MASSACHUSETTS

CONNECTCENTER USER GUIDE

INTRODUCTION

ConnectCenter™, owned and maintained by Optum, is an eTool for real-time transactions and professional claim submission. ConnectCenter is available to all providers contracted with Blue Cross Blue Shield of Massachusetts.

Medical and dental providers can use ConnectCenter to:

- Verify benefits and eligibility
- Check claim status

Medical providers can:

- Submit and verify referrals
- Submit professional (1500) claims, including BlueCard® and Federal Employee Program claims

Authorizations

For authorization *submission* and *verification*, use our eTool, Authorization Manager. (Reminder: Submit an authorization request—not a referral—for **outpatient rehab (PT/OT)**.)

However, you can use ConnectCenter to learn authorization requirements.

ACCESSING CONNECTCENTER

Log in to our Provider Central website, bluecrossma.com/provider. On the left-hand side of the secure homepage, you'll see an eTools box. Click on ConnectCenter.

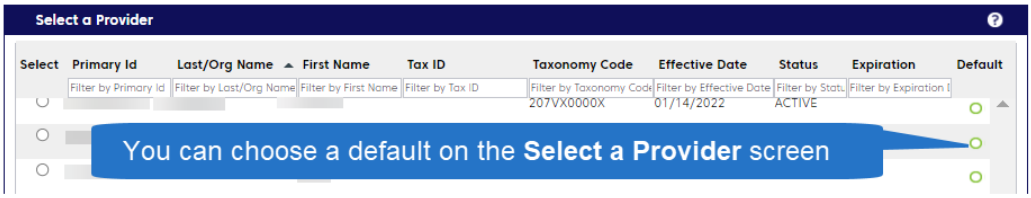
If you do not see the link, talk to the person in your practice or organization who is set up as administrator of your Provider Central account. They can grant you access to this tool.

You can also access ConnectCenter via the **eTools** tab in the main navigation bar. This page includes tips and resources for using the tool.

ENTERING YOUR PROVIDERS

It's a good idea to save default provider information in the Admin area of ConnectCenter. It needs to be done only once, and it will save you time in future inquiries.

1. Enter provider information by going to **Admin>Provider Management**. Read our Provider Management Quick Tip for help.
2. Save defaults for Requesting Provider, Billing Provider, and Rendering Provider. Defaults can be saved in Provider Management records and also in the **Select a Provider** screen.



NAVIGATING AND ENTERING DATA

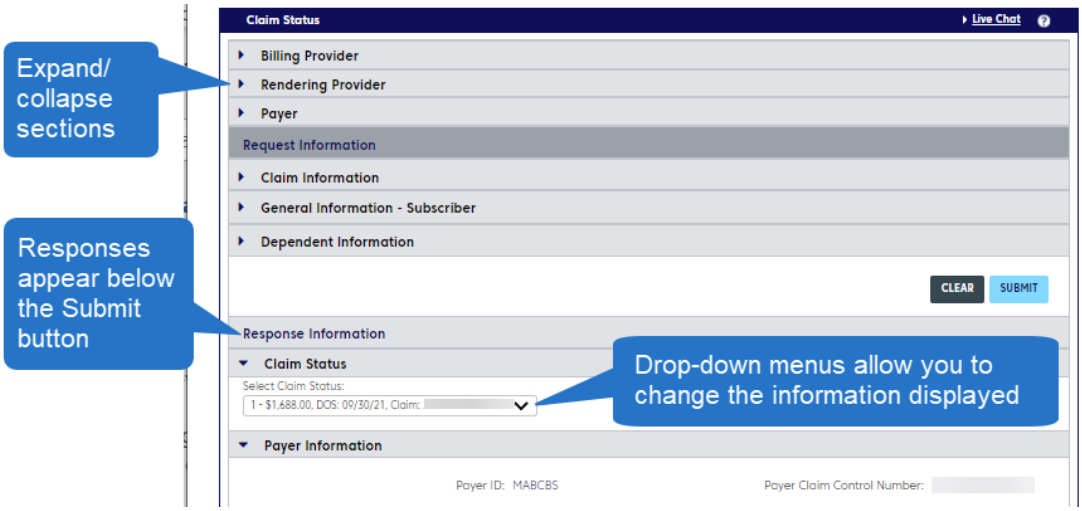
Required fields are marked with a red asterisk or a red outline. Be sure to complete them accurately. Include a prefix with the member ID number.

Dates must be entered in the MM/DD/YYYY format.

Do not use dashes when entering information like phone numbers, zip codes, and tax ID numbers.

Some ConnectCenter pages have expand/collapse sections (also called “accordions”). It is helpful to collapse sections you don’t need.

Inquiry responses appear at the bottom of the page (under the **Submit** button) and may include drop-down menus for changing the category of information displayed.

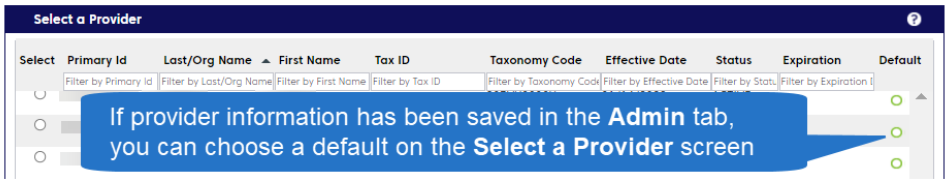


BENEFITS AND ELIGIBILITY

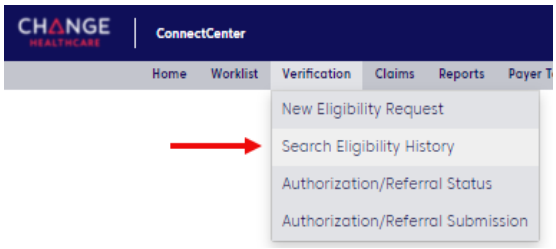
You can use ConnectCenter to verify eligibility for Massachusetts, out-of-state (BlueCard), Federal Employee Program, and international Blue Cross Blue Shield members. *Responses are returned from the Blue plan that the member is contracted with, and the level of detail varies.*

