chapter 1

From Prescription to Payment:

Becoming a Pharmacy Technician Insurance Specialist

Learning Outcomes

After completing this chapter, you will be able to define the key terms and:

1-1. Discuss the importance of pharmacy benefits to patients, providers, and the pharmacy practice.

1-2. Discuss the key features of medical insurance.

1-3. Describe the main types of medical insurance plans that provide coverage for patients.

1-4. Describe the ten steps in the pharmacy billing cycle.

1-5. Discuss the effects of billing errors on the success of the pharmacy practice.

Chapter Outline

Key Terms

accounts receivable (AR)
adjudication
benefits
billing cycle
coinsurance
copayment
deductible
EDI (electronic data interchange)
electronic prescribing (eRx)
explanation of benefits (EOB)
formulary
health plan
insurance payers
managed care
managed care organization (MCO)
maximum benefit limit
medical insurance
medically necessary
noncovered (excluded) services
pharmacy benefit
pharmacy claim
pharmacy management (PM) system
pharmacy technician insurance specialist
point of sale (POS)
policyholder
preferred drug list
premium
prescription drug list (PDL)
providers
remittance advice (RA)

The Importance of Pharmacy Benefits

In an average year, according to the U.S. Department of Health and Human Services Agency for Health Research and Quality, Americans spend around $180 billion on outpatient prescription medications. Of this total, $32 billion is spent on cardiovascular drugs, $25 billion on hormones, and $24 billion on central nervous system drugs. Cholesterol-lowering medications and antidepressants round out the top five with costs of about $20 billion each. This expenditure is growing and is expected to continue to increase. In addition, for the first time, more than half of Americans are taking prescription medicines regularly for chronic health problems.

Paying for these vital drugs is a matter of concern to patients, physicians, hospitals, pharmacists, and the health plans that help patients cover the costs. This chapter describes the basics of pharmacy benefits as a component of health insurance, the work flow in the pharmacy practice that supplies and bills for the prescriptions, and especially the role of the **pharmacy technician insurance specialist.** This title describes the vital job of getting paid for prescriptions, whether in a large pharmacy practice where individuals specialize in various tasks or a small practice where the same individual may handle this role, as well as others, such as filling prescriptions.

pharmacy technician insurance specialist job title that describes the vital job of getting paid for prescriptions, whether the setting is a large pharmacy practice where individuals specialize in various tasks or a small practice where the same individual may handle this role as well as others, such as filling prescriptions

Tech Check

About how much do Americans spend on outpatient prescription medications in an average year?

What groups are particularly concerned with paying for prescription drugs?

Medical Insurance Basics

Everyone, no matter how healthy, needs medical care at some time. People need preventive care, such as routine checkups and vaccinations, to stay healthy. They also need medications and treatment for sicknesses, accidents, and injuries. A person who receives health care owes a charge for the medical services and supplies, such as prescription drugs, that are involved.

To be able to afford the charges, many people in the United States have **medical insurance,** which is an agreement between a person, who is called the **policyholder,** and a **health plan.** Health plans, also known as **insurance payers** (or *carriers*), are organizations that offer financial protection in case of illness or accidental injury. Medical insurance helps pay for the policyholder's medical treatment.

medical insurance agreement between a person and a health plan that enables individuals to be able to afford medical expenses

policyholder individual who enters into an agreement with a health plan to receive medical insurance

health plan organization that offers financial protection in case of illness or accidental injury (also known as *insurance payer*)

insurance payers organizations that offer financial protection in case of illness or accidental injury (also known as *health plans*)

premium fee paid monthly to a health plan by a person who buys medical insurance

benefits payments made by a health plan for medical services

providers hospital, physician, and other medical staff members and facilities that offer medical services

The Insurance Contract

A person who buys medical insurance pays a **premium** to a health plan. In exchange for the premium, the health plan agrees to pay amounts, called **benefits,** for medical services. Medical services include the care supplied by **providers**—hospitals, physicians, and other medical staff members and facilities. Benefits usually start once the policyholder has paid a certain

amount each year, called the **deductible.** Some contracts, do not demand deductibles, providing *first-dollar-coverage* that begins with the first charge of the year.

deductible amount paid by a policyholder each year before benefits from a health plan will start

What Is Medically Necessary?

