Docket #0542 Date Filed: 05/24/2024

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)

SUPPLEMENT TO 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 (the "Supplemental

[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.

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Cure Objection"), which supplements United's previous objection [Docket. No. 410], filed on May 1, 2024 (the "Original Cure Objection"), to the *Notice to 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 $100,783,067.82.

In support of this Supplement Cure Objection, United respectfully 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.

[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.

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 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. Pursuant to the PPA, the charge amount set forth on each claim Invitae submits to United is not to exceed the fee Invitae ordinarily would charge another person regardless of whether the person is one of United's members (the "Customary Charge"). PPA, §§ 1.3, 2.1(vi); *see id.* at Payment Appendix. In every claim Invitae submits to United, Invitae represents and warrants that the charge amount set forth on the claim is the Customary Charge. *Id.* § 2.1(vi). Thus, notwithstanding any specific rate set forth in a fee schedule, the charge amount set forth on each claim Invitae submits to United is not to exceed the Customary Charge. *Id.* §§ 1.3, 2.1(vi); *see id.* at Payment Appendix.

14. In addition, 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

[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.

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. *Id.* at Payment Appendix. Invitae is required to accurately describe the services provided in its claims. *See, e.g.*, 2023 UnitedHealthcare Care Provider Administrative Guide for Commercial and Medicare Advantage [hereinafter, the "2023 Comm. & Medicare Guide"],[6] at 24, 156; *see generally* Exhibit A, UnitedHealthcare Commercial Reimbursement Policy, Molecular Pathology Policy, Professional, Policy No. 2021R6009B (Apr. 1, 2021).

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. *See generally, e.g.*, Exhibit B, UnitedHealthcare Commercial Advance Notification Prior Authorization Requirements (effective May 1, 2022) (requiring prior authorization/notification for genetic and molecular testing to include BRCA1/2 gene testing, and noting "[p]ayment will be authorized for those CPT codes registered with the Genetic and Molecular Testing Prior Authorization/Notification Program for each specified genetic test").

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

[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.

[6] The 2023 Comm. & Medicare Guide is available at: https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/2023-UHC-Administrative-Guide.pdf

coverage under the member's health plan, lack of medical necessity, or submission not in compliance with HIPAA standard data set requirements. *See, e.g.*, PPA, § 6.5.

18. Pursuant to the PPA, Invitae must repay any overpayments within 30 days of written or electronic notice of the overpayment. *Id.* § 6.10. Further, the PPA provides that recovery of overpayments may be accomplished by offsets against future payments. *Id.*

C. United's Overpayments to Invitae

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

19. 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"),[7] 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").[8] 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").[9]

[7] 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).

[8] *See Ariz. Health Care Cost Containment Sys. v. Ctrs. 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").

[9] *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

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

21. 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. Such knowing misrepresentation of services is a violation of Invitae's obligations under the PPA. *See, e.g.*, PPA, § 2.1(vi); 2023 Comm. & Medicare Guide, at 24, 156.

22. 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.

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

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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").

24. Meanwhile, 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. 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.

25. 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 (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

26. 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

27. 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.[10] United's Original Claim and First Amended Claim (both defined below) did not include these additional amounts.

[10] United has received appropriate state regulatory approval to pursue overpayments on behalf of individual state Medicaid programs from the following states: California, Florida, New Jersey, New York, Ohio, Tennessee, Texas, Washington, and Wisconsin. 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

28. Of the foregoing overpayment amounts, an aggregate $7,174.20 is attributable to dates of service prior to the effective date of the PPA (the "Pre-PPA Overpayment Amounts"). United is not seeking recovery of such amounts, and United amended the First Amended Claim to remove the Pre-PPA Overpayment Amounts.

29. In sum, United overpaid Invitae no less than an aggregate $38,047,169.79 (the "Review Overpayments") for claim lines for CPT codes 81162 and 81479 with dates of service from January 1, 2017, through February 6, 2023.[11] 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

30. 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 services were provided after the member's insurance coverage was terminated; (v) the claim was allowed in an incorrect amount under the contract; (vi) the services

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 the Second Amended Claim (defined below) to include such amounts.

[11] *See, e.g.*, *Ratanasen v. State of Cal., Dep't of Health Servs.*, 11 F.3d 1467, 1470–71 (9th Cir. 1993) (rejecting provider's challenge to California Department of Health Services' use of sampling and extrapolation to establish overpayment claim in bankruptcy action); *United States v. Fadul*, No. CIV.A. DKC 11-0385, 2013 WL 781614, at *14 (D. Md. Feb. 28, 2013) ("Courts have routinely endorsed sampling and extrapolation as a viable method of proving damages in cases involving Medicare and Medicaid overpayments where a claim-by-claim review is not practical."). This amount is in the alternative to the extent the Customary Charge/Review Overpayment (as defined below) is not allowed in its entirety.

were not covered when billed with an invalid diagnosis code; or (vii) a corrected bill was submitted.

31. 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 "Original Overpayments"), which remain due and owing to United.

3. Overpayments for Charges Exceeding the Customary Charge

32. As previewed in the Original Cure Objection, United has been investigating additional overpayments arising from the Invitae's practice of submitting claims well in excess of the Customary Charge.[12]

33. In violation of the PPA, United has learned that Invitae has habitually submitted claims with charge amounts far in excess of the Customary Charge. For example, the vast majority of claims that Invitae has submitted to United for hereditary cancer panel tests had charge amounts ranging from $1,500 to $6,000 while, at the same time, Invitae has apparently offered patients a "cash price" as low as $250 for the exact same service.

34. Similarly, the vast majority of claims that Invitae has submitted to United for carrier screenings had charge amounts ranging from $1,500 to $7,500, notwithstanding the fact that Invitae has apparently offered patients a "cash price" as low as $250 for the first patient and $100 for such patient's reproductive partner, for the same service.

[12] In the Original Cure Objection, United noted that it "is actively investigating this conduct and will supplement this objection upon a determination of the full scope of damages it has suffered." (Docket No. 410 at 12.) Further, United expressly "reserve[d] 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." (*Id.* at 17.)

35. Thus, Invitae routinely violated the PPA by charging United more than the Customary Charge for the same service. Indeed, as noted above, Invitae has charged United between four and in some instances as much as thirty times more than it charged other persons. The exceptionally inflated amounts Invitae has charged United were inherently unreasonable.

36. Based on United's investigation to date, and excluding any Medicaid claims where United has not received appropriate regulatory approval to pursue overpayments, United has overpaid Invitae by $91,251,580.15 (the "Preliminary Customary Charge Overpayment") under the PPA as a result of Invitae submitting claims to United with charge amounts in excess of the Customary Charge. These overpayments were made across 76 different CPT codes and an aggregate 121,483 claim lines.

37. The vast majority of the Preliminary Customary Charge Overpayment is attributable to overpayments on claim lines for CPT code 81162 ($40,515,128.54) and CPT code 81479 ($38,155,720.85). However, as described above in Part I(C)(1), many of those claim lines should not have been paid at all and United is seeking recovery of those payments as part of the Review Overpayment. As such, the Preliminary Customary Charge Overpayment must be supplemented by the amounts attributable to those claim lines of CPT codes 81162 and 81479 that should not have been paid at all.

38. The calculation of the additional amounts attributable to claim lines that should not have been paid at all is as follows, for each of CPT codes 81162 and 81479: (i) *first*, identify the number of claim lines with a date of service between January 1, 2017 and February 6, 2023, inclusive, where United paid to Invitae an amount in excess of the Customary Charge; (ii) *second*, multiply the foregoing number of claim lines by the aberrancy rate identified in United's review of the Probe Sample Claims; (iii) *third*, multiply the total from (ii) by the Customary Charge

applicable to such claim lines, and (iv) *fourth*, deduct the amounts attributable to Medicaid claim lines where United has not yet received appropriate regulatory approval to pursue such overpayments (i.e., deduct the product of multiplying the number of Medicaid claim lines where United paid in excess of the Customary Charge in states where United has not yet received regulatory approval to pursue overpayments by the aberrancy rate and by the Customary Charge for such claim lines).[13] This calculation for each of CPT codes 81162 and 81479 is summarized in the below chart.

CPT Code	**81479**		**81162**	
Number of Claim Lines Where United Paid in Excess of the Customary Charge for Dates of Service 1/1/17 through 2/6/23	6,489	24,260	39	53,380
Aberrancy Rate	48.08%	48.08%	45.45%	45.45%
Customary Charge	$250.00	$450.00	$250.00	$450.00
SUBTOTAL ("Suppl. Review Overpayment")	$779,977.80	$2,916,052.00	$4,431.38	$6,065,302.50
Number of Medicaid Claim Lines Comprising Suppl. Review Overpayment Where United Has Not Yet Received Regulatory Approval[14]	514	600	0	1214
Amount of Suppl. Review Overpayment Attributable to Medicaid Claim Lines Where United Has Not Yet Received Regulatory Approval	$111,209.04	$72,120.00	$-	$137,940.75
SUBTOTAL BY CUSTOMARY CHARGE	$668,768.76	$2,843,932.00	$4,431.38	$5,927,361.75

[13] United reserves its right to further amend and supplement this Supplemental Cure Objection to include additional amounts for Medicaid claims once it receives appropriate regulatory approval to pursue overpayment recoveries from such states.

[14] This excludes Medicaid claims for all states other than California, Florida, New Jersey, New York, Ohio, Tennessee, Texas, Washington, and Wisconsin.

TOTAL	**$3,512,700.76**	**$5,931,793.13**

39. The additional amounts attributable to those claim lines of CPT codes 81162 and 81479 that should not have been paid at all—$3,512,700.76 and $5,931,793.13, respectively—must therefore be added to the Preliminary Customary Charge Overpayment of $91,251,580.15 to arrive at a total overpayment of $100,696,074.04 (the "Customary Charge/Review Overpayment").

D. The Debtors' Bankruptcy Case

40. 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.

1. United's Proof of Claim

41. In connection with the Original Overpayments (but excluding overpayments attributable to United's Community & State line of business[15]), on April 12, 2024, United filed a proof of claim in the amount of $36,780,598.87 (Claim No. 830) (the "Original Claim"). Immediately after filing the Original Claim, United identified a typographical error, and, as a result, United also filed on April 12, 2024 an amended proof of claim in the amount of $36,780,598.87 (Claim No. 849) (the "First Amended Claim").[16]

42. After filing the First Amended Claim,[17] United identified additional pre-petition amounts due and owing to it under the PPA as a result of the Debtor submitting claims with charge amounts far in excess of the Customary Charge.

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

[16] A true and correct copy of the First Amended Claim was attached to the Original Cure Objection. (*See* Dkt.. No. 410, at Ex. A.)

[17] In the First Amended Claim, United expressly asserted a claim that includes "any and all other amounts now owing or hereafter accrued and owing to United, regardless of whether such amounts are unliquidated, and/or contingent,

43. Accordingly, on May 22, 2024, United filed an amended proof of claim in the amount of $100,783,067.82 (the "Second Amended Claim"). The Second Amended Claim identified additional amounts due and owing to United under the PPA as a result of the Customary Charge/Review Overpayment and the authorization to pursue Medicaid program recoveries in certain states in connection with the Review Overpayment, and also removed the Pre-PPA Overpayment Amounts. A true and correct copy of the Second Amended Claim is attached hereto as **Exhibit C**.

44. 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 of service will change over time. In addition, United intends to amend its Second Amended Claim if it receives additional state regulatory approval to pursue overpayments on behalf of individual state Medicaid programs.

45. Further, 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,[18] and such amounts will be due and owing under the PPA.

2. The Debtors' Assumption Notice

46. 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

and/or unmatured, including but not limited to, those amounts due to United under the PPA and/or a United health insurance plan." (Claims Reg., Claim No. 849, at Attachment ¶ 34(c).) Consistent therewith, United further reserved the right to amend or supplement the First Amended Claim to, *inter alia*, restate liquidated and unliquidated components of the claim, update the total estimated exposure with respect to any unliquidated claims, reflect additional claims owed to United to the extent discovered after the filing of such claims, or for any other reason it deems appropriate. (*Id.* at Attachment ¶ 42.)

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

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.)

47. 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.)

48. 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"):

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.)

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

II. LIMITED OBJECTION

50. 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.

51. United hereby submits this supplemental 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.

52. 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.

53. As of the Petition Date, an aggregate amount of $100,783,067.82 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. 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.

54. 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.

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

III. RESERVATION OF RIGHTS

56. 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.[19]

IV. CONCLUSION

57. 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.

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

Dated: May 24, 2024

Respectfully submitted,

By: */s/ Joseph C. Barsalona II*

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EXHIBIT A

UnitedHealthcare®

Commercial Reimbursement Policy
CMS 1500
Policy Number 2021R6009B

Molecular Pathology Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations. UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Table of Contents

Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Commercial Reimbursement Policy
CMS 1500
Policy Number 2021R6009B

Policy

Overview

This policy describes the information required when claims are submitted for Molecular Pathology services utilizing Tier 1 and Tier 2 Molecular Pathology codes, Genomic Sequencing Procedures (GSP) and other Molecular Multianalyte Assay codes, Proprietary Laboratory Analysis (PLA) codes and unlisted code 81479.

All services described in this policy may be subject to additional UnitedHealthcare reimbursement policies including, but not limited to, the Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy, the Laboratory Services Policy, the Add-On Policy, and the CCI Editing Policy.

Reimbursement Guidelines

According to the American Medical Association (AMA) molecular pathology procedure code selection is typically based on the specific gene(s) that is being analyzed. Genes are described using Human Genome Organization (HUGO) approved gene names and are italicized in the code descriptors. Gene names were taken from tables of the HUGO Gene Nomenclature Committee (HGNC) at the time the CPT codes were developed. The AMA has provided Claim Designations using these abbreviated gene names and/or analytes. These Claim Designations are crosswalked to the appropriate codes to report on the Molecular Pathology Gene Table provided in the Pathology and Laboratory section of the AMA CPT codebook.

Codes that describe tests to assess for the presence of gene variants use common gene variant names. Typically, all of the listed variants would be tested. However, these lists are not exclusive. If other variants are also tested in the analysis, they would be included in the procedure and not reported separately. The molecular pathology codes include all analytical services performed in the test (eg, cell lysis, nucleic acid stabilization, extraction, digestion, amplification, and detection).

Tier 1 molecular pathology codes represent gene-specific and genomic procedures. Molecular pathology procedures that are not specified in a Tier 1 code should be reported using either the appropriate Tier 2 code or the unlisted molecular pathology procedure code, 81479.

