BlueCross BlueShield of Montana

Clear Claim Connection™ (C3) 6.0
General Information and Instructions for Providers

Introduction
Clear Claim Connection (C3) is a Web-based code auditing reference tool designed to mirror how payer organizations evaluate code combinations during the auditing of claims. The C3 disclosure solution enables a payer organization to share the claim auditing rules and clinical rationale inherent in the Change Healthcare code auditing products with their contracting providers and internal users. The information provided is proprietary to Blue Cross and Blue Shield of Montana (BCBSMT).

C3 at BCBSMT
The C3 function is available to registered Availity® Provider Portal users. C3 is available to all BCBSMT independently contracted providers and has been in effect since February 2011. The ClaimsXten logic in the BCBSMT claims processing system is mirrored through C3. **It is important to note that C3 does not contain all of the claim edits and processes used by BCBSMT in adjudicating claims and the results from use of the C3 tool are not a guarantee of the final claim determination.**

This information is not applicable to Medicare Advantage members.

Basic Terms
Below are some of the basic terms to assist users with understanding the C3 system.

Clinical Rationale/Clinical Edit Clarification
The clinical explanation of an edit or group of edits including expanded descriptions of codes, narrative describing the relationship between codes and a summary of the justification for the edit.

Sources/Sourcing
The Change Healthcare Edit Development Process involves a comprehensive evaluation and analysis of nationally recognized and accepted medical coding guidelines and ”sources” during the standard development cycle of the clinical knowledge bases for code auditing products.

The sources referenced include, but are not limited to:
- The American Medical Association’s Current Procedural Terminology (CPT®),
- The CPT Assistant,
- The CPT Coding Symposium,
- Specialty Society Coding Guidelines
- and Medicare Guidelines.

Change Healthcare also utilizes the input of customers at large as well as over 600 practicing physician consultants. A credentialing process conducted by Change Healthcare exists to ensure that practicing physician consultants are currently licensed, board-certified, have 5 or more years practice experience and provide direct patient care for at least 8 hours per week.

Sign On
Providers may access the C3 application through the Availity portal. Information on how to become a registered Availity user, at no cost, is available on the Availity website at availity.com. Once registered with Availity, follow the steps below to access C3:
1. Log into Availity and select Payer Spaces from the navigation menu
2. Choose Blue Cross and Blue Shield of Montana
3. Select the Applications tab
4. Select “Research Procedure Code Edits.”

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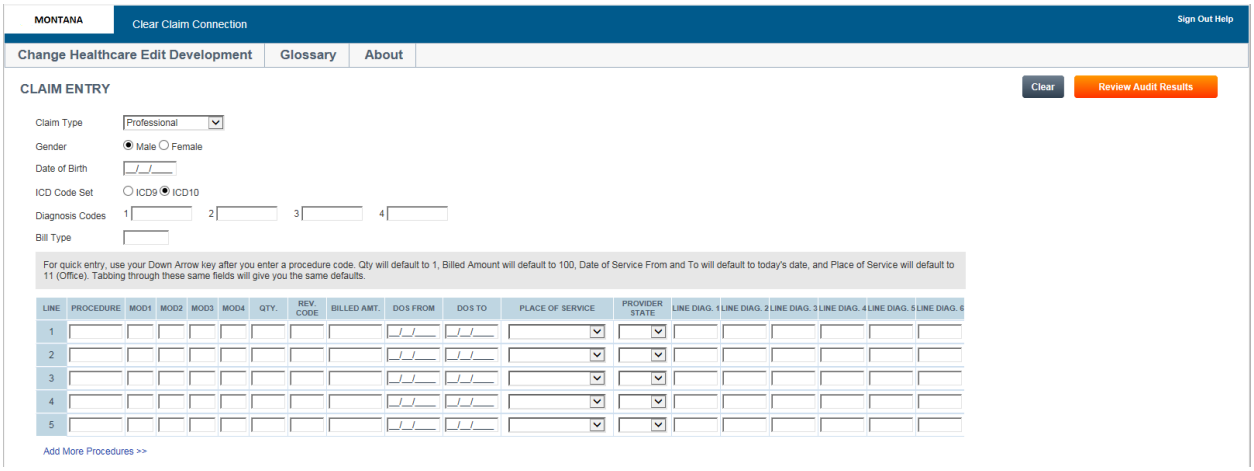
Sign Out

To sign out of the C3 Application; single left click on the Sign Out icon, and close your internet browser.

