PACE

and

EASY PRINT

A Guide to using Medicare Remit Easy Print (MREP) with PACE

INTRODUCTION

The Medicare Easy Print product was chosen for use by PACE and other Programs administered by The Department of Aging for its ease of use as well as familiarity to the provider community. However, since it was designed for providers submitting Medicare claims, some of the features designed for Medicare do not apply to the PACE application.

Even though some minor functionality is not available, providers transitioning from a paper remittance advice to an electronic R/A will immediately notice some of the advantages of the electronic file over a paper document. These advantages include the ability for the provider to store the R/A on his or her computer for easy retrieval as well as the ability to search for claims by prescription number, NDC , cardholder's name or date of service. Additionally, since the R/A's don't have to be printed, sorted and mailed, they are available earlier. The R/A is usually posted on the website the Wednesday before the R/A date. For example, the R/A dated Friday July 18, 2008, was available Wednesday July 16, 2008.

Although this document is intended to be used after providers review the CMS Easy Print Manual, it is acknowledged that some providers may wish to retrieve their Remittance Advice from the website and explore Easy Print's functionality through experience. In either case this document can be used as a guide to address some of the features of Easy Print as well as to identify those functions that did not "translate" from PACE to the Medicare format.

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I. VIEWING THE RETRIEVED DOCUMENT

Providers retrieving their R/A will see a screen containing all the claims on the R/A. Some of the columns have familiar headings, while others do not. A Medicare to PACE glossary is included at the end of this guide, but for ease of use, the following field translations are presented:

MEDICARE TERMS	NAME	ACNT	ICN	BILLED AMT	PAID AMT	FROM DATE	TO DATE	ASY
PACE TERMS	same	Prescription number	Internal Control Number is named the Control Reference Number by PACE	This amount is the lower of the provider submitted amount in the U&C or Patient Pay Submitted field.	Amount paid by the Program	Date of Service	Date of Service	Assignment. The Medicare field will always be populated with a "Y"

Providers see the following six (6) function files. Each file contains different information or permits a specific action. Placing the cursor over each file identifies its functionality. Because Easy Print is a Medicare designed product, some of the features of the SEARCH function do not apply to PACE. Providers highlighting the Search window in the SEARCH file will view a list of search criteria. The PACE available criteria are listed in the SEARCH column.

CLAIM LIST	CLAIM DETAIL	REMIT SUMMARY	DATA VIEW	SEARCH	GLOSSARY
				BENE ACCOUNT NUMBER (cardholder's prescription number)	NOTE: These are Medicare terms, not PACE terminology.
				BENE (cardholder's) LAST NAME	
				HICN (cardholder's Program ID number)	
				ICN = PACE CRN	
				NDC	
				RENDERING PROVIDER NUMBER (will always be the provider's NPI)	
				SERVICE DATE	

II. ACCESSING THE CLAIM DETAIL OR REMITTANCE ADVICE

This heading information appears when providers choose to view or print the claim detail for specific cardholder(s) or the entire remittance advice.

The location of operations for the PACE Program.

FIRSTHEALTH/PACE
4000 CRUMS MILL RD
SUITE 301
HARRISBURG, PA 17112

Although adapted for use with PACE and other Department of Aging administered programs, Easy Print was developed by CMS as a Medicare product.

MEDICARE
REMITTANCE
NOTICE

Provider's NPI,
Date of the R/A.
EFT banking trace number
Page number.

The Pay-To name and address of the Provider as it appears on the Provider Enrollment form.

PACE PHARMACY
123 MAIN ST
OURTOWN, PA 111111111

PROVIDER #: 1112223334
DATE: 08/01/2008
CHECK/EFT #: 080805PACE0390000
PAGE #: 1

REND PROV SERV DATE POS NOS PROC MODS BILLED ALLOWED DEDUCT COINS GRP/RC-AMT PROV PD

NAME SMITH, JOHN HIC 111111111 ACNT 0213151 ICN 813781998301 ASG Y MOA

III. CLAIM EXAMPLES

The following examples show the application of Medicare terms to PACE terms. A glossary of PACE Codes accompanies this document.

Please note the following PACE specific adaptation.

- **The dollar amount displayed in the BILLED column is the <u>lower</u> of either the provider submitted amount in the U&C or Patient Pay Amount field**.
- **Although claims are submitted with the amount received from the primary payer, this amount <u>does not</u> appear on the PACE R/A EXCEPT when the received TPL is used in pricing (See Example # 3). Providers should contact the primary payer or review their transaction history if this information is needed.**
- **The ALLOWED amount is the calculated maximum the provider can receive from the program and/or the cardholder.**
- **The DEDUCT is the PACENET premium.**
- **The COINS column is the Program allowed copay amount. This amount may be less than the PACE/PACENET copay.**

NOTE: The following examples are actual claims with the provider, cardholder name and ID fictionalized.

THE FOLLOWING HEADINGS APPEAR WHEN VIEWING EITHER THE ENTIRE REMITTANCE ADVICE OR SPECIFIC CLAIM DETAIL.
Example 1 will define all headings and should be referenced when necessary. *NOTE: Dashed vertical lines have been added in Example 1 for explanation purposes.*

EXAMPLE # 1: PACE CARDHOLDER WITH NO OTHER PRESCRIPTION INSURANCE.

Claim Information:
Claim is submitted to PACE with a U&C of $129.35 and an Other Coverage Code (OCC) of 0 (Cardholder has no other prescription coverage.)

(1) REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT		PROV PD
(2) NAME DOE,	JANE	HIC 123456789			ACNT	0214154	ICN	813882437001		ASG Y	MOA	
(3) 1112223334	0517 051708		100	00781140505		129.35	88.83	0.00	6.00	OA-42	40.52	82.83
(4) PT RESP	6.00			CLAIM TOTALS		129.35	88.83	0.00	6.00		40.52	82.83
(5)ADJ TO TOTALS: PREV PD					INTEREST	0.00	LATE FILING CHARGE			0.00	NET	82.83

Lines #1 & #3

REND PROV: NPI of the pharmacy rendering service: 1112223334. NOTE: The Easy Print R/A is designed to identify various providers rendering service to a patient. For the PACE application, the Rendering Provider will always be the pharmacy submitting the claim.

