

# Customer Portal (CP) Real Time Submissions For Dentists User Manual



**Medical Services Branch**



Claims Replacement Project

# Table of Contents

- Module ONE: Overview ..... 1
  - Learning Objectives..... 1
  - Overview of Customer Portal..... 1
  - Benefits of Customer Portal..... 1
- Module TWO – Getting Started ..... 2
  - Getting Started..... 2
  - Logging In..... 2
  - Multi-Factor Authentication (MFA) ..... 2
- Module THREE – Navigating Customer Portal ..... 3
  - Top Menu Bar..... 3
  - Home Page ..... 4
  - Navigation Menu ..... 5
- Module FOUR – Dentists Submitting Real-Time Claims..... 6
  - What is Real-Time Submission?..... 6
  - Submissions for Dentists ..... 6
- Module FIVE – Provider Remittance Advice..... 13
  - Provider Remittance Advice..... 13
- Module SIX – Query Claims ..... 14
  - Query Claims..... 14
  - Claim Query ..... 14
  - Supplementary Claim Information ..... 15
  - Query Claims..... 16
  - How to Run a Claim Query..... 19
  - How to Run a Supplementary Claim Information Query ..... 21
  - Handling Rejected Line Items..... 24
    - Scenario #1 ..... 24
    - Scenario #2 ..... 24
    - Scenario #3 ..... 25
    - Scenario #4 ..... 25
    - Scenario #5 ..... 26
- Module SEVEN – Contact Us..... 27
  - Contact Us ..... 27
  - MSB Directory ..... 27

# Module ONE: Overview

## Learning Objectives

Upon completion, learners will have an understanding of:

- The advantages of Customer Portal.
- Who uses Customer Portal?
- How to enter and submit claims in **Real Time**.

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## 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. All users will have authorization to submit patient claims to Saskatchewan Health for compensation.

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).

## 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 in **Real-Time**.
2. Submit a query submission on individual claims.
3. Ability to access payment schedules, newsletters, and 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 a 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 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's 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

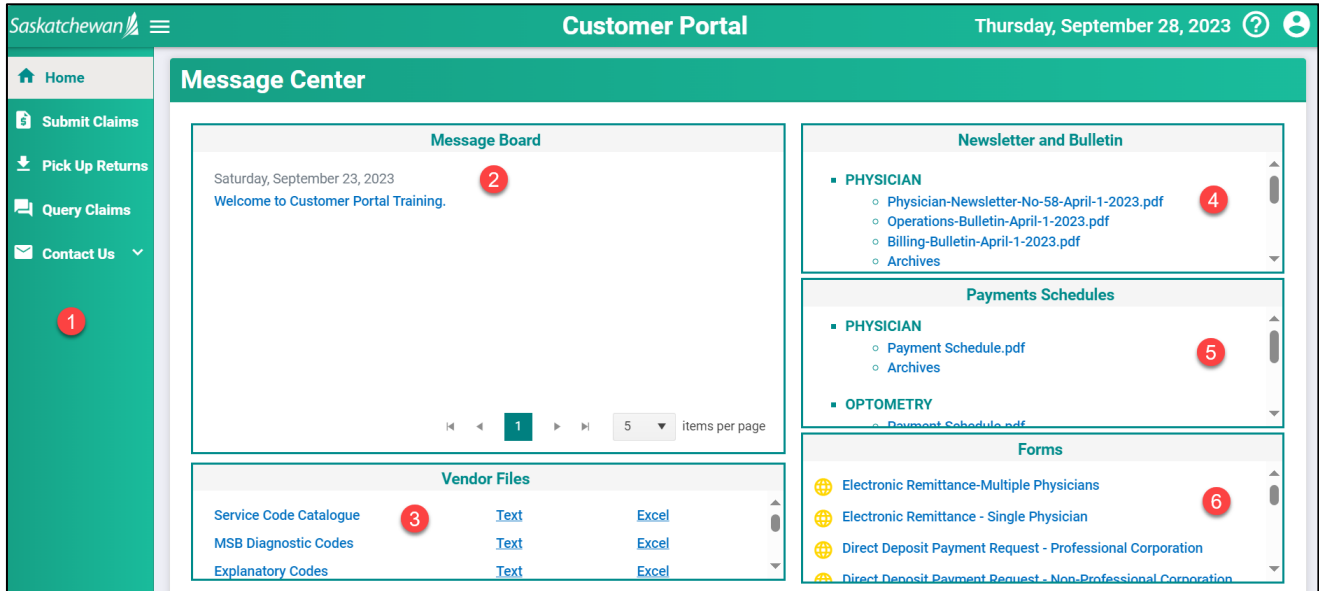
The top menu bar in Customer Portal provides four main options:



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

## Home Page

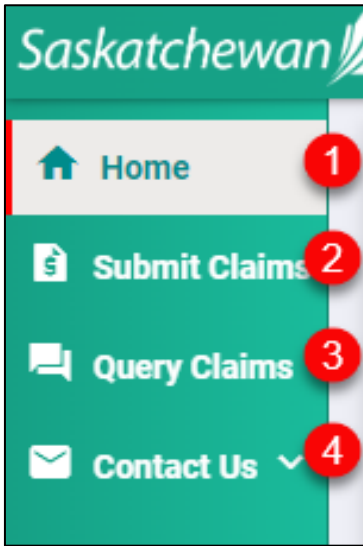
The **Home Page** or **Landing Page** is the first screen that appears when logging into Customer Portal. It serves as a gateway to the application’s features and functionality.



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	User enters in claim details and submits the claim in Real Time.
3	Query Claims	Users can search for submitted claims with the option of adding additional information or recovering an already submitted claim.
4	Contact Us	Provides several options for contacting Medical Services.

# Module FOUR – Dentists Submitting Real-Time Claims

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## What is Real-Time Submission?

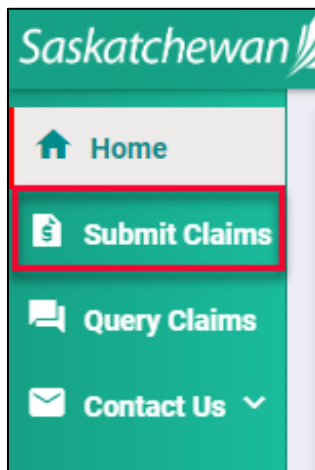
Real-Time submission refers to the process of submitting claim information through an online system (Customer Portal). When a claim is submitted in real-time, it means the data is transmitted and received immediately by the Claims Processing System (CPS), allowing for quick processing and adjudication of the claim.

## Submissions for Dentists

Your profile will be set to match your credentials so that when you click on **Submit Claim**, your professional information is pre-loaded.

All fields marked with a **red asterisk \*** are mandatory fields. Your claim cannot be submitted if a mandatory field(s) is left blank. Other fields are optional; however, it is highly recommended to enter as much information as possible. The level of detail provided directly correlates with the accuracy of the adjudication process for your claim.

1. Click on **Submit Claims**.





- Several fields will be pre-populated based on your profile. These fields will have a grey background and cannot be adjusted or changed. Review these fields to ensure the information is accurate. The **Corporation ID** will be an open field ONLY if you are incorporated.

**Service Provider**

Medical Provider's Details Real Time Claim

Provider Province \* Billing No \* Last Name First Name Clinic No \* Mode \* Corporation ID

SK [ ] [ ] [ ] [ ] 002 1 Corporation ID [ ]

---

Clinic Name Address City Province Postal Code

Dental [ ] SASKATOON SK S7W 0T4

- Your **Clinic No** and **Mode** will automatically populate. If you submit claims for different clinics and/or modes, alternate options are available in the drop-down menus.

