341 Wellness Drive • Myrtle Beach, South Carolina 29579
Phone. (843) 488-5550 • Web. www.ce-prn.com • Email. info@ce-prn.com • Fax. (843) 488.5554

Demystifying the Pharmacy Insurance Claim

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Faculty
Alex Evans, PharmD, BCGP
Ascension St. Vincent's Health Center

Community pharmacists and technicians bill insurance claims every day, but especially in chain pharmacies reimbursement issues are not pursued at an individual store level. Because of this, there is little opportunity for many pharmacists to understand everything involved in the reimbursement of a claim. A thorough understanding of it, however, will help both resolve insurance claims as well as find opportunities to improve profitability.

Learning Objectives

Pharmacist

1. Identify the path of a prescription insurance claim after it leaves the pharmacy
2. Recognize common rejections, what they mean, and when and how they should be overridden
3. Identify key elements of the revenue cycle of a pharmacy, from submission to final payment
4. Recognize ways that pharmacy managers can improve profitability with insurance and reduce liability

Pharmacy Technician

1. Identify the path of a prescription insurance claim after it leaves the pharmacy
2. Recognize common rejections, what they mean, and when and how they should be overridden
3. Identify key elements of the revenue cycle of a pharmacy, from submission to final payment
4. Recognize overrides that require pharmacist-only intervention

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Target Audience

Pharmacists, Pharmacy Technicians

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PHARMCON
341 Wellness Drive, Myrtle Beach, South Carolina 29579

Introduction

In 2016 prescription drug spending accounted for nearly 10% of all healthcare spending, at a total cost of $328.6 Billion.[1,2,3] In addition, prescription drugs account for 22% of payer premium spending according to a recent analysis.[4] Unfortunately, Fraud Waste and Abuse (FWA) is all too common among this spending; CMS reclaimed over $2.6 billion dollars in 2017 due to issues related to FWA.[5] In order to protect the pharmacy's revenue and the pharmacy and pharmacist's liability, it is imperative that community pharmacists have a good understanding of how prescription drug insurance works, the major payers, and common mistakes that can lead to either auditing losses or liability.

A solid foundation in the inner workings of prescription drug insurance can also help pharmacists as they navigate patients through the system and assist with receiving a paid claim for their medications. This CE focuses primarily on claims associated with daily dispensing; while direct and indirect renumeration (DIR) fees ultimately affect reimbursement, both DIR fees and pharmacist-led clinical services are not within the scope of this article.

Types of payers

Government payers – An overview

Government payers include Medicaid, Medicare, and Tricare, which covers primarily low-income families, the elderly, and active-duty and retired military and their families. According to the most recent figures, Medicaid and Medicare alone account for over 37% of all national healthcare expenditures, at a total cost of $1.238 Trillion.[1] For pharmacies, the government is a major source of revenue and it is critical that pharmacists have a good understanding of how to bill claims correctly through government payers.

Medicaid and Medicaid were established in 1965 under the Lyndon Johnson administration, at a time when about half of the nation's elderly had no medical insurance. Just as with the decades-long debate about the nationalization of healthcare, beginning as early as Truman's New Deal attempts, there was fierce opposition to the establishment of Medicare and Medicaid. The American Medical Association was one of the largest opponents, stating that it will "put the government smack into your hospital" and Ronald Reagan warned that "one of the traditional methods of imposing statism or socialism on a people is by way of medicine." Prior to Lyndon Johnson, Kennedy campaigned hard for it, stating "The fact of the matter is that what we are now talking about doing, Europe did years ago."[6,7,8] It is interesting that similar debates about national healthcare and the future of the ACA are persisting to this day.

Tricare

The Dependents Medical Care Act was signed into law in 1956 and covered active-duty military, retired military, and their dependents. Military beneficiaries received care through either a military hospital or by 1966 through a program, known as CHAMPUS, where the government allowed beneficiaries to use private health systems. After a series of reforms and improvements, the program was eventually renamed Tricare. It allows beneficiaries to choose among numerous coverage options that patients often mention in the pharmacy, including Tricare Prime, Tricare for Life, and Tricare Select.[9,10,11]

Medicaid

Medicaid covers primarily low-income families and is funded jointly by the federal and state governments but administered by the states, so that every state has a different Medicaid plan and design.[7] An important issue when billing Medicaid is that by law it is always the 'payer of last resort,' so that every other insurance plan the patient has must be billed prior to billing Medicaid. This is known as Third Party Liability, and under the Deficit Reduction Act of 2005 third parties are required to provide eligibility and coverage information on their enrollees to Medicaid to prevent incorrectly billed claims. In the case that a claim is still paid out by Medicaid which they were not liable for (i.e. the patient's primary coverage should have paid), states are required by law to go after the money.[12]

