12. NIHB Pharmacy Claims Submission Kit: Attachments

12.1 Provider Statement – Pharmacy, Messages and Explanations

The NIHB Health Information and Claims Processing Services (HICPS) system assigns three-character Reject and Warning Codes 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. Below, is an ordered list of the NIHB Codes, messages and explanations that may appear on the Provider Statement - Pharmacy, cross-referenced with the applicable CPhA Codes. Where no applicable NIHB Code exists (shown as N/A) the CPhA Code is shown.

Standard CPhA Codes:

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 (for example, C5 - plan maximum exceeded; C8 - no record of this beneficiary, etc.). The wording of the CPhA messages displayed on the pharmacy terminal may be different from the wording used on the statement, due to the pharmacy software. Providers requiring clarification of CPhA messages 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 by the NIHB HICPS system to clarify the status of a Claim in certain situations.

Point of Service Free-Format Messages (indicated below as Claim **statement messages):**

Claims must be submitted to Express Scripts Canada through POS technology with the exception of the first Claim for infants under one year of age who have not yet registered with Indian and Northern Affairs Canada (INAC), and for Claims over 30 days past the date of service. Any reimbursement made is in accordance with NIHB Program benefit policies and payment schedules. Provider Claims must be submitted to the NIHB Program within one year of the date on which the services were provided.

Free-format messages may appear as part of the NIHB HICPS POS system's response to a Claim submission. POS free-format messages are very similar to the messages that appear on Provider Statement - Pharmacy. To understand why a specific free format message was sent, refer to the description of the corresponding NIHB rejection or warning message listed in Provider Statement - Pharmacy Messages and Explanations.

The following free-format messages apply only to Claims submitted via POS. For messages that appear on the Provider Statement - Pharmacy, refer to POS Free-Format Messages.

Drug/Drug Interaction Potential – Code: ME – Indicates that drug may interact with another current drug, based on an accurate days supply submission.

Duplicate Therapy – Code: MX – Indicates that 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 2/3 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 2/3 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 Providers for Claims that meet one of the criteria below:

- Use of Methadone for treatment of opioid dependency (pseudo-DIN 00908835), and at the same time, use of one or more opioid drug entities.
- Use of three (3) or more different opioid drug entities.
- Use of three (3) or more different benzodiazepine drug entities.
- Use of three (3) or more opioid drug entities, and three (3) or more drug entities and three or more benzodiazepine drug entities.

DUR information is conveyed in the form of Reject and Warning Messages, depending on the severity of the potential problem. Claims prompting the following DUR messages will be rejected: Duplicate drug (MW), Duplicate drug multi-pharmacy (MY) and Drug/drug interaction potential (ME) (where the free form message indicates "Interact-SV drug name qty fill date") (i.e., a potential severe interaction), and Potential Overuse=/Abuse Indicated (NE).

Following an appropriate intervention, the Provider can re-submit the rejected Claims with a CPhA Intervention Code (see below for the applicable Intervention Codes).

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

Intervention Codes	
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	Patient Gave Adequate Explanation. Rx Filled As Written
UG	Cautioned Patient. Rx Filled As Written
UI	Consulted Other Sources. Rx Filled As Written
UJ	Consulted Other Sources. Altered Rx And Filled
UN	Assessed Patient, Therapy Is Appropriate
UL	Rx Not Filled – Pharmacist Decision
MR	Patient Lost Medication. Rx Refilled

The "UL" Intervention Code only overrides the DUR rejects for regions for which the Refusal to Dispense program applies.

NIHB Code	Description
R01 CPhA Codes: NF, D7	
Message	Methadone Dosing Overlap.
Explanation	This Claim has not been paid because the day's supply submitted on the current methadone Claim is overlapping with the day's supply on a previously paid methadone Claim.
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.
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 (DOS). This message is only set on methadone Claims submitted via Point-of-Service (POS).
R04 CPhA Codes: D1	
Message	This Is Not An Eligible Benefit.
Explanation	The Claim was not paid due to the item is not covered under the NIHB Program. Client may be eligible for benefit on an exceptional basis, contact the Drug Exception Centre (DEC) at 1-800-580-0950.
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), or; 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	Description
Claim Statement Message	Infant Claim. This message is generated in combination with CPhA Code A6 (submit manual Claim) for the first Claim made using supporting parent identification information. The first Claim must be submitted manually using the NIHB Pharmacy Claim Form. Subsequent Claims may be submitted via POS.
R06 CPhA Codes: CD	
Message	Client is not eligible for this benefit.
Explanation	The Claim has not been paid due to the item is not covered under the NIHB Program because of the age or gender of the Client. This restriction applies to benefits such as incontinence supplies and vitamins.
Claim Statement Message	Special Authorization (SA) required. This message appears along with the R06 message and the CPhA Code RP when the data elements of a Claim submitted with an SA do not match the data elements specified in the SA. It indicates the toll-free number for the applicable DEC (1-800-580-0950) where Providers can call for assistance.
R07 CPhA Code: A3	
Message	This Is a Duplicate Claim.
Explanation	The Claim cannot be paid due to the Claim is a duplicate of a Claim previously submitted by the Provider's pharmacy. The match is based on the following data elements: DOS, Provider Number, Client Number, and DIN.
R08 CPhA Code: C6	
Message	The Patient Is Over 65 - Submit To Ont. Drug Benefit.
Explanation	In the Ontario region, the Claim has not been paid because the item is eligible under the ODB (Ontario Drug Benefit) Program. Direct the Claim to the ODB first, and then send to NIHB for Clients co-pay and/or deductible.
Claim Statement Message	The patient is over 65 - submit to ODB. If Claim is submitted from Ontario Region, this message is generated in combination with CPhA Code C6 (patient has other coverage).
R09 CPhA Codes: RP	
Message	LRB, Max exceeded, requires spec auth.
Explanation	This message is set for SA Claim whose data elements do not match those specified in the SA or is excluded for coverage by the SA.

