

Fill in this information to identify the case:

Debtor 1 COMPANION DX REFERENCE LAB, LLC

Debtor 2 _____
(Spouse, if filing)

United States Bankruptcy Court for the: Southern District of Texas

Case number 16-33427

Official Form 410

Proof of Claim

04/16

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 of 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? U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Name of the current creditor (the person or entity to be paid for this claim)

Other names the creditor used with the debtor CENTERS FOR MEDICARE & MEDICAID SERVICES

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

3. Where should notices and payments to the creditor be sent? **Where should notices to the creditor be sent?** **Where should payments to the creditor be sent? (if different)**

Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

Name Charlotte Foster, Assoc Regional Administrator Name _____

Number 150 S. Independence Mall West, Suite 216 Number _____ Street _____ Street _____

City Philadelphia State PA ZIP Code 19106 City _____ State _____ ZIP Code _____

Contact phone 215-861-4219 Contact phone _____

Contact email charlotte.foster@cms.hhs.gov Contact email _____

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

4. Does this claim amend one already filed? No
 Yes. Claim number on court claims registry (if known) _____ Filed on _____
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? _____

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: 1 2 0 1

7. How much is the claim? \$ 16,258,280.01 . 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.
 Medicare Overpayments (see attached)

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

Nature of property:

Real estate. If the claim is secured by the debtor's principal 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 amounts 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: _____

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.

- No
 Yes. Check one:

- Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).
- Up to \$2,850* 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 \$12,850*) 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.

Amount entitled to priority

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

* Amounts are subject to adjustment on 4/01/19 and every 3 years after that for cases begun on or after the date of adjustment.

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:

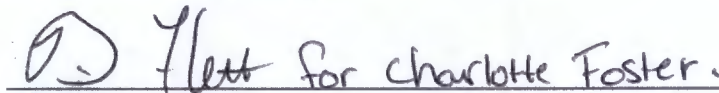
- I am the creditor.
- I am the creditor's attorney or authorized agent.
- I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
- I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment 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 a 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 01/06/2017
MM / DD / YYYY


 Signature

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

Name Charlotte G. Foster
First name Middle name Last name

Title Associate Regional Administrator

Company U.S Department of Health and Human Services
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address 150 S. Independence Mall West, Suite 216
Number Street

Philadelphia PA 19106
City State ZIP Code

Contact phone 215-861-4219 Email charlotte.foster@cms.hhs.gov

Region:
Contract Number: 04412000000 04412000000
Workload: 04412 04412-JH B
Debtor Type: 69
Work Load-Customer Number: 04412-CL1201-1003180027
Customer Name: 04412-CL1201-1003180027-COMPANION DX REFERENCE LAB L

Receivables Balance Summary Report
As of GL Date : 05-JAN-2017

Report Date:05-JAN-17 09:31 AM
Page:1 of 5

Table with columns: AR Number, Age of AR, Original DCN#, Trx. Type, Reas Code, Disc Code, DTM Date, Cost RPT FYE Date, Original Amount, Creation Date, Interest Accrued To Date, Recoupment Amount, Receipt Amount, Last Collection Date, Last Adjusted Amount, Last Activity Date, Current Balance, P/I Due, AR Status Code, N I C. Contains multiple rows of transaction data.

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Account	Age	Original	Trx.	Reas	Disc	DTM	Cost	RPT	Original	Creation	Interest	Recoupment	Receipt	Last	Last	Current	P/I	Status	N
Number	AR	DCN#	Type	Code	Code	Date	FYE	Date	Amount	Date	To Date	Amount	Amount	Collection	Activity	Balance	Due	Code	C
455716132 7 296090CNX		22992924	XXDM- INTERES T			27MAY16			1.14		28DEC16					1.14			BNK
455716132 7 296040CNX		22992925	XXDM- INTERES T			27MAY16			1.14		28DEC16					1.14			BNK
455716132 7 296140CNX		22992926	XXDM- INTERES T			27MAY16			1.14		28DEC16					1.14			BNK
455716132 7 296100CNX		22992927	XXDM- INTERES T			27MAY16			1.14		28DEC16					1.14			BNK
455716132 223 296020CN		45221522 6622650	XBPROV- MR- CLAIM- 935 T	T	N	27MAY16			209.74		04JAN17					209.74			BNK
455716132 183 296020IC		21242818	XDM- INTERES T			27MAY16			8.75		04JAN17					8.75			BNK

Region: Receivables Balance Summary Report Report Date: 05-JAN-17 09:31 AM
 Contract Number: 04412000000 04412000000 As of GL Date : 05-JAN-2017 Page: 4 of 5
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----- Transactions ----- Activities -----