Some states have Medicaid programs designed to assist people with coverage who would not otherwise qualify for Medicaid due to income. Terms for this program include Share of Cost, Medically Needy Medicaid, and Spend-Down program. Every month, individuals enrolled in this program must 'spend-down' their income in excess of the limit on medical care prior to Medicaid covering their care. The spend-down amount is determined by the states and goes by different terms, such as the Medically Needy Income Limit (in Florida) or the Maintenance Needs Allowance (in California).[13,14] Unfortunately, in the author's experience after the patient meets the MNIL for the month the processing time can be long enough that coverage is not activated in the computer system until the next month, when the patient's MNIL resets. One remediating factor is that the share of cost typically does not need to be paid, it just needs to be owed. If a patient receives a large bill at the beginning of the month they can immediately submit that bill towards their MNIL.[14,15]

Medicare

Medicare is a federally-funded program primarily for the elderly and includes Part A, B, C, and D. Medicare Part A covers hospital services, while Medicare Part B covers a variety of outpatient and rehabilitation services, including some pharmacy services such as immunizations, medical supplies, and certain medications. Medicare Part C, also known as Medicare Advantage, is a program where private insurance companies are paid by the federal government to administer Medicare Parts A and B on their behalf. Medicare Part D covers prescription medications.[16,17]

Medicare Part B

For a pharmacy to become a participating provider for Medicare B, they must first choose whether to only sell non-accredited products or both accredited and non-accredited products. Non-accredited products include erythropoietin, immunosuppressants, infusion drugs, nebulized medications, oral chemotherapy, and oral nausea medications. Accredited products include a long list of durable medical equipment (DME), but pharmacies that are accredited bill commonly for diabetic testing supplies. Pharmacies wanting to get in the DME business will also need accreditation.[18,19]

If choosing only to sell non-accredited products, the pharmacy will submit the CMS-855S application, along with other necessary documentation and the application fee, to a contracted third-party that is different depending on the state they are in. States are divided into jurisdictions and contracts are awarded to vendors for each jurisdiction. These companies are known as Medicare Administrative Contractors (MAC). It is the job of the MAC to administer Medicare Part A

and B on behalf of the federal government, including the processing of applications according to federal law.[18,19,20]

For pharmacies choosing to bill accredited durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) through Medicare B, they must go through several additional steps. DMEPOS products that require accreditation include diabetic testing supplies, canes and crutches, blood pressure machines, surgical dressings, parenteral and enteral nutrition, and most immunizations. To begin, pharmacies select an accreditation organization, submit the CMS-855S application, and the accreditation organization reviews the pharmacy's policies and procedures, verifies licensure for the pharmacy and pharmacist(s), and finally conducts the on-site survey. Examples of accrediting organizations include the National Association of Boards of Pharmacy (NABP) and The Joint Commission.[18,19,21]

Because of the complexity of the CMS-855S application, many pharmacies choose to enlist consultants to assist with filling out and submitting the application on their behalf, especially if they are seeking accreditation. Of note, the process can take a long time to complete so whether deciding to hire a consultant or not planning is crucial; CMS reports that even in the case there are no deficiencies in the application it can take up to 9 months to become accredited.[19]

Practice Pearl The limited list of medications that are covered under Medicare B are considered excluded medications (i.e. not covered) under Medicare Part D. Because of this, if a patient has both Part B and Part D and a claim is submitted to Part D for a Part B covered drug it will deny and should be resubmitted to Medicare Part B.[22]

Medicare Part D

Medicare Part D covers prescription medications and is the primary focus of the community pharmacist. Medicare Part D is administered by numerous private insurance companies, all of which have their individual formularies and features. Medicare Part D plans do, however, always consist of four different coverage periods[23]:

a. The deductible period: Just like with private insurance, a patient has to pay a certain amount of money out of pocket, known as their deductible, before the insurance will help pay for the medications. As of 2018, no deductible could be higher than $405.
b. Initial coverage period: After the deductible is met the patient will receive help paying for their medications and will have a copay. After a certain amount is paid by the insurance company (most often $3750) this period expires. As a pharmacist you can help patients stay in this initial coverage period by getting their most expensive medications switched to less expensive ones, if appropriate.
c. Coverage gap: This is also known as the 'donut hole.' This is the period when patients must again pay for their medications, although there are programs funded by the federal government and manufacturers to alleviate the high costs during this period.
d. Catastrophic coverage: After the patient has spent $5,000 in True Out of Pocket Costs (TrOOP), they enter the catastrophic coverage period for the remainder of the year. During this time their copays will be very low. It is important to note that copays, full payments for medications paid during the coverage gap, and amounts

paid by some other agencies count towards TrOOP; monthly insurance premiums and the cost of medications not covered otherwise do not.[24]

Practice Pearl: This is important because if, for example, a patient is in their coverage gap and is prescribed a brand-name medication that requires a prior authorization (PA) it is in their best interest to get the PA approved prior to purchasing the drug, even if their payment will be the same. If it is not approved and the pharmacy runs the medication as cash, then it is considered a non-covered drug and does not go towards meeting their TrOOP.

