Preface

The Pharmacy Point of Sale module does electronic billing for outpatient pharmacy. It also interfaces to various Accounts Receivable packages.

Please direct any comments or questions regarding this system to the RPMS Support Center at:

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Division of Information Resources
5300 Homestead Road, NE
Albuquerque, New Mexico 87110
(505) 248-4371 or (888) 830-7280
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1.0 **Introduction**

The User Manual for the Point of Sale Application (POS) is intended to guide you through the process of submitting your pharmacy claims as well as act as a reference to help you get started in setting up the POS system to your specifications. It will also serve as a quick reference as you gain expertise in the use of POS. Submitting claims through POS should become a comfortable task for you within a short time frame.

You are already familiar with the goals and business solutions offered by the POS system. The goal of this manual is to help you and your staff derive the benefits of using the POS system in a rapid manner. The user friendly features of the POS system will aid you in becoming an expert user.

The User Manual is divided into five sections.

1. User Menu
2. Manager Menu
3. Billing Menu
4. Reports Menu
5. Statistics and Miscellaneous

The first section, “User Menu” discusses the basic elements of submitting pharmacy claims to insurers through the POS system. All users need to be familiar with this section of the manual. Appendix A contains a list of rejection codes and reasons and will be a necessary reference as you begin to use the POS system.

Section two, “Manager Menu” details the procedures and setup features that would require management level decision-making. All users need to be familiar with the functions of the Manager Menu, although access to the menu should be limited.

In section three, “Billing Menu,” the interface with Third Party Billing and Accounts Receivable is explored. The pharmacy and the billing department need to make some decisions on who is responsible for certain billing and research processes at the site. Appendix C provides some examples of insurer explanation of benefits (EOBs) sent in response to POS claims.

Section four is devoted to the “Reports Menu.” Reports can be accessed from the User, Manager, and Billing menus so all users have the ability to create all reports discussed in the manual. Appendix B provides examples of some.
The fifth section, “Statistics and Miscellaneous” instructs on the use of the statistics screen. The statistics screen is mainly designed as a POS management tool. In addition to information regarding the statistics screen, you may wish to add other information concerning the POS system in this section of the manual.

Appendix D is a copy of the Configuration Survey for your reference. You may want to place a copy of your completed survey in Appendix D for future inquiries into the setup of your POS system. You may need to refer to it if you call the RPMS Support Center.

Appendix E is only applicable for sites for are running a background scan. If you are such a site, this section gives you information regarding the options on the background menu.
2.0 User Menu

The User Menu allows you to submit, resubmit or reverse claims. You may also edit and print data. A variety of reports and surveys can be accessed to help you manage your Point of Sale (POS) process. The Pharmacy POS User Menu is accessed from the core menu shown in Figure 1.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>Pharmacy POS User Menu</td>
</tr>
<tr>
<td>MGR</td>
<td>Pharmacy POS Manager Menu</td>
</tr>
<tr>
<td>BILL</td>
<td>RX Point of Sale Billing Menu</td>
</tr>
<tr>
<td>RPT</td>
<td>Pharmacy electronic claims reports</td>
</tr>
</tbody>
</table>

Select the “U” option to access the User Menu shown in Figure 2:

---

**PHARMACY POINT OF SALE V1.0**
**MT EDGEcombe HOSPITAL**
**Pharmacy POS User Menu**

---

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>Claims data entry screen</td>
</tr>
<tr>
<td>RPT</td>
<td>Pharmacy electronic claims reports</td>
</tr>
</tbody>
</table>

Select Pharmacy POS User Menu Option:

---

Figure 2: User Menu

2.1 Claims Data Entry Screen

The main Pharmacy POS screen shows all of your patients and prescriptions that have been active in the past fifteen minutes (see NOTE below). Selection of option “U” on the User Menu produces the screen displayed in Figure 3.

**Note:** The time frame is customizable. Use the EV option, described in the next section.

<table>
<thead>
<tr>
<th>#</th>
<th>PATIENT/PRESCRIPTION</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>done MING, ELLA MAE</td>
<td><strong>FINISHED</strong> ** unbillable**</td>
</tr>
<tr>
<td>2</td>
<td>COTRIMOXAZOLE SS TAB</td>
<td>no insurance native beneficiary</td>
</tr>
<tr>
<td>3</td>
<td>done WINSON, JAMES</td>
<td><strong>FINISHED</strong> ** 1 payable ** 1 rejected</td>
</tr>
<tr>
<td>4</td>
<td>AMOXICILLIN 250MG/5ML</td>
<td>payable</td>
</tr>
</tbody>
</table>
Figure 3: Claims Data Entry Screen

Screen elements from left to right can be described as follows:

- **Line Number:** You need the line numbers when using functions such as “REV” (Reverse a Paid Claim) and “LOG” (Print Claim Log).

- **The % completed or the word "done" next to patient names:** In this example, both claims have been processed, so both patient records are marked as “done.”

- **The patient’s name:** The prescription(s) are shown below each name.

- **The comments:**
  - On the patient line, the comments section summarizes the results of all of the patient’s prescriptions. Observe that on the second patient in this example (line 3), the summary says that one claim was paid and the other was rejected.
  - On the prescription line, the comments section tells specifically what happened to that prescription.
    - On line 2, we see that the patient had no insurance information and that she is a native beneficiary. If you know that the patient does have insurance, have the coverage updated in RPMS Registration and then use the “RES” option to resubmit the claim.
    - On line 4, we see that the claim for Amoxicillin was accepted and it will be paid. If you need to reverse the claim, use the “REV” option.
    - On line 5, we see that the claim for Miracle Balm was rejected and the reason for rejection is shown. Sometimes rejected claims can be turned into payable claims by changing data. Perhaps the insurance group number is wrong (registration) or a smaller quantity might be covered by insurance (pharmacy). If the prescription was refilled too soon, perhaps it will be payable in a few days.

Several commands are shown in the menu at the bottom of the screen. They are explained in Section 2.3.

To exit from this screen, use the command “Q” (Quit). The “Quit” command is what is known as a “hidden command” in a ListManager screen.
2.2 Submitting Claims to the Point of Sale System

The “NEW” option displays a ScreenMan data entry screen for entering claims. When to use the “NEW” option depends on how the Point of Sale system is configured. Refer to Section 2.8 for a detailed discussion. The POS system will be configured to send claims either automatically (see section 2.2.1) or automatically through a background job (see section 2.2.2), depending on how your site is set up.

2.2.1 Automatic RPMS Pharmacy Package Claims Submission

(This is the preferred RPMS POS method for submitting claims.)

If your RPMS Pharmacy package sends claims automatically, your POS system will be configured in the manner detailed below.

- Every time you enter or edit a prescription in the RPMS Pharmacy package, the claim is automatically submitted to Point of Sale. No further action is necessary. Edits may also cause a previous claim to be reversed before being resubmitted.
- If, in RPMS Pharmacy, you marked the prescription for Manual Bill, you may use the “NEW” option to enter the claim in Point of Sale.
- When you edit/delete/return to stock a prescription in the RPMS Pharmacy package, a claim reversal is automatically submitted through Point of Sale. No further action is necessary.
- Use “UD” (Update the Display) or “CU” (Continuous Update) to monitor the progress and results of claims and reversals.
- On occasion, you might use the “NEW” option to submit a claim, if neither the “RES” Resubmit option nor the RPMS Pharmacy Edit are appropriate.

2.2.2 Automatic Point of Sale Background Claims Submission

(This is an RPMS POS feature but not the preferred method for submitting claims.)

If your Point of Sale system sends claims automatically through a background job, your POS system will be configured in the manner detailed below.

- Every time you enter a prescription in the RPMS Pharmacy package, the claim is automatically submitted to Point of Sale. No further action is necessary.
- Prescription edits in RPMS Pharmacy have no effect on Point of Sale. You may need to manually reverse (“REV”) and create a (“NEW”) claim if there is a material difference, such as quantity dispensed.
- Every time you return-to-stock a prescription in the RPMS Pharmacy package, a claim reversal is automatically submitted through Point of Sale. No further action is necessary.
• If you cancel a prescription in the RPMS pharmacy package without doing a return-to-stock, the prescription must be manually reversed (“REV”).

• Use “UD” (Update the Display) or “CU” (Continuous Update) to monitor the progress and results of claims and reversals.

• On rare occasions, you might use the “NEW” option to submit a claim.

### 2.2.3 Manual Point of Sale Data Entry Claims Submission

If your Point of Sale system requires manual data entry, your POS system will be configured to enter and submit claims through the “NEW” option. Review Figure 4, the “NEW Send new claims” screen. A detailed description of the process can be found in Section 2.8, New Send New Claims.

| Ask Insurance? NO | +------------------+ | <PF1> E when done, to file claims |
| Ask Preauth #? NO | PHARMACY | <PF1> Q to quit without filing claims |
| Ask Qty/Price? NO | POINT OF | <PF3> insert/overstrike modes |
| Ask Fill Date? NO | SALE | <PF4> to go back one field |
| Ask Overrides? NO | DATA ENTRY | Arrow keys may be used, too |

```
+------------------+
Prescription NDC/CPT/HCPCS - Patient - - - - Drug - - - - - - - - Fill Date
1 ____________
2
3
4
5
6
7
8
9
```

COMMAND: Insert

Press <PF1>H for help

Figure 4: NEW Send New Claims Screen

### 2.3 Description of Options on the Pharmacy POS Screen

**NEW = Send new claims**: This option is discussed in Section 2.2, Submitting Claims to the Point of Sale System.

**CU = Continuous update**: This option updates the screen repetitively, once about every fifteen seconds. You can watch claims processing on their way from 0% to 100% complete on this screen. Press the “Q” key ("quit") to stop the continuous update function.
**UD = Update the Display:** Similar to “CU” above, this option updates the screen with the latest information about patients' prescriptions and their progress through the claims processing. The difference is the screen will only update once and you will go back to the menu. This is the default prompt upon entering the module.

**EV = Edit View Screen:** Use this option to change the selection of claims displayed on the data entry screen. You can vary the display based on user (who entered the prescriptions and claims) or patient.

- **One User:** Identify the user. You may also change the parameters that control how long a completed transaction remains on the screen and how long between updates during the “CU” Continuous Update mode.

  Select Action: EV   Edit view screen

  Display for 1:One user or 2:All users or 3:One patient? : (1/2/3): 1// 1   One user

  Select POS user: YOURNAME,HERE//   SOMEONE,ELSE

  Enter the number of MINUTES, the length of time that completed transactions will be retained on the screen.

  Retention time: 15//

  Enter the number of SECONDS between updates when the display is in CONTINUOUS UPDATE MODE.

  Seconds between updates: 15//

- **All Users:** The prompt to select a user is absent since data from all users will be displayed. All other processes are the same.

- **One Patient:** Identify the patient by keying in name, partial name or chart number. In the case of partial name, FileMan will present a list of patients to choose from. If you enter a chart number, you may be presented with a list of visits for the patient from which you will need to select one visit. You may also choose how many historical days to look for this patient’s claims. The data entry screen is then updated with the prescriptions, the transaction date, and the fill date (see Figure 5). This feature is useful if you need to reverse or resubmit old claims.

  Select Action: EV   Edit view screen

  Display for 1:One user or 2:All users or 3:One patient? : (1/2/3): 1// 3   One patient

  Prescriptions for which patient? SMITH,DELLA G

  Enter the number of DAYS to go back to find Point of Sale activity for SMITH,DELLA G

  Number of days: 30//

  PHARMACY POINT OF SALE   Nov 16, 2000 08:13:21   Page:   1 of  1
All prescriptions for patient SMITH,DELLA G
With activity in the past 30 da

<table>
<thead>
<tr>
<th>#</th>
<th>PATIENT/PRESCRIPTION</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>done SMITH,DELLA G</td>
<td>** FINISHED ** ALL not electronic **</td>
</tr>
<tr>
<td>2</td>
<td>CIMETIDINE 400MG TAB</td>
<td>OCT 28@13:33, FILL OCT 10@ No insurance,Native b</td>
</tr>
<tr>
<td>3</td>
<td>ESTROGENS, CONJ. 1.25M</td>
<td>OCT 28@13:33, FILL OCT 10@ No insurance,Native b</td>
</tr>
<tr>
<td>4</td>
<td>MEDROXYPROGESTRONE 1OM</td>
<td>OCT 28@13:33, FILL OCT 10@ No insurance,Native b</td>
</tr>
<tr>
<td>5</td>
<td>MULTIVIT W/MINERALS &amp;</td>
<td>OCT 28@13:33, FILL OCT 10@ No insurance,Native b</td>
</tr>
</tbody>
</table>

Figure 5: Point of Sale Activity for a Patient

2.4 Selecting Patients and Claims to Dismiss/Print/Cancel/Reverse

The POS screen in Figure 6 will be used as an example in the discussions of section 2.4.

```
PHARMACY POINT OF SALE Nov 16, 2000 05:36:50 Page: 1 of 2
All prescriptions With activity in the past 15 min
# PATIENT/PRESCRIPTION COMMENTS
1 done ANDERSON,ROBERT ** FINISHED ** not electronic **
2 BECLOMETHASONE NASAL I No insurance,Native ben.[Previously: Reversed pa
3 done DEMETRIUS,TIMOTHY CHAR ** FINISHED ** not electronic **
4 IBUPROFEN 400MG TAB No insurance,PENDING VERIFICATION,INDIAN/ALASKA
5 done HANLEY,ELLEN GRACE ** FINISHED ** BOTH not electronic **
6 FUROSEMIDE 20MG TAB No insurance,Native ben. (1075818.00001)
7 POTASSIUM CHLORIDE 1OM No insurance,Native ben. (1075819.00001)
8 done HOSMER,JERRI E ** FINISHED ** not electronic **
9 NORETHINDRONE 0.35MG T No insurance,Native ben. (1018313.00011)
10 done MURPHY,MARY MARGARET ** FINISHED ** 1 rejected *1 not electronic **
11 HYDROCORTISONE 1% OINT No insurance,Native ben. (1075812.00001)
12 AQUAPHILIC OINT Rejected(68:FILLED AFTER COVERAGE EXPIRED,40:PHA
13 done NUGENT,ARTHUR CULVER ** FINISHED ** not electronic **
+ Enter ?? for more actions >>>
NEW Send new claims DIS Dismiss patient RCA Request cancellation
CU Continuous update SP Print single patient REV Reverse a paid claim
UD Update the display PA Print all RES Resubmit a claim
ev Edit view screen LOG Print claim log REC Print receipt/DUR data
Select Action:UD//
```

Figure 6: Claims Data Entry Screen
Selecting Claims by Line Number: Several options ask you to identify claims and patients by line number. These are the line numbers in the leftmost column. When you see the prompt

```
Select item(s): (1-13):
```

You may respond with:

- A single line number. Example - Select item(s): (1-13): 4
- A list of line numbers. Example - Select item(s): (1-13): 1,3,7
- A range of line numbers. Example - Select item(s): (1-13): 8-10
- Combinations of the above.

**DIS = Dismiss Patient:** If a patient's prescriptions have finished processing and you want to remove the patient's information from your screen without waiting for the fifteen minutes, use “**Dismiss.**” *To access this option, type in DISM. Review the example in Figure 7.*

```
NEW  Send new claims      DIS  Dismiss patient      RCA  Request
CU   Continuous update    SP   Print single patient REV  Reverse a paid
claim                        PA   Print all            RES  Resubmit a claim
UD   Update the display   LOG  Print claim log      REC  Print receipt/DUR
EV   Edit view screen     UD   Update the display   PA   Print all            RES  Resubmit a claim
data                        PA   Print all            LOG  Print claim log      REC  Print receipt/DUR
Select Action:UD//
Select Action:UD// **DISM** Dismiss patient
Select item(s): (1-13): 3
DEMETRIUS,TIMOTHY CHARLES will be dismissed.
```

Figure 7: Example of Dismiss Data Entry

The screen is then updated. Timothy is gone and the patients after him have moved up to replace him entry. An example is shown in Figure 8.

```
#       PATIENT/PRESCRIPTION   COMMENTS
1 done ANDERSON,ROBERT ** FINISHED ** not electronic **
2 reversed BECLOMETHASONE NASAL I No insurance,Native ben.[Previously:
3 done HANLEY,ELLEN GRACE ** FINISHED ** BOTH not electronic **
4 Furosemide 20MG TAB No insurance,Native ben. (1075818.00001)
5 POTASSIUM CHLORIDE 10M No insurance,Native ben. (1075819.00001)
6 done HOSMER,JERRI E ** FINISHED ** not electronic **
7 NORETHINDRONE 0.35MG T No insurance,Native ben. (1018313.00011)
8 done MURPHY,MARY MARGARET ** FINISHED ** 1 rejected *1 not
   electronic **
9 HYDROCORTISONE 1% OINT No insurance,Native ben. (1075812.00001)
10 AQUAPHILIC OINT Rejected(68:FILLED AFTER COVERAGE
EXPIRED,40:PHA
11 done NUGENT,ARTHUR CULVER ** FINISHED ** not electronic **
12 FORMULA X 20MG TAB Paper claim to COMPANY (1078818.00001)
```
SP = Print Single Patient: In figure 8, on line 10, there is not enough room to see all of the rejection reasons. You can scroll to the right to see the data, as explained later, or use the “SP” option to get a hard copy of everything on that line. The printout wraps the text so the entire message can be seen as shown in Figure 9.