Tier 2 molecular pathology codes are used to report procedures not listed in Tier 1 molecular pathology codes. They are arranged by level of technical resources and interpretive work by the physician or other qualified health care professional. Each Tier 2 code lists the specific analytes associated with the procedure code level. The Tier 2 code reported must have the specific analyte listed under the code or is a code match to the Claim Designation on the AMA Molecular Pathology Gene Table. In order to identify the analyte being tested under the code submitted, an appropriate Claim Designation code or Abbreviated Gene Name must be submitted on the claim. This information should be submitted in field 2400 SV101-7 in the electronic claim form or in the shaded area of the service line in section 24 on a paper claim form. In order to identify the information, a ZZ qualifier is required to be placed without a space or hyphen in front of the Claim Designation code or Abbreviated Gene Name (example: ZZCLRN1).

Genomic sequencing procedures (GSPs) and other molecular multianalyte assays codes should be used when the components of the descriptor(s) are fulfilled regardless of the technique used to provide the analysis, unless specifically noted in the code descriptor. When a GSP assay includes gene(s) that is listed in more than one code descriptor, the code for the most specific test for the primary disorder sought should be reported, rather than reporting multiple codes for the same gene(s).

In addition to Tier 1, Tier 2 and GSP procedure codes, the AMA created Proprietary Laboratory Analysis (PLA) codes. Other CPT code(s), including unlisted codes, should not be used to report single or multianalyte services that may be reported with that specific PLA code. These codes encompass all analytical services required for the analysis (eg, cell lysis, nucleic acid stabilization, extraction, digestion, amplification, hybridization and detection).

Individual Tier 1 or Tier 2 codes are considered components to GSP, PLA, or unlisted codes reported for Multianalyte testing on the same specimen. Individual Tier 1 or Tier 2 codes submitted in addition to a GSP, PLA or unlisted code 81479 will be denied.

According to the AMA, code 81479, unlisted molecular pathology procedure, should only be used for a unique procedure that is not adequately addressed by any other CPT code. It should be reported only once per patient, per specimen and date of service to identify the services provided. In order to identify the molecular pathology procedure performed the provider must submit the unique test ID provided through the National Institutes of Health (NIH) Genetic Testing Registry (GTR). The GTR unique test ID proceeding the decimal should be submitted in field 2400 SV101-7 on the electronic claim form or in the shaded of the service line in section 24 on a paper claim form (example: GTR123456789). The units for CPT code 81479 will be limited by the number of separate specimen types processed on a single patient and each unit of 81479 should be reported on a separate line with a unique GTR test ID for each unit reported (example: testing performed on bone marrow and a blood specimen for different genetic scenarios would be reported on separate lines with the specific GTR test ID listed on each line). Additional information regarding the NIH GTR can be found at: https://www.ncbi.nlm.nih.gov/gtr/

When multiple molecular biomarkers are tested on the same date of service it is considered to be a multianalyte panel and requires reporting with a single CPT code. The appropriate genomic sequencing procedure (GSP) code or Proprietary Laboratory Analysis (PLA) code should be submitted when multi-gene testing is performed instead of submitting the individual Tier 1 and Tier 2 codes. When a GSP or PLA does not describe the multianalyte testing performed, the unlisted CPT code 81479 may be reported to encompass all testing performed. When an unlisted CPT code is reported on the same date of service that a GSP or PLA code is reported for multianalyte testing, only one multianalyte testing code is allowed to encompass all testing performed and the GSP or PLA code will take precedence.

Definitions	
Molecular Pathology	Molecular pathology procedures are medical laboratory procedures involving the analyses of nucleic acid (i.e., DNA, RNA) to detect variants in genes that may be indicative of germline (eg, constitutional disorders) or somatic (eg, neoplasia) conditions, or to test for histocompatibility antigens (eg, HLA).
Genomic Sequencing Procedures and Other Molecular Multianalyte Assays	Genomic sequencing procedures (GSPs) and other molecular Multianalyte assays GSPs are DNA or RNA sequence analysis methods that simultaneously assay multiple genes or genetic regions relevant to a clinical situation. They may target specific combinations of genes or genetic material, or assay the exome or genome.
Proprietary Laboratory Analysis (PLA) Codes	These codes describe proprietary clinical laboratory analyses and can be either provided by a single (“sole-source”) laboratory or licensed or marketed to multiple providing laboratories (eg, cleared or approved by the Food and Drug Administration [FDA]). These codes include advanced diagnostic laboratory tests (ADLTs) and clinical diagnostic laboratory tests (CDLTs) as defined under the Protecting Access to Medicare Act (PAMA) of 2014.

Questions and Answers

1	**Q:** Can I report separate molecular pathology CPT codes in instead of a PLA CPT code? **A:** Per the AMA, when a PLA code is available to report a given proprietary laboratory service the service should not be reported with any other CPT code(s) and other CPT code(s) should not be used to report services that may be reported with the specific PLA code.
2	**Q:** The testing for HPA1, HPA2, HPA3, and HPA4 was performed to rule out neonatal alloimmune thrombocytopenia. Would it be correct to report CPT codes 81105, 81106, 81107, and 81108 for this testing? **A:** No, multiple molecular variants tested on the same date of service are considered a multianalyte panel and requires reporting with a single CPT code. The test panel provided should be reported with the PLA (when applicable for the provider), GSP, or other MAA multiple analyte code. In the absence of an existing code, the panel of tests provided may be registered on the NIH GTR and submitted with the unlisted CPT code 81479.
3	**Q:** The testing provided overlapped two different GSP codes. Should I report both GSP codes? **A:** Only one GSP CPT code may be reported for the testing provided. The CPT guidelines for use of the GSP codes indicate when a GSP assay includes gene(s) that are listed in more than on code descriptor, the code for the most specific test for the primary disorder sought should be reported.
4	**Q:** Laboratory XYZ performed testing that fits the PLA code descriptor; however the PLA test was not marketed to Laboratory XYZ by the proprietary clinical laboratory or manufacturer. May the PLA test code be reported? **A:** No, the proprietary clinical laboratory or manufacturer may market the right to use their tests to multiple laboratories. These codes may only be reported by registered proprietary laboratory or laboratories that have the proprietary relationship with the proprietary clinical laboratory or manufacturer.
5	**Q:** When would it be appropriate to report 81479? **A:** It would be appropriate in the following scenarios: • The single gene or analyte analyzed is not represented by an existing Tier 1 or Tier 2 code. If the analyte is not listed in the Tier 1 descriptor or under one of the Tier 2 codes, 81479 should be used. • Multiple gene variants were analyzed in a single test panel and there is not an appropriate PLA, GSP, or other MAA test code to report
6	**Q:** When would it be appropriate to report more than one CPT code 81479 on a single date of service? **A:** From a CPT coding perspective, code 81479, unlisted molecular pathology procedure, should only be reported once per patient, per specimen and date of service to identify the services provided because it does not identify a specific service. When registering more than one CPT code 81479 on the NIH GTR, the appropriate specimen type may be selected (i.e. amniotic fluid, bone marrow, fresh tissue, saliva, urine, etc.) Each CPT code 81479 reported should be listed on separate claim lines with their respective GTR ID. In addition, if requested, the patient records should support that different specimens were tested.
7	**Q:** A test was performed on the anginine vasopressin receptor 2 gene. How should this be reported? **A:** Report Tier 2 code 81404 with ZZAVPR2 in field 2400 Sv101-7 on the electronic claim form or in the shaded area of the service line in section 24 on a paper claim form.
8	**Q:** How do I register my test in the NIH GTR? **A:** Labs can register tests via the GTR submission user interface after they create a MyNCBI credential and a lab record. This may take 2-3 business days. Once a lab has an active lab record, the lab can begin registering tests. Additional information ca be found at: https://www.ncbi.nlm.nih.gov/gtr/docs/submit/
9	**Q:** What are the benefits of registering tests in the NIH GTR? **A:** In addition to providing information about the current scope of genetic testing technologies, NCBI resources seek to improve access to information about medically important variation.
10	**Q:** Is it appropriate to report multiple codes using a modifier 59 when different methodologies and genes are tested on a single specimen?

	A: Testing on a single specimen should be reported with a single code (Tier 1, Tier 2, PLA, GSP, or when no other code is applicable, the unlisted code 81479). The code reported for the testing on the single specimen includes testing by all methodologies, all genes and analytes, all components (specimen preparation, DNA/RNA quantification, etc.) and all analytical services performed for the test. In the rare situation that separate specimen(s) are tested on the same patient on the same date of service for distinctly separate indications, the initial specimen is reported without a modifier and an additional code may be reported with an appropriate modifier for the additional specimen tested. The use of a modifier to identify a different indication on the same date of service must be supported by the test requisition form and documentation. Per the CMS National Correct Coding policy if the single procedure is performed, only one unit of service may be reported. Modifiers should not be used to report multiple codes when a single specimen is tested.

Codes	
81105 – 81364	Tier 1 Molecular Pathology Codes
81400 – 81408	Tier 2 Molecular Pathology Codes
81410 – 81471	Genomic Sequencing Procedures (GSP) and Other Molecular Multianalyte Assay (MAA) Codes
0001U – 0247U	Proprietary Laboratory Analysis (PLA)

Attachments	
010121_Tier 1 Molecular Patholog **Tier 1 Molecular Pathology Codes**	This list contains CPT codes categorized as Tier 1 Molecular Pathology codes.
010120_Tier 2 Molecular Patholog **Tier 2 Molecular Pathology Codes**	This list contains CPT codes categorized as Tier 2 Molecular Pathology codes.
010121_Genomic Sequencing Procedu **Genomic Sequencing Procedures (GSP) Codes**	This list contains CPT codes categorized as Genomic Sequencing Procedures (GSP) codes.
040121_Proprietary Laboratory Analyses **Proprietary Laboratory Analyses (PLA) Codes**	This list contains CPT codes categorized as Proprietary Laboratory Analyses (PLA) codes.

Resources
American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System or other CMS publications and services

History	
4/1/2021	Policy Version Change Code Section: Updated Proprietary Laboratory Analysis (PLA) Policy List Change: Proprietary Laboratory Analyses (PLA) Codes
1/1/2021	Policy Version Change Code Section: Updated Proprietary Laboratory Analysis (PLA) Policy List Change: Tier 1 Molecular Pathology Codes, Genomic Sequencing Procedures GSP Codes and Proprietary Laboratory Analyses PLA Codes updated.
10/1/2020	Policy Version Change Code Section: Updated Proprietary Laboratory Analysis (PLA) Questions and Answers Section: Added Q&A #10 Policy List Change: Proprietary Laboratory Analyses (PLA) Codes
7/1/2020	Policy Version Change Policy List Change: Proprietary Laboratory Analyses (PLA) Codes
5/14/2020	Policy Version Change Policy List Change: Proprietary Laboratory Analyses (PLA) Codes
2/10/2020	Policy Version Change Update to Reimbursement Guidelines and Q&A #1.
1/1/2020	Policy Version Change Updated code lists with January 2020 code changes.
11/1/2019	Policy implemented by UnitedHealthcare Employer & Individual
4/26/2019	Policy approved by the Reimbursement Policy Oversite Committee

EXHIBIT B

Prior Authorization Requirements for UnitedHealthcare

Effective May 1, 2022

General Information

This list contains notification/prior authorization review requirements for care providers who participate with United Healthcare Commercial for inpatient and outpatient services, as referenced in the 2022 UnitedHealthcare Care Provider Administrative Guide

Specific state rules may apply. For more information on whether authorization is required or not, please go to UHCprovider.com and click on the UnitedHealthcare Provider Portal button in the top right corner. Then, select the Prior Authorization and Notification tool tile on your Provider Portal dashboard.

This list changes periodically. Updates are announced routinely in the UnitedHealthcare *Network News*. If viewing a printed copy, please visit **UHCprovider.com/priorauth** > Advance Notification and Plan Requirement Resources > Select a Plan Type for the most current information.

To provide notification/request prior authorization, please submit your request online or by phone:

- **Online:** Use the Prior Authorization and Notification tool on UnitedHealthcare Provider Portal. Go to **UHCprovider.com** and click on the UnitedHealthcare Provider Portal button in the top right corner. Then, select the Prior Authorization and Notification tool tile on your Provider Portal dashboard.
- **Phone: 877-842-3210**

Notification/prior authorization is not required for emergency or urgent care.

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Arthroplasty	Prior authorization required	23470	23472	23473	23474
		24360	24361	24362	24363
		24365	24370	24371	25441
		25442	25443	25444	25446
		25449	27120	27122	27125
		27130	27132	27134	27137
		27138	27437	27438	27440
		27441	27442	27443	27445
		27446	27447	27486	27487
		27700	27702	27703	
Arthroscopy	Prior authorization required .	Prior authorization is required for all states. 29826	29843	29871	
		Prior authorization is required for all states. In addition, site of service will be reviewed as part of the prior authorization process for the following codes except in AK, MA, PR, TX, UT, VI and WI.			

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Arthroscopy (continued)		29805	29806	29807	29819
		29820	29821	29822	29823
		29824	29825	29827	29828
		29830	29834	29835	29836
		29837	29838	29840	29844
		29845	29846	29847	29848
		29860	29861	29862	29863
		29870	29873	29874	29875
		29876	29877	29879	29880
		29881	29882	29883	29884
		29885	29886	29887	29888
		29889	29891	29892	29893
		29894	29895	29897	29898
		29899	29914	29915	29916
Bariatric surgery Bariatric surgery and specific obesity-related services	Notification/prior authorization required There is a Center of Excellence requirement for coverage of bariatric surgery and services. In certain situations, bariatric surgery and other obesity-related services aren't covered by some benefit plans. For more information, please call **877-842-3210**.	43644	43645	43659	43770
		43771	43772	43773	43774
		43775	43842	43843	43845
		43846	43847	43848	43860*
		43865*	43886	43887	43888
		*Notification/prior authorization required for the following diagnosis codes: E66.01, E66.09, E66.1-E66.3, E66.8, E66.9, Z68.1, Z68.20 - Z68.22, Z68.30-Z68.39, Z68.41-Z68.45			
Behavioral health services	Many of our benefit plans only provide coverage for behavioral health services through a designated behavioral health network.	For specific codes requiring prior authorization, please call the number on the member's health plan ID card to refer for mental health and substance abuse/substance services.			
Bone growth stimulator Electronic stimulation or ultrasound to heal fractures	Prior authorization required	20974	20975	20979	
Breast reconstruction (non-mastectomy) Reconstruction of the breast except when following mastectomy	Prior authorization required	19300	19316	19318	19325
		19328	19330	19340	19342
		19350	19357	19361	19364
		19367	19368	19369	19370
		19371	19380	19396	L8600
		Notification/prior authorization not required for the following diagnosis codes:			
		C50.019	C50.011	C50.012	C50.111
		C50.112	C50.119	C50.211	C50.212
		C50.219	C50.311	C50.312	C50.319
		C50.411	C50.412	C50.419	C50.511
		C50.512	C50.519	C50.611	C50.612
		C50.619	C50.811	C50.812	C50.819

