



Non-Insured Health Benefits (NIHB)

Pharmacy Claims Submission Kit



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EXPRESS SCRIPTS®

Any comments or requests for information may be transmitted to:
Express Scripts Canada
Provider Relations Department
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5

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1. Introduction

1.1 Purpose of NIHB Pharmacy Claims Submission Kit

For information related to **Medical Supplies & Equipment (MS&E) items**, please refer to the NIHB MS&E Claims Submission Kit located on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca

Express Scripts Canada's Non-Insured Health Benefits (NIHB) Pharmacy Claims Submission Kit (also referred to as "Kit") sets out additional terms and conditions for the submission of Claims under the Pharmacy Provider Agreement (referred to as "Agreement"). In addition, the Provider Guide for Pharmacy Benefits supports the Kit in providing information on the administration of the NIHB Program (also referred to as the "Program"), its policies, and the extent and limitations of the Program's benefit coverage.

This Kit is also designed to help Providers understand how the Express Scripts Canada Health Information and Claims Processing Services (HICPS) system operates. It outlines the role of the Provider, and contains all the information Providers need to submit Claims.

It is important for the Provider to understand all of the terms and conditions defined in the Kit to ensure the accuracy of any Claims submitted. It is the Providers' responsibility to obtain for reference purposes, the most current version of this Kit, which is updated quarterly throughout each year, as required. A notification of Kit updates is posted prior to the circulation date.

All documents (Announcements, Kit, Agreement, Pharmacy Newsletters, and the Provider Guide for Pharmacy Benefits) are available for download in Portable Document Format (PDF) on the NIHB Claims Services Provider Website (also referred to as "Provider Website"). Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to [Section 6.2.1 Provider Claims Processing Call Centre](#)). All questions or comments regarding the Kit should also be directed to the Provider Claims Processing Call Centre.

1.2 Interpretation

In the event of a conflict between the terms and conditions of the Pharmacy Provider Agreement and the terms and conditions of an Annex or the Kit, the terms and conditions of the Agreement shall prevail (refer to Section 12.2 (6) of the Agreement).

In the event this Kit does not address a Claims submission or data transmission matter, or in the event of uncertainty as to a term or condition, the Provider may contact Express Scripts Canada to discuss the matter, and Express Scripts Canada will address the issue or provide direction to resolve the question.

Note Quebec Pharmacy Providers Only: In the event of a conflict between the terms and conditions of the Kit and the Agreement between the Association québécoise des pharmaciens propriétaires (AQPP) and Health Canada, the terms and conditions of such Agreement shall prevail.

1.3 General Terms

The general terms and conditions governing the relationship between you, the Provider and Express Scripts Canada are set out in the Agreement. Express Scripts Canada reserves the right to update this Kit.

This Kit contains additional terms and conditions, and procedures for verifying Client eligibility, as well as Claims eligibility, submission, adjudication, payment, reversals, and audit. Providers are bound by, and must follow the terms, conditions, and procedures in this Kit in respect of Claims submitted by them under the Agreement.

1.4 Defined Terms

In addition to those throughout the Kit, which are defined parenthetically, the following chart displays defined terms and definitions that are used in this Kit.

Refer to the list below of terms and definitions that are relevant for background information for this Kit and the Program.

Term	Definition
AANDC (formerly INAC)	Refers to the department of Aboriginal Affairs and Northern Development Canada.
Applicable laws, rules and regulations regarding the practice of Pharmacy	Limited to applicable rules of practice established by provincial or territorial Pharmacy colleges, regulatory or licensing authorities.
Claim	A request for payment submitted by a Provider to Express Scripts Canada for the provision of Pharmacy services to Clients in accordance with the Agreement, Kit, and policies of the Program.
Client	A natural person who is eligible to receive Pharmacy services in accordance with the eligibility criteria in Section 4.1 Client Identification and Eligibility of the Kit.
COB	The Coordination of Benefits between two or more drug benefit plans, whether public, private or a combination of public and private coverage.
CPhA	The Canadian Pharmacists Association.
CR	NIHB Client Reimbursement. A Health Canada authorized approval to accept the Claim made directly by a Client or a first payer such as a Band, parent, or guardian who has paid for services rendered.
DEC	The Drug Exception Centre (DEC) handles all Prior Approval (PA) requests for drug benefits. Refer to PA .
Delisted	A Pharmacy service Provider who is no longer an eligible NIHB Provider.
Drug Benefit List (DBL)	A drug item list established by Health Canada that is updated quarterly and sets out the prescription and over-the-counter drugs for which the Pharmacy Provider may submit Claims to Express Scripts Canada in accordance with the Agreement when it dispenses such drugs to Clients.
DUR	The Drug Utilization Review, more particularly explained in Section 4.2.2 Drug Utilization Review Program .
EDI	Electronic Data Interchange that electronically captures and processes submitted Pharmacy Claims online in real time presenting Pharmacy Providers with an immediate response

Term	Definition
	regarding the status of the submitted Claim.
EFT	Electronic Funds Transfer is an electronic delivery of Claim payments, directly deposited into the Provider's designated bank account on the day the payment is issued.
EOB	Explanation of Benefits is a written statement displaying all of the details of the Claims paid and not paid resulting from a request.
Express Scripts Canada (formerly ESI Canada)	On behalf of the Program, Express Scripts Canada is the health Claims management company responsible for processing the Claims submitted through the Program.
FNIH	First Nations and Inuit Health.
FNIH(B)	First Nations and Inuit Health Branch of Health Canada.
FPT	Federal Pharmacy and Therapeutics committee. An advisory body of health professionals established to provide evidence based Pharmacy and medical advice to the drug benefit plans of six federal departments (Health Canada, Veterans Affairs, Royal Canadian Mounted Police, Correctional Services Canada, National Defense and Citizenship and Immigration Canada).
Health Canada	Department of Health (Canada).
HICPS	Health Information and Claims Processing Services system. This system includes all services used to process Claims, to support Providers with the processing and settlement of their Claims, and to ensure compliance with the Program Policies including audit, reporting and financial control practices.
NDCV	The Next Day Claims Verification Program is a component of the Express Scripts Canada Provider Audit Program, which consists of a review of Claims submitted by Providers the day following receipt by Express Scripts Canada.
NIHB Pharmacy Claims Submission Kit (referred to as the "Kit")	The Kit is provided by Express Scripts Canada, amended from time to time and made available to the Provider by Express Scripts Canada. The Kit sets out the additional terms and conditions for the submission of Claims under the Agreement.
NIHB Program (referred to as the "Program")	Non-Insured Health Benefits Program of Health Canada. The Program manages a specified range of drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention, mental health counseling, and assistance with medical transportation which are provided to eligible registered First Nations when they are recognized Inuit persons and not covered by other benefit plans.
Other Coverage	Benefits available to Clients of the Program, in whole or in part, from a provincial, territorial or first payer health care program.
Pharmacy Claim Statement	A detailed listing is sent by Express Scripts Canada to the Provider, Client or first payer providing the necessary information with regard to Pharmacy Claim payment.
Pharmacy Provider Agreement (referred to as the "Agreement")	The Express Scripts Canada Agreement, the Annexes thereto, and any amendments thereto made in writing.

Term	Definition
Pharmacy Services	The provision and dispensing of any drugs allowed by the Program to Clients in accordance with the terms and conditions of the Agreement, applicable laws, and professional standards of practice and the dispensing provisions of the Kit.
PA	Prior Approval. A Program coverage confirmation issued by a Health Canada Regional Office or the Drug Exception Centre to a Provider to ensure that the Provider is advised that the Client is eligible for the specific drug/ medical supplies and equipment benefits or services dispensed. The approval is issued primarily for items identified as requiring authorization before being dispensed for purchase.
PIPEDA	Personal Information Protection and Electronic Documents Act (Canada).
POS Technology	The Point of Service (POS) where a Claim is submitted when a prescription is filled.
Prescriber ID	A reference number that a Prescriber of medication, medical supplies or professional services uses to identify themselves.
Provider	An accredited Pharmacy outlet having on staff a licensed pharmacist or a physician authorized to dispense prescription medications by the respective provincial/ territorial regulatory authority for which the "Agreement" has been completed, signed and accepted by Express Scripts Canada.
Provider Guide for Pharmacy Benefits	A guide, which provides information on the administration of the Program, its policies, and the extent and eligibility of the Program's benefit coverage and is used in conjunction with this Kit.
Provider Number	A unique reference number assigned to the Provider as identification to facilitate the submission of Claims for adjudication and to receive payment.
PWGSC	Department of Public Works and Government Services Canada.
Regional Office	Health Canada Regional Offices across Canada.
U&C (Usual and Customary Professional Fee)	The lowest dispensing fee charged by the Provider to customers of its business who are not Clients and are not covered by any drug insurance plan on the date that it is provided, including any discounts or special promotions offered on such date by the Provider. Express Scripts Canada shall not take into account, for the purposes of calculating the lowest dispensing fee, unusual and exceptional transactions made on a discounted dispensing fee basis by the Provider to or in respect of: <ul style="list-style-type: none"> (i) Health care professionals undertaken as a professional courtesy; (ii) Employees of the Provider; (iii) Compassionate discounts given on non-routine financial need basis that make up less than 1% of the Provider's dispensing activity, and;

Term	Definition
	(iv) Other exceptional cases agreed to in writing by Express Scripts Canada.

2. Background

2.1 Health Canada NIHB Program

Further details on Health Canada's NIHB Program, can be located on Health Canada's website at www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/index-eng.php

Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre (refer to [Section 6.2.1 Provider Claims Processing Call Centre](#)).

2.2 Roles and Responsibilities of Express Scripts Canada

Express Scripts Canada administers the HICPS system for Pharmacy benefits covered by the Program. The responsibility encompasses certain aspects of Pharmacy benefits processing and payment of Claims, and extends to Provider registration, verification, audit and recovery where deemed appropriate.

Express Scripts Canada has the authority and responsibility to ensure that Claims paid for services provided to Clients are made in accordance with the Program policies and are consistent with [Section 4. General Claims Submission Procedures](#) outlined in this Kit.

In the context of Pharmacy benefit management, Express Scripts Canada is not an insurance company but is mandated to receive, analyze, verify and proceed with payment of, as applicable, all Claims submitted electronically or manually by Providers and Clients through the Program. Express Scripts Canada also communicates and responds to Provider enquiries. All Client reimbursements should be referred to the nearest Health Canada Regional Office. A listing of the Health Canada Regional Offices can be located on the Health Canada website at www.hc-sc.gc.ca/contact/fniah-spnia/index-eng.php#nihb

2.3 Roles and Responsibilities of Providers

The submission of a Claim by a Provider indicates understanding and acceptance of the terms and conditions for submitting Claims through the Program; as well as the requisite Provider eligibility requirements as defined in the Kit under [Section 3.1.4 Terms and Conditions](#) and [Section 4.1 Client Identification and Eligibility](#).

2.3.1 Client Reimbursement

Pharmacy Providers are encouraged to submit Claims directly so that Clients do not incur charges at the POS when receiving Pharmacy Services, as per definition in Section 1 (8) of the Agreement.

When a Client pays directly for Pharmacy Services, as defined in Section 1 (8) of the Agreement, the Client may seek reimbursement upon completion of a NIHB Client Reimbursement Request Form, within one year from the date of service or date of purchase. The NIHB Client Reimbursement Request Form can be located on the Health Canada website at www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/form_reimburse-rembourse-eng.php In addition, a listing of the Health Canada

Regional Offices and Drug Exception Centre (DEC) can be located on the Health Canada website at www.hc-sc.gc.ca/contact/fniah-spnia/index-eng.php#nihb

2.4 HICPS System

The HICPS system is the electronic Claims adjudication system which automatically receives, processes, and approves or denies Claims as defined in Section 1 (2) of the Agreement based on Program policies, guidelines, and criteria. The Claim is entered with the mandatory data elements as stipulated in the Kit.

The HICPS system captures Claims sent electronically from the Provider via Personal Computer (PC) based on Pharmacy Practice Management Systems. An electronic system which transmits Claims and returns an electronic response via a data network. Data is transmitted respecting the format specified by the current CPhA Electronic Claim Standard¹.

For manual Claims, after data is keyed from the NIHB Pharmacy Claim Form, the Claim is submitted for adjudication to the HICPS system. The system checks to determine if the Provider, Client, and Claims are eligible.

Depending on the action taken, the Claim is either:

- Accepted (perhaps adjusted) to the Provider and paid.
- Returned to the Provider as a result of insufficient information and/ or due to ineligibility. A list of error messages, explanations, and CPhA error messages are listed in [Section 7. Pharmacy Statement Messages and Explanations](#).
- Returned to Provider for completion (manual Claim).

3. Pharmacy Provider Registration

Providers wishing to submit Claims for services provided to Clients must register by fully completing and signing an Agreement.

Registered Providers in the Program benefit from many services from Express Scripts Canada, such as:

- Electronic Funds Transfer (EFT):
 - A free and secure electronic payment service that directly deposits Claim payments into a Provider's designated bank account on the day the payment is issued.
- Electronic Data Interchange (EDI):
 - A POS Claim submission service which submits Claims electronically and directly from the Provider's office software in real time, acknowledging the result of the Claim immediately. To purchase software, Providers are instructed to contact the respective association for a list of certified software vendors.
- Provider Website at www.provider.express-scripts.ca which provides access to:
 - Alerts regarding changes to the HICPS system.
 - Late-breaking news, including Health Canada Bulletins, and Announcements.
 - Drug Benefit Lists (DBL).
 - Pharmacy Newsletters.

¹ To obtain a copy of the CPhA Electronic Claim Standard, contact the Canadian Pharmacists Association at 1785 Alta Vista Drive Ottawa, ON K1G 3Y6, Telephone No.: 613-523-7877; and Fax No.: 613-523-0445.

- o Various NIHB Forms.
- o Policy and Program Information (Provider Guide for Pharmacy Benefits).

3.1 Pharmacy Provider Registration Process

To be eligible for registration with Express Scripts Canada under the Program, the Provider shall be bound by and comply with the provisions of all applicable laws, rules and regulations of the provincial or territorial statutory organizations and other governmental bodies having jurisdiction over Pharmacies. The Provider shall maintain, at all times, all required federal, provincial, or territorial and local licenses, certificates and permits that are necessary to allow for the provision of pharmacy services to Clients.

