9. BILLING THE PROGRAM PLANS

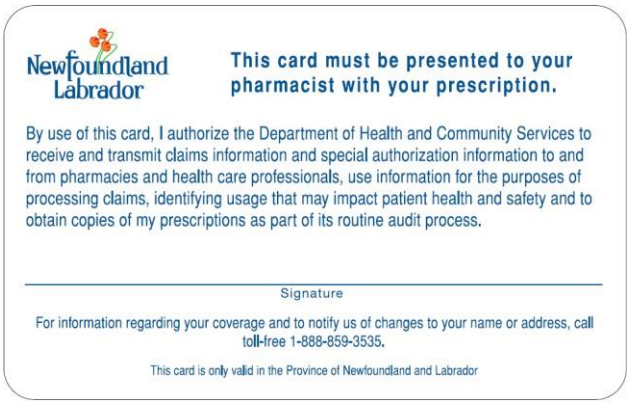
The Program will receive claims and claim reversals through two submission mechanisms:

1. Real-Time Claim Submission and Adjudication;

2. Paper-Based Claim Submission.

9.1 Client Identification

Cards are issued on an individual basis, with one card and card number per Beneficiary. The same card is used for all Program plans and the cards do not contain specific plan or eligibility information (e.g., coverage dates, co-pay rates et cetera). These details are managed in the Program system and changes are communicated in writing to the Beneficiary through Beneficiary Eligibility Confirmation letters from the Program. The Program card contains the: Cardholder Name (First Name, Surname), Date of Birth, Gender, and Card Number. The following figures show the format of the card.



The card number (also referred to as Provincial Health Number – PHN) is the Beneficiary MCP number, which is the primary identifier.

When the eligibility information for a Beneficiary changes, a new card is not issued – the Program card is a permanent card that relies upon the Program system to assess claims based on the most up-to-date eligibility data for the Beneficiary.

9.2 Claim Information for On-line Adjudication

The Program accepts three specific types of transactions through its real-time claims adjudication system:

- Claim Submission (CPhA Type ’01’ transaction);
- Claim Reversal (CPhA Type ’11’ transaction);
- Daily Reconciliation Report (CPhA Type ‘30’ transaction)

Claim Submission

The following general rules apply in submitting a claim:

- The claim submission must use the CPhA v3 “01” transaction;
- The Program coverage within the claim must be set to ‘AUTO’;
- Original claims can be submitted up to 90 days following the dispensing date; resubmissions for previously submitted but rejected claims can be submitted up to 1 year following the dispensing date;
- Any Drug Utilization Review (DUR) results must be managed in accordance with CPhA V3 standards (see Appendix E for additional information on DUR actions and messaging).

Appendix F describes the specific information to be provided for a real-time claim. Fields referenced with “must” are considered mandatory on a claim submission.

9.3 Prescriber Numbers

All claims submitted to the Program must be ordered by a Prescriber and have a supporting prescription. However, the Program will also cover prescriptions written by:

- a Nurse Practitioner as long as the prescription is in keeping with direction given by the Newfoundland and Labrador Pharmacy Board (NLPB) regarding Nurse Practitioners’ Prescriptions.

- a Dentist as long as the prescription is in keeping with direction given in the *Dental Act, 2008.*

- an Optometrist as long as the prescription is in keeping with the direction set by the *Diagnostic and Therapeutic Drug Regulations* under *the Optometry Act, 2004*.

- A Pharmacist as long as the prescription is in keeping with the direction set by the *Authorization to Prescribe Regulations* under *The Pharmaceutical Services Act, 2012*.

Claims billed under the Program must have an identification number for the Prescriber.

PHYSICIAN

The physicians' Prescriber numbers start with an "F", "P", "R", "L", "M" followed by a leading zero along with their unique number. Please be advised that there are exceptions whereby this does not apply. Physicians who have left the province, retired or deceased within the current year do not require a leading zero.
e.g., F01234 (current active physician)
e.g., F1234 (non-active physician)

NURSE PRACTITIONER

The nurses' Prescriber numbers start with an "N" followed by a leading nine along with their four unique numbers. No leading Zero. e.g., N91234

DENTIST

The dentists' Prescriber numbers start with a "D" followed by a leading eight along with their four unique numbers. No leading Zero. e.g., D81234

OPTOMETRIST

The optometrists' Prescriber numbers start with a "T" followed by a leading seven along with their four unique numbers. No leading Zero.
e.g., T71234

