

Customer Portal (CP) and Accuro Local Clients Claim Submissions User Manual



Medical Services Branch



Claims Replacement Project

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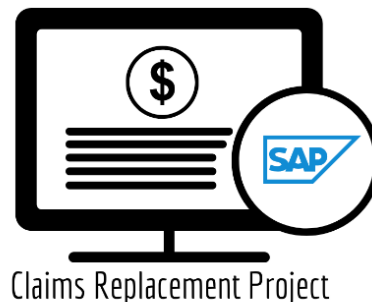
Module ONE: Overview

Learning Objectives

Upon completion of this course, learners will have an understanding of:

- How to submit claims through a **Batch** submission using the Accuro Application and Customer Portal.
- How to navigate the new features of Customer Portal.

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Overview of Customer Portal

Accuro's Application and **Medical Services' new Customer Portal** will work together, allowing you to submit batch file claims, retrieve daily and bi-weekly return files, query claims, and submit support tickets.

Claim submissions will involve both the **Accuro Application** and **Customer Portal**.

Daily return files are new and will be available through **Customer Portal**. The Daily Return file provides a list of rejected claims from the prior days submissions and is available each morning. These claims can be reviewed, updated/changed and re-submitted, with the goal of having that claim(s) paid on the next bi-weekly run.

Customer Portal (CP) is a web-based application, providing options to query claims, submit support tickets and contact MSB.

Benefits of the Accuro Application and Customer Portal

Accuro Application	Customer Portal
• Submit claims	• Submit claim queries, including adding document attachments to claims.
• Upload Bi-weekly Return Files	• Retrieve Validation reports
• View paid and rejected responses	• Retrieve Bi-Weekly Return Files
• Adjust rejected claims and re-submit	• Retrieve Daily Return Files
	• Retrieve MSB contact information
	• Access to view and download frequently used forms and payment schedules
*** Uploading Daily Return Files in Accuro will be added in future releases.	

Module TWO – Accuro Local Clients - Changes & Updates

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With the implementation of Medical Services' new Claims Processing System a few changes and updates will occur, along with a few items remaining the same.

What stays the same?

The following items will have no change, or very minor changes, with the new Medical Services system:

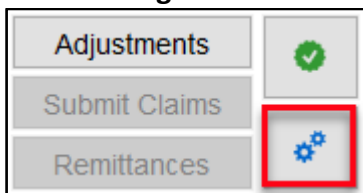
Updating a rejected claim

Updating a rejected claim remains the same process and continues to be done through Accuro's Application. Make the appropriate adjustments to the claim in Accuro and mark the claim(s) for resubmission.

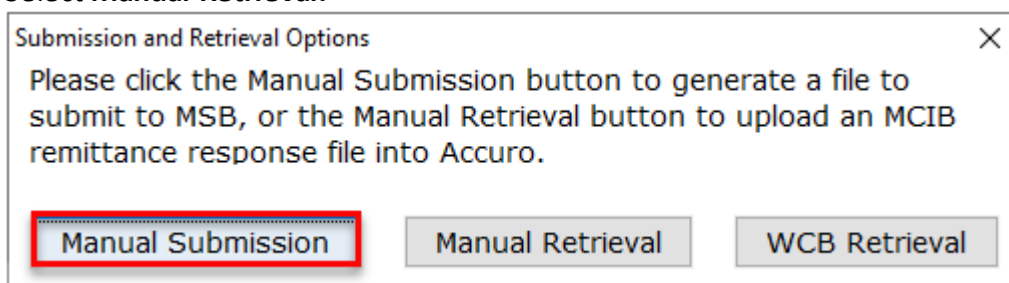
Remittances (Bi-weekly Return Files)

The Bi-weekly Return files continue to be available through the Accuro Application, are available after the bi-weekly pay run and remain in the same format. There is one slight adjustment when retrieving this file.

1. Click **Claims**.
2. Click the **Cog Wheel**. **NOTE:** The Submit Claims and Remittances buttons are greyed out.



3. Select **Manual Retrieval**.



4. Select **Bi-Weekly File**.

What is New?

The new system has several enhancements to benefit you when submitting claims and monitoring the status of claims.

New Clinic Number

Clinic 000 has been eliminated. If you use **Clinic 000** a new clinic number will be assigned to you and sent via email. Your new clinic number will need to be updated in Accuro **AFTER** Go-Live but **PRIOR** to your first submission. This update is only required the very first time you log into Accuro after Go-Live. All profile changes are saved.

Follow these steps to update your Clinic Number in Accuro.

1. Login to **Accuro**.
2. Click **F2 (Provider Management)**.
3. Select **Provider**.
4. Click **Cog wheel** button (Configure).
5. Click **Next** to reach **Billing Options**.
6. Enter the 3-digit Numeric/Alphanumeric number in **Clinic Number** field.
7. Enter the 3-digit Numeric/Alphanumeric number in **Group Number** field.
8. Click **Next** -> Click **Next** -> Click **Finish**.



There is no change to your Group Number, however, once in this screen be sure to confirm it is correct.

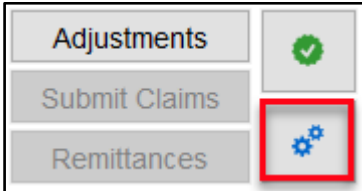
Claim Submissions

Submitting claim files is a two-step process. The first step starts with the Accuro application, and the second step is with Customer Portal.

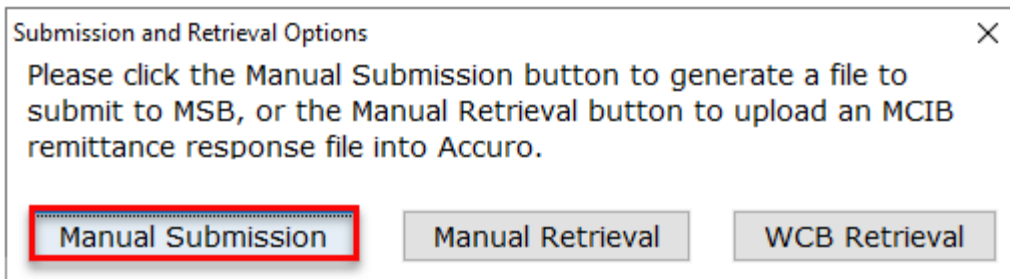
First Step – Accuro Application

Once claims are entered in the Accuro application and ready for submission, follow these steps:

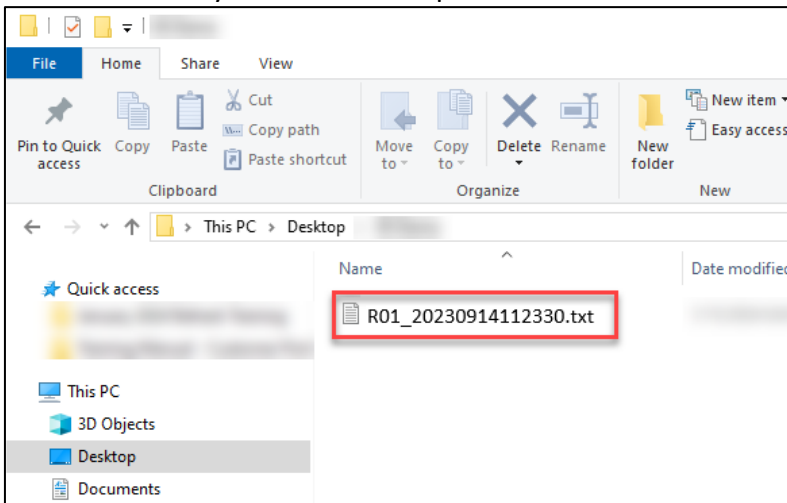
1. Click the **Cog Wheel**. **NOTE:** The Submit Claims and Remittances buttons are greyed out.