Licensure is validated prior to registration through communication with the provincial or territorial licensing bodies by Express Scripts Canada, Provider Relations Department.

Providers wishing to provide services to Clients must complete and sign the Agreement in its entirety signifying their intent to participate in and adhere to the terms and conditions of the Program.

The term of the Agreement shall commence on the effective date (start date) of the unique Provider Number issued by Express Scripts Canada.

Upon receipt of *all pages* of the Agreement at Express Scripts Canada, the Agreement is forwarded to the Health Canada Regional Office for review, subsequent to which the Provider's registration may be approved or denied. All applications for registration as a Provider are subject to review by the Program.

A copy of the Agreement can be located on the Provider Website at www.provider.express-scripts.ca available in Portable Document Format (PDF). Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to [Section 6.2.1 Provider Claims Processing Call Centre](#)).

3.1.1 Pharmacy Legal Entities

The policy of Express Scripts Canada is to register and enter into the Agreement only with individual Pharmacy legal entities, and in respect of each separate Pharmacy location. In this way, the Agreement may be with a corporation, partnership or proprietorship or franchisee corporation that owns and operates a specific Pharmacy location.

Express Scripts Canada will not sign Agreements covering a chain of pharmacies or with (or only with) a shareholder of a Pharmacy entity or a parent company of a Pharmacy entity. Where an entity owns more than one Pharmacy location, each separate Pharmacy location (if it is a separate legal entity) will be required to sign the Agreement. Where several Pharmacy locations are part of a single legal entity, a separate Agreement will be needed for each Pharmacy location with the same Provider. At a minimum, every separate Pharmacy location will be assigned a separate unique Provider Number.

3.1.1.1 Quebec Pharmacies

The First Nations and Inuit Health (FNIH) Regional Office in Quebec maintains a master agreement with the l'Association québécoise des pharmaciens propriétaires (AQPP) on behalf of all pharmacies in Quebec, registered to provide services to NIHB Clients.

The Pharmacy Provider must contact AQPP to initiate the registration process, and the necessary completed documentation is then forwarded to Express Scripts Canada (fax 1-855-622-0669) for registration.

3.1.2 Approval/ Unique Provider Number

With the exception of Quebec Pharmacies (refer to [Section 3.1.1.1 Quebec Pharmacies](#)).

If the request for registration is approved, Providers are then assigned a unique Provider Number by Express Scripts Canada.

This number is used to identify the Provider and to properly pay the Provider for Claims adjudicated by Express Scripts Canada and to ensure payments for the services are directed to the appropriate registered Pharmacy location. The unique Provider Number **must** be used when submitting all Claims for payment and in all communications with Express Scripts Canada.

3.1.3 Pharmacy Documentation and Updates

The Agreement sets forth the relationship between the eligible Pharmacy Provider and Express Scripts Canada for the Program. Providers must abide with all Program requirements as outlined in this Kit, and other communications that are distributed to Providers by Health Canada and/ or Express Scripts Canada in a timely manner via the Provider Website, e-mail, fax or mail.

Pharmacy Providers also supplying general Medical Supplies and Equipment (MS&E) benefits must ensure to complete the Qualified Assessments - Medical Supplies/ Equipment section of Annex C. Only after completing this section may a Provider submit MS&E items for the services approved and rendered by the Pharmacist using the unique Provider Number. For additional details, refer to [Section 3.1.4 Terms and Conditions](#) in the Kit.

Note To submit Claims for specialized MS&E items, a licensed MS&E service professional must be registered by the respective provincial/ territorial regulatory authority. To submit MS&E items through the Program, the MS&E Provider must complete, sign, and submit an Express Scripts Canada Medical Supplies & Equipment Provider Agreement for approval located on the Provider Website at www.provider.express-scripts.ca

The Program policy, drug benefits, Claim submission, and payment information is made available to Providers through:

- Kits (Pharmacy and/ or MS&E).
- Bulletins.
- Provider Guide for Pharmacy Benefits and/ or Provider Guide for Medical Supplies & Equipment.
- Pharmacy Newsletters and/ or MS&E Newsletters.
- Broadcast Messages via Pharmacy Claim Statement and/ or MS&E Claim Statement.
- DBL and/ or MS&E Benefits and Criteria List.
- Announcements.

It is important that Providers retain the most current documentation to ensure Program requirements are met. Additional information is outlined in the Agreement. All documents can be located on the Provider Website with the exception of claim statements.

3.1.4 Terms and Conditions

In order for a Provider to be eligible for payment of services rendered to Clients, the Provider must adhere to the Program terms and conditions as set out in the Agreement, this Kit, and the Pharmacy Newsletters and/ or MS&E Newsletters that include without limitation:

- Provider Licensure and Eligibility Requirements ([Section 4.1 Client Identification and Eligibility](#)).
- Client Eligibility Requirements ([Section 4.1 Client Identification and Eligibility](#)).
- Requirements for Coordination of Benefits with other Health Plans ([Section 4.2 Coordination of Benefits](#)).
- Submission Process and Supporting Documentation Requirements ([Section 4. General Claims Submission Procedures](#)).
- Benefit Coverage and/ or Applicable Limitations ([Section 4.4 Benefit Coverage and Limitations](#)).
- Requirements to submit to and assist in any audit conducted by Express Scripts Canada of Claims submitted through the Program ([Section 5. Provider Audit Program](#)).
- Requirements to Maintain Relevant Documentation and Records ([Section 5.3.5.6 Documentation Requirements for Audit Purposes](#)).

In addition, extra billing for an item cost is prohibited. As such, any amount billed to a Client is subject to audit recovery (refer to [Section 5.1 Audit Objectives](#)) (e.g. any dispensing fees exceeding the difference between the Provider's Usual and Customary (U&C) Professional Fee and the NIHB maximum allowed dispensing fee).

The Provider shall, without limitation, provide the following services in connection with the Agreement:

- Verification of Client Eligibility:
 - The Provider must take steps to verify that the individual is eligible for benefits under the Program, and identify the existence of other benefit coverage, if applicable.
- Dispensing:
 - Dispense benefit items to each Client in accordance with all applicable laws and regulations, applicable Program policies, administrative requirements, procedures as stipulated in this Kit, and the Provider Guide for Pharmacy Benefits.

3.1.4.1 Electronic Claims Submission

Submit each prescription drug Claim to Express Scripts Canada in the most current CPhA Claims Transmission Standard for processing and payment, for which submission shall include, among other things:

- A valid Prescriber ID as assigned by the respective Provincial or Territorial Regulatory Authorities.
- Drug Identification Number (DIN) for the original package size from which the benefit item is dispensed, or the pseudo-DIN used to identify medical supplies and equipment.

Note In general, Claim quantities are the number of units dispensed wherever possible (i.e., number of tablets, capsules, milliliters, grams, etc.). For products that are dispensed in packages (i.e., oral contraceptives, inhalers), submit Claim

quantities according to your provincial public plan convention (for example, Pharmacies in Saskatchewan and Ontario submit inhalers as a package of one (1)).

- Actual day's supply.
- Usual and Customary (U&C) Professional Fee up to the maximum negotiated NIHB regional dispensing fee.
- Actual Acquisition Cost (ACC) or as defined by negotiated regional schedules up to the NIHB maximum.
- Applicable mark-ups, up to the maximum defined by negotiated regional schedules (where applicable).

If a Claim cannot be transmitted online, the dispensing Provider makes reasonable attempts to retransmit the Claim. If such retransmission fails, the Provider should contact the Provider Claims Processing Call Centre (refer to [Section 6.2.1 Provider Claims Processing Call Centre](#)) as soon as reasonably practical to make acceptable alternative arrangements. Electronic Claims must be submitted within thirty (30) days from the dispensing date.

Mandatory Fields

- Client Number or Band and Family Number (must be entered for EDI Claims).
- Client's Last Name.
- Client's First Name.
- Client's Date of Birth.
- Date of Service (must be in valid date format YYYY-MM-DD, and cannot be a future date).
- DIN/ Item Number (all eight positions must be valued, cannot be all zeroes, and must be a valid Item Number that exists on the Express Scripts Canada item database).
- Prescription Number (must be numeric and greater than zero).
- Drug/ Item Cost (must be numeric and greater than zero).
- Quantity (must be numeric and greater than zero).
- Day's Supply (must be numeric and greater than zero, mandatory for Drug items).

3.1.4.2 Non-Electronic Claims Submission

It is beneficial for the Pharmacy Provider to be able to submit Claims electronically (according to CPhA Claims transmission standards) as this is the most rapid and efficient manner of Claims submission. However, in the event a manual Claim has to be submitted, it may be sent to Express Scripts Canada using the NIHB Pharmacy Claim Form. Claims older than one (1) year from the dispensing date are not be accepted for processing and returned to the Provider.

- Standards of Service - When providing Pharmacy Services to Clients (including counseling services), the Provider acts in accordance with all applicable laws, and the standards of practice required by its professional body.
- Compliance with Applicable Law, Permits and Licenses (refer to Section 3.1 (1) of the Agreement).
- Drug Utilization Review (DUR).
- Compliance with DBL and Kit.

The Provider and its personnel shall:

- Cooperate with Express Scripts Canada's procedures for utilization review and generic substitution, as set forth from time to time in the Kit.
- Comply with the applicable DBL when dispensing benefit items to Clients.

The Provider and its personnel **shall not**:

- Implement any substitution program for Clients of the Program that is inconsistent with provincial regulations regarding interchangeability or with the Program, including the applicable DBL.

3.1.5 Change of Provider Information

In order to keep Provider records up-to-date, avoid unpaid Claims, and non-delivery of Health Canada and Express Scripts Canada communications (e.g., Pharmacy Claim Statements, Pharmacy Newsletters, etc.) via e-mail, fax, or mail, the Provider **must** notify Express Scripts Canada immediately of any changes to information provided in the registration process.

A *verbal request* is accepted at the Provider Claims Processing Call Centre to change:

- Fax number.
- Phone number.
- E-mail address.
- Current address (*correction only*).
- Preferred communication method (fax, e-mail, mail).

All other types of changes need to be completed on the Modification to Pharmacy and Medical Supplies and Equipment Provider Information Form and sent to Express Scripts Canada as indicated on the form.

These include, but are not limited to:

- Name and ownership change.
- Adding/ modifying EFT information.
- Pharmacy closed down, no longer open.

Providers can download a copy of the Modification to Pharmacy/ Medical Supplies and Equipment Provider Information Form from the Provider Website at www.provider.express-scripts.ca and submit as indicated on the form. Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to [Section 6.2.1 Provider Claims Processing Call Centre](#)).

Providers residing outside of Quebec wishing to change ownership or change their business and trading name **must** complete a new Agreement, at which time a new unique Provider Number is assigned. Download a copy of the Agreement from the Provider Website at www.provider.express-scripts.ca

Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to [Section 6.2.1 Provider Claims Processing Call Centre](#)).

Quebec Pharmacies, all new registrations and modification to pharmacies must be completed with the AQPP.

3.1.6 Termination of Provider Registration

The Provider's registration may be terminated at any time by the Provider or Express Scripts Canada as per Section 11 (1) of the Agreement.

Either party may terminate this Agreement at any time without cause upon providing the other party with forty-five (45) days written notice to terminate. Providers are to send the written notice of termination of Provider enrolment, sent by fax or registered mail to:

Fax No.:

1-855-622-0669

Mail:

Express Scripts Canada
Provider Relations Department
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5

Upon termination, Express Scripts Canada will not process further Claims from the Provider, which are dated after the termination date. The Provider may, however, submit Claims manually for services provided *prior* to the termination date, and any amounts owed to the Provider by Express Scripts Canada up to the termination date will be paid within sixty (60) days of the termination.

Termination of Provider registration does not terminate any rights or obligations of the Provider or Express Scripts Canada regarding the Express Scripts Canada Provider Audit Program activities. Please refer to [Section 5 Provider Audit Program](#) or other sections of the Agreement, as per Section 11 (3) of the Agreement.

4. General Claims Submission Procedures

4.1 Client Identification and Eligibility

The Provider is responsible to verify that a Client is eligible for benefit coverage under the Program and to identify the existence of other benefit coverage, if applicable.

An eligible Client must be identified as a resident of Canada, and have status of one of the following:

- Registered First Nations must be registered Indians according to the Indian Act.
- An Inuk recognized by one of the Inuit Land Claim Organizations.
- A child less than one year of age, whose parent is an eligible Client.

To facilitate verification, all Client identification information must be provided for each Claim:

- Surname (under which the Client is registered).
- Given names (under which the Client is registered).
- Date of birth (YYYY-MM-DD).
- Client Identification Number.

It is recommended that Clients who have an Indian Status identification card be asked to present their card on each visit to the Provider to ensure that the Client information is entered correctly and to protect against mistaken identity.

4.1.1 Required Identifiers for Recognized Inuit Clients

One of the following identifiers is required for recognized Inuit Clients:

- Government of the Northwest Territories (GNWT) Health Plan Number:
 - Inuit Clients from the Northwest Territories may present a health plan number issued by the GNWT. This number is valid in any region of Canada and is cross-referenced to the First Nations and Inuit Health Branch (FNIHB) Client Identification Number. This number begins with the letter "T" and is followed by seven digits.
- Government of Nunavut (NU) Health Plan Number:
 - Inuit Clients from Nunavut may present a health plan number issued by the Government of Nunavut. This number is valid in any region of Canada and is cross-referenced to the FNIHB Client Identification Number. This is a nine-digit number starting with a "1" and ending with a "5".
- FNIHB Client Identification Number (N-Number):
 - This is a Client Identification Number issued by FNIHB to recognized Inuit Clients. This number begins with the letter "N" and is followed by eight digits.

The NWT/ NU Health Canada Card or letter (Health Canada letterhead) identifying the individual, and accompanied by picture identification is sufficient identification for Clients.

4.1.2 Required Client Identification Numbers for Eligible First Nations Clients

One of the following identifiers is required for registered First Nations Clients:

- AANDC Registration Number:
 - This is a ten-digit number issued by Aboriginal Affairs and Northern Development Canada (AANDC). The AANDC Registration Number is the preferred method of identifying First Nations Clients.