PHARMACIST

For the pharmacist exercising Medication Management, the number is the NLPB License Number.
e.g., 12345 – minus the dash between the second and third digits

9.4 Response Codes

9.4.1 Drug Utilization Review

The Program system performs a number of Drug Utilization Review (DUR) checks on a claim. These DUR checks look for a number of potential problems with the medication billed in the claim, such as possible drug interactions or dosing errors. If a problem is detected during the DUR a warning or alert is returned using a standard CPhA response code and message, and in many cases the Provider may re-submit the claim with an acceptable CPhA Response/Intervention Code (Please ensure you have adequate documentation on the beneficiary file to support use of the Response/Intervention Code). Appendix E lists the standard DUR messages that may be returned by the Program system, and the appropriate Response/Intervention codes that may be used for each message. Use of any response code other than a designated code will result in a claim being rejected.

9.4.2 Adjudication Messages

When a claim is adjudicated within the Program system, messages are returned with rejected claims indicating the nature of the problems that occurred or adjustments that were made in the adjudication process. These responses are standard CPhA response codes. Appendix H describes the business rules used by the Program for the adjudication of claims, while Appendix E lists the standard response codes used by the Program system and possible causes for each message.

9.5 Adjustments

A benefit claim may require a reversal (e.g., if a previously recorded dispense was not filled or picked-up by the Beneficiary). The following general rules apply to reversals:

- Reversals are performed using the CPhA v3 “11” transaction;
- Medications not picked up by the Beneficiary must have the full cost of claims reversed to NLPDP and returned to stock (if medication can be returned to stock, for example: a compounded prescription product cannot be returned to stock) within thirty (30) days of the service (dispensing) date;
- Reversals due to billing adjustments must be done within twelve months of the dispensing date;

- Resubmissions of reversed and subsequently corrected claims must be done within twelve months of the dispensing date; and

- All billing adjustments require the reversal of the original dispense and resubmission of the corrected dispense using the original dispense date.

With regards to the submission of claim reversals, the submitted reversal must conform to the following:

- The reversal must use the adjudication date as supplied by the Program system on the claim being reversed;
- Must use the same New/Refill Code value as originally submitted;

- Must use the same Original Prescription Number value as originally submitted;

- Must use the same Refills / Repeats value as originally submitted;

- Must use the same Current Prescription Number value as originally submitted; and

- Must perform the reversal within twelve months of original adjudication date.

9.6 Payments and Statements

The Program system supports the request and delivery of an Accumulated Daily Totals report, providing a summary of transactions adjudicated on a given day for that particular Provider.

9.6.1 Payment

Electronic Claims Payment – Paper Claims

Payment occurs every second Thursday with a cut-off on the Wednesday of the week prior to the payment run date. This will include claims keyed up to the end-of-day on Wednesday. The payment statements will be available for retrieval the following Monday after paymentElectronic Fund Transfer and manual cheques are released the following week after cut-off.

Electronic Claims Payment – Real Time

Payment occurs every second Thursday with a cut-off on the Wednesday of the week prior to the payment run date. This will include claims

submitted up to the end-of-day on Wednesday. The payment statements will be available for retrieval the following Monday after payment.

The transmission system will provide rejected claim details (with appropriate error codes) at time of transmission. This will make it possible for the Provider to correct the submitted claim and re-submit.

Payment Statements – Online

After the payment run is complete the Payment Statement file is made available electronically. Providers are able to connect and pick up this file at their convenience. The information on this file is in the format of a transaction file rather than a textual file. The file could be used to automatically reconcile paid claims to claims submitted, however; it is the Provider's responsibility to provide the appropriate software. Providers who have chosen to use electronic claim submission receive their remittance advice only in electronic form. No paper copies are provided except in special circumstances. It is recommended that Providers retrieve their payment statements from the servers within a reasonable time period for reconciliation. In an effort to maintain space capacity, data files are purged every 45 days. Consideration can be given to the restoration of files on a case by case basis.

The Payment Statement contains a header record, a detailed payment record and a reject record. This file contains the total number of claims paid and the dollar amount for the date specified. In addition, this file also lists a breakdown of the number of claims paid along with the amount paid to each plan.

Payment Statements – Paper Claims

Paper based Providers can download their statement electronically and payment is sent by EFT.

Policy Amendment History

	Effective Date
Original Policy	November 30, 2011
Revision # 1	June 18, 2020