assure
Claims

Pharmacy Manual

The information contained in this pharmacy manual does not apply to pharmacy providers located in the province of Québec.

August 2023

TELUS Health

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General information

Section 1
General information

TELUS Health Solutions Inc. ("TELUS Health")
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www.telushealth.com
TELUS Health Assure claims pharmacy support centre: 1 800 668-1608

About TELUS Health

TELUS Health is a leading force in the healthcare industry, delivering innovative IT solutions in telehomecare, electronic medical and health records, consumer health, benefits management and pharmacy management. TELUS Health gives health authorities, providers, benefit insurers, physicians and consumers the power to turn information into better health outcomes. For more information about TELUS Health, please visit **www.telushealth.com**.

Assure Health Inc. was established in September of 1988. In November of 1999, Emergis Inc. ("Emergis") acquired Assure Health. In January 2008, TELUS Corporation demonstrated its strategic commitment to healthcare with the acquisition of Emergis and now provides for the electronic submission of "pay-direct" health claims including prescription drug claims from point-of-service to the adjudicator/payer.

As a part of our network, your pharmacy realizes benefits in processing, as follows:

- Determination of product eligibility for most claims
- Balancing of transactions
- Instant confirmation of coverage of cardholders and their dependents
- Automated payment of each transaction to a bank account of your choice (electronic funds transfer, "EFT")
- Toll-free access to our pharmacy support centre where your questions can be answered and your problems can be resolved

TELUS Health processes claims from pharmacies only by electronic data interchange (EDI). It is our policy that we do not accept paper claims submitted by a pharmacy for reimbursement. EDI processing provides the capability to handle more options to plan designs and formularies, as the system's "online" facility makes communication of every variation instantaneous. Where provincial plans offer drug benefits to residents, TELUS Health can co-ordinate the public and private sector obligations, determining the primary payment responsibility, i.e. whether we (on behalf of our insurance carriers) are responsible for the claim, and return that information to you while the cardholder is still at the dispensary. We also provide co-ordination of claims payment between most private payers. All claims are adjudicated based on the various co-pay and deductible amounts selected by the insurance carriers and their policyholders. This manual identifies the policies that are to be followed for adjudication of claims for TELUS Health Assure claims card cardholders. From time to time, policy changes will be communicated to you through faxed/ mailed/ or electronic updates. These communications will be considered part of, or modification to, the policies and procedures as set out in this manual. They will be deemed accepted by you after 30 days' written notice has been provided to you, if you continue to submit claims to the Assure Health Network and do not terminate your provider agreement with TELUS Health.

Communicating with cardholders: The insurer's prerogative

TELUS Health sincerely appreciates the role that the pharmacy staff plays in facilitating the smooth operation of pay direct drug plans. Thank you for helping the cardholder take advantage of the most efficient means of processing their insurance claims.

The most frequent reasons for problems occurring at the point of service are that the cardholder information provided to us by the insurance carriers does not match that transmitted by the pharmacy or the prescribed drug is not covered by the plan. The insurance carrier is the only party capable of addressing these situations in that they maintain all cardholder eligibility records and determine all parameters for claims payment.

The insurance carriers are very protective of their relationships with the plan sponsors and the cardholders. Therefore, they have asked that TELUS Health have no direct contact with the plan sponsors and/or the cardholders. The only exception is for audit purposes or to communicate the result of a request for Prior Authorization (Section 9). **Please do not give the TELUS Health Assure claims pharmacy support centre phone number to the cardholder.** This number is for the exclusive use of our pharmacy providers.

When the problem cannot be resolved by calling the TELUS Health Assure claims pharmacy support centre, advise the cardholder to contact their benefits department through the cardholder's employer. If the issue has resulted in non-payment of the claim, your best course of action is to collect cash from the cardholder. When the problem is resolved, the cardholder can submit the pharmacy receipt to the insurance carrier for reimbursement.

Section 2

The TELUS Health Assure claims card™

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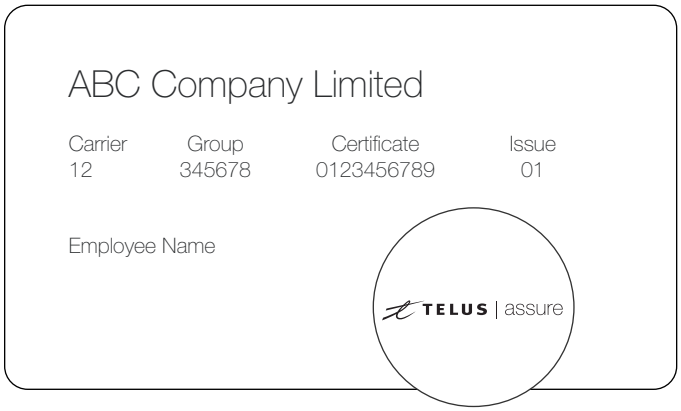
The TELUS Health Assure claims card™

The TELUS Health Assure claims card will vary with respect to artwork and design depending on the insurance carrier and/or the policyholder. The common characteristics of TELUS Health Assure claims cards include the following:

- The Assure logo is most often present in the bottom right hand corner of the card.
- The cardholder's unique 18-20-digit ID number is shown in the middle side of the card.
- There will always be a name that appears on the line directly beneath the 18-20-digit ID number. This could be the name of the employee, the spouse or a dependent child. It is important to determine whether the person named on the card is the employee, or a dependent, in order to select the correct relationship code when submitting claims.
- In addition to the traditional plastic cards, some groups are opting to use paper cards for their employees. These cards may be available for employees to print from a secure website.