The ten-digit AANDC Registration Number consists of the following:

- The first three digits represent the band with which the individual is associated.
 - Where applicable, the remaining seven digits uniquely identify the individual Band Number and Family Number.
- Band Number and Family Number:
 - If an AANDC Registration Number is not available, a Band Number, and Family Number may also be used as Client identification, where applicable.
 - FNIHB Client Identification Number (B-Number):
 - In specific and exceptional cases, some First Nations Clients may have numbers issued by FNIHB. This number begins with the letter B, and is followed by eight-digits.

4.1.3 Individuals Excluded from the Program

These individuals are *not* eligible to receive benefits through the Program:

- First Nations and Inuit Clients incarcerated in a federal, provincial/ territorial or municipal corrections facility.

- First Nations children who are in the care of provincial/ territorial social service agencies.
- Those individuals who are in a provincially/ territorially funded institutional setting, such as nursing homes.

4.1.4 Special Provision for First Nations and Inuit Children under One Year of Age

Special identification provisions for children less than one year of age are in place to allow adequate time for parents, eligible for benefits under the Program, to register their newborn children with the applicable aboriginal organization.

If a child of less than one year of age has not been registered, Clients (parents) should be referred to the respective office or organization:

Clients	Office/ Organization
First Nations	Their Band Office or the Registration Services Unit of AANDC at 1-819-953-0960.
Inuit in the Northwest Territories and Nunavut	Their respective territorial Department of Health and Social Services and Inuit organization.
Inuit Residing Outside of the Northwest Territories and Nunavut	The nearest Health Canada Regional Office.

The first Claim for drug items for all children must be manually submitted to Express Scripts Canada using the NIHB Pharmacy Claim Form. Subsequent Claims submitted on behalf of the child may be submitted via electronic submission and must include the child's parent's primary identifier (such as AANDC, Client or Band/ Family Number, FNIHB Client Identification Number, NWT or NU health plan number) in the **Client Identification Number** field, and the child's identifiers in the Surname, Given Name, and Date of Birth fields.

Note To ensure ongoing Client eligibility, parents must obtain a Client Identification Number from the respective Registrar Office/ organization for the child prior to the child's first birthday.

4.1.5 NIHB Administered by First Nations and Inuit Organizations

The Program is sometimes administered by First Nations and Inuit organizations and/ or territorial Health Authorities through specific arrangements. These arrangements may lead to the creation of alternate health service delivery models.

In cases where a Client is no longer covered under the Program for a specific benefit type, Providers are notified through the Pharmacy Newsletter of the appropriate new benefit administrator. At that time, members of those groups receive benefits through their First Nations or Inuit organizations rather than through the Program. Providers are directed to the respective First Nations or Inuit organization for further information.

The following First Nations/ Inuit organizations have assumed the administration for the delivery of Pharmacy benefits:

- Akwesasne Band #159
- Bigstone Cree Nation #458
- James Bay Cree (9 bands):
 - o Naskapis #081
 - o Chisasibi #058

- o Eastmain #057
- o Nemiscau #059
- o Waskaganish #061
- o Waswanipi #056
- o Wemindji #060
- o Whapmagoostui #095
- o Mistassini #075
- Nunatsiavut Government (formerly the Labrador Inuit Health Commission)
- Nisga'a Valley Health Board:
 - o Gingolx #671 (Kincolith)
 - o Gitakdamix #677 (New Aiyanih)
 - o Lakalzap #678 (Greenville)
 - o Gitwinksilkw #679 (Canyon City).

4.2 Coordination of Benefits

Providers must confirm with each Client for each Claim whether Other Coverage exists. If the Client confirms that Other Coverage exists, the Provider must submit the Claim to the other payer *first* before submitting for Program coverage.

The first payer may be provincial (e.g., Assistive Device Program), territorial or private health care plans, and can include Social Services, Workers Compensation Board (WCB), and employee benefit programs. After the first payer processes the Claim and generates an Explanation of Benefits (EOB), the EOB and a copy of the Claim can be sent to Express Scripts Canada for processing. The EOB must include the amounts paid by the first payer.

Note The Program only covers eligible Claims which are *not* covered by another first payer plan.

4.2.1 Coordination of Benefits with the Ontario Drug Benefit

For eligible Clients over 65 years of age and social service recipients, Ontario pharmacists must coordinate drug benefits and pursue payment through the Ontario Drug Benefit (ODB) Program prior to submitting a Claim through the Program.

For drugs listed on the ODB Limited Use Benefit List, Ontario Providers must determine whether the Client is eligible under the ODB Program before sending a Claim to Express Scripts Canada. This may include contacting the Prescriber to determine if the Client meets ODB criteria. Results must be documented and kept on file in the Client's profile for review during an on-site audit. If the pharmacy software does not allow proper submission and payment for the drug, Providers are requested to submit the Claim manually to Express Scripts Canada and contact their vendor to update the software.

Failure to maintain proper documentation results in the Provider having to re-submit the Claim.

Effective December 9, 2011, it is no longer necessary for Pharmacy Providers to submit a Special Services Fee (SSF) for Clients who are eligible to receive Ontario Drug Benefits (ODB) when submitting a NIHB coordinated ODB Claim to Express Scripts Canada.

As a result of this change, ODB Claims (provincial coordination of benefits in Ontario) will continue to be entered with the Drug Cost, Dispensing Fee, Mark-up, and the amount

covered by the provincial program as the submitted "First Payer Share" in the appropriate fields with the CPhA Intervention Code "DA".

In addition, selected drugs that have Client frequency limits will generate "CR - Patient is Exceeding Dosage Safety Limit" when NIHB Client frequency limits are exceeded for ODB Coordination of Benefits Claims. This serves only as a warning at this time and the Claim will still be processed.

Should you have any questions, please contact the Provider Claims Processing Call Centre (refer to [Section 6.2.1 Provider Claims Processing Call Centre](#)).

4.2.2 Drug Utilization Review Program

All Claims go through the Drug Utilization Review (DUR) Program process when submitted via POS. This also applies to Claims which were first sent to a provincial/territorial plan and were not reimbursed by the plan.

This process ensures that Providers are advised of potential drug-related problems or interactions. As such, the purpose of DUR is not to replace professional judgment or individualized Client care in the delivery of healthcare services, but to enhance it with additional information. Once the Provider has reviewed the DUR warning message and has consulted the Prescriber, the Client, or other sources where applicable, it may be appropriate for the Provider to resubmit the returned Claim with a valid CPhA Intervention Code.

The Program requires that Providers document the nature of their intervention directly on the prescription hard copy or on the electronic Client profile, and that the documented intervention be retained for audit purposes as supporting documentation. Claims reviewed as part of the DUR Program process are subject to audit and may be recovered if the nature of the Provider's intervention is not documented.

Appropriate supporting documentation includes, but is not limited to:

- Date of intervention.
- Pharmacist's summary of the intervention.
- Documented communication with the physician, caregiver, and/ or Client.
- Reason for early refill (medication lost, destroyed, stolen, physician changed dosage or Client going out of town for a period greater than the day's supply remaining on the current refill).

For more information, contact the Provider Claims Processing Call Centre (refer to [Section 6.2.1 Provider Claims Processing Call Centre](#)).

4.2.3 Refusal to Fill (Dispense) Fee

A Pharmacy Provider in British Columbia, Saskatchewan, or Manitoba may decide not to fill (dispense) a prescription when a Claim has been returned through the DUR, and it is deemed to be in the best interest of the Client. The Refusal to Fill (Dispense) is only applied to EDI Claims.

In these cases, a fee equal to the Providers U&C fee may be charged to the Program through the Refusal to Fill (Dispense) Fee. The Provider is advised to re-submit the original Claim and use "UL" Intervention Code, along with the original information on their Claim.

4.3 Prior Approval Process for Drug Benefits

A Prior Approval (PA) may be required from DEC under the following circumstances:

- "Exceptions" for items that do not appear on the DBL.
- "Limited Use Benefits" for items that appear on the DBL.
- "Open Benefits" for items that appear on the DBL, but have quantity frequency limitations.
- "Open Benefits" for items that appear on the DBL, but the total amount Claimed exceed \$999.99 or the 100-day supply limit.

Some special requests outside published criteria for "Limited Use Drug Benefits" and drug items not listed on the DBL may be considered for coverage in special circumstances on an exception basis, and require a PA.

Note MS&E PAs given through the Health Canada Regional Offices are for an item, not the cost of the item, and as such, Providers are prohibited from billing the Program above the Actual Acquisition Cost (ACC).

4.3.1 Prior Approval Process for Prescription Drugs

The Pharmacist contacts the DEC and provides details about the: prescription, Prescriber, Pharmacist, and the Client.

If required, the DEC analyst faxes a copy of the Exception or Limited Use Drug Request Form to the Prescriber. The physician or eligible Prescriber completes the form stating the exceptional medical need for the drug.

The response is reviewed and a decision made. The decision is communicated to the Pharmacist via a faxed Confirmation Letter - the decision process can take up to a few days. The time for approval is dependent on the physician or licensed Prescriber providing the required information.

PAs are entered electronically on the Claims processing system. The date of dispense should be indicated to the analyst to ensure that the Date of Service (DOS) is included in the approval period to avoid returned Claims.

4.3.2 Prior Approval Confirmation Letter

Once approval is granted, a Prior Approval Confirmation Letter with the applicable dates and PA details is faxed to the Provider. Please retain this Prior Approval Confirmation Letter for billing purposes and/ or to validate any discrepancies.

When submitting the Claim, Providers must be sure to include the date of service (dispense date). This date is important as it will determine if the Claim will be paid:

- PAs for one-time dispense items are dated the day the request is set up in the system. Claims with dates of service (date of dispense) prior to the date of the PA will be returned. If a request to consider backdating the PA start date is received from the Provider at the time of the call, the DEC may backdate the PA start date.
- PAs for multiple dispense items or items approved after the date of dispense (with justification) are dated the day of the request with a start and expiry date. The DOS on the Claim must be after the start and before the end date on the PA or the Claim will be returned.

Prior Approval Confirmation Letters for drug items involving refills may indicate:

- Max. Dispensing Fee.
- Unit Cost.
- Max. Number of Refills.

- First Payer Share.
- Minimum Quantity/Claim.
- Item Number.
- Item Name.
- Start and Expiry Date.
- Mark-up approved for each Claim adjudicated against a PA (instead of the total mark-up allowed for all Claims adjudicated against the PA).
- Total approved amounts for the quantity and dollar amounts for all Claims adjudicated for an item against the PA up to the indicated number of refills (instead of the approved quantity and dollar amount for each Claim).
- General Comments.

4.3.2.1 Confirmation

If a PA is granted, the Provider is provided with a PA Number for billing purposes. The Provider should record this number and make note of the approval details (e.g., description, quantity, dollar value, and any time limitations).

A Prior Approval Confirmation Letter with the applicable dates and PA details is sent by e-mail, fax, or mail to the Provider. The Prior Approval Confirmation Letter should be retained for billing purposes.

4.3.2.2 Claim Submission with a Prior Approval

When submitting a Claim for an item that has been prior approved, ensure that the PA Number on the Claim matches the PA Number on the PA Confirmation Letter and that the Date of Service is the dispense date.

A comprehensive review of mandatory information in transmissions and submission options can be reviewed by referring to [Section 7. Pharmacy Statement Messages and Explanations](#).

4.3.3 Emergency Supply Process

Not all drugs are eligible for emergency dispensing. When an eligible drug requiring a PA is needed on an emergency basis and the criteria for an automated PA have not been met (i.e., a Claim is submitted online and PA is not electronically granted, as indicated by the generated CPhA message), and access to the DEC is not possible (i.e., statutory holidays and after hours of operation), a Pharmacist may dispense an initial course of treatment (maximum four (4) day's supply).

The Provider must then resubmit the returned Claim through the PA process as soon as the DEC is available through regular business hours so that the DEC can review the request for emergency supply coverage right away.

After an emergency dispense, Providers must follow the usual PA process to dispense the balance of the prescription. If a PA is granted for the remainder of the prescription, the:

- a) Pharmacist will receive a PA Number and details of the approved benefit by mail or fax.
- b) PA Number must then be included on the subsequent submitted Claim. Claim submissions for drugs dispensed as an emergency supply during regular hours of operation of the DEC are subject to recovery.

4.3.4 Auto Approval Procedure

The HICPS system has the capacity to automatically adjudicate a number of medications to reduce the time the Client waits to get the medication. The enhancement to the PA process is of great benefit to Providers as it enables faster electronic processing of certain Claims without the need to call the DEC.

The system verifies pre-requisite drug therapy as identified in the DBL for Limited Use Criteria.

In certain situations, the system will provide a prompt to Pharmacists to continue with the PA process automatically, and if the Pharmacists select this prompt, the request will automatically be sent to DEC for review without necessitating a call to the DEC. In this way, DEC can immediately send a review questionnaire (BEQ) to the physician, and thereby reduce the workload of Pharmacists by eliminating the call to the DEC.

If a request for one of these drugs does not comply with the Limited Use criteria, the Claim will generate a CPhA Code RW - Special Authorization Required and message SA Needed - Re-submit With [DR]. To proceed the Provider may initiate a PA request to the DEC by submitting the Claim with the Intervention Code DR.

The resubmitted (DR) Claim will return, returning with CPhA Response Code "RZ" Response Code "RZ" (request for Coverage Logged) along with message Submitted for Review: Case # XXXXXX. The Case # serves as your confirmation of a logged request for PA with the DEC.

The DEC will then follow-up with the Provider to verify the PA request, and collect additional information as required.

Consult the quarterly DBL to view the full listing of drugs that are eligible for Auto-Approval at www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/pharma-prod/med-list/index-eng.php

4.3.5 Processing and Payment of Claims

For any billing method used by Providers the Claim **must** include all the required data elements to enable the efficient processing and payment of Claims. Data elements must be submitted in the same order as displayed on the NIHB Pharmacy Claim Form.

Manual Claims should be submitted *at least every two (2) weeks* using a computer generated form or NIHB Pharmacy Claim Form, if the Claim is older than 30 days, otherwise reversal and corrections can be completed via POS.

