Non-Insured Health Benefits (NIHB)

Pharmacy Claims Submission Kit

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Express Scripts Canada
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Express Scripts Canada

NIHB Pharmacy Claims Submission Kit

Any comments or requests for information may be transmitted to:

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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 Provider Claims Submission Kit located on the NIHB Claims Services Provider Website

Express Scripts Canada's Non-Insured Health Benefits (NIHB) Pharmacy Claims Submission Kit (also referred to as Kit) sets out terms and conditions for the submission of claims under the Pharmacy Provider Agreement (referred to as Agreement).

For NIHB Program policies on the pharmacy benefits please refer to the Guide for Pharmacy Benefits. The Guide for Pharmacy Benefits also lists website addresses to required forms.

This Kit is 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 and that all required elements are completed 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 annually, as required. A notification of Kit updates is posted on the NIHB Claims Services Provider Website thirty (30) days prior to the circulation date.

All documents (announcements, Kit, Agreement, pharmacy newsletters and the Guide for Pharmacy Benefits) are available on the NIHB Claims Services Provider Website (also referred to as provider website). Providers who do not have Internet access or email, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to Section 8.2.2 Provider Claims Processing Call Centre). All questions or comments regarding the Kit should also be directed to the Provider Claims Processing Call Centre at 1 888 511-4666.

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 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.

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 the Indigenous Services Canada (ISC), the terms and conditions of such Agreement shall prevail.

1.3. 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's 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 eligibility requirements (Section 3 Pharmacy Provider Registration)
- Client eligibility requirements (Section 4 Client Identification and Eligibility).
- Requirements for co-ordination of benefits with other health plans (Section 5.3 Co-ordination of Benefits)
- Submission process and supporting documentation requirements (Section 5 General Claims Submission Procedures)
- Benefit coverage and/ or applicable limitations (Section 5.9 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 6 Provider Audit Program)
- Requirements to maintain relevant documentation and records (Section 6.3.5.6 Documentation Requirements for Audit Purposes)

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

- 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 Guide for Pharmacy Benefits.
        - Co-operate 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.
        - 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).

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.

1.3.1. General Terms

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

This Kit contains terms and conditions, procedures for verifying benefit eligibility, as well as claims submission, adjudication, payment, reversals and audit. Providers are bound by and must follow the terms, conditions and procedures in the Kit, the Agreement and the Guide for Pharmacy Benefits.

1.3.2. 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
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 person who is eligible to receive pharmacy services in accordance with the eligibility criteria in Section 4 Client Identification and Eligibility of the Kit.
Coordination/Co-ordination of Benefits (COB)	Clients covered by more than one health plan. If the plan does not pay the full amount of an expense, the claim can be submitted to the other plan for the balance.
Canadian Pharmacists Association (CPhA)	The Canadian Pharmacists Association represents the pharmacy community in Canada.
Client Reimbursement (CR)	An NIHB authorized approval to accept the claim made directly by a client or a first payor such as a band, parent or guardian who has paid for services rendered.
Crown-Indigenous Relations and Northern Affairs (CIRNA)	Crown-Indigenous Relations and Northern Affairs is a federal department that was established in 2017.
Drug Exception Centre (DEC)	The DEC handles all prior approval (PA) requests for drug benefits. Refer to **PA.**

Term	Definition
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 annually 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.
Drug Utilization Review (DUR)	The drug utilization review is explained in detail in Section 7.4 Drug Utilization Review.
Electronic Data Interchange (EDI)	Electronic data interchange electronically captures and processes submitted pharmacy claims online in real-time presenting pharmacy providers with an immediate response regarding the status of the submitted claim.
Electronic Funds Transfer (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.
Explanation of Benefits (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 NIHB Program, Express Scripts Canada is responsible for processing the claims submitted through the Program.
First Nations Health Authority (FNHA)	In 2013, the British Columbia (BC) First Nations Health Authority (FNHA) assumed responsibility for the design, management and delivery of supplementary health benefits to First Nations residing in BC. On October 1, 2017, the administration of the majority of pharmacy benefits was transferred to BC PharmaCare.
First Nations and Inuit Health Branch (FNIHB)	FNIHB refers to the First Nations and Inuit Branch which is part of the federal Department of Indigenous Services Canada (established in 2017). FNIHB was formerly part of Health Canada.
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. The Guide is available at canada.ca/en/health-canada/services/first-nations-inuit-health/reports-publications/non-insured-health-benefits/guide-pharmacy-benefits-non-insured-benefits.html

Term	Definition
Health Information and Claims Processing Services (HICPS) 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.
Indigenous and Northern Affairs Canada (INAC)	Refers to the former department of Indigenous and Northern Affairs Canada. The department was dissolved when the new federal departments CIRNA and ISC were created in 2017. (Formerly Indian and Northern Affairs Canada and Aboriginal Affairs and Northern Development Canada).
Indigenous Services Canada (ISC)	Indigenous Services Canada is a federal department (established in 2017). The Non-Insured Health Benefits Program reports to ISC.
Next Day Claims Verification Program (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 to the enrolled providers and sets out terms and conditions for the submission of claims.
Non-Insured Health Benefits Program (NIHB Program) (referred to as the Program)	The NIHB Program is ISC's national, medically necessary health benefits program that provides coverage for benefit claims for a specified range of drugs, dental care, vision care, medical supplies and equipment, mental health counselling and medical transportation for eligible First Nations people and Inuit when these benefits or services are otherwise not insured by provinces and territories or other private insurance plans.
Other Coverage	Benefits available to clients of the Program, in whole or in part, from a provincial, territorial or first payor health care program.
Pharmacy Claim Statement	A listing of claims that were entered and settled, which includes adjudication messages. Express Scripts Canada issues the provider claim statement twice a month.
Pharmacy Provider Agreement (referred to as the Agreement)	The Express Scripts Canada Agreement, the annexes thereto and any amendments thereto made in writing.
Pharmacy Benefits	The provision and dispensing of any drugs allowed by the Program to clients in accordance with the terms

