

# Customer Portal (CP) Claim Query User Manual



**Medical Services Branch**



Claims Replacement Project

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# Module ONE – Claim Query

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

## Medical Services Branch



Claims Replacement Project

## 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

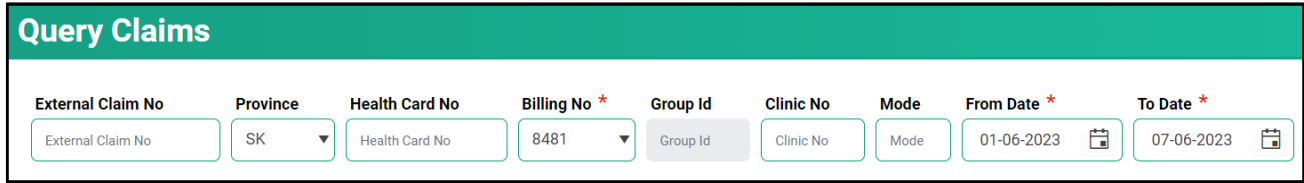
**Supplementary Claim Information** is typically used when supporting documentation must be added to the claim, or a special request, like time extension or Medical Consultant Review, is required. All claims queried with **Supplementary Claim Information** are reviewed by MSB. After reviewing the claim,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

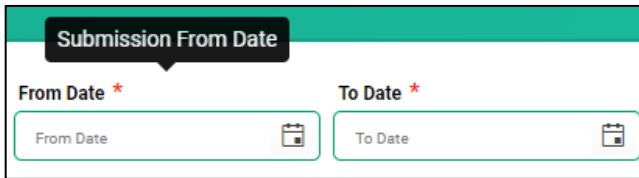
To query a claim certain claim criteria must be entered. All mandatory fields must be entered to perform the query. However, additional search fields can also be entered. The more specific the search criteria, the more defined the results.



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**

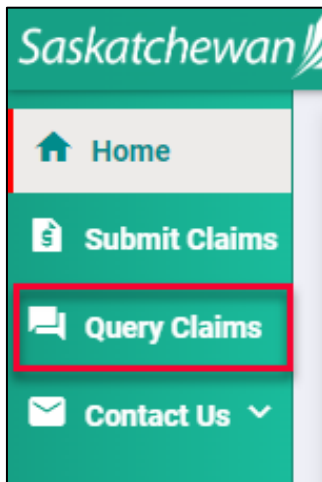


A close-up of the "Submission From Date" and "To Date" fields. A callout box labeled "Submission From Date" points to the "From Date" field. Both fields have calendar icons and are marked with a red asterisk to indicate they are mandatory.

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**.



When querying a claim for a claim that was submitted **PRIOR** to the new system going live, the **Submission To** and **From Date** must be the **run date of the payment run the claim was originally submitted on**.



- 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.

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:

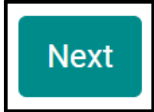
	CPS Claim No.	Ext Claim No.	Prov	HSN	Sub SC	DOS From	DOS To	Status	Paid SC	Paid LOS	Paid NOS	Paid Eligible A...	Paid Total A...	Explan Codes
<input type="checkbox"/>	1030023043		SK	370163829	038U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA
<input type="checkbox"/>	1030023043		SK	370163829	037U	2023-06-15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

	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**.



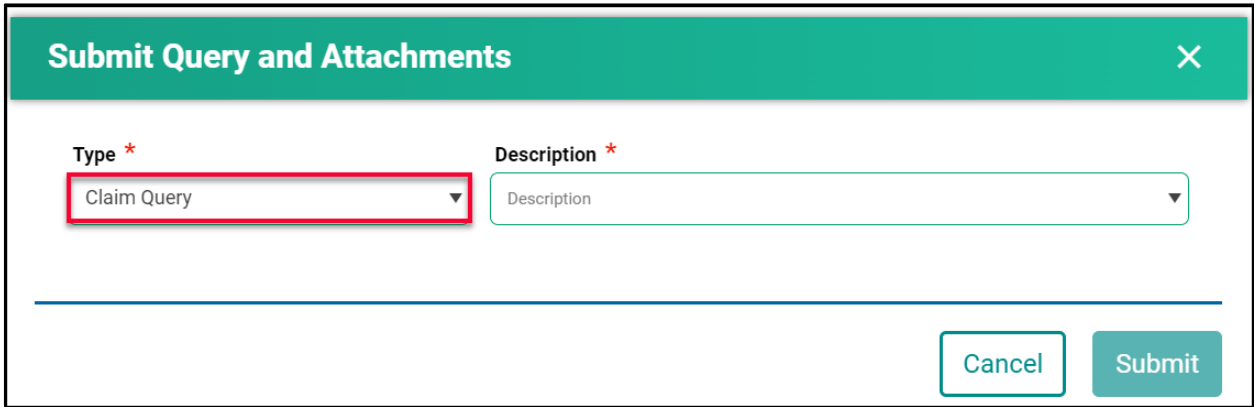
8. Select either **Claim Query** or **Supplementary Claim Information**. Then follow the steps listed below for each query type.

