C3 USER GUIDE

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CLEAR CLAIM CONNECTION™ (C3) USER GUIDE

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Clear Claim Connection (C3) Overview

What is C3?

Clear Claim Connection (C3) is an online code editing reference tool operated by a third party (Change Healthcare), designed to display how coding combinations are evaluated by the Change Healthcare *ClaimsXten®* coding software during claim processing. The tool is not available for dental code edit audits. With this transparency tool, BCBSAZ claims payment policies, related rules, edit clarifications, and source information is easily accessible and available for online viewing 24/7.

The information received via the C3 tool does not constitute coverage, medical advice or guarantee of payment. It is not meant to prescribe, designate, or limit procedures or medical care to members. If there is a difference between information received on C3 and the member's benefit program, the member's benefit program will govern. The C3 tool is not configured to display information from the BCBSAZ Medical Coverage Guidelines.

The tool is set up to display the code edits that are *currently* being used for the date of service you entered.

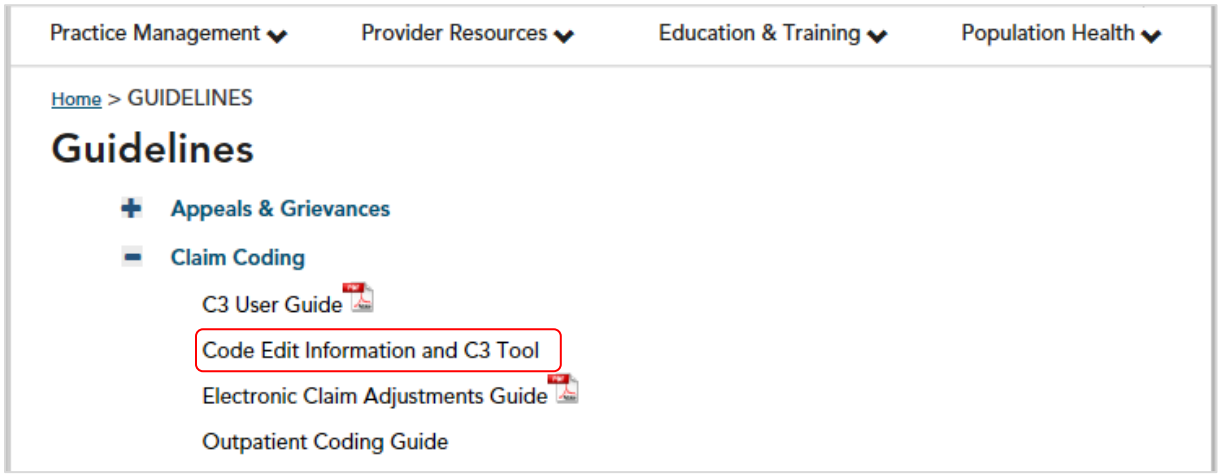
Benefits of C3

The C3 tool makes it possible for BCBSAZ network providers to:

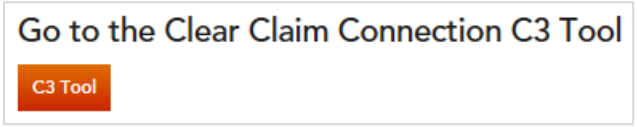
- View the appropriate coding and supporting edit clarifications with references to national coding standards and guidelines.
- Determine the appropriate code or code combination representing the service for accurate billing purposes.
- Access the edit clarifications on a denied claim after a remittance advice (RA) statement has been received from BCBSAZ.

Where to find the C3 tool?

Access the C3 tool through the secure provider portal at "Provider Resources > Guidelines > Claim Coding > Code Edit Information and C3 Tool." If you don't have access to the online claims resources, check with your office manager or administrator to be sure you have been assigned a user role with claims access.