Sample TELUS Health Assure claims card



The Cardholder Identification Number

Each cardholder is issued a unique 18-20-digit ID number that appears on their TELUS Health Assure claims cards and contains the following information:

- The first two digits identifies the cardholder's insurance carrier, also referred to as the carrier number
- The next six digits identifies the group or policy number
- The next ten digits identifies the certificate number
- The last two digits identifies the issue number (AdjudiCare and Desjardins cardholders will not have an issue number)

It is very important that claims be processed using the correct numbers to ensure that there are no unnecessary rejects for the cardholder when new cards are issued.

Carrier number

The following insurance carriers and payers currently use TELUS Health to adjudicate drug claims for their clients. In the following chart, the preceding numbers represent the insurance carriers' or payers' identification number, also commonly referred to as the carrier identification or the carrier number.

11	Canada Life
12	PSHCP (Public Service Health Care Plan)
22	Chambers Plan / CINUP / Johnston Group
23	UV Insurance
29	Equitable Life
34	AdjudiCare
35	Groupe Financier AGA Inc.
37	WSBC-BC (WorkSafe BC)
40	Global
44	Maximum Benefit / First Canadian / Johnston Group
49	WSIB (Workplace Safety Insurance Board)
51	Desjardins Insurance
62	Beneva
80	eSampling

The cardholder name line

There are many options available when printing the name on the TELUS Health Assure claims card. Some plan sponsors choose to print the name of the primary cardholder on all cards issued for the family. Some will have cards issued with the name of the primary cardholder on one and the spouse's name on the other. Some cards for dependent students may be issued in the name of the student, if attending school away from home. For this reason, it is important to determine the relationship prior to submitting the claim to TELUS Health for adjudication.

The second name line

There is an optional field used to enter customized messages. Types of information that could appear on this line are:

- The primary cardholder's company name
- The spouse's/dependent's name if the surname is different to that of the primary cardholder
- The abbreviation "OA" which indicates an overage dependent covered through the primary cardholder
- Plan design messages i.e. "DED EQUALS DISP FEE" or "EDI PROCESSING ONLY"
- "DIFFÉRÉ/DEFERRED" on electronic reimbursement cards

Other text

Other forms of text or messages that could appear on the front of the TELUS Health Assure claims card are as follows:

Dependent – this indicates the age at which benefits cease for dependent children (i.e. 18, 19, 21 or 25) for those cardholders with family coverage. On the day that the dependent reaches the maximum age, coverage will automatically be terminated. If the dependent is in full-time attendance at an accredited school, college, or university, they must register annually with their insurance carrier/plan sponsor. Their coverage would be continued until they reach the maximum age as determined for overage dependents. Some overage dependents will have their own card with "OA" and/or an expiry date. A disabled dependent may have "DD" shown on their card.

Deductible – this varies among plan sponsors and refers to an amount of money that represents the cardholder's out of pocket portion. Their deductible could be indicated as a dollar/cents amount ("$.35", "$2.00" etc.), as a percentage of the total cost of the claim ("10%", "20%", "10% MAX TO $5.00"), or equal to the professional fee ("FEE"). A plan sponsor can choose to combine both a deductible and a co-insurance. Some plans incorporate one or more levels of coverage where the deductible and/or co-insurance vary depending on the DIN dispensed. You will be advised of the exact amount covered by the insurance carrier at the time of processing.

Maximum professional fee (fee caps) – a plan sponsor may set a limit (dollar or percentage) on the amount of professional fee that will be paid out by the plan. Any amount above the set limit up to the usual and customary fee becomes the responsibility of the cardholder and is charged to them at the discretion of the pharmacy.

Due to the increasing complexity of plan designs, some plan sponsors will elect to keep some fields on the card blank (i.e. deductibles, maximums and plan types). Other cards, for example, those issued to college or university students, may require secondary identification such as a student ID number. In this case, the cardholder number is not shown on the front of the card.

Relationship code and date of birth

The input of the correct date of birth in the approved format is critical to the EDI adjudication process, as is the correct relationship code (**"Rel. Code"**) of the cardholder/dependent for whom drugs are being dispensed. Use of the proper rel. code is important as it allows TELUS Health to be able to validate claims as well as apply the TELUS Health Assure claims drug utilization review (DUR) (Section 5) and to determine various individual plan limits such as deductibles, maximums, out-of-pocket accumulator, etc.

TELUS Health and the CPhA3 standard use the following rel codes. If your software is using the CPhA3 standard or another approved format, the system will automatically change it to the TELUS Health rel code.

TELUS	CPhA3 Standard	
Code	**Standard**	**Card Description**
01	0	**The primary cardholder:** usually an employee of the plan sponsor. The name of the primary cardholder usually appears on the card.
02	1	**Spouse of the primary cardholder:** in some instances, the name of the spouse appears on the card, either secondary to that of the primary cardholder, or by itself. A separate card may be issued in the name of the spouse alone in such cases as when the spouse goes by a different surname.
03	2	**Dependent child of the primary cardholder:** usually a minor up to age 18 or 19 but could be 20 or older, depending on the terms of the group benefit plan.
04	3	**Overage dependent child of the primary cardholder:** is still eligible for coverage because of full-time education. In some cases, separate cards are issued in the name of the overage student. Such cards will present themselves with the letters "OA" and an expiry date, usually the end of the school year.
05	4	**Overage disabled dependent child of the primary cardholder:** is still eligible for coverage because of a mentally or physically disabling condition. In some cases, separate cards may be issued in the name of the disabled dependent. Such cards present themselves with the letters "DD".