2. Click on **Manual Submission**.



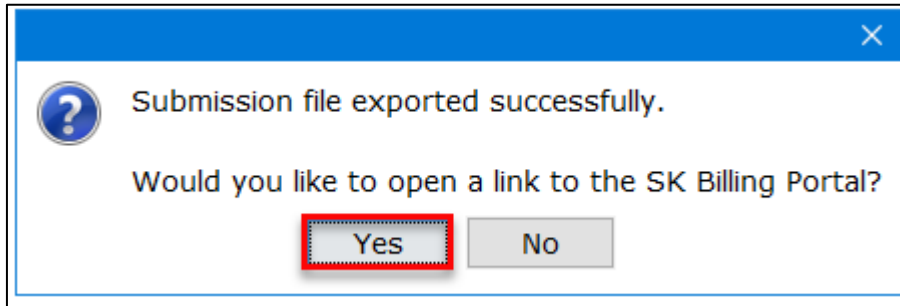
3. **Save** the file on your local desktop or shared file location.



You are required to Save a file for each group that you are submitting for.



- Click **OK**.



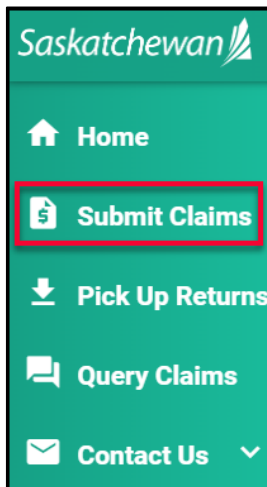
If No is selected the claims will not be marked as submitted in Accuro.

- Navigate to **Customer Portal** to upload your files to Medical Services.

Second Step – Customer Portal

Uploading your batch file through Customer Portal allows for a seamless transfer of your claim files. After logging into Customer Portal, follow these steps:

- Click on **Submit Claims**.

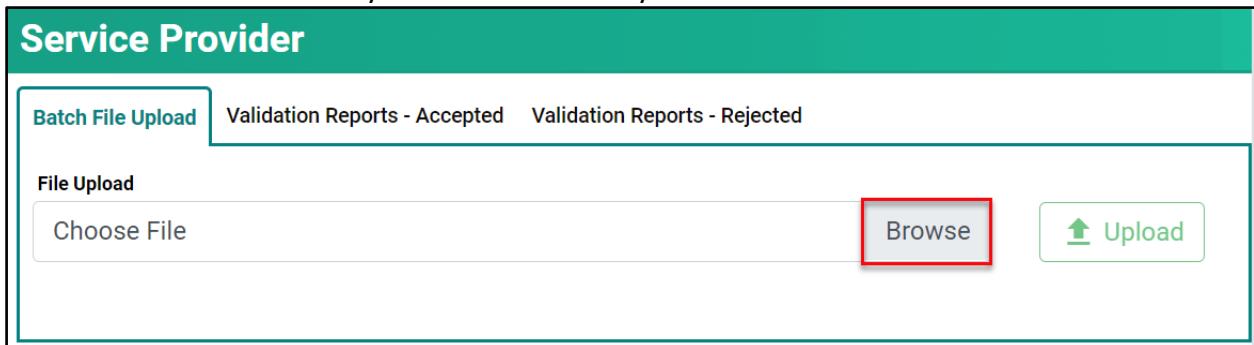


Module THREE and Module FOUR provide details on how to log into Customer Portal for the first time and how to navigate within Customer Portal.

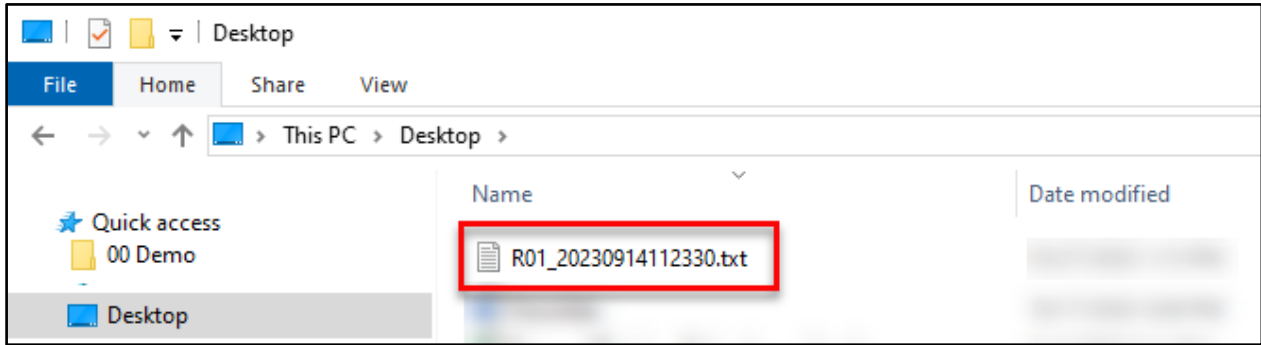


Be sure to review these modules to become familiar with Customer Portal.

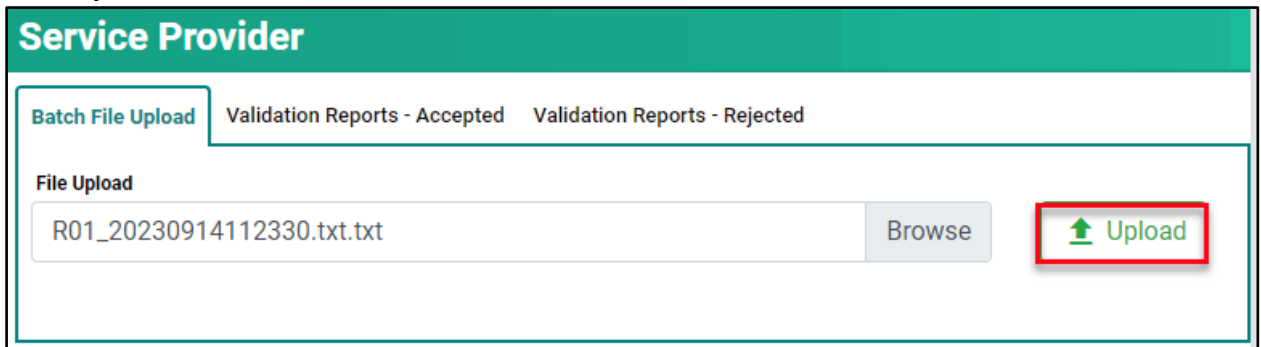
- Click on **Browse** to retrieve your file from a locally saved location.



