

# Customer Portal (CP) Batch Submissions User Manual



**Medical Services Branch**



Claims Replacement Project

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# Module ONE: Overview

## Learning Objectives

Upon completion, learners will have an understanding of:

- The advantages of Customer Portal.
- Who uses Customer Portal?
- How to submit claims through a **Batch** submission.

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## Claims Replacement Project

## Overview of Customer Portal

**Customer Portal (CP)** is a web-based application, used by physicians, dentists, optometrists, health care providers and internal Medical Services teams to submit medical claims (at a later time hospital claims will also be submitted) to Saskatchewan Health (MSB) for payment of services provided.

Customer Portal is a 'pass through' application for claims. Meaning it does not store claim information in a database of its own. Rather, it transfers (sends) claim files through a secured portal to the Claims Processing System (CPS) (behind firewall).

Users will be individual health care providers, clinics, service bureaus and internal Medical Services Branch teams, who have authorization to submit medical claims to Saskatchewan Health for compensation.

## Benefits of Customer Portal

The benefits of Customer Portal are numerous, and users will identify many more as they begin to use the application. Some of the top benefits are:

1. Submit claims through a **Batch** process.
2. Retrieve validation reports and daily and bi-weekly return files.
3. Submit a query submission on individual claims.
4. Ability to access payment schedules, newsletters, and frequently used forms on the portal's home page.

# Module TWO – Getting Started

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## 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 THREE – Navigating Customer Portal

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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

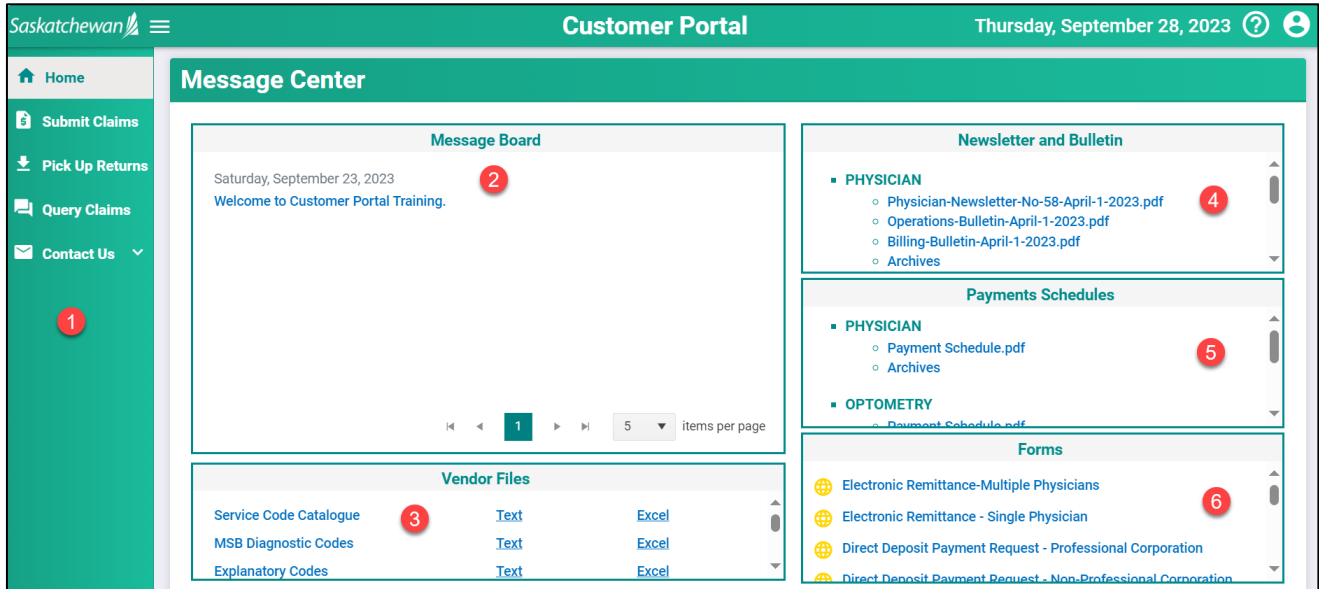
The top menu bar in Customer Portal provides four main options:



	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.

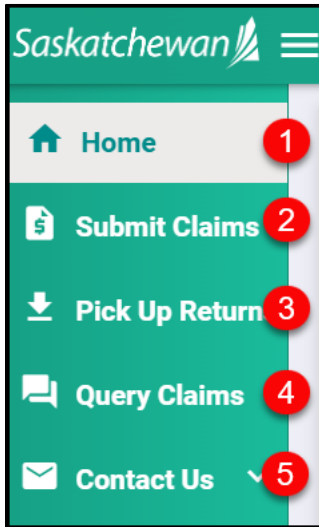


Area	Description
1	<b>Navigation Menu</b> A list of areas in Customer Portal the user can access, explore, and navigate to other areas of the application.
2	<b>Message Board</b> The Message Board hosts important information and updates. This section will be continually updated with current news and messages.
3	<b>Vendor Files</b> Commonly used Vendor Files, such as the Service Code Catalogue, MSB Diagnostic Codes and Explanatory Codes are located here for easy access.
4	<b>Newsletter and Bulletin</b> The most recent Newsletters and Bulletins are posted for reference, along with archived versions of each.
5	<b>Payment Schedules</b> 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.
6	<b>Forms</b> The most frequently used forms are located here. Click once to open the form, complete the fillable pdf, then save/or print as needed.



## Navigation Menu

The side Navigation Menu is a list of actions that can be performed within Customer Portal

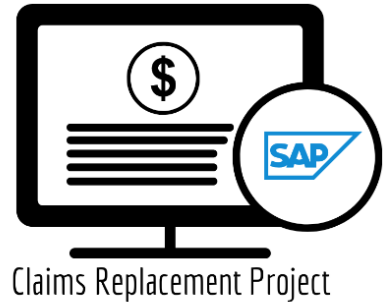


Each option will be elaborated on in the following modules.

	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 FOUR – Batch File Submissions

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## Batch File Submissions

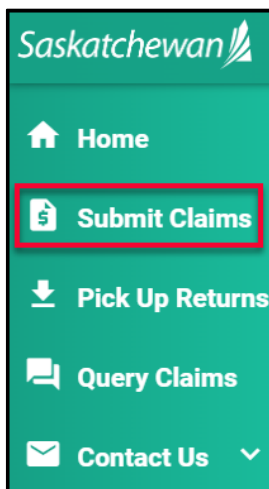
Batch file submissions are performed by Service Bureaus and Vendors as they submit several claims at the same time. Submitting batch files can be done as often as needed.

Access to submitting batch files follows your user profile. Therefore, your user profile will be set to allow batch submissions.

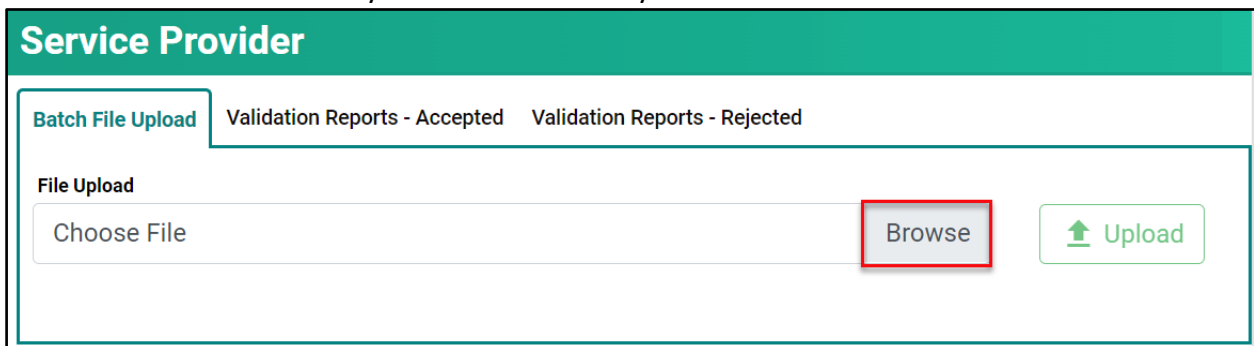


This process is NOT for those that use a vendor set up with an Application Programming Interface (API) to submit claims. As of go-live that includes all Acurro, Perspect and CBS clients.