PA = Print All: This option will prompt for an output device and will send a copy of the screen to selected printer.

LOG = Log of Processing: This option prints a detailed history of the processing for the prescription. It is a good tool for diagnosing problems. An example of the prompts to generate the log are shown in Figure 10.
**RCA = Request Cancellation:** This option can be used to stop a claim before it is transmitted to the insurance company. If you don’t catch it in time and the claim is paid, use “REV” to reverse the transaction. “RCA” has no effect on paper claims (use “REV” or “RES” instead). “RCA” has no effect on rejected claims. Review an example of the process in Figure 11.

![Select Action:UD// RCA Request cancellation](Figure 11: Example of Request Cancellation)

**REV = Reverse a paid claim:** For an electronic claim the “REV” option sends a claim reversal request to the insurer. Watch the screen to monitor the progress of the reversal request. Review an example of the process in Figure 12.

![Select Action:UD// REV Reverse a paid claim Select the line(s) with the paid claim(s) you wish to reverse.](Figure 12: Example of Reverse a Paid Claim)

**RES = Resubmit a claim:** This option resubmits a claim. The processing is redone from the beginning, so that the latest registration and pharmacy data is picked up. If the claim was previously paid, the original claim is first reversed and then the resubmission is done. Review an example of the process in Figure 13.

![Select Action:UD// RES Resubmit a claim Select the line(s) with the claim(s) you wish to resubmit.](Figure 13: Example of Resubmit a Claim)

Observe that the Comments line shows the new status first, followed by the previous results in brackets.
**REC** = Print Receipt/DUR Information: This option prints a summary of the transaction, similar to what a commercial pharmacy’s receipt would show. The contents of the receipt can be customized for your pharmacy. The next example doesn’t have any financial information, such as co-pay amounts but you might want your receipts to show this information. Point of Sale can also be set up to automatically print receipts.

The DUR (Drug Utilization Review) information is perhaps the most valuable part of the option. When the insurer responds to a claim, sometimes DUR information is included. You can tell because the comments part of the line begins with “DUR!” like this:

```
88 ALBUTEROL INHALER DUR! Payable. Much more data that doesn't fit
```

Sometimes DUR data comes in a rejection response. A common example is when a patient has had the prescription filled recently at another pharmacy. The insurer might even tell us the fill date as part of the rejection and the next refill date on which the claim would be payable. Review Figure 14 for an example of the information that can be provided.

---

**Select Action:** UD// REC Print receipt/DUR info
Enter the line numbers for which you wish to print a receipt and DUR info:

Select item(s): (79-91): **88**
Send report to device: HOME// printer  Right Margin: 80//

Printing DUR info...
... for BRIGHAM, CARLA...

BRIGHAM, CARLA
Cardholder ID Number: xxxxxxxxxxx
Electronic Payor: MEDICAID
Claim ID: C00-002286-68488
ALBUTEROL INHALER
Quantity: 17
NDC Number: 00172-4390-18
Date Filled: NOV 15,2000
Prescription Number: 1777354
Prescription Status: CLAIM PAYABLE
Authorization Number: 0
DUR Response Data:
Drug Conflict Code: Excessive Drug Doses (Over Utilization)
Severity Index Code:
Other Pharmacy Indicator: 0
Previous Date of Fill: 00000000
Qty. of Previous Fill: 0
Database Indicator: 4
Other Prescriber Indicator: 0
Message: DAILY DOSE OVER:  1.09
Message: CLAIM ACCEPTED

Done

---

**Figure 14; Example of DUR (Drug Utilization Review)**
2.5 Resubmitting claims

Ideally, each claim gets submitted and paid on the first try. Sometimes claims have to be submitted more than once.

**Example:** A claim is rejected because of an invalid cardholder ID number. The error is corrected in RPMS Registration. The claim may then be resubmitted.

**Example:** A claim is submitted but then it's noticed that the wrong NDC number has been entered. The method of fixing this error depends on how your Point of Sale system is configured.

- If your system is configured so that the RPMS Pharmacy package does data entry, then edit the prescription, changing the NDC number. RPMS Pharmacy will instruct Point of Sale to do a reversal if necessary and then to resubmit the claim.
- Otherwise, the problem can be fixed by doing manual data entry.
  - Wait for the original claim to finish processing.
  - If the claim was payable, reverse the paid claim.
  - Use the “NEW” option. Enter the prescription number and the correct “NDC” number.

Do not resubmit claims that have not been completely processed.

2.6 Navigating Multi-page Screens and Wide Screens

**Scrolling Up and Down:** When you have lots of patients and prescriptions and they don't all fit on one screen, you will be able to see all the data by navigating the screen using the following keys in the manner listed below.

<table>
<thead>
<tr>
<th>Key</th>
<th>Command</th>
</tr>
</thead>
<tbody>
<tr>
<td>+</td>
<td>Go to the next page (in a multi-page screen)</td>
</tr>
<tr>
<td>-</td>
<td>Go to the previous page</td>
</tr>
<tr>
<td>DIS</td>
<td>Dismiss patient (as discussed previously in Section 2.3).</td>
</tr>
</tbody>
</table>

**Scrolling Left and Right:** Such as when there are rejection codes that don't fit on the available screen width.
2.7 Pharmacy Electronic Claims Reports

The second option on the User Menu, “Pharmacy Electronic Claims Reports” is presented in the Reports Section of Point of Sale documentation.

2.8 NEW Send new claims

The NEW Send new claims option is accessed from the Claims Data entry screen discussed in Section 2.1 of this manual. When you access this option by entering “New” a ScreenMan data entry screen for entering claims will display.

2.8.1 Introduction to the New Send New Claims Data Entry Screen

The data entry program is built using ScreenMan, a screen-oriented interface for editing and displaying data that is used in many other RPMS and VA applications. Figure 15 shows an example of a Claims Data Entry Screen. The parts of this screen are:

- **Data Entry Section:** The numbered rows in the middle are where you input claims data, as indicated by the column headers (Prescription, NDC, Patient, Drug, Fill Date).
- **Control Commands:** The navigation aids shown in the top right corner are some basic ScreenMan control commands.

Exit the screen in either of two ways:

- After the claims input is complete and you want to submit the claims, press <F1> followed by E. (<PF1> can be substituted for <F1>.)
- If you have done some claims input and decide you don't want to submit these claims, use <F1> Q. You will exit the input screen and no data is affected.

Controls for navigation:

- <F3> controls whether your input is in insert or overstrike mode. The active mode appears in the bottom right corner of the screen. In the example of the Claims Data Entry Screen in Figure 15, the “Insert” mode is listed as the active mode.
- <F4> moves your cursor backward one field. For example, if you are at the NDC/CPT/HCPCS column and you press <F4>, it moves your cursor back one field to the Prescription column.
- `<TAB>` moves your cursor forward one field.
- Arrow keys `<↑>`, `<↓>`, `<←>`, and `<→>` move your cursor upward can be used to move the cursor left, right, up, and down.
- `<ENTER>` completes the input for a field and moves the cursor to the next field.

**Additional Data Prompts:** In the top left corner, you will find a list of settings that control whether certain extra data will be required for the claim. These settings will be discussed later in this section.

**Command line:** If you arrive at this line, various commands like Exit and Quit are available, which are the same as the `<F1> E` and `<F1> Q`.

<table>
<thead>
<tr>
<th>Ask Insurance? NO</th>
<th>&lt;PF1&gt; E when done, to file claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask Preauth #? NO</td>
<td>PHARMACY &lt;PF1&gt; Q to quit without filing claims</td>
</tr>
<tr>
<td>Ask Qty/Price? NO</td>
<td>POINT OF &lt;PF3&gt; insert/overstrike modes</td>
</tr>
<tr>
<td>Ask Fill Date? NO</td>
<td>SALE &lt;PF4&gt; to go back one field</td>
</tr>
<tr>
<td>Ask Overrides? NO</td>
<td>DATA ENTRY Arrow keys may be used, too</td>
</tr>
</tbody>
</table>

Prescription NDC/CPT/HCPCS – Patient – – – – Drug – – – – – – – – Fill Date
1
2
3
4
5

COMMAND: [Insert]

Press <PF1>H for help

Figure 15; Example of Claims Data Entry Screen

## 2.8.2 Basic Data Entry

**Step 1:** When you access the Claims Basic Data Entry Screen, the cursor is at Line 1 in the Prescription column. Type the prescription number as shown in the example (Figure 16) and press `<ENTER>`.

<table>
<thead>
<tr>
<th>Ask Insurance? NO</th>
<th>&lt;PF1&gt; E when done, to file claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask Preauth #? NO</td>
<td>PHARMACY &lt;PF1&gt; Q to quit without filing claims</td>
</tr>
<tr>
<td>Ask Qty/Price? NO</td>
<td>POINT OF &lt;PF3&gt; insert/overstrike modes</td>
</tr>
<tr>
<td>Ask Fill Date? NO</td>
<td>SALE &lt;PF4&gt; to go back one field</td>
</tr>
<tr>
<td>Ask Overrides? NO</td>
<td>DATA ENTRY Arrow keys may be used, too</td>
</tr>
</tbody>
</table>

Prescription NDC/CPT/HCPCS – Patient – – – – Drug – – – – – – – – Fill Date
1
2
3
4

Figure 16; Example of Basic Claims Data Entry, Enter Pharmacy Number
Several things happen as a result (review Figure 17).

- The patient, drug, and fill date fields are completed for you. The most recent refill is taken.

- The cursor moves to the NDC column.

```
Figure 17: Example of Claims Basic Data Entry, After Pharmacy Number is Entered

Step 2: Type the NDC number, with or without dashes (see Figure 18). Depending on your individual site's system setup, the NDC number might default. Press <ENTER>.

```

```
Figure 18: Example of Claims Data Entry, Adding NDC Number

Step 3. Observe that the cursor moves to the Prescription column on the next line. Either enter another prescription, or use <F1> E or <F1> Q to complete the transaction.

If you wish to edit the transaction, you can return to the first line by using the <↑> key to move your cursor upward. For example, if you wanted to edit the NDC number, the <↑> key would bring you to Line 1 Prescription column. Then <TAB> would move you ahead one field to the NDC column in Line 1. Review the example in Figure 19.
```
Ask Insurance? NO  <PF1> E when done, to file claims
Ask Preauth #? NO  PHARMACY  <PF1> Q to quit without filing claims
Ask Qty/Price? NO  POINT OF  <PF3> insert/overstrike modes
Ask Fill Date? NO  SALE  <PF4> to go back one field
Ask Overrides? NO  DATA ENTRY  Arrow keys may be used, too

Prescription NDC/CPT/HCPCS - Patient - - - Drug - - - - - - Fill Date
1 `372001  00781-1883-10 SMALLEY,KAREN LEE RANITIDINE 150MG TABLET
NOV 1
2 ____________
3
4
5
6
7
8
9

COMMAND: Press <PF1>H for help
Insert

Figure 19; Example of Enter Another Prescription

When you use <F1> to submit claims, a message like this appears, as a confirmation.

Submitting claims...
SMALLEY,KAREN LEE `372001 RANITIDINE 150MG TABLET
...done.

You will then be returned to the main POS screen showing the status of the prescriptions being processed.

2.8.3 Using Bar Codes for Data Entry

The POS package allows submittal of claims via bar code scanning if your pharmacy package allows printing of bar codes on prescription labels.

2.8.4 NDC number input

NDC number input works best if your site has an up-to-date AWP MED-TRANSACTION file. When you input the NDC number, the drug name, as found in the AWP MED-TRANSACTION file, appears at the bottom of the screen as a confirmation.
2.8.5 Finding a Prescription Without the Number

In the Prescription column, type FIND to do a lookup by patient as shown in Figure 20.

![Figure 20; Example of Finding a Prescription by Patient Name]

At the next prompt, type the patient's name, or a substantial part of it as shown in Figure 21. If there are multiple matches, choose among them.

![Figure 21; Example of Selecting a Patient Name]

Then select which visit (see Figure 22). The visit dates, clinics, and count of prescriptions are shown, starting with the most recent visit. If a visit had only one prescription, the drug name is shown. Key "^" to exit without selecting a visit. (This page is not part of ScreenMan so the <F1> commands do not apply.)

![Figure 22; Example of Selecting a Visit]

If you see a prompt for Prescription or Non-prescription item, always pick P - Prescription.
If the visit had more than one prescription, the next step is to **choose which prescription** (See Figure 23).

---

**Figure 23; Example of Selecting a Prescription**

You are then brought back to the original screen as shown in Figure 24, with the data filled in as specified by your selections.

---

**Figure 24; Example of Screen with Specified Data**

### 2.8.6 Preauthorization Numbers

You will need to include preauthorization numbers on some claims as demonstrated in this example. The data entry screen is set up to do the fastest, shortest input possible, by prompting for the prescription number and NDC number.

**Step 1.** Before typing the prescription number, we need to change the "Ask preauth #" field from “NO” to “YES.” To do this, press the <↑> key to move your cursor upward to the “Ask preauth #” field and key in a “Y” shown in Figure 25. Then use the <ENTER> key or the <↓> key to get back to the Prescription column in line 1.

Type the prescription number and the NDC number as usual.
Step 2. After you type the NDC number, a **pop-up window** will appear (see Figure 26). This window is used for insurance and pricing data as well as pre-authorization. Type the pre-authorization number at the prompt.

There are two ways to get out of the pop-up window:

- The shortcut out is to press <F1> C.
- Or go through the "Done with this page?" prompt. ScreenMan will also give you a "Close" command at the bottom of the screen.

After the pop-up window is dismissed, you are returned to Line 2 to enter another claim, or press <F1> E or <F1> Q.

2.8.7 **Editing Insurance**

Change the "Ask insurance?" setting to YES. Review the procedure to change settings on the data entry screen in section 2.8.6. First, you will see a pop-up window (see Figure 27). It shows the primary insurance and you will have a chance to view/edit the order of insurance.
Ask Insurance? YES <PF1> C to close this pop-up page
Ask Preauth #? NO PHARMACY <PF1> E when done, to file claims
Ask Qty/Price? NO POINT OF <PF3> insert/overstrike modes
Ask Fill Date? NO SALE <PF4> to go back one field
Ask Overrides? NO DATA ENTRY Arrow keys may be used, too
+--------------------------------------------------------------------------+
| 1  FRANKLIN, AVIE M <PF1> C to close this pop-up page | 1  CARBAMAZEPINE 200MG TAB |
| 1  | Order (Enter 1, 2, 3 next to the Primary, Secondary, Tertiary insurances)| |
| 1  | 1st PAID PRESCRIPTIONS | |
| 1  | 2nd SMART AGENCY | |
| 1  | 3rd GENERAL HEALTH RESOURCES LTD. | |
| 1  | Total Price: $ | |
| 1  | Done with this page? YES | |
--------------------------------------------------------------------------+

Figure 27; Example of Ask Insurance Pop-up Screen

When you answer “YES,” another pop-up window appears as shown in Figure 28.

Ask Insurance? YES <PF1> C to close this pop-up page
Ask Preauth #? NO PHARMACY <PF1> Q to quit without filing claims
+--------------------------------------------------------------------------+
| 1  FRANKLIN, AVIE M | 1  CARBAMAZEPINE 200MG TAB |
| 1  Primary insurance: | Price per unit: $ |
| 1  | PAID PRESCRIPTIONS | |
| 1  | Do you want to view/edit | Qty x Price = $ |
| 1  | the ORDER of INSURANCE? NO | Dispensing Fee: $ |
| 1  | Preauthorization #: | |
|---------------------------------------------------------------------------------------------------------------|

Figure 28; Example of Second Ask Insurance Pop-up Screen

If a different insurance should be primary, navigate to its position in the Order column using the arrow keys. Key a “1” and press <ENTER>. ScreenMan will change the selected insurance to indicate “1st” and automatically adjust the order of the old 1st to be the 2nd insurance.

When done, use <F1> C to close the pop-up page. You go back to the first pop-up page, at which point you can use <F1> C again to close it.

2.8.8 Editing the Price and Quantity

Change the “Ask Qty/Price?” setting to YES. The pop-up window shown in Figure 29 will appear.
Ask Insurance? NO                          <PF1> E when done, to file claims
Ask Preauth #? YES                         PHARMACY <PF1> Q to quit without filing claims
Ask Qty/Price? YES                          POINT OF <PF3> insert/overstrike modes
Ask Fill Date? NO                           SALE <PF4> to go back one field
Ask Overrides? NO                           DATA ENTRY Arrow keys may be used, too

+--------------------------------------------------------------------------+
|   1  FRANKLIN, AVIE M <PF1> C to close this pop-up page                 |
| 1  |   AMLODIPINE BESYLATE 5MG TAB - - - - - PRICING - - - - -              |
| 2  |                                               Quantity:  60           |
| 3  | Primary insurance: Price per unit: $1.33787                             |
| 4  |                                               from PSRX-AWP            |
| 5  | Do you want to view/edit Qty x Price = $80.27                           |
| 6  |     the ORDER of INSURANCE? NO Dispensing Fee: $4.50                    |
| 7  |                                            Total Price: $84.77          |
| 8  | Preauthorization #: 12345                                               |
| 9  | Done with this page? YES                                               |
+--------------------------------------------------------------------------+

Figure 29: Example of Ask Qty/Price Pop-up Screen

You can change the quantity or the unit price and the total will be updated. When you have completed your changes, use <F1> C to close the pop-up page.

