

***Medical
ABC
6.3
Training***

Version 2

For the latest version of this training manual, please visit the TeamPraxis website at: www.teampraxis.com/help_desk and click on the Palmetto link

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Introduction

This training document overviews the usage of the new features in Medical ABC including new fields, forms, and processes that allow Medical ABC to meet new requirements in medical claims processing. Some of these new mandates include sending Medicare claims to Palmetto GBA and National Drug Code dosage calculation requirement.

Please read this document in its entirety before applying any of this knowledge to your Medical ABC system.

System Requirements

Required Platform: You must be on Medical ABC 6.3, or greater to use the functions relating to Palmetto GBA, the CMS-1500 form, and other minor issues.

Palmetto GBA claim requirements

Palmetto GBA was selected by the Centers for Medicare & Medicaid Services (CMS) to process fee-for-service Medicare claims and perform related duties as the Medicare Administrative Contractor (MAC) for both Parts A and B of the Medicare benefit program. The MAC Jurisdiction 1 region includes California, Hawaii, Nevada, American Samoa, Guam, and the Northern Mariana Islands.

As of August 4, 2008, all MAC Jurisdiction 1 claims will be processed by Palmetto GBA. Changes have been made to Medical ABC to meet Palmetto GBA's electronic and paper claim processing requirements.

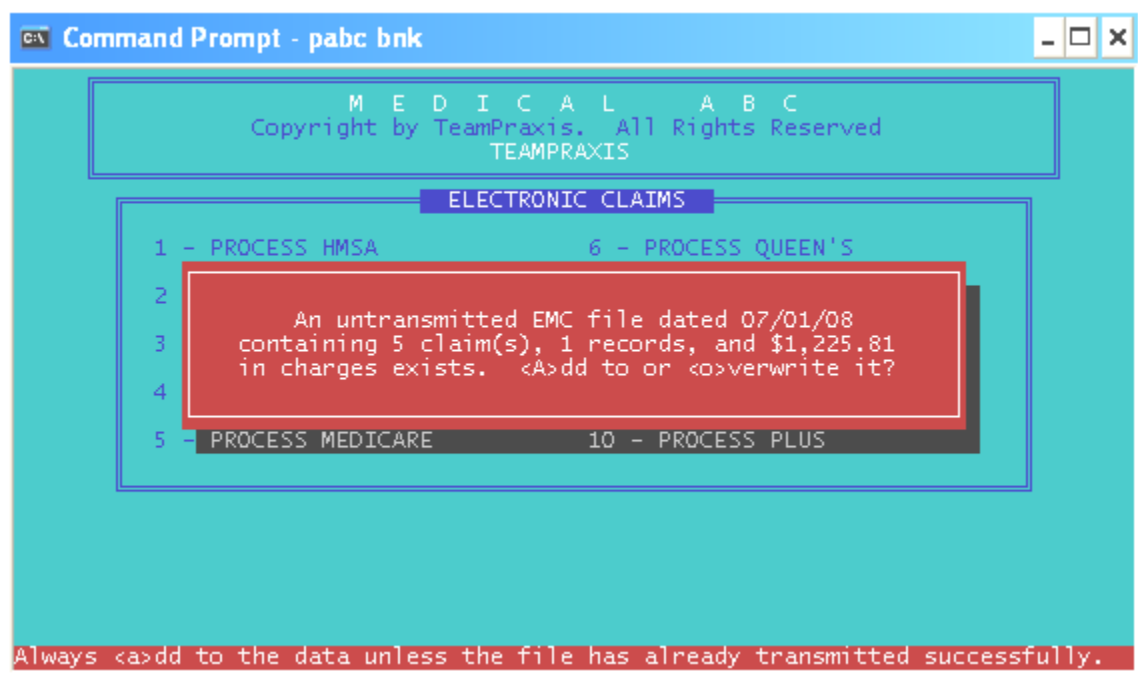
The electronic claims generator in Medical ABC has been updated to meet Palmetto GBA electronic claim, or 837 file, requirements. These include various identification number changes and other 837 file requirements.

