CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
IMAGIMED, LLC

I. PREAMBLE

Imagimed, LLC (Imagimed) hereby enters into this Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). Contemporaneously with this CIA, Imagimed is entering into a Settlement Agreement with the United States. For purposes of this CIA, "Imagimed" shall mean any Imagimed Open MRI site, including but not limited to the "Imagimed Sites" listed on Attachment 1 to this CIA and the following: (1) Imagimed, LLC and its wholly-owned subsidiaries and affiliates identified in Appendix D; (2) any other corporation, limited liability company, partnership, or any other legal entity or organization in which Imagimed, LLC or a wholly-owned subsidiary or affiliate owns a direct or indirect ownership interest in; and (3) any other corporation, limited liability company, partnership, or any other legal entity or organization in which Imagimed, LLC or a wholly-owned subsidiary or affiliate has a control interest.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by Imagimed under this CIA shall be five years from the effective date of this CIA. The "Effective Date" shall be the date on which the final signatory of this CIA executes this CIA. Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."

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

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

1. "Arrangements" shall mean every arrangement or transaction that:

a. involves, directly or indirectly, the offer, payment, solicitation, or receipt of anything of value; and is between Imagimed and any actual or potential source of health care business or referrals to Imagimed or any actual or potential recipient of health care business or referrals from Imagimed. The term "source of health care business or referrals" shall mean any individual or entity that refers, recommends, arranges for, orders, leases, or purchases any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program and the term "recipient of health care business or referrals" shall mean any individual or entity (1) to whom Imagimed refers an individual for the furnishing or arranging for the furnishing of any item or service, or (2) from whom Imagimed purchases, leases or orders or arranges for or recommends the purchasing, leasing, or ordering of any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program; or

b. is between Imagimed and a physician (or a physician's immediate family member (as defined at 42 C.F.R. § 411.351)) who makes a referral (as defined at 42 U.S.C. § 1395nn(h)(5)) to Imagimed for designated health services (as defined at 42 U.S.C. § 1395nn(h)(6)).

2. "Focus Arrangements" means every Arrangement that:

a. is between Imagimed and any actual source of health care business or referrals to Imagimed and involves, directly or indirectly, the offer, payment, or provision of anything of value; or

b. is between Imagimed and any physician (or a physician's immediate family member) (as defined at 42 C.F.R. § 411.351)) who makes a referral (as defined at 42 U.S.C. § 1395nn(h)(5)) to Imagimed for designated health services (as

defined at 42 U.S.C. §1395nn(h))(6)).

Notwithstanding the foregoing provisions of Section II.C.2, any Arrangement that satisfies the requirements of 42 C.F.R. § 411.356 (ownership or investment interests), 42 C.F.R. § 411.357(g) (remuneration unrelated to the provision of designated health services); 42 C.F.R. § 411.357(i) (payments by a physician for items and services); 42 C.F.R. § 411.357(k) (non-monetary compensation); 42 C.F.R. § 411.357(m) (medical staff incidental benefits), 42 C.F.R. § 411.357(o) (compliance training), 42 C.F.R. § 411.357(q) (referral services), 42 C.F.R. § 411.357(s) (professional courtesy), 42 C.F.R. § 357(u) (community-wide health information systems), or any exception to the prohibitions of 42 U.S.C. § 1395nn enacted following the Effective Date that does not require a written agreement shall not be considered a Focus Arrangement for purposes of this CIA.

3. "Covered Persons" includes:

   a. all owners, officers, directors, and employees of Imagimed;

   b. all owners, officers, directors, and employees of Imagimed; and

   c. all contractors, subcontractors, agents, and other persons who provide patient care items or services or who perform billing, coding, or other functions on behalf of, or in conjunction with, Imagimed or at any location where Imagimed provides services, including but not limited to the Imagimed Sites listed in Attachment 1, excluding vendors whose sole connection with Imagimed is selling or otherwise providing medical supplies or equipment to Imagimed and who do not bill the Federal health care programs for such medical supplies or equipment.

4. "Arrangements Covered Persons" includes each Covered Person who is involved with the development, approval, management, or review of Imagimed's Arrangements.

5. "Relevant Covered Persons" includes Covered Persons involved in the delivery of patient care items or services and/or in the preparation or submission of claims for reimbursement from any Federal health care program.

III. CORPORATE INTEGRITY OBLIGATIONS

Imagimed shall establish and maintain a Compliance Program that includes the following elements:

A. Compliance Officer and Committee and Board Obligations

1. *Compliance Officer*. Within 120 days after the Effective Date, Imagimed shall appoint an individual to serve as its Compliance Officer and shall maintain a Compliance Officer for the term of the CIA. The Compliance Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements. The Compliance Officer shall be a member of senior management of Imagimed, shall report directly to the Chief Executive Officer of Imagimed, shall make periodic (at least quarterly) reports regarding compliance matters directly to the Board of Directors of Imagimed, and shall be authorized to report on such matters to the Board of Directors at any time. The Compliance Officer shall not be or be subordinate to the General Counsel or Chief Financial Officer. The Compliance Officer shall be responsible for monitoring the day-to-day compliance activities engaged in by Imagimed as well as for any reporting obligations created under this CIA. Any noncompliance job responsibilities of the Compliance Officer shall be limited and must not interfere with the Compliance Officer's ability to perform the duties outlined in this CIA.

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

2. *Compliance Committee*. Within 120 days after the Effective Date, Imagimed shall appoint a Compliance Committee. The Compliance Committee shall, at a minimum, include the Compliance Officer and other members of senior management necessary to meet the requirements of this CIA (e.g., senior executives of relevant departments, such as billing, clinical, human resources, audit, and operations). The Compliance Officer shall chair the Compliance Committee and the Committee shall support the Compliance Officer in fulfilling his/her responsibilities (e.g., shall assist in the analysis of Imagimed's risk areas and shall oversee monitoring of internal and external audits and investigations). The Compliance Committee shall meet at least quarterly.

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

3. *Board of Directors Compliance Obligations*. The Board of Directors (or a committee of the Board) of Imagimed (Board) shall be responsible for the review and oversight of matters related to compliance with Federal health care program requirements and the obligations of this CIA. The Board must include independent (i.e., non-executive) members.

The Board shall, at a minimum, be responsible for the following:

a. meeting at least quarterly to review and oversee Imagimed's Compliance Program, including but not limited to the performance of the Compliance Officer and Compliance Committee; and

b. for each Reporting Period of the CIA, adopting a resolution, signed by each member of the Board summarizing its review and oversight of Imagimed's compliance with Federal health care program requirements and the obligations of this CIA.

At minimum, the resolution shall include the following language:

"The Board of Directors has made a reasonable inquiry into the operations of Imagimed's Compliance Program including the performance of the Compliance Officer and the Compliance Committee. Based on its inquiry and review, the Board has concluded that, to the best of its knowledge, Imagimed has implemented an effective Compliance Program to meet Federal health care program requirements and the obligations of the CIA."

