# Customer Care Abbreviations, Definitions and Terms – P

**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** |
| **P1** | Plan Member Letter | Letter for a plan member |
| **P2P** | Peer to Peer | The physician or clinical reviewer and the physician or other health care professional requesting authorization for coverage or to discuss a denial of a provider-administered medication pre-authorization request. |
| **P&P** | Policies & Procedures | A policy is a set of general guidelines that outline the organization's plan for tackling an issue. A procedure explains a specific action plan for carrying out a policy. |
| **PA** | Physician Associate | Medical professional who diagnoses an illness, develops, and manages treatment plans, prescribes medications, and often serves as a patient’s principal health care provider. |
| **PA** | Prior Authorization | A Prior Authorization (PA) or Exception is an approval process that benefit plans require for certain medications before they can be covered. A Prior Authorization (PA) or Exception makes sure that a member is getting the right medication for their condition. It may also help keep costs down, so they don’t overpay.  Requirements depends on the benefit plan. Here are common reasons a Prior Authorization (PA) or Exception may be needed:   * There may be a lower cost option that’s just as effective. * The medication has potential for misuse or abuse. * The medication is for certain conditions or diagnoses The requestor will not be able to request an Appeal prior to PA or Exception being completed and denied. |
| **PAAD** | Pharmaceutical Assistance to the Aged and Disabled | A state-funded program within New Jersey, as a part of the Department of Human Services. Helps eligible seniors and individuals with disabilities save money on their prescription drug costs |
| **PACE** | Program of All-Inclusive Care for the Elderly (PACE) | Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility. To qualify for PACE, you must be 55 or older, live in the service area of a PACE organization, need a nursing home-level of care (as certified by your state) and be able to live safely in the community with help from PACE. PACE covers all Medicare- and Medicaid-covered care and services, and other services that the PACE team of health care professionals decides are necessary to improve and maintain your health. |
| **PAF** | Prior Approval-FEP | Department (specific to the FEP client) that reviews submitted prescriptions and will dispense allowed quantities or will contact prescribers to request therapy information in order to determine coverage based on plan specification. |
| **PA-FEP** | Prior Authorization-FEP | Department (specific to the FEP client) that reviews submitted prescriptions and will dispense allowed quantities or will contact prescribers to request therapy information in order to determine coverage based on plan specification. |
| **PAH** | Pulmonary Arterial Hypertension Diagnosis /19 | A type of high blood pressure that affects arteries in the lungs and in the heart. |
| **PAL** | Patient Advisory Leaflet | Counseling Sheet that is part of the AMOS Print Packet. |
| **PAMC** | Prior Auth/Medical Certification | A management process used by insurance companies to determine if a prescribed product or service will be covered. |
| **PAP** | Patient Assistance Program | Programs created by pharmaceutical and medical supply manufacturers to help patients in financial need purchase necessary medications and supplies. |
| **PAP** | Pay As Presented | Method of claims reimbursement in which the claim is paid in full, whether or not the prescription is for a covered item. |
| **PAR** | Prior Authorization Queue | Department which addresses client specific prior approval guidelines. |
| Prior Approval Required | Medication requires a special review to determine if the plan will pay for it. |
| **PB** | Premium Billing | Billing that is processed the first week of the month prior to the coverage month and is due and payable on the first day of the coverage month. |
| **PBA** | Plan Benefit Attribute | Client-driven plan benefit guideline that defines plan benefits such as drug coverage, covered days’ supply, etc. |
| **PBM** | Pharmacy Benefits Manager | Refers to a business that helps to manage the drug benefit of a medical plan through various cost-containment efforts for different groups (employers, managed care organizations, health plans, unions, etc.)    An organization that manages pharmacy benefits offered by a health plan, insurer, or employer.  Acronym applied to companies such as our PBM who proactively manage drug benefits for insurance carriers, employers, HMOs, and other Managed Care organizations. PBM’s generally act as a health care consultant; provide member education; provide competitive pricing; and many other economic and service programs to manage this increasing important component of health care. \*Also known as (Pharmacy Benefit Management).    **theSource:** Refers to a business that helps to manage the drugs benefit of a medical plan through various cost-containment efforts for different groups (employers, managed care organizations, health plan, unions, etc.). |
| Pharmacy Benefits Management | An organization contracted to administer a Client’s prescription benefits, according to specific conditions set by the Client. Since prescription benefit costs are billed to, and paid by the Client at actual cost, a Prescription Benefit Manager’s primary objective is to assist the Client in controlling those costs. |
| **PBM Hold** | Pharmacy Benefit Manager Hold | All holds will be represented with an **Order Comment** explaining why it is being placed on hold.    **Note:** CII medications will **NOT** be placed on hold. |
| **PBO** | Plan Benefit Override | Refers to the process that enables either the Client’s Benefits Administrator or our staff when authorized to “override” a plan’s terms and conditions by applying a systematic override code. Upon entry of the override code, appropriate billing will be assigned to the client.    PBOs are used to approve or deny filling of a prescription by either a retail pharmacy or through mail order. It is an Account edit that allows general plan design limitations to be bypassed, permitting a claim to approve or pay. Some examples of plan design limitations include days’ supply, co-payment amounts, or refill restrictions. Plan Benefit Override availability is determined by the client.    PBO allows a covered medication to be filled (usually earlier than plan expected) rather than a PA which would be needed when the medication needs additional information to see if the plan would cover the medication. |
| **PBP** | Plan Benefit Package or Program Group Profile | Group of items for a member who is enrolled in a particular group. |
| **PBR** | Prescriber | A physician, dentist or other person licensed, registered, or otherwise permitted by the U.S. or the jurisdiction in which he or she practices, to issue prescriptions for drugs for human use. |
