



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 New Mexico (BCBSNM).

C3 at BCBSNM

The C3 function is available to registered Availity® Provider Portal users. C3 is available to all BCBSNM independently contracted providers and has been in effect since February 2011. The ClaimsXten logic in the BCBSNM 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 BCBSNM 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 New Mexico
3. Select the Applications tab
4. Select "Research Procedure Code Edits."

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	<p>The type of claim being audited:</p> <ul style="list-style-type: none"> Professional Facility (Inpatient) Facility (Outpatient) <p><i>Note: BCBSNM does not currently use "Facility (Inpatient)."</i></p>
Gender	<p>The gender of the patient</p> <ul style="list-style-type: none"> Male Female
Date of Birth	The date of birth of the patient
ICD Code Set	<p>The type of ICD codes billed on the claim</p> <ul style="list-style-type: none"> ICD-9 ICD-10 <p><i>Note: Default value will be ICD-10.</i></p>
Diagnosis Codes 1	<p>The primary diagnosis code</p> <p><i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i></p>
Diagnosis Codes 2	<p>The secondary diagnosis code</p> <p><i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i></p>
Diagnosis Codes 3	<p>The tertiary diagnosis code</p> <p><i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i></p>
Diagnosis Codes 4	<p>The fourth diagnosis code</p> <p><i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i></p>

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 <i>Note: When keying a procedure code ensure all alpha characters are entered in upper case.</i>
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 <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
Line Diag. 2	The secondary diagnosis code billed on the service line <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
Line Diag. 3	The tertiary diagnosis code billed on the service line <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
Line Diag. 4	The fourth diagnosis code billed on the service line <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
Line Diag. 5	The fifth diagnosis code billed on the service line <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
Line Diag. 6	The sixth diagnosis code billed on the service line <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
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.

NEW MEXICO
Clear Claim Connection

CHANGE HEALTHCARE EDIT DEVELOPMENT
Close

Overview and Sources

The Change Healthcare Edit Development Process involves a comprehensive evaluation and analysis of nationally recognized and accepted medical coding guidelines and referenced sources. A standardized process is utilized during the development cycle of each clinical Knowledge Pack update. The clinical integrity of the Auditing Logic and Rules is intended to withstand the scrutiny of payors, providers, experts, regulators, lawyers and special interest groups.

Sources referenced include the American Medical Association's Current Procedural Terminology (CPT), the CPT Assistant, the CPT Coding Symposium, National Specialty Society coding guidelines and CMS/Medicare guidelines. Change Healthcare maintains a Clinical Consulting Network of 600 practicing physician consultants with specific clinical and coding expertise. Change Healthcare's Clinical Outreach initiative is a program to invite review of the auditing logic by national medical specialty societies.

The Process

The Change Healthcare clinical development team of physicians, nurses, coding specialists, and industry experts use nationally recognized and accepted medical coding guidelines and sources to establish the auditing logic in Change Healthcare KnowledgePacks. The edit development process is conducted on an ongoing basis to ensure accuracy regarding the interpretation of codes, coding conventions, and modifiers. Considerations during edit development include determination of the most likely clinical scenario and determination of the most clinically intense procedure using Relative Value Units (RVUs) published by Centers for Medicare and Medicaid (CMS).

In addition to the published code definitions and usage guidelines identified earlier, Change Healthcare accepts feedback from health plans, specialty associations, and medical provider groups in an ongoing process of maintaining up-to-date and appropriate auditing logic.

Change Healthcare recognizes that all health plans do not have identical benefit and medical payment policies. Customizations of the auditing logic by a health plan to reflect their unique coding requirements, coverage and benefit guidelines, and medical reimbursement policies are therefore not covered by the Change Healthcare edit development and support process.

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.

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Clear Claim Connection

Glossary
Close

Age

An edit that occurs when an age-specific procedure code is assigned to a patient whose age is outside the designated range for that procedure.

Allow

This recommendation type indicates that there is no edit for a submitted procedure code. This indicator does not guarantee how a claim will be processed though, and additional payment rules regarding benefits and eligibility may apply.

Allow - Add

This recommendation type indicates that an additional procedure line(s) was added by the system during the editing of a claim.

Alternate Code Recommendation

An edit that identifies an alternate procedure code that will be recommended for addition to a claim when a discrepancy is detected between a submitted procedure code and the patient's age or gender or place of service relative to that procedure code.