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Breast reconstruction (non-mastectomy) (continued)		C50.911	C50.912	C50.919	C50.029
		C50.021	C50.022	C50.121	C50.122
		C50.129	C50.221	C50.222	C50.229
		C50.321	C50.322	C50.329	C50.421
		C50.422	C50.429	C50.521	C50.522
		C50.529	C50.621	C50.622	C50.629
		C50.821	C50.822	C50.829	C50.921
		C50.922	C50.929	C79.81	D05.90
		D05.00	D05.01	D05.02	D05.10
		D05.11	D05.12	D05.80	D05.81
		D05.82	D05.91	D05.92	Z85.3
		Z90.10	Z90.11	Z90.12	Z90.13
		Z42.1			
Cancer supportive care	Prior authorization required for colony-stimulating factor drugs and bone-modifying agent administered in an outpatient setting for a cancer diagnosis *Codes J0897, J1442, J1447, J2506, Q5101, Q5108, Q5110, Q5111, Q5120 and Q5122 also require prior authorization for non-oncology DX. See Injectable medications section below.	**Anti-Emetics that require prior authorization:** **Akynzeo® (palonosetron/fosnetupitant)** J1454 **Cinvanti™ (aprepitant)** J0185 **Emend® (fosaprepitant)** J1453 **Sustol® (granisetron extended release)** J1627 **Bone-modifying agent that requires prior authorization:** **Denosumab (Prolia®, Xgeva®)** J0897* **Injectable colony-stimulating factor drugs that require prior authorization:** **Filgrastim (Neupogen®)** J1442* **Filgrastim-aafi (Nivestym™)** Q5110* **Filgrastim-sndz (Zarxio®)** Q5101* **Pegfilgrastim (Neulasta®)** J2506* **Pegfilgrastim-apgf (Nyvepria™)** Q5122* **Pegfilgrastim-bmez (Ziextenzo®)**			

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
Cancer supportive care (continued)		Q5120* **Pegfilgrastim-cbqv (UDENYCA™)** Q5111* **Pegfilgrastim-jmdb (Fulphila™)** Q5108* **Sargramostim (Leukine®)** J2820 **Tbo-filgrastim (Granix®)** J1447* **Trilaciclib (Cosela™)** J1448 For prior authorization requests, please submit requests online by using the Prior Authorization and Notification tool on UnitedHealthcare Provider Portal. Go to **UHCprovider.com** and click on the UnitedHealthcare Provider Portal button in the top right corner. Then, select the Prior Authorization and Notification tool tile on your Provider Portal dashboard. Or, call **888-397-8129**.
Cardiology	Notification/prior authorization required for participating physicians for outpatient and office-based diagnostic catheterizations, echocardiograms, electrophysiology implants, and stress echocardiograms prior to performance	For notification/prior authorization, please submit requests online by using the Prior Authorization and Notification tool on UnitedHealthcare Provider Portal. Go to **UHCprovider.com** and click on the UnitedHealthcare Provider Portal button in the top right corner. Then, select the Prior Authorization and Notification tool tile on your Provider Portal dashboard. Or, call **866-889-8054**. For more details and the CPT codes that require notification/prior authorization, please visit **UHCprovider.com/priorauth** > Cardiology > Commercial.
Cardiovascular	Prior authorization required	**Cardiology** 33285 37220 37221 37224 37225 37226 37227 37228 37229 93580** 93653 93656 E0616 **Vascular** 75710* 75716* **Prior authorization is required for patients ages 18 and older. See the Congenital Heart Disease section in this document for patients under age 18 *Prior authorization required for the following diagnosis codes: E08.51 E08.52 E08.59 E08.621 E09.51 E09.52 E09.59 E09.621 E10.51 E10.52 E10.59 E10.621 E11.51 E11.52 E11.59 E11.621 E13.51 E13.52 E13.59 E13.621 I70.201 I70.202 I70.203 I70.208 I70.209 I70.211 I70.212 I70.213

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Cardiovascular (continued)		I70.218	I70.219	I70.221	I70.222
		I70.223	I70.228	I70.229	I70.231
		I70.232	I70.233	I70.234	I70.235
		I70.238	I70.239	I70.241	I70.242
		I70.243	I70.244	I70.245	I70.248
		I70.249	I70.25	I70.261	I70.262
		I70.263	I70.268	I70.269	I70.291
		I70.292	I70.293	I70.298	I70.299
		I70.301	I70.302	I70.303	I70.308
		I70.309	I70.311	I70.312	I70.313
		I70.318	I70.319	I70.321	I70.322
		I70.323	I70.329	I70.331	I70.332
		I70.333	I70.334	I70.335	I70.338
		I70.339	I70.341	I70.342	I70.343
		I70.344	I70.345	I70.348	I70.349
		I70.35	I70.361	I70.362	I70.363
		I70.369	I70.391	I70.392	I70.393
		I70.399	I70.401	I70.402	I70.403
		I70.408	I70.409	I70.411	I70.412
		I70.413	I70.418	I70.421	I70.422
		I70.423	I70.428	I70.429	I70.431
		I70.432	I70.433	I70.434	I70.435
		I70.438	I70.439	I70.441	I70.442
		I70.443	I70.444	I70.445	I70.448
		I70.449	I70.461	I70.462	I70.463
		I70.468	I70.469	I70.491	I70.492
		I70.493	I70.498	I70.499	I70.501
		I70.502	I70.503	I70.508	I70.509
		I70.511	I70.512	I70.513	I70.518
		I70.519	I70.521	I70.522	I70.523
		I70.528	I70.529	I70.531	I70.532
		I70.533	I70.534	I70.535	I70.538
		I70.539	I70.541	I70.542	I70.543
		I70.544	I70.545	I70.548	I70.549
		I70.561	I70.562	I70.563	I70.568
		I70.569	I70.591	I70.592	I70.593
		I70.598	I70.599	I70.601	I70.602
		I70.603	I70.608	I70.609	I70.611
		I70.612	I70.613	I70.618	I70.619
		I70.621	I70.622	I70.623	I70.628
		I70.629	I70.631	I70.632	I70.633
		I70.634	I70.635	I70.638	I70.639
		I70.641	I70.642	I70.643	I70.644
		I70.645	I70.648	I70.649	I70.661

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Cardiovascular (continued)		I70.662	I70.663	I70.668	I70.669
		I70.691	I70.692	I70.693	I70.698
		I70.699	I70.701	I70.702	I70.703
		I70.708	I70.709	I70.711	I70.712
		I70.713	I70.718	I70.719	I70.721
		I70.722	I70.723	I70.728	I70.729
		I70.731	I70.732	I70.733	I70.734
		I70.735	I70.738	I70.739	I70.741
		I70.742	I70.743	I70.744	I70.745
		I70.748	I70.749	I70.761	I70.762
		I70.763	I70.768	I70.769	I70.791
		I70.792	I70.793	I70.798	I70.799
		I70.8	I70.90	I70.91	I70.92
		I72.3	I72.4	I72.8	I72.9
		I73.89	I73.9	I74.3	I74.4
		I74.5	I74.8	I74.9	I75.021
		I75.022	I75.023	I75.029	I75.89
		I77.1	I77.2	I77.70	I77.72
		I77.77	I77.79	I96	L03.115
		L03.116	L97.319	L97.329	L97.419
		L97.429	L97.511	L97.512	L97.513
		L97.519	L97.521	L97.522	L97.529
		L97.819	L97.828	L97.829	L97.909
		L97.919	L97.929	L98.491	L98.499
		M79.604	M79.605	M79.606	M79.609
		M79.651	M79.652	M79.659	M79.661
		M79.662	M79.669	M79.671	M79.672
		M79.673	M79.674	M79.675	M79.676
		M86.661	M86.662	M86.669	M86.671
		M86.672	M86.679	M86.8X7	Q27.30
		Q27.32	Q27.39	Q27.8	Q27.9
		Q87.2	R93.6	S35.511A	S35.512A
		S81.801A	S81.802A	S81.809A	S91.301A
		S91.302A	S91.309A	T82.312A	T82.318A
		T82.319A	T82.338A	T82.392A	T82.398A
		T82.399A	T82.818A	T82.856A	T82.858A
		T82.868A	T82.898A	Z95.820	Z98.62
Cartilage implants	Prior authorization required	27412	27415	27416	29866
		29867	29868	J7330	S2112
Cerebral seizure monitoring–Inpatient video Electroencephalogram (EEG)	Prior authorization required for inpatient services Prior authorization is not required for outpatient hospital or ambulatory surgical center	95700	95711	95712	95713
		95714	95715	95716	95718
		95720	95722	95724	95726

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
Chemotherapy services	Notification/prior authorization required for injectable chemotherapy drugs administered in an outpatient setting, including intravenous, intravesical and intrathecal, for a cancer diagnosis	**Injectable chemotherapy drugs that require prior authorization:** • Chemotherapy injectable drugs (J9000–J9999), Leucovorin (J0640), Levoleucovorin (J0641, J0642), Leuprolide acetate (J1950), Leuprolide (J1952) • Chemotherapy injectable drugs that have a Q code • Chemotherapy injectable drugs that have not yet received an assigned code and will be billed under a miscellaneous Healthcare Common Procedure Coding System (HCPCS) code For prior authorization requests, please submit requests online by using the Prior Authorization and Notification tool on UnitedHealthcare Provider Portal. Go to **UHCprovider.com** and click on the UnitedHealthcare Provider Portal button in the top right corner. Then, select the Prior Authorization and Notification tool tile on your Provider Portal dashboard. Or, call **888-397-8129**.
Clinical trials A rigorously controlled study of a new drug, medical device or other treatment on eligible human subjects subject to oversight by an Institutional Review Board (IRB)	Prior authorization required	S9988 S9990 S9991
Cochlear and other auditory implants A medical device within the inner ear and an external portion to help persons with profound sensorineural deafness achieve conversational speech	Prior authorization required	69710 69714 69930 L8614 L8619 L8690 L8691 L8692
Congenital heart disease Congenital heart disease-related services, including pre-treatment evaluation	Prior authorization required	For prior authorization, please call **888-936-7246** or the notification number on the back of the member's health plan ID card. **Congenital heart disease codes:** 33251 33254 33255 33256 33257 33258 33259 33261 33404 33414 33415 33416 33417 33476 33478 33500 33501 33502 33503 33504 33505 33506 33507 33600 33602 33606 33608 33610 33611 33612 33615 33617 33619 33641 33645 33647 33660 33665 33670 33675 33676 33677 33681 33684 33688 33690 33692 33694 33697 33702 33710 33720 33724 33726 33730 33732 33735 33736 33737 33750

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
Congenital heart disease(continued)		33755 33762 33764 33766 33767 33768 33770 33771 33774 33775 33776 33777 33778 33779 33780 33781 33786 33788 33802 33803 33820 33822 33840 33845 33851 33852 33853 33917 33920 33924 93580 93581 *See the Cardiovascular section of this document for patients ages 18 and older
Continuous Glucose Monitor	Prior authorization required with Type 2 Diabetes Diagnosis	A4226 A9276 A9277 A9278 E0787 K0553 K0554
Cosmetic and reconstructive procedures Cosmetic procedures that change or improve physical appearance without significantly improving or restoring physiological function. Reconstructive procedures that treat a medical condition or improve or restore physiologic function	Prior authorization required	Prior authorization is required for all states. 11960 11970 11971 14020 14021 14061 14302 15570 15572 15574 15730 15733 15740 15756 15820 15821 15822 15823 15830 15847 15877 15878 15879 17999 21137 21138 21139 21172 21175 21179 21180 21181 21182 21183 21184 21230 21235 21256 21260 21261 21263 21267 21268 21275 21280 21282 21295 21740 21742 21743 28344 30540 30545 30560 30620 54400 54401 54405 67900 67901 67902 67903 67904 67906 67908 67909 67911 67912 67914 67915 67916 67917 67921 67922 67923 67924 67950 67961 67966 Q2026 Prior authorization is required for all states. In addition, site of service will be reviewed as part of the prior authorization process for the following codes except in AK, MA, PR, TX, UT, VI and WI. 17106 17107 17108
Durable medical equipment (DME)	Notification/prior authorization required only for DME codes listed with a retail purchase or cumulative rental cost of more than $1,000 Prosthetics are not DME – see Orthotics and prosthetics. Some home health care services may qualify under the durable medical	A7025 A7026 E0194 E0265 E0266 E0277 E0296 E0297 E0300 E0302 E0304 E0328 E0329 E0466 E0471 E0483 E0745 E0764 E0766 E0770 E0784 E0984 E0986 E1002 E1003 E1004 E1005 E1006

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
Durable medical equipment (DME) (continued)	equipment requirement but are not subject to the $1,000 retail purchase or cumulative retail rental cost threshold – see Home health services. Power mobility devices and accessories, lymphedema pumps and pneumatic compressors require notification/prior authorization regardless of the cost.	E1007 E1008 E1010 E1016 E1018 E1236 E1238 E1399 E1802 E1805 E1825 E1830 E1840 E2402 E2502 E2504 E2506 E2508 E2510 E2511 E2512 E2599 K0005 K0012 K0014 K0812 K0848 K0849 K0850 K0851 K0852 K0853 K0854 K0855 K0856 K0857 K0858 K0859 K0860 K0861 K0862 K0863 K0864 K0868 K0869 K0870 K0871 K0877 K0878 K0879 K0880 K0884 K0885 K0886 K0890 K0891 S1040
End-stage renal disease (ESRD) dialysis services Services for treating end-stage renal disease, including outpatient dialysis services	Prior authorization required when members are referred to an out-of-network care provider for dialysis services Prior authorization not required for ESRD when a member travels outside of the service area Please note: Your agreement with us may include restrictions on referring members outside of the UnitedHealthcare network.	For notification/prior authorization, please call **877-842-3210**. To enroll or refer a member to the UnitedHealthcare ESRD Disease Management Program, please contact the Kidney Resource Service at **866-561-7518**.
Foot surgery	Prior authorization required	Prior authorization is required for all states. In addition, site of service will be reviewed as part of the prior authorization process for the following codes except in AK, MA, PR, TX, UT, VI and WI. 28285 28289 28291 28292 28296 28297 28298 28299
Functional endoscopic sinus surgery (FESS)	Prior authorization required	31240 31253 31254 31255 31256 31257 31259 31267 31276 31287 31288
Gender dysphoria treatment	Prior authorization required	**Notification or prior authorization required for the following regardless of diagnosis code:** 55970 55980 **Notification or prior authorization required for the following when submitted with a diagnosis code F64.0, F64.1, F64.2, F64.8, F64.9 or Z87.890:** 14000 14001 14041 15734 15738 15750 15757 15758 19303 53410 53430 54125 54520 54660 54690 55175 55180 56625 56800 56805 57110 57335 58260 58262

