MASSACHUSETTS

CONNECTCENTER QUICK START

INTRODUCTION

ConnectCenter™ is an eTool for real-time transactions and professional claim submission. It is a product of Change Healthcare (CHC).

You can use ConnectCenter to:

- Verify benefits and eligibility
- Check claim status
- 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.

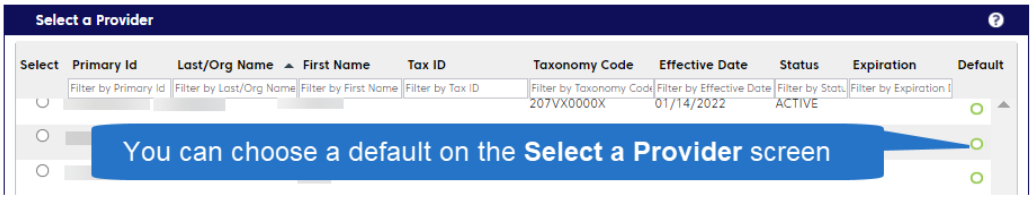
If you do not see the link, talk to the person in your practice or organization who is set up as administrator of your Provider Central account. They can grant you access to this tool.

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

BEFORE YOU BEGIN

To save time later, it is strongly recommended that you:

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

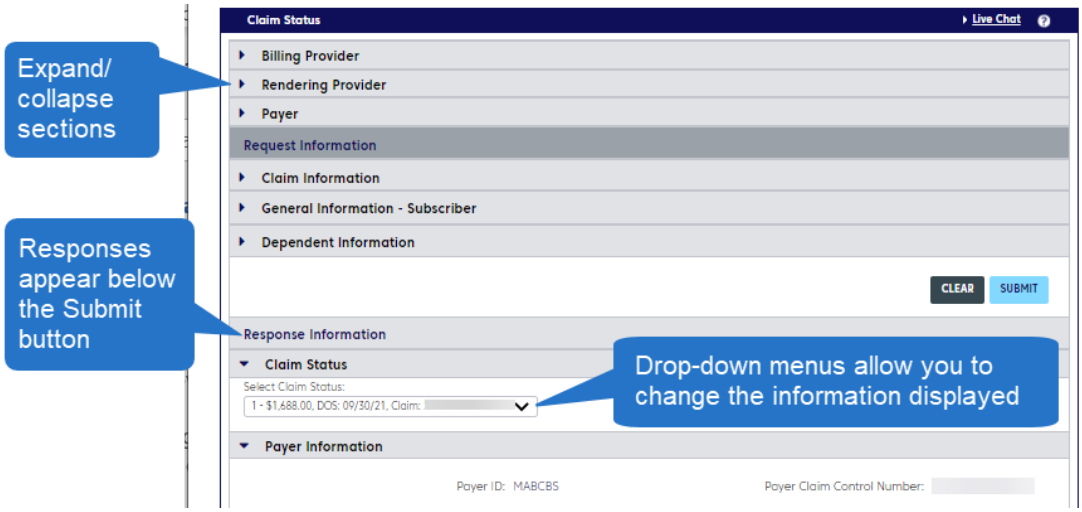
Required fields are marked with a red asterisk or a red outline. Be sure to complete them accurately. Include a prefix with the member ID number.

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.

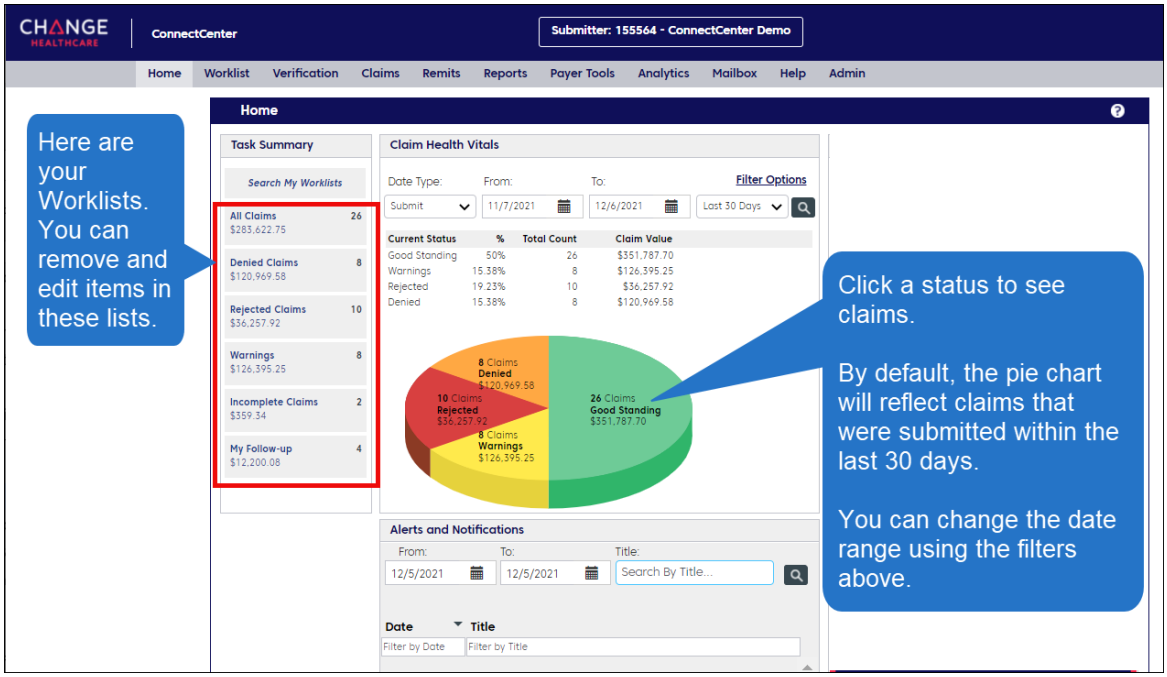
Inquiry responses appear at the bottom of the page (under the **Submit** button) and may include drop-down menus for changing the category of information displayed.



