

EXHIBIT A

**CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
LEESBURG REGIONAL MEDICAL CENTER, INC.**

I. PREAMBLE

Leesburg Regional Medical Center, Inc. (“Hospital”) 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 by its officers, directors, employees, physicians, contractors, and agents 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”). Contemporaneously with this CIA, Hospital is entering into a Settlement Agreement with the United States, and this CIA is incorporated by reference into the Settlement Agreement.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by Hospital 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.

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

C. The scope of this CIA shall be governed by the following definitions:

1. “Covered Persons” includes:

- a. all of Hospital's officers, directors, and employees;
 - b. all contractors and agents that provide patient care items or services or that perform billing or coding functions on behalf of Hospital, but excluding vendors whose sole connection with Hospital is selling medical supplies or equipment to it; and
 - c. all physicians with staff privileges at Hospital.
2. "Relevant Covered Persons" includes each Covered Person who is involved directly or in a supervisory role in the preparation or submission of claims for items or services (including, but not limited to, coding or billing) to any Federal health care program.

III. CORPORATE INTEGRITY OBLIGATIONS

Hospital has a Corporate Compliance Program. Hospital and the OIG agree that Hospital may utilize and adapt any components of the Compliance Program existing at the time of execution of this CIA as necessary to be in compliance with the corporate integrity obligations assumed by Hospital pursuant to this CIA. To the extent that Hospital's existing Compliance Program can not be adapted or maintained to meet the corporate integrity obligations of this CIA, Hospital shall adopt new components to its Compliance Program, so that the Compliance Program shall include the following elements, for the term of this CIA:

A. Compliance Officer and Committee.

1. *Compliance Officer and On-site Compliance Officer.* Hospital has appointed an individual to serve as its Compliance Officer. The Compliance Officer shall 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. In addition to its current Compliance Officer, Hospital has appointed an On-site Compliance Officer. The On-site Compliance Officer shall be a member of senior management of Hospital. The On-site Compliance Officer shall make periodic (at least quarterly) reports regarding compliance matters directly to the Board of Directors of Hospital, and shall be authorized to report on such matters to the Board of Directors at any time. The On-site Compliance Officer shall be responsible

for monitoring the day-to-day compliance activities engaged in by Hospital as well as for any reporting obligations created under this CIA.

Hospital shall report to the OIG, in writing, any changes in the identity or position description of the Compliance Officer or On-site Compliance Officer, or any actions or changes that would affect the Compliance Officer or On-site 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.* Within 90 days of the Effective Date of this CIA, Hospital shall appoint a Compliance Committee. The Compliance Committee shall, at a minimum, include the On-site Compliance Officer and other members of senior management necessary to meet the requirements of this CIA (e.g., senior executives of relevant departments, such as billing, clinical, human resources, audit, and operations). The On-site Compliance Officer shall chair the Compliance Committee and the Committee shall support the On-site 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 internal and external audits and investigations).

Hospital 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.* Hospital has established a written Code of Conduct, and the Code of Conduct has been distributed to all Covered Persons. Hospital shall continue the promotion of, and adherence to, the Code of Conduct as an element in evaluating the performance of all employees. Within 120 days of the Effective Date, the Code of Conduct shall be revised and reissued to include, at a minimum, the following:

- a. Hospital'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. Hospital's requirement that all of its Covered Persons shall be expected to comply with all Federal health care program requirements and with Hospital's own Policies and Procedures as implemented pursuant to Section III.B (including the requirements of this CIA);
- c. the requirement that all of Hospital's Covered Persons shall be expected to report to the Compliance Officer or other appropriate individual designated by the Hospital suspected violations of any Federal health care program requirements or of Hospital's own Policies and Procedures;
- d. the possible consequences to both Hospital and Covered Persons of failure to comply with Federal health care program requirements and with Hospital'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 Hospital's commitment to maintain confidentiality, as appropriate, and non-retaliation with respect to such disclosures.