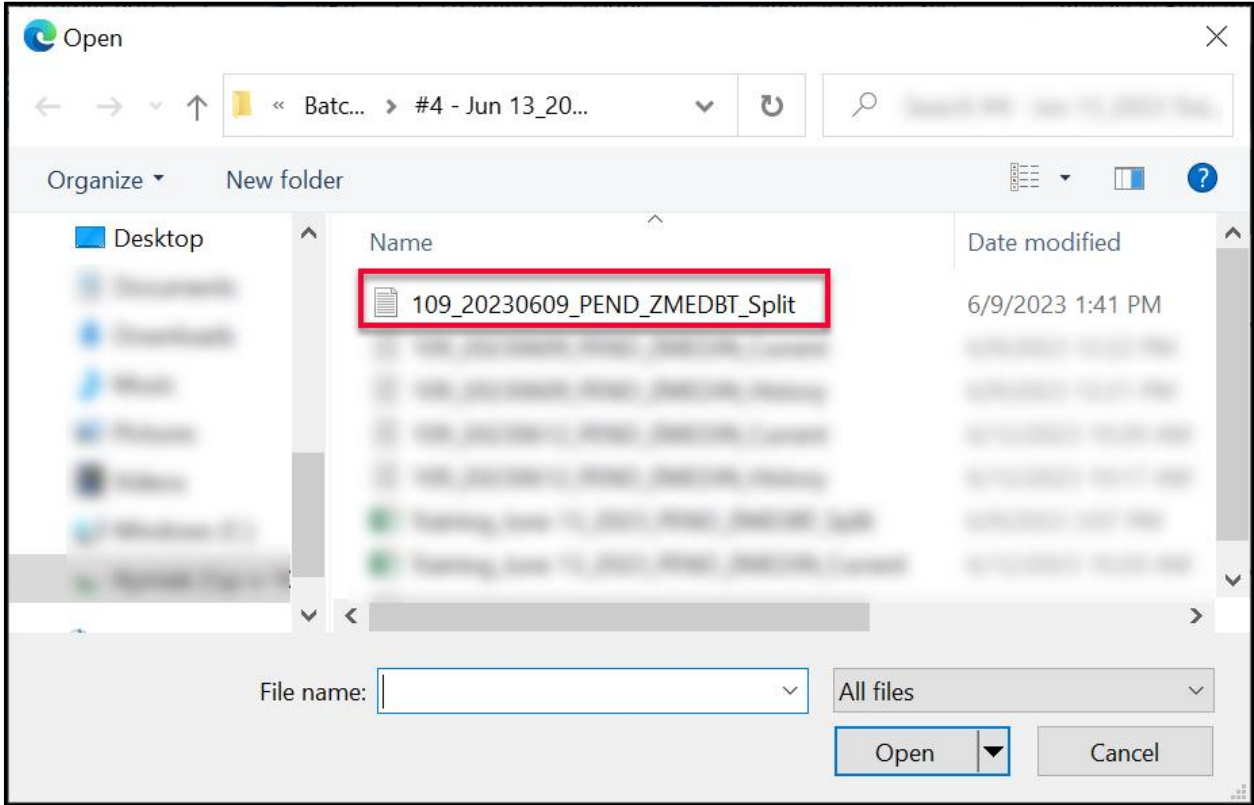
1. Click on **Submit Claims**.



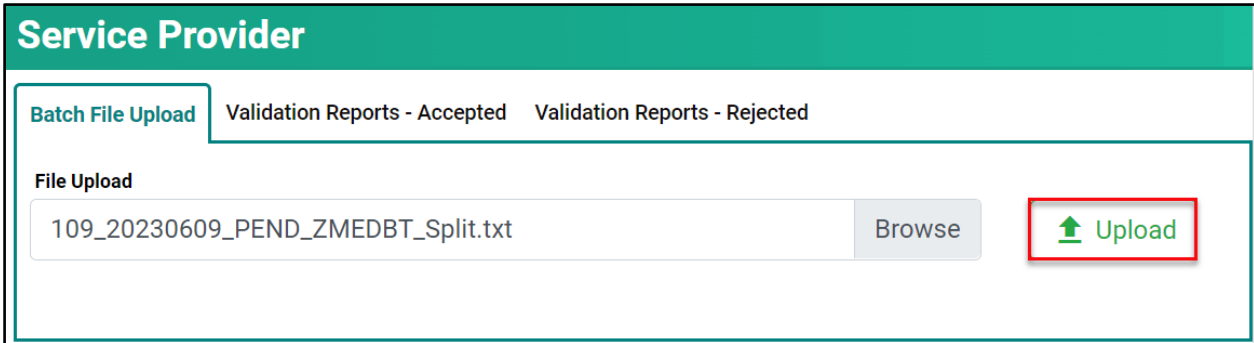
2. Click on **Browse** to retrieve your file from a locally saved location.



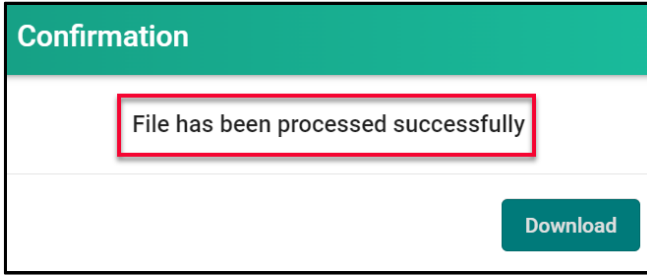
3. Find the file you wish to upload then **double-click** on the file name.



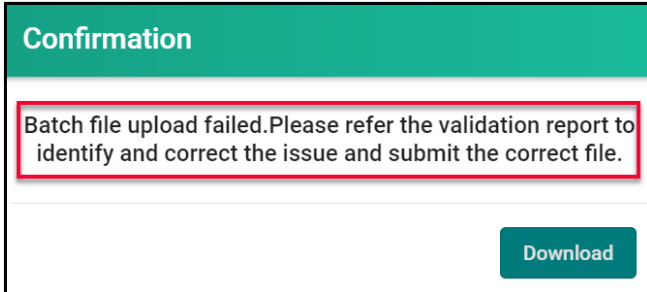
4. Click **Upload**.



