# Customer Care Abbreviations, Definitions and Terms – C

**Each Alpha section will have two separate tables:**

1. Abbreviation, Term and Definition
2. Term and Definition

**Note:** Terms will not be duplicated in both lists.

**Quicker Search Results:** Depress **Ctrl+f →** Type in Keyword **→** Click **Find Next.**

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| **Abbreviation** | **Term** | **Definition** |
| **C2C** | C2C Innovative Solutions, Inc. | As of 02/01/2021, all appeals, reconsiderations, and 2nd Level of Part D appeals are handled by “C2C Innovative Solutions, Inc.” (C2C), a Qualified Independent Contractor (QIC) / Independent Review Entity (IRE). |
| **C2C** | Carrier To Carrier | The internal process by which open, non-Controlled Rx refills are transferred from one carrier (Client / RX Group) to another. See [Transfer Existing Rx to New Account (Carrier-to-Carrier/Open Rx Transfer)(004727)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=3a6af7a1-b552-4822-b26e-a01fcdafb2a7). |
| **Cap** | Capsule | A dosage form of some medications. |
| **C/G** | Carrier Group | The structure of a client’s hierarchy, which describes how plan Beneficiaries are grouped into smaller logical subsets. It ensures that invoices and reports reflect the client’s organization. |
| **C:D** | **Connect:** Direct | Used for any MBEST file loads from SPAPS, CMS, especially the auto-enrolled Beneficiaries. |
| **CAGM** | Carrier/Account/Group/Member | The structure of a client’s hierarchy, which describes how plan Beneficiaries are grouped into smaller logical subsets. It ensures that invoices and reports reflect the client’s organization. This subset ties directly to one Beneficiary. |
| **CAS** | Clinical Authorization System | Secondary workflow processing system. |
| **CARE** | Customer Care or Member Services | The unit that processes incoming calls & requests from members. They work in conjunction with the mail pharmacies and Clinical Care Services teams to provide issue resolution. |
| **CAT** | Catastrophic Coverage Phase | Assures that the Beneficiary only pays a small coinsurance amount or copayment for covered drugs for the rest of the calendar year. |
| **CAT1** | Category 1 | Applies to standard retroactive requests that do not go to the Retro Validation Team. CAT1 transactions are submitted directly from the plan to MARx via electronic batch file. **Includes:** Disenrollment from employer/union sponsored plan, Code 72 Retro correction to 4Rx, and documented systems failure issues. |
| **CAT2** | Category 2 | Applies to Retroactive Enrollment and Disenrollment (including PBP change) requests with Effective Dates within 3 months or those resulting from automatic actions taken by CMS systems that are identified and reported timely. |
| **CAT3** | Category 3 | Applies to Retroactive Enrollment and Disenrollment (including PBP change) requests with Effective dates 4 months or older or not identified and reported timely from TRR/MMR during plan reconciliation. CAT3 corrections require the CMS RO Account Manager’s approval before submission to the Retroactive Processing Contractor (RPC). |
| **CAP** | Corrective Action Plan | A corrective action plan (CAP) is a step by step plan of action that is developed to achieve targeted outcomes for resolution of identified errors |
| **CAPER** | Care Academy Performance Evaluation Report | Performance report used in LearningHub, formerly known as LEARNet, the training website used for Colleagues of CVS Health. |
| **CB, C/B,**  **or  CBK** | Callback or Changeback | A call received from a member or prescriber in response to a message that was left by our representative. Also used when a Clinical Intervention medication has been changed back to the original prescribed medication. |
| CBalso known as Chargeback | Money that is returned to a wholesaler by a manufacturer to compensate the wholesaler for the difference between its acquisition cost and the contracted price agreed upon in advance by the wholesaler and wholesaler’s retail customers |
| **CBA** | Cost/Benefit Analysis | An economic analysis that measures benefits in terms of dollars and determines a gain or loss among the products or services compared. |
| **CBC** | Center for Beneficiary Choices | A branch of the Center for Medicare & Medicaid Services (CMS). |
| **CC or C/C** | Credit Card or Care Consideration | Credit Card: Card used to make payments. |
| **CCA** | Credit Card Authorization | An approval from a card issuer, usually through a credit card processor, that the customer has sufficient funds to cover the cost of the transaction. It can also refer to the procedure of acquiring that authorization from the issuer |
| **CCB** | Change Control Board | Now called Change Management Board (CMB) |
| **CCF** | Consultative Call Flow | A systematic approach to:   * Increase the probability of favorable and/or specific outcomes. * Build relationships by establishing trust. * Establishes the atmosphere of a consultative environment. * Provide our customer with consistency and the highest level of customer service possible. |
| **CHF** | Congestive Heart Failure | A chronic condition in which the heart doesn't pump blood as well as it should. |
| **CHV** | Communication History Viewer | This is displayed on the View Activity screen in PeopleSafe. |
| **CCIPE** | Customer Care Inbound PreEnrollment | Inbound calls, initiated by the member to Customer Care, prior to the enrollment into a plan. |
| **CCM** (Prev. known as MPP) | Customer Care Mail or Managed Plan Program | Clinical programs that reach out to prescribers with requests for cost effective changes to prescriptions based on clinical information. |
| **CCP** | Credit Card Pre-Authorizations | A service offered by credit and debit card providers whereby the provider puts a hold of the amount approved by the cardholder, reducing the balance of available funds until the merchant clears the transaction. |
| **CCR** | Customer Care Representative or Custom Care Retail | The associate that processes/answers questions from members. Also refers to clinical programs that are administered at the retail level |
| **CC Refund** | Credit Card Refund | Apply a credit back to the credit card to reduce the balance owed. |
| **CCM** | Current Calendar Month | Represents the calendar month and year that was current as of the time when the transaction was accepted by MARx for processing. For batch, the current month is derived from the batch file transmission date; for User Interface transactions, the Current Month is derived from the system data at the time of transaction submission. |
| **CCRPH** | Clinical Counseling Pharmacist | A pharmacist who staffs our Clinical Care Services department to assist with clinical questions about a member’s medication. |
| **CCS** | Clinical Care Services | The department which takes inbound calls dealing with clinical issues from Members and/or Physicians |
| **CCSA** | Customer Care System Access | A branch of the Customer Care Leadership Team that sometimes sends out internal communications to assist Customer Care Representatives with access to the various systems used in their job. |
| **CDH** | Cardholder | 1. Insured or Beneficiary Primary person receiving the PBM benefits coverage in whose name the card is issued. |
| **CDHP** | Consumer Driven Health Plan | A type of health insurance plan that allows members to use health savings accounts (HSA’s), health reimbursement accounts (HRA’s), or similar medical payment accounts to pay routine healthcare expenses directly. |
| **CDS** | Controlled Dangerous Substance |  |
| **CEA** | Cost Effectiveness Analysis | Economic analysis that measures the relative value or effectiveness of one product or service versus another. Commonly reported as a C/E ratio or quality of life year (QALY) saved. |
| **CEF** | Client Exception Form | Plan Sponsor-specific forms that can assist a beneficiary with possibly obtaining coverage exceptions for their medications, which could include Non-Formulary, Step Therapy, Quantity Limit, and Tiering Exceptions. This also includes Prior Authorization. |
| **CGDP** | Coverage Gap Discount Program | Program that makes manufacturer discounts available to eligible Medicare beneficiaries receiving applicable, covered Part D drugs, while in the coverage gap. |
| **CH** | Control Hold |  |
| **CHI** | Chicago | CVS Pharmacy distribution center located in Palatine, IL |
| **CHAMP** | Civilian Health and Medical Program of the Uniformed Services | This is an insurance program that provides health care coverage to members of the military and their families. |
