Real-Time Claims Reference Guide

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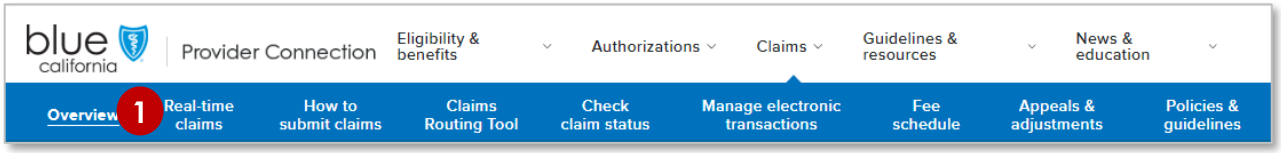
11/2020

Real-Time Claims – overview and navigation

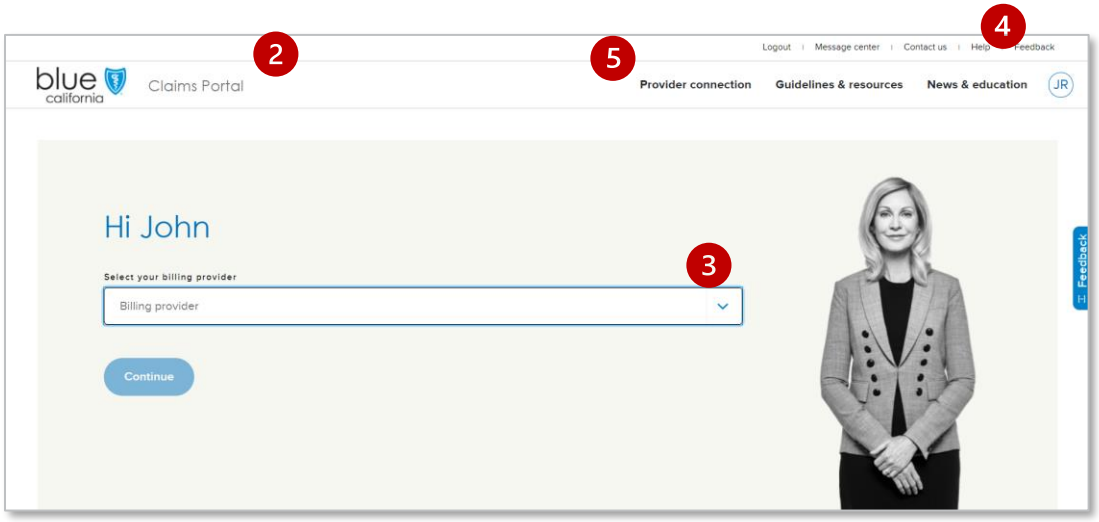
Background: Real-Time Claims is an online estimator and claims submission tool that adjudicates most claims in 3-9 seconds, speeding up time to payment for services. This tool launches from the *Claims* section of Provider Connection and access is granted by your organization's Provider Connection account manager.

Instructions:

1. Log in to Provider Connection. From the home page, click *Claims* from the white navigation bar, then click **Real-time claims.**



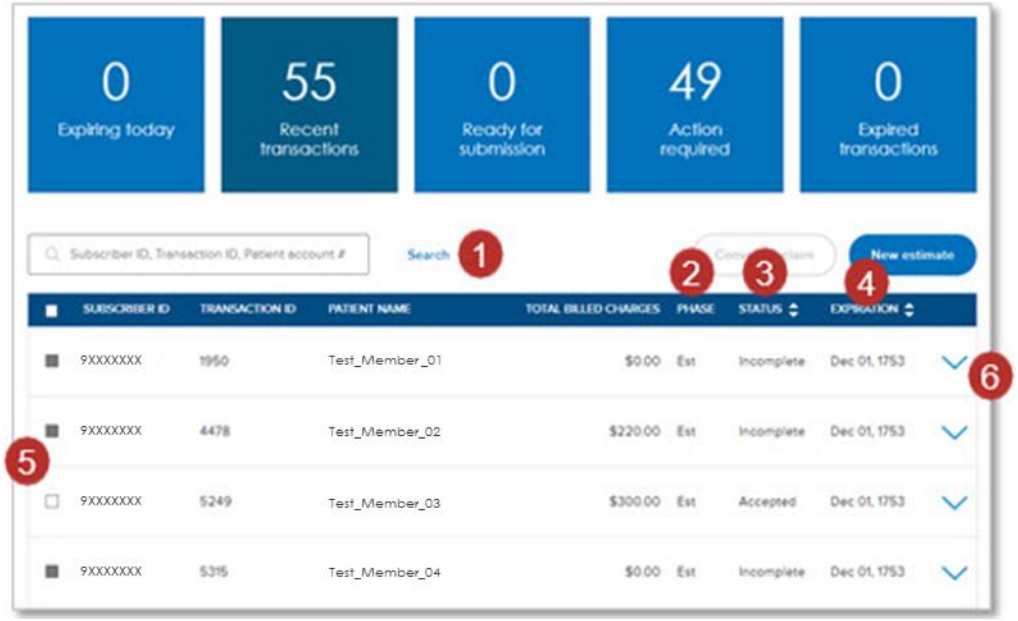
2. Real-Time Claims opens. Note that you do not need a separate log in to access the Real-Time Claims tool.
3. Select a provider from the drop-down list and click **Continue**. The providers listed are based on your Provider Connection login.
4. **Help** is available in the upper right corner.
5. Resources are available within Real-Time Claims including a link back to **Provider Connection**, **Guidelines and resources**, and **News & education** sections.



