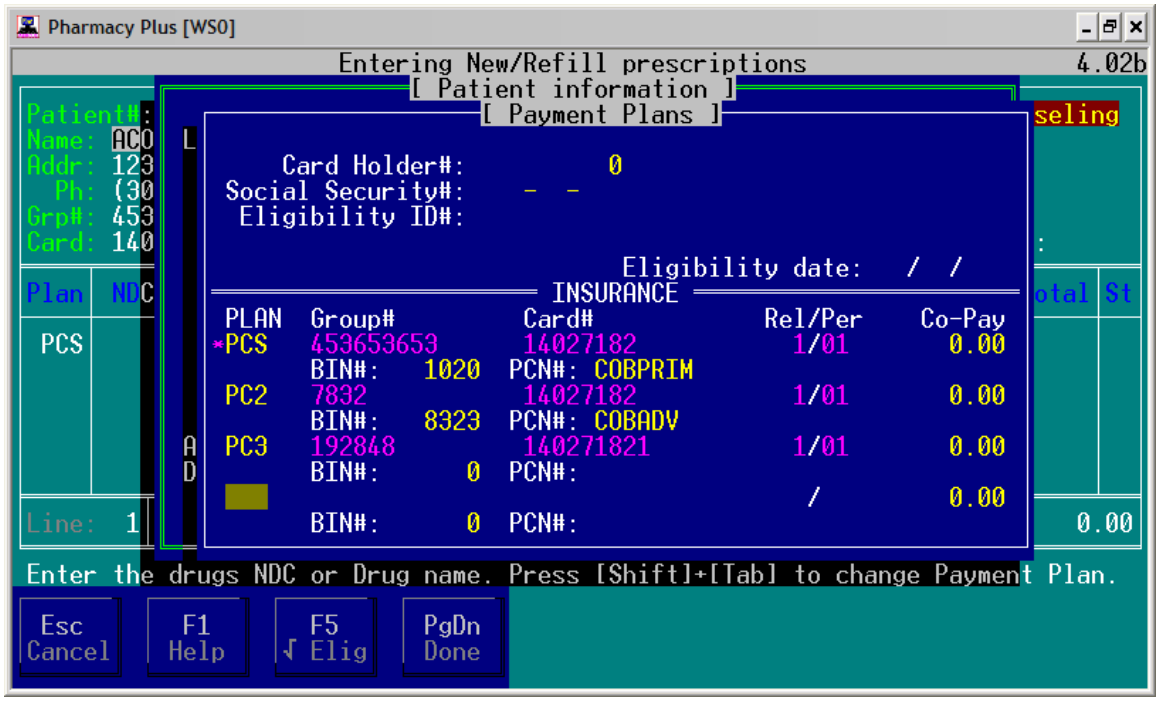
TRANSMITTING A MEDICARE PART D CLAIM

Eligibility checking

The main purpose of the eligibility checking is to provide a way for the pharmacy to determine which prescription drug plan (PDP) the patient has signed up for. Although the patient is responsible for investigating the PDPs and enrolling in a PDP that best suits their needs, there is a good possibility that the patient will not remember which plan they have enrolled in when they come into the store. To further complicate this situation, groups of patients will be automatically enrolled in PDPs and some patients will not receive their PDP cards before getting their prescriptions filled for he first time. With this thought in mind, the eligibility checking function will provide a method for finding out the current information concerning a patient.

Eligibility checking can be accomplished from the "New/Refill prescription screen", after the patient has been selected, press [**F4**] to get the Patient information screen, then pressing [**F2**] for the "Payor" list and then [**F5**] to check Eligibility.



FIELDS REQUIRED FOR ELIGIBILITY CHECKING:

1. Patients Name (Last Name, First Name).
2. Zip code (can be optional)
3. DOB (Date of Birth).
4. Last four digits of the Social Security Number in the Card Number.

Eligibility is provided by the Eligibility Facilitator NDC (National Data Corporation, help desk 800-895-0333). They will take the information you have provided and find a match.

You can find more information at www.AbacusRx.com, click on Support (password ABACUS), then click on Instruction.

