How to prescreen claims with Clear Claim Connect (C3)

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

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

Follow this three-step process:

1. Locate
2. Simulate
3. Recalibrate
**Locate C3 on the Provider Connection portal**

A. Log in to Blue Shield of California’s Provider Connection at [blueshieldca.com/provider](http://blueshieldca.com/provider) with your existing username and password.

B. From the Provider Connection home screen, go to **Claims** by clicking one of the links highlighted below.

C. Click the blue box shown below in the **Claims Tools** section to access C3.
C3’s top row menu bar

1. Locate C3 home screen for claim entry

- View information about the process and sources used to develop the C3 edits.
- View C3 claim screening terminology.
- View information regarding C3 copyright and licensure information.
- Sign out when you are finished and wish to exit C3.
- Access online Help’s searchable support tool.
Simulate claims with C3

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

- Enter claim information
- Review claim audit results
- View clinical edit clarifications
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
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**

Tip: The more information you provide, the better the result.
C3 will highlight missing information

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.
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 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.
C3’s clinical edit clarifications

Recalibrate

Consider other coding combinations if needed

**Inquiry**
Why is procedure V2520 with units of service disallowed?

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2520</td>
<td>CONTACT LENS HYDROPHILIC, SPHERICAL, PER LENS</td>
</tr>
</tbody>
</table>

**Response**
Medically Unlikely Edit (MUE): An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day’s supply. The MUE edits were developed based on anatomic considerations, HCPCS/CPT code descriptors, CPT instructions, CMS policies, nature of service/procedure, nature of analyte, nature of equipment, and clinical judgment. Prior to implementation, all edits were reviewed by national healthcare organizations, and their alternative recommendations were taken into consideration. Source: CMS Office of Financial Management / Program Integrity Group; CMS Pub 100-08 Medicare Program Integrity- Transmittal 155, Change Request 4209.

Therefore, procedure code V2520 with units of service is not recommended for reimbursement.

**Sources**
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
   - Pay particular attention to the required criteria for the code. This will help you determine the reason C3 recommended the claim edits given the rules that were applied.
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