SERV DATE: Month/Day – Month/Day/Year of the prescription dispensed: 5/17*(to)* 5/17/2008. Easy Print displays the date of service in this format.

POS: Place Of Service: N/A- will be blank. It is always the pharmacy.

NOS: Number Of Services = Quantity dispensed--100

PROC: MEDICARE Procedure Code = Drug NDC 00781140505

MODS: HCPCS modifiers: N/A- will be blank.

BILLED: The amount used to calculate reimbursement. For claims received with both the U&C price and the Patient Pay Amount (Field 433-DX) the amount used for the reimbursement calculation will be the lower of the two. Since there was **no** primary insurance and therefore no primary co-pay (Patient Pay Amount); the amount submitted in the U&C field of $129.35 appears.

ALLOWED: Allowed amount: The calculated amount allowed from both the program and the cardholder is $88.83.

DEDUCT: Appears in PACENET claims only. The amount attributed toward the PACENET premium. The cardholder is enrolled in PACE, not PACENET; therefore 0.00's appear.

COINS: Coinsurance Due: This is the Program calculated copay due from the cardholder. Depending on the allowed amount, it *may* be less than the PACE/PACENET copay. This example has the PACE generic copay of $6.00.

GRP/RC-AMT: **Group Reason Code Amount**: The GRP/RC is **OA-42**: "**Other Adjustments –charges exceed maximum allowed amount".** The amount **(AMT**)allowed of $88.83 was exceeded by $40.52 -- the difference between the BILLED amount - $129.35 and the ALLOWED amount - $88.83.($129.35 - $88.83 = $40.52)

PROV PD: Amount paid to provider by the Program for this claim: $82.83

Line #2 **(to be read across.)**

NAME: (of cardholder): Jane Doe

HIC: Health Insurance Claim number: The cardholder's Program ID number -- varies from PACE to CRDP, to SPBP etc.

ACNT: Patient account number or the prescription number as assigned by the provider.

ICN: Internal Control Number. PACE, CRDP, SPBP and other Programs refer to this as the CRN, Control Reference Number. This number is unique to the claim and is used for internal tracking.

ASG: Indicates if assignment is accepted. This will always be "Y".

MOA: Medicare Outpatient Adjudication remark code: N/A; will be blank.

Line #4

PT RESP: Patient Responsibility: The provider is being paid $6.00(copay) by the cardholder.

CLAIM TOTALS: The Amounts listed are identified by the headings in Line 1. BILLED = $129.35, ALLOWED =$88.83, DEDUCT = $0, COINS (PACE COPAY)= $6.00, GRP/RC-AMT = $40.52, PROV PD = $82.83.

Line #5

ADJ TO TOTALS: (Adjustment to Totals): **PREV PD:** No value appears because no adjustment was made for this claim.

INTEREST: Any interest due from the Program would appear here.

LATE FILING CHARGE: This is a Medicare calculated field and does not apply to PACE, CRDP, SPBP etc..

NET: Amount paid, $82.83, by the Program.

EXAMPLE # 2: PACE CARDHOLDER WITH PART D PRESCRIPTION COVERAGE.

Claim Information:

Submitted U&C is $354.15 (Note this amount is NOT displayed. See BILLED under Line #3 below.) Patient Pay amount transmitted to PACE in Field 433-DX is $5.60 (Low Income Subsidy [LIS] cardholder). The cardholder has a LIS copay of $5.60. PACE pays $0.00.

(1) REND PROV	SERV DATE	POS NOS	PROC	MODS	**BILLED**	**ALLOWED**	**DEDUCT**	**COINS**	GRP/RC-AMT	**PROV PD**
(2) NAME DOE BETTY		HIC 999999999		ACNT 5482214		ICN 816580015101		ASG Y	MOA	
(3) 1112223334 0613 061308		30	00002411730		**5.60**	**5.60**	**0.00**	**5.60**		**0.00**
(4) →				**REM: 74**						
(5) **PT RESP**	**5.60**		CLAIM TOTALS		5.60	5.60	0.00	5.60	0.00	0.00
(6) ADJ TO TOTALS: PREV PD			INTEREST	0.00	LATE FILING CHARGE		0.00	NET	0.00	

Line #3:

BILLED: The lower of the billed amount or the U&C ($354.15) or Patient Pay Amount ($5.60) appears.

ALLOWED: The calculated amount allowed from both the program and the cardholder is $5.60.

DEDUCT: **=** 0 No PACENET premium.

COINS: LIS copay from the primary plan is $5.60. PACE copay is $6.00. Program returns the lower**.**

PROV PD: Allowed amount of $5.60 is due to the provider from the cardholder; no payment due to the provider from the Program.

Line # 4:

REM: (Remarks) **74**. Code 74 will always appear **when the program is paying $0.00**. Note: depending on the claim, payment *may* be due from the cardholder as this example illustrates.

Line # 5:

PT RESP:(Patient Responsibility) = $5.60

EXAMPLE # 3: PACE CARDHOLDER WITH A PART D PLAN. PATIENT PAY AMT + TPL EXCEEDS U&C.

Claim Information:

Claim submitted with a U&C of $6.49. Patient Pay Amount submitted to PACE in Field 433-DX is $4.04. TPL amount submitted to PACE is $3.47.
NOTE: According to the information received from the provider, the primary payer paid the provider $3.47 and returned a copay (amount to collect from the cardholder) of $4.04.

