New Claims Processing System Information

Business Rule Changes and Impact

Within our new claims processing system, several service code business rules have been modified to improve how we assess your claim submissions. These changes may impact a variety of claims you submit. In some circumstances this may result in faster payment due to the new systems capability to process claims therefore, reducing the need for manual intervention. However, **it may also result in more claim rejections if your claim submission does not include the required claim information**. We recommend you take the time to review and understand the impact of these changes to ensure timely processing of your claim submissions.

Customer Portal Training

For training resources related to the content described in this document please visit eHealth: https://www.ehealthsask.ca/services/CustomerPortal/Pages/Training.aspx

Claims Submission Validation (Batch File and Real-Time)

Physicians are responsible to ensure claim submissions are sent to Medical Services for payment of insured services rendered. To check if your claim submission was received you must utilize your Customer Portal (CP) account.

- **Batch File Submissions** – Check the validation report, either in Customer Portal or your vendor software. The validation report will show if your submission was accepted or rejected.

  A rejected validation report means there is an error in the input file and the entire submission has failed. Review the validation report to determine the reason for the failure. Make the appropriate changes to the input file and then resubmit the entire file.

- **Real-Time Submissions** – Review the confirmation message on your screen when your claim is submitted. The message will confirm if your claim was adjudicated, rejected, or pended.

  If your claim is rejected, query the claim in Customer Portal to determine the reason for rejection.

Please Note: Claims successfully submitted do not guarantee payment. You must download the return (remittance) files after the bi-weekly claims processing run to reconcile claims.

Submission Deadline/Cut-off

The bi-weekly cut-off to submit claims through Customer Portal is Monday at 6:00pm (CST) prior to the bi-weekly run.

The daily cut-off for claim submissions is 6:00pm Monday to Friday. This ensures access to your Daily Return File the following business day.

Please refer to the pay run calendar for the cut-off dates for 2024. Please be advised that Statutory holidays that fall on a Monday will result in changes to the cut-off please see the impact noted below. For access to the 2024 calendar please visit eHealth: https://www.ehealthsask.ca/services/resources/establish-operate-practice/Documents/2024%20Run%20Calendar.pdf

Normal Pay Runs: Monday run day with a 6:00PM cut-off ➞ Return/Remittance files will be available for pick-up at 6:00AM on Wednesday ➞ Payment will occur on the following Monday.

Statutory Holidays on a Monday: Statutory holiday falls on a Monday ➞ Tuesday will become the run day with a 6:00PM cut-off ➞ Return/Remittance files will be available for pick-up at 6:00AM on Thursday ➞ Payment will occur on the following Tuesday.

Claims Reconciliation

It is recommended to reconcile your claim submissions on a regular basis and in a timely manner to avoid claims approaching the six-month time limit.

There are two types of reconciliation:

- **Daily Reconciliation** (batch submissions only) – The Daily Return File indicates the status of the items submitted the previous day. This includes all items that were rejected and may or may not require a correction to be made. Items with a status of Rejected are to be reviewed, noting the Explanatory Code. In some cases, the item(s) may require re-submission (i.e., Invalid HSN – Explanatory Code AA). In other cases, the item is to be queried through Customer Portal in order to make a correction on the existing claim rather than resubmitting. This will result in a quicker turn around on fixing the item(s), does not create a duplicate claim and will allow the system to process your claim on the next bi-weekly run. For additional information on this process please see below.

- **Bi-Weekly Reconciliation** – The Bi-Weekly File consists of the Payment List, Rejected List and Pended List. Use this file to account for all items submitted. Totals of each category are included to assist with reconciling the submission. The Bi-weekly Return File will be categorized by doctor, clinic, mode, and professional corporation or non-professional corporation.

For all batch submissions, it is highly recommended to reconcile your claim submissions daily using the Daily Return File, along with a bi-weekly reconciliation of the entire submission.

For Real-Time submissions, your bi-weekly return file will be mailed to you, at which time, reconciling your claim submissions is recommended.

Please Note: For claims with multiple line items, please wait until ALL line items have been paid or rejected before submitting a query claim or resubmitting. If one of the items is pended, it is recommended that you wait until MSB has finished assessing the entire claim.

Claims Resubmission (Software Vendor) versus Query Claims (CP)

The new Claims Processing System retains all claim items on history. As a result, resubmission of any claim item(s) should be rare and only occur when the data included in the original claim submission is incorrect, such as the Health Services Number. Rejected claim item(s) will be returned to you with up to three explanatory codes. The descriptions of each explanatory code can be found in the applicable Payment Schedule.