Real-Time Claims dashboard

The Real-Time Claims dashboard is the first thing you see after selecting a provider. The clickable blue tiles give you a bird's eye view of your transactions and serve as a filter.

- Expiring today
- Recent transactions
- Ready for submission
- Action required
- Expired transactions



1. **Search** – Use the search field to search by Subscriber ID, Transaction ID, or Patient Account Number.
2. **Phase** – Indicates whether the transaction is an estimate (Est) or a claim (blank).
3. **Status** – Click the arrows to sort by ascending or descending order. Status displayed are: Accepted, Incomplete, Processing, Processed, and Expired.
4. **Expiration** – The most recent transaction will appear at the top of the table. Click the arrows to sort by chronological or reverse chronological order. Note that estimates expire 7 days after they are created.
5. **Open/Closed boxes** – An open or empty box means the estimate is ready to be converted to a claim. A closed or filled-in box means either the estimate is not ready to be converted to a claim because it has incomplete information, or because it has expired. If the estimate is expired, you may re-run the estimate before converting it to a claim.
6. **Transaction details** - Click the down arrow in any record to see details.

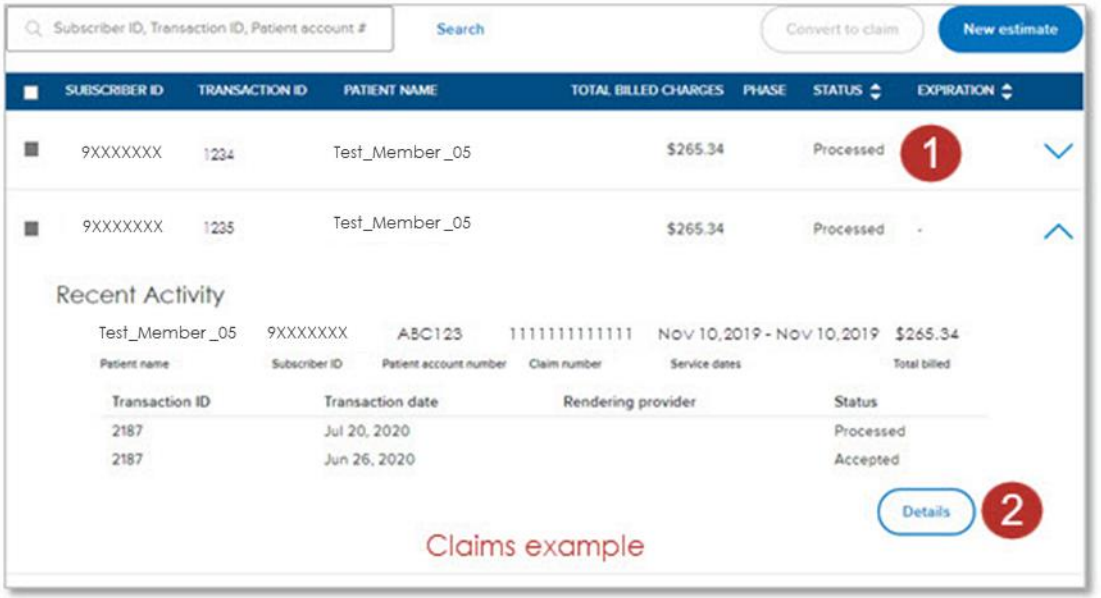
Transaction details

The *Recent Activity* section includes the following about a transaction:

- Patient information: Patient name, Subscriber ID, and Patient account number (designated by provider).
- Claim information: Claim number, Service dates, and Total billed amount.