If the Board is unable to provide such a conclusion in the resolution, the Board shall include in the resolution a written explanation of the reasons why it is unable to provide the conclusion and the steps it is taking to implement an effective Compliance Program at Imagimed.

Imagimed shall report to OIG, in writing, any changes in the composition of the Board, or any actions or changes that would affect the Board's ability to perform the

duties necessary to meet the obligations in this CIA, within 15 days after such a change.

B. Written Standards

1. *Code of Conduct*. Within 120 days after the Effective Date, Imagimed shall develop, implement, and distribute a written Code of Conduct to all Covered Persons. Imagimed shall make the promotion of, and adherence to, the Code of Conduct an element in evaluating the performance of all employees. The Code of Conduct shall, at a minimum, set forth:

a. Imagimed's commitment to full compliance with all Federal health care program requirements, including, but not limited to its commitment to prepare and submit (or cause the submission of) accurate claims consistent with such requirements;

b. Imagimed's requirement that all of its Covered Persons shall be expected to comply with all Federal health care program requirements and with Imagimed's own Policies and Procedures;

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

d. the right of all individuals to use the Disclosure Program described in Section III.F, and Imagimed's commitment to nonretaliation and to maintain, as appropriate, confidentiality and anonymity with respect to such disclosures.

Within 120 days after the Effective Date, each Covered Person shall certify, in writing or in electronic form, that he or she has received, read, understood, and shall abide by Imagimed's Code of Conduct. New Covered Persons shall receive the Code of Conduct and shall complete the required certification within 30 days after becoming a Covered Person or within 120 days after the Effective Date, whichever is later.

Imagimed shall periodically review the Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such review. Any

revised Code of Conduct shall be distributed within 30 days after any revisions are finalized. Each Covered Person shall certify, in writing, that he or she has received, read, understood, and shall abide by the revised Code of Conduct within 30 days after the distribution of the revised Code of Conduct.

2. *Policies and Procedures*. Within 120 days after the Effective Date, Imagimed shall implement written Policies and Procedures regarding the operation of Imagimed's compliance program, including the compliance program requirements outlined in this CIA and Imagimed's compliance with Federal health care program requirements. The Policies and Procedures also shall address:

a. 42 U.S.C. § 1320a-7b(b) (Anti-Kickback Statute) and 42 U.S.C. § 1395nn (Stark Law), and the regulations and other guidance documents related to these statutes, and business or financial arrangements or contracts that generate unlawful Federal health care program business in violation of the Anti-Kickback Statute or the Stark Law; and

b. the requirements set forth in Section III.D (Compliance with the Anti-Kickback Statute and Stark Law).

Within 120 days after the Effective Date, the relevant portions of the Policies and Procedures shall be distributed to all Covered Persons whose job functions relate to those Policies and Procedures. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures.

At least annually (and more frequently, if appropriate), Imagimed shall assess and update, as necessary, the Policies and Procedures. Within 30 days after the effective date of any revisions, the relevant portions of any such revised Policies and Procedures shall be distributed to all Covered Persons whose job functions relate to those Policies and Procedures.

C. Training and Education

1. *General Training*. Within 120 days after the Effective Date, Imagimed shall provide at least two hours of General Training to each Covered Person. This training, at a minimum, shall explain Imagimed's:

a. CIA requirements; and

b. Compliance Program, including the Code of Conduct.

New Covered Persons shall receive the General Training described above within 30 days after becoming a Covered Person or within 120 days after the Effective Date, whichever is later. After receiving the initial General Training described above, each Covered Person shall receive at least one hour of General Training in each subsequent Reporting Period.

2. *Arrangements Training*. Within 120 days after the Effective Date, each Arrangements Covered Person shall receive at least three hours of Arrangements Training, in addition to the General Training required above. The Arrangements Training shall include a discussion of:

a. Arrangements that potentially implicate the Anti-Kickback Statute or the Stark Law, as well as the regulations and other guidance documents related to these statutes;

b. Imagimed's policies, procedures, and other requirements relating to Arrangements and Focus Arrangements, including but not limited to the Focus Arrangements Tracking System, the internal review and approval process, and the tracking of remuneration to and from sources of health care business or referrals required by Section III.D of the CIA;

c. the personal obligation of each individual involved in the development, approval, management, or review of Imagimed's Arrangements to know the applicable legal requirements and Imagimed's policies and procedures;

d. the legal sanctions under the Anti-Kickback Statute and the Stark Law; and

e. examples of violations of the Anti-Kickback Statute and the Stark Law.

New Arrangements Covered Persons shall receive this training within 30 days after the beginning of their employment or becoming Arrangements Covered Persons, or within 120 days after the Effective Date, whichever is later.

After receiving the initial Arrangements Training described in this Section, each

Arrangements Covered Person shall receive at least two hours of Arrangements Training, in addition to the General Training, in each subsequent Reporting Period.

3. *Specific Training*. Within 120 days after the Effective Date, each Relevant Covered Person shall receive at least two hours of Specific Training in addition to the General Training required above. This Specific Training shall include a discussion of:

a. the Federal health care program requirements regarding the accurate coding and submission of claims;

b. the Federal health care program supervision requirements;

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

d. the personal obligation of each individual involved in the claims submission process to ensure that such claims are accurate;

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

f. the legal sanctions for violations of the Federal health care program requirements; and

g. examples of proper and improper medical documentation practices; and

h. examples of proper and improper claims submission practices.

New Relevant Covered Persons shall receive this training within 30 days after the beginning of their employment or becoming Relevant Covered Persons, or within 120 days after the Effective Date, whichever is later.

After receiving the initial Specific Training described in this section, each Relevant Covered Person shall receive at least one hour of Specific Training, in addition to the General Training, in each subsequent Reporting Period.

4. *Board Member Training*. Within 120 days after the Effective Date, Imagimed shall provide at least two hours of training to each member of the Board of Directors, in addition to the General Training. This training shall address the responsibilities of board members and corporate governance.

New members of the Board of Directors shall receive the Board Member Training described above within 30 days after becoming a member or within 120 days after the Effective Date, whichever is later.

5. *Certification.* Each individual who is required to attend training shall certify, in writing or in electronic form, 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 designee) shall retain the certifications, along with all course materials.

6. *Qualifications of Trainer.* Persons providing the training shall be knowledgeable about the subject area.

7. *Update of Training.* Imagimed shall review the training annually, and, where appropriate, update the training to reflect changes in Federal health care program requirements, any issues discovered during internal audits or the Arrangements Review or Claims Review, and any other relevant information.

8. *Computer-based Training.* Imagimed may provide the training required under this CIA through appropriate computer-based training approaches. If Imagimed chooses to provide computer-based training, it shall make available appropriately qualified and knowledgeable staff or trainers to answer questions or provide additional information to the individuals receiving such training.