One of the ways pharmacists can help their Medicare patients is by helping them select the plan that is best for them during open-enrollment; to do so, use the *Medicare Find a Plan* tool available at: https://www.medicare.gov/find-a-plan/questions/home.aspx. Enter the patient's zip code and all of their medications and it will populate a list of health insurance plans, the total cost each month, when the patient will enter each phase of coverage, and a breakdown of their monthly costs. It also provides a lot of other information on the insurance company, including service ratings, contact information, and more.

Commercial payers

In the author's experience the most common categories of commercial payers to be aware of are employer-sponsored health plans and manufacturer vouchers. In the case of the patient with commercial coverage, by law it is billed before Medicaid and Tricare[12,25] and is almost always the primary payer.

A common misunderstanding among patients (and often even other healthcare professionals) with manufacturer vouchers (i.e. 'copay cards') is that if their primary insurance does not cover the medication that it can be run through the voucher for the same copay that is on the card. While terms vary among copay cards, the manufacturers do not usually allow this because they will then not be reimbursed anything for the medications. Under their ideal scenario, the manufacturers make money because they only pay the pharmacy the difference between the patient's copay without the voucher and the advertised copay on the voucher and are then able to sell more of their medication at a high cost, which the insurer pays for. For example, if a manufacturer sells a medication for $500 and offers the patient a coupon that will pay up to $75 of their copay, then they will still gross $425 from the sale of that medication.

In providing coupons, manufacturers are able to influence the tiered formulary intended to discourage the use of more expensive medications and increase the sales of their own products at an increased cost the patient does not see upfront. They also increase drug costs by weakening the negotiating leverage that Pharmacy Benefit Managers (PBM) have with manufacturers when setting up their formulary. Because the reimbursement provided to the pharmacy is considered a kickback, copay cards cannot be used with government-funded insurance plans.[26,27]

On the other hand, for many brand-name medications there is no suitable alternative; one analysis found that out of the 200 highest-expenditure medications 51% had either no substitute or only another branded substitute.[28] In those cases, coupons are of enormous benefit to the patient and allow them access to a medication they would not otherwise have access to. As a community pharmacist part of our job is ensuring adherence and often coupons are a critical tool for us in doing so. Also, many patients are not aware that coupons exist for the medications they are already on and

so they can be an easy way to provide excellent service, build loyalty at your pharmacy, and relieve the patient of high copays. One of the author's favorite things to do when there is down time is to browse through the will-call section of the pharmacy, find prescriptions that are eligible for coupons, and bill those coupons before the patient comes. It is very rewarding to see how delighted the patient is when they arrive at the pharmacy expecting a high copay and instead pay nothing or very little for their medication.

Another type of manufacturer voucher is the free trial card. While they also might encourage patients to utilize more expensive medications, they allow time for the pharmacist and physician to determine the next steps for the patient without an interruption in therapy. Such steps could include finding a suitable alternative to the prescribed medication, helping the patient apply for a patient assistance program, or obtaining a Prior Authorization, if that option is available. It is also preferable to samples being provided by the manufacturer because it allows the pharmacist a chance to perform the clinical checks for appropriateness and drug interactions.

PRACTICE PEARL Even with a free trial it is best practice to run the claim through the patient's insurance first to determine coverage and then run the free trial. If the claim is rejected or too high of a copay through the primary insurance, the pharmacist and physician can work to decide if coverage needs to be worked on for the prescribed medication (prior authorization or tier exception, for example) or if the patient needs to be switched to a different medication.

Affordable Care Act marketplace plans[29,30]

A final type of plan commonly encountered in the community pharmacy is plans found through a healthcare exchange created by the Affordable Care Act (ACA). Passed in March 2010, the ACA was written with the intent to a) subsidize health insurance for low-income families to expand coverage, b) expand the Medicaid program, and c) encourage improvements in healthcare delivery to lower overall healthcare costs. Patients needing health insurance coverage can utilize the healthcare exchanges, also known as the healthcare marketplace, to obtain coverage. Patients needing to find and select a plan can go to https://www.healthcare.gov/get-coverage/ to enroll in a plan either during open enrollment or after eligible life changes. Of note, under the ACA all insurance companies offering plans through healthcare exchanges are required to offer certain minimum standards for coverage, termed essential health benefits. This includes prescription drugs, and as an example birth control is spelled out as a prescription drug class that is required to be covered.

The insurance card - what is a BIN, PCN, and group number?

