

CLEAN CLAIM AND PPO CONFLICTS

by Ron E. Peck, Esq.

The response to our [March Discussion of Clean Claims](#), and the conflicts that arise from contradictory definitions, was overwhelming. Indeed, it seems that many, if not most, of The Phia Group's clients have suffered due to conflicts arising over Clean Claim definitions.

State and Federal laws exist which assign deadlines to claims administrators once a clean claim is received; but that begs the question – what is a clean claim?

In general, providers and PPO networks will often define a “Clean Claim” as a charge submitted utilizing a HCFA or UB-92 form. The same agreements that so define Clean Claims, also impose deadlines on benefit plans to process the charges within a certain period of time after the Clean Claim has been submitted.

Benefit Plans are limited, however, by extensive plan language. The plan language which administrators must adhere to includes exclusions, coordination of benefits, and other provisions that require a thorough analysis of every charge's origin. To an administrator, a claim is not “clean” until all relevant details and documentation, adequate to determine whether the claim is actually payable by the Plan, is received.

In short, the definition of a clean claim varies.

Medicare offers some guidance, as it defines a Clean Claim as one that has no defect, impropriety, lack of required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment. 42 C.F.R. § 422.500.

The Phia Group has developed innovative plan language to deal with this controversy, and seeks to have all of its clients define what Clean Claims are, clearly and explicitly, in their documents. By defining Clean Claims before entering into (or renewing) agreements with other entities that seek to define Clean Claims for themselves, our clients can better control when the deadline-clock starts ticking.

Unfortunately, Clean Claims aren't the only basis for dispute between benefit plan administrators, PPOs, and providers.

Most administrators believe it is reasonable to assume that “billed charge” language within PPO contracts equates to usual, customary, and reasonable fees. In other words, many of our clients enter into PPO agreements assuming that the discounts are being taken from reasonable charges. This may not always be so.

Indeed, what the plan administrator may consider to be unreasonable, not usual, not customary, and thus exceeds the maximum amount payable, conflicting language in the

PPO agreement may state that the PPO rate (which is greater than the administrator's definition of U&C) can't be challenged.

Consider also a scenario where the Plan states that pre-certification / pre-authorization does not equate to a guarantee of coverage, but the PPO Network Access Agreement states that pre-certification / pre-authorization binds the Plan to coverage.

The thing to remember is that plan fiduciaries may enter into contractual relationships with PPOs, but are responsible for discharging assets of the Plan in strict accordance with terms of the Plan.

We encourage you to contact our legal team to discuss these issues. To set an appointment, please call 888-986-0080 and speak to Cindy Monfils at extension 155. Ms. Monfils can also be reached at cmofils@phiagroup.com.