American Society of Anesthesiologists' Anesthesia Crosswalk

This edit adopts the American Society of Anesthesiologists' (ASA) Crosswalk Table, which converts procedure codes to anesthesia codes, as appropriate, when a claim for anesthesia services is submitted with other than a designated anesthesia code.

Assistant Surgeon

An edit that identifies when an assistant surgeon is inappropriately billing for a procedure/service.

Clinical Edit Clarification

The rationale or justification provided for an edit. In Clear Claim Connection, recommendations with either Review or Disallow status can access the Clinical Edit Clarification feature.

Correct Coding Initiative (CCI)

Developed by the Centers for Medicare and Medicaid Services (CMS), the national Correct Coding Initiative is designed to promote national correct coding methodologies and to eliminate improper coding.

Deleted Procedure

Clear Claim Connection maintains and recognizes deleted procedures by developing edits between deleted procedures and newly added procedures that Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS) recommend for reporting.

Clear Claim Connection maintains edits for deleted procedures for a period of three years following their deletion by the American Medical Association (AMA) and CMS.

Disallow

This recommendation type indicates that there is an edit for a submitted procedure code. Access the Clinical Edit Clarification feature to get more information on why the procedure code received this type of recommendation. This indicator does not guarantee how a claim will be processed though, and additional payment rules regarding benefits and eligibility may apply.

Duplicate

This edit occurs when a procedure code description contains terminology that does not permit multiple submissions of that procedure for a single date of service. This includes the following terms:

- Bilateral
- Unilateral/bilateral
- Single/multiple

A duplicate edit also occurs when a procedure is submitted multiple times to the point that it exceeds the maximum allowance that would be clinically appropriate.

Edit

Clear Claim Connection produces edits to identify codes that may be inappropriately billed. The result of this process generates recommendations of either Disallow or Review. Access the Clinical Edit Clarification feature to get more information.

Gender Conflict

This edit occurs when a gender-specific procedure code is incorrectly assigned based on the gender of the patient referenced on the claim.

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.

NEW MEXICO Clear Claim Connection Close

ABOUT

Product Name: Clear Claim Connection™
Version: 6.0

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Help

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

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Claim Entry Screen

The Claim Entry screen is used to enter claim information for claims auditing. The following are required fields:

- Claim Type - Professional, Facility (Outpatient), or Facility (Inpatient)
- Gender
- Date of Birth
- Procedure code is required
- Revenue code is required if Facility
- Date of Service (From and To)
- Place of Service

Note: Clear Claim Connection includes a configurable interface. Contact your Change Healthcare Implementation Consultant to assist.

To Enter Claim Information

1. Make a selection from the Claim Type drop-down (Professional is the default).
2. Select the patient's gender and type their date of birth (MM/DD/YYYY).
3. Make an ICD Code Set selection (ICD10 is the default).
4. You can enter up to four claim-level ICD-9 or ICD-10 diagnosis codes.
5. Bill Type field: If a Facility (Outpatient) claim, the system pre-populates the field with '131' (Hospital, Outpatient). If a Facility (Inpatient) claim, the system pre-populates the Bill Type field with '111' (Hospital, Inpatient). If desired, you can easily overtype the value that appears.
6. In the first line of the grid, go to the PROCEDURE field and enter a procedure code.
- Note: For quick data entries, press 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 DATE OF SERVICE TO will default to today's date, and PLACE OF SERVICE will default to 11 (Office).
7. You have the option to enter up to four modifier codes (MOD1 - MOD4).
8. From the QTY: field you can enter the number of procedures performed.
9. If a facility claim, a valid revenue code should be entered. If not a facility claim, an optional revenue code can be entered for the type of service being billed.
10. You can also enter the dollar billed amount.
11. Complete the DATE OF SERVICE FROM and DATA OF SERVICE TO fields. If no dates are entered, the fields default to the current date as you tab to the next field(s).
- If you edit the DOS From in an existing line to an earlier date and hit Tab, the DOS To date does not change.
- If you change the DOS From in an existing line to a later date, the DOS To changes to match the DOS From. When adding subsequent lines and tab through, the DOS From and DOS To are auto-populated to match the previous line.
- If you change the DOS To (earlier date), the DOS From is not updated and a validation error appears.
12. Select a place of service from the drop-down and choose the type of facility where the service was performed. If no selection is made, the field defaults to a value of 11.
13. The rendering provider's location state can be selected from the drop-down.
14. Up to six line-level diagnosis codes can be entered.
15. Repeat the previous steps for each line of the grid, as needed. If more lines are needed for the claim, click Add More Procedures (additional lines appear).

