Technician Tutorial:
Billing Rx Drugs

These days, most Rxs are paid for by third parties, such as a government health plan or a plan offered through an insurance company. Submitting claims for Rxs to these third-party payers is one of the primary functions of pharmacy technicians in the community setting. (In the hospital setting, third-party billing is done outside of the pharmacy, so technicians are not typically involved.) It is very important that claims are submitted correctly. Incorrect submissions can result in rejections, audits, or even allegations of fraud. And once a claim has been submitted incorrectly, it may be difficult and time-consuming to fix. It's easy to imagine how third-party coverage issues can be frustrating for everyone involved. Pharmacy technicians can help the process run smoothly by knowing how to successfully submit claims, troubleshoot problems, and communicate with patients, prescribers, and other healthcare providers about issues that may arise.

e-Rx
TRINTELLIX 10 MG DAW: 0=NOT SPCFD QTY: 30 REFILLS: 2 SIG: **1POQD**

Renee, a 67-year-old female, is in the pharmacy today to pick up a prescription that was electronically prescribed during an office visit earlier in the day. You check the computer and see that an e-Rx was transmitted to the pharmacy a few minutes ago for the antidepressant medication Trintellix *10 mg, 1 tablet by mouth once daily, dispense 30, with 2 refills. Renee tells you she would like to wait. You ask Renee for her insurance card since you haven't filled any prescriptions for her in a while. The insurance card says "Medicare Rx" on it. You know this means that she has a Medicare Part D prescription drug plan.*

What are the different types of prescription drug plans?

In the US, many employers purchase medical and prescription insurance for their employees. In fact, around 49% of Americans get health insurance coverage through their employers. People can also purchase their own individual plans, such as through the US Affordable Care Act's "Marketplace." Non-government-funded health insurance plans are typically referred to as "commercial" plans.

The US government also funds health insurance for individuals who qualify. For instance, Medicaid is a federal and state program for low-income families, seniors, and individuals with mental or physical disabilities. Medicare is a federally funded program designed for people of any income who are age 65 and older, as well as some individuals under age 65 with certain disabilities or other special circumstances.

Although Canada has a universal healthcare system, this does not include universal coverage for prescription drugs. Therefore, similar to the US, individuals in Canada may get their prescriptions paid for through employer- or government-sponsored plans, or by buying their own coverage.

Prescription drug plans are usually bundled together with medical or health insurance plans (*Aetna*, *Blue Cross Blue Shield*, etc). Pharmacy benefit managers (PBMs), such as *OptumRx* or *Express Scripts*, are often used to handle Rx claims. PBMs act as intermediaries between payers and pharmacies. Patients may have a separate insurance card for pharmacy benefits, in addition to their card for medical benefits. Ask patients for both cards since some vaccines or certain types of drugs may need to be billed to the patient's medical insurance. If a patient only has one card, the information for the PBM should be on the back of that card.

Medicare Part D prescription drug plans ("PDP") can be added onto "original" Medicare (Medicare Parts A and B) to cover prescription drugs. With original Medicare, Part A covers costs associated with hospital or long-term care admissions, while Part B covers outpatient services (physician visits, etc), certain vaccines (influenza, pneumococcal, etc), medical supplies, and equipment (durable medical equipment [DME]). Since many pharmacies fill prescriptions for vaccines and DME (diabetes testing supplies, etc), you may be responsible for billing Medicare Part B. Billing Part B for eligible vaccines is typically a similar approach as how you bill vaccines and prescription drugs to other plans. However, billing Part B for DME has some unique considerations and requirements. For more details, review our CE, *Durable Medical Equipment (DME) for Medicare Patients*.

Part C plans are an alternative to original Medicare, and some of these plans have a prescription drug benefit, referred to as an "MA-PD" (Medicare Advantage-Prescription Drug) plan. While patients with original Medicare plus a Part D plan need to provide their "red, white, and blue" card as well as a separate insurance card for their Rx drug coverage, patients with an MA-PD plan will not have a "red, white, and blue" card and may have just one card with info needed to bill both the health plan and prescription plan.

How do prescription drug plans work?

Prescription drug plans have certain features designed to keep Rx drug costs low. This is sometimes referred to as managed care. Prescription drug plans are usually set up with a monthly premium, which the patient pays to participate in the prescription drug plan. Prescription drug plans may have an annual deductible, where the patient must pay full price for their Rxs until a specific dollar amount is met. Plans also typically require patients to pay a co-pay for each prescription. The co-pays can vary from plan to plan, and from drug to drug, and usually kick in once the deductible has been met. Co-pays can be a flat amount, such as $10, or a percentage of the drug cost, such as 25%, known as coinsurance.

