FPGEE®

Management Review

Questions & Answers

2026-2027 Edition



PREPARATION

MANAGEMENT

Questions & Answers

By Manan H Shroff R.Ph 2026-2027 Edition

RxExam's FPGEE®

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MANAN SHROFF

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PREFACE:

I am very happy to introduce this review book that covers the major portion of pharmacy management and pharmacoeconomics. As in recent years, FPGEE exam is putting more weight on management and the economic portion of the pharmaceutical field, which has inspired me to introduce a book that may help students to answers questions in the exam related to these topics.

I tried to cover all the pharmacy management and pharmacoeconomics aspects in this book. The reason to introduce this review book is to provide foreign students with enough information regarding the management aspect of health care in the U.S.

The students must try to understand the information provided in this guide since that's the only way to apply your logic to answer management and economics related questions in the exam. You may not receive straightforward questions from this book, however the information presented in this book will definitely help you to guess the best logical answer for a given question.

I hope my efforts will bring you much success.

Best of luck,

Manan H. Shroff

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QUESTIONS

1. For two drug products to be considered bioequivalent:

I. The rate of absorption between the products shall differ by -20% or +25% or less.

II. The 90% confidence interval for the ratio of the mean response shall be within the limits of 0.8 and 1.25.

III. The extent of absorption between the products shall differ by -20% or +25% or less.

a. I only
b. I and II only
c. II and III only
d. All

2.A prescription for Lorazepam issued on January 1st should not be filled after:

a. April 1.
b. July 1.
c. December 31.
d. November 30.

3. Which of the following statements is/are **TRUE ABOUT** physician assistants (PAs)?

I. PAs are healthcare professionals licensed to practice medicine under the physician's supervision.

II. PAs are allowed to write prescriptions.

III. PAs are educated in the medical model designed to complement physician training.

a. I only
b. I and II only
c. II and III only
d. All

4. Current DUR procedure in most health plans usually focuses on:

I. Product-centered DUR study.
II. Patient-centered DUR study.
III. Healthcare system-centered DUR study.

a. I only
b. I and II only
c. II and III only
d. All

5.Which of the following is/are **TRUE** about the Medicare Advantage Plan?

I. The Medicare Advantage plan includes HMOs offering prescription drug coverage.

II. The Medicare Advantage plan includes PPOs offering prescription drug coverage.

III. The Medicare Advantage plan was formerly known as Medicare + Choice.

a. I only
b. I and II only
c. II and III only
d. All

6. The Medicare Part D prescription drug benefit program was enacted as part of the Medicare Prescription Drug under the:

a. DBA.
b. OBRA.
c. MCA.
d. MMA.

7. Which of the following factors is the most responsible for lower medication adherence rates in blood-glucose lowering therapy?

a. Medication side effects
b. Frequent dosing
c. Lack of perceived regimen benefits
d. Medication costs

8. A patient seems to be reluctant to answer Mr. Shah's direct questions about her compliance with high blood pressure medication. What type of questions should Mr. Shah ask to get a more detailed explanation? [**Select ALL That Apply**].

a. Open-ended
b. Closed-ended
c. Authorize
d. Affirmative

9. According to **WHO**, health is defined as:

a. The absence of illness.

b. A healthy state of well-being, free from disease.

c. A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

d. The overall condition of an organism at a given time in regard to soundness of body.

10. Which of the following codes is classified as a "Diagnosis-code" in the current healthcare setting?

I. ICD 10
II. CPT
III. NDC

a. I only
b. I and II only
c. II and III only
d. All

11. Mrs. Gomes states, "I am tired of taking this medication. Sometimes I don't take them like I should." Mr. Shah responds by saying, "How long have you been taking this medication, Mrs. Gomes? Is it causing you any particular side effects?" Mr. Shah's response is an example of what type of response?

a. Analyzing
b. Evaluating
c. Quizzing
d. Advising

12. The **Poison Prevention Packaging Act** is enforced by the:

a. FDA.
b. CPSC.
c. DEA.
d. FTC.

13. The approval of new packaging and labeling of already marketed drugs should be done by filling a(n):

a. NDA.
b. ANDA.
c. SNDA.
d. IND.

14. All of the following are disease specific quality of life instruments **EXCEPT**:

a. AIMS.
b. FLIC.
c. QOLIE.
d. KDQOL.

15. What should be measured in the **CUA** study?

I. Cost
II. Consequences
III. Survival rate

a. I only
b. I and II only
c. II and III only
d. All

16. Schedule V prescription controlled drugs:

a. Can be refilled 999 times.
b. Can be refilled 5 times.
c. Can be refilled indefinitely.
d. Can never be refilled.