HOME PAGE RESOURCES

Your home page includes a summary of the claims submitted through ConnectCenter in the last 30 days. Click a status in the pie chart to see claims with that status.

On the left side of your home page, you’ll see your **Worklists**. You can use these lists to manage claims that you may wish to correct and resubmit. Worklists are explained further on page 11.



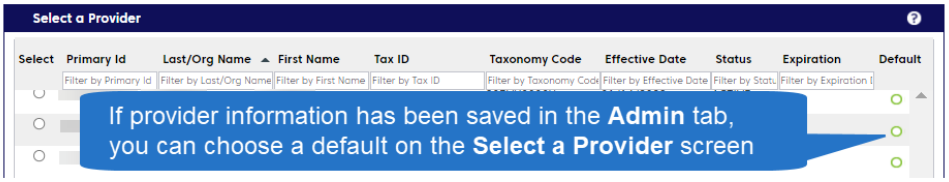
BENEFITS AND ELIGIBILITY

You can use ConnectCenter to verify eligibility for Massachusetts, out-of-state, 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.*

Key steps

1. Go to **Verification>New Eligibility Request**.

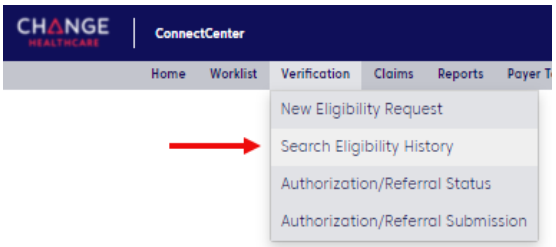
2. Enter or find the requesting provider.
   - If you have entered providers using the **Admin** tab, you can choose a default Requesting Provider from the **Select a Provider** screen.



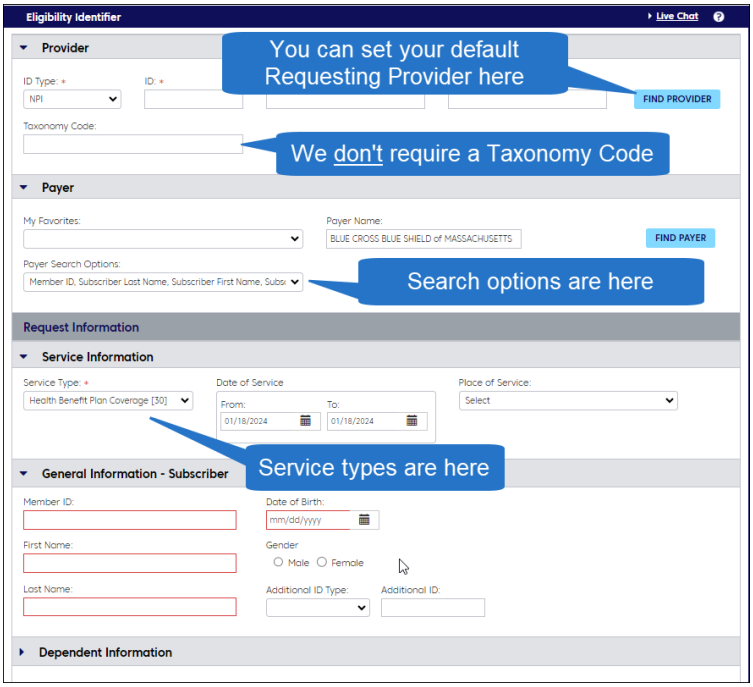
3. The default **Payer Search Option** is for member ID number and subscriber date of birth. Select another option if desired.
   - For out-of-state members, you must enter the member's ID number (***including prefix***), name, and date of birth.

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**.

