Customer Portal (CP)
Query Claim
User Manual

Medical Services Branch

Claims Replacement Project

Saskatchewan

Table of Contents

Query Claim

The **Query Claim** function is used when additional information is required for a claim, or when a claim needs to be recovered after it has been submitted to Medical Services Branch (MSB). There are two types of queries:

Claim Query

Use this option when a claim needs to be recovered. For example:

- If incorrect information was entered on claim submission,
- The claim was billed in error, or
- For Workers Compensation Board (WCB) purposes.

Once the claim has been recovered, if required, the claim can be resubmitted with the correct information.

Supplementary Claim Information

Use this option to add supporting documentation to a claim or for a special request. For example:

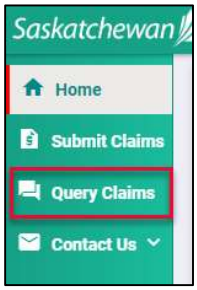
- When requested to provide additional information (e.g., OR report),
- To appeal for reassessment of a claim, or
- Request a time limit extension.

Query and Claim Status

A claim can also be queried to determine:

- The status of the claim – determine if it is paid, pended, or rejected.
- The status of a query – determine the status of the query.

1. Click on **Query Claims.**

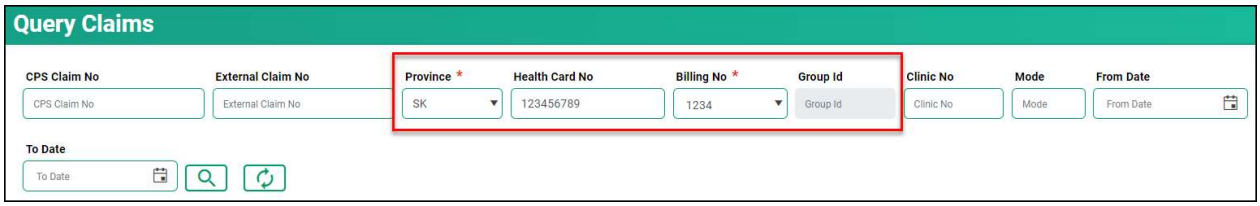


2. Enter the following:
   - CPS 10-digit claim number **OR** the Health Card Number
   - Province of Health Card Number (defaults to SK)
   - Associated Billing Number and Group ID combination

CPS 10-digit Claim Number

OR

Health Card Number



- **Batch File Submitters** – associated Group ID is required.
- **Real Time Submitters** – Group ID is not required.

3. Click 

4. A list of claims matching the search criteria is displayed. Scroll to the right to see if the claim has been queried. If so, the status of the query, the date the query was submitted, and the query type will be populated.

CPS Clai...	Ext Claim..	Prov	HSN	Sub SC	DOS From	DOS To	Status	Paid SC	Paid LOS	Paid NOS	Paid Eligibl..	Paid Tota..	Explan Codes	Query Status	Query Created..	Query Type
103		SK	940	171Z	2024-09-09	2024-09-09	PAID	171Z	1	1	141.80	141.8				
103		SK	940	162Z	2024-09-09	2024-09-09	REJECTED				0.00	0.00				
103		SK	940	171Z	2024-08-08	2024-08-08	PAID	171Z	1	1	141.80	141.8	BH	OPEN	2024-10-22	ZCQAP2
103		SK	940	162Z	2024-08-08	2024-08-08	PENDED				0.00	0.00		OPEN	2024-10-22	ZCQAP2
103		SK	940	150Z	2024-01-15	2024-01-15	PAID	150Z	1	1	99.95	99.95				
103		SK	940	150Z	2024-01-15	2024-01-15	PAID	150Z	1	1	99.95	99.95	B0	COMPLETED	2024-10-22	ZCQAU
103		SK	940	150Z	2024-01-15	2024-01-15	PAID	150Z	1	1	99.95	99.95	B0	COMPLETED	2024-10-22	ZCQAU
103		SK	940	150Z	2024-01-15	2024-01-15	PAID	150Z	1	1	99.95	99.95	B0	COMPLETED	2024-10-22	ZCQAU

The following outlines the information provided in the columns:

Query Status	Description
Blank	The claim has not been queried.
Open	The claim has been queried and MSB is reviewing the claim.
Completed	The claim was queried and MSB has completed their review. Check the Status column to determine if the claim has paid, pended, or rejected.