The health plan issues the policyholder an insurance policy that contains a list of covered medical services that is called a *schedule of benefits*. Benefits commonly include payment of medically necessary medical treatments received by policyholders and their dependents. The Health Insurance Association of America defines the insurance term **medically necessary** as "medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice." In general, these conditions surrounding medical procedures and medications must be met to be considered necessary:

medically necessary insurance term referring to appropriate medical treatment given under generally accepted standards of medical practice

- They match the patient's illness.
- They are not elective. They are required to treat a condition, rather than being elected to be done by the patient.
- They are not experimental. The procedures or medications must be approved by the appropriate federal regulatory agency, such as the Food and Drug Administration (FDA).
- They are furnished at an appropriate level. Simple diagnoses usually require simple procedures or medications; complex conditions may require multiple medications for effective control.

What Is Covered?

Insurance may cover a number of different items, including primary medical care, emergency care, and surgery. Many health plans also cover preventive medical services, such as annual physical examinations, pediatric and adolescent immunizations, prenatal care, and routine cancer screening procedures such as mammograms. The policies list treatments that are covered at different rates and medical services that are not covered. For example, a plan may pay 80 percent of most treatments but a smaller percentage of the charges for vision services such as eyeglasses.

Policies that have a **pharmacy benefit** usually provide coverage for a selection of prescription medications. The plan's **prescription drug list (PDL)**—which is also known as a **preferred drug list** or a **formulary**—contains the FDA-approved brand-name and generic medications the plan covers. It also describes the permitted sources of the PDL, which may include local pharmacies and online (Internet) or mail suppliers.

The medical insurance policy also describes **noncovered (excluded) services**—what it does not pay for. For example, dental care is generally not included in the medical insurance policy; however, separate dental insurance plans are available for purchase. Also, if a new policyholder has a medical condition that was diagnosed before the policy was written—known as a *preexisting condition*—a health plan may not cover medical services for its treatment.

pharmacy benefit feature of a policy that provides coverage for selection of prescription medications

prescription drug list (PDL) list containing the Food and Drug Administration (FDA)-approved brand-name and generic medications a plan covers (also known as a *formulary* or *preferred drug list*)

preferred drug list list containing the Food and Drug Administration (FDA)-approved brand-name and generic medications a plan covers (also known as a *formulary* or *prescription drug list*)

formulary list containing the Food and Drug Administration (FDA)-approved brand-name and generic medications a plan covers (also known as a *preferred drug list* or *prescription drug list*)

noncovered (excluded) services services that a medical insurance policy does not pay for

What Are the Limitations?

Plans often have a **maximum benefit limit** (also called a lifetime limit), a monetary amount after which benefits end, and they may also impose

maximum benefit limit monetary amount after which a plan's benefits end

lifetime limits for particular conditions. For example, the plan may have a $500,000 lifetime limit on all benefits covered under the plan for any policyholder and a $2,000 limit on benefits provided for a specific health condition of an individual policyholder. Some plans may also have an annual benefit limit that restricts the amount payable in a given year.

Most health plans have cost-containment practices to help control costs. For example, patients may be required to choose from a specific group of physicians and hospitals for all medical care. A visit to a specialist may require a referral from the patient's primary care physician. A second physician's opinion may be required before surgery can be reimbursed. Also, many services that previously involved overnight hospital stays are now covered only if done during daytime clinic visits, with patients recuperating at home. Pharmacy benefit plans have similar restrictions.

Types of Plans

Indemnity Plans

In the past, most medical insurance policies in the United States were *indemnity* plans, which cover the medical costs policyholders incur when they receive treatment for accidents and illnesses. If a policyholder or a covered *dependent* (a spouse, child, or other relative specified in the insurance policy) gets sick, the health plan pays most of the bill.

