



FREQUENTLY ASKED QUESTIONS ABOUT CONNECTCENTER

Background

Effective May 2, 2022, Change Healthcare will be replacing Online Services with a new tool called ConnectCenter. It will have a modern user interface that allows for new features not available on the old tool.

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Questions about the transition

Q: Do I have to switch from Online Services to ConnectCenter?

A: Yes. ConnectCenter is replacing an old but very similar tool known as Online Services. ConnectCenter is an eTool that allows providers to inquire on the status of member eligibility, claims and referrals. It also allows for the creation of new claims and referrals.

Q: When do I have to start using ConnectCenter?

A: We will begin phasing out Online Service’s capabilities over the next several months, so we encourage all providers to familiarize themselves with ConnectCenter as soon as possible.

Important dates:

July 22: Existing Online Services users will no longer have access to professional claim submission functionality using Direct Data Entry in Online Services.

August 12: Online Services will be retired for all users.

Q: With this change in claim submission, will BCBS MA be expanding the window for correction, resubmission and reimbursement on claims?

A: No. One of the reasons that access to Online Services and ConnectCenter is being provided for an overlapping 3 month period is to ensure that everyone has enough time to follow through with claims submitted on Online Services, prior to its termination

Q: **Why are you making this change when Online Services worked fine?**

A: This new tool performs many of the same functions as Online Services but will offer useful new features that Online Services did not. Introducing this tool allows us to keep up with the constantly changing landscape of the health care industry and will provide users with a more modern interface.

Q: **I or someone else in my office would like to attend a training and learn more.**

A: Please review the Provider Central [ConnectCenter page](#) for links to trainings sessions, quick tips, and other materials. Trainings will be offered weekly through August.

Q: **What are some action steps I should take for this transition?**

- A:**
- Notify anyone within your organization who uses Online Services and your billing agency about this change.
 - New Provider Central users approved by your organization (as part of the Provider Central registration process) will only be given access to ConnectCenter and will receive an error message if attempting to access Online Services.
 - Plan to attend one of our [upcoming training sessions](#) and to review our online quick tips and videos to help support this transition. These can be found on the **Provider Central [ConnectCenter page](#)**.
 - If your workflow includes using Online Services for **authorization** inquiries or submission, be sure to begin using [Authorization Manager](#) immediately. These authorization functions cannot be performed in ConnectCenter.

Q: **How do I access ConnectCenter? Do I need a new account or login?**

A: No, you don't need to create a separate logon or account. Just log on to Provider Central, then go to **eTools>ConnectCenter** and select **GO NOW** button to open ConnectCenter.

Q: **Can I restrict what features my staff can access?**

A: Currently you cannot. As with Online Services, all users are automatically provided access to all types of transactions

Q: **Can I access payers other than Blue Cross Blue Shield of Massachusetts in ConnectCenter? I have a separate Emdeon Office account that I use for other payers, can I continue to use it?**

A: Access to out-of-state members, or Blue Card patients, continues to be supported. You will use the Blue Cross Blue Shield of Massachusetts payer to submit claims and perform a status check for these members. Note also that ConnectCenter is available for provider purchase on an all-payer basis, providing access to additional plans. If you are currently a user of the all-payer version of Online Services (Emdeon Office), you should know that it will also terminate this year. Migration support specialists will be contacting you within the next couple of months to discuss available alternatives. You may continue to use it until advised otherwise.

Q: If I submit claims through another channel, is ConnectCenter useful to me?

A: Yes, you can check eligibility and claim status and submit referrals in ConnectCenter regardless of how or where you send your claims.

Q: Do I need to make any changes to my use of PaySpan as a result of this change?

A: No. If you currently receive reimbursement through PaySpan, you can switch from submitting claims through Online Services to ConnectCenter with no impact to your claims payment.

Q: I currently submit claims to Blue Cross using the SFTP site. Can I continue to do that, or do I need to transition to ConnectCenter?

A: You can continue to submit claims using the SFTP site. However, you will need to use ConnectCenter to check eligibility and claims status and submit referrals.

Q: What is a submitter ID? What is a biller ID?

A: ConnectCenter assigns an ID called a submitter ID to each provider office or provider organization. This arbitrary 6-digit number will be displayed next to the name of your practice at the top of the ConnectCenter window. While you don't need to memorize the number, it will be included on most reports and also in service interactions with our customer support team.

The billing ID of 214049 identifies your account as sponsored by Blue Cross Blue Shield of Massachusetts and will be shared by your account and all other accounts also sponsored by Blue Cross Blue Shield of Massachusetts.

Q: Does my submitter ID change?

A: For most providers, your submitter ID will never change. However:

- if you work for a billing agency with multiple Provider Central affiliations corresponding to your different customers, you may have a separate submitter ID per client
- if you work in a hospital or other large organization with multiple departments or offices, you may have separate submitter IDs per department

In all cases, your submitter ID should correspond exactly to the context of your account in Provider Central.

Q: I have multiple submitter IDs in ConnectCenter and I am having trouble getting the correct organization to open when I click Go Now. What should I do?

A: To switch from one account another within ConnectCenter you will need to select the appropriate organization in Provider Central and then choose the Go Now button from eTools to re-launch ConnectCenter.

Please be aware that ConnectCenter may cache your credentials. If you find that the submitter is not changing as expected, please try clearing the browser cache before re-opening ConnectCenter.

Do not open ConnectCenter multiple times in the same browser with different accounts as this will create unpredictable results.

If you need to access ConnectCenter for multiple accounts at once please try one of the following:

- Use separate browsers, for example account A in Chrome and account B in Edge
- Use your browser's Incognito or Private mode. One way to access this is to right click on the icon of the browser you normally use to start it and choose InPrivate,

Private or Incognito from the pop-up. Be sure you have opened the browser in separate windows, not just separate tabs of the same browser window

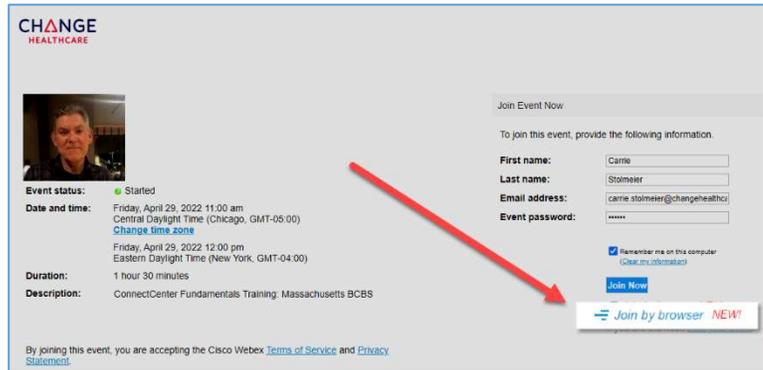
Webex Training

Q: How do I sign-up for training? When is the next training?

