NIHB Pharmacy Claims Submission Kit

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

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1. Introduction

1.1 General Terms

The general terms and conditions governing the relationship between you, the Provider and Express Scripts Canada are set out in the Pharmacy Provider Agreement. This Non-Insured Health Benefits (NIHB) Pharmacy Claims Submission Kit (also referred to as the "Kit") contains additional terms and conditions, and procedures for verifying Client eligibility, as well as Claims eligibility, submission, adjudication, disputes, payment, reversals, and audit. Providers are bound by, and must follow, the terms, conditions and procedures in this Kit in respect of Claims submitted by them under the Pharmacy Provider Agreement.

1.2 NIHB Pharmacy Claims Submission Kit

This Kit is designed to help Providers understand how Express Scripts Canada's 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.

This Kit may be amended at any time by Express Scripts Canada, alone, and any such amendments or updates are posted on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca effective immediately, unless otherwise stated. A notice of updates is provided in accordance with the notice mechanisms listed in *Section 5.2 Pharmacy Provider Agreement Documentation and Updates*.

It is the Providers' responsibility to have the most current version of this Kit available for reference at all times. It is expected of the Provider to obtain an up to date version of the Kit at the beginning of each Release quarter (February, May, August and November) of each year. A copy may be downloaded from the NIHB Claims Services Provider Website at www.provider.express-scripts.ca or through a request made to Express Scripts Canada for a paper copy.

Should you have any questions or comments about the Kit, contact the Provider Claims Processing Call Centre at 1-888-511-4666.

1.3 Interpretation

In the event that any of the terms and conditions found in this Kit is inconsistent with those of the Pharmacy Provider Agreement, the terms and conditions of the Pharmacy Provider Agreement shall prevail to the extent of the conflict or inconsistency.

In the event this Kit does not address a Claims submission or data transmission matter or in the event of uncertainty as to a term or condition, the Provider may contact Express Scripts Canada to discuss the matter, and Express Scripts Canada address the issue or provide direction to resolve the question. However, in the event the parties cannot resolve an uncertainty or disagreement pertaining to the interpretation of this Kit, the parties will then refer the matter to Health Canada who shall provide a direction to the parties pertaining to the issue.

Quebec Pharmacy Providers Only: In the event of a conflict between the terms and conditions of the Kit and of the agreement between the Association

Québécoise des Pharmaciens Propriétaires (AQPP) and Health Canada, the terms and conditions of such agreement shall prevail.

2. Legal Definitions and Glossary Terms

2.1 Legal Definitions

The following terms are used in this Kit as short forms and their definitions are detailed in the chart below:

Term	Description
Claim	A Claim for payment submitted by a Provider to Express Scripts Canada for the provision of pharmacy services to Clients in accordance with the Pharmacy Provider Agreement and the Kit.
Client	A person who is eligible to receive NIHB pharmacy services in accordance with the eligibility criteria in *Section 5.1 Provider Eligibility Requirements* of this Kit.
COB	The Coordination of Benefits (COB) between two or more drug benefit plans, whether private or a combination of public and private coverage.
CPhA	The Canadian Pharmacists Association.
DUR	The Drug Utilization Review, more particularly explained in *Section 6.3 Drug Utilization Review Program*.
FNIH	The First Nations and Inuit Health Regional Office (s) of Health Canada.
FNIH(B)	The First Nations and Inuit Health Branch of Health Canada.
Health Canada	The Department of Health (Canada).
NIHB Drug Benefit List (DBL)	The list established by Health Canada and updated by it from time to time which sets out the prescription and Over-the-Counter (OTC) drugs, for which the Provider may submit Claims to Express Scripts Canada in accordance with the Pharmacy Provider Agreement.
NIHB Pharmacy Claims Submission Kit or "Kit"	The Kit, which is provided by Express Scripts Canada and updated from time to time and sets out additional terms and conditions for the submission of Claims under the Pharmacy Provider Agreement.
NIHB Program or Program	The Non-Insured Health Benefits (NIHB) Program of Health Canada, which provides coverage for a specified range of drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health counseling, and medical transportation, which are provided to eligible First Nations and Inuit persons and not covered by other benefit plans.
Other Coverage	Benefits available to Clients of the NIHB Program, in whole or in part, from a provincial, territorial or third party health care plan.
Pharmacy Provider Agreement	The Express Scripts Canada, Pharmacy Provider Agreement, the Annexes thereto, and any amendments thereto made in writing.

Term	Description
POS	The Point of Service (POS) or location where a transaction occurs such as a retail store or pharmacy terminal.
Prescriber ID	A reference number that a prescriber of medication, medical supplies or professional services uses to identify themselves.
Provider	The party who signs the Pharmacy Provider Agreement.
Provider ID	A reference number that is used to identify a Provider.
PWGSC	Means the Department of Public Works Government Services Canada.
Usual and Customary (U & C) Professional Fee	A dispensing fee that the Provider charges to customers for prescriptions. Express Scripts Canada must be informed of the pharmacy's current U & C professional fee posted, registered or charged to customers, for transactions other than those for which the provincial or federal government is the payer. All changes to the U & C professional fee must be communicated to Express Scripts Canada in writing, either by mail or fax, immediately upon the change.

2.2 Glossary Terms

Term	Description
Express Scripts Canada	The health Claims management company that is responsible for the processing of Claims submitted through the NIHB Program.
FPT	Federal Pharmacy and Therapeutics committees. An advisory body of health professionals established to provide evidence based pharmacy and medical advice to the drug benefit plans of six federal departments (Health Canada, Veterans Affairs, Royal Canadian Mounted Police, Correctional Services Canada, National Defense and Citizenship and Immigration Canada).
HICPS	Health Information and Claims Processing Services system. Includes all services used to process NIHB Claims, to support Providers with the processing and settlement of their Claims, and to ensure compliance with NIHB Program Policies, including audit, reporting and financial control practices.
INAC	The department of Indian and Northern Affairs Canada, also known as the department of Indian Affairs and Northern Development (DIAND). The department is responsible for two mandates, Indian and Inuit Affairs and Northern Development, which together support Canada's Aboriginal and northern peoples in the pursuit of healthy and sustainable communities and broader economic and social development objectives.
PIPEDA	The Personal Information Protection and Electronic Documents Act (PIPEDA) (Canada). An Act to support and promote electronic commerce by protecting personal information that is collected, used or disclosed in certain circumstances, by providing for the use of electronic means to communicate or record information or

Term	Description
	transactions and by amending the Canada Evidence Act, the Statutory Instruments Act and the Statute Revision Act.