17. Pharmacies may transfer the refill prescription for Schedule III, IV and V controlled substances only:

a. One time.
b. Two times.

c. Three times.
d. Four times.

18. Which of the following is/are principal components of **Pharmacy Benefit Management (PBM)** program? [**Select ALL That Apply**]

a. Drug formulary.
b. Mandatory generic substitution.
c. Prescription co-payment.
d. Prospective DUR.

19. Which of the following shall be included in protocol prepared pursuant to the collaborative drug therapy management agreement?

I. The list of specific drug or drugs to be managed by the pharmacist.

II. The terms and conditions under which drug therapy may be implemented, modified or discontinued.

III. The conditions and events upon which the pharmacist is required to notify the physician.

a. I only
b. I and II only
c. II and III only
d. All

20. The warning "Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed" is required when dispensing:

I. Schedule II controlled drugs.
II. Schedule III controlled drugs.
III. Schedule V controlled drugs.

a. I only
b. I and II only
c. II and III only
d. All

21. Which of the following are classified as **NTI** drugs?

I. Carbamazepine
II. Theophylline
III. Naltrexone

a. I only
b. I and II only
c. II and III only
d. All

22. Which of the following barriers has the most significant effect on communication between pharmacists and prescribers?

a. Time
b. Knowledge
c. Attitude
d. Money

23. In the case of an emergency situation, a pharmacist may dispense a controlled substance listed in Schedule II upon receiving oral authorization of a prescribing individual practitioner, provided that:

I. The quantity prescribed and dispensed is limited to 30 units of prescribed drug.

II. Within 7 days after authorizing an emergency oral prescription, the prescribing individual practitioner shall cause a written prescription for the emergency quantity prescribed to be delivered to the dispensing pharmacist.

III. If the prescribing individual practitioner is not known to the pharmacist, he must make a reasonable effort to determine that the oral authorization came from a registered individual practitioner.

a. I only
b. I and II only
c. II and III only
d. All

24. Common abuses of the fee-for-service system include which of the following?

I. Churning
II. Upcoding
III. Unbundling

a. I only
b. I and II only
c. III only
d. All

25. The program of palliative and supportive care services that provides physical, psychological, social, and spiritual care for terminally ill persons, their families, and other loved ones is defined as:

a. Home infusion care.
b. Skilled nursing facility care.
c. Hospice care.
d. Long-term care.

26. The partial filling of Oxycodone + APAP to a patient who resides in Charlestown Nursing Home (LTCF) should be done within:

a. 24 hours from its initial filling.
b. 72 hours from its initial filling.
c. 48 hours from its initial filling.
d. 60 days from its initial filling.

27. What is the most stated reason for noncompliance?

a. Cost
b. Forgetfulness
c. Side effects
d. Confusion

28. A diabetic patient has been asked: "Have you ever had a low blood sugar reaction?" by a caregiver provider. This type of question usually:

a. Encourages patients to discuss the disease.

b. Is classified as too personal and should not be asked.

c. Discourages patients to discuss the disease.

d. Is classified as the most appropriate question according to Blooms Taxonomy of Education.

29. Which of the following community pharmacy provider networks have the highest reimbursement rates and program costs?

a. Pre-contracted networks
b. Customized networks
c. Closed networks
d. Specialized networks

30. Medicare is a health insurance program for:

I. People 65 years of age and older.
II. People with disabilities younger than 65 years of age.
III. People with End-Stage Renal Disease.

a. I only
b. I and II only
c. II and III only
d. All

31. If the expiration date on a bulk bottle of Cephalexin is May (Current Year), the drug should not be used after:

a. April 30.
b. May 31.
c. May 1.
d. April 15.

32. Which of the following is the correct DEA number for Dr. Bridge, Robert?

a. AB 3254767
b. BB 1244691
c. AR 1354789
d. MR 2489432

33. The **Medicare Advantage Program** is also known as:

a. Medicare Part A.
b. Medicare Part B.

c. Medicare Part C.
d. Medicare Part D.

34. A personal care health service given to a patient who is an outpatient, without admission to a hospital or other facility is defined as:

a. Primary care.
b. Ambulatory care.
c. Manage care.
d. Secondary care.

35. What are instruments to measure utility values?

I. Rating scale
II. Standard gamble
III. Time-trade off

a. I only
b. I and II only
c. II and III only
d. All

36. The principal goal of the **Cost Minimization Analysis (CMA)** study would be to determine: [**Select ALL That Apply**]

a. The long-term outcome of the particular illness.

b. The cost associated with two different treatments that have clinically identical effectiveness.

c. The benefits in terms of monetary units.

d. Cost and outcomes in monetary units.