A: Register for upcoming training sessions by choosing a session from the Provider Central ConnectCenter page. Please note that there are several different training focuses so be careful to select the correct topic.

Q: I am having trouble joining the WebEx training. What should I do?

A: If you are having difficulty launching the WebEx tool, try using the browser-based version of the WebEx tool by choosing the “Join by browser” link instead of the “Join Now” button.



You can also use the dial-in number (844-245-7693) to access the audio portion of the training if you are having difficulty with computer audio,

Q: I can't hear! How do I fix the audio?

A: There should be an audio button in the WebEx controls. Try clicking the downward pointing arrow that should be right next to the Un-Mute/Mute button (it kind of looks like it is part of the unmute button.) The pop-up list should provide an option for switching the audio part of the training to your phone. WebEx can call you so joining is easy.

Q: Where do I find the WebEx Meeting Number?

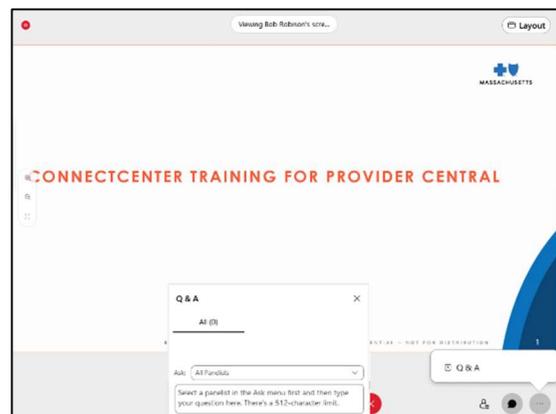
A: The dial-in number and meeting ID are provided in the confirmation email you received after registering

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Q: How do I ask questions during the training?

A: WebEx provides a Q&A window that should be used to ask questions during the training. Please do not ask questions using the chat window as panelists are not able to see questions posted to chat. Depending on which version of WebEx you are using, you can open the Q and A window by moving your cursor over the tool bar tab at the top or bottom of your browser window. You may need to click “More” to pop-up a menu that provides the Q&A option, as shown here. The Q&A window should “float” so that you can drag it out of the way. If you have more



than one monitor, you may find it convenient to move the Q&A window to screen that is not displaying the training.

Q: I was not able to attend/understand the entire training. What should I do?

A: Following each training we will send a copy of the slides and a video of the session to all attendees. In the event that the training is interrupted by significant technical issues, we will include video of an alternate session, instead.

Alternately, you are welcome to sign-up for more than one training session.

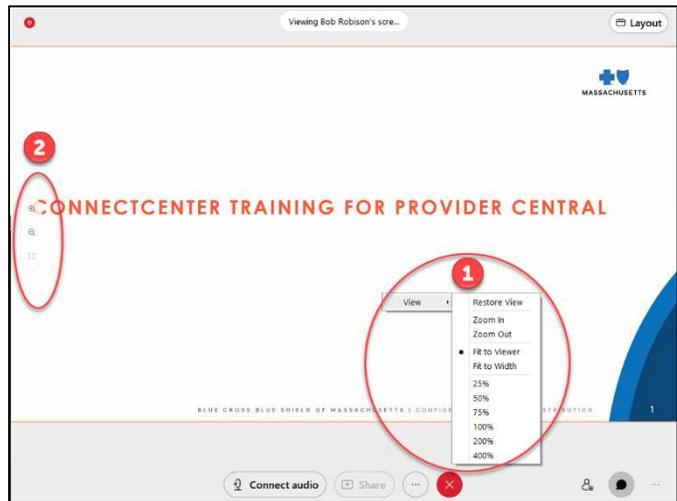
If you feel that the information you need is not being covered in these sessions, please review additional resources published in the ConnectCenter eTools page and/or referenced in the copy of the presentation sent to training participants.

Q: How do I zoom in the WebEx to make the screens large enough to read?

A: We recommend that you plan to watch the training from a computer with the largest screen you have available. A phone screen will be extremely challenging.

WebEx provides two ways to zoom in your screen in order to make the presentation larger.

1. Right click anywhere on screen. A pop-up menu with a "View" option should display. Click View to open a list of zoom options for selection
2. Move your mouse to the left side of the window, about half-way up (or down) the page. Plus, minus and full screen controls will appear.



Comparison between ConnectCenter and Online Services

Q: How is navigation in ConnectCenter different from Online Services?

A: 1) Screen and field names have been updated. A few examples appear below.

| Online Services | ConnectCenter |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Eligibility tab and Service Review tab | Verification tab. Includes pages for eligibility and referral transactions. |
| Service Review>New Review | Verification>Authorization/Referral Submission (Reminder: Although this field name suggests both authorization and referral submission capabilities, you can only use it to submit referrals. Please use Authorization Manager to submit authorization requests.) |
| Setup>Providers | Admin>Provider Management |

2) The **Claims** menu is similar in both tools. However, in addition to claim status inquiries, ConnectCenter offers a new feature: Claim Search.



3) There is no Message Center in ConnectCenter.

4) For new claims, the information you once obtained in the **Reporting & Analytics** tab of Online Services is now available through claim searches and homepage resources.

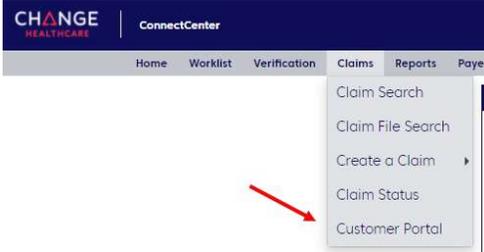
Q: Will information I saved or created in Online Services be migrated to ConnectCenter?

A: User accounts have been migrated and all **Users** who have accessed Online Services in the last year should be able to access ConnectCenter without any further set-up.