NIHB Code	Description
R10 CPhA Code: B1	
Message	Invalid Provider ID.
Explanation	Provider is not registered as an NIHB Provider on DOS.
R12 CPhA Code: 32, 34, 37, 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: a) Surname (CPhA: 38); b) Given Names (CPhA: 37); c) DOB (CPhA: 34); and d) Client Identification Number (CPhA: 32). Check the Claim for missing or incomplete information and provide the required information, or if greater than 30 days by correcting the information on the Provider Statement - Pharmacy.
R15 CPhA Code: 57	
Message	Day's Supply Must Equal Seven for Dosette Packaging.
Explanation	The day's supply exceeds seven days on this submitted Claim flagged as a dosette Claim (the "P" in the SSC field functions as the flag).
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 POS Reversals. Further benefit information is provided in the Policies Section.
R17 CPhA Code: 56	
Message	DIN/GP #/PIN ERROR
Explanation	All eight (8) positions must be valued, cannot be all zeros, and must be valid item number that exists on the Express Scripts Canada database. 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 POS Reversals. Further benefit information is provided in the Policies Section.
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,

NIHB Code	Description
	incomplete, or erroneous information and provide the required information by following the Claims correction procedures outlined in POS Reversals. Further benefit information is provided in the Policies Section.
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 POS Reversals. Further benefit information is provided in the Policies Section.
R20 CPhA Code: C6	
Message	Submit Claim to Provincial or Territorial Health Plan.
Explanation	The Claim has not been paid due to a provincial or territorial health plan covers part of the item. Direct the Claim to the appropriate plan (applies to Ontario).
Claim Statement Message	Submit to provincial/territorial health plan. This message is generated in combination with CPhA Code C6 (patient has other coverage).
R21 CPhA Code: A1	
Message	Period for Submitting Claims Has Expired.
Explanation	The Claim has not been paid due to the Claim was submitted more than one year after the service was rendered. In addition this applies to Claims that Providers attempt to submit after the 30 day limit for POS Claims has been exceeded.
R22 CPhA Code: 61	
Message	Prescriber ID Error (License or Billing Number).
Explanation	The Prescriber ID number can be alphanumeric and cannot be zeros. The Provider should check the Claim for missing, incomplete, or erroneous information and provide the required information by following the Claims correction procedures outlined in POS Reversals. Further benefit information is provided in the Policies Section.
R23 CPhA Code: C2	
Message	Service Provided Prior to Client's Start Date.
Explanation	The Claim cannot be paid due to the DOS is prior to the start date for the Client's NIHB coverage.
R24 CPhA Code: C3	
Message	Service Provided After Client's End Date.
Explanation	The Claim cannot be paid due to the DOS is after the

