CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
MUSKOGEE REGIONAL MEDICAL CENTER

I. PREAMBLE

Muskogee Regional Medical Center ("Medical Center") 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, ("Covered Persons") 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, Medical Center is entering into a Settlement Agreement with the United States, and this CIA is incorporated by reference into the Settlement Agreement.

Medical Center represents that prior to the execution of this CIA, Medical Center voluntarily established a Compliance Program ("Compliance Program") which provides, *inter alia*, for a Compliance Officer, a Compliance Team, a Standards of Conduct Manual, Policies and Procedures, Education and Training, periodic assessments of compliance with the laws governing participation in the Federal health care programs, and a confidential hotline, for the purpose of ensuring Medical Center's compliance with the Federal health care programs.

Pursuant to this CIA, Medical Center agrees to operate the Compliance Program in a manner consistent with the requirements of this CIA and to adopt or modify any components of the Compliance Program as necessary in order to be in compliance with all of the corporate integrity obligations under this CIA.

II. TERM OF THE CIA

The period of the compliance obligations assumed by Medical Center 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 remain in effect until OIG has completed its review of the final annual report and any additional materials submitted by Medical Center pursuant to OIG's request.

III. CORPORATE INTEGRITY OBLIGATIONS

Medical Center represents that it currently has in place a Corporate Compliance Program and a Code (Standard) of Conduct, which apply to all employees of the Medical Center. As part of this CIA, Medical Center agrees that the Corporate Compliance Program and Standard of Conduct shall remain in effect for three years from the effective date of this CIA and that such Corporate Compliance Program includes, at a minimum, the following features applicable to Medical Center:

A. Compliance Officer and Committee.

1. *Compliance Officer.* Medical Center represents and agrees that, in accordance with its Corporate Compliance Program, a Compliance Officer is responsible for developing, implementing, monitoring, revising and reporting on compliance with the requirements set forth in the Corporate Compliance Program and Standard of Conduct, and with the requirements of the Federal health care programs. The Compliance Officer shall make regular reports, at least quarterly, regarding compliance matters directly to the Medical Center Chief Executive Officer and/or to the Executive Committee of the Board of Trustees of Medical Center. The Compliance Officer shall be responsible for any reporting obligations created under this CIA.

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, must be reported to OIG, in writing, within 15 days of such a change.

2. *Compliance Team.* Medical Center represents and agrees that in accordance with its Corporate Compliance Program, a Compliance Team exists that is chaired by the Compliance Officer. The Compliance Team's composition includes senior executives of each major department such as billing, clinical, human resources and

operations. The Compliance Officer shall oversee the Compliance Team and the Compliance Team shall support the Compliance Officer in fulfilling his/her responsibilities.

Any changes in the composition of the Compliance Team, or any actions or changes that would affect the Compliance Team's ability to perform the duties necessary to meet the obligations in this CIA, must be reported to OIG, in writing, within 15 days of such a change.

B. Written Standards.

1. *Code of Conduct.* Medical Center has developed and distributed a Standards of Conduct Manual to all employees. Within 120 days of the effective date of this CIA, Medical Center shall ensure, to the extent it has not already been performed, that the Standards of Conduct Manual (the "Code of Conduct") has been distributed to all Covered Persons as defined in this CIA. Medical Center shall make the promotion of, and adherence to, the Code of Conduct an element in evaluating the performance of all employees. The Standards of Conduct Manual shall, at a minimum, continue to include the following standards:

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

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

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

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

New Covered Persons shall receive the Standards of Conduct Manual and shall complete the required certification within 30 days after becoming a Covered Person or within 120 days of the effective date of the CIA, whichever is later.

Medical Center shall annually review the Standards of Conduct Manual to determine if revisions are appropriate and shall make any necessary revisions based on such a review. Any revisions to the Standards of Conduct Manual shall be distributed to each Covered Person within 30 days after such changes are approved by the Compliance Team. Covered Persons who are employees of Medical Center shall certify that they have received, read, understood and will abide by the revised Standards of Conduct Manual within 30 days of the distribution of such revisions.

2. *Policies and Procedures.* Medical Center has represented to the OIG that it has implemented written Policies and Procedures regarding the operation of Medical Center's compliance program and its compliance with Federal health care program requirements. To the extent not already addressed by the Policies and Procedures and, within 120 days of the effective date of this CIA, Medical Center shall ensure that, at a minimum, the Policies and Procedures address:

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

b. provide disciplinary guidelines and methods for employees or other individuals to make disclosures or otherwise report on compliance issues to Medical Center management through the Confidential Disclosure Program required by section III.E;

c. 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; and

d. require 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.

Within 120 days of the effective date of the CIA, the relevant portions of the Policies and Procedures shall be distributed, to the extent they have not been already, 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), Medical Center 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.