37. Which of the following is an advantage of using **Cost of Illness Analysis (CIA)**?

I. This method allows researchers to collect and assess disease specific data.

II. It provides a true definition of the particular illness.

III. It provides researchers information about epidemiology and potential outcome of illness, and the consequences associated with the illness.

a. I only
b. I and II only
c. II and III only
d. All

38. Which of the following factors affect(s) the prescriber's drug selection?

I. Medical management protocols
II. Financial incentives
III. Formularies

a. I only
b. I and II only
c. II and III only
d. All

39. What is often used by employers and health benefit consultants in evaluating the efficiency of health plan?

a. PCP
b. RAD
c. UPC
d. MLR

40. Which of the following helps to calculate pharmacy program performance metrics?

a. Acid ratio
b. MLR ratio
c. PMPM cost ratio
d. DUR/DUE ratio

41. The abuse of prescription drugs in the United States is:

a. An ongoing problem that is unlikely to change.

b. On the rise and has a dramatic impact on society in a multi-factorial way.

c. Mostly due to endemic prescribing problems.

ANSWERS

1.(d) All. According to the Orange Book, the FDA will consider a generic product equivalent to a brand (innovator) drug when both the rate and extent of absorption are not significantly different when administered in the same molar dose of therapeutic ingredient under similar experimental conditions in single or multiple-dose studies.

The FDA has established specific statistical standards to make the determination of bioequivalence. Two basic criteria must be met for two products to be considered bioequivalent:

1. The rate and extent of absorption between the innovator (also called the "reference") company's product and that of the generic manufacturer's formulation may differ by -20%/+25% or less.

2. The 90% confidence interval (CI) for the ratio of the mean response (i.e. AUC, Cmax) of the generic product to the innovator, using log-transformed data, is within the limits of 0.8 to 1.25.

2. (b) The prescription for Schedule III, IV and V drugs should not be filled after six months (July 1) from the date issued, or refilled more than 5 times within a 6-month period.

3. (d) All. Physician assistants (PAs) are healthcare professionals licensed to practice medicine under the physician's supervision.

As part of their comprehensive responsibilities, PAs conduct physical exams, diagnose and treat illnesses, order and interpret laboratory tests, counsel on preventive healthcare, assist in surgery, and in most states can write prescriptions.

Because of the close working relationship the PAs have with physicians, they are educated in the medical model designed to complement physician training.

4. (a) Current DUR procedures in most healthcare plans focus on product-centered utilization trends. For example, at the time of analyzing the DUR study most of the attention is given to drug products in terms of dollar costs and total unit dispensing rate. This sometimes may result in unwarranted physician inquiries and intervention that are not clinically significant.

For example, if a patient is taking a proton pump inhibitor for several months, the computer will mark the patient profile to be reviewed for DUR under the category of "exceeds appropriate duration of use." The DUR performer in this type of study does not look in depth for the past patient history of severe erosive esophagitis or gastric surgery.

In most cases, the drug has been used appropriately; however the person performing the DUR has been forced into product-centered DUR without considering the patient past history or clinical status.

Switching to patient-centered DUR study provides more accurate clinical status of the patient and helps controlling healthcare cost as well as provides more efficient healthcare related services. In this type of study, importance is primarily given to inappropriate utilization of medications and screening of targeted patient-population.

For example, patients who are elderly with prior history of bone fractures and falls may be screened for drugs that may potentially cause additional falls and fractures or for drugs that may adversely affect bone mass index. This may include excessive or inappropriate use of sedatives or benzodiazepines, which may cause additional falls.

5. (d) All. Medicare Part C, formerly known as "Medicare+Choice," is now known as "Medicare Advantage." If a patient is entitled to receive Medicare Part A and enrolled in Part B, he/she is eligible to switch to a Medicare Advantage plan, provided that the patient resides in the plan's

service area. Medicare Advantage provides the following options:

1. HMO plans, otherwise known as Health Maintenance Organization plans, emphasize preventive care but without coverage for providers or facilities outside the HMO network. They almost always require a network primary care physician referral to access a network specialist; they usually offer drug benefits.

2. POS plans, otherwise known as Point of Service Plans, offer a network of preferred providers, like HMO plans, but also provide reduced benefits for providers or facilities outside the HMO network. They typically require a referral from a network primary care physician to access a network specialist; they sometimes offer drug benefits.

3. Regionally Expanded Preferred Provider Organization (PPO) plans are similar to POS plans but have broader geographic access to network providers in a larger service area, and with reduced benefits outside the PPO network. They do not typically require a referral from a network primary care physician to access network specialists. They may or may not offer drug benefits.

