Pharmacy Claims Manual

March 2020

1. INTRODUCTION TO GREEN SHIELD CANADA

Green Shield Canada (GSC) is a not-for-profit corporation federally registered by the Office of the Superintendent of Financial Institutions. The head office of the company is in Windsor, Ontario, with executive offices in Toronto, Ontario. Sales offices are located in Windsor, London, and Toronto, Ontario; Montreal and Quebec City, Quebec; Calgary, Alberta; and Vancouver, British Columbia.

GSC is governed by a board of directors, made up of representatives from the provider professions, business, labour, and management. GSC administers benefit plans – including drug, dental care, extended health services, audio and vision, as well as semi-private hospital and nursing home – for groups and individuals.

The drug plans provide prescription drugs to plan members upon the presentation of their identification card to a participating pharmacy. GSC is billed directly by the pharmacy for the drugs and services rendered. In addition, our service agreement provides for repayment to the plan members under certain conditions where participating pharmacies are not available.

Some extended health plans also provide for the dispensing of prescription drugs, but payment in some cases must be made by the plan member directly to the pharmacy at the time of dispensing. The plan member then must request a reimbursement from GSC, in accordance with their contract and/or deductible features.

1.1 Office Locations

Southwestern Region

WINDSOR – Head Office and Claims Processing for Canada
8677 Anchor Drive, P.O. Box 1606
Windsor, Ontario N9A 6W1
Phone: 519.739.1133
1.888.711.1119

LONDON
225 Queens Avenue, Suite 1220
London, Ontario N6A 5R8
Phone: 519.673.4410
1.800.265.4429

Central Region

TORONTO – Executive Office and Individual and Association Sales
5140 Yonge Street, Suite 2100
Toronto, Ontario M2N 6L7
Phone: 416.221.7001
1.800.268.6613

MONTREAL

2020-1002 Sherbrooke Street W.
Montreal, Quebec V3J 0A9
Phone: 514.788.8938
1.855.789.9214

QUEBEC CITY

Complexe Jules-Dallaire-T3
1190 - 2820 Boulevard Laurier
Québec, QC G1V 0C1
Phone: 418.656.9341
1.844.201.1012

Western Region

CALGARY

Bow Valley Square 4
250-6th Avenue SW, Suite 1220
Calgary, Alberta T2P 3H7
Phone: 403.262.8533
1.888.962.8533

VANCOUVER

Three Bentall Centre
595 Burrard Street, Suite 833, Box 49265
Burnaby, British Columbia V7X 1L2
Phone: 604.444.4408
1.800.665.1494

2. CLAIMS SUBMISSION OPTIONS

2.1 OLTP (Online Transaction Processing)

OLTP claims are adjudicated in real time. This procedure permits instant verification of patient and drug eligibility. The majority of claims are processed in this way using the CPhA Pharmacy Claim Standard. Any pharmacies not currently using OLTP may wish to pursue this option with their software vendor.

Transactions supported by the CPhA Claims Processing Standard Version 3.0 include:

- Claim submissions
- Reversal
- Daily Totals
- Daily reconciliation

2.2 Manual Claims

GSC accepts claims paper or electronic that are generated by the various pharmacy computer software vendors. Manual claim forms may be downloaded from **providerconnect.ca.**

3. IDENTIFICATION (ID) CARDS

When enrolled in a GSC plan, a plan member is issued an ID card. This card must be presented at the pharmacy for verification with each prescription filled. Each card contains the following information:

FRONT:

1) Plan member name
2) Plan member identification number
   a) The plan member's "family number" is the prefix numbers (before the hyphen), ABC123456789
   b) The plan member's personal identification number is the suffix numbers (after the hyphen), i.e., 00
3) Company Name
4) GSC Contact Centre toll-free number

BACK:

1) Dependent name and identification number
   a) The spousal personal identification number is the suffix number 01*
   b) The spousal personal identification number in the case of remarriage is the suffix numbers, 21*, 31*, or 41*.
   c) The dependent personal identification number is the suffix numbers, 02*, 03*, 04*, etc.

* Each of these numbers must correspond to the correct initials of the plan member or dependent and agree with the name on the prescription.

4. CLAIM PROCEDURES FOR MANUAL CLAIMS

4.1 Where to Send Claims

Upload to GSC through providerConnect®

1. Select "Send a Form or Document" from the "What You Need" drop-down menu on **providerconnect.ca**.
2. On the interactive form:
   "Send Form or Document to:" select GSC
   "Form or Document:" select Other
3. Complete the remainder of the form with your provider number, name, etc.
4. Under "Attach form or document," upload the completed and scanned claim form.
5. Under "Additional Information," type **Attention drug claims department**.

Mail claims

Green Shield Canada
8677 Anchor Drive, P.O. Box 1606
Windsor, ON, N8N 5G1

Submit all hand-written and computer printed claim forms to the attention of:
DRUG DEPARTMENT

4.2 Green Shield Canada Manual Claim Form

Manual claim forms may be downloaded from **providerconnect.ca.**

4.3 Special Claims, Medical Equipment and Supplies

Examples: surgical stockings, aerochambers, and glucose monitoring systems (GMS)

These items are not benefits of any drug plan. However, they may be a benefit of the patient's extended health services (EHS) coverage.

Please follow the claim procedures outlined below:

- The pharmacy must call the GSC Contact Centre at:
  LOCAL 519-739-1133
  TOLL FREE 1-888-711-1119

- GSC will advise of:
  - Eligibility
  - Doctor's prescription requirements
  - Full authorization

Claims must be submitted on your store invoice, not a regular drug claim form, and must contain the following:

- Patient's name and address
- GSC patient number
- Name of item provided
- Retail dollar amount

- Your GSC account number
- Date of service

Note (a) Items required for sports activities only or as a result of work-related injury or motor vehicle accident are not eligible. When calling for pre-authorization, if the patient is a resident of a hospital or a long term care facility, we must be advised, as this may affect their eligibility for certain items. Claims are processed and payments are issued daily.

(b) Medical equipment and supplies are not subject to the patient's drug co-pay, however they may be subject to co-pays and/or deductibles applicable to their EHS coverage.

Submit claims by uploading the claim information to GSC on **providerconnect.ca**. Follow the steps shown above.

Or mail claims to:

Green Shield Canada
8677 Anchor Drive, P.O. Box 1606
Windsor, ON, N8N 5G1
Attention: E.H.S. Department

5. CLAIM PROCEDURES FOR ONLINE CLAIMS TRANSMISSION

5.1 Special Claims

(a) Extemporaneous Mixtures, Topical Extemporaneous Compounds Policy

Topical Extemporaneous Compounds:

Eligible Ingredients	Eligible Bases
Camphor	Aquaphor Ointment (02009609)
Benzoin Tincture	Dermabase (00067350)
Liquor Carbonis Detergens (LCD)	Glaxal Base (00295604)
Coal Tar	Anhydrous Lanolin (01923129)
Salicylic Acid	Petrolatum Jelly (00094854)
Menthol	Eucerin Ointment (00900907)
Sulfur	Taro Base (00960063)
Tar Distallate	Rougier Base (00964956)
Erythromycin Powder	Mediderm Cream Base (00961582)
Clindamycin Powder	Transal Base (00962511)
Ketoconazole Powder	
Metronidazole Powder	
Clotrimazole Powder	
Miconazole Powder	

One or more of any of the Eligible Ingredients may be added to:

1. Any of the listed Eligible Bases.
2. Any topical drug product that is already a benefit of the individual's drug offering.

