The Non-Insured Health Benefits (NIHB) Program
Information for Providers Regarding Coordination of Pharmacy Benefits with Alternate Health Coverage

Questions and Answers

What is coordination of benefits?

Coordination of benefits refers to the order in which benefits coverage is accessed when a client has coverage under multiple plans/programs. The NIHB Program is a publicly funded program designed to supplement any alternate health coverage an eligible First Nations or Inuit client may have. Clients are required to access any other health coverage for which they are eligible prior to accessing the NIHB Program. Providers are required to submit claims to the client's alternate health coverage first and the NIHB Program will then coordinate payment with the other payer for eligible benefits.

When was this policy implemented?

Coordination of benefits has always been part of the mandate of the NIHB Program. Starting July 16, 2012, the Program will be implementing administrative measures to ensure that benefits are coordinated when clients have access to a third party insurer.

Does the coordination of benefits affect clients' coverage under the NIHB Program?

Clients are still entitled to the same benefits under the NIHB Program as they would be, regardless of any alternate health coverage. Coordination of benefits simply means that the NIHB Program will pay the remaining amount of a client's claim for the eligible benefits not paid for by their other health plan.

How can providers help a client update their coverage status to ensure the coordination of benefits?

Pharmacy providers should confirm that the client has provided the most up-to-date information regarding their health coverage by asking the client if any changes were made to their current health coverage when processing prescriptions for NIHB clients.

What should providers do if they receive a message indicating that *"patient has other coverage"* when submitting to the NIHB Program?

This message means that the provider must submit to the alternate health coverage prior to accessing the NIHB Program. When a client is unable to provide information about their alternate coverage, pharmacy providers can adjudicate claims using the appropriate intervention code to adjudicate coordination of benefits. In such cases, providers are required to:

- demonstrate that an attempt was made to obtain coverage from the alternate health plan; and
- attach relevant documentation to the prescription hardcopy to be retained on file for future audit purposes.

What should providers do if a client's alternate health coverage has been terminated?

When the provider receives a response from the alternate health plan indicating, "coverage terminated before service", the provider is required to:

- print the message as proof and attach to the prescription hardcopy to be retained on file for future audit purposes;
- print a second copy of the message and provide a copy to the client; and
- direct the client to submit the second copy to their Health Canada regional office.

The claim may then be adjudicated with the appropriate intervention code for coordination of benefits.

What should providers do if they receive a message indicating that the "*DIN/PIN/GP #/SSC not a benefit* " under a client's alternate health coverage?

Documentation showing that an attempt was made to obtain coverage from the alternate health coverage must be attached to the prescription hardcopy for future audit purposes and the appropriate intervention code can be used by the pharmacy provider to adjudicate the claim.

What should providers do if they receive a message indicating, "*Plan Maximum Exceeded"* when submitting to the alternate health coverage?

Documentation showing that an attempt was made to obtain coverage from the alternate health plan must be attached to the prescription hardcopy for future audit purposes and the appropriate intervention code can be used by the pharmacy provider to adjudicate the claim.

<u>What should providers do if they receive a message indicating a "*DIN/GP #/PIN Error" or "Special Authorization (SA) Required"* when submitting to the client's alternate health coverage?</u>
Documentation showing that an attempt was made to obtain relevant PIN and coverage from the alternate health plan must be attached to the prescription hardcopy for future audit purposes and the appropriate intervention code can be used by the pharmacy provider to adjudicate the claim.

<u>How are deferred payment plans coordinated with the NIHB Program?</u>
A deferred payment plan is one where the client pays for the prescription at point-of-sale and the pharmacy submits the prescription claim on-line to the plan on the client's behalf. The client then receives reimbursement directly from the alternate health coverage. Any remaining amount from the prescription claim that was not covered in full by the deferred payment plan can then be submitted to the NIHB Program for manual reimbursement.

The client must submit the following to the Health Canada regional office:

- a completed and signed NIHB Client Reimbursement form;
- a statement of benefits from the deferred payment plan; and
- a copy of the official prescription receipt.

The NIHB Program does not coordinate on-line with deferred payment plans. The client is required to submit these claims manually to the Program through their Health Canada regional office. Please note that all requests for reimbursement of eligible benefits must be made ***within one year from the date of service***.

<u>How are manual plans coordinated with the NIHB Program?</u>
A manual plan means that the client pays for their prescriptions at the time of purchase and submits their claims to the manual plan for reimbursement. Any remaining amount from the prescription claim can then be submitted to the NIHB Program for reimbursement.

The client must submit the following to the Health Canada regional office:

- a completed and signed NIHB Client Reimbursement form;
- a statement of benefits from the manual plan; and
- a copy of the official prescription receipt.

The NIHB Program does not coordinate on-line with manual plans. The client is required to submit these claims manually to the Program through their Health Canada regional office. Please note that all requests for reimbursement of eligible benefits must be made ***within one year from the date of service***.

Where can providers find out more information about coordination of benefits?

More information regarding coordination of benefits can be obtained by contacting the Express Scripts Canada (ESC) toll-free line at: 1-888-511-4666 or by visiting the Health Canada website at: http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/pharma-prod/index-eng.php .

HEALTH CANADA REGIONAL OFFICES
TOLL-FREE TELEPHONE NUMBERS

British Columbia
1-800-317-7878

Saskatchewan
1-800-667-3515

Manitoba
1-800-665-8507

Northern Region (NWT and NU)
1-888-332-9222

Northern Region (YK)
1-866-362-6717 or 1-866-362-6719

Alberta
1-800-232-7301

Ontario
1-800-640-0642

Quebec
1-877-483-1575

Atlantic (PEI, NS, NB, NL)
1-800-565-3294