

1. Third Party Administration

The T-Rex One Enterprise system has all the features you need to perform billing and adjudication tasks for third party insurance plans, such as:

- Processing claims and reversals.
- Formatting and setting up warning and exception messages.
- Manipulating third party plan information.
- Downtime processing and auto-re submittal.
- Post adjudication exception processing.
- Billing administration and claim format administration.

You set up most of these features during third party administration.

Note: These topics contain definitions of T-Rex One Enterprise terminology and concepts. These terms and concepts may be referred to by various other names and the ideas that form a concept may be grouped in other ways throughout the industry.

Common Tasks in Third Party Administration

- The Third Party Administration Search Windows.
- Setting Effective Dates, Termination Dates, and Status.
- Using Tree Structures.

Common Window Elements in Third Party Administration

- The Third Party Administration Menu.
- Search Window Elements and General Elements.
- Address Elements.

Concepts in Third Party Administration

These topics describe Third Party Administration concepts:

- Setting Up Third Party Claim Formats.
- Prescription Filling and Claim Submission.
- Additional Set Up Tasks.
- Viewing Claims.

Third Party Administration Overview

The topics in the Third Party Administration group, let you familiarize yourself with third party administration as well as other set up tasks that fall under the umbrella of the Third Party Administration menu. They contain several different views of what is involved in setting up information for third party insurance plans, including:

- An overview of the third party billing and adjudication process. For details go to Third Party Plan Administration and Setting Up Third Party Claim Formats.
- Some information about setting up cash and online third party external pre-edit processing. For details go to Third Party Plan Administration.
- An overview of the process of setting up third party related information, and of the concepts involved. For details go to Third Party Plan Administration.
- An overview of the commands in the **Third Party Administration** menu and information about where to look for more information about each command. For details go to The Third Party Administration Menu.

These topics also introduce some procedures that are commonly performed during the setup of third party plan information. For details go to Common Window Elements.

Third Party Plan Administration

In the T-Rex One Enterprise system, you create third party plans that are used to bill pharmacy claims to a third party processor or payer. Creating a plan includes setting up and defining the rules for the specific processor or payer including the following:

- **Third Party Plan Set Up** and Pre-edit Conditions for the plan, including:
 - Required fields, such as, **Third Party Name** and **Code**.
 - Billing and reversal time frames.
 - Plan effective and termination dates.

- Pharmacies eligible to submit claims to the plan.
- Note:** During network administration (performed using the **Third Party Administration, Network Administration** command), you can create a network of all stores eligible to submit claims to a plan.
- DAW (dispense as written) code rules.
- Partial fill billing rules, if partial fill is permitted.
- Compound prescription billing requirements.
- Coordination of benefits billing rules (which plan to bill first, etc.)
- Custom Messaging.
- **Pricing Rules Set Up.** This includes specifying the following:
 - Cost used to determine billing and contract prices.
 - Dispensing fee.
 - Copay based on the drug dispensed.
 - Low payment tolerances.
- **Pre-Edit exceptions Set Up.** Pre-edit exceptions are also called pre-adjudication exceptions. This feature lets your pharmacy staff identify, view, and correct prescription errors before they are submitted to a third party for adjudication. This includes setting up:
 - Plan parameters, such as limits on quantity dispensed, days supply, and refills.
 - Drug coverage rules, such as whether a drug is covered or not, whether it is a formulary or non-formulary drug, whether generic substitution or prior authorization is required.
 - Rules to determine the type of message (hard, soft, or informational) that the system generates if a pre-edit exception is found. A hard warning message indicates a prescription cannot be filled unless the error is corrected. A soft warning message stops processing, but can be overridden by administrator authorization from the corporate help desk or by a prior authorization. An informational warning message allows processing to continue if desired.
- **Claims submission information.** This includes setting up for each processor:
 - BIN.
 - PCN (Processor Control Number).
 - Claim billing format.

Setting Up Third Party Claim Formats

In addition to setting up the third party plan, you need to define the acceptable claim format to be used for billing the processor or payer. This claim format is based on the NCPDP 5.1 Telecommunication Standard (that defines which data fields are mandatory for billing claims and those fields that are optional).