Use of the correct relationship code with the wrong date of birth (DOB) will result in the rejection of the claim. This also applies when the correct DOB is used with the wrong relationship code. It is essential that both match the information in our system in order to facilitate payment.

Section 3

TELUS Health Assure
claims pharmacy support centre

Section 3
TELUS Health Assure claims pharmacy support centre

Contact information and hours of operation

TELUS Health Assure claims pharmacy support centre: 1 800 668-1608
Monday – Friday 8:00 am – midnight Eastern Time (EST)
Saturday and Sunday 9:00 am – 8:00 pm (EST)
Public holidays 12:00 pm – 8:00 pm (EST) *

*The days considered public holidays are indicated at the bottom of the page.

When contacting the TELUS Health Assure claims pharmacy support centre, please have your 10-digit provider number available. **These phone lines are for pharmacies ONLY.** DO NOT give cardholders the TELUS Health Assure claims pharmacy support centre telephone number. If cardholders have any questions or concerns, they should contact their benefits department at their place of employment.

Electronic providers do not need to contact the TELUS Health Assure claims pharmacy support centre to determine eligibility of a drug, or cardholder eligibility or verify plan parameters prior to submitting a claim. Simply submit the claim and eligibility will automatically be verified. The TELUS Health Assure claims pharmacy support centre is unable to confirm eligibility in advance. The only exception to this is when the pharmacy needs to determine eligibility of compound claims. It is always wise to check that a compound is eligible before filling a prescription. If you are experiencing a systems problem, please contact your software vendor.

Holiday schedule

Holiday	Hours of operation
Family Day	(February) 9:00 a.m. to 8:00 p.m. (EST)
Good Friday	Noon to 8:00 p.m. (EST)
Easter	Noon to 8:00 p.m. (EST)
Victoria Day	Noon to 8:00 p.m. (EST)
Canada Day	Noon to 8:00 p.m. (EST)
Civic Holiday (August)	9:00 a.m. to 8:00 p.m. (EST)
Labour Day	Noon to 8:00 p.m. (EST)
Thanksgiving Day	Noon to 8:00 p.m. (EST)
Christmas Eve	8:00 a.m. to 8:00 p.m. (EST)
Christmas Day	Noon to 8:00 p.m. (EST)
Boxing Day	Noon to 8:00 p.m. (EST)
New Year's Eve	8:00 a.m. to 8:00 p.m. (EST)
New Year's Day	Noon to 8:00 p.m. (EST)

Section 4

General policies and procedures

Section 4
General policies and procedures

Procedures

The provider shall honour all Assure cards properly presented and not discriminate in any manner against the holder of an Assure card or the type of claim.

When billing through the Assure claims card for a patient, any and all claims must be billed entirely through the Assure system.

Validation of electronic claims

Electronic submission of a claim offers the advantage of immediate verification of cardholder eligibility and instant processing of each transmitted claim. It is at all times the responsibility of the pharmacy and the dispensing pharmacist to ensure that:

- The cardholder (or the authorized dependent of the cardholder) presents a valid TELUS Health Assure claims card, and the pharmacist verifies the cardholder identification, including name, date of birth and rel code.
- The cardholder has a valid prescription that abides by provincial regulations and TELUS Health policies (which for greater clarity include the contents of this manual as well as all updates, modifications, and communications sent to the pharmacies by TELUS Health), including regulations on expiration limits on prescription authorizations from an authorized prescriber.
- Dispensing, operating or billing behaviors are not in contravention of any federal or provincial act or regulation, any applicable by-law, any practice policies set forth by provincial pharmacy regulatory bodies or any generally accepted standards of pharmacy practice.

Note: Any online claims found, pursuant to an audit (Section 6), to have been inaccurately submitted under a valid TELUS Health Assure claims card for a cardholder who does not have coverage under that benefits card, will be charged back to the pharmacy.

Rejected claims are accompanied by an explanation of the reason for rejection. Pharmacies have 90 days from the dispensing date to submit or re-submit the claim electronically.

Paper claims

Please be advised that the pharmacy will not be reimbursed for paper claims. Only the cardholder may receive reimbursement from a paper claim. If TELUS Health finds that your pharmacy is submitting paper claims for reimbursement, your pharmacy will be subject to further audit and investigation.

Incorrect date of birth

TELUS Health uses the date of birth as one of our key identifying features. As such, it is imperative that the pharmacist enters the correct date of birth to ensure the proper identity of the individual using the TELUS Health Assure claims card. If the support centre gave out this information, it would compromise the integrity of the identification process.

The TELUS Health Assure claims pharmacy support centre is allowed to confirm whether the birth date you have on file is the same as that supplied to TELUS Health by the insurance carrier. If the cardholder confirms that the birth date you have on file is correct but it differs from our cardholder information, then the cardholder must contact his or her employer in order to rectify the situation. The insurance carrier will inform TELUS Health of the revised information shortly after receiving notification of the required change from the cardholder.

If this situation arises and the cardholder cannot wait for the information to be corrected (it may take a few days), the cardholder should pay and submit the receipt to their insurance carrier.

Claim void ownership changeover – Open window/claim retransmission (accounts requiring settling)

Prior to a provider change of ownership taking place, providers are responsible for ensuring that all previously submitted claims that have not been received by the plan member but are still at the pharmacy are voided. All voids must be processed before the new provider number has been activated otherwise the claim will be deducted from the new account after the change of ownership.

