Indiana Department of Insurance
Patient's Compensation Fund

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PATIENT'S COMPENSATION FUND FAQS

PART I: CERTIFICATES OF INSURANCE AND eFILING

Please review the Certificate of Insurance eFiling User Manual before contacting the PCF with questions not addressed in the FAQs.

1. COI Electronic Filing Site Security

1.1. How secure is the electronic filing system? What about payment security?

You may access the State of Indiana's information on security at http://www.in.gov/core/policies.html. The policies you are looking for may be found under Security Policy and/or Privacy Policy. Your payment method information is protected using Secure Sockets Layer (SSL) technology. This means that any private information you give us will be automatically encrypted before it is sent over the Internet.

1.2. Is payment information saved in the system?

No. For your security, payment information is not retained by the system and must be re-entered each time you make a payment.

2. Creating an Account – Carrier, Producer, Or Self Insured?

2.1. Should users register as an insurance carrier or producer? What if a hospital is registering as a self-insured entity?

There is a difference between account types and the permissions currently allowed for each, but there may only be one Administrator per account.

If you are registering your account with a NAIC number, then you are a carrier. As a carrier, you may have as many Carrier Filers and/or Carrier Payers on the account as needed. Each user should have a unique username and password. Carrier accounts are associated with one specific carrier name and NAIC number. **Surplus Lines carriers may not have an eFiling account; all certificates for surplus lines carriers must be entered from an account registered to an Indiana licensed Surplus Lines Producer.**

If you are registering with an Indiana License number, then you are a producer. A producer submits certificates for various insurance carriers and may edit the carrier name and NAIC number fields. A producer account is currently set up to allow only one user per account. A

future enhancement may allow a producer account to mirror the rights and privileges currently afforded to carrier accounts.

Hospitals may register as self-insured pursuant to IC 34-18-4-1(3). Self-insured hospitals and entities establishing financial responsibility by means other than insurance must contact the Department at PCF-COI@idoi.IN.gov or 317-232-5065 to discuss filing requirements.

2.2. When organizations have multiple NAIC numbers that must be kept separate from one another, can an insurance carrier have more than one account associated with the same name?

You may only register an account with one NAIC number.

2.3. Does an insurance carrier have to go through an approval process to submit PCF Certificates of Insurance?

The insurance carrier must be admitted or authorized to conduct business in Indiana. You can look up carriers using the Consumer Inquiry Portal. **Surplus Lines carriers may not have an eFiling account; all certificates for surplus lines carriers must be entered from an account registered to an Indiana licensed Surplus Lines Producer.**

2.4. Can users enter more than one authorized signer name on their account?

Not at this time.

2.5. Can you explain each of the user roles available?

Each user type is defined as the following:

- *Carrier Admin* – This person registers the account. An Admin has full account access allowing the Admin to manage other users on the account, review all billing information, and maintain authorized signatures.
- *Carrier Payer* – The Carrier Payer may submit certificates, including via bulk submission, make payments, view previous filings, view credits and reports, and search payments.
- *Carrier Filer* – This role is limited to submitting certificates, including bulk submission, viewing previous filings, and viewing credits and reports. After submitting certificates, the Carrier Filer must add them to the make payments queue for a carrier payer or

carrier admin to proceed with payment.

3. Admin Management

3.1. What user role(s) can see and make changes in the Admin Management module?

For carrier accounts, only the person who registered the account is designated with the Carrier Admin role. No other users may view or make changes in the Admin Management module. Producer accounts currently have only one user, who is the Producer Admin on the account.

3.2. What are the benefits and responsibilities of being the designated Admin?

The Admin user has the responsibility of adding or deleting authorized signers on the account. The Admin must also add or delete other users and assign them specific user roles. The Admin will also receive copies of emails regarding payments that are ready to be completed. **The Admin contact information must be kept up to date.** Please contact PCF-COI@idoi.IN.gov for assistance if necessary. The PCF is not responsible for undelivered emails.

3.3. When there is more than one person in an organization who should have the Admin rights, how can they also be designated as an admin?

Once an account has been registered, the initial Admin may designate other users with the Admin role.

3.4. Who should be designated as the Admin?

Whoever registers the account automatically becomes the Admin for the account. This will usually be someone in the organization with decision-making authority.

4. Participation

4.1. Who can participate in the Indiana Patient's Compensation Fund?

Any entity and/or individual as defined by IC 34-18-2-14 may participate in the Indiana Patient's Compensation Fund. Any member of the medical field that is not specifically listed under Indiana Code 34-18-2-14 may not participate on an individual basis, but would need to qualify through the entity that employs the health care provider in accordance with IC 34-18-2-14. This includes students attending a higher education institution for training in health care.

4.2. Can CNAs participate individually in the Indiana Patient's Compensation Fund?

No. CNAs could only be covered as an employee of a qualified hospital, nursing home, or business entity.

4.3. Can federal employees participate in the Indiana Patient's Compensation Fund?

Actions for alleged negligent or wrongful acts or omissions of federal employees come within the provisions of the Federal Tort Claims Act ("FTCA;" 28 U.S.C. 2671-80; 28 C.F.R. parts 14 and 15; 45 C.F.R. part 35). The Federally Supported Health Centers Assistance Act of 1992, 42 U.S.C. 233(g)-(n), provides FTCA coverage to federally supported health centers and their employees for acts or omissions occurring on or after January 1, 1993, or when the Health Center was deemed eligible for coverage, whichever is later. Under the provisions of the FTCA, an action may not be instituted upon a claim against the United States for money damages caused by the negligent act of any Federal employee acting within the scope of their employment unless the claimant first presents the claim to the appropriate federal agency and the claim is finally denied by the agency in writing and sent by certified or registered mail.

4.4. How does an individual or entity become a participant in the PCF?

The health care provider must first purchase the appropriate underlying limits from an insurance carrier authorized or eligible to conduct business in Indiana, unless a hospital self-insures or the provider has arranged proof of financial responsibility through cash or a surety bond in accordance with IC 34-18-4-1(2). When insurance is purchased, the insurance carrier or producer determines the surcharge owed and collects the surcharge from the provider. All filings should be made by the insurance carrier or producer.

4.5. Can an out-of-state business entity become a qualified provider under the Indiana Medical Malpractice Act?

Yes, as long as the entity falls within the definition of health care provider under IC 34-18-2-14(7) and complies with IC 23.

4.6. If a health facility "employs" someone with a Professional Employer Organization (PEO), can that person be covered by the health facility's professional liability coverage and the PCF?

In 2005, Indiana passed a statute addressing PEOs in general (IC 27-16). Pursuant to IC 27-

16-2-5, the person is co-employed by the client (health facility) and the PEO. Under IC 27-16-7-4, the client (health facility) is responsible for the professional acts of the co-employee. However, this responsibility can be altered by specific contract language under IC 27-16-7-2. The individual who is co-employed can be covered by the facility's professional liability coverage and PCF if appropriate under the contract.