AR Number	Age of AR	Original DCN#	Trx. Type	Reas Code	Disc Code	DTM Date	Cost FYE	RPT Date	Original Amount	Creation Date	Interest To Date	Recoupment Amount	Receipt Amount	Last Collection Date	Last Activity Date	Current Balance	P/I Due	Status Code	N C
455716132 223 296110CN		45281523 1142430	XBPROV- MR- CLAIM- 935 T	T	N	27MAY16			285.25	04JAN17						285.25			BNK
455716132 183 296110IC		21242819	XDM- INTERES T			27MAY16			11.90	04JAN17	11.90					11.90			BNK
455716132 223 296030CN		45281523 1142400	XBPROV- MR- CLAIM- 935 T	T	N	27MAY16			285.25	04JAN17						285.25			BNK
455716132 183 296030IC		21242825	XDM- INTERES T			27MAY16			11.90	04JAN17	11.90					11.90			BNK
455716132 223 296080CN		45221522 5919710	XBPROV- MR- CLAIM- 935 T	T	N	27MAY16			285.25	04JAN17						285.25			BNK
455716132 183 296080IC		21242826	XDM- INTERES T			27MAY16			11.90	04JAN17	11.90					11.90			BNK
455716132 223 296060CN		45281523 1142310	XBPROV- MR- CLAIM- 935 T	T	N	27MAY16			285.25	04JAN17						285.25			BNK
455716132 183 296060IC		21242827	XDM- INTERES T			27MAY16			11.90	04JAN17	11.90					11.90			BNK

Region: Receivables Balance Summary Report Report Date: 05-JAN-17 09:31 AM
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 Customer Name: 04412-CL1201-1003180027-COMPANION DX REFERENCE LAB L

04412-CL1201-1003180027-C	Item Count:	34	TOTAL:	14,943,529.90	1,324,457.66	9,592.00	0.00	120,384.81	16,258,280.01
69	Item Count:	34	TOTAL:	14,943,529.90	1,324,457.66	9,592.00	0.00	120,384.81	16,258,280.01
04412-JH B	Item Count:	34	TOTAL:	14,943,529.90	1,324,457.66	9,592.00	0.00	120,384.81	16,258,280.01
Report	Item count:	34	TOTAL:	14,943,529.90	1,324,457.66	9,592.00	0.00	120,384.81	16,258,280.01



MEDICARE
A Medicare Contractor

Letter Number: 20027731

Date: 01/26/2016

COMPANION DX REFERENCE LAB L
DEPARTMENT 1400
P O BOX 1144
HOUSTON, TX 772511144

FIRST REQUEST

RE : MMA 935 - Overpayment Amount
Provider Name: COMPANION DX REFERENCE LAB L
Provider Number: 1003180027
Outstanding Balance: \$14,816,591.93

Dear Sir/Madam,

This is to inform you that you have received a Medicare payment in error which has resulted in an overpayment of \$14,816,591.93. This amount is subject to Section 935(f)(2) of the Medicare Modernization Act (MMA) (Section 1893(f)(2) of the Social Security Act), Limitation on Recoupment. The purpose of our letter is to request that this amount be repaid to our office. The attached listing explains how this happened.

Why you are responsible:

You are responsible for being aware of correct claim filing procedures. In this situation, you billed and/or received payment for services you should have known you were not entitled to. Therefore, you are not without fault and are responsible for repaying the overpayment amount. If you dispute this determination please follow the appropriate appeals process listed below. Applicable authorities: Section 1870(b)(c) of the Social Security Act; Subsections 405.350 - 405.359 of Title 42 CFR, Subsections 404.506 - 404.509, 404.510a and 404.512 of Title 20 of the United States Code of Federal Regulations and 20 CFR.

What you should do:

Please return the overpaid amount to us by 02/24/2016 and no interest charge will be assessed.

We request that you refund this amount in full. If you are unable to make refund of the entire

Novitas Solutions, Inc.
PO Box 3063, Mechanicsburg, PA 17055-1806
www.novitas-solutions.com

amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan (where one is approved) would run from the date of this letter.

Make the check payable to Medicare Part B and send it with **a copy of this letter** to:

Novitas Solutions, Inc.
ATTN: Cashier
PO Box 3106
Mechanicsburg, PA 17055-1822

You may elect to have your overpayment(s) repaid through the immediate recoupment process and avoid paying by check or waiting for the standard recoupment process that begins on day 41 from date of the initial demand letter. A request for immediate recoupment must be received in writing no later than the 16th day from the date of initial demand letter. You must specify whether you are submitting:

1. A one-time request for the current overpayment and all future overpayments, or
2. A request for the current overpayment addressed in this demand letter only.

This process is voluntary and for your convenience. Your request must specifically state you understand you are waiving potential receipt of interest payment pursuant to Section 1893(f)(2) for the overpayments. Note: Such interest may be payable for certain overpayments reversed at the Administrative Law Judge (ALJ) level or subsequent levels of appeal.

Visit our website at www.novitas-solutions.com for additional information and instructions for **Immediate Recoupment**.

You may fax your request to the number mentioned at the end of this letter.

Payment Withholding:

If payment in full is not received by 02/24/2016, payments to you can be withheld (Recoupment) until payment in full is received or if you have not submitted an acceptable extended repayment request and/or a valid and timely appeal is received.

Please complete an extended repayment schedule (ERS) package if you are unable to make full payment at this time, and would like to request an ERS. Details for completing the ERS package are included on our Website at www.novitas-solutions.com. If you would like to receive an ERS package by mail, please call the telephone number listed at the end of this letter.

