IRONSHORE HEALTHCARE REGULATORY LIABILITY POLICY APPLICATION

If space is insufficient to answer any question fully, please attach a separate sheet.

I. GENERAL INFORAMTION

1. Organizational Information

Applicant Name:		Years in Business:	
Principal Address:			
Website Address:			
Primary Contact:		Phone Number:	
Email Address:		SIC Code/NAICS Code	

Business Organization: (please check all that apply)

Not For Profit ☐ For Profit Corporation ☐ Partnership ☐ Limited Liability Corporation ☐ Publicly Traded ☐

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

2. Nature of Operations (e.g. Acute Care Hospital, Physician Group):

3. List all subsidiaries and owned entitles of the Applicant applying for coverage. (Attach an entity organizational relationship chart).

4. If the institution is not for profit, are there any divisions or subsidiaries that are for-profit? ☐ Yes ☐ No
(If yes, please attach details)

5. If the institution is not for profit, are there any plans to convert to for-profit status in the next 12 months? ☐ Yes ☐ No
(If yes, please attach details)

6. Have there been any mergers or acquisitions involving the institution within the last 6 years? ☐ Yes ☐ No
(If yes, please attach details)

7. Are any plans for a merger, acquisition or consolidation being considered? ☐ Yes ☐ No
(If yes. please attach details)

8. Is the institution 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 billings:

9. Does this organization manage any healthcare facilities or physician groups for any other separate and distinct entity? ☐ Yes ☐ No

(If yes, please identify the entity for which the institution provides management services that include medical billings, and please attach details on the number and nature of facilities managed by the institution)

II. LICENSE AND ACCREDITATION STATUS OF INSTITUTION

1. Is the institution currently licensed by Federal and/or State Government? ☐ Yes ☐ No
   If yes, by whom is the institution licensed:

2. List of associations which the institution is currently a member of:
   (a) American Hospital Association: ☐
   (b) Federation of American Hospitals: ☐
   (c) State Hospital Association: ☐
   (d) American Nursing Home Association: ☐
   (e) JCAHO: ☐
   (f) Other: ☐

Institute for Medical Quality; College of American Pathologists; Accreditation Assoc. for Ambulatory Health Care; CASA

III. COMPLIANCE

1. Does the institution have a Medical Billings or Chief Compliance Officer? ☐ Yes ☐ No
   If yes, please detail the following:
   (a) Name, Job Title and length of service:
   (b) If the length of service of the current Chief Compliance Officer is less than two years what was the length of service of the prior Chief Compliance Officer:
   (c) Duties and responsibilities regarding Medical Billings:
   (d) Percentage of time devoted to Medical Billings matters:

   (Please attach a Compliance Organization Chart that defines hierarchical and reporting relationships)

2. Do you have a compliance program in place? ☐ Yes ☐ No
   If yes, does the Compliance Program include the following:
   (a) Standards or Code of Conduct? ☐ Yes ☐ No
   (b) Compliance Plan? ☐ Yes ☐ No
   (c) Policies and Procedures? ☐ Yes ☐ No
   If yes to question 2, please provide the following details:
   (d) How often are these documents updated and revised? ☐ Annually, ☐ Biannually, ☐ every three years

(e) Are certifications obtained from all employees Indicating they have read and understood the policies and procedures and agreed to abide by them? ☐ Yes ☐ No

(f) When was the Compliance Program implemented?

_____

(g) What compliance software is currently used?

_____

(h) If none, please describe oversight being used:

_____

_____

_____

3. Does your institution have a billing compliance program? ☐ Yes ☐ No
If not, please describe your billing guidelines:

_____

_____

_____

4. Do you have a Compliance Committee? ☐ Yes ☐ No
If yes, please detail who is on the Committee and how often they meet:

_____

_____

_____

(a) Are minutes of the Compliance Committee maintained? ☐ Yes ☐ No

(b) If yes, for how long are the minutes kept on file? _____

5. Does the Chief Compliance Officer report to a Board Committee? ☐ Yes ☐ No
If yes,

(a) What is the name of this Committee? _____

(b) How often does the Chief Compliance Officer meet with his Committee? _____

6. Does a three year compliance budget exist? ☐ Yes ☐ No

7. How many dedicated full time employees do you have for compliance? _____

8. How many hours of compliance training is performed and how often? _____

9. Did your Institution have a compliance effectiveness analysis conducted in the past three years? ☐ Yes ☐ No

(a) Was this analysis conducted internally or by an external independent firm? ☐ Internal ☐ External
If external, what firm was used? _____
(Please attach a copy of the most recent analysis)

