IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITEDHEALTHCARE OF PENNSYLVANIA, INC. d/b/a UNTEDHEALTHCARE COMMUNITY PLAN, *Plaintiff*, vs. NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC, *Defendant*.	Case No. 2:25-cv-07187-MAK

DEFENENDANT NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC'S MOTION TO DISMISS PLAINTIFF UNITEDHEALTHCARE OF PENNSYLVANIA, INC. D/B/A UNITEDHEALTHCARE COMMUNITY PLAN'S COMPLAINT

Pursuant to Federal Rules of Civil Procedure 9(b), 12(b)(1), and 12(b)(6), Defendant NorthStar Anesthesia of Pennsylvania, LLC (NorthStar) respectfully moves to dismiss Plaintiff UnitedHealthcare of Pennsylvania, Inc. d/b/a UnitedHealthcare Community Plan's (United) Complaint, with prejudice. In the alternative, NorthStar moves to dismiss United's Complaint without prejudice under the primary jurisdiction doctrine. In support of this Motion, NorthStar relies upon the accompanying Memorandum in Support. Pursuant to Local Rule 7.1(f), NorthStar respectfully requests oral argument on this Motion.

United rushed to federal court to challenge the eligibility of a single $7,075 independent dispute resolution (IDR) award under the No Surprises Act (NSA), bypassing every available administrative remedy and before ever contacting NorthStar, who agrees the award was ineligible.

First, United's fraud claim must be dismissed under Rules 9(b) and 12(b)(6) because United admits it knew the dispute was ineligible and objected to the IDR Entity (IDRE), negating justifiable reliance, and because the IDRE's failure to properly evaluate eligibility—not NorthStar's conduct—was the proximate cause of any alleged injury.

Second, this Court lacks subject matter jurisdiction under Rule 12(b)(1) because the Declaratory Judgment Act provides no independent jurisdictional basis, and United's fraud claim fails the *Grable* test, meaning no federal question lies.

Third, NorthStar's prompt corrective actions—including requesting the IDRE reopen and correct the award—render United's claims moot and leave the Court with no effectual relief to grant.

Alternatively, this Court should defer to CMS under the primary jurisdiction doctrine, as IDR eligibility is a technical issue within CMS's expertise and CMS is already positioned to resolve both parties' pending administrative matters.

As the Court is aware, the Parties have exchanged Rule 408 communications and have participated in mediation with Hon. Joseph P. Walsh (Ret.), with another mediation session scheduled for March 10, 2026. In NorthStar's Rule 408 letters, NorthStar outlined the bases for the instant Motion to Dismiss. Counsel for United has stated that United opposes the relief requested in NorthStar's Motion.

WHEREFORE, NorthStar respectfully requests that this Court enter the attached proposed Order granting its Motion and dismissing United's Complaint with prejudice, or in the alternative, without prejudice under the primary jurisdiction doctrine.

Dated: March 6, 2026

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CERTIFICATE OF SERVICE

I hereby certify that on March 6, 2026, I electronically filed the foregoing Defendant NorthStar Anesthesia of Pennsylvania LLC's Motion to Dismiss Plaintiff UnitedHealthcare of Pennsylvania, Inc. d/b/a UnitedHealthcare Community Plan's Complaint with the Clerk of Court using the CM/ECF system which will automatically send email notification of such filing to all Counsel of Record.

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IN THE UNITED STATES DISTRICT COURT
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MEMORANDUM IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS

INTRODUCTION

Plaintiff UnitedHealthcare of Pennsylvania, Inc. d/b/a UnitedHealthcare Community Plan (United) rushed into this Court with a 41-page Complaint challenging the eligibility of a single independent dispute resolution (IDR) award of $7,075 to Defendant NorthStar Anesthesia of Pennsylvania, LLC (NorthStar) under the federal No Surprises Act (NSA). United sued without paying the IDR award. It sued without allowing the Centers for Medicare & Medicaid Services (CMS) to resolve the administrative complaint United filed based on the same IDR award. It sued without pursuing the final phase of the IDR process, through which it could have obtained an administrative reopening and correction of the IDR award, plus a refund of the fees it paid to the IDR entity (IDRE), on the ground the dispute was ineligible for IDR. It sued without bringing a statutory claim for a vacatur of the IDR award on the ground the IDRE exceeded its authority. Finally, it sued without making a phone call to NorthStar, which agrees the IDR award was ineligible, and would have consented to an administrative reopening and correction.

Congress designed and CMS implemented the IDR process knowing that disagreements about eligibility do not equate to fraud and should be resolved more efficiently than this. They put the onus on issuers like United to not only raise but also substantiate their eligibility objections before the IDRE. And they vested the IDRE with the authority to resolve such objections before deciding the merits. As part of the IDR process, CMS encouraged parties to seek the administrative reopening and correction of any IDR award affected by a "jurisdictional error" like ineligibility. CMS did so with the understanding that Congress granted each party the statutory right to sue for a vacatur of any IDR award that exceeds the IDRE's authority because of ineligibility.

United bypassed all these options for resolving the alleged eligibility dispute in this case. It chose the most litigious alternative available because it is part of UnitedHealth Group, a multi-

billion-dollar global insurance conglomerate that is unhappy about the favorable IDR awards NorthStar and other providers get through lawful participation in IDR. United wants the Court to deter such participation by supplanting the current IDR process with a draconian strict liability regime for ineligible disputes that neither Congress nor CMS contemplated.

United's unhappiness with the system Congress designed and CMS implemented is no basis for a fraud claim against NorthStar. Nor is it a basis for federal question jurisdiction. Nor is it a reason for this Court invest resources in a dispute that CMS is poised to resolve.

This Court should dismiss United's fraud claim under Federal Rules of Civil Procedure 9(b) and 12(b)(6) because United has not adequately alleged the essential elements of justifiable reliance and proximate causation, with particularity or otherwise.

The Court should dismiss United's entire Complaint under Federal Rule of Civil Procedure 12(b)(1) because United's claim under the Declaratory Judgment Act (DJA) does not supply an independent basis for subject matter jurisdiction. To the extent United has adequately alleged fraud, there is no actually disputed and substantial federal question embedded in that claim. What is more, the corrective actions taken by NorthStar moot both claims; ineligible IDR awards for NorthStar and against United are already rare statistically, and the corrective actions taken by NorthStar reinforce that an ineligible IDR award is unlikely to recur here.

Alternatively, the Court should dismiss United's Complaint without prejudice under the primary jurisdiction doctrine, so that CMS may use its technical and policy expertise to resolve United's administrative complaint against NorthStar, as well as NorthStar's recent request to the IDRE and CMS to reopen and correct the IDR award. There is no sound reason for this Court to expend its resources on this case before CMS completes its work.

PROCEDURAL HISTORY

United filed its Complaint on December 19, 2025, and served NorthStar on December 24, 2025. On January 8, 2026, the parties filed a Consent Motion to extend NorthStar's time to respond. The Court granted the Motion and required the parties to continue efforts to resolve the dispute. On January 14, 2026, NorthStar sent United a letter explaining NorthStar's views on United's claims. On January 19, 2026, United provided its own Rule 408 Letter, which NorthStar responded to on January 26, 2026. The parties engaged in mediation on February 20, 2026 before Hon. Joseph P. Walsh (Ret.). A second mediation session is scheduled for March 10, 2026, at 1:00 p.m. The parties have not yet resolved the litigation.[1]

BACKGROUND

I. The NSA and the IDR process

The NSA is a federal law enacted in 2020 as part of the Consolidated Appropriations Act of 2021. It amended the Public Health Service Act, the Employee Retirement and Income Security Act of 1974, and the Internal Revenue Code to protect patients from unexpected medical bills when they receive care from certain providers that do not participate with the patient's group health plan or health insurance issuer. For example, when a plan covers participating physician services at participating facilities, it must also cover those services when furnished by non-participating (out-of-network) physicians. *See, e.g.*, 42 U.S.C. §§ 300gg-111(a)(1), (b)(1), 300gg-112(a). A patient who receives services from a non-participating physician must pay only the cost-sharing

[1] United's affiliates, however, have begun pursuing similar civil actions in other circuits. *United Healthcare Srvcs., Inc. v. Concord Co. of Tenn., PLLC*, No. 3:26-cv-00070-DJH (W.D. Ky. filed Jan. 30, 2026); *UnitedHealthcare Ins. Co. v. Maui Mem. Emerg. Med. Assocs.*, No. 1:26-cv-00040 (D. Haw. filed Jan. 30, 2026); *Az. Physicians IPA, Inc. d/b/a UnitedHealthcare Cmty. Plan of Az. v. IAS Arizona PLLC*, No. 2:26-cv-00667 (D. Ariz. filed Jan. 30, 2026); *UnitedHealthcare Srvcs., Inc. v. RG Anesthesia, LLC*, No. 1:26-cv-00563 (N.D. Ga. filed Jan. 30, 2026).

for the services at the in-network level. *See, e.g., id.* §§ 300gg-111(a)(1)(C)(i), (b)(1)(B), 300gg-112(a)(1). The plan must pay the non-participating physician the out-of-network rate[2] determined through the process created by the statute. *See, e.g., id.* §§ 300gg-111(a)(1)(C)(iv)(II), (b)(1)(D).

Under the statutory process, the plan must make an initial payment or send a denial notice to the physician within 30 days of receiving the bill. If the physician believes the initial payment is below the out-of-network rate, then he or she may initiate "open negotiations" within 30 days of receiving the initial payment. The parties then have 30 days to try to agree on the out-of-network rate. *See, e.g.*, *id.* §§ 300gg-111(c)(1)(A), 300gg-112(b)(1)(A).

If open negotiations fail, then the physician may initiate IDR within four days after the 30-day negotiation period ends. *See, e.g.*, *id.* §§ 300gg-111(c)(1)(B), 112(b)(1)(B). The parties must select a certified IDR entity (or the Secretary selects one if they cannot agree), and each side submits a payment offer within 10 days. *See, e.g.*, *id.* §§ 300gg-111(c)(5)(B)(i)(I), 300gg-112(b)(5)(B). The IDRE then selects one of the two offers within 30 days. *See, e.g.*, *id.* §§ 300gg-111(c)(5)(A)(i)-(ii), 300gg-112(b)(5)(A). Once the out-of-network rate is determined through either IDR or open negotiations, the plan must pay the non-participating physician within 30 days. *See, e.g.*, *id.* §§ 300gg-111(c)(6), 300gg-112(b)(6).

