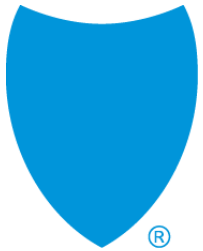


Introduction to Clear Claim Connection (C3)

Agenda

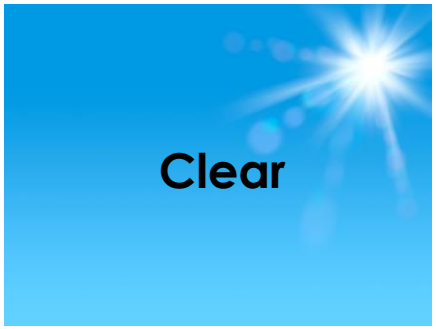
1. What is Clear Claim Connection (C3)?
2. Why should I use C3?
3. How do I use C3?
4. Where can I find learning resources?
5. What are your questions?

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

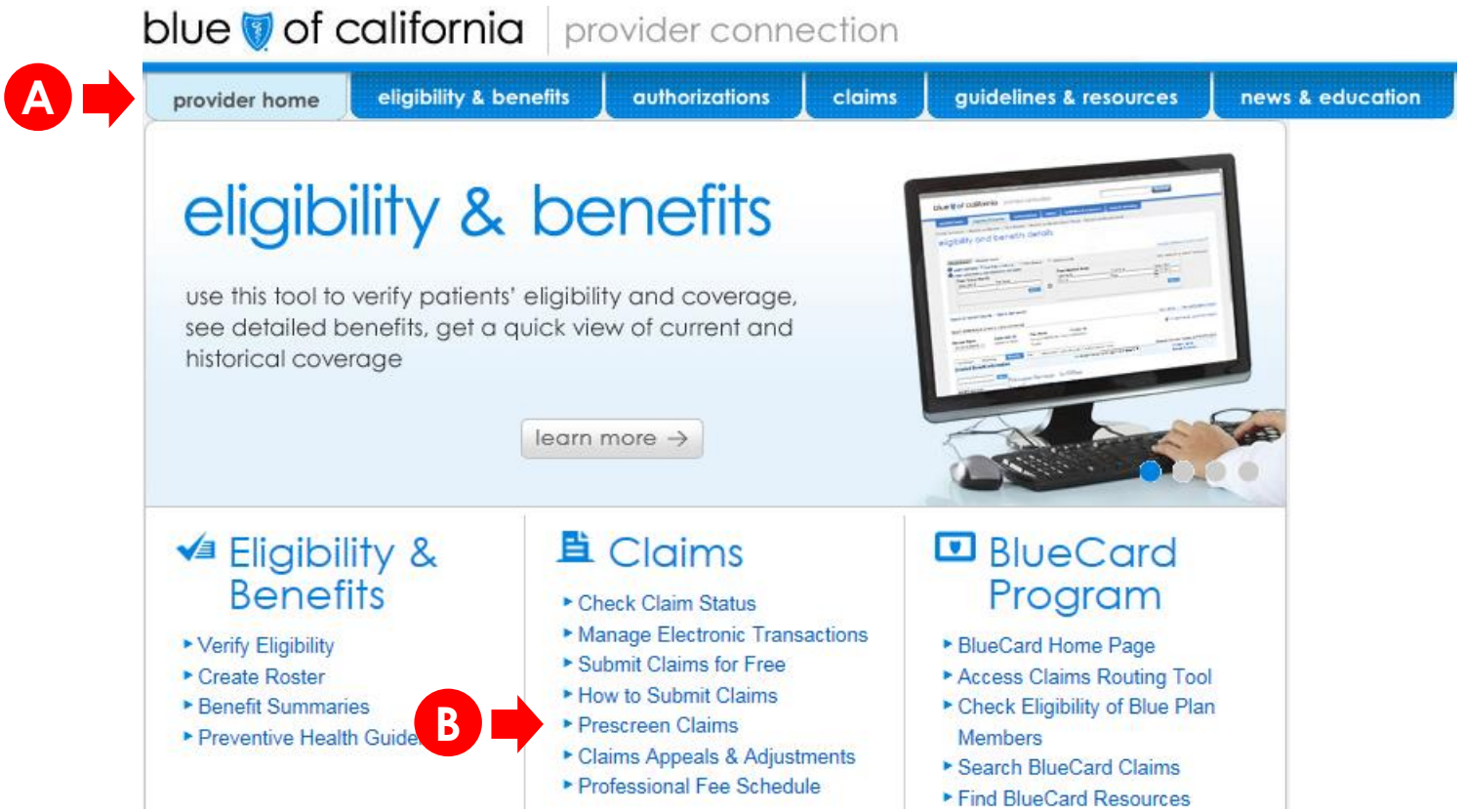
2. Simulate

3. Recalibrate

How do I locate C3 on the Provider Connection portal?

1 Locate

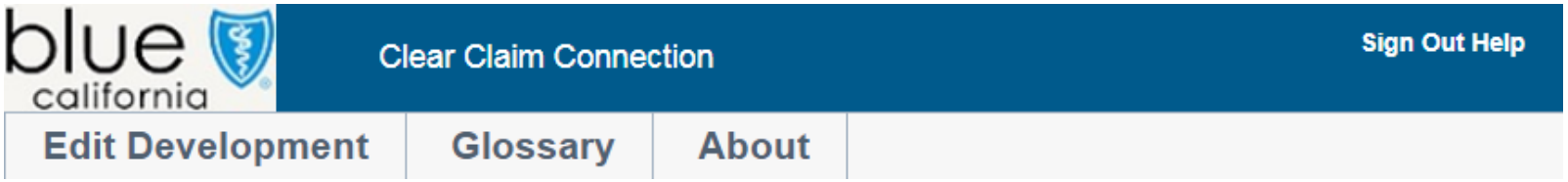