NIHB Code	Description
	end date for the Client's NIHB coverage.
R25 CPhA Code: 64	
Message	Claim Does Not Comply With Terms of Prior Approval.
Explanation	The Claim has not been paid due to it does not comply with the terms of the NIHB PA. Quantity per Claim has to match quantity per Claim on PA. Refer to your copy of the Prior Approval Confirmation.
Claim Statement Message	Does not comply with PA. This message is generated in combination with CPhA Code 64 (Special Authorization Number/ Code error).
R26 CPhA Code: 64	
Message	Prior Approval Service Date Violation.
Explanation	The Claim has not been paid due to the DOS doesn't correspond with the approval effective dates as follows: • For a one time PA, DOS is before approval date or greater than one year from the approval date. • For standing order PAs, DOS is before start date or after expiry date for the PA.
Claim Statement Message	PA service date violation. This message is generated in combination with CPhA Code 64 (Special Authorization Number/ Code error).
R27 CPhA Code: 64	
Message	Prior Approval Number Is Invalid.
Explanation	The Claim has not been paid due to the PA number is invalid for the possible reasons listed below: • Incorrect PANumber. • Incorrect Client Number. • Incorrect Provider Number. • Incorrect item Number. • Item wasn't approved. • PA isn't ready to be billed against. The Provider should check their records to determine if the PA number, the associated Client Identification Number, and the Benefit Codes were submitted correctly. If an error was made, supply the correct information following the Claims correction procedures outlined in POS Reversals.
Claim Statement Message	PA number is invalid. The Claim has not been paid due to the PA number is invalid for the specified Client and benefit. The Provider should check their records to determine if the PA number, the associated Client identification number, and the Benefit Codes were submitted correctly. If an error was made, supply the correct information following the

NIHB Code	Description
	Claims correction procedures outlined in POS Reversals.
R28 CPhA Codes: 66	
Message	Drug Cost/Product Value Error.
Explanation	The drug and/ or item cost 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 the POS Reversals. Further benefit information is provided in the Policies Section.
R29 CPhA Code: A2	
Message	Claim is post dated.
Explanation	This must be in valid YYYY-MM-DD format and cannot be future date. If check fails, message is generated. 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 POS Reversals.
R30 CPhA Code: C6	
Message	Client Has Alternative Coverage, Contact FNIH Regional Office.
Free Format Message	Alternate Coverage. Contact FNIH Regional Office.
Explanation	The Claim has not been paid due to the FNIH 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 FNIH Regional Office for direction on where to submit the Claim.
Claim Statement Message	Alternate coverage, contact FNIH. This message is generated in combination with CPhA Code C3 (coverage expired before date of service), and may pertain to bands that have now assumed responsibility of the NIHB Program. The Provider should contact their regional FNIH office to determine the eligibility of the Client.
R47 CPhA Code: 64	
Message	Special Authorization for This Item Used Up By Previous Claim.
Explanation	The Claim has not been paid due to the SA for this item has been used up by a previous Claim, based on day's supply paid.
Explanation: Claim Statement Message	SA for item is used up. This message is generated in combination with CPhA Code 64 (SA Number/Code Error).

NIHB Code	Description
R48 CPhA Code: 64	
Message	Prior Approval for This Item Used Up By Previous Claim.
Explanation	The Claim has not been paid due to 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.
Claim Statement Message	PA for item is used up. This message is generated in combination with CPhA Code 64 (SA Number/Code error).
R49 CPhA Code: CP	
Message	Benefit Requires Prior Approval.
Explanation	The Claim has not been paid because it requires PA from FNIH. Benefits that require prior approval are: limited use items over $999.99. PA procedures are detailed in Prior Approval Process of the NIHB Pharmacy Claims Submission Kit.
Claim Statement Message	Benefit requires PA. This message is generated in combination with CPhA Code CP (eligible for special authorization); indicating that the benefit claimed requires PA.
R49 CPhA Code: RW	
Message	Benefit requires PA.
Explanation	The submitted Claim fails the auto approval criteria.
Claim Statement Message	SA Needed; Resubmit With [DR] To Proceed.
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 NIHB Pharmacy Claims Submission Kit.
R51 CPhA Code: RZ	
Message	Provider Requested PA Coverage.
Explanation	The Provider resubmits with a DR Intervention Code - the Claim that was previously rejected with RW/ R49. The Claim is resubmitted to generate an automatic PA/ Case request.
Claim Statement Message	Submitted for Review; Case # XXXXXXXX.
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 DOS.

