CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
AMERICAN MEDICAL RESPONSE OF MASSACHUSETTS, INC.

I. PREAMBLE

American Medical Response, Inc., on behalf of its wholly owned subsidiary, American Medical Response of Massachusetts, Inc. ("AMR") hereby enters into this Corporate Integrity Agreement ("CIA") with the Office of Inspector General ("OIG") of the United States Department of Health and Human Services ("HHS") to promote compliance with the statutes, regulations and written directives of Medicare, Medicaid and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f))("Federal health care program requirements") by AMR's officers, directors, employees, persons and entities engaged to bill/submit claims for reimbursement, and all other individuals responsible for the provision, marketing or documentation of items or services reimbursable by Federal health care programs, or in the preparation of claims, reports or other requests for reimbursement for such items or services ("Covered Persons"). The obligations set forth in this CIA apply only to AMR's operations with respect to American Medical Response of Massachusetts, Inc., not with respect to other AMR entities and operations. Contemporaneously with this CIA, AMR is entering into a Settlement Agreement with the United States, and this CIA is incorporated by reference into the Settlement Agreement.

II. TERM OF THE CIA

The period of the compliance obligations assumed by AMR under this CIA shall be three years from the Effective Date of this CIA (unless otherwise specified). The "Effective Date" of this CIA shall be the date on which the final signatory of this CIA executes this CIA.

Sections VII, VIII, IX, X, and XI shall expire no later than 120 days from the OIG's receipt of: (1) AMR's final annual report; or (2) any additional materials submitted by AMR pursuant to the OIG's request, whichever is later.

III. CORPORATE INTEGRITY OBLIGATIONS

Prior to the execution of this CIA, AMR established a Compliance Program and hereby agrees to maintain its Compliance Program for the duration of this CIA. In addition, to the extent not already implemented and for the duration of this CIA, AMR agrees to supplement its Compliance Program by adhering to the obligations contained in this CIA, including the maintenance of a Compliance Program that includes the following elements:

A. Compliance Officer and Committee.

1. *Compliance Officer.* AMR shall continue to have an individual serve as Compliance Officer. The Compliance Officer shall continue to be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements. The Compliance Officer shall continue to be a member of senior management of AMR or its owner Laidlaw, Inc., shall continue to make periodic (at least quarterly) reports regarding compliance matters directly to the Compliance Committee, and shall continue to be authorized to report on such matters to the Laidlaw, Inc. Board of Directors at any time. The Compliance Officer shall continue to be responsible for monitoring the day-to-day compliance activities engaged in by AMR as well as for any reporting obligations created under this CIA.

AMR shall report to the OIG, in writing, any changes in the identity or position description of the Compliance Officer, or any actions or changes that would affect the Compliance Officer's ability to perform the duties necessary to meet the obligations in this CIA within 15 days of such a change.

2. *Compliance Committee.* AMR shall continue to operate its corporate-level Compliance Committee composed of, among others, the Chief Executive Officer, the Chief Operating Officer, the Chief Financial Officer, the Vice President of Revenue Management, and the Compliance Officer. The Compliance Officer shall chair the Compliance Committee and the Committee shall support the Compliance Officer in fulfilling his/her responsibilities (*e.g.*, shall assist in the analysis of the organization's risk areas and shall oversee monitoring of audits and investigations).

AMR shall report to the OIG, in writing, any changes in the composition of the Compliance Committee, or any actions or changes that would affect the Compliance Committee's ability to perform the duties necessary to meet the obligations in this CIA within 15 days of such a change.

B. Written Standards.

1. *Code of Conduct.* AMR shall continue to maintain a written Code of Conduct. The Laidlaw Companies Code of Conduct, "The Right Road," has been distributed to all directors, officers, and employees employed by AMR on or after December 31, 1998. AMR shall distribute the Code of Conduct to all other Covered Persons within 90 days of the Effective Date of this CIA. AMR shall make the promotion of, and adherence to, the Code of Conduct an element in evaluating the performance of all employees. At a minimum, the Code of Conduct sets forth:

a. AMR's commitment to full compliance with all Federal health care program requirements, including its commitment to prepare and submit accurate claims consistent with such requirements;

b. AMR's requirement that all of its Covered Persons shall be expected to comply with all Federal health care program requirements and with AMR's own Policies and Procedures as described in section III.B (including the requirements of this CIA);

c. the requirement that all of AMR's Covered Persons shall be expected to report to the Compliance Officer or other appropriate individual designated by AMR suspected violations of any Federal health care program requirements or of AMR's own Policies and Procedures;

d. the possible consequences to both AMR and Covered Persons of failure to comply with Federal health care program requirements and with AMR's own Policies and Procedures and the failure to report such non-compliance; and

e. the right of all individuals to use the Disclosure Program described in section III.E, and AMR's commitment to maintain confidentiality, as appropriate, and non-retaliation with respect to such disclosures.

Each Covered Person shall certify annually, in writing, that he or she has received, read, understood, and will abide by the Code of Conduct. New Covered Persons shall receive the Code of Conduct and shall complete the required certification within one month after becoming a Covered Person.

AMR shall periodically review the Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such a review. Any such revised Code of Conduct shall be distributed within 30 days of finalizing such changes. Covered Persons shall certify that they have received, read, understood and will abide by the revised Code of Conduct within 30 days of the distribution of such revisions.

2. *Policies and Procedures*. AMR shall continue to implement written Policies and Procedures regarding the operation of AMR's compliance program and its compliance with Federal health care program requirements. At a minimum, the Policies and Procedures shall continue to address:

a. the subjects relating to the Code of Conduct identified in section III.B.1; and

b. measures designed to ensure that AMR fully complies with all applicable Medicare, Medicaid and other Federal health care programs' statutes, regulations and guidelines.

The relevant portions of the Policies and Procedures shall continue to be made available to all individuals whose job functions are related to those Policies and Procedures. Appropriate and knowledgeable staff should continue to be available to explain the Policies and Procedures.