Term	Definition
	and conditions of the Agreement, applicable laws, and professional standards of practice and the dispensing provisions of the Kit.
Prior Approval (PA)	A program coverage confirmation issued by the Drug Exception Centre to a provider to ensure that the provider is advised that the client is eligible for the specific drug dispensed. The approval is issued primarily for items identified as requiring authorization before being billed to the program. Please refer to the MS&E claims submission kit regarding MS&E benefits or services.
Personal Information Protection and Electronic Documents Act (PIPEDA)	The Personal Information Protection and Electronic Documents Act is a Canadian law relating to data privacy. It governs how private sector organizations collect, use and disclose personal information in the course of commercial business.
Point of Service (POS) Technology	The point of service (POS) is where a claim is submitted electronically when a prescription is filled.
Prescriber ID	A number, as assigned by the respective provincial or territorial regulatory authority (where applicable), that is used to identify the prescriber.
Prescriber ID Reference	Providers must enter a two (2) character alphanumeric code called a prescriber identification (ID) code, which identifies the prescriber type. The prescriber type can be a physician, nurse practitioner, or any other licensed practitioner with authorization to prescribe within the scope of practice in his/her province or territory. Providers must enter a code which identifies the prescriber type (e.g., nurse practitioner, physician, pharmacist, etc.).
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 Number	A unique reference number assigned to the provider as identification to facilitate the submission of claims for adjudication and to receive payment.
Regional Office	FNIHB regional offices across Canada.
Special Authorization (SA)	An SA is an authorization that is provided for the client for coverage either on a temporary or permanent basis. Allows providers to claim certain items (drugs for pharmacy) without having to request a PA.

Term	Definition
Usual and Customary Professional Fee (U&C)	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: (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. (iv) Other exceptional cases agreed to in writing by Express Scripts Canada.

2. Background

2.1. 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 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 5 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, 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 inquiries. All client reimbursements should be referred to the nearest FNIHB regional office. A listing of the FNIHB regional offices can be located on the Government of Canada website at canada.ca/en/health-canada/corporate/contact-us/non-insured-health-benefits.html.

2.2. Department of Indigenous Services Canada NIHB Program

Further details on ISC's NIHB Program, can be located on the Government of Canada's website at canada.ca/nihb.

Providers who do not have Internet access or email may contact the Provider Claims Processing Call Centre (refer to Section 8.2.2 Provider Claims Processing Call Centre).

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 1.3 Terms and Conditions and Section 4 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 point of service (POS) when receiving pharmacy services, as per definition in Section 5.3 (1) 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 for eligible benefits/amounts upon completion of a NIHB Client Reimbursement Request Form, within one (1) year from the date of service or date of purchase. The NIHB Client Reimbursement Request Form is located on the Government of Canada website at canada.ca/en/health-canada/services/first-nations-inuit-health/non-insured-health-benefits/benefits-information/client-reimbursement-request-form-non-insured-health-benefits-first-nations-inuit-health-canada.html.

In addition, a listing of the FNIHB Canada regional offices is located on the Government of Canada website at canada.ca/en/health-canada/corporate/contact-us/non-insured-health-benefits.html.

2.4. Health Information and Claims Processing Services (HICPS) System

HICPS is an electronic claims adjudication system that processes, pays or rejects 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 a personal computer based on pharmacy practice management systems, an electronic system that transmits claims and returns an electronic response via a data network. Data is transmitted respecting the format specified by the current CPhA Electronic Claim Standard[1].

Note: 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 determines 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 7.1 Pharmacy Claim Statement Messages

[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.

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 can contact the respective association for a list of certified software vendors.
- NIHB Claims Services Provider Website at provider.express-scripts.ca where the following resources are available:
  - Alerts regarding changes to the HICPS system
  - Bulletins and Announcements
  - Drug benefit list (DBL)
  - Pharmacy and MS&E newsletters
  - Various NIHB forms
  - Program policy information (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 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 terms of the Agreement shall commence on the effective date (start date) of the unique provider number issued by Express Scripts Canada. A copy of the Agreement can be located on the NIHB Claims Services Provider Website at provider.express-scripts.ca.

Providers who do not have Internet access or email may contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to Section 8.2.2 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, proprietorship or franchisee corporation that owns and operates a specific pharmacy location.

Express Scripts Canada will not sign Agreements covering a chain of pharmacies, 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 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. The necessary completed documentation is then forwarded to Express Scripts Canada (fax: 1 855 622-0669) for registration.

3.1.2. Unique Provider Number

Upon registration approval, providers are assigned a unique provider number by Express Scripts Canada. Please note that this is not applicable to Quebec pharmacies (refer to Section 3.1.1.1 Quebec Pharmacies). This number is used to identify the provider and to properly reimburse 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.

3.2. 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 ISC and/ or Express Scripts Canada in a timely manner via the NIHB Claims Services Provider Website, email, fax or mail.

