

Clear Claim Connection (C3) Claims Editor Tool

—
Provider Tutorial

PREMERA

C3 Claims Editor

Test billing scenarios and code combinations against ClaimsXTen (CXT) editing software

- Test coding scenarios before billing.
- This tool only looks for coding and clinical edits (not specific to member benefits).
- It doesn't account for the second-pass editor.

The screenshot shows the 'CHANGE HEALTHCARE EDIT DEVELOPMENT' web application. The header includes the 'CHANGE HEALTHCARE' logo and 'CLEAR CLAIM CONNECTION™'. Navigation links for 'CHANGE HEALTHCARE EDIT DEVELOPMENT', 'GLOSSARY', and 'ABOUT' are present. The main section is titled 'CLAIM ENTRY' and contains several form fields: 'Claim Type' (dropdown menu), 'Gender' (radio buttons for Male, Female, Unspecified), 'Date of Birth' (text input), 'ICD Code Set' (radio buttons for ICD10), and 'Bill Type' (text input). There are 'CLEAR' and 'REVIEW AUDIT RESULTS' buttons. A disclaimer text explains the tool's purpose and limitations. Below the text is a table for entering claim data.

LINE	PROCEDURE	MOD1	MOD2	MOD3	MOD4	QTY	REV. CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE 1	LINE 2	LINE 3	LINE 4	LINE 5	LINE 6	NDIC NUMBER	NDIC UNIT	NDIC UOM	
1																						
2																						
3																						
4																						
5																						

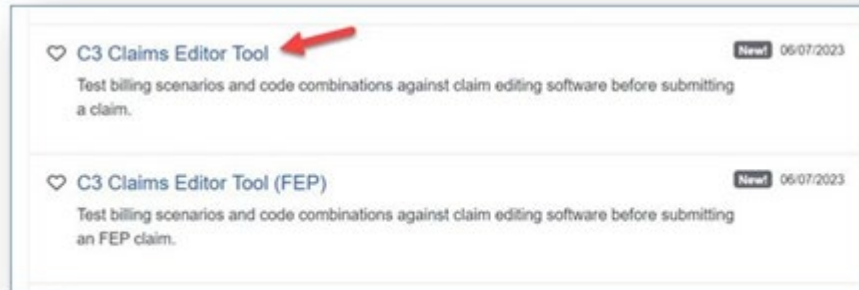
[Add More Procedures >>](#)

C3 Claims Editor

How to locate and use the tool

- To access the C3 Claims Editor Tool, sign in to [availity.com](https://www.availity.com).
- Go to the Premera **Payer Space>Resources** and select **C3 Claims Editor Tool**.

Click the heart icon to add the tool link to your favorites



C3 Claims Editor

Claims entry

- Complete the required highlighted fields.
- Select **Review Audit Results**.

The screenshot displays the 'CLAIM ENTRY' section of the C3 Claims Editor. The interface includes a header with 'CHANGE HEALTHCARE EDIT DEVELOPMENT', 'GLOSSARY', and 'ABOUT' links. The main content area contains several form fields: 'Claim Type' (dropdown menu set to 'Professional'), 'Gender' (radio buttons for Male, Female, Unspecified), 'Date of Birth' (text input with '04/29/1984'), 'ICD Code Set' (radio buttons for ICD10), and 'Bill Type' (text input). A 'CLEAR' button and a 'REVIEW AUDIT RESULTS' button are located in the top right corner. A red arrow points to the 'REVIEW AUDIT RESULTS' button. Below the form fields is a paragraph of explanatory text. At the bottom, there is a table with columns for 'LINE', 'PROCEDURE', 'MOD1', 'MOD2', 'MOD3', 'MOD4', 'QTY.', 'REV. CODE', 'BILLED AMT.', 'DOS FROM', 'DOS TO', 'PLACE OF SERVICE', 'PROVIDER STATE', 'LINE DIAG.', 'LINE DIAG.', 'LINE DIAG.', 'LINE DIAG.', 'LINE DIAG.', 'LINE DIAG.', 'NDC NUMBER', 'NDC UNIT', and 'NDC UDM'. The first row of the table is populated with data: Line 1, Procedure 17003, QTY 1, BILLED AMT 100, DOS FROM 04/21/2023, DOS TO 04/21/2023, PLACE OF SERVICE 11 (Office), PROVIDER STATE E119.

Using this tool, a provider can enter a combination of codes they want to bill and receive an informational description of how Premera's claims editing software generally edits the submitted code combination. The description provided by the tool is based solely on the information entered and doesn't consider any other information such as claims history, eligibility, benefit, pricing or other specific member or group information. Note: This tool only provides information based on Premera's first-pass claims editing software and doesn't include our second-pass editing software.