At least annually (and more frequently if appropriate), AMR shall assess and update as necessary the Policies and Procedures. Within 30 days of the effective date of any revisions, the relevant portions of any such revised Policies and Procedures shall be made available to all individuals whose job functions are related to those Policies and Procedures.

C. Training and Education.

The Compliance Department shall be responsible for all training and education set forth below. All training and education set forth below shall be approved and coordinated by the Compliance Department and shall be conducted or supervised by the Compliance

Department.

1. *General Training.* Within 120 days of the Effective Date of this CIA, AMR, under the supervision of its Compliance Department, shall provide general training to each Covered Person. This training, at a minimum, shall explain AMR's:

a. CIA requirements (at least one hour); and

b. Compliance Program, including the Code of Conduct and the Policies and Procedures as they pertain to general compliance issues. (at least one hour). All Covered Persons who have received compliance program training within the nine months preceding the Effective Date of the CIA need not receive such training again during the first year of the CIA.

New Covered Persons shall receive the general training described above within 30 days of becoming a Covered Person or within 120 days after the Effective Date of this CIA, whichever is later. After receiving the initial training described above, each Covered Person shall receive at least one hour of general training annually.

2. *Specific Training.* Within 120 days of the Effective Date of this CIA, each Covered Person who is involved in the delivery of patient care items or services and/or in the preparation or submission of claims for reimbursement from any Federal health care program, including but not limited to medical transportation personnel, business development and marketing personnel, communications and dispatch personnel, and billing and patient business services personnel, (hereinafter referred to as "Relevant Covered Persons") shall receive at least four hours of specific training annually in addition to the general training required above. This specific training shall include a discussion of:

a. the submission of accurate bills for services rendered to Federal health care program beneficiaries;

b. policies, procedures and other requirements applicable to the documentation of medical records;

c. the personal obligation of each individual involved in the billing process to ensure that such billings are accurate;

d. applicable reimbursement statutes, regulations, and program requirements and directives;

e. the legal sanctions for improper billings; and

f. examples of proper and improper billing practices.

Persons providing the training must be knowledgeable about the subject area.

Relevant Covered Persons shall receive this training within 60 days of the beginning of their employment or becoming Relevant Covered Persons or within 120 days of the Effective Date of this CIA, whichever is later. An AMR employee who has completed the specific training shall review a new Relevant Covered Person's work, to the extent that the work relates to the delivery of patient care items or services and/or in the preparation or submission of claims for reimbursement from any Federal health care program, until such time as the new Relevant Covered Person completes his/her applicable training.

3. *State and Local Government Employees.* AMR shall offer the general and specific training described above to all State and Local Government employees who fall within the definition of "Covered Persons" or "Relevant Covered Persons." In its Annual Report, AMR shall identify the measures it has taken to encourage the participation in training by such State and Local Government employees and shall list the numbers of such State and Local Government employees who attended training the prior year.

4. *Certification.* Each individual who is required to attend training shall certify, in writing, that he or she has received the required training. The certification shall specify the type of training received and the date received. The Compliance Department shall maintain a record of training activities, including retaining the employee certifications and a copy of all course materials. These shall be made available to the OIG, upon request.

D. Review Procedures.

1. *General Description.* AMR shall conduct annual reviews of its billing and coding practices either by retaining an outside compliance firm or by using its own staff pursuant to the Internal Claims Review Option. Both of these options are described below.

a. Outside Compliance Firm Option. If AMR elects this option, then within 120 days of the Effective Date of this CIA, AMR shall retain an entity such as an accounting, auditing or consulting firm (hereinafter "Outside Compliance Firm") to perform review engagements to assist AMR in assessing and evaluating its billing and coding practices and systems pursuant to this CIA and the Settlement Agreement. Each Outside Compliance Firm retained by AMR shall have expertise in the billing, coding, reporting and other requirements of the particular section of the health care industry pertaining to this CIA and in the general requirements of the Federal health care program(s) from which AMR seeks reimbursement. Each Outside Compliance Firm shall assess, along with AMR, whether it can perform the engagement in a professionally independent fashion taking into account any other business relationships or other engagements that may exist.

b. Internal Claims Review Option. For the first Reporting Period (as defined in Section III.D.1.d), AMR may use its own staff or contractors to conduct an internal review of its billing and coding practices with respect to the Federal health care programs ("Internal Claims Review Option"), which review shall comply with all of the requirements outlined in Section III.D and in Appendix A to this CIA ("Claims Review"). Following its review of AMR's most recently submitted Annual Report, if, in its sole discretion, the OIG determines that AMR's internal Claims Review satisfactorily establishes the adequacy of AMR's billing and compliance practices pursuant to this CIA, the OIG may allow AMR to continue to perform the internal Claims Review in conformance with the requirements of Section III.D and Appendix A to this CIA for Reporting Periods two and three of this CIA. To the extent that the OIG permits AMR to perform internal Claims Reviews, AMR shall submit all information required by the provisions outlined in Section III.D and in Appendix A to this CIA.

c. Retention of Independent Review Organization. If AMR chooses the Internal Claims Review Option, then within 120 days of the Effective Date of this CIA, AMR shall retain an entity such as an accounting, auditing or consulting firm (hereinafter "Independent Review Organization" or "IRO") to perform review engagements to

assist AMR in assessing and evaluating its billing and coding practices and systems pursuant to this CIA and the Settlement Agreement. Each IRO retained by AMR shall have expertise in the billing, coding, reporting and other requirements of the particular section of the health care industry pertaining to this CIA and in the general requirements of the Federal health care program(s) from which AMR seeks reimbursement. Each IRO shall assess, along with AMR, whether it can perform the IRO engagement in a professionally independent fashion taking into account any other business relationships or other engagements that may exist.

c. IRO Verification or Claims Review

i. If AMR chooses the Internal Review Option, for the first Reporting Period, the IRO shall conduct a review of at least 20% of the sampling units reviewed by AMR in its internal Claims Review ("Verification Review").

ii. If AMR is permitted to perform the internal Claims Review after the first Reporting Period, the IRO shall conduct a Verification Review for each of those successive years of the CIA.

iii. If the OIG does not allow AMR to perform the Claims Review internally after the first Reporting Period, the IRO shall conduct the Claims Review for each successive year of the CIA.