| **PBUM** | Premium Billing Invoice | Billing statement. |
| **PCI** | Payment Card Industry  Or  Payment Card Industry Data Security Standard | PCI data includes credit card number, cardholder name, expiration date, service code, PIN, card verification code (CVC2/CVV2/CID) and/or full magnetic stripe data. |
| Payment Card Industry Data Security Standard: Security requirements issued by the major card associations for merchants to ensure that payment card information (credit/debit cards) is secure from compromise or loss. |
| **PCL** | Paper Claims | Drug reimbursement claims filed via paper (usually filed by the member).    Member’s claims are adjudicated for those members with Paper Claims Benefits. Members file the appropriate completed our Claim Form and Pharmacy Receipts seeking reimbursement. Members may assign their benefits to a pharmacy in lieu of reimbursement to themselves. Paper claims are generally a result of a failed retail transaction, member not having their ID card etc. In certain instances Paper Claims is the only method of reimbursement such as International Claims, claims while on vacation such as an RX obtained on a Cruise Ship etc.    **Claims Eligibility Policy:** Our claims policy is to process claims only for dates of fill within our eligibility dates. We will not process claims for dates prior to the eligibility date with our PBM or change a previous fill date on a claim to the first date of our eligibility.    **Types of Member Claims:**     * **Standard Member Claim**- The member submits a completed Standard Claim form & pharmacy receipt(s). The total charge is considered against the plan benefits.   + Documentation submitted must at a minimum contain the following data:     - Fill Date     - NABP #     - RX #     - NDC or Drug Name     - Quantity and Day Supply     - Amount Paid for the prescription and/or Copay amount     - Member information     - Member name * **Coordination of Benefits Claims**- The plan design must have co-ordination of benefits & paper claims provisions. The member submits a completed Co-ordination of Benefit Claim form and at least one of the following: Pharmacy receipts indicating other insurance, an Explanation of Benefits from the Primary Insurer, a statement of cost from the primary insurer or a computer-generated cost summary from the provider of service.   + Documentation submitted must at a minimum contain the following data:     - Fill Date     - NABP #     - RX #     - NDC or Drug Name     - Quantity and Day Supply     - Amount Paid for the prescription and/or Copay amount     - Member information     - Member name * **International Claims**- The plan design must have international & paper claims provisions. The member submits a standard Claim Form and documentation to support the international claim.   + Documentation submitted must at a minimum contain the following data:     - Fill Date & Country in which the RX was filled     - NDC or Drug Name     - Quantity and Day Supply     - Amount Paid for the prescription and/or Copay amount     - Member information     - Member name * **Nursing Home Claims**- The plan design must have Nursing Home Benefits and Paper Claims provisions.   + Nursing Home claims refer to whether a client covers prescriptions dispensed by the nursing home pharmacy. If they (family member or nursing home) pick up the Rx at an in-network or out-of-network pharmacy they (the member or assignee) would submit a claim from the pharmacy that dispensed it, it would not tie to the nursing home benefit and be processed as a regular retail claim.   + The member, or in this case generally the provider of service (with assignment of benefits), submits a completed standard Claim Form.   + The fact that the member resides in a nursing home must be checked off (new block on new claim forms) or annotated on the claim. Nursing Home plan design provisions generally do not have restricted days supply’s etc. Documentation submitted must at a minimum contain:     - Fill Date     - NABP #     - RX #     - NDC or Drug Name     - Quantity and Day Supply     - Amount Paid for the prescription and/or Copay amount     - Member information     - Member name   + When a prescription plan member is in a nursing home, they still need prescription medication (in some cases the need is increased). Some nursing homes have internal pharmacies and some have contracts with local retail pharmacies for the dispensing of prescription medications. In almost all cases, the nursing home pays the cost of the prescription, up front, and then requires reimbursement.   + Some plans cover all nursing home costs through their major medical plans and do not cover the costs of prescription medications dispensed in a nursing home or rehabilitation facility through their prescription benefit plan.   + Some plans, however, do cover the costs of prescription medication dispensed in a nursing home through their prescription benefit plan.      * **Government Claims**   **Note:** Clients with PCL in their plan design cannot deny governmental claims reimbursements for their members who qualify for the program below. They must have assignment of benefits or another carrier reimburse the government.   * + Refer to Client Information – Plan Design for special exception processing.      * **VA Claims**   + Members who are VA eligible and elect to utilize their VA Benefits vs our PBM Benefits assign the PBM Benefits including any copay reimbursement to the VA. (Assignment of Benefits)   + The VA does not bill Medicare under any circumstance.   + Public Law 99-272 Prohibits Federal Agencies from billing Medicare.   + The VA is responsible to file a claim with the carrier identified by the member for the VA’s cost of care.   + We as the member’s carrier processes the HCFA 1500 submitted by the VA and reimburses the VA according to the clients plan design benefit.   + The VA requires the veteran to pay a co-payment for all outpatient prescriptions of 30 days or less for use in treating a NON-SERVICE connected disability or condition. These co pays are the veterans’ responsibility and not reimbursable by us. * **Medicaid**   + We process Medicaid Claims for members that are eligible for RX benefits through our (Retail) and have Paper Claims benefits. The member who is eligible for State Assistance (Medicaid) assigns their benefits to the state.   + When the member is eligible to receive State Aid, they can go to a retail pharmacy and obtain their prescription with their Medicaid Card paying no co pay or minimal co pay. The pharmacy submits the claim to the State and is reimbursed. The State in turn files a claim with our PBM under pay & pursue procedures to recoup their cost.   + Medicaid Co pays are the responsibility of the Medicaid Member and not reimbursable.   + We as the client’s agent for RX benefits must reimburse the State. The State is always the payor of last resort and was authorized assignment of benefits by the member to participate in the Medicaid program.   + We reimburse the State the plan benefit amount or Medicaid paid amount, whichever is less. When the plan benefit amount is more than the Medicaid Paid amount, the claim is adjusted down to the Medicaid Paid Amount. Medicaid is never reimbursed more than they paid.   + Medicaid claims are not subject to a stale date and are calculated as in-network in determining the benefit. * **Medicare**   + We process Medicare Claims as secondary for clients with Co-ordination of Benefits provisions. A Co-ordination of Benefits Claim form is submitted to us with the Medicare EOB attached.   + When a member is Medicare eligible and utilizes their Medicare Benefit the provider of service submits a claim to Medicare to be considered. Effective July 2001, by law members cannot submit a claim to Medicare.   + If Medicare Eligible, Medicare reimburses the provider of service 80% of the Medicare Allowable and forwards an Explanation of Benefits to the provider of service & member. The remaining 20% of the Medicare allowable can be considered against our PBM plan benefits when the provider of service or member submits a Co-ordination of Benefit Claim form to us with the Medicare EOB attached.     **Our Explanation of Benefits & Checks:**   * Claims are adjudicated Monday through Friday during business hours of 6:30 AM to 4 PM CST. * Upon adjudication files are downloaded twice weekly to a Third Party Vendor. * The third party vendor produces the explanation of benefits and checks. * The files run on Tuesday night into Wednesday morning, and Friday night into Saturday morning. * The explanation of benefits and checks are mailed on Wednesdays and Saturdays of each week. * Refer to Plan Design for specific coverage. |
| **PCN/Proc Ctrl** | Processor Control Number | A secondary number on a health insurance card that is used to route pharmacy claim transactions for health insurers. If customer has prescription coverage, then the plan must have a BIN or PCN |
| **PCP** | Primary Care Prescriber or Physician | Initial care giver and who may make referral decisions for the client (aka ‘PCP,’ ‘gatekeeper,’ ‘PCM’ or primary care manager).    PCPs are not usually specialists, rather they are general or family practitioners, doctors of internal medicine, pediatrics or OB/GYN. Nurse practitioners and prescriber’s assistants can also be PCP’s. |
| **PCRS** | Prescription Claim Reimbursement Statement | Supplies the claim(s) data for any prescriptions processed by Paper Claims in RxClaim. This statement provides claim numbers, drug, dates of fill, and status of the claim. |
| **PCSK9** | Proprotein Convertase Subtilisin/Kexin Type 9 | Name of medication used to help regulate/reduce cholesterol.     PCSK9 Drugs are no longer distributed by CVS. |
| **PCT** | Prerequisite Contingent Therapy | Before allowing a plan member to receive the drug on the claim, the plan member is required to use other prescription therapy for a specified duration and within a specified period of time. |
| **PCUG** | Plan Communications User Guide | <http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html>  (Also noted under [Other Resources](https://thesource.cvshealth.com/nuxeo/nxfile/default/c1f1028b-e42c-4b4f-a4cf-cc0b42c91606/ncf:generated_pdf/HD%2017428%20Customer%20Care%20Abb%20and%20Definitions%201-4-22.docx.html?changeToken=10735-0&inline=true#_Other_Resources)). |
| **PD** | Previous Denial | A denial was received from the prescriber previously to the same question. |
| **PDE** | Prescription Drug Event | Every time a beneficiary fills a prescription under Medicare Part D, a prescription drug plan sponsor must submit a **summary record** called the prescription drug event (PDE) data to CMS. The PDE data are not the same as individual drug claim transactions but are summary extracts using CMS-defined standard fields. |
| **PDL** | Preferred Drug Lists | Refers to medications that may be on a formulary in a multiple tier benefit design that allows for co-payment at the time of service equal to that charged for second-tier or midlevel cost.    **Example:** A member would pay the next highest co-payment for the preferred drug after the generic co-payment amount, not the highest co-payment overall in the benefit plan.    An economically modeled, clinically approved subset of our national “Clinical Formulary and Prescribing Guidelines.”  The list meets the needs of at least 85% of members requiring therapy in a given therapeutic class. |
| **PDP** | Prescription Drug Plan | A standalone plan that only covers prescription drugs. |
| **PDS** | Potential Direct Sales | direct sales program offered to beneficiaries of clients whose pharmacy benefit plan does not cover certain medicines or products but does provide access to them at a discounted price. |
| **PE** | Prescription Entry | Formerly known as “general translation.”  This is the area in which submitted prescriptions are entered into the LINKS system. |
| **PENCD** | Plan Enhancement for Non-Covered Drug Program | Program enhancement that offers plan member discounts on drugs not covered through their funded plan. Refer to the CIF for specific information for that member.  **Note:** If a member calls in about this, please DO NOT refer to this as PENCD. This is internal jargon only. |
| **Pend** | Pending | Awaiting further review or still under initial review. |
| **Percentage AWP** | Percent of Average Wholesale Price | Percentage of AWP to be reimbursed by the Plan. |
| **Per HX** | Per History | Based on existing drug history. |
| **Per PPT** | Per Participant or Per Participant Request | Request/communication made by the member. |
| **PFFS** | Private Fee For Service | A type of Medicare Advantage Plan that allows beneficiaries to use any doctor or hospital anywhere in the country as long as that provider accepts the plan’s terms and conditions. This plan must cover all Medicare benefits and may offer additional benefits. |
| **PG** | Page | A single side of a piece of paper. |
| **P/G** | Plan and Group | Identified the plan and group of the member. |
| **PGST** | Performance Group Step Therapy | Formerly known as Performance Step Therapy. |
| **PM** | Processing Month | Month in which the prescription was processed. |
| **PHD** | Pharmacy Help Desk | Receives phone calls from retail pharmacies, requesting assistance with retail pharmacy electronic transaction, rejected claim resolution, claim adjudication, triage support regarding pharmacy payment, network enrollment and any other general contract support. |
| **PHI** | Protected Health Information | Health information that is individually identifiable. **Examples** of PHI include (but are not limited to) SSN, DOB, name, Rx #, and drug name. |
| **PHX** | Phoenix mail facility or Phoenix Call Center | Our mail order pharmacy and Phoenix Customer Care Call Center in Phoenix, AZ. |
| **PIC** | Pharmacist in Charge | The licensed pharmacist whose name appears on a pharmacy license and who is responsible for all aspects of the operation related to the pharmacy. |
| **PII** | Personally Identifiable Information | Any piece of information which can potentially be used to uniquely identify, contact, or locate a single person. |
