SKeClaim™

Version 2

User Guide

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

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About SKeClaim™

SKeClaim provides the tools to prepare your medical claim files for electronic submission to the Medical Services Branch (MSB) of the Saskatchewan Ministry of Health for payment, and for tracking and reporting submissions, returns and payments.

The original MediBill program was first introduced in 1987 as a DOS application, and has been in continual use ever since by both individual practitioners and clinics alike. SKeClaim is descended from that original, and strives to maintain the qualities that made MediBill such a lasting success. It is a billing tool only, and all development has been aimed at making it efficient and easy to use for that task.

We would like to take this opportunity to thank Judie & Peter Williams of Williams Medibill Services for pushing us to originally develop the package. Without them MediBill would probably never have gotten off the ground.

We would also like to thank our testing team for their help in the development and testing of the program, and to all of our users for suggesting ways to make it better.

A special thank-you goes out to the folks at the MSB for their patience in putting up with all our questions about file formats and such during the development of SKeClaim.

If you have any suggestions for improving the program or things that you would like to see in a future release, please send your ideas and suggestions to us at the following address:

R.S. Digital Solutions
5708 - 47 Street
Stony Plain, Alberta
T7Z 1C6

Email: support@rsds.ca
Web: https://skeclaim.rsds.ca

Above all, thank you for choosing SKeClaim to meet your medical billing needs.

How to Use this Manual

This manual is designed to lead the user through the different functions of the program, from setup through to actual claim submission and processing of return files. The manual has been broken down into chapters, each dealing with a different aspect of the use of the program.

It is recommended that you read through each section of the manual before using that section of the program. However, if you're like most people, you haven't got the time or patience to do this. There is a separate Quick Start Guide provided with the SKeClaim package, which covers just enough of the basics to get the program up and running.

Some conventions used in this manual include the following:

- Special keys are shown in square brackets. For example, [F1] refers to the first function key. Some of the special key names will be abbreviated.

- Key combinations are shown in uppercase characters joined with a hyphen. For example, CTL-ALT-DEL means to hold down the [Ctrl] and [Alt] keys and press the [Delete] key.

The manual is intended to be used as a "how to" reference document, and used to guide you through a function. Before long, you will likely be comfortably using the features of the program and will only have to refer to the manual on rare occasions. The reason for this is that the program is mainly menu driven, and context sensitive help is available simply by pressing the [F1] Help key.

Billing Conceptual Process

Overview

This section 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 section 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)

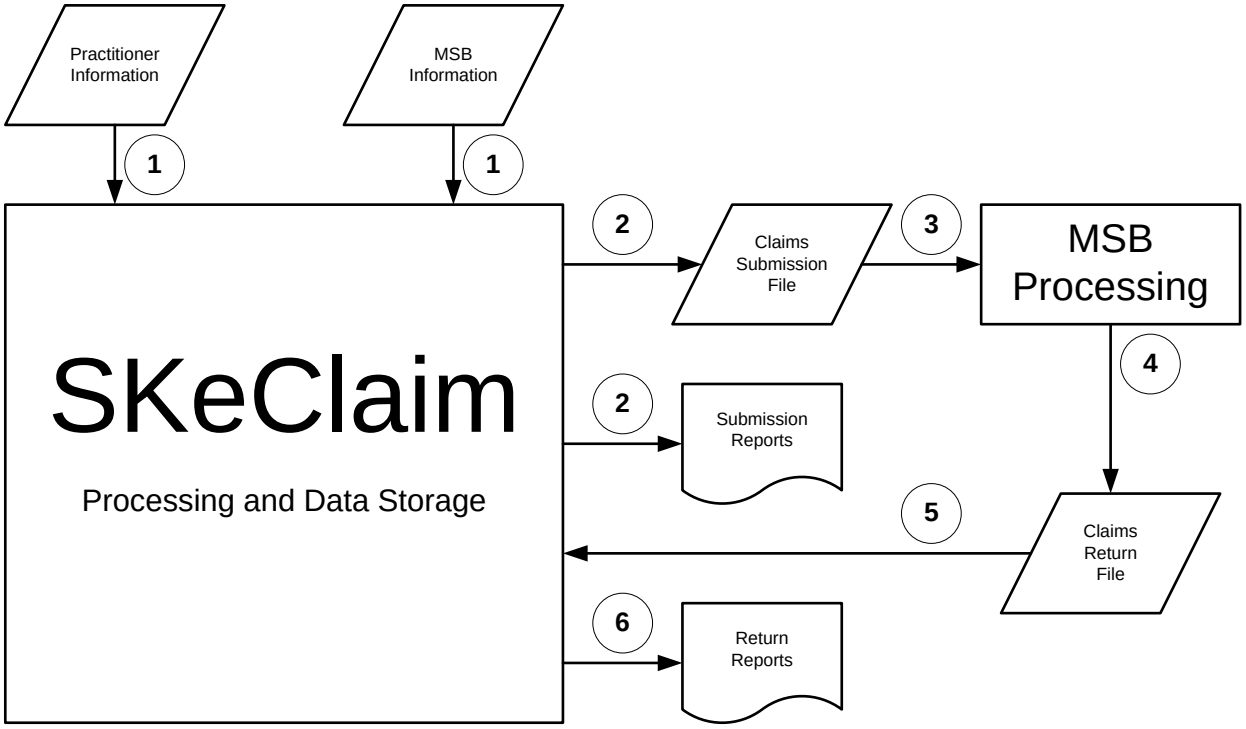
In general, each of the nine potential claim sequence lines is structured as follows:

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
		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.

Getting Started

System Requirements

SKeClaim runs under Microsoft Windows 7 or later, and requires the Microsoft .NET framework version 4.8. If the appropriate version of .NET is not found during installation, you will be prompted to download and install it from the Microsoft web site.

The program requires a minimum of 20 MB of free disk space to install, not including any space requirements for installing the correct version of the .NET framework. Additional disk space will be required during operation to accommodate the working database.

Installation

Installation of the software is fully automated and performed through an installation program. During installation, you will be prompted to download and install the .NET framework version 4.8 from Microsoft if it is not already installed on the computer.

In addition to installing the SKeClaim software, a blank copy of the working database will be installed in the C:\SKeClaim directory, the default location for the data file. When installing updates, your existing data file will be re-used if possible. If the existing file cannot be used because of a change in the file structure for the new release, it will be retained for conversion.

Configuration

If this is an update from a prior version of SKeClaim, the program will attempt to use your existing database and settings. If the database structure has changed from the prior version, when first run the program will save a copy of your current database and then convert it to the new structure automatically.

Once any previous information has been converted, you should review the configuration settings using the Edit → Settings option from the toolbar on the Main Menu. Please see the Settings section for additional information.

If the Main Menu header does not indicate that the program is registered you will need to enter your registration code. The registration screen is opened using the Help → Register option from the toolbar on the Main Menu. Please see the Registration section for additional information.

Finally, you should obtain and import the most recent International Diagnostic Codes (IDC), Fee Schedule, and Referring Doctors files from the Medical Services Branch (MSB). These files are made available to practitioners and companies that have agreements in place to submit claims information to MSB electronically through the Internet. When first run, SKeClaim will try to download and import the files automatically. This includes a fee code descriptions file from the SKeClaim web site, which will

support enhanced lookup functionality when entering claim records. The file import utility is available using the Tools → Update Support Tables option from the toolbar on the Main Menu. Please see the Updating Support Tables section for additional information.

On-Line Help

Online help is available from within SKeClaim, and can be called in two ways. For detailed information about a field or a form, press the [F1] key, and a context-sensitive help system window will be displayed. When there is no specific help available for a field, general help regarding the screen containing the field will be displayed.

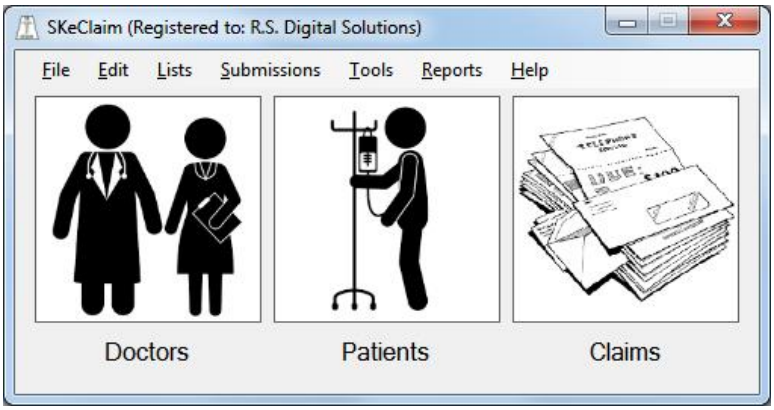
For general help including the table of contents or index for the help system, select either the Help → Contents or the Help → Index option from the toolbar on the Main Menu.

The help system can also be displayed without running SKeClaim by opening it from the All Programs → SKeClaim folder in the Start Menu.

Main Menu

The Main Menu is the launch point for all of the functionality of the SKeClaim package. The toolbar is used to provide access to the various data entry screens, the claims submission and return processing, reporting, and the support tools.

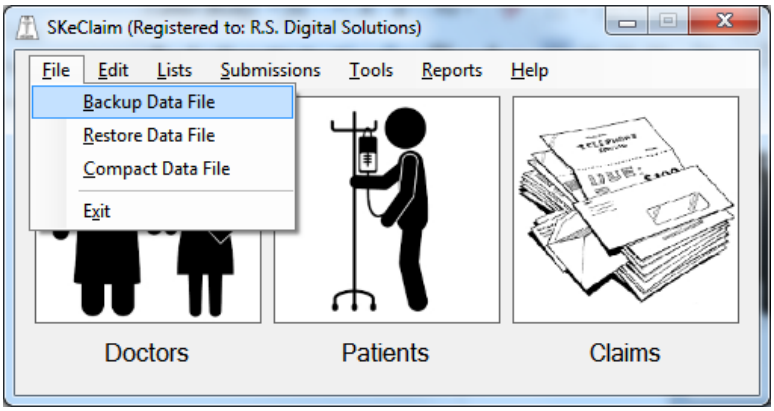
In addition to the toolbar, the three main data entry activities (i.e. Doctors, Patients and Claims) are available by clicking on the images.



Closing the Main Menu will close all other open screens and exit the program.

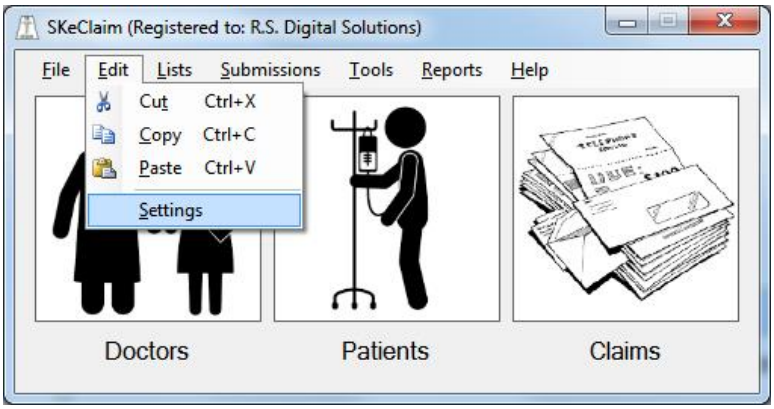
Tool Bar: File

The File section allows access to data file backup and restore, data file compact and repair, and the option to exit the program.



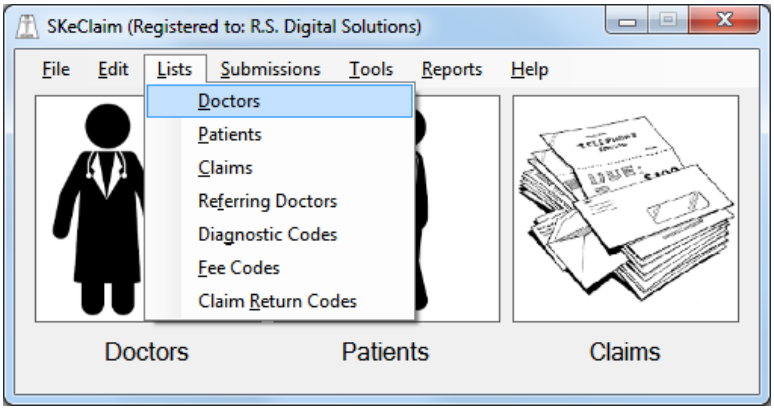
Tool Bar: Edit

The Edit section allows access to the configuration settings screen.



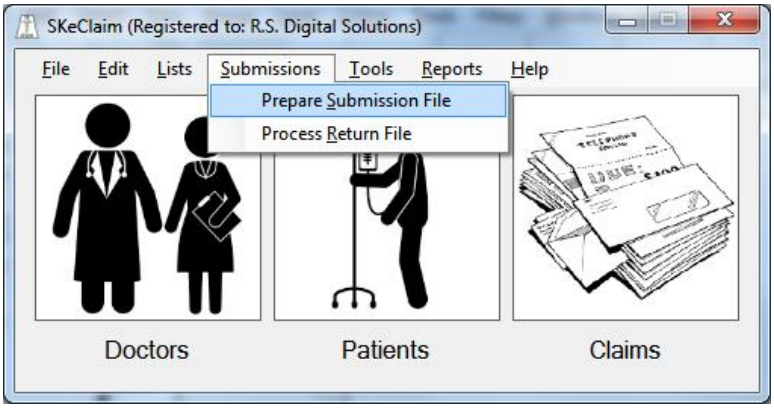
Tool Bar: Lists

The Lists section allows access to the Doctors table, the Patients table, the Claims table, and the other supporting tables in the database. The Doctors, Patients and Claims lists can also be displayed by clicking on their respective images on the Main Menu.



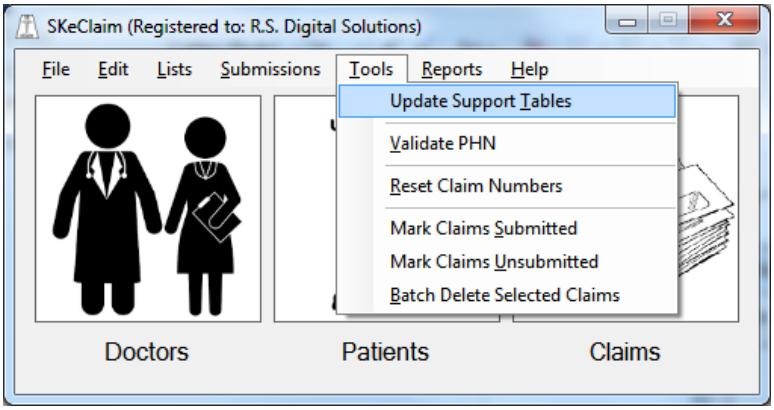
Tool Bar: Submissions

The Submissions section provides access to the screens for preparing a claim submission file or processing a return file. The Prepare Submission File selection displays a new window where you can select the parameters and create a new claim submission file for transmitting to the MSB for processing and payment.



Tool Bar: Tools

The Tools section provides access to miscellaneous tools for maintaining the database and validating a patient's Personal Health Number (PHN).

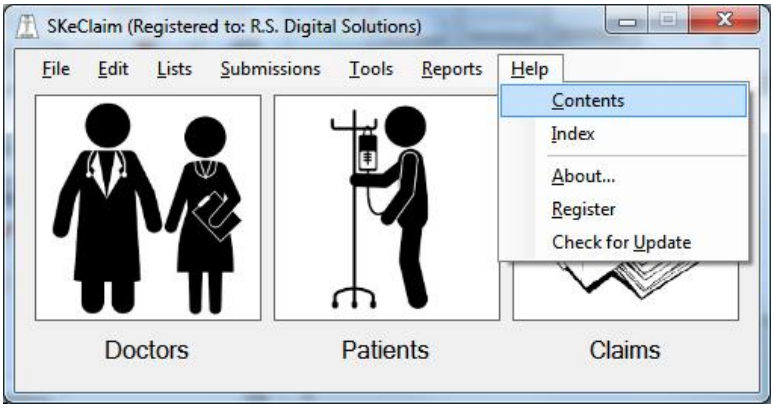


Tool Bar: Reports

The Reports section displays a new window where you can select the parameters and generate various reports from the system. Once a report is generated, it can be printed or saved as a Portable Data Format (PDF) file.

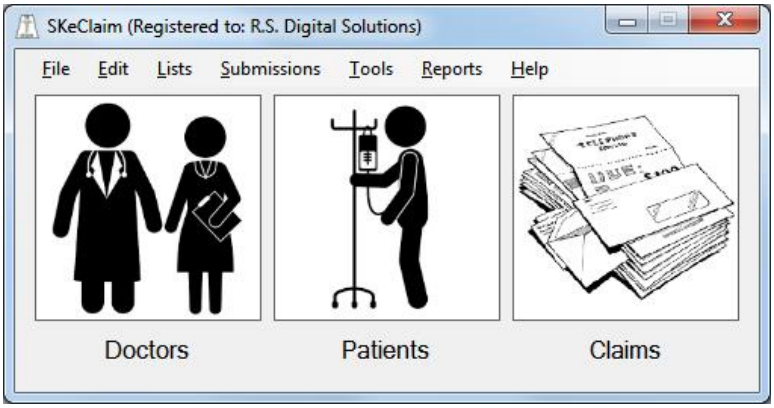
Tool Bar: Help

The Help section provides access to the integrated help system (contents and index), as well as a window providing some brief information about the program (e.g. current version). This section also allows you to open a window to enter your registration information to unlock the claims submission and returns processing functionality, and allows you to check the web site for program updates.