Note: Click Clear if your entries need to be removed and reentered.

15. When finished, click Review Claim Audit Results. The Claim Results screen appears.

Note: If an error is encountered, the field is highlighted and an error message displays. Make the correction(s) and click Review Audit Results again.

Menu Bar (top-left of the screen)

Change Healthcare Edit Development
View information about the process and sources used to develop the Clear Claim Connection edits. When you are finished viewing the information, click Close to return to the screen where you accessed this option.

Glossary
View Clear Claim Connection terminology with regard to claims auditing. When you are finished viewing the information, click Close to return to the screen where you accessed this option.

About
View product name and version number, as well as information regarding the Clear Claim Connection copyright and licensure information. When you are finished viewing the information, click Close to return to the screen where you accessed this option.

Top-right of the screen

Sign Out
Exit Clear Claim Connection.

Help
View online help. When you are finished viewing the help, click Close to return to the screen where you accessed this option.

Note: Refer to your Clear Claim Connection Implementation & Training Manual for detailed information.

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.

NEW MEXICO																	Clear Claim Connection		Sign Out Help																																																																		
Change Healthcare Edit Development																	Glossary		About																																																																		
AUDIT RESULTS																	Current Claim		Create New Claim																																																																		
<p>The results displayed do not represent application of all BCBSNM code auditing rules and edits, and do not guarantee how this claim will be processed. For information on additional edits/rules that may apply to the claim, please go to the BCBSNM website: https://www.bcbsnm.com/</p> <p>Claim Type: Professional Gender: Male Date of Birth: 01/01/1982 ICD Code Set: ICD10 Diagnosis Codes: 1 F80.1 2 3 4 Bill Type</p> <p>Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarification.</p> <table border="1"> <thead> <tr> <th>LINE</th> <th>PROCEDURE</th> <th>DESCRIPTION</th> <th>MOD1</th> <th>MOD2</th> <th>MOD3</th> <th>MOD4</th> <th>QTY.</th> <th>REV CODE</th> <th>BILLED AMT.</th> <th>DOS FROM</th> <th>DOS TO</th> <th>PLACE OF SERVICE</th> <th>PROVIDER STATE</th> <th>LINE DIAG. 1</th> <th>LINE DIAG. 2</th> <th>LINE DIAG. 3</th> <th>LINE DIAG. 4</th> <th>LINE DIAG. 5</th> <th>LINE DIAG. 6</th> <th>RVU</th> <th>PAY %</th> <th>RECOMM</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>99281</td> <td>EMERGENCY DEPT VISIT</td> <td></td> <td></td> <td></td> <td></td> <td>12</td> <td></td> <td>100</td> <td>09/26/2020</td> <td>09/26/2020</td> <td>11 (Office)</td> <td>New Mexico</td> <td>F80.1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>DISAL</td> </tr> <tr> <td>2</td> <td>99213</td> <td>OFFICE/OUTPATIENT VISIT EST</td> <td></td> <td></td> <td></td> <td></td> <td>1</td> <td></td> <td>100</td> <td>09/26/2020</td> <td>09/26/2020</td> <td>11 (Office)</td> <td>New Mexico</td> <td>F80.1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>n/a</td> <td></td> <td>ALL</td> </tr> </tbody> </table>																	LINE	PROCEDURE	DESCRIPTION	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	RVU	PAY %	RECOMM	1	99281	EMERGENCY DEPT VISIT					12		100	09/26/2020	09/26/2020	11 (Office)	New Mexico	F80.1						0		DISAL	2	99213	OFFICE/OUTPATIENT VISIT EST					1		100	09/26/2020	09/26/2020	11 (Office)	New Mexico	F80.1						n/a		ALL
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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 <i>Note: BCBSNM does not currently use this field.</i>
Pay %	The percent to be paid for the procedure code of the service line entered on the "Claim Entry" screen

	Entry” screen <i>Note: BCBSNM does not currently use this field.</i>
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.

NEW MEXICO
Clear Claim Connection
Sign Out Help

Change Healthcare Edit Development
Glossary
About

Current Claim
Review Audit Results
Print
Create New Claim

CLINICAL EDIT CLARIFICATIONS

Inquiry
Why is procedure 99281 disallowed when submitted with procedure 99213?

Procedure	Description
99213	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY, COUNSELING AND COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. TYPICALLY, 15 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99281	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING, COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR.

