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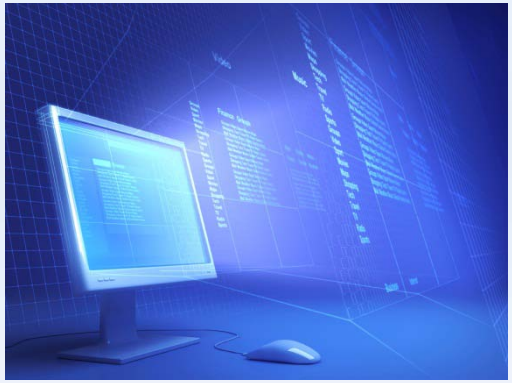
The ERRP Center

ERRP Reimbursement Training
Claim Lists:
Dos and Don’ts

Welcome to the Claim Lists:

Dos and Don’ts Webinar

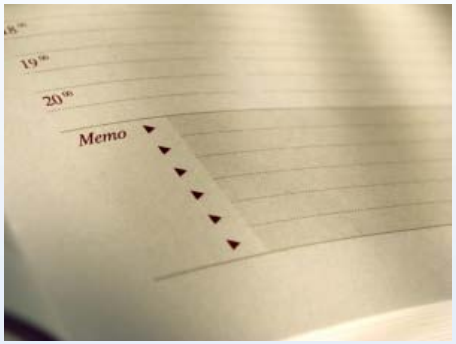


The following training is designed to assist in submitting an error-free Claim List resulting in a successful reimbursement.

Housekeeping

- Webinar will last approximately 90 minutes
- Presentation will last approximately 1 hour
- Questions during the presentation may be submitted using the Q&A feature located in the panel to the right of the presentation
- In addition, at the end of the presentation, the phone lines will be opened for live questions lasting approximately 30 minutes
- Questions may be emailed to education@errp.gov before or after the Webinars
- Both answered and unanswered questions will be used to enhance education and training materials on the ERRP Public Website http://www.errp.gov/
- Limited capacity of 250 Participants/per webinar. Webinars will be held:
  - July 19, 2011 10 am and 2 pm Eastern Time
  - July 21, 2011 10 am and 2 pm Eastern Time

Agenda



- ❑ General Claim List Submission
- ❑ Specific Claim Detail Fields
- ❑ Reimbursement Timeframes
- ❑ Q&A Period

Agenda

General Claim List Submission

- Cost Adjustments
- Claims Prior June 1, 2010
- Claim List File Formatting
- Data Types
- Claim Adjustments
- Trailer Amounts Matching Summary Cost Data

General Claim List Submission
Cost Adjustments

❑ Cost Adjustment Amount Field

- To report post point-of-sale price concessions (for example, rebates from drug manufacturers), ***not*** point-of-sale price concessions.

❑ When and Where to Report Price Concessions

- Report on the Cost Adjustment Layout
- Must be reported at the level of the Member ID/Member Group ID combination

Refer to http://errp.gov/download/ERRP_Allocating_Price_Concessions.pdf for additional information.

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General Claim List Submission
Cost Adjustments

- There are two Cost Adjustment record types, the CA Cost Adjustment Layout and the CB Cost Adjustment Layout.
  - The CA Cost Adjustment Layout (CA record type) is used to report price concessions for claims with an Incurred Date ***on or after*** June 1, 2010.
  - The CB Cost Adjustment Layout (CB record type) is used to report price concessions for claims with an Incurred Date ***before June 1, 2010.***

- Plan Sponsors with plans that have a start date prior to June 1, 2010 and have cost adjustment claim records for claims with an Incurred Date before June 1, 2010 must report those cost adjustment claims separately from cost adjustments on claims incurred on or after June 1, 2010.

- The Cost Adjustment records are ***only required*** when cost adjustments apply. A Claim List does not need to contain this record layout to be considered complete.

General Claim List Submission
Claims Prior June 1, 2010

Claims incurred before June 1, 2010

- Count only towards the cost threshold
- Are NOT eligible for reimbursement
  - Since claim amounts incurred before June 1, 2010 that exceed the Cost Threshold are not eligible for reimbursement, pre-6/1/2010 claim amounts that exceed the Cost Threshold per unique person must be added in the Limit Reduction field on the Cost Data Entry Edit page.
  - Prior to June 1, 2010, eligible claims up to and including the claim that exceeds the Cost Threshold per unique person must be reported on the Claim List. Add the amounts in excess of the Cost Threshold per unique person to the Limit Reduction field, which will enable the cost amounts reported on the Claim List to match the Summary Cost Data.

General Claim List Submission
Claims Prior June 1, 2010

Example:

- Assumptions:
  - ✓ Early Retiree has claims totaling $25,000 prior to June 1, 2010. On or after 6/1/2010 the Early Retiree incurs an additional $11,000 in Early Retiree claims.
  - ✓ No post point-of-sale price concessions and therefore no Cost Adjustment records are involved
  - ✓ No Costs Paid By Early Retiree are involved

Cost Paid by Plan Amount	Prior to June 1, 2010 Total Claim Amount	After June 1, 2010 Claims Total	Limit Reduction Amount
$ 36,000.00	$ 25,000.00	$ 11,000.00	$ 10,000.00

The Cost Paid by Plan amount, for the Early Retirees is $36,000 ($25,000 + $11,000). The dollar amount that must be reported in the Limit Reduction field in the ERRP SWS is $10,000 above the threshold. ($25,000 claims prior to June 1, 2010 - $15,000 which is the threshold reduction).