A screenshot of a web form titled "Submit Query and Attachments" with a teal header bar and a close button (X) in the top right. The form contains two required fields: "Type \*" and "Description \*". The "Type" dropdown menu is open, showing two options: "Claim Query" and "Supplementary Claim Information", both of which are highlighted with a red rectangular border. The "Description" field is currently empty. At the bottom right of the form, there are two buttons: "Cancel" and "Submit".

## How to Run a Claim Query

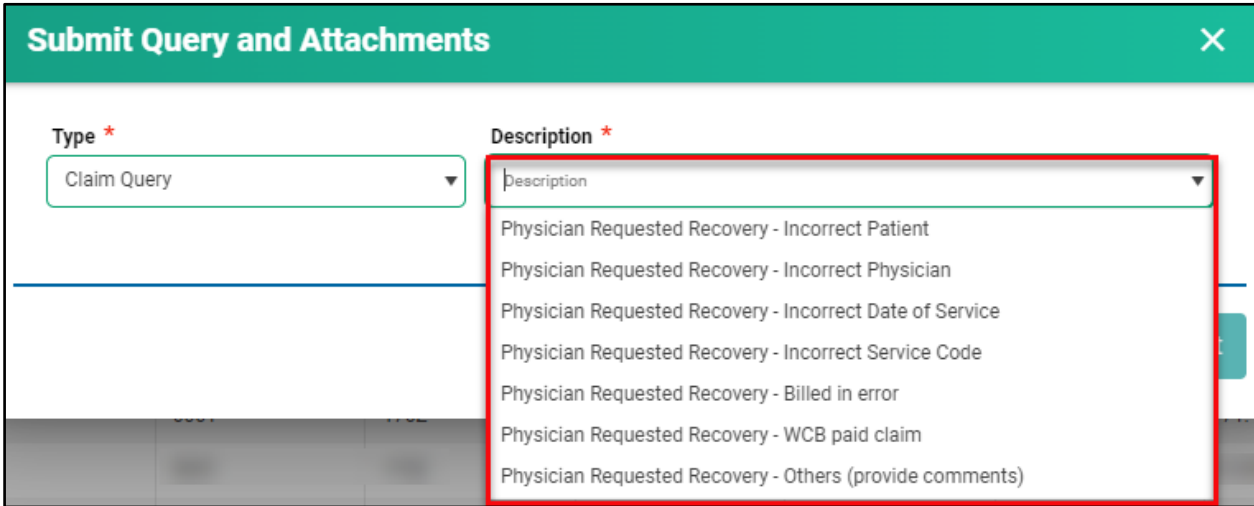
When recovering a claim due to an error on the initial submission, use the **Claim Query** option.