| **PITT** | Pittsburgh Call Center | Location of a Customer Care team. |
| **PJ** | Pharmacist Judgment | Used by pharmacists when using professional judgment on illegible prescription information. |
| **PKI** | Public Key Infrastructure | A structure under which a certification authority verifies the identity of applicants; issues, renews, and revokes digital certificates; maintains a registry of public keys; and maintains an up-to-date certificate revocation list. |
| **PLE** | Plan Limit Exceeded | Surpassed a plan design limitation. |
| **PLN** | Plan Design | Benefit plan limitations set by the client  Refers to the terms and conditions for prescription benefit coverage according to the contracts between us and the Client organization. General terms and conditions for each plan can be found in each Client’s file, although final adjudication of all claims will be according to the Plan Benefit Administration (PBA) code.    Plan Design defines co-payment amounts, drugs covered, deductible, delivery systems that can be used and many other details regarding how each member can use their benefits plan. |
| **PLS** | Please | A function word to express politeness or emphasis in a request. |
| **PM** | Processing Month | Month in which the prescription was processed. |
| **PMA** | Pharmacy Management Application | DEA uses it defining the system or application performing EPCS functions. Consists of data bases and applications, etc. |
| **PMP** | Prescription Monitoring Program | The New York State Department of Health’s Bureau of Narcotic Enforcement maintains an online PMP Registry. This online program allows prescribers to review patients’ recent controlled substance prescription history at any time, giving them more information to exercise professional judgment in treating patients. |
| **PMPM** | Per Member Per Month | Common unit of measure by which comparisons may be made across groups or differing health care organizations. In a capitated health plan, it is the amount prepaid to a provider for each subscriber, regardless of services actually used. |
| **PMT** | Payment | Various forms of monies to be applied to an order.   * Visa * MasterCard * Discover * American Express * Personal Checks * Money Order or Cashier’s Check * Voucher/Coupon * Any available credit on account * Electronic Check |
| **PNR** | Performance Network Program Trimester | Retail Pharmacies receive PNR reports because they participate in one or more Performance Networks for the plan year. |
| **POA** | Power of Attorney | Power of Attorney is a legal document, which authorizes the designated individual to manage **all** aspects of a member’s account. This form should be suggested in instances when the member feels a representative should have access to unlimited PHI and authorization to make changes to the account, such as address and payment changes.     A POA must be specific to medical or healthcare decisions.  Valid until authorization is revoked or member is deceased. |
| **POD** | Point of Dispensing | Ability of a prescriber to prescribe and dispense medication electronically. |
| **POS** | Point of Sale | Refer to retail location transactions. |
| Pharmacy electronic billing systems. |
| **POW** | Powder | A form of dosage for medication, typically used in compound medications. |
| **PP** | Per Profile | Information found on mail order service forms. |
| **PPACA** | Patient Protection and Affordable Care Act (PPACA) aka Affordable Care Act (ACA) | The comprehensive health care reform law passed in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law. |
| **PPI** | Proton Pump Inhibitor | A therapeutic class of drugs to include used to treat various stomach / esophageal conditions. |
| **PPLSFE or PSF** | PeopleSafe | The system that we use at CVS/Caremark to pull up member accounts in order to place orders, look at plan design information, check current balances, apply overrides, submit tasks to other departments, and more. |
| **PPN** | Preferred Pharmacy Network | This plan design allows members to receive lower copays if they used a preferred pharmacy. |
| **PPO** | Preferred Provider Organization | Organization that establishes contracts with a network of prescribers and hospitals to provide healthcare services to enrolled members at a predetermined fee. PPO members must pay additional fees for utilizing services outside the network. |
| **PPS** | Pharmacy Professional Service | The services provided by the pharmacists in monitoring of prescription, poison control centers, storage, distribution, drug procurement, counselling of patients, dispensing of medicines, drug utilization review, and evaluation for the betterment of patients. |
| **PPT** | Participant | Refers to plan benefit members or patient. |
| **PPT Calls** | Participant Calls | Telephone calls to themember to obtain necessary information for order processing or to communicate order information. |
| **PPT ID** | Participant ID | Unique ID assigned to the member by the Vendor. We will not be able to search by this ID. It is of no utility to our CCRs. |
| **PPT Ltr** | Participant Letter | One of our communication instruments with the member. |
| **PPT Svcs** | Participant Services | Department at the mail facilities that is the liaison between the member and Customer Care responsible for executing special requests or in resolving issues. |
| **PPV or PV2** | Pharmacist Product Verification | Pharmacist function in the dispensing area of the pharmacy whereby the pharmacist verifies that the drug inside the bottle matches the bottle label. |
| **Prev Hx** | Previous History | Refers to past drug history. |
| **PRC** | Pharmacy Resource Center | Telephone intervention service provided to Event-Based and Savings Guaranteed Performance Network pharmacies, to assist them obtaining prescriber approval for drug interchange. |
| **PRC** | Possible Region Change | Identifies a possible region change. |
| **PRN** | As Needed | Refers to taking drugs only when symptoms occur as opposed to routinely. |
| **PRU (replaced SRU)** | Presidential Recovery Unit (Replaced Service Recovery Unit) | The goal of the Presidential Recovery Unit is to improve the member experience through the resolution of escalated issues and the elimination of controllable issues. It is an internal group committed to swift validation of member issues and reporting of findings.  POLICY: The CVS Caremark Policy is to refer any compliant that meets the following criteria for the Presidential Recovery Unit to create a case, perform a thorough investigation, and maintain records of all escalations received. This process is inclusive of any client guarantee requirements. |
| **PS** | Participant Services | The department at the mail facilities that is the liaison between the member and Customer Care responsible for executing special requests or in resolving issues. |
| **PSAO** | Pharmacy Services Administrative Organization | Legal network of pharmacies that contract with health plans, insurers, or employers to provide medication services for plan subscribers. |
