

Customer Portal (CP) and Perspect 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 Perspect's **billing software**.
- The advantages and features of MSB's Customer Portal.

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Overview of Using Perspect's Billing Software and MSB's Customer Portal

Perspect's billing software 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 continue to be submitted through **Perspect's billing software**. The retrieval of the standard bi-weekly return files will also continue to be available to you through Perspect's billing software.

Daily return files are new and will also be available through **Perspect's billing software**. The Daily Return file provides you with 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 Perspect and Customer Portal

Perspect	Customer Portal
• Submit claims	• Submit claim queries, including adding document attachments to claims.
• Retrieve Validation reports	• Retrieve MSB contact information
• Retrieve Bi-weekly Return Files	• Access to view and download frequently used forms and payment schedules
• Retrieve Daily Return Files	
• Adjust rejected files and re-submit	

Module TWO – 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 several items staying the same.

What stays the same?

The following items will have no change with the new Medical Services system:

Submitting claims

The submission of claims remains the same process. Follow your current process to enter and submit claims in Perspect.

Updating a rejected claim

Updating a rejected claim remains the same process and continues to be done through Perspect's billing software. An alternative option to updating a rejected claim can be done through Customer Portal's query feature. See **Module SIX – Query Claims** for more information.

Bi-weekly Return Files

The Bi-weekly Return files are available after the bi-weekly pay run, remain in the same format and can be retrieved and viewed the same way.

It is encouraged to reconcile your submissions on a daily and/or bi-weekly basis. As always, the Bi-weekly Return File is available to be downloaded.

A screenshot of a web application interface. At the top, there's a navigation bar with links: Home, New Claims, Submitted Claims, Paid Claims, Rejected Claims, Search Claims, Reports (highlighted with a blue box), Account Management, Manual, and Log off. Below this is a section titled 'View Return Files'. It shows a table with columns: Download Date, Run Code, Return File Type, Return File Name, and Total App. Two rows are visible: one for a BiWeekly Return file from 01/09/2023 with a total of \$697.40, and another for a Daily Return file from 01/09/2023 with a total of \$0.00. Below the table, a file download dialog is open, showing the file path 'C:\Users\Personal\MB5\Files\Demo Download Files' and the file name 'IO21_261_20230901010618.txt'. A large red watermark 'Copyright 2023. Not for Distribution.' is overlaid on the screenshot.

Alternatively, selecting **Paid Claims** or **Rejected Claims** allows you to view each claim individually.



What Changes will Perspect Handle?

With the new system upgrade at Medical Services, the following changes will be implemented and taken care of by Perspect on your behalf. You will also receive communication regarding the change *IF* you have been impacted.

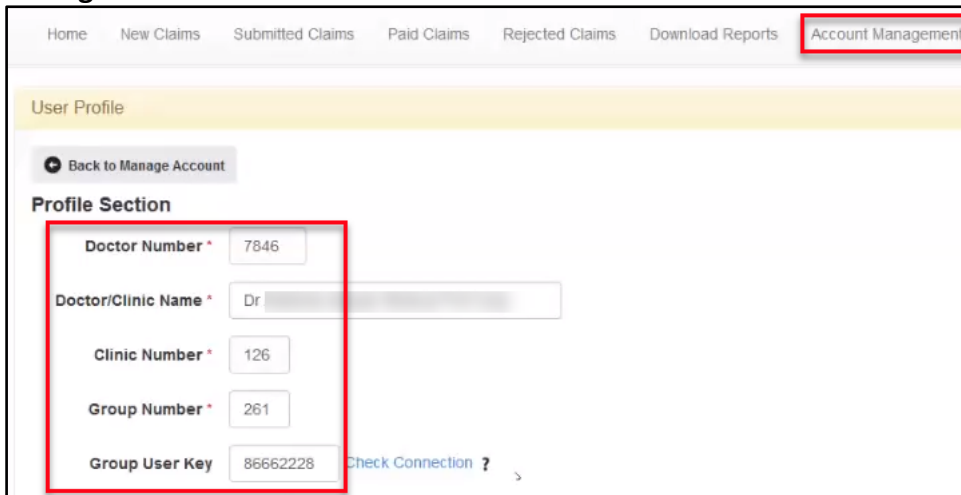
New Clinic Number

Clinic 000 has been eliminated. If you use **Clinic 000** a new clinic number has been assigned and emailed to you. Perspect will update your clinic number in their billing software AFTER the last submission in the MSB's old system and BEFORE the new submission in MSB's new system. No action is required on your part. However, it is important for you to keep a record of your new clinic number for future use.

New Group User Key

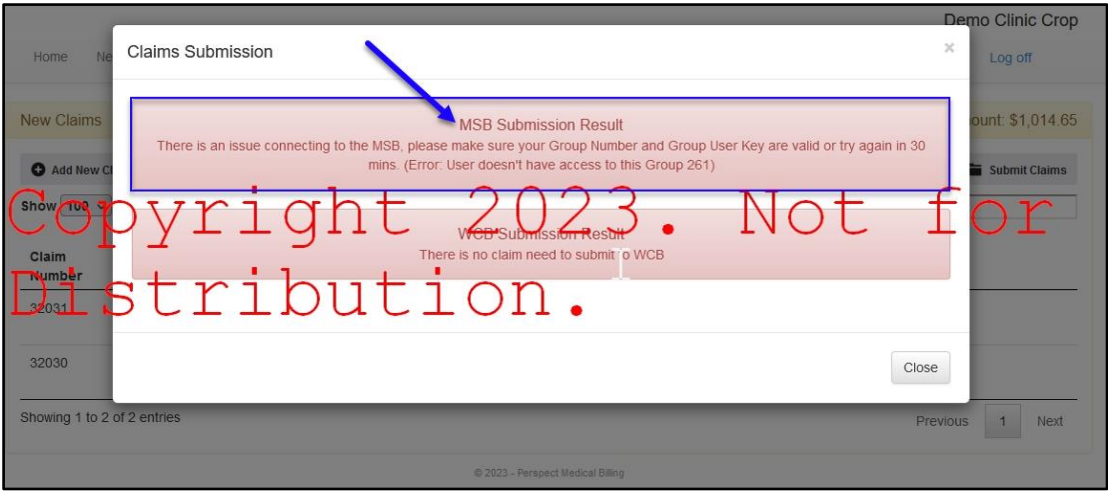
A **Group User Key** is required for entering claims in the Perspect application. This replaces the current Certificates. The Group User Key will be emailed to you just prior to Go-Live. Perspect will update your Group User Key in the billing software. No action is required on your part.