If you are going to change the quantity, it changes only the quantity billed for. The quantity dispensed, as stored in the Prescription file, is not changed. Before changing the quantity be aware of all contractual or legal implications of making an adjustment to quantity.

The "from PSRX-AWP" (shown on line 4 of Figure 29) indicates the source of the unit price. There are several possible places where pharmacy prices can be stored; the choice is made at the time Point of Sale is installed and cannot be altered here.

2.8.9 Choosing a different Fill Date

When you type a prescription number and the prescription has had refills, the Point of Sale system assumes you mean the most recent fill.

If you wish to submit a claim for an earlier fill, there are two ways of doing it:

- In the main User Screen, use EV Edit View Screen to view past Point of Sale activity for One Patient. If the claim for the earlier fill had been processed through Point of Sale, you can RES Resubmit one claim from that point, which is the easiest way to process a claim for an earlier fill.

- Use this data entry screen to select an earlier fill. Begin by changing the "Ask fill date?" setting to YES (Figure 30). After you enter the prescription number, the cursor jumps to the Fill Date column. (If the prescription has no refills, the cursor will just go directly to the NDC field, even if you set "Ask fill date" to YES.)
Figure 30; Example of Editing Ask Fill Date

- If you know the exact fill date for which you want to process the claim, type it here. The date must be one of the fill dates already on file for this prescription. This screen cannot be used to change the fill dates stored in the Prescription File. The date can be typed in any acceptable RPMS form, such as 10/29 or OCT 29, etc.

- If you do not know the exact fill date, type FIND. The dialogue leads you through selecting a fill date, as shown in Figure 31.

Figure 31; Example of Find when Editing Ask Fill Date

2.8.10 Overrides

There are dozens of fields defined by the NCPDP, any of which might be required by a particular insurer to fulfill a claim. Not all of these fields can be obtained from RPMS or Pharmacy databases.

In the rare instance that you need to send a different value for any of these fields, change the "Ask overrides?" setting to YES as shown in Figure 32.
Figure 32; Example of Ask Overrides Pop-up Screen

How do you know if you need to override an NCPDP field value in order to get a claim to be payable? It would happen in an extraordinary circumstance, probably at the direction of the insurance company's Help Desk. For example, suppose that you had to send a value of “3” in the Dispense As Written field. The pop-up page is shown in Figure 33.

For NCPDP FIELD, type the field name or number. Then type the value in the second column.

Figure 33; Example of Dispense as Written Field

Use <F1> C to close the page when you have completed the transaction.

For a complete list of NCPDP field numbers and names, use the Reports menu (RPT), Other reports (OTH), and List NCPDP Fields (FLD).
3.0 **Manager Menu**

The Manager Menu allows you to setup the Point of Sale system with options that are specific to your site and to maintain pricing and insurance data. The ellipsis (…) following the menu option indicates that this option opens with a sub-menu. Enter a question mark (?) at any prompt to obtain a help menu.

3.1 **Pharmacy POS Manager Menu**

The *Pharmacy POS Manager Menu* is accessed from the core menu. Option “MGR” will produce the following sub-menu shown in Figure 34.

```
SET    Pharmacy Point of Sale Setup Menu ...
MGR    Statistics & misc. options screen...
RPT    Pharmacy electronic claims reports ...
COMM   Communications - View Dial Out Log File
BACK   Pharmacy POS background scan ...
USER   Claims data entry screen...
TEST   Test it (send claim, receive response)
```

Select Pharmacy POS Manager Menu Option:

Figure 34; Pharmacy POS Manager Menu

3.2 **Pharmacy Point of Sale Setup Menu**

The *Pharmacy Point of Sale Setup Menu* is accessed from the POS Manager Menu. Option “MGR” will produce the following sub-menu shown in Figure 35.

```
BAS    Edit basic pharmacy POS parameters
DIAL   Edit pharmacy POS dial out settings ...
PHAR   Edit pharmacy POS pharmacy data
INS    Edit Pharmacy POS Insurance settings ...
USER   Edit pharmacy POS user preferences
BILL   Unbillable/Billable POS items menu ...
PRI    Enter/edit Pricing formulas
MISC   Miscellaneous setup programs ...
PROV   Enter/Edit providers' ID #s
SETS   POS Setup - Summary of Insurers
SETD   POS Setup - Detailed Report
```

Figure 35; Pharmacy Point of Sale Setup Menu
### 3.2.1 Edit Basic Pharmacy POS Parameters

The **Edit Basic Pharmacy POS Parameters Option** is accessed from the Pharmacy Point of Sale Setup Menu. Select option “BAS” for a series of prompts to scroll through.

There are three ways to input data to Point of Sale:

- **Manual**: Claims are input on the data entry screen, often with a bar code scanner. The input is done separately from the RPMS Pharmacy, after the RPMS data entry is complete.

- **RPMS RX CALLS POS**: The RPMS Pharmacy package has been enhanced so that pharmacy package functions (such as filling, editing, refilling) automatically make requests for claims and claim reversals.

- **Background Scanner of PSRX**: A background job in the Point of Sale package monitors the prescription file for released and canceled prescriptions. The background job initiates claims and claim reversals as appropriate.

Choose a default dial out: This is the destination to which your insurance claims are sent. This is either going to be the WebMD (Envoy) switch or the NDC switch. A purchase order agreement with a switch company should already be in place.

For most IHS sites the appropriate answer is **ENVOY DIRECT VIA T1 LINE**. Some sites might use modems to send claims.

For **modem use only**: Answer with “?” to see a list of all the possible dial outs. If your switch offers a variety of (800) numbers, choose any one; the one selected should not affect the data transmission. If your switch offers a choice between (800) numbers and a local 950 number, choose the 950 number if offered in your area. The switch’s Help Desk can tell you whether the 950 number is available in your area.

---

**How will data be input to Point of Sale?: //**

<table>
<thead>
<tr>
<th>Choose from:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 MANUAL</td>
<td></td>
</tr>
<tr>
<td>1 RPMS RX CALLS POS</td>
<td></td>
</tr>
<tr>
<td>2 BACKGROUND SCANNER OF PSRX</td>
<td></td>
</tr>
</tbody>
</table>

**What is the default dial-out to send claims to?: //**

**Answer with ABSP DIAL OUT NAME**

<table>
<thead>
<tr>
<th>Choose from:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ENVOCO (800) 669-0099</td>
<td></td>
</tr>
<tr>
<td>ENVOCO (800) 683-3437</td>
<td></td>
</tr>
<tr>
<td>ENVOCO (800) 854-5417</td>
<td></td>
</tr>
<tr>
<td>...ENVOCO DIRECT VIA T1 LINE</td>
<td></td>
</tr>
<tr>
<td>NDC (800) 654-4518</td>
<td></td>
</tr>
</tbody>
</table>
Dialing outside the facility: If you are using a modem to send claims, the modem needs to dial a toll free number to communicate with the switch. Indicate here what number needs to be dialed to obtain an outside line. Often times this is a 9.

To get an outside line, what number should be dialed?:

Accounts Receivable System: If your Point of Sale system is going to interface to an Accounts Receivable Application, please specify which Accounts Receivable package will be used.

- If you use the RPMS 3rd Party Billing Package and you will be using the Point of Sale interface to that billing package, answer the prompt with 3RD PARTY BILLING.
- If you do not want the RPMS 3rd Party Billing Package to interface with the Point of Sale package, answer NONE at the prompt.
- If you are using an Accounts Receivable Billing Package other than the RPMS 3rd Party Billing/AR package, contact the RPMS Support Center for information regarding a POS interface.

What Accounts Receivable system is used?: //

The Standard Pricing Formula: A price is calculated by taking the UNIT PRICE times some MULTIPLIER plus a DISPENSING FEE. The values you specify here become your STANDARD pricing formula. Different pricing formulas can be set up later; specify on the Standard pricing formula at this time.

- Unit Price of a drug: There are various places where the unit price of a drug is found. The answer to this question should be known from the pre-installation planning for Point of Sale installation (see Appendix D).
- Multiplier: Usually this is 1 (for 100%) or a decimal value very close to 1, such as .95 (for 95%).
- Dispensing Fee: Enter the dollars and cents amount of the dispensing fee charged by your pharmacies.

Where do we find the UNIT PRICE of a drug?: //
Choose from:

<table>
<thead>
<tr>
<th>APSAMDF</th>
<th>AWP MED TRANSACTION FILE (Most Commonly Used)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSCPT</td>
<td>ILC A/R CHARGE FILE</td>
</tr>
<tr>
<td>PSDRUG-PPDU</td>
<td>DRUG FILE PRICE PER DISPENSE UNIT</td>
</tr>
<tr>
<td>PSDRUG-AWPPDU</td>
<td>DRUG FILE AWP PER DISP UNIT</td>
</tr>
<tr>
<td>PSRX-UNIT</td>
<td>PRESCRIPTION FILE UNIT PRICE</td>
</tr>
</tbody>
</table>
3.2.2  Edit Dial Out Settings

The Edit Pharmacy POS Dial Out Settings Menu is accessed from the POS Manager Menu (review Section 3.2). Option “DIAL” will produce the sub-menu shown in Figure 36.

<table>
<thead>
<tr>
<th>BAS</th>
<th>Basic settings for POS dial out</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEF</td>
<td>Select default destination for claims</td>
</tr>
<tr>
<td>ADV</td>
<td>Advanced settings for POS dial out</td>
</tr>
</tbody>
</table>

Figure 36; Edit Pharmacy POS Dial Out Setting Menu

3.2.2.1 Basic Settings for POS Dial Out Using Direct T1 line to Envoy

Basic settings will suffice for almost all situations. The Basic Settings for POS Dial Out menu is located on the Edit Pharmacy POS Dial Out Settings Menu (review section 3.2.1). Select option “BAS” for a series of prompts to scroll through. If the basic option does not satisfy your needs, contact your system manager for information on options “DEF” and “ADV.” Option “RPMS” is discussed in Section 3.2.5.4.

If you are sending all your claims using the ENVOY DIRECT VIA T1 LINE dial out, the only question that matters is the connection type question. Leave all others blank.

- **Connection Type:**

  CONNNECTION TYPE: IP ADDRESS TCP// 3  T1 LINE TO ENVOY

  Choose from:
  
  1. TRADITIONAL MODEM
  2. IP ADDRESS TCP
  3. T1 LINE TO ENVOY

- **Device Number:** Enter the Mumps device number for a “Traditional Modem” configuration, this is the device number you assigned to the modem during Mumps Sysgen. For a “IP Address TCP” configuration in MSM, this is usually device number 56. Note that this device need not be set up in the RPMS Device Table.

- **IP Address:** Enter the IP address of the T1 connection, if necessary.

- **TCP Port Number:** Enter the port number of the T1 connection.
3.2.2.2 Basic Settings for POS Dial Without Using Direct T1 line to Envoy

The Basic Settings for POS Dial Out menu is located on the Edit Pharmacy POS Dial Out Settings Menu (review section 2.1.3). Select option “BAS” for a series of prompts to scroll through. If the basic option does not satisfy your needs, contact your system manager for information on options “DEF” and “ADV.” Option “RPMS” is discussed in Section 3.2.5.4.

Set up information about the modem being used to send claims:

- **Modem Type:** Answer with “?” to see a list of the modem types supported. If your exact modem type appears in the list, choose it.
  - Avoid choosing any of the 1200 (as in 1200 baud) entries. These should only be used for special situations. (Please call the RPMS Support Center for information)
  - Avoid choosing on the generic entries. If you choose one of the generics, such as MULTITECH GENERIC, be advised that it is not necessarily going to work for any Multitech modem.
- **Baud Rate:** The answer should always be 2400.
- **Connection Type:** If your modem is connected directly to your RPMS machine, choose “Traditional Modem.” If the modem is connected to an IP Address, choose “IP Address TCP.”

```
CONNECTION TYPE: IP ADDRESS TCP// ?
Choose from:
1        TRADITIONAL MODEM
2        IP ADDRESS TCP
```

- **Device Number:** Enter the Mumps device number for a “Traditional Modem” configuration, this is the device number you assigned to the modem during Mumps Sysgen. For a “Terminal Service TCP” configuration in MSM, this is usually device number 56. Note that this device need not be set up in the RPMS Device Table.
- **IP Address:** Enter the IP address. (The IP Address name may appear as an option.
- **Server Port Name:** Enter the IP Address port name to which the modem is attached (e.g., TCP PORT NUMBER: 3002//).
- **Default Dial Out:** This is the same setting as described previously (e.g., ENVOY (800) 669-0099//).

3.2.3 Edit POS Pharmacy Data

The Edit Pharmacy POS Pharmacy Data is accessed from the POS Manager Menu. Option “PHAR” will display a series of prompts to scroll through.
The first step is to get a list of your RPMS Pharmacy system’s Outpatient Sites. One way to do this is to use FileMan. See the example in Figure 37.

```
VA FileMan 21.0
Select OPTION: PRINT FILE ENTRIES
OUTPUT FROM WHAT FILE: 59 OUTPATIENT SITE (4 entries)
SORT BY: NAME//
START WITH NAME: FIRST//
FIRST PRINT FIELD: NAME
THEN PRINT FIELD:

*************************
Heading (S/C): OUTPATIENT SITE LIST Replace
DEVICE: Right Margin: 80//
OUTPATIENT SITE LIST NOV 6,2000 06:33 PAGE 1
NAME
-------------------------------------
CHEM
PARKER
PEACH SPRINGS
SUPAI

Figure 37; Example of FileMan Outpatient Site List
```

In general, set up one Pharmacy entry for each Outpatient Site. You may simplify things and group more than one Outpatient Site under the same Pharmacy if those Outpatient Sites are considered to be one pharmacy by all outside agencies. That is, you may group Outpatient Sites together under a single entry if all of the following are true.

- They have the same NCPDP number (which means they are considered to be a single pharmacy from the viewpoint of most private insurance companies).
- They have the same WebMD (Envoy) Terminal ID (which means they are considered to be a single pharmacy from the viewpoint of the switch).
- They have the same Medicaid Pharmacy number (which means that they are considered to be a single pharmacy from the viewpoint of the Medicaid FI.

In this example, PARKER, SUPAI, and CHEM appear under one pharmacy entry. But PEACH SPRINGS has a different NCPDP number, so it is set up as a different POS Pharmacy. This is true whether the multiple pharmacies are within the same locale or in different cities.

- **Pharmacies Name:** Usually this will be the same as the Outpatient Site. If you have more than one Outpatient Site grouped under the same NCPDP number, pick any one, usually the main one, to use as the name here.
**Outpatient Site**: One or more of the RPMS pharmacy package's “Outpatient Sites” (File 59) must be associated with this POS pharmacy entry. Enter the names of all the Outpatient Sites that go under this Pharmacy entry. For example:

| Select ABSP POINT OF SALE PHARMACIES NAME: PARKER |
| Select ABSP POINT OF SALE PHARMACIES NAME: SUPAI |
| Select ABSP POINT OF SALE PHARMACIES NAME: CHEM |
| Select ABSP POINT OF SALE PHARMACIES NAME: |

**WebMD (Envoy) Terminal ID**: If you are transmitting claims via the WebMD (Envoy) switch, this number is required. It is assigned by WebMD (Envoy) following the submission of the purchase order. If you do not know your WebMD (Envoy) Terminal ID number call the WebMD (Envoy) Help Desk at (888) 545-6127.

**NCPDP Number**: This is a number assigned to your pharmacy by the NCPDP. It used to be called the NABP number.

**DEFAULT DEA #**: Many insurers require the prescriber's DEA number as part of the claim. If your pharmacy has a DEA # that may be used in case a prescriber doesn't have his DEA # on file with you, enter that default DEA # here.

**Medicaid #**: If you are sending claims to your state's Medicaid program, and Medicaid has assigned a special Medicaid pharmacy number to your pharmacy, enter that number here. It is usually required as part of the Medicaid claim.

**Default Medicaid Provider #**: Usually, Medicaid assigns ID numbers to prescribers and those numbers must be sent as part of a Medicaid claim. If you have a default number which may be used when you don't have a provider's Medicaid number on file enter that number here.

**Insurer-Assigned #**: Usually, private insurance claims require the NCPDP #. But if any insurers have special numbers assigned to your pharmacy to be used on their claims, then enter those insurers and the numbers they assigned to you.

### 3.2.4 Edit Insurance Settings

The *Edit Pharmacy POS Insurance Settings Menu* is accessed from the POS Manager Menu. Selection of option “INS” will produce the sub-menu shown in Figure 38.

<table>
<thead>
<tr>
<th>SYS</th>
<th>Insurance selection parameters (system-wide)</th>
</tr>
</thead>
<tbody>
<tr>
<td>INS</td>
<td>Quick setup of insurer</td>
</tr>
<tr>
<td>ADV</td>
<td>Advanced setup of insurer</td>
</tr>
<tr>
<td>RPMS</td>
<td>Enter/edit RPMS Insurance file RX settings</td>
</tr>
<tr>
<td>SUM</td>
<td>POS Setup - Summary of Insurers</td>
</tr>
</tbody>
</table>

*Figure 38; Edit Pharmacy POS Insurance Selection Parameters*
3.2.4.1 Insurance Pharmacy POS Selection Parameters (System-Wide)

The Insurance Selection Parameters (system-wide) is accessed from the Edit Insurance Selection Parameters Menu. Selection of option “SYS” will lead you to a series of prompts to scroll through.