| **PSC** | Product Selection Code | Standard codes defined by the National Council for Prescription Drug Programs (NCPDP). A PSC/DAW code is submitted for each claim. The code defines the basic reason the drug was selected such as:   * 0 – NO PSC indicated * 1 – Dispense as Written by the prescriber. Prescribed selected brand. * 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 (product not available) * 9 – Other     In addition, the codes may influence pharmacy reimbursement and member co-payment in MAC programs. Individual state regulation may affect PSC/DAW codes. |
| Professional Service Code | For POS safety review for reject codes for pharmacists. |
| **PSCO** | Patient Services Call Questions (1st, 2nd, or 3rd, day Patient call) | Indicates whether this is the first call, second call, or third call being made to the member regarding a question on a prescription/order. |
| **PSD** | Post Ship DAW | A conflict description where the prescriber had previously approved the generic substitution. |
| **PSM** | Post Ship MP | A conflict description where the prescriber had previously approved a prescription change pertaining to the Custom Care Mail (CCM) program. |
| **PSO** | Post Ship OTC | After shipping over the counter |
| **PSP** | Preferred Specialty Pharmacy | To maximize the patient benefit of drug treatments, preferred specialty pharmacy networks are used to deliver high-quality, accessible pharmacy services. Both may similarly limit the number of pharmacies that may dispense and manage patients on a certain specialty drug. |
| **PSQ** | Participant Services Queue | The queue for the team that handles member callbacks when they are sent automated messages/emails. |
| **PSR** | Patient Services Representative | Responsible for a variety of activities related to patient intake and care. They work in medical offices and serve as the first point of contact for patients entering the facility. |
| **PSSC** | Physical Security Support Center | [PhysicalSecuritySupport@CVSHealth.com](mailto:PhysicalSecuritySupport@CVSHealth.com) (Important email to report any security related issue). |
| **PST** | Post Ship TIP | A conflict description where the prescriber had previously approved the formulary request. |
| **PTV** | Pharmacist Translation Verification | Pharmacist function in the front end of the pharmacy whereby the pharmacist verifies the computer Rx information matches the original Rx written by prescriber. |
| **PUE** | Prior Use Exception | Applies to Commercial plans **ONLY**. Must be verified if allowed by the Client in the CIF:  Allows for a short-term override for formulary-excluded drugs for net new clients that adopt this strategy.  Disrupted members (those who are taking a medication that will be excluded under the CVS Caremark formulary) whose plan benefit allows for member initiated PUE will receive a letter that their drug will not be covered under the new plan.  The letter instructs members to talk with their prescriber and obtain a new prescription for a preferred medication.  It also contains verbiage that if extra time is needed to talk with their prescriber, they can call Care to request a temporary override.   * If the client allows for PUE, overrides are available for any formulary-excluded drug.  The override can be used regardless of where the member is filling.  **Example:**Specialty, Mail Order, Retail * Most clients who use the PUE strategy allow for overrides up to (usually 90 but can be verified in the CIF) after go-live date. |
| **PV** | Pharmacist Translation Verification | Pharmacist function in the front end of the pharmacy whereby the pharmacist verifies the computer Rx information matches the original Rx written by prescriber. |
| **PVC** | PV-Clinical | Clinical Team. |
| **PVE** | Pharmacist Verification Exception | Queue utilized by a pharmacist in Pharmacist Translation Verification where they can request that the prescriber be contacted for additional clarification on a prescription. |
| **PVN** | PTV Non-Conversion or Prescription Verification Non-Clinical | Prescription Verification Non Clinical - When a prescription is in process in LINKS, i.e. PeopleSafe, and there is a question with the prescription itself, (meaning, we are unsure of the dosage, MD DEA# is not legible, we cannot read the name of the medication, etc.), it will go into “Divert-PVN” to determine if we need to contact the prescriber, have a pharmacist double check the prescription, etc. |
| **PWO** | Payment without order | Order does not have a form of payment. |
| **PWO** | Premium Withholdings | Related to Medicare. The amount taken out of the Social Security payment monthly to pay for medical plan. |
| **PWS** | Premium Withhold System |  |

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| **Term** | **Definitions** |
| Plan Sponsor | The client which may be the primary member’s employer of health plan. |
| Package Size | This references the weight, volume or sometimes number of uses contained within a package. The package size of a medication can be found on the Drug Details and the Test Claims Screens within PeopleSafe. |
| Paid Incentive Fee | For vaccine claims that include and administration fee for a provider’s administration of the vaccine to a beneficiary, the paid incentive fee is the fee the plan pays based on the submitted incentive (administration fee) for the provider’s service. |
| Part D Late Enrollment Penalty Reconsideration Request Form | The LEP reconsideration request form is sent by the Part D plan sponsor at the same time it sends an enrollee the “LEP Notification Letter” notifying him or her about the imposition of an LEP.  The beneficiary sends his or her completed and signed LEP reconsideration request form to C2C Innovative Solutions, Inc., an Independent Review Entity (IRE) under contract with Medicare in accordance with the filing instructions provided on the form.   * If after the 90-day attestation period has expired and the beneficiary disagrees with the penalty amount or in cases where a beneficiary has an LEP assessed by a prior MED D, prescription drug plan, the beneficiary can submit an LEP reconsideration form to the IRE, C2C, to be considered for an appeal. |
| Partial Quantity | A Therapy Protocol medication filled for less than the Full Quantity because:  Rx was written for less than the Full Quantity  Rx was filled for a partial quantity the last time it was filled (Last Date of Fill) |
| Participant Hold Indefinite | Member has not specified a date (only indicates to hold it). |
| Participant Hold Until | Member requests a hold until a specific date. |
| Participant ID | Member ID; Unique numbers and sometimes (alpha) characters identifying each client’s plan members eligible for pharmacy benefits. Often is the member’s social security number. Privacy compliance and confidentially of Member IDs is of paramount importance to us and our clients. |
| Participant Profile | Refers to a specific set of information maintained in the systems data files. Participant profile information includes drug allergies, diagnosis, and conflict rules that apply to the member. |