Once the changes are made by Perspect, you can view your profile information by clicking **Account Management**.



The screenshot shows the Perspect application's 'User Profile' page. At the top, a navigation bar includes links for 'Home', 'New Claims', 'Submitted Claims', 'Paid Claims', 'Rejected Claims', 'Download Reports', and 'Account Management'. The 'Account Management' link is highlighted with a red box. Below the navigation bar, the 'User Profile' section is displayed. A 'Back to Manage Account' button is visible. The 'Profile Section' contains several input fields: 'Doctor Number *' (7846), 'Doctor/Clinic Name *' (Dr.), 'Clinic Number *' (126), 'Group Number *' (261), and 'Group User Key' (86662228). A red box highlights the 'Doctor Number', 'Clinic Number', 'Group Number', and 'Group User Key' fields. To the right of the 'Group User Key' field is a 'Check Connection ?' link.

If an error occurs during submission and the error message is related to your Clinic Number, Group Number or Group User Key please contact Perspect to resolve the issue.



What is New?

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

Validation Reports

A validation report will be presented upon submission of your claims in Perspect. The validation report notifies if the submission was **Accepted** or **Rejected**.

Successful Submission

Successful submissions state the file was **Accepted**. No further action is required at this point. All claims submitted within that submission have been sent to Medical Services.

The screenshot displays the MSB Claims Submission interface. A blue box highlights the 'MSB Submission Result' message, which states: 'MSB claims had submitted to the MSB site successfully. A new window is opened to show the submitted claims from MSB, please print it out for your reference. If a new window does not popup, please click [here](#) to open the window and allow popup for this site!'. Below this, a 'Validation Report - 261-20231005305253.pdf' is shown. The report includes a table with the following data:

Clinic	Doctor	Corporation Indicator	Claims	Records	Services	89 Recs	Comments	Fee Sub
126	7846		2	8	4	0	2	\$621.45
Totals:			2	8	4	0	2	\$621.45

A large red watermark 'Copyright 2023. Not for Distribution.' is overlaid across the center of the image.

Unsuccessful Submission

When a submission is **Rejected**, it means there is an error on your submission. The errors **MUST** be fixed, and your file **MUST** be re-submitted. If errors are not fixed and the file is not re-submitted, your claim submissions will not be received by Medical Services.

The validation report for a rejected file indicates the reason it failed. There can be several reasons a file rejects. Review the **Reject Description** field to troubleshoot the reason for failure. Changes and updates need to be made and then the file can be resubmitted. The following are a few samples of a rejected submission along with the description of why the file rejected.

Sample Rejected Submission for a Duplicate

MSB Submission Result
MSB claims had been rejected by MSB.
A new window is opened to show the rejected reasons from MSB, please print it out for your reference.
If a new window does not popup, please click [here](#) to open the window and allow popup for this site!

Validation Report - 261-20231004100604.pdf

Claims Submission Validation Report
File Name : 261_20231004100604.pdf
Submission Date : Wed Oct 04 10:16:04 CST 2023
Group Number : 261
Status : **Rejected**

Clinic	Doctor	Corporation Indicator	Claims	Records	Services	89 Recs	Comments	Fee Sub
126	7846		2	8	4	0	2	\$621.45
Totals:			2	8	4	0	2	\$621.45

Clinic	Doctor No	Corporation Indicator	Reject Description	Claim No
NA	NA	NA	Multiple Records with same Claim Number and same Sequence Number	32020
NA	NA	NA	Multiple Records with same Claim Number and same Sequence Number	32021

Sample Rejected Submission for an Ineligible Physician

MSB Submission Result
MSB claims had been rejected by MSB.
A new window is opened to show the rejected reasons from MSB, please print it out for your reference.
If a new window does not popup, please click [here](#) to open the window and allow popup for this site!

WCB Submission Result
There is no claim need to submit to WCB

Validation Report - 261-20231004105836.pdf

Claims Submission Validation Report
File Name : 261_20231004105836.txt
Submission Date : Wed Oct 04 10:58:36 CST 2023
Group Number : 261
Status : **Rejected**

Clinic	Doctor	Corporation Indicator	Claims	Records	Services	89 Recs	Comments	Fee Sub
126	ABCD		2	8	4	0	2	\$621.45
Totals:			2	8	4	0	2	\$621.45