- **Grace Period**: The insurance selection "grace period" allows a prescription to be filled beyond the coverage expiration date. This is a system-wide default setting; you can override it on an insurer-by-insurer basis.
  - How insurance is selected: Point of Sale selects insurance by looking at the RPMS Registration data and assigning a point value to each coverage a patient has. Based on these scores, Point of Sale chooses primary, secondary, and tertiary insurance for billing a prescription. The insurance selection criteria include:
  - Points for the type of insurance: Medicaid, private, Medicare, Railroad, and self pay/uninsured.
  - Points based on applying certain other rules to choose from among private insurers.
  - Points for particular insurers.
  - The insurer added most recently to the patient’s registration record.
    - Enter the base scores for each insurance type. For example, if private insurance is primary, Medicare is secondary, and Medicaid is tertiary, then you might give private insurance 900 points, Medicare 600 points, Medicaid and Railroad each 300 points and self pay 100 points. For example:

<table>
<thead>
<tr>
<th>INS BASE PRVT:</th>
<th>900</th>
</tr>
</thead>
<tbody>
<tr>
<td>INS BASE CARE:</td>
<td>600</td>
</tr>
<tr>
<td>INS BASE CAID:</td>
<td>300</td>
</tr>
<tr>
<td>INS BASE RR:</td>
<td>300</td>
</tr>
<tr>
<td>INS BASE SELF:</td>
<td>100</td>
</tr>
</tbody>
</table>

- **Additional Insurance Rules**: Select any additional insurance rules that might be needed for distinguishing among private insurers.

Do you want to see a list of all the AVAILABLE rules? NO// YES

DEVICE: HOME;80;999

All of the available INSURANCE SELECTION RULES

<table>
<thead>
<tr>
<th>NAME</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>

Some of the available insurance selection rules are shown in Figure 39.
<table>
<thead>
<tr>
<th>Rule</th>
<th>Description</th>
<th>Necessary Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthday Rule (2 Parents)</td>
<td>If a child is covered by policies from two parents’ employment, the policy through the parent whose birthday comes first in the calendar year is the one that takes precedence.</td>
<td>The relationship to policyholder, the policy holder employer, and the policy holder date of birth are critical to making this rule work as intended. If a policy holder date of birth is missing, a midyear date will be used.</td>
</tr>
<tr>
<td>Employment Before Private Insurance</td>
<td>If insurance through employment takes precedence over insurance through private purchase, select this rule.</td>
<td>Currently Disabled. While this rule still appears in the insurance rule selection process, its functionality is disabled at this time. Selection and assigning of this rule will not effect the determination of insurance at the claim generation level.</td>
</tr>
<tr>
<td>Employment Before Spouse Insurance</td>
<td>If insurance through your employment is to take precedence over insurance under a spouse's employment coverage, select this rule.</td>
<td>Currently Disabled. While this rule still appears in the insurance rule selection process, its functionality is disabled at this time. Selection and assigning of this rule will not effect the determination of insurance at the claim generation level.</td>
</tr>
<tr>
<td>Policy Holder is Self</td>
<td>This rule can be used to assign bonus points to policies where the policyholder is SELF.</td>
<td>Beware of how this rule may interact with the EMPLOYMENT BEFORE PRIVATE INSURANCE rule; it’s important to choose an appropriate value when using both rules simultaneously.</td>
</tr>
<tr>
<td>Workers Comp Rule</td>
<td>Visits may be marked as work-related (V POV file has data).</td>
<td>Insurers may be marked as worker's comp only, never, or both worker's comp and non-worker's comp claims (ABSP POINT OF SALE INSURER file has data). This rule takes these settings into consideration and adjusts the order of insurance accordingly.</td>
</tr>
</tbody>
</table>

Figure 39; Table of Insurance Rules

Select any additional insurance rules that might be needed for distinguishing among private insurances.

Do you want to see a list of the rules that are IN USE now? NO/

Usually, the plus points value for a rule is about 10 or 20 and the minus points value is 0. The INS RULE ORDER tells what order the rules are applied, from low to high. 10, 20, 30, etc. are good choices for ORDER.
Select INS RULE ORDER:
Do you want to go back and edit the rules again? NO//

- **Extra Points for Specific Insurers:** If there is a particular insurance which should always be given extra points, plus or minus, use the Advanced setup of insurer and put the assigned number of points in the RX PRIORITY field. For example, if your site has a special rule that says AMALGAMATED INSURANCE is always to be chosen above any other coverage, then you could assign 1000 points to that company and it would always show up at the top of the list.

This concludes the system-wide insurance setup. There is another setup program to setup specific insurers with their electronic formats, insurance selection settings, grace period override, etc.

### 3.2.4.2 Quick Setup of Insurer

The *Quick Setup of Insurer* is accessed from the Edit Insurance Selection Parameters Menu. Selection of option “INS” will produce a series of prompts to scroll through.

The quick setup of insurer is all you need to start sending claims to a particular insurer. Before doing this, be sure to have the necessary contracts in place. Also, be sure that the insurer’s NCPDP Record Format is supported by Point of Sale.

For a comprehensive list of the available formats, including the WebMD (Envoy) plan numbers, use RPT/OTH/FMT.

At the NCPDP Record Format question, you may answer with the WebMD (Envoy) plan number of the BIN number, as well as the record format name.

Note that all of the state Medicaid format names have the state first, such as NEW MEXICO MEDICAID< OKLAHOMA MEDICAID, etc. The Blue Cross Blue Shield insurers are names as “BC/BS” followed by the state name, such as BC/BS ARIZONA.

Sometimes the format name might not match the insurer name. For example, OPTIONS HEALTH CARE uses the format KAISER PERM> OPTIONS CLASSIC. You can always ask the insurer for the WebMD (Envoy) plan number. The BIN number might help to find the right plan, but ultimately you may need to know the plan number, since several plans can have the same BIN.

Contact the RPMS Support Center to make requests for new formats. See also option “INS” *Survey Insurers by Frequency* in the “SURV” *Surveys of RPMS Database* on the Reports Menu to probe your system and see which insurers are used most often by your patients.
For the Pricing Formula most insurers will be linked to the Standard Pricing Formula. If you have a different pricing policy for a particular insurer, setup the special pricing formula and then setup the insurer. (See section 2.1.8 for details on setting up different pricing formulas).

<table>
<thead>
<tr>
<th>Select ABSP POINT OF SALE INSURER NAME: ?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answer with ABSP POINT OF SALE INSURER NAME</td>
</tr>
<tr>
<td>Choose from:</td>
</tr>
<tr>
<td>BC/BS OF ARIZONA INC.</td>
</tr>
<tr>
<td>BC/BS OF AZ.-PPO</td>
</tr>
<tr>
<td>BC/BS OF AZ.=PPO</td>
</tr>
</tbody>
</table>

You may enter a new ABSP POINT OF SALE INSURER, if you wish

<table>
<thead>
<tr>
<th>Answer with INSURER NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you want the entire 1022-Entry INSURER List? N (No)</td>
</tr>
<tr>
<td>Select ABSP POINT OF SALE INSURER NAME: BC( BLUE CROSS/CROSSE )</td>
</tr>
</tbody>
</table>

The following matches were found:

1: BC/BS OF ARIZONA INC.: P.O. BOX 1200 Domain: AZ
   PHOENIX, AZ 85001-1200
2: BC/BS OF AZ.=PPO: 3404 W. CHERYL DR.,SUITE 280
   PHOENIX, AZ 85051-9588

Select 1-2: 1

Select the electronic claim FORMAT

| RX - NCPDP Record Format: BC/BS OF AZ// |

Select the PRICING METHOD

| RX - PRICING METHOD: STANDARD// |

Select ABSP POINT OF SALE INSURER NAME:

### 3.2.4.3 Advanced Setup of Insurer

The *Advanced Setup of Insurer* is accessed from the Edit Pharmacy POS Insurance Selection Parameters Menu (review Section 3.2.1). Select option “ADV” to begin the process.

Advanced Setup of Insurer is seldom needed. Some examples of when it might be used are setting a special dispensing fee or grace period for a particular insurer. Contact the RPMS Support Center for assistance.

### 3.2.4.4 Enter/edit RPMS Insurance file RX settings

The *Enter/edit RPMS Insurance File RX Settings* option is accessed from the Edit Pharmacy POS Insurance Selection Parameters Menu (review Section 3.2.5). Option “RPMS” will produce a series of prompts to scroll though.
The RPMS Insurer file has a field named RX BILLING STATUS. Pharmacy Point of Sale uses this field to determine whether the insurer can be billed for pharmacy. If the value is U, then Pharmacy Point of Sale will never select this insurer. If the value is O (letter O) or blank, then the insurance could be selected.

The example on the top of the following page shows how to mark Medicare as unbillable for pharmacy.

```
Select Edit Pharmacy POS Insurance settings Option: 4 Enter/edit RPMS Insurance file RX settings
Select INSURER NAME: MEDICARE
The following matches were found:
1: MEDICARE - PO BOX 833913
   RICHARDSON, TX 75083-3913
2: ...
Select 1-6: 1
RX BILLING STATUS: // U UNBILLABLE
```

3.2.4.5 POS Setup - Summary of Insurers

The POS Setup – Summary of Insurers is accessed from the Edit Pharmacy POS Insurance Selection Parameters Menu (review Section 3.2.5). Option “SUM” will produce a report that shows which insurers are configured for electronic claims. Review an example of this report in Section 5.2.2 of the Report Manual.

3.2.5 Edit Pharmacy POS User Preferences

The Edit Pharmacy POS User Preferences is accessed from the POS Manager Menu. Option “USER” is seldom needed. If you do manual input of Point of Sale claims and you want to change the defaults of the data entry screen, use this option to make those changes.

3.2.6 Unbillable/Billable POS Items Menu

The Unbillable/Billable POS Items Menu is accessed from the POS Manager Menu. Selection of option “BILL” produces the sub-menu shown in Figure 40. There are three ways to specify billable or unbillable drugs.

```
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>OTC</td>
<td>Set billable status of OTC drugs</td>
</tr>
<tr>
<td>NDC</td>
<td>Enter/edit unbillable NDC #s</td>
</tr>
<tr>
<td>NAME</td>
<td>Enter/edit unbillable drug names</td>
</tr>
</tbody>
</table>
```

Figure 40; Edit Pharmacy POS Insurance Selection Parameters Menu
3.2.6.1 Set Billable Status of OTC drugs

The *Set Billable Status of OTC Drugs* option is accessed from the Unbillable/Billable POS Items Menu. Option “OTC” enters the setting that determines whether OTC drugs are Unbillable.

The selection of OTC (over the counter) drugs as unbillable is the most common option. This checks the DRUG file, Field 3 (DEA, SPECIAL HDLG). If the field contains a ‘9’, then the drug is an OTC for the purposes of Point of Sale. Respond to the following prompts and press <enter>.

<table>
<thead>
<tr>
<th>UNBILLABLE OTC: ?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choose from:</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

If you set OTC drugs to be unbillable but a certain insurance company does accept claims for OTC drugs, you can set that one insurer's record to say that the OTCs are billable. This is for situations where an insurer has a different policy on OTCs.

3.2.6.2 Enter/edit unbillable NDC #'s

The *Enter/edit unbillable NDC #'s* option is accessed from the Unbillable/Billable POS Items Menu. Option “NDC” provides entry to this module.

You can specify billable/unbillable status for NDC numbers. The NDC numbers you enter must be 11 digits, without the dashes. First, enter NDC numbers that are unbillable, system-wide

Select UNBILLABLE NDC #:

Now, enter NDC numbers that are unbillable/billable for specific insurers.

Select ABSP POINT OF SALE INSURER NAME:

**Note:** If the system-wide rule says the drug is billable, then only the insurer's unbillable test is made; and conversely, if the system-wide test says unbillable then only the insurer's billable test is made.
3.2.6.3 Enter/edit unbillable drug names

The Enter/edit unbillable Drug Names option is accessed from the Unbillable/Billable POS Items Menu. Selection of option “NAME” will produce the prompts for setup. Drugs can be marked as billable/unbillable by the drug name. Contact the RPMS Support Center for assistance.

<table>
<thead>
<tr>
<th>***** Name-based rules for billable insurances *****</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Mumps IF commands to set $T true or false (True means Unbillable if you're entering Unbillable rules; True means Billable if you're entering Billable rules). The variable X contains the drug name, converted to uppercase.</td>
</tr>
</tbody>
</table>

3.2.7 Enter/Edit Pricing Formulas

The Enter/Edit Pricing Formulas is accessed from the POS Manager Menu. Selection of option “PRI” produces a series of prompts to scroll through.

The Point of Sale system has a STANDARD pricing policy. When Point of Sale is first installed, you have only the STANDARD pricing formula. You can have different pricing policies based on insurer. If you want an entirely different pricing policy for a particular insurer, create the formula here and then edit the insurer's record to link it to the pricing policy.

If you want the Standard pricing policy but just a different dispensing fee for a particular insurer, you do NOT need a separate pricing formula. You can do an advanced edit of the insurer and enter a different dispensing fee there.

Do you want to see a report of the pricing formulas you have set up now?
NO/

Select ABSP POINT OF SALE - PRICING TABLES NAME: STANDARD

The pricing policy named STANDARD is the default one. Enter the unit price of a drug. You may enter a “?” for a list of choices.

The most common selections are:
APSAMDF - if you have the AWP MED-TRANSACTION file with regular updates (Most Commonly Used)
PSRX-AWP - if you are using the pharmacy package w/direct POS interface
PSRX-UNIT - if you are using the Prescription file, UNIT PRICE OF DRUG

UNIT PRICE SOURCE: PSRX-UNIT/

FORMULA can be LINEAR: multiply unit price by quantity
STEP: bring up unit price to the next 'step' value before multiplying.
Right now, only LINEAR is supported
Indicate the multiplier you would like. If you want to take the unit price as is, then answer with 1, which is the same as 100% of unit price. If you want to take 95% of the unit price, such as if you are charging 95% of the AWP, answer with .95. Other multipliers can be entered, similarly depending upon your contract agreements.

MULTIPLIER: 1/

Finally, add on the dispensing fee.

DISPENSING FEE: 4.50/
DESCRIPTION:
1>The STANDARD pricing formula is always used unless an insurer is specifically marked for a different pricing formula.
2>specifically marked for a different pricing formula.
EDIT Option:

This completes the editing of the STANDARD pricing formula. This formula applies to all claims, both electronic and paper, unless the insurer has been specifically marked with some different pricing formula.

To mark an insurer with a particular pricing formula go to the Manager menu, then the Setup menu, then the Insurance. Select the Advanced setup and put the name of the pricing formula in the field named RX - PRICING METHOD.

3.2.8 Miscellaneous Setup Programs

The Miscellaneous Setup Programs Menu is accessed from the POS Manager Menu. Selection of option “MISC” produces the sub-menu shown in Figure 41.

OK Parameters for Oklahoma Medicaid

Figure 41; Miscellaneous Setup Programs

3.2.8.1 Parameters for Oklahoma Medicaid

The Parameters for Oklahoma Medicaid Option is accessed through the Miscellaneous Setup Programs Menu. This option configures some special parameters for Oklahoma Medicaid. You should use the following values:

Select ABSP SETUP NAME: `1 (` is above the TAB on many keyboards)
OK MEDICAID INSURANCE NAME: OKLAHOMA MEDICAID
OK MEDICAID LIMIT: 3
OK MEDICAID CYCLE (SECONDS): 15
3.2.9 Enter/Edit providers’ ID #s

The Enter/Edit Providers’ ID #s is accessed from the POS Manager Menu. Option “PROV” prompts for a provider’s name and then presents the provider ID number fields from the RPMS New Person file.

Select NEW PERSON NAME: SMITH, JOHN
DEA#: Enter/edit ID numbers as appropriate.
MEDICAID PROVIDER NUMBER:
UPIN NUMBER:
MEDICARE PROVIDER NUMBER:

3.2.10 POS Setup – Summary of Insurers

The POS Setup – Summary of Insurers is accessed from the POS Manager Menu. Option “SETS” produces a list of insurers set-up for electronic claims at your site, grouped by Dial Out and then by electronic claims format within each Dial Out. Review the example shown in Figure 42.

PHARMACY ELECTRONIC CLAIMS INSURERS  DEC 7,2000  12:39  PAGE 1

<table>
<thead>
<tr>
<th>Ins.</th>
<th>Disp Fee</th>
<th>Per</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sel.</td>
<td>Pricing Formula</td>
<td>Override Override</td>
</tr>
<tr>
<td>Insurer</td>
<td>Pts.</td>
<td></td>
</tr>
</tbody>
</table>

-----

===== DIAL OUT to: ENVOY (800) 669-0099
Using electronic FORMAT: OKLAHOMA MEDICAID
MEDICAID STANDARD
OKLAHOMA MEDICAID STANDARD

Figure 42; Example of the Summary of Insurers Report

3.2.11 POS Setup – Detailed

The POS Setup - Detailed is accessed from the POS Manager Menu. Selection of option “SETD” produces a report showing the configuration setup of your site. An example is shown in Figure 43.