Once you receive an "accepted" eligibility response from the processor, the insurance information will be pre-filled for you. This includes the Group number, Card number, Person code, BIN number and Processor control number and if the insurance is not in the list of Payment Plans you have defined, it will be created for you. The system will know that payment plan is a supplemental coverage, if it has a BIN number.

NOTE: If you receive eligibility information electronically, any existing Payment Plan information may be overwritten.

CAN NOT GET INFORMATION FROM ELIGIBILITY FACILITATOR.

If you cannot get eligibility information, you will need the patient card information, to get all the information necessary for billing. The following information is required:

1. Insurance BIN (Bank Identification Number).
2. Insurance PCN (Processor Control Number).
3. Patients Group Number.
4. Patients Card Number.
5. Patients Person code (Card holder, Member, Spouse, Child….).
6. Patients Relationship to Card holder code (Card holder, Spouse, Dependent ….).

If you did not get information via the Eligibility Check screen, you may create all the required data manually by following the steps below:

1. First create the Payment Plan.
   To create a Payment Plan:
   a. Go to the FILE section.
   b. Select Payment Plan (Insurance) function by pressing [Enter].
   c. Once in the Payment Plan screen, press [F2] to create a Payment Plan (You will be asked if you want to search for insurance plans, answer "No").
   d. Enter a unique Payment Plan code, keep in mind Payment Plan codes beginning with "A", "C" and "M" are reserve for Accounts Receivable, Cash and Medicaid respectively.
   e. Enter the Name of the Insurance, this is only used for your reference.
   f. Enter the BIN number, provided by the patient or Insurance/CMS.
   g. Enter the PCN number, provided by the patient or Insurance/CMS.
   h. Press the [PgDn] key to save and exit from the Payment plan file. You are now ready to use this Payment Plan, remember the Payment Plan code you have assigned, you will need to enter this code in the patient information.
2. Enter the information in the Patient file.
   Update the Patient information with the new Payment Plan, Group number, Card number, person and relationship code.
   a. Go to "New/Refill Prescription", and press the [Enter] key to get into the screen.
   b. Enter the Patients Last name, First name and press the [Enter] key. A list of Patients matching the name entered will be displayed, select the correct

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patient from the list by pressing the [Enter] key to select or press the [Esc] key to be asked to create new Patient record.

c. Verify or enter the Patients information.
d. Press [F2] – Payors, to enter all the Insurance company the patient has coverage with.
    i. Enter the Payment Plan code previously created.
    ii. Enter the Group number.
    iii. Enter the Card number.
    iv. Enter the Cardholders relationship code.
    v. Enter the Person code.
    vi. The Co-payment field is not required, but may be used for internal accounting.
    vii. The BIN number is used for multi-payor claim processing and is required for all such claims. If the patient has more than one Insurance that may pay for a claim, you will need to enter the BIN number to tell the system that the Insurance may be used for multi-payor claims.
    viii. The PCN number is used for multi-payor claim processing and is required for all such claims. If the patient has more than one Insurance that may pay for a claim, you will need to enter the PCN number to tell the system that the Insurance may be used for multi-payor claims.
    ix. Enter all the Insurance the patient has coverage with then press [PgDn] to save the information entered. You are now ready to bill with the new insurance information.

BILLING TO A ONE INSURANCE PLAN.

If the patient has only one coverage entered in the Payor list of the Patient information screen. Then only one insurance can be billed for all Rx claims.

Billing to a single payor is done the same way as before.

1. Enter the Payment Plan code.
2. Enter the products NDC or Name (if entered by name you will have to select the product from the list).
3. Enter the date the Prescription was written and dispensed.
4. Enter the Prescribe quantity and the quantity being dispensed.
5. Enter the Sig code or write Rx instructions.
6. Press [PgDn] when done entering prescription information. You are now ready to transmit the prescription to the insurance.

NOTE: CMS claims (Medicare Part D) can only be transmitted one at a time. This is a retriction by CMS and Insurance carriers, due to the complexity of tracking the patients true deductible between multiple insurance carriers.

