

Frequently Asked Questions

1. General

State the type of company (corporation, partnership, etc.) **Corporation**

What types of organizations do you usually work with? **Corporations and public entities (including school districts, cities, counties, and government unions)**

Name, address, city, state, zip code, and telephone number of firm's locations.

Minneapolis: 13700 Watertower Circle
Plymouth, MN 55441
763-383-4800

Chicago: 340 Quadrangle Drive
Bolingbrook, IL 60440
630-759-1311

Detroit: 4660 South Hagadorn Road #210
East Lansing, MI 48823
517-351-6616

Cleveland: 1920 Georgetown Road
Hudson, Ohio 44236
330-528-3929

Location of headquarters: **13700 Watertower Circle
Plymouth, Minnesota**

Description and history of entity **See exhibit – “AssureCare History and Description”**

How long have you provided claims administration services? **22 years**

Please provide a copy of your firm's most recent SAS70. **Available Upon Request**

How many participants does your firm provide services? **In excess of 100,000 member lives**

Please describe your organization's vision for the types of coverage for which you are currently providing services. What are the long-term plans for each business unit or organization?

AssureCare is an integrated single source healthcare management company resulting in a customized end-to-end solution that includes a PPO matrix designed to optimize access and discounts available in your area. The matrix would be integrated with utilization management, large case management, claims administration, aggressive claim discounts, and effective reporting. Long-term plans include enhancing capacity and efficiency through technology, training, recruiting and retaining experienced and talented staff.

What is your organization's commitment to quality client service? **AssureCare takes pride in our customer service model. We will staff with a dedicated client service team with primary and backup ensuring the highest quality customer service**

How much annual turnover is there in the account management group? **None in past five years**

What services can we expect from your client service representative? **An AssureCare client service representative will be available in person for employee meetings, annual workshops, and quarterly meetings. In addition to reasonable requests for other services in person, our service representative can also be available via conference calls, etc.**

Frequently Asked Questions

2. Regulatory

HIPAA Compliance: Describe your readiness for HIPAA including privacy, transaction and code sets?

AssureCare is tested and HIPAA compliant for privacy and for the following transaction code sets:

ANSI X12 (v. 4010 and earlier) HIPAA transaction sets, healthcare claims (837), eligibility (270, 271), claim status (276, 277), health services review (278), premium payments (820), enrollment (834), claim payment (835), 997, NSF, UB92

AssureCare also provides a complete HIPAA compliance support package for all clients

3. COBRA and HIPAA Administration Support

What information would you require from the client in order to provide COBRA continuation services?

AssureCare requests that a term form (hard copy or electronic) be filled out with name, social security number, type of coverage and last day of employment.

Describe your COBRA continuation administration system.

Travis COBRA software is regarded as one of the premier software solutions for COBRA continuation software. Some examples of the many features are:

- a) **Provide COBRA notification and election forms to each qualified beneficiary.**
- b) **Provide payment coupons for premium submissions upon election of COBRA.**
- c) **Track the PQB's payment history.**
- d) **Notify the PQB of delinquency in premiums.**
- e) **Notify the PBQ of termination of COBRA due to premium delinquency.**
- f) **Provide COBRA extension notices – when applicable.**
- g) **Provide notification to a PBQ of any plan changes with regard to open enrollment.**
- h) **Provide notifications to a PBQ of any COBRA rate increase.**
- i) **Provide consulting services to employers on COBRA.**

Provide a list of your HIPAA services

- a) **Provide Certificates of Credible Coverage upon employee/dependent terminations.**
- b) **Send Duplicate certificates upon request**
- c) **Upon receipt of a Certificate of Credible Coverage, investigate remaining pre-existing condition limitations and notify employee/dependent of their remaining pre-existing time.**
- d) **Provide employers with “model” notice of employee's rights regarding portability of coverage and their “special enrollment” rights to the plan.**
- e) **Answer employer and employee questions**
- f) **Ensure that late enrollees are allowed in the plan according to “special enrollment” rules.**

Frequently Asked Questions

4. Claims and Administration

What are your firm's accuracy percentage goals for quality?