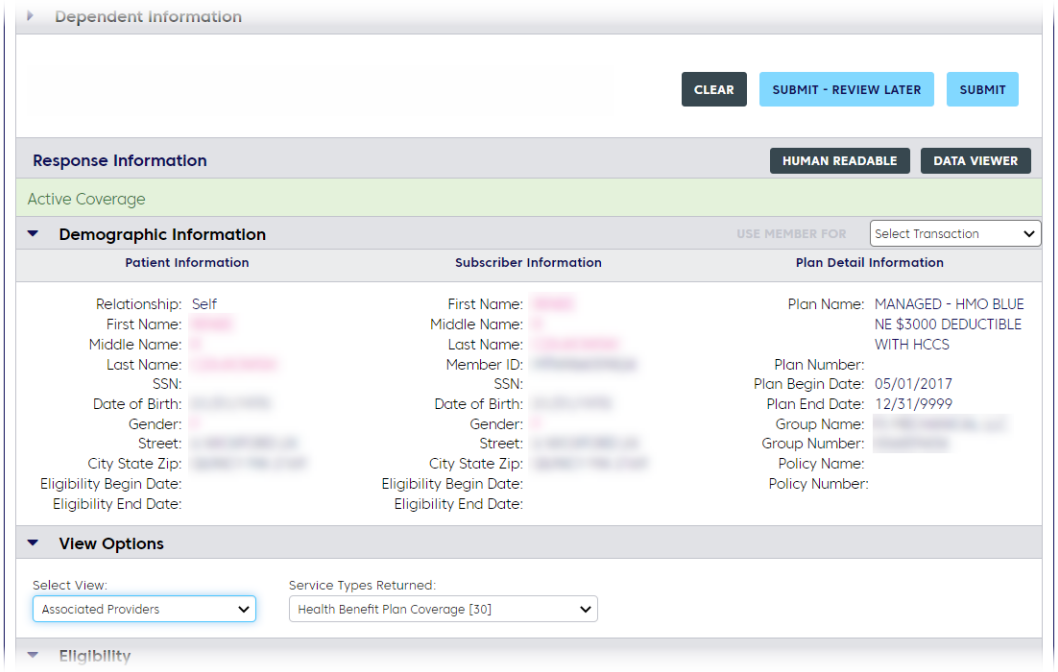


This screenshot shows the **Eligibility Request** screen:



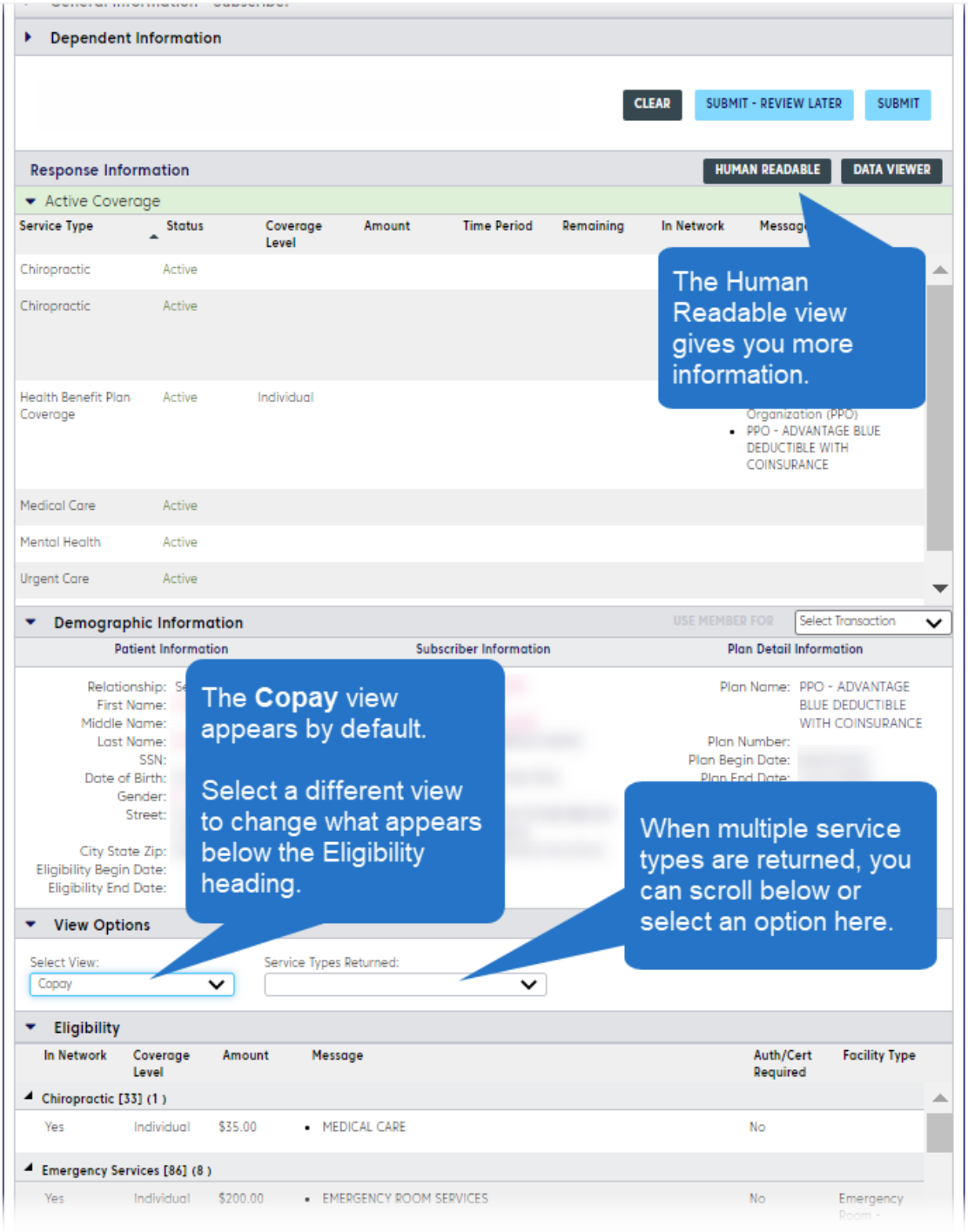
UNDERSTANDING THE RESULTS

Your results will appear at the bottom of the page.