Within 90 days of the Effective Date of the CIA, each Covered Person who has not already done so shall certify, in writing, that he or she has received, read, understood, and will abide by Hospital's Code of Conduct. At its own discretion, Hospital may fulfill its distribution obligations under this Section by revising and reissuing its current Code of Conduct or by issuing to all Covered Persons a newsletter, e-mail, or other update to the Code of Conduct addressing the requirements of this section III.B.1. New Covered Persons shall receive the Code of Conduct and shall complete the required certification within one month after becoming a Covered Person or within 90 days of the Effective Date of the CIA, whichever is later. Additionally, the following shall constitute Hospital's obligations under this Section III.B.1 with respect to physicians with staff privileges: (i) Hospital shall distribute the Code of Conduct to all physicians with staff privileges in accordance with the time requirements for other Covered Persons as set forth in this Section III.B.1; (ii) Hospital shall use its best efforts to obtain the written certifications described above; and (iii) Hospital shall keep records of the percentage of physicians who have completed the certification requirement.

Hospital 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.* Hospital has implemented written Policies and Procedures regarding the operation of Hospital's compliance program and its compliance with Federal health care program requirements. At a minimum, the Policies and Procedures shall:

- a. address the subjects relating to the Code of Conduct identified in Section III.B.1; and
- b. require that all diagnosis codes submitted for claims purposes to any Federal health care program be properly supported by documentation of the diagnosis by the treating physician in the patients medical record.

The Policies and Procedures have ben distributed to all individuals whose job functions are related to those Policies and Procedures. Appropriate and knowledgeable staff should be available to explain the Policies and Procedures.

At least annually (and more frequently if appropriate), Hospital 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 distributed to all individuals whose job functions are related to those Policies and Procedures.

Hospital shall within 120 days of the Effective Date implement a policy that requires that all inpatient claims with a principal diagnosis of 482.89 or 482.83 (or any successors to these codes) intended for submission to Medicare shall first be subject to pre-billing review to ensure the diagnosis code was properly assigned, and Hospital shall distribute said policy to all individuals whose job functions are related to the same.

C. Training and Education.

1. *General Training.* Hospital shall continue to provide reasonable and appropriate general training as part of Hospital's regular in-services to each Covered Person. This training, at a minimum, shall promote and explain Hospital's:

- a. CIA requirements; and
- b. Compliance Program (including the Code of Conduct and the Policies and Procedures as they pertain to general compliance issues).

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 such reasonable and appropriate general training annually.

General compliance training (as described above) provided to Covered Persons by Hospital during the six months immediately prior to the execution of this CIA may be credited towards the training time requirements set forth in this Section III.C.1, however, Hospital shall meet the requirements of this section by updating any such training, as appropriate, via e-mail, newsletter, flyer, or other appropriate medium.

2. *Coding Training.* Within 120 days of the Effective Date of this CIA, each Relevant Covered Person shall receive at least five hours of coding training in addition to the general training required above. This coding 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 coding training must be knowledgeable about the subject area.

Relevant Covered Persons shall receive this coding training within 30 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. A Hospital employee who has completed the coding training shall review a new Relevant Covered Person's work, to the extent that the work relates to 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 or her applicable training.

After receiving the initial training described in this Section, every Relevant Covered Person shall receive at least three hours of coding training annually.

3. *Exception for Physicians with Privileges.* Notwithstanding any other provision of this CIA, Hospital shall make the General Training and the Coding Training, where appropriate, available to all physicians with privileges at Hospital, and shall use its best efforts to encourage their attendance and participation. The On-site Compliance Officer shall maintain records of the percentage of all physicians with privileges who attend such training.

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 On-site Compliance Officer (or his or her designee) shall retain the certifications, along with all course materials. These shall be made available to OIG, upon request.

D. Review Procedures.

1. *General Description.*

a. Retention of Independent Review Organization. Within 120 days after the Effective Date, Hospital shall retain an entity (or entities), such as an accounting, auditing, or consulting firm (hereinafter “Independent Review Organization” or “IRO”), to perform reviews to assist Hospital in assessing and evaluating its billing and coding practices and certain other obligations pursuant to this CIA and the Settlement Agreement. Each IRO retained by Hospital 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 Hospital seeks reimbursement. Each IRO shall assess, along with Hospital, whether it can perform the IRO review in a professionally independent and/or objective fashion, as appropriate to the nature of the engagement, taking into account any other business relationships or engagements that may exist. The IRO(s) review shall address and analyze Hospital’s billing and coding to the Federal health care programs (“Claims Review”) and shall analyze whether Hospital sought payment for certain unallowable costs (“Unallowable Cost Review”).

b. Frequency of Claims Review. The Claims Review shall be performed annually and shall cover each of the Reporting Periods. Orlando Regional Healthcare System shall perform all components of the Claims Review, subject to Section III.D.1.d. The IRO shall perform a Verification Review, described in Section III.D.1.c, below.

c. IRO Verification Review. The IRO shall conduct a review of at least 20% of the sampling units reviewed by Orlando Regional Healthcare System in its internal Claims Review (“Verification Review”).