5. If the file upload was successfully, this message is presented:



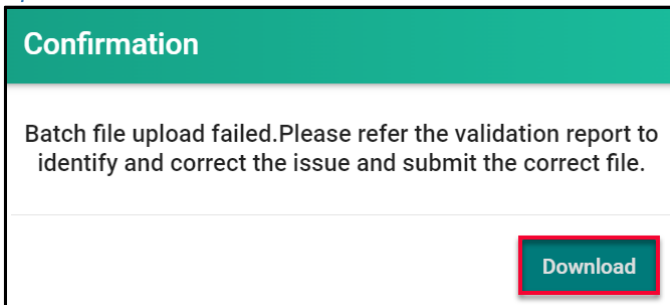
If the file upload was unsuccessful, this message is presented:



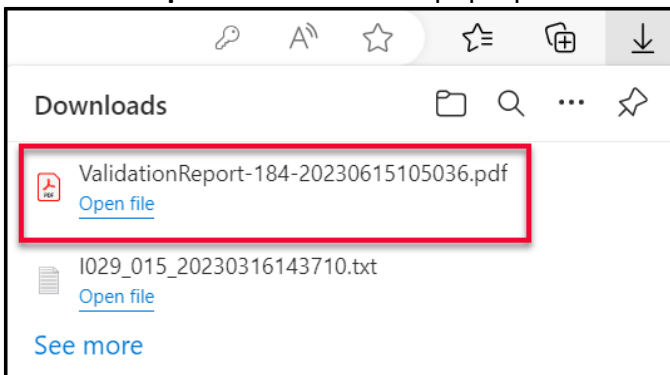
6. In either case, the **Validation Report** must be viewed. It is important to view the **Validation Report** when the file upload fails, as the report will provide details on why it failed.

The **Validation Report** can be viewed in one of two ways.

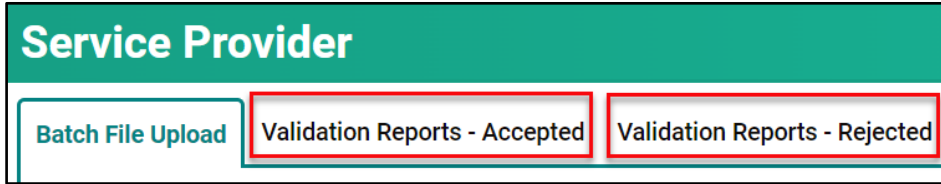
*Option #1* – Click **Download**.



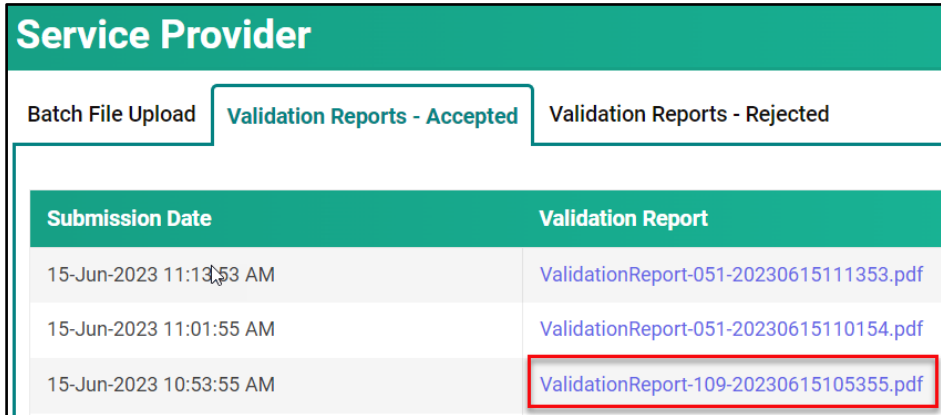
Select the **report name** from the pop-up window.



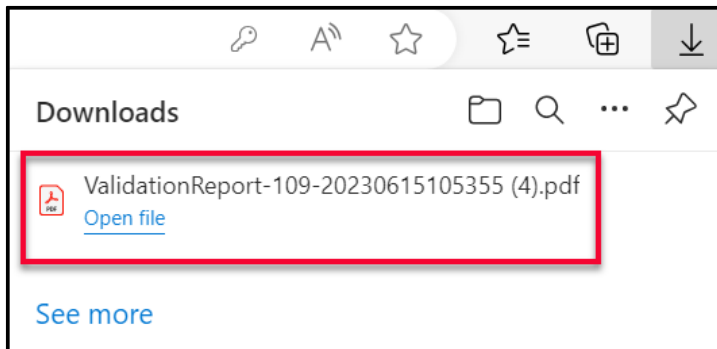
*Option #2* – Click the **Validation Reports – Accepted** or **Validation Reports - Rejected** tab.



Click on the **report name**, under the appropriate tab.



Select the **report name** from the pop-up window.



7. The **Validation Report** provides details on the file upload. If the file upload was successful, the report status shows **Accepted**.

Claims Submission Validation Report							
File Name : 109_20230612_PEND_ZMEDJN_Test.txt							
Submission Date : Thu Jun 15 10:53:55 CST 2023							
Group Number : 109							
Status : <b>Accepted</b>							
Clinic	Doctor	Claims	Records	Services	89 Recs	Comments	Fee Sub
247	4011	4	6	4	0	0	\$288.80
Totals:		4	6	4	0	0	\$288.80

If the file upload was unsuccessful the report status shows **Rejected** along with a description of why the upload failed. This file can be adjusted/modified/checked and re-uploaded.

Claims Submission Validation Report			
File Name : 109_20230609_PEND_ZMEDBT_Split.txt			
Submission Date : Thu Jun 15 10:51:26 CST 2023			
Group Number : 184			
Status : <b>Rejected</b>			
Clinic	Doctor No	Reject Description	Claim No
NA	NA	Duplicate Input File	NA

When a batch file upload fails, the ENTIRE submission fails. This means that every claim in that batch failed to upload.

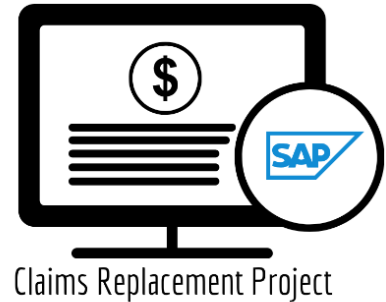
Review the reason for rejection and then make the appropriate updates/changes and then resubmit the batch file.



Consult your vendor if required.

# Module FIVE – Pick Up Returns

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## 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

## 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 because based on the Assessment Rules the claim is not payable.

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 the return file to account for all items submitted. Totals of each category are included to assist with reconciling the submission.

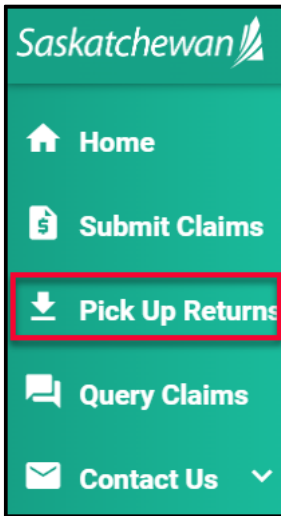
The **Bi-weekly Return File** will be categorized by doctor, clinic, mode, and professional corporation or non-professional corporation.

## Retrieving Daily Return Files

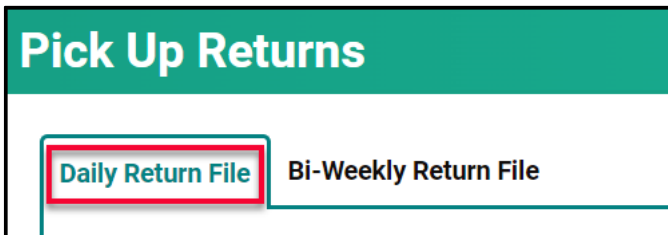
**Daily Return Files** are available every business day morning through the **Pickup Returns** option in Customer Portal.

