

Delaware Clean Claim Definition

DE Administrative Code

Title 18, 1300 Health Insurance Provisions, Section 4

- **4.0 Clean Claim Defined**
 - 4.1 A nonelectronic claim by a provider, other than an institutional provider, is a clean claim if the claim is submitted using the Centers for Medicare and Medicaid Services (CMS) Form 1500 or, if approved by the Commissioner or CMS, a successor to that form. Data for all relevant fields must be provided in the format called for by the form in order for the claim to constitute a clean claim.
 - 4.2 A nonelectronic claim submitted by an institutional provider is a clean claim if the claim is submitted using the CMS Form UB-92, or, if approved by the Commissioner or CMS, a successor to that form. Data for all relevant fields must be provided in the format called for by the form in order for the claim to constitute a clean claim.
 - 4.3 An electronic claim by a provider, including an institutional provider, is a clean claim if the claim is submitted using the appropriate ASC X12N 837 format in compliance with the standards specified at 45 CFR §162.1102 or any successor regulation.
 - 4.4 If allowed by federal law, a carrier and provider may agree by contract to use fewer data elements than are required by the relevant form or format.
 - 4.5 An otherwise clean claim submitted by a provider that includes additional fields, data elements, or other information not required by this Regulation is considered to be a clean claim for the purposes of this Regulation.
 - 4.6 A claim by a policyholder that is submitted in the carrier's standard form using information called for by said forms, with all of the required fields completed, is a clean claim.
 - 4.7 Any claim submitted by a provider or policyholder that includes an unspecified, unclassified or miscellaneous code or data element to constitute a clean claim shall also include appropriate supporting documentation or narrative which explains the unspecified, unclassified or miscellaneous code and describes the diagnosis and treatment or service rendered.
- **6.0 Processing of Clean Claim**
 - 6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:
 - 6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;

- 6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;
- 6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;
- 6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.
- 6.2 The request pursuant to section 6.1.4 must describe with specificity the clinical information requested and relate only to information the carrier can demonstrate is specific to the claim or the claim's related episode of care. A provider is not required to provide information that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by the provider whose services are the subject of inquiry. A carrier may make only one request under this subsection in connection with a claim. A carrier who requests information under this subsection shall take action under sections 6.1.1 through 6.1.3 within 15 days of receiving properly requested information.
- 6.3 A carrier shall be limited to one request on the same claim beyond that provided for in section 6.2 as may be necessary to:
 - 6.3.1 administer a coordination of benefits provision; or
 - 6.3.2 determine whether a claim is a duplicate.

• 7.0 Unfair Practice

- Within a 36 month period, three instances of a carrier's failure to comply with Section 6 of this Regulation shall give rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. §2304.

• 8.0 Interest

- The Commissioner may order a carrier found to have violated Section 6 of this Regulation to pay to a provider or policyholder the amount of the claim or bill plus interest at the maximum rate allowable to lenders under Delaware law. Such interest shall be computed from the date the claim or bill for services was first required to be paid. The remedy permitted by this Section is in addition to, and does not supplant, any other remedies available to the Commissioner or the provider.

• 9.0 Waiver

- The provisions of this regulation may not be waived, voided, or nullified by contract.