# Customer Care Abbreviations, Definitions and Terms – D

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

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

**Note:** Terms are not duplicated in both lists.

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| **Abbreviation** | **Term** | **Definition** |
| **DB** | Direct Bill/Database | A type of payment plan in which beneficiaries can enroll when paying their monthly premiums. |
| **D/C** | Discontinue | To Stop. Any prescription that is discontinued cannot be reordered and will need a new prescription to fill. |
| **DC** | Doctor Call | Call made to a prescriber by a registered pharmacist for clarification of a prescription, or to obtain a prescription over the telephone. |
| **DCG** | Diagnostic Cost Group | Risk adjustment methodology used to predict current or future patient costs. |
| **DAW** | Dispense as Written (Call for Generic Conversion) | A prescription written for brand only whereby the prescriber is contacted to request if generic is appropriate to dispense.  When a prescriber writes a prescription, he may designate on the form that the prescription must be dispensed as written. This means substitutions (usually generic drugs) may not be used. This is called a prescriber DAW. Under certain circumstances the pharmacy of the cardholder may also request that the prescription be dispensed as written.  With both types of DAWs, the cardholder *may* incur a Cost difference. Review CIF for DAW rules    A prescribing directive to pharmacists to dispense only the medication ordered: Prevents generic drug substitution. Also see PSC codes.  0 - No DAW indicated  1 - Dispense as written by the prescriber  2 - Substitution allowed, member requested brand.  3 - Substitution allowed, pharmacist requested brand  4 - Generic available, not in stock  5 - Substitution allowed, brand dispensed as generic  6 - Override  7 - Brand mandated by law  8 - Substitution allowed, no generic available in marketplace  9 – Other |
| **DAW1** | Dispense as Written per physician | Prescriber indicates generic is not to be substituted. |
| **DAW2** | Dispense as Written per member | Member indicates generic is not to be substituted. |
| **DAW3** | Dispense as Written | Substitution allowed; pharmacist selected product dispensed. |
| **DAW4** | Dispense as Written | Substitution allowed; no generic available (generic out of stock). |
| **DAW5** | Dispense as Written | Substitution allowed; brand drug dispensed as generic.  **Note:** DAW 5 Branded Generics are ONLY available at Caremark Mail Order. |
| **DAW6** | Dispense as Written | Override. |
| **DAW7** | Dispense as Written | Substitution not allowed; brand mandated by law. |
| **DAW9** | Dispense as Written | Applied when Clients’ plans use the CVS Caremark standard formulary, when plans requiring Brand to be dispensed and there is a generic available but not added to the plans formulary except for states that have mandatory generic substitution laws  **Note:** This code is typically listed as other to represent another scenario not found with codes 0-8. The DAW 9 will represent “other”; drugs that are categorized as brand but will be coded to process at the generic coinsurance. |
| **DS** | Day’s Supply | Number of days’ worth of medication a prescriber prescribes. The number of days’ worth of medication allowed by the prescription benefit plan. |
| **DC** | Doctor Calls | The department which addresses drug interactions and illegible/missing prescription information. |
| **DDI or DI** | Drug to drug interaction | Indicates that the prescribed medication may potentially interact with the member’s other medications. |
| **DDPS** | Drug Data Processing System | Performs detailed validation, reports processing outcomes and stores Prescription Drug Event (PDE) records. |
| **DEA** | Drug Enforcement Agency | Governmental agency that oversees and enforces the laws and regulations of the use of federally approved drugs. |
| **DEA#** | Drug Enforcement Agency Number | * A unique number given to prescribers which gives them authority to prescribe controlled substances. The DEA number is nine digits long. * The number assigned to a prescriber by the agency for tracking purposes and identification on all drugs prescribed by the prescriber. |
| **Dec** | Decrease | To reduce. |