D. Compliance with the Anti-Kickback Statute and Stark Law

1. *Focus Arrangements Procedures*. Within 120 days after the Effective Date, Imagimed shall create procedures reasonably designed to ensure that each existing and new or renewed Focus Arrangement does not violate the Anti-Kickback Statute and/or the Stark Law or the regulations, directives, and guidance related to these statutes (Focus Arrangements Procedures). These procedures shall include the following:

a. creating and maintaining a centralized tracking system for all existing and new or renewed Focus Arrangements (Focus Arrangements Tracking System);

b. tracking remuneration to and from all parties to Focus Arrangements;

c. tracking service and activity logs to ensure that parties to the Focus Arrangement are performing the services required under the applicable Focus Arrangement(s) (if applicable);

d. monitoring the use of leased space, medical supplies, medical devices, equipment, or other patient care items to ensure that such use is consistent with the terms of the applicable Focus Arrangement(s) (if applicable);

e. establishing and implementing a written review and approval process for all Focus Arrangements, the purpose of which is to ensure that all new and existing or renewed Focus Arrangements do not violate the Anti-Kickback Statute and Stark Law, and that includes at least the following: (i) a legal review of all Focus Arrangements by counsel with expertise in the Anti-Kickback Statute and Stark Law, (ii) a process for specifying the business need or business rationale for all Focus Arrangements, and (iii) a process for determining and documenting the fair market value of the remuneration specified in the Focus Arrangement;

f. requiring the Compliance Officer to review the Focus Arrangements Tracking System, internal review and approval process, and other Focus Arrangements Procedures on at least an annual basis and to provide a report on the results of such review to the Compliance Committee; and

g. implementing effective responses when suspected violations of the Anti-Kickback Statute and Stark Law are discovered, including disclosing Reportable Events and quantifying and repaying Overpayments pursuant to Sections III.I and III.J when appropriate.

2. *New or Renewed Arrangements*. Prior to entering into new Focus Arrangements or renewing existing Focus Arrangements, in addition to complying with the Focus Arrangements Procedures set forth above, Imagimed shall comply with the

following requirements (Focus Arrangements Requirements):

a. Ensure that each Focus Arrangement is set forth in writing and signed by Imagimed and the other parties to the Focus Arrangement;

b. Include in the written agreement a requirement that each party to a Focus Arrangement who meets the definition of a Covered Person shall complete the Arrangements Training required by Section III.C.2 of this CIA. Additionally, Imagimed shall provide each party to the Focus Arrangement with a copy of its Code of Conduct and Stark Law and Anti-Kickback Statute Policies and Procedures;

c. Include in the written agreement a certification by the parties to the Focus Arrangement that the parties shall not violate the Anti-Kickback Statute and the Stark Law with respect to the performance of the Arrangement.

3. *Records Retention and Access*. Imagimed shall retain and make available to OIG, upon request, the Focus Arrangements Tracking System and all supporting documentation of the Focus Arrangements subject to this Section and, to the extent available, all non-privileged communications related to the Focus Arrangements and the actual performance of the duties under the Focus Arrangements.

E. Review Procedures

1. *General Description*.

a. *Engagement of Independent Review Organization(s)*. Within 90 days after the Effective Date, Imagimed shall engage one or more individuals or entities, such as accounting, auditing, law, or consulting firm (hereinafter "Independent Review Organization(s)" or "IRO(s)"), to perform the reviews listed in this Section III.E. The applicable requirements relating to the IRO(s) are outlined in Appendix A to this CIA, which is incorporated by reference.

b. *Retention of Records*. The IRO(s) and Imagimed shall retain and make available to OIG, upon request, all work papers,

supporting documentation, correspondence, and draft reports (those exchanged between the IRO(s) and Imagimed) related to the reviews.

c. *Responsibilities and Liabilities*. Nothing in this Section III.E affects Imagimed's responsibilities or liabilities under any criminal, civil, or administrative laws or regulations applicable to any Federal health care program including, but not limited to, the Anti-Kickback Statute, the Stark Law.

2. *Arrangements Review*. An IRO shall perform an Arrangements Review and prepare an Arrangements Review Report as outlined in Appendix B to this CIA, which is incorporated by reference.

3. *Claims Review*. An IRO shall review Imagimed's coding, billing, and claims submission to the Federal health care programs and the reimbursement received (Claims Review) and shall prepare a Claims Review Report, as outlined in Appendix C to this CIA, which is incorporated by reference.

4. *Unallowable Cost Review*. If applicable, for the first Reporting Period, the IRO shall conduct a review of Imagimed's compliance with the unallowable cost provisions of the Settlement Agreement. The IRO shall determine whether Imagimed 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 Imagimed or any affiliates. 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 shall determine if such adjustments were proper. In making this determination, the IRO may need to review cost reports and/or financial statements from the year in which the Settlement Agreement was executed, as well as from previous years.

5. *Unallowable Cost Review Report.* The IRO shall prepare a report based upon the Unallowable Cost Review performed (Unallowable Cost Review Report). The Unallowable Cost Review Report shall include the IRO's findings and supporting rationale regarding the Unallowable Costs Review and whether Imagimed has complied with its obligation not to charge to, or otherwise seek payment from, federal or state

payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable federal or state payors any unallowable costs included in payments previously sought from such payor.

6. *Validation Review*. In the event OIG has reason to believe that: (a) Imagimed's Arrangements Review, Claims Review, or Unallowable Cost Review fails to conform to the requirements of this CIA; or (b) the IRO's findings or Arrangements Review, Claims Review, or Unallowable Cost Review results are inaccurate, OIG may, at its sole discretion, conduct its own review to determine whether the Arrangements Review, Claims Review, or Unallowable Cost Review complied with the requirements of the CIA and/or the findings or Arrangements Review, Claims Review, or Unallowable Cost Review results are inaccurate (Validation Review). Imagimed shall pay for the reasonable cost of any such review performed by OIG or any of its designated agents. Any Validation Review of Reports submitted as part of Imagimed's final Annual Report shall be initiated no later than one year after Imagimed's final submission (as described in Section II) is received by OIG.

Prior to initiating a Validation Review, OIG shall notify Imagimed of its intent to do so and provide a written explanation of why OIG believes such a review is necessary. To resolve any concerns raised by OIG, Imagimed may request a meeting with OIG to: (a) discuss the results of any Arrangements Review, Claims Review, or Unallowable Cost Review submissions or findings; (b) present any additional information to clarify the results of the Arrangements Review, Claims Review, or Unallowable Cost Review or to correct the inaccuracy of the Arrangements Review or Unallowable Cost Review; and/or (c) propose alternatives to the proposed Validation Review. Imagimed agrees to provide any additional information as may be requested by OIG under this Section III.E.6 in an expedited manner. OIG will attempt in good faith to resolve any Arrangements Review, Claims Review, or Unallowable Cost Review issues with Imagimed 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 OIG.

7. *Independence and Objectivity Certification.* The IRO shall include in its report(s) to Imagimed a certification that the IRO has (a) evaluated its professional independence and objectivity with respect to the reviews conducted under this Section III.E and (b) concluded that it is, in fact, independent and objective, in accordance with the requirements specified in Appendix A to this CIA.