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

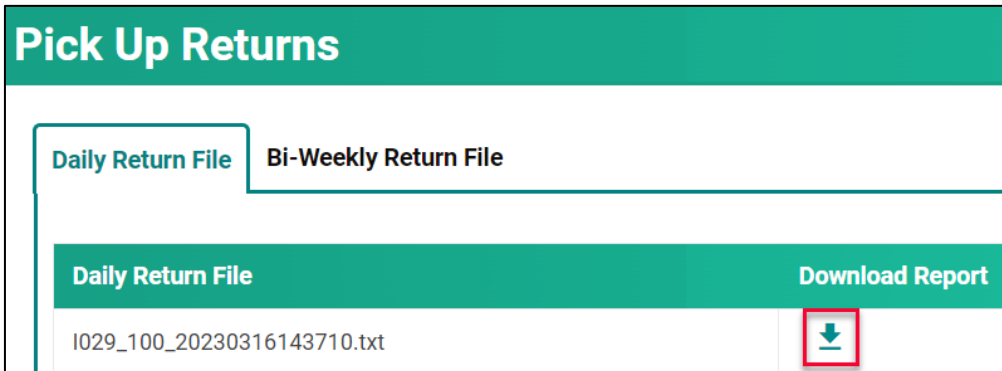
1. Click on **Pick Up Returns**.



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. Some billing software is designed to view the file in an easy-to-read format. If your software does not have this feature or if you do not use billing software, refer to the **Reading the Daily Return .txt File** document for Assistance.



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

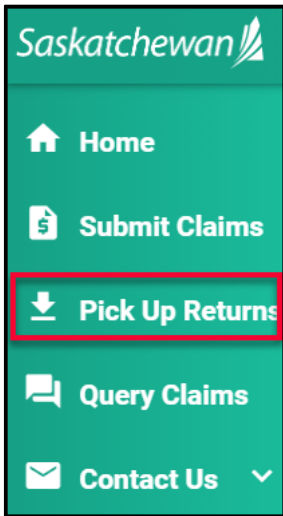
6. It is important to review this file so the rejected claims can be fixed and re-submitted.

## Retrieving Bi-Weekly Return Files

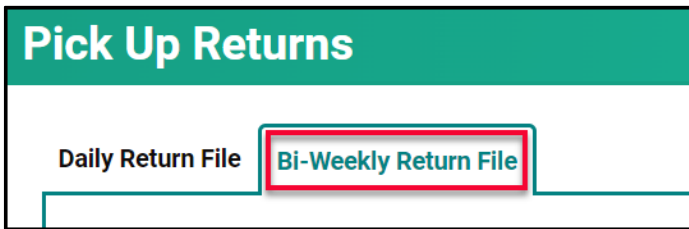
**Bi-Weekly Return File** is available the morning of the pay day, through the **Pick Up Returns** option in Customer Portal.

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

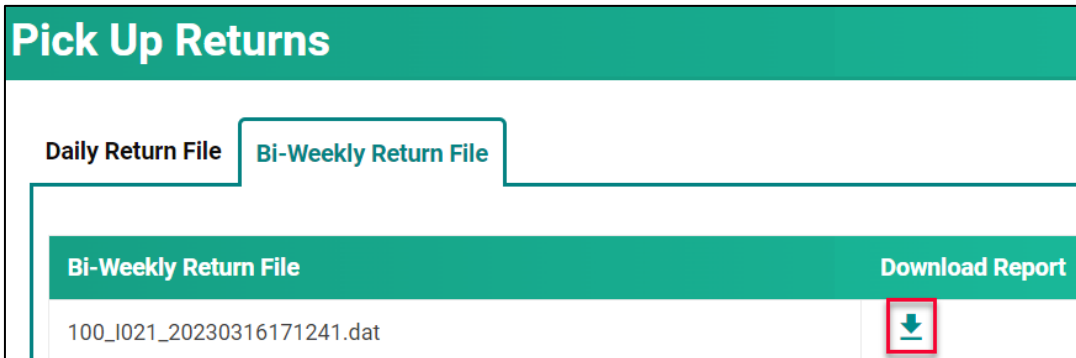
1. Click on **Pick Up Returns**.



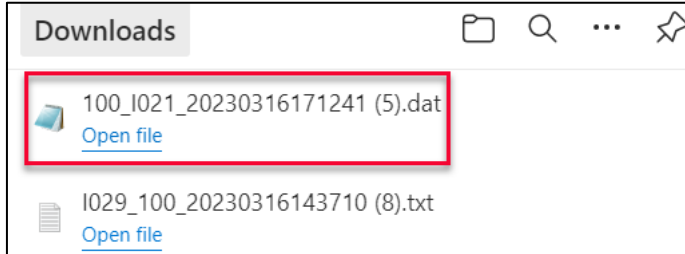
2. Click on **Bi-Weekly Return File**.



3. Click on  to **Download Report**.



- Click on the report name in the **Download List** to open it.



- This file opens as a text file. Some billing software is designed to view the file in an easy-to-read format. If your software does not have this feature or if you do not use billing software, refer to the **Reading the Bi-Weekly Return .txt File** document for Assistance.
- It is important to review this file as it includes a reconciliation of the files submitted against the files paid, rejected, and pending.



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

# Module SIX – Query Claims

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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 line item is returned so updates can be made. Once updated, it can be re-submitted for adjudication.
- The claim is **Pended** for a manual review by MSB. After review, the claim 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

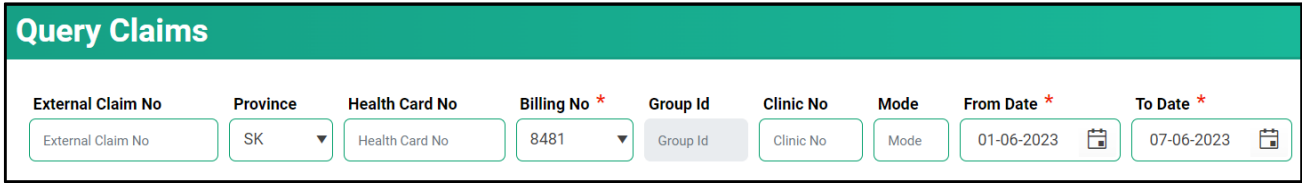
**Supplementary Claim Information** is typically used when supporting documentation must be added to the claim, or a special request, like time extension or Medical Consultant Review, is required. All claims queried with **Supplementary Claim Information** are reviewed by MSB. After reviewing the claim,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

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

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

## Query Claims

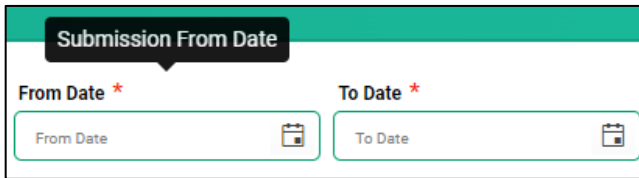
To query a claim certain claim criteria must be entered. All mandatory fields must be entered to perform the query. However, additional search fields can also be entered. The more specific the search criteria, the more defined the results.



The screenshot shows a search form titled "Query Claims" with the following fields: External Claim No (text input), Province (dropdown menu with "SK" selected), Health Card No (text input), Billing No \* (dropdown menu with "8481" selected), Group Id (text input), Clinic No (text input), Mode (text input), From Date \* (calendar icon, showing "01-06-2023"), and To Date \* (calendar icon, showing "07-06-2023").

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**

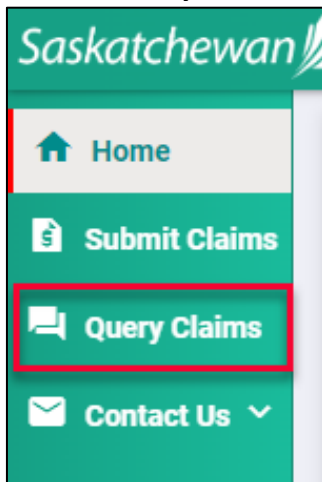


This close-up shows the "Submission From Date" and "To Date" fields. Both are labeled with a red asterisk (\*). The "From Date" field contains the text "From Date" and has a calendar icon. The "To Date" field contains the text "To Date" and has a calendar icon.

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**.