2128.12 UNBILLABLE DRUG NAME:

----- Miscellaneous other settings -----  
1501 OUTSIDE LINE: 9

Also included in this report:
A printout of file 9002335.55: ABSP POINT OF SALE - DIAL OUT
A printout of file 9002335.54: ABSP POINT OF SALE - MODEM TYPES
A printout of file 9002335.53: ABSP POINT OF SALE - PRICING TABLES
(There are no specific settings for individual users.)

DEVICE: Right Margin: 80//

...SORRY, JUST A MOMENT PLEASE...

POINT OF SALE - DIAL OUT LIST  OCT 31,2000  07:56
PAGE 1

-----------------------------------------------------------------------------------------------
NAME: DEFAULT  MODEM TYPE: MULTITECH MT5600xx
DESCRIPTION:
This is the default dial-out. It should be set up to match the site's primary POS modem's characteristics. Use 9002335.99 field 440.01, DEFAULT DIAL-OUT, to point to the specific dial-out to be used for filling in any blanks - primarily the phone number.
-
The reason for this field is so that you don't have to fill in the dial-out field on all the individual insurers.
BAUD RATE: 2400  DEVICE #: 56
CONNECTION TYPE: IP ADDRESS TCP  IP ADDRESS: 161.223.196.27
TCP PORT NUMBER: 3002

NAME: ENVOY (800) 669-0099  SWITCH TYPE: ENVOY
DESCRIPTION:
Tranxact 2400 baud available in all states
PHONE #: 18006690099

DEVICE: Right Margin: 80//

...HMMM, HOLD ON...

-----------------------------------------------------------------------------------------------
NAME: MULTITECH MT5600xx  CONNECT MESSAGE: CONNECT 2400
WRITE NEWLINE AFTER COMMAND: YES
INITIALIZATION STRING:
AT&F0E0Q0V1X4&E0&E3&K0%C0\N0$SB2400+MS=2,0,2400,2400,,
2400
QUERY FOR STATUS: ATI0+MS?&V0
QUERY LOOK FOR OK: YES

NAME: U.S. ROBOTICS Courier 2400e  CONNECT MESSAGE: CONNECT
WRITE NEWLINE AFTER COMMAND: YES
INITIALIZATION STRING: ATEOF1V1&B0&H0&I0&M0&N0S9=3
OTHER SETUP INFO: E0 - Command mode echo off F1 - Local echo off once a connection has been established V1 - Result codes Verbal mode &B0 - rate detected from AT command (?) (B3 would be 1200, B4 2400) &H0 - Flow control disabled (Transmit data) &I0 - Flow control disabled (Received data) &M0 - Normal mode (normal or error control modes) (what does ARQ mean?) &N0 - Normal link operations (N2 1200 baud, N3 2400 baud) S9=3 - tenths of a second needed to recognize connection made
QUERY FOR STATUS: ATI4  QUERY TIMEOUT: 5
QUERY LOOK FOR OK: YES

DEVICE: Right Margin: 80//

...SORRY, LET ME PUT YOU ON 'HOLD' FOR A SECOND...
3.3 Statistics and Miscellaneous

The Statistics and Miscellaneous menu is accessed from the POS Manager Menu. Selection of option “MGR” will produce a screen showing communications statistics and claims status. Please refer to the Statistics and Miscellaneous section of this manual for a detailed discussion of this menu option.

3.4 Pharmacy Electronic Claims Reports

The Pharmacy Electronic Claims Reports menu is accessed from the POS Manager Menu. Selection of option “RPT” will produce the report sub-menu shown in Figure 44. Refer to the Reports Menu section for a detailed discussion of reports.

Figure 43; Example of Detailed POS Setup

Figure 44; Pharmacy Electronic Claims Reports Menu
3.5 Communications - View Dial Out Log File

The *Communications – View Dial Out Log File* option is accessed from the POS Manager Menu (review Section 3.1).

Point of Sale maintains log files of its modem communications. This can be of use in diagnosing modem and communications problems. It asks for which Dial Out, and an output device. The most recent log file is printed. At the end of the report, you have option to look at the previous log file, and then the one before that, and so on. An example of the report is shown on the following page in Figure 45.

| DISPLAY log file for which Dial Out: ENVOY (800) 669-0099// |
|-------------------------|-------------------------|
| DEVICE:                 |                         |
| 16:03:25 NOV 30,2000@16:03:25 58408,57805 3001130.160325 946.1 |
| Sender/Receiver Job 5 begins; DIALOUT=3 |
| ABSPOSAB - MODEM - OPEN - device 128 |
| ABSPOSAB - MODEM - E0 to turn echo off |
| ABSPOSAW - MODEM - Waiting for string OK |
| ABSPOSAW - MODEM - WAITSTR - Received expected OK |
| 16:03:26 ABSPOSAB - MODEM - FLUSH - 2 byte(s) - \013\010 |
| ABSPOSAB - MODEM - INIT - ATZ command |
| ABSPOSAW - MODEM - Waiting for string OK |
| ABSPOSAW - MODEM - WAITSTR - Received expected OK |
| 16:03:44 ABSPOSAW - MODEM - WAITCHAR - Received ACK |
| ABSPOSAW - MODEM - Waiting for: $C(2) timeout 60 |
| 16:03:46 ABSPOSAW - MODEM - WAITCHAR - Received STX |
| ABSPOSAM - 2 - STX received from host |
| ABSPOSAM - 3 - Gathering response from host |
| ABSPOSAR - RESP - Begin gathering host system's response |
| 16:03:51 ABSPOSAR - RESP - Received 1289 characters |
| ABSPOSAM - 3 - Received 1289 bytes; LRC 104 |
| ABSPOSAM - 6 - Send ACK to host |
| ABSPOSAM - CLAIM - END - #425 |
| ABSPOSAW - MODEM - Waiting for any of: $C(4) $C(5) timeout 3 |
| 16:03:52 ABSPOSAW - MODEM - WAITCHAR - Received EOT |
| ABSPOSAW - MODEM - Received EOT from host |
| ABSPOSAM - WAITCHAR tells us that modem is disconnected. |
| ABSPOSQ3 - Complete transactions: 1 |
| 16:03:54 ABSPOSAW - MODEM - FLUSH - 10 byte(s) - --|\%uUB?v\027M |
| ABSPOSAW - MODEM - CLOSE - device 128 |
| 16:04:04 Sender/Receiver Job 5 ends |
| DONE*ABSPOSQ |

Figure 45; Example of Dial Out Log

3.6 Pharmacy POS Background Scan

The *Pharmacy POS Background Scan* menu is accessed from the POS Manager Menu option “BACK.”

This option was used during beta testing. Do not use.
3.7 Claims Data Entry Screen

The Claims Data Entry Screen menu is accessed from the POS Manager Menu option “USER.” Refer to the User Menu section which examines this screen in detail.

3.8 Test It (Send Claim, Receive Response)

The Claims Data Entry Screen menu is accessed from the POS Manager Menu option “TEST.”

The test option sends a test claim and, if your dial out is configured correctly and working, a response is received. The test claim is a bogus claim, therefore a rejection is expected.

Here is an example. The prompt for the “Q” or “L” repeats every few seconds until the response is received. When the response is received, the FileMan contents are dumped and the message “The test succeeded!” prints.

If you don’t receive a response within 60 seconds, there is probably something wrong. Use the “L” option to print the communications log; it may reveal the problem. Use “Q” to quit the function.

The claim is rejected; this is the expected result. The data in the test claim is made up and you wouldn’t want it to come back payable.

The test may not work after regular business hours if the test claim is sent to an insurer whose claims systems do not have 24 hour connectivity.

Review the test transmission shown in Figure 46.

---

This is a test of the send-and-receive mechanism. It sends a test claim to an insurer. The claim should be rejected; it is only a test claim and the data is made-up. Create 9002335.02 claim for NEBRASKA MEDICAID TEST Sending the test claim... it's been handed to the background job. Wait several seconds for the response - probably about 60 seconds for a modem connection, or 30 seconds for the T1 line. Type Q to Quit; L to view log file of transmission Waiting for response to the test message... Q to Quit; L to view Log: Q to Quit; L to view Log: Q to Quit; L to view Log: Q to Quit; L to view Log: Q to Quit; L to view Log: Q to Quit; L to view Log: Q to Quit; L to view Log: Q to Quit; L to view Log: Yes, response received!

ID: P01-002286-100012  Date/Time Response Received: JAN 15, 2001@15:07:03
<table>
<thead>
<tr>
<th>Version/Release Number: 3C</th>
<th>Transaction Code: 01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Status (Header): A</td>
<td>Plan Identification: FO</td>
</tr>
<tr>
<td>Medication Order: 1</td>
<td></td>
</tr>
<tr>
<td>Response Status (Prescription): REJECTED CLAIM</td>
<td></td>
</tr>
<tr>
<td>Reject Count: 04</td>
<td></td>
</tr>
<tr>
<td>Message: PROVIDER NUMBER MISSING OR INVALID</td>
<td></td>
</tr>
<tr>
<td>Reject Code(s): 05</td>
<td></td>
</tr>
<tr>
<td>Reject Code(s): 52</td>
<td></td>
</tr>
<tr>
<td>Reject Code(s): 54</td>
<td></td>
</tr>
<tr>
<td>Reject Code(s): 38</td>
<td></td>
</tr>
</tbody>
</table>

**RAW DATA RECEIVED:**

3C01A FO R0405525438 PROVIDER NUMBER
MISSING OR INVALID
FP

The test succeeded!

---

**Figure 46; Example of Report of Test Transmission**
4.0 Billing Interface for Third Party Billing

This section describes the Pharmacy Point of Sale interface with the RPMS Third Party Billing package and Accounts Receivable package. The purpose of the interface is to create Third Party Billing records corresponding to payable electronic claims.

Prior to this, it is assumed that the Site Manager has

- configured Point of Sale to include the interface with RPMS Third Party Billing.
- allocated the ABSPZ BILLER and ABSPZ REPORTS keys to the Business Office personnel who need access to Pharmacy Point of Sale reports.
- allocated the ABSPZ USER key to Business Office personnel who are authorized to initiate and reverse claims using the Point of Sale Data Entry screen.

4.1 The Point of Sale Billing Menu

There are no special billing functions on the Point of Sale Billing menu because all of the billing work is done elsewhere.

- Charges are posted silently and automatically as pharmacy transactions complete.
- Payments are posted to the RPMS Accounts Receivable Package.

There is a Billing Menu; however, it simply links to a couple of Point of Sale tools that may be useful in a billing situation. (Review Figure 47)

4.1.1 Pharmacy Electronic Claims Reports

The Pharmacy Electronic Claims Report Menu and sub-menus can be accessed from the RX Point of Sale Billing Menu by selecting option “RPT.” Refer to the Reports section of this manual for a detailed discussion of this option.
4.1.2 Claims Data Entry Screen

The Claims Data Entry Screen can be accessed from the RX Point of Sale Billing Menu by selecting option “PPOS.” Refer to the User Menu section for a detailed discussion of this option.

You will use it in rare cases where you need to reverse a previously payable claim or file a new electronic claim. Depending on your site's business practices, this could require total, some, or no coordination with pharmacy staff. The PPOS option may not be available on your menu. As a general rule, leave data entry to the pharmacy as much as possible.

Data entry from the Business Office may be needed in the case of a rejected claim that can be resubmitted for payment, if the pharmacy has not already taken care of the rejection. For example, if the registration data had an incorrect cardholder ID number and the claim was rejected, but a week later, the correct number is available, the claim should be rebilled. You might correct the registration data, then resubmit the claim. Each site will determine the department responsible for resubmission of claims.

4.2 Posting Pharmacy Charges to Accounts Receivable

Normally, the pharmacy initiates all Point of Sale claims and reversals and some of the resulting charges are silently and automatically posted to Accounts Receivable by the POS interface to Third Party Billing.

Charges are posted to Accounts Receivable automatically when

- an electronic claims transaction completes.
- the insurer indicates that the claim is payable.
- or the insurer indicates that the claim has been "Captured".

A captured claim means that the insurer acknowledges receipt of the electronic claim but has deferred adjudication. The result of the adjudication will appear on a future Explanation of Benefits (EOB) from the insurer.

The rest of the charges are not posted to Accounts Receivable. These include

- Charges for patients without insurance.
- Charges for patients with insurance, but the insurance can't be billed electronically.
- Charges for patients with insurance, but the drug is unbillable (such as over-the-counter drugs).
- Unsuccessful electronic claims (rejected by the insurance).
4.3 Reversed Claims

The pharmacy may reverse some claims. Sometimes the claim is reversed and never resubmitted, such as if the prescription is canceled and the drugs are returned to stock. Sometimes the claim is reversed and then resubmitted, such as when the prescription quantity or the NDC number is changed.

4.4 Posting Payments

The insurers pay electronic claims usually within a week or two. A check and an EOB will be sent to your site, and the payments are posted against the charges created.

In Appendix C, figure 67, is an example of an EOB from Oklahoma Medicaid, as processed by Unisys. Note that the only identifying item on this EOB is the prescription number. This is an internal prescription number, so when accessing the record, the lookup number must be preceded by the “’” accent key (located over the tab key and to the left of the “1” key on most keyboards), as in ’123456. Review the example below the Note.

**Note:** External prescription numbers are not used for reference because the NCPDP Standards for pharmacy electronic claims define a prescription number as 7 digits, no alpha characters allowed. Some RPMS pharmacies use prescription numbers with an alpha character, such as 123456A. Point of Sale is not allowed to send a prescription number with an alpha character—the claim would be rejected because of a M/I PRESCRIPTION NUMBER. The internal prescription number, (the number assigned by FileMan) is sent to the insurer. FileMan's way of accepting internal numbers as input is to use the "’" character, located above the TAB and to the left of the 1 on most keyboards.

Select PRESCRIPTION RX #: ’77789 77789 LISINOPRIL 10MG TAB

Appendix C, Figure 68, is an example of an EOB from New Mexico Medicaid as processed by Consultec.

4.5 Rejections

Each site will determine whether the pharmacy department or the billing department is responsible for investigating rejected claims. Business Office personnel may need to become familiar with the rejection codes and the techniques for dealing with rejected claims. See Appendix A for more information regarding rejection codes.
5.0 Reports Menu

The Reports Menu provides a variety of reports and surveys which can help you manage your Point of Sale (POS) process. The Pharmacy Electronic Claims Reports menu is accessed from the core menu shown in figure 1 of the User Section. Selection of option “RPT” will produce the sub-menu shown in Figure 48.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLA</td>
<td>Claim results and status</td>
</tr>
<tr>
<td>SET</td>
<td>Setup (Configuration) reports</td>
</tr>
<tr>
<td>SURV</td>
<td>Surveys of RPMS database</td>
</tr>
<tr>
<td>OTH</td>
<td>Other Reports</td>
</tr>
</tbody>
</table>

Figure 48; Pharmacy Electronic Claims Reports Menu

5.1 Claim Results and Status

The Claim Results and Status menu is accessed from the Pharmacy Electronic Claims Reports menu (review Figure 48). Selection of option “CLA” will produce the sub-menu shown in Figure 49. You will need to determine the frequency each report will be generated for your site, depending on prescription volume and business needs.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAY</td>
<td>Payable claims report</td>
</tr>
<tr>
<td>REJ</td>
<td>Rejected claims report</td>
</tr>
<tr>
<td>CAP</td>
<td>Captured claims report</td>
</tr>
<tr>
<td>PAP</td>
<td>Paper claims report</td>
</tr>
<tr>
<td>UN</td>
<td>Uninsured claims report</td>
</tr>
<tr>
<td>DUP</td>
<td>Duplicate claims report (should be none)</td>
</tr>
<tr>
<td>MISS</td>
<td>Find prescriptions missed by POS</td>
</tr>
<tr>
<td>NRV</td>
<td>Reversals needed</td>
</tr>
<tr>
<td>URM</td>
<td>Update Report Master File for a date range</td>
</tr>
<tr>
<td>REC</td>
<td>Recent transactions</td>
</tr>
<tr>
<td>STR</td>
<td>List possibly stranded claims</td>
</tr>
<tr>
<td>DAY</td>
<td>TOTALS - by RELEASED DATE</td>
</tr>
<tr>
<td>INS</td>
<td>TOTALS - by INSURER</td>
</tr>
</tbody>
</table>

Figure 49; Claim Results and Status Menu

The reports (PAY through MISS) are oriented to the pharmacy's record of the Released Date/Time and the latest status of the claim. Therefore, the same report can give different results if it's run on different days. For example, suppose you print the PAY report for January 17 at the end of the day. On January 18, you print the REJ report, make corrections to Cardholder ID numbers, resubmitt the claims and receive payment. On January 19, you re-run the PAY report for January 17 and receive different totals than contained on the original report. The totals will change again if on January 20 an unopened prescription dispensed on January 17th is returned to the pharmacy and the claim is reversed. Another way reports could change over time is the pharmacy record change of Released Date/Time so a prescription is attributed to a different date on a subsequent report.
5.1.1 Payable Claims Report

The *Payable Claims Report* is accessed from the Claim Results and Status Menu (review Section 5.1). Option “PAY” will produce a report that lists payable electronic claims, grouped by insurer. Both billed and paid amounts are shown. An example of a full report can be viewed in Appendix B, Figure 63.