Note: Your provider must be enrolled with Palmetto GBA prior to sending Medicare claims as of Monday, August 4, 2008. Providers who have enrolled with Palmetto GBA should have received a new password in order to login to their server. If you have not received your new password, please contact Palmetto GBA EDI Support at (866)749-4301.

Appending Medicare electronic claims disabled

To meet Palmetto GBA requirements, the ability to append Medicare electronic claim files has been disabled.

Medical ABC displays a dialogue box when processing a Medicare electronic claim batch when there is an existing Medicare electronic claims file that has not been transmitted.



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Users will no longer be able to add to an existing Medicare electronic claim file. The action of typing "A" to add will bring up the following message:



The "A" function to add is still available for HMSA, Quest, and Plus electronic claims.

Note: Overwriting an EMC file will lose claim data that may have been intended to be sent to the insurance company. It is recommended that you send your EMC file before you process a new EMC batch.

Medicare paper claims

Various changes have been made to Medicare paper claims to meet Palmetto GBA requirements. These changes include the suppression of insurance name and address on Medicare paper claims, subscriber birth dates with 4-digit year, and removal of tax line on Medicare secondary paper claims.

New Medicare addresses for paper claims

As of August 4, 2008, providers send paper claims to new Medicare addresses:

Part B Claims

J1 MAC – Palmetto GBA
PO Box 1051
Augusta, GA 30903-1051

Part B Medicare Secondary Payer

J1 MAC – Palmetto GBA
PO Box 1687
Augusta, GA 30903-1687

Note: Keep in mind that Medical ABC no longer prints the insurance name and address in the top right corner of Medicare paper claims. Also, Medical ABC limits the insurance record to contain only one address. Please use discretion if adding an additional insurance record to contain the second address.

Medicaid and Medicare NDC requirements

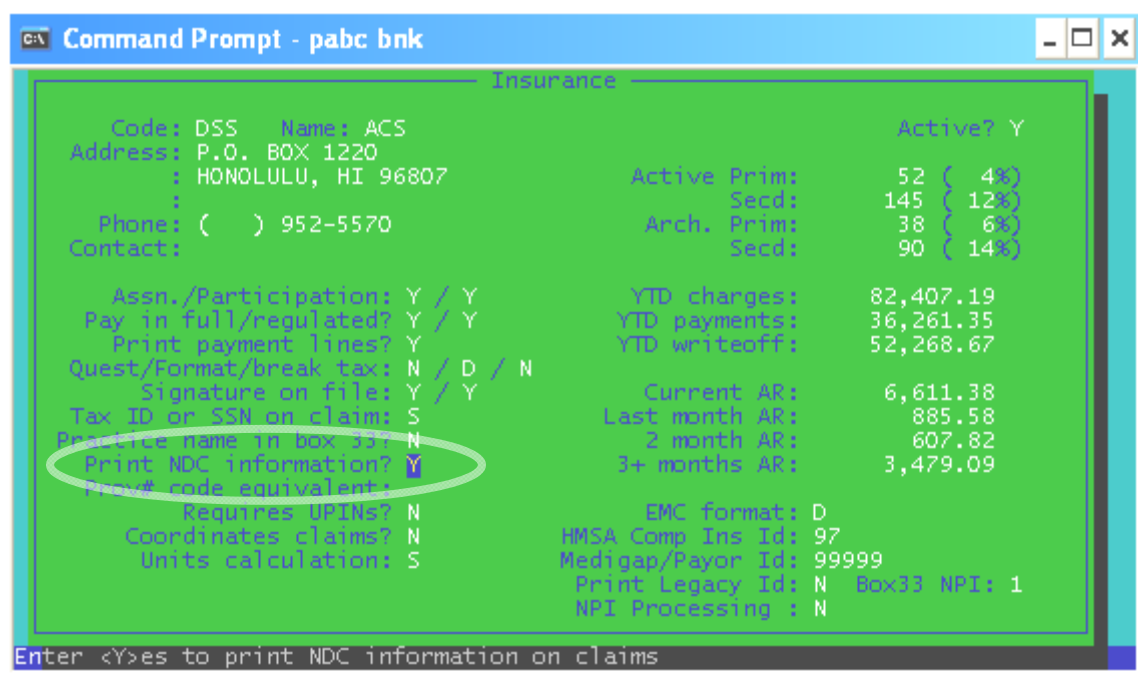
As of July 1, 2008, Medicare and Medicaid implemented new NDC requirements and Medical ABC has been updated to meet these mandates. Medicare and Medicaid now require the quantity of NDC billing units when submitting hard copy claims containing both HCPCS and NDC information. Medical ABC provides a conversion rate in order to compute the NDC billing unit quantity. The following sections will guide you through applying the conversion rate into Medical ABC.