Reversals and corrections (with the stated reason for reversal) to previously paid Claims should be submitted on the Pharmacy Claim Statement.

A complete listing of billing and payment guidelines may be located by referring to [Section 7. Pharmacy Statement Messages and Explanations](#).

4.3.6 Methadone Billing (Pseudo-DIN 00908835)

Methadone used for the treatment of opioid dependence does not require a PA except in the Atlantic Region (New Brunswick, Newfoundland and Labrador, Nova Scotia, and Prince Edward Island) where methadone is considered a Limited Use Benefit (LU).

Pseudo-DIN 00908835 must be used when submitting a Claim for methadone that is compounded for treatment of opiate dependency. Claims submitted with another pseudo-DIN will be subject to reclaim.

The following information must be taken into consideration when submitting methadone Claims:

- The treating physician has assessed the client and prescribed methadone maintenance treatment in accordance with the policies and procedures outlined by their province of residence.
- The Client is 16 years of age or older.
- The day's supply on previously paid methadone Claims must be used before any other day's supply can be dispensed to a Client.
- There is a seven (7) day supply limit for methadone.
- This limit is the maximum number of doses that can be dispensed to a Client in one day.
- Dispensing fees submitted on methadone Claims must be based on the number of doses dispensed to the Client, and must not exceed the pricing guidelines for the Provider's province/ territory.
- The methadone prescribing physician agrees to be the only prescriber of benzodiazepines and opioids for this client while he/she is receiving methadone therapy.
- A different Provider cannot submit methadone Claims for the same Client on the same date of service. The client agrees that NIHB coverage of opioids and benzodiazepines will be restricted to the methadone prescriber while he/she is receiving methadone therapy.
- The prescriber billing number will be used to identify the authorized prescriber and will be requested by the analysts at the Drug Exception Centre. Please ensure to use the exact number for future claims of benzodiazepines and opioids (i.e., leading zeros matter). LU forms for methadone will be made available in authorized methadone prescribers' offices or clinics.

To facilitate the PA process, physicians are to complete the Methadone Request Form ahead of time and provide the form to the NIHB client to bring to their Pharmacy. When a pharmacist receives a completed form, please call the NIHB Drug Exception Centre (DEC) to obtain a case number, then fax it to the DEC.

NIHB clients that are already receiving methadone for opioid dependence prior to August 15, 2011 will be grandfathered as to not interrupt their methadone maintenance therapy. However, the NIHB Program will work with the client's treating physician and pharmacist to ensure the limited use criteria is followed within an appropriate time frame.

Current methadone reimbursement policies will remain in effect. For additional details, please refer to the Provider Guide for Pharmacy Benefits on Health Canada's website www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_drug-med/2010-prov-four-guide/index-eng.php

4.3.7 Special Authorization Confirmation Letters

An approval may be given by Health Canada's DEC via a Special Authorization (SA) Confirmation Letter to the Pharmacy Provider for a drug or drug group specific request.

The confirmation letter of approval is sent directly to the Pharmacy Provider, presenting:

- Item Code.
- Item Name.
- Eligible.
- Day's Supply.

- Maximum Quantity per Claims.
- Total Quantity.
- Drug Group Name.
- Start Date.
- End Date.

In addition, the confirmation letter states “Where indicated as eligible, please bill directly. Claims submitted against this SA will not be adjudicated correctly if the Claim is submitted with a Prior Approval (PA) number” with any additional comments.

4.4 Benefit Coverage and Limitations

Additional information of eligible benefits, and benefits with Program limitations and services requiring a PA, refer to the Provider Guide for Pharmacy Benefits located on the Provider Website at www.provider.express-scripts.ca (select **Policy and Program Information**) or contact the respective Health Canada Regional Office to request a copy.

Prescribed drugs are available to eligible FNIH Clients when **all** of the below conditions are satisfied:

- The item is listed on the current DBL, exceptions may be considered on a case by case basis.
- The item has been prescribed by a licensed Prescriber (licensed by and in good standing with the respective governing body or province in which they practice and the prescription has been written in accordance with the applicable provincial Prescriber guidelines) such as but not limited to:
 - o General Practitioner.
 - o Specialist.
 - o Nurse Practitioner.
 - o Midwife.
- The prescription is valid (as defined by federal and provincial legislation) and written by a valid Prescriber. Note that the original prescription must be kept on file for two years or as long as it is being dispensed against, if longer than two years. Valid prescriptions must be kept on file for two years after the last dispense date (not the date of prescription).
- The item on the DBL is dispensed by a licensed pharmacist or physician authorized by the College of Pharmacists to dispense and who has registered with Express Scripts Canada.
- When required, a PA has been provided by the DEC (for more information on the process, refer to [Section 4.3 Prior Approval for Drug Benefits](#)).
- The Provider will not switch a Client’s prescription to a drug that is not a formulary drug on the DBL, except for generic substitution opportunities or where required by medical necessity. The Provider shall not implement any substitution program for a Client that is inconsistent with the DBL.
- The item is not available to the Client under a federal, provincial, territorial or first payer health care plan. For additional policy information, refer to [Section 4.2 Coordination of Benefits](#).

Note Providers must comply with the Provider criteria to ensure the prescribing authority adheres to the Program Policy. Provincial rules and regulations for prescribing authority may not be applicable under the Program. In cases where NIHB policies differ from provincial policies about who may prescribe, the NIHB policies prevail.

The DBL is available for download on the Provider Website at www.provider.express-scripts.ca (select Drug Benefit List) or Health Canada website at www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/pharma-prod/med-list/index-eng.php The DBL updates are generally updated on a quarterly basis.

4.4.1 Open Benefits

Open benefits are those drugs listed in the DBL do not have established criteria, frequency limitations, gender/ age limitations, or PA requirements.

4.4.2 Limited Use Benefits

Certain drug products may be inappropriate for general listing, but have value in specific circumstances. These products may be recommended as "limited use benefits" with specific criteria for provision as a benefit under the Program. A product is designated for limited use when:

- It has the potential for widespread use outside the indications for which benefit it was prescribed.
- It has proven effectiveness, but is associated with predictable severe adverse effects.
- It is usually a second or third line choice for treatment and is required because of allergies, intolerance, treatment failure or non-compliance with a first line alternative.
- It is very costly and a therapeutically effective alternative is available as a benefit.

There are three types of limited use benefits:

- Limited use benefits that do not require PA but have age or gender limitations. Examples: Multivitamins (which are benefits for children up to 6 years of age), and prenatal and postnatal vitamins (which are benefits for women of childbearing age, 12 to 50 years old).
- Limited use benefits that require a PA.
- Benefits which have a quantity and frequency limit. A maximum quantity of a drug is allowed within a specified period of time. No PA is required for the Client to obtain the allowable quantity of the drug within the specified period. For example, drugs with a quantity and frequency limit include smoking cessation products. Clients are eligible to receive a specified quantity over a specified period of time smoking cessation products which is renewable for twelve (12) months from the day the initial prescription was filled.

4.4.3 Exceptions

Drugs which are not listed in the DBL may be approved in special circumstances upon receipt of a completed "Exception Drugs Request Form" from an eligible Prescriber. Requests for exceptions are considered when:

- The prescription is for a recognized clinical indication and dose which is supported by published evidence or authoritative opinion.
- There is supporting evidence that available alternatives are ineffective, toxic, or contraindicated (personal preference alone does not justify an exception).
- There is significant evidence that the requested drug is superior to drugs already listed as Program benefits.

- A Client has experienced an adverse reaction with a best price alternative drug, and a higher cost alternative is requested by the Prescriber.

4.4.4 Exclusions

Certain drug products are not within the scope of the Program. These products are not reimbursed as benefits under the Program:

- Anti-obesity drugs.
- Household products (regular soaps and shampoos).
- Cosmetics.
- Alternative therapies, including glucosamine and evening primrose oil.
- Megavitamins.
- Drugs with investigational/ experimental status.
- Vaccinations for travel indications.
- Hair growth stimulants.
- Fertility agents and impotence drugs.
- Selected over-the-counter products.
- Codeine containing cough preparations.
- Darvon[®] and 642[®] (propoxyphene) - effective June 1, 2004.
- Stadol NS[®] and generics (butorphanol tartrate nasal spray) - effective August 1, 2005.
- Fiorinal[®], Fiorinal[®] C ¼, Fiorinal[®] C ½ and generics (Butalbital containing analgesics with and without codeine) - effective August 1, 2005.

Refer to Exclusions by the Common Drug Review and the NIHB Drugs and Therapeutics Advisory Committee (DTAC) found within the DBL Section for drugs that are excluded from the Program as recommended by the Common Drug Review (CDR), and the FPT Committee.

4.4.5 Appeal Process

When a benefit is denied, three (3) levels of appeal are available under the Program which the Client, parent or their legal guardian can initiate. At each level, supporting information from the Prescriber or Provider must accompany the appeal.

The following information should be included:

- The condition (diagnosis and prognosis) for which the benefit is being requested.
- Alternatives that have been tried.
- Relevant diagnostic test results.
- Justification for the proposed benefit or service, and any additional supporting information.

Information outlining the procedures of appeal is available on the Health Canada website at www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/appe/index-eng.php

Items excluded under the Program are not subject to the appeal process. Please direct Clients to the respective Health Canada Regional Office for additional information.

4.4.6 Special Promotion/ Coupon/ Discounts

A Client shall not benefit, directly or indirectly from special promotions or incentives including coupons, discounts, points or rebates in the form of cash, and/ or goods that may be offered by Pharmacy or MS&E Providers. To the extent permitted by applicable law, the Program shall receive the benefits of these promotions.

As a result, the amount claimed through the Program must be the residual amount after application of the promotion.

4.4.7 Formulary for Chronic Renal Failure Clients

The Program has established a special formulary for chronic renal failure Clients to provide access to drugs not listed on the DBL, which are required on a long-term basis. Eligible products are listed in DBLs.

New Clients requiring drugs on the special formulary will be identified for coverage through the usual PA process. Once the Client is confirmed as eligible, coverage will automatically be extended to all drugs in the special formulary for as long as needed.

4.4.8 Palliative Care Formulary

Clients diagnosed with a terminal illness and are near the end of life will be eligible to receive a list of supplemental benefits that are not included in the DBL. The Palliative Care Formulary includes medications used to provide comfort to those near the end of life.

Requests for any of the DINs on the Palliative Care Formulary are to be made to the DEC at 1-800-580-0950 (English) or 1-800-281-5027 (French). This will generate a Palliative Care Application Form, which will then be faxed to the prescribing physician.

Once completed and submitted, the recipient will be eligible for all medications on the Palliative Care Formulary if the following criteria are met:

- The recipient is not receiving care in a provincially covered hospital or provincially covered long-term care facility; and,
- The recipient has been diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less.

Once approved, the recipient will be eligible for all medications on the Palliative Care Formulary for six (6) months without the need for further PA. If coverage is required beyond the initial six (6) months, an additional six (6) months may be granted upon receipt of another completed Palliative Care Application Form.

During the six (6) month coverage period, a maximum 30 day supply will be reimbursed at any one time.

5. Provider Audit Program

5.1 Audit Objectives

The objective of the Express Scripts Canada Provider Audit Program is to confirm that Claims have been submitted in compliance with the Terms and Conditions of the Program including:

- Detect and recover for billing/ Claim irregularities.

- Ensure there is a valid prescription order (as defined by provincial and federal regulations) and supporting documentation for the provided services as stated in Agreement and the Kit.
- Ensure appropriate billing of the actual acquisition cost of drugs or as defined by negotiated regional schedules up to the NIHB maximum.
- Ensure appropriate billing applicable mark-ups, up to the maximum defined by negotiated regional schedules (where applicable).
- Ensure the dispensing fee Claimed/ and paid does not exceed a Provider's U&C professional fee.
- Ensure that the services paid for were received by eligible Program Clients.
- Validate active licensure of Providers.
- Ensure the rationale for DUR overrides and all other interventions are noted with adequate supporting documentation.
- Ensure compliance with the Program.

Express Scripts Canada reserves the right to withhold future payments to Providers, pending receipt of monies found paid in error. Providers may contact the Provider Claims Processing Call Centre to clarify or appeal the payment error reversal.

The Express Scripts Canada Provider Audit Program does not focus on professional practice issues. If a practice related issue arises during an audit and if the issue cannot be resolved directly with the Provider, Express Scripts Canada or Health Canada may refer the matter to the respective regulatory body.

5.2 Provider Responsibilities

The Provider shall cooperate with Express Scripts Canada in all audit activities based on generally accepted industry practices. Upon request, the Provider shall grant access to its location to Express Scripts Canada to inspect, review and reproduce during regular business hours, any Pharmacy records maintained by the Provider pertaining to Clients, as Express Scripts Canada deems necessary to determine compliance with the terms outlined in the documents outlined in [Section 3.1.3 Pharmacy Documentation and Updates](#).

5.3 Provider Audit Components

To carry out all audit components of the Program, Express Scripts Canada requires access to information, including, but not limited to the following:

- Client's profile.
- Original prescription.
- Shipping invoices.
- Internal invoices.
- Manufacturers' invoices (to determine Actual Acquisition Cost).
- Documentation of item received by the Client (such as Methadone Log Books).
- Evidence of additional coverage (to coordinate benefits).

5.3.1 Next Day Claims Verification Program

The Next Day Claims Verification (NDCV) Program consists of a review of a defined sample of Claims submitted by Providers the day following receipt by Express Scripts Canada.

Providers may be contacted to provide copies of prescriptions, records/ charts and/ or internal invoices as well as any other supporting financial data. If the requested documents are not available for review or if any errors are detected through this process the audited Claim amount will be adjusted or denied for payment.

Claims submitted for extemporaneous mixtures which do not contain at least one ingredient on the DBL will be reversed in the system and subject to reclaim. If the requested documents are not available for review, or if any errors are detected through this process, the audited amount will be adjusted.

5.3.2 Client Confirmation Program

Confirmation consists of a monthly mailing out to a randomly selected sample of Clients to confirm the receipt of the benefit that has been billed on their behalf.

5.3.3 Provider Profiling Program

Profiling consists of a review of the billings of all Providers against selected criteria and the determination of the most appropriate follow-up activity if concerns are identified. All Claims are subject to an audit review.