F. Disclosure Program

Within 90 days after the Effective Date, Imagimed shall establish a Disclosure

Program that includes a mechanism (e.g., a toll-free compliance telephone line) to enable individuals to disclose, to the Compliance Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with Imagimed'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. Imagimed shall appropriately publicize the existence of the disclosure mechanism (e.g., via periodic e-mails to employees or by posting the information in prominent common areas).

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

The Compliance Officer (or 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.

G. Ineligible Persons

1. *Definitions*. For purposes of this CIA:

a. an "Ineligible Person" shall include an individual or entity who:

i. is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or nonprocurement programs; or

ii. has been convicted of a criminal offense that falls

within the scope of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

b. "Exclusion Lists" include:

i. the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at http://www.oig.hhs.gov); and

ii. the General Services Administration's System for Award Management (available through the Internet at http://www.sam.gov).

2. *Screening Requirements.* Imagimed shall ensure that all prospective and current Covered Persons are not Ineligible Persons, by implementing the following screening requirements.

a. Imagimed shall screen all prospective Covered Persons against the Exclusion Lists prior to engaging their services and, as part of the hiring or contracting process, shall require such Covered Persons to disclose whether they are Ineligible Persons.

b. Imagimed shall screen all Covered Persons against the Exclusion Lists within 90 days after the Effective Date and on a monthly basis thereafter.

c. Imagimed shall implement a policy requiring all Covered Persons to disclose immediately any debarment, exclusion, suspension, or other event that makes that person an Ineligible Person.

Nothing in Section III.G affects Imagimed's responsibility to refrain from (and liability for) billing Federal health care programs for items or services furnished, ordered, or prescribed by an excluded person. Imagimed understands that items or services furnished, ordered or prescribed by excluded persons are not payable by Federal health care programs and that Imagimed may be liable for overpayments and/or criminal, civil, and administrative sanctions for employing or contracting with an excluded person regardless of whether Imagimed meets the requirements of Section III.G.

3. *Removal Requirement.* If Imagimed has actual notice that a Covered Person has become an Ineligible Person, Imagimed shall remove such Covered Person from responsibility for, or involvement with, Imagimed's business operations related to the Federal health care programs and shall remove such Covered Person from any position for which the Covered Person's compensation or the items or services furnished, ordered, or prescribed by the Covered 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 Covered Person is reinstated into participation in the Federal health care programs.

4. *Pending Charges and Proposed Exclusions*. If Imagimed has actual notice that a Covered Person is charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a), 1320a-7(b)(1)-(3), Imagimed shall take all appropriate actions to ensure that the responsibilities of that Covered Person have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, or resident, or any claims submitted to any Federal health care program.

H. Notification of Government Investigation or Legal Proceedings

Within 30 days after discovery, Imagimed shall notify OIG, in writing, of any ongoing investigation or legal proceeding known to Imagimed conducted or brought by a governmental entity or its agents involving an allegation that Imagimed 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. Imagimed shall also provide written notice to OIG within 30 days after the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the investigation or proceedings, if any.

I. Repayment of Overpayments

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

2. *Repayment of Overpayments*.

a. If, at any time, Imagimed identifies or learns of any Overpayment, Imagimed shall repay the Overpayment to the

appropriate payor (e.g., Medicare fiscal intermediary or carrier) within 60 days after identification of the Overpayment and take remedial steps within 90 days after identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the Overpayment from recurring. If not yet quantified, within 60 days after identification, Imagimed shall notify the payor of its efforts to quantify the Overpayment amount along with a schedule of when such work is expected to be completed. Notification and repayment to the payor shall be done in accordance with the payor's policies.

b. 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.

J. Reportable Events

1. *Definition of Reportable Event*. For purposes of this CIA, a "Reportable Event" means anything that involves:

a. a substantial Overpayment;

b. 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;

c. the employment of or contracting with a Covered Person who is an Ineligible Person as defined by Section III.G.1.a; or

d. the filing of a bankruptcy petition by Imagimed.

A Reportable Event may be the result of an isolated event or a series of occurrences.

2. *Reporting of Reportable Events*. If Imagimed determines (after a

reasonable opportunity to conduct an appropriate review or investigation of the allegations) through any means that there is a Reportable Event, Imagimed shall notify OIG, in writing, within 30 days after making the determination that the Reportable Event exists.

3. *Reportable Events under Section III.J.1.a.* For Reportable Events under Section III.J.1.a, the report to the OIG shall be made within 30 days of the identification of the Overpayment, and shall include:

a. a description of the steps taken by Imagimed to identify and quantify the Overpayment;

b. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

c. a description of Imagimed's actions taken to correct the Reportable Event; and

d. any further steps Imagimed plans to take to address the Reportable Event and prevent it from recurring.

4. *Reportable Events under Section III.J.1.b and c.* For Reportable Events under Section III.J.1.b and III.J.1.c, the report to OIG shall include:

a. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

b. a description of Imagimed's actions taken to correct the Reportable Event;

c. any further steps Imagimed plans to take to address the Reportable Event and prevent it from recurring; and

d. if the Reportable Event has resulted in an Overpayment, a description of the steps taken by Imagimed to identify and quantify the Overpayment.

5. *Reportable Events under Section III.J.1.d.* For Reportable Events

under Section III.J.1.d, the report to the OIG shall include documentation of the bankruptcy filing and a description of any Federal health care program authorities implicated.

6. *Reportable Events Involving the Stark Law*. Notwithstanding the reporting requirements outlined above, any Reportable Event that involves only a probable violation of section 1877 of the Social Security Act, 42 U.S.C. §1395nn (the Stark Law) should be submitted by Imagimed to the Centers for Medicare & Medicaid Services (CMS) through the self-referral disclosure protocol (SRDP), with a copy to the OIG. The requirements of Section III.I.2 that require repayment to the payor of any identified Overpayment within 60 days shall not apply to any Overpayment that may result from a probable violation of only the Stark Law that is disclosed to CMS pursuant to the SRDP. If Imagimed identifies a probable violation, then Imagimed is not required by this Section III.J to submit the Reportable Event to CMS through the SRDP.

IV. SUCCESSOR LIABILITY; CHANGES TO BUSINESS UNITS OR LOCATIONS

A. Change or Closure of Unit or Location

In the event that, after the Effective Date, Imagimed changes locations or closes a business unit or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, Imagimed shall notify OIG of this fact as soon as possible, but no later than within 30 days after the date of change or closure of the location.

B. Purchase or Establishment of New Unit or Location

In the event that, after the Effective Date, Imagimed purchases or establishes a new business, business unit or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, Imagimed shall notify OIG at least 30 days prior to such purchase or the operation of the new business unit or location. This notification shall include the address of the new business unit or location, phone number, fax number, the location's Medicare and state Medicaid program provider number and/or supplier number(s), and the name and address of each Medicare and state Medicaid program contractor to which Imagimed currently submits claims. Each new business, business unit or location and all Covered Persons at each new business, business unit or location shall be subject to the applicable requirements of this CIA.