As part of the Hospital’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 the Verification Review performed.

d. IRO Claims Reviews: Following its review of the Hospital's Annual Report, if, in its sole discretion, OIG determines that Orlando Regional Healthcare System's internal reviews were not satisfactory, OIG may require that all aspects of future Claims Reviews be performed by the IRO.

e. Frequency of Unallowable Cost Review. The IRO shall perform the Unallowable Cost Review for the first Reporting Period.

f. Retention of Records. The IRO and Hospital shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (those exchanged between the IRO and Hospital) related to the reviews.

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. Orlando Regional Healthcare System or the IRO shall randomly select and review a sample of 50 Medicare Paid Claims submitted by or on behalf of Hospital. The Paid Claims shall be reviewed based on the supporting documentation available at Hospital or under Hospital'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, Hospital should, as appropriate, further analyze any errors identified in the Discovery Sample. Hospital recognizes that the OIG or another 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, Orlando Regional Healthcare System and/or the IRO shall perform a Full Sample and a Systems Review, as described below.

b. Full Sample. If necessary, as determined by procedures set forth in Sections III.D.1 and III.D.2.a, Orlando Regional Healthcare System and/or the IRO 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 Hospital or under Hospital'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, Orlando Regional Healthcare System may use the Items sampled as part of the Discovery Sample, 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 Hospital 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, Orlando Regional Healthcare System or the IRO, as determined by the procedures set forth in section III.D.1, shall also conduct a Systems Review. Specifically, for each claim in the Discovery Sample and Full Sample that resulted in an Overpayment, Orlando Regional Healthcare System or the IRO 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.

Orlando Regional Healthcare System or the IRO 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, the Hospital 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. Hospital 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*. Depending on whether the Hospital conducted an internal Claims Review with an IRO Verification Review or the IRO conducted the Claims Review, Orlando Regional Healthcare System and/or the IRO 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. *Unallowable Cost Review*. The IRO shall conduct a review of Hospital’s compliance with the unallowable cost provisions of the Settlement Agreement.

a. The IRO shall determine whether Hospital has complied with its obligations not to charge to, or otherwise seek payment from, Federal or State payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable Federal or State payors any unallowable costs included in payments previously sought from the United States, or any State Medicaid program. This unallowable cost analysis shall include, but not be limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by Hospital or any of its subsidiaries. To the extent such cost reports, cost statements, information reports or payment requests, even if already settled, have been adjusted to account for the effect of the inclusion of the unallowable costs, the IRO will determine if such adjustments were proper. In making this determination, the IRO may need to review cost reports and/or financial statements from the year in which the Settlement Agreement was executed, as well as from previous years.

5. *Unallowable Cost Review Report.* The IRO shall prepare a report based upon the Unallowable Cost Review performed. The Unallowable Cost Review Report shall include the IRO's findings and supporting rationale regarding the Unallowable Costs Review and whether Hospital has complied with its obligation not to charge to, or otherwise seek payment from, Federal or State payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable Federal or State payors any unallowable costs included in payments previously sought from such payor.

6. *Validation Review.* In the event the OIG has reason to believe that: (a) Hospital's Claims Review or Unallowable Cost Review fails to conform to the requirements of this CIA; or (b) Orlando Regional Healthcare System and/or the IRO'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"). Hospital 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 Hospital's final submission (as described in section II) is received by the OIG.

Prior to initiating a Validation Review, the OIG shall notify Hospital 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, Hospital may request a meeting with the OIG to discuss the results of any Claims Review or Unallowable Cost Review submissions or findings; present any additional or relevant information to clarify the results of the Claims Review or Unallowable Cost Review to correct the inaccuracy of the Claims Review; and/or propose alternatives to the proposed Validation Review. Hospital 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 or Unallowable Cost Review with Hospital 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.

7. *Independence/Objectivity Certification.* The IRO shall include in its report(s) to Hospital a certification or sworn affidavit that it has evaluated its professional independence and/or objectivity, as appropriate to the nature of the engagement, with regard to the Claims Review or Unallowable Cost Review and that it has concluded that it was, in fact, independent and/or objective.