A. Log in to Blue Shield of California's Provider Connection at **blueshieldca.com/provider** with your existing username and password.
B. From the Provider Connection home screen, go to the ***Claims* section** and click on the ***Prescreen Claims* link** to access C3.
C. Read the Terms & Conditions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



What is on C3's top row menu bar?

1 Locate

C3 home screen for claim entry



How do I simulate claims with C3?

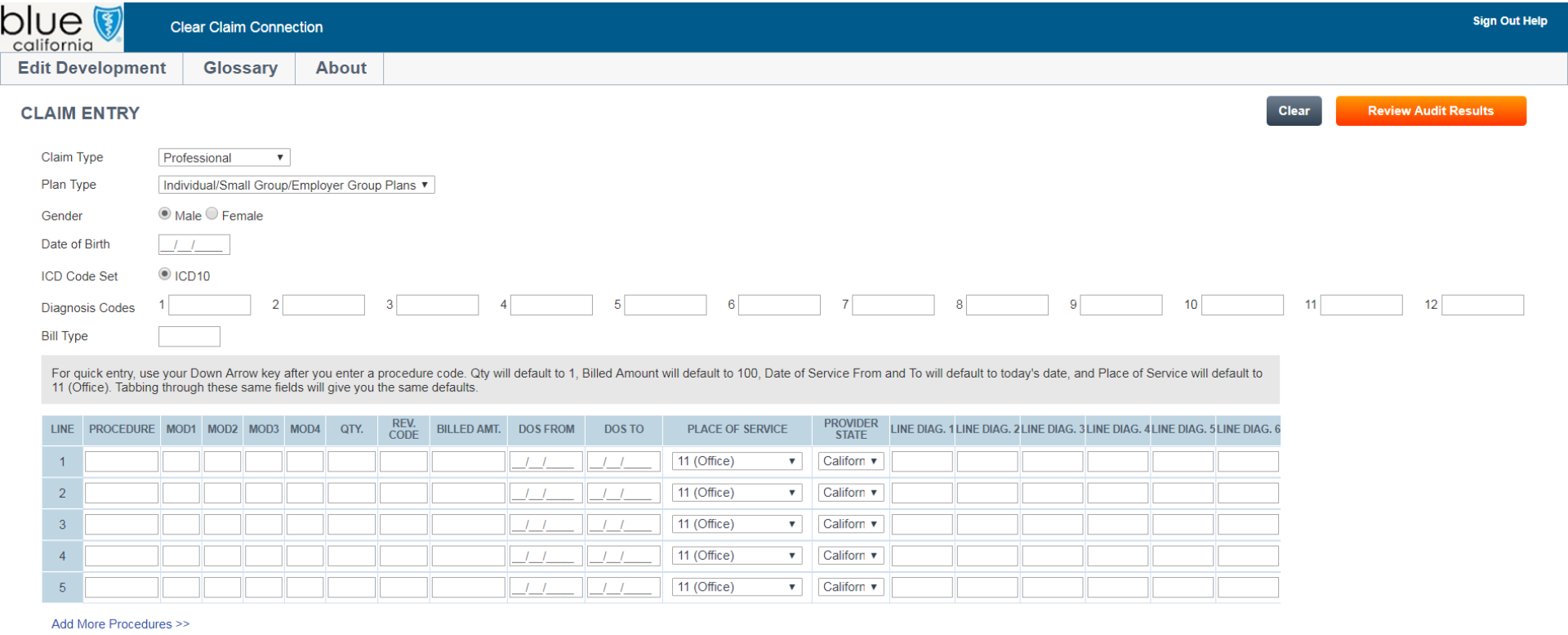
It's a simple process to review the recommendations and rationales for a claim.

