INSIGHT

The QS/1 Magazine

THE PRESSURE IS ON:

October 2005

QS/1

www.qs1.com

With the Medicare Part D implementation date of January 1, 2006 quickly approaching, QS/1 realizes this subject is a major concern for every pharmacy in the industry. We hope to calm your fears and frustrations and address your foremost concerns in this issue of *Insight*.

Our goal is to have every QS/1 customer equipped and ready to process Medicare claims by January 1, 2006. We are currently testing with the Facilitators and will keep our customers updated with the latest information through our website at www.qs1.com. Our site will also contain links to other sites containing information that is pertinent to Medicare Part D.

QS/1 is also happy to announce that we have also made every effort to ensure that customers using the older release 17.8 will also receive the adaptations necessary for accurately processing Medicare Part D claims. QS/1's Service Packs are designed to quickly deliver software enhancements and other changes that are necessary for compliance with Medicare Part D. This issue has included an article that will help you to better understand what Service Packs are, as well as the advantages of receiving updates in this way.

While Medicare Part D has caused much frustration, the aftermath of Hurricane Katrina has caused an even greater source of frustration for all those left in her path of devastation. In an immediate response, QS/1 began offering its pharmacy system, which contains all of the essentials for prescription processing, to all of the pharmacies that were affected by Hurricane Katrina. This was in an effort to help our customers, as well as those who are not, to provide patients with needed medications.

QS/1 would like to take this opportunity to express our concerns and sympathies to all of our customers and their families who were affected by this disaster.

Tammy Devine
Vice President, QS/1

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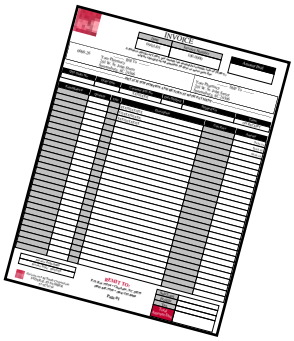

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Trade Shows
Product Updates
From the Support Center
In Your Area

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Marketing for Hospital Referrals:
Are You Competing on a Level Playing Field?

by Jack Evans and Jeffrey S. Baird, Esq.

Marketing to hospitals is a challenge under normal circumstances considering the number of decision makers in any given facility. But what if:

- A competitor is directly or indirectly paying the hospital for referrals?
- The hospital never rotates the HME providers on its referral list?
- The hospital only refers to one HME provider?
- The hospital owns its own HME operation and never refers patients to other HME providers?

After listening to attendees speak out at our seminar programs on marketing during last October's Medtrade, we found that there are a number of challenges facing HME providers when marketing to hospitals. These include:

1. Hospitals normally do not use a referral list and often do not give a patient a choice when selecting an HME provider. Denying a patient his or her freedom of choice violates 42 U.S.C. § 1395a(a), which is aptly entitled "Free choice by patient guaranteed."

2. When hospitals do use referral lists they normally do not rotate the HME providers on their lists and usually refer only to the top name.

3. Some HME providers enter into sham joint ventures or management arrangements with hospitals that are nothing more than a subterfuge to funnel remuneration to the hospitals.

4. Some hospitals ask HME providers to perform work that the hospitals would normally be obligated to perform.

Traditional Hospital Referrals

Marketing to hospitals is an integral component of the HME provider's overall business strategy. One or more employees dedicate their time on a full- or part-time basis to visit local hospitals and healthcare professionals to generate patient referrals. These employees build relationships with referral sources based upon their proven reliability, accessibility and worthiness.

Referral sources are identified and prioritized. These referral sources are visited monthly, often weekly and sometimes several times each week. Once the referral is made, the HME provider's responsibilities include qualifying the patient's HME needs, identifying and ordering the appropriate medical equipment and supplies, delivering the order at the designated time, and educating the patient on the equipment usage.

HME Provider's Duties at Discharge

Where do the HME provider's duties begin in relation to a patient's discharge? Traditionally the hospital discharge planner or case manager contacts the HME provider when a patient is about to be discharged. However, hospitals have become overwhelmed with the growing number of patients and shrinking number of support staff.

Many discharge planners are demanding that HME providers perform their work for them, such as pulling the patient's file, copying the face sheet, specifying and ordering the appropriate HME, contacting the patient's physician for approval and coordinating delivery with the patient's discharge time.

"Marketing to hospitals is an integral component of the HME provider's overall business strategy."

The problem with the HME provider performing work for the hospital is that the Medicare/Medicaid anti-kickback statute may be implicated. The government might argue that the services provided by the HME provider constitute "something of value" in exchange for referrals from the hospital.

What to Do?

Unfortunately, many HME providers do not have to worry about their role at a patient's discharge because they never receive any referrals from the hospital. The HME provider must first determine how the hospital refers patients before the provider will know how to be involved in the patient's discharge. In making this determination,

the HME provider should address the following:

1. **If the hospital uses a rotating list, then how does it do so?** How is the list compiled? Are there minimum requirements for an HME provider to be on this list? Once on this list, how does the rotation system work? Are selections made by discharge planners or according to time periods? Is the list alphabetical but not rotating?

2. **If a rotating list is not used, then how are HME providers selected?** Are patients given any choice in selection? Does the hospital only refer to one HME provider? If not, what prerequisites are necessary for the provider to receive referrals? Do HME providers have to be preferred providers? Do they have to provide all HME products and services – or at least accept all referrals and then subcontract what they cannot provide themselves? Do the HME providers need to have an employee stationed at the hospital at all times?

3. **Preferred providers.** If the majority of patients at a hospital are covered by a particular third-party insurance company, then an HME provider must be a contracted provider in order to be eligible for referrals of those covered patients. If a national or major regional HME provider already has an exclusive contract with the payor, then the independent provider needs to enlist advocates to speak on its behalf. The HME provider should have customers and physicians write letters to the payor endorsing its products and services. In addition, the HME provider needs to encourage its customers to notify the payor that their HME provider is their provider of choice.

4. **No payment, no referral.** Unfortunately, there are HME providers and hospitals that enter into a joint venture or management arrangements that are nothing more than a disguise for the HME provider to pay remuneration to the hospital for referrals. Such a sham arrangement is a violation of the Medicare/Medicaid anti-kickback statute. For example, in a sham joint venture, the HME provider puts up the risk capital, the HME provider runs the venture and the hospital's share of the profits from the venture is nothing more than a reward for referring to the venture.

Likewise, in a turnkey management arrangement, the hospital owns an HME operation "on paper," but in reality the HME provider furnishes all of the services and products, "on behalf of the hospital," to the patients. As discussed in the Office of Inspector General's April 2003 Special Advisory Bulletin entitled "Contractual Joint Ventures," the true supplier is not the hospital, but is either the HME provider or a "contractual joint venture" formed by the HME provider and the hospital.

Either way, all that the hospital is doing is referring its patients to the HME operation run by the HME provider, collecting revenue from Medicare, paying most of the revenue to the HME provider as a "management fee," and pocketing the difference. This is nothing more than a disguised kickback and the Medicare/Medicaid anti-kickback statute is violated. If an HME provider becomes aware of a sham joint venture or turnkey management arrangement, then it can take one or more of the following steps:

1. A healthcare attorney can write a letter to his or her client, the independent HME provider that discusses the legal problems with the sham arrangement. The HME provider can share the letter with the hospital.

2. If the preceding step does not work, then the healthcare attorney can send a letter directly to the hospital or to the hospital's attorney.

3. If the preceding steps still do not work, then the healthcare attorney can send a letter, describing the sham arrangement, to the Department of Justice or Office of Inspector General, with a copy to the hospital administrator. Such a letter will probably instigate an investigation into the sham arrangement.

Most HME providers are dependent on patient referrals for the majority of their revenue. The issue remains how to capture these referrals. Generally speaking, referrals are based upon relationships. Healthcare professionals must be able to trust the HME provider to care for their patients at home.

Successful HME providers take care of their customers and are accessible to their referral sources. Over time, this competence builds trust. The end result is that the HME provider becomes an extension of a healthcare professional's continuum of patient care.

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FIRSTDATABANK
The Knowledge Inside™

Drug Pricing Policy

First DataBank Inc. publishes several drug price data fields, including Wholesale Acquisition Cost, Direct Price, Suggested Wholesale Price, Blue Book AWP and Alternative Benchmark Price.

In an effort to keep our customers informed of industry changes, we think the following information from First Data Bank (FDB) is important for you to read. While the article is written to vendor partners (QS/1) as a warning of changes to come, the content will benefit you, the pharmacy owner and operator, as well. The article focuses on how AWP currently is derived and how Average Benchmark Pricing (ABP) will be the standard for pricing in the future. It is imperative that you keep in mind that this pricing standard will replace AWP some time in the future, provided the manufactures participate in providing FDB with the appropriate data. While reading this article, keep in mind that many principles in the industry will be impacted, including the Third Parties. Currently this is all the information we have on-hand, but QS/1 will continue to work closely with FDB and provide updates as they are made available on the QS/1 website.

Wholesale Acquisition Cost (WAC) (previously referred to as Net Wholesale Price) as published by First DataBank represents the manufacturer's published *catalog* or *list* price for a drug product to wholesalers. (*For purposes of this Drug Price Policy, the term "manufacturer" includes manufacturers, repackagers, private labelers and other suppliers.*) WAC does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions in price. First DataBank does not perform any independent investigation or analysis of actual transaction prices for purposes of reporting WAC. First DataBank relies on manufacturers to report or otherwise make available the values for the WAC.

Direct Price as published by First DataBank represents the manufacturer's published catalog or list price for a drug product to non-wholesalers. Direct Price does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. First DataBank does not perform any independent investigation or analysis of actual transaction prices for purposes of reporting Direct Price. First DataBank relies on manufacturers to report or otherwise make available the values for the Direct Price.

Suggested Wholesale Price (SWP) as published by First DataBank represents the manufacturer's suggested price for a drug product from wholesalers to their customers (i.e., retailers, hospitals, physicians and other buying entities). SWP is a suggested price and does not represent actual transaction prices. First DataBank relies on manufacturers to report or otherwise make available the values for the SWP.

Blue Book AWP (BBAWP) as published by First DataBank is intended to represent an average of wholesalers' catalog or list prices for a drug product to their customers (i.e., retailers, hospitals, physicians and other buying entities). However, for those drug products generally not distributed through the wholesaler sales channel, the BBAWP data field will reflect the same value as the Direct Price.