NIHB Code	Description
R77 CPhA Code: A3	
Message	Rx# previously paid for same DOS Client.
Explanation	The payment has been denied because all the data elements match the data elements of a previously settled Claim already on file. Refer to R07.
W03 CPhA Code: DM	
Message	Day's Supply Exceed Plan Limit.
Explanation	Day's Supply reduced to conform to NIHB day's supply dispensing limit guidelines of seven day's supply for a specified DOS.
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 NIHB pricing guidelines. Refer to the details of the NIHB pricing agreement for the appropriate region.
W05 CPhA Code: N/A	
Message	Claims Paid On Parent ID until 1st Birthday Only.
Explanation	The claimant could not be verified as an NIHB Client. However, since the claimant is an infant under one year of age, and the infant's parent was verified as an NIHB Client, the Claim has been paid. This provision allows time for parents to register the infant and only applies until the infant's first birthday. Claims for services provided after the infant's first birthday is rejected if the infant cannot be verified as an NIHB Client.
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 NIHB pricing guidelines. Refer to the details of the NIHB pricing in the agreements with the appropriate region.
Claim Statement Message	Reduced to NIHB pricing guidelines. This message is generated in combination with CPhA Code DJ (drug cost adjusted).
W11 CPhA Codes: E2, E3	
Message	Claim Is Reduced To NIHB Share.
Explanation	Generated on Claims which have the NIHB share amount reduced from the Third Party Share value being asked of NIHB to be paid. For items submitted with a third party 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	Description
Claim Statement Message	Claim is reduced to NIHB share. This message is generated in combination with CPhA Code E2 (Claim co-coordinated with government plan).
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.
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 100.
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 FNIH. The Provider should refer to the Prior Approval Form or Prior Approval Confirmation Notice, which will indicate the NIHB-approved maximum dollar amount.
Claim Statement Message	Adjusted to comply with PA. This message is generated in combination with CPhA Code 64 (SA Number/Code Error).
W18 CPhA Code : DH	
Message	DF Reduced on Chronic Drug Based on Based Days 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. Where the day supplies paid for Claims submitted for subsequent fills of chronic-use drugs is less than 28 days, the DG will be calculated according to the following formula: (DF/28) x paid based supply. For additional information about the Short-Term dispensing fee policy, please see the Short-Term Dispensing Policy section via www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/pharma-prod/faq-foq-eng.php
W19 CPhA Code: DH	
Message	Dispensing Fee Is Disallowed or Reduced To NIHB Guidelines.
Explanation	Drug dispensing fee disallowed or reduced to conform to NIHB dispensing fee guidelines, or Prior Approval Confirmation. Refer to details of the NIHB pricing in

NIHB Code	Description
	your region.
W20 CPhA Code: DS	
Message	Markup Is Disallowed or Reduced To NIHB Pricing Guidelines.
Explanation	Drug mark-up disallowed or reduced to conform to NIHB pricing guidelines, or Prior Approval Confirmation. Refer to details of the NIHB pricing guidelines in agreements with the appropriate region.
N/A CPhA Code: A8	
Message	No Reversal Made, Original Claim Is Missing.
Explanation	The system is unable to locate the original Claim in order to reverse it. Contact Provider Claims Processing Call Centre at 1-888-511-4666.
N/A CPhA Code: A6	
Message	Infant Claim.
Explanation	The system rejected this Claim due to it is the first Claim for an infant using the parent's INAC number. Submit this Claim manually.
N/A CPhA Code: 72	
Message	Special Services Fee Error.
Explanation	If the Claim was sent to provincial plan first and the SSF field isn't numeric.
N/A CPhA Code: 75	
Message	Previously Paid Error.
Explanation	Claim sent to a third party plan first and the Intervention Code is not DA or DB.
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.
N/A CPhA Code: NQ	
Message	Drug Not Eligible for Trial Rx.
Explanation	This item not flagged as a trial prescription drug.
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.
N/A CPhA Code: NX	
Message	Quantity Exceeds Trial Days Period.
Explanation	The day' supply is greater than seven days. Therefore,

NIHB Code	Description
	the drug is not eligible for the Trial Prescription Program.
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 days. Therefore, the drug is not eligible for the trial prescription program, since less than seven days is an insufficient quantity for a trial period.
N/A CPhA Code: NZ	
Message	Trial Balance Given Too Late.
Explanation	The Provider must submit the trial balance Claim no later than 14 days after the trail Claim.
N/A CPhA Code: OA	
Message	Trial Balance Given Too Soon.
Explanation	Providers cannot submit the trail balance Claim until at least four days after the trial Claim.
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 rejected.
N/A CPhA Code: OE	
Message	Trial Balance Already Dispensed.
Explanation	The balance of the trial prescription has been previously dispensed.
N/A CPhA Code: NR	
Message	Drug Not Suitable for Dosette Packaging
Explanation	The item being claimed is not considered for dosettes.
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.

12.2 Mandatory Information in Transmission and Submission Options

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

12.2.1 Submission Options

All Claims for drug items must be submitted through POS technology, except for these two situations, which must be submitted on paper using the NIHB Pharmacy Claim Form:

- The first Claim for drug items for an infant under one year of age who has not registered with INAC or the Northern Governments. 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 POS must include the child's parent's primary identifier (such as INAC, Client or band/family number) in the Client identification number field and the infant's identifiers in the surname, given name and birth date fields.
- Re-submissions for drug items after a period exceeding 30 days.

12.2.2 Point of Service

Pharmacy Providers must submit Claims for drug items and may submit Claims for items via POS for real-time adjudication. The POS is available to Pharmacy Providers 24 hours per day, seven days a week. The current process used by many Providers when submitting Claims in excess of $999.99 whereby Claims are split into multiple Claims leads to other problems (for example, multiple dispensing fees being charged for single items, confusing patient files, etc.), and therefore Claims should be submitted as one single entry for the total dollar amount.

