PTCB Billing and Reimbursement Assessment-based Certificate Exam Content Outline for Public Use

Programs and Eligibility (26.67%)
Insurance programs and terminology (e.g., Medicare [Parts A, B, and D], Medicare Advantage, Medicaid [MCO, FFS], private insurance [HMO, PPO], copay, coinsurance)
Third-party reimbursement types (e.g., Pharmacy Benefit Managers [PBMs], patient assistance programs [PAPs], Medication Prescription Payment Plans [MPPPs])
Healthcare reimbursement systems in different settings (e.g., home health, long-term care, home infusion, hospitals, community pharmacy, ambulatory clinics)
Eligibility requirements for federally-funded insurance programs (e.g., Medicare, Medicaid, TRICARE)
Eligibility requirements for financial assistance programs and 340B programs
Pharmacy Claims Processing and Adjudication (36.67%)
Pharmacy claim processing terminology (e.g., adjudication, formulary, non-formulary, third-party billing, payer, Collaborative Practice Agreements)
Information required to submit pharmacy billing claims
General pharmacy claim submission process (e.g., data entry, verification, adjudication)
Third-party claim rejection troubleshooting and resolution
Methods for determining drug cost and sale prices (e.g., AWP, dispensing fees, gross and net profit, acquisition cost, 340B cost)
Coordination of benefits (i.e., process to determine payer(s) and patient responsibilities)
Reimbursement policies for all plans being billed, regardless of contracted payers, HMOs, PPO, CMS, or private plans
Process to determine formulary coverage and formulary alternatives
Medical Claims Processing and Adjudication (8.33%)
Clinical services performed by pharmacists that can be billed as medical claims (e.g., annual wellness visits, chronic care management, continuous glucose monitoring)
Medical claim processing terminology (e.g., Medicare Administrative Contractors [MACs], HCPCS codes, modifiers, ICD codes, Collaborative Practice Agreements, CMS categorization of providers and personnel, medically unlikely to edit [MUE], bulk charges)
Information required to submit medical billing claims, including "incident to" billing (e.g., Level I and II HCPCS codes, level of supervision, service location)
Prior Authorization (18.33%)
Prior authorization terminology (e.g., ePA, formulary exception, quantity limitation, Collaborative Practice Agreements, appeals, external review)
Information required to submit medical/pharmacy prior authorization (e.g., patient and prescriber information, drug, dose)
General process of prior authorization
Third-party prior authorization rejection troubleshooting and resolution
Audits and Compliance (10.00%)
Audit and compliance terminology, including accrediting bodies and surveys (e.g., URAC, The Joint Commission, CMS, DNV)
Documentation requirements for claims billed to federally-funded insurance programs (e.g., Medicare, Medicaid, TRICARE)

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Federal laws, regulations, and requirements pertaining to CMS and HRSA audits
Purpose and process for different types of audits (e.g., desktop, additional documentation request [ADR], Targeted Probe and Educate [TPE], Comprehensive Error Rate Testing [CERT], Recovery Audit Contractors [RAC], manufacturer audit, payer audit)
Quality assurance documentation required for compliance with government agencies, prescription drug plans, and PBMs