Abacus Systems of Miami, Inc.,
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Visit our web site at
www.AbacusRx.com

MEDICARE DME POS BILLING

Our goal is to offer independent and chain customers a complete billing solution designed to accommodate the busy environment of the retail pharmacy. We believe that the best solution is one that requires the least amount of interaction between the Pharmacist/Patient and the billing service. Our solution takes the burden of complicated billing away from the pharmacy and does it at a price that will make Medicare billable products an area that will help boost a pharmacies profitability.

Submit your Medicare on-line through your pharmacy system just like any other third party!

Abacus provides a convenient and thorough method for billing Medicare DME and Part B Vaccinations claims point-of-fill through the Pharmacy Plus - Pharmacy software eliminating the need for additional costly software, double entry and training.

* Diabetic supplies
* Ostomy Supplies
* Inhalation Drugs/Supplies
* Anti-Cancer Drugs
* Immunosuppressive Drugs
* Flu/Pneumo Vaccines
* Rentals
* Enteral Formula and Equipment

Payment assignment

* Assignment accepted by pharmacy or patient and payment remitted to pharmacy, Corporate office, or patient.
* Coordination of benefits handled whether Medicare is the primary or secondary insurer. Other insurance amounts automatically reported to participating secondary insurer.

Claim edits

Our real-time edits enforce compliance to HCFA policy significantly reducing costly rejects.
Each claim is processed at the point of fill and the complete claim is captured: Edits included, but are not limited to:

* Product Coverage.
* Doctor DEA / UPIN number and demographic verification.
* Patient ID and demographic verification.
* Product NDC / HCPCS code coverage and automatic modifier determination.
* MAC price, minimum/maximum quantity verification.
* Diagnosis code to product verification.
* Coordination of Benefits, and patient/pharmacy assignment.
* Refill too soon and Min/Max Quantity determination.
* Assignment of benefits determined by pharmacy or Third party coordinator.
* Patient annual deductible verification.
* Automatic quantity conversions for inhalation products.
* Non-covered items may be submitted when required by state Medicaid.
* ML to MG conversion on inhalation drugs.
* NDC to HCPCS conversion.
* DEA to UPIN conversion.
* Package/unit quantity conversion on diabetic supplies, etc.

After your claim has passed our extensive edit checks, the claims is transmitted and a response is returned in seconds.

Pricing

One time installation/setup charge: $495   Support: $35/mo.   Alwin Data will charge for each POS transaction: 40¢
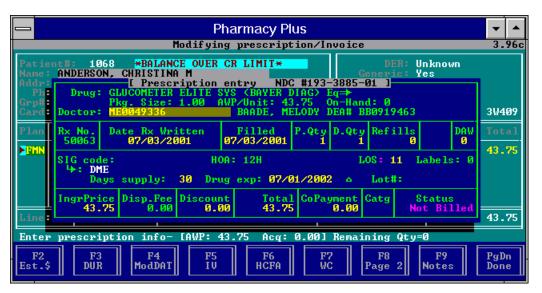
INSTRUCTION TO BILL MEDICARE DME:

A Medicare part B (DME) claim is processed in the same way an insurance claim is processed via the Pharmacy software. The only difference is two extra fields the must be filled (CPT code and Diagnosis). Below you will find a sample of the Payment plans normally used and the location of the CPT and Diagnosis field.

1. Create payment plan for Medicare Assignment and NON-Assignment as follows:

Plan	Description	Plan ID	NCPDP version	Phone
FMN	**MEDICARE-Forced NON-Assignment**	**5917**	**51**	**(800) 879-6153**
FMA	**MEDICARE-Assignment**	**5200**	**51**	**(800) 879-6153**

2. Call Allwin Data, Inc. (the clearing house) to register and for questions pertaining to Medicare part B claims at **(800) 879-6153**

3. Create your claim the same as if creating a Insurance Rx:

4. Once the fields have been filled, press the [F6] key to enter the pertinent Medicare/DME data and the following screen will appear:

INSTRUCTION TO BILL MEDICARE DME (CONT')