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Gender dysphoria treatment (continued)		58290	58291	58292	58661
		58720	58940	64856	64892
		64896			
Genetic and molecular testing to include BRCA gene testing	Prior authorization required for genetic and molecular testing performed in an outpatient setting Care providers requesting laboratory testing will be required to complete the prior authorization/notification process, which includes indicating the laboratory and test name. Payment will be authorized for those CPT codes registered with the Genetic and Molecular Testing Prior Authorization/Notification Program for each specified genetic test. Notification/prior authorization required for BRCA testing before DNA sequencing is performed. The ordering care provider must notify the laboratory conducting the test and the laboratory will notify UnitedHealthcare.	81105	81106	81107	81108
		81109	81110	81111	81120
		81121	81161	81162	81163
		81164	81165	81166	81167
		81168	81170	81171	81172
		81173	81174	81175	81176
		81177	81178	81179	81180
		81181	81182	81183	81184
		81185	81186	81187	81188
		81189	81190	81191	81192
		81193	81194	81200	81201
		81203	81204	81205	81208
		81209	81212	81216	81218
		81220	81222	81223	81224
		81225	81226	81227	81228
		81229	81230	81231	81232
		81233	81234	81236	81237
		81238	81239	81240	81241
		81242	81243	81244	81245
		81246	81247	81248	81249
		81250	81251	81252	81253
		81254	81255	81256	81257
		81258	81259	81260	81261
		81262	81263	81264	81265
		81266	81267	81268	81269
		81271	81272	81273	81274
		81276	81277	81278	81279
		81283	81284	81285	81286
		81287	81288	81289	81290
		81291	81292	81294	81295
		81297	81298	81300	81302
		81303	81304	81305	81306
		81307	81309	81310	81312
		81313	81314	81315	81316
		81317	81318	81319	81320
		81321	81322	81323	81324
		81325	81326	81327	81328
		81329	81330	81331	81332
		81333	81334	81335	81336
		81337	81338	81339	81340
		81341	81342	81343	81344
		81345	81346	81347	81348
		81350	81351	81352	81353
		81355	81357	81360	81361
		81362	81363	81364	81370
		81371	81372	81373	81375

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Genetic and molecular testing to include BRCA gene testing (continued)		81376	81377	81378	81379
		81380	81381	81382	81383
		81400	81401	81402	81403
		81404	81405	81406	81407
		81408	81410	81411	81412
		81413	81414	81415	81416
		81417	81419	81420	81430
		81431	81432	81433	81434
		81435	81436	81437	81438
		81439	81440	81442	81443
		81445	81448	81460	81465
		81470	81471	81479	81507
		81518	81519	81520	81521
		81522	81546	81554	81595
		81599	87481	87482	87505
		87506	87507	87510	87511
		87512	87623	87797	87798
		87799	87800	87801	0001U
		0004M	0006M	0007M	0012U
		0013U	0014U	0016U	0017U
		0018U	0022U	0023U	0026U
		0027U	0030U	0031U	0032U
		0033U	0034U	0040U	0046U
		0049U	0055U	0060U	0068U
		0070U	0071U	0072U	0073U
		0074U	0075U	0076U	0084U
		0087U	0088U	0097U	0111U
		0129U	0136U	0137U	0154U
		0155U	0157U	0158U	0159U
		0160U	0161U	0168U	0169U
		0170U	0171U	0172U	0173U
		0175U	0177U	0179U	0180U
		0181U	0182U	0183U	0184U
		0185U	0186U	0187U	0188U
		0189U	0190U	0191U	0192U
		0193U	0194U	0195U	0196U
		0197U	0198U	0199U	0200U
		0201U	0203U	0205U	0209U
		0214U	0215U	0216U	0217U
		0218U	0221U	0222U	0229U
		0230U	0231U	0232U	0234U
		0235U	0236U	0237U	0238U
		0245U	0246U	S3870	
Home health care – Non-nutritional	Notification/prior authorization required only in outpatient settings, to include member's home	T1000	T1002	T1003	

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Hysterectomy – Inpatient only Vaginal hysterectomies	Prior authorization required for inpatient vaginal hysterectomies Prior authorization not required for outpatient vaginal hysterectomies	58267	58270	58275	58280
		58294			
Hysterectomy – Inpatient and outpatient procedures Abdominal and laparoscopic surgeries	Prior authorization required	58150	58152	58180	58541
		58542	58543	58544	58550
		58552	58553	58554	58570
		58571	58572	58573	
Infertility Diagnostic and treatment services related to the inability to achieve pregnancy	Prior authorization required	55870	58321	58322	58323
		58345	58752	58760	58970
		58974	58976	76948	89250
		89251	89253	89254	89255
		89257	89258	89259	89260
		89261	89264	89268	89272
		89280	89281	89290	89291
		89335	89337	89342	89343
		89344	89346	89352	89353
		89354	89356	S4011	S4013
		S4014	S4015	S4016	S4022
		S4023	S4025	S4026	S4028
		S4030	S4031	S4035	S4037
		The following codes only require prior authorization if the DX code is also listed:			
		52402	54500	54505	55550
		58140	58145	58146	58545
		58546	58660	58662	58670
		58672	58673	58740	58770
		89398			
		DX codes:			
		E23.0	N46.01	N46.021	N46.022
		N46.023	N46.024	N46.025	N46.029
		N46.11	N46.121	N46.122	N46.123
		N46.124	N46.125	N46.129	N46.8
		N46.9	N97.0	N97.1	N97.2
		N97.8	N97.8	N97.9	N98.1
Injectable medications A drug capable of being injected intravenously through an intravenous infusion, subcutaneously or intra-muscularly	Prior authorization required Specific state rules may apply. For more information on whether authorization is required or not, and to submit a prior authorization request and, for UHC Commercial Non-PAR providers, to submit a Pre-Determination request, the provider must log into UHCProvider.com and click on the UnitedHealthcare Provider Portal button in the upper right corner.	**Aduhelm®** *****			
		J0172			
		Alpha1-Proteinase			
		J0256	J0257		
		Anemia			
		J0896	J1437	J1439	Q0138
		Asthma – Nucala®/Xolair®/Cinqair®/Fasenra®			
		J0517	J2182	J2357	J2786

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
Injectable medications (continued)	Submit the request using the Specialty Pharmacy Transactions tile on the Provider Portal Dashboard. For questions about this online authorization process, the provider may call Optum: **888-397-8129** Hemophilia codes ONLY: To submit a prior authorization request and, for UHC Commercial Non-PAR providers to submit a Pre-Determination request, the provider must Log into UHCProvider.com and click on the UnitedHealthcare Provider Portal button in the upper right corner. Submit the request using the Specialty Pharmacy Transactions tile on the Provider Portal Dashboard. For questions about this online authorization process, the provider may call Optum: **888-397-8129**	**Blood modifying agents** J1300 J1303 J0223 **Central Nervous System Agents** J0222 J1426 J1427 J1429 J2326 J3032 **Collagenase** J0775 **Dermatology** J7352 **Endocrine** J0224 J0800 J3241 **Enzyme deficiency – POS 19 and 22 only** J0180 J0221 J1322 J1458 J1743 J1931 J2504 J2840 J3397 **Enzyme replacement therapy** C9085 J0567 J1786 J3060 **Erythropoiesis Stimulating Agents**** J0885 **Gaucher's disease – POS 19 and 22 only** J3385 **Gene therapy** J3398 J3399 **Hemophilia** J7170 J7175 J7177 J7178 J7179 J7180 J7181 J7182 J7183 J7185 J7186 J7187 J7188 J7189 J7190 J7191 J7192 J7193 J7194 J7195 J7198 J7199 J7200 J7201 J7202 J7203 J7204 J7205 J7207 J7208 J7209 J7210 J7211 J7212 **Hereditary Angioedema (HAE)** J0596 J0597 J0598 J1290 **Immune globulin** 90283 90284 J1459 J1554 J1555 J1556 J1557 J1558 J1559 J1561 J1566 J1568 J1569 J1572 J1575 J1599

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
Injectable medications (continued)		**Immuno modulator** C9086 J0638 J0490 J1823 J9210 **Inflammatory – All POS** J0129 J0717 J1602 J1745 J3262 J3358 J3380 Q5103 Q5104 Q5121 **Multiple sclerosis** J0202 J2323 J2350 **Nexviazyme®** J0219 **Osteoperosis** J0897*** **Other codes** J0584 J1301 J1746 J2507 J3111 J3245 J0741 **Rare Conditions** J1305 **Rituximab** J9311 J9312 Q5115 Q5119 Q5123 **RSV Prophylaxis** 90378 **Saphnello™** J0491 **Sickle Cell disease** J0791 **Sodium hyaluronate** J7320 J7321 J7322 J7324 J7325 J7326 J7327 J7329 J7331 J7332 **Therapeutic Radiopharmaceuticals**** A9513 A9590 A9606 A9699 **Unclassified and temporary codes** C9090* C9399* J3490* J3590* **White blood cell colony stimulating factors***** J1442 J1447 J2506 Q5101 Q5108 Q5110 Q5111 Q5120 Q5122 Please check our *Review at Launch for New to Market Medications* policy for the most up-to-date information on

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
Injectable medications (continued)		drugs newly approved by the Food & Drug Administration (FDA) and included on our *Review at Launch Medication List*. Pre-determination is highly recommended for the drugs on the list. The *Review at Launch for New to Market Medications* policy is available at **UHCprovider.com >** Menu > Policies and Protocols > Commercial Policies > Medical & Drug Policies and Determination Guidelines for UnitedHealthcare Commercial Plans. * For unclassifiedand temporary codes C9090, C9399, J3490 and J3590, notification/prior authorization is only required for Cutaquig®, Nulibry™, Revcovi™ and Ryplazm® ** For prior authorization, please submit requests online by using the Prior Authorization and Notification tool on UnitedHealthcare Provider Portal. Go to **UHCprovider.com** and click on the UnitedHealthcare Provider Portal button in the top right corner. Then, select the Specialty Pharmacy Transactions tile on your Provider Portal dashboard. Or, call **888-397-8129** *** For codes J0897, J1442, J1447, J2506, Q5101, Q5108, Q5110, Q5111 Q5120 and Q5122, prior authorization is required for both oncology and non-oncology DX. For oncology DX please see *Cancer supportive care* section above. For non-oncology DX submit online at **UHCProvider.com** > UnitedHealthcare Provider Portal > Specialty Pharmacy Transactions tile on your Provider Portal dashboard or call **877-842-3210** **** For code J0885 prior authorization is required for both oncology and non-oncology DX. Prior authorization is not required for ESRD diagnosis. *****Effective 06/01/2022 **As stated in the UHC medical drug policy, Aduhelm® is unproven and not medically necessary for the treatment of Alzheimer's disease due to insufficient clinical evidence of efficacy.**
Inpatient admissions- post- acute services	Prior authorization and notification of admission date required for these facilities providing post-acute inpatient services: • Acute care hospitals • Acute inpatient rehabilitation • Critical access hospitals • Long-term acute care hospitals • Skilled nursing facilities	
MR-guided focused ultrasound (MRgFUS) to treat uterine fibroid MR-guided focused ultrasound procedures and treatments	Prior authorization required MR-guided focused ultrasound is a covered service for certain benefit plans, subject to the terms and conditions of those benefit plans, which generally are as follows: • A physician and/or facility must confirm coverage of the service for the member. • A hospital and/or facility must be contracted with UnitedHealthcare.	0071T 0072T

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
MR-guided focused ultrasound (continued)	Members have no out-of-network benefits for MRgFUS. • A member must consent in writing to the procedure acknowledging that UnitedHealthcare doesn't believe sufficient clinical evidence has been published in peer-reviewed medical literature to conclude the service is safe and/or effective. • A member must agree in writing to not hold UnitedHealthcare responsible if they're not satisfied with the results. • A physician and facility must have demonstrated experience and expertise in MRgFUS, as determined by UnitedHealthcare. • A physician and facility must follow U.S. Food & Drug Administration (FDA)-labeled indications for use.				
Non-emergency air transport Non-urgent ambulance transportation by air between specified locations	Prior authorization required	A0430 S9960	A0431 S9961	A0435	A0436
Orthognathic surgery Treatment of maxillofacial functional impairment	Prior authorization required	21050 21125 21143 21150 21159 21194 21199 21210 21243 21247 21296	21060 21127 21145 21151 21160 21195 21206 21215 21244 21248 21299	21121 21141 21146 21154 21188 21196 21208 21240 21245 21249	21123 21142 21147 21155 21193 21198 21209 21242 21246 21255
Orthotics	Prior authorization required only for orthotics codes listed with a retail purchase or cumulative rental cost of more than $1,000	L0220 L0486 L1680 L1720 L2005 L2037 L3253 L3901 L3975	L0480 L0636 L1685 L1755 L2020 L2038 L3485 L3904 L3976	L0482 L0638 L1700 L1844 L2034 L2330 L3766 L3961 L3977	L0484 L1640 L1710 L1846 L2036 L3251 L3900 L3971
Out-of-network services A recommendation from a network physician or other health care provider to a	Prior authorization required Your agreement with UnitedHealthcare may include restrictions on directing members				

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
hospital, physician or other health care provider who is not contracted with UnitedHealthcare	outside the health plan network. Your patients who use non-network physicians, health care professionals or facilities may have increased out-of-pocket expenses or no coverage.				
Pain Management and Injection	Prior authorization required	62320	62322	62324	62325
		62326	62327	62350	62351
		62360	62361	64451	64484
		64520	64620	64640	E0782
		E0783	E0785	E0786	G0260
Physical Therapy/Occupational Therapy (PT/OT)	Physical therapy and/or occupational therapy visits performed by care providers contracted by Optum Physical Health require prior authorization, which includes the plan member's initial evaluation. After the initial visit, care providers must complete and submit a Patient Summary Form (PSF) through OptumHealth Physical Health's website at: myoptumhealthphysicalhealth.com. PSFs should be sent within three days of initiating a plan member's treatment and must be received within 10 days from the initial date of service listed on the form.	For specific information on prior authorization requirements based upon Provider Specialty or for network status inquiries, please visit **myoptumhealthphysicalhealth.com** > Tools and Resources and use the UHC Quick Group Check. Or, call OptumHealth Physical Health **888-329-5182**.			
Potentially unproven services (including experimental/ investigational and/or linked services) Services, including medications, determined to be ineffective in treating a medical condition and/or to have no beneficial effect on health outcomes Determination made when there's insufficient clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published, peer-reviewed medical literature	Prior authorization required	26340	33361	33362	33363
		33364	33365	33366	33369
		33477	36514	64722	0376T
		A9274			
Pregnancy	Voluntary notification for case and disease management enrollment: Please provide us with voluntary notification of a pregnancy diagnosis. Notification allows UnitedHealthcare to enroll a pregnant member in the Healthy Pregnancy Program, our case and disease management program, before their baby's arrival. As part of these programs, members will have	**Upon confirmation of pregnancy, please notify us for ICD-10-CM codes:**			
		O09.00	O09.01	O09.02	O09.03
		O09.10	O09.11	O09.12	O09.13
		O09.211	O09.212	O09.213	O09.219
		O09.291	O09.292	O09.293	O09.299
		O09.30	O09.31	O09.32	O09.33
		O09.40	O09.41	O09.42	O09.43