Screens

Claim Entry

The "Claim Entry" screen can be used to enter claim information to determine code edits that may apply. Below is an example of the Claim Entry screen, along with fields that appear on this screen and their descriptions.



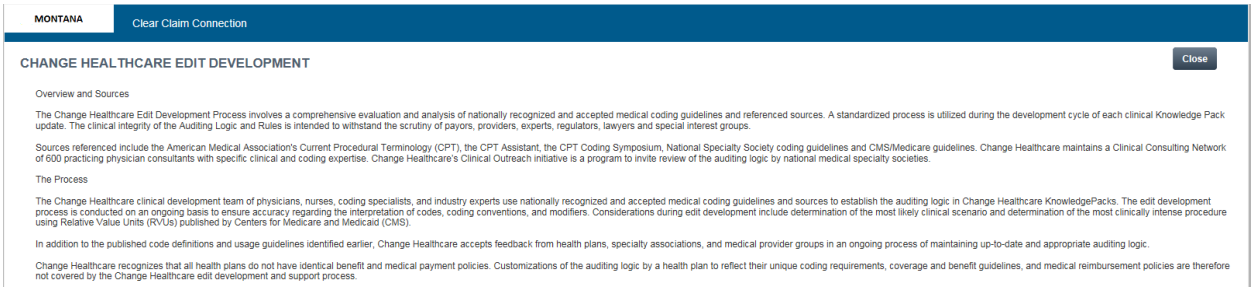
Field	Description
Claim Type	The type of claim being audited: • Professional • Facility (Inpatient) • Facility (Outpatient) *Note: BCBSMT does not currently use "Facility (Inpatient)."*
Gender	The gender of the patient • Male • Female
Date of Birth	The date of birth of the patient
ICD Code Set	The type of ICD codes billed on the claim • ICD-9 • ICD-10 *Note: Default value will be ICD-10.*
Diagnosis Codes 1	The primary diagnosis code *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
Diagnosis Codes 2	The secondary diagnosis code *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
Diagnosis Codes 3	The tertiary diagnosis code *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
Diagnosis Codes 4	The fourth diagnosis code *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*

Bill Type	The type of bill for the claim being audited
Procedure	The CPT/Healthcare Common Procedure Coding System (HCPCS) code billed on the service line *Note: When keying a procedure code ensure all alpha characters are entered in upper case.*
Mod1	The first modifier billed on the service line
Mod2	The second modifier billed on the service line
Mod3	The third modifier billed on the service line
Mod4	The fourth modifier billed on the service line
Qty	The number of units billed on the service line
Rev Code	The revenue code billed on the service line
Billed Amt.	The amount billed on the service line
DOS From	The earliest date of service billed on the service line
DOS To	The latest date of service billed on the service line
Place of Service	The place of service billed on the service line
Provider State	The state the provider rendering the services is physically located in
Line Diag. 1	The primary diagnosis code billed on the service line *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
Line Diag. 2	The secondary diagnosis code billed on the service line *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
Line Diag. 3	The tertiary diagnosis code billed on the service line *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
Line Diag. 4	The fourth diagnosis code billed on the service line *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
Line Diag. 5	The fifth diagnosis code billed on the service line *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
Line Diag. 6	The sixth diagnosis code billed on the service line *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
Add More Procedures>>	Single left- click to adds five additional service lines for entry providing a maximum of ten lines of service
Clear	Single left- click to resets the screen to its default appearance
Review Audit Results	Single left- click to submits the entered claim information for clinical edit review
Change Healthcare Edit Development	Single left- click to access the “Change Healthcare Edit Development” screen