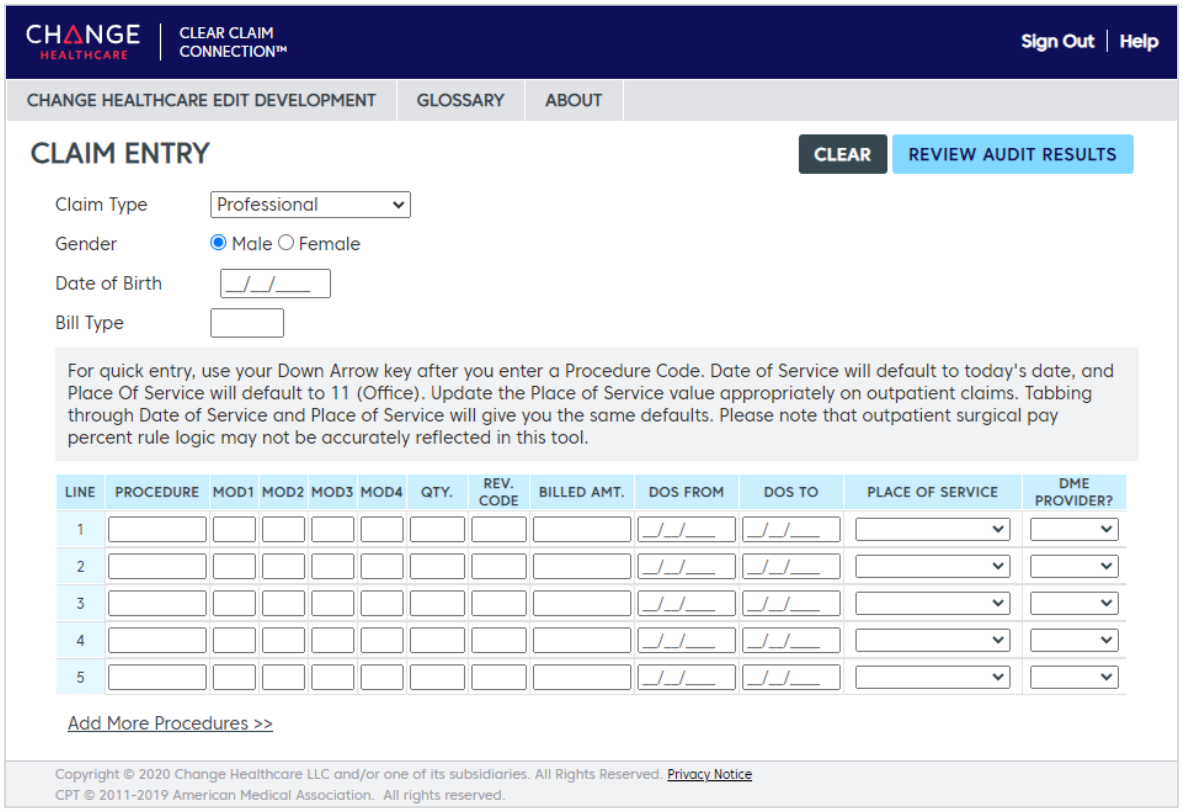
From the **Code Edit Information and C3 Tool** page, scroll down and click the button to access the C3 tool:



Please note: An automatic timer logs the user off after 30 minutes of no activity.