3. Background

3.1 Role and Responsibilities of Health Canada

Health Canada is the federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances. Its goal is that Canada's population be one of the healthiest in the world as measured by longevity, lifestyle, and effective use of the public health care system.

Provinces and territories have primary jurisdiction over health. Health care services include insured hospital care and primary health care, such as physicians and other health professional services. Like any other residents, First Nations people and Inuit access these insured services through provincial and territorial governments.

There are a number of health-related goods and services that are not insured by provinces and territories or other private insurance plans. To support First Nations people and Inuit in reaching an overall health status that is comparable with other Canadians living in similar geographic circumstances, Health Canada's Non-Insured Health Benefits (NIHB) Program provides coverage for a limited range of drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health counseling, and medical transportation when they are not insured elsewhere.

The First Nations and Inuit Health Branch Head Quarters (**FNIHB) (HQ)** is located in Ottawa and is responsible for establishing NIHB policy and managing the NIHB Program, contracting the processing of Claims, establishing rules and guidelines for the provision of benefits including defining NIHB benefits, and determining program guidelines and Prior Approval (PA).

The First Nations and Inuit Health **(FNIH) (Regions)** is divided into ten geographical regions. They are responsible for: implementing national policy in the regions and communicating this policy to Providers, Clients, and provincial governments; negotiating contracts with Providers and establishing pricing guidelines, pharmacy PAs (with the exception of those for drugs) and Client Reimbursements (CR), assisting Clients with questions concerning the NIHB Program and directing First Nations and Inuit Clients to the appropriate source to obtain the necessary Client Identification Numbers.

3.2 Role and Responsibilities of Express Scripts Canada

Express Scripts Canada, pursuant to a contract with Public Works and Government Services Canada (PWGSC) and Health Canada, administers the HICPS for pharmacy benefits covered through the NIHB Program. The responsibility encompasses all aspects of pharmacy benefits processing and payment of Claims and extends to 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 NIHB Program policies and are consistent with the Claims submission guidelines outlined in this Kit.

In the context of pharmacy benefit management, Express Scripts Canada is not an insurance company, but is mandated to receive, analyze and proceed with payment of, as applicable, all Claims submitted electronically or manually by Providers through the NIHB Program.

For more information, contact the Provider Claims Processing Call Centre at 1-888-511-4666.

3.3 Health Information and Claims Processing Services

Health Information and Claims Processing Services (HICPS) is the electronic Claims adjudication system which automatically receives, processes, and approves or denies pharmacy Claims based on NIHB Program rules.

The NIHB HICPS system captures Claims sent through Personal Computer (PC) based Pharmacy Practice Management Systems. An electronic data network processes the Claims and returns an electronic response. Data is transmitted respecting the format specified by the current CPhA Electronic Claim Standard1.

The Claim is entered with the mandatory data elements as stipulated in the Attachments to this Kit found on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca

After data is keyed from the NIHB Pharmacy Claim Form, the Claim is submitted for adjudication. The system checks to determine if the Provider and Client are eligible. It also verifies that the item is an eligible benefit, checks for duplicate Claim status, completes third party edits, and any rate and frequency violations. All data are displayed on the screen along with the Claim doc# (Reference #), Status (R – Rejected, A – Accepted, B - Cutback and S - Suspended), and any NIHB and/ or CPhA Codes generated from adjudication.

Depending on the action taken, the Claim is either:

- Accepted (perhaps adjusted) to the Provider and paid.
- Rejected to the Provider as a result of insufficient information and/ or due to ineligibility. A list of NIHB Error Messages and CPhA Error Messages are listed in the Attachments to this Kit on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca

4. Express Scripts Canada Privacy Policies

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

[1] To obtain a copy of the CPhA Electronic Claim Standard, contact the Canadian Pharmacists Association at 1785 Alta Vista Drive Ottawa, Ontario, K1G 3Y6, Telephone 613-523-7877; and Fax 613-523-0445.

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

E-mail:	ESICanada_privacy@express-scripts.com
Website:	www.express-scripts.ca/privacy/
Telephone:	1-888-677-0111 (ask for the Privacy Officer)
Mail:	Attention: Privacy Office Express Scripts Canada 5770 Hurontario Street, 10th Floor Mississauga, ON L5R 3G5

5. Pharmacy Provider Agreement

5.1 Provider Eligibility Requirements

Providers wishing to provide services to Clients must register and sign a Pharmacy Provider Agreement with Express Scripts Canada. Express Scripts Canada will obtain a confirmation from the provincial college for the accreditation of the pharmacy. Both the Agreement and the accreditation are then forwarded to the Health Canada Regional Office for review, subsequent to which the Provider's registration may be authorized or denied.

The Provider's effective date in the NIHB Program is established on the date on which both parties have signed the Pharmacy Provider Agreement. The Provider's end date in the NIHB Program is established on the date the Provider notifies Express Scripts Canada in writing that the Provider no longer chooses to be an NIHB Provider, on the date stated in the letter issued by Express Scripts Canada informing the Provider of the effective date of delisting (for example, the date the Provider is no longer an eligible NIHB Provider and therefore cannot submit Claims in the Program), or on the date the Pharmacy Provider Agreement is terminated, according to the termination process outlined in the Pharmacy Provider Agreement (for example, the Provider is retired; change in ownership or resulting from audit findings).

Claims submitted with a service date prior to the Provider's effective date in the NIHB Program or subsequent to the Provider's end date/ date of termination in the NIHB Program are not eligible for payment.

5.2 Pharmacy Provider Agreement Documentation and Updates

The Express Scripts Canada Pharmacy Provider Agreement sets forth the relationship between Express Scripts Canada and eligible pharmacy Providers for the NIHB Program. After the Pharmacy Provider Agreement has been signed and completed by the Provider, and approved by the appropriate FNIH Regional Office; Providers are provided with a Provider ID, and then eligible to forward Claims to Express Scripts Canada. Providers are expected to abide with all NIHB Program responsibilities as outlined in the Kit and other NIHB communications.