Glossary	Single left-click to access the “Glossary” screen
About	Single left-click to access the “About” screen
Help	Single left-click to access the “Help” screen

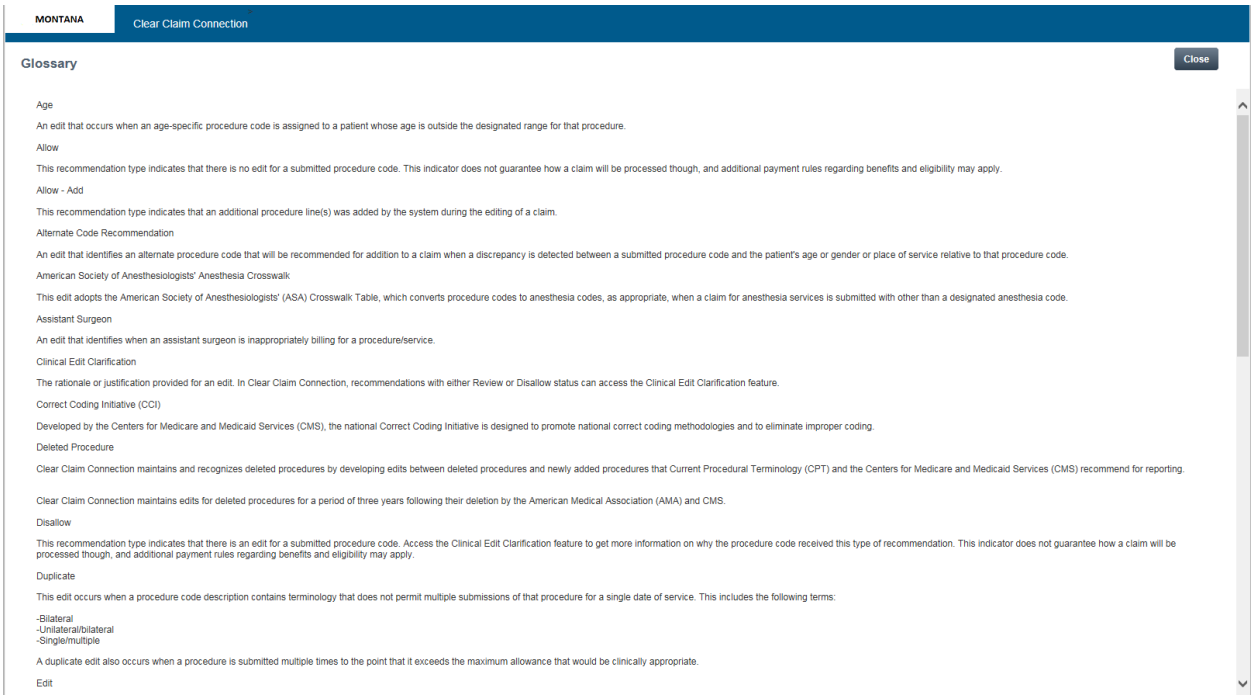
Change Healthcare Edit Development

The “Change Healthcare Edit Development" screen allows a user to view information about the processes and sources used to develop the C3 edits. When the user is finished viewing the information, the user may click “Close” to return to the screen where the user accessed the option. Below is an example of the Change Healthcare Edit Development screen.