5.3.4 Desk Audit Program

This consists of a review of a defined sample of Claims focusing on a particular issue evident in a Provider's billings. The Provider is requested to submit records to Express Scripts Canada for administrative review.

5.3.5 On-Site Audit Program

The purpose of the on-site audit is to verify paid Claims against Client records. Providers may be selected as a result of information gained through any of the components of the Express Scripts Canada Provider Audit Program, and any additional information received.

5.3.5.1 Stages of an On-Site Audit

Express Scripts Canada contacts the Provider at least three (3) weeks prior to the proposed on-site audit date. Wherever possible, an every effort is made to accommodate the audit date with the Provider's schedule. The date agreed upon for the on-site audit is confirmed by fax with the Provider by way of an On-site Audit Confirmation Letter.

The Pharmacy Audit Specialist(s) requires:

- Work space, chairs.
- Access to an electrical outlet(s).
- Access to and assistance in retrieving computerized Client profiles with a staff member.
- A dedicated staff member on-site to retrieve hard copy prescriptions and associated information.
- Access to the individual who will be responding to the audit report.

The Pharmacy Audit Specialist arrives at approximately 9 a.m. or at a mutually agreed upon time. The audit is expected to take place until 5 p.m. each scheduled audit day (unless otherwise mutually agreed-upon). At 9 a.m. on the first day of the audit, the

Pharmacy Audit Specialist provides a brief orientation to the audit process and answers any questions.

5.3.5.2 Pre-Audit/ Entrance Interview

The Provider is asked to describe the records filing system for tracking prescriptions, and whether the documentation for Claim transactions is maintained on hard copy or electronically on the Client's profile. The Provider is requested to dedicate- an on-site staff member to retrieve the records for the Pharmacy Audit Specialists to review. The Pharmacy Audit Specialist will indicate to the Provider that a Post-Audit Summary is supplied at the end of the on-site audit.

5.3.5.3 Conduct of the On-Site Audit

Remaining Claims documentation not provided on-site will be listed for recovery in the Initial Audit Report. Claims not supported by the required documentation appear as recoveries in the Initial Audit Letter and Initial Audit Report to the Provider.

5.3.5.4 Post-Audit Interview

At the end of the on-site audit, the Pharmacy Audit Specialists provides a general overview of the categories of errors found. The final audit results won't be complete until the Pharmacy Audit Specialists has conducted additional analysis, such as, but not limited to, Client and Prescriber confirmations. During the Post-Audit Exit Interview, the Provider is provided with a standard checklist to complete and send to Express Scripts Canada, which serves to confirm the audit process conducted at the respective on-site audit.

5.3.5.5 Audit Report

A report of the audit findings is sent to the Provider within sixty (60) days of the on-site audit. If there are delays in meeting this deadline, a letter is sent to the Provider advising of the delay and the revised delivery date for sending the Audit Letter and Audit Report. Once the Audit Letter and Audit Report are received, and in the event that there are audit observations resulting in recovery of Claims, the Provider has thirty (30) days to respond to Express Scripts Canada. If the Provider needs additional time to respond, a request for additional time is to be sent in writing to Express Scripts Canada.

Within sixty (60) days of the response from the Provider, Express Scripts Canada sends a letter and report of the final audit findings to the Provider. In the event that there are final audit findings resulting in recovery of Claims, the Provider has thirty (30) days from the date of the final audit letter in which to submit a cheque (payable to the Receiver General for Canada) to Express Scripts Canada for the reimbursement of the identified overpayment. Failure to respond within thirty (30) days of the date of letter, a withhold is placed against the Provider's payment statements until recovery is paid in full.

5.3.5.6 Documentation Requirements for Audit Purposes

Providers must retain a copy of the original prescription on file for two (2) years or as long as it is being dispensed against, if longer than two (2) years in accordance with provincial/ territorial requirements. Claims for which the original prescription or supporting documentation (such as invoices and Methadone Log Books) is not available for review including those with PAs may be recovered through the Express Scripts Canada Provider Audit Program. A unique Prescription Number must be assigned by the Provider for each item dispensed and claimed.

Hard copy and electronic Client records are reviewed where documentation is required (documentation of DUR - overrides, therapy change, etc.). The types of documentation needed are requested at the beginning of the audit in order to facilitate the process.

5.3.5.7 Supporting Documentation

Proper documentation of any intervention is required for verification against the Program's billing criteria. Appropriate supporting documentation includes, but is not limited to:

- Date of intervention.
- Summary of the intervention by the Pharmacist.
- Documented communication with the physician, caregiver, and/ or Client.
- Reason for early refill (e.g., medication lost, destroyed, stolen, physician changed dosage, or Client going out of town for a period greater than the day's supply remaining of the current refill).
- Manufacturer's invoices required to substantiate invoice cost plus applicable negotiated maximum NIHB mark-up.
- Shipping invoices.
- Internal invoices.
- Evidence of additional coverage (to support Coordination of Benefits (COB)).
- Items awaiting pick-up (to verify pickup within thirty (30) days of fill or Claim reversal is required).
- Documentation to verify that the Clients are eligible as registered First Nations or recognized Inuit.
- Methadone Log Book.

A separate valid prescription (as defined by federal and provincial legislation) is required for each member of a family for the reimbursement of Claims submitted through the Program.

Separate Claims must be submitted for each Client using the Client's own unique Client Identification Number and Prescription Number to ensure accurate Client drug profiles. This includes prescriptions for products used by more than one person in the family at the same time such as head lice treatment.

5.3.6 Reference Documents

For more information about the Provider administration Express Scripts Canada Provider Audit Program activities, refer to the:

- NIHB Annual Report.
- Agreement.
- Pharmacy Newsletters.
- Bulletins
- Provider Guide for Pharmacy Benefits.
- DBL.
- Provincial and federal drug and Pharmacy legislation.

Providers may refer to the Agreement, Provider Guide for Pharmacy Benefits, DBL and DBL updates, and the Pharmacy Newsletters which are located on the Provider Website at www.provider.express-scripts.ca

Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to [Section 6.2.1 Provider Claims Processing Call Centre](#)).

The Annual Report may be viewed and downloaded from the Health Canada website at www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/2011_rpt/index-eng.php

5.3.7 Additional Audit Information

Providers requiring additional information about the Express Scripts Canada Provider Audit Program may contact Express Scripts Canada in writing at the following address:

Express Scripts Canada
Manager, Business Integrity – Pharmacy and MS&E
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5

6. Pharmacy Forms and Resources

6.1 Pharmacy Forms

All Pharmacy forms listed below are located on the the Provider Website at www.provider.express-scripts.ca

Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre to request a copy of any of the items below by fax or mail (refer to [Section 6.2.1 Provider Claims Processing Call Centre](#)).

- Pharmacy Provider Agreement.
- NIHB Pharmacy Claims Submission Kit.
- NIHB Pharmacy Claim Form.
- Modification to Pharmacy and Medical Supplies and Equipment Provider Information Form.

6.2 Resources

6.2.1 Provider Claims Processing Call Centre

The call centre is available to registered Pharmacy Providers of the Program:

Phone No.:

1-888-511-4666

Extended Hours of Operation:

Monday to Friday: 6:30 a.m. to 12 a.m. Eastern Time

Saturday, Sunday and Statutory Holidays: 8 a.m. to 12 a.m. Eastern Time

6.2.2 Mailing Address for Pharmacy Claims

Pharmacy Claims are to be mailed to the following address:

Express Scripts Canada
NIHB Pharmacy Claims
P.O. Box 1353, Station K
Toronto, ON M4P 3J4

6.2.3 Other Correspondence

Other correspondence for fax and mail are as follows:

Fax Number:

1-855-622-0669

Mail:

Express Scripts Canada
Provider Relations Department
5770 Hurontario St., 10th Floor
Mississauga, ON L5R 3G5

6.2.4 Express Scripts Canada Privacy Policies

Express Scripts Canada must follow all applicable privacy laws.

Express Scripts Canada's privacy policy is based on applicable privacy laws in Canada, including the federal Personal Information Protection and Electronic Documents Act (PIPEDA) and the Privacy Act.

For more information regarding Express Scripts Canada's Privacy Policy, contact:

E-mail:

ExpressScriptsCanada_Privacy@Express-Scripts.com

Website:

www.express-scripts.ca/about/privacy-policy

Telephone:

905-712-8615 or 1-888-677-0111 (ask for the Privacy Officer)

Mail:

Express Scripts Canada
Privacy Office
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5

6.2.5 Really Simple Syndication Feed

Really Simple Syndication (RSS) is a useful tool for keeping updated on your favorite websites. Updates to the site are broadcast to subscribers through an RSS feed.

Sign up for an RSS feed and a message will appear in your feed reader every time new information is added to that section of the Health Canada website. When an update is sent out, it includes a headline and a small amount of text, either a summary or the lead-in to the larger story.

RSS feeds have addresses like a website, but you can't read them directly with your browser. They have a different format than web pages, so you'll view garbled text if you try. In order to receive RSS feeds, you must have an aggregator, otherwise called a feed reader. There are a number of free aggregators online, and with a little searching you will be able to find an interface that appeals to you. In addition to availability on your computer, RSS feeds can also be read on PDAs and cell phones.

6.2.5.1 Add to your Aggregator

To add your aggregator, you can do so in one of two ways:

1. Most sites that offer an RSS feed have an RSS or XML button on their homepage that you can click on and instantly add that feed to your aggregator.
2. Depending on your aggregator, you may instead need to copy and paste the URL of the feed into the program.

By either method, the feed will be available as soon as you've added it, and your next update could arrive at any given moment. If you decide that you no longer want to receive updates, simply delete the feed or URL from your aggregator.

6.2.5.2 Add E-mail to RSS Services

There is also an added service where you can register online to have the RSS feed sent directly to your e-mail account.

The following are a few free online services that let you subscribe to RSS feeds via e-mail:

- FeedBlitz at www.feedblitz.com
- Yahoo! Alerts at <http://alerts.yahoo.com>

Express Scripts Canada does not support these websites. We accept no responsibility or liability for your use of, or reliance on, content provided or any malicious programs on the websites. These links are provided for your information and convenience only.

To receive e-mail notices through an e-mail RSS service:

1. Copy the .xml URL link
2. Paste it into the e-mail subscription page.

Websites:

- Health Canada, NIHB Program:
www.hc-sc.gc.ca/fniah-spnia/index-eng.php
- Express Scripts Canada, Corporate Website:
www.express-scripts.ca
- Express Scripts Canada, NIHB Claims Services Provider Website:
www.provider.express-scripts.ca

For more details on Health Canada RSS feeds, visit:

www.hc-sc.gc.ca/home-accueil/help-aide/rss-eng.php#what

7. Pharmacy Statement Messages and Explanations

The HICPS system assigns three-character reject and warning codes with messages that appear on the Pharmacy Claim Statement.

Reject Code		Warning Code	
"R" followed by two numeric characters	Text message explains why the Claim was returned.	"W" followed by two numeric characters	Text message explains the Claim was adjudicated with modifications.

7.1 Pharmacy Claim Statement Details

The Pharmacy Claim Statement accompanies the Claims payment cheque and provides information about each drug, and medical supplies and equipment Claim processed. If payments are made through EFT, monies are deposited in the Provider's assigned bank account and the Pharmacy Claim Statement is mailed to the Provider's business address where the service was rendered. The Pharmacy Claim Statement may provide additional Client identification information, which should be added to the Client's records and be used for all future Claim submissions.

The Pharmacy Claim Statement lists all submitted and entered Claims settled, adjusted Claims, and Claims returned all during the current period. Returned Claims include the appropriate return message explaining the reason each Claim was not paid. Express Scripts Canada issues the Pharmacy Claim Statement twice a month on the 1st and 16th of the month in either English or French, depending on the Provider's language of choice.

7.1.1 Corrections to Claims using the using the Pharmacy Claim Statement

Providers can use the Pharmacy Claim Statement to reconcile accounts and to make corrections.

The existing information should not be erased. A line should be used to strike through the information that needs to be changed. Indicate the correction to the Claim(s) directly below the existing information on the Pharmacy Claim Statement and forward the applicable page to Express Scripts Canada within twelve (12) months from the date of service for re-adjudication of the Claim and to secure payment. Claims submitted more than twelve (12) months from the date of service will be returned with the R21 Message - Period for Submitting Claims has Expired.

Providers who re-submit using a Pharmacy Claim form **must** clearly indicate the Claim is a re-submission by checking the "Resubmission" box located at the top of the claim form.

7.1.2 Standard CPhA Codes

The CPhA Codes are used for POS by all Canadian insurance carriers to communicate status of a Claim.

CPhA Codes are composed of two characters (alpha, alpha-numeric or numeric), and can be decoded with Pharmacy software packages. The wording of the CPhA messages displayed on the Pharmacy terminal may be different from the wording in the Kit due to the Pharmacy software. Providers requiring clarification of CPhA codes should contact their software vendor. A maximum of five CPhA messages (including DUR messages) can be sent back to the Provider for each Claim. Free-format messages may also be displayed to clarify the status of a Claim in certain situations.

7.1.3 POS Free-Format Messages

CPhA Standard allows for a POS free-format message with up to three (3) lines of forty (40) characters each. All adjudication free-format messages are set first, followed by DUR messages and broadcast messages.

Free-format messages are transmitted to Providers in the standard CPhA Claim response format, which allows for transmission of three (3) forty (40) character messages. Within the EDI Claim response, these forty (40) position fields are transmitted

as three (3) unique fields one after another. The actual display of these messages on the Provider’s software differs by software vendor package.

The following free-format messages apply only to Claims submitted via POS.