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.

12.2.3 Point of Service: Data Elements

The Required Data Elements Table applies only to Claims submitted via POS:

Field	Description
Bank Identification Number (BIN)	BIN may or may not be entered by the Provider (in some cases it is assigned automatically by the software, eliminating the need to enter it at the pharmacy level). The BIN for NIHB Claims is 610068.
Version Number	For example, if a pharmacy's software is based on version 3 of the CPhA Pharmacy Claim Standard, the version number would be 3. In most cases, the software assigns this number automatically, eliminating the need to enter it at the pharmacy level. Providers required to enter this information manually should contact their

Field	Description
	software vendor to determine the version number of their pharmacy software.
Transaction Code	Indicates the type of transaction a Provider wishes to perform. In most cases, Transaction Codes are assigned automatically by the software, eliminating the need to enter them at the pharmacy level. Providers required to enter this information manually may use CPhA Standard Transaction Codes 01-Claim, 11-Reversal, or 30-Daily Totals. For information about the use of Transaction Codes, Providers should contact their pharmacy software vendor.
Provider Software Identification Number	In most cases, the software assigns a Provider software identification number automatically, eliminating the need to enter them at the pharmacy level. Providers should contact their pharmacy software vendor to automate the entry of information in this field.
Provider Software Version	Indicates the version of the Provider software. The vendor assigns the numbers automatically.
Pharmacy Identification Code	This unique 10-digit Identification Number is the pharmacy number assigned to the pharmacy by Express Scripts Canada upon registration as an NIHB Provider.
Provider Transaction Date	Equivalent to DOS, this date should be entered in the correct date format (YYYY-MM-DD), and must be within 30 days of the process date.
Trace Number	Trace numbers are unique numbers usually produced sequentially by the pharmacy's software each time a transaction is transmitted allowing Providers to trace all Claims submitted via POS. There may be rare instances where a Provider is required to enter a trace number manually. For additional information about assigning trace numbers, Providers should contact their software vendor.
Carrier Identification	Identifies the specific plan type or benefit program, which accepts responsibility for the Claim being submitted (for example, NIHB Program). In most cases, the software assigns carrier identification numbers automatically, eliminating the need to enter them at the pharmacy level. For information about automating the entry of information in this field, Providers should contact their software vendor.
Group Number or Code	This is a number or code, assigned to identify a specific group of benefit recipients within a carrier designation, (for example, NIHB Program Clients). In most cases, the software assigns the Group Number or Code automatically, eliminating the need to enter them at the pharmacy level. For information about automating the entry of information in this field, Providers should contact their software vendor.

Field	Description
Client Identification Number	A unique number used to identify a Client who is eligible to receive benefits under the NIHB Program. When submitting Claims through POS, this number may be one of: • A 10-digit number currently issued to eligible First Nations Clients by INAC. • Three-digit band number, immediately followed by the five-digit family number identifying the family unit within the eligible First Nations Client's band. • B or N alpha prefix followed by an eight-digit number issued to certain eligible First Nations and recognized Inuit Clients by FNIHB. • Health Plan Number issued to recognized Inuit Clients by the Governments of NWT and Nunavut. 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 a zero in front of the four-digit family number.
Patient Date of Birth (DOB)	The Client's DOB. Partial dates are not acceptable. The Client's date of birth is mandatory for NIHB POS Claims, and must be entered in the correct date format (YYYY-MM-DD).
Patient First Name	The given name under which the Client is regsitered 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.
Patient Last Name	The surname under which the Client is registered as an eligible First Nations or recognized Inuit Client.
Patient Gender	If entered, must be M (Male) or F (Female).
New/ Refill Code	Indicates whether the prescription is new or a refill/ repeat. In most cases, the software assigns this information automatically, eliminating the need to enter it at the pharmacy level. If the Provider's version of software requires manual entry of this information, these codes are acceptable: N - New prescription. R - Prescription refill/ repeat.
Original Rx Number	This number is assigned to prescriptions on the original DOS (for example, the number assigned to a "new prescription"), and is required when submitting Claims for refills/ repeats. The original prescription number is usually assigned automatically by the system, but may have to be entered manually.
Current Rx Number	The prescription number assigned by the pharmacy for the item dispensed.