As part of AMR's Annual Report, the IRO shall submit a report that verifies that the requirements outlined in Section III.D and in Appendix A to this CIA have been satisfied and shall report the results, sampling unit by sampling unit, of any Verification Review or Claims Review performed.

d. Frequency of Claims Review. Regardless of which option is chosen, the Claims Review shall be performed annually and shall cover each of the one-year periods of the CIA beginning with the Effective Date of this CIA ("Reporting Period"). The Claims Review shall be conducted in accordance with Section III.D and Appendix A

to this CIA.

e. Retention of Records. AMR, the Outside Compliance Firm and the IRO shall retain and make available to the OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (including those exchanged between the IRO, the Outside Compliance Firm and/or AMR related to the Claims Review).

2. *Claims Review.*

The Claims Review shall include a Discovery Sample and, if necessary, a Full Sample. The definitions, procedures, and reporting requirements applicable to the Claims Review are outlined in Appendix A to this CIA, which is incorporated by reference.

a. Discovery Sample. A sample of 50 Paid Claims submitted by or on behalf of AMR shall be randomly selected and reviewed. The Paid Claims shall be reviewed based on the supporting documentation available at AMR or under AMR's control and applicable billing and coding regulations and guidance to determine whether the claim submitted was correctly coded, submitted, and reimbursed.

i. Results of Discovery Sample. If the Error Rate (as defined in Appendix A) for a Discovery Sample is less than 5%, no additional sampling is required, nor is a Systems Review required. (Note: The threshold listed above does not imply that this is an acceptable error rate. Accordingly, AMR should, as appropriate, further analyze any errors identified in the Discovery Sample. AMR recognizes that the OIG or other HHS component, in its discretion and as authorized by statute, regulation, or other appropriate authority, may also analyze or review Paid Claims included, or errors identified, in the Discovery Sample.)

ii. If a Discovery Sample indicates that the Error Rate is 5% or greater, then a Full Sample and a Systems Review shall be performed, as described below.

b. Full Sample. If necessary, as determined by procedures set forth in Sections III.D.1 and III.D.2.a, AMR and/or the IRO and/or the Outside Compliance Firm, as applicable, shall perform an additional sample of Paid Claims using commonly accepted sampling methods and in accordance with Appendix A to this CIA. The Full Sample should be designed to (i) estimate the actual Overpayment in the population with a 90% confidence level and with a maximum relative precision of 25% of the point estimate and (ii) conform with the Centers for Medicare and Medicaid Services' statistical sampling for overpayment estimation guidelines. The Paid Claims shall be reviewed based on supporting documentation available at AMR or under AMR's control and applicable billing and coding regulations and guidance to determine whether the claim submitted was correctly coded, submitted, and reimbursed. For purposes of calculating the size of the Full Sample, the Discovery Sample may serve as the probe sample, if statistically appropriate. Additionally, the Items sampled as part of the Discovery Sample may be used, and the corresponding findings for those 50 Items, as part of its Full Sample. The OIG, in its full discretion, may refer the findings of the Full Sample (and any related workpapers) received from AMR to the appropriate Federal health care program payor, including the Medicare contractor (*e.g.*, carrier, fiscal intermediary, or DMERC), for appropriate follow-up by that payor.

c. Systems Review. If a Discovery Sample identifies an Error Rate of 5% or greater, a Systems Review shall also be conducted. Specifically, for each claim in the Discovery Sample and Full Sample that resulted in an Overpayment, AMR or the IRO or the Outside Compliance Firm, as applicable, shall perform a "walk through" of the system(s) and process(es) that generated the claim to identify any problems or weaknesses that may have resulted in the identified Overpayments. AMR or the IRO or the Outside Compliance Firm, as applicable, shall report its observations of the Systems Review and shall develop recommendations on suggested improvements to the system(s) and the process(es) that generated the claim.

d. Repayment of Identified Overpayments. In accordance with

Section III.H.1, AMR shall repay within 30 days any Overpayment(s) identified in the Discovery Sample or the Full Sample (if applicable), regardless of the Error Rate, to the appropriate payor and in accordance with payor refund policies. AMR shall make available to the OIG any and all documentation that reflects the refund of the Overpayment(s) to the payor and the associated documentation.

3. *Claims Review Report.* AMR or the IRO or the Outside Compliance Firm, as applicable, shall prepare a report based upon the Claims Review performed (the "Claims Review Report"). Information to be included in the Claims Review Report is detailed in Appendix A to this CIA.

4. *Validation Review.* In the event the OIG has reason to believe that: (a) AMR's Claims Review fails to conform to the requirements of this CIA; or (b) AMR and/or the IRO's and/or the Outside Compliance Firm's findings or Claims Review results are inaccurate, the OIG may, at its sole discretion, conduct its own review to determine whether the Claims Review or Unallowable Cost Review complied with the requirements of the CIA and/or the findings or Claims Review results are inaccurate ("Validation Review"). AMR agrees to pay for the reasonable cost of any such review performed by the OIG or any of its designated agents so long as it is initiated before one year after AMR's final submission (as described in section II) is received by the OIG.

Prior to initiating a Validation Review, the OIG shall notify AMR of its intent to do so and provide a written explanation of why the OIG believes such a review is necessary. To resolve any concerns raised by the OIG, AMR may request a meeting with the OIG to discuss the results of any Claims Review submissions or findings; present any additional or relevant information to clarify the results of the Claims Review to correct the inaccuracy of the Claims Review; and/or propose alternatives to the proposed Validation Review. AMR agrees to provide any additional information as may be requested by the OIG under this section in an expedited manner. The OIG will attempt in good faith to resolve any Claims Review with AMR prior to conducting a Validation Review. However, the final

determination as to whether or not to proceed with a Validation Review shall be made at the sole discretion of the OIG.

5. *Independence Certification.* The IRO and the Outside Compliance Firm, if applicable, shall include in its report(s) to AMR a certification or sworn affidavit that it has evaluated its professional independence with regard to the Claims Review and that it has concluded that it was, in fact, independent.

