CERTIFICATION OF COMPLIANCE AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
PHYSICIAN SPECIALISTS IN ANESTHESIA, P.C. AND PHYSICIAN PAIN SPECIALISTS, P.C.

I. PREAMBLE

Physician Specialists in Anesthesia, P.C. and Physician Pain Specialists, P.C. (as successor to Physician Specialists in Pain Management) (collectively referred to as "Provider") hereby enters into this Certification of Compliance Agreement (CCA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS). Contemporaneously with this CCA, Provider is entering into a Settlement Agreement with the United States, and this CCA is incorporated by reference into the Settlement Agreement.

The effective date of this CCA shall be the date on which the final signatory of this CCA executes this CCA (Effective Date). Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."

II. INTEGRITY REQUIREMENTS

Provider shall, for a period of five years from the Effective Date of this CCA:

A. Continued Implementation of Compliance Program. Provider shall continue to implement its Compliance Program, as described in the attached Declaration (which is incorporated by reference as Appendix A), and continue to provide, at a minimum, the same level of resources currently provided, throughout this time period. Provider may amend its Compliance Program as it deems necessary, so long as those amendments are consistent with the overall objective of ensuring compliance with the requirements of Medicare, Medicaid, and all other Federal health care programs, as defined in 42 U.S.C. § 1320a-7b(f).

B. Reporting of Overpayments. Provider shall promptly refund to the appropriate Federal health care program payor any identified Overpayment(s). For purposes of this Agreement, an "Overpayment" shall mean the amount of money Provider has received in excess of the amount due and payable under any Federal health care program requirements. If, at any time, Provider identifies or learns of any Overpayment, Provider shall notify the payor (e.g., Medicare fiscal intermediary or carrier) within 30 days after identification of the Overpayment and take remedial steps within 60 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. Also, within 30 days after identification of the Overpayment, Provider shall repay the Overpayment to the appropriate payor to the extent such Overpayment has been quantified. If not yet quantified, within 30 days after identification, Provider 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, and for Medicare contractors, shall include the information contained on the Overpayment Refund Form, provided as Appendix B to this CCA. Notwithstanding the above, notification and repayment of any Overpayment amount that is routinely reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

C. Reportable Events. Provider shall report to OIG in writing within 30 days after making a determination (after a reasonable opportunity to conduct an appropriate review or investigation of the allegations) that there is a Reportable Event, which shall mean anything that involves: (1) a substantial Overpayment, or (2) 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. In such report, Provider shall include the following information:

1. If the Reportable Event results in an Overpayment, the report to OIG shall be made at the same time as the notification to the payor required in Section II.B, and shall include all of the information on the Overpayment Refund Form, as well as:

a. the payor's name, address, and contact person to whom the Overpayment was sent; and

b. the date of the check and identification number (or electronic transaction number) by which the Overpayment was repaid/refunded;

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

3. a description of Provider's actions taken to correct the Reportable Event; and

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

D. Notification of Government Investigation or Legal Proceedings. Within 30 days after discovery, Provider shall notify OIG, in writing, of any ongoing investigation or legal proceeding known to Provider conducted or brought by a governmental entity or its agents involving an allegation that Provider 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. Provider 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.

E. Annual Reporting Requirements. Provider shall submit to OIG annually a report that sets forth the following information for each Reporting Period (Annual Report):

1. A description of any material amendments to its Compliance Program and the reasons for such changes;

2. Any changes to the level of resources dedicated to its Compliance Program and the reasons for such changes;

3. A summary of all relevant internal and/or external reviews, audits, or analyses of its Compliance Program (including, at a minimum, the objective of the review, audit, or analysis; the protocol or methodology for the review, audit, or analysis; and the results of the review, audit, or analysis) and any corrective action plans developed in response to such reviews, audits, or analyses;

4. A summary of all relevant internal and/or external reviews, audits, or analyses related to surgical anesthesiology, and pain management services (including, at a minimum, the objective of the review, audit, or analysis; the protocol or methodology for the review, audit, or analysis; and the results of the review, audit, or analysis) and any corrective action plans developed in response to such reviews, audits, or analyses;

5. 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 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; and

6. A certification by the Compliance Officer that: (a) during the Reporting Period, Provider has complied with the requirements of this Section II; and (b) he has reviewed the Annual Report and has made reasonable inquiry regarding its content and believes that the information in the Annual Report is accurate and truthful.