| **CHG** | Change or Changed | An Alteration |
| **CHRG** | Charge | To place a payment on a credit card. |
| **CICS** | Customer Information Control System | Application (within 3270) originally developed to provide transaction processing for IBM mainframes. Used to access information on Eligibility, ECLIPS, etcetera. |
| **CII** | Schedule 2 Drug | A narcotic medication grouped with DEA Schedule 2 medications. |
| **CIF** | Client Information Form | Located under the Client Information tab in TheSource, the CIF is used to access plan design highlights or other client specific information needed to resolve the plan member’s inquiry. |
| **CIM** | Cimetidine | A drug used to treat stomach ailments. |
| Customer Interaction Management | The process an organization follows to handle all the interactions with its customers. |
| **Ck** | Check | A written order to a person instructing a bank/financial institution to provide money. |
| **Clar** | Clarification | To make something clear; often time used when contacting prescribers about a prescription question. |
| **CLC** | Customer Location Code (Claims Department) |  |
| Client Liaison Coordinator | Individuals who assist with reporting Client Issues within the CIF. |
| **CLF** | Closed Loop Feedback | A process that occurs when a member provides a dissatisfactory survey response. The Member Experience and Quality team reach out to the dissatisfied member to close the loop and solve the issue that caused the dissatisfaction. As a result of the outreach, members may call Customer Care directly and request to speak to the CLF Team. These calls should be transferred to senior team as a procedural transfer. |
| **CM** | Credit Memo | Communication indicating a member’s account has funds that can be used. |
| **CMA** | Certified Medical Assistant | Any medical assistant that has received and has met the certification requirements set by the American Association of Medical Assistants (AAMA). Medical assistants often take medical histories and record vital signs of patients. Medical assistants complete administrative and clinical tasks in the offices of physicians, hospitals, and other healthcare facilities. Their duties vary with the location, specialty, and size of the practice. |
| **CMA** | Cost Minimization Analysis | Most common type of economic analysis used in pharmacy benefit management to determine the lowest cost of equally acceptable medication alternatives (generics). |
| **CMB** | Change Management Board | Formerly known as Change Control Board (CCB). |
| **CMK** | CVS Caremark | A prescription benefits manager. |
| **CMP** | Compounding Queue | The queue in which prescriptions are placed that need to be compounded. |
| **CMP** | Communications Messaging Platform | System used to communicate messages to members about a variety of topics, such as order status, refill reminders, savings opportunities, etcetera via email, phone call, or text message. |
| **CMR** | Comprehensive Medication Review | A systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, Care Giver, prescriber, or other authorized individual. |
| **CMS** | Centers for Medicare and Medicaid Services | A federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards. |
| **CMS MAC** | HealthCare Finance Administrative Maximum Allowable Cost | A pricing strategy set by the government for generic drugs, regardless of manufacturer.  The dollar amount that is typically considered payment-in-full by an insurance company. |
| **CMT** | Comment or Comments | Notes entered in the mail order prescription processing system. |
| **CNR** | Conversion Entry Queue | The queue in which prescriptions are placed that need to be changed as a result of a prescriber contact or doctor calls made a judgment. |
| **CNSLD** | Consolidated | Placing together as multiple prescriptions placed into one order. |
| **CO** | Central Office | The office that serves as the administrative center of an enterprise. |
| **COB** | Coordination of Benefits | The practice of ensuring insurance claims are not paid multiple times when an enrollee is covered by several health plans at the same time.   * The idea behind coordination of benefits is to ensure that the payments of plans do not exceed 100% of the covered charges. * The provision coordinates the health care benefits in the order in which the multiple health plans must pay benefits. * Under the COB provision, insurance companies share the burden without overpaying. * The primary plan will pay the claims first and the unpaid balance will be paid by the secondary plan to the limit of its responsibility. * Benefits are coordinated between the Health plans to ensure that the member received full coverage. However, over insurance or excess coverage is not permitted under COB.   Claim information submitted to allow their plan to pay as the secondary provider.  Making determinations with persons with dual eligibility.   1. Coverage Information provided by the client on cardholders that may be covered under two separate medical plans. Coverage will be tracked as primary or secondary. Eligible insured are typically obligated to use the primary coverage first.   Whenever a member has more than one prescription reimbursement program, administration of the two programs is coordinated so that the member DOES NOT receive benefits greater than the cost of the medication. Not all Clients participate in COB, and not all members have more than one benefits provider. |
| **COB Operations** | Coordination of Benefits Operations | Area within Reconciliation Services (RS) that validates and processes claims to coordinate benefits for Medicare Part D Beneficiaries. |
| **COB Survey** | Coordination of Benefits Survey | A method of contacting the Medicare Part D Beneficiary to obtain OHI information. |
| **COBC** | Coordinator of Benefits Contractor or Confirmation | The Coordination of Benefits (COB) Contractor consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. |
| **COBC Record** | Coordinator of Benefits Contractor Record | A record containing Other Health Insurance (OHI) information for the Beneficiary. |
| **CO** | Complete (used in AMOS) | Order has been shipped |
| **COA** | Certified Ophthalmic Assistant | Involved with providing eye care advice to patients and ensuring that patient records are up to date. |
| **COBRA** | Consolidated Omnibus Budget Reduction Act of 1985 | 1. Legislation that requires group health plans of covered employers to give employees and family plan members the opportunity to continue contract their health care coverage at their own expense at group rates in circumstances where coverage would otherwise end. 2. An employee who has terminated the original relationship with the plan sponsor but has opted under federal legislation to continue coverage at his/her own expense. COBRA payments can be administered through a COBRA benefits office or the CLIENT’s benefits office depending on the client’s organizational structure. |
| **COC** | Current Order Charge | Copay charge for current order. |
| **CONC** | Concierge Services | Vendors partners provide patients with advocacy services that help support their health care needs including pharmacy questions, concerns or issues providing an enhanced, more personal level of service. Exp. Alliant, Aetna Concierge, RXBenefits, RX Solutions, Included Health.  They are considered Third Party callers. |
| **CONF** | Confirmed | Issue has been verified. |
| **COLL** | Collections | Amount that has been received |
| **Cont.** | Continued | To move to next step or page. |
| **C1** | Controlled Substance Schedule I | Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse.  Schedule I drugs are the most dangerous drugs of all the drug schedules with potentially severe psychological or physical dependence. Some examples of Schedule I drugs are: Heroin, lysergic acid diethylamide (LSD), Marijuana (cannabis)3,4-methylenedioxymethamphetamine (ecstasy), methaqualone, and peyote  Marijuana (cannabis) is still considered a schedule I drug according to the DEA, although some states allow the use of it for medical reasons. |
| **C2** | Controlled Substance Schedule II | Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, less abuse potential than Schedule I drugs, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous.  Some examples of Schedule II drugs are: Cocaine, methamphetamine (Desoxyn), methadone (Dolophine), hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Hydrocodone, Adderall, and Ritalin |