A non-initiating party may contest the eligibility of a claim submitted to IDR. A non-initiating party who contests eligibility *must first submit the challenge, together with any supporting information*, to the IDRE. *See* 45 C.F.R. § 149.510(c)(1)(iii) ("[T]he non-initiating party must . . . provide information regarding the Federal IDR process's inapplicability through the Federal IDR portal . . ."). CMS put the onus on the non-initiating party to present evidence

[2] The "out-of-network rate" means the agreed-upon amount reached before or during open negotiations, or if the parties do not agree, the amount determined by the IDRE. *See* 42 U.S.C. § 300gg-111(a)(3)(K)(ii).

demonstrating the ineligibility of a claim. The IDRE must then evaluate and resolve the eligibility issue before determining the out-of-network rate. *Id.* § 149.510(c)(1)(v); *Fed. IDR Process Guidance for Disputing Parties*, CMS, § 5.5 (Dec. 2023); *Fed. IDR Process Guidance for Certified IDR Entities*, CMS, §§ 4.4, 4.6.2 (Oct. 2022).

CMS recognized that IDREs sometimes issue IDR awards on ineligible claims. It "determined that a process for reopening disputes to correct errors identified after dispute closure [wa]s needed," and expanded the existing IDR process to include one. *See Fed. IDR Technical Assistance for Certified IDR Entities and Disputing Parties*, CMS, p.1 (June 2025). If the plan identifies an error by the IDRE, whether clerical, jurisdictional, or procedural, the error "should be corrected by reopening a closed dispute[.]" *Id*. A jurisdictional error exists "where the eligibility of the item or service was incorrectly determined based on" the dispute "relat[ing] to an item or service payable by . . . Medicaid[.]" *Id.* at p.3. CMS's view is that when an IDRE incorrectly adjudicates an ineligible dispute, it is best resolved by the IDRE and CMS. *Id*. at p.1.

Congress provided the final means for an aggrieved party to get relief: a statutory action for judicial review to vacate the IDR award. Under the NSA, the determination of an IDRE is "binding upon the parties involved[.]" 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I). But a party dissatisfied with a determination may file an action for vacatur under the provisions of the Federal Arbitration Act (FAA) codified at 9 U.S.C. § 10. *Id.* § 300gg-111(c)(5)(E)(i)(II). Under §10(a), a court may vacate an IDR award where, among other reasons, the IDRE exceeded its powers. 9 U.S.C. § 10(a)(4). An IDRE exceeds its powers by adjudicating an ineligible dispute.

In short, Congress created and CMS implemented a process to streamline the resolution of disputes between nonparticipating providers and issuers regarding the out-of-network rate. They understood that disagreements about eligibility would arise within that process in the absence of

fraud. For that reason, they created administrative and judicial mechanisms at nearly every step in the process to help facilitate the efficient adjudication of such disagreements.

II. The Parties

NorthStar and its affiliated companies together have more than 4,000 clinicians providing anesthesia services to patients at more than 300 facilities in more than 20 states. *Professional Anesthesia Services*, NorthStar Anesthesia (visited Feb. 9, 2026). NorthStar's affiliated companies have network agreements with United's affiliated companies for more than 70% of the case volume treated by NorthStar's affiliated companies' providers around the country. Balthazor Decl., ¶ 6. NorthStar, however, provides anesthesia services only to patients in Pennsylvania, where NorthStar lacks a network agreement with United. *Id.* ¶ 7.

United is part of UnitedHealth Group (UHG), which offers healthcare services and benefits. *Our Businesses - UnitedHealth Group*, UHG (visited Feb. 9, 2026). UHG is the seventh-largest company in the world. *Fortune Announces 2025 Fortune Global 500 List*, PR Newswire (visited Feb. 9, 2026). And it is the largest health insurer in the United States. *Health insurance giants tighten grip on U.S. markets*, Am. Med. Ass'n (visited Feb. 9, 2026).

III. The Complaint and NorthStar's Revenue Cycle Process

United's Complaint alleges a single instance where NorthStar, through its vendor HaloMD, initiated IDR for an ineligible dispute. Compl. ¶¶ 54–75. The IDR yielded an award of $7,075 to NorthStar. Compl. ¶ 76. United has never paid this award. Balthazor Decl., ¶ 29. Thus, United's only costs in the IDR were a non-refundable administrative fee of $115 paid to CMS, and a refundable fee of up to $1,150 paid to the IDRE. Compl. ¶¶ 86, 96.

NorthStar believes its unique revenue cycle process contributed to the outcome before the IDRE. The revenue cycle process is unique because the facility (e.g., the hospital) hosting the

patient's procedure conducts the financial intake of the patient. NorthStar does not. Balthazor Decl., ¶ 8. Therefore, NorthStar does not receive the patient's health insurance card. Instead, NorthStar receives a face sheet with the patient's insurance information from the facility. *Id.* NorthStar's billing vendor, Arietis Health, uses the information from the face sheet to manually populate the claim for submission to United. *Id.* ¶¶ 9–10. As part of that process, an individual Arietis data user must manually select an "insurance plan" from a drop-down menu in the billing system. *Id.* ¶ 10.

Here, it appears that an Arietis data user selected the incorrect "insurance plan" from the drop-down menu. *Id.* ¶ 32. The face sheet from the facility contained the plan name "UHC PA COMM PLAN." *Id.* The Arietis data user selected a United commercial plan from the drop-down menu instead of a United managed Medicaid plan. *Id.*

The revenue cycle process also involves Arietis's creation of a summary of the 835 electronic file which United transmits to Arietis in connection with processing the claim.[3] Arietis uses the summary for revenue cycle functions like the posting of payments. The summary has historically omitted the information from the remittance payer field in the 835, which shows whether the processed claim relates to a commercial, Medicaid, or MA plan. *Id.* ¶ 15.

As discussed in greater detail below, NorthStar presented the dispute to its IDR vendor, HaloMD, for potential submission to IDR because the "insurance plan" selected in the billing system was a commercial plan, and NorthStar was nonparticipating with United. *Id.* ¶ 22. The

[3] The 835 has the same information as United's provider remittance advice (PRA). *See* *EDI transactions and code sets*, UnitedHealthcare (visited Feb. 9, 2026) ("The electronic provider remittance advice (EPRA) . . . is created from the data provided in the EFT 835."). The electronic 835 is commonly used by payors and providers, instead of the hard copy PRA, to improve accuracy and efficiency in processing claims. But it is not readable by a human, hence the need for the summary that is readable. Balthazor Decl., ¶ 14.

incorrect plan selection contributed to NorthStar's good-faith belief that the dispute was eligible for IDR.

IV. The IDR Process in this Case

On March 3, 2025, HaloMD initiated the open negotiation phase of the IDR process for NorthStar by sending an Open Negotiation Notice to United. Balthazor Decl., ¶ 23, Ex. B at NSTAR_000002–07. On March 7, 2025, United told HaloMD the dispute was ineligible for open negotiations because United either was "not able to identify this member *or* the member is covered under a plan not eligible for the NSA dispute process," and to "please refer to your PRA for additional information." *Id.* ¶ 24, Ex. C at NSTAR_000008 (emphasis added).

On April 8, 2025, HaloMD requested that United provide documentation that "another entity is the correct payor or NSA handler for this claim[.]" *Id.* ¶ 25, Ex. D at NSTAR_000010. HaloMD sent the request to a United email address labeled "No Reply." *Id.* It is unclear whether United received the request. In any event, HaloMD received no documentation from United in response to the request. *Id.* ¶ 25.

Lacking further information or documentary support from United, HaloMD escalated the dispute to the IDRE on April 15, 2025. *Id.* ¶ 26, Ex. E at NSTAR_000013–17. The IDRE awarded $7,075 to NorthStar on May 23, 2025. *Id.* ¶ 27, Ex. F at NSTAR_000018–22. The IDRE reasoned that United "only submitted an objection to the eligibility of the dispute and did not submit any other persuasive argument in its favor." *Id.* at NSTAR_000020. The IDRE "overruled [United's] objection based on the evidence (or lack thereof) provided by the parties. [NorthStar] however submitted a brief and a persuasive argument in its favor." *Id.* United's own failure to submit evidence—or even a persuasive argument in support of its objection—was the IDRE's stated basis for the award.

On June 26, 2025, United emailed the IDRE and copied HaloMD. *Id.* ¶ 28. United stated the dispute was "not eligible for the NSA process due to this member's plan being a Medicaid plan." *Id.* ¶ 29, Ex. G at NSTAR_000023. United added that it "submitted a complaint on the CMS Portal using the No Surprises Complaint Form" instead of seeking a reopening and correction of the award pursuant to CMS guidance. *Id.*; *Fed. IDR Technical Assistance for Certified IDR Entities and Disputing Parties*, CMS (June 2025). United did not copy NorthStar leadership on its complaint to CMS or its subsequent email to the IDRE and HaloMD. Balthazor Decl., ¶ 28. In fact, United did not reach out to NorthStar leadership at all. *Id.* ¶¶ 28, 30.

V. NorthStar's Business Practices and Corrective Actions

United served its civil action on NorthStar on Christmas Eve without first contacting NorthStar's leadership or allowing CMS to resolve United's administrative complaint. Balthazor Decl., ¶ 30. NorthStar promptly investigated United's allegations. *Id.* ¶ 31. NorthStar first came to appreciate that the IDR award was ineligible after investigating. *Id.*

NorthStar agrees that disputes regarding the rates paid on managed Medicaid and Medicare Advantage (MA) claims are ineligible for IDR. NorthStar's general business practice is to present only certain disputes to HaloMD for potential submission to IDR. Namely, disputes which NorthStar believes in good faith to be eligible for IDR. *Id.* ¶ 17. NorthStar's general business practice is to hold back claims that NorthStar believes in good faith to involve Medicaid or MA claims because NorthStar's position is that such claims are ineligible for IDR. *Id.* ¶ 18. NorthStar filters out such claims from those it presents to HaloMD for potential submission to IDR. *Id.*

Consistent with these general business practices, NorthStar's data demonstrates that ineligible IDR awards for NorthStar against United are rare. In calendar year 2025, NorthStar presented 955 disputes with United to HaloMD. *Id.* ¶ 35. NorthStar reviewed its records regarding

these disputes during its investigation and found two more that involved Medicaid or MA claims and yielded ineligible IDR awards. *Id.* NorthStar also found a similarly ineligible dispute pending in the IDR process. *Id.* The three ineligible IDR awards (including the one identified in the Complaint) represent .31% of the 955 total disputes with United that NorthStar presented to HaloMD last year.

