Payment Policy | Clean Claim Criteria

EFFECTIVE DATE: 12|01|2011
POLICY LAST UPDATED: 07|28|2014

OVERVIEW

NOTE: The effective date of this policy reflects the date that Blue Cross Blue Sheild of RI (BCBSRI) documented a long-standing reimbursement policy. The information is this policy does not indicate a change in the way that BCBSRI covers/reimburses the services/procedures described in this policy.

For information about timely filing requirements, please see the Timely Filing policy.

PRIOR AUTHORIZATION

Prior authorization review is not required

POLICY STATEMENT

This is an administrative policy.

MEDICAL CRITERIA

None

BACKGROUND

Fee-for-service and encounter claims (claims that are considered paid but have no actual dollars paid, for example a claim paid by capitation) will be processed in accordance with contractual and regulatory requirements.

Turnaround time for adjudicating claims is counted from the first day a claim is received to the date the claim payment or denial is mailed to the provider and/or member.

Definitions

"Clean" Claim vs. "Non-Clean" Claim:

A claim for payment of health care services that is submitted via an acceptable claim form or electronic format with all required fields completed with accurate and complete information in accordance with the insurer's requirements, is considered "clean" if the following conditions are met:

I. the services must be eligible, provided by an eligible provider and provided to a person covered by the insurer;
II. the claim has no material defect or impropriety, including, but not limited to any lack of required substantiating documentation or incorrect coding;
III. there is no dispute regarding the amount claimed;
IV. the payer has no reason to believe that the claim was submitted fraudulently or there is no material misrepresentation;
V. the claim does not require special treatment or review that would prevent the timely payment of the claim;
VI. the claim does not require coordination of benefits, subrogation, or other third party liability;
VII. services must be incurred during a time where the premium is not delinquent (this condition does not apply to BlueCHiP for Medicare members).

If additional documentation (e.g., medical records) involves a source outside Blue Cross & Blue Shield of Rhode Island (BCBSRI), the claim is not considered clean.

Note: Claims Management uses these criteria to insure that all claims, from both contracted and non-contracted providers, are paid within expected timeframes as outlined by contracts and regulatory agencies.

Clean Claim Requirements for Professional Providers

All of the following information is required for a claim to be accepted for processing:

All numbers in parentheses, e.g., (1), refer to item numbers on the CMS-1500 claim form.

I. Valid and properly formatted member identification number (1a)
II. Patient's full name (2)
III. Patient's date of birth (3)
IV. Date of service(24A)
V. Industry standard diagnosis codes (24E)
VI. Industry standard place of service codes (24B)
VII. Industry standard procedure codes (CPT, ICD-9 CM) (24D)
VIII. Charge information and units (24F and 24G)
IX. Service providers name, address, and National Provider Identifier (NPI) (33 and 33a)
X. Provider's federal tax identification number (TIN) (25)

The following information is required for all labs, imaging, diagnostic tests, and durable medical equipment claims.

Referring or ordering provider's National Provider Identifier (NPI) (17 and 17b) must be listed on all claims with the exception of evaluation and management (E&M) services. This information should be completed on all claims for services such as labs, other diagnostic testing, radiology, and PT/OT.

When the ordering physician is also the performing physician, as is often the case with in-office clinical labs such as a urine dipstick, the performing physician should enter his/her information in boxes 17 and 17b.

When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in box 17.

Only one servicing provider per claim.

All mandatory fields must be complete and accurate.

Missing or incomplete information will result in a claim being rejected back to the provider.

Claims submitted with any of the following require clinical documentation at the time the claim is submitted to be considered complete:

- codes with an assistant surgeon modifier (80, 81, 82), assistant-at-surgery modifier (AS), or co-surgeon modifier (62)
- codes with modifiers that indicate additional or unusual services (22, 23, 24, 52, 53, 66)
- services filed with an unlisted code as defined by CPT

- services performed during the post-operative period denied as global
- prolonged services

Please see the BCBSRI CMS-1500 (02/12) Form Completion Information Guide for more information:

https://www.bcbsri.com/sites/default/files/CMS-1500-02-12-BCBSRI-Mandatory-Field-Document-0714.pdf

COVERAGE

BlueCHiP for Medicare |
Commercial |
Not Applicable

CODING

Not applicable

RELATED POLICIES

None

PUBLISHED

Provider Update	Apr 2011

REFERENCES

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1221.pdf

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf.

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.