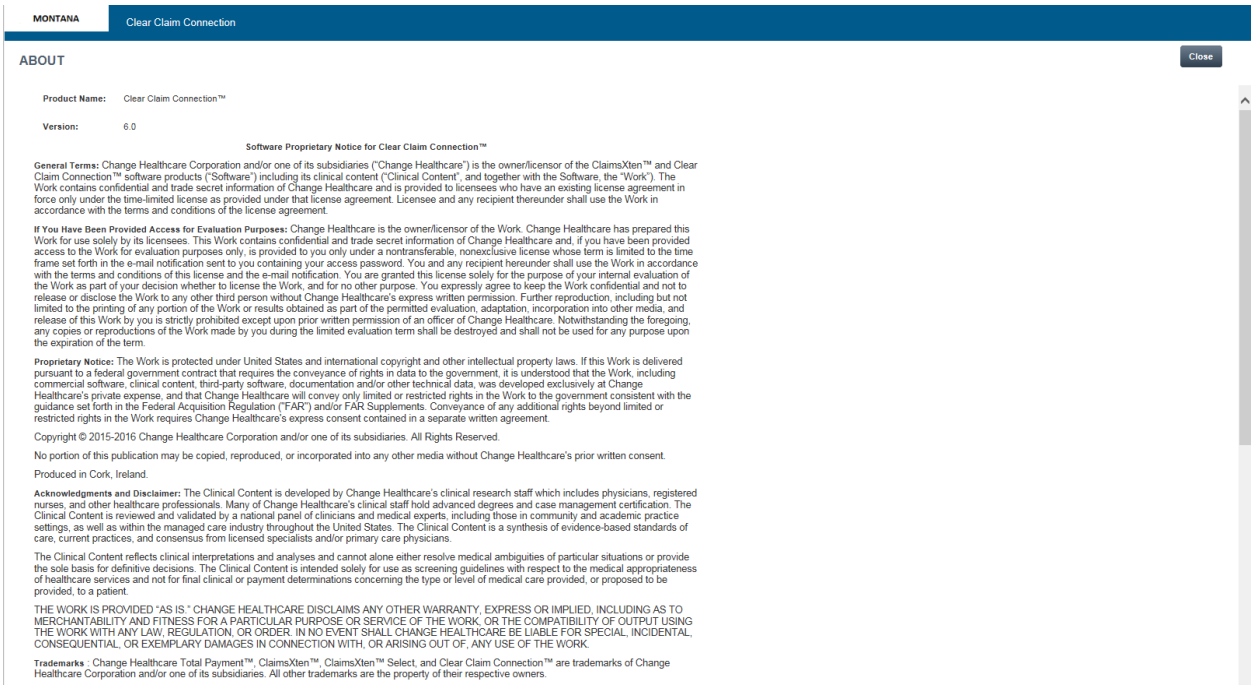
Glossary

The "Glossary" screen allows a user to view C3 terminology about code auditing. When the user is finished viewing the information, click “Close” to return to the screen where the user accessed the option. Below is an example of the Glossary screen.