In Summary

- ✓ Exceeding Cost Threshold ($15,000)→ Excess Dollar Amount Limit Reduction (ERRP SWS Cost Summary)

General Claim List Submission
Claims Prior June 1, 2010

For Plan Years starting before June 1, 2010				
Early Retiree	**Costs Paid Before 6/1/2010**	**Threshold Reduction**	**Paid Amount Over Threshold**	**Amount Added to Limit Reduction***
Robert Smith	$53,000.00	$15,000.00	$38,000.00	$38,000.00
Sally Jane	$63,000.00	$15,000.00	$48,000.00	$48,000.00
Chris Jones	$20,000.00	$15,000.00	$5,000.00	$5,000.00
Totals	**$136,000.00**	**$45,000.00**	**$91,000.00**	**$91,000.00**

* **Add the accumulated excess of the Early Retirees' Threshold Reduction to the Limit Reduction Field. This amount must be added to the existing value in the Limit Reduction field if applicable.**

General Claim List Submission File Formatting

❑ Correct Comma Placement

These consecutive commas indicate blank fields with correct comma placement.

```
DP,1234567890,20100101,123456789A, Plan A,1142781942,N,20110816,19480128,1,7900,1,20100706,20100706,11,99213,,,,,1,6211,,,,UN,1,XX,1234567890,17356,7900
DP,1234567890,20100101,123456789A, Plan A,1142781953,N,20110816,19480128,1,0,3,20100716,20100716,11,XXXXX,,,,,1,6211,,,,UN,1,XX,1234567890,17356,26000
DP,1234567890,20100101,123456789A, Plan A,1142781953,N,20110816,19480128,1,0,4,20100716,20100716,11,99100,,,,,1,6211,,,,UN,1,XX,1234567890,17356,0
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CB,1234567890,20100101,123456789A, Plan A,19480128,1,29
FT,1234567890,20100101,1,3,9,28,8900,282,,,,,8
```

General Claim List Submission File Formatting

- **Grouping of Claim Lines**
  - Claims from the same Early Retiree do not have to be grouped together or placed in any particular order
- **SWS and mainframe Claim List Layout**
  - Claim line item details from the same claim must be together
- **Mainframe Claim List Layout**
  - Lines immediately following the claim header must be claim lines associated to the claim header

Cumulative Claim List Reminder

- ✓ All applicable Claim List Layouts (Professional, Institutional, Prescription, Cost Adjustment) must be submitted in **one Claim List.**
- ✓ Each submitted Claim List replaces the previously submitted Claim List for that plan year.

General Claim List Submission Data Types

Data Type	Description
Required	Field must be completed with valid values.
Situational	Field must be completed with valid values in certain situations as described in the "Description/Value" column.
Optional	Field is not required and may be left blank if not available/not applicable.

Example of an Invalid Value within a Field:

✓ (R) Service Location Zip Code = 21987 ← Valid Value
✗ (R) Service Location Zip Code = 99999 ← Invalid Value
✗ (R) Service Location Zip Code = [Blank] ← Invalid Value

✓ (R) Member Gender = 1 ← Valid Value
✗ (R) Member Gender = F ← Invalid Value

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General Claim List Submission Data Types

Data Type	Description	Example
A*	▪ Must be Alphabetic character(s)	Smith
A/N*	▪ Must be alphabetic, numeric, or special characters (unless otherwise noted) or ▪ Combination of alphabetic and numeric character(s)	S1234
N**	▪ Must be Numeric character(s)	6875

NOTE: When using applications such as Excel, numeric and alphanumeric fields must be formatted as text to eliminate truncation of numbers (e.g., zip codes starting with zero, etc.)

* Can be blank only if not required (R) field

** Cannot be blank but must be zero filled if field is required. Also cannot contain decimals, negative values, or any other non-numeric values.

General Claim List Submission
Claim Adjustments

When reporting a claim that was adjusted, it is important to note that the ERRP Center requires that only the final total amount paid after the adjustment be reported. The claim detail lines included in the Claim List must contain the final adjusted amounts. Reporting the adjustment in multiple claim lines will adversely affect totals and potentially cause claim list errors.

For example:

If the original claim was reported to the ERRP Center with a Cost Paid by Plan Amount of $100, and the claim was adjusted at a later date for an additional $50 for a total Cost Paid by Plan of $150, the subsequent claim list submission must include one claim line item for $150—not one claim line item for the original $100 and an additional claim line item for the total adjusted amount of $150. That would incorrectly total $250.00 instead of expected $150.00.

