Customer Portal (CP) and CBS Claim Submissions

User Manual

Medical Services Branch

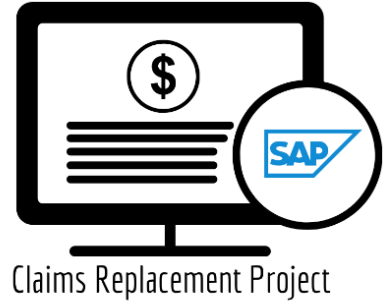Claims Replacement Project

Saskatchewan

Table of Contents

Module ONE: Overview

Medical Services Branch

Learning Objectives

Upon completion of this course, learners will have an understanding of:

- How to submit claims through CBS's billing software.
- The advantages and features of MSB's Customer Portal.

Claims Replacement Project

Overview of Using CBS's Billing Software and MSB's Customer Portal

CBS' billing software and **Medical Services' new Customer Portal** will work together, allowing you to submit batch file claims, retrieve daily and bi-weekly return files, query claims, and submit support tickets.

Claim submissions will continue to be submitted through **CBS's billing software**. The retrieval of the standard bi-weekly return files will continue to be available after the pay run. In addition, a daily return file has been added, allowing you to view the rejected claim submissions the very next day. These claims can be reviewed, updated/changed and re-submitted, with the goal of having that claim(s) paid on the next bi-weekly run.

Customer Portal (CP) is a web-based application, providing options to query claims, submit support tickets and contact MSB.

Benefits of CBS and Customer Portal

CBS	Customer Portal
• Submit batch claim files	• Submit claim queries
• Retrieve Validation reports	• Retrieve MSB contact information
• Retrieve Bi-weekly Return Files	• Access to view and download frequently used forms and payment schedules
• Retrieve Daily Return Files	
• Adjust rejected files and re-submit	

Module TWO – Navigating CBS

Medical Services Branch

Claims Replacement Project

With the new system upgrade at Medical Services, **Clinic 000** has been eliminated. If you use **Clinic 000** a new clinic number has been assigned to you.
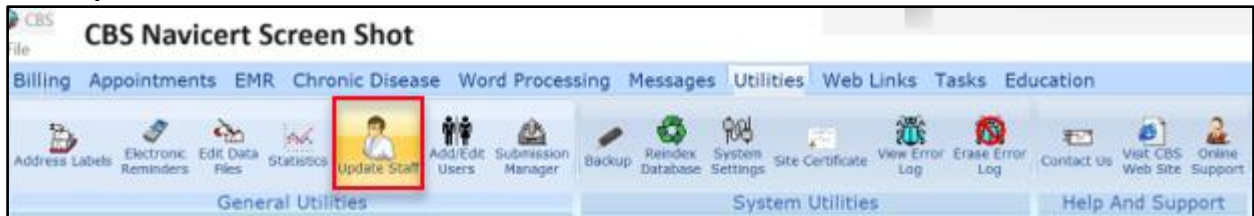
It is recommended to update your new clinic number in CBS after go-live but prior to your first submission and then save the changes. Once updated you will not have to change or update it again.
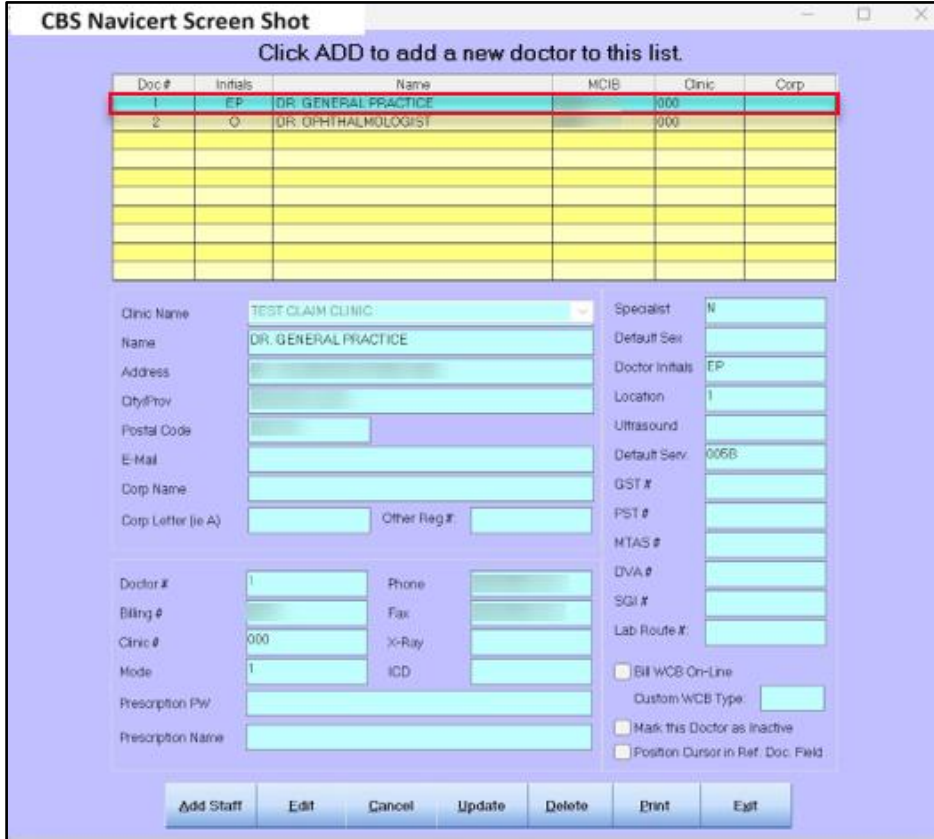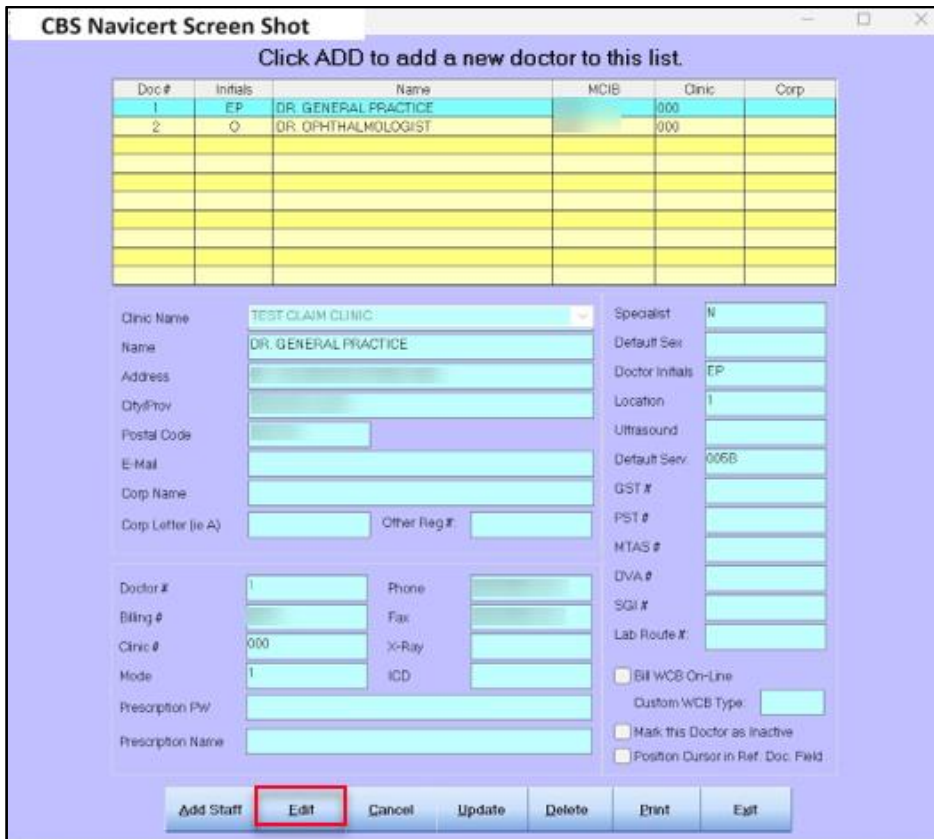
Changing the Clinic Number

1. Click on **Utilities.**
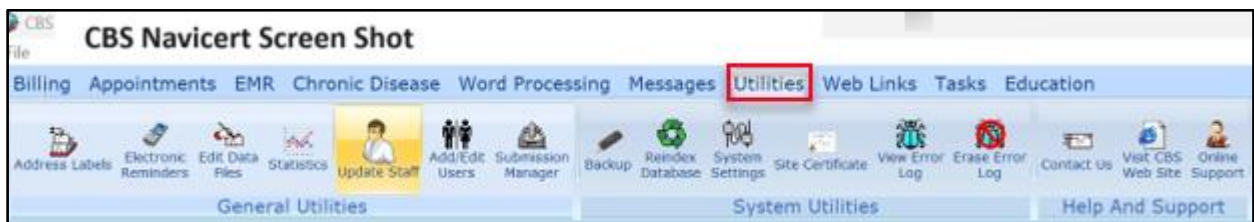
2. Click **Update Staff.**

3. Click on the **Doctor to update.**

4. Click **Edit.**

5. Enter the doctor's **new clinic number**.

6. Click **Update.**

Preparing the File for Submission

Prepare the file for submission as normal. Then follow these steps to complete the submission.

