Beazley Remedy New Business Regulatory Liability Application

THE APPLICABLE LIMITS OF LIABILITY AND ARE SUBJECT TO THE RETENTIONS.
PLEASE READ THIS POLICY CAREFULLY.

Please fully answer all questions and submit all requested information. Terms appearing in bold face in this Application are defined in the Policy and have the same meaning in this Application as in the Policy. If you do not have a copy of the Policy, please request it from your agent or broker. This Application, including all materials submitted herewith, shall be held in confidence.

1. ORGANIZATIONAL INFORMATION:

Applicant Name:		Years in Business	
Principal Address:			
Primary Business Activity:		SIC Code/NAICS Code	
Total Assets			
Annual Revenue			
Number of Employed Physicians			
Number of beds			
Business Organization: For Profit Corporation___ Partnership ___ Limited Liability Corporation ___ Not-For-Profit Tax Exempt Corp___ Not-For-Profit Taxable Corp___ Publicly Traded___ Other ___			

If Applicant is a subsidiary of another company, please provide the name of the Parent Company:

_____

A. Nature of Operations_____

Please list all subsidiaries including ownership by percentage:

Subsidiary Name	Applicant's Ownership Percentage	Nature of Business
	%	
	%	
	%	

Attach additional page if necessary.

B. Is the Applicant a party to any joint venture arrangements or partnership agreements? ☐ Yes ☐ No

If yes, please attach details.

C. 1. Has the Applicant been involved with any mergers or acquisitions within the last 6 years? ☐ Yes ☐ No

If yes, please attach details.

2. Are there any plans for a merger, acquisition or consolidation in the next 12 months? ☐ Yes ☐ No

   If yes, please attach details.

D. 1. Is the Applicant managed by an independent healthcare facility management group or similar entity? ☐ Yes ☐ No

   If yes, please identify the managing entity and if they are responsible for medical billing.

   _____

2. Does the Applicant manage any healthcare facilities or physician groups for any other separate and distinct entity that it doesn't have ownership interest? ☐ Yes ☐ No

   If yes, please identify the entity for which the institution provides management services that include medical billings.

   _____

2. COMPLIANCE:

A. Does the Applicant have a Medical Billings or Chief Compliance Officer? ☐ Yes ☐ No

1. Name and length of service: _____
2. Percent of time devoted to medical billing matters: _____
3. Whom does the Compliance Officer report to? _____
4. How often does the Compliance Office meet with the board and/or CEO? _____

B. 1. Does the applicant have a formal compliance program in place? ☐ Yes ☐ No

   If yes, when was the policy implemented? _____

   If yes, does the Applicant's policy include the following:

   a. Education and training ☐ Yes ☐ No

   b. Internal billing audits ☐ Yes ☐ No

   c. External billing audits ☐ Yes ☐ No

   d. External legal consultant ☐ Yes ☐ No

   e. External coding consultant ☐ Yes ☐ No

2. If yes to question B:

   a. How often are these documents updated? _____

   b. Has the governing board formally adopted the compliance program? ☐ Yes ☐ No

   c. Are certifications obtained from all employees indicating that they have read and Understood the policies and procedures and agree to abide by them? ☐ Yes ☐ No

3. Does the Applicant have a Compliance Committee? ☐ Yes ☐ No

If yes, who sits on the committee and how often do they meet?_____

_____

4. How many dedicated full time employees does the Applicant have for compliance?_____
5. Has the Applicant had an external compliance effectiveness analysis conducted? ☐ Yes ☐ No

   If yes, please provide the name of the firm and the date of the review? _____
6. Does the Applicant screen employment applicants and existing healthcare providers rendering services against the Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals and Entities? ☐ Yes ☐ No
7. Does the Applicant screen employment applicants and existing healthcare providers Against the General Services Administration's List of Parties Debarred from Federal Programs? ☐ Yes ☐ No
8. Does the Applicant have an Annual Compliance Audit/Analysis Work plan that includes billing, coding and documentation compliance? ☐ Yes ☐ No
9. Does the Applicant have a Conflict of Interest Policy? ☐ Yes ☐ No
10. Does your organization have a Code of Conduct Policy? ☐ Yes ☐ No

3. BILLING PROCEDURES:

A. 1. Who performs government funded healthcare program billing for the Applicant?
   _____

2. If billing is performed in house is the department centralized? ☐ Yes ☐ No
3. Is any billing performed by a third party? ☐ Yes ☐ No

   If yes, please provide the following:

   a. Percentage of total billings performed by third party:_____
   b. Third party company's name: _____

      Address:_____

      City: _____State: _____ Zip code: _____
   c. Describe any common ownership between the Applicant and third party

      _____
   d. Does the third party company have a compliance program? ☐ Yes ☐ No

4. Is the Applicant performing internal audits and compliance analysis? ☐ Yes ☐ No

   If yes, please provide the following:

   a. How often and by whom? _____

   b. What percentage of files are internally audited or otherwise analyzed for compliance?