- Drug/ Drug Interaction Potential (Code: ME)
 - o Indicates that drug may interact with another current drug, based on an accurate day’s supply submission.
- Duplicate Therapy (Code: MX)
 - o Indicates the Client has received a drug from the same therapy class.
- Duplicate Therapy Multi-Pharmacy (Code: MZ)
 - o Indicates that the Client has received a drug from the same therapy class; however, the original prescription was filled at another Pharmacy.
- Duplicate Drug (Code: MW)
 - o Indicates that the Client has received the same drug (same chemical entity) and has used less than two thirds of the medication based on the day’s supply.
- Duplicate Drug Multi-Pharmacy (Code: MY)
 - o Indicates that the Client has received the same drug (same chemical entity) and has used less than two thirds of the medication based on the day’s supply; however, the original prescription was filled at another Pharmacy.
- Potential Overuse/ Abuse Indicated (Code: NE)
 - o Indicates potential overuse/ abuse of specified drug entities. Sent to Provider for Claims that meet one of the criteria below:

Use of Methadone for treatment of opioid dependency (pseudo-DIN 00908835), and at the same time, use of one or more opioid drug entities:

- Use of three (3) or more different opioid drug entities.
- Use of three (3) or more different benzodiazepine drug entities.
- Use of three (3) or more opioid drug entities, and three (3) or more drug entities and three or more benzodiazepine drug entities.

DUR information is conveyed in the form of reject and warning messages, depending on the severity of the potential problem. Claims prompting the following DUR messages will be returned: Duplicate drug (MW), Duplicate drug multi-Pharmacy (MY) and Drug/ drug interaction potential (ME) (where the free form message indicates “Interact-SV drug name qty fill date”) (e.g., a potential severe interaction), and Potential Overuse/ Abuse Indicated (NE).

7.1.4 CPhA Intervention Codes

The Provider can re-submit the returned Claims with a CPhA Intervention Code (see below for the applicable Intervention Codes), if applicable.

The following codes are used to override ME, MW, MY, and NE rejections.

Intervention Code	Description
UA	Consulted Prescriber and Filled Rx As Written
UB	Consulted Prescriber and Changed Dose
UC	Consulted Prescriber and Changed Instruction For Use
UD	Consulted Prescriber and Changed Drug

Intervention Code	Description
UE	Consulted Prescriber and Changed Quantity
UF	Client Gave Adequate Explanation. Rx Filled As Written
UG	Cautioned Client Rx Filled As Written
UI	Consulted Other Sources. Rx Filled As Written
UJ	Consulted Other Sources. Altered Rx And Filled
UN	Assessed Client, Therapy Is Appropriate
UL	Rx Not Filled – Pharmacist Decision
MR	Client Lost Medication. Rx Refilled

Note The “UL” Intervention Code may be used to request payment of the dispensing fee only for regions in which the Refusal to Dispense Program applies.

7.1.5 Codes, Messages and Explanations

Below is an ordered list of the codes (displayed as RXX), messages and explanations that may appear on the Pharmacy Claim Statement, cross-referenced with the applicable CPhA Codes.

Where no applicable NIHB Code exists (shown as N/A), the CPhA Code is shown.

NIHB Code/ CPhA Code	Description
NIHB Code: R01/ CPhA Codes: NF, D7	
Message	Methadone Dosing Overlap.
Explanation	This Claim has not been paid because the day's supply submitted on the current methadone Claim is overlapping with the day's supply on a previously paid methadone Claim.
NIHB Code: R02/ CPhA Code: KP	
Message	Multiple Providers Not Allowed For Client Methadone Claims On The Same Date Of Service.
Explanation	This Claim cannot be paid because more than one Provider has submitted a methadone Claim for the same Client on the same date of service.
NIHB Code: R03/ CPhA Code: DM	
Message	Day's Supply Exceed Plan Limit.
Explanation	This Claim has not been paid because the day's supply submitted on the Claim exceeds NIHB day's supply dispensing limit guidelines of seven day's supply for a specified Date of Service. This message is only set on methadone Claims submitted via POS.
NIHB Code: R04/ CPhA Codes: D1	
Message	This Is Not An Eligible Benefit.
Explanation	The Claim was not paid because the item is not covered under the Program. Client may be eligible for benefit on an exceptional basis, contact the DEC at 1-800-580-0950.

NIHB Code/ CPhA Code	Description
NIHB Code: R05/ CPhA Codes: C8	
Message	Claimant Could Not Be Verified as an NIHB Client.
Explanation	<p>The Claim cannot be paid because the claimant could not be verified as an NIHB Client. The verification problem may be due to the fact that the claimant:</p> <ul style="list-style-type: none"> a) Has not used their registered surname, given names, or Date of Birth (DOB), or; b) Has made an error in specifying the Client identification number. <p>In such cases, it may only be necessary for the claimant to provide more accurate Client identification information. However, if the claimant is not registered as an NIHB Client, it is necessary for the claimant to do so before service can be provided.</p>
NIHB Code: R06/ CPhA Codes: CD	
Message	Client is not eligible for this benefit.
Explanation	The Claim has not been paid because the item is not covered under the Program because of the age or gender of the Client. This restriction applies to benefits such as incontinence supplies and vitamins.
NIHB Code: R07/ CPhA Code: A3	
Message	This Is a Duplicate Claim.
Explanation	The Claim cannot be paid because the Claim is a duplicate of a Claim previously submitted by the Provider's Pharmacy. The match is based on the following data elements: Date of Service, Provider Number, Client Number, DIN, and RX#.
NIHB Code: R08/ CPhA Code: C6	
Message	The Client Is Over 65 - Submit To Ont. Drug Benefit.
Explanation	In the Ontario region, the Claim has not been paid because the item is eligible under the ODB (Ontario Drug Benefit) Program. Direct the Claim to the ODB first, and then send to NIHB for Clients co-pay and/or deductible.
NIHB Code: R09/ CPhA Codes: RP	
Message	LRB, Max exceeded, requires spec auth.
Explanation	This message is set for SA Claim whose data elements do not match those specified in the SA or is excluded for coverage by the SA.
NIHB Code: R10/ CPhA Code: B1	
Message	Invalid Provider ID.
Explanation	Provider is not registered as an NIHB Provider on Date of Service.

NIHB Code/ CPhA Code	Description
NIHB Code: R12/ CPhA Code: 32, 34, 37, 38	
Message	Insufficient Client Information to Adjudicate Claim.
Explanation	<p>The Claim did not provide sufficient information to determine if the claimant is an NIHB Client. To facilitate Client verification, this Client information must be provided for each Claim:</p> <ul style="list-style-type: none"> • Surname (CPhA: 38); • Given Names (CPhA: 37); • DOB (CPhA: 34); and • Client Identification Number (CPhA: 32). <p>Check the Claim for missing or incomplete information and provide the required information, or if greater than thirty (30) days by correcting the information on the Pharmacy Claim Statement.</p>
NIHB Code: R15/ CPhA Code: 57	
Message	Day's Supply Must Equal Seven for Dosette Packaging.
Explanation	The day's supply does not equal seven (7) days on this submitted Claim flagged as a Dosette Claim (the "P" in the SSC field functions as the flag).
NIHB Code: R16/ CPhA Code: 53	
Message	Original Prescription Number Error.
Explanation	<p>The prescription number must be numeric and greater than zero.</p> <p>The Provider should check the Claim for missing, incomplete, or erroneous information and provide the required information by following the Claims correction procedures outlined in Section 7.2.4 Payment Information under POS Reversals.</p>
NIHB Code: R17/ CPhA Code: 56	
Message	DIN/GP #/ PIN ERROR
Explanation	<p>All eight (8) positions must be valued, cannot be all zeros, and must be valid item number that exists on the Express Scripts Canada database.</p> <p>The Provider should check the Claim for missing, incomplete, or erroneous information and provide the required information by following the Claims correction procedures outlined in Section 7.2.4 Payment Information under POS Reversals.</p>
NIHB Code: R18/ CPhA Code: 58	
Message	Quantity Error.
Explanation	<p>The quantity must be numeric and greater than zero.</p> <p>The Provider should check the Claim for missing, incomplete, or erroneous information and provide the required information by following the Claims correction procedures outlined in Section 7.2.4 Payment Information under POS Reversals.</p>

NIHB Code/ CPhA Code	Description
NIHB Code: R19/ CPhA Code: 59	
Message	Day's Supply Error.
Explanation	The day's supply must be numeric and greater than zero. This is mandatory for drug items. The Provider should check the Claim for missing, incomplete, or erroneous information and provide the required information by following the Claims correction procedures outlined in Section 7.2.4 Payment Information under POS Reversals .
NIHB Code: R20/ CPhA Code: C6	
Message	Submit Claim to provincial or territorial health plan.
Explanation	The Claim has not been paid because a provincial or territorial health plan covers part of the item. Direct the Claim to the respective plan (applies to Ontario).
NIHB Code: R21/ CPhA Code: A1	
Message	Period for Submitting Claims Has Expired.
Explanation	The Claim has not been paid because the Claim was submitted more than one year after the service was rendered. In addition this applies to Claims that Providers attempt to submit after the 30 day limit for POS Claims has been exceeded.
NIHB Code: R22/ CPhA Code: 61	
Message	Prescriber ID Error (License or Billing Number).
Explanation	The Prescriber ID number can be alphanumeric and cannot be all zeros. The Provider should check the Claim for missing, incomplete, or erroneous information and provide the required information by following the Claims correction procedures outlined in Section 7.2.4 Payment Information under POS Reversals .
NIHB Code: R23/ CPhA Code: C2	
Message	Service Provided Prior to Client's Start Date.
Explanation	The Claim cannot be paid because the Date of Service is prior to the start date for the Client's NIHB coverage.
NIHB Code: R24/ CPhA Code: C3	
Message	Service Provided After Client's End Date.
Explanation	The Claim cannot be paid because the Date of Service is after the end date for the Client's NIHB coverage.
NIHB Code: R25/ CPhA Code: 64	
Message	Claim Does Not Comply With Terms of Prior Approval.
Explanation	The Claim has not been paid because it does not comply with the terms of the PA. Quantity per Claim has to match quantity per Claim on PA. Refer to your copy of the Prior Approval Confirmation.

NIHB Code/ CPhA Code	Description
NIHB Code: R26/ CPhA Code: 64	
Message	Prior Approval Service Date Violation.
Explanation	<p>The Claim has not been paid because the DOS does not correspond with the criteria for approval dates as follows:</p> <ul style="list-style-type: none"> a) For a one-time PA, the DOS cannot be prior to the approval date or greater than one year from the approval date. b) For standing order PAs, the DOS is before the start date or after the expiry date for the PA.
NIHB Code: R27/ CPhA Code: 64	
Message	Prior Approval Number Is Invalid.
Explanation	<p>The Claim has not been paid because there wasn't a match with the PA record for the following one or more reasons::</p> <ul style="list-style-type: none"> • Mismatch PA Number. • Mismatch Client Number. • Mismatch Provider Number. • Mismatch item Number. • Item wasn't approved. • PA isn't ready to be billed against. <p>The Provider should check their records to determine if the PA number, the associated Client Identification Number, and the Benefit Codes were submitted correctly. If an error was made, supply the correct information following the Claims correction procedures outlined in Section 7.2.4 Payment Information under POS Reversals.</p>
NIHB Code: R28/ CPhA Codes: 66	
Message	Drug Cost/Product Value Error.
Explanation	<p>The drug and/ or item cost must be numeric and greater than zero.</p> <p>The Provider should check the Claim for missing, incomplete, or erroneous information and provide the required information by following the Claims correction procedures outlined in the Section 7.2.4 Payment Information under POS Reversals.</p>
NIHB Code: R29/ CPhA Code: A2	
Message	Claim is postdated.
Explanation	<p>This must be in valid YYYY-MM-DD format and cannot be future date. If check fails, message is generated.</p> <p>The Provider should check the Claim for missing, incomplete, or erroneous information, and provide the required information by following the Claims correction procedures outlined in the Section 7.2.4 Payment Information under POS Reversals.</p>

NIHB Code/ CPhA Code	Description
NIHB Code: R30/ CPhA Code: C6	
Message	Client Has Alternative Coverage, Contact FNIH Regional Office.
Explanation	The Claim has not been paid because the Health Canada records indicate that the Client has alternative coverage for the indicated item. In some cases, the Client may belong to a Band that has assumed responsibility for the administration of NIHB. Contact the Health Canada Regional Office for direction on where to submit the Claim.
NIHB Code: R47/ CPhA Code: 64	
Message	Special Authorization for This Item Used Up By Previous Claim and quantity paid.
Explanation	The Claim has not been paid because the SA for this item has been used up by a previous Claim, based on day's supply paid.
NIHB Code: R48/ CPhA Code: 64	
Message	Prior Approval for This Item Used Up By Previous Claim.
Explanation	The Claim has not been paid because the PA for this item has been used up by a previous Claim. The quantity submitted or dollar amount submitted has exceeded the quantity or dollar amount left in the PA. Refer to your copy of the Prior Approval Confirmation.
NIHB Code: R49/ CPhA Code: CP	
Message	Benefit Requires Prior Approval.
Explanation	The Claim has not been paid because it requires PA from Health Canada. Benefits that require a PA are items over \$999.99. PA procedures are detailed in Prior Approval Process of the Kit.
NIHB Code: R49/ CPhA Code: RW	
Message	Benefit requires PA.
Explanation	The submitted Claim fails the auto approval criteria.
NIHB Code: R50/ CPhA Code: CO	
Message	Quantity exceeds frequency limits.
Explanation	The Claim has not been paid because the quantity/ frequency limit for the drug/ item has been exceeded. Detailed information is outlined in the Limited Use Benefits in the Kit.
NIHB Code: R51/ CPhA Code: RZ	
Message	Provider Requested PA Coverage.
Explanation	The Provider resubmits with a DR Intervention Code - the Claim that was previously returned with RW/ R49. The Claim is resubmitted to generate an automatic PA/ Case request.