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BILLING SUPPLEMENTAL COVERAGE (Billing a claim to multiple payors).

The process is automatic, you simply create a prescription the same way you do now. The system will transmit to the first coverage, then the second and then the tertiary. You can also, asked to be prompt before transmitting (see, this option under the Configuration Preferences). If you receive a "NO COVERAGE" message back from the processor for a secondary or tertiary claim, place a "N" for no coverage under the Status field, so that the claim is not transmitted again to the processor.

How to bill to multiple payors:

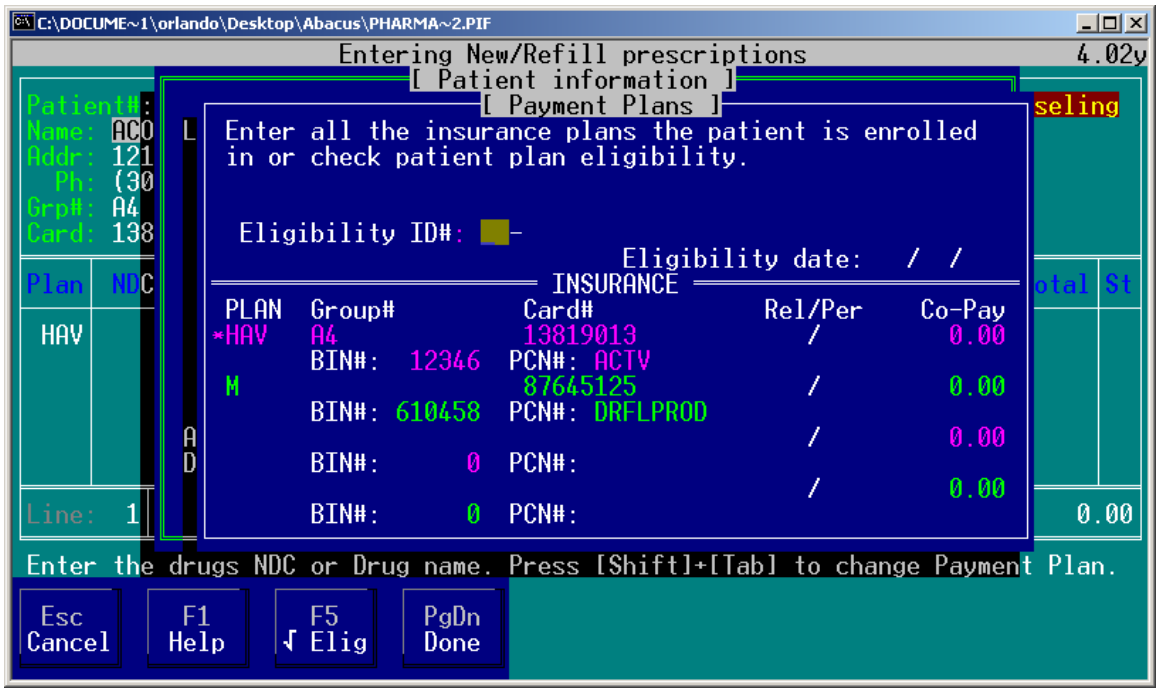
A prescription claim can be billed to the multiple payors (primary and supplemental coverages), if the patient has multiple coverages (payors) defined in the Payor [F2] screen in the patient information screen. A payor is said to belong to the multiple payor group if they have a BIN and PCN number in the payor list.

1. You begin by creating a prescription the same as for a single payor.
2. Press [F10] to save and answer "Yes" to the "Transmit claim" question.
3. You will receive a reply the same way as a single claim. If the claim was adjudicated, you will receive a "Payable" status and an authorized amount. If the claim was denied, in order to transmit to the secondary insurance you must enter a "N" for "No coverage" in the prescription status field.
4. Once you press [Esc] to exit the claim response screen, you will be ask if you want to bill the second payor. If you answer "Yes", you will be ask a multiple choice question as to why you are billing to the secondary insurance, this will let the insurance know what you are billing them (for the full Rx claim amount or only the co-payment). For example, if the claim was denied coverage by the primary insurance, you may want to select "3-Other Coverage-Claims not Covered". If you where paid by the primary insurance payor and you want to submit the co-payment to the secondary insurance, you may want to select "8-Claim is a billing for a co-payment".
5. Once you answer the above question, the prescription will be billed to the second insurance. You will then receive a reply as you did with the first insurance.
6. If you have a Tertiary insurance payor the above process is repeated for this payor.

