CLEAN CLAIM DEFINITION

Clean Claim Requirements

At QualCare, our goal is to process all claims at initial submission. Before we can process a claim, it must be a "clean" or complete claim submission, which includes the following information, based upon the services for which reimbursement is claimed:

- implant invoices
- prescription for physical therapy
- itemization of dates for physical therapy from facility
- itemized bill for Inpatient Facilities for partially approved admissions
- prosthesis invoice
- trip notes for ambulance transport
- standard Diagnostic Related Groupings (DRG) or Revenue codes (facility)
- standard Health Care Procedure Coding System (HCPCS) code sets and modifiers
- standard Current Procedural Terminology (CPT®) code sets and modifiers
- standard International Classification of Diseases (ICD-10) codes
- accurate entries for all the fields of information contained in the UB04 * or CMS-1500 forms*

The following modifiers **do not** require clinical records: CPT modifiers 26, 52, 63, or 90

Except as noted, we routinely require clinical documentation at the time a claim is submitted for the following categories of claims to be considered complete:

- codes to which an assistant surgeon modifier (80, 81, or 82), assistant-at-surgery modifier (AS), or co-surgeon modifier (62) is attached that do not normally require surgical assistance or co-surgeons
- an 'unlisted code' as defined in the Index of CPT under 'Unlisted Services and Procedures'
- a code that is not otherwise specified (NOS)
- a code that is not otherwise classified (NOC)
- procedures that are potentially cosmetic
- procedures that may be experimental/investigational/unproven
- procedures that are medically necessary for some indications and not for others
- services performed in an unexpected place of service, such as office services performed in an outpatient surgery center
- codes appended with a modifier indicating additional or unusual services (e.g., 22, 23, 24, 53, 59, or 66)

Types of clinical documentation that may be requested include:

- emergency room notes
- facility notes
- anesthesia notes and time
- facility/MD notes
- operative notes
- radiology interpretation and report
- lab results
- MD office notes

Emergency Services by out-of-Network providers and facilities

Since out-of-network providers and facilities are not bound by provider contract terms, and out-of-network services are generally limited to emergency or urgent services, we will always require the documentation listed above as applicable for such claims to be considered ‘clean’.

This policy is not designed to limit the requirement that medical records be submitted for precertification purposes.

Medical Necessity Guidelines

Guidelines for Medical Necessity and payment policy are available to public inquiry on the provider sections of all websites. These guidelines are based on nationally accepted evidence based clinical criteria and supplemented by a number of payment policies developed by Qualcare. These policies are located at https://www.qualcareinc.com/Providers/providers_medicalpolicies.aspx

Use of non-participating providers is only permitted for unforeseen circumstances related to a medical emergency or when previously approved by the Health Plan.