Claims for prescription medications started being processed electronically in the late 1980's, and in order to do so the claims needed to be submitted electronically to the correct insurer for processing. For that insurers borrowed a term from the credit card industry and created a Bank Identification Number (BIN), which in the pharmacy industry became known as a Processor Identification Number; the acronym BIN, however, stuck. The 6-digit number was originally issued by the National Council for Prescription Drug Programs (NCPDP), although as of January 2017 insurance companies must apply for an 8-digit Issuer Identification Number (IIN) through the American National Standards Institute (ANSI). This number identifies an insurance company; if an insurer wishes, they can also apply for a Processor Control Number (PCN), still through NCPDP, to identify different plans and benefit packages among their slate of offerings. Not all health insurance companies need to or wish to differentiate their plans with the use of a PCN number, so there will

be cards that do not have one. Finally, the Rx Group Number is used most of the time when identifying specific employers and their individual health plans. All Insurers that issue identification cards to beneficiaries must adhere to the NCPDP's *Healthcare Identification Card Pharmacy and/or Combination ID Card Implementation Guide*, which describes the ANSI telecommunication standards required to protect patient privacy and security during the transmission of healthcare claims.[31,32,33]

Following the path of a prescription insurance claim

Switches

Once leaving the pharmacy, the claim will then hit a service that routes the claims to the proper insurance company or PBM based on the identifiers described above. These are known as 'switches'; examples of companies that offer switching services include RelayHealth and Emdeon. Switches usually charge a fee for every transaction, although they might also charge a flat monthly rate. Of note, this price is independent of insurance payment, so if an insurance company rejects the claim and it needs to be reprocessed the switch fee will be charged again.[34,35,36] Switches (and other companies) also offer a variety of services that are bundled in one package to improve a pharmacy's reimbursement and reduce exposure to liability. These are collectively known as *pre and post edits (PPE)*, and examples include[35]:

1. AWP resubmission: Average Wholesale Prices (AWP) will fluctuate on a regular basis. Unfortunately, if a pharmacy is only updating their drug record files in the computer system weekly or monthly, in times of rising drug costs they will submit an AWP to the insurance company that is lower than the current AWP of the medication. Often this can result in underpayment of claims; in order to correct this, the switch will automatically check for differences in AWP and resubmit with the higher AWP when there is a difference to maximize reimbursement.
2. DAW Code validation: Dispense as Written (DAW) codes are most often used to specify reasons to the insurance company why a branded medication was dispensed; the default, DAW 0, means that there was no product selection indicated. Other examples include a) the physician wrote brand name only, b) the patient wanted brand name, c) the generic was not available on the marketplace, or 4) brand drug mandated by law. If a DAW code is selected that is inconsistent with the product chosen (ex. brand selected but DAW 0 used), the switch can reject that claim before it gets to the insurance company to avoid auditing issues.[37]
3. Quantity and days' supply validation: Checks for errors in days' supply based on the product and quantity entered. A common example includes entering the wrong quantity for inhalers (entering it in the pharmacy software system as '1,' when the correct quantity is the number of grams).
4. DEA Verification: The switch will automatically verify a prescriber's DEA number to ensure it is valid and in good standing.

PRACTICE PEARL At times the rejection sent back by the switch for DEA verification is actually incorrect. In order to correct this issue, the pharmacist will need to a) Visit the Drug Enforcement Administration's DEA Registration Validation website at: https://apps.deadiversion.usdoj.gov/webforms/validateLogin.jsp. Enter all of the

pharmacy information to access the site, then enter the prescriber's DEA number to determine if it is valid. b) If it is in fact valid, enter a Submission Clarification Code (SCC, field 420-DK) of either 42 or 43 to indicate "Prescriber ID submitted is valid and prescribing requirements have been validated" or "Prescriber's DEA is active with DEA authorized prescriptive right." It is best practice to print the page from the DEA website indicating the DEA is valid and staple it to the prescription. Although a technician is able to perform all of the above steps, because of legal issues with filling a control without a valid DEA it is best practice for the pharmacist to at least verify the DEA information found by the technician.[38]

5. NPI verification: As with the DEA number, the switch will also validate the prescriber's National Provider Identifier (NPI) and can send the claim back if it is not valid. Options to obtain the correct NPI include either calling the prescriber's office or using the NPI Lookup tool located here: https://npiregistry.cms.hhs.gov/
6. NDC verification: This service will check for discontinued or outdated National Drug Codes (NDC's) and reject the claim so that it can be resubmitted with a valid NDC.

PRACTICE PEARL: At times you will receive a rejection from the switch that actually does not need to be corrected but instead needs to be pushed through to the payer. A good example in the author's experience is with Transderm-Scop: although most pharmacies are willing to break packages and sell even one patch at a time, the author's pharmacy's switching service is designed to reject the claim for incorrect package size and ask to have it corrected to the full box. In these cases, submitting a 9999 or 9998 in the Prior Authorization field will override the switch's PPE and tell the switch to submit the claim to the payer. This is one example of how it can save time and is important to understand whether the rejection is coming from the switch or from the payer.

Medicare Part D Transaction Facilitator

If a patient is Medicare Part D eligible but is either unsure of coverage or does not have their coverage information with them the pharmacy can send an eligibility verification request, called an E1 transaction, through a Medicare Part D Transaction Facilitator (or just facilitator). The facilitator will check the Medicare database and return eligibility information to the pharmacy if there is a match.[39] Another relevant service the facilitator provides is to transfer the amount spent towards a patient's True Out of Pocket Costs (TrOOP) to another insurance company in the event the patient switches plans in the middle of the year. It is important to note that if a patient does switch plans mid-year, all the TrOOP costs they have incurred so far in the year *will* be transferred to the new company – they do not need to start over again.[24]

Payer

Finally, after the claim is submitted by the pharmacy, sent to the switch, and possibly sent through the Medicare Part D Facilitator, it arrives at the payer. Once the payer receives the claim it will make a coverage determination and send the claim back to the switch, where it ultimately gets routed back to the pharmacy.[35] Of note, payers generally also charge a fee, in addition to the fee charged by the switch, to process each claim submitted.

