

**PIMA HEALTH SYSTEM
STANDARDS AND PROCEDURES**

SUBJECT: Clean Claim Determination	Claims CL II 0005
APPLICABLE TO: Claims Division	
EFFECTIVE DATE: 12/02 APPROVED BY: <i>Mary Kaehler by Signature</i>	
SUPERSEDES: 3/97, 12/97, 12/98, 2/01	

I. STATEMENT OF PURPOSE:

This policy establishes guidelines for determining clean claims and handling of all claims.

II. DEFINITIONS:

A “Clean Claim” is: A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity. (ARS 36-2904 (H)(1))

III. STANDARDS:

- A. PHS will only pay for covered services rendered for eligible members enrolled with Pima Health Care System (PHS) at the time services were provided.
- B. PHS will only pay for services which have been authorized by the PHS QM/UM Division or otherwise specified by contract.
- C. PHS will not pay for any services which are in excess of those outlined by the PHS referral.
- D. PHS will not pay providers who do not have an AHCCCS ID number.
- E. PHS will only process clean claims for payment that meet the following criteria:
 - 1. Claims initially submitted within six (6) months from the last date of service unless otherwise indicated by contract.
 - 2. Claims submitted on a proper form (UB-92, HCFA 1500) or in a format that indicates the specific services and charges being billed.
 - 3. Claims sent for medical review are not counted against the 30 day payment period during the period they are being reviewed.

4. Claims for the balance after Medicare require a copy of the explanation of Medicare benefits (EOMB). If services are covered by Medicare and Medicare has been denied, the claims must be submitted with a copy of the denial.
5. All claims requiring medical review (see policy CL II 0017 - Medical Review Standards for Claims Processors) must include documentation for processing, unless otherwise stated in the contract.
6. Claims which do not meet the standards set above will be documented on the provider's remit stating the reason(s) for the denial of payment.
7. Providers must resubmit corrected claims within 6 months from the last date of service or in accordance with contract.