- 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 also be clicked on to select the date. **NOTE:** The date range can only be seven days.

**Query Claims**

CPS Claim No: [CPS Claim No] External Claim No: [External Claim No] Province: [SK] Health Card No: [Health Card No] Billing No \*: [4733] Group Id: [Group Id]

Clinic No: [Clinic No] Mode: [Mode] From Date \*: [15-10-2023] To Date \*: [21-10-2023]

- Enter additional query criteria as desired.

4. Click

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

**Query Claims**

CPS Claim No: [CPS Claim No] External Claim No: [External Claim No] Province: [SK] Health Card No: [Health Card No] Billing No \*: [4733] Group Id: [Group Id] Clinic No: [Clinic No] Mode: [Mode] From Date \*: [15-10-2023] To Date \*: [21-10-2023]

	CPS Claim No.	Ext Claim No.	Prov	HSN	Sub SC	DOS From	DOS To	Status	Paid SC	Paid LOS	Paid NOS	Paid Eligible A.	Paid Total A.	Explan Codes
<input type="checkbox"/>	1030023043		SK	370163829	038U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA
<input type="checkbox"/>	1030023043		SK	370163829	037U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA
<input type="checkbox"/>	1030023043		SK	370163829	036U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA

1 - 10 of 86 items

- Place a check mark in the line item you wish to query. 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 a time.

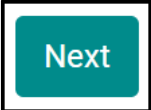
**Query Claims**

CPS Claim No: [CPS Claim No] External Claim No: [External Claim No] Province: [SK] Health Card No: [Health Card No] Billing No \*: [4733] Group Id: [Group Id] Clinic No: [Clinic No] Mode: [Mode] From Date \*: [15-10-2023] To Date \*: [21-10-2023]

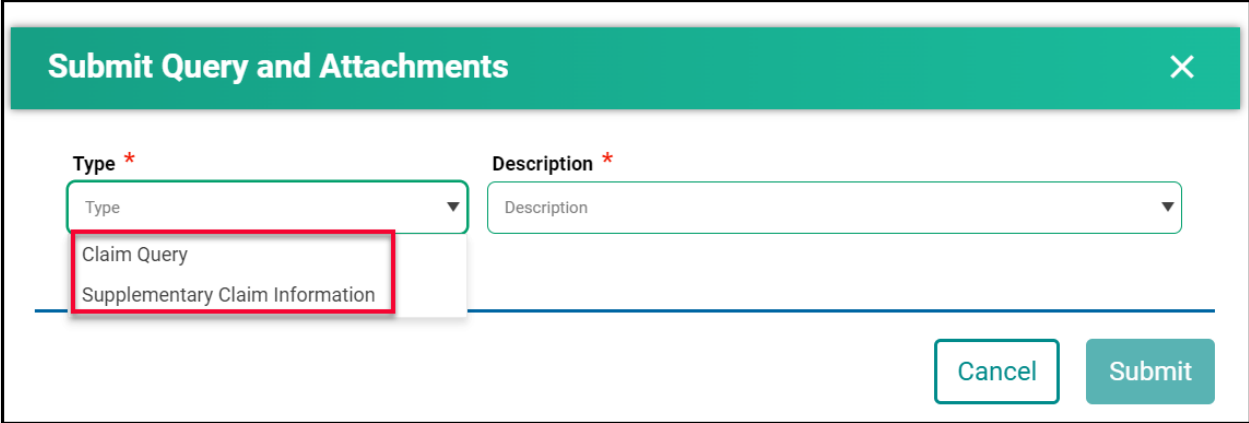
	CPS Claim No.	Ext Claim No.	Prov	HSN	Sub SC	DOS From	DOS To	Status	Paid SC	Paid LOS	Paid NOS	Paid Eligible A.	Paid Total A.	Explan Codes
<input checked="" type="checkbox"/>	1030023043		SK	370163829	038U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA
<input type="checkbox"/>	1030023043		SK	370163829	037U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA
<input type="checkbox"/>	1030023043		SK	370163829	036U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA

1 - 10 of 86 items

7. Click **Next**.



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

A screenshot of a web form titled "Submit Query and Attachments" with a teal header bar. The form contains two dropdown menus: "Type \*" and "Description \*". The "Type \*" dropdown is open, showing two options: "Claim Query" and "Supplementary Claim Information", both of which are highlighted with a red rectangular border. Below the dropdowns are two buttons: "Cancel" and "Submit".

**Submit Query and Attachments** [X]

**Type \*** [Type] [v]  
Claim Query  
Supplementary Claim Information

**Description \*** [Description] [v]

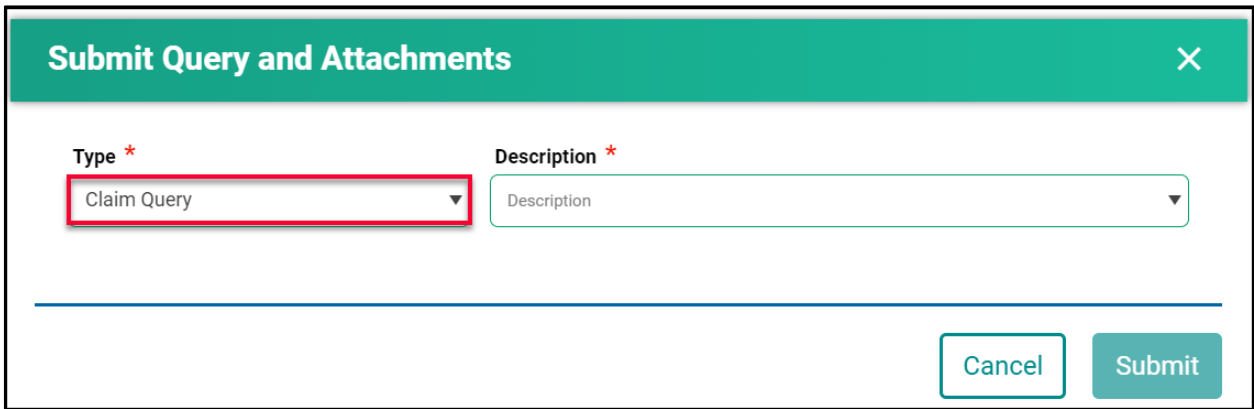
[Cancel] [Submit]



## How to Run a Claim Query

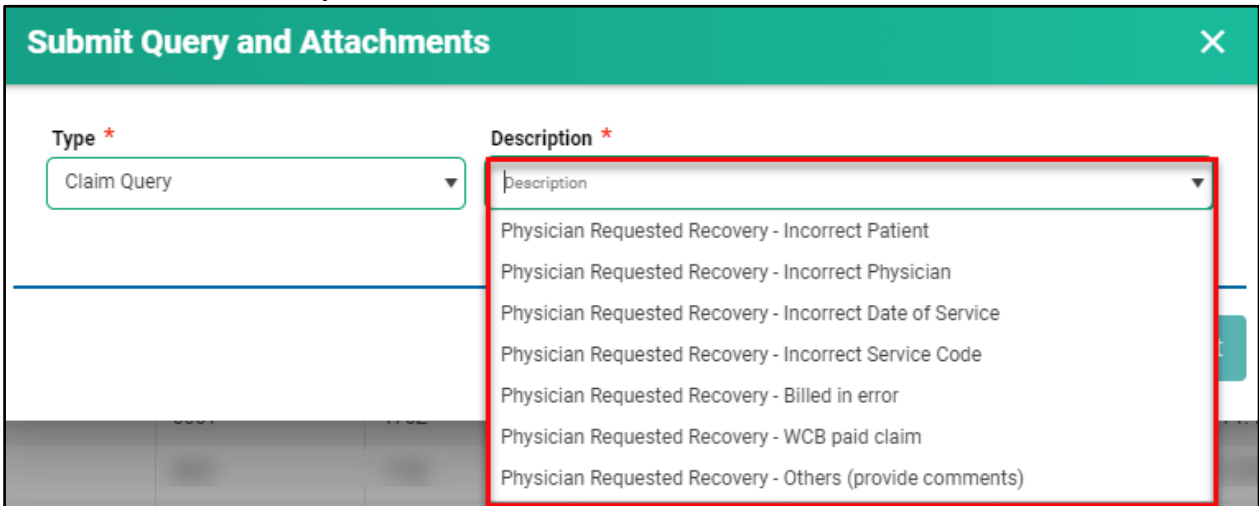
When recovering a claim due to an error on the initial submission, use the **Claim Query** option.