Insurance record setup

The insurance records for Medicaid and Medicare must be setup to print NDC information to meet paper claim mandates.

Action	Results or Notes
1) At main menu, select Reference File Maintenance (7).	
2) Select Insurances (3).	
3) Select desired Insurance code.	Insurance Edit screen appears. Set Print NDC information to "Y"

Note: Do this for both Medicaid and Medicare insurance records



NDC Terminology

To assist in understanding the following sections, a list of new terms and definitions is provided.

Terms and Definitions

Example 1

Example 2

HCPCS Amount: The amount of product in a HCPCS billing unit (may be found in the HCPCS description)

10mcg

10mg

HCPCS Billing Unit: The unit billed.

1

1

NDC Amount: The amount of product in a package or NDC billing unit (may be found on the NDC label)

250mcg/ml

500mg

NDC Unit of Measure: The unit of measure associated with NDC amount in the package

1

1

NDC Billing Unit: the unit of measure when billing NDC quantity.

**UN = Units
ML = Milliliter
GR = Grams
F2 = International Units**

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ML = Milliliter
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Conversion Rate: The rate to convert HCPCS quantity to NDC quantity. Derived by dividing the HCPCS amount by the NDC amount.

0.04
(10mcg ÷ 250mcg/ml=0.04ml)

0.02
(10mg ÷ 500mg = 0.02)

HCPCS Quantity Billed: The total number of HCPCS derived by dividing the administered amount by the HCPCS amount. This will be inputted via service entry.

75
If 750mcg was administered and the HCPCS amount is 10mcg, then the HCPCS Quantity Billed is 75.

10
If 100mg was administered and the HCPCS amount is 10mg, then the HCPCS Quantity Billed is 10.

NDC Quantity Billed: The portion of NDC amount that is administered which is printed on Medicaid/Medicare paper claims preceded by the NDC Billing Unit of Measure. Derived by multiplying the conversion rate with the HCPCS Quantity Billed. This will be computed by Medical ABC.

ML3
If the conversion rate is 0.04 and the HCPCS quantity billed is 75, then the NDC quantity billed is 3.
(0.04 x 75 = 3)

UN0.20
If the conversion rate is 0.02 and the HCPCS quantity billed is 10, then the NDC quantity billed is 0.20.
(0.02 x 10 = 0.20)

Populating NDC fields

NDC information fields are located in the right side of the CPT Edit screen.

Action	Results or Notes
1) At main menu, select Reference File Maintenance (7).	
2) Select CPTS (1).	
3) Select desired HCPCS code that will contain the NDC information.	CPT Edit screen appears. Set NDC? to "Y"

Note: New fields have been created in the CPT Edit screen to meet NDC dosage calculation requirements.



Inputting NDC code

For Medicaid, the NDC code must be in the 5-4-2 format, which is the latest NDC format.

If the provided NDC is in the 4-4-2 format, add a leading zero to the first segment of the NDC.