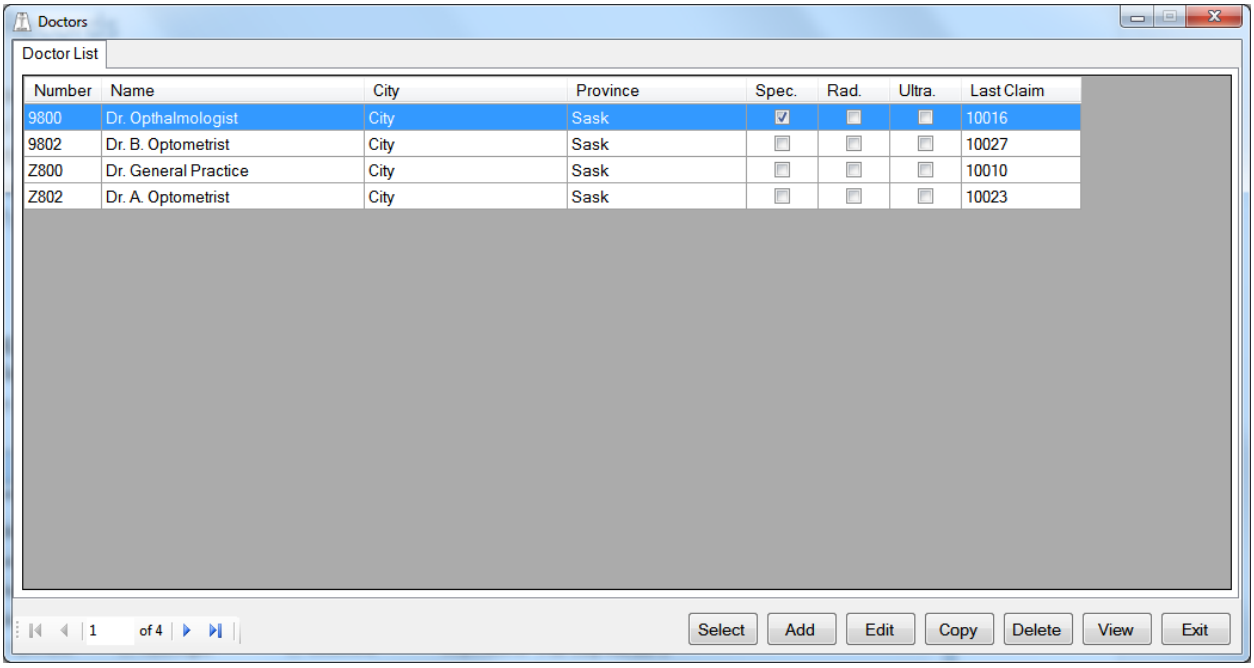
Images: Quick Access

The three images on the main menu provide fast one-click access to the three main data tables: Doctors; Patients; and Claims.

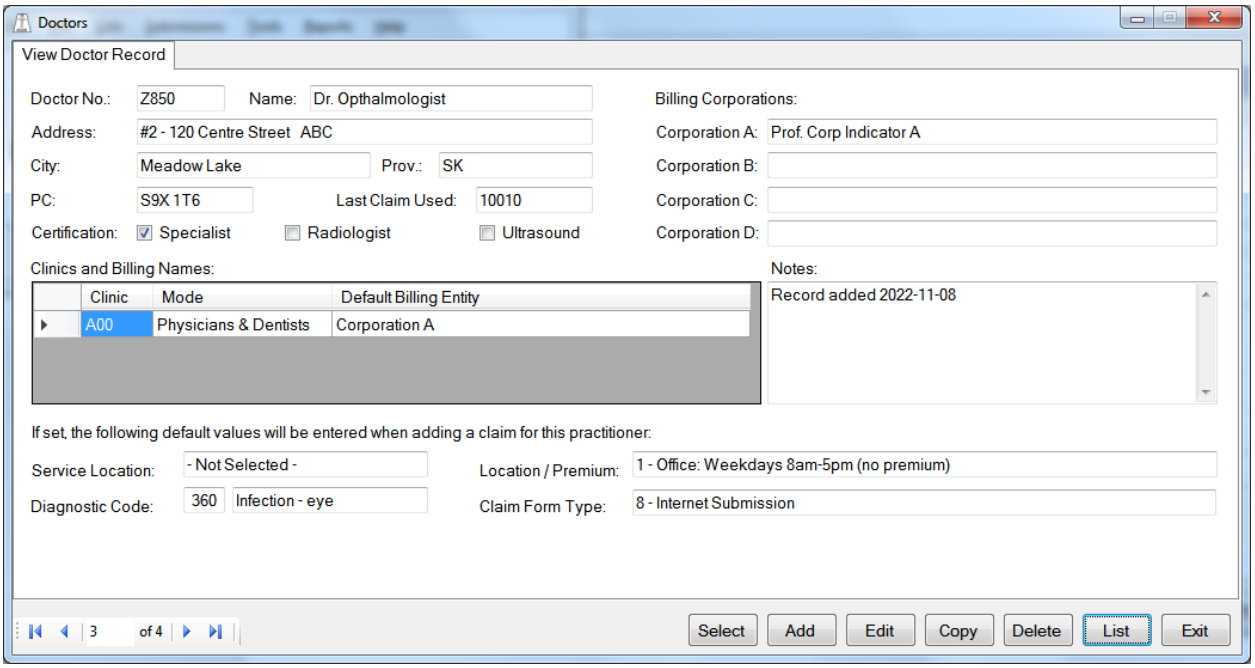


Doctors Records

When the Doctors screen is opened, the doctor records are displayed in a list. This is the list of practitioners for which billing claims may be submitted. From this list, you have the options of adding, editing, deleting or selecting (if the screen is opened for looking up a doctor) a doctor record, as well as refreshing the list. Double clicking an item in the list will display the item, or transfer the item to the claim form if you are doing a lookup.



When adding, editing or copying a doctor record, the doctor record form will be displayed. If adding a record, the fields will be set to their default values. If copying a record, the fields will be set to the values of the record being copied, with the exception of the Doctor Number field which will be blank.



The record contains the Doctor Number and name.

Next comes the practitioner's address, followed by the last claim number used. Then follow indicators if the practitioner is a specialist, a radiologist or has ultrasound entitlement.

The right-hand side of the screen captures the names of up to four corporations under which the practitioner might bill, and a section for any notes that you wish to associate with the practitioner.

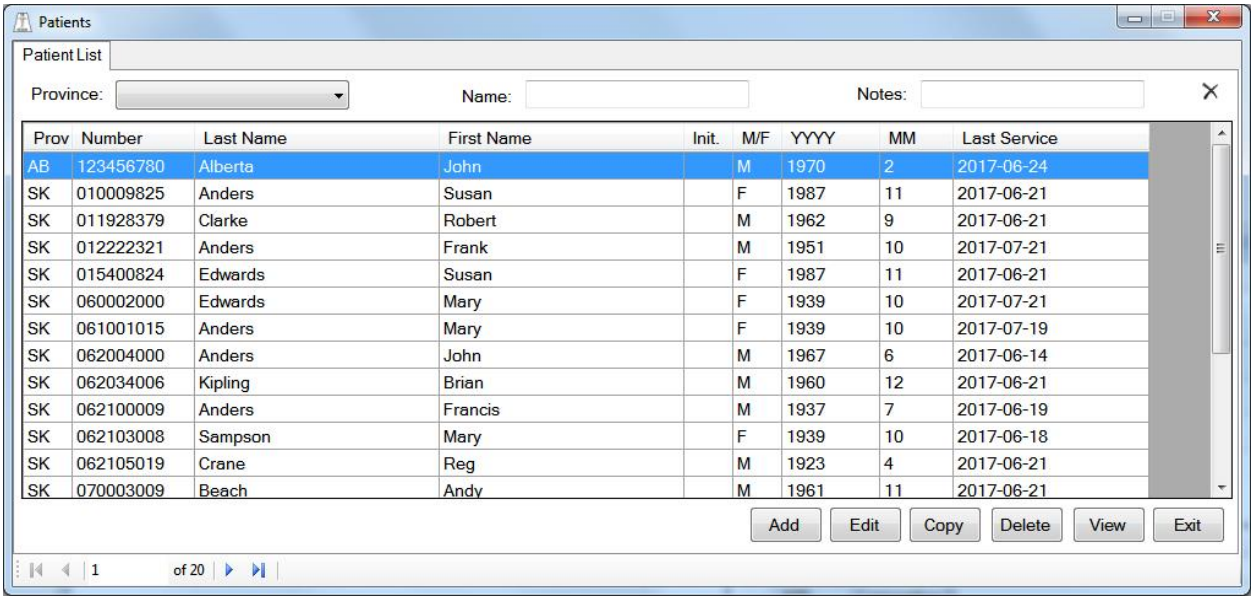
This is followed by a list of the clinics with which the practitioner is associated, including the mode which identifies the practitioner billing type, and the default billing entity for that clinic.

The lower portion of the screen contains the optional default values that will be entered automatically when adding a claim for the practitioner.

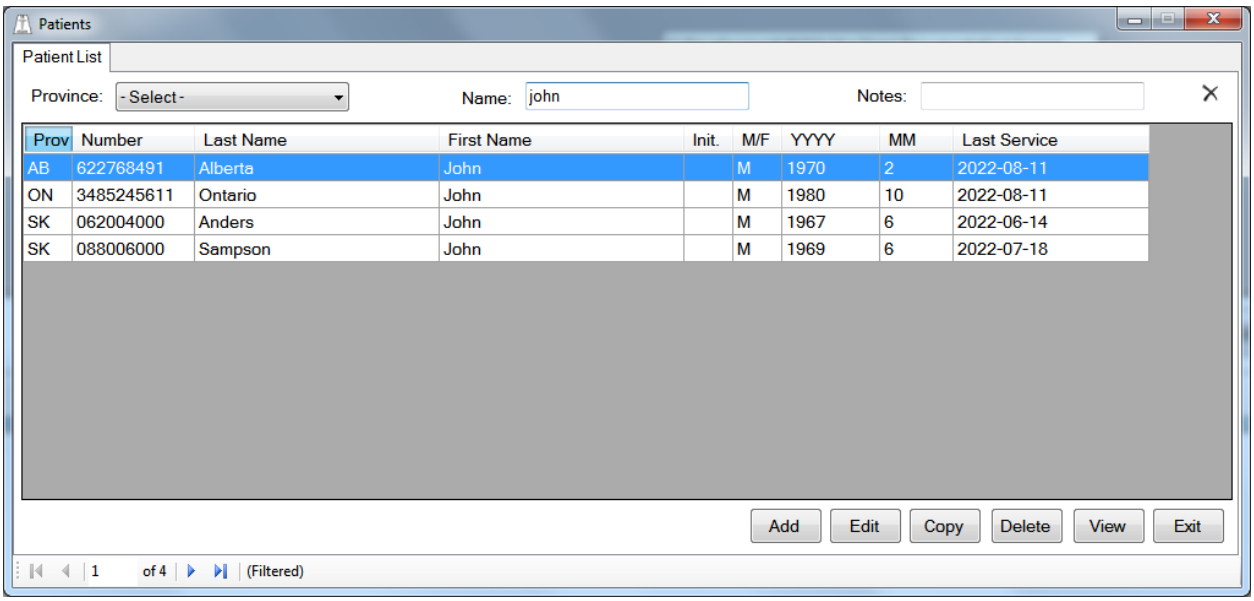
Some basic validation will be performed prior to saving the record.

Patients Records

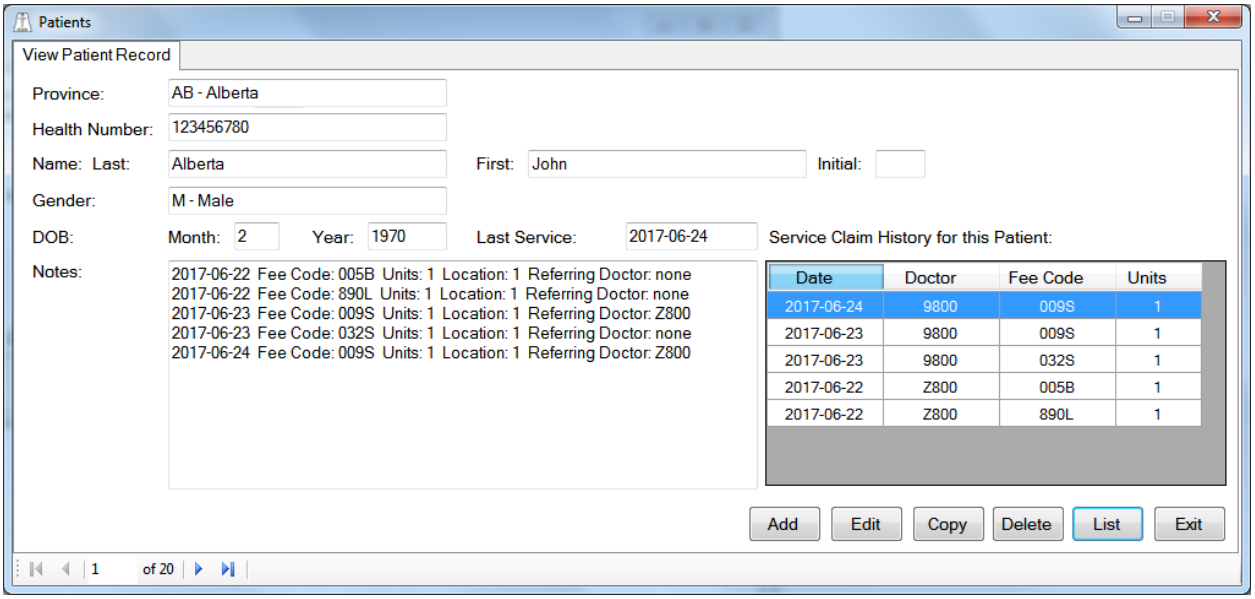
When the Patients screen is opened, the patient records are displayed in a list. This is the list of patients for which billing claims may have been submitted. From this list, you have the options of adding, editing, deleting or selecting (if the screen is opened for looking up a patient) a patient record, as well as refreshing the list. Double clicking an item in the list will display the item, or transfer the item to the claim form if you are doing a lookup.



The list can be filtered to enable quick lookup of a particular patient.



When adding, editing or copying a patient record, the patient record form will be displayed. If adding a record, the fields will be set to their default values. If copying a record, the fields will be set to the values of the record being copied, with the exception of the Health Number field which will be blank.



The record contains the patient's last and first names, their province of residence, personal health number (PHN), month and year of birth, gender and the date of the last service performed for the patient. There is also a field to capture any notes that you may wish to associate with a patient.

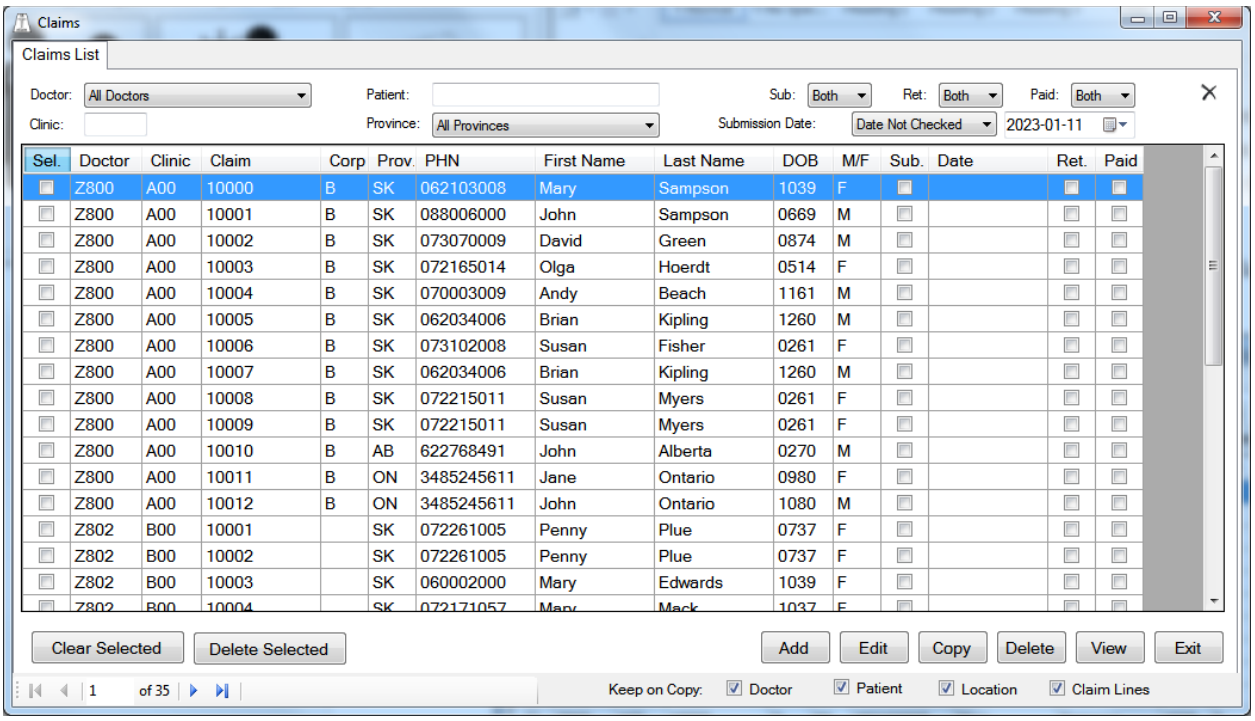
The program automatically saves claim information to a claim history table when new claim service records are added. This service history can be used to quickly determine the last time a specific service was performed to assist in determining the eligibility of a service claim restricted to the number of occurrences within a specified period (e.g.: consultations). In addition, there is an option to have the program automatically add service information to the notes field whenever a claim record is saved for the patient.