General Claim List Submission
Claim Adjustments Example

EXAMPLE - Original Claim Submission EXAMPLE	
Claim Number	Cost Paid by Plan
123456789	$100.00 (ORIGINAL PAID AMOUNT)
Total Cost Paid by Plan	**$100.00**

EXAMPLE – Claim Adjusted upward for additional $50.00 Claim Submission – INCORRECT EXAMPLE	
Claim Number	Cost Paid by Plan
123456789	$100.00 (ORIGINAL PAID AMOUNT)
123456789-0	$150.00 (TOTAL PAID AMOUNT)
Total Cost Paid by Plan	**$250.00**

EXAMPLE – Claim Adjusted upward for additional $50.00 Claim Submission – CORRECT EXAMPLE	
Claim Number	Cost Paid by Plan
123456789-0	$150.00 (TOTAL PAID AMOUNT)
Total Cost Paid by Plan	**$150.00**

General Claim List Submission
Trailer Amounts Matching Summary Cost Data

- **Total Cost Paid by Plan (FT09)**
  - Subtracting the Total Cost Adjustment amount in this Trailer record from this Total Cost Paid by Plan amount **must equal** the amount entered in the Cost Paid By Plan field in the Summary Cost Data in the ERRP Secure Website.
- **Total Cost Paid by Early Retiree (FT10)**
  - Must equal the amount entered in the Cost Paid By Early Retiree field in the Summary Cost Data in the ERRP Secure Website.
- **Total Cost Adjustment (FT11) = Total Cost Adjustment Fields**
  - The aggregated total of all Cost Adjustment Amount fields (in the Cost Adjustment records CA06 and CB06) included in the Claim List. Reminder: CA06 – Cost Adjustment Amount (on or after June 1, 2010) and CB06 – Cost Adjustment Amount (before June 1, 2010)
- **Total Number of Unique Retirees (FT06)**
  - Count of the unique Early Retirees within the Claim List identified by Unique Person identifier (UPI). **Note:** If there is one unique person (i.e. one UPI) with two Member ID/ Group ID combinations, the unique retiree count must just be one.

General Claim List Submission Dos and Don'ts

Don't	report pre 6/1/2010 cost adjustments on the CA record
Do	**remember to report cost adjustments and price concessions using the cost adjustment record layout**
Don't	forget that Cost Adjustment reporting is only necessary where applicable
Do	**include the excess claim paid amount prior to 6/1/2010 over the threshold in the limit reduction**
Don't	forget to provide data for ALL required fields including zeros for numeric values when applicable
Do	**provide data for ALL required fields**
Don't	forget that all Claim List layout records (Prof, Inst, Rx, and Cost Adjustment) must be submitted in ***one*** Claim List
Do	**make sure Claim List Trailer amounts match Summary Cost Data as applicable**
Don't	report an adjusted claim that was adjusted to a zero or negative paid amount - omit from Claim List instead
Do	**provide only the final total amount when reporting adjusted claims**
Don't	include commas or special characters in the Claim List and ERL filename (spaces are accepted) otherwise the file will be rejected
Do	**accumulate Thresholds on an individual Early Retiree (UPI) basis**

Specific Claim Detail Fields From Required to Optional

Specific Claim Detail Fields

- From Required (R) to Optional (O)
- Additional Field Requirements:
  - ✓ Claim Number/ Claim Line Item Number
  - ✓ Diagnosis Code and Qualifier
  - ✓ Provider ID and Qualifier
  - ✓ Service Location Zip Code
  - ✓ Type of Bill
  - ✓ Bundled Services

New Changes to Specific Claim Detail Fields From Required to Optional

Field Name	Field No.	Data Type	Required/ Optional/ Situational	Description
Place of Service	DP08	**A**/N	**O**	Code value used to identify the location/facility where the service was rendered.
Quantity Qualifier	DP19 DI28	A/**N**	**O**	Code value used to identify the type of measurement used in the Unit Quantity field. Visit ERRP.gov Reference Materials for the updated Claim List Layout options in this field.
Unit of Quantity	DP20 DI29	N	**O**	Quantity of services/product delivered.
Unit of Measure	DX19	A/**N**	**O**	Code value specifies the type of Quantity Reported for prescription claims. Visit ERRP.gov Reference Materials for the updated Claim List Layout options in this field.
Quantity Dispensed	DX20	N	**O**	Quantity of services/products delivered for prescription claims.
Prescriber Provider ID Qualifier	DX21	**A**/N	**O**	Code value that defines the type of Prescriber Provider ID reported in the Prescriber Provider ID field for prescription claims.
Prescriber ID	DX22	**A**/N	**O**	ID of the Prescriber for prescription claims.

Bold *indicates the Data Type has been updated.*

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Specific Claim Detail Fields
Additional Field Requirements – Claim/Line Number

Field Name	Field No.	Data Type	Required/ Optional/ Situational	Description
Claim Number	HP04 HI04 HX04	A/N	R	Unique ID of a given claim that is assigned by the claim processing system or as defined by the Plan Sponsor.
Claim Line Item Number	DP05 DI05 DX04	N	R	Line Number uniquely identifying the Service line associated within a claim.