The policy of an indemnity plan lists the services that are paid for and the amounts that are paid. The benefit may be for all or part of the charges. In many cases, the policyholder owes a percentage of the fees, usually called **coinsurance.** For example, the schedule of benefits in a medical insurance policy may say that it pays 80 percent of the fees for surgery performed in a hospital and that the policyholder must pay 20 percent. Under this contract, if the policyholder has surgery in the hospital and the bill is $2,000, the health plan pays 80 percent of $2,000, or $1,600. The policyholder is responsible for the coinsurance—the other 20 percent, or $400 in this example.

coinsurance percentage of the fees owed by the policyholder

Managed Care Plans

Under indemnity plans, it is difficult for insurance payers to control costs because there are few restrictions on how much providers can charge, especially for new technology, drugs, and procedures. To counter this trend, the concept of **managed care** was introduced. Managed care is a way of supervising medical care with the goal of ensuring that patients get needed services in the most appropriate, cost-effective setting.

managed care method of supervising medical care with the goal of ensuring that patients get needed services in the most appropriate, cost-effective setting

managed care organization (MCO) plan that establishes links among provider, patient, and payer by combining the delivery of services with the financing and management of health care

To accomplish the goal of managed care, financing and management of health care are combined with the delivery of services. A **managed care organization (MCO)** establishes links among provider, patient, and payer. Instead of only the patient's having a policy with the health plan, under managed care *both* the patient and the provider have agreements with the MCO. The patient agrees to the payments for the services, and the provider agrees to accept the fees the MCO offers for services. This arrangement gives the managed care plan more control over the services the provider performs and the fees the plan pays.

Managed care is the leading type of health plan, and many different kinds of managed care programs are available. These are covered in detail in Chapter 3. In some cases, patients pay fixed premiums at regular time periods, such as monthly, that cover all services and medications that will be received. A patient may also pay a **copayment**—a small fixed fee, such as $10 for a generic drug. In some plans, the *copay* is a percentage of the amount the provider receives. In either case, the copayment must always be paid by the patient at the time of service.

copayment small fixed fee paid by a patient for a drug

Sources of Medical Insurance

Some patients are covered by private insurance; others qualify for programs sponsored by state or federal governments.

Private Plans

Private health plans offer a variety of types of medical insurance coverage. Most people enrolled in private insurance are covered under group contracts—policies bought by employers or other organizations to cover employees or those who belong to the organization. Other plans are policies purchased by people who do not qualify as members of a group. Private insurance plans are covered in Chapter 3.

Government Programs

The following are the most common government plans in effect in the United States:

- *Medicare:* Medicare is a federal health plan that covers most citizens aged sixty-five and over, people with disabilities, people with end-stage renal disease (ESRD), and dependent widows.
- *Medicaid:* Low-income people who cannot afford medical care are covered by Medicaid, which is cosponsored by the federal and state governments. Medicaid is run by the state, and matching federal dollars are available for states that satisfy certain requirements, such as providing prenatal care and child vaccinations. Qualifications and benefits vary by state.
- *TRICARE (formerly CHAMPUS):* TRICARE covers expenses for dependents of active-duty members of the uniformed services and for retired military personnel. It also covers dependents of military personnel who were killed while on active duty.
- *CHAMPVA:* The Civilian Health and Medical Program of the Department of Veterans Affairs is a program for veterans with permanent service-related disabilities and their dependents. It also covers surviving spouses and dependent children of veterans who died from service-related disabilities.
- *Workers' compensation:* People with job-related illnesses or injuries are covered under workers' compensation insurance through their employers. Workers' compensation benefits vary according to state law.

These government health plans, as well as state-sponsored drug coverage programs, are described in Chapters 4 and 5.

Tech Check

What are the terms for the two entities that form an agreement, that makes medical insurance available to people?

What does a policyholder pay to a health plan in order to receive benefits?

What are the possible sources of medical insurance?

The Pharmacy Practice Billing Cycle

point of sale (POS) drug plan benefits received at the time the pharmacy technician insurance specialist processes a person's prescriptions

billing cycle ten-step work flow followed at a pharmacy to care for patients' financial matters

People who are covered by a drug plan receive their benefits when the pharmacy technician insurance specialist processes their prescriptions at the **point of sale (POS).** The **billing cycle** for a patient's pharmacy benefits follows a ten-step work flow, as shown in Table 1.1 and explained below.