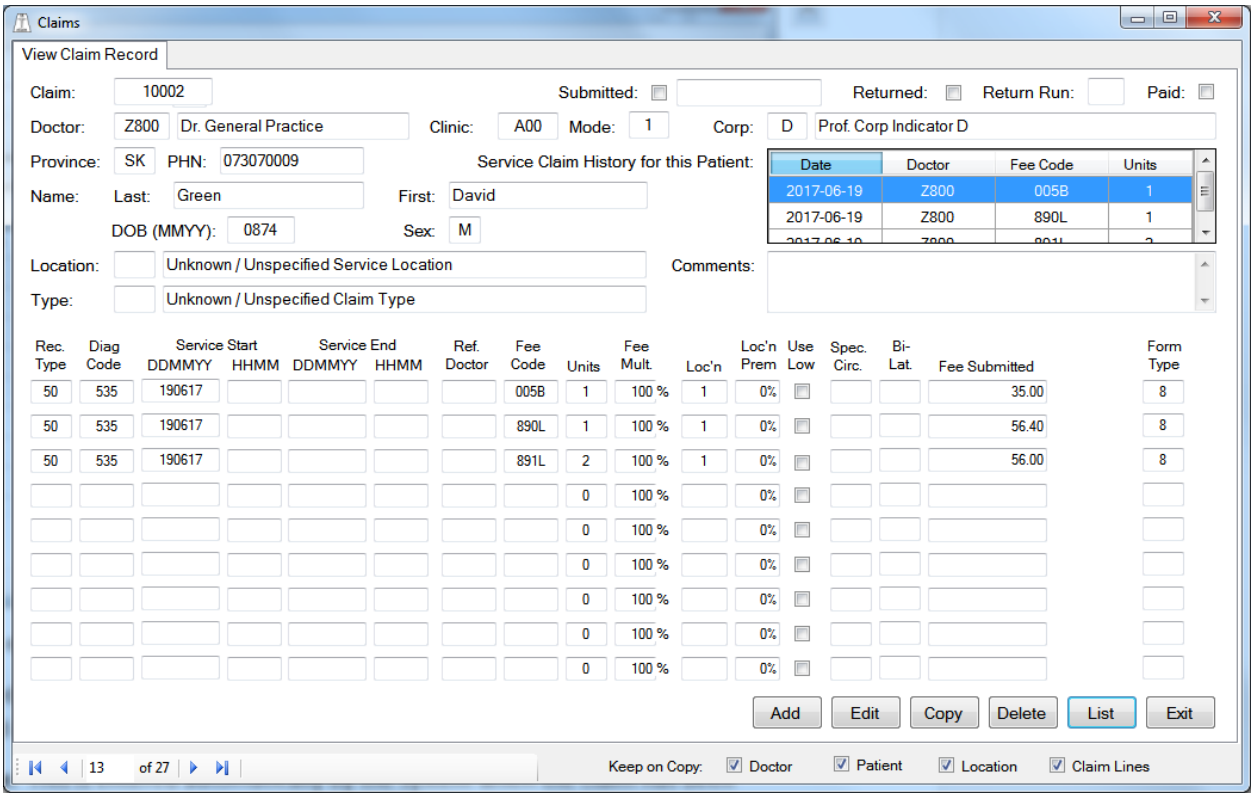
Note that when a patient record is saved, a check will be performed on the PHN entered to ensure that the number meets the validation criteria. For more information about validation, please see the PHN Validation section.

Claim Records

When the Claim Records screen is opened, the claim records are displayed in a list, including some basic information such as the doctor, patient, and whether or not the claim has been submitted for payment. From this list, you have the options of adding, editing, copying all or part of a claim to a new claim record, or deleting a claim record.

The list can also be filtered to allow the user to quickly locate a specific claim.





The information recorded for each claim record includes:

Claim Number: This is entered automatically by the system and cannot be changed by the user. If the doctor information is changed on an existing record, a new claim number will be assigned.

Submitted Indicator and Date: This is entered automatically by the system when the claim has been submitted. If you specifically choose to edit a submitted record, you can remove the submitted indicator and date so that the record will be included on the next submission for that doctor.

Doctor and Clinic: This identifies the doctor that performed the services and for whom the claim is being submitted. This is validated against the list of doctors entered into the database.

Mode: This indicates the billing mode for the claim. This will automatically default to the setting in the doctor's record for the selected clinic.

Corporation: This indicates whether the claim is being submitted for the individual practitioner or on behalf of a corporation. This will automatically default to the setting in the doctor's record.

Province and PHN: This identifies the patient for whom the service was provided. This is validated against the list of patients entered into the database. If there is no matching patient record, it will be added automatically when the claim record is saved.

Date of Birth (DOB), Gender and Name: These fields are automatically filled in when an existing patient record has been selected. They may be overwritten to accommodate special situations such as a newborn child receiving treatment under the mother's PHN.

Service Location: The service location code for the service provided, as required. This is validated against the list of service location codes provided by the Medical Services Branch (MSB).

Claim Type: The claim type code for the service provided, if required. This is validated against a list of claim types provided by the Medical Services Branch (MSB).

Comment: This is an optional comment associated with the claim to provide additional information or clarification.

Following this information, which is common to all services on the claim, comes the claim sequence information—one line per service. The information for the sequence lines includes:

Type Code: This identifies whether the line is for a visit / procedure (50), or whether it is for hospital care (57).

Diagnostic Code: The diagnostic code for the service provided. This is validated against the list of diagnostic codes provided by the Medical Services Branch (MSB).

Start and End Dates and Times: These are the dates and times (if required) related to the service. For visit / procedure records no end date is required because it is not reported on the claim submission. Hospital care records must show an end date within the same month as the start date. Hospital care services that span a month-end must be submitted on separate claims for each month.

Referring Doctor: This is the number of the referring doctor, if any, for the service on the claim sequence line. The referring doctor numbers are available for lookup, and the number entered will be validated. The validation can be disabled in the Validations section of the program settings. This is to allow the use of numbers that may not be recorded in the system because the latest updates provided by the Medical Services Branch (MSB) may not have been applied.

Fee Code: This is the code identifying the service provided. It will be validated against the list of fee codes in the Fee Schedule provided by the Medical Services Branch (MSB).

Number of Units: This is the number of service units provided for the selected fee code. In most cases this will be one. Numbers greater than one will be validated against the fee code record to confirm that multiple units are allowed.

Fee Multiplier: This is an optional multiplier that should be applied to the fee, to accommodate situations where the practitioner is only eligible for a portion of the fee. Generally this will be 100%. This will be reset to 100% automatically if the fee code specifies that it should always be billed at 100%.

Location: The location code for the service provided. This is validated against the list of location codes provided by the Medical Services Branch (MSB). This code is used to determine whether a premium is applicable to the fee submitted. The premium will be displayed next to the location code.

Use Low Fee: This is an indicator of whether the low fee should be used rather than the high fee. In most cases, the high fee is the one to be used; however, certain circumstances require use of the low fee. Hovering the mouse pointer over the checkbox will provide specific information regarding the fee

code entered as well as a recommendation based on the current claim and sequence line information. This recommendation is updated automatically as new information is entered.

Special Circumstances Code: This indicates whether there are special circumstances impacting the service billed for this fee code. This is validated against the list of special circumstances codes provided by the Medical Services Branch (MSB).

Bilateral Indicator: If required, this indicates whether the procedure applied to the left, right or both sides of the patient. This is validated against the list of bilateral codes provided by the Medical Services Branch (MSB).

Fee Submitted: This is the amount of the fee submitted for the current claim sequence line. It is calculated automatically based on the fee code, number of units, multiplier and use low fee indicator. The value can be overwritten if required. Note that location premiums should not be included.

Form Type Code: This indicates the type of submission form. In most cases this will be "8" which signifies submission by internet, but it may be "E" requesting an Electronic Medical Record (EMR) transaction fee on this service that is recorded in an approved EMR system. This is validated against the list of form type codes provided by the Medical Services Branch (MSB).

The data entry screen has been designed to allow fast data entry of claim records with minimal use of drop down menus and other functions requiring the mouse. All data entry is done using the keyboard, and the [Tab] key is used to move between fields. The record can be saved using ALT-S, ALT-N which saves the record and starts a new blank record, or ALT-C which saves the record and starts a new record with the specified information copied from the current record.

Claim lines may be entered in any order and the program will automatically sort them into the correct order when preparing the submission file. The information on the claim record will be validated prior to the record being saved.

Even though there are no buttons specifically provided for looking up information, the lookup lists can be accessed by double clicking or pressing ALT-L on the field to be looked up. These fields include doctor number, patient province and PHN, location codes, diagnostic codes, record type, start and end dates (calendar popup), fee codes and referring doctors.

The system will also display a list of the services claimed for the specified patient. This service history can be used to quickly determine the last time a specific service was performed to assist in determining the eligibility of a service claim restricted to the number of occurrences within a specified period (e.g.: consultations).

Note that if you have entered information for a patient not in the database, it will be saved to a new patient record when the claim record is saved.

Support Tables

In addition to the three main data tables—doctors, patients and claims—there are a number of other tables with information used to support the application. These are used for validation and looking up information when preparing claims for submission for processing claim submission return files.

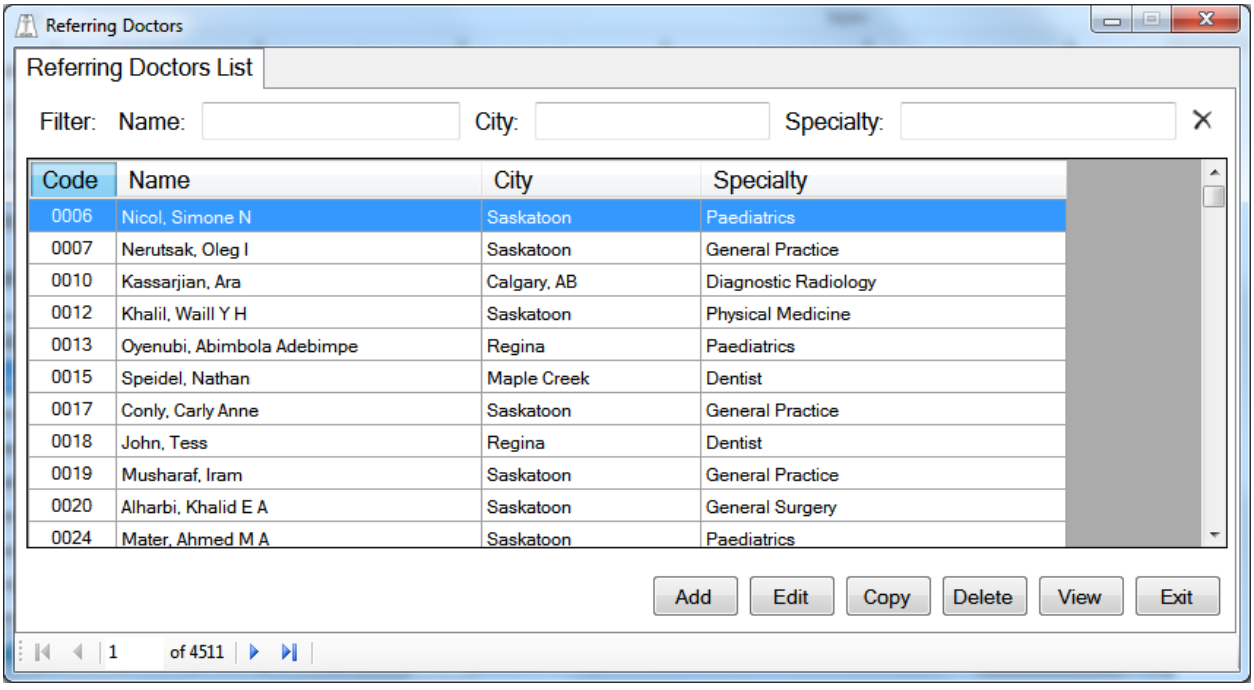
SKeClaim maintains a set of dates for each item of support table information – The effective start and end date – and automatically selects the appropriate information based on the service dates in a claim. This way the user can update the tables as soon as the information is available without accidentally using information before its effective date.

In general, any updates required to the information in these tables will be done by importing update files provided by the Medical Services Branch (MSB) or R.S Digital Solutions. In the odd case where a change needs to be made or a new code added and an update file is not yet available, the system provides the same adding or editing capabilities as for the three main tables.

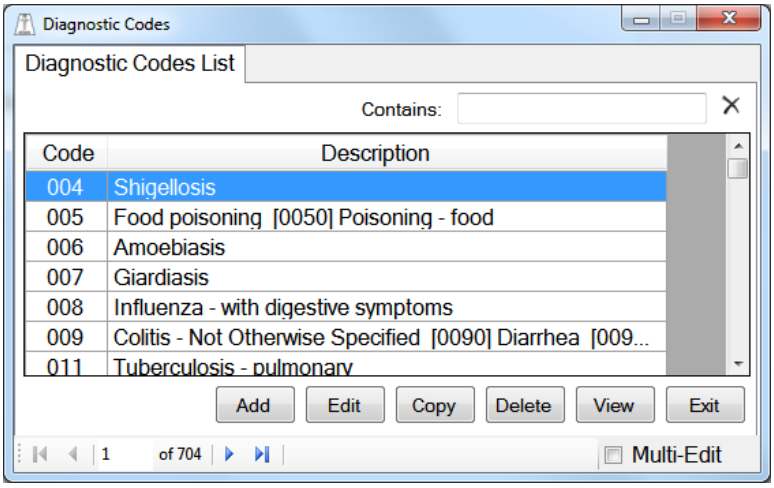
Viewing Lists

The various support tables available from the Lists option on the Main Menu. The support tables include:

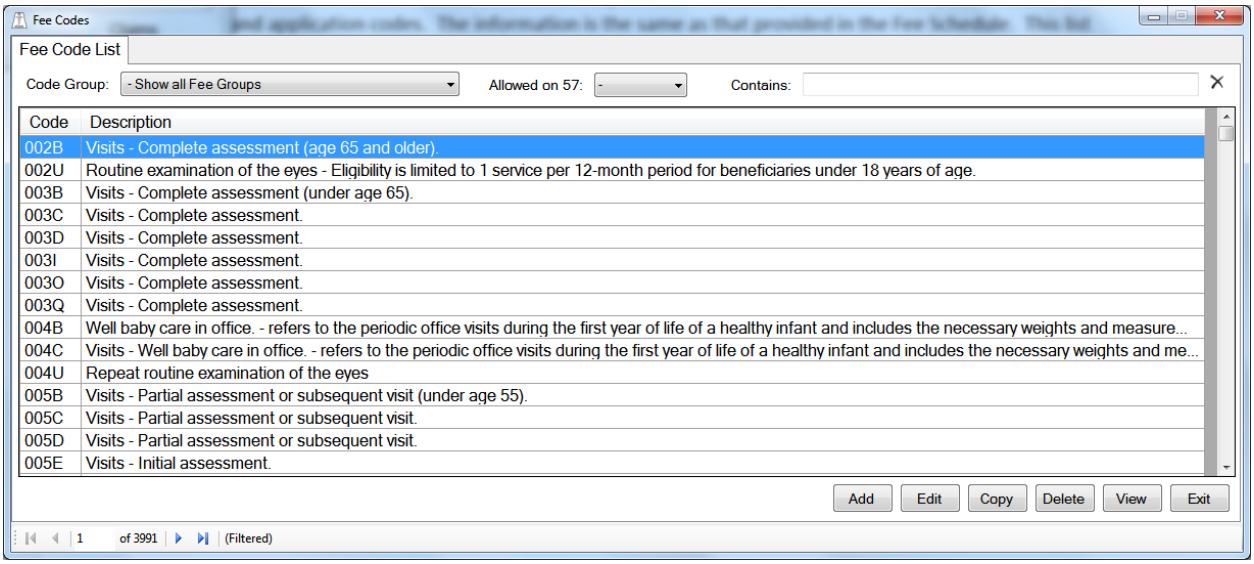
Referring Doctors: This is a list of all doctors registered in Saskatchewan which may be used as referring doctors on claims. This list is available as an update file provided by the Medical Services Branch (MSB). The list can also be filtered to allow the user to quickly locate a specific doctor.



