WHAT IS MANAGED CARE ERRORS AND OMISSIONS LIABILITY COVERAGE?

Managed Care Errors and Omissions is written to:

- Provide coverage under a broad definition of Managed Care Professional Services
- Respond to enrollees, members or patients allegations of negligent medical care
- Respond to disputes surrounding contractual arrangements with physicians, medical groups or other authority in the provision of health care services
- Respond to allegations of improper administration of medical services, billing, credentialing and a multitude of managed care activities
- Respond when a Managed Care Organization is brought into a medical malpractice claim
- Protect the actions of duly constituted Committee Members
- Protect the company’s assets;

Why Companies Should Consider Buying Managed Care Errors and Omissions Liability Coverage?

- Managed Care Organizations involved in provider contracting; provider credentialing, provider network peer review, utilization review; disease and case management; claims administration; administration, management and marketing of health and managed care plans; quality assurance and review; and establishment of provider networks
- Specific coverage for breach of confidentiality or improper disclosure of protected medical information under HIPAA managed care activities
- Broad provider selection coverage for claims by members alleging negligent selection and for claims related to credentialing

What types of organizations should consider Managed Care Errors and Omissions Coverage?

Managed Care Organizations (MCOs) Defined: Any system or organization which affiliates with healthcare providers to implement health care using managed care concepts including pre-authorization of treatment, utilization review, and a fixed network of providers.
The list of Managed Care Organizations may include:

- Accountable Care Organization (ACO)
- Administrative Services Organization (ASO)
- Health Maintenance Organization (HMO)
- Independent Practice Association (IPA)
- Management Services Organization (MSO)
- Physician Hospital Organization (PHO)
- Physician Medical Group (MG)
- Preferred Provider Organization (PPO)
- Third Party Administrator (TPA)
- Utilization Review Organization (URO)

Current Business Trends Point to Purchasing Managed Care Errors and Omissions Coverage

- Inadequate Payor ability to reimburse for medical services rendered;
- Reformation of the healthcare delivery system structure with the creation of new organizations, evolving physician/health plan relationships and increased financial implications and responsibilities;
- Development of Pay for Performance initiatives;
- Further regulation of Unfair Billing Practices;
- Downward pressure on health care expense and cost reduction measures;
- Increased visibility to protecting the security of health information; and
- Merger and Acquisition activity within the health care delivery system.

What are Sources of Managed Care Errors and Omissions Claims?

- Provider Selection
- Antitrust matters
- Provider “Pay for Performance”
- Regulatory actions
- Physician or provider panel administration
- Credentialing and peer review
- Utilization review
- HIPAA and privacy issues
- Administration of Health Care Plans
- Electronic Medical Records (EMR)
- Claims services, improper or delayed billing
- Vicarious liability
- Denial of benefit
- Delay in authorization of medical care