Step 1: Receipt of Prescription

electronic prescribing (eRx) use of software by a physician to transmit an order

The receipt of a prescription order starts the pharmacy billing cycle. This step—for either a new prescription or a refill—may occur through several means:

- The patient or caregiver personally phones in the prescription or presents it at a face-to-face meeting.
- The physician or physician representative phones in the prescription.
- The physician or physician representative faxes the prescription.
- In a small percentage of transactions, the physician uses software to transmit an order via **electronic prescribing (eRx).**

Table 1.1 Pharmacy Billing Cycle

1	Receipt of Prescription
2	Patient Interview
3	Filling of Prescription
4	Pharmacy Claim Transmittal
5	Payer Adjudication
6	Point-of-Sale Patient Payment
7	Calculation of Payer Claim Balance
8	Accounts Receivable Follow-Up
9	Payment Processing
10	Collections and Problem Resolution

fyi Electronic Prescribing

Most pharmacies are equipped to accept electronic prescriptions sent by physicians. The use of eRx has several advantages: it eliminates the problem of illegible prescriptions; allows the use of clinical decision support to reduce preventable errors such as drug-drug interactions, drug-allergy reactions, dosing errors, and therapeutic duplication; improves communication through all parts of the prescribing chain; and results in better records.

Step 2: Patient Interview

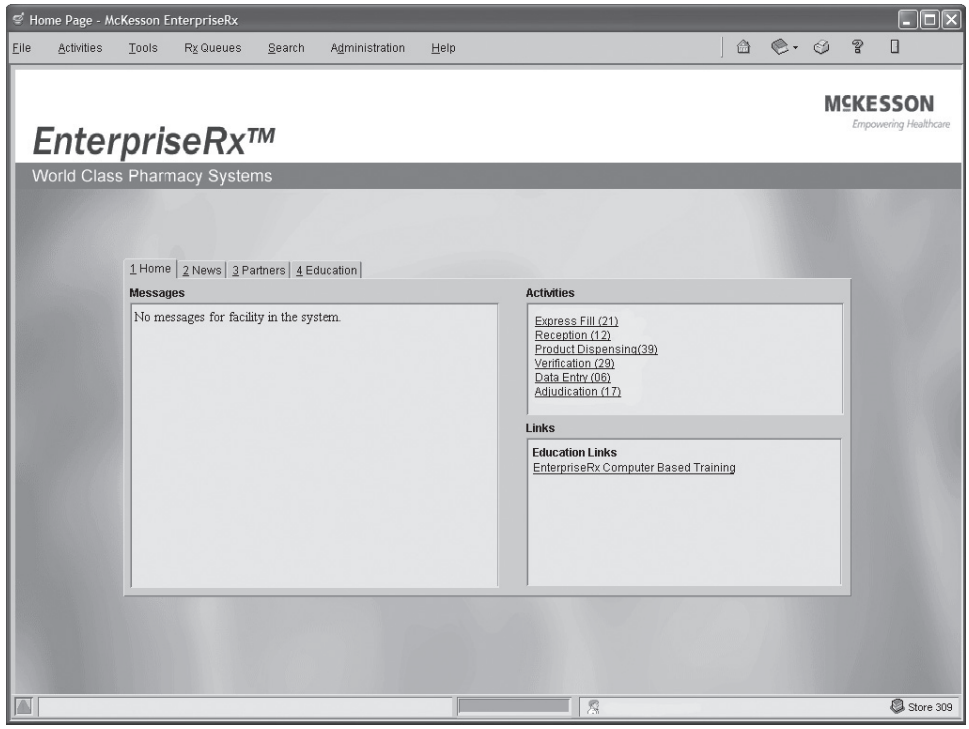
The second step in the billing work flow sets the stage for processing a prescription when an insurance plan is involved. During this step, the patient or the caregiver is interviewed to determine whether the patient is a returning or a new customer of the pharmacy and is covered by a prescription drug plan.

If the patient responds that prescription benefits apply, the insurance specialist asks to see the applicable insurance card and then asks a series of questions to help determine the status of coverage. The answers to these questions are entered or verified in the **pharmacy management (PM) system,** which stores, processes, transmits, and receives billing data (see Figure 1.1). The necessary information includes the following:

pharmacy management (PM) system system that stores, processes, transmits, and receives billing data

- First name, middle initial, and last name.
- Gender (*F* for female or *M* for male).