1. Click on **Prepare.**
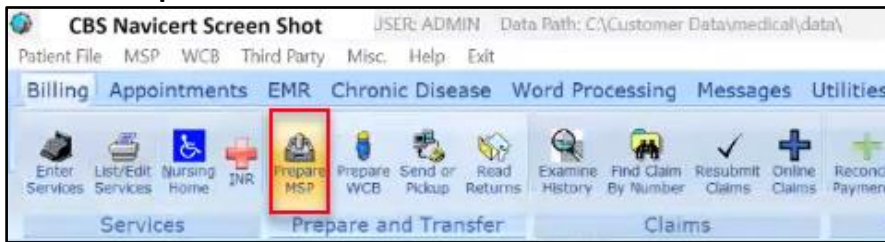
2. Enter the **Group Number.**

3. Click **Prepare Billings.**
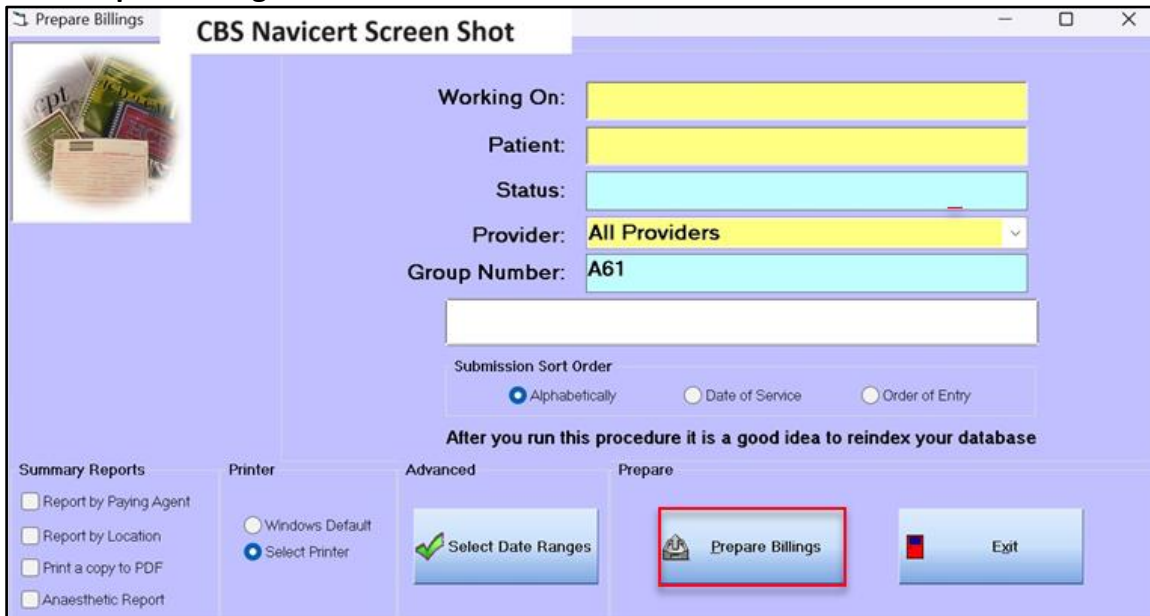
4. If clinic 000 has NOT been changed, the following pop-up message will appear.
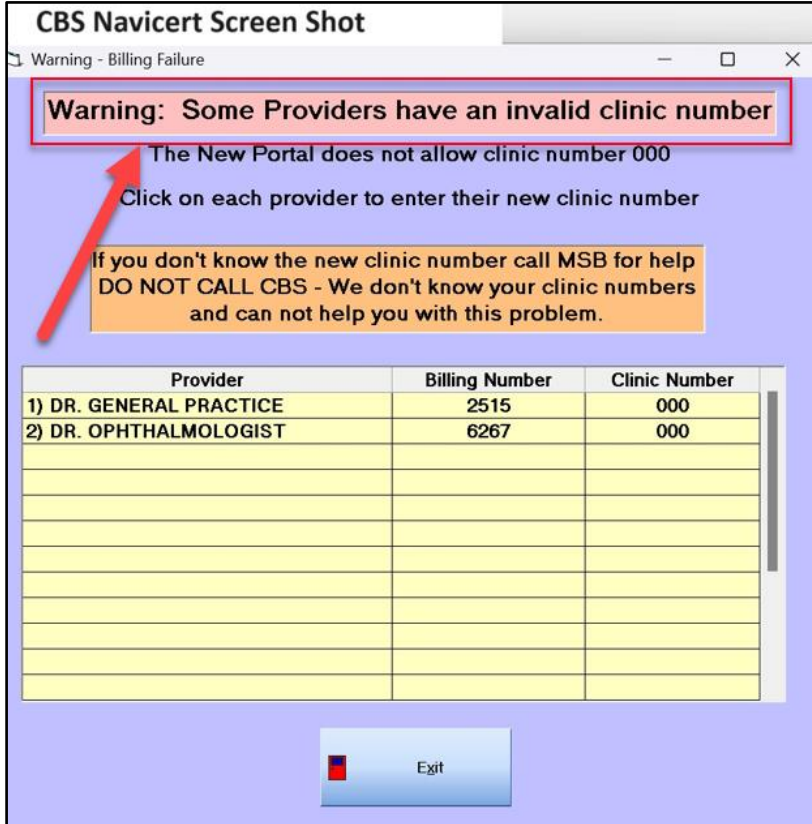
New clinic numbers take effect on Go-Live.

Entering your new clinic number PRIOR to Go-Live will cause errors.

Your new clinic number will only work with the new portal.
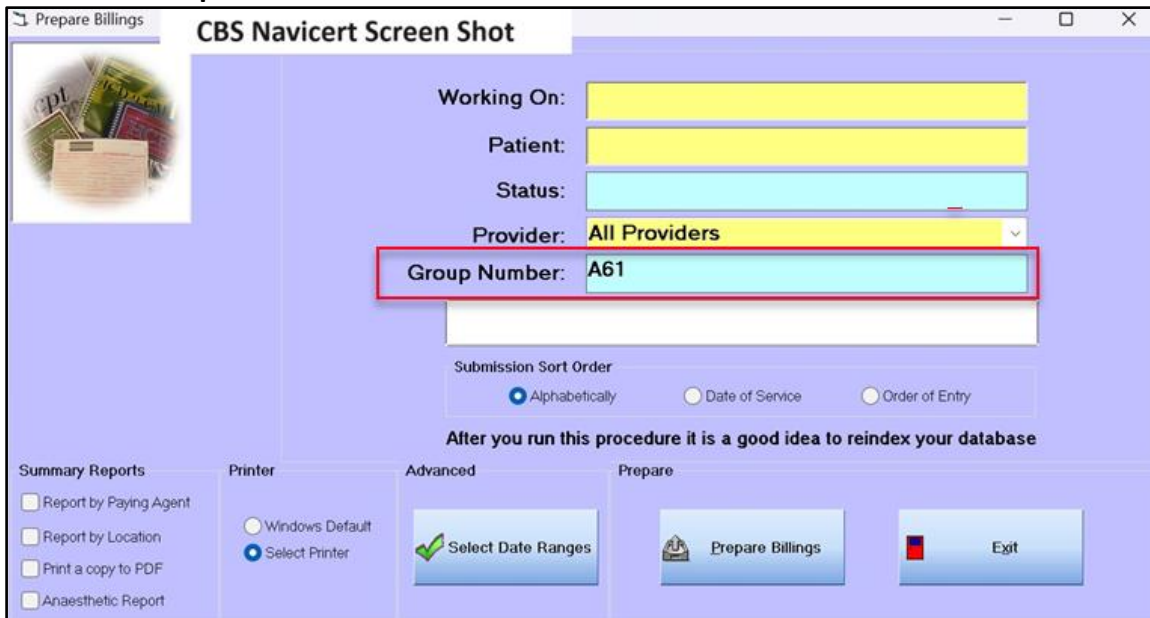
5. Click on the **Doctor** and enter the **new clinic number** in the pop-up window, then click **OK**. This _must be_ completed for all doctors with clinic 000.
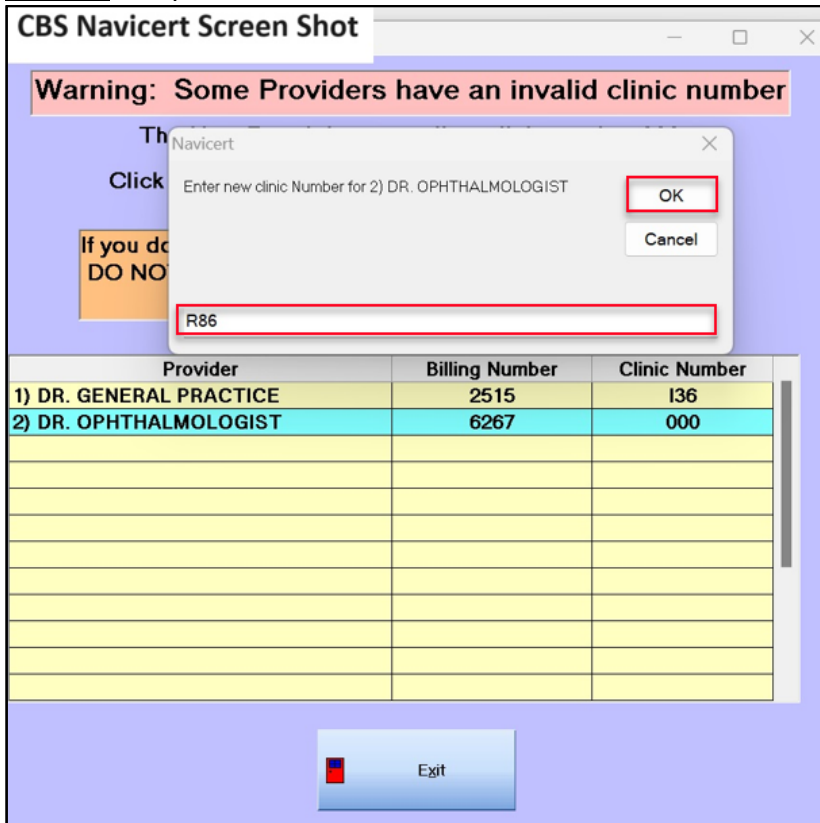
6. When all doctor's clinic numbers have been updated, click **Exit.**
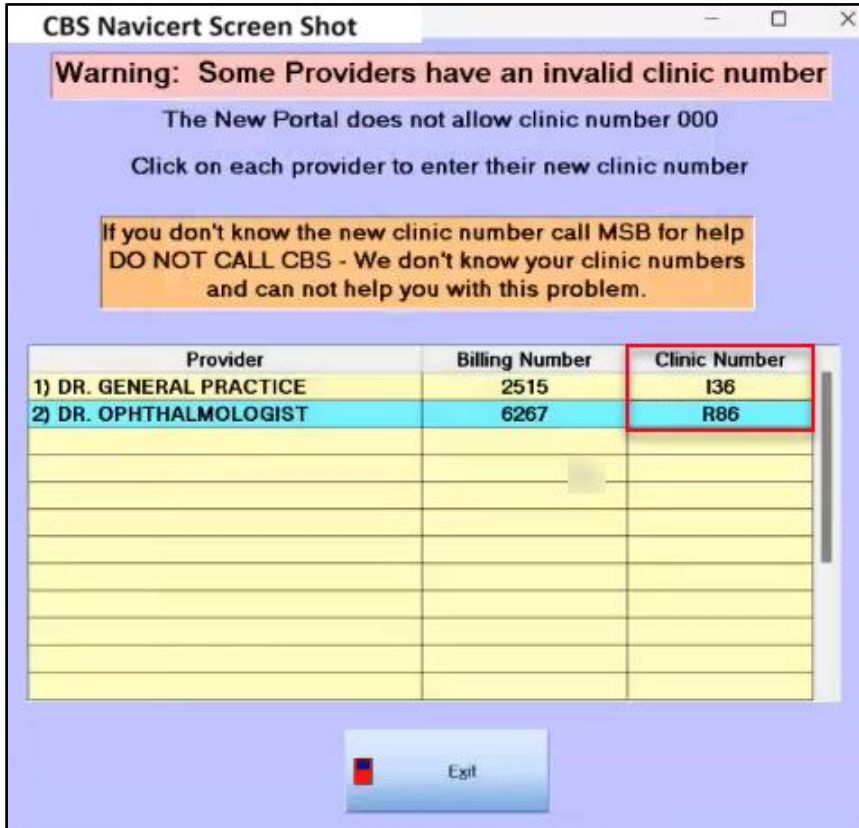
7. Ensure the printer is ready and then click **Yes.**
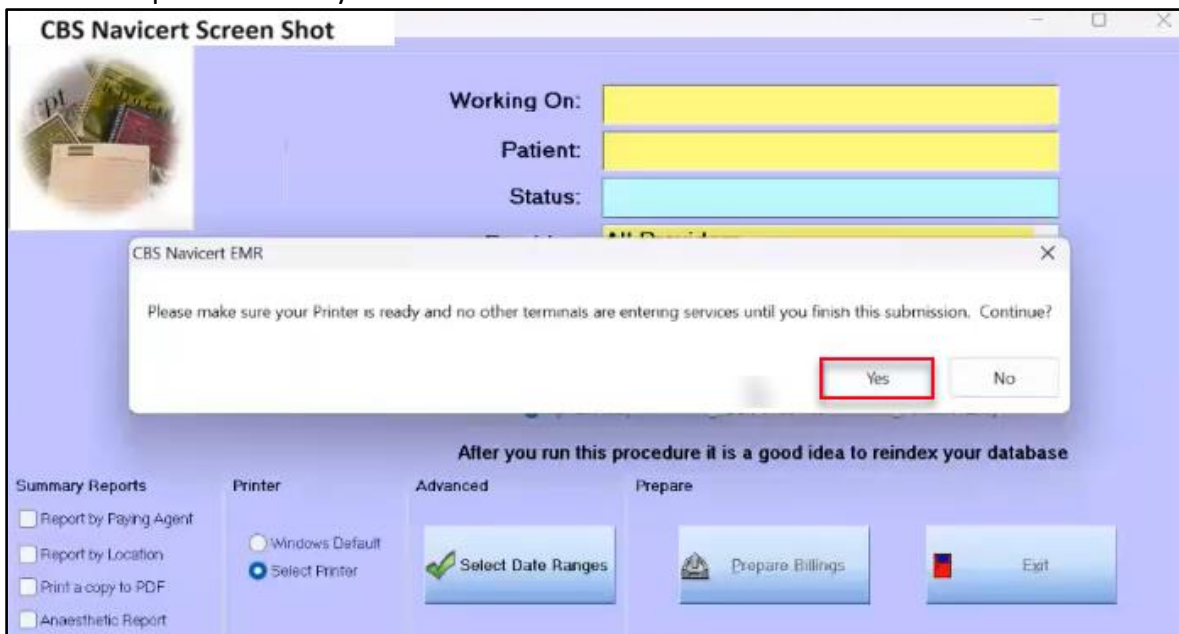
8. Select the correct printer and click **Select Printer.**
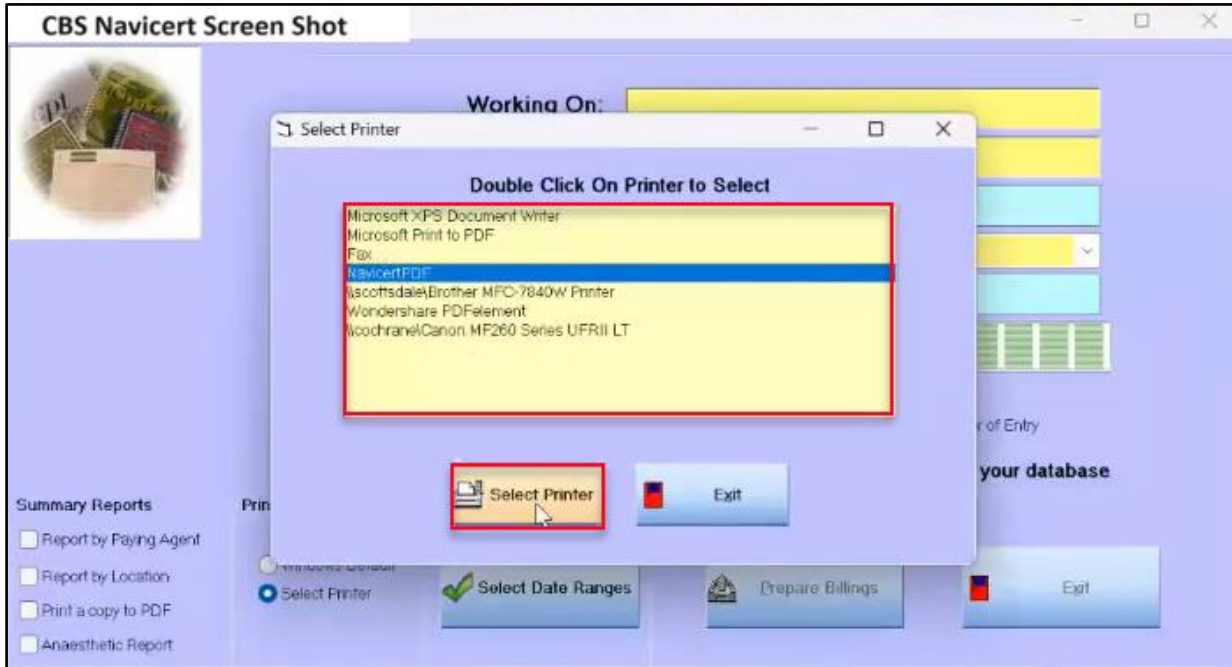
9. The screen will display the print job.