The Provider is required to review and complete all pages of the Pharmacy Provider Agreement and return to Express Scripts Canada. Pharmacy Providers also supplying Medical Supplies and Equipment (M&E) benefits must ensure to complete the Qualified Assessments -

Medical Supplies/ Equipment section of Annex C. Only after completing this section may a Provider submit MS&E items.

For additional details, refer to *Section 5.4 Terms and Conditions* in the Kit.

A new Provider ID is not provided until the Pharmacy Provider Agreement is completed and signed in its entirety, and received at Express Scripts Canada.

Program policy and claim submission/ payment information are made available to Providers through:

- Regular updates on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca
- Non-Insured Health Benefit Bulletins.
- Non-Insured Health Benefit Newsletters.
- Ad hoc Broadcast Messages.
- NIHB Drug Benefit List (DBL).

It is important that Providers retain the most current documentation to ensure Program requirements are met. Visit the NIHB Claims Services Provider Website at www.provider.express-scripts.ca for access to NIHB Contact Information, Bulletins, Newsletters, Notices and much more. Additional information is outlined in the Pharmacy Provider Agreement.

For information on billing and payments, refer to the Attachments to this Kit on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca

For information on Provider audits, refer to *Section 8. Provider Audit*.

5.3 Process for Registering with Express Scripts Canada/ Provider ID

How to Register:

1. Visit the NIHB Claims Services Provider Website at www.provider.express-scripts.ca to obtain a copy of the Pharmacy Provider Agreement; or contact the Provider Claims Processing Call Centre at 1-888-511-4666 to obtain a copy of the Pharmacy Provider Agreement and applicable Annexes by fax, e-mail or mail.
2. Fax or mail the completed Pharmacy Provider Agreement to:

Fax:	905-712-0669
Mail:	**Attention:** Provider Relations Express Scripts Canada 5770 Hurontario Street, 10th Floor Mississauga, ON L5R 3G5

If the request for registration is approved, Providers are assigned an individual Provider ID upon signing the Express Scripts Canada Pharmacy Provider Agreement. This number is used to identify the Provider and to properly pay the Provider for Claims adjudicated by Express Scripts Canada. The individual Provider ID must be used when submitting all Claims for payment and in all communication with Express Scripts Canada.

Express Scripts Canada's policy is to register and enter into a Pharmacy Provider Agreement only with individual pharmacy legal entities, and in respect of each separate pharmacy location. In this way, the Pharmacy Provider Agreement may be with a corporation, partnership or proprietorship or franchisee corporation that owns and operates a specific pharmacy location. Express Scripts Canada will not sign Agreements covering a chain of pharmacies or with (or only with) a shareholder of a pharmacy entity or a parent company of a pharmacy entity. Where an entity owns more than one pharmacy location, each separate pharmacy location (if it is a separate legal entity) will need to sign a Pharmacy Provider Agreement. Where several pharmacy locations are part of a single legal entity, there will need to be a separate Pharmacy Provider Agreement in respect of each pharmacy location with the same Provider. At a minimum, every separate pharmacy location will be assigned a separate Provider ID.

5.4 Terms and Conditions

The following terms and conditions apply to all services covered under the NIHB Program. In order for a Provider to be eligible for payment of services rendered, the Provider must adhere to the Program's terms and conditions as set out in the Pharmacy Provider Agreement and the Kit, which include:

- Client eligibility requirements (*Section 6.2.1 Client Identification and Eligibility*).
- Provider licensure and eligibility requirements (*Section 5.1 Provider Eligibility Requirements*, *Section 6.2.1 Client Identification and Eligibility*).
- Benefit coverage and/ or applicable limitations (*Section 6.3 NIHB Benefit Coverage and Limitations*).
- Requirements for Coordination of Benefits with other health plans (*Section 6.2.4 Coordination of Benefits*).
- Submission process and supporting documentation requirements (*Section 6. Claims Submission and Processing*).
- Requirements to maintain relevant documentation and records (*Section 7.2.3.5 Documentation Requirements for Audit Purposes*).
- Requirements to submit to and assist in any audit conducted by Express Scripts Canada of Claims submitted through the NIHB Program (*Section 7.2.1 Provider Responsibility*).

Requirements for payment restrictions and accepting payment from Express Scripts Canada in full for products and services (for example, any dispensing fees exceeding the difference between the Provider's Usual and Customary (U&C) Professional Fee and the NIHB maximum allowed dispensing fee are not to be charged to Clients. In addition, extra billing for an item cost is prohibited. As such, any amount billed to a Client is subject to audit recovery) (*Section 7.2 Audit Objectives*).

The Provider shall provide the following services in connection with the Pharmacy Provider Agreement:

1. **Verification of Client Eligibility -** The Provider must take steps to verify that the individual is eligible for benefits under the NIHB Program and to identify the existence of other benefit coverage, if applicable. For further information, refer to the Provider Eligibility Requirements, *Section 5.1 Provider Eligibility Requirements* herein.

2. **Dispensing -** Dispense NIHB Benefit items to each Client in accordance with all applicable laws and regulations and the applicable NIHB Program policies, administrative requirements and procedures as stipulated in this Kit, and the Provider Guide for Pharmacy Benefits located on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca (select Policy and Program Information) or contact your FNIH Regional Office for a copy.

Claims Submission and Processing

A. Electronic Claims Submission

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

- Valid Prescriber ID as assigned by the appropriate Provincial Regulatory Authorities.
- Drug Identification Number (DIN) for the original package size from which the NIHB benefit item is dispensed, or the pseudo-DIN used to identify medical supplies and equipment.
- Actual day's supply.
- Client Address;
- 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; and
- 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 as soon as reasonably practical by telephone 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 Electronic Data Interchange (EDI) Claims.
- Patient's Last Name.
- Patient's First Name.
- Patient's Date of Birth (DOB).
- Date of Service (DOS) (must be in valid date format YYYY-MM-DD, and cannot be a future date).
- DIN/ Item Number (all eight positions must be valued, cannot be all zeroes, and must be valid Item Number that exists on the Express Scripts Canada item database).