Pharmacy providers also supplying general MS&E benefits must ensure to complete the qualified assessments - medical supplies/equipment section of Annex C, section E. Only after completing section E 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 1.3 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 NIHB Claims Services Provider Website at 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)
- Fax broadcast
- Guide for Pharmacy Benefits and/ or 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 that 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.

3.3. Change of Provider Information

In order to keep provider records up-to-date, avoid unpaid claims and non-delivery of ISC and Express Scripts Canada communications (e.g. pharmacy claim statements, pharmacy newsletters, etc.) via email, 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
- Email address
- Current address (correction only)
- Preferred communication method (fax, email or 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:

- 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 NIHB Claims Services Provider Website at provider.express-scripts.ca and submit as indicated on the form. Providers who do not have internet access or email, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to Section 8.2.2 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 NIHB Claims Services Provider Website at provider.express-scripts.ca.
>
> Providers who do not have internet access or email, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to Section 8.2.2 Provider Claims Processing Call Centre).
>
> **Quebec pharmacies:** all new registrations and modification to pharmacies must be completed with the AQPP.

3.4. 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 Number:
1 855 622-0669

Mail:
Express Scripts Canada
Provider Relations
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 the provider's responsibility regarding Express Scripts Canada's Provider Audit Program activities. Please refer to Section 6 Provider Audit Program or Section 11 (3) of the Agreement.

4. Client Identification and 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. Once client eligibility is validated, the provider must document any alias names. 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 (1) year of age, whose parent is an eligible client
    - For unregistered children over the age of one and under the age of 18 months, please call the DEC for assistance.

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.

Please note that due to privacy issues it is not the responsibility of ESC to provide client ID numbers. This information must be obtained by the provider from the client during the verification of client eligibility.

4.1. 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 Non-Insured Health Benefits (NIHB) client identification number. This number begins with the letter T and is followed by seven (7) digits.
- Government of Nunavut (GNU) health plan number:
    - Inuit clients from Nunavut may present a health plan number issued by the GNU. This number is valid in any region of Canada and is cross-referenced to the NIHB client identification number. This is a nine (9) digit number starting with a one (1) and ending with a five (5).

- NIHB client identification number (N-Number):
  - This is a client identification number issued by NIHB to recognized Inuit clients. This number begins with the letter N and is followed by eight (8) digits.

The NWT/NU Health Care card or NIHB N# letter (on Health Canada or Government of Canada letterhead) identifying the individual and accompanied by picture identification is sufficient identification for clients.

4.2. Required Client Identification Numbers for Eligible First Nations Clients

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

- Registration number
  - This is a 10- digit number, issued by the Government of Canada (now issued by CIRNA, but formerly by INAC or AANDC), to clients registered under the Indian Act. It is commonly called a *status card*. The registration number is the preferred method of identifying First Nations clients.
- If a client does not know their registration number, providers can call the Provider Claims Processing Call Centre for assistance. Providers must have the name or number of the client's band, the client's full given name and date of birth before calling.
- NIHB client identification number (B-number)
  - In specific and exceptional cases, some First Nations clients may have numbers issued by NIHB. This number begins with the letter B and is followed by eight (8) digits.

4.3. Individuals Excluded from the Program

The following individuals are not eligible to receive benefits through the Program:

- First Nations and Inuit who are not resident in Canada
- First Nations and Inuit individuals incarcerated in a federal, provincial/ territorial or municipal corrections facility
- First Nations and Inuit individuals who are in a provincially/ territorially funded institutional setting which provides its residents with supplementary health benefits as part of their care, such as nursing homes
- First Nations and Inuit children who are in provincially/ territorially funded care. However, if the NIHB Program is the first point of contact to request health benefits/services for a child who would otherwise be NIHB-eligible, the Program will provide NIHB-eligible benefits to the child and follow-up with the respective provincial/territorial agency.

4.4. Special Provision for First Nations and Inuit Children under One (1) year of age

Special identification provisions for children less than one (1) 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 less than one (1) 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 CIRNA at 1 819 953-0960.
Inuit residing 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 FNIHB 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 CIRNA, client or band/ family number, NIHB 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.

4.5. 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
- First Nations Health Authority (British Columbia)
- James Bay Cree (10 bands):
    - Naskapis #081

  - Chisasibi #058
  - Eastmain #057
  - Nemiscau #059
  - Waskaganish #061
  - Waswanipi #056
  - Wemindji #060
  - Whapmagoostui #095
  - Mistassini #075
  - Ouje-Bougoumou Cree Nation #089
- Nunatsiavut Government (formerly the Labrador Inuit Health Commission)
- Nisga'a Valley Health Board:
  - Gingolx #671 (Kincolith)
  - Gitakdamix #677 (New Aiyanish)
  - Lakalzap #678 (Greenville)
  - Gitwinksilkw #679 (Canyon City)

5. General Claims Submission Procedures

Claims older than one (1) year from the date of service will not accepted for processing and will not be eligible for payment. All claims, including supporting documents, must be received by the NIHB Program within one (1) year from the date of service to be eligible for payment (refer to section 4.0 Payment and Reimbursement of the Guide for Pharmacy Benefits).

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 7.1 Pharmacy Claim Statement Messages.

5.1. Electronic Claims Submission

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, midnight to 6 a.m. as required
- Maintenance window when the system is down from Sundays, midnight to 6 a.m.

All claims submitted using EDI are either accepted or returned in real time; there are no pended claims.

- POS
  - 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.

    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.

