SKeClaim™

Billing Concepts Guide

Medical Billing Software for the
Medical Services Branch of the Saskatchewan Ministry of Health

Purpose of this Guide

This guide is intended to provide a conceptual overview of the medical billing claims submission process in the Province of Saskatchewan, and the role that SKeClaim plays in this process. This is to help develop a basic understanding for those that are not familiar with these processes.

Most of the information presented in this Guide is provided in the "Payment Schedule for Insured Services" and the "Specifications for Automated Claim Submissions", both published by the Saskatchewan Ministry of Health. In addition, MSB provides a document entitled "Medical Services Branch Billing Process" and an "Online Billing Course", both of which are available from their website.

Main Elements

The three primary elements required for a billing submission are:

1. The doctor: The practitioner that performed the service being billed.

2. The patient: The person for whom the service was performed.

3. The services: A list of the services performed by the practitioner for the patient.

The claim record combines these three elements, along with some additional information, into a concise record which is then submitted to the Medical Services Branch (MSB) of the Saskatchewan Ministry of Health for payment.

The doctors and patients are maintained in separate lists (tables) to avoid retyping information for each claim and to provide consistent information which only needs to be validated once. Additional information lists (tables) used for consistency and validation include:

- Diagnostic Codes,
- Fee Codes and Associated Fees,
- Referring Doctors.

These are all related to the services being billed by the practitioner.

Claim Record

As noted earlier, the claim record pulls all the related information together so that it can be submitted for payment. The claim record is separated into two sections: common information; and service-specific information.

The common information relates to the overall claim and includes things such as doctor, patient, location and diagnosis. The service-specific information is contained in claim sequence lines, one service

per line. There can be no less than one and no more than nine claim sequence lines (numbered 0 through 8) as part of a single claim record. The claim sequence lines contain specific information such as service type, date and fee claimed.

In general, a claim record is structured as follows:

Section	Information	Attribute	Source / Validation
Common	Claim	Number	Auto-Assigned
		Submission Date	Auto-Assigned
	Doctor	Number	Doctors Table
		Name	Doctors Table
		Clinic	Doctors Table
		Corporation	Doctors Table
	Patient	Province	Patients Table
		Health Number (PHN)	Patients Table
		Name	Patients Table
		Date of Birth (MM/YY)	Patients Table
		Gender	Patients Table
	Service	Location	Locations Table
		Claim Type	Claim Types List
		Comment	(if required)
Services	Claim Sequence 0 to 8	See Below	(as required)

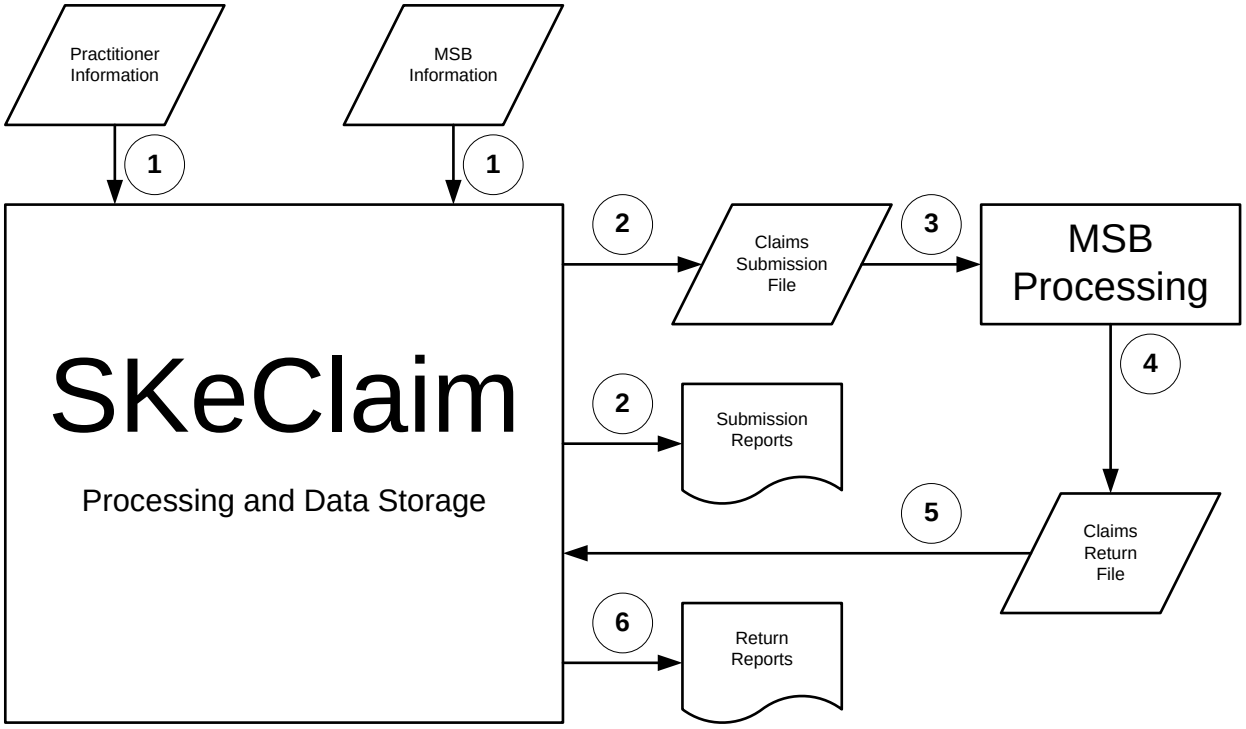
In general, each of the nine potential claim sequence lines is structured as follows:

Section	Information	Attribute	Source / Validation
Service	Claim Sequence	Number	Auto-Assigned (0-8)
	Service	Type Code	Type Code List
		Diagnosis	Diagnostic Codes Table
		Start Date	Calendar
		Start Time	(if required)
		End Date	(if service type “57”)
		End Time	(if required)
		Referring Doctor No.*	Referring Doctor Table
		Fee Code	Fee Codes Table
		Number of Units	1 through 99
		Fee Multiplier	(default 100%)
		Location and Premium	Location Code List
		Special Circumstances	(if required)
		Bilateral Indicator	(if required)
		Fee Submitted**	Calculated
		Facility Number	Facility Number Table
		Form Type	Form Type Code List

* Only required if the service was performed on a referral basis.

** The fee corresponding to the fee code entered is adjusted based on the “use low fee” setting, and is then multiplied by the number of units of the service. This value can be overridden.

Simplified Process Flow



1. Information provided by the practitioner (e.g. doctor, patient, and services provided) and by MSB (e.g. diagnostic codes, fee schedule, and referring doctors list) are collected within SKeClaim.

2. SKeClaim processes the information and prepares a claims submission file and printed reports.

3. The claims submission file is submitted by the practitioner to MSB for processing and payment.

4. MSB processes the submitted file and produces a return file.

5. The practitioner retrieves the return file from MSB.

6. SKeClaim processes the return file to update the database and prepare printed reports.

Submission File

The submission file is the file containing the claims information which is submitted to MSB for processing and payment. This file must conform to format specifications provided by MSB in order to be accepted for processing. This is where SKeClaim comes in.

The program looks through all of the claim / claim sequence records that have been entered and identifies those which have not yet been submitted for payment. It formats the information in

accordance with the file format specifications, including adding header and trailer lines as appropriate. The file produced can then be submitted to MSB through their on-line system. The program will also mark the claim / claim sequence records as having been submitted, so that they are not accidentally submitted a second time.

Return File

The return file is the file returned from MSB indicating the results of processing a submission file. Like the submission file, the return file conforms to format specifications provided by MSB.

SKeClaim interprets the information in the return file and prepares a report for each practitioner, expanding the return code into an explanation for any claims returned for correction or paid at a different rate. In addition, paid claims are removed from the application database. Reports can be generated at any time, whether or not the claim records have been removed from the database, based on the information in the return file.

SKeClaim's Role

The role of the SKeClaim software can be likened to that of an interpreter. It takes the service claim information provided and converts it to a format that can be used by MSB. It then takes the information returned from MSB and provides it in a format that can be read and understood by the user. It also provides some checking to help ensure that the information submitted is in accordance with the Fee Schedule, and avoid claims from being returned for correction or rejected.