- Prescription Number (must be numeric and greater than zero).
- Drug/ Item Cost (must be numeric and greater than zero).
- Quantity (must be numeric and greater than zero).
- Day's Supply (must be numeric and greater than zero; mandatory for Drug items).

It is the responsibility of Providers to enter the correct Prescriber ID reference and Prescriber Numbers when submitting Claims and to ensure the Claim is accurate and complete.

B. Non-Electronic Claims Submission

The Provider should make an effort to be able to submit Claims electronically (according to CPhA Claims transmission standards) as this is the most rapid and efficient manner of Claims submission. In the event that this is not possible, the Claim may be submitted 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.

1. **Standards of Service -** When providing NIHB 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. In addition, Providers shall not provide services at standards less than customarily provided locally by other Providers in the community and in serving other customers. The Provider shall not refuse to provide services to Clients who are eligible under the NIHB Program unless, in the Provider's reasonable professional judgment, such services should not be provided.
2. **Compliance with Applicable Law, Permits and Licenses -** The Provider shall, and shall cause its personnel and any pharmacists it employs or contracts with to be bound by and comply with the provisions of the Pharmacy Provider Agreement and all applicable laws, rules and regulations of the provincial or territorial statutory organizations, and other governmental bodies having jurisdiction over Providers. The Provider shall, and shall cause its personnel and any pharmacists it employs or contracts with to maintain in good standing, at all times, all required federal, provincial, or territorial and local licenses, certificates and permits that are necessary to allow the Provider to dispense NIHB benefit items to Clients. The Provider shall provide evidence of such good standing, certification and license without charge to Express Scripts Canada, Health Canada, a designee of Express Scripts Canada or Health Canada, within five days of written request by Express Scripts Canada. The Provider shall notify Express Scripts Canada in writing immediately in the event of any suspension, revocation, restriction or limitation on any such license, certificate or permit.
3. **Drug Utilization Review Compliance with NIHB Benefit List and Kit**

   The Provider shall, and shall cause its staff to:

   - Cooperate with Express Scripts Canada's procedures for utilization review and generic substitution, as set forth from time to time in the Kit; and
   - Comply with the applicable NIHB Benefit List when dispensing NIHB benefit items to Clients.
   - The Provider may not implement any substitution program for Clients of the NIHB Program that is inconsistent with provincial regulations

regarding interchangeability or with the NIHB Program, including the applicable NIHB Benefit List.

5.5 Change of Provider Information

Providers must inform Express Scripts Canada immediately upon change of any of their information communicated upon registration.

Providers may download a copy of the Express Scripts Canada Modification to Pharmacy and Medical Supplies and Equipment Provider Information Form from the NIHB Claims Services Provider Website at www.provider.express-scripts.ca or by contacting the Provider Claims Processing Call Centre directly at 1-888-511-4666 for a copy of the form. This form may be used to complete any of the following:

- Request to submit Claims using the Electronic Data Interchange (EDI) or CPhA standard;
- Change of current information (for example, address, dispensing fee); and,
- Start, change or stop Electronic Funds Transfer (EFT); and,
- Increase/decrease to Usual and Customary (U&C) Professional Fee

The form is to be completed in hard copy by the Provider and forwarded via e-mail or fax to Express Scripts Canada.

Providers residing outside of Quebec wishing to change ownership or change their business and trading name must complete a new Pharmacy Provider Agreement, which a new Provider ID is assigned at that time.

For Quebec Pharmacies, all new registrations and modification to pharmacies are received from AQPP.

6. General Claims Submission Procedures

6.1 Client Identification and Eligibility

An eligible recipient must be identified as a resident of Canada and one of the following:

- Eligible First Nations, including registered Indians according to the Indian Act.
- An Inuk recognized by one of the Inuit Land Claim Organizations.
- An infant less than one year of age, whose parent is a Client.

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

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

It is recommended that Clients who have an 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.

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

6.1.2 Client Identification Numbers for Eligible First Nations

One of the following identifiers for Client Identification Numbers are required for recognized eligible First Nations Clients:

- **INAC Registration Number (also known as the Department of Indian Affairs and Northern Development (DIAND) Treaty or Status Number)** – This is a 10-digit number issued by INAC. The INAC Registration Number is the preferred method of identifying First Nations Clients. The 10-digit INAC Registration Number consists of the following:
  - The first three digits represent the band with which the individual is associated; and
  - Where applicable, the remaining seven digits uniquely identify the individual.
- **Band Number and Family Number –** If an INAC Number is not available, a Band Number, and Family Number may also be used as Client identification, where applicable.
- **FNIHB Client Identification Number (B-Number) –** In specific and exceptional cases some Clients may have numbers issued by FNIHB. This number begins with the letter: B, and is followed by eight digits.

6.1.3 Special Provision for First Nations and Inuit Infants under One Year of Age

Health Canada has established special identification provisions for infants less than one year of age. These provisions are in place to allow adequate time for parents, eligible for benefits under the NIHB Program, to register their newborn children with the applicable organization.

If an infant of less than one year of age has not been registered, Clients should be referred to the appropriate office or organization:

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

The first Claim for drug items for an infant, including Inuit infants under one year of age who has not been registered with the applicable organization must be submitted to Express Scripts Canada using the NIHB Pharmacy Claim Form. All subsequent Claims for that infant can be processed online once the initial manual Claim is submitted to and paid by Express Scripts Canada. Subsequent Claims submitted on behalf of the infant via electronic submission must include the child's parent's primary identifier (such as INAC, Client or Band/ Family Number, FNIHB Client Identification Number, NWT or NU health plan number) in the **Client Identification Number** field and the infant's identifiers in the surname, given name, and date fields.

To ensure ongoing Client eligibility parents must obtain a Client Identification Number from the appropriate registrar office/ organization for the infant prior to the infant's first birthday.

6.1.4 Excluded Individuals

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

- Registered First Nations and Inuit Clients incarcerated in a federal, provincial, territorial or municipal corrections facility are the responsibility of the correctional facility.
- Children in the care of provincial social service agencies are the responsibility of the province; and
- Those individuals who are in a provincially funded institutional setting.