10. Does the Applicant and all others entities seeking coverage screen employment applicants and existing employees credentialed physicians, agency nurses and others rendering services against the Department of Health and Human Services Office of Inspector General's List of Excluded individuals and Entitles? ☐ Yes ☐ No

11. Does the Applicant and all other entitles seeking coverage screen employment applicants, employees, vendors physicians and contractors against the General Services Administration's List of Parties Debarred from Federal Programs? ☐ Yes ☐ No

12. Does the Applicant and all other entitles seeking coverage have an Annual Compliance Audit/Analysts Work plan that includes determining billing, coding and documentation compliance, Stark, EMTALA, etc? ☐ Yes ☐ No
(Please attach a copy of the most recent Audit/Analysis Work Plan)

13. Does your organization have a Conflicts of Interest Policy and Procedure? ☐ Yes ☐ No
(Please attach a copy of the Conflicts of Interest Policy)

IV. BILLING PROCEDURES

1. Who performs Federally-funded healthcare program billing (including, but not limited to, Medicare and Medicaid)?

Medicare: _____

Medicaid: _____

Other federally-funded health care program: _____

If other, what is the program name (Such as Tricare, Indian Health Service, etc.): _____

(a) If performed in house, is it centralized? ☐ Yes ☐ No

2. Is any billing performed by a third party billing company? ☐ Yes ☐ No
If yes, please provide the following details:

(a) Percentage of total billings performed by third party billing company: 0%

(b) Billing Company's Name: _____

Address: _____

City: _____ State: _____ Postcode: _____

(c) Please describe any common ownership that exists between the applicant's organization and the third party billing company:

_____

_____

_____

(d) Does the third party billing company have a compliance program? ☐ Yes ☐ No

(e) Has your Institution ever used a contingency fee based billing consultant? ☐ Yes ☐ No
If yes, for what years and in what specific areas?

_____

3. Do you perform any billing services on behalf of any third party? ☐ Yes ☐ No
If yes, please provide details:

_____

_____

_____

4. Does your organization have a written policy regarding collection of receivables balances? ☐ Yes ☐ No

If yes, does the policy Include write-off & outstanding balances, co-payments and deductibles? ☐ Yes ☐ No

5. Does the applicant, parent (If the applicant is a subsidiary of another company), owned entitles, subsidiaries and third party billing company have a credit balance policy that Includes the timely determination and resolution, including refund of credit balances, as applicable on billing and contracting Procedures? ☐ Yes ☐ No

6. Are you performing internal audits and compliance analysis Including but not limited to fraud and abuse or Stark violations? ☐ Yes ☐ No

   If yes please detail 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) How often are internal audits performed on physician contracting procedures? _____

   (e) How often do you have an internal audit or analysis to check for billing, coding and documentation errors? _____

   (f) Does the internal audit or compliance analysis include the evaluation of Federally-funded health programs? ☐ Yes ☐ No

   (g) Do you use Internal auditing software? ☐ Yes ☐ No

   If yes, what software is being used? _____

7. What edition of the 100-9, OPT and HCPCS manuals are you currently using for your organization?

   _____

8. Are billing and procedure codes monitored to timely alert management of possible up-coding, over-utilization, DRG Creep, duplicate billing, unbundling, billing for items or services not rendered, incorrect piece. of service coding, incorrect modifier usage, improper clinical trial claims (as applicable), clustering, improper billing for discharges In lieu of transfer, National Correct Coding initiative contraventions, or any other billing, coding or documentation anomalies? ☐ Yes ☐ No

9. Does the Applicant and other entities seeking coverage conduct medical necessity analysis, including but not Limited to determining the correspondence between lCD-9 codes and CPT/HCPCS codes as defined in National Coverage Determinations, commercial insurers medical coverage policies, etc.? ☐ Yes ☐ No

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

11. Does the applicant have a formalized compliance monitoring plan that specifies key compliance, (financial and operational) indicators such as the number of denied and returned to provider claims by payor and error code and aberrant patterns or trends and unusual fluctuations in coding and compliance with frequency limits, etc.? ☐ Yes ☐ No

12. Briefly describe the procedure, if any, for identifying potential Incorrect Medical Billings: (Attach details)

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

    (b) How are they then investigated? _____

13. Briefly describe the disciplinary procedure, if any, for personnel performing incorrect medical billings:

    _____

    _____

    _____

14. In the past three years, how many employees have received written warnings, suspensions or terminations for billing coding or documentation infractions, HIPAA violations or other compliance related infractions?

