Customer Portal (CP) Real Time Submissions For Optometrists

User Manual

Medical Services Branch

Claims Replacement Project

saskatchewan.ca

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Table of Contents

Module ONE: Overview 1
- Learning Objectives 1
- Overview of Customer Portal 1
- Benefits of Customer Portal 1

Module TWO – Getting Started 2
- Getting Started 2
- Logging In 2
- Multi-Factor Authentication (MFA) 2

Module THREE – Navigating Customer Portal 3
- Top Menu Bar 3
- Home Page 4
- Navigation Menu 5

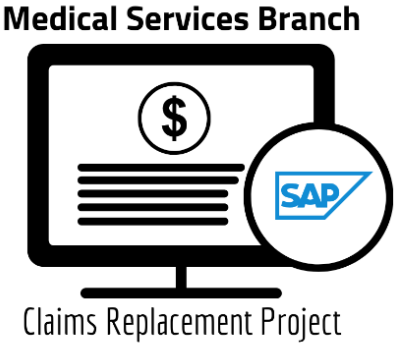
Module FOUR – Optometrists Submitting Real-Time Claims 6
- What is Real-Time Submission? 6
- Submissions for Optometrists 6

Module FIVE – Provider Remittance Advice 14
- Provider Remittance Advice 14

Module SIX – Query Claims 15
- Query Claims 15
- Claim Query 15
- Supplementary Claim Information 16
- Query Claims 17
- How to Run a Claim Query 20
- How to Run a Supplementary Claim Information Query 22
- Handling Rejected Line Items 25
  - Scenario #1 25
  - Scenario #2 25
  - Scenario #3 26
  - Scenario #4 26
  - Scenario #5 27

Module SEVEN – Contact Us 28
- Contact Us 28
- MSB Directory 28

Module ONE: Overview



Learning Objectives

Upon completion, learners will have an understanding of:

- The advantages of Customer Portal.
- Who uses Customer Portal?
- How to enter and submit claims in **Real Time**.

Overview of Customer Portal

Customer Portal (CP) is a web-based application, used by physicians, dentists, optometrists, health care providers and internal Medical Services teams to submit medical claims (at a later time hospital claims will also be submitted) to Saskatchewan Health (MSB) for payment of services provided. All users will have authorization to submit patient claims to Saskatchewan Health for compensation.

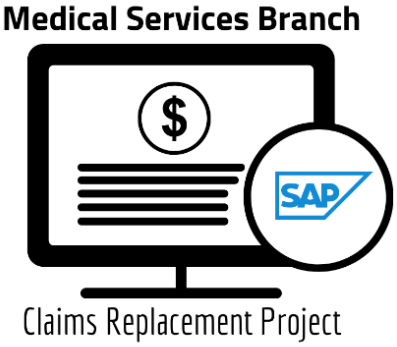
Customer Portal is a 'pass through' application for claims. Meaning it does not store claim information in a database of its own. Rather, it transfers (sends) claim files through a secured portal to the Claims Processing System (CPS) (behind firewall).

Benefits of Customer Portal

The benefits of Customer Portal are numerous, and users will identify many more as they begin to use the application. Some of the top benefits are:

1. Submit claims in **Real-Time**.
2. Submit a query submission on individual claims.
3. Ability to access payment schedules, newsletters, and forms on the portal's home page.

Module TWO – 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

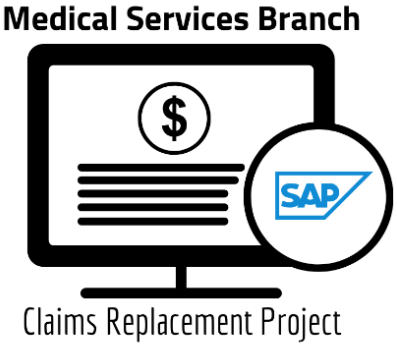
Once fully registered in the Physician Registry (this includes having your direct email address registered with your profile), a welcome email and password reset email will be sent to you. Follow the prompts to reset your password to login to Customer Portal. Your userid will be your registered email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

Multi-Factor Authentication (MFA)

Logging into 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 THREE – 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.

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

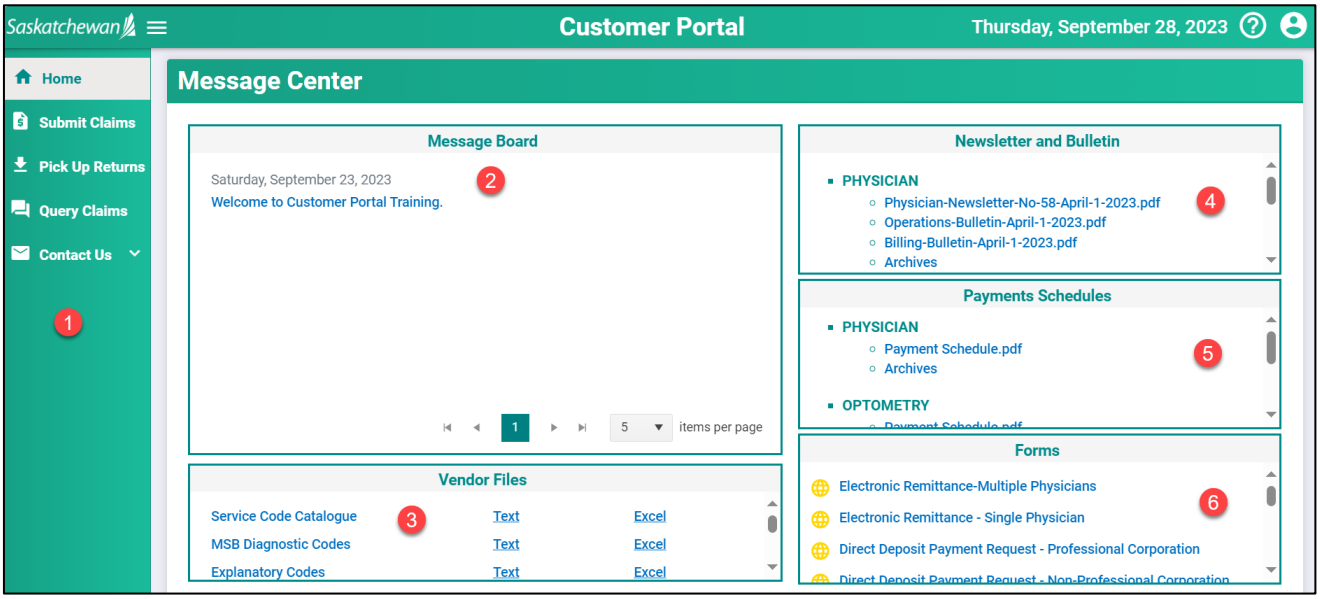
Top Menu Bar

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

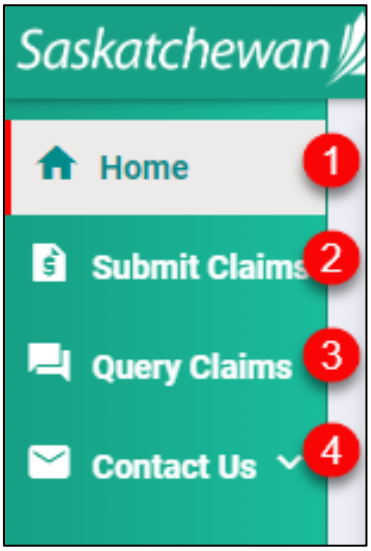
The **Home Page** or **Landing Page** is the first screen that appears when logging into Customer Portal. It serves as a gateway to the application's features and functionality.



	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 Codes are located here for easy access.
4	**Newsletter and Bulletin**	The most recent Newsletters and Bulletins are posted for reference, along with archived versions 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.
6	**Forms**	The most frequently used forms are located here. Click once to open the form, complete the fillable pdf, then save/or print as needed.

Navigation Menu

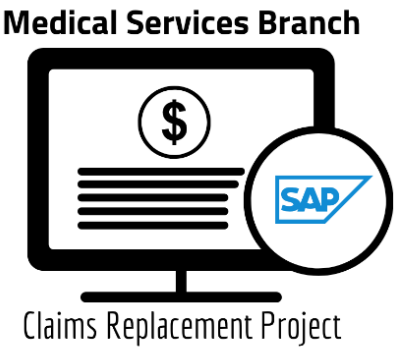
The side Navigation Menu is a list of actions that can be performed within Customer Portal



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**	User enters in claim details and submits the claim in Real Time.
3	**Query Claims**	Users can search for submitted claims with the option of adding additional information or recovering an already submitted claim.
4	**Contact Us**	Provides several options for contacting Medical Services.

Module FOUR – Optometrists Submitting Real-Time Claims



What is Real-Time Submission?

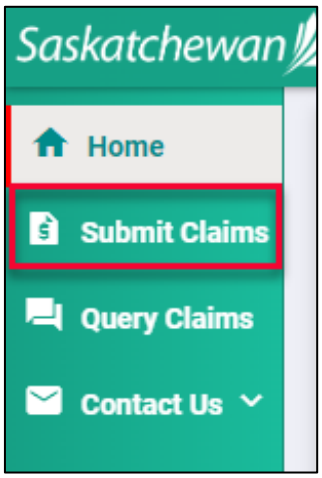
Real-Time submission refers to the process of submitting claim information through an online system (Customer Portal). When a claim is submitted in real-time, it means the data is transmitted and received immediately by the Claims Processing System (CPS), allowing for quick processing and adjudication of the claim.

Submissions for Optometrists

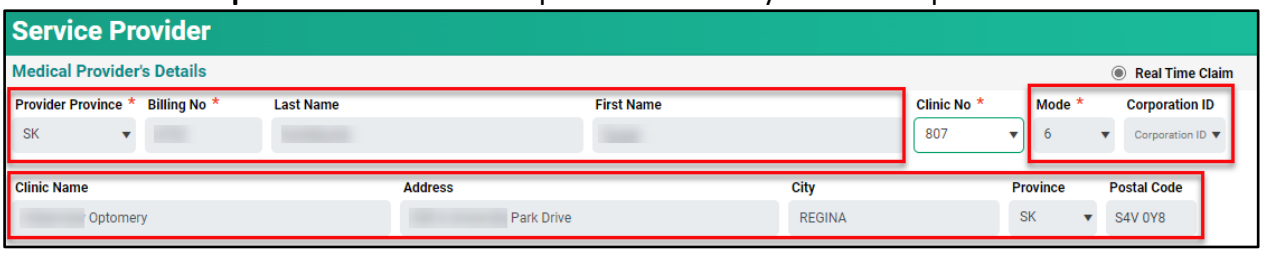
Your profile will be set to match your credentials so that when you click on **Submit Claim**, your professional information is pre-loaded.