**Service Provider**

Medical Provider's Details Real Time Claim

Provider Province \* Billing No \* Last Name First Name Clinic No \* Mode \* Corporation ID

SK [ ] [ ] [ ] [ ] 002 1 Corporation ID [ ]

---

Clinic Name Address City Province Postal Code

Dental [ ] SASKATOON SK S7W 0T4

- Enter the **Patient Information**, which includes their **Health Card No.**, **Last Name**, **First Name**, **Date of Birth** and **Gender**.

**Patient's Details**

Health ID Province \* Health Card No. \* Last Name \* First Name \* Birth Month & Year \* Gender \*

SK [ ] Health Card No. [ ] Last Name [ ] First Name [ ] MM/YYYY [ ] Gender [ ]

- The Claim Type and Service Location are optional fields. However, if that information is critical to the claim be sure to select the correct option from the drop-down menu.

**Medical Claims**

Claim Type Service Location

Claim Type [ ] Service Location [ ]

- Enter the **Service Date From** in the format of YYYY-MM-DD.

**Medical Claims**

Note : At least one line item is required to submit a claim +

Service Date From \* Service Date To ICD-9 Code \* Service Code \* Units \* Billed Amount \* LOS \* Referred By Start Time Stop Time Special Circ Bilateral Ind Facility No

2023-06-01 YYYY-MM-DD ICD-9 Code Service Code 1 Billed Amoi LOS [ ] Referred E Start TI... Stop Time Special ... [ ] Bilateral Ind [ ] Facility No

- The **Service Date To** is NOT a mandatory field and is only required for services that occur over several days.

**Medical Claims**

Note : At least one line item is required to submit a claim +

Service Date From \* Service Date To ICD-9 Code \* Service Code \* Units \* Billed Amount \* LOS \* Referred By Start Time Stop Time Special Circ Bilateral Ind Facility No

2023-06-01 YYYY-MM-DD ICD-9 Code Service Code 1 Billed Amoi LOS [ ] Referred E Start TI... Stop Time Special ... [ ] Bilateral Ind [ ] Facility No

8. Enter the **ICD-9 Code**.

**Medical Claims**  
 Note : At least one line item is required to submit a claim +

Service Date From *	Service Date To *	ICD-9 Code *	Service Code *	Units *	Billed Amount *	LOS *	Referred By	Start Time	Stop Time	Special Circ	Bilateral Ind	Facility No
2023-06-01	YYYY-MM-DD	525	Service Code	1	Billed Amo	LOS	Referred By	Start Time	Stop Time	Special C...	Bilateral Ind	Facility No

9. Enter the **Service Code**.

**Medical Claims**  
 Note : At least one line item is required to submit a claim +

Service Date From *	Service Date To *	ICD-9 Code *	Service Code *	Units *	Billed Amount *	LOS *	Referred By	Start Time	Stop Time	Special Circ	Bilateral Ind	Facility No
2023-06-01	YYYY-MM-DD	525	094Z	1	Billed Amo	LOS	Referred By	Start Time	Stop Time	Special C...	Bilateral Ind	Facility No

10. Enter the **Units** associated with the claim. It will default to 1 but can be changed.

**Medical Claims**  
 Note : At least one line item is required to submit a claim +

Service Date From *	Service Date To *	ICD-9 Code *	Service Code *	Units *	Billed Amount *	LOS *	Referred By	Start Time	Stop Time	Special Circ	Bilateral Ind	Facility No
2023-06-01	YYYY-MM-DD	525	094Z	1	Billed Amo	LOS	Referred By	Start Time	Stop Time	Special C...	Bilateral Ind	Facility No

18. Enter the **Billed Amount** for the claim. This amount should reflect the correct amount based on the Service Code and the number of units entered.

**Medical Claims**  
 Note : At least one line item is required to submit a claim +

Service Date From *	Service Date To *	ICD-9 Code *	Service Code *	Units *	Billed Amount *	LOS *	Referred By	Start Time	Stop Time	Special Circ	Bilateral Ind	Facility No
2023-06-01	YYYY-MM-DD	525	094Z	1	410.05	LOS	Referred By	Start Time	Stop Time	Special C...	Bilateral Ind	Facility No

19. Enter the **LOS (Location of Service)**, by selecting from the drop-down menu or by typing the number into the field.

**Medical Claims**  
 Note : At least one line item is required to submit a claim +

Service Date From *	Service Date To *	ICD-9 Code *	Service Code *	Units *	Billed Amount *	LOS *	Referred By	Start Time	Stop Time	Special Circ	Bilateral Ind	Facility No
2023-06-01	YYYY-MM-DD	525	094Z	1	410.05	LOS	Referred By	Start Time	Stop Time	Special C...	Bilateral Ind	Facility No

1 - Office  
 2 - Hospit In-Patient  
 3 - Hospit Out-

20. Enter the **Referred By** 4-digit doctor number, if applicable.

**Medical Claims**  
 Note : At least one line item is required to submit a claim +

Service Date From *	Service Date To *	ICD-9 Code *	Service Code *	Units *	Billed Amount *	LOS *	Referred By	Start Time	Stop Time	Special Circ	Bilateral Ind	Facility No
2023-06-01	YYYY-MM-DD	525	094Z	1	410.05	1 - ...	Referred By	Start Time	Stop Time	Special ...	Bilateral Ind	Facility No

21. Enter the **Start Time** and **Stop Time** if the Service Code entered requires this information.

**Medical Claims**  
 Note : At least one line item is required to submit a claim +

Service Date From	Service Date To	ICD-9 Code	Service Code	Units	Billed Amount	LOS	Referred By	Start Time	Stop Time	Special Circ	Bilateral Ind	Facility No
2023-06-01	YYYY-MM-DD	525	094Z	1	410.05	1 - ...	Referred By	Start Time	Stop Time	Special ...	Bilateral Ind	Facility No

22. Enter the **Special Circumstances**, if applicable.

**Medical Claims**  
 Note : At least one line item is required to submit a claim +

Service Date From	Service Date To	ICD-9 Code	Service Code	Units	Billed Amount	LOS	Referred By	Start Time	Stop Time	Special Circ	Bilateral Ind	Facility No
2023-06-01	YYYY-MM-DD	525	094Z	1	410.05	1 - ...	Referred By	Start Time	Stop Time	Special Cir	Bilateral Ind	Facility No

1 - 1 of 1 items per page

Other Remarks

Special Circumstance Indicator	Description
TF	<b>Billing Technical Fees Only</b> (Service Codes with Fee Determinant W or X) (Has three fees – ie. 11W or 100X)
PF	<b>Interpretation Fees Only</b> (Service Codes with Fee Determinant W or X) (Has three fees – ie. 11W or 100X)
CF	<b>Combined Tech and Interp. Fees</b> (Service Codes with Fee Determinant W or X) (Has three fees – ie. 11W or 100X)
TA	<b>Takeover - Anesthetic</b>

23. Enter the **Bilateral Indicator**, using the drop-down menu, if applicable.

**Medical Claims**  
 Note : At least one line item is required to submit a claim +


Service Date From	Service Date To	ICD-9 Code	Service Code	Units	Billed Amount	LOS	Referred By	Start Time	Stop Time	Special Circ	Bilateral Ind	Facility No
2023-06-01	YYYY-MM-DD	525	094Z	1	410.05	1 - ...	Referred By	Start Time	Stop Time	Special ...	Bilateral Ind	Facility No

1 - 1 of 1 items per page

Other Remarks


24. Enter the **Facility No**, if applicable.


**Medical Claims**

Note : At least one line item is required to submit a claim 

Service Date From *	Service Date To	ICD-9 Code *	Service Code *	Units *	Billed Amount *	LOS *	Referred By	Start Time	Stop Time	Special Circ	Bilateral Ind	Facility No
2023-06-01	YYYY-MM-DD	525	094Z	1	410.05	1 - ...	Referred By	Start Time	Stop Time	Special ...	Bilateral Ind	Facility No



If additional line(s) are required for the claim details, click on the  to add a new line. Then follow the above steps to enter the appropriate information.