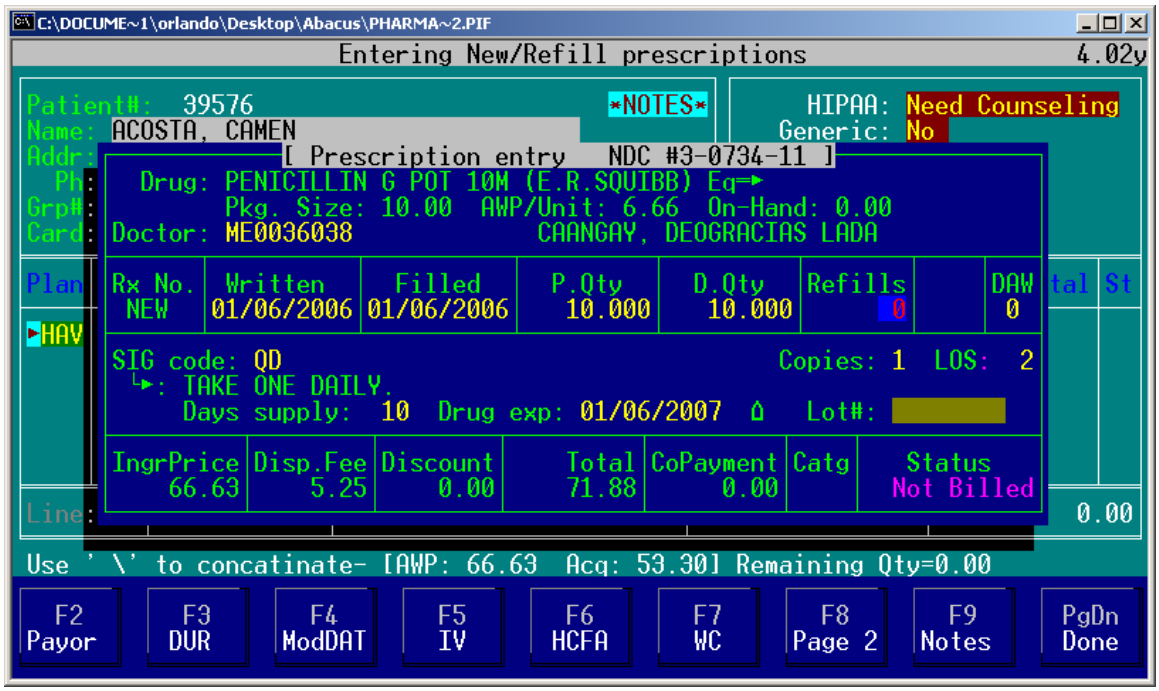
Once a prescription is adjudicated or rejected by the insurance, the insurance BIN, Date and Amount of the adjudication or rejection code (only if 41) will be stored. To let the secondary or tertiary insurance know what was the outcome of the billing to the previous insurance. The Rx status, Authorization number and Authorized amount are also stored individually.

The following are screen samples of a multi-payor claim:

You can find more information at www.AbacusRx.com, click on Support (password ABACUS), then click on Instruction.



When a patient has multiple payors, you must first enter all the payors in the patient payor [F2] screen.



Next, create the prescription and transmit it to the primary payor.