8. *Internal Claims and Unallowable Cost Review Option.* Orlando Regional Healthcare System, may, at Hospital's option, conduct the Claims Reviews and Unallowable Cost Review set forth above. If Hospital chooses to exercise the Internal Claims and Unallowable Cost Review Option, the results shall be validated by an IRO as set forth within Section III.D.1.c, above, and as set forth within this Section III.D.8.

Prior to exercising the Internal Claims and Unallowable Cost Review Option, Hospital and Orlando Regional Healthcare System agree: (i) to develop and adopt a written formal audit workplan for Orlando Regional Healthcare System consistent with the terms of the CIA and in conjunction with the IRO; (ii) to devote sufficient resources and staff to enable the audit workplan to be implemented; and (iii) that Orlando Regional Healthcare System shall assign persons to the Internal Claims Reviews and Internal Unallowable Cost Review who are qualified and experienced in accepted auditing and control processes, and who possess expertise in billing, coding, and Medicare program requirements applicable to inpatient hospital services. In addition, Hospital and Orlando Regional Healthcare System agree that the persons assigned to implement the Internal Claims Reviews and Internal Unallowable Cost Review shall not include persons who were involved in the submission of bills or claims to the Medicare programs during the period to be audited and shall not include persons who are presently involved in such submissions.

Consistent with the requirements of Section III.D.2, the Internal Claims Review shall include a Claims Review, if applicable, a Systems Review, and the required respective reports of findings. In addition to the requirements of Section III.D.4, above, the Internal Unallowable Cost Review Report shall include a report from an IRO that verifies that the requirements of Section III.D.4 have been satisfied.

If Hospital decides not to exercise its Internal Claims and Unallowable Cost Review Option, the requirements applicable to engagement of an IRO to perform the engagements set forth within this Section III.D shall remain in effect for the term of this CIA.

E. Disclosure Program.

Hospital has established a Disclosure Program, that includes a mechanism (e.g., a toll-free compliance telephone line) to enable individuals to disclose, to the Compliance Officer, On-site Compliance Officer, or some other person who is not in the disclosing

individual's chain of command, any identified issues or questions associated with Hospital'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. Hospital shall 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 emphasize a non-retribution, non-retaliation policy, and shall include a reporting mechanism for anonymous communications for which appropriate confidentiality shall 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, Hospital 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 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 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.* Hospital shall not hire as an employee, engage as a contractor, or grant staff privileges to, any Ineligible Person. To prevent hiring or contracting with any Ineligible Person, Hospital shall continue to screen all prospective

employees and prospective contractors prior to engaging their services and screen physicians prior to granting staff privileges 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) Hospital to refrain from billing Federal health care programs for services of the Ineligible Person.

3. *Review and Removal Requirement.* Within 120 days of the Effective Date of this CIA, Hospital shall review its list of current employees, contractors, and physicians with staff privileges against the Exclusion Lists. Thereafter, Hospital shall review its list of current employees, contractors, and physicians with staff privileges against the Exclusion Lists annually. In addition, Hospital shall require employees and contractors to disclose immediately any debarment, exclusion, suspension, or other event that makes the employee an Ineligible Person.

If Hospital has actual notice that an employee, contractor, or physician with staff privileges has become an Ineligible Person, Hospital shall remove such person from responsibility for, or involvement with, Hospital'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 Hospital 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, the Hospital shall 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, patient or resident, 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, Hospital shall notify OIG, in writing, of any ongoing investigation known to Hospital or legal proceeding conducted or brought by a governmental entity or its agents involving an allegation that Hospital 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. Hospital shall also provide written notice to OIG within 30 days of the resolution of the matter, and shall provide 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 Hospital 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, Hospital identifies or learns of any overpayments, Hospital 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, Hospital 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, Hospital 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 Hospital determines through any means that there is a Material Deficiency, Hospital shall notify 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 Hospital's actions taken to correct the Material Deficiency; and
- (iv) any further steps Hospital 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, Hospital 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, Hospital shall notify 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. REPORTS

A. Initial Availability and Certification. Within 150 days after the effective date of this CIA, Hospital's On-site Compliance Officer shall be available to the OIG to summarize the status of Hospital's implementation of the requirements of this CIA. The On-site Compliance Officer shall also certify in writing by that date that:

1. the Policies and Procedures required by Section III.B have been developed, are being implemented, and have been distributed to all appropriate Covered Persons;
2. all Covered Persons have completed the Code of Conduct certification required by Section III.B.1 along with the

percentage of physicians with staff privileges who have completed the certification requirement; and

