

**AMENDMENT TO THE  
INTEGRITY AGREEMENT  
BETWEEN THE  
OFFICE OF INSPECTOR GENERAL  
OF THE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
AND  
ARUN ARORA, MD**

The Office of Inspector General (OIG) of the Department of Health and Human Services and Arun Arora, MD entered into an Integrity Agreement effective September 20, 2023 (“Arora IA”). Under Section X.B of the Arora IA, the Arora IA may be modified only with the written consent of both Arora and OIG.

The OIG and Arora hereby agree that the Arora IA shall be modified by adding the following Appendix C to the Arora IA.

**APPENDIX C**

**QUARTERLY CLAIMS REVIEW**

A. Quarterly Claims Review. The IRO shall perform the Quarterly Claims Review for each three-month period of the second and third Reporting Periods in lieu of the Claims Review described in Appendix B. However, the first six months of second Reporting Period will be combined into one Quarterly Claims Review.

1. *Definitions.*

- a. “Paid Claim” means a fee-for-service claim submitted by Arora and for which Arora has received reimbursement from the Medicare program.
- b. “Population” means all Paid Claims during the three-month period covered by the Quarterly Claims Review.
- c. “Overpayment” means the amount of money Arora has received in excess of the amount due and payable under Medicare program requirements, as determined by the IRO in connection with the Quarterly Claims Review performed under this Appendix.
- d. “Error Rate” means the percentage of net Overpayments identified in the Quarterly Claims Review Sample. The net Overpayment shall

be calculated by subtracting all underpayments identified in the Quarterly Claims Review Sample from all Overpayments identified in the Quarterly Claims Review Sample. The Error Rate is calculated by dividing the net Overpayment by the total dollar amount associated with the Paid Claims in the Quarterly Claims Review Sample.

2. *Quarterly Claims Review Sample.* Within 15 days following the end of each three-month period during the second and third Reporting Period of the IA, the IRO shall select a random sample of 30 Paid Claims (Quarterly Claims Review Sample). The IRO shall review the Paid Claims based on Arora's documentation and the applicable Medicare program requirements to determine whether the items and services furnished were medically necessary and appropriately documented, and whether the claim was correctly coded, submitted, and reimbursed.

3. *Other Requirements.*

- a. Supplemental Materials. The IRO shall request all documentation required for its review of the Paid Claims in the Quarterly Claims Review Sample and Arora shall furnish such documentation to the IRO prior to the IRO initiating its review of the Quarterly Claims Review Sample. If the IRO accepts any supplemental documentation from Arora after the IRO has completed its initial review of the Quarterly Claims Review Sample (Supplemental Materials), the IRO shall include the following in the Quarterly Claims Review Report: (i) a description of the Supplemental Materials, (ii) the date the Supplemental Materials were accepted, (iii) the IRO's reason(s) for accepting the Supplemental Materials, and (iv) the relative weight the IRO gave to the Supplemental Materials in its review.
- b. Paid Claims without Supporting Documentation. Any Paid Claim for which Arora cannot produce documentation shall be considered an error and the total reimbursement received by Arora for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims without documentation is not permitted.
- c. Use of First Sample Drawn. The first set of Paid Claims selected shall be used for the Quarterly Claims Review Sample (i.e., it is not permissible to generate more than one list of random samples and then select one for use).

4. *Repayment of Estimated Overpayment.* The findings of the Quarterly Claims Review Sample shall be used by the IRO to estimate the actual Overpayment in the Population with the point estimate and a two-sided 90% confidence interval. Within 60 days of receipt of the Claims Review Report, Arora shall repay the lower limit of the two-sided 90% confidence interval (Estimated Overpayment) to the Centers for Medicare and Medicaid Services (CMS). Documentation of Arora's refund of the Estimated Overpayment to CMS shall be submitted to OIG with Arora's Annual Report. OIG, in its sole discretion, may refer the findings of the Claims Review Sample to CMS for appropriate follow up.

B. Claims Review Report. The IRO shall prepare a Claims Review Report for each Quarterly Claims Review that includes the following information:

1. *Claims Review Methodology.*
  - a. Claims Review Objective. A statement of the objective intended to be achieved by the Quarterly Claims Review.
  - b. Claims Review Population. A description of the Population subject to the Quarterly Claims Review.
  - c. Source of Data. A description of (1) the process used to identify Paid Claims in the Population and (2) the specific documentation and other information sources relied on by the IRO when performing the Quarterly 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 Quarterly Claims Review was conducted and what was evaluated.
  - e. Supplemental Materials. The information regarding any Supplemental Materials required by A.3.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 description or identification of the statistical sampling software package used by the IRO.
3. *Claims Review Findings.*
- a. Narrative Results.
    - i. A description of Arora's billing and coding system(s), including the identification, by position description, of the personnel involved in coding and billing.
    - ii. A description of controls in place at Arora to ensure that all items and services furnished by Arora are correctly coded, appropriately documented, and medically necessary.
    - iii. A narrative explanation of the results of the IRO's review of the Quarterly Claims Review Sample, including an explanation of all errors identified by the IRO.
  - b. Quantitative Results.
    - i. Total number and percentage of instances in which the IRO determined that the coding of the Paid Claims submitted by Arora differed from what should have been the correct coding.
    - ii. Total number and percentage of instances in which the IRO determined that a Paid Claim was not appropriately documented.
    - iii. Total number and percentage of instances in which the IRO determined that a Paid Claim was for items or services that were not medically necessary.
    - iv. Total dollar amount of Paid Claims included in the Quarterly Claims Review Sample and the net Overpayment associated with the Quarterly Claims Review Sample.
    - v. Error Rate in the Quarterly Claims Review Sample.
    - vii. An estimate of the actual Overpayment in the Population with the point estimate and a two-sided 90% confidence interval.

viii. A spreadsheet of the Quarterly Claims Review results that includes the following information for each Paid Claim:

1. Federal health care program billed;
2. Beneficiary health insurance claim number;
3. Date of service;
4. Code submitted (e.g., DRG, CPT code, etc.);
5. Code reimbursed;
6. Allowed amount reimbursed by payor;
7. Correct code (as determined by the IRO);
8. Correct allowed amount (as determined by the IRO);
9. Whether the item or service was medically necessary;
10. Whether the item or service was appropriately documented; and
11. The 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 Arora's billing and coding system or to Arora's controls for ensuring that all items and services billed to the Medicare program by Arora are correctly coded, appropriately documented, and medically necessary, based on the findings of the Quarterly Claims Review.

4. *Credentials*. The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Quarterly Claims Review and (2) performed the Quarterly Claims Review.

5. *Submission to the OIG*. The Quarterly Claims Review Report shall be submitted to the OIG within 60 days following the end of the three-month period covered by each Quarterly Claims Review.

ON BEHALF OF ARUN ARORA, MD

/Arun Arora/  
ARUN ARORA, MD

3-24-25  
DATE

/David M. Traskey/  
DAVID TRASKEY  
GARFUNKEL WILD, P.C.  
ARUN ARORA, MD

03/24/2025  
DATE

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

/Susan Gillin/  
SUSAN E. GILLIN  
Assistant Inspector General for Legal Affairs  
Office of Inspector General  
U. S. Department of Health and Human Services

3/25/25  
DATE

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Senior Counsel  
Office of Inspector General  
U. S. Department of Health and Human Services

5/20/25  
DATE