Provider information created for claim submission in Online Services **will** be migrated to ConnectCenter where possible. The following information stored in Online Services will **not** be moved to ConnectCenter.

| Type of Information | Details |
|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Inquiries stored in the Batch Manager such as eligibility, claim status, referral status or referral submission requests | Access any information you have stored in Batch Manager until August 12, 2022. You can export these transactions from Online Services if you expect to need them after that date. You cannot import transactions from Online Services into ConnectCenter. |
| Claims created in Online Services | After August 12, you will have access to this information for 15 months through the ConnectCenter Customer Portal. To get your |



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| | <p>system-generated Customer Portal User Name, click the My Settings button in the top right-hand corner of your screen. Make a note of this ID.</p> <p>Then go to Claims>Customer Portal (which was called Reporting & Analytics in Online Services). Click Forget Password? to create a new password. If you have any difficulty with the password reset, please contact the Customer Portal support team at: (866) 924-4634 Enter option 3. Log in to the Customer Portal with the Customer Portal User Name and Password to search for your claim.</p>  |
| <p>Patients created in Online Services</p> | <p>Use member eligibility history to develop a replacement patient library. Every time you check a member's eligibility status, the results will be stored in Eligibility history. Access a saved member from history and initiate a claim from that member's record to quickly create a new claim for that member.</p> |
| <p>Claim Confirmation Reports (secure email)</p> | <p>Emailed claim reports and claim confirmation reports will not be migrated. Much of the information available in these claim confirmation reports is duplicative of information available in Reporting & Analytics. See above instructions related to the Customer Portal for instructions about longer term access to Reporting & Analytics reports.</p> |
| <p>Favorite lists of Diagnosis, Procedure or other medical codes</p> | <p>ConnectCenter does not support favorites lists of medical codes. Instead, it provides "type ahead" that allows you to type a few characters of the code's description and the correct code will display for selection. This code assistance will ultimately save you time.</p> |
| <p>Provider information used in real-time transactions such as eligibility and claim status</p> | <p>ConnectCenter has a single provider list that can be used in both real-time and claim requests, instead of the multiple lists found in Online Services.</p> |

Q: How do I check the status of my claims?

A: Claim status inquiries are explained in the [ConnectCenter Quick Start](#). Another resource, [Checking claim status](#), will be updated on May 1, 2022, to include information about both ConnectCenter and PlaySpan.

Q: If I submitted an authorization request using Online Services before the new site launches, how can I check the status of it?

A: For authorization *submission* and *verification*, use our eTool, [Authorization Manager](#).

ConnectCenter does not have the capability to submit authorization requests, so we encourage you to begin using Authorization Manager as soon as possible if you don't currently use it. It is a fast and efficient way to submit and check authorization requests.

However, you can use ConnectCenter to learn authorization requirements. To do this:

- Perform an eligibility inquiry using the appropriate **Service Type**.
- Click **Submit** and confirm that "Copay" appears in the **Select View** drop-down menu.
- Authorization requirements will appear in the row with copayment information.

Q: I'm not finding what I was looking for in my eligibility results. What should I do?

A: Eligibility functions are explained in the [ConnectCenter Quick Start Guide](#). Tips:

- Be sure you selected the most appropriate **Service Type**.
- Change what is displayed by using the **Select View** and **Service Types Returned** filters.
- Click the **Human Readable View** button (below the **Submit** button) for the complete response.

Provider Management questions

Q: How do I associate the providers in my office to my new account? What is the benefit?

A: Using Provider Management saves you time by eliminating the need to re-enter common provider information for each transaction. You can add your providers by choosing **Admin>Provider Management** from the ConnectCenter main menu. For more details see [Provider Management](#) and the Getting Started guide.

Q: How do I set a default provider?

A: You can create a personal set of default settings by going to **Admin>Provider Management** to see a list of all providers associated with your account. If the provider you need is not listed, you can add it.

Once you have selected or created your most frequently used provider, you should see 3 checkboxes corresponding to the three different types of default providers.

- Select **Requesting Provider** to make the current provider the default for inquiries such as eligibility and claim status, as well as for referrals.
- Select **Billing Provider** to set the default billing provider for claims.
- Select **Rendering Provider** to set the default rendering provider for claims.

Any given provider can be used as the default for one or more of these three options.

You can also set or change the default provider from the eligibility form, the claim form, or several other ConnectCenter forms by using the **Find Provider** button to see a list of providers for your use.

Although your co-workers will be able to see providers that you create (and vice versa) your choice of default providers will **not** apply to other users associated with your account.

Q: If my billing and performing provider information is the same should I check all three checkboxes in the default section,

A: Yes, that would be appropriate. It is not necessary for you to include performing provider information on your claim when the billing and performing provider on the same. Therefore, you may prefer to leave the rendering / performing default checkbox unchecked. However, either checked or unchecked works for rendering provider default.

Q: Is a psychologist or other behavioral health professional considered a physician in ConnectCenter?

A: Within Provider Management, the physician/non-physician option is used to differentiate a person from an organization. If your provider has a first name, select physician. If your provider does not have a first name, select non-physician.

Q: I added myself as the Rendering / Performing Provider in Provider Management, but my information is not showing up on the claim. Any suggestions?

A: The default rendering provider is used to fill fields that you can only see on the Claim Details tab, in the rendering provider section. It is not used to prefill the line level providers in box 24J because those fields should not normally be used at all.

- Include line level rendering provider information on your claim only when the provider you are identifying is different than the rendering provider for other services billed on the same claim
- Supply a claim level rendering provider only if the provider details you need to include are different from those associated with the Billing Provider. For example, this is useful for those who need to enter a Group NPI for billing but also need to include an individual NPI as the rendering provider ID.
- Make sure to specify a default Billing provider in order to cause boxes 25 and 33 to be auto filled.

Q: I use two different NPIs for billing, but Provider Management only has space for one. Where do I put the other?

A: If your claims require you to enter a Group NPI with your billing provider information but an individual NPI for your rendering or service provider information, you will need to create two separate records in Provider Management. It is OK if the two records have the same or similar names. Just be sure that the record with the Group NPI is marked as your billing provider default. while the one with the Individual NPI is marked as your rendering provider default.

Q: How do I store additional service locations?

A: If your service location is different than your billing address, or if you have multiple service locations, you may want to create entries in Provider Management for each location. When adding a service address to Provider Management you will need to have a unique ID for that provider. However, any given NPI can only be added in Provider Management once. If you don't have a distinct NPI for each address you need to store, a work-around in the Provider Management screen is to change the ID Type to API. You can then enter anything you please in the ID field. The Service Location find provider button will not retrieve the value of the "API" you've created into the claim.

Q: Are individual and group organizations both listed in Provider Management?