Many processors require different fields to adjudicate a claim. So, you can define specific formats for specific processors and payers. This process includes the following:

- Specifying the additional required fields for a processor.
- If necessary, changing the default mapping of fields in the system to corresponding NCPDP fields.
- Redefining default field formats and length.
- Defining which identifiers should be submitted in the claim either by defining identifiers during plan set up or by defining them in the claim format. Plan identifiers defined in the plan setup override claim format identifiers.

For example, in **Plan Administration** during Billing rules set up, you might define the **Product/Service ID** so that the NDC Number for a product is submitted in this field. You would also need to link a claim format that was defined to include the field. Then, when a claim is submitted, the field would be submitted, as dictated by the claim format. The actual data submitted would be the NDC number and according to NCPDP standards, a qualifier for the NDC number.

- Assigning a name to the format. This name is used during plan set up to link the format to the plan.

Prescription Filling and Claim Submission

Once a plan has been created and published (status that makes the plan available for live production), you (meaning a user of the T-Rex One Enterprise system workflow) can submit claims for patients with coverage under the plan. In general a prescription passes through these steps in the system workflow and background processing:

1. During the workflow process, the pharmacy user adds third party plan information to a patient's profile, usually in reception or data entry. Any information needed for coordination of benefits is also added at this time.
2. After you complete the data entry workflow step, the system performs the following tasks using the third party plan setup information associated with the **Patient Profile**:
 - Pricing the prescription according to the pricing rules defined in the plan setup.
 - Running the pre-edit process based on the parameters and rules defined for the plan, and T-Rex One Enterprise rules. If the system finds an exception, depending upon how the pre-edit exception rules are set, the user may be required to make a change to the prescription before proceeding to the next step.
 - Conducting an internal DUR. Depending upon the system configuration, you may be required to address the clinical concerns identified before proceeding to the next step.
 - If the plan (or plans, if a patient has more than one insurance plan, such as, Medicaid as well as a commercial insurance plan) accepts or requires online claims, the system creates the claim in the appropriate claim format. During

the creation and formatting of the claim, the system determines which identifiers to submit on the claim by reviewing the identifier settings in the plan setup rules and the claim format rules.

- The system electronically submits online claims to the processor using a claims switch or direct connection (an external pre-edit service such as the NDCHealth Information Network). After processing a claim, the switch forwards it to the designated processor as identified by the BIN and PCN from the plan setup.
3. After a pharmacy submits an electronic claim, the processor returns an approved or rejected response through the switch that sent it. If appropriate, the switch can perform post-edit checks.
 - If you contract with a data or external business partner, when claims are returned from a switch, they along with all other transactions, are submitted to that data partner.
 - Approved claims continue to the next workflow step, typically Dispensing.
 - Rejected claims go to the Adjudication Exception Queue or the DUR Exception Queue depending on the nature of the rejection.
 - In addition, the system conducts post adjudication edits on the claim to identify profit margin exceptions. Profit margin exceptions also go to the Adjudication Exception Queue.
 4. From the Adjudication Exception Queue, you can modify and resubmit rejected claims and correct profit margin exceptions. From the DUR Exception Queue, you can address clinical concerns identified by the processor and resubmit the claim with the appropriate professional service and result of service responses.

Note: You can configure automatic re-submittal (auto re-try) so that if a claim is rejected due to processor downtime, it will be re-submitted after the specified amount of time. If the Rx needs to be filled before adjudication can occur, you can pull it from the exceptions queue, and using information in the system, the T-Rex One Enterprise system can determine the copay, and move it forward in the workflow.
 5. Once the processor approves a previously rejected claim, the prescription moves to the next workflow step, typically Dispensing.

Third Party Set Up and Setup Concepts

Most third party plan and some third party plan related information is set up using commands on the **Third Party Administration** menu. Some information for adjudication of cash and non-online claims is also set up using commands in that menu.

In addition, you need to set up some application options using the **Application Options** command on the **Administration** menu. This command lets you set up third party maintenance, billing and pricing information that appears at various workflow steps in the system.