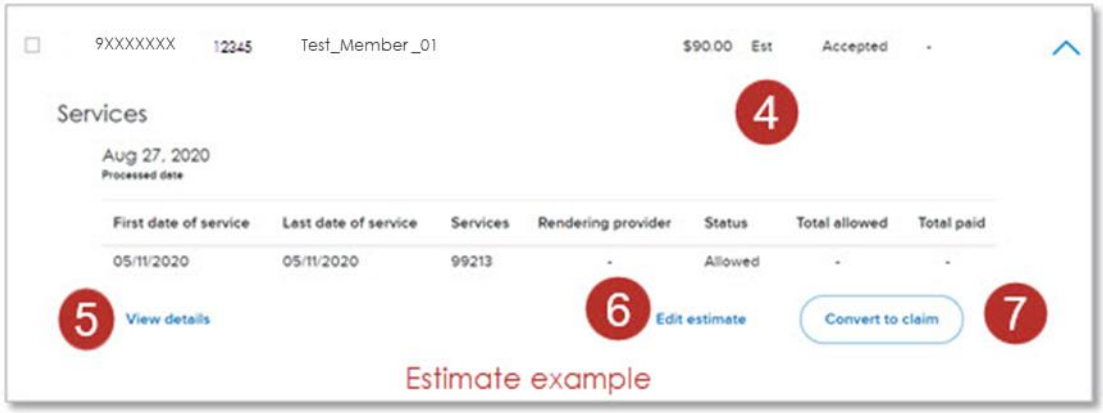
For Claims:

1. Status changes are listed in reverse chronological order, with the most recent activity on top.
2. Click the **Details** button to see additional information (Estimate Details page).
3. Transaction steps are listed in the *Recent Activity* table.

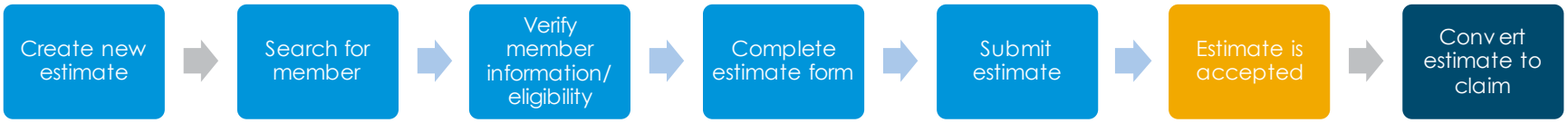


For Estimates:

4. *PHASE* shows as Est.
5. Click **View details** to see the Estimate Details page for complete information.
6. Click **Edit estimate** or re-run the estimate if it has expired.
7. Once the estimate is completed and accepted by the Real-Time Claims tool, the **Convert to Claim** button will appear.