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┌─────────────────────────────────────────────────────────────┐
│                      Pharmacy Plus                      ▼  ▲  │
│               Modifying prescription/Invoice            3.96c │
│ Patient#:  1068   *BALANCE OVER CR LIMIT*          DER: Unknown│
│ Name: ANDERSON, CHRISTINA M                     Generic: Yes  │
│ Addr:      ┌──[ HCFA/MEDICARE - PRODUCT ENTRY ]──┐           │
│   Ph:  Drug: GL│ Fill out this form when billing Medicare │3W409│
│ Grp#:       Pk│ see the Report menu to print HCFA form.  │     │
│ Card: Doctor: ME│                                        │     │
│ Plan  Rx No.  Da│ Issue Rx number: Y    Rx Lables: 0  DAW│Total│
│ ▶FMN   50063    │    Description: GLUCOMETER ELITE SYSTEM  0│    │
│                 │         Doctor: ME0049336               │43.75│
│       SIG code: │ Date of service: 07/03/2001 -  /  /  abels: 1│
│        ↳: DME   │         Place: 12         Type: H        │    │
│           Days  │     CPT/HCPCS: A4255   Modifier:         │    │
│       IngrPrice │      Diagnosis: 25000      Days:   30  tatus │
│         43.75   │ Times to rebill:  0                    t Billed│
│ Line:           │          Units:   1      Total:   43.75 │43.75│
│                 └────────────────────────────────────────┘     │
│ Enter prescription info- [AWP: 43.75  Acq: 0.00] Remaining Qty=0│
│ ┌──────┐ ┌──────┐ ┌──────┐                                     │
│ │ Esc  │ │  F1  │ │ PgDn │                                     │
│ │Cancel│ │ Help │ │ Done │                                     │
│ └──────┘ └──────┘ └──────┘                                     │
└─────────────────────────────────────────────────────────────┘
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5. The CPT and Diagnosis code are required if transmitting to Medicare. These fields can be selected from a list if left empty and you press the [Enter] key. The "Place", "Type" and "Modifier" are used only when printing to the HCFA-1500 forms. Press the [PgDn] key to save and exit the above screen, you will be shown the prescription screen.

Note: If you need to print a HCFA-1500 form, more fields are required; you will need to enter a "Place", "Type" and "Modifier".

The rest of the process is the same as when processing an insurance claim and like an Insurance claim you will receive an instant authorization or rejection on the claim. Medicare part B claims are transmitted to a switch vendor (EMDEON CORP or NDC) then they are sent to Allwin Data (where they are processed and a reply is generated), the claim response is then sent to the Pharmacy. The process takes about 6 seconds via DSL.

THE MOST POPULAR CPT AND DIAGNOSIS CODES ARE ON THE FOLLOWING PAGE

Questions pertaining to Medicare part B claim can be answered by Allwin Data at at **(800) 879-6153**

Frequently asked questions regarding Medicare DME part B

1. **How does the DMERC define a physician letter when requested to demonstrate medical need?**
A physician's letter must be from the prescribing physician on his/her letterhead. It describes the specific medical conditions of the patient and documents medical need for the item being prescribed. It cannot be a form letter or typed by the supplier for the physician to sign. The letter is expected to provide rationale for the items(s) ordered as well as quantities or frequencies provided to the patient.

2. **What is the useful lifetime for durable medical equipment, and can a patient automatically get a new piece of equipment at the end of the useful lifetime period?**
The useful lifetime for DME is five years. A patient is not automatically eligible for a new piece of equipment at the end of the five-year period.

3. **Can a supplier advertise that it provides durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) "at no cost" to Medicare beneficiaries?**
Under the Medicare program, the beneficiary is responsible for any unmet deductible amount and applicable coinsurance. In addition, the supplier is responsible for collecting these amounts from the beneficiary for services rendered. It would be misleading to indicate otherwise to Medicare beneficiaries either verbally or in any marketing or advertising material.

4. **What is a break in service?**
A break in service is a temporary interruption in the use/billing of equipment. The medical need for the item continues; however, a new benefit period does not begin.

5. **How is claim jurisdiction determined?**
Jurisdiction is determined by the state where the beneficiary permanently resides.

6. **Who should I contact for HCPCS coding questions?**
Please contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for HCPCS coding questions at (877) 735-1326.

7. **Do I have to have an Assignment of Benefits (AOB) for each item billed to Medicare?**
Yes, an AOB must be obtained for each item billed to Medicare.

8. **What information can be accessed through Claim Status Inquiry?**
You can access the amounts of the last three payments, the dates of the payments, and the number of checks for each payment.