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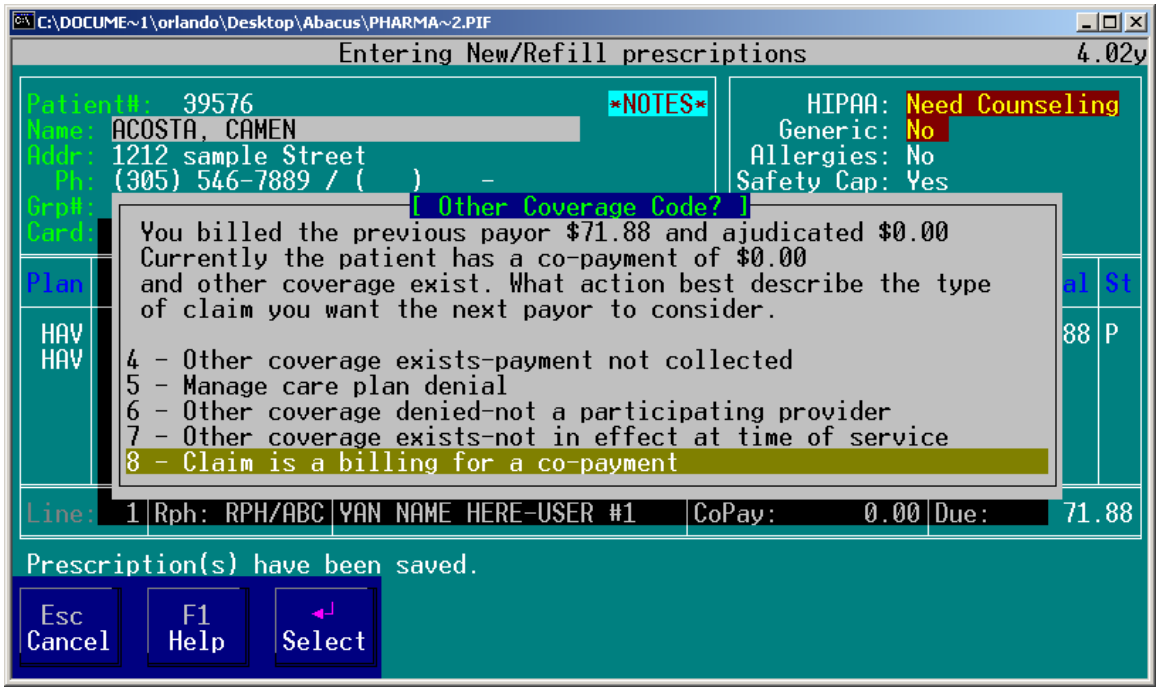
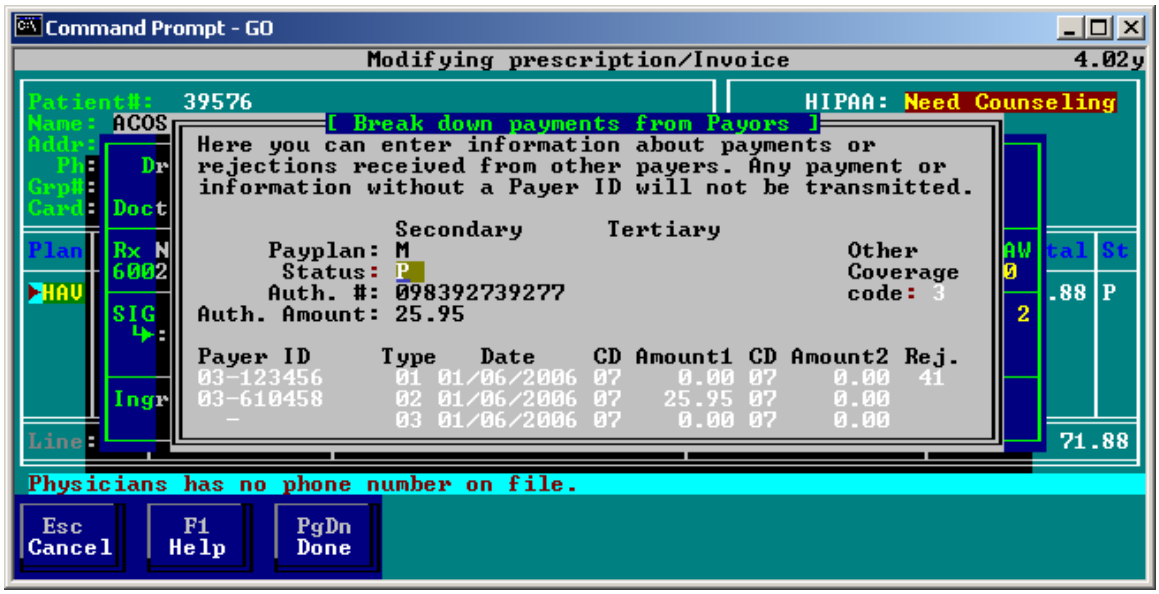
Once the prescription is transmitted the payor will respond with either a payable or reject response. If the payor rejects the claim due to “No coverage”, you will need to enter a “N” under the prescription Status. Otherwise, the claim will have a status of “unbilled” and we be transmitted again.