Overall process flow



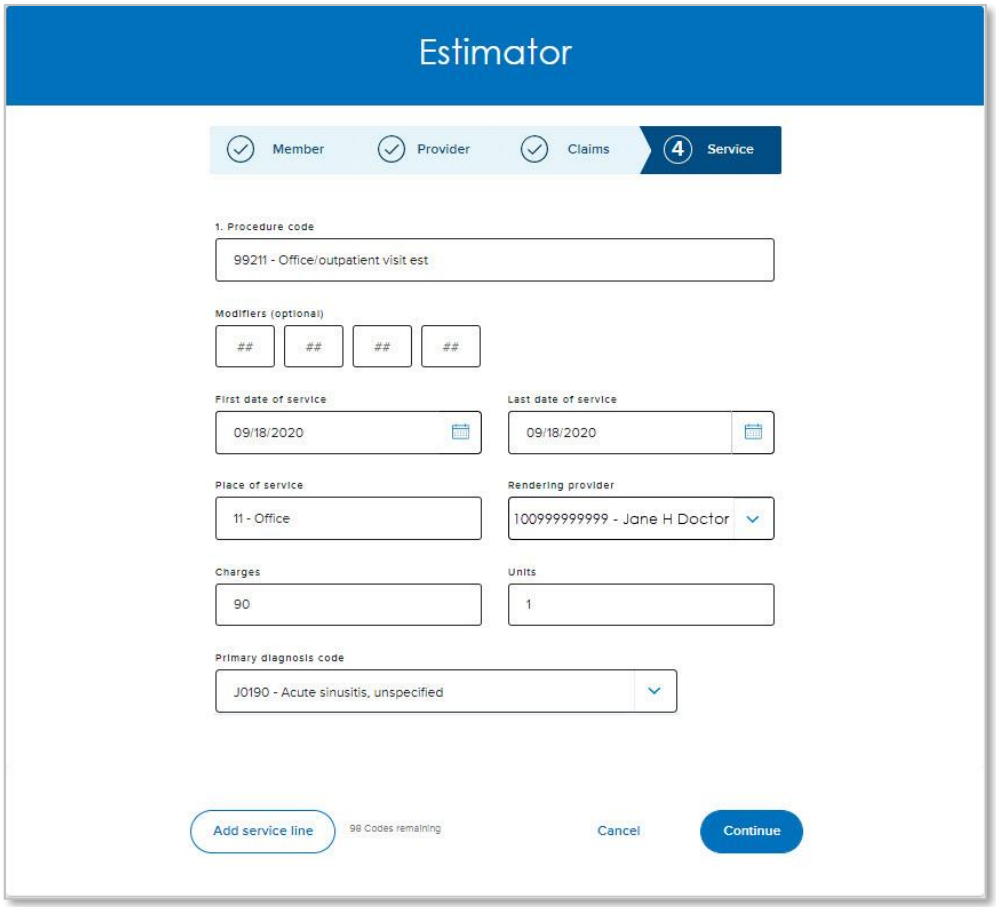
You must first create an estimate before it can be converted to a claim for submission. Below is the overall process flow.

1. From the *Real-Time Claims dashboard*, click the **New Estimate** button at the top right of the table.
2. Perform a Member search to verify eligibility. Enter the *Date of service start* and *Date of service end*, then enter the *Subscriber ID*. For dates use the calendar icon to select the dates or enter the dates as *MM/DD/YYYY*.
3. A list of members associated with the Subscriber ID appear. Select your member from the list, then click the **Select member** button in the right corner. Be sure to verify the member date of birth (DOB) and confirm the member's eligibility dates.
4. The Estimator tool appears. The progress bar at the top shows you where you are in the process:

- Member - review member information and click the **Verify member** button if correct. Click the **Change member** button if needed.
- Provider – fill in all fields unless listed as optional. Claim type is defaulted to Medical. Select Claim sub type, ether Medical or Hospital and click **Continue**. If the Continue button is dimmed, it means you have not completed all required fields.
- Claim - fill in all fields unless listed as optional and click **Continue**. Use whole numbers (no decimal places) for the diagnosis code. Note that *Patient account number* is mandatory. Use your office patient account number.