| **DED** | Deductible | * The amount of money the member is required to pay out of pocket before the insurance benefits go into effect. It is a specific amount of money determined by the client as a cost containment measure. The member pays full price for the medication until the deductible is met, then they begin to pay their co-payment amount. This is also known as “Front-End Deductible” or “FED”. * A predetermined prescription drug expense which must be paid 100% by the covered individual or family prior to the beginning of plan coverage. Once the deductible is met, prescription drug coverage for amounts over and above the individual or family co-payment is billed to the plan sponsor (Benefits Provider): * **Annual Deductible** - These expenses are generally tracked and accumulated on a 12-month basis. * **Family Deductible** - Coinsurance begins or benefits cease when any combination of family plan members reaches the family specified limit. Applicable to all eligibility modes. By submitting family status codes of S=Single or individual; T=Two- Party; F=Family. In the eligibility record, a client may communicate varying benefit levels by family unit. * **Two-Party** - Coinsurance begins or benefits cease when two-party families reach the two-party specified limit. Applicable to all eligibility modes with submission of family status codes (S-T-F). * **Individual Deductible** - Coinsurance begins or benefits cease for each individual at specified limits. Applicable to plan member-based eligibility or Matched modes to track individual reimbursements.   I will take a look at your plan design to determine if the deductible is impacting the price of your medication.  Also see [Embedded Deductible (051673)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=882db71b-67fb-4521-8de7-6026d47b7191) and [Integrated Deductible (051681)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=7980fd12-104b-4071-94f5-3dee9c060cb0). |
| **Dep** | Dependent | A person the member is responsible for. A dependent can be any of the following:   * Spouse * Child * Student * Disabled dependent * Dependent adults |
| **DESI** | Drug Efficacy Study Implementation | DESI drugs were classified by the FDA in 1962 as safe but not proven fully effective by today’s standards.  These drugs were first marketed between 1938 and 1962, which were approved as safe but required no showing of effectiveness for FDA product approval. The DESI program subsequently made a determination of “fully effective” for most of the products and they remain in the marketplace. A few DESI products remain classified as less than fully effective while awaiting final administrative disposition. Also classified as DESI are many products listed as identical, similar, or related to actual DESI products.   * 2 Non-DESI/IRS or DESI/IRS drugs determined to be safe and effective (IRS = identical, related, or similar to current DESI drugs) * 3 DESI/IRS Drugs under review * 4 Less Than Effective (LTE) DESI/IRS drugs for some indications * 5 Less Than Effective (LTE) for all indications * 6 Less Than Effective (LTE) withdrawn from market |
| **DF** | Dosage Form | Indicates the physical form of a dose of medication, such as a tablet, capsule, or injection. |
| **Dff Dr** | Different Doctor | Indicates prescription written by a different prescriber than other prescriptions. |
| **DFRP** | Default Responsive Person | Where there are two POA’s on file and both are added on the account, the 2nd POA must be entered and marked as termed with the next day’s date and coded as DFRP. |
| **DFUD** | Do Not Fill Until Date | The prescription has a date written on the prescription image AND includes a statement from the prescriber: Do Not Fill Until Date/Earliest fill date followed by a date in the future from the date written.  The prescription cannot be filled or released from hold prior to the DFUD provided by the prescriber. |
| **DH** | Doctor Hold | Resolution code used to place an Rx on DPR Hold while awaiting prescriber response. |
| **DIA** | Diabetic Queue | The queue in which prescriptions are placed for diabetic drugs and supplies. |
| **DIF** | DMERC Information Form | DIF is a form required by Medicare to help document the medical necessity and other coverage criteria for selected durable medical equipment, prosthetics, orthotics, and supplies. |
| **DIFF** | Different | Not identical. |
| **Digital Signature** | Digital Signature | Is an encryption or encapsulation of the key fields on an eRx and it is needed to ensure that no tampering is done before it reaches the pharmacy. In cases where the prescriber’s software does not provide signing capability, they will use a Signature Indicator (SI) in which case the pharmacy vendor (i.e., Verizon) will have to digitally sign the prescription on the pharmacy’s behalf to “lock down” the prescription before the pharmacy can begin to process it. SureScripts will check to see if the transaction was digitally signed and contain either the signature or the flag. SureScripts will not validate the signature. Verizon will validate the signature. |