      _____

   c. What internal monitoring techniques or systems are in place?

      _____

   d. Does the Applicant perform an internal audit or analysis to check for billing, coding, documentation and compliance errors? ☐ Yes ☐ No

      If yes, does the Applicant's audits check for the following anomalies?

      1. Up-coding ☐ Yes ☐ No
      2. Over utilization ☐ Yes ☐ No
      3. Duplicate billing ☐ Yes ☐ No
      4. Unbundling ☐ Yes ☐ No
      5. Billing for items and/or services not rendered ☐ Yes ☐ No
      6. Incorrect place of service coding ☐ Yes ☐ No
      7. Incorrect modifier usage ☐ Yes ☐ No
      8. Improper clinical trial claims (as applicable) ☐ Yes ☐ No
      9. Inpatient when outpatient was correct ☐ Yes ☐ No
      10. Medical necessity ☐ Yes ☐ No

   e. Does the Applicant use internal auditing software? ☐ Yes ☐ No

      If yes, what software is used? _____

5. Does the Applicant monitor free and/or discounted samples of medications, equipment and replacement medical devices to guard against co-mingling with purchased inventory or inappropriate billing for items dispensed? ☐ Yes ☐ No

6. Are all contracts and referral relationships reviewed by counsel to ensure they conform to STARK and Anti kickback statutes? ☐ Yes ☐ No

7. Does the Applicant monitor non-monetary compensation for compliance? ☐ Yes ☐ No

8. Briefly describe the procedure when potential incorrect medical billing is identified?

   _____

   a) To whom, by title, are such potential incidents reported? _____

   b) How are they investigated? _____

   c) Disciplinary procedure for personnel performing incorrect medical billings?

      _____

d) In the past 3 years how many employees have received written warnings, suspensions or terminations for billing coding or documentation infractions? _____

9. Does the Applicant have a hotline or other reporting mechanism to report knowledge or questions concerning incorrect billings procedures or any other compliance concerns? ☐ Yes ☐ No

   a. If yes, what is the average number of complaints per month? _____
   b. If yes, what are the follow up procedures on the complaints? _____
   _____

10. Does the Applicant have a non-retaliation policy for whistleblowers? ☐ Yes ☐ No

    If yes, is it updated in accordance with the Deficit Reduction Act and other applicable laws and regulations? ☐ Yes ☐ No

11. Are exit interviews performed on all employees including billing and compliance staff? ☐ Yes ☐ No

    If yes, does the interview include a request for information on any known compliance deficiencies within the Applicants organization? ☐ Yes ☐ No

    Is the exiting employee asked to sign the exit interview document? ☐ Yes ☐ No

4. ERRORS & OMISSIONS:

A. 1. Has the Applicant ever been subject to an investigation or action including but not limited to Qui Tam, False Claims Act, STARK and Anti kickback excluding routine audits? ☐ Yes ☐ No

If yes, please attach details

If yes, please complete the following:

a. Did the Applicant employ external counsel? ☐ Yes ☐ No
b. Was a medical expert engaged? ☐ Yes ☐ No
c. Was a forensic auditing firm used? ☐ Yes ☐ No
d. Did the Applicant employ the services of an independent audit or consulting company to review or analyze the findings? ☐ Yes ☐ No
e. Was the Applicant subject to any fines or penalties with respect to medical billings? ☐ Yes ☐ No
f. Was a settlement reached between the two parties? ☐ Yes ☐ No

2. Does the Applicant experience routine audits or reviews either by or on behalf of the government? ☐ Yes ☐ No

If yes, please answer the following;

a. On average how many audits and/or reviews are performed annually?_____

b. What percentage of the audits and/or reviews were appealed? _____

c. What percentage of the audit and/or review appeals were successful? _____

5. CODING INFORMATION:

A. 1. What is the approximate split between the billing processed performed by credentialed and non-credentialed staff?

Credentialed: _____%

Non-Credentialed:_____%

2. Does the Applicant have written policies and procedures for coders? ☐ Yes ☐ No

   If yes, when were they last updated? _____

3. Does the Applicant track and analyze opioid prescriptions to identify outliers for questionable prescribing patterns from all insured entities and employed physicians? ☐ Yes ☐ No

4. Does the Applicant have a Risk Management program that addresses governance, employee training and initiatives surrounding opioid prescriptions? ☐ Yes ☐ No