E. Disclosure Program.

AMR shall continue to operate a Disclosure Program that includes a mechanism (*e.g.*, a toll-free compliance telephone line) to enable individuals to disclose, to the Compliance Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with AMR's policies, conduct, practices, or procedures with respect to a Federal health care program, believed by the individual to be a potential violation of criminal, civil or administrative law. AMR shall continue to appropriately publicize the existence of the disclosure mechanism (*e.g.*, via periodic e-mails to employees or by posting the information in prominent common areas).

The Disclosure Program shall continue to emphasize a non-retribution, non-retaliation policy, and shall continue to include a reporting mechanism for anonymous communications for which appropriate confidentiality will be maintained. Upon receipt of a disclosure, the Compliance Officer (or designee) shall gather all relevant information from the disclosing individual. The Compliance Officer (or designee) shall make a preliminary, good faith inquiry into the allegations set forth in every disclosure to ensure that he or she has obtained all of the information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that it reasonably: (1) permits a determination of the appropriateness of the alleged improper practice; and (2) provides an opportunity for taking corrective action, AMR shall conduct an internal review of the allegations set forth in such a disclosure and ensure that proper follow-up is conducted.

The Compliance Officer (or his or her designee) shall continue to maintain a disclosure log, which shall include a record and summary of each disclosure received (whether anonymous or not), the status of the respective internal reviews, and any corrective action taken in response to the internal reviews. The disclosure log shall be available to the OIG, upon request.

F. Ineligible Persons.

1. Definition. For purposes of this CIA, an "Ineligible Person" shall be any individual or entity who: (a) is currently excluded, debarred or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs; or (b) has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred or otherwise declared ineligible.

2. Screening Requirements. AMR shall continue its policy to not hire as employees or engage as contractors any Ineligible Person. To prevent hiring or contracting with any Ineligible Person, AMR shall continue to screen all prospective employees and prospective contractors prior to engaging their services by: (a) requiring applicants to disclose whether they are Ineligible Persons; and (b) appropriately querying the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at http://epls.arnet.gov) and the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at http://oig.hhs.gov) (these lists will hereinafter be referred to as the "Exclusion Lists"). Nothing in this section affects the responsibility of (or liability for) AMR to refrain from billing Federal health care programs for services of the Ineligible Person.

3. Review and Removal Requirement. AMR shall review annually its list of current employees and contractors against the Exclusion Lists. In addition, AMR shall continue to require employees and contractors to disclose immediately any debarment, exclusion, or other event that makes the employee an Ineligible Person.

If AMR has actual notice that an employee or contractor has become an Ineligible Person, AMR shall continue its policy to remove such person from responsibility for, or involvement with, AMR's business operations related to the Federal health care programs and shall remove such person from any position for which the person's salary or the items or services rendered, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds at least until such time as the person is reinstated into participation in the Federal health care programs.

4. Pending Charges and Proposed Exclusions. If AMR has actual notice that an employee or contractor is charged with a criminal offense related to any Federal health care program, or is proposed for exclusion during his or her employment or contract term, AMR shall continue its policy to take all appropriate actions to ensure that

the responsibilities of that employee or contractor have not and shall not adversely affect the quality of care rendered to any beneficiary or patient, or the accuracy of any claims submitted to any Federal health care program.

G. Notification of Government Investigation or Legal Proceedings.

Within 30 days of discovery, AMR shall notify the OIG, in writing, of any ongoing investigation known to AMR or legal proceeding conducted or brought by a governmental entity or its agents involving an allegation that AMR has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. AMR shall also provide written notice to the OIG within 30 days of the resolution of the matter, and shall provide the OIG with a description of the findings and/or results of the proceedings, if any.

H. Reporting.

1. Overpayments

a. Definition of Overpayments. For purposes of this CIA, an "overpayment" shall mean the amount of money AMR has received in excess of the amount due and payable under any Federal health care program requirements.

b. Reporting of Overpayments. If, at any time, AMR identifies or learns of the existence of any overpayments, AMR shall notify the payor (*e.g.*, Medicare fiscal intermediary or carrier) within 30 days of identification of the overpayment and take remedial steps within 60 days of identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the overpayments from recurring. Also, within 30 days of identification of the overpayment, AMR shall repay the overpayment to the appropriate payor to the extent such overpayment has been quantified. If not yet quantified, within 30 days of identification, AMR shall notify the payor of its efforts to quantify the overpayment amount along with a schedule of when such work is expected to be completed. Notification and repayment to the payor should be done in accordance with the payor's policies, and for Medicare contractors, must include the information

contained on the Overpayment Refund Form, provided as Appendix B to this CIA. Notwithstanding the above, notification and repayment of any overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

2. Material Deficiencies.

a. Definition of Material Deficiency. For purposes of this CIA, a "Material Deficiency" means anything that involves:

(i) a substantial overpayment; or

(ii) a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized.

A Material Deficiency may be the result of an isolated event or a series of occurrences.

b. Reporting of Material Deficiencies. If AMR determines through any means that there is a Material Deficiency, AMR shall notify the OIG, in writing, within 30 days of making the determination that the Material Deficiency exists. The report to the OIG shall include the following information:

(i) If the Material Deficiency results in an overpayment, the report to the OIG shall be made at the same time as the notification to the payor required in section III.H.1, and shall include all of the information on the Overpayment Refund Form, as well as:

(A) the payor's name, address, and contact person to whom the overpayment was sent; and

(B) the date of the check and identification number (or electronic transaction number) by which the overpayment was repaid/refunded;

(ii) a complete description of the Material Deficiency, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

(iii) a description of AMR's actions taken to correct the Material Deficiency; and

(iv) any further steps AMR plans to take to address the Material Deficiency and prevent it from recurring.