| **DIH** | In House over 4 days | Applies to **FEP Members ONLY!!!**  Any prescription that has been in-house for 4 or more days, without reaching a status of “Complete ACC,” is considered to be Delayed In-House for FEP. Prescriptions that are DIH require expedited handling. |
| **DIN** | Drug Identification Number | Canadian equivalent of the National Drug Code (NDC). |
| **DIQ** | Drug In Question | Indicates the medication that is being referred to. |
| **DIR** | Directions | The instructions placed on a prescription to inform the member how to take the medication. |
| **DS** | Direct Sales | Client may allow their plan members to get medications not covered by the plan, thru home delivery, at 100% of the PBM Discount cost.  This benefit also includes medications with limits, the plan member can get medication with the limit at their copay and home delivery will call the plan member to see if they want to get the remainder of the prescription at 100% of the PBM Discount cost. |
| **DISC** | Discover Card | Type of credit card. |
| **DISP** | Dispensed | The product / quantity that will be sent to the member. This may be in increments of individual tablets, package sizes, or liquid measurement. |
| **DM** | Disease Management | Accordant. A set of programs designed to help members with chronic conditions (diabetes, asthma, ulcers, hypertension, etc.) better manage their conditions through lifestyle modifications, adherence to prescription protocols, etc. |
| **DIV** | Divert or Diverted | Divert: A specialized payment solution that allows for payment requests to be sent in real time so that card payments can be actioned during an interaction with a member.  Diverted: Prescription is routed to another area. |
| **DLN** | Document Locator Number | A unique number assigned to a state tax return. |
| **DM** | Debit Memo | The documentation used to provide debit information. |
| **DME** | Durable Medical Equipment | **Examples** include but are not limited to: Diabetic shoes, incontinence supplies, oxygen tanks, wheelchairs, compression socks, and C-PAP machines/supplies. |
| **DMR** | Direct Member Reimbursement | This is a process when a member pays “out-of-pocket” for a prescription and submits the receipt and claims for the reimbursement. Upon adjudication, a paid claim will generate a check for the member. |
| **DNC** | Drug Not Covered | The medication being filled is not covered under the member’s plan. |
| **DOB** | Date of Birth | The day on which the member was born. |
| **DOCNB** | Document Number | Number assigned to each claim that is processed. The first three digits are the cycle number, the last nine digits are a reference number for the claim. |
| **DOD** | Date of Death | The date that a member was declared deceased. |
| **DOE** | Date of Entitlement | Refers to the month that you become entitled to a disability benefit. |
| **DOF** | Date of Fill | The date that the prescription is being filled. |
| **DOI** | Date of Issuance | The date that a check was issued. If it has been over 180 days since the date of issuance of a check, it is considered a stale dated check, requiring a replacement. |
| Description of Issue | Used as an abbreviation in notation of the issue being described. |
| **DO** | Dose Optimization | * Promotes the use of cost-effective single daily-dose regimens while improving plan member health through simplification of the patient’s dosing regimen. * Allows our PBM and its clients to direct plan member prescriptions to an appropriate strength of a given medication. * A Point-of-service program that rejects a claim for selected drugs with special claim responses and messaging to a pharmacy when multiple daily doses of a Dose Optimization drug are prescribed, and a higher strength single daily dose is available and clinically appropriate. |
| **DOR** | Digital Order Release | The functionality for beneficiaries to release their order on the Member Web Portal (Caremark.com) by resolving the issue causing the prescription order to be placed hold. |
| **DOS** | Date of Service | The date a service was performed or received by a member. |
| **DP** | Data Process | Order is ready for shipping (in AMOS). |
| **DAW** | Dispense as Written Drug Rules | See [Generic Drug Rules (051677)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=f23a25b7-196e-4513-b846-f916b376b8a9) definition. |