A: Yes, both can be added. If you plan to submit claims through ConnectCetner, we highly recommend that both be added. If not, your group NPI alone may be sufficient.

Q: Only one of the providers in my practice is listed in Provider Management. How do I add the others?

A: For details on how to create a provider see the [Provider Management Getting Started Guide](#) or [Video](#). However, unless you plan to create claims in ConnectCenter, it is not necessary to include all your providers in Provider Management. For tasks such as checking the status of a member's eligibility or the status of a claim, your Group NPI is likely to be sufficient.

Providers creating claims online will typically need to create records for all their group and individual NPIs. In some cases, additional provider entries to store extra service locations may also be helpful.

Q: I use a social security number as my Tax ID. Where do I put that in Provider Management?

A: Enter your Social Security Number in the Tax ID field. Please be aware that when the provider information is retrieved into a claim it will default Box 25 as a type of Tax ID and not Social Security Number. You will need to check the Social Security Number box.

Q: What is a taxonomy code? How do I find out what my taxonomy code is?

A: A taxonomy code is a representation of your medical specialty. It is a 10- character code. In Online Services, the same information was contained in a 3-character Specialty Code stored as part of claim provider settings.

Where provider information has been migrated from Online Services to ConnectCenter, the taxonomy code has been copied over from the Online Services specialty code.

If the taxonomy field in Provider Management is blank, try this:

- Copy your NPI from the ID field then clear that field.
- Click on any other field on the Provider Management form
- Click back into the ID field and paste your NPI back in
- Click on any other field on the Provider Management form

After these steps, ConnectCenter will look-up your taxonomy in the NPPES database and enter the result into the taxonomy field. Save the provider record with the taxonomy so that you retrieve it into your claims in the future.

Eligibility and benefits questions

Q: Online Services provides information in the eligibility response that I cannot find in the ConnectCenter eligibility. Where should I look?

A: The ConnectCenter eligibility response is organized in an interactive fashion featuring “views” of related benefit information. You can select separate views for **co-pay, co-insurance, deductible, and out of pocket max** benefits to see details. If you cannot find the information you need in the view that seems most appropriate, click the **Human Readable** option to access a complete version of the eligibility response.

Q: Will Behavioral Health benefit detail be available in Eligibility?

A: Yes, the eligibility information available in ConnectCenter is identical to the detail available in Online Services.

Q: Why don't I see Mental Health listed in the Service Types available in the benefit response?

Why doesn't the eligibility response show any information about Speech or Occupational Therapy?

A: By default, eligibility inquiries are submitted with the Health Benefit Plan coverage type selected. When this is used, benefit information about a broad range of services is included in the response, but this default response is not exhaustive.

To obtain information about service types that are not listed, change the service type to match the one you are interested in.

Even when an inquiry using the default Health Benefit Plan Coverage returns a little information about your type of service, you may find that change the service type criteria in the request may result in a response containing additional detail.

Q: Can I select my favorite or default service type?

A: We don't currently have a way to configure the default service type. However, ConnectCenter will re-use the last used service type until you log-out. Also, you can quickly pick a service type by going to the service type field and entering the first character of the service type name in order to quickly access the part of the list where your preferred service type is located.

Q: Where can I find provider information in my eligibility response? Where do I find network limitations information?

A: Choose the **Provider View** to see any provider information included in an eligibility response, as well as any Blue Cross Blue Shield network restrictions.

Q: How can I tell if Blue Cross Blue Shield of Massachusetts is primary?

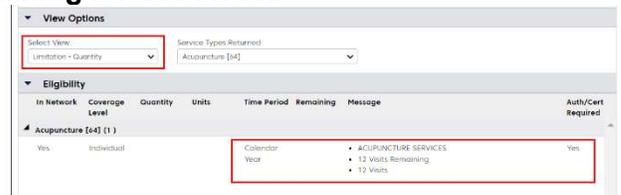
A: ConnectCenter will respond with Coordination of Benefit information if the member has shared this information with BCBSMA. Eligibility responses for members with Medicare replacement or supplemental plans will carry primacy information as well. You can find guidelines on the [Coordination of Benefits page](#).

Q: Where can I find Medicare or other coordination of benefit information in my eligibility response?

A: Choose the **Coordination of Benefit** view to see plan network ID, Medicare information or other COB included that may be available in an eligibility response.

Q: How can I see how many visits are remaining for a service?

A: Perform an eligibility inquiry and choose “Limitation – Quantity” from the **Select View** menu. Benefit usage information for some service types like Chiropractic or Vision may also be included with the active/inactive information for each type of service.



Q: How do I know the start/end dates of a “Service period”?

A: Use the Human Readable button to open the Human Readable View, search for the either current year or the phrase “Service Year” and scroll to the match. In the example here, the member’s Service Year is 5/1/2022 – 4/30/2023.



Q: After opening the Human Readable screen (Or the Data View) screen how do I get back to the response?

A: Use your browser’s back button.

Q: How do I know if telehealth is accepted?

A: Perform an eligibility inquiry using the service type for the services being rendered. Telehealth benefits will be returned as part of the benefit response and shown in the Message section. For additional Telehealth questions please visit [Telehealth](#).

Q: Does ConnectCenter provide information on hearing aid benefits?

A: No. Like Online Services, ConnectCenter doesn’t provide information about hearing aids.

Q: Can I check benefits for patients outside of Massachusetts? Are Blue Card members supported?

A: Yes, the eligibility information available to you through ConnectCenter is identical to that available in Online Services. Only the display format has changed.

Q: Am I required to enter the MTN or XXH prefixes to the subscriber ID?

A: Yes

Q: How do I check eligibility on a twin?

A: To inquire on a twin, triplet, etc., please include the patient’s Member ID, Date of Birth and **First & Last name** on the inquiry. In rare circumstances, when this information is not enough to determine the member’s eligibility (due to similar names, for example), an error message will be returned. Please contact Provider Services in this case.

Q: How do I print the eligibility response?

A: Use Ctrl-P to print the eligibility information currently displayed on screen. If you are viewing the interactive version of the response, you may need to change the “View” and print again to capture the information in each you View you need.

An option for printing the entire response at once is to choose the Human Readable button. Use Ctrl-P on that screen to print the entire response at once.

Q: Can I create a claim directly from an eligibility inquiry?

A: Yes. In the eligibility response, select the **Use Member For** button to create a claim with the same provider/patient information.

Claims submission questions

Q: With this change in claim submission, will BCBS MA be expanding the window for correction, resubmission and reimbursement on claims?