- Both Claim Number and Claim Line Item Number are required fields.
- If each claim number and claim line item number is unique it will be traceable back to Claim List Response File edits. Without this level of unique traceability, the value of the Claim List Response File will be diminished.
- For audit purposes, the methodology for the assignment of the Claim Line Item Numbers must be retained by the Plan Sponsor.
- If Claim Line Item Numbers are not assigned by the claim processor, the Plan Sponsor must assign such numbers (e.g. default to 01, 02, etc.).
- ERRP Center recommends a Claim List contain only unique Claim Numbers, even if this means reassigning Claim Numbers assigned by the claim processing system as necessary.

Specific Claim Detail Fields
Additional Field Requirements – Diagnosis Code

Field Name	Field No.	Data Type	Required/ Optional/ Situational	Description
Principal Diagnosis Code	DP15 DI10	A/N	R	Primary diagnosis code associated with the Member's condition.
Other Diagnosis Codes	DP16, DP17, DP18, DI11, DI12, DI13, DI14, DI15	A/N	O	Other diagnosis code associated with the Member's condition.

- Must be a valid ICD code.
- The Principal Diagnosis Code is a required field. If not provided the entire claim list will reject. If the Principal Diagnosis Code is not available, omit this claim from the Claim List.
- Other than trailing spaces and/or one decimal, special characters are not allowed.
- The presence of the decimal is optional for ICD-9; however the decimal is not allowed for ICD-10.
- ICD-9 code length must be at least 3 contiguous characters and no greater than 5 contiguous characters (when submitted without a decimal) or at least 4 contiguous characters and no greater than 6 contiguous characters (when submitted with a decimal).
- ICD-10 code length must be at least 3 contiguous characters and no greater than 7 contiguous characters.
- Don't forget to provide the associated ICD Qualifier fields to indicate if the ICD diagnosis or procedure code provided is an ICD-9 code (1) or ICD-10 code (2).

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Specific Claim Detail Fields
Additional Field Requirements – ICD Procedure Code

Field Name	Field No.	Data Type	Required/ Optional/ Situational	Description
Principal ICD Procedure Code	DI16	A/N	S	Principal procedure performed within an institutional setting.
Other ICD Procedure Codes	DI17 DI18 DI19 DI20 DI21	A/N	O	Other procedures performed within an institutional setting.

- The Principal ICD Procedure Code is required only when a procedure is performed. If no procedure is performed, the field is optional. Consequently, the field is defined as S (situational).
- Other than trailing spaces and/or one decimal, special characters are not allowed.
- The presence of the decimal is optional for ICD-9; however the decimal is not allowed for ICD-10.
- ICD-9 code must be 3 - 4 contiguous characters (without decimals) or 4-5 contiguous characters (with decimals).
- ICD-10 code must be 7 contiguous characters.

Specific Claim Detail Fields
Additional Field Requirements – Provider ID

Field Name	Field No.	Data Type	Required/ Optional/ Situational	Description
Rendering Provider ID	DP22	A/N	R	ID of the Provider/Supplier rendering the services to the Member.
Rendering Provider ID Qualifier	DP21	A/N	R	Code value used to identify the type of Provider ID reported in the Rendering Provider ID field. XX = NPI, 24 = EIN, 34 = SSN, G2 = Plan Provider ID, 99 = Other
Facility Provider ID	HI12	A/N	R	ID of the Facility where item/service was provided.
Facility Provider ID Qualifier	HI11	A/N	R	Code value that defines the type of Provider ID reported in the Facility Provider ID field. XX = NPI, 24 = EIN, 34 = SSN, G2 = Plan Provider ID, 99 = Other
Prescription Service Provider	HX11	A/N	R	ID of the Pharmacy or Supplier for prescription claims. In most cases, will be the NABP number.
Prescription Service Provider ID Qualifier	HX10	A/N	R	Code value that defines the type of Service Provider ID reported in the Prescription Service Provider ID field. XX = NPI, 07 = NABP, 24 = EIN, 34 = SSN, G2 = Plan Provider ID, 99 = Other

- Since the Provider ID field is required, the Provider ID Qualifier field is also required to inform the ERRP Center about the type of data contained in the various Provider ID fields (e.g. Rendering Provider ID, Facility Provider ID, and Prescription Service Provider ID). If the Provider ID field is not available, omit this claim from the Claim List.

Specific Claim Detail Fields
Additional Field Requirements – Zip Code

Field Name	Field No.	Data Type	Required/ Optional/ Situational	Description
Service Location Zip Code	DP23 DI30 DX23	N	R	US Zip Code of the location where service was rendered.

- The Service Location Zip Code field is required on all claims submitted to the ERRP Center on a Claim List in order to ensure that the service or item was furnished in the United States, pursuant to the policy guidance published on September 28, 2010.
- Further, for derived health benefit costs reported by a Plan Sponsor pursuant to capitated arrangements, the Service Location Zip Code is important since it may be used to determine whether the derived cost amount that the Plan Sponsor submits for a health benefit item or service is reasonable in light of the specific market that the insurer is serving.
- If unable to provide the Service Location Zip Code for a claim, the claim is not eligible for reimbursement through the ERRP and must be omitted from the Claim List.