4.7. How are emergency room groups and physician-owned facilities rated?

Physicians pay the surcharge for their appropriate class, with any allowable credits. This must be done separately from facilities or practices that they may own, in whole or in part. Facilities that are not specifically licensed as nursing homes or hospitals pay surcharge at a rate of 100% of the underlying premium, subject to the statutory minimum surcharge.

5. Limits of Liability

5.1. What limits must an individual provider/facility carry when participating in the Indiana Patient's Compensation Fund (PCF)?

Please refer to IC 34-18-4-1.

5.2. What if a provider carries higher limits and participates in the PCF?

Limits of liability for the Indiana exposure are those stated under IC 34-18-4-1. It is the Department's position that if higher limits are maintained those limits must be tendered before a claimant would be eligible to receive excess damages from the PCF and the health care provider would not receive the full benefit of the excess coverage.

5.3. Can entities/locations that are owned by the same parent share in the limits of the parent corporation?

It depends on how the entities are registered with the Indiana Secretary of State's office. If each entity/location is a separate legal entity, each one will need to maintain separate limits of liability and qualify separately under the PCF. If the entity/location is registered as an assumed name under the parent, the entity/location may share in limits of the parent corporation.

5.4. Can physicians who are employed by ER Groups/Physician Owned Facilities share in the limits of the group or facility?

No, per 760 IAC 1-21-10(c), each physician and Independent Ancillary Provider must file individual proof of financial responsibility and pay the appropriate surcharge. Per 760 IAC 1-21-10(d), no Ancillary Provider may include a physician or Independent Ancillary Provider in its qualification.

6. Certificates

6.1. How are PCF Certificates of Insurance printed when they are filed electronically?

At this time, Certificates of Insurance cannot be printed. For credentialing purposes, the credentialing agency or provider may access the PCF database at IndianaPCF.com, search for the provider, and print a confirmation letter associated with a specific policy.

6.2. Is surcharge automatically calculated by the Electronic Filing System?

Yes. The system is designed to calculate surcharge and any penalties based upon the specialty class code of the provider, effective dates, and any credits or pro-ration you enter. This includes any amended or cancelled certificates that are filed. **However, if you believe the surcharge calculated incorrectly for any reason, please contact the PCF at PCF-COI@idoi.IN.gov before submitting payment.**

6.3. The provider ID number entered does not return the correct provider information. How can this be corrected?

First, confirm what is already on the database at IndianaPCF.com and confirm the license number with Professional Licensing at www.in.gov/pla. Then, please contact the PCF for further assistance at PCF-COI@idoi.IN.gov.

6.4. When the provider ID number is entered, the following error appears "Provider ID Verification Failed. If this is a new provider enrollment with the PCF, please contact pcf-coi@idoi.IN.gov to have provider added to the system." What type of information must be provided to the PCF in order to get this provider added?

If you are entering a certificate for a provider that has not previously participated in the PCF, you must first notify the PCF. Please send an email to the email address listed above with the

health care provider's name; license number of an individual, hospital, or nursing home; full **business** address (addresses are visible in a public database so home addresses are not recommended); and ISO code (specialty class code) for entry into the PCF database. There may be different or additional requirements for different provider types or circumstances (e.g., a copy of the current license is required for Private Mental Health Institutions, the NCSBN ID is required when enrolling a Compact nurse, the PSYPACT Mobility Number is required when enrolling a PSYPACT psychologist, etc.). Once you receive a provider ID from the PCF, you will be able to proceed with filing the certificate.

6.5. What penalties will assess if a new provider is not entered into the PCF database right away?

Filers should send new enrollments to the PCF at least ten days before surcharge is due.

6.6. How is the email address for the provider entered?

This information is no longer required. Confirmation letters that were previously sent via mail or email by the PCF may now be obtained by visiting the PCF database at IndianaPCF.com, searching by provider, selecting the provider, viewing the policy, and clicking "Print Confirmation Letter."

6.7. Is there a fine for entering a certificate incorrectly?

There are no fines for errors on a certificate. However, please be aware that if you do not file the certificate within the statutory timeframe, or if user error results in a certificate being files late, the usual penalties will be assessed. **Please do not wait until the last possible day to file a certificate, as system traffic may cause the filing to attach to the PCF database late, which may cause a penalty to assess**.

6.8. When is surcharge due to the PCF, and what penalties are assessed for untimely filing?

Please refer to Bulletin 147. Be aware of the following penalties for late filing of PCF Certificates of Insurance that are due in addition to surcharge. The penalty will be calculated for you automatically and will appear next to the surcharge amount on the Manage Certificates page. The penalty will increase if the certificate crosses a penalty threshold while you are waiting to submit payment.

Surcharge received by the insurer, risk manager, or producer more than 30 days before payment is remitted to the PCF incurs a 10% penalty.

In **addition** to the above penalty, filings received**:**

Days From Effective Date	Additional Penalty	Total Penalties
91 - 120	10%	20%
121 - 150	20%	30%
151 - 180	50%	60%

Please Note: While the PCF coverage dates must *usually* match the dates of the underlying policy, there is an exception when PCF coverage is added mid-term. When PCF coverage is added mid-term, the effective date of PCF coverage should be entered as the start date instead of the underlying policy's start date. This will prevent unnecessary fees from being assessed. For claims made policies, this will usually become the retro date, too. Please contact PCF-COI@idoi.IN.gov if you have any questions.

6.9. Will the electronic filing system alert users when they enter something incorrectly?

If the system recognizes an error, you will be alerted with an error message in red explaining the reason for the error when you violate a business rule. However, data entry errors will not necessarily trigger an error code. Please verify that you have entered all the information correctly before continuing or submitting information. **When entering filings manually (i.e., not via bulk submission), it is recommended that you disable autofill: autofill may overwrite your entries creating significant, time-consuming errors in the database.** Penalties caused by inaccurate filings are not waived by the PCF.

6.10. The following message was received after filing: "Certificate has been marked for Agency Approval." What does this mean?

You received this message because the certificate was flagged for the agency to review and either approve or reject the certificate. You will be notified via email once this has been completed. The certificate will reflect Pending Status on your Manage Certificates page until it is approved or rejected. The certificate will automatically route to the Make Payments queue for payment if approved. If the certificate is rejected, it will be deleted and you will receive a

notification email. If your certificate is marked with a 'P' in your Manage Certificates queue but you have not received an email, please contact PCF-COI@idoi.IN.gov as it may be necessary to update the contact information on your account.

If you are prompted to submit an appeal letter, please refer to Appendix C in the Certificate of Insurance eFiling User Manual for detailed instructions. If an appeal letter is needed for a certificate filed through the PCF's eFiling system, it must be received within **five (5)** business days from the date the certificate is created, or the certificate will be rejected.

6.11. Are electronic signatures acceptable on PCF Certificates of Insurance?

Yes, electronic signatures are acceptable.

7. Ancillary Providers, Independent Ancillary Providers, and Physicians

7.1. Where can ISO codes for providers be found?

ISO Codes may be found in Rule 60 and the Rule 21 Rates Chart available on the Medical Malpractice Surcharge Rates and Calculation Sheets page.

7.2. What are the class codes/surcharge calculations for health care providers that are not licensed as physicians, nursing homes, or hospitals?