Figure 1.1 Sample screen from McKesson's EnterpriseRx, a pharmacy management system.



- Martial status (*S* for single, *M* for married, *D* for divorced, *W* for widowed).
- Birth date, using four digits for the year.
- Home address and telephone number (area code with seven-digit number).
- If the patient is a minor (under the age of majority according to state law) or has a medical power of attorney in place (such as a person who is handling the medical decisions of another person), the responsible person's name, gender, marital status, birth date, address, Social Security number, telephone number, and employer information. For a schoolchild, the status of full-time or part-time student is recorded. In most cases, the responsible person is a parent, guardian, adult child, or someone else acting with legal authority to make health care decisions on behalf of the patient.
- The name of the patient's drug plan and identifying numbers, such as the group identification number.
- The plan policyholder's name and demographic information if not the patient (the policyholder may be a spouse, divorced spouse, guardian, or other relation).
- If the patient is covered by another drug plan, the name and policyholder information for that plan.
- Food and drug allergies.

Step 3: Filling of Prescription

The assigned pharmacy staff member fills the prescription order after drug utilization and drug interactions are reviewed by the pharmacist. Medication is filled properly utilizing the HIPAA-mandated NDC numbers (see Chapter 2) for correct product selection and payer prescription payments.

Step 4: Pharmacy Claim Transmittal

pharmacy claim information transmitted to a payer that identifies the policyholder, the prescriber, the pharmacy sending the claim, and the medications being supplied

EDI (electronic data interchange) claims that are sent electronically between the pharmacy management system and the payer

After the prescription is filled, information is sent to the payer to permit a payment decision. A **pharmacy claim** is "filed," or transmitted; it identifies the policyholder (and the patient, if he or she is not the policyholder), the prescriber (the licensed physician or other author of the prescription), the pharmacy that is sending the claim, and the medications that are being supplied. Most pharmacies file claims for their patients, and most claims are sent electronically by **EDI (electronic data interchange)** between the pharmacy management system and the payer, although in some cases the claim may be on paper, a *paper claim*.

Step 5: Payer Adjudication

adjudication payer's processing of claim data to decide whether a drug is covered by the patient's plan and properly utilized

In the fifth step, the claim is adjudicated by the payer. **Adjudication** means the payer's processing of claim data to determine whether the drug is covered by the patient's plan and is being properly utilized. The claim is monitored by the payer for the amount provided, overutilization, and correctly dispensed medications. If these points are correct, the payer then compares the charges with the terms of the patient's benefit plan and calculates what the patient owes, as well as what the insurance plan is going to pay.

This payment information is returned electronically to the pharmacy for the next step in the cycle. Because this transaction happens very quickly, usually in a matter of seconds, it is often referred to as *real-time claim adjudication (RTCA)*.

Step 6: Point-of-Sale Patient Payment

The next step is to give the patient the prescription and collect payment. This may be in the form of cash, a check, a credit card, or a debit card. Consultation by the pharmacist is offered on the proper administration of the drug. The patient may also sign an insurance log, establishing that he or she actually received the medication.

Step 7: Calculation of Payer Claim Balance

In the seventh step, the payer starts internal processing of the claim for payment to the pharmacy. The amount the patient paid is subtracted from the total the payer specified as the intended payment, and this amount is then due from the payer to the pharmacy. From the pharmacy's point of view, this balance due is an **accounts receivable (AR).**

accounts receivable (AR)
remaining balance due after an initial payment has been made

Step 8: Accounts Receivable Follow-Up

The balance due on the claim is likely to be paid thirty to sixty days after the date of service. An important job of the pharmacy technician insurance specialist is to follow up on balances due from payers. The AR needs to be collected as rapidly as possible to provide funds for the continued operation of the pharmacy practice.

