] United's contracts with such third parties to administer self-funded insurance plans expressly authorize United to pursue any and all overpayments administered by United and paid by such third parties.

2. United's network providers agree to provide services to United's members, to accept reimbursement at specific fixed rates for those services, and to not bill United's members

[1] The last four digits of Debtor Invitae Corporation's tax identification number are 1898.

[2] United's fully insured plans and the third party self-insured plans administered by United (together and separately) are referred to herein as being United health insurance plans, with their members referred to as being United's members.

for any other amounts (except under limited circumstances). United's network providers are also required to refer United's members only to other in-network providers or to use reasonable commercial efforts to direct United members only to other in-network providers. In exchange, United's network providers receive certain benefits, including access to members of United's health insurance plans as a source of patients.

3. Out-of-network (or "non-network") providers have not entered into any provider agreement with United. United has not agreed to pay out-of-network providers any predetermined amounts for services provided to United's members, and out-of-network providers have not agreed to refrain from charging United members for the balance of whatever portion of the provider's charges United does not pay. Out-of-network providers must either bill the member directly for services rendered or obtain an assignment of the member's health plan and bill United directly for its services standing in the shoes of the member. Generally, out-of-network providers charge and bill United and plan members at rates set by the providers, which are almost always higher than the contractual rates agreed to between United and its network providers. United members are also subject to being billed by their out-of-network providers for the difference between the provider's charges and the amount of reimbursement paid by United. This is in addition to the cost-sharing amounts United members must pay under their plan.

4. United's health insurance plans typically require United members to pay for some portion or all of the charges submitted by medical providers for the services such members receive, typically until a certain out-of-pocket maximum has been met. These member payment responsibilities (also called cost-sharing obligations) generally consist of a combination of a deductible (the amount of money a member must pay for services before his or her insurance

benefits are triggered), coinsurance (the percentage of a provider's charges the member must pay for services received after his or her deductible has been met), and copays (a flat amount per visit).

5. United's members must pay the cost-sharing amounts required under their health insurance plan for the services rendered to them to be covered and eligible for benefits paid by United. United reserves the right under its health plans to recover payments made to providers where member payment responsibilities were not paid or not required to be paid.

6. The cost-share obligations of United's members are generally lower for services they receive from network providers than for services from non-network providers, and members are protected from being billed by network providers for the difference between their plan's reimbursement to the network provider and the provider's billed charge. This structure allows United's members to obtain medical services from in-network providers with minimal financial risk or out-of-pocket expenses.

7. United aims to provide the individuals covered by the benefit plans it insures and administers with comprehensive healthcare coverage at affordable costs, from well-qualified medical professionals, at professionally staffed and accredited medical facilities.

8. The cost-sharing obligations of United's members are an important check on fraud, waste, and abuse. Since it is members, not their plans, who control the services they receive, members' payment responsibilities sensitize members to unnecessary or overpriced services, resulting in more affordable healthcare for all members (as well as healthcare consumers, generally).

B. United's Relationship with the Debtor

9. Invitae Corporation (the "Debtor") is a provider of clinical laboratory testing services.

10. United and the Debtor are parties to a National Ancillary Provider Participation Agreement with an effective date of January 1, 2017, which has been amended from time to time (the "PPA").[3]

11. Pursuant to the PPA, the Debtor agreed to provide certain covered services to United's members, in exchange for certain fees.

12. Prior to 2017, the Debtor was not among the network of providers contracted with United. Thus, if a United member sought medical services from the Debtor prior to the effective date of the PPA, such services were considered to be "out-of-network," and subject to higher co-pays and deductibles.

13. Pursuant to the PPA, United agreed to pay claims for covered services in accordance with the Payment Policies (as defined in the PPA), and according to the lesser of (i) the fee for health care services charged by the Debtor that does not exceed the fee the Debtor would ordinarily charge another person regardless of whether the person is one of United's members (the "Customary Charge"), and (ii) the applicable fee schedule.

14. Under the PPA, the Debtor must submit claims to United as described in the Protocols (as defined in the PPA), and using current, correct, and applicable coding. In particular, all claims submitted under the PPA must use Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS") procedure codes, with modifiers

[3] The PPA contains United's highly confidential and sensitive commercial information. While the Debtor should have a copy of the PPA, other parties in interest may request copies of the PPA by written request to United's counsel and upon the entry into either an acceptable confidentiality agreement or the entry of an appropriate protective order. If requested by the Court, United will provide a copy of the PPA to it for *in camera* review.

where appropriate,[4] ICD-10-CM codes[5] or its successor, and other codes in compliance with the Health Insurance Portability and Accountability Act's ("HIPAA") standard data set requirements.

15. Under the PPA and the Protocols, certain procedure codes have prior authorization requirements, which allow United to verify if services are medically necessary and covered, or prior notification requirements.

16. In addition, differing diagnoses and/or services have varying member cost-sharing obligations under United's health insurance plans.

17. Under the PPA, a claim may be denied for, among other reasons, not following the Protocols, lack of prior notification or prior authorization when required, untimely filing, lack of coverage under the member's health plan, lack of medical necessity, or submission not in compliance with HIPAA standard data set requirements.

18. Misrepresenting the diagnoses and/or services provided to obtain higher payment or payment for noncovered services may be fraud. *See* 18 U.S.C. § 1347.

19. Pursuant to the PPA, the Debtor must repay any overpayments within 30 days of written or electronic notice of the overpayment. Further, the PPA provides that recovery of overpayments may be accomplished by offsets against future payments.

[4] HCPCS is a standardized code system for submitting claims to the Centers for Medicare & Medicaid Services ("CMS"), and is comprised of two principal subsystems: HCPCS Level I consists of the CPT code set developed and maintained by the American Medical Association to describe medical, surgical, radiology, laboratory, anesthesiology, and evaluation/management services of health care providers; and HCPCS Level II is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT code set, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office.