10. Retrieve and review the printout. If it is correct, click **Yes.**
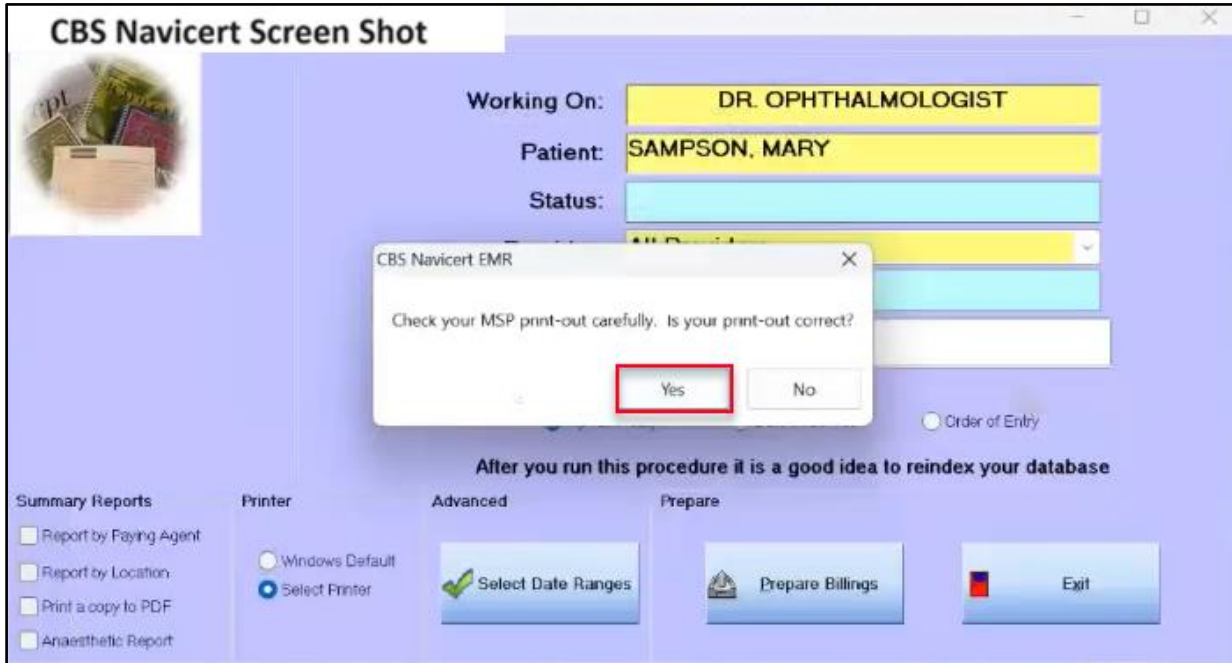
11. Ensure the correct **Group Number** and **Group User Key** are entered.
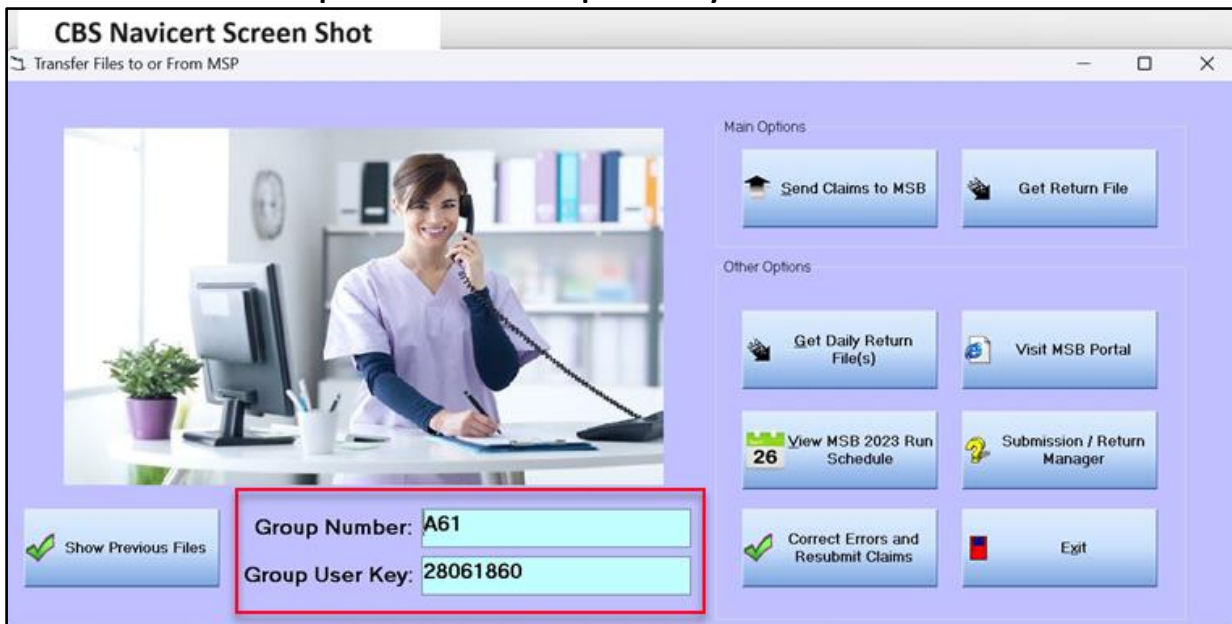
You cannot submit claims to MSB if you do not have the Group User Key.

Your Group User Key will be emailed to you.

The system will remember the Group Number and Group User Key once entered.

12. Click **Send Claims to MSB.**
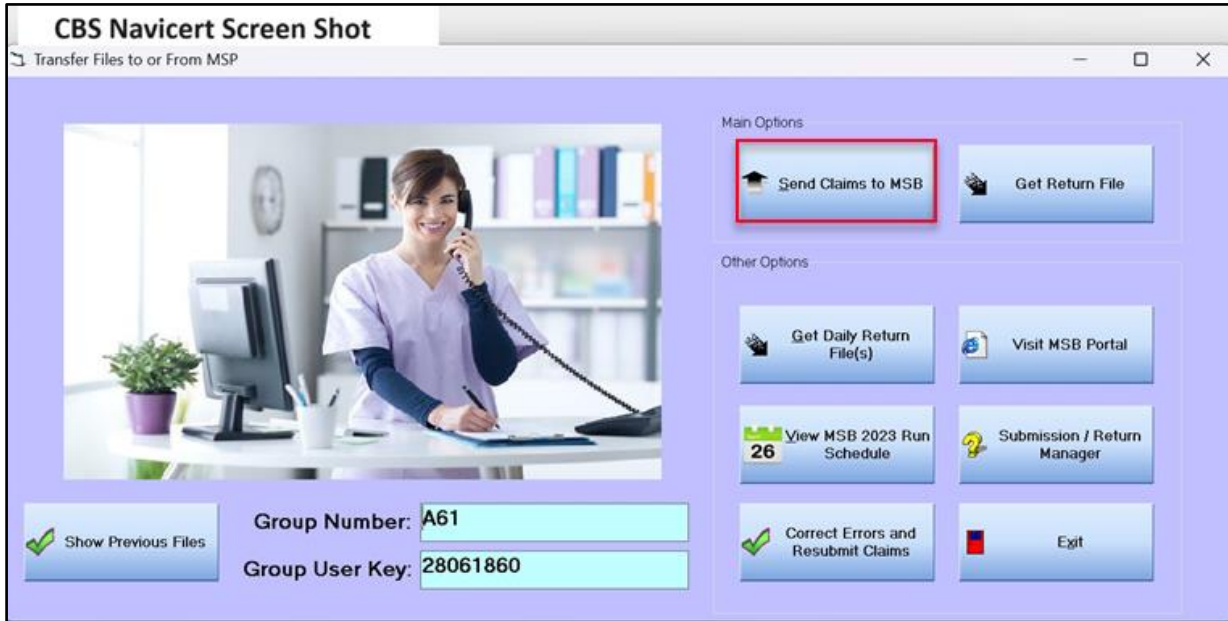
13. When confirmation of the upload is received, click **Ok.**
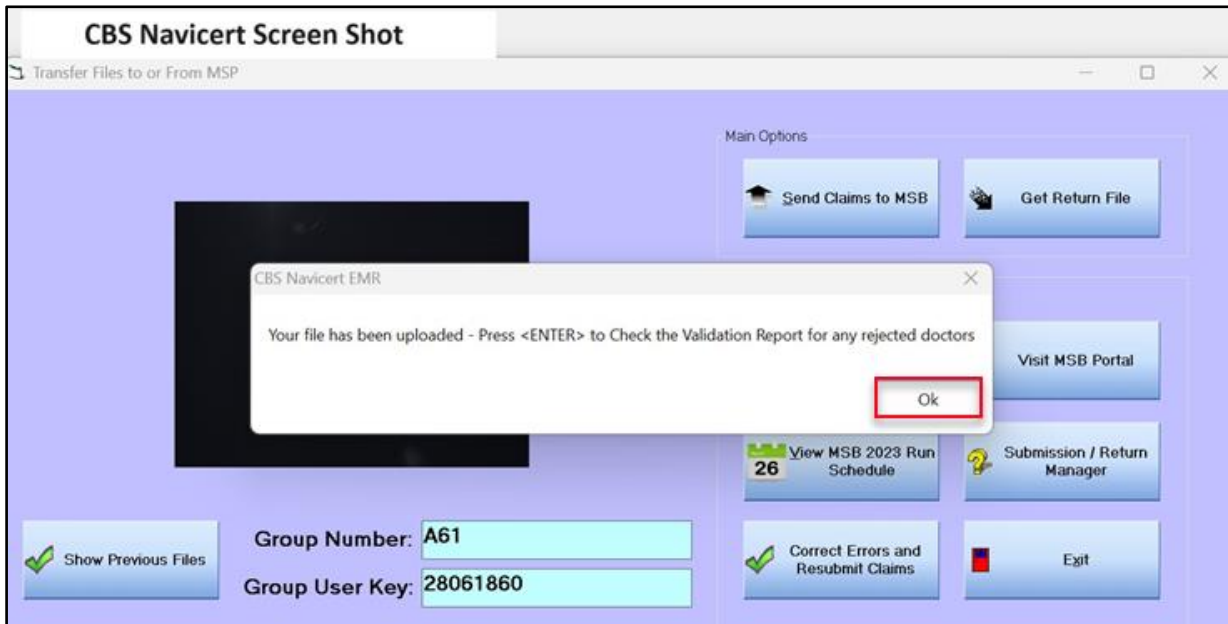
Validation Reports

When a batch file is successfully submitted, a validation report, stating it if was successful or unsuccessful, will be available.