Reimbursement structures

A very important aspect of a pharmacy's financial viability, and one of continuous debate and negotiation, is the reimbursement structure. One of the most common structures offered to pharmacies contracted will reimburse the lowest of three prices[40]:

1) *Usual and Customary* (U & C, i.e. the "cash price")

2) *The contracted rate*. The contracted rate is a formula that can look something like this: Average Wholesale Price (AWP) – 22% + $1.25 dispensing fee. It varies from one contract to the next.

3) *The Maximum Allowable Cost (MAC).* This is a list created by the Pharmacy Benefits Manager (PBM) that sets an upper limit for reimbursement of certain medications. MAC is typically thought of as being reserved for generic medications so branded medications would be the lowest of either U & C or contracted rate; however, this varies significantly from one contract to the next. PBM's can also create a different MAC list for different pharmacies. . As noted in Managed Care magazine, the PBM can define MAC as "the unit price established by the PBM for a multisource drug included on PBM's MAC lists developed for PBM's clients, *which may be amended from time to time by PBM, in its sole discretion*." In doing so, a PBM can decide when to add or remove a generic medication from their MAC list and manipulate drug prices to minimize reimbursement. Under most contracts, if the medication is not on the MAC list, then the only options left are contracted rate or cash price. If the contracted rate is lower than what the MAC would have been had it been on the MAC list, then the PBM effectively reduces reimbursement from the omission.

PRACTICE PEARL An important point to note in this pricing structure is that if the cash price is the lowest of the three rates then that is what the pharmacy will be reimbursed. Unfortunately, mistakes can easily be made when submitting claims due to package size errors; for example, if the pharmacy is submitting Advair (fluticasone/salmeterol) and submits "1" for the package size when the pharmacy software system lists one inhaler as "60" (for 60 puffs), the cash price will be submitted to the insurance company as 1/60th of the actual cash price. As noted previously, switch companies offer services in their pre and post edits to reduce the chance of this error occurring; however, at times the mistake can make it through the switch and the pharmacy could dispense at a significant loss.

Final Payment

Once a payment is issued from the payer to the pharmacy for medications dispensed, the payer also issues an Electronic Remittance Advice (ERA). In it, the payer lists necessary claim payment information, such as every prescription submitted for the period (including rejected claims), the U & C and ingredient cost submitted, the transaction processing fee taken by the payer, and the reimbursed amount. Pharmacies can then use that to post payment to the account to verify payment for the prescription. Payers will still issue remittance advice by mailing a paper invoice, although this is less efficient and pharmacies can reduce administrative burden by ensuring they are enrolled in ERA for their major payers. If provided on paper, this statement is called a Standard Paper Remit (SPR).[41,42,43]

For most pharmacies, posting payments from the ERA to the account for every claim would be incredibly time-consuming and cost-prohibitive. Because of this, services known as claims reconciliation services have been created to identify unpaid claims. To do so, the service will access

your switch data to gather all of the claims, electronically match them with the ERA, and then report non-payment or underpayment back to the pharmacy. Many services offer web portals for the pharmacy to have ready access to unpaid claims. After identifying non- or underpayment pharmacies can then go after the claims and increase revenue.[44]

Another way pharmacies can improve efficiency and improve security is to ensure that they are enrolled in Electronic Funds Transfer (EFT) for every payer that participates in the service. Receiving paper checks for reimbursement will take longer and thus lengthen the revenue cycle, they can get lost in the mail, and they can more easily be diverted. There are companies that even offer Central Pay services, where they will collect all payments for a pharmacy or chain of pharmacies, divide the revenue by location, and then pay each location. For independents, for example, that own several stores, setting up separate bank accounts for each store and the enrolling all of those stores in EFT could be incredibly time consuming, and Central Pay services offer the ability to significantly reduce time collecting payment.[45]

The pharmacy audit: Maximizing reimbursement and minimizing liability

Payers audit pharmacies because of billing history, referral from a FWA hotline, a routine, random audit, or other reasons that might signify a potential for FWA to the payer. Often it is in the form of a desk audit, where the pharmacy will be required to fax documentation back to the payer, but can also be an on-site audit. During an on-site audit, the auditor might ask for a lot of different documentation and can include the original prescription, the prescription label, licensing and insurance information, invoices, and signature logs. Most often they will send out a letter in advance to allow the pharmacy to prepare.[46]

PRACTICE PEARL Be sure to use the letter to fully prepare for the audit. This includes pulling all prescription books (if the pharmacy does not have scanned prescriptions) and making advance copies of all required documentation – licenses, etc. – so that it is ready to go when the auditor comes.