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



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

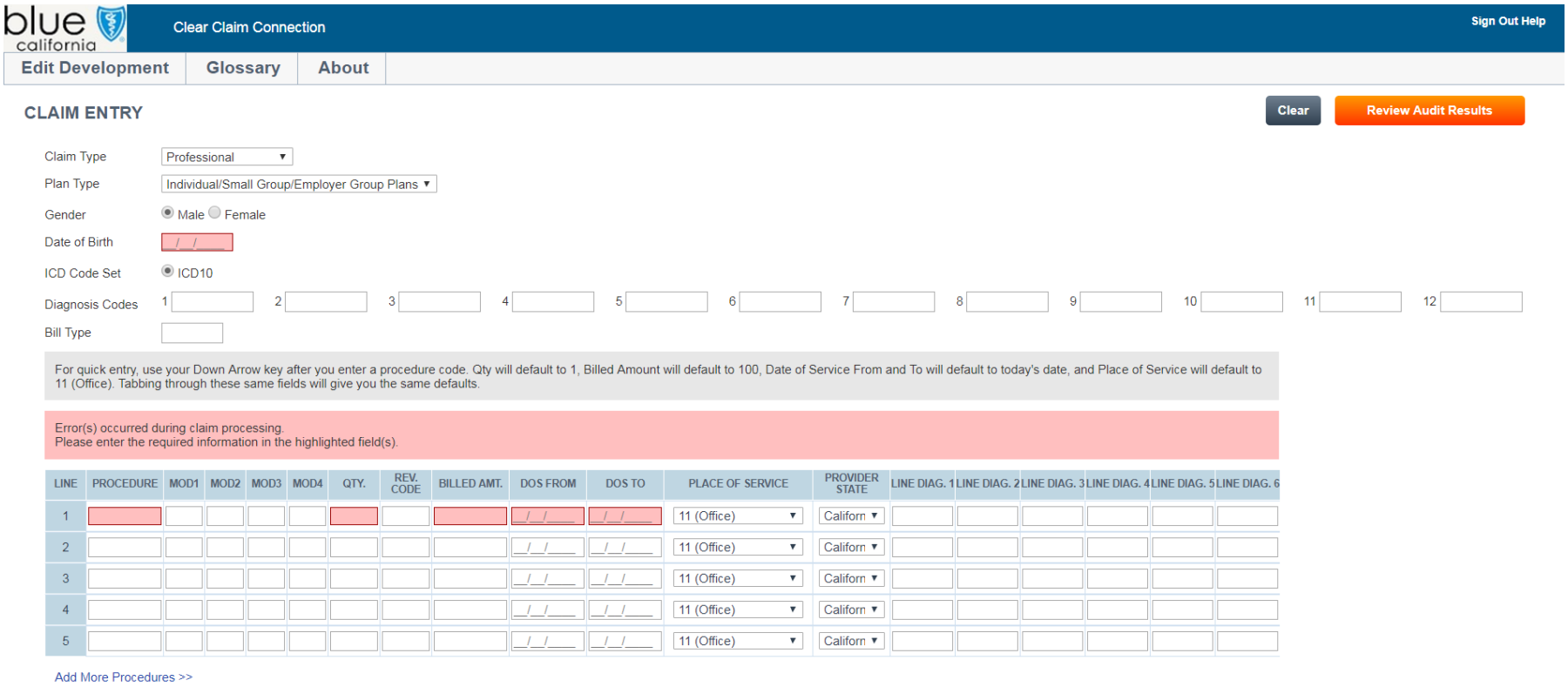
- Claim level ICD-10 diagnosis code(s)
- Bill type
  (The default is professional claims and the field is left blank. If it's a facility outpatient claim, the field will automatically display hospital outpatient #131 but you can type over that value if desired.)
- Two-character modifier(s) codes associated 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.



