User Manual

1. **Login**

To login to our software, visit: https://billing.statgo.ca/

Enter your login credentials and click "Sign in"

Note: You should have received your login credentials in an email from our support team when you initially registered with StatGo. A temporary password is provided in the email, which we strongly urge you to change upon your first login.
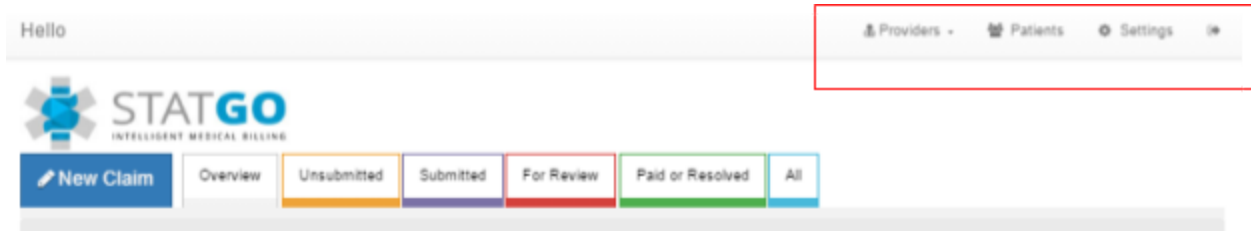
If you forgot your password, that's ok, just click on the "Forgot password?" link in the left-hand corner of the screen.
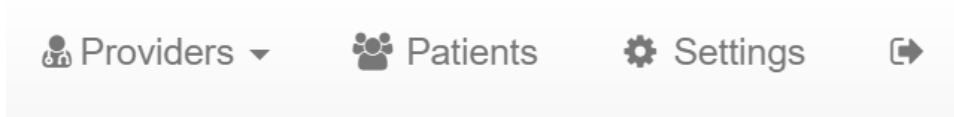
| user-test@statgo.ca |
| ●●●●●●●● |

Forgot password?   Sign in

2. Menu Bar

Located in the top right of your screen.


Enlarged Menu Bar:

Providers
This section lists all the providers registered with StatGo and allows you to view their provider profile and make edits to it. Currently physicians who work at more than one hospital frequently set up a provider for each location to allow for easier billing entry. We would be happy to help you set these up.

Patients
This section lists all the patients for which you have previously submitted a claim. Search through your patient list by claim date (or date range), name or PHN. Access patient profile to view patient information and make any necessary changes.
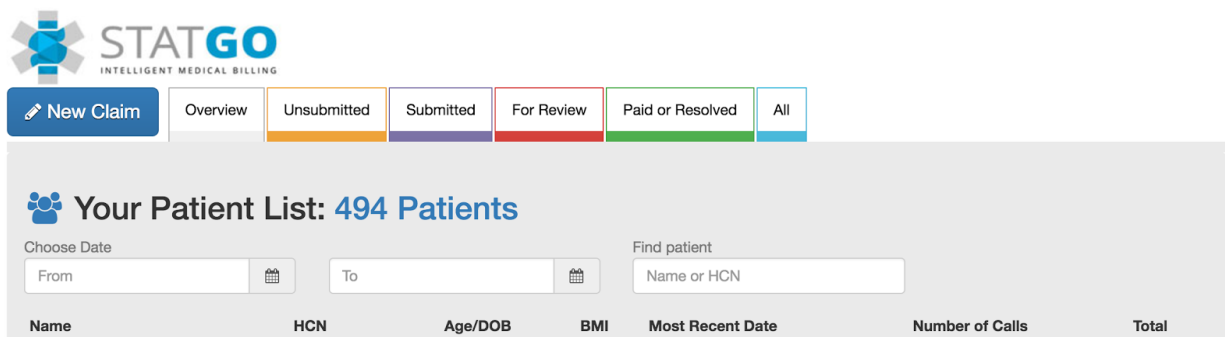
Settings
Allows you to access your profile, make changes and reset/change your password.