Health care providers who are **not** licensed as physicians, nursing homes, hospitals, or Independent Ancillary Providers are considered Ancillary Providers and are assessed surcharge at the rate of 100% of the underlying professional liability premium or the statutory minimum surcharge of $100, whichever is greater. This statutory minimum surcharge applies to all health care providers. Members of corporations or partnerships and Independent Ancillary Providers (defined under 760 IAC 1-21) MUST establish financial responsibility separately from such business entities in accordance with IC 34-18-4-4 and 760 IAC 1-21.

7.3. Where can the current percentages charged for providers who are not licensed as a physician, nursing home, or hospital be found?

All other provider surcharges are found at 760 IAC 1-21-8. Please review Rule 21 Rates available on the Medical Malpractice Surcharge Rates and Calculation Sheets page.

7.4. What is the ISO code for providers engaged in telemedicine?

There is no specific ISO code for telemedicine. The ISO code for the provider's specialty should be used.

7.5. There are nine types of providers listed under the definition of Independent Ancillary Provider (IAP); however, the definition states that IAP "is not limited to" the nine providers listed. What other types of providers would qualify as an IAP?

If a health care provider's license type is listed in the definition of IAP found in 760 IAC 1-21-2(9), the provider is an IAP; if the provider is licensed as a physician, the provider is a physician; otherwise, the provider is considered an Ancillary Provider under 760 IAC 1-21-2(1). See also: FAQ 4.1.

7.6. If an entity (other than a hospital or nursing home) provides financial responsibility for itself and all employees, including Independent Ancillary Providers (IAPs), do IAPs need to qualify separately even if they are employees?

Yes. Entities (other than a hospital or nursing home) are Ancillary Providers (APs), and APs may not include IAPs in their qualification, so the IAPs must qualify separately in the PCF. An IAP and a corporation can share an underlying policy if they have separate limits of liability required by the Medical Malpractice Act.

8. Part-time and Other Credits

8.1. Can the credits allowed in Rule 60 be applied on non-physician surcharges?

Part-time credits can be applied to both physicians, as provided in 760 IAC 1-60-5, and Independent Ancillary Providers (IAPs), as provided in 760 IAC 1-21-8(4). IAPs may not claim any other credits. Surcharges for Ancillary Providers who are not IAPs are calculated on a percentage of premium; therefore, any discounts given on the underlying coverage would already be accounted for when calculating the surcharge amount.

8.2. Can providers with individual limits take multiple credits, and is there a limit on such credits?

Multiple credits (discounts) are **NOT** allowed. The insurer may apply the greatest credit applicable.

8.3. How is a "newly licensed" physician calculated in relation to credits?

Newly licensed physicians can claim credits for the first two *policy* years of practice. These credits do not apply to a physician who went back to school and changed specialties or who moved to Indiana after practicing in another state.

8.4. Is part-time rating applicable to the number of hours worked in Indiana only?

Yes.

8.5. When can the Medical School Faculty credit be applied?

The Medical School Faculty credit of 67% can only be applied if the physician is engaged in research or teaching at a medical school as defined in IC 25-22.5-1-1.1(h). To be eligible for the credit, no more than thirty percent (30%) of the physician's time may be spent treating patients whose treatment is unrelated to the physician's duties at the medical school.

8.6. Does a physician's license have to be listed with an "inactive" status with the Professional Licensing Agency (PLA) to qualify for the retired credit with the PCF? What is the PCF's definition of retired status?

Yes, the license must be inactive. Pursuant to IC 25-22.5-6-1, retired status means that the provider has ceased to practice. If the provider is volunteering for any amount of time without compensation, and without prescriptive authority, then the provider is still considered retired and may use the retired credit option. If there is any compensation for the volunteer work or the provider will write prescriptions, the provider is no longer considered retired and should notify PLA.

9. Surplus Lines Carriers and Alien Insurers

9.1. Who is responsible for making the filings to the PCF if coverage is written through an eligible surplus lines carrier or an alien insurer included in the most recent version of the NAIC's Quarterly Listing of Alien Insurers?

When coverage is written through an eligible surplus lines carrier or an alien insurer included in the most recent version of the NAIC's Quarterly Listing of Alien Insurers, PCF Certificates of Insurance and surcharge payment must be remitted by a licensed Indiana surplus lines producer. The "Authorized Signature" field must match the name of the licensed Indiana

surplus lines producer. When submitting a new or renewal certificate using a surplus lines carrier or alien insurer, the certificate will be routed to the agency for approval. You will receive an email notification advising whether the certificate has been approved or rejected.

Surplus Lines carriers may not have an eFiling account; all certificates for surplus lines carriers must be entered from an account registered to an Indiana licensed Surplus Lines Producer.

9.2. If coverage is issued through an authorized surplus lines carrier or alien insurer, is the agent required to remit tax on the PCF surcharge amount due?

No tax is due on the PCF surcharge amount.

10. Providers – Multiple Policies

10.1. How is surcharge calculated for a provider who holds multiple policies?

The agent/insurance carrier for the second policy would have to determine how the provider is currently qualified with the PCF.

- If both policies are at the same classification and the first policy is full time, the minimum $100 surcharge will be assessed for the second policy. If the first policy is part time, a $100 minimum cannot be paid for the second policy; surcharge must be paid to bring the first policy into full-time status.
- If the second policy is at a lower classification than the first, then the minimum $100 surcharge will be assessed.
- **If the second policy is at a higher classification than the first, the difference between the higher classification surcharge and the lower classification surcharge will be calculated with the difference due.**

10.2. How is surcharge calculated for a provider who has more than one specialty?

If a provider is practicing in different specialties of different classifications, the surcharge due is for the higher classification.

11. Locum Tenens

11.1. How are filings made for a locum tenens provider?

A filing for a locum tenens provider can be made two ways:

- The provider can purchase coverage for a year and take the applicable credits; or
- A PCF Certificate of Insurance could be filed for each assignment the provider works.

11.2. How is surcharge calculated for locum tenens providers?

As with all other filings, the system is designed to calculate surcharge based upon the effective dates that are entered. If the policy is less than a year, then you will be asked to confirm whether this is a pro-rated or locum tenens policy. If the calculation comes to less than $100, the system will default to the $100 minimum surcharge.

12. Reporting Endorsements (Tail Coverage)

12.1. What surcharge is assessed for reporting endorsements (tail policies) for hospitals, nursing homes, Independent Ancillary Providers, and physicians falling under Rule 60?

The surcharge is $100 for hospitals, nursing homes, Independent Ancillary Providers, and Rule 60 physicians (including locum tenens) for each reporting endorsement issued.

12.2. What surcharge and rating methodology will apply to reporting endorsements (tail policies) for Ancillary Providers (providers not licensed as a physician, Independent Ancillary Provider, nursing home, or hospital)?

Ancillary Providers pay reporting endorsement surcharge at 100% of the underlying reporting endorsement premium, or the $100 minimum surcharge, whichever is higher.