Add as many additional lines as needed. If a line is added in error, click the  at the end of the line to remove it.


25. In some cases, additional **Provider Remarks** are required and can be entered into the **Other Remarks** field. This is an open forum to type. Be as detailed as possible. There is a maximum of 770 characters. This field is optional.

**Other Remarks**


Add in additional details and supporting information for the claim adjudication.

*Maximum Characters : 770 , Current Characters Count: 80*

26. If a detailed report of supporting documentation is required, the document can be attached to the claim in Customer Portal. The file format can be in pdf, word, excel, jpeg, png.

Click on the .


**Document Attachment and Submission**


**Upload Documents** 

File Name	Document Type	Comments
No records available.		

27. Click on **Browse** to select the file from your desktop/laptop.

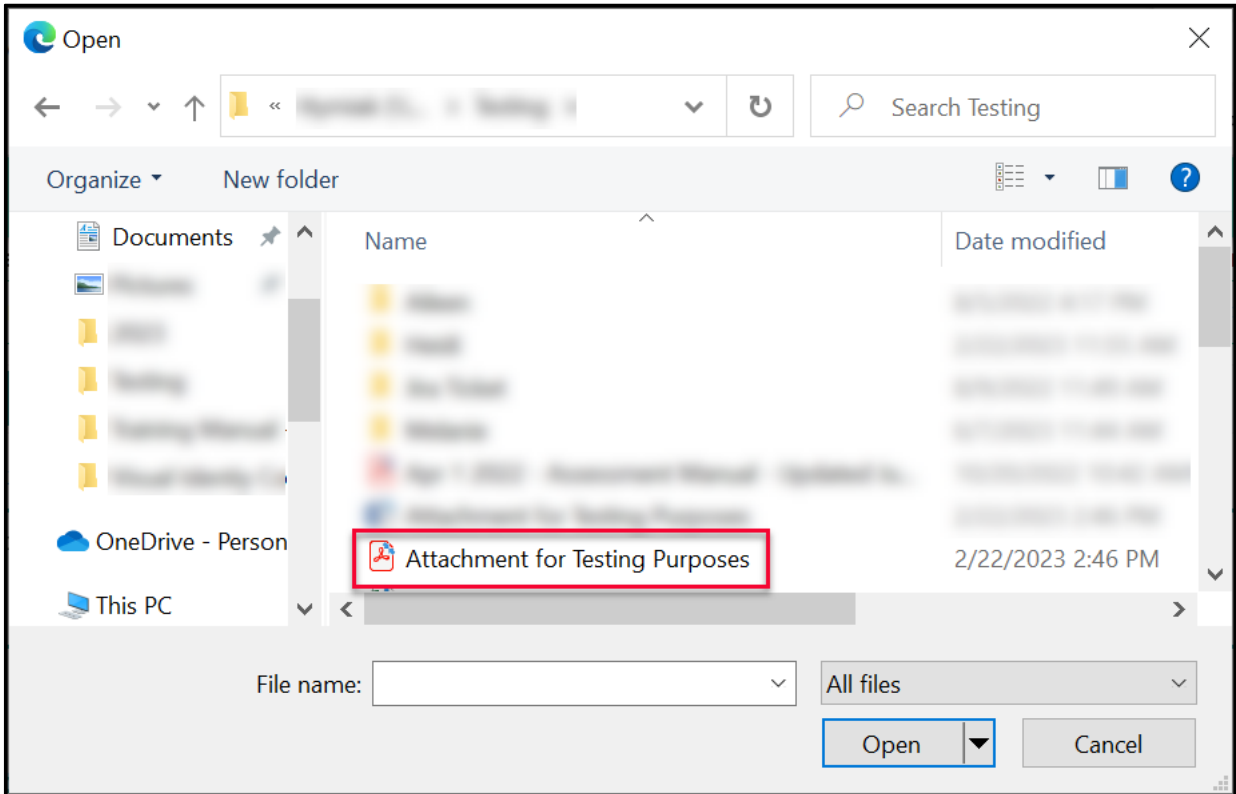
**Document Attachment and Submission**

**Upload Documents** 

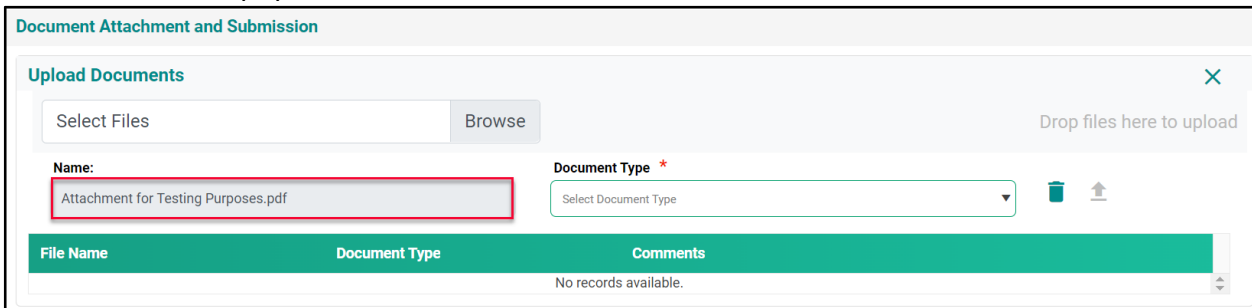
Select Files  Drop files here to upload

File Name	Document Type	Comments
No records available.		

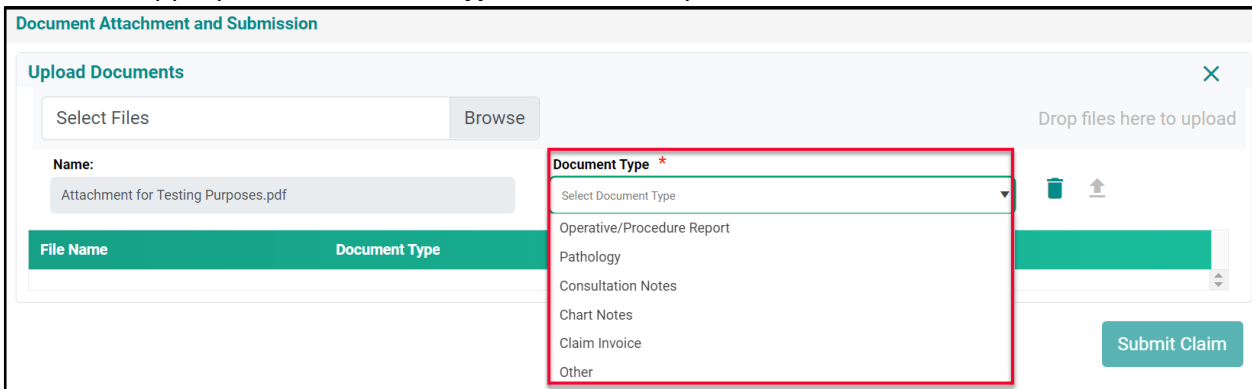
28. Find the file you wish to upload then **double-click** on the file name.



