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<th>Version</th>
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<td>• Updates to FNHA Client Eligibility section, FNHA Submitting Supporting</td>
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<td>Documentation section</td>
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1.0 Introduction

Thank you for being a part of Pacific Blue Cross’s network of Providers. Together we can help improve the health and wellbeing of British Columbians. As part of our commitment to service, Pacific Blue Cross publishes this reference guide to assist Providers with submitting claims on behalf of Members.

It is important that you read this guide and become familiar with its contents. Every time a claim is submitted to Pacific Blue Cross, it indicates your understanding of, and agreement with the terms, conditions, and guidelines set out in this guide.

Icons

Icons have been added throughout this document to highlight content. They are:

- New Icon Information has been added/updated.
- Important Icon Important information to benefits or submission requirements.

There is a Glossary in the Appendix that outlines terms specific to this Reference Guide.

2.0 About Pacific Blue Cross

Pacific Blue Cross, a not-for-profit company, has been British Columbia’s leading benefits Provider for over 70 years. Our comprehensive understanding of changing health care needs fuels our commitment to service.

Pacific Blue Cross is an independent, not-for-profit organization. Because we're not-for-profit, our resources are used to serve stakeholders, not stockholders. This means any financial surplus we generate is completely reinvested into the business for the current and future benefit of our Members.

Together with BC Life, our subsidiary, we provide health, dental, life, disability, and travel coverage to nearly 1.4 million British Columbians through employee group plans and through individual plans for those who do not have coverage with their employer. Pacific Blue Cross and BC Life continue to respond to customers’ needs in plan design, administration and technology.

Contact Us

Local (Within Metro Vancouver): 604-419-2000
Toll-Free: 1-877-PAC-BLUE
Website: providernet.ca
3.0 Blue Cross Plans

This guide has been structured to assist you in submitting claims for Pacific Blue Cross Members. Before you submit claims for our Members, we want to inform you about the different Blue Cross Plans. Some plans are controlled by Pacific Blue Cross while National Blue Cross plans may be controlled by any one of the Canadian Blue Cross carriers. It is important to understand these differences, when applicable.

3.1 Plans

Pacific Blue Cross administers many different types of plans that can be classified into three broad categories:

1. **Employer/Association-Sponsored Plans**: These are group plans sponsored by employers, unions, associations, or trusts, that provide benefit coverage for their Members.

2. **Individual Health Plans**: These are plans purchased by individuals in British Columbia and the Yukon where group coverage is not available. Individuals may be self-employed, without employer benefits, choose to supplement their employer’s benefits, or retired.

3. **Government-Funded Plans**: These are plans for individuals in British Columbia and the Yukon that are funded by a government program. Examples of government-funded plans are:
   - **First Nations Health Authority (FNHA)** provides coverage for its clients. As of September 16, 2019, Pacific Blue Cross will administer medical supply and equipment, vision, hearing, dental and some pharmacy claims on their behalf.

Please refer to the First Nations Health Authority sections in this guide for further information.
4.0 Identifying Blue Cross Members

4.1 Overview
There are different types of identification that you can use to verify that a customer is covered by Blue Cross. Members are to present their identification cards prior to receiving the good or service from the Provider.

4.2 Pacific Blue Cross Identification Cards
A Member’s Pacific Blue Cross card is a single-sided paper card that is the size of a bank card.

Pacific Blue Cross identification cards refer to the Member’s Group ID as a policy number, which is a unique number assigned to each participating company or group (plan sponsor). The Client ID is listed next on the card as the Identification Number and is unique to the Member. The same Group and Client ID should be used for each Member of the family.

In some instances, a third party administers employee benefits on behalf of Pacific Blue Cross and may issue their own wallet-sized card (e.g. student plans). In these cases, the Pacific Blue Cross logo does not appear on the card; however, Pacific Blue Cross is listed as the carrier (insurer). These cards should also be accepted as valid cards.

4.3 Status Cards
First Nations Health Authority (FNHA) clients use their Certificate of Indian Status (Status Card) as their identification card. As of September 16, 2019, eligible claims for FNHA clients can be submitted to Pacific Blue Cross as follows:

FNHA Group ID: 40000
FNHA Client ID: Status Number

For further information on about FNHA client identification and eligibility see the FNHA Section of this guide.
4.4 National Blue Cross Identification Cards
A Member’s National Blue Cross card is double-sided and plastic, similar to bank cards but without raised lettering. The design of these cards is consistent across all regions. Customers have the option of an English or French card, based on the Member’s preference.

Blue Cross Contact Numbers
Local (British Columbia): 604-419-2381
Toll Free: 1-888-873-9200

Card information includes: Member’s name, ID number, and policy number.

Note: Member and dependent Client IDs are listed on the back of the card. Please ensure that the correct Client ID is being submitted when submitting for a dependent under the plan.

As part of the Canadian Association of Blue Cross Plans, Pacific Blue Cross processes drug claims for Members of national clients in British Columbia and Yukon.

National drug claims are transmitted in a similar manner as standard Pacific Blue Cross groups. The table below summarizes the differences in adjudication between Pacific Blue Cross plans and National Blue Cross plans:

<table>
<thead>
<tr>
<th></th>
<th>Pacific Blue Cross Plans</th>
<th>National Blue Cross Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reversal of a Claim</td>
<td>PBC claim reversals can only be done within one year of the claim being billed.</td>
<td>National claim reversals can only be done within 30 days of the claim being billed.</td>
</tr>
<tr>
<td>Payment Method</td>
<td>Payment and claim statements are produced weekly for PBC claims.</td>
<td>Payment of National claims is every two weeks on a separate PBC statement.</td>
</tr>
</tbody>
</table>

Note: The above table applies to pharmacies in all provinces with a PBC Pharmacy Agreement for claims submitted for Pacific Blue Cross plans, and, BC & YK Providers with a PBC pharmacy agreement for claims submitted for National Blue Cross plans.
5.0 Becoming a Pacific Blue Cross Provider

5.1 Overview
Becoming a Pacific Blue Cross Provider allows you to submit claims to Pacific Blue Cross on behalf of your patients. This helps increase your customers’ convenience and satisfaction and increases your business’ efficiency.

All applications to become a Pacific Blue Cross Provider are reviewed for Provider-specific requirements.

Pacific Blue Cross reserves the right to determine who is eligible as a Provider.

5.2 Qualified Staff
The Provider verifies that their staff are duly registered under the laws of their province or territory to practice (if applicable); or they are qualified for the given purpose and having complied with specific requirements (if applicable).

The Provider agrees to advise Pacific Blue Cross as soon as reasonably possible if:
- their qualified staff are no longer in their employment, or
- their duly registered staff are no longer registered to practice with their regulatory college, or
- their duly registered staff have limits or conditions placed on their registration.

Pacific Blue Cross will not pay (or will recover payments through an Audit) for services rendered by a Provider whose staff:
- are not appropriately qualified or duly registered to practice,
- provide services outside of their scope of practice,
- contravene any applicable Provincial or Federal legislation, or any generally accepted standards of practice established by the Provider’s Association or College,
- provide services outside of any limits and conditions on their practice.

5.3 Pacific Blue Cross Pharmacy Agreement
The Owner or Director of Business, or the President/Signing Authority for a Chain are required to sign our Pharmacy Agreement prior to claims being transmitted.

Note: A change of ownership will require re-application and signing of a new agreement.
5.4 How to Register as a Pacific Blue Cross Pharmacy Provider

Visit providernet.ca for the application form for new registrations.

To begin the registration process follow the prompts. It’s important that all information be accurate and complete so that there are no delays.

Before submitting your application, ensure that you have the following attached:

- A current copy of the operating permit
- Pharmacy accreditation number
- Name of the business owner

For Providers, a list of resources are also available on our website including:
- FAQs
- Client-Specific Fee Supplements
- Registration Checklist

Pacific Blue Cross will review your application.

- If your application is successful we will issue you a Provider ID. This ID is unique to your store. Each location of a chain store requires its own Provider ID.
  - Your Provider ID and temporary password will be sent to the email you provided on your application. You will then need to activate your account in PROVIDERnet. This is explained further in Section 6.3.
- If your application is denied, you will be emailed the reason and may re-apply (if applicable).

5.5 Helpful PROVIDERnet® Terminology

As you are going through the application process, there may be some terms that are not familiar to you, or terms that are used in a very specific context. To assist you in the application process, we have outlined these terms here.

**Business owners** must agree to the terms and conditions stated in the Pacific Blue Cross Pharmacy Agreement. Business owners acknowledge accountability for any claims submitted, by licensed healthcare professionals, duly registered staff, qualified employees, subcontractors, or independent contractors working at their store, and paid to themselves or their business by Pacific Blue Cross.

**Primary Administrator:** A person who has access to add/edit banking information and who also has access to electronic claim statements through PROVIDERnet

Examples: Office manager, owner, front desk staff (if applicable)

**Provider:** This refers to the physical store.

Examples: Pharmacy on Main Street, Total Pharmacy, 123 Pharmacy on 2nd Avenue
Effective October 2019

**Standard Administrator**: This is an optional secondary account to the Primary Administrator account; they do not have access to updating banking information and cannot view claim statements.

Examples: Front desk staff, any staff member

⚠️ **Key Points**

- Primary Administrator and Standard Administrator email addresses **must be unique**. This is because each email address is linked to an access profile.
- Web accounts that are not in use for six months are automatically deactivated for security; you will have to call us at 604-419-2000 or 1-877-PAC-BLUE to reactivate your account.
6.0 About PROVIDERnet

6.1 Overview
All approved Pacific Blue Cross Providers will be given access to PROVIDERnet.

PROVIDERnet is a comprehensive website that is designed for Pacific Blue Cross Providers. It includes access to current and past communications and resources. You can sign up for direct deposit, electronic statements, and keep your information up-to-date simply by visiting providernet.ca.

6.2 Technical Requirements
Using PROVIDERnet is simple, easy and secure.

Visit pac.bluecross.ca/browsers for detailed information on web browser requirements and tips on connection and screen resolution.

6.3 Activate Your PROVIDERnet Account
Once your application has been approved, you will receive an email that includes your Provider ID.

To activate your web account, click on the activation code in your email.
Enter your Provider ID and the Account Activation Code you received in your email.

Create your password and challenge questions.

Read the User Agreement and Privacy Policy, then click the I accept the User Agreement and Privacy Policy checkbox.

You have successfully created your account and will be sent a confirmation email.
6.4 Administer User Accounts

PROVIDERnet has two types of user accounts for pharmacies:

1. Primary Administrator
2. Standard Administrator

The Primary Administrator can set up a Standard Administrator. Generally, the Primary Administrator is the owner or director of the pharmacy, whereas the Standard Administrator may have an administrative function within the pharmacy.

Select Account > Administer User Accounts > Create New User Account

Enter First Name, Last Name and Email of the person you want assigned to that role.
Select Role either Primary Administrator or Standard.