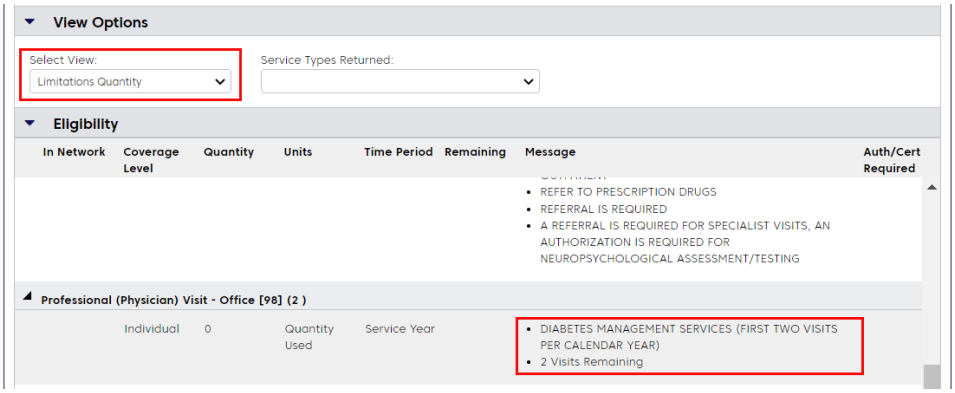
The response information will include a red bar when a member's plan is no longer active.

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.

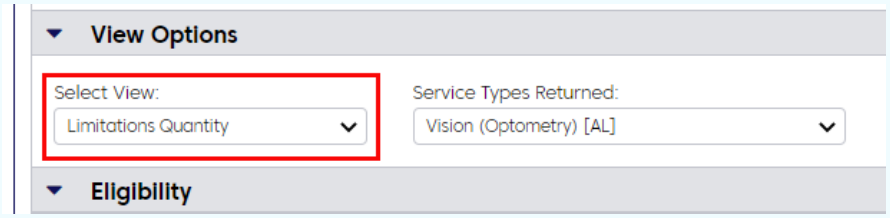
- For the benefit maximum and visits remaining, select “Limitations – Quantity.”
    - Reminder: Accumulated amounts are based on claims that were processed at the time of the inquiry and are not a guarantee of payment.



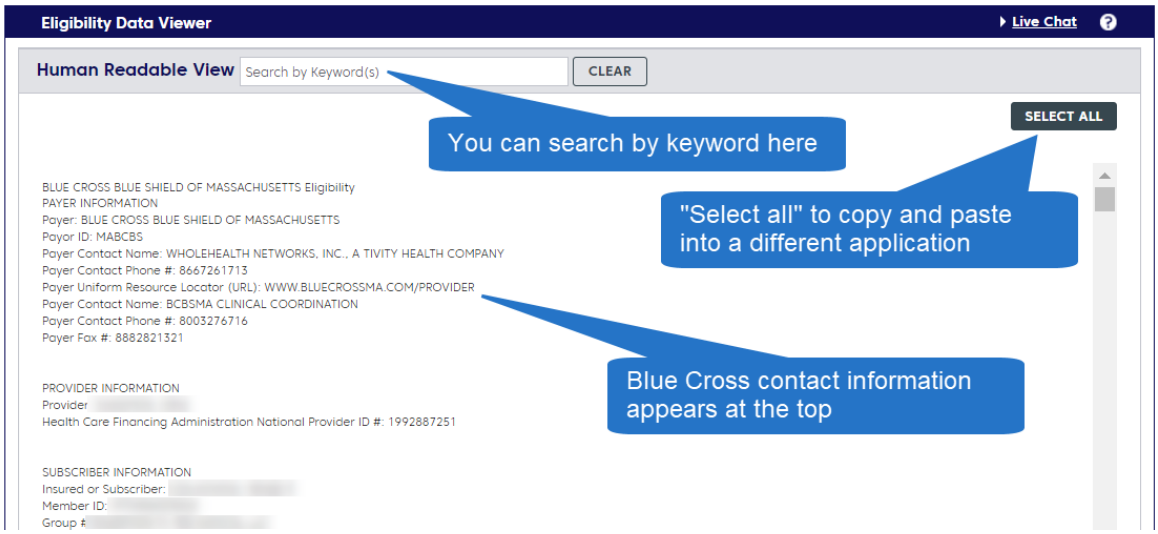
HUMAN READABLE VIEW

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
- **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
- Primary care provider contact information

* 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.

Key steps

1. Select a search method.
    - For claims *you submitted through ConnectCenter*, you can perform a fast search by going to **Claims>Claim Search**.
    - 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).
2. Complete the minimum number of required or appropriate fields and click **Submit**.

Tips

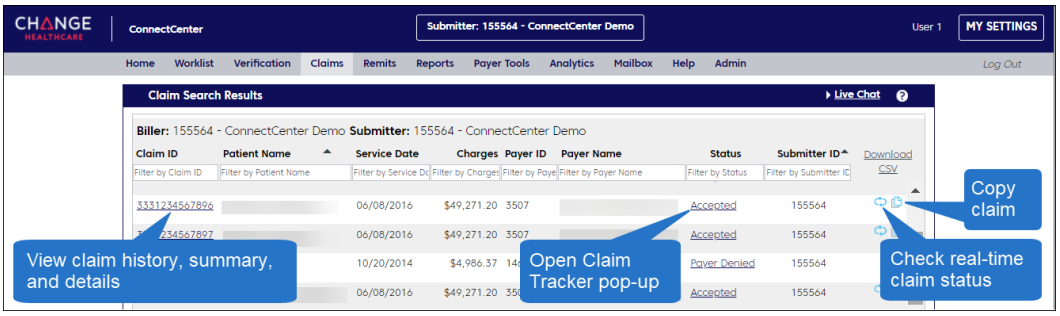
- You can begin a claim status inquiry from your eligibility search results. In the **Demographic Information** row, open the **Select Transaction** drop-down menu and select **Claim Status**. Then click the button, **Use Member For**. This will carry the member's policy information to the **Claim Status**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

For more details about checking claim status, refer to our Checking Claim Status Quick Tip.