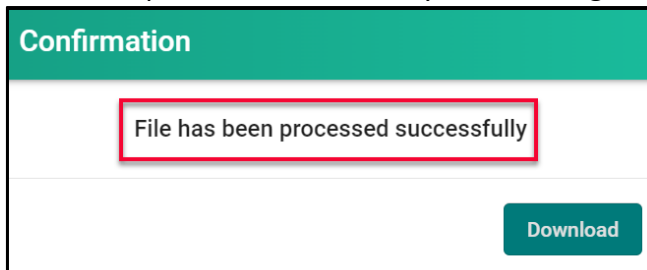
3. Find the file to upload, from **Step #3 above**, then **double-click** on the file name.



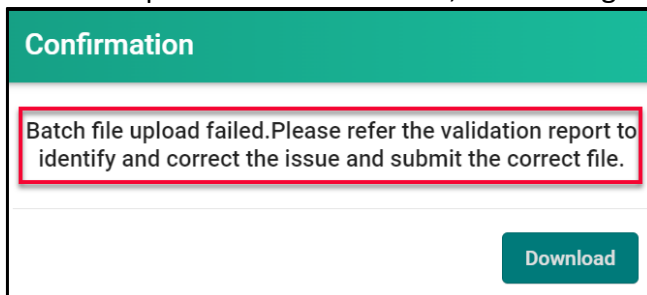
4. Click **Upload**.



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



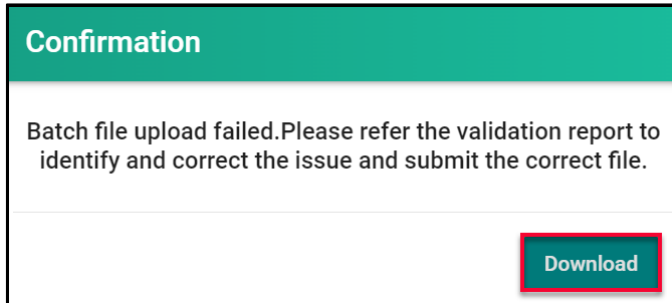
If the file upload was unsuccessful, this message is presented:



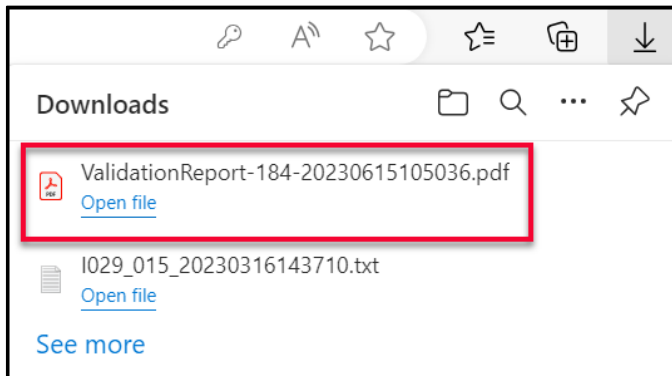
6. In either case, the **Validation Report** can be viewed. It is important to view the **Validation Report** when the file upload fails, as the report will provide details on what failed.

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

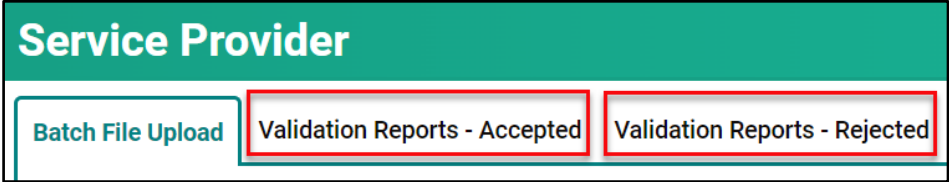
Option #1 – Click **Download**.



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



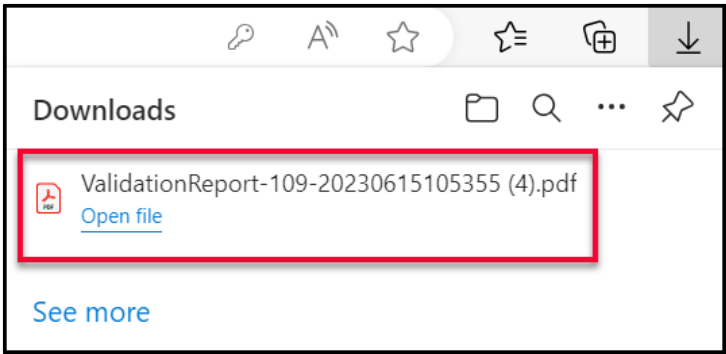
Option #2 – Click the **Validation Reports – Accepted** or **Validation Reports - Rejected** tab.



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

Service Provider	
Batch File Upload	Validation Reports - Accepted
Submission Date	Validation Report
15-Jun-2023 11:13:53 AM	ValidationReport-051-20230615111353.pdf
15-Jun-2023 11:01:55 AM	ValidationReport-051-20230615110154.pdf
15-Jun-2023 10:53:55 AM	ValidationReport-109-20230615105355.pdf

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



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

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

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

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

Daily Return File

Daily Return Files are a new feature and provide the ability to view all rejected claims from the previous days' submission. Those rejected claims can be updated/fixed/changed and resubmitted. This leads to a quicker turnaround for claims to be paid.

The Daily Return File is a feature within Customer Portal and is documented in **Module 5 – Pick-Up Returns** of this manual.

When viewing the rejected claim(s) take note of the Explanatory Code and corresponding description as this explains the reason for the rejection.

It is highly recommended to view the rejected claims daily. The Daily Return Files are available the day following a submission (Monday through Friday).

Query Claims

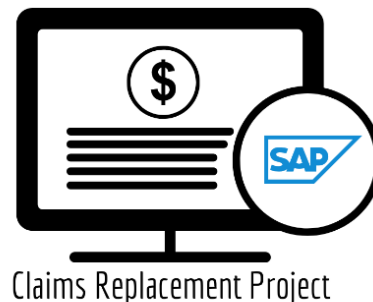
Claims that have been rejected and require additional documentation, such as a consultation report or descriptive letter, or claims that need to be recovered can be done so through Customer Portal.

See **Module 6 – Query Claims** in this manual for details on how to do each.

Module THREE – Getting Started

Getting Started

Several authorized users will access Customer Portal over the Internet. To ensure only authorized users gain access to Customer Portal, eHealth Saskatchewan requires Multi-Factor Authentication (MFA).



Logging In

Once fully registered in the Physician Registry (this includes having your direct email address registered with your profile), a welcome email and password reset email will be sent to you. Follow the prompts to reset your password to login to Customer Portal. Your userid will be your registered email address. The password you personally set must conform to eHealth Saskatchewan password complexity policy to be accepted.

Multi-Factor Authentication (MFA)

Logging onto 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 FOUR – Navigating Customer Portal

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.

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Claims Replacement Project

Explore the module to learn about the **Home Page** also referred to as the **Landing Page**.