NIHB Code/ CPhA Code	Description
NIHB Code: R66/ CPhA Code: 34	
Message	Date of Service Must Be After DOB.
Explanation	The Claim has not been paid due to the Client's DOB is after the Date of Service.
NIHB Code: R77/ CPhA Code: A3	
Message	Rx# previously paid for same Date of Service Client.
Explanation	The payment has been denied because all the data elements match the data elements of a previously settled Claim already on file. Refer to R07.
NIHB Code: W03/ CPhA Code: DM	
Message	Day's Supply Exceed Plan Limit.
Explanation	Day's supply reduced to conform to NIHB day's supply dispensing limit guidelines of seven day's supply for a specified Date of Service.
NIHB Code: W04/ CPhA Code: D8	
Message	Lowest-Cost-Equivalent Pricing Has Been Applied.
Explanation	The amount claimed has been reduced to the amount allowed for the lowest-cost equivalent, according to pricing guidelines. Refer to the details of the NIHB pricing agreement for the respective region.
NIHB Code: W05/ CPhA Code: N/A	
Message	Claim Paid On Parent ID until 1st Birthday Only.
Explanation	The claimant could not be verified as an NIHB Client. However, since the claimant is a child under one year of age, and the child's parent was verified as an NIHB Client, the Claim has been paid. This provision allows time for parents to register the child and only applies until the child's first birthday. A Claim for services provided after the child's first birthday is returned if the child cannot be verified as an NIHB Client.
NIHB Code: W09/ CPhA Code: DJ	
Message	Drug/ Item Cost Is Reduced To NIHB Pricing Guidelines.
Explanation	The amount claimed for drug/ item cost has been reduced to conform to pricing guidelines. Refer to the details of the NIHB pricing in the agreements with the respective region.
NIHB Code: W11/ CPhA Codes: E2, E3	
Message	Claim Is Reduced To NIHB Share.
Explanation	Generated on Claims which have the NIHB share amount reduced from the first payer share value being asked of NIHB to be paid. For items submitted with a first payer share amount and sent to another plan first, the NIHB payable amount has been reduced to a maximum allowed as per NIHB pricing rules.

NIHB Code/ CPhA Code	Description
NIHB Code: W12/ CPhA Code: QT	
Message	Part of Claim Exceeds Frequency Maximum And Is Disallowed.
Explanation	The quantity amount claimed has been reduced to conform to the frequency limitation allowed.
NIHB Code: W13/ CPhA Code: Quantity of Claim is Reduced to Maximum Allowed	
Message	Quantity of Claim Is Reduced to Maximum Allowed.
Explanation	The amount claimed has been reduced to conform to the maximum allowable day's supply of 100.
NIHB Code: W17/ CPhA Code: 64	
Message	Claim Adjusted To Comply With Terms of Prior Approval.
Explanation	The quantity amount claimed is reduced to comply with the terms of PA set out by Health Canada. The Provider should refer to the Prior Approval Form or Prior Approval Confirmation Letter, which will indicate the NIHB-approved maximum dollar amount.
NIHB Code: W18/ CPhA Code : DH	
Message	DF Reduced on Chronic Drug Based on Based Day's Supply Paid.
Explanation	The Dispensing Fee (DF) paid has been reduced to conform to the NIHB Short-Term Dispensing Fee policy. The Program only pays one DF per 28-day's supply for subsequent fills of chronic use drugs. Where the day supplies paid for Claims submitted for subsequent fills of chronic-use drugs is less than 28 days, the DF will be calculated according to the following formula: $(DF / 28) \times \text{paid based supply}$. For additional information about the Short-Term Dispensing Fee Policy, please see the Short-Term Dispensing Policy section via www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/pharma-prod/faq-fog-eng.php
NIHB Code: W19/ CPhA Code: DH	
Message	Dispensing Fee Is Disallowed or Reduced To NIHB Guidelines.
Explanation	Drug dispensing fee disallowed or reduced to conform to dispensing fee guidelines or Prior Approval Confirmation. Refer to details of the NIHB pricing in the respective region.
NIHB Code: W20/ CPhA Code: DS	
Message	Markup Is Disallowed or Reduced To NIHB Pricing Guidelines.
Explanation	Drug mark-up disallowed or reduced to conform to pricing guidelines or Prior Approval Confirmation. Refer to details of the NIHB pricing guidelines in agreements

NIHB Code/ CPhA Code	Description
	with the respective region.
NIHB Code: N/A/ CPhA Code: A8	
Message	No Reversal Made, Original Claim Is Missing.
Explanation	The system is unable to locate the original Claim in order to reverse it. Contact Provider Claims Processing Call Centre at 1-888-511-4666.
NIHB Code: N/A/ CPhA Code: A6	
Message	Child Claim.
Explanation	The system returned this POS Claim since it is the first Claim for a child using the parent's AANDC number. Submit Manual Claim.
NIHB Code: N/A/ CPhA Code: 75	
Message	Previously Paid Error.
Explanation	Claim sent to a first payer plan first and the Intervention Code is not DA or DB.
NIHB Code: N/A/ CPhA Code: D9	
Message	Call Adjudicator.
Explanation	An unknown error occurred. Contact the Provider Claims Processing Call Centre at 1-888-511-4666.
NIHB Code: N/A/ CPhA Code: NQ	
Message	Drug Not Eligible for Trial Rx.
Explanation	This item not flagged as a trial prescription drug.
NIHB Code: N/A/ CPhA Code: NT	
Message	Not Suitable-Similar Item On Trial Rx.
Explanation	The system verified that the Client received this drug before. Therefore, it is not eligible for the Trial Prescription Program.
NIHB Code: N/A/ CPhA Code: NX	
Message	Quantity Exceeds Trial Days Period.
Explanation	The day' supply is greater than seven (7) days. Therefore, the drug is not eligible for the Trial Prescription Program.
NIHB Code: N/A/ CPhA Code: NY	
Message	Insufficient Quantity for Trial Days Period.
Explanation	The day's supply for the trial Claim is less than seven (7) days. Therefore, the drug is not eligible for the trial prescription program, since less than seven (7) days is an insufficient quantity for a trial period.
NIHB Code: N/A/ CPhA Code: NZ	
Message	Trial Balance Given Too Late.
Explanation	The Provider must submit the trial balance Claim no later than fourteen (14) days after the trail Claim.

NIHB Code/ CPhA Code	Description
NIHB Code: N/A/ CPhA Code: OA	
Message	Trial Balance Given Too Soon.
Explanation	Providers cannot submit the trail balance Claim until at least four (4) days after the trial Claim.
NIHB Code: N/A/ CPhA Code: OD	
Message	No Trial Rx on Record, Balance Rejected.
Explanation	The trial Claim was not found on the system and the trail balance Claim has been returned.
NIHB Code: N/A/ CPhA Code: OE	
Message	Trial Balance Already Dispensed.
Explanation	The balance of the trial prescription has been previously dispensed.
NIHB Code: N/A/ CPhA Code: NR	
Message	Drug Not Suitable for Dosette Packaging.
Explanation	The item being claimed is not considered for dosettes.
NIHB Code: N/A/ CPhA Code: NE	
Message	Potential Overuse/ Abuse Indicated.
Explanation	The Client is using a combination of drug entities that has the potential for misuse or abuse.

7.2 Submission Options and Mandatory Data to be Submitted in Pharmacy Claims

Outlined below is the information on submission options and mandatory data requirements for submission of Pharmacy Claims.

7.2.1 Claim Submission Options

Pharmacy Providers may submit electronic Claims and same day reversals for Pharmacy Services using EDI for real time adjudication.

This option is available to Pharmacy Providers 24 hours a day, seven (7) days a week; excluding the:

- Standard service window when the system is down on Fridays, 12 a.m. to 6 a.m. as required
- Maintenance window when the system is down from Sundays, 12 a.m. to 6 a.m.

All Claims submitted using EDI are either accepted or returned in real time; there are no pending Claims. Two types of Claim submission options are explained below.

- POS:
 - o Pharmacy Providers must submit Claims for drug items and may submit Claims for items via POS for real time adjudication. The POS system is available to Pharmacy Providers 24 hours per day, seven (7) days a week. The current process used by many Providers when submitting Claims in excess of \$999.99 whereby Claims are split into multiple Claims leads to other problems (e.g., multiple dispensing fees being charged for single items,

confusing Client files, etc.), and therefore Claims should be submitted as one single entry for the total dollar amount.

Note The names of the entry fields displayed on the Pharmacy terminal may be different from the names of the required data elements due to the specific Pharmacy vendor software in place. For clarification of the field names on the Pharmacy terminal, the Provider should contact their Software Vendor.

- Manual:
 - All Claims for drug items must be submitted through POS technology with the exception of the following two (2) situations, which must be submitted on paper using the NIHB Pharmacy Claim Form:
 - The first Claim for drug items for a child less than one year of age who has not yet registered with AANDC or the Territorial Governments. All subsequent Claims for that child can be processed online once the initial manual Claim is submitted to and paid by Express Scripts Canada. Subsequent Claims submitted on behalf of the child via POS must include the child's parent's primary identifier (such as AANDC, Client or band/ family number) in the Client identification number field and the child's identifiers in the surname, given name and birth date fields.
 - Re-submissions after a period exceeding thirty (30) days.

7.2.2 Claims Submission – Required Data Elements

The required data elements apply only to Claims submitted via POS:

Field	Description
Bank Identification Number (BIN)	BIN may or may not be entered by the Provider (in some cases it is assigned automatically by the software, eliminating the need to enter it at the Pharmacy level). The BIN for NIHB Claims is 610068.
Version Number	For example, if a Pharmacy's software is based on version 3 of the CPhA Pharmacy Claim Standard, the version number would be 3. In most cases, the software assigns this number automatically, eliminating the need to enter it at the Pharmacy level. Providers required to enter this information manually should contact their software vendor to determine the version number of their Pharmacy software.
Transaction Code	Indicates the type of transaction a Provider wishes to perform. In most cases, Transaction Codes are assigned automatically by the software, eliminating the need to enter them at the Pharmacy level. Providers required to enter this information manually may use CPhA Standard Transaction Codes 01-Claim, 11-Reversal, or 30-Daily Totals. For information about the use of Transaction Codes, Providers should contact their Pharmacy software vendor.
Provider Software Identification Number	In most cases, the software assigns a Provider software identification number automatically, eliminating the need to enter them at the Pharmacy

Field	Description
	level. Providers should contact their Pharmacy software vendor to automate the entry of information in this field.
Provider Software Version	Indicates the version of the Provider software. The vendor assigns the numbers automatically.
Pharmacy Identification Code	This unique 10-digit Identification Number is the Pharmacy number assigned to the Pharmacy by Express Scripts Canada upon registration as an NIHB Provider.
Provider Transaction Date	Equivalent to Date of Service, this date should be entered in the correct date format (YYYY-MM-DD), and must be within thirty (30) days of the process date.
Trace Number	Trace numbers are unique numbers usually produced sequentially by the Pharmacy's software each time a transaction is transmitted allowing Providers to trace all Claims submitted via POS. There may be rare instances where a Provider is required to enter a trace number manually. For additional information about assigning trace numbers, Providers should contact their software vendor.
Carrier Identification	Identifies the specific plan type or benefit Program, which accepts responsibility for the Claim being submitted (e.g., Program). In most cases, the software assigns carrier identification numbers automatically, eliminating the need to enter them at the Pharmacy level. For information about automating the entry of information in this field, Providers should contact their software vendor.
Group Number or Code	This is a number or code, assigned to identify a specific group of benefit recipients within a carrier designation, (e.g., Program Clients). In most cases, the software assigns the Group Number or Code automatically, eliminating the need to enter them at the Pharmacy level. For information about automating the entry of information in this field, Providers should contact their software vendor.
Client Identification Number	A unique number used to identify a Client who is eligible to receive benefits under the Program. When submitting Claims through POS, this number may be one of: <ul style="list-style-type: none"> • A 10-digit number currently issued to eligible First Nations Clients by AANDC. • Three-digit band number, immediately followed by the five-digit family number identifying the family unit within the eligible First Nations Client's band. • B or N alpha prefix followed by an eight-digit number issued to certain eligible First Nations and recognized Inuit Clients by FNIHB. • Health Plan Number issued to recognized Inuit Clients by the Governments of NWT and Nunavut. <p>Note Previously, AANDC issued nine-digit numbers to their Clients (some of which may still be in</p>

Field	Description
	use today). These numbers consisted of a four-digit family number immediately following the three-digit band number. Insert a zero in front of the four-digit family number.
Client Date of Birth (DOB)	The Client's DOB. Partial dates are not acceptable. The Client's date of birth is mandatory for POS Claims, and must be entered in the correct date format (YYYY-MM-DD).
Client First Name	The given name under which the Client is registered as an eligible First Nations or recognized Inuit Client. Submission of more than one given name is preferred to facilitate Client verification. Initials are not acceptable.
Client Last Name	The surname under which the Client is registered as an eligible First Nations or recognized Inuit Client.
Client Gender	If entered, must be M (Male) or F (Female).
New/ Refill Code	Indicates whether the prescription is new or a refill/ repeat. In most cases, the software assigns this information automatically, eliminating the need to enter it at the Pharmacy level. If the Provider's version of software requires manual entry of this information, these codes are acceptable: <ul style="list-style-type: none"> • N - New prescription. • R - Prescription refill/ repeat.
Original Rx Number	This number is assigned to prescriptions on the original Date of Service (e.g., the number assigned to a "new prescription"), and is required when submitting Claims for refills/ repeats. The original prescription number is usually assigned automatically by the system, but may have to be entered manually.
Current Rx Number	The prescription number assigned by the Pharmacy for the item dispensed.
DIN/ GP#/ PIN	The Drug Identification Number (DIN) or Item Code.
Quantity	The quantity (number of units) of the item dispensed. Providers should enter the actual quantity in this field for each Claim (e.g., bags, boxes, items, etc.).
Day's Supply	Providers must use this field to enter the number of days of treatment contained in the prescription or for "as needed" prescriptions to provide an estimated number of days of treatment.
Prescriber ID	The Prescriber ID as entered by the Provider on the Claim submission must be the same as required by the Provincial/ Territorial Pharmacare Program.
Prescriber ID Reference	This field allows Providers to enter a code which identifies the Prescriber type (e.g., or nurse practitioner, physician, pharmacist, etc.).
Special Authorization (SA) Number or Code	A SA issued by FNIHB before the Provider may dispense certain drugs.