A: No. One of the reasons that access to Online Services and ConnectCenter is being provided for an overlapping 3 month period is to ensure that everyone has enough time to follow through with claims submitted on Online Services, prior to its termination

Q: What is the difference between professional and institutional claims?

A: Professional claims (CMS 1500) are used to bill provider services. Institutional claims (UB04) are used to bill facility services. Currently, institutional claims are not available in ConnectCenter.

Q: Can I send a secondary or tertiary claim?

A: Yes, you can submit primary, secondary, or tertiary claims to Blue Cross Blue Shield of Massachusetts.

Q: Would you please provide some examples of correctly completed claims?

A: In the 5 examples below, the top half of the claim form, where patient demographics are entered, is the same. Therefore, the top half is included in only the first example.

- [Mental Health Claim - full form, With tips](#)
- [Mental Health / Telehealth Claim - bottom half only](#)
- [Chiropractic Claim - bottom half only](#)
- [Speech Therapy Claim - bottom half only](#)
- [Vision Claim - bottom half only](#)

Q: Can I print a copy of a claim?

A: To print any screen, including claim forms, use Ctrl-P. Although the ConnectCenter claim screen looks very similar to the CMS1500 form, printing this form will NOT create a document that fits neatly on a standard size piece of paper with the lines and boxes of a standard CMS1500 form.

Q: Once I submit a claim, can I pull it up, change the dates, then resubmit as a new claim?

A: Yes! We highly recommend the use of copy a claim to streamline the claim entry process. A couple of tips:

- Choose a claim that has been paid to be sure that you are not copying errors from earlier claims. If you are just starting out, it may be worth waiting for a first claim to be paid before choosing a claim to copy.
- Copy twice! Use Claim Search to find a good claim. After using Copy to begin the process of duplicating the claim, consider just hitting Save and then going out to the Incomplete Claim work queue. The claim you just copied will now be in the Incomplete list. Choose "Work" and then immediately "Copy." Now finish creating your new claim. As a result of that second "Copy" command, a copy of the claim will remain in the Incomplete Claim list even after you've submitted your most recent changes to the claim. That means that for the NEXT claim for this patient, you will be able to find the claim to copy in the Incomplete Claim worklist rather than needing to search for it. This can save time and keystrokes.

- Remember, whenever you “Work” a claim from the Incomplete Claim list, unless you choose “Copy” after you choose “Work” (and before you hit “Submit Form”) than Submitting the claim will remove it from the Incomplete Work List. If you wish to retain claims in the Incomplete list to use as templates, use Copy!

Q: Can attachments be uploaded for claims that require additional documentation?

A: Not currently

Q: Can I correct claims or submit appeals?

A: You can correct claims and resubmit them through ConnectCenter, but you cannot use ConnectCenter to submit appeals

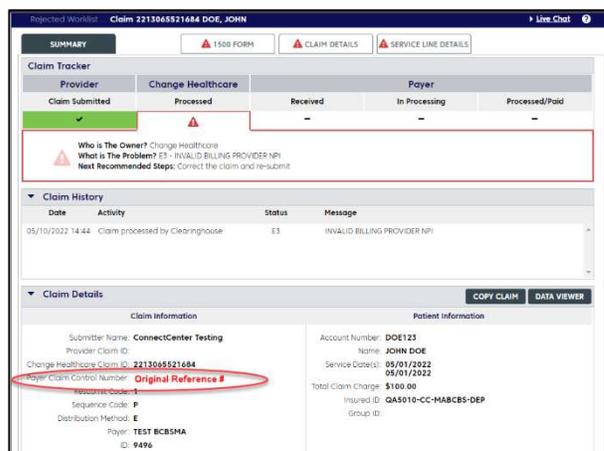
Q: If I correct a rejected claim, is that considered a resubmission?

A: In most cases, correcting a rejected claims IS a resubmission. However, if the status of the claim indicates “Rejected by CHC” that means the claim was not sent to Blue Cross Blue Shield of Massachusetts and the correction is NOT considered a resubmission.

Q: How do I correct or replace a claim?

A: For a claim originally created in ConnectCenter:

- Start by retrieving the original claim through either Claim Search or the Rejected Claim work list.
- On the “Summary” tab, copy the Payer Claim Control Number.
- Choose Copy to create a new claim.
- In addition to making the corrections desired, be sure to select “Replacement Claim” from Box 22. Also, in box 22 you complete the field called Original Ref No. by pasting the number copied from the Summary tab



For a claim created in Online Services or any system other than ConnectCenter, you may re-enter the claim in ConnectCenter and make your corrections as you re-key the claim. You should still use Box 22 to indicate that the claim is a replacement. You may be able to find the original reference number included with the information showing that the claim rejected. If not, the payer’s claim control number can often be retrieved by checking Claim Status on the rejected claim. You can use Claim Status in ConnectCenter to do this, even on claims created elsewhere.

Q: If I submit claims through Ability (or PlaySpan or Online Services or anything other than ConnectCenter) can I view claims on ConnectCenter?

A: No matter how you create claims, you CAN check the status of those claims using the Claim Status feature in ConnectCenter. However ConnectCenter tools such as the Claim Health Vitals and Work Lists can only show claims that were submitted in ConnectCenter. ConnectCenter’s Claim Search and Claim Reports features are also available only for claims submitted through ConnectCenter.

Q: Can I forward claims from Online Services to ConnectCenter?

A: No, there is no ability to forward claims from Online Services to ConnectCenter. You will be able to access claims in either Online Services or the Customer Portal for long enough that you can follow them through to final adjudication,

Q: Will ConnectCenter provide a look-up feature for procedure and diagnosis codes?

A: Yes, ConnectCenter provides a type-ahead option for many types of codes including ICD10 diagnosis code and CPT/HCPCS procedure codes. To use this feature begin typing a keyword in spot where the code needs to be entered. By the time you've entered the third character, a list of codes with matching descriptions will pop up for selection. Add additional characters to shorten the picklist.

Q: The iterative errors found after validation can sometimes be confusing. It seems like you need to fix only 2 things, but if those are corrected you may get different additional errors when you hit validate again. Help?