3. all Covered Persons have completed the applicable training and executed the certification(s) required by Section III.C. along with the percentage of physicians with staff privileges who have completed the training;

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

B. Annual Reports. Hospital shall submit to OIG Annual Reports with respect to the status of, and findings regarding, Hospital'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. any change in the identity, position description, or other non-compliance job responsibilities of the Compliance Officer or On-site Compliance Officer and any change in the membership of the Compliance Committee described in Section III.A;
2. a certification by the Compliance Officer or On-site Compliance Officer that:
 - a. all Covered Persons have completed any Code of Conduct certifications required by Section III.B.1;
 - b. all Covered Persons have completed the applicable training and executed the certification(s) required by Section III.C;
 - c. Hospital 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 OIG, upon request.

3. 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;
4. a copy of all training materials used for the training required by Section III.C (to the extent it has not already been provided as part of the Implementation Report or otherwise), a description of such training conducted during the Reporting Period, 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;
5. a complete copy of all reports prepared pursuant to Orlando Regional Healthcare System's and the IRO's billing and compliance engagements, including a copy of the methodology used, along with a copy of the IRO's engagement letter;
6. Hospital's response and corrective action plan(s) related to any issues raised by the reviews performed by Orlando Regional Healthcare System and the IRO(s);
7. a revised summary/description of all engagements between Hospital and the IRO, including, but not limited to, any outside financial audits, compliance program engagements, or reimbursement consulting, if different from what was submitted as part of the Implementation Report;
8. a certification from the IRO regarding its professional independence and/or objectivity from Hospital;

9. a summary of Material Deficiencies (as defined in Section III.H) identified during the Reporting Period and the status of any corrective and preventative action relating to all such Material Deficiencies;
10. 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: inpatient Medicare, outpatient Medicare, Medicaid (report each applicable state separately) 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;
11. 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;
12. a description of any personnel actions (other than hiring) taken by Hospital 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;
13. 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;
14. a description of all changes to the most recently provided list (as updated) of Hospital'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; and

15. the certification required by Section V.C.

The first Annual Report shall be received by the OIG no later than 90 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

C. Certifications. The Implementation Report and Annual Reports shall include a certification by the Compliance Officer or On-site Compliance Officer that: (1) except as otherwise described in the applicable report, Hospital is in compliance with all of the requirements of this CIA, to the best of his or her knowledge; and (2) the Compliance Officer or On-site 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: Hospital 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. Hospital 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:

If to OIG:

Administrative and Civil Remedies Branch
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
Telephone: (202) 619-2078
Facsimile: (202) 205-0604

If to Hospital:

R. Patton McConnell
Vice President - Finance and Chief Financial Officer
Leesburg Regional Medical Center
600 East Dixie Avenue
Leesburg, FL 34748
Telephone: (352) 323-5002
Facsimile: (352) 323-5009

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

VIII. DOCUMENT AND RECORD RETENTION

Hospital 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 Hospital prior to any release by OIG of information submitted by Hospital pursuant to its obligations under this CIA and identified upon submission by Hospital as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, Hospital shall have the rights set forth at 45 C.F.R. § 5.65(d). Hospital 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

Hospital 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, Hospital and 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 Hospital 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 Hospital 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 Hospital fails to meet any of the deadlines for the submission of the Implementation Report or the Annual Reports to OIG.

4. A Stipulated Penalty of \$2,000 (which shall begin to accrue on the date the failure to comply began) for each day Hospital employs, contracts with, or grants staff privileges to an Ineligible Person, as defined in Section III.F, and that person: (i) has responsibility for, or involvement with, Hospital'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 Hospital 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 Hospital 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 Hospital fails to grant access.)

6. A Stipulated Penalty of \$1,000 for each day Hospital fails to comply fully and adequately with any obligation of this CIA. In its notice to Hospital, OIG shall state the specific grounds for its determination that Hospital has failed to comply fully and adequately with the CIA obligation(s) at issue and steps the Hospital must take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after Hospital 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. Hospital 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 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 Hospital fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if 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 Hospital receives 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 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 Hospital has failed to comply with any of the obligations described in Section X.A and after determining that Stipulated Penalties are appropriate, OIG shall notify Hospital of: (a) Hospital'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, Hospital shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties; or (b) request a hearing before an HHS administrative law judge ("ALJ") to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event Hospital elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until Hospital cures, to 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 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 OIG's decision that Hospital has materially breached this CIA, which decision shall be made at 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 Hospital to report a Material Deficiency, take corrective action and make the appropriate refunds, as required in Section III.H;
- 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 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 Hospital constitutes an independent basis for Hospital's exclusion from participation in the Federal health care programs. Upon a determination by OIG that Hospital has materially breached this CIA and that exclusion should be imposed, OIG shall notify Hospital of: (a) Hospital's material breach; and (b) 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.* Hospital shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to OIG's satisfaction that:

- a. Hospital is in compliance with 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) Hospital has begun to take action to cure

the material breach; (ii) Hospital is pursuing such action with due diligence; and (iii) Hospital has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If at the conclusion of the 30-day period, Hospital fails to satisfy the requirements of Section X.D.3, OIG may exclude Hospital from participation in the Federal health care programs. OIG will notify Hospital in writing of its determination to exclude Hospital (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, Hospital wishes to apply for reinstatement, Hospital 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 OIG’s delivery to Hospital 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, Hospital 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, 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 Hospital was in full and timely compliance with the obligations of this CIA for which the OIG demands payment; and (b) the period of noncompliance. Hospital 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 OIG with regard to a finding of a breach of this CIA and orders Hospital to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless Hospital 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 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 Hospital 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) Hospital had begun to take action to cure the material breach within that period;
 - (ii) Hospital has pursued and is pursuing such action with due diligence; and
 - (iii) Hospital provided to OIG within that period a reasonable timetable for curing the material breach and Hospital has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for the Hospital, only after a DAB decision in favor of OIG. Hospital's election of its contractual right to appeal to the DAB shall not abrogate the OIG's authority to exclude Hospital 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 Hospital may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the

exclusion shall take effect 20 days after the DAB decision. Hospital agrees to waive its 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 Hospital, Hospital will be reinstated effective on the date of the original exclusion.

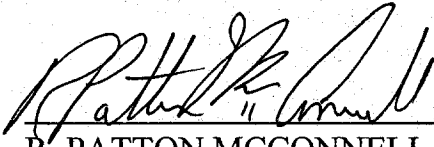
4. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for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

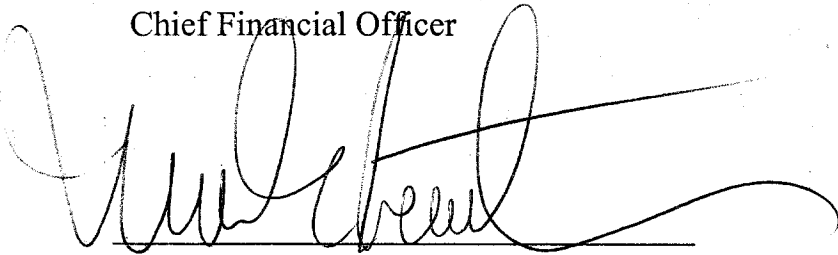
- A. This CIA shall be binding on the successors, assigns, and transferees of Hospital;
- B. This CIA shall become final and binding on the date the final signature is obtained on the CIA;
- C. Any modifications to this CIA shall be made with the prior written consent of the parties to this CIA;
- D. OIG may agree to a suspension of Hospital's obligations under the CIA in the event of Hospital's cessation of participation in Federal health care programs. If Hospital withdraws from participation in Federal health care programs and is relieved from its CIA obligations by the OIG, Hospital agrees to notify OIG 30 days in advance of Hospital's intent to reapply as a participating provider or supplier with the Federal health care programs. Upon receipt of such notification, OIG will evaluate whether the CIA should be reactivated or modified.
- E. The undersigned Hospital 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 HOSPITAL



R. PATTON MCCONNELL
Vice President - Finance and
Chief Financial Officer

1-15-03
DATE



MARK W. PEARLSTEIN, ESQ.
Approved as to Form Only

1-16-03
DATE

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



LEWIS MORRIS
Chief Counsel to the Inspector General
Office of Inspector General
U. S. Department of Health and Human Services

1/14/03
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 Hospital 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 Hospital for inpatient treatment and for which Hospital has received reimbursement from the Medicare program.
- d. Population: All Items for which Hospital has submitted a code or line item and for which Hospital has received reimbursement for inpatient treatment 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 net Overpayments shall be calculated by subtracting all underpayments identified in the sample from all gross Overpayments identified in the sample including: (i) all payment errors identified by Orlando Regional Healthcare System and not verified by the IRO; (ii) all payment errors identified by the IRO and not identified by Orlando Regional Healthcare System; and (iii) all payment errors identified by Orlando Regional Healthcare System and verified by the IRO. (Note: Any potential cost settlements or other supplemental payments should 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.)