(1) REND PROV	SERV DATE	POS	NOS	PROC	MODS	**BILLED**	**ALLOWED**	**DEDUCT**	**COINS**	**GRP/RC-AMT**		**PROV PD**
(2) NAME DOE, JAYNE				HIC 999999999		ACNT 5519090		ICN 816580048701		ASG Y	MOA	
(3) 1112223334	0613 061308	30		00406035705		**6.49**	**6.49**	**0.00**	**3.02**	**OA-23**	**3.47**	**0.00**
(4)			**REM: 74**									
(5) **PT RESP**	**3.02**	CLAIM TOTALS				6.49	6.49	0.00	3.02		3.47	0.00
(6) ADJ TO TOTALS: PREV PD		INTEREST	0.00	LATE FILING CHARGE						0.00	NET	0.00

Line #3:
BILLED AMOUNT: = $6.49.

The lower of the billed amount or the U&C ($6.49) or Patient Pay Amount ($4.04) ***usually*** appears in the BILLED amount field. However this provider has submitted claim data that has the total reimbursement by the primary being more than what was billed. In these instances, PACE logic enters the Amount ***allowed* by the Program,** not the Patient Pay Amount in the ALLOWED field. The **ALLOWED amount = $6.49**. Coincidentally this amount--$6.49-- is the same as the BILLED amount (30 tablets X unit price of $0.0830 = $2.49 + $4.00 dispensing fee = $6.49).

DEDUCT: **= $0.00** (no PACENET premium)
COINS: **= $3.02** (The ALLOWED amount minus the Primary TPL payment or $6.49 - $3.47 = $3.02)
GRP/RC-AMT: **= $3.47.** NOTE: The TPL of $3.47, identified by **OA-23**, appears in this claim because it was used to calculate the copay.
PROV PD: **= $0.00**
Line #4:

REM: 74. The program is paying $0.00. Note: depending on the claim, payment *may* be due from the cardholder as this example also illustrates.

Line #5:

PT RESP: Patient Responsibility is $3.02, *not* the $4.04 received from the primary since the $4.04 would result in the provider receiving more reimbursement **from all sources** than was billed. To illustrate, the primary copay is $4.04 + the amount the primary paid is $3.47 = $7.51; which is ***greater*** than the billed amount of $6.49.

EXAMPLE # 4: PACENET CARDHOLDER. MEDICARE PART D PARTNER PLAN; $0.00 GENERIC COPAY.

Claim Information:

Part D partner plan has a monthly premium of $25.50.
Claim submitted to PACE with a U&C of $10.25; $0 in the Patient Pay Submitted field (433-DX). Other Coverage Amount (TPL) received from the Primary payer is $9.30. Note: The TPL amount received on the claim from the provider is not reproduced on the RA *unless* it is used in the reimbursement calculation.

(1) REND PROV	SERV DATE	POS NOS	PROC	MODS	**BILLED**	**ALLOWED**	**DEDUCT**	**COINS**	**GRP/RC-AMT**	**PROV PD**
(2) NAME PACE PAUL	HIC 999999999	ACNT 0214117			ICN 813782192401			ASG Y	MOA	
(3) 1112223334	0516 051608	30 00527132510			**0.00**	**0.00**	**0.00**	**0.00**		**0.00**
(4)			**REM: 74**							
(5) PT RESP	0.00		CLAIM TOTALS		0.00	0.00	0.00	0.00		0.00
(6) ADJ TO TOTALS: PREV PD			INTEREST		0.00	LATE FILING CHARGE		0.00	NET	0.00

EXPLANATION:
Line #3:

BILLED: The amount used to calculate reimbursement.
The provider submitted a U&C of $10.25. The primary plan has a $0.00 copay for generics, therefore, the Patient Pay Amount field contains $0.00. The lower value,$0.00 appears.

ALLOWED: The primary plan's response indicated $0.00 was due from the cardholder. Program logic uses this value as the amount to be included in the pricing algorithm.

DEDUCT: **= 0.** Because $0.00 appears in the ALLOWED column, *even* ***if the premium has not yet been collected*, no premium amount can be collected.**

COINS: Coinsurance Due: Since the primary response indicates the cardholder has a $0 dollar copay, PACE logic chooses the lower of the PACENET copay of $8.00 or the primary's copay of $0.00, which appears in the Patient Pay Amount Field. NOTE**:** *Although the provider submitted a TPL $9.30 that was received from the primary payer, this amount of $9.30 was not used in the reimbursement calculation and therefore does* ***not*** *appear on the R/A.*

GRP/RC-AMT: Group Reason Code Amount: blank for this example.
PROV PD: Amount paid to provider by the Program for this claim--$0.00.

Line #4:

REM: 74. No amount paid to the provider by the Program.

Line #5:

PT RESP: 0.00. The rest of the line explanations follow Example 1 logic.

EXAMPLE # 5: PACENET CARDHOLDER. PART D PARTNER; PREMIUM & PARTIAL COPAY COLLECTED.

Claim Information:

Premium of $21.60 is collected at pharmacy. The entire premium and a partial PACENET copay has been collected. Primary Plan copays are: Tier 1: $7.00, Tier 2: $23.75, Tier 3: $94.00; Tier 4: 25%.

Claim submitted to PACE with a U&C of $163.75; $23.75 (primary plan Tier 2 copay) in the Patient Pay Amount field (433-DX) and Other Coverage Amount (TPL) received from the Primary payer of $104.79.
Note: The TPL amount of $104.79 is not reproduced because it is not used in the reimbursement calculation..

(1) REND PROV	SERV DATE	POS NOS	PROC	MODS	**BILLED**	**ALLOWED**	**DEDUCT**	**COINS**	**GRP/RC-AMT**	**PROV PD**
(2) NAME PACENET, PATRICIA			HIC 123123123		ACNT 0208808		ICN 813781909301		ASG Y	MOA
(3) 1112223334	0516 051608		90 00169008281		**23.75**	**23.75**	**21.60**	**2.15**		**0.00**
(4)			**REM: 74**							
(5) **PT RESP**	**23.75**		CLAIM TOTALS		20.00	20.00	21.60	2.15	0.00	0.00
(6) ADJ TO TOTALS: PREV D			INTEREST		0.00	LATE FILING CHARGE			0.00 NET	0.00

Line #3

BILLED: The amount used to calculate reimbursement.
The amount used for the reimbursement calculation will be the lower of the submitted U&C and Patient Pay Amount and will appear in this field. The provider submitted U&C field contains $163.75; Patient Pay Amount field contains the Tier 2 copay of $23.75. Therefore $23.75 appears in the BILLED column.

