

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

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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 **Claims** by clicking one of the links highlighted below.
- C. Click the blue box shown below in the **Claims Tools** section to access C3.

The screenshot shows the Blue Shield of California Provider Connection portal. The top navigation bar includes links for Log in, Message center, Account management, Manage my profile, Contact us, Help, and Feedback. The main navigation menu has tabs for Eligibility & benefits, Authorizations, Claims, Guidelines & resources, and News & education. The 'Claims' tab is highlighted with a red box. Below the navigation is a banner with the text 'Powerful provider tools and resources at your fingertips' and a photo of a woman. A blue box below the banner contains the text 'Welcome to Provider Connection' and 'Find out what's new for Blue Shield and Blue Shield of California Promise Health Plan providers. Discover improved tools and helpful resources to support your practice.' Below this are two buttons: 'Get Blue Shield providers' guide' and 'Get Blue Shield Promise providers' guide'. The main content area has three columns: 'Eligibility & benefits', 'Authorizations', and 'Claims'. The 'Claims' column is highlighted with a red box and contains the text 'Access tools to prescreen, submit and check the status of submitted claims.' and a list of links: 'Claim status', 'Professional fee schedule', 'Claims routing tool', 'Electronic transactions management', 'Claims submission instructions', and 'Claims appeals and adjustments'. A red arrow points from the 'Claims' button to a callout box on the right.

Clear Claim Connection (C3)
Use our simulation tool to prescreen claims, view claim auditing rules, payment policies, and more.

C3's top row menu bar

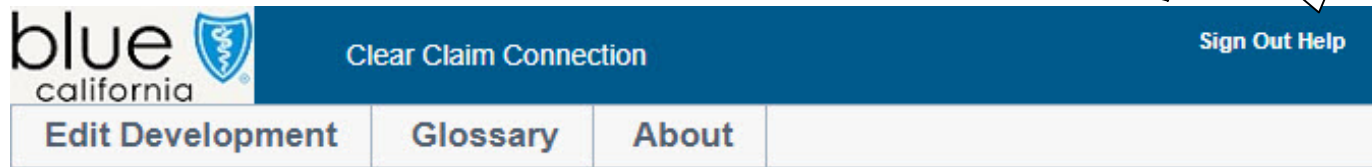
1

Locate

C3 home screen for claim entry

Sign out when you are finished and wish to exit C3.

Access online Help's searchable support tool.



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.

Simulate claims with C3

2

Simulate

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



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

CLAIM ENTRY

Clear Review Audit Results

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) if Professional or blank if Facility (Outpatient). Tabbing through these same fields will give you the same defaults. Please note: All Alpha characters must be Upper Case (such as Procedure Codes, Modifiers, Diagnosis etc.) Lowercase Alpha characters will cause an error.

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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value="11 (Office)"/>	<input type="text" value="Califorr"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value="11 (Office)"/>	<input type="text" value="Califorr"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value="11 (Office)"/>	<input type="text" value="Califorr"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value="11 (Office)"/>	<input type="text" value="Califorr"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value="11 (Office)"/>	<input type="text" value="Califorr"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Add More Procedures >>

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

Tip: The more information you provide, the better the result.



C3 will highlight missing information

2

Simulate

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

blue shield of california Clear Claim Connection Sign Out Help

Edit Development Glossary About

CLAIM ENTRY Clear Review Audit Results

Claim Type: Professional
Plan Type: Individual/Small Group/Employer Group Plans
Gender: Male (selected) Female
Date of Birth: [Redacted]
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) if Professional or blank if Facility (Outpatient). Tabbing through these same fields will give you the same defaults. Please note: All Alpha characters must be Upper Case (such as Procedure Codes, Modifiers, Diagnosis etc.) Lowercase Alpha characters will cause an error.

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.	DO'S FROM	DO'S TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG. 1	LINE DIAG. 2	LINE DIAG. 3	LINE DIAG. 4	LINE DIAG. 5
1	[Redacted]	[]	[]	[]	[]	[Redacted]	[]	[Redacted]	[Redacted]	[Redacted]	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.