| **C3** | Controlled Substance Schedule III | Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence.  Schedule III drugs abuse potential is less than Schedule I and Schedule II drugs but more than Schedule IV.  **Examples:** Products containing less than 90 milligrams of codeine per dosage unit (Tylenol with codeine), ketamine, anabolic steroids, testosterone |
| **C4** | Controlled Substance Schedule IV | Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence.  **Examples:** Schedule IV drugs are Xanax, Soma, Valium, Ativan, Talwin, Ambien, Tramadol |
| **C5** | Controlled Substance Schedule V | Schedule V drugs, substances, or chemicals are defined as drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics.  Schedule V drugs are generally used for antidiarrheal, antitussive, and analgesic purposes.  **Example:** Cough preparations with less than 200 milligrams of codeine or per 100 milliliters (Robitussin AC), Lomotil, Motofen, Lyrica, Parepectolin |
| **Conv** | Conversion | A change made on a prescription with prescriber approval. |
| **COORS** | Claims Online Operations Research System | Database within RECAP system that contains information on both pharmacy and direct claims processed in previous cycles. It indicates if the claim has paid or rejected and includes all the claim information. |
| **CORR** | Correct | Something that is accurate or right. |
| **COS** | Client Online Services | Display member eligibility data and history.  Real-time member enrollment and update of member information.  Search tools for finding a pharmacy, prescriber, and product information.  Viewing member accumulations, plan details and claims history.  Review and create prior authorizations and overrides for immediate claims processing. |
| **COT** | Certified Ophthalmic Tech | Medical professionals who assist ophthalmologists in caring for patients' eyes and eyesight. Ophthalmic technicians are authorized to carry out more duties than an ophthalmic assistant, but they may still require the supervision of a licensed medical technologist when providing advanced care |
| **Court Retrans** | Courtesy Retranslation or Keyship Request (quantity received different than desired) | Member received 30 day supply requested to be changed to 90 day supply. |
| CD | Coverage Determination | Any decision made by or on behalf of a Part D Plan Sponsor regarding payment or benefits to which an enrollee believes he or she is entitled.  There are different types of Coverage Determinations:  1. Prior Authorization   * Uses pre-established criteria to make a decision.  1. Exceptions  * **Examples:** Tiering, Non - Formulary, Quantity, and Step Therapy * Considers a prescriber’s supporting statement when making a decision.  1. Paper Claims   **Note:** Claims associated with a Coverage Determination will be backdated to the date of the first rejected claim.  To determine who can make a valid Coverage Determination request, refer to the Authorized Persons Who Can Start a Coverage Determination or Redetermination section. |
| **CD&A** | Coverage Determination & Appeals Med D | The department responsible for the Medicare reviews for coverage determinations and appeals. |
| **CP** | Cold Pack | A type of packaging where medication is placed into a blue, thermal bag with a tamper sticker, placed into a Styrofoam cooler and sandwiched between gel ice packs and Styrofoam.  The amount of ice packs will be determined by the weather of the current season. |
| **CPDC** | Creditable Prescription Drug Coverage | Prescription drug coverage (like from an employer or union), that is, on average, at least as good as the Medicare standard prescription drug coverage. |
| **CPDR** | Capsule Delayed Release | Medications that are designed to release the active ingredient(s) later after taking it. |
| **CPDS or CPB** | Compliance Dose | A change in prescription recommended to a prescriber which may possibly reduce either the number of tablets taken per day or the number of times a medication needs to be taken per day. |
| **CPHT** | Certified Pharmacy Technician | A pharmacy technician that has passed a state certified exam. |
| **CPM** | Current Payment Month |  |
| **CR** | Credit | Credit issued to member’s mail order account. |
| **CR** | Credit | The ability of a customer to obtain goods or services before payment, based on the trust that payment will be made in the future. |
| **CR** | Change Request |  |
| **CC** | Credit Card | Debit Card Payments - One Time or Recurring (Automatic) Credit Card / Debit Card (**RCD**)  Payment of the MED D monthly premium via a major Credit Card or Debit Card.  **Examples:** Visa, MasterCard, American Express, Discover.  **One Time Credit Card / Debit Card Payments**   * SilverScript beneficiaries ONLY can go online to [www.silverscript.com](http://www.silverscript.com) to complete a one-time payment. * SilverScript beneficiaries ONLY can make a one-time credit card payment at a CVS Retail Pharmacy. * Blue MedicareRx and SilverScript beneficiaries can contact us through the IVR or Customer Care Representatives (**CCRs**) to place a one-time credit card payment over the phone.   **Recurring (Automatic) Credit Card / Debit Card Payments**   * The monthly premium is automatically charged to the beneficiary’s credit card / debit card each month. * The beneficiary does NOT receive a monthly invoice statement. * If the beneficiary has been terminated, otherwise disenrolled or has a credit balance on file, an invoice statement may be sent on request.   With EFT/ACH and recurring credit card / debit card payments, the beneficiary’s entire balance is deducted each month automatically (up to a maximum amount of $300) automatically.  **Note:** Balances above $300 require member consent be noted on account, otherwise beneficiaries will be contacted for approval of full balance charge. No approval on record will result in removal of RCD.  **Example:** On the first withdrawal from the bank account or charge to the credit card / debit card, if the beneficiary owes more than one month of premiums, the system will take ALL that is due, and not just one month’s premium. |
| **COA** | Credit on Account | The plan member has a positive account balance that is applied to an order and this positive balance may or may not be sufficient to cover the cost of the order.  This is showing with a (**-**) minus sign in front of the (**$**) dollar amount to show that it is an amount credited to the account and to differentiate between a credit and debit amount.) |
| **Crm** | Cream | A topical dosage form. |
| **CRR** | Customer Research Request | Request to review or reevaluate a claim because some information may have been missing or inputted incorrectly into the system causing adjudication process to calculate incorrectly. |
| **CRSP** | Correspondence | Information sent in by a member with a prescription order. |
| **CRT** | Call Resolution Team | Customer Service Senior Team for Aetna Commercial and Med D. |
| **CRX** | Change or Correct Prescription | Changing the prescription due to prescriber approved changed or originally entered incorrectly. |
| **C/S** | Customer Service | The assistance and advice provided by a company to those people who buy or use its products or services. |
| **CSA** | Controlled Substances Act | The Controlled Substances Act (CSA) establishes a unified legal framework to regulate certain drugs that are deemed to pose a risk of abuse and dependence. |
| **CSB** | Configurable State Benefits | Benefits provided by the state. |
| **CSR** | Texas Department of Public Safety (Formerly the DPS#) Controlled Substances Registration includes the state of South Carolina. | The prescriber must have their CSR # on file in order to fill a prescription for a controlled substance. |
| **CTI** | Computer Telephony Integration | Allows a data transfer of vital member information from the IVR to a screen pop-up within the CCR’s desktop. |
| **CTM** | Complaints Tracking Module | A module within the Health Plan Management System (HPMS) which assists CMS and our contracted plans in tracking and resolving beneficiary complaints.  It is the Centers for Medicare and Medicaid Services’ (CMS) central repository for complaints received from various CMS sources, including, but not limited to, 1-800-Medicare call centers and regional offices. |