Logout
Securely end your session by exiting the software.

3. New Claim - Patient and Location information

Step 1:
Date/Time: Enter the service date, start and end time of the encounter.

Step 2:

Billing Type (choose this before entering patient info): Select type of billing, options available are: Province, Territory, WCB, Good Faith or Other.

Step 3:

Patient information - by default the patient information you need to enter in order to have a claim generated and paid will be displayed.

> For example: For an Alberta patient you need Name and PHN. But for an out of province patient you require - Name, PHN, Address, DOB, Gender.
> Additional information can alway be entered by expanding the patient details section:

▼ Patient Details

When you expand patient details you will see the following screen:

Step 4:

Turn on/off BMI modifier for this patient. Turning this on will automatically modify the codes you enter with the appropriate BMI modifier.

New Claim - Location and Facility information:

Step 1 - Confirm Facility/Location:
Confirm your service location (example Chinook Regional Hospital) and your functional centre (example SURG for surgical patients). SURG can generally be used for most anesthesia billings except the following:

1) ICU visits 03.05a must specify **ICU** as a functional centre
2) Non hospital surgical facilities - eye clinic/dental clinic - must use **SGSU**

The Facility and Centre here will be populated with your default settings if you are working at a different facility you may change it here.

Step 2: Enter referring practitioner
You may search from the list or enter the PRACID if you know it. If you cannot find the referring practitioner on the list you can just enter the name.

Step 3: Confirm Encounter Number

"Encounters" are defined by AHS in the SOMB General rule 1.14.

"To be recorded as separate encounters, multiple services provided to a patient may not be initiated by the physician, or may not be a continuation of a service which began earlier in the day. An example of continuation of services is the time spent with a patient to review x-ray or laboratory results ordered during an examination of the patient earlier in the day. If the patient initiates the second and subsequent encounter(s) or the physician is requested to attend the patient by hospital or nursing home staff, additional encounters may be claimed."

If you are seeing a patient for a second or additional encounter in the same day you will need to change this number to Encounter 2 or 3 or 4 etc as appropriate.

Step 4: Enter admission date if billing code 03.03D
Admission date is required for code 03.03D, otherwise can be left blank.

Advanced Tab:
Provides additional options for newborns etc.

4. Health Service Code (HSC) Entry

1. Enter a New Health Service Code

New health service code are entered into the "Add a new Code" field:

Add a new Code

[   ] + Add

Codes can be entered either by number or looked up using description:

Add a new Code

[Appen   ] + Add

59.0 A : **Appen**dectomy {**Appen**dectomy with or without abscess}

Once Added a code appears below as part of the "Procedure Calculation" an automated "Time calculation" also appears:

Procedure Calculation:

59.0 A : Appendectomy {Appendectomy with or without abscess}

Appendectomy {Appendectomy with or without abscess}

Modifiers

[   ] +

- 1 +   ANE —

▼ Advanced

Time Calculation (autocalculated):
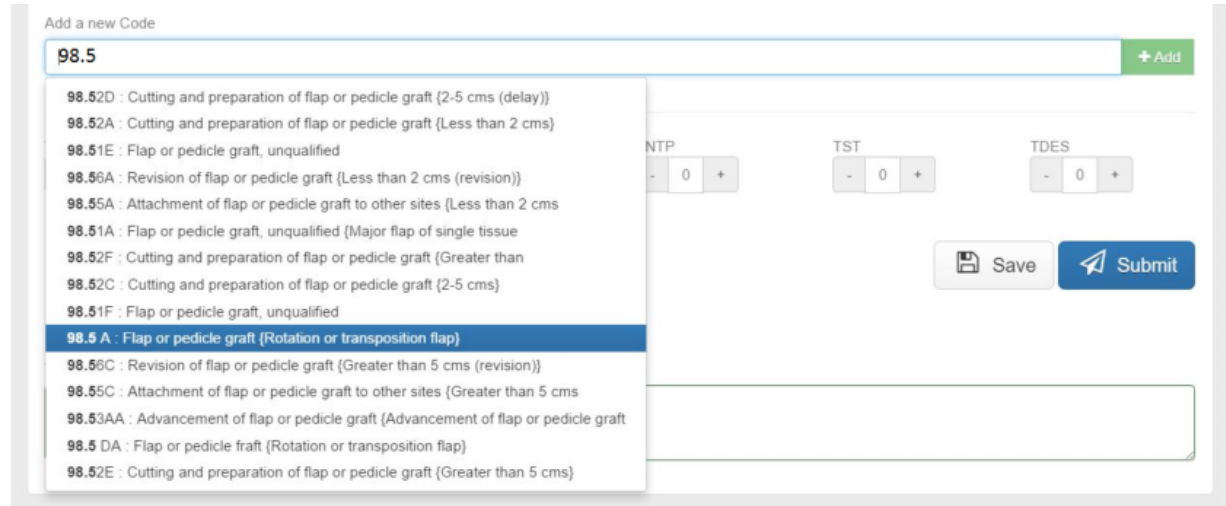
59.0 A : Appendectomy {Appendectomy with or without abscess}

Appendectomy {Appendectomy with or without abscess}

Modifiers (ANEST, ,)   3 units $54.87
Diagnoses (, ,)

Procedure and Time calculations will update as you add new codes.

NOTE: Both calculations occur simultaneously as you enter codes. When you submit or save your billing you can compare the calculations to determine which provides more lucrative reimbursement.

Time calculations are based on the "start" and "end" times you enter into the software. These times ARE NOT forwarded to AHS, they are simply used to calculate the relevant time units.
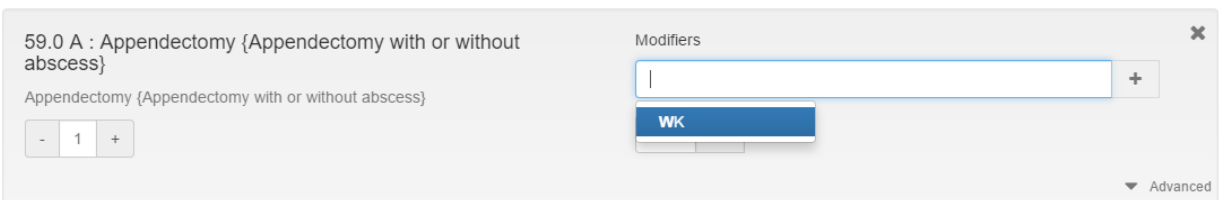
NOTE: Certain codes may be more difficult to locate because of their formatting (example 98.5 A) in this case it is best to enter the first few digits of the code and then look down the list provided, choose the option and click "+Add"