| **DPC** | Doctor Phone Call | When a conflict cannot be resolved by a pharmacist, a call is made to the prescribing prescriber to obtain his/her assistance in resolving the conflict. |
| **DPC Q** | Prescription in queue for Doctor Call Team | A prescription, located in the Doctor Call queue, which requires further review by a pharmacist or necessitates prescriber contact to provide clarification/information. |
| **DPH** | Delayed Prescriber Hold | A hold placed on an order due to a delayed prescriber response. |
| **DPO** | Diplomatic Post Office | Associated with U.S. embassies and consulates. |
| **DPS** | Department of Public Safety | The Texas Department of Public Safety (DPS) requires the prescriber’s current valid DPS registration number on prescriptions for Schedule II-V controlled substances.  For Schedule II substances, the DPS is required to belong to the prescribing physician.  For Schedule III-V drugs, the prescribing practitioner may be a properly registered physician’s assistant or an advanced practice nurse. These physicians (M.D.s) would still need to provide their DEA numbers with their prescriptions. |
| **DPQ** | Doctor Prescribed Quantity | The amount of medication the doctor has requested be filled for a particular medication. |
| **DPR** | Delayed Prescriber Response | Prescriber hold. |
| **Dr** | Doctor | The physician/prescriber on a prescription. |
| **DSM** | Disease State Management | Comprehensive, integrated programs to target costly disease states (such as diabetes, asthma) through active interventions or utilization of medications that can contain overall costs. The goal is to produce the best overall member care outcomes at the most effective cost. |
| **Drg Nm** | Drug Name | The name of a particular medication being prescribed. |
| **DrO** | Medical Doctor’s Office | The office in which a member is seen/ followed by a doctor. |
| **DrOC** | Medical Doctor’s Office Closed | The office in which a member is seen/ followed by a doctor and is currently closed. |
| **DRR** | Drug Regimen Review | Type of drug utilization review to identify inappropriate or potentially harmful drug therapy. This is a term typically used in hospitals. |
| **DS** | Day Supply | The numbers of days that a medication should last if used as prescribed by the doctor. |
| **DSNP** | Dual Special Needs Plan | A Medicare Advantage plan that provides health benefits for people who are eligible for both Medicare and Medicaid. |
| **DT** | Date | The day of the month or year as specified by a number. |
| **DTRR** | Daily Transaction Reply Report | A report that CMS provides to Part D sponsors containing details of the rejected and accepted enrollment transactions that CMS has processed for a Part D sponsor's contract(s) |
| **DTS** | Diabetic Testing Supplies | Supplies used to treat beneficiaries who have diabetes, typically in the form of administration of insulin. This can include, syringes, needles, alcohol swabs, inhaled insulin devices, meters, lancets, test strips, etc. |
| **DU** | Drug Utilization | Ability to monitor and assess the appropriateness, safety, and efficacy of drug therapy and usage; often used synonymously with Drug Utilization Review. |
| **DUE** | Drug Use Evaluation | Quality assessment review of drug utilization. |
| **DUP** | Duplicate | A potential duplicated prescription. |
| **Dup Tx** | Duplicate Therapy | The prescribed medication has a similar therapeutic effect as another in the member’s profile. |
| **DUR** | Drug Utilization Review | The prescription being requested has a clinical issue that needs to be addressed by a pharmacist. |
| **DUR Q** | Drug Utilization Queue | This is the queue in which a prescription being requested has a clinical issue that needs to be addressed by a pharmacist. |
| **DWCB** | Doctor will call back | Prescriber contact was made, and the pharmacy is awaiting a response by phone. |
| **DWFB** | Doctor will fax back | Prescriber contact was made, and the pharmacy is awaiting a response by fax. |
| **Dx** | Diagnosis | A medical condition determined by a doctor. |

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| **Term** | | **Definition** | |
| Debit | | An entry recording an amount owed, listed on the left-hand side or column of an account. (A payment made or owed). | |
| Dual Lines of Eligibility | | Two lines of eligibility are displayed in the system, but at least one piece of information is different (usually the group code or eligibility dates) | |
| Duplicate Lines of Eligibility | | Two identical lines of eligibility are displayed in the system for the same member. | |