Key Points
- Each pharmacy must setup its own web account.
- The Primary Administrator is the accountable person for the pharmacy account and is responsible to set up web accounts for others in your pharmacy.
- When staff leave the pharmacy it’s important to terminate their web account.
- Web accounts that are not in use for 6 months are automatically deactivated.
- When you sign up for direct deposit you will only receive electronic statements.

Note: Remember to reapply if there a change of ownership at your Pharmacy.
6.5 Set Up Direct Deposit
Setting up Direct Deposit can only be completed by the Primary Administrator.

Note: To ensure privacy and security, Pacific Blue Cross staff cannot set up direct deposit information. This is a self-serve function only.

Navigate to the Account tab menu option and select Payments > Direct Deposit
Select Update Direct Deposit Info and follow the prompts to add your business’ banking information.
Read the Terms and Conditions before you click save.

Note: Pharmacy Providers can only have one bank account attached to each Provider location.

6.6 Keeping Your Information up to Date
It is your responsibility to keep your records with Pacific Blue Cross up to date. Please ensure that you notify Pacific Blue Cross in the event of any changes to ownership within 7 business days before the change is to occur.

To update your information, visit providernet.ca and click EXISTING PROVIDERS > PHARMACY > Account Management > Make UPDATES to your account for the following:
• Close Pharmacy
• Change of Ownership
• Change of Address
• Change of Operating Name

6.7 Forgot Your Password?
If you have forgotten your password to log in to PROVIDERnet, go to the login page and select Forgot your password?

Enter your Provider ID Number and email address, then click Continue.
You will be prompted to answer one of your challenge questions. After successfully answering your challenge question, a temporary password link will be sent to the email address associated with the account.

Now you can log in to your account and update your password.

**Note:** *This temporary password is only active for 24 hours.*

---

### 6.8 Claim Statements

Once you sign up for direct deposit, you will automatically switch from paper to electronic statements. An email will be sent to the Primary Account holder’s email address to advise you when the statement is ready to view in PROVIDERnet. To access your PDF statement:

Click on the **Claims** tab, then click **Claim Statements**.

Use the **Published** date range to search and then click **Retrieve**.

Click **View** to open the PDF claim statement.
7.0 Claiming Procedures

7.1 Overview
Prior to submitting claims to Pacific Blue Cross, there are several key claiming guidelines. The Provider will submit claims in accordance with the criteria in this Pacific Blue Cross Reference Guide, alongside the criteria of the applicable Fee Guides/Schedules/Supplements for specific plans that Pacific Blue Cross administers or may participate in (e.g. FNHA).

7.2 Network Connections
BlueNet® (All Canadian Pharmacies)

BlueNet is a free, real-time response system available for pharmacies to transmit claims electronically to Pacific Blue Cross.

To access BlueNet, you need a computer that has software from your pharmacy software vendor. Your IP address from your computer location is required. If you aren’t sure what your IP address is, your internet service Provider can provide you with that information.

Connections to Pacific Blue Cross systems are secured. Data stored at Pacific Blue Cross is accessible only to individuals who are authenticated and authorized to access the information.

BlueNet is available system is available from 5 a.m. to midnight, Pacific Time, seven days a week, including statutory holidays.

Pacific Blue Cross reimburses eligible claims, subject to plan deductibles, maximums, and limits, at the applicable plan percentages indicated in the Member’s plan design.

Your pharmacy can electronically transmit prescription drug claims and certain diabetes supplies (insulin, testing strips, lancets and syringes) for Pacific Blue Cross and National Blue Cross Members.

Note: Medical Supplies & Equipment can be submitted through BlueNet only for First Nations Health Authority clients at this time.

Please note: Claimstream (Pharmacies East of British Columbia and the Yukon)
Pacific Blue Cross uses the Claimstream network for all provinces and territories east of British Columbia and Yukon. Claimstream is a Canada-wide network that enables the secure electronic transmission of pharmacy claims from Providers to benefit carriers for real-time adjudication. Claimstream is an initiative of Alberta Blue Cross that is jointly supported by Pacific Blue Cross.

Claimstream is designed to be transparent to health service Providers. If you are transmitting electronic claims to Pacific Blue Cross from anywhere in Canada, your software should show Pacific Blue Cross in your benefit carrier dropdown menu. If this is not the case, confirm with your software vendor that they are connected to the Claimstream network.

If you are transmitting an electronic claim to Pacific Blue Cross east of British Columbia and Yukon and have difficulties, please call Claimstream toll-free at 1-855-498-8089 or e-mail Claimstream at support@claimstream.ca
Note: Pacific Blue Cross systems returns the standard CPhA V3.0 segment G (totals) and H (segment details) to Pharmacies. Please check with your software vendor for specific implementation details.

7.3 Integration with Government Plans
Where applicable, all claims must first be sent to the applicable provincial/territorial plan (i.e. BC PharmaCare, Alberta Coverage for Seniors, Saskatchewan PharmaCare etc.) prior to submission to Pacific Blue Cross.

If a Pharmacy is no longer enrolled to transmit claims to their applicable provincial/territorial plan, Pacific Blue Cross will terminate the Pharmacy Agreement between the pharmacy and Pacific Blue Cross, in accordance with section 17.3e of the Pharmacy Agreement. Pacific Blue Cross will not accept any claims, electronic or otherwise, from pharmacies that are not transmitting claims to their applicable provincial/territorial plan. These pharmacies must advise Pacific Blue Cross Members that they will be unable to receive reimbursement from PBC for their prescription(s) and redirect them to another pharmacy if they want to be reimbursed.

7.4 Claiming Methods
Prescription drug claims for many Pacific Blue Cross Members can be transmitted electronically.

There are three methods of claims submission:

1. Pay Direct using the BlueNet® real-time pharmacy claims adjudication system
2. Reimbursement plans where the Member pays the pharmacy in full and then the Member submits a receipt to Pacific Blue Cross for reimbursement
3. Deferred payment is when a Member with a plan pays for a drug at the point of sale and the pharmacy transmits the claim electronically on the Member’s behalf, eliminating the need for the Member to submit a claim form.

Note: If your system shows that the customer has additional coverage with another carrier or Blue Cross plan, do not transmit any amounts to the secondary payor. Collect the full amount for the prescription and issue a paid-in-full receipt. Once the customer receives an Explanation of Benefits from the primary plan, they can forward this information along with the drug receipt to a secondary carrier for additional reimbursement.

Cheques and claim statements are produced and mailed once weekly for Pacific Blue Cross plans and once every two weeks for National Blue Cross plans.
7.5 Claims Transmission

Pacific Blue Cross follows CPhA Version 3 Claim submission standards and must be submitted via software that is compliant with this standard. To transmit an electronic claim to Pacific Blue Cross, after any required provincial/territorial adjudication (as applicable), the pharmacist must ensure the transmission of the record includes the following fields:

<table>
<thead>
<tr>
<th>Claims Transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Carrier ID</strong></td>
</tr>
<tr>
<td><strong>Group/Policy/Section Number</strong></td>
</tr>
<tr>
<td><strong>Identification Number/Client ID</strong></td>
</tr>
<tr>
<td><strong>Patient Name</strong></td>
</tr>
<tr>
<td><strong>Patient Code/Dependent Number</strong></td>
</tr>
<tr>
<td><strong>Date of Birth</strong></td>
</tr>
<tr>
<td><strong>Relationship Code</strong></td>
</tr>
</tbody>
</table>

All of the above information must match Pacific Blue Cross records in order to facilitate payment. If information is incorrect or missing it may result in a rejected claim.

### Relationship Codes

| 0 = Cardholder                              | 4 = Disabled dependent                        |
| 1 = Spouse                                  | 5 = Dependent student                         |
| 2 = Child under age                         | 9 = Not known                                 |
| 3 = Child over age                          |                                                |
7.6 Use Correct Quantities

To ensure accurate claim payment for certain types of prescription drugs and diabetic supplies, it is important to always indicate the correct quantity.

*I.e. Victoza™ is supplied as a multidose pen. All claims for Victoza™ should be entered into your software by volume in mLs. For example, each pen contains 3mL so if there are two pens, then the quantity is 6mL.*

**Note:** For all provinces, use the British Columbia PharmaCare’s “Correct Quantities for PharmaCare Claims” document. To view the complete document, please visit: https://www2.gov.bc.ca/assets/gov/health/health-drug-coverage/pharmacare/correctquant.pdf

<table>
<thead>
<tr>
<th>General items</th>
<th>Enter quantity using this unit of measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creams or ointments</td>
<td>Weight in grams</td>
</tr>
<tr>
<td>Inhalers</td>
<td>Number of doses or volume in millilitres (see inhaled medications list on PharmaCare website)</td>
</tr>
<tr>
<td>Liquid (oral)</td>
<td>Volume in millilitres</td>
</tr>
<tr>
<td>Liquid (injectable)</td>
<td>Volume in millilitres or number of vials (see injectables list on PharmaCare website)</td>
</tr>
<tr>
<td>Nebulizers</td>
<td>Volume in millilitres</td>
</tr>
<tr>
<td>Patches</td>
<td>Number of patches</td>
</tr>
<tr>
<td>Powders for injection</td>
<td>Grams or number of vials (see injectables list on PharmaCare website)</td>
</tr>
<tr>
<td>Pre-loaded syringes</td>
<td>Number of syringes</td>
</tr>
<tr>
<td>Sprays</td>
<td>If product package indicates number of doses, enter the number of doses. Otherwise, use volume in millilitres</td>
</tr>
<tr>
<td>Suppositories</td>
<td>Number of suppositories</td>
</tr>
<tr>
<td>Table/capsules/caplets</td>
<td>Number of tablets or capsules or caplets</td>
</tr>
</tbody>
</table>

**Vaccine format**

<table>
<thead>
<tr>
<th>Enter quantity using this unit of measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powder for solution</td>
</tr>
<tr>
<td>Liquid vial</td>
</tr>
<tr>
<td>Pre-filled syringe</td>
</tr>
</tbody>
</table>

Injection fees or administrative charges for providing a vaccination are not eligible under Pacific Blue Cross drug plans. Only the drug cost, mark-up, and the pharmacy’s usual and customary dispensing fee should be transmitted with the claim for a non-publicly funded vaccine. Only some plans provide drug coverage for vaccines.
Effective October 2019

7.0 Claiming Procedures

7.6.1 Insulin Pump Supplies
For plans that allow insulin pump supplies, such as infusion sets/kits and insulin pump reservoirs/cartridges, are to be submitted at the retail price with no dispensing fee.

To ensure accurate claim payment, insulin pump supplies must be transmitted with the correct quantity. The quantity will vary depending on the number of items in the package. For example, the Medtronic Paradigm Silhouette Infusion Set/Combo contains 10 cannulas and 10 tubing. The quantity that should be entered for this specific item is 20 (10 cannulas + 10 tubing). Insulin pump supplies can be transmitted electronically using the following PINS and correct quantities that are indicated on the BC PharmaCare Website: 
gov.bc.ca/pharmacarepharmacists

Note: This list may change frequently. Visit the website above for the most recent product list.

