$1,000,000 OF AUDIT INSURANCE COVERAGE

Physicians Regulatory Insurance Program
Underwritten by Lloyds of London ®
Over 40,000 Healthcare Practitioners Covered Nationwide

Federal and State Government entities are not alone in the increasing scrutiny of healthcare providers and physicians. This scrutiny extends to billing, coding, privacy (HIPAA), Anti-kickback and illegal referrals (Stark), Emergency Medical Treatment (EMTALA) and other violations. Medicare, Medicaid, and commercial insurance companies are launching aggressive efforts to enforce billing compliance and to recover overpayments. In many cases demands for repayment are calculated from extrapolated audits leaving the provider to defend huge amounts based on a sampling of case files.

The False Claims Act imposes liability even if a person submitting a claim does not have actual knowledge that a claim is false. Healthcare practitioners are legitimately concerned that a single unintentional violation of one of the many regulations could bankrupt their practice. Below are some of the more common regulatory issues faced by healthcare practitioners and how this program responds to them.

MEDICARE, MEDICAID, OIG & RAC POST-PAYMENT AUDIT COVERAGE

EXPOSURE & RISK: Government allegations of fraud and abuse through non-compliant billing and coding practices. Demand for repayment of alleged overpayments, including fines, penalties and interest.

COVERAGE: Indemnifies the practitioner up to **$1,000,000** and pays all fines, penalties and interest, as well as the cost of legal defense including attorney's fees, expert witnesses and costs for reproduction of case files, documentation and shadow audits.

COMMERCIAL PAYOR AUDIT COVERAGE

EXPOSURE & RISK: Commercial payor allegations of fraud and abuse including demands for repayment of alleged overpayments, and in some cases, penalties and interest.

COVERAGE: Coverage expands beyond governmental audits to include all commercial insurance carriers. Indemnifies the practitioner up to **$1,000,000** and pays all fines, penalties and interest, as well as the cost of legal defense including attorney's fees, expert witnesses and costs for reproduction of case files, documentation and shadow audits.

HIPAA VIOLATIONS

EXPOSURE & RISK: Rules and regulations governing the restricted use of patient information.

COVERAGE: Indemnifies the practitioner up to **$1,000,000** and pays all fines and penalties levied by Federal or State enforcement agencies as a result of allegations of HIPAA violations Also includes all costs of legal representation and defense.

STARK & ANTI-KICKBACK VIOLATIONS

EXPOSURE & RISK: Non-compliant referral agreements and anti-kickback violations.

COVERAGE: Indemnifies the practitioner up to **$1,000,000** and pays all fines and penalties levied by Federal or State enforcement agencies as a result of allegations of Stark or Anti-Kickback violations. Also includes all costs of legal representation and defense.

EMTALA VIOLATIONS

EXPOSURE & RISK: Healthcare practitioners who are involved in emergency medicine have exposure and risk under the Emergency Medical Treatment Active Labor Act (EMTALA). Fines and penalties for violations can run into hundreds of thousands of dollars.

COVERAGE: Provides defense and indemnity up to **$1,000,000** covering all legal fees and representation costs, fines and penalties if allegations of non-compliance are made against practitioners who provide emergency medical care.

AUDIT TARGETS: INDIVIDUAL HEALTHCARE PRACTITIONERS AND PHYSICIAN GROUPS

PROGRAM FEATURES

- **Up to 6 years retroactive coverage**
- **Payment of all fines and penalties up to $1,000,000 ($5,000,000 for groups)**
- **Coverage for all defense costs including attorneys fees, consultants, expert witnesses, reproduction costs and shadow audits, after $2,500 deductible**
- **Simple underwriting process (completion of a 3 page application)**
- **Average premium is $1,400-$1,600 annually per physician, discounts for groups**
- **Fast, no obligation quotes and approvals**
- **Underwritten by Lloyds of London**

CALL 800.260.7066
FOR AN APPLICATION OR MORE INFORMATION

MED RISK MANAGEMENT Associates Inc.

www.auditinsurance.com

Completing the Audit Insurance Application

Please follow these instructions carefully. Call 800-260-7066 for further assistance.

Section 1 – General Information

- Please answer all questions. If a question does not apply, write NA or None.
- In the boxes, enter the number of practitioners in the named entity, whether employed or contracted. List all others to be covered on the Census in Section IV.

Section II – Payor Information

- Please provide a combined total for all practitioners for all information requested, otherwise risk cannot be determined.

