PartnerRe

Claims Administrator Questionnaire

About PartnerRe

PartnerRe is an acknowledged leader in providing risk management solutions to accident and health markets around the world. Our team of experienced professionals develops innovative, client-specific solutions by thoroughly understanding our clients' goals, risk tolerance and exposures. Then, using a suite of proven, proprietary financial and analytical tools, we design an effective risk management program with extensive support services. Our broad portfolio of programs and services, together with our commitment to customer service and long-term partnerships, has made us the preeminent accident and health reinsurer in the industry.

These programs and services include:

- HMO and medical reinsurance
- Employer and provider excess of loss
- Specialty medical
- International medical
- ***PULSE*** + Plus™
- Structured risk programs

PULSE + Plus™ is available to all our medical clients and is one of the largest and most comprehensive programs available to support, educate, and assist our clients in effectively managing their risk through quality, integrated solutions that optimize clinical and financial outcomes.

PartnerRe is a top reinsurer worldwide with total assets of $23 billion and total capital of $7.5 billion, as well as a solid track record of growth and profitability since it was formed over 20 years ago. PartnerRe Health leverages the strength of a financially strong and dynamic organization to better serve our clients with products and services that create financial peace of mind.

At PartnerRe helping clients successfully manage accident and health risk is what we do. We believe in providing the highest quality of programs and services and creating solutions in anticipation of changes in the market, to meet the needs of our clients.

For more information about PartnerRe, please visit www.PartnerRe.com.

General Information

BUSINESS PROFILE

Full legal name of firm: _____

Corporate address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Website: _____

Tax Identification Number: _____

Please list all other locations: *(Please attach additional page if necessary.)*

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Website: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Website: _____

Please list other companies in which you have a financial interest. *(i.e., insurance companies, PPOs, HMOs, MGUs, brokerage firms, etc.)*

Has your business changed names and/or used a d.b.a. or operated under an assumed name? ☐ Yes ☐ No *If yes, please explain.*

Number of self-funded medical clients: _____ Number of self-funded medical employee lives: _____

Please provide a breakout of your self-funded medical clients by group size.

Employee Count	Number of Self-Funded Clients
0 - 100	
101- 300	
301 - 500	
501 - 700	
700 - 1000	
1001+	
Total	

MANAGEMENT AND STAFFING

Please provide the following contact information:

President	Name		Title
	Phone	E-mail	Location
Sales/ Marketing	Name		Title
	Phone	E-mail	Location
Premium/ Billing	Name		Title
	Phone	E-mail	Location
Claims Processing	Name		Title
	Phone	E-mail	Location
Stop Loss Claims	Name		Title
	Phone	E-mail	Location
Medical Management	Name		Title
	Phone	E-mail	Location
IT	Name		Title
	Phone	E-mail	Location

Compliance, Legal and License

Please attach evidence of insurance for E&O, professional liability and your Fidelity bond. Evidence must clearly show current policy period, amounts of coverage, coverage limits, deductible and if this is a claims made policy.

Please provide a copy of your comprehensive general liability policy, if applicable. Evidence must clearly show current policy period, amounts of coverage, coverage limits and the deductible.

Do you purchase criminal liability insurance? ☐ Yes ☐ No *If yes, on which employees?*

Have claims been made against any of the above policies within the past two years? ☐ Yes ☐ No *If yes, please explain.*

If your operating jurisdiction(s) require(s) licensing, are you licensed as a:

Type	No	Yes	States	License Number	Effec. Date	Term Date
Third Party Administrator						
Managing General Agent						
Agency						
Broker						
Other, please define:						

Please provide a copy of the current license(s) listed in the chart above.

Describe all lawsuits within the last 5 years and any current pending lawsuits.

Have any of the principals in your firm or any of your employees (former or current), ever been indicted or convicted of mishandling/misappropriating any insurance company or client funds? ☐ Yes ☐ No *If yes, please explain.*

Has your firm or its principals been involved in an audit from the Departments of Labor, Health & Human Services, or Insurance?
☐ Yes ☐ No *If yes, please explain.*

Describe your current procedures for handling client or insured complaints and state insurance department complaints.

How do you stay updated on changing legal requirements for self-insured medical plans?

How do you inform your clients of these changes?