Insurance company audits can present significant financial risk to the pharmacy. In the case there is missing information or a missing prescription, insurance companies can chargeback the entire reimbursed amount of the medication. Some of the most common reasons for a chargeback include a) billing an incorrect days' supply, b) failing to document the billed DAW code, c) failing to have adequate documentation of either the prescription or proof of pickup, d) improper documentation of override codes used, or e) inadequate directions for use.[46]

Calculating days' supply

A comprehensive guide from Medicare on common errors in billing dosage forms can be found here: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/pharmacy-auditing-dispensing.html

Common mistakes include[47,48]:

1. Topicals: Prescriptions still come across quite often with directions of "Apply to Affected Areas" for topicals. Unfortunately these directions are unclear and put the pharmacy at risk for a chargeback. Directions should include the area that the patient is to apply the topical medication to and how often. One method to determine how much cream will be used for each application is the *fingertip unit*, which is the amount of medicine that

will stretch from the end of an adult finger to the first joint, and is estimated at 0.5g for an average male and 0.4g for an average female. This figure is then multiplied by the estimated number of fingertip units necessary to cover various areas of the body to arrive at a total days' supply for the medication. Also, remember that some medications, such as diclofenac 1% gel or Santyl (collagenase), need to be dosed exactly.

2. Diabetic testing supplies, insulin syringes, and pen needles: Probably the most common package size for lancets, testing strips, and either pen needles or syringes is 100 count; unfortunately this quantity doesn't translate well into 30- or 90-day supplies. A common auditing issue arises when a patient is testing blood glucose, for example, three times daily and the claim is submitted with a 100-count box of testing strips for a 30 day supply. Because this is a 90-day supply and a smaller box is available, a 50-count box of testing strips should have been dispensed. In the case that a smaller box is unavailable (i.e. most lancets), it is acceptable to bill a 100-count box for 30 days because the package cannot be broken.
3. Inhalers: The total number of puffs in the inhaler should be divided by the total maximum puffs the patient could use per day. For example, for ProAir or Ventolin (200 puffs per inhaler), a prescription written as "1-2 puffs PO q4-6 hours PRN" should be submitted as 200 puffs/12 puffs per day= 16 or 17 day supply. If this is mistakenly submitted as a 30 day supply the patient could run out of medication before the insurance company will pay for a refill.
4. Injectables: Computer systems often express the total quantity in milliliters, not in number of syringes. For example, enoxaparin 30mg/0.3mL, #9 syringes, would be submitted as 2.7, not 9. The volume of liquid in each syringe (0.3mL) x the total number of syringes (9) = the total quantity for claim submission (2.7mL).
5. Eye drops: Twenty drops per milliliter is a very common estimation to use when calculating eye drops. Also, consider whether the patient is using the medication in one or both eyes when performing the calculation; if it is unclear from the prescription, contact the provider to clarify.
6. Beyond-use dating: There are numerous medications that have limited beyond-use dating and the limited dating needs to be taken into consideration when calculating days supply. Lantus, for example, is only stable for 28 days once it is removed from the refrigerator[50]; if the patient is receiving one vial (1000 units) and using 10 units per day, the correct days' supply is still 28 days.

Other common auditing issues[46,49]:

Improper DAW Code Submitted: As stated previously, pre and post edits can assist in catching this error, but many pharmacies get chargebacks because of improper documentation of a DAW 2 (patient requests brand). If the patient does ask for brand and DAW 2 is submitted, a statement to that effect must be on the face of the hardcopy.

Lack of adequate record keeping: The payer will ask to see both the prescription and the proof of pickup for the prescription. If either of those are missing a chargeback could occur.

Lack of documentation of override codes: There are numerous overrides a pharmacist can use to receive a paid claim through the pharmacy software system, and if those are not properly

documented the payer can issue a chargeback. DUR codes are a good example – you cannot enter M0 "Prescriber Consulted" and 1B "Filled prescription as is" if you have not spoken with the physician and documented that conversation.

Commonly Used DUR Codes

Professional Service Code	Result of Service Code
M0: Prescriber consulted	1B: Filled prescription as is
P0: Patient consulted	1G: Filled with prescriber approval
R0: Pharmacist consulted other source	

Of note, DUR codes should only be overridden by pharmacists. Having a discussion with the physician about the risks and benefits of a prescription drug therapy (the conversation that would be documented with an M0) is not a delegable task in most states. Even in the case another DUR override code is used – for example, R0 "Pharmacist consulted other source" – this implies that a reference of some sort was used to determine the appropriateness of therapy. This is also not a delegable task. Delegating this task to a pharmacy technician presents not only auditing issues but safety issues for the patient and legal issues for the pharmacy and pharmacist.