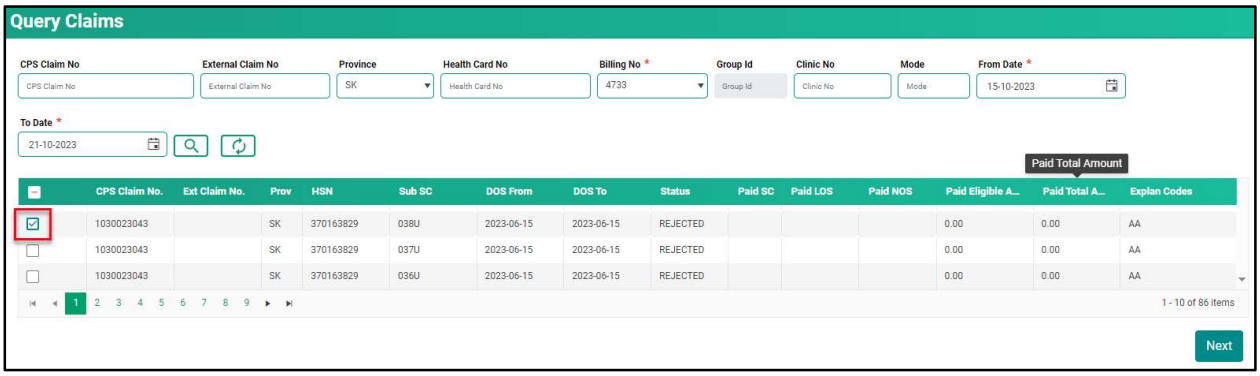
Query Created	Description
Date	Date of most recent query submission.

Query Type	Supplementary Claim Information Options
ZCQCOM	Provide Required Comment or Explanation
ZCQATT	Attach Required Documentation
ZCQTL	Explan Code CM-CN - Request for Time Limit Extension
ZCQPGA	Explan Code RA – RZ - Routine Audit and Recovery
ZCQAP1	First Level of Appeal - Request for General Reassessment by a Claims Supervisor
ZCQAP2	Second Level of Appeal - Request for Medical Consultant Review
ZCQAP3	Request for Medical Assessment Board review

Claim Query – Recovery of a Claim

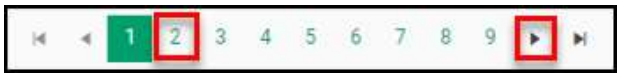
If the claim has not been queried, proceed to submit a query to recover the claim that was submitted in error.

1. Place a check mark in the appropriate line item.



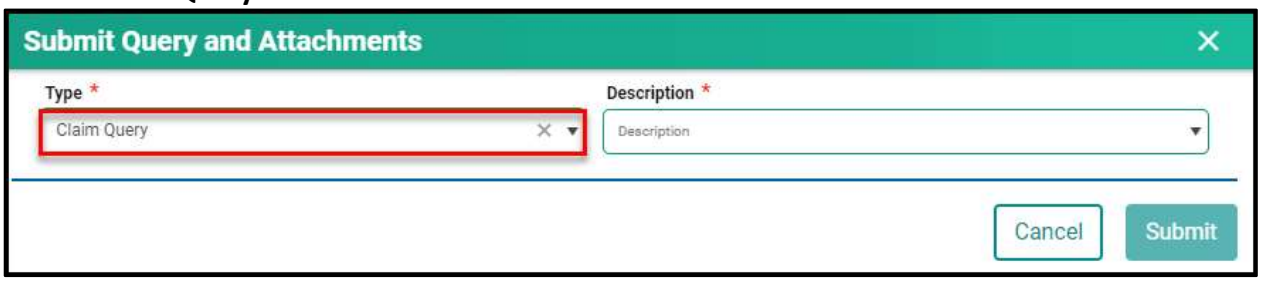
To select additional claim items to be actioned for the same reason (e.g., recovery), hold the CTRL key and click the check box by the claim number.

Please note, only 10 claims are displayed at a time. To view more claims, click the next page number or the arrow at the bottom of the screen, to view and select additional claims.