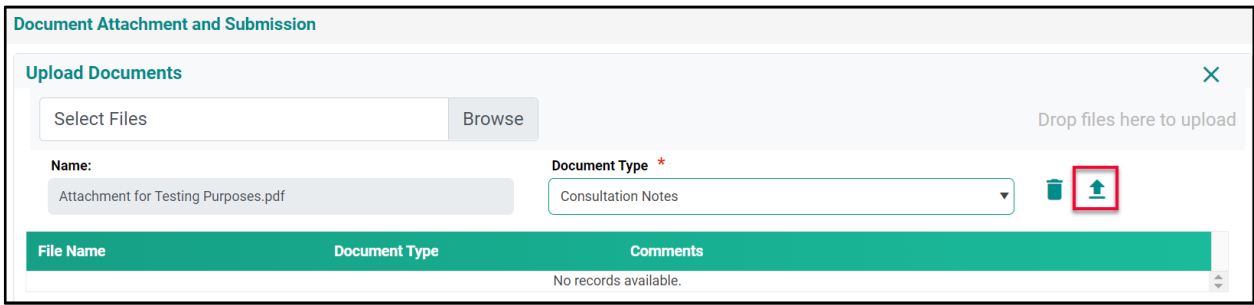
29. The file name will populate under the **Name** field.



30. Select the appropriate **Document Type** from the drop-down menu.

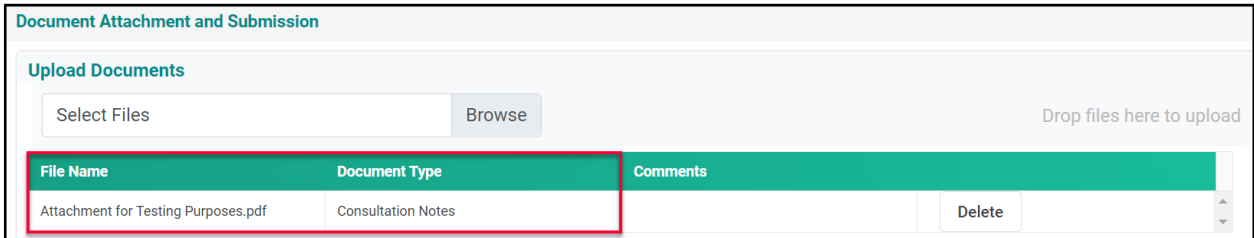


31. Click the  to upload your file.



File Name	Document Type	Comments
No records available.		

32. Once the file has uploaded, the **File Name** and **Document Type** will appear in the window.

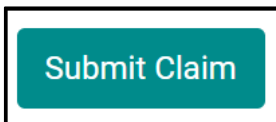


File Name	Document Type	Comments
Attachment for Testing Purposes.pdf	Consultation Notes	



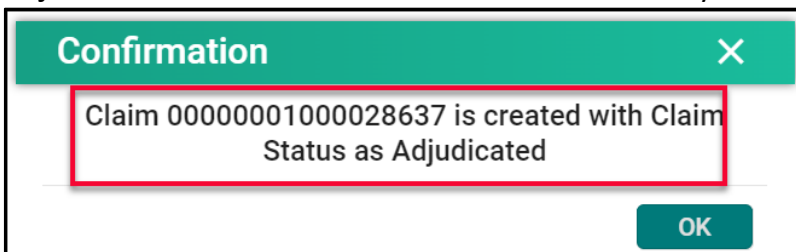
At this point, all claim information has been entered. Take a moment to review the data entered to ensure accuracy. **It is recommended to take a screen shot of the claim for your records, as once Submitted the claim cannot be viewed again.**

33. Click **Submit** when all details of the claim have been entered.



If the **Submit Claim** button is greyed out it means there is a mandatory field of information missing on the claim. The field missing the information will be highlighted in **red font**. Enter in the required information and then click the **Submit Claim** button.

34. When the **Confirmation** message appears displaying, the **claim number** and the **status of Adjudicated** click **OK**. Your claim has been successfully submitted for adjudication.



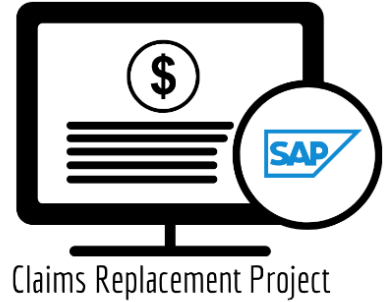
Confirmation

Claim 00000001000028637 is created with Claim Status as Adjudicated

OK

# Module FIVE – Provider Remittance Advice

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## Provider Remittance Advice

On a bi-weekly basis, the **Provider Remittance Advice (Bi-Weekly Return File)** is mailed via Canada Post. The **Provider Remittance Advice** provides a summary of all claims submitted along with the status of each claim. It is recommended to reconcile the **Provider Remittance Advice** to your submitted claims.

The **Provider Remittance Advice** will itemize the claims based on their status:

- **Paid (Payment List)** claims paid on the bi-weekly run.

Saskatchewan												
Payment List												
Payee Name		Run Code	Payment Date	Payment Mode	Clinic	Doctor Number	Prof.Crop.					
LastName208		ad	2023-03-24	1	687	2087						
Payee Name	Province Code	Health Services Number	Claim #	Date of Service	Submitted			Paid				Explain Code
					Code	Fees	Code	# of Srvs	Fee	Premiums	Prog. Payments	
	SK		1000023793	2022-12-21	580P	100.00	580P	1	100.00	0.00	0.00	
	SK		1000023794	2022-12-21	580P	100.00	580P	1	100.00	0.00	0.00	
<b>Total</b>						200.00		2	200.00	0.00	0.00	

- **Pended** claims are under review by MSB.

Saskatchewan													
Pended List													
Payee Name		Run Code	Payment Date	Payment Mode	Clinic	Doctor Number	Prof. Crop.						
LastName2087 FirstName		ad	2023-03-24	1	687	2087							
Payee Name	Province	Health Services Number	Sex	Date of Birth	Claim#	Ref. Provider	Date of Service From	Date of Service To	LOS	Submitted			Explain Code
										# of Services	Code	Fees	
	SK		F	1990-03	1000023793		2022-12-21	2022-12-21		1		0.00	
<b>Total</b>										0		1.00	

- **Rejected** claims require adjustments to be made by your office. Review the Explanatory Code to understand why the claim was rejected, then either make the appropriate adjustment(s) and re-submit the claim or query the claim to add additional information.