First DataBank historically relied upon wholesalers to provide information relating to their catalog or list prices for purposes of publishing the AWP.

First DataBank periodically surveyed full-line national wholesalers to determine the average mark-up applied to a manufacturer's line of products or a specific product. The average mark-up of the wholesaler(s) responding to the survey was applied against the WAC or Direct Price with the resulting value populating the AWP field. In certain instances, the responding wholesaler(s) would accept a manufacturer's suggested wholesale price, in which case the AWP and SWP would reflect the same value.

First DataBank has discontinued surveying drug wholesalers for information relating to their catalog or list prices. However, for purposes of publishing AWP, First DataBank has "frozen" the last average wholesale mark-up previously provided to First DataBank through the wholesaler survey process and will no longer update such mark-up. Upon receipt of a change in drug pricing from a manufacturer, this mark-up is applied against the WAC or, if a WAC is not available, the Direct Price, with the resulting value populating the AWP field. For those manufacturer product lines for which wholesalers historically accepted the manufacturer's Suggested Wholesale Price, First DataBank will continue to populate the Blue Book AWP and the Suggested Wholesale Price with the same value. As a result, Blue Book AWP will vary solely as a result of changes in pricing information provided by manufacturers.

For those drug manufacturers and lines of products for which First DataBank does not maintain a historical mark-up (e.g., new manufacturers), AWP will be determined

by applying a standardized mark-up of 25 percent for prescription drugs and 23 percent for over-the-counter drugs over the manufacturer's WAC or, if a WAC is not available, over the manufacturer's Direct Price. To the extent that neither the WAC nor the Direct Price is available, First DataBank will populate the AWP and the Suggested Wholesale Price with the same value. The standardized mark-ups adopted by First DataBank were determined through a historical analysis of the Blue Book AWP for prescription and over-the-counter drugs as published by First DataBank, as further described below under "Alternative Benchmark AWP." However, for those drug products generally not distributed through the wholesaler sales channel, the AWP data field will reflect the same value as the Direct Price.

AWP does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. First DataBank does not perform any independent investigation or analysis of actual transaction prices for purposes of reporting AWP. AWP may not accurately approximate a wholesaler's catalog or list price for the sale of a drug product to its customers. Further, wholesalers may not use catalog or list prices as a basis for determining actual transaction prices. First DataBank does not perform any independent investigation or analysis of list or catalog prices for purposes of reporting AWP and no longer surveys wholesalers for purposes of publishing AWP.

Alternative Benchmark Price (ABP). The Alternative Benchmark Price is based solely upon a manufacturer's WAC, or if the WAC is not available, the manufacturer's Direct Price. The Alternative Benchmark Price will not give effect to the SWP provided by manufacturers, regardless of whether such value historically was accepted by wholesalers. First DataBank will calculate the Alternative Benchmark Price by applying standardized mark-ups to the manufacturer's WAC or Direct Price, as follows:

Prescription drugs. For prescription drugs, First DataBank will utilize a standardized mark-up of 25 percent over the manufacturer's WAC or, if a WAC is not available, over the manufacturer's Direct Price.

Over-the-counter drugs. For over-the-counter drugs, First DataBank will utilize a standardized mark-up of 23 percent over the manufacturer's WAC or, if a WAC is not available, over the manufacturer's Direct Price.

Notwithstanding the foregoing, for those drug products generally not distributed through the wholesaler sales channel, the Alternative Benchmark Price will reflect the same value as the Direct Price.

First DataBank will not publish the Alternative Benchmark Price for any drug product for which a manufacturer fails to report or otherwise make available the WAC or Direct Price. A list of manufacturers and the relevant products that do not report or make available a WAC or Direct Price will be available on our website at http://www.firstdatabank.com/customer_support/drug_pricing_policy.

The standardized mark-ups adopted by First DataBank were determined through a historical analysis of the AWP for all prescription and over-the-counter drugs as published by First DataBank as of December 31, 2001-2004. Such analysis included only those product lines for which a wholesaler mark-up was applied against WAC or Direct Price and generally excluded any product line or specific drug product for which a wholesaler accepted a manufacturer's suggested wholesale price. Such analysis further excluded all private label drug products, repackaged drug products, bulk chemicals, herbals and non-drug items. The standardized mark-up represents the cumulative average difference between the (i) AWP and (ii) WAC, or Direct Price (as applicable) for the universe of prescription drug products and over-the-counter drug products with the resulting cumulative averages rounded to the nearest whole percentage point.

Following a reasonable period of time necessary to allow First DataBank customers to evaluate and adopt the Alternative Benchmark Price, First DataBank intends to discontinue reporting AWP under its current methodology and to substitute the Alternative Benchmark Price as its sole AWP data field. However, to insure that First DataBank will be able to continue offering its customers a comprehensive database of pricing information, First DataBank intends to continue publishing Blue Book AWP at least until such time as manufacturers report or otherwise make available to First DataBank either the WAC or Direct Price for at least 95 percent of all prescription and over-the-counter products. As of June 30, 2005, manufacturers reported WAC or Direct Price for approximately 57 percent of all prescription and over-the-counter products contained in the NDDF Plus database. First DataBank will update the foregoing percentage on a quarterly basis.

First DataBank relies on manufacturers and other third parties to report or otherwise make available the values for the above referenced drug price data fields and, as a result, such data fields are subject to the availability of the relevant information. First DataBank reserves the right, in its sole discretion, to change this Drug Price Policy without notice. Please check back and refer to First DataBank's Drug Price Policy as you review and utilize the pricing information contained in First DataBank's products.

SureScripts
The prescription for better healthcare™

Connected to the SureScripts electronic prescribing network

QS/1 is Ready, Set, Go for Electronic Prescribing

Today, more than 85 percent of community pharmacies in the U.S. have software that is certified to connect to the SureScripts network. **QS/1 clients using CRx, NRx, PrimeCare and RxCare Plus systems belong to this group.** QS/1 can upgrade your CRx or RxCarePlus system for electronic or e-prescribing, allowing you to exchange prescription information with local physicians whose software is also certified to connect to the SureScripts network.

However, chain pharmacies are going live on the network far faster than independent pharmacies; in fact, one in three chain pharmacies is already exchanging prescription information with physicians via the SureScripts network, and they're moving because they like the speed and efficiency electronic prescribing offers. **Independent pharmacies have to get connected to stay competitive!** If you are not ready to communicate prescription information with physicians electronically, **call your QS/1 representative and ask to develop a plan to get connected to the SureScripts network for electronic prescribing.**

E-Prescribing Update

E-prescribing transactions are currently taking place in 46 states. However, a list of the top e-prescribing states reveals the disparity between chain and independent pharmacies connected to the SureScripts network:

Percent of Chains vs. Independents Connected to the SureScripts Network

States	Chains	Independents
Arizona	66%	6%
California	69%	1%
Rhode Island	95%	31%
Maryland	72%	1%
Massachusetts	84%	6%
Florida	77%	3%
Texas	69%	1%
New York	63%	1%
New Jersey	58%	2%
Nevada	65%	0%
Michigan	64%	1%
Ohio	64%	5%
Pennsylvania	63%	3%
Virginia	70%	1%

Top E-Prescribing States:

Arizona: Chains: 66%; Independents: 6%.
Connected chains: CVS/Pharmacy, Osco Drug, Rite Aid, Sam's Club, Walgreens and Wal-Mart

California: Chains: 69%; Independents: 1%
Connected chains: Albertsons, CVS/Pharmacy, Longs, RiteAid, Sam's Club, Sav-on Pharmacy, Walgreens and Wal-Mart

Florida: Chains: 77%; Independents 3%
Connected Chains: Albertsons, CVS/Pharmacy, FamilyMeds, Kash N' Karry, Navarro Drugs, Publix, Sam's Club, Sav-on Pharmacy, Sweetbay, Walgreens and Wal-Mart

Maryland: Chains: 72%; Independents: 1%
Connected Chains: Acme, CVS/Pharmacy, Eckerd, Giant, Giant Eagle, FamilyMeds, Happy Harry's, RiteAid, Sam's Club, Sav-On Pharmacy, Walgreens and Wal-Mart
Massachusetts: Chains: 84%; Independents: 6%
Connected Chains: Brooks, CVS/Pharmacy, Hannaford Bros, FamilyMeds, Sam's Club, Stop and Shop, Walgreens and Wal-Mart
Nevada: Chains: 65%; Independents: 0%
Connected Chains: CVS/Pharmacy Longs, RiteAid, Sam's Club, Sav-on Drugs, Walgreens, Wal-Mart
New Jersey: Chains: 58%; Independents: 2%
Connected Chains: Acme, CVS/Pharmacy, Duane Reade, Happy Harry's, Sam's Club, Sav-on Pharmacy, Shop Rite, Stop & Shop, Walgreens, Wal-Mart
New York: Chains: 63%; Independents: 1%
Connected Chains: CVS/Pharmacy, Duane Reade, Drug World, Eckerd, FamilyMeds, Hannaford Bros, RiteAid, Sam's Club, Stop & Shop, Walgreens, Wal-Mart
Ohio: Chains: 64%; Independents: 5%
Connected Chains: Acme Fresh Markets, CVS/Pharmacy, FamilyMeds, Giant Eagle, Kroger, Meijer, RiteAid, Sam's Club, Sav-Mor, Walgreens, Walmart
Pennsylvania: Chains: 63%; Independents: 3%
Connected Chains: Acme, CVS/Pharmacy, FamilyMeds, Giant Eagle, Happy Harry's, RiteAid, Sam's Club, Sav-on Pharmacy, Wal-Mart
Rhode Island: Chains: 95%; Independents: 31%
Connected Chains: Brooks, CVS/Pharmacy, Sam's Club, Stop & Shop, Target, Walgreens, Wal-Mart
Texas: Chains: 69%; Independents: 1%
Connected Chains: Albertsons, RiteAid, Sam's Club, Sav-on Pharmacy, Walgreens, Wal-Mart
Virginia: Chains: 70%; Independents: 1%
Connected Chains: CVS/Pharmacy, Eckerd, Food City, Giant, RiteAid, Sam's Club, Walgreens, Wal-Mart