4. PSO plans, otherwise known as Provider-Sponsored Organizations, are similar to the POS plans but are usually organized with physicians that practice in a regional or community hospital. There may or may not be coverage for providers or facilities outside the PSO network, depending upon the plan designs offered.

They may require a referral from a network primary care physician to access network specialists. They typically offer drug benefits.

6. (d) The Medicare Part D prescription drug benefit program was enacted as part of the Medicare Prescription Drug, Improvement and Modernization Act, which has become better known as simply the Medicare Modernization Act (MMA) of 2003.

7. (b) A recent review of the research related to medication adherence reported that adherence rates for blood-glucose lowering therapy ranged from 65% to 85%, with lower rates (36% to 54%) reported for certain populations (e.g. Medicaid recipients) and regimens requiring more frequent dosing.

There were a number of reasons cited in these studies for lower adherence rates, including patients' inadequate understanding of the regimen, medication side effects, lack of perceived regimen benefits, medication costs, and regimen complexity.

8. (a) Open-ended questions are questions that encourage people to talk about whatever is important to them. They help to establish rapport, gather information, and increase understanding. They are the opposite of closed ended questions, which typically require a simple brief response such "yes" or "no". Open-ended questions invite others to "tell their story" in their own words. They do not lead people in a specific direction.

Open-ended questions should be used frequently, though not exclusively, in conversation. When asking open-ended questions, one must be ready and willing to listen to the response.

To illustrate closed-ended vs. open-ended questions, consider the following examples. The topic is the same in both questions, but the responses likely will be very different.

Did you have a good relationship with your parents? (closed-ended)

Tell me about your relationship with your parents. (open-ended).

9. (c) According to WHO, health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

10. (a) The U.S. Department of Health and Human Services (HHS) announced a final rule that will facilitate the United States' ongoing transition to an electronic health care environment through the

adoption of new healthcare code sets for use in electronic health care transactions. This rule adopts updated versions of the code sets, under the authority of HIPAA (ICD-10 final rule). The ICD-10 code sets replace the current ICD-9-CM code set.

ICD-10 codes must be used on all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2013. Otherwise, claims and other transactions will be rejected, and will need to be resubmitted.

ANSI X12 version 4010 is the current HIPAA electronic transaction standard. However, version 4010 is not capable of handling ICD-10 Procedure and Diagnosis Codes. By Federal mandate, ANSI X12 version 5010 will be the HIPAA electronic transaction standard as of January 1, 2012. Version 5010 includes support for ICD-10 diagnosis and procedure codes.

Today, the industry uses about 13,500 unique ICD-9-CM volume 1 & 2 codes to describe diagnosis. ICD-9 diagnosis codes are 3-5 digits in length (e.g., 821.01 – Closed Fracture of shaft of femur). With the ICD-10-CM mandate, the length of diagnosis codes will increase to 3-6 alphanumeric characters plus a qualifier (e.g., S72.344 – Displaced spiral fracture of shaft of right femur). There will be about 69,000 codes with a much greater level of specificity.

The industry currently uses about 4,000 unique ICD-9-CM volume 3 codes to describe inpatient procedures. ICD-9 procedure codes are 3-4 digits in length (e.g., 47.01 – Laparoscopic appendectomy). With the ICD-10-PCS mandate, the length of inpatient procedure codes will increase to 7 alphanumeric characters (e.g., ODTJ4ZZ – Laparoscopic appendectomy). There will be about 72,000 unique codes with much greater detail than the current procedure codes.

11. (c) Mr. Shah's response is an example of a quizzing response.

12. (b) The Poison Prevention Packaging Act is generally enforced by the CPSC (Consumer Product Safety Commission).

The FDA is known as the Food and Drug Administration.

The DEA is known as the Drug Enforcement Administration, which regulates the Federal controlled substance act.

The FTC is known as the Federal Trade Commission; it generally regulates unfair business practice and antitrust violations.

13.(c) The approval of new packaging and labeling of already marketed drugs should be done by filling out a Supplement New Drug Application (SNDA).