C. Training and Education.

1. *General Training.* Medical Center has represented to the OIG that it provides annual compliance training to all employees. To the extent that it has not already been provided since January 1, 2001, Medical Center shall, within 120 days of the effective date of this CIA, provide adequate and appropriate general training to each Covered Person who is an Employee of Medical Center or Contract Employee. This training, at a minimum, shall explain Medical Center'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 Employees or Contract Employees shall receive the general training described above within 30 days of becoming employed by Medical Center or within 120 days after the effective date of this CIA, whichever is later. After receiving the initial training described above, each Employee or Contract Employee of Medical Center shall receive adequate and appropriate general training on an annual basis. All training materials used in the general compliance training will be provided to OIG in the Implementation Report. Thereafter, training materials shall be made available to OIG, upon request.

2. *Coding Training.* Within 120 days of the effective date of this CIA, each Covered Person that is an Employee or Contract Employee of Medical Center who is involved directly or in a supervisory role in the preparation or submission of inpatient claims for items or services (including, but not limited to, coding or billing) to any Federal health care program (hereinafter referred to as "Relevant Covered Persons") shall receive at least three 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 Medicare and other 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 Medical Center 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 the applicable coding training.

Training provided to affected Covered Persons since February 1, 2001, that satisfies a requirement of section III.C shall be deemed to meet the 120 day time frame imposed by this section. However, Medical Center must still maintain attendance certifications and training course materials to receive credit for any such 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. *Certification.* Each Covered Person 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 Officer (or his or her designee) shall retain the certifications, along with all course materials. These shall be made available to OIG, upon request.

4. *Exception for Physicians and Allied Health Professionals with Privileges.* Medical Center shall make the general and specialized training described above available to all physicians and allied health professionals with privileges at Medical Center and, to the extent feasible, shall encourage their attendance and participation in such training. Medical Center shall monitor the attendance at such training and shall maintain a record of those attendees.

D. Review Procedures.

1. *General Description.*

a. Retention of Independent Review Organization. Within 120 days of the effective date of this CIA, Medical Center shall retain an entity (or entities), such as an accounting, auditing or consulting firm (hereinafter "Independent Review Organization" or "IRO"), to

perform review engagements to assist Medical Center in assessing and evaluating its billing and coding practices of Medicare inpatient claims and its compliance obligations pursuant to this CIA and the Settlement Agreement. Each Independent Review Organization retained by Medical Center 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 Medical Center seeks reimbursement. Each IRO shall assess, along with Medical Center, whether it can perform the IRO engagements in a professionally independent fashion taking into account any other business relationships or other engagements that may exist.

b. Types of Engagements. The Independent Review Organization(s) shall conduct two separate engagements. One engagement shall address Medical Center's billing and coding of inpatient claims to the Medicare program ("Billing Engagement"). The second engagement shall address Medical Center's compliance with the obligations assumed under this CIA and the Settlement Agreement ("Compliance Engagement").

c. Frequency of Billing and Compliance Engagements. The Billing Engagement shall be performed annually, (unless the OIG, at its sole discretion, relieves Medical Center of its obligation to retain an IRO to conduct a Billing and Compliance Engagement and instead allows Medical Center to conduct an internal review that year following the same parameters set forth above), and shall cover each of the one-year periods beginning with the effective date of this CIA. The IRO(s) shall perform all components of each annual Billing Engagement. The Compliance Engagement shall be performed by the IRO for the first one-year period beginning with the effective date of this CIA.

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

2. *Billing Engagement.* The Billing Engagement shall be composed of two separate reviews, a "Claims Review" and a "Systems Review." The Claims Review and corresponding Claims Review Report are discussed in detail in Appendix A to this CIA, which is incorporated by reference.

a. Claims Review. The IRO shall perform a Claims Review to identify any overpayments through an appraisal of Paid Claims submitted by Medical Center for inpatient treatment to the Medicare program. The Claims Review shall be performed in accordance with the procedures set forth in Appendix A to this CIA.

b. Claims Review Report. The IRO shall prepare a report based upon each Claims Review performed ("Claims Review Report"). The Claims Review Report shall be created in accordance with the procedures set forth in Appendix A to this CIA.

c. Systems Review. The IRO shall review Medical Center's billing and coding systems and/or operations and cost report preparation process (the "Systems Review"). The Systems Review shall consist of a thorough review of the following:

i. Medical Center's billing systems and/or operations relating to inpatient claims submitted to the Medicare program (including, but not limited to, the operation of the billing system, safeguards to ensure proper claim submission and billing, and procedures to correct inaccurate billing); and

ii. Medical Center's coding systems and/or operations relating to inpatient claims submitted to the Medicare program (including, but not limited to, the process by which claims are coded, safeguards to ensure proper coding, and procedures to correct inaccurate coding).

d. Systems Review Report. The IRO shall prepare a report based upon each Systems Review performed ("Systems Review Report").