Section III – Billing Procedures

- If you do not have a billing compliance program, please attach your billing guidelines.
- Answer all "If yes" questions if the previous response was "yes".
- The CPT manual edition in use must not be more than 2 years old.
- Add full details where needed for "Yes" answers.

Section IV – Professional Census

- List all staff here – practitioners, therapists, PAs, billers and all other employees for all offices or locations. The census determines who is covered. If there is someone you want/need to be covered, they MUST be listed on the census. Be sure to include the practitioners counted in Section 1.

Section V – Physician/Practitioner Warranty

- You must respond to the two warranty statements. If you answer "no" (cannot agree) to either of the statements, a written detailed explanation is required. Be sure to include your signature and the date.

Mail application and requested documents to:
Med Risk Management Associates Inc.
4276 Steed Terrace
Winter Park, FL 32792

Fax or email documents to:
Fax: 305-574-3753
Email: info@auditinsurance.com

What Happens Next?

Med Risk Management Associates will forward your application to the underwriter for review. The underwriter usually provides an answer within 7 to 10 days. Once approved, you will receive notification from Med Risk Management, along with your formal proposal outlining the details of coverage. The proposal contains pages for your signature indicating your acceptance and payment options. The proposal must be accepted within 30 days or it will expire and reapplication will be required.

Faxing the signed acceptance, payment preference and a copy of your check to the insurance underwriter for the full or partial premium binds coverage as of that moment. After faxing, the original signed agreement and your check must be mailed and received by the underwriter within 30 days, or coverage will be cancelled. You will receive the policy from the insurance carrier in the mail within 60 days.

Physicians Regulatory Insurance Program Application

Agency Med Risk Management Associates Inc		Contact Neil M. Peiman	
Address 4276 Steed Terrace			
City Winter Park	State FL.		Zip Code 32792
Business Phone 800-260-7066	Fax 305-574-3753	E-mail Address	info@auditinsurance.com

The insurance for which you are applying is a claims-made and reported form of coverage. Only claims first made and reported to the Underwriters on or after the effective date but before the end of the Policy Period, or any applicable extended reporting period, will be covered, subject to any retroactive date.

This Application will give the Underwriters an understanding of your billing practices. The completion of this application does not bind coverage. **All questions must be answered completely**. If a question is not applicable, answer by stating "Not Applicable" or "NA". If the answer to a question is none, answer by indicating "None" or "O". If more space is needed to answer a question, attach a separate piece of paper and identify the question to which it pertains. **The Physician/Practitioner Warranty Statement (Section V) must be completed and signed by an officer of the practice.**

I. GENERAL INFORMATION

Applicant's Name (If entity please state)			
Address			
City	State		Zip Code
Business Phone	Fax		

Requested Effective Date	Requested Retroactive Period
	☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ 6 Years

Name of entity as it is to appear on policy documents

Type of entity (i.e. P.A., P.C., LLP, Partnership)

Specialties of practice:

Named entity coverage is available only when all practitioners (employed or contracted) apply.

Please provide the following census information, including all practitioners whether employed or contracted:

Number of Practitioners in Group	Number of Physicians working more than 20 hours per week	Number of Physicians working 20 hours or less per week	Number of Nurse Practitioners/Midwives/ CRNAs	Number of RNs, LPNs and Physician Assistants

II. PAYOR INFORMATION

Please provide the following information regarding the "Payor Mix" of your practice:

Payor Source	Gross Billings for the past 12 months	Collections for the past 12 months
Medicare	$	$
Medicaid	$	$
Medicare Founded HMO	$	$
All Other (Commercial, Cash, etc.)	$	$
Total	$	$

Total for all Payors should equal gross billings and collections for the entire practice