ALLOWED: $23.75

DEDUCT: PACENET PREMIUM = $21.60

COINS: The PACENET copay is $2.15. The amount billed and allowed was $23.75. The premium is $21.60. A total amount of $23.75 was due to the provider by the cardholder. The copay is the difference between the premium and the allowed amount--$23.75 - $21.60 = $2.15. Although the PACENET copay for this drug is $15.00, the total payment to the provider can not exceed the allowed amount of $23.75. Therefore, the PACENET copay is only $2.15.

GRP/RC-AMT: Blank for this example.

PROV PD: The Program pays the provider $0.00.

Line #4:

REM: 74 No amount paid to the provider by the Program

Line #5:

PT RESP: Patient Responsibility: The provider should have collected $23.75 from the cardholder. (Premium of $21.60 + copay of $2.15). The rest of the line explanations follow Example 1 logic.

EXAMPLE #6 : PACENET CARDHOLDER. PART D NON-PARTNER PLAN'S COPAY EXCEEDS PACENET COPAY.

Claim Information:

Non-partner plan. PACENET cardholder's premium is billed by plan. Primary Plan copays are: Tier 1: $5.00, Tier 2: $20.00, Tier 3: $50.30; Tier 4: 25%.
Claim submitted to PACE with a U&C of $168.90; $20.00 (primary plan Tier 2 copay) in Patient Pay Submitted field (433-DX).
Other Coverage Amount (TPL) received from the Primary payer is $110.78.
Note: The TPL amount of $110.78 does not appear.

(1) REND PROV	SERV DATE	POS NOS	PROC	MODS	**BILLED**	**ALLOWED**	**DEDUCT**	**COINS**	**GRP/RC-AMT**	**PROV PD**
(2) NAME PACENET, PATRICIA		HIC 133333333	ACNT 0212141					ICN 813781961201	ASG Y	MOA
(3) 1112223334	0516 051608	30 00173064255			**20.00**	**20.00**	**0.00**	**15.00**		**5.00**
(4) **PT RESP**	**15.00**		CLAIM TOTALS		20.00	20.00	0.00	15.00	0.00	5.00
(5) ADJ TO TOTALS: PREV PD			INTEREST		0.00	LATE FILING CHARGE			0.00 NET	5.00

Line #3

BILLED: The amount used to calculate reimbursement.
The amount used for the reimbursement calculation will be the lower of the submitted U&C and Patient Pay mount and will appear in this field. The U&C field contains $168.90; Patient Pay Amount field contains the Tier 2 copay of $20.00; therefore,$20.00 appears in the BILLED column.

ALLOWED: $20.00

DEDUCT: PACENET PREMIUM of $0.00. Non-partner plan. Cardholder receives monthly bill from the plan.

COINS: PACENET copay is $15.00. The amount billed and allowed was $20.00. The premium is $0.00.
A total amount of $20.00 is due to the provider from all sources.

GRP/RC-AMT: No data appears.

PROV PD: The Program pays the provider $5.00.

Line #4:

PT RESP: Patient Responsibility: The provider was paid $15.00 by the cardholder.
Claim Totals: Billed: 20.00; ALLOWED $20.00; DEDUCT:(Premium)$0; COINS:(Copay)$15.00; PROV PD:$5.00

EXAMPLE # 7: PACENET CARDHOLDER WITH PRIMARY COVERAGE IN THE DOUGHNUT HOLE.

Claim Information:

Primary accepts claim, pays provider $0.00 and returns amount cardholder is to pay. Claim submitted to PACENET with an OCC of 4 (other coverage exists, payment not collected.)

Claim submitted with a U&C of $264.08. Patient Pay Amount returned from the primary payer and transmitted to PACE in Field 433-DX is $231.22.

(1) REND PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
(2) NAME DOE, ROBERT		HIC 333333333		ACNT 5620404		ICN 816580016301			ASG Y	MOA
(3) 1112223334 0613 061308		60 50458030150		**231.22**	**223.71**	**0.00**	**15.00**		**OA-42**	**7.51**	**208.71**
(4) PT RESP 15.00		CLAIM TOTALS		231.22	223.71	0.00	15.00			7.51	208.71
(5) ADJ TO TOTALS: PREV PD		INTEREST		0.00	LATE FILING CHARGE			0.00		NET	208.71

Line #3

BILLED Amount: The lower of the U&C ($264.08) or Patient Pay Amount ($231.22) appears in the BILLED amount field.

ALLOWED: $223.71. (Unit price of $3.66189 x 60 tablets + $4.00 dispensing fee.)

DEDUCT: 0.00. No PACENET premium for this claim.

COINS: $15.00 PACENET Copay.

GRP/RC–AMT: The code OA-42 precedes the value of $7.51. The calculated allowed amount ($223.71) due the provider exceeds the billed amount ($231.22) by $7.51 ($231.22 - $223.71= $7.51).

PROV PD: $208.71.

Line #4:

PT RESP: Patient Responsibility: The provider was paid $15.00 by the cardholder.

Claim Totals: Billed: 231.22; ALLOWED $223.71; DEDUCT:(Premium)$0.00; COINS:(Copay)$15.00; PROV PD:$208.71

IV. PAID CLAIMS with E.O.B. (Explanation of Benefit) CODES

Explanation: Claims may be approved by PACE/PACENET and accompanied by codes identified as Remarks (REM). These claims may initially deny. If the provider calls, a medical exception (REM 88) *may* be granted, resulting in a paid claim. Other paid claims may have a REM code to inform the provider of a claim specific circumstance. For example, in previous examples 4 and 5, the claim was processed, but no payment was made by PACE or PACENET. This "no payment due" is accompanied by the REM 74. The examples below illustrate examples of common EOB's.

