BlueCross BlueShield of Oklahoma

Updates to ClaimsXten™
Frequently Asked Questions

1. What is ClaimsXten?

ClaimsXten is the code auditing tool developed by McKesson Information Solutions, Inc. It replaced the ClaimCheck® code auditing software with expanded claim processing capabilities, including automated claim review and code auditing. ClaimsXten offers flexible, rules-based claims management with the capability of creating customized rules, as well as the ability to read historical claims data. This will assist in adjudicating claims in a manner that is more efficient and cost effective.

2. Does this affect all providers that submit claims to Blue Cross and Blue Shield of Oklahoma (BCBSOK)?

At this time, only **professional (including ancillary providers)** paper and electronic claims that are submitted to BCBSOK will be evaluated and processed according to the ClaimsXten code-auditing software rules and clinical rationale.

3. How will notification of new rules be provided?

- Watch the News and Updates and/or the *Blue Review* sections of our Provider website for updates and information regarding the ClaimsXten tool, including notification of the implementation of new rules.
- View the current ClaimsXten Rules Descriptions document in the Claims and Eligibility/Submitting Claims section of our Provider website.

4. Will these rules have the ability to read historical claims data?

Yes. ClaimsXten will continue to identify services that have been previously submitted in conjunction with the current claim being evaluated.

5. Will I see messages on my electronic payment summary (EPS) or provider claim summary (PCS)?

Yes. Examples of condensed versions of the messages are provided below for your convenience. For the complete messages, refer to your PCS or EPS.

- **Medically Unlikely Edit (MUE) of Durable Medical Equipment (DME) Rule** – Durable Medical Equipment billed exceeds the total number of units allowed.
- **Durable Medical Equipment (DME) Maximum Payment Rule** – The maximum allowance for the DME has been exceeded.

6. What if I disagree with how the claim was evaluated/adjudicated?

For any issue with a claim that has been denied utilizing ClaimsXten logic, you should continue to follow the current process for requesting a review of a previously adjudicated claim. Complete and submit a Claim Review Form to BCBSOK, including all required information, such as claim and provider data, the reason for the review request (check the ClaimsXten box) and any necessary documentation. The Claim Review Form is available in the Education and Reference Center/Forms of the BCBSOK Provider website at bcbsok.com/provider.HYPERLINK "http://www.bcbsok.com/provider/"

7. How can I determine how coding combinations on a particular claim may be evaluated by ClaimsXten during the claim adjudication process?

Clear Claim Connection™ (C3) will continue to be the provider resource that allows disclosure of claim auditing rules and clinical rationale to the BCBSOK contracting provider network. C3 is a free online reference tool that mirrors the logic behind the code-auditing software. You must be registered with Availity™ to gain access to C3.

8. How do I gain access to C3?

After logging on to the Availity provider portal, look for *Claims Management/Research Procedure Code Edit*. If you are not currently a registered user, visit Availity to sign up.

- Availity Users – After logging on to the Availity provider portal, look for *Claims Management/Research Procedure Code Edit*. If you are not currently a registered user, visit Availity at availity.com to sign up, or contact Availity Client Services at 800-AVAILITY (282-4548).

9. Where can I go for more information or assistance?

Continue to watch upcoming issues of the *Blue Review* provider newsletter, and the News and Updates section of the Provider website at bcbsok.com/provider for articles and important announcements. You may also contact your provider representative for assistance.

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.