All fields marked with a red asterisk * are mandatory fields. Your claim cannot be submitted if a mandatory field(s) is left blank. Other fields are optional; however, it is highly recommended to enter as much information as possible. The level of detail provided directly correlates with the accuracy of the adjudication process for your claim.

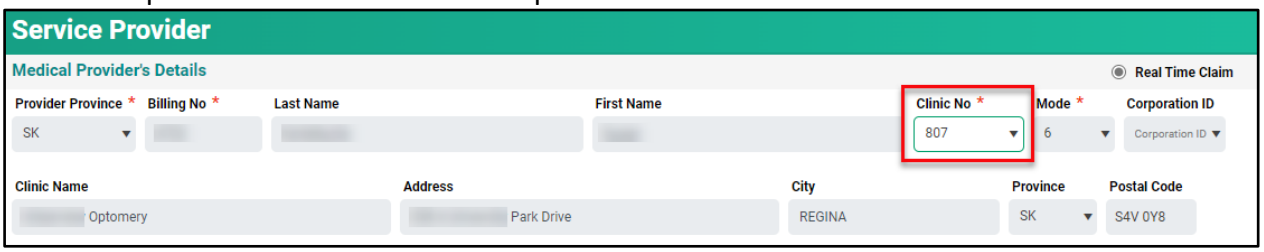
1. Click on **Submit Claims.**



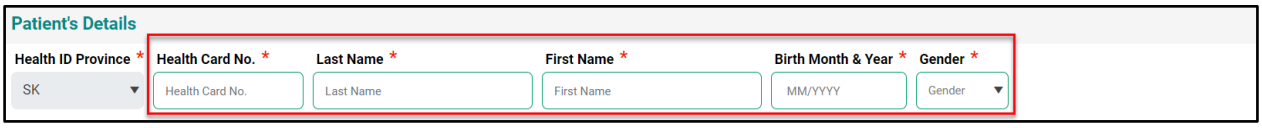
2. Several fields will be pre-populated based on your profile. These fields will have a grey background and cannot be adjusted or changed. Review these fields to ensure the information is accurate. The **Corporation ID** will be an open field ONLY if you are incorporated.



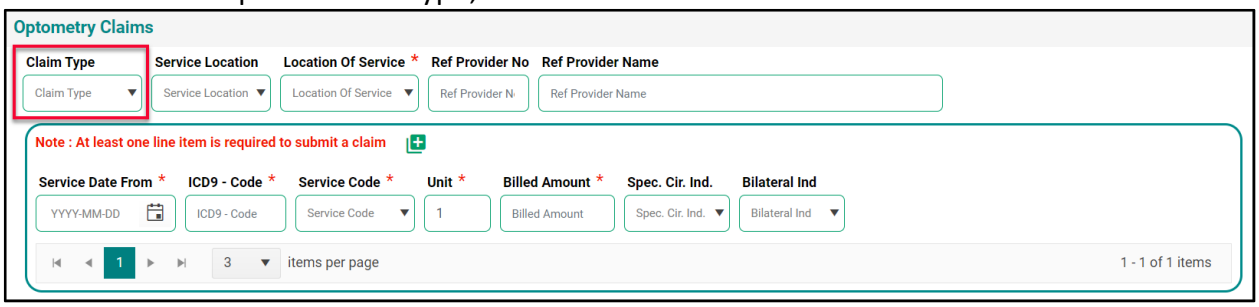
3. Your **Clinic No** and **Mode** will automatically populate. If you submit claims for different clinics, alternate options are available in the drop-down menus.



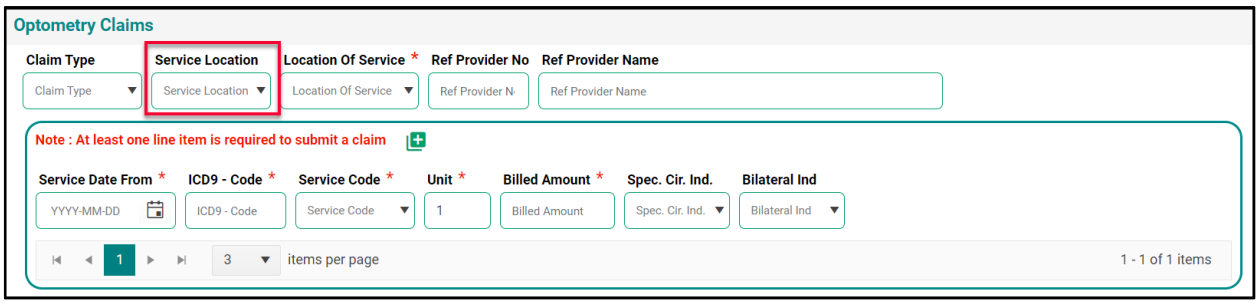
4. Enter the **Patient Information**, which includes their **Health Card No., Last Name, First Name, Date of Birth** and **Gender.**



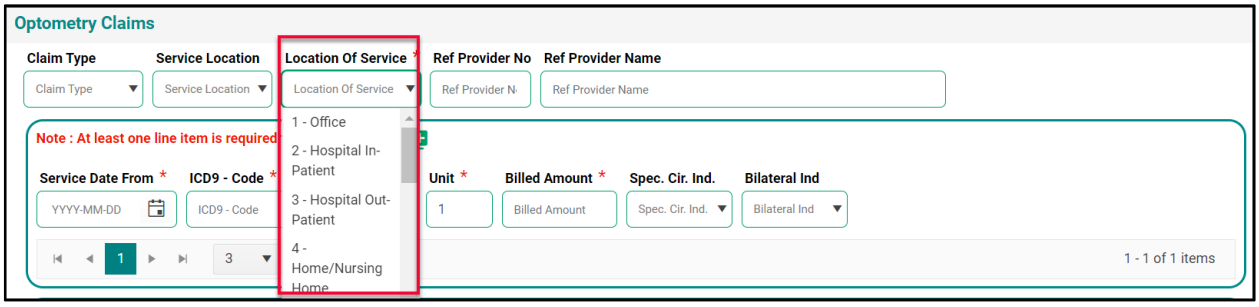
5. Click on the drop-down for **Claim Type.** Select the appropriate option for your claim. If your claim does not require a Claim Type, leave the field blank.



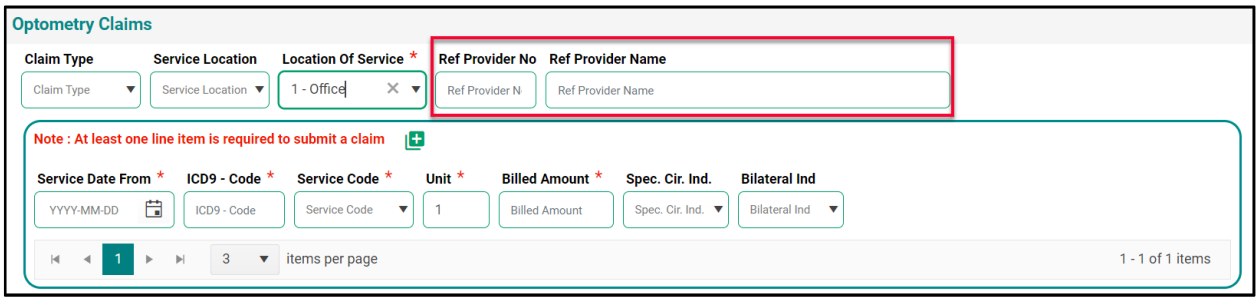
6. Click on the drop-down for **Service Location.** Select the appropriate option for your claim. The location options will reflect the locations that match your profile. If your claim does not require a Service Location, leave the field blank.



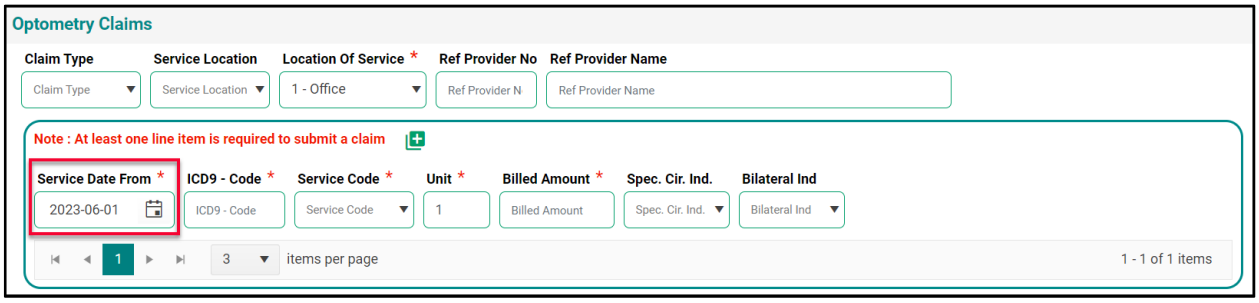
7. Enter the **Location of Service**, by selecting from the drop-down menu or by typing the number into the field.



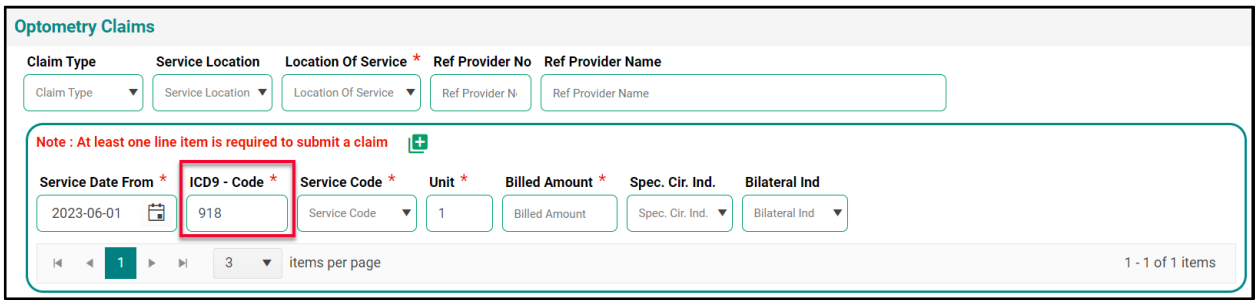
8. Enter the **Ref Provider No** (4-digits) and the **Ref Provider Name**, if applicable.