Example # 8: Paid claim with Medical exception—REM: 88

REND PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME DOE, JOHN		HIC 444444444		ACNT 5697388			ICN 817080085301		ASG Y MOA	
1112223334	0618 061808	2 00074379902			1476.49	1466.49	0.00	9.00	OA-42 10.00	1457.49
					REM: 88					
PT RESP 9.00		CLAIM TOTALS			1476.49	1466.49	0.00	9.00	10.00	1457.49
ADJ TO TOTALS: PREV PD				INTEREST	0.00	LATE FILING CHARGE			0.00 NET	1457.49

Example # 9: Paid claim. Cardholder identified as eligible for Low Income Subsidy (LIS)--- REM: DX

Amount of $16.46 appearing in Patient Pay Amount field (433-DX) exceeds LIS (Low Income Subsidy).

REND PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME DOE, JOHN		HIC 444444444		ACNT 5419176			ICN 816680706401		ASG Y MOA	
1112223334	0614 061408	45 00472037945			16.46	**16.46**	0.00	6.00	10.46	
					REM: DX					
PT RESP 6.00		CLAIM TOTALS			16.46	16.46	0.00	6.00	0.00	10.46
ADJ TO TOTALS: PREV PD				INTEREST	0.00	LATE FILING CHARGE			0.00 NET	10.46

Example #10: Paid claim. Primary prior authorization approved and no provider payment ---- REM: 75 & 74

REND PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME DOE, JOHN		HIC 444444444		ACNT 5656237			ICN 817084223401		ASG Y MOA	
1112223334	0510 051008	22 00056017075			0.00	0.00	0.00	0.00		0.00
					REM: 75 74					
PT RESP 0.00		CLAIM TOTALS			0.00	0.00	0.00	0.00	0.00	0.00

V. VOIDED CLAIMS

Explanation: Most claims are voided by the provider. In some instances, claims may be voided by the program at the direction of the Department of Aging. Monies voided at the direction of the Department appear on the summary page and are identified with the PROVIDER ADJUSTMENT CODE: WO

Voided claims appear in the approved claims summary section and are identified with monetary amounts having a negative (-) sign. Claims voided by the provider, as illustrated in the 2 examples below, ALWAYS have the number "8" in the 5th position of the ICN. In example # 11, the ICN 816886322501 has an 8 in the 5th position as does example # 12 with ICN 816583095301. In some instances, providers void claims even though they were receiving no payment from the Program as demonstrated by Example # 12.

Example #11. Claim voided by the provider. Provider payment reduced by $8.24.

REND PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT		PROV PD
NAME DOE, JANE		HIC 555555555		ACNT 5348179			**ICN 816886322501**		ASG Y	MOA	
1112223334 1219 121907		30 58177088601			**-14.24**	**14.24**	**0.00**	**-6.00**			**-8.24**
				REM: 01 04							
PT RESP 0.00		CLAIM TOTALS			**-14.24**	**-14.24**	**0.00**	**-6.00**		**0.00**	**-8.24**
ADJ TO TOTALS: PREV PD		INTEREST			0.00		LATE FILING CHARGE		0.00	NET	**-8.24**

Example #12. Claim voided by the provider. Provider payment reduced by $0.00.

REND PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT		PROV PD
NAME DOE, JOHN		HIC 444444444		ACNT 5438704			**ICN 816583095301**		ASG Y	MOA	
1112223334 0225 022508		30 00185077101			-24.12	-32.70	0.00	0.00	CR-23	-32.70	0.00
				REM: 74					CR-42	8.58	
PT RESP 0.00		CLAIM TOTALS			-24.12	-32.70	0.00	0.00		-24.12	0.00
ADJ TO TOTALS: PREV PD		INTEREST			0.00	LATE FILING CHARGE			0.00	NET	0.00

VI. GLOSSARY OF COMMONLY USED MEDICARE TERMS

Each Easy Print R/A has a Glossary, identified in the VIEW tab, containing the codes that appear on the current R/A. The Easy Print Glossary defines the reason codes that appear on the Remittance Advice.

As stated earlier, Easy Print is designed for Medicare and uses Medicare codes. PACE uses NCPDP (National Council of Prescription Drug Programs) error codes. When PACE codes appear as EOB's, they are accompanied with Medicare definitions which do not apply to PACE claims. For example the NCPDP code 88 identifies a DUR code accompanying a paid medical exception claim. It is not an "Adjustment Amount." Therefore, providers using the Easy Print product should ignore the Medicare definitions and apply the PACE NCPDP definitions. Common codes appearing on claims are identified below with their NCPDP (PACE) and the Easy Print definitions. A complete listing of PACE Remittance Advice codes can be found on pages 21-24.

Code	NCPDP—PACE Definition	Medicare Easy Print Glossary Definition
01	M/I BIN Number May appear on provider submitted reversals	ANSI message missing from Easy Print. Refer to website http://www.wpc-edi.com/codes for verbiage.
02	M/I Processor Control Number May appear on provider submitted reversals	ANSI message missing from Easy Print. Refer to website http://www.wpc-edi.com/codes for verbiage.
6E	M/I Other Payer Reject Code	ANSI message missing from Easy Print. Refer to website http://www.wpc-edi.com/codes for verbiage.
22	M/I DAW Indicator	Payment adjusted because this care may be covered by another payer per coordination of benefits.
23	**N/A Medicare definition applies**	Payment adjusted due to the impact of prior payer(s) adjudication.
28	M/I Date Prescription Written	Coverage not in effect at the time the service was provided.
42	**N/A Medicare definition applies**	Charges exceed our fee schedule or maximum allowable amount.
74	Other Carrier payment meets or exceeds payable. No payment due.	Indirect Medical Education Adjustment
75	Prior Authorization (PA) required	- Direct Medical Education Adjustment.
79	Refill Too Soon (Over-ride granted)	Cost Report days. (Handled in MIA15)
88	DUR Error (Medical Exception granted)	Adjustment amount represents collection against receivable created in prior overpayment.
CR	**N/A Medicare definition applies**	- Correction and Reversals
DX	M/I Patient Pay amount submitted	ANSI message missing from Easy Print.
OA	**N/A Medicare definition applies**	- Other adjustments
PR	**N/A Medicare definition applies**	Patient Responsibility
PX	Non Matched Other Payer ID	ANSI message missing from Easy Print
WO	**N/A Medicare definition applies**	Overpayment Recovery

VII. EASY PRINT GLOSSARY EXAMPLE:

As stated earlier, all the codes appearing on each Easy Print R/A appear in the Easy Print Glossary. The R/A used in this Easy Print Guide example had these codes identified in the Medicare Glossary tab.