In general, the commands in the Third Party Administration menu let you set up the following types of information:

- **Destination.** The Destination information sets up the ability to electronically submit prescription claims directly to third party payers and (or) to multiple claims processors. This information configures the communications protocol.
- **Processor.** This is the organization that is responsible for validating a plan's requirements. When setting up a processor, you link a destination to the processor and set up such information as billing address and contact information.
 - When setting up a plan, you assign or link a processor or processors to the plan or any of its associated networks or groups. If a plan changes processors, you update its processor information.
 - You select a processor for cash and non-online claims during global set up of an external pre-edit driver.
- **Claim Format.** A claim format defines the information used for billing of claims, and claim reversals. When setting up a claim format you specify various segments of information to include when billing, such as header, patient, insurer, claim, pharmacy, prescriber, and pricing information. Within each segment you specify the fields to include, and the format and mapping for each field.
 - You assign or link claim formats to third party plans during **Plan Administration**, to data partners during **Data Partner Administration**, and link to a global cash and a global non-online claim billing format when setting up **Global Settings**.
- **Network.** A pharmacy network defines store eligibility for a plan and how the various third party plan rules are administered. Such networks let you group pharmacies together based on shared characteristics. For example, you can create a network of all chain stores in the state, of all mail order pharmacies, or of some arbitrary characteristic such as participation in a specific third party plan.

Note: The stores that you add to networks must already be set up in **Facility Maintenance**.

 - Setting up pharmacy networks lets you address the fact that third party plans can have different pricing and coverage rules depending upon the classification of a store. You can define various characteristics such as store eligibility, plan parameters, and pricing rules independently for each classification.
 - These networks exist independently of a plan, but you can assign or link them to a plan.
 - Plan rules pass down to a network, but at the same time networks can define exceptions to a plan's rules since the rules for a linked network supersede a plan's rules. This means you do not need to add an entirely new plan for a few stores with minor exceptions. You can easily vary the eligibility and pricing rules depending on the network.
 - You link a network to a plan during **Plan Administration**.
- **Pricing.** In **Pricing Administration** for third parties, you set up pricing rules for

third party plans. You can set up and maintain various lists, selected formulas, and calculation tables for third party plans. This information is used to generate the billing and contract price and copay for the product(s) submitted on a third party claim.

Note: When setting up lists, you can define data filters so that you can apply variations in pricing, filtering by numerous data types including product, patient, prescriber, prescription, facility, etc. This lets you determine the price formula based on characteristics of a data type. For example, you could apply different pricing rules for patients over 65.

- **Global Settings.** These settings are set once for the entire system. Global settings include the following:
 - Auto retry settings for claim re-submittal.
 - Cash and non-online claim settings for external pre-edit processing, including the external pre-edit processor name, and claim billing formats for cash and non-online claims.
 - Defining reject codes as downtime or duplicate codes as well as defining custom reject codes.
- **Data Partner.** If you contract with a data partner or external business partner, you need to set up information needed to submit online claims to that data partner.
 - For every transaction, failed and paid, third party and cash, between the Data Entry and Product Dispensing workflow steps, the system creates a transaction and submits it online to your data partner.
 - In Data Partner Administration, by linking to established claim formats, you can define NCPDP 5.1 fields to submit to the data partner.
 - You can build an exclusions list for a data partner. For example, you might do this if you have exclusive distribution rights for dispensing certain product(s) and you want to hold back information on the product from a data partner.
- **Third Party Plans.** During Plan Administration you define a third party insurance plan's rules; including rules regarding the plan setup, coverage limits, billing, accepted claim formats, data handling, formulary, and current processor.
 - You can define a 2-or 3- level hierarchy for a plan. With the top level being the plan information and rules, and the second tier being a linked network or networks whose rules supersede the plan's rules. The third level would be a group that belongs to a network as described in the following bulleted paragraph.
 - If applicable you can define one or several groups that belong to the plan. Groups are employers, credit unions, or trade associations which provide coverage for individuals and sometimes their dependents. Groups can be assigned at the plan or network level. Group rules supersede both plan and network rules.

You might want to define a group if its rules differ from a plan's general rules or a network's rules. For example, a store may be eligible for a plan but not eligible for a specific group within the plan. In such a case, you might exclude, say, an employer group from a network of stores.

You can define plan rules for a plan, its linked networks, or its groups.

Note: When setting up rules, you can define data filters so that you can filter the rules by numerous data types including product, patient, prescriber, prescription, facility, etc. For example, you could determine product use based on product characteristics. This includes whether a product is covered by a plan, what claim format to use for a product when billing to a plan, etc. Or, you could determine what claim format to use based on patient age.

Additional Set Up Tasks

Note: The following two administration tasks are not necessary for a prescription to successfully pass through the system workflow, but need to be set up in certain situations.