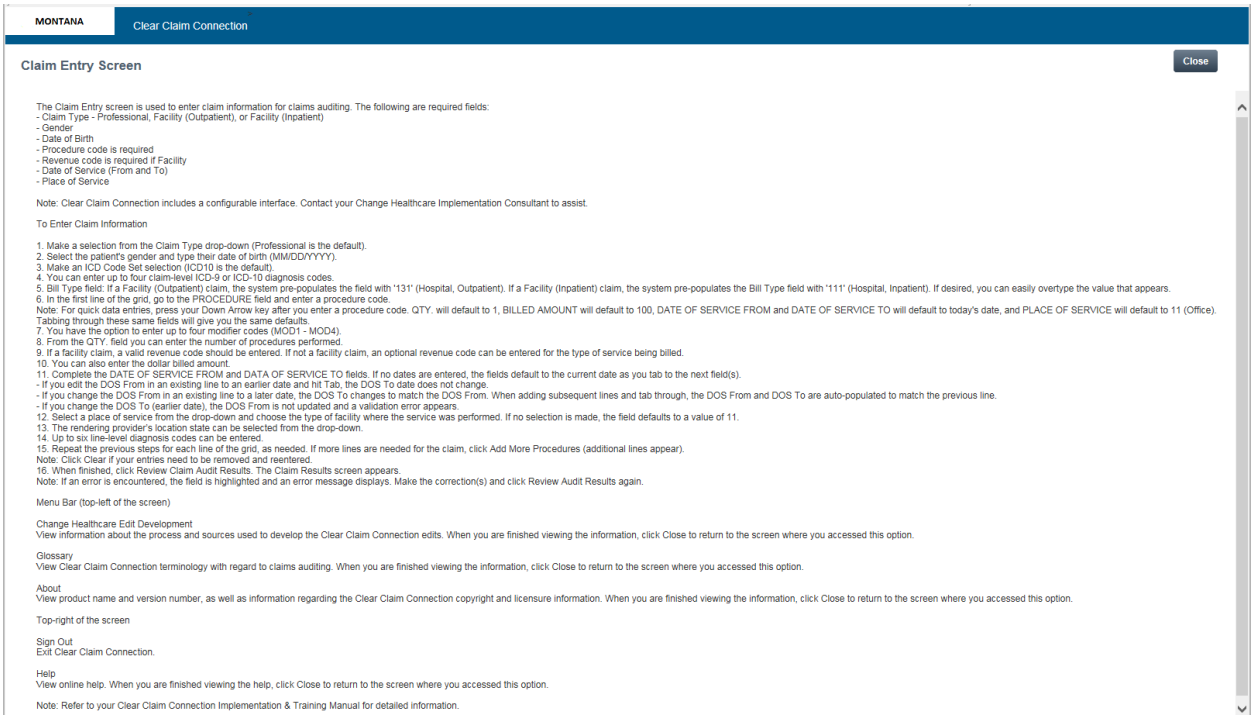
About

The "About" screen allows a user to view the product name and version number, as well as information regarding the C3 copyright and licensure information. When a user is finished viewing the information, click “Close” to return to the screen where the user accessed the option. Below is an example of the About screen.



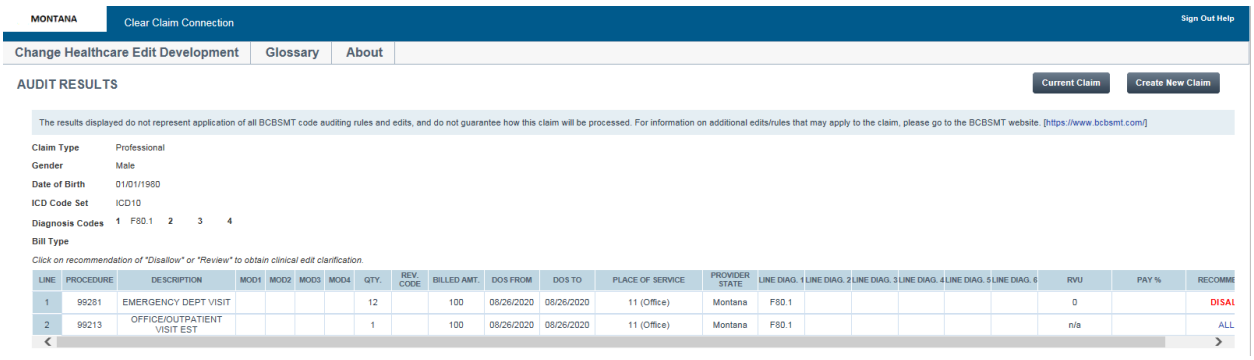
Help

The "Help" screen can be used to obtain assistance with utilizing the C3 application. Below is an example of the Help screen.



Audit Results

The "Audit Results" screen displays the results of the code edits that apply to the information entered on the Claim Entry screen. Below is an example of the Audit Results screen, along with fields that appear on this screen and their descriptions.