14. Click **OK** to view the **Validation Report.**
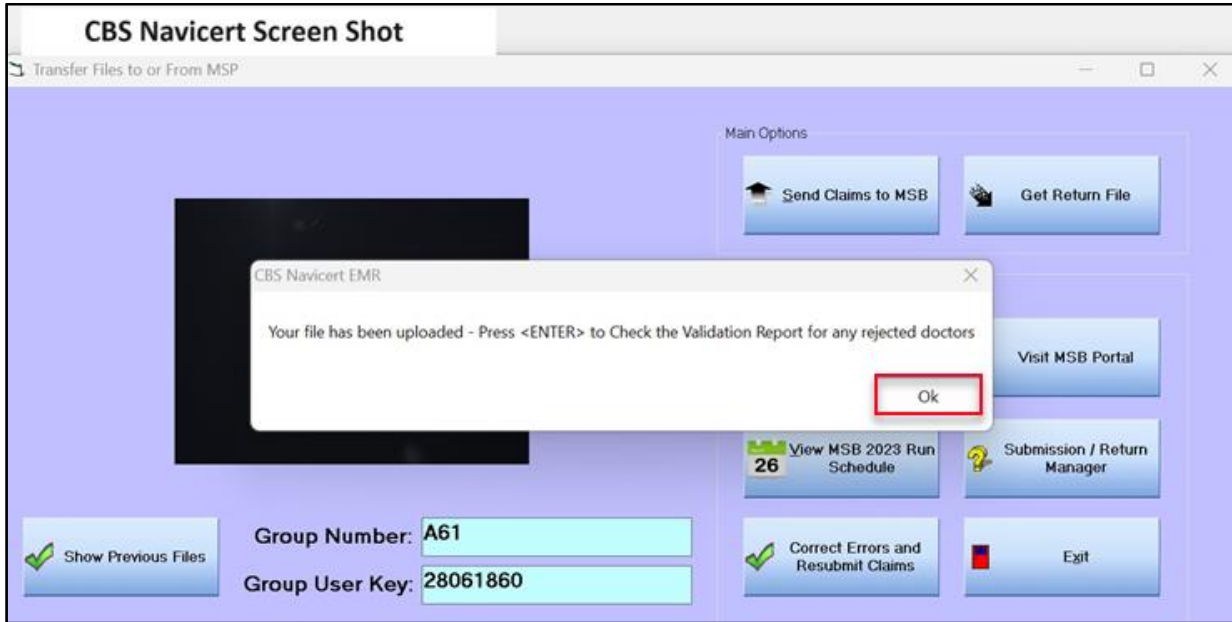
15. When no errors are detected in the batch file, the validation report will say **Accepted** and will include totals for the submission.

16. When errors are detected in the batch file, the validation report will say **Rejected** and states the reason for the rejection.

If system errors occur contact CBS at 1-800-563-4666.

If errors are due to the Physician Registry set-up contact MSB at 1-800-605-2965

Retrieving Past Validation Reports

Previous validation reports can be viewed, referenced, and printed as needed.

1. Click **Show Previous Files.**

2. **Double click** on a file to view.
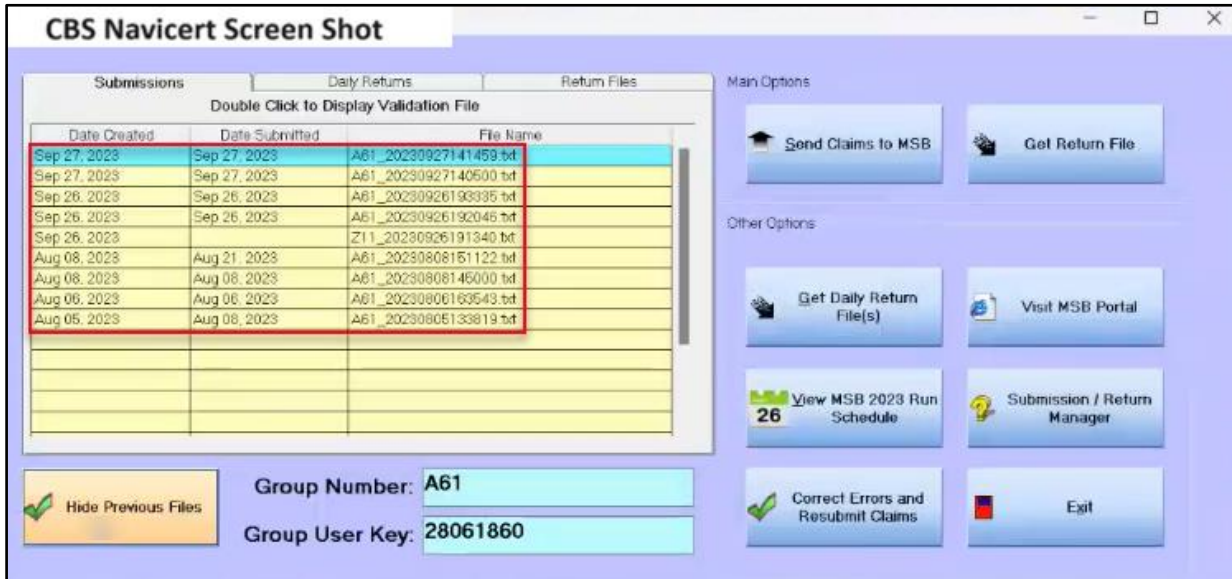
3. **Zoom in/out, view** and/or **prin**t or **exit,** as needed.

CBS Navicert Screen Shot

Claims Submission Validation Report

File Name : A61_20230927141459.txt
Submission Date : Wed Sep 27 14:15:46 CST 2023
Group Number : A61
Status : Accepted

Clinic	Doctor	Corporation Indicator	Claims	Records	Services	89 Recs	Comments	Fee Sub
I36	2515		15	37	23	3	9	$2,649.40
R86	6267		11	39	35	0	2	$1,641.30
	Totals		26	76	58	3	11	$4,290.70

Zoom In

Zoom Out

Print

Exit

Daily Return Files

Daily Return Files are available the day following the submission (Monday through Friday). The Daily Return File will show all items that were rejected in yesterday's batch submission. It is highly recommended to view the Daily Return File daily. All rejected items are to be addressed.

1. Click on **Get Daily Return File(s).**

2. Click **Yes.**
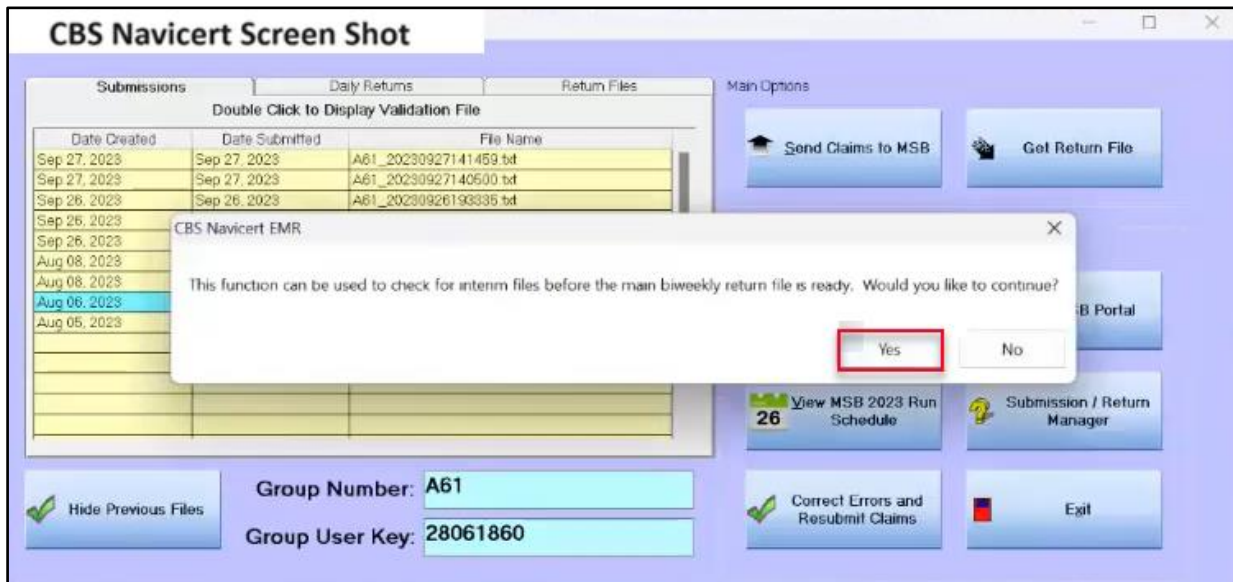
3. Click **Yes.**
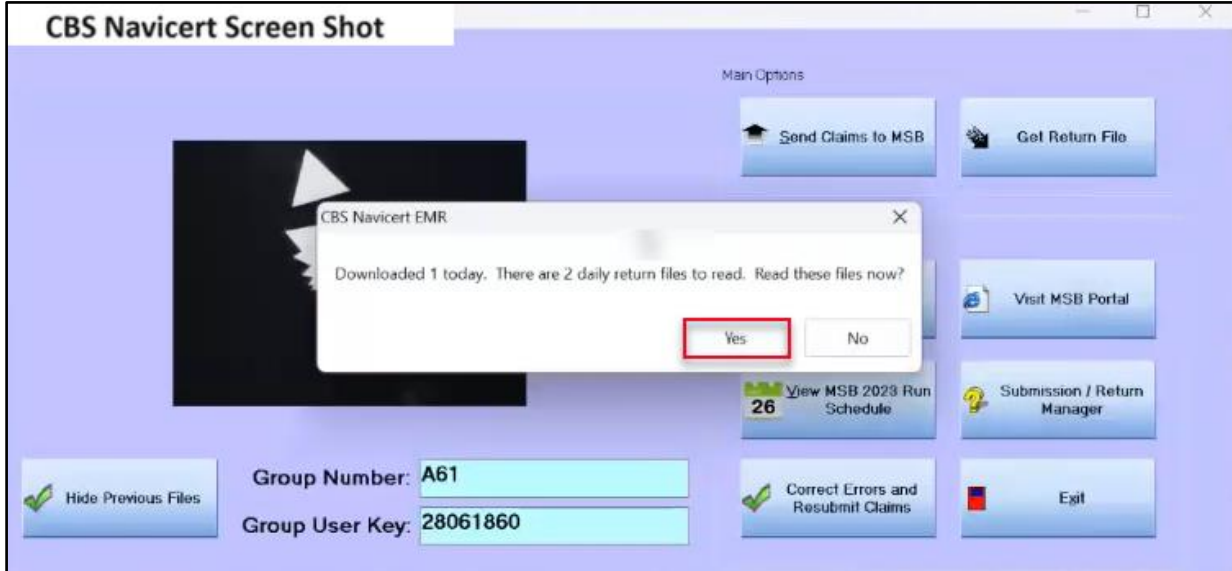
4. Daily Return file displays.