While ineligible IDR awards involving Medicaid or MA claims are rare statistically, NorthStar took prompt corrective actions through Arietis and HaloMD as soon as NorthStar appreciated that the dispute here was ineligible. *Id.* ¶ 33. Arietis identified the data user who incorrectly mapped the United plan and issued a written warning to that individual. *Id.* ¶ 34. Arietis reviewed its standard operating procedures and conducted a training of its data users to reinforce the importance of accuracy in data entry. *Id.* And Arietis initiated the process of modifying its summaries of 835s to include the remittance payer field, which will enable NorthStar to consider that field when determining whether to present disputes to HaloMD for potential submission to IDR in the future. *Id.*

HaloMD sought a reopening and correction of the IDR award here with the IDRE. *Id.* ¶ 36. Specifically, HaloMD alerted the IDRE to the jurisdictional error affecting the dispute: "Erroneous inclusion/exclusion of Medicare, Medicaid, CHIP, TRICARE, IHS, or VA-covered services[.]" *Id.* ¶ 36, Ex. H at NSTAR_000025. HaloMD then asked the IDRE to reopen the dispute, rescind the original payment determination, reverse the eligibility determination to reflect that the dispute is ineligible, close the dispute as ineligible, and refund all IDRE fees in full to each party. *Id.* at NSTAR_000026. HaloMD took similar steps on the two additional IDR awards identified by NorthStar. *Id.* ¶ 36. Finally, HaloMD withdrew the pending ineligible dispute from IDR. *Id.*

NorthStar informed United of these corrective actions before filing this Motion.

LEGAL STANDARD

A Court must dismiss under Rule 12(b)(1) whenever it lacks subject matter jurisdiction. *Biggs El v. Shapiro*, 2026 U.S. Dist. LEXIS 16408, at *8 (E.D. Pa. Jan. 28, 2026) (citation omitted). There are two types of 12(b)(1) motions: "those that attack the complaint on its face and those that attack subject matter jurisdiction as a matter of fact." *Waterman v. Paychex, Inc.*, 2025 U.S. Dist. LEXIS 208267, at *7 (E.D. Pa. Oct. 22, 2025) (quoting *Petruska v. Gannon Univ.*, 462 F.3d 294, 302 n.3 (3d Cir. 2006)). Where a facial challenge "challenges subject matter jurisdiction without disputing the facts alleged in the complaint" a factual challenge "challenges 'subject matter jurisdiction because the facts of the case . . . do not support the asserted jurisdiction.'" *Id.* (citations omitted). In the face of a factual attack, "no presumptive truthfulness attaches to plaintiff's allegations, and . . . the plaintiff [has] the burden of proof that jurisdiction does in fact exist." *Charlton v. Comm't.*, 611 F. App'x 91, 94 (3d Cir. 2015) (citation omitted) (quoting *Mortensen v. First Fed. Sav. & Loan Ass'n*, 549 F.2d 884, 891 (3d Cir. 1977)) (alterations in *Charlton*). When jurisdiction is attacked factually, "a court may consider and weigh evidence outside the pleadings to determine if it has jurisdiction." *Id.* (citation omitted).

A motion under Rule 12(b)(6) challenges the facial plausibility of a claim. *Gilles v. Progress Advanced Ins. Co.*, 2025 U.S. Dist. LEXIS 260346, at *3 (E.D. Pa. Dec. 17, 2025). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). This tenet is "inapplicable to legal conclusions." *Id.* at *3–4 (quoting *Iqbal*, 556 U.S. at 678).

ARGUMENT

I. The Complaint Fails to Allege Fraud (Count 2) with Particularity

Claims of fraud are subject to heightened pleading requirements. Federal Rule of Civil Procedure 9(b) requires that "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake." The Complaint fails to meet this bar.

a. United Has Failed to Plead Justifiable Reliance with Particularity

Fraud requires: "(1) a representation; (2) which is material to the transaction at hand; (3) made falsely, with knowledge of its falsity or recklessness as to whether it is true or false; (4) with the intent of misleading another into relying on it; (5) justifiable reliance on the misrepresentation; and (6) the resulting injury was proximately caused by the reliance." *Marion v. Bryn Mawr Trust Co.*, 288 A.3d 76, 87–88 (Pa. 2023) (citation omitted). The plaintiff must justifiably rely on the defendant's misrepresentation; reliance by a non-party tribunal is legally insufficient. *Id*.

For instance, in *Angino v. Branch Banking & Trust Co.*, 2020 U.S. Dist. LEXIS 37104 (M.D. Pa. Mar. 4, 2020), the plaintiffs alleged that fraud by the defendant caused an adverse state court ruling. The fraud was supposedly "relied upon in the entering of judgment and injured [p]laintiffs[.]" *Id.* at *10. The district court dismissed the fraud claims with prejudice because "plaintiffs have not, and cannot, plead justifiable reliance." *Id*. It explained that "[p]laintiffs cannot state a claim for fraud because they did not rely on any representation [defendant] made in the state court action." *Id*. Indeed, they disputed the defendant's representation. *Id.* at *10–11.

So too here. United alleges NorthStar made false attestations about the eligibility of a dispute involving a managed Medicaid claim. But United alleges it knew the dispute was ineligible and lodged an objection with the IDRE on April 16, 2025. Compl. ¶ 73. United further alleges it sent a letter to the IDRE on May 2, 2025, reiterating the same basic objection. Compl. ¶ 75. These allegations negate any claim of reliance by United. Any reliance by the IDRE "***is not the type of reliance required for fraud***." *Angino*, 2020 U.S. Dist. LEXIS 37104, at *10–11 (emphasis added).

Perhaps recognizing this fatal flaw, United contends that "NorthStar's deliberate misrepresentation to the IDRE, on which the IDRE relied, forced United to rely on the misrepresentation because once the IDRE determined the dispute was eligible, United had no choice but to proceed with the process . . ." Compl. ¶ 110. United's theory of forced reliance is a legal conclusion which the Court should disregard under Rule 12(b)(6). *Santiago v. Warminster Twp.*, 629 F.3d 121, 131–32 (3d Cir. 2010). It is also contrary to the IDRE's reasoning and the IDR process itself. The IDRE explained that it accepted NorthStar's eligibility argument because United chose to present no evidence or argument in support of its eligibility objection. United then chose to forego the leg of the IDR process through which United may obtain a reopening and correction of the IDR award. United was not forced to do anything; its theory of forced reliance is meritless because it twice declined to exercise its rights in the IDR process.

b. United Has Failed to Plead Causation with Particularity

To support its fraud claim, United must "establish 'some direct relation between the injury asserted and the injurious conduct alleged.'" *City of Phila. v. Beretta U.S.A. Corp.*, 277 F.3d 415, 423 (3d Cir. 2002) (citation omitted). A direct relation is "a key element for establishing proximate causation, independent of and in addition to other traditional elements of proximate cause." *Id.* (citation omitted). United fails to plead this key element. Indeed, United establishes the exact opposite: the proximate cause of United's alleged injury was the IDRE or United itself, not NorthStar.

United alleges the IDRE "inexplicably determined the claim in favor of NorthStar," "made no explicit determination that the claim was eligible for IDR resolution," and "made no reference to United's multiple submissions explaining the claim was against a Medicaid plan." Compl. ¶¶ 76, 77, 79. United then goes even further, alleging the IDRE "refused to adequately consider

pertinent and material evidence [about claim eligibility] and thereby prejudiced United's rights," and "was derelict in its duty to determine eligibility of the Medicaid claim submitted by NorthStar." *Id*. at ¶¶ 79, 84. By United's own admission, the IDRE could have and should have determined eligibility in favor of United and was derelict in its duty to do so. These admissions show United's theory is the IDRE proximately caused United's alleged injury. At a minimum, the admissions sever any alleged "direct relation between the injury asserted" and the conduct of NorthStar. *Beretta U.S.A. Corp.*, 277 F.3d at 423.

As discussed above, United chose to forego the leg of the IDR process through which it could have obtained a reopening and correction of the IDR award. This choice was the proximate cause of United's alleged injury. Alternatively, it severed any alleged "direct relation between the injury asserted" and the conduct of NorthStar. As discussed previously, Congress and CMS created multiple administrative and judicial avenues in the IDR process for resolving disagreements about eligibility because they anticipated that such disagreements would arise in the absence of fraud. United's strategic decision to bypass those avenues in order to pursue a sweeping, unprecedented judicial remedy is the proximate cause of any harm it allegedly suffered.

United's fraud claim fails on myriad grounds and must be dismissed.

II. This Court lacks Federal Question Jurisdiction over United's Complaint

United alleges the Court has federal question jurisdiction under 28 U.S.C. § 1331 "because resolution of the claims in this Complaint raises disputed and substantial questions under the NSA, a federal statute, and will require judicial interpretation of the NSA." Compl. ¶ 9. United has brought Declaratory Judgment Act (DJA) and a state common law fraud claim.[4] The DJA does not

[4] United does not bring a claim for vacatur under the NSA and FAA. Together, these statutes authorize federal courts to vacate IDR awards when the IDRE exceeds its authority, which is exactly what United alleges occurred here. Compl. ¶ 90.

"provide an independent basis for subject-matter jurisdiction; it merely defines a remedy." *Allen v. Debello*, 861 F.3d 433, 444 (3d Cir. 2017).

United has no viable state common law fraud claim for the reasons explained above. Even assuming a viable fraud claim, United must still meet the test set forth in *Grable & Sons Metal Products, Inc. v. Darue Engineering & Manufacturing*, 545 U.S. 308 (2005). Under *Grable*, "federal jurisdiction over a state law claim will lie if a federal issue is: (1) necessarily raised, (2) actually disputed, (3) substantial, and (4) capable of resolution in federal court without disrupting the federal-state balance approved by Congress." *Manning v. Merrill Lynch Pierce Fenner & Smith, Inc.*, 772 F.3d 158, 163 (3d Cir. 2014) (citation omitted). It is not enough that a federal issue merely be implicated. Rather, the federal issue must be "substantial." *Cohen v. Trs. of the Univ. of Pa.*, 2025 U.S. Dist. LEXIS 213868, at *4 (E.D. Pa. Oct. 30, 2025). Here, there is no federal question jurisdiction because United fails the *Grable* test.