| **CTP** | Certificate to Prescribe | One of the Ohio state board requirements is the transmission of the CTP number. For several years now, the state of Ohio has had a requirement in its prescribing rules that prescriptions written by mid-level practitioners such as physician assistants, nurse practitioners, etcetera, are required to include their CTP number.  This number is issued to these practitioners after they have completed the requisite training and testing in order to have prescriptive authority in the state.  The CTP number is required to be on prescriptions issued by these health care professionals so that pharmacists will know that they are certified to prescribe and that their prescriptions are legal. The requirement that the CTP number be on prescriptions applies regardless of the form of the prescription |
| **Ctrl Rx** | Controlled Substance | A drug that is classified in the DEA narcotic classification system. |
| **CTS Specialty** | Caremark Therapeutic Services or Specialty Pharmacy Services | The Division within the PBM that provides both medications and extended care services to plan members with critical, difficult to treat conditions such as hemophilia or multiple sclerosis.  CTS dispense the medications for these disease states (often these medications are extremely expensive, and not routinely stocked at the local pharmacy). Additionally, CTS also provides home health services, access to nurses, disposal of biohazard supplies, etcetera.  Some prescriptions originally submitted to PBM pharmacies are transferred to CTS; information regarding these types of transfers will be found in the “comments” function. |
| **CTU** | Continue to Use | Continue to use letter. Advises member that they can continue to fill prescriptions while their enrollment issue is being corrected. |
| **CUID** | Client Unique Identification | Similar to an NPI, which is a unique identifying number assigned to healthcare providers. |
| **CUR TX** | Current Therapy | The medication a member is currently taking. |
| **CCM** | CustomCare Mail | Program ensures the clinical appropriateness and cost–efficiency of individual prescriptions. Clinical pharmacists intervene before the drug is dispensed to optimize therapeutic choices and decrease inefficient and unnecessary prescribing. |
| **CWF** | Common Working File | The Common Working File database is CMS’ Beneficiary database. |
| **CY** | Calendar Year | The year starting from January 1 and ending December 31. |
| **CXL** | Cancel | To not process a request. |

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| **Term** | **Definition** |
| Calendar Year | A “calendar year” is the period of 365 or 366 days from January 1 to December 31. |
| Call Pull Credit | Request to pull a previous member call and verify if there was an error on the part of our PBM. |
| Cancellation Date | Date a group on ECLIPS cancels our PBM coverage or changes plan sponsors. This date is supplied by the plan sponsor. |
| Cancellation of Disenrollment | A beneficiary request (via phone call or in writing) to disenroll from our PBM client plan if the request was received prior to the effective date of disenrollment. |
| Cancellation of Enrollment | Request to cancel a previously submitted enrollment application PRIOR to the enrollment effective date. |
| Cancel Order | Prevents all prescriptions within an order from being filled at the present time. However, order can be filled at a later date. You should use the Cancel Order button in the order status screen. |
| Cancel Prescription | Removing a prescription from a processing order. However, Rx can be filled or refilled at a later date. You should use the Cancel Prescription button in the Order Status screen |
| Capitation | Fixed amount paid to a provider in advance per member, regardless of the number or type of services subsequently used by the member. Typically expressed as “per member per month” (PMPM) or “per member per year” (PMPY). |
| Cardholder Audit | A review of specific cardholder claims data performed at the request of a plan sponsor. Individual cardholder trends are reviewed for signs of excessive medication, detrimental patterns of usage, multiple pharmacies, incompatible types of drugs, unusual therapy for member age or gender, and improbable member relationships within a family unit. |
| Cardholder Limit | Dollar amount that the member is eligible to have outstanding (not paid) and still receive prescriptions as determined by their plan. |
| Cardholder Name | Primary cardholder whose name appears on the ID card. |
| Cardholder Number | Unique number assigned to the primary ID cardholder. May be cardholder’s or beneficiary’s Social Security number, but we expect a continued shift to assigned identification numbers as HIPAA regulations become effective. |
| Card Program | Use of a pharmaceutical benefit identification “card” that entitles a member to receive medications as a covered benefit through a participating pharmacy. |
| Cards | Cards are the plastic, credit card size item used by our cardholder. At initial Issue cards are cards sent to new cardholders in a new group with other plan member communication materials. Maintenance cards are issued when a cardholder misplaces a card or changes information that appears on the card. |
| Care Med D Book of Business | All Med D, excluding Healthfirst and Aetna. |
| CashPro | Website provided by Bank of America (BOA) where information for daily receivables is stored. This includes checks, coupons, and correspondence. |
| CareSelect | National network of pharmacies used by some of our clients. CareSelect has fewer participating pharmacies, but lower effective rates than our PBM National Network. |
| Carrier/Group | The combination used to signify both the Plan Sponsor (Carrier) and the specific Group under it.  **Example of a Carrier/Group:**  0007/0023 0007 - Carrier = BCBS 0023 = Group Marley, Inc. |
| Carrier/Group Exception | Series of table’s resident on the RECAP Tandem database which provide for exceptions to the plan. |
| Carrier Name | Term used to identify any Plan Sponsor - the underwriter of an insured account or the company name of a self-administered account.  This name is often used on management reports sent to the Plan Sponsor. |
| Carrier Number | An assigned alpha/ numeric identifier for the Plan Sponsor (insurance company, self-administered account, third-party administrator, multiple employer trust, health maintenance organization). Each plan sponsor may have more than one carrier number. |
| Carve Out | Separately designed and administered benefit plans for high-cost or difficult-to-manage benefits, such as mental health and pharmacy. |
| Case Management | A member care management process used to contain costs and enhance quality of care for a select member population, such as those with congestive heart failure, asthma, and diabetes. Member care is typically overseen by a case manager. |
| Catastrophic Coverage | A Medicare Part D term referring to the last phase of coverage. The beneficiary has reached their individual TrOOP goal and their copay responsibility is reduced. Amounts are reset on an annual basis. |
| CDS | Controlled Dangerous Substance. |
| Claim Sequence Number | Follows the RxClaim number and designates how many times a claim has been submitted.  **Example:** 72209001003-3. Which means the claim was submitted 3 times. |
| Class 1 Medication Dispensing Error | A preventable prescription error that has potential to cause harm to a patient due to dispensing the wrong drug, wrong strength, wrong dosage form, wrong directions, or to the wrong patient. |
| Cold Transfer | Transfer using your phone, dial the phone number, and release. |
| Comorbidity | The presence of one or more additional conditions often co-occurring with a primary condition. Comorbidity describes the effect of all other conditions an individual patient might have other than the primary condition of interest and can be physiological or psychological. |
| Certificate of Coverage | Required by state laws. It is a description of benefits listed in a health insurance or prescription drug plan and given to the member. |
| Chemical Equivalent | Generic These are medications containing essentially the same active ingredients, strength and dosage delivery form that meet existing federal standards. Generally, chemically equivalent generics are available from multiple sources. |
| Claim | A request for reimbursement of prescription costs submitted to the adjudication process.  A claim can be submitted three ways:   * Mail - using a prescription card, through one of our PBM mail order pharmacies * Retail - Pharmacies may submit a claim electronically on behalf of the plan member. * Paper - An insured may submit a claim using the Direct Reimbursement Claim Form. |
| Claim Administrator | Any entity that reviews and determines whether to pay claims to enrollees or providers on behalf of the health benefits plan. |