Compounding of two or more creams/ointments that are already benefits of the plan are eligible with or without additional eligible ingredients.

Compounds must contain an active ingredient in a therapeutic concentration that is an eligible benefit of the plan member's offering.

Compounds for cosmetic purposes such as baldness, dry skin, or facial wrinkles are not eligible benefits.

Extemporaneous Compounds:
Any compound (oral, topical, injectable, etc.) that duplicates the formulation of a manufactured pharmaceutical product (current or discontinued) is not eligible.

Unproven compounds are not eligible benefits. For example, drugs intended for oral use that are compounded into a topical mixture would be considered unproven.

Claims for compounds intended to be used orally, rectally, vaginally, injected, ophthalmic or otic preparations must contain a DIN of an eligible product to be covered. Compounds in which a pure raw chemical is used are ineligible. Any compounded item that is considered "experimental" in nature is ineligible.

Compounded prescriptions for "Triple P" therapy that use *Prostin VR*® as an ingredient are not eligible benefits of GSC as erectile dysfunction is not an approved indication of this product. Such claims must use alprostadil powder or *Caverject*® to be considered eligible for coverage.

Although the GSC Compound Policy does not explicitly list levigating agents such as water and glycerin as eligible ingredients, it is recognized that these excipients are necessary for some compounds. The addition of such agents in small amounts will not render the entire compound ineligible. However, in cases where the amount of such ingredients is significant enough to be more than a simple levigating agent, the compound may be considered ineligible.

Please note that any extemporaneous compound claim submitted electronically, though paid initially, will be reversed should audit determine it ineligible based on GSC's Compound Policy.

Claim adjudication cannot fully determine the eligibility of each ingredient without auditing claims. Claims are audited randomly, but may also be targeted based on a high cost in relation to the submitted DIN/PIN.

Topical extemporaneous compounds should be submitted using the DIN/PIN of the vehicle (base). All other compounds should be submitted using the DIN/PIN of the active ingredient.

If you are unsure as to the eligibility of the compound, it is recommended that you contact our Contact Centre for verification prior to submitting the claim.

(b) Compound Codes

Below is a table of CPhA standard codes for compounded products. Please use the appropriate code for the corresponding mixture when submitting your prescription.

Code	Type of Compound
0	compounded topical cream
1	compounded topical ointment
2	compounded external lotion
3	compounded internal use liquid
4	compounded external powder
5	compounded internal powder
6	compounded injection or infusion
7	compounded eye/ear drop
8	compounded suppository
9	compounded other

(c) Generic Plans

If a plan member/patient has a mandatory product selectable plan, product selection will occur (i.e., if a generic exists), in all applicable cases except if the doctor has specified "no substitution" (i.e., CPhA Product Selection field = 1, Doctor's choice). Our adjudication process applies this rule and returns a response code indicating that generic plan product selection has occurred.

Some GSC plans have a copayment that is dependent on product selection. A product select code of 1 (physician no substitute) or 2 (patient no substitute) should only be used in those situations where a legally interchangeable product would be otherwise available. This will ensure the application of the correct copayment.

5.2 Frequently Used PINs

Use pseudo-DINs (PINs) assigned by your provincial formulary, or those created by GSC for diabetic supplies, lancets, and some other items.

A list of frequently used pseudo-DINs (PINs) is available at providerconnect.ca in the What You Need/Pharmacy Provider section. Instructions on accessing this list are available in Appendix II.

Billing of these items are on a cost + fee basis, therefore, the cost of the product, the markup, and the pharmacy's professional fee must be submitted in separate fields for adjudication by GSC.

5.3 Relationship Code

The relationship field must always be populated as it is a requirement for some GSC plans.

Below is a table of standard codes for relationships that should be used when setting up the patient in your pharmacy system. Select the appropriate code to show the relationship of the patient to the cardholder when submitting your prescription.

Code	Relationship
0	cardholder
1	spouse
2	child underage
3	child overage
4	disabled dependent
5	dependent student

5.4 Coordination of Benefits

Coordination of benefits is part of the Online Claims Adjudication System. Claims may be coordinated with all public and privately administered plans.

Where GSC is advised of dual coverage, our system will administer coordination of benefits in accordance with the industry guidelines.

A patient's primary payer is that for whom the patient is the plan member. In the case of dependents, the primary payer will be the plan belonging to the parent whose birthday falls earliest in the calendar year (not necessarily the oldest parent).

GSC will reimburse the secondary claim up to the full eligible price of the drug according to GSC pricing files. Any amount a pharmacy charges in excess of that amount will not be reimbursed, and this amount will not be eligible for manual pricing adjustments with GSC. **NOTE**: Our provider agreements with pharmacies prevent any extra billing.

GSC supports electronic coordination of benefits between more than two other payers. If GSC is your patient's third payer, enter the appropriate intervention code to continue adjudication.

5.5 Drug Loyalty Cards

Drug, or brand, loyalty cards are payment cards designed to be used like a drug insurance card. These cards are specifically designed to assist plan members in obtaining a higher-cost brand-name medication instead of the generic.

GSC requires that any drug claim submitted to a brand loyalty card program must be submitted as if the loyalty card program is the plan member's secondary plan. Here's how it works:

- If a patient is covered by only one drug benefits plan (private or public), the claim should be submitted to this plan first, then any unpaid amount remaining is submitted to the loyalty card program.

- If the patient is covered by two drug benefit plans (private or public), the claim should be submitted to the primary plan first, followed by the brand loyalty card program, and then to the patient's other drug plan (if an unpaid amount remains on the claim).

5.6 Drug Utilization Review

Prospective Drug Use Review (DUR) is part of the online claims adjudication system. Prospective DUR analyses both previous prescription claims data and the current

prescription to identify potential drug therapy problems. The system is designed to detect potential problems related to the patient's drug therapy. Such problems may be prevented when the online claims adjudication system provides additional information to the pharmacist.

Pharmacists may evaluate this extra information, in consultation with the prescriber, another pharmacy, the patient (if appropriate), or by checking the pharmaceutical literature, to resolve the potential problem.

The DUR process is started after the validation of patient, DIN/PIN, and pharmacy ID eligibility. Through analysis and retrieval of historical and current prescription claims data, the prospective DUR system will warn of potential problems with the current prescription. All potential problems are formatted into a response message, and/or response code.