- a) Financial/payment: **99% financial accuracy/98% payment accuracy**
- b) Examining/coding: **95% processing accuracy**
- c) Communication/customer service: **98% drop rate**

What is your claim turnaround time? **95% of claims processed within 10 business days**

Describe your internal audit procedures. **Claims are randomly selected and placed on hold automatically in the system for daily audit. Reporting is maintained by claim examiner, group and claim office. Payment, Processing and Financial Accuracy is maintained.**

Describe your training for claims processors. What is the average training time before a claims processor is given full payment authorization?

New hires are provided a 4 week on-the-job training course, with emphasis on quality and customer service. They are provided with claim administration and policy and procedure documentation as well as system training. Full payment authorization given per claims manager's recommendation after 90 days.

Describe your COB procedures. **COB information is requested at enrollment and updated yearly. Information is documented in claims system. Edits for other carrier payments are automatically returned to the analyst.**

What database do you use to determine reasonable fee allowances for health claims? For dental claims? How frequently are your R&C screens updated?

Ingeni X is used to determine reasonable fee allowances for health and dental claims. Databases updated semi-annually.

Describe your guidelines and procedures to protect against claim fraud. **Fraud and Abuse education and training is provided to all employees of AssureCare on a continuing basis. Procedures are in place to identify, refer, manage and deter fraudulent claims submitted by either claimants or providers. System controls, such as software to screen and flag prospective claims under specific circumstances, as well as generation of random audit samples are utilized.**

For each of the following, please indicate whether your computer system is programmed for automatic detection, requires manual intervention, or is not routinely checked:

Situation	Automated	Manual	Not Routinely Checked
Duplicate Charges	X		
On inpatient claims, the # of days confined against admission and discharge dates	X		
Potential experimental, cosmetic, chiropractic, mental/nervous	X		
Reconciles diagnostic code to procedure code for consistency	X		
Medical Necessity of services		X	
Workers' Compensation benefits		X	
Coordination of Benefits	X		
Deductible, OOP, Family Maximums	X		
Negotiated provider arrangements	X	X	

Frequently Asked Questions

What is your procedure for requesting additional information? **Claim is placed in “pend” status and letter requesting additional information is sent. If not received within 45 days, claim is denied for insufficient information.**

How does the computer system track a pending claim? **Once a claim is pending, a unique claim number is assigned and a system-generated letter is sent. A Claim status of “p” is assigned to the claim. After the initial letter requesting the information is sent, the claim system generates a follow up within 45 days. System reports are generated and reviewed monthly.**

Describe your hospital audit procedure. At what dollar amount would an audit be initiated? **Hospital Bill Audits are performed based on specific claim criteria. For example, total charges equaling \$10,000 or more, or a specific revenue code equaling 25% of the total bill, would generate a request for an audit. Upon meeting the criteria, the analyst will process 80% of the total charges, and pend 20% of the bill pending results of the audit. Claims are referred to a specific vendor for the audit to be performed. Once the audit is complete, payment is made based on the results of the audit.**

Subrogation should be pursued in every situation where legally permissible. Describe how you process subrogation and third party reimbursements.

Based on specific criteria a claim will be identified for subrogation review either thru analyst intervention or system edits designed to flag potential claims by condition, diagnosis, or place of occurrence. Once potential subrogation is identified, the claim is pending, and a letter requesting additional claim information is sent to the claimant. The claimant is also notified of the plan’s subrogation rights, and is requested to sign a Subrogation Agreement, which by signing, the claimant acknowledges the plan’s rights to third party reimbursement and agrees to provide all requested information necessary to enforce the right of recovery. Once all required information is received, the claim is processed. The file is then referred to a subrogation expert and a letter of notification and lien is forwarded to the patient’s attorney. The subrogation expert monitors the case thru follow up until the case is resolved, at which time the plan exercises its right of recovery and recoups the dollars paid by the plan.