IV. NEW BUSINESS UNITS OR LOCATIONS

In the event that, after the Effective Date of this CIA, AMR of Massachusetts changes locations or sells, closes, purchases or establishes new business units related to the furnishing of items or services that may be reimbursed by Federal health care programs, AMR shall notify the OIG of this fact as soon as possible, but no later than within 30 days of the date of change of location, sale, closure, purchase or establishment. This notification shall include the location of the new operation(s), phone number, fax number, Medicare provider number(s) (if any), and the corresponding contractor's name and address that has issued each Medicare provider number. All Covered Persons at such locations shall be subject to the applicable requirements in this CIA (*e.g.*, completing certifications and undergoing training).

V. ANNUAL REPORTS

AMR shall submit to the OIG Annual Reports with respect to the status of, and findings regarding, AMR's compliance activities for each of the three one-year periods beginning on the Effective Date of the CIA. (The one-year period covered by each Annual Report shall be referred to as "the Reporting Period"). Each Annual Report shall include:

1. the name, address, phone number, and position description of the Compliance Officer required by section III.A, and a summary of other non-compliance job responsibilities the Compliance Officer may have;

2. the names and positions of the members of the Compliance Committee required by section III.A;

3. a copy of AMR's Code of Conduct required by section III.B.1;

4. in the first Annual Report, a copy of all compliance-related Policies and Procedures required by section III.B.2 and a summary of all other Policies and Procedures required by section III.B.2;

5. in subsequent Annual Reports, a summary of any significant changes or amendments to the Policies and Procedures required by section III.B and the reasons for such changes (*e.g.*, change in contractor policy) and copies of any compliance-related Policies and Procedures;

6. a copy of all training materials used for the training required by section III.C, a description of such training, including a description of the targeted audiences, length of sessions, which sessions were mandatory and for whom, percentage of attendance, and a schedule of when the training sessions were held;

7. a certification by the Compliance Officer and the American Medical Response, Inc. Chief Executive Officer that:

a. the Policies and Procedures required by section III.B have been developed, are being implemented, and have been made available to all appropriate Covered Persons;

b. all Covered Persons have completed the Code of Conduct certification required by section III.B.1;

c. all Covered Persons have completed the applicable training and executed the certification(s) required by section III.C; and

d. AMR has complied with its obligations under the Settlement Agreement: (i) not to resubmit to any Federal health care program payors any previously denied claims related to the Covered Conduct addressed in the Settlement Agreement, and not to appeal any such denials of claims; (ii) not to charge to or otherwise seek payment from Federal or State payors for unallowable costs (as defined in the Settlement Agreement); and (iii) to identify and adjust any past charges or claims for unallowable costs.

The documentation supporting this certification shall be available to the OIG, upon request.

8. a description of the Disclosure Program required by section III.E;

9. the identity of the IRO and any Outside Compliance Firm, a summary/description of all engagements between AMR and the IRO or Outside Compliance Firm, including, but not limited to, any outside financial audits, compliance program engagements, or reimbursement consulting, and the proposed start and completion dates of the first annual review;

10. a certification from the IRO and/or any Outside Compliance Firm regarding their professional independence from AMR;

11. a summary of personnel actions (other than hiring) taken pursuant to section III.F.;

12. a list of all of AMR's operating entities corresponding to a Medicare provider number (including locations and mailing addresses) and the corresponding name and provider number under which each entity is doing business, the corresponding phone numbers and fax numbers, and the name and address of the Medicare contractor to which the AMR entity currently submits claims;

13. a description of AMR's corporate structure, including identification of any parent and sister companies, subsidiaries and their respective lines of business;

14. a complete copy of all reports prepared by the IRO or Outside Compliance Firm and pursuant to the Claims Reviews conducted by AMR as set forth in Section III.D., including a copy of the methodology used, along with a copy of the IRO's and Outside Compliance Firm's engagement letter;

15. AMR's response and corrective action plan(s) related to any issues raised by the IRO and the Outside Compliance Firm and by AMR's own Claims Reviews;

16. a summary of Material Deficiencies (as defined in III.H) identified during the Reporting Period and the status of any corrective and preventative action relating to all such Material Deficiencies;

17. a report of the aggregate overpayments that have been returned to the Federal health care programs. Overpayment amounts should be broken down into the following categories: Medicare, Medicaid (report each applicable state separately, if applicable) and other Federal health care programs. Overpayment amounts that are routinely reconciled or adjusted pursuant to policies and procedures established by the payor do not need to be included in this aggregate overpayment report;

18. a summary of the disclosures in the disclosure log required by section III.E that: (a) relate to Federal health care programs; or (b) allege abuse or neglect of patients;

19. a description of any personnel actions (other than hiring) taken by AMR as a result of the obligations in section III.F, and the name, title, and responsibilities of any person that falls within the ambit of section III.F.4, and the actions taken in response to the obligations set forth in that section;

20. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to section III.G. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

21. a description of all changes to the most recently provided list (as updated) of AMR's locations (including locations and mailing addresses) as required by section V.A.11, the corresponding name under which each location is doing business, the corresponding phone numbers and fax numbers, each location's Federal health care program provider identification number(s), and the contractor name and address that issued each provider identification number;

22. the certification required by section V.C.; and

23. identification of the measures AMR has taken to encourage the participation in training by State and Local Government employees and a listing of the percentages of State and Local Government employees who attended training the prior year, as required by section III.C.

The first Annual Report shall be received by the OIG no later than 60 days after

the end of the first Reporting Period. Subsequent Annual Reports shall be received by the OIG no later than the anniversary date of the due date of the first Annual Report.

C. Certifications. The Annual Reports shall include a certification by the Compliance Officer that: (1) except as otherwise described in the applicable report, AMR is in compliance with all of the requirements of this CIA, to the best of his or her knowledge; and (2) the Compliance Officer has reviewed the Report and has made reasonable inquiry regarding its content and believes that the information is accurate and truthful.

D. Designation of Information. AMR shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act ("FOIA"), 5 U.S.C. § 552. AMR shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing after the Effective Date of this CIA, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG:

Civil Recoveries Branch - Compliance Unit
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, SW
Washington, DC 20201
Phone: 202.619.2078
Fax: 202.205.0604

AMR:

Anthony O. Boswell, Esq.
Corporate Compliance Officer
Laidlaw Inc.
600 Six Flags Drive, Suite 300

Arlington, TX 76011
Phone: 817.652.9974
Fax: 817.652.9983

and

James J. Graham, Esq.
Jones, Day, Reavis & Pogue
51 Louisiana Avenue, NW
Washington, DC 20001
Phone: 202.879.3939
Fax: 202.626.1700

Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery or other means, provided that there is proof that such notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt.