[5] The International Classification of Diseases ("ICD") is published by the World Health Organization. As used herein, "ICD-10-CM" is the International Classification of Diseases, 10th Revision, Clinical Modification.

20. The PPA's provisions governing the submission and the validity of claims are substantially the same as those set forth in United's health insurance plans, which would have been applicable during any time period in which the Debtor was out-of-network with United.

C. United's Overpayments to the Debtor

1. Overpayments Identified from Claims Review Using RAT-STATS Software

21. Prior to the Petition Date (defined below), United conducted a review of certain of the Debtor's paid claims to verify consistency with coding and billing requirements and to ensure payment accuracy. Using RAT-STATS software developed by the Office of the Inspector General of the Department of Health and Human Services ("HHS OIG"),[6] United identified a statistically valid, random sample ("SVRS") of claims paying CPT codes 81162 and 81479, utilizing a 95% confidence rate, an anticipated rate of occurrence of 50%, and a desired precision rate of 10%, with dates of service from September 1, 2015 to February 6, 2023 (the "Review Period").[7] From the SVRS, United used RAT-STATS to identify two probe samples: a probe sample of 77 claim lines for CPT code 81162 (the "81162 Probe Sample"); and a probe sample of 52 claim lines for CPT code 81479 (the "81479 Probe Sample" and together with the 81162 Probe Sample, the "Probe Sample Claims").[8]

[6] According to the HHS OIG website, "RAT-STATS is a free statistical software package that providers can download to assist in a claims review. The package, created by OIG in the late 1970s, is also the primary statistical tool for OIG's Office of Audit Services." OIG.com, RAT-STATS - Statistical Software, https://oig.hhs.gov/compliance/rat-stats/ (last visited March 22, 2024).

[7] *See Arizona Health Care Cost Containment Sys. v. Centers for Medicare & Medicaid Servs.*, No. CV-21-00952-PHX-DWL, 2023 WL 4661809, at *16 (D. Ariz. July 20, 2023) (finding a sampling approach utilizing RAT-STATS to be "well-supported by statistical literature").

[8] *See Duffy v. Lawrence Mem'l Hosp.*, No. 2:14-CV-2256-SAC-TJJ, 2017 WL 1277808, at *3 (D. Kan. Mar. 31, 2017) (directing defendant to utilize RAT-STATS, and noting the "software includes a Sample Size Determination feature to ensure that a statistically valid sample is drawn, which in turn allows for making a 'fair guess' and drawing conclusions from the sample to the universe").

22. United then requested medical records to review the propriety of the Probe Sample Claims.

23. United's review of the Probe Sample Claims and the associated medical records identified, among other things, that the Debtor submitted claims to United seeking payment for genetic testing services performed on members using inaccurate, higher-paying CPT codes than the codes applicable to the services performed by the Debtor. United's investigation also revealed that the prior authorization requests and the prior notifications that were being submitted to United misrepresented the laboratory test(s) that the Debtor would be performing.

24. Within the Probe Sample Claims, an aggregate 60 claim lines were not supported based on misrepresentations of the services provided. Specifically, United found that 45.45% of the claim lines in the 81162 Probe Sample and 48.08% of the claim lines in the 81479 Probe Sample were unsupported by the underlying medical records, and, thus, were improperly paid. Attached hereto as **Exhibit A** is a chart summarizing United's review of the Probe Sample Claims.[9]

25. The misrepresentations within the 81162 Probe Sample all concern the Debtor performing and billing for a different test than was authorized. Specifically, prior authorization was often sought, or advance notification was often provided, for tests performed by the Debtor that would be covered under United's health insurance plans, but the underlying medical records showed that the Debtor performed a different test for which United did not grant prior authorization or the Debtor did not provide advance notification. Further, in many of those instances, the underlying medical records showed that the test that the Debtor performed was a large panel test that United only covers if certain criteria are met.

[9] Exhibit A does not include detailed claims information with the protected health information of United's members, but such information can be made available upon the entry of an appropriate protective order. Each of the de-identified claim lines set forth on Exhibit A has been assigned as a unique identifier to permit later re-identification.

26. Meanwhile, as set forth in Exhibit A, there were a variety of misrepresentations within the 81479 Probe Sample, including, but not limited to, performing and billing for a different test than was authorized. By way of illustration, for at least nine of the unsupported claims, the Debtor identified a single gene test that United automatically approved under an advance notification process based on the representation of the nature of the test, but the actual test run and billed was a much larger multi-gene panel test that (often testing dozens of genes) would have required prior authorization with a review of medical criteria to justify such a test.

27. There were a variety of additional bases for the unsupported claims within the 81479 Probe Sample, including billing under an inaccurate code based on the test performed, the test was not registered with United, unbundling services, the underlying test was unproven and not covered under the PPA and the Protocols, lack of test order for the test performed, and lack of a medical record establishing that the test was actually performed.