| Claim Form | Form submitted to the payer by the provider of service or the member to receive the reimbursement for a drug or medical service.  These included private claim forms, HCFA 1500s, UB92s, universal claim forms, and various state Medicaid forms. |
| Claim Limitations | Claim limitations contain or limit a Plan’s or member’s exposure to high drug prices by placing a ceiling on the amount that a member or plan will be charged for the price of the dispensed drug. For example, some plan sponsors will initiate a ceiling on the price paid for a single medication of $3000, $5000, or some other amount or a very different application of a claim limitation is a rule whereby if a co‑payment amount is set, but the medication cost is less than the co‑payment, the co‑payment amount is charged. This assists to offset the usual occurrence of the cost of the medication being more than the co‑payment amount. |
| Claim of HIPAA Violation | Caller states their or another customer’s HIPAA rights have been violated. |
| Claim Pull | Request to simply obtain a copy of the claim documents submitted for a member. No research will be performed.  If the claim was processed incorrectly or if something is missing **DO NOT REQUEST A CLAIM PULL**, request a Customer Research Request (CRR). |
| Class 1 (one) | A “Class 1 (one)” refers to problems with the way a prescription was translated, or filled, which poses a potential danger to the member.  **Class 1 (one) errors include:**   * Incorrect Directions * Incorrect Medication/Strength * Incorrect Member Name * Prescriber Name Translated Incorrectly * Incorrect Drug * Incorrect Drug Strength * Incorrect Member Name * Mixed/Incorrect Medication Dispensed * Incorrect Member Name on Rx Vial Label |
| Client | The organization (usually an employer, but not always) that, through their benefit programs, contracts with our PBM to manage their members’ prescription benefits. |
| Client Code | Used to identify the member’s company as well as identify specific plan design information for the member.  **Note:** This is the code needed to register on our web site. This is also known as the Group Code. |
| Client Number | Unique 6-digit number assigned to a carrier/group or set of carrier/groups in the RECAP system, which combined, define a common business entity. The Client Number serves as a delimiter for Group Tracking and “Term from Add” processing. |
| Client Services/QL | The portal which houses PeopleSafe and other applications built upon our PBM application engine known as QL. |
| Client Termed | * Record is found with Member and/or Spouse and/or dependent file is displaying ‘Client Termed’instead of ‘Eligible’ or ‘Ineligible’;however, they claim to have our PBM benefits. * Member may show as ‘Ineligible’ even if the client has termed their plan. |
| Clinical Care Department | The department within our PBM that handles calls of a clinical nature including drug ingredients, adverse side effects, alternative drugs, etcetera. |
| Clinical Indications | Generally accepted use for a medication to treat a medical condition. This is regulatory confirmation of proven use by the U.S. Food and Drug Administration (FDA). |
| Clinical Interventions | Prescriptions processed through our PBM are subject to analysis (by a pharmacist) for medical safety/effectiveness and compliance with the client’s plan design. Whatever problems exist with a prescription, the prescription is diverted, through a queuing process, to our PBM Clinical Intervention Services department. |
| Clinical interventions for brand generic | Substitute for prescribed brand formulary brand (sometimes called “branded generic”) if no generic is available. |
| Clinical Programs | Our suite of Clinical Programs is known as our PBM Enhanced Offering, and includes:   * CustomCare Mail * CustomCare Retail * Prescriber Profiling Plus * UR Pharmacy Management * AdvancedCare \*\* * Accordant \*\*   \*\* In addition to the plan sponsor making the program available, the member must enroll in the program.  **Note:** To determine which Clinical Programs are available for a member, refer to Clinical Programs under Plan Designs. Do not discuss Clinical Programs with member when their plan sponsor has not made the program available.  **CustomCare Mail:** This program works towards optimizing pharmacy utilization through concurrent analysis of the member’s mail and retail drug history and ensures all prescriptions are safe and clinically appropriate for the member receives it. Approximately 95% of our Accounts use the CustomCare Mail program.  Before dispensing a home delivery prescription, a PBM pharmacist evaluates the prescription for:   * Product selection * Dosage * Duration * Approved diagnosis   If this review identifies a more appropriate therapy the pharmacist contacts the prescriber to discuss the issue and to identify a clinically acceptable alternative. In many cases, the pharmacist provides information regarding the member or the drug about which the prescriber is unaware, such as new dosages of a medication available in the marketplace, or new guidelines for a medication from the manufacturer. More than half the time, the prescriber agrees with the PBM pharmacist and authorizes a change in therapy. However, it’s important to note that if the prescriber does not authorize the change, we don’t make the change. If a change is authorized, the pharmacists then log the change into the Clinical Intervention tracking system, which allows us to quantify and report client savings from the program in an auditable format.  The features of CustomCare Mail include:   * Concurrent activity, triggered by a mail prescription * Uses integrated history (mail and retail) for consultations * Changes implemented at point of dispensing * Proactive prescriber interaction * Guaranteed savings to the client   The Benefits of CustomCare Mail include:   * Lowers mail drug spend * Educate prescriber on potential drug conflict or drug induced disease conditions they may not be aware due to multiple prescribers treating the same member. * Continually enhanced to proactively address pharmaceutical advancements * Promotes prescriber prescribing of cost effective drugs and treatment regimens that are clinically appropriate   **CustomCare Retail:** This program is a powerful tool that evaluates the member’s long-term, integrated (mail and retail) drug history to improve clinical outcomes. Through retrospective analysis (looking at history), we identify members who might be at risk for drug conflicts or drug-induced disease conditions. Retrospective analysis also highlights opportunities to reduce unnecessary prescriptions or to simplify therapies.  After a potential problem is identified by our PBM Clinical Pharmacists, a letter is sent alerting the prescriber of a prescribing choice that might prove inappropriate over the long term. The alert letter also includes more cost-effective or clinically effective therapies and encourages the prescriber to respond directly to our PBM regarding whatever changes they may make in the member’s drug treatment. We track and measure prescriber response to the alert letter as well as any changes in the member’s drug utilization patterns subsequent to the intervention.  With CustomCare Retail, we are able to identify the problem prior to interacting with the prescriber. This practice eliminates any unnecessary involvement with the prescriber.  The Features of CustomCare Retail include:   * Retail focused * Letter based program with significant clinical review * Guaranteed savings to the client   The Benefits of CustomCare Retail include:   * Lowers overall drug spend * Educate prescriber on potential drug conflict or drug induced disease conditions of which they may not be aware due to multiple prescribers treating the same member. * Intervene on retail prescription without member disruption. * Pharmacist review eliminates unnecessary involvement with the prescriber.   **Prescriber Profiling Plus:** This program identifies prescribers whose prescribing patterns are outside the standard of care guidelines, within specific disease categories. The analysis includes the following information:   * Prescriber’s average cost per prescription, number of prescriptions per member per month, cost per member by disease category plus percentage of prescriptions outside guidelines. * Comparison of prescriber to peers (specialty group) in the region by disease category * Clinical initiatives addressing specific highly utilized therapeutic categories such as antibiotics, NSAIDs/ Cox-II inhibitors, and antihypertensive agents. * Member-specific, actionable information.   