Requests to access benefits for these individuals should be submitted to the appropriate facility/ organization.

6.1.5 NIHB Provided through First Nations and Inuit Organizations

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

Providers are notified, through the NIHB Newsletters of changes to the responsibility for the delivery of the NIHB benefits. At that time, members of those groups receive benefits through their First Nations or Inuit organizations rather than through the NIHB Program. Providers are directed to the appropriate First Nations or Inuit organizations for further information.

The following First Nations/ Inuit Organizations have assumed responsibility for the delivery of pharmacy benefits:

- Akwesasne Band #159.
- Bigstone Cree Nation #458.
- Nunatsiavut Government (formerly the Labrador Inuit Health Commission).
- Nisga'a Valley Health Board.
- Gingolx (Kincolith) #671.
- Gitakdamix (New Aiyanish) #677.
- Lakalzap (Greenville) #678.
- Gitwinksilkw (Canyon City) #679.

6.2 Coordination of Benefits

Providers must confirm with each Client for each Claim whether Other Coverage exists. If the Client confirms that Other Coverage exists the Provider must submit the Claim to the other payer first before submitting for NIHB coverage. Third party carriers may be provincial/ territorial or private health care plans and can include Social Services, Workers Compensation Board, and employee benefit programs. Once the third party processes the Claim and returns an Explanation of Benefits (EOB), the Provider may send the Claim to Express Scripts Canada for processing.

The NIHB Program is only responsible for eligible Claims which are not covered by another third party plan).

6.2.1 Coordination of Benefits with the Ontario Drug Benefit

For eligible Clients over 65 years of age and social service recipients, Ontario pharmacists must coordinate drug benefits and pursue payment through the Ontario Drug Benefit (ODB) Program prior to submitting a Claim through the NIHB Program. For drugs listed on the ODB Limited Use Benefit list, Ontario Providers must determine whether the Client is eligible under the ODB Program before sending a Claim to Express Scripts Canada. This may include contacting the prescriber to determine if the Client meets ODB criteria. Results must be documented and kept on file in the Client's profile for review during an on-site audit. If the software does not allow proper submission and payment for the drug, Providers are requested to submit the Claim manually to Express Scripts Canada and contact their vendor to update the software.

Failure to maintain proper documentation results in the Provider having to resubmit the Claim.

6.3 Drug Utilization Review Program

All NIHB Claims go through the Drug Utilization Review (DUR) Program process when submitted via the POS system. This also applies to Claims which were first sent to a provincial or 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 health care services, but to enhance it with

additional information. Once the Provider has reviewed the DUR reject message and has consulted the prescriber, the Client, or other sources where appropriate, the Provider can resubmit the rejected NIHB Claim with a valid CPhA Intervention Code.

The NIHB Program requires that Providers document the nature of their intervention directly on the prescription hard copy or on the electronic patient profile, and that the documented intervention be retained for audit purposes as supporting documentation. NIHB 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 patient.
- Reason for early refill (medication lost, destroyed, stolen, physician changed dosage or patient going out of town for a period greater than the days' supply remaining on the current refill).

For more information, contact the Provider Claims Processing Call Centre to speak directly with a Customer Service Representative.

6.4 Prior Approval

Prior Approvals (PA) are primarily provided under the following circumstances:

- "Exceptions" for items that do not appear on the NIHB DBL
- "Limited Use Benefits" for items that appear on the NIHB DBL
- "Open Benefits" for items that appear on the NIHB DBL, but have maximum category limitations
- "Open Benefits" for items that appear on the NIHB DBL, but the total amount claimed exceeds $1000.00 or the 100-day supply limit

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

The NIHB Program has established a single call centre to provide efficient responses to all PA requests for drugs that are not on the NIHB DBL (drug exception) or require prior approval, as well as to questions regarding quantity or frequency limitations for extemporaneous mixtures containing exception or limited use drugs, prescriptions on which prescribers have indicated "No Substitution", and Claims that exceed $999.99 or the 100-day supply limit per fill for open benefits.

Prior Approval for Prescription Drugs

The pharmacist contacts the national NIHB Drug Exception Centre (DEC). The NIHB DEC (also referred to as the "DEC") requests details about the prescription, prescriber, pharmacist, and the Client.

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

The response is reviewed and a decision made. The decision is communicated to the pharmacist via a faxed Confirmation Letter. The decision process may take a few days. The time for approval is dependent on the physician or licensed prescriber providing the information.

PAs are entered electronically on the Claims processing system. The date of dispense should be indicated to the analyst so it can be reflected in the PA to avoid rejected Claims.

Drug/Pharmacy Information

Once approval is granted, a Confirmation Letter with the applicable dates and PA details is faxed to the Provider. Please retain this Confirmation Letter for billing purposes and/or to validate any discrepancies. When submitting the Claim, Providers must be sure to include the date of service (dispense date). This date is important, as it will determine if the Claim will be paid:

- PAs for one time dispense items are dated the day the request is set up in the system. Claims with dates of service (date of dispense) prior to the date of the prior approval will be rejected. If a request to backdate the prior approval start date is received from the Provider at the time of the call, the NIHB 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 end date. The date of service on the Claim must be after the start and before the end date on the PA or the Claim will be rejected.

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

- Dispensing fee
- Unit cost
- Number of refills
- Third party share
- Minimum quantity/Claim
- Item Number
- Item name
- Start and end date
- Mark-up approved for each Claim adjudicated against a prior approval (instead of the total mark-up allowed for all Claims adjudicated against the PA)
- Total approved amounts for the quantity and dollar amounts for all Claims adjudicated against the PA up to the indicated number of refills (instead of the approved quantity and dollar amount for each Claim)
- General comments

6.4.1 Appeal Process

When a Client is denied a benefit, three levels of appeal are available under the NIHB Program, which only the Client can initiate. At each level, the appeal must be submitted in writing and must be accompanied by supporting information from the health care Provider.

The following information should be included:

- The condition (diagnosis and prognosis) for which the benefit is being requested.
- Alternatives that have been tried.
- Relevant diagnostic test results.
- Justification for the proposed benefit.