28. Extrapolating the 45.54% aberrancy rate across the Review Period's universe of paid claim lines for CPT code 81162, excluding United's Community & State line of business (which includes Medicaid programs), United overpaid the Debtor by $20,074,172.19 for claim lines for CPT code 81162 with dates of service within the Review Period. This overpayment was calculated as follows:

Number of Claim Lines in 81162 Probe Sample that Are Not Supported	35	a
Number of Claim Lines in 81162 Probe Sample that Are Supported	42	b
Aberrancy Rate*	45.45%	c
Aggregate Payments within 81162 Probe Sample	$97,326.46	d
Unsupported Payments within 81162 Probe Sample	$48,260.80	e
Aggregate Payments in Review Period (excluding Community & State line of business)	$34,228,259.84	f
Number of Paid Claim Lines within Review Period	33,600	g
Overpayments Attributable to Community & State line of business within Review Period	$985,085.99	h

Extrapolated Overpayment Amount	**$20,074,172.19**	=(e/a)*c*g-h

29. Extrapolating the 48.08% aberrancy rate across the Review Period's universe of paid claim lines for CPT code 81479, excluding United's Community & State line of business (which includes Medicaid programs), United overpaid the Debtor by $16,619,432.90 for claim lines for CPT code 81479 with dates of service within the Review Period. This overpayment was calculated as follows:

Number of Claim Lines in 81479 Probe Sample that Are Not Supported	25	a
Number of Claim Lines in 81479 Probe Sample that Are Supported	27	b
Aberrancy Rate*	48.08%	c
Aggregate Payments within 81479 Probe Sample	$72,010.79	d
Unsupported Payments within 81479 Probe Sample	$37,447.31	e
Aggregate Payments in Review Period (excluding Community & State line of business)	$23,413,462.12	f
Number of Paid Claim Lines within Review Period	24,237	g
Overpayments Attributable to Community & State line of business within Review Period	$834,614.26	h
Extrapolated Overpayment Amount	**$16,619,432.90**	=(e/a)*c*g-h

30. In sum, United overpaid the Debtor no less than an aggregate $36,693,605.09 (the "Review Overpayments") for claim lines for CPT codes 81162 and 81479 with dates of service within the Review Period. United's payments to the Debtor were based on the Debtor's specific representations about the accuracy and completeness of its claim submissions.

2. Additional Overpayments Identified in the Ordinary Course

31. In addition to the Review Overpayments, United will periodically overpay a claim for a variety of ordinary course reasons that arise in the day-to-day operations of United and the Debtor under the PPA. Examples of "ordinary course" reasons giving rise to such overpayments include, but are not limited to, the following: (i) the member's benefit package did not cover the services provided; (ii) the claim did not meet Medicare National Coverage Determinations and/or

Local Coverage Determinations criteria; (iii) the member had primary coverage through another insurance carrier; (iv) the service(s) were provided after the member's insurance coverage was terminated; (v) the claim was allowed in an incorrect amount under the contract; (vi) the service(s) are not covered when billed with an invalid diagnosis code; or (vii) a corrected bill was submitted.

32. Prior to the Petition Date, the Debtor received additional overpayments as a result of "ordinary course" reasons in the aggregate amount of $86,993.78 (the "Ordinary Course Overpayments"), which remain due and owing to United. A chart summarizing the Ordinary Course Overpayments is attached hereto as **Exhibit B**.[10]

II. THE DEBTOR'S BANKRUPTCY FILING AND UNITED'S CLAIM

33. On February 14, 2024 (the "Petition Date"), the Debtor filed a voluntary petition under Chapter 11 of Title 11 of the United States Code (the "Bankruptcy Code") in this Court.

34. This Proof of Claim is hereby filed in the Debtor's bankruptcy case in the amount of $36,780,598.87 due and owing to United as set forth below (the "Claim"), which represents the following:

a. $36,693,605.09 for the Review Overpayments under the PPA, as more particularly described in Section I(C)(1) above;

b. $86,993.78 for the Ordinary Course Overpayments under the PPA, as described in Section I(C)(2) above; and

c. any and all other amounts now owing or hereafter accrued and owing to United, regardless of whether such amounts are unliquidated, and/or

[10] Exhibit B does not include detailed claims information with the protected health information of United's members, but such information can be made available upon the entry of an appropriate protective order.

contingent, and/or unmatured, including but not limited to, those amounts due to United under the PPA and/or a United health insurance plan.

35. To the best of United's knowledge, no payments have been made on the Claim.

36. To the best of United's knowledge, no judgment has been rendered on the Claim.

37. The Debtor has asserted that certain amounts are owed to it for prepetition services provided to United's members. To the extent that any such amounts are determined to be owed from United to the Debtor, United herein asserts a right of setoff against such amounts under 11 U.S.C. § 506(a)(1).

38. United expressly reserves its right to recoup the Claim from future payments made to the Debtor and nothing herein is or should be deemed a waiver of United's recoupment rights.

39. Further, United expressly reserves the right to file a motion for relief from the automatic stay to effectuate its right of setoff under 11 U.S.C. §§ 362(d) and 553(a).

40. The recitations in this Claim are not intended in any way to limit United's rights with respect to the legal basis for making the Claim, and if the Claim is challenged, United shall not be deemed to have waived any legal position it might otherwise have to the amount of such Claim.

41. In executing and filing this Claim, United does not waive any obligation owing to it, any right to any security held by it or for its benefit, any right to claim specific assets, or any other right or rights of action that it has or may have against the Debtor or any other person, and United hereby expressly reserves such rights. Further, United expressly reserves the right to require any or all of the Claim to be paid as an administrative claim of the Debtor's estate under 11 U.S.C. § 503(b).

42. United also expressly reserves the right to file further pleadings and documents to amend or supplement this Claim in any respect from time to time to: (i) restate liquidated and unliquidated components of the Claim, including the amount by which the Claim may be secured by United's right of set-off and/or recoupment; (ii) update the total estimated exposure with respect to any unliquidated claims asserted herein; (iii) request payment of administrative expenses under 11 U.S.C. § 503(b) (whether in respect of claims asserted herein or otherwise); (iv) reflect additional claims owed to United to the extent discovered after the filing hereof; or (v) for any other reason it deems appropriate, including without limitation to claim all amounts due with respect to any pre-petition or post-petition professional fees and/or expenses and interest.