12.3. What happens if a locum tenens physician moves to another carrier that elects to pick up prior acts?

If a locum tenens physician moves to another carrier that elects to pick up prior acts, a reporting endorsement from the new carrier is required reflecting the beginning date of the first assignment and the ending date of the last assignment with the previous carrier, with the understanding that the new reporting endorsement will only cover the dates reflected on each assignment certificate. The reporting endorsement filed by the new carrier will cancel out all

previous endorsements filed by or on behalf of the previous carrier. The $100 minimum surcharge must be remitted.

12.4. Does the PCF prohibit companies from offering limited tail?

The PCF does not prohibit limited tail, but the company must file the reporting endorsement reflecting the date for which prior acts coverage is to begin through the date that reporting endorsement will expire. The company must also notify the PCF at least thirty days prior to the expiration of the reporting endorsement, by filing a PCF Certificate of Insurance indicating the effective date of expiration. If the company fails to notify the Department in the above manner, the PCF will hold the company liable for any claims filed after the expiration date of the reporting endorsement, per IC 34-18-13-4.

12.5. Does a reporting endorsement need to be submitted to the PCF for a provider who shares in the limits of the hospital under a claims made policy and leaves or his/her employment?

No. The provider would continue to be covered under the PCF as long as the hospital continues to pay surcharge as a qualified provider. If a complaint is filed, the Department may initially indicate the provider is not qualified, until a signed statement from the risk manager of the hospital is submitted stating that the provider was a covered employee at the time of the occurrence and that the appropriate amount of surcharge was paid to include the provider under the hospital's coverage.

12.6. Does a reporting endorsement need to be filed for a provider going from individual limits to shared limits of a hospital? What about a physician or of Independent Ancillary Provider (IAP) who has individual limits under a group policy and ends their employment?

The answer is yes for both scenarios. A provider who does not purchase tail coverage for the individual policy will not be considered qualified for any claims filed after the expiration date of the individual coverage, and a provider who does not file tail coverage when they leave the group policy will not be considered qualified for any claims filed after the expiration date of their claims made coverage.

13. Certificates – Hospitals

13.1. Can users submit a certificate for a hospital electronically? How do users send in the hospital worksheet formerly used for calculating surcharge?

Yes, hospital certificates are submitted electronically. Specific provider information will appear in the electronic system once the hospital's license number has been enrolled. The filer will complete an electronic worksheet for the system to calculate surcharge. Hospital and nursing home certificates may not be entered via Bulk Submission.

13.2. Are Independent Ancillary Providers required to obtain separate limits per 760 IAC 1-21-10(c) if employed by a hospital?

No. An Independent Ancillary Provider only requires separate limits if he or she is employed by an entity other than a hospital or nursing home. An institution of higher education may include dentists and optometrists who are faculty members in its school of dentistry and school of optometry, respectively, acting within the scope of their employment as faculty members, and may also include in its qualification a fellow, resident, or student of the institution pursuing a degree as a health care provider listed in IC 34-18-2-14(1) or as a pharmacist with respect to activities that are associated with their educational requirements.

13.3. May a hospital provide coverage to physicians and surgeons on its policy?

Hospitals may cover **employed** physicians within the limits of the hospital's liability for exposures arising from such employment. Such hospitals must have this exposure calculated into the hospital's surcharge, by use of the employed physician rate. Self-insured hospitals and/or their producers must conduct an audit on a quarterly basis by tracking all additions and/or deletions of employed physicians or other significant changes to exposures most recently filed with the PCF. Coverage only applies to employed physicians acting within the scope of their employment.

13.4. Can individuals who are classified as residents or fellows share in hospital limits even though they do not fall within the definition of "Employed Physician" found in 760 IAC 1-21-2(6)?

Yes. Because of the unique nature of the relationship between institutions, such as universities and hospitals, and residents and fellows, the PCF allows residents and fellows to share the institution's limits with regard to activities associated with the residency or fellowship. This policy was promulgated in 760 IAC 1-21-10(8)(h). However, to share in the institution's limits

fellows must participate in a full-time fellowship with no additional practice, except for part-time "moonlighting" work. Residents and fellows should check with the institution to determine the institution's practice and protocols regarding professional liability insurance for residents and fellows.

13.5. Can the credits available for health care providers identified under Rule 60 be taken for physicians sharing in the limits of a hospital?

The credits available in Rule 60 may be applied to the annual surcharges for physicians identified under Rule 60. Only one credit can be applied for each physician.

13.6. What are the discounts for hospitals with risk management programs?

There are no discounts for hospital risk management programs. Hospitals **without** a risk management or quality assurance program must pay a 10% penalty.

13.7. What defines an acceptable risk management program?

Any program that meets the licensing requirements of the Indiana Department of Health will be considered acceptable for purposes of surcharge calculation.

13.8. Where can the current surcharge rates for hospitals be found?

Surcharge rates for physicians and hospitals can be found in 760 IAC 6-1-9.

13.9. Can entities affiliated with a hospital share in the hospital's limits?

Only the entities listed on the hospital's Department of Health license application can share in the hospital's limits. If an entity is not listed on the hospital's license application, it must obtain its own limits, unless the entity listed is strictly a DBA of the hospital and not a separate legal entity.

To make this determination, follow these steps:

1. Check how the facility or entity is licensed by using the following websites:
    - Indiana Department of Health
    - Indiana Professional Licensing Agency
    - Indiana Secretary of State

2. If the facility or entity is licensed as a hospital, check the following website to identify all facilities listed on the hospital's license application with the Indiana Department of Health, to determine which locations may share in the hospital's liability limits: https://www.in.gov/health/reports/QAMIS/hosdir/index.htm.
3. If the facility or entity is not listed on the hospital's application with the Indiana Department of Health or does not hold a license as a hospital, it must obtain separate liability limits. Conduct a search of the Indiana Professional Licensing Agency first, and then the Secretary of State, to determine how the entity is licensed or authorized.
4. If the facility or entity does not appear on any of the above websites, check whether the name given is a DBA of the hospital/entity. If it is listed as a DBA, that name must be reported to the PCF for coverage to be extended to the DBA in accordance with 760 IAC 1-21-10.
5. If the entity does not hold a hospital or nursing home license, it must be submitted under ISO code 80999. If the entity does hold a license from the Indiana Department of Health, it must be submitted under ISO code 90000 (hospital) and 80923 (nursing home).

13.10. If a hospital becomes the license holder for a nursing home, but a previous license holder (nursing home) manages the facility, including the employment of personnel, what is the proper way to qualify all of the entities?

In the scenario that has been most frequently presented to the PCF, the hospital receives a nursing home license separate from its license to operate a hospital. The former license holder continues to manage the nursing home's daily operations through a contract with the hospital license holder. The hospital holds a separate license for the nursing home; it is not listed as an additional location on the hospital's hospital license. The remainder of this answer assumes such a scenario and refers to the former license holder as the "management company."

Each separate legal entity must qualify separately with the PCF and hold separate limits of liability. The parties can decide whether they share an underlying insurance policy or hold separate ones, as long as each entity holds separate limits of liability for the proper statutory amounts. Either entity may be the first named insured.

The hospital's limits of liability for the nursing home should be determined by the size of the facility. The management company would be considered an Ancillary Provider and should file

using ISO code 80999.