Describe your excess claim reporting procedures. **AssureCare provides excess loss carriers with monthly reporting on claimants meeting 50% or greater of the specific deductible, year-to-date aggregate census and claims paid, and potential catastrophic claims. Any other information required by carriers is provided on an ad-hoc basis.**

What cost saving services does your organization provide? Indicate the savings in dollar amount saved and as a percentage of total charges that are attributed to each of these services.

Claim Investigation, Coordination of Benefits, Duplicate Charges, Ineligible Charges, Negotiated Network Savings, Subrogation, Usual & Customary Savings, Clinical Editing (Unbundling)

Are claims re-priced in-house? **Yes, claims are re-priced in-house**

Please describe the claims payment system. More specifically, when was the last system conversion/update? Are your systems HIPAA compliant?

AssureCare’s last system upgrade was completed Oct 2003. The current claims system is Trizetto 3.1 release. Trizetto proclaims the 3.1 to be HIPAA compliant.

Please describe who will be processing claims. Is there a team approach? What is the average level of processing experience for the individual/team?

A dedicated team of Claims Examiners\Customer Service personnel will be assigned to your account. The average level of processing experience is 10 years.

Will an EOB go to employees if no payment is required by the employee? **An EOB is generated in all circumstances after a claim is adjudicated whether or not payment is required by the employee.**

Please address how a major claim backlog would be handled.

If and when a claim backlog occurs, a backlog reduction program is put in place to reduce the claims backlog in a timely fashion. Additional claims examiners are immediately assigned to the account and daily production goals are established. Claims examiners are assigned from within the other AssureCare Corporation locations.

Please describe your Disaster Recovery System that is currently in place. **AssureCare utilizes duplicate mainframes and operating systems backed up daily.**

Frequently Asked Questions

How does your claims system handle claims when the co-insurance level is set at different levels for charges attributable to in-network, out-of-network and out-of-area providers?

Co-Insurance levels are set within a plan, based on provider network affiliation

Is this an automated process or a manual process? Provide specific information.

This is an automated process. Provider records are tied to networks; the system checks the plan of benefits for applicable networks, checks the provider record for network affiliation, and if the two match, directs the service charge to the appropriate coinsurance level

Generally describe how procedures are handled when a claim is processed.

Claim data is entered into the system; eligibility is verified (automated); provider data is verified (valid provider, in/out of network); service data is validated (dates, ICD9, CPT-4, R&C, provider fee schedule amounts, etc.). Once validation is complete, system applies plan benefits and payment is calculated. Check cycle is run according to group schedule, check and EOB are released after funding. If any data is incomplete or incorrect, claim is pended and letter requesting information is generated

Does the eligibility file include COB information?

COB information is tracked for member and all dependents by date. If a valid COB record exists for the claimant, the information is displayed and the examiner is forced to use the COB option during claim processing

Do you track eligibility history? How? For how long?

Eligibility history is stored and maintained in the enrollment file. Effective/thru dates of coverage period, group, location, plan, coverage type, benefit class, status and COB information are kept from initial date of enrollment to termination. If changes to history are made, the file stores the change reason and date the change was processed

Do you process facility, professional, and ancillary claims on the same computer system? If different systems are used, how are deductibles and out-of-pocket limits coordinated among the systems? Describe in detail.

One claim system is used for all claim types above. Limits and accumulators are driven by the plan in force on the date the claim was incurred

5. Claims Settlement Capabilities

What claim diagnosis and procedure coding system do you use?

ICD-9 (Ingenix/MDR) and CPT-4/HCPCS/Revenue codes are used

Do you include modifier codes in addition to the normal five digit codes? **Yes**

What additional codes and/or modifiers are required to process claims?

Modifier list includes: 21,22,23,24,25,26,32,47,50,51,52,53,54,55,56,57,58,59,62,66,76,77,78,79,80,81,82,90,91,99.