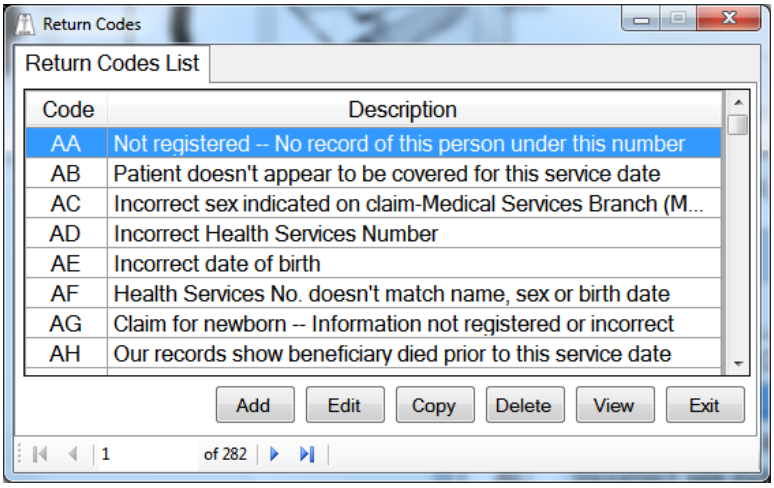
Diagnostic Codes: This is a list of the diagnostic codes which may be used on claims. This list is available as an update file provided by the Medical Services Branch (MSB). The list can also be filtered to allow the user to quickly locate a specific diagnostic code.



Fee Codes: This is a list of the fee codes that may be used on claims, and contains information such as rates and application codes. The information is the same as that provided in the Fee Schedule. This list is available as an update file provided by the Medical Services Branch (MSB). The list can also be filtered to allow the user to quickly locate a specific fee code.



Claim Return Codes: This is a list of the explanation codes used when claim submissions are returned for correction. The information is the same as that provided in the Fee Schedule. This list is available as an update file provided by R.S. Digital Solutions.



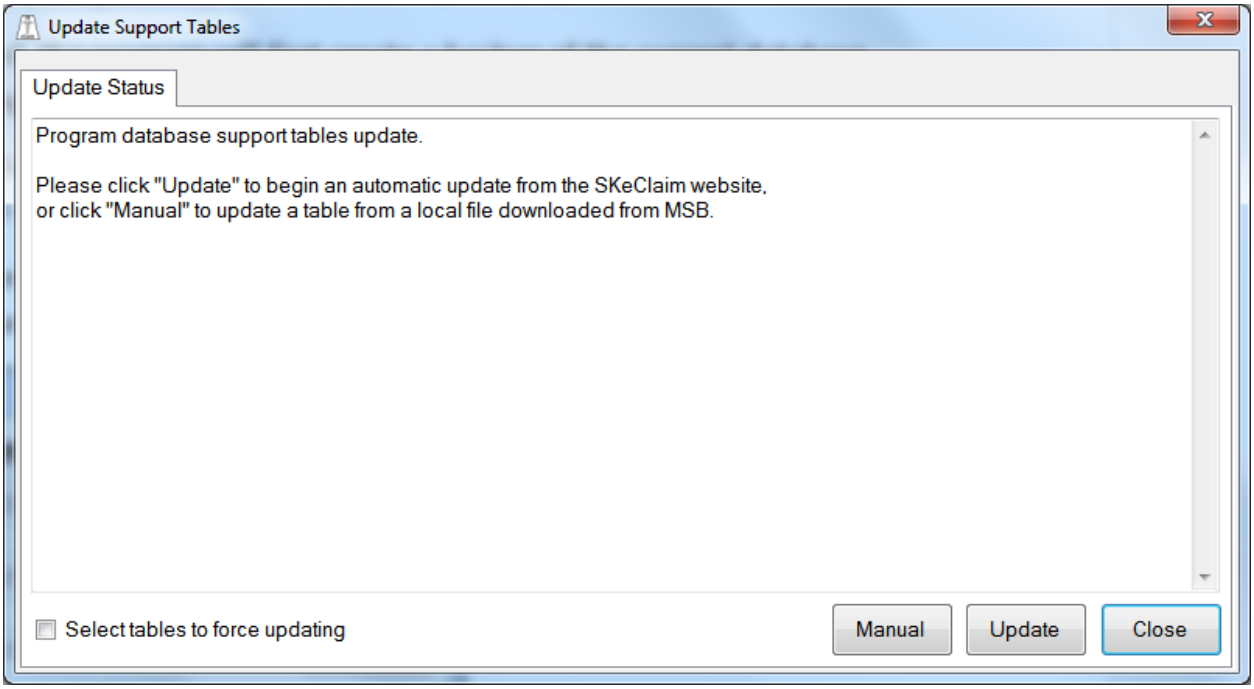
Updating Support Tables

Generally, all support table updating is performed automatically by the program. SKeClaim can be set to check for support table updates each time the program is started, or the checks can be performed manually using the Tools → Update Support Tables option from the Main Menu.

When automatic updating is performed, the program will first create a backup of the current database file. In the event an error occurs during the update, the backup file is automatically restored.

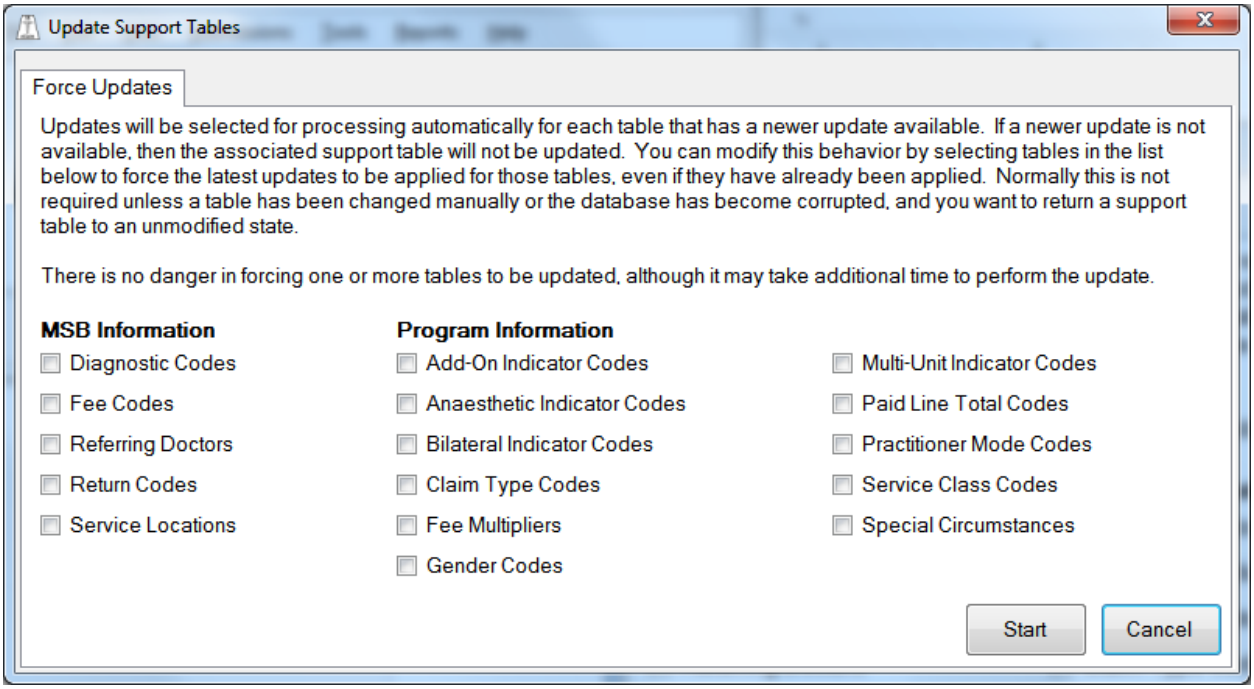
When performing manual updates, it is strongly recommended that the user first save a backup copy of the database to enable recovery in the event of problems during the update.

Updates will be selected for processing automatically for each table that has a newer update available. If a newer update is not available, then the associated support table will not be updated.

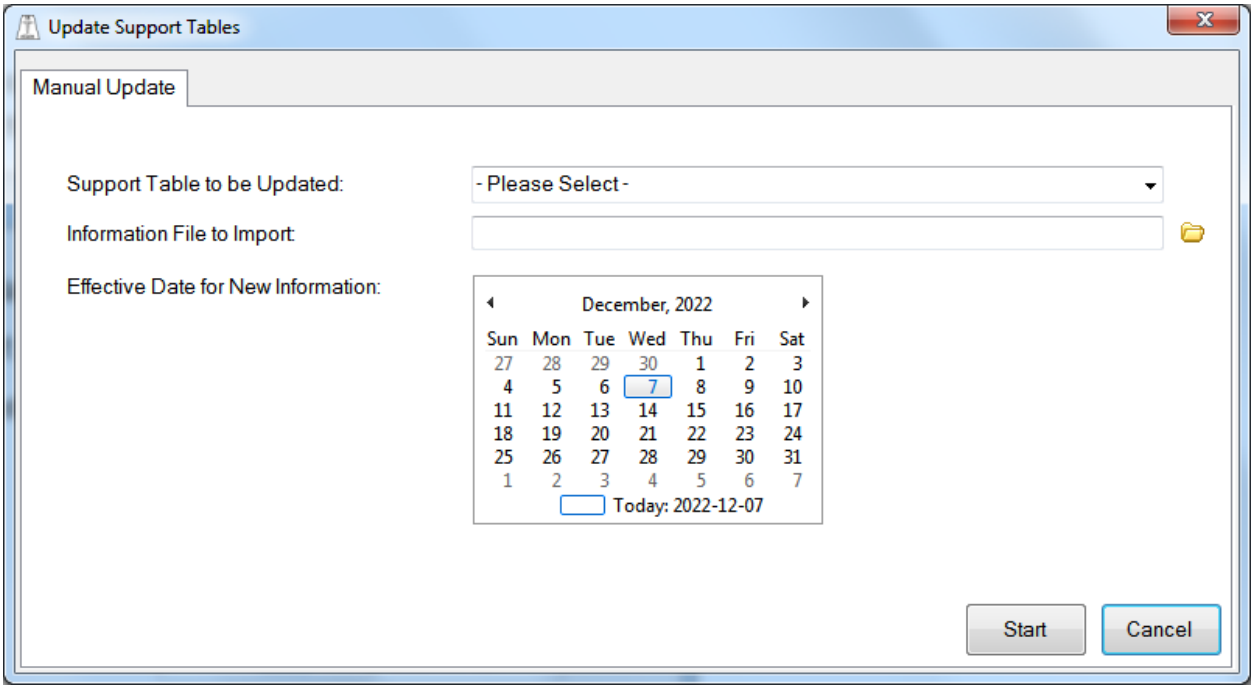


The user can also select tables which will be forced to be updated even if they are shown as being at the latest version. Normally this is not required unless a table has been changed manually or the database has become corrupted, and you want to return a support table to an unmodified state.

There is no danger in forcing one or more tables to be updated, although it may take additional time to perform the update.



Alternately, the user has the option of manually updating the tables using files provided by MSB or R.S. Digital Solutions by selecting the Manual option for the appropriate table.



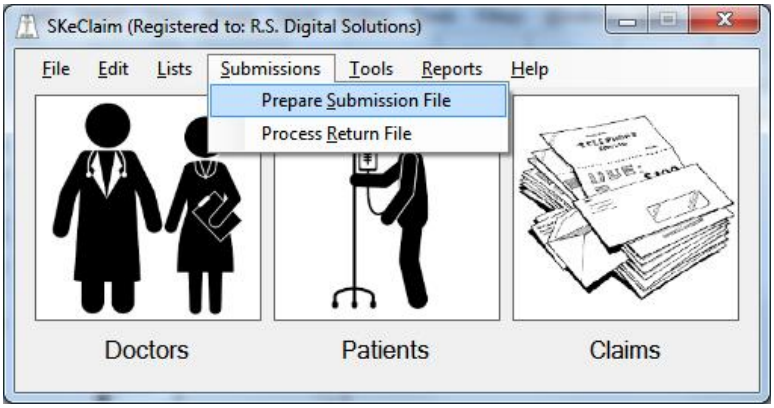
To import an update file you first select the table to be updated, and then select the file to import using the Browse button. The name and path of the selected file will be displayed in the text box. Then you set the effective date of file that you are importing, and start the update.

When a manual import is requested, the system first checks that the import file exists and can be read. It then checks to see that a backup of your existing database file has been created. If both of these conditions are met, the import proceeds, with the progress shown on a progress bar. The user is notified when the import is complete.

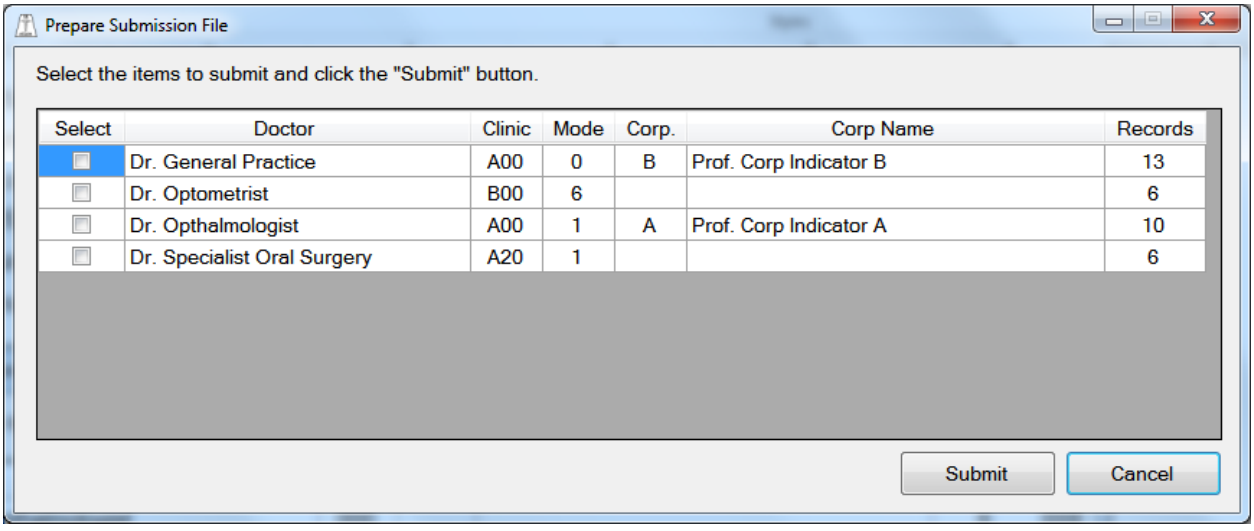
Note: Once a file has been imported the import cannot be undone. For this reason, a backup copy of the database file is created before beginning a file import. Once the import is complete and the information checked, the backup file may be deleted.

Preparing a Submission

Once you have your claim information entered, the next step is to prepare a claim submission file to send to the Medical Services Branch (MSB). The submission file preparation screen is called using the Submissions → Prepare Submission File option from the toolbar on the Main Menu.



The submission file preparation screen allows you to select the doctors to include in the submission, as well as the location and name of the output file. By default, the output file name will include your billing group number and the date and time the file was created, in the format specified by MSB. You can also select whether or not to mark the records as having been submitted. This allows you to produce temporary test files to use for test reports for review prior to the final submission. The records should be marked as having been submitted when you produce the output file that you send to MSB. Failing to do this could result in you including the same claims on a future submission.



Even though there are tools for marking claim records as not having been submitted, it is recommended that the user save a backup copy of the database prior to creating a submission file and marking the records as submitted.

The submission file must be transmitted to MSB using their specified software and process.

Processing a Return

There are two different types of return files produced by MSB when you submit a claim file. The first is returned the day following the submission, and is referred to as a "Daily Return File". The second is returned following the processing after the deadline for the bi-weekly submission, and is referred to as the "Bi-Weekly Return File". The "Daily Return File" is essentially a subset of the "Bi-Weekly Return File", and contains only the returned (rejected) records so that they can be corrected and resubmitted before the deadline for submissions. Note that that there will be no Daily Return File available from MSB if there were no claims returned for correction.

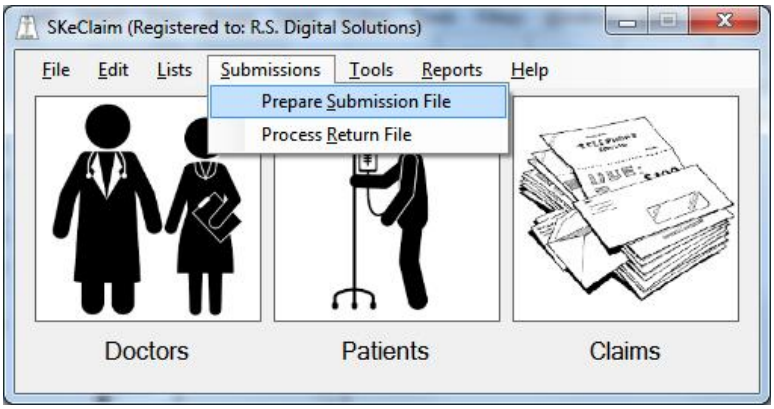
Processing a Daily Return File

Daily Return Files should **not** be processed using the Submissions → Process Return File option from the toolbar on the Main Menu. The reason is that this file only contains information about the claims that were returned (rejected) and not the claims that were paid.

The correct processing for these files is to generate a Return Report based on the return file. This will provide information regarding the claims that were rejected, including any notes provided by MSB regarding the reasons the claim was rejected and instructions regarding correction before resubmitting.

Processing a Bi-Weekly Return File

Once you have received a Bi-Weekly Return File from the Medical Services Branch (MSB), you will need to process it to remove the paid claims from the database. The claims return processing screen is called using the Submissions → Process Return File option from the toolbar on the Main Menu.