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Pregnancy (continued)	access to the Healthy Pregnancy app and other available resources. Voluntary notification doesn't indicate or imply coverage, which is determined according to the member's benefit plan. Please notify us only once per pregnancy. We're not requesting notification for ancillary services, such as ultrasound and lab work. After notification, please contact us if the member is no longer appropriate for the Healthy Pregnancy Program – for example, if a pregnancy is terminated.	O09.511	O09.512	O09.513	O09.519
		O09.521	O09.522	O09.523	O09.529
		O09.611	O09.612	O09.613	O09.619
		O09.621	O09.622	O09.623	O09.629
		O09.70	O09.71	O09.72	O09.73
		O09.891	O09.892	O09.893	O09.899
		O09.90	O09.91	O09.92	O09.93
		O12.00	O12.01	O12.02	O12.03
		O12.10	O12.11	O12.12	O12.13
		O12.20	O12.21	O12.22	O12.23
		O21.0	O21.1	O21.8	O21.9
		O24.011	O24.012	O24.013	O24.111
		O24.112	O24.113	O24.311	O24.312
		O24.313	O24.811	O24.812	O24.813
		O24.911	O24.912	O24.913	O26.00
		O26.01	O26.02	O26.03	O26.831
		O26.832	O26.833	O26.839	O30.001
		O30.002	O30.003	O30.011	O30.012
		O30.013	O30.031	O30.032	O30.033
		O30.041	O30.042	O30.043	O30.091
		O30.092	O30.093	O30.101	O30.102
		O30.103	O30.111	O30.112	O30.113
		O30.121	O30.122	O30.123	O30.191
		O30.192	O30.193	O30.201	O30.202
		O30.203	O30.211	O30.212	O30.213
		O30.221	O30.222	O30.223	O30.291
		O30.292	O30.293	O30.91	O30.92
		O30.93	O47.00	O47.02	O47.03
		O47.1	O47.9	O60.00	O60.02
		O60.03	O99.011	O99.012	O99.013
		O99.280	O99.89	Z32.01	Z33.1
		Z34.00	Z34.01	Z34.02	Z34.03
		Z34.80	Z34.81	Z34.82	Z34.83
		Z34.90	Z34.91	Z34.92	Z34.93
		Z36			
Prostate Procedures	Prior authorization required	52441	52442	53850	55866
		55874			
Prosthetics	Prior authorization required only for prosthetic codes listed with a retail purchase or cumulative rental cost of more than $1,000	L5010	L5020	L5050	L5060
		L5100	L5105	L5150	L5160
		L5200	L5210	L5230	L5250
		L5270	L5280	L5301	L5321

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
Prosthetics (continued)		L5331 L5400 L5420 L5530 L5535 L5540 L5585 L5590 L5616 L5639 L5643 L5649 L5651 L5681 L5683 L5703 L5707 L5724 L5726 L5728 L5780 L5795 L5814 L5818 L5822 L5824 L5826 L5828 L5830 L5840 L5845 L5848 L5856 L5858 L5930 L5960 L5966 L5968 L5973 L5979 L5980 L5981 L5987 L5988 L6000 L6010 L6020 L6026 L6050 L6055 L6120 L6130 L6200 L6205 L6310 L6320 L6350 L6360 L6370 L6400 L6450 L6570 L6580 L6582 L6584 L6586 L6588 L6590 L6621 L6624 L6638 L6648 L6693 L6696 L6697 L6707 L6881 L6882 L6884 L6885 L6900 L6905 L6910 L6920 L6925 L6930 L6935 L6940 L6945 L6950 L6955 L6960 L6965 L6970 L6975 L7007 L7008 L7009 L7040 L7045 L7170 L7180 L7181 L7185 L7186 L7190 L7191 L7499 L8042 L8043 L8044 L8049 V2629
Radiation Therapy	Prior authorization required	**IGRT** 77014 77387 G6001 G6002 G6017 **IMRT** Intensity-Modulated Radiation Therapy 77385 77386 G6015 G6016 **Proton Beam** Focused radiation therapy that uses beams of protons (tiny particles with a positive charge) 77520 77522 77523 77525 **Special/Associated Services** 77331 77370 77399 77470 **SRS/SBRT** 77371 77372 77373 G0339 G0340 **Standard Radiation Therapy (2D/3D)** Prior Auth required only when obtained with diagnosis codes in the following ranges:

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
Radiation Therapy (continued)		C34.00 - C34.92, C50.011 - C50.929, C61, C79.51 - C79.52, C84.7A, D05.00 - D05.92 77401 77402 77407 77412 G6003 G6004 G6005 G6006 G6007 G6008 G6009 G6010 G6011 G6012 G6013 G6014 **Y90** Implantable Beta-Emitting Microspheres for treatment of malignant tumors S2095 79445 To submit an online request for prior authorization, sign in to UnitedHealthcare Provider Portal to access the Prior Authorization and Notification tool. Select the "Radiology, Cardiology, Oncology, and Radiation Therapy" box. After selecting Commercial as the product type, you will be directed to another website to process the authorization requests
Radiology	Prior authorization required for participating physicians who request these advanced outpatient imaging procedures: • Certain CT, MRI, MRA and PET scans • Nuclear medicine and nuclear cardiology procedures	Care providers ordering an Advanced Outpatient Imaging Procedure are responsible for providing notification/requesting prior authorization before scheduling the procedure. For notification/prior authorization, please submit requests online by using the Prior Authorization and Notification tool on UnitedHealthcare Provider Portal. Go to **UHCprovider.com** and click on the UnitedHealthcare Provider Portal button in the top right corner. Then, select the Prior Authorization and Notification tool tile on your Provider Portal dashboard. Or, call **866-889-8054**. For more details and the CPT codes that require notification/prior authorization, please visit **UHCprovider.com/priorauth** > Radiology > Commercial.
Rhinoplasty Treatment of nasal functional impairment and septal deviation	Prior authorization required	30400 30410 30420 30430 30435 30450 30460 30462 30465
Sinuplasty	Prior authorization required	31295 31296 31297 31298
Site of service (SOS) – Office-based program	Prior authorization required if performed in an outpatient hospital setting or ambulatory surgery center Prior authorization not required if performed in an office Prior authorization not required for care providers in AK, MA, PR, TX, UT, VI and WI.	**Dermatologic** 11402 11403 11406 11422 11404 11420 11421 11423 11424 11426 11442 **General Surgery** 19000 **Muscular/Skeletal** 27096 64479 64490 64493 20552 20553 **Neurologic** 62270 62321 64633 64635 **OB/GYN** 57460 **Respiratory**

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
		31579
Site of service (SOS) – Outpatient hospital **Site of service (SOS) – Outpatient hospital (continued)**	Prior authorization only required when requesting service in an outpatient hospital setting Prior authorization not required if performed at a participating Ambulatory Surgery Center (ASC) Prior authorization not required for care providers in AK, MA, PR, TX, UT, VI and WI.	**Carpal tunnel surgery** 64721 **Cataract surgery** 66821 66982 66984 **Cosmetic and reconstructive** 13101 13132 14040 14060 14301 21552 21931 **Ear, nose and throat (ENT) procedures** 21320 30140 30520 69436 69631 **Gynecologic procedures** 57522 58353 58558 58563 58565 **Hernia repair** 49505 49585 49587 49650 49651 49652 49653 49654 49655 **Liver biopsy** 47000 **Miscellaneous** 20680 **Ophthalmologic** 65426 65730 65855 66170 66761 67028 67036 67040 67228 67311 67312 **Tonsillectomy and adenoidectomy** 42821 42826 **Upper and lower gastrointestinal endoscopy** 43235 43239 43249 45378 45380 45384 45385 **Urologic procedures** 50590 52000 52005 52204 52224 52234 52235 52260 52281 52310 52332 52351 52352 52353 52356 54161 55040 55700
Site of service – Outpatient hospital expansion	Prior authorization only required when requesting service in an outpatient hospital setting	**Auditory System** 69100 69110 69140 69145

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Site of service – Outpatient hospital expansion (continued)	Prior authorization not required if performed at a participating Ambulatory Surgery Center (ASC) Prior authorization not required for care providers in AK, MA, PR, RI, TX, UT, VI and WI.	69205	69222	69310	69320
		69421	69424	69433	69440
		69450	69505	69550	69602
		69610	69620	69632	69633
		69635	69636	69641	69642
		69643	69644	69645	69646
		69650	69660	69661	69662
		69801	69805	69806	
		Cardiovascular System			
		33215	33216	33241	35045
		36000	36010	36012	36215
		36246	36556	36569	36571
		36581	36582	36589	36590
		36821	36901	36902	37242
		37248	37607	37609	37761
		37765	37766	37785	
		Digestive System			
		40520	40525	40810	40812
		40814	40816	41110	41112
		41113	41520	41825	42100
		42104	42106	42107	42140
		42330	42335	42405	42408
		42410	42415	42420	42425
		42440	42450	42500	42650
		42800	42804	42808	42810
		42831	42870	43191	43195
		43197	43200	43202	43214
		43220	43226	43229	43233
		43236	43237	43238	43241
		43242	43245	43246	43247
		43248	43250	43251	43253
		43254	43255	43259	43260
		43261	43270	43450	43453
		44340	44360	44361	44364
		44369	44376	44377	44380
		44381	44382	44385	44386
		44388	44389	44392	44394
		44705	45100	45171	45172
		45190	45305	45334	45335
		45340	45341	45342	45346

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Site of service – Outpatient hospital expansion (continued)		45349	45350	45379	45381
		45386	45390	45398	45505
		45541	45560	45905	45910
		45915	45990	46020	46030
		46080	46083	46200	46220
		46221	46230	46250	46255
		46257	46258	46261	46262
		46270	46275	46280	46285
		46288	46320	46505	46606
		46607	46610	46612	46615
		46706	46707	46750	46910
		46917	46924	46930	46940
		46945	46946	46947	46948
		49082	49083	49180	49250
		49422	49520	49521	49525
		49550	49553	49570	49572
		49656	G0105	G0121	
		Endocrine System			
		62281			
		Eye and Ocular Adnexa			
		65400	65420	65435	65436
		65710	65750	65755	65756
		65772	65778	65779	65780
		65800	65815	65820	65850
		65865	65875	65920	66172
		66185	66250	66682	66710
		66711	66825	66840	66850
		66852	66983	66985	66986
		66987	66988	67005	67010
		67025	67039	67041	67042
		67043	67101	67105	67107
		67108	67110	67113	67120
		67121	67145	67210	67218
		67220	67221	67314	67316
		67318	67345	67400	67412
		67414	67420	67445	67550
		67560	67700	67800	67801
		67805	67808	67840	67875
		67880	67935	67938	67971
		67973	67975	68100	68110

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Site of service – Outpatient hospital expansion (continued)		68115	68135	68320	68440
		68700	68720	68750	68811
		68815			
		Female Genital System			
		56405	56420	56440	56441
		56442	56501	56515	56605
		56620	56700	56740	56810
		56821	57000	57061	57065
		57100	57105	57106	57130
		57135	57240	57250	57260
		57268	57282	57283	57287
		57295	57300	57410	57415
		57420	57421	57425	57452
		57454	57456	57461	57500
		57505	57510	57511	57513
		57520	57530	57700	57720
		57800	58100	58120	58263
		58560	58561	58562	58700
		58925			
		Foot Surgery			
		28295			
		Hemic and Lymphatic Systems			
		38221	38222	38500	38505
		38510	38520	38525	38740
		38760			
		Integumentary System			
		10121	10180	11010	11012
		11440	11441	11443	11444
		11446	11450	11451	11462
		11463	11470	11471	11601
		11602	11603	11604	11620
		11621	11622	11623	11624
		11640	11641	11642	11643
		11644	11750	11755	11760
		11770	11772	12031	12032
		12034	12035	12041	12042
		12051	12052	13100	13120
		13121	13131	13151	15100
		15120	15220	15240	15576
		15760	15770	15850	17000

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Site of service – Outpatient hospital expansion (continued)		17004	17110	17111	17311
		17313	19101	19110	19112
		19120	19125		
		Male Genital System			
		54001	54055	54057	54060
		54100	54110	54150	54162
		54163	54164	54300	54360
		54450	54512	54530	54600
		54620	54640	54700	54830
		54840	54860	55041	55060
		55100	55110	55120	55500
		55520	55540		
		Musculoskeletal System			
		20200	20205	20220	20225
		20240	20245	20520	20525
		20526	20551	20600	20604
		20605	20606	20610	20611
		20612	20693	20694	20912
		21011	21012	21013	21014
		21030	21031	21040	21046
		21048	21315	21325	21330
		21335	21336	21337	21356
		21550	21555	21556	21557
		21920	21930	21932	21933
		22900	22901	22902	22903
		23071	23075	23076	23120
		23140	23150	23405	23415
		23430	23440	23480	23615
		23630	23700	24000	24006
		24065	24066	24071	24073
		24075	24076	24101	24102
		24105	24110	24120	24130
		24147	24200	24201	24300
		24310	24340	24341	24342
		24343	24357	24358	24366
		24515	24516	24586	24615
		24665	24666	25000	25071
		25073	25075	25076	25085
		25105	25107	25109	25110
		25111	25112	25115	25118

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Site of service – Outpatient hospital expansion (continued)		25120	25130	25151	25210
		25215	25230	25240	25260
		25270	25275	25280	25290
		25295	25350	25445	25545
		25605	25606	25607	25608
		25609	25624	25628	25645
		25652	25810	25825	26011
		26020	26045	26055	26070
		26075	26080	26105	26110
		26111	26113	26115	26116
		26121	26123	26160	26180
		26200	26210	26215	26236
		26320	26350	26356	26357
		26392	26410	26418	26420
		26426	26432	26433	26437
		26440	26442	26445	26455
		26480	26500	26502	26516
		26520	26525	26530	26535
		26540	26541	26542	26567
		26608	26615	26650	26665
		26676	26715	26727	26735
		26742	26746	26756	26765
		26841	26842	26850	26860
		26862	26910	26951	26952
		27006	27043	27045	27047
		27048	27062	27093	27095
		27310	27323	27324	27327
		27328	27329	27331	27332
		27334	27335	27337	27339
		27340	27345	27347	27372
		27403	27407	27418	27570
		27606	27613	27614	27618
		27619	27620	27626	27632
		27634	27638	27640	27658
		27659	27665	27680	27685
		27690	27696	27705	27720
		27756	27788	28005	28010
		28011	28020	28022	28035
		28039	28041	28043	28045
		28047	28055	28060	28080