| Participating Provider | Prescribers and pharmacies who have signed agreements with an insurer to accept the insurer’s payment for services as payment in full. |
| Pass Thru | (Transactions verified first) Clients that request we adjudicate or check for validity their claims, but to pass the claims on to the client, to process the billing and reimbursement of the claims. |
| Payer | Entity which is liable to pay for the medical costs of injury, disease, or disability of a recipient. |
| Payment Exception | Divert that occurs after adjudication has completed due to payment issues. |
| Pen Needle | A hollow needle which is embedded in a plastic hub and attaches to injection pens |
| Performance Health | Series of disease prevention and management programs that help members with chronic disease. |
| Performance Mail | Variety of programs whereby the distribution of specific drugs to plan members may be achieved through the use of one of our Mail Order pharmacies. |
| Performance Rx | System of incentives and cost-containment devices designed to encourage payers, drug manufacturers, pharmacists, plan members, and prescribers to work together to help control the cost of prescription-drug benefits.  The Performance Rx package has three main components:   * **Performance Network** - A national network of chain and independent pharmacies that have agreed to deliver enhanced dispensing performance to our customers * **Performance Drug List** - A subset of our national Clinical Formulary that contains drugs identified as the most effective from a clinical and cost standpoint. The Performance Drug List includes therapeutic classes that cover 70 percent of a typical member population’s drug therapy needs * **Performance Drug Interventions** - Influence activities that guide members and prescribers toward the most clinically appropriate, cost-effective medications.   The Performance Rx players are:   * Payers * Members * Prescribers * Pharmacists * Pharmaceutical Manufacturers |
| Person Code | All members of a Family Plan will use the same health insurance card information that allows healthcare providers to verify coverage, arrange payment for services and answer questions about claims and benefits. There will be identical Member ID, BIN, PCN and GRP numbers, but the person codes (last two digits of ID) will be unique to each member on a specific account. The person code if you’re the policyholder might be 00 or 01, while dependents on the policy might have numbers ending in 02 (spouse), 03 (child), 04 (child), etc. |
| Personal Choice Drug | A drug that is a choice because it might improve a member’s life, function, or appearance as opposed to a drug taken to cure or manage an illness. |
| Pharmacare | Pharmacy Benefit Manager (PBM), subsidiary of CVS Health. Name of the PBM for Legacy our Mail Order Clients, operating on a different platform than PeopleSafe. |
| Pharmaceutical Care | Represents a wide range of pharmacist services (assessment, monitoring, education, etc.) that promote comprehensive, coordinated management of a member’s medication use with the goal of optimum outcomes. |
| Pharmacoeconomics | Field of study and set of methodological tools for comparing costs and outcomes of drug or service utilization. The three most common types of analysis are cost-minimization (avoidance), cost-benefit, and cost-effectiveness. |
| Pharmacoepidemiology | Field of study and science of determining or promoting appropriate pharmaceutical intervention(s), either on a member population or individual member and prescriber basis. |
| Pharmacology | Science of dealing with the chemistry and physiologic use or effects of a medication in humans. |
| Pharmacy Audits | Analysis of specific pharmacy records and data conducted by our specially trained auditing team at the individual pharmacy location. The purpose of such audits is to verify pharmacy compliance with established our standards for filing claims and receiving reimbursement. |
| Pharmacy Billing & Payment | Invoicing to and collection of Pharmacy fees due. Disbursement of funds to a Pharmacy for products/services delivered/rendered to a plan member under the drug pricing & reimbursement terms of the Pharmacy Network selected by the Insurer of the plan member. |
| Pharmacy Chain | Group of pharmacies centrally owned and operated to deliver prescription drug dispensing and related services under a common company name. |
| Pharmacy Closed Panel | Listing of pharmacies who will participate in a client’s program. The pharmacy will be listed by name and pharmacy number. |
| Pharmacy Database | Database containing information pertaining to each individual pharmacy, such as pharmacy name, type of pharmacy, method of claims submission, payment method, etc. Statistical information on the number of paid claims and rejects for each cycle, as well as adjustment totals, is also provided. This database is usually used in conjunction with the Chain Database and Address Database. |
| Pharmacy Fees | Base rate charged by us to a participating pharmacy for our service rendered. Generally consists of per claim base administrative charge, enrollment charge, activation charge, and claim audit charge. (Relating to Administrative Fees) |
| Pharmacy Generic Incentive | Utilization of specific financial incentives and/or increased dispensing fees or reimbursement levels for the purpose of encouraging pharmacy behavior in the direction of generic substitution wherever possible and appropriate. |
| Pharmacy Innovation Company | Being a Pharmacy Innovation Company includes:   * Offering of information to plan members so they can take full advantage of their benefits. * Delivering of personalized savings and health opportunities. * Giving plan members better and more personalized advice on managing their health and their health care costs. * Building strong relationships with plan members at every point of interaction, i.e., on the phone, by mail, online, and at retail. |
| Pharmacy Leaflet | The paper document that lists the member’s name, prescriber name, pharmacy address, medication name and quantity, and last fill date and other information related to the prescription. |
| Pharmacy Network | Identifies the retail Pharmacy Network assigned to the client’s prescription benefit plan. Generally, clients choose one of our “standard” networks (National Network or CareSelect); however, clients may also determine their own “custom” network for their retail prescription benefits.  Includes pharmacies who have agreed to dispense prescriptions for the membership of the PBM’s clients. When a PBM contracts with a pharmacy, the agreement includes two things:   * Drug Ingredient Cost * Dispensing Fee   Pharmacy services vendors, such as a group of community pharmacies that have contractual arrangements with a PBM or insurer to provide medication and/or pharmaceutical care services to a covered population.  A group of pharmacies that agree to dispense cost-effective medications at a special reimbursement formula. We have several pharmacy networks of different sizes and with different levels of pricing to meet the varying needs of its customers. Pharmacy can participate in several networks. |
