Glossary of Terms

You may find that some of the language in your prescription drug benefit plan is unfamiliar. Leaf Health's glossary explains some commonly used terms and acronyms to help you navigate your pharmacy benefits contract or explanation of benefits.

Adjudicate

The act of processing a pharmacy claim. The plan sponsor or insurer contracts with the pharmacist and defines the terms and conditions of reimbursement for dispensing a drug.

Average Wholesale Price (AWP)

Price of a prescription drug as identified by drug pricing services or other sources nationally recognized in the retail prescription drug industry, selected by the Pharmacy Benefit Manager.

Benefit Design

Rules that structure insurance plans and dictate how members can access covered services.

Business Associate Agreement (BAA)

Legal contract between a healthcare provider and an individual or organization that will receive access to, transmit, or store Protected Health Information (PHI) as part of its services for the provider.

Basis of Cost (BOC)

The foundation where the cost is determined. For example, if Usual and Customary (U&C) is the basis of cost, we can assume that the pharmacy established the cost. Similarly, a claim with Maximum Allowable Cost (MAC) as a basis of cost uses the respective PBM's MAC listing.

Brand Name Drug

A patented drug marketed by the original drug manufacturer following its FDA approval. The manufacturer receives a patent on the drug giving it the right to make it without competition. When a patent expires on a brand-name drug, other companies can start making the drug after receiving FDA approval. A brand-name drug is usually known by its trade name ("Motrin®") rather than by its chemical (or generic) name ("ibuprofen").

Concurrent Drug Utilization Review (CDUR)

Evaluation of drug therapy and intervention, if necessary, while the patient is undergoing treatment. Proactively warns the dispensing pharmacist of a broad range of safety considerations specific to prescriptions presented by the patient.

Claim Adjudication System

The system is utilized to process the payment or denial of a pharmacy or medical claim.

Claim Runout

The period following the end of a Plan Year or the termination of a Participant's participation in the Plan during which the Participant may submit claims to the Plan for expenses incurred during the Plan Year or the Participant's participation.

Coordination of Benefits (COB)

Instances where a member has benefits with more than one insurance plan.

Coinsurance

The amount the patient may have to pay to share the cost of services. Coinsurance is a percentage.

Compound

A medication made by a pharmacist where ingredients are combined, mixed, or altered to create a unique drug for an individual patient.

Compound Code

This field indicates whether the dispensed drug was mixed or not.

Concurrent Drug Utilization Review (CDUR)

Online, real-time edits using the claims database help identify potential drug-related problems.

Contract Year

The consecutive 12-month period beginning on the effective date. Sometimes referred to as a Plan Year.

Copayment

The amount a patient is required to pay to share the cost of the medical service or supply. A copayment is usually a flat dollar amount rather than a percentage.

Covered Drugs

Prescription drugs, supplies, and specialty products that are covered under the plan benefit.

Dispense as Written (DAW)

Indicates the prescriber's instruction about substitution of generic equivalents or order to dispense the specific product written. **DAW**-1 occurs when the prescriber writes a prescription dictating to the pharmacist to administer the brand-name drug. **DAW-2** occurs when the member specifically requests the brand-name drug instead of the generic version while at the pharmacy.

Deductible

The amount a patient must pay before the prescription drug plan or other insurance begins to pay.

Direct Member Reimbursement (DMR)

Reimbursement for a paper claim and receipt submitted by a member for covered drugs dispensed by a participating pharmacy.

Dispensing Fee Paid

The amount of money paid to a pharmacist for rendering a professional service involving the preparation and dispensing of a prescribed drug.

Dispensing Status

The dispensing status of an ordered prescription (dispensed, partially dispensed, or not dispensed). This Transaction is used for original prescriptions, refills, and renewals.

Days' Supply (DS)

The number of days' supply of medication dispensed by the pharmacy will consist of the amount the pharmacy enters for the prescription.

Dosage Unit (DU)

The amount of medication administered to a patient in a single dose.

Drug Utilization Review (DUR)

The practice of drug utilization review ensures patient safety and manages medication therapy by examining a patient's physician orders and checking for drug-drug, drug-allergy, drug-food, and drug-condition interactions using patient factors such as gender, age, weight, medical history, and current treatments.