Specific Claim Detail Fields
Additional Field Requirements – Type of Bill

Field Name	Field No.	Data Type	Required/ Optional/ Situational	Description
Type of Bill	HI10	A/N	R	National Uniform Billing Committee (NUBC) Code value which identifies the specific type of bill for institutional claims. Typically for industry standard, Type of Bill is a four character field, with the first character being a leading zero. For ERRP purposes it is a three character field; drop the leading zero (first character). For ERRP, the first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence.

- If the Type of Bill information is available for your Institutional claims, report the correct Type of Bill code.
- If the Type of Bill is not available for your Institutional claims, for inpatient acute hospital bills, populate this field with a value of "999."
- When Type of Bill is not available for all other Institutional claims, populate this field with "000."
- When the Type of Bill field is populated with a "999" or any value starting with "11", the Admission Date is the incurred date. Otherwise, the From Date is the incurred date.

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Specific Claim Detail Fields
Additional Field Requirements – Bundled Services

- **The ERRP Center allows reporting bundled Professional and Institutional services.**

  - **Institutional**

    For an institutional claim, to report health benefit items or services for which payment by the Plan Sponsor (or plan) to a provider was bundled, the value 'XXXX' must be used in the Revenue Code field and reported on a separate claim line detail record. Also, one or more claim line detail records, immediately following the claim line with the 'XXXX' entered in the Revenue Code field, must include the details about the items and/or services that were paid by the plan in the bundled payment. Do so by making Item Plan Paid Amount (DI31) equal to $0 AND by populating one or more of the following fields with a valid value:

    - Principal ICD Procedure Code (DI16)
    - Revenue Code (DI22)
    - Procedure Code (DI23)

Note: Without one or more of these fields populated with valid values on subsequent lines to identify the bundled services, the claim, and therefore the entire Claim List, will be rejected.

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Specific Claim Detail Fields
Additional Field Requirements – Bundled Services

➢ Institutional - continued

- ❑ Multiple claim detail lines for a single claim may have the 'XXXX' Revenue Code; however, the claim line with 'XXXX' must always be followed by a claim detail line(s) that has one or more of the previously mentioned fields (Principal ICD Procedure Code, Revenue Code, and Procedure Code) and an Item Plan Paid Amount equal to $0 before the next bundled ('XXXX' Revenue Code) line.

- ❑ The Item Plan Paid Amount for the claim detail line with the 'XXXX' Revenue Code value should be greater than $0 if the Plan Sponsor (or plan) made a bundled payment to a provider for health benefit items or services.

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Specific Claim Detail Fields
Additional Field Requirements – Bundled Services

Example of Bundled Institutional Service reported <u>correctly</u>.

Claim No.	Line	Revenue Code	ICD Procedure	HCPCS/CPT/HIPPS	Item Plan Paid Amount
123	001	XXXX			15000
123	002	0121			0
123	003	0020			20000
123	004	XXXX			15000
123	005			E2750	0

- Correct Example: There is at least one detail line reported for a given claim with Principal ICD Procedure Code (DI16), Revenue Code (DI22), and/or Procedure Code (D123) and an Item Plan Paid Amount equal to $0 after an ‘XXXX’ and before the next ‘XXXX’ or the end of claim detail lines.

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Specific Claim Detail Fields
Additional Field Requirements – Bundled Services

Example of Bundled Institutional Service reported incorrectly.

Claim #	Line	Revenue Code	ICD Procedure	HCPCS/CPT/HIPPS	Item Plan Paid Amount
123	001	XXXX			15000
123	002	0121			0
123	003	0250			0
123	004	XXXX			15000

- Incorrect Example: There is no detail line, with Principal ICD Procedure Code (DI16), Revenue Code (DI22), and/or Procedure Code (DI23) and an Item Plan Paid Amount equal to $0, after the last 'XXXX' detail line and before the end of claim detail lines for the given claim.

Specific Claim Detail Fields
Additional Field Requirements – Bundled Services

➢ Professional

- ❑ For a professional claim, to report health benefit items or services for which payment by the Plan Sponsor (or plan) to a provider was bundled, the value 'XXXXX' must be used in the Procedure Code (DP09) field and reported on a separate claim line detail record.
- ❑ Also, one or more subsequent claim line detail records immediately following the claim detail record with the value 'XXXXX' in the Procedure Code (DP09) field, must include the details about the items and/or services that were paid by the plan in the bundled payment.
- ❑ Do so by making the Item Plan Paid Amount equal to $0 AND by populating the Procedure Code field with a valid value.

NOTE: Without a specific Procedure Code on a subsequent detail line to identify the bundled service(s), the claim, and the entire Claim List, will be rejected.

Specific Claim Detail Fields
Additional Field Requirements – Bundled Services

➢ Professional – Continued

- ❑ Multiple claim detail lines may have the ‘XXXXX’ Procedure Code; however, the ‘XXXXX’ must be followed by a claim detail line with a valid Procedure Code along with an Item Plan Paid Amount equal to $0 before the next bundled (‘XXXXX’ Procedure Code) line.
- ❑ The Item Plan Paid Amount for the claim detail line with the ‘XXXXX’ Procedure Code value should be greater than $0 if the Plan Sponsor (or plan) made a bundled payment to a provider for health benefit items or services.