Plans often have a list of drugs they cover (referred to as a formulary) and categorize those drugs into three to five tiers based on cost. Tier 1 and tier 2 drugs are both preferred or "on formulary." Tier 1 drugs typically include generics and have the lowest co-pay. Tier 2 drugs usually consist of brand medications preferred by the plan, or "preferred brands," and have a higher co-pay than tier 1 drugs. Tier 3 or 4 drugs usually include non-preferred brand medications or medications that may only be covered in certain situations. Patients may have to pay much more for these. Specialty medications (high-cost meds with complex handling, administration, monitoring, etc) will often be included in higher tiers, such as tier 4 or tier 5.

How do pharmacies get paid by insurance plans?

Most of the time, billing occurs at the time an Rx claim is processed online. When a claim is filed electronically, you know almost immediately whether it's approved or rejected. Claims can be rejected for a variety of reasons which will be covered in later sections.

The amount a third-party payer reimburses the pharmacy for an Rx is usually based on the cost of the medication plus a dispensing fee or other allowable markup. However, the cost of the med is not typically the actual amount the pharmacy paid for it. It is usually the average wholesale price (AWP; the average of what wholesalers charge pharmacies for a drug) minus a certain percentage. The pharmacy may get paid electronically through funds transfers to its bank account, or they may receive a check payment from the payer.

Keep in mind that the healthcare system is focusing more and more on improving the quality of healthcare while reducing overall costs. This means that providers, including pharmacies, are no longer simply being paid based on the products or services they deliver. Third-party payers are starting to include performance on quality measures (a tool used to measure the quality of healthcare provided) into pharmacy contracts. For example, in the US, you may have heard of "DIR" (Direct and Indirect Remuneration) fees. This is a fee

charged by a PBM that in some cases may be based on the pharmacy's performance on quality measures. The better a pharmacy performs on quality measures tracked by the plan, the lower the DIR fee will be. Ultimately, the DIR fee amount lowers the pharmacy's reimbursement for dispensed prescriptions.

What information requires close attention when submitting insurance claims?

You can prevent incorrect payments or rejected claims by accurately submitting important details, such as the patient's name, plan information, National Drug Code (NDC) number (Drug Identification Number [DIN] in Canada), quantity, days' supply, directions for use, origin code, International Classification of Diseases (ICD) diagnosis code (may be required for some Medicare Part B DME), and Dispense As Written (DAW) code. In Canada, there may be different intervention codes used for billing that vary by province and computer operating systems.

DAW codes tell US payers why a specific product is being used and are single-digit numbers 0 through 9. For example, DAW 0 is used when there's no preference and a generic is okay to dispense, DAW 1 means the prescriber requires a brand, and DAW 2 indicates a brand is requested by the patient. Pharmacy computer systems generally default to a DAW code of "0" when a prescription order is entered. Never use DAW "1" if the prescriber has not in fact documented that the brand is requested. This could be a big financial hit for pharmacies during insurance audits if there isn't proper documentation. Make a habit to document additional explanations whenever possible for DAW codes "2" through "9."

Origin codes describe where the Rx came from and may be required by some payers, such as for Medicare Part D plans. They're single-digit numbers 1 through 5 that tell payers if the Rx is written, faxed, e-prescribed, etc. For example, an origin code of "1" should be assigned to paper Rxs, "2" should be assigned to an Rx that was received over the phone, "3" is assigned to e-Rxs, "4" to faxed prescriptions, and "5" for cases where a new Rx number needs to be created from an existing valid prescription, such as a transferred prescription. In Canada, you may be able to choose the Rx type (written, verbal, faxed, etc) from a drop-down menu.

ICD diagnosis codes are used in the US to classify diseases, injuries, signs/symptoms, etc, and may be included on prescriptions to point out why a product is needed. There are about 70,000 codes, one for each medical condition or issue. For example, ICD code E11.9 indicates the patient has type 2 diabetes and E10.9 means the patient has type 1 diabetes. Follow your pharmacy's policy for ensuring ICD codes are documented. Medicare Part B and other payers may require ICD codes for some Rxs, such as diabetes testing supplies.