States to Watch for Increasing Physician Activity:
Today, SureScripts has contracted with over 50 physician technology vendors and has already certified 25 electronic-prescribing or electronic-health record systems for a connection into the SureScripts network. These vendors collectively represent 150,000 existing physician users that are being targeted for conversion from current fax communications with pharmacies to true EDI transactions. They work closely with SureScripts to keep a steady eye on geographies where future physician activity is anticipated in the short-term. Other promising states for increases in e-prescribing activity and the chain pharmacies that are ready to communicate with physicians as soon as they are activated include:

Arkansas: Albertsons, Sam's Club and Wal-Mart
Hawaii: Longs Drugs, Sam's Club and Wal-Mart
Illinois: CVS/Pharmacy, Meijer, Osco Drug, Sam's Club, Walgreens and Wal-Mart
Kentucky: CVS/Pharmacy, Food City, Meijer, RiteAid, Sam's Club, Walgreens and Wal-Mart
Minnesota: Albertsons, CVS/Pharmacy, Sam's Club, Walgreens and Wal-Mart
Missouri: CVS/Pharmacy, Osco Drug, Sam's Club, Walgreens and Wal-Mart
North Carolina: CVS/Pharmacy, Eckerd, FamilyMeds, Kerr Drug, Sam's Club, Walgreens and Wal-Mart
Tennessee: CVS/Pharmacy, FamilyMeds, Food City, RiteAid, Sam's Club, Walgreens and Wal-Mart
Washington: Albertsons, Longs, RiteAid, Sav-on Pharmacy, ShopKo and Walgreens
Wisconsin: Sam's Club, Walgreens and Wal-Mart

Special Note – Michigan: Pharmacy regulations to make e-prescribing permissible are being finalized. Once this is squared away, Michigan also shows promise for significant activity, especially with Detroit's Big Three auto manufacturers committed to e-prescribing for their health plans.

Don't Get Left Behind - Get Connected

We urge independent community pharmacies to get on board for e-prescribing, especially in light of the disparity between chain and independent pharmacy readiness:

- **Want to get connected to the SureScripts Electronic Prescribing Network? Call QS/1 today at 1.800.845.7558.**

- **Want to know how to save on e-prescribing transaction costs? Visit www.surescripts.com/membership for details.**

-Barbara Kramer-Zarins, Manager, Marketing Communications

Service Packs:
Advanced Update Delivery

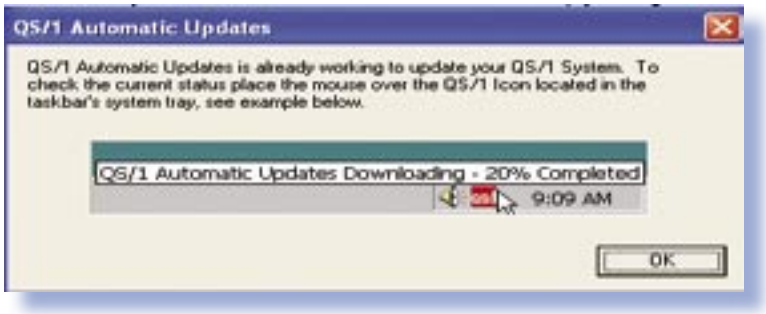
QS/1 is making great strides in technical support with the implementation of Service Packs. Service Packs make it possible for QS/1 customers to easily receive program enhancements.

As software programs became increasingly larger, transmitting them via dial-up modem was becoming more of a time issue for customers. "We needed to find a way to overcome the limitations of the dial-up process" said Sonny Anderson, Director of Systems and Technology, QS/1. Because Service Packs allow us to move higher volumes of data quickly and provide rapid delivery of updates, the perfect solution was formed. "This advancement certainly allows our services to be more proactive," Anderson explained.

A tremendous advantage with Service Packs is that QS/1 can deliver application level software and any systems level software, including faxing capabilities and Interactive Voice Response (IVR) with ease. The Service Pack system is Internet-based and works best when broadband access is available. For those using dial-up modems, the system works equally as well, just allow for more time to complete the download.

As QS/1 continues to look to the future and develop quality products, we think the implementation of Service Packs will continue to be an invaluable tool, focusing on customer convenience and improved technical support.

Service Packs are quickly becoming the wave of the future in QS/1 program updates largely because of their ease of use and convenience. Because this is a relatively new service, we want to clear up any confusion associated with the terminology associated with Service Packs and the very mechanics that comprise them.



Service Packs:
Questions & Answers...

What is a Service Pack?
A Service Pack is an update to a current release. Many new features, as well as program updates are included. Service Packs are issued every six to eight weeks and contain a broad span of information. Service Packs are available for most QS/1 application level software and any systems level software, including faxing capabilities and Interactive Voice Response (IVR).

What is an Addendum?
Addendums are issued weekly and contain updates for existing programs previously found in Service Packs. Addendums are included in each Service Pack.

What is a QSU?
Quick Service Updates are very specific program updates that are sent only to select customers who are encountering a very specific issue. QSU's are made available daily to these customers and serve as "quick updates."

How will Medicare Part D be addressed in Service Packs?
Necessary changes for Medicare Part D will be implemented starting in Service Pack 14 and will continue with each Service Pack until all updates have been released.

How are Service Pack updates downloaded?
Updates are sent electronically from QS/1. An icon at the bottom of the screen indicates when updates are ready to be installed. Simply double-click on the icon to begin the process and follow the step by step instructions. In addition, Service Packs may also be loaded from a CD/DVD and are also found on our website, www.qs1.com.

Advantages of QS/1's Service Packs:

- Updates can be downloaded without interrupting business.
- Since downloading and installation is not one continuous process, installs can be scheduled for a time when the computer is unattended and most convenient for you.
- The system is proactive instead of reactive.
- The system can deliver all different types of software for the client and server.
- Service Packs make same day program updates a reality for QS/1 customers.

Kerry Philbeck, Creative Services Technician, QS/1

Paperless Invoicing

Paperless invoicing will soon be available to QS/1 customers through the ability to view account invoices online.

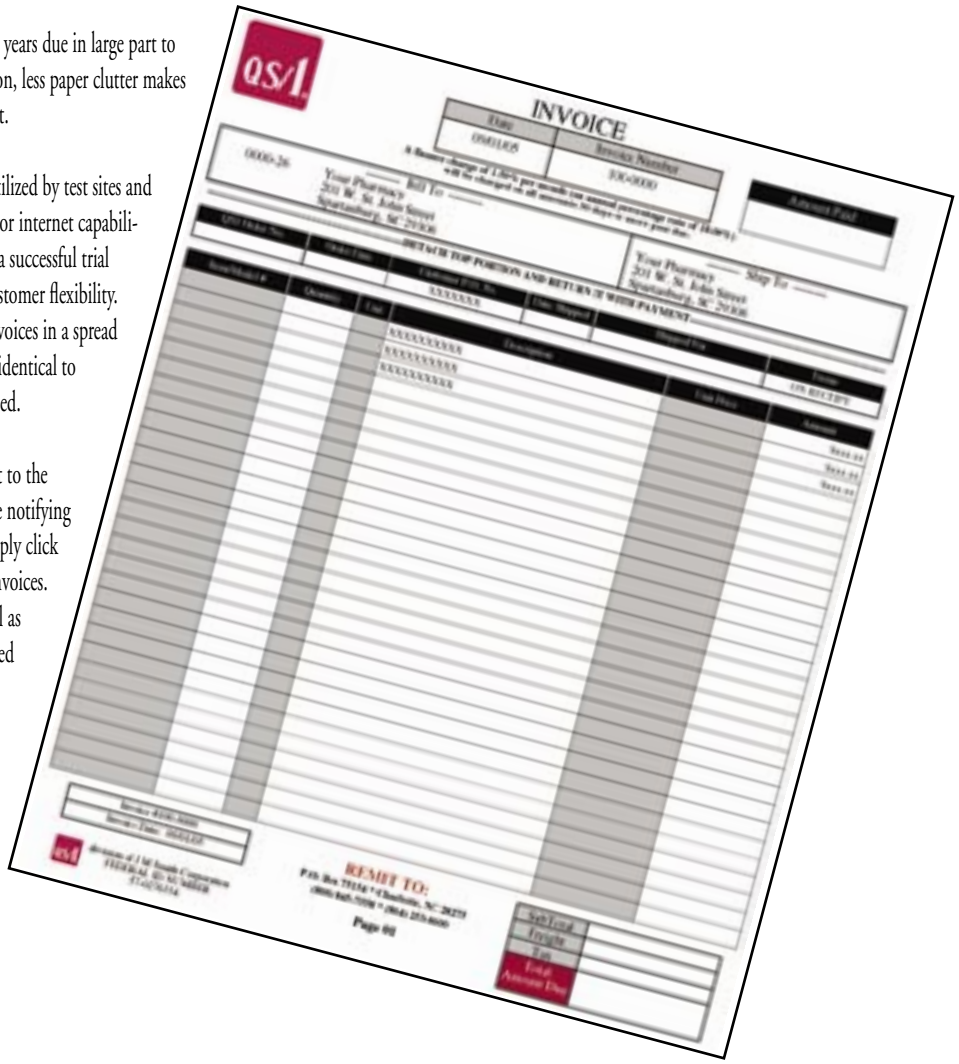
"Now, our customers do not have to wait for invoices and statements to be sent through the mail. All the information they need to manage their business account is just a click away," said Brent Thomasson, QS/1 Finance Manager.

Paperless invoicing has become popular in recent years due in large part to customer convenience and satisfaction. In addition, less paper clutter makes for a cleaner, more efficient working environment.

Our online invoicing service is currently being utilized by test sites and will be available to QS/1 customers with dial-up or internet capabilities by late Fall 2005. All initial testing indicates a successful trial period. An advantage to paperless invoicing is customer flexibility. "Customers now have the ability to download invoices in a spread sheet format for modification, or to print copies identical to those they currently receive," Thomasson explained.

When invoices are posted online an e-mail is sent to the designated pharmacy or institution representative notifying them that the invoices are ready for viewing. Simply click on the link contained in the e-mail to view the invoices. As an added convenience, current invoices as well as those dating back at least 12 months will be posted online.

QS/1 strives to deliver the latest technology and services. New features, such as paperless invoicing, increase office efficiency by providing easy access to your QS/1 accounts.



