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?

<table>
<thead>
<tr>
<th>C3 does</th>
<th>C3 does not</th>
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<tbody>
<tr>
<td>Offer a beneficial, but not</td>
<td>Submit claims</td>
</tr>
<tr>
<td>mandatory, supplemental</td>
<td>Provide claims pricing or reimbursement information</td>
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<tr>
<td>simulation reference tool of how</td>
<td>Imply member eligibility</td>
</tr>
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<td>claims may be audited</td>
<td>Indicate the service is covered</td>
</tr>
<tr>
<td>Provide coding information</td>
<td>Guarantee if or how the claim will be paid</td>
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<tr>
<td>Disclose claims payment policies</td>
<td>Consider pre-authorization requirements or benefits</td>
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<tr>
<td>Provide straightforward claim</td>
<td>Include PHI since it is not member specific</td>
</tr>
<tr>
<td>audit results</td>
<td>Access claim history</td>
</tr>
<tr>
<td>Explain potential claim decisions</td>
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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?

<table>
<thead>
<tr>
<th>Can prescreen claims</th>
<th>Cannot prescreen claims</th>
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<tbody>
<tr>
<td>• Individual/Small Group/Employer Group Plans</td>
<td>• Care First (Medi-Cal and Medicaid)</td>
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<tr>
<td>• Medicare Advantage</td>
<td></td>
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<tr>
<td>• Shared Advantage</td>
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<tr>
<td>• Federal Employee Health Plan</td>
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<td>• Medicare Supplement</td>
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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?

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.
What is on C3’s top row menu bar?

C3 home screen for claim entry
How do I simulate claims with C3?

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

1. Enter claim information
2. Review claim audit results
3. View clinical edit clarifications
How do I enter claim information?

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
What are the required and optional claim entry fields?

**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?

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

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?

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 code(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.
What are C3’s clinical edit clarifications?

Consider other coding combinations if needed.

<table>
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<tr>
<th>Inquiry</th>
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<tr>
<td>Why is this procedure disallowed?</td>
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</table>

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
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<tbody>
<tr>
<td>97116</td>
<td>THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING (INCLUDES STAIR CLIMBING)</td>
</tr>
<tr>
<td>97530</td>
<td>THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES</td>
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<th>Response</th>
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<tr>
<td>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. If two procedures only differ in that one is described as a &quot;simple&quot; procedure and the other as a &quot;complex&quot; procedure, the &quot;simple&quot; procedure is included in the &quot;complex&quot; procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites. If two procedures only differ in that one is described as a &quot;simple&quot; procedure and the other as a &quot;complicated&quot; procedure, the &quot;simple&quot; procedure is included in the &quot;complicated&quot; procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites. If two procedures only differ in that one is described as a &quot;limited&quot; procedure and the other as a &quot;complete&quot; procedure, the &quot;limited&quot; procedure is included in the &quot;complete&quot; procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites. If two procedures only differ in that one is described as an &quot;intermediate&quot; procedure and the other as a &quot;comprehensive&quot; procedure, the &quot;intermediate&quot; procedure is included in the &quot;comprehensive&quot; procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites. If two procedures only differ in that one is described as a &quot;superficial&quot; procedure and the other as a &quot;deep&quot; procedure, the &quot;superficial&quot; procedure is included in the &quot;deep&quot; procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites. If two procedures only differ in that one is described as an &quot;incomplete&quot; procedure and the other as a &quot;complete&quot; procedure, the &quot;incomplete&quot; procedure is included in the &quot;complete&quot; procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites. If two procedures only differ in that one is described as an &quot;external&quot; procedure and the other as an &quot;internal&quot; procedure, the &quot;external&quot; procedure is included in the &quot;internal&quot; 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.</td>
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| Sources |
|!  |
| n/a |
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

2. Enter claim information

3. Review claim audit results

4. View clinical edit clarifications
How can I get more help using C3?

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

<table>
<thead>
<tr>
<th>Job aid with step-by-step instructions</th>
<th>FAQ</th>
<th>Webinar recording</th>
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These tools, and all provider learning resources, will be found under the News & Education tab.

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?

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<td>c. Click the Prescreen Claims link</td>
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<tr>
<td>d. Read the Terms &amp; Conditions and click I agree to continue</td>
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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:

Blue Shield of California provider connection

Provider Connection > News and Education

Provider Education & Communication

Register for Webinars
AuthAccel Online Authorization Training
Tools and Tutorials
News and Announcements

news and education

find tools, tutorials, and more

Welcome, Eric C3test
Log Out

Helpful Resources
• Exclusive PPO Provider Toolkit
• Authorizations
• Clinical Policies And Guidelines
• BlueCard Program
• Provider Demographic Information
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

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<tr>
<th>For...</th>
<th>Call...</th>
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<tbody>
<tr>
<td>• Authorizations</td>
<td>Provider Customer Service Help Line:</td>
</tr>
<tr>
<td>• Billing</td>
<td>(800) 541-6652</td>
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<td>• Eligibility</td>
<td></td>
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<tr>
<td>• Benefits</td>
<td></td>
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<tr>
<td>• Claims</td>
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<td>• Technical issues with website</td>
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<td>• Network confirmation</td>
<td>Provider Information and Enrollment:</td>
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<tr>
<td>• Contract questions</td>
<td>(800) 258-3091</td>
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<td>• Rates</td>
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<td>• Pharmacy Call Center</td>
<td>(800) 535-9481</td>
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<tr>
<td>• BlueCard eligibility and benefits</td>
<td>(800) 676-BLUE</td>
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<td>• BlueCard claims</td>
<td>(800) 622-0632</td>
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