The Systems Review Report shall include the IRO's findings and supporting rationale regarding:

i. the strengths and weaknesses in Medical Center's billing systems and/or operations;

ii. the strengths and weaknesses in Medical Center's coding systems and/or operations; and

iii. any recommendations the IRO may have to improve any of these systems, operations, and processes.

3. *Compliance Engagement.*

a. Compliance Review. The IRO shall conduct a review of Medical Center's compliance activities ("Compliance Review"). The Compliance Review shall consist of a review of Medical Center's adherence to the obligations set forth in sections I through VIII of this CIA, and a review of Medical Center's compliance with certain provisions of the Settlement Agreement.

i. CIA Obligations Review. The IRO shall assess and evaluate Medical Center's compliance with the obligations set forth in sections I through VIII of this CIA.

ii. Unallowable Costs Review. The IRO shall determine whether Medical Center 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 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 Medical Center or any of its subsidiaries, and to request, and agree, that such cost reports,

cost statements, information reports or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the unallowable costs. 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. To the extent that such a review has already been completed, Medical Center shall furnish the results of any such review(s) as well as the identity and qualifications of the reviewing party to the OIG. If acceptable to the OIG, such review(s) shall be accepted in lieu of this requirement.

b. Compliance Review Report. The IRO shall prepare a report based upon the Compliance Review performed (the "Compliance Review Report"). The Compliance Review Report shall include:

i. the IRO's findings, supporting rationale, and a summary of such findings and rationale regarding Medical Center's compliance with the terms of sections I through VIII of the CIA, as applicable; and

ii. the IRO's findings and supporting rationale regarding whether Medical Center 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

Based on the results of the first Compliance Engagement and on the results of the Billing Engagement for the first year of the term of this Agreement, OIG may, at its sole discretion, relieve Medical Center of its obligation to retain an IRO to conduct a Billing and Compliance Engagement for the second year of this Agreement and will instead allow Medical Center to conduct an internal review that year following the same parameters set forth above.

4. *Validation Review.* In the event the OIG has reason to believe that: (a) Medical Center's Billing or Compliance Engagement fails to conform to the requirements of this CIA; or (b) the findings or Claims Review results are inaccurate, the OIG may, at its sole discretion, conduct its own review to determine whether the Billing and Compliance Engagements comply with the requirements of the CIA and/or the findings or Claims Review results are inaccurate. Medical Center 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 the Medical Center's final submission (as described in section II) is received by the OIG. No costs shall be assessed if there is a finding that Medical Center's Billing and Compliance Engagements conform to the requirements of the CIA and that the Claims Review results are accurate.

Prior to initiating a Validation Review, the OIG shall notify Medical Center of its intent to do so and provide an explanation for believing why such a review is necessary. In order to resolve any concerns raised by the OIG, Medical Center may request a meeting with the OIG to discuss the results of any Engagement submissions or any Claims Review findings; present any additional or relevant information to clarify the results of the Engagements or to correct the inaccuracy of the Claims Review; and/or propose alternatives to the proposed Validation Review. Medical Center 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 Billing or Compliance Engagement and/or Claims Review issues with Medical Center 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.* Within 120 days from the effective date of this CIA, the IRO shall provide to Medical Center a certification or sworn affidavit that it has evaluated its professional independence with regard to the Billing and Compliance Engagements and that it has concluded that it is, in fact, independent based upon its applicable professional standards. Such certification shall be included in Medical Center's Implementation Report submission.

E. Disclosure Program.

Medical Center has represented to the OIG that it has implemented a Disclosure Program, that includes a toll-free compliance telephone line that enables 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 Medical Center'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. Medical Center shall be required to maintain this Disclosure Program, including operation of the compliance telephone line, for the duration of this CIA. Medical Center agrees to continue to 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, confidential communications. 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, Medical Center 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 related to the provision of health care items or services, but has not yet been excluded, debarred or otherwise declared ineligible.

2. *Screening Requirements.* Medical Center shall not hire, engage as a contractor, or grant staff privileges to, any Ineligible Person. To prevent hiring or contracting with any Ineligible Person, Medical Center shall 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) reviewing 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://www.hhs.gov/oig) (these lists will hereinafter be referred to as the "Exclusion Lists").