| Pharmacy Master | Database gives detailed pharmacy information. It contains such information as the pharmacy address when they became a plan member pharmacy and if the pharmacy is part of RECAP and RxClaim networks. |
| Pharmacy Missed Opportunities | Information on incidents where opportunity for drug interchange as advised by us was not acted upon and caused a pharmacy to lose a reward. |
| Pharmacy Number | Identifying number assigned to each member pharmacy. The first two digits identify the state and the last four identify the pharmacy.  The identifying 6-digit number assigned to each pharmacy on the Pharmacy database. The first two digits identify the state code and the last four digits identify the pharmacy within the state.  If the first two digits of the pharmacy are “61” through “66”, the pharmacy is a Mail Order Pharmacy. If the first two digits are greater than “87”, the pharmacy is Canadian. A 7th digit, the check digit, is not currently used. |
| Pharmacy Network Selection/Design | Insurer (Insurance Carrier, Self-Insured or Managed Care Organization) selection of existing Pharmacy Networks as primary, secondary, and tertiary (3rd insurance) or upon an Insurer’s request tailoring a Pharmacy Network to fit their needs. If member does have additional insurance, they can fill for COB if plan allows. |
| Pharmacy Payment | Payment of funds to a Pharmacy for products/services delivered/rendered to a plan member under the drug pricing and reimbursement terms of the Pharmacy Network selected by the insurer of the plan member. |
| Pharmacy Practice Standards | Specific requirements developed by the U.S. governing the performance of its pharmacists and operations of its home delivery pharmacies to ensure the delivery of high-quality service to members. |
| Pharmacy Receipt | The paper copy of what was purchased at the retail pharmacy that is printed by the cash register. |
| Pharmacy Reimbursement | Total amount paid to the pharmacy by the insurer. This amount usually is the ingredients cost plus the dispensing fee minus the copay. |
| Phase III Client | Term sometimes used within the CIF for Clients when Eligibility is handled by their Benefits Office. |
| Phase III Client List | Archived list of Phase III Clients that is no longer utilized. |
| Phone Log In ID | ID assigned to specific telephone extension for a user to be identified with the acceptance of incoming phone calls or to record certain data. |
| Placed Order | An order that has been placed but not yet moved to the Main screen and is viewable in the Refill Status screen. Stop Sees can be used on placed orders not showing on the Main Screen. |
| Plan | Outline of covered items, dispensing limitations, and payment guidelines contained on the Plan database, as determined by the Plan Sponsor. |
| Plan Changes | Signifies any changes that a client might want to make with their plan. Both the client and Advance must be in agreement to any and all changes to the plan. |
| Plan Database | Database contains a description of all our plans. It includes what drugs are and are not covered by the plan, if a cost containment program is part of the plan, and the dispensing limitations. |
| Plan Exclusion | List of drugs that are not to be covered under a client’s specific client plan |
| Plan Number/Plan Code | Number assigned to allow processor to store pertinent information about the items that are covered/non-covered, insulin NDC specials, NDC exclusions and inclusions, refill age limits, prior authorization limits and processing DAW codes. |
| Plan Member Identification Information | Information for our plan members, including account numbers, addresses, and social security numbers. |
| Plan Sponsor | Health care and prescription benefit organizations which apply to the Center for Medicare & Medicaid Services in order to create a Medicare Part D plan. |
| Point of Prescribing | Ability of a prescriber to prescribe medication electronically. |
| Practice Guidelines | Systematically developed policies, treatment protocols, or critical care pathways that are issued in advance of delivery of health care services that promote appropriate, rational utilization of services or medications to a member population. |
| Praluent | Brand name for a PCSK9 medication used to help regulate/reduce cholesterol.  PCSK9 Drugs are distributed by CVS Retail and In Network pharmacies. Mail Order and Specialty no longer fill these medications. |
| Pre-Auth Programs | Some plans require a pre-authorization by the plan before certain medications will be covered by the plan. Generally, pre-authorizations are tied to an appropriate diagnosis (i.e., The medication is considered “medically necessary” and is being prescribed in accordance with pharmaceutical guidelines), but some are also tied to clinical programs (CustomCare Mail, and CustomCare Retail). See Client Plan Design. |
| Precertification | Also known as Prior Authorization. |
| Pre-enrollment | The beneficiary does not have a completed application on file, which means they will not have an active account in PeopleSafe. |
| Premium | The monthly amount to be paid by the Beneficiary for coverage. |
| Premium Subsidy | When qualified for Low Income Subsidy, the beneficiary is eligible for financial assistance towards their monthly Part D premium.    One of the following percentages (0%, 25%, 50%, 75%, 100%) will display in MARx, indicating how much financial assistance the beneficiary will receive towards their premium. |
| Prescriber Acceptance | Health care provider approval that is required for member participation in a health management program. |
| Prescriber Dispensing | Client has the choice of covering prescriptions dispensed in a prescriber’s office.   * No coverage for medication dispensed in a prescriber’s office. * All medications dispensed and consumed in a prescriber’s office. * Medication dispensed in a prescriber’s office but no coverage for medication consumed in the prescriber’s office. |
| Prescriber Hold Until | The prescriber is expected to respond by a certain date. For example, the prescriber is on vacation, but will respond within one week |
| Prescriber Hold Until  Delayed Prescriber Response | Involves the handling of incomplete prescriptions that require clarification from the prescriber. There are two types of Delayed Prescriber Response Hold:   * Prescriber Hold Until * Prescriber Indefinite Hold |
| Prescriber Indefinite Hold | The future response date is unknown. For example, we may hear back from the prescriber several days after the prescription is placed on hold, or it might be weeks until a response is received. |
| Prescriber Number | Identification number used primarily by HMOs to uniquely identify each prescriber in their network in order to facilitate rejection of claims received for services rendered by a non-plan member prescriber. It may or may not be the prescriber DEA#. The prescriber number may be used to sort reports prepared for the HMO. |