Occasionally, a transaction may need to be processed at a different date from the original dispense date. The dispense date must reflect the actual supply date. Any claim transmitted electronically beyond the 90-day limit will be rejected as “claim too old”. The pharmacy can collect cash from the cardholder who will then submit the receipt to their insurance carrier for reimbursement.

The claim void (reversal) transaction is used to cancel or void a claim that has been successfully processed through TELUS Health. Most pharmacies have the capability to void claims up to ninety days after the dispense date. Should you find that TELUS Health was charged for a claim that was never received by the cardholder, or you have a claim which needs to be voided and falls outside of this 90-day void window, or you are having difficulties in voiding a claim within the 90-day void window, please contact the TELUS Health Assure claims pharmacy support centre for assistance.

Please note that the 90-day window is available for voiding and rebilling a claim. Resubmissions for prescriptions dispensed outside the 90-day resubmission window will not be accepted electronically. Before voiding any claims, ensure that the affected claim has not been adjusted by the TELUS Health audit department. The adjustment to account notices are sent out by the TELUS Health audit department to communicate the results of an audit and to identify which claims have been adjusted. Voiding any of the claims that appear on the adjustment to account will result in multiple deductions of funds from the provider's account. TELUS Health will not be held responsible for reimbursing providers for claims that have been voided in this manner.

Claim retransmission requests

TELUS Health allows requests for retransmission of claims that are accidentally voided. A "window" may be opened for the pharmacy to retransmit the claim online if the claim is voided outside the TELUS Health 90-day retransmission window. In order for TELUS Health to review your retransmission request, please contact the TELUS Health Assure claims pharmacy support centre. Be aware that these requests are evaluated on a case-by-case basis. In addition, no open window will be authorized for deferred payment, card termination, rejected claims, non-pack size unit issues or for claims previously submitted under a provider number which is no longer active. Claims are only eligible for re-transmission under active provider numbers only.

Balancing transactions

Pharmacies are expected to complete some daily balancing transactions to reconcile with the TELUS Health bank deposit. In order to do this we recommend that you follow this procedure:

1. At the beginning of each day, submit a totals request for the previous business day (net settlement report) to us via EDI. This report will show you a summary of any applicable transactions.

2. At the end of each day, it is important to submit a daily totals request (claims balance inquiry) to us. This report will show you the total number of claims submitted, voids submitted and the sum total of the amount to be paid.

This total does not include transactions fees or deposit information. We recommend that you compare this report with a totals report that is generated from your pharmacy management software to ensure that the two systems balance. Should discrepancies be found, a more detailed report could be obtained from your pharmacy management software to assist in finding the error. Should it be necessary to void a claim and re-send it, it should be dealt with immediately. The pharmacy support centre will also be available to assist you with the same day discrepancies. If a detailed report is requested on paper, a processing charge may apply.

Note: For Western provinces, TELUS Health operates on Eastern Time (ET). Claims processed after midnight ET will show up in the next day's totals.

Pharmacy payment options

- **Next day payment:** Payment directly into the provider's authorized account value dated for the next banking day for a transaction fee of $0.20 per paid claim.

- **Twice a month payment:** Payment directly into the provider's authorized account for a transaction fee of $0.10 per paid claim. For transactions submitted for processing between the 16th and the end of each calendar month, the payment will be deposited into your account on the first available banking day after the 1st of the following month. For transactions submitted for processing between the 1st and the 15th of each calendar month, the payment will be deposited into your account on the first available banking day after the 16th of the month.

- **Payment 30 days transaction date:** Payment directly into the provider's authorized account value dated for the next available banking day after 30 days for transaction submitted for processing at no cost. This is not a once a month lump sum payment, this is a daily deposit 30 days after the transaction date.

TELUS Health has the right to adjust from time to time the transaction fees shown in the confirmation letter, subject to a 30 days' notice to the provider. The provider has 14 days from the date of the notice of change to change the payment option in effect at that time or to cancel the agreement; otherwise, the services will be charged according to the new rates as of the effective date.

Pharmacy provider portal

Pharmacies can use the TELUS Health pharmacy provider portal (https://pharmacyregistration.telushealth.com) to retrieve their payment reconciliation reports any time.

Pharmacies will be able to select either their Assure or PSHCP provider number for which to generate the payment reconciliation reports and download generated reports.

Please note that at this time, only one login per pharmacy location is supported by TELUS Health. This means that only one user can log on to the portal at a given time. If the same proprietor owns multiple pharmacy locations, each location will have its own provider portal login.

In your provider agreement with TELUS Health, you agree that you will register for the portal as per the procedures provided. The access and use of the portal is limited to the pharmacy's employees as authorized by the pharmacy owner/ manager, and not to any customer, end-user or other third party.

For additional information, please refer to the Terms and Conditions section in your provider agreement with TELUS Health.

Payment reconciliation

With the payment reconciliation report, pharmacies can obtain information about the following:

- Claims: A list of the transactions that have been adjudicated within the defined time period
- Audit: A document outlining the transactions that were invoiced as part of the TELUS Health audit program on the date pertaining to transaction date being reported on
- Summary: A summary of the provider deposit information

Pricing

Determination of prescription pricing

Pricing policies vary from province to province and therefore regional differences between pharmacies may occur. Some payment schedules may be based on the usual and customary dispensing fee of a pharmacy, and others on a negotiated fee for all pharmacies within a province.

Despite these differences, one common rule applies:

The total amount charged to the cardholder shall not exceed the amount that would be charged to a cash-paying customer or other private pay direct cardholders.

This ensures that all insurance carriers are competing on a level playing field and reduces the incentive for them to direct the cardholder to lower cost pharmacies.