Rebuttal Process:

Under our existing regulations 42 CFR section 405.374, Providers and other Suppliers will have 15 days from the date of this demand letter to submit a statement of opportunity to rebuttal. The rebuttal process provides the debtor the opportunity to submit a statement and/or evidence stating why recoupment should not be initiated. The outcome of the rebuttal process could change how or if we recoup. If you have reason to believe the withhold should not occur on **03/06/2016**, you must notify this office before **02/09/2016**. We will review your documentation. Our office will advise you of our decision in 15 days from receipt of your request. However, this is not an appeal of the overpayment determination, and it will not delay recoupment before a rebuttal response has been rendered.

The rebuttal statement does not cease recoupment activities consistent with section 935 of the MMA.

How to Stop Recoupment:

Even if the overpayment and any assessed interest has not been paid in full you can stop Medicare from recouping any payments. If you act quickly and decidedly, Medicare will permit providers to **stop recoupment** at two points. The first occurs if we receive a valid and timely request for a redetermination within 30 days from the date of this letter. We will stop or delay recoupment pending the results of the appeal.

We will again stop recoupment if, following **an unfavorable or partially favorable redetermination** decision if you decide to act quickly and file a valid request for reconsideration with the Qualified Independent Contractor (QIC). The address and details on how to file a request for reconsideration will be included in the redetermination decision letter.

What are the timeframes to stop recoupment:

First Opportunity: To assist us in expeditiously stopping the recoupment process, we request that you clearly indicate on your appeal request that this is a 935 overpayment appeal for a redetermination to:

Novitas Solutions, Inc. - 935 APPEALS REDETERMINATION
PO Box 3110
Mechanicsburg, PA 17055-1826

Second Opportunity: If the redetermination decision is 1) **unfavorable** we can begin to recoup **no earlier than the 60th day** from the date of the Medicare redetermination notice (Medicare Appeal Decision Letter), or 2) if the decision is **partially favorable** we can begin to recoup no earlier than the 60th day from the date of the Medicare revised overpayment Notice/Revised Demand Letter. Therefore, it is important to act quickly and decidedly to limit recoupment by requesting a valid and timely reconsideration within 60 days of the appropriate notice/letter. The address and details on how to file a request for reconsideration will be included in the redetermination decision letter.

What Happens following a reconsideration by a Qualified Independent Contractor (QIC):

Following **decision or dismissal** by the QIC, if the debt has not been paid in full, we will begin or resume recoupment whether or not you appeal to the next level of Administrative Law Judge (ALJ).

NOTE: Even when recoupment is stopped, interest continues to accrue.

Interest Assessment:

If you do not refund in 30 days: In accordance with 42 CFR 405.378 simple interest at the rate of 9.75 percent will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment interest will continue to accrue on the remaining principal balance, at the rate of 9.75 percent. In addition, please note that Medicare rules require that payment be either received in our office by 02/24/2016 or use the United States Postal Service Postmark by that date for the payment to be considered timely. A metered mail postmark received in our office after 02/24/2016 will cause an additional month's interest to be assessed on the debt.

Medicaid Offset:

If this matter is not resolved, CMS may instruct the Medicaid State Agency to withhold the Federal share of any Medicaid payments that may be due you or related facilities until the full amount owed Medicare is recouped, Title 42 CFR, Section 447.30(g). These recoveries will be in addition to any recoupments from other Medicare funds due you until the full amount owed to Medicare is recovered.

If you wish to appeal this decision:

If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days from the date of this letter. **However, if you wish to avoid recoupment from occurring, you need to file your request for redetermination within 30 days from the date of this letter as described above.** Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter. Please send your request for redetermination to:

Novitas Solutions, Inc. - 935 APPEALS REDETERMINATION
PO Box 3110
Mechanicsburg, PA 17055-1826

If you have filed a bankruptcy petition:

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Should you have any questions, please contact your overpayment consultant at the following:

Provider - Part B: 855-252-8782

Part B Immediate Recoupment - Fax: 717-728-8728

Part B Extended Repayment Request: 855-252-8782

We look forward to hearing from you shortly.

Sincerely,

Medicare Part B
Recovery Unit

Enclosure: How This Overpayment Was Determined

Invoice Number: 4412013001

Claim No.	Beneficiary Name	HIC No.	Service Date From	Service Date To	Amount Overpaid	Paid Date	Provider No.
MR CASE-#5258854	VARIOUS	VARIOUS	10/02/2014	01/20/2015	\$14,816,591.93	01/22/2015	1003180027

Reason for Overpayment: Based on Medicare guidelines, the service(s) on the original claim was not considered medically necessary. This decision is based on either the documentation that was submitted or the failure by the physician/supplier to furnish information that was requested to support the claim. Therefore, payment was made to you in error.

Companion DX Reference Lab, LLC
Case # 16-33427
Interest Amount Included in Proof of Claim

<u>Interest Amount</u>
\$1,435,025.72
13.92
32.92
32.92
32.92
32.92
4.56
4.56
4.56
4.56
1.14
1.14
1.14
1.14
8.75
11.90
11.90
11.90
11.90
<u>\$1,435,250.47</u>