First Databank

Like Medi-Span, First Databank offers drug pricing information for drug pricing analysis and comparison, formulary management, and drug utilization review through a drug pricing database.

Formulary

A list of drugs that are covered under a prescription drug plan. More commonly called a preferred drug list or PDL. ***Open formulary*** – In an open formulary, your employees have the broadest access when it comes to filling their prescriptions. ***Closed formulary*** – With a closed or limited formulary design, you can restrict access to specific brand-name or higher-tier drugs to help bring down your overall net pharmacy spend.

Fraud, Waste, and Abuse (FWA)

A comprehensive program designed to help drug benefit sponsors detect, correct, and prevent fraud, waste, and abuse.

Generic Drugs

A drug that is produced and distributed without patent protection. The generic drug may still have a patent on the formulation, but not on the active ingredient.

Generic Equivalent

A generic drug whose active ingredients are identical in chemical composition to its brand-name counterpart.

~~Generic Product Indicator~~

~~An indicator will distinguish a product either priced as a generic drug or as a brand.~~

GN/MS/SS

Generic/Multi-Source/Single-Source

Generic Product Identifier (GPI)

A Therapeutic Class maintained by Medi-Span® that defines pharmaceutically equivalent drug products. Products with the same 14-character GPI are identical to active ingredients, dosage form, route, and strength.

Generic Sequence Number (GSN)

Uniquely identifies a product specific to its agent, dosage form, strength, and route of administration. It is not unique across manufacturers and/or package sizes. The digits which make up the GSN have no significance. Rather, the GSN is used to group generically equivalent pharmaceutical products.

HIPAA

Health Insurance Portability and Accountability Act of 1996. A federal law outlining the requirements that employer-sponsored group insurance plans, insurance companies, and managed care organizations must satisfy to provide health insurance coverage in the individual and group healthcare markets.

Implementation Date

The date that the PBM starts processing claims for a participating group.

Ingredient Cost

The cost of the drug product as stated on the drug claim, or as calculated by multiplying the quantity of drug dispensed times its unit cost. In simple terms, it is AWP less the contract pharmacy discount.

Low-income subsidy (LIS or LICS)

A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.

Maximum Allowable Cost (MAC)

The highest unit price a drug will be paid. It is specific to a group of pharmaceutical equivalents.

MAC List

A list composed of specific prescription drugs that have a reimbursement rate based on the actual acquisition costs paid by pharmacies.

Mail Order Pharmacy

Pharmacy that is licensed to dispense prescription drugs through the mail.

Manufacturer Rebate

Cash payments made by pharmaceutical manufacturers to PBMs that are theoretically designed to act as drug discounts.

Maximum Allowable Benefit

The maximum allowable (dollar) benefit is set by the health plan limiting the prescription benefits available to a member or family. Once the maximum is met, members are usually required to pay cash for future prescriptions.

Medicare Part A

Covers various forms of hospital stays. Its focus is inpatient care in hospitals, skilled nursing facilities, hospices, and critical access hospitals. Home health care is also covered under this plan.

Medicare Part B

Covers medical services and supplies. The plan covers doctor's visits and other services including occupational and physical therapists, outpatient care, and additional home health care.

Medicare Part C

Also known as the Medicare Advantage Plan, Part C. Combines both Part A and Part B. Part C differs from the other plans because it is supplied through private insurance companies. Medicare has approved these companies and often offer additional benefits and lower costs.

Medicare Part D

Medicare Part D is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006.

Medication Therapy Management Program (MTM)

A free program that is available through all Part D plans to certain members who have multiple chronic conditions, take numerous medications, and are at risk for spending more on annual Part D covered drug costs than a certain cost threshold.

Medi-Span

Like First Databank, Medi-Span offers drug pricing information for drug pricing analysis and comparison, formulary management, and drug utilization review through a drug pricing database.

Member Submitted Claim

Paper claim submitted by a member for a covered drug dispensed by a participating pharmacy for which the member paid cash.