Top Menu Bar

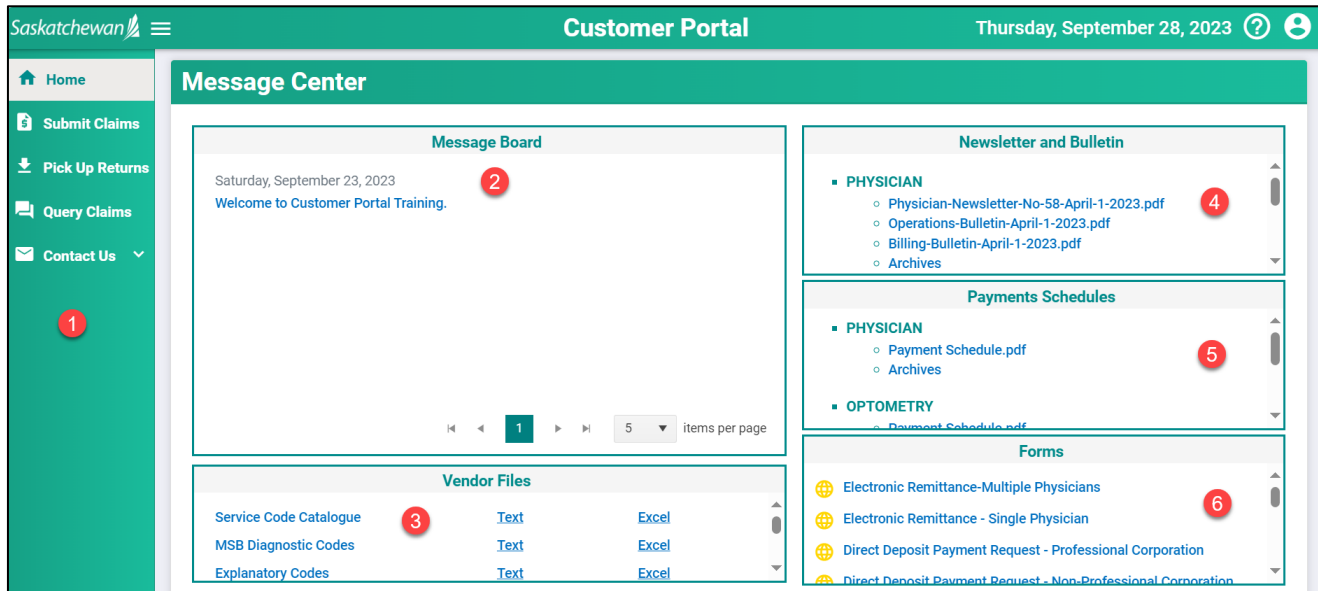
The top menu bar in Customer Portal provides four main options:



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

Home Page

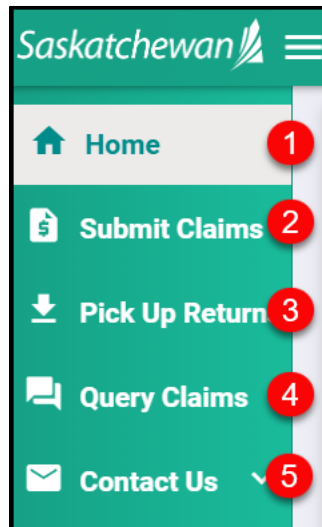
The **Home Page** or **Landing Page** is the first screen that appears when logging into Customer Portal. It serves as a gateway to the application's features and functionality.



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

Navigation Menu

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



Each option will be elaborated on in the following modules.

Area		Description
1	Home	Clicking on Home takes the user back to the Home Page.
2	Submit Claims	Users enter in the claim details and submit batch file claims.
3	Pick Up Returns	Users can retrieve their Daily and Bi-weekly Returns here.
4	Query Claims	Users can search for submitted claims with the option of adding additional information or recovering an already submitted claim.
5	Contact Us	Provides several options for contacting Medical Services

Module FIVE– Pick Up Returns

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Claims Replacement Project

Pick Up Return Files

Pick Up Return Files indicate the status of the claims submitted and can be viewed through Customer Portal.

There are two types of Return Files:

- Daily Return Files
- Bi-Weekly Return Files

Daily Return Files

Daily Return Files display all rejected line items from the previous day's submission. All rejected line items, along with the corresponding explanatory code need to be reviewed to determine the following:

- A correction to the original submission is required (i.e., Invalid HSN – Explanatory Code AA,
- The line item needs to be queried to add additional information or documentation,
- No further action is required as the claim is not payable, based on the Assessment Rules.

Following the above three guidelines ensures a faster turn-around on fixing rejected line items, does not create a duplicate line item and ultimately allows the claim to be paid on the next bi-weekly run.

If the re-submitted item(s) still has an error, it will be returned, in the next **Daily Return File**, with a new Explanatory Code. Using the guidelines above, the line item(s) need to be reviewed to determine if it should be resubmitted, queried through Customer Portal or no further action is required. This process can occur multiple times in a two-week period.

NOTE: Only re-submit items that have invalid data or incorrect information (i.e., invalid character, Mode 1 vs Mode 0, Professional Corporation indicator missing, etc. or items rejected with Explanatory Code ZA, ZC or ZR)



If a service code is to be changed (i.e., change from a 3B to a 5B) query the item (see Module 6 – Query Claims). There is no need to resubmit in this instance as the new Claims Processing System keeps a history of all submitted items.

Bi-Weekly Return Files

Bi-weekly Return Files consists of the Payment List, Rejected List and Pended List. Use this file to account for all items submitted. Totals of each category are included to assist with reconciling the submission.

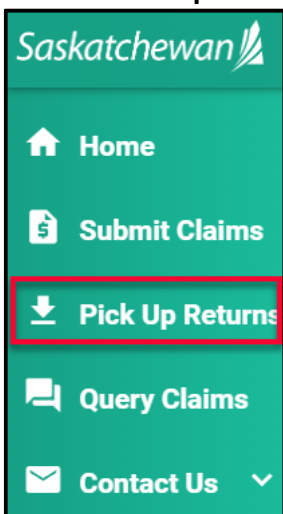
The **Bi-weekly Return File** will be categorized by doctor, clinic, mode, and professional corporation or non-professional corporation.

Retrieving Daily Return Files

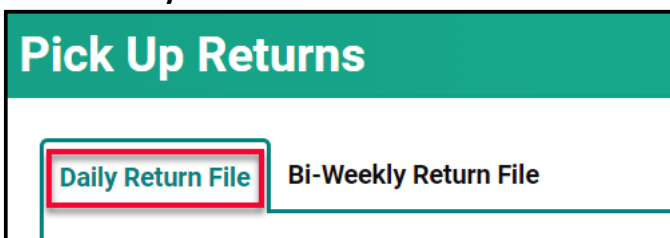
Daily Return Files are available every business day morning through the **Pickup Returns** option in Customer Portal.

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

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



2. Click on **Daily Return Files**



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

Pick Up Returns

Daily Return File

Bi-Weekly Return File

Daily Return File	Download Report
I029_100_20230316143710.txt	

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

Downloads

I029_100_20230316143710 (8).txt

[Open file](#)

I029_100_20230316143710 (7).txt

[Open file](#)

5. This file opens as a text file.
6. It is important to review this file so the rejected claims can be fixed and re-submitted.



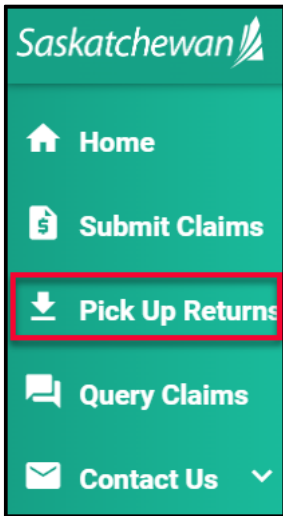
Refer to
Reading the Daily Return .txt File
located on
eHealth Saskatchewan’s website to
assist in reading the .txt return file.