Field	Description
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 (for example, 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 number as entered by the Provider on the Claim submission must be the same as required by the provincial/ territorial Pharmacare Program. Claims for repair labour and replacement parts must be submitted with "999Repair" in the prescriber field, or they are rejected and displayed on the Provider Statement – Pharmacy with an R14 Error (Insufficient Benefit Information to Adjudicate Claim): • British Columbia - Physician or Nurse Practitioner License Number. • Alberta - Physician or Nurse Practitioner License Number. • Saskatchewan - Physician's Provincial Billing Number or Nurse Practitioner License Number. • Manitoba - Physician or Nurse Practitioner License Number. • Ontario - Physician or Nurse Practitioner License Number. • Quebec - Physician or Nurse Practitioner License Number. • New Brunswick - Physician's Provincial Billing Number or Nurse Practitioner License Number. • Nova Scotia - Physician or Nurse Practitioner License Number. • Prince Edward Island - Physician or Nurse Practitioner License Number. • Newfoundland - Physician or Nurse Practitioner License Number. • Yukon - Physician's Territorial Billing Number. • Northwest Territories - Physician or Nurse Practitioner License Number. • Nunavut - Physician or Nurse Practitioner License Number.
Prescriber ID Reference	This field allows Providers to enter a code which identifies the prescriber type (i.e., or nurse practitioner, physician, pharmacist, etc.).
Special Authorization (SA) Number or Code	A SA issued by FNIHB before the Provider may dispense certain drugs.

Field	Description
Intervention/ Exception Codes	Used by Providers to override Drug Utilization Review (DUR) Messages, after consulting the prescriber, the Client, or other sources. Standard CPhA Intervention Codes (listed in the DUR are accepted by the NIHB HICPS system).
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 third party. Leave blank if not applicable.
Pharmacist Identification	Field allows Providers to identify themselves when overriding a DUR warning message. Providers should enter their appropriate statutory number, with the appropriate Intervention Code.
Adjudication Date	Only required for submitting online reversals. In most cases, the software automatically assigns the adjudication date, eliminating the need to enter it at the pharmacy level. If keyed manually, the adjudication date must be entered in the correct date format (YYYY-MM-DD). The date must be within thirty (30) days of original adjudication date. If the date is greater than thirty (30) days after the original adjudication date, a reversal may be submitted by either a paper Claim or a copy of the Provider Statement – Pharmacy.

12.2.4 NIHB Pharmacy Claim Form Data Elements

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

- The first drug item Claim for an infant under one year of age who has not yet registered with INAC.
- Re-submissions for drug items after a period exceeding 30 days.

The following describes the required data elements for each Section of the NIHB Pharmacy Claim Form including: Client Information, Information for Each Prescribed Item, Pharmacy Information and Parent Information (Required for Infants Less than One Year of Age).

12.2.4.1 Client Information: Data Elements

Field	Description
Client Surname	The surname under which the Client is registered as an eligible First Nations or recognized Inuit Client.
Client Given Name	The given name under which the Client is registered as an eligible First Nations or recognized Inuit Client. Submission of more than one given name is preferred to facilitate Client verification. Initials are not acceptable.

Field	Description
Client Date of Birth (YYYY-MM-DD)	The Client's full birth date in year-month-day format (for example, 1992-05-13 represents 13 May 1992). Partial birth dates are not acceptable.
Client Identification Number	A unique number used to identify a Client who is eligible to receive benefits under the NIHB Program. This number may be one of: • 10-digit number issued to eligible First Nations Clients by INAC. • Three-digit band number, immediately followed by the five-digit family number identifying the family unit within the eligible First Nations Client's band. • An alpha prefix followed by an eight-digit number issued to certain eligible First Nations and recognized Inuit Clients by FNIHB. • Health plan number issued to recognized Inuit Clients by the Governments of NWT and Nunavut.
Band Number	A three-digit number (for example, 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 (for example, 04120) identifying the family unit within the band to which an eligible First Nations Client belongs. The family number, when submitted in combination with the Client's band number, is an acceptable alternative to the Client identification number for an eligible First Nations Client. If the family number on the eligible First Nations Client's registration card is only four digits, insert a zero in front of the four-digit number.

12.2.4.2 Information for Each Prescribed Item: Data Elements

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

Field	Description
	during Claim adjudication. Leave blank if not applicable.
Quantity	The quantity (number of units) of the item dispensed.
Prescription Number	The prescription number assigned by your pharmacy for the item dispensed.
Drug/ Item Cost	The total ingredient or acquisition cost for all units of the drug or item dispensed.
Dispensing Fee	The dispensing fee for the item dispensed. Leave blank if not applicable.
Mark-up	The dollar amount of any mark-up for the item, based on the established percentage. Leave blank if not applicable.
Third-Party Share	The dollar amount of any portion of the Claim which is billable to a provincial or territorial program or other third party. Leave blank if not applicable.
Amount Claimed	The sum of the drug/ item cost, dispensing fee, and Mark-up for the item, less any third-party share.
Day's Supply	Estimate of number of days of treatment contained in the prescription.
Total	The total dollar amount claimed for all items (up to three) listed on the NIHB Pharmacy Claim Form.
Prescriber	The prescriber number as entered by the Provider on the Claims submission must be the same as required by the provincial/ territorial Pharmacare Program. Claims for repair, labour, and replacement parts must be submitted with "999Repair" in the prescriber field or they are rejected on the Provider Statement – Pharmacy with an R14 Error (Insufficient Benefit Information to Adjudicate Claim): • British Columbia - Physician or Nurse Practitioner License Number. • Alberta - Physician or Nurse Practitioner License Number. • Saskatchewan - Physician's Provincial Billing Number or Nurse Practitioner License Number. • Manitoba - Physician or Nurse Practitioner License Number. • Ontario - Physician or Nurse Practitioner License Number. • Quebec - Physician or Nurse Practitioner License Number. • New Brunswick - Physician's Provincial Billing Number or Nurse Practitioner License Number. • Nova Scotia - Physician or Nurse Practitioner License Number. • Prince Edward Island - Physician or Nurse Practitioner License Number. • Newfoundland - Physician or Nurse Practitioner