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

If Medical Center has notice that an employee, contractor, or physician with staff privileges has become an Ineligible Person, Medical Center shall remove such person from responsibility for, or involvement with, Medical Center'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 Medical Center has 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, the Medical Center 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, Medical Center shall notify OIG, in writing, of any ongoing investigation or legal proceeding conducted or brought by a governmental entity or its agents involving an allegation that Medical Center 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. Medical Center 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 Medical Center has received in excess of the amount due and payable under any Federal health care program requirements. Medical Center may not subtract any underpayments for purposes of determining the amount of relevant "overpayments" for CIA reports.

b. Reporting of Overpayments. If, at any time, Medical Center identifies or learns of any overpayments, Medical Center 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 discovery (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, Medical Center 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, Medical Center 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 contractor should be done in accordance with the

contractor 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 received by Medical Center; 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 Medical Center determines through any means that there is a Material Deficiency, Medical Center 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) on which the overpayment was repaid/refunded (if the overpayment has not been repaid/refunded at the time of this report, Medical Center shall provide this information to the OIG at the time of repayment/refund);

(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 Medical Center's actions taken to correct the Material Deficiency; and

(iv) any further steps Medical Center 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, Medical Center changes locations or purchases or establishes new business units related to the furnishing of items or services that may be reimbursed by Federal health care programs, Medical Center shall notify OIG of this fact as soon as possible, but no later than within 30 days of the date of change of location, 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. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report. Within 120 days after the effective date of this CIA, Medical Center shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA. This Implementation Report shall include:

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

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

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

4. 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. 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;

6. a certification by the Compliance Officer that:

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

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

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

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

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

8. the identity of the IRO(s), a summary/description of all engagements between Medical Center and the IRO, 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;

9. a certification from the IRO regarding its professional independence from the Medical Center;

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

11. a list of all of Medical Center's locations (including locations and mailing addresses), the corresponding name under which each location is doing business, the corresponding phone numbers and fax numbers, each location's Medicare provider identification number(s) and the contractor's name and address that issued each provider identification number;

12. to the extent not already furnished to OIG, or if modified, a description of Medical Center's corporate structure, including identification of any parent and sister companies, subsidiaries and their respective lines of business; and

13. the certification required by section V.C.

B. Annual Reports. Medical Center shall submit to OIG Annual Reports with respect to the status of, and findings regarding, Medical Center'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 and any change in the membership of the Compliance Team described in section III.A;

2. a certification by the 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. Medical Center 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 the IRO's billing and compliance engagements, including a copy of the methodology used, along with a copy of the IRO's engagement letter, unless the OIG waived the IRO requirement and instead allowed the Medical Center to conduct an internal review that year in which case copies of all final reports generated pursuant to that internal review shall be provided to the OIG;

6. Medical Center's response and corrective action plan(s) related to any issues raised by the IRO(s) or the internal review if the OIG allowed the Medical Center to conduct an internal review that year;

7. a revised summary/description of all engagements between Medical Center 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 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;

9. 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;

10. 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;

11. a description of any personnel actions (other than hiring) taken by Medical Center 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;

12. 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;

13. a description of all changes to the most recently provided list (as updated) of Medical Center's locations (including locations and mailing addresses) as required by section V.A.10, 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

14. the certification required by section V.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 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 that: (1) except as otherwise described in the applicable report, Medical Center 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: Medical Center 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. Medical Center 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:

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
Facsimile: (202) 205-0604

If to Medical Center:

David Clay
Compliance Officer
Muskogee Regional Medical Center
300 Rockefeller Drive
Muskogee, Oklahoma 74401
Phone: (918) 684-2553
Facsimile: (918) 684-2552

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 Medical Center's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of Medical Center's locations for the purpose of verifying and evaluating: (a) Medical Center's compliance with the terms of this CIA; and (b) Medical Center's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by Medical Center 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 Medical Center'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. Medical Center agrees to assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. Medical Center's employees may elect to be interviewed with or without a representative of Medical Center present.

Nothing in this CIA, or any other communication or report made pursuant to this CIA, shall constitute a waiver by Medical Center of Medical Center's attorney-client, attorney work product, or other privileges. The existence of any such privilege shall not excuse Medical Center's obligation to comply with the provisions of this CIA, *e.g.*, by providing all documents necessary to determine whether Medical Center is in compliance with the terms of this CIA.

VIII. DOCUMENT AND RECORD RETENTION

Medical Center 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 Medical Center prior to any release by OIG of information submitted by Medical Center pursuant to its obligations under this CIA and

identified upon submission by Medical Center as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, Medical Center shall have the rights set forth at 45 C.F.R. § 5.65(d). Medical Center 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

Medical Center 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, Medical Center 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 Medical Center fails to have in place any of the obligations described in section III:

a. a Compliance Officer;

b. a Compliance Team;

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 Medical Center 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 Medical Center 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 Medical Center employs, contracts with, or grants staff privileges to an Ineligible Person and that person: (i) has responsibility for, or involvement with, Medical Center'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 Medical Center 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 Medical Center 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 Medical Center fails to grant access.)