Retrieving Bi-Weekly Return Files

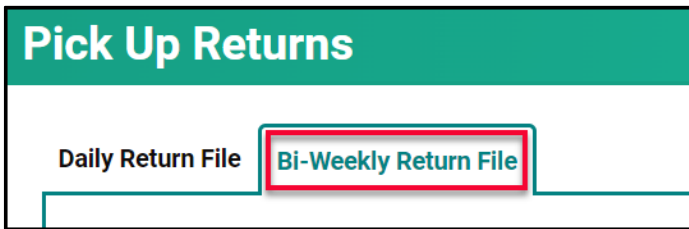
Bi-Weekly Return File is available the morning of the pay date, through the **Pick Up Returns** option in Customer Portal.

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

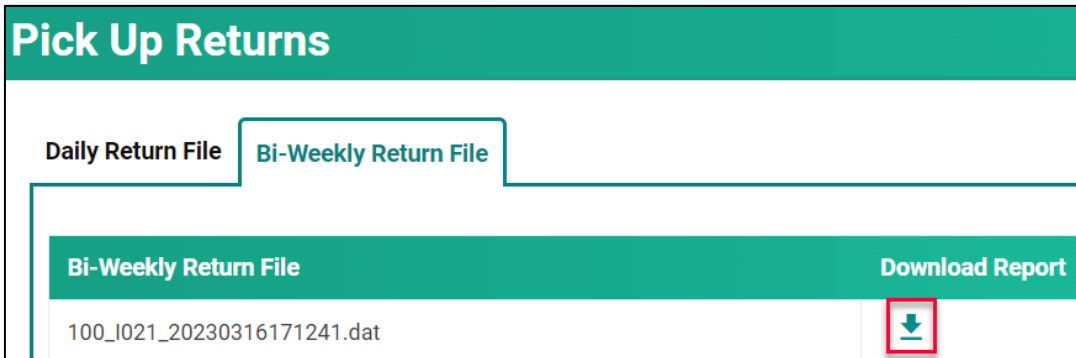
1. Click on **Pick Up Returns**.



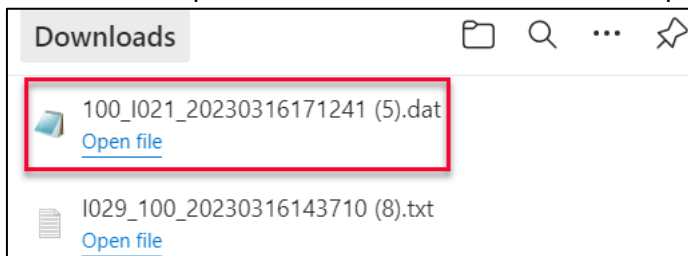
2. Click on **Bi-Weekly Return File**.



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



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



- This file opens as a text file.
- It is important to review this file as it includes a reconciliation of the files submitted against the files paid, rejected, and pended.



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

Module SIX – Query Claims

Query Claims

From time to time, additional information needs to be added to a claim or a claim needs to be recovered after it is submitted. This can be done through a **query**.

There are two types of queries:

- Claim Query
- Supplementary Claim Information

Claim Query

A **Claim Query** is used when a claim must be recovered. Typically, this occurs when incorrect information was entered on the original claim. When a recovery is requested through the **Claim Query** one of two things happens.

- The claim is **Rejected** with an **Explanatory Code of BP**. The rejected file is returned so updates can be made. Once the claim is updated, it can be re-submitted for adjudication.
- The claim is **Pended** for a manual review by MSB. After reviewing the pended claim, it 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

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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:

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

Query Claims

External Claim No	Province	Health Card No	Billing No *	Group Id	Clinic No	Mode	From Date *	To Date *
External Claim No	SK	Health Card No	8481	Group Id	Clinic No	Mode	01-06-2023	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**

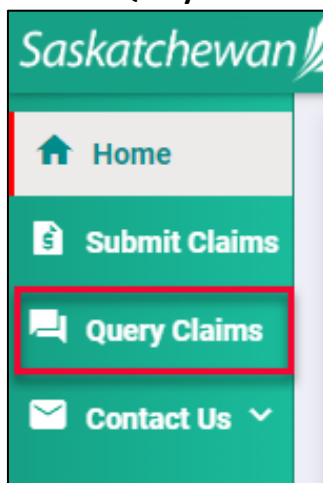
Submission From Date

From Date *	To Date *
From Date	To Date

The **From Date** and **To Date** must be the **Submission Date** of the claim. In other words, the dates entered for the query must be the date the claim was submitted to MSB not the service date.



1. Click on **Query Claims**.



- Enter the three mandatory fields of **Billing No** (auto populated or selected from the drop-down list), **From Submission Date** and **To Submission Date**. Date format is DD-MM-YYYY. The calendar icons can be clicked on to select the date. **NOTE:** The date range can only be seven days

Query Claims

CPS Claim No: External Claim No: Province: Health Card No: **Billing No ***: Group Id:

Clinic No: Mode: **From Date ***: **To Date ***:

- Enter additional query criteria as desired.



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

Query Claims

CPS Claim No: External Claim No: Province: Health Card No: **Billing No ***: Group Id: Clinic No: Mode: **From Date ***: **To Date ***:

	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
☐	1030023043		SK	370163829	038U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA
☐	1030023043		SK	370163829	037U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA
☐	1030023043		SK	370163829	036U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA

1 - 10 of 86 items

Next

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

Query Claims

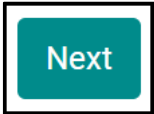
CPS Claim No: External Claim No: Province: Health Card No: **Billing No ***: Group Id: Clinic No: Mode: **From Date ***: **To Date ***:

	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
☒	1030023043		SK	370163829	038U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA
☐	1030023043		SK	370163829	037U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA
☐	1030023043		SK	370163829	036U	2023-06-15	2023-06-15	REJECTED				0.00	0.00	AA