1. Select **Claim Query**.



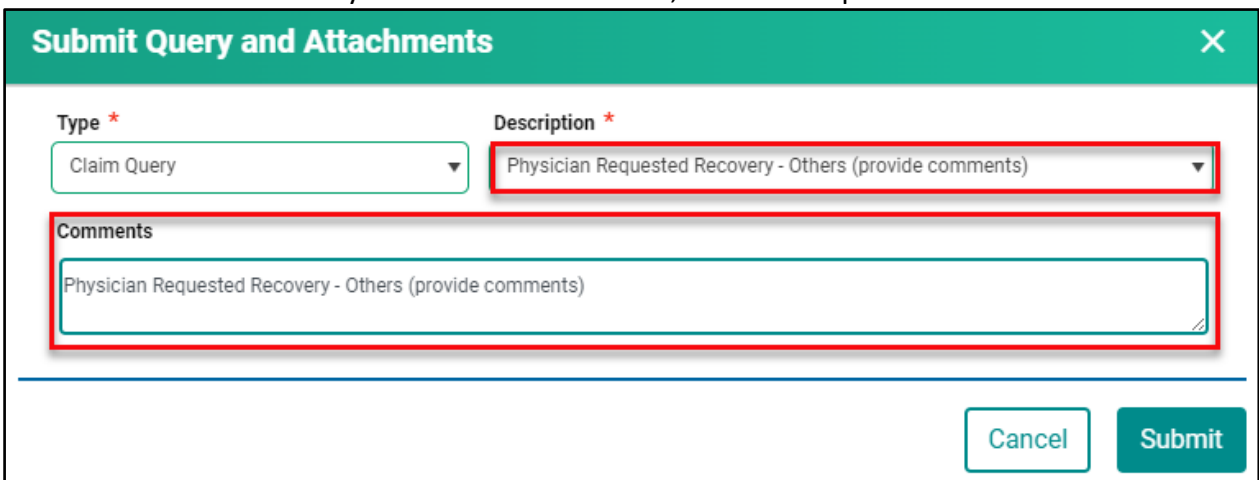
The screenshot shows a form titled "Submit Query and Attachments" with a close button (X) in the top right corner. There are two dropdown menus: "Type \*" and "Description \*". The "Type \*" dropdown is highlighted with a red box and has "Claim Query" selected. The "Description \*" dropdown is empty. At the bottom right, there are "Cancel" and "Submit" buttons.

2. Select the correct **Description**.



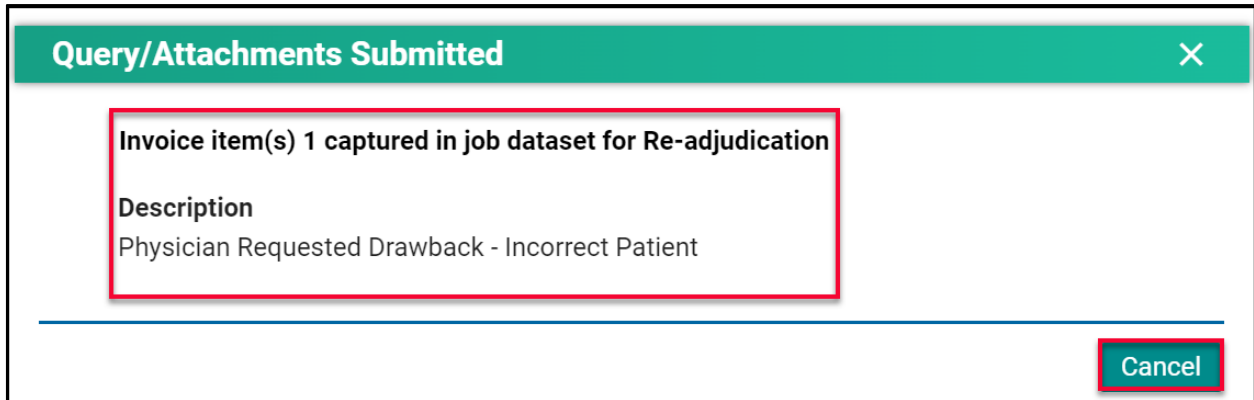
The screenshot shows the same "Submit Query and Attachments" form. The "Type \*" dropdown is still "Claim Query". The "Description \*" dropdown is open, showing a list of options: "Description", "Physician Requested Recovery - Incorrect Patient", "Physician Requested Recovery - Incorrect Physician", "Physician Requested Recovery - Incorrect Date of Service", "Physician Requested Recovery - Incorrect Service Code", "Physician Requested Recovery - Billed in error", "Physician Requested Recovery - WCB paid claim", and "Physician Requested Recovery - Others (provide comments)". The dropdown menu is highlighted with a red box.

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

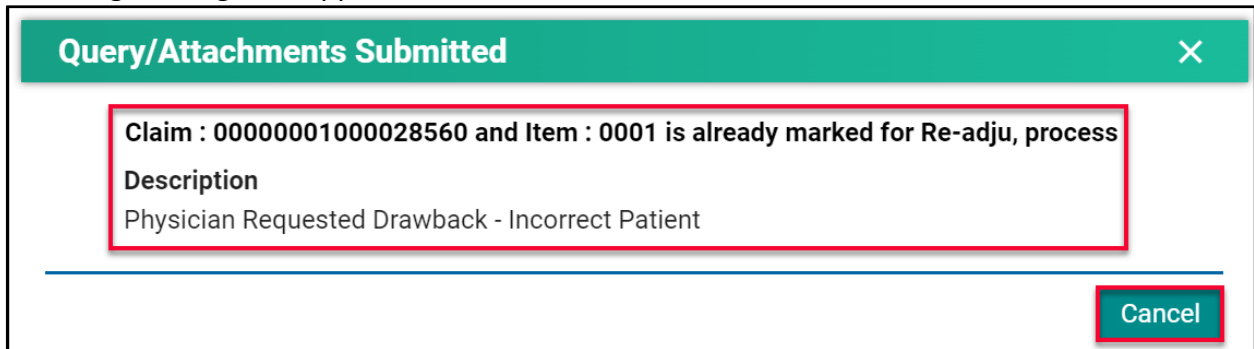


The screenshot shows the "Submit Query and Attachments" form. The "Type \*" dropdown is "Claim Query". The "Description \*" dropdown is "Physician Requested Recovery - Others (provide comments)". Below the dropdowns is a "Comments" text area, which is highlighted with a red box and contains the text "Physician Requested Recovery - Others (provide comments)". At the bottom right, there are "Cancel" and "Submit" buttons.