15. Does your organization have a 'hotline', or other reporting mechanism, where employees, contractors, third party vendors, patients, or other community members can report knowledge or questions concerning incorrect billings procedures, or any other compliance concerns? ☐ Yes ☐ No

16. Does your organization have a non-retaliation policy for whistleblowers updated in accordance with the Deficit Reduction Act and other applicable laws and regulations? ☐ Yes ☐ No

V. BILLING ERRORS & OMISSIONS

1. Has your institution ever been subject to a medical billings audit by any entity either by or on behalf of the government or by a commercial payor excluding routine audits? ☐ Yes ☐ No

   If yes, please detail the following:

   (a) Have any audits or analysis shown that you were not compliant with the regulatory billing guidelines?

   (b) Were you subject to any fines or penalties with respect to medical billings? ☐ Yes ☐ No
   If yes, what was the total monetary amount involved:

   (c) Did you employ the services of an Independent audit or consulting company to review or analyze the findings of the audit? ☐ Yes ☐ No
   If yes, what were their findings?

   (d) Have you engaged an external panel of advisors to assist on audits or analysis, for example, attorneys, forensic accountants, physicians, registered nurses and billing/coding consultants? ☐ Yes ☐ No
   If yes, please provide details:

2. How many RAG, ZPIC, MIG or other Billing integrity Contractor audits have occurred In the last 12 months?

3. Has your institution ever received from any government entity the below outlining the intent to audit your organization:

   (a) A letter? ☐ Yes ☐ No

   (b) Subpoena? ☐ Yes ☐ No

   (c) Search Warrant? ☐ Yes ☐ No

   (If yes to any of the above, please attach a copy)

4. Have you experienced any investigations or actions by Medicare or Medicaid or other Federally-funded health care programs arising out of 'Never Events? ☐ Yes ☐ No
   If yes, please provide details:

5. Have you experienced any investigations or actions by Medicare or Medicaid or other Federally-funded health care programs arising out of Same Day, One Day Stays, Two Day Stays or Readmissions? ☐ Yes ☐ No

VI. STARK

1. Has your Institution ever been subject to a Stark investigation or action by any entity by or on behalf of the government? ☐ Yes ☐ No
   If yes, please detail the following:
   (a) Were you subject to any fines or penalties? ☐ Yes ☐ No
   If yes, what was the total monetary amount Involved:
   (b) Did you employ the services of an independent audit or a consulting company to analyze the findings of the audit or evaluation? ☐ Yes ☐ No
   If yes, what were their findings?

2. Are all contracts and referral relationships reviewed by counsel to ensure they conform to anti-kickback statutes? ☐ Yes ☐ No
3. Does the applicant end other entities seeking coverage monitor non-monetary compensation for compliance? ☐ Yes ☐ No

VII. EMTALA

1. Has your institution ever been subject to en EMTALA investigation or law suit by any entity either by or on behalf of the government or by a patient? ☐ Yes ☐ No
   If yes, please provide details on the investigation or claims:
   (a) Were you subject to any fines or penalties? ☐ Yes ☐ No
   If yes, what was the total monetary amount was involved:

VIII. CODING INFORMATION

1. Please detail the number of Health information Coding personnel in your organization in the following categories:
   RRA - Registered Health information Administrator:
   RHIT - Registered Health information Technician:
   CCS/CCS-P — Certified Coding Specialist (AHIMA):
   CPC/CPC-H — Certified Procedural Coder (MPG):
   CIRCO - Certified In Interventional Cardio Vascular Coding (AAPC):

Non-credentialed staff: _____

2. Are the coders regularly educated? ☐ Yes ☐ No
   If yes, please detail the education/certification programs used:

   _____

   _____

3. Do you have written policies and procedures for coders? ☐ Yes ☐ No
   (a) Are they updated yearly? ☐ Yes ☐ No

4. The approximate split between the billings processed performed by credentialed and non-credentialed staff:

   Credentialed _____
   Non-Credentialed _____

5. All are certified coders certifications current and educational requirements met in accordance with the certifying organization such as the American Health Information Management Association (AHIMA), the American Academy of Professional Coders, etc.? ☐ Yes ☐ No

IX. 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:		

Payor Source	Gross Billings for the 2nd year previous	Collections for the 2nd year previous
Medicare:		
Medicaid:		
Medicare Advantage:		
Commercial Payor:		
Private Payor:		
All Other:		
Total:		

Please see list of 5 largest commercial payors and their percentage of revenue.

