Payment Policy: Cost to Charge Adjustments on Clean Claim Reviews

Reference Number: CC.PI.06
Product Types: ALL
Effective Date: 06/2014
Last Review Date: 06/2025

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

It is the policy of the Company to comply with provisions set forth in federal and state guidelines. To comply with these provisions, the Company has the fiduciary obligation to review facility charges on a prepay or postpay basis to help assure that such charges are free of potential defects or improprieties. The Company is also obligated to verify whether facility charges comply with applicable billing standards.

One element of the clean claim reviews is identifying significant and material discrepancies between the amount billed for and the underlying cost of an implantable supply item or pharmaceutical. This "Cost-to-Charge Discrepancy" evaluation calls attention to line items that appear to have been billed in error.

Section 2203 of the CMS Provider Reimbursement Manual specifically requires that each facility create and maintain "an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services."

In order to ensure the Company only pays for those charges that "reasonably and consistently relate to the cost of providing the services," the Company has put into effect the following procedure.

Application
Institutional providers

POLICY STATEMENT:
This policy provides clarification on the facility billed charges that will be evaluated for cost-to-charge as part of the clean claim review process.

PURPOSE:
The purpose of this policy is to define the requirements for the proper application of the cost-to-charge adjustments identified by clean claim reviews.

PROCEDURE:

1. The clean claim reviews will compare the amounts billed for implantable supply items against the objective data regarding the amounts facilities pay for such implantable supply items that is maintained in the ECRI Institute's database of medical/surgical supplies and implants. ECRI Institute is designated an Evidence-Based Practice Center by the U.S. Agency for Healthcare Research and Quality and listed as a federal Patient Safety Organization by the U.S. Department of Health and Human Services. In this database, hospitals populate with the amounts they actually pay for implantable devices.

2. The clean claim reviews will compare the amounts billed for pharmaceuticals against the AWP (average wholesale price) of such pharmaceuticals that is provided by the website www.reimbursementcodes.com, Medispan AWP or ECRI Institute's database. These tools provide Current AWP package pricing, Medicare Part B ASP and hospital APC/OPPS drug pricing information for FDA approved drug codes.

3. When a clean claim review identifies a significant "Cost-to-Charge Discrepancy," the Company will assign the allowable reimbursement to an amount that is 8 times the median amount the ECRI database indicates that facilities pay for the same implantable supply item or 8 times the AWP price listed for the same pharmaceutical. This adjusted billed

   amount should allow for the provider to be reimbursed for the actual direct cost incurred to obtain the item, plus the indirect costs associated with the storage, maintenance and usage of item identified.

4. If a facility can provide documentation (i.e. invoices) demonstrating that it incurred a cost of greater than the allowed amount, the Company will review the documentation and respond as appropriate.

References

CC.PI.04 Clean Claim Reviews
CC.PI.10 Unbundling Adjustments on Clean Claim Reviews

Revision History	
June 2014	New Policy Document
June 2015	Annual Review
March 2016	Annual Review
March 2017	Annual Review
March 2018	Annual Review
May 2019	Annual Review
June 2020	Annual Review
May 2021	Annual Review

May 2022	Annual Review
September 2022	Ad Hoc Review – Template updated and change to cover all LOB
September 2023	Annual Review
September 2024	Annual Review
September 2024	Format Updated to HP Requirement
September 2024	Posted
June 2025	Annual Review- Clarifying language added

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

 Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.