ALBERTA BLUE CROSS PHARMACEUTICAL SERVICES PROVIDER AGREEMENT

COMPLIANCE VERIFICATION

BENEFACT UPDATE

NUMBER 1A • SEPTEMBER 2019

Overview

As an authorized provider, all pharmacies with an active Alberta Blue Cross Pharmaceutical Services Provider Agreement (Agreement) are bound by all the terms and conditions contained therein. It is the responsibility of the pharmacy provider to be familiar with and understand all the requirements of their agreement. As outlined in the Agreement, all claims submitted to Alberta Blue Cross for payment are subject to Compliance Verification Reviews and Alberta Blue Cross retains the right to recover payments when appropriate.

Alberta Blue Cross's expectation is that claims must be submitted according to:

- all requirements of the Agreement;
- applicable legislation and ministerial orders;
- regulatory body standards of practice;
- plan coverage; and
- Alberta Blue Cross policies and standards.

When findings are identified in a Compliance Verification Review, there are several actions that Alberta Blue Cross can take, depending on the nature, severity and financial significance of the findings. These include:

- recovery of overpayments;
- report the findings to the Alberta College of Pharmacy;
- termination of the Alberta Blue Cross Pharmaceutical Services Provider Agreement;
- purse civil action; and
- report the findings to law enforcement.

Common areas of non-compliance and overpayments

The following are common areas where claims for payment by pharmacies are not compliant, which can result in overpayments.

The requirements listed below should be reviewed in conjunction with the following:

- TheAlberta Blue Cross Pharmaceutical Services Provider Agreement (**https://www.ab.bluecross.ca/providers/pharmacy-agreement.php**)

- Reference Guide for Alberta Pharmacies (**https://www.ab.bluecross.ca/providers/pharmacy-resources.php)**

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1. Documentation Requirements

Claims require supporting documentation, as outlined in all sources as referenced above, and must be completed and included at the time of the claim for the documentation to support claims to Alberta Blue Cross.

a. Direct bill drug claims

Alberta Blue Cross requires an authorized prescription where required under legislation. We review prescription documentation to confirm compliance with federal and provincial legislation, as well as standards issued by the Alberta College of Pharmacy.

In cases where a prescription is not required, pharmacies must retain documentation to support the claim. This documentation must include the following elements:

- the plan member name and address,
- a description of the product/service including the name and DIN/PIN/NPN,
- the service date,
- the quantity dispensed,
- the directions for use,
- the name and/or initials of the dispensing pharmacist, and
- an original prescription number and transaction number.

Common areas of non-compliance

- missing prescription documentation,
- missing date of authorization,
- missing authorizing prescriber signature,
- using electronic signatures on their own,
- not creating prescription documentation when a pharmacist is prescribing, and
- missing the total quantity authorized.

b. Pharmacy services claims

Claims for pharmacy services require supporting documentation as outlined in the Alberta College of Pharmacy Standards of Practice and the Ministerial Order. In addition, plan members receiving pharmacy services must meet all criteria outlined in the Ministerial Order for services to be eligible.

Common areas of non-compliance

Comprehensive Annual Care Plan (CACP) and Standard Medication Management Assessment (SMMA) initial assessments

- missing date of service,
- missing or unclear details of the service provided,
- missing or incomplete medical history (BPMH),
- missing signatures and date signed—both the plan member and pharmacist must sign and date the initial assessment,
- missing clearly documented eligibility criteria such as chronic diseases or details of the proposed follow-up,

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- missing documentation of the name and relationship when a substitute decision maker signs the initial assessment, and
- completing a CACP or SMMA initial assessment in advance of the plan member's eligibility date and waiting to claim it when the plan member is eligible.

SMMA initial assessments for tobacco cessation services

- missing documentation of agreement to quit smoking,
- plan member is not willing to quit smoking, and
- plan member is not receiving pharmacological support for tobacco cessation.

CACP and SMMA follow-up assessments

- missing the name and signature of the pharmacist who completed the service—plan members are not required to sign follow-up assessments,
- missing specific details of the follow-up or resulting intervention,
- missing date of service, and
- missing documentation of how the plan member was contacted.

Assessment for a trial prescription

- missing the original prescription and documentation showing that a reduced quantity of the drug product was dispensed,
- the drug product was not a new, not previously prescribed drug product, and
- submitting a claim when a pharmacy follows up on a plan member's tolerance to a drug product not dispensed with a reduced quantity as part of a trial.

Prescribing at initial access or to manage ongoing therapy

- submitting a claim when the drug product is not a Schedule 1 drug product or blood product, and
- missing the reduced to writing prescription which must be created at the time of the service and contain all elements outlined in in standards and legislation, including the rationale for prescribing.

Assessment for an adaptation of a prescription

- adapting a prescription that is not new, and
- missing the elements outlined in standards and legislation, including the rationale for adaptation or renewal.

Assessment for the administration of a product by injection

- submitting a claim for a drug product not listed as an injection in relevant Drug Benefit Lists or Supplements, and
- submitting a claim when the drug product is an influenza vaccine or travel vaccine.

Assessment for refusal to fill a prescription

- the reason for the refusal to fill is not documented, and
- submitting a claim for refusing an early refill.

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2. Frequent Dispensing

Pharmacies must follow the requirements and obligations of the Agreement and the Quantitative Limits section of the Reference Guide for Alberta Pharmacies when submitting claims with frequent dispensing.