1. Select **Claim Query**.



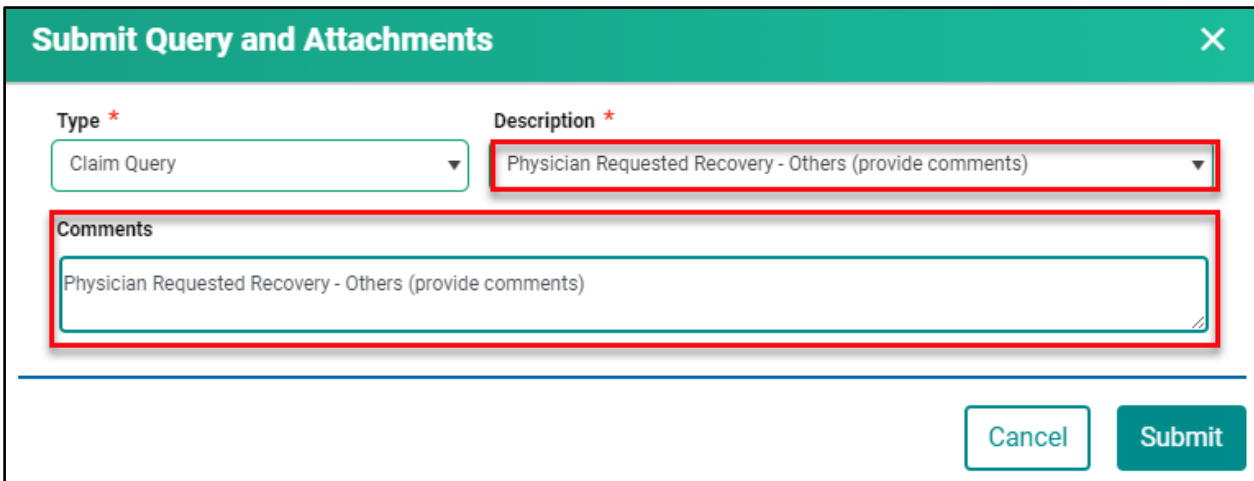
The screenshot shows a form titled "Submit Query and Attachments" with a close button (X) in the top right corner. There are two dropdown menus: "Type \*" and "Description \*". The "Type \*" dropdown is highlighted with a red box and contains the text "Claim Query". The "Description \*" dropdown contains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

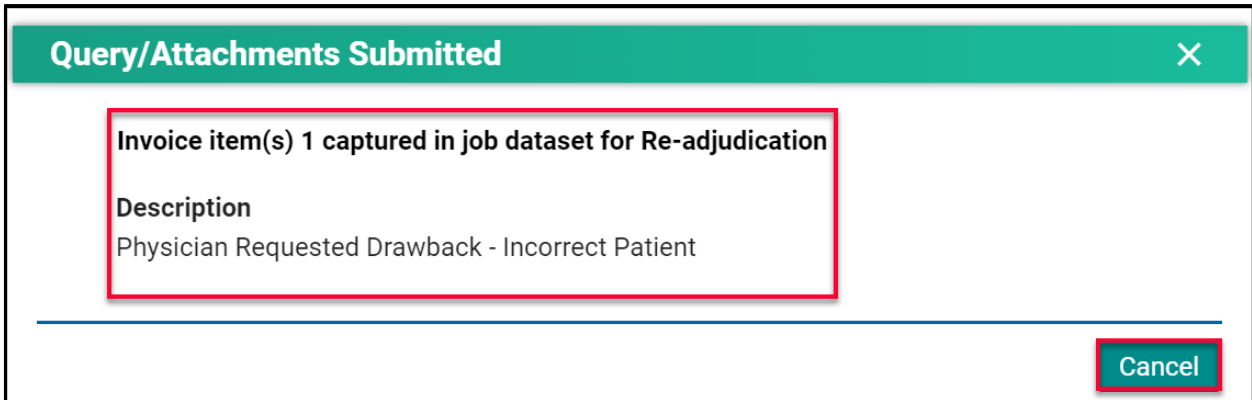
3. If **Physician Requested Recovery – Others** is selected, enter in a detailed comment explaining the reason for the recovery. For all other selections, move to step 4.