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.

Nothing in this CCA, or any communication or report made pursuant to this CCA, shall constitute or be construed as a waiver by Provider of Provider's attorney-client, work product, or other applicable privileges. Notwithstanding that fact, the existence of any such privilege does not affect Provider's obligation to comply with the provisions of this CCA.

F. Notifications and Submission of Annual Reports. Unless otherwise specified in writing after the Effective Date, all notifications and Annual Reports required under this CCA shall be submitted to the following addresses:

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, D.C. 20201
Telephone: 202-619-2078
Facsimile: 202-205-0604

Physician Specialists in Anesthesia, P.C. and Physician Pain Specialists, P.C.:

Dr. John Stephenson
Physician Specialists in Anesthesia, P.C.
Physician Pain Specialists, P.C.
5671 Peachtree Dunwoody Road
Suite 530
Atlanta, GA 30342
Telephone: 404-851-5638

Facsimile: 404-851-1649

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

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

H. Document and Record Retention. Provider shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs, or to compliance with this CCA, for six years (or longer if otherwise required by law).

III. BREACH AND DEFAULT PROVISIONS

Provider is expected to fully and timely comply with all of the Integrity Requirements set forth in this CCA.

A. Stipulated Penalties for Failure to Comply with Certain Obligations. As a contractual remedy, Provider and OIG hereby agree that failure to comply with the Integrity Requirements set forth in this CCA 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 Provider fails to establish and

implement any of the following compliance program elements as described in the Declaration attached to this CCA as Appendix A:

a. a Compliance Officer;

b. a Compliance Committee;

c. a written Code of Conduct;

d. written Policies and Procedures;

e. the annual training of all owners, officers, directors, board members, employees, medical staff, agents, and other persons who provide patient care items or services on behalf of Provider;

f. an internal audit unit that performs periodic reviews to monitor Provider's compliance with Federal health care program requirements; and

g. a Disclosure Program.

2. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day Provider fails to meet any deadlines for the submission of Annual Reports to OIG as described in Section II.E.

3. A Stipulated Penalty of $2,000 (which shall begin to accrue on the date the failure to comply began) for each day Provider has as an owner, officer, or director, an excluded individual, or for each day Provider employs, contracts with, or has as an agent, an excluded individual and that person: (a) has responsibility for, or involvement with, Provider's business operations related to the Federal health care programs; or (b) is in a position for which the person's salary or the items or services furnished, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds. The Stipulated Penalty described in this Subsection shall not be demanded for any time period during which Provider can demonstrate that it did not discover the person's exclusion or other ineligibility after making a reasonable inquiry (as described in Paragraph 7 of the Declaration) as to the status of the person).

4. A Stipulated Penalty of $1,500 for each day Provider fails to grant access to the information or documentation as required in Section II.G of this CCA. (This Stipulated Penalty shall begin to accrue on the date Provider fails to grant access.)

5. A Stipulated Penalty of $5,000 for each false certification submitted by or on behalf of Provider as part of its Annual Reports or otherwise required by this CCA.

6. A Stipulated Penalty of $1,000 for each day Provider fails to comply fully and adequately with any Integrity Requirements of this CCA. OIG shall provide notice to Provider , stating the specific grounds for its determination that Provider has failed to comply fully and adequately with the Integrity Requirement(s) at issue and steps Provider shall take to comply with the Integrity Requirements of this CCA. (This Stipulated Penalty shall begin to accrue 10 days after Provider receives 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 1-5 of this Section III.A.

B. Timely Written Requests for Extensions. Provider 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 CCA. 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 Provider 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 Provider 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 Provider has failed to comply with any of the obligations described in Section III.A and after determining that Stipulated Penalties are appropriate, OIG shall notify Provider of: (a) Provider's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties (this notification is referred to as the "Demand Letter").