(a) DUR Modules

Four prospective DUR modules are working in this initial stage:

- Drug Interactions
- Double Doctoring
- Multiple Pharmacies
- Compliance (i.e., Fill too soon/too late)

Additional modules, such as Therapeutic Duplication, Min/Max Range Check (Therapy Duration), or Drug Dosage Checks may be added in the future.

Response codes or messages associated with DUR process include:

- Drug/drug interaction potential .....ME
- May be double doctoring .....MH
- Multiple pharmacy use indicated ..... MI
- Fill too soon.....D7
- Fill too late..... DE
- Call adjudicator D9

(b) DUR Messages

DUR message codes can be informational messages or overrideable warnings. The system has the flexibility to accept a pharmacist's intervention code on overrideable warnings. Intervention codes are optional on information messages.

(c) Overrideable Warnings

When an overrideable warning appears, the claim has **not** been approved for payment because a potential problem has been detected. The pharmacist must investigate the problem and use an appropriate intervention code with the pharmacist ID number before the claim can be paid. Each warning has to be answered, with one or more assigned and approved intervention codes. The claim will then be paid, assuming no other conditions exist.

(d) Information Messages

When an information message appears, the claim has been approved for payment but there is a cautionary message. The message advises that a potential problem may exist and should be investigated. The message does not have to be answered.

(e) Detailed Message (Response) Information

DUR messages are provided on one of three possible message text lines. This allows for the text translation of a potential problem identified by the message Code. If there are more than three potential messages, a message “Insufficient space for all DUR warnings” and code DD are sent. The subject of all DUR messages may be obtained by phoning the GSC Contact Centre.

(f) Intervention Codes

The action to resolve DUR problems is shown through intervention codes. An intervention code is required only for overrideable warnings and for information messages requiring the reversal of a paid claim.

The table of approved CPhA messages and intervention codes is at the end of this section. It is important for pharmacists to familiarize themselves with these messages and codes. If an incorrect code is used the transaction will be rejected and must be resubmitted.

When an appropriate intervention code to explain the exact action taken cannot be located, contact the GSC Contact Centre for assistance.

(g) Claim Rejections

For all unpaid claims with an overrideable DUR warning message, the system will check for the presence of an acceptable intervention code and pharmacist ID number. Claims will not be paid if the intervention codes and/or pharmacist ID are unacceptable or missing.

(h) Claim Resubmissions

When a claim is received by the adjudication system, it does not know whether this is a later submission of an earlier claim. Therefore, if a claim is rejected because of unacceptable intervention code and/or the absence of the pharmacist ID, the claim must be resubmitted.

(i) D9: Call Adjudicator

If a denied or pending claim has occurred five times for the same participant with the same DIN on the same day, online transmissions will not be permitted until the Customer Service Centre is contacted. An agent will be able to advise the appropriate intervention code to use where applicable. If the claim continues to deny for other reasons, the “D9: Call Adjudicator” message will continue to appear. The Contact Centre will continue to assist.

(j) Claim Reversal

All claims with an informational message are adjudicated and will be paid. Therefore, if the prescription is changed by the pharmacist, (e.g., change of drug, Rx not filled), **the claim must be reversed**.

(k) Contact Centre

GSC's toll-free Contact Centre is available to help health care professionals with inquiries at 1.888.711.1119. Personnel will be available from the hours of 8:30 a.m. to 8:30 p.m. (Eastern Time), Monday to Friday. After-hours service is available through voice messaging, and GSC personnel will return your call on the following business day.

(l) Limitations

The information provided in these DUR modules is advisory only and is intended to supplement the current information available to health care professionals. It is not intended to replace professional judgment or individualized patient care and consultation in the delivery of health care services.

(m) Drug/Drug Interactions

This module is designed to detect potential drug interactions between the prescription being claimed and other prescriptions that are considered "active" in the patient's utilization file. The module can identify potential interactions for single ingredients and combination products.

When a patient's prescription is submitted to the system, the DIN/PIN is compared to the patient's historical DIN/PINs. If interactions are noted, a response message and a response code will be generated to advise of the potential problem(s). (Interactions are based on clinical significance by First DataBank and adapted for Canadian content.) This database uses three reference sources: Hansten's Drug Interactions, Facts & Comparisons, and USPDI.

The First DataBank's three levels of significance are:

Level 1 – **Contraindicated Drug Combination:** This drug combination is clearly contraindicated in all cases and should not be dispensed or administered to the same patient.

Level 2 – Severe Interaction: Action is required to reduce risk of severe adverse interaction.

Level 3 – Moderate Interaction: Assess risk to patient and take action as needed

If an interaction is found, the pharmacy will be sent a response message "Drug/Drug Interaction Potential," and/or a response code "ME."

The response message contains:

- Severity code for the potential interaction
- DIN of historical drug
- Brand name of historical drug (up to the maximum for one message line)

E.g. *L3*00749354*Apo-Metoprolol 50mg tab*

Meaning:

- A severity Level 3 (Moderate) potential interaction has been identified. The current prescription being claimed interacts with a drug in the patient's profile.
- The interacting drug is identified through the DIN number "00749354" and the brand name of the drug is Apo-Metoprolol 50mg tab.

NOTE: Overrideable messages are unpaid until an intervention code is sent.

If there are more than three text messages to be reported through DUR, a response message – "Insufficient space to report all messages" – and response code – "DD" – will be sent. Complete messages can be obtained by phoning the GSC Contact Centre.

(n) Double Doctoring – Multiple Pharmacies

These two separate modules are designed to locate patients who might be "shopping" to obtain specific drugs that have the potential to be abused (e.g., narcotic analgesics, psychotherapeutic agents, sedatives/hypnotics) through multiple prescribers or pharmacies.

When a patient's prescription is submitted to the system the therapeutic class is compared to each historical prescription. Checking is based on the claims having the same therapeutic categories prescribed by different prescribers, or dispensed by different pharmacies.

If double doctoring or multiple pharmacy is noted, informational response message and response code is generated to advise of the potential problem(s).

(o) Compliance – Fill Too Soon/Too Late

When a patient's prescription is submitted to the system, the DIN/PIN is compared to each historical DIN/PIN. Checking is based on the predicted duration of therapy of the prescription in the current profile. (Based on previous claims accuracy.)

D7: FILL TOO SOON

This module is designed to detect a patient's possible overuse of drugs, through renewal dates, and days' supply on prescriptions, and calculating that the patient may be taking excessive doses [Fill Too Soon].

The "Fill too Soon" DUR module will return an overrideable message. Pharmacists are asked to use their professional judgment in these cases to

choose an acceptable intervention code. The following are applicable intervention codes when encountering a "fill too soon" response:

MK = *Good Faith Emergency Coverage Established*
MN = *Replacement Claim Due to Dose Change*
MV = *Vacation Supply*

DE: FILL TOO LATE

Through renewal dates and days' supply on prescriptions, it is calculated that the patient may be taking inadequate doses [Fill Too Late].