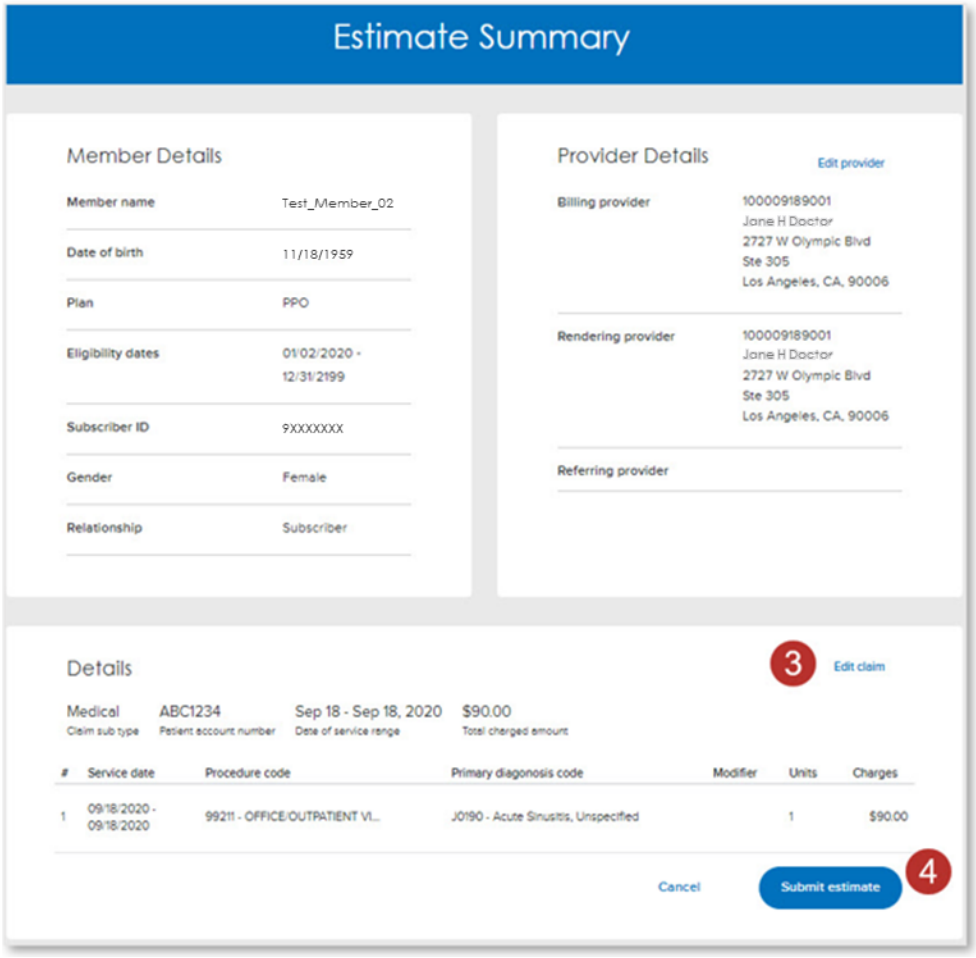
Creating an estimate

- Services – complete all the fields unless listed as optional.
    1. Enter **Procedure code** (CPT) and any **Modifiers**, if applicable.
    2. Use the calendar icon to select a date or enter *MM/DD/YYYY*.
    3. **Place of service** field has predictive search capabilities.
    4. **Charges** – enter the dollar amount without a dollar sign.
    5. **Units** – enter at least one unit of service.
    6. **Primary diagnosis code** – select from the dropdown list; options are based on what you entered as codes in the Claims section.
    7. **Add service line** – click this button if you need additional lines you may add up to 99 codes.
    8. Click **Continue**.



Estimate summary

1. The *Estimate Summary* page displays.
2. Review all information to make sure all entries are correct. Confirm *Provider Details* information and click **Edit provider**, if needed.
3. Click **Edit claim** at the top of the *Details* section to modify your claim estimate. You will be taken back to the claim portion of the Estimator.
4. Click **Submit estimate**.



Once you have submitted your estimate, a status will appear on the dashboard. The *Phase* will now be Est.

Status options include:

- Accepted - the estimate has been accepted by the system, and is available to be converted to a claim.
- Incomplete – indicates that more information is needed, and the estimate cannot move forward.

SUBSCRIBER ID	TRANSACTION ID	PATIENT NAME	TOTAL BILLED CHARGES	PHASE	STATUS	EXPIRATION
9XXXXXXX	14307	Test_Member_01	$100.00	Est	Accepted	-
9XXXXXXX	14342	Test_Member_02	$0.00	Est	Incomplete	-

Converting an estimate to a claim

Background: Once an estimate has been accepted, you may convert it to a claim. Estimates are good for 7 days, and may be edited before converting to a claim. Here are options:

1. Immediately/within 7 days - You may convert an estimate to a claim immediately after the estimate is accepted or up to 7 days after accepted. From the dashboard click the **down arrow** for your estimate.
2. Click the **Convert to claim** button. Note that if an estimate has expired, you must re-run the estimate to ensure it is based on the most current information (member eligibility, deductible, etc.) and you will have the opportunity to edit any information if needed. Click the **down arrow** for the estimate, then select the **Edit estimate** button and confirm that the information is still correct. Once the estimate is re-run, it will be valid for 7 days.
3. Expire now – In some cases you may want to expire an estimate manually. By doing so, you will have the opportunity to re-run the estimate. The new estimate will remain valid for another 7 days.
4. Multiple claims – You may select up to 20 estimates to be converted to a claim at the same time. From the *Real-Time Claims dashboard*, select the estimates by checking the open box, then click the **Convert to claim** button at the top right of the summary table. You will receive a message when it is done processing that states how many claims were accepted.