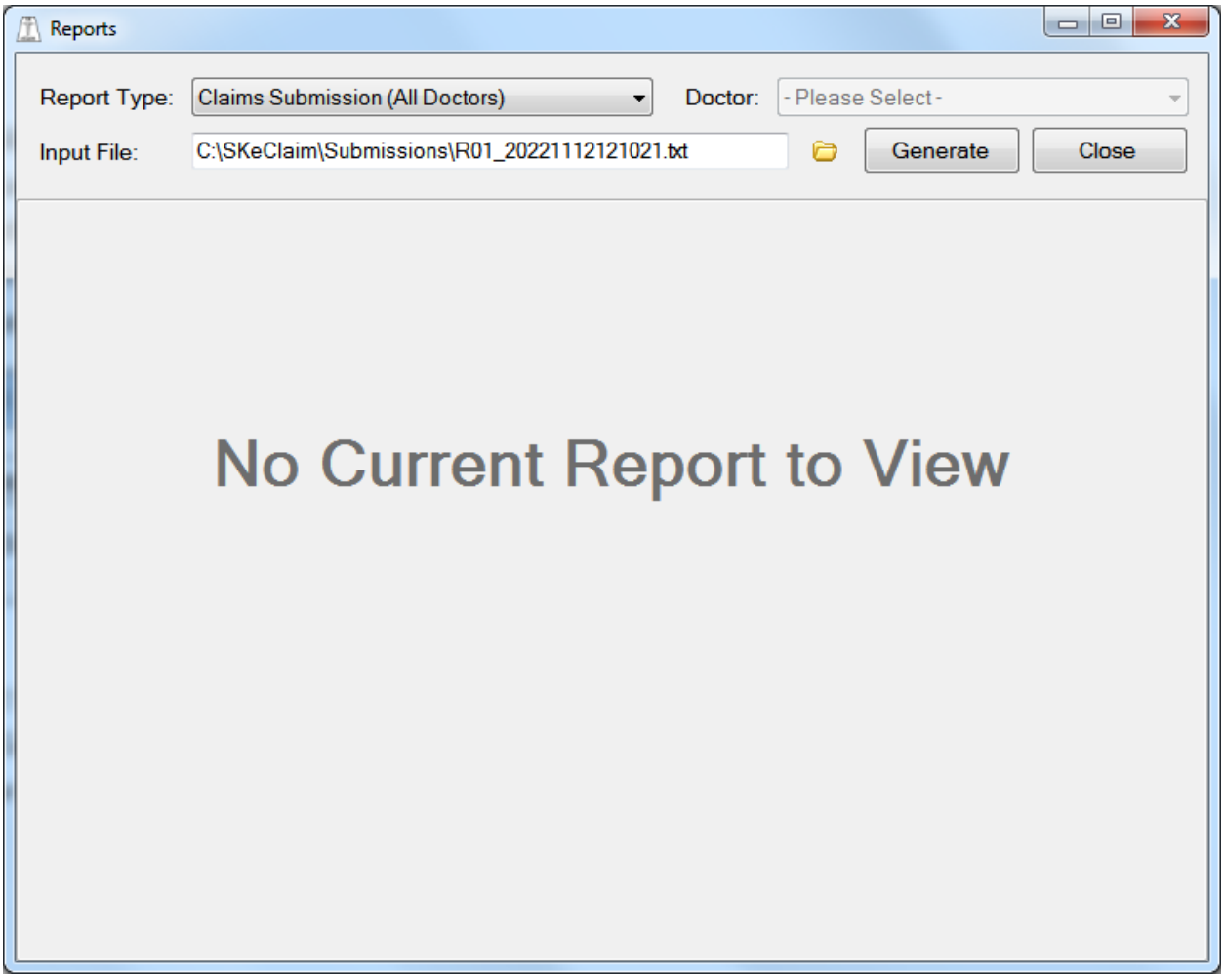


The claims return processing screen allows you to select the location and name of the return file that you received from MSB. It also provides some options about removing selected records from the database, as well as the option of keeping the temporary backup of your database file after processing.

Note that the return reports are generated directly from the claim submission return file and not from the claims information in the database. It is strongly recommended that you retain a copy of each Bi-Weekly Return File that you receive from MSB for your records.

Preparing Reports

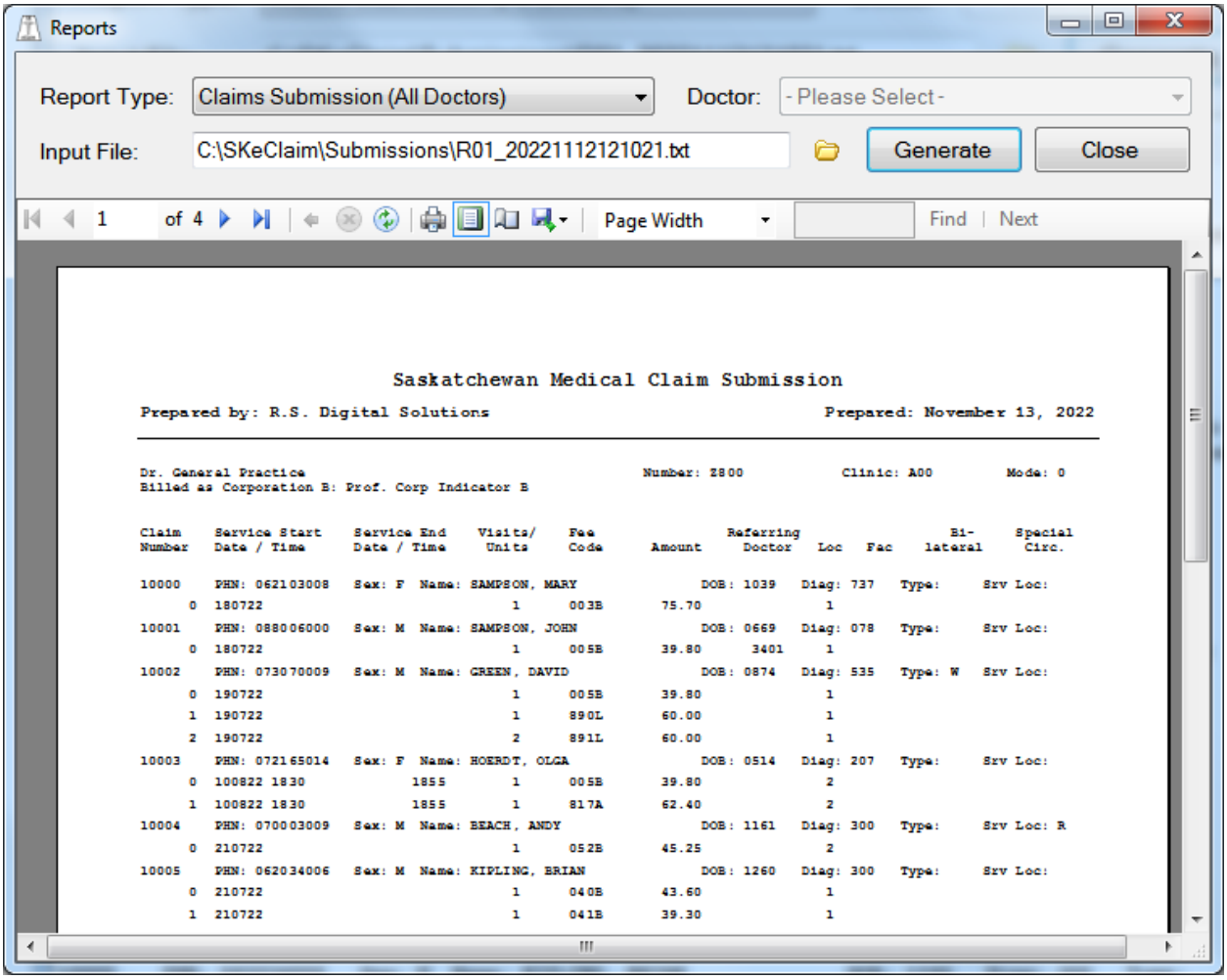
The system provides the ability to generate reports for printing or saving as Portable Document Format (PDF) files. These include claim submission reports, claim submission return reports (both Daily and Bi-Weekly Return Reports), and a diagnostic report showing a list of patients in the database that have personal health numbers (PHNs) that fail the validation tests. The report generation screen is called using the Reports option from the toolbar on the Main Menu.



You simply select the report type that you want, along with any other required parameters such as input file or doctor, and click the Generate button to create the report. Once generated, the report can be viewed on screen, printed or exported by using the options on the report toolbar.

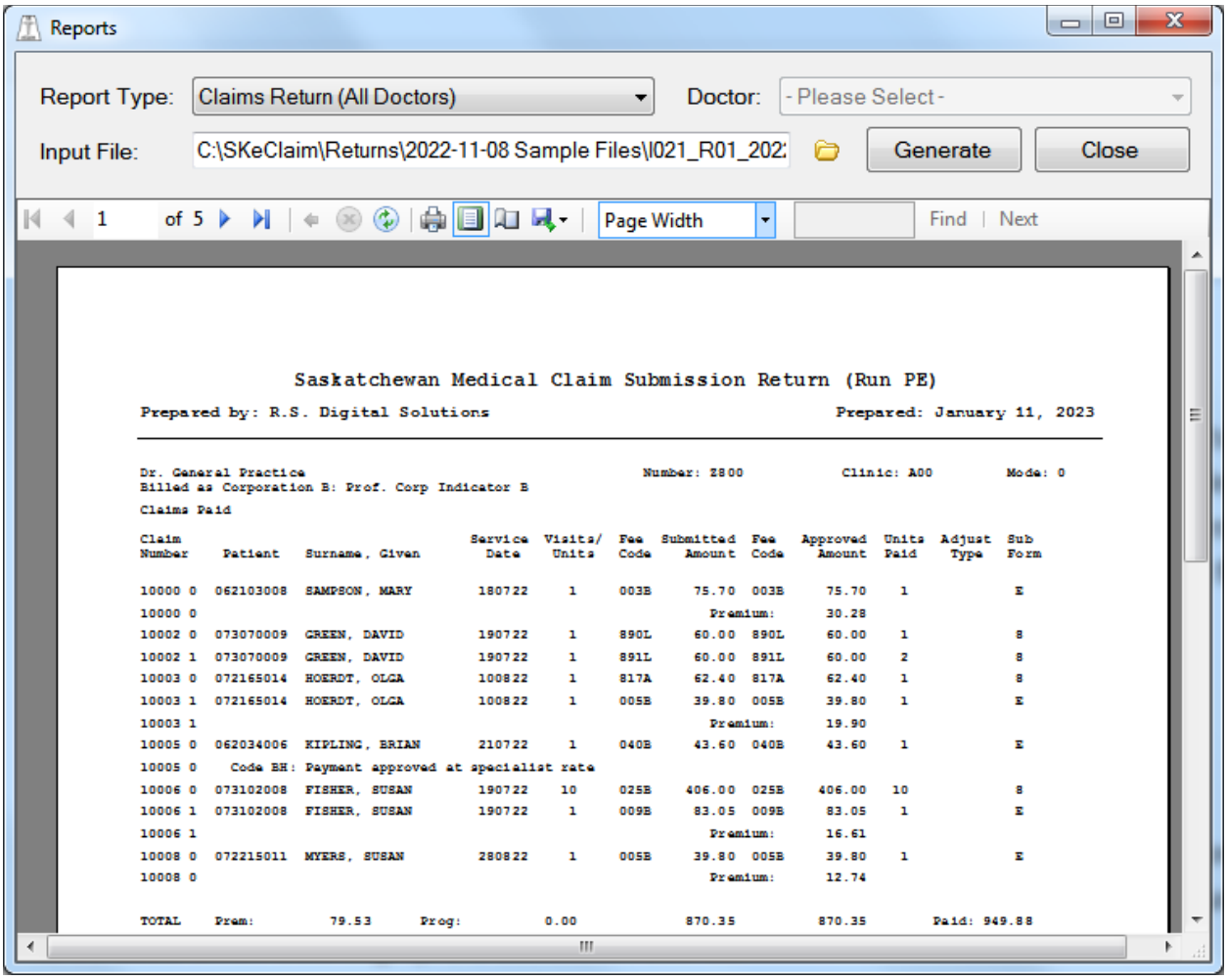
Claim Submission Reports

The claim submission report provides a printed record of the information submitted by a practitioner for payment. The report is based on the information found in the claim submission file selected. There are two types of claim submission reports. The first is a report including all practitioners that submitted claims in the selected file. The second is the same report filtered for a single practitioner.



Claim Processing Return Report

The claim processing return report provides a printed record of the processing results of a claim submission. This report is based on the information found in the claim return file selected, either a Daily Return File or a Bi-Weekly Return File. There are two types of claim processing return reports. The first is a report including all practitioners with claims that were processed in the selected file. The second is the same report filtered for a single practitioner.



Saskatchewan Medical Claim Submission Return (Run PE)

Prepared by: R.S. Digital Solutions Prepared: January 11, 2023

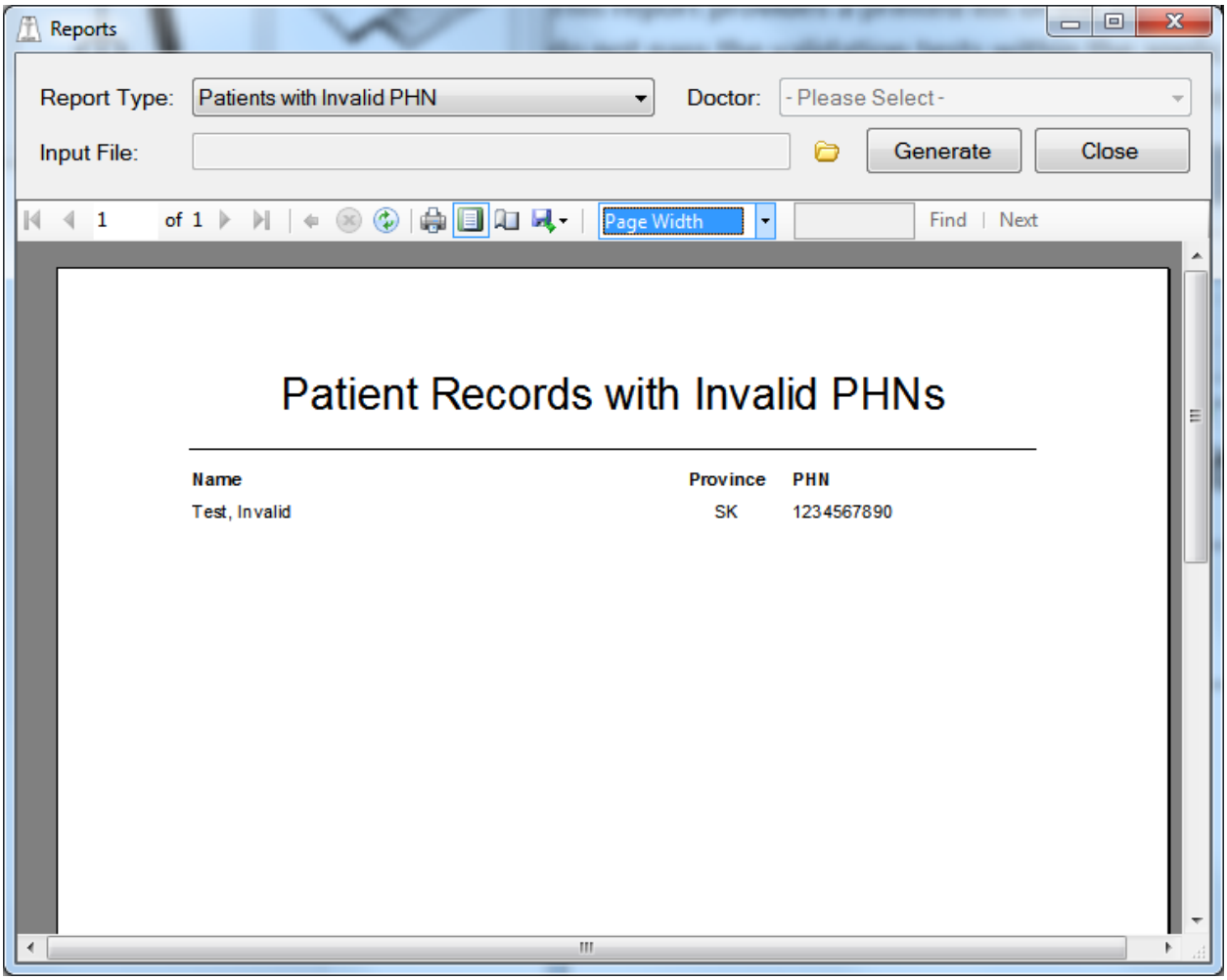
Dr. General Practice Number: Z800 Clinic: A00 Mode: 0
Billed as Corporation B: Prof. Corp Indicator B
Claims Paid

Claim Number	Patient	Surname, Given	Service Date	Visits/ Units	Fee Code	Submitted Amount	Fee Code	Approved Amount	Units Paid	Adjust Type	Sub Form
10000 0	062103008	SAMPSON, MARY	180722	1	003B	75.70	003B	75.70	1		E
10000 0						Premium:		30.28			
10002 0	073070009	GREEN, DAVID	190722	1	890L	60.00	890L	60.00	1		8
10002 1	073070009	GREEN, DAVID	190722	1	891L	60.00	891L	60.00	2		8
10003 0	072165014	HOERDT, OLGA	100822	1	817A	62.40	817A	62.40	1		8
10003 1	072165014	HOERDT, OLGA	100822	1	005B	39.80	005B	39.80	1		E
10003 1						Premium:		19.90			
10005 0	062034006	KIPLING, BRIAN	210722	1	040B	43.60	040B	43.60	1		E
10005 0	Code BH: Payment approved at specialist rate										
10006 0	073102008	FISHER, SUSAN	190722	10	025B	406.00	025B	406.00	10		8
10006 1	073102008	FISHER, SUSAN	190722	1	009B	83.05	009B	83.05	1		E
10006 1						Premium:		16.61			
10008 0	072215011	MYERS, SUSAN	280822	1	005B	39.80	005B	39.80	1		E
10008 0						Premium:		12.74			

TOTAL Prem: 79.53 Prog: 0.00 870.35 870.35 Paid: 949.88

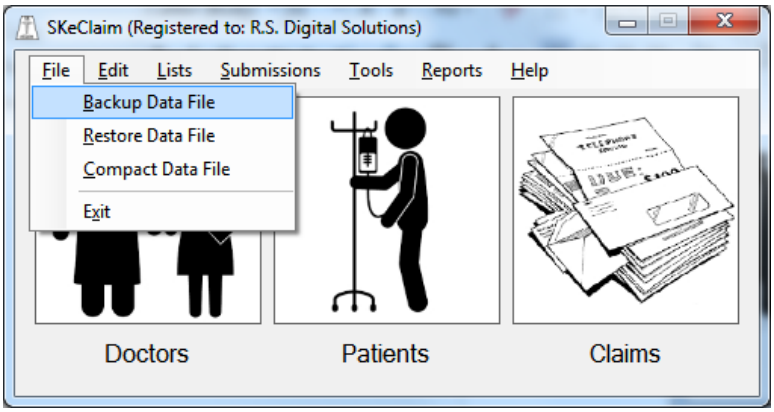
Patients with Invalid PHN Report

This report provides a printed list of the patient records in the database whose personal health numbers do not pass the validation tests within the application. This report is generally used as a diagnostic tool to be used when cleaning up the database records.