How to perform the inquiry

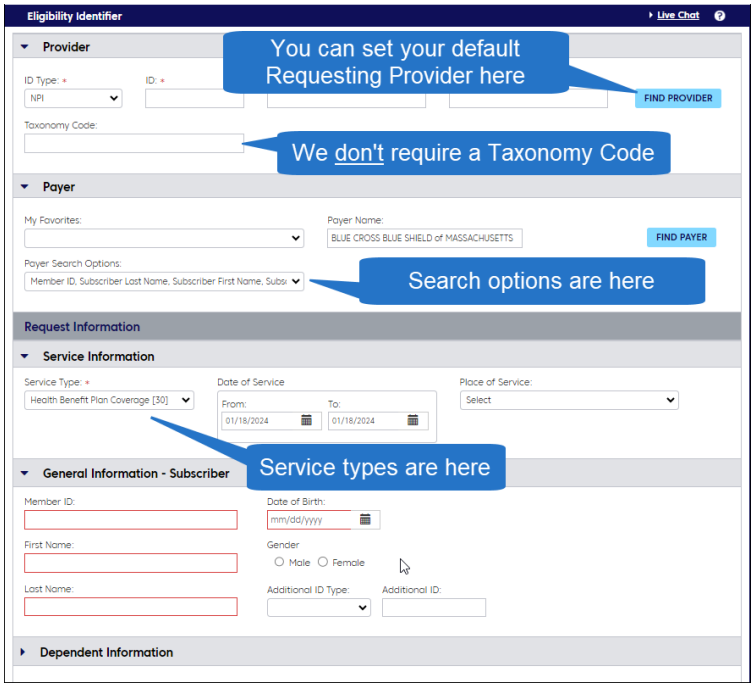
1. Go to **Verification>New Eligibility Request**.
2. Enter or find the requesting provider.
    - If you have entered providers using the **Admin** tab, you can choose a default Requesting Provider from the **Select a Provider** screen.



3. The default **Payer Search Option** is for member ID number and subscriber date of birth. Select another option if desired.
    - For out-of-state (BlueCard) members, select the search option using the member's ID number (***including prefix***), name, and date of birth.
4. For detailed benefits information, go to the **Service Type** dropdown menu and select a specific service type. The default option, Health Benefit Plan Coverage, includes many common services.
5. Click **Submit**.
    - The **Submit – Review Later** button is useful if you would like to submit several inquiries before reviewing responses. Access your responses by going to **Verification>Search Eligibility History**.

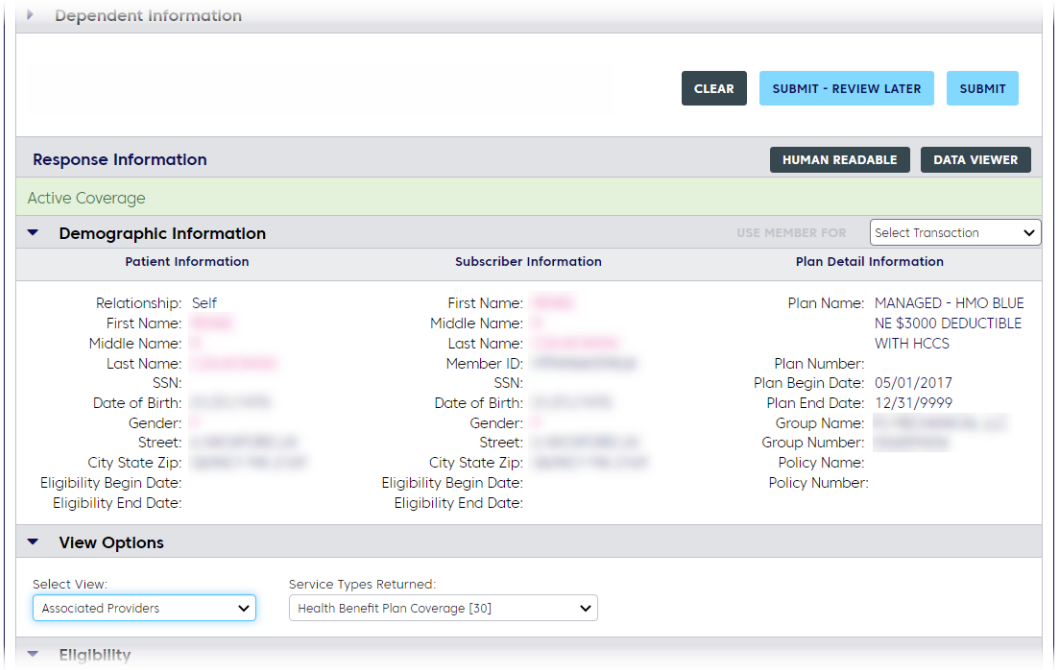


This screenshot shows the **Eligibility Request** screen:



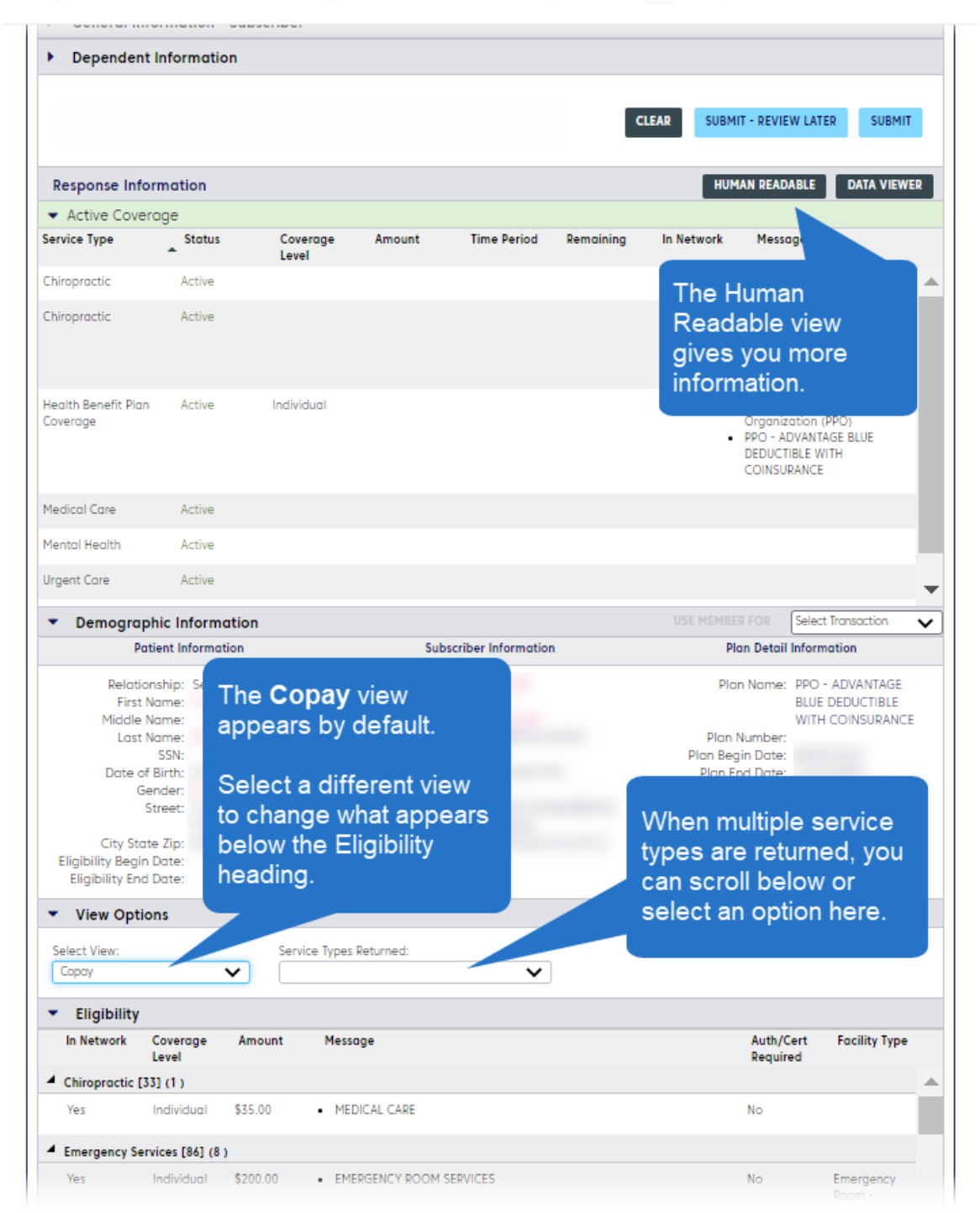
Understanding eligibility inquiry results

Your results will appear at the bottom of the page.



The response information will include a red bar when a member's plan is no longer active.

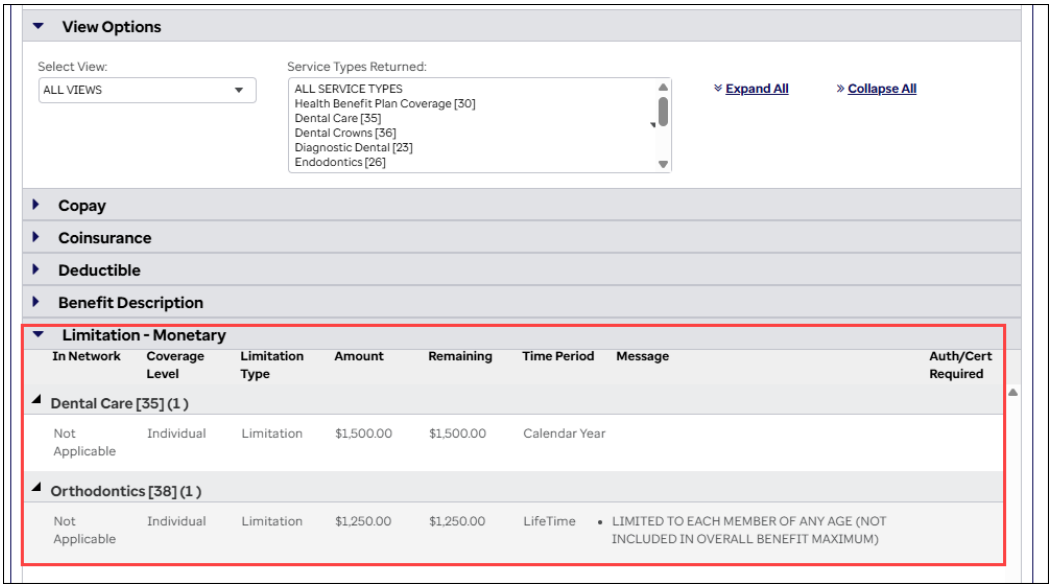
Benefits information appears below the demographic information. Depending on the member's plan and the type of service, your results may include details on authorization requirements, co-insurance, copayments, and deductibles.