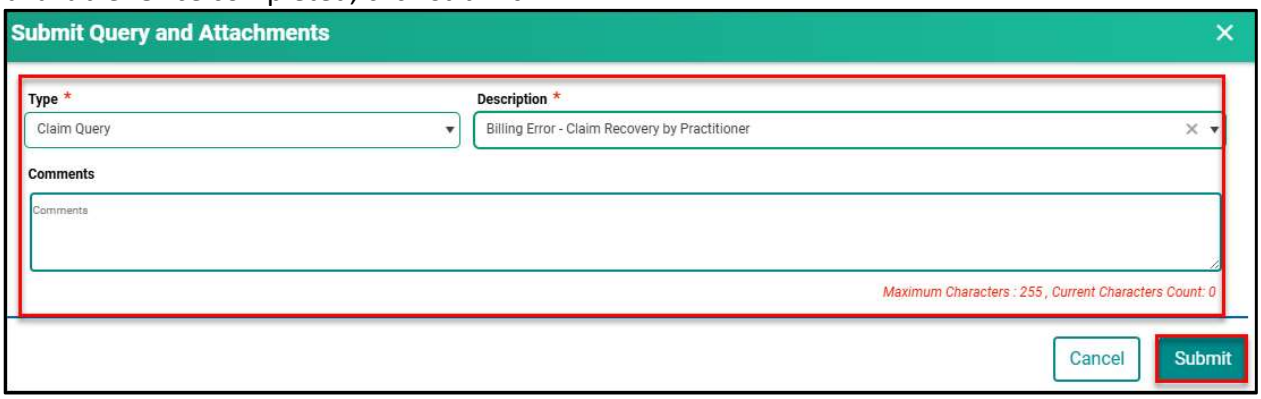
2. Click **Next.**

3. Select **Claim Query.**

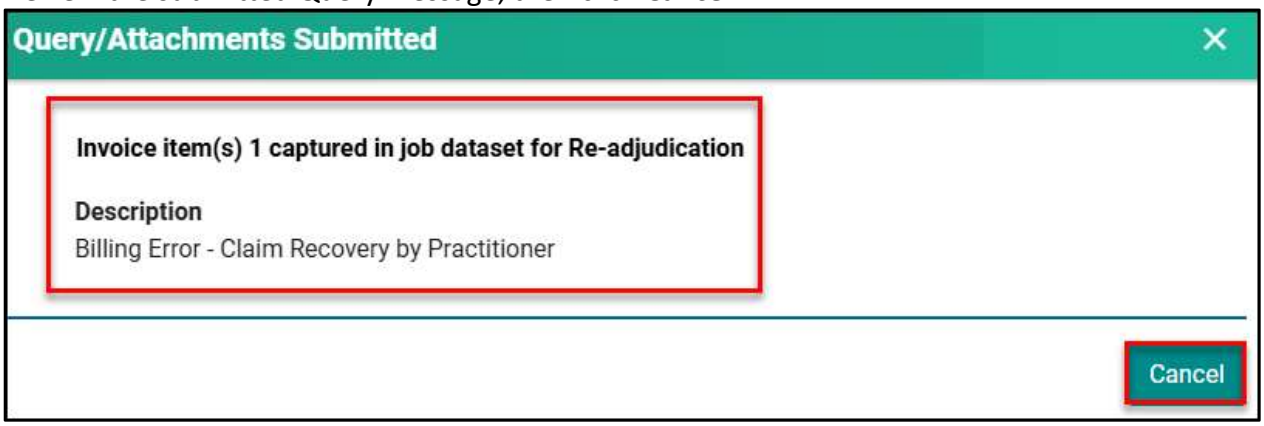


4. Select the correct **Description.**

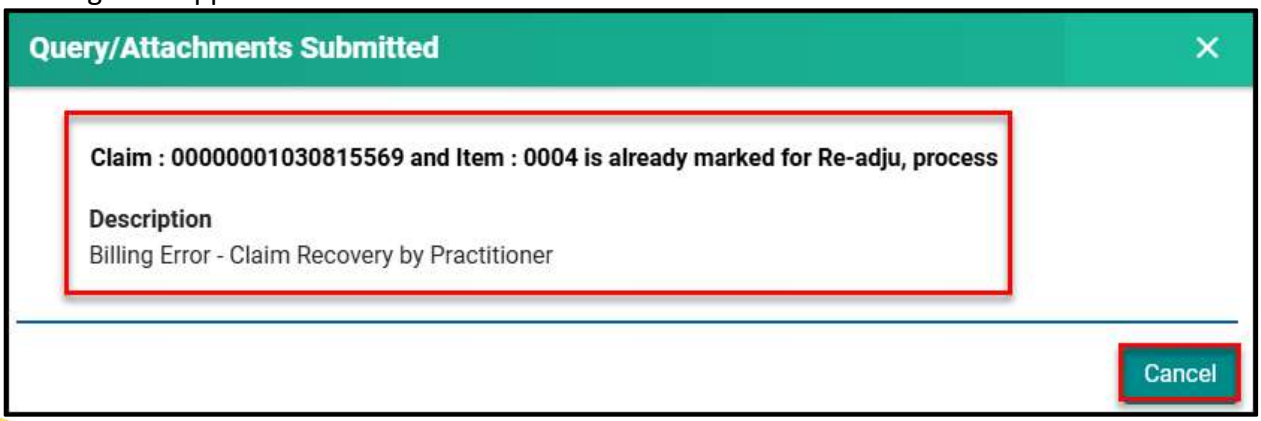
5. When selecting**, Billing Error – Claim Recovery by Practitioner,** an optional comment section is available. Once completed, click **submit.**