A: You are correct. The validation runs in multiple passes. Initially it will alert you only if missing required fields. If all required fields are found to have been completed, the next level of issues will be evaluated. The second level of review considers conditional edits based on the content of your claim. Not only can this create new alerts, but these alerts may change between Validations since correcting one issue may create another. As complicated as this sounds, it has the advantage of walking you through the process of resolving all problems up front rather than apprising you of problems hours or days after you've submitted what you thought was a good claim. We highly recommend starting a new claim by copying a similar, previously accepted claim as a way to minimize both errors and effort on an on-going basis.

Q: Field formats:

- I keep receiving an error indicating invalid service date.
- The error says that a 9-digit zip code is required
- The diagnosis code lookup results in an ICD code that has no period in it

What is the expected format?

- A:**
- All dates must be entered as dd/mmm/yyyy You must include leading 0s and slashes.
 - If you don't know the "+ four" portion of your zip code, please add "0000"
 - The decimal should be omitted from ICD10 diagnosis codes

Q: I am trying to enter start date of service in box 24A but the form won't let me type anything.

A: Make sure that you are clicking in the white area that makes up the bottom half of each service line. If you click in the correct location, a blue outline will pop-up to help show you where to type.

Another way to highlight the area where the date needs to be entered is to click "Validate." That will cause all missing required fields to be outlined in red.

| 24. A. Date(s) of Service | |
|---------------------------|------------|
| From: | To: |
| MM/DD/YYYY | MM/DD/YYYY |
| 1 | 05/01/2022 |
| 2 | |

Q: How do I add diagnosis code pointers in box 24E ?

A: In ConnectCenter pointers are alphabetic characters between A and L rather than numeric values. (Online services used 1-9 followed by 0, A, B and C to cover the 12 allowed pointers.)

Q: **When I validate my claims, I get an error that I cannot use a PO Box in my billing address. I have always used a PO Box for billing / My address on file with BCBS Massachusetts is a PO Box. What should I do?**

A: While physical addresses are preferred, you can get around the validation blocking PO Box in the Billing Address by saving your address as either "Post Office Box" or just "Box" without the P.O.

Remember to make this correction in Provider Management so that you don't have to change it on every new claim.

Q: **What does this mean? 55|MISSING SRV LINE REND PRV LAST/ORG NAME**

A: This means that you have included an NPI in box 24J, for the line level rendering provider, but you have neglected to include the name of that provider. There are a couple of ways to fix this:

- The preferred way is to empty the field and not send an NPI. Unless the provider for a particular service line is different than the provider for the rest of the claims, this information isn't needed
- If the service line provider IS different and needs to be entered, than the preferred way to do that is to use the + icon to access Find Provider and pull in the provider from there. When you do that, the name can be retrieved with the ID
- The last option, which you might need if the service provider isn't in your Provider management list, would be to go to the Service Line Details tab. At the top of the page select (click on) the line that needs the special provider. On the bottom half of the page scroll to the rendering provider section. Add the provider's name in that area.

Q: **What does this mean? 35 Missing Claim Ref Prov Last/Org Name**

A: If you include the NPI of a referring provider in box 17b, you must also include the referring provider's name in box 17. The error above indicates that NPI was provided without name.

Q: **What does this mean? 69|MISSING RELATED CAUSES CODE**

A: This indicates that you have a state indicated in Box 10 of the CMS1500 Form. The state field should not be completed unless one of the causes boxes is marked with a Y. Please remove the state and try again.

Q: **What should I do about the problem that the claim form doesn't allow for the location code 02 for telehealth?**

A: Although telehealth is not (yet) an option in the type-ahead list for the place of service field, you may enter the 02 anyway. Where the patient is participating from their home, 12 for Home is also frequently used.

Q: **Do I still need to enter modifiers on my claim?**

A: Yes. If you were previously required to include line level modifiers due to your choice of procedure code or place of service code, then that requirement has not changed, and you should continue to include the same modifiers in the modifier fields.

For example, the modifier GT is frequently used with the 02 place of service to indicate that the telehealth visit took place over a synchronous video call (such as zoom). Less commonly, a visit using some form of delayed communication (email) would use a GQ modifier.

Q: What do I enter in the Patient Account Number field?

A: This typically used for a patient identifier assigned by the provider. Therefore, you can put anything you like there.

It is typically not the same as the patient's subscriber ID, but if that is easiest for you, that would be acceptable. Something as simple as the patient's last name can also work, despite not necessarily being unique across all of your patients.

Q: How do I save / store / retrieve service locations?

A: If your service location is different than your billing address, or if you have multiple service locations, you may want to create entries in Provider Management for each location. Once an address has been added to Provider Management you will be able to use the Find Provider button (+) to retrieve the address into a claim.

When adding a service address to Provider Management you will need to have a unique ID for that provider. However, any given NPI can only be added in Provider Management once. If you don't have a distinct NPI for each address you need to store, a work-around in the Provider Management screen is to change the ID Type to API. You can then enter anything you please in the ID field. The Service Location find provider button will not retrieve the value of the "API" you've created into the claim.

Q: What is the difference between denied claims and rejected claims?

A: Denied claims have been adjudicated by Blue Cross, Blue Shield of Massachusetts and found to not require payment for contractual reasons such as:

- Patient's deductible is not met
- Amount charged exceeds allowed amount
- Patient and Provider are not in the same network
- Patient does not have active coverage for the relevant service

Rejected claims are those that contain an error that prevents the claim from being adjudicated at all. Rejected claims can be corrected and resubmitted. Denial and partial denial are typically a final status that can only be challenged through an appeal process. Because ConnectCenter is not currently able to receive remittance advice (ERAs, EOBs) from Blue Cross Blue Shield of Massachusetts, you are unlikely to see claims in a Paid or Denied status. Instead, Accepted and Rejected are likely to be the final statuses available.

Q: When would a claim have a warning status?

A: The ConnectCenter Warning status is very rarely used but may indicate an unexpected alert related to the claim.

Q: It has been weeks since I submitted my claims and they are still showing a status of Acknowledged. When will this change?

A: Because ConnectCenter does not have access to your EOBs and ERAs (remittance advice) Acknowledged may be the final state that your claims can get to. This state means that BCBSMA has received the claims.

What you can do is to use the Claim Status option from each claim. So for example if you click on the green pie slice in Claim Health Vitals to retrieve all your Acknowledged

claims, there should be a Claim Status icon on each row. Click these to initiate a status check for each claim. The first thing that will happen is that the claim status screen will open showing you the status for that particular claim. A little later (15-30 minutes) a new entry will show up on the Summary tab for that claim which will describe what was discovered (whether the claim is still being processed or has been finalized.) Once you've received the Claim Status response for the first claim on your list, use the browser Back button to return to your list of claims so that you can check the status on the next claim listed.

