POLICY AND PROCEDURE

POLICY NAME: Clean Claim Reviews	**POLICY ID:** CC.PI.04
BUSINESS UNIT: Corporate	**FUNCTIONAL AREA:** Payment Integrity
EFFECTIVE DATE: 11/1/12	**PRODUCT(S):** All
REVIEWED/REVISED DATE: 9/1/22, May 2022, May 2021, June 2020, May 2019, March 2018, March 2017, March 2016, December 2014, November 2013	
REGULATOR MOST RECENT APPROVAL DATE(S):	

POLICY STATEMENT:
This policy provides clarification on the facility billed charges that will be evaluated for the clean claim review process.

PURPOSE:
The purpose of this policy is to define the requirements for the proper application of the clean claim reviews.

SCOPE:
This policy applies to all directors, officers, and employees of Centene Corporation, its affiliates, health plans, and subsidiary companies (collectively, the "Company").

POLICY:
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.

PROCEDURE:

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)
   Prepayment
   Inpatient claims > $25,000 payable charges
   Inpatient claims that hit DRG outlier
   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. Medical records are requested when the reviewer finds it necessary.

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 up with medical records, invoices, doctor orders, provider contracts or billing policies, or other clinical information provided by the facility, those unpaid charges will be paid to the provider at that time.

REFERENCES: CC.PI.06 Cost to Charge Adjustments on Clean Claim Reviews
CC.PI.10 Unbundling Adjustments on Clean Claim Reviews

ATTACHMENTS:

ROLES & RESPONSIBILITIES: Payment Integrity manages the vendor(s) who conduct the clean claim reviews. Payment Integrity also manages the internal team (Payment Integrity Review Unit – PIRU) who also conduct clean claim reviews. Claims Operations processes payment of the member claim based on the findings identified in the clean claim reviews.

REGULATORY REPORTING REQUIREMENTS:

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy Document		11/1/12
Annual Review	Annual review/updating of terminology	November 2013
Annual Review	Annual review/updating of terminology	December 2014
Annual Review	Annual review/updating of terminology	March 2016
Annual Review	Annual review/updating of terminology	March 2017
Annual Review	Annual review/updating of terminology	March 2018
Annual Review	No revision	May 2019
Annual Review	No revision	June 2020
Annual Review	Addition of PIRU reviews	May 2021
Annual Review	Eliminated mention of vendor and PIRU	May 2022
Ad Hoc Review	Updated template	September 2022

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.