6. Review the submitted Query message, then click **Cancel.**



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



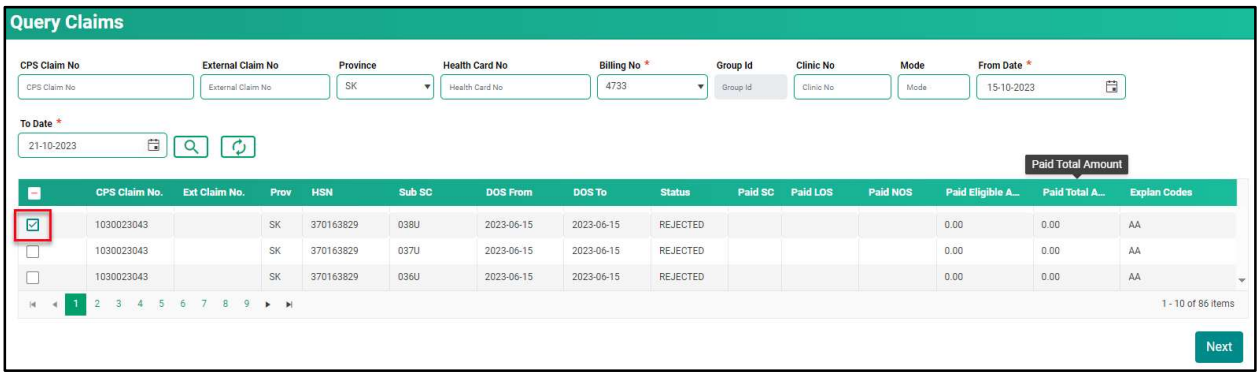
Once a claim is recovered, the claim status updates to **rejected**, with one of the following explanatory codes:

Explanatory Code	Claim Query Categories
BP	Billing Error - Claim Recovery by Practitioner
CW	WCB Claim - Claim Recovery by Practitioner

Supplementary Claim Information Query

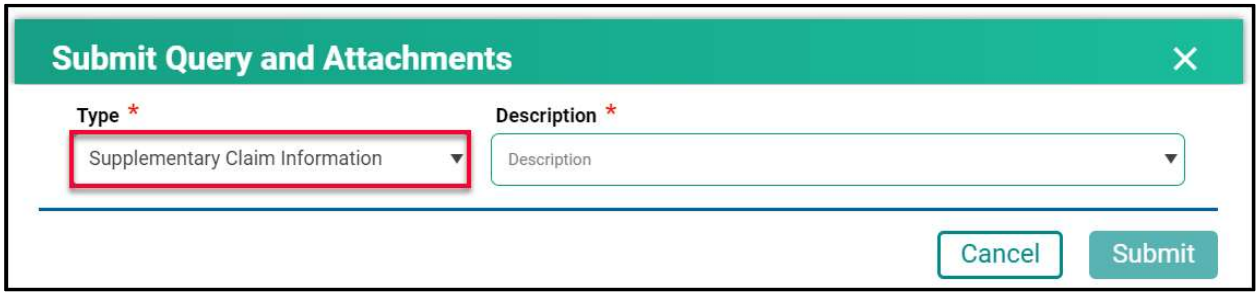
If the claim has not been queried, proceed to submit a query to add additional comments and/or attach additional documentation to the claim.