An SNDA can be used for:

1. Change in labeling and packaging of already marketed drugs.

2. Change in manufacturing location.

3. Any change in synthesis of drugs.

4. Change in production procedure of drugs.

14.(d) There are hundreds of health-related quality of life instruments available. There are mainly divided into following two categories:

1. Disease-specific instruments
2. Generic/general instruments

1. Disease Specific Instruments: They provide detailed information in terms of functioning and well-being that may be associated with a particular disease. They are classified into the following categories:

1. Disease specific (e.g. hypertension, diabetes)
2. Population specific (e.g. elderly, infant)
3. Function specific (e.g. sexual functioning)
4. Condition or problem specific (e.g. pain)

Examples of disease-specific instruments:

1. Arthritis Impact Measurement Scale (AIMS)
2. Asthma Quality of Life Questionnaires (AQLQ)
3. Diabetes Quality of Life (DQOL)
4. Functional Living Index Cancer (FLIC)
5. Quality Of Life In Epilepsy (QOLIE)
6. HIV Overview of Problems-Evaluation System (HOPES)

2. Generic/General Instrument: As the name suggests, general instruments put more emphasis on all conditions that have a general effect on the quality of life. The general/generic instruments provide a better picture of a disease or condition.

The KDQOL (Kidney Disease Quality Of Life) is the perfect example of a general/generic instrument, and it can be further explained by learning profile and utility-based instruments.

15.(b) I and II only. **Cost-Utility Analysis**: It is defined as a method where costs are measured in terms of dollar amounts and consequences are measured in terms of quality of life.

Cost-effective analyses and cost-utility analyses are almost same; the only difference between them is the unit of consequences or therapeutic outcomes. The former measures the outcomes in natural units (e.g. reduction in blood pressure or cholesterol); while the latter relies on quantity-adjusted life gain years.

Cost-Utility Ratio: Costs($)/Utilities (e.g. QALY, Quality Adjusted Life Years) QALY is the number of years at full health compared to the number of years of illness. A year of perfect health would be calculated as 1.0 measured on QALY, and death would equal 0.

For example, six years of perfect health would be counted as 6.0 QALY, whereas six years of living with cancer, with each year having a utility of 0.4, would be valued at 2.4 QALY.

16.(b) Schedule V prescription controlled drugs can be refilled 5 times.

17. (a) The one-time transfer of the original prescription information for a controlled substance listed in Schedules III, IV, or V, if any authorized refills remain, for the purpose of dispensing is permissible between pharmacies within six (6) months from the date the prescription was issued.

However, pharmacies electronically sharing a real-time, on-line database may transfer up to the maximum refills permitted by law and the prescriber's authorization.

18. (a, b and c) The principal components of Pharmacy Benefit Management (PBM) program are:

1. A legally enforceable benefit design contract that outlines covered and excluded benefits.

2. A defined physician provider network under the contract with the health plan.

3. A defined pharmacy provider network under the contract with the health plan or PBM.

4. A community pharmacy network with the point-of-sale (POS) computer adjudication system.

5. A drug formulary.

6. A mandatory generic substitution program.

7. Pharmaceutical manufacturer discounts or rebates.

8. A patient prescription co-payment.

9. Retrospective drug utilization review (DUR).

10. Drug formulary conversion.

11. Compliance improvement.

12. Disease management program.

19.(d) All. Each protocol developed, pursuant to the collaborative drug therapy management agreement, shall contain detailed direction concerning the actions that the pharmacist may

perform for that patient. The protocol shall include, but need not be limited to:

(1). the specific drug or drugs to be managed by the pharmacist,

(2). the terms and conditions under which drug therapy may be implemented, modified or discontinued,

(3). the conditions and events upon which the pharmacist is required to notify the physician, and

(4). the laboratory tests that may be ordered. All activities performed by the pharmacist in conjunction with the protocol shall be documented in the patient's medical record.

The pharmacist shall report at least every thirty days to the physician regarding the patient's drug therapy management.

The collaborative drug therapy management agreement and protocols shall be available for inspection by the Departments of Public Health and Consumer Protection. A copy of the protocol shall be filed in the patient's medical record.

20.(b) The warning "Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed" is required for filling Schedule II, III and IV controlled drugs. This cautionary label is not required when dispensing the Schedule V controlled substance or dispensing the drug which is used for Double Blind Study.

21.(b) I and II only. The FDA has acknowledged that there are certain drugs in which small changes in the dose and/or blood concentration may potentially affect the drug's pharmacological and toxicological properties.

These drugs are known as Narrow Therapeutic Index (NTI) drugs. The list of such drugs is:

1. Phenytoin.
2. Carbamazepine.
3. Theophylline.
4. Levothyroxine.
5. Lithium carbonate.
6. Digoxin.
7. Warfarin sodium.

22.(c) Attitude is the major barrier that prevents pharmacists from communicating effectively with prescribers. There are a number of barriers that prevent an effective communication between pharmacists and other healthcare professionals. Out of these, attitude, time, and knowledge are major concerns.

1. Attitude
2. Time and money
3. Skill and knowledge

1. Attitude: The attitude is the most common barrier that prevents the effective communication between pharmacists and prescribers.