VII. OIG INSPECTION, AUDIT AND REVIEW RIGHTS

In addition to any other rights the OIG may have by statute, regulation, or contract, the OIG or its duly authorized representative(s) may examine or request copies of AMR's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of AMR's locations for the purpose of verifying and evaluating: (a) AMR's compliance with the terms of this CIA; and (b) AMR's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by AMR to the OIG or its duly authorized representative(s) at all reasonable times for inspection, audit or reproduction. Furthermore, for purposes of this provision, the OIG or its duly authorized representative(s) may interview any of AMR's employees, contractors, or agents who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and the OIG. AMR agrees to assist the OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon the OIG's request. AMR's employees may elect to be interviewed with or without a representative of AMR present.

VIII. DOCUMENT AND RECORD RETENTION

AMR shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs, or to compliance with this CIA, for four years (or longer if otherwise required by law).

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, the OIG shall make a reasonable effort to notify AMR prior to any release by the OIG of information submitted by AMR pursuant to its obligations under this CIA and identified upon submission by AMR as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, AMR shall have the rights set forth at 45 C.F.R. § 5.65(d). AMR shall refrain from identifying any information as exempt from release if that information does not meet the criteria for exemption from disclosure under FOIA.

X. BREACH AND DEFAULT PROVISIONS

AMR is expected to fully and timely comply with all of its CIA obligations.

A. Stipulated Penalties for Failure to Comply with Certain Obligations. As a contractual remedy, AMR and the OIG hereby agree that failure to comply with certain obligations set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as "Stipulated Penalties") in accordance with the following provisions.

1. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day AMR fails to have in place any of the obligations described in section III:

a. a Compliance Officer;

b. a Compliance Committee;

c. a written Code of Conduct;

d. written Policies and Procedures;

e. a requirement that Covered Persons be trained; and

f. a Disclosure Program.

2. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day AMR fails to retain an IRO, as required in section III.D.

3. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day AMR fails to meet any of the deadlines for the submission of the Implementation Report or the Annual Reports to the OIG.

4. A Stipulated Penalty of $2,000 (which shall begin to accrue on the date the failure to comply began) for each day AMR employs or contracts with an Ineligible Person and that person: (i) has responsibility for, or involvement with, AMR's business operations related to the Federal health care programs; or (ii) is in a position for which the person's salary or the items or services rendered, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds (the Stipulated Penalty described in this paragraph shall not be demanded for any time period during which AMR can demonstrate that it did not discover the person's exclusion or other ineligibility after making a reasonable inquiry (as described in section III.F) as to the status of the person).

5. A Stipulated Penalty of $1,500 for each day AMR fails to grant access to the information or documentation as required in section VII of this CIA. (This Stipulated Penalty shall begin to accrue on the date AMR fails to grant access.)

6. A Stipulated Penalty of $1,000 for each day AMR fails to comply fully and adequately with any obligation of this CIA. In its notice to AMR, the OIG shall state the specific grounds for its determination that AMR has failed to comply fully and adequately with the CIA obligation(s) at issue and steps AMR must take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after AMR receives notice from the OIG of the failure to comply.) A Stipulated Penalty as described in this paragraph shall not be demanded for any violation for which the OIG has sought a Stipulated Penalty under paragraphs 1-5 of this section.

B. Timely Written Requests for Extensions. AMR may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file

any notification or report required by this CIA. Notwithstanding any other provision in this section, if the OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after AMR fails to meet the revised deadline set by the OIG. Notwithstanding any other provision in this section, if the OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after AMR receives the OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by the OIG at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties.

1. Demand Letter. Upon a finding that AMR has failed to comply with any of the obligations described in section X.A and after determining that Stipulated Penalties are appropriate, the OIG shall notify AMR of: (a) AMR's failure to comply; and (b) the OIG's exercise of its contractual right to demand payment of the Stipulated Penalties (this notification is hereinafter referred to as the "Demand Letter").

2. Response to Demand Letter. Within 10 days of the receipt of the Demand Letter, AMR shall either: (a) cure the breach to the OIG's satisfaction and pay the applicable Stipulated Penalties; or (b) request a hearing before an HHS administrative law judge ("ALJ") to dispute the OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in section X.E. In the event AMR elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until AMR cures, to the OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this CIA and shall be grounds for exclusion under section X.D.

3. Form of Payment. Payment of the Stipulated Penalties shall be made by certified or cashier's check, payable to: "Secretary of the Department of Health and Human Services," and submitted to the OIG at the address set forth in section VI.

4. Independence from Material Breach Determination. Except as set forth in section X.D.1.c, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for the OIG's decision that AMR has materially breached this CIA, which decision shall be made at the OIG's discretion and shall be governed by the

provisions in section X.D, below.

D. Exclusion for Material Breach of this CIA

1. Definition of Material Breach. A material breach of this CIA means:

a. a failure by AMR to report a Material Deficiency, take corrective action and make the appropriate refunds, as required in section III.H, provided that any of the following individuals at AMR had notice of the reportable event: an officer, director, a senior executive, the compliance officer or a director or manager in the Compliance Department;

b. a repeated or flagrant violation of the obligations under this CIA, including, but not limited to, the obligations addressed in section X.A;

c. a knowing failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with section X.C; or

d. a failure to retain and use an Independent Review Organization in accordance with section III.D.

2. Notice of Material Breach and Intent to Exclude. The parties agree that a material breach of this CIA by AMR, as described herein, constitutes an independent basis for AMR's exclusion from participation in the Federal health care programs. Upon a determination by the OIG that AMR has materially breached this CIA and that exclusion should be imposed, the OIG shall notify AMR of: (a) AMR's material breach; and (b) the OIG's intent to exercise its contractual right to impose exclusion (this notification is hereinafter referred to as the "Notice of Material Breach and Intent to Exclude").