Using C3: Enter claim information

CLAIM ENTRY window

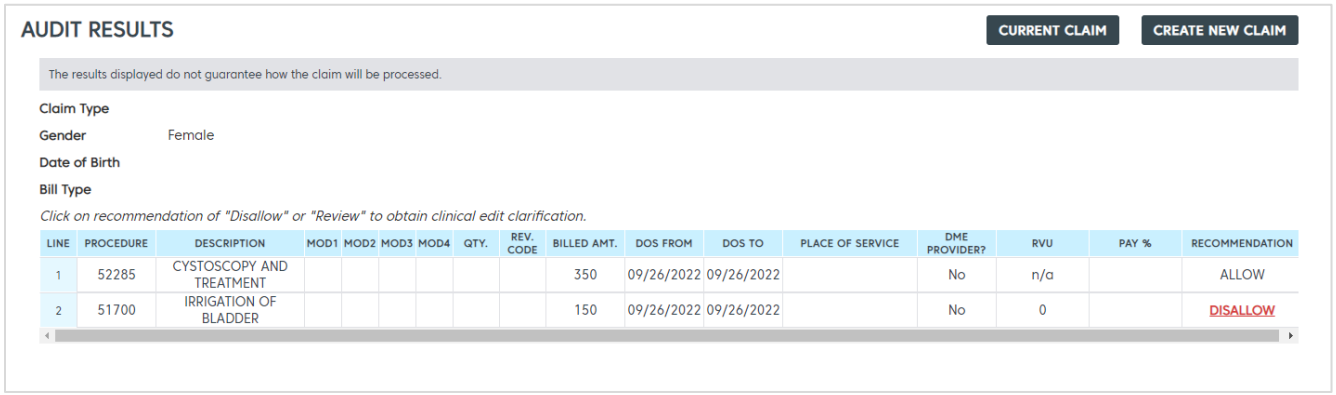


How to enter claim information

Claim Type **Gender / Date of Birth** **Bill Type**	• Select the appropriate claim type (professional, facility outpatient, or facility inpatient). • Enter the required patient information (gender and date of birth). • Bill type is only applicable to outpatient claims and is not a required field.
PROCEDURE	Enter a five-character procedure code (must be a valid CPT or HCPCS code and at least one is required). If you need to add more than five procedures, click on the Add More Procedures link. You can list up to ten procedures.
MODIFIERS	If one or more modifiers are applicable to the current claim and procedure, you can supply modifier codes associated with each procedure. Enter these modifier codes in the Mod 1 through Mod 4 fields, as appropriate. Each modifier must be a valid CPT or HCPCS modifier. Each must be valid for the procedure code on the current line.
QUANTITY	Enter quantity information as applicable.
REVENUE CODE	Revenue code is only applicable to outpatient claims. Entering revenue code information will provide more accurate results. Include the leading zero (0) on three-digit codes.
BILLED AMOUNT	This is a required field.
DATE OF SERVICE	In the Date of Service “from” and “to” fields, specify the date or date range of the procedure. By default, C3 automatically populates the Date of Service fields with the current date. You can accept this date or supply another. The tool is set up to display the edits that are *currently* being used for the date of service you entered.
PLACE OF SERVICE	This field defaults to place of service code 11. Ensure the default is changed as applicable.
DME PROVIDER?	Providers credentialed with the DME specialty must indicate “Yes” in this field for accurate results.
REVIEW AUDIT RESULTS	When your claim entry is complete, click **Review Audit Results** to view the results.

View audit results

After you enter claim information and click **Review Audit Results**, the **AUDIT RESULTS** window appears showing the results of the claim edits:



About the AUDIT RESULTS window

The **AUDIT RESULTS** window displays everything that was entered on the previous screen, along with the following additional information:

PROCEDURE — Additional procedures may be added during the editing of a claim. As a result, you may see more lines of procedure information than you originally entered.

DESCRIPTION — A pound sign (#) displayed in the first position of the description indicates that the procedure has been deleted. In such cases, the following notification message appears: # indicates a deleted procedure per CPT.

RVU — Displays the relative value units assigned to the procedure by CMS. This information may be pertinent to certain edit results.

PAY % — Displays cutback percentage as applicable.

RECOMMENDATION — Displays results of the procedure code audit, as follows:

- **ALLOW**—there is no edit for the submitted procedure code (no clarification necessary).
- **DISALLOW**—there is an edit for the submitted procedure code. For additional information, click on this field to view the edit clarification (as described in the next section).
- **REVIEW**—the procedure code should be evaluated against the edit clarification to determine whether the data entered and/or the procedure codes can be corrected prior to submission. A status of REVIEW might also indicate that additional information is required to process the claim.

Only those procedure lines displaying DISALLOW or REVIEW are eligible for edit clarification inquiries. These recommendations indicate that the procedure generated an edit during the claim auditing process. Click on the **DISALLOW** or **REVIEW** field in the **RECOMMENDATION** column to view the clarifications and sources for that procedure.