5.1.2 Rejected Claims Report

The *Rejected Claims Report* is accessed from the Claim Results and Status Menu (review Section 5.1). Option “RJT” will produce a report that lists rejected claims, grouped by insurer and patient. The billed amount is shown and the most expensive prescriptions are listed first for each patient. The rejection reasons, as received from the insurer in response to the electronic claim, are shown. The insurer's Help Desk phone number is at the top of the report. An example of a full report can be viewed in Appendix B, Figure 64.

Tips for calling an insurer Help Desk.

- Research the claim first. It will save time for you and the Help Desk if all the information required to solve the problem is available during the call.
- Have the pharmacy's NCPDP number (also known as an NABP number) available. That is usually the first question the Help Desk asks. If your Point of Sale system deals with multiple outpatient sites, each site could have a different NCPDP number.
- The insurer recognizes claims by the FileMan internal entry prescription number; that's why the report uses the internal rather than the external number.
- If there's an WebMD (Envoy) rejection code (EV and a number), call WebMD (Envoy), not the insurer.

5.1.3 Captured Claims Report

“CAP” lists captured claims. These are claims that the insurer acknowledges receiving, but for which adjudication has been deferred. The result—payment or rejection—will be known when the EOB arrives.

5.1.4 Paper Claims Report

The *Paper Claims Report* is accessed from the Claim Results and Status Menu (review Section 5.1). Option “PAP” lists paper claims. Point of Sale doesn't actually produce paper claims—these are claims that could be billed to various other insurers through the RPMS 3rd Party Billing system. If you have numerous claims for a particular insurer, consider sending the claims electronically. The format might
already be included in Point of Sale (See RPT/OTH/FMT.). A contract with the insurer is required before electronic claims will be accepted.

5.1.5 Uninsured Claims Report

The *Uninsured Claims Report* is accessed from the Claim Results and Status Menu (review Section 5.1). Option “UN” lists claims for uninsured patients. The claims are grouped by the patients' eligibility status. This is especially useful if there are claims for non-beneficiaries and you want to know the number and value of such claims.

5.1.6 Duplicate Claims Report

The *Duplicate Claims Report* is accessed from the Claim Results and Status Menu (review Section 5.1). Option “DUP” lists duplicates of payable electronic claims. This happens if the claim has already been paid and it is submitted to the insurer again without having first been reversed. In general, this should never happen.

5.1.7 Find Prescriptions Missed by POS

The *Find Prescriptions Missed by POS* report is accessed from the Claim Results and Status Menu (review Section 5.1). Option “MISS” lists claims missed by Point of Sale. If your site does manual data entry to Point of Sale, you might want to run this report regularly. Otherwise, there should never be any missed claims.

5.1.8 Reversals Needed

The *Reversals Needed* report is accessed from the Claim Results and Status Menu (review Section 5.1). Option “NRV” lists all the claims for prescriptions which are deleted (or marked for deletion) or marked with a RETURNED TO STOCK date/time.

5.1.9 Update Report Master File for a Date Range

The *Update Report Master File for a Date Range* report is accessed from the Claim Results and Status Menu (review Section 5.1). Option “URM” updates the Report Master file thoroughly for a date range that you specify. Each of the preceding reports (“PAY” through “MISS”) does a quick update of the Report Master file and then uses the Report Master file as the source of its data. It may be possible for a transaction to be missed in the reports if the Prescription file dates change, or if certain activities are separated by a day or more. Use “URM” if 100% accuracy (rather than 99% accuracy) is needed.
5.1.10 Recent Transactions

The *Recent Transactions* report is accessed from the Claim Results and Status Menu (review Section 5.1). Option “REC” will summarize recently completed transactions. You will be prompted for a date range. This report lists transactions starting with the most recent and working backward. The completion time and the elapsed time in seconds are also reported. The date of your previous parameter selection will be displayed. You will be prompted for starting and ending dates, which in most instances will be “T” (today). An example of a full report can be viewed in Appendix B, Figure 65.

5.1.11 List Possibly Stranded Claims

The *List Possibly Stranded Claims* report is accessed from the Claim Results and Status Menu (review Section 5.1). Option “STR” will produce a report that will allow you to view claims that did not finish processing due to an unexpected software or hardware problem. The hoped for result is

```
***NO RECORDS TO PRINT***.
```

If there are any stranded claims, RPMS Support Center can run a program to clean them up and then the claims can be resubmitted. Parameters can be entered to focus on a particular day as shown with the following prompt.

```
* Previous selection: START TIME not null
  START WITH START TIME: FIRST// t-2 (NOV 19, 2000)
  GO TO START TIME: LAST// t (NOV 21, 2000@24:00:00)
```

5.1.12 Totals - by Released Date

The *Totals – by Released Date* report is accessed from the Claim Results and Status Menu (review Section 5.1). Option “DAY” totals each day's Point of Sale activity by categories (see column headings in Figure 50).

“SHORTED” amounts are the difference between the amount billed in the electronic claim and the amount the insurer replied with as “PAYABLE.” The shorted figure may include what the insurer has designated as patient co-pay. “PAPER” refers to claims for patient with insurance, but for which electronic claims are not yet set up. “UNINSURED” includes both native beneficiaries and non-natives without any insurance coverage on file.

<table>
<thead>
<tr>
<th>POINT OF SALE TOTALS</th>
<th>FEB 3, 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>From JAN 27, 2001 thru FEB 3, 2001</td>
<td>11:34 AM</td>
</tr>
<tr>
<td>PAYABLE</td>
<td>SHORTED</td>
</tr>
<tr>
<td>JAN 29, 2001</td>
<td>157.78</td>
</tr>
</tbody>
</table>
5.1.13 Totals - by Insurer

The Totals – by Insurer report is accessed from the Claim Results and Status Menu (review Section 5.1). Option “INS” prompts you for a range of insurer names and then a range of prescription released dates. See the examples in Figures 51 and 52 on the following page.

- To get totals for just one insurer, answer both START WITH and GO TO with the same insurer name.
- To see the total for uninsured patients as well, answer the START WITH prompt with @. The uninsured total will be the first one in the report and is labeled as EMPTY.
### 5.2 Setup (Configuration) Reports

The **Setup (Configuration) Reports** menu is accessed from the Pharmacy Electronic Claims Reports menu (review Section 3.4). Option “SET” will produce the sub-menu shown in Figure 53:

| DET    | POS Setup - Detailed Report |
| SUMI   | POS Setup - Summary of Insurers |
| USER   | Display user preference settings |

**Select Setup (Configuration) reports Option:**

Figure 53; Setup (configuration) Reports Menu

#### 5.2.1 POS Setup - Detailed

The **POS Setup – Detailed** is accessed from the Setup (Configuration) Reports menu (review Section 5.2). Option “DET” produces a listing of the current configuration settings for your Point of Sale system. You will need to respond to the device prompt several times when you select this option. This report should be generated after completing the initial setup to verify that all information was correctly entered and again when changes are made to verify the alteration.

#### 5.2.2 POS Setup - Summary of Insurers

The **POS Setup – Summary of Insurers** is accessed from the Setup (Configuration) Reports menu (review Section 5.2). Option “SUMI” produces a report that lists the following properties for each Insurer that is part of your system.
• Pricing formula
• Dispense fee override
• Grace per override
  – Insurance Selection points
You will want to run this report to verify insurer information has been correctly entered after the initial setup.

5.2.3 Display User Preference Settings

The Display User Preference Settings is accessed from the Setup (Configuration) Reports menu (review Section 5.2). Option “USER” produces a list, sorted by user, of the preferences set for each user. The following items are listed for each user.

• Ask insurance
• Ask preauthorization
• Ask pricing
• Ask fill date
• Define NDC

5.2.4 Surveys of RPMS Database

The Surveys of RPMS Database menu is accessed from the Pharmacy Electronic Claims Reports menu. Option “SURV” will produce the sub-menu shown in Figure 54.

<table>
<thead>
<tr>
<th>INS</th>
<th>Survey insurers by frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROV</td>
<td>Survey if recent providers have ID #s</td>
</tr>
<tr>
<td>VOL</td>
<td>Survey of volume</td>
</tr>
<tr>
<td>DIV</td>
<td>Survey pharmacy divisions</td>
</tr>
<tr>
<td>BEN</td>
<td>Survey patients' beneficiary/eligibility status</td>
</tr>
</tbody>
</table>

Figure 54; Survey of RPMS Data Menu

5.2.5 Survey Insurers by Frequency

The Survey Insurers by Frequency is accessed from the Surveys of RPMS Database menu. Option “INS” will begin the process.

Use this survey to see which private insurers are most common among your patients. This helps you decide which insurers should be targeted for pharmacy agreements.
In the example in Figure 55, you will see that Alaska Medicaid claims are already being sent electronically. *Blue Cross of Washington and Alaska* is the most common primary insurance not yet being sent electronically.

Survey insurances from recent prescriptions to see which additional formats we might like to have.

Start date: SEP 12, 2000/
...thinking...

DEVICE: HOME/
Right Margin: 80/
Survey of Insurers (ABSPOS32) 11-NOV-00 1:09 PM

<table>
<thead>
<tr>
<th>Count</th>
<th>Name</th>
<th>Now sending format</th>
</tr>
</thead>
<tbody>
<tr>
<td>2656</td>
<td>SELF PAY (‘1552)</td>
<td></td>
</tr>
<tr>
<td>510</td>
<td>ALASKA MEDICAID (‘543)</td>
<td>ALASKA MEDICAID</td>
</tr>
<tr>
<td>92</td>
<td>BLUE CROSS OF WA/AK (‘1075)</td>
<td></td>
</tr>
<tr>
<td>73</td>
<td>BLUE CROSS &amp; BLUE SHIELD (‘137)</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>GREAT WEST LIFE ASSURANCE (‘132)</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>AETNA US HLTHCARE (ASE) (‘1508)</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>AETNA US HLTHCARE (RSE) (‘1509)</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>CHAMPUS (‘123)</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>MAILHANDLERS BENEFIT PLAN (‘931)</td>
<td></td>
</tr>
</tbody>
</table>

Figure 55; Example of the Survey Insurers by Frequency Report

5.2.6 Survey if Recent Providers Have ID #s

The *Survey if Recent Providers have ID #s* is accessed from the Surveys of RPMS Database menu. Option “PROV” will begin the process. Review the report in Figure 56 on the following page.

Prescribers' ID numbers are required on most electronic claims. Commercial insurance claims usually require the DEA number and Medicaid claims usually require the Medicaid number.

In many if not most cases, your pharmacy's default numbers may be used when individual prescribers' numbers are not on file.

However, if you want to send claims with prescribers' actual ID numbers, this report helps you decide which numbers to try to obtain first. It looks back in time and tallies how many fills and refills are due to each prescriber.

To enter/edit the provider ID numbers in the RPMS database, go to the Manager Menu and then the Setup Menu and pick option “PROV,” *Enter/Edit Providers' ID #s.*

Survey prescribers from recent prescriptions and see if we have DEA #s, Medicaid #s, etc. on file for them.

Start date: SEP 12, 2000/
...thinking...
5.2.7 Survey of Volume

The Survey of Volume is accessed from the Surveys of RPMS Database menu (review Section 5.2). Option “VOL” begins the process. You will enter a date range you wish to review for the number of transactions that are recorded via POS. The report lists data in a weekly format, sub-divided by daily totals.

5.2.8 Survey Pharmacy Divisions

The Survey Pharmacy Divisions is accessed from the Surveys of RPMS Database menu. Option “DIV” begins the process. Review an example of the report in Figure 57. This survey reports fills and refill counts by Outpatient Site.

5.2.9 Survey Patients’ Beneficiary/eligibility Status

The Survey Patients’ Beneficiary/eligibility Status is accessed from the Surveys of RPMS Database menu (review Section 5.2). Option “BEN” begins the process.

This survey counts how many fills and refills were made, sorted by the patients' beneficiary classification and eligibility status. Review an example of the report in Figure 58.
5.3 Other Reports

The **Other Reports** menu is accessed from the Pharmacy Electronic Claims Reports menu (review Section 5.3). Option “OTH” will produce the sub-menu in Figure 59.

<table>
<thead>
<tr>
<th>FMT</th>
<th>List electronic claims formats</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLD</td>
<td>List NCPDP Fields</td>
</tr>
</tbody>
</table>

Select Other reports Option:

![Figure 59; Other Reports Menu](image)

5.3.1 List Electronic Claims Formats

The **List Electronic Claims Formats** report is accessed from the Other Reports menu (review Section 5.3). Option “FMT” produces a list of electronic insurers, their format and the insurer Help Desk phone number. Review the example in Figure 60.

<table>
<thead>
<tr>
<th>Format</th>
<th>Envoy Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALASKA MEDICAID</td>
<td>002286</td>
</tr>
<tr>
<td>BC/BS OF AZ</td>
<td>603017</td>
</tr>
<tr>
<td>OKLAHOMA MEDICAID</td>
<td>004402</td>
</tr>
</tbody>
</table>

Production/Testing Status: PRODUCTION

<table>
<thead>
<tr>
<th>Envoy Plan</th>
<th>BIN</th>
<th>Number</th>
<th>Help Telephone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALASKA MEDICAID</td>
<td>002286</td>
<td>5772</td>
<td>(800) 325-1810</td>
</tr>
<tr>
<td>BC/BS OF AZ</td>
<td>603017</td>
<td>(405) 271-6349</td>
<td></td>
</tr>
<tr>
<td>OKLAHOMA MEDICAID</td>
<td>004402</td>
<td>2763</td>
<td>(405) 271-6349</td>
</tr>
</tbody>
</table>
The **List NCPDP Fields** report is accessed from the Other Reports menu (review Section 5.3). Option “FLD” produces a list of NCPDP numbers and their corresponding file names. This report is seldom, if ever, needed.
6.0 **Statistics and Miscellaneous options**

The Statistics and Miscellaneous Options Screen allows you to view information that is useful in managing your POS functionality. This screen is accessed from the Pharmacy POS Manager Menu through option “MGR,” (review Figure 61).

![Pharmacy POS Manager Menu](image)

The screen shown in Figure 62 will appear. This is the first of three pages of statistical information. The “action” selections are explained following the screen.

![Page one of the Statistical Screens](image)

### 6.1 UC - Update continuously

The statistics are updated every few seconds. Press Q to stop the updating and select a different option.

**UC** - Update continuously

**U1** - Update the display
The statistics are updated once.

6.2 **Z - Zero (clear) stats**

The statistics are reset to zero. This is useful for looking at short-term averages, such as during a time of heavy activity. You may choose to either zero your local copy of the statistics, or to zero the permanent copy.

6.3 **TMR - Transmitter status**

Use this option to turn the transmitter-receiver activity off and on. This might be useful if you are going to reboot an IP address or swap modems. Another case might be if the switch company is not reachable, such as during a phone system failure.

While the transmitter is off, claims accumulate with status = 50 (waiting to transmit) and all claims will be submitted when the transmission connection is re-established.

6.4 **POK - Poke the queues**

If something has gone wrong internally and claims are stuck in some status without being able to advance, "poking" the processing queues might work around the problem.

6.5 **JOB - Number of transmitters**

You can define a maximum number of transmitter-receiver jobs by using this option. You might use it if you added more modems and wanted to make sure the system was able to make use of them all at once.
Appendix A: Rejection Codes

The following list of rejection codes is grouped by general area of concern: registration and insurance information, pharmacy information, network and communications, and miscellaneous rejections. Each section contains suggestions on procedures to follow for each general type of rejection.

A.1 Rejections related to registration and insurance information

One or more of the rejection codes listed below will display when the insurer denies the claim for demographic or eligibility concerns. When you receive a rejection response, proceed as follows:

1. If the rejection is due to incorrect demographic information, verify that the data in PCC is correct.
2. If PCC data was corrected, retransmit the claim.
3. If the rejection is invalid, print a LOG and notify support.
4. If the rejection is valid, bill to next payer or write-off balance.

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>06</td>
<td>M/I GROUP NUMBER</td>
</tr>
<tr>
<td>07</td>
<td>M/I CARDHOLDER ID NUMBER</td>
</tr>
<tr>
<td>09</td>
<td>M/I BIRTHDATE</td>
</tr>
<tr>
<td>10</td>
<td>M/I SEX CODE</td>
</tr>
<tr>
<td>M/I</td>
<td>RELATIONSHIP CODE</td>
</tr>
<tr>
<td>25</td>
<td>M/I PRESCRIBER ID*</td>
</tr>
<tr>
<td>35</td>
<td>M/I PRIMARY PRESCRIBER*</td>
</tr>
<tr>
<td>52</td>
<td>NON-MATCHED CARDHOLDER ID</td>
</tr>
<tr>
<td>65</td>
<td>PATIENT IS NOT COVERED</td>
</tr>
<tr>
<td>67</td>
<td>FILLED BEFORE COVERAGE EFFECTIVE</td>
</tr>
<tr>
<td>68</td>
<td>FILLED AFTER COVERAGE EXPIRED</td>
</tr>
<tr>
<td>69</td>
<td>FILLED AFTER COVERAGE TERMINATED</td>
</tr>
<tr>
<td>70</td>
<td>NDC NOT COVERED*</td>
</tr>
<tr>
<td>71</td>
<td>PRESCRIBER IS NOT COVERED*</td>
</tr>
<tr>
<td>72</td>
<td>PRIMARY PRESCRIBER IS NOT COVERED*</td>
</tr>
<tr>
<td>CA</td>
<td>M/I PATIENT FIRST NAME</td>
</tr>
<tr>
<td>CB</td>
<td>M/I PATIENT LAST NAME</td>
</tr>
</tbody>
</table>
A.2 Rejections Related to RPMS Pharmacy Information

One or more of the rejection codes listed below will display when the insurer denies the claim for invalid prescription related data. When you receive a rejection response, proceed as follows:

1. If the rejection is due to incorrect prescription data, verify data in the Pharmacy Package.
2. If PCC data was corrected, retransmit the claim.
3. If the rejection is invalid, print a LOG and notify the insurer’s Help Desk.
4. If the rejection is valid, bill to next payer or write-off balance.