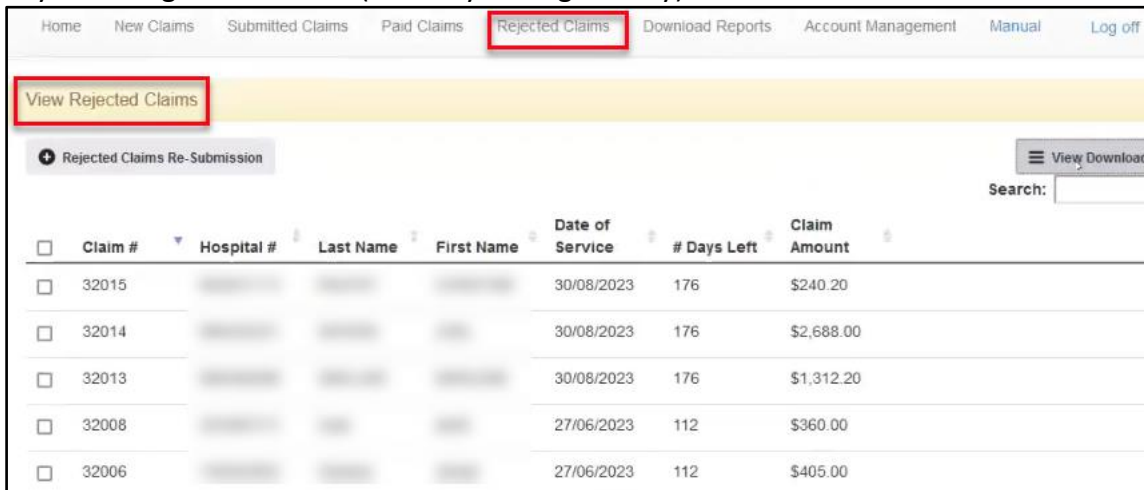
Clinic	Doctor No	Corporation Indicator	Reject Description	Claim No
NA	NA	NA	Multiple Records with same Claim Number and same Sequence Number	32030
NA	NA	NA	Multiple Records with same Claim Number and same Sequence Number	32031
126	ABCD	NA	Physician Not Eligible to Submit	32030

Daily Return File

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

The Daily Return File can be viewed in a report format or individually by claim. When viewing the rejected claim(s) take note of the Explanatory Code and corresponding description as this explains the reason for the rejection. The claim can be updated on the Perspect billing software screen and quickly re-submitted for processing.

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



Home	New Claims	Submitted Claims	Paid Claims	Rejected Claims	Download Reports	Account Management	Manual	Log off
View Rejected Claims								
Rejected Claims Re-Submission								
View Download								
Search:								
☐	Claim #	Hospital #	Last Name	First Name	Date of Service	# Days Left	Claim Amount	
☐	32015				30/08/2023	176	\$240.20	
☐	32014				30/08/2023	176	\$2,688.00	
☐	32013				30/08/2023	176	\$1,312.20	
☐	32008				27/06/2023	112	\$360.00	
☐	32006				27/06/2023	112	\$405.00	

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 the manual for details on how to do each.

Module THREE – Getting Started in Customer Portal

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Getting Started

Several authorized users will access Customer Portal over the Internet. To ensure only authorized users gain access to Customer Portal, eHealth Saskatchewan requires 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 the 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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Explore the module to learn about the **Home Page** also referred to as the **Landing Page**.

Top Menu Bar

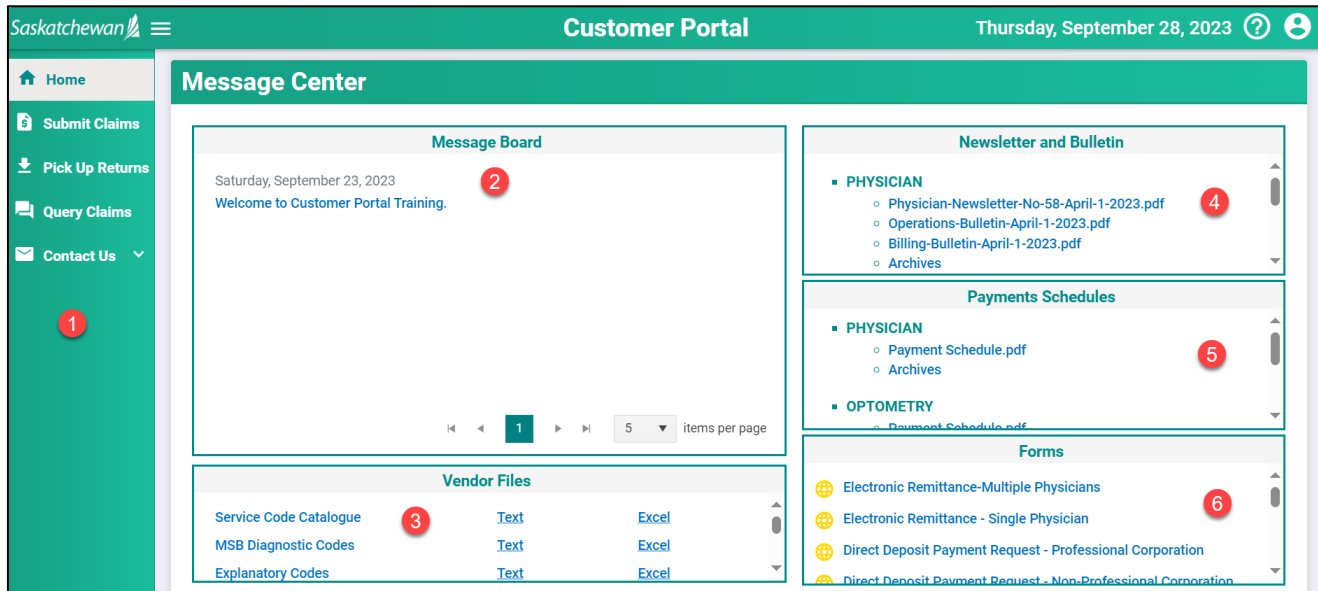
The top menu bar in Customer Portal provides four main options:



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

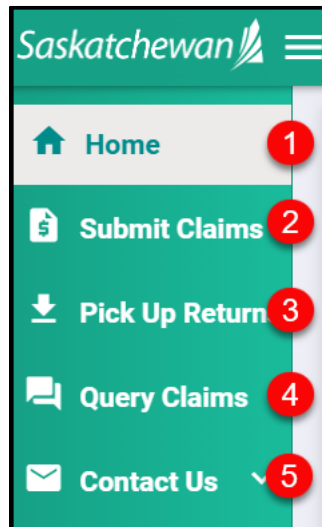
The **Home Page** or **Landing Page** is the first screen that appears when logging into Customer Portal. It serves as a gateway to the application's features and functionality.



	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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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



Viewing and retrieving the Daily Return File and Bi-weekly Return file through Customer Portal is an **alternative** option. These files are identical to the files that can be viewed and retrieved from Perspect.

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.

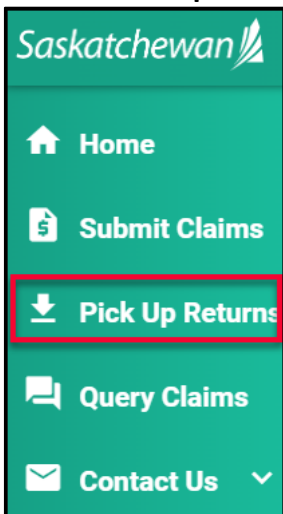
The **Bi-weekly Return File** will be categorized by doctor, clinic, mode, and professional corporation or non-professional corporation.

Retrieving Daily Return Files

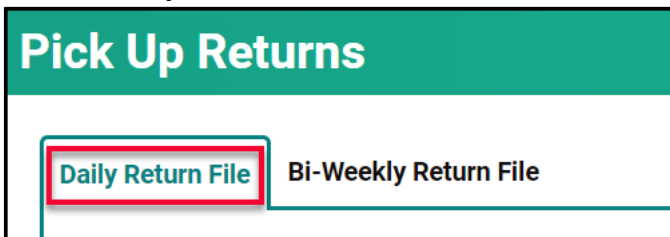
Daily Return Files are available every business day morning through the **Pickup Returns** option in Customer Portal.

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.

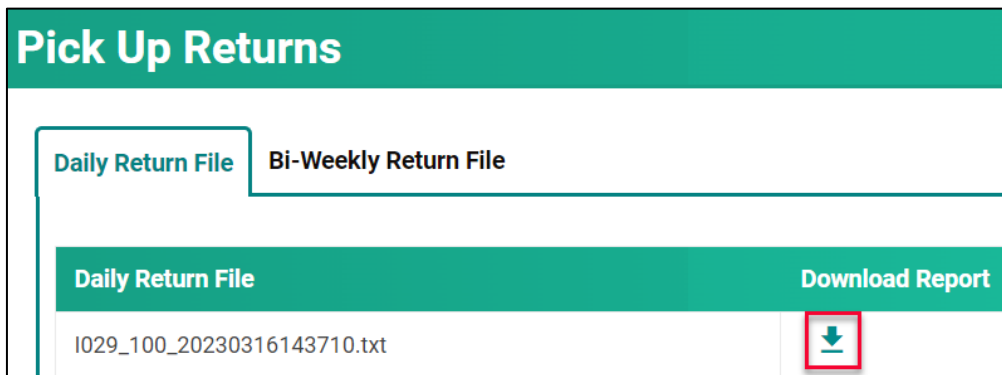
1. Click on **Pick Up Returns**.



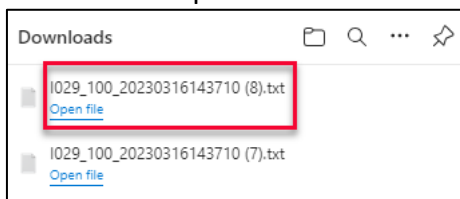
2. Click on **Daily Return Files**



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



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



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.



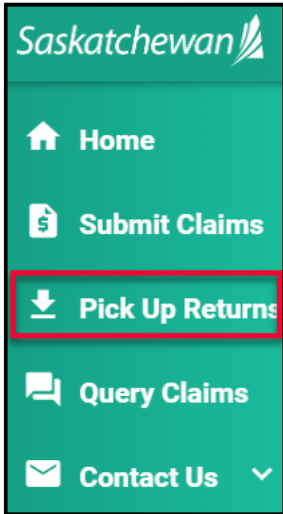
Refer to
Reading the Daily Return .txt File
located on
eHealth Saskatchewan's website to
assist in reading the .txt return file or
view the **Daily Return File** in your
Perspect Software.

Retrieving Bi-Weekly Return Files

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

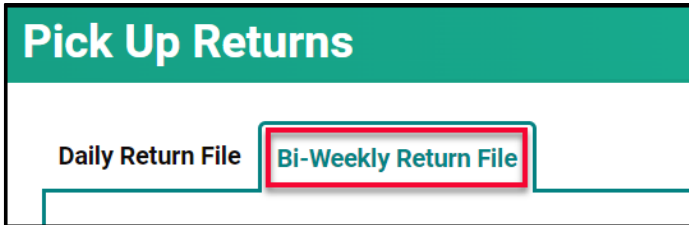
It is recommended to view your **Bi-Weekly Return File** on pay day to ensure the payments made reconcile with the claims sent and make adjustments on **rejected** claims as needed.