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 well as reference ID type) 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 (e.g., extemporaneous mixtures, blood glucose test strips), 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 and inhalers), please 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.
- 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 8.2.2 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 first and last 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 zeros (0), and must be a valid item number that exists on the Express Scripts Canada item database)
- Prescriber ID
- Prescriber ID reference number (must be numeric and greater than zero (0))
- Prescription number
- Drug/ item cost (must be numeric and greater than zero (0))
- Quantity (must be numeric and greater than zero (0))
- Day's supply (must be numeric and greater than zero (0), mandatory for drug items)
- Bank identification number
- Version number of the CPhA standard
- Transaction code
- Provider software identification number
- Provider software version
- Pharmacy identification code
- Provider transaction date
- Trace number
- Carrier identification
- Group number or code
- Client gender
- New/refill code
- Pharmacist identification
- Adjudication date (*only for reversals*)

5.2. Manual Claims

Claims must be submitted via POS except for claims more than 30 days old and first claims for infants less than one (1) year of age that do not have their own client number. 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 rejected.

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 (1) year of age who has not yet registered with CIRNA 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. Until the infant has their own client number any claims submitted on behalf of the child via POS must include the child's parent's primary identifier (such as CIRNA, 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.

5.2.1. Manual Claims Submission – Required 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 (1) year of age who has not yet been registered with CIRNA.
- 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 (1) year of age)

Field	Description
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: • A ten (10) digit number currently issued to eligible First Nations clients by CIRNA. • Three (3) 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 (8) digit number issued to certain eligible First Nations and recognized Inuit clients by NIHB. • Health plan number issued to recognized Inuit clients by the Governments of NWT and Nunavut. **Note:** Previously, INAC issued nine-digit numbers to their clients (some of which may still be in use today). These numbers consisted of a four-digit family number immediately following the three-digit band number. Insert

Field	Description
	a zero (0) in front of the four (4) digit family number.
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).
Date of Service (DOS)	Date the service was provided.
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.
Last Name	The surname under which the client is registered as an eligible First Nations or recognized Inuit client.
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.
Special Authorization (SA)	An SA is an authorization that is provided for the client for coverage either on a temporary or permanent basis. Allows providers to claim certain items (drugs for pharmacy) without having to request a PA.
Special Service Code (SSC)	Providers may submit a Special Service Code (SSC) on pharmacy claims. During claim adjudication the NIHB HICPS system only recognizes SSC values 'O', 'P', and '2' to submitted claims. SSC value 'P' is used for dosette claims submitted by providers in Quebec, the SSC value '2' (pharmacist intervention) is used for items where the client would use the product on a short term basis.
Intervention/ Exception Codes	Used by providers to override DUR messages; may also be used to identify special coverage or payment rules.

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Field	Description
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 payor. Leave blank if not applicable.

5.2.1.1. Client Information: Data Elements

Field	Description
Surname	The surname under which the client is registered as an eligible First Nations or recognized Inuit 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 to facilitate client verification. Initials are not acceptable.
Date of Birth (YYYY-MM-DD)	The client's full birth date in year-month-day format. 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: • Ten (10)-digit number issued to eligible First Nations clients by CIRNA. • Three (3)-digit band number, immediately followed by the five (5)-digit family number identifying the family unit within the eligible First Nations client's band. • An alpha prefix followed by an eight (8)-digit number issued to certain eligible First Nations and recognized Inuit clients by NIHB. • Health plan number issued to recognized Inuit clients by the Governments of Nunavut.
Band Number	A three (3)-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

Field	Description
	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 (4) digits, insert a zero (0) in front of the four (4) digit number.

5.2.1.2. 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.

5.2.1.3. Parent Information (Child Less than One (1) year of age): Data Elements

A child less than one (1) year of age, who has not yet been registered as an eligible First Nations or recognized Inuit, may receive benefits if one of the child's parents can be verified as an eligible First Nations or recognized Inuit client.

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

In such a case, the child's surname, all given names, and the date of birth (date format YYYY-MM-DD) must also be entered in the appropriate fields in the client information section of the NIHB Pharmacy Claim Form. All other requirements as described above in Section 5.2.1.1. Client Information: Data Elements should reflect the parent's information.

5.3. Co-ordination of Benefits

Some NIHB clients may have coverage provided through a provincial/ territorial or private health care plan, which can include social services, Workers Compensation Board (WCB), and employee benefit programs. Claims for NIHB clients with alternate coverage should be submitted to the other plan or program first.

Claims submitted to Express Scripts Canada involving co-ordination of benefits (COB) must clearly show the amount paid by the other plan or a written explanation of the way coverage was declined in order to be processed. The NIHB Program will then co-ordinate payment for eligible benefits based on the payment or decision of the other plan.

Where a client is no longer eligible for coverage that was previously available, the provider or the client is asked to communicate this to the FNIHB Regional Office so that the client's file can be updated.

Note that claims submitted for services that are insured through certain provincial or territorial health plan will be rejected.

5.3.1. Co-ordination of Benefits with the Ontario Drug Benefit

Some NIHB clients living in Ontario may be eligible for drug coverage under the Ontario Drug Benefit Program.

NIHB clients who are age 24 or under who are eligible for OHIP+ may access drug coverage from either NIHB or through the OHP+ program. For such clients, claims do not need to be co-ordinated.

For all other NIHB clients who are also eligible for other ODB coverage, Ontario pharmacists must co-ordinate drug benefits and pursue payment through the Ontario Drug Benefit (ODB) program prior to billing the NIHB Program.