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>M/I DATE FILLED</td>
</tr>
<tr>
<td>16</td>
<td>M/I PRESCRIPTION NUMBER</td>
</tr>
<tr>
<td>17</td>
<td>M/I NEW-REFILL CODE</td>
</tr>
<tr>
<td>18</td>
<td>M/I METRIC QUANTITY</td>
</tr>
<tr>
<td>19</td>
<td>M/I DAYS SUPPLY</td>
</tr>
<tr>
<td>20</td>
<td>M/I COMPOUND CODE</td>
</tr>
<tr>
<td>21</td>
<td>M/I NDC NUMBER</td>
</tr>
<tr>
<td>22</td>
<td>M/I DISPENSE AS WRITTEN CODE</td>
</tr>
<tr>
<td>23</td>
<td>M/I INGREDIENT COST</td>
</tr>
<tr>
<td>25</td>
<td>M/I PRESCRIBER ID*</td>
</tr>
<tr>
<td>28</td>
<td>M/I DATE PRESCRIPTION WRITTEN</td>
</tr>
<tr>
<td></td>
<td>M/I NUMBER REFILLS AUTHORIZED</td>
</tr>
<tr>
<td></td>
<td>M/I PRIMARY PRESCRIBER</td>
</tr>
<tr>
<td>54</td>
<td>NON-MATCHED NDC NUMBER</td>
</tr>
<tr>
<td>55</td>
<td>NON-MATCHED NDC PACKAGE SIZE</td>
</tr>
<tr>
<td>73</td>
<td>REFILLS ARE NOT COVERED</td>
</tr>
<tr>
<td>79</td>
<td>REFILL TOO SOON</td>
</tr>
<tr>
<td>80</td>
<td>DRUG-DIAGNOSIS MISMATCH</td>
</tr>
<tr>
<td>88</td>
<td>DUR REJECT ERROR</td>
</tr>
</tbody>
</table>

*or could be PCC information

Rejections related to the network and communications beyond local control.
One of the rejection codes listed below will display when the insurer is unavailable or unable to accept transmissions. Usually, Point of Sale will handle this situation for you and the claim will be retried every so often. In some cases, the insurer's computer may be shut down overnight, but the retries will continue every couple of hours until a response is received.

If you receive a rejection response, proceed as follows:

1. The claim can probably be retransmitted at a later time.
2. If the problem persists, the insurer’s system support should be notified.

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>96</td>
<td>SYSTEM UNAVAILABLE/HOST UNAVAILABLE</td>
</tr>
<tr>
<td>97</td>
<td>PLANNED UNAVAILABLE</td>
</tr>
<tr>
<td>98</td>
<td>SCHEDULED DOWNTIME</td>
</tr>
<tr>
<td>99</td>
<td>PAYOR UNAVAILABLE</td>
</tr>
<tr>
<td>100</td>
<td>CONNECTION TO PAYOR IS DOWN</td>
</tr>
</tbody>
</table>

### A.3 Miscellaneous Rejections

The rejection codes listed below should display infrequently. When you receive a rejection response print a LOG and notify support if any of these occur.

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>M/I BIN</td>
</tr>
<tr>
<td>02</td>
<td>M/I VERSION NUMBER</td>
</tr>
<tr>
<td>03</td>
<td>M/I TRANSACTION CODE</td>
</tr>
<tr>
<td>04</td>
<td>M/I PROCESSOR CONTROL NUMBER</td>
</tr>
<tr>
<td>05</td>
<td>M/I PHARMACY NUMBER</td>
</tr>
<tr>
<td>08</td>
<td>M/I PERSON CODE</td>
</tr>
<tr>
<td>12</td>
<td>M/I CUSTOMER LOCATION CODE</td>
</tr>
<tr>
<td>13</td>
<td>M/I OTHER COVERAGE CODE</td>
</tr>
<tr>
<td>14</td>
<td>M/I ELIGIBILITY OVERRIDE CODE</td>
</tr>
<tr>
<td>24</td>
<td>M/I SALES TAX</td>
</tr>
<tr>
<td>25</td>
<td>M/I PRESCRIBER ID</td>
</tr>
<tr>
<td>26</td>
<td>(FUTURE USE)</td>
</tr>
<tr>
<td>27</td>
<td>(FUTURE USE)</td>
</tr>
<tr>
<td>30</td>
<td>M/I P.A./M.C. CODE AND NUMBER</td>
</tr>
<tr>
<td>31</td>
<td>(FUTURE USE)</td>
</tr>
<tr>
<td>32</td>
<td>M/I LEVEL OF SERVICE</td>
</tr>
<tr>
<td>33</td>
<td>M/I PRESCRIPTION ORIGIN CODE</td>
</tr>
<tr>
<td>Code</td>
<td>Explanation</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>34</td>
<td>M/I PRESCRIPTION DENIAL OVERRIDE</td>
</tr>
<tr>
<td>36</td>
<td>M/I CLINIC ID</td>
</tr>
<tr>
<td>37</td>
<td>(FUTURE USE)</td>
</tr>
<tr>
<td>38</td>
<td>M/I BASIS OF COST</td>
</tr>
<tr>
<td>39</td>
<td>M/I DIAGNOSIS CODE</td>
</tr>
<tr>
<td>40</td>
<td>PHARMACY NOT CONTRACTED WITH PLAN ON DATE OF SERVICE</td>
</tr>
<tr>
<td>41</td>
<td>SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYOR</td>
</tr>
<tr>
<td>42-49</td>
<td>(FUTURE USE)</td>
</tr>
<tr>
<td>50</td>
<td>NON-MATCHED PHARMACY NUMBER</td>
</tr>
<tr>
<td>51</td>
<td>NON-MATCHED GROUP NUMBER</td>
</tr>
<tr>
<td>53</td>
<td>NON-MATCHED PERSON CODE</td>
</tr>
<tr>
<td>56</td>
<td>NON-MATCHED PRESCRIBER ID</td>
</tr>
<tr>
<td>57</td>
<td>NON-MATCHED P.A./M.C. NUMBER</td>
</tr>
<tr>
<td>58</td>
<td>NON-MATCHED PRIMARY PRESCRIBER</td>
</tr>
<tr>
<td>59</td>
<td>NON-MATCHED CLINIC ID</td>
</tr>
<tr>
<td>60-64</td>
<td>(FUTURE USE)</td>
</tr>
<tr>
<td>66</td>
<td>PATIENT AGE EXCEEDS MAXIMUM AGE</td>
</tr>
<tr>
<td>74</td>
<td>OTHER CARRIER PAYMENT MEETS OR EXCEEDS PAYABLE</td>
</tr>
<tr>
<td>75</td>
<td>PRIOR AUTHORIZATION REQUIRED</td>
</tr>
<tr>
<td>76</td>
<td>PLAN LIMITATIONS EXCEEDED</td>
</tr>
<tr>
<td>77</td>
<td>DISCONTINUED NDC NUMBER</td>
</tr>
<tr>
<td>78</td>
<td>COST EXCEEDS MAXIMUM</td>
</tr>
<tr>
<td>81</td>
<td>CLAIM TOO OLD</td>
</tr>
<tr>
<td>82</td>
<td>CLAIM IS POST-DATED</td>
</tr>
<tr>
<td>83</td>
<td>DUPLICATE PAID/CAPTURED CLAIM</td>
</tr>
<tr>
<td>84</td>
<td>CLAIM HAS NOT BEEN PAID/CAPTURED</td>
</tr>
<tr>
<td>85</td>
<td>CLAIM NOT PROCESSED</td>
</tr>
<tr>
<td>86</td>
<td>SUBMIT MANUAL REVERSAL</td>
</tr>
<tr>
<td>87</td>
<td>REVERSAL NOT PROCESSED</td>
</tr>
<tr>
<td>89</td>
<td>REJECTED CLAIM FEES PAID</td>
</tr>
<tr>
<td>90</td>
<td>HOST HUNG UP</td>
</tr>
<tr>
<td>91</td>
<td>HOST RESPONSE ERROR</td>
</tr>
<tr>
<td>94</td>
<td>INVALID MESSAGE</td>
</tr>
<tr>
<td>95</td>
<td>TIME OUT</td>
</tr>
<tr>
<td>Code</td>
<td>Explanation</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>99</td>
<td>HOST PROCESSING ERROR</td>
</tr>
<tr>
<td>CE</td>
<td>HOME PLAN</td>
</tr>
<tr>
<td>CF</td>
<td>EMPLOYER NAME</td>
</tr>
<tr>
<td>CG</td>
<td>EMPLOYER STREET ADDRESS</td>
</tr>
<tr>
<td>CH</td>
<td>EMPLOYER CITY ADDRESS</td>
</tr>
<tr>
<td>CI</td>
<td>EMPLOYER STATE ADDRESS</td>
</tr>
<tr>
<td>CJ</td>
<td>EMPLOYER ZIP CODE</td>
</tr>
<tr>
<td>CK</td>
<td>EMPLOYER PHONE NUMBER</td>
</tr>
<tr>
<td>CL</td>
<td>EMPLOYER CONTACT NAME</td>
</tr>
<tr>
<td>CM</td>
<td>PATIENT STREET ADDRESS</td>
</tr>
<tr>
<td>CN</td>
<td>PATIENT CITY ADDRESS</td>
</tr>
<tr>
<td>CO</td>
<td>PATIENT STATE ADDRESS</td>
</tr>
<tr>
<td>CP</td>
<td>PATIENT ZIP CODE</td>
</tr>
<tr>
<td>CQ</td>
<td>PATIENT PHONE NUMBER</td>
</tr>
<tr>
<td>CR</td>
<td>CARRIER ID NUMBER</td>
</tr>
<tr>
<td>CT</td>
<td>PATIENT SOCIAL SECURITY NUMBER</td>
</tr>
<tr>
<td>DP</td>
<td>M/I DRUG TYPE OVERRIDE</td>
</tr>
<tr>
<td>DQ</td>
<td>M/I USUAL AND CUSTOMARY</td>
</tr>
<tr>
<td>DR</td>
<td>M/I DOCTORS LAST NAME</td>
</tr>
<tr>
<td>DS</td>
<td>M/I POSTAGE AMOUNT CLAIMED</td>
</tr>
<tr>
<td>DT</td>
<td>M/I UNIT DOSE INDICATOR</td>
</tr>
<tr>
<td>DU</td>
<td>M/I GROSS AMOUNT DUE</td>
</tr>
<tr>
<td>DV</td>
<td>M/I OTHER PAYOR AMOUNT</td>
</tr>
<tr>
<td>DW</td>
<td>M/I BASIS OF DAYS SUPPLY DETERMINATION</td>
</tr>
<tr>
<td>DX</td>
<td>M/I PATIENT PAID AMOUNT</td>
</tr>
<tr>
<td>DY</td>
<td>INJURY DATE</td>
</tr>
<tr>
<td>DZ</td>
<td>CLAIM REFERENCE ID NUMBER</td>
</tr>
<tr>
<td>E1</td>
<td>ALTERNATE PRODUCT TYPE</td>
</tr>
<tr>
<td>E2</td>
<td>ALTERNATE PRODUCT CODE</td>
</tr>
<tr>
<td>E3</td>
<td>INCENTIVE AMOUNT SUBMITTED</td>
</tr>
<tr>
<td>E4</td>
<td>DUR CONFLICT CODE</td>
</tr>
<tr>
<td>E5</td>
<td>DUR INTERVENTION CODE</td>
</tr>
<tr>
<td>E6</td>
<td>DUR OUTCOME CODE</td>
</tr>
<tr>
<td>E7</td>
<td>METRIC DECIMAL QUANTITY</td>
</tr>
<tr>
<td>E8</td>
<td>OTHER PAYOR DATE</td>
</tr>
<tr>
<td>M1</td>
<td>PATIENT NOT COVERED IN THIS AID CATEGORY</td>
</tr>
<tr>
<td>M2</td>
<td>RECIPIENT LOCKED IN</td>
</tr>
<tr>
<td>Code</td>
<td>Explanation</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>M3</td>
<td>HOST PA/MC ERROR</td>
</tr>
<tr>
<td>M4</td>
<td>PRESCRIPTION NUMBER/TIME LIMIT EXCEEDED</td>
</tr>
<tr>
<td>M5</td>
<td>REQUIRES MANUAL CLAIM</td>
</tr>
<tr>
<td>M6</td>
<td>HOST ELIGIBILITY ERROR</td>
</tr>
<tr>
<td>M7</td>
<td>HOST DRUG FILE ERROR</td>
</tr>
<tr>
<td>M8</td>
<td>HOST PROVIDER FILE ERROR</td>
</tr>
<tr>
<td>MZ</td>
<td>ERROR OVERFLOW</td>
</tr>
</tbody>
</table>
Appendix B: Report Samples

Appendix B contains examples of the claims results and status reports used with the Point of Sale system.

B.1 Example of the Payable Claims Report

<table>
<thead>
<tr>
<th>Trans. Date</th>
<th>Presc/Fill</th>
<th>$Billed</th>
<th>Ins.Pd.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>JAN 29,2001</td>
<td>Axxxx,Rxxx</td>
<td>39.92</td>
<td>10.46</td>
<td>ALLOPURINOL 300MG</td>
</tr>
<tr>
<td></td>
<td>Cxxxxxx,Fxxxxx</td>
<td>14.95</td>
<td>8.36</td>
<td>POTASSIUM CHLORID</td>
</tr>
<tr>
<td></td>
<td>Hxxxx,Rxxxxxx</td>
<td>37.27</td>
<td>33.48</td>
<td>ALBUTEROL METERED</td>
</tr>
<tr>
<td></td>
<td>'377952/0</td>
<td>35.82</td>
<td>32.18</td>
<td>AEROCHAMBER</td>
</tr>
<tr>
<td></td>
<td>'377953/0</td>
<td>71.51</td>
<td>64.12</td>
<td>FLUNISOLIDE 250MC</td>
</tr>
<tr>
<td></td>
<td>Oxxxxxxxxx,xxxxxxx</td>
<td>10.12</td>
<td>9.18</td>
<td>ERYTHROMYCIN 250M</td>
</tr>
</tbody>
</table>

Figure 63; Example of the Payable Claims Report

B.2 Example of the Claims Rejection Report

<table>
<thead>
<tr>
<th>Trans. Date/Time</th>
<th>Claim ID</th>
<th>Presc/Fill</th>
<th>NDC Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>JAN 29,2001 08:27</td>
<td>P01-004402-100130</td>
<td>'361776/4</td>
<td>65197000301</td>
<td>TRIAMTERENE 100MG CAP</td>
</tr>
<tr>
<td></td>
<td>M184xxx</td>
<td>60</td>
<td>99.61</td>
<td>70: NDC NOT COVERED</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>**** Bxxxxx,Gxxxxx</td>
</tr>
<tr>
<td>JAN 29,2001 14:47</td>
<td>P01-004402-100133</td>
<td>'377937/0</td>
<td>00026851351</td>
<td>CIPROFLOXACIN 500MG TABLE</td>
</tr>
<tr>
<td></td>
<td>M022xxx</td>
<td>20</td>
<td>94.78</td>
<td>76: PLAN LIMITATIONS EXCEEDED</td>
</tr>
<tr>
<td>JAN 29,2001 15:04</td>
<td>P01-004402-100134</td>
<td>'377943/0</td>
<td>00597008214</td>
<td>IPRATROPİUM BROMİDE INHAL</td>
</tr>
<tr>
<td></td>
<td>M022xxx</td>
<td>14</td>
<td>43.37</td>
<td>76: PLAN LIMITATIONS EXCEEDED</td>
</tr>
<tr>
<td>JAN 29,2001 15:04</td>
<td>P01-004402-100134</td>
<td>'377942/0</td>
<td>00597007017</td>
<td>METAPROTERENOL INHALER</td>
</tr>
<tr>
<td></td>
<td>M022xxx</td>
<td>14</td>
<td>31.07</td>
<td>76: PLAN LIMITATIONS EXCEEDED</td>
</tr>
</tbody>
</table>
Figure 64; Example of Claims Rejection Report

**B.3 Recent Transactions Report**

<table>
<thead>
<tr>
<th>ENTRY #</th>
<th>PATIENT</th>
<th>DRUG</th>
<th>RESULT</th>
<th>COMPLETED TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>372878.00011</td>
<td>XXXXXXX,XXXXX</td>
<td>RANITIDINE 1</td>
<td>E REVERSAL ACCE</td>
<td>12:35 PM 25</td>
</tr>
<tr>
<td>374474.00001</td>
<td>XXXXX,XXXXXXX</td>
<td>IBUPROFEN 40</td>
<td>PAPER</td>
<td>12:28 PM 3</td>
</tr>
<tr>
<td>374469.00001</td>
<td>XXXXXXX,XXXXXX</td>
<td>APAP WITH CO</td>
<td>E PAYABLE</td>
<td>11:33 AM 59</td>
</tr>
<tr>
<td>357267.00041</td>
<td>XXXXXX,XXXXXXX</td>
<td>SIMVASTATIN</td>
<td>E REVERSAL ACCE</td>
<td>9:39 AM 26</td>
</tr>
<tr>
<td>357267.00041</td>
<td>XXXXX,XXXXXXX</td>
<td>SIMVASTATIN</td>
<td>E PAYABLE</td>
<td>9:30 AM 49</td>
</tr>
<tr>
<td>372874.00001</td>
<td>XXXXXXX,XXXXX</td>
<td>TEMAZEPAM 15</td>
<td>E REJECTED</td>
<td>8:44 AM 51</td>
</tr>
<tr>
<td>365302.00021</td>
<td>XXXX,XXXXX</td>
<td>ASPIRIN 325M</td>
<td>PAPER</td>
<td>8:44 AM 1</td>
</tr>
</tbody>
</table>

Figure 65; Example of the Recent Transactions Report
Appendix C: EOB Samples

Appendix C contains examples of Explanation of Benefits (EOBs) sent by insurers in response to Point of Sale Claims.