United alleges the federal issue is whether disputes involving managed Medicaid claims are eligible for IDR under the NSA. Compl. ¶ 102. NorthStar agrees with United that managed Medicaid claims are ineligible for IDR under the NSA. The meaning of the NSA is undisputed between the parties on this point. Because the interpretation of the NSA is wholly "incidental" to United's fraud claim, United cannot possibly meet the "actually disputed" requirement of the *Grable* test. *See MHA LLC v. Healthfirst, Inc.*, 629 F. App'x 409, 414 (3d Cir. 2015) (finding no "discrete federal issue" without "a dispute over the meaning of particular statutory text."); *accord Commonwealth v. TAP Pharm. Prods.*, 415 F. Supp. 2d 516, 524 (E.D. Pa. 2005); *Hoffnagle v. Conn. Water Co.*, 2024 U.S. Dist. LEXIS 173275, at *5–6 (D. Conn. Sept. 25, 2024).

What is more, United's federal issue is not substantial.[5] The resolution of whether managed Medicaid claims are ineligible for IDR under the NSA will not dispose of the case, nor will it control in numerous other cases. *Kalick v. Nw. Airlines Corp.*, 372 F. App'x 317, 320 (3d Cir. 2010) (citing *Empire HealthChoice Assur., Inc. v. McVeigh*, 547 U.S. 677, 700 (2006)). The Court must still determine whether NorthStar's submission of an ineligible dispute to IDR under the NSA was a materially false representation, made with the requisite intent; whether United justifiably relied upon the representation; and whether the representation proximately caused and had a direct relation to the alleged harm to United. These determinations are situation-specific ones that turn on an investigation of the facts. *Benjamin v. JBS S.A.*, 516 F. Supp. 3d 463, 470–71 (E.D. Pa. 2021); *see also Behrens v. BMO Harris Bank, N.A.*, 2017 U.S. Dist. LEXIS 119480, at *16 (N.D. Ill. July 31, 2017). United cannot meet the "substantial" requirement of the *Grable* test because its fraud claim is fact bound.

This Court must accordingly dismiss the Complaint for lack of subject matter jurisdiction.

III. NorthStar's Prompt Corrective Actions Render United's Claims Moot

Article III of the U.S. Constitution confers jurisdiction only over "cases and controversies." U.S. Const. art. III, § 2, cl. 1. A case is moot when "developments occur during the course of adjudication that eliminate a plaintiff's personal stake in the outcome of a suit or prevent a court from being able to grant the requested relief." *Hamilton v. Bromley*, 862 F.3d 329, 335 (3d Cir. 2017) (citation omitted). If the court cannot grant "'any effectual relief whatever to the prevailing party' then the case is moot." *Clark v. Gov. of N.J.*, 53 F.4th 769, 775 (3d Cir. 2022). "[M]ootness concerns itself with whether the same legal controversy will recur." *Id.* at 778.

[5] The Court need not reach this factor if it finds the issue is not actually disputed. *TAP Pharm. Prods.*, 415 F. Supp. 2d at 525. ("[T]he absence of an 'actually disputed' issue of federal law . . . renders any discussion of substantiality superfluous.").

NorthStar's prompt corrective actions to improve its revenue cycle process have mooted United's claims for declaratory and injunctive relief. Specifically, NorthStar had Arietis issue a written warning to the Arietis data user that chose the incorrect United plan, further train all Arietis data users, and begin the process of modifying the summaries of United's 835s to include the information from the remittance payer field, allowing NorthStar to consider that information when evaluating claims for submission to IDR. Ineligible IDR awards for NorthStar and against United are already rare statistically (.31% in 2025), and these corrective actions make it "absolutely clear that the allegedly wrongful behavior [cannot] reasonably be expected to recur." *Hartnett v. Pa. State Educ. Ass'n*, 963 F.3d 301, 306 (3d Cir. 2020) (citation omitted); *cf. Smith v. Keycorp. Mortg., Inc.*, 151 B.R. 870, 874 (N.D. Ill. 1993) ("[D]efendant has written plaintiff acknowledging an error, waiving its right to collect the late charges, and has accepted plaintiff's tendered payments, making the mortgage current and the injunction and declaratory relief claims moot.").

To be sure, the mootness doctrine also asks whether the Court would be able to grant "effectual relief" to a prevailing party. *Clark*, 53 F.4th at 775. The Court cannot grant "effectual relief" to United here because NorthStar's corrective action through HaloMD delivers all available retrospective relief to United. HaloMD sought a reopening and correction of the IDR award, specifically asking the IDRE to reopen the dispute, reverse the eligibility determination, close the dispute as ineligible, and refund the IDRE fee to United. The imminent refund of the IDRE fee leaves the Court with no effectual, retrospective relief to grant to United.[6]

[6] As noted, United paid a non-refundable administrative fee of $115 to CMS when the process advanced from open negotiations to IDR. United paid the fee *before* NorthStar allegedly defrauded United during the IDR process. What is more, United concedes it would have been responsible for the fee as a prevailing party in IDR. Compl. ¶ 86. The fee cannot possibly constitute a damage proximately caused by, and related directly to, alleged fraud on United during the IDR process.

The voluntary cessation exception to mootness does not apply here because NorthStar agrees managed Medicaid claims are ineligible for IDR. *See, e.g.*, *United States v. Virgin Islands*, 363 F.3d 276, 285 (3d Cir. 2004) ("GVI's continued defense of . . . the contract prevents the mootness argument from carrying much weight."); *Rd.-Con, Inc. v. City of Phila.*, 120 F.4th 346, 357 (3d Cir. 2024) ("Unlike in *Hartnett* . . . Philadelphia has never conceded error."); *Walter v. SEPTA*, 2007 U.S. Dist. LEXIS 22985, at *22–23 (E.D. Pa. Mar. 28, 2007) ("[T]he Court notes that defendant continues to assert the substantive defense that SEPTA is not required to provide paratransit services for patrons when needed key stations are unavailable[.]").

This Court should dismiss the entire Complaint because United's claims are moot.

IV. Alternatively, this Court Should Dismiss the Complaint Without Prejudice and Defer to CMS Under the Primary Jurisdiction Doctrine

Primary jurisdiction is a prudential doctrine of deference to administrative agencies. It "comes into play whenever enforcement of the claim requires the resolution of issues which, under a regulatory scheme, have been placed within the special competence of an administrative body[.]" *United States v. Western Pac. R. Co.*, 352 U.S. 59, 63–64 (1956).

Courts in the Third Circuit consider four factors when evaluating whether to defer to the primary jurisdiction of an agency in the first instance: (1) whether the question involves technical or policy considerations within the agency's expertise; (2) whether the question is within the agency's discretion; (3) whether there is a substantial danger of inconsistent rulings; and (4) whether a prior application to the agency has been made. *AT&T Corp. v. PAB, Inc.*, 925 F. Supp. 584, 589–90 (E.D. Pa. 1996) (citation omitted); *see also Ferrare v. IDT Energy, Inc.*, 2015 U.S. Dist. LEXIS 74849, at *11 n.7 (E.D. Pa. June 10, 2015) (staying case under the primary jurisdiction doctrine and declining to hear plaintiff's DJA claim). On balance, these factors weigh in favor of dismissing United's Complaint without prejudice and allowing CMS to address the underlying

IDR eligibility and compliance issues by resolving NorthStar's request to reopen and correct the IDR award as well as United's administrative complaint to CMS.

Eligibility for IDR is a technical issue within the expertise and discretion of CMS. As previously discussed, CMS has published regulations that require a plan to submit any eligibility challenge to the IDRE. *See* 45 C.F.R. § 149.510(c)(1)(iii). The IDRE must then evaluate and resolve the eligibility issue. *Id.* § 149.510(c)(1)(v); *Fed. IDR Process Guidance for Disputing Parties*, CMS, § 5.5 (Dec. 2023); *Fed. IDR Process Guidance for Certified IDR Entities*, CMS, §§ 4.4, 4.6.2 (Oct. 2022). If the plan disagrees with the IDRE, then it may request that the IDRE and CMS reopen and correct the IDR award. *See Fed. IDR Technical Assistance for Certified IDR Entities and Disputing Parties,* CMS, p.3 (June 2025).

Compliance with the IDR process is similarly a technical and policy issue within the expertise and discretion of CMS. Congress authorized the Secretary of Health and Human Services to investigate and resolve complaints of provider noncompliance. 42 U.S.C. §§ 300gg-134(b)(1), (b)(3). The Secretary delegated this authority to CMS, which now accepts, investigates, and resolves complaints by payers alleging provider noncompliance with the IDR process. *No Surprises Complaint Form: Complaint Category*, CMS (visited Feb. 9, 2026). "Through the CMS investigation process, CMS has directed . . . providers . . . to take remedial and corrective actions to address instances of noncompliance[.]" *CMS Compliant Data and Enforcement Report on Health Insurance Market Reforms*, CMS (visited Feb. 9, 2026).

United submitted its administrative complaint to CMS before suing NorthStar. United's administrative investigation and subsequent civil action present NorthStar with a substantial danger of inconsistent rulings. The more prudent approach is for the Court to dismiss United's Complaint without prejudice to refiling and allow CMS to first investigate and resolve NorthStar's

request for a reopening and correction of the IDR award and United's administrative complaint. This Court's deference to the agency's technical and policy expertise in the first instance will conserve judicial resources and inform the Court's consideration of the merits of any refiled civil action. It will also encourage payers like United to seek relief from CMS or the provider before rushing into federal court over a single ineligible IDR award.

CONCLUSION

United has not adequately pleaded fraud. Regardless, this Court lacks subject matter jurisdiction because there is no federal question embedded in the fraud claim, and NorthStar's corrective actions moot the Complaint in its entirety. To the extent this Court has federal question jurisdiction over a valid fraud claim, it should dismiss the Complaint without prejudice and permit CMS to first resolve the pending administrative proceedings as a prudential matter.