The attitudes and expectations of pharmacists are developed on the basis of previous experience. Due to complex healthcare settings, pharmacists believe that physicians are usually unapproachable, and therefore many pharmacists simply avoid contacting the physician unless it is strictly necessary.

One of the conferences in the UK reported that "pharmacists see doctors as diagnosticians" whereas physicians see themselves as a last resource to provide health-related services to patients, and physicians see pharmacists as medication dispensers, while pharmacists see themselves as "drug experts."

2. Time and money: Lack of time is an excuse provided by pharmacists to avoid communication with other healthcare professionals.

However, it is also true that many pharmacists who work in retail settings have no sufficient help to provide extended health-related services to patients.

It is the plan administrator's responsibility to provide adequate help and financial incentive to pharmacists to encourage them to extend their services beyond dispensing.

This way, a healthcare cost can be effectively controlled (e.g. by preventing drug interactions or eliminating a duplicate therapy before dispensing) and optimum therapeutic outcomes can be achieved.

3. Skill and knowledge: The lack of skill and knowledge may prevent many pharmacists from offering counseling to patients. This may happen when pharmacists are not in touch with their colleagues or avoid communication with other healthcare professionals.

A major barrier is the inability of pharmacists to communicate with physicians due to the anticipation of attitudes from prescribers. Also, pharmacists may not have all the information about the patient's current medication history, which may lead to poor communication with patients.

23.(c) In the case of an emergency situation a pharmacist may dispense a controlled substance listed in Schedule II upon receiving oral authorization of a prescribing individual practitioner, provided that:

(1). The quantity prescribed and dispensed is limited to the amount adequate to treat the patient during the emergency period (dispensing beyond the emergency period must be pursuant to a paper or electronic prescription signed by the prescribing individual practitioner);

(2). The prescription shall be immediately reduced to writing by the pharmacist and shall contain all information required by law, except for the signature of the prescribing individual practitioner;

(3). If the prescribing individual practitioner is not known to the pharmacist, he must make a reasonable effort to determine that the oral authorization came from a registered individual practitioner, which may include a callback to the prescribing individual practitioner using his phone number as listed in the telephone directory and/or other good faith efforts to insure his identity; and

(4). Within 7 days after authorizing an emergency oral prescription, the prescribing individual practitioner shall cause a written prescription for the emergency quantity prescribed to be delivered to the dispensing pharmacist. In addition to conforming to the requirements of §1306.05, the prescription shall have written on its face "Authorization for Emergency Dispensing," and the date of the oral order. The paper prescription may be delivered to the pharmacist in person or by mail, but if delivered by mail it must be postmarked within the 7-day period.

Upon receipt, the dispensing pharmacist must attach this paper prescription to the oral emergency prescription that had earlier been reduced to writing.

For electronic prescriptions, the pharmacist must annotate the record of the electronic prescription with the original authorization and date of the oral order.

The pharmacist must notify the nearest office of the Administration if the prescribing individual practitioner fails to deliver a written prescription to him; failure of the pharmacist to do so shall void the authority conferred by this paragraph to dispense without a written prescription of a prescribing individual practitioner.

(5). Central fill pharmacies shall not be authorized under this paragraph to prepare prescriptions for a controlled substance listed in Schedule II upon receiving an oral authorization from a retail pharmacist or an individual practitioner.

24.(d) All. Medical providers who bill Medicare, Medicaid, and other Government programs use a standardized system of numerical codes for patient services. In this way, insurers and the Government do not have to work out what services were provided from numerous records or from thousands of different types of coding or billing systems.

Misuse of these standardized codes to obtain more money than is allowed by law is commonly termed **"UPCODING" or "UPCHARGING"**.

Each Medicare billing code is tied to a particular group of services and will eventually result in a reimbursement to the physician or other provider (hospital, psychologist, chiropractor, etc.) based upon the code entered by the provider. Providers have financial incentives to "upcode" or increase the bill by exaggerating or even falsely representing what medical conditions were present and what services were provided.

For example, when a 2-minute visit for diagnosis and treatment of an upper respiratory condition (i.e. a cold without complications) is "upcharged" from a very low reimbursement rate code by intentionally using codes for a more serious ailment.

Thus, the "URI" or "upper respiratory infection" diagnosis is altered to indicate that the patient was suffering from a more severe bronchitis and sinus infection, with some breathing impairment requiring nebulizer treatment, and the patient required a full 1-hour office visit. In either case, whether the additional services billed were not even provided or if provided but not medically needed, a fraudulent "upcharge" occurs.

Churning occurs when a physician provides a service to a patient more frequently than is necessary for the purpose of billing for more services. For example, a psychiatrist may require more sessions with the patient than are recommended for the condition.