The appeal is reviewed by a health care consultant, who provides a recommendation to the authorizing Health Canada officer. The final decision is made by Health Canada, based on the consultant's recommendation, the Client's specific needs, the availability of alternatives, and the NIHB Policy.

Information outlining the levels of appeal and contact information is available on the Health Canada website at www.hc-sc.gc.ca (select First Nations, Inuit & Aboriginal Health; Non-Insured Health Benefits; Benefits Information; Procedures for Appeals)procedures for Appeals Section. Items that are excluded under the NIHB Program are not subject to the Appeal Process.

6.4.2 Confirmation

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

A Prior Approval Confirmation Letter with the applicable dates and PA details is mailed or faxed to the Provider. The Prior Approval Confirmation Letter should be retained for billing purposes.

6.4.3 Claim Submission with a Prior Approval

When submitting a Claim for an item that has been prior approved, ensure that the PA Number is included and corresponds to the details of the Prior Approval Confirmation Letter.

The dates are important as they determine the payment of the Claim. A date on a PA for:

- One time item (with no start and end date), the DOS on the Claim must be the same or after the date of the PA, or the Claim is rejected.
- With a start and end date, the DOS on the Claim must be within the start and end date on the PA or the Claim is rejected.

When a PA is set up for a one year period, billing must be in accordance with Client usage. No more than a three month supply can be dispensed and billed at a time.

6.5 Mandatory Information in Transmission and Submission Options

For a comprehensive review of mandatory information in transmissions and submission options, refer to the Attachments to this Kit on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca

6.6 Billing and Payment Guidelines

The billing methods available to Providers depend on the type of drug items rendered to Clients. Regardless of the billing method used by Providers, all required data elements must be supplied to enable the efficient processing and payment of claims.

For a complete listing of billing and payment guidelines, refer to the Attachments to this Kit located on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca

6.6.1 Methadone Billing (Pseudo-DIN 00908835)

Methadone used for the treatment of addictions does not require a Prior Approval (PA). Pseudo-DIN 00908835 must be used when submitting a Claim for methadone that is compounded for treatment of opiate dependency. Claims submitted with another pseudo-DIN will be subject to reclaim.

The following billing rules must be adhered to when submitting methadone Claims:

- The days supply on previously paid methadone Claims must be used before any other days supply can be dispensed to a Client.
- There is a 7-day supply limit for methadone.
- This limit is the maximum number of doses that can be dispensed to a Client in one day.
- Dispensing fees submitted on methadone Claims must be based on the number of doses dispensed to the Client, and must not exceed NIHB pricing guidelines for the Provider's province/ territory.
- A different Provider cannot submit methadone Claims for the same Client on the same date of service.

6.7 Provider Statement and Claim Messages

Provider Statement - Pharmacy

The Provider Statement - Pharmacy accompanies the Claims payment cheque and provides information about each drug, medical supply and equipment Claim processed. If payments are made through Electronic Funds Transfer (EFT), the Provider Statement - Pharmacy is mailed to the Provider's business address. The Provider Statement – Pharmacy may provide additional Client identification information, which should be added to the Client's records and be used for all future Claims submissions.

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

Providers can use the Provider Statement - Pharmacy to reconcile accounts and the statement must be referenced when making inquiries. Please indicate corrections to Claims directly below the existing information and forward the applicable page of the statement to Express Scripts Canada within 12 months of the service date for re-adjudication of the Claim.

Pharmacy Claim Messages

The NIHB HICPS system assigns three-character Reject and Warning Codes along with messages that appear on the Provider Statement - Pharmacy. A Reject Code, composed of an

"R" followed by two numeric characters and a text message, explains why the Claim was rejected. A Warning Code, composed of a "W" followed by two numeric characters and a text message, explains that the Claim was adjudicated with modifications.

Refer to Section 12. NIHB Pharmacy Claims Submission Kit: Attachments for a list of the NIHB Codes, Messages and Explanations that may appear on the Provider Statement - Pharmacy, cross-referenced with the applicable CPhA Codes on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca

One-Year Billing Policy

Providers have one year from the date of service to secure payment. Claims submitted more than one year after the date of service will be rejected with the R21 message Period for submitting Claims has expired.

7. NIHB Benefit Coverage and Limitations

For additional information refer to the Provider Guide for Pharmacy Benefits located on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca or request a copy from your FNIH Regional Office.

Prescribed drugs are available to eligible First Nations and Inuit Clients when all of these conditions are satisfied:

- The item is on the current NIHB DBL.
- The item has been prescribed by a licensed practitioner (licensed by and in good standing with the appropriate governing body or province in which they practice and the prescription has been written in accordance with the applicable provincial prescriber guidelines) such as but not limited to:
  - Medical Doctors.
  - Medical Specialists.
  - Dentists.
  - Nurse Practitioners.
  - Midwifes.
  - Pharmacists.
- The prescription is valid (as defined by federal and provincial legislation) and written by a valid prescriber. Note that the original prescription must be kept on file for two years or as long as it is being dispensed against, if longer than two years. Valid prescriptions must be kept on file for two years after the last dispense date (not the date of prescription).
- The item on the NIHB DBL is dispensed by a licensed pharmacist or physician authorized by the College of Pharmacists to dispense and who has registered with Express Scripts Canada.
- PA, when required, has been provided by the NIHB DEC of FNIHB (refer to Prior Approval for more information on the process).

- The Provider will not switch a Client's prescription to a drug that is not a formulary drug on the NIHB DBL, except for generic substitution opportunities or where required by medical necessity. The Provider shall not implement any substitution program for a Client that is inconsistent with the NIHB DBL.
- The item is not available to the Client under a federal, provincial, territorial or third party health care plan. For additional information, refer to the Coordination of Benefits Policy.

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

The NIHB DBL can be found on the NIHB Claims Services Provider Website at www.provider.express-scripts.ca or by contacting the Provider Claims Processing Call Centre to request a copy. The NIHB DBL is generally updated on a quarterly basis.