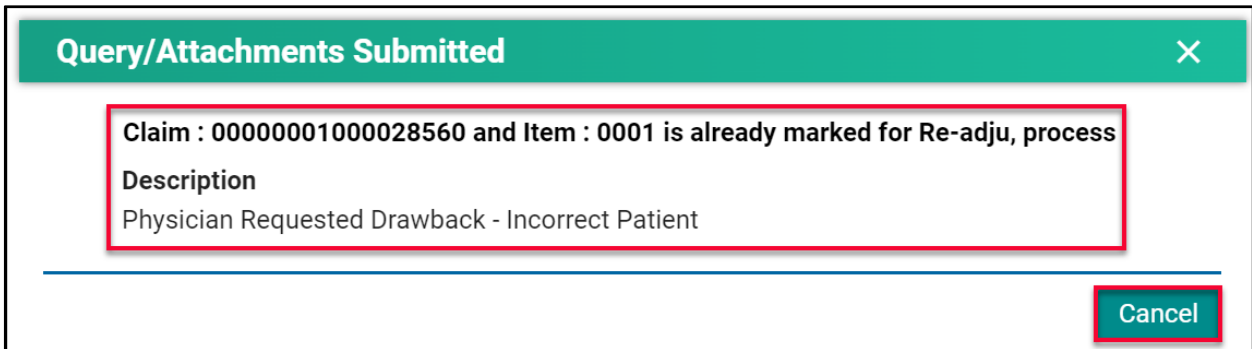
The screenshot shows the "Submit Query and Attachments" form. The "Type \*" dropdown is "Claim Query" and the "Description \*" dropdown is "Physician Requested Recovery - Others (provide comments)". Below these is a "Comments" text area, which is highlighted with a red box and contains the text "Physician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



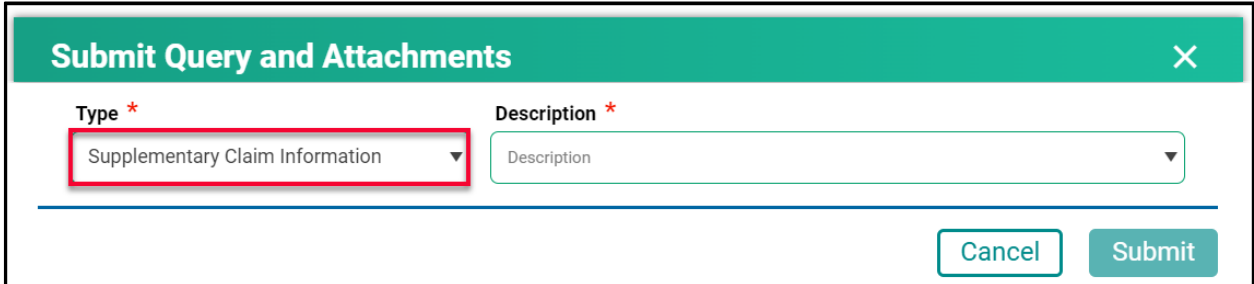
**NOTE:** If a query is submitted on a claim that already has an outstanding query on it, the following message will appear.



## How to Run a Supplementary Claim Information Query

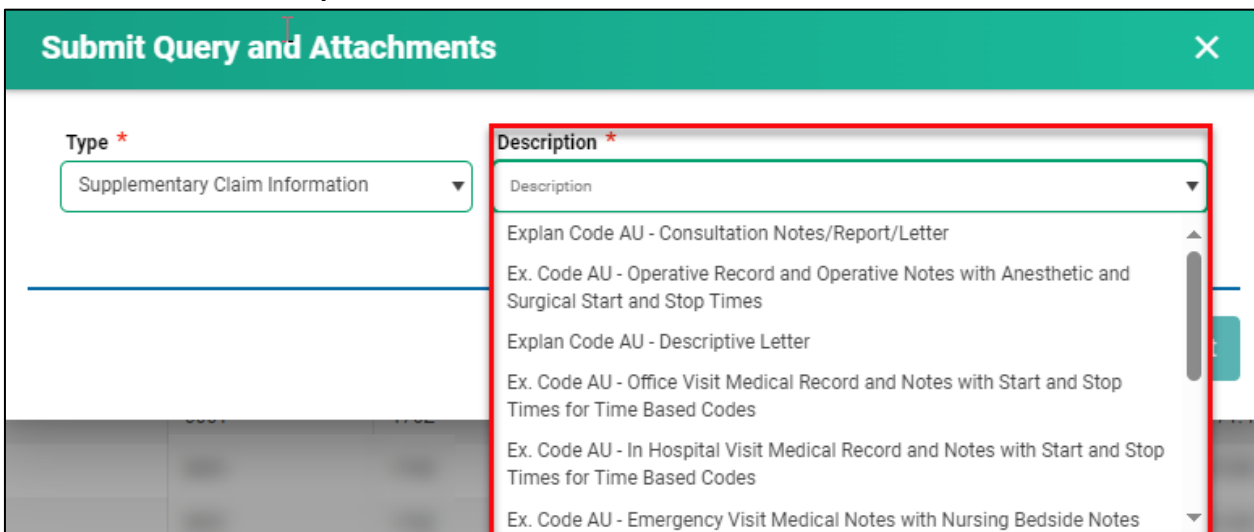
When additional documentation and/or comments are required on a claim, use the **Supplementary Claim Information Query**.