7.7 Claim Responses
After a pharmacy transmits an electronic claim for adjudication, Pacific Blue Cross returns a response that will advise the pharmacist if the claim:

- Was successfully adjudicated. The amount paid along with any response codes and/or messages are displayed.
- Was rejected from adjudication. The response codes and/or messages returned with the claim are displayed.
- Was successfully adjudicated and specific plan or Pharmacy Agreement limits were applied. Example: deductibles were applied
- Encountered network errors. System-generated messages are displayed.

Pacific Blue Cross can return up to five CPhA response codes, plus three short Pacific Blue Cross text messages to explain claim payment or reason for refusal. More detailed explanatory messages may appear on your weekly statement.

Pacific Blue Cross follows CPhA Claim Standard Version 3.0 for the response code record layout. Please contact your software vendor for information on how messages appear.

Note: Entry of claim data, response messages and screen displays may vary depending on the software vendor.

7.8 Reversing a Claim
A claim transmitted in error can be voided by doing a claim reversal. A claim reversal voids the original entry made. A reversal can be done before or after payment is made, and up to one calendar year after the original submission date. For National Blue Cross Plans, within 30 days after the original submission date. Your software vendor will be able to provide the procedure to reverse the claim.

If a reversal is done before payment is made, the original and reversing lines appear on your next remittance statement. If a reversal is done after payment is made, the reversing line will appear on your next remittance statement.

If the reversal is successful, a confirmation message appears on your computer screen. If the reversal is not successful, the appropriate response codes and Pacific Blue Cross messages appear on your screen.
7.9 Assignment of Payment (AOP)

7.9.1 Overview
Assignment of Payment (AOP) is a service that Pacific Blue Cross offers on an exception basis for Members with financial hardship, or when an item’s cost exceeds $1,000, or for plans that do not allow pay-Provider electronic Claims. Pacific Blue Cross will pay the Provider directly for manually submitted eligible claims when an AOP is included.

While it is at the Provider’s discretion whether to enter into this arrangement, it is important to note that the Provider agrees to provide the product to the Member prior to the manual submission to Pacific Blue Cross. It is the customer’s responsibility to follow these steps:

1. Contact the Pacific Blue Cross Customer Service Department to request an AOP on a one-time exception basis due to financial hardship, or because the item is over $1,000. This form is also available on Provider.net.ca clicking EXISTING PROVIDERS > PHARMACY > Forms > Assignment of Payment.

2. If the expense (in excess of $1,000) is required on a regular basis and an on-going AOP is required; the Member must submit this request, in writing to Pacific Blue Cross stating the reason for the request. Pacific Blue Cross will provide a decision in writing to the customer and the on-going AOP, if approved.

3. By signing the AOP form, the customer takes full responsibility for any portion not covered by the plan. The Provider is obligated to bill the full balance to the customer. Any discounting to the expense must be done prior to submission to Pacific Blue Cross. Discounting on the balance not covered by the plan is not acceptable.

7.9.2 AOP Claim Submission
Pacific Blue Cross requires the completed AOP form be mailed back along with the original receipt/invoice. Pacific Blue Cross will adjudicate the claim in accordance with the plan and issue payment directly to the Provider. Any unpaid balance, subject to the Pacific Blue Cross Pharmacy Agreement limits, must be billed to the patient.

AOPs must be submitted with official receipts or invoices which must indicate the total value being claimed as the "patient pays" amount. Receipts should not have a value as “PBC pays” amount if the claim has not been adjudicated through any Pacific Blue Cross plan.

Please note incomplete AOP forms will be rejected and must be resubmitted. The claim must be resubmitted with all required information and received at Pacific Blue Cross within the plan’s claiming deadline.

Claims received past the deadline will not be considered. Please contact Pacific Blue Cross if you need to confirm the claiming deadline of a specific plan, as this does vary from plan to plan.

7.10 Deferred Payment Drug Plans
A Member with a deferred payment drug plan pays for a drug at the point of sale and the pharmacy transmits the claim electronically on the Member’s behalf, eliminating the need for the Member to submit a claim form.

How deferred payment works:

1. The pharmacy transmits the claim electronically on behalf of their customer in the same manner as any plan.
2. Pharmacy receives a response message stating: QJ=Deferred payment – Patient to Pay. The Plan Pays field will show as zero ($0).

3. Collect the full amount for the prescription and issue a paid-in-full receipt to your customer.

4. Pacific Blue Cross automatically issues payment and/or explanation of benefits and sends it directly to the customer. There is no need for the patient to manually submit a Claim.

**Note:** If your system shows that the customer has additional coverage with another carrier or Blue Cross plan, do not transmit any amounts to the secondary payor. Collect the full amount for the prescription and issue a paid-in-full receipt. Once the customer receives an Explanation of Benefits from the primary plan, he/she can forward this information along with the drug receipt to a secondary carrier for additional reimbursement.
8.0 Drugs

8.1 Drug Plan Types
There are variations within Pacific Blue Cross drug plans which may include one or more of the following plan-management functions:

- Follow PharmaCare’s low cost alternative and reference drug program pricing
- Have pre-existing exclusion clauses
- Mimic British Columbia PharmaCare’s* drug formulary
- Consider the lowest generic equivalent price
- Consider certain drugs as eligible if an application to BC PharmaCare* for Special Authority has been made
- Consider drugs that require prior approval from Pacific Blue Cross
- Consider certain drugs as ineligible under any circumstances
- Include restrictions to the allowed mark-up above the British Columbia manufacturer’s list price
- Don’t pay dispensing fees, while others may limit this amount, which may or may not mimic the provincial/territorial plan’s dispensing fee allowances

Note: Some plans may include more than one of the above restrictions. Refer to the claims’ response code(s) or contact Pacific Blue Cross if you have questions.

* For questions about British Columbia PharmaCare’s formulary or pricing, please visit their website at gov.bc.ca/pharmacare or call 604-682-7120.

Drug coverage is based on the plan sponsor’s contract and may have co-payment, deductibles or pre-existing clauses associated with it. It is the pharmacy’s responsibility to always collect the full co-payment amount from the customer.

8.2 Drugs Covered Through a Provincial Agency
Drugs that may be eligible for coverage through an Agency of the Provincial Health Services Authority or similar provincial Agency (e.g. BC Cancer Agency, BC Centre for Excellence in HIV/AIDS, BC Renal agency, etc.) will reject with the following response code:

<table>
<thead>
<tr>
<th>Response Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HD</td>
<td>patient may qualify for gov’t program</td>
</tr>
</tbody>
</table>

If there is public funding in the applicable province, the Member must speak with their physician about obtaining this coverage. If there isn’t public funding, Pacific Blue Cross will require a letter from the Member’s physician indicating the medical condition and the reason coverage is denied/not provided by the relevant agency in order to review for eligibility under the Member’s plan.
8.3 Mark-Up Limits
As defined in the Pharmacy Agreement, mark-up refers to the total of all amounts added to the manufacturer's list price and includes any wholesale upcharge, retail mark-up and any other amounts in excess of the manufacturer's list price.

The maximum pharmacy mark-up payable by Pacific Blue Cross is specified in Appendix A of the Pharmacy Agreement. Charges in excess of these limits cannot be billed to Pacific Blue Cross or to the Member.

**Adjudicating to mark-up limits**
A pharmacy that transmits a claim with a mark-up in excess of the maximum mark-up defined in Appendix A of the Pharmacy Agreement will receive the following response code and message data line:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Message Data Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>EY</td>
<td>Max cost/upcharge paid, do not claim balance</td>
<td>$XXX Not Billable / Patient Pays $XXX</td>
</tr>
</tbody>
</table>

When a claim is approved with the above message, the pharmacy must not collect the value shown as "not billable" from the Member, as this is the amount in excess of the Pharmacy Agreement.

8.4 Blue RX
Blue RX is a managed drug formulary. By definition a formulary is a list of prescription drugs covered by a health insurance plan. The purpose of a managed drug formulary is to identify and promote the most cost-effective medication. Drugs that are more expensive without offering better treatment outcomes are not covered or are only covered if first line therapy has been tried and failed.

The prior authorization categories listed below are higher cost or second line drugs that require prior approval before they can be covered under the Blue RX plan. The required forms are available online for Members to present to their prescriber for completion at: pac.bluecross.ca/BlueRX. Completed forms are sent to Pacific Blue Cross to determine eligibility.

Prior Authorization Categories (note these are subject to change):
- Asthma or COPD Therapy
- Depression
- Diabetes
- Gastrointestinal / Ulcer Therapy
- Oral Anticoagulants
- Osteoporosis

In some cases, if the prescribing physician is a specialist in the therapeutic area (e.g. Respirologist for asthma), then the physician does not have to fill out the form. However, the Member will still need to complete the form, identify the specialist physician on the form and submit to Pacific Blue Cross for review.

Completion of the forms does NOT imply approval for the drug. Coverage is based on the provisions of the Extended Health Care plan. Pharmacies or Members can also view our website for forms or more information at: pac.bluecross.ca/BlueRX.
The response code will determine the type of authorization that is required:

<table>
<thead>
<tr>
<th>Response Code</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>DX</td>
<td>Drug must be authorized</td>
<td>Have the Member complete the Pacific Blue Cross Prior Authorization form</td>
</tr>
<tr>
<td>RW</td>
<td>Special Authorization (SA) required</td>
<td>Have the Member complete the PharmaCare Special Authority form</td>
</tr>
</tbody>
</table>

### 8.5 Prior Authorization for Higher Cost Drugs

To promote cost effective use of high cost medications, all Pacific Blue Cross Members will require prior authorization before certain high cost medications are eligible for coverage. Like other insurance carriers, Pacific Blue Cross proactively helps to ensure sustainability of drug plans into the future by providing thoughtful drug plan management strategies.

Drugs which require prior authorization will reject with the following response codes, advising the pharmacist and the Member what form of prior authorization is required.

Please pay attention to the response code:

<table>
<thead>
<tr>
<th>Response Code</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>DX</td>
<td>Drug must be authorized</td>
<td>Have the Member complete the Pacific Blue Cross Prior Authorization form</td>
</tr>
<tr>
<td>RW</td>
<td>Special Authorization (SA) required</td>
<td>Have the Member complete the PharmaCare Special Authority form</td>
</tr>
</tbody>
</table>

Pacific Blue Cross Prior Authorization forms are available at providernet.ca under the pharmacy section. Members are also able to access the forms at pac.bluecross.ca/members/forms or by logging in to their Member Profile account.

### 8.6 Claims Greater than $9,999.99

For drug claims with total value greater than $9,999.99, the following procedure is recommended:

- Split the quantity so that total cost (drug cost + dispensing fee) is less than $9,999.99
- The first claim may be transmitted with the dispensing fee (only one dispensing fee will be eligible)
- Subsequent claims should be transmitted with $0 dispensing fee and with the intervention code of MP-valid claim - value $1,000.00 to $9,999.99. Do not use UF-patient gave adequate explanation. Rx filled as written or any other intervention code for these claims.
- Claims for any drug with a per unit cost greater than $9,999.99 must be submitted manually.