Prescriber Profiling Plus shifts away from traditional analysis by medical specialty and focuses on prescribing by disease state. The analysis identifies prescribers actually treating key disease states and allows for communication through educational mailings and peer-comparison prescribing analyses within the disease state. Prescriber Profiling Plus also allows for the identification of key prescribing practices of high cost and heavily utilized drugs. Prescribers can be educated on more cost effective therapies and receive fewer benign mailings and more specific pertinent information to keep in mind for treating their members.  The Features of Prescriber Profiling Plus include:   * Client specific * Disease centric * Quantifiable savings to client * Actionable * Information provided quarterly, with follow-up mailing in 6 months. Prescribers receive trended (period-over-period) report of their performance. * Program consists of 8 mailings per year to the prescriber   The Benefits of Prescriber Profiling Plus include:   * Used to educate prescriber to prescribe therapeutic and cost effective medications. * Provides valuable information to support prescribers in prescribing specific members the most optimal therapy. * Identifies prescribers with outlier prescribing patterns. * Compares prescriber drug selection and utilization to peer group within disease category. * Communicates with educational mailings and peer comparison prescribing analysis within disease state. * Incorporates HEDIS/ NCQA (Health plan Employers Data Information Set/National Committee for Quality Assurance) requirements.   **UR Pharmacy Management:** This comprehensive program bridges pharmacy and medical management by systematically identifying high-risk members. A clinical team monitors for potentially high-risk situations and consults with prescribers to:   * Improve therapy, or * Reduce and/or prevent medication-related complications.   No other Pharmacy Benefit Management company offers this Preventative, integrated health management approach. Members have access to a toll-free consultation line where they can receive confidential clinical counseling from a PBM Clinical Pharmacist, as well as learn about drug interactions, the importance of compliance, and other issues about their therapy. In addition, members can ask questions about over the counter drugs, herbals, and other diseases, etcetera.  Just a few of the conditions targeted by UR Pharmacy Management are:   * Alzheimer’s * Cancer * Congestive heart failure * G.I. disorder * High risk diabetes * Hypertension * Infectious disease (Acute) migraine   The Features of UR Pharmacy include:   * Disease specific clinical algorithms * Clinical review of high-risk members * Bridges pharmacy and medical management * Specialized drug to disease management programs * Quarterly review   **The Benefits of UR Pharmacy include:**   * Avoids medical/drug complications in high-risk members which unnecessary hospital visits or prescriptions leading to cost savings. * Clinical pharmacist intervention direct with prescriber, no member interruption * Synergistically achieve a higher level of health care quality through collaboration with Pharmacist, Case Manager and Prescriber * Offers ability to clinically assess success of drug treatment in conjunction with Prescribers.   **AdvancedCare:** This is a unique member management program designed to reduce illness-related health care spending and improve quality of life by:   * Intervening on health and lifestyle conditions, identified through member medication review, member education and general quality of life (QOL) survey tools.   **Examples:** Behavioral Health Management, Morbid Obesity, and Smoking Cessation   * Providing general member education on medication, health related information and self-management tools * Targeting total population within selected medical conditions   AdvancedCare is unique to the marketplace in that it targets/manages health conditions. The program’s cross-functional healthcare resources provides member and prescriber materials, QOL survey to optimize overall treatment plan for individual members. Education plays a vital part of AdvancedCare. It includes specific member and prescriber education pieces to impact quality of life and improves member understanding of their health condition. Inbound member calls are made possible with a toll free number for support. This program also improves prescriber awareness of current “best practices” in medication therapy and lifestyle modification.  The Features of AdvancedCare include:   * Complete drug review of members within the targeted health conditions by a clinical pharmacist * Provide specialized health education programs. * Provide quality of life survey * Condition specific education.   The Benefits of AdvancedCare include:   * Guaranteed savings to the client * Avoids medical/drug complications in high risk members and members perceived to be well-managed. * Clinical pharmacist interventions * Synergistically achieve a higher level of health care quality through escalations of specialized resources: Pharmacists, case managers, nurses, dieticians, and prescribers * Provides pamphlet-based education. * Avoids medical/drug complications that impact medical pharmaceutical trend. * Informs prescriber of member’s actual management/severity of condition * Provides proactive awareness of problematic areas to members.   **Accordant:** These Disease Management Programs improve the quality of healthcare for members while at the same time helping control overall medical costs. Each Accordant Program was developed in house by our PBM using nationally recognized treatment guidelines from the American College of Rheumatology, the National Institutes of Health, and other organizations.  Because we knew that truly best practice disease management might require a variety of medical and pharmaceutical approaches that should not be limited to one particular product or protocol, we accepted no manufacturer involvement or financial support.  Accordant is unique in the marketplace in two major ways. First, it is the only disease management program that offers unlimited one-on-one counseling and disease education. At the heart of this member-focused, personalized approach are the Accordant Nurse Educators, whose ongoing support empowers members to:   * Take a more active role in their own care. * Improve adherence with prescribed therapies. * Enhance both clinical, financial, and quality of life outcomes.   Each member is given a unique, clinician-developed teaching/education plan that incorporates the prescriber’s prescribed drug therapies but goes beyond them to proactively empower the member’s ability to:   * Manage their disease. * Minimize symptoms and side effects of treatment. * Encourage self-care and Preventative health measures. * Improve adherence with optimal diet and exercise regimens that many members find difficult to maintain.   The Accordant portfolio currently covers these major conditions:   * Asthma * Diabetes * Chronic obstructive pulmonary disease * Congestive heart failure * Coronary disease * Peptic ulcer disease * Osteoarthritis * Pediatric asthma   The Features of Accordant are:   * Total member management * Toll free number to enroll if eligible. * Prescriber coordination involvement * Regularly scheduled outbound calls   The Benefits of Accordant are:   * Guaranteed savings to the client * Health care cost savings * Increase adherence with drugs/lifestyle changes. * Personalized attention * One on one member counseling * Understand dynamics of disease * Inform prescriber of member’s actual management/severity of disease * Provide proactive awareness of problematic areas. * Mimic business/wellness objectives * Provide quality of life survey |
| Closed Formulary | Members are covered only on formulary drugs, unless exempted through a formal appeals process. They can obtain non-formulary drugs only if they are willing to pay the full cost of the drug. |
| Closed Prescriber File | Listing of prescribers who will participate in a client’s program. The prescribers will be listed by name and state ID number or DEA number. Usually, a default prescriber number is provided to allow claims to pay if the prescriber ID number is not provided, if it is incorrect, or not on file at the point of sale. |
| Contracted Rate | The pre-negotiated cost of the medication using the member’s insurance. |
| Cold Transfer | Call made to another party without introduction of the member. |
| Copay Credit | Member is wanting a copay credit formerly known as a CSE Credit Request |