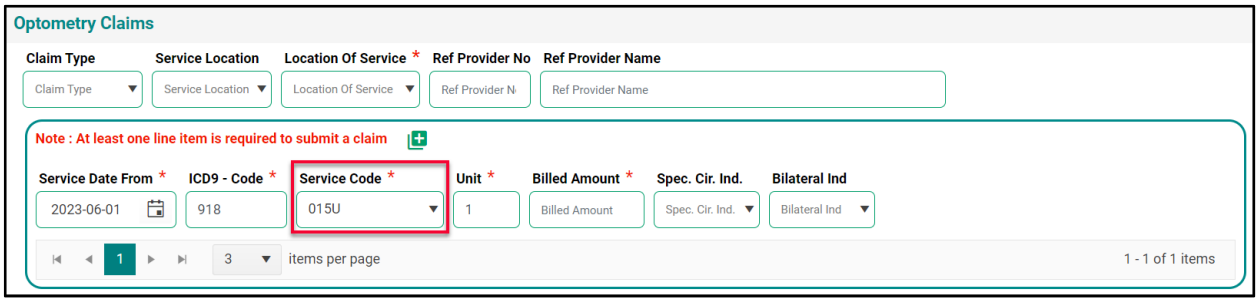
13. Enter the **Service Date From** in the format of YYYY-MM-DD.



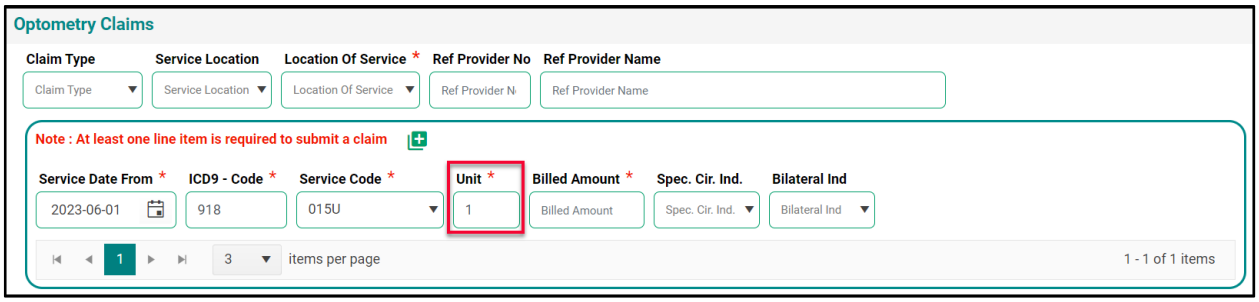
14. Enter the **ICD-9 Code.**



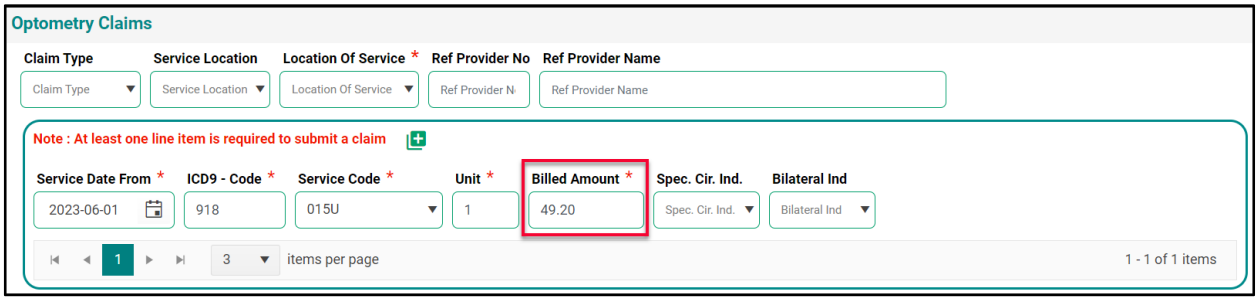
15. Enter the **Service Code.**



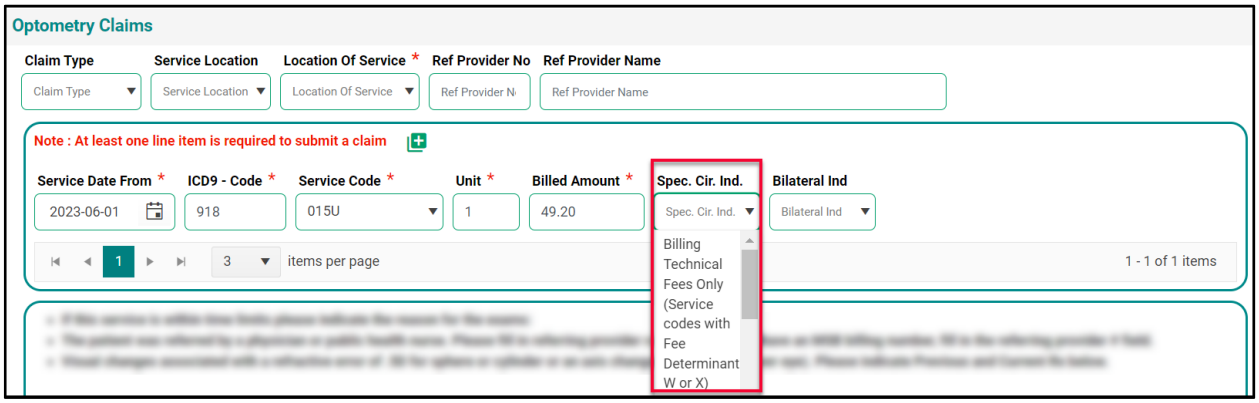
16. Enter the **Units** associated with the claim. It will default to 1 but can be changed.



17. Enter the **Billed Amount** for the claim. This amount should reflect the correct amount based on the Service Code and the number of units entered.

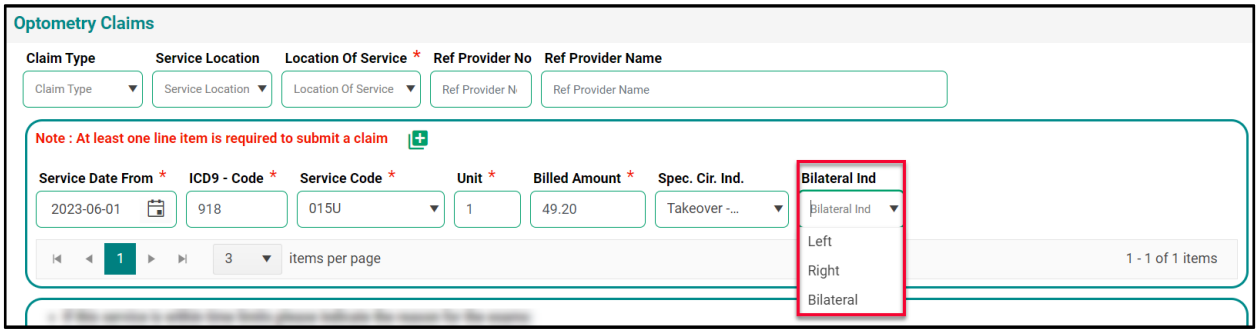


18. Enter the **Special Circumstances**, if applicable.



Special Circumstance Indicator	Description
TF	**Billing Technical Fees Only** (Service Codes with Fee Determinant W or X) (Has three fees – i.e., 11W or 100X)
PF	**Interpretation Fees Only** (Service Codes with Fee Determinant W or X) (Has three fees – i.e., 11W or 100X)
CF	**Combined Tech and Interp. Fees** (Service Codes with Fee Determinant W or X) (Has three fees – i.e., 11W or 100X)
TA	**Takeover - Anesthetic**

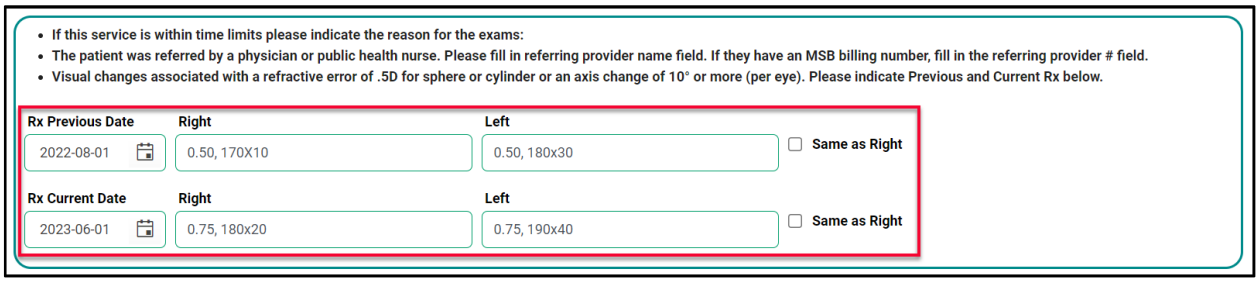
19. Enter the **Bilateral Indicator**, using the drop-down menu, if applicable.



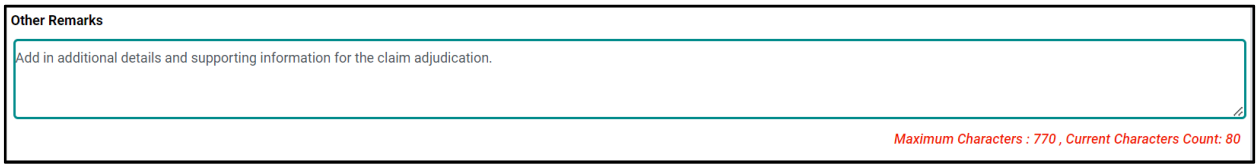
If additional line(s) are required for the claim details, click on the to add a new line. Then follow the above steps to enter the appropriate information.

Add as many additional lines as needed. If a line is added in error, click the at the end of the line to remove it.

20. Complete the appropriate fields ***if*** the claim for the patient meets this criterion. An example may be:

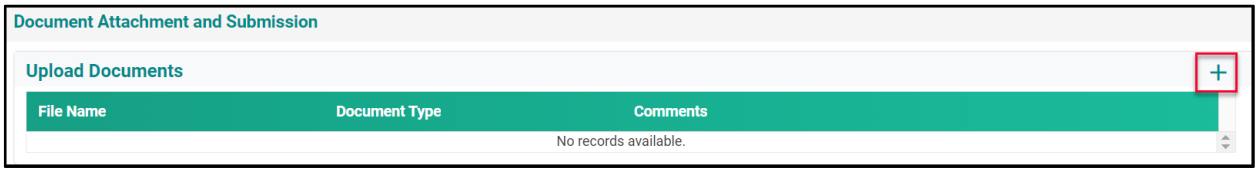


21. In some cases, additional **Provider Remarks** are required and can be entered into the **Other Remarks** field. This is an open forum to type. Be as detailed as possible. There is a maximum of 770 characters. This field is optional.