1. Place a check mark in the appropriate line item.

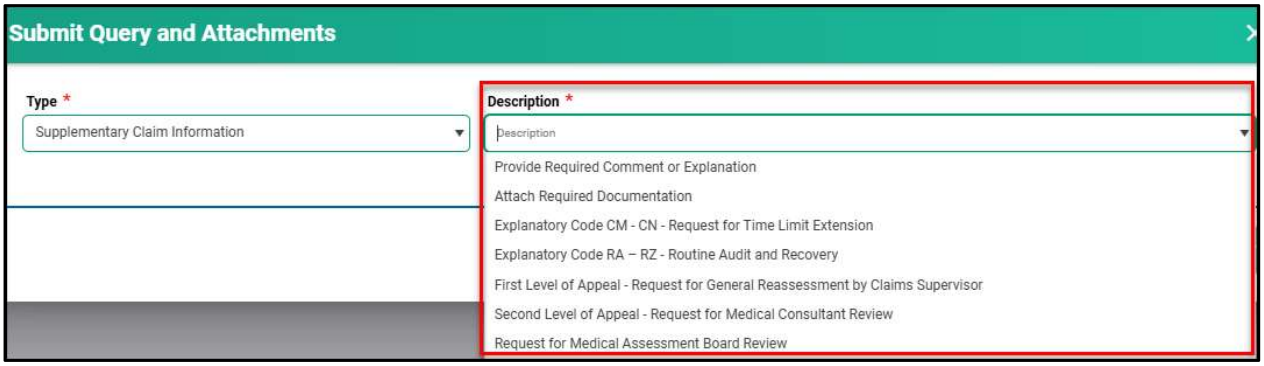


2. Click **Next.**

3. Select **Supplementary Claim Information.**



4. Select the correct **Description.**



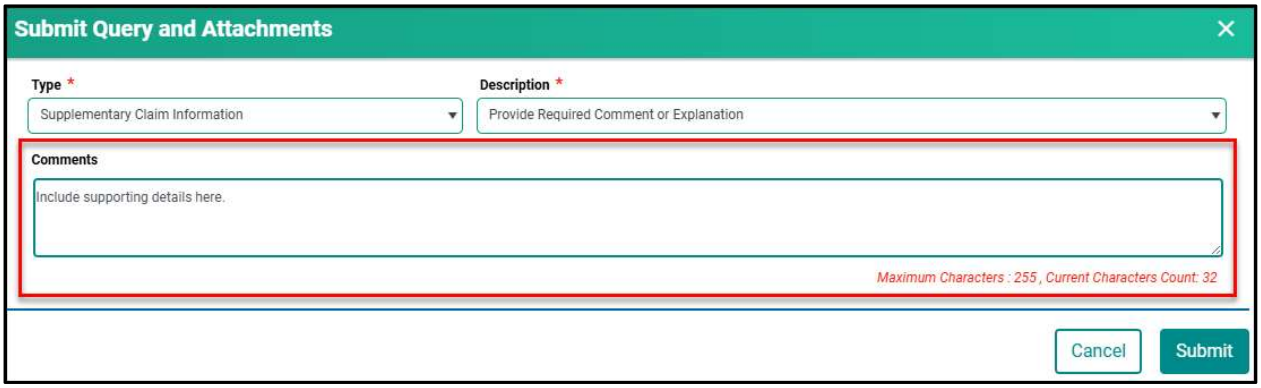
Step 1: Refer to the Payment Schedule for your claim specific service code(s) and review the explanatory code(s) attached to determine the additional information required for your claim to be assessed.

Step 2: Determine which **Supplementary Claim Information** option is appropriate for your claim's specific scenario.

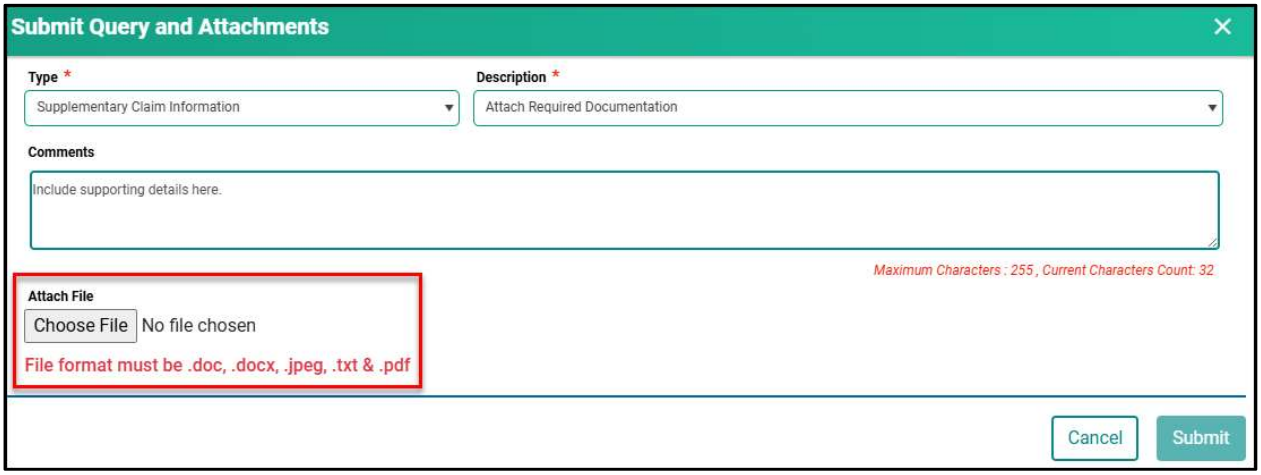
Step 3: To confirm or check the status of your query, re-query the claim using the Health Card Number or CPS 10-digit number (as per above).