5. Does the Applicant have in place a quality improvement or peer review committee that addresses clinical and administrative review or monitoring of physician prescribing practices including opioids? ☐ Yes ☐ No

6. Does the Applicant have any physician arrangements with compensation linked to prescription drugs? ☐ Yes ☐ No

6. PAYOR INFORMATION:

Payor Source	Gross Billings for the current year	Collections for the current year
Medicare:	$	$
Medicaid:	$	$
Medicare Advantage:	$	$
Commercial Payor:	$	$
Private Payor:	$	$
All other:	$	$
Total:	$	$

Payor Source	Gross Billings for the 1st year previous	Collections for the 1st year previous
Medicare:	$	$
Medicaid:	$	$
Medicare Advantage:	$	$
Commercial Payor:	$	$
Private Payor:	$	$
All other:	$	$
Total:	$	$

7. COVERAGE INFORMATION:

	Regulatory Liability
Current:	
Limit	
Retention	
Premium	
Insurer	

Policy Period	
Requested:	
Limit	
Retention	
Effective Date	

A. APPLICANTS IN MISSOURI: DO NOT ANSWER THE FOLLOWING QUESTION.

Have any of the Applicant's current liability insurers indicated intent not to offer renewal terms? ☐ Yes ☐ No

If yes, please attach details.

8. LOSS HISTORY:

1. Is the Applicant now or have they been operating under a Deferred Prosecution Agreement, Settlement Agreement, Corporate Integrity Agreement or a Certification of Compliance Agreement or any similar Federal or State issued agreement involving business practices? ☐ Yes ☐ No
2. Has any claim or suit for regulatory liability ever been made against the Applicant proposed for this insurance that has not been reported to the current insurer or any prior insurer? ☐ Yes ☐ No
3. Has the Applicant ever been sued or deselected by a commercial payor? ☐ Yes ☐ No
4. In the past 6 years has the Applicant or any entity seeking coverage made a formal disclosure to a government agency regarding improper billing, coding or documentation practices or violations of the Stark Law or Anti kickback statute? ☐ Yes ☐ No

If yes to any question in Loss History above, please provide details for each including, as applicable, the type of claim, proceeding or complaint; how it was resolved or whether it is still pending, any amounts paid as defense, settlement or damages and whether any insurance responded to the claim as well as any corrective actions taken as a result of or in response to the claim.

REPRESENTATION:

As of the date of this Application, does any Applicant, director, officer or other proposed Insured have knowledge or information of any fact, circumstance, situation, event or transaction which may give rise to a claim under this proposed insurance? ☐ Yes ☐ No

If yes, please provide details.

It is agreed that any Claim based upon or arising out of any claim or fact, circumstance, situation, event or transaction which was or should have been disclosed in the Representation above is excluded from coverage under the proposed insurance.

ATTACHMENTS: Attach the following materials regarding the Applicant:

- Audited financial statements
- Compliance effectiveness analysis report and findings performed by external firm
- Individual organizational charts for compliance hierarchy
- Entity organizational chart
- Audit/Analysis work plan
- Compliance Plan

FRAUD WARNING DISCLOSURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED EMPLOYEE OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AUTHORIZED EMPLOYEE AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE UNDERWRITER OF SUCH CHANGES, AND THE UNDERWRITER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

NOTHING CONTAINED HEREIN OR INCORPORATED HEREIN BY REFERENCE SHALL CONSTITUTE NOTICE OF A CLAIM OR POTENTIAL CLAIM SO AS TO TRIGGER COVERAGE UNDER ANY CONTRACT OF INSURANCE. NO COVERAGE SHALL BE AFFORDED FOR ANY CLAIMS NOT PROPERLY REPORTED UNDER THE TERMS AND CONDITIONS OF THE APPLICABLE POLICIES.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE UNDERWRITER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

REPRESENTATION:
I represent to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by Applicant within 90 days of proposed effective date, or as required by underwriting quote and terms.

Name of Applicant	Title
Signature of Applicant	Date
Name of Applicant	Title
Signature of Applicant	Date

PLEASE MAKE CERTAIN ALL QUESTIONS ARE ANSWERED AND THAT ALL APPLICABLE SUPPLEMENTS IF APPLICABLE ARE COMPLETED. THIS APPLICATION WILL NOT BE PROCESSED UNLESS ALL QUESTIONS ON THIS APPLICATION AND APPLICABLE SUPPLEMENTS ARE ANSWERED.

*If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

☐ Electronic Signature and Acceptance – Authorized Representative

☐ Electronic Signature and Acceptance - Producer