Database Tools

The database tools include the ability to back-up the database file, restore from a previous backup, and compact the file. The tools are found under the File option from the toolbar on the Main Menu.



Backup Database

When the Backup Database option is selected you are prompted for a directory and file name to save the current database file. The default is a file name with the current date and time stamp located in the default backup directory.

Restore Database

When the Restore Database option is selected, you are prompted for a database file to restore. The initial directory shown is the default backup directory. Once a file is selected, it is tested to confirm that it is the correct file version for the program. You are then asked to confirm that you want to restore this file. Note that restoring the file will overwrite the current file and any changes will be lost.

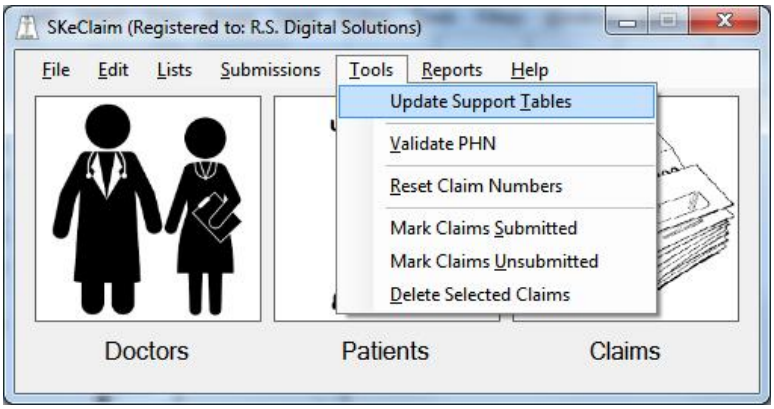
If you just want to temporarily look at a previous backup file, you can back-up your current file first. Then after restoring and viewing your previous file, you can restore the file that you just backed up.

Compact Database

As records are stored, edited and deleted, the size of the database file will continue to grow. In addition to wasting disk space, the bloated file will eventually begin to affect program performance. It is recommended that you periodically compact the database to avoid these problems. As a precaution in case something goes wrong, the system creates a temporary backup file prior to compacting the database. In the event of a problem while compacting, the temporary backup file is automatically restored.

Miscellaneous Tools

There are a variety of tools provided for managing some of the information stored in the database, including updating the support tables, validating patients' personal health numbers (PHNs), and marking and removing selected claim records. These tools are found under the Tools option from the toolbar on the Main Menu.

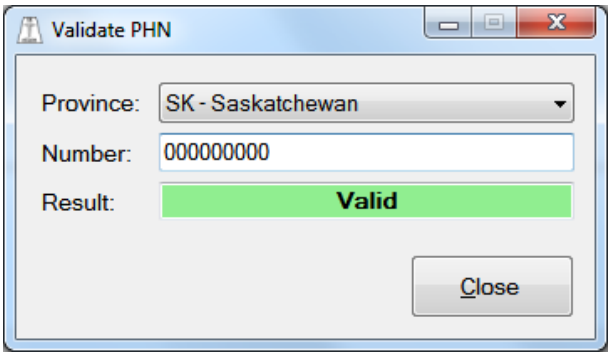


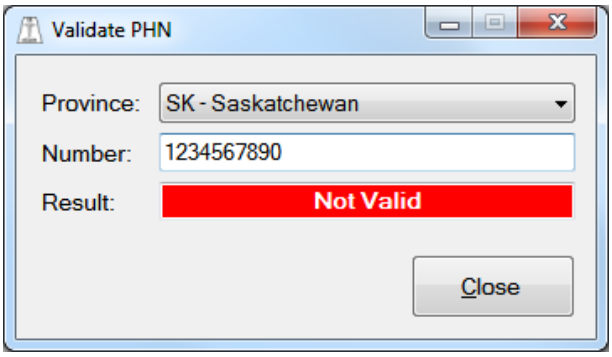
Update Support Tables

This is covered in detail in the Updating Support Tables section.

Validate PHN

This option brings up a screen for you to enter the province and PHN that you want to validate.



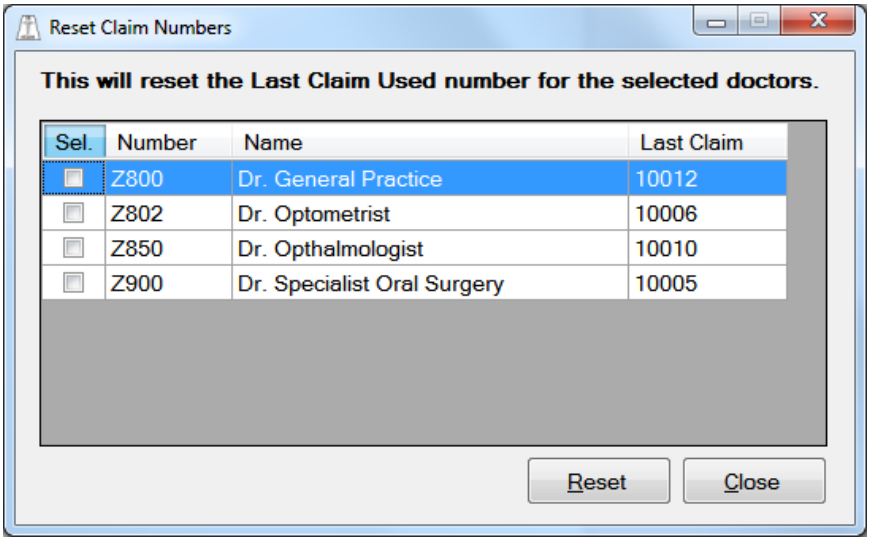


You simply select the province and enter the number to be tested. The result of the validation test will be displayed automatically.

Note that testing is performed using the best validation information available, and that the results do not guarantee that a PHN is correct for an individual patient.

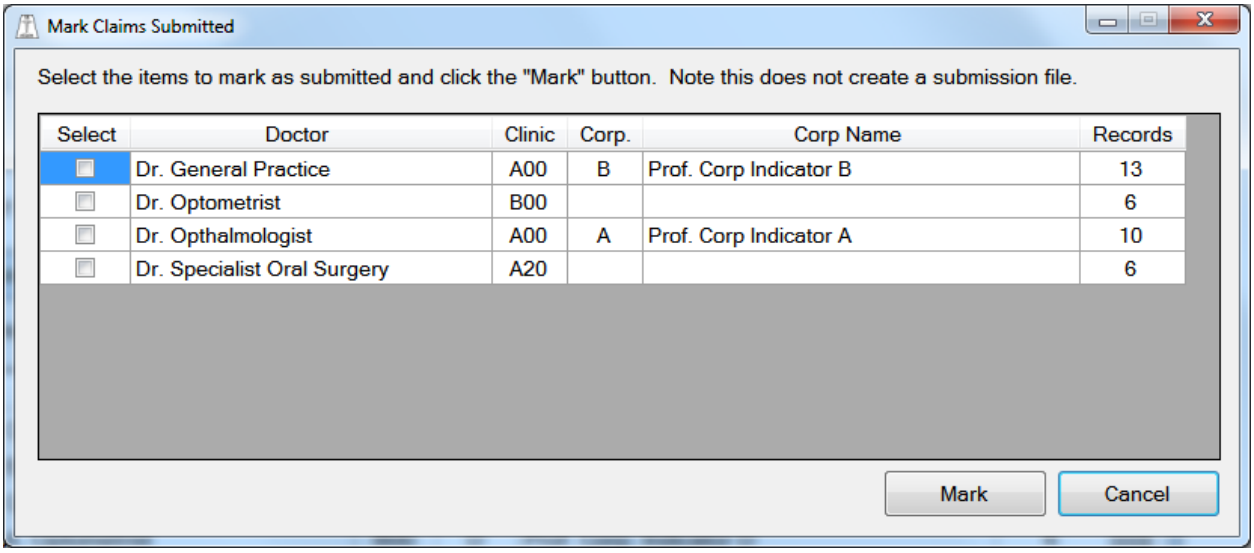
Reset Claim Numbers

The reset claim numbers tool allows you to quickly reset the numbering for all practitioners such that the next claim entered begins with the number 10000. This is typically done at the beginning of a new year to easily track the number of claims submitted for the year by a practitioner.



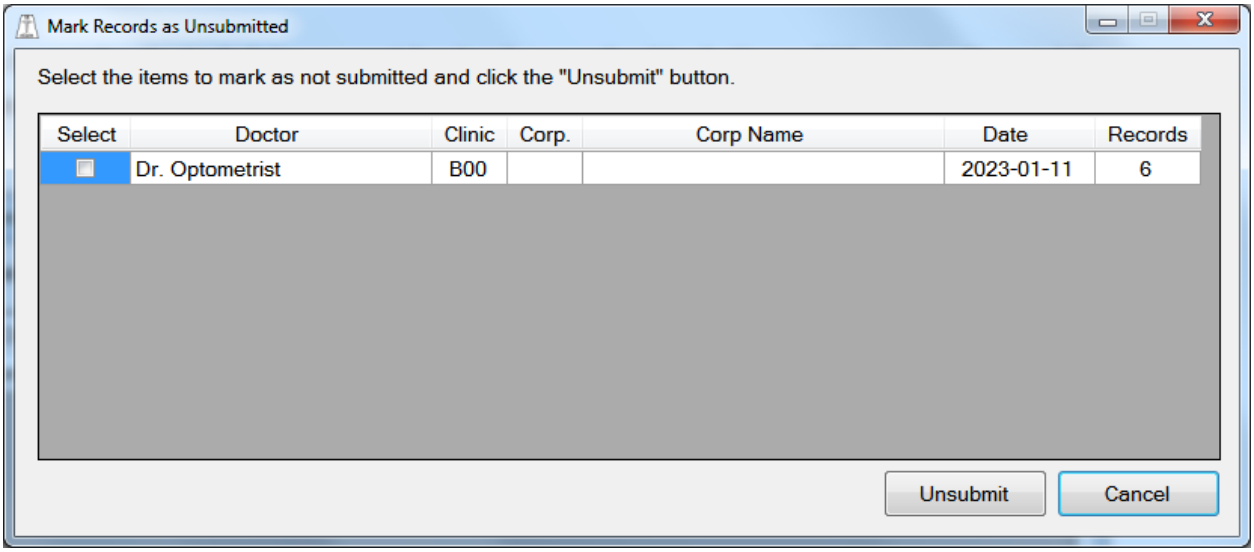
Mark Claims Submitted

This tool allows you to mark selected claims as having been submitted. It would be typically used if a submission file was created and the claims had not been marked at that time.



Mark Claims Unsubmitted

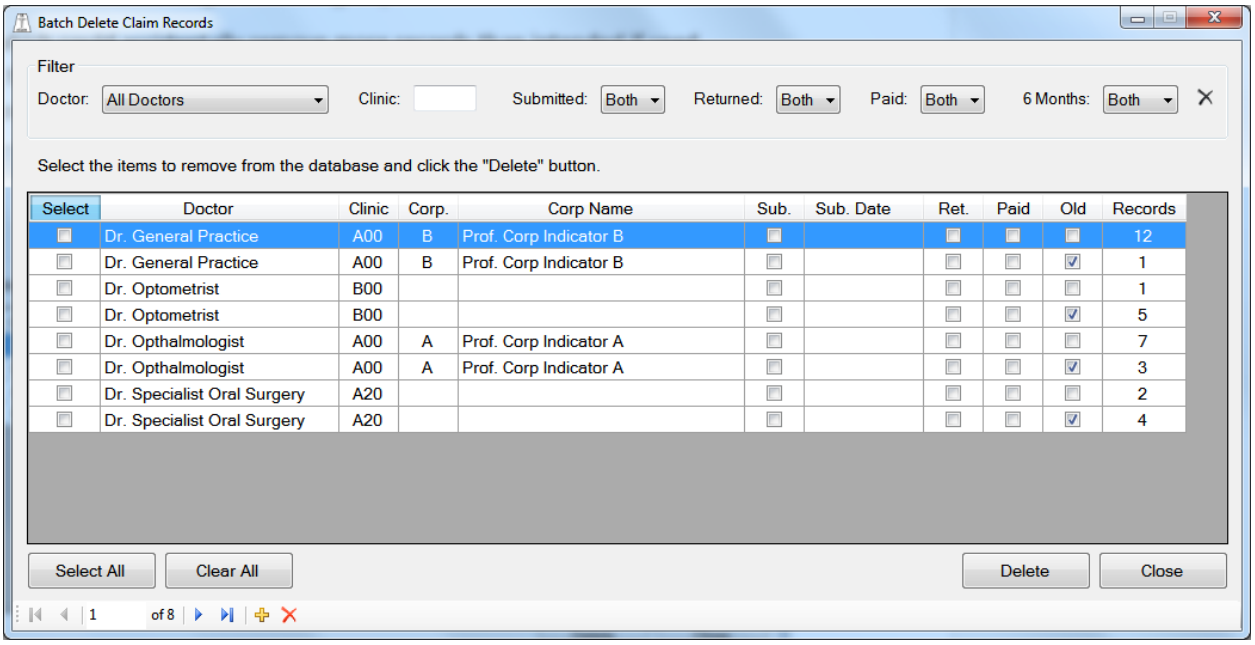
This tool allows you to mark selected claims as not having been submitted. It would be typically used if a submission file was created and subsequently misplaced or damaged such that it needed to be recreated.



Delete Selected Claims

This tool allows you to batch remove claim records from the database based on selected criteria. It would be typically used to remove claims that have been returned and paid (and hadn't been removed when processing the return file), removing unsubmitted claim records older than six months, or removing claim records for a practitioner no longer with the group.

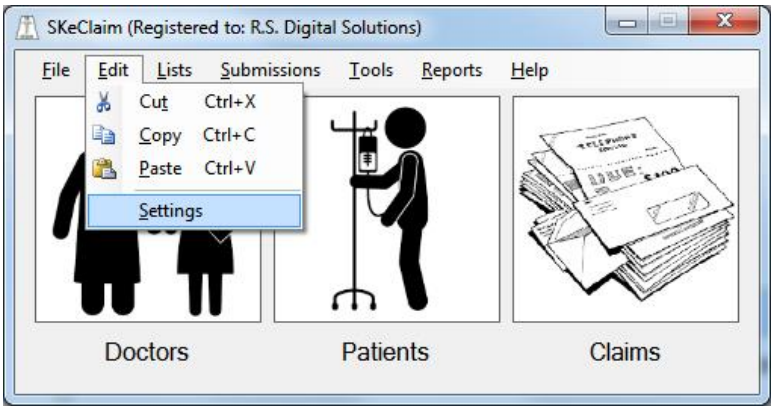
This is a very powerful tool which could accidentally remove more records than intended if used improperly. For this reason, the program will automatically create a backup of the database file before processing the selected removal request.