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

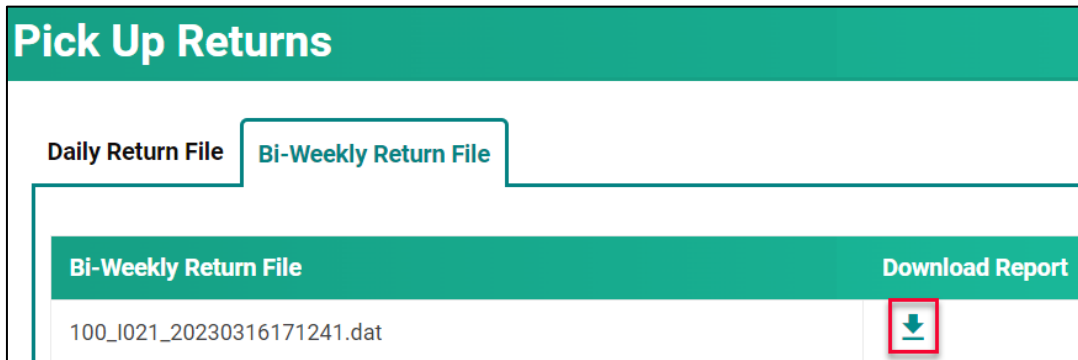


The **Bi-Weekly Return File** is also viewable in your Perspect software.

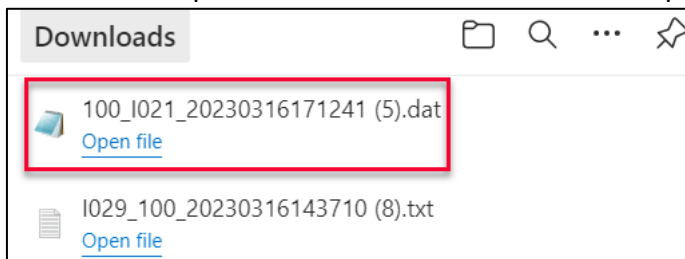
2. Click on **Bi-Weekly Return File**.



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



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



5. This file opens as a text file.
6. 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 or
view the **Bi-Weekly Return File** in your
Perspect Software.

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 happen:

- 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**

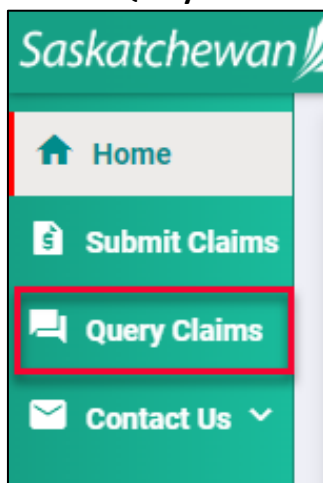
Submission From Date

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

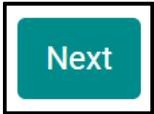
CPS Claim No: External Claim No: Province: Health Card No: Billing No *: Group Id: Clinic No: Mode: From Date *: To Date *:

	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

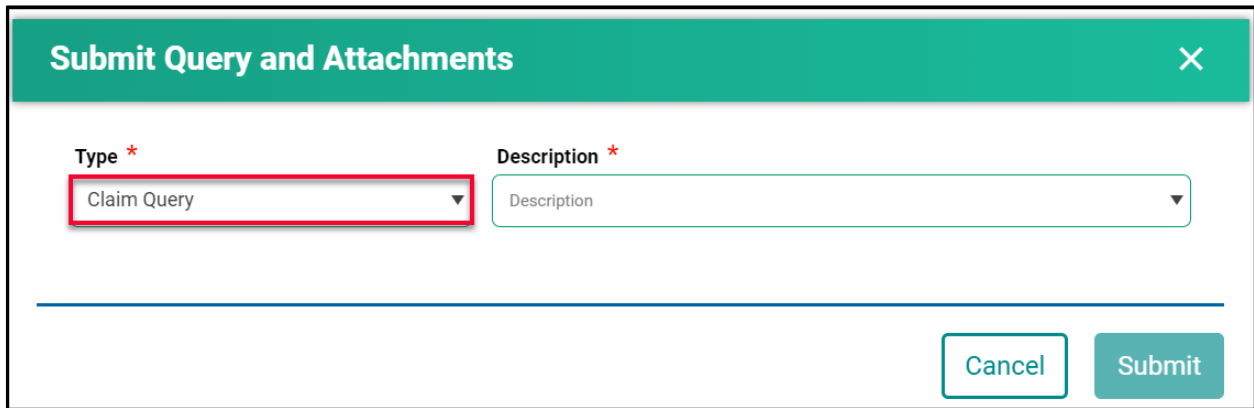
Cancel

Submit

How to Run a Claim Query

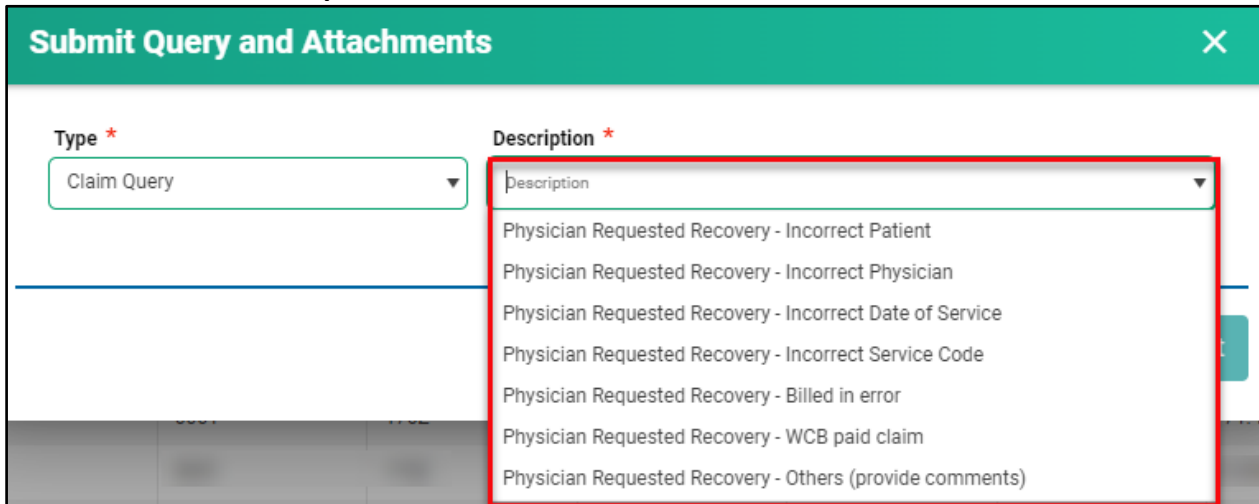
When recovering a claim due to an error on the initial submission, use the **Claim Query** option.

1. Select **Claim Query**.



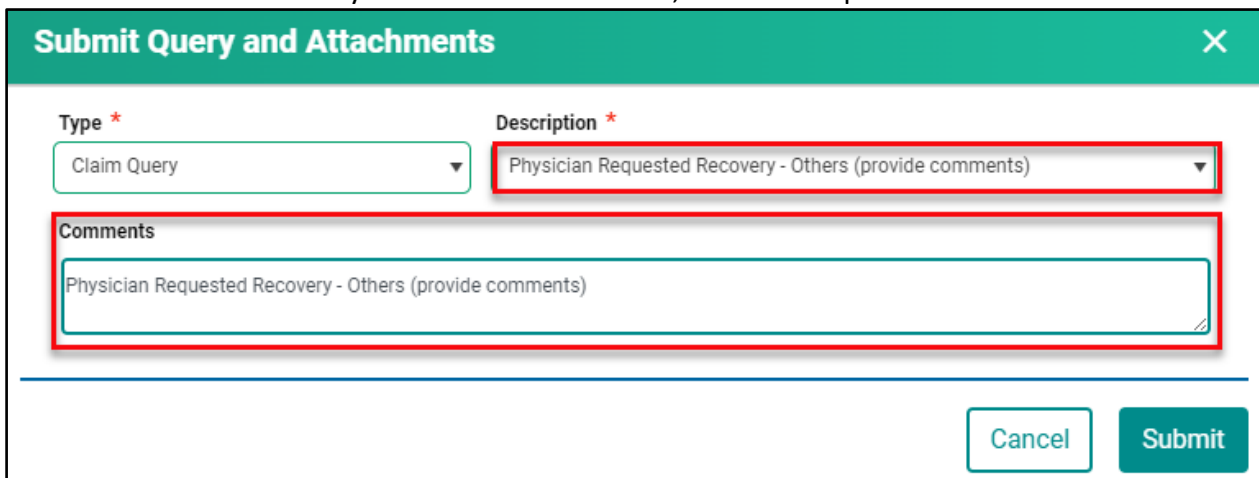
The screenshot shows a form titled "Submit Query and Attachments" with a close button (X) in the top right corner. There are two dropdown menus: "Type *" and "Description *". The "Type *" dropdown is set to "Claim Query" and is highlighted with a red box. The "Description *" dropdown is empty and shows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

3. If **Physician Requested Recovery – Others** are 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 dropdowns is a text area labeled "Comments" which contains the text "Physician Requested Recovery - Others (provide comments)" and is also highlighted with a red box. At the bottom right, there are two buttons: "Cancel" and "Submit".

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

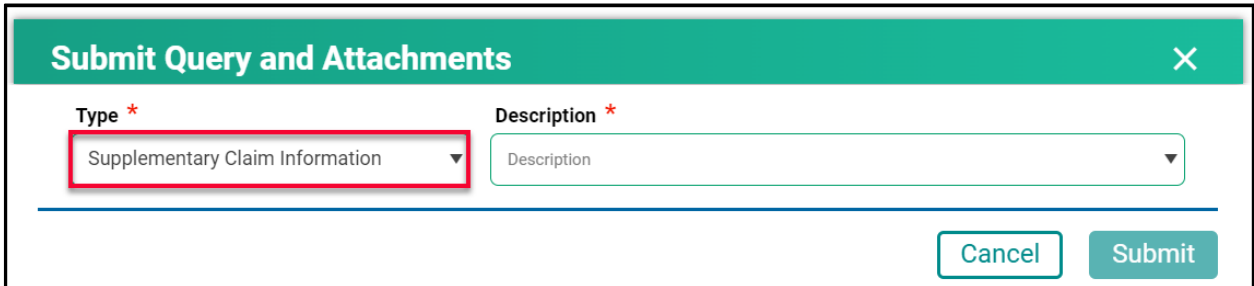
Description
Physician Requested Drawback - Incorrect Patient