The "Fill too Late" module of the DUR system is informational only.

As always, pharmacists must fully document the use of any intervention codes.

Sample DUR Claim Processing and Reversal Intervention Codes

Response Code	Message Description	Response Type	Condition Generating Response Code	Intervention Code by Pharmacist and Description
ME	Drug/Drug Interaction Potential	SEVERITY LEVEL 2 Information message	Indicates a potential drug/drug interaction between the prescription being filled and one which the patient is already receiving. The claim has been approved for payment. However, if the Rx is not filled, the claim may be reversed using the appropriate intervention codes	UD= consulted prescriber and changed drug UL= pharmacist decision Rx not filled
ME	Drug/Drug Interaction Potential	SEVERITY LEVEL 1&3 Overrideable Warning	Indicates a potential drug/drug interaction between the prescription being filled and one which the patient is already receiving. **The claim has not been approved for payment**. The claim may be processed by using the appropriate intervention codes.	UA= consulted prescriber and filled Rx as written UC= consulted prescriber and changed instructions for use UB= consulted prescriber and changed dose UF= patient gave adequate explanation. Rx filled as written UI= consulted other source. Rx filled as written UG= cautioned patient. Rx filled as written
MH	May Be Double Doctoring	Information Message	Indicates that the patient may be visiting multiple prescribers to obtain drugs that have a potential to be abused. The claim has been approved for payment. However, if Rx is not filled, the claim may be reversed using the applicable intervention code.	UD= consulted prescriber and changed drug UL= pharmacist decision Rx not filled UE= consulted prescriber and changed quantity
MI	Poly-pharmacy Use Indicated	Information Message	Indicates that the patient may be visiting multiple pharmacies to obtain drugs which have a potential to be abused. The claim has been approved for payment. However, if Rx is not filled, the claim may be reversed using the intervention codes.	UD= consulted prescriber and changed drug UL= pharmacist decision. Rx not filled UE= consulted prescriber and changed quantity

Response Code	Message Description	Response Type	Condition Generating Response Code	Intervention Code by Pharmacist and Description
D7	Fill Too Soon	Overrideable Warning	Indicates a refill should not be required at this time. **The claim has not been approved for payment**. The claim may be processed by using the appropriate intervention codes.	MK= good faith emergency coverage established. MN= replacement claim due to dose change MV= vacation supply
DE	Fill Too Late	Information Message	Indicates a refill is overdue at this time. The claim has been approved for payment. The dispensing agent may want to ensure that the patient is compliant and taking adequate doses.	
D9	Call Adjudicator	Call Contact Centre 1.888.711.1119	Indicates that there have been excessive online submissions for the same participant on the same day for the same DIN.	As determined with the assistance of a customer service agent.
OF	Initial Days Supply	Overrideable Warning	Indicates the first claim for this medication for a given patient. May be overridden if the patient is already established on drug.	NH= Initial Rx program declined
OC	Initial Days Supply	Overrideable warning	Indicates that a claim initially denied due to the Initial Days Supply program was resubmitted with a reduced days supply, but without a corresponding reduction in quantity. If it is not possible to further reduce quantity due to package size constraints, an override may be used	NF= Override-Quantity appropriate
HD	Patient May Qualify for Government Plan	Overrideable Warning (Ontario)	Indicates that the plan member is a senior and that the claim may qualify as a Limited Use drug through ODB. The claim has not been approved for payment. The claim may be processed using the appropriate intervention code if the plan member does not meet the criteria described by ODB for coverage of the drug product.	MS= Non-formulary benefit. This intervention code may be used if the plan member does not qualify for coverage by ODB for the drug claimed. DA= Secondary claim – original to provincial plan.
KX	Patient Now Eligible for Maintenance Supply	Information Message	This message may be seen when a drug claimed was previously reduced due to GSC's Initial Days Supply program. The response code indicates that the quantity claimed is less than the balance remaining from the original claim. The claim has not been approved for payment. The claim may be resubmitted for the balance of the initially prescribed supply.	MN= Replacement claim due to dose change. For example, this intervention code may be used to allow payment when the dose has been reduced pending the results of the initial 30-day trial.
KR	Patient Not Eligible for Product	Overrideable warning	This may be seen on claims for narcotic preparations in children under a safe age for use. In this situation, may be overridden if the pharmacist has consulted the prescriber but the prescriber still requests the prescription filled as written.	UA= Consulted prescriber and filled Rx as written.
DR	Days Supply Lower Than	Overrideable warning	Indicates that the plan member requires a larger supply to comply with our 90-day	ER= Override days supply limit for period.

Response Code	Message Description	Response Type	Condition Generating Response Code	Intervention Code by Pharmacist and Description
	Minimum Allowable		maintenance rule. Pharmacist must use professional judgement in assessing patient eligibility to determine a clinical need for overriding.	DH= Rx synchronized pursuant to rule 19
D6	Maximum Cost Exceeded	Overrideable warning	Indicates that a claim cost exceeds $499.99. If cost is accurate, pharmacy must input appropriate corresponding code depending on the claim cost.	MO= Valid claim – value $500.00 to $999.99. MP= Valid claim – value $1,000.00 to $9,999.99.
EQ	Reject, Prov. Plan Enrolment Required	Overrideable warning	Indicates that the claim may be eligible for reimbursement under a provincial plan. If the plan member does not meet the criteria set for a restricted benefit, for example, being ineligible under the AB formulary due to age or gender restrictions, then the pharmacy can use the override code.	DY= Not eligible for prov. plan coverage
QQ	Drug ineligible – specialty program drug	Overridable warning (Ontario)	Indicates that the claim may be eligible for reimbursement under the Exceptional Access Program (EAP) in Ontario.	DW= applied to provincial plan and rejected DX= applied to provincial plan, decision pending DY= not eligible for provincial plan coverage SW= rejected by provincial plan. Bypass other programs. SX= pending provincial plan. Bypass other programs

The use of any intervention code should be supported with relevant documentation on the prescription hard copy.

(p) Overview of Adjudication Messages

All transactions submitted online are adjudicated to determine eligibility. Transactions may be approved, rejected, or flagged for attention and pharmacists' intervention.

The *response code* is a code established by CPhA to identify a particular claim problem. This may or may not be displayed on your computer, depending on your vendor (as noted above).

The *message(s) (response)* displayed on your pharmacy computer may be a brief explanation of the response code provided by your software vendor according to current claim standards

The *intervention code* is a code established by CPhA to identify an action taken by the dispensing pharmacist. In some cases, these may be shown as a list of messages on your computer, depending on your vendor (as noted above).

(q) Intervention Codes

Intervention codes are again CPhA codes that cover DUR intervention procedures or identify special coverage/payment rules.

The use of intervention codes is described in the appropriate sections of this manual.