| Co‑payment | Co‑payments are the out of pocket portion of the cost of prescriptions that plan members pay to purchase them either through mail order or at retail locations. Typically, co‑payments are structured as “flat” dollar amounts - at either one, two, or three tiers of cost. However, some co‑payments are structured as co-insurance, better known as a percentage of co‑payments, and are a percentage of the cost of the medication.  **Tiered Co‑payment:**  The two-tier co‑payment structure with separate co pay levels for generic and brand which allows the member to save money when a generic is available and appropriate. The three-tier co‑payment structure with separate co pay levels for generic, formulary brands, and non-formulary brands that allows members to consider the economics of the prescription choices they and their prescribers make, and to assume a greater financial responsibility in those cases where the choices are more costly to a plan sponsor.  Generally, co‑payments are structured as follows:   * $xx (lowest co‑payment amount) = Generic products * $xx (middle co‑payment amount) = Preferred products * $xx (highest co‑payment amount) = Non-preferred products   When a prescription is dispensed for a non-preferred product that has no preferred equivalent, the plan sponsor determines which co‑payment amount (middle or highest) will be charged.  Co-Insurance is often referred to as percentage co‑payments. Most often, percentage co‑payments are applied at Retail pharmacies, but some plans apply co-insurance at mail order. The specific co‑payment that a member will pay for a prescription, when co-insurance is applied, is a percentage of the cost of the discounted cost of the medication, for a specific quantity of medication. Therefore, the quantity of the medication drives your conversation with members regarding their costs.  **Note:** Remember that some clients will set minimum/maximum co‑payment amounts associated with percentage co‑payments.  **Example:** We have a client that at retail (POS), charge a 25% Brand co‑payment with a $10 minimum and $50 maximum charge amount, and a 25% Generic co‑payment with a $5 minimum and a $25 maximum charge amount.  Members can clearly see how beneficial their prescription benefit plan is to them, as they will understand the true cost of the medication, and that their plan sponsor pays the balance of the cost of the medication, outside the co-insurance amount. Often, members are able to control their out of pocket costs when a generic is available, and appropriate. |
| COB Survey Letter | Letter required by CMS guidelines to be sent to the MED D beneficiary annually in order to gather details on any other prescription insurance which they own. |
| Coding | A system of uniform language used to accurately describe medical, surgical, and diagnostic services, and thereby provide and effective means for reliable nationwide communication among prescribers, members, and third parties. |
| Coinsurance | * Generally, a fixed percentage of the medication cost set by the plan, which may vary with every fill and required to be paid by the member before or after meeting an established policy deductible. * The subscriber or member’s share of the liability determined by an insurer for a particular claim. |
| Commercial Insurers | A private insurance company (excluding government programs and blue cross and blue shield plans) that provides health care coverage to its subscribers. |
| Compliance | Member adherence to a prescribed drug regimen or treatment plan, or provider adherence to health plan guidelines such as formulary, practice protocols, etcetera. |
| Compound | A prescription requiring a registered pharmacist to mix two or more drugs to create the prescription written by a prescriber. |
| Comprehensive Formulary | Complete list of drugs which are covered under the plan. |
| Computerized Participant Record | Electronic Participant Record (EPR) or Longitudinal Medical Record Refers to the capture, reporting and maintenance of a member’s complete medical health record using electronic technology. |
| Conflict Rules | Predefined conditions within the system which cause prescription claims to be routed to an intervention queue for resolution. |
| Contingent Therapy | Grandfathering or Step Therapy Adjudication engine will look back into a member’s history to see if they have a specific designated drug in their history for a specified period of time before a specific drug will be approved on-line. This is also referred to as Electronic Prior Authorization (ePA). |
| Contraceptives Coverage Exemption | Under the ACA, non-grandfathered health plans must cover contraceptive services for women, with no cost-sharing.  However, group health plans established by certain religious employers have been granted an exemption from this requirement entirely and certain religious organizations are eligible for an accommodation that would allow them to avoid paying for these services if they object to doing so on religious grounds while still ensuring that their plan members have access to the contraceptive services without any cost sharing. |
| Contraceptive Devices | Devices which physically obstruct or prevent pregnancy. |
| Contraindication | Member condition that makes medication treatment harmful and generally not useful to manage a member’s disease. |
| Controlled Drug | A legend drug which has the potential of causing addiction or abuse. These medications come under the jurisdiction of the Controlled Substances Act.  Most controlled substances are regulated by both the federal **(DEA, FDA)** and state governments. The [Controlled Substance State Laws (004776)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=10965139-fc1c-42f6-92ac-7933d76a9117) includes a short list of state controlled substances that are not federally regulated. The list of controlled medications can be viewed in the [Controlled Substances by CSA Schedule (013688)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=7172ebe6-dbba-42eb-82ca-969b41a22763).  **Controlled substances are divided into five Schedules (also called Classes):**  **Schedule I or C1** - The drugs in this schedule have no accepted medical use in the United States and have a high potential for abuse.  **Examples:** Heroin, Peyote, Marijuana, LSD, Mescaline, psilocybin, tetrahydrocannabinols, ketobemidone, levomoramid, racemoramide, benZylmorphine, dihydromorphine, nicocodeine, nicomorphine, and methaqualone  **Schedule II or C2** – The drugs in this schedule have a high potential for abuse with severe psychic or physical dependence liability. Schedule II controlled substances consist of certain narcotic, stimulant, and depressant drugs.  **Examples:** Codeine, Demerol, Dexedrine, Dolophine, Morphine, M S Contin, Opium, Oxycodone (perdodan), Pantopon, Leritine, Numorphan, Percocet, Ritalin, and Tylox  **Schedule III or C3** - The drugs in this schedule have an abuse potential less than those in Schedules I and II and include Compounds containing limited quantities of certain narcotic drugs.  **Examples:**  Alprazolam, Halcion, Anabolic Steroids    **Schedule IV or C4** - The drugs in this schedule have an abuse potential less than those listed in Schedule II.  **Examples:** Valium, Tylenol with Codeine, Xanax  **Schedule V or C5** - Limited abuse potential. Primarily small amounts of narcotics (codeine) used as antitussives and antidiarrheals. Under federal law, limited quantities may be purchased without a prescription directly from a pharmacist. The purchaser must be at least 18 years of age and furnish suitable identification. Transactions must be recorded by the dispensing pharmacist and be available for DEA review.  **Examples:** Robitussin AC, Guiatex AC, Antituss CG/syrup with codeine |
| Copay | 1. Plan member’s share of the prescription drug cost.  * Single co-payment plan: Plan member pays the same dollar amount for co-payment regardless of whether a brand or generic is dispensed. * Dual co-payment plan: Plan member generally incurs a lower co-payment if a generic drug is dispensed and pays a higher co-payment if a brand is dispensed. * Three Tier co-payment plan: Plan member pays a variable co-payment based on the status of the drug dispensed (preferred; non‑preferred; neutral). * Dollar Copay: Client sets a standard and/or generic flat dollar copay to be collected at the point of sale. * Percent Copay: We will calculate a percentage of the claim to be paid by the cardholder at the point of sale. * Dollar and Percent Copay: Flat dollar amount plus a percentage figured in.  1. A fixed amount of money required to be paid by the member at the time of receiving medical or pharmacy services. Differential of tiered copayments are generally used to manage access to medications while containing costs of the plan.  * The portion of the cost of a prescription paid by the member. Co-payments charged under our PBM prescription benefit plans are set by the client and vary from plan to plan. Some clients have a standard co-payment, some have a higher co-payment for brand medications than for generic medication, and under some plans the co-payment is a percentage of the cost of the prescription. Generally speaking, if a plan has a deductible, plan co-payments are not effective until the deductible amount has been met. |