| Diagnostic Test | | A diagnostic or viral test tells you if you have a current infection. Molecular PCR and antigen tests are both types of diagnostic tests Antibody Test - An antibody test tells you if you had a previous infection. | |
| Day Supply Maximum | | Maximum number of days a member is allowed to purchase at one time as defined by the Plan. | |
| Decision Support System | | Software that taps into database resources to assist providers in making decisions among various care options. | |
| Delivery Systems | | Indicates which distribution channels are available to this member such as:   * MAIL Order Pharmacy (MOR) * PAPER Claims (PCL) * POS (Retail Pharmacy) benefits (POS)   **Note:** Some plans may allow limited use of a specific channel. Please check Refill Restriction information within the individual’s PBA screen for these limitations. | |
| De Minimis | | The premium dollar amount above the LIS benchmark (also called premium liability). It represents the premium amount that a PDP sponsor must volunteer to pay if their premium amount is above the LIS benchmark for their region and they want to retain their LIS Med D beneficiaries and avoid the CMS LIS re-assignment process. | |
| De Minimis Compensation | | (See also [De Minimis](#DeMinimis)) Through regulation, CMS has created an exception for non-monetary compensation provided to a physician of up to $300 per year in value. This regulation places certain restrictions on the compensation, and requires that:   * The compensation may not be determined in any manner that takes into account the volume or value of referrals or other business generated by the referring physician. * The compensation may not be solicited by the physician or the physician's practice. * The compensation relationship does not violate the Federal Anti-Kickback Statute.   In regard to the final requirement pertaining to compliance with the Federal Anti-Kickback Statute, the Office of Inspector General (OIG) Compliance Program Guidance to Pharmaceutical Manufacturers recommends compliance with the PhRMA Code on Interactions with Health Care Professionals (PhRMA Code) with respect to gifts and gratuities to physicians. | |
| Denial | | Refusal of a payer to cover a particular benefit, such as a drug or medical service. | |
| Dependent Age Limit | | Clients may specify at what age dependents eligibility will end. This is client specific and could include dependent eligibility ending at age 18, 19, 20, etc. Dependent coverage can also depend on student status or disabilities. | |
| Desktop Site | | Full size version of a website, naturally accessible from a basic personal computer.  A desktop site usually allows full accessibility to a website while the mobile app and/or mobile sites only offers a limited or framed view of a website. | |
| Detailing | | Process by which manufacturers or related pharmacists’ experts inform prescribers about medications, including safety and efficacy, and sometimes cost. | |
| Diabetes | | Occurs when an individual’s pancreas doesn’t produce enough insulin to control the amount of glucose, a vital energy source, in the bloodstream. | |
| Diabetic Kits | | Indicates whether plan allows special pricing for diabetic supplies purchased (kit). | |
| Diabetic Supplies | | Refers to glucose test strips, needles, syringes needed by the member for diabetes care. May or may not be covered under Prescription benefit plans. | |
| Diagnosis Code | | A code to indicate a medical condition; code is determined by a doctor:  In order for any medications to be processed under Medicare part B for mail order a 5-digit diagnosis code is needed, as well as a handwritten signature and date on the prescription. A new diagnosis code is needed for each new prescription. | |
| Diagnostic Agents/Aids | | General category given to test kits which may be able to test for glucose, pregnancy, ovulation, and occult blood. | |
| Dietary Supplements | | Products or nutrients which are given orally to provide calories to members who may not be able to obtain their calories through food sources. | |
| Direct Bill | | | The beneficiary has selected to pay his/her monthly premium via cash (Incomm - Pay at Pharmacy option ONLY), check or money order and receives a monthly invoice. |
| Direct Subsidy | | A monthly subsidy paid from CMS to the Medicare D plan each month for every enrolled Beneficiary, to reduce the Beneficiary’s Premium. Without the Direct Subsidy, Beneficiary Premiums would be $90 or more. |
| Direct Claims | | Paper Claims that are manually completed and submitted by plan members or by pharmacies for processing. |