43. United expressly reserves the right to pursue any third parties for the amounts of this Claim, including, but not limited to, the officers, directors, and members of the Debtor or the Debtor's affiliates, and/or any other persons or entities that participated in any conduct resulting in the Claim.

44. Filing of this Claim is not and shall not be deemed or construed as: (a) an election of remedies; (b) a consent by United to the jurisdiction of this Court or any other court with respect to proceedings, if any, commenced in any case against or otherwise involving United; (c) a consent by United to a jury trial in this Court or any other court in any proceeding as to any and all matters so triable herein or in any case, controversy or proceeding related hereto, pursuant to 28 U.S.C. §157(e) or otherwise; (d) a waiver of the right of United to a trial by jury in any proceeding so triable herein or in any case, controversy or proceeding related hereto, notwithstanding the designation or not of such matters as "core proceedings" pursuant to 28 U.S.C. §157(b)(2), and whether such jury trial is pursuant to statute or the United States Constitution; (e) a waiver of the right of United to have final orders in non-core matters or matters in which the Bankruptcy Court

cannot constitutionally enter a final order entered only after *de novo* review by a District Court judgment; (f) a waiver of the right of United to have the reference withdrawn by the District Court in any matter subject to mandatory or discretionary withdrawal; (g) a waiver of any past, present or future default under the PPA or any other agreement by and between the Debtor and United; (h) a waiver or limitation of any rights of United, including, without limitation, a waiver of rights, claims, actions, defenses, set-offs or recoupments to which United is or may be entitled under agreements, in law or in equity, all of which rights, claims, actions, defenses, set-offs and recoupments are expressly reserved by United; (i) a waiver of any right to compel arbitration of any disputes under the PPA; or (j) an admission by United that any property held by Debtor (or any debtor affiliate) is property of the estate.

EXHIBIT A

Unique Identifier	Date of Service	Procedure Code	Procedure Code Description	Modifier	Units	Amount Charged	Amount Paid	Findings With Respect to Whether Payment Was Supported
81162 Probe Sample								
81162 Probe Sample Claim 1	Jul-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 2	Jul-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 3	Jun-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 4	Jun-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	0	$6,400.00	$1,115.20	Supported
81162 Probe Sample Claim 5	Jun-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 6	Jun-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized.
81162 Probe Sample Claim 7	Jun-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 8	May-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL		1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 9	Apr-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 10	Apr-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 11	Apr-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL		1	$3,750.00	$1,115.20	Supported
81162 Probe Sample Claim 12	Apr-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized.
81162 Probe Sample Claim 13	Apr-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized.
81162 Probe Sample Claim 14	Apr-2021	81162	BRCA1&2 SEQ & FULL DUP/DEL	33	1	$3,750.00	$1,115.20	Not Supported. The provider performed and billed for a different test than authorized.
81162 Probe Sample Claim 15	Mar-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 16	Mar-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 17	Mar-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,115.20	Supported
81162 Probe Sample Claim 18	Feb-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 19	Jan-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized.
81162 Probe Sample Claim 20	Jan-2021	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,115.20	Supported
81162 Probe Sample Claim 21	Dec-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 22	Dec-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 23	Dec-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 24	Nov-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL		1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized.
81162 Probe Sample Claim 25	Nov-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 26	Nov-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized.
81162 Probe Sample Claim 27	Nov-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,115.20	Supported
81162 Probe Sample Claim 28	Oct-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 29	Oct-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 30	Oct-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 31	Oct-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. There was no order documented for the test performed.
81162 Probe Sample Claim 32	Oct-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than submitted for payment. The test performed requires prior authorization.
81162 Probe Sample Claim 33	Oct-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.

Unique Identifier	Date of Service	Procedure Code	Procedure Code Description	Modifier	Units	Amount Charged	Amount Paid	Findings With Respect to Whether Payment Was Supported
81162 Probe Sample Claim 34	Oct-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL		1	$3,750.00	$1,115.20	Supported
81162 Probe Sample Claim 35	Oct-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 36	Sep-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	0	$3,750.00	$1,115.20	Supported
81162 Probe Sample Claim 37	Sep-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 38	Sep-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,115.20	Supported
81162 Probe Sample Claim 39	Sep-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 40	Sep-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 41	Sep-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 42	Aug-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,115.20	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires a prior authorization.
81162 Probe Sample Claim 43	Aug-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 44	Aug-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 45	Aug-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 46	Aug-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 47	Jul-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 48	Jul-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 49	Jul-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 50	Jul-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than submitted for payment. The test performed requires prior authorization.
81162 Probe Sample Claim 51	Jun-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 52	Jun-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Supported
81162 Probe Sample Claim 53	Jun-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,115.20	Supported