5. Click **OK** to Correct Errors and Resubmit.
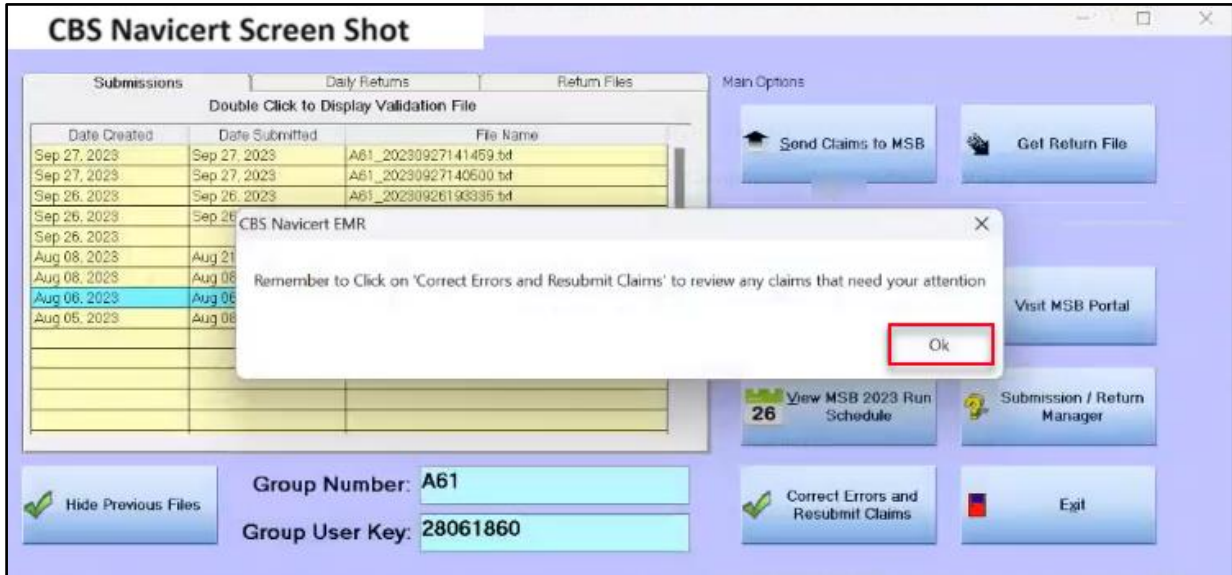
Correct Errors and Resubmit Claims

Errors on claims can be reviewed, updated, and resubmitted, using the **Correct Errors and Resubmit Claims** feature.

1. Click on **Correct Errors and Resubmit Claims.**

2. Review the list of rejected claims, paying close attention to the **Explanatory Code** and **Explanatory Code Description.**

3. Update and change the rejected claim as needed, and then click **Resubmit.** The claim will be captured and resubmitted in the next batch upload.

4. Alternatively, if the claim is to be ignored (not fixed or reprocessed), click **Ignore.**

5. Repeat these steps until all rejected claims have been addressed.

Bi-Weekly Return Files

Bi-weekly Return files are available after the bi-weekly pay run. It is encouraged to review this file and reconcile your files to ensure all submitted claims are accounted for.

1. Click **Get Return File.**

2. Click **Yes.**
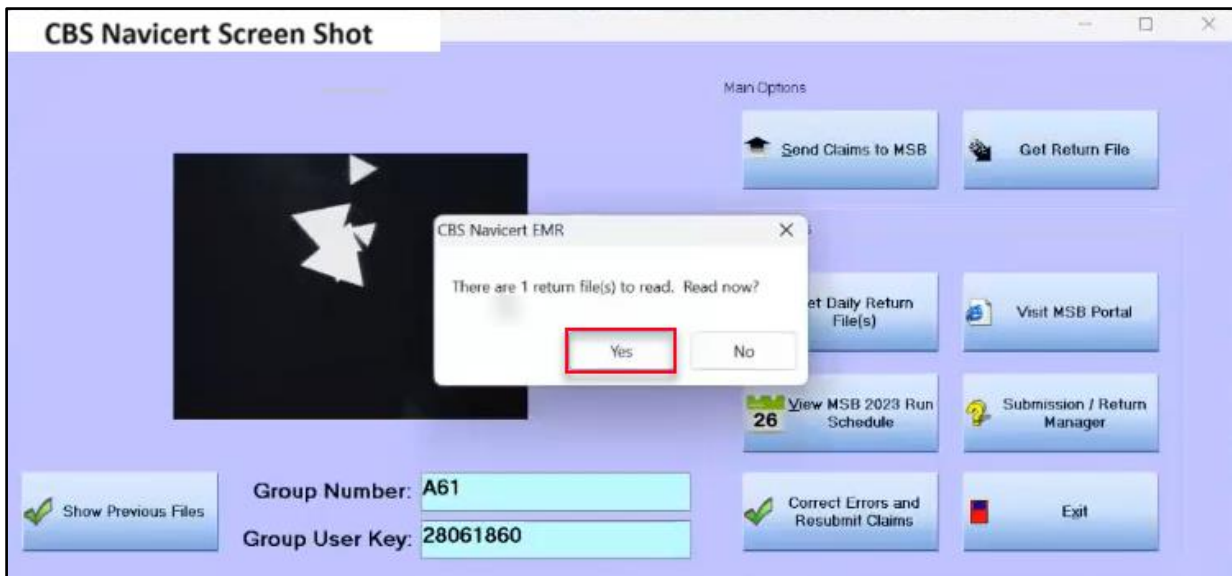
3. View the file to see the claims that were paid, rejected and/or pended. Use this file to reconcile your files.

Accessing Customer Portal

MSB's Customer Portal can be accessed through CBS's portal or by entering (and saving) the website link. The website link can be found in the email communications that included your login information.

Full details on accessing and navigating Customer Portal are in the next modules.

Module THREE – Getting Started in Customer Portal

Medical Services Branch

Claims Replacement Project

Getting Started

Several authorized users will access Customer Portal over the Internet. To ensure only authorized users gain access to Customer Portal, eHealth Saskatchewan requires Multi-Factor Authentication (MFA).

Logging In

Once fully registered in the Physician Registry (this includes having your direct email address registered with your profile), a welcome email and password reset email will be sent to you. Follow the prompts to reset your password to login to Customer Portal. Your userid will be your registered email address. The password you personally set must conform to eHealth Saskatchewan password complexity policy to be accepted.

Multi-Factor Authentication (MFA)

Logging into Customer Portal for the first time will also trigger the Multi-Factor Authentication (MFA) process.

Refer to the **Multi-Factor Authentication (MFA) User Manual** to set up the MFA.

Module FOUR – Navigating Customer Portal

Medical Services Branch

Claims Replacement Project

All users of Customer Portal will have a similar experience when logging into the application. The application features and functionality have a comparable look and feel regardless of the user's profile, except for the Payment Schedules. The Payment Schedules match the user's role and profession, meaning a medical physician will see the Medical Payment Schedule, an Optometrist will see the Optometry Payment Schedule and a Dentist will see the Dental Payment Schedule.

Explore the module to learn about the **Home Page** also referred to as the **Landing Page.**

Top Menu Bar

The top menu bar in Customer Portal provides four main options:

	Area	Description
1	**Navigation Menu**	Clicking on the three lines minimizes the side Navigation menu.
2	**Date**	Displays today's date.
3	**Help Menu**	Access the MSB Directory and contact information.
4	**User Profile**	Displays the users' userid (email address) and the logout feature.

Home Page

The **Home Page** or **Landing Page** is the first screen that appears when logging into Customer Portal. It serves as a gateway to the application's features and functionality.

	Area	Description
1	**Navigation Menu**	A list of areas in Customer Portal the user can access, explore, and navigate to other areas of the application.
2	**Message Board**	The Message Board hosts important information and updates. This section will be continually updated with current news and messages.
3	**Vendor Files**	Commonly used Vendor Files, such as the Service Code Catalogue, MSB Diagnostic Codes and Explanatory (EOB) Codes are located here for easy access.
4	**Newsletter and Bulletin**	The most recent Newsletters and Bulletins are posted for reference, along with archived options of each.
5	**Payment Schedules**	The three most recent Payment Schedules, along with access to archived Payment Schedules are located here for easy access. A medical physician will see the Medical Payment Schedule, an Optometrist will see the Optometry Payment Schedule and a Dentist will see the Dental Payment Schedule. Those that submit claims for more than one profession will see the Payment Schedule for each profession.
6	**Forms**	The most frequently used forms are located here. Click once to open the form, complete the fillable pdf, then save and/or print as needed.

Navigation Menu

The side Navigation Menu is a list of actions that can be performed within Customer Portal
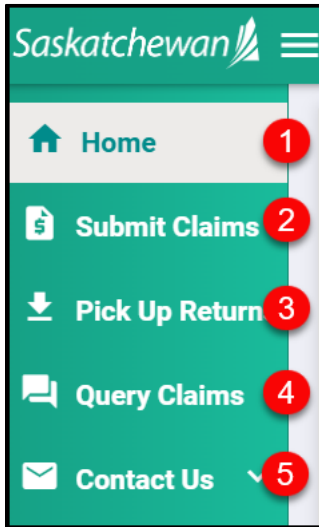
Each option will be elaborated on in the following modules.

	Area	Description
1	**Home**	Clicking on Home takes the user back to the Home Page.
2	**Submit Claims**	Users enter in the claim details and submit batch file claims.
3	**Pick Up Returns**	Users can retrieve their Daily and Bi-weekly Returns here.
4	**Query Claims**	Users can search for submitted claims with the option of adding additional information or recovering an already submitted claim.
5	**Contact Us**	Provides several options for contacting Medical Services.

Module FIVE – Pick Up Returns

Medical Services Branch

Claims Replacement Project

Pick Up Return Files

Pick Up Return Files indicate the status of the claims submitted and can be viewed through Customer Portal.

There are two types of Return Files:
- Daily Return Files
- Bi-Weekly Return Files

Viewing and retrieving the Daily Return File and Bi-weekly Return file through Customer Portal is an *alternative* option. These files are identical to the files you can view and retrieve from CBS.

Daily Return Files

Daily Return Files display all rejected line items from the previous day's submission. All rejected line items, along with the corresponding explanatory code need to be reviewed to determine the following:
- A correction to the original submission is required (i.e., Invalid HSN – Explanatory Code AA,
- The line item needs to be queried to add additional information or documentation,
- No further action is required as the claim is not payable, based on the Assessment Rules.

Following the above three guidelines ensures a faster turn-around on fixing rejected line items, does not create a duplicate line item and ultimately allows the claim to be paid on the next bi-weekly run.

If the re-submitted item(s) still has an error, it will be returned, in the next **Daily Return File**, with a new Explanatory Code. Using the guidelines above, the line item(s) need to be reviewed to determine if it should be resubmitted, queried through Customer Portal or no further action is required. This process can occur multiple times in a two-week period.

NOTE: Only re-submit items that have invalid data or incorrect information (i.e., invalid character, Mode 1 vs Mode 0, Professional Corporation indicator missing, etc. or items rejected with Explanatory Code ZA, ZC or ZR)

If a service code is to be changed (i.e., change from a 3B to a 5B) query the item (see Module 6 – Query Claims). There is no need to resubmit in this instance as the new Claims Processing System keeps a history of all submitted items.

Bi-Weekly Return Files

Bi-weekly Return Files 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.

Retrieving Daily Return Files

Daily Return Files are available <u>every business day morning </u>through the **Pick Up Returns** option in Customer Portal.

It is recommended to view your **Daily Return File** each morning, make the appropriate adjustments to the rejected claims and re-submit. This will ensure your claim(s) are paid quickly and efficiently.

