

CLAIMS SCENARIOS

01. REGULATORY PROCEEDING – STARK LAW SELF-DISCLOSURE

During the due diligence phase of a practice sale, the insured ophthalmology practice identified potential compliance concerns involving profit distributions to physician owners. The distributions were tied to facility-fee production, creating potential allegations that the compensation arrangement violated federal self-referral and anti-kickback laws.

The insured voluntarily disclosed the matter to the appropriate federal regulator and initially reported it to TMHCC as a potential claim. The matter later triggered coverage as a Stark Proceeding when the government issued a proposed settlement agreement alleging Stark Law and anti-kickback violations.

TMHCC coordinated the coverage response under the MEDEFENSE® Plus policy and reimbursed the insured \$50,000 in covered amounts. The claim remained open for approximately 35 months before it was ultimately resolved and closed.

02. BILLING ERRORS PROCEEDING – GOVERNMENT INVESTIGATION AND PAYMENT SUSPENSION

Over the life of the claim, TMHCC paid approximately \$46,000 in covered defense costs and approved audit-related expenses.

A healthcare clinic specializing in alternative treatment services received a Civil Investigative Demand from the U.S. Department of Justice while also undergoing a separate review of alleged false claims submitted to Medicare and other federal healthcare programs. The investigation focused on billing for electric cell signaling treatments and related vitamin injections.

The government alleged that the clinic had improperly used certain therapy billing codes and modifiers, and had submitted claims for services that allegedly did not meet Medicare requirements. As part of the investigation, the clinic received a request for records, became subject to a post-payment review, and experienced a suspension of Medicare payments.

The matter triggered Billing Errors Proceeding coverage under the insured's MEDEFENSE® Plus policy once the government alleged billing errors and pursued reimbursement-related demands arising from the alleged false claims. TMHCC provided reimbursement for covered defense costs and approved audit-related expenses incurred while the insured responded to the government investigations. The matter was ultimately resolved through a settlement between the insured and the government in November 2023. No indemnity payment was requested from TMHCC. Over the life of the claim, TMHCC paid approximately \$46,000 in covered defense costs and approved audit-related expenses.

03. FALSE CLAIMS ACT INVESTIGATION – CIVIL INVESTIGATIVE DEMAND (CID)

A cardiac monitoring services provider was served with a Civil Investigative Demand from the U.S. Department of Justice in connection with a federal False Claims Act investigation. The investigation focused on false claims submitted to federal healthcare programs for remote cardiac monitoring services and reimbursement billing practices associated with the insured's New York location.

Federal authorities alleged that certain services may have been billed using reimbursement rates higher than those permitted.

As the investigation progressed, the government identified approximately \$14 million in alleged overpayments and began discussing potential settlement options, although no formal settlement demand had initially been issued.

The matter triggered coverage under the insured's MEDEFENSE® Plus policy as a Billing Errors Proceeding based on the government's allegations of false claims and improper reimbursement billing practices. TMHCC reimbursed more than \$404,000 in covered defense costs and related legal expenses, subject to applicable policy terms and rate limitations.

The scenarios used are examples of the types of claims and associated costs commonly seen and do not represent a comprehensive explanation of any one particular claim. While the subject coverage is designed to address certain risks and associated costs, coverage may not be available in all circumstances. Each reported claim will be evaluated on a case-by-case basis. The actual policy or endorsement language should be referenced to determine coverage applicability and availability.

04. BILLING ERRORS PROCEEDING – FALSE CLAIMS ACT INVESTIGATION

As the investigation progressed, the government presented a detailed summary of its allegations and issued an initial settlement demand of approximately \$512,544, including alleged overpayments and penalties.

A physical therapy practice received a Civil Investigative Demand from the U.S. Department of Justice in connection with a False Claims Act investigation. The government alleged that the insured had submitted false Medicare claims as part of an anti-kickback arrangement with a referral source.

The matter was initially reported to TMHCC as a potential claim. As the investigation progressed, the government presented a detailed summary of its allegations and issued an initial settlement demand of approximately \$512,544, including alleged overpayments and penalties. Because the presentation included both billing errors and a written settlement demand, the matter triggered Billing Errors Proceeding coverage under the insured's MEDEFENSE® Plus policy.

TMHCC provided reimbursement for covered defense costs as the insured responded to the investigation and participated in mediation. Following extensive investigation and negotiation, the matter was resolved with a \$100,000 settlement between the insured and the government. TMHCC paid approximately \$137,000 in covered amounts over the life of the claim, including covered defense expenses.

05. BILLING ERRORS PROCEEDING – MEDICARE AND MEDICAID OVERPAYMENT DEMANDS

A wound care provider was investigated by federal and state healthcare authorities for alleged billing errors and overpayments related to claims submitted for reimbursement. The matter began with federal repayment demand totaling approximately \$8,236 and later escalated when Missouri Medicaid issued an overpayment demand of approximately \$361,945.

The allegations centered on improper billing practices and questions concerning the medical necessity of certain services. In response, the insured faced Medicare and Medicaid audits, appeals, expert review, and a comprehensive shadow audit to assess the scope of the government's findings and support the defense.

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Through extensive review and appeals before Medicare and Missouri administrative bodies, the insured's Medicaid repayment exposure was reduced from \$361,945 to approximately \$428.

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06. BILLING ERRORS PROCEEDING – MULTIPLE CIVIL INVESTIGATIVE DEMANDS

Over the course of the matter, TMHCC paid and reimbursed approximately \$452,000 in covered defense costs and related expenses.

A healthcare provider received two Civil Investigative Demands (CIDs) from the U.S. Attorney's Office in connection with a federal False Claims Act investigation. The government sought records and information to determine whether the insured had improperly billed for services and received payments from Medicare and other federal healthcare programs.

The matter triggered Billing Errors Proceeding coverage under the insured's MEDEFENSE® Plus policy based on the government's allegations concerning improper billing and receipt of payments from federal healthcare programs. TMHCC provided reimbursement for covered defense costs and approved expenses incurred while the insured responded to the government's requests and defended its billing practices.

The response required extensive legal, technical, and consulting support, including legal fees, data collection and management expenses, consulting expert fees, and other approved investigation-related costs. Over the course of the matter, TMHCC paid and reimbursed approximately \$452,000 in covered defense costs and related expenses.

07. DISCIPLINARY PROCEEDINGS* – MULTIPLE LICENSING BOARD COMPLAINTS

The insured received five separate complaints filed with a state professional licensing board. The complaints arose after several patients became dissatisfied with the care provided by the insured and transferred their treatment to another physician. That physician subsequently filed the complaints with the licensing board concerning the insured's care of each patient.

Each complaint was handled as a distinct claim under the insured's purchased Disciplinary Proceedings Sublimit. Tokio Marine HCC (TMHCC) coordinated the response and provided coverage for the legal and professional expenses associated with addressing the five matters before the licensing board.

The matters were resolved through consent orders, and TMHCC paid a total of \$59,633 in covered amounts under the purchased Disciplinary Proceedings Sublimit for the five claims.

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*Optional enhancement at the end of the page.

Tokio Marine HCC is the marketing name used to describe the affiliated companies under the common ownership of HCC Insurance Holdings, Inc., a Delaware-incorporated insurance holding company. Headquartered in Houston, Texas, Tokio Marine HCC is a leading specialty insurance group with offices in the United States, the United Kingdom and Continental Europe.

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