Unique Identifier	Date of Service	Procedure Code	Procedure Code Description	Modifier	Units	Amount Charged	Amount Paid	Findings With Respect to Whether Payment Was Supported
81162 Probe Sample Claim 54	May-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 55	May-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 56	May-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,115.20	Not supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 57	Apr-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 58	Apr-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL		1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 59	Mar-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$1,115.20	Not Supported. The provider performed and billed for a different test than submitted for authorization.
81162 Probe Sample Claim 60	Jan-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$825.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81162 Probe Sample Claim 61	Jan-2020	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$3,750.00	$810.00	Supported
81162 Probe Sample Claim 62	Nov-2019	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$1,500.00	$825.00	Supported
81162 Probe Sample Claim 63	Oct-2019	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$1,500.00	$825.00	Supported
81162 Probe Sample Claim 64	Sep-2019	81162	BRCA1&2 GEN FULL SEQ DUP/DEL		1	$35.72	$35.72	Supported
81162 Probe Sample Claim 65	Jun-2019	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$1,500.00	$825.00	Not Supported. The provider performed and billed for a different test than submitted for authorization.
81162 Probe Sample Claim 66	Jun-2019	81162	BRCA1&2 GEN FULL SEQ DUP/DEL		1	$18.08	$18.08	Supported
81162 Probe Sample Claim 67	Apr-2019	81162	BRCA1&2 GEN FULL SEQ DUP/DEL		1	$1,500.00	$1,467.06	Supported
81162 Probe Sample Claim 68	Apr-2019	81162	BRCA1&2 GEN FULL SEQ DUP/DEL		1	$1,500.00	$799.00	Supported
81162 Probe Sample Claim 69	Feb-2019	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$1,500.00	$825.00	Supported
81162 Probe Sample Claim 70	Feb-2019	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$1,500.00	$799.00	Supported
81162 Probe Sample Claim 71	Nov-2018	81162	BRCA1&2 GEN FULL SEQ DUP/DEL		1	$1,500.00	$825.00	Supported
81162 Probe Sample Claim 72	Nov-2018	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$1,500.00	$825.00	Not Supported. The provider performed and billed for a different test than authorized.
81162 Probe Sample Claim 73	Sep-2018	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$1,500.00	$825.00	Not Supported. The provider performed and billed for a different test than submitted for authorization.
81162 Probe Sample Claim 74	Mar-2018	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$1,500.00	$825.00	Supported
81162 Probe Sample Claim 75	Feb-2018	81162	BRCA1&2 GEN FULL SEQ DUP/DEL		1	$1,500.00	$825.00	Supported
81162 Probe Sample Claim 76	Dec-2017	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$1,500.00	$825.00	Supported
81162 Probe Sample Claim 77	Nov-2017	81162	BRCA1&2 GEN FULL SEQ DUP/DEL	33	1	$1,500.00	$825.00	Supported
81479 Probe Sample								
81479 Probe Sample Claim 1	Jul-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The record did not specify an order for the test.
81479 Probe Sample Claim 2	May-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The test performed requires a prior authorization. The test performed should be billed under a different code.
81479 Probe Sample Claim 3	Apr-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Supported
81479 Probe Sample Claim 4	Apr-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The provider performed a non-registered test.

Unique Identifier	Date of Service	Procedure Code	Procedure Code Description	Modifier	Units	Amount Charged	Amount Paid	Findings With Respect to Whether Payment Was Supported
81479 Probe Sample Claim 5	Apr-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The test performed requires prior authorization. The test performed should be billed under a different code.
81479 Probe Sample Claim 6	Apr-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Supported
81479 Probe Sample Claim 7	Apr-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Supported
81479 Probe Sample Claim 8	Apr-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81479 Probe Sample Claim 9	Mar-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Supported
81479 Probe Sample Claim 10	Mar-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The provider performed one panel test; however, billed multiple separate gene tests to represent being run individually.
81479 Probe Sample Claim 11	Feb-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires a prior authorization.
81479 Probe Sample Claim 12	Jan-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The tests performed is unproven.
81479 Probe Sample Claim 13	Jan-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Supported
81479 Probe Sample Claim 14	Jan-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$990.00	Not Supported. The provider performed and billed for a different test than authorized.
81479 Probe Sample Claim 15	Jan-2021	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Supported
81479 Probe Sample Claim 16	Dec-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The tests performed is unproven.
81479 Probe Sample Claim 17	Oct-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed should be billed under a different code.
81479 Probe Sample Claim 18	Oct-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$7,500.00	$3,000.00	Not Supported. The provider performed and billed for a different test than authorized. The provider performed a non-covered, unproven test.
81479 Probe Sample Claim 19	Oct-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Supported
81479 Probe Sample Claim 20	Oct-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$241.36	Supported
81479 Probe Sample Claim 21	Aug-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Supported
81479 Probe Sample Claim 22	Jul-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires a prior authorization.
81479 Probe Sample Claim 23	Jul-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$7,500.00	$3,000.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires a prior authorization.
81479 Probe Sample Claim 24	Jul-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The tests performed requires prior authorization.
81479 Probe Sample Claim 25	Jun-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not supported. The provider performed and billed for a different test than authorized. The test performed should be billed under a different code.
81479 Probe Sample Claim 26	Jun-2020	81479	UNLISTED MOLECULAR PATHOLOGY		280	$234.10	$46.82	Not Supported. The record did not reflect the test was performed.