Under hospital outpatient use, the codes are; 25,27,50,52,58,59,73,74,76,77,78,79,91.

What features to control cost and claim abuse are built into your claims processing system (UCR, medical claim review, etc.)?

UCR - from Ingenix, (United HealthCare)

ClinicalLogic – a knowledge-based sub-system of the Trizetto ClaimFacts adjudication software

How are claim savings quantified and reported?

Claim system provides reporting capabilities for standard and customized reports, i.e. Paid Claims Analysis, Benefit Analysis, etc. Savings are identified thru use of remark codes linked to ineligible amounts

Frequently Asked Questions

Are reasonable and customary limits applied to the following services:

Hospital Special Services	No
Surgical	Yes
Medical	Yes
Laboratory	Yes
Anesthesia	Yes
Chiropractic	Yes
Pediatrics	Yes
Radiology	Yes
Other (specify)	Dental, All professional fees

Describe how your claims system detects “unbundling” or upcoding of charges? Is it an “on-line” or freestanding process?

On on-line batch program is used to detect applicable services to be reviewed; any claims meeting specific criteria are placed in a ‘hold’ status for supervisor review. Once investigation is complete, and any adjustment to allowable amounts are made, claim is released for payment

If you use a free-standing software program, how is it integrated into your processing system?

Daily batch program is run before the check cycle to identify charges that meet the edits in place; once claim is identified, it is placed on hold for review

Do you have standard edits for claims referral to retrospective medical claim review? If yes, please list.

Trilogy Administration guidelines are utilized

Do you identify any service for 100% retrospective claim review?

Physical Therapy, Chiropractic, Home Health, Private Duty Nursing, Sleep Apnea

What criteria do you use for retrospective medical claim review? (Provide details for decisions of medical necessity, appropriateness, experimental procedures, etc.)

Trilogy and MRI guidelines are applied; claims meeting specific criteria are identified and referred to supervisor for review and benefit determination

Describe the action that you would take and the personnel you would involve in a claim investigation triggered by an unacceptable charge level or unnecessary treatment.

Two vendors are used for discount negotiation when an out of network claim exceeding UCR is identified; if no discount can be negotiated, claim is reduced to UCR, claimant and provider notified by remark code. Claims identified for appropriateness of treatment are referred to supervisor, supporting documentation is requested and reviewed, and benefit determination is made based on Trilogy guidelines and documentation received

How do you process a claim when the provider has waived or reduced the required co-payment?

Payment is based on actual charge incurred; if CoPay is waived, total charge is reduced by that amount

Describe your investigative procedures relative to suspected fraudulent claims.

Fraud and Abuse education and training is provided to all employees of AssureCare on a continuing basis. Procedures are in place to identify, refer, manage and deter fraudulent claims submitted by either claimants or providers. System controls, such as software to screen and flag prospective claims under specific circumstances, as well as generation of random audit samples are utilized.

Frequently Asked Questions

6. Service Capabilities

WHICH OF THE FOLLOWING SERVICES CAN YOUR ORGANIZATION PROVIDE? IF ANY REQUESTED SERVICE IS SUBCONTRACTED TO ANOTHER FIRM, PLEASE INDICATE THE NAME OF THAT ORGANIZATION.

- a. Development of plan document and amendments for members: **Yes, AssureCare, internally**
- b. Development and printing of employee booklets: **Yes, Preferred vendors: Holden Business Forms, Corbel Printing services**
- c. Printing and distribution of employee ID cards: **Yes, AssureCare internally or subcontract to PBM**
- d. Monthly Fund Billing/Eligibility: **Yes, AssureCare internally**
- e. Check printing and distribution: **Yes, subcontracted to ABF**
- f. COBRA/HIPAA administration: **Yes, AssureCare internally**
- g. Specific and Aggregate claim reporting and filing: **Yes, AssureCare internally**
- h. Prescription drug card and mail order program support services (assume Express Scripts or PCS): **Yes, AssureCare internally**
- i. Can you provide Section 125 Plan administration services. **Yes, AssureCare internally**

7. UTILIZATION REVIEW/CASE MANAGEMENT

What utilization review services are available “in-house” at your firm?