3. Opportunity to Cure. AMR shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to the OIG's satisfaction that:

a. AMR is not in material breach of the obligations of the CIA cited by the OIG as being the basis for the material breach;

b. the alleged material breach has been cured; or

c. the alleged material breach cannot be cured within the 30-day period, but that: (i) AMR has begun to take action to cure the material breach; (ii) AMR is pursuing such action with due diligence; and (iii) AMR has provided to the OIG a reasonable timetable for curing the material breach.

4. Exclusion Letter. If at the conclusion of the 30-day period, AMR fails to satisfy the requirements of section X.D.3, the OIG may exclude AMR from participation in the Federal health care programs. The OIG will notify AMR in writing of its determination to exclude AMR (this letter shall be referred to hereinafter as the "Exclusion Letter"). Subject to the Dispute Resolution provisions in section X.E, below, the exclusion shall go into effect 30 days after the date of the Exclusion Letter. The exclusion shall have national effect and shall also apply to all other Federal procurement and non-procurement programs. Reinstatement to program participation is not automatic. If at the end of the period of exclusion, AMR wishes to apply for reinstatement, AMR must submit a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution

1. Review Rights. Upon the OIG's delivery to AMR of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, AMR shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they applied to the Stipulated Penalties or exclusion sought pursuant to this CIA. Specifically, the OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board ("DAB"), in a manner consistent with the provisions in 42 C.F.R. §§ 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within 10 days of the receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days of receipt of the Exclusion Letter.

2. Stipulated Penalties Review. Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether AMR was in full and timely compliance with the obligations of this CIA for which the OIG

demands payment; and (b) the period of noncompliance. AMR shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. The OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to stipulated penalties. If the ALJ agrees with the OIG with regard to a finding of a breach of this CIA and orders AMR to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless AMR requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of the OIG, the Stipulated Penalties shall become due and payable 20 days after the DAB issues its decision.

3. Exclusion Review. Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be:

a. whether AMR was in material breach of this CIA;

b. whether such breach was continuing on the date of the Exclusion Letter; and

c. whether the alleged material breach could not have been cured within the 30-day period, but that:

(i) AMR had begun to take action to cure the material breach within that period;

(ii) AMR has pursued and is pursuing such action with due diligence; and

(iii) AMR provided to the OIG within that period a reasonable timetable for curing the material breach and AMR has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to the OIG, or, if the ALJ rules for AMR, only after a DAB decision in favor of the OIG. AMR's election of its contractual right to appeal to the DAB shall not abrogate the OIG's authority to exclude AMR upon the issuance of an ALJ's decision in favor of the OIG. If the ALJ sustains the determination of the OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such

a decision, notwithstanding that AMR may request review of the ALJ decision by the DAB. If the DAB finds in favor of the OIG after an ALJ decision adverse to the OIG, the exclusion shall take effect 20 days after the DAB decision. AMR agrees to waive [its/his/her] right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of AMR, AMR will be reinstated effective on the date of the original exclusion.

4. Finality of Decision. The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA.

XI. EFFECTIVE AND BINDING AGREEMENT

Consistent with the provisions in the Settlement Agreement pursuant to which this CIA is entered, and into which this CIA is incorporated, AMR and the OIG agree as follows:

A. This CIA shall be binding on the successors, assigns, and transferees of AMR. However, the OIG shall waive successor liability (1) if AMR is in full compliance with this CIA at the time of any sale, and (2) upon receipt of verified proof to the OIG's satisfaction that AMR has wholly divested itself of any interest or involvement, direct or indirect, in the transferred or assigned entity, that the successor is an independent entity unrelated in any manner to AMR, that the successor has acquired its interest at fair market value in an arms' length transaction, and that the successor has policies, procedures and practices in effect to ensure its compliance with the requirements of Medicare, Medicaid and all other Federal health care programs.

B. This CIA shall become final and binding on the date the final signature is obtained on the CIA;

C. Any modifications to this CIA shall be made with the prior written consent of the parties to this CIA;

D. The OIG may agree to a suspension of AMR's obligations under the CIA in the event of AMR's cessation of participation in Federal health care programs. If AMR withdraws from participation in Federal health care programs and is relieved from its CIA obligations by the OIG, AMR agrees to notify the OIG 30 days in advance of AMR's intent to reapply as a participating provider or supplier with the Federal health care

programs. Upon receipt of such notification, the OIG will evaluate whether the CIA should be reactivated or modified.

E. The undersigned AMR signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatory represents that he is signing this CIA in his official capacity and that he is authorized to execute this CIA.

ON BEHALF OF AMERICAN MEDICAL RESPONSE, INC.

_____ _____

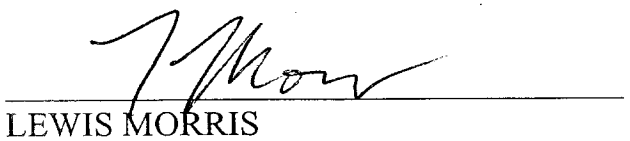
NAME: DATE
POSITION:

ON BEHALF OF AMERICAN MEDICAL RESPONSE OF MASSACHUSETTS, INC.

_____ _____

NAME: DATE
POSITION:

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES



LEWIS MORRIS
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

5/29/02
DATE

APPENDIX A

A. Claims Review.

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

a. Overpayment: The amount of money AMR has received in excess of the amount due and payable under any Federal health care program requirements.

b. Item: Any discrete unit that can be sampled (*e.g.*, code, line item, beneficiary, patient encounter, etc.).

c. Paid Claim: A code or line item submitted by AMR and for which AMR has received reimbursement from any Federal health care program.

d. Population: All Items for which AMR has submitted a code or line item and for which AMR has received reimbursement from the Medicare program (*i.e.*, a Paid Claim) during the 12-month period covered by the Claims Review. To be included in the Population, an Item must have resulted in at least one Paid Claim.

e. Error Rate: The Error Rate shall be the percentage of net overpayments identified in the sample. The Error Rate is calculated by dividing the net Overpayment identified in the sample by the total dollar amount associated with the Items in the sample. If AMR is permitted to perform the Claims Review internally with the IRO verification, the following payment errors should be included in calculating the error rate: (i) all payment errors identified by AMR and not verified by the IRO; and (ii) all payment errors identified by the IRO and not identified by AMR.