Unique Identifier	Date of Service	Procedure Code	Procedure Code Description	Modifier	Units	Amount Charged	Amount Paid	Findings With Respect to Whether Payment Was Supported
81479 Probe Sample Claim 27	Jun-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,475.00	Not Supported. The provider performed and billed for a different test than authorized.
81479 Probe Sample Claim 28	Apr-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Supported
81479 Probe Sample Claim 29	Mar-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The record did not reflect the test was performed.
81479 Probe Sample Claim 30	Mar-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81479 Probe Sample Claim 31	Feb-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. The record was not received for the date of service.
81479 Probe Sample Claim 32	Feb-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$1,500.00	Not Supported. There was no test order for the test performed.
81479 Probe Sample Claim 33	Jan-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$500.00	Not supported. The provider performed and billed for a different test than authorized. The test performed requires prior authorization.
81479 Probe Sample Claim 34	Jan-2020	81479	UNLISTED MOLECULAR PATHOLOGY		1	$3,750.00	$475.00	Supported
81479 Probe Sample Claim 35	Oct-2019	81479	UNLISTED MOLECULAR PATHOLOGY		3	$42.22	$33.78	Supported
81479 Probe Sample Claim 36	Oct-2019	81479	UNLISTED MOLECULAR PATHOLOGY		267	$1,435.49	$1,435.49	Not supported. The provider performed and billed for a different test than authorized. The test performed requires a prior authorization. The test performed should be billed under a different code.
81479 Probe Sample Claim 37	Sep-2019	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,500.00	Supported
81479 Probe Sample Claim 38	Sep-2019	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,500.00	Supported
81479 Probe Sample Claim 39	Aug-2019	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,500.00	Supported
81479 Probe Sample Claim 40	Jul-2019	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,500.00	Supported
81479 Probe Sample Claim 41	Jul-2019	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,350.00	Supported
81479 Probe Sample Claim 42	Jun-2019	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,500.00	Supported
81479 Probe Sample Claim 43	Apr-2019	81479	UNLISTED MOLECULAR PATHOLOGY		280	$1,438.34	$1,438.34	Supported
81479 Probe Sample Claim 44	Nov-2018	81479	UNLISTED MOLECULAR PATHOLOGY		1	$1,500.00	$500.00	Supported
81479 Probe Sample Claim 45	Oct-2018	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,500.00	Supported
81479 Probe Sample Claim 46	Oct-2018	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,500.00	Supported
81479 Probe Sample Claim 47	Aug-2018	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,500.00	Supported
81479 Probe Sample Claim 48	Jul-2018	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,500.00	Not Supported. The test performed requires a prior authorization. The test performed should be billed under a different code.
81479 Probe Sample Claim 49	Jul-2018	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,500.00	Supported
81479 Probe Sample Claim 50	Jun-2018	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,500.00	Supported
81479 Probe Sample Claim 51	May-2018	81479	UNLISTED MOLECULAR PATHOLOGY		3	$1,500.00	$1,500.00	Supported
81479 Probe Sample Claim 52	Oct-2017	81479	UNLISTED MOLECULAR PATHOLOGY		1	$1,500.00	$525.00	Supported

EXHIBIT B

Date of Service	Paid Amount	Overpayment Amount	Overpayment Description
Feb-2023	$ 417.48	$ 417.48	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Jul-2021	$1,115.20	$ 694.42	Claim does not meet Medicare LCD/NCD criteria.
Jul-2023	$2,400.00	$ 2,400.00	KS Non Covered Codes/QMB Covered Codes. Line 1 Code 81479
Nov-2023	$2,400.00	$ 2,400.00	Precertification/authorization/notification/pre-treatment absent.
Aug-2023	$ 421.65	$ 421.65	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Jul-2022	$ 417.48	$ 417.48	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
May-2023	$ 421.65	$ 421.65	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Jan-2023	$ 800.80	$ 379.15	Claim should have allowed $421.65 for all services.
Jan-2023	$ 800.80	$ 379.15	Claim should have allowed $421.65 for all services.
Jan-2023	$ 800.80	$ 379.15	Claim should have allowed $421.65 for all services.
Jan-2023	$ 800.80	$ 379.15	Claim should have allowed $421.65 for all services.
Jan-2023	$ 800.80	$ 379.15	Claim should have allowed $421.65 for all services.
Jan-2023	$ 800.80	$ 379.15	Claim should have allowed $421.65 for all services.
Mar-2023	$ 421.65	$ 421.65	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Jan-2023	$1,500.00	$ 373.65	Incorrect payment allowed Outpatient services. CPT code 81162 should have allowed $1126.35. Total claim allowable = $1126.35.
Jan-2023	$1,500.00	$ 373.65	Incorrect payment allowed Outpatient services. CPT code 81162 should have allowed $1126.35. Total claim allowable = $1126.35.
Dec-2022	$1,500.00	$ 373.65	Incorrect payment allowed Outpatient services. CPT code 81162 should have allowed $1126.35. Total claim allowable = $1126.35.
Dec-2023	$ 31.68	$ 31.68	Procedure code 81243 for service date included in payment for procedure code 81229 on claim number [REDACTED - PHI].
Jul-2022	$ 417.48	$ 417.48	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Aug-2022	$ 417.48	$ 417.48	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Dec-2023	$ 31.68	$ 31.68	Procedure code 81243 for service date included in payment for procedure code 81229 on claim number [REDACTED - PHI].
Oct-2023	$2,400.00	$ 2,400.00	Laboratory Services Reimbursement Policy - Lab Testing with Incorrect POS Line 1 Code 81479

Dec-2023	$ 31.68	$ 31.68	Procedure code 81243 for service date included in payment for procedure code 81229 on claim number [REDACTED - PHI].
Mar-2023	$ 310.00	$ 310.00	Services provided after member termination date of 02/28/2021
Jun-2022	$1,500.00	$ 1,500.00	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Nov-2023	$ 979.42	$ 979.42	Services provided after member termination date of 11/30/2022
Apr-2023	$ 11.25	$ 11.25	Our records indicate that this member never had active coverage under this policy.
Aug-2023	$1,115.20	$ 1,115.20	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
Apr-2018	$1,500.00	$ 675.00	Units exceed recommended units for CPT 81479 based on Medically Unlikely Edits list (MUE). Correct allowed is $0.00. Patient Responsibility is $0.00. Correct payment is $0.00.
Mar-2023	$ 455.43	$ 33.78	Claim should have allowed $421.65 for all services.
Apr-2021	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code.
Apr-2021	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code.
Oct-2021	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code.
Feb-2022	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code.
Feb-2022	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code.
Feb-2022	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code.
Feb-2022	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code.
Apr-2021	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code
Oct-2021	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code
Nov-2021	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code
Dec-2021	$ 417.48	$ 92.70	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code
Jan-2022	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code
Jan-2022	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code
Apr-2021	$ 417.48	$ 417.48	CPT 81420 and 81507 are not covered when billed with an invalid diagnosis code.
Aug-2023	$ 411.65	$ 411.65	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Dec-2022	$1,507.20	$ 1,507.20	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Oct-2023	$ 160.48	$ 160.48	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Sep-2023	$ 157.13	$ 157.13	Member had primary coverage through Medicare for this date of service. Please submit claim to Medicare for reimbursement.
Jul-2022	$1,115.20	$ 1,115.20	Member had primary coverage through Medicare for this date of service. Please submit claim to Medicare for reimbursement.
Jan-2022	$3,750.00	$ 2,217.32	Please refund -Incorrect contract rate applied

