MSB Training for Outstanding Customer Portal FAQ's

March 15, 2024

Medical Services Branch

Claims Replacement Project

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Training and Support

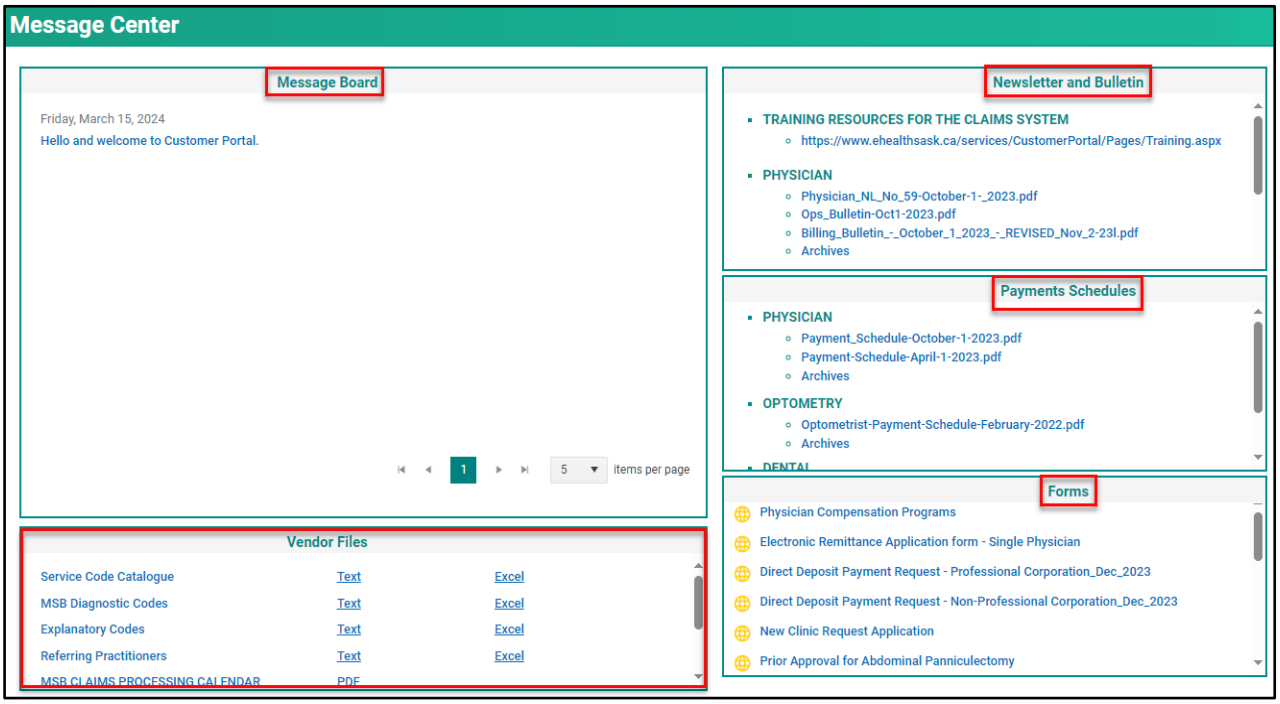
Training Tools/Resources Link:
https://www.ehealthsask.ca/services/CustomerPortal/Pages/Training.aspx

1. **Are training tools, such as training manuals, videos, and training recordings available? If so, where can I find them?**

   All training material is available on our eHealth website using link above.

2. **Where can I find a list of Referring Practitioners, Explanatory Codes, etc.?**

   The home page of Customer Portal includes many resourceful documents. Please refer to the home page when requiring these documents.



Validation Reports, Daily Return Files and Bi-Weekly Return Files

1. What do I do if my submission fails, and my validation report states rejected?

Review the validation report to see why it was rejected. The error description will identify the reason for rejection. If the error is due to a single claim, the claim number will be identified. If the error is due to a configuration issue (duplicate file) a claim number will not be identified.