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Specific Claim Detail Fields
Additional Field Requirements – Bundled Services

Example of Bundled Professional Service reported correctly.

Claim #	Line	Procedure Code	Item Plan Paid Amount
123	001	XXXXX	11000
123	002	01210	0
123	003	99250	0
123	004	XXXXX	20000
123	005	99213	0
123	006	33250	0

- Correct Example: There is at least one detail line with Procedure Code (DP09) and an Item Plan Paid Amount equal to $0 after an 'XXXXX' detail line and before the next detail line with a Procedure Code of 'XXXXX' or the end of claim detail lines.

Specific Claim Detail Fields
Additional Field Requirements – Bundled Services

Example of Bundled Professional Service reported <u>incorrectly</u>.

Claim #	Line	Procedure Code	Item Plan Paid Amount
123	001	XXXXX	11000
123	002	01210	0
123	003	99250	0
123	004	XXXXX	20000

- Incorrect Example: There is no detail line, with Procedure Code (DP09) and an Item Plan Paid Amount equal to $0, after the last 'XXXXX' detail line and before the end of claim detail lines for the given claim.

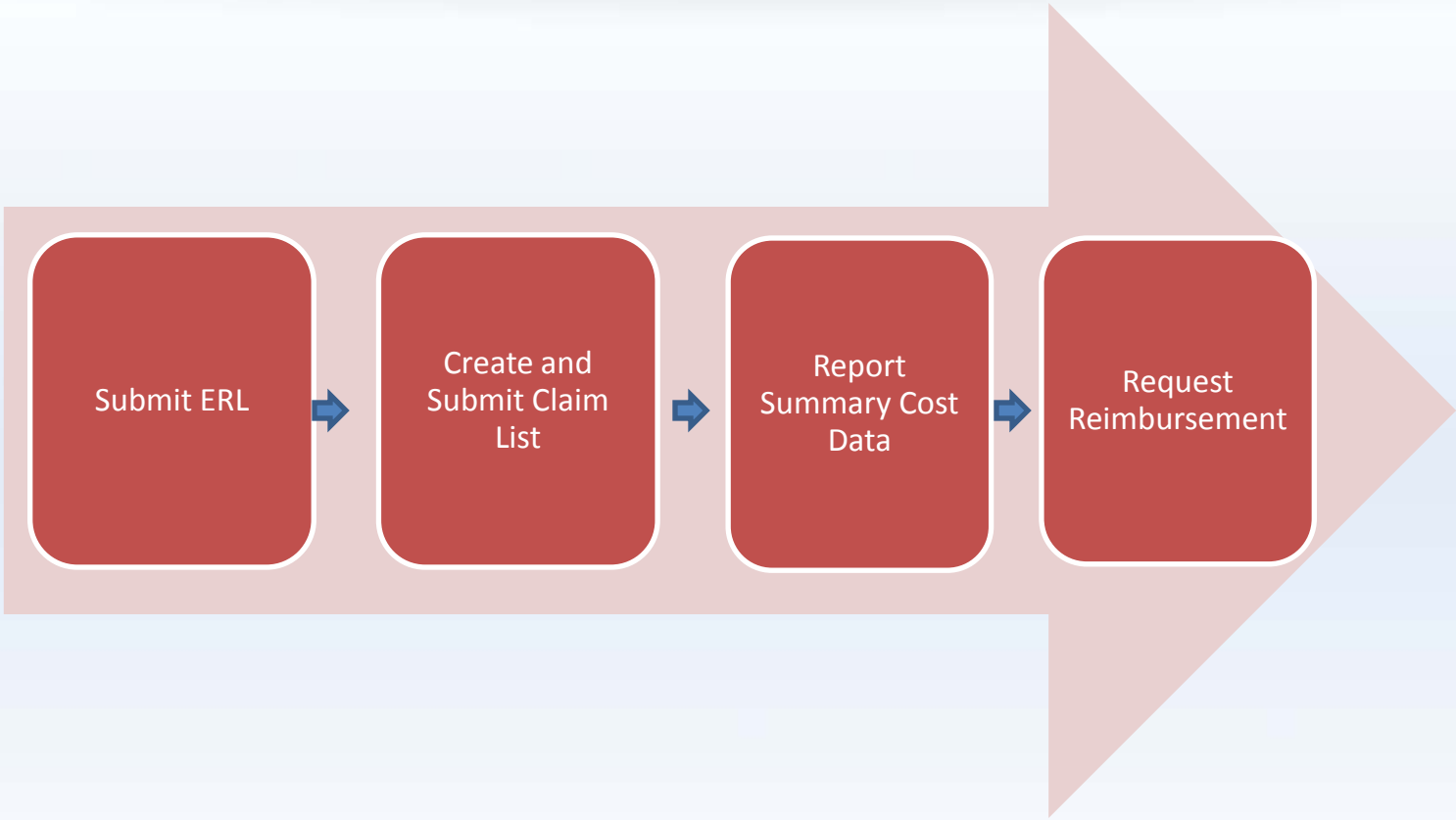
General Claim List Submission Dos and Don'ts