- For all claims submitted to TELUS Health, no balance billing is allowed for differences between your ingredient cost and that allowed by the TELUS Health default price file. In the event a manufacturer decreases their price for a product and you have remaining inventory purchased with the previous higher cost, please contact the manufacturer directly, as TELUS Health is not responsible for manufacturer price decreases.
- If you have a cardholder who has a deferred payment plan (see page 19), the same principle applies. You cannot collect from your cardholder the difference between your ingredient cost and that allowed by the TELUS Health price file where TELUS Health is the primary payer.
- For the e-sampling program, you receive payment from the participating pharmaceutical manufacturer(s) via the electronic adjudication system.

When a claim is submitted, our adjudication system bases payment to you on your usual and customary professional fee and on our price files of drug costs. Our price files are based on a number of reliable sources.

In your provider agreement with TELUS Health, you agree that you will accept our adjudicated cost payment and will not charge the cardholder any excess amount. Please refer to page 18 under "What can be charged to cardholders?". Failure to comply with any TELUS Health policies may result in revocation of your provider number(s) with a possible blackout period where you may not be permitted to reapply for a provider number with TELUS Health.

In the event that your actual acquisition cost exceeds the amount allowed by our system, you can contact our TELUS Health Assure claims pharmacy support centre at 1-800-668-1608 and arrange to fax us the most recent invoice supporting your claim to 1-888-334-6878. For provinces where the payment schedule is based on manufacturer list price (MLP), pricing adjustments are allowed only when the MLP exceeds the amount allowed by our system. Please reference the claim that was affected and include your provider number. Any invoice which is submitted must be received within 7 days of the dispense date of the prescription. Please note, only adjustments of $2.00 or more per DIN will be considered.

In the event a manufacturer decreases their price for a product and you have stock with the previous higher cost, please contact the manufacturer directly, as TELUS Health is not responsible for manufacturer price decreases. Furthermore, if a generic product is on backorder, the pharmacy is responsible for checking all available suppliers for stock, or obtaining another generic interchangeable product before submitting for the brand name. If all generic interchangeable products are temporarily unavailable, then brand name submissions will be honoured. However, once the generics are available, brand name claims will be cutback to generic pricing.

Keeping a level playing field

EDI pay-direct drug plans are an increasingly popular employee benefit that is advantageous to both your pharmacy and your customers. The concept that EDI cardholders should be charged no more than your regular price (i.e. should not be discriminated against just because they carry the TELUS Assure claims card) is critical to its success. This includes charges for diabetic supplies and oral contraceptives where reduced dispensing fees often apply. The pharmacy should bill TELUS Health EDI cardholders no more than it would charge cash paying customers or other private pay direct cardholders. Your contract with us includes this as a requirement.

This also means that if you make any special deals with any pay-direct network, you must apply the same pricing concessions to TELUS cardholders. We provide pharmacies with a level playing field with respect to competition. In turn, our agreement with your pharmacy assures that our affiliated insurance carriers are accorded the same cost benefits as you provide our competitors.

Note: This does not preclude you from entering into preferred provider arrangements with single plan sponsors or industry based associations (trade associations).

What can be charged to cardholders?

Most plans have various forms of co-payment (deductibles, co-pays, co-insurance), which require the cardholder to pay a portion of the cost of the prescription. Some plans have dispensing fee caps or deductibles equal to the dispensing fee, which limit the amount paid by the plan for your professional services. Other plans limit payment to the cost of alternative drugs, such as generics, or to drugs on a controlled formulary. The remainder, which may be submitted to the secondary payer in a COB scenario, is referred to as the residual amount.

Please note that the residual amount is subject to the cardholder's private plan rules (e.g. deductibles, co-insurance, etc.). For public to private coordination of benefits (COB) claims, TELUS Health would only pay up to the maximum amount the first payer would pay, as private insurance is intended to supplement coverage.

Under your provider agreement with TELUS Health, differences in adjudicated prices on claims can only be passed along to the cardholder under the following circumstances:

- Difference between your usual and customary dispensing fee and the maximum dispensing fee paid under the plan (does not apply in New Brunswick, Newfoundland, Nova Scotia and Prince Edward Island).
- Difference in price between a brand name product and a generic, if the cardholder chooses the brand name product, and it has not been ordered as "no substitution" by the physician.
- Difference in cost for a drug covered by a plan that uses reference based pricing (RBP) and/or therapeutic equivalents, e.g., a claim for ranitidine being paid based on the cost of cimetidine.
- Difference in cost for a drug reimbursed by a custom carrier price file (indicated by return code 6028: maximum allowable cost paid).
- Difference in cost for the extra amount dispensed for quantities filled in excess of the maximum supply allowed on the plan, e.g., cardholder requests a 60-day supply, but the plan pays only 34 days at a time.
- Any deductibles, co-insurances, and other plan limits applied to the claim.

We make every attempt to maintain fair price files, reflecting reasonable purchase prices. The adjudication process will indicate to you the maximum amount reimbursed by TELUS Health for the drug cost, including eligible mark-up. Other than the above circumstances, if your drug cost submitted exceeds the amount allowed by our adjudication system, you are not allowed to charge the difference in drug cost to the cardholder, where TELUS Health is the primary payer.

Please ensure that the pharmacy receipt provided to the patient accurately reflects the true out of pocket costs charged to the patient/plan member by the pharmacy. Any discrepancies identified will be addressed through audit proceedings.