Claims Submission Validation Report

File Name : **999_20240315081010.txt**
Submission Date : Thu Feb 15 13:50:22 CST 2024
Group Number : 999
Status : Rejected

Clinic	Doctor	Corporation Indicator	Claims	Records	Services	89 Recs	Comments	Fee Sub
123	1234		3	6	3	0	1	$91.30
123	4567		12	15	12	1	0	$477.60
123	8989		18	39	37	0	0	$37.00
123	5678		31	36	34	0	0	$1086.93
Totals:				96	3	0	1	$1692.83

Clinic	Doctor No	Corporation Indicator	Reject Description	Claim No
123	1234	NA	Referring Practitioner cannot be 000 or same number as Billing Practitioner Number. Entire submission File rejected. Contact Vendor/Software Provider to fix input file and resubmit.	58585
123	1234	A	Duplicate Input File * Entire Submission File rejected. Contact Vendor/Software Provider to fix input file and resubmit.	NA

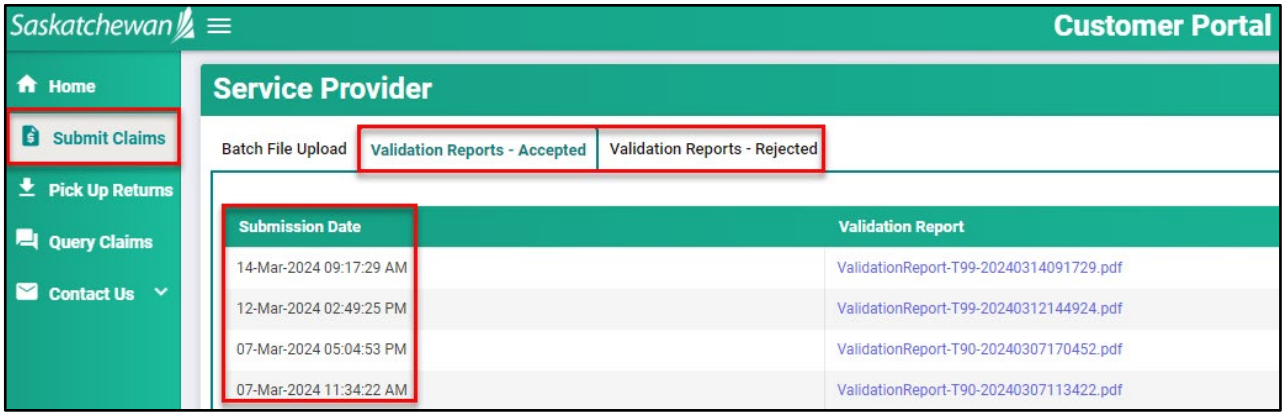
Fix the error and resubmit the entire batch submission. If required, reach out to your vendor or MSB for support.

When a validation report is rejected, the ***entire*** submission has been rejected.

2. How do I view my validation report?

Your validation report can be viewed through Customer Portal, by clicking on **Submit Claims** and then clicking on either the **Validation Reports Accepted** or **Validation Reports Rejected.**

All validation reports are date and time stamped. Make note of the date and time of your submission for ease of access. Scroll through the list to find the correct report and then click on the validation report link (in blue) to open the .txt file.



3. What is a Daily Return File vs a Bi-weekly Return File?

The **Daily Return File** includes **only Rejected** items from the previous day's claim submission processing. It provides an opportunity to review the rejections, make applicable corrections and resubmit the corrected claims, if applicable.

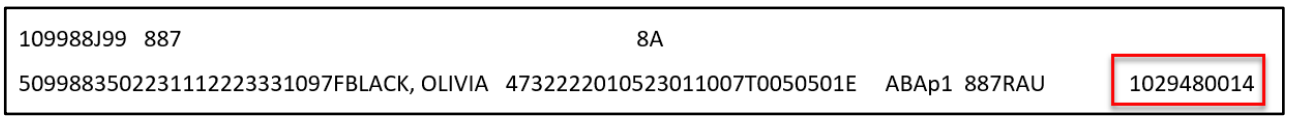
The **Bi-weekly Return File** is a list of **Paid, Rejected and Pended** items processed, within the two-week bi-weekly period, prior to the payment run cut-off.