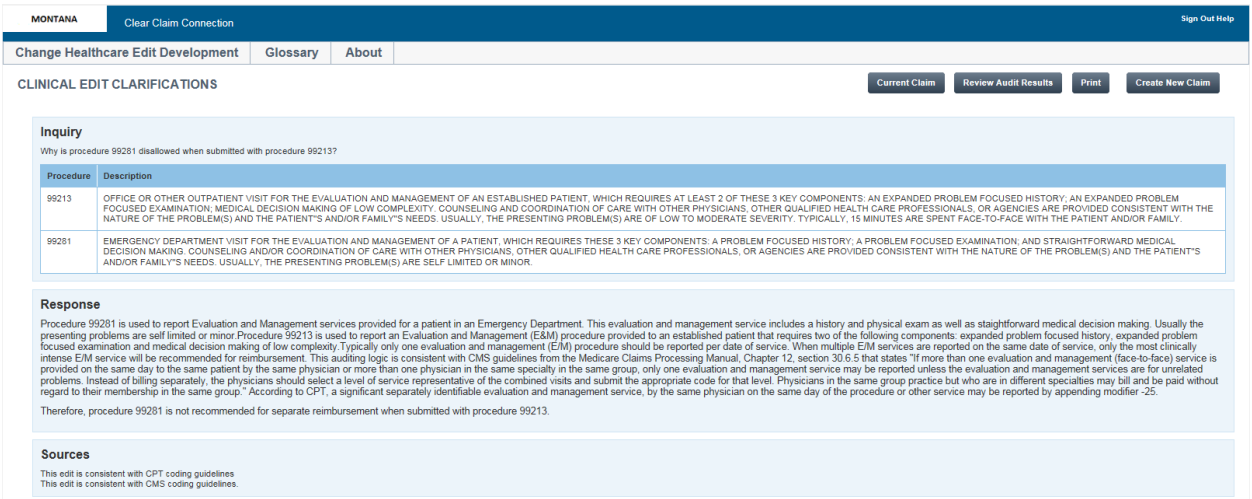


Field	Description
Procedure	The CPT/HCPCS code for the service line entered on the "Claim Entry" screen
Description	The description of the CPT/HCPCS code for the service line entered on the "Claim Entry" screen
Mod1	The first modifier of the service line entered on the "Claim Entry" screen
Mod2	The second modifier of the service line entered on the "Claim Entry" screen
Mod3	The third modifier of the service line entered on the "Claim Entry" screen
Mod4	The fourth modifier of the service line entered on the "Claim Entry" screen
Qty.	The number of units of the service line entered on the “Claim Entry” screen
Rev Code	The revenue code of the service line entered on the “Claim Entry” screen
Billed Amt.	The amount billed on the service line entered on the “Claim Entry” screen
DOS From	The earliest date of service of the service line entered on the “Claim Entry” screen
DOS To	The latest date of service of the service line entered on the “Claim Entry” screen
Place of Service	The place of service of the service line entered on the “Claim Entry” screen
Provider State	The state the provider rendering the services is physically located in entered on the “Claim Entry” screen
Line Diag 1	The primary diagnosis code of the service line entered on the "Claim Entry" screen
Line Diag 2	The secondary diagnosis code of the service line entered on the "Claim Entry" screen
Line Diag 3	The tertiary diagnosis code of the service line entered on the "Claim Entry" screen
Line Diag 4	The fourth diagnosis code of the service line entered on the "Claim Entry" screen
Line Diag 5	The fifth diagnosis code of the service line entered on the "Claim Entry" screen
Line Diag 6	The sixth diagnosis code of the service line entered on the "Claim Entry" screen
RVU	The relative value unit value for the procedure code of the service line entered on the “Claim Entry” screen *Note: BCBSMT does not currently use this field.*
Pay %	The percent to be paid for the procedure code of the service line entered on the “Claim

	Entry” screen *<u>Note</u>: BCBSMT does not currently use this field.*
Recommend	Indicates if the service should be allowed or denied
Current Claim	Returns the user to the "Claim Entry" screen with the previously entered data inputted
Create New Claim	Returns the user to the "Claim Entry" screen with the default values reset
Change Healthcare Edit Development	Single left-click to access the “Change Healthcare Edit Development” screen
Glossary	Single left-click to access the “Glossary” screen
About	Single left-click to access the “About” screen
Help	Single left-click to access the “Help” screen

Clinical Edit Clarifications

The "Edit Clarifications" screen displays the rationale of a claim edit denial received on the Claim Audit Results. Below is an example of the Edit Clarifications screen, along with fields that appear on this screen and their descriptions.