Kerry Philbeck, Creative Services Technician, QS/1

Customer Spotlight

Senior Care Pharmacy

Lakeland, FL

Evelyn Beach, Director of the Senior Care Pharmacy in Lakeland, Florida, has been a QS/1 customer for the last five years. Although Beach has only been with Senior Care since 2002, she has worked in the pharmaceutical industry nearly two decades. During that time she has learned how to manage every aspect of a pharmacy and has gained knowledge that has proven to be invaluable at Senior Care. This prior knowledge and experience has helped Beach to fill many different roles at Senior Care.

"I wear many hats. I not only fill prescriptions, I also manage data-entry and dispensing, keep medical records for our long-term care facility, as well as oversee the IT department and the Quality Assurance module within our pharmacy," said Beach.

Beach's staff certainly appreciates her versatility. One way they show their appreciation is through loyalty. Some of Beach's core staff have been with her since 1992 and have even made job changes just to remain under her direction over the years.

"I have an excellent staff. In two months they've added 1000 beds [to the Senior Care facility] and my staff has really worked as a team to take care of the residents," acknowledged Beach.

Senior Care staff

In return, Beach strives to make Senior Care's work environment less stressful on her staff by keeping up-to-date with technology. For example, going paperless has helped to increase efficiency while uncluttering valuable work space at Senior Care.

"I am always tuned-in to how I can make their jobs easier by using QS/1's products," said Beach.

QS/1's PrimeCare system helps Senior Care Pharmacy meet the needs of their long-term care residents. The Workflow feature of PrimeCare has enabled Senior Care to minimize errors by scanning the barcodes of labels and prescription bottles. Workflow also ensures that what the pharmacy bills for is what is being sent out.

"Using Workflow gives our pharmacists the time to use their clinical skills to monitor and oversee residents, which allows for better management of patient therapy, while minimizing increasing costs for resident's care," said Beach.

Pharmacies, such as Senior Care, that provide for long-term care residents sometimes meet up with special challenges. That is why Beach and her colleagues have found it helpful to maintain an open relationship by sharing helpful ideas and information with each other.

"Last year one of our sister pharmacies decided to implement QS/1's innovative technology because of what they saw it doing for our pharmacy," said Beach.

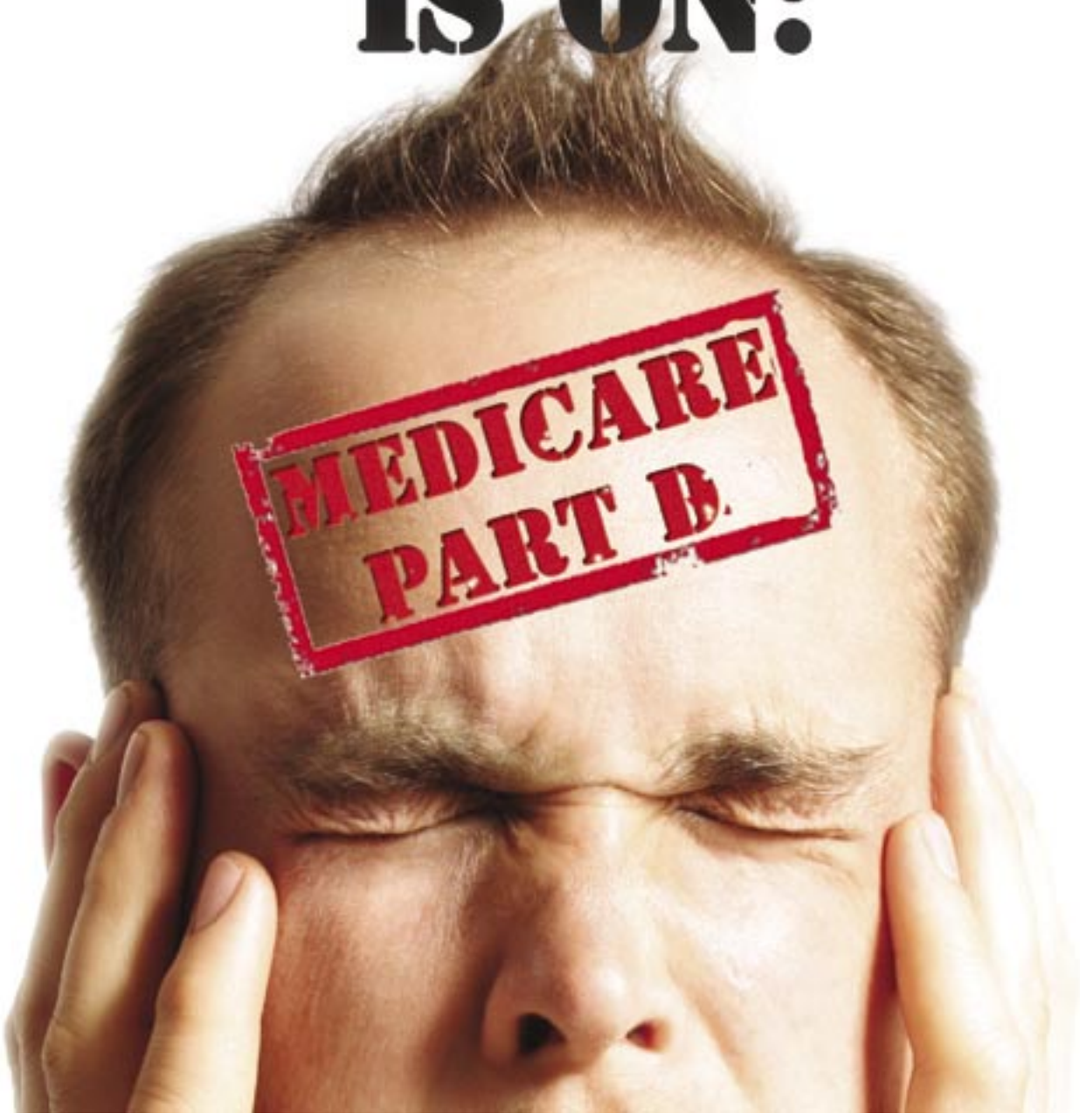
Beach also recently shared her knowledge of Medicare Part D at the QS/1 Customer Conference that was held in Orlando, Florida this past July.

"We need to be proactive and I am planning to use QS/1's formulary modules and Workflow to help manage the monster that Medicare Part D is going to be," said Beach.

Melanie Hershberger, Staff Writer, QS/1

JAN. 1, 2006

THE PRESSURE IS ON:



The implementation of Medicare Part D is the biggest change the pharmaceutical industry has seen in years. January 1, 2006 is fast approaching and with it an increase of confusion and frustration is being expressed from both sides of the pharmacy counter. The lack of customer education regarding Medicare Part D, coupled with very little information being disseminated to pharmacists has created many concerns that need to be addressed and questions that need to be answered.

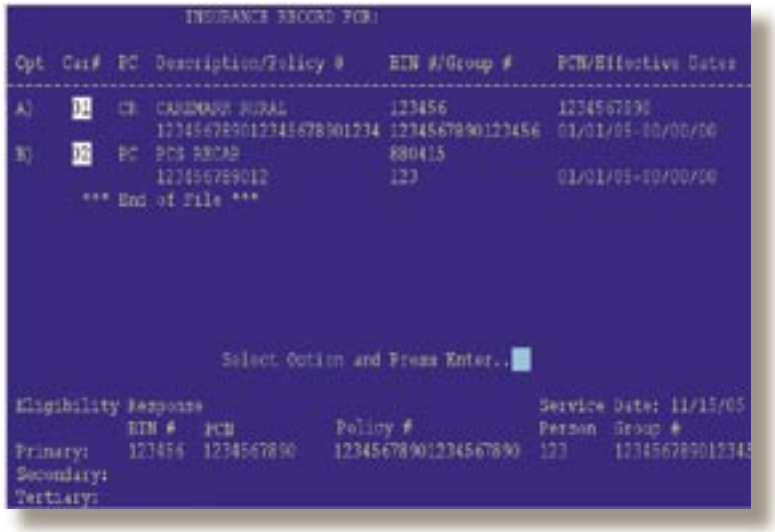
QS/1 has been very active in understanding the requirements of Medicare Part D and has been attending and participating in many industry forums which include: NACDS, NCPA, NCPDP, ASCP, ASAP and CMS. In response to these requirements, QS/1 has been working on software solutions in the pharmacy system and PowerLine. The following article will explain various aspects of Medicare Part D and the system software additions and changes that QS/1 has made to enable a smooth transition into the New Year.

QS/1 plans to focus on several areas in the system to facilitate Medicare Part D processing. In preparation for eligibility checking, there are several eligibility functions that will be added to the system. Also, since Part D coverage will further complicate patient's insurance, tertiary billing will be implemented in the pharmacy system.

Prescription Drug Plans

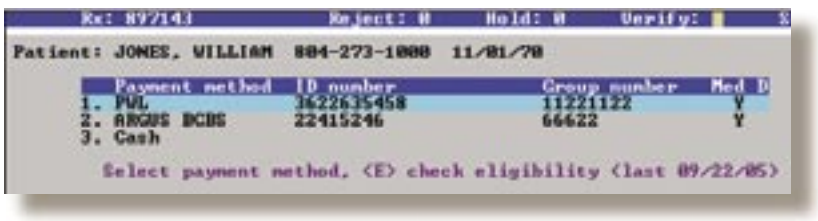
The most significant change in the system that will facilitate Medicare Part D requirements will be the eligibility functions. The main purpose of the eligibility functions is to provide a way for the pharmacy to determine which prescription drug plan (PDP) the patient has signed up for. Although the patient is responsible for investigating the PDPs and enrolling in a PDP that best suits their needs, there is a good possibility that the patient will not remember which plan they have enrolled in when they come into the store. To further complicate this situation, groups of patients will be automatically enrolled in PDPs and some patients will not receive their PDP cards before getting their prescriptions filled for the first time. With this thought in mind, these eligibility functions will provide a method for finding out the current information concerning a patient with only a few key strokes and a small amount of patient information. Please keep in mind that these functions are being added in service pack 14 of 18.1 for RxCare, PrimeCare and NRx and 18.4 for CRx, so in order to use these functions, your pharmacy will need to be on 18.1 and be prepared to update to service pack 14 before the end of this year. Preparing now will save stress and headaches later. A very limited eligibility check will be available in 17.8 for those pharmacies who cannot get to 18.1 before the end of the year.