6. A Stipulated Penalty of $1,000 for each day Medical Center fails to comply fully and adequately with any obligation of this CIA. In its notice to Medical Center, OIG shall state the specific grounds for its determination that Medical Center has failed to comply fully and adequately with the CIA obligation(s) at issue and steps the Medical Center must take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after the date that OIG provides notice to Medical Center 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. Medical Center 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 Medical Center 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 Medical Center 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 Medical Center 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 Medical Center of: (a) Medical Center'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, Medical Center 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 Medical Center elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until Medical Center 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 Medical Center 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 Medical Center 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 Medical Center constitutes an independent basis for Medical Center's exclusion from participation in the Federal health care programs. Upon a determination by OIG that Medical Center has materially breached this CIA and that exclusion should be imposed, OIG shall notify Medical Center of: (a) Medical Center'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.* Medical Center 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. Medical Center 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) Medical Center has begun to take action to cure the material breach; (ii) Medical Center is pursuing such action with due diligence; and (iii) Medical Center has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If at the conclusion of the 30-day period, Medical Center fails to satisfy the requirements of section X.D.3, OIG may exclude Medical Center from participation in the Federal health care programs. OIG will notify Medical Center in writing of its determination to exclude Medical Center (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, Medical Center wishes to apply for reinstatement, Medical Center 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 Medical Center 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, Medical Center 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

Medical Center was in full and timely compliance with the obligations of this CIA for which the OIG demands payment; and (b) the period of noncompliance. Medical Center shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders Medical Center to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless Medical Center 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 Medical Center 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) Medical Center had begun to take action to cure the material breach within that period;

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

(iii) Medical Center provided to OIG within that period a reasonable timetable for curing the material breach and Medical Center 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 Medical Center, only after a DAB decision in favor of OIG. Medical Center's election of its contractual right to appeal to the DAB shall not abrogate the OIG's authority to exclude Medical Center 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 Medical Center 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. Medical Center 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.

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, Medical Center and OIG agree as follows:

A. This CIA shall be binding on the successors, assigns, and transferees of Medical Center;

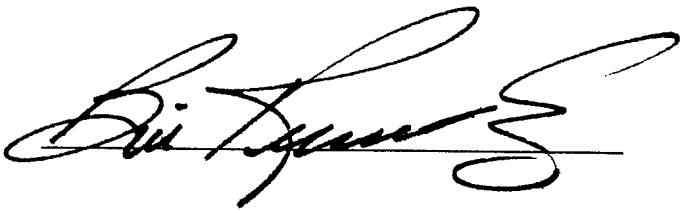
B. This CIA shall become final and binding on the date the final signature is obtained on the CIA;

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 Medical Center's obligations under the CIA in the event of Medical Center's cessation of participation in Federal health care programs. If Medical Center withdraws from participation in Federal health care programs and is relieved from its CIA obligations by the OIG, Medical Center agrees to notify OIG 30 days in advance of Medical Center'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 Medical Center 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 MUSKOGEE REGIONAL MEDICAL CENTER



8/28/01
DATE

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DATE

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DATE

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

DATE

Attachment 1

Claim Review Results

Federal Health Care Program Billed	Bene HIC #	Date of Service	Procedure Code Submitted	Procedure Code Reimbursed	Allowed Amount Reimbursed	Correct Procedure Code (IRO determined)	Correct Allowed Amt (IRO determined)	Dollar Difference between Amt Reimbursed and Correct Allowed Amt

APPENDIX A

A. Claims Review.

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

a. Claims Review Sample: A statistically valid, randomly selected, sample of items selected for appraisal in the Claims Review.

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

c. Overpayment: Consistent with the definition of Overpayment as articulated in section III.H.1.a of the CIA, the amount of money Medical Center has received in excess of the amount due and payable under any Federal health care program requirements. For the purposes of the Claims Review and all reporting to the OIG under this CIA, Medical Center shall not subtract or "net out" underpayments when determining the amount of relevant Overpayments.

d. Paid Claim: A code or line item submitted by Medical Center and for which Medical Center has received reimbursement from the Medicare program.

e. Population: All inpatient Items for which Medical Center has submitted a code or line item and for which Medical Center 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.

f. Probe Sample: A sample of Items selected through simple random sampling from the Population for the purpose of estimating the mean and standard deviation of the Population. The estimated mean and standard deviation of the Population are to be used to calculate the minimum number of Items to be included in the Claims Review Sample.

g. RAT-STATS: OIG's Office of Audit Services Statistical Sampling Software. RAT-STATS is publicly available to download through the Internet at "www.hhs.gov/oig/oas/ratstat.html".