Submit NDC (or DIN) numbers correctly. These are required to identify meds and need to be provided when billing Rxs. NDC numbers are divided into three segments, in any of these formats: xxxx-xxxx-xx, xxxxx-xxx-xx, or xxxxx-xxxx-x. The first segment is the labeler code because it identifies the labeler, or manufacturer. The second segment is the product code since it identifies the product and strength, such as lansoprazole 15 mg capsules. The last segment is the package code since it identifies the package size, such as a 30-count bottle. This is a total of 10 digits. Some computer systems require 11-digit NDC numbers. In this case, you'll need to add a "leading zero" to the section that has too few digits to make an 11-digit number. For example, if your computer requires five digits in the first segment, the NDC you type in might look like 0xxxx-xxxx-xx if the product's NDC only has four digits in its first segment.

Different container sizes of the same med will have the same NDC numbers except for the last segment. For example, generic atorvastatin 40 mg tablets that come in bottles of 30 and 90 from the same manufacturer will have almost the same NDC number, except the last two digits will be different.

Some meds can have more than one NDC. This is true when multiple individual packages come in one box. There may be an NDC for the individual packages and a different NDC for the box. For example, you may see this with some generic azithromycin 250 mg five-day blister packs. Some computer systems take the NDC

number from the whole box, and some systems support the NDC number for the individual packs. Check with your pharmacist to make sure you are using the right NDC.

In Canada, a unique 8-digit DIN is assigned to each medication and this number will be different for the same medication from a different manufacturer. Unlike the NDC number, there is only one DIN for each medication regardless of the package size.

Always make sure to use bar-code scanning and match the NDC (or DIN) on the product to the NDC (or DIN) in the computer. This helps prevent the wrong product or package size from being dispensed. Dispensing the wrong product can lead to a medication error, in addition to insurance issues. And dispensing the wrong container size can throw your inventory off, short the patient, or give the patient too much of a med.

You may run into a scenario where it's possible to use two different NDC (or DIN) numbers to fill the same Rx, such as if you have an open bottle from one generic manufacturer and need to open a second bottle from a different generic manufacturer. Refer to your company's policies on how to approach this situation. It will usually involve submitting a claim for each specific NDC (or DIN) and the quantity dispensed, and then labeling each Rx product separately. If you dispense two products but bill under just one NDC (or DIN), you won't have a record of the actual product dispensed in case of a recall, the Rx bottle will be misbranded if it bears the name of only one manufacturer, and it may be considered fraudulent to bill for an NDC (or DIN) other than the one dispensed. Furthermore, an accurate quantity dispensed is necessary for inventory purposes. Be aware that dispensing two products with different appearances may also confuse the patient, so it's important that the patient is informed about any changes.

Clarify Rx directions that say "Take (or use) as directed." This practice may not be allowed by some insurers and is generally frowned upon. Plus, Rxs with these vague directions are often the focus of pharmacy audits. Work with the pharmacist to obtain exact directions so that you can calculate an accurate days' supply.

Enter accurate quantities to be dispensed. This is needed to calculate the correct days' supply. For reimbursement purposes, quantities for liquids are usually entered as the number of mL instead of the number of vials or packages dispensed. For example, one vial of insulin contains 10 mL of insulin, so you should enter the quantity as 10 mL. Entering a quantity of "1" vial may cause inadequate reimbursement. This may be communicated as "1 mL" being dispensed, instead of the full 10 mL contained in one vial. For topicals, enter weight in grams, not 1 tube or 1 jar. For oral liquid medications, enter mLs instead of ounces in most cases (30 mL = 1 ounce, so a 4 oz bottle contains 120 mL of liquid).

Make sure the correct days' supply has been calculated. Entering an inaccurate days' supply is a common cause of misbilling. Misbilling can necessitate that a claim be reversed, which can be time-consuming or even result in a fine from an insurance audit. Pay particular attention when entering days' supplies for meds that aren't solid oral dosage forms, such as insulin and other injectables, oral liquids, eye and ear drops, and topical meds (creams, ointments, etc), since these may require more steps in the days' supply calculation. You might need to gather additional info, such as the size of the treatment area with a topical med. Double-check days' supplies that have been automatically calculated by your computer system against the directions and quantity.

You make sure to enter the correct DAW number (0) and origin code (3 for an e-Rx). Since the Rx is for 30 tablets, you make sure to select the NDC number for the 30-count bottle. You double-check the directions that have autopopulated from the e-Rx sig, "Take 1 tablet once daily," and the days' supply that the computer system calculated from the quantity and directions. You confirm that a days' supply of 30 makes sense.