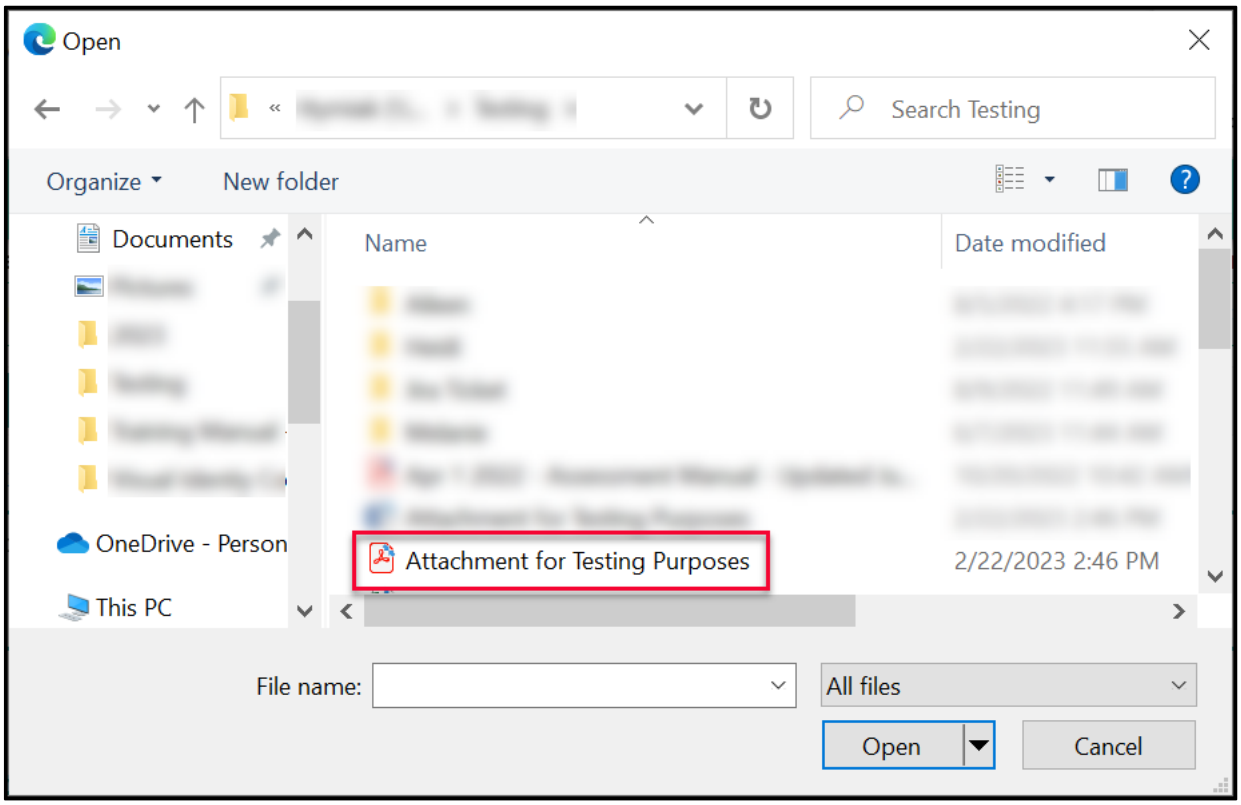
22. If a detailed report of supporting documentation is required, the document can be attached to the claim in Customer Portal. The file format can be in pdf, word, excel, jpeg, png.

Click on the .

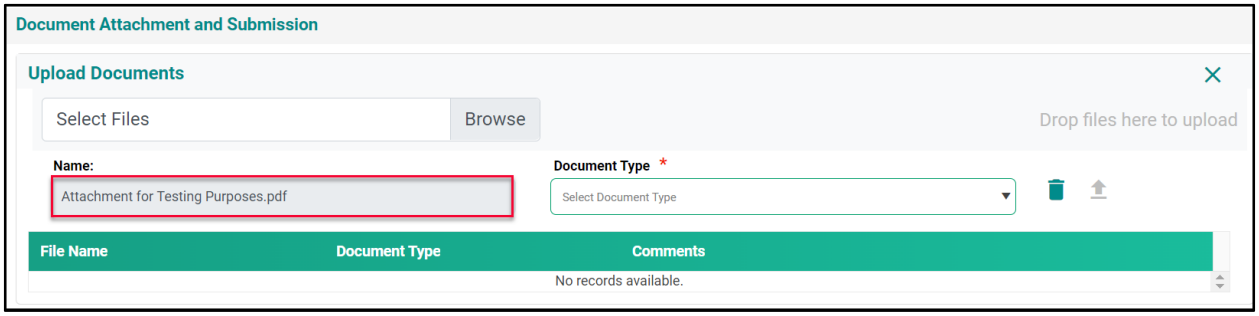


23. Click on **Browse** to select the file from your desktop/laptop.

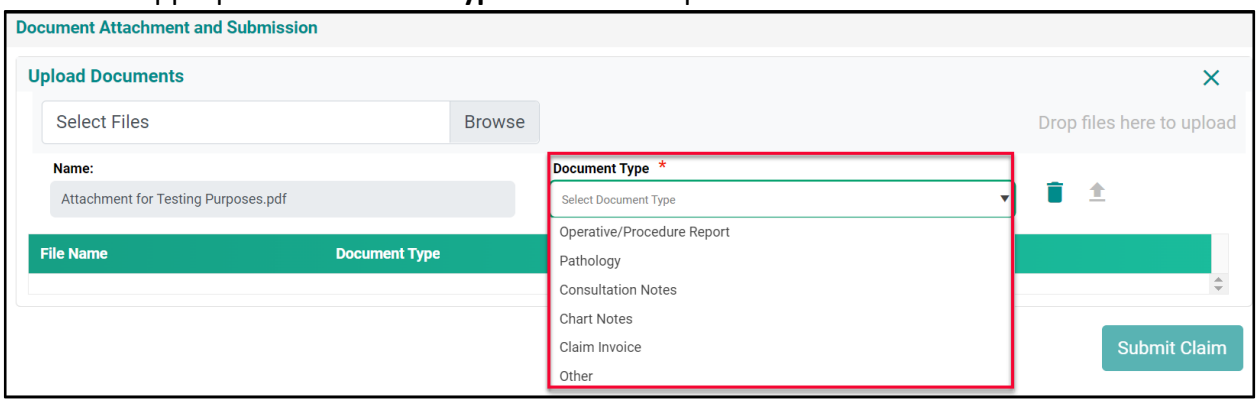
24. Find the file you wish to upload then double-click on the file name.



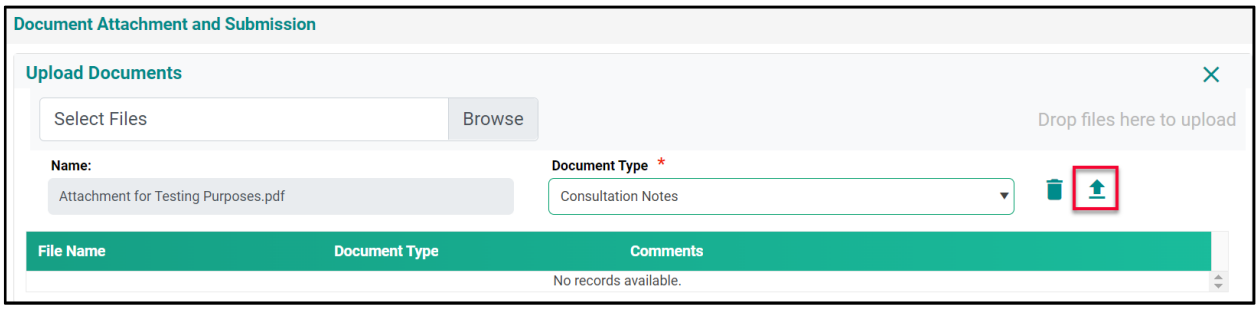
25. The file name will populate under the **Name** field.



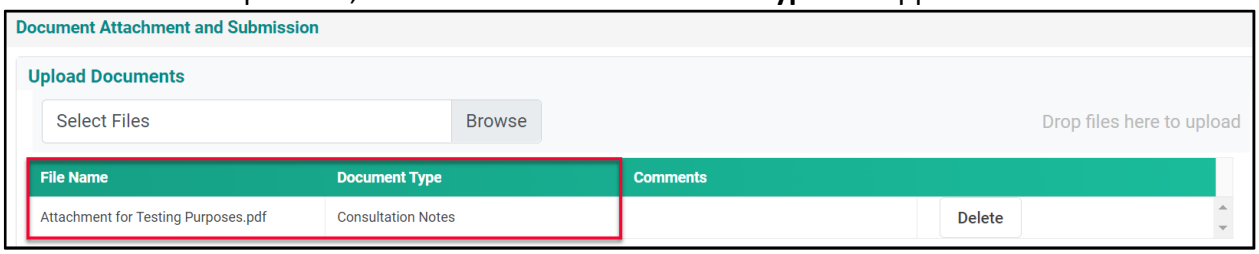
26. Select the appropriate **Document Type** from the drop-down menu.



27. Click the to upload your file.

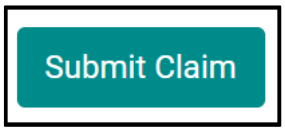


28. Once the file has uploaded, the **File Name** and **Document Type** will appear in the window.



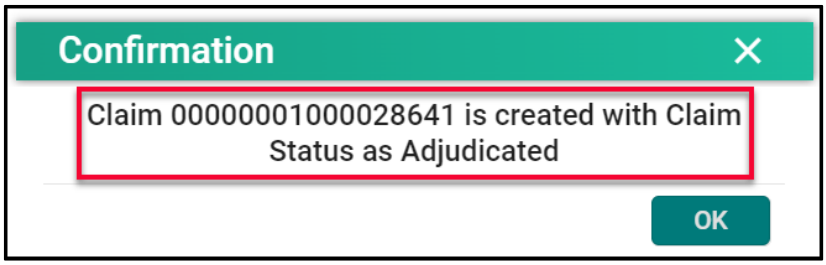
At this point, all claim information has been entered. Take a moment to review the data entered to ensure accuracy. **It is recommended to take a screen shot of the claim for your records, as once Submitted the claim cannot be viewed again.**

29. Click **Submit** when all details of the claim have been entered.



If the **Submit Claim** button is greyed out it means there is a mandatory field of information missing on the claim. The field missing the information will be highlighted in red font. Enter in the required information and then click the **Submit Claim** button.

30. When the **Confirmation** message appears displaying, the **claim number** and the **status of Adjudicated** click **OK.** Your claim has been successfully submitted for adjudication.



Module FIVE – Provider Remittance Advice

Medical Services Branch

Claims Replacement Project

Provider Remittance Advice

On a bi-weekly basis, the **Provider Remittance Advice (Bi-Weekly Return File)** is mailed via Canada Post. The **Provider Remittance Advice** provides a summary of all claims submitted along with the status of each claim. It is recommended to reconcile the **Provider Remittance Advice** to your submitted claims.

The **Provider Remittance Advice** will itemize the claims based on their status:

- **Paid (Payment List)** claims paid on the bi-weekly run.