Supplementary Claim Information Options
Provide Required Comment or Explanation • Include the requested information as a comment to support your request as per the Payment Schedule. • Example: Explanatory code DA
Attach Required Documentation • Attach the requested documentation to support your request as per the Payment Schedule. • Examples: Explanatory codes AU/AZ requiring the operative report, medical/case record or a descriptive letter, a written report for higher payment request for unusual time, skill or attention required for management of a medical condition.
Explan Code CM – CN - Request for Time Limit Extension • Attach the requested documentation to support your request as per the Payment Schedule.
Explan Code RA – RZ - Routine Audit and Recovery • Attach the requested documentation to support your request as per the Payment Schedule.
First Level of Appeal - Request for General Reassessment by a Claims Supervisor • First Level Appeal can **only** be selected once you have provided a comment or attachment. • First Level of Appeal is a request for your claim to be reassessed because you are dissatisfied with the initial assessment. • Attach additional documentation to support your appeal request per the Payment Schedule.
Second Level of Appeal - Request for Medical Consultant Review • Second Level Appeal can **only** be selected once a First Level of Appeal is complete. • Second Level of Appeal is a request for your claim to be reassessed by a Medical Consultant as you are dissatisfied with the First Level of Appeal decision. • Attach a **detailed letter directly from the physician** that includes information required to support your request as per the Payment Schedule. This includes: a list of all declined or disputed services, what specifically is being disputed, rationale for the appeal and any/all corresponding medical records.
Request for Medical Assessment Board Review • This appeal option can **only** be selected once a Second Level of Appeal is complete. • This is a request for your claim to be reassessed by the Medical Assessment Board. • Attach a letter and the reasons the claim should be re-considered per the Payment Schedule.

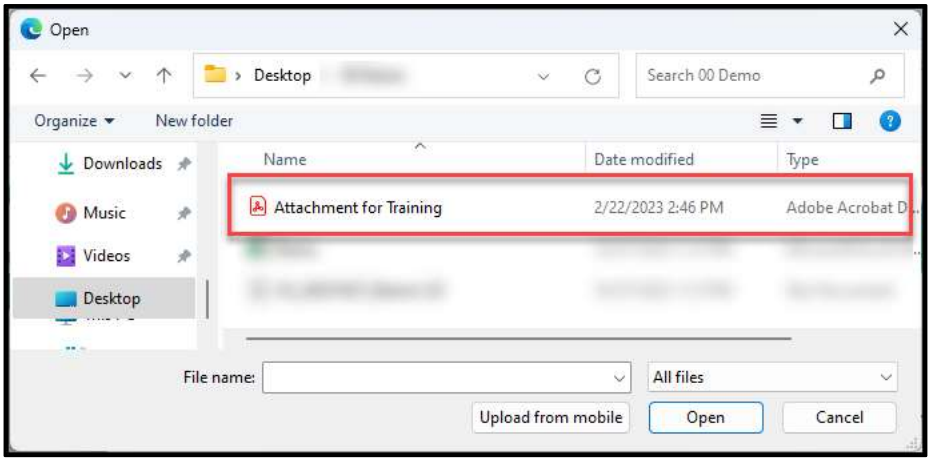
5. If the selection provides an option to add a comment, include details to support your query.