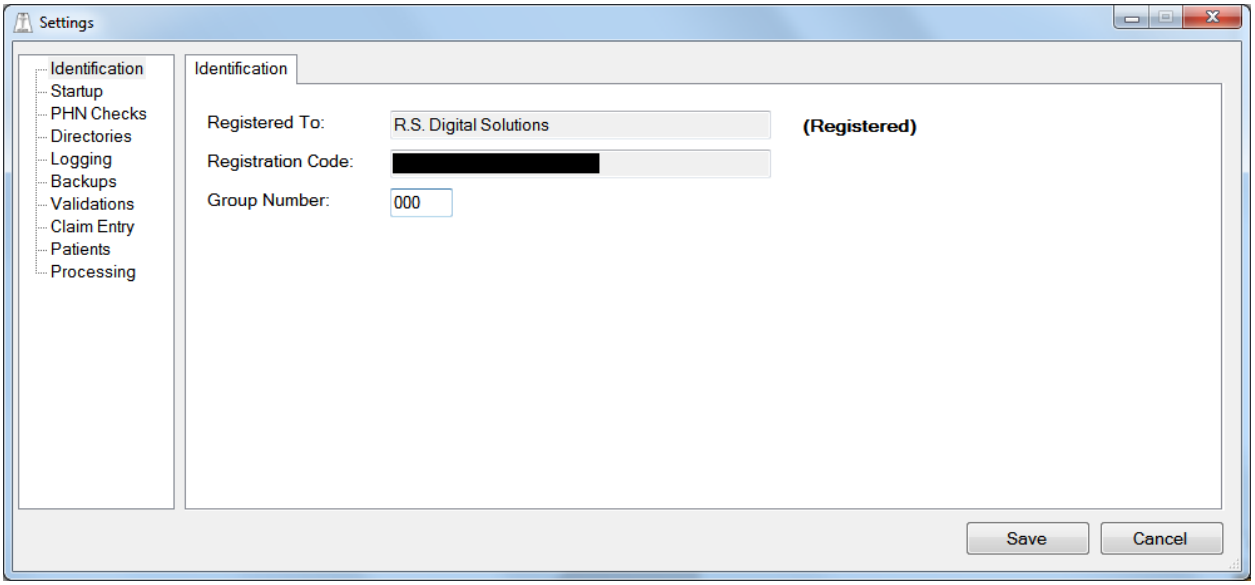
Select	Doctor	Clinic	Corp.	Corp Name	Sub.	Sub. Date	Ret.	Paid	Old	Records
☐	Dr. General Practice	A00	B	Prof. Corp Indicator B	☐		☐	☐	☐	12
☐	Dr. General Practice	A00	B	Prof. Corp Indicator B	☐		☐	☐	☑	1
☐	Dr. Optometrist	B00			☐		☐	☐	☐	1
☐	Dr. Optometrist	B00			☐		☐	☐	☑	5
☐	Dr. Opthalmologist	A00	A	Prof. Corp Indicator A	☐		☐	☐	☐	7
☐	Dr. Opthalmologist	A00	A	Prof. Corp Indicator A	☐		☐	☐	☑	3
☐	Dr. Specialist Oral Surgery	A20			☐		☐	☐	☐	2
☐	Dr. Specialist Oral Surgery	A20			☐		☐	☐	☑	4

Settings

The settings screen allows you to define some defaults to be used when using SKeClaim. This screen is called using the Edit → Settings option from the toolbar on the Main Menu.



Identification

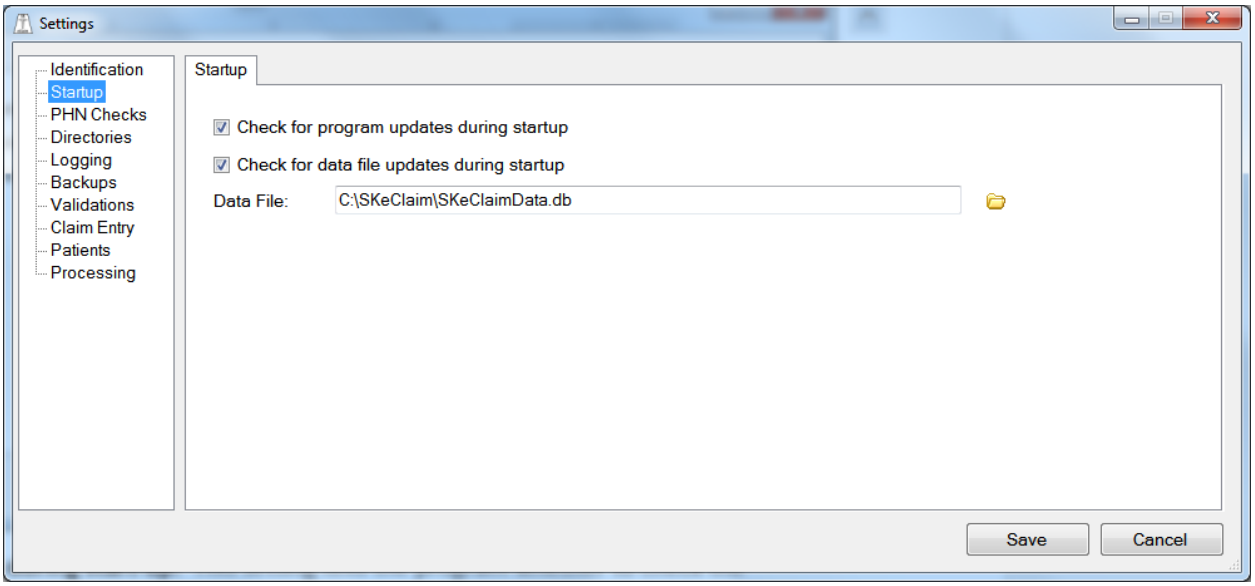


Registered To: This is the name entered on the Registration Screen when registering the software.

Registration Code: This is the code entered on the Registration Screen when registering the software.

Group Number: This is the group number that is used for submitting claims for payment. The number is assigned by the Medical Services Branch (MSB) of the Saskatchewan Ministry of Health.

Start-up

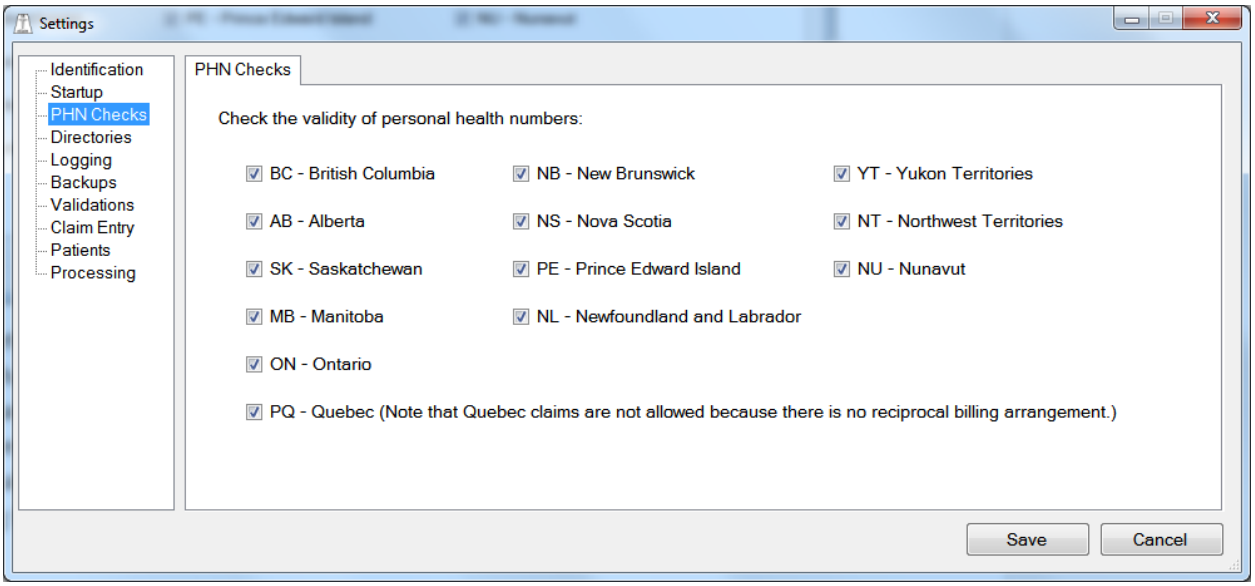


Check for program updates during start-up: This setting tells the program whether to check the SKeClaim support site on the Internet for a newer version of the program. If a newer version is found, you are given the option of downloading and installing it.

Check for data file updates during start-up: This setting tells the program whether to check the SKeClaim support site on the Internet for a newer version of the support tables. If a newer version is found, you are given the option of downloading and installing it.

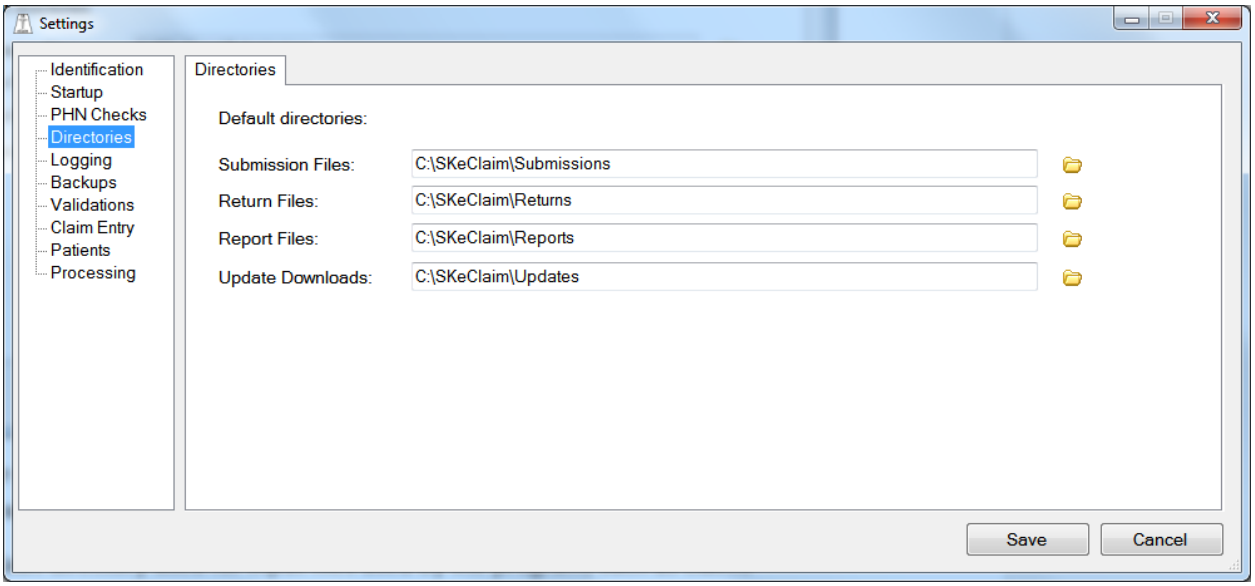
Data File: This is the name of the data file currently used by the program. This can be changed to use a different data file, such as a previous backup version of the file or a file in a different directory.

PHN Checks



PHN Checks: This setting determines which provinces will have their personal health numbers (PHNs) checked for validity. Note that testing is performed using the best validation information available, and that the results do not guarantee that a PHN is correct for an individual patient. Although unlikely, there could be some "false positives" or "false negatives". All Saskatchewan PHNs are checked thoroughly to ensure that the number is valid. In some cases the program will perform checking regardless of the settings, such as when using the PHN Checker tool.

Directories



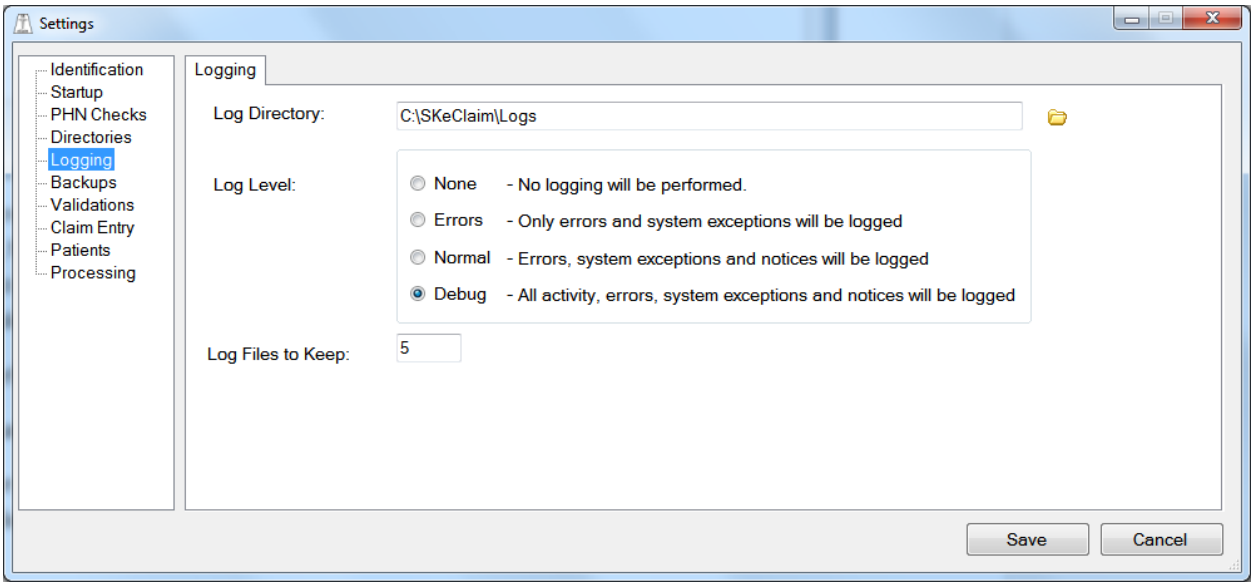
Submission Files: This is the default directory used for output files produced by the program, such as claim submission files. You will be allowed to change the location used for each output file produced.

Return Files: This is the default directory used for input files used by the program, such as claims submission return files. You will be allowed to change the location used for each input file used.

Report Files: This is the default directory used for report files produced by the program, such as claims submission or return reports. You will be allowed to change the location used for each report file produced.

Update Downloads: This is the default directory used for program and support table updates downloaded from the Internet. Once the updates have been applied, the files can be deleted.

Logging



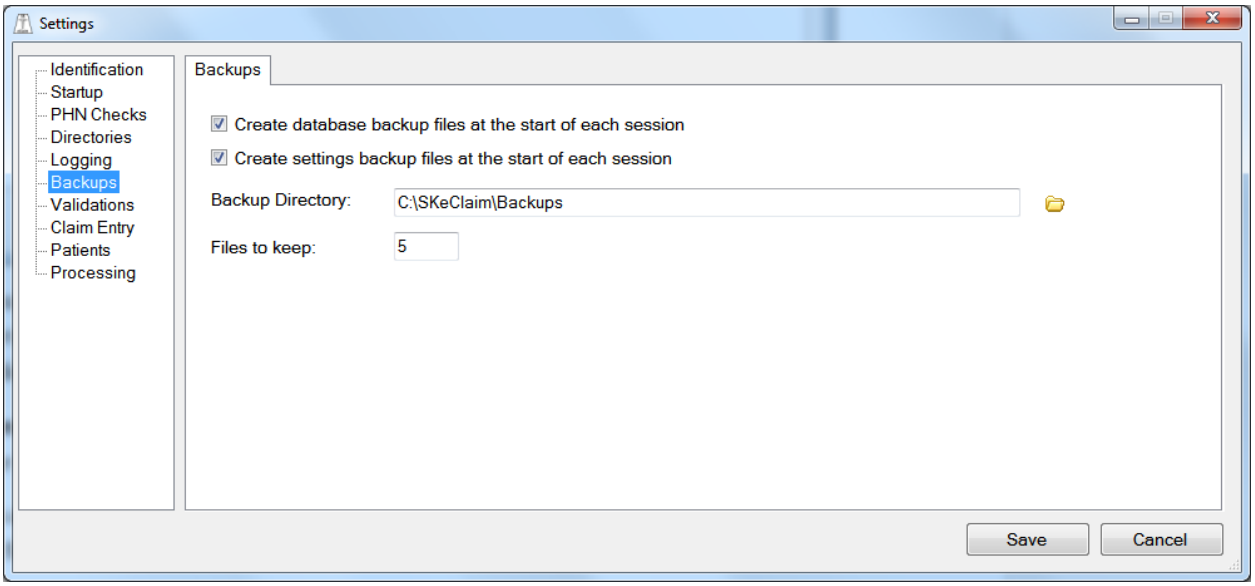
If enabled, the system will create a log file during each session. The amount of information collected can be selected by the user, from no log file at all to extremely detailed debugging information. Typically this would be set to Errors or Normal. Information stored in the log file can be extremely helpful when reporting problems to R.S. Digital Solutions. The log files are stored as simple text files.

Log Directory: This is the default directory used for session log files produced by the program.

Log Level: This defines the amount of information stored in the session log files.

Log Files to Keep: This is the maximum number of session log files to keep. When the program closes, it will remove the oldest log files to leave only the selected number of files.

Backups



If enabled, the system will automatically create backup copies of the database and settings files at the start of each session. The program uses the settings file named SKeClaim.ini which can be found in the C:\ProgramData\SKeClaim directory. The settings file is stored as a simple text file.