Do	make sure you include ALL required fields on your Claim List
Do	provide Type of Bill field if available, if not use default values as applicable
Do	adhere to requirements for reporting bundled services
Do	provide the ICD Qualifier on each line to advise if Diagnosis code/ICD Procedure code is ICD-9 or ICD-10
Do	provide the associated Prov ID Qualifier field on each claim
Do	provide the Service Location Zip Code
Don't	leave required Provider ID fields blank

Important Timeframes

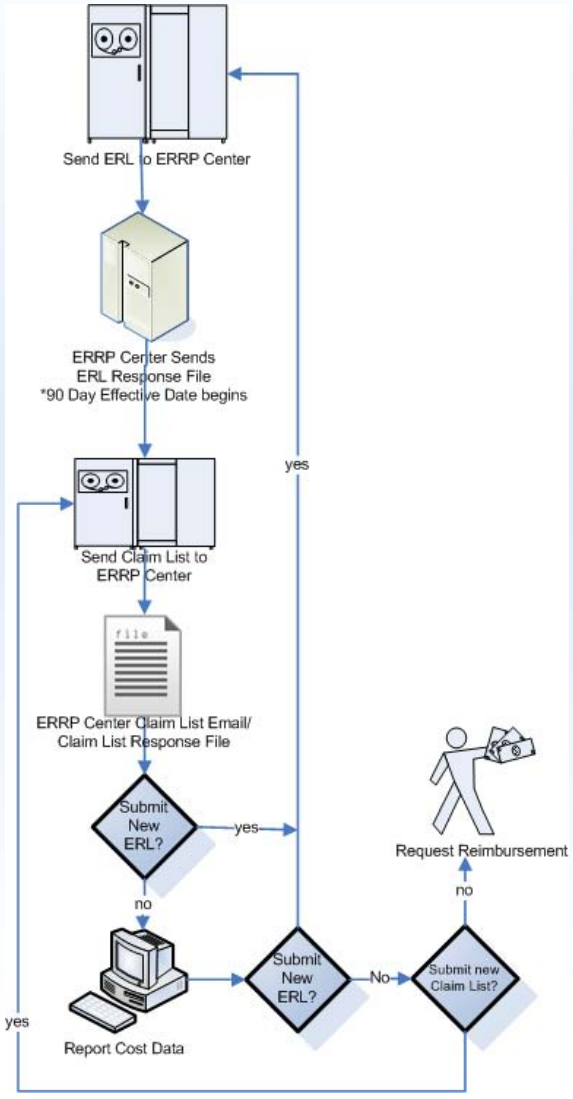
- Reimbursement Flow
- Claim List Quality Assurance Review
- March 30, 2012
- Claim List Response Files

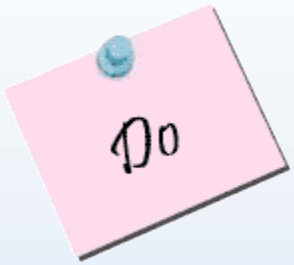
Important Timeframes Reimbursement Flow



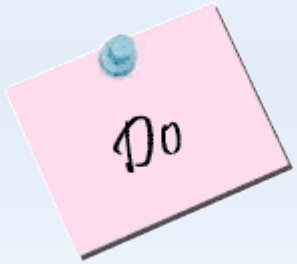
ERL Response Files expire 90 days after creation, or at the time a reimbursement request is submitted (whichever is first), to ensure that Plan Sponsors have up-to-date information about the ERRP-eligibility of individuals covered by their plan.

Important Timeframes Reimbursement Flow





Submit a revised ERL (if necessary), the Claim List and Summary Cost Data will also need to be updated and resubmitted.



Submit a revised Claim List (if necessary), the Summary Cost Data will also need to be updated and resubmitted.

ERL Response Files expire 90 days after creation

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Important Timeframes
Claim List Quality Assurance Review

- Claim Lists associated with a reimbursement request which were submitted after April 2011 and before the implementation of the Claim List Response File implementation will be subject to a quality review to ensure that reimbursement requests comply with existing program requirements.
- ERRP Center will verify that the data reported in the Claim List substantiates the data in the associated Summary Cost Data and reimbursement request.
- Specifically, we make sure the:
  - ✓ Claim List is formatted properly
  - ✓ Amounts in the Total Cost Paid by Plan and Total Cost Paid by Early Retiree fields in the Claim List Trailer Record match the amounts in the Cost Paid by Plan (minus applicable Cost Adjustments) and Cost Paid by Early Retiree fields reported in the Summary Cost Data in the Secure Website; and
  - ✓ Required fields are populated with valid data.