Figure 66; Example of Explanation of Benefits from Oklahoma Medicaid

Figure 67; Example of Explanation of Benefits from Oklahoma Medicaid Continued
Figure 68; Example of Explanation of Benefits from New Mexico Medicaid All Transactions Denied

Figure 69; Example of Explanation of Benefits from New Mexico Medicaid Continued, All Transactions Denied
Figure 70: Example of Explanation of Benefits from New Mexico Medicaid Continued, All Transactions Denied

```
SANTA FE INDIAN HOSPITAL

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM

FINANCIAL TRANSACTIONS:

<table>
<thead>
<tr>
<th>ACCOUNT</th>
<th>DECREASE</th>
<th>NET CREDIT</th>
<th>BALANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

REMITTANCE TOTAL: 0

There was no payment due the provider for this remittance cycle.

YEAR-TO-DATE TOTAL PAID (1099): 0

YEAR-TO-DATE CLAIM COUNT: 0
```

Figure 71: Example of New Mexico Medicaid EOB Transactions Paid and Denied

```
SANTA FE INDIAN HOSPITAL

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM

REMITTANCE ADVICE

RECEIPT ID: 0913277
RECEIPT NAME: R F LER SMITH
RECEIVED DATE: 01/09/01
RECEIVED AMOUNT: 0.00

RECEIVED AMOUNT: 0.00

PAYMENT AMOUNT: 0.00

STATUS: DENY
```

Figure 72: Example of New Mexico Medicaid EOB Transactions Paid and Denied

```
SANTA FE INDIAN HOSPITAL

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM

REMITTANCE ADVICE

RECEIPT ID: 0913277
RECEIPT NAME: R F LER SMITH
RECEIVED DATE: 01/09/01
RECEIVED AMOUNT: 0.00

RECEIVED AMOUNT: 0.00

PAYMENT AMOUNT: 0.00

STATUS: DENY
```
### Figure 73; Example of New Mexico Medicaid EOB Transactions Paid

<table>
<thead>
<tr>
<th>DATE</th>
<th>POS RX NO</th>
<th>RECIPIENT ID</th>
<th>RECIPIENT NAME</th>
<th>RXN CHAR</th>
<th>DRG CHAR</th>
<th>NDC</th>
<th>ALLOWD-QU</th>
<th>BILLING</th>
<th>BILLING-AMOUNT</th>
<th>TAX AMOUNT</th>
<th>TPL</th>
<th>PAYMENT</th>
<th>EOB</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/04/01</td>
<td>0967626</td>
<td>N N</td>
<td>00001232</td>
<td>0009718502</td>
<td>20.00</td>
<td>5.78</td>
<td>5.28</td>
<td>0.00</td>
<td>5.28</td>
<td>0.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/05/01</td>
<td>096763</td>
<td>N N</td>
<td>00001232</td>
<td>00015019204</td>
<td>120.00</td>
<td>8.65</td>
<td>8.65</td>
<td>0.00</td>
<td>8.65</td>
<td>0.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/05/01</td>
<td>0968016</td>
<td>N N</td>
<td>00001232</td>
<td>0002560922</td>
<td>120.00</td>
<td>9.24</td>
<td>7.15</td>
<td>0.00</td>
<td>7.15</td>
<td>0.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/05/01</td>
<td>0968037</td>
<td>N N</td>
<td>00001232</td>
<td>00045019204</td>
<td>120.00</td>
<td>8.65</td>
<td>8.65</td>
<td>0.00</td>
<td>8.65</td>
<td>0.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/05/01</td>
<td>0968037</td>
<td>N N</td>
<td>00001232</td>
<td>00056071391</td>
<td>120.00</td>
<td>7.31</td>
<td>7.31</td>
<td>0.00</td>
<td>7.31</td>
<td>0.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/05/01</td>
<td>0968038</td>
<td>N N</td>
<td>00001232</td>
<td>00066071391</td>
<td>120.00</td>
<td>7.31</td>
<td>7.31</td>
<td>0.00</td>
<td>7.31</td>
<td>0.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/05/01</td>
<td>0968039</td>
<td>N N</td>
<td>00001232</td>
<td>00076071391</td>
<td>120.00</td>
<td>7.31</td>
<td>7.31</td>
<td>0.00</td>
<td>7.31</td>
<td>0.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/05/01</td>
<td>0968039</td>
<td>N N</td>
<td>00001232</td>
<td>00076071391</td>
<td>120.00</td>
<td>7.31</td>
<td>7.31</td>
<td>0.00</td>
<td>7.31</td>
<td>0.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06/05/01</td>
<td>096804</td>
<td>N N</td>
<td>00001232</td>
<td>00015019204</td>
<td>120.00</td>
<td>8.65</td>
<td>8.65</td>
<td>0.00</td>
<td>8.65</td>
<td>0.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

User Manual  EOB Samples  74
Appendix D: Configuration Survey

Complete the Configuration Survey once the agreements with the insurance companies and the purchase order to WebMD (Envoy) are complete. Survey responses provide the implementation team with guidelines to install the POS software and to implement site-specific business needs.

D.1 Software Requirements

a. Kernel V. 8.0 or higher
b. FileMan V. 21 or higher
c. IHS Patient Dictionaries (AUPN) V 99.1
d. Pharmacy V. 6.0, including patch 03 or higher
e. IHS Dictionary (Pointers) (AUT) V 98.10, including patch 08
f. *Third Party Billing V. 2.4, including patch 05
g. *Accounts Receivable V 1.5, including patch 01
h. *Accounts Receivable V 1.3 patch 02 (must be installed following the installation of V 1.5)

*These starred requirements only apply to sites using the RPMS Third Party Billing or Accounts Receivable software. If the site is using a COTS Third Party Billing and/or Accounts Receivable package, disregard the respective RPMS requirement.

Refer to the technical manual for instructions on estimating the disk space required by the Point of Sale software.

D.2 Registration Requirements

In order for POS to achieve its maximum potential, registration data in RPMS must be current. Rejections and delays in correct billing may occur if coverage has lapsed and no update has been made to patient’s insurance data. Pay special attention to the following registration categories.

- Demographics
- Group Insurance Data
- Worker’s Compensation Information
- Accident Information
D.3 Determining which Insurers will be Sent Electronic Claims

The following three steps will help you develop a list of insurers to be your first POS target group. Much of your POS system configuration is determined by which insurers you will send electronic claims.

D.3.1 Step 1: Review the List of Electronic Claims Formats

The first step is to become familiar with the list of electronic claim formats. You can only do this if you have the Point of Sale software package installed.

1. Select the Reports Menu.
2. Select Other Reports Menu.
3. Select FMT option. (See Figure 74)

```
****** PHARMACY POINT OF SALE V1.22 ******
* MT EDGECUMBE HOSPITAL *
* Pharmacy electronic claims reports *

CLA    Claim results and status ...
SET    Setup (Configuration) reports ...
SURV   Surveys of RPMS database ...
OTH    Other reports ...

Figure 74; Reports Menu
```

4. Select Pharmacy Electronic Claims Reports Option: OTH Other Reports.
5. Select FMT List Electronic Claims Formats.
6. Select Other Reports Option: FMT List Electronic Claims Formats. The report shows the available formats and whether they are in production status, development phase, or testing phase. (See Figure 75 for an example of the report.)

```
PHARMACY ELECTRONIC CLAIMS FORMATS NOV 28,2000 10:16 PAGE 1

Format                BIN         Number  Help Telephone #
-----------------------------------------------
Production/Testing Status: PRODUCTION
ALASKA MEDICAID        002286              
BC/BS OF AZ            603017        5772  (800) 325-1810
OKLAHOMA MEDICAID      004402        2763  (405) 522-7300
PCS                   610415           1 (800) 345-5413

Production/Testing Status: DEVELOPMENT
NEW MEXICO MEDICAID    610084        (800)365-4944
```

PHARMACY POINT OF SALE V 1.0
D.3.2 Step 2: Decide Which Insurance(s) to Set-up First.

Determine which insurance companies to set up. Before you can set up insurance companies to receive electronic claims, you must have the required pharmacy agreements in place.

1. Determine which insurance companies to set up to receive electronic claims.

2. Complete any necessary agreements between yourself and the insurance companies.

3. Mark the insurance companies for electronic claims in the Point of Sales program. (See Manager Menu, Section 3.2, for step-by-step instructions.)

D.3.3 Step 3: Add Additional Insurers after Go Live

You can add insurers anytime after the Point of Sale setup has been completed.

1. Use the Insurance Survey program as described in the Reports Menu, Section 5.2, to see which insurers are most common.

2. Use the setup program to configure the insurer for electronic claims.

D.4 Survey Questions

Complete this portion of the Configuration Survey as follows:

- Answer questions by selecting the appropriate answer.
- The implementation team will use the completed survey as a guideline when installing the POS software.

1. How is data entered into the Point of Sale system? (Check one of the following.)

☐ Scanning bar codes.
When the drugs are dispensed, pharmacy personnel scan the bar-coded labels.
of the prescription and the bottle. (Keyboard entry can also be done.)

**Pharmacy package calls Point of Sale.**
The RPMS pharmacy package is configured to automatically request the Point of Sale program to send claims and claim reversals as necessary. (The latest pharmacy package update with appropriate modifications is required to use this option.)

**Point of Sale monitors pharmacy activity.**
The Point of Sale program will scan the prescription file for new activity and automatically submit claims and claim reversals. (This is being phased out in favor of Pharmacy Package calls Point of Sale. Use it only if the new pharmacy package is not available or if other considerations prevent installation of the new pharmacy package. Be advised that the NRV report must be run periodically to identify claims which need to be reversed.)

2. Provide the following insurance information.

a. Arrange the following insurance types in order of coordination of benefits, starting with choice for primary insurance. (Rank highest to lowest; 1 being the highest and 4 being the lowest.)

   Medicaid
   Medicare
   Private insurance
   Railroad Retirement

b. List insurers that should always be primary, regardless of other coverage.

c. Sort private insurers. Review the list of order of insurance rules in the Manager Manual. List the rules that apply to your site in the order which the rules should be applied.

1. 
2. 
3. 
4. 

3. List all insurers set to "no bill" in the RPMS Insurance File.

a. Dental insurers: Do not list dental insurers here. Mark all DENTAL insurances' RX BILLING STATUS field to UNBILLABLE.

b. List other insurers set to "no bill." Verify that their RX BILLING STATUS is set to UNBILLABLE.

c. List insurers that are Worker's Compensation only.
4. Provide the following information on your current Accounts Receivable System Package.

a. Does your site use the RPMS 3rd Party Billing/Accounts Receivable interface?  
   Yes □  No □

b. What is the RPMS 3rd Party Billing version number?  
   ______

   What is the version number?
   ______

   c. Does your site use another accounts receivable system?  
      Yes □  No □

      If yes, explain. (Consult with development if interface is needed.)  
      ______

   Will your site use a T1 connection direct to WebMD (Envoy)? If “Yes”, 
   skip to question 6. If “No”, provide the following information about your 
   modem configuration:  
   Yes □  No □

   MSM device number of directly connected modem from SYSGEN, if 
   applicable:  
   ______

   Special dialing to reach an outside line:  
   ______

   Other phone system requirements affecting modem usage:  
   ______
   ______
   ______

6. Pricing Tables Set-up.

a. Which file and field contains the correct unit price? Check one.

   □ Pharmacy package, PRESCRIPTION file, AWP field, (only select 
     this if your site has the Pharmacy package modification which 
     supports Pharmacy–to-POS direct interface).

   □ AWP-MED TRANSACTION file’s AWP field.

   □ Other

   If other, explain.  
   ______

   List your site’s standard pricing formula? (Example: 100% of AWP + 
   dispensing fee)  
   ______

   What is your standard dispensing fee?  
   ______
d. List special cases of different dispensing fees for certain insurers.

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Dispensing Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>


e. List any special cases of different pricing formulas for certain insurers.

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Pricing Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

f. Does your site have any different pricing policy for uninsured non-beneficiaries?

___

g. Does your site use AWP monthly updates?

___

7. For each pharmacy associated with your site, complete the information in the table below. (Include all pharmacies that use the RPMS Pharmacy package on your system. For additional pharmacies, please copy and attach a second table.)

<table>
<thead>
<tr>
<th>Pharmacies:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Sites: (for this pharmacy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCPDP Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WebMD (Envoy) Terminal ID Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy Medicaid Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Default Provider Medicaid Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Default DEA Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Insurer Assigned Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Should over-the-counter drugs be marked as billable system-wide?  

Yes ☐  No ☐

If yes, list any insurer-specific exceptions of over-the-counter drugs that are billable. Give the NDC number if possible, or describe the rule in terms of the drug name otherwise.

____
b. List any non-OTC drugs that should be marked as non-billable system wide? Give the NDC numbers if possible, or describe the rule in terms of the drug name.

c. Describe insure-specific exceptions:
Describe any situations where a drug that is marked as unbillable should be considered billable for a particular insurer.

Describe any situations where a billable drug should be considered as unbillable for a particular insurer.
Appendix E: Special Notes for Operation of the Background Scan of the Prescription File

The background scan of the prescription file is a temporary method of input being used at some sites. The modified pharmacy package that directly calls Point of Sale is preferred.

Here are the basics of managing the background scan process.

- After installing Point of Sale, start the background scanning job
- After system down time, start the background scanning job
- Before installing Point of Sale patches or updates, stop the background scanning job. Remember to start it again when the installation completes.

There is a status check program. If the status has a "?", such as "RUNNING?", then a system error has occurred. You should stopping and restarting the background scanning job.

There is no harm in starting the background scanning job multiple times. A duplicate job will detect that another such job is already running and stop quietly.

Review the following examples in Figures 76 thru 79.

```
STAR   Start Pharmacy POS background scan
STOP   Stop Pharmacy POS background scan
STAT   Status of Pharmacy POS background scan
LOG    Print log file of Pharmacy POS background scan

Select Pharmacy POS background scan Option: STAT Status of Pharmacy POS background scan
Status of POS background job: RUNNING
ABSPOSR1 CURRENT JOB: 56
ABSPOSR1 LAST DATETIME: FEB 02, 2001@03:59:04
ABSPOSR1 STOP SIGNAL: RUNNING ABSPOSR1 POLLING INTERVAL: 30
ABSPOSR1 REACH BACK: 30 ABSPOSR1 INDEX FOR NEW CLAIMS: AL
ABSPOSR1 INDEX FOR REVERSALS: AJ

Press ENTER to continue:
```

Figure 76; Option “STAR” on Background Job Menu
Select Pharmacy POS background scan Option: **STOP** Stop Pharmacy POS background scan
Stopping the background scanner job.........
Press ENTER to continue:

**Figure 77; Option “STOP” on Background Job Menu**

```
STAR   Start Pharmacy POS background scan
STOP   Stop Pharmacy POS background scan
STAT   Status of Pharmacy POS background scan
LOG    Print log file of Pharmacy POS background scan

Select Pharmacy POS background scan Option: **STAT** Status of Pharmacy POS background scan
Status of POS background job: STOPPED

ABSPOSR1 CURRENT JOB: 56
ABSPOSR1 LAST DATETIME: FEB 02, 2001@04:00:04
ABSPOSR1 STOP SIGNAL: STOPPED          ABSPOSR1 POLLING INTERVAL: 30
ABSPOSR1 REACH BACK: 30                 ABSPOSR1 INDEX FOR NEW CLAIMS: AL
ABSPOSR1 INDEX FOR REVERSALS: AJ

Press ENTER to continue:

Select Pharmacy POS background scan Option: **STAR** Start Pharmacy POS background scan
The background scanner is now STOPPED
Taskman will start the background scanner job.
```

**Figure 78; Option “STAT” on Background Job Menu**

```
Select Pharmacy POS background scan Option: **LOG** Print log file of Pharmacy POS background scan
Print background job's log file

Print log file for what date? // **T-1** (FEB 01, 2001)
DEVICE: HOME//
Log file #3010201.3
0:00:09  FEB 1,2001@00:00:09 58471,9 3010201.000009 3010201.3
  Background claim submitter running as job 23
0:00:39 Polling
0:01:09 Polling
0:01:39 Polling
```

**Figure 79; Option “LOG” on Background Job Menu**