7.1 Open Benefits

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

7.2 Limited Use Benefits

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

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

There are three types of limited use benefits:

- Limited use benefits that do not require PA. These include Multivitamins (which are benefits for children up to 6 years of age), and prenatal and postnatal vitamins (which are benefits for women of childbearing age (12 to 50 years).
- Limited use benefits that require prior approval.
- Benefits which have a quantity and frequency limit. A maximum quantity of a drug is allowed within a specified period of time. No PA is required for the Client to obtain the allowable quantity of the drug within the specified period. Drugs with a quantity and frequency limit include smoking cessation products. Clients are eligible to receive a three month supply of smoking cessation products over a one year period which is renewable 12 months from the day the initial prescription was filled.

7.3 Exception Criteria

Drugs which are not listed in the NIHB DBL may be approved in special circumstances upon receipt of a completed "Exception Drugs Request Form" from the attending physician or dentist. Requests for exceptions are considered when:

- The prescription is for a recognized clinical indication and dose which is supported by published evidence or authoritative opinion.
- There is supporting evidence that available alternatives are ineffective, toxic, or contraindicated (personal preference alone does not justify an exception).
- There is significant evidence that the requested drug is superior to drugs already listed as program benefits.
- A Client has experienced an adverse reaction with a best price alternative drug, and a higher cost alternative is requested by the prescriber.

7.4 Exclusions

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

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

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

7.5 Termination of Alternate Coverage

When an eligible Client no longer has benefit coverage through another private or public health care plan, Claims submitted to the NIHB Program require a letter from the Client or the Provider on behalf of the Client, stating that they are no longer eligible under their previous plan. The date coverage ended must be included in the letter.

7.6 Appeal Procedures

There are three levels of appeal available under the NIHB Program which only the Client can initiate. At each stage, supporting information from the prescriber or Provider must accompany the appeal; therefore, it is important that this information be included along with the Client letter:

- The condition for which the drug is being requested.
- The diagnosis and prognosis (including what other drugs were tried).
- Any relevant diagnostic test results.
- The justification for the proposed drug and any additional supporting information.

An appropriate independent consultant will review the appeal and then provide a recommendation to the FNIHB staff. FNIHB will make the final decision based on the consultant's recommendation, the Client's specific needs, the availability of alternatives, and NIHB policy.

Information outlining the levels of appeal and contact information is available on the Health Canada website at www.hc-sc.gc.ca (select First Nations, Inuit & Aboriginal Health; Non-Insured Health Benefits; Benefits Information; Procedures for Appeals).

Items excluded under the NIHB Program are not subject to the appeal process. Please direct Clients to the appropriate FNIH Regional Office for additional information.

7.7 Special Promotion / Coupon / Discounts

An NIHB Client shall not benefit, directly or indirectly from special promotions or incentives including coupons, discounts, points or rebates in the form of cash, and/ or goods that may be offered by pharmacy or medical supplies and equipment Providers to the extent permitted by such promotions and applicable law, the NIHB Program shall receive the benefits of these promotions.

7.8 Special Formulary for Chronic Renal Failure Patients

The NIHB Program has established a special formulary for chronic renal failure patients to provide access to drugs not listed on the NIHB DBL, which are required on a long-term basis. Eligible products are listed in Non-Insured Health Benefits Drug Benefit List.

New patients requiring drugs on the special formulary will be identified for coverage through the usual Prior Approval (PA) process. Once the patient is confirmed as eligible, coverage will automatically be extended to all drugs in the special formulary for as long as needed.

8. Provider Audit

8.1 Overview

As a publicly funded program, it is a requirement to account for the expenditure of public funds. The Provider Audit Program contributes to the fulfillment of this accountability. The Pharmacy Provider Agreement signed by Providers allows Express Scripts Canada to verify paid Claims against pharmacy records, to confirm the Claims have been billed in compliance with the terms and conditions of the NIHB Program.

The audit activities are conducted on paid Claims. The period of audit coverage is at the discretion of Express Scripts Canada.

All audit activities from the selection of Providers for audit, to issuance of audit documentation to Providers regarding the findings, are reviewed and approved by representatives of Health Canada.

Health Canada and Express Scripts Canada highly regard and value the services provided to Clients. The Provider Audit Program shares information with Providers about proper billing methods, and verifies paid Claims against the NIHB Program billing requirements. Claims which do not meet these requirements are subject to recovery.

8.2 Audit Objectives

The objectives of the NIHB Provider Audit Program are to:

Detect billing/ Claim irregularities:

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

The Provider Audit Program process does not focus on professional practice issues at the audit site. It is recognized that it is the responsibility of the jurisdiction's regulatory body to investigate professional practice issues. If a practice related issue arises during an audit and if the issue cannot be resolved directly with the service Provider, the auditor may refer the matter to the appropriate regulatory body.

8.3 Provider Responsibility

The Provider shall cooperate with Express Scripts Canada in all audit activities based on generally accepted industry practices. Upon request, the Provider shall grant access to its location to Express Scripts Canada or a third party authorized by Express Scripts Canada to inspect, review and reproduce, during regular business hours, any pharmacy records maintained by the Provider pertaining to Clients, or the Pharmacy Provider Agreement or the Kit, as Express Scripts Canada deems necessary to determine compliance with the terms outlined in these documents.

8.4 Provider Audit Components

The components of the Provider Audit Program are outlined below. To carry out the Next Day Claims Verification (NDCV) and on-site 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 applicable markup).
- Documentation of item received by the Client.
- Evidence of additional coverage (to coordinate benefits).

8.4.1 Next Day Claims Verification Program

The Next Day Claims Verification (NDCV) Program consists of a review of Claims submitted by Providers the day following receipt by Express Scripts Canada. Providers may be contacted to provide copies of prescriptions and/ or invoices as well as any other supporting financial data. Any errors detected through this process results in the Claim being denied for payment. Claims submitted for extemporaneous mixtures which do not contain at least one ingredient on the NIHB DBL is reversed on the system and subject to reclaim.

8.4.2 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.

8.4.3 Provider Profiling Program

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

8.4.4 Desk Audit Program

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

8.4.5 On-Site Audit Program

An on-site audit consists of the selection of a sample of Claims for validation with a Provider's records through an on-site audit. Providers are not randomly selected for audit. Providers may be selected for an on-site audit as a result of information gained through many of the components of the Provider Audit Program.

