CENTENE Corporation

Payment Policy: Duplicate Pharmacy and Medical Claims

Reference Number: CC.PP.165
Product Types: All
Last Review Date: June 17, 2021

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Patients have the ability to receive payment for pharmaceutical drugs either through their medical benefit or through their pharmacy benefit manager (PBM).

Historically, a pharmacy benefit manager (PBM) is a third-party administrator of prescription drug programs. PBMs are primarily responsible for developing and maintaining the formulary, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers, and processing and paying prescription drug claims. For the most part, they work with self-insured companies and government programs striving to maintain or reduce the pharmacy expenditures of the plan while concurrently trying to improve health care outcomes.

As a result of the alternative benefit of the PBM, there may be instances where there could be a duplicate billing for that member for the same drug on the date of service for the medical pharmaceutical claim and the PBM claim.

The Health Plan's objective of this policy is the identification of duplicate payments made by both a member's medical benefit and pharmacy benefit. In these instances, providers were reimbursed for a medication on the medical benefit that was also supplied and billed by the member's PBM. This dual reimbursement would result in duplicate payments being issued for that member.

Duplicate billing of pharmacy and medical benefits may occur in the following scenarios:

- A drug was filled at the specialty pharmacy and shipped to the physician's office.
- The medication administered to the patient at the physician's office was supplied by the specialty pharmacy and not purchased by the physician's office.
- The physician's billing professional reviewed the medical record and billed the administered drug not realizing it was supplied by the specialty pharmacy.
- The drug, erroneously billed by the doctor's office on the medical benefit, is identified by the Health Plan and submitted for recovery.

Application
The Health Plan will review claims and/or claim drug lines along with member treatment history in the outpatient professional setting only (POS 11). If a service was billed on the medical benefit within a certain date span as a specialty pharmacy billing the same treatment on the PBM benefit, this additional billing indicates that the drug or supply was provisioned to the provider via the specialty pharmacy for administration in the office and should have not paid twice

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Reimbursement
Any drug erroneously billed by the doctor's office on the medical benefit, will be identified by the Health Plan and will be submitted for recovery.

Documentation Requirements
Provider may provide supporting medical record documentation when submitting a dispute or appeal.

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.
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CPT/HCPCS Code	Descriptor
NA	NA

Modifier	Descriptor
NA	NA

ICD-10 Codes	Descriptor
NA	NA

Definitions:
Pharmacy Benefit Manager**:** In the United States, a pharmacy benefit manager is a third-party administrator of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans. According to the American Pharmacists Association, "PBMs are primarily responsible for developing and maintaining the formulary, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers, and processing and paying prescription drug claims." PBMs operate inside of integrated healthcare systems, as part of retail pharmacies, and as part of insurance companies.

Related Documents or Resources
NA

References
1. Gryta, T. (2021). What is a "'Pharmacy Benefit Manager?'" Retrieved 4 March 2021, from https://www.wsj.com/articles/SB10001424053111903554904576460322664055328

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2. *"Pharmacy Benefit Management" (PDF)*. American Pharmacists Association. July 9, 2009. Retrieved March 4, 2021 from : https://www.pharmacist.com/sites/default/files/files/Profile_24_PBM_SDS_FINAL_090707.pdf

Revision History	
6/17/2021	Initial Policy Draft

Important Reminder
For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members

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and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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