Saskatchewan													
Rejected List													
Payee Name		Run Code	Payment Date	Payment Mode	Clinic	Doctor Number	Prof.Crop.						
LastName17		ad	2023-03-24	1	071	1617							
Payee Name	Province	Health Services Number	Sex	Date of Birth	Claim #	Ref. Provider	Service From	Service To	LOS	Submitted			Explain Code
										# of Srvs	Code	Fees	
	SK		F	2022-05-06	1000020663		2023-02-01	2023-02-01	2	1	580N	50.00	FM
<b>Total</b>										1		50.00	

# Module SIX – Query Claims

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## Query Claims

From time to time, additional information needs to be added to a claim or a claim needs to be drawn back 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

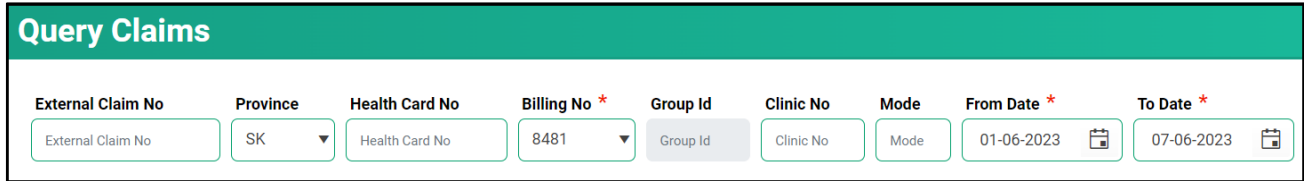
**Supplementary Claim Information** is typically used when supporting documentation must be added to the claim, or a special request, like time extension or Medical Consultant Review, is required. All claims queried with **Supplementary Claim Information** are reviewed by MSB. After reviewing the claim,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

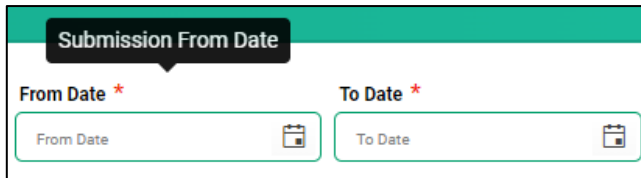
To query a claim certain claim criteria must be entered. All mandatory fields must be entered to perform the query. However, additional search fields can also be entered. The more specific the search criteria, the more defined the results.



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, date "01-06-2023"), and To Date \* (calendar icon, date "07-06-2023").

The mandatory fields are:

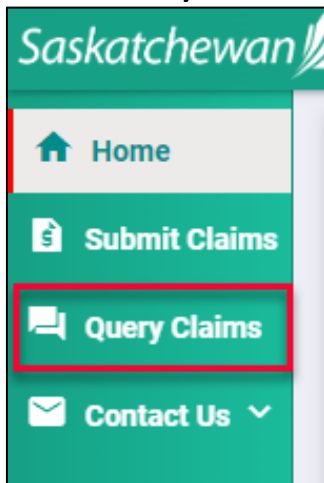
- **Billing No** (Auto-populated based on your login profile. If set to bill for more than one billing number, select the appropriate number from the drop-down list.)
- **Submission From Date**
- **Submission To Date**



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 Date** and **To 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.

The screenshot shows the 'Query Claims' form with the following fields and values:

- CPS Claim No: [Empty]
- External Claim No: [Empty]
- Province: SK
- Health Card No: [Empty]
- Billing No: 4733
- Group Id: [Empty]
- Clinic No: [Empty]
- Mode: [Empty]
- 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.

The screenshot shows the 'Query Claims' results table with the following data:

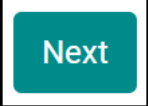
	CPS Claim No.	Ext Claim No.	Prov	HSN	Sub SC	DOS From	DOS To	Status	Paid SC	Paid LOS	Paid NOS	Paid Eligible A...	Paid Total A...	Explan Codes
<input type="checkbox"/>	1030023043		SK	370163829	038U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA
<input type="checkbox"/>	1030023043		SK	370163829	037U	2023-06-15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

- 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.

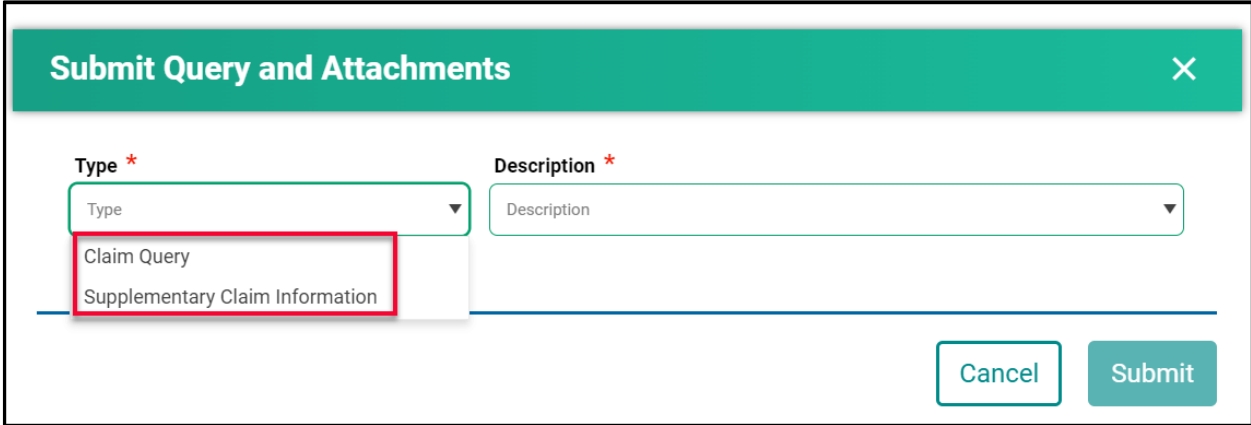
The screenshot shows the 'Query Claims' results table with the first row selected (checked):

	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

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 close button (X) in the top right corner. 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 Description \*

