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Third party issues

By Sandi Hutty, B.S.P.

Statement of objectives

Upon successful completion of this lesson, the technician should be able to:

1. **Understand the role of the adjudicator.**
2. **Understand the various components of a prescription drug plan claim.**
3. **Implement procedures to minimize problems with administration of third party issues.**

Introduction

Prescription drug benefit plans, while being an integral part of providing medication to patients, have become more and more intrusive in the work of a dispensary. A study by the Canadian Pharmacists Association concluded that the need to explain and deal with prescription drug plan issues involves considerable expense and increases the administrative workload in a pharmacy.[1] The study found that, on average, 31 per cent of all prescriptions required some sort of follow-up, and this extra work cost $3.10 per prescription in salary costs.[1]

Pharmacy Post's 2002 Survey of Pharmacy Owners & Managers showed that the situation is getting worse, with more than 80 per cent of pharmacy owners stating that their pharmacy is spending an increased amount of time on third party issues and that this extra time interferes with their ability to provide patient care.[2] Since most of the third party issues are technical rather than clinical in nature, pharmacy technicians are the most logical people to handle them.

History

Prescription drug plans have only existed in their current format for about 25 years. When they began in the late 1970s, pharmacies did not have computers and claims were submitted manually. The forms used were similar to manual credit card forms still in use today, and they were submitted on a regular basis, the frequency depending on how busy the pharmacy was. As computers were introduced, the claims were submitted in a variety of ways: printed in the pharmacy and mailed, printed at a central location and mailed, or transmitted tape-to-tape to the payer. In all of these scenarios, the pharmacy could potentially wait from two weeks to several months to have the claim paid or refused. A significant amount of paperwork and staff time was necessary to record the claims sent, check for payment discrepancies and rejections, and follow up on problem claims.

When prescription drug plan claims are submitted today, they are done so in an almost instantaneous transmission to the Pharmacy Benefit Manager (PBM) or, as this lesson will refer to them, the adjudicator. At the time of transmission, the pharmacy knows whether or not the claim will be paid and how much of the submitted amount will actually be received. Before the claim is finalized it's extremely important to read and understand all components of the payment screen because it's usually here that the pharmacy discovers limitations to coverage (e.g., days supply cutbacks, generic pricing). Logically, one would think that this online process has reduced the workload for dealing with prescription drug plans but, as mentioned in the introduction, this is not the case. The workload has merely shifted from being primarily paperwork to becoming a type of on-the-spot problem solving.

Third party adjudicators

Other than the pharmacist and the patient/beneficiary, there are three players involved in a third party billing: the plan sponsor/employer, the insurer and the adjudicator. A plan sponsor, or provider of prescription drug benefits, can be a government agency (e.g., provincial drug plans), an employer or union, or a private individual (in the case of individual coverage). Insurers administer the

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benefits program, of which the prescription drug plan is part.

Although adjudicators are the agents that pharmacies have the most contact with when processing prescription drug claims, it must be remembered that they are just that: agents. In some cases, they are the direct agent of the employer/plan sponsor (e.g., Liberty Health, Green Shield) and in others they are the agent of the insurer (e.g., BCE Emergis, Eclipse, ClaimSecure), which is in turn the agent of the employer/plan sponsor. Because they handle only a limited part of the prescription drug plan process, the adjudicators' authority to make changes to beneficiary information is often limited. It is important to remember that adjudicators pay claims on behalf of someone else and that someone else makes the decisions about the level of coverage and the type of payment.

Part of the confusion in pharmacies stems from the differences in the way adjudicators describe their various plans, show the information on their beneficiary cards, and transmit claim information back to the pharmacies. Of course, the adjudicators do not want to create problems and spend considerable time and energy providing as much information as possible about their plan designs, product information numbers (PINs), and prior authorization procedures in the form of handbooks and binders. Adding to the confusion, every plan sponsor's beneficiary base and financial situation is different, and the combination of this variation and the ever-increasing need to keep costs under control has led to many variations in plan type.

Prescription drug plan components

Adjudicators are responsible for the day-to-day administrative details of a prescription drug plan. In order to do this, they maintain a large number of complicated databases, including beneficiary information, drug information and formulary listings. A prescription drug plan claim can be broken down into a number of different components: the beneficiary, the drug supplied and the deductible and/or co-payment. The databases interlink and provide information on these components.

Beneficiary: A beneficiary is someone who has coverage under a prescription drug plan. A beneficiary database will include such information as the date of birth of all family members included under that coverage, their relationship to the main beneficiary (spouse, dependant child, overage dependant, etc.) and any special coverage information, such as exclusions based on existing medical conditions. Adjudicators always maintain beneficiary databases as part of their responsibility. Problems can arise when the database contains incorrect information (e.g., birth date), and the necessary corrections must go through several channels before the information in the database itself can be changed. Some adjudicators get their beneficiary information directly from the employer and others get it from the insurer. When the information comes from the insurer, the process of changing information can be quite lengthy.