Add a new Code

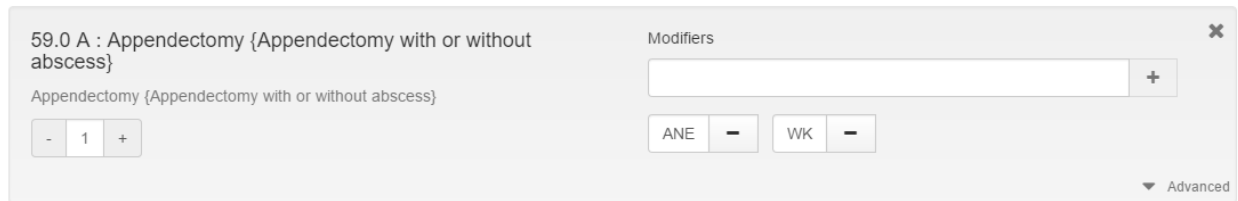98.5   **+Add**

> 98.52D : Cutting and preparation of flap or pedicle graft {2-5 cms (delay)}
> 98.52A : Cutting and preparation of flap or pedicle graft {Less than 2 cms}
> 98.51E : Flap or pedicle graft, unqualified   NTP   TST   TDES
> 98.56A : Revision of flap or pedicle graft {Less than 2 cms (revision)}   -   0   +   -   0   +   -   0   +
> 98.55A : Attachment of flap or pedicle graft to other sites {Less than 2 cms
> 98.51A : Flap or pedicle graft, unqualified {Major flap of single tissue
> 98.52F : Cutting and preparation of flap or pedicle graft {Greater than
> 98.52C : Cutting and preparation of flap or pedicle graft {2-5 cms}   💾 Save   ✈ Submit
> 98.51F : Flap or pedicle graft, unqualified
> **98.5 A : Flap or pedicle graft {Rotation or transposition flap}**
> 98.56C : Revision of flap or pedicle graft {Greater than 5 cms (revision)}
> 98.55C : Attachment of flap or pedicle graft to other sites {Greater than 5 cms
> 98.53AA : Advancement of flap or pedicle graft {Advancement of flap or pedicle graft
> 98.5 DA : Flap or pedicle fraft {Rotation or transposition flap}
> 98.52E : Cutting and preparation of flap or pedicle graft {Greater than 5 cms}

2. Add modifiers/diagnostic codes/supporting text

Type the modifier into the modifier box and click the + (plus) button to add it:

Procedure Calculation:

59.0 A : Appendectomy {Appendectomy with or without   Modifiers   ✕
abscess}

Appendectomy {Appendectomy with or without abscess}

-    1   +   +

                                                                            WK

                                                                                                            ▼ Advanced

Added modifiers appear under the modifier entry box/field they can be removed by clicking the - (minus) button.

Procedure Calculation:

Modifiers such as ANE and BMI are automatically added based on your settings. For example the BMI toggle:

Other things to consider

- Once the BMI toggle has been turned on for a specific patient, it will be saved on that patient's profile for all future claim submissions.

- Other modifiers such as surcharges: NTAM, WK etc. or CMPD must be added as needed.

- Modifiers added to the "Procedure Calculation" will be applied to the "Time Calculation" if they are applicable.

- There are a few codes that do not have an anesthetic modifier (ANE or ANEST) these codes can only be billed at the SURGICAL rate the AHCIP - Thus, it should be removed unless you intend to bill this as a proceduralist rather than anesthesiologist.

3. Entering a diagnostic code

The system will generally prompt you when diagnostic codes are required.

Needed for: Consults and Visits
Most non anesthetic codes require a diagnostic code. Most commonly this would include consult code (03.08A) and visit codes (03.03D).

Not Required: When billing for anesthetics
We would suggest you **DO NOT** enter diagnostic codes if you a billing anesthetic codes as they are not required and this may result in a rejection of your anesthetic claim if the code does not align with the surgical code.

These codes can be entered into the diagnostic codes section of the software. You can either search by name or number.

For anesthetic consultations/visits usually more general codes are accepted by Alberta Health. We have placed several of these general "**popular codes**" below the diagnostic code section - to add these simply click them.

4. Change number of calls

Edit the number of call by clicking plus and minus under the code:

03.08L : Consultation, described as comprehensive {Prolonged anesthesia

Consultation, described as comprehensive {Prolonged anesthesia

| - | 4 | + |

5. Calculator

As you enter codes the software simultaneously calculates both **the procedure** and **time fees**. Both calculations appear on screen. The procedure calculation first and then the auto calculated time fee - which is based on the time you have previously entered, as you adjust the time the fee will be recalculated.