Type Description

Claim Query

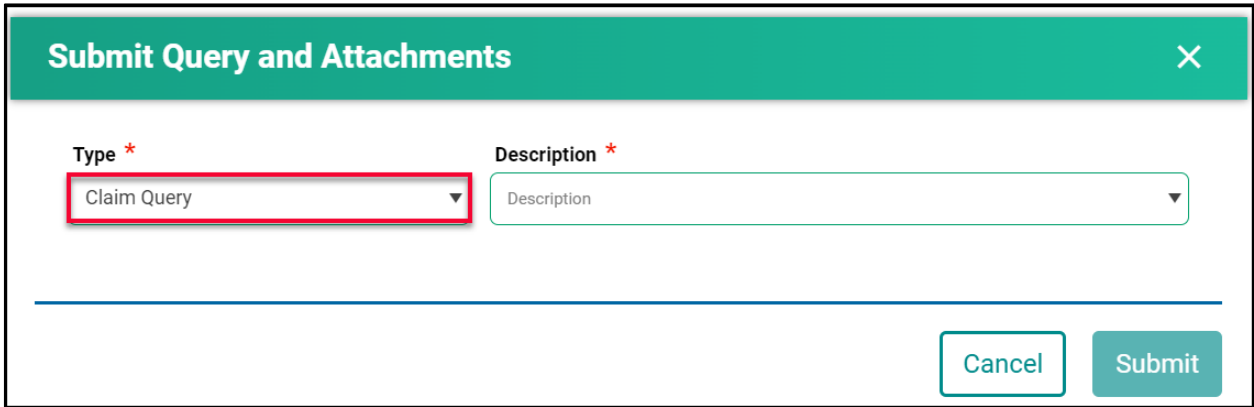
Supplementary Claim Information

Cancel Submit

## How to Run a Claim Query

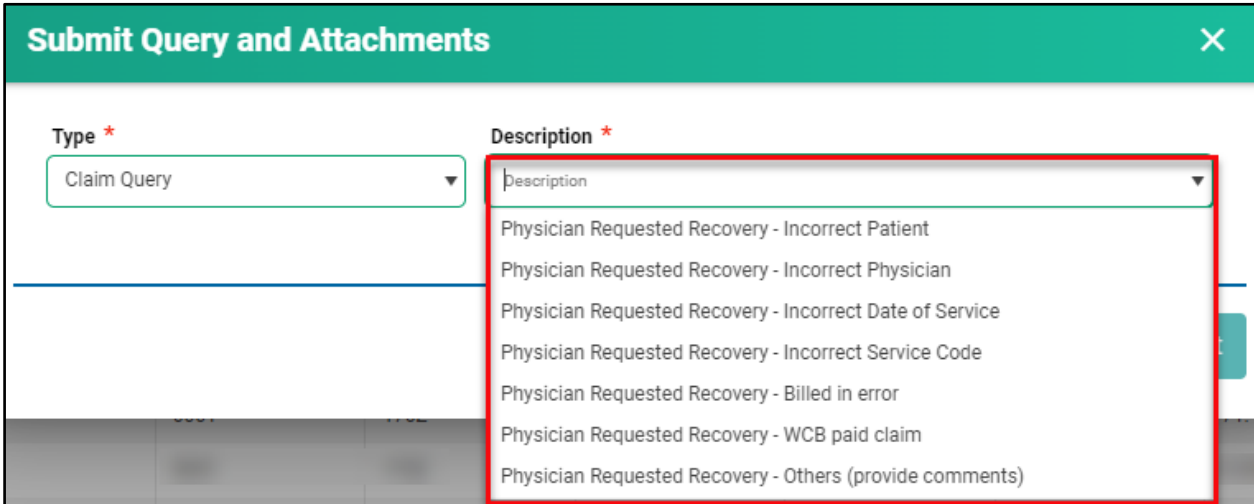
When drawing back a claim due to an error on the initial submission, use the **Claim Query** option.

1. Select **Claim Query**.



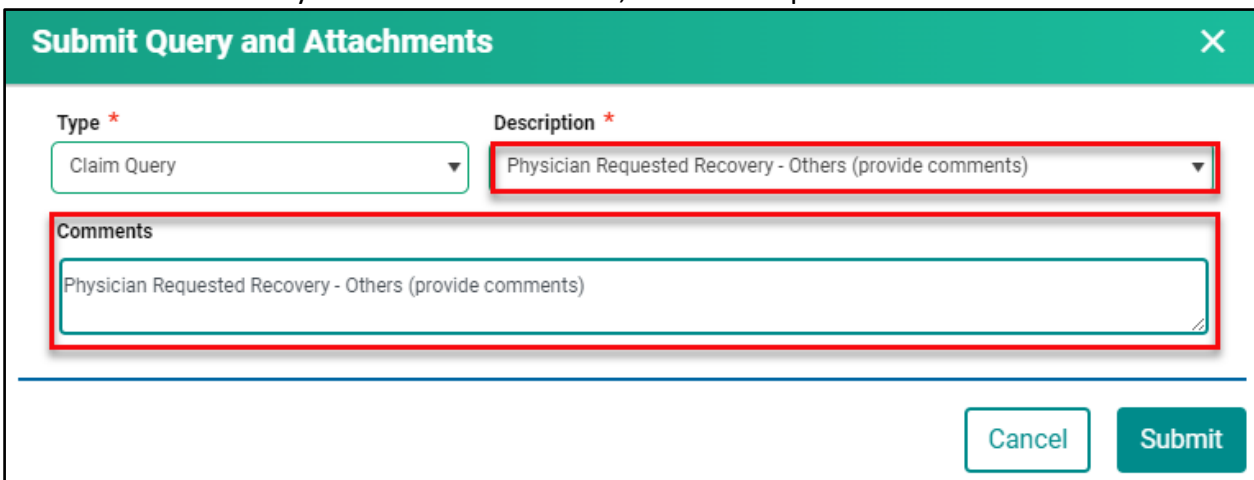
The screenshot shows a form titled "Submit Query and Attachments" with a close button (X) in the top right corner. There are two dropdown menus: "Type \*" and "Description \*". The "Type \*" dropdown is highlighted with a red box and contains the text "Claim Query". The "Description \*" dropdown contains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

2. Select the correct **Description**.



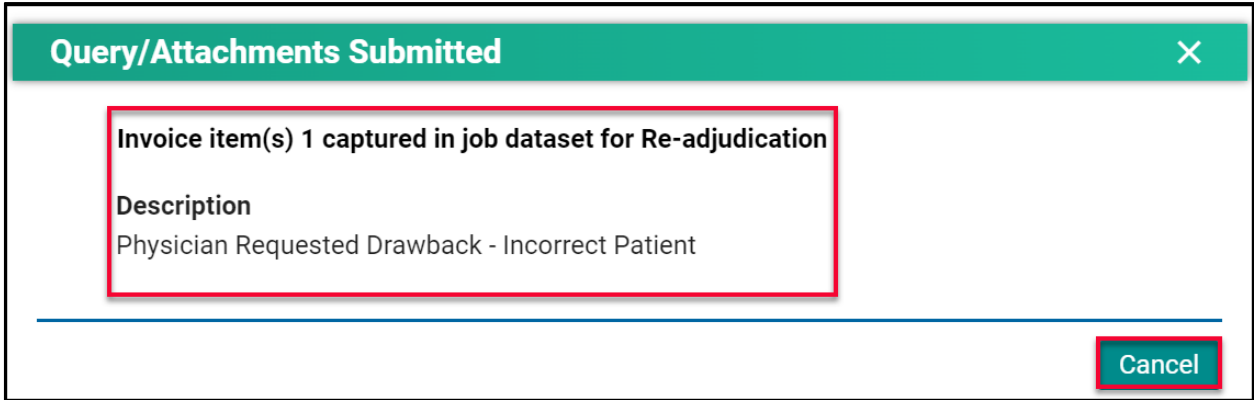
The screenshot shows the same "Submit Query and Attachments" form. The "Type \*" dropdown is still set to "Claim Query". The "Description \*" dropdown menu is open, showing a list of options. The entire dropdown menu is highlighted with a red box. The options are: "Description", "Physician Requested 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)".

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.

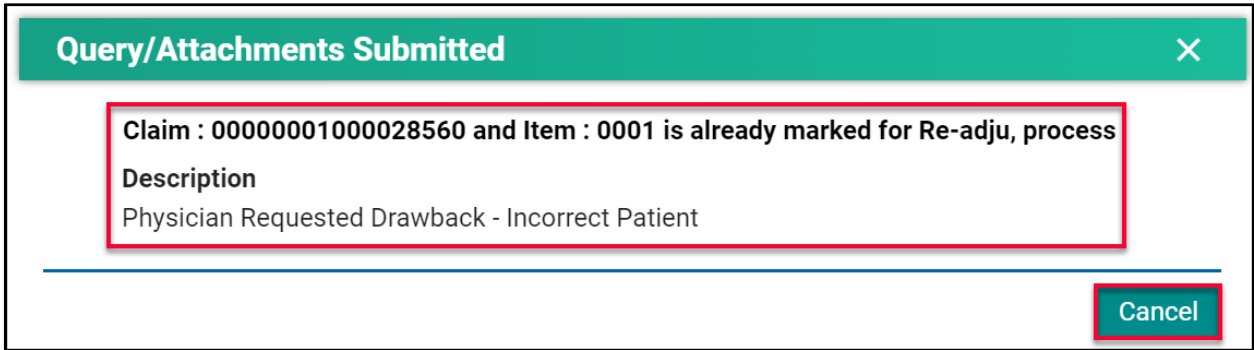


The screenshot shows the "Submit Query and Attachments" form. The "Type \*" dropdown is "Claim Query". The "Description \*" dropdown is highlighted with a red box and contains "Physician Requested Recovery - Others (provide comments)". Below the dropdowns is a "Comments" field, also highlighted with a red box, containing 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**.