LINE	PROCEDURE	MOD1	MOD2	MOD3	MOD4	QTY.	REV. CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG.	LINE DIAG.	LINE DIAG.	LINE DIAG.	LINE DIAG.	LINE DIAG.	NDC NUMBER	NDC UNIT	NDC UDM	
1	17003					1		100	04/21/2023	04/21/2023	11 (Office)		E119									
2																						
3																						
4																						
5																						

[Add More Procedures >>](#)

C3 Claims Editor

See audit results

- View the claim audit results to see if a code is **allowed** or **disallowed**.
- If a code is **disallowed**, click the “**Disallow**” link under recommendation to see edit details.

CHANGE HEALTHCARE | CLEAR CLAIM CONNECTION™ Sign Out | Help

CHANGE HEALTHCARE EDIT DEVELOPMENT | GLOSSARY | ABOUT

AUDIT RESULTS

[CURRENT CLAIM](#) [CREATE NEW CLAIM](#)

This tool is designed for informational purposes only and isn't a guarantee of payment. Coverage and/or payment for any service is based upon the information contained on a submitted claim, claims history, the plan's payment policies, and the member's eligibility and benefits available in the member's plan. Note: This tool only provides information based on Premera's first-pass claims editing software and doesn't include our second-pass editing software.

Claim Type Professional
Gender Male
Date of Birth 04/29/1984
ICD Code Set ICD10
Bill Type

Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarification.

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	NDC NUMBER	NDC UNIT	NDC UOM	RVU	PAY %	RECOMMENDATION
1	17003	DESTRUCT PREMALG LES 2-14					1		100	06/21/2023	06/21/2023	11 (Office)		E11.9									0		DISALLOW

C3 Claims Editor

See edit rationale (clinical edit clarifications)

- The tool provides details about why the code is **disallowed**.

Use these buttons to make edits to the claim scenario, print, or create a new claim scenario

CHANGE HEALTHCARE EDIT DEVELOPMENT | GLOSSARY | ABOUT | Sign Out | Help

CHANGE HEALTHCARE EDIT DEVELOPMENT | GLOSSARY | ABOUT

CLINICAL EDIT CLARIFICATIONS

[CURRENT CLAIM](#) [REVIEW AUDIT RESULTS](#) [PRINT](#) [CREATE NEW CLAIM](#)

Inquiry
Why is procedure 17003 disallowed?

Procedure	Description
17003	DESTRUCTION (EG. LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTMENT), PREMALIGNANT LESIONS (EG. ACTINIC KERATOSES); SECOND THROUGH 14 LESIONS, EACH (LIST SEPARATELY IN ADDITION TO CODE FOR FIRST LESION)

Response
According to CPT guidelines published by the AMA, "Add-on codes are always performed in addition to the primary service or procedure, and must never be reported as a stand-alone code."
Therefore, procedure 17003 is disallowed.

Sources
AMA

C3 Claims Editor

See audit results (continued)

- In this scenario, one procedure code is **allowed** and the other is **disallowed**.
- Click the “**disallow**” link under recommendation to see edit details.

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CHANGE HEALTHCARE EDIT DEVELOPMENT | GLOSSARY | ABOUT

AUDIT RESULTS

[CURRENT CLAIM](#) [CREATE NEW CLAIM](#)

This tool is designed for informational purposes only and isn't a guarantee of payment. Coverage and/or payment for any service is based upon the information contained on a submitted claim, claims history, the plan's payment policies, and the member's eligibility and benefits available in the member's plan. Note: This tool only provides information based on Premera's first-pass claims editing software and doesn't include our second-pass editing software.

Claim Type Professional
Gender Male
Date of Birth 09/27/1990
ICD Code Set ICD10
Bill Type

Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarification.

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	NDC NUMBER	NDC UNIT	NDC UOM	RVU	PAY %	RECOMMENDATION	
1	99215	OFFICE O/P EST HI 40-54 MIN					1		100.00	06/26/2023	06/26/2023	11 (Office)	Washington	E11.9									0		DISALLOW	
2	11720	DEBRIDE NAIL 1-5					1		300.00	06/26/2023	06/26/2023	11 (Office)	Washington	E11.9										n/a		ALLOW

C3 Claims Editor

See edit rationale (clinical edit clarifications)

The tool provides details about why the code is **disallowed**.

The screenshot displays the 'CLINICAL EDIT CLARIFICATIONS' section of the C3 Claims Editor. At the top, there are navigation links for 'CHANGE HEALTHCARE EDIT DEVELOPMENT', 'GLOSSARY', and 'ABOUT'. On the right, there are buttons for 'CURRENT CLAIM', 'REVIEW AUDIT RESULTS', 'PRINT', and 'CREATE NEW CLAIM'. The main content area is titled 'Inquiry' and asks 'Why is this procedure disallowed?'. Below this is a table with two columns: 'Procedure' and 'Description'. The first row shows procedure 11720, 'DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 1 TO 5'. The second row shows procedure 99215, 'OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND HIGH LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 40-54 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.' Below the table is a 'Response' section with a red arrow pointing to the text. The response explains that HCPCS/CPT codes define procedures and that integral services have CPT codes for reporting. It states that procedure 11720 is not recommended for separate reimbursement because it is an integral part of procedure 99215. At the bottom, there is a 'Sources' section with a red arrow pointing to 'CMS'.