Multisource Indicator or MONY

A term used by Medi-Span to indicate the generic status of a drug. Valid values for a drug are:

- M=Single-Source, co-licensed product. The product is co-licensed and considered a single-source product despite being available from multiple labelers.
- O=Multi-Source, originator product. Products available from multiple labelers are the industry standard.
- N=Single-Source product. Single-source product is available from one labeler.
- Y=Multi-Source Product. Multi-source products are available from multiple labelers.

Maximum Out-of-Pocket (MOOP)

The limit on the total coinsurance and deductible you will pay in any calendar year—Multi-Source A prescription drug for which there are both brand and generic versions.

Multi-Source Drug

A drug product that contains the same active drug substance in the same dosage form and is marketed by more than one pharmaceutical manufacturer.

National Association of Boards of Pharmacy (NABP)

A nonprofit organization that supports and works with the state boards of pharmacy to protect the public's health.

National Council for Prescription Drug Programs (NCPDP)

An organization that promotes data interchange and processing standards to the pharmacy service sector of the healthcare industry.

Non-Disclosure Agreement (NDA)

A legally binding contract that establishes a confidential relationship. The party or parties signing the agreement agree that sensitive information they may obtain will not be made available to any others. An NDA may also be referred to as a confidentiality agreement.

National Drug Code (NDC)

A system designed to provide drugs in the United States with a specific 11-digit number that identifies the labeler, product, and trade package size. Originally created under Medicare to help identify drugs for reimbursement. Digits 1-5 identify the manufacturer, digits 6-9 the strength/dosage, and digits 10-11 the package size.

Non-formulary

A drug not contained on a health plan’s formulary list or preferred drug list.

Out of Pocket (OOP)

A non-reimbursable expense paid by a patient. Out-of-pocket expenses can also include covered fees the patient is responsible for before his or her health plan benefits kick in at 100% coverage.

Over the Counter (OTC)

Any medication that may be legally purchased without a doctor’s prescription, including, but not limited to, aspirin, antacids, vitamins, minerals, or herbal preparations.

Prior Authorization (PA)

The process of obtaining advanced approval of coverage for a health care service or medication. Also known as a Coverage Determination.

Paid Claim

Claim that has been approved for payment.

Participating Pharmacy

Any licensed Retail, Mail Order, or Specialty pharmacy contracted with a PBM to provide covered drugs to members.

Patient Pay Amount

The dollar amount the beneficiary paid that is not reimbursed by a third party. For example, copayments, coinsurance, deductible, or other patient pay amounts.

Pharmacy Benefit Manager (PBM)

An organization that provides administrative services in processing and analyzing prescription claims for pharmacy benefit and coverage programs.

Prescription Drug Event (PDE)

A summary record that a prescription drug plan sponsor must submit to CMS every time a beneficiary fills a prescription under Medicare Part D. The PDE data are not the same as individual drug claim transactions but are summary extracts using CMS-defined standard fields.

Prescription Drug Plan (PDP)

Prescription drug coverage offered under a policy, contract, or plan approved as specified in 42 CFR Section 423.272 and offered by a PDP sponsor that has a contract with CMS that meets the contract requirements under subpart K.

Pharmacy Spread

The margin created when PBMs contract with pharmacies at a lower price than was negotiated with drug plan sponsors.

Plan

A sponsor's drug benefit program that offers covered prescription drugs to its members.

PLPRO

Patient Liability Reduction due to Other Payer Amount. This field considers coordination of benefits that reduce patient liability, excluding any TrOOP-eligible payers.

Per Member Per Month (PMPM)

PMPM is an indicator for healthcare expenditure, and it is analyzed against different Health status category parameters. It is calculated by deriving the average total healthcare costs for a single member in a month.

Prescription Drug

A pharmaceutical drug that legally requires a medical prescription to be dispensed.

Prescriber Identifier

A prescriber's unique identification number. CMS will transition to the use of the NPI when it is implemented. In the interim, CMS requires a DEA number whenever it uniquely identifies the prescriber and is allowed by State law.

Prescription/Service Ref. Number

The prescription reference number assigned by the pharmacy at the time the prescription is filled.

Pricing Source

Nationally available reporting service of pharmaceutical pricing, such as Medi-Span, for prescription drug pricing.

Product/Service Identifier

Identifies the dispensed drug using a National Drug Code (NDC). The NDC is reported in NDC11 format.