Jul-2022	$ 160.00	$ 160.00	Please refund -Coordination of benefits - submit claim to primary carrier
Jan-2023	$1,485.00	$ 1,485.00	Please refund -Corrected bill submitted
Jan-2023	$1,500.00	$ 1,500.00	Please refund -Corrected bill submitted
Sep-2022	$1,115.20	$ 1,115.20	Please refund -Claim paid at incorrect benefit level
Oct-2022	$ 295.00	$ 295.00	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Dec-2022	$1,485.00	$ 989.84	This claim processed using an incorrect allowed amount according to the network contract in effect for this date of service. Claim should allow $309.19 less $15.00 patient responsibility.
Oct-2023	$2,400.00	$ 1,634.74	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
May-2023	$ 421.65	$ 421.65	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Apr-2023	$2,160.00	$ 2,160.00	Please refund -Claim paid for services not covered per benefit package
Jul-2023	$2,385.00	$ 2,385.00	Please refund -Not Medically Necessary
Jan-2021	$1,500.00	$ 1,500.00	Services provided after members termination date of 12/31/2020.
Aug-2021	$ 6.86	$ 6.86	Please refund -Incorrect interest paid
May-2022	$ 417.48	$ 40.00	Please refund -Incorrect contract rate applied
Dec-2021	$ 142.97	$ 142.97	Please refund -Incorrect interest paid
Dec-2021	$ 295.00	$ 295.00	Please refund -Incorrect interest paid
Jan-2023	$ 9.75	$ 9.75	Please refund -Incorrect interest paid
Jan-2023	$ 6.34	$ 6.34	Please refund -Incorrect interest paid
Dec-2022	$ 29.13	$ 29.13	Please refund -Incorrect interest paid
Apr-2021	$1,500.00	$ 1,500.00	Corrected claim received and processed under number [REDACTED - PHI] on 05/17/2022 with check [REDACTED].
May-2021	$ 638.00	$ 638.00	Facility and Professional services were separately billed and processed for this member for the same confinement date range. This has resulted in an overpayment due to conflicting place of service codes. The Global/ Technical/ or Professional component reimbursement for the service codes billed on this claim was not appropriate since this member was confined in a facility as an inpatient for the billed dates of service.
Aug-2023	$ 338.51	$ 338.51	Additional Information Received And Reviewed
Aug-2023	$ 164.30	$ 164.30	Additional Information Received And Reviewed
Oct-2023	$ 139.14	$ 139.14	Claim paid for services provided after members termination of coverage
Dec-2023	$ 199.60	$ 199.60	Corrected bill submitted
Feb-2022	$ 465.45	$ 465.45	Corrected bill received on [REDACTED - PHI] causing an overpayment.
Feb-2022	$ 429.00	$ 429.00	Claim paid for services prior to receipt of Explanation Of Benefits from primary carrier.
Feb-2022	$ 209.94	$ 209.94	Claim paid for services prior to receipt of Explanation Of Benefits from primary carrier.
Feb-2022	$ 371.47	$ 371.47	Claim paid for services prior to receipt of Explanation Of Benefits from primary carrier.

Feb-2022	$ 372.08	$ 372.08	Claim paid for services prior to receipt of Explanation Of Benefits from primary carrier.
Feb-2022	$ 353.02	$ 353.02	Corrected bill received on [REDACTED - PHI] causing an overpayment.
Jul-2022	$ 381.48	$ 381.48	Corrected bill received on [REDACTED - PHI] causing an overpayment.
Jul-2022	$ 979.60	$ 979.60	Corrected bill received on [REDACTED - PHI] causing an overpayment.
Dec-2022	$ 375.80	$ 375.80	Corrected bill received on [REDACTED - PHI] causing an overpayment.
Dec-2022	$ 375.18	$ 375.18	Corrected bill received on [REDACTED - PHI] causing an overpayment.
Dec-2022	$ 212.03	$ 212.03	Corrected bill received on [REDACTED - PHI] causing an overpayment.
Dec-2022	$ 356.55	$ 356.55	Corrected bill received on [REDACTED - PHI] causing an overpayment.
Nov-2023	$ 421.65	$ 421.65	ssprov
May-2021	$1,115.20	$ 1,115.20	Claim does not meet Medicare LCD/NCD criteria.
Jun-2021	$1,115.20	$ 1,115.20	Claim does not meet Medicare LCD/NCD criteria.
May-2021	$1,115.20	$ 1,115.20	Claim does not meet Medicare LCD/NCD criteria.
May-2021	$1,115.20	$ 1,115.20	Claim does not meet Medicare LCD/NCD criteria.
May-2021	$ 311.06	$ 311.06	Claim does not meet Medicare LCD/NCD criteria.
May-2021	$1,115.20	$ 1,115.20	Claim does not meet Medicare LCD/NCD criteria.
Apr-2021	$1,115.20	$ 1,115.20	Claim does not meet Medicare LCD/NCD criteria.
Sep-2021	$1,115.20	$ 1,115.20	Claim does not meet Medicare LCD/NCD criteria.
May-2021	$1,115.20	$ 1,115.20	Claim does not meet Medicare LCD/NCD criteria.
Sep-2020	$ 425.00	$ 425.00	Claim does not meet Medicare LCD/NCD criteria.
Aug-2021	$ 472.48	$ 472.48	Claim does not meet Medicare LCD/NCD criteria.
Aug-2021	$1,115.20	$ 1,115.20	Claim does not meet Medicare LCD/NCD criteria.
May-2023	$1,200.00	$ 1,200.00	Claim does not meet Medicare LCD/NCD criteria.
Mar-2023	$1,709.07	$ 533.07	Corrected bill submitted.
Sep-2021	$ 813.00	$ 122.80	Service does not meet Medicare NCD/LCD criteria. Procedure code 81432 does not meet Z code requirements.
May-2023	$2,400.00	$ 2,400.00	Services provided after Member Coverage End Date.
Sep-2023	$ 421.65	$ 421.65	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Sep-2023	$ 421.65	$ 421.65	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Oct-2023	$ 379.49	$ 379.49	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Oct-2021	$1,200.00	$ 84.80	Member had primary coverage through other carrier for this date of service. Please submit claim to primary carrier for reimbursement.
Jan-2023	$1,500.00	$ 1,500.00	Please refund -Claim paid for services not covered per benefit package
Jun-2022	$ 129.31	$ 129.31	Please refund -Corrected bill submitted
Apr-2022	$1,350.00	$ 1,350.00	Please refund -Claim paid for services not covered per benefit package