Drug: All available products in the marketplace are listed in an adjudicator's drug database. A product is identified by a drug identification number (DIN) or a product identification number (PIN). PINs are used to identify products that are not assessed by the federal government Health Protection Branch as a pharmaceutical (for example, glucose testing agents or extemporaneous compounds). Problems arise with PINs because each adjudicator assigns a different number to products, and this variation can lead to confusion when submitting a claim.

In addition to DINs/PINs for each product, a drug database will include:

- Interchangeability information for each province. Interchangeability rules vary from province to province, and maintaining this information can be quite complex. Some provinces (e.g., British Columbia) consider drugs to be interchangeable if they have the same amount of active ingredient, have comparable activity in the body and are the same type of formulation. Other provinces (e.g. Ontario, Saskatchewan, Nova Scotia) only consider products interchangeable if they are listed as such in the province's own government formulary.
- Drug schedules for each province. Previously, prescription status (prescription-requiring or over-the-counter) was assigned by the federal government under the Food and Drugs Act and the Narcotic Control Act. Individual provinces gave prescription-requiring status to additional products, leading to provincial variations in legal status of some drugs. The National Association of Pharmacy Regulatory Authorities (NAPRA) has since harmonized standards across Canada and reduced the number of provincial variations.
- Pricing information for each province. Pricing for a product can vary considerably from province to province and is usually a function of whether or not that product is covered by the provincial drug plan and what type of pricing controls that province has for items on its plan.

Formularies: A formulary is, simply put, a series of rules that specifies which of a list of drugs in a drug database are covered under a prescription drug plan. Adjudicators frequently refer to a formulary by number and provide a description of all of their formularies in their hand book. The plan sponsor, when signing a contract with an insurer, will decide which of the available formularies will be used for the prescription drug plan.

A formulary will determine what is paid for from the list of drugs on the database. Some classes of drugs

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may be excluded from coverage. This can be as simple as saying that only prescription-requiring medications, and not OTC products, will be covered. It can exclude such classes as cosmetic (e.g., hair growth agents), fertility or erectile dysfunction agents. It can also specifically include certain classes of drugs such as smoking cessation agents (on the basis that they contribute to the overall long-term health of beneficiaries) or inhalation spacer devices (on the basis that they boost the effectiveness of the inhaled medication). A formulary can also state that certain dosage forms will not be covered on the grounds that they do not provide enough of an increased benefit to the patient for a large increase in price.

A formulary will also determine how payment for that list of drugs is to occur. Payment may be limited to the "generic price," i.e., the lowest price in a group of drugs that are considered interchangeable in that province. Within that parameter, the plan may or may not allow the full price to be paid for a brand name product when the physician has written "no substitution" on the prescription.

Under some formularies, specific new and expensive products are covered for beneficiaries only under certain circumstances, and special forms must be completed (e.g., prior or special authorizations, limited use), either by the physician or the pharmacist, before those products will be covered. Some plans have rules for a particular drug class (e.g., COX-2 anti-inflammatory agents, quinolone antibiotics); others will deal with individual products (e.g., rofecoxib, ciprofloxacin).

Still further rules may be placed around a list of drugs that are defined as maintenance drugs, i.e., long-term therapy that the patient takes once stabilized. In some instances, adjudication messages will recommend dispensing a three-month supply of one of these drugs. Conversely, if a product is not considered a maintenance drug, quantities may be limited to a 30-day supply.

Trial prescriptions are yet another option under some formularies. Some products have side effects that are known to cause patients to stop taking them. When paying for the first prescription for one of these drugs, the plan may cover only a limited supply, usually seven, 10 or 30 days. If the product is tolerated, the full amount may then be dispensed.

Deductibles and co-payments: Deductibles and co-payments are the parts of the cost of prescriptions that must be paid for by the beneficiary. These vary from plan to plan and can lead to frustration and confusion for both the beneficiary and the pharmacy. A plan may have one or the other, a combination of both, or neither.

Deductibles are the amounts that must be paid by the beneficiary and/or family before the claims in a prescription drug plan begin to be paid by the plan itself. This deductible is usually annual and may follow the calendar year or an artificial year determined by the plan sponsor. For example, in Ontario the deductible year for the Ontario Drug Benefit Plan begins on August 1.

A co-payment is the amount that a beneficiary must pay for each and every prescription. The co-pay can be a fixed dollar amount (e.g., $1.00, $5.00) or a percentage of the total prescription cost (e.g., 10%, 20%). This issue becomes clouded when a plan will put a limit on the amount of a professional dispensing fee it will pay (e.g., $5.00) and the balance of the fee becomes included as part of the co-payment.