Other clinical rejections provided by the pharmacy software system should also only be overridden by pharmacists, and it is important that the technician alert the pharmacist to it when it is noticed; ideally, the computer system would be designed so that only pharmacists can override clinical rejections. The following are examples of overrides that necessitate some level of judgement about appropriateness or safety of therapy and should be left to the pharmacist:

1. Minimum/Maximum doses per day exceeded: Software systems are designed to alert the pharmacist to an unusual dose; a good example would be Brilinta (ticagrelor) dosed once daily rather than the suggested twice daily dosing or Remeron (mirtazapine) dosed three times daily which exceeds typical dosing intervals.
2. Look alike/sound alike: Most pre and post edit services have rejections related to medication safety. A common one is "look alike sound alike (LASA)" to ensure the correct medication is being filled, and is overridden with a 6666 in the Prior Authorization (PA) field. For legal, safety, and liability reasons, this rejection should only be overridden by pharmacists.
3. Drug interactions: Most software systems are designed not to allow technicians to override drug interactions but, in the case a system is not, drug interactions should never be overridden by technicians.

PRACTICE PEARL: A best practice is to maintain a compliance binder in the pharmacy that has all documentation necessary for auditing and inspection purposes. It should contain locations of all records that are too large to keep in a binder (invoices, etc.). Examples of records are copies of licenses (originals should be displayed), liability insurance, CMEA Self-Attestation (Combat Methamphetamine Epidemic Act), any state-specific requirements, and policies and procedures. It should also provide contact information for the pharmacy manager. In doing so, even if an auditor

or inspector comes while a new and/or float pharmacist is there, they will know where all records are.

Conclusions

A thorough understanding of the types of insurance, how a pharmacy claim works including all intermediaries, common errors and auditing issues, and the pharmacist and pharmacy technician's role in accurate billing is necessary to prevent liability and reduce exposure to chargebacks and penalties. This knowledge is also crucial to maintain profitability in an era of shrinking reimbursement rates and increasing pressure from payers and PBMs alike.

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Contributing Faculty
Alex Evans, PharmD, BCGP
Ascension St. Vincent's Health Center

Executive Editor
Kevin Hope, RPh
Clinical Pharmacy Education Specialist
PharmCon, Inc.

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LESSON EVALUATION

Please fill out this section as a means of evaluating this lesson. The information will aid us in improving future efforts. Either circle the appropriate evaluation answer, or rate the item from 1 to 7 (1 is the lowest rating; 7 is the highest).

1a. **PHARMACISTS ONLY:** Does this lesson meet the learning objectives? (Circle choice).

Identify the path of a prescription insurance claim after it leaves the pharmacy	YES	NO
Recognize common rejections, what they mean, and when and how they should be overridden	YES	NO
Identify key elements of the revenue cycle of a pharmacy, from submission to final payment	YES	NO
Recognize ways that pharmacy managers can improve profitability with insurance and reduce liability	YES	NO

1b. **TECHNICIANS ONLY:** Does this lesson meet the learning objectives? (Circle choice).

Identify the path of a prescription insurance claim after it leaves the pharmacy	YES	NO
Recognize common rejections, what they mean, and when and how they should be overridden	YES	NO
Identify key elements of the revenue cycle of a pharmacy, from submission to final payment	YES	NO
Recognize overrides that require pharmacist-only intervention	YES	NO

2. Was the program independent & non-commercial? YES NO

	Low Relevance						Very Relevant
3. Relevance of topic	1	2	3	4	5	6	7

4. What did you like **MOST** about this lesson? _____

_____

5. What did you like **LEAST** about this lesson? _____

_____

6. How would you improve this lesson? _____

_____

PLEASE MARK THE CORRECT ANSWER(S)

1. After leaving the pharmacy, a claim next goes to:
   a. The payer
   b. The E1 transaction facilitator
   c. The switch
   d. CHAMPUS

2. The pharmacist submits a claim without a prescriber NPI number in the NPI field. They get a rejection that says, "missing or invalid NPI number." This rejection is most likely coming from which of the following?
   a. The payer
   b. The switch's pre and post edits (PPE)
   c. The Medicare Part D Transaction Facilitator
   d. The CMS-855S
   e. Ronald Reagan

3. Which of the following products are not covered under Medicare D for patients who also have Medicare B?
   a. Antibiotics
   b. Anti-emetics
   c. Immunosuppressants
   d. Nebulized solutions
   e. A, C, and D
   f. B, C, and D
   g. A, B, C, and D

4. After meeting their True Out of Pocket Costs (TrOOP), Medicare D patients enter which of the following?
    a. Deductible period
    b. Donut hole
    c. Catastrophic coverage
    d. Coverage gap
    e. B and D

5. A patient with Medicare Part D presents a prescription for Synthroid, DAW 1, which is subsequently denied because it requires a Prior Authorization. Which of the following is the next best step?
    a. Inform the patient the medication is not covered, and they will need to pay cash
    b. Request a PA from the Pharmacy Benefits Manager (PBM)
    c. Request a PA from the physician
    d. Run a copay card, if available