| Direct Formulas | | Reimbursement level for a direct claim. May or may not provide same level of benefit to plan member as when using our card at a network pharmacy. |
| Direct Medical Costs | | Monetary transactions and represent costs that are incurred in providing the care.  **Examples:** DMC include payments for purchasing a pharmaceutical product, the salary of a health professional, the prescriber’s fee, or purchasing a diagnostic test. |
| Disconnected Calls | | Beneficiary hangs up the phone (beneficiary initiated disconnect).  In this case, NO callback needs to be attempted. |
| Disaster Emergency | | Any unplanned event that can cause deaths or significant injuries and that can shut down business, disrupt operations, cause physical or environmental damage, or threaten to interrupt a member’s therapy. |
| Disaster Emergency Overrides | | Unplanned event that can cause deaths or significant injuries to employees, customers, or the public; or that can shut down your business, disrupt operations, cause physical or environmental damage, or threaten the facility.  Any non-standard occurrence that may impair the ability of us to function as intended. This may include house fire, auto accident, facility disaster, systems disruptions, and disruption of supply chain, bioterrorism, natural disaster, and widespread employee safety. |
| Disclosure | | The release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information. “Disclosure” indicates an issue that should be reported to the Privacy Office but does not require immediate action.  **Examples:**   * Mailing an ID card to the wrong person. * Sending a Claims History Report or any document with PHI to a wrong recipient. * Sending a fax, that contains PHI to an unintended recipient (including physicians). * Leaving a voice message with PHI at an incorrect phone number. * Mailing a prescription to an incorrect person’s address. * Mailing a prescription Rx hardcopy to an incorrect person. * Sending any type of mailing letter or leaflet which contains PHI to an incorrect person. * Repetitive callers indicating a mass mailing error with PHI or PII. |
| Discontinued Rx | | Converts Rx to an inactive state, therefore preventing it from being filled again. Requests of this nature can only be requested by the prescribing prescriber or the member for whom the is written. |
| Discount | | Contractually agreed percent reduction off (AWP) for prescription drugs dispensed by a network pharmacy. (Brand & Generic drugs) |
| Disenrollment | | Termination of coverage after an enrollee’s effective date with our Part D Services, L.L.C.’s client plan |
| Disenrollment Effective Date | | Date the beneficiary’s MED D prescription coverage is no longer effective.   * Identified in Dunning Letters #2 and #3 (CMS Exhibits 20 and 21) * The first date without coverage (always the first of the month)   **Example:** Termed 4/30/18, Disenrollment Effective 5/1/18 |
| Disenrollment form | | Form sent to beneficiary requesting voluntary disenrollment. |
| Dispensing Fee | | * The amount paid to a pharmacy for distributing each medication in addition to the medication ingredient cost. * A professional fee for the pharmacist. The fee generally varies based on the negotiated AWP percent reimbursement and sometimes the generic/brand indicator of the drug. The fee is typically established with the Plan Sponsors selection of a pharmacy network. It may however also vary from state to state depending on requirements and Plan Sponsor request. |
| Dispensing Limitations | | Amount normally prescribed by a prescriber, but may have limitations established by plan sponsor, i.e., not to exceed say a 34-day supply or 100-unit doses, whichever is less, as an example. (See also Days’ Supply) |
| Dispensing Mail Order Pharmacy | | One of our mail order pharmacies is assigned to dispense prescriptions for members in clients’ prescription benefit plans.  **Caution:** While a member’s plan sponsor may have a pharmacy designated as the primary, on occasion orders will be transferred to another pharmacy based on type of medication or backlog volume between the pharmacies. (Check the pharmacy on the order to verify) |
| Dispensing Pharmacy | | Pharmacy that shipped the order (originating pharmacy). |
| Dispensing Prescriber | | A prescriber who dispenses medication directly to a member. The plan sponsor has the option of covering or not covering such medication. |
| Distributive Services | | These are medication delivery-related services performed by pharmacists including acquisition, storage, handling, and repackaging, dispensing, and administering medications. |