Dated: March 6, 2026

/s/ Julie A. Busta

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Counsel for Defendant NorthStar Anesthesia of Pennsylvania LLC

CERTIFICATE OF SERVICE

I hereby certify that on March 6, 2026, I electronically filed the foregoing Memorandum in Support of Defendant's Motion to Dismiss with the Clerk of Court using the CM/ECF system which will automatically send email notification of such filing to all Counsel of Record.

/s/ Julie A. Busta

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITEDHEALTHCARE OF PENNSYLVANIA, INC. d/b/a UNTEDHEALTHCARE COMMUNITY PLAN, *Plaintiff*, vs. NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC, *Defendant*.	Case No. 2:25-cv-07187-MAK

DECLARATION OF MICHELLE BALTHAZOR IN SUPPORT OF DEFENDANT NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC'S MOTION TO DISMISS

I, Michelle Balthazor, declare, pursuant to 28 U.S.C. § 1746 as follows:

1. My name is Michelle Balthazor. I serve as Vice President – Revenue Cycle Management for NorthStar Anesthesia and have held this role since August 2025.

2. Before assuming my current position at NorthStar, I held roles in revenue cycle management and healthcare technology at organizations including Optum, Change Healthcare, and the Advisory Board, where my responsibilities included oversight of clearinghouse operations, payer-facing processes, and implementation functions relevant to the general subject matter of this declaration.

3. I submit this declaration in support of Defendant Northstar Anesthesia of Pennsylvania, LLC's (NorthStar's) Motion to Dismiss the Complaint filed by Plaintiff United Healthcare of Pennsylvania, Inc. (United) in *UnitedHealthcare of Pennsylvania, Inc. d/b/a*

UnitedHealthcare Community Plan v. NorthStar Anesthesia of Pennsylvania, LLC, Case No. 2:25-cv-07187-MAK (E.D.Pa.).

4. My declaration testimony is based on my direct firsthand knowledge plus business records, federal independent dispute resolution (IDR) records, other information from NorthStar personnel and vendors, and public domain information.

NORTHSTAR AND ITS REVENUE CYCLE PROCESS

5. NorthStar is an anesthesia management company that provides anesthesia services to patients at hospitals and other facilities.

6. NorthStar's affiliated companies have network agreements with United's affiliated companies for more than 70% of the case volume treated by the providers of NorthStar's affiliated companies around the country.

7. NorthStar, however, provides anesthesia services only to patients in Pennsylvania, where NorthStar is out-of-network with United.

8. NorthStar's revenue cycle process is unique because the hospital or other facility hosting the patient's procedure typically conducts the financial intake of the patient—not NorthStar. As a consequence, NorthStar typically does not interact with patients during intake and does not receive patients' insurance cards. NorthStar typically receives a face sheet from the facility which contains insurance information for the patient.

9. NorthStar outsources part of its billing operations to vendor Arietis Health. Arietis bills claims to payors like United on NorthStar's behalf.

10. Arietis uses the information from the face sheet to populate the electronic claim in its electronic billing system. This process is partly manual; an individual Arietis data user selects

the "insurance plan" associated with the claim from a drop-down menu in the billing system during the entry of data in the Arietis billing system.

11. When submitting a claim to a payor like United, Arietis does not use the "insurance plan" selected in the billing system. Arietis instead submits claims under the payor's identification number (payor ID). Arietis adheres to this practice for claims to United because so many of United's commercial, Medicaid, and MA plans use United's payor ID at the electronic clearinghouse. United processes the claims based on the plan information it maintains, not on the "insurance plan" that Arietis selects in its billing system.

12. When processing the claim, the payor sends an electronic remittance advice (also known as an ERA, or 835) to Arietis. An 835 is the standard electronic format used by payors and providers in lieu of paper remittance advices because it improves accuracy, efficiency, and automation in claims reconciliation.

13. The 835 may include remark codes from the payor about its processing of the claim. These remark codes include N877, N830, and N859, which are applied to claims processed under the federal No Surprises Act (NSA) and state surprise billing laws.

14. Arietis uses information from the 835 during the revenue cycle process, including: the automated posting of payments, adjustments, denial codes, and other adjudication details. Because an 835 is a machine-readable electronic data file rather than a human-readable document, Arietis must translate or summarize the data into a format that its staff can review and use.

15. The "remittance payer" field in the 835 contains information showing the name of the patient's insurance plan. Historically, Arietis's summary has not included information from the "remittance payer" field because Arietis does not need the information to post payments, adjustments, denial codes, or other adjudication details.

16. NorthStar outsources part of its federal IDR operations to its vendor, HaloMD. These operations include the initiation of open negotiations, the pursuit of IDR awards after open negotiations, and reopenings and corrections of IDR awards reached in error.

17. NorthStar's general business practice has always been to present only certain disputes to HaloMD for potential submission to IDR. In 2025 and prior years, NorthStar presented disputes to HaloMD where Arietis selected a commercial plan as the "insurance plan" in the billing system and where NorthStar was nonparticipating with the plan, or where the payor applied at least one of three NSA remark codes, N877, N830, or N859, to the processed claim. NorthStar accepted the payor's remark code about the application of the NSA at face value.

18. NorthStar' general business practice has never been to present disputes to HaloMD that NorthStar believes in good faith to involve Medicaid or MA claims because NorthStar's position is that such disputes are ineligible for IDR. NorthStar has always sought to exclude such disputes from those it presents to HaloMD for potential submission to IDR.

19. Historically, HaloMD has applied additional filters to the disputes presented by NorthStar before HaloMD submits any of these disputes to IDR. NorthStar has provided data files to HaloMD for use in this filtering process. The data files contain data from Arietis's billing system. NorthStar has provided the data files to HaloMD as frequently as five days per week. HaloMD may consider these data files when assessing whether to exclude any disputes from submission to IDR.

THE IDR AWARD UNDERLYING UNITED'S LAWSUIT

20. United's allegations center on a patient who received anesthesia services from NorthStar and was covered through UnitedHealthcare Community Plan, a managed Medicaid plan. Compl. ¶ 55.

21. NorthStar's records show NorthStar provided the services on or about January 29, 2025. NorthStar (through Arietis) submitted an electronic claim for $6,450.00 to United. United processed the claim and paid $1,440.72 to NorthStar. United sent an 835 to Arietis. Arietis summarized the 835, posted the payment, and gave NorthStar access to the summary. A copy of the summary is attached as Exhibit A.

22. NorthStar believed in good faith that United underpaid the claim and that the resulting dispute was eligible for IDR because the "insurance plan" selected in the billing system was a commercial plan, and NorthStar was a nonparticipating provider with United. NorthStar accordingly presented the dispute to HaloMD for potential submission to IDR.

23. HaloMD initiated open negotiations by submitting an "Open Negotiation Notice." A copy of the email transmitting this notice is attached as Exhibit B.

24. United then emailed HaloMD, stating the claim was ineligible for IDR pre-negotiation because United either was "not able to identify this member or the member is covered under a plan not eligible for the NSA dispute process, please refer to your PRA for additional information." A copy of United's email is attached as Exhibit C.

25. HaloMD then emailed United and requested "documented evidence that another entity is the correct payor or NSA handler for this claim[.]" A copy of HaloMD's email is attached as Exhibit D. NorthStar has no record of HaloMD receiving a response from United to this email.

26. HaloMD eventually initiated IDR proceedings for NorthStar against United. A copy of the email transmitting the Notice of IDR Initiation is attached as Exhibit E.

27. Ediphy Advisors LLC, the Independent Dispute Resolution Entity (IDRE) tasked with resolving this particular dispute, awarded $7,075 to NorthStar. Ediphy Advisors stated that it based its determination on United having "only submitted an objection to the eligibility of the

dispute" and by not submitting "any other persuasive argument in its favor." Ediphy Advisors "overruled [United's] objection based on the evidence (or lack thereof) provided by the parties. [NorthStar] however submitted a brief and a persuasive argument in its favor." A copy of Ediphy Advisors' payment determination is attached as Exhibit F.

28. United emailed Ediphy Advisors and copied "northstarnsa@halomd.com," which is a HaloMD email address. United stated that the claim was "not eligible for the NSA process due to this member's plan being a Medicaid plan." United also stated that it "submitted a complaint on the CMS Portal using the No Suprises Complaint Form." United did not copy NorthStar leadership on its email to the IDRE and HaloMD or its administrative complaint to the Centers for Medicare & Medicaid Services (CMS). A copy of United's email is attached as Exhibit G.

29. NorthStar did not receive payment on the IDR award.

UNITED'S LAWSUIT AND NORTHSTAR'S CORRECTIVE ACTIONS

30. United served its Complaint on NorthStar on December 24, 2025. NorthStar leadership did not receive any outreach from United about the Complaint before United served the Complaint. NorthStar likewise did not receive any outreach from CMS about United's administrative complaint.

31. After NorthStar received the Complaint, it investigated the allegations. The investigation included consultation with Arietis and HaloMD. It was not until NorthStar investigated that it first appreciated that the underlying dispute was ineligible for IDR.

32. NorthStar concluded that an Arietis data user selected the incorrect "insurance plan" from the drop-down menu in the billing system when manually entering data. The face sheet referred to "UHC PA COMM PLAN." The data user selected a United commercial plan from the drop-down menu instead of a United managed Medicaid plan. Because the claim appeared to be

associated with a commercial plan, and NorthStar was not participating with United, NorthStar presented the dispute to HaloMD for potential submission to IDR.

33. Once NorthStar appreciated the dispute was ineligible for IDR, it took prompt corrective actions, including through Arietis and HaloMD.

34. Arietis identified the data user who incorrectly mapped the United plan and issued a written warning to that individual. Arietis reviewed its standard operating procedures and conducted a training for its data users to reinforce the importance of accuracy in data entry. And Arietis initiated the process of modifying its summaries of 835s to include the remittance payer field, which will enable NorthStar to consider that field when determining whether to present disputes to HaloMD for potential submission to IDR in the future.

35. NorthStar, working with Arietis and HaloMD, checked the status of all 955 disputes with United that NorthStar presented to HaloMD for potential submission to IDR in 2025. NorthStar found two more disputes that involved Medicaid or MA claims and yielded ineligible IDR awards. NorthStar also found a similarly ineligible dispute pending in the IDR process.