For drugs listed on the ODB Limited Use Benefit list, Ontario pharmacists must obtain prior approval through ODB before billing the NIHB Program. This may require contacting the prescriber to determine if the client meets ODB criteria. Results must be documented and kept on file in the NIHB client's profile for review during on-site audit. Failure to maintain proper documentation will result in a payment recovery.

Claims co-ordinated with the ODB program will be reimbursed in accordance with ODB's Condition on the Payment of Dispensing. NIHB will reimburse providers the ODB co-pay and deductible when billed in accordance with program requirements. Please note in the case of discrepancies between the ODB dispensing fee policy and the NIHB STD policy and in the absence of the ODB dispensing fee policy, the NIHB policy takes precedence.

For co-ordination of benefits between ODB and NIHB, the following rules apply:

- Claims are to be adjudicated through ODB first, then through NIHB as the second payor (i.e., NIHB will only reimburse the copay or deductible as applicable).
- For drugs eligible for coverage under ODB through Limited Use (LU) benefit, claims must be adjudicated through ODB first. In the event that a patient does not meet the ODB LU eligibility criteria, the claim can be processed directly through NIHB. Proper documentation must be kept on file (e.g., confirming diagnosis with prescriber or reason for ineligibility through ODB).
- For short-term dispensing claims, ODB policy allows for up to two (2) dispensing fees per month while NIHB policy allows for one (1) dispensing fee per month. In a co-ordination of benefit instance, NIHB will mirror the ODB policy (i.e., NIHB will allow a second copay to be adjudicated within a calendar month). NIHB will pay the copays for ODB co-ordinated claims; however, once the maximum number of dispensing fees has been paid by ODB in a one-month period, NIHB will not pay additional dispensing fees.

5.4. Drug Utilization Review Program

Claims go through the DUR process when submitted through 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 8.2.2 Provider Claims Processing Call Centre).

5.5. Refusal to Fill (Dispense) Fee

A pharmacy provider in British Columbia, Saskatchewan or Manitoba may decide not to 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.

5.6. Reversals for Prescribed Medication Not Picked Up by Clients

When a client has not picked up a prescription within 30 days, the original paid claim must be reversed and resubmitted for payment of just the dispensing fee.

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, must mirror that of the reversed claim. Items that

are dispensed daily but not picked up should be reversed but are not eligible resubmission for payment of the dispensing fee..

Where the drug item is an eligible compound and reinsertion 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.

5.7. Prior Approval Process for Drug Benefits

If a client is prescribed a pharmacy item that requires a PA, the provider must contact the DEC and provide details about the prescription, prescriber, pharmacist and the client. A DEC analyst faxes a copy of the Exception or Limited Use Drug Request Form to the prescriber.

- The prescriber completes the form stating the exceptional medical need for the drug and returns the form to DEC. The response is reviewed and a decision is made. The time for approval is dependent on the physician or licensed prescriber providing the required information.
- NIHB enters a PA 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.
    - PAs for one (1) time dispense items are dated the day the request is setup in the system. Claims with dates of service (date of dispense) prior to the date of the PA will be rejected. 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 rejected.
- If approval is granted, a prior approval confirmation letter with the applicable dates and PA details is faxed to the provider. Please retain the prior approval confirmation letter for billing purposes and/ or to validate any discrepancies.

Note: PAs given through the Drug Exception Centre 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 (AAC) and applicable regional mark-up fee. Providers are reminded that the PA number should not be included in the billing if the item was approved by SA . For more details about SA, please refer to section 5.7.3. Special Authorization Confirmation Letters

5.7.1. 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 submission 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 5.2.1 Claim Submission – Required Data Elements.

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 a 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), then a pharmacist may dispense an initial course of treatment (seven (7) day maximum 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.

5.7.2. 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 with the CPhA 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.

5.7.3. Special Authorization Confirmation Letters

An approval may be given by 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. Please note that the PA number should not be included in the billing if there is an SA number assigned

5.8. Claims Payment when Billing Privileges are Terminated

All requests for payment for claims prior to the termination of billing privileges must be made within one (1) year from the date of service. Claims with a service date on and subsequent to the date of termination are not eligible for payment to the provider.

5.9. Benefit Coverage and Limitations

For information on NIHB-eligible benefits, limitations and services requiring a PA, refer to the Guide for Pharmacy Benefits located on the NIHB website canada.ca/en/health-canada/services/first-nations-inuit-health/reports-publications/non-insured-health-benefits/guide-pharmacy-benefits-non-insured-benefits.html and the NIHB Drug Benefit List at canada.ca/en/health-canada/services/first-nations-inuit-health/non-insured-health-benefits/health-provider-information/drug-pharmacy-information/drug-benefit-list-health-provider-drug-pharmacy-information-non-insured-health-benefits-first-nations-inuit-health-canada.html.

5.9.1. Special Promotions, Coupons and Discounts

In situations where a promotion, coupon and/or discount applies to a client, Providers must deduct their total value from the claim. The amount claimed through the Program must be the residual amount after application of any promotion, coupon and/or discount.

Please see the Guide for Pharmacy Benefits for complete policy (canada.ca/en/health-canada/services/first-nations-inuit-health/reports-publications/non-insured-health-benefits/guide-pharmacy-benefits-non-insured-benefits.html#a42RS).

6. Provider Audit Program

6.1. 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 the 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 of 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 policies.

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 ISC may refer the matter to the respective regulatory body.