Unbundling or fragmentation occurs when a physician bills separately for services that are normally reported as one service.

Medicare and Medicaid often have special reimbursement rates for a group of procedures commonly done together, such as typical blood test panels by clinical laboratories. Some health care providers seeking to increase profits will "unbundle" the tests and bill separately for each component of the group, which totals more than the special reimbursement rates.

25.(c) The program of palliative and supportive care services that provides physical, psychological, social, and spiritual care for terminally ill persons, their families, and other loved ones is defined as hospice care.

Hospice services are available in both the home and inpatient settings. It normally includes pain relief and support services, physician and nursing services coordination, in-home care, therapy, and counseling.

To be eligible for hospice, an individual must be diagnosed as terminally ill (i.e. life expectancy of six months or less without intervention). Palliative care is any form of medical care or treatment that concentrates on reducing the severity of the symptoms of a disease or slows its progress rather than providing a cure. It aims at improving quality of life, and particularly at reducing or eliminating pain.

26.(d) The partial filling of a prescription for a controlled substance listed in Schedule II is permissible if the pharmacist is unable to supply the full quantity called for in a written or emergency oral prescription and he makes a notation of the quantity supplied on the face of the written prescription, written record of the emergency oral prescription, or in the electronic prescription record.

The remaining portion of the prescription may be filled within 72 hours of the first partial filling; however, if the remaining portion is not or cannot be filled within the 72-hour period, the pharmacist shall notify the prescribing individual practitioner. No further quantity may be supplied beyond 72 hours without a new prescription.

A prescription for a Schedule II controlled substance written for a patient in a Long Term Care Facility (LTCF) or for a patient with a medical diagnosis documenting a terminal illness may be filled in partial quantities to include individual dosage units.

If there is any question whether a patient may be classified as having a terminal illness, the pharmacist must contact the practitioner prior to partially filling the prescription.

Both the pharmacist and the prescribing practitioner have a corresponding responsibility to assure that the controlled substance is for a terminally ill patient.

The pharmacist must record on the prescription whether the patient is "terminally ill" or an "LTCF patient." A prescription that is partially filled and does not contain the notation "terminally ill" or "LTCF patient" shall be deemed to have been filled in violation of the Act. For each partial filling, the dispensing pharmacist shall record on the back of the prescription (or on another appropriate record, uniformly maintained, and readily retrievable) the date of the partial filling, quantity dispensed, remaining quantity authorized to be dispensed, and the identification of the dispensing pharmacist. The total quantity of Schedule II controlled substances dispensed in all partial fillings must not exceed the total quantity prescribed.

Schedule II prescriptions for patients in an LTCF or patients with a medical diagnosis documenting a terminal illness shall be valid for a period not to exceed 60 days from the issue date unless sooner terminated by the discontinuance of medication.

27.(b) Forgetfulness is the most stated reason for noncompliance.

Statements	% of Total
Forgetfulness	39.6%
Side effects	17.7%
Drug perceived as not necessary	12.5%
Confusion	11.5%
Cost	10.4%

28.(c) This type of question is classified as a closed-ended question. Open-ended questions usually encourage discussion more effectively than closed-ended questions. Closed-ended questions can be answered yes or no; open-ended questions require a more detailed response and are therefore more appropriate to build successful patient-practitioner relationship.

For example: Closed-ended question: “Have you ever had a low blood sugar reaction?”

Open-ended question: “How do you feel when you have a low blood sugar reaction?”

29. (a) Pre-contracted community pharmacy provider networks have the highest reimbursement rates and program costs among all the other choices. There are four types of community pharmacy networks:

1. Open, pre-contracted or shelf network
2. Restricted, preferred or customized network
3. Exclusive or closed network
4. Specialized network.

1. <u>Open, pre-contracted or shelf network:</u>

This type of network usually enrolls any pharmacy in the network if the pharmacy agrees with the terms and conditions of the provider.

This network also gives the advantage to plan members by providing the broadest access. Since the base reimbursement rate is inversely proportional to the size of the network, open networks usually have the highest reimbursement rates and program costs.

2. <u>Restricted, preferred or customized network:</u>

In this type, fewer pharmacies are available within a network compared to open networks, and therefore the reimbursement cost and plan member cost is less compared to open network systems.

3. <u>Exclusive or closed network:</u>

It locks out any pharmacy not enrolled in the network. It offers very limited access to plan members for prescription services and therefore it has the lowest reimbursement rate and plan cost.

4. Specialized network:

It is developed to provide a specific class or type of drug to plan members. Examples include interferon (a drug related to AIDS), injectables, etc. It also covers specialized services such as home infusion or anticoagulation clinics.