Please note that the pharmacist ID is mandatory.

Only two intervention codes will be accepted on a single transaction.

Common Intervention/Exception Codes

Code	Description
DH	Rx synchronized pursuant to rule 19
DW	Applied to provincial plan and rejected
DX	Applied to provincial plan, decision pending
DY	Not eligible for provincial plan coverage
ER	Override days supply limit for period
MH	Override prescriber ID (if practitioner prescribing privileges have been suspended or restricted – the override should not be applied)
MK	"Good faith" emergency coverage established
MM	Replacement claim, drug cost only
MN	Replacement claim due to dosage change
MO	Valid claim value of $500.00 to $999.99
MP	Valid claim of $1,000.00 to $9,999.99
MQ	Valid claim-quantity over limit
MV	Vacation supply
MY	Long term care Rx split for compliance
NF	Override – quantity appropriate
NH	Initial Rx program declined
SW	Rejected by provincial plan. Bypass other programs
SX	Pending provincial plan. Bypass other programs
UA	Consulted prescriber and filled Rx as written
UB	Consulted prescriber and changed dose
UC	Consulted prescriber and changed instructions for use
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 source. Rx filled as written
UD	Consulted prescriber and changed drug……To Reverse Claim
UH	Counseled patient. Rx not filled……To Reverse Claim
UK	Consulted other sources. Rx not filled……To Reverse Claim
UL	Rx not filled. Pharmacist decision ……To Reverse Claim

5.7 Initial Days Supply for New Prescriptions

To reduce drug waste associated with unused medication; all **new** prescriptions for GSC drug benefits will be limited to an initial 30-day supply.

If a GSC plan participant has not received a prescription for an identical drug within the last twelve months (filled at any pharmacy), the prescription will be considered new. If the days' supply submitted on the initial prescription is greater than 30 days, the claim will be rejected. It may then be resubmitted for a reduced days' supply.

If such a claim is rejected, the pharmacy will receive a response message "**OF – initial Rx days supply exceeded.**"

Changes in dose (e.g., levothyroxine 0.1mg to levothyroxine 0.125mg) and changes in brand (e.g., generic substitution) are **not** considered brand new prescriptions.

This program will apply to all GSC plans. However, there are situations in which such a quantity reduction may not be appropriate. Pharmacists are encouraged to use their professional judgment in these cases. For example:

- The patient has received physician samples sufficient to constitute a reasonable trial of the new drug.
- The drug was initiated and the patient stabilized in a hospital or institutional setting.
- The patient is a new GSC plan participant who is already established on the new drug.
- The patient is vacationing and will be unable to receive the balance of the prescription.

If the participant has such a reason to opt out, then the pharmacist must document the reason on the prescription. An intervention code of "**NH – Initial Rx program declined**" may be used to override.

If a claim is resubmitted with a reduced days' supply but without a corresponding reduction in quantity, the claim will also deny with the response code "**OC – Quantity reduction required**." If it is not possible to further reduce the prescribed quantity, the intervention code "**NF – Override-quantity appropriate**" may be used to override.

All drug molecules will be affected by this program, with the exception of insulin. In addition, some individual products will be excluded where the smallest package size constitutes a supply greater than 30 days (e.g., *Didrocal*). Prescriptions for less than a 30-days' supply will not be affected.

5.8 Initial Days Supply for High Cost Drugs

This policy applies to oral drugs that are considered high cost. An initial maximum 10-day supply is allowed. Once it is determined that the patient can tolerate the drug, a maximum supply of 30 days can be filled for each subsequent refill.

The intent of this initiative is to prevent wastage, promote adherence, and encourage safe handling and storage of these sometimes hazardous agents.

5.9 Maintenance Medication Fill Limits

GSC will limit the number of fills to five per year for maintenance drugs included in the list published on the providerConnect® website. Claims for drugs deemed to be maintenance will be denied if dispensed for less than a three-month supply; the response code from the GSC system for these claims will be: "DR = days' supply lower than minimum allowable." The use of an applicable intervention code will be allowed in individual situations where dispensing of a three-month supply may not be appropriate at that time. Use of the intervention codes listed below will be subject to audit and must be supported with relevant documentation on the prescription hard copy.

ER = *Override days' supply limit for period*
MN = *Replacement claim due to dose change*
MY = *Long term care Rx split for compliance*
DH = Rx synchronized pursuant to rule 19

For patients requiring ongoing, more frequent dispensing – due to a cognitive impairment or other issue – an exception request form (available on GSC's providerConnect® website) must be submitted outlining the clinical rationale supporting the request. GSC's pharmacy team will review the request, and where appropriate, grant an exemption to the policy. Requests for exemptions should be based on sound clinical reasoning.

5.10 Refusal to Fill

GSC will reimburse pharmacies for "refusals to fill." Pharmacists have always had the right/responsibility to refuse to fill certain prescriptions based on their professional judgment. Some examples of reasons to refuse to fill a prescription include:

- Therapeutic duplication (drug may not be necessary)
- Sub-optimal response (drug is not producing desired result)
- Adverse drug reaction
- Dangerously high dose
- False/altered prescriptions

Necessary requirements that should be documented and available for audit include:

- Dialogue between the prescriber and pharmacist
- Outcome
- Communication with the patient explaining the outcome of the dialogue between prescriber and pharmacist

The following situations will *not* be accepted for reimbursement:

- Medication not in inventory (i.e., backordered)
- DUR responses (i.e., fill too soon)
- Changing the prescription to an eligible benefit

Billing a claim for 'Refusal to fill'

- Enter the DIN of the drug involved into the dispensary software system as currently done when filling a prescription.

- The value "**1**" needs to be entered in Special Service Code field, the Quantity field, and the Days Supply field.
- $22.00 needs to be entered into Special Service Fee.
- Adjudicate the claim.

Notes

- Compensation will only be provided for GSC-adjudicated claims where GSC is first payor. There will be no coordination with similar provincial plans.
- This program is only available through Online Adjudication or a Deferred Drug Plan, where pharmacy providers receive the payment of the claim. Manual claims will not be paid.

Please keep supporting documentation in a readily retrievable manner as claims can be audited by the GSC Benefit Utilization Department and payment reversed.

5.11 Codeine and Hydrocodone Products for Children

Health Canada guidelines state that children under 12 years should not be given codeine-containing products. As well, children under six years should not be given hydrocodone containing products. As a safety precaution, if a pharmacy submits a codeine-containing product and the child is less than 12 years of age OR a hydrocodone-containing product and the child is less than six years of age, a response code "KR – Patient not eligible for product" will be returned. If the pharmacist has consulted the prescriber and the prescription is to be filled as written, then an override code "UA – Consulted prescriber and filled Rx as written" can be used.