{ 04 } - ANSI message missing from Easy Print. Refer to website http://www.wpc-edi.com/codes for verbiage.

{ 23 } - Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments

{ 28 } - Coverage not in effect at the time the service was provided.

{ 41 } - Discount agreed to in Preferred Provider contract.

{ 42 } - Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)

{ 6E } - ANSI message missing from Easy Print. Refer to website http://www.wpc-edi.com/codes for verbiage.

{ 74 } - Indirect Medical Education Adjustment.

{ 75 } - Direct Medical Education Adjustment.

{ 79 } - Cost Report days. (Handled in MIA15)

{ 88 } - Adjustment amount represents collection against receivable created in prior overpayment.

{ CR } - Correction and Reversals

{ DX } - ANSI message missing from Easy Print. Refer to website http://www.wpc-edi.com/codes for verbiage.

{ OA } - Other adjustments

{ PR } - Patient Responsibility

{ PX } - ANSI message missing from Easy Print. Refer to website http://www.wpc-edi.com/codes for verbiage.

{ WO } - Overpayment Recovery

VIII. PACE EASY PRINT REPORTS

The CMS Medicare Easy Print product contains six different report types. Some of these are available as PACE reports while others are not. The following is a brief description of the adaptation of PACE information to the Medicare format.

- Adjusted Service Lines Report: Adjusted claims appear as voids and will appear on this report. Adjusted or voided claims (those with negative amounts) will also appear on the entire remittance advice (see sample ENTIRE REMITTANCE at the end of this section.)
- COB / NON-COB Claims:
    - COB claims: COB claims are those that are processed and forwarded to additional payers. Since PACE does not forward claims to additional payers, no claims will appear.
    - NON-COB claims: <u>All</u> processed claims will appear as NON-COB Claims.

- Deductible/COINS Service Lines: Three (3) reports are available.
    - The Deductible Lines Report will display only those claims that had a PACENET premium collected at the pharmacy.
    - The COINS Report Lines will display those claims with a copay being collected. Claims with a premium may also appear in this report.
    - Deductible/COINS Lines Report will display all claims with either a premium **or** copay being collected.

- Denied Service Lines: With the introduction of real time processing, PACE discontinued printing most denied claims. Logic dictated that since providers were immediately aware of a denied claim, the correction would be made, when possible, to have the claim paid. Since then, the only denied claims that print on the R/A are claims denied when accepted by the Department of Aging for authorized exception processing. With Easy Print, that same logic will continue. Additionally, the Easy Print program logic defines a denied claim as a claim in which the ALLOWED AMT is zero (0). The claim may have been accepted by the Program for processing; thereby permitting a label to be produced at the pharmacy, but no payment is being received by the pharmacy from either the Program or the cardholder.

- Other Adjustments: No report will print.

- Entire Remittance: As indicated, providers can either view the entire remittance advice on their PC using the PREVIEW function or print a paper copy.

IX. ENTIRE REMITTANCE TOTAL PAGE EXAMPLE:

Explanation: By entering the Entire Remittance option on the Report tab, the entire Remittance can be previewed or printed. This example illustrates the totals that appear at the end of PACE PHARMACY'S R/A.

FIRSTHEALTH/PACE
PROVIDER #1112223334
CHECK/EFT # 000111PACE 0399999

PACE PHARMACY
PAGE 47
R/A DATE

MEDICARE
REMITTANCE
NOTICE

REND PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME PACE, PAUL		HIC 999999999		ACNT 6733605		ICN 814284061101			ASG Y MOA	
1112223334 0521 052108		480	00472132016		1.05	1.05	0.00	1.05		0.00
PT RESP	1.05		CLAIM TOTALS		1.05	1.05	0.00	1.05	0.00	0.00
ADJ TO TOTALS: PREV PD				INTEREST	0.00	LATE FILING CHARGE			0.00 NET	0.00

REND PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME PACE, PAUL		HIC 999999999		ACNT 6733605		ICN 814284062801			ASG Y MOA	
1112223334 0521 052108		480	00472132016		-1.05	0.00	0.00	-1.05		0.00
PT RESP	0.00		CLAIM TOTALS		-1.05	0.00	0.00	-1.05	0.00	0.00
ADJ TO TOTALS: PREV PD				INTEREST	0.00	LATE FILING CHARGE			0.00 NET	0.00

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	683	$25,506.36	23,892.50	656.22	3,355.34	3,362.88	18,131.92	20.00	18,111.92

NOTE: The total line identifies all claims and amounts billed and allowed. The Billed Amount *minus* the Deductible Amount *minus* the Coinsurance Amount *minus* the Reason Code Amount *equals* the Provider Paid Amount. In this example, since there is a Provider Adjustment Amount of $20.00, it is subtracted from the Provider Paid Amount to arrive at the Check Amount.

BILLED AMT		DEDUCT AMT		COINS AMT		TOTAL RC-AMT		PROV PD AMT		PROV ADJ AMT		CHECK AMT
$25,506.36	**-**	**656.22**	**-**	**3,355.34**	**-**	**3,362.88**	**=**	**18,131.92**	**-**	**20.00**	**=**	**18,111.92**

X. REMITTANCE ADVICE SUMMARY EXAMPLE:

Providers wanting to view and/or print their Remittance Advice Summary will see the following information when accessing the Remit Summary screen.