The hospital's liability limit for the nursing home should also be separate from its liability limit for its hospital exposure unless the hospital is self-insured. **Self-insured entities cannot provide coverage for any other entity, including a nursing home**.

13.10.1 Can the management company qualify with the PCF?

Yes. As long as it is organized or registered under Indiana law, that as one of its functions, provides health care, and it is determined to be eligible for coverage as a health care provider under IC 34-18 for its health care function, the management company would fall under the definition of a health care provider found in IC 34-18-2-14(7).

13.10.2 Who is responsible for paying surcharge to the PCF?

Surcharge must be paid for each entity if it is to be considered a qualified health care provider and enjoy the benefits of Indiana's Medical Malpractice Act. The PCF does not dictate who is responsible for making payment of the surcharge.

13.10.3 What surcharge applies?

If the nursing home operates under a nursing home license, it should qualify using the nursing home ISO code (80923) and nursing home rates (760 IAC 1-21-8.5) to calculate surcharge. If the hospital includes the nursing home in its hospital license, the nursing home should qualify under the hospital's filing, using the hospital ISO code (90000) and hospital rates to calculate surcharge. A corporation pays 100% of its underlying premium for qualification, or the $100 statutory minimum.

Example:

- Previously, LTC, Inc. owned a nursing home, Great Living Center, with 150 beds, held the license, and managed its operations. Now, County Hospital holds Great Living Center's license under the name County Hospital DBA Great Living Center. Under a contract, LTC, Inc. manages the operations of Great Living Center for County Hospital, including employing the staff. Staff members include Independent Ancillary Providers, Ancillary Providers, and other non-physician employees. County Hospital holds the nursing home license separate from its

hospital license. Both LTC, Inc. and County Hospital wish to be qualified health care providers.

- County Hospital's insurance carrier or producer will file a PCF Certificate of Insurance for Great Living Center. Its surcharge will be determined using the nursing home bed rate. The liability can be covered under the same policy as County Hospital's hospital liability, but County Hospital's annual aggregate is separate from Great Living Center's aggregate.
- LTC, Inc.'s insurance carrier or producer will file a PCF Certificate of Insurance as an Ancillary Provider. Its surcharge will be 100% of the underlying premium. If LTC, Inc. is an additional insured on County Hospital's policy, surcharge is 100% of the additional premium attributable to the additional insured. The $100 statutory minimum applies. The liability can be covered under the same policy as County Hospital's, but LTC, Inc.'s annual aggregate is separate from Great Living Centers's annual aggregate.
- Because LTC, Inc. qualifies as an Ancillary Provider, its Independent Ancillary Provider employees must qualify separately in the PCF and have separate underlying limits of liability.
- Either County Hospital or LTC, Inc. can pay the surcharge for either entity.
- If County Hospital qualifies but LTC, Inc. does not, LTC, Inc. is not a qualified health care provider, and the Medical Malpractice Act's limits on damages do not apply to claims against LTC, Inc.
- If LTC, Inc. qualifies but County Hospital DBA Great Living Center does not, County Hospital is not a qualified health care provider for claims of malpractice occurring at Great Living Center, and the Medical Malpractice Act's limits on damages do not apply to claims against Great Living Center.

13.11. How does a hospital self-insure with the PCF?

Contact PCF-COI@idoi.IN.gov for more information. Per 760 IAC 1-21-5(6), **a self-insured hospital or psychiatric hospital may only obtain occurrence-based coverage.** Claims made coverage is not available.

14. Certificates – Nursing Homes

14.1. Do nursing homes owned by the same entity have to maintain separate limits?

Yes, if each of the facilities is separately licensed through the Department of Health then separate limits must be maintained. This can be determined from the Indiana Department of Health website.

14.2. How is surcharge calculated for nursing homes?

Nursing homes pay a per bed rate as set out under 760 IAC 1-21-8.5. The nursing home calculation worksheet is part of the electronic filing process and the information that is entered is used to calculate surcharge.

14.3. What ISO code is used when qualifying a nursing home with the PCF?

The ISO code for nursing homes is 80923.

14.4. Are Independent Ancillary Providers required to obtain separate limits per 760 IAC 1-21-10(c) if employed by a nursing home?

No. An Independent Ancillary Provider only requires separate limits if they are employed by an entity other than a hospital or nursing home.

14.5. If a hospital holds the license for a nursing home, but a previous license holder manages the facility, including the employment of personnel, what is the proper way to qualify the entities?

Please refer to the Hospitals section of the FAQs.

15. DBAs

15.1. Do DBAs have to be reported on the health care provider's PCF Certificate of Insurance filed with the PCF to be afforded coverage?

Yes, per 760 IAC 1-21-10(b), if a physician operates under a DBA, he should report the DBA on his PCF Certificate of Insurance. However, including a DBA on a PCF Certificate of Insurance does not allow an individual to include employees. A sole practitioner physician must organize or register an entity under state law and qualify the business entity in the PCF to obtain coverage for employees. Further information on informal business associations may be obtained at https://inbiz.in.gov/BOS/home/index. *However, any separate legal entity must have*

independent coverage.

15.2. Is a $100 minimum surcharge owed for each DBA added to the health care provider's filing?

No, this is not a per DBA surcharge amount. Appropriate surcharge, subject to the $100 minimum, is owed for each PCF *Certificate of Insurance* filing adding DBAs after the initial or renewal certificate has been filed. Multiple DBAs can be included on a certificate, but only $100 will be owed. Please refer to 760 IAC 1-21-10(b).

15.3. Is it necessary that an assumed business name be registered with the Indiana Secretary of State to be recognized as a qualified health care provider?

Not necessarily. The PCF allows a business that is known by an alias and not required to be organized or registered under Indiana law to include the DBA so the businesses can avoid unnecessary litigation regarding qualification.

For example, John Smith, M.D., may have a sign on the door that says "Smith's Medical Clinic." Dr. Smith is a sole proprietor who does not have a corporation and is not registered with the County Recorder, and *does not wish to cover employees*. Smith's Medical Clinic could be appropriately added as a DBA on Dr. Smith's PCF Certificate of Insurance.

If Smith's Medical Clinic is registered as a formal business association, such as an LLC, with the Secretary of State, then it needs to qualify with the PCF separately from Dr. Smith.

If Dr. Smith has employees who he wants to be covered under Smith's Medical Clinic, then the business entity must be organized or registered under Indiana law. Businesses organized outside Indiana must comply with Indiana law regarding registration. Please refer to the Secretary of State's website at https://inbiz.in.gov/BOS/home/index for more details on this process.

15.4. Can DBAs be reported under a hospital if not listed as a facility operating under the hospital license as indicated under 760 IAC 1-21-10(a)?

Please refer to the Hospitals section of the FAQs.

16. Amending or Cancelling Certificates

16.1. If a filing for a provider is submitted on a paper certificate, can it still be amended or canceled electronically?

All paper filings must be amended or cancelled via paper. You may only amend or cancel a filing electronically if the new or renewal filing was entered electronically. Please note that if an amended or cancelled paper filing results in return surcharge, this credit will be placed on your current eFiling account with the PCF.