Converting an estimate to a claim

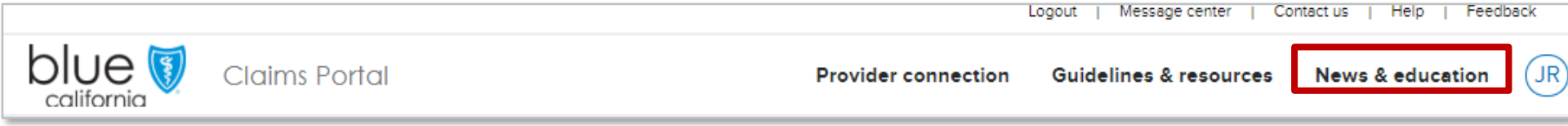
Once you click the **Convert to Claim** button, the Real-Time Claims tool will validate data and start processing. When it is done processing you will receive a confirmation message.

Claims status will be displayed in the *Real-Time Claims dashboard*. In some cases, processing make take a bit longer, in which case, the transaction status will be listed as processing. Check the dashboard for updates.

Status options include:

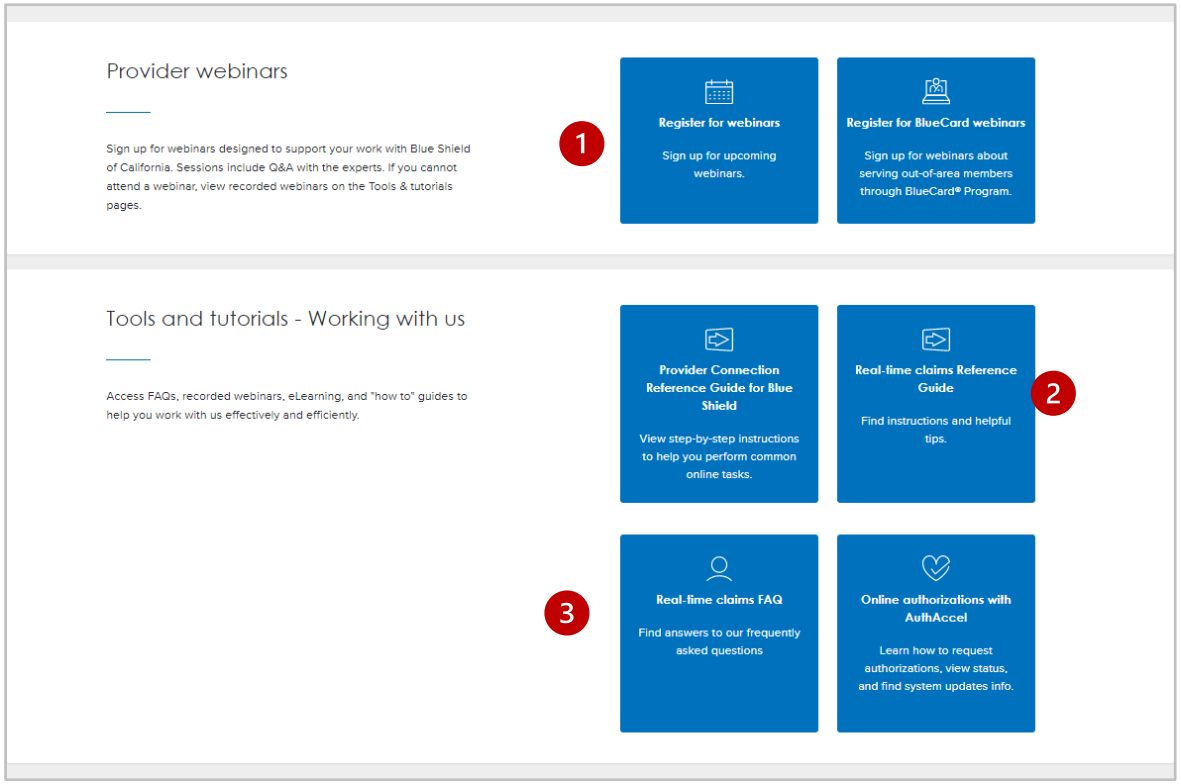
- Accepted – the claim has been accepted by the system.
- Processing – in some cases, the system may need more time to process the claim. Check back: The status will be updated in the dashboard. DO NOT try to convert the claim again.
- Pending for review - this message appears when there are additional action items such as a prior authorization (PA) is required and a reference to AuthAccel will appear. Once the authorization request is approved, the status will be updated automatically and the claim will be processed.
- Multiple claims – when converting multiple claims at once, each claim will be processed individually and you will see individual transaction statuses on the dashboard.

Real-Time Claims resources



Check the News & education page for more resources.

1. Provider webinars
2. Reference Guide – this guide is updated as needed, download the latest version here.
3. FAQs
4. eLearning – *available soon!*



For additional questions, contact Blue Shield Provider Services: (800) 541-6652