Documentation to support frequent dispensing must be completed prior to the initiation of frequent dispensing and retained by the pharmacy for CVR purposes and is valid for one year. Documentation must be completed each year in cases where the requirement for frequent dispensing extends beyond one year.

If a plan member requires dispensing of drug products used on a chronic or long-term basis with a quantity of between 28 and 89 days supply, pharmacies must document the following information at the time of the claim:

- the plan member's request for frequent dispensing OR
- the health care provider's request for frequent dispensing for one of the following reasons:
  - o increased compliance,
  - o abuse control,
  - o determination of therapeutic effectiveness, or
  - o potential drug sensitivities.

If a plan member requires dispensing of these therapies with a one to 27 days supply, the Frequent Dispensing Policy (FDP) applies. Pharmacies must document the following at the time of the claim:

- the plan member's identification information including name, PHN and date of birth;
- who initiated the request and the date of the request;
- the name of each drug product;
- the timeframe for frequent dispensing and the required frequency;
- the rationale for frequent dispensing (acceptable criteria are outlined in the FDP)
  - o note: the Special Services Code corresponding to the eligibility criteria is not considered documentation of the rationale, but a data element of the claim; and
- the rationale for why less frequent dispensing is not appropriate.

If a prescribing physician requests frequent dispensing, this information must be documented. If it is not present on the initial request, the pharmacy must obtain the information and document it.

Common areas of non-compliance

- missing authorization—the pharmacy does not have authorization, it is obtained after dispensing or in response to a CVR;
- submitting claims with a one to 27 days supply at the plan member's request;
- blanket letters from any source (such as care facilities, prescribers, etc.) which are not specific to a plan member, do not provide a time frame for frequent dispensing, and do not outline the drug products to be dispensed frequently;
- using notations on prescriptions such as "bubble pack", "dosette", etc. as valid authorization;
- backdating or creating documentation after receiving a request for documentation; and
- using a previous prescription to authorize frequent dispensing on subsequent prescriptions (unless the documentation on the previous prescription meets the requirements of the FDP and is retained an provided on request).

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3. Corresponding frequency of claiming and dispensing

Claims must be submitted with the same frequency as the drug product is provided to the plan member. That is, the days supply submitted MUST correlate directly to the amount dispensed to the plan member.

Common areas of non-compliance

- dispensing drug products weekly to a plan member and submitting claims daily, and
- dispensing drug products every three months to a plan member and submitting claims monthly.

Note: all claims are subject to the additional provisions of the Frequent Dispensing Policy and other quantitative limits. Additional dispensing fees and upcharges claimed will be considered an overpayment, regardless if the pharmacy has authorization to dispense the drug products daily.

4. Pharmacy inventory to support claims

Pharmacies must retain all invoices and other documentation regarding drug product purchases as it is required to support claims to Alberta Blue Cross. For clarity, the volume of claims submitted for any dispensed drug products must correlate to the volume of drug product ordered by the pharmacy.

This includes purchases made from

- wholesale companies (such as McKesson, Imperial, etc.),
- retail outlets, and
- transfers/purchases from other pharmacies, distributors or suppliers.

For a pharmacy inventory review, the pharmacy must provide the following information for each drug product in the review:

- documentation to support drug product purchases,
- opening and closing inventory, and
- the total quantity dispensed to all pharmacy customers.

Note: pharmacies must ensure that they are claiming the correct Drug Identification Number/Product Information Number (DIN/PIN) corresponding to the product that is dispensed and submitting the correct unit of issue.

Common areas of non-compliance

- purchase invoices do not support the total quantity claimed,
- submitting claims with an incorrect DIN or PIN, or
- documentation is not retained when purchasing drug products from non-registered wholesalers (such as retail outlets, other pharmacies).

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5. Co-payment discounting

The Agreement outlines the pharmacy's obligations to collect the co-payment from plan members. Where the benefit plan requires a plan member to pay a portion of the cost of their prescriptions, the pharmacy is required to collect the full amount from the plan member. Any and all reductions to the co-payment amount whereby the plan member is not directly contributing to said amount, must be shared proportionally between the plan member and Alberta Blue Cross. That is, the same reduction in co-payment amount that is granted to the plan member by the provider must also be granted to Alberta Blue Cross by the provider. Refer to Appendix A, Section 5.1 of the Agreement.

Common areas of non-compliance

- providing a discount on the co-payment amount that is owed,
- waiving the co-payment if it is under a certain dollar amount, or
- submitting weekly claims and collecting co-payments based on monthly or 100 day supply dispensing.

6. Best price clause

Pharmacies must ensure that the total amount charged to a plan member does not exceed the amount charged to any other Alberta Blue Cross plan member, or any customers covered by other insurance carriers, or any cash-paying customers for the same drug product. Refer to Section 3.6 of the Agreement.

Common areas of non-compliance

- discounting or waiving the dispensing fee for friends and family,
- waiving the co-payment for specific groups of people (such as seniors, students or teachers), or
- providing a drug product at a lower cost to specific groups of people.

When you have questions:

For assistance with benefit or claim inquiries, please contact an Alberta Blue Cross Pharmacy Services Provider Relations contact centre representative at:

780-498-8370 (Edmonton and area) • **403-294-4041** (Calgary and area) • **1-800-361-9632** (toll free)
FAX 780-498-8406 (Edmonton and area) • **FAX 1-877-305-9911** (toll free)

Alberta Blue Cross offers online access to current Pharmacy Benefacts and supplemental claiming information to assist with the submission of your direct bill drug claims. **Visit ab.bluecross.ca/providers/pharmacy-home.php**

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