Cancel

How to Run a Supplementary Claim Information Query

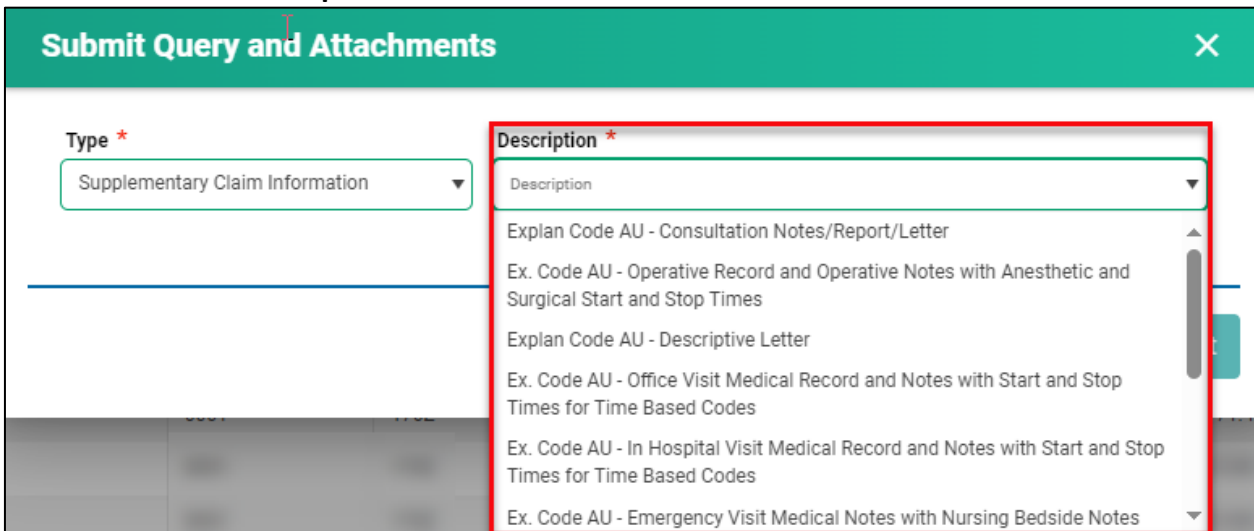
When additional documentation and/or comments are required on a claim, use the **Supplementary Claim Information Query**.

1. Select **Supplementary Claim Information**.



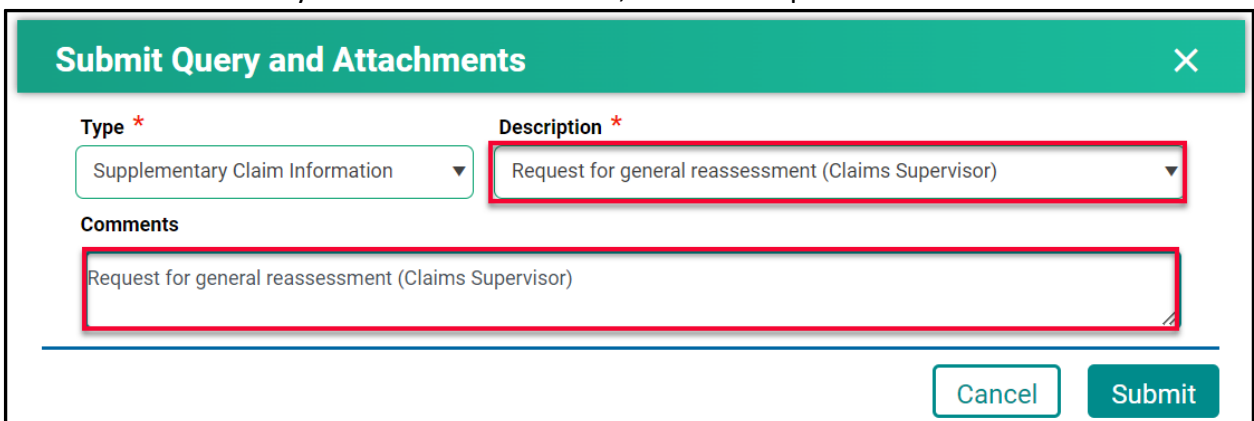
The screenshot shows a modal window titled "Submit Query and Attachments" with a close button (X) in the top right corner. Inside the modal, there are two dropdown menus. The first dropdown, labeled "Type *", is open and shows "Supplementary Claim Information" as the selected option. The second dropdown,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