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Payment List

Sample

Payee Name	Run Code	Payment Date yyyy-mm-dd	Payment Mode	Clinic	Doctor Number	Prof.Crop.
LastName2 [illegible] 08	ad	2023-03-24	1	687	2087	

Payee Name	Province Code	Health Services Number	Claim #	Date of Service	Submitted		Paid					Explan Code
				yyyy-mm-dd	Code	Fees	Code	# of Srvs	Fee	Premiums	Prog. Payments	
[illegible]	SK	[illegible]	1000023793	2022-12-21	580P	100.00	580P	1	100.00	0.00	0.00	
[illegible]	SK	[illegible]	1000023794	2022-12-21	580P	100.00	580P	1	100.00	0.00	0.00	
Total						200.00		2	200.00	0.00	0.00	

- **Pended** claims are under review by MSB.

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Pended List

Sample

Payee Name	Run Code	Payment Date yyyy-mm-dd	Payment Mode	Clinic	Doctor Number	Prof. Crop.
LastName2087 FirstNam[illegible]	ad	2023-03-24	1	687	2087	

Payee Name	Province	Health Services Number	Sex	Date of Birth	Claim#	Ref. Provider	Date of Service From	Date of Service To	LOS	Submitted		
				yyyy-mm			yyyy-mm-dd	yyyy-mm-dd		# of Services	Code	Fees
[illegible]	SK	[illegible]	F	1990-03	1000023793		2022-12-21	2022-12-21		1		0.00
Total										0		1.00

- **Rejected** claims require adjustments to be made by your office. Review the Explanatory Code to understand why the claim was rejected, then either make the appropriate adjustment(s) and re-submit the claim or query the claim to add additional information.

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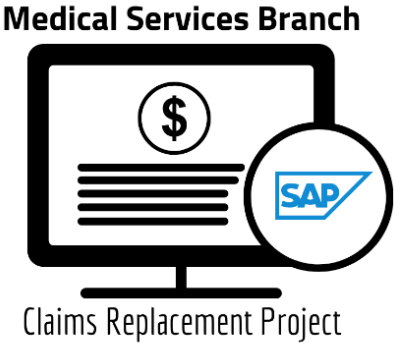
Rejected List

Sample

Payee Name	Run Code	Payment Date yyyy-mm-dd	Payment Mode	Clinic	Doctor Number	Prof.Crop.
[illegible]stName1[illegible]N[illegible]17	ad	2023-03-24	1	071	1617	

Payee Name	Province	Health Services Number	Sex	Date Of Birth	Claim #	Ref. Provider	Service From	Service To	LOS	Submitted			Explan Code
				yyyy-mm-dd			yyyy-mm-dd	yyyy-mm-dd		# of Srvs	Code	Fees	
[illegible]	SK	[illegible]	F	2022-05-06	1000020663		2023-02-01	2023-02-01	2	1	580N	50.00	FM
Total										1		50.00	

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 drawn back 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 line item is returned so updates can be made. Once updated, it can be re-submitted for adjudication.
- The claim is **Pended** for a manual review by MSB. After review, the claim will either be **Paid** or **Rejected** with an **Explanatory Code.**

The categories to select from for a **Claim Query** are:

Claim Query Categories	Result
Physician Requested Recovery – Incorrect Patient	Rejected = Explan Code of BP
Physician Requested Recovery – Incorrect Physician	Rejected = Explan Code of BP
Physician Requested Recovery – Incorrect Date of Service	Rejected = Explan Code of BP
Physician Requested Recovery – Incorrect Service Code	Rejected = Explan Code of BP
Physician Requested Recovery – Incorrect Billed in error	Rejected = Explan Code of BP
Physician Requested Recovery – Incorrect WCB paid claim	Rejected = Explan Code of BP
Physician Requested Recovery – Others (provide comment	Pended for Manual Review

Supplementary Claim Information

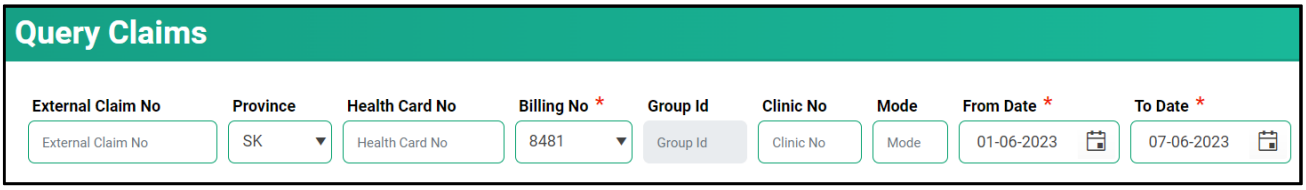
Supplementary Claim Information is typically used when supporting documentation must be added to the claim, or a special request, like time extension or Medical Consultant Review, is required. All claims queried with **Supplementary Claim Information** are reviewed by MSB. After reviewing the claim,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

The categories to select from for **Supplementary Claim Information** are:

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

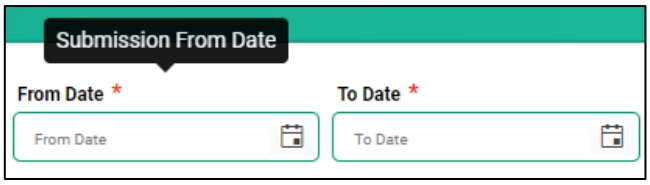
Query Claims

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, the more defined the results.



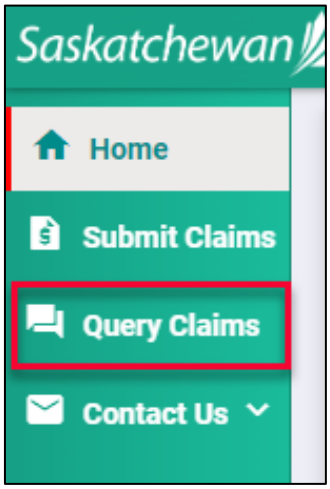
The mandatory fields are:

- **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

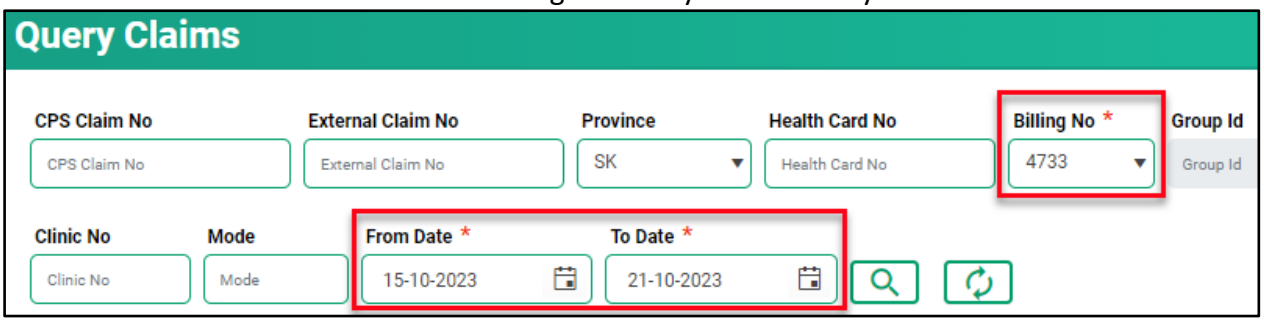


The **From Date** and **To Date** must be the **Submission Date** of the claim. In other words, the dates entered for the query must be the date the claim was submitted to MSB not the service date.

1. Click on **Query Claims.**



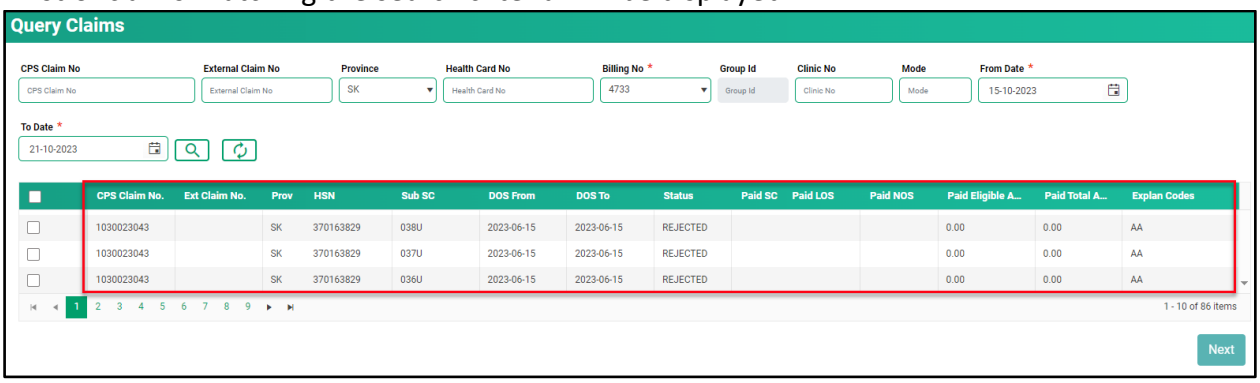
2. Enter the three mandatory fields of **Billing No** (auto populated or selected from the drop-down list), **From Date** and To Date. Date format is DD-MM-YYYY. The calendar icons can also be clicked on to select the date. **NOTE:** The date range can only be seven days.



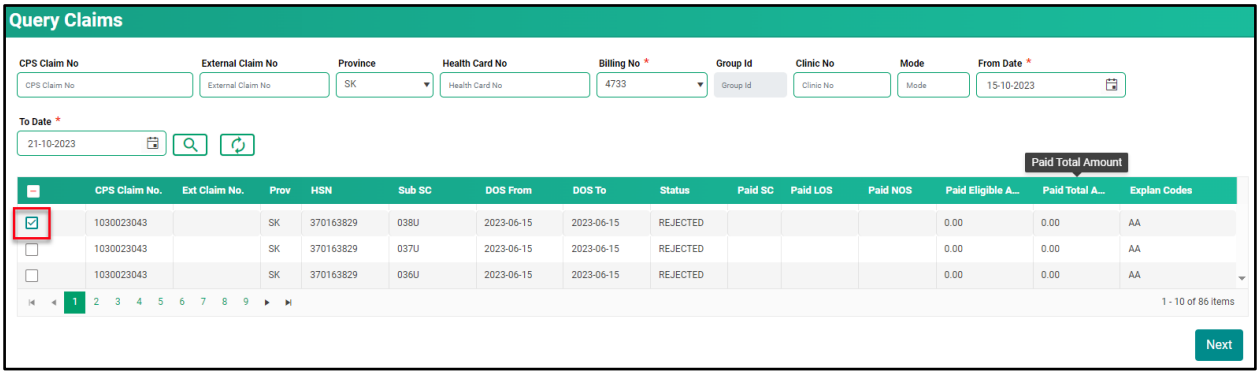
3. Enter additional query criteria as desired.