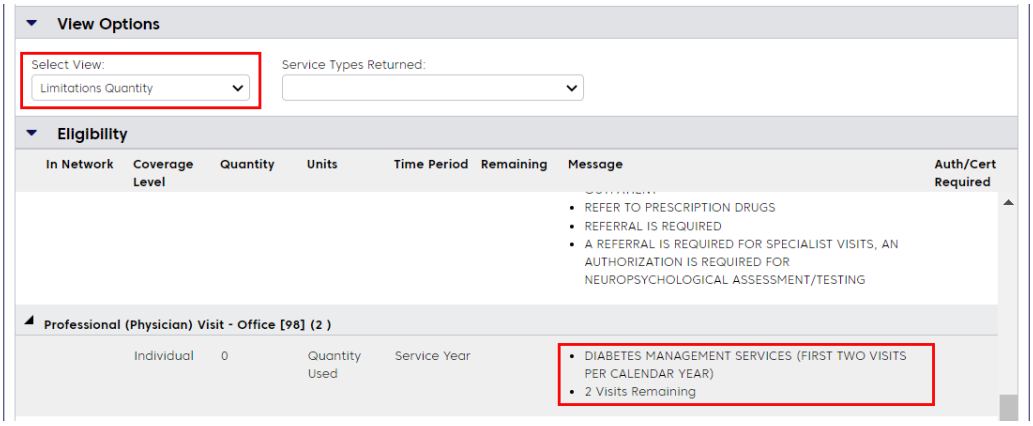
- Authorization requirements appear in the "Copay" view.
- Network information appears in the "Providers" view.

- If relevant to the service and the member's plan, you may see page sections called "Limitation – Quantity" or "Limitation – Monetary." Open these areas to see benefit maximums and visits remaining.
    - Reminder: Accumulated amounts are based on claims that were processed at the time of the inquiry and are not a guarantee of payment.

Here you see monetary limitations for a dental plan:



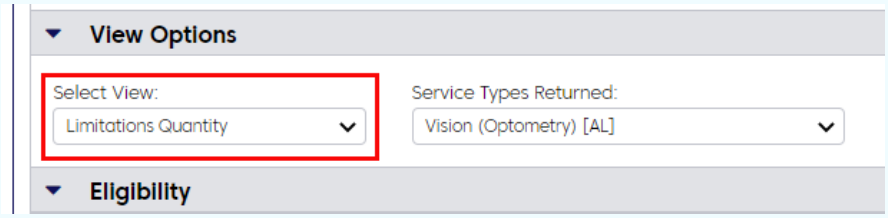
Here is an example for a medical plan with quantity limitations for diabetes management services. In this example, the user accessed the information using the "Select View" option for "Limitations – Quantity."



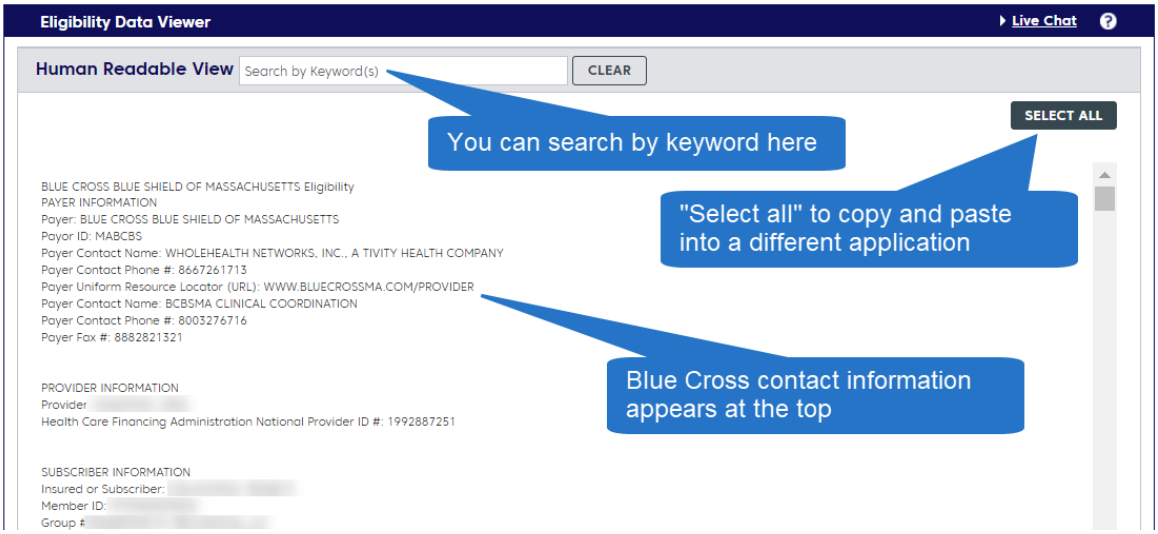
"Human Readable View"

If you find that **Select View** and **Service Types Returned** filters are more limiting than you would like, you can click the **Human Readable** button (below the **Submit** and **Clear** buttons) to access the complete response.

Tip: Before using the Human Readable view, review the options in the **Select View** dropdown menu:



When you open the Human Readable view, you can scroll or use the search field to move quickly through the results.



The Human Readable view begins with Blue Cross contact information. Other sections vary depending on the member's plan and product, but often include:

- Subscriber Information
- Primary care provider contact information
- **Coverage Level*** (such as "Family")
- **Insurance Type*** (such as HMO or PPO)
- **Plan Coverage Description***
    - Plan Coverage Description may appear multiple times in different places to indicate details such as the product name, whether the account is self-insured or fully insured, or whether the product has a certain benefit design feature. Here are some examples:
        - Plan Coverage Description - 1: PPO - ADVANTAGE BLUE DEDUCTIBLE WITH COINSURANCE
        - Plan Coverage Description - 2: SELF INSURED (or FULLY INSURED)
        - Plan Coverage Description - 3: HOSPITAL CHOICE COST SHARING

* These items are useful search terms in the Human Readable View.

Sections in the Human Readable view are numbered and appear in a format like this: ELIGIBILITY AND BENEFIT INFORMATION - 2

To understand the results, read all lines that are marked with the same number, and then read neighboring sections.