Step 9: Payment Processing

Generally all prescriptions filled within a certain date range are paid electronically or by check in a single transaction. If the payment is received electronically, payment is made directly into the pharmacy's bank account. If the payment is received in the form of a check, the pharmacy must deposit the funds. The pharmacy also receives a document called a **remittance advice (RA)** (also called an **explanation of benefits,** or **EOB**) showing the detail for each claim. The RA is checked to verify that each claim reimbursed by a payer is correct according to the expected payment—a process called *reconciliation*.

remittance advice (RA)
document that comes to a pharmacy showing the details for a claim (also known as an *explanation of benefits*)

explanation of benefits (EOB)
document that comes to a pharmacy showing the details for a claim (also known as a *remittance advice*)

Step 10: Collections and Problem Resolution

In the processing of many transactions, it is possible that there will be payment problems. For example, the claim may not match the payer's payment, or the patient's check may not clear. In the case of hugely expensive *specialty drugs* such as some cancer treatments, patients may want to establish a payment plan so that the bill can be spread out over time.

In the rare case that a paper claim is filed, the claim is sent after the patient receives the prescription and is then paid by the payer. The payer requires that the claim form be legible and filed in a timely manner. When the payer issues payment on a paper claim, the claim form is matched to the remittance and reviewed for proper payment. Appropriate outstanding balances may then be billed to the patient.

The pharmacy technician insurance specialist follows up on all uncollected sums, tracks and solves problems, and works to ensure maximum appropriate payment for the pharmacy practice.

Tech Check

List the steps of the pharmacy billing cycle in order.

What person working in a pharmacy is vital to the success of the pharmacy billing cycle?

Procedures, Communication, and Information Technology in the Pharmacy Billing Cycle

Each step of the billing process has three parts: (1) following procedures, (2) communicating effectively, and (3) using information technology.

Following Procedures

Each step in pharmacy practice billing cycle has procedures. Some procedures involve administrative duties, such as entering data and updating patients' records. Other procedures are done to comply with government regulations, such as keeping computer files secure from unauthorized viewing. In most pharmacies, policy and procedure manuals are available that describe how to perform major duties.

Communicating Effectively

Communication skills are as important as knowing about specific forms, codes, and regulations. A pleasant tone, a friendly attitude, and a helpful manner when gathering information increase patient satisfaction. Interpersonal skills enhance the billing process by establishing professional, courteous relationships with people of different backgrounds and communication styles. Effective communicators have the skill of empathy; their actions convey that they understand the feelings of others.

Equally important are effective communications with pharmacists and other staff members. Conversations must be brief and to the point, showing that the speaker values the provider's time. People are more likely to listen when the speaker is smiling and has an interested expression, so speakers should be aware of their facial expressions and should maintain moderate eye contact. In addition, good listening skills are important.

Billing Tip

Pharmacy Management Programs: EnterpriseRx

In this text, McKesson's EnterpriseRx is used to illustrate typical PM data entry screens and printed reports.

Using the Pharmacy Management System

Pharmacy technician insurance specialists use information technology (IT)—computer hardware and software information systems—every day. For example, the use of billing programs that are part of a pharmacy management system streamlines the process of creating and following up on pharmacy claims sent to payers and following up on payments received.

A Note of Caution: What Information Technology Cannot Do

Although computers increase efficiency and reduce errors, they are not more accurate than the individuals who are entering the data. If people make mistakes while entering data, the information the computer produces will be incorrect. Computers are very precise and also very unforgiving. While the human brain knows that *flu* is short for *influenza,* the computer regards them as two distinct conditions. If a computer user accidentally enters a name as *ORourke* instead of *O'Rourke,* a human might know what is meant; the computer does not. It would probably respond with a message such as "No such patient exists in the database."

Tech Check

What are the three parts of each step of the pharmacy billing process?

What limits the accuracy and efficiency of computers?

Effects of Pharmacy Claim Errors

Efficient and accurate completion of the pharmacy claim process helps a pharmacy practice run smoothly. The job of the pharmacy technician insurance specialist is especially important because much of the income of a pharmacy practice comes from insurance payments. Errors in filing claims slow the reimbursement process and interfere with other work. Filing inaccurate claims can also result in reduced payments or denials and problems with customers.

Lower Payment or Denied or Delayed Claims

A typographical error or incorrect code may communicate the wrong policyholder or medication to the payer. This can result in a lower benefit payment or in denial of the claim. If the health plan must request additional information, payment will be delayed. The payer's claims department can correct an error, but it takes time, so issuing the benefit payment will take longer.