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Site of service – Outpatient hospital expansion (continued)		28086	28088	28090	28092
		28100	28103	28104	28108
		28110	28111	28112	28113
		28118	28119	28120	28122
		28124	28126	28153	28160
		28190	28192	28193	28200
		28208	28225	28232	28234
		28238	28250	28272	28280
		28286	28288	28306	28310
		28312	28313	28315	28322
		28475	28476	28496	28515
		28525	28645	28666	28675
		28755	28760	28810	28825
		29800	29804	29900	29901
		29902	29906		
		Nervous System			
		64425	64530	64561	64581
		64585	64600	64610	64642
		64644	64646	64647	64702
		64718	64719	64774	64776
		64782	64784	64788	64795
		64831	64835		
		Respiratory System			
		30000	30020	30100	30110
		30115	30118	30130	30220
		30310	30580	30630	30801
		30802	30930	31020	31030
		31032	31200	31205	31525
		31526	31528	31529	31530
		31535	31536	31540	31541
		31545	31570	31571	31574
		31575	31576	31578	31591
		31611	31622	31623	31624
		31625	31628	31652	32408
		32555	32557		
		Urinary System			
		50430	50435	50575	50688
		51102	51702	51710	51715
		51720	51726	51728	51729
		52001	52007	52214	52265

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
Site of service – Outpatient hospital expansion (continued)		52275 52276 52282 52283 52285 52287 52300 52315 52317 52320 52325 52327 52330 52341 52344 52354 52450 52500 52630 52640 53020 53230 53260 53265 53270 53440 53445 53450 53500 53605 53665 54065
Sleep apnea procedures and surgeries Maxillomandibular advancement or oral pharyngeal tissue reduction for treatment of obstructive sleep apnea	Prior authorization required. Applies to inpatient or outpatient procedures and surgeries, including, but not limited to, palatopharyngoplasty – oral pharyngeal reconstructive surgery that includes laser-assisted uvulopalatoplasty. Applies only for surgical sleep apnea procedures and not sleep studies.	Prior authorization is required for all states. 21685 41599 Prior authorization is required for all states. In addition, site of service will be reviewed as part of the prior authorization process for the following codes except in AK, MA, PR, TX, UT, VI and WI. 42145
Sleep studies Laboratory-assisted and related studies, including polysomnography, to diagnosis sleep apnea and other sleep disorders	Prior authorization required Excludes sleep studies performed in the home. Not applicable to sleep apnea procedures and surgeries – see Sleep apnea procedures and surgeries.	95805 95807 95808 95810 95811
Specific medications as indicated on the prescription drug list (PDL)	Notification/prior authorization required for certain medications to make sure they're a covered benefit for the indication for which they're prescribed. For a list of medications requiring notification/prior authorization, please refer to the PDL at UHCprovider.com > Menu > Resource Library > Drug Lists and Pharmacy > UnitedHealthcare Prescription Drug List. Please call 800-711-4555 when prescribing medications that require notification/prior authorization. You may also fax specialty medication requests to 877-342-4596.	
Spinal cord stimulators Spinal cord stimulators when implanted for pain management	Prior authorization required	Prior authorization is required for all states. 63650 63655 63662 63664 63685 63688 64553 64570 L8679 L8680 L8682 L8683 L8685 L8686 L8687 L8688 Prior authorization is required for all states. In addition, site of service will be reviewed as part of the prior authorization process for the following codes except in AK, MA, PR, TX, UT, VI and WI. 63661 63663
Spinal surgery	Prior authorization required	Prior authorization is required for all states 20930 20931 20939 22100 22101 22102 22103 22110 22112 22114 22116 22206

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Spinal surgery (continued)		22207	22208	22210	22212
		22214	22216	22220	22222
		22224	22226	22510	22511
		22512	22515	22532	22533
		22534	22548	22551	22552
		22554	22556	22558	22585
		22586	22590	22595	22600
		22610	22612	22614	22630
		22632	22633	22634	22800
		22802	22804	22808	22810
		22812	22818	22819	22830
		22840	22841	22842	22843
		22844	22845	22846	22847
		22848	22849	22850	22852
		22853	22854	22855	22856
		22857	22858	22859	22861
		22862	22864	22865	22899
		27279	27280	63001	63003
		63005	63011	63012	63015
		63016	63017	63020	63030
		63035	63040	63042	63043
		63044	63045	63046	63047
		63048	63050	63051	63055
		63056	63057	63064	63066
		63075	63076	63077	63078
		63081	63082	63085	63086
		63087	63088	63090	63091
		63101	63102	63103	63170
		63172	63173	63185	63190
		63191	63197	63200	63250
		63251	63252	63265	63266
		63267	63268	63270	63271
		63272	63273	63275	63276
		63277	63278	63280	63281
		63282	63283	63285	63286
		63287	63290	63295	63300
		63301	63302	63303	63304
		63305	63306	63307	63308
		0095T	0098T	0164T	0309T
		Prior authorization is required for all states. In addition, site of service will be reviewed as part of the prior authorization process for the following codes except in AK, MA, PR, TX, UT, VI and WI.			
		22513	22514		

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
Stimulators – not related to spine Implantation of a device that sends electrical impulses	Prior authorization required	**Bone growth stimulator** E0747 E0748 E0749 E0760 **Neurostimulator** 43647 43648 43881 43882 61863 61864 61867 61868 61885 61886 64555 64568 64590 64595 0312T 0313T 0314T 0315T 0316T 0317T
Transplant Organ or tissue transplant or transplant related services before pre-treatment or evaluation	Prior authorization required for transplant or transplant-related services before pre-treatment or evaluation	For transplant and CAR T-cell therapy services, including Abecma® (Idecaptagene Cicleucel), Breyanzi® (Lisocabtagene), Kymriah™ (tisagenlecleucel) Tecartus™ (brexucabtagene autoleucel) and Yescarta™ (axicabtagene ciloleucel), please call **888-936-7246** or the notification number on the back of the member's health plan ID card. **Bone marrow harvest** 38240 38241 38242 S2150 **Evaluation for transplant** 99205 **Heart** 33940 33944 33945 **Heart/lung** 33930 33935 **Intestine** 44132 44133 44135 44136 S2053 **Kidney** 50300 50320 50323 50340 50360 50365 50370 50380 50547 **Kidney/Pancreas** S2065 **Liver** 47135 47143 47147 **Lung** 32850 32851 32852 32853 32854 32856 S2060 S2061 **Pancreas** 48551 48552 48554 **Services related to transplants** 32855 33933 38206 38208 38209 38210 38212 38213 38214 38215 38232* 44137

United Healthcare

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization
Transplant (continued)		44715 44720 44721 47133 47140 47141 47142 47144 47145 47146 50325 S2054 S2140 S2142 S2152 **CAR-T cell therapy** 0537T 0538T 0539T 0540T Q2041 Q2042 Q2053 Q2054 Q2055 *Code 38232 will only require prior authorization for an oncology diagnosis
Vein procedures Removal and ablation of the main trunks and named branches of the saphenous veins in the treatment of venous disease and varicose veins of the extremities	Prior authorization required	36468 36470 36471 36473 36474 36475 36476 36478 36479 37243 37700 37718 37722 37780
Ventricular assist devices (VAD) A mechanical pump that takes over the function of the damaged ventricle of the heart and restores normal blood flow	Prior authorization required	Please call the notification number on the member's ID card. Then, fax the form provided by the nurse to the Optum VAD Case Management Team at **855-282-8929**. 33927 33928 33929 33975 33976 33979 33981 33982 33983

United Healthcare

EXHIBIT C

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 8602515000	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) 849 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? _____

24113622405220000000000016

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?** $ 100,783,067.82 . **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

24113622405220000000000016

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 05/22/2024
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

24113622405220000000000016

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
Eric Goldstein, Esq., Shipman and Goodwin LLP
One Constitution Plaza

Hartford, CT, 06103
USA
Phone:
8602515000
Phone 2:
Fax:
Email:
egoldstein@goodwin.com

Has Supporting Documentation:
Yes, supporting documentation successfully uploaded
Related Document Statement:

Has Related Claim:
Yes
Related Claim Filed By:

Filing Party:
Creditor

Other Names Used with Debtor:

Amends Claim:
Yes - 849, 4/12/2024
Acquired Claim:
No

Basis of Claim:
See attachment

Last 4 Digits:
No

Uniform Claim Identifier:

Total Amount of Claim:
100,783,067.82

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 22-May-2024 9:43:39 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 SECOND AMENDED 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. United also provides health insurance benefits to members under Medicare Advantage plans, as well as to members under managed Medicaid programs in certain states.

[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.

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 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 (as defined in the PPA) to United's members, in exchange for certain fees.

12. Pursuant to the PPA, the charge amount set forth on each claim the Debtor submits to United is not to exceed the fee the Debtor ordinarily would charge another person regardless of whether the person is one of United's members (the "Customary Charge"). PPA, §§ 1.3, 2.1(vi); *see id.* at Payment Appendix. In every claim the Debtor submits to United, the Debtor represents and warrants that the charge amount set forth on the claim is the Customary Charge. *Id.* § 2.1(vi). Thus, notwithstanding any specific rate set forth in a fee schedule, the charge amount set forth on each claim the Debtor submits to United is not to exceed the Customary Charge. *Id.* §§ 1.3, 2.1(vi); *see id.* at Payment Appendix.

13. In addition, 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. *Id.* § 6.1. In particular, all claims submitted under the PPA must use Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS") procedure codes, with

[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.

modifiers 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. *Id.* at Payment Appendix. The Debtor is required to accurately describe the services provided in its claims. *See generally, e.g.*, UnitedHealthcare Commercial Reimbursement Policy, Molecular Pathology Policy, Professional, Policy No. 2021R6009B (Apr. 1, 2021).

14. 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. *See, e.g.*, UnitedHealthcare Commercial Advance Notification Prior Authorization Requirements (effective May 1, 2022) (requiring prior authorization/ notification for genetic and molecular testing to include BRCA1/2 gene testing, and noting "[p]ayment will be authorized for those CPT codes registered with the Genetic and Molecular Testing Prior Authorization/Notification Program for each specified genetic test").

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

16. 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. *See, e.g.*, PPA, § 6.5.

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[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.

17. Pursuant to the PPA, the Debtor must repay any overpayments within 30 days of written or electronic notice of the overpayment. *Id.* § 6.10. Further, the PPA provides that recovery of overpayments may be accomplished by offsets against future payments. *Id.*

C. United's Overpayments to the Debtor

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

18. 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 Ariz. Health Care Cost Containment Sys. v. Ctrs. 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").

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

20. 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 testing that the Debtor would be performing. Such knowing misrepresentation of services is a violation of the Debtor's obligations under the PPA. *See, e.g.*, PPA, § 2.1(vi); 2023 Comm. & Medicare Guide, at 24, 156.

21. 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]

22. The misrepresentations within the 81162 Probe Sample all concern the Debtor performing and billing for a different test than was authorized. (*See* Ex. A, at 1–3.) 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

[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.

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.

23. 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. (*See* Ex. A, at 3–5.) By way of illustration, for at least nine of the unsupported claims, United automatically approved a single gene test 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. 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.

24. 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	$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

25. 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

26. 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 codes 81162 and 81479 with dates of service within the Review Period.[10]

27. Of the foregoing overpayment amounts, an aggregate $7,174.20 is attributable to dates of service prior to the effective date of the PPA (the "Pre-PPA Overpayment Amounts"). United is not seeking recovery of such amounts.

28. In sum, United overpaid the Debtor no less than an aggregate $38,047,169.79 (the "Review Overpayment") for claim lines for CPT codes 81162 and 81479 with dates of service from January 1, 2017 through February 6, 2023.[11] 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

29. 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 services were provided after the member's insurance coverage was

[10] United has received appropriate state regulatory approval to pursue overpayments on behalf of individual state Medicaid programs from the following states: California, Florida, New Jersey, New York, Ohio, Tennessee, Texas, Washington, and Wisconsin. United reserves its right to further amend this claim upon receipt of appropriate state regulatory approval to pursue overpayments from additional states.

[11] *See, e.g.*, *Ratanasen v. State of Cal., Dep't of Health Servs.*, 11 F.3d 1467, 1470–71 (9th Cir. 1993) (rejecting provider's challenge to California Department of Health Services' use of sampling and extrapolation to establish overpayment claim in bankruptcy action); *United States v. Fadul*, No. CIV.A. DKC 11-0385, 2013 WL 781614, at *14 (D. Md. Feb. 28, 2013) ("Courts have routinely endorsed sampling and extrapolation as a viable method of proving damages in cases involving Medicare and Medicaid overpayments where a claim-by-claim review is not practical.").

terminated; (v) the claim was allowed in an incorrect amount under the contract; (vi) the services were not covered when billed with an invalid diagnosis code; or (vii) a corrected bill was submitted.

30. 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**.[12]

3. Overpayments for Charges Exceeding the Customary Charge

31. In violation of the PPA, United has learned that the Debtor has habitually submitted claims with charge amounts far in excess of the Customary Charge. For example, the vast majority of claims that the Debtor has submitted to United for hereditary cancer panel tests had charge amounts ranging from $1,500 to $6,000 while, at the same time, the Debtor has apparently offered patients a "cash price" as low as $250 for the exact same service.

32. Similarly, the vast majority of claims that the Debtor has submitted to United for carrier screenings had charge amounts ranging from $1,500 to $7,500, notwithstanding the fact that the Debtor has apparently offered patients a "cash price" as low as $250 for the first patient and $100 for such patient's reproductive partner, for the same service.

33. Thus, the Debtor routinely violated the PPA by charging United more than the Customary Charge for the same service. Indeed, as noted above, the Debtor has charged United between four and in some instances as much as thirty times more than it charged other persons. The exceptionally inflated amounts the Debtor has charged United were inherently unreasonable.

[12] 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.

34. Based on United's investigation to date, and excluding any Medicaid claims where United has not received appropriate regulatory approval to pursue overpayments, United has overpaid the Debtor by $91,251,580.15 (the "Preliminary Customary Charge Overpayment") under the PPA as a result of the Debtor submitting claims to United with charge amounts in excess of the Customary Charge. These overpayments were made across 76 different CPT codes and an aggregate 121,483 claim lines.

35. With respect to the Preliminary Customary Charge Overpayment, attached hereto as **Exhibit C** is a chart identifying:

- each CPT code for which United paid to Invitae an amount in excess of the Customary Charge;
- the Customary Charge for each CPT code;[13]
- the aggregate number of claim lines where each CPT code was overpaid; and
- the aggregate amount by which the Debtor was overpaid for each CPT code.

36. The vast majority of the Preliminary Customary Charge Overpayment is attributable to overpayments on claim lines for CPT code 81162 ($40,515,128.54) and CPT code 81479 ($38,155,720.85). However, as described above in Part I(C)(1), many of those claim lines should not have been paid at all and United is seeking recovery of those payments as part of the Review Overpayment. As such, the Preliminary Customary Charge Overpayment must be supplemented by the amounts attributable to those claim lines of CPT codes 81162 and 81479 that should not have been paid at all.