In the example below, section 6 indicates the individual deductible and section 7 indicates the individual deductible remaining. (Additional sections – not shown – might indicate the family deductible and the family deductible remaining.)

ELIGIBILITY AND BENEFIT INFORMATION - 6

Eligibility Benefit Information - 6: Deductible

Coverage Level - 6: Individual

Service Type - 6: Health Benefit Plan Coverage

Time Period Qualifier: Service Year

Monetary Amount - 6: $3,000.00 ←

Message - 6 - 1: DEDUCTIBLE DOES NOT APPLY TO MOST PREVENTIVE HEALTH SERVICES, PRESCRIPTION DRUG BENEFITS AND CERTAIN OTHER SERVICES AS NOTED.

ELIGIBILITY AND BENEFIT INFORMATION - 7

Eligibility Benefit Information - 7: Deductible

Coverage Level - 7: Individual

Service Type - 7: Health Benefit Plan Coverage

Time Period Qualifier: Remaining

Monetary Amount - 7: $2,625.00 ←

Message - 7 - 1: DEDUCTIBLE DOES NOT APPLY TO MOST PREVENTIVE HEALTH SERVICES, PRESCRIPTION DRUG BENEFITS AND CERTAIN OTHER SERVICES AS NOTED.

CLAIM STATUS

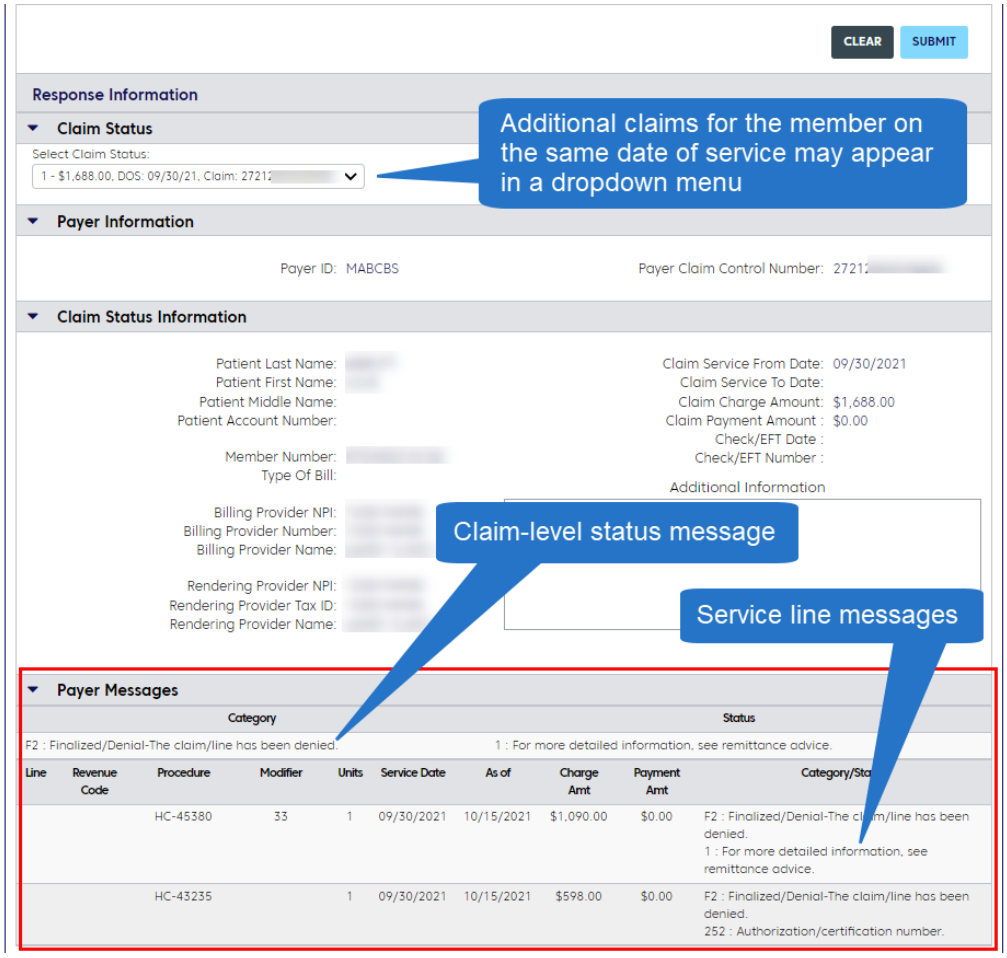
You can inquire on the status of any claim sent to Blue Cross Blue Shield of Massachusetts for processing.

How to perform the inquiry

1. Select a search method.
    - For any claim submitted to Blue Cross Blue Shield of Massachusetts, you can go to **Claims>Claim Status**. You will need to enter or select the billing provider, the date of service, and member information (ID, name, and date of birth).
    - For 1500 claims you submitted *through ConnectCenter*, you can perform a fast search by going to **Claims>Claim Search**.
2. Complete the minimum number of required or appropriate fields and click **Submit**.
    - Tip: You can begin a claim status inquiry from your eligibility search results. In the **Demographic Information** row, open the **Select Transaction** drop-down menu and select **Claim Status**. Then click the button, **Use Member For**. This will carry the member's policy information to the **Claim Status** screen.