Field	Description
	License Number. • Yukon - Physician's Territorial Billing Number. • Northwest Territories - Physician or Nurse Practitioner License Number. • Nunavut - Physician or Nurse Practitioner License Number.
Prior Approval Number	An authorization number, which must be issued by the DEC before the Provider dispenses certain drugs.

12.2.4.3 Pharmacy Information: Data Elements

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

12.2.4.4 Parent Information (Required for Infants Less than One Year of Age): Data Elements

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

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

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

Field	Description
Parent's Surname	The surname under which the parent is registered as an eligible First Nations or recognized Inuit Client.
Parent's Given Names	The given names under which the parent is registered as an eligible First Nations or recognized Inuit Client. Submission of more than one given name is preferred to facilitate Client verification. Initials are not acceptable.
Parent's Date of Birth (YYYY-MM-DD)	The parent's full birth date in year-month-day format (for example, 1956-05-13 represents 13 May 1956). Partial birth dates are not acceptable.
Parent's Client Identification Number	The number under which the parent is identified as an eligible First Nations or recognized Inuit Client. This number may be one of: • A 10-digit number issued to eligible First Nations Clients by INAC.

Field	Description
	• Three-digit band number, immediately followed by the five-digit family number identifying the family unit within the eligible First Nations Client's band. • An alpha prefix followed by an eight-digit number issued to certain eligible First Nations and recognized Inuit Clients by FNIHB. • Health Plan number issued to recognized Inuit Clients by the Governments of NWT and Nunavut.
Parent's Band Number	A three-digit number (for example, 002, 311) identifying the band to which an eligible First Nations Client's parent belongs. The band number, when submitted in combination with the family number, is an acceptable alternative to the Client identification number for an eligible First Nations Client.
Parent's Family Number	A five-digit number (for example, 04120) identifying the family unit within the band to which an eligible First Nations Client belongs. The family number, when submitted in combination with the Client's band number, is an acceptable alternative to the Client identification number for an eligible First Nations Client. If the family number on the eligible First Nations Client's registration card is only four digits, insert a zero in front of the four-digit number.

12.2.4.5 Payment Information

- **Adjudication Date:** This data element is only required for submitting online reversals. In most cases, the software automatically assigns the adjudication date, eliminating the need to enter it at the pharmacy level. If keyed manually, the adjudication date must be entered in the correct date format (YYYY-MM-DD). The date must be within thirty (30) days of original adjudication date. Paper Claims must be submitted if after thirty (30) days beyond original adjudication date.
- **Pharmacy Reimbursement:** Health Canada reimburses pharmacies in a timely manner, in accordance with the terms and conditions of the applicable Pharmacy Provider Agreement and of the Kit, and following a specific and predetermined method of payment.
- **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 Pharmacy Provider Agreement, any amendments to the same, or the Kit. The resulting amount is herein referred to as a "Net Payment". Claims for drug items must have data elements submitted in the same order as on the NIHB Pharmacy Claim Form.

In certain circumstances and under existing arrangements, Pharmacy Providers can submit paper Claims for items directly to FNIH Regional Offices.

- **Payment Schedule:** Unless the applicable Pharmacy Provider Agreement provides otherwise, the pharmacies shall be paid on a twice-per-month schedule. The payment run date takes place automatically on the 1st and 16th of every month. Payment run date for the 1st include Claims processed from the 16th to end of the month (for example,

February 28th or 29th or the 30th or 31st as the case may be for the remaining months); payment run date for the 16th include Claims processed from the 1st to the 15th. The payment date is within two business days following the Payment Run Date, unless a weekend or bank holiday falls between. Payment date is the day that cheques, Electronic Funds Transfer (EFT) payments and statements are released.