4. Click

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

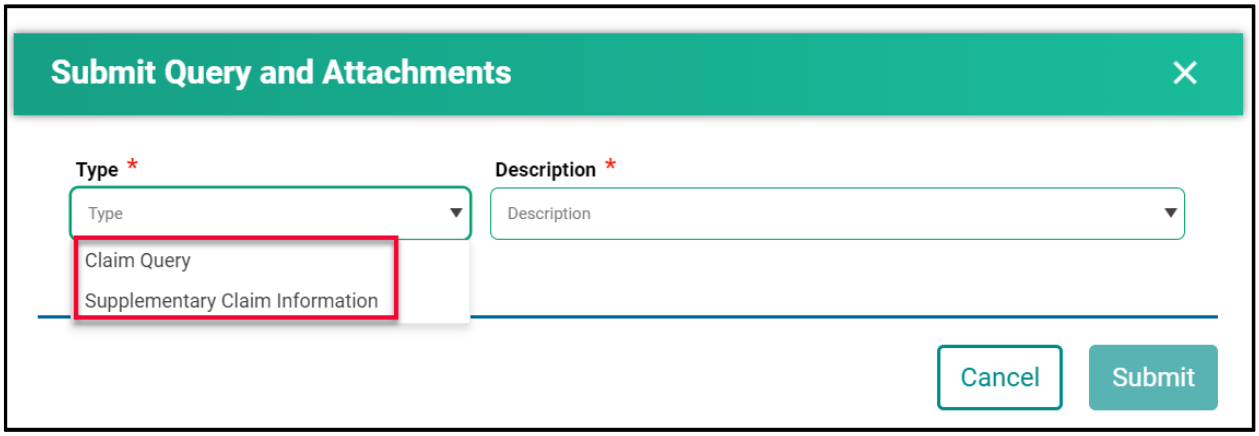


6. Place a check mark in the line item you wish to query. A check mark can be placed in more than one line item. This is beneficial if several claims are queried for the same reason (i.e., recovery or adding an EOB). If a claim query requires an attachment, it is best to do this one a time.



7. Click **Next.**

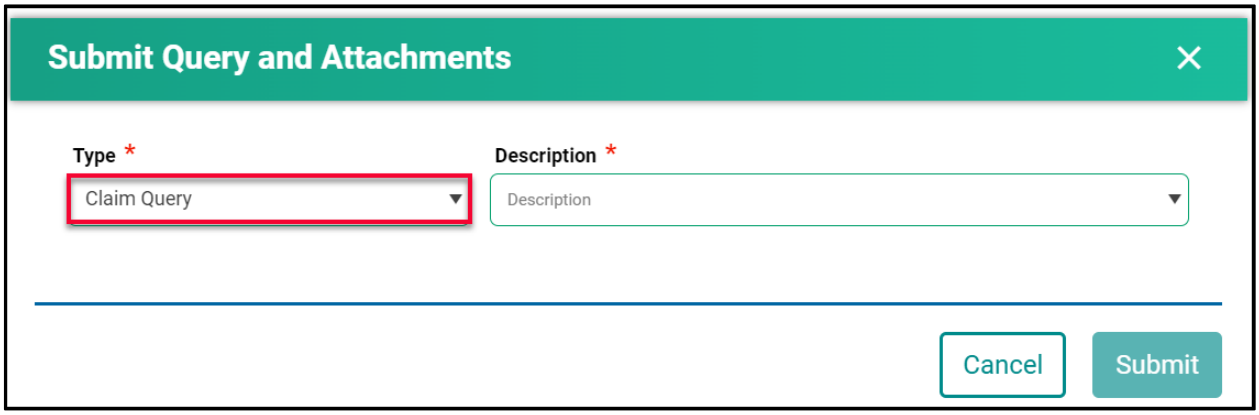
8. Select either **Claim Query** or **Supplementary Claim Information.** Then follow the steps listed below for each query type.



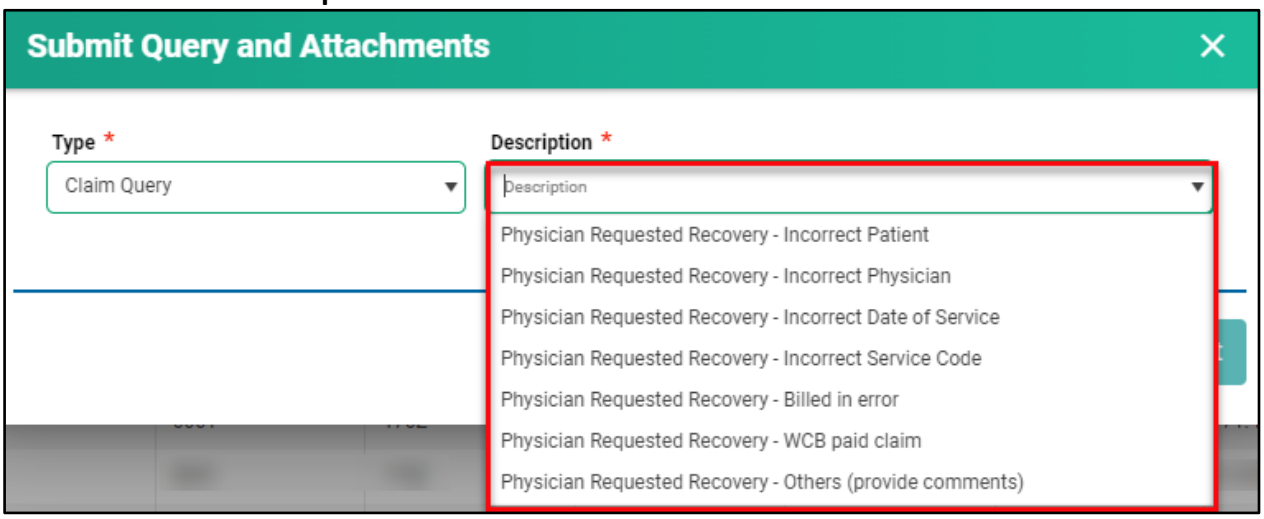
How to Run a Claim Query

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

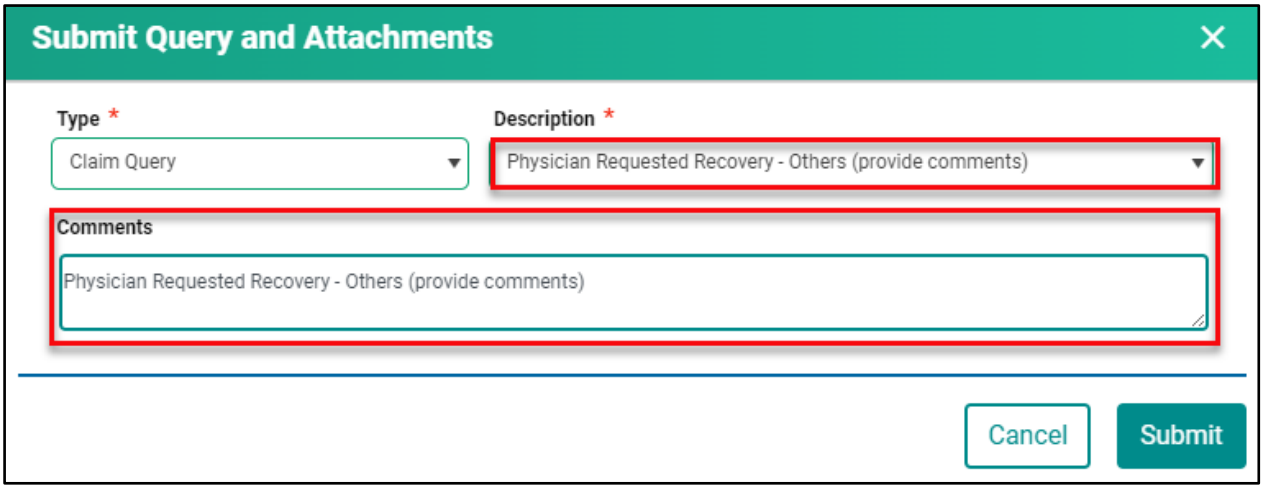
1. Select **Claim Query.**



2. Select the correct **Description.**

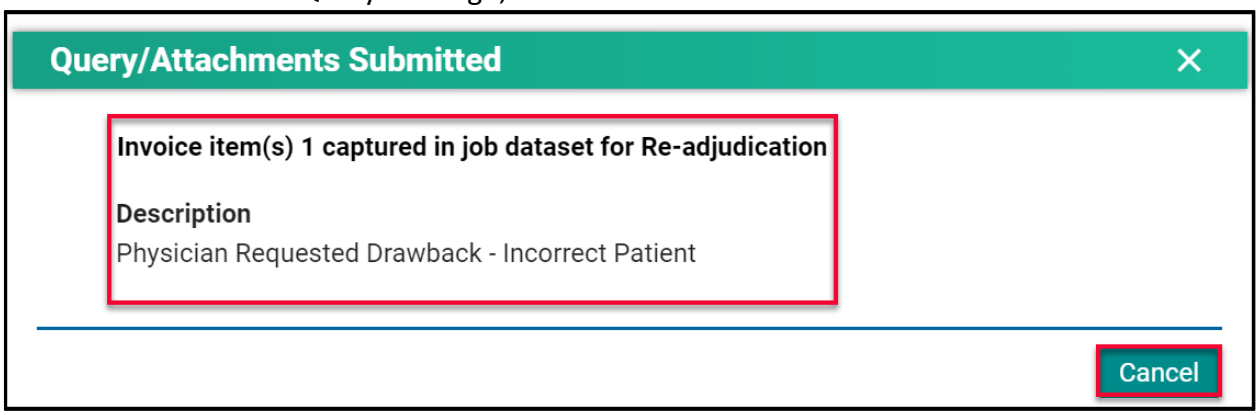


3. If **Physician Requested Recovery – Others** is selected, enter in a detailed comment explaining the reason for the recovery. For all other selections, move to step 4.