6.2. Provider Responsibilities

The provider shall co-operate 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, review and reproduce during regular business hours, any pharmacy records maintained by the provider pertaining to paid claims for clients, as Express Scripts Canada deems necessary to determine compliance with the terms detailed in the documents outlined Section 3.2 Pharmacy Documentation and Updates.

6.3. Provider Audit Components

The Express Scripts Canada Provider Audit Program involves multiple components, as outlined below. 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)
  - Express Scripts Canada requests invoices within a thirty (30) day period to ensure that the invoice cost is current for the date of the claim and to minimize calculation errors due to price fluctuations.
- Documentation of item received by the client (such as methadone log books)
- Evidence of additional coverage (to co-ordinate benefits)

6.3.1. 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.

6.3.2. Client Confirmation Program

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

6.3.3. 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.

6.3.4. Desk Audit Program

The Desk Audit Program 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.

6.3.5. On-Site Audit Program

The purpose of the onsite 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.

6.3.5.1. Stages of an Onsite Audit

Express Scripts Canada contacts the provider at least three (3) weeks prior to the proposed onsite audit date. Wherever possible, every effort is made to accommodate the audit date with the provider's schedule. The date agreed upon for the onsite audit is confirmed by fax with the provider by way of an onsite audit confirmation letter.

The pharmacy audit specialist(s) requires:

- Work space, chairs.
- Access to an electrical outlet(s).
- Assistance in retrieving computerized client profiles with a staff member.
- A dedicated staff member onsite 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.

6.3.5.2. 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 onsite 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 onsite audit.

6.3.5.3. Conduct of the Onsite Audit

The purpose of the onsite audit is to verify paid claims against pharmacy records. Claims documentation not provided onsite 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.

6.3.5.4. Post-Audit Interview

At the end of the onsite audit, the pharmacy audit specialist provides a general overview of the categories of errors found. The final audit results are not complete until the pharmacy audit specialist has conducted additional analysis, such as, but not limited to, client and prescriber confirmations. During the post-audit exit interview, the provider is given a high level summary of the audit observations as well

as a checklist to complete and return to Express Scripts Canada. The checklist confirms the audit process was conducted at the respective onsite audit and provides an opportunity for comments.

6.3.5.5. Audit Report

A report of the audit findings is sent to the provider within sixty (60) days of the onsite 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 initial audit letter and initial 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 receipt of the response from the provider, Express Scripts Canada sends a final audit letter and final audit report of the 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 the final audit letter will result in a hold against the provider's payment statements until recovery is paid in full.

6.3.5.6. Documentation Requirements for Audit Purposes

Providers must retain a copy of the original prescription and documentation on file for three (3) 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.

6.3.5.7. Supporting Documentation

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 COB)
- Items awaiting pick-up (to verify pickup within thirty (30) days of fill or claim reversal is required)
- 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.

6.3.6. Reference Documents

For Express Scripts Canada Provider Audit Program reference documents, refer to the:

- NIHB annual report
- Agreement
- Pharmacy and MS&E newsletters
- Bulletins
- Guide for Pharmacy Benefits
- DBL
- Provincial and federal drug and pharmacy legislation

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

Providers who do not have Internet access or email, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to Section 8.2.2 Provider Claims Processing Call Centre).

The annual report may be viewed and downloaded from the NIHB Claims Services Provider website at provider.express-scripts.ca/annual_report.

6.3.7. 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

7. Pharmacy Claim Statement

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 settled claims, adjusted claims and rejected claims during the current period. Rejected claims include the appropriate reject message explaining the reason each claim was not paid. Express Scripts Canada issues the pharmacy claim statement twice a month in either English or French, depending on the provider's preferred language.

7.1. Pharmacy Claim Statement Messages

The HICPS system assigns three (3)-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 (2) numeric characters	Text message explains the claim was adjudicated with modifications.

7.2. 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.

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.

7.3. Codes, Messages and Explanations

Below is an ordered list of the NIHB rejection and warning codes, messages and explanations that may appear on the pharmacy claim statement, cross-referenced with the applicable CPhA Codes sent at POS.

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

Please review the CPhA Pharmacy Claims Standard for code descriptions.

NIHB Code/CPhA Code	Description
NIHB Code: R01/CPhA Codes: NF and 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.
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 a case by case basis, contact the DEC at 1 800 580-0950.
NIHB Code: R05/CPhA Codes: C8	
Message	Claimant Could Not Be Verified as an NIHB Client
Explanation	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: a) Has not used their registered surname, given names, or date of birth (DOB) b) Has made an error in specifying the client identification number. 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.
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

NIHB Code/CPhA Code	Description
	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 client's co-pay and/or deductible.
NIHB Code: R09/CPhA Codes: UN	
Message	Claim Does Not Comply with Terms of 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: R12/CPhA Code: 32, 34, 37 and 38	
Message	Insufficient Client Information to Adjudicate Claim
Explanation	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: • Surname (CPhA: 38) • Given names (CPhA: 37) • DOB (CPhA: 34) • Client identification number (CPhA: 32) 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.
NIHB Code: R15/CPhA Code: 57	