1. Click on **Pick Up Returns.**
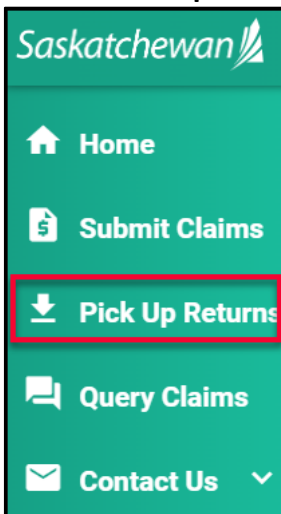
2. Click on **Daily Return Files**
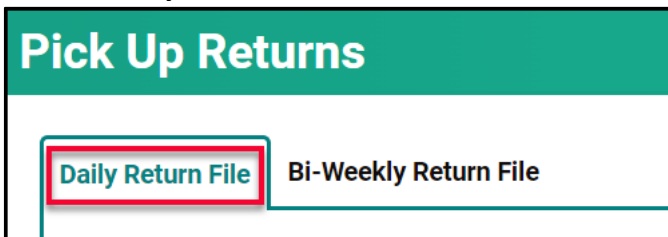
3. Click on ⬇️ to **Download Report.**
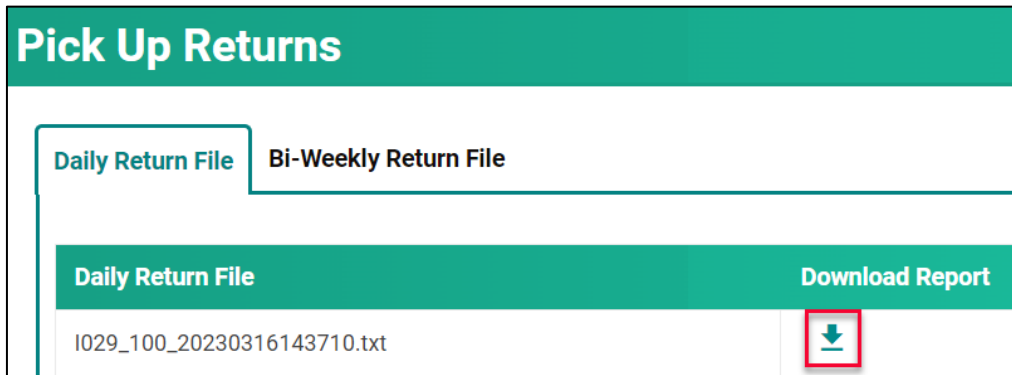
4. Click on the report name in the **Download List** to open it.
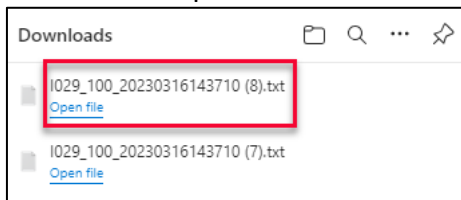
5. This file opens as a text file.

6. It is important to review this file so the rejected claims can be fixed and re-submitted.

Refer to
Reading the Daily Return .txt File
located on
eHealth Saskatchewan's website to assist in reading the .txt return file or view the **Daily Return** file in your CBS Software.

Retrieving Bi-Weekly Return Files

Bi-Weekly Return File is available the morning of the pay date, through the **Pick Up Returns** option in Customer Portal.

It is recommended to view your **Bi-Weekly Return File** on pay day to ensure the payments made reconcile with the claims sent and make adjustments on **rejected** claims as needed.

1. Click on **Pick Up Returns.**

The **Bi-Weekly Return File** is also viewable on your CBS software.

2. Click on **Bi-Weekly Return File.**
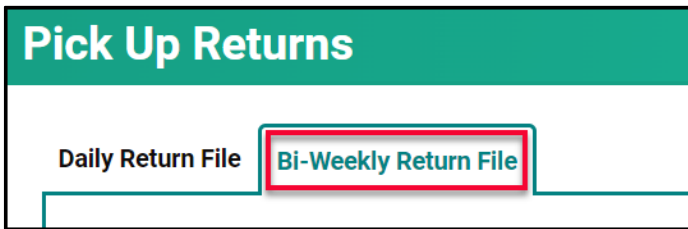
3. Click on [↓] to **Download Report.**
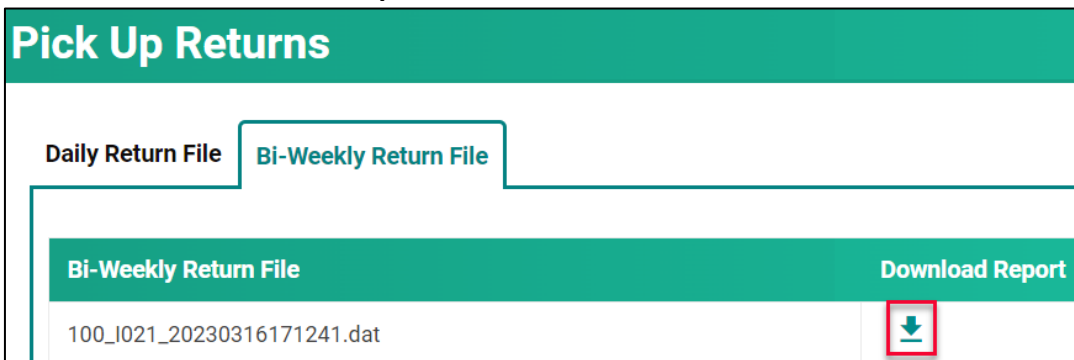
4. Click on the report name in the **Download List** to open it.
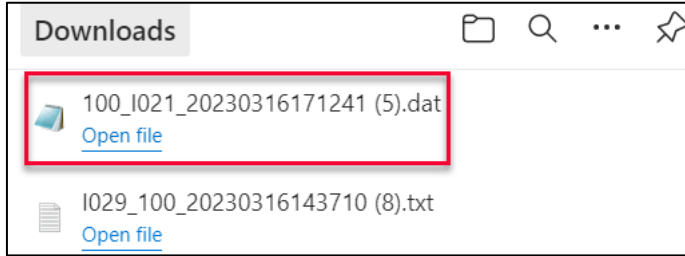
5. This file opens as a text file.

6. It is important to review this file as it
    includes a reconciliation of the files
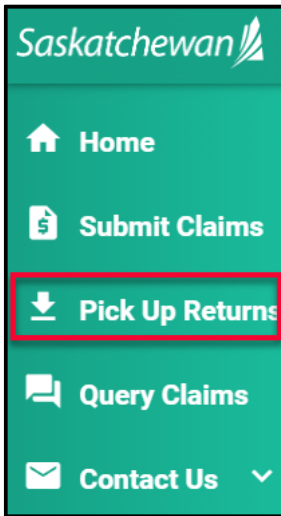   submitted against the files paid, rejected, and pended.

Refer to
**Reading the Bi-Weekly Return .txt
File** located on
eHealth Saskatchewan's website to
assist in reading the .txt return file or
view the **Bi-Weekly Return** file in your
CBS Software.

Module SIX – Query Claims

Medical Services Branch

Claims Replacement Project

Query Claims

From time to time, additional information needs to be added to a claim or a claim needs to be recovered after it is submitted. This can be done through a **query.**

There are two types of queries:
- Claim Query
- Supplementary Claim Information

Claim Query

A **Claim Query** is used when a claim must be recovered. Typically, this occurs when incorrect information was entered on the original claim. When a recovery is requested through the **Claim Query** one of two things happens.

- The claim is **Rejected** with an **Explanatory Code of BP.** The rejected file is returned so updates can be made. Once the claim is updated, it can be re-submitted for adjudication.
- The claim is **Pended** for a manual review by MSB. After reviewing the pended claim, it will either be paid or **Rejected** with an **Explanatory Code.**

The categories to select from for a **Claim Query** are:

Claim Query Categories	Result
Physician Requested Recovery – Incorrect Patient	Rejected = Explan Code of BP
Physician Requested Recovery – Incorrect Physician	Rejected = Explan Code of BP
Physician Requested Recovery – Incorrect Date of Service	Rejected = Explan Code of BP
Physician Requested Recovery – Incorrect Service Code	Rejected = Explan Code of BP
Physician Requested Recovery – Incorrect Billed in error	Rejected = Explan Code of BP
Physician Requested Recovery – Incorrect WCB paid claim	Rejected = Explan Code of BP
Physician Requested Recovery – Others (provide comment	Pended for Manual Review

Supplementary Claim Information

Supplementary Claim Information is typically used when supporting documentation must be added to the claim, or a special request, like time extension or Medical Consultant Review, is required. All claims queried with **Supplementary Claim Information** are reviewed by MSB. After reviewing the claim, it will either be **Paid** or **Rejected** with an **Explanatory Code.**

The categories to select from for **Supplementary Claim Information** are:

Supplementary Claim Information Categories	
Explan Code AU – Consultation Notes/Report/Letter	Reviewed by MSB
Explan Code AU – Operative Record and Operative Notes with Anesthetic and Surgical Start and Stop Times	Reviewed by MSB
Explan Code AU – Descriptive Letter	Reviewed by MSB
Ex. Code AU – Office Visit Medical Record and Notes with Start and Stop Times for Time Based Codes	Reviewed by MSB
Ex. Code AU – In Hospital Visit Medical Record and Notes with Start and Stop Times for Time Based Codes	Reviewed by MSB
Ex. Code AU – Emergency Visit Medical Notes with Nursing Bedside Notes with Start and Stop Times for Time Based Codes	Reviewed by MSB
Explan Code AZ – Current and Previous Procedure Operative Record and Report	Reviewed by MSB
Explan Code RA – RZ (Routine Audit and Recovery)	Reviewed by MSB
Request for extension of time limit (Explan code CM – CN)	Reviewed by MSB
Request for general reassessment (Claims Supervisor)	Reviewed by MSB
Request for Medical Consultant review	Reviewed by MSB
Request for Medical Assessment Board review	Reviewed by MSB

Query Claims

To query a claim certain claim criteria must be entered. All mandatory fields must be entered to perform the query. However, additional search fields can also be entered. The more specific the search criteria are the more defined the results.
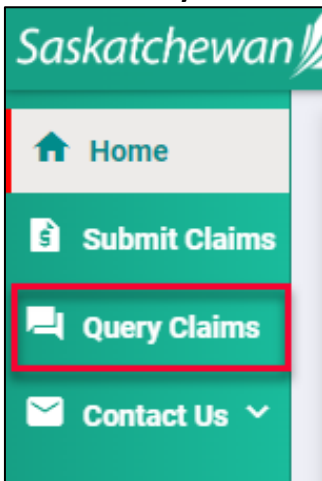

The mandatory fields are:

- **Billing No** (Auto-populated based on your login profile. If set to bill for more than one billing number, select the appropriate number from the drop-down list).
- **Submission** From Date
- **Submission** To Date

The **From Date** and **To Date** must be the **Submission Date** of the claim. In other words, the dates entered for the query must be the date the claim was submitted to MSB not the service date.

1. Click on **Query Claims.**

2. Enter the three mandatory fields of **Billing No** (auto populated or selected from the drop-down list), **From Submission Date** and **To Submission Date**. Date format is DD-MM-YYYY. The calendar icons can be clicked on to select the date. **NOTE:** The date range can only be seven days.