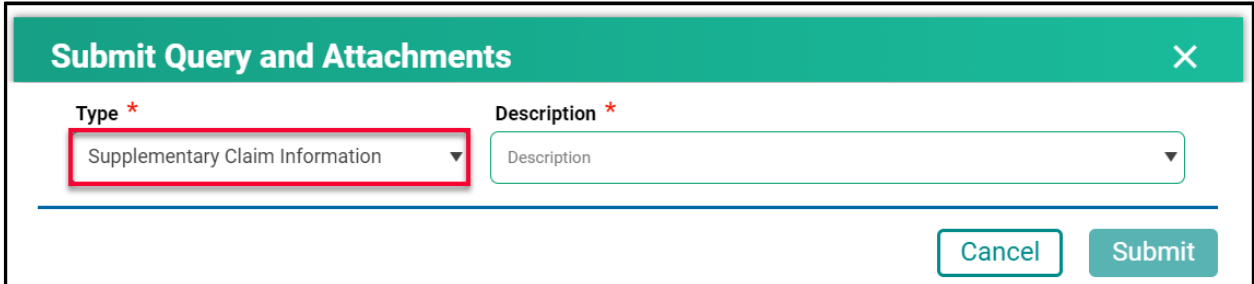
**NOTE:** If a query is submitted on a claim that already has an outstanding query on it, the following message will appear.



## How to Run a Supplementary Claim Information Query

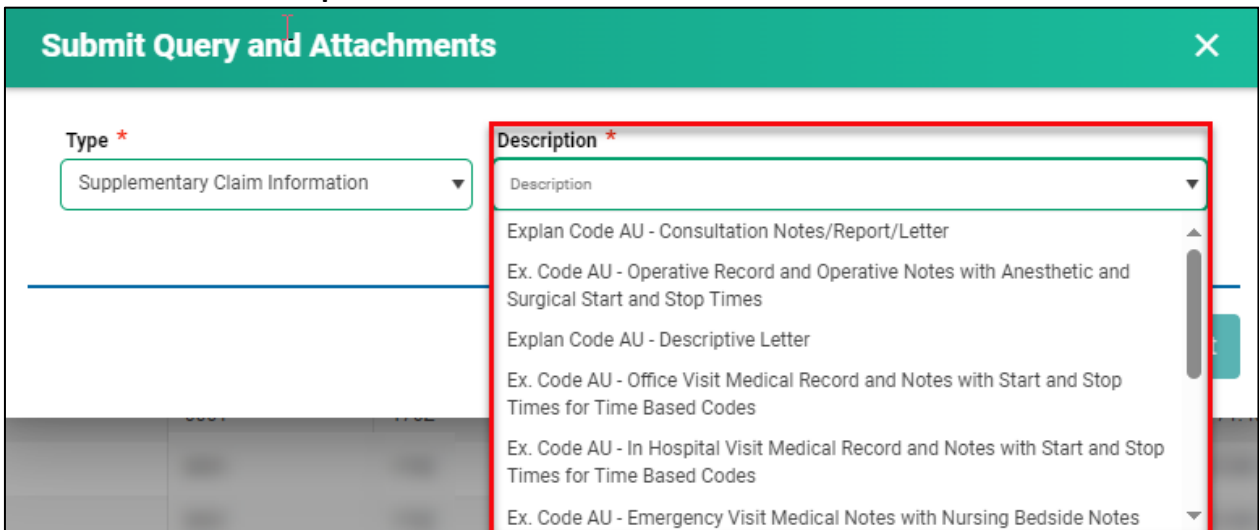
When additional documentation and/or comments are required on a claim, use the **Supplementary Claim Information Query**.

1. Select **Supplementary Claim Information**.



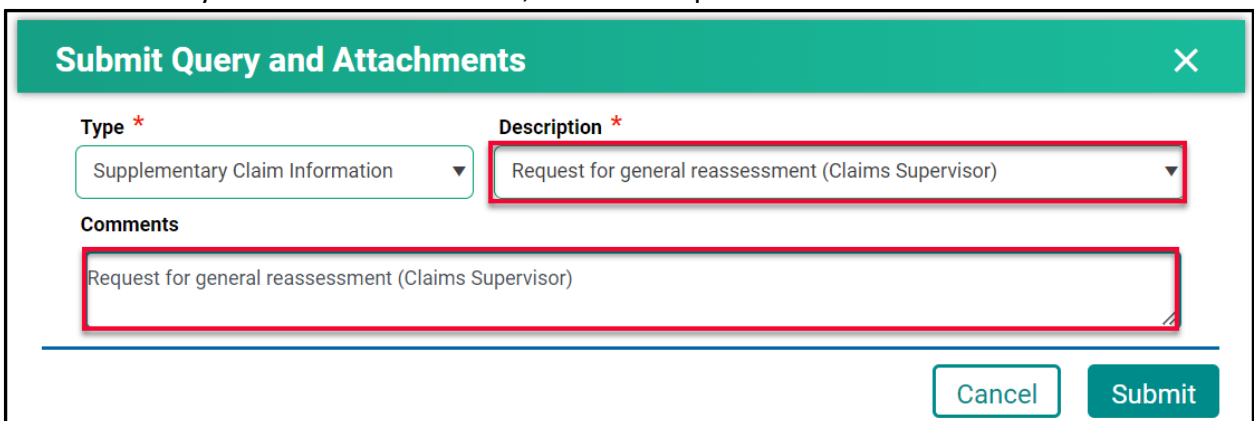
The screenshot shows a modal window titled "Submit Query and Attachments" with a close button (X) in the top right corner. Below the title bar, there are two dropdown menus. The first is labeled "Type \*" and has "Supplementary Claim Information" selected. The second is labeled "Description \*" and has "Description" selected. At the bottom right, there are two buttons: "Cancel" and "Submit".

2. Select the correct **Description**.



The screenshot shows the same modal window as above, but the "Description \*" dropdown menu is expanded. The options listed are: "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".

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 modal window with the "Description \*" dropdown menu selected to "Request for general reassessment (Claims Supervisor)". Below this, there is a text area labeled "Comments" which contains the text "Request for general reassessment (Claims Supervisor)". At the bottom right, there are two buttons: "Cancel" and "Submit".