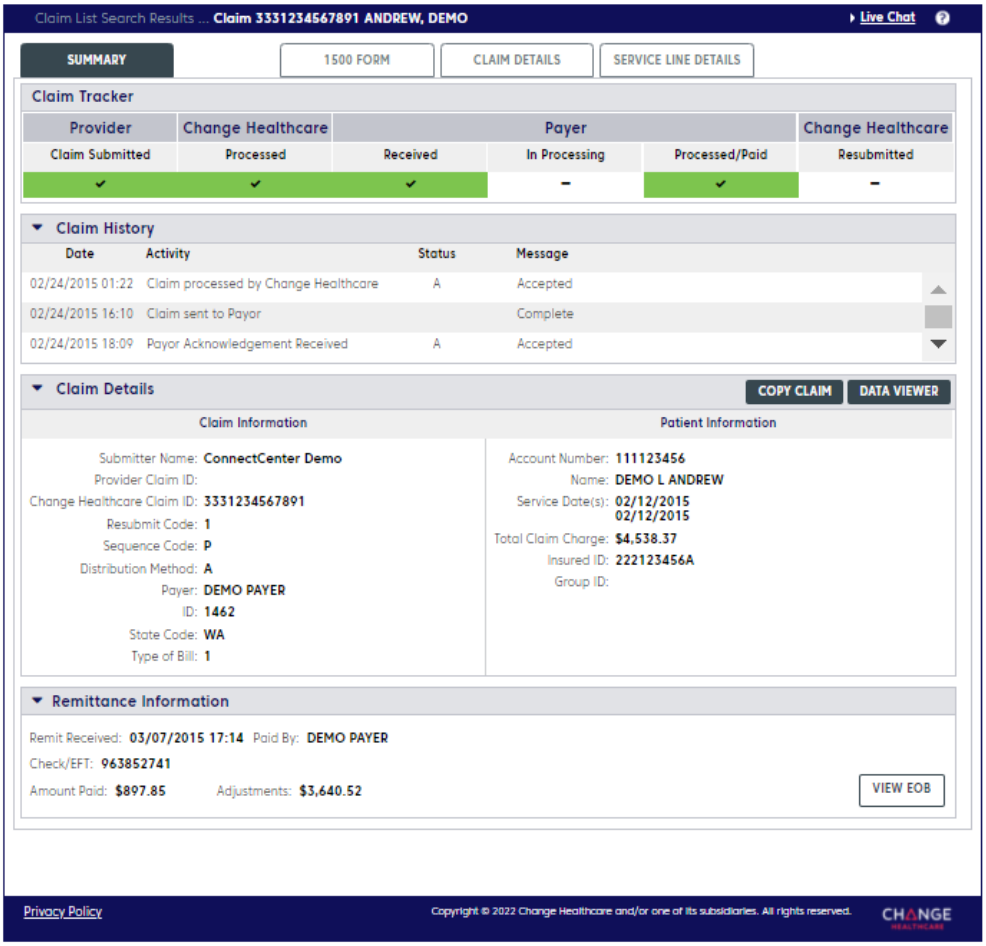
UNDERSTANDING THE RESULTS

Claim search results

- If you perform a 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.



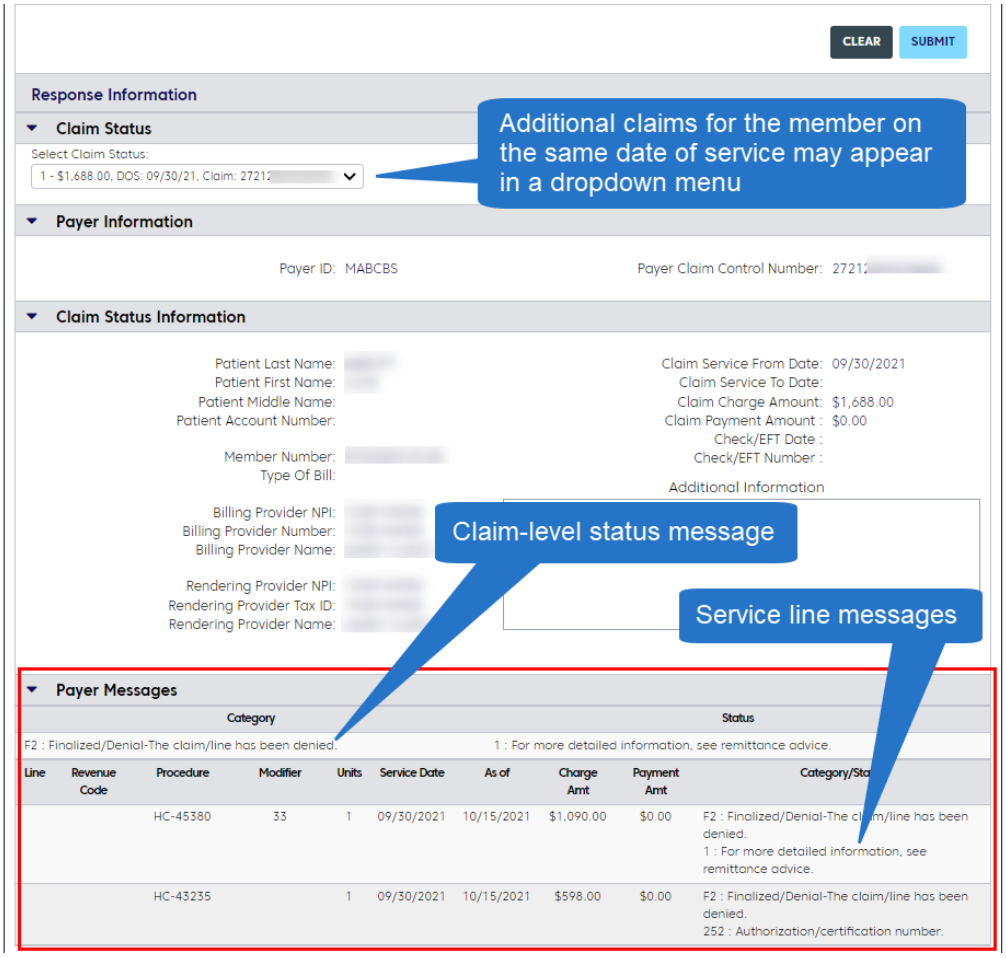
- The icon for real-time claim status ( ) will be displayed for any claim that has been submitted to Blue Cross but has not yet reached a state of final adjudication. Click the icon to display claim status inquiry results like the example shown in the next section.
- If you copy a claim, it will appear 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.