Eligibility checking will require setting up a Facilitator price code and carrier record in order to transmit and receive eligibility information. A new field called "Facilitator Price Code" is being added to the FastClaim options for PrimeCare and RxCare Plus. In NRx, the new field is called "Facilitator Price Plan." In CRx, "Medicare Facilitator Setup" was added to the Third Party menu. When eligibility checking is done, the pharmacy system will look



RxCare Plus and PrimeCare

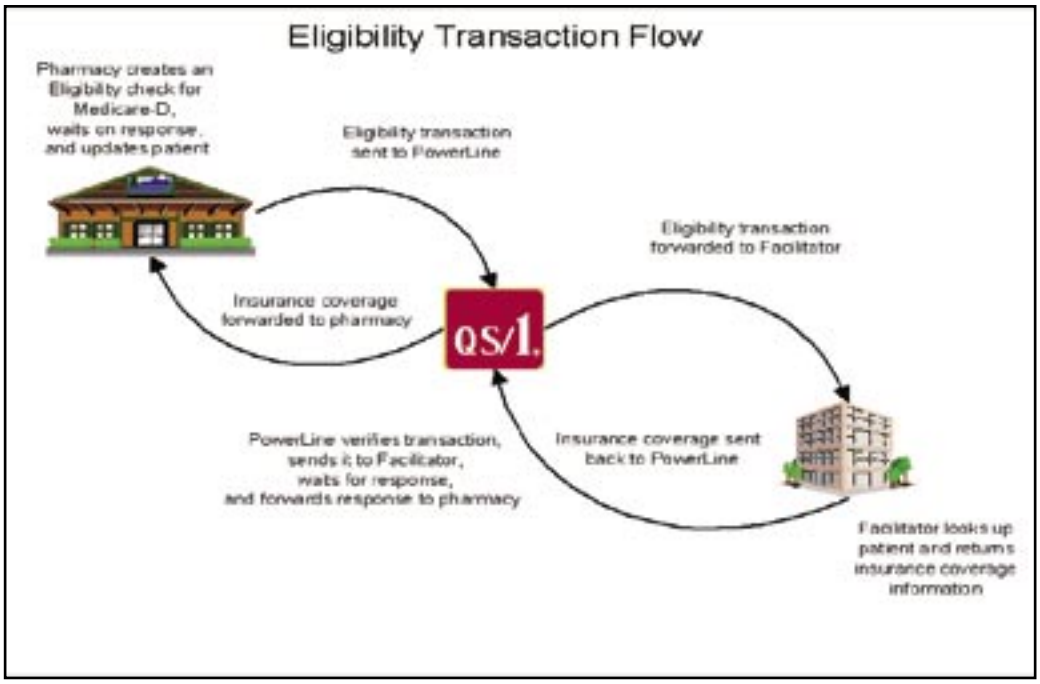
NRx



CRx

up the Facilitator price code/plan and carrier to use the information in order to process eligibility requests and responses.

In order to send eligibility transmissions, certain patient information will be required. The patient's birth date, gender, name and zip code are all fields that are required in order to identify a patient. In addition to these fields, the last four digits of the social security number or Medicare HIC ID number could be necessary for these transmissions. The social security number is already on the patient. The 20-digit HIC ID number is being added to the patient record to provide an additional option to identify the patient during the eligibility checks. The eligibility check function will be available from either the patient or insurance screen. This will be done on the patient insurance scan using a "M" function in RxCare Plus and PrimeCare, and "Ctrl-M" in NRx. The eligibility function will send a NCPDP eligibility transaction to the Facilitator. On the insurance scan, the eligibility information will display along with the date of service as it was received in the response from the last eligibility check. The pharmacist will have a function to update the patient's insurance with the eligibility information. In order to more easily match patient insurance with the eligibility response, the insurance scan will be changed to include the processor control number and the patient insurance scan will be changed to include the bin number and processor control number. In CRx, the eligibility check function will be available in Patient Maintenance, Dispensing and when editing a rejected claim. Once an eligibility response is received any changes necessary to the patience insurance will need to be modified manually.

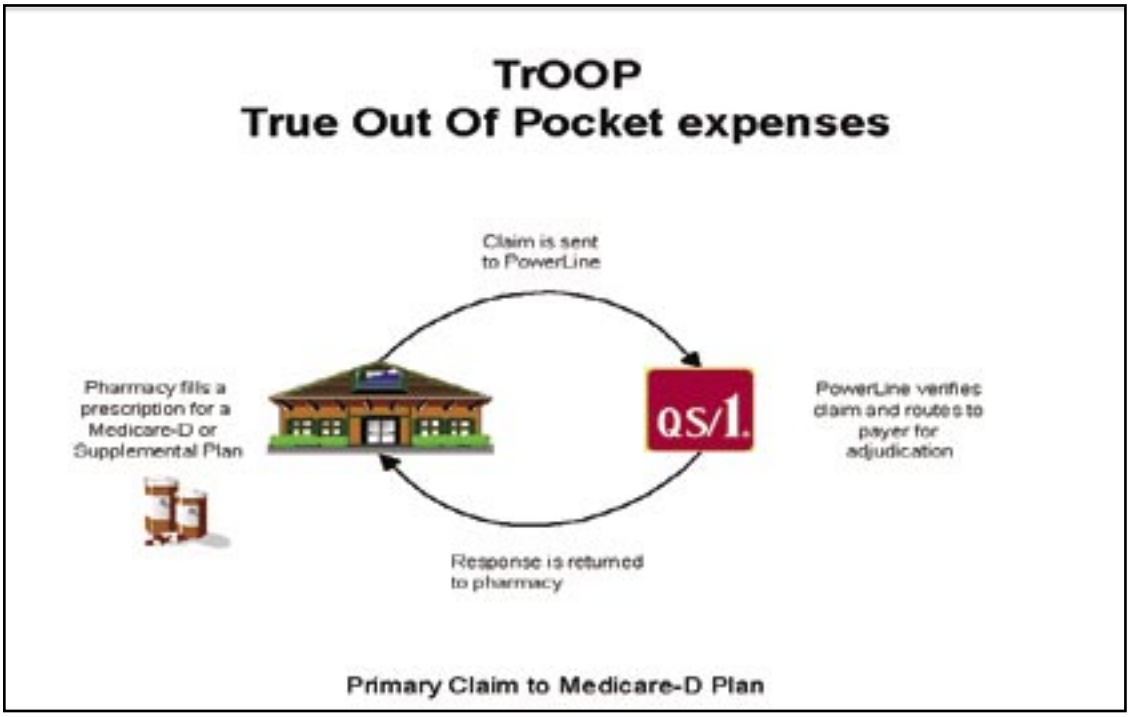


The electronic claims log will display the eligibility transactions and responses that are being transmitted. Selecting on an eligibility transaction will display the eligibility information from the electronic claims log scan. From the eligibility screen, the pharmacist will have functions to update the patient insurance or go to the patient's insurance screen. An "I" function in RxCare Plus, or F5 in PrimeCare or NRx will take the pharmacist or technician to the patient insurance scan where they will be able to view the information and update the patient's insurance as necessary.

An eligibility check will also be added as an option from the prescription record. In addition to having the eligibility check done from the patient and insurance, there will be an option to do a batch eligibility check. This will be done using the batch FastClaim third party program (ELG).

For 17.8 users, the Eligibility Check, View Response Information and Update Patient Insurance functions will be available from the patient insurance screen. Pharmacies will also see the eligibility transactions and responses in the electronic claims log scan.

The following dates are important to know concerning prescription drug plans and eligibility checking. Contracts for PDPs will have been awarded by 09/15/05. Internal testing will begin on 10/15/05. Internal testing is the testing that occurs between the various pharmacy software vendors and the Facilitator. Pharmacies will not be able to do any testing at this point. November 5, 2005 is when open enrollment begins for the PDPs. Also on 11/15/05, the Facilitator eligibility communication will go live, so pharmacies will be able to send eligibility inquiries to the Facilitator at this point. November 15, 2005 is the most significant date other than 01/01/06, because the pharmacies can do the eligibility inquiries, but to get the eligibility information from the Facilitator, the patient must have already signed up for a PDP, which most likely will not happen until the end of the year is closer. In contrast, all dual eligible (Medicaid/Medicare) patients will be randomly auto-assigned to a PDP in October 2005. The dual eligible beneficiary will have until December 31, 2005 to enroll in the auto-assigned PDP or change to a different PDP. Only 900,000 dual eligibles will automatically go Part D on 01/01/06.