1. Select **Supplementary Claim Information**.



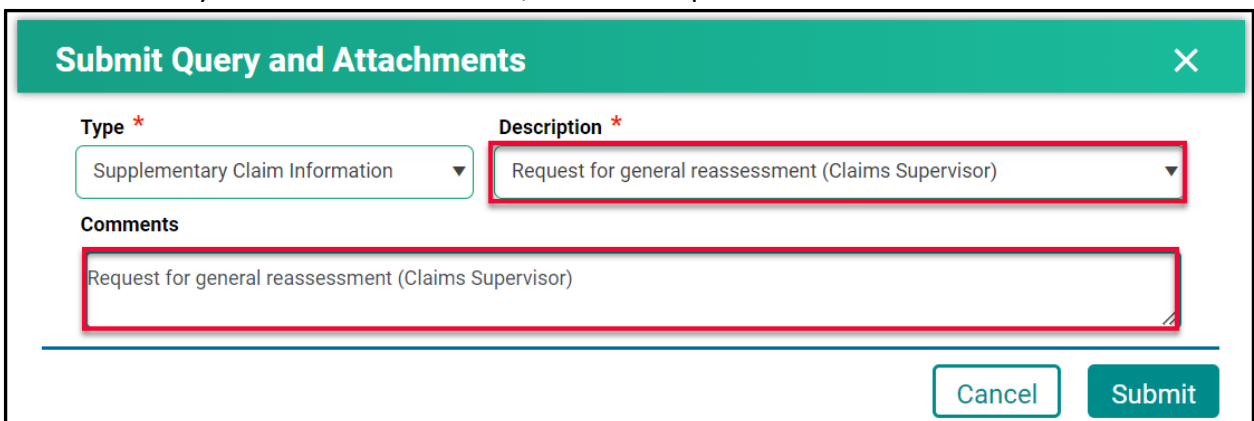
The screenshot shows a modal window titled "Submit Query and Attachments" with a close button (X) in the top right corner. Below the title bar, there are two dropdown menus. The first is labeled "Type \*" and has "Supplementary Claim Information" selected. The second is labeled "Description \*" and has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