Procedure Calculation:

57.6 A : Total colectomy {Total colectomy with or without ileostomy}
Total colectomy {Total colectomy with or without ileostomy}

Modifiers

- 1 +

ANE −

Supporting Text

Diagnostic Codes

Popular Codes: General Sympt - 780.9 (Gen Surg/Gyn/Plastics/ENT/Other) | Neurosurg/Spine - 349.8 | Orthopedics -781 | Urology 788.9 | Blood Patch 349.0

Base $652.00 * 1 call(s) => apply modifiers = $652.00 + surcharge of $0.00

▼ Advanced

65.61A : Repair of incisional hernia with graft or prosthesis {Repair of incisional
Repair of incisional hernia with graft or prosthesis {Repair of incisional

Modifiers

- 1 +

ANE −   LVP75 −

Supporting Text

Diagnostic Codes

Popular Codes: General Sympt - 780.9 (Gen Surg/Gyn/Plastics/ENT/Other) | Neurosurg/Spine - 349.8 | Orthopedics -781 | Urology 788.9 | Blood Patch 349.0

Base $324.03 * 1 call(s) => apply modifiers = $324.03 + surcharge of $0.00

▼ Advanced

Time Calculation (autocalculated):

57.6 A : Total colectomy {Total colectomy with or without ileostomy}
Total colectomy {Total colectomy with or without ileostomy}

Modifiers (2ANES, ,)   12 units $263.40
Diagnoses (, ,)

TWK	TEV	TNTA	TNTP	TST	TDES
- 0 +	- 0 +	- 0 +	- 0 +	- 0 +	- 0 +

By Procedure ☐ $976.03
By Time ☐ $263.40
Surcharge $0.00
After Hours $0.00
Estimated Total $976.03

💾 Save   ✈ Submit

The software will sum up the two amounts and select the higher amount for submission. If you wish you may manually override this by checking either to procedure of time box.

Surcharges, After Hours Time Premiums and Notes

Surcharges - If applicable surcharges (WK, NTPM, NTAM, EV) can be added to any of the codes you submit. The amount of the surcharges are displayed below the time/procedure amounts.

After hours Time Premiums - Time premiums (03.01AA) can be added simply by clicking the plus/minus buttons for the applicable premium. The dollar amount the these premiums is also displayed separately.

TWK	TEV	TNTA	TNTP	TST	TDES
- 0 +	- 4 +	- 0 +	- 0 +	- 0 +	- 0 +

Notes

There is a section for your notes or messages to StatGo billing staff at the bottom of the page. This information **WILL NOT** be submitted to Alberta Health with you claim. It is for your records/internal use only.   If you are submitting supporting text for your claim it should be placed in the 'Supporting text" box below the health service code.

6. Viewing Claim Level Information

Once a you have submitted your "encounter" each health service code is turn into a "claim" which will be sent to Alberta Health. You may view details on you claims by clicking the blue button adjacent to the billing code.

Claim level data provides details on each claim including a full transaction history. Here is where track your claims progress and see the comments from StatGo billing agents if they need to troubleshoot you claim. To see these messages 'hover' your mouse pointer over the text bubble.

You can also review all the data associated with your claims as well as view associated claims.

7. Tabs

Unsubmitted Tab

Here you will find a list of claims that you have prepared and saved. These claims will remain in this section until you resume completing them and submit them for processing.

Submitted Tab

A list of all the claims that have been generated and submitted. They will remain in this tab until they are processed by our software and sent to Alberta Health Services for processing.

For Review Tab

Here you will see a list of the claims that were submitted for processing but have not been accepted by Alberta Health Services. An explanatory code will be displayed under "Explanations" along with a note as to why the claim was refused. By clicking on claim, you will be able to return to it to review and edit/resubmit the claim.

Paid or Resolved Tab

Once your claims have been processed and paid by Alberta Health Services, they will end up in this section. You can refer to them at any point in time in the future. Claims that were not paid but have been resolved by you or our billing agents will also appear under this tab.

Resolved Claims

Choose Date

| From | 🗓 | | To | 🗓 | | Find patient | Name or HCN |

| Patient | Initial Claim | Paid | Difference | Code | Status | Explanations | Date |

All Tab

This tab displays all claims that were prepared, saved or submitted. You can retrieve any historical claims by date, patient name, patient health care number or by the claim status.

All Claims

Choose Date

| From | 🗓 | | To | 🗓 | | Find patient | Name or HCN | Status | |

Questions?

Please contact us at support@statgo.ca or by phone at
1-800-516-0818