[13] Upon information and belief, for certain CPT codes where the Customary Charge otherwise was $250, the Debtor offered a "cash price" of $450 if the testing performed was for pediatric diagnostic testing or for prenatal diagnostic testing. Therefore, in calculating the Preliminary Customary Charge Overpayment and the Customary Charge/Review Overpayment (defined below), for any CPT code where the Customary Charge otherwise was $250, United made an assumption in favor of the Debtor that the Customary Charge was $450 when (i) the patient was under 18 years of age on the date of service, or (ii) the primary diagnosis indicated that the patient was pregnant.

37. The calculation of the additional amounts attributable to claim lines that should not have been paid at all is as follows, for each of CPT codes 81162 and 81479: (i) *first*, identify the number of claim lines with a date of service between January 1, 2017 and February 6, 2023, inclusive, where United paid to Invitae an amount in excess of the Customary Charge; (ii) *second*, multiply the foregoing number of claim lines by the aberrancy rate identified in United's review of the Probe Sample Claims; (iii) *third*, multiply the total from (ii) by the Customary Charge applicable to such claim lines, and (iv) *fourth*, deduct the amounts attributable to Medicaid claim lines where United has not yet received appropriate regulatory approval to pursue such overpayments (i.e., deduct the product of multiplying the number of Medicaid claim lines where United paid in excess of the Customary Charge in states where United has not yet received regulatory approval to pursue overpayments by the aberrancy rate and by the Customary Charge for such claim lines).[14] This calculation for each of CPT codes 81162 and 81479 is summarized in the below chart.

CPT Code	**81479**		**81162**	
Number of Claim Lines Where United Paid in Excess of the Customary Charge for Dates of Service 1/1/17 through 2/6/23	6,489	24,260	39	53,380
Aberrancy Rate	48.08%	48.08%	45.45%	45.45%
Customary Charge	$250.00	$450.00	$250.00	$450.00
SUBTOTAL ("Suppl. Review Overpayment")	$779,977.80	$2,916,052.00	$4,431.38	$6,065,302.50

[14] United reserves its right to further amend this claim to include additional amounts for Medicaid claims once it receives appropriate regulatory approval to pursue overpayment recoveries from such state.

Number of Medicaid Claim Lines Comprising Suppl. Review Overpayment Where United Has Not Yet Received Regulatory Approval[15]	514	600	0	1214
Amount of Suppl. Review Overpayment Attributable to Medicaid Claim Lines Where United Has Not Yet Received Regulatory Approval	$111,209.04	$72,120.00	$-	$137,940.75
SUBTOTAL BY CUSTOMARY CHARGE	$668,768.76	$2,843,932.00	$4,431.38	$5,927,361.75
TOTAL	**$3,512,700.76**		**$5,931,793.13**	

38. The additional amounts attributable to those claim lines of CPT codes 81162 and 81479 that should not have been paid at all—$3,512,700.76 and $5,931,793.13, respectively—must therefore be added to the Preliminary Customary Charge Overpayment of $91,251,580.15 to arrive at a total overpayment of $100,696,074.04 (the "Customary Charge/Review Overpayment").

39. United's claim for that portion of the Customary Charge/Review Overpayment attributable to those claim lines of CPT codes 81162 and 81479 that should not have been paid at all is in the alternative to United's demand for the Review Overpayment.

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

40. 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.

[15] This excludes Medicaid claims for all states other than California, Florida, New Jersey, New York, Ohio, Tennessee, Texas, Washington, and Wisconsin.

41. On April 12, 2024, United filed a proof of claim in the amount of $36,780,598.87 (Claim No. 830) (the "Original Claim"). Immediately after filing the Original Claim, United identified a typographical error, and, as a result, United also filed on April 12, 2024 an amended proof of claim in the amount of $36,780,598.87 (Claim No. 849) (the "First Amended Claim").

42. Since filing the First Amended Claim,[16] United has identified additional pre-petition amounts due and owing to it under the PPA as a result of the Debtor submitting claims with charge amounts far in excess of the Customary Charge. Moreover, United is amending the First Amended Claim to remove the Pre-PPA Overpayment Amounts.

43. Accordingly, this Second Amended Proof of Claim is hereby filed in the Debtor's bankruptcy case in the amount of $100,783,067.82 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, which is an alternative basis for recovery if the Customary Charge/Review Overpayment is not allowed in full;

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

[16] In the First Amended Claim, United expressly asserted a claim that includes "any and all other amounts now owing or hereafter accrued and owing to United, regardless of whether such amounts are unliquidated, and/or contingent, and/or unmatured, including but not limited to, those amounts due to United under the PPA and/or a United health insurance plan." Claims Reg., Claim No. 849, at Attachment ¶ 34(c). Consistent therewith, United further reserved the right to amend or supplement the First Amended Claim to, *inter alia*, restate liquidated and unliquidated components of the claim, update the total estimated exposure with respect to any unliquidated claims, reflect additional claims owed to United to the extent discovered after the filing of such claims, or for any other reason it deems appropriate. *Id.* at Attachment ¶ 42.

c. $100,696,074.04 for the Customary Charge/Review Overpayment under the PPA, as more particularly described in Section I(C)(3) above (with that portion of the Customary Charge/Review Overpayment attributable to those claim lines of CPT codes 81162 and 81479 that should not have been paid at all in the alternative to the Review Overpayment); and

d. any and all other amounts now owing or hereafter accrued and owing to United, regardless of whether such amounts are unliquidated, and/or contingent, and/or unmatured, including but not limited to, those amounts due to United under the PPA and/or a United health insurance plan.

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

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

46. 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).

47. 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.

48. 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).

49. 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.

50. 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).

51. 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.

52. 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.

53. 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.

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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	

EXHIBIT C

CPT Code	CPT Code Description	Invitae Corporation's Customary Charge	Number of Claim Lines Overpaid	United's Aggregate Overpayments
81162	BRCA1&2 GEN FULL SEQ DUP/DEL	$250, except pediatric and prenatal $450	52,348	$ 40,515,128.54
81163	BRCA1&2 GENE FULL SEQ ALYS	$250, except pediatric and prenatal $450	2	$ 1,171.22
81165	BRCA1 GENE FULL SEQ ALYS	$250, except pediatric and prenatal $450	2	$ 700.00
81167	BRCA2 GENE FULL DUP/DEL ALYS	$250, except pediatric and prenatal $450	1	$ 1,225.00
81170	ABL1 GENE	$250, except pediatric and prenatal $450	6	$ 1,450.28
81173	AR GENE FULL GENE SEQUENCE	$250, except pediatric and prenatal $450	2	$ 2,150.00
81175	ASXL1 FULL GENE SEQUENCE	$250, except pediatric and prenatal $450	1	$ 20.60
81185	CACNA1A GENE FULL GENE SEQ	$250, except pediatric and prenatal $450	3	$ 1,416.91
81201	APC GENE FULL SEQUENCE	$250, except pediatric and prenatal $450	82	$ 22,514.46
81203	APC GENE DUP/DELET VARIANTS	$250, except pediatric and prenatal $450	2	$ 700.00
81205	BCKDHB GENE	$250, except pediatric and prenatal $450	17	$ 1,981.26
81211	BRCA1&2 SEQ & COM DUP/DEL	$250, except pediatric and prenatal $450	75	$ 47,804.57
81216	BRCA2 GENE FULL SEQ ALYS	$250, except pediatric and prenatal $450	1	$ 1,250.00
81217	BRCA2 GENE KNOWN FAMIL VRNT	$ 200.00	3	$ 19.17
81220	CFTR GENE COM VARIANTS	$250, except pediatric and prenatal $450	1,453	$ 981,045.30
81222	CFTR GENE DUP/DELET VARIANTS	$250, except pediatric and prenatal $450	4	$ 1,550.00
81223	CFTR GENE FULL SEQUENCE	$250, except pediatric and prenatal $450	39	$ 16,089.52
81225	CYP2C19 GENE COM VARIANTS	$250, except pediatric and prenatal $450	3	$ 453.60
81226	CYP2D6 GENE COM VARIANTS	$250, except pediatric and prenatal $450	1	$ 382.00
81229	CYTOG ALYS CHRML ABNR SNPCGH	$ 450.00	1,708	$ 1,594,143.20
81233	BTK GENE COMMON VARIANTS	$250, except pediatric and prenatal $450	2	$ 485.20
81236	EZH2 GENE FULL GENE SEQUENCE	$250, except pediatric and prenatal $450	5	$ 350.00
81238	F9 FULL GENE SEQUENCE	$250, except pediatric and prenatal $450	1	$ 1,250.00

81243	FMR1 GEN ALY DETC ABNL ALLEL	$250, except pediatric and prenatal $450	1	$	650.00
81252	GJB2 GENE FULL SEQUENCE	$250, except pediatric and prenatal $450	2	$	2,500.00
81254	GJB6 GENE COM VARIANTS	$250, except pediatric and prenatal $450	1	$	1,250.00
81255	HEXA GENE	$250, except pediatric and prenatal $450	1	$	201.97
81257	HBA1/HBA2 GENE	$250, except pediatric and prenatal $450	16	$	4,308.61
81272	KIT GENE TARGETED SEQ ANALYS	$250, except pediatric and prenatal $450	1	$	950.00
81290	MCOLN1 GENE	$250, except pediatric and prenatal $450	3	$	2,709.07
81292	MLH1 GENE FULL SEQ	$250, except pediatric and prenatal $450	141	$	12,155.75
81295	MSH2 GENE FULL SEQ	$250, except pediatric and prenatal $450	3	$	1,082.66
81298	MSH6 GENE FULL SEQ	$250, except pediatric and prenatal $450	49	$	6,005.71
81302	MECP2 GENE FULL SEQ	$250, except pediatric and prenatal $450	3	$	95.99
81306	NUDT15 GENE COMMON VARIANTS	$250, except pediatric and prenatal $450	1	$	320.00
81307	PALB2 GENE FULL GENE SEQ	$250, except pediatric and prenatal $450	11	$	4,316.00
81317	PMS2 GENE FULL SEQ ANALYSIS	$250, except pediatric and prenatal $450	94	$	9,402.76
81320	PLCG2 GENE COMMON VARIANTS	$250, except pediatric and prenatal $450	3	$	931.08
81321	PTEN GENE FULL SEQUENCE	$250, except pediatric and prenatal $450	14	$	1,001.64
81323	PTEN GENE DUP/DELET VARIANT	$250, except pediatric and prenatal $450	1	$	30.00
81324	PMP22 GENE DUP/DELET	$250, except pediatric and prenatal $450	16	$	2,121.12
81328	SLCO1B1 GENE COM VARIANTS	$250, except pediatric and prenatal $450	1	$	320.00
81329	SMN1 GENE DOS/DELETION ALYS	$250, except pediatric and prenatal $450	2	$	356.53
81334	RUNX1 GENE TARGETED SEQ ALYS	$250, except pediatric and prenatal $450	1	$	1,225.00
81345	TERT GENE TARGETED SEQ ALYS	$250, except pediatric and prenatal $450	2	$	1,390.00
81350	UGT1A1 GENE COMMON VARIANTS	$250, except pediatric and prenatal $450	1	$	320.00

81351	TP53 GENE FULL GENE SEQUENCE	$250, except pediatric and prenatal $450	13	$	2,349.14
81355	VKORC1 GENE	$250, except pediatric and prenatal $450	1	$	320.00
81361	HBB GENE COM VARIANTS	$250, except pediatric and prenatal $450	1	$	39.97
81362	HBB GENE KNOWN FAM VARIANT	$ 200.00	1	$	400.00
81363	HBB GENE DUP/DEL VARIANTS	$250, except pediatric and prenatal $450	1	$	350.00
81364	HBB FULL GENE SEQUENCE	$250, except pediatric and prenatal $450	29	$	9,420.27
81381	HLA I TYPING 1 ALLELE HR	$250, except pediatric and prenatal $450	1	$	320.00
81402	MOPATH PROCEDURE LEVEL 3	$250, except pediatric and prenatal $450	2	$	447.28
81404	MOPATH PROCEDURE LEVEL 5	$250, except pediatric and prenatal $450	28	$	2,876.55
81405	MOPATH PROCEDURE LEVEL 6	$250, except pediatric and prenatal $450	65	$	9,578.67
81406	MOPATH PROCEDURE LEVEL 7	$250, except pediatric and prenatal $450	49	$	5,583.51
81407	MOPATH PROCEDURE LEVEL 8	$250, except pediatric and prenatal $450	148	$	25,971.12
81408	MOPATH PROCEDURE LEVEL 9	$250, except pediatric and prenatal $450	672	$	468,547.71
81410	AORTIC DYSFUNCTION/DILATION	$250, except pediatric and prenatal $450	25	$	486.54
81411	AORTIC DYSFUNCTION/DILATION	$250, except pediatric and prenatal $450	21	$	10,316.55
81413	CAR ION CHNNLPATH INC 10 GNS	$250, except pediatric and prenatal $450	19	$	17,006.38
81415	EXOME SEQUENCE ANALYSIS	$ 1,250.00	186	$	263,856.31
81416	EXOME SEQUENCE ANALYSIS	$ 1,250.00	42	$	203,519.00
81419	EPILEPSY GEN SEQ ALYS PANEL	$250, except pediatric and prenatal $450	672	$	221,478.39
81420	FETAL CHRMOML ANEUPLOIDY	$ 99.00	20,213	$	5,661,194.01
81432	HRDTRY BRST CA-RLATD DSORDRS	$250, except pediatric and prenatal $450	1,500	$	819,271.04
81433	HRDTRY BRST CA-RLATD DSORDRS	$250, except pediatric and prenatal $450	432	$	38,426.72
81434	HEREDITARY RETINAL DISORDERS	$250, except pediatric and prenatal $450	1	$	290.00
81435	HEREDITARY COLON CA DSORDRS	$250, except pediatric and prenatal $450	4,704	$	1,027,472.63
81436	HEREDITARY COLON CA DSORDRS	$250, except pediatric and prenatal $450	2,046	$	440,035.13

81439	HRDTRY CARDMYPY GENE PANEL	$250, except pediatric and prenatal $450	287	$	36,955.79
81442	NOONAN SPECTRUM DISORDERS	$250, except pediatric and prenatal $450	31	$	19,307.53
81443	GENETIC TSTG SEVERE INH COND	$250, except pediatric and prenatal $450	652	$	528,986.65
81448	HRDTRY PERPH NEURPHY PANEL	$250, except pediatric and prenatal $450	57	$	34,127.69
81479	UNLISTED MOLECULAR PATHOLOGY	$250, except pediatric and prenatal $450	33,455	$	38,155,720.85
	PRELIMINARY CUSTOMARY CHARGE OVERPAYMENT TOTALS		**121,483**	**$**	**91,251,580.15**

