RESOURCE AND PATIENT MANAGEMENT SYSTEM

Pharmacy Point of Sale
(ABSP)

Patch Addendum

Version 1.0 Patch 37
March 2010

Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico
Preface

The requirements and functionality outlined in the Software Requirement Specification Indian Health Service Point of Sale (POS) Version 1.0 Patch 37 include the following:

1. POS Claim Transfer to 3PB
2. Close Rejected Claims Report and Menu Options
3. Accounts Receivable Statistical Report Menu Options
4. Medicaid Eligibility Modification
5. Oklahoma Medicaid Parameter Modification
6. ABSP Routine Modifications
7. New and Modified POS 5.1 Formats

Security

This patch uses the same security keys as described in the Pharmacy Point-of-Sale (ABSP) User Manual, Version 1.0.
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1.0 Introduction

Please review these changes and add a copy of them to any printed documentation your site may be using for ABSP Version 1.0. These changes will be integrated into future versions of the software and user manuals, and will no longer be considered an addendum at the time of the next release.

Patch 37 of Pharmacy Point of Sale (POS) Version 1.0 contains the following changes:

- POS Claim Transfer to 3PB
- Close Claim Function
- Accounts receivable (A/R) Financial Report Menus
- Medicaid Eligibility Modification
- Oklahoma Medicaid Parameter Modification
- ABSP Routine/Data Dictionary Definition Modifications
- New and Adjusted POS 5.1 Formats
2.0 POS Claim Transfer to 3PB

This section provides the details of the enhancement made to the Pharmacy POS package. With the release and installation of the 3PB Patch 2, POS will transfer all claims with a Payable response and claims with a Rejected response from the processor to the 3PB package.

The following rejected claims will not transfer to the 3PB package.

- 85: Claim Not Processed
- 95: Time Out
- 96: Scheduled Downtime
- 97: Payer Unavailable
- 98: Connection to Payer is Down
- R8: Syntax Error
- NN: Transaction Rejected at Switch or Intermediary
3.0 Close Rejected POS Claims

This option allows the user to close claims that were initially returned as “Rejected” for the following reasons.

- Claim Too Old
- Refill Too Soon
- Plan Limitation Exceeded

Claims that have already been closed will no longer display on the POS User Screen.

The Close Claim option is accessed by typing CLO at the “Select Action” prompt on the POS User Screen. The system prompts the user for the line number of the claim he/she is closing.

![Figure 3-1: Entering a Prescription Line Item to Close Rejected Claim](image)

The system redisplayss the selected line item and notes that this item will be closed using the same information entered into the “closed claim reasons name” prompt. The system prompts the user to continue.
All prescriptions for patient DEMO, PATIENT
With activity in the past 5 days

<table>
<thead>
<tr>
<th>#</th>
<th>PATIENT/PRESCRIPTION</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>done PATIENT, DEMO ** FINISHED ** 6 rejected *1 not electronic **</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>ASPIRIN* 325MG EC TAB  MAR 11@13:09 Unbillable to ins.; Native ben</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>CLOPIDOGREL* 75MG TAB  MAR 11@13:09 Rejected(79:Refill Too Soon);</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>GEMFIBROZIL 600MG TABL MAR 11@13:09 Rejected(79:Refill Too Soon);</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>LISINOPRIL* 40MG TAB   MAR 11@13:09 Rejected(79:Refill Too Soon);</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>METOPROLOL* 50MG TAB   MAR 11@13:09 Rejected(79:Refill Too Soon);</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>INSULIN GLARGINE 100U/ MAR 9@12:24 Rejected(79:Refill Too Soon);</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>METFORMIN* 500MG TAB   MAR 12@09:30 Rejected(79:Refill Too Soon);</td>
<td></td>
</tr>
</tbody>
</table>

Enter ?? for more actions >>>

Prescription #1735937 Refill #3 (ABSP59=1735937.00031)
Patient: PATIENT, DEMO
This claim has a status of : E REJECTED
This claim can be closed CONTINUE CLOSING CLAIM? YES//YES

Figure 3-2: Typing YES to continue close claim request

After typing YES, the user is prompted for a closed claim reason code.

Enter ?? for more actions >>>

C Claim Too Old
R Refill Too Soon
P Plan Limit Exceeded

CLOSE REASON: C// R

Figure 3-3: Listing of Closed Claim Reason Codes
When the claim is successfully closed, the system displays a message stating the claim was closed.

**Figure 3-4: Displaying system message for closing the claim**

The patient’s prescription line items no longer display.

**Figure 3-5: Closed Item is No Longer Displayed**
4.0 Reopen Closed Claims (Hidden Option)

The Reopen Closed Claims option allows the user to reopen closed claims directly from the POS User Screen.