8.4.5.1 Stages of an On-Site Audit

Express Scripts Canada contacts the Provider at least three weeks prior to the proposed on-site audit date. Every effort is made to accommodate the audit date with the Provider's schedule. The date agreed upon for the on-site audit is confirmed by fax with the Provider.

The auditor(s) requires:

- Work space, chairs.
- Access to a photocopier.
- Assistance to retrieve computerized Client profiles with a staff member.
- Assistance to retrieve hard copy prescriptions and associated information.
- Access to an electrical outlet(s).
- Access to the individual who will be responding to the Audit Report.

The auditor arrives at approximately 9 a.m. or at mutually agreed upon time. The audit is expected to take 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 auditor provides a brief orientation to the audit process, and answers any questions.

8.4.5.2 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 asked whether the prescription records under review are to be retrieved by their staff or the auditors. The auditors indicate to the Provider that a post-audit summary is supplied at the end of the on-site audit.

8.4.5.3 Conduct of the On-Site Audit

The purpose of the on-site audit is to verify paid Claims against pharmacy records. At the end of each audit day, a list of prescriptions or documents not found by the auditor is provided to the Provider. The Provider has the opportunity to locate and supply the documentation to the auditor the next audit day. Documentation not provided by the end of the on-site portion of the audit, can be submitted to the auditors upon receipt of the initial audit report of audit findings. Claims not supported by the required documentation appear as recoveries in the Audit Letter and Report to the Provider.

8.4.5.4 Post-Audit Interview

At the end of the on-site audit, the auditor provides a general overview of the categories of errors found. The final audit results won't be complete until the auditor has conducted additional analysis, such as, but not limited to, Client and prescriber confirmations. During the post-audit exit interview, the Provider is provided with a standard checklist to complete and

send to Express Scripts Canada, which serves to confirm the audit process conducted at the respective on-site audit.

8.4.5.5 Audit Report

A report of the audit findings is sent to the Provider within 60 days of the on-site audit. If there are delays in meeting this deadline, a letter is sent to the Provider advising of the delay and the revised delivery date for sending the Audit Letter and Report. Once the Audit Letter and Report are received, and in the event that there are audit observations resulting in recovery of Claims, the Provider has 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 60 days of the response from the Provider, Express Scripts Canada sends a letter and report of the final audit findings to the Provider. In the event that there are final audit findings resulting in recovery of Claims, the Provider has 30 days from the date of the letter in which to submit a cheque (payable to the Receiver General) to Express Scripts Canada for the reimbursement of the identified overpayment. Failure to respond within 30 days of the date of the letter results in a Withhold against the Provider's payment statements until recovery is paid in full.

8.4.5.6 Documentation Requirements for Audit Purposes

Providers must retain a copy of the original prescription on file for two years or as long as it is being dispensed against, if longer than two years in accordance with provincial or 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 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.

Proper documentation of any intervention is required for verification against the Program's billing criteria. Safety and protection are outside the mandate of the Provider Audit Program and the NIHB Program as these roles are dictated under law by the respective colleges. 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 (for example, 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 30 days of fill or Claim reversal is required).
- Documentation to verify that the Clients are eligible as registered First Nations or recognized Inuit.
- Documentation to verify that the Clients are eligible as residents of Canada or as students or migrant workers outside of Canada who are registered or eligible for registration under a provincial or territorial health insurance plan.
- 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 NIHB 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.

For more information on audit activities, refer to the NIHB Program Annual Report located on the Health Canada Website at www.hc-sc.gc.ca (select First Nations, Inuit & Aboriginal Health, and Non-Insured Health Benefits).

8.5 Reference Documents

- Express Scripts Canada Pharmacy Provider Agreement.
- Non-Insured Health Benefits/ Express Scripts Canada Newsletters (issued quarterly).
- Non-Insured Health Benefits Program Drug Bulletins.
- NIHB Program agreement with provincial pharmacy associations.
- Provincial and Federal drug and pharmacy legislation.
- Provider Guide for Pharmacy Benefits.

8.6 Additional Information

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

Attention: Business Integrity Consultant
Express Scripts Canada
5770 Hurontario Street, 10th Floor, Mississauga, ON, L5R 3G5

9. Contact Information

Source	Details
Express Scripts Canada Provider Claims Processing Call Centre	Telephone: 1-888-511-4666
Express Scripts Canada Provider Relations Department	Fax: 905-712-0669
	Address: **Attention:** Provider Relations Express Scripts Canada 5770 Hurontario Street, 10th Floor, Mississauga, ON L5R 3G5
NIHB Claims Services Provider Website	www.provider.express-scripts.ca

For general inquiries please e-mail the Provider Relations department at NIHBProviderRelations@express-scripts.com

10. Really Simple Syndication Feeds

Really Simple Syndication (RSS) enables Providers to keep automatically informed of new information and updates to the Health Canada Website. When Providers sign up for the RSS feed, a message appears in the feed-reader every time new information is added to that section of the Health Canada Website. Updates usually include a headline with a small amount of type, either a summary or a lead-in to the larger story. RSS feeds have addresses similar to web pages but operate on a different format; in order to receive information from them a Provider's computer must be equipped with an aggregator or feed-reader: a number of them are available free online. Adding a new website (RSS feed) to an aggregator is a simple process of going to the site in question, clicking on the RSS or XML button on the home page or copying and pasting the URL, depending on the type of aggregator. Either method makes the feed available to Providers, instantly and regularly.

Websites

Health Canada:

www.hc-sc.gc.ca (visit First Nations, Inuit & Aboriginal Health, and then Non-Insured Health Benefits for First Nations and Inuit)

Express Scripts Canada:

www.express-scripts.ca

11. Annexes

- NIHB Pharmacy Claim Form
- Provider Statement - Pharmacy
- Prior Approval Confirmation Letter

- Express Scripts Canada Modification to Pharmacy and Medical Supplies and Equipment (MS&E) Provider Information Form

12. NIHB Pharmacy Claims Submission Kit: Attachments

12.1 Provider Statement - Pharmacy, Messages and Explanations

12.2 Mandatory Information in Transmission and Submission Options

12.3 Trial RX Program