See exhibit - CareLine Utilization Review

How does the claims system interface with the Utilization Review program?

AssureCare’s preferred Utilization Review vendors have direct access to our claims systems allowing for real-time entry of Pre-Certification and Case information. The vendors enter specific case information into the systems, which is then returned to the claims analysts during claims processing.

Of the services listed above, which of the following do they include?

	Yes	No
Specialty referrals	<u> X </u>	<u> </u>
Home Health Care	<u> X* </u>	<u> </u>
Ancillary Services	<u> X* </u>	<u> </u>
Inpatient surgical procedures	<u> X </u>	<u> </u>
Outpatient surgical procedures	<u> X* </u>	<u> </u>
X-ray & Laboratory procedures	<u> X* </u>	<u> </u>
Inpatient Mental/Nervous/Substance Abuse	<u> X </u>	<u> </u>
Outpatient Mental/Nervous/Substance Abuse	<u> X* </u>	<u> </u>

**when medical necessity is questioned*

Describe the provider fee negotiation programs you offer. **Bill or fee negotiation programs provided by independent companies including: GBS Care, HHC Roffe, and Medical Claims Resources.**

Frequently Asked Questions

8. Eligibility

How is an insured person's eligibility assigned and maintained? **New enrollees are entered into the claim system identified by social security number. Enrollment forms are completed by the insured, and the information is transferred to the claim system by an enrollment analyst. Information such as group, effective dates, type of coverage, and insured and dependent demographics are stored and maintained in the file.**

How often can eligibility information be updated? **Daily**

Do you maintain eligibility information on the employee and each of the family members separately? **Yes**

What is your accuracy standard and turnaround time for loading new groups, updates, and changes?
99% Accuracy Standard for electronic eligibility with 2-week turnaround time for loading new groups, 5 business days for updates and changes.

Can monthly eligibility (terms/add/changes) be handled electronically? If yes, please explain the format and procedures.
YES

Eligibility (including terms/adds/changes/) can be managed through:

- **AssureCare's web sight**
- **Direct Internet connections**
- **Dedicated terminals**
- **AssureCare will:**
- **Assess your company's IT capabilities and needs**
- **Assist with hardware and software installation**
- **Provide on-line and/or on sight training**

9. Customer Service

Who will be answering employee claims questions? Will there be a dedicated customer service team?
The dedicated team of customer services representatives will answer the employee claims questions. A management team is also assigned to ensure quality service

What information is customer service able to reference when giving specific plan information to employees?
Customer Service can reference eligibility, claims history and the master plan documents directly within our claims system to provide specific plan information. All information provided will be in accordance and follow the HIPAA Privacy Standards

Is customer service able to see a copy of the EOB on the system when responding to questions?
YES

Do you have a toll free phone number for customer service?
Yes

9. Reporting

Explain or provide a sample of your experience reporting capabilities. How is the information transmitted---hard copy or electronically? Is there an additional cost for ad hoc reports not included in your standard package?

See Exhibit Standard Reports Sample

Information is transmitted either electronically or hard copy.

There is not a fee for non-labor intensive ad-hoc reports.

What timelines are in place for providing reports?

Monthly reporting is provided by the 15th of the month following the month in which the reports are referenced.

Frequently Asked Questions

10. Stop Loss

Do you provide immediate reimbursement for claims above the Stop Loss levels? If not, what is the average turn-around for reimbursement?

AssureCare recommends that all excess loss contracts contain a specific advance clause. Our Experience regarding normal reimbursement time with specific advance is 7 to 45 days.

Do you charge an additional fee to submit information directly to the Stop Loss carrier? **NO**

11. Prescription Drug

What PBM's do you have relationships with?