CERTIFICATE OF SERVICE

I hereby certify that on May 24, 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
State Attorney General	Minnesota Attorney General	Attn Bankruptcy Department	445 Minnesota St Suite 1400			St Paul	MN	55101-2131		651-296-3353		ag.replies@ag.state.mn.us
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
State Attorney General	Rhode Island Attorney General	Attn Bankruptcy Department	150 S. Main St.			Providence	RI	02903		401-274-4400	401-222-2995	ag@riag.ri.gov
State Attorney General	Tennessee Attorney General	Attn Bankruptcy Department	P.O. Box 20207			Nashville	TN	37202-0207		615-741-3491	615-741-2009	agattorneys@ag.tn.gov
State Attorney General	Georgia Attorney General	Attn Bankruptcy Department	40 Capital Square, SW			Atlanta	GA	30334-1300		404-656-3300	404-657-8733	Agcarr@law.ga.gov
Counsel to Pacific Biosciences of California, Inc.	Wilson Sonsini Goodrich & Rosati, P.C.	Alison L. Genova	1301 Avenue of the Americas, 40th Floor			New York	NY	10019		212-999-5800		agenova@wsgr.com
State Attorney General	Nevada Attorney General	Attn Bankruptcy Department	Old Supreme Ct. Bldg.	100 N. Carson St		Carson City	NV	89701		775-684-1100	775-684-1108	AgInfo@ag.nv.gov
State Attorney General	Vermont Attorney General	Attn Bankruptcy Department	109 State St.			Montpelier	VT	05609-1001		802-828-3171		ago.info@vermont.gov
Counsel to Snowflake Inc.	Nelson Mullins Riley & Scarborough LLP	Alan F. Kaufman	330 Madison Avenue, 27th Floor			New York	NY	10017		212-413-9016		alan.kaufman@nelsonmullins.com
Counsel to Laboratory Corporation of America Holdings and Labcorp Genetics. Inc.	Hogan Lovells US LLP	Allison M. Wuertz	390 Madison Avenue			New York	NY	10017		212-918-3000		allison.wuertz@hoganlovells.com
State Attorney General	South Dakota Attorney General	Attn Bankruptcy Department	1302 East Highway 14	Suite 1		Pierre	SD	57501-8501		605-773-3215	605-773-4106	atghelp@state.sd.us
State Attorney General	Kentucky Attorney General	Attn Bankruptcy Department	700 Capitol Avenue	Capitol Building, Suite 118		Frankfort	KY	40601-3449		502-696-5300		attorney.general@ag.ky.gov
State Attorney General	Missouri Attorney General	Attn Bankruptcy Department	Supreme Court Bldg	207 W. High St.	P.O. Box 899	Jefferson City	MO	65101		573-751-3321	573-751-0774	attorney.general@ago.mo.gov
State Attorney General	Alaska Attorney General	Attn Bankruptcy Department	1031 West 4th Avenue, Suite 200			Anchorage	AK	99501-1994		907-269-5100	907-276-3697	attorney.general@alaska.gov
State Attorney General	Colorado Attorney General	Attn Bankruptcy Department	Ralph L Carr Colorado Judicial Building	1300 Broadway, 10th Fl		Denver	CO	80203		720-508-6000	720-508-6030	attorney.general@coag.gov
State Attorney General	Connecticut Attorney General	Attn Bankruptcy Department	165 Capitol Avenue			Hartford	CT	06106		860-808-5318	860-808-5387	attorney.general@ct.gov
State Attorney General	Maine Attorney General	Attn Bankruptcy Department	6 State House Station			Augusta	ME	04333		207-626-8800		attorney.general@maine.gov
State Attorney General	Delaware Attorney General	Attn Bankruptcy Department	Carvel State Office Bldg.	820 N. French St.		Wilmington	DE	19801		302-577-8338		attorney.general@state.de.us
State Attorney General	New Hampshire Attorney General	Attn Bankruptcy Department	33 Capitol St.			Concord	NH	03301		603-271-3658	603-271-2110	attorneygeneral@doj.nh.gov
State Attorney General	Oregon Attorney General	Attn Bankruptcy Department	1162 Court St. NE			Salem	OR	97301-4096		503-378-4400	503-378-4017	AttorneyGeneral@doj.state.or.us; Lisa.Udland@doj.state.or.us
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
State Attorney General	Utah Attorney General	Attn Bankruptcy Department	Utah State Capitol Complex	350 North State Street, Suite 230		Salt Lake City	UT	84114-2320		801-538-9600	801-538-1121	bankruptcy@agutah.gov
State Attorney General	South Carolina Attorney General	Attn Bankruptcy Department	P.O. Box 11549			Columbia	SC	29211		803-734-3970	803-253-6283	bankruptcy@scag.gov
State Attorney General	Illinois Attorney General	Attn Bankruptcy Department	James R. Thompson Ctr	100 W. Randolph St.		Chicago	IL	60601		312-814-3000		bankruptcy_notices@ilag.gov
SEC Regional Office	Securities & Exchange Commission	NY Regional Office	Regional Director	100 Pearl St., Suite 20-100		New York	NY	10004-2616		212-336-1100	212-336-1320	bankruptcynoticeschr@sec.gov; nyrobankruptcy@sec.gov
State Attorney General	Texas Attorney General	Attn Bankruptcy Department	300 W. 15th St			Austin	TX	78701		512-463-2100	512-475-2994	bankruptcytax@oag.texas.gov; communications@oag.texas.gov
State Attorney General	Arizona Attorney General - CSS	Attn Bankruptcy Department	PO Box 6123	MD 7611		Phoenix	AZ	85005-6123				BCEIntake@azag.gov
Counsel to Workday, Inc.	Perkins Coie LLP	Bradley A. Cosman	2525 E. Camelback Road	Suite 500		Phoenix	AZ	85016-4227		602-351-8205	602-648-7000	BCosman@perkinscoie.com
Counsel to the Required Holders and Deerfield Partners, L.P	Sullivan & Cromwell	c/o Ari Blaut, Ben Beller, James L. Bromley, David M. Rosenthal	125 Broad Street			New York	NY	10004-2498		212-558-1656; 212-558-3334		blauta@sullcrom.com; bellerb@sullcrom.com; bromleyj@sullcrom.com; rosenthald@sullcrom.com
Counsel to Thermo Fisher Scientific Entities (Thermo Fisher Scientific, Inc., Life Technologies Corporation, Life Technologies AS, and Thermo FisherScientific Baltics UAB)	Tucker Arensberg, P.C.	Beverly Weiss Manne, Maribeth Thomas	1500 One PPG Place			Pittsburgh	PA	15222		412-566-1212	412-594-5619	bmanne@tuckerlaw.com; mthomas@tuckerlaw.com

Master Service List

Description	CreditorName	CreditorNoticeName	Address1	Address2	Address3	City	State	Zip	Country	Phone	Fax	Email
Top 30 Creditor and Official Committee of Unsecured Creditors	Workday, Inc.	Carlos Garcia	6110 Stoneridge Mall Road			Pleasanton	CA	94588		365-258-2619		carlos.garcia@workday.com; accounts.receivable@workday.com
State Attorney General	Florida Attorney General	Attn Bankruptcy Department	PL-01 The Capitol			Tallahassee	FL	32399-1050		850-414-3300	850-487-2564	citizenservices@myfloridalegal.com; oag.civil.eserve@myfloridalegal.com
State Attorney General	Guam Attorney General	Attn Bankruptcy Department	ITC Bldg	590 S Marine Corps Dr, Suite 901		Tamuning	Guam	96913		671-475-3324 x5200; 671-475-2710	671-477-4703; 671-472-2493	civillitigation@oagguam.org
Counsel to Page Sorensen	Law Offices of Claire Cochran, P.C.	Claire Cochran	100 Pine Street, Suite 1250			San Francisco	CA	94111				Claire@clairecochranlegal.com
State Attorney General	West Virginia Attorney General	Attn Bankruptcy Department	State Capitol Bldg 1 Rm E-26	1900 Kanawha Blvd., East		Charleston	WV	25305		304-558-2021	304-558-0140	consumer@wvago.gov
State Attorney General	Alabama Attorney General	Attn Bankruptcy Department	501 Washington Ave	PO Box 300152		Montgomery	AL	36104-0152		334-242-7300		consumerinterest@Alabamaag.gov
State Attorney General	Oklahoma Attorney General	Attn Bankruptcy Department	313 NE 21st St			Oklahoma City	OK	73105		405-521-3921	405-521-6246	ConsumerProtection@oag.ok.gov
State Attorney General	Montana Attorney General	Attn Bankruptcy Department	Justice Bldg	215 N. Sanders 3rd Fl	PO Box 201401	Helena	MT	59620-1401		406-444-2026	406-444-3549	contactocp@mt.gov
Counsel to Thermo Fisher Scientific Entities (Thermo Fisher Scientific, Inc., Life Technologies Corporation, Life Technologies AS, and Thermo FisherScientific Baltics UAB)	Turner Law Firm, LLC	Andrew R. Turner	76 South Orange Avenue - Suite 306			South Orange	NJ	07079		973-763-5000	973-763-0568	courts@turnerlaw.net; aturner@turnerlaw.net
Co-Counsel to the Official Committee of Unsecured Creditors	White & Case LLP	J. Christopher Shore, Harrison Denman, Andrew Zatz, Samuel P. Hershey, Ashley Chase, Brett Bakemeyer	1221 Avenue of the Americas			New York	NY	10020		212-819-8200		cshore@whitecase.com; harrison.denman@whitecase.com; azatz@whitecase.com; sam.hershey@whitecase.com; ashley.chase@whitecase.com; brett.bakemeyer@whitecase.com
Counsel to EPAM Systems, Inc	McGuireWoods LLP	Connor W. Symons	800 East Canal Street			Richmond	VA	23219-3916				csymons@mcguirewoods.com
Co-Counsel to Natera Inc.	McDermott Will & Emery LLP	Darren Azman, Deanna D. Boll	One Vanderbilt Avenue			New York	NY	10017-3852		212-547-5400		dazman@mwe.com; dboll@mwe.com
State Attorney General	Wisconsin Attorney General	Attn Bankruptcy Department	Wisconsin Dept. of Justice	114 East, State Capitol	PO Box 7857	Madison	WI	53707-7857		608-266-1221	608-294-2907	dojbankruptcynoticegroup@doj.state.wi.us
Counsel to Pacific Biosciences of California, Inc.	Wilson Sonsini Goodrich & Rosati, P.C.	Erin R. Fay, Catherine Lyons, Lynzy McGee	222 Delaware Avenue, Suite 800			Wilmington	DE	19801		302-304-7600		efay@wsgr.com; clyons@wsgr.com; lmcgee@wsgr.com
Counsel to Vaco LLC	Bradley Arant Boult Cummings LLP	Elisha J. Kobre	1445 Ross Avenue, Suite 3600			Dallas	TX	75202		214-257-9785	214-939-8787	ekobre@bradley.com
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
Official Committee of Unsecured Creditors	Workday, Inc.	Attn Erin Anderegg	6110 Stoneridge Mall Road			Pleasanton	CA	94588		602-373-3082		Erin.Anderegg@workday.com
State Attorney General	Louisiana Attorney General	Attn Bankruptcy Department	PO Box Box 94005			Baton Rouge	LA	70804		225-326-6079; 225-326-6000	225-326-6797; 225-326-6096	Executive@ag.louisiana.gov; ConstituentServices@ag.louisiana.gov
State Attorney General	Puerto Rico Attorney General		PO Box 9020192			San Juan	PR	00902-0192		787-721-2900, Ext. 1502, 1503		fernando.figueroa@justicia.pr.gov
Counsel to Snowflake Inc.	Nelson Mullins Riley & Scarborough LLP	Gregory A. Taube, Adam D. Herring	201 17th Street NW, Suite 1700			Atlanta	GA	30363		404-322-6143		greg.taube@nelsonmullins.com; adam.herring@nelsonmullins.com
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Counsel to the 2028 Convertible Noteholders	White & Case	c/o Harrison Denman & Chris Shore	1221 Avenue of the Americas			New York	NY	10020-1095		212-819-2567; 212-819-8394		hdenman@whitecase.com; cshore@whitecase.com
State Attorney General	New Jersey Attorney General	Attn Bankruptcy Department	Richard J. Hughes Justice Complex	25 Market St	PO Box 080	Trenton	NJ	08625-0080		609-292-8740	609-292-3508	Heather.Anderson@law.njoag.gov; NJAG.ElectronicService.CivilMatters@law.njoag.gov
Counsel to MassMutual Asset Finance LLC	Gellert Scali Busenkell & Brown, LLC	Holly Smith Miller	901 Market Street, Suite 3020, 3rd Floor			Philadelphia	PA	19107		215-238-0012		hsmith@gsbblaw.com
State Attorney General	Iowa Attorney General	Attn Bankruptcy Department	Hoover State Office Bldg	1305 E. Walnut Street		Des Moines	IA	50319		515-281-5164	515-281-4209	IDR.Bankruptcy@ag.iowa.gov
State Attorney General	Indiana Attorney General	Attn Bankruptcy Department	Indiana Govt Center South	302 West Washington St 5th Fl		Indianapolis	IN	46204		317-232-6201	317-232-7979	info@atg.in.gov
State Attorney General	Pennsylvania Attorney General	Attn Bankruptcy Department	16th Floor, Strawberry Square			Harrisburg	PA	17120		717-787-3391	717-787-8242	info@attorneygeneral.gov
State Attorney General	Virgin Islands Attorney General	Attn Bankruptcy Department	34-38 Kronprindsens Gade	GERS Bldg 2nd Fl		St. Thomas	VI	00802		340-774-5666 ext. 107		info@usvidoj.com
Claims and Noticing Agent	KCC	Leanne Rehder Scott	222 N. Pacific Coast Highway, Suite 300			El Segundo	CA	90245				InvitaeInfo@kccllc.com
Co-Counsel to CSC Leasing Co.	Woods Rogers Vandeventer Black PLC	James K. Donaldson	901 East Byrd Street, Suite 1600			Richmond	VA	23219		804-343-5028	804-325-4391	jed.donaldson@wrvblaw.com

Master Service List

Description	CreditorName	CreditorNoticeName	Address1	Address2	Address3	City	State	Zip	Country	Phone	Fax	Email
Counsel to Wilmington Savings Fund Society, FSB	ArentFox Schiff LLP	Jeffrey R. Gleit, Brett D. Goodman, Nicholas A. Marten	1301 Avenue of the Americas, 42nd Floor			New York	NY	10019		212-484-3900		Jeffrey.Gleit@afslaw.com; Brett.Goodman@afslaw.com; Nicholas.Marten@afslaw.com
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
Counsel to the Required Holders and Deerfield Partners, L.P	Wollmuth Maher & Deutsch LLP	James Lawlor, Joseph F. Pacelli, Nicholas A. Servider	500 Fifth Avenue, 12th Floor			New York	NY	10110		212-382-3300	212-382-0050	JLawlor@WMD-LAW.com; JPacelli@WMD-LAW.com; nservider@wmd-law.com
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