| Copay Exceptions | A table resident on the RECAP Tandem database which allows for copay exceptions such as zero copay for certain drugs and variable copays by day’s supply which is not allowed on the current ECLIPS file. Often referred to as copay “tags.” |
| Co-Payment Level | When qualified for Low Income Subsidy, the beneficiary is eligible for financial assistance with the copayment/coinsurance charged for covered Part D prescriptions.  One of the following levels will display, indicating how much financial assistance the beneficiary will receive towards their Part D copayment/coinsurance: 1, 2, 3, 4 |
| Cost Share | Cost share by definition is the share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.  DAW rule is similar to Balance Billing , as it is the difference between what is allowed by the plan and what is charged. This difference is passed onto the member only and not shared by the plan. |
| Cost Shifting | The redistribution among payer sources. In pharmacy, it is a process by which a manufacturer or provider gives a discount to one sector and then passes along the cost to another sector. |
| Counter Detailing | Process of educating or influencing prescriber behavior in a managed care environment toward use of the drug formulary or preferred medications. |
| Coverage | * Used to describe the possible payment status of a health service, drug, or device for which the insurer might provide reimbursement. * Defines who may be considered eligible for prescription benefits under the cardholder’s plan typically: Member only, family, member & spouse, etcetera. |
| Coverage Code | Identifies who is covered by the PBM program, that is, Cardholder Only, Family Coverage with dependents through the age indicated. Used in combination with “standard” eligibility mode. |
| Contraceptives Coverage Exemption | Under the ACA, non-grandfathered health plans must cover contraceptive services for women, with no cost-sharing. However, group health plans established by certain religious employers have been granted an exemption from this requirement entirely and certain religious organizations are eligible for an accommodation that would allow them to avoid paying for these services if they object to doing so on religious grounds while still ensuring that their plan members have access to the contraceptive services without any cost sharing. |
| Coverage Services | Specific services, products, and supplies for which third party payers may provide reimbursement. |
| Created Order | An order that has been scanned will always have an Order Number and be viewable on the Main Screen. Stop Sees cannot be used on orders showing on the Main Screen. |
| Credentialing | Review process of a provider who applies for participation in a health plan by providing information on specific criteria initially, as well as on an ongoing basis as a member in the plan. |
| Credible Statement | The beneficiary must provide the plan with a credible statement that failure to pay was due to circumstances outside of the individual’s control or could not foresee. |
| Creditable Coverage | Prescription Drug coverage that pays out (on average) as much or more than the standard Medicare Part D drug coverage. |
| Crosswalk ID | Reference plan member identification number that is different than, but is linked to, the plan member’s Internal ID, such as the SSN#. It is sometimes referred to as an Alternate ID.  A plan member’s eligibility record may be viewed by searching for either the Crosswalk ID or Internal ID. Both ID numbers are linked.  In situations in which the Internal ID is the member’s SSN#, using a Crosswalk ID allows us to use an alternate ID in place of the SSN# to help keep this information confidential for the member. |
| Current Year | Refers to the current calendar year. |
| Cumulative Uncovered Months | Total months that a Beneficiary was not enrolled in a Part D plan or did not have creditable coverage. |
| CustomCare Retail | Program extends the value of CustomCare Mail to the retail setting by notifying prescribers, by mail, of possible opportunities to reduce unnecessary prescriptions or to simplify therapies based on clinical review of retail prescription filling patterns. |
| Custom Formulary | A drug list/formulary that is specifically tailored to the needs of a particular healthcare plan or organization rather than using a pre-defined, standard formulary. |
| Customer Care | Division of the PBM that supports the plan member (beneficiary, insured) to resolve concerns or questions regarding his/her available benefits, as well as prescription claims that are submitted.  Resolution of plan member’s inquiries on their benefit terms, retail pharmacy locations, order, and distribution of prescriptions by mail. |
| Customer Care Phone Number | Each client is assigned a telephone number to reach Customer Care. This number can be dedicated and utilized by only one client or it can be used by several clients. |
| Custom Network | Special group of pharmacies assembled for the purpose of fulfilling the drug benefit requirements of a specific client or group of clients.  This arrangement may result in lower client costs due to lower drug reimbursement levels and/or lower dispensing fees to the participating pharmacies.  Refer to Preferred Provider Organization |
| CVS Caremark Help | Our entry-level health management program focuses on education of the member with respect to their diseased state/medical condition and the importance of medication adherence. This program strives to improve plan member’s self-care and promote awareness of lifestyle issues in the treatment of disease. |
| CVS Caremark National Pharmacy & Therapeutics Committee | P&T Committee This committee is comprised of an independent group of external prescribers, pharmacists, and a medical ethicist. None of the members of this Committee are employees of our PBM.  The National P&T Committee review and approve all drugs in consideration for our PBM Formularies and Drug Lists. |
| CVS Opportunity (T-14) | A letter will be generated when an opportunity is identified for a Plan Member who is currently filling a maintenance medication at a CVS/pharmacy. This opportunity is alerted to the same CVS/pharmacy to contact the prescriber and obtain a 90-day script.  **Note:** This opportunity/letter is internally referenced as “T-14” (this code does not display on the letter).  **Sample member letters:**   * [Maintenance Choice Mandatory Participating MChoice Pharmacy Sample Member Letter (065082)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=7eafccae-b948-4184-9f5a-48c63a83b999) * [Incentivized Maintenance Choice Participating MChoice Pharmacy Sample Member Letter (065083)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=6b834279-42ca-4eec-883a-33daef9dfcd2) |
| Cycle | System runs every other weekend (26 per year) to pay pharmacies for claims processed through RECAP & RxClaim during the previous two weeks.  Plan Sponsors are billed for all claims paid during that two-week period. Pharmacy checks, remittance advices, adjustment advice and reject notices, as well as claim billing invoices and Client Accounting Tapes all process on a cycle basis. |
| Cycle Cut-Off Date | Date all claims must be received through RECAP or RxClaim system in order to be included in the current Cycle payment.  This date displays on all output from the Cycle and is also known as the Cycle date. |
| Cycle Date | Date that checks and reports are generated. Presently, one cycle occurs approximately every two (2) weeks. |
| Cycle Number | The number assigned to each claim cycle. Generally, two cycles per month within both RECAP and RxClaim system identifies the period when the claim was processed and the pharmacy pay period.  Some client specific cycles do exist on both clam processing platforms. |

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