C. Sale of Business, Business Unit or Location

In the event that, after the Effective Date, Imagimed proposes to sell any or all of its business, business units or locations (whether through a sale of assets, sale of stock, or other type of transaction) that are subject to this CIA, Imagimed shall notify OIG of the proposed sale at least 30 days prior to the sale of such business, business unit or location. This notification shall include a description of the business, business unit or location to be sold, a brief description of the terms of the sale, and the name and contact information of the prospective purchaser. This CIA shall be binding on the purchaser of the business, business unit or location, unless otherwise determined and agreed to in writing by the OIG.

V. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report

Within 150 days after the Effective Date, Imagimed shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA (Implementation Report). The Implementation Report shall, at a minimum, include:

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

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

3. the names of the Board members who are responsible for satisfying the Board of Directors compliance obligations described in Section III.A.3;

4. a copy of Imagimed's Code of Conduct required by Section III.B.1;

5. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be made available to OIG upon request);

6. a summary of all Policies and Procedures required by Section III.B (copies of the Policies and Procedures shall be made available to OIG upon request);

7. the following information regarding each type of training required

by Section III.C:

a. a description of such training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions; and

b. the number of individuals required to be trained, percentage of individuals actually trained, and an explanation of any exceptions.

8. a description of (a) the Focus Arrangements Tracking System required by Section III.D.1.a, (b) the internal review and approval process required by Section III.D.1.e; and (c) the tracking and monitoring procedures and other Focus Arrangements Procedures required by Section III.D.1;

9. a description of the Disclosure Program required by Section III.F;

10. the following information regarding each IRO(s): (a) identity, address, and phone number; (b) a copy of the engagement letter; (c) information to demonstrate that the IRO has the qualifications outlined in Appendix A to this CIA, (d) a summary and description of any and all current and prior engagements and agreements between Imagimed and the IRO; and (e) a certification from the IRO regarding its professional independence and objectivity with respect to Imagimed;

11. a description of the process by which Imagimed fulfills the requirements of Section III.G regarding Ineligible Persons;

12. a list of all of Imagimed'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 and state Medicaid program provider number(s) and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which Imagimed currently submits claims;

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

14. the certifications required by Section V.C.

B. Annual Reports

Imagimed shall submit to OIG annually a report with respect to the status of, and findings regarding, Imagimed's compliance activities for each of the five Reporting Periods (Annual Report). Each Annual Report shall include, at a minimum:

1. any change in the identity, position description, or other noncompliance job responsibilities of the Compliance Officer and any change in the membership of the Compliance Committee described in Section III.A;

2. the Board resolution required by Section III.A.3;

3. a summary of any changes or amendments to Imagimed's Code of Conduct required by Section III.B.1 and the reason for such changes, along with a copy of the revised Code of Conduct;

4. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be made available to OIG upon request);

5. 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);

6. the following information regarding each type of training required by Section III.C:

   a. a description of the initial and annual training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions; and

   b. the number of individuals required to complete the initial and annual training, the percentage of individuals who actually completed the initial and annual training, and an explanation of any exceptions.

A copy of all training materials and the documentation to support this information shall be made available to OIG upon request.

7. a description of (a) any changes to the Focus Arrangements Tracking System required by Section III.D.1.a; (b) any changes to the internal review and approval process required by Section III.D.1.e; and (c) any changes to the tracking and monitoring procedures and other Arrangements Procedures required by Section III.D.1;

8. a complete copy of all reports prepared pursuant to Section III.E, along with a copy of the IRO's engagement letter;

9. Imagimed's response to the reports prepared pursuant to Section III.E., along with corrective action plan(s) related to any issues raised by the reports;

10. a summary and description of any and all current and prior engagements and agreements between Imagimed and the IRO, if different from what was submitted as part of the Implementation Report;

11. a certification from the IRO regarding its professional independence and objectivity with respect to Imagimed;

12. a summary of Reportable Events (as defined in Section III.J) identified during the Reporting Period and the status of any corrective action relating to all such Reportable Events;

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

14. a summary of the disclosures in the disclosure log required by Section III.F that relate to Federal health care programs (the complete disclosure log shall be made available to OIG upon request);

15. any changes to the process by which Imagimed fulfills the requirements of Section III.G regarding Ineligible Persons;

16. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.H. 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;

17. a description of all changes to the most recently provided list of Imagimed's locations (including addresses) as required by Section V.A.12; the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's Medicare and state Medicaid program provider number(s) and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which Imagimed currently submits claims; and

18. the certifications required by Section V.C.

The first Annual Report shall be received by 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. to the best of his or her knowledge, except as otherwise described in the applicable report, Imagimed is in compliance with all of the requirements of this CIA;

2. to the best of his or her knowledge, Imagimed has implemented procedures reasonably designed to ensure that all Focus Arrangements do not violate the Anti-Kickback Statute and Stark Law, including the Focus Arrangements Procedures required in Section III.D of the CIA;

3. to the best of his or her knowledge, Imagimed has fulfilled the requirements for New and Renewed Focus Arrangements under Section III.D.2 of the CIA;

4. he or she has reviewed the Report and has made reasonable inquiry regarding its content and believes that the information in the Report is accurate and truthful; and

5. to the best of his or her knowledge, Imagimed has complied with its obligations under the Settlement Agreement: (a) 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; (b) not to charge to or otherwise seek payment from federal or state payors for unallowable costs (as defined in the Settlement Agreement); and (c) to identify and adjust any past charges or claims for unallowable costs;

D. Designation of Information

Imagimed 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. Imagimed 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, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG: Administrative and Civil Remedies Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, S.W.
Washington, DC 20201
Telephone: 202.619.2078
Facsimile: 202.205.0604

Imagimed: Dennis Rossi, MD, Compliance Officer
Imagimed, LLC
9601 Blackwell Road
Rockville, Maryland 20850
Telephone: 301.250.7897
Facsimile: 301-251-7898

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. Upon request by

OIG, Imagimed may be required to provide OIG with an electronic copy of each notification or report required by this CIA in searchable portable document format (pdf), in addition to a paper copy.

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

VIII. DOCUMENT AND RECORD RETENTION

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

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify [Provider] prior to any release by OIG of information submitted by Imagimed pursuant to its obligations under this CIA and identified upon submission by Imagimed as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, Imagimed shall have the rights set forth at 45 C.F.R. § 5.65(d).

X. BREACH AND DEFAULT PROVISIONS

Imagimed 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, Imagimed and OIG hereby agree that failure to comply with certain obligations as 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 Imagimed fails to establish and implement any of the following obligations as described in Section III:

a. a Compliance Officer;

b. a Compliance Committee;

c. the Board of Directors compliance obligations;

d. a written Code of Conduct;

e. written Policies and Procedures;

f. the training of Covered Persons, Arrangements Covered Persons, Relevant Covered Persons and Board Members;

g. the Focus Arrangements Procedures and/or Focus Arrangements Requirements described in Sections III.D.1 and III.D.2;

h. a Disclosure Program;

i. Ineligible Persons screening and removal requirements;

j. notification of Government investigations or legal proceedings; and

k. reporting of Reportable Events.