**Note:** Pacific Blue Cross only allows the MP Intervention Code for splitting claims on a limited list of drugs.
8.7 Frequency of Dispensing Policy (British Columbia Only)
PharmaCare’s Frequency of Dispensing Policy will cover:

- Daily dispensing: One (1) dispensing fee per patient, per drug (DIN), per day—to a maximum of three (3) dispensing fees per patient, per day.

- Dispensing every 2 – 27 days: One (1) dispensing fee per patient, per drug (DIN), per prescribed supply—to a maximum of five (5) fees per patient, per prescribed supply

If the pharmacy charges customers directly for additional dispensing fees, when the Members are below their Fair PharmaCare Annual Family Maximum, Pacific Blue Cross may reimburse the Member or pharmacy, provided there is no restriction under the Member’s benefit plan.

For Members who have reached their Fair PharmaCare Annual Family Maximum, pharmacies are not permitted to collect additional dispensing fees from customers under this policy. Pacific Blue Cross prescription drug plans do not provide coverage for any dispensing fees in excess of the PharmaCare policy. Neither the customer nor Pacific Blue Cross should be charged for these additional dispensing fees.

Pacific Blue Cross will closely monitor the billing of these claims and will perform post audit reviews on pharmacy claims to recover any additional dispensing fee payments.

Customers who request more frequent dispensing, or do not meet the clinical criteria for more frequent dispensing, are responsible for any additional dispensing fees not payable by PharmaCare.
8.8 Maximum Day Supply

Pacific Blue Cross requires the number of days' supply to be indicated on all official pharmacy receipts for prescription drug reimbursement claims across Canada. If your pharmacy software is not already printing this information on your receipts, please indicate the number of days' supply on the official pharmacy receipt. This is a mandatory requirement for Pacific Blue Cross’ adjudication system and omission of this information will delay claims processing.

Pacific Blue Cross limits payment for eligible drugs and medicines dispensed at any one time to a reasonable and customary quantity not exceeding a 100-day supply for most medications (excludes non-standard plans with different day supply limits). In an effort to address safety concerns, promote medication adherence and minimize drug wastage, Pacific Blue Cross further limits coverage of narcotics and high cost drugs to a 35-day supply.

Additional expenses for quantities in excess of 100 days/35 days/allowable day supply are the Member’s responsibility.

If a prescription exceeds the 100-day supply limit, Pacific Blue Cross coverage will be reduced to a 100-day supply based on the drug cost and day supply information transmitted with the claim. In this instance, you will receive the following response code:

<table>
<thead>
<tr>
<th>Response Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SD</td>
<td>Days supply exceeds plan limit</td>
</tr>
</tbody>
</table>

If a prescription for a narcotic or high cost drug exceeds a 35-day supply, Pacific Blue Cross coverage will be reduced to a 35-day supply based on the drug cost and day supply information transmitted with the claim. In these cases, you will receive the following response code:

<table>
<thead>
<tr>
<th>Response Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SD</td>
<td>Days supply exceeds quantity authorized</td>
</tr>
</tbody>
</table>

Exceptions

Vacation Supply/Remote Location

Exceptions may be made for people going on an extended vacation or for those who live in rural areas where travel time to the nearest pharmacy exceeds two hours. Using the appropriate intervention code will increase the day supply limit on narcotic and high cost drugs:

<table>
<thead>
<tr>
<th>Intervention Code</th>
<th>Indication</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MV</td>
<td>Vacation Supply</td>
<td>Used for an extended absence outside the covered life’s province of residence. Allows up to a 200-day supply for drugs normally reduced to the 100-day supply limit. Allows up to a two month supply for narcotic and high cost drugs.</td>
</tr>
<tr>
<td>EQ</td>
<td>Remote Location</td>
<td>Used for instances where the covered life lives in a rural or remote area – at least two hours travel time to nearest pharmacy. Allows up to a 200-day supply for drugs normally reduced to the 100-day supply limit. Allows up to a two month supply for narcotic and high cost drugs.</td>
</tr>
</tbody>
</table>
High cost drugs with longer than 35-day supply
Coverage for certain high cost drugs such as Infliximab, Omalizumab, Vedolizumab, and other biologics given at intervals less frequent than once a month, are limited to a 60-day supply and exceptions for vacation supply/rural area allows up to a 120-day supply.

Note: Intervention codes are to be used based on the pharmacist’s professional judgement at the time of entering the claim and at the request of the Member for these specific situations only. Codes MV and EQ will not be accepted for any other reason, as Pacific Blue Cross does not allow any other exemptions to the Maximum Day Supply limitations. All claims are subject to audit review. Any intervention code used should be documented in the prescription hard copy or refill log.

8.9 Early Refills
When receiving a Drug Utilization Review (DUR) warning for Refill Too Soon, ensure that at least 75% of the previously dispensed supplies have been used before processing the new supply.

If a prescription is filled prior to 75% of the previously dispensed supply being used, Pacific Blue Cross will reject the claim and transmit the following response code:

<table>
<thead>
<tr>
<th>Response Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7</td>
<td>Refill too soon</td>
</tr>
</tbody>
</table>

Note: Pacific Blue Cross DUR checks are done against the cardholder's entire claim history, and not limited to claims dispensed from your pharmacy.

Pharmacists should use their professional judgement to determine if there is a valid reason for an early refill, such as a dosage change. If an early refill is required, pharmacists can override the DUR warning for Refill Too Soon with the appropriate intervention code and document their decision on the prescription’s hardcopy or refill log; Documentation is subject to audit review.

8.10 Prescriber's Choice
Claims submitted with the CPhA Product Selection (D.62.03) code 1 = prescriber’s choice, are subject to audit.
The prescriber’s choice Product Selection code should only be used when the prescriber has clearly indicated "no substitution" on the original prescription as per provincial regulatory standards.
8.11 Compounds

Pacific Blue Cross will only adjudicate compounded claims submitted with a valid BC PharmaCare Compound Prescription Product Identification Number (PIN), which are available on the BC PharmaCare website at gov.bc.ca/pharmacarepharmacists. All pharmacies across Canada should refer to BC PharmaCare’s website to determine the correct PIN to submit the compound claim to Pacific Blue Cross. **Pharmacies should not be submitting compounds with Health Canada assigned drug identification numbers (DINs).**

**Note:** This list may change frequently. Visit the website above for the most recent product list.

**Which compounds can/cannot be transmitted?**

For a compounded prescription to be eligible for electronic transmission to Pacific Blue Cross, the pharmacist must ensure that the compound:

- Contains an active ingredient that legally requires a prescription in the jurisdiction it is dispensed
- Has ingredients that are approved and available for sale and distribution in Canada
- Is not commercially available in the same strength (exceptions will be reviewed if the commercially available product is out of stock)
- Does not contain an ineligible ingredient provided below

**Ineligible compounds**

Compounds containing the following ineligible ingredients are not eligible for electronic transmission. Please advise the Member to submit the claim manually for review:

- Non-prescription medications
- Natural Health Products (NPNs)
- Ingredients for cosmetic use, such as minoxidil
- Homeopathic products
- Products not approved for sale and distribution in Canada
- DHEA

**Do not** use compound PINs for:

- Medical equipment
- Items that are not compounded
- Vitamins
- Ostomy or other supplies
- Products or drugs listed in section 9.2.3 *Products/Drugs that Require Manual Submission by the Member of this guide.*
- Items listed above in **Ineligible compounds**

If unsure whether the compound should be transmitted electronically, issue an official Pharmacy receipt indicating all active ingredients with the appropriate BC PharmaCare PIN, to the customer for manual submission.

**Note:** Any compounded mixture transmitted and paid electronically is subject to review by Pacific Blue Cross. Should it be determined that a compound is ineligible, based on these guidelines, the expense will be reversed and charged back to the pharmacy.
Submitting a Compound - breakdown of costs /fees
When submitting a claim for a compound electronically, the Compounding Charge (also known as the “Mixture Fee” in some pharmacy software programs) must be indicated separately in the Compound Charge field on your pharmacy software and will be adjudicated in accordance with the Member’s plan. Compounds must also be transmitted with the appropriate compound codes as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>Compound Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Compounded topical cream</td>
</tr>
<tr>
<td>1</td>
<td>Compounded topical ointment</td>
</tr>
<tr>
<td>2</td>
<td>Compounded external lotion</td>
</tr>
<tr>
<td>3</td>
<td>Compounded internal use liquid</td>
</tr>
<tr>
<td>4</td>
<td>Compounded external powder</td>
</tr>
<tr>
<td>5</td>
<td>Compounded internal powder</td>
</tr>
<tr>
<td>6</td>
<td>Compounded injection or infusion</td>
</tr>
<tr>
<td>7</td>
<td>Compounded eye/ear drop</td>
</tr>
<tr>
<td>8</td>
<td>Compounded suppository</td>
</tr>
<tr>
<td>9</td>
<td>Other compound</td>
</tr>
</tbody>
</table>

When a Member is submitting a pharmacy receipt for manual reimbursement, the pharmacy should ensure the Compounding Charge is displayed separately or added to the Drug Cost portion.

Dispensing Fee
The Dispensing Fee charged on compounded prescriptions should represent the usual and customary dispensing fee or professional fee of the pharmacy. Compound charges or “mixture fees” should never be added to the dispensing fee. Please refer to the section above, submitting a Compound – breakdown of costs/fees for more information on the correct way to submit a compound charge to Pacific Blue Cross.
9.0 Medical Supplies and Equipment

9.1 Overview
A limited number of medical supplies, such as blood glucose test strips and insulin pump supplies, can be submitted electronically from the pharmacy to Pacific Blue Cross, using the relevant BC PharmaCare PIN. Pacific Blue Cross is now introducing electronic claiming of additional medical supplies and equipment dispensed from pharmacies. At this time, electronic claiming of these additional items is limited to the First Nations Health Authority (FNHA) under Group ID 40000. Pacific Blue Cross Members covered under other policies, where submitting for medical supplies and equipment is not yet available for electronic submission, must submit the claim manually for consideration under their plan.

The following is a quick reference tool and is not intended to be an exhaustive list. For a complete list of medical supplies and equipment PINs eligible for electronic submission to Pacific Blue Cross please see our FNHA Fee Supplement.