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.

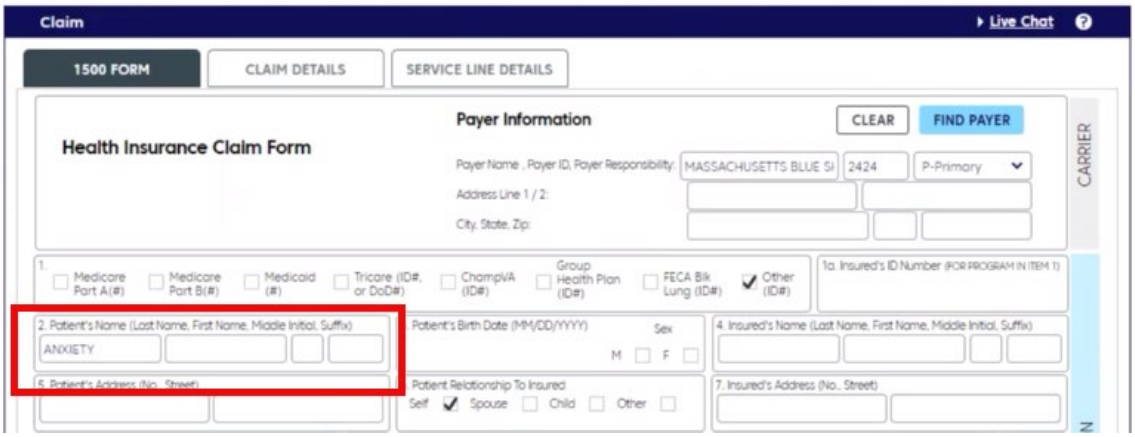


WORKLISTS

Worklists are available through the **Home** page and **Worklist** tab. If you submit claims through ConnectCenter, you can use worklists to:

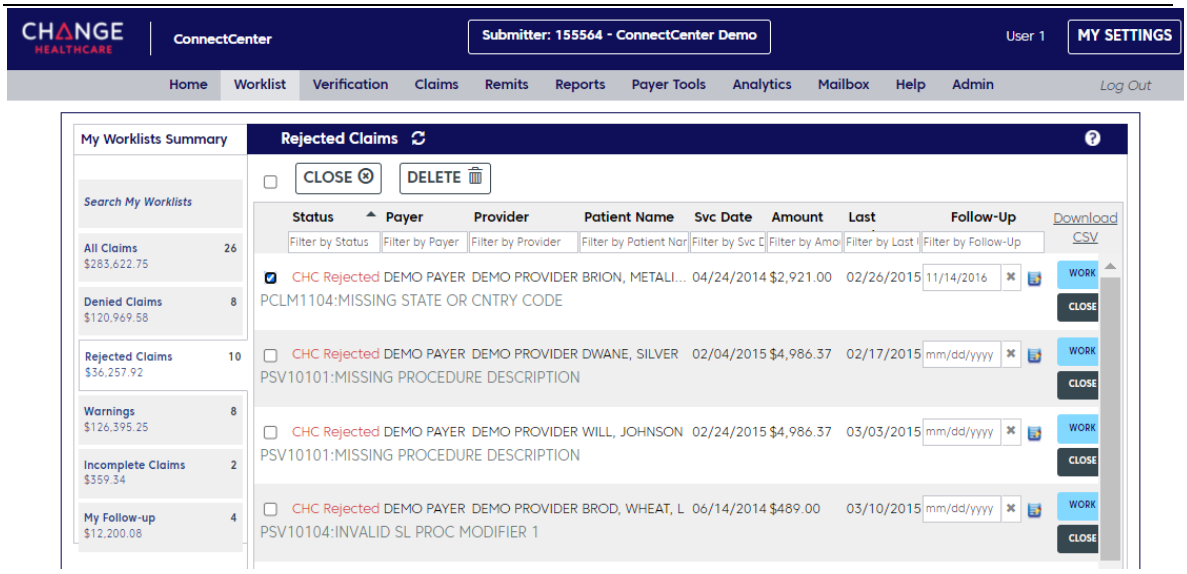
- Identify and correct problematic claims
- Create and use claim "templates" (by opening a claim in the Incomplete Claims worklist and copying it)

> When creating a claim to use as a template, enter a keyword (like the diagnosis, or, if you're working for a billing agency, the provider name) into the **Patient Last Name** field. The label will help you choose the correct template in your Incomplete Claims worklist.
>
> The following screenshot was created using an ICD-10 diagnosis code for anxiety, so the Patient Last Name field includes the word "anxiety."