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**

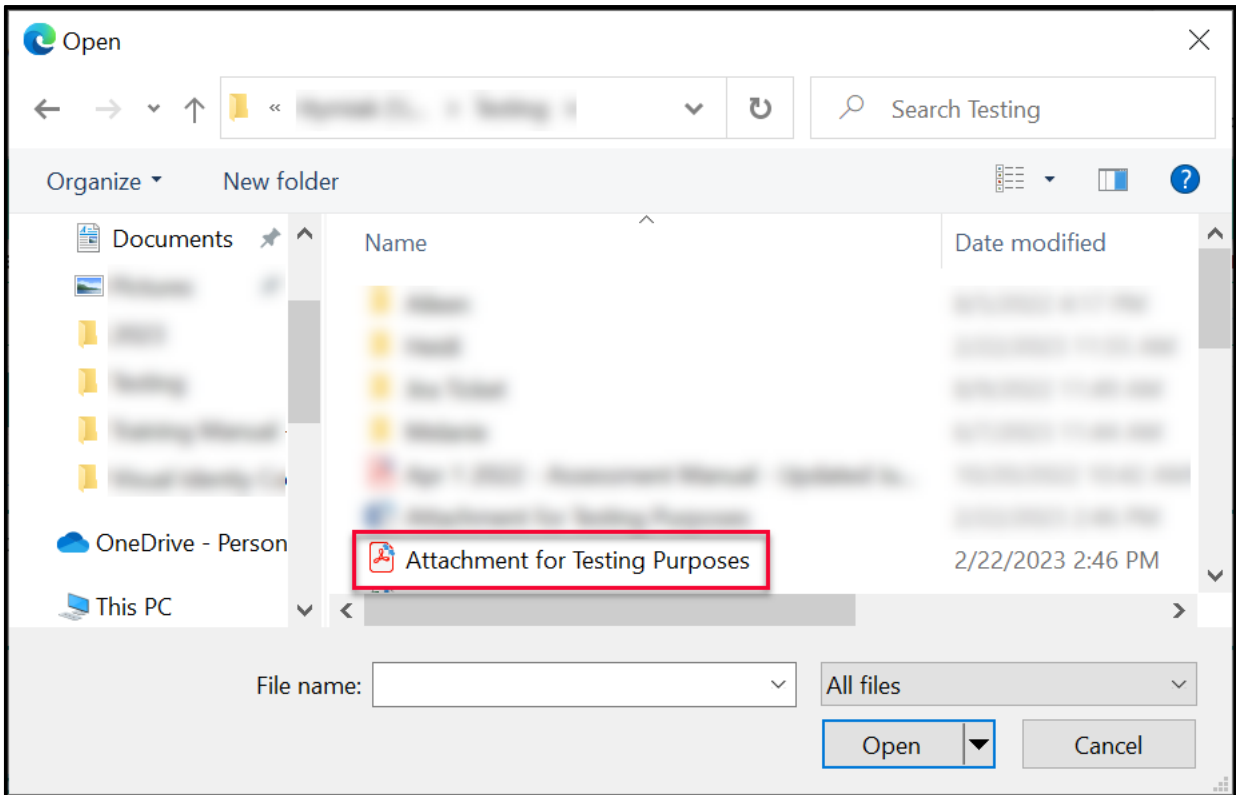
Type \*  
Supplementary Claim Information

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**

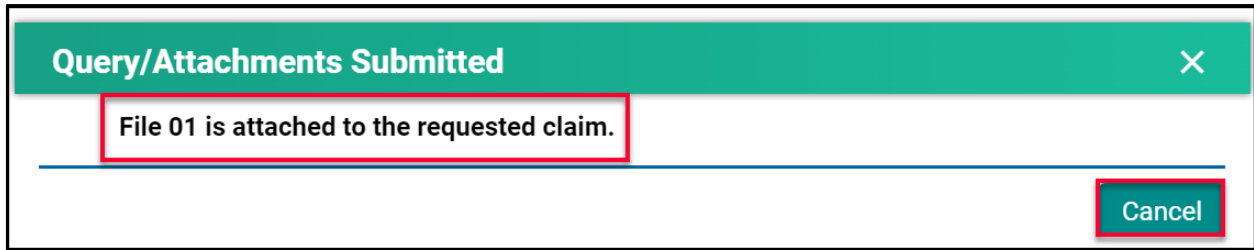
Type \*  
Supplementary Claim Information

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 [X]

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:

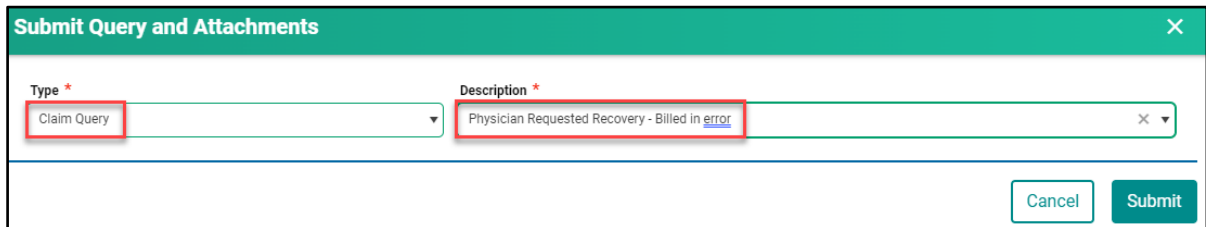
- No action required. 9B will be paid on the next bi-weekly run and 795A cannot be paid based on the Assessment Rules.

### 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). The form contains two dropdown menus. The first dropdown is labeled "Type \*" and has "Claim Query" selected. The second dropdown is labeled "Description \*" and has "Physician Requested Recovery - Billed in error" selected. 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.