**Note:** The ABSP MANAGER security key is required to use the Reopen Closed Claims option.

This option is accessed by typing **ROC** at the “Select Action” prompt on the POS User Screen. At the “Select Closed Claims for which patient?” prompt, enter the name of the patient.

---

Figure 4-1: Accessing the Reopen Closed Claims Option
5.0 Closed Claims Report

The Closed Claims Report option lists claims that have been successfully transmitted to the payer, have been returned rejected, and have been closed using the POS Close Claim Action option.

Access the report by typing CLO at the “Select Claim Results and Status Option” prompt on the Claim Results and Status Option screen.

---

**PHARMACY POINT OF SALE V1.0 P37**

**PHARMACY POINT OF SALE V1.0 P37**

**FORT WASHAKIE HEALTH CENTER**

**Claim results and status**

---

**PAY** Payable claims report

**REJ** Rejected claims report

**CAP** Captured claims report

**PAP** Paper claims report

**UN** Uninsured claims report

**REC** Recent transactions

**RCR** Rejected Claims by Reject Code

**WRR** Worked Rejection Report

**CLO** Closed Claim Report

Select Claim results and status Option:

---

**Figure 5-1: Accessing the Closed Claims Report Option**

After making a selection, the following prompts for released date range, close claim reason, and device display.

---

* Previous selection: RELEASED DATE from Feb 14,2010 to Mar 16,2010@24:00
START WITH RELEASED DATE: Feb 14,2010// T-30 (FEB 14, 2010)
GO TO RELEASED DATE: Mar 16,2010// T (MAR 16, 2010)
START WITH CLOSED REASON: FIRST// REFILL TOO SOON
GO TO CLOSED REASON: LAST//
DEVICE: Right Margin: 80// Right Margin: 80//

**Figure 5-2: Selecting Close Claim Reason Option**

---

<table>
<thead>
<tr>
<th>DEMO HEALTH CENTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI #1234567891</td>
</tr>
<tr>
<td>NCPDP (NABP) #5555555</td>
</tr>
<tr>
<td>Medicaid #4444444</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Internal RX#</th>
<th>Cardholder ID</th>
<th>Group Number</th>
<th>Closed Date</th>
<th>Closed By</th>
<th>Closed Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CLOSED REASON: Refill Too Soon</td>
</tr>
</tbody>
</table>

---

Patch Addendum
March 2010
** DEMO, PATIENT
1735937 998046508
MAR 16, 2010 09:41 BRADY, CHRISTINA L Refill Too Soon
79: Refill Too Soon
Press ENTER to continue:

Figure 5-3: Closed Claims Report
6.0 A/R Financial Report Menus

This section provides instructions on the A/R Financial Report menus.

6.1 Period Summary Report (PSR)

The PSR report is one of the main A/R reports used during the facility’s month end process. This report provides a summary of all bills that were posted or had an A/R transaction activity. The report can be sorted for all billing sources for a specified date range, including total billed, payment, adjustment amounts, and more detailed parameters, which assists the manager with printing customized reports.

**Note:** This report contains data for visit location(s) regardless of billing location.

To run the Period Summary Report, follow these steps:

1. Type **PSR** at the “Select Financial Reports Menu Option” prompt in the Financial Reports menu located in the A/R Reports menu.

   The screen shown in Figure 6-1 displays.

   ![Figure 6-1: Period Summary Report (Steps 1–2)]

   *NOTE:* This report will contain data for VISIT location(s) regardless of BILLING location.

2. Type the name of the visit location at the “Select Visit LOCATION:” prompt or press the Enter key to select all locations.

   **Note:** If a location name is entered, the report will only include information about that location.

3. Type the number that corresponds to the desired mode of sorting your report at the “Select criteria for sorting;” prompt.
Note: Only one sort method can be selected.

Choices for sorting are the following:

- 1 A/R ACCOUNT
- 2 CLINIC TYPE
- 3 VISIT TYPE
- 4 DISCHARGE SERVICE
- 5 ALLOWANCE CATEGORY
- 6 BILLING ENTITY
- 7 INSURER TYPE

4. Type the start date for the report at the “Select Beginning Date:” prompt.

5. Type the end date for the report at the “Select Ending Date:” prompt.

6. Run the report by responding to the “Output DEVICE:” prompt as follows:
   - Type the name of the printer to print this report.
   - Press the Enter key to view this report on the monitor.

The figure below shows an example of this report. The user’s actual report will vary based on the parameters he/she choose.
This completes the procedure for creating the period summary report.

6.2 A/R Statistical Report

The A/R Statistical Report should be used to identify accurate collection amounts. This report shows what services have been billed, paid, and collected based on the approval date, the visit date, or the export date. This report may be sorted by clinic or visit type.

To generate the A/R Statistical Report, follow these steps:

1. Type **STA** at the “Select Financial Reports Menu Option:” prompt.
2. Type the number of the first parameter with which you want to restrict the report.