1 - 10 of 86 items

Next

7. Click **Next**.



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

Submit Query and Attachments

Type *

Type

Claim Query

Supplementary Claim Information

Description *

Description

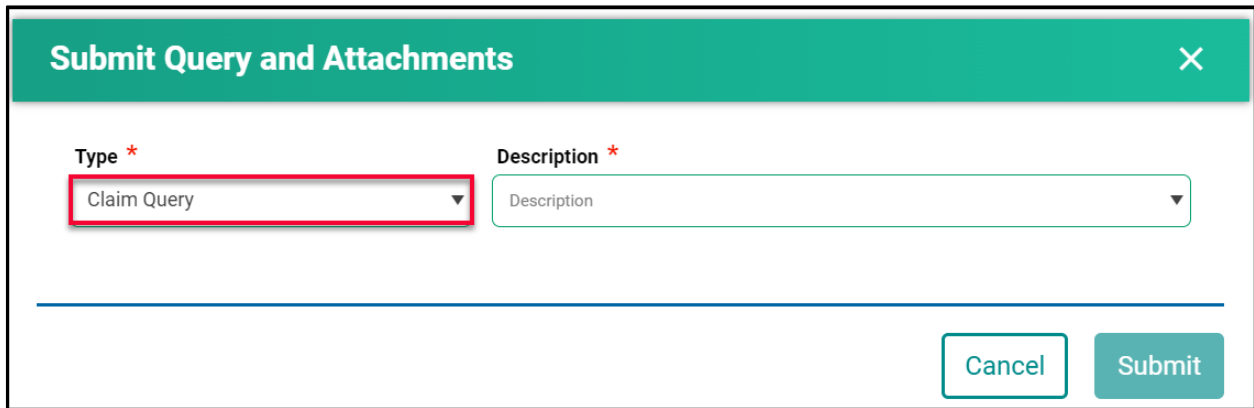
Cancel

Submit

How to Run a Claim Query

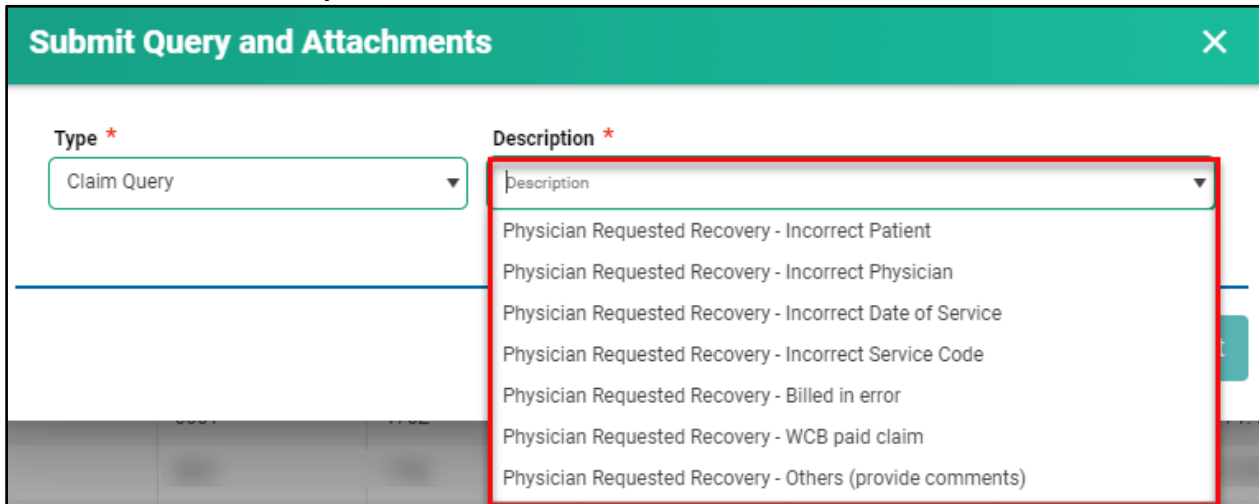
When recovering a claim due to an error on the initial submission, use the **Claim Query** option.

1. Select **Claim Query**.



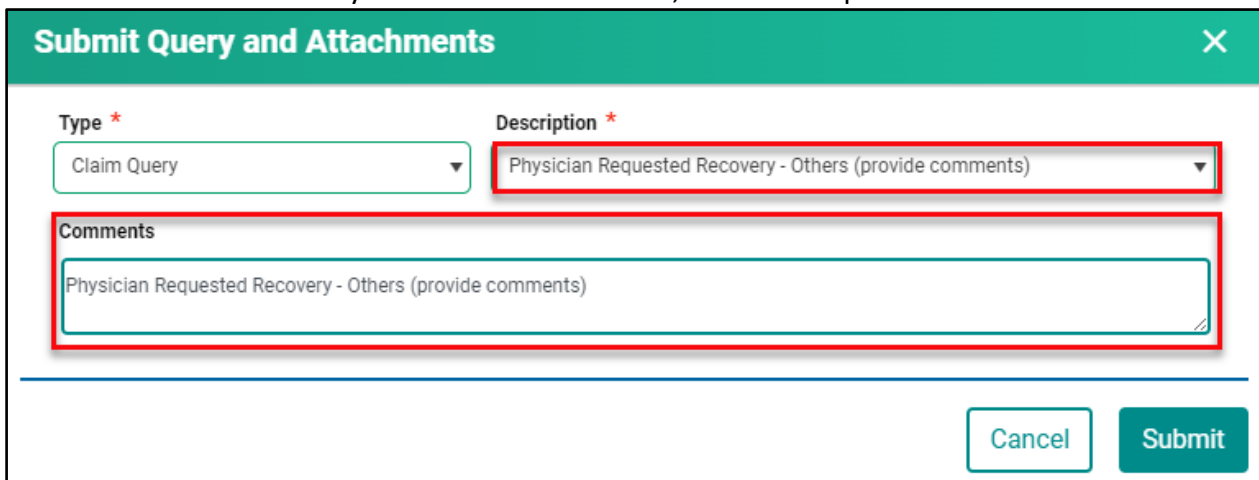
The screenshot shows a form titled "Submit Query and Attachments" with a close button (X) in the top right corner. There are two dropdown menus: "Type *" and "Description *". The "Type *" dropdown is set to "Claim Query" and is highlighted with a red box. The "Description *" dropdown is currently empty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

2. Select the correct **Description**.



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

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 set to "Claim Query". The "Description *" dropdown is set to "Physician Requested Recovery - Others (provide comments)" and is highlighted with a red box. Below the dropdown, there is a "Comments" section with a text area that contains the text "Physician Requested Recovery - Others (provide comments)". This text area is also highlighted with a red box. At the bottom right, there are "Cancel" and "Submit" buttons.

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

Query/Attachments Submitted

Invoice item(s) 1 captured in job dataset for Re-adjudication

Description
Physician Requested Drawback - Incorrect Patient

Cancel

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

Query/Attachments Submitted

Claim : 00000001000028560 and Item : 0001 is already marked for Re-adju, process

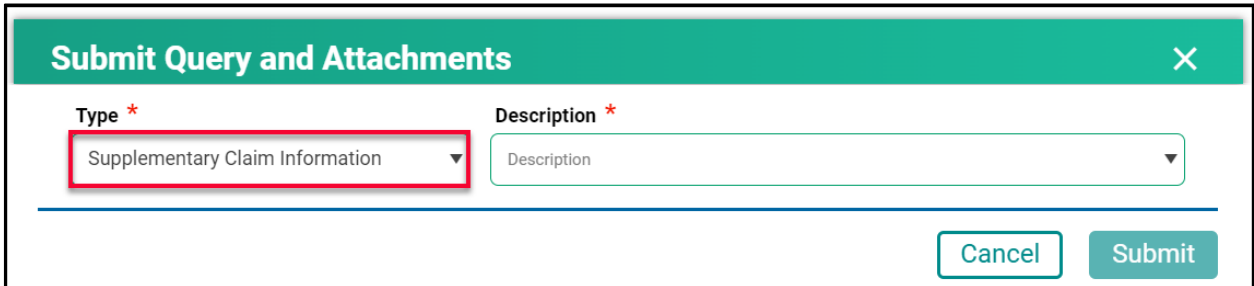
Description
Physician Requested Drawback - Incorrect Patient