6. PLAN ELIGIBILITY & POLICY INFORMATION

6.1 Limitations

(a) Common Exclusions Under Most Plans

- Diaphragms, condoms, contraceptive foams and jellies, or appliances normally used for contraception
- Natural Health Products (NPN), e.g., oral vitamin products, herbals, and homeopathic products
- Cosmetic products
- Atomizers, appliances and prosthetic devices, and/or diagnostic monitoring equipment
- Drugs and/or devices that are or may be classified as experimental in nature, or for which Notice of Compliance has not been issued or has been revoked
- Products that do not have a DIN
- Biological sera, preventive immunization vaccines, or injectables that are not prescribed or administered by a qualified medical practitioner, or injectables that are supplied under any federal, provincial, or municipal health program.
- Prescriptions that the patient is eligible to receive under the Workplace Safety & Insurance Board
- Prescriptions reimbursed from a federal, provincial, or municipal agency or foundation

- Prescriptions due to a motor vehicle accident
- Any medication that the patient is eligible to receive under various provincial drug benefit plans

(b) Fertility Drugs
GSC has groups with restrictions on the usage of fertility drugs. Fertility drugs include follicle stimulating hormone and luteinizing hormone (i.e., Pergonal®), nafarelin (i.e., Synarel®), cetroelix (i.e., Cetrotide®) and others. Some groups with this limitation may offer coverage for fertility drugs through reimbursement only. The plan members have been advised that prescription claims for fertility drugs must be paid and refunded through reimbursement. These claims cannot be submitted directly by the pharmacy. A receipt should be issued and the patient may submit the paid account to GSC for processing.

Other groups may have maximums placed on fertility drugs that may not apply to other therapeutic classifications in their plan.

(c) Annual Drug Maximums
GSC has groups with an annual dollar maximum on their drug plan. Once the patient has exceeded this dollar amount, any claims exceeding this maximum are the responsibility of the patient.

(d) Oral Contraceptive Quantities
For plans that have oral contraceptives as a benefit, it is permissible to dispense up to a 90-day supply on a single prescription. Only 13 packs per year are permitted. Quantities exceeding this amount will be reduced to the maximum allowed. Some plans may have exceptions to this.

(e) Smoking Cessation
GSC has standard limitations for smoking cessation products. Plans where smoking cessation products are eligible, (i.e., patches, gum, sprays, and lozenges) utilization will be limited to one three-month supply of patches and one three-month supply of gum per year, to be used consecutively, but not simultaneously.

This means that a patient, if eligible, may receive 98 patches, 1050 pieces of gum, 4200 buccal sprays, OR 1232 lozenges per year, based on the first claim date. Bupropion (e.g., Zyban®) and varenicline (e.g., Champix®) tablets are limited to 168 tablets per year.

These limits may vary based upon the request of the plan sponsor.

GSC offers a comprehensive Smoking Cessation Program whereby smoking cessation products are linked with cognitive services provided by qualifying pharmacists. Prescription smoking cessation medications are eligible benefits, and pharmacies are reimbursed for their services. Some clients have chosen to include this program as part of their offering. Further information can be found on our website at: www.providerconnect.ca/SmokingCessation/Intro.aspx

(f) Vaccines

Vaccine coverage is coordinated with the various provincial and territorial public health agencies. Vaccines are given by public health according to a dosage schedule based on age and gender. At specified age ranges certain vaccines may not be covered by GSC if the individual is able to obtain it from public health. A list of vaccines covered by public health is available from each provincial or territorial health ministry and also from Health Canada.

The coverage of vaccines by GSC will be determined by a number of factors and may include public health policies, age, gender, and vaccine duration of effect.

(g) Methadone for Substance Abuse

Methadone is to be dispensed using a commercially available product (i.e., Methadose®, Metadol-D®) and the quantity dispensed must be adjudicated in milliliters (mL). Which commercial product to use is based on the clinical indication of that product's drug monograph. Either one total claim or multiple claims on a single day may be submitted as follows:

- A total of seven claims (where each claim represents one day of treatment) may be submitted per patient on a single day. Subsequent claims in the same day will deny as duplicate claims.
- A usual and customary dispensing fee will be paid on the first (witnessed dose) claim each day.
- Claims for carries will be adjudicated in accordance with GSC's substance abuse treatment payment schedule.
- Each patient receiving methadone is restricted to 365 doses per year.
- Should you not wish to submit multiple claims per day, one claim of up to seven days may be submitted for the total quantity dispensed.

NOTE: Commercially available methadone products may not be submitted as a compound.

In certain provinces, methadone stock solution can still be compounded. If that is the case the following may apply until there is a change in that province's or territory's regulation:

- Only one methadone claim per day may be submitted. However, the claim will pay for a maximum allowable fee AND a maximum allowable compounding fee. The compounding portion of the fee will be a direct function of the number of carries and will increase as the number of days' supply increases.
- For example, a three-day supply will pay COST + $9.89 + CMPD FEE, and a five-day supply will pay COST + $9.89 + HIGHER CMPD FEE. As stated earlier, the compounding fee will be adjusted to allow for the increase in the number of days supplied.
- Methadone claims are subject to audit based on our post-audit analysis of compounds. If the information submitted online does not coincide with our post-audit of methadone claims, your account will be adjusted accordingly.

(h) Methadone for Pain or Palliative Care
Methadone for pain or palliative care must be submitted using a commercially available product (e.g., Metadol®). Which commercial product to use is based on the clinical indication of that product's drug monograph.

(i) Buprenorphine for Substance Abuse
Claims for buprenorphine may be submitted as follows:

- A total of one claim per patient per dosage strength per day may be submitted. The claim should include the witness dose and carry doses. (E.g., for a claim of one witness and 13 carries, one claim of 14 doses for a 14-day supply may be submitted.) Subsequent claims of the same dosage strength in the same day will deny as duplicate claims.
- A usual and customary dispensing fee will be paid on the total claim.

(j) Diabetic Test Strips
GSC's test strip allowances for plan members are as follows:

- Non-insulin dependent diabetics are allowed 600 strips per year (from the first paid claim).
- Insulin-dependent diabetics are allowed 3000 strips per year (from the first paid claim).

6.2 Co-Payments and Deductibles

GSC plans have a variety of co-payment and deductible options.

A co-payment may be $0.35 per Rx, $1.00 per Rx, $2.00 etc. per Rx, it may be a 10%, 20% or 30% etc., per Rx, of the total Rx price. The co-payment may also be equal to the pharmacy dispensing fee, or be equal to the pharmacy dispensing fee less a specified dollar amount.

A deductible may consist of $10.00, $15.00, $25.00, $50.00 per person ($20.00, $30.00, $50.00, $100.00 per family) applied annually. This could be either once each calendar year or once each 12 consecutive-month period, beginning from the date of the first prescription in each period, or the effective date of the patient's plan.

The online system advises pharmacists of any applicable co-payments or deductibles. If there is a co-pay or deductible, this amount must be collected at the pharmacy.

NOTE: Provider Agreements prohibit balance billing any amount greater than the adjudicated co-pay, except in limited instances such as Mandatory Product Selection, Maximum Allowable Costs, etc.

