

8. Billing Pharmacy

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8.1 About Point-of-Sale Pharmacy Billing

The Point-of-Sale (POS) allows pharmacists to send claims to the Pharmacy Benefit Administrator (PBA) and subsequently to the insurer, via a telecommunications network as they are filling the prescriptions at the facility, and have those claims adjudicated online or in real time.

The following online functions are usually performed:

- Verify client eligibility.
- Verify claim data validity.
- Perform online duplicate services detection and drug caps.
- Verify coverage of drug due to formulary restrictions, obsolete dates or other reasons.
- Price the claim and provide co-pay and reimbursement amounts.
- Perform the detection of conflicts prior to filling the prescription.
- Obtain PRIOR authorization.

With Point-of-Sale, drugs are entered into the Pharmacy package, which will be forwarded electronically to the insurer. If the claim is denied, an error report will be generated back to the pharmacy from the insurer. At this point, either a designated person in the pharmacy will research, correct, and re-submit electronically the corrected error for all rejections, or the same list will be sub-divided by area of responsibility between the Billing office and Pharmacy.

As example of the latter, the Billing office would work with Registration, if an incorrect pharmacy insurer number was listed or if the patient was not covered under the policy; whereas, the Pharmacy would be responsible for researching rejections related to NDC (National Drug Code) number errors, drug not covered under the formulary, or prescription was denied due to 30-day limitation.

Once the pharmacy is paid, the Billing and Accounts Receivable (AR) packages will be updated and reconciled. If the claim is denied, neither the Billing nor the AR system is updated.

As a precaution with Point-of-Sale, the biller should review all clinic bills to assure that none of the drugs billed electronically are also being submitted to the billing package with the clinic claim.

When the prescription is filled, the pharmacy enters the prescription data into the RPMS Pharmacy Point of Sale application.

If an agreement is not in place to bill electronically with the pharmacy insurer or the facility has elected not to bill electronically via Point-of-Sale, a pharmacy charge will be entered into the Pharmacy package and forwarded to the Billing package. It will then be the responsibility of the Billing Office to generate a hard-copy claim using a Universal Claim form.

Many pharmacy insurers are requesting that billing for pharmacy services be done electronically versus manually and will defer or limit payment for those submitted manually. Therefore, all facilities are encouraged to move forward with electronic pharmacy billing.

8.2 Guidelines for Submitting a Claim Form Manually

- The exact name and address of the pharmacy must be included on the form.
- The National Association of Boards of Pharmacy Number (NABP) assigned to your specific pharmacy must be listed.
- The pharmacist must sign the form.
- The Rx number assigned to the pharmacy must be included.
- Use “N” for a new prescription; use “R” for a refill.
- Enter the number of tablets or capsules dispensed, the number of grams of ointments or powers, or “cc” or “ml” amounts of liquids. Use whole units only.
- Enter the number of days of medicine this prescription will supply.
- Enter the eleven-digit National Drug Code (NDC) number assigned to the product.
- Enter the prescriber’s DEA number.
- Enter the total charge for this prescription or product.

8.3 Reasons for Pharmacy Denials

- Duplicate claim submission
- Not a covered drug
- Patient not covered under pharmacy insurance plan
- Not provided or authorized by designated provider
- Incomplete or invalid place of service listed
- Did not complete or enter accurately the referring/order/supervising physician's name and/or their UPIN number
- Did not complete or enter the correct NPI and/or billing name or address
- Information required to make the payment was missing
- Modifier was missing or inaccurate
- Dispensing drugs for more than 30 days
- Dispensing drugs before the 30 days
- Max on Medicare drug program allowance (\$600 cap)
- Incorrect NDC number
- Missing group number