3. Enter additional query criteria as desired.

4. Click

5. A list of claims matching the search criteria will be displayed.

6. Place a check mark in the line item you wish to review. A check mark can be placed in more than one line item. This is beneficial if several claims are queried for the same reason (i.e., recovery). If a claim query requires an attachment, it is best to do this one at a time.
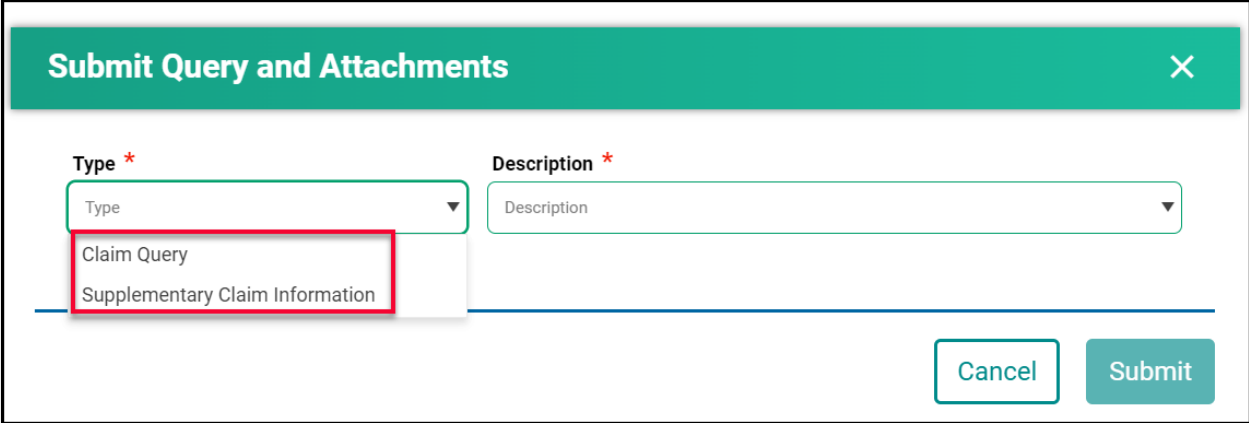
7. Click **Next.**

8. Select either **Claim Query** or **Supplementary Claim Information.** Then follow the steps listed below for each query type.
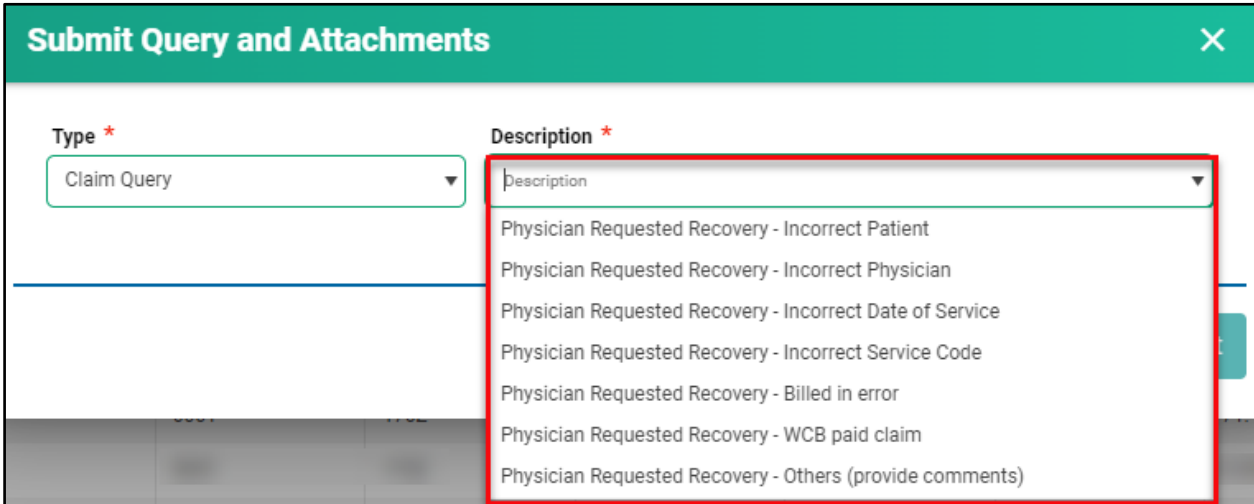
How to Run a Claim Query

When recovering a claim due to an error on the initial submission, use the **Claim Query** option.
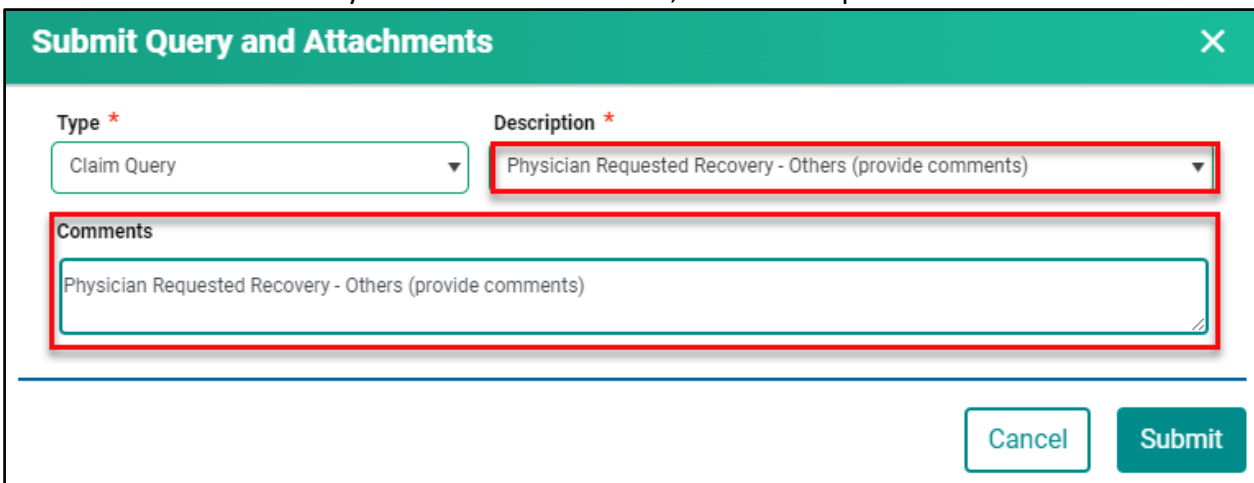
1. Select **Claim Query.**

2. Select the correct **Description.**

3. If **Physician Requested Recovery – Others** are selected, enter in a detailed comment explaining the reason for the recovery. For all other selections, move to step 4.
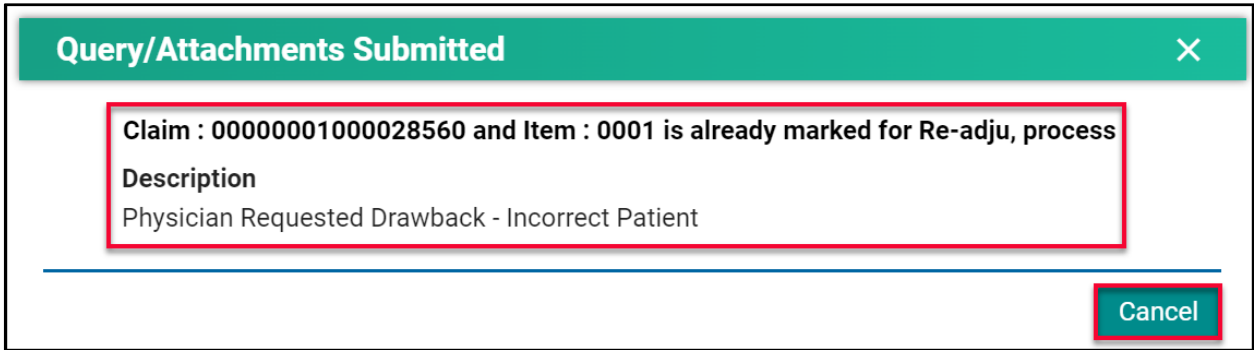
4. Click **Submit.**

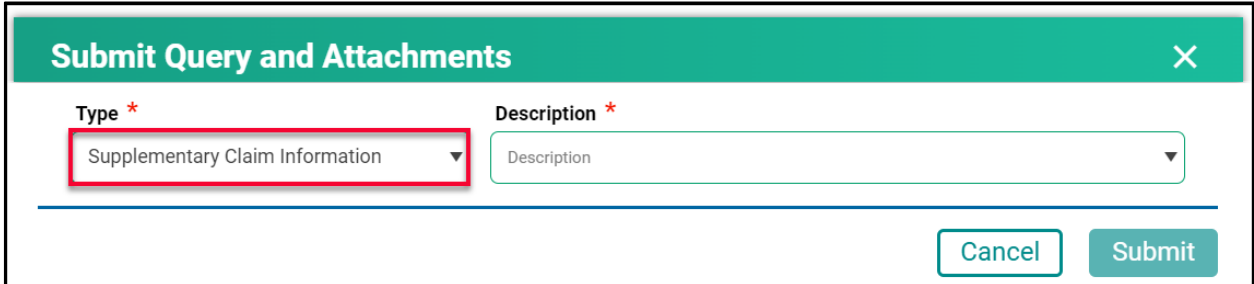5. Review the submitted Query message, then click **Cancel.**
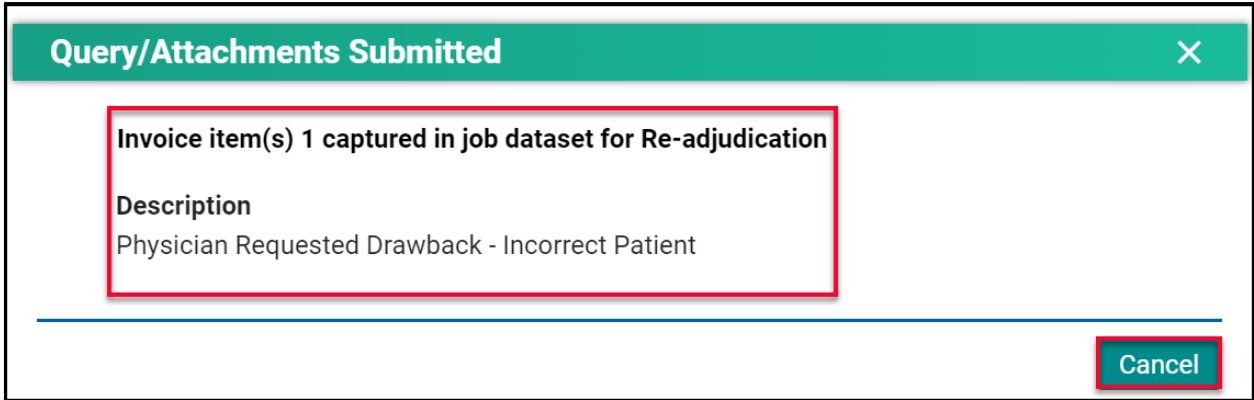
NOTE: If a query is submitted on a claim that already has an outstanding query on it, the following message will appear.

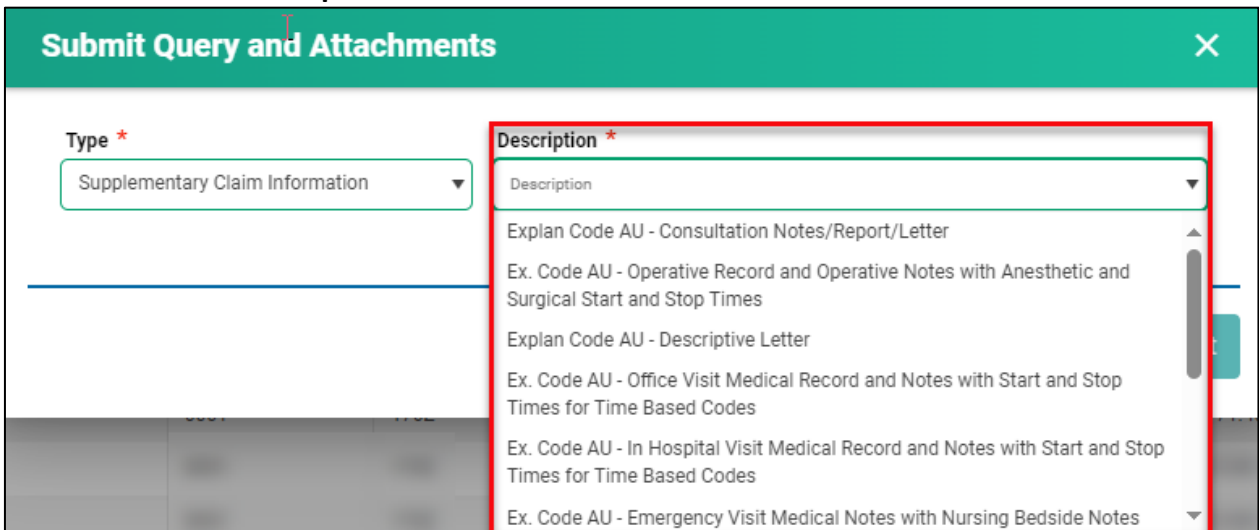## How to Run a Supplementary Claim Information Query

When additional documentation and/or comments are required on a claim, use the **Supplementary Claim Information Query.**
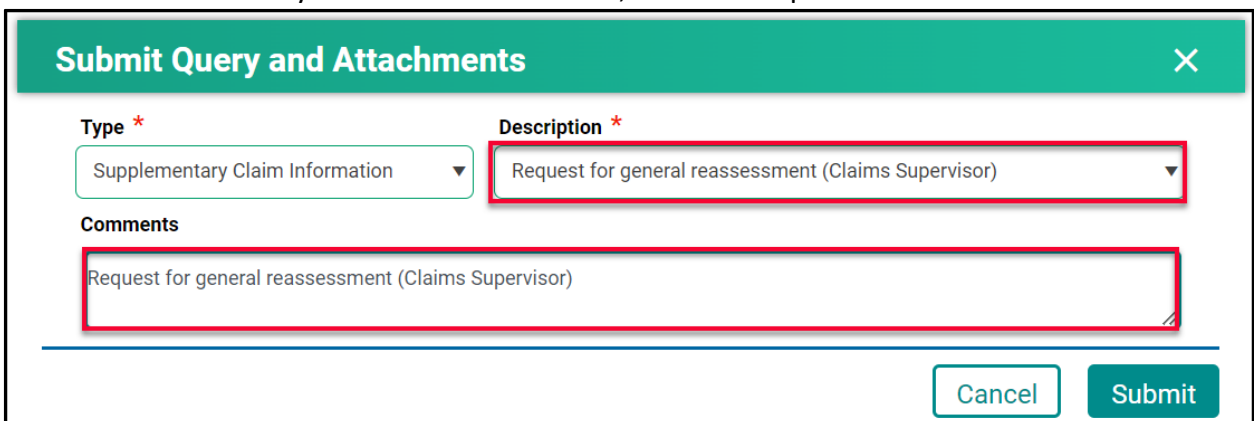
1. Select **Supplementary Claim Information.**

2. Select the correct **Description.**

3. If **Request for general reassessment** is selected, enter in a detailed comment explaining the reason for the recovery. For all other selections, move to step 4.