Disruption of Other Work

When a pharmacy technician insurance specialist has to send a corrected claim or fill out a request for a review, the time spent means that new claims for other patients have to wait. Correcting information may also require the assistance of the pharmacist or other members of the office staff, who then must interrupt their activities.

Problematic Customer Relations

If a patient has already paid for services, errors in the claim process can slow reimbursement. The pharmacy technician insurance specialist or another member of the office staff may have to interrupt activities to handle inquiries and complaints.

Working as a Pharmacy Technician Insurance Specialist

Pharmacy technician insurance specialists are employed by community pharmacies, which may be independently owned or part of a chain. They also work in clinics, for health plans, for hospitals or nursing homes, and in other health care settings. Pharmacy technician insurance specialists analyze patients' prescriptions and collect payments for drugs from health plans and patients.

Pharmacy technician insurance specialists also handle the administrative work that is part of the payment process. These activities include preparing and sending pharmacy claims, communicating with health plans to follow up on claims, entering charges and payments in the pharmacy management program, and handling bill collection. They may gather information from patients and answer written or oral questions from both patients and payers, maintaining the confidentiality of patients' data.

Completion of a pharmacy technician insurance specialist or medical assisting program at a postsecondary institution is an excellent background for an entry-level position. Professional certification, additional study, and work experience contribute to advancement.

Tech Check

Where does much of the income of a pharmacy practice come from?

What three negative effects can errors in filing claims cause?

Chapter Summary

1. With around $180 billion being spent on outpatient prescription medications annually in the United States and with expected growth in expenditures, paying for drugs is a matter of concern for patients, physicians, hospitals, pharmacists, and the health plans that help patients cover the costs. As a result, the role of the pharmacy technician insurance specialist is of the utmost importance to the success of a pharmacy.
2. To afford medical expenses, many people enter into agreements with health plans to receive medical insurance. The policyholder pays a premium to the health plan to receive benefits and care from providers—hospitals, physicians, and other medical staff members and facilities. The health plan informs the policyholder about which medical services are considered medically necessary and which are noncovered (excluded) services, the drugs available on its formulary, and the limitations placed on benefits.
3. Several main types of health insurance provide coverage to patients. Indemnity plans generally cover the medical costs policyholders incur when they receive treatment for accidents and illnesses. Managed care plans supervise medical care with the goal of ensuring that patients get needed services in the most appropriate, cost-effective setting. Medical insurance is available through private health plans and various state and federal government programs.
4. The steps in the pharmacy billing cycle are (a) receipt of prescription, (b) patient interview, (c) filling of prescription, (d) pharmacy claim transmittal, (e) payer adjudication, (f) point-of-sale patient payment, (g) calculation of payer claim balance, (h) accounts receivable follow-up, (i) payment processing, and (j) collections and problem resolution. These steps are designed to provide the best possible service for a patient at

the pharmacy, while regulating the pharmacy's financial practices.

5. Efficient and accurate completion of pharmacy claims is very important; errors in filing claims slow the reimbursement process and interfere with other work. When errors are made, the consequences may also include lower payment or denied claims and problematic customer relations.

Chapter Review

Multiple Choice

Read the question and select the best response.

1. Which of these terms refers to the selection of prescription medications offered by a health plan?
   A. formulary
   B. prescription drug list
   C. preferred drug list
   D. all of the above

2. What is the final step in the pharmacy billing cycle?
   A. collections and problem resolution
   B. payer adjudication
   C. payment processing
   D. accounts receivable follow-up

3. Which of these terms is the name of the document received by the pharmacy that shows the detail for each claim?
   A. explanation of benefits
   B. remittance advice
   C. pharmacy claim
   D. both A and B

4. When a pharmacy files a patient's claim electronically by EDI, the data are sent between which two entities?
   A. the policyholder and the payer
   B. the pharmacy management system and the policyholder
   C. the pharmacy management system and the payer
   D. the prescriber and the policyholder

5. Which of the following would *not* result from inaccurately filing claims?
   A. lower payments
   B. easier customer relations
   C. denied/delayed claims
   D. disruption of work