   **Note:** After each selection, the user’s choices are listed and the user is presented with the inclusion list.

3. Continue identifying all inclusion parameters for restricting the report, then press the Enter key at a blank “Select One or More of the above Inclusion Parameters:” prompt to continue.

4. Type **Y** (Yes) or **N** (No) at the “Include Clinic or Visit Type?” prompt. If the user types **N** (No), skip to Step 5. If the user types **Y** (Yes), he/she will be prompted to enter additional parameters.

   a. Type **V** or **C** at the “Sort Report by [V]isit Type or [C]linic:” prompt.
   b. If the user types **V**, he/she will be prompted to select a visit type. If the user types **C**, he/she will be prompted to choose a clinic. To view a list of choices, type ?? at the prompt.

5. Type **Y** (Yes) or **N** (No) at the “Do you wish to include Cancelled bills?” prompt.

6. Type the name of a print device at the “DEVICE” prompt.
<table>
<thead>
<tr>
<th>VISIT TYPE</th>
<th>VISITS</th>
<th>PATIENTS</th>
<th>BILLED AMOUNT</th>
<th>PAID AMOUNT</th>
<th>ADJ AMOUNT</th>
<th>UNPAID AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZERO-PAY CLA</td>
<td>1</td>
<td>1</td>
<td>185.00</td>
<td>0.00</td>
<td>0.00</td>
<td>185.00</td>
</tr>
<tr>
<td>INPATIENT</td>
<td>3</td>
<td>3</td>
<td>10,234.29</td>
<td>13,267.00</td>
<td>-4,044.00</td>
<td>1,011.29</td>
</tr>
<tr>
<td>OUTPATIENT</td>
<td>24</td>
<td>5</td>
<td>4,448.14</td>
<td>308.00</td>
<td>110.00</td>
<td>4,030.14</td>
</tr>
<tr>
<td>CROSSOVER (I)</td>
<td>1</td>
<td>1</td>
<td>776.00</td>
<td>0.00</td>
<td>0.00</td>
<td>776.00</td>
</tr>
<tr>
<td>EMERGENCY RO</td>
<td>2</td>
<td>1</td>
<td>221.41</td>
<td>100.00</td>
<td>50.00</td>
<td>71.41</td>
</tr>
<tr>
<td>PHARMACY</td>
<td>1</td>
<td>1</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>DENTAL</td>
<td>4</td>
<td>3</td>
<td>169.00</td>
<td>27.00</td>
<td>63.00</td>
<td>79.00</td>
</tr>
<tr>
<td>PROFESSIONAL</td>
<td>8</td>
<td>7</td>
<td>4,514.76</td>
<td>260.00</td>
<td>0.00</td>
<td>4,254.76</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>44</td>
<td>13</td>
<td>20,548.60</td>
<td>13,962.00</td>
<td>-3,821.00</td>
<td>10,408.60</td>
</tr>
</tbody>
</table>

This completes the process for printing the A/R Statistical Report.
7.0 Medicaid Eligibility Modification

Modification made to the ABSPOS29 to allow POS claims to be processed against termed Medicaid plans on the patient’s Patient Registration Page 4 profile.

<table>
<thead>
<tr>
<th>IHS REGISTRATION EDITOR</th>
<th>MEDICAID</th>
<th>DEMO HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT, DEMO</td>
<td>(upd:MAR 17, 2010) HRN#:109876 (CHS &amp; DIRECT)</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------</td>
<td>---------------</td>
</tr>
<tr>
<td>NUMBER</td>
<td>(updated)</td>
<td>ELIG DATE</td>
</tr>
<tr>
<td>STATE: NEBRASKA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. 123456789 (MAR 17, 2010)</td>
<td>2. JAN 1,2010</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>JAN 1,2009</td>
<td>NOV 20,2009</td>
</tr>
<tr>
<td></td>
<td>JAN 1,2008</td>
<td>JUN 30,2008</td>
</tr>
<tr>
<td>5. PRIM CARE PROVIDER:</td>
<td>GROUP NAME:</td>
<td>GROUP NUMBER:</td>
</tr>
<tr>
<td>6. GROUP NAME:</td>
<td>PLAN NAME:</td>
<td></td>
</tr>
<tr>
<td>7. PLAN NAME:</td>
<td>RATE CODE:</td>
<td></td>
</tr>
<tr>
<td>8. RATE CODE:</td>
<td>CC ON FILE:</td>
<td></td>
</tr>
<tr>
<td>9. CC ON FILE:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Last edited by: BRADY,CHRISTINA on Mar 17, 2010

ENTER <E>dit a field OR <D>elete an eligibility date:
8.0 Parameters for Oklahoma Medicaid Modification

The Parameters for Oklahoma Medicaid option is accessed through the Miscellaneous Setup Programs menu. This option configures some special parameters for Oklahoma Medicaid to set the limit of claims that process through to Oklahoma Medicaid to avoid Plan Limitation Rejections. At the beginning of each month, the Oklahoma Medicaid Plan Limit is reset to zero.