Field	Description
Current Claim	Returns the user to the "Claim Entry" screen with the previously entered data inputted
Review Audit Results	Returns the user to the "Audit Results" screen with the previous claim audit results
Print	Opens a printable version of the “Clinical Edit Clarifications" screen for printing purposes
Create New Claim	Returns the user to the "Claim Entry" screen with the default values reset
Inquiry:	The question being answered on the “Clinical Edit Clarifications" screen
Procedure	The CPT/HCPCS code for the disallowed service line selected on the “Audit Results" screen

Description	The description of the CPT/HCPCS code for the disallowed service line selected on the "Audit Results" screen
Response	Detailed rationale of why the service line should be disallowed
Sources	Source(s) that justifies the clinical edit being applied
Change Healthcare Edit Development	Single left-click to access the “Change Healthcare Edit Development” screen
Glossary	Single left-click to access the “Glossary” screen
About	Single left-click to access the “About” screen
Help	Single left-click to access the “Help” screen

Procedures

Completing the Claim Entry Screen for Facility Claims:

Below is the process to follow to complete the Claim Entry screen for facility claims.

Step	Action
1	How many service lines does the claim have? • Five or less, go to Step 3 • Ten or less, go to Step 2 • Eleven or more, claim must be entered in the C3 system
2	Single left-click "Add More Procedures>>"
3	Single left-click the “Claim Type” drop-down menu and then single left-click on the appropriate value: • Facility (Inpatient) for an inpatient claim • Facility (Outpatient) for an outpatient claim *Note: BCBSMT does not currently use “Facility (Inpatient).”*
4	Single left-click the radio button adjacent to the gender of the patient on the claim in the "Gender" field
5	Enter the date of birth of the patient in the "Date of Birth" field
6	Single left-click the radio button adjacent to the ICD code set that the claim is billed with
7	Enter the primary diagnosis code in the “Diagnosis Codes 1" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
8	Enter the secondary diagnosis code in the "Diagnosis Codes 2" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
9	Enter the tertiary diagnosis code in the "Diagnosis Codes 3" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
10	Enter the fourth diagnosis code in the "Diagnosis Codes 4" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
11	Enter the type of bill of the claim being entered in the “Bill Type” field

12	Enter the CPT/HCPCS code for the service line in the "Procedure" field *Note: When keying a procedure code ensure all alpha characters are entered in upper case.*
13	Enter the first modifier for the service line in the "Mod1" field *Note: When keying a modifier ensure all alpha characters are entered in upper case.*
14	Enter the second modifier for the service line in the "Mod2" field *Note: When keying a modifier ensure all alpha characters are entered in upper case.*
15	Enter the third modifier for the service line in the "Mod3" field *Note: When keying a modifier ensure all alpha characters are entered in upper case.*
16	Enter the fourth modifier for the service line in the "Mod4" field *Note: When keying a modifier ensure all alpha characters are entered in upper case.*
17	Enter the units for the service line in “Qty.” field
18	Enter the revenue code for the service line in the “Rev Code” field
19	Enter the billed amount for the service line in the “Billed Amt.” field
20	Enter the earliest date of service of the service line in the “DOS From" field
21	Enter the latest date of service of the service line in the “DOS To" field
22	Single left-click the "Place of Service" drop-down menu and then single left-click the place of service of the service line
23	Single left-click the “Provider State” drop-down menu and then single left-click the state the provider rendering the services is physically located in
24	Enter the primary diagnosis code of the service line in the “Line Diag. 1" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
25	Enter the secondary diagnosis code of the service line in the “Line Diag. 2" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
26	Enter the tertiary diagnosis code of the service line in the “Line Diag. 3" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
27	Enter the fourth diagnosis code of the service line in the “Line Diag. 4" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
28	Enter the fifth diagnosis code of the service line in the “Line Diag. 5" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
29	Enter the sixth diagnosis code of the service line in the “Line Diag. 6" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
30	Repeat steps 12 - 29 for all service lines
31	Single left-click "Review Audit Results"

Completing the Claim Entry Screen for Professional Claims

Below is the process to follow to complete the Claim Entry screen for professional claims.