What must be done if a prescription claim is rejected?

If you get a drug utilization review (DUR)-related rejection message (e.g., drug-drug interaction, drug-disease interaction, dose too high or low), you should inform the pharmacist.

Some prescription claims may be rejected by the insurance because the drug requires a "prior authorization" (PA), or "special authorization" in Canada, by the plan. PAs often require additional documentation from the prescriber in order to ensure the drug is prescribed in a safe and/or cost-effective manner. More information on PAs is provided in the next section.

"Step therapy" may be another reason that an Rx claim gets rejected. Step therapy means the plan requires trying a less-expensive medication before the more expensive medication will be covered. Most low-cost generic meds work just as well as expensive brand names. If the rejection indicates step therapy is required, look to see if the adjudication screen message provides alternative meds that are covered to save you a call to the insurance company. When explaining step therapy rejections to patients, avoid saying, "Your insurance will only cover a cheaper drug," since this may imply the lower-cost med is of a lower quality and may not work as well. Instead say, "Your insurance company wants you to try another medication first, before paying for this medication." You'll want to find out if the patient has already tried the lower-cost medication. Sometimes patients pay cash for their meds and the insurance may not have record of the patient already trying the preferred, lower-cost med.

Insurance companies also implement "drug not covered" rejections for medications that are not on formulary at all. The denied claim message may include alternatives that are covered. If not, you or the patient can call the plan to find out what is covered.

"Refill too soon" rejections are often encountered in the pharmacy. These occur when the patient should have enough medication from a previous Rx fill to last them longer than the date the refill is processed. It's best to communicate with the patient when this happens. Their prescriber may have told them to take more of the med or the patient may be going out of town. Or they may not need the medication for a few days anyway and will appreciate being told when the Rx can be filled so they don't waste a trip to the pharmacy.

"Quantity limit" rejections occur when a plan limits the days' supply of medication they'll pay for at once. For example, with some plans the maximum days' supply may be less when filling the Rx at a community pharmacy versus mail order (e.g., 30 vs 90 days). These can be corrected by resubmitting the claim for the new quantity and days' supply allowed by the insurance. Be sure to inform the patient when this happens.

When contacting a PBM to handle rejections, you may have to stay on hold for an extended length of time. Suggest that patients return later and offer to call the patient to provide an update when you have more info. Make sure you have the most current contact information in your computer system before the patient leaves. Waiting to talk to someone from the insurance company can be frustrating, but always be courteous and provide a clear and concise explanation for a quick resolution. Have key info ready, including your pharmacy's NPI or NABP number (or provider number in Canada) and the patient's name, date of birth, ID number, group number, etc. Document important details, such as the name of the person you spoke to, the date/time of the call, and notes about the situation including any authorizations, reference numbers, changes, etc. For more tips on how to effectively communicate with insurance companies, prescribers, and patients, get our toolbox, *Soft Skills for Pharmacy Techs*, and tutorial, *Improving the Patient Experience*.

After entering Renee's Rx info into the computer and submitting it to the insurance, you get a rejection informing you that her drug plan requires a prior authorization for Trintellix.

How should prior authorizations be handled?

PA requirements can be frustrating. Techs can help by clearly conveying what a PA is to patients. For example, you could explain to a patient that, "This medication requires something called a prior authorization. A prior authorization is when the insurance wants more information from your prescriber about why they've prescribed this medicine. There may be less-expensive alternatives that work better or just as well, and the plan wants to make sure this is the only medicine the prescriber feels comfortable with you taking. It can take

several days for this process to be completed, but we'll contact your prescriber today so they could start working on submitting information to the insurance to get this prior authorization approved."

Check with the pharmacist to see if the medication is critical and needs to be started as soon as possible. In this case, the payer may need to be contacted to try to get a small supply of the medication approved to tide the patient over while the PA is in process.

In some cases, reaching out to the prescriber about a PA may lead to the prescriber trying a different med that is covered by the insurance. In this scenario, you must reverse the claim submitted for the original Rx. Failure to do so could cause a couple of problems. First, to bill the insurance company for the med without dispensing it is fraud. (Some pharmacies have a system in place to identify filled Rxs not picked up by the patient, so they can reverse the insurance claim and avoid fraud allegations.) Second, the payer might reject the new Rx as duplicate therapy, since the original med requiring a PA can have similar effects as the new med.

Even when PA requests are approved, the patient's co-pay may still be high. It is a good idea to inform patients of high co-pays, ideally before preparing or ordering the Rx, so that early action can be taken.