Response
Procedure 99281 is used to report Evaluation and Management services provided for a patient in an Emergency Department. This evaluation and management service includes a history and physical exam as well as straightforward medical decision making. Usually the presenting problems are self limited or minor. Procedure 99213 is used to report an Evaluation and Management (E&M) procedure provided to an established patient that requires two of the following components: expanded problem focused history, expanded problem focused examination and medical decision making of low complexity. Typically only one evaluation and management (E&M) procedure should be reported per date of service. When multiple E&M services are reported on the same date of service, only the most clinically intense E&M service will be recommended for reimbursement. This auditing logic is consistent with CMS guidelines from the Medicare Claims Processing Manual, Chapter 12, section 30.6.5 that states "If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level. Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group." According to CPT, a significant separately identifiable evaluation and management service, by the same physician on the same day of the procedure or other service may be reported by appending modifier -25.
Therefore, procedure 99281 is not recommended for separate reimbursement when submitted with procedure 99213.

Sources
This edit is consistent with CPT coding guidelines.
This edit is consistent with CMS coding guidelines.

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? <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Facility (Inpatient) for an inpatient claim • Facility (Outpatient) for an outpatient claim <p><i>Note: BCBSNM does not currently use "Facility (Inpatient)."</i></p>
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 <p><i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i></p>
8	Enter the secondary diagnosis code in the "Diagnosis Codes 2" field <p><i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i></p>
9	Enter the tertiary diagnosis code in the "Diagnosis Codes 3" field <p><i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i></p>
10	Enter the fourth diagnosis code in the "Diagnosis Codes 4" field <p><i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i></p>
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 <i>Note: When keying a procedure code ensure all alpha characters are entered in upper case.</i>
13	Enter the first modifier for the service line in the "Mod1" field <i>Note: When keying a modifier ensure all alpha characters are entered in upper case.</i>
14	Enter the second modifier for the service line in the "Mod2" field <i>Note: When keying a modifier ensure all alpha characters are entered in upper case.</i>
15	Enter the third modifier for the service line in the "Mod3" field <i>Note: When keying a modifier ensure all alpha characters are entered in upper case.</i>
16	Enter the fourth modifier for the service line in the "Mod4" field <i>Note: When keying a modifier ensure all alpha characters are entered in upper case.</i>
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 <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
25	Enter the secondary diagnosis code of the service line in the "Line Diag. 2" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
26	Enter the tertiary diagnosis code of the service line in the "Line Diag. 3" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
27	Enter the fourth diagnosis code of the service line in the "Line Diag. 4" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
28	Enter the fifth diagnosis code of the service line in the "Line Diag. 5" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
29	Enter the sixth diagnosis code of the service line in the "Line Diag. 6" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
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? <ul style="list-style-type: none"> • 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 <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
8	Enter the secondary diagnosis code in the "Diagnosis Codes 2" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
9	Enter the tertiary diagnosis code in the "Diagnosis Codes 3" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
10	Enter the fourth diagnosis code in the "Diagnosis Codes 4" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
11	Enter the CPT/HCPCS code for the service line in the "Procedure" field <i>Note: When keying a procedure code ensure all alpha characters are entered in upper case.</i>
12	Enter the first modifier for the service line in the "Mod1" field <i>Note: When keying a modifier ensure all alpha characters are entered in upper case.</i>
13	Enter the second modifier for the service line in the "Mod2" field <i>Note: When keying a modifier ensure all alpha characters are entered in upper case.</i>
14	Enter the third modifier for the service line in the "Mod3" field <i>Note: When keying a modifier ensure all alpha characters are entered in upper case.</i>
15	Enter the fourth modifier for the service line in the "Mod4" field <i>Note: When keying a modifier ensure all alpha characters are entered in upper case.</i>
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 <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
23	Enter the secondary diagnosis code of the service line in the "Line Diag. 2" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
24	Enter the tertiary diagnosis code of the service line in the "Line Diag. 3" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
25	Enter the fourth diagnosis code of the service line in the "Line Diag. 4" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
26	Enter the fifth diagnosis code of the service line in the "Line Diag. 5" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
27	Enter the sixth diagnosis code of the service line in the "Line Diag. 6" field <i>Note: When keying a diagnosis code all digits, including the decimal, must be entered.</i>
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. BCBSNM will normally load this additional data to the BCBSNM 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 bcbsnm.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.

Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

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