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Important Timeframes
Claim List Quality Assurance Review

- If the Claim List passes the quality assurance review, it will be included in the next available weekly payment batch, assuming the Plan Sponsor is otherwise in good standing.
- Claim Lists that do not pass the quality assurance review will be rejected and the corresponding reimbursement request will be cancelled.
- When a reimbursement request is cancelled, the following will occur:
  - ✓ Email notification to AR and AM providing reasons for Claim List rejection
  - ✓ Claim List status changed from 'Received' to 'Invalid' in ERRP SWS
  - ✓ ERL Expiration Date will be reset back to the Expiration Date applicable as of the day the Reimbursement Request was submitted, unless a subsequent ERL was provided after the reimbursement request was submitted.

  For example, an ERL was submitted with a Response File Expiration Date of 8/15/2011. A reimbursement request was submitted on 7/5/2011 which expired the ERL, setting the ERL Response File Expiration Date on the ERRP SWS to 7/5/2011. When the reimbursement request is cancelled, the ERL Response File Expiration Date will be reset to the original date of 8/15/2011.

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Important Timeframes
Claim List Quality Assurance Review

- If a Plan Sponsor is notified that its reimbursement request is cancelled, it may submit a new, corrected reimbursement request after:
  - ✓ updating and submitting a new Early Retiree List (if applicable)

    NOTE: Ensure the ERL is not about to expire since each ERL expires 90 days after its corresponding ERL Response File is created.

  - ✓ revising and resubmitting the Claim List
  - ✓ updating and submitting the Summary Cost Data
- A Plan Sponsor must not submit a Claim List until it is reasonably confident that the Claim List is error-free.
- Each new reimbursement request will be reviewed by ERRP in the order it is received, based on the date of request.

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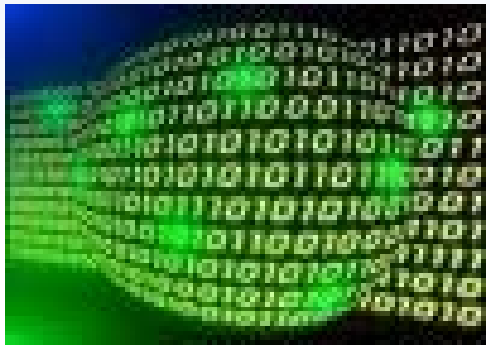
Important Timeframes
Claim List Response Files

- ERRP Center originally communicated that Claim List Response Files would begin in August however that timeframe will be rescheduled.
- Until such time when Claim List Response files are available; the ERRP Center will provide Plan Sponsors feedback from the Claim List Quality Assurance Reviews.
- There are significant differences between the information the Plan Sponsor will receive as a result of the Claim List Quality Assurance Review process and the information to be received in the Claim List Response File.



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Important Timeframes
Claim List Response Files

Claim List Quality Assurance Review

- ERRP Center will review Claim List in 'Received' status and associated with a reimbursement request—after reimbursement request is submitted.
- ERRP Center will send an email to Plan Sponsor AM and AR indicating claim list errors were found in the Claim List and the reimbursement request was cancelled.
- Plan Sponsor will review the error reason code message(s) in an email and search the Claim List for the error condition(s) and the record(s) with the applicable error(s).

Claim List Response Files

- ERRP Center will review each Claim List prior to Summary Cost Data submission.
- ERRP Center will send a detailed Claim List Response File to the Plan Sponsor the same way the Claim List was submitted (MF or SWS).
- ERRP Center will identify errors and advise which specific record number(s) and field(s) for which error(s) were found.
- Once a claim list passes editing, it will receive an 'Accepted' status.

Important Timeframes
Claim List Response Files

A Claim List passing the Claim List Quality Assurance Review may not necessarily pass the Claim List Response File processing.

With the introduction of the Claim List Response File, the Claim List will be scrutinized in detail for additional error conditions not included in the prior Claim List Quality Assurance Review.

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Important Timeframes
March 30, 2012

By **March 30, 2012**, to substantiate any Summary Cost Data submitted in prior reimbursement requests, all Plan Sponsors that have received reimbursement MUST:

1. **Submit an up-to-date and error-free Claim List after the Claim List Response File feature has been implemented, *AND***
2. **A corresponding reimbursement request**

General Claim List Submission Dos and Don'ts

Do	**correct errors identified in canceled reimbursement email**
Don't	wait too long after ERL Response file is received to request reimbursement – ERL expires in 90 days
Do	**submit an up-to-date and error-free Claim List and corresponding reimbursement request by 3/30/2012 to substantiate prior reimbursement requests**
Don't	submit Claim List until reasonably confident it is error-free

Opening up the phone lines for questions

- Questions received from various mediums:
  - ✓ Questions emailed to education@errp.gov
  - ✓ Webinar Q&A chat feature
  - ✓ Phone
- Questions answered are not in any particular order
- Goal is to provide as much information as possible so Plan Sponsor community will submit error-free Claim Lists

Contact Information

- **Early Retiree Reinsurance Program Center:**
  - Email: help@errp.gov
- **Call Toll-free:**
  - 877-574-ERRP (877-574-3777)
  - TTY for hearing impaired: 877-575-ERRP (877-575-3777)
- **ERRP Center is available:**
  - Monday through Friday, 10:30AM - 7:00PM, ET