The field identifiers are self explanatory. As explained previously, the COINSURANCE AMOUNT is the copay collected from the cardholder and the DEDUCTIBLE AMOUNT is the PACENET premium which is also collected from the cardholder.

R/A page with recovery identified with WO

Easy Print v2.3 PROVIDER PAYMENT SUMMARY REPORT VER: 004010X091A1

PROVIDER NAME : PACE PHARMACY PROVIDER #: 1112223334
CHECK/EFT TRACE NUMBER : 080708PACE0391111 CHECK DATE: 07/04/08

TOTAL CLAIMS : 683

BILLED AMOUNT	:	25506.36
TOTAL REASON CODE ADJUSTMENT AMOUNT	:	3362.88
TOTAL ALLOWED AMOUNT	:	23892.50
TOTAL COINSURANCE AMOUNT	:	3355.34
TOTAL DEDUCTIBLE AMOUNT	:	656.22
TOTAL PAID TO PROVIDER	:	18131.92
TOTAL INTEREST AMOUNT	:	0.00
TOTAL CHECK/EFT AMOUNT	:	18111.92

PROV ADJ CODE1: WO FCN: 0899999999 HIC: AMT: 20.00

XI. GLOSSARY OF PACE REMITTANCE ADVICE CODES

NCPDP	PACE/NCPDP DESCRIPTION
	"M/I" means MISSING/INVALID
01	M/I BIN NUMBER
02	M/I VERSION NUMBER
03	M/I TRANSACTION CODE
04	M/I PROCESSOR CONTROL NUMBER
05	PROVIDER NUMBER INVALID
06	M/I GROUP NUMBER
07	M/I CARDHOLDER NUMBER
09	M/I BIRTH DATE
11	M/I PATIENT RELATIONSHIP CODE
12	M/I PATIENT LOCATION
13	OTHER COVERAGE CODE INVALID
15	M/I DATE FILLED
16	M/I PRESCRIPTION/SERVICE REFERENCE NUMBER
17	M/I FILL NUMBER
19	M/I DAYS SUPPLY (DAYS SUPPLY=ZERO OR > 30 DAYS)
20	M/I COMPOUND CODE
21	M/I PRODUCT/SERVICE (NDC)
22	M/I DAW INDICATOR
23	M/I INGREDIENT COST
25	M/I PHYSICIAN
28	M/I DATE RX WRITTEN
29	M/I NUMBER OF REFILLS AUTHORIZED
32	M/I LEVEL OF SERVICE
33	M/I PRESCRIPTION ORIGIN CODE
39	M/I DIAGNOSIS CODE
4C	M/I COORDINATION OF BENEFITS/OTHER BENEFITS COUNT
40	PROVIDER NOT ELIGIBLE ON DATE OF SERVICE
41	SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYER
41	SUBMIT BILL TO MEDICARE DISCOUNT PROGRAM
5C	M/I OTHER PAYER COVERAGE TYPE
50	NON-MATCHED PROVIDER NUMBER (PROVIDER NOT ON FILE)
51	NON-MATCHED GROUP ID(CARDNUMBER NOT FOUND IN PACE, CRDP, ETC. FILE)
52	NON-MATCHED CARDHOLDER I.D.(CARDHOLDER NOT ON FILE)
54	NON-MATCHED PRODUCT/SERVICE ID (NDC NOT ON FILE)
55	NON-MATCHED PRODUCT PACKAGE SIZE
56	NON-MATCHED PRESCRIBER (PHYSICIAN NOT ON FILE)
6C	M/I OTHER PAYER ID QUALIFIER
6E	M/I OTHER PAYER REJECT CODE

NCPDP	PACE/NCPDP DESCRIPTION
60	PRODUCT/SERVICE NOT COVERED FOR PATIENT AGE
61	PRODUCT/SERVICE NOT COVERED FOR PATIENT GENDER
62	PATIENT/CARDHOLDER ID NAME MISMATCH
63	INSTITUTIONALIZED PATIENT. PRODUCT/SERVICE ID NOT COVERED
64	CLAIM SUBMITTED DOES NOT MATCH PRIOR AUTHORIZATION
65	PATIENT IS NOT COVERED
67	FILLED BEFORE COVERAGE EFFECTIVE
68	FILLED AFTER COVERAGE EXPIRED
69	FILLED AFTER COVERAGE TERMINATED (CARDHOLDER NOT ELIGIBLE ON DOS)
69	FILLED BEFORE SWIF COVERAGE EFFECTIVE
69	FILLED AFTER SWIF COVERAGE EXPIRED
7C	M/I OTHER PAYER ID
70	COSMETIC DRUG NOT COVERED
70	NOT ON FORMULARY
70	PRODUCT/SERVICE NOT COVERED
70	NDC NOT COVERED FOR PROVIDER TYPE
71	PRESCRIBER IS NOT COVERED
73	REFILLS ARE NOT COVERED
74	OTHER CARRIER PAYMENT MEETS OR EXCEEDS PAYABLE
75	PRIOR AUTHORIZATION REQUIRED
76	PLAN LIMITS EXCEEDED
76	SUBMIT TO HIGHMARK WITH HIGHMARK SPECIFIC CODE
77	DISCONTINUED PRODUCT/SERVICE ID NUMBER
78	COST EXCEEDS MAXIMUM
79	REFILL TOO SOON
80	DRUG-DIAGNOSIS MISMATCH
81	CLAIM TOO OLD
82	CLAIM IS POST-DATED
83	DUPLICATE PAID CLAIM
84	CLAIM NOT PAID
85	CLAIM NOT PROCESSED
87	REVERSAL NOT PROCESSED
88	DUR REJECT/MAX DOSE DISPENSED
88	DUR REJECT
88	DUR REJECT/DRUG NOT COVERED FOR PATIENT AGE
88	DUR REJECT/EXCEEDS MAX INITIAL DOSE
90	HOST HUNG UP
91	HOST RESPONSE ERROR
92	HOST UNAVAILABLE TRY AGAIN LATER
95	TIME OUT
96	SCHEDULED DOWNTIME