Commercial Payor	% of Revenue
	0%
	0%
	0%
	0%
	0%

XI. PATIENT POPULATION

Patient Population	In-Patient	Out-Patient
Total number of beds:		
Average length of stay:		
Estimated occupancy rate (%)		

Billing as a Percentage of Medical Bills	In-Patient	Out-Patient
Estimated percentage of bills to Federally Funded Programs	0%	0%
Emergency Services:		
Medical Services:		
Surgical Services:		
Laboratory Services:		
Home Health Care:		
Other:		
Total number of physicians employed:		

IX. COVERAGE

1. Does your institution purchase any form of Insurance with respect of Healthcare Regulatory Liability Insurance? ☐ Yes ☐ No

   If yes, please specify limit purchased, and previous carriers, including any sublimit purchased within your Directors & Officers, Medical Professional Liability Insurance, Privacy Security, Billing E&O, HIPAA, STARK, EMTALA:

Carrier(s)	Limit Purchased	Carrier(s)	Limit Purchased

2. Has the insurance of the type for which the Applicant is now applying ever been declined, cancelled or had the renewal thereof refused to the proposed insured? ☐ Yes ☐ No
   If yes, please give full details:

3. Does your institution purchase any form of Directors & Officers insurance? ☐ Yes ☐ No
   If yes, please specify the limit purchased, underlying amounts and the carrier:

Carrier	Limit Purchased	Underlying Amounts

4. Does your institution purchase any form of Medical Malpractice insurance? ☐ Yes ☐ No
If yes, please specify the limit purchased, underlying amounts and the carrier:

Carrier	Limit Purchased	Underlying Amounts

X. INSURANCE AND CLAIM HISTORY

1. Limits of Liability: Indicate the limit of liability requested: Per Claim _____ Aggregate _____

2. List your prior Regulatory Liability Insurance for each of the last four (4) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

3. Are you now or have you ever operated under a Deferred Prosecution Agreement, Settlement Agreement, Corporate Integrity Agreement, Integrity Agreement or a Certification of Compliance Agreement or any similar State issued agreement involving business practices including but not limited to STARK, EMTALA, HIPAA and Medical Billing Errors & Omissions? ☐ Yes ☐ No
(If Yes, please attach details)

4. Has any claim or suit for regulatory liability ever been made against you or any organization propped for this insurance that has not been reported to the current insurer or any prior insurer? ☐ Yes ☐ No
(If Yes, please attach details)

5. Have you or anyone within the entity ever been investigated of sanctioned by any local, state or federal government or agency regarding the delivery of health care services or reimbursement thereof? ☐ Yes ☐ No
(If Yes, please attach details)

6. Have you or anyone within the entity ever been sued or deselected by a commercial payor? ☐ Yes ☐ No
(If Yes, please attach details)

7. In the past six 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 Anti-Kickback or Stark Law? ☐ Yes ☐ No

   (a) If yes, please describe the nature, amount of the disclosure and amount ultimately repaid:

_____

_____

_____

8. Are you or any organization proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may give rise to a claim or suit? ☐ Yes ☐ No
If yes, please describe. If no, please write "none"

Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company, for any claim, suit or circumstance based upon wrongful acts prior to the effective date of the Applicant's policy, if issued.

XI. ATTACHMENTS

Attach the following materials regarding the Applicant:

1. Latest audited financial statements.
2. Compliance effectiveness analysis report performed by an outside firm.
3. Individual organizational charts for compliance hierarchy.
4. Code of conduct policy.
5. Conflict of interest policy.
6. Schedule of Provider Numbers for each entity and individual.

NOTICE TO THE APPLICANT – PLEASE READ CAREFULLY

The undersigned is authorized by the applicant and declares that the statements set forth herein and all written statements and materials furnished to the underwriters in conjunction with this application are true. Signing of this application does not bind the applicant or the underwriters to complete the insurance, but it is agreed that the statements contained in this application, any supplemental attachments, and the materials submitted herewith are the basis of the contract should a policy be issued and have been relied upon by the underwriters in issuing any policy.

This application and materials submitted with it shall be retained on file with the underwriters and shall be deemed attached to and become part of the policy if issued. The underwriters are authorized to make any investigation and inquiry in connection with this application as it deems necessary.

The applicant agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, the applicant will, in order for the information to be accurate on the effective date of the insurance, immediately notify the underwriters of such changes, and the underwriters may withdraw or modify any outstanding quotations or authorizations or agreements to bind the insurance.

I have read the foregoing application of insurance and represent that the responses provided on behalf of the applicant are true and correct.

The undersigned declares that the person(s) and organization(s) proposed for this insurance understand that:

(I) The policy for which the application is made applies only to “claims” first made during the “policy period”.

(II) Unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by “claim expenses” and, in such event, the company will not be liable for “claim expenses” or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy; and

(III) Unless amended by endorsement, “claim expenses” shall be applied against the “retention” and “coinsurance”.

WARRANTY

I warrant 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 _____ CEO, President _____

Signature of Applicant _____ Date _____

Name of Applicant _____ Compliance Officer _____

Signature of Applicant _____ Date _____