Coordination of benefits: While not technically a component of claim, coordination of benefits has the potential to create confusion. It occurs when a family has two different prescription drug plans and the claim remnants (deductible and/or co-payment) from the first insurer get submitted to the second insurer for further payment. This usually occurs when both husband and wife work for companies that provide drug plans. It can also occur when a retired patient has coverage through the provincial government plan as well as retirement benefits.

The role of the technician

Given all of the above variables, the only way to know whether or not an item is covered and how much of the cost the beneficiary will be responsible for is to actually process a claim. The claim may be accepted, accepted with a cost adjustment or refused. In the last two cases, another attempt at payment will typically be made, resulting in time lost in the dispensary and, potentially, an angry customer. A technician has many opportunities to streamline information in the dispensary and limit the amount of time lost on adjudication issues.

- Capture all of the information from a patient's prescription drug benefit card. In many instances, coverage details are printed on the card, including the formulary number, dispensing fee limits, and deductible and co-payment amounts.
- Make sure that all adjudicator handbooks are up to date and easily accessible. These books provide a great deal of information about coverage issues, such as formulary descriptions, PIN listings and prior authorization rules. For example, with the formulary number from the patient's benefit card, the formulary description can be looked up and details of the plan coverage determined. During quiet times in the pharmacy, technicians should become familiar with these resources so that information can be readily retrieved when required.
- Have the basic contact information, such as telephone number and name of contact person, for each adjudicator readily accessible. Post this list by the telephone or place it in a binder in a central location.
- Check all coverage information thoroughly before calling an adjudicator's customer service number. In many instances, problems are created by inaccuracies in entering beneficiary information.
- If a particular plan always creates a problem, contact the employer or a beneficiary for a copy of the benefits book. No employer wants dissatisfied employees and most will gladly supply a copy of the plan design.
- Use the adjudicators' websites and bookmark them on your Internet browser. These sites have much of the same information that is in the handbooks. Some examples of the sites are: www.greenshield.ca, www.emergis.com, www.claimsecure.com, www.esi-canada.com, www.atl.bluecross.ca, www.liberty-health.com and www.bluecross.ca. Visit and become familiar with these sites so that they can be accessed efficiently when the need arises.
- Promote in-store communication. Talk to your fellow workers, institute a communications notebook to record information that should be passed on to all dispensary workers and make notes in

patients' computer profiles. The few seconds that you spend on documentation could save someone else stressful minutes.

• Educate your patients about how to contact their insurer or employer's benefits department to learn more about their coverage.

• Have brochures available to give to patients to help them understand the complexities of their benefits coverage. There are two good ones available: "It's Your Drug Plan" by the Pharmacy Association of Nova Scotia, and "It's your drug plan: Get the facts" by *Pharmacy Post* and the Canadian Stakeholder Steering Committee on Drug Plans.[3,4]

Currently, third party online adjudication is a mixed blessing. By understanding the interplay of the various components of a prescription drug plan and putting some of the above suggestions into practice, technicians have the opportunity to help take out the "mixed" and enjoy the "blessing" of this technological marvel.

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QUESTIONS

1. What percentage of prescriptions requires some sort of follow-up?
a) 81%
b) 70%
c) 31%
d) 85%

2. All of the following statements are true except:
a) Prescription drug plans have always existed.
b) Initially, claims had to be submitted manually.
c) It used to take between two weeks and a few months to have a claim paid.
d) With online adjudication, a pharmacy knows almost instantly how much will be paid for a claim.

3. Adjudicators decide what claims are paid and how they are paid.
a) True.
b) False.

4. In general, adjudicators always:
a) Get beneficiary information from the employer.
b) Get beneficiary information from insurance companies.
c) Make immediate changes to beneficiary information when called by a pharmacy.
d) Maintain databases on plan beneficiaries.

5. Which of the following is characteristic of a formulary?
a) The drugs covered are identified by DINs/PINs.
b) It will pay for every drug in a drug database.
c) It describes coverage rules for classes of drugs.
d) a and c.
e) All of the above.

6. A prescription drug plan will always have either a deductible or a co-payment.
a) True.
b) False.

7. A patient with coordination of benefits:
a) Has two different prescription drug plans.
b) Never has to pay a deductible or a co-payment.
c) Is always retired.
d) a and c.
e) All of the above.

8. When a problem arises with a claim, helpful information may be found:
a) On the patient's benefit card.
b) In the adjudicator's handbook.
c) On the adjudicator's website
d) All of the above.
e) None of the above.

9. Patients covered by a generic plan may sometimes be able to get a more expensive brand covered.
a) True.
b) False.

10. Which of the following ways does a formulary use to specify how some particular classes of drugs are covered under a prescription drug plan?
a) Trial prescription.
b) Special authorization.
c) Co-payments.
d) a and b.

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09/CECard/Sept 9/18/03 11:21 AM Page 2

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