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 Imagimed fails to engage and use an IRO, as required in Section III.E, Appendix A, Appendix B, and/or Appendix C.

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 Imagimed fails to submit the Implementation Report or any Annual Reports to OIG in accordance with the requirements of Section V by the deadlines for submission.

4. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day Imagimed fails to submit the annual Arrangements Review Report, Unallowable Cost Review Report, or Claims Review, in accordance with the requirements of Section III.E and Appendix B and/or Appendix C.

5. A Stipulated Penalty of $1,500 for each day Imagimed fails to grant access as required in Section VII. (This Stipulated Penalty shall begin to accrue on the date Imagimed fails to grant access.)

6. A Stipulated Penalty of $50,000 for each false certification submitted by or on behalf of Imagimed as part of its Implementation Report, Annual Report, additional documentation to a report (as requested by the OIG), or otherwise required by this CIA.

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

B. Timely Written Requests for Extensions

Imagimed 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 Imagimed 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 Imagimed 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 Imagimed 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 Imagimed of: (a) Imagimed's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties. (This notification shall be referred to as the "Demand Letter.")

2. *Response to Demand Letter*. Within 10 days after the receipt of the Demand Letter, Imagimed 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 Imagimed elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until Imagimed 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 electronic funds transfer to an account specified by OIG in the Demand Letter.

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 Imagimed 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 Imagimed to report a Reportable Event, take corrective action, and make the appropriate refunds, as required in Section III.J;

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 engage and use an IRO in accordance with Section III.E, Appendix A, Appendix B, and/or Appendix C.

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

3. *Opportunity to Cure*. Imagimed 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. Imagimed is in compliance with the obligations of the CIA cited by 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) Imagimed has begun to take action to cure the material breach; (ii) Imagimed is pursuing such action with due diligence; and (iii) Imagimed has provided to OIG a

reasonable timetable for curing the material breach.

4. *Exclusion Letter*. If, at the conclusion of the 30-day period, Imagimed fails to satisfy the requirements of Section X.D.3, OIG may exclude Imagimed from participation in the Federal health care programs. OIG shall notify Imagimed in writing of its determination to exclude Imagimed. (This letter shall be referred to 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 Imagimed's receipt of the Exclusion Letter. The exclusion shall have national effect and shall also apply to all other Federal procurement and nonprocurement programs. Reinstatement to program participation is not automatic. After the end of the period of exclusion, Imagimed may apply for reinstatement by submitting 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 Imagimed 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, Imagimed 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 after receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after receipt of the Exclusion Letter.

2. *Stipulated Penalties Review*. Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether Imagimed was in full and timely compliance with the obligations of this CIA for which OIG demands payment; and (b) the period of noncompliance. Imagimed shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to Stipulated Penalties. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders Imagimed to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless Imagimed 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 Title 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 Imagimed 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) Imagimed had begun to take action to cure the material breach within that period; (ii) Imagimed has pursued and is pursuing such action with due diligence; and (iii) Imagimed provided to OIG within that period a reasonable timetable for curing the material breach and Imagimed 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 Imagimed, only after a DAB decision in favor of OIG. Imagimed's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude Imagimed upon the issuance of an ALJ's decision in favor of OIG. If the ALJ sustains the determination of OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that Imagimed 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. Imagimed shall waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of Imagimed, Imagimed shall be reinstated effective on the date of the original exclusion.

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

XI. EFFECTIVE AND BINDING AGREEMENT

Imagimed and OIG agree as follows:

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

C. This CIA constitutes the complete agreement between the parties and may not be amended except by written consent of the parties to this CIA;

D. OIG may agree to a suspension of Imagimed's obligations under this CIA based on a certification by Imagimed that it is no longer providing health care items or services that will be billed to any Federal health care program and that it does not have any ownership or control interest, as defined in 42 U.S.C. §1320a-3, in any entity that bills any Federal health care program. If Imagimed is relieved of its CIA obligations, Imagimed will be required to notify OIG in writing at least 30 days in advance if Imagimed plans to resume providing health care items or services that are billed to any Federal health care program or to obtain an ownership or control interest in any entity that bills any Federal health care program. At such time, OIG shall evaluate whether the CIA will be reactivated or modified.

E. The undersigned Imagimed signatory represents and warrants that he is 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.

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

ON BEHALF OF IMAGIMED

/Scott Buchanan/ 8/2/13

SCOTT BUCHANAN
President and Chief Executive Officer
Imagimed, LLC

DATE

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

/Robert K. DeConti/ 8/16/13

ROBERT K. DECONTI DATE
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

/Keshia B. Thompson/ 8/16/2013

KESHIA B. THOMPSON DATE
Senior Counsel
Office of Inspector General
U. S. Department of Health and Human Services

ATTACHMENT 1

IMAGIMED SITES

Open MRI of Amsterdam

Open MRI of Brewster

Open MRI of DeWitt

Open MRI of Elmira

Open MRI of Fishkill

Open MRI of Middletown

High-Field Open MRI of Tarrytown

High-Field Open MRI of Utica

Open MRI of Williamsport

Open MRI of Yorktown

Open MRI of Germantown/PNI

APPENDIX A

INDEPENDENT REVIEW ORGANIZATION

This Appendix contains the requirements relating to the Independent Review Organization (IRO) required by Section III.E of the CIA.

A. IRO Engagement

1. Imagimed shall engage one or more IROs that possess the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO(s) shall conduct the review in a professionally independent and objective fashion, as set forth in Paragraph D. Within 30 days after OIG receives the information identified in Section V.A.10 of the CIA or any additional information submitted by Imagimed in response to a request by OIG, whichever is later, OIG will notify Imagimed if the IRO(s) is/are unacceptable. Absent notification from OIG that the IRO(s) is/are unacceptable, Imagimed may continue to engage the IRO(s).

2. If Imagimed engages a new IRO(s) during the term of the CIA, the IRO(s) shall also meet the requirements of this Appendix. If one or more new IRO(s) is/are engaged, Imagimed shall submit the information identified in Section V.A.10 of the CIA to OIG within 30 days of engagement of the IRO(s). Within 30 days after OIG receives this information or any additional information submitted by Imagimed at the request of OIG, whichever is later, OIG will notify Imagimed if the IRO(s) is/are unacceptable. Absent notification from OIG that the IRO(s) is/are unacceptable, Imagimed may continue to engage the IRO(s).