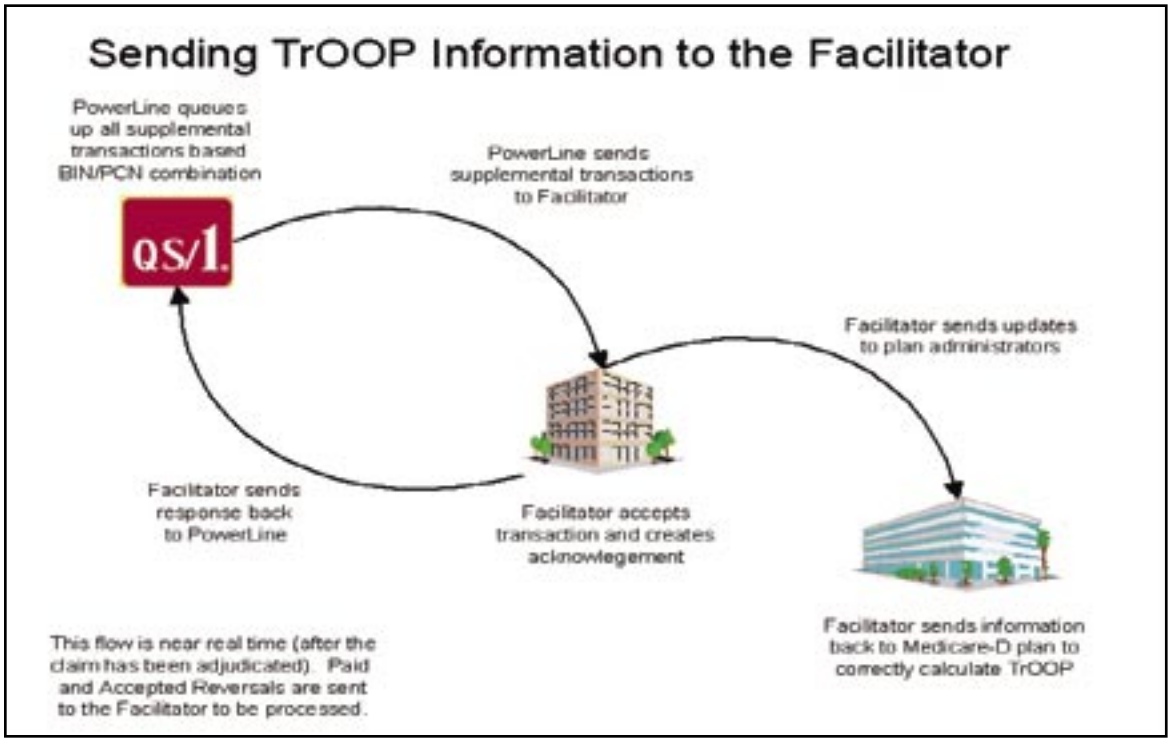


TrOOP

Every Medicare Part D plan has to know what the True Out Of Pocket (TrOOP) expenses are for each beneficiary that is within its plan. The process begins when a Medicare Part D beneficiary has a prescription filled at a pharmacy. The claim is electronically transmitted to PowerLine. PowerLine will verify the transaction and route it on to the Medicare Part D payer for adjudication. If the beneficiary does not have supplemental coverage, the process is complete because they do not have to coordinate benefits with any other payer. When they have supplemental coverage the process becomes more complicated. Once the primary payer has adjudicated the claim, the pharmacy then submits the Rx to the secondary payer(s). The primary payer needs to know the outcome of supplemental payer's adjudication. TrOOP reporting is handled by PowerLine. PowerLine will forward information for all supplemental plans to the Facilitator. There is no charge to the pharmacy for reporting TrOOP information. Every supplemental plan will have a unique BIN/PCN (Bank Identification Number / Processor Control Number) combination that tells PowerLine to forward the information to the TrOOP Facilitator. QS/1 will work closely with the payer community and the Facilitator to maintain the list of BIN/PCNs.

In cases where there are multiple payers on a claim, the reversals must be processed in the reverse order that they were billed. For example, the primary cannot be reversed prior to the secondary being reversed and the secondary cannot be reversed prior to the tertiary being reversed.

QS/1 is working with the Facilitator to make the process for reporting TrOOP seamless for our pharmacy customers and all Medicare Part D beneficiaries. Since the TrOOP reporting will be done internally with PowerLine, the logic is not connected with any service pack in particular. The TrOOP reporting will be implemented on January 1, 2006 and will be available for 18.1, 17.8 and prior releases.



Tertiary Billing

Because Part D coverage will further complicate patients' insurance, tertiary billing is another area that is being addressed in Service Pack 14,18.4 for CRx customers. Tertiary billing will have a significant effect in many areas of the pharmacy system. Changes for tertiary billing will occur in store information, prescription processing, electronic claims processing, third party billing, reports, file maintenance and reconciliation.

Store Information

Changes in store information will be relatively minor. A new field under store identification for the national provider ID (NPI) will be added. The NPI can already be entered for price codes/plans, doctors and employees. Immediate Tertiary Adjudication and Send Tertiary Amount as Patient Paid Amount will be added to the plan parameter information screen of the price codes/plans.

Prescription Processing

In prescription processing, several new fields will need to be added to the prescription to provide for tertiary billing. The main prescription screen will have a field for the tertiary price code/plan. Tertiary Authorization, Tertiary Authorization Type and Tertiary Other Coverage Code will be added to the additional Rx information screen, on the B screen in RxCare Plus, the F11 screen in PrimeCare, and claim information in NRx. Also on the same screen, Denial Override will be renamed to Submission Clarification Code and a new submission clarification code field will be added for the secondary and tertiary coverage.

On the transaction screen, a third line for tertiary coverage will be added under the billing information section of the transaction. The ability to reverse, resubmit or edit the tertiary will also be added to the main screen. The billing screen will remain the same for tertiary billing with the exception of the Denial Override field which will be changed to Submission Clarification Code.

Label routines will be added for the tertiary price code/plan and description. For PrimeCare customers only, the patient billing matrix (F9 then F10) and patient payor table (accessed from the patient screen) will be increased to handle tertiary billing.

Electronic Claims Log

The electronic claims log will be changed to handle tertiary billing. The log will display tertiary claims along with their responses just as it is done now for primary and secondary claims. DURs and rejects will be processed the same way. If the immediate tertiary adjudication indicator is set to Y, tertiary adjudication will be attempted as soon as a paid response is received from the secondary coverage.

Third Party Billing

At this point, the 1500 form (15A) will be the only third party form to experience change. This will be done on an as needed basis, since third parties have been using electronic claims for years and no longer require or accept paper billing. If there is a form that is needed, please contact the Customer Support Center. As far as other reports are concerned, options will be added for selecting and sorting on the tertiary fields that have been added to the prescription and transaction. As always, these tertiary fields will also be available for printing or displaying when running customized reports or data export. The only other area under third party processing that will be addressed is the Resub, Secondary, Batch FastClaim Select. An option for tertiary will be added to this area.

File Maintenance

Batch file updates in file maintenance allow for manual changes to the transaction record. The same changes that were made to the transaction screen in prescription processing will need to be made in batch file transaction updates.

Reconciliation

The last area that needs to be addressed for tertiary billing is reconciliation. Both the manual payment posting (presorted) and manual payment posting programs in reconciliation will need to be changed to add an option for posting tertiary carriers. Similarly, the reconciliation report, status report, 3rd party receivables report and month-end report will all need an additional option for the tertiary carrier.

Electronic Prescribing

After Service Pack 14 is completed, there are still a several areas that will continue to be researched. The Medicare Modernization Act had an emphasis on e-prescribing. As a way to support this process, QS/1 is gathering the necessary information to store a current, central database for doctor information. The main purpose of this database would be to store the doctor information that is necessary to receive and transmit data electronically between the doctor's office and the pharmacy. This would allow for receiving new prescriptions from the doctor as well as sending additional refill requests to the doctor and receiving responses back from the doctor's office. There are fields on the doctor record for level one, two and three IDs. These fields would be stored in the central database and when necessary, the pharmacy could update a doctor or do a batch update of the entire doctor file in order to get the most current information regarding the doctor. In addition to the information necessary to do electronic transmissions, this database would also be used for storing and updating doctor demographic information as well as new IDs such as the NPI number.

Another minor issue that is being addressed in Service Pack 14 is the visibility of the prescription information received for an electronic prescription from the doctor. Currently the information is only visible on the new prescription screen.

The pharmacy system is being changed in order to pull up the electronic information from the doctor at any time desired, just as it is done for the prescription image.

Formulary Enhancements

Formularies are another area that is being researched in order to make the formulary management easier for the pharmacy. This has proven to be a difficult task because of the lack of any central database for formulary information. CMS has no provision for providing this data. QS/1 is actively trying to find resources to provide this information.

Medication Therapy Management Services (MTMS)

As you may know, the MMA also included a section on Medication Therapy Management Services (MTMS). This is another area for you to discuss with the PDPs as you are negotiating your contracts. What is known is that most of the PDPs are not going to immediately implement these programs on a widespread basis. It is encouraging to know that pharmacists now have specific CPT codes for use when billing for medication therapy management. These new codes went into effect this summer and are: 0115T, Initial Service (15 minutes); 0116T, Subsequent Service (15 minutes); and 0117T, Additional Time Modifier (additional 15 minute segments added to either of the preceding codes). The use of these codes is not limited to Medicare. Pharmacy organizations are encouraging their use for all medication therapy management billings.

Information Concerning PrimeCare Users Only:

There have been indications that the PDPs are not going to routinely accept post billing transactions. Because of the need to keep TrOOP (True Out Of Pocket) up-to-date, the PDPs are going to expect real-time online adjudication of all Part D claims. This is going to have a major impact on all LTC/ALF pharmacies that are dispensing in less than full month quantities that post bill. If you are a bingo card pharmacy that is already prebilling or demand fill pharmacy, you are probably fine with your current operations. On the other hand, if you are doing a seven, or 14 day, or other frequency exchange type of dispensing and billing retrospectively, you will need to rethink your operations completely. One suggestion is to discuss these issues with the PDPs as you negotiate your contracts. When you analyze it, you will realize that most of the PDPs are familiar with the retail model and unfamiliar with the LTC/ALF model.

E-prescribing poses other issues for long-term care and assisted living pharmacies. As mentioned in a previous *Insight* article, the draft regulation was published in January 2005 with a comment period that ended in April 2005. The draft regulation dealt with the retail, two-way e-prescribing model. ASCP and NCPDP sent detailed comments to CMS regarding the three-way communications necessary for effective e-prescribing in LTC. The final regulations should have been published by the time this article is in your hands. We will discuss those regulations in more detail in the January edition. Keep in mind that we are still waiting on the DEA to determine how they want to implement electronic signatures. Until the DEA decides this very important issue, e-prescribing for controlled substances is on hold.

Recently NCPDP formed a long-term care work group; it is Workgroup 14. We are always looking for more participants in the work group activities. You do not have to be an NCPDP member to join a task group, you just need to have an industry interest. There are currently ongoing task groups on the following topics: E-Prescribing, Electronic Health Record in collaboration with HL7, LTC Billing Issues, and Consultant Pharmacist Data issues. If you are interested in getting involved, please send an email to jhancock@qs1.com.

This article has attempted to address some of your major concerns about Medicare Part D and the impact it will have on your pharmacy and pharmacy system. QS/1's Central Management System continues to work out details to support Medicare Part D. As these become available, our staff will provide updates to all QS/1 customers via the QS/1 web page www.qs1.com. Although the goal of this article has been to discuss the changes that are being made in the pharmacy system in response to Part D requirements, there might be other aspects of this change that have not been mentioned in this article.

Further Resources for Changes in Response to Medicare Part D:

www.cms.hhs.gov/medicarereform/
www.ncpdp.org
www.pstac.org/aboutus/profsvc.html
www.apha.org
www.nacds.org
www.ncpanet.org
www.ascp.com/MedicareRx/

Kevin Crowe, Sr. Support Engineer, QS/1; Jim Hancock, Sales Manager, QS/1; John Schmidt, Supervisor, Product Analyst, QS/1

QS/1 Customer Conference

ORLANDO 2005

July 20-24

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Retail HME:
Your Front-End Profit Center
QS/1 Customer Conference
Jack Evans


Menu Changes

Everyone at QS/1 would like to thank our customers who joined us in Orlando for the 2005 QS/1 Customer Conference. The week was a great success and we thoroughly enjoyed talking with you. See you in St. Louis!