9. **What if a patient does not want a claim filed to Medicare?**
If there is an order, you must file a claim on behalf of the beneficiary under the Mandatory Submission of Claims Act.

10. **Can a supplier opt not to accept assignment on drugs?**
No. Section 114 of the Benefits Improvement and Protection Act (BIPA) of 2000 states that payment for any drug covered under Part B of Medicare may be made only on an assignment-related basis.

11. **Are suppliers allowed to charge a beneficiary for completing or filing a claim on the beneficiary's behalf?**
Suppliers may not charge the beneficiary for completing or filing a Medicare claim on the beneficiary's behalf.

12. **What are claim filing requirements for non-covered Medicare services?**
Suppliers are required to file claims on behalf of Medicare beneficiaries for non-covered Medicare services if the patient requests a

formal Medicare determination.

13. **Where is Medigap information reported on the CMS-1500 claim form?**
Medigap information is listed in Item 9 on the CMS-1500 claim form.

14. **Can suppliers downcode a DMEPOS item and only bill Medicare for what they think will be covered?**
A supplier must bill Medicare with the HCPCS code for whatever item was provided. Only Medicare can downcode the item once medical necessity determination is made.

15. **On assigned claims, what can be collected up front from the beneficiary?**
On assigned claims, you can collect payment for any unmet deductibles, 20% co-insurance, and items statutorily non-covered by Medicare. **Do not** indicate amounts collected in Item 29 of the CMS-1500 claim form.

16. **On assigned claims, can the supplier collect payment from the beneficiary above the Medicare allowable?**
Yes, if the beneficiary chooses an upgrade item and signs and dates an Advance Beneficiary Notice (ABN). For further details on ABNs, please refer to Chapter 7 in the Region C DMERC *DMEPOS Supplier Manual*.

17. **Can suppliers bill Medicare for delivery and/or shipping of DMEPOS items?**
No. Per ?5105 of the *Medicare Carriers Manual*, delivery and services are an integral part of a DMEPOS supplier's cost of doing business. The cost of delivery and service are typically taken into account by suppliers when determining their customary charges. Therefore, these costs are already included in the calculation for fee schedules and allowables.

18. **If a beneficiary has a secondary insurance policy that does not coordinate benefits and pays the supplier more than the co-pay, is the supplier mandated by law to refund the insurance company?**
Yes. When a supplier accepts assignment on a claim filed to Medicare, that supplier agrees to accept the Medicare allowable as payment in full. Acceptance of payments above and beyond the Medicare allowable is a violation of the Medicare assignment agreement, whether the payment is from the beneficiary or an insurer.

19. **What can suppliers do about other suppliers who routinely tell patients that they will write off the 20% co-payment?**
Such activities should be reported to the Benefit Integrity Unit at (877) 867-4852. Routinely waiving the 20% co-payment could be perceived as an enticement to gain Medicare business.

20. **When should a supplier file a hard copy claim versus an electronic media claim?**
Suppliers should file claims electronically whenever possible. The only time a claim should be filed hard copy is if required by policy or if the additional documentation does not fit into the electronic narrative record (HA0).

21. **Can a supplier key an ICD-9 diagnosis code on the electronic CMN if the physician indicated a narrative diagnosis on the hard copy CMN?**
No. The CMN completion instructions on the back of the CMN instruct the physician to provide ICD-9 codes. If there is a narrative diagnosis, the instructions have not been followed. Suppliers who transmit CMNs electronically cannot provide information that is not on the CMN.

22. **If a patient has Fee-for-Service (FFS) Medicare, enters a Medicare HMO and then goes back to FFS, is a CMN required?**
If a beneficiary is in a Medicare HMO for 60+ days, a new CMN is required, as a break in need has occurred. If the beneficiary is in the Medicare HMO for less than 60 days, a new CMN is not required, as FFS Medicare will pick up from the last payment.

23. **What does the KX modifier indicate?**
The KX modifier indicates the presence of documentation as defined by local medical review policy in the beneficiary record/file.

24. **What are the three methods of delivery?**
The three methods of delivery are:

> o Delivery direct to the patient,

> o Delivery via shipping service (i.e., U.S. Postal Service, FedEx, UPS, etc.), and

o   Delivery to a skilled nursing facility.

25. **How long must a supplier retain beneficiary medical records for claims filed to Medicare?**
Per the *Program Integrity Manual*, records should be maintained for seven years.