Claims Administration

MANAGEMENT AND STAFFING

Please indicate staff size:

Staff	Qty
Claims Examiners	
Clerical Support	
Customer Service	

Staff	Qty
Technical Support	
Management	
Supervision	

Staff	Qty
Stop Loss Claims	
Other *(please define)*	

Please provide the following information for lead stop loss claims filing personnel:

Name	Title
Phone	E-mail

TRAINING

Please describe your ongoing training programs for HIPAA and fraud compliance.

CLAIMS SYSTEM

Name of software system:_____

Are you utilizing the most current version available? ☐ Yes ☐ No

Is the software leased or owned? ☐ Leased ☐ Owned If owned, in what year was it purchased? _____

Have you modified the standard system in any way? ☐ Yes ☐ No

If yes, please explain: _____

Do you plan to change or upgrade your system within the next year? ☐ Yes ☐ No

If yes, please explain: _____

Is your system compliant to HIPAA and HITECH standards? ☐ Yes ☐ No

If no, please explain: _____

Please provide a copy of your IT security policy.

Is secure e-mail used? ☐ Yes ☐ No What software is used to ensure PHI security?_____

What is your record retention guideline for on-line claims data? _____

ELIGIBILITY

Describe procedures for adding, deleting and changing plan participant information and their benefits.

How is eligibility determined during claims adjudication?

How do you determine if an employee was actively at work on the claim's date of service?

What documentation do you require to validate continued total disability for a dependent over the limiting age?

How is COBRA eligibility confirmed?

Describe your procedure for verifying coordination of benefits.

Describe your procedure for verifying Medicare eligibility.

Describe your procedure regarding late plan entrants.

Are duties such as eligibility maintenance, claims processing and provider file creation segregated? ☐ Yes ☐ No *If no, please explain:*

CLAIMS ADJUDICATION

Percentage of claims received electronically? _____ Percentage of claims automatically adjudicated? _____

What is the hospital claim auto-adjudication authority limit? _____

Are paper claims scanned for reference and/or storage? ☐ Yes ☐ No *If no, please explain.*

Are scanned images or paper copies available to the claims examiner during the adjudication process? ☐ Yes ☐ No *Please explain.*

Do you utilize automated software to:	Pre-Adjudication	Post-Adjudication/ Pre-Payment	Post-Payment	Vendor/ Software Name
Apply usual and customary				
Identify medical management opportunities				
Identify subrogation opportunities				
Identify COB issues				
Identify potential fraud situations				
Identify potential cost containment opportunities				
Claim edit software (bundling)				
Multiple/bilateral surgeries				
Out of network discounts				
Out of network negotiations				
Overpayment recovery				
Hospital bill audits				
Professional medical review				

If you answered yes to any of the circumstances in the chart above, are claims rerouted electronically to the appropriate area for handling?
☐ Yes ☐ No *If no, please explain:*

What procedures are in place to detect and enforce reimbursement for subrogation, coordination of benefits and workers' compensation?

Please confirm that the following information is provided when submitting a claim to the employer stop loss carrier:

Proof of Eligibility	☑ **Provided**
Claimant's unique identification number	
Claimant's first and last name	
Claimant's date of birth	
Claimant's effective date of coverage	
Claimant's coverage status	
Name of the health plan – PPO, HMO etc.	
Claimant's termination date, if applicable	
Proof of Loss	☑ **Provided**
Subscriber's name	
Subscriber's unique identification number	
Claim or reference number	
Dates of service	
Provider's name	
Provider type – (in or out-of-network)	
Procedure code (CPT, HCPCS, revenue codes and modifiers)	
Units	
Billed amount	
Paid amount	
DRG code, if applicable	
Diagnosis code	
Place of service code (Standard CMS POS code)	
Type of bill – field locator four on UB04	
Two digit discharge code – field locator on UB04	
Claim Services – when relevant	☑ **Provided**
Documentation of other insurance coverage investigation	
Medicare effective date, as well as the reason for Medicare enrollment	
Documentation of pre-existing condition investigation or certificate of creditable coverage	
Employee work status, including explanation of how coverage was maintained while the employee was not actively at work – may include COBRA election forms and proof of COBRA payments; leave of absence details, total disability determination, etc.	
Supporting Documentation	☑ **Provided**
Copies of pre-authorization and/or hospital pre-certification, etc.	
Case management progress reports	
Copy of UB04 for any hospital claims with paid charges exceeding $500,000	
Itemized bills for any hospital confinement with paid charges exceeding $1,000,000	

Does your claim system automatically apply network discounts during the claim adjudication process? ☐ Yes ☐ No *If no, please explain.*

Please describe your criteria for requesting an itemized bill.