B. IRO Qualifications

Each IRO shall:

1. assign individuals to conduct the Arrangements Review who are knowledgeable in the requirements of the Anti-Kickback Statute and the Stark Law and the regulations and other guidance documents related to these statutes;

2. assign individuals to conduct the Claims Review and Unallowable Cost Review, if applicable, have expertise in the billing, coding, supervision, reporting, and other requirements applicable to imaging claims and in the general requirements of the Federal health care program(s) who pay for claims for services performed at Imagimed locations;

3. assign individuals to design and select the Claims Review and Arrangements Review samples who are knowledgeable about the appropriate statistical sampling techniques;

4. assign individuals to conduct the coding review portions of the Claims Review who have a nationally recognized coding certification and who have maintained this certification (e.g., completed applicable continuing education requirements); and

5. have sufficient staff and resources to conduct the reviews required by the CIA on a timely basis.

C. IRO Responsibilities

Each IRO shall:

1. perform each Arrangements Review, Claims Review, and if applicable, the Unallowable Cost Review, in accordance with the specific requirements of the CIA;

2. if in doubt of the application of a particular Federal health care program policy or regulation, request clarification from the appropriate authority (e.g., fiscal intermediary or carrier);

3. follow all applicable Federal health care program rules and reimbursement guidelines in making assessments in the Claims Review;

4. respond to all OIG inquires in a prompt, objective, and factual manner;

5. prepare timely, clear, well-written reports that include all the information required by Appendices B and C to the CIA.

D. IRO Independence and Objectivity

The IRO(s) must perform the Arrangements Review and the Claims Review in a professionally independent and objective fashion, as defined in the most recent Government Auditing Standards issued by the United States Government Accountability Office.

E. IRO Removal/Termination

1. *Provider and IRO*. If Imagimed terminates any IRO or any IRO withdraws from the engagement during the term of the CIA, Imagimed must submit a notice explaining its reasons for termination or the reason for withdrawal to OIG no later than 30 days after termination or withdrawal. Imagimed must engage a new IRO in accordance with Paragraph A of this Appendix and within 60 days of termination or withdrawal of an IRO.

2. *OIG Removal of IRO*. In the event OIG has reason to believe that an IRO does not possess the qualifications described in Paragraph B, is not independent and objective as set forth in Paragraph D, or has failed to carry out its responsibilities as described in Paragraph C, OIG may, at its sole discretion, require Imagimed to engage a new IRO in accordance with Paragraph A of this Appendix. Imagimed must engage a new IRO within 60 days of termination of an IRO.

Prior to requiring Imagimed to engage a new IRO, OIG shall notify Imagimed of its intent to do so and provide a written explanation of why OIG believes such a step is necessary. To resolve any concerns raised by OIG, Imagimed may present additional information regarding the IRO's qualifications, independence or performance of its responsibilities. OIG will attempt in good faith to resolve any differences regarding any IRO with Imagimed prior to requiring Imagimed to terminate an IRO. However, the final determination as to whether or not to require Imagimed to engage a new IRO shall be made at the sole discretion of OIG.

APPENDIX B

ARRANGEMENTS REVIEW

The Arrangements Review shall consist of two components: a systems review and a transactions review. The IRO shall perform all components of each Arrangements Review. If there are no material changes to Imagimed's systems, processes, policies, and procedures relating to Arrangements, the Arrangements Systems Review shall be performed for the first and fourth Reporting Periods. If Imagimed materially changes the Arrangements systems, processes, policies and procedures, the IRO shall perform an Arrangements Systems Review for the Reporting Period in which such changes were made in addition to conducting the systems review for the first and fourth Reporting Periods. The Arrangements Transactions Review shall be performed annually and shall cover each of the five Reporting Periods.

A. Arrangements Systems Review. The Arrangements Systems Review shall be a review of Imagimed's systems, processes, policies, and procedures relating to the initiation, review, approval, and tracking of Arrangements. Specifically, the IRO shall review the following:

1. Imagimed's systems, policies, processes, and procedures with respect to creating and maintaining a centralized tracking system for all existing and new and renewed Focus Arrangements (Focus Arrangements Tracking System), including a detailed description of the information captured in the Focus Arrangements Tracking System;

2. Imagimed's systems, policies, processes, and procedures for tracking remuneration to and from all parties to Focus Arrangements;

3. Imagimed's systems, policies, processes, and procedures for tracking service and activity logs to ensure that parties to the Focus Arrangement are performing the services required under the applicable Focus Arrangement(s) (if applicable);

4. Imagimed's systems, policies, processes, and procedures for monitoring the use of leased space, medical supplies, medical devices, equipment, or other patient care items to ensure that such use is consistent with the terms of the applicable Focus Arrangement(s) (if applicable);

5. Imagimed's systems, policies, processes, and procedures for initiating Arrangements, including those policies that identify the individuals with

authority to initiate an Arrangement and that specify the business need or business rationale required to initiate an Arrangement;

6. Imagimed's systems, policies, processes, and procedures for the internal review and approval of all Arrangements, including those policies that identify the individuals required to approve each type or category of Arrangement entered into by Imagimed, the internal controls designed to ensure that all required approvals are obtained, and the processes for ensuring that all Focus Arrangements are subject to a legal review by counsel with expertise in the Anti-Kickback Statute and Stark Law;

7. the Compliance Officer's annual review of and reporting to the Compliance Committee on the Focus Arrangements Tracking System, Imagimed's internal review and approval process, and other Arrangements systems, process, policies, and procedures;

8. Imagimed's systems, policies, processes, and procedures for implementing effective responses when suspected violations of the Anti-Kickback Statute and Stark Law are discovered, including disclosing Reportable Events and quantifying and repaying Overpayments when appropriate; and

9. Imagimed's systems, policies, processes, and procedures for ensuring that all new and renewed Focus Arrangements comply with the Focus Arrangements Requirements set forth in Section III.D.2 of the CIA.

B. Arrangements Systems Review Report. The IRO shall prepare a report based upon each Arrangements Systems Review performed. The Arrangements Systems Review Report shall include the following information:

1. a description of the documentation (including policies) reviewed and personnel interviewed;

2. a detailed description of Imagimed's systems, policies, processes, and procedures relating to the items identified in Section A.1-9 above;

3. findings and supporting rationale regarding weaknesses in Imagimed's systems, processes, policies, and procedures relating to Arrangements described in Section A.1-9 above; and

4. recommendations to improve Imagimed's systems, policies, processes, or procedures relating to Arrangements described in Section A.1-9 above.

C. Arrangements Transactions Review. The Arrangements Transactions Review shall consist of a review by the IRO of 50 randomly selected Focus Arrangements that were entered into or renewed by Imagimed during the Reporting Period. The IRO shall assess whether Imagimed has complied with the Focus Arrangements Procedures and the Focus Arrangements Requirements described in Sections III.D.1 and III.D.2 of the CIA, with respect to the selected Focus Arrangements.

The IRO's assessment with respect to each Focus Arrangement that is subject to review shall include:

1. verifying that the Focus Arrangement is maintained in Imagimed's centralized tracking system in a manner that permits the IRO to identify the parties to the Focus Arrangement and the relevant terms of the Focus Arrangement (i.e., the items/services/equipment/space to be provided, the amount of compensation, the effective date, the expiration date, etc.)