36. HaloMD requested a reopening and correction of the dispute underlying the Complaint. Specifically, HaloMD alerted Ediphy Advisors to the jurisdictional error affecting the dispute. HaloMD then asked Ediphy Advisors to reopen the dispute, rescind the original payment determination, reverse the eligibility determination to reflect that the dispute is ineligible, close the dispute as ineligible, and refund all IDRE fees in full to each party. A copy of HaloMD's email to Ediphy Advisors is attached as Exhibit H. HaloMD took similar steps regarding the two additional ineligible IDR awards identified by NorthStar. Finally, HaloMD withdrew the pending ineligible dispute identified by NorthStar from IDR.

* * *

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: March 6, 2026

Signed by:
Michelle Balthazor
2CFF265B4E704A8...

Michelle Balthazor

EXHIBIT A

RAWAT,
TANUJA

ARIETIS HEALTH LLC.

Claim Detail

02/28/2025
08:11 AM

ERA File : UHCP.500016106.022425.5010

Payer Name: UNITEDHEALTHCARE OF PENNSYLVANIA INC
Payer Address: PO BOX 5290,,KINGSTON,NY,

Payee Name: NORTHSTAR ANESTHESIA OF PENNSYLVANIA LLC [NPI: 1700218989]
Payee Address: 6225 NORTH STATE HIGHWAY 161 SUITE 200,

Claim #	Patient	Service Provider	Billed	Paid	Pat. Resp.	Payer Control#	Status Code	Message

Payer Name: UNITEDHEALTHCARE OF PENNSYLVANIA INC
Payer Address: PO BOX 5290,,KINGSTON,NY,

Payee Name: NORTHSTAR ANESTHESIA OF PENNSYLVANIA LLC [NPI: 1700218989]
Payee Address: 6225 NORTH STATE HIGHWAY 161 SUITE 200,

Date: 02/26/2025 **Ref #:** 25053B1000560970 **Amount :** 1800.90 **NPI:** 1700218989

Processable Claims

C021406975 PHI 6450.00 1440.72 0.00 RA3530443100 Processed as Primary

Code : 01967 Modifier : AAP3 Billed : 6450.00 Paid : 1440.72 Service Date : PHI

Reason Code : CO45 Amount : 5009.28 Qty : 0

NSTAR_000001

EXHIBIT B

Outlook

Northstar Anesthesia NSA Submission Request for RA3530443100

From NorthstarNSA@halomd.com <NorthstarNSA@halomd.com>
Date Mon 3/3/2025 8:45 PM
To UHG_IDR_Disputes@uhc.com <UHG_IDR_Disputes@uhc.com>
Cc NorthstarNSA <NorthstarNSA@halomd.com>; Nikko Carbonel <Nikko.Carbonel@halomd.com>

2 attachments (90 KB)

726743-nsarequestattachment-information on the parties and items.pdf; 726743-nsarequestattachment-open negotiation notice.pdf;

NOTICE OF OPEN NEGOTIATION INITIATION BY PROVIDER

UNDER THE NO SURPRISES ACT

Pursuant to the No Surprises Act, Congress has established an independent dispute resolution (“IDR”) for payment disputes between certain out-of-network providers and insurers.

The qualified payment amount ("QPA") calculated and established by insurers based on statutory methodology is one of the factors to be considered in the IDR process.

The Act defines QPA as:

> The median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such insurer that are offered within the same insurance market . . .) as **the total maximum payment** (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, **on January 31, 2019**, for the same or a similar item or service that is provided by a provider **in the same or similar specialty** and provided in the **same geographic region** in which the item or service is furnished…Id. § 300gg-111(a)(3)(E)(i)(I).

The QPA for any given item or service is established once and subsequently adjusted annually for inflation, as outlined in Id. § 300gg-111(a)(3)(E)(i)(II).

Upon a Provider's request, the Act mandates that Insurers MUST furnish specific details about the QPA methodology used for the initial claim calculations.

Consequently, the Provider formally requests the Insurer to timely and immediately respond and disclose:

1. Whether the QPA for items and services involved included contracted rates that were not on a fee-for-service basis for those specific items and services and whether the QPA for those items and services was determined using underlying fee schedule rates or a derived amount;

2. If the plan used an eligible database to determine the QPA, and information to IDENTIFY WHICH SPECIFIC DATABASE was used;

3. If a related service code was used to determine the QPA for a new service code, information to identify the related service code; and

4. If applicable, a statement that the plan's contracted rates include risk-sharing, bonus, or other incentive-based or retrospective payments or payment adjustments for covered items and services that were excluded for purposes of calculating the QPA.

Further, in light of the recent ruling in *Texas Medical Association vs United States Department of Health and Human Services, Case No. 6:22-cv-450-JDK*, certain QPA regulations and methodologies have been identified as unlawful under the No Surprises Act, which include:

• **Inclusion of Rates not Provided:** The inclusion of contracted rates for services that providers have not provided. Reference: August FAQs (FAQ 14); 86 Fed. Reg. 36,872, at 36,889.

• **Out-of-Specialty Rates:** The inclusion of out-of-specialty rates in the QPA calculation. Reference: 45 C.F.R. § 149.140(a)(12).

• **Exclusion of Risk Sharing and Other Payments:** The exclusion from the QPA calculation of risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments. Reference: 45 C.F.R. § 149.140(b)(2)(iv); 45 C.F.R. § 149.140(b)(3)(i).

• **Use of Rates from All Plans by Self-insured Group Insurers:** Permitting self-insured group Insurers to use rates from all plans administered by a third-party administrator in calculating the QPA. Reference: 45 C.F.R. § 149.140(a)(8)(iv).

Given this court ruling, the Provider requests the Insurer verify that the QPA calculations for the disputed claim did not incorporate the aforementioned unlawful rates and methodologies.

The Provider is including the Explanation of Benefits Form for the disputed claim as a required document in open negotiation process. If the Insurer decides to delegate the IDR open negotiation process of this claim to a third-party representative or an agent, the Provider hereby requests that the Insurer provides affirmation that such representative or agent possesses FULL AUTHORIZATION to:

• Determine the claim's eligibility for IDR under NSA;

• Verify the QPA methodology utilized by the Insurer;

- **Engage in direct negotiations with the Provider;**
- **Reach a definitive settlement with the Provider;**
- **Formalize a DUALLY binding settlement agreement with the Provider on the Insurer's behalf;**
- **Guarantee prompt payment of the agreed settlement amount to the Provider on the Insurer's account.**

To be unequivocally clear, the Provider has supplied all requisite documentation within this correspondence to lawfully initiate open negotiation process. It is the sole responsibility of the Insurer to equip its chosen authorized agent with all of Insurer's pertinent information and documentation and all the documentation submitted by the Provider to engage in open negotiation process.

The Provider will NOT bear the burden of resending the same documentation already provided and attached hereto. Any oversight or omission in this regard falls squarely on the Insurer's shoulders, and the Provider expects not to be subjected to redundancy or unnecessary duplication in these proceedings.

Provider's Settlement Offer:

Attached hereby is the Open Negotiation Notice for claim #: RA3530443100.

The Provider proposes a settlement of **$6,385.50** as a fair and a reasonable payment for the medical procedure provided.

The Provider strongly urges the Insurer to thoroughly consider this settlement offer. Bypassing a settlement would compel both parties to shoulder additional costs and necessitate involving an Independent Dispute Resolution Entity ("IDRE")—a process that is both less efficient and more financially taxing.

The Provider requests a timely response from the Insurer regarding QPA methodology and offer presented by . Please direct all correspondence to NorthstarNSA@halomd.com.

This correspondence serves two distinct purposes:

1. Notification of Open Negotiations Under the No Surprises Act (NSA): Pursuant to the requirements of the NSA, this letter constitutes formal notice that the out-of-network Provider has initiated Open Negotiations regarding a payment dispute involving specific medical procedures rendered to members of Health Plan. These services were billed to Health Plan for reimbursement under a particular health care claim, and this notification serves to formally engage the Open Negotiations process.

1. REPEATED REQUEST FOR IN-NETWORK CONTRACT NEGOTIATIONS: In addition, and as a separate matter, the out-of-network Provider hereby formally requests to engage in good faith negotiations with Health Plan to establish fair and reasonable in-network contract rates. The out-of-network Provider has provided medically necessary services to a substantial number of Health Plan's members, and it is in the mutual interest of both parties to negotiate terms that reflect appropriate and fair reimbursement for the services rendered. The out-of-network Provider respectfully requests that Health Plan present in-network rates that are equitable, with the goal of establishing an in-network agreement. Such an

agreement will serve to improve member access to critical medical services at predictable costs. Given the specialized nature of the services provided by the out-of-network Provider, which necessitate significant expertise and operational investments, we further request that Health Plan assign a representative with full authority to negotiate contract terms, including reimbursement rates. Please be advised that the out-of-network Provider will not engage via Health Plan's portal or automated systems for this matter and expects direct negotiations with an authorized decision-maker to ensure a timely and productive resolution. Please contact us at distinct email to communicate about in-network negotiations at payor-contracting@halomd.com to arrange a meeting with an authorized representative, either in-person or virtually. We look forward to your prompt response to this request.

Thank you,

HaloMD

]>

OMB Control No. 1210-0169
Expiration Date: 11/30/2025

Open Negotiation Notice

03/03/2025

Patient Name:	PHI
Patient Account:	
DOS:	
Claim #:	RA3530443100
Provider:	NorthStar Anes Pennsylvania LLC (1700218989)
Health Plan:	UHC CHOICE PLUS

You are receiving this notice because NorthStar Anes Pennsylvania LLC (1700218989) health care provider is disputing the out-of-network rate for Medical services provided to a patient insured by you as a health plan or as a health plan administrator. More information regarding these items or services is provided below. The No Surprises Act provides a Federal independent dispute resolution (Federal IDR) process that group health plans, health insurance issuers of group and individual health insurance coverage, and FEHB carriers and out- of-network or nonparticipating health care providers, facilities, and providers of air ambulance services may utilize to determine the out-of-network rate for certain services following the end of an open negotiation period. The Federal IDR process is available only for certain services, such as out-of-network emergency services, certain services provided by out-of-network providers at an in-network facility, or air ambulance services. The Federal IDR process is also only available if a state All-Payer Model Agreement or specified state law does not apply.

What is an open negotiation period?