16.2. How can users amend or cancel a certificate electronically?

Ancillary Providers Only: The system does not pro-rate returned surcharge for Ancillary Providers. Before cancelling an Ancillary Provider certificate, file an amendment to update the underlying premium to receive returned surcharge if necessary.

Manual Entry: The original certificate will appear after clicking "File an Amended/Cancellation Certificate" in the Submit a Certificate queue and entering the search information. Once you find the Certificate, click either Amend or Cancel to proceed. Some fields may be modified, such as provider name and address, policy effective dates, retro date and premium. Click continue and then enter the effective date of the change and the change reason. Clicking continue and verifying will move the certificate to the Manage Certificates page. You may continue entering additional certificates before proceeding with payment.

Bulk Submission: The bulk submission upload will begin to calculate the surcharge for each record on the spreadsheet. This could take anywhere from an hour to several hours to complete. Once the submission is ready for payment, the user will receive an email to proceed.

16.3. How can users report a cancellation with 30 days' prior notice to the Commissioner? Carriers and producers are rarely notified of a cancellation until the last minute or after an effective date. Is this a new requirement for the PCF?

Paragraph 3 on the bottom of the Certificate includes notice that 30 days' prior notice must be received for cancellations or reductions in liability for a policy. This 30-day notice requirement is statutory pursuant to IC 34-18-13-4.

16.4. I just entered and paid for a certificate by mistake. Is there a grace period for cancellations?

For a claims made or occurrence policy you can use any cancellation date if you file the

cancellation within the first 30 days of the start date. This includes cancelling it back to the start date, sometimes called a flat cancel. Please see 16.2 regarding Ancillary Providers if applicable.

16.5. How does an insurer handle return of surcharge issues?

Insurers that return premium due to cancellation or other reasons should also return the applicable surcharge. Once a certificate is filed and paid electronically, then the credit will appear on the user's account. Under IC 34-18-5-2(e), the PCF is to collect $100 as a minimum surcharge, even if a provider's surcharge calculation results in a lesser amount. Minimum surcharge should always be considered "earned" for purposes of return of surcharge, meaning that no portion of the $100 minimum will be prorated and returned. Surcharge amounts beyond the minimum are not refunded, but placed as a credit on the user's account.

16.6. How should credit be used on future filings?

The current available credit on an account can be viewed in the Credits & Reports module. The user then has the option of applying any portion of the available credit during the checkout process during the next payment to the PCF. The PCF will not issue a refund in place of a credit.

17. Payments / Search Payments

17.1. How long do users have to complete a payment?

Payment must be completed by 6:00 p.m. on the business day following the day the payment process began. Holidays and weekends are not considered business days. This policy is the same for all payment options. If a payment is not completed by the deadline, then the payment is removed and the certificates go to the Submit a Certificate queue to begin the process again. **Please note that you only have 10 days from entry to pay for a certificate or it will become unavailable for payment.** Payment for a certificate may fail if a penalty threshold is passed between the date of filing and attempted payment. The certificate may also fail if it does not meet the 30-day notice requirement (IC 34-18-13-4) or 180-day late-filing limit (IC 34-18-3-5).

17.2. What happens if users begin the payment process for either manually entered or bulk certificates but do not complete it?

All payments that are initiated are assigned a Payment ID number. You may locate this payment in the Search Payments queue, where you have the option of paying or removing it. Removing means only that the payment is removed; the certificates will then go back to the Make Payments queue to be reselected later.

17.3. How long does it take after users upload the bulk submission form before they can complete the payment?

This time will vary, depending on website traffic and the number of certificates contained in the upload. You are encouraged not to wait until the last day or two to upload the form as the processing time may cause a filing to be late, for which penalties may accrue.

17.4. What form of payment is accepted on the electronic system?

The only forms of acceptable payment are Visa, MasterCard, or ECheck. A credit card payment will incur an additional fee that is charged at a percentage of the total payment. If paying by ECheck, you must enter your routing number and account number. To ensure that your payment will process successfully, you will need to notify your financial institution of the ACH ID number 935600015E. If you fail to provide this number to your institution and your payment is refused, then you may incur an additional returned payment fee in addition to any other applicable penalties for late payments.

17.5. How long does it take the ACH payment option to debit a checking account?

ACH payments usually complete within 3 – 5 business days.

18. Fees

18.1. Is there an additional fee to file electronically?

No, there is no longer an additional fee to file electronically.

18.2. Is there a subscription fee to use the Bulk Submission option?

No, there are no longer any subscription fees for Bulk Submissions.

19. Previous Filings

19.1. When clicking on View Previous Filings, the certificate cannot be found.

If you entered a certificate, but have not yet paid for it, either it will be in the Manage Certificates page under Submit a Certificate, or it will be in the Make Payments queue. **A certificate is not considered "filed" until successful payment has been made and it has attached to the PCF database; this also applies to amendments/cancellations for which you anticipate returned surcharge.** If you have successfully submitted and paid for the certificate, then by providing the search information, you should be able to locate the certificate in the Search Payments queue.

19.2. The necessary information has been entered into the search criteria fields, but the certificate that has been filed cannot be located.

Make sure that any certificates you are trying to locate on the system have been filed electronically. Certificates submitted via paper cannot be found on the electronic filing system. Please search further at www.IndianaPCF.com to verify that the certificate appears on the PCF database.

20. eFiling Credits and Reports

20.1. When users have credits with the PCF, can they request a refund?

The PCF does not issue refunds; returned surcharge is credited to your eFiling account for your future use. You have the option of transferring all or some of the credit to another eFiling account; email PCF-COI@idoi.IN.gov to request a credit transfer.

20.2. Can users see how their credit has been used or applied on the account?

Yes. Return surcharge will be indicated by the amount in parentheses, and credit that is being used will be listed as a regular charge. Your total available amount of credit will be shown in the top left portion of the screen. You may also export this information into an Excel spreadsheet.

20.3. Can credits be transferred to another PCF COI eFiling account?

Yes, in some situations. Please email PCF-COI@idoi.IN.gov for assistance.

21. Bulk Submission

21.1. What file type do we need for Bulk Submission?

This form is provided for you in an .xls format (Excel) available on the electronic filing system or by clicking the link for the spreadsheet. Please verify that the document is saved as Excel 97-2003 Workbook (*.xls) and not another version.

21.2. Is the spreadsheet sent directly to the PCF via the email address listed on the Welcome (log in) page?

No. The form should be uploaded via the website by clicking on Bulk Submission and following the instructions for completion.

21.3. What happens if the system detects an error while checking the entries? Will the whole submission be considered "failed"?

You will have the option to edit or delete certificates with errors and upload them again. Once a certificate has failed, it cannot be included in the same bulk submission payment as those that were successful. Certificates that are edited go directly to the Submit a Certificate (Manage Certs) queue for manual payment processing.

21.4. Is there a minimum or maximum character length for any of the fields? For example, a provider's license # is eight (8) numbers and does not include an alpha character, but would there be a limit for the provider name?

There are character limits for some fields; they are identified on the Bulk Submission File Upload document. Hover over each column heading to see more information.