NIHB Code/CPhA Code	Description
Message	Day's Supply Must Equal 7 or a Multiple of 7 for Dosette Claim.
Explanation	The day's supply does not equal seven (7) days or a multiple 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	The prescription number must be numeric and greater than zero. 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 7.5 Payment Information* under **POS Reversals.**
NIHB Code: R17/CPhA Code: 56	
Message	DIN/GP #/Pin Error
Explanation	All eight (8) positions must be valued, cannot be all zeros and must be a valid item number that exists on the Express Scripts Canada database. 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 7.5 Payment Information* under **POS Reversals**.
NIHB Code: R18/CPhA Code: 58	
Message	Quantity Error
Explanation	The quantity must be numeric and greater than zero. 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 7.4.1 Payment Information* under **POS Reversals**.
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 7.5 Payment Information* under **POS Reversals**.
NIHB Code: R20/CPhA Code: C6	
Message	Submit Claim to Provincial /Territorial Health Plan

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NIHB Code/CPhA Code	Description
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 (1) year after the service was rendered. In addition this applies to claims that Providers attempt to submit after the thirty (30) day limit for POS claims has been exceeded.
NIHB Code: R22/CPhA Code: 61	
Message	Prescriber ID Error
Explanation	The prescriber ID number (license or billing number) can be alphanumeric but cannot be all zeros. The provider should send the actual prescriber ID and check the claim for missing, incomplete, or erroneous information and provide the required information by following the claims correction procedures outlined in *Section 7.5 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 on claim cannot be less than the minimum quantity per claim on PA. Refer to your copy of the prior approval confirmation.
NIHB Code: R26/CPhA Code: 64	
Message	Prior Approval Service Date Violation

NIHB Code/CPhA Code	Description
Explanation	The claim has not been paid because the DOS does not correspond with the criteria for approval dates as follows: a) For a one-time PA, the PA date cannot be after the date of service, the PA date is on the PA confirmation letter. b) For standing order PAs, the PA start and expiry dates have to include the date of service. The PA has to be set up in such a way that the DOS is within the effective date of the PA.
NIHB Code: R27/CPhA Code: 64	
Message	Prior Approval Number Is Invalid
Explanation	The claim has not been paid because there was not a match with the PA record for the following one or more reasons: • Mismatch PA number • Mismatch client number • Mismatch provider number • Mismatch item number • Item was not approved • PA isn't ready to be billed against The provider should check their records to ensure that there is a match between 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 7.5 Payment Information* under **POS Reversals.**
NIHB Code: R28/CPhA Codes: 66	
Message	Drug Cost/Product Value Error.
Explanation	The drug and/ or item cost must be numeric and greater than zero (0). 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 7.5 Payment Information* under **POS Reversals.**
NIHB Code: R29/CPhA Code: A2	
Message	Claim is postdated
Explanation	This must be in valid YYYY-MM-DD format and cannot be future date. If check fails, message is generated.

NIHB Code/CPhA Code	Description
	The provider should check the claim for missing, incomplete or erroneous information and provide the required information within 30 days. If it is greater than 30 days, make the appropriate corrections to the hard copy of the statement and fax to Express Scripts Canada. To reverse a claim, please follow the claims correction procedures outlined in the *Section 7.5 Payment Information* under **POS Reversals.**
NIHB Code: R30/CPhA Code: C6	
Message	Client Has Alternative Coverage, Contact FNIH regional office
Explanation	The claim has not been paid because the ISC 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 FNIHB regional office for direction on where to submit the claim.
NIHB Code: R31/CPhA Code: CD	
Message	Client Not Entitled To Drug Claimed
Explanation	The client is not entitled to the drug that has been claimed.
NIHB Code: R32/CPhA Code: C6	
Message	Client Has Alternative Coverage Contact FNHA
Explanation	The client has additional plan coverage. Please contact FNHA.
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 ISC. Items exceed maximum dollar value per claim. 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/CPhA Code	Description
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 for the claim that was previously returned with RW/ R49. The claim was resubmitted to generate an automatic PA/ case request. This is confirmation that a request was received.
NIHB Code: R52/CPhA Code: RD	
Message	Eligible for Prior Approval
Explanation	The claim has not been paid as it is eligible for a prior approval. PA procedures are detailed in the prior approval process of the Kit.
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 DOS Client -provider
Explanation	The payment has been denied because all the data elements match the data elements of a previously settled claim already on file.
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 (7) 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	Claims Paid On Parent ID until 1st Birthday Only

NIHB Code/CPhA Code	Description
Explanation	The claimant could not be verified as an NIHB client. However, since the claimant is a child under one (1) 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 rejected 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 and E3	
Message	Claim Is Reduced To NIHB Share
Explanation	Generated on claims which have the NIHB share amount reduced from the first payor share value being asked of NIHB to be paid. For items submitted with a first payor 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: 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: CN	
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 a hundred (100).
NIHB Code: W15/CPhA Code: E2	
Message	Claim Coordinated with Govt Plan
Explanation	Claim has been coordinated with a government plan. Generated on claims which have been sent first to the government plan with an intervention code of DA and then sent to NIHB as the second payor.
NIHB Code: W16/CPhA Code: QU	
Message	Claim is Reduced to NIHB Share

NIHB Code/CPhA Code	Description
Explanation	Generated on claims which have the NIHB share amount reduced from the amount being asked of NIHB to be paid. The NIHB payable amount has been reduced to a maximum allowed as per NIHB pricing rules.
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 ISC. The provider should refer to the Prior Approval Confirmation Letter, which will indicate the NIHB-approved quantity amount.
NIHB Code: W18/CPhA Code : DR	
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-days' supply for subsequent fills of chronic use drugs.
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	Mark-up disallowed or reduced to conform to pricing guidelines or prior approval confirmation. Refer to details of the NIHB pricing guidelines in agreements with the respective region.
NIHB Code: W21/CPhA Code: VA	
Message	Days Supply Lower Than Minimum Allowable Of 7
Explanation	The dispensing Fee (DF) paid has been reduced to conform to the NIHB Short-Term Dispensing Fee Policy. The Program only allows one DF per 7 days for chronic drugs.
NIHB Code: W50/CPhA Code: CR	
Message	Patient is exceeding dosage safety limit
Explanation	Client is exceeding the dosage safety limit
NIHB Code: N/A/ CPhA Code: A8	