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

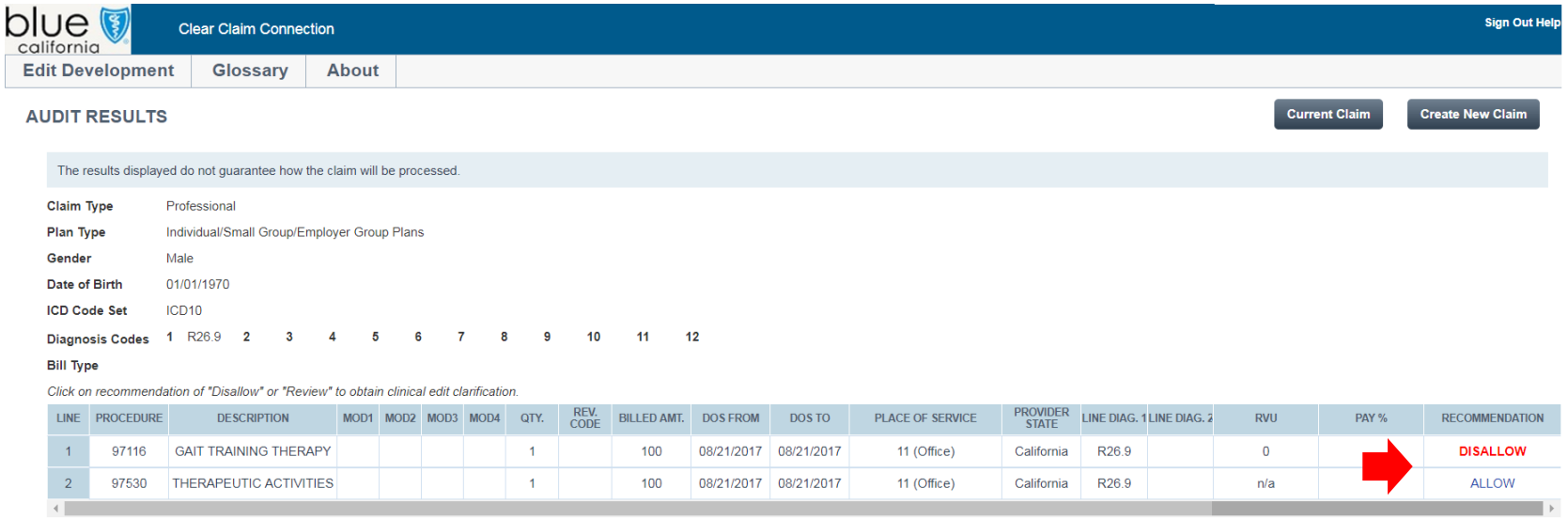
Each procedure is accompanied by a recommendation:

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.



What are C3's clinical edit clarifications?

3 **Recalibrate**

Consider other coding combinations if needed

blue california | 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

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

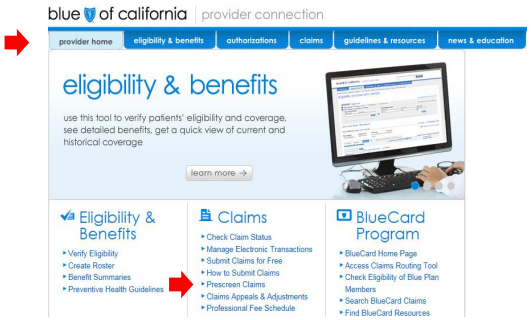
- Enter the required claim information
- View the claim audit results: Allow, Allow-Add, Review, Disallow
- Study the clinical edit clarifications for Review and Disallow results