<table>
<thead>
<tr>
<th>Description</th>
<th>Group ID 40000</th>
<th>All other PBC Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Glucose Test Strips</td>
<td>Submit using PHC** PIN</td>
<td>Submit using PHC PIN</td>
</tr>
<tr>
<td>Blood Ketone Strips</td>
<td>Submit using PIN 11120002</td>
<td>Submit using PIN 11120002</td>
</tr>
<tr>
<td>Insulin Pump Supplies*</td>
<td>Submit using PHC PIN</td>
<td>Submit using PHC PIN</td>
</tr>
<tr>
<td>Ketostix</td>
<td>Submit using PIN 11120003</td>
<td>Submit using PIN 11120003</td>
</tr>
<tr>
<td>Lancets</td>
<td>Submit using PIN 11120004</td>
<td>Submit using PIN 11120004</td>
</tr>
<tr>
<td>Needles and syringes for insulin use</td>
<td>Submit using PIN 00999725</td>
<td>Submit using PIN 00999725</td>
</tr>
<tr>
<td>Needles and syringes for non-diabetic use</td>
<td>Submit using PIN 11200016</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>Submit using PHC PIN</td>
<td>Requires manual submission</td>
</tr>
<tr>
<td>Spacer Device</td>
<td>Submit using PHC PIN</td>
<td>Requires manual submission</td>
</tr>
</tbody>
</table>

*Please refer to insulin pump supplies section for further details on submitting the correct quantity for these items.  
** PHC refers to BC PharmaCare PIN

9.2 Electronic Claim Submission
When submitting electronic claims for medical supplies and equipment, charges for the item should be included in the Drug Cost/Product Value and Cost Upcharge fields. Claims with values in the Professional Fee, Compounding Charge, or Special Services Fee(s) fields will be rejected, as these fees are not eligible for medical supplies and equipment.

After a pharmacy transmits a medical supply or equipment claim for adjudication, Pacific Blue Cross returns a response that will advise the pharmacist if the claim:

- Was successfully adjudicated. The amount paid along with any response codes and/or messages are displayed.
- Was rejected from adjudication. The response codes and/or messages returned with the claim are displayed.
- Was successfully adjudicated and specific plan limits were applied. Example: deductibles were applied.
- Encountered network errors. System-generated messages are displayed.
Pacific Blue Cross can return up to five CPhA response codes, plus three short Pacific Blue Cross text messages to explain claim payment or reason for refusal. Claims for medical supplies and equipment will appear on your regular weekly statement. More detailed explanatory messages may appear on your weekly statement.

9.0 Medical Supplies and Equipment

9.2.1 Pre-determination Required
If a claim rejects with response code RD Eligible for Prior Approval, the item requires pre-determination before being considered under the plan.

Once the pre-determination has been submitted, it will either be approved or rejected by Pacific Blue Cross. If the pre-determination has been approved, you will then be able to electronically submit a claim for that item for the Member.

Please refer to the FNHA Fee Supplement to learn more about the specific requirements for pre-determination.

9.2.3 Item is not a benefit
If you have submitted a claim for a Member and the response message indicates that this is an Ineligible Benefit (response code D1 ‘DIN/PIN/GP #/SSC not a benefit), this could mean that the item is either not eligible to be submitted electronically or, that it is not covered under a Member’s benefit plan.

Consult the appropriate fee supplement (i.e. the FNHA Fee Supplement) to confirm whether a PIN is eligible and any associated pre-determination requirements/criteria. If a Member’s plan does not feature a fee supplement, you can charge the Member and get them to submit a claim manually.

9.2.3 Products Requiring Manual Submission
If a claim rejects with response code A6 ‘submit manual claim’, this policy does not allow electronic claiming of medical supplies and equipment. Claims for medical supplies and equipment must be submitted manually by the Member.

Note that medical supplies and equipment may not be eligible under all Pacific Blue Cross extended health care plans and may require prior authorization before being eligible. Members should contact Pacific Blue Cross to inquire about eligibility prior to purchasing the product.

When mailing in the claim, the Member must:
1. Complete a Pacific Blue Cross Extended Health Care claim form
2. Attach official pharmacy receipts
3. Attach a letter or Pacific Blue Cross Prior Authorization request form, as applicable, from the attending physician that indicated the diagnosis and medical necessity for the use of the item, if required.

Please refer to the FNHA Claiming Procedures to learn more about how a pharmacy can submit manual claims on behalf of FNHA clients for Medical Supply & Equipment claims.
9.3 Specific Product and Service Details

9.3.2 Diabetes Supplies

Pacific Blue Cross will only adjudicate blood glucose test strips and insulin pump supplies submitted with a valid BC PharmaCare Product Identification Number (PIN), which are available on the BC PharmaCare website at [gov.bc.ca/pharmacarepharmacists](http://gov.bc.ca/pharmacarepharmacists). All pharmacies across Canada should refer to BC PharmaCare’s website to determine the correct PIN to submit the diabetic supply claim to Pacific Blue Cross.

**Note:** *BC Pharmacare's list may change frequently. Visit the website above for the most recent product list.*

Based on best evidence, and in alignment with BC PharmaCare’s quantity limits, a Member’s annual limit of blood glucose test strips is determined by the diabetes treatment they are receiving.

**Annual Limit for Blood Glucose Test Strips (BGTS):**

<table>
<thead>
<tr>
<th>Diabetes Treatment Category</th>
<th>Number of BGTS allowed within a calendar year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members managing diabetes with insulin</td>
<td>3,000</td>
</tr>
<tr>
<td>Members on medications with a high risk of causing hypoglycemia</td>
<td>400</td>
</tr>
</tbody>
</table>

**Examples include:** Chlorpropamide (DiabineseTM), Gliclazide (DiamicronTM), Glimepiride (AmarylTM), Glyburide (DiabetaTM), Repaglinide (GluconormTM), Tolbutamide (OrinaseTM)

| Members on medications with a low risk of causing hypoglycemia, or patients using blood glucose test strips without the addition of insulin or diabetic medications | 200 |

**Important note:**
In certain circumstances, periodic increases in testing may be warranted, resulting in a need for more blood glucose test strips than a Member’s annual limit allows. Members who meet specific criteria and are not on insulin can request an additional 100 test strips per year by having their prescriber complete a [Pacific Blue Cross Additional Blood Glucose Test Strips request form](http://www.pacificbluecross.com) on their behalf.

9.4 Rentals

If a Member’s plan allows for pay-Provider relationships, rentals from a medical supplier may be allowed at the discretion of Pacific Blue Cross or according to the provisions of the Member’s contract.

If the item is not available for purchase, Pacific Blue Cross will consider a rental. If an item is unavailable on a rental basis, or it is required for a chronic disability, the purchase of the item may be considered. Reimbursement for rental equipment will be made monthly and reimbursement for rental equipment will not exceed the total purchase price of similar equipment.

9.2.4 MS&E Claims Greater than $9,999.99

For Pharmacies Submitting MS&E Claims greater than $9,999.99 please submit these claims through Assignment of Payment. Consult the appropriate fee supplement (i.e. the [FNHA Fee Supplement](http://www.fnha.org)) to confirm whether a MS&E is eligible to be submitted though a Provider Health Claim Form.
10.0 Coordination of Benefits (COB)

10.1 Guidelines
Pacific Blue Cross bases order of submission rules off the Canadian Life and Health Insurance Association (clhia.ca) guidelines. Total reimbursement will never exceed 100% of the eligible amount (excludes non-standard plans who allow for different eligible amounts).

They are:

1) The plan where the person is covered as a Member.
2) The plan where the person is covered as a dependent spouse.
3) If a person is a Member (cardholder) of two plans, priority goes to:
   i. the plan where the Member is an active full-time employee.
   ii. the plan where the Member is an active part-time employee.
   iii. the plan where the Member is a retiree.
4) Primary coverage for dependent children is determined by:
   i. the plan of the parent with the earlier birth date (MM/DD) in the calendar year.
   ii. the plan of the parent whose first name begins with the earlier letter in the alphabet when the parents have the same birth date.
5) In situations of separation or divorce, where there is single custody, the following order applies:
   i. the plan of the parent with custody of the child.
   ii. the plan of the spouse of the parent with custody of the child.
   iii. the plan of the parent not having custody of the child.
   iv. the plan of the spouse to the parent not having custody of the child.
6) In situations of separation or divorce where there is joint custody, the following order applies:
   i. the plan of the parent with earlier birth date (MM/DD) in the calendar year.
   ii. the plan of the parent with later birth date (MM/DD) in the calendar year.
   iii. the plan of the spouse of the parent with earlier birth date (MM/DD) in the calendar year.
   iv. the plan of the spouse of the parent with later birth date (MM/DD) in the calendar year.

Total reimbursement will never exceed 100% of the eligible amount (excludes non-standard plans who allow for different eligible amounts).

10.2 External COB
For customers whose additional coverage is with another health benefits carrier, continue to submit two claims with the pertinent plan information with each claim to each benefits carrier. The amount paid by the primary plan is always required along with your claim form when submitting a COB claim where Pacific Blue Cross is the secondary plan.

10.3 Provide all COB Information
To prevent the delay of assessment please provide any pertinent information that will assist Pacific Blue Cross in determining the order of payment. It is a requirement to retain proof of payment (copy of the Explanation of Benefits) when another carrier is involved. This assists with the processing of a claim when deductibles or limitations are reached under the primary plan. If the primary plan is no longer in effect, please contact Pacific Blue Cross to provide the termination date.
10.4 Some Plans May Not Allow COB
The Member should verify eligibility with the plan administrator as some plans do not allow duplicate coverage. If the extended health care plan provisions do not allow duplicate coverage, you must check the validity of any pre-determination before providing items and/or services.

10.5 Some Plans are Always Primary
A plan that does not have a COB provision is always primary and pays before a plan that does have a COB provision.

10.6 Some Plans are Always Secondary
Some plans always pay last. Here is a quick reference for some COB plans:

<table>
<thead>
<tr>
<th>External Insurance</th>
<th>Blue Cross Insurance</th>
<th>Secondary Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>✔</td>
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<td>✔</td>
</tr>
<tr>
<td>✗</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>✗</td>
<td>✗</td>
<td>CLHIA Guidelines</td>
</tr>
</tbody>
</table>

10.7 Dual Pacific Blue Cross Coverage
For Drug claims when there are two Pacific Blue Cross plans, the pharmacy only needs to transmit one claim with one of the Member's policy and ID numbers. Pacific Blue Cross will automatically coordinate the claim under all Pacific Blue Cross plans that the patient has coverage under and the total payable amount in the response will be the combined total of all amounts payable under both plans.

For Medical Supplies and Equipment claims, Pacific Blue Cross will automatically coordinate the claim under all Pacific Blue Cross plans if both plans allow electronic submission of the item. However, if the primary policy does not allow electronic submission of the item, the claim will be rejected. The claim must be submitted manually by the Member.

Please refer to the FNHA Claiming Procedures to learn more about how a pharmacy can submit manual claims on behalf of FNHA clients for Medical Supply & Equipment claims.
11.0 Pacific Blue Cross Statements

11.1 Overview
Pacific Blue Cross will issue a statement to the Provider outlining claim payment details. If you have registered for PROVIDERnet and for direct deposit, you can access your claim statements through your account. If you have not registered for direct deposit you will receive paper claim statements. Both the PDF available in PROVIDERnet and the paper statement display the same information.

The details of the statements are outlined below:

1. Provider name and address – This is your mailing address.
2. Date – The date the statement was produced.
3. Your ID Number – Your Pacific Blue Cross Provider ID.
4. Page number.
5. Cheque number/Direct Deposit Number – The payment number that appears on a physical cheque attached to the statement or on the Electronic Funds Transfer (EFT) statement.