Cancel

How to Run a Supplementary Claim Information Query

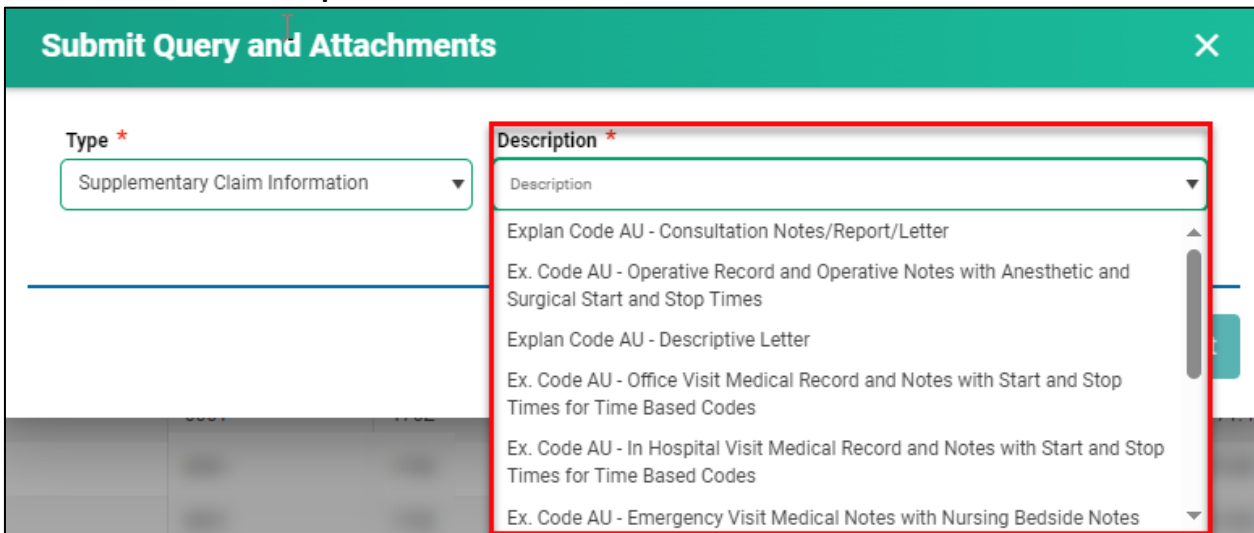
When additional documentation and/or comments are required on a claim, use the **Supplementary Claim Information Query**.

1. Select **Supplementary Claim Information**.



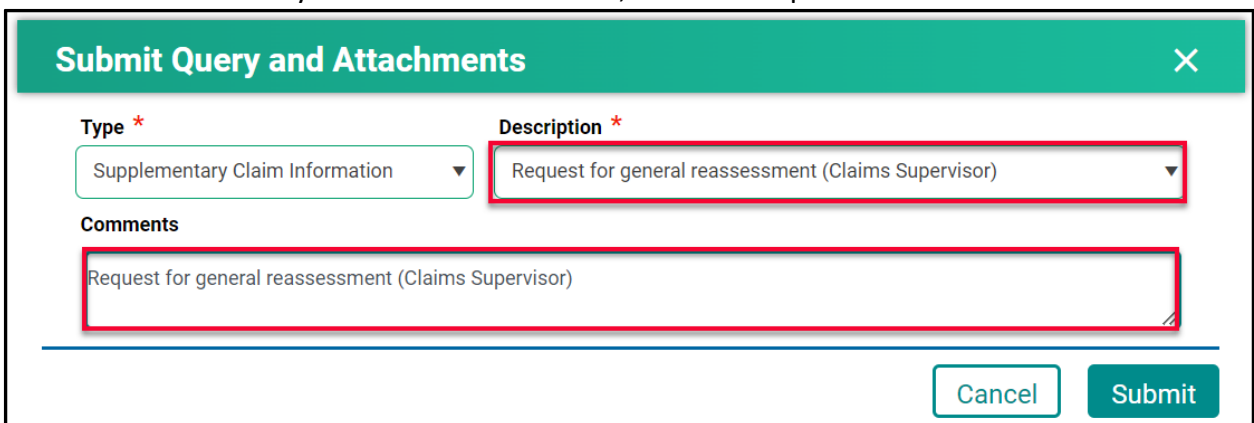
The screenshot shows a modal window titled "Submit Query and Attachments" with a close button (X) in the top right corner. Inside the modal, there are two dropdown menus. The first dropdown, labeled "Type *", is open and shows "Supplementary Claim Information" as the selected option. The second dropdown, labeled "Description *", is currently empty and shows "Description" as the placeholder text. At the bottom right of the modal, there are two buttons: "Cancel" and "Submit".

2. Select the correct **Description**.



The screenshot shows the same "Submit Query and Attachments" modal window. The "Type *" dropdown is still set to "Supplementary Claim Information". The "Description *" dropdown is now open, displaying a list of options. The options include "Explain Code AU - Consultation Notes/Report/Letter", "Ex. Code AU - Operative Record and Operative Notes with Anesthetic and Surgical Start and Stop Times", "Explain Code AU - Descriptive Letter", "Ex. Code AU - Office Visit Medical Record and Notes with Start and Stop Times for Time Based Codes", "Ex. Code AU - In Hospital Visit Medical Record and Notes with Start and Stop Times for Time Based Codes", and "Ex. Code AU - Emergency Visit Medical Notes with Nursing Bedside Notes". The "Description" placeholder is at the top of the list. The "Cancel" and "Submit" buttons are still visible at the bottom right.

3. If **Request for general reassessment** 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" modal window. The "Type *" dropdown is still "Supplementary Claim Information". The "Description *" dropdown is open and shows "Request for general reassessment (Claims Supervisor)" as the selected option. Below the dropdowns, there is a text area labeled "Comments" which contains the text "Request for general reassessment (Claims Supervisor)". The "Cancel" and "Submit" buttons are at the bottom right.

