



Introduction to Clear Claim Connection (C3)

Agenda

1 What is Clear Claim Connection (C3)?

2 Why should I use C3?

3 How do I use C3?

4 Where can I find learning resources?

5 What are your questions?

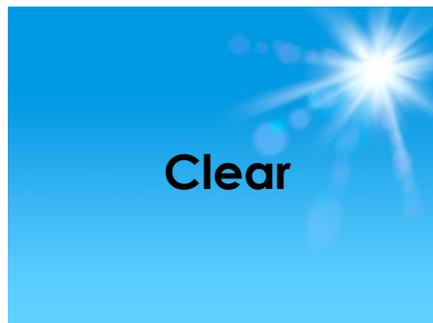


What is Clear Claim Connection (C3)?

Prescreen claims

C3 simulates claim auditing by entering different codes on mock claims to immediately see their allow/review/disallow recommendations.

It enables providers to transparently view our current claim auditing rules, edit recommendations and clinical rationales from nationally recognized sources.



What is C3's scope?

C3 does

- Offer a beneficial, but not mandatory, supplemental simulation reference tool of how claims may be audited
- Provide coding information
- Disclose claims payment policies
- Provide straightforward claim audit results
- Explain potential claim decisions

C3 does not

- Submit claims
- Provide claims pricing or reimbursement information
- Imply member eligibility
- Indicate the service is covered
- Guarantee if or how the claim will be paid
- Consider pre-authorization requirements or benefits
- Include PHI since it is not member specific
- Access claim history

C3 results don't guarantee how the claim will be processed due to contract variations, plan eligibility, deductions, and coordination of benefits that may impact final payment of a claim.



Who can use C3?

Can prescreen claims

- Professional providers
(who are licensed to practice a healthcare profession)
- Ancillary providers
(any provider that does not provide services in an inpatient or outpatient facility)
- Outpatient facilities
(outpatient hospitals and hospital-based laboratories)
- Ambulatory surgery centers
(ASCs)

Cannot prescreen claims

- Blue Shield of California third party contracted and non-contracted providers
- Out-of-state providers



What plan types does C3 support?

Can prescreen claims

- Individual/Small Group/Employer Group Plans
- Medicare Advantage
- Shared Advantage
- Federal Employee Health Plan
- Medicare Supplement

Cannot prescreen claims

- Care First (Medi-Cal and Medicaid)



How is C3 going to make my job easier?

Because prescreening claims with C3 ...

- Improves coding accuracy, leading to more effective and efficient claims processing and payment
- Previews claim payment policies and audit rules proactively and transparently
- Provides industry-supportable clinical integrity for procedures
- Lessens or removes the need to call customer service asking why a claim was denied
- Circumvents the need for Blue Shield to ask for records due to inaccurate coding
- Enhances member satisfaction by avoiding the extra steps and costs associated with erroneous billing
- Is easy to use, uses provider-friendly language, requires minimal data entry and provides automatic defaults for frequent entries



How do I use C3?

Follow this three-step process:



1. Locate



2. Simulate



3. Recalibrate



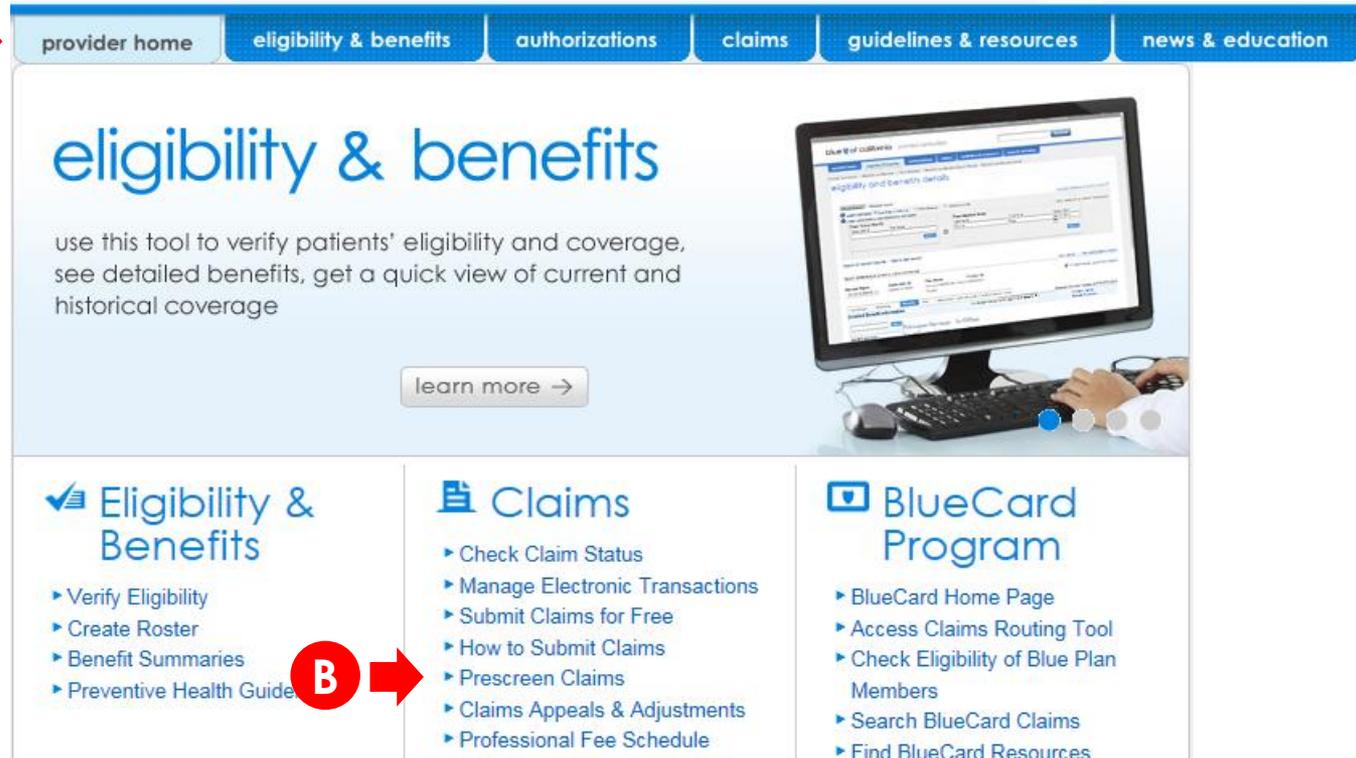
How do I locate C3 on the Provider Connection portal?

1

Locate

- A. Log in to Blue Shield of California's Provider Connection at **blueshieldca.com/provider** with your existing username and password.
- B. From the Provider Connection home screen, go to the **Claims section** and click on the **Prescreen Claims link** to access C3.
- C. Read the Terms & Conditions and click **I agree** to continue.

blue  of california | provider connection



provider home | eligibility & benefits | authorizations | **claims** | guidelines & resources | news & education

eligibility & benefits

use this tool to verify patients' eligibility and coverage, see detailed benefits, get a quick view of current and historical coverage

[learn more →](#)

Eligibility & Benefits

- ▶ Verify Eligibility
- ▶ Create Roster
- ▶ Benefit Summaries
- ▶ Preventive Health Guide

Claims

- ▶ Check Claim Status
- ▶ Manage Electronic Transactions
- ▶ Submit Claims for Free
- ▶ How to Submit Claims
- ▶ **Prescreen Claims**
- ▶ Claims Appeals & Adjustments
- ▶ Professional Fee Schedule

BlueCard Program

- ▶ BlueCard Home Page
- ▶ Access Claims Routing Tool
- ▶ Check Eligibility of Blue Plan Members
- ▶ Search BlueCard Claims
- ▶ Find BlueCard Resources



What is on C3's top row menu bar?

1

Locate

C3 home screen for claim entry



How do I simulate claims with C3?

2

Simulate

It's a simple process to review the recommendations and rationales for a claim.



How do I enter claim information?

2

Simulate

C3 claim entry screen

- Choose your claim and plan type
- Enter the member's information, the procedure codes, modifiers (if any) and the date of the service
- Click the Review Audit Results button

Clear Review Audit Results

CLAIM ENTRY

Claim Type: Professional

Plan Type: Individual/Small Group/Employer Group Plans

Gender: Male Female

Date of Birth: / /

ICD Code Set: ICD10

Diagnosis Codes: 1 [] 2 [] 3 [] 4 [] 5 [] 6 [] 7 [] 8 [] 9 [] 10 [] 11 [] 12 []

Bill Type: []

For quick entry, use your Down Arrow key after you enter a procedure code. Qty will default to 1, Billed Amount will default to 100, Date of Service From and To will default to today's date, and Place of Service will default to 11 (Office). Tabbing through these same fields will give you the same defaults.

