FIRST AMENDMENT TO THE CORPORATE INTEGRITY AGREEMENT BETWEEN THE OFFICE OF INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE MEDICAL CENTER OF CENTRAL GEORGIA, INC., D/B/A THE MEDICAL CENTER, NAVICENT HEALTH

I. PREAMBLE

The Medical Center of Central Georgia, Inc., doing business as The Medical Center, Navicent Health (MCCG),[1] and the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) hereby enter into this First Amendment (Amendment) to the Corporate Integrity Agreement (CIA) that was executed by and between MCCG and OIG and that became effective on April 23, 2015. Contemporaneously with this Amendment, The Medical Center, Navicent Health is entering into a Settlement Agreement with the United States.

Pursuant to Section XI.B of the CIA, the CIA may not be amended except by written consent of the parties to the CIA. MCCG and OIG hereby agree that the CIA between MCCG and OIG shall be amended as described below in this Amendment.

II. AMENDMENTS

A. The period of the compliance obligations assumed by MCCG under the CIA and Amendment shall be five years from the Amendment Effective Date, as defined below in Section III.A of this Amendment. Each one-year period, beginning with the one-year period following the Amendment Effective Date, shall be referred to as a "Reporting Period."

B. The Claims Review provisions outlined in Section III.D.2 of the CIA and Appendix B of the CIA shall remain in effect through the original five-year period of the CIA, which was effective on April 23, 2015. The first sentence of Section A in Appendix B of the CIA is amended to read: "The IRO shall perform the Claims Review in the First, Second, Fourth, and Fifth Reporting Periods."

[1] For purposes of this CIA, "MCCG" shall mean The Medical Center of Central Georgia, Inc., doing business as The Medical Center, Navicent Health and its directly or indirectly wholly-owned subsidiaries and affiliates that provide hospital services. For purposes of this CIA, MCCG does not include Hospice of Central Georgial or Central Georgia PET, LLC.

C. The Inpatient Medical Necessity and Appropriateness Review provisions outlined in Section III.D.3 of the CIA and Appendix C of the CIA shall remain in effect through the original five-year period of the CIA, which was effective on April 23, 2015.

D. The Validation Review provisions outlined in Section III.D.4 of the CIA shall remain in effect through the original five-year period of the CIA, which was effective on April 23, 2015.

E. Section III.D of the CIA is amended to add the following paragraph at the end of Section III.D of the CIA:

6. *Ambulance Claims Review.* The IRO shall review MCCG's coding, billing, and claims submission to the Federal health care programs and the reimbursement received for ambulance transportation services (Ambulance Claims Review) and shall prepare an Ambulance Claims Review Report, as outlined in Appendix D of the Amendment to the CIA, which is incorporated by reference.

F. Section V.A of the CIA (Implementation Report) is amended to add the following paragraph after Section V.A.16 of the CIA:

17. MCCG has previously submitted a written report to OIG summarizing the status of its implementation of the requirements of the CIA effective on April 23, 2015. Within 120 days after the Amendment Effective Date, MCCG shall submit a written report to OIG summarizing the status of its implementation of the additional requirements of this Amendment (Amendment Implementation Report). The Amendment Implementation Report shall include:

a. a list of all Policies and Procedures not previously provided that relate to MCCG's compliance with Federal health care program requirements for coding, billing, and claims submission for ambulance transportation services (copies of the Policies and Procedures shall be made available to OIG upon request);

b. a certification from the Compliance Officer that (1) to the best of his or her knowledge, MCCG is in compliance with all of the requirements of this Amendment; and (2) he or she has reviewed the Amendment Implementation Report and has made reasonable inquiry regarding its content and believes that the information in the report is accurate and truthful.

III. EFFECTIVE AND BINDING AGREEMENT

A. All terms and conditions of the CIA not modified in this Amendment shall remain in effect for five years after the Amendment Effective Date. The Effective Date of this Amendment shall be the date the final signatory signs this Amendment (Amendment Effective Date).