- **Payment Method:** EFT payment is available to pharmacies providing Express Scripts Canada with access to a bank account for payment deposit. If EFT is elected as the preferred method of payment, complete Section 3 - EFT Payments of the Express Scripts Canada Modification to Pharmacy and Medical Supplies and Equipment Provider Information 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 in the Express Scripts Canada 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 Express Scripts Canada Modification to Pharmacy and Medical Supplies and Equipment Provider Information Form and forwarding the request to Express Scripts Canada.
- **POS Reversals:** The "Claim Reversal" transaction is used to reverse a previously submitted and paid POS transaction. It is used in situations where the Provider has a need to either correct a previously submitted 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 30 days) reversals. In order to reverse a Claim, the original Claim being reversed must be found on the database. Otherwise, the reversal is rejected with an A8 CPhA Code. In both cases, the NIHB HICPS system generates a "Claim Adjustment" reversing the impact of the original Claim. All three Claims appear on the Provider's statement: the original Claim, the reversal and the corrected Claim. Claims that require reversal more than 30 days after the original submission must be submitted manually on the NIHB Pharmacy Claim Form or on a copy of the Provider Statement - Pharmacy, up to one year from the original date of service.

12.2.4.5.1 Reversals for Prescribed Medication Not Picked Up by Client

- **Compounds:** Where the drug item is a compound and re-insertion into the pharmacy's inventory is not possible, Express Scripts Canada pays the Provider for both the drug and dispensing fee. Therefore, a reversal is not necessary. DUR is not affected.
- **Prescribed Medication:** The submission of a Claim for a dispensing fee where the Client has not picked up a drug, which can be re-inserted to inventory, only applies to drugs with a dispensing fee dollar value. For Non-POS dispensing fee Claims, once the original Claim containing both the dispensing fee and the drug item cost has been reversed, a NIHB Pharmacy Claim Form containing pseudo-DIN 55555555 in the Item Code field must be completed. The information on the new Claim, with the exception of pseudo-DIN 55555555, must mirror that of the reversed Claim. For POS dispensing fee Claims, once the reversal of the original Claim containing both the dispensing fee and the drug item cost is complete, the Provider must submit a Claim online using pseudo-DIN 55555555 in the DIN No./ Item Number field. The information on the new Claim, with the exception of pseudo-DIN 55555555, must mirror that of the reversed Claim.

12.3 Trial Rx Program

12.3.1 What is a Trial Rx Program?

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

12.3.2 How will the Trial Rx Program Drugs be Handled?

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

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

If the DIN is part of the Trial Rx Program a message "TP" is generated indicating, "TP – PATIENT IS ELIGIBLE FOR TRIAL RX".

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

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

12.3.3 Adjudication Process for the Trial Rx Program

1. DIN/ Item# s qualifying for the Trial Rx program are identified by the "Trial Rx" indicator on the Coverage Details screen (maintained by specified FNIHB users via the DBL Interface).
2. The first Claim should be submitted with CPhA Intervention Code "MT" (Trial Rx Program).
3. The system first verifies that the "Trial Rx" indicator for the submitted DIN/ Item# is equal to "Y", otherwise the Claim is rejected with CPhA Code "NQ" - Drug not eligible for trial Rx).
4. If "Trial Rx" is equal to "Y", then a check is done to ensure that the day's supply submitted is equal to seven.
    - If < 7, the Claim is rejected with CPhA Code "NY" (Insufficient quantity for trial days period).
    - If > 7, the Claim is rejected with CPhA Code "NX" (Quantity exceeds trial day's period).
    - Next,a check is done to ensure that a previously accepted/ paid Claim does not exist in the Client's Claims history for the same Item # within two years of the current

date of service; otherwise, the Claim is rejected with CPhA Code "NT" (Not suitable – similar item on recent Trial Rx).

- If all above conditions are met, the Claim is processed according to regular cost verification rules.

5. The balance of the prescription should be submitted as the second Claim, with CPhA Intervention Code "ND" (Trial Rx Balance).
   - The system verifies that the "Trial Rx" indicator for the submitted DIN/ Item# is equal to "Y", otherwise the Claim is rejected with CPhA Code "NQ" (Drug not eligible for trial Rx).
   - If "Trial Rx" is equal to "Y", then a check is done to ensure that the Claim is in fact the second Claim for this patient, for this Item #.
   - If no first Trial Rx Claim exists, the Claim is rejected with CPhA Code "OD" (No Trial Rx on record, balance rejected).
   - If a second Trial Rx Claim already exists, the Claim is rejected with CPhA Code "OE" (Trial balance already dispensed).
   - If a valid second Claim, an additional check is done to ensure that the DOS is at least four days after the first Claim, and also within 14 days of the first Claim, otherwise the Claim is rejected with CPhA Code "OA" (Trial Rx balance given too soon) or "NZ" (Trial Rx balance given too late), respectively.
6. If all above conditions are met, the Claim is processed according to regular cost verification rules.

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