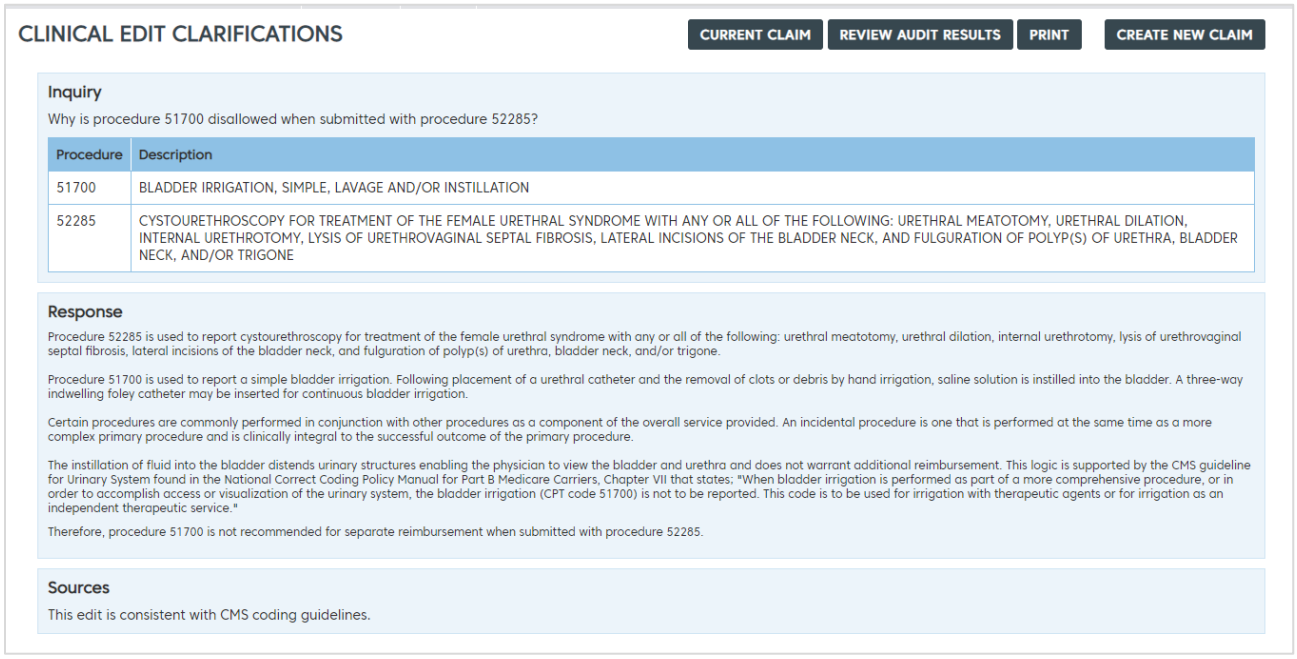
The **AUDIT RESULTS** window also displays the following controls:

CURRENT CLAIM — Click to re-display the Claim Entry window (to edit and re-submit the claim for auditing).

CREATE NEW CLAIM — Click to display a blank Claim Entry window.

Review clinical edit clarifications

The CLINICAL EDIT CLARIFICATION window displays the response and sources for each procedure. To print a copy of the edit clarifications, click on the “Print” link in the upper right corner.



Other features of the C3 tool

The C3 tool offers the following additional options:

Change Healthcare Edit Development	Get information about the process and sources used to develop the C3 edits.
Glossary	See C3 auditing terminology.
About	See C3 product name, version, copyright, licensure information, notices.
Sign Out	Exit from the C3 tool.
Help	Access instructions for the current display window.

Need help?

- For instructions on the current display window, click the “Help” link in the upper right corner.
- For tech support in accessing or using the C3 tool, please contact eSolutions at (602) 864-4844 or 1 (800) 650-5656.
- For questions or more information about code edits, please contact your network contract specialist (NCS) or call Provider Partnerships at (602) 864-4321 or 1 (800) 232-2345, ext. 4231.