2. **Other Requirements**.

a. Paid Claims without Supporting Documentation. For the purpose of appraising Items included in the Claims Review, any Paid Claim for which AMR cannot produce documentation sufficient to support

the Paid Claim shall be considered an error and the total reimbursement received by AMR for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation shall not be permitted.

b. Use of First Samples Drawn. For the purposes of all samples (Discovery Sample(s) and Full Sample(s)) discussed in this Appendix, the Paid Claims associated with the Items selected in each first sample (or first sample for each strata, if applicable) shall be used. In other words, it is not permissible to generate more than one list of random samples and then select one for use with the Discovery Sample or Full Sample.

B. Claims Review Report. The following information shall be included in each Claims Review Report for each Discovery Sample and Full Sample (if applicable):

1. **Claims Review Methodology**

a. Sampling Unit. A description of the Item as that term is utilized for the Claims Review. For purposes of this Claims Review, the term "Item" may refer to any discrete unit that can be sampled (*e.g.*, claim, line item, beneficiary, patient encounter, etc.).

b. Claims Review Population. A description of the Population subject to the Claims Review.

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

d. Sampling Frame: A description of the sampling frame, which is the totality of Items from which the Discovery Sample and, if any, Full Sample has been selected and an explanation of the methodology used to identify the sampling frame. In most circumstances, the sampling frame will be identical to the Population.

e. Source of Data: A description of the specific documentation relied upon by AMR and/or the IRO and/or the Outside Compliance

Firm, as applicable, when performing the Claims Review (*e.g.*, medical records, physician orders, certificates of medical necessity, requisition forms, specific local medical review policies and the contractors that issued such policies, title and transmittal number of CMS program memoranda, specific cites in the Medicare carrier or intermediary manual or bulletins, other policies, regulations, or directives).

f. Review Protocol: A narrative description of how the Claims Review was conducted and what was evaluated.

2. **Claims Review Findings**

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

b. AMR's and/or IRO's and/or the Outside Compliance Firm's findings, supporting rationale, and a summary of such findings and rationale regarding the Claims Review, including the results of the Discovery Sample and the results of the Full Sample (if any) with the gross Overpayment amount, the net Overpayment amount, and the corresponding Error Rate(s) related to the net Overpayment. Note: for the purpose of this reporting, any potential cost settlements or other supplemental payments shall not be included in the net Overpayment calculation. Rather, only underpayments identified as part of the Discovery Sample or Full Sample (as applicable) shall be included as part of the net Overpayment calculation.

c. AMR's and/or the IRO's and/or the Outside Compliance Firm's findings and recommendations concerning the Systems Review (if any).

3. **Statistical Sampling Documentation**

a. The number of Items appraised in the Discovery Sample and, if applicable, in the Full Sample.

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

c. A copy of the statistical software printout(s) estimating how many Items are to be included in the Full Sample.

d. A description or identification of the statistical sampling software package used to conduct the sampling.

4. **Claims Review Results**

a. Total number and percentage of instances (based on AMR's internal Claims Review, if applicable) in which AMR determined that the Paid Claims submitted ("Claims Submitted") differed from what should have been the correct claim ("Correct Claim"), regardless of the effect on the payment.

b. Total number and percentage of instances (based on AMR's internal Claims Review, if applicable) in which the Claim Submitted differed from the Correct Claim and in which such difference resulted in an Overpayment to AMR.

c. Based on AMR's or IRO's and/or the Outside Compliance Firm's Claims Review, total dollar amount of paid Items included in the sample and the net Overpayment associated with the sample.

d. For each Discovery and Full Sample performed by AMR pursuant to the Internal Claims Review Option: (i) the number of Items the IRO verified; (ii) the number of instances in which the IRO disagreed with AMR's payment determinations; and (iii) the dollars associated with the difference between the IRO's and AMR's payment determinations.

e. Error Rate in the sample, as defined in section A.1.e of this Appendix.

f. A spreadsheet of the Claims Review results that includes the following information for each Paid Claim appraised: Federal health care program billed, beneficiary health insurance claim number, date of service, procedure code submitted, procedure code reimbursed, allowed

amount reimbursed by payor, correct procedure code (as determined by AMR's internal billing review), correct procedure code (as determined by the IRO verification), correct allowed amount (as determined by AMR's internal billing review), correct allowed amount (as determined by the IRO verification), dollar difference between allowed amount reimbursed by payor and the correct allowed amount (determined by AMR's internal billing review); and dollar difference between allowed amount reimbursed by payor and the correct allowed amount (determined by the IRO verification).

4. **Systems Review.** Observations and recommendations on possible improvements to the system(s) and process(es) that generated the Overpayment(s) in the sample(s).

5. **Credentials.** The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Claims Review; (2) performed the Claims Review; and (3) performed the verification review, if applicable.

ON BEHALF OF AMR

ANTHONY O. BOSWELL, ESQ. — DATE
Compliance Officer and Corporate Counsel
American Medical Response, Inc.

ROBERT P. LATORRACA — 6/3/02 DATE
President and Chief Executive Officer
American Medical Response of Massachusetts, Inc.

ON BEHALF OF AMR

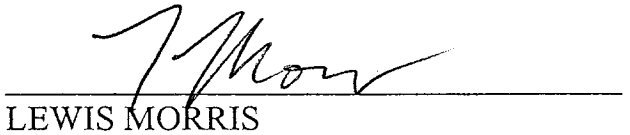
Anthony O Boswell 5/31/02

ANTHONY O. BOSWELL, ESQ. DATE
Compliance Officer and Corporate Counsel
American Medical Response, Inc.

_____ _____

ROBERT P. LATORRACA DATE
President and Chief Executive Officer
American Medical Response of Massachusetts, Inc.

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES



5/29/02

LEWIS MORRIS
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

DATE