| Donut Hole | | Often used as a term to describe being in “Coverage Gap” stage of Med D accumulations. |
| Dose | | Unit of medication. |
| Dosing | | The quantity of medication to take at a time or per day. **Examples:**   * QD = One once a day * BID = Two a day * TID = Three a day * QID = Four a day * UD/AD = As directed * QOD = Every other day |
| Dropped Calls | | The beneficiary’s call is lost due to technology reasons or CCR accidently disconnects the call.  In this case attempt to call the beneficiary back using AUX code to resolve the issue. |
| Drug Benefit Design | | The structure and schedule of the drug coverage specifications used to adjudicate prescription claims. Some items included are Benefit Limitation, Plan member Cost Share, Drug Coverage/exclusions/exceptions, Maintenance Drug Coverage, Prior Authorization Requirements, and Overrides. |
| Drug Coverage Level | | A term that refers to the 4 phases of coverage that a beneficiary may move through based on spending accumulations. |
| Drug-Drug Interaction | | A potentially dangerous drug combination or a drug combination which requires special monitoring or dosage alterations of one or both drugs. When a potential drug-drug interaction is detected by the DUR system, an alert message is transmitted to the pharmacy through the RECAP or RxClaim system. |
| Drug Id | | We assigned identification number that uniquely identifies a group of drugs with a specific plan design. |
| Drug List | | Preferred brand name medicines that have been evaluated for effectiveness and safety (for example, side effects and drug-to-drg interactions) when compared to similar medicines. |
| Drug Lockouts | | A tool of the Performance Interventions (PI) program. An extension of drug selection management allows a sponsor to prevent reimbursement if a non-preferred drug is dispensed and can be applied in either Drug-Specific or Class-Specific ways. |
| Drug Misadventures | | Errors in ordering, transcribing, dispensing, and administering a medication to a member. |
| Drug Spend/Cost | | The combined total out of pocket cost paid by the plan and beneficiary.   * The beneficiary pays copays or coinsurance for their prescriptions. * The plan sponsor (client) pays the remaining balance of the cost of the drug. * Copays or coinsurance will continue to be charged until both the beneficiary and the plan sponsor (client) together have reached the specified Drug Spend amount. |
| DSI | | Software vendor coordinating transactions between prescriber’s offices and Medicare Part D plans for vaccine administration claims. |
| Dual Eligible | | Individual eligible for both Medicare and Medicaid benefits. |
| Dual Enrollee | | Beneficiaries that are eligible for both Medicare and Medicaid. |
| Dual Source | | Drug with more than one manufacturer for brand medication. A dual source drug “usually” does not have a generic substitution (same drug, different manufacturers). |
| Dunning | | The beneficiary is active in the plan but owes past due premiums. They are at risk of being disenrolled from their Medicare Part D prescription drug coverage. |
| Duplicate Eligibility | | Refers to file duplication in which a member has two or more records. When duplicate records exist, CCR’s must look at both, since there may be member history in any/all of the records. The CCR is responsible for placing a comment to request that the histories be merged. |
| Duplicate EOB (Explanation of Benefits) | | Duplicate of statement showing an itemized list of a member’s pharmacy benefit transactions. If member is requesting this statement, recommend to the member that they obtain an itemized printout of all their medications from their retail pharmacy. |
| Dynamic Dependent Creation | | Dynamic dependent creation is a process that allows a dependent to be added to a primary cardholder’s eligibility through claims submission from a retail or mail pharmacy.  The process allows a retail or mail pharmacy to create a dependent’s demographics (first and last name, date of birth, etc.) in PeopleSafe during the transmission of a claim. As long as the primary cardholder is eligible and has a coverage level that allows for dependents to be covered, the claim transaction will be successful. After successful transmission of the claim, the dependents demographics will be stored in PeopleSafe and viewable on the Main Screen.  To verify if a client is using this process, refer to plan member’s Plan Design. |

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