LINE	PROCEDURE	MOD1	MOD2	MOD3	MOD4	QTY.	REV. CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG. 1	LINE DIAG. 2	LINE DIAG. 3	LINE DIAG. 4	LINE DIAG. 5	LINE DIAG. 6
1	[]	[]	[]	[]	[]	[]	[]	[]	/ /	/ /	11 (Office)	Californ	[]	[]	[]	[]	[]	[]
2	[]	[]	[]	[]	[]	[]	[]	[]	/ /	/ /	11 (Office)	Californ	[]	[]	[]	[]	[]	[]
3	[]	[]	[]	[]	[]	[]	[]	[]	/ /	/ /	11 (Office)	Californ	[]	[]	[]	[]	[]	[]
4	[]	[]	[]	[]	[]	[]	[]	[]	/ /	/ /	11 (Office)	Californ	[]	[]	[]	[]	[]	[]
5	[]	[]	[]	[]	[]	[]	[]	[]	/ /	/ /	11 (Office)	Californ	[]	[]	[]	[]	[]	[]

Add More Procedures >>

What are the required and optional claim entry fields?

2

Simulate

Required

- **Claim type**
(Professional or Facility Outpatient)
- **Plan type**
- **Patient's gender**
- **Date of birth**
- **Procedure code**
(CPT or HCPCS)
- **Quantity of procedures performed**
(Defaults to 1)
- **Revenue code**
(For facility claims only)
- **Place of service**
(Required for professional claims only – press tab for Office “11” default. Leave blank for facility claims.)

Optional

- Claim level ICD-10 diagnosis code(s)
- Bill type
(The default is professional claims and the field is left blank. If it's a facility outpatient claim, the field will automatically display hospital outpatient #131 but you can type over that value if desired.)
- Two-character modifier(s) codes associated with the procedure if applicable
- Billed amount
- Date of service from and to
(Defaults to current date)
- Provider State (Defaults to CA)
- Procedure line diagnosis codes

Entering information into optional fields can potentially make a big difference in the results.



Will C3 remind me if I missed any information?

2

Simulate

Yes, C3 will remind you with pop-up messages if you missed any required information on the claim entry screen.

blue
california
Clear Claim Connection [Sign Out Help](#)

[Edit Development](#) | [Glossary](#) | [About](#)

CLAIM ENTRY

Claim Type:

Plan Type:

Gender: Male Female

Date of Birth:

ICD Code Set: ICD10

Diagnosis Codes: 1 2 3 4 5 6 7 8 9 10 11 12

Bill Type:

For quick entry, use your Down Arrow key after you enter a procedure code. Qty will default to 1, Billed Amount will default to 100, Date of Service From and To will default to today's date, and Place of Service will default to 11 (Office). Tabbing through these same fields will give you the same defaults.

Error(s) occurred during claim processing.
 Please enter the required information in the highlighted field(s).

LINE	PROCEDURE	MOD1	MOD2	MOD3	MOD4	QTY.	REV. CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG. 1	LINE DIAG. 2	LINE DIAG. 3	LINE DIAG. 4	LINE DIAG. 5	LINE DIAG. 6
1									// //	// //	11 (Office)	Californ						
2									// //	// //	11 (Office)	Californ						
3									// //	// //	11 (Office)	Californ						
4									// //	// //	11 (Office)	Californ						
5									// //	// //	11 (Office)	Californ						

[Add More Procedures >>](#)

Information alerts are triggered for empty or invalid fields such as date of birth, procedure, quantity, billed amount and date of service and for invalid procedure, modifier and diagnosis codes. To make a correction, click in the specified field and re-type the correct information.

What are C3's claim audit results?

2

Simulate

Each procedure is accompanied by a recommendation:

Allow: Indicates there is no edit for the procedure code(s) submitted.

Allow Add: Indicates that additional procedure line(s) were added by the system such as unbundling or quantity expansion.

Review: Indicates that the procedure code(s) should be evaluated against the information on the Clinical Edit Clarification to determine if the data entered and/or procedure codes(s) can be corrected prior to submission. Review may also indicate that additional information is required to process the claim.

Disallow: Indicates that there is an edit for the procedure(s) submitted. Review the Clinical Edit Clarification for more information.