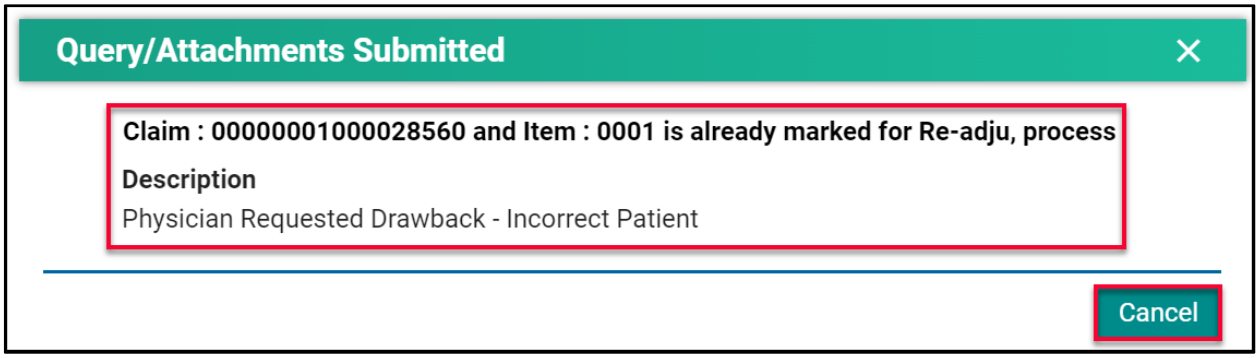


4. Click **Submit.**

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



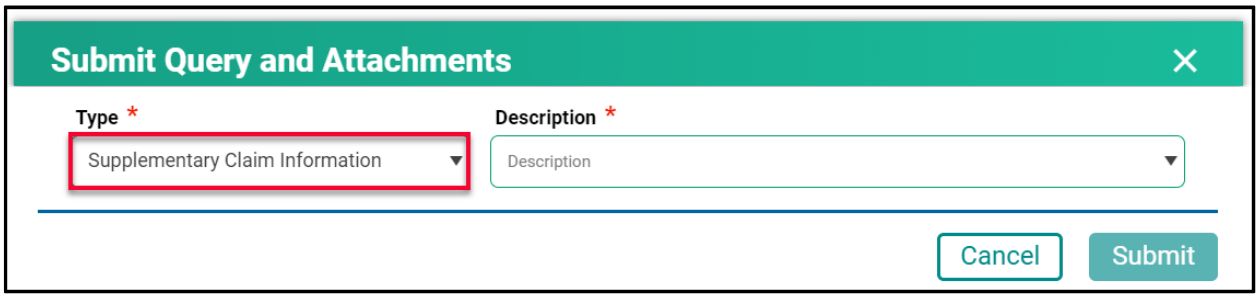
NOTE: If a query is submitted on a claim that already has an outstanding query on it, the following message will appear.



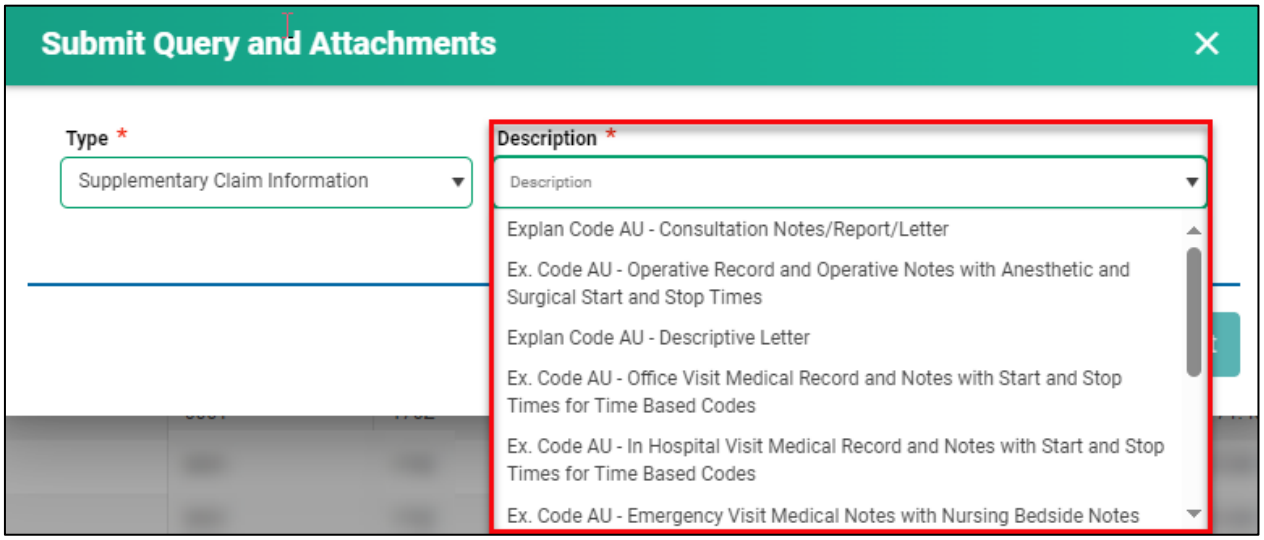
How to Run a Supplementary Claim Information Query

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

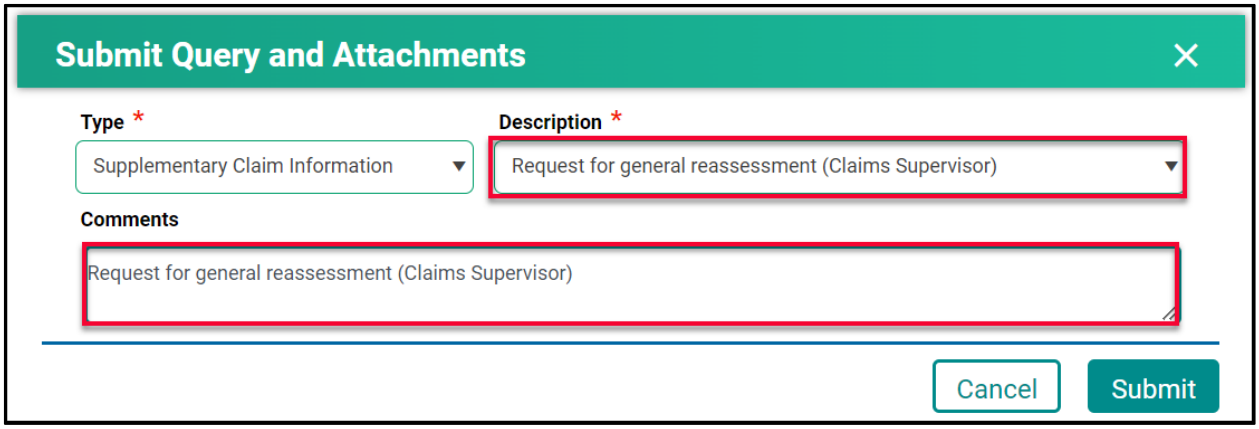
1. Select **Supplementary Claim Information.**



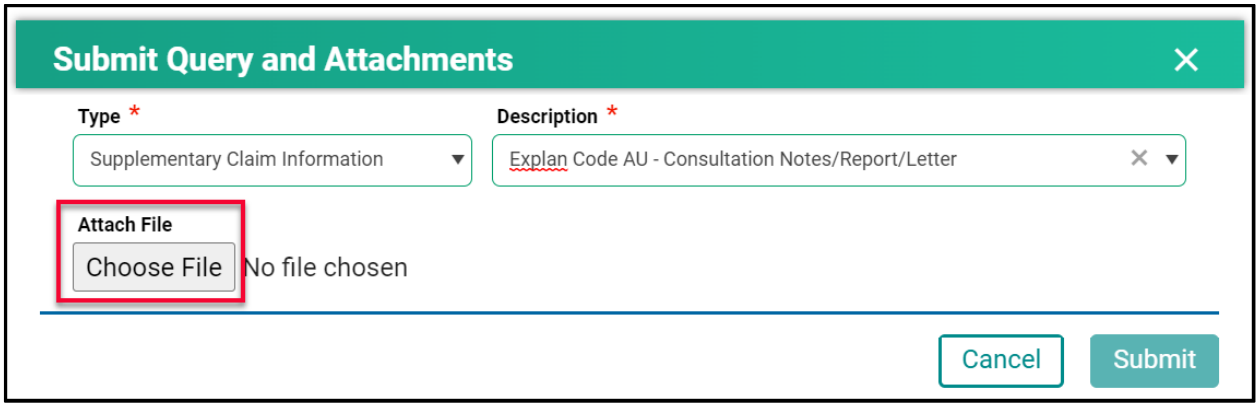
2. Select the correct **Description.**



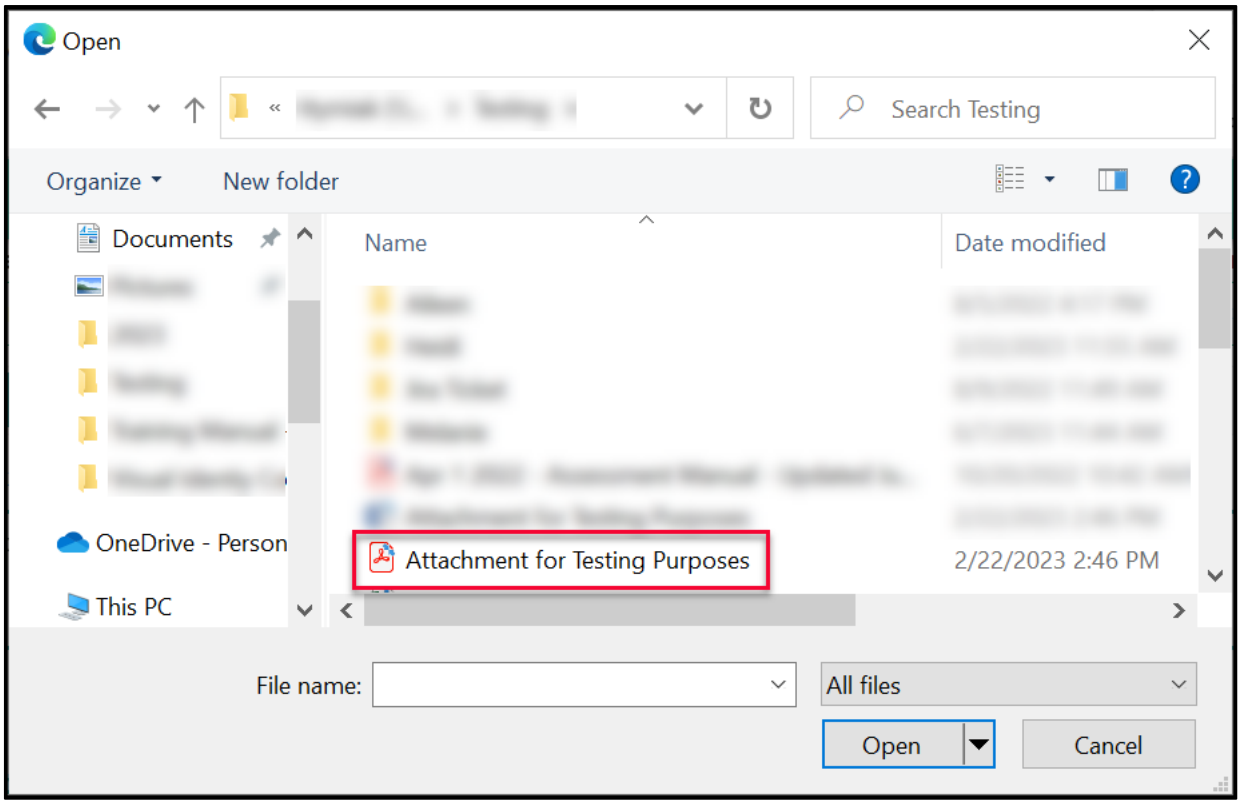
3. If **Request for general reassessment** is selected, enter a detailed comment explaining the reason for the recovery. For all other selections, move to step 4.