4. Click **Submit**.
5. Review the submitted Query message, then click **Cancel**.



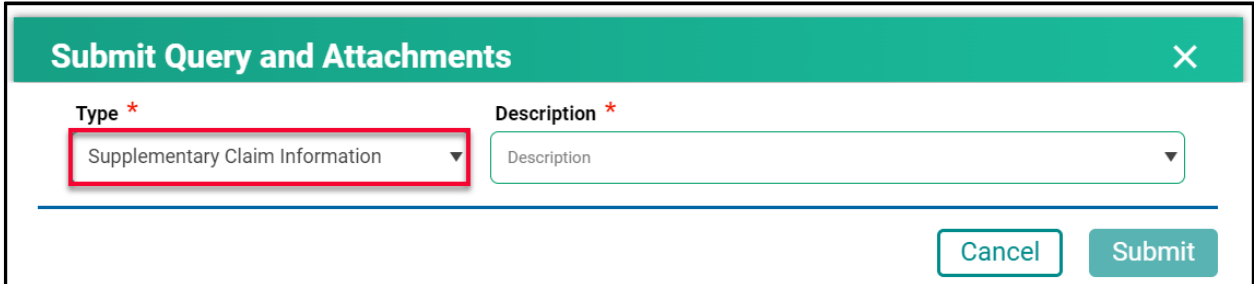
**NOTE:** If a query is submitted on a claim that already has an outstanding query on it, the following message will appear.



## How to Run a Supplementary Claim Information Query

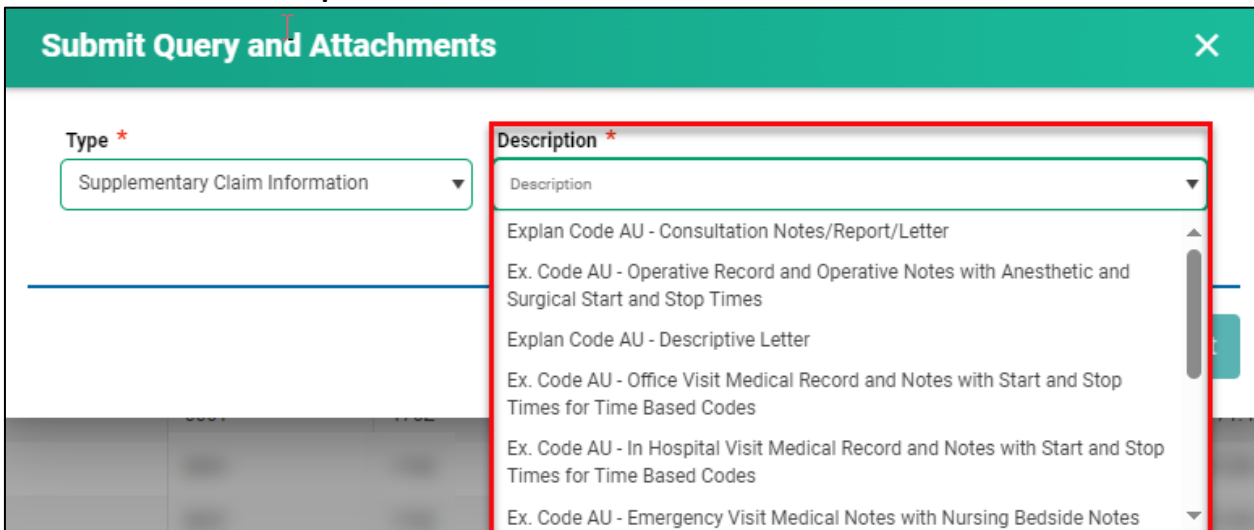
When additional documentation and/or comments are required on a claim, use the **Supplementary Claim Information Query**.

1. Select **Supplementary Claim Information**.



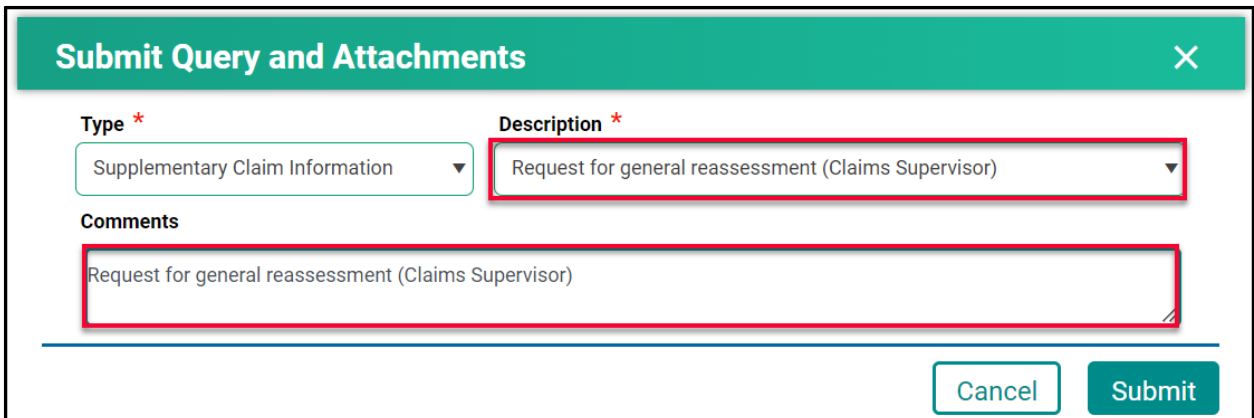
The screenshot shows a form titled "Submit Query and Attachments" with a close button (X) in the top right corner. There are two dropdown menus: "Type \*" and "Description \*". The "Type \*" dropdown is highlighted with a red box and contains the text "Supplementary Claim Information". The "Description \*" dropdown contains the text "Description". At the bottom right, there are two buttons: "Cancel" and "Submit".

2. Select the correct **Description**.



The screenshot shows the same "Submit Query and Attachments" form. The "Type \*" dropdown is still set to "Supplementary Claim Information". The "Description \*" dropdown is expanded, showing a list of options: "Description", "Explain Code AU - Consultation Notes/Report/Letter", "Ex. Code AU - Operative Record and Operative Notes with Anesthetic and Surgical Start and Stop Times", "Explain Code AU - Descriptive Letter", "Ex. Code AU - Office Visit Medical Record and Notes with Start and Stop Times for Time Based Codes", "Ex. Code AU - In Hospital Visit Medical Record and Notes with Start and Stop Times for Time Based Codes", and "Ex. Code AU - Emergency Visit Medical Notes with Nursing Bedside Notes". The entire dropdown menu is highlighted with a red box.

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



The screenshot shows the "Submit Query and Attachments" form. The "Type \*" dropdown is still "Supplementary Claim Information". The "Description \*" dropdown is now set to "Request for general reassessment (Claims Supervisor)". Below this, there is a "Comments" section with a text area containing the text "Request for general reassessment (Claims Supervisor)". The text area is highlighted with a red box. At the bottom right, there are two buttons: "Cancel" and "Submit".