- **Agency Type.** If you want the system to rank insurance plan use for a patient, you need to set up agency types. In Agency Type Administration you set up the possible agency types and their priority.
 - When setting up a third party plan, you select an agency type. Then, in a patient's third party record (**Patient Profile**, Third Party tab), the system uses the agency type to rank a patient's insurance plans.
 - This information is used in assigning COB priorities, and the default billing order of the plans. For details go to Agency Type Administration.
- **OCNA.** In OCNA Administration you set up OCNA (Other Carrier Name and Address) information used to identify Medigap insurers for Medicare patients (including the OCNA number for each OCNA insurer).

Viewing Claims

- **Claim Information View.** After a third party plan is set up, and claims are being adjudicated, you can search for claims and view detailed information for them. Transmitted information as well as some non transmitted information is available for viewing. The transmitted information you see is determined by the claim format for the claim.

The Third Party Administration Menu

- **Agency Type.** If you want the system to rank patient insurance plan use, this lets you set up possible agency types and their priority. For details go to Agency Type Administration.
- **Claim Formats.** lets you define the information used for billing claims, claim

reversals, eligibility verification, and for receiving responses to a claim. For details go to Claim Formats Administration Overview.

- **Data Partner Administration.** lets you set up information for submitting information to an external data partner. For details go to Data Partner Administration.
- **Destination Administration** lets you set up electronic submittal parameters. For details go to Destination Administration Overview.
- **Global Settings.** lets you set up auto retry settings for claim re-submittal, cash and non-online claim settings for external pre-edit processing, and reject codes and related messages that appear in the **Adjudications Exceptions** window when a claim is rejected by a processor. For details go to Global Settings Administration.
- **Network Administration** lets you set up Networks of pharmacies to link to third party plans. For details go to Network Administration Overview.
- **OCNA Administration.** For Medicare patients lets you set up OCNA numbers and insurers. For details go to OCNA Administration.
- **Plan Administration** lets you set up third party plans. For details go to Plan Administration - Plan Structure - Overview and Plan Administration - Setting Up - Overview.
- **Pricing Administration** lets you set up third party pricing rules. For details go to the pricing maintenance section.
- **Processor Administration** lets you set up those organizations that are responsible for validating a plan's requirements. For details go to Processor Administration Overview.
- **Claim Information View.** lets you view existing claims, and detailed information for a selected claim. For details go to Viewing Claims.

Commonly Performed Tasks

This section describes general tasks that apply to more than one of the commands in the **Third Party Administration** menu.

The Third Party Administration Search Windows

All commands within **Third Party Administration** except **Agency Type** involve searching for existing items.

- Most of the commands in the **Third Party Administration** menu take you first to a **Search** window, where you can type or select search criteria to search for existing, related information and if appropriate add new information.

Note: Within **Plan Administration**, you can also search for an existing plan and add a new plan from the **Actions** menu **Search** command.

To use a search window:

1. Type or select the search criteria and then select **Enter**.
Note: In some search windows, no search criteria needs to be entered, you can search for all results by pressing **Enter**. This includes searching for claim formats from within **Plan Administration**, and searching from the **Global Settings** window.
2. If there are more items found than can appear in the list at one time, select the **Page Up** or **Page Down** button until you find the item you want.
3. If you want to work with an item found by the search use the **Up** or **Down Arrow** keys to move the highlight to the correct row, and then press **Enter**.
4. (If available) To add a new item, select **Add New** <Item Name>.

Note: <Item Name> will be Plan, Network, Processor, OCNA Number, Destination, Claim Format, or Data Partner.

For details go to the related sections referenced for each command in The Third Party Administration Menu topic.

Setting Effective Dates, Termination Dates, and Status

Throughout **Third Party Administration** there are date fields for setting **Effective** and **Termination** dates. The settings for these fields determine whether the status of the entity for which you are setting the date is **Active** or **Inactive**. This includes:

- **Plan Administration.**
(For the plan as a whole, any of its groups or linked networks, or rule sets.)
- **Network Administration.**
- **Processor Administration.**
- **Pricing Administration.**
- **Claim Formats Administration.**
- **Data Partner Administration.**

You can set a date by typing it, or by selecting it using the calendar tool to the right of the date field. The **Effective Date** is always required, but the **Termination Date** is optional. It must be the same as or later than the **Effective Date**.