Health Claim Summary

6. Total amount claimed - The total amount for all Members on the statement.
7. Amount paid by PBC plan - The total amount covered by all Pacific Blue Cross plans.
8. Total payment amount - The total payment amount once co-payments and deductible have been satisfied.

Details

9. Claim ID - The number assigned to each transaction.
10. Purchase Date - The date shown is the exact date the items were purchased.
11. Qty – The quantity.
12. Product or Service - The description of the product or service.
13. Claimed amount - The total cost of the service.
14. Eligible Amount - The amount that is eligible under the plan.
15. Deductible amount - The amount applied to the plan’s deductible (if applicable).
16. Co-payment amount - The portion the Member pays out of pocket.
17. Percent covered – The plan percentages vary based on plan design.
18. Plan Paid Amount – The amount the plan pays.
19. Message Code – The explanation of claim payment or reason for refusal.
20. Policy number – This identifies the Pacific Blue Cross plan.
21. ID number – This identifies each Pacific Blue Cross Member.
22. Customer name.
11.2 Sample Statement

Effective October 2019

00002
PHARMACY NAME
ADDRESS
CITY PROVINCE Postal

DIRECT DEPOSIT STATEMENT
Mmm DD, YYYY
Your ID Number: 1234567890
Direct Deposit Number or Cheque Number:
1234567890

*** Payment may take up to 3 business days to be deposited to your account ***

Health Claim Summary
Total claimed amount: $100.00
Amount paid by PBC plan: $90.00
Total payment amount: $80.00

Details

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Service Date</th>
<th>Qty</th>
<th>Product or Service</th>
<th>Claimed Amount</th>
<th>Eligible Amount</th>
<th>Deductible Amount</th>
<th>Co-payment Amount</th>
<th>Percent Covered</th>
<th>Plan Paid Amount</th>
<th>Message Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>000000000</td>
<td>Mmm DD, YYYY</td>
<td>60.0</td>
<td>RX/DD 1234567</td>
<td>100.00</td>
<td>100.00</td>
<td>0.00</td>
<td>0.00</td>
<td>80%</td>
<td>60.00</td>
<td>C0500, C5329</td>
</tr>
<tr>
<td>Total for Patient</td>
<td></td>
<td></td>
<td></td>
<td>100.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>80.00</td>
<td></td>
</tr>
</tbody>
</table>

C0500 - Claim is coordinated with other plans.
C5329 - The dispensing fee has been processed up to your plan's limit. The excess amount is not eligible for reimbursement.

C5329 - We considered the drug cost portion up to the maximum your plan allows. The excess amount is not eligible under your plan.

Policy Number: 123456 ID Number: 123456 Patient Name: John Smith

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Service Date</th>
<th>Qty</th>
<th>Product or Service</th>
<th>Claimed Amount</th>
<th>Eligible Amount</th>
<th>Deductible Amount</th>
<th>Co-payment Amount</th>
<th>Percent Covered</th>
<th>Plan Paid Amount</th>
<th>Message Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>000000000</td>
<td>Mmm DD, YYYY</td>
<td>60.0</td>
<td>RX/DD 1234567</td>
<td>100.00</td>
<td>100.00</td>
<td>0.00</td>
<td>0.00</td>
<td>100%</td>
<td>0.00</td>
<td>C0500, C2401</td>
</tr>
<tr>
<td>Total for Patient</td>
<td></td>
<td></td>
<td></td>
<td>100.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

C0500 - Claim is coordinated with other plans.
C2401 - The policy and/or practitioner is not eligible to submit electronic claims.

Total for Provider ID: BC00000XXX 100.00
80.00

PLEASE RETAIN FOR TAX PURPOSES
12.0 Fraud Prevention

We want to encourage Providers to learn how to recognize and report fraud in order to help stop it.

12.1 Help Prevent Identity Fraud

Prior to accepting coverage and completing a sale for a new customer, check that they have either one piece of PRIMARY ID or two pieces of SECONDARY ID to verify their identity as a Pacific Blue Cross Member.

<table>
<thead>
<tr>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Driver’s license</td>
<td>• Provincial/Territorial health care plan card</td>
</tr>
<tr>
<td>• Passport</td>
<td>• Birth certificate</td>
</tr>
<tr>
<td>• Provincial/Territorial ID card issued by the Province/Territory</td>
<td>• Canadian citizenship card</td>
</tr>
<tr>
<td>• Police Identity Card issued by RCMP or Municipality</td>
<td>• Landed immigrant status papers</td>
</tr>
<tr>
<td>• Certificate of Indian Status Card</td>
<td>• Naturalization certificate</td>
</tr>
<tr>
<td>• Student ID card</td>
<td>• Marriage certificate</td>
</tr>
<tr>
<td>• Birth Certificate</td>
<td>• Change of Name certificate</td>
</tr>
<tr>
<td></td>
<td>• ID or Discharge Certificate from External Affairs Canada or Canadian Armed Forces</td>
</tr>
<tr>
<td></td>
<td>• Consular ID card</td>
</tr>
</tbody>
</table>

12.2 Whistleblower Hotline

Pacific Blue Cross is committed to protecting the integrity of the benefit plans provided to Members. The Whistleblower Hotline is a program that allows Members, Providers and employees to anonymously report fraud and unethical behaviour. Administered by an independent third party on behalf of Blue Cross, all information relating to the report is kept private, confidential and secure, including any caller or Member communication. The Whistleblower Hotline is available at pbc-ethics.com or call 1-800-661-9675. Pacific Blue Cross will investigate all incidents reported.
13.0 Provider Guidelines

13.1 Legal Terms and Conditions
When Providers register for PROVIDERnet, they must accept and comply to the PROVIDERnet Legal Terms and Conditions. They must accept these terms before creating their PROVIDERnet account. These terms are also re-acknowledged each time online Banking is updated.

13.2 Payment of Claims
Pacific Blue Cross plans provide coverage for some expenses. Pacific Blue Cross reimburses claims at the applicable contractual plan percentages.

The Provider understands that Pacific Blue Cross contracts may contain deductibles, co-payment amounts, dollar limitations and maximum provisions. Payment of the uninsured portion, including the co-payment, is the customer’s responsibility.

13.2.1 PharmaCare Balance Billing (BC Pharmacies)
Section 3.3 of the Pharmacy Agreement states the following:
“Where a Member has achieved full coverage status under an applicable provincial program, the Pharmacy agrees not to charge Pacific Blue Cross or the Member for those Products covered fully under the provincial program formulary.”

Incorrect billing submitted to a Pacific Blue Cross plan is in violation of the Pacific Blue Cross Pharmacy Agreement and will be adjusted as an overpayment. See the Overpayment section of this guide, for more information.

13.2.2 Partial Payment
The Provider certifies that every claim for services submitted to Pacific Blue Cross is a true and accurate account of services rendered, is properly payable, and is unpaid or partially unpaid by another payer (e.g. provincial government agency or benefit carrier). If there is another payer, the Provider will advise Pacific Blue Cross and submit the amount paid by the previous plan(s)/will forward a copy of the primary plan’s Explanation of Benefits statement in order for PBC to coordinate payment.

13.2.3 Billing and Co-Payment
The Provider must bill the actual product or service being provided. If a discount is given to the Member, bill the actual discounted amount. It is the Provider’s responsibility to collect any co-payment amount from the Member; the co-payment must be collected whether the fee is discounted or not. The co-payment is the Member’s responsibility.

13.2.4 Insured and Non-Insured Charges
The cost of any goods or services must not differ between insured and non-insured customers. If discounting to non-insured customers, the same discounted fee should be extended to insured Members.

13.2.5 Claiming Deadline
Submit claims as soon as possible at point of sale. In no event will payment be made on any claim received later than one year from the date of service (excludes non-standard plans with different claiming deadlines).
13.2.6 Items not Picked Up
If a Member cancels a request for an item or is unable to pick up an item, the Provider may not submit a claim for this item to Pacific Blue Cross for reimbursement.

**Note:** Some plans publish guidelines to support providers when clients do not pick up an item. Please refer to the [FNHA Fee Supplement](#) for further information.

13.2.8 Overpayment/Adjustment
In the event that there is an overpayment, Pacific Blue Cross will adjust the balance owing on a future statement. An overpayment may result from a claim adjustment request from your office or a case where Pacific Blue Cross identified a claim that needed to be adjusted. **Pacific Blue Cross cannot accept your Provider’s cheque to refund for an overpayment or adjustment while ongoing claims are being processed for your Provider location.**

Please continue to notify us of adjustments by mail, on a paper claim or on a copy of your statement. You can also request an adjustment by calling Customer Services at 604-419-2000 or 1-877-PAC-BLUE. Once the error is adjusted, the correction will show on your next statement.

In situations when an overpayment is not recovered from your next payment, Pacific Blue Cross will invoice the office. In this case, please send Pacific Blue Cross a personal cheque or return our computer-generated cheque.

Pacific Blue Cross requests your cooperation to only send cheques if your office receives an invoice indicating an amount is owed to Pacific Blue Cross.

13.2.9 Currency
Pacific Blue Cross will pay all claims in Canadian dollars.

13.3 Relatives
Pacific Blue Cross will not pay for goods and services provided to a Member who is a close relative to a Provider, or who lives in the same dwelling as the Provider.

13.4 Confidentiality of Personal Information
Pacific Blue Cross and Providers will collect, use, disclose and retain the personal information of Members in compliance with the applicable provincial or federal privacy legislation in the province or territory where the goods or services are provided.

13.5 Indemnity
The Provider shall indemnify and save Pacific Blue Cross and its directors, employees and agents harmless from and against any and all damages, losses, expenses or liabilities (including assessed costs of litigation and assessed legal fees) awarded against or incurred by Pacific Blue Cross to the extent that such damages, losses, expenses or liabilities are brought in connection with items provided by the Provider.

13.6 Intellectual Property
Neither Pacific Blue Cross nor the Provider shall reproduce or use the corporate name or logos owned or licensed by one another in any written material without prior written consent.

13.7 Endorsements
A Provider cannot make claims that their products or services have been endorsed over another Providers’ by Pacific Blue Cross, either in writing or orally.

13.8 Assignment
The Provider cannot assign any of their rights or responsibilities with Pacific Blue Cross without Pacific Blue Cross’ written consent.
13.9 Amendment
Pacific Blue Cross reserves the right to amend this reference guide from time to time and Pacific Blue Cross shall post the guide online at providernet.ca.

The Provider acknowledges and agrees it has read this Reference Guide, understands all of the provisions and will comply with the rules and procedures currently in force. The Provider is responsible and agrees to access the current Reference Guide from the Pacific Blue Cross website at pac.bluecross.ca/PROVIDERnet. Pacific Blue Cross may amend the Reference Guide annually or as required and will notify the Provider when amended.

13.10 Termination of Pay Direct Privilege
If a Provider location is closing permanently, they must inform Pacific Blue Cross in writing. The Pay-Provider relationship previously established with Pacific Blue Cross will be terminated.

If a Provider fails to comply with any of the items in this reference guide, their status may be reviewed, and Pacific Blue Cross may refuse to accept claims from the Provider.

Pacific Blue Cross reserves the right to refuse claims from a Provider where there is suspicion, or an active investigation of and/or evidence of fraud, misrepresentation or abuse and terminate from the Pacific Blue Cross registry.

If the ownership of a Provider location is transferred to a new owner, this transfer date will mark the end of the pay-Provider relationship previously established with Pacific Blue Cross. The Provider must inform Pacific Blue Cross in writing prior to the change of ownership and must apply to enter a new pay-Provider relationship with Pacific Blue Cross.

Pacific Blue Cross reserves the right to determine which Providers are eligible in its pay direct arrangement and may refuse, suspend, or revoke this privilege if a Provider fails to adhere to the provisions outlined in this guide.

If Pacific Blue Cross removes the pay direct privilege from a Provider, Pacific Blue Cross will not accept claims from the Provider.
14.0 Audit

14.1 Background
Pacific Blue Cross has process controls in place for the purpose of ensuring that claims submitted are appropriate and compliant with any contractual obligations. In addition, Pacific Blue Cross employs a comprehensive audit approach to gain further assurance that claims submitted by pharmacies are accurate and valid.

All claims submitted to Pacific Blue Cross may be subject to audit by our Audit, Investigations and Quality Assurance Department. Audits are performed to ensure drug claims, and other eligible benefits and services paid by Pacific Blue Cross are in compliance with the Pacific Blue Cross Pharmacy Agreement, applicable benefits contracts, and the Pharmacy Reference Guide.

It is important to note that successful adjudication of a claim does not prohibit Pacific Blue Cross from auditing the claim or the Pharmacy that submitted the claim. If during an audit it is found that inappropriate information or processes, lack of required records or documentation, have resulted in a successful adjudication result of one or more claims, Pacific Blue Cross retains the right to recover payments previously made.

14.2 Audit Performance
Audits are performed by the Pacific Blue Cross Audit, Investigations and Quality Assurance Department.

Pacific Blue Cross auditors are staff or agents of Pacific Blue Cross and are authorized to conduct audits for the organization.

Pacific Blue Cross auditors (or agents):
- Perform the Provider audit and prepare the Result Letter.
- Investigate tips and complaints from other Providers, Members, Plan Sponsors, former employees and the general public.
- Make quality assurance recommendations to Pacific Blue Cross Management based upon audit outcomes.

Audits may be conducted on-site at the Store or via a desk audit, or a combination thereof.

An audit may employ different evidence gathering methods such as, but not limited to, telephone or in-person staff/agent interviews, written correspondence, and Member/Provider verification letters.

14.3 Audit Selection
Selection of a Provider for audit may be made by random selection, payment analytics and comparison of claims data, tips received through the Pacific Blue Cross Whistleblower hotline, complaint, or other means.

14.4 Audit Notification
A Provider will be notified of the audit by means of a formal letter.

If the Provider is selected for an onsite audit, Pacific Blue Cross will contact the Provider in advance of the date and time for the onsite audit to provide reasonable notice to accommodate the needs of the Provider, unless Pacific Blue Cross has reasonable grounds to believe that the Provider would not cooperate with the auditors if given such notice.

Notification of a desk audit does not preclude Pacific Blue Cross from initiating an on-site audit if the record and documentation review supports a more in-depth audit.
14.5 Auditor Access
If a Store is selected for an onsite audit, the Store owners or directors will ensure that all store staff and its agents will co-operate with the audit. This includes:

- Providing Pacific Blue Cross Auditor(s) or agents access to the site, and
- Granting access to the original required records for review, copying and scanning.

14.6 Confidentiality
All records and documentation used for the audit shall be kept confidential. All personal information shall not be disclosed to any person, unless required by law or authorized in accordance with applicable privacy legislation.

14.7 Auditable Records
During a Store audit, Pacific Blue Cross will audit all Provider records and documentation relevant to the identified claims submissions, billing and payment for services and supplies provided to Members of Pacific Blue Cross.

The Store must retain and make available all relevant original records and documentation that support the claims submission and make the records and documentation available for Pacific Blue Cross’ audit. The records that may be audited include, but are not limited to:

- Manufacturer, distributor, and wholesaler invoices;
- Prescription records and associated documentation;
- Relevant inventory management records;
- Patient charts and appointment records; and
- Any other record that is relevant to Claims submissions, billings and payments.

If a Store is selected for a desk audit, a request will be made by formal letter for copies of relevant records. The store has thirty (30) days, or a longer time as agreed by the parties, to provide the requested records.

If a Store is selected for an on-site audit, Pacific Blue Cross Auditors or agents will make copies of the relevant records at the time of the on-site audit. Any records outstanding at the conclusion of the on-site audit will be noted and the store will be provided fourteen (14) days, or a longer time as agreed by the parties, to provide the requested records.

If the time period has passed to produce the records and the requested records have not been produced, Pacific Blue Cross will reasonably conclude that no records exist to support a claim, or the documentation supporting a claim is incomplete or insufficient.

14.8 Disallowed Claims
In the context of an audit, if in the reasonable opinion of Pacific Blue Cross auditors or agents, no records exist to support a claim, or the documentation supporting a claim is incomplete or insufficient, the claim will be disallowed, and any amount associated with the claim will be owing to Pacific Blue Cross.

14.9 Result Letter
A Result Letter will be provided to the Store at the conclusion of the audit.

The Result Letter will identify:

- The results of the audit and the methodologies used to determine the results.
- Any audit recovery due to disallowed claims and the methodology used to calculate the recovery.

The Store has thirty (30) days, or a longer time as agreed by the parties, to respond to the Result Letter by:

- Confirming the results, or
- Requesting reconsideration of the results and providing relevant additional information, documents or materials to support the request. Reconsideration may be requested for the following reasons:
  - identification of recovery calculation errors and/or
  - identification of information, documents or materials that may have been overlooked

If the Store does not respond within thirty (30) days, or a longer time as agreed by the parties, then Pacific Blue Cross will reasonably conclude that no response is forthcoming, and the Result Letter will stand to identify the conclusion of the audit.

If the Store requests a reconsideration and after PBC reviews the request, Pacific Blue Cross may issue a new Result Letter.

The Result Letter will identify conclusion of the audit with either:
  - No further action or
  - Required recovery of funds.

In the event of a recovery of funds, the Result Letter will outline any recovery options, if applicable.

15.0 Privacy and Member Consent

At Pacific Blue Cross, it is our responsibility to protect the confidentiality and security of our Members’ personal information. Under the Personal Information Protection Act, consent is required for the disclosure of an individual’s Personal Information. Member consent can be given verbally or in writing.
16.0 **Appendix 1: First Nations Health Authority - Effective September 16th, 2019**

16.1 Introduction
The First Nations Health Authority (FNHA) is the first province-wide health authority of its kind in Canada. The FNHA is the health and wellness partner to over 200 diverse First Nations communities and citizens across BC. In 2013, the FNHA began a new era in BC First Nations health governance and health care delivery by taking responsibility for the programs and services formerly delivered by Health Canada. Since then the FNHA has been working to address service gaps through new partnerships, closer collaboration, health systems innovation, reform and redesign of health programs and services for individuals, families, communities and Nations.

The FNHA is also a champion of culturally safe practices throughout the broader health care system. Taking a leadership role, the FNHA actively works with its health partners to embed cultural safety and humility into health service delivery and improve health outcomes for First Nations people.

The FNHA’s community-based services are largely focused on health promotion and disease prevention and include:
- Primary health care through more than 130 medical health centres and nursing stations;
- Child, youth and maternal health;
- Mental health and wellness;
- Communicable disease control;
- Environmental health and research;
- Health benefits;
- eHealth and telehealth;
- Health and wellness planning; and
- Health infrastructure and human resources.

The FNHA has partnered with Pacific Blue Cross to administer medical supply and equipment, pharmacy, vision, hearing, and dental claims.

16.2 Overview
The sections that follow outline only where there are different procedures for FNHA clients.

The majority of FNHA pharmacy benefits for FNHA are administered through the BC PharmaCare program Plan W. Pacific Blue Cross will cover a select number of drugs and devices for Plan W beneficiaries, in addition to coverage for FNHA clients not enrolled in Plan W.

Pacific Blue Cross administers the following benefits:
1. Medical Supplies & Equipment (MS&E) claims.
2. Eligible prescription and non-prescription drugs for a small number of FNHA clients who do not have coverage under BC Pharmacare Plan W formulary.
3. A FNHA maintained formulary of prescription and non-prescription drugs that are not covered by Pharmacare Plan W.

For more information about what is covered, predetermination requirements and claiming criteria refer to the [FNHA Fee Supplement](#).
16.3 Client Identification
As outlined in Identifying Blue Cross Members, FNHA Clients will use their Status Number as found on their Status Card as their identification number for Pacific Blue Cross Benefits. A Status Card contains a 10-digit number, issued by the Government of Canada to Clients registered under the Indian Act. The policy number for FNHA Clients is 40000. Status Cards are unique to each individual. The only time that more than one individual will be registered under a status card is when a child under 18 months has not yet been registered; in this case they will be registered under the parent’s status card.

To verify the identity of a new FNHA client please accept either one piece of primary ID or two pieces of secondary ID to verify that the Status Number provided by the client matches their identity as outlined in Section 11.1.

If a First Nations client has not registered for a Status Card or has an incorrect status number, please contact FNHA Health Benefits for Assistance at 1-855-550-5454 or email HealthBenefits@fnha.ca.

16.3.1 Children under 18 months
Status Cards are unique to each individual. The only time that more than one individual will be registered under a Status Card is when a child under 18 months has not yet been registered; in this case they will be registered under the parent’s status card.

To submit claims for Children under the age of 18 months, please use CPhA Field Number C.36.03 relationship code: “Others =1”.
16.4 Client Eligibility
First Nations Health Authority determines who is eligible for Health Benefits under the Health Benefits Program, but HB Clients will, at a minimum, include those individuals who are:

(a) a status Indian registered pursuant to the Indian Act or a child of less than eighteen months (18) of age, at least one of whose parents is a status Indian; and

(b) a resident of the province of British Columbia within the meaning of the Medical Services Plan; and

(c) not funded or insured for a particular benefit system, or benefit plans provided by:
   (i) federal legislation, a federal policy or under agreements entered into by Canada which fund such a benefit directly or which fund third parties to provide the benefit, excluding employment benefit plans; and/or
   (ii) a First Nations organization pursuant to self-government agreements, land claim agreements, contribution arrangements or internal policies or plans.

Enrollment in the Health Benefits Program is managed by First Nations Health Authority. Enrollment can be verified in PROVIDERnet by using a policy number 40000 and the client’s Status Number or by calling FNHA at 1-855-550-5454.

Note: There are four groups that are not covered by the FNHA because they are in a self-government agreement and have assumed the administration of their own benefits. This includes the following groups:
1) Nisga’a Nation:
   • Gingolx #671 (Kincolith)
   • Gitakdamix #677 (New Aiyansh)
   • Lakalzap #678 (Greenville)
   • Gitwinksihlkw #679 (Canyon City)
2) Inuit
3) Mohawks of Akwesasne #159
4) Bigstone Cree #458
16.5 Claiming Procedures

16.5.1 Software Configurations
To support the correct adjudication of Pharmacy claims on behalf of FNHA clients, pharmacies need two changes in their Practice Management Software.

1) Pharmacies will need to update the patient information in their software systems to show Pacific Blue Cross as the Carrier (Carrier ID: E1).
2) Pharmacies submitting MS&E items for FNHA clients will be required to update their software to use Pharmacare and/or Pacific Blue Cross PINs for claims submission. This includes new PINs that Pacific Blue Cross will issue for new MS&E items.
   - To update your system:
     - Contact your software vendor if you receive centralized updates or
     - Manually configure your software as per your usual business practice.

Software Vendor Best Practices:
- Software Vendors should create a NEW plan in their systems to support this transition.
- Please do not re-direct the current NIHB plan (with Express Scripts) to PBC.
- Pharmacies will still need to have access to the NIHB/Express Scripts plan in their systems if the Pharmacy is supporting a non-FNHA client with access to NIHB benefits.
- When naming the new plan, please utilize the description field to ensure that both FNHA and PBC are included to distinguish from other Plans.

16.5.2 Check Member Claiming Requirements
The FNHA Fee Supplement is your guide to claiming requirements for FNHA clients. In the Fee Supplement you will find detailed information about which items/services are eligible for reimbursement and whether any additional documentation is required.

16.5.3 Submitting Supporting Documentation
Pre-determinations can be helpful for Providers to know how much a product/service will be reimbursed by the plan and whether there are any specific claiming requirements.

Pacific Blue Cross will accept paper pre-determinations submitted by mail or fax (for FNHA clients only: 604.677.0277) for FNHA clients. Incomplete forms will be rejected and must be resubmitted.

Download and print out the FNHA - Health Claim/Pre-determination Form from our website.

- At the top of the form, select “pre-determination.”
- Fill in sections 1 – 4 of the Claim Form (signatures are not required on a pre-determination) and print it.
  - If you are filling it in by hand, please use blue or black ink only.
- Enclose copies of all supporting medical documentation (if required).

Pre-determinations mailed to Pacific Blue Cross will be responded to by mail. A copy of the Pre-determination will be sent the client on their Member Profile (under Authorized Products and Services).

If additional documentation is required to process the pre-determination for the expense you are submitting on the Member’s behalf, PBC will reject the pre-determination and provide reasons for the rejection in a custom response message. You may then submit this additional information to PBC as:
1. A new pre-determination with all relevant information, or
2. A revised submission that includes the missing information and references the rejected pre-determination ID number. You may also attach a copy of the EOB statement that they received to indicate that it is a resubmission.
16.6 Medical Supplies and Equipment PINs for FNHA
Certain medical supplies and equipment are eligible to be dispensed by pharmacies for FNHA clients using the respective Pharmacare and/or Pacific Blue Cross PINs. Please refer to the FNHA Fee Supplement which indicates the PINs eligible for electronic submission.

16.7 Submitting a Paper Medical Supply and Equipment Claim
To submit a paper claim on behalf of an FNHA client, begin by downloading and printing out the FNHA - Health Claim/Pre-determination Form from our website.

- At the top of the page, select “Claim.”
- Fill in all sections of the Claim Form and print it.
  - if you are filling it in by hand, please use blue or black ink only.
- Include a full quote for the product or service
- Ensure all supporting medical documents are included

Note: Please ensure that both the client and Provider have signed the form. Incomplete forms will be rejected and must be resubmitted.

16.8 Exclusions
Please review the FNHA Fee Supplement for any specific exclusions.

16.9 Contact Information
For FNHA Health Benefits Pharmacy Inquiries contact the FNHA at:

Phone: 1-855-550-5454
Email: HealthBenefits@fnha.ca
## Appendix 2: Intervention Codes

<table>
<thead>
<tr>
<th>Intervention Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DA</td>
<td>Secondary claim – original to provincial plan</td>
</tr>
<tr>
<td>DB</td>
<td>Secondary claim – original to other carriers</td>
</tr>
<tr>
<td>EQ</td>
<td>Valid reason to exceed days supply limit</td>
</tr>
<tr>
<td>MP</td>
<td>Valid claim – value $1,000.00 to $9,999.99</td>
</tr>
<tr>
<td>MV</td>
<td>Vacation supply</td>
</tr>
</tbody>
</table>

Pharmacies are expected to document valid reasons for use of these codes. These codes are also subject to audit by Pacific Blue Cross. Indicate the use of the intervention code on the prescription hardcopy or refill log for audit purposes.
## Appendix 3: Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Agreement</td>
<td>Means an Agreement between Pacific Blue Cross and a group, plan sponsor, or Subscriber under which Blue Cross administers a supplementary health benefits plan for eligible health benefits.</td>
</tr>
<tr>
<td>British Columbia Driver's License with Personal Health Number</td>
<td>The driver's license that (a) is issued by ICBC on or after February 10, 2013, as indicated on the license, to a person in accordance with the Motor Vehicle Act, and (b) contains the person's Personal Health Number, and includes a duplicate of that license, as issued under section 33 of the Motor Vehicle Act.</td>
</tr>
<tr>
<td>British Columbia Services Card with Personal Health Number</td>
<td>The physical credential that (a) is issued to a person on enrolment, or renewal of enrolment, with the plan, and (b) contains the person's Personal Health Number and includes a replacement or a duplicate of that card, as issued by a provincial identity information services Provider.</td>
</tr>
<tr>
<td>Business Owner</td>
<td>A Business Owner is an individual or entity who owns a business. Business owners acknowledge accountability for any claims that are submitted, whether personally or by licensed healthcare professionals, duly registered staff, qualified employees, subcontractors, or independent contractors working at their clinic, and paid to themselves or their business by Pacific Blue Cross.</td>
</tr>
<tr>
<td>Claim</td>
<td>A request for payment submitted by a Provider to Pacific Blue Cross for the provision of drugs and/or medical supplies and equipment to clients in accordance with the Agreement, Reference Guide, and policies of the Program.</td>
</tr>
<tr>
<td>Client</td>
<td>A person who is eligible to receive benefits from the First Nations Health Authority, and/or the Ministry of Social Development and Poverty Reduction, and/or the Ministry of Children and Family Development in accordance with the eligibility criteria in the relevant sections of this Reference Guide.</td>
</tr>
<tr>
<td>Close Relative</td>
<td>A spouse, child, brother, sister, parent, grandparent or grandchild of a Member.</td>
</tr>
<tr>
<td>Coordination Co-ordination of Benefits (COB)</td>
<td>This is applicable if a Member is covered by more than one health plan. If the plan does not pay the full amount of an expense, the claim can be submitted to the other plan to consider the balance.</td>
</tr>
<tr>
<td>Co-payment</td>
<td>A portion of an insured’s costs that must be paid by the insured as a condition of the insurer paying the remaining portion.</td>
</tr>
<tr>
<td>Deductible</td>
<td>Means the amount the Member must pay before Blue Cross will make any benefit payments under a policy.</td>
</tr>
<tr>
<td>Dependent</td>
<td>Means any of the following individuals: 1. One spouse of the Member. 2. Any unmarried child, stepchild, legally adopted child, or legal ward (not a foster child) under 21 and financially dependent on the Member or the Spouse. 3. Unmarried child under 25 who is in full-time attendance at a recognized educational institute. 4. Any unmarried disabled child who is living with and is financially dependent on the Member and/or Spouse.</td>
</tr>
<tr>
<td>Electronic Funds Transfer (EFT)</td>
<td>Electronic funds transfer is an electronic delivery of claim payments, directly deposited into the Provider’s designated bank account on the day the payment is issued.</td>
</tr>
<tr>
<td><strong>Explanation of Benefits (EOB)</strong></td>
<td>Explanation of benefits is a written statement displaying all the details of the claims paid and not paid resulting from a request. EOBs can be issued on Paper or Electronically.</td>
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<tr>
<td><strong>Government plan</strong></td>
<td>Means the health, drug, and dental benefit coverage that Canadian federal, provincial and/or territorial governments provide for their residents, including any plan that provides insurance as required by statute, but does not mean group benefit plans provided to government employees.</td>
</tr>
<tr>
<td><strong>High Cost Drugs</strong></td>
<td>Pacific Blue Cross defines high cost drugs as any drug with a maximum annual amount equal or greater than $10,000 considering the typical dose that is prescribed and the number of doses that a claimant would typically receive each year.</td>
</tr>
<tr>
<td><strong>Member</strong></td>
<td>The person, having coverage who has a direct relationship with the Contract holder or the Participating Employer.</td>
</tr>
<tr>
<td><strong>British Columbia Personal Health Number (PHN)</strong></td>
<td>A unique lifetime identifier for health care in British Columbia. PHN remains the same, regardless of any changes to a resident's personal status.</td>
</tr>
<tr>
<td><strong>Personal Information</strong></td>
<td>Means any information about an identifiable individual.</td>
</tr>
<tr>
<td><strong>Practitioner</strong></td>
<td>Means a person legally licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial or national body, which establishes standards of competence and conduct for that profession. This excludes a Practitioner residing with or related to the Member, Client or Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Practitioner based on ineligibility, or based on the Practitioner's qualifications or conduct.</td>
</tr>
<tr>
<td><strong>Prescription</strong></td>
<td>Means a written order for the use of a medicine, treatment, product or service by an eligible prescriber in accordance with the terms of the Benefit Agreement.</td>
</tr>
<tr>
<td><strong>Primary Administrator</strong></td>
<td>In PROVIDERnet, this is a person who has access to add/edit banking information and who also has access to submit an electronic claim.</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>Means a person, group, or other entity currently licensed, certified, or registered to provide an eligible service, medical supply, or equipment by the appropriate licensing, certification, or registration authority in the jurisdiction where the services or equipment are provided or, where no such authority exists, has a certificate of competency from the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. We reserve the right to refuse the service, medical supply or equipment from the Provider based on ineligibility or based on the Provider’s qualifications or conduct.</td>
</tr>
<tr>
<td><strong>Provider Number</strong></td>
<td>A unique reference number assigned to the Provider as identification to facilitate the submission of claims for adjudication and to receive payment.</td>
</tr>
<tr>
<td><strong>Qualified Staff</strong></td>
<td>Staff who are qualified for the given purpose and have complied with specific requirements.</td>
</tr>
<tr>
<td><strong>Spouse</strong></td>
<td>Means: a) the person legally married to the Member, or b) a Member's spouse, as that term is defined within the appropriate provincial, federal, or territorial legislation, as amended from time to time. Only one Spouse is eligible for coverage at any one time.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Standard Administrator</td>
<td>In PROVIDERnet, this is a secondary account to the Primary Administrator account. They can submit claims on the Primary Administrator’s behalf; they do not have access to updating banking information and cannot view claim statements.</td>
</tr>
<tr>
<td>Store</td>
<td>A business that sells products to the public for use or consumption rather than for resale.</td>
</tr>
</tbody>
</table>