B. The undersigned MCCG signatories represent and warrant that they are authorized to execute this Amendment. The undersigned OIG signatories represent that they are signing this Amendment in their official capacities and that they are authorized to execute this Amendment.

C. This Amendment may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same Amendment. Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this Amendment.

ON BEHALF OF THE MEDICAL CENTER, NAVICENT HEALTH

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8-1-2017

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ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
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APPENDIX D

AMBULANCE CLAIMS REVIEW

A. Ambulance Claims Review. The IRO shall perform the Ambulance Claims Review annually to cover each of the five Reporting Periods of the Amendment. The IRO shall perform all components of each Ambulance Claims Review.

1. *Definitions*. For the purposes of the Ambulance Claims Review, the following definitions shall be used:

a. Overpayment: The amount of money MCCG has received in excess of the amount due and payable under Medicare or any state Medicaid program requirements, as determined by the IRO in connection with the Ambulance Claims Review performed under this Appendix D.

b. Paid Claim: A claim for ambulance transportation services, including any associated additional mileage claims, submitted by MCCG and for which MCCG has received reimbursement from the Medicare program or a state Medicaid program.

c. Population: The Population shall be defined as all Paid Claims during the 12-month period covered by the Ambulance Claims Review.

2. *Ambulance Claims Review Sample.* The IRO shall randomly select and review a sample of 100 Paid Claims for ambulance transportation services (Ambulance Claims Review Sample) consisting of the following categories of Paid Claims: (1) 30 Basic Life Support Emergency Paid Claims; (2) 15 Basic Life Support Non-Emergency Paid Claims; (3) 30 Advanced Life Support Emergency Paid Claims; (4) 15 Advance Life Support Non-Emergency Paid Claims; and (5) 10 Specialty Care Transport Paid Claims. The IRO shall review each category of Paid Claims separately. The Paid Claims shall be reviewed based on the supporting documentation available at MCCG's office or under MCCG's control and applicable Medicare and state Medicaid program requirements to determine whether the items and services furnished were medically necessary and appropriately documented, and whether the claim was correctly coded, submitted, and reimbursed. For each Paid Claim in the Ambulance Claims Review Sample that results in an Overpayment, the IRO shall review the system(s) and process(es) that generated the Paid Claim and identify any problems or weaknesses that may have resulted in the identified Overpayments. The IRO shall provide its observations and recommendations on suggested improvements to the system(s) and the process(es) that generated the Paid Claim.

3. *Other Requirements.*

a. Supplemental Materials. The IRO shall request all documentation and materials required for its review of the Paid Claims in the Ambulance Claims Review Sample and MCCG shall furnish such documentation and materials to the IRO prior to the IRO initiating its review of the Ambulance Claims Review Sample. If the IRO accepts any supplemental documentation or materials from MCCG after the IRO has completed its initial review of the Ambulance Claims Review Sample (Supplemental Materials), the IRO shall identify in the Ambulance Claims Review Report the Supplemental Materials, the date the Supplemental Materials were accepted, and the relative weight the IRO gave to the Supplemental Materials in its review. In addition, the IRO shall include a narrative in the Ambulance Claims Review Report describing the process by which the Supplemental Materials were accepted and the IRO's reasons for accepting the Supplemental Materials.

b. Paid Claims without Supporting Documentation. Any Paid Claim for which MCCG cannot produce documentation shall be considered an error and the total reimbursement received by MCCG for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not permitted.

c. Use of First Samples Drawn. For the purposes of the Ambulance Claims Review Sample discussed in this Appendix, the first set of Paid Claims selected shall be used (i.e., it is not permissible to generate more than one list of random samples and then select one for use with the Ambulance Claims Review Sample).

4. *Repayment of Identified Overpayments.* MCCG shall repay within 60 days the Overpayment(s) identified by the IRO in the Ambulance Claims Review Sample, in accordance with the requirements of 42 U.S.C. § 1320a-7k(d) and 42 C.F.R. § 401.301-305 (and any applicable CMS guidance) (the "CMS overpayment rule"). If MCCG determines that the CMS overpayment rule requires that an extrapolated Overpayment be repaid, MCCG shall repay that amount at the mean point estimate as calculated by the IRO. MCCG shall make available to OIG all documentation that reflects the refund of the Overpayment(s) to the payor. OIG, in its sole discretion, may refer the findings of the Ambulance Claims Review Sample (and any related work papers) received from MCCG to the appropriate Medicare or state Medicaid program contractor for appropriate follow up by the payor.