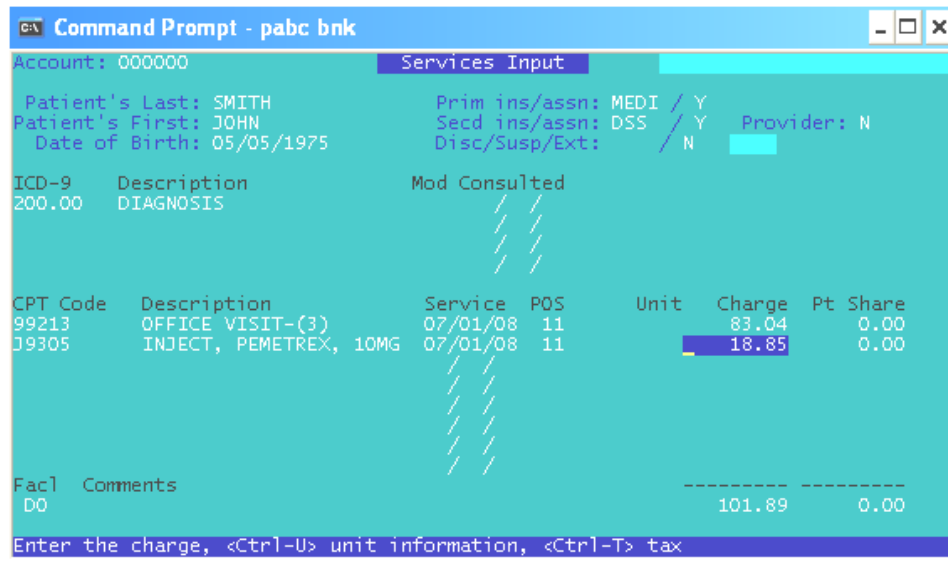
If the provided NDC is in the 5-3-2 format, add a leading zero to the second segment of the NDC.

If the provided NDC is in the 5-4-1 format, add a leading zero to the third segment of the NDC.

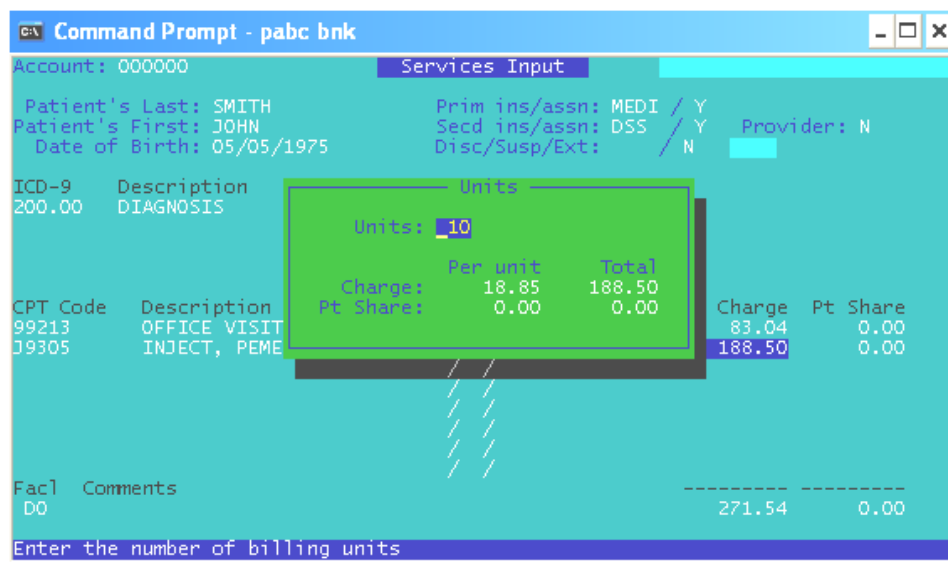
Input the NDC code into the NDC code fields in the 5-4-2 format.

HCPCS Service Entry

Inputting a service line HCPCS remains the same. After the HCPCS is entered, place the cursor into the charge field.



Press Ctrl-U to bring up the Units dialogue box. Enter the HCPCS billing unit quantity into the Units field. For example, 10 HCPCS amounts were used.



For Medicaid and Medicare hard copy claims, the service line for drugs with HCPCS and NDC definition will contain two lines of information—NDC and HCPCS. The NDC information includes NDC qualifier—N4, the NDC code, the NDC billing unit, and the NDC quantity billed. The HCPCS information includes the HCPCS—J-Code and the NCPES quantity billed.

Note: In instances where you have a single HCPCS code with multiple NDC code, please make sure that the correct HCPCS code is selected that would bring up the desired NDC code.

Medicare electronic claim reports from Palmetto

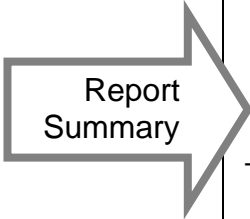
Medicare returns new reports when submitting electronic claims. Providers will no longer receive Claims Confirmation (GENRPT) and Batch Detail Control Listing (BDCL) reports. These reports were specific to Noridian processing.