2. ***Description of Claims Review.*** The Claims Review shall consist of an appraisal of a statistically valid sample of Items (the Claims Review Sample) that can be projected to the total Population.

a. Confidence and Precision Requirements. The Claims Review Sample must contain a sufficient number of Items so that if the Overpayments identified in the Claims Review Sample were projected to the Population, the projection would provide a 90% confidence level and a maximum relative precision (i.e., semi-width of the confidence interval) of plus or minus 25% of the point estimate. In other words, if the Claims Review Overpayment results were projected to the Population at a 90% confidence level, the confidence interval (expressed in dollars) must be sufficiently narrow that the upper bound of the confidence interval would not exceed 125% of the midpoint of the confidence interval (the point estimate), and the lower bound of the confidence interval would not be less than 75% of the midpoint of the confidence interval.

b. Use of a Probe Sample to Determine Claims Review Sample Size. To determine how many Items must be included in the Claims Review Sample to meet the 90% confidence level and 25% precision requirements, the mean and the standard deviation of the Population must be estimated. These estimates shall be developed through the use of a single Probe Sample. The Probe Sample shall be used to determine the minimum Claims Review Sample size through one of the two following options:

i. *Probe Sample with a Minimum Size of Thirty Items.* The Probe Sample shall include at least 30 Items, and shall be selected through the use of RAT-STATS' "Random Numbers" function. Once all Paid Claims associated with the Items included in the Probe Sample have been reviewed, the estimated mean and standard deviation of the Population shall be determined. This determination is based on the Overpayment amount received by Medical Center for each Item

in the sample. The "Variable Appraisals" function of RAT-STATS shall be used to calculate the estimated mean and standard deviation of the Population. For purposes of estimating the mean and standard deviation of the Population, and entering this information into the "Variable Appraisals" function of RAT-STATS, any underpayment identified for a Paid Claim in the Probe Sample shall be treated as a zero overpayment. If no Overpayments are found in this Probe Sample, then a second Probe Sample, of at least 30 Items, must be selected and reviewed. The estimated mean and standard deviation of the Population (based on the amount of Overpayments received by Medical Center for each sample Item) shall be determined from this Probe Sample, using RAT-STATS' "Variable Appraisals" function. If no Overpayments are found in this second Probe Sample, then the Claims Review can be terminated with the results of the second Probe Sample, and the results of the two Probe Samples shall be reported in lieu of the Claims Review when preparing and submitting the Claims Review Report (see section B, below); or

ii. *Probe Sample with a Minimum Size of Fifty Items*. The Probe Sample shall include at least 50 Items, and shall be selected through the use of RAT-STATS' "Random Numbers" function. Once all Paid Claims associated with the Items included in the Probe Sample have been reviewed, the estimated mean and standard deviation of the Population shall be determined. This determination is based on the Overpayment amount received by Medical Center for each Item in the sample. The "Variable Appraisals" function of RAT-STATS shall be used to calculate the estimated mean and standard deviation of the Population. For purposes of estimating the mean and standard deviation of the Population, and entering this information into the "Variable Appraisals" function of RAT-STATS, any underpayment identified for a Paid Claim in the Probe Sample shall be treated as a zero overpayment. If no Overpayments are found in this 50 Item Probe Sample, then the Claims Review can be terminated with the review of the Probe Sample and the results of the Probe Sample shall be reported in lieu of the results of the Claims Review when

preparing and submitting the Claims Review Report (see section B, below).

c. Calculation of Claims Review Sample Size and Selection of the Claims Review Sample. The estimates of the mean and the standard deviation of the Population obtained through the review of the Probe Sample shall be used to calculate the minimum size of the Claims Review Sample. In order to determine the minimum number of Items that must be included in the Claims Review Sample to meet the 90% confidence level and 25% precision requirements, RAT-STATS' "Sample Size Estimators" (located under the "Utility Programs" file) shall be used. The Claims Review Sample shall be selected by using RAT-STATS' "Random Numbers" function, and shall be selected from the entire Population, with the Population including those Items reviewed as part of the Probe Sample, so that all Items in the Population have an equal chance of inclusion in the Claims Review Sample.

d. Item Appraisal. For each Item appraised (either as part of the Claims Review Sample or of the Probe Sample), only Paid Claims shall be evaluated. Every Paid Claim in the Claims Review Sample shall be evaluated by the IRO to determine whether the claim submitted was correctly coded, submitted, and reimbursed. Each appraisal must be sufficient to provide all information required under the Claims Review Report.

e. Paid Claims without Supporting Documentation. For the purpose of appraising Items included in the Claims Review and/or the Probe Sample, any Paid Claim for which Medical Center cannot produce documentation sufficient to support the Paid Claim shall be considered an error and the total reimbursement received by Medical Center for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not permitted.

f. Use of First Samples Drawn. For the purposes of all samples (Probe Sample(s) and Claims Review Sample(s)) discussed in this Appendix, the Paid Claims associated with the Items selected in the first sample (or first

sample for each strata, if applicable) shall be used. In other words, it is not permissible to generate a number of random samples and then select one for use as the Probe Sample or Claims Review Sample.