Understanding claim status inquiry results

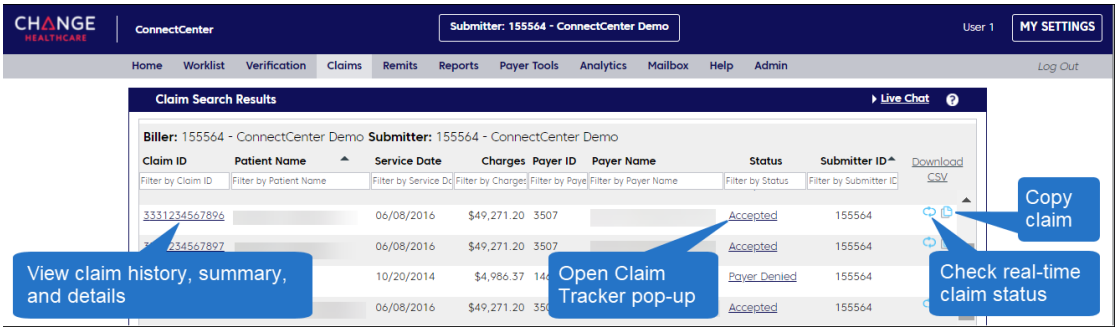
- Your results will appear at the bottom of the **Claim Status** page after you click the **Submit** button.
- If more than one claim matches your search criteria, a drop-down menu will appear under the **Claim Status** heading. Select a claim to see its status.
- Claim-level status messages—at the top of the **Payer Messages** section—will be followed by a service line table. Each line will include procedure code, service dates, charges, and adjudication status. If adjudication is complete, the payment amount appropriate to each service line will also be available.



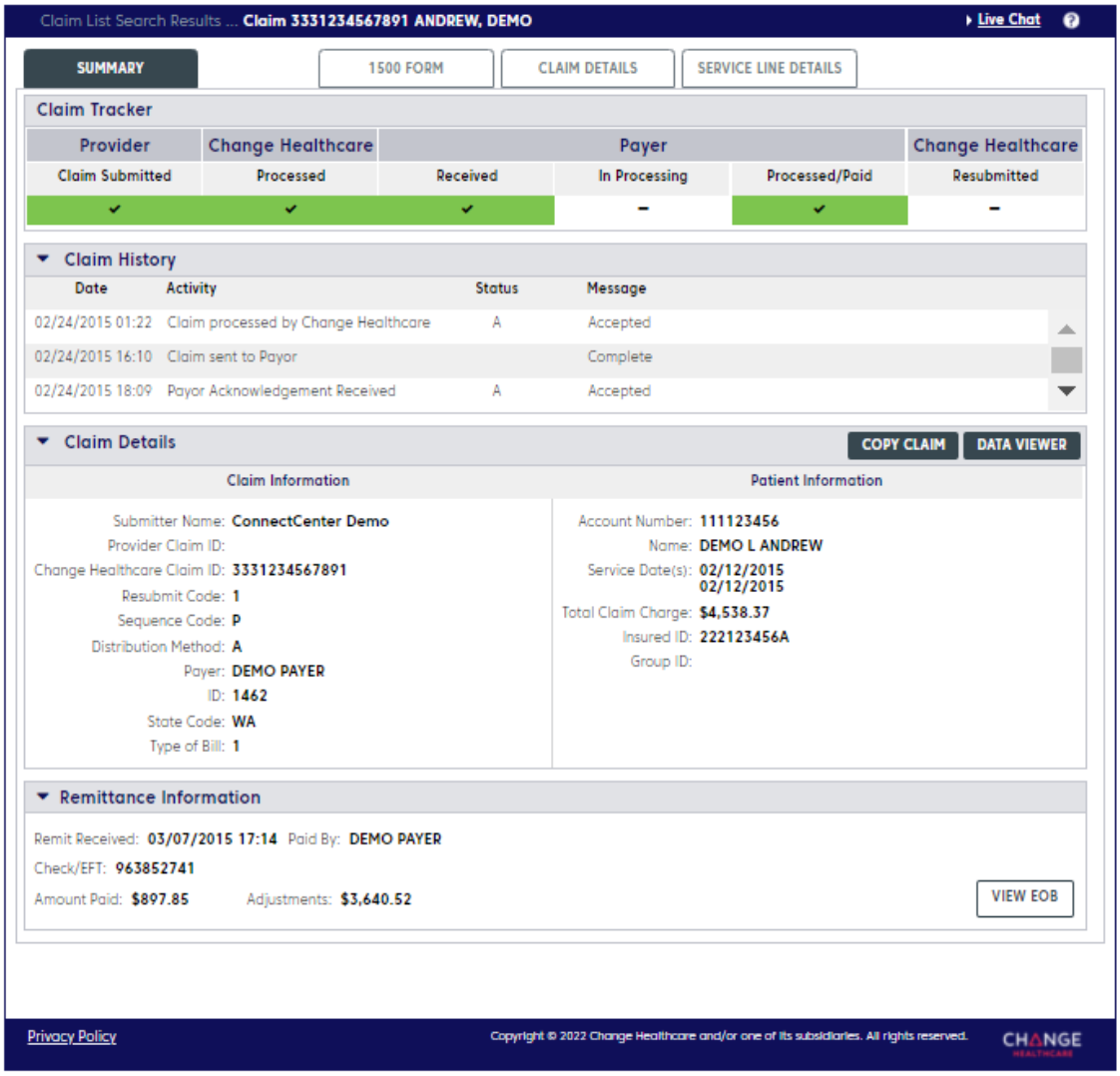
Fast searches for 1500 claims submitted through ConnectCenter

For 1500 claims you submitted through ConnectCenter, you can perform a fast search by going to **Claims>Claim Search.** Claims that match your search criteria will appear in a list. You can:

- sort your results by clicking a column heading
- filter your results by entering data in a field under a heading
- click a link for more information, as shown in the screenshot below.



- The icon for real-time claim status ( ) will be displayed for any claim that has been submitted to Blue Cross but has not yet reached a state of final adjudication. Click the icon to display claim status inquiry results like the example shown in the next section.
- If you copy a claim, it will appear in your **Incomplete Claims** worklist.
- Click the claim ID number to see a claim summary like the one below. The summary includes a claim tracker, history, and details.