The open negotiation period is a period of up to 30 business days to determine an agreed-upon amount for the total out-of-network rate (including any cost sharing) for an item or service furnished by a nonparticipating provider, nonparticipating facility, or a nonparticipating provider of air ambulance services to a participant, beneficiary, or enrollee in a group health plan, group or individual health insurance policy, or FEHB carrier and for which a payment is required to be made by the plan or coverage.

What happens at the end of the open negotiation period?

If we have not agreed upon a payment amount by the end of the open negotiation period, 04/11/2025 either of us may initiate the Federal IDR process by 04/17/2025 under which a certified IDR entity will select the payment amount for the item(s) and/or service(s) at issue.

Initiating the Federal IDR process does not prohibit us from agreeing on a payment amount after the open negotiation period has ended and before the certified IDR entity determines the payment amount.

For more information on the Federal IDR process and to obtain the notice to initiate the Federal IDR process, visit https://www.nsa-idr.cms.gov.

]>

Information on the Parties and Item(s) and/or Service(s)

NorthStar Anes Pennsylvania LLC (1700218989) is initiating an open negotiation period with UHC CHOICE PLUS for the out-of-network rate of the following item(s) and/or service(s). To negotiate, please contact me (the initiating party) at the e-mail address or number below:

Item(s) and/or service(s):

Description of item(s) and/or service(s)	Claim #	Name of provider, and National Provider Identifier (NPI)	Date provided	Service code	Units billed per code	Initial payment (if no initial payment amount, write N/A)	Offer for total out-of-network rate (including any cost sharing)
NEURAXIAL LABOR ANALG/ANES PLND VAGINAL DELIVERY	RA3530443100	NorthStar Anes Pennsylvania LLC (NPI: 1700218989)	01/29/2025	01967	1283	1440.72	6,385.50

Megan Rausch

Signature

03/03/2025

Date

Megan Rausch

Print Name

Provider Representative

Relationship to Person(s) or entity

2915 W Bitters Rd #201, San Antonio, TX 78248

Mailing Address

(210) 598-4263

Telephone Number

NorthstarNSA@halomd.com

Email Address

Please keep a copy of this notice for your records.

EXHIBIT C

Outlook

NSA Open Negotiation Qualification-Case Number 5134274

From OON Mgmt <oon_mgmt@uhc.com>
on behalf of
UHG Negotiations No Reply <uhg_negotiations_noreply@uhc.com>
Date Fri 3/7/2025 8:52 AM
To NorthstarNSA <NorthstarNSA@halomd.com>

CAUTION: External Email

Please email any follow-up questions or concerns to uhg_idr_disputes@uhc.com. Any emails not sent to uhg_idr_disputes@uhc.com may be missed and no response sent.

Member Name: PHI

Date of Service:

Claim Number: RA3530443100

Service Code(s): 01967

Dear Provider:

We are in receipt of your request for Open Negotiation received on 03/02/2025. This letter is to inform you that the request does not qualify for Federal NSA IDR Pre-Negotiation. This case is ineligible for the following reason(s):

- We are either not able to identify this member or the member is covered under a plan not eligible for the NSA dispute process, please refer to your PRA for additional information.

If you have any questions please let us know. Thank you in advance for your time and attention.

Additionally, please ensure you review the Provider Remittance Advice to ensure all claims are eligible for negotiation and are being sent to the correct contacts

Negotiation requests are processed through our provider portal - www.uhcprovider.com. Select Reconsideration Request and then OON Negotiation to submit the request. For assistance in using the portal, contact provider services center at 877-842-3210.

Thank You,

UnitedHealthcare

EXHIBIT D

Outlook

Re: NSA Open Negotiation Qualification-Case Number 5134274

From NorthstarNSA <NorthstarNSA@halomd.com>
Date Tue 4/8/2025 10:32 AM
To UHG Negotiations No Reply <uhg_negotiations_noreply@uhc.com>

Good morning,

We are writing in response to your rejection of our open negotiation notice, in which you assert that you are neither the NSA handler nor the payor for this claim. However, upon reviewing the Explanation of Benefits (EOB) for this claim, it is clear that your organization is listed as the payor, and your email address is included as the point of contact.

As the payor listed on the EOB, you are obligated under the No Surprises Act to handle the open negotiation process for this claim. The responsibility for processing and responding to open negotiation notices falls to the payor or the designated Third Party Administrator (TPA) acting on their behalf. Given that your email address is listed on the EOB and you are the payor, we are proceeding under the assumption that your organization is the appropriate contact for this claim.

Unless you can provide documented evidence that another entity is the correct payor or NSA handler for this claim, we expect that you will engage in the open negotiation process as required under the No Surprises Act.

Please review your records and provide confirmation of your role in this matter, as well as a prompt response to our open negotiation notice. We look forward to your timely reply to resolve this matter in compliance with the No Surprises Act.

Thank you,
Northstar-HaloMD

HALOMD
No Surprises Act Leading Experts

From: OON Mgmt <oon_mgmt@uhc.com> on behalf of UHG Negotiations No Reply <uhg_negotiations_noreply@uhc.com>
Sent: Friday, March 7, 2025 9:52 AM
To: NorthstarNSA <NorthstarNSA@halomd.com>
Subject: NSA Open Negotiation Qualification-Case Number 5134274

CAUTION: External Email

Please email any follow-up questions or concerns to uhg_idr_disputes@uhc.com. Any emails not sent to uhg_idr_disputes@uhc.com may be missed and no response sent.

Member Name: PHI

Date of Service:

Claim Number: RA3530443100

Service Code(s): 01967

Dear Provider:

We are in receipt of your request for Open Negotiation received on 03/02/2025. This letter is to inform you that the request does not qualify for Federal NSA IDR Pre-Negotiation. This case is ineligible for the following reason(s):

- We are either not able to identify this member or the member is covered under a plan not eligible for the NSA dispute process, please refer to your PRA for additional information.

If you have any questions please let us know. Thank you in advance for your time and attention.

Additionally, please ensure you review the Provider Remittance Advice to ensure all claims are eligible for negotiation and are being sent to the correct contacts

***Negotiation requests are processed through our provider portal - www.uhcprovider.com. Select Reconsideration Request and then OON Negotiation to submit the request. For*

*assistance in using the portal, contact provider services center at 877-842-3210.***

Thank You,

UnitedHealthcare

EXHIBIT E

Outlook

Notice of IDR Initiation for DISP-3004314

From NorthstarNSA@halomd.com <NorthstarNSA@halomd.com>
Date Tue 4/15/2025 12:59 PM
To UHG_IDR_Disputes@uhc.com <UHG_IDR_Disputes@uhc.com>

1 attachment (50 KB)
IDRNoticeOfInitiation_DISP-3004314_4-15-2025.pdf;

CAUTION: External Email

Hello,

This Is Notice Of IDR Initiation For the following claim number

RA3530443100

The IDR was submitted Today 04/15/2025

Thank You,
HaloMD

Notice of IDR Initiation

OMB Control Number: 1210-0169 Expiration Date: 06/30/2025

Dispute Reference Number: DISP-3004314

Qualification Questions

Was the service in question provided prior to 1/1/2022?

No

I'm a(n):

Health care provider

Tax ID:

463047726

National Provider Identifier (NPI):

1700218989

Health Plan Type:

Either partially or fully self-insured private (employment-based) group health plan

ERISA Plan self insured

Yes

When did the open negotiation period start?

03/04/2025

Proof of Open Negotiation Documentation:

726743-ProofOfOpenNegotiation-726743-proofofopennegotiation.pdf

Did the health care provider, health care facility, or provider of air ambulance services get consent from the participant, beneficiary, or enrollee to waive surprise billing protections for these items or services?

No

What are you disputing today?

Single dispute

Health Care Provider, Health Care Facility, or Provider of Air Ambulance Services Information or TPA

Name:
NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC

Hospital, Facility or Group Name:
NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC

Mailing Address:
PO Box 612625

City: Dallas
State: TX
Zip Code: 75261

Email: northstarnsa@halomd.com
Phone: (210) 598-4264
Fax:

Primary Point-of-contact

Name:

Mailing Address:

City:
State:
Zip Code:

Email:
Phone:

Secondary point-of-contact

Name:

Mailing Address:

City:
State:
Zip Code:

Email:
Phone:

Group Health Plan / Health Insurance Issuer / FEHB Carrier Information or TPA

Name:
UHC CHOICE PLUS

Mailing Address:
PO Box 31394

City:	State:	Zip Code:
Salt Lake City	UT	84131

Email:	Phone:	Fax:
uhg_idr_disputes@uhc.com	(877) 797-8819	

Primary Point-of-contact

Name:

Mailing Address:

City:	State:	Zip Code:

Email:	Phone:

Secondary point-of-contact

Name:

Mailing Address:

City:	State:	Zip Code:

Email:	Phone:

Line Item

NEURAXIAL LABOR ANALG ANES PLND VAGINAL DELIVERY

Claim Number:
RA3530443100

Date of the qualified IDR item or service:
01/29/2025

Qualifying Payment Amount (QPA):
$1440.72

Qualifying Payment Amount documentation:
726743-EOB-726743_5951576_eob.pdf
726743-nsarequestattachment-open negotiation notice.pdf
726743-nsarequestattachment-information on the parties and items.pdf

Cost sharing amount allowed:
$0.00

Initial payment amount for the item(s) and/or service(s):
$1440.72

Type of Qualified Item(s) or Service(s):
Professional service(s)

Service Code:
01967

Place of Service Code:
21

Location of Service:
PA

Additional Supporting Documentation:

Certified IDR entity legal business name:
C2C Innovative Solutions, Inc.

Third Party Attestation:
Yes

Conflict of Interest Attestation

☑ I, the undersigned initiating party (or representative of the initiating party), attest that to the best of my knowledge the preferred certified IDR entity does not have a disqualifying conflict of interest and that the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) within the scope of the Federal IDR process.

Signature:
HaloMD ASD

Date:
04/15/2025

EXHIBIT F

Outlook

Your IDR Payment Determination

From Auto Reply Federal IDR Questions <auto-reply-federalidrquestions@cms.hhs.gov>
Date Fri 5/23/2025 9:28 PM
To NorthstarNSA <northstarnsa@halomd.com>; uhg_idr_disputes@uhc.com <uhg_idr_disputes@uhc.com>
Cc uhg_idr_disputes@uhc.com <uhg_idr_disputes@uhc.com>

1 attachment (10 KB)
DISP-3004314_FinalPaymentDetermination.pdf;

CAUTION: External Email

IDR dispute status: Payment Determination Made
IDR reference number: DISP-3004314

EdiPhy Advisors, L.L.C. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number DISP-3004314 and has made a final payment determination. Attached is a PDF of the final written payment determination.