NIHB Code/CPhA Code	Description
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 CIRNA number; submit first claim as a manual claim.
NIHB Code: N/A/ CPhA Code: 75	
Message	Previously Paid Error
Explanation	Claim sent to a first payor plan and the intervention code is not DA or DB. For COB claims, please specify on the claim if the private plan paid before the provincial plan.
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

NIHB Code/CPhA Code	Description
Explanation	The provider must submit the trial balance claim no later than fourteen (14) days after the trail claim.
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 eligible 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.

7.4. Drug Utilization Review

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) (e.g. a potential severe interaction) and Potential Overuse/ Abuse Indicated (NE).

- Drug/ Drug Interaction Potential (Code: ME)
  - Indicates that drug may interact with another drug in the clients' current claims history, based on an accurate day's supply submission.
- Duplicate Therapy (Code: MX)
  - Indicates the client has received a drug from the same therapy class.
- Duplicate Therapy Multi-Pharmacy (Code: MZ)
  - 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)
  - 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)
  - 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)
  - Indicates potential overuse/ abuse of specified drug entities. Sent to provider for claims that meet one of the criteria below:
    - Use of Methadone Maintenance Treatment (MMT) of opioid dependency, 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.

7.4.1. 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 for 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
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.

7.5. 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 twice a month. 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 providers who provide 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 (1) year from the original date of service.

- For POS in most cases, the software automatically assigns an adjudication date of the original claim that needs to be reversed, 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. Reversals must be requested using the statement, if the provider's system date is greater than thirty (30) days from the DOS of the original claim. A paper Claim must be returned if submitting after thirty (30) days from the original adjudication date.

7.5.1. Trial R_x Program

7.5.1.1. What is a Trial R_x Program?

A Trial R_x 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 (physician if necessary) before the remainder of the prescription is dispensed. Drug side effects are often the major reason clients discontinue important drug therapy.

7.5.1.2. How will the Trial R_x Program Drugs Be Handled?

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

Under the Trial R_x Program, clients receive a seven (7) 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 voluntary; therefore, if a claim is submitted for a Trial R_x DIN/ Item number without a Trial R_x intervention code, the claim is processed according to regular cost verification rules.

If a claim is submitted for Trial Rx DIN/ Item number using the MT (Trial R_x Program) or the ND (Trial R_x balance) intervention codes, then the claim is processed according to the Trial R_x Program rules.

7.5.1.3. Adjudication Process for the Trial R_x Program

1. The first claim should be submitted with CPhA intervention code MT (Trial R_x Program). If the drug is not eligible for the Trial R_x Program, the claim is returned with CPhA code NQ - Drug not eligible for trial R_x.
2. The day's supply submitted must be equal to seven (7).
   - 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 number 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 number 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 number. If no first Trial R_x claim exists, the claim is returned with CPhA code OD (no Trial R_x on record, balance rejected).
   - If a second Trial R_x 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 R_x balance given too soon) or NZ (Trial R_x balance given too late), respectively.

4. If all above conditions are met, the claim is processed.

There are no corresponding NIHB codes for Trial R_x returns, therefore, the CPhA code and description is printed on the pharmacy claim statement.

8. Pharmacy Forms and Resources

8.1. Pharmacy Documents and Forms

All pharmacy forms listed below are located on the provider website at provider.express-scripts.ca.

Providers who do not have internet access or email, 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 8.2.2 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

8.2. Resources

8.2.1. Really Simple Syndication Feed

Really Simple Syndication (RSS) is a useful tool to receive updates from websites. Updates are broadcasted 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 Government of 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 cannot be viewed accurately in an Internet browser since the formats are different. In order to receive RSS feeds, you must have an aggregator or a feed reader. There are a number of free aggregators interfaces available online. In addition to availability on your computer, RSS feeds can also be read on mobile devices.

8.2.1.1. Adding an Aggregator

To add an aggregator:

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

By either method, the feed will be available as soon as it has been added, and the next update could arrive at any given moment. To remove RSS feed updates, delete the feed or URL from your aggregator.

8.2.1.2. Adding an Email to the RSS Service

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

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

To receive email notices through an email RSS service:

1. Copy the .xml URL link
2. Paste it into the email subscription page.

Websites:

- ISC, NIHB Program:
  canada.com/nihb
- Express Scripts Canada, corporate website:
  express-scripts.ca

- Express Scripts Canada, NIHB Claims Services Provider Website: provider.express-scripts.ca

For more details on RSS feeds, visit:

open.canada.ca/en/rss-feeds

8.2.2. Provider Claims Processing Call Centre

The call centre is available to registered pharmacy providers of the Program.

Phone Number:
1 888 511-4666

Extended Hours of Operation:
Monday to Friday: 6:30 a.m. to midnight. Eastern Time
Saturday, Sunday and Statutory Holidays: 8 a.m. to midnight Eastern Time

8.2.3. 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

8.2.4. 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

9. 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:

Email:
ExpressScriptsCanada_Privacy@Express-Scripts.com

Website:
express-scripts.ca/about/privacy-policy

Telephone Number:
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