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.

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 Hospital cannot produce documentation sufficient to support the Paid Claim shall be considered an error and the total reimbursement received by Hospital for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not 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 the 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.

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 documentation relied upon by Orlando Regional Healthcare System and/or IRO when performing the Claims Review (e.g., medical records, physician orders, certificates of medical necessity, requisition forms, local medical review policies, CMS program memoranda, 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. *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 by the IRO.

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

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

3. *Claims Review Findings.*

a. Narrative Results.

- i. A description of Hospital's billing and coding system(s), including the identification, by position description, of the personnel involved in coding and billing.
- ii. A narrative explanation of Orlando Regional Healthcare System's and the IRO's findings and supporting rationale (including reasons for errors, patterns noted, etc.) 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.

b. Quantitative Results.

- i. Total number and percentage of instances (based on Orlando Regional Healthcare System's internal Claims Review, if applicable) in which Orlando Regional Healthcare System 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.
- ii. Total number and percentage of instances (based on the Hospital'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 the Hospital.
- iii. Based on Orlando Regional Healthcare System's or IRO's Claims Review, total dollar amount of paid Items included in the sample and the net Overpayment associated with the sample.
- iv. For each Discovery and Full Sample performed by Orlando Regional Healthcare System: (i) the number of Items the IRO verified; (ii) the number of instances in which the IRO disagreed with the Orlando Regional Healthcare System's payment

determinations; and (iii) the dollars associated with the difference between the IRO's and Orlando Regional Healthcare System's payment determinations.

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

vi. 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 Orlando Regional Healthcare System's internal billing review), correct procedure code (as determined by the IRO verification), correct allowed amount (as determined by the Orlando Regional Healthcare System'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 Orlando Regional Healthcare System'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, findings, and recommendations on possible improvements to the system(s) and process(es) that generated the Overpayment(s).

5. *Credentials*. The names and credentials of the individuals who: (a) designed the statistical sampling procedures and the review methodology utilized for the Claims Review; and (b) performed the Claims Review.

OVERPAYMENT REFUND

TO BE COMPLETED BY MEDICARE CONTRACTOR

Date: _____
 Contractor Deposit Control # _____ Date of Deposit: _____
 Contractor Contact Name: _____ Phone # _____
 Contractor Address: _____
 Contractor Fax: _____

TO BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER

Please complete and forward to Medicare Contractor. This form, or a similar document containing the following information, should accompany every voluntary refund so that receipt of check is properly recorded and applied.

PROVIDER/PHYSICIAN/SUPPLIER NAME _____
 ADDRESS _____
 PROVIDER/PHYSICIAN/SUPPLIER # _____ CHECK NUMBER# _____
 CONTACT PERSON: _____ PHONE # _____
 AMOUNT OF CHECK \$ _____ CHECK DATE _____

REFUND INFORMATION

For each Claim, provide the following:

Patient Name _____ HIC # _____
 Medicare Claim Number _____ Claim Amount Refunded \$ _____
 Reason Code for Claim Adjustment: _____ (Select reason code from list below. Use one reason per claim)

(Please list all claim numbers involved. Attach separate sheet, if necessary)

Note: If Specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment: _____

For Institutional Facilities Only:

Cost Report Year(s) _____
 (If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements:

Do you have a Corporate Integrity Agreement with OIG? Yes No

Reason Codes:

<u>Billing/Clerical Error</u>	<u>MSP/Other Payer Involvement</u>	<u>Miscellaneous</u>
01 - Corrected Date of Service	08 - MSP Group Health Plan Insurance	13 - Insufficient Documentation
02 - Duplicate	09 - MSP No Fault Insurance	14 - Patient Enrolled in an HMO
03 - Corrected CPT Code	10 - MSP Liability Insurance	15 - Services Not Rendered
04 - Not Our Patient(s)	11 - MSP, Workers Comp.(Including Black Lung	16 - Medical Necessity
05 - Modifier Added/Removed	12 - Veterans Administration	17 - Other (Please Specify)
06 - Billed in Error		
07 - Corrected CPT Code		