Tammy Devine, Vice President, QS/1

Customer Conference

July 19 - 22, 2006

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St. Louis, MO

$130 / night

Ask for the QS/1 Rate

Group Reservations 800.444.2326

QS/1®

Courtesy: St. Louis Convention & Visitors Commission

FamilyCare™

by Martin Winters, Industry Network Specialist

Claim Reconciliation

FamilyCare's claim reconciliation service received a significant upgrade recently. Claim payment information can now be downloaded from the member's reconciliation website and then uploaded into their RxCare Plus system. Payment information will be entered into the appropriate transaction record. This enhancement will save many hours compared to hand-posting the payment information; time that can be better spent recovering payments on claims that were under paid or not paid at all.

The original web-based reports remain and are still an excellent resource for reviewing claim payment data on a Third Party by Third Party bias.

FamilyCare is able to provide electronic claim reconciliation for CareMark, CareMarkPCS, Express Scripts, TriCare, Medimpact, First Health and Wellpoint.

Medicare Part D

Contracting with the Third Party payer is ongoing. Currently, FamilyCare has contracted with 22 payers and will continue to respond to any new plans as they appear. A list with these payers and their reimbursement rates was faxed to all FamilyCare members in mid-August. This list will be updated as needed and a finial list will be sent in mid-November. We have learned that if you currently have a contract with MedcoHealth, Humana or Cigna they will auto enroll you into their Medicare D plan.

FamilyCare's Cash Rebate Program

As the name implies, this is a manufactures rebate program for cash (private pay) prescriptions. Payment for the second quarter of this program was made in September with the average member pharmacy receiving over $400.00. If you are not enrolled into this program and would like to be, please contact us at FamilyCare@QS1.com. As with all data collection programs, the data is HIPPA compliant.

QS/1 WebServices Enhance CornerDrugstore.com

CornerDrugstore.com is making technological strides to continually provide services that increase pharmacy efficiency and productivity through patient satisfaction. Because of this commitment, there are many new developments with CornerDrugstore.com.

We are changing the face of CornerDrugstore from the inside out!

The Inside...The New and Improved Pharmacy Connection

Pharmacy Connection is the control panel for your pharmacy website and serves as the relationship builder between you and CornerDrugstore. While visiting Pharmacy Connection at **http://ImanagerRx.com** you may access your account by providing your user name and password for the Member Sign-In.

The capability to edit your webpage, check online orders, send bulk e-mail messages to your customers and check site activity have been available for some time on Pharmacy Connection. Visit the website to have access to additional developments in this sleek, newly designed version of the website.

The Skin Variation Tool and the Pharmacy News section are new additions to the pharmacy module. The Skin Variation Tool allows you to customize the color scheme of your website. You may select one of seven color schemes and then preview your site to view the result. Pharmacy News provides you the opportunity to post pharmacy specific news on your webpage.

Visit Pharmacy Connection today and read the monthly marketing tip and view extensive sales and marketing tools that assist you in advertising your website to your customers.

The Outside...New Service Offerings with CornerDrugstore.com

Your patients can now refill their prescription(s) online in a matter of seconds with Express Refills! CornerDrugstore.com developed Express Refills in response to the recommendation to simplify the process of submitting an online refill. This new addition to every CornerDrugstore website allows your patients the opportunity to submit a prescription refill without having to establish a personal account.

The patient's last name, prescription number, and valid phone number are all that are required to submit a refill through the Express Refills section. This streamlined process can be faster than calling the pharmacy's Interactive Voice Response (IVR) system or calling a pharmacy technician to request a refill on the telephone.

Tom Greco, Store Manager and Pharmacist in Charge of Hillsboro Pharmacy, stated, "Offering the Express Refills option to our pharmacy customers has significantly increased the amount of prescription refill requests that our pharmacy is receiving via our website. Not only is this option quicker and more convenient for our pharmacy customers, it increases pharmacy efficiency and accuracy when refilling prescriptions."

All prescription refill requests are validated to ensure patient safety and accuracy. Once validation has occurred, the prescription refill request will be transmitted to your pharmacy management system. If a prescription refill request fails the validation test, both the patient and the pharmacy are immediately sent notification indicating why the refill could not be processed and what action is required.

Prescription Validation Update

To aid the validation process, QS/1 WebServices announces Qdirect. This new service provides a direct connection between your pharmacy management system and QS/1. The connection facilitates real-time prescription refill validation with the data present in the pharmacy management system.

"We must strive to improve our WebServices as newer technologies and web tools become available to us," said Thomas Woods, QS/1 Sr. Web Developer. "We will strive to continually deliver more intelligent and efficient modules that will improve pharmacy workflow and patient satisfaction."

For additional information on these new developments or to add CornerDrugstore.com to your current pharmacy services, contact CornerDrugstore Support at 1.800.559.5489.

We Value Your Comments and Suggestions!

We are continuously modifying CornerDrugstore.com so that it may serve as an extension of your pharmacy. We field calls, we answer questions, but ultimately we listen to your suggestions. Your opinion is valuable, e-mail CornerDrugstore Support at Support@CornerDrugstore.com to submit any product enhancement suggestions.

by Tranaka Oglesby, Customer Support Associate, QS/1

VISA Certification

PCI Compliance Update

Due to the increasing number of credit card fraud cases and the rise of e-commerce, Visa implemented CISP (Cardholder Information Security Program) in June 2001, in order to minimize access to credit card data by creating more stringent security requirements. These new globalized security requirements comprise the PCI (Payment Card Industry) Security Standard. When all requirements are met and the standard is in place, the opportunity for outside parties to obtain sensitive credit card information is dramatically reduced. QS/1 is working hard to assure PCI compliance.

The PCI Data Security Standard is the model for transaction security and for maintaining the integrity and safety of privileged cardholder data.

"In order for us to communicate and distribute credit card transactions, we must have certification. It has become a requirement," explained Sonny Anderson, Director of Systems and Technology for QS/1.

The PCI Security Standard decreases the opportunity for outsiders to obtain sensitive credit card information by limiting the amount of exposure, storage and access to credit card data. Thus, creating a higher level of consumer confidence in using credit cards.

In April 2005, QS/1 contracted a PCI certified assessor to evaluate its credit card transaction security safeguards associated with . QS/1 immediately began addressing any issues that were verbally expressed for remediation in order to expedite the response to PCI's formal report. Some issues that have been addressed include: maintaining 90 days of video coverage focused on the Data Center door, maintaining a log of all visitors to the Data Center, as well as formal written procedures on how to dispose of hardware that has come in contact with Credit Card data.

QS/1 also received a formal written report from the assessor noting issues that need to be addressed. Presently, all issues have been addressed and QS/1 is now working with the third party assessor in order to complete a report on compliance. Once complete, the PCI assessors will submit the report to Visa for certification.

Kerry Philbeck, Creative Services Technician, QS/1

Service Pack 12

Service Pack 12 is currently being delivered. An icon at the bottom of the screen indicates when updates are ready to be installed, but a manual check for updates is also available from the QS/1 menu.

Service Pack 12 includes the following:
- Customized Reporting in Data Export as well as a Report Scheduler, which works as a replacement for macros in NRx.
- Point-of-Sale and HME have integrated and a Register Management replacement is now available.
- Document Imaging exists in NRx, RxCare Plus and PrimeCare.

For optimal access to Service Pack updates, Internet access via broadband connection is recommended. A dial-up connection will work for updates, but the time frame necessary to perform the download will be greatly increased. Remember that the option to download the Service Pack updates to a separate computer, then building a CD to install updates is a viable possibility. An icon at the bottom of the screen indicates when updates are ready to be installed. Simply double-click on the icon and follow the step-by-step instructions to complete the download.

System One Update

Point-Of-Sale was recently updated to replace Register Management for our stand-alone HME customers. As a result of customer input, we have made program changes to improve the interaction between our pharmacy POS and HME. For customers with all three products residing on the same server, you will soon have an upgrade option to allow the ability to check-out an HME customer at the register, charge it to his or her pharmacy account and provide them with a single statement. In addition, you can add OTC items at the time of check-out and provide the patient with a single receipt.

In Service Pack 12, the ability to scan a multi-page document and save it as a single document has been added.

CRx Product Updates:

In 18.3 we have linked the Pharmacist and Security user files together. We have also added password protection to the Change Pharmacist option. A new field, Prompt for Pharmacist was added to Security Options (menu path 7.3.7.4). User Roles, Pharmacist, General User and Technician, were added to Security Options (menu path 7.3.7.1). If the Prompt for Pharmacist is set to Y, the system checks the user role. If user role is pharmacist, the pharmacist is set as the user just logged in. If the user is a technician, a pop-up displays and a pharmacist must be selected from the list in order to log onto the system. If the user role is general user, the option to select a pharmacist does not display because general users can have restricted access to the system.

Add new pharmacists to the system in Security Maintenance Add User (menu path 7.3.7.2) and set the user role to pharmacist. The Change Pharmacist option (menu path 1.5) is now used only to switch the pharmacist, not to add/edit pharmacist information.

We have also added new print options to Price Update Services (menu path 7.3.2). The price update report is currently set to Print-to-Paper as the default option. The new options are: Print-to-Paper, Print-to-File or Do Not Print a Report.

PrimeCare Product Updates:

In 18.3 we added the ability to send your third party claims using the Internet. We also incorporated the same changes within the Pharmacist and Security user files, as was done in the Retail product. End of Day reports have been enhanced by adding the Prescription Sales Analysis and Sales Summary by Plan reports.

PrimeCare Updates for SP12

There are a number of things for PrimeCare users to look for in 18.1 Service Pack 12.

1. There are a couple of changes to the Refill Request form. These apply to the printed and faxed form. The form now supports multiple sigs. Please be aware that there is limited space for sig text, but Sig 1, Sig 2 and Sig 3 will print for a total of 200 characters. Another new feature is the ability to print the facility's address on the form rather than the patient's. This feature can be activated in the Refill Request setup options page. Additionally, the price code and group code (if present) now print.

2. There is a new function to validate room number length on input. If you specify the facility has a WRRRB format, then the system will check for five characters in the room number field. If more or less characters are detected, an error message displays. The store file switch under Prescription Processing options will activate this option. We have also added WRRR and WWRRR as valid room formats for the facility record.