Once the primary prescription has a Status, the secondary payor will be billed.



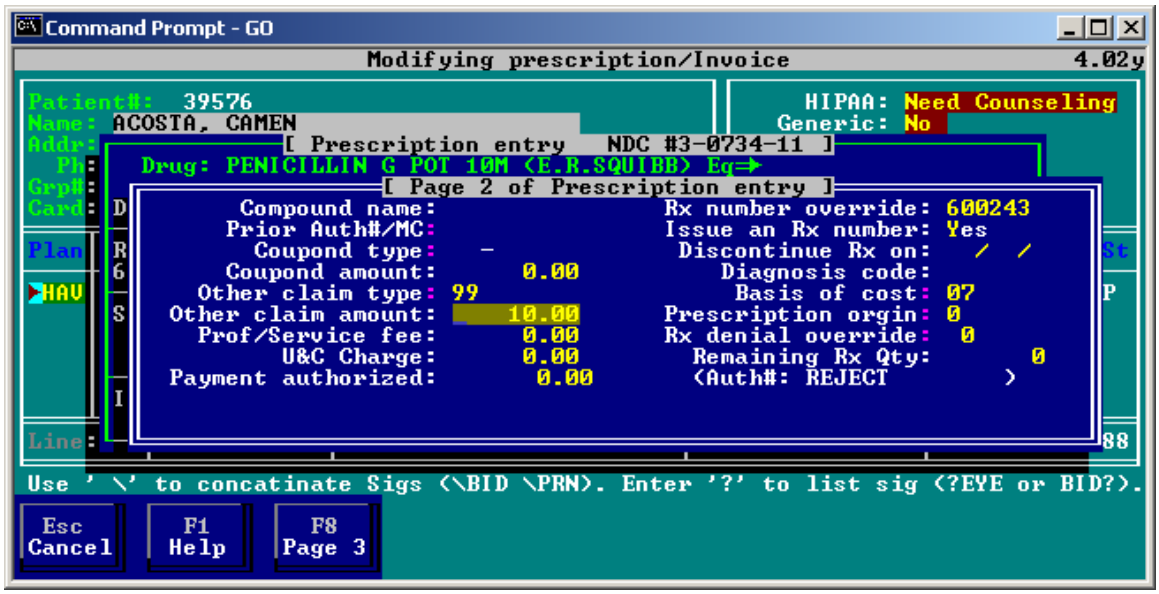
You will now see the above screen, here you will specify the reason you are billing the insurance for the claim. The claim will be transmitted and the results will be displayed.

Lets see what information will be written in the prescription payor screen.



As you see, you will get the Status, the authorization and the authorized amount from the secondary payor. The information on the lower part of the screen, is data kept by the system to inform the next payor of the result of previous payors (this information is required by payors and is mostly automatically generated by the system, but can be manually override).

If the reason for billing the secondary or tertiary payor is to collect a co-payment (ie., you selected "8-Claim is a billing for a co-payment"), the system will automatically place the co-payment amount being billed in the "Other claim amount" field and a "99" will be also entered in the "Other claim type" field, as required by the insurance as show below.



If you elected to bill a secondary or tertiary insurance a co-payment, and later change your mind, you will need to manually remove the values in both fields ("Other claim type" and "Other claim amount").