Step	Action
1	How many service lines does the claim have? • Five or less, go to Step 3 • Ten or less, go to Step 2 • Eleven or more, claim must be entered in the C3 system
2	Single left-click "Add More Procedures>>"
3	Single left-click the “Claim Type” drop-down menu and then single left-click “Professional”
4	Single left-click the radio button adjacent to the gender of the patient on the claim in the "Gender" field
5	Enter the date of birth of the patient in the "Date of Birth" field
6	Single left-click the radio button adjacent to the ICD code set that the claim is billed with
7	Enter the primary diagnosis code in the “Diagnosis Codes 1" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
8	Enter the secondary diagnosis code in the "Diagnosis Codes 2" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
9	Enter the tertiary diagnosis code in the "Diagnosis Codes 3" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
10	Enter the fourth diagnosis code in the "Diagnosis Codes 4" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
11	Enter the CPT/HCPCS code for the service line in the "Procedure" field *Note: When keying a procedure code ensure all alpha characters are entered in upper case.*
12	Enter the first modifier for the service line in the "Mod1" field *Note: When keying a modifier ensure all alpha characters are entered in upper case.*
13	Enter the second modifier for the service line in the "Mod2" field *Note: When keying a modifier ensure all alpha characters are entered in upper case.*
14	Enter the third modifier for the service line in the "Mod3" field *Note: When keying a modifier ensure all alpha characters are entered in upper case.*
15	Enter the fourth modifier for the service line in the "Mod4" field *Note: When keying a modifier ensure all alpha characters are entered in upper case.*
16	Enter the units for the service line in “Qty.” field
17	Enter the billed amount for the service line in the “Billed Amt.” field
18	Enter the earliest date of service of the service line in the “DOS From" field
19	Enter the latest date of service of the service line in the “DOS To" field
20	Single left-click the "Place of Service" drop-down menu and then single left-click the place of service of the service line

21	Single left-click the “Provider State” drop-down menu and then single left-click the state the provider rendering the services is physically located in
22	Enter the primary diagnosis code of the service line in the “Line Diag. 1" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
23	Enter the secondary diagnosis code of the service line in the “Line Diag. 2" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
24	Enter the tertiary diagnosis code of the service line in the “Line Diag. 3" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
25	Enter the fourth diagnosis code of the service line in the “Line Diag. 4" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
26	Enter the fifth diagnosis code of the service line in the “Line Diag. 5" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
27	Enter the sixth diagnosis code of the service line in the “Line Diag. 6" field *Note: When keying a diagnosis code all digits, including the decimal, must be entered.*
28	Repeat steps 11 - 27 for all service lines
29	Single left-click "Review Audit Results"

Utilizing the "Claim Audit Results" Screen

Below is the process to follow to complete the "Claim Audit Results" screen.

Step	Action
1	Determine the service lines that are disallowed
2	Single left-click "Disallow"
3	Repeat steps 1 - 2 for each disallowed line

ClaimsXten Quarterly Updates

Please note that new and revised CPT and HCPCS codes are periodically added to or deleted from the ClaimsXten code auditing tool software by the software vendor on a quarterly basis and are not considered changes to the software version. BCBSMT will normally load this additional data to the BCBSMT claim processing system after receipt from the software vendor and will confirm the effective date via the *News and Updates* section of our website at *bcbsmt.com/provider*. Advance notification of updates to the ClaimsXten software version also will be posted on our Provider website. Information may appear in the *Blue Review* provider newsletter as well.