The screenshot shows the 'Clear Claim Connection' interface. At the top, there are navigation links for 'Edit Development', 'Glossary', and 'About'. Below this, there are buttons for 'Current Claim' and 'Create New Claim'. The main section is titled 'AUDIT RESULTS' and contains a disclaimer: 'The results displayed do not guarantee how the claim will be processed.'

Key claim details are listed:

- Claim Type: Professional
- Plan Type: Individual/Small Group/Employer Group Plans
- Gender: Male
- Date of Birth: 01/01/1970
- ICD Code Set: ICD10
- Diagnosis Codes: 1 R26.9, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12
- Bill Type: (blank)

A note states: 'Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarification.'

LINE	PROCEDURE	DESCRIPTION	MOD1	MOD2	MOD3	MOD4	QTY.	REV. CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG. 1	LINE DIAG. 2	RVU	PAY %	RECOMMENDATION
1	97116	GAIT TRAINING THERAPY					1		100	08/21/2017	08/21/2017	11 (Office)	California	R26.9		0		DISALLOW
2	97530	THERAPEUTIC ACTIVITIES					1		100	08/21/2017	08/21/2017	11 (Office)	California	R26.9		n/a		ALLOW

A red arrow points from the 'DISALLOW' recommendation for line 1 to the 'ALLOW' recommendation for line 2.

What are C3's clinical edit clarifications?

3

Recalibrate

Consider other coding combinations if needed



Clear Claim Connection

Sign Out Help

Edit Development

Glossary

About

CLINICAL EDIT CLARIFICATIONS

Current Claim

Review Audit Results

Print

Create New Claim

Inquiry

Why is this procedure disallowed?

Procedure	Description
97116	THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING (INCLUDES STAIR CLIMBING)
97530	THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES

Response

The CPT Manual often describes groups of similar codes differing in the complexity of the service. Unless services are performed at separate patient encounters or at separate anatomic sites, the less complex service is included in the more complex service and is not separately reportable. Several examples of this principle follow: 1. If two procedures only differ in that one is described as a "simple" procedure and the other as a "complex" procedure, the "simple" procedure is included in the "complex" procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites. 2. If two procedures only differ in that one is described as a "simple" procedure and the other as a "complicated" procedure, the "simple" procedure is included in the "complicated" procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites. 3. If two procedures only differ in that one is described as a "limited" procedure and the other as a "complete" procedure, the "limited" procedure is included in the "complete" procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites. 4. If two procedures only differ in that one is described as an "intermediate" procedure and the other as a "comprehensive" procedure, the "intermediate" procedure is included in the "comprehensive" procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites. 5. If two procedures only differ in that one is described as a "superficial" procedure and the other as a "deep" procedure, the "superficial" procedure is included in the "deep" procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites. 6. If two procedures only differ in that one is described as an "incomplete" procedure and the other as a "complete" procedure, the "incomplete" procedure is included in the "complete" procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites. 7. If two procedures only differ in that one is described as an "external" procedure and the other as an "internal" procedure, the "external" procedure is included in the "internal" procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

Therefore, this procedure is not recommended for separate reimbursement.

Sources

n/a



Blue Shield of California



Clear Claim Connection demonstration



To sum up how to use C3:

1. Locate

Log in to Blue Shield's Provider Connection at blueshieldca.com/provider

On the Provider Connection home screen, go to the *Claims* section

Then click the *Prescreen Claims* link

Read the Terms & Conditions and click *I agree to continue*

2. Simulate

Enter the required claim information

View the claim audit results: Allow, Allow-Add, Review, Disallow

Study the clinical edit clarifications for Review and Disallow results

3. Recalibrate

Consider other coding combinations if needed

To sum up how to use C3:

1. Access on Provider Connection

The screenshot shows the 'eligibility & benefits' page on the Provider Connection portal. It includes a navigation bar with links for 'provider home', 'eligibility & benefits', 'authorizations', 'claims', 'guidelines & resources', and 'news & education'. The main content area features a large heading 'eligibility & benefits' and a sub-heading 'use this tool to verify patients' eligibility and coverage, see detailed benefits, get a quick view of current and historical coverage'. Below this, there are three main sections: 'Eligibility & Benefits', 'Claims', and 'BlueCard Program'. The 'Eligibility & Benefits' section includes links for 'Verify Eligibility', 'Create Roster', 'Benefit Summaries', and 'Preventive Health Guidelines'. The 'Claims' section includes links for 'Check Claim Status', 'Manage Electronic Transactions', 'Submit Claims for Free', 'How to Submit Claims', 'Prescreen Claims', 'Claims Appeals & Adjustments', and 'Professional Fee Schedule'. The 'BlueCard Program' section includes links for 'BlueCard Home Page', 'Access Claims Routing Tool', 'Check Eligibility of Blue Plan Members', 'Search BlueCard Claims', and 'Find BlueCard Resources'. A red arrow points to the 'Eligibility & Benefits' section.

2. Enter claim information

The screenshot shows the 'Clear Claim Connection' form. It includes a navigation bar with 'Edit Development', 'Glossary', and 'About'. The main content area is titled 'CLAIM ENTRY' and includes a 'Clear' button and a 'Review Audit Results' button. The form fields include: 'Claim Type' (Professional), 'Plan Type' (Individual/Small Group/Employer Group Plans), 'Gender' (Male/Female), 'Date of Birth' (MM/DD/YYYY), 'ICD Code Set' (ICD10), 'Diagnosis Codes' (1-12), and 'Bill Type'. Below the form fields, there is a table for 'LINE' with columns for 'PROCEDURE', 'MOOD', 'MOOD', 'MOOD', 'MOOD', 'QTY', 'REV CODE', 'BILLED AMT', 'DOS FROM', 'DOS TO', 'PLACE OF SERVICE', 'PROVIDER STATE', 'LINE DMS1', 'LINE DMS2', 'LINE DMS3', 'LINE DMS4', 'LINE DMS5', and 'LINE DMS6'. The table contains 5 rows of data. Below the table, there is a link for 'Add More Procedures -->'. A red arrow points to the 'Review Audit Results' button.

3. Review claim audit results

The screenshot shows the 'Audit Results' page. It includes a navigation bar with 'Edit Development', 'Glossary', and 'About'. The main content area is titled 'AUDIT RESULTS' and includes a 'Current Claim' button and a 'Create New Claim' button. Below the buttons, there is a section for 'The results displayed do not guarantee how the claim will be processed'. This is followed by a table with columns for 'Claim Type', 'Plan Type', 'Gender', 'Date of Birth', 'ICD Code Set', 'Diagnosis Codes', and 'Bill Type'. Below this, there is a table for 'LINE' with columns for 'PROCEDURE', 'DESCRIPTION', 'MOOD', 'MOOD', 'MOOD', 'MOOD', 'QTY', 'REV CODE', 'BILLED AMT', 'DOS FROM', 'DOS TO', 'PLACE OF SERVICE', 'PROVIDER STATE', 'LINE DMS1', 'LINE DMS2', 'RVU', 'PAY %', and 'RECOMMENDATION'. The table contains 2 rows of data. Below the table, there is a link for 'Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarifications'.

4. View clinical edit clarifications

The screenshot shows the 'Clinical Edit Clarifications' page. It includes a navigation bar with 'Edit Development', 'Glossary', and 'About'. The main content area is titled 'CLINICAL EDIT CLARIFICATIONS' and includes a 'Current Claim' button, a 'Review Audit Results' button, a 'Print' button, and a 'Create New Claim' button. Below the buttons, there is a section for 'Inquiry' with a link for 'View in my procedure dashboard?'. This is followed by a table with columns for 'Procedure' and 'Description'. The table contains 2 rows of data. Below the table, there is a section for 'Response' with a link for 'Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarifications'. This is followed by a table with columns for 'Procedure', 'Description', 'MOOD', 'MOOD', 'MOOD', 'MOOD', 'QTY', 'REV CODE', 'BILLED AMT', 'DOS FROM', 'DOS TO', 'PLACE OF SERVICE', 'PROVIDER STATE', 'LINE DMS1', 'LINE DMS2', 'RVU', 'PAY %', and 'RECOMMENDATION'. The table contains 2 rows of data. Below the table, there is a link for 'Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarifications'.

How can I get more help using C3?