4. If I don't check the Daily Return file, will those rejected claims appear on the Bi-Weekly Return file?

Yes, all rejected claims for the bi-weekly time frame will appear on the Bi-Weekly Return file.

5. Where do I see the Claims Processing System (CPS) claim number on the .txt Daily Return file?

The claim number is located on the far right-hand side of the .txt file.



6. **What is the difference between a claim item rejection on daily or bi-weekly return file versus a rejection on the batch submission?**

   <u>Claim Item Rejection (Daily or Bi-weekly Return Files)</u>

   A claim item will be rejected if it fails against one or multiple business rule. The daily and bi-weekly return files include the explanatory code. Based on the explanatory code one of three actions is required:

   a. The claim item requires an update/change within your billing system and a resubmission. The change is made in your vendor software and that item is resubmitted as part of your next batch submission.
   b. The claim item requires additional notes or documentation. This requires the claim item to be queried in Customer Portal and the appropriate notes or documentation attached.
   c. No action is required as the claim items failed against the business rules and cannot be paid.

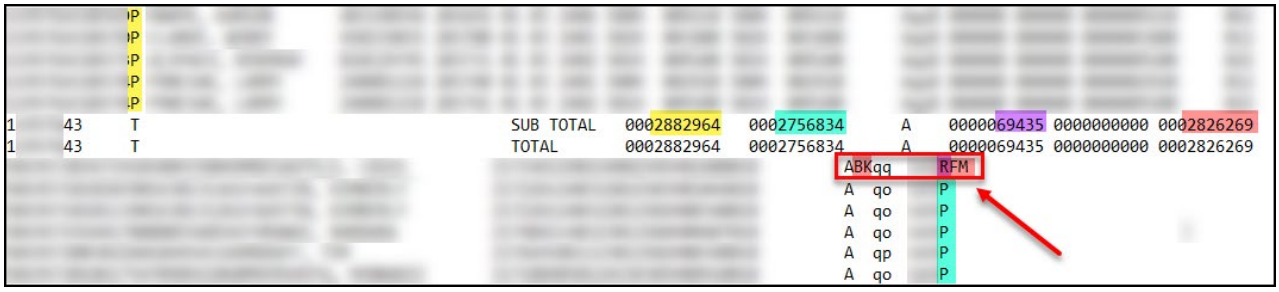
   <u>Batch File Submission Rejection (Validation Report)</u>

   When a batch file submission is rejected, it is typically due to a configuration issue (i.e. physician ineligible to submit, duplicate file, etc.) causing the entire submission not to pass through to the Claims Processing System. The reason for rejection is stated on the validation report. The error must be fixed, and the entire batch submission must be resubmitted.

7. **When reviewing the daily or bi-weekly return file (in .txt format), how will I know which line item is rejected?**

   The explanatory code(s) will display on the line with the rejected service code. A rejected claim item can include up to three explanatory codes.

   The first explanatory code appears before the run code. The status **R** (rejected) is followed by the two explanatory codes. In the example below, the line item includes two explanatory codes: **BK** and **FM** along with the **R** to represent it was rejected.



Group Information

1. **Why do I see other physicians listed when I query claims in Customer Portal and when I review my return files?**

   All physicians that have been part of the group (past or present) will display when querying claims in Customer Portal, on validation reports and on daily and bi-weekly return files.

Claim Query

1. **When do I query a claim and when do I fix the claim in my vendor software and resubmit?**

   Query claim: used when additional information is required, or the claim needs to be recovered. (i.e., request a recovery because a claim was billed in error, provide additional information for the claim, submit a document). Common explanatory codes: AU, DM.

   Fix the error on the claim in your vendor software and resubmit with your next submission: used when the claim has changed from how it was originally submitted (i.e., change to the service code, provider, or date of service). Common explanatory codes: AJ, ZA, ZC.

2. **Can we query a claim that rejected on the Validation Report?**

   No. When a validation report rejects, the entire submission is rejected. This means all claims within the batch submission failed and were not sent to the Claims Processing System at MSB.

   A claim can only be queried after it has processed through the Claims Processing System.