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 'AUDIT RESULTS' section of a web application. At the top, there is a navigation bar with the Blue Shield of California logo, 'Clear Claim Connection', and links for 'Edit Development', 'Glossary', and 'About'. A 'Sign Out Help' link is in the top right. Below the navigation bar are two buttons: 'Current Claim' and 'Create New Claim'. A disclaimer states: 'The results displayed do not guarantee how the claim will be processed.' Below this, claim details are listed: Claim Type (Professional), Plan Type (Individual/Small Group/Employer Group Plans), Gender (Male), Date of Birth (01/01/1986), and ICD Code Set (ICD10). There are 12 diagnosis codes, with '1 H18' selected. Below the diagnosis codes is the 'Bill Type' section and a note: 'Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarification.' The main part of the screenshot is a table with 18 columns: LINE, PROCEDURE, DESCRIPTION, MOD1, MOD2, MOD3, MOD4, QTY., REV. CODE, BILLED AMT., DOS FROM, DOS TO, PLACE OF SERVICE, PROVIDER STATE, LINE DIAG. 1, RVU, PAY %, and RECOMMENDATION. Two rows are shown. Row 1: LINE 1, PROCEDURE V2520, DESCRIPTION CONTACT LENS HYDROPHILIC, QTY. 24, BILLED AMT. 100, DOS FROM 05/19/2017, DOS TO 05/19/2017, PLACE OF SERVICE 11 (Office), PROVIDER STATE California, LINE DIAG. 1, RVU 0, PAY %, and RECOMMENDATION DISALLOW. Row 2: LINE 2, PROCEDURE V2520, DESCRIPTION CONTACT LENS HYDROPHILIC, QTY. 2.00, BILLED AMT. 100, DOS FROM 05/19/2017, DOS TO 05/19/2017, PLACE OF SERVICE 11 (Office), PROVIDER STATE California, LINE DIAG. 1, RVU n/a, PAY %, and RECOMMENDATION ALLOW-ADD. A red arrow points from the 'DISALLOW' recommendation in row 1 to the 'ALLOW-ADD' recommendation in row 2.

LINE	PROCEDURE	DESCRIPTION	MOD1	MOD2	MOD3	MOD4	QTY.	REV. CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG. 1	RVU	PAY %	RECOMMENDATION
1	V2520	CONTACT LENS HYDROPHILIC					24		100	05/19/2017	05/19/2017	11 (Office)	California		0		DISALLOW
2	V2520	CONTACT LENS HYDROPHILIC					2.00		100	05/19/2017	05/19/2017	11 (Office)	California		n/a		ALLOW-ADD

C3's clinical edit clarifications

3

Recalibrate

Consider other coding combinations if needed

The screenshot shows the Blue Shield of California website interface. At the top left is the Blue Shield of California logo. To its right is the text "Clear Claim Connection". Below this is a navigation bar with links for "Edit Development", "Glossary", and "About". A main header reads "CLINICAL EDIT CLARIFICATIONS". On the right side of this header are four buttons: "Current Claim", "Review Audit Results", "Print", and "Create New Claim". The main content area is titled "Inquiry" and contains the question "Why is procedure V2520 with units of service disallowed?". Below the question is a table with two columns: "Procedure" and "Description". The table contains one row with "V2520" in the "Procedure" column and "CONTACT LENS HYDROPHILIC, SPHERICAL, PER LENS" in the "Description" column. Below the table is a "Response" section with a paragraph explaining the Medically Unlikely Edit (MUE) and its application to procedure V2520. At the bottom of the page is a "Sources" section.

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california

Clear Claim Connection

Edit Development Glossary About

CLINICAL EDIT CLARIFICATIONS

Current Claim Review Audit Results Print Create New Claim

Inquiry

Why is procedure V2520 with units of service disallowed?

Procedure	Description
V2520	CONTACT LENS HYDROPHILIC, SPHERICAL, PER LENS

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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