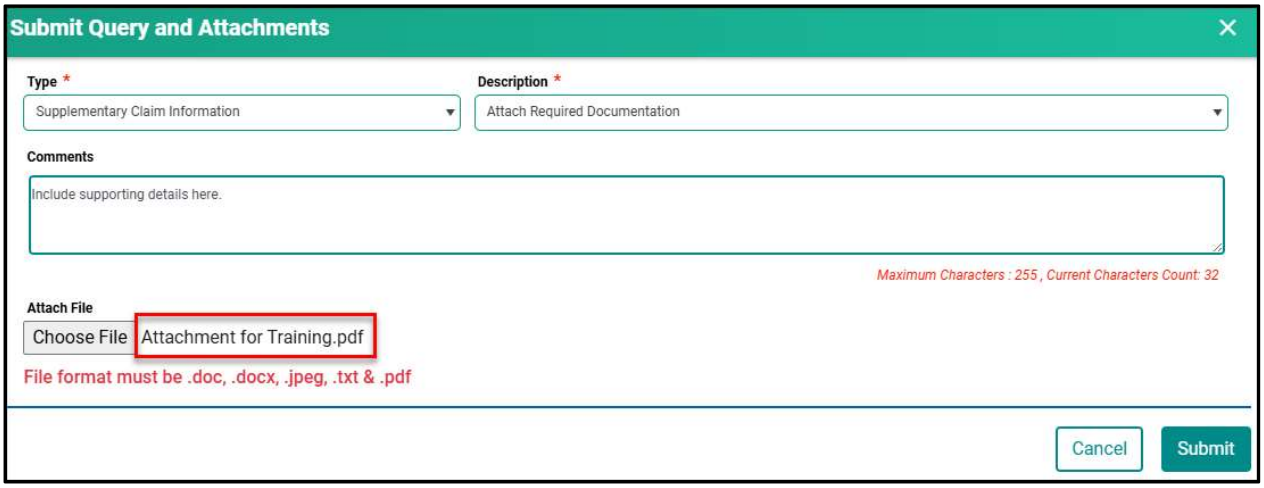
6. If the selection provides an option to attach a document to support your query, click **Choose File.** The file format can be in .doc, .docx, .jpeg, .txt, and .pdf.



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

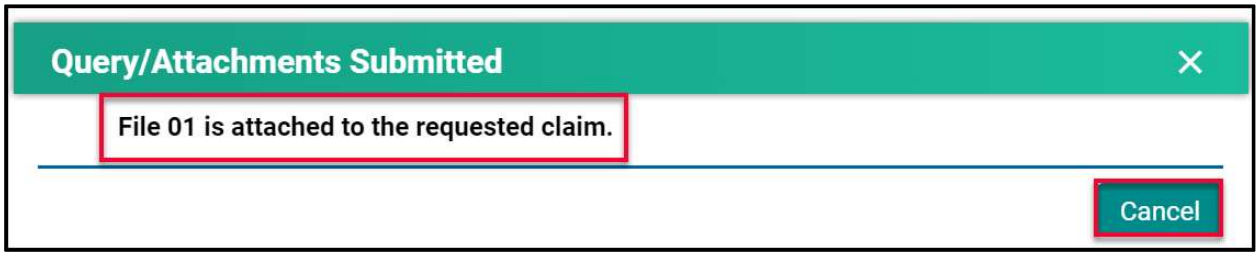


8. The file name will populate in the pop-up window.



9. Click **Submit.**

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



To attach more than one document to the same claim, repeat the above steps.

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.
- A query is *not* required.

Scenario #2

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

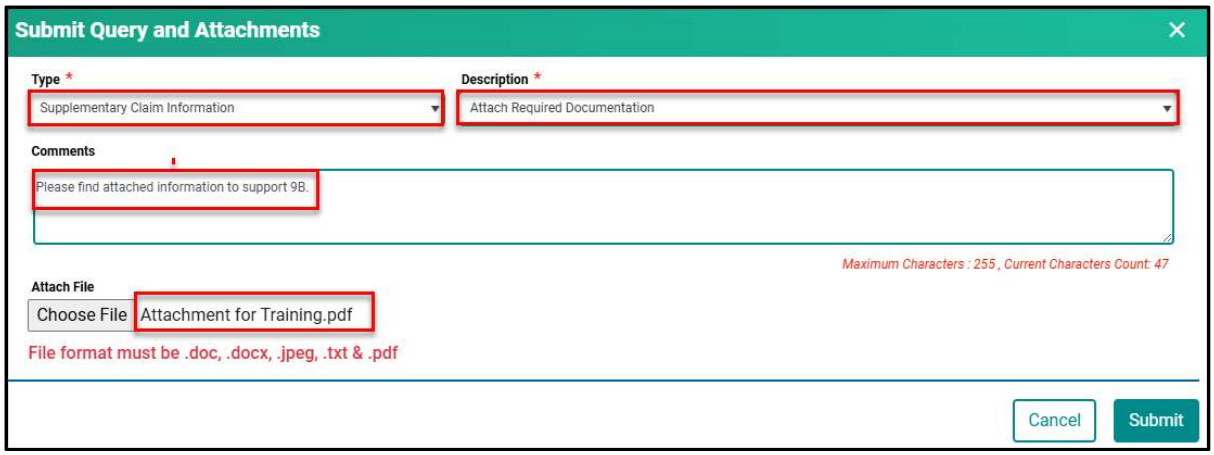
- Line 1 - 9B
- Line 2 – 890L

After the adjudication process, the results were:

- Line 1 - 9B – Rejected with an explanatory code of AU (MSB requires more information to adjudicate the claim).
- Line 2 – 890L – Paid

Action required:

- Query the line item with 9B to add the appropriate report/documentation.