Please describe your process regarding limits for large claim approvals.

Do you have the ability to track claims paid outside of the Plan Document and/or stop loss contract? ☐ Yes ☐ No *If no, please explain:*

Please provide your procedure for handling refunds, voids and third-party recoveries. Please include your procedure for insuring that recovered dollars are refunded to the carrier when a stop loss reimbursement occurs.

Can you generate refunds, voids and recovery reports by claimant, policyholder and policy year? ☐ Yes ☐ No *If no, please explain:*

Please indicate if the following items are available on-line by the claims examiners.

Item	☑ On-line
Plan document/SPD	
Claims administration policies and procedures	

Item	☑ On-line
ICD-9/10	
CPT	

Please describe your procedure for independent claim reviews (IRO).

Do you have the ability to submit claims data to the carrier in an electronic format such as:

☐ Excel file ☐ CSV ☐ Flat file *If no, please explain:*

COST CONTAINMENT SERVICES

Please describe how the case management team is made aware of cost containment services provided by the stop loss carrier.

CUSTOMER SERVICE

Do customer service representatives or claims examiners, if applicable, capture diagnosis and/or procedure codes when verifying benefits and refer inquiries with trigger diagnosis codes to medical management for review? ☐ Yes ☐ No *Please explain.*

QUALITY ASSURANCE

Please describe the criteria for internal claims audits.

Percent of total claims audited annually?	
What dollar threshold prompts an audit?	
For new hires, what percentage of claims are audited and for what timeframe?	
Are results communicated to your staff?	
Procedural accuracy goal	

Actual procedural accuracy	
Financial accuracy goal	
Actual financial accuracy	
Turn-around time goal	
Actual turn-around time	
HIPAA compliance verified?	

Has the claims department been audited by a third party for accuracy? ☐ Yes ☐ No
If yes, please provide name of the audit firm, date and description of the audit.

Please provide the type of audit performed. (Check all that apply and note date.)

☐ CPA/5500 _____ ☐ CPA/Performance _____

☐ Carrier/MGU _____ ☐ SAS 70 – Type 2 _____

Reporting

Please provide the contact information for key personnel involved in generating and submitting monthly carrier reports.

Name	Title	Years of Experience	Phone	E-mail

Please provide a sample reporting package including 50% notification, trigger diagnosis report, pending claim report, large case management notes and an aggregate report.

Do you have the ability to provide large claim notification based on diagnosis? ☐ Yes ☐ No *If no, please explain.*

Are claims paid outside of the plan document or stop loss contact indicated in your reporting package? ☐ Yes ☐ No *If no, please explain.*

Do you have the ability to submit reports to the carrier in an electronic format such as:

☐ Excel file ☐ CSV ☐ Flat file *If no, please explain:*

Do you have the ability, without incurring additional outside consulting or vendor charges, to create an ad hoc query to your claims data if necessary and required by the carrier in order to adjudicate claims? ☐ Yes ☐ No *If no, please explain:*

Please describe your procedure for early notification of potentially large/catastrophic claims to the carrier?

Networks

Please provide information for each network utilized. *Please include any wrap networks.*

Network Name	Specialty	Percentage of Claims with Network Discount Applied	Average Provider Savings	Average Hospital Savings	In-Network Utilization Provider	In-Network Utilization Hospital

If the wrap network you utilize only affords a 5-10% discount, do you accept it? ☐ Yes ☐ No *If no, please explain.*

Please explain your out-of-network negotiation process.

Do any PPO networks apply multiple surgery, assistant surgery, etc. reductions to pricing? ☐ Yes ☐ No *If no, please explain.*
(Please provide network specific answers.)

How frequently do you update network discounts? _____

Medical Management and Cost Containment

MANAGEMENT AND STAFFING

Please provide the contact information for key personnel involved in generating and submitting monthly carrier reports.

Name	Title	Years of Experience	Phone	E-mail

MEDICAL MANAGEMENT SERVICES

What medical management and cost containment services do you offer?

Please describe how you integrate utilization management, complex case management, disease management and cost containment services:

Please describe your criteria regarding a referral for medical necessity/peer review.

Please describe what triggers a referral to case management review. Please include a description for those cases that are not identified by utilization review intake.

Please describe your complex case management program.

Please describe your internal communication between utilization review, case management, claims and finance.