2. *Response to Demand Letter.* Within 10 days after the receipt of the Demand Letter, Provider 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 III.E. In the event Provider elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until Provider 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 CCA and shall be grounds for exclusion under Section III.D.

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

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

D. Exclusion for Material Breach of this CCA.

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

a. a failure by Provider to report a Reportable Event, take corrective action, and make the appropriate refunds, as required in Section II.C;

b. a repeated or flagrant violation of the obligations under this CCA, including, but not limited to, the obligations addressed in Section III.A; or

c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section III.C.

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

3. *Opportunity to Cure.* Provider 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. Provider is in compliance with the requirements of the CCA 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) Provider has begun to take action to cure the material breach; (ii) Provider is pursuing such action with due diligence; and (iii) Provider has provided to OIG a reasonable timetable for curing the material breach.

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

E. Dispute Resolution.

1. *Review Rights.* Upon OIG's delivery to Provider of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CCA, Provider 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 CCA. 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 CCA shall be: (a) whether Provider was in full and timely compliance with the requirements of this CCA for which OIG demands payment; and (b) the period of noncompliance. Provider 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 CCA and orders Provider to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless Provider 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 CCA shall be:

a. whether Provider was in material breach of this CCA;

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) Provider had begun to take action to cure the material breach within that period; (ii) Provider has pursued and is pursuing such action with due diligence; and (iii) Provider provided to OIG within that period a reasonable timetable for curing the material breach and Provider 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 Provider, only after a DAB decision in favor of OIG. Provider's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude Provider 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 Provider 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. Provider 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 Provider, Provider 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 CCA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CCA.

IV. EFFECTIVE AND BINDING AGREEMENT

Provider and OIG agree as follows:

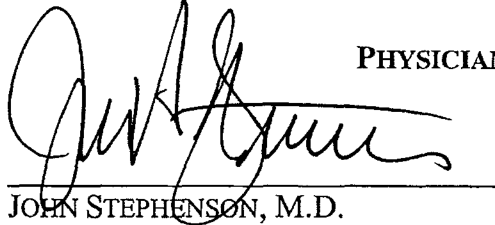
A. This CCA shall be binding on the successors, assigns, and transferees of Provider;

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

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

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

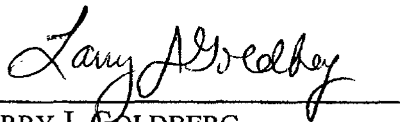
ON BEHALF OF PHYSICIAN SPECIALISTS IN ANESTHESIA, P.C.
AND
PHYSICIAN PAIN SPECIALISTS, P.C.



JOHN STEPHENSON, M.D.
Chairman of the Board and
Compliance Officer

6-18-04
DATE

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



LARRY J. GOLDBERG
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

6/28/04
DATE

OVERPAYMENT REFUND

TO BE COMPLETED BY MEDICARE CONTRACTOR

Date:______________
Contractor Deposit Control #______________ Date of Deposit: ____________________
Contractor Contact Name:________________________________Phone #________________________
Contractor Address:____
Contractor Fax:

TO BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER

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

PROVIDER/PHYSICIAN/SUPPLIERNAME____
ADDRESS____
PROVIDER/PHYSICIAN/SUPPLIER #________________CHECK NUMBER#__________________
CONTACT PERSON:________________________________PHONE #__________________
AMOUNT OF CHECK $______________ CHECK DATE______________

REFUND INFORMATION

For each Claim, provide the following:
Patient Name____________________________________HIC #__________________________
Medicare Claim Number__________________Claim Amount Refunded $______________
Reason Code for Claim Adjustment:_____ (Select reason code from list below. Use one reason per claim)

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

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

For Institutional Facilities Only:
Cost Report Year(s) ____________________
(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)
For OIG Reporting Requirements:
Do you have a Corporate Integrity Agreement with OIG? ________Yes __________No

Reason Codes:

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

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

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