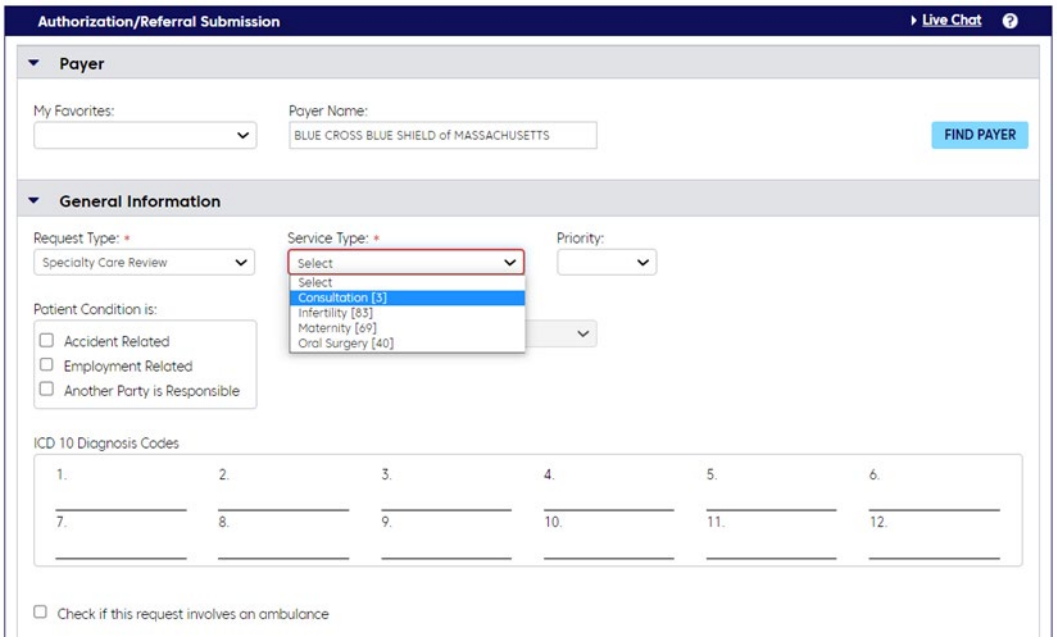
REFERRAL SUBMISSION

Reminder: Submit an authorization request—***not*** a referral—for **outpatient rehab (PT/OT)** and **home health care for Medicare HMO Blue members**. Use Authorization Manager for these services.

How to submit a referral

1. Go to **Verification>Authorization/Referral Submission**. (Reminder: do not use ConnectCenter for authorization requests.) Complete required and appropriate optional fields. Do not enter procedure or service line level information.
    - For the **Type** field, you will usually select “Visits.”
    - Place of Service codes can be found here.
2. Click **Submit**.

The following screenshot shows the **Authorization/Referral Submission** screen.



REFERRAL INQUIRIES

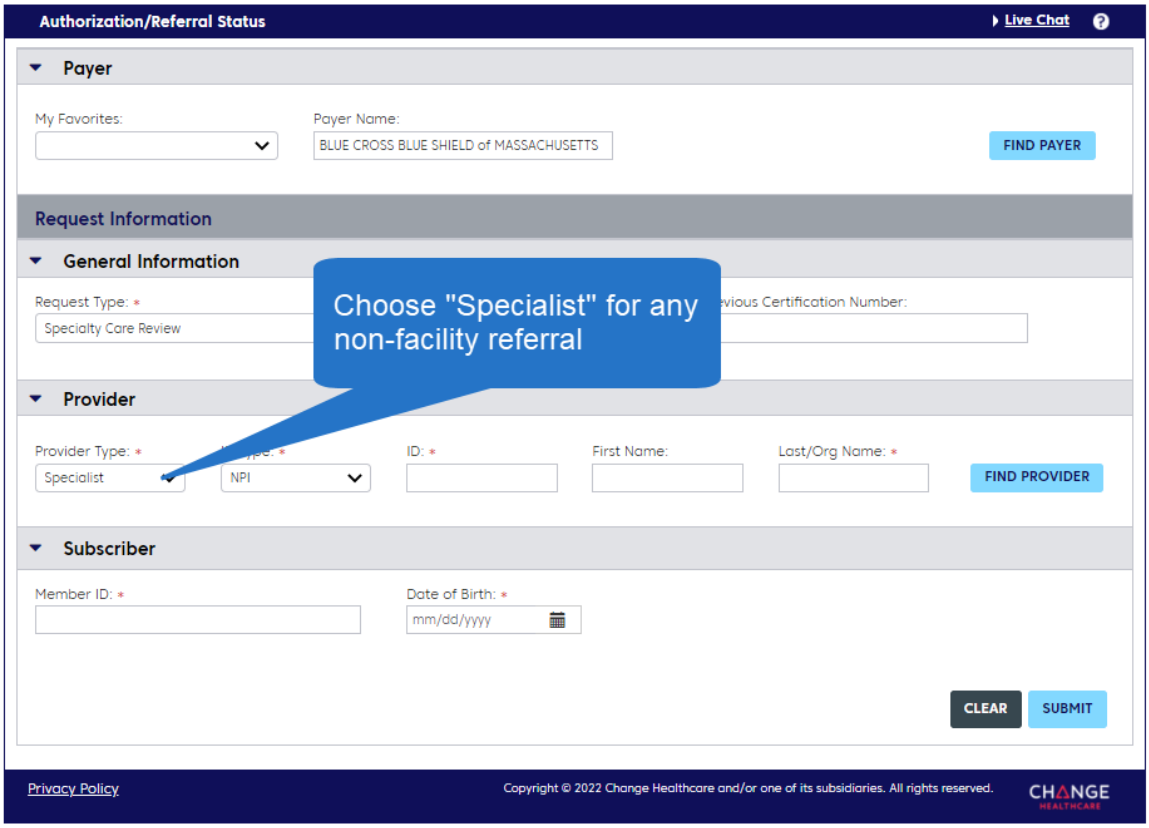
Referral inquiries will return results only if:

- The member's coverage is active at the time of the inquiry
- The referral is active (that is, the timeframe has not lapsed).