The Parameters for Oklahoma Medicaid has been modified to allow POS claims that have been reversed for an Oklahoma Medicaid patient to be added back to the Oklahoma Medicaid Limit in order to allow a new POS claim to be processed to Oklahoma Medicaid for payment.

**Note**: The reversal functionality will be released in POS Patch 38.
9.0 **ABSP Routine/Data Dictionary Definition Modification**

The following routines were modified for POS patch 37:

<table>
<thead>
<tr>
<th>Routine</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSPOS25</td>
<td>Avoids error: $ZE=&lt;UNDEFINED&gt;B+10^ABSPOS25</td>
</tr>
<tr>
<td>ABSPOS29</td>
<td></td>
</tr>
<tr>
<td>ABSPOS6D</td>
<td></td>
</tr>
<tr>
<td>ABSPOSAP</td>
<td>Avoids error: GETNEXT1+10^ABSPOSAP</td>
</tr>
<tr>
<td>ABSPOSBB</td>
<td></td>
</tr>
<tr>
<td>ABSPOSCC</td>
<td></td>
</tr>
<tr>
<td>ABSPOSCF</td>
<td>Avoids error: $ZE=&lt;SUBSCRIPT&gt;XLOOP+37^ABSPOSCF</td>
</tr>
<tr>
<td>ABSPOSEV</td>
<td></td>
</tr>
<tr>
<td>ABSPOSM2</td>
<td></td>
</tr>
<tr>
<td>ABSPOSMF</td>
<td></td>
</tr>
<tr>
<td>ABSPOSQG</td>
<td>Avoids error: DIALOUT+3^ABSPOSQG when IEN59 is empty</td>
</tr>
<tr>
<td>ABSPOSUA</td>
<td></td>
</tr>
</tbody>
</table>

The following data dictionary definitions were altered for POS patch 37:

- ABSP LOG OF TRANSACTIONS
- ABSP PHARMACIES
- ABSP TRANSACTION
10.0 POS 5.1 Formats

10.1 New 5.1 POS Formats

<table>
<thead>
<tr>
<th>FORMAT NAME</th>
<th>BIN #</th>
<th>PCN #</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDAHO MEDICAID 014864 5.1</td>
<td>014864</td>
<td>IDMEDICAID</td>
</tr>
<tr>
<td>TROOP EXTENDED 5.1</td>
<td>011727</td>
<td>2222222222</td>
</tr>
<tr>
<td>PRIORITY HLTH PDP 5.1</td>
<td>012353</td>
<td>03700000</td>
</tr>
<tr>
<td>EMPLOYER’S HEALTH OPTIONS 5.1</td>
<td>004527</td>
<td>HDN</td>
</tr>
<tr>
<td>PERFORM 5.1</td>
<td>610077</td>
<td>0466300010</td>
</tr>
<tr>
<td>MCKESSON 5.1</td>
<td>610500</td>
<td>HDS</td>
</tr>
<tr>
<td>MAINE EMP MUTUAL 5.1</td>
<td>600471</td>
<td>2021</td>
</tr>
<tr>
<td>TOGETHER RX ACCESS 5.1</td>
<td>600428</td>
<td>03130000</td>
</tr>
<tr>
<td>KAISER PERM SOUTH CA MPD 5.1</td>
<td>011172</td>
<td>SCCMS</td>
</tr>
<tr>
<td>FAMILY PACT 5.1</td>
<td>610442</td>
<td>NONE</td>
</tr>
<tr>
<td>BCBS MEDICARE ADV PDP 5.1</td>
<td>004915</td>
<td>ZEG</td>
</tr>
</tbody>
</table>

10.2 Adjusted 5.1 Formats

- ALL 5.1 FORMATS
  - Added Field 403 ‘Fill Number’ in Claim Segment
- COMMUNITY MUTUAL PDP 5.1
  - Added Field 430 ‘Gross Amount Due’ in Pricing Segment
- REGENCE RXEDO 5.1
  - Updated format based on new payer sheet
- PRESBYTERIAN PDP 5.1
  - Removed special coding for field 301 ‘Group ID’ in Insurance Segment
- GEHA 5.1
  - Added Field 311 ‘Patients Last Name’ in Patient Segment
- PAID 5.1
  - Added Field 311 ‘Patients Last Name’ in Patient Segment
Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

**Phone:** (505) 248-4371 or (888) 830-7280 (toll free)

**Fax:** (505) 248-4363

**Web:** [http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm](http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm)

**Email:** support@ihs.gov