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

**Submit Query and Attachments**

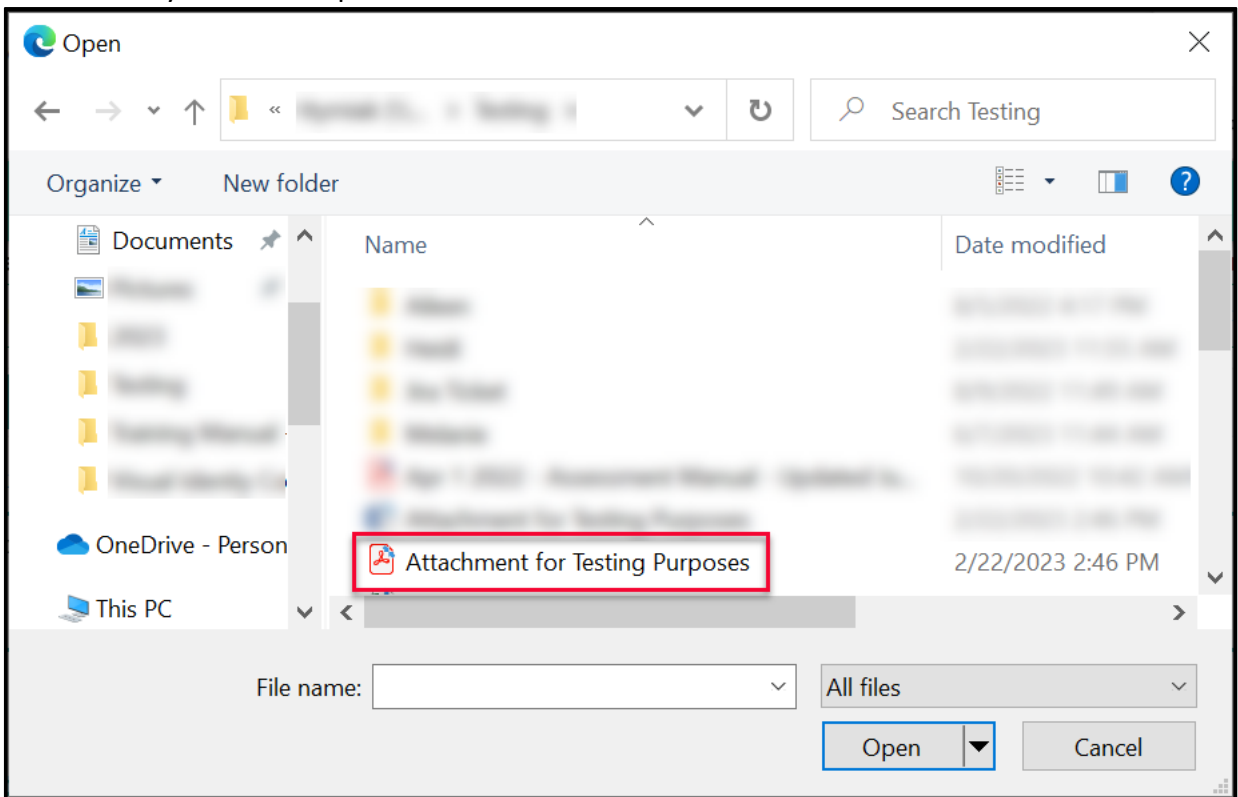
Type \*  
Supplementary Claim Information

Description \*  
Explan Code AU - Consultation Notes/Report/Letter

Attach File  
Choose File No file chosen

Cancel Submit

- 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.

**Submit Query and Attachments**

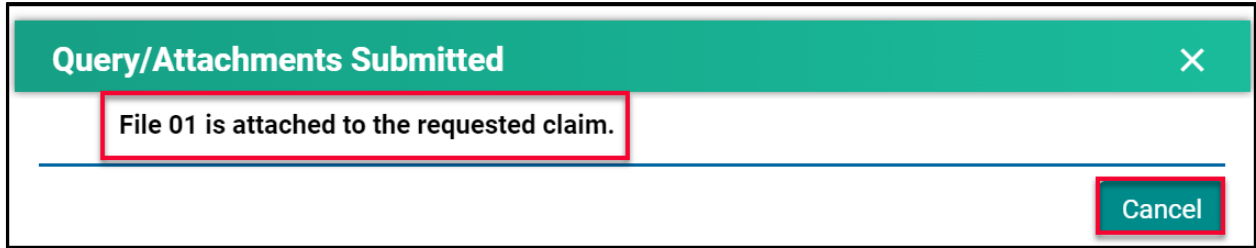
Type \*  
Supplementary Claim Information

Description \*  
Explan Code AU - Consultation Notes/Report/Letter

Attach File  
Choose File Attachment f... Purposes.pdf

Cancel Submit

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

#### Action required:

- 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

#### Action required:

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

**Submit Query and Attachments** [X]

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.

The screenshot shows a web form titled "Submit Query and Attachments" with a green header and a close button (X). Below the header, there are two dropdown menus. The first is labeled "Type \*" and has "Claim Query" selected. The second is labeled "Description \*" and has "Physician Requested Recovery - Billed in error" selected. At the bottom right of the form, there are two buttons: "Cancel" and "Submit".

- 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.

#### Action required:

- 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.

**Submit Query and Attachments** [X]

Type \* [Supplementary Claim Information] Description \* [Request for general reassessment (Claims Supervisor)]

Comments

Physician saw the same patient, in the same clinic, on the same day as follows:

First visit  
Patient came in for a complete physical assessment (3B) at 9am.

Second visit  
Patient returned at 3pm in the afternoon as they broke their ankle. Physician assessed their ankle and sent them to the ER (5B).

Attach File

Choose File No file chosen

File format must be .doc, .docx, .jpeg, .txt & .pdf

Cancel Submit

- No action required on the claim with 3B.



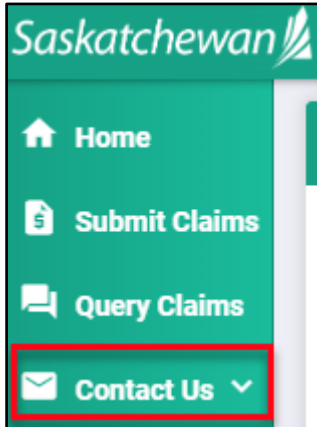
# Module SEVEN – Contact Us

## Contact Us

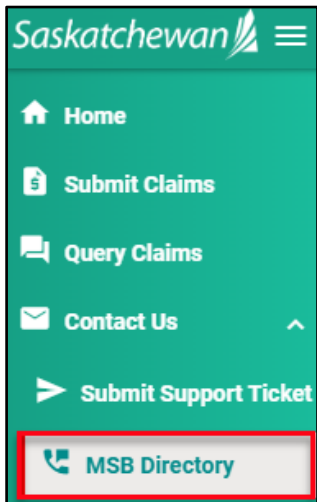
When requiring support with a claim or Customer Portal call **1-800-605-2965**, Monday to Friday from 8:00am to 5:00pm.

## MSB Directory

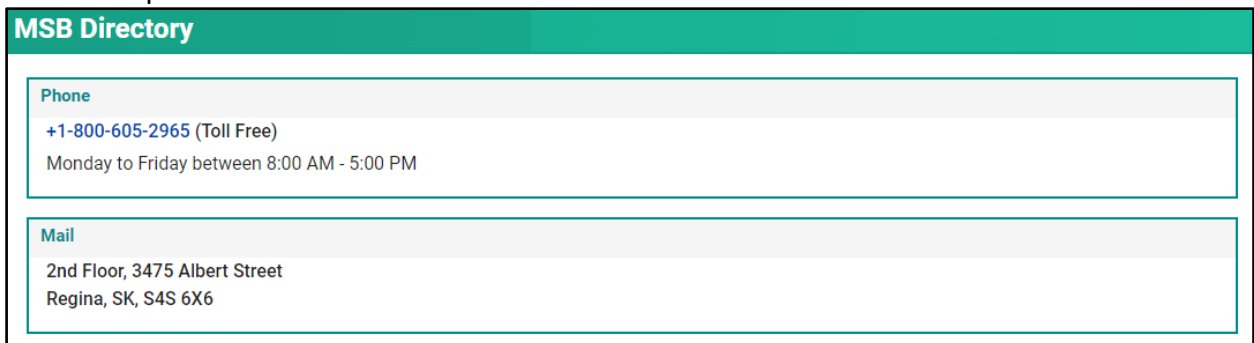
1. Click on **Contact Us**.



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



3. Select an option to contact MSB.



## Medical Services Branch



Claims Replacement Project