How to perform the inquiry

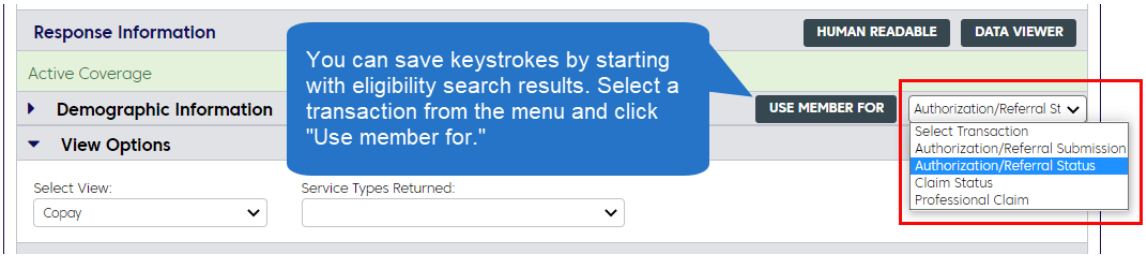
1. Go to **Verification>Authorization/Referral Status**.
2. Complete all required fields and only required fields. Note:
    - For **Provider Type**, select "Specialist" for any individual provider (non-facility).
    - Leave the **Previous Certification Number** field blank.
3. Click **Submit**.

The following screenshot shows the **Authorization/Referral Status** screen.



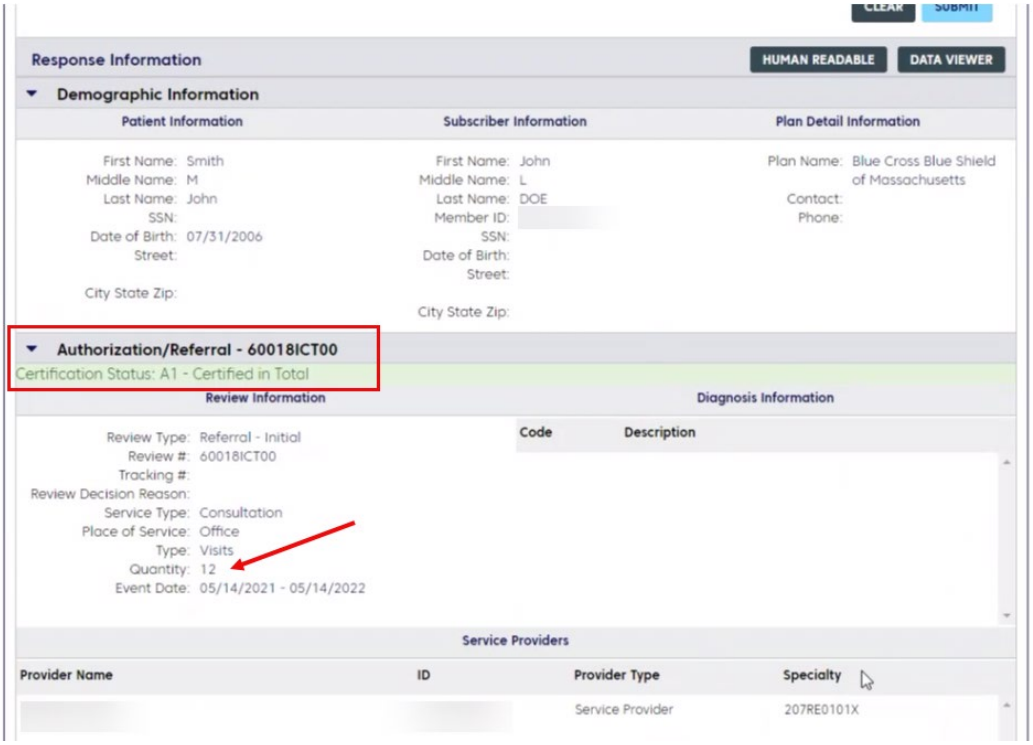
Tip:

- You can begin a referral inquiry from your eligibility search results. In the **Demographic Information** row, open the **Select Transaction** drop-down menu and select **Authorization/Referral Status**. Then click the button, **Use Member For**. This will carry the member's policy information to the **Authorization/Referral Status** screen.



Understanding referral inquiry results

- Results that match your search criteria will appear at the bottom of the page. An open referral will be indicated in a green bar.
- Under the **Review information** heading, you'll see the referral date range and visit quantity.



ADDITIONAL RESOURCES

More resources are available on our ConnectCenter page. For additional help, contact Optum's ConnectCenter support at **1-800-527-8133**.

- Select **option 2** for claims or claim status.
- Select **option 3,** then **option 1** for eligibility.

For help with Provider Central, please contact Blue Cross Blue Shield's EDI/Provider Self-Service Support Team at providercentral@bcbsma.com or **1-800-771-4097, option 2**.

DOCUMENT HISTORY

04/22	New document.
08/22	Updated screenshots for benefits and eligibility.
11/22	New screenshots and simplified instructions for referral submission. Added link for Place of Service codes.
01/24	Updated references to home health care. Authorization required now for Medicare HMO Blue only. Removed references to Online Services. Updated screenshot for eligibility search.
01/25	Updated reference to home health care since authorization is no longer required for Medicare HMO Blue.
03/25	Updated Related Resources.
03/26	Changed template. Updated document to reflect that ConnectCenter can now be used by dental providers. Updated Change Healthcare to Optum.

MPC_020216-2M (03/26)