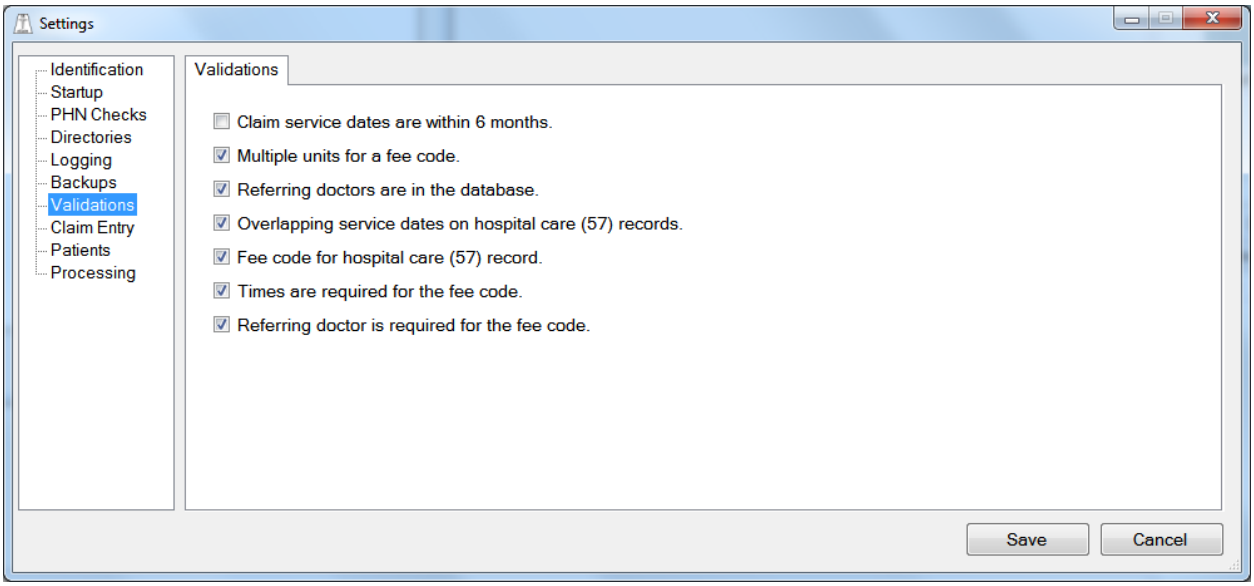
Create database backup files at the start of each session: This setting determines whether or not a backup copy of the database file will be created each time the program is started.

Create settings backup files at the start of each session: This setting determines whether or not a backup copy of the settings file will be created each time the program is started.

Backup Directory: This is the default directory used for backup files produced by the program, such as copies of the current data file.

Files to Keep: This is the maximum number of automatic database and settings backup files to keep. When the program closes, it will remove the oldest files to leave only the selected number of backup files. Backup files created by the user will not be automatically deleted.

Validations



When storing claim records, the program will perform a number of validation checks prior to saving the record to the database. Some of the validation testing cannot be disabled (e.g.: fee codes), while other tests can be optionally disabled. Normally all validations should be enabled; however, there may be some situations where it is necessary to by-pass a check.

Claim service dates are within 6 months: Normally MSB requires that claims must be submitted within 6 months of the service date. This check would possibly be disabled to allow for the re-submission of a claim that had been returned. When disabled, the check will still be performed but will be reported as a warning rather than an error, and the claim will be allowed to be saved.

Multiple units for a fee code: The fee schedule indicates whether the number of units for a fee code is limited to one, or whether multiple units are allowed. This allows the user to by-pass that check. When disabled, the check will still be performed but will be reported as a warning rather than an error, and the claim will be allowed to be saved.

Referring doctors are in the database: Normally the program will check that a referring doctor appears in the list provided by MSB. This check would possibly be disabled to allow for the entry of a new doctor that began practicing since the last referring doctors list was issued, although the preferred method would be to manually add the new doctor to the Referring Doctors support table. When disabled, the check will still be performed but will be reported as a warning rather than an error, and the claim will be allowed to be saved.

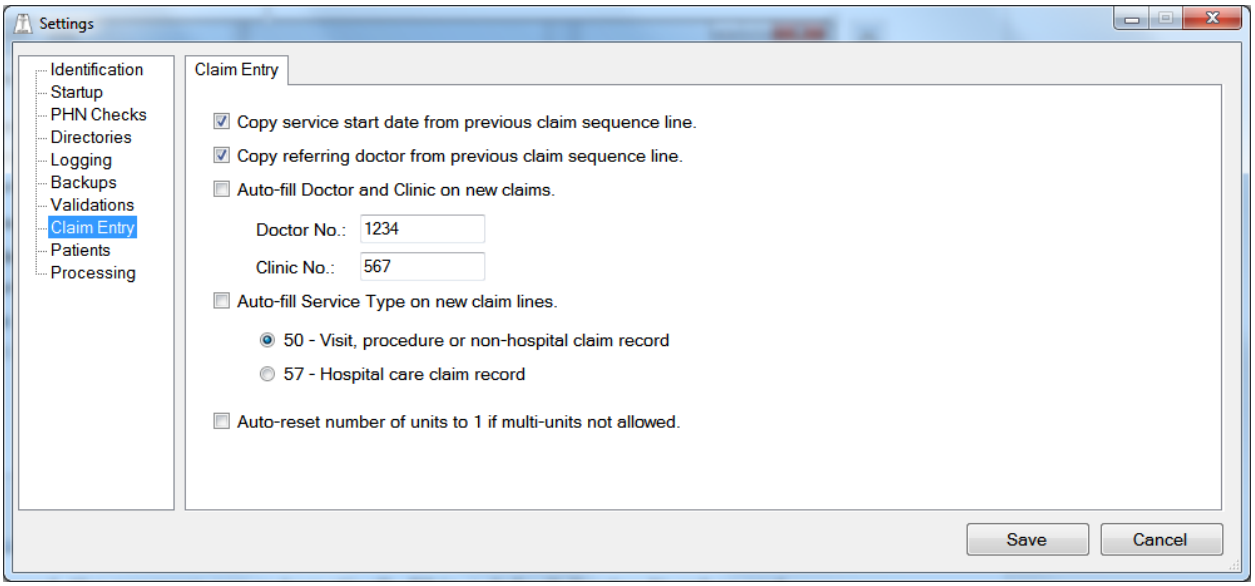
Overlapping service dates on hospital care (57) records: Hospital care records are not allowed to have overlapping dates on the same claim record. This check would possibly be disabled to accommodate a change in the requirement by MSB that has not yet been updated in the program. When disabled, the check will still be performed but will be reported as a warning rather than an error, and the claim will be allowed to be saved.

Fee code for hospital care (57) record: Only specified fee codes are allowed on hospital care (57) records. This check would possibly be disabled to accommodate a change in the requirement by MSB that has not yet been updated in the program. The "Allowed on 57 Record" setting for the individual fee codes can also be modified in the Fee Codes support table. When disabled, the check will still be performed but will be reported as a warning rather than an error, and the claim will be allowed to be saved.

Times are required for the fee code: Some fee codes are time-based and require start and end times to be entered. This check would possibly be disabled to accommodate a change in the requirement that has not yet been updated in the program. The "Requires Start Time" and "Requires End Time" settings for the individual fee codes can also be modified in the Fee Codes support table. When disabled, the check will still be performed but will be reported as a warning rather than an error, and the claim will be allowed to be saved.

Referring doctor is required for the fee code: Fees for some procedures require that the procedure be referred. In those cases, a referring doctor must be shown on the claim line. The "Requires a Referring Doctor" setting for the individual fee codes can also be modified in the Fee Codes support table. When disabled, the check will still be performed but will be reported as a warning rather than an error, and the claim will be allowed to be saved.

Claim Entry



When adding a new claim record, the program can automatically fill in a default Doctor Number and Clinic Number. When adding claim record sequence lines, the program can automatically fill in a default Service Type and some information based on the previous sequence line. The specific items that can be automatically filled in can be disabled individually.

If enabled, the specified default Service Type code will be automatically entered on a claim sequence line if the service type field is blank and a service start date is entered. If the service type field is already filled in, it will not be changed automatically.

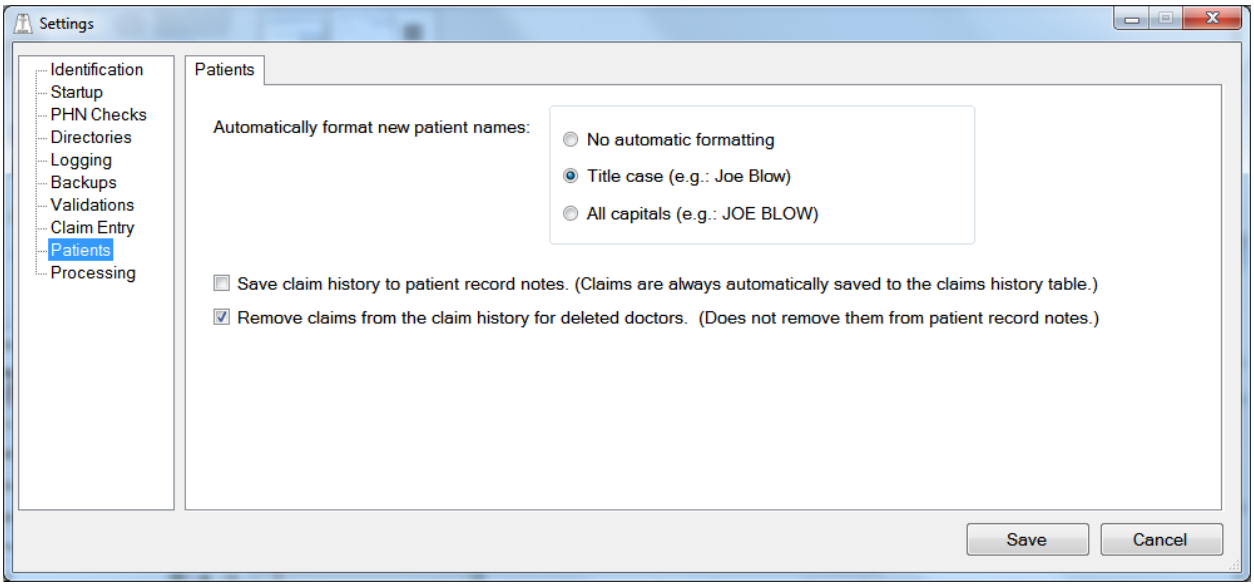
The items that can be automatically copied from the previous sequence line are:

- Service start date
- Referring doctor number

Note that the information will not be automatically carried forward from previous claim records.

If enabled, the system will also automatically reset the number of units to 1 if multiple units are not allowed for that fee code.

Patients

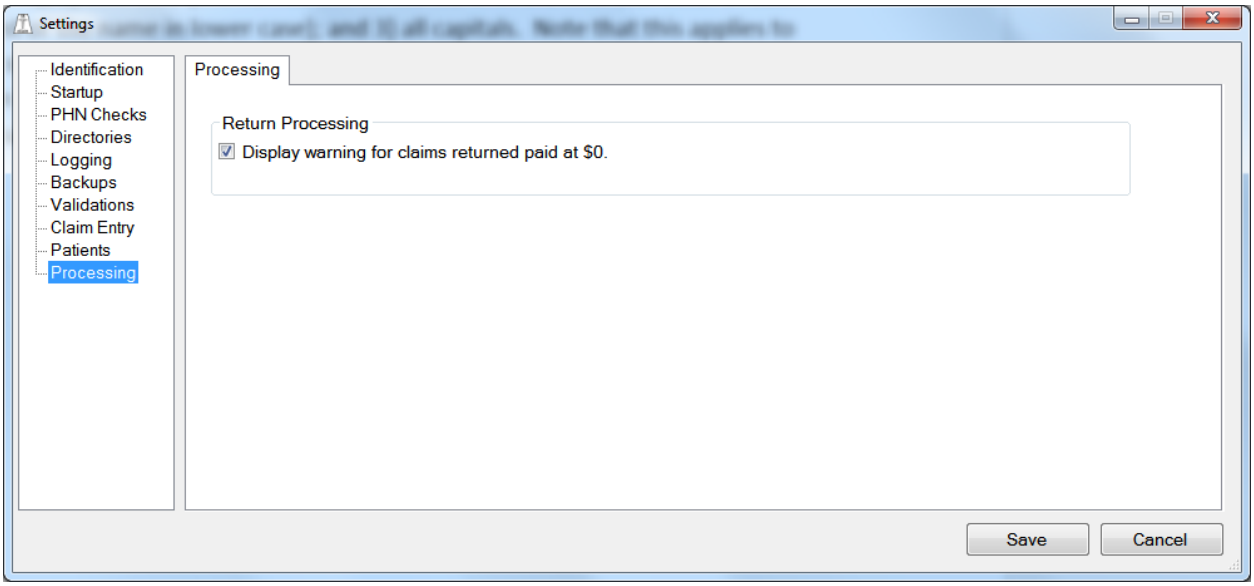


Automatically format new patient names: This setting determines whether or not new patients added to the database will have their names automatically formatted. The options are: 1) no formatting (the name will be stored as entered); 2) title case (the names will be stored with the first character of each name capitalized and the rest of the name in lower case); and 3) all capitals. Note that this applies to the way that the names are stored in the database and displayed in the program only. The names will be written to the submission files in all upper case as required by the MSB data submission specifications, and will appear in all upper case in the submission and return reports.

Save claim history to patient record notes: This setting determines whether or not the program will save a copy of the service information to the notes on a patient record whenever a claim is saved. By default this is disabled because it could result in a huge database file if there are a lot of services performed and inactive patients are not purged from the database. In general, it is expected that the practitioner would maintain patient records separately. Note that the claim information will automatically be saved to the claim history table regardless of the state of this setting.

Remove claims from the claims history for deleted doctors: This setting determines whether or not the system will automatically remove any claims history records for a doctor that has been deleted from the system. Note that this will not remove the information from the notes field on the patient record.

Processing



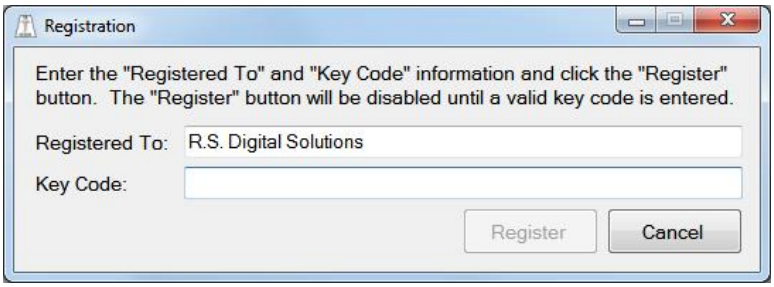
Display warning for claims returned paid at $0: On occasion claims are processed as paid with the paid amount of $0. In some cases the claim needs to be revised and resubmitted before it will be paid. Since the return file shows them as paid, the normal processing in SKeClaim is to mark the claim record as paid and close or delete the record depending on the user's settings. This check displays a warning popup if $0 paid claim items are found when preparing return reports or processing a return file. When disabled, the check will not be performed and no warning will be displayed.

Other Items

The following are some additional topics with respect to using the SKeClaim program.

Registering the Program

In order to create claim submission files and process claim submission return files, the program must be registered. This registration screen is called using the Help → Register option from the toolbar on the Main Menu.



The registration and payment form is included in the SKeClaim installation package. Once this has been processed, you will be sent the "Registered To" and "Key Code" information to unlock the program and enable you to process claim submission and return files.

The "Registered To" name appears in the header of all claim submission and return reports.

You can also register SKeClaim from the website at https://skeclaim.rsds.ca/register.

When Things Go Wrong

In spite of all the planning, testing and best efforts, occasionally something gets missed and things go wrong. The first line of defense is to back up your data files regularly. At least this will allow you to recover your data to a point in time.

Most error messages generated by the program will give you some idea of the cause of the problem. In many cases simply trying the task again will correct it. In cases where a problem is recurring and cannot be resolved using the information in the error message, please send an email to support@rsds.ca including as much information about the problem as possible, including the task being attempted, screen prints of the error messages, and a copy of the log file if one has been generated. We will review the problem and may contact you for additional information to ensure a proper solution.

Appendix 1: License Agreement

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7. CHANGES

The specifications of this PROGRAM and the terms and conditions of its registration are subject to change at any time upon the sole and exclusive discretion of the LICENSOR without prior or future notification to the USER.

8. AMBIGUITY

As partial consideration for this agreement and use of the PROGRAM, the USER hereby agrees that any ambiguity contained in the agreement shall be construed most favorably to the LICENSOR.

9. SEVERABILITY

Should any term of this EULA be declared void or unenforceable by any court of competent jurisdiction, such declaration shall have no effect on the remaining terms hereof.

10. NON-ENFORCEMENT

The failure of either party to enforce any rights granted hereunder or to take action against the other party in the event of any breach hereunder shall not be deemed a waiver by that party as to the subsequent enforcement of rights or subsequent actions in the event of future breaches.

Last Updated: 2023-01-11

Appendix 2: Provincial PHN Formats

The format of personal health numbers vary by the province. The formats are:

AB: 9 digit number.

BC: 10 digit number.

MB: 9 digit number.

NB: 9 digit number.

NL: 12 digit number.

NS: 10 digit number.

NT: One of “D”, “H”, “M”, “N” or “T” followed by 7 digit number.

NU: 9 digit number beginning with “1”.

ON: 10 digit number.

PE: 8 digit number.

PQ: 4 characters followed by 8 digit number.

SK: 9 digit number.

YT: 9 digit number.

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