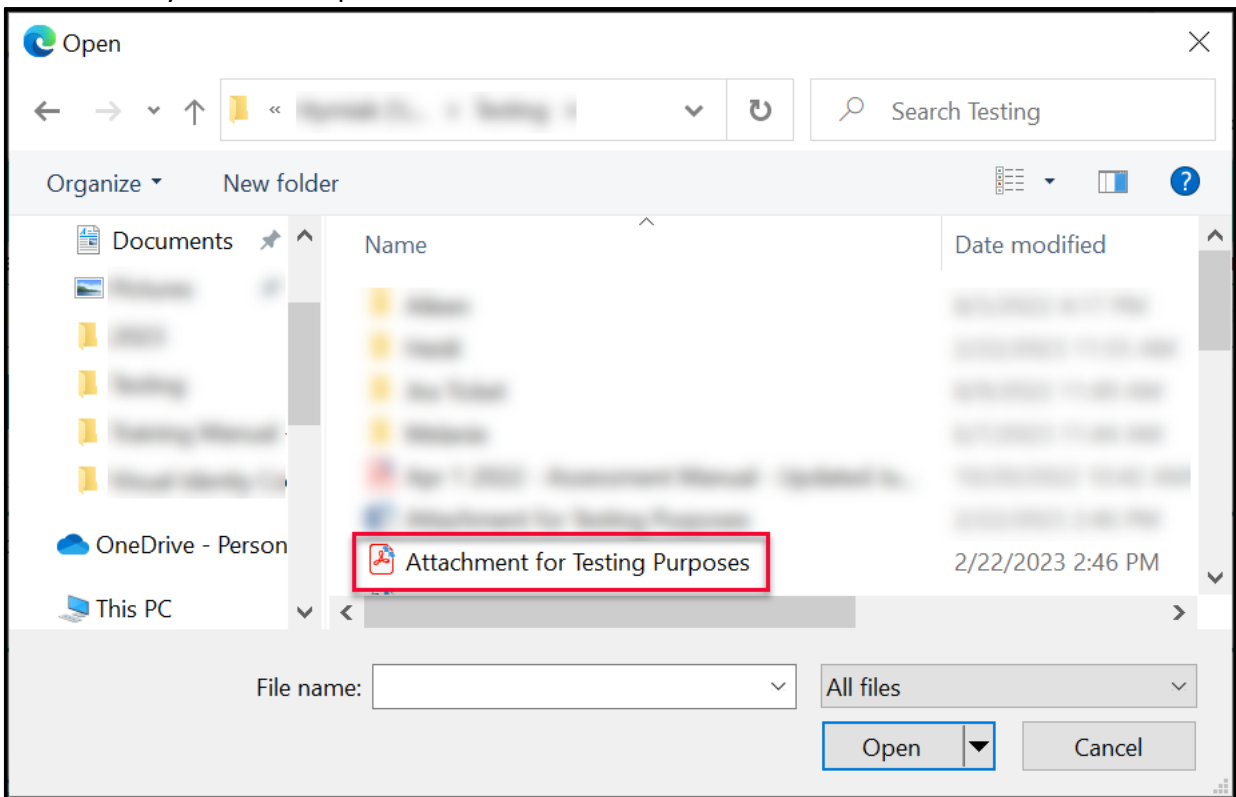
Type *
Supplementary Claim Information

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

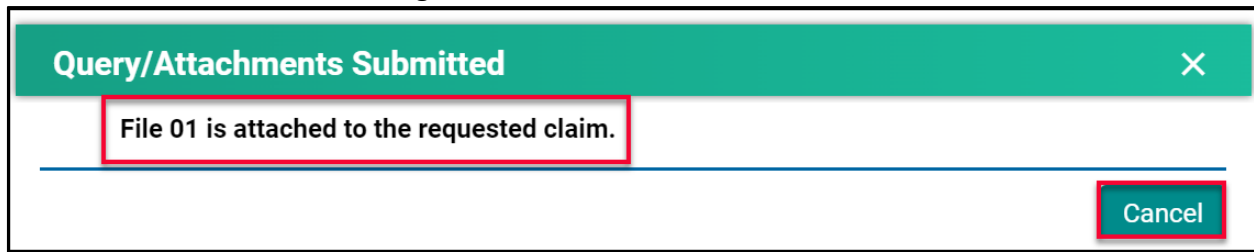
Type *
Supplementary Claim Information

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:

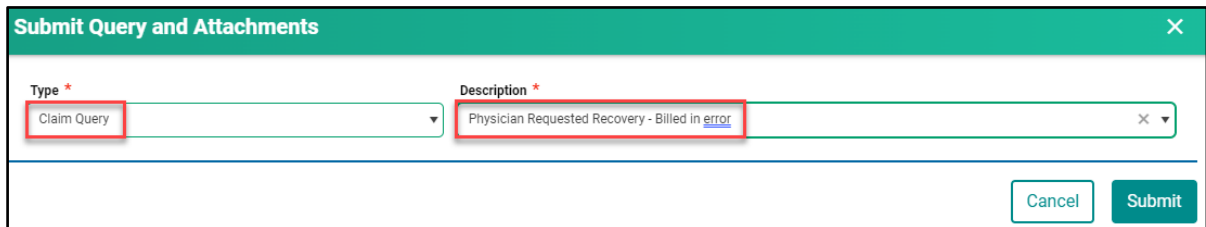
- No action required. 9B will be paid on the next bi-weekly run and 795A cannot be paid based on the Assessment Rules.

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.

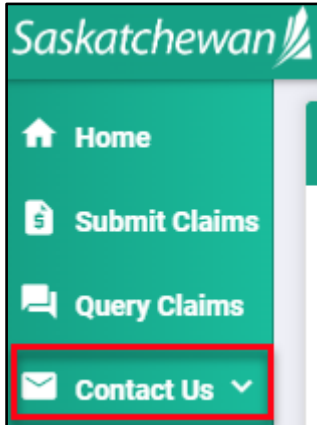
Module SEVEN – Contact Us

Contact Us

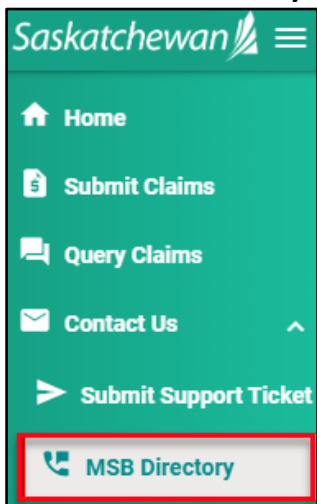
When requiring support with a claim or Customer Portal call **1-800-605-2965**, Monday to Friday from 8:00am to 5:00pm.

MSB Directory

1. Click on **Contact Us**.



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



3. Select an option to contact MSB.

A screenshot of the 'MSB Directory' page. The page has a teal header with the text 'MSB Directory'. Below the header, there are two sections: 'Phone' and 'Mail'. The 'Phone' section contains the text '+1-800-605-2965 (Toll Free)' and 'Monday to Friday between 8:00 AM - 5:00 PM'. The 'Mail' section contains the text '2nd Floor, 3475 Albert Street' and 'Regina, SK, S4S 6X6'.

Medical Services Branch



Claims Replacement Project