- 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:

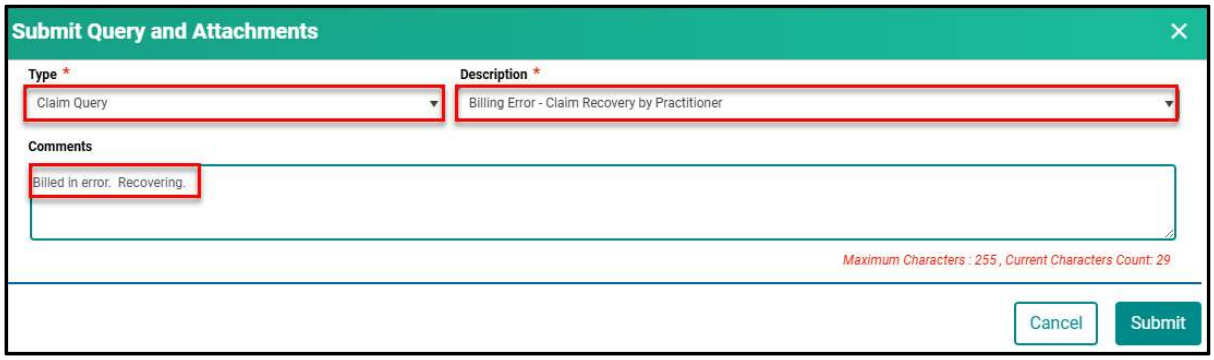
- No action required. 9B will be paid on the next bi-weekly run and 795A cannot be paid based on the Assessment Rules.

Scenario #4

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

Action required:

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



- Once the claim has been recovered, the status will change to **rejected** with explan code **BP.**
- To confirm the claim was recovered, query the claim to find the claim status.
- Submit a new claim with the correct information using your billing software.

Scenario #5

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

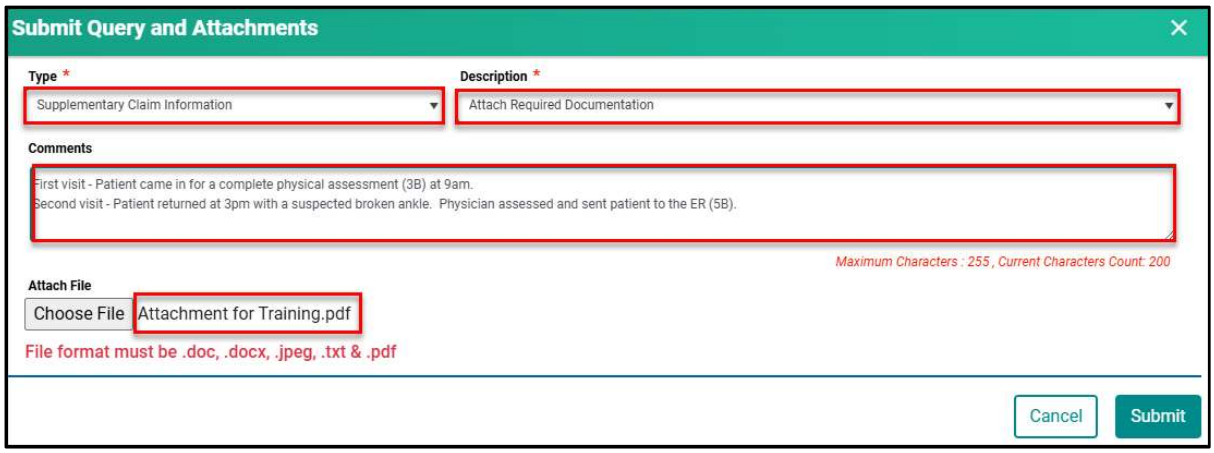
- Claim #1 – 3B for a complete physical done in the morning.
- Claim #2 – 5B as the patient returned to the clinic for a broken ankle.

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.



- No action required on the claim with 3B.