The above screen can be found by pressing the [F2] key from the prescription detail screen. This screen list the "status" of all the supplemental coverage, along with payments received (the payment information will be entered automatically by the system when a payable response is received. However, "Not covered" or other rejection code may not be automatically entered by the system. Some insurance may require that you manually enter a rejection code under the "Rej." field to let them know that you attempted to bill the insurance but was rejected because it was not covered.

Field definition:

1. Secondary Payment Plan – The payment plan code that will be billed as the second insurance. This code was retrieved from the second insurance payment plan found in patient payor screen with a BIN number.
2. Secondary Status – This is the resulting status of the claim when billed to the secondary insurance.
3. Secondary Authorized number – This is the Authorization number received when the secondary insurance adjudicates the claim.
4. Secondary Authorized amount – This is the Authorized amount received when the secondary insurance adjudicates the claim.
5. Other Coverage Code – This code specifies the reason why you are billing the claim to the secondary or tertiary insurance.
6. Payer ID – This is the BIN number of the primary, secondary or tertiary payor, prefixed with a "03" to indicate the number is a BIN.
7. Type – This code specifies the payor (01=Primary, 02=Secondary, 03=Tertiary).

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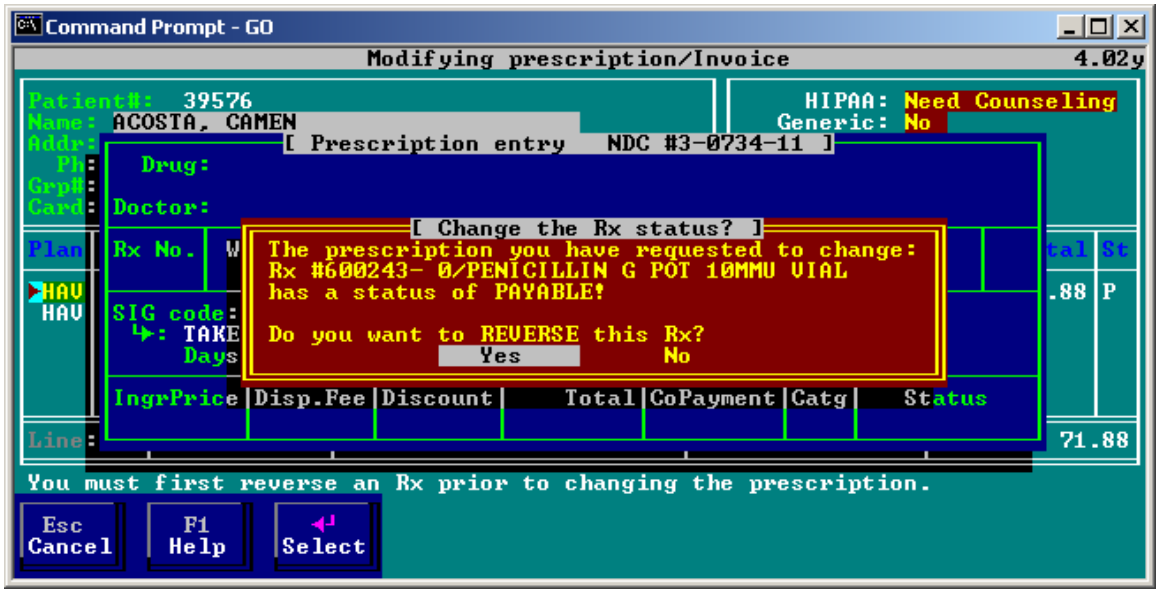
8. Payer Date – This is the date of adjudication or rejection.
9. CD – Is a code that specifies what the billing was for as defined below:
    a. "01" = Delivery
    b. "02" = Shipping
    c. "03" = Postage
    d. "04" = Administrative
    e. "05" = Incentive
    f. "06" = Cognitive Service
    g. "07" = Drug Benefit
    h. "08" = Sum of all reimbustments
    i. "98" = Coupond
    j. "99" = Other

10. Amount1 – This is the adjudicated by the primary, secondary or tertiary insurance.
11. CD – Same as above, but applies to Amount2.
12. Amount2 – This is the second amount they adjudicated.
13. Rej. – This is the rejection code field, if an insurance rejects the claim you can enter at the request of the insurance a code of the rejection. This field will be filled by the computer only for code 41 "Not covered".