Please provide the following information:

Service	Internal	Vendor Name and Contact Information	URAC Accredited?
Utilization review/Concurrent review			
Case management			
Complex case management			
Transplants			
Oncology			
Neonatology			
Discharge planning			
High risk maternity management			
Home health care			

Service	Internal	Vendor Name and Contact Information	URAC Accredited?
Peer review / medical necessity review			
Pre-certification of ambulatory surgery			
Pre-certification of high cost diagnostic tests			
Pre-certification of in-patient hospital confinements			
Retrospective review			
Disease management			
Chronic Kidney Disease			
ESRD (pre/active dialysis)			
Dialysis			
Heart Disease			
Asthma			
Behavioral Health			
Wellness program			
Specialty pharmacy			
Predictive modeling			

Please provide network information for each specialty network utilized. This includes transplants, behavioral health, maternity management, specialty pharmacy, home health care, etc.

Network Name	Specialty	Percentage of Claims with Network Discount Applied	Average Savings	In-Network Utilization Provider	In-Network Utilization Hospital

Pharmacy Benefit Manager

Please provide the following information:

PBM Name	Pharmaceutical Data Integrated into Utilization Review (Y/N)	Pharmaceutical Data Integrated into Case Management (Y/N)	Individual Claim Data Loaded into System from PBM (Y/N)

What is the process for pre-authorization of high-cost pharmaceuticals? *Please include biomedicals, bioidenticals and injectables.*

Do your pharmacy or hospital contracts include negotiated rates for hospital administered (inpatient) prescription drugs?

☐ Yes ☐ No *If yes, are these charges carved out? Please describe.*

Please describe how you engage the stop loss carrier when specialty drugs will incur large losses.

Premium Accounting

Please provide the following information for key accounting personnel:

Name	Title	Years of Experience	Phone	E-mail

Can you provide census and premium funding data electronically? ☐ Yes ☐ No *If no, please explain.*

Can you accept and send ACH financial transactions? ☐ Yes ☐ No *If no, please explain.*

Please provide a description of the security of client funds:

How often do you generate premium billings for insurance coverage?_____

When are premium reminder notices sent?_____

For non-payment of stop loss premiums, how are lapse notices sent? _____

Can you remit premiums to the stop loss carrier net of commissions? ☐ Yes ☐ No *If no, please explain.*

Please describe your audit process for premium accounting.

Claim Funding

Are the claim funding accounts general claim accounts or a plan sponsor owned account? _____

If applicable, who balances the general fund? Please provide their contact information below.

Name	Title	Years of Experience	Phone	E-mail

Employer Stop Loss

Describe your process for filing claims to the stop loss carrier.

Please list the stop loss carriers with whom you currently have business.

Name of Carrier	Amount of Cases	Amount of Annual Premium	Number of Employee Lives

Do you have underwriting authority for any stop loss carrier? ☐ Yes ☐ No *If yes, please explain and list which companies for whom you have underwriting authority.*

Has any carrier terminated their relationship with you within the past 5 years? ☐ Yes ☐ No *If yes, please explain.*

Sales and Marketing

What is your target market for self-funding?

Do you specialize in an industry? ☐ Yes ☐ No *If yes, please explain.*

What percentage of business is written on a direct basis versus an outside broker?

Direct _____**%** Broker _____ % Other _____ %

When do you disclose fees, compensation, etc. to the client?

☐ In the initial proposal ☐ In the service agreement ☐ 5500 filing ☐ Other, please explain:

How many new clients/lives have you **SOLD** within the past year?

Employee Count	Number of Self-Funded Clients	Lives
0 - 100		
101- 300		
301 - 500		
501 - 700		
700 - 1000		
1001+		
Total		

Attachments

Please use this checklist and provide the following attachments. If any items cannot be provided, please explain:

- ☐ Copy of errors and omissions policy
- ☐ Copy of professional liability policies
- ☐ Copy of current Fidelity bond
- ☐ Copy of TPA, MGA, agency, broker and agent license for each applicable state
- ☐ Premium account flowchart/description
- ☐ Claim account flowchart/description
- ☐ Samples of claims reports available to insurers and/or reinsurers
  (incl. 50% report, trigger diagnosis report, pending claims report, large case management notes and an aggregate report.)
- ☐ Sample plan document

Explanation of items not provided:

I certify that the information on this application is accurate to the best of my knowledge and belief. I also understand that routine inquiries, including credit inquiries, may be made of any or all of the individuals and firms noted herein as references.

Signature: _____ Date: _____

Print Name: _____

Title: _____

Please return this form via secured e-mail.