Payment Policy: Clean Claim Reviews

Reference Number: CC.PI.04
Product Types: ALL
Effective Date: 11/2012
Last Review Date: 03/2025

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

This policy provides clarification on the facility billed charges that will be evaluated for the clean claim review process. It is the policy of the Company to comply with provisions set forth in federal guidelines and the contract with the state in which they operate and meets or exceeds all requirements and timeframes outlined in the contract. To comply with these provisions, the Company has the fiduciary obligation to review facility charges prior to payment on a clean claim basis, to help assure that such charges are free of potential defects or improprieties. The Company is also obligated to question whether facility charges comply with applicable billing standards. The purpose of this policy is to define the requirements for the proper application of the clean claim reviews.

Application

Institutional providers

Procedure

1. 1. The Company will review all hospital claims against established referral criteria to determine eligibility for high-dollar review.

   Claim referral criteria-BEST PRACTICE (Plan-Specific criteria may apply)
   Pre-payment or Post-payment
   Inpatient claims > $25,000 payable charges
   Inpatient claims that hit DRG outlier or % of billed charges
   Any other concerning claims

2. Using the above criteria, clean claim reviews will be conducted on those claims eligible. The clean claim review is performed using the itemized bill.

3. As a basis, the following criteria is utilized to complete the clean claim review:

   - Providers' billing complies with CMS, Health Plan Benefits, and if applicable state Medicaid coverage
   - Provider's billed charges must "reasonably and consistently" relate to their underlying costs (CMS Provider Reimbursement Manual Section 2203)
   - Charges must constitute reimbursable benefits under the applicable plan
   - Charges otherwise comply with Billing Guidelines promulgated through the CMS Provider Reimbursement Manual and the Uniform Billing Editor.
     - » The billed acuity level (rev code) complies with the underlying resource consumption threshold specified in the Uniform Billing Editor

KEY CATEGORIES OF ERRORS AND DISCREPANCIES:

- Billing errors - Charges not billed correctly (i.e. pharmaceutical and implant markups exceeding 8 times presumed cost, duplicate billing, data keying errors, inappropriate interval, component of a primary procedure, more than 24 hours of a daily therapy billed, etc.)
- Experimental/Plan Language Benefit – Experimental or investigational drug or treatments that are not reimbursable
- Incorrect Bill Type – Charges were submitted on wrong bill type, such as HCFA 1500
- Incorrect Charges – The price of an item or the number of items billed were perceived to have a discrepancy
- Insufficient Description – Service/item lacks enough detail to properly evaluate charge on its merit
- Level of care – Billed charges are not supported by the patient's acuity level
- Non-Covered – Service/item that is not covered by the Health Plan benefit
- Not Authorized – Service/item that is not authorized when authorization is required
- Quality of care issues – Never events and hospital acquired conditions
- Unbundling – Charges for supplies and services that are considered routine, built into the cost of room & board and/or are an integral and necessary components of another procedure or service provided and are not separately billable on inpatient claims

4. A Claim Review Report, which lists all of the exceptions found on the claim, is sent to the Provider/Facility. The Company pays the clean portion of the claim per the clean claim review recommendation within all timely payment requirements.

5. Reponses to any claim appeals are provided as necessary, and the Company will work to support their findings on all resolution efforts with the providers. If, during the resolution process, any of the billing exceptions can be cleared with medical records, invoices, doctor orders, provider contracts or billing policies, or other clinical information provided by the facility, those unpaid or recovered charges will be paid to the provider at that time.

References

1. *CC.PI.06 Cost to Charge Adjustments on Clean Claim Reviews*
2. *CC.PI.10 Unbundling Adjustments on Clean Claim Reviews*

Revision History	
November 2012	New Policy Document
November 2013	Annual Review
December 2014	Annual Review
March 2016	Annual Review
March 2017	Annual Review
March 2018	Annual Review

May 2019	Annual Review
June 2020	Annual Review
May 2021	Annual Review
May 2022	Annual Review
September 2022	Ad Hoc Review – Template update
September 2023	Annual Review
September 2024	Annual Review
September 2024	Format Updated to HP Requirement
September 2024	Posted
March 2025	Annual Review

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.