6. What is the term for the money paid to a health plan by a patient to receive benefits?
   A. copayment
   B. premium
   C. formulary
   D. pharmacy claim

7. A monetary amount imposed by a health plan after which benefits end is known by which term?
   A. remittance advice
   B. adjudication
   C. coinsurance
   D. maximum benefit limit

8. Which of the following is *not* a government health plan?
   A. Medicare
   B. workers' compensation
   C. adjudication
   D. CHAMPVA

9. The payer's processing of claim data to decide whether a drug is covered by a patient's plan and is properly utilized is known by which name?
   A. adjudication
   B. coinsurance
   C. explanation of benefits
   D. pharmacy benefit

10. Which of the following types of information probably would *not* be stored in a pharmacy management system?
    A. the patient's marital status
    B. the patient's food preferences
    C. the patient's food allergies
    D. the name of the patient's drug plan and identifying numbers

11. Which of the following is *not* part of each step of the billing process?
    A. communicating effectively
    B. following procedures
    C. problem resolution
    D. using information technology

12. What is the program of supervising medical care with the goal of ensuring that patients get needed services in the most appropriate, cost-effective setting known as?
    A. managed care plan
    B. indemnity plan
    C. coinsurance
    D. government plan

13. Which of these groups owes a pharmacy the money known as *accounts receivable* after the patient has paid?
    A. the provider
    B. the payer
    C. the policyholder
    D. none of the above

14. What is the term for the money a policyholder may owe as a percentage of the fees paid by a health plan?
    A. deductible
    B. premium
    C. benefit
    D. coinsurance

15. Which of the following services would *not* be considered medically necessary?
    A. procedures that match a patient's illness
    B. procedures that are required, rather than elected by the patient
    C. procedures that are experimental
    D. procedures approved by the Food and Drug Administration

Matching

Match the key term with the appropriate definition.

_____ 1. Hospital, physician, and other medical staff members and facilities that offer medical services

_____ 2. Services that a medical insurance policy does *not* pay for

_____ 3. Percentage of the fees owed by the policyholder

_____ 4. Payments made by a health plan for medical services

_____ 5. A small fixed fee paid by a patient for a generic drug

_____ 6. An individual who enters into an agreement with a health plan to receive medical insurance

_____ 7. Appropriate medical treatment given under generally accepted standards of medical practice

_____ 8. Amount paid by a policyholder each year before benefits from a health plan will start

_____ 9. Fee paid monthly to a health plan by a person who buys medical insurance

_____ 10. Organizations that offer financial protection in case of illness or accidental injury

A. copayment
B. coinsurance
C. health plan
D. provider
E. premium
F. benefits
G. deductible
H. policyholder
I. noncovered (excluded) services
J. medically necessary

True/False

Indicate whether the following statements are true or false.

_____ 1. Experimental medical procedures are considered medically necessary.

_____ 2. An agreement between a health plan and a policyholder is known as medical insurance.

_____ 3. Pharmacy technician insurance specialists do *not* need to be concerned with the steps of the pharmacy billing cycle.

_____ 4. Much of the income of a pharmacy practice comes from insurance payments.

_____ 5. The maximum benefit limit set by a health plan is a monetary amount after which benefits end.

_____ 6. The role of the pharmacy technician insurance specialist is vital to the success of a pharmacy.

_____ 7. The three parts of each step of the billing process are following procedures, communicating effectively, and problem resolution.

_____ 8. Pharmacies do not file claims for their patients.

_____ 9. Health plans pay premiums to the policyholder for the benefits they receive.

_____ 10. Indemnity plans and managed care plans are both valid types of medical insurance.

Short Answer

Think carefully about the following questions, and write your answers in the space provided.

1. In what ways does the job of a pharmacy technician insurance specialist affect the success of a pharmacy? Explain your answer.

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2. Why is it important for pharmacy technician insurance specialists to follow the pharmacy billing cycle?

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Internet Activities

1. Using a search engine such as Google, review some of the various medical insurance plans that are available. Try using key words for your search, such as *insurance, medical, health,* and *plan*.

2. Use a search engine to research topics related to the jobs, training, and certifications available for pharmacy technician insurance specialists in your area and nationwide.