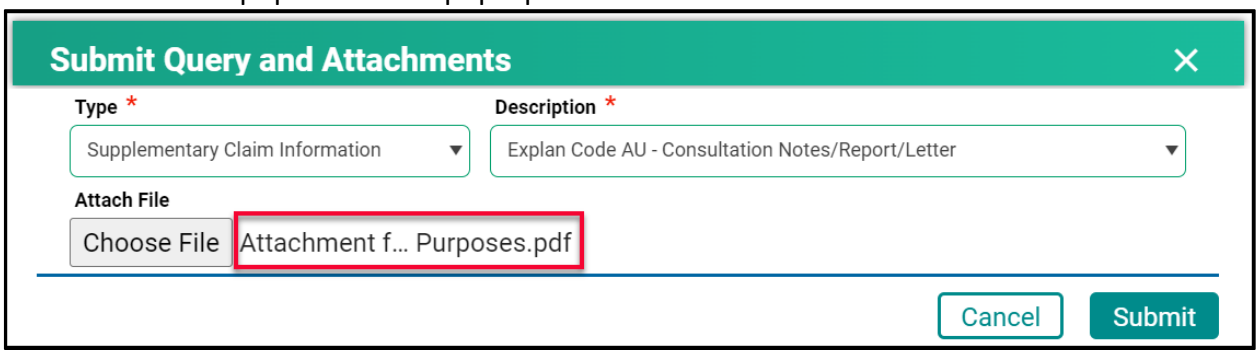
4. For all other selections a document(s) must be uploaded. Click **Choose File.** The file format can be in pdf, word, excel, jpeg, png.



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

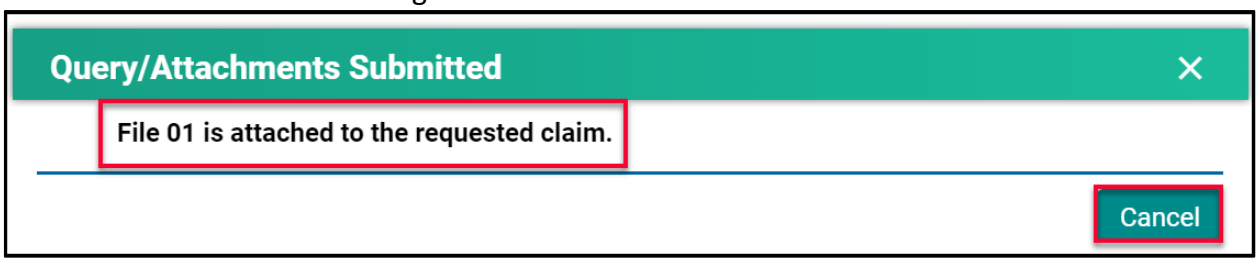


6. The file name will populate in the pop-up window.



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:

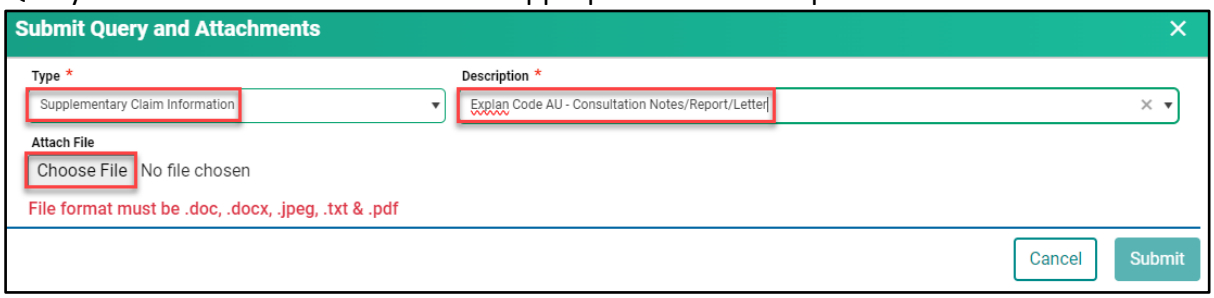
- Line 1 - 9B
- Line 2 – 890L

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



- 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:

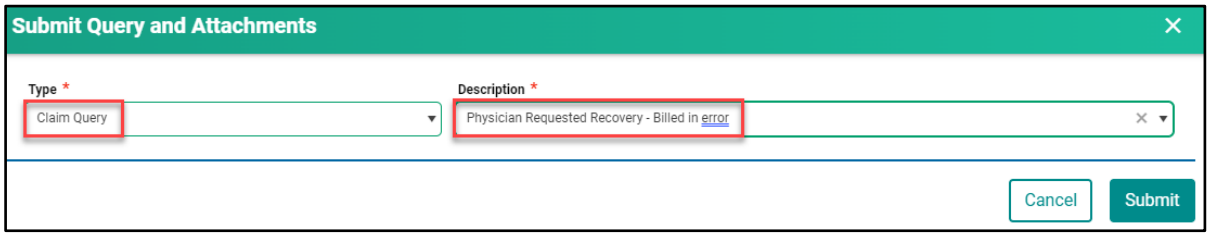
- No action required. 9B will be paid on the next bi-weekly run and 795A cannot be paid based on the Assessment Rules.

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.



- 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:

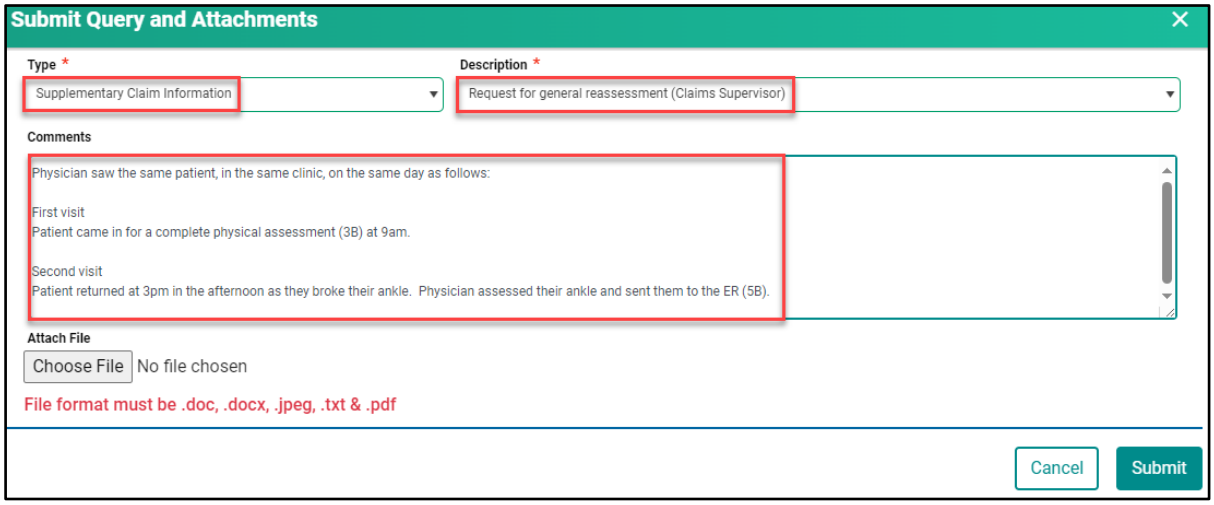
- Claim #1 – 3B for a complete physical done in the morning.
- Claim #2 – 5B as the patient returned to the clinic for a broken ankle.

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.



No action required on the claim with 3B.

Module SEVEN – Contact Us

Medical Services Branch

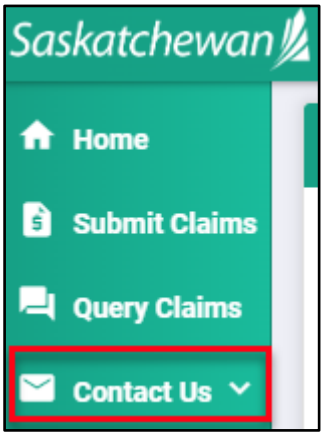
Claims Replacement Project

Contact Us

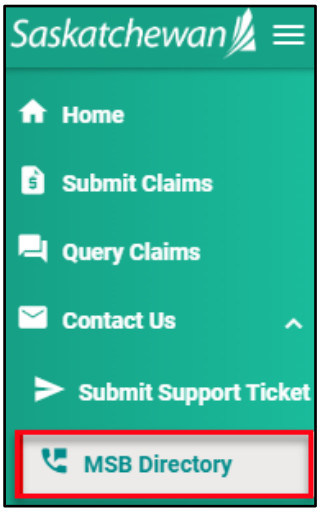
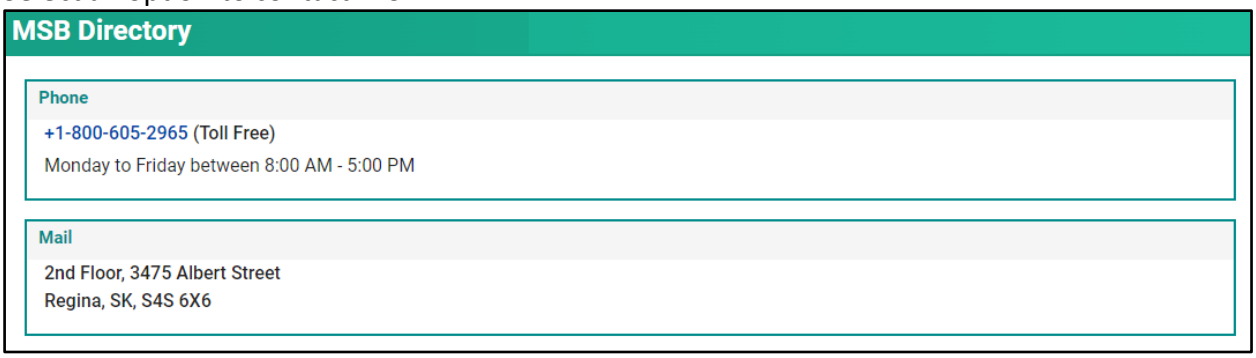
When requiring support with a claim or Customer Portal call **1-800-605-2965**, Monday to Friday from 8:00am to 5:00pm.

MSB Directory

1. Click on **Contact Us.**



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



3. Select an option to contact MSB.