6.3 Product Selection and No Substitution

When a prescribed product selectable drug is listed in a Provincial Formulary (e.g., Ontario Drug Benefit), it is eligible for **"product selection,"** with some exceptions (see below).

GSC reimburses the pharmacy at the lowest-priced generic as indicated in the provincial formulary. Some provincial regulations may vary slightly.

There are three standard options for payment based on product selection:

- A plan where either the physician OR patient can request “no substitution.”
- A “physician’s choice” product selectable plan which only allows the physician to request “no substitution.”
- A “mandatory product selectable plan” which only allows payment for the lowest price generic regardless of who requests “no substitution.”

When a physician, patient, or pharmacy indicates or requests **“no substitution,”** the following indicators must be entered in the appropriate “no substitution”/product selection field when submitting claims.

OLTP System	Explanation
1	■ Doctor no substitution
2	■ Patient no substitution
3	■ Lowest cost brand in the pharmacy inventory
4	■ Existing Therapy

6.4 Enhanced Generic Substitution (EGS)

Some plan members may be subject to EGS. Regardless of interchangeability, the maximum benefit will be limited to the cost of the lowest-price alternative generic drug. The current list of EGS drugs will be published regularly on providerConnect®. To get to the list, go to providerConnect.ca, then go to the menu option “What you Need.” Once selected, select “Pharmacy Provider” from the drop-down menu and this will take you to the pharmacy menu. There will be a link under Pharmacy Manuals named Enhanced Generic Substitution. This is where the EGS list can be found.

6.5 Frozen Formularies

GSC has groups with drug benefits frozen on specific dates. Any “new drug” introduced after that date will not be a benefit of the patient’s plan and will be their responsibility.

New drugs are defined as any ingredient(s) that received notice of compliance after a specific date OR has a new delivery system (e.g., *Spiriva® Inhalation Capsules* vs Spiriva® Respimat®).

Please note that a generic equivalent of a previously approved drug would not be considered “new,” but a *copy*, and would be a benefit. New drugs are chemicals not previously available for treatment.

If a claim is submitted for a drug that is not a benefit due to a frozen formulary, a response code of “D1” and a message “DIN/PIN/GP #/SSC not a benefit” will be received and the drug will be the responsibility of the patient.

6.6 Controlled Formularies

GSC has groups with drug benefits controlled at specific levels and any "new drugs" will be added only if they are included in the Ontario Drug Benefit Formulary. Drugs may become ineligible if less costly substitutes become available and are removed by the group. Any new drug not included in the plan is the responsibility of the patient.

6.7 Tiered Formularies

GSC has plans that have a tiered formulary. Drugs are grouped into tiers and assigned a different co-pay on each tier based on the tier the drug product is assigned to on the GSC system. Note that tiers can change at any time, and as such, the individual's reimbursement for a given drug can change with no notice. Notices are not sent out for tier changes.

6.8 Managed Formularies

GSC also has groups with formularies that include drug products that are benefits only if a patient fits specific medical criteria (exception drugs). If an initial claim is submitted for an exception drug, a response code of "DX" and a message "Drug must be authorized" will be received.

At this point, the pharmacist is able to go into the providerConnect® portal and print off the special authorization form the patient requires. To get there, go to providerConnect.ca, then go to the menu option "What you Need." Once selected, select "Pharmacy Provider" from the drop-down menu and this will take you to the pharmacy menu. There will be a link under Pharmacy Forms named Drug Authorization Forms. Click on this link to access the list of drugs that have special authorization forms that can be printed out.

Alternatively, the patient can be directed to log into their Plan Member Online Services website account to obtain the form.

This form is to be completed by the patient and physician and returned to GSC for evaluation. If approved, the claim may be submitted and will be accepted as any other drug claim.

6.9 Specialty Drug Preferred Provider Network

Some GSC plans will require plan members to obtain certain high cost specialty drugs from specific pharmacies in the preferred provider network (PPN).

If a claim is being adjudicated by a pharmacy not part of the network, the claim will be denied. The plan member must obtain the medication from the specialty drug PPN. As these medications require prior approval from GSC, the plan member will have received information on the PPN when approval was given.

6.10 Maximum Allowable Cost

The Maximum Allowable Cost (MAC) option sets a maximum dollar amount on the eligible portion of a prescription in a therapeutic class of drugs. The price of the most cost-effective drug in the class is used to set the eligible amount that will be reimbursed. MAC or Reference Based Pricing may be applicable in all provinces except Quebec.

Currently this option addresses only four high utilization classes of drugs with the possibility of more being added in the future:

- Proton Pump Inhibitors (PPIs) (Losec®, Prevacid®, Pariet®, etc.)
- HMG-CoA Reductase Inhibitors (statins)
- Angiotensin Converting Enzyme Inhibitors (ACEI)
- Angiotensin Receptor Blockers (ARB or ACE II)

Drug plans may have some or all of these MAC drug classes in their plan design. Other classes of drugs may be incorporated into this pricing arrangement over time.

6.11 Unscheduled Products and Natural Health Products

Drug products that are unscheduled by the National Association of Pharmacy Regulatory Authorities (NAPRA) are non-benefits of most GSC plans.

Products that are considered Natural Health Products and assigned a Natural Product Number (NPN) by Health Canada are non-benefits of *most* GSC plans.

6.12 Dispensing Fee

GSC will pay a professional fee for the dispensing of each prescription. In Ontario, it will be the lesser of the pharmacist's usual and customary posted fee or the GSC weighted average professional fee as determined by GSC. The provincial (base) fee will be used in other provinces. Pharmacies should register their usual and customary fees with GSC's Provider Records Department. In Ontario, each pharmacy's registered fee is used in the calculation of the GSC weighted average professional fee.

6.13 Dispensing Quantities & Fees Based on Days Supply

Prescription claims will be processed in the amount prescribed, up to a maximum of 100-days' supply. The allowed fee will be paid in accordance with the provincial fee schedules.

An exception to the above for vacation supplies will be allowed to a maximum of 183 days. GSC will reimburse fees for supplies exceeding 100 days to 183 days as follows:

Quantity	Fee that can be claimed
101-120 DAYS	1 1/3 Fees
121-150 DAYS	1 2/3 Fees
151-183 DAYS	2 Fees

Please note, to qualify for multiple dispensing fees, it is essential that the number of days' supply is indicated on the claim submission. If left blank, payment will be made based on one dispensing fee. In addition, the intervention code "MV" should be used to identify the claim as a vacation supply and as an exception to the standard 100-day supply limitation.

6.14 Ingredient Cost

The cost of ingredients is defined as the cost published or paid by any provincial drug plan, or the net cost price published by the manufacturer (manufacturer list price or MLP)

plus 10 per cent, or the wholesale cost price published by the manufacturer plus 12.5 per cent. GSC considers all other factors to be covered by the dispensing fee.