Worklists for submitted claims reflect claims processed in the last six months. After six months, claims will drop off the worklists, but they are accessible from the Claim Search for two years.

Below is an example of a worklist for rejected claims. All claims with a “CHC Rejected” status need to be corrected before they can be sent to Blue Cross for adjudication. Choose **Work** to open a rejected claim and view error details. When you correct the claim for resubmission, be sure to use the **Validate** option to ensure that all errors have been resolved.



Worklists can be filtered using fields under each column heading. You can close an item, delete it from your Worklist, or enter a follow-up date. (Items with a follow-up date appear in the My Follow-up Worklist.)

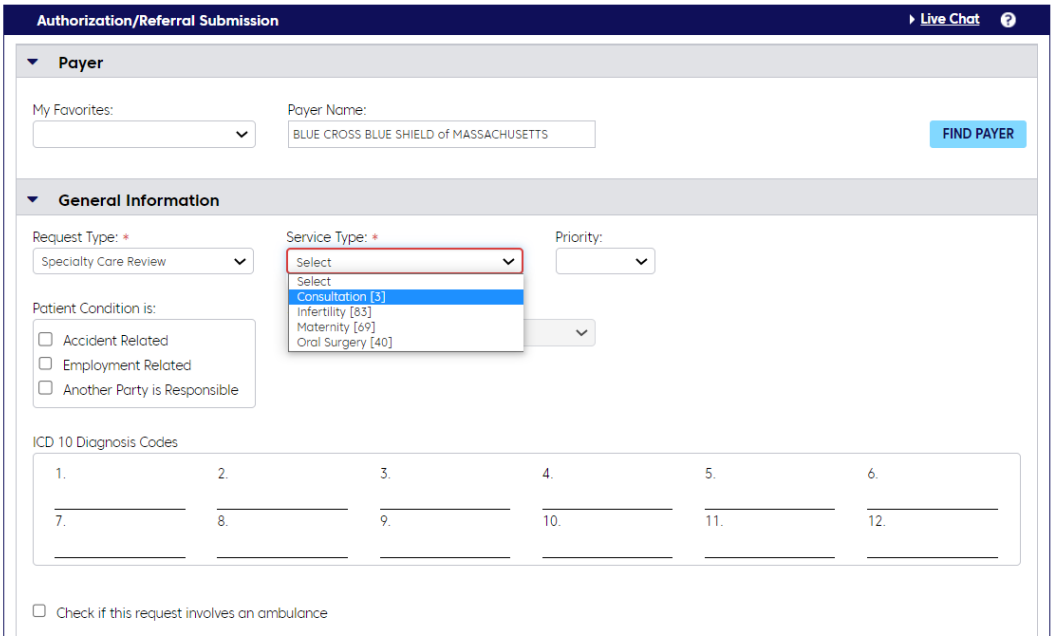
REFERRAL SUBMISSION

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.

Key steps

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

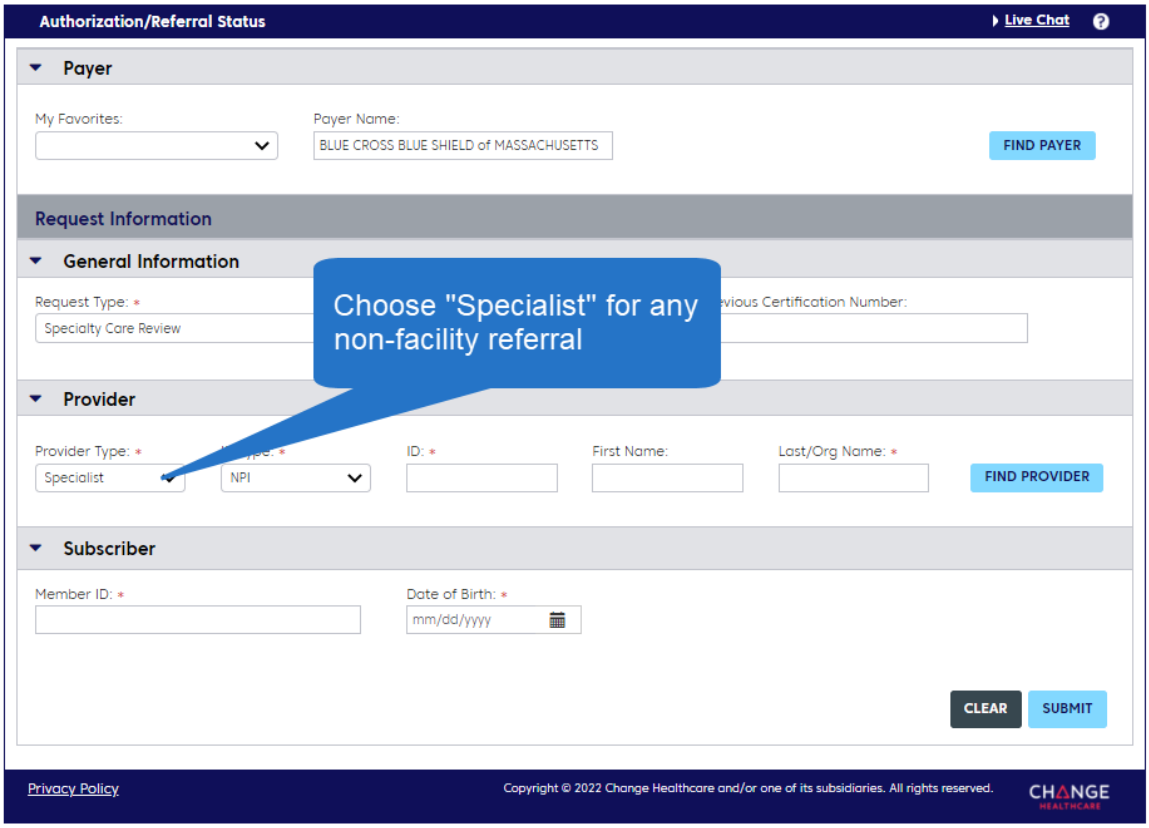
Referral inquiries will return results only if:

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

Key steps

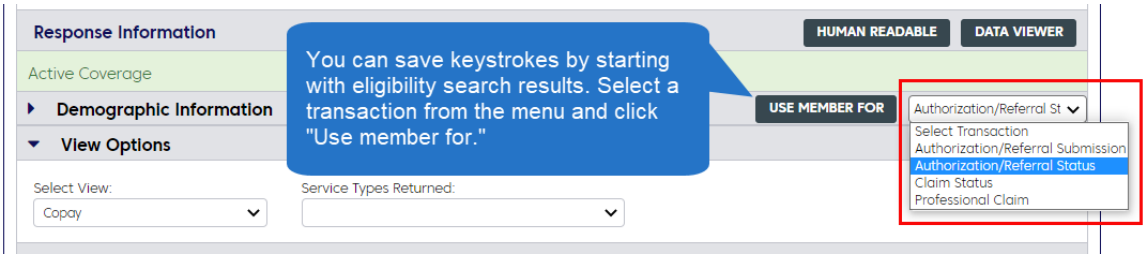
1. Go to **Verification>Authorization/Referral Status**.
2. Complete all required fields and only required fields. Note:
    - For **Provider Type**, select "Specialist" for any individual provider (non-facility).
    - Leave the **Previous Certification Number** field blank.
3. Click **Submit**.

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



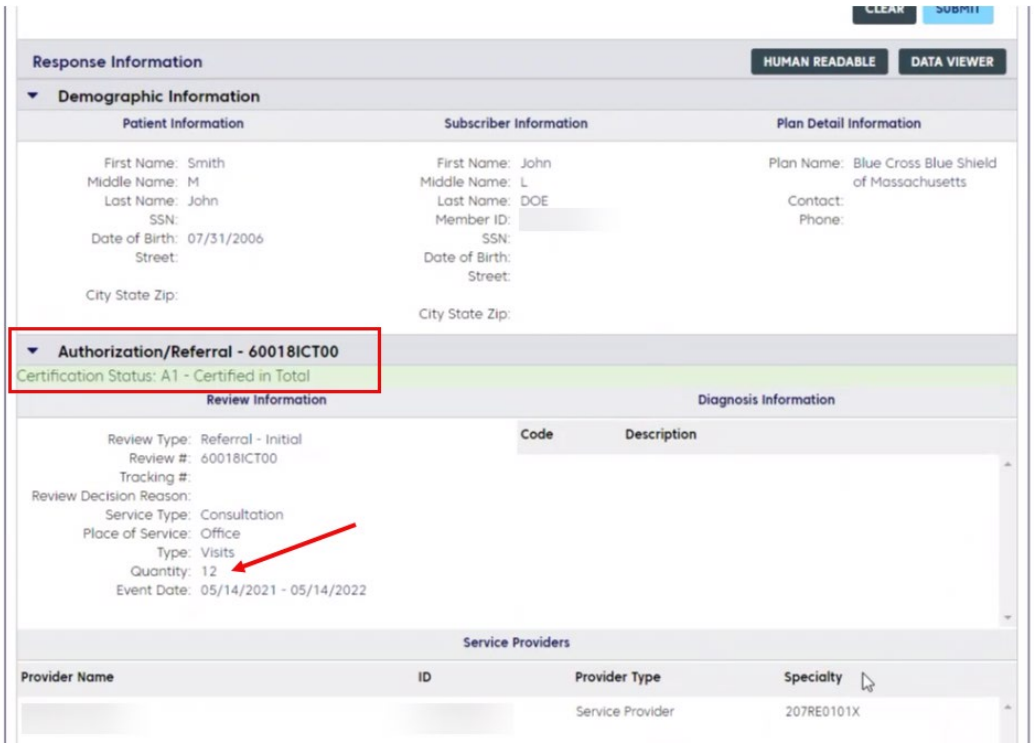
Tip:

- 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 THE 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.



RELATED RESOURCES

More resources are available on our ConnectCenter page. For additional help, contact Change Healthcare'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

4/15/22	New document.
8/3/22	Updated screenshots for benefits and eligibility.
11/4/22	New screenshots and simplified instructions for referral submission. Added link for Place of Service codes.
1/1/24	Updated references to home health care. Authorization required now for Medicare HMO Blue only. Removed references to Online Services. Updated screenshot for eligibility search.
1/1/25	Updated reference to home health care since authorization is no longer required for Medicare HMO Blue.
3/6/25	Updated Related Resources.