21.5. What is the COI Confirmation Number and how can it be found? Is this an optional field?

This number is for those who are adding amendments/cancellations to their bulk submission after surcharge payment has been received for the original filing and the certificate has attached to the PCF database. The COI Confirmation Number can be viewed by clicking the Payment ID Number associated with the original filing or by searching at IndianaPCF.com. This is an optional field unless you are filing an amendment or cancellation.

21.6. Is the Surcharge Received date also an optional field?

The entry will be processed with this field blank, but this field should be completed if the filing is made 30 or more days after the effective date.

21.7. Please explain the Surcharge Credit Type. For example, is the OVER 25 UNDER 31 the 25% part-time credit?

Yes. If the provider has a credit, then you would enter a code number associated with the credit from the instructions sheet of the Bulk Submission File.

21.8. Will you further explain the three fellowship credits, Codes 13, 14 and 15?

Please see 760 IAC 1-60-5 for a full definition of the three fellowship credit options.

- Code 13 = Full-time (and engaged in no other practice) 50% credit;
- Code 14 = full-time surcharge for medical practice outside fellowship; and
- Code 15 = 50% of surcharge due for specialty class of fellowship.

21.9. Why are some of the column headings highlighted in green?

These fields are highlighted to inform you that they are optional fields and do not require an entry for the filing to process.

21.10. What should be entered for the premium amount? Is this the amount of the surcharge?

The carrier's underlying premium amount should be entered here. An amount must be entered, even if it is $0.00. The system will automatically calculate surcharge after the certificates have been successfully uploaded.

21.11. What should be entered as the Certificate Type for a Reporting Endorsement (tail) policy?

A reporting endorsement is a Certificate Type 1 (New Filing), and Policy Type ID 3 (Reporting Endorsement).

21.12. Please explain in more detail the Organization Name, and Individual or Organization Code.

If you enter “Organization” in column V, then you must enter an Organization Name in the next field. If you enter “Individual” then you will fill in any fields pertaining to an individual.

21.13. How is the Provider Address Zip Code entered?

You may enter either the five (5) or nine (9) digit zip code for the provider; either is acceptable. No special characters (-) are allowed.

21.14. There is an additional column entitled Provider Med Licenses under column AH. What is this?

Some providers may have more than one medical license number. In that case, each additional license number must be entered and separated by a comma.

21.15. How are multiple DBAs entered on the form? What if there are 99 DBAs for one provider?

Under the column “Provider Business Aliases,” you should enter all DBAs for the provider, each one separated by a comma. This can be completed using a cut and paste method from another document.

21.16. What is the minimum and maximum number of certificates that can be entered at one time for each bulk upload?

You may upload between 1 and 200 policies on each submission.

21.17. In 2011, the PCF said the insured provider’s email address must be entered. Is there a column for this on the form?

The PCF no longer requires the email address for providers. Letters previously emailed to the providers and carriers can be retrieved via the PCF database by visiting www.in.gov/idoi/pcf, selecting the provider and associated policy, and clicking Print Confirmation Letter.

21.18. What should be entered as the change reason for an amended or cancelled policy?

Please refer to the instructions sheet of the Bulk Submission File. Each reason type has a

designated amend/cancel code that must be entered on the Bulk Submission File spreadsheet.

21.19. What is the timeframe for entering and uploading an adjustment (amended or cancelled) filing before penalties are assessed?

The same procedure and timeframe pertain to bulk filing as with filing a manually entered certificate. Amended filings resulting in additional surcharge owed must be entered and uploaded within 30 days of receipt of surcharge from the provider, or within 60 days of the effective date of the change, whichever is less. Cancellations or reductions in liability must be paid for and received by the PCF 30 days' prior to the effective date of the cancellation or reduction.

21.20. Will filers receive an itemized list of all of the certificates contained in this submission once they receive a Payment Notification email?

No. You will need to log into the system and click on the Search Payments queue. Each payment is assigned a Payment ID number that you may click on to see all the certificates filed with that payment.

21.21. Can you explain the Provider Types listed on the instructions sheet?

There are specific ISO Codes that identify each type of provider on the Bulk Submission File Upload spreadsheet. Based upon this ISO Code, you will enter either Ancillary, Independent Ancillary, or All Other Types. Please refer to Rule 21 for the AP and IAP provider types and Rule 60 (All Other Types) for more information. Nursing Homes (80923) and Hospitals (90000) cannot be submitted via bulk submission.

21.22. What should be entered if a provider is Full-Time?

If no credit code is entered, then the system defaults automatically to Full-Time.

22. Bulk Search

22.1. When going into the Bulk Search and viewing a certificate contained in the payment ID, there is a column showing a Record ID. What is this and when would this number be needed?

A Record ID is the identification number assigned to a certificate. If there are questions

regarding the certificate, this is how the vendor can find it.

22.2. When looking in Bulk Search, listed under the heading "Status" each of the submissions has a different status. Why is this?

You will see one of four status descriptions for each submission. New means that an upload has occurred, but has not completed the upload process yet. Processed indicates that the certificates contained within the bulk upload have completed the verification process. Requires Action signifies that one or more of the certificates within the submission must be edited before payment can be made. After editing, the certificate(s) showing as previously failed will be routed to the Manage Certificates screen. Pending means that the uploaded certificates are awaiting payment completion.

23. Statutory Changes, Surcharge Changes, and Other Changes

23.1. Is the Department required to send any type of notification to the insurance carriers regarding changes to the statute, rules, bulletins, etc.?

No, but the Department does maintain a list of interested parties who wish to receive notifications of changes. If you would like to have your name added to the listing, please email PCF-COI@idoi.IN.gov.

23.2. Will users be notified if there are enhancements to the PCF-COI Electronic Filing System or the Electronic COI Filing Procedures in the future?

The PCF will make every effort to send notifications via the distribution list if there are changes. If you have not already done so, please email PCF-COI@idoi.IN.gov to have your email address added to the PCF distribution list. However, you may want to check the date or version of the document you may be viewing periodically to verify you are using the most recent version.

23.3. If surcharge rates decrease, does the IDOI have a stated position on cancel/rewrites to gain the benefit of the new rates? Conversely, if rates are scheduled to increase, does the IDOI have a stated position on cancel/rewrites to maintain the old rates?

Canceling and rewriting a policy to take advantage of a lower surcharge is prohibited. Please refer to Bulletin 238.

PART II: CLAIM REPORTING, PROPOSED COMPLAINTS, AND MEDICAL REVIEW PANELS

24. Settled or Adjudicated Claim Reporting

Please review https://www.in.gov/idoi/medical-malpractice/filing-a-medical-malpractice-complaint/settled-or-adjudicated-claim-reporting/ before contacting the Indiana Patient's Compensation Fund ("PCF") with complaint questions not addressed in the FAQs.

24.1. Does an insurance carrier or a self-insured hospital have to file with the Department notice of a claim against a health care provider if a proposed complaint has not been filed with the Department?