For Ontario only:
Brand-name drugs will be reimbursed at 15 per cent above manufacturer list price and generic drugs will be reimbursed at 10 per cent above manufacturer list price.

6.15 Maximum Time to Submit Claims

Claims can be submitted or reversed for online or manual processing for up to 12 months after the initial date of service.

6.16 Lost, Stolen, or Incorrect Use of Prescription Medicine

GSC considers the initial dispensing of a prescription to be the responsibility of the plan, and payment is made accordingly. However, it is the plan member's (patient's) responsibility to safeguard that medication against breakage, theft or damage, or incorrect use. The replacement of such medicine is the responsibility of the patient.

6.17 Deferred Payment Claims

The GSC Deferred Payment Plan requires the pharmacy to submit the claim online, the plan member pays the pharmacy, and then plan member receives reimbursement from GSC. The steps in this plan design are:

a) The pharmacy submits the claim online to GSC for adjudication.
b) The pharmacy will see a response code "QJRC" which stands for:
   QJ – Deferred payment; patient to pay pharmacists
   RC – Transmitted to insurer
c) The plan member pays the pharmacy in full.
d) The plan member's reimbursement will be processed by GSC on the fifth calendar day after the claim is submitted. A four-day hold is in place to allow the pharmacy to reverse the claim if needed.

It is important to note that individuals who have secondary coverage will have to wait for a claim statement to be issued by GSC before submitting manually to the secondary plan.

6.18 Specialty Provincial Drug Program Integration

GSC integrates benefits with specialty provincial drug programs that may be available in each province. Pharmacies should be aware of the programs available and ensure that claims are adjudicated through the provincial specialty program first for each plan member that qualifies for the program.

7. NON-SUBMISSABLE CLAIMS

7.1 Plan Member Reimbursement Only

GSC has plan member reimbursement only plans. Plan members enrolled in these plans must pay for their prescriptions and submit their claims directly to GSC for processing.

Pharmacies cannot submit claims directly to GSC for plan members with reimbursement only plans.

The usual computer generated prescription receipts are adequate for such claims. Claims for extemporaneous compounds must identify the ingredients.

8. PRESCRIPTION RECEIPTS FOR PATIENTS WHO PAY CASH

To assist your customers when they submit your prescription receipts for processing, please provide the following information:

- the dollar amount paid
- the drug name and DIN
- strength of medication
- quantity dispensed
- prescription number
- pharmacy name and address
- compound ingredients (if possible)

Please note that cash register receipts or copies of credit or debit card transactions alone are not acceptable.

9. CLAIMS SUBMISSION REVIEW

All prescription drug and medical equipment claims submitted must be authentic and accurate and relate to a product that has been dispensed to a plan member under an existing GSC plan. GSC reserves the right to audit or conduct a review of any claims submitted by a pharmacy or a service provider either before or after payment. This audit or review may include steps to obtain documentation or verification from either the pharmacy, plan member, or the service provider. Each pharmacy must therefore keep accurate and complete records that should at a minimum allow GSC to verify the identity and address of the plan member, the prescription, the equipment or supplies provided, the retail dollar amount, the date on which the request for the prescription, equipment, or supplies was provided, and the date on which the prescription, equipment, or supplies were dispensed to the plan member. If GSC determines during an audit or review of the submission that the claim as submitted cannot be verified, is not authentic, or is not accurate, GSC may reverse any payment made and credit the reversal against future amounts owed or seek re-payment. GSC will advise the pharmacy of the specific reversals and reserves the right to terminate direct or other submission privileges at any time.

APPENDIX I – Pharmacy Claim Submission Agreement

The Pharmacy Claim Submission Agreement is generated electronically on providerConnect®. Visit the website at providerconnect.ca and go to the menu option "Provider Registry." Once selected, select "Pharmacy" from the drop-down menu and this will take you to a fillable form. The complete website address is:

www.providerconnect.ca/ProviderEnrolment/PharmacyAccount.aspx

Fill out all the information requested on the form and click on submit. The system will generate a Provider of Service Agreement based on the information on the form. You will then be able to print out the agreement on paper.

APPENDIX II – PINs and PseudoPINs

Selected PINs and pseudoPINs are available from the providerConnect® website.

To get to the list, go to providerconnect.ca, then go to the menu option “What you Need”. Once selected, select “Pharmacy Provider” and this will take you to the pharmacy menu. There will be a link under Pharmacy Manuals called Frequent Used PINs for Billing Purposes. Click on this link to download the latest list.

APPENDIX III – Value-based Pharmacy

(Effective July 1, 2020)

GSC's Value-based Pharmacy reimbursement framework (VBP framework) focuses on quality of care. It will apply only to pharmacies that have earned a year-end Pharmacy Quality Rating (Quality Rating), which is published every March, and will tie the Quality Rating to pharmacy reimbursement. The Quality Rating is available to pharmacies and plan members through our secure online services platforms. Pharmacies that do not achieve a Quality Rating during any given Performance Period (as defined below) will continue to be paid according to the existing reimbursement framework in place.

The VBP framework is based on a 12-month cycle and is tied to defined periods of performance measurement – known as the Performance Period – that will in turn impact reimbursement for defined periods of time – known as the Reimbursement Period. Pharmacies achieving a Quality Rating in any given Performance Period will see their payments adjusted by a pre-specified percentage during the corresponding 12-month Reimbursement Period. Adjustment percentages will be reset annually and communicated to pharmacies by way of a Pharmacy Update that will be sent every March before the next Reimbursement Period takes effect.

Statements will show information regarding the VBP Adjustment Amount applied and the Adjusted Payment Amount issued for pharmacies that have a Quality Rating and that are subject to the VBP framework during a specific Reimbursement Period. For lower-rated pharmacies, a negative adjustment will be applied to each payment that falls during the corresponding Reimbursement Period, while a positive adjustment will be applied for higher-rated pharmacies. Where a negative adjustment is applied, a safeguard has been built into the calculation to protect estimated drug acquisition costs and to ensure the overall reimbursement per statement is never below that cost.

GSC's VBP framework will operate through a dedicated pool of funds called the Pharmacy Performance Pool (the Pool). Higher performing pharmacies will be reimbursed additional bonuses withdrawn from the Pool while lower performing pharmacies will contribute to the Pool. The activity of the Pool, including the amounts withheld and bonuses paid, will be reported to the pharmacy community annually to ensure complete transparency and accountability.

Further details about GSC's VBP framework and specific up-to-date information regarding reimbursement can be found on providerConnect®. Go to the menu option "What You Need." Then, select "Pharmacy Provider" from the drop-down menu and this will take you to the pharmacy menu. All information for "Value-based Pharmacy" is available there. The website address for the pharmacy menu is:

https://www.providerconnect.ca/AdminContent/Forms.aspx?type=pharmacy

NOTE: The VBP framework may be amended from time to time at GSC's sole discretion.