3. Another new function validates the group code. If you attempt to load a patient into an group code that does not have a corresponding facility, you will get a warning message. Although the system warns, it will not stop the entry.

4. A duplicate NDC warning has been added during drug entry.

5. Three new features have been added to the Security section of the system: the ability to require special characters, require upper/lower case and assign an administrator.

6. There are a number of new label routines including a Routine for Payor from the Patient Billing Matrix and the ICD9 code and description.

RxCare Plus:

18.1.12 RxCare Plus Enhancements

Security Access

There is an added option 'Void Checked Out Tx' to Security Access Codes. Type **Y** to allow employee to void a transaction. If this is flagged N, and the employee tries to void a checked out transaction, the error message '<User ID>: Access Denied for Void of Checked Out Transaction' displays.

Prescription Processing

There is an added a warning message if you attempt to add a new drug and the NDC already exists in the system. The message is "NDC Already Exists. Press Enter to Add Drug or Escape to Quit." Press ENTER to continue adding the drug, or Esc to quit and not add the drug. A new display, "UPC Verification Complete - Matched" appears when a match is found on UPC during the verification step of Workflow. A Status column has also been added to the Sig Record scan.

General Reports

The Daily Audit now prints the pharmacist's name, instead of the initials, on the recap sheet. A print option 'Printer Number' to the Transaction Billing History report has been added. Type the printer number to which the report should print. The Refill Request Report now prints the Price Code, Patient Group Code and Multiple Sigs.

Accounts Receivable

A print option 'Pmnt Due Date' to Statement Formats A,B,D, and E has been added. Type the payment due date in this field to print on the statement in the following format: PMT DUE..MM/DD/YY.

Nursing Home Processing

The Patient Medical Record number prints on each page of the Side Effects Report.

From The Support Center

Visit our website at www.qs1.com and check out the Frequently Asked Questions section.

RxCare Plus:

When you receive the message 'Customer Aged - Unable to Post'on Auto-Posting Proof Report or posting a charge/credit/payment manually, run a File Compression on the A/R File.

PrimeCare:

Prior to 18.1, the user could print a label in Workflow before completion of the verification stop by pressing the F5 key. 1n 18.1, this method was modified to defer label printing until verification has been completed.

In 18.1, new fields have been added to the control record of several physcians orders and MARS. If you are having issues with your forms printing incorrectly, update the control record and then check your options. To update the control record, go to F3-Facility/Unit Mangement, F13-Update Facility/Unit Control Record Options (for RxCare Plus: F-Nursing Home Processing, N-Update Nursing Home Control Record Options). To check your control record options, go to F3-Facility Unit Management, F9-Facility/Unit Record Management (for RxCare Plus: F-Nursing Hope Processing, I-Control Record Maintenance), access your facility and then tab to the appropriate form and press enter. It is very important that you review each field in the control record and make sure that it is answered correctly. If you have any questions about what a field means, the defintions are available in your help files and on our website at www.qs1.com.

Hardware:

It is import to regularly check the backups. If using ultrabac you can check the backup using the following steps. Double click on the Ultrabac icon, Click on logs and then backup. Next, go to the last file and open it. It should be the current date. Go to the bottom of the log to see if there is a backup summary. The summary will read backup complete and have the files selected and completed.

POS:

An optional feature has been added to prevent a transaction from being voided unless the POS transaction has been voided first. In Service Pack 12 or higher, this can be turned on or off under security acces.

CRx 18.1 and 18.2:

You can now change third parties from Internet to Dial-up under the Online Setup:
4-File Maintenance
7-Third Party
2-Online Setup: Choose a Third Party, choose 'A' for Advance Options and change #2 Connection Type to 'N' for Internet or 'D' for Dial-up. This will change the connection type for all third parties.

If you need assistance, call the Customer Support Center at 1.800.441.1995, option 2 for Software Support.

CRx Hardware: Backup

Please be aware of automatic backup failures that occur on all versions of Windows after the daylight-saving time change. Check your backup logs daily. If you experience any problems with your automatic backups, call the Customer Support Center at 1.800.441.1995, option 4 for Hardware.

CMS 18.1 Delphi:

Under Tools, Central Management Security, Add/Edit User, on the Roles tab, the security administrator can view the security restrictions for each role listed. If no roles have the security access the administrator is looking for, you can create a custom role by clicking on the green plus sign to add the access. This will allow the administrator to select access for each individual category. Once saved, the custom role can be selected under the users tab. If more than one role is selected under the users tab, the most restrictive access for each category will be applied to that user.

If you need assistance, call the Customer Support Center at 1.800.441.1995, option 3 for CMS Chain Support.

Norton Antivirus

Check your subscription date to ensure that it has not expired. If it has expired and you have Internet access, update your program to ensure that it checks for the most current virus definitions and that Automatic Live Updates is activated. If you do not have Internet access, contact Symantec for the update.

IN YOUR AREA

Training Seminars

NORTHEAST REGION

Mechanicsburg, PA: (717)795-2700
10/11/2005 PrimeCare: Basic Processing
01/10/2006 RxCare Plus: A/R Third Party Reconciliation

Sturbridge, MA: (800) 648-7428
10/18/2005 RxCare Plus: A/R and Third Party Processing
01/24/2006 Point of Sale: Basic Processing

SOUTHEAST REGION

Miami, FL: (800) 889-9183
11/10/2005 RxCare Plus: A/R
11/16/2005 PrimeCare: Workflow
11/17/2005 PrimeCare: Facility Unit and Billing Matrix
12/15/2005 Point of Sale: Basic Processing

Orlando, FL: (800) 889-9183
10/13/2005 RxCare Plus: Review & Enhancements
10/20/2005 Point of Sale: Inventory
12/08/2005 RxCare Plus: Nursing Home

Spartanburg, SC: (800) 889-9183
10/11/2005 PrimeCare: Workflow
10/12/2005 PrimeCare: Facility Unit and Billing Matrix
10/13/2005 RxCare Plus: Review & Enhancements
10/20/2005 Point of Sale: Inventory
11/10/2005 RxCare Plus: A/R
12/08/2005 RxCare Plus: Nursing Home
12/15/2005 Point of Sale: Basic Processing

GULF STATES REGION

Brandon, MS: (800) 233-6204
10/11/2005 RxCare Plus: 18.1 Review & Enhancements
10/11/2005 Point of Sale: 18.1 Review & Enhancements

Dallas, TX: (800) 248-0096
11/08/2005 RxCare Plus: 18.1 Review & Enhancements
11/08/2005 Point of Sale: 18.1 Review & Enhancements

Houston, TX: (800) 248-0096
12/06/2005 RxCare Plus: 18.1 Review & Enhancements
12/06/2005 Point of Sale: 18.1 Review & Enhancements

MID-ATLANTIC REGION

Lexington, KY: (866) 441-7011
10/20/2005 Point of Sale: Enhancements
11/10/2005 RxCare Plus: Medicare Part D & MTM
11/15/2005 RxCare Plus: Understanding Your System Set-up

Richmond, VA: (877) 392-5851
10/20/2005 CRx: Update & Enhancements
11/15/2005 PrimeCare: Enhancements
11/17/2005 RxCare Plus: Medicare Part D & MTM

Indianapolis, IN: (800) 637-5251
10/13/2005 RxCare Plus: A/R and Reconciliation
11/10/2005 Point of Sale: Inventory Control
12/08/2005 RxCare Plus: Medicare Part D & MTM

MIDWEST REGION

Pleasant Hill, MO: (800) 541-5358
12/13/2005 RxCare Plus: Workflow
12/14/2005 PrimeCare: Workflow
12/15/2005 RxCare Plus: Prescription Processing
12/20/2005 All Products: Hardware-Basic Windows

Rapid City, SD: (800) 541-5358
11/15/2005 RxCare Plus: Review & Enhancements

Saint Paul, MN: (800) 541-5358
10/25/2005 CRx: Basic Processing
10/26/2005 RxCare Plus & PrimeCare: Basic Processing
11/16/2005 RxCare Plus & PrimeCare: Report Logic
11/29/2005 RxCare Plus: A/R - General Reports
12/13/2005 Point of Sale: Basic Processing
01/10/2005 All Products: Hardware-Basic Windows

WEST COAST REGION

Valencia, CA: (866) 848-1942
10/17/2005 RxCare Plus: Prescription Processing
10/21/2005 RxCare Plus: A/R & 3rd party Reconciliation
11/01/2005 RxCare Plus: Prescription Processing
11/15/2005 RxCare Plus: California Medicaid
11/16/2005 RxCare Plus: Tickler File
11/17/2005 RxCare Plus: Workflow
12/05/2005 RxCare Plus: Prescription Processing

Seattle, WA: (866) 848-1942
10/04/2005 RxCare Plus: Workflow
10/06/2005 PrimeCare: Fill List
10/11/2005 SystemOne: GUI Reporting
11/07/2005 RxCare Plus: Prescription Processing
11/11/2005 RxCare Plus: Report Logic
11/17/2005 SystemOne: Claims Follow-up Process
11/29/2005 Point of Sale: Report Logic
12/12/2005 RxCare Plus: Prescription Processing
12/13/2005 RxCare Plus: Inventory Control

* Special times and pricing. Please call the regional office for more details.

IN YOUR AREA

Trade Shows

Springfield, IL
September 30-October 2, 2005:
Illinois Pharmacists Association (http://www.ipha.org/)

Fort Lauderdale, FL
October 15-19, 2005:
National Community Pharmacists Association - NCPA Booth #212 (http://www.ncpanet.org/)

Research Triangle Park, NC
October 16-18, 2005:
North Carolina Association of Pharmacists (http://www.ncpharmacists.org/)

Atlanta, GA
October 18-20, 2005:
MedTrade Fall Booth # 1963 (http://www.medtrade.com/)

Chapel Hill, NC
October 20, 2005:
HL7 Conference 2005

Las Vegas, NV
October 23-25, 2005:
Western Food Industry Expo

Boston, MA
November 9-11, 2005:
American Society of Consultant Pharmacists - ASCP Booth # 1814 (http://www.ascp.com/)

Columbus, OH
November 9-10, 2005:
Ohio Association of Medical Equipment Services - OAMES (http://www.oames.org/)

Las Vegas, NV
December 4-8, 2005:
American Society of Health-System Pharmacists (http://www.ashp.org/)

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