CHANGE HEALTHCARE EDIT DEVELOPMENT | **GLOSSARY** | **ABOUT** | **Sign Out** | **Help**

CLINICAL EDIT CLARIFICATIONS

CURRENT CLAIM | **REVIEW AUDIT RESULTS** | **PRINT** | **CREATE NEW CLAIM**

Inquiry

Why is this procedure disallowed?

Procedure	Description
11720	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 1 TO 5
99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND HIGH LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 40-54 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.

Response

HCPCS/CPT codes define procedures include services that are integral. Integral services have CPT codes for reporting service when not performed as an integral part of another procedure. Services integral to HCPCS/CPT code are procedures included in services based on standards of medical/surgical practice. It is inappropriate to report services alone that are integral to another procedure. NCCI edits are based on standards of medical/surgical practice. Services that are integral to another become component parts of comprehensive service. Integral component services have their own HCPCS/CPT codes. NCCI edits place comprehensive service in column one and component service in column two. A component service integral to comprehensive service is not separately reportable; column two codes can not be reported separately with column one code. Services are integral to large numbers of procedures. Other services are integral to a limited number of procedures. Examples of large number of procedures include: * Cleansing, shaving and prepping of skin* Draping and positioning* Insertion of intravenous access for medication administration* Insertion of urinary catheter* Sedative administration by physician performing procedure (Chapter II, Anesthesia Services)* Local, topical or regional anesthesia administered by physician performing procedure* Surgical approach including identification of anatomical landmarks, incision, evaluation of surgical field, debridement of traumatized tissue, lysis of adhesions, isolation of structures limiting access to surgical field such as bone, blood vessels, nerve, muscles including stimulation for identification or monitoring* Surgical cultures* Wound irrigation* Insertion/removal of drains, suction devices, pumps into same site* Surgical closure and dressings* Application, management, and removal of postoperative dressings and analgesic devices (peri-incisional) * TENS unit* Institution of Patient Controlled Anesthesia* Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, or transcription necessary to document services provided* Surgical supplies, for specific situations where CMS policy permits separate payment* Chapters in Manual address issues related to standards of medical/surgical practice for procedures covered. It is not possible because of space limitations to discuss all NCCI edits based on principle of standards of medical/surgical practice. There are general principles that can be applied to edits as follows: * Component service is accepted standard of care when performing comprehensive service. * Component service usually necessary to complete comprehensive service. * Component service is not separate procedure when performed with comprehensive service.

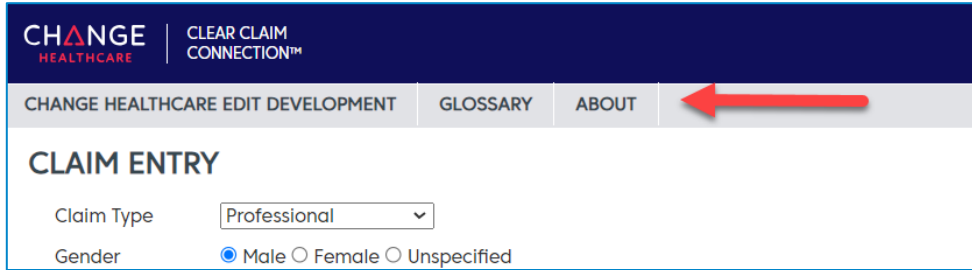
Therefore, this procedure is not recommended for separate reimbursement.

Sources

CMS

Resources

- Additional C3 resources located at the top of the page.



The screenshot shows the top navigation bar of the CHANGE Healthcare website. The header is dark blue with the logo 'CHANGE HEALTHCARE' and 'CLEAR CLAIM CONNECTION™'. Below the header is a light gray navigation bar with links for 'CHANGE HEALTHCARE', 'EDIT DEVELOPMENT', 'GLOSSARY', and 'ABOUT'. A red arrow points to the 'ABOUT' link. Below the navigation bar is a white section titled 'CLAIM ENTRY' with a 'Claim Type' dropdown menu set to 'Professional' and a 'Gender' section with radio buttons for 'Male', 'Female', and 'Unspecified'.

- Technical issues:
 - Experiencing an issue bringing up the C3 Claims Editor Tool in Availity? Call Availity at **800-282-4548**, 8 a.m. to 8 p.m., Eastern Time, Monday - Friday.
 - Experiencing an issue within the C3 Claims Editor Tool? Go to Availity **Payer Spaces>Resources>Contact Premera** and call customer service for assistance.

Thank you

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