Field	Description
Intervention/ Exception Codes	Used by Providers to override DUR Messages; may also be used to identify special coverage or payment rules.
Drug Cost/ Product Value	Total ingredient or acquisition cost for all units of the drug or item dispensed.
Cost Upcharge	Dollar amount of any Mark-up for the item, based on the established percentage leave blank if not applicable.
Professional Fee	Dispensing fee for the item, leave blank if not applicable.
Previously Paid	Dollar amount of any portion of the Claim that has been paid by a provincial or territorial program or other first payer. Leave blank if not applicable.
Pharmacist Identification	Field allows Providers to identify themselves when overriding a DUR warning message. Providers should enter their appropriate statutory number, with the appropriate Intervention Code.
Adjudication Date	Only required for submitting online reversals. In most cases, the software automatically assigns the adjudication date, eliminating the need to enter it at the Pharmacy level. If keyed manually, the adjudication date must be entered in the correct date format (YYYY-MM-DD). The date must be within thirty (30) days of original adjudication date. If the date is greater than thirty (30) days after the original adjudication date, a reversal may be submitted by either a paper Claim or a copy of the Pharmacy Claim Statement.

7.2.2.1 NIHB Pharmacy Claim Form: Data Elements

The NIHB Pharmacy Claim Form was designed for use in these specific situations only:

- The first drug item Claim for a child less than one year of age who has not yet registered with AANDC.
- Re-submissions for drug items after a period exceeding thirty (30) days.

The following describes the **required data elements** for each section of the NIHB Pharmacy Claim Form including:

- Client Information.
- Claim Information for each Prescribed Item.
- Pharmacy Information and Parent Information (Required for Children Less than One Year of Age).

7.2.2.1.1 Client Information: Data Elements

Field	Description
Client Surname	The surname under which the Client is registered as an eligible First Nations or recognized Inuit Client.
Client Given Name	The given name under which the Client is registered as an eligible First Nations or recognized Inuit Client. Submission of more than one given name is preferred

Field	Description
	to facilitate Client verification. Initials are not acceptable.
Client Date of Birth (YYYY-MM-DD)	The Client's full birth date in year-month-day format (e.g., 1992-05-13 represents 13 May 1992). Partial birth dates are not acceptable.
Client Identification Number	A unique number used to identify a Client who is eligible to receive benefits under the Program. This number may be one of: <ul style="list-style-type: none"> • 10-digit number issued to eligible First Nations Clients by AANDC. • Three-digit band number, immediately followed by the five-digit family number identifying the family unit within the eligible First Nations Client's band. • An alpha prefix followed by an eight-digit number issued to certain eligible First Nations and recognized Inuit Clients by FNIHB. • Health plan number issued to recognized Inuit Clients by the Governments of NWT and Nunavut.
Band Number	A three-digit number (e.g., 002, 311) identifying the band to which an eligible First Nations Client belongs. The band number, when submitted in combination with the Client's family number, is an acceptable alternative to the Client identification number for an eligible First Nations Client.
Family Number	A five-digit number (e.g., 04120) identifying the family unit within the band to which an eligible First Nations Client belongs. The family number, when submitted in combination with the Client's band number, is an acceptable alternative to the Client identification number for an eligible First Nations Client. If the family number on the eligible First Nations Client's registration card is only four digits, insert a zero in front of the four-digit number.

7.2.2.1.2

Claim Information for Each Prescribed Item: Data Elements

Field	Description
Date of Service (YYYY-MM-DD)	The date on which the item was provided to the Client in year-month-day format (e.g., 1992-05-13 represents 13 May 1992).
DIN/ Item Code	The DIN or Item Code.
Special Service Code	Providers may submit a Special Service Code (SSC) on manual Pharmacy Claims. During Claim adjudication, the HICPS system only applies SSC values "P" and "2" to submitted Claims. SSC value "P" is used for Dosette Claims submitted by Providers in Quebec, and SSC value "2" (Pharmacist Intervention) is used for chronic-use drug Claims submitted by Providers in all other provinces and territories in order to override the W18 Code (DF Reduced on Chronic Drugs Based on Day's Supply Paid). All other SSC values are ignored during Claim adjudication. Leave

Field	Description
	blank if not applicable.
Quantity	The quantity (number of units) of the item dispensed.
Prescription Number	The prescription number assigned by your Pharmacy for the item dispensed.
Drug/ Item Cost	The total ingredient or acquisition cost for all units of the drug or item dispensed.
Dispensing Fee	The dispensing fee for the item dispensed. Leave blank if not applicable.
Mark-up	The dollar amount of any mark-up for the item, based on the established percentage. Leave blank if not applicable.
Third-Party Share	The dollar amount of any portion of the Claim which is billable to a provincial or territorial Program or other first payer. Leave blank if not applicable.
Amount Claimed	The sum of the drug/ item cost, dispensing fee, and Mark-up for the item, less any third-party share.
Day's Supply	Number of days of treatment contained in the prescription.
Total	The total dollar amount claimed for all items (up to ten) listed on the NIHB Pharmacy Claim Form.
Prescriber ID	The Prescriber ID as entered by the Provider on the Claims submission must be the same as required by the Provincial/ Territorial Pharmacare Program.
Prior Approval Number	An authorization number, which must be issued by the DEC before the Provider dispenses certain drugs.

7.2.2.1.3 Pharmacy Information: Data Elements

Field	Description
Pharmacy Name	Name of the Pharmacy submitting the Claim may be formatted as determined by the Pharmacy.
Pharmacy Address	Address of the Pharmacy submitting the Claim may be formatted as determined by the Pharmacy.
Pharmacy Provider Number	Number assigned to the Pharmacy upon registration as an NIHB Provider.

7.2.2.1.4 Parent Information (Child Less than One Year of Age): Data Elements

The first Claim must be submitted manually using the NIHB Pharmacy Claim Form; subsequent Claims may be submitted via POS.

A child less than one year of age, who has not yet registered as an eligible First Nations or recognized Inuit Client, may receive benefits if one of the child's parents can be verified as an eligible First Nations or recognized Inuit Client.

In such a case, the child's surname, all given names, and the date of birth (date format YYYY-MM-DD) must be entered in the appropriate fields in the Client Information Section of the NIHB Pharmacy Claim Form and this information about the parent must be provided:

Field	Description
Parent's Surname	The surname under which the parent is registered as an eligible First Nations or recognized Inuit Client.
Parent's Given Names	The given names under which the parent is registered as an eligible First Nations or recognized Inuit Client. Submission of more than one given name is preferred to facilitate Client verification. Initials are not acceptable.
Parent's Date of Birth (YYYY-MM-DD)	The parent's full birth date in year-month-day format (e.g., 1956-05-13 represents 13 May 1956). Partial birth dates are not acceptable.
Parent's Client Identification Number	The number under which the parent is identified as an eligible First Nations or recognized Inuit Client. This number may be one of: <ul style="list-style-type: none"> • A 10-digit number issued to eligible First Nations Clients by AANDC. • Three-digit band number, immediately followed by the five-digit family number identifying the family unit within the eligible First Nations Client's band. • An alpha prefix followed by an eight-digit number issued to certain eligible First Nations and recognized Inuit Clients by FNIHB. • Health Plan number issued to recognized Inuit Clients by the Governments of NWT and Nunavut.
Parent's Band Number	A three-digit number (e.g., 002, 311) identifying the band to which an eligible First Nations Client's parent belongs. The band number, when submitted in combination with the family number, is an acceptable alternative to the Client identification number for an eligible First Nations Client.
Parent's Family Number	A five-digit number (e.g., 04120) identifying the family unit within the band to which an eligible First Nations Client belongs. The family number, when submitted in combination with the Client's band number, is an acceptable alternative to the Client identification number for an eligible First Nations Client. If the family number on the eligible First Nations Client's registration card is only four digits, insert a zero in front of the four-digit number.

7.2.3 Reversals for Prescribed Medication Not Picked Up by Client

- **Compounds:**
 - Where the drug item is an eligible compound and re-insertion into the Pharmacy's inventory is not possible, Express Scripts Canada pays the Provider for both the drug and dispensing fee. Therefore, a reversal is not necessary. DUR is not affected.
- **Prescribed Medication:**
 - The submission of a Claim for a dispensing fee where the Client has not picked up a drug, which can be re-inserted to inventory, only applies to drugs

with a dispensing fee dollar value. Once the original Claim containing both the dispensing fee and the drug item cost has been reversed, the Provider must submit a Claim using pseudo-DIN 55555555 in the DIN No./ Item Number field. The information on the new Claim, with the exception of pseudo-DIN 55555555, must mirror that of the reversed Claim.

7.2.4 Payment Information

- **Pharmacy Reimbursement:**
 - Pharmacy Providers are reimbursed in a timely manner, in accordance with the terms and conditions of the applicable Agreement and of the Kit.
- **Net Payments:**
 - The Pharmacy receives payment for: (1) Services provided in relation to a covered medication; and (2) Other reimbursable services, as set forth in the applicable Agreement, any amendments to the same or the Kit. The resulting amount is herein referred to as a "Net Payment".
- **Payment Schedule:**
 - Unless the applicable Agreement provides otherwise, Pharmacy Providers shall be paid on a twice-per-month schedule. The payment run date takes place automatically on the 1st and 16th of every month. Payment run date for the 1st include Claims processed from the 16th to end of the month (e.g., February 28th or 29th or the 30th or 31st as the case may be for the remaining months); payment run date for the 16th include Claims processed from the 1st to the 15th. The payment date is within two (2) business days following the Payment Run Date, unless a weekend or bank holiday falls between. Payment date is the day that cheques, EFT payments and statements are released.
- **Payment Method:**
 - EFT payment is available to Pharmacy providing Express Scripts Canada with access to a bank account for payment deposit. If EFT is elected as the preferred method of payment, complete the Modification to Pharmacy and Medical Supplies and Equipment Provider Information Form and forward to Express Scripts Canada as indicated on the form. Pharmacies which do not provide EFT information are paid by cheque. For timely receipt of payments, ensure that the correct mailing address is captured on the Modification to Pharmacy and Medical Supplies and Equipment Provider Information Form. A Pharmacy receiving payments by cheque and wishing to switch to EFT payment can do so at any time by completing the Modification to Pharmacy and Medical Supplies and Equipment Provider Information Form.
- **POS Reversals:**
 - The "Claim Reversal" transaction is used to reverse a previously paid POS transaction. It is used in situations where the Provider has a need to either correct a previously paid Claim or totally reverse or cancel a previously submitted Claim. There are two types of Provider submitted "Claim Reversal" transactions: same day reversals and prior day (up to thirty (30) days) reversals. In order to reverse a Claim, the original Claim being reversed must be found on the database. Otherwise, the reversal is returned with an A8 CPhA Code. In both cases, the HICPS system generates a "Claim Adjustment" reversing the impact of the original Claim. All three transactions appear on the Pharmacy Claim Statement: the original Claim, the reversal

and the corrected Claim. Claims that require reversal more than thirty (30) days after the original submission must be submitted manually on the Pharmacy Claim Form or on a copy of the Pharmacy Claim Statement, up to one year from the original date of service.

- o In most cases, the software automatically assigns an adjudication date, eliminating the need to enter it at the Pharmacy level. If keyed manually, the adjudication date must be entered in the correct date format (YYYY-MM-DD). The date must be within thirty (30) days of original adjudication date. A paper Claim must be returned if submitting after thirty (30) days from the original adjudication date.

7.3 Trial Rx Program

7.3.1 What is a Trial Rx Program?

A Trial Rx Program is intended to help determine if a Client can tolerate a specific drug without experiencing side effects. Providing a limited supply during the trial period eliminates unnecessary waste and provides the opportunity for a discussion with the pharmacist (and physician, if necessary) before the remainder of the prescription is dispensed. Drug side effects are often the major reason Clients discontinue important drug therapy.

7.3.2 How will the Trial Rx Program Drugs be Handled?

This Program is only applicable to EDI Claims for British Columbia and Saskatchewan with or without a verified PA#.

Under the Trial Rx Program, Clients receive a seven day supply of a new medication in order to determine if the drug is tolerated. The Program is designed to minimize waste of medication resulting from Client intolerance, and reduce the incidence of drug-related problems through increased Client monitoring and follow-up by the pharmacist.

This Program is a voluntary program; therefore, if a Claim is submitted for a Trial Rx DIN/ Item# (identified by Trial Rx Indicator = Y on the Coverage Details screen) without a Trial Rx Intervention Code, the Claim is processed according to regular cost verification rules.

If a Claim is submitted for Trial Rx DIN/ Item # using the "MT" (Trial Rx Program) or the "ND" (Trial Rx Balance) Intervention Codes, then the Claim is processed according to the Trial Rx Program Rules.

7.3.3 Adjudication Process for the Trial Rx Program

The DIN/ Item No. qualifying for the Trial Rx Program are identified by the "Trial Rx" indicator.

1. The first Claim should be submitted with CPhA Intervention Code "MT" (Trial Rx Program). If the drug is not eligible for the Trial Rx Program, the Claim is returned with CPhA Code "NQ" - Drug not eligible for trial Rx.
2. The day's supply submitted must be equal to seven:
 - If less than seven (7), the Claim is returned with CPhA Code "NY" (Insufficient quantity for trial day's period).
 - If greater than seven (7), the Claim is returned with CPhA Code "NX" (Quantity exceeds trial day's period).

- If a previously accepted/ paid Claim exists in the Client's Claims history for the same Item No. within two years of the current DOS; the Claim is returned with CPhA Code "NT" (Not suitable – similar item on recent Trial Rx).
 - If all above conditions are met, the Claim is processed.
3. The balance of the prescription should be submitted as the second Claim with CPhA Intervention Code "ND" (Trial Rx Balance).
- If the drug for the submitted DIN/ Item No. is not eligible for the Trial Rx Program, the Claim is returned with CPhA Code "NQ" (Drug not eligible for Trial Rx).
 - Ensure that the Claim is in fact the second Claim for this Client, for this Item No. If no first Trial Rx Claim exists, the Claim is returned with CPhA Code "OD" (No Trial Rx on record, balance rejected).
 - If a second Trial Rx Claim already exists, the Claim is returned with CPhA Code "OE" (Trial balance already dispensed).
 - If this a valid second Claim, the Claim's DOS must be at least four (4) days after the first Claim, and also within fourteen (14) days of the first Claim, otherwise the Claim is returned with CPhA Code "OA" (Trial Rx balance given too soon) or "NZ" (Trial Rx balance given too late), respectively.
4. If all above conditions are met, the Claim is processed.

There are no corresponding NIHB Codes for Trial Rx returns; therefore, the CPhA Code and description is printed on the Pharmacy Claim Statement.