NCPDP	PACE/NCPDP DESCRIPTION
97	PAYER UNAVAILABLE
98	CONNECTION TO PAYER IS DOWN
AA	PATIENT SPEND-DOWN NOT MET
AB	DATE WRITTEN IS AFTER DATE FILLED
AC	PRODUCT NOT COVERED, NON-PAR. MANUFACTURER
AD	BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLAIM TYPE
AE	QMB (QUALIFIED MEDICARE BENEFICIARY) BILL MEDICARE
AG	DAYS SUPPLY LIMITATION FOR PRODUCT/SERVICE
AJ	GENERIC DRUG REQUIRED
AK	M/I SOFTWARE VENDOR/CERTIFICATION ID
AM	M/I SEGMENT IDENTIFICATION
A9	M/I TRANSACTION COUNT
B2	M/I SERVICE PROVIDER ID QUALIFIER
CA	M/I PATIENT FIRST NAME
CB	M/I PATIENT LAST NAME
CC	M/I CARDHOLDER FIRST NAME
CD	M/I CARDHOLDER LAST NAME
CW	M/I ALTERNATE ID
DR	M/I PRESCRIBER LAST NAME
DQ	M/I USUAL & CUSTOMARY CHARGE
DU	GROSS AMOUNT DUE
DV	M/I OTHER PAYER AMOUNT PAID
DX	M/I PATIENT PAID AMOUNT SUBMITTED
DY	M/I DATE OF INJURY
DZ	M/I CLAIM REFERENCE ID
ED	M/I COMPOUND INGREDIENT QUANTITY
EE	M/I COMPOUND INGREDIENT DRUG COST
EM	M/I (ORIGINAL) PRESCRIPTION NUMBER/REFERENCE QUALIF.
EY	M/I PROVIDER ID QUALIFIER
EZ	M/I PRESCRIBER ID QUALIFIER
E1	M/I PRODUCT SERVICE ID QUALIFIER
E7	M/I QUANTITY DISPENSED
E8	M/I OTHER PAYER DATE
E9	M/I PROVIDER ID
HB	M/I OTHER PAYER AMOUNT PAID COUNT
HC	M/I OTHER PAYER AMOUNT PAID QUALIFIER
H7	M/I OTHER AMOUNT CLAIMED SUBMITTED COUNT
H8	M/I OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER
H9	M/I OTHER AMOUNT CLAIMED SUBMITTED
M1	PATIENT NOT COVERED IN THIS AID CATEGORY
M2	RECIPIENT LOCKED IN (TO PROVIDER)
M2	RECIPIENT LOCKED IN (TO THERAPEUTIC CLASS)

NCPDP	PACE/NCPDP DESCRIPTION
NN	TRANSACTION REJECTED AT SWITCH OR INTERMEDIARY
PA	PA (Medical Exception) EXHAUSTED/NOT RENEWABLE
PB	INVALID TRANSACTION COUNT FOR TRANSACTION CODE
PC	M/I CLAIM SEGMENT
PD	M/I CLINICAL SEGMENT
PE	M/I COB/OTHER PAYMENTS SEGMENT
PF	M/I COMPOUND SEGMENT
PJ	M/I INSURANCE SEGMENT
PK	M/I PATIENT SEGMENT
PM	M/I PHARMACY PROVIDER SEGMENT
PN	M/I PRESCRIBER SEGMENT
PP	M/I PRICING SEGMENT
PS	M/I TRANSACTION HEADER SEGMENT
PX	NON-MATCHED OTHER PAYER ID
P3	COMPOUND INGREDIENT COMPONENT COUNT DOES NOT MATCH NUMBER OF REPETITIONS
P4	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT DOES NOT MATCH NUMBER OF REPETITIONS
P6	DATE OF SERVICE PRIOR TO DATE OF BIRTH
P9	FIELD IS NON-REPEATABLE
RB	MULTIPLE PARTIALS NOT ALLOWED
RC	DIFFERENT DRUG ENTITY BETWEEN PARTIAL & COMPLETION
RE	M/I COMPOUND PRODUCT ID QUALIFIER
RF	IMPROPER ORDER OF DISPENSING STATUS CODE ON PARTIAL FILL TRANSACTION
RG	M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER ON COMPLETION TRANSACTION
RH	M/I ASSOCIATED PRESCRIPTION/SERVICE DATE ON COMPLETION TRANSACTION
RJ	ASSOCIATED PARTIAL FILL TRANSACTION NOT ON FILE
RK	PARTIAL FILL TRANSACTION NOT SUPPORTED
RM	COMPLETION TRANSACTION NOT PERMITED WITH SAME DATE OF SERVICE AS PARTIAL TRANSACTION
RN	PLAN LIMITS EXCEEDED ON INTENDED PARTIAL FILL VALUES
RP	OUT OF SEQUENCE “P” REVERSAL ON PARTIAL FILL TRANSACTION
RS	M/I ASSOCIATED PRESCRIPTION/SERVICE DATE ON PARTIAL TRANSACTION
RT	M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE DATE ON PARTIAL TRANSACTION
RU	MANDATORY ELEMENTS MUST OCCUR BEFORE OPTIONAL DATA ELEMENTS IN A SEGMENT
R1	OTHER AMOUNT CLAIMED SUBMITTED COUNT DOES NOT MATCH NUMBER OF REPETITIONS
R2	OTHER PAYER REJECT COUNT DOES NOT MATCH NUMBER OF REPETITIONS
R6	PRODUCT/SERVICE NOT APPROPRIATE FOR THIS LOCATION
R7	REPEATING SEGMENT NOT ALLOWED IN SAME TRANSACTION
R8	SYNTAX ERROR
R9	VALUE IN GROSS AMOUNT DUE DOES NOT FOLLOW PRICING FORMULA
TE	M/I COMPOUND PRODUCT ID