4. For all other selections a document(s) will need to be uploaded. Click **Choose File.** The file format can be in pdf, word, excel, jpeg, png.

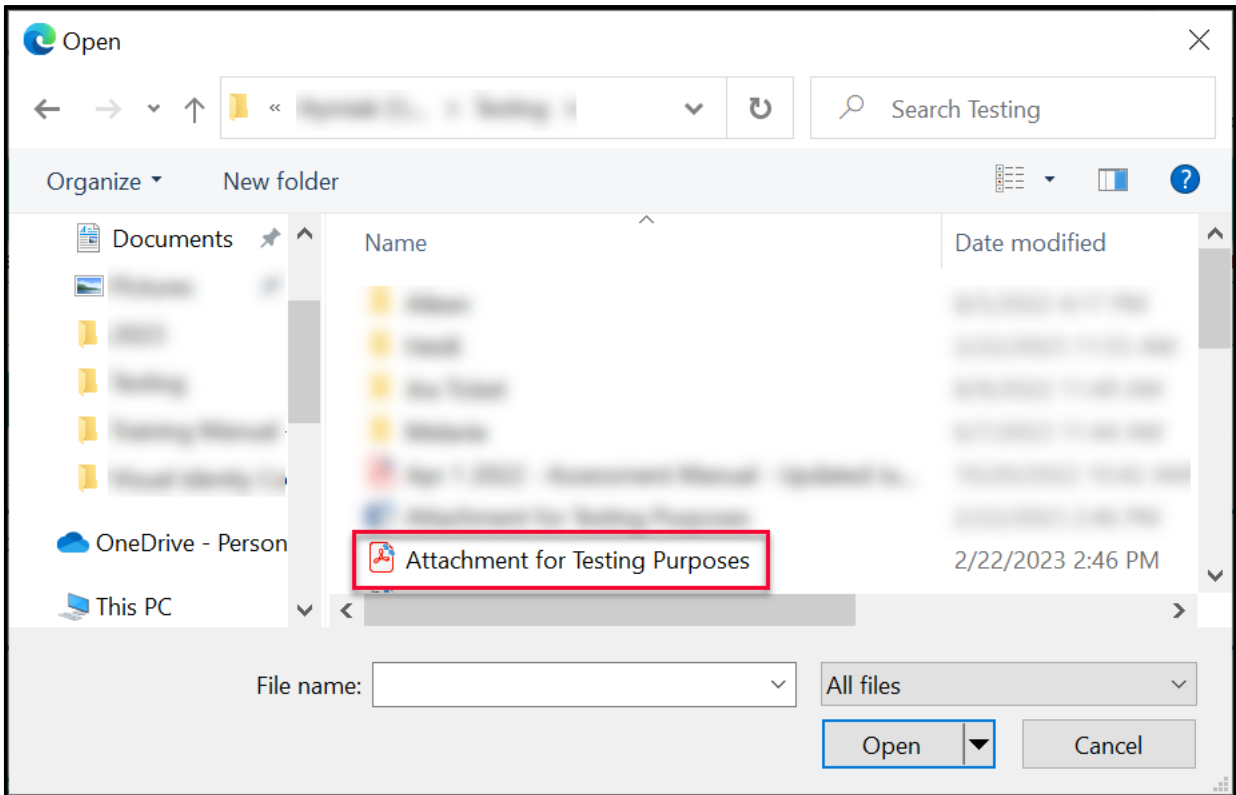5. Find the file you wish to upload then double-click on the file name.
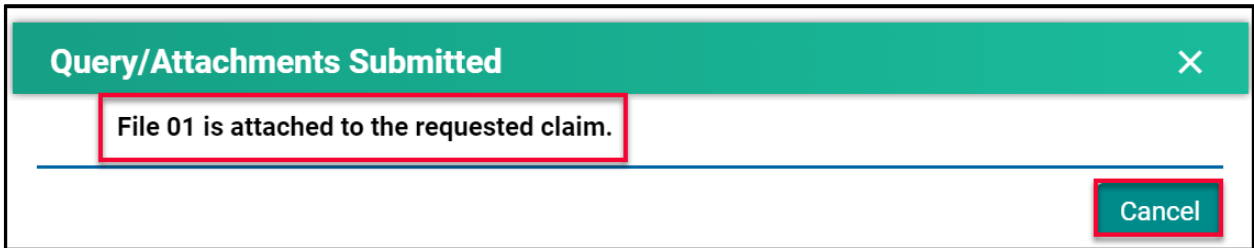
6. The file name will populate in the pop-up window.

7. Click **Submit.**

8. Review the confirmation message and then click **Cancel.**

Handling Rejected Line Items

Scenario #1

Your claim was originally submitted with the following two-line items:

- Line 1 - 9B
- Line 2 – 890L

After the adjudication process, the results were:

- Line 1 - 9B – Rejected with an explanatory code of BJ (missing referring doctor)
- Line 2 – 890L – Paid

<u>Action required:</u>

- Resubmit 9B, using your billing software, with the correct referring doctor's billing number.
- No action is required for 890L as it will be paid on the next bi-weekly run.

Scenario #2

Your claim was originally submitted with the following two-line items:

- Line 1 - 9B
- Line 2 – 890L

After the adjudication process, the results were:

- Line 1 - 9B – Rejected with an explanatory code of AU (MSB is auditing all 9B claims submitted by this physician)
- Line 2 – 890L – Paid

<u>Action required:</u>

- Query the line item with 9B to add the appropriate Consult Report

Submit Query and Attachments	✕
Type * Supplementary Claim Information ▼	**Description** * Explan Code AU - Consultation Notes/Report/Letter ✕ ▼
Attach File Choose File No file chosen	
File format must be .doc, .docx, .jpeg, .txt & .pdf	
	Cancel Submit

- No action is required for 890L as it will be paid on the next bi-weekly run.

Scenario #3

Your claim was originally submitted with the following two-line items:
- Line 1 - 9B
- Line 2 – 795A

After the adjudication process, the results were:
- Line 1 - 9B – Paid
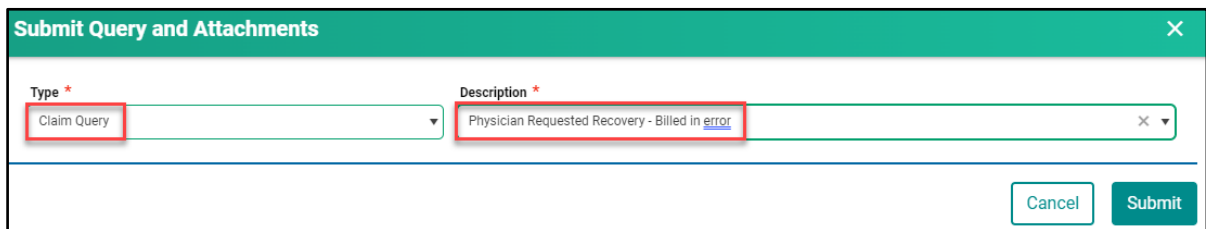- Line 2 – 795A - Rejected with an explanatory code of BK (service is not payable)

Action required:
- No action required. 9B will be paid on the next bi-weekly run and 795A cannot be paid based on the Assessment Rules.

Scenario #4

Your claim was submitted, and all line items passed through the Assessment Rules and will be paid on the next bi-weekly run. However, you realize incorrect information was submitted on the claim.

Action required:
- The day following your submission (can only query a claim after the daily processing run is completed by the Claims Processing System), query the claim in Customer Portal to recover the claim. All line items associated with this claim will have a status of Paid.

- Once the claim has been recovered, resubmit the claim with the correct information. You can confirm that the claim was recovered by querying the claim again or by checking your Daily Return File after the daily processing run is completed by the Claims Processing System. All the line items will have a status of Rejected with explanatory code BP.

Scenario #5

The following claims were submitted on the same day, by the same physician, in the same clinic for the same patient:

- Claim #1 – 3B for a complete physical done in the morning.
- Claim #2 – 5B as the patient returned to the clinic for a broken ankle.

After the adjudication process, the results were:

- Claim #1 – 3B – Paid as it was the first claim submitted.
- Claim #2 – 5B – Rejected with an explanatory code DA as there was no comment attached to the original claim explaining the scenario.

<u>Action required</u>:

- Query the claim with 5B to add a comment. If a supporting document would be beneficial in explaining the scenario feel free to attach one.
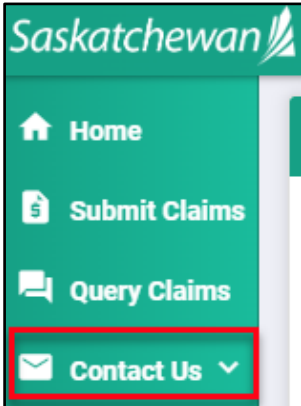

- No action required on the claim with 3B.
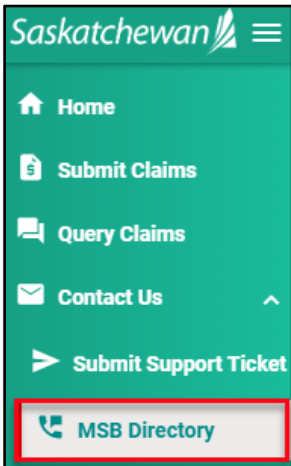
Module SEVEN – Contact Us

Contact Us

When requiring support with a claim or Customer Portal call **1-800-605-2965**, Monday to Friday from 8:00am to 5:00pm.
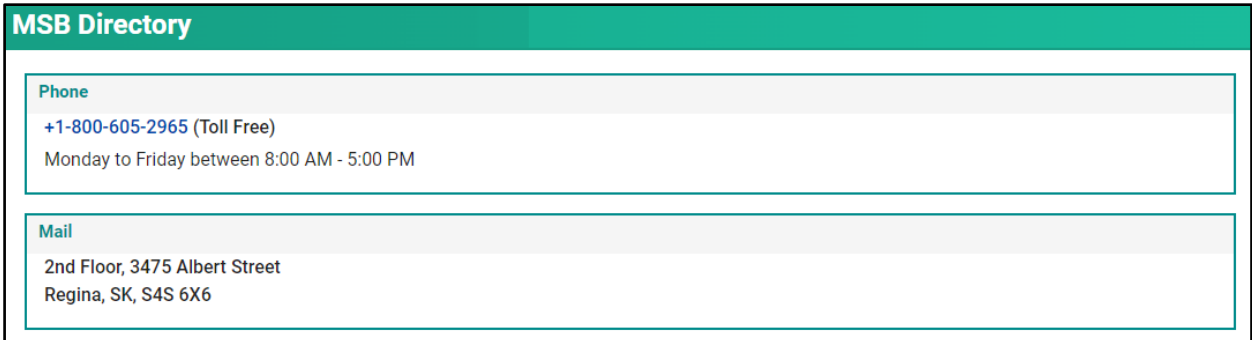
MSB Directory

1. Click on **Contact Us.**

2. Click on **MSB Directory** to view the contact details.

3. Select an option to contact MSB.