Jan-2023	$ 15.88	$ 15.88	Please refund -Provider billed in error
Oct-2022	$1,500.00	$ 1,500.00	These services were previously allowed on claim number [REDACTED - PHI] for $1500.00 processed 05/10/2023 with check number [REDACTED].
Jan-2023	$1,350.00	$ 998.89	Services provided after Member Coverage End Date.
Sep-2023	$1,111.00	$ 1,111.00	Please refund -Provider billed in error
Dec-2023	$ 25.34	$ 25.34	Please refund -Unbundled service - disallowed service considered inclusive of another billed service on same date of service by same provider
Sep-2023	$2,400.00	$ 2,400.00	Please refund -Not Medically Necessary
Jul-2023	$1,680.00	$ 1,680.00	Please refund -Not Medically Necessary
Nov-2023	$ 31.68	$ 31.68	Please refund -Unbundled service - disallowed service considered inclusive of another billed service on same date of service by same provider
Mar-2022	$ 417.48	$ 417.48	This claim was reconsidered by UnitedHealthcare medical benefits. We are seeking the Healthcare Reimbursement payment of $417.48, issued on 03/16/22 on check number [REDACTED].
Mar-2022	$1,500.00	$ 1,500.00	Please refund -Not Medically Necessary
May-2022	$ 114.89	$ 114.89	This claim was reconsidered by UnitedHealthcare medical benefits. We are seeking the Healthcare Reimbursement payment of $114.89, issued on 05/31/22 on check number [REDACTED].
Apr-2022	$ 417.48	$ 417.48	This claim was reconsidered by UnitedHealthcare medical benefits. We are seeking the Healthcare Reimbursement payment of $417.48, issued on 05/26/22 on check number [REDACTED].
Dec-2022	$1,500.00	$ 1,500.00	This claim was reconsidered by UnitedHealthcare medical benefits. We are seeking the Healthcare Reimbursement payment of $1,500.00, issued on 01/09/23 on check number [REDACTED].
Feb-2023	$ 421.65	$ 421.65	This claim was reconsidered by UnitedHealthcare medical benefits. We are seeking the Healthcare Reimbursement payment of $421.65, issued on 03/13/23 on check number [REDACTED].
Feb-2023	$1,500.00	$ 1,500.00	Please refund -Claim paid for services not covered per benefit package
Jan-2023	$1,500.00	$ 1,078.35	Please refund -Corrected bill submitted
		$ 86,993.78	

CERTIFICATE OF SERVICE

I hereby certify that on May 1, 2024, a copy of foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's CM/ECF System. In addition, I hereby certify that I have served a copy of the foregoing via electronic mail, unless otherwise noted, upon the below-listed parties.

/s/ Joseph C. Barsalona II
Joseph C. Barsalona II

Master Service List

Description	CreditorName	CreditorNoticeName	Address1	Address2	Address3	City	State	Zip	Country	Phone	Fax	Email
VIA EMAIL												
Counsel to ASB De Haro Place, LLC and 1400 16th Street LLC	DLA Piper LLP (US)	Aaron S. Applebaum	1201 North Market Street, Suite 2100			Wilmington	DE	19801		302-468-5700	302-394-2341	aaron.applebaum@us.dlapiper.com
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State Attorney General	American Samoa Attorney General	Attn Bankruptcy Department	Department of Legal Affairs	Executive Office Bldg., 3rd Floor	P.O. Box 7	Utulei	American Samoa	96799		684-633-4163	684-633-4964	ag@la.as.gov
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State Attorney General	Idaho Attorney General	Attn Bankruptcy Department	700 W. Jefferson Street Suite 210	PO Box 83720		Boise	ID	83720-0010		208-334-2400	208-854-8071	bankruptcy@ag.idaho.gov
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Counsel to ASB De Haro Place, LLC and 1400 16th Street LLC	DLA Piper LLP (US)	Eric D. Goldberg	2000 Avenue of the Stars	Suite 400 North Tower		Los Angeles	CA	90067		310-595-3000	310-595-3300	eric.goldberg@us.dlapiper.com

Master Service List

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U.S. Trustee for the District of New Jersey	Office of the United States Trustee for the District of New Jersey	Jeffrey Sponder	One Newark Center, Suite 2100			Newark	NJ	07102		973-645-3014	973-645-5993	jeffrey.m.sponder@usdoj.gov
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