B. Claims Review Report. The following information shall be included in each Claims Review Report:

1. ***Claims Review Methodology***

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

b. Sampling Unit: A description of the Item as that term is utilized for the Claims Review. As noted in section A.1.b above, for purposes of this Billing Engagement, the term "Item" may refer to any discrete unit that can be sampled (e.g., claim, line item, beneficiary, patient encounter, etc.).

c. Claims Review Population: A description of the Population subject to the Claims Review.

d. Sampling Frame: A description of the sampling frame, which is the totality of Items from which the Probe and Claims Review Sample have 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. Sources of Data: A description of the documentation relied upon by the IRO when performing the Claims Review (e.g., medical records, physician orders, certificates of medical necessity, requisition forms, local medical review policies, HCFA 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 Probe Sample(s) and in the Claims Review Sample.

b. A copy of the RAT-STATS printout of the random numbers generated by the "Random Numbers" function.

c. A copy of the RAT-STATS printout of the "Sample Size Estimators" results used to calculate the minimum number of Items for inclusion in the Claims Review Sample.

d. A copy of the RAT-STATS printout of the "Variable Appraisals" function results for the Probe Sample.

e. The Sampling Frame used in the Probe Sample(s) and the Claims Review Sample will be available to the OIG upon request.

3. ***Claims Review Results***

a. Total number and percentage of instances in which the IRO determined that the Paid Claim submitted by Medical Center ("Claim 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 in which the Claim Submitted differed from the Correct Claim and in which such difference resulted in an Overpayment to Medical Center.

c. The total dollar amount of all Paid Claims in the Claims Review Sample and the total dollar amount of Overpayments associated with the Paid Claims identified by the Claims Review. (This is the total dollar amount of the Overpayments identified in section B.3.b above.) The IRO may, in its report to Medical Center, identify underpayments, but any underpayments identified during the Claims Review shall not be offset or "netted out" of

the total dollar amount of Paid Claims or of the Overpayments when reporting these amounts in the Claims Review Report to the OIG.

d. 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 the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount. (See Attachment 1 to this Appendix.)

4. ***Credentials.*** The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Claims Review; and (2) 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/SUPPLIERNAME_____
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 reaso
n 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:

Billing/Clerical Error
01 - Corrected Date of Service
02 - Duplicate
03 - Corrected CPT Code
04 - Not Our Patient(s)
05 - Modifier Added/Removed
06 - Billed in Error
07 - Corrected CPT Code

MSP/Other Payer Involvement
08 - MSP Group Health Plan Insurance
09 - MSP No Fault Insurance
10 - MSP Liability Insurance
11 - MSP, Workers Comp.(Including Black Lung
12 - Veterans Administration

Miscellaneous
13 - Insufficient Documentation
14 - Patient Enrolled in an HMO
15 - Services Not Rendered
16 - Medical Necessity
17 - Other (Please Specify)
_____

AMENDMENT TO THE CORPORATE INTEGRITY AGREEMENT BETWEEN THE OFFICE OF INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND MUSKOGEE REGIONAL MEDICAL CENTER

The Office of Inspector General ("OIG") of the Department of Health and Human Services and Muskogee Regional Medical Center ("Muskogee") entered into a Corporate Integrity Agreement ("CIA") on August 28, 2001.

1. Pursuant to Section XI.C. Muskogee's CIA, modifications to the CIA may be made with the prior written consent of both the OIG and Muskogee. Therefore, the OIG and Muskogee hereby agree that Muskogee's CIA will be amended as follows:

   Section III.D, Review Procedures of the CIA is hereby superceded by the attached new Section III.D, Review Procedures.

   Appendix A of Muskogee's CIA is hereby superceded by the attached new Appendix A.

2. The OIG and Muskogee agree that all other sections of Muskogee's CIA will remain unchanged and in effect, unless specifically amended upon the prior written consent of the OIG and Muskogee.

3. The undersigned Muskogee signatory represents and warrants that he is authorized to execute this Amendment. The undersigned OIG signatory represents that he is signing the Amendment in his official capacity and that he is authorized to execute this Amendment.

4. The effective date of this Amendment will be the date on which the final signatory of this Amendment signs this Amendment.

ON BEHALF OF MUSKOGEE REGIONAL MEDICAL CENTER

Bill Kennedy
President/CEO

DATE

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

9/16/02
DATE

D. Review Procedures.

1. *General Description.*

a. Retention of Independent Review Organization. Within 120 days of the effective date of this CIA, Medical Center 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 Medical Center in assessing and evaluating its billing and coding practices and systems, and its compliance obligations pursuant to this CIA and the Settlement Agreement. Each IRO retained by Medical Center 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 Medical Center seeks reimbursement. Each IRO shall assess, along with Medical Center, whether it can perform the IRO review in a professionally independent fashion taking into account any other business relationships or other engagements that may exist. The IRO(s) review shall address and analyze Medical Center's billing and coding to the Federal health care programs ("Claims Review"), shall analyze whether Medical Center sought payment for certain unallowable costs ("Unallowable Cost Review"), and shall analyze Medical Center's compliance with the obligations assumed under this CIA and the Settlement Agreement ("Compliance Review").