Palmetto GBA will instead return an Acknowledgement (997) and a Response (RSP) report for each file uploaded. The Response (RSP) report will replace the GENRPT and BDCL reports and will detail file, batch, and claim level edits.

If you have any questions regarding the reports please refer to the Palmetto GBA GPNet Edits Manual located on our TeamPraxis' website www.teampraxis.com/help_desk or access the Palmetto GBA website through www.palmettogba.com/j1 under the EDI Section.

The RSP report comes back from Medicare as soon as the claims are electronically sent. They come back in the following format:

Sample RSP report with no errors



rEDI-link - Claim Acceptance Response			
Response Date: 2008/07/10 Response Type: INITIAL Response Time: 23:04:32			
SENDER: XMCARE		GATEWAY PRODUCTION NETWORK (GPNET)	
PAYOR: 01202		HI,AM SAMOA,GUAM,N.MARIANAS Format: ANSI	
SUBMITTER	ID: HI00100	FILE ID: 976447	Status: ACCEPTED/TEST
Total Claims:	5	Charges:	\$3333.83
Claim Rejects:	0	Charges:	\$0.00

PROVIDER	ID: 1010101010	BATCH ID: 0001	0001 Status: ACCEPTED/TEST
Total Claims:	1	Charges:	\$83.04
Claim Rejects:	0	Charges:	\$0.00

PROVIDER	ID: 1010101010	BATCH ID: 0001	0002 Status: ACCEPTED/TEST
Total Claims:	1	Charges:	\$839.27
Claim Rejects:	0	Charges:	\$0.00

PROVIDER	ID: 1010101010	BATCH ID: 0001	0003 Status: ACCEPTED/TEST
Total Claims:	1	Charges:	\$839.27
Claim Rejects:	0	Charges:	\$0.00

PROVIDER	ID: 1010101010	BATCH ID: 0001	0004 Status: ACCEPTED/TEST
Total Claims:	1	Charges:	\$732.98
Claim Rejects:	0	Charges:	\$0.00

PROVIDER	ID: 1010101010	BATCH ID: 0001	0005 Status: ACCEPTED/TEST
Total Claims:	1	Charges:	\$839.27
Claim Rejects:	0	Charges:	\$0.00
END OF REPORT			


```
R MSG-X0B NPI NOT ON CROSSWALK IN 2310B LOOP > 123456789
-----
PROVIDER ID: 1010101010  BATCH ID: 819601 0001  Status: REJECTED/PROD
  Total Claims:    1      Charges: $202.97
  Claim Rejects:   1      Charges: $202.97

R MSG-Y3G NPI SUBMITTED NOT ON CROSSWALK 2010AA >1234567890
R MSG-V0B EMC Enrollment required HL= REF-02
R MSG-Y1K BILLING PROVIDER SSN OR EIN NOT ON CROSSWALK REF-NM

PATIENT: TEST          CLARE  PCN: 0000858421  Status: REJECTED
INSURED:                ID: 555123333A

  First DOS: 2007/08/15      Charges: $202.97  Payor: C99999
R MSG-X0B NPI NOT ON CROSSWALK IN 2310B LOOP > 1234567890
END OF REPORT
```

As with previous reports, take note of the summary first, correct rejections if any, regenerate, reprocess, and resend claim to Medicare.

When a report is downloaded from Medicare, Medical ABC will automatically print out the report for your convenience. Reports may be opened manually and viewed using WordPad. RSP files will be contained in the Medical ABC EMC directory.

Note: The Interactive Mode option has been disabled in the Medicare EMC menu. Users will not be able to manually download missing reports or electronic remittances from Medicare. If you have received a Medicare check but have not received an electronic file, you must call Medicare to request that a copy of the explanation of benefits be mailed to your office.

Palmetto GBA Medicare contact numbers

As of August 4, 2008, contact numbers for Medicare are:

Provider Customer Service
(866) 931-3901

Medicare Part B Interactive
Voice Response (24 Hours)
(866) 931-3903

Electronic Data Interchange
(866) 749-4301

TTY (Teletypewriter – use of
telephone for hearing impaired)
(866) 931-3902

Call Center Hours are 7am to 5pm PST.