6. A patient with commercial coverage presents to the pharmacy with a prescription for Eliquis, for which there is no approved generic. The Eliquis requires a PA. Which of the following is the next best step(s)?
    a. Request a PA from the physician
    b. Request a PA from the Pharmacy Benefits Manager (PBM)
    c. Run a free trial card, if available
    d. Inform the patient the medication is not covered and they will need to pay cash
    e. A and D
    f. A and C
    g. A, B, C, and D

7. What is the purpose of a Processor Control Number (PCN)?
    a. To identify the insurance company
    b. To identify a specific plan among all the insurer's plans
    c. To identify employers utilizing a specific insurer
    d. To identify the Pharmacy Benefits Manager (PBM)

8. Which of the following are services offered by pharmacy switching services?
    a. To reduce pharmacy exposure to liability
    b. To route the prescription claim to the correct insurer
    c. To determine patient benefit eligibility
    d. A and B
    e. A, B, and C

9. You receive a rejection, with a message from the switch, stating that the prescriber's DEA number is invalid. What is your next step for resolving the situation?
    a. Inform the patient the prescriber is not allowed to write for controlled substances
    b. Lookup their DEA number to determine if it is valid
    c. Override the switch with '9999' in the Prior Authorization field
    d. Call the DEA to inform them the prescriber is attempting to write controls without a valid DEA number

10. Which of the following is not typically part of the reimbursement pricing structure between the pharmacy and the payer?
    a. The cash price
    b. The contracted rate
    c. The patient's copay
    d. Maximum Allowable Cost (MAC)

11. Which of the following are advantages of setting up reimbursement of EFT and receiving ERA's rather than SPR's?
    a. Increased security
    b. Shortened revenue cycle
    c. More revenue
    d. Reduced administrative costs
    e. A, B, and D
    f. A, C, and D
    g. A, B, C, and D

12. Which of the following is not typically part of the reimbursement pricing structure between the pharmacy and the payer?
    a. Billing incorrect days' supply
    b. Lack of documentation for Dispense as Written (DAW) code 2
    c. Failure to provide a signature log to prove pickup
    d. A and C
    e. A, B, and C

13. Why should a Drug Utilization Review (DUR) reject only by overridden by pharmacists?
    a. Drug Utilization Review is not a delegable task in most states
    b. A pharmacist review should be performed for patient safety
    c. Technicians overriding the DUR codes could present legal or auditing issues
    d. A, B, and C

14. A physician writes a prescription for Xalatan (latanoprost) eye drops, 2.5mL, #1 bottle. The instructions are to "Use one drop in each eye every night at bedtime." Which of the following is the most appropriate days' supply to submit to the payer?
    a. 30
    b. 25
    c. 90
    d. 50

15. The pharmacy receives a prescription for a ProAir inhaler, with 200 puffs. The directions are "Inhale 1 puff by mouth four times daily as needed." Which of the following is the most appropriate days' supply to submit to the payer?
    a. 25
    b. 16
    c. 30
    d. 90

16. The pharmacy receives a prescription for blood glucose testing strips, #100, to use twice daily to check blood glucose. The patient's insurance pays for a maximum of a 30-day supply. Which of the following is the most appropriate package size to dispense to the patient?
    a. 100 count
    b. 50 count
    c. 25 count
    d. Two boxes of 50 count
    e. A or D

17. Your pharmacy receives a prescription for Brilinta (ticagrelor) for a patient that has coverage through Tricare and Medicaid. They would also like to use a copay card. Select the correct billing order.
    a. Tricare, Medicaid, Copay card
    b. Medicaid, Copay Card, Tricare
    c. Tricare, Medicaid; inform the patient they cannot use a copay card
    d. Medicaid, Tricare; inform the patient they cannot use a copay card

18. A pharmacist receives a DUR rejection for a potential drug-drug interaction. The pharmacist reviews the claim and then calls the physician. After discussion they determine the benefits outweigh the risk and that both medications should be dispensed. Which of the following DUR override codes should be used to override the rejection?
    a. R0, 1B
    b. M0, 1B
    c. T5, 1G
    d. R3, 1B

19. When running a claim, you receive a Pre-and post-edit (PPE) rejection stating that the provider's NPI (National Provider Identifier) number is invalid. What is the most appropriate next step?
    a. Call the provider's office to ask for their NPI
    b. Use the NPI lookup tool
    c. Wait until the patient comes back to ask them for the physician's NPI
    d. Inform the patient that the provider is not allowed to prescribe medications
    e. A or B
    f. A, B, C, or D would be appropriate

20. The pharmacy technician runs a claim for lamotrigine 150mg. It is then rejected by the pre- and post-edits with a rejection that says "Look alike sound alike. Verify drug and put 6666 in the prior authorization (PA) field if correct." What is the technician's next best step?
    21. Enter 6666 in the PA field to route the claim to the label queue
    22. Alert the pharmacist to the rejection
    23. Leave it in the error queue for the pharmacist to find later
    24. Leave it in the error queue for the pharmacist to find later
    25. Inform the patient the insurance company will not pay for the medication