b. Frequency of Claims Review. The Claims Review shall be performed annually and shall cover the following one year periods: (i) August 28, 2001 through August 27, 2002; (ii) August 28, 2002 through August 27, 2003; and (iii) August 28, 2003 through August 27, 2004. The IRO(s) shall perform all components of each annual Claims Review unless the OIG, at its sole discretion, relieves Medical Center of its obligation to retain an IRO to conduct a Claims Review and instead allows Medical Center to conduct an internal review that year following the same parameters set forth above.

c. Frequency of Unallowable Cost Review. The Unallowable Cost Review shall be performed by the IRO for the first one-year reporting period beginning with the effective date of this CIA.

d. Frequency of Compliance Review. The Compliance Review shall be performed by the IRO for the first one-year period beginning with the effective date of this CIA.

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

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

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

i. If the Error Rate (as defined in Appendix A) for the Discovery Sample is less than 5%, no additional sampling is required, nor is the Systems Review required. (Note: The threshold listed above does not imply that this is an acceptable error rate. Accordingly, Medical Center should, as appropriate, further analyze any errors identified in the Discovery Sample. Medical Center 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 the Discovery Sample indicates that the Error Rate is 5% or greater, 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 Section III.D.2.a, the IRO shall perform an additional sample of Paid Claims using commonly accepted sampling methods and in accordance with

Appendix A. The Full Sample should be designed to (1) 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 (2) 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 Medical Center or under Medical Center'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, Medical Center 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 Medical Center 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 Medical Center's Discovery Sample identifies an Error Rate of 5% or greater, Medical Center's IRO shall also conduct a Systems Review. Specifically, for each claim in the Discovery Sample and Full Sample that resulted in an Overpayment, the IRO should 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. The IRO shall provide to Medical Center the IRO's observations and 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 of the CIA, Medical Center agrees to 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. Medical Center agrees to make available to the OIG any and all documentation that reflects the refund of the Overpayment(s) to the payor.

3. *Claims Review Report.* 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.

4. *Pre-Billing Review Report.* Medical Center shall prepare a report regarding the pre-billing review required in section III.B.2.d. This report shall be included in the Annual Report.

5. *Unallowable Cost Review.* The IRO shall conduct a review of Medical Center's compliance with the unallowable cost provisions of the Settlement Agreement. The IRO shall determine whether Medical Center 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 Medical Center or any of its subsidiaries. To the extent that 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.

6. *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 Medical Center 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.

7. *Compliance Review.* The IRO shall conduct a review of Medical Center's compliance activities. The Compliance Review shall consist of a review of Medical Center's compliance with the obligations set forth in each section of this CIA.

8. *Compliance Review Report.* The IRO shall prepare a report based upon the Compliance Review performed. The Compliance Review Report shall include the IRO's

findings and supporting rationale regarding Medical Center's compliance with the terms of each section of the CIA, as applicable.

9. *Validation Review.* In the event the OIG has reason to believe that: (a) Medical Center's Claims Review, Unallowable Cost Review or Compliance Review fails to conform to the requirements of this CIA; or (b) 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, Unallowable Cost Review or Compliance Review complied with the requirements of the CIA and/or the findings or Claims Review results are inaccurate ("Validation Review"). Medical Center 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 Medical Center's final Annual Report and any additional information requested by the OIG is received by the OIG.

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

10. *Independence Certification.* The IRO shall include in its report(s) to Medical Center a certification or sworn affidavit that it has evaluated its professional independence with regard to the Claims Review, Unallowable Cost Review, and Compliance Review and that it has concluded that it is, in fact, independent.

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 Medical Center 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 Medical Center and for which Medical Center has received reimbursement inpatient treatment from the Medicare program.

d. Population: All Items for which Medical Center has submitted a code or line item and for which Medical Center 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 net Overpayments shall be calculated by subtracting all underpayments identified in the sample from all gross Overpayments identified in the sample. (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 Medical Center cannot produce documentation sufficient to support the Paid Claim shall be considered an error and the total reimbursement received by Medical Center 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 the 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 Medical Center'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 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 in which the IRO determined that the Paid Claims submitted by Medical Center ("Claim 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 in which the Claim Submitted differed from the Correct Claim and in which such difference resulted in an Overpayment to Medical Center.

iii. Total dollar amount of paid Items included in the sample and the net Overpayment associated with the sample.

iv. Error Rate in the sample.

v. 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 the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount. (See Attachment 1 to this Appendix.)

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: (1) designed the statistical sampling procedures and the review methodology utilized for the Claims Review; and (2) performed the Claims Review.