On Provider Connection (blueshieldca.com/provider/news-education/home.sp)

Job aid with step-by-step instructions

FAQ

Webinar recording

These tools, and all provider learning resources, will be found under the *News & Education* tab

The screenshot shows the Blue Shield of California Provider Connection website. At the top, the logo "blue of california" is followed by "provider connection" and a search bar with a "SEARCH" button. Below this is a navigation menu with tabs: "provider home", "eligibility & benefits", "authorizations", "claims", "guidelines & resources", and "news & education". A red arrow points to the "news & education" tab. Below the navigation menu, the page content is divided into three main sections. On the left is a sidebar with links: "Register for Webinars", "AuthAccel Online Authorization Training", "Tools and Tutorials", and "News and Announcements". The middle section is titled "news and education" and features a large graphic with the text "find tools, tutorials, and more" and an image of a laptop displaying "Provider Education & Communication" with a stethoscope resting on it. On the right is a user profile section for "Eric C3test" with a "Log Out" link and a "Helpful Resources" list including: "Exclusive PPO Provider Toolkit", "Authorizations", "Clinical Policies And Guidelines", "BlueCard Program", and "Provider Demographic Information".

C3 learning resources will also be linked directly to the Claim tab's "Payment Policies and Rules" and "How to Submit Claims" sections

Or call Provider Customer Service at (800) 541-6652

Clear Claim Connection (C3) Instructions

What is C3?

C3 prescreens claims. It simulates claim auditing by testing different CPT and HCPCS codes to see their allow/allow add/review/disallow recommendations.

It enables providers to transparently view Blue Shield's current claim auditing rules and clinical rationales from nationally recognized sources.

Why should I use C3?

Prescreening claims improves coding accuracy which leads to more efficient processing and payment.

What is C3's scope?

C3 does:

- Offer a beneficial, but not mandatory, supplemental simulation reference tool of how claims may be audited
- Provide coding information
- Disclose claims payment policies
- Provide straightforward claim audit results
- Explain potential claim decisions

C3 does not:

- Submit claims
- Provide claims pricing or reimbursement information
- Imply member eligibility
- Indicate the service is covered
- Guarantee if or how the claim will be paid

How do I use C3?

1. Locate	2. Simulate	3. Recalibrate
a. Log in to Blue Shield's Provider Connection at blueshieldca.com/provider	a. Enter required claim information	a. Consider other coding combinations if needed
b. On the Provider Connection home screen, go to the <i>Claims</i> section	b. Review claim audit results	
c. Click the <i>Prescreen Claims</i> link	c. Study the clinical edit clarifications for Review and Disallow results	
d. Read the Terms & Conditions and click <i>I agree to continue</i>		

Where can I find more learning resources?

The webinar recording with slide deck, this job aid and the FAQ will be posted on Provider Connection:

The screenshot shows the Blue Shield of California Provider Connection website. At the top, there is a search bar with the text 'blue of california provider connection' and a 'SEARCH' button. Below the search bar is a navigation menu with tabs for 'provider home', 'eligibility & benefits', 'authorizations', 'claims', 'guidelines & resources', and 'news & education'. The 'news & education' tab is selected. The main content area features a 'news and education' header with the text 'find tools, tutorials, and more' and an image of a laptop displaying 'Provider Education & Communication' with a stethoscope. On the right side, there is a 'Welcome, Eric C3test' message with a 'Log Out' link and a 'Helpful Resources' section listing: 'Exclusive PPO Provider Toolkit', 'Authorizations', 'Clinical Policies And Guidelines', 'BlueCard Program', and 'Provider Demographic Information'. On the left side, there are links for 'Register for Webinars', 'AuthAccel Online Authorization Training', 'Tools and Tutorials', and 'News and Announcements'.

We hope you use C3 because ...



- Prescreening claims improves coding accuracy which leads to more efficient processing and payment
- You can transparently view our current claim rules, payment policies and clinical rationales
- It removes the need to call customer service to ask why a claim was denied
- It circumvents the need for Blue Shield to ask for records due to inaccurate coding
- It enhances member satisfaction by avoiding the extra steps associated with erroneous billing
- It's easy to use



Resources

For...

- Authorizations
- Billing
- Eligibility
- Benefits
- Claims
- Technical issues with website

Call...

Provider Customer Service Help Line:
(800) 541-6652

- Network confirmation
- Contract questions
- Rates

Provider Information and Enrollment:
(800) 258-3091

- Pharmacy Call Center

(800) 535-9481

- BlueCard eligibility and benefits

(800) 676-BLUE

- BlueCard claims

(800) 622-0632