Q: Is Closed the same as submitted? What does Open and Closed mean in the Worklist?

A: No, the Open/Closed status found in the worklists are entirely separate from status of your claims in terms of the progress from Incomplete to Accepted (or Rejected) to Paid (or Denied).

ConnectCenter worklists track the "to-do" status of your claim. A to-do item is added if a claim hasn't been submitted (is incomplete) or if the claim is rejected or denied. Submitting an incomplete will automatically close the to-do item previously attached to the incomplete claim. However, for to-do items related to rejected or denied claims, you must manually select the "Close" (or "Delete") item to eliminate it from the visible worklist. Claims with an accepted status typically will not have a to-do item in any of the worklists.

Q: When you say that ConnectCenter does not provide accesses to remittance information, does that mean it won't show if a claim is paid or not?

A: For the most part, it is correct that ConnectCenter will not show whether a claim is paid or not. However, you can use the Claim Status feature to retrieve payment information. If you use the Claim Status button that is found on each submitted claim, the payment status will be attached to that claim for future reference.

Q: Can I create a Batch of claims?

A: In ConnectCenter when you choose the **Submit Form** button on the claim form, the claim is immediately placed in queue to submit to Blue Cross Blue Shield of Massachusetts, in a batch of one. Once a day, all the claims destined for Blue Cross Blue Shield of Massachusetts will be sent over. For claims created in ConnectCenter, the concept of batch does not apply. A file of claims created in another system can be uploaded through ConnectCenter, and would be referred to as a batch.

Q: After clicking "Submit Form" from the claim creation screen, do I need to go to a claim list and click again (to submit a batch) ?

A: No. Unlike Online Services, once the claim is Submitted from the claim form screen it is transferred to the payer. Unless an error is detected, no further action is needed from you to cause the claim to be processed.

Q: Without batching, how do I organize or report on which claims I submitted when? How can I determine which claims I submitted on a given day (or during a specific week) ? What if I want to print the list of claims I submitted?

A: The Claim Search option allows you to retrieve all claims submitted during a time interval of your choosing. Claim Search also provides an option to export summary information about these claims. You can always print the list displayed using Ctrl-P or other browser print controls.

Q: How often do our claims get sent to Blue Cross Blue Shield of Massachusetts?

A: Once a day, at 1PM Eastern.

Q: What address goes in the address field at the top of the claim form?

A: The Blue Cross Blue Shield of Massachusetts address belongs in the payer address field. While it is fine to leave this field out, if you enter it once the system will remember it and you will not need to think about it again. Even if you are sending claims to an out of state BCBS plan, the Massachusetts address is appropriate.

Data Capture
PO Box 986020
Boston, MA 02298

Q: If my claim is going out-of-state do I need to specify the out-of-state or federal BCBS plan in the payer section? Should I use Find Payer to select the correct BCBS Payer ID?

A: No. All claims for any BCBS plan should go to Blue Cross Blue Shield of Massachusetts. In fact, most of the Find Payer buttons in ConnectCenter will only return Blue Cross Blue Shield of Massachusetts as an option. (The exception relates to creation of secondary claims.)

Q: Am I required to check eligibility to have patient information saved for use in claims?

A: Not entirely. You are **not required** to check eligibility on a patient prior to creating a claim. However, if you wish to develop a list of patients for repeated use in claims than you **do** want to use one (or both) of these two options:

- Check member eligibility so that your Eligibility History becomes a patient roster, from which you can initiate claim creation
- Use Claim Search to find prior claims for the same patient and Copy to create a new claim

Q: Online Services was so simple. Why complicate matters?

A: While we understand the frustration resulting from being forced to transition to something new, ConnectCenter really is not more complicated. In terms of following up on claim status and correcting issues, ConnectCenter is much simpler. It is true that the differences will take some time and effort to get used to. However, once you create the claim templates you need, you should find it VERY easy to use

Patient List questions

Q: Will my patient list be copied from Online Services to ConnectCenter? Will I have to re-enter my clients in ConnectCenter?

A: Patients/Clients will not be copied from Online Services and therefore will need to be re-entered in ConnectCenter. One option is to member eligibility history to develop a replacement patient library. Every time you check a member's eligibility status, ConnectCenter stores the results in **Eligibility** history. You can access a saved member from history and initiate a claim from that member's record to quickly create a new claim for that member. Once you've created at least one claim for a patient, it is also possible to use that existing claim as a starting point for future claims for the same patient.

Q: Can I print or export my patient list from Online Services?

A: No, Online Services does not let you print or export your patient list, but there are some workarounds that may be helpful.

1. Make the number of patients on each page of the patient list as large as possible to reduce the number of times you need to repeat the steps below. If your maximum patient list size is less than 500, select the Customize link (found on the far right end of the dark blue bar at the top of the page, or by clicking the pencil icon next to the Message Center title on the home page) to increase the page size. When the Customize window opens, click the Patient List tab and increase the value in the list labeled "Select # of patients per page." Make sure that all the columns listed as available for display are checked for inclusion. Once you have completed this customization (if needed), go to the Patient List.
2. Use the print icon (found just above the Customize link at the top of the page) or ctrl-P command to print the contents of the Patient List page. If you have more than 500 patients, you will need to repeat this process for each group of 500. Or you can use ctrl-A to select everything on the page and then ctrl-C to copy highlighted information into your computer's memory. Open a program like Excel or Google Sheets and type Ctrl-V or select the paste command. In newer versions of Excel, you can use the Paste-Special command to open a window in which you can specify that you want to paste "Text" instead of "HTML" -- this will avoid unnecessary copying of check boxes and action buttons.
3. If you have more than 500 patients, advance to the next page in Online Services and then use ctrl-A and ctrl-C to select the next group. Return to your spreadsheet and scroll to the bottom of the previously pasted text. Paste (or Paste Special) again. Once you've pasted everything, you will need to delete rows and columns that contain items found on the Online Services page that are not helpful.

Q: How long is member eligibility stored in ConnectCenter?

A: Every time you check benefits on a member, the results will be saved for 6 months. To extend the stored record for more time, simply access the patient in **Eligibility History** and click the Submit button to update the benefit inquiry to add an additional six months. You can update the eligibility start date at the same time to confirm that the patient is still covered.

Q: Do we need to create a patient list before submitting a claim? Do I have to check member eligibility before creating a claim?