3. Recalibrate

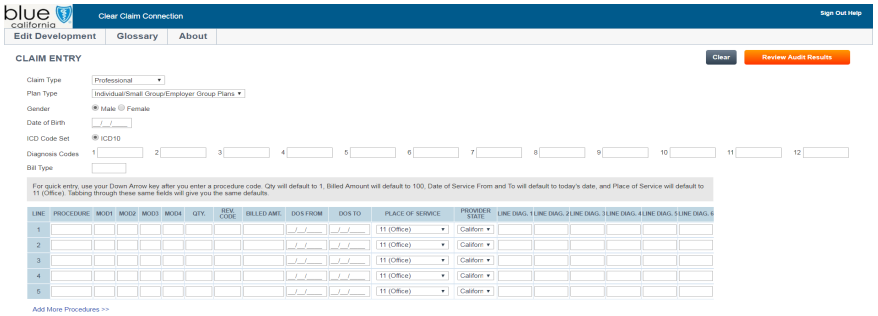
- Consider other coding combinations if needed

To sum up how to use C3:

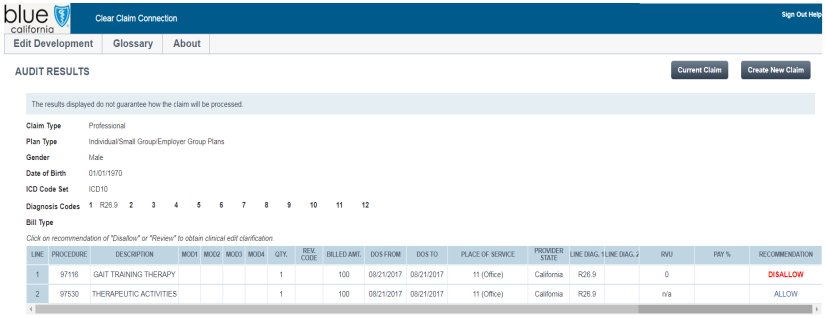
1. Access on Provider Connection



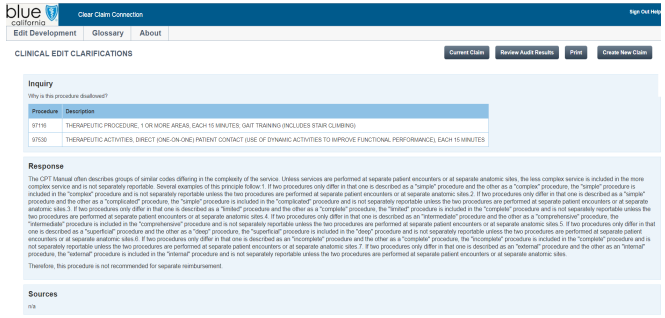
2. Enter claim information



3. Review claim audit results



4. View clinical edit clarifications

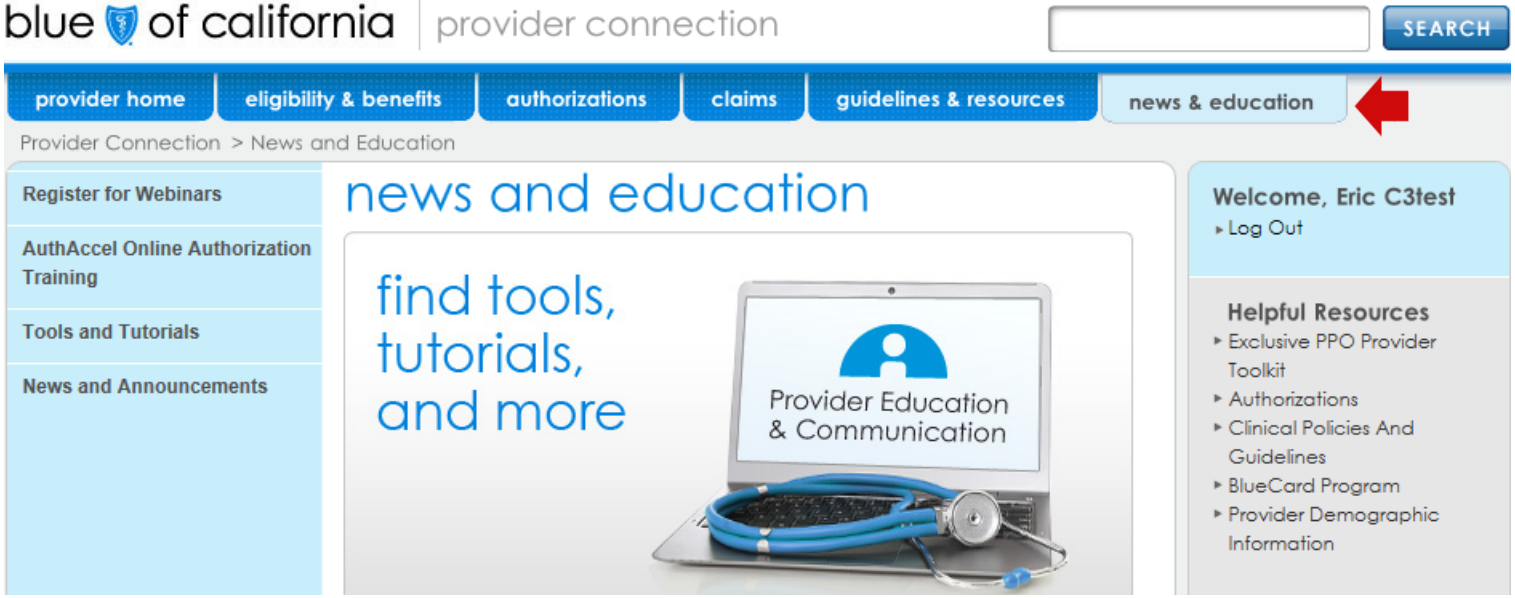


How can I get more help using C3?

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

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



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:

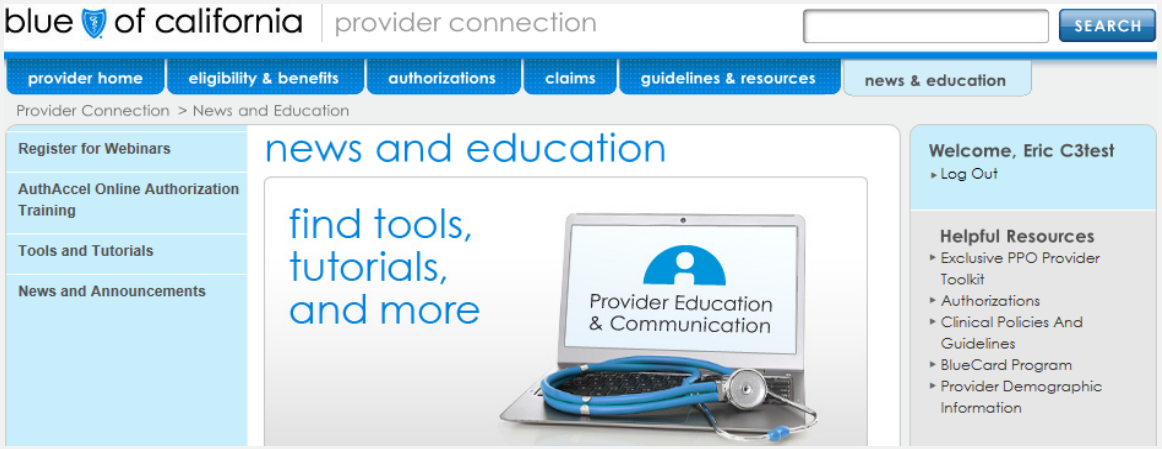
- Submit claims
- Provide claims pricing or reimbursement information
- Imply member eligibility
- Indicate the service is covered
- Guarantee if or how the claim will be paid

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 *Claims* section	b. Review claim audit results	
c. Click the *Prescreen Claims* link	c. Study the clinical edit clarifications for Review and Disallow results	
d. Read the Terms & Conditions and click *I agree* to continue		

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:



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…	Call…
• Authorizations • Billing • Eligibility • Benefits • Claims • Technical issues with website	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**