Resources
Visit the No Surprises website for additional IDR resources.

Contact information
For questions, contact EdiPhy Advisors, L.L.C.. Include your IDR Reference number referenced above.

Thank you,
The IDR Review Team

IDR dispute status: Payment Determination Made
IDR reference number: DISP-3004314

EdiPhy Advisors, L.L.C. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-3004314** and has determined that NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, EdiPhy Advisors, L.L.C. has determined that the out-of-network payment amount of **$7,075.00** offered by NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC is the appropriate out-of-network rate for the item or service 01967 on claim number RA3530443100 under this dispute.

EdiPhy Advisors, L.L.C. based this determination on a review of the following:

NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC submitted an offer of $7,075.00

UHC CHOICE PLUS submitted an offer of $0.00

For each of the following determination factors, an "x" in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act)	X	
2	The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided	X	
3	The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual	X	
4	The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service	X	
5	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
6	Additional information submitted by a party	X	

Final Determination Rationale

For each of the determination factors for which there is an "x" in the *Initiating Party* and/or *Non-Initiating Party* column of the above chart, this means the party provided supporting

information (regardless of whether the information provided persuaded the Arbitrator that the factor should inform his/her decision). If the “additional information factor” is not checked, this may mean that either (i) no information other than information related to the specific factors was provided; or (ii) additional information was provided but the Arbitrator, in her/his sole discretion, determined such information was not related to the offers OR it was prohibited by the law. You must observe the decision rationale below to know which party provided the evidence that persuaded the IDRE to rule for the Prevailing Party on each factor.

The IDRE considered all the briefs and all permissible arguments and evidence submitted by the parties. The IDRE did not consider arguments or evidence which is prohibited by applicable regulations or guidance. The QPA and all additional information for which evidence was offered or arguments were made, as indicated, were considered and the following circumstances and information were found to weigh in favor of the Prevailing Party and were found to outweigh any information offered by the non-prevailing party. Any factor listed here was given sufficient weight by the arbitrator to influence the outcome of the decision:

(1) Level of Training/Experience of provider or facility (necessary to care)

If the Arbitrator concluded in her/his sole discretion that the submitting party failed to provide sufficient evidence on one of the other factors then it was not given weight and it will not be listed above in the rationale.

If there are any additional arguments or evidence among the rationale, the Arbitrator did consider them and if any of these arguments were given weight they are discussed here:

The IDRE notes that the NIP (Health Plan) only submitted an objection to the eligibility of the dispute and did not submit any other persuasive argument in its favor. The IDRE has overruled the NIP’s objection based on the evidence (or lack thereof) provided by the parties. The IP (Provider) however submitted a brief and a persuasive argument in its favor. Based on the evidence submitted, the IDRE ruled in favor of the IP (provider). To the extent the Initiating Party provided information about the usual and/or customary or out-of-network reimbursement rates for the services at issue, the IDRE is prohibited from considering this information under the regulations and it was given no weight. However, evidence of the in-network rates paid by other Issuers in the same market for the same services, when those issuers have a similar market share to the NIP, may have been considered on the topic of the Issuer’s good faith negotiations to the extent the Initiating Party submitted the evidence to support its offer as the appropriate OON rate. The IP says that the rate for interoperative monitoring CPT codes is artificially low because it includes “ghost rates.”

Accordingly, the IDRE concludes Prevailing Party's offer represents the best value of the IDR qualified services at issue in this dispute for these line items and that party’s offer should be the Out of Network rate paid on the referenced claims.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider or facility** when the amount of the offers selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider or facility and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

- **A non-participating provider or facility owes a refund to a plan, issuer or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FHHB carrier has paid to the non-participating provider or facility and 2) any cost sharing paid by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. EdiPhy Advisors, L.L.C. has determined that UHC CHOICE PLUS is the non-prevailing party in DISP-3004314 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816–8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar item or service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar item or service.

The initiating party with respect to dispute number DISP-3004314 was NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC. The initiating party’s NPI is 1700218989 and TIN is 463047726. The non-initiating party was UHC CHOICE PLUS. The 90-calendar day cooling off period begins on May 23, 2025 . Please retain this information for your records.

If the end of the open negotiation period for such an item or service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources
Visit the No Surprises website for additional IDR resources.

Contact information
For questions, contact EdiPhy Advisors, L.L.C.. Include your IDR Reference number referenced above.

Thank you,

EdiPhy Advisors, L.L.C.

EXHIBIT G

Outlook

DISP-3004314

From OON Mgmt <oon_mgmt@uhc.com>
on behalf of
UHG Negotiations No Reply <uhg_negotiations_noreply@uhc.com>
Date Thu 6/26/2025 10:41 AM
To EdiPhy Advisors, L.L.C. <IDRE@medmanagementllc.com>
Cc NorthstarNSA <northstarnsa@halomd.com>

ATTN: Please email any follow-up questions or concerns to uhg_idr_disputes@uhc.com. Any emails not sent to the uhg_idr_disputes@uhc.com may be missed and no response sent.

Hello,

We are in receipt of your determination for DISP-3004314.

Upon review, we found that claim RA3530443100 was not eligible for the NSA process due to this member's plan being a Medicaid plan. Currently, we are unable to reprocess this claim per the determination; however, we have submitted a complaint on the CMS Portal using the No Surprises Complaint Form with confirmation number 00918488. Once we receive a response from CMS regarding this dispute, we will review the case and process according to the guidance provided by CMS. If you have any questions related to this dispute, please feel free to email those to uhg_idr_disputes@uhc.com. We appreciate your patience in this matter.

We appreciate your help with this matter!

Thank You,

UnitedHealthcare

**********Please leave this and all below text intact when responding to this Email**********
refCS:ba30cf02-301a-f011-b553-005056a8e917:refCS refEID:7b8152f2-a352-f011-b556-005056ace3f2:refEID

EXHIBIT H

Outlook

Request to Reopen, Rescind, Reverse Eligibility and Close Award Determination DISP- 3004314

From HaloMD Legal Review <HaloMDLegalReview@halomd.com>
Date Tue 1/13/2026 4:42 PM
To sf-idre-disputes@ediphy.com <sf-idre-disputes@ediphy.com>; IDRE@medmanagementllc.com <IDRE@medmanagementllc.com>

4 attachments (516 KB)
DISP-3004314_FinalPaymentDetermination.pdf; Insurance Card_DISP-3004314_Redacted.pdf; VOB_DISP-3004314_Redacted.pdf; EOB_ DISP-3004314_Redacted.pdf;

Dispute # 3004314

IDR Entity,

Attached please find the Award Determination Notice for Dispute at issue, which we request be reopened under the Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties (June 2025) ("TA").

1. IDR Entity Error Identified by Initiating Party (Jurisdictional Errors)

Each identified jurisdictional error applicable to this dispute is marked below:[5]

☐ Incorrect determination that the item/service is eligible under NSA despite plan year beginning prior to January 1, 2022

☐Misclassification of an AllPayer Model Agreement or specified State L-aw Plan as eligible

☑ Erroneous inclusion/exclusion of Medicare, Medicaid, CHIP, TRICARE, IHS, or VA–covered services

☐ Failure to recognize provider participation status (in-network vs. out--of---network) on date of service provided to patient

☐ Failure to recognize facility participation status (in-network vs. out--of---network)

☐ Single CPT submission or batched claim (or batched CPTs) did not have an allowed amount established by health plan

☐ Other: _____

2. Protocol for Reopening a Closed Dispute

Under the TA:

"If a disputing party identifies an error after the certified IDR entity closes the dispute … The certified IDR entity should then report the error to the Departments … by submitting a request to reopen the closed dispute via the Federal IDR portal. If the Departments determine that the error is a … jurisdictional error, they will approve the reopening of the dispute in the Federal IDR portal, which will allow the certified IDR entity to … reverse a determination of eligibility."[3]

3. Information Requested from Non--Initiating Party

To facilitate reconciliation upon verification of ineligibility, the non-initiating- party is asked to provide, within 15 calendar days:

- Proof that payment of the original award determination was issued (e.g., remittance advice, transaction records).
- Confirmation that the initiating party received and collected such payment.
- Banking information or mailing address (or ACH details) to which the initiating party should refund the full award amount once the dispute is officially deemed ineligible by the Departments.

4. Requested Actions Under TA

In reliance upon this guidance, we request that [Certified IDR Entity] and the Departments:

1. Reopen this dispute via the Federal IDR portal.
2. Rescind the original payment determination.
3. Reverse the eligibility determination to reflect that the dispute is not eligible under the NSA.
4. Close the dispute as ineligible.
5. Refund all certified IDR entity fees in full to each party within 30 business days of close date of dispute as ineligible. in full to each party within 30 business days of reopening.

5. Fee Refund Requirement

The TA explicitly provides that:

"If the correction of an error reverses a determination that a dispute was or was not eligible for the Federal IDR process, the certified IDR entity must … refund...the parties for the certified IDR entity fee as appropriate for the resulting eligibility determination."[4]

Accordingly, we request full refunds of certified IDR entity fees to each party which paid the IDR Entity fees in the amount paid by each party.

6. Next Steps

Please confirm receipt of this request and advise on the reopening of **Dispute # 3004314**

Thank you,
HaloMD

NMR

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITEDHEALTHCARE OF PENNSYLVANIA, INC. d/b/a UNTEDHEALTHCARE COMMUNITY PLAN, *Plaintiff*, vs. NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC, *Defendant*.	Case No. 2:25-cv-07187-MAK

ORDER

AND NOW, this ____ day of _____, 2026, having considered Defendant NorthStar of Pennsylvania, LLC's Motion to Dismiss Plaintiff UnitedHealthcare of Pennsylvania Inc. d/b/a UnitedHealthcare Community Plan's Complaint (ECF 26), Defendant's Memorandum in Support, Plaintiff's Opposition, and Defendant's Reply, it is hereby **ORDERED** the Motion is **GRANTED**. Plaintiff UnitedHealthcare of Pennsylvania Inc. d/b/a UnitedHealthcare Community Plan's Complaint is dismissed with prejudice.

KEARNEY, J.