To set the **Effective** or **Termination Date** you can either:

- Type the date:
 - a. Select or Tab to the date field.

- b. Type the date in the format mm/dd/yyyy.
 - c. Press **Enter**.
- Select a date using the calendar tool (the calendar icon) to the right of the date field.
 - a. Select the calendar icon to the right of the date field (Tab to the icon and press **Enter**).
 - b. If the day you want is in the current month, select the day (press the right, left, up, and down arrow keys to move the highlight over the day you want) and then press **Enter**.
 - c. If the day you want is not in the current month, select the month or month and year in either of the following ways:
 - Select the left or right arrow head on either side of the month or year until the month (or month and year) you want appears, then select the day you want (press the right, left, up, and down arrow keys to move the highlight over the day you want), and press **Enter**.
 - Press the up and down arrow keys until the month and year you want appears, then press the right, left, up, and down arrow keys to move the highlight over the day you want. When the correct day, month, and year appear in the calendar, press **Enter**.

Using Tree Structures

In Third Party Administration, **Plan Administration** and **Pricing Administration** both have windows that have two panes.

- There is always a left hand pane containing the **Actions** menu, and either the plan administration tree or the pricing tree.
- There is always a left hand pane which when appropriate contains an information window.
- The actual fields and other elements in the information window differ depending upon what part of the tree you select.

The tree consists of an expandable vertical structure:

- In Plan Administration, this structure contains nodes that represent rule sets, groups and linked networks.
- In Pricing Administration, it contains tables, formulas, and lists.

To use a tree structure:

1. Select the **Plus Sign (+)** to the left of an item (or node) in the list to expand the item and see the sub-items (the nodes below it). (Use the **Up** and **Down Arrow** keys to move the highlight to an item with a **Plus Sign** to its left. Then use the **Right Arrow** key to expand the item.)

Notice that when appropriate system displays the information window for the selected item in the right hand pane.

Note: To collapse the item, select the **Minus Sign** to the left of an item. (Use the **Up** and **Down Arrow** keys to move the highlight to an item with a **Minus Sign** to its left. Then use the **Left Arrow** key to collapse the item.)

2. To view the information window for an item without a plus sign to its left, select the item (move the highlight to the item.).

Note: If the navigation tree loses focus to the right hand pane, select the node again (use the Tab key to tab through the fields until focus returns to the navigation tree).

Common Window Elements

The elements in the following tables are frequently found in windows throughout the system. They are described here and then this topic is referenced in the various tables where they appear.

- Search Window Elements and General Elements.
- Address Elements.

Search Window Elements and General Elements

Element	Description
Search button (Enter)	Select this button to search for an existing item.
Cancel button (Esc)	Select this button to cancel the search or other process and close the related window.
results table	In search windows, displays the list of records that match the information you enter. The columns vary from window to window depending upon the information found.
Page Up button (Page Up key)	Select Page Up , as needed, to view the previous page of items that match the information you enter.
Page Down button (Page Down key)	Select Page Down , as needed, to view the next page of items that match the information you enter.

Displaying... results message	In search windows, displays information about the number of items found.
Effective Date	This is the date the item becomes effective. For details go to Setting Effective Dates, Termination Dates, and Status.
Termination Date	(Optional) This is the date the item becomes inactive. For details go to Setting Effective Dates, Termination Dates, and Status.
Status	Status can be Active or Inactive . If the effective date is in the past and there is no termination date, or if the effective date is in the past and the termination date is in the future, the status is Active . For details go to Setting Effective Dates, Termination Dates, and Status.
Save button	Select Save , to save the information in the current window.
OK button	Select OK to close the current window add the information in it to a table.

Address Elements

Element	Description
Address 1	Type the first line of the address.
Address 2	Type the second line of the address.
City	Type the city where the address is located.
State	Select the state code for the address.
ZIP Code	Type the ZIP Code for the address. When you type a ZIP code the system verifies that it is valid, and checks to see that the related information, (City and State) are on record for the ZIP Code. If appropriate, the system provides a list of valid City and State combinations for the ZIP Code. You can override the suggestions.
Country	If appropriate, select a country. If you type a ZIP Code, the country is set to USA. If you select Other, the system enters FC (foreign country) for the State code.
Telephone	Type the appropriate area code and telephone number.
Fax	Type the Fax number, area code first.