Yes, per IC 34-18-9-2, a medical liability insurer of a health care provider against whom an action has been filed under IC 34-18-8-6(a) shall provide written notice to the Commissioner within thirty (30) days after filing of the action, and upon final disposition of the action. Notifications may either be emailed to PCFClaims@idoi.IN.gov or mailed to:

Indiana Department of Insurance
Medical Malpractice Division
311 West Washington Street, Suite 103
Indianapolis, Indiana 46204-2787

24.2. How and when are reserve notifications filed?

An insurance carrier or self-insured hospital setting a reserve must make the appropriate filing as per IC 34-18-9-3(a) and Bulletin 119. Reserve notifications may either be emailed to PCFClaims@idoi.IN.gov or mailed to:

Indiana Department of Insurance
Medical Malpractice Division
311 West Washington Street, Suite 103
Indianapolis, Indiana 46204-2787

24.3. How and when are settlement notifications filed?

A health care provider's insurer or risk manager must file a settlement notification within sixty days after the final disposition, and it should include the information listed in IC 34-18-9-3(b) and Bulletin 119. Please note that if settlement notifications are not filed, the claim will remain

open on the Department's records. Even if there is no settlement against the provider, the insurer is welcome to submit a settlement notification as this will facilitate closing of the file. Settlement notifications may either be emailed to PCFClaims@idoi.IN.gov or mailed to:

Indiana Department of Insurance
Medical Malpractice Division
311 West Washington Street, Suite 103
Indianapolis, Indiana 46204-2787

25. Proposed Complaints for Medical Malpractice

Please review https://www.in.gov/idoi/medical-malpractice/filing-a-medical-malpractice-complaint/ before contacting the Indiana Patient's Compensation Fund ("PCF") with complaint questions not addressed in the FAQs.

25.1. Does a proposed complaint have to be signed?

Either the counsel of record needs to sign the complaints or the pro se plaintiff.

25.2. Can a claim be expunged without an order from a court if a plaintiff requests it?

No. Once a claim is filed, it becomes a matter of public record. We cannot expunge without an order from a judge.

25.3. If a provider has claims made coverage, does that mean they definitely have coverage for all claims made?

No. When health care providers have claims made policies, to be covered for a particular claim they must have had a claims made policy in place at the time of the alleged malpractice AND an active claims made policy with a retro date the covers the alleged date(s) of malpractice when the claim is filed, or they must have had a claims made policy in place at the time of the alleged malpractice AND an active reporting endorsement with a retro date that covers the alleged date(s) of malpractice when the claim is filed.

There are two types of reporting endorsements:

- *Limited Reporting Endorsement (Limited Tail)* - A limited reporting endorsement provides coverage for *a fixed period of time* (usually one or two years) for claims that

arise after the end of the claims made policy for incidents that occurred or are alleged to have occurred while the claims made policy was active.

The "From" date for a limited reporting endorsement is the same as the end or cancel date of the related claims made policy. The "To" date for a limited reporting endorsement is the date on which extended coverage ends; claims filed after that date will not be covered by the PCF unless different coverage is in place.

- *Unlimited Reporting Endorsement (Unlimited Tail)* - An unlimited reporting endorsement provides *indefinite coverage* for claims that arise after the end of the claims made policy for incidents that occurred or are alleged to have occurred while the claims made policy was active.

  The "From" date for an unlimited reporting endorsement is the same as the retro date of the related claims made policy. The "To" date for an unlimited reporting endorsement is the same as the end or cancel date of the related claims made policy.

25.1. Do DBAs have to be reported on the health care provider's PCF Certificate of Insurance filed with the PCF to be afforded coverage?

Yes, per 760 IAC 1-21-10(b), if a physician operates under a DBA, he should report the DBA on his PCF Certificate of Insurance. However, including a DBA on a PCF Certificate of Insurance does not allow an individual to include employees. A sole practitioner physician must organize or register an entity under state law and qualify the business entity in the PCF to obtain coverage for employees. Further information on informal business associations may be obtained at https://inbiz.in.gov/BOS/home/index. *However, any separate legal entity must have independent coverage*.

26. Medical Review Panels

Please review https://www.in.gov/idoi/medical-malpractice/filing-a-medical-malpractice-complaint/medical-review-panel/ before contacting the Indiana Patient's Compensation Fund ("PCF") with complaint questions not addressed in the FAQs.

26.1. Does a provider need to be qualified under the Act to serve on a Medical Review Panel?

No. IC 34-18-10-5 Eligibility for Panel Membership, provides that: *Except for health care providers who are health facility administrators, all health care providers in Indiana, whether in the teaching profession or otherwise, who hold a license to practice in their profession shall be available for selection as members of the medical review panel. Health facility administrators may not be members of the medical review panel.*

27. National Practitioner Data Bank

27.1. Why is the Patient's Compensation Fund reporting a payment in a provider's name?

A payment made by the PCF to a plaintiff is made on behalf of every health care provider who participates in a settlement that allows the plaintiff access to the PCF. Under federal law, the PCF is required to report medical malpractice payments, made on behalf of physicians, to the National Practitioner Data Base ("NPDB").

27.2. How will people know that multiple reports to the NPDB only involve one claim of malpractice?

You are allowed to submit comments to the NPDB. Instructions on how to do so are included in the report that you received from the NPDB.

27.3. An insurance company only paid a fraction of the settlement with the plaintiff, and other health care providers paid the rest. How does the Patient's Compensation Fund decide how much to report on behalf of each health care provider?

The PCF reports payments to the NPDB in the same proportion that each health care provider participated in the *present value* of the settlement with the plaintiff. For example:

i) A physician and a hospital participated in a settlement with a plaintiff and will eventually pay the plaintiff the amount specified in IC 34-18-14-3(b).
ii) The present value of the payments made is $187,001.
iii) The hospital made a cash payment of $62,334 (1/3 of the $187,001), and the physician paid $124,667 (2/3 of the $187,001).
iv) The Patient's Compensation Fund paid $300,000 in excess damages.
v) The report to the NPDB would show a payment of $200,000 on behalf of the physician

(2/3 of the $300,000). The PCF would not report a payment on behalf of the hospital if the payment were made solely for the benefit of the hospital. If, however, the payment was made by the hospital on behalf of a second physician, the PCF would report $100,000 (1/3 of the $300,000) on behalf of the second physician.

27.4. Why are providers not consulted regarding the amount of payment that was made to a plaintiff from the Patient's Compensation Fund?

Under the Indiana Medical Malpractice Act, you have a right to object to a Petition for Excess Damages demanded by a plaintiff within twenty days after you are served with a copy of the summons and plaintiff's petition for excess damages. If you think that you were not served properly, you should contact your attorney. If a health care provider does not file an objection, the PCF proceeds with litigation of the claim independently.

27.5. Where can more information about the NPDB and its requirements be found?

The NPDB web site is https://www.npdb.hrsa.gov. The *NPDB Guidebook* is available in PDF form under the heading "Resources" on the NPDB web site.

27.6. Can a provider dispute the report?

The copy of the report that you received from the NPDB includes a notice of how to file a dispute. Follow those instructions. If you do not have the report sent to you by the NPDB, go to https://www.npdb.hrsa.gov/pract/howToSubmitAStatement.jsp and follow the instructions there.