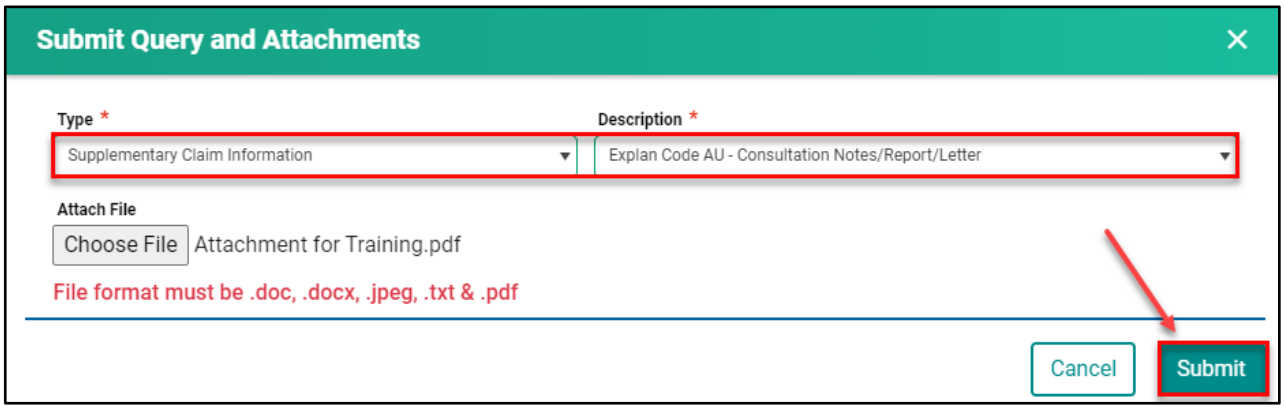
3. **What date is used for the To and From dates in a query?**

   The submission date is required when querying a claim. Follow these dates to ensure your query is successful.

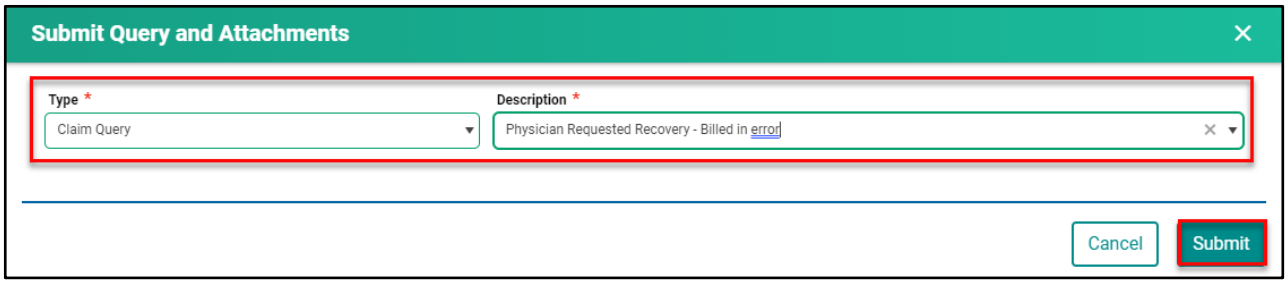
Submitted AFTER Feb 13	• Use exact date of submission
Backlogged Claims Not Processed	• Use February 13, 2024
Claims Processed in Old System	• Use the payment run date of when your claim was submitted. • For Example: Submitted on November 10, 2023 (run qh), use November 14, 2023, as the submission date

4. **When I query a claim to add an attachment or note, is the claim automatically submitted to MSB?**

   When a query for **Supplementary Claim Information** is submitted with an attachment and/or note, the claim is automatically submitted. No further action is required.



   When a **Claim Query** is submitted, the claim is automatically recovered (rejected). Please check the daily return file, the following day, for confirmation. You can then fix the claim in your vendor software and resubmit with your next batch submission, if applicable.



5. **Can we continue to submit documentation by mail or fax?**

   All documentation must be submitted through the Query Claim feature in Customer Portal. Faxing and mailing documentation for claims is no longer accepted.

6. **When attaching documentation on a queried claim, can a ZIP file be uploaded?**

   No, ZIP files are not accepted. Acceptable file types are: .doc, .docx, .jpeg, .txt and .pdf.