After you explain the prior authorization rejection to Renee, the pharmacist reaches out to the prescriber's office to get the process started. However, upon speaking with the prescriber, it's decided to have Renee try duloxetine first, instead of Trintellix. *The pharmacist takes an oral Rx for duloxetine and hands it to you. Before filling the new Rx for duloxetine, you make sure to reverse the claim for* Trintellix *and put that prescription on hold for now.*

How should claims for partial fills be handled?

In general, when submitting claims, it's a good idea to avoid doing anything that requires patients to pay extra co-pays, causes the third-party payer to pay extra dispensing fees, or results in submission of claims for medication that is not actually dispensed. Familiarize yourself with the policies regarding partial fills in your pharmacy, to avoid any actions that might be considered fraud.

Partial fills may be required due to lack of sufficient stock to dispense the full Rx quantity. Plans usually allow you to bill the Rx as you normally would and have the patient return for the balance. But if the patient doesn't return in a certain amount of time as specified by company policy, you must reverse the claim and bill for the correct amount. Alternatively, some pharmacy policies may require giving the patient a few tablets without charge and waiting until the patient returns for the balance before submitting the claim.

If a patient runs out of certain medications but has no refills, emergency fills with a small quantity may be allowed pending refill authorization. (Refer to your state's laws for more details on when this is permitted.) As with the situation above where stock was inadequate to fill the prescription, most plans want to be billed only once in this situation as well. In most cases, you can deduct the emergency supply from the prescription, depending on your pharmacy's policy and what your state allows.

If a patient only wants part of their Rx filled (e.g., Rx is for a 90-day supply, but the patient only wants a 30-day supply), document the patient's request in case there's any question in the future. This documentation can explain why you billed the Rx multiple times and collected multiple dispensing fees, instead of just one.

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"Cheat Sheet" for Billing Rx Drugs

How do pharmacies get paid for prescription drugs?

Pharmacies have contracts with various insurance companies for the payment of drugs and services. The amount that an insurance company will reimburse a pharmacy for prescriptions is outlined in the contract and is usually based on the cost of the medication plus a dispensing fee or other allowable markup. When a patient has a prescription to fill, the claim is submitted electronically. Since the insurance company is billed at the time a prescription claim is processed, you know almost immediately whether it's approved or rejected. The pharmacy eventually gets paid at an interval of time that is agreed upon in the contract with the insurance company (e.g., once a month).

What are some examples of the different types of payers pharmacies may bill prescriptions to?

- government plans (e.g., Medicaid or Medicare in the US)
- pharmacy benefit managers (PBMs; *OptumRx*, *Express Scripts*, etc)
- health plans (*Aetna*, *Blue Cross Blue Shield*, etc)

Why is payment for prescription drugs sometimes rejected by insurance companies?

Claims can be rejected for a variety of reasons. For example, incorrect information may have been submitted, it may be too soon for the patient to refill the medication, or the medication may require prior authorization or step therapy.

How should insurance rejections be handled?

It depends on the specific rejection. If there was an error in the information submitted to the insurance company, then correct the information and try to resubmit the claim. Make sure to enter all information correctly, such as the patient's name, plan information, NDC (or DIN) number, quantity, days' supply, directions for use, origin code, ICD diagnosis code (usually required for Medicare Part B durable medical equipment), and DAW code. If the rejection message mentions a prior authorization or step therapy requirement, you should get the pharmacist involved to work with the prescriber to submit the prior authorization request or change the med to an alternative. Be sure to reverse the claim that generated the prior authorization or step therapy rejection if the prescriber orders a different medication for the patient. If you don't understand the insurance rejection message, or if it's too vague (e.g., "drug not covered"), it's best to call the insurance company to get more information, such as alternative meds that are covered. DUR-related rejections should be referred to the pharmacist for review.

What can be done to help prevent insurance rejections and ensure billing accuracy?

- Know your pharmacy's policies on how to handle partial fills.
- Always dispense the NDC (or DIN) that you billed the insurance for.
- Check with the pharmacist if you are unsure of which NDC (or DIN) number to use when billing.
- Clarify any "Take (or use) as directed" sigs and get additional information as needed (e.g., size of area being treated for topical creams or ointments) to help determine an accurate days' supply.
- Submit the correct quantity and clarify with the pharmacist if you are unsure of whether to enter the quantity in terms of number of package sizes versus volume or weight.

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