When resubmitting, ensure you amend the claim item(s) using your billing software, according to the explanatory code(s) received and re-submit the existing claim item(s) with the corrections required. Simply resubmitting the entire claim, instead of amending the existing claim, will create a duplicate as the original claim remains on history.

Query Claims in Customer Portal when:

- Wishing to recover a claim,
- Requesting a review (i.e., time limit extension, general reassessment, medical consultant review, etc.),
- Required to attach additional documentation (i.e., consult notes, descriptive letter, etc.)

Faxes No Longer Accepted

Any items previously faxed will need to be attached to the specific claim. This can be done in one of two ways:

- **Real-time submissions** (formerly known as paper/card submissions) can attach all documentation to the claim during the initial submission.
- **Batch submissions** and **Real-time submissions** can query the claim in Customer Portal. This replaces the Request for Review of Reassessment.

Contact Information

To contact Medical Services please use the following contact number 1-800-605-2965, Monday – Friday 8:00-4:45pm.

December 29, 2023

New Fields for Claims Submissions

To following fields have been added as part of the input file.

1. **Group Number**

   The group number is a unique identifier that is included in your Customer Portal profile. The group number ensures the segregation and confidentiality of information. Users having the same group number will have billing access to all the practitioners in the same group.

   The group number is now included on the header record in the batch file. This addition allows for the claim to be returned to the same group that submitted the file.,

2. **Special Circumstances Indicator**

   The field values are:
   TF – Billing Technical Fees Only (Service codes in the W or X Section with 3 fees)
   PF – Interpretation Fees Only (Service codes in the W or X Section with 3 fees)
   CF – Combined Tech and Interp. Fees (Service codes in the W or X Section with 3 fees)
   TA – Takeover – Anesthetic

3. **Bilateral Indicator**

   The field values are:
   L – Left
   R – Right
   B – Bilateral

4. **Start Time**

   The field values are between 0000 to 2359 (24-hour format and midnight is 0000)

5. **Stop Time**

   The field values are between 0000 to 2359 (24-hour format and midnight is 0000)

6. **Facility Number**

   This is a future release that will not be implemented at go-live to have designated numbers to uniquely identify locations of service.

7. **Claim Type**

   The field values are:
   P – Used when prior approval is requested by MSB.
   W – Used when a service is submitted to WCB but is rejected, as it is not WCB's responsibility. The comment "not WCB" has been moved to this field.
   D – Used when a service is submitted to the Department of Veteran Affairs but is rejected, as it is not their responsibility. The comment "not DVA" has been moved to this field.

8. **Service Location**

   R – Regina
   S – Saskatoon

9. **Comment Record**

   The comment record allows up to 10 comment records per claim for a total of 770 characters., Ensure the comment includes the line item(s) and service code(s) being commented on.

Claims Completion Submission Notes

The new Claims Processing System requires applicable information to assess your claim submissions. Failure to include the required information will result in claim rejections. Please see below for examples.

1. **Demographic Validation:** The system will verify your submission against PHRS. When submitting a claim you must include the first name, last name, date of birth, year of birth and sex as displayed on PHRS. Only one of these criteria can be incorrect for your claim to be processed. The remaining demographic data must include the matching information as shown on the Person Health Registration System (PHRS).

2. **Start and Stop Time:** The codes 815C, 919A, 012C, 013C, 015C, 016C, 220A, 221A, 222A, 223A, 224A, 225A, 226A, 335H, 336H, 337H, 338H, 339H, 700L, 816C, 918A, 926A, 927A and 928A require start and stop times as indicated in the Physician Payment Schedule. This information must be entered in the Start and Stop fields. It is no longer accepted in the comment field.

For a service with start and stop times that crossover midnight, please see example below:

Claim & Sequence	Type	Date	Start	End	Fee Code	Units
12345-0	50	150722	2340	2355	095L	1
12345-1	50	150722	2355	0010	220A	1
12345-2	50	150722	0010	0025	221A	1
12345-3	50	150722	0025	0050	222A	2

3. **Unilateral and Bilateral Procedures:** Claim submissions must indicate left or right for each code for unilateral services. If a service is completed bilaterally, it must be indicated as such.

4. **Emergency Room Coverage Program (ERCP):** The claim must include the demographics as outlined in the Emergency Room Coverage Preamble:
   Last Name: City/Town or Area as indicated on the Payment Schedule
   First Name: ER Coverage

5. **Base and Add Service Codes:** If the base service code pends for manual assessment, the add code will be rejected. Do not query this claim until the entire claim has been assessed.

6. **Required Fields:** a reminder to please ensure all required fields for each claim and claim item(s) are included on the submission. Failure to do so will result in claim rejection.