30.(d) All. Medicare is a health insurance program for:

1. People 65 years of age and older.

2. Some people with disabilities less than 65 years of age.

3. People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has two parts:

1. Part A (Hospital Insurance)-Part A helps pay for care in a hospital, some skilled nursing facilities, hospice, and some home health care. Most people do not have to pay a monthly payment (premium) for Part A because they (or a spouse) paid Medicare taxes while they were working.

2. Part B (Medical Insurance) - Part B helps pay for doctors, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care.

Most people get their Medicare health care coverage in one of two ways. The costs vary depending on the plan, coverage, and the services member use.

31.(b) If the expiration date on a bulk bottle of Cephalexin is MAY (current year), the drug should not be used after May 31 (current year).

32.(b) The authenticity of the DEA number can be verified by the following:

1. The first letter A or B normally indicates dispensing. The second letter should be the first initial of the prescriber's last name.

2. Now add the first, third and fifth numbers, which is 1 + 4 + 6 = 11.

3. Add the sum of the second, fourth and sixth number and multiply by "2," which is 2 + 4 + 9 = 15 x 2 = 30.

4. Add this sum to the first sum, 11 + 30 = 41; the right-most number of this sum (**1**) must be the ninth number of the DEA number.

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33.(c) The Medicare Advantage program is also known as Medicare Part C.

34. (b) Ambulatory care or outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of hospitals.

35.(d) All. Utilities for a particular disease can be calculated by the following methods:

1. Through estimation.
2. Through the literature.
3. Through actual measurement.

Physicians, specialties, researchers or special panels can assign the utility value for a particular disease.

There are three instruments that help to measure utility values. These are:

1. Rating scale.
2. Standard gamble.
3. Time-trade off.

Rating scale: A rating scale is a set of categories designed to elicit information about a quantitative or a qualitative attribute. In the social sciences,

particularly psychology, common examples are the Likert response scale and 1-10 rating scales in which a person selects the number which is considered to reflect the perceived quality of a product.

Standard gamble: The standard gamble is a method used to measure health utilities of varying health states and allow for comparisons across populations and different clinical settings. These health utility scores are useful as measures of outcome for quality of life and applicable to economic evaluation studies. Nonetheless, the measurement process can be cognitively challenging, and controversies remain regarding raters and rating methods.

Time-trade off: Time-Trade-Off (TTO) is a tool used in health economics to help determine the quality of life of a patient or group. The individual will be presented with a set of directions such as:

Imagine that you are told that you have 10 years left to live. In connection with this you are also told that you can choose to live these 10 years in your current health state or that you can choose to give up some life years to live for a shorter period in full health. Indicate with a cross on the line the number of years in full health that you think is of equal value to 10 years in your current health state.

The line usually ranges from 1 to 10 and the person's score is calculated by dividing the number corresponding to their cross by 10.

For example, if someone marks a cross at 4 on the TTO line, they would be given a TTO score of 0.4. This number is often used in turn to calculate quality-adjusted life years or QALYs. In our example if this person were to live for 4 years at their current health state this would be equal to 1.6 QALYs (4 x .4). QALYs enable health care decision makers to combine mortality and morbidity into a single interval scale.

The major advantage of a cost-utility analysis is that it is the only analysis method that calculates consequences or outcomes in terms of the quality of a patient's life. The only disadvantage associated with this method is a lack of uniform or standardized methods to calculate utility values for diseases.

36.(b) Cost Minimization Analysis (CMA):

This type of analysis is used to examine the cost associated with two or more alternatives that are clinically equivalent in terms of outcomes. Equivalency must be established before conducting an analysis. Furthermore, equivalency studies must include not only therapeutic outcomes but also the type of adverse effects associated with therapies.

Cost minimization can be calculated by using the following formula:

Cost (dollars) of intervention A <, =, or > Cost (dollars) of intervention B

An example of a cost minimization analysis would be a comparison of two treatments with the same drug but different routes of administration.

In both cases, if the therapeutic outcomes as well as the incidence and type of adverse reactions remain the same, then one should chose the less expensive and laborious route of administration of the drug.

37.(d) All. Cost of Illness Analysis:

This type of evaluation method includes all costs and consequences related to treating a particular disease. It is really important to conduct a Cost of Illness Analysis before initiating further economic evaluation. Advantages of using Cost of Illness Analysis:

1. This method allows researchers to collect and assess disease specific data.

2. It provides a true definition of the particular illness.

3. It provides researchers information about epidemiology and potential outcome of illness, and the consequences associated with the illness.

PREPARATION

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