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

Submit Query and Attachments

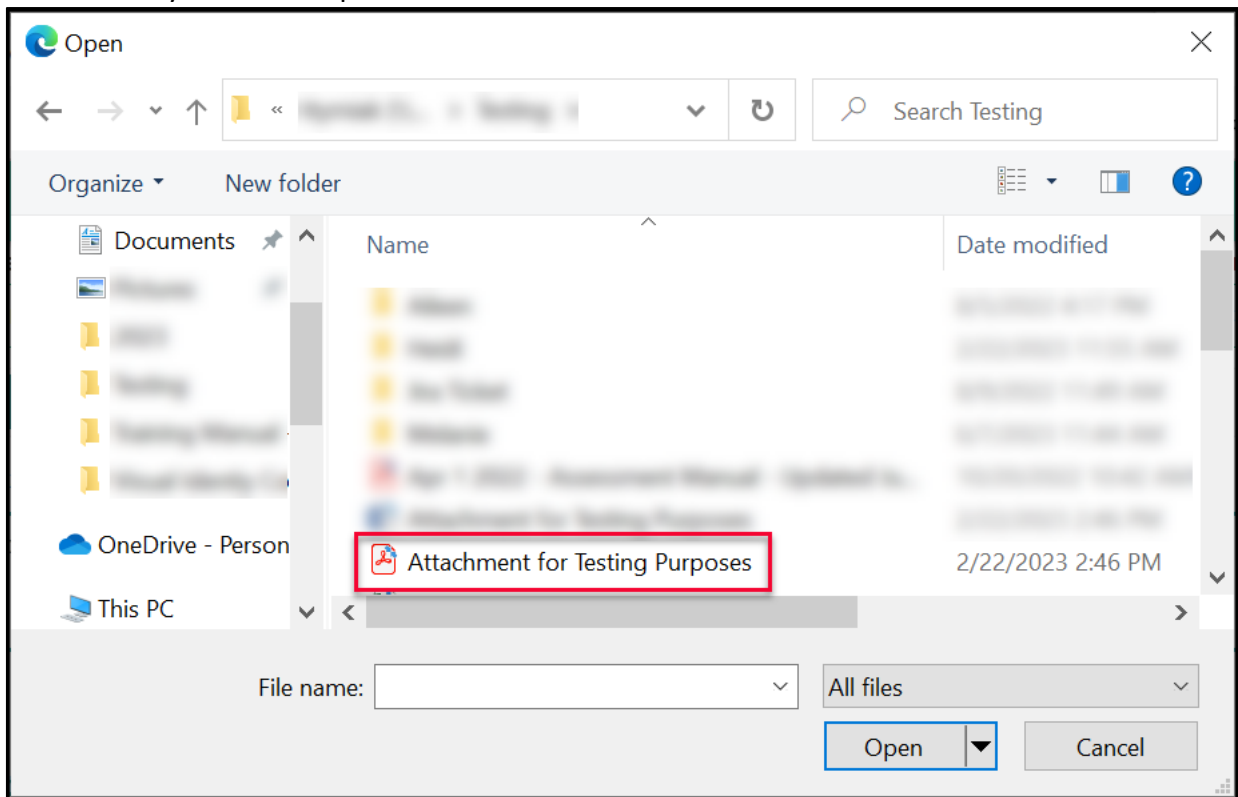
Type *
Supplementary Claim Information

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

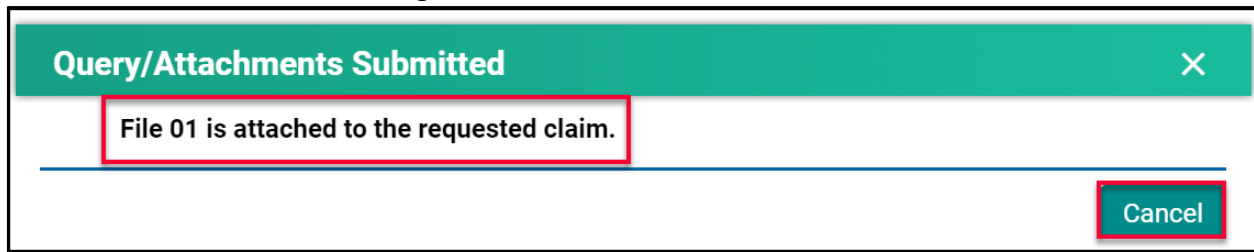
Type *
Supplementary Claim Information

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

Submit Query and Attachments

Type *
Supplementary Claim Information

Description *
Explain Code AU - Consultation Notes/Report/Letter

Attach File
Choose File No file chosen

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

Cancel Submit

- No action is required for 890L as it will be paid on the next bi-weekly run.
-

Scenario #3

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

- Line 1 - 9B
- Line 2 – 795A

After the adjudication process, the results were:

- Line 1 - 9B – Paid
- Line 2 – 795A - Rejected with an explanatory code of BK (service is not payable)

Action required:

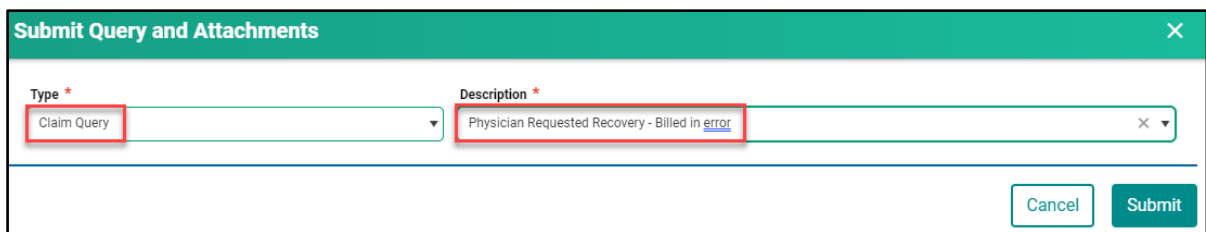
- No action required. 9B will be paid on the next bi-weekly run and 795A cannot be paid based on the Assessment Rules.

Scenario #4

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

Action required:

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



Submit Query and Attachments

Type *
Claim Query

Description *
Physician Requested Recovery - Billed in error

Cancel 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.

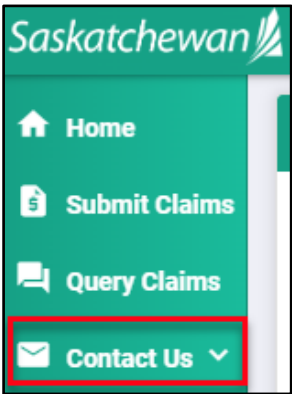
Module SEVEN – Contact Us

Contact Us

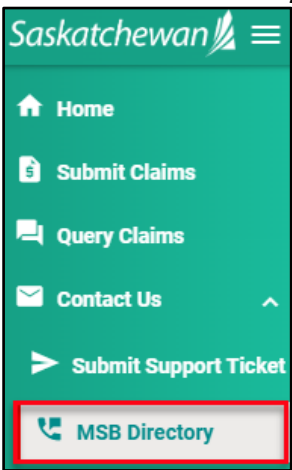
When requiring support with a claim or Customer Portal call **1-800-605-2965**, Monday to Friday from 8:00am to 5:00pm.

MSB Directory

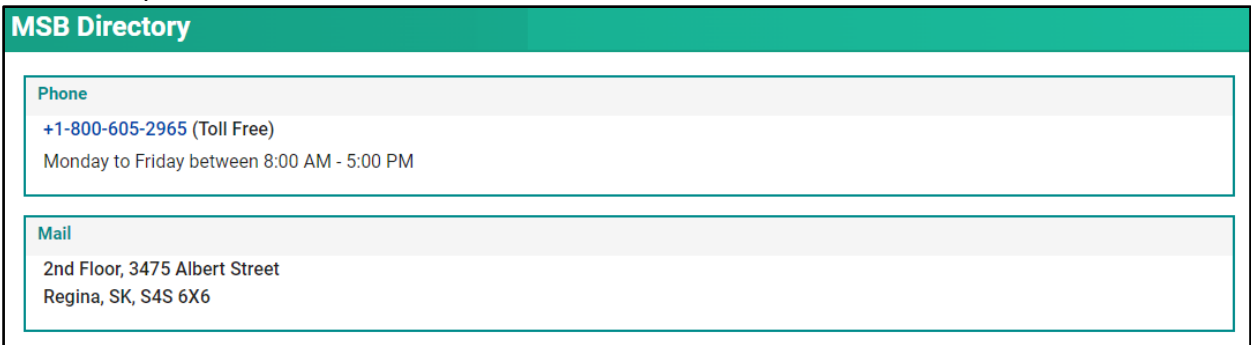
1. Click on **Contact Us**.



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



3. Select an option to contact MSB.



Medical Services Branch



Claims Replacement Project