REVERSING A MULTI-PAYOR CLAIM

Reversing a multi-payor claim works almost like reversing a single payor claim.



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1. Go to “Modify prescription” from the menu.
2. Enter the prescription number and press [enter].
3. Press [Enter] on the prescription to reverse and you will see the above screen.
4. Select “Yes”. This will change the prescription status of all payor to “Reverse”.
5. Transmit the claim, the last payor will be reversed first then the previous (Tertiary, Second then the Primary payor). You will have to sumit the reversal to each payor, you will be asked by the system.

INSURANCE PLANS (more information on Payment Plans)

You now have two methods of identifying a new insurance or processor, you can either enter the Plan ID (assigned by Emdeon formely WebMD) as you did before or you can enter the actual insurance BIN (Bank Identification Number) and PCN (Processor Control Number) found on the patients ID card. If you enter both, the system will use the BIN and PCN. The look of the Payment Plan screen has also changed (shown below).

REPORTS

The authorization amount on all reports now reflects the total of all the authorizations received from the primary and supplemental coverage.

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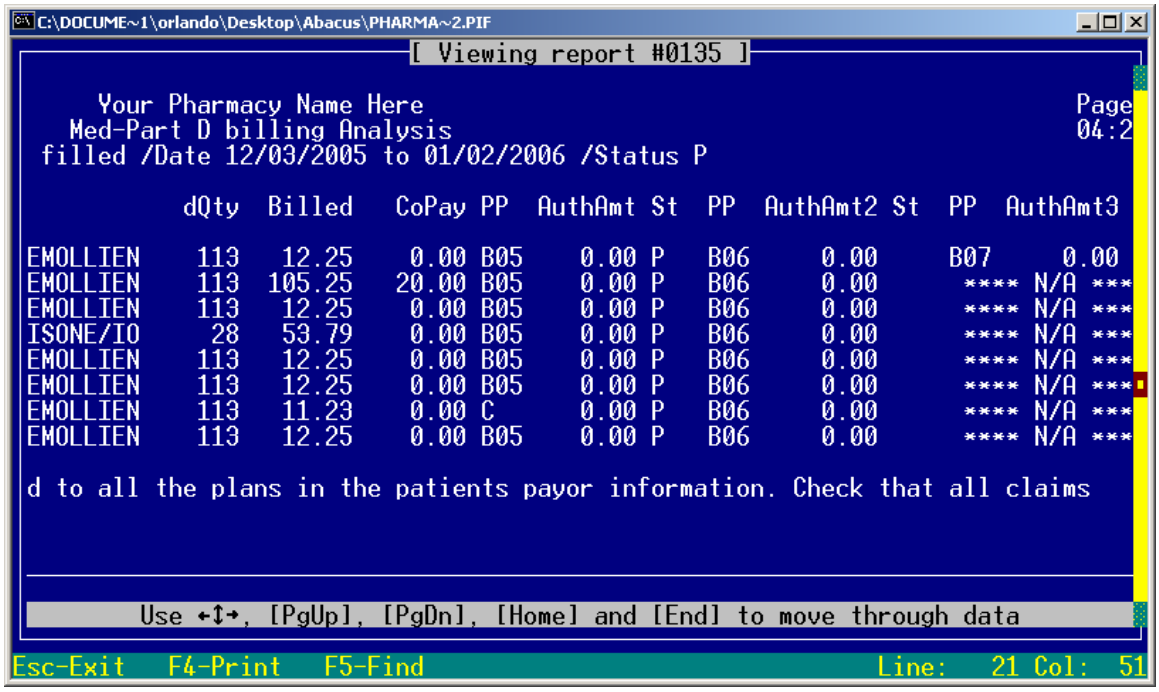

The “Med-Part D billing Analysis” report, found under the Report menu, can assist you in locating any multi-payor claim where the claim was not submitted to all payors.

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