2. verifying that the Focus Arrangement was subject to the internal review and approval process (including both a legal and business review) and obtained the necessary approvals and that such review and approval is appropriately documented;

3. verifying that the remuneration related to the Focus Arrangement is properly tracked;

4. verifying that the service and activity logs are properly completed and reviewed (if applicable);

5. verifying that leased space, medical supplies, medical devices, and equipment, and other patient care items are properly monitored (if applicable); and

6. verifying that the Focus Arrangement satisfies the Focus Arrangements Requirements of Section III.D.2 of the CIA.

D. Arrangements Transaction Review Report. The IRO shall prepare a report based on each Arrangements Transactions Review performed. The Arrangements Transaction Review Report shall include the following information:

1. *Review Methodology*

a. Review Protocol: A detailed narrative description of the procedures performed and a description of the

sampling unit and universe utilized in performing the procedures for the sample reviewed.

b. Sources of Data: A full description of the documentation and other information, if applicable, relied upon by the IRO in performing the Arrangements Transaction Review.

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

2. *Review Findings.* The IRO's findings with respect to whether Imagimed has complied with the Focus Arrangements Procedures and Focus Arrangements Requirements with respect to each of the randomly selected Focus Arrangements reviewed by the IRO. In addition, the Arrangements Transactions Review Report shall include observations, findings and recommendations on possible improvements to Imagimed's policies, procedures, and systems in place to ensure that all Focus Arrangements comply with the Focus Arrangements Procedures and Focus Arrangements Requirements.

APPENDIX C

CLAIMS REVIEW

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

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

a. Overpayment: The amount of money Imagimed or an entity authorized to submit claims and receive payment for items or services provided at Imagimed ("Imagimed Billing Entity") has received in excess of the amount due and payable under any Federal health care program requirements.

b. Paid Claim: A claim submitted by Imagimed or an Imagimed Billing Entity and for which Imagimed or an Imagimed Billing Entity has received reimbursement from any Federal health care program.

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

d. 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 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 Paid Claims in the sample.

2. *Discovery Sample.* The IRO shall randomly select and review a sample of 50 Paid Claims (Discovery Sample). The Paid Claims shall be reviewed based on the supporting documentation available at Imagimed's office, under Imagimed's

control, or under an Imagimed Billing Entity's control, and applicable billing and coding regulations and guidance to determine whether the claim was correctly coded, submitted, and reimbursed.

If the Error Rate (as defined above) for the Discovery Sample is less than 5%, no additional sampling is required, nor is the Systems Review required. (Note: The guidelines listed above do not imply that this is an acceptable error rate. Accordingly, Imagimed should, as appropriate, further analyze any errors identified in the Discovery Sample. Imagimed recognizes that 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 or any other segment of the universe.)

3. *Full Sample*. If the Discovery Sample indicates that the Error Rate is 5% or greater, the IRO shall select an additional sample of Paid Claims (Full Sample) using commonly accepted sampling methods. The Full Sample shall 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 selected for the Full Sample shall be reviewed based on supporting documentation available at Imagimed, under Imagimed's control, or under an Imagimed Billing Entity's control, and applicable billing and coding regulations and guidance to determine whether the claim was correctly coded, submitted, and reimbursed. For purposes of calculating the size of the Full Sample, the Discovery Sample may serve as the probe sample, if statistically appropriate. Additionally, the IRO may use the Paid Claims sampled as part of the Discovery Sample, and the corresponding findings for those Paid Claims, as part of its Full Sample, if: (1) statistically appropriate and (2) the IRO selects the Full Sample Paid Claims using the seed number generated by the Discovery Sample. OIG, in its sole discretion, may refer the findings of the Full Sample (and any related workpapers) received from Imagimed 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.

4. *Systems Review*. If Imagimed's Discovery Sample identifies an Error Rate of 5% or greater, Imagimed's IRO shall also conduct a Systems Review. The Systems Review shall consist of the following:

a. a review of Imagimed's billing and coding systems and processes relating to claims submitted to Federal health care programs (including, but not limited to, the operation of the billing system, the process by which claims are coded, safeguards to ensure proper coding, claims submission and

billing; and procedures to identify and correct inaccurate coding and billing);

b. for each claim in the Discovery Sample and Full Sample that resulted in an Overpayment, the IRO shall review the system(s) and process(es) that generated the claim and identify any problems or weaknesses that may have resulted in the identified Overpayments. The IRO shall provide its observations and recommendations on suggested improvements to the system(s) and the process(es) that generated the claim.

5. *Other Requirements*

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

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

c. Use of First Samples Drawn. For the purposes of all samples (Discovery Sample(s) and Full Sample(s)) discussed in this Appendix, the Paid Claims selected in each first sample shall

be used (i.e., it is not permissible to generate more than one list of random samples and then select one for use with the Discovery Sample or Full Sample).

6. *Repayment of Identified Overpayments.* Imagimed shall repay within 30 days any Overpayment(s) identified in the Discovery Sample or the Full Sample (if applicable), regardless of the Error Rate, to the appropriate payor and in accordance with payor refund policies. Imagimed shall make available to OIG all documentation that reflects the refund of the Overpayment(s) to the payor.

B. Claims Review Report. The IRO shall prepare a Claims Review Report as described in this Appendix for each Claims Review performed. 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. Claims Review Population. A description of the Population subject to the Claims Review.

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

c. Source of Data. A description of the specific 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 (including title and policy number), CMS program memoranda (including title and issuance number), Medicare carrier or intermediary manual or bulletins (including issue and date), other policies, regulations, or directives).

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

e. Supplemental Materials. A description of any Supplemental Materials as required by A.5.a., above.

2. *Statistical Sampling Documentation*

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

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

c. A description or identification of the statistical sampling software package used to select the sample and determine the Full Sample size, if applicable.

3. *Claims Review Findings*

a. Narrative Results

i. A description of Imagimed'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).

b. Quantitative Results

i. Total number and percentage of instances in which the IRO determined that the Paid Claims submitted by Imagimed (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 Imagimed.

iii. Total dollar amount of all Overpayments in the sample.

iv. Total dollar amount of Paid Claims included in the sample and the net Overpayment associated with the sample.

v. Error Rate in the sample.

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

c. Recommendations. The IRO's report shall include any recommendations for improvements to Imagimed's billing systems, coding system, based on the findings of the Claims Review

4. *Systems Review Findings*. The IRO shall prepare a Systems Review Report based on the Systems Review performed (if applicable) that shall include the IRO's observations, findings, and recommendations regarding:

a. the strengths and weaknesses in Imagimed's billing systems and processes;

b. the strengths and weaknesses in Imagimed's coding systems and processes;

c. possible improvements to Imagimed's billing and coding systems and processes to address the specific problems or weaknesses that resulted in the identified Overpayments.

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.

APPENDIX D

IMAGIMED, LLC SUBSIDIARIES AND AFFILIATES

1. Open MRI of Amsterdam, LLC
2. Open MRI of Brewster, LLC
3. Open MRI of Hudson, LLC