Scenarios and Explanatory Codes

1. **I've submitted a claim with a base code. The add code has yet to be submitted, resulting in the base code rejecting? What do I do?**

   The base code is usually not dependent on the add code being submitted for majority of cases. However, there are certain codes that must be billed with the "add" code.

   For example, 64B must be billed with 65B, 66B, 67B and/or 68B. If only 64B is submitted, the claim will be rejected. If this occurs, 64B must be resubmitted with the appropriate add codes.

2. **I've submitted a claim with a base and an add code. The base code pended for manual review and the add code rejected. What do I do?**

   A pended line item is waiting for a manual review by a Claims Analyst. If the base code is paid, the Claims Analyst will re-adjudicate the add code and both will pay. If the base code is rejected, the add code will remain rejected. For example:

   All 25B, 26B, etc. service codes are pended, which in turn causes all the 700A and 701A service codes to reject.

   When the pended claims are reviewed by the Claims Analyst, and if all business rules are met, the pended and rejected line items will be paid.

3. **All claims related to emergency room coverage are rejecting AJ. Why?**

   It is important to ensure that all data entered on the claim is correct and follows the information in the Payment Schedule:

   The services involving emergency room coverage cannot be paid as:
   1) The physician is not eligible to bill these codes;
   2) Another physician has been paid for the same time period in this community;
   3) The incorrect dummy HSN has been used for this community;
   4) An incorrect clinic has been used for this community;
   5) Another ICD code must be used for regular services provided to a beneficiary; or
   6) An incorrect service code, day of the week or amount has been used.

For example, the first name must be **ER Coverage** and the dummy HSN used must match the community.

Please download a copy of the EMERGENCY ROOM COVERAGE (ehealthsask.ca) billing information sheet.

4. **Several claims with time-based service codes are rejecting with an Explanatory Code of BX and/or QD? How do I fix this?**

As per the Payment Schedule, these explanatory codes require very specific information to be submitted on the claim submission. It is important to ensure the information submitted is correct. If an update or change is required, make the change in your software and resubmit the claim with the next batch submission.

For example, **BX** is a time-based service, and requires the following criteria to be met:

- Time requirements have not been met; therefore, no payment can be made; or
- The service code descriptor states "greater portion thereof" or "major portion thereof", and the greater/major portion of the time component has not been met; therefore, the additional time units are not payable; or
- Start and Stop Times provided do not correspond to the number of units billed.

Explanatory code **QD** applies to certain service codes and the days the service occurred on.

- This service code applies to a specific day and/or time. OR
- 700A is only billable on a Statutory holiday (or on the day designated in lieu, when the statutory holiday falls on a Saturday or Sunday). OR
- 701A is only billable on a Saturday or Sunday.

All time-based service codes require the time to be entered in military time (field values are between 0000 to 2359 (24-hour format and midnight is 0000)). In addition, the stop time of one code, must be the start time of the next. For example:

Surgical Assist 30J/31J -- Assist = 1hr 15mins

- 30J = 1hr – 1300-1400
- 31J = 15mins – 1400-1415

5. **I have items paid and rejected with the explanatory code BV. What does this mean?**

   As per the Payment Schedule, **BV** states the payment is based on the appropriate service code and amount listed for the date provided. For example:

   - 5B billed with LOS C --- Claim will pay as submitted.
   - 839A billed with LOS C --- 839A will be paid with LOS 3 with explanatory code BV (839A is not eligible for premium)
   - 5B billed on a non-weekend or Stat with LOS B --- Claim will pay as submitted.
   - 816A billed on a non-weekend or Stat with LOS B --- 816A will be rejected with explanatory codes BV (816A is not eligible for premium) and QD (816A is only billable on a weekend or stat)

6. **I submitted a claim with the service code of 40B. Does it require start and stop times?**

   Based on the Payment Schedule, 40B does not require start and stop times.

7. **Why have my claims rejected with an explanatory code of CE?**

   The explanatory code CE refers to the physician's registration and licensing. Please verify physician's eligibility and dates of service submit. If physician is eligible to submit for those dates of service, please call 1-800-605-2965 to log the issue with the Physician Registry and Support Services Unit.