Advance PCS and/or Express Scripts. AssureCare maintains a direct electronic access with Advance PCS and Express Scripts. We also have relationships with several other national PBM's.

How is Rx eligibility sent and how often? What is the turn-around time for employees to be active in the Rx system?

Rx eligibility is sent electronically or by tape one to three times weekly depending on PBM. Turn around time can be within three business days.

12. Electronic Capability

Can you receive electronic claims? **Yes**

Can you send claims electronically, i.e. re-pricing, audit, etc.? **Yes**

What are your "on-line" capabilities?

Through AssureCare's Internet Access and Virtual-on-Site services, on-line capabilities include but not limited to:

- Plan Detail access for employers, providers, and employees
- SPD access for employers and employees
- Eligibility lookup for employers, providers, and employees
- Limited eligibility update access for employees (address, phone, et)
- Eligibility adds, deletes and changes for employers
- Claims history access for employers, providers, and employees
- Claims drill down access for employers, providers, and employees
- Claim Status access for employers, providers, and employees
- Report access for employers
- Claim detail access for employers, providers, and employees
- Deductible information access for employers, providers, and employee
- ID Card requests for employers and employees
- Electronic loads
- Financial forecasting
- Prescription drug services

Can participants view claims or claim status on-line? **Yes**

13. Software

What software do you use, e.g. Erisco, RIMS, etc.? What version? **Rims 3.1**

Are you planning now or when do you foresee your next upgrade or conversion? **No**

Frequently Asked Questions

14. Fees

Do you have a start-up fee? Yes x No _____
 If yes, is the start-up fee a one-time fee or payable annually at renewal?
Start up fee is a one time only fee.

What services are provided with the start-up fee?

Systems plan design; systems setup-build-audit & testing; billing set-up and testing; invoice set-up & testing; draft, print & audit ID cards; load, edit and audit eligibility; load, edit and audit COBRA participants; load, edit and audit accumulators; hospital, UR & PPO setup; eligibility extract & distribution to PBM's and other vendors; plan document draft and print set-up; audit and test adjudication system; employee enrollment meetings; employee orientation meetings and materials; on-site client systems software install and training

Outlined below is a list of services that you may or may not have included in your monthly administrative fees. Please indicate in the left-hand column if the services described are included in your fees. If these services are not included, indicate the additional cost to provide them. Add to the list any other services that are included in your monthly fees. Add any other services you provide and the additional costs.

<u>Services</u>	<u>Included</u>	<u>Not Included</u>	<u>Available at an Additional Cost</u>
Summary Plan Descriptions			
- preparation	<u> x </u>		\$ _____
- printing		<u> x </u>	\$ <u>2.45 per book</u>
Network Directories	<u> x </u>		\$ _____
Plan Document Preparation	<u> x </u>		\$ _____
Identification Cards			
- preparation	<u> x </u>		\$ _____
- printing	<u> x </u>		\$ _____
- distribution	<u> x </u>		\$ _____
EOB's	<u> x </u>		\$ _____
Claim Forms			
- preparation	<u> x </u>		\$ _____
- printing	<u> x </u>		\$ _____
Underwriting/ Actuarial Services		<u> x </u>	\$ <u>actual cost</u>
Checks			
- cost per check issued		<u> x </u>	\$ <u>actual cost</u>
- printing charges		<u> x </u>	\$ <u>actual cost</u>
Eligibility Certification	<u> x </u>		\$ _____
1099 Forms (including those under \$600)			
- submit to IRS	<u> x </u>		\$ _____
- send to providers	<u> x </u>		\$ _____
- provide the employer with a list of providers and amounts on 1099s	<u> x </u>		\$ _____
Banking Charges	<u> x </u>		\$ _____

Will you agree to change rates/ fees only on the anniversary date (no mid-year changes)? **Yes**

Do you have minimum enrollment requirements by location? **No**

Describe plan materials that would be given to enrollees.

Manual or electronic enrollment is available. Initial Plan materials are custom designed per customer specifications.