Protected Health Information (PHI)

Any individually identifiable member health information as governed by HIPAA.

Quantity Dispensed

This field indicates how many dosage units of the medication were dispensed in the current drug event.

Retiree Drug Subsidy (RDS)

A program offered by the Centers for Medicare & Medicaid Services (CMS) to reimburse municipalities, unions, and private employers for a portion of their eligible expenses for retiree prescription drug benefits.

Retrospective Drug Utilization Review (RDUR)

Retrospective drug utilization review refers to drug therapy review that after patients has got the medication. The RDUR intervention program is aimed at patients at risk of drug-induced illness, potential drug overutilization, and the monitoring of physicians' prescribing activities.

Reconciliation

Following a pharmacy claim review, the plan sponsor and the PBM review audit findings. Reports provide drive down to the claims level, allowing for investigation and response of identified issues.

Route of Administration

The path by which a drug is taken into the body. Routes of administration are usually classified by application location (or exposition).

RxCUI

RxNorm Concept Unique Identifier. RxNorm is organized around concepts that are assigned unique identifiers. A concept is a collection of names identical in meaning. For example, Accuneb 0.042% inhalation solution and A lbuterol 0.417 MG/ML Inhalant Solution [Accuneb] name the same concept. In RxNorm, the second of these is designated as the preferred form of the name, so it's assigned a concept unique identifier (CUI) of C1169664. This CUI always designates the same concept, no matter the form of the name and no matter in what table it is found. Drugs whose names map to the same CUI are taken to be the same drug, identical to ingredients, strengths, and dose forms.

RxNorm

A standardized nomenclature for clinical drugs produced by the National Library of Medicine. RxNorm links these names to many drug vocabularies commonly used in pharmacy management and drug interaction software.

Service Provider Identifier

Identifies the pharmacy where the prescription was filled. CMS will transition to using the National Provider Identifier (NPI) when it is implemented. In the interim, this field typically contains the NCPDP number to which all NCPDP billers are assigned.

Service Provider Identifier Qualifier

This field indicates the type of provider identifier used in field 11 (Service Provider Identifier).

Single Source Brand

Single-source brand drugs are those drugs that do not have a generic equivalent and are manufactured by the company that originated the drug. Patent laws protect single-source brand drugs.

Single Source Generic

When patent protection is exhausted for a brand drug, in most cases, one manufacturer is awarded a six-month exclusive right to produce the generic form of that brand drug. Initially, the generic form of this drug is considered a single source generic since there is only one manufacturer.

State Pharmaceutical Assistance Program (SPAP)

State-provided prescription drug subsidies to low-income elderly or disabled residents as supplemental or “wrap around” benefits to Part D.

Specialty Drugs

Prescription medications that require special handling, administration, or monitoring. These drugs are used to treat complex, chronic, and often costly conditions.

Specialty Pharmacy

State-licensed business focused on administering specialty pharmaceuticals covered under a patient's pharmacy insurance benefit.

Tiered Formulary

Formulary list of preferred prescription drugs in which different drugs have different co-pays. Each drug is assigned to a specific "tier" within the formulary. The most cost-effective drugs, often generic drugs, belong to the most preferred tier and typically have the lowest co-pay. In contrast, the least cost-effective drugs are the least preferred tier and have the highest copay.

TrOOP

True out-of-pocket (TrOOP) costs are the expenses that count toward a person's Medicare drug plan out-of-pocket threshold. TrOOP costs determine when a person's catastrophic coverage portion of their Medicare Part D prescription drug plan will begin.

Usual and Customary Price (U & C)

The price the pharmacy would have charged a cardholder for that prescription on that day for that member if they were not in a managed plan. This includes all applicable discounts including, but not limited to, Senior Citizen discounts, frequent shopper and special member discounts, or other discounts intended to attract customers.

Wholesale Acquisition Cost (WAC)

The list price for wholesalers, distributors, and other direct accounts before any rebates, discounts, allowances, or other price concessions that the supplier of the product might offer.

Zero Balance Claim

Prescription claims for which the plan paid zero dollars due to members' copay or coinsurance covering the entire cost of the claim.