- 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**

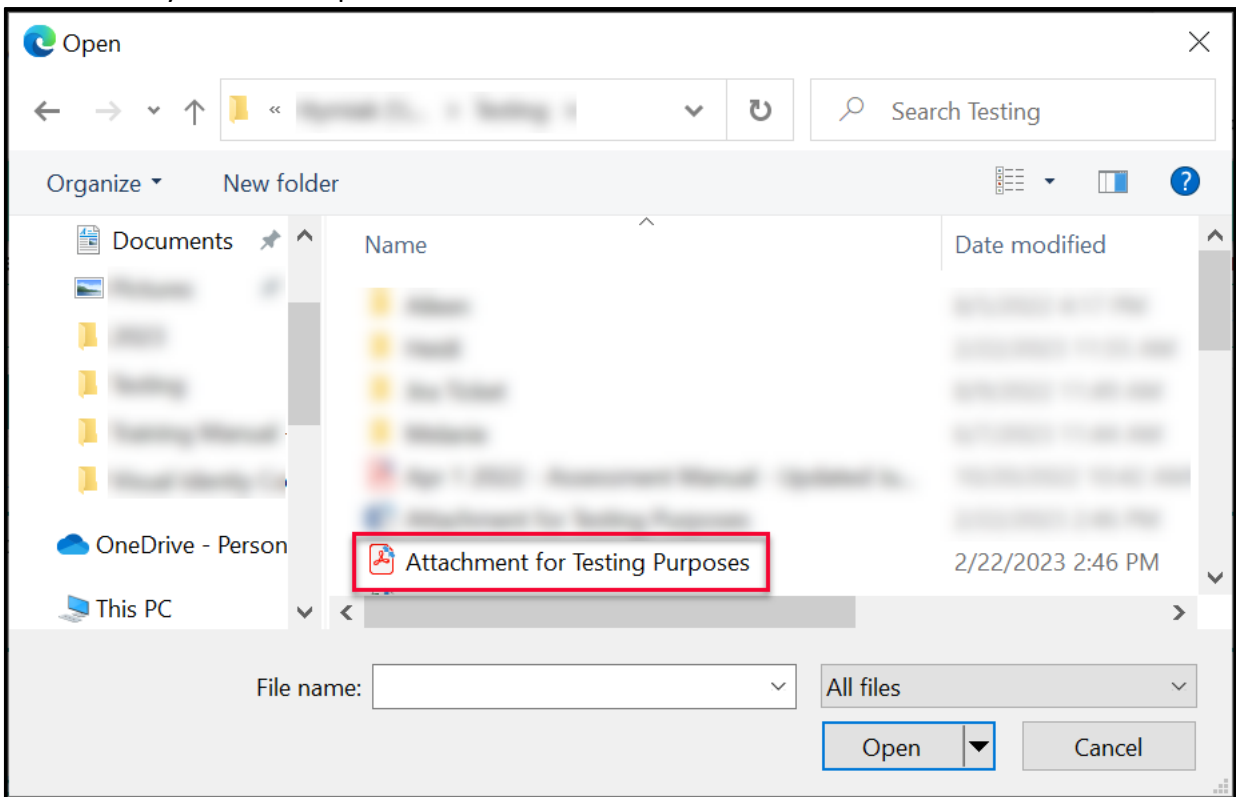
Type \*  
Supplementary Claim Information

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

Attach File  
Choose File No file chosen

Cancel Submit

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



- The file name will populate in the pop-up window.

**Submit Query and Attachments**

Type \*  
Supplementary Claim Information

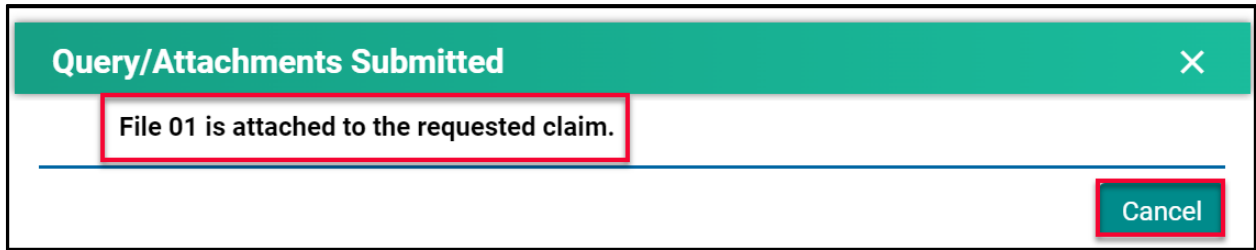
Description \*  
Explan Code AU - Consultation Notes/Report/Letter

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

The screenshot shows a dialog box titled "Submit Query and Attachments". It has two dropdown menus: "Type" with the selected value "Supplementary Claim Information" and "Description" with the selected value "Explan Code AU - Consultation Notes/Report/Letter". Below these is an "Attach File" section with a "Choose File" button and the text "No file chosen". A red note below the file section says "File format must be .doc, .docx, .jpeg, .txt & .pdf". At the bottom right, there are "Cancel" and "Submit" buttons.

- 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". It features two dropdown menus. The first dropdown, labeled "Type", has "Claim Query" selected. The second dropdown, labeled "Description", has "Physician Requested Recovery - Billed in error" selected. The word "error" in the description is underlined. At the bottom right of the form 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**

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.

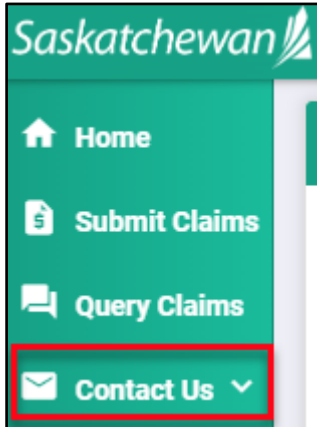
# Module SEVEN – Contact Us

## Contact Us

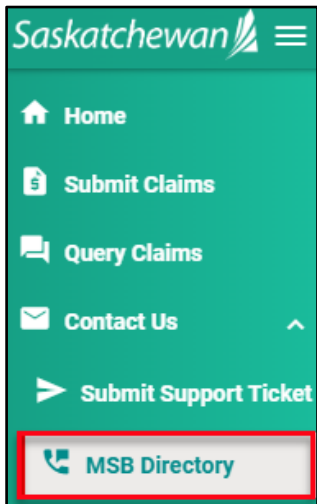
When requiring support with a claim or Customer Portal call **1-800-605-2965**, Monday to Friday from 8:00am to 5:00pm.

## MSB Directory

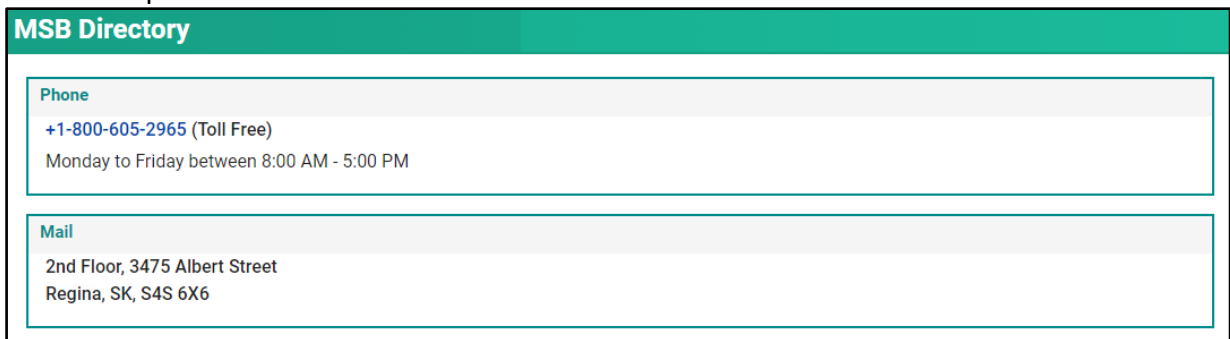
1. Click on **Contact Us**.



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



3. Select an option to contact MSB.



## Medical Services Branch



Claims Replacement Project