III. BILLING PROCEDURES

Does your practice have a billing compliance program? If answering "no", please describe your billing guidelines on a separate piece of paper	☐ YES ☐ NO
Does your practice have a written policy regarding collection of receivables balances?	☐ YES ☐ NO
If answering "yes", does the policy include write-offs of outstanding balances, co-payments and deductibles?	☐ YES ☐ NO
What edition of the CPT manual are you currently using for your practice?	
Does your practice keep EOB files after they are recorded in the billing system?	☐ YES ☐ NO
Does your practice keep a separate file of outstanding/denied/questioned EOBs?	☐ YES ☐ NO
Are all contracts and referral relationships reviewed by outside counsel to ensure they conform with anti-kickback statutes?	☐ YES ☐ NO
Are billing and procedure codes monitored to alert practice management of possible upcoding, over-utilization or other billing anomalies?	☐ YES ☐ NO
Does your Practice monitor free and / or discounted samples of medications and supplies to guard against co-mingling with purchased inventory or inappropriate billing for items dispensed?	☐ YES ☐ NO
Does the entity/ physician transmit any protected health information electronically?	☐ YES ☐ NO
If yes, does the entity comply with HIPAA's Privacy Rule for Covered entities?	☐ YES ☐ NO
Is any physician required (by medical staff documents at any hospital's emergency department) to serve "on-call" for patients requiring emergency treatment?	☐ YES ☐ NO
If yes, is the physician familiar with their responsibilities under EMTALA as they apply to individual physicians?	☐ YES ☐ NO

If answering "yes" to any of the following questions, please describe in detail, on a separate sheet of paper, each incident.	
Have you or anyone within the entity ever been reviewed by the State Board of Medical Examiners?	☐ YES ☐ NO
Have you or anyone within the entity ever lost any medical practice privileges, other than voluntary termination, with any provider?	☐ YES ☐ NO
Have you or anyone within the entity ever been investigated or sanctioned by any local, state or federal government or agency regarding the delivery of health care services or reimbursement thereof?	☐ YES ☐ NO
Have you or anyone within the entity ever been involved in a stark / anti-kickback investigation?	☐ YES ☐ NO
Have you or anyone within the entity ever been sued or deselected from a commercial payor?	☐ YES ☐ NO

If billing is currently performed by a third party billing company please provide the following information:		
Billing Company's Name		
Address		
City	State	Zip Code
Please describe any common ownership that exists between the Applicant's practice and the third party billing company.		
Does the third party billing company have a compliance program?	☐ YES ☐ NO	

If billing is currently performed in-house please provide the following information:

Number of individuals responsible for billing	* Number of credential billers

* A Credential Biller is one who has completed certification course relative to billing and coding procedures.

IV. PROFESSIONAL CENSUS

Please provide a complete list of all professional staff and their designation below. This page may be duplicated as necessary. Signatures are not required in this section. Please type or print legibly.

	Name	Designation	Full Time	Part Time
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

V. PHYSICIAN/PRACTITIONER WARRANTY (To be completed and signed by an officer of the entity)

An officer of the practice must read the following statement:

The Undersigned warrants and represents that, to the best of his/her knowledge, the statements herein are true, and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application. It is represented that the particulars and statements contained in the Application, and any materials submitted (which shall be on file with the Underwriters and shall be deemed attached, as if physically attached) are the basis for the proposed insurance and are to be considered incorporated into and constituting a part of the proposed insurance.

The Undersigned agrees that in the event this Application contains misrepresentations or fails to state facts materially affecting the risk assumed by the Underwriters, any insurance issued shall be void in its entirety.

The Undersigned agrees that, if after the date of this Application and prior to issuance of any insurance, any occurrence, event or other circumstance should render any of the information contained in this Application inaccurate or incomplete, the Undersigned shall notify the Underwriters of such occurrence, event or circumstance, and shall provide the Underwriters with information that would complete, update or correct the information contained in this Application. Any outstanding quotations may be modified or withdrawn at the sole discretion of the Underwriters.

The Underwriters are hereby authorized to make an investigation and inquiry in connection with this application as it may deem necessary.

The Undersigned warrants that they are duly authorized by the by laws of the group or entity to execute this warranty on behalf of the group or entity, and confirms that they have made the necessary inquiries to assure underwriters of the accuracy of the statements made hereon.

An officer of the practice must answer the following two statements, sign and date below. If you cannot agree to either of the following two statements, please attach a detailed explanation.

Statement 1. I agree with the above physician/practitioner warranty.

Statement 2. I have no knowledge of any specific claims or facts, circumstances, situations, events or transactions that may result in a claim which may be covered by the proposed policy.

PLEASE BE SURE TO RESPOND TO BOTH STATEMENTS WHERE INDICATED AND SIGN AND DATE WHERE INDICATED, UNDATED SIGNATURES CANNOT BE ACCEPTED.

Applicant's Name (Please type or print legibly)	Signature / Title	Date	Response to Statement 1	Response to Statement 2
			☐ YES ☐ NO	☐ YES ☐ NO