A: No! We recommend looking up a patient's eligibility prior to submitting claim only because it saves you time and effort. You may skip this step if you prefer.

Claim Status questions

Q: What is the difference between Claim Search, Claim File Search, and Claim Status?

A: Claim Search and Claim File Search will provide the status of the claim as it processes through Change Healthcare as well as any status information returned by BCBS MA after the payer receives the claim.

- Use **Claim File Search** only if you uploaded claims to ConnectCenter as an 837 file.
- Use **Claim Search** to find uploaded claims and claims created inside ConnectCenter. The Claim Search feature will allow claims to be viewed, corrected, copied, or even used to initiate a claim status inquiry.

Claim Status returns the status of the claim *after* it has reached Blue Cross Blue Shield of Massachusetts.

- Use **Claim Status** to check the status of claims regardless of whether or not the claim was submitted through ConnectCenter.

Q: If I submit claims through something other than ConnectCenter, can I view claims on ConnectCenter?

A: No matter how you create claims, you CAN check the status of those claims using the Claim Status feature in ConnectCenter. However, ConnectCenter tools such as the Claim Health Vitals and Work Lists can only show claims that were submitted in ConnectCenter. ConnectCenter's Claim Search and Claim Reports features are also available only for claims submitted through ConnectCenter.

Q: If, after looking up claim status, I find that the claim is denied, does ConnectCenter allow for submission of an appeal to the claim denial?

A: No. ConnectCenter does not currently support appeals of denied claims.

Q: I had more than 1 claim that should match the search criteria I entered, where are the rest?

A: A list of all claims that match the search criteria can be found at the top of the response, directly under the header reading "Claim Status." This numbered list will contain a small amount of summary information about each claim. Change the selected claim in this list in order to update the remainder of the response page to display the selected claim.

Q: When I change the selected claim, the response doesn't update to show the new claim. Help !!?

A: When the claim in the "Select Claim Status" list is changed, it is not always obvious that the claim displayed as changed. The information in the left-hand column of the Claim Status Information section will never change. The details that change between claims will be those in the right-hand column. Details below the Payer Messages title may also differ between claims.

Referral and Authorization questions

Q: Can I submit Authorizations in ConnectCenter?

A: No. You must use Authorization Manager for all authorization submissions or status Inquiries, including for Physical Therapy, Occupational Therapy, and Speech Therapy reviews. To access Authorization Manager, go to the Blue Cross Provider Portal and go to **eTools>Authorization Manager**.

Q: If I have multiple requesting providers, will a drop-down list be shown?

A: No. Instead, you would use the Find Provider button to access the Provider Management page and select the appropriate providers as needed.

Q: How do I add multiple PCPs to use with a referral?

A: Go to Admin and choose Provider Management. Use Create to add a new provider. See the Provider Management section of this FAQ for more details.

Q: What service types are allowed in a referral request?

A: The only supported referral types are Consultation, Infertility, Maternity, and Oral Surgery.

Q: Will it make a difference if a different service type, such as "Medical Care" is selected?

A: Yes. A referral containing any service type other than Consultation, Infertility, Maternity and Oral Surgery will be rejected

Q: Can I inquire on the status of PT, ST, OT or rehab referrals in ConnectCenter?

A: No. You will need to use Authorization Manager

Q: I cannot find my referral (or authorization) in Authorization Manger. What should I do?

A: Please follow up with BCBSMA Provider Services. The Authorization Manager user guide can be found by searching "Authorization Manager" on Provider Central. Additional Authorization Manager resources are available [here](#).

Q: Can I cancel or correct an existing referral?

A: No. ConnectCenter does not provide any ability to cancel or revise a referral.

Q: What do I enter in the Place of Service field?

A: This is a type-ahead field that will allow you to enter keywords found in the description of the place of service. For example, if you enter "of" than "Office" will pop-up in a picklist for selection. If I click on "Office" 11 will be selected into the POS field because 11 is the correct code for Office.

Remittance questions

Q: Can remittances (EOB, ERA, EOP) be accessed in ConnectCenter?

A: No. You should continue using PaySpan to obtain payment details.

Q: Will PaySpan be integrated to ConnectCenter? How do I access PaySpan?

A: PaySpan will not be integrated with ConnectCenter. You should continue to access it from Provider Central by going to **eTools > PaySpan**.

Support questions

Q: During what hours is the Customer Support line open?

A: 8AM – 6:30PM Eastern, Monday through Friday
Both chat and phone lines are open during these hours. Emails and Service Tickets are accepted continuously.

Q: How do I reach Blue Cross Blue Shield of Massachusetts for assistance?

A:

| Topic | Contact Information |
|---------------------------------------|----------------------------------------------|
| Login or Account Setup | (800) 771-4097 providercentral@bcbsma.com |
| Claim Adjudication or Member Benefits | (800) 882-2060 |

Q: How do I reach Change Healthcare for assistance?

A: Change Healthcare can be reached in many ways. Within ConnectCenter, options for Chat and Support Ticket creation are available. Additionally, under the Help menu, the Contact Us page provides the phone numbers and email addresses of the support teams. Specifically for phone support, use the following:

| Topic | Contact Information |
|--------------------------------------------------------|---------------------------|
| Eligibility or Referrals | (800) 527-8133, option 4 |
| Claims | (800) 527-8133, option 2 |
| Customer Portal (for Online Services Claim History) | (866) 924-4634, option 3. |

Q: How do I know whether to call Change Healthcare or Blue Cross Blue Shield of Massachusetts?

A:

| Topic | Contact |
|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| Unable to Launch ConnectCenter Account Setup Requests | Blue Cross Blue Shield of Massachusetts |
| Problems using eligibility, referrals or claims in ConnectCenter | Change Healthcare |
| Concerns about missing or incorrect status information returned when checking eligibility status, claim status or referral status | Blue Cross Blue Shield of Massachusetts |
| Error messages indicating Change Healthcare is having an issue | Change Healthcare |
| Provider Credentialing | Blue Cross Blue Shield of Massachusetts |
| ERA, Payments and Remits | Blue Cross Blue Shield of Massachusetts and/or PaySpan |
| Authorizations | Blue Cross Blue Shield of Massachusetts |

Q: If an eligibility inquiry does not return the member information I need, can I get help through Chat finding additional member benefit details?

A: No. ConnectCenter's support team are experts in how the ConnectCenter application works. They are not Blue Cross Blue Shield of Massachusetts employees. They have no access to benefit information beyond what is available in the eligibility inquiry.