B. Ambulance Claims Review Report. The IRO shall prepare an Ambulance Claims Review Report as described in this Appendix for each Ambulance Claims Review performed. The following information shall be included in the Ambulance Claims Review Report.

1. *Ambulance Claims Review Methodology.*

   a. Ambulance Claims Review Population. A description of the Population subject to the Ambulance Claims Review.

   b. Ambulance Claims Review Objective. A clear statement of the objective intended to be achieved by the Ambulance Claims Review.

   c. Source of Data. A description of (1) the process used to identify Paid Claims in the Population and (2) the specific documentation relied upon by the IRO when performing the Ambulance Claims Review (e.g., medical records, physician orders, certificates of medical necessity, requisition forms, local medical review policies (including title and policy number), CMS program memoranda (including title and issuance number), Medicare carrier or intermediary manual or bulletins (including issue and date), other policies, regulations, or directives).

   d. Review Protocol. A narrative description of how the Ambulance Claims Review was conducted and what was evaluated.

   e. Supplemental Materials. A description of any Supplemental Materials as required by A.3.a., above.

2. *Statistical Sampling Documentation.*

   a. A copy of the printout of the random numbers generated by the "Random Numbers" function of the statistical sampling software used by the IRO.

   b. A description or identification of the statistical sampling software package used by the IRO.

3. *Ambulance Claims Review Findings.*

a. Narrative Results.

i. A description of MCCG's ambulance billing and coding system(s), including the identification, by position description, of the personnel involved in ambulance coding and billing.

ii. A description of controls in place at MCCG to ensure that all ambulance transportation services billed to Medicare or a state Medicaid program are medically necessary and appropriately documented.

iii. A narrative explanation of the IRO's findings and supporting rationale (including reasons for errors, patterns noted, etc.) regarding the Ambulance Claims Review, including the results of the Ambulance Claims Review Sample.

b. Quantitative Results. For each category of Paid Claims identified in Section A.2 of this Appendix, please provide:

i. Total number and percentage of instances in which the IRO determined that the coding of the Paid Claims submitted by MCCG differed from what should have been the correct coding and in which such difference resulted in an Overpayment to MCCG.

ii. Total number and percentage of instances in which the IRO determined that a Paid Claim was not appropriately documented and in which such documentation errors resulted in an Overpayment to MCCG.

iii. Total number and percentage of instances in which the IRO determined that a Paid Claim was for items or services that were not medically necessary and resulted in an Overpayment to MCCG.

iv. Total dollar amount of all Overpayments in the Ambulance Claims Review Sample.

v. Total dollar amount of Paid Claims included in the Ambulance Claims Review Sample.

vi. Error Rate in the Ambulance Claims Review Sample. The Error Rate shall be calculated by dividing the Overpayment in the Ambulance Claims Review Sample by the total dollar amount associated with the Paid Claims in the Ambulance Claims Review Sample.

vii. An estimate of the actual Overpayment in the Population at the mean point estimate.

viii. A spreadsheet of the Ambulance Claims Review results that includes the following information for each Paid Claim: Federal health care program billed, beneficiary health insurance claim number, date of service, code submitted (e.g., DRG, CPT code, etc.), code reimbursed, allowed amount reimbursed by payor, correct code (as determined by the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount.

c. Recommendations. The IRO's report shall include any recommendations for improvements to MCCG's ambulance billing and coding system or to MCCG's controls for ensuring that all ambulance transportation services billed to Medicare or a state Medicaid program are medically necessary and appropriately documented, based on the findings of the Ambulance Claims Review.

4. *Credentials*. The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Ambulance Claims Review and (2) performed the Ambulance Claims Review.