| Prescriber Profiling Plus | This program identifies prescribers whose prescribing patterns fall outside the standard of care guidelines, within specific disease categories. Prescribers are then provided with educational materials and more in-depth peer comparison analyses within specific disease states to better detail the clinical and cost issues at stake in prescribing medications.  A means of comparing prescribing behaviors (or other medical orders) among prescribers in order to benchmark and/or improve quality of care. Prescriber information is often sorted by specialty or diagnosis, and profiling can be used in a managed care setting as an incentive for quality improvement. |
| Prescriber Request Hold | The prescriber cannot postdate a prescription; however they can request the prescription not be filled until a specific date. |
| Prescription History | This is a request that requires prescription information in addition to the dollar amounts. A Prescription History report includes the following information:   * Pharmacy Name * Fill Date * Rx Number * NDC Number * Drug Name * Drug Strength * Quantity Dispensed * Total Gross Cost * Total Member Cost * Total Net Cost |
| Prescription Medication | These medications are available and allowed to be marketed in the United States by the FDA. They require an authorized prescriber’s prescription for that drug to be dispensed to a member. |
| Presidential Recovery Unit | A nice piece of news is considering this request came directly from the Presidential Response Unit, we have been given approval from our leadership team to post these updates without having to get individual approvals from your subcommittee chairs.  POLICY: The CVS Caremark Policy is to refer any compliant that meets the following criteria for the Presidential Recovery Unit to create a case, perform a thorough investigation, and maintain records of all escalations received. This process is inclusive of any client guarantee requirements. |
| Preventative Care | Comprehensive care, such as vaccinations, annual exams and prescreening programs that emphasize prevention, early detection, and treatment of conditions. |
| Preventative Medicine | Efforts directed toward the prevention of disease. |
| Preventative Drug List | A list of drugs that have been approved by the Food and Drug Administration (FDA) to be used in the prevention of various medical conditions. This list includes drugs that are used for a Preventative purpose the majority of the time. However, there may be drugs on the list that may be used for non-Preventative purposes. Once implemented, drugs on the Preventative Therapy List will automatically bypass the deductible at the point-of-sale and process with the applicable co-pay or co-insurance instead. The copay or coinsurance paid for Preventative drugs will accumulate toward a member’s Out of Pocket (OOP) limit.  **Note:** The client determines if the drugs on this list will bypass the deductible. |
| Primary Address | Address the member has identified as the principal location to send his/her mail orders. It was formerly called Mail Order Default.  Common examples of what a member may say to reveal a primary address type include:   * “My new address is…” * “I have moved to…” * “Please update my address to…”   If member uses a Mail Order Form to place a refill order, advise the caller you can onlyupdate his/her individual address and those for any minor children.  Confirmation is required from the other adult members on the account before their individual addresses can be changed. |
| Primary Coverage or Primary Insurance | The main (primary) insurance used to cover a member.   * All claims must process through the primary insurance before it can be processed by the secondary insurance. * All claims will reject in the secondary insurance if not processed through the primary insurance first.   **Note:** A member may carry two insurance policies and consider one to be primary and the other to be secondary.   * Unless an account is coded as being secondary, primary rules will apply. * If second account is *not* coded as secondary, it will be treated as a primary account.   Any claims processed on a second (not secondary) account will be subject to all adjudication rules of that account but will not reject because it was not submitted to the primary account first. |
| Primary Plan Member | Person through whom our prescription benefits originate. Usually, this person is an employee of the client (either active or retired), but not always since the client can sometimes be a union or trade association, or an independent insurance company (such as Cigna, Blue Cross/Blue Shield, Prudential, etc.). |
| Primary Prescriber Number | Primary provider as selected by the insured, who is authorized to prescribe drugs. This is usually a DEA number. |
| Prior PBM | Prior PBM sends us open/in-process RX and we do the same when a member leaves us. We do not do this today for controlled substances. |
| Premium Billing Statements | A statement is similar to an invoice, a statement has 24 months of payment details, and an invoice only captures the current month’s premium. A statement must be requested as needed by the beneficiary and cannot be sent out automatically each month for beneficiaries enrolled in auto-pay options. |
| Premium Billing Invoices | An invoice is similar to a statement, an invoice only captures the current month’s premium, and a statement has 24 months of payment details. A copy of an invoice must be requested as needed by the beneficiary. Members enrolled in an auto-pay option may request a statement as invoices are not generated. |
| Proposal | Document provided to clients or potential clients in response to a Request for Proposal or RFP. It contains information on the vendor interested in supplying a service and responses to the questionnaire that usually comes with the RFP. |
| Propylthiouracil | \*\*Do not Abbreviate  Drug name – error prone – never abbreviate. An anti-thyroid agent. |
| Prospect | Someone who is eligible for Medicare D |
| Protected Health Information / Disclosure | Request that requires the total information that we have on file for the member regardless of what division they have contacted or have utilized. This is an all-inclusive report. The report should be available for printing within two business days. |
| Protocols | Guidelines for specific treatment options once a diagnosis has been made that are designed to obtain the best overall outcome in the majority of cases. See Practice guidelines. |
| Provider(s) | Person or place licensed to deliver health care services. Include but are not limited to Physicians, Nurse Practitioners, Hospitals, Long Term Nursing Care Centers, etc. |
| Pull Through | Pull through happens when the sale or use of one product “pulls through” the purchase or use of another.  **Example:** Purchase of a car could also trigger the purchase of tinted windows and keyless entry. |

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