8. **Please explain when the bilateral indicator is required.**
   The **Bilateral Indicators** are**:**

   - L – Left
   - R – Right
   - B – Bilateral

   For all **Unilateral Procedures**, please indicate left or right for each code if done bilaterally.
   For all **Bilateral Procedures**, please indicate left, right or bilateral.

   See example located on next page.

For example:

- **88T – procedure completed bilaterally.**
  - Must be submit as two lines:
    - 88T bilateral indicator L88T bilateral indicator R
- **93T – procedure completed bilaterally.**
  - 93T is unilateral or bilateral and only one is payable even if done bilaterally.
  - Must submit as one line.
    - 93T bilateral indicator B
- **380M – done on the left hip**.
  - Must submit as one line:
    - 380M bilateral indicator L

9. Why is my claim rejected with an explanatory code of BH when both physicians are oral surgeons?

The rate submitted does not match the listed rate in the Dental Payment Schedule or MSB paid at less or more than the amount submitted. Refer to the Payment Schedule for details on the **BH** explanatory code. Make the appropriate updates to your claim and resubmit the claim on the next batch submission.

10. Several of our claims were rejected with an explanatory code of CM. These claims were paid, then recovered and we resubmitted them?

The time limit for claims submission is 6 months from the date of service. The Claims Processing System checks the date the claim was received against the date of service. If the claim was originally paid and then subsequently recovered/rejected, please do not resubmit as the resubmitted claim will be treated like a new claim. To determine the exact status of the claim, use the Query Claims function in Customer Portal.

11. Why did my claim(s) reject with an explanatory code of BU? What is the proper way to submit these types of claims?

Please check the BU explanatory code in the Payment Schedule as it may have rejected for several reasons. For example:

- The surcharge was billed by itself – (i.e., 815A without the visit service).
- Two surcharges were billed.
- The service code(s) billed with the surcharge are not eligible for a surcharge.

12. When I bill for CDM, I get an error stating, 'not proper order'. What is the correct order to submit?

This error is likely generated from your vendor software. The correct order to submit is:

1. 64B
2. 65B/66B/67B/68B

Please note: The new Claims Processing System requires the correct diagnostic code for each of the following codes:

- 64B – 250, 410-414, 425, 428, 429, 490, 491, 492, 496, 518 and 519
- 65B – 250
- 66B – 410-414
- 67B – 425, 428, 429
- 68B – 490, 491, 492, 496, 518, 519

13. If a physician works on-call in two hospitals, are they required to have different clinic numbers for each hospital?

If the physician is set up as a solo clinic, then they do not require two different clinic numbers.

14. It appears that one duplicate claim was paid and the other is pended. Do I wait until the pended claim is reviewed by a Claims Analyst before doing anything with it?

Yes. Allow the Claims Analysts to review the pended claim, along with all the history claims, to determine if all related claims will be paid or rejected.

15. When reviewing the bi-weekly return files, several old claims from 2020, 2021, 2022 appear? In some cases, an old claim is being returned. Why is this happening?

The file received by MSB, from WCB, triggered a re-adjudication of old claims (beyond one-year). MSB has since overridden those changes to ensure the claims were not recovered/amended. No further action is required. However, if the impacted WCB claim is within one-year from the DOS please action the claim accordingly.

16. When do we use the drop down 'not a WCB claim'?

This is a field in your vendor software that corresponds to a new, non-mandatory field in the new Claims Processing System. The new field is called **Claim Type**.
The field values are:

- **P** – Used when prior approval is requested by MSB.
- **W** – Used when a service is submitted to WCB but is rejected, as it is not WCB's responsibility. The comment "not WCB" has been moved to this field.
- **D** – Used when a service is submitted to the Department of Veteran Affairs but is rejected, as it is not their responsibility. The comment "not DVA" has been moved to this field.

Enter a value in this field, only if it is required for the claim.

17. Are claim numbers being reused?

The 10-digit Claims Processing System claim numbers are not reused. They are assigned every time a claim is submitted. The 5-digit external claim number assigned by your billing software can be re-used.