Professional fees

Fees charged for professional services, such as injection, medication review, prescription extension, etc., are currently not eligible for electronic billing. A receipt clearly indicating that the fee(s) being charged are for professional services may be provided by pharmacies to patients for manual submission.

Deferred payment plans

A deferred payment program differs from regular pay direct plans in that it provides payment to the insured at a future date based on a predetermined period of time or dollar threshold as determined by the plan sponsor. The cardholder will present their card to the pharmacy for processing; the pharmacy submits the claim in "real time" to TELUS Health for adjudication. At this point the cardholder will be required to pay the pharmacy the entire cost of the claim and will be automatically reimbursed for the portion of the claim that their plan sponsor is responsible for (total claim minus co-pay and deductible), either by cheque or by EFT. Payment is generated once the specified period of time has elapsed or the accumulation of claims reaches a specified dollar threshold. By processing claims electronically, this allows electronic drug utilization review (DUR) to take place. The amount paid to the pharmacy directly by TELUS Health will always be zero. The message sent is "Deferred Payment: Cardholder to pay Pharmacy". Cardholders are not required to submit their receipts manually to their insurance company. If the cardholder does not collect the drug within **2 days** of the dispense date, please void the claim. This is essential so that a payment is not made to the cardholder for a drug that has not been picked up from the pharmacy.

NOTE: IF A CARDHOLDER HAS MULTIPLE TELUS HEALTH PLANS, AND THE PRIMARY PLAN IS A DEFERRED PLAN, THERE CANNOT BE AN ELECTRONIC CO-ORDINATION OF BENEFITS. THE CARDHOLDER MUST SUBMIT ANY RESIDUAL PORTION OF THEIR CLAIM MANUALLY TO THEIR SECONDARY PLAN.

Government programs

WorkSafe BC (WSBC)

The WorkSafe BC of British Columbia has a specific card for injured workers. The WSBC client benefit card is for cardholder use only and does not supply benefits for any dependents. WSBC is the primary payer of eligible injured workers' claims. The pharmacy should initially send the claims to BC PharmaCare with an intervention code of DE so that the DUR process takes place. The claim should then be sent to TELUS Health for adjudication.

Please note as a government agency, WSBC is following BC PharmaCare guidelines with respect to pricing and days' supply of eligible medications. WSBC will not reimburse the claimant for any prescription amount in excess of the BC PharmaCare pricing guidelines. Also note that any portion of a claim not paid online by WSBC (e.g., dispensing fee, drug cost) cannot be charged to the cardholder nor coordinated with a secondary private plan.

Ontario Workplace Safety and Insurance Board (WSIB)

The Ontario Workplace Safety and Insurance Board oversees Ontario's workplace safety education and training system, and provides disability benefits to workers injured on the job.

The WSIB drug benefit program pays for medication prescribed by physicians for work-related injuries or illnesses. The program also has an automated online approval and billing system that allows Ontario pharmacies to obtain authorization for worker's prescriptions over the Internet and to bill TELUS Health directly through the system.

Please note that any portion of a claim not paid online by WSIB (e.g., dispensing fee, drug cost) cannot be charged to the cardholder nor coordinated with a secondary private plan.

Documentation requirements

For all claims submitted through the TELUS Health Assure claims card system, TELUS Health requires that legible documentation be available on all prescriptions. As a standard, TELUS Health requires that there is a valid prescription prior to processing the prescription claim, as the claim may be subject to audit and full recovery.

Authorization for prescriptions

TELUS Health requires a properly authorized prescription for claims submitted electronically and that this prescription is obtained prior to submitting the claim electronically. This includes both prescription requiring items and over the counter ("OTC") items. An authorized prescriber can order a prescription. TELUS Health considers authorized prescribers to be as follows: physician, surgeon, dentist or other healthcare professional prescriber* in good standing with their governing body. Any provincial restrictions placed on prescribing practices are followed by TELUS Health (e.g. a specific list of drugs that a practitioner can prescribe from).

* Where provincial laws permit these persons to prescribe.

Verbal refill authorizations and verbal prescriptions

For all claims submitted to TELUS Health, it is required that documentation be available on all verbal prescriptions, and verbal authorizations for refills on both prescription requiring claims and OTC claims. Verbal prescriptions must be received from an authorized prescriber (see Authorization for prescriptions on page 19), and must be reduced to writing by the receiving pharmacist or entered into the computer record as a log/unfill prescription. This documentation must be recorded prior to processing the claim to ensure there is a reference to verify the prescription claim.

The documentation must include the following:

- The date that the authorization was received
- The plan member's full name
- The drug name, strength, quantity and directions for use
- The prescriber's name
- The signature of the receiving pharmacist
- The number of refills (if authorized) and the interval between refills (if applicable)

It is also required that all properly completed verbal orders, faxed authorizations, etc., be retained with the prescription hardcopies for future reference. It is important that pharmacy records are complete and accurate. Any authorizations provided are only valid for the duration of the individual prescription. Only the information provided on each new authorization will be considered valid. Records must contain an independent audit trail. That means, the "piggybacking" of a new authorization onto an existing authorization does not meet this requirement

Pharmacist prescribing/adaptation

Where provincial regulations allows for the pharmacist extended scope of practice, TELUS Health will accept pharmacist prescribed/adapted claims based on plan design coverage, provided that there is appropriate documentation as required by the province's regulatory college and that it is documented prior to submitting the claim.

Continued care prescription (CCP)/prescription adaptation by a pharmacist

TELUS Health supports online submission of continued care prescriptions ("CCP") authorized by a pharmacist. We understand pharmacists are required to adapt/prescribe a drug by complying with the provincial prescription adaptation regulations when filling a prescription. The regulation does not further govern the submission of pharmacist prescribed claims to third party payers. To minimize any misunderstanding, please follow the claim submission instructions below for all CCP or adapted prescriptions by a pharmacist.

Note: The pharmacist must write the CCP prior to billing the claim online to TELUS for payment

The CCP documentation must include the following five (5) components:

1. The date of authorization
2. Plan member's full name
3. Drug name, strength, quantity, and direction for use
4. Prescribing pharmacist's full name, license number and signature
5. Number of refills (if authorized)

For OTC medications, TELUS Health does not accept quantities such as "1 year supply", "18 month supply" or "unlimited refills until a prescription expires" without specific directions.

For non-specific directions, we require the total quantity authorized in numerical value and the total number of refills (if applicable).

Changing an authorized prescription

Where provincial regulatory bodies require, it is required that documentation be available on all authorized changes to existing prescription orders. These changes must be received from an authorized prescriber and must be reduced to writing by a pharmacist, prior to processing the claim. TELUS Health requires written documentation from the prescriber to dispense time interval medication outside of the specified number of days on the original authorization.

Dispensing reduced quantities

Where provincial regulatory bodies require, the plan member's signature must appear on the prescription should a lesser quantity be dispensed than what was originally prescribed by the authorized prescriber. On claims where a lesser quantity is dispensed due to plan limitations (i.e. prescribed 200 days but plan limits to 100 day supply), the plan member's signature is not required.

Minimum reasonable quantity

To support waste reduction (particularly for high cost drugs) through appropriate dispensing practices, the minimum reasonable quantity must be dispensed when dispensing a prescription for a medication with multiple pack sizes. If for any reason the minimum reasonable quantity is not dispensed, rationale for this discrepancy must be documented. These claims will be subject to audit by TELUS Health and adjusted back to the pharmacy if rationale is not documented. TELUS Health reserves the right to recover paid amounts based on the available pack sizes at the time of dispensing.

Example:

Recommended dose: 120mg
Available pack sizes: 50mg/0.5ml vial & 100mg/1ml vial
Minimum reasonable quantity: 1x50mg/0.5ml & 1x100mg/1ml

If 2x100mg pack sizes are dispensed without documentation of rationale, the excess dispensed dose will be adjusted back to the pharmacy through audit.

Documentation retention

For submission of claims to TELUS Health, it is required that documentation (original written or verbal prescriptions, computer generated hardcopies – where required by law, forms etc.) pertaining to claims processed using the TELUS Health Assure claims drug engine must be retained, and available, on all prescriptions; written, verbal, refill authorizations (written or verbal), and OTC claims. Prescription retention periods must follow your provincial regulations. TELUS Health may audit and may recover on any claims that have been adjudicated through the TELUS network.

No substitution

Where provincial regulatory bodies require, the authorized prescriber prior to processing the claim, in order for TELUS Health to pay for the cost of the Brand name medication online, must indicate as such in one of the following ways:

1. Handwrite the order for "no substitution" or initial the stamp in the section provided on the written prescription from the physician. A pharmacy can verbally verify a "no substitution" as long it is received and dated prior to the claim being submitted for payment and is documented according to the TELUS Health documentation requirements.
2. On a verbal prescription, the order for a "no substitution" must be ordered by the authorized prescriber, and handwritten by the pharmacist who is recording the verbal prescription, prior to processing the claim, along with the date documented prior to the claim being submitted.
3. On an electronic or printed prescription the physician must indicate "no substitution" in the document.

Prescriptions bearing the handwritten notation "no substitution" on the actual prescription as ordered by the prescriber, may be eligible for payment above the cost of the lowest priced interchangeable product, when flagged as "N" for "no substitution" or product selection = "1" (prescriber's choice) for CPhA3 EDI claims.

Pharmacist's signature/initials required

Where provincial regulatory bodies require, TELUS Health requires the pharmacist's signature/initials or electronic signature to be present on the computer-generated hardcopy as confirmation that the claim was indeed dispensed by a pharmacist, and not processed in error.

Prescription not dated

As the date of authorization is needed to determine the expiration of the prescription as a whole, and/or expiration of authorized repeats, TELUS Health requires this information to be present on all prescription documentation for claims transmitted through the TELUS Health Assure system. The date is also required to determine if the authorization was received prior to processing the claim online.

Policies

Classes of drugs that may have restrictions

Plan sponsors may choose to exclude or restrict access to specific classes of drugs for a group or division and unit. Restriction may be in terms of dollar value paid in a year or as a lifetime maximum. The most common restrictions are (this is a non-exhaustive list):

- Fertility treatments
- Smoking cessation
- Preventative vaccines
- Antiobesity/anorexiant
- Erectile dysfunction

Days' supply / early refill

The correct days' supply is essential for DUR and accurate adjudication. We understand that it can be difficult when there are no dosing instructions on the prescription. However, a reasonable estimate is preferable to filling the field with an automatic 30 days.

When receiving a DUR warning for early refill, ensure that at least two-thirds of the previously dispensed supply has been used before processing the new supply. Please note that TELUS Health DUR checks are done against the plan member's entire claim history, and not limited to claims dispensed from your pharmacy. Should a plan member require an early refill, for reasons other than a change in prescribed dosage, they are required to pay cash for the claim, and submit the receipt, along with the reason for the early refill, to their insurance carrier for payment. If you have concerns about dispensing prescriptions after receiving the warning message, please contact our pharmacy support centre for clarification.

Additionally, should the cardholder require an amount in excess of the maximum days' supply allowed on the plan, they are required to pay cash for the amount of the prescription in excess of the allowed amount, and submit to their insurance carrier for payment, along with the reason for the larger supply. These situations include:

- Lost medications
- Changes between manufacturers (different generic/brand switch)
- Vacation supplies

See also Vacation supply and replacement supplies.

Note that in all situations, the pharmacy must consider the amount of medication still on hand with the plan member before considering submitting claims for additional supplies.

If you have concerns about dispensing prescriptions after receiving the warning message, contact our pharmacy support centre for clarification.

Dispensing the same drug more than once in a five (5) day period

If a product, other than an antibiotic, narcotic or controlled drug, is dispensed more than once within a five (5) day period, the second (and other) claim(s) will be treated as either a balance owing from the original prescription, or a duplicate claim. For a balance owing, a professional fee may not be claimed as part of this second transaction. If the claim is considered a duplicate claim of the original prescription, the entire payment for the second (and other) claim(s) will be recovered by TELUS Health.

The only exception to this would be if the drug were allowed as part of TELUS Health administered trial drug program.

Vacation supply

Groups commonly allow for 34 days' supply for non-maintenance drugs and 100 days' supply for maintenance drugs, however, other configurations are possible. When a cardholder or dependent requests a vacation supply period that is greater than the standard limits, the pharmacy is to **transmit a single claim** with the correct days' supply and use the MV intervention code. If the vacation supply exceeds the allowed vacation days' supply determined by the cardholder's insurance carrier, TELUS Health will cut back the cost to the allowed days' supply and the pharmacy can have the cardholder pay for the difference. The return message from the drug adjudication engine will be "**QUANTITY ADJUSTED**". The cardholder can then manually submit a claim to their insurance carrier and ask for reimbursement of the out-of-pocket amount.

Compliance packaging

The use of compliance packaging may be subject to review through the audit process, including consultation with the physician and/or insurance carrier for appropriateness of use. Please ensure your records include all documentation for every new or renewal authorization, and who requested the compliance packaging.

TELUS Health will only be responsible for the multiple dispensing fees and markup in a given month should the compliance packaging order be requested by the original authorized prescriber. Where the drug is a high cost/specialty item (e.g. biologics, hepatitis C therapy, rare disease therapy), dispensing of a reduced quantity will only be allowed if deemed to be reasonable based on accepted clinical practice guidelines and the patient history.

If the pharmacy or the cardholder is requesting the compliance packaging, then TELUS Health will only pay for 1 fee in a given month (with the exception of the trial program). The cardholder would be responsible for paying the additional fees incurred in that month. Any additional fees and markup billed without the proper supporting documentation will be adjusted back to the pharmacy through audit. No blanket letters of any kind are accepted. Documentation for reduced day's supply must be clearly documented on each new prescription. If claims are being billed for compliance packaging on a weekly basis then claims should only be billed once 5 days have passed (on the 6th day).

This is done to ensure that TELUS Health is paying for only the additional costs incurred because of a medical necessity determined by the physician. If a pharmacist or plan member feels that there is a compliance issue, then discussions with the prescribing physician should occur regarding their concerns. At that point, the physician would determine the best course of action to take for optimum plan member compliance.

Dispensed amount should match electronically billed amount

With the exception of short supply or balance owing situations, the quantity dispensed should match the quantity billed electronically. Otherwise, these claims may be subject to audit, recovery and possible escalation measures. As an example, if a member is picking up blister pack medications monthly, but the pharmacy is billing these claims on a weekly basis, these claims will be subject to audit, recovery, and a potential referral to regulatory colleges due to inappropriate billing practice.

Replacement supplies (lost/stolen/spoiled prescriptions)

If a medication is lost/stolen/damaged/spoiled the cardholder must pay for the replacement prescription and submit the receipts to their insurance company with a note of explanation. The pharmacist is not to submit the claim to TELUS Health a second time or as an early refill.

Procedure for submitting claims for diabetic supplies (excluding diabetic devices)

Use the pseudo-DIN (PIN) customarily assigned by your provincial formulary or by TELUS Health for specific diabetic items. Please refer to: **https://www.telus.com/en/health/health-professionals/pharmacies/support-documents** for the most up to date list of diabetic PINs, or call the pharmacy support centre for a hard copy of this list.

When processing claims for diabetic supplies through the TELUS Health network, proper documentation is still required on all these claims, similar to all other claims that come through the TELUS network. Required documentation is as follows; authorization, written or verbal, must be reduced to writing (pen to paper) or the claim may be placed on hold/logged and filled from that log. TELUS Health will no longer accept prescriptions under the generic term of "diabetic supplies" for audit purposes; rather they will need to be itemized and specifically named, such as test strips, lancets, pen tips, needles, etc. A specific numeric quantity must also be present on the prescription so that a proper total authorized quantity can be calculated.

Reimbursement handling for free and discounted meters and training fees

The pharmacy is responsible for payment of all income and other taxes in respect of payments made to the pharmacy for reimbursement of free and discounted meters and training fees. By seeking reimbursement for free meters, the pharmacy states that the meters sought for reimbursement were purchased by the pharmacy for a price approximating full market value and were provided free of charge to the cardholder and no other form of reimbursement was sought from any other source in respect of those meters. By seeking reimbursement for discounted meters as prescribed by the meter manufacturer, the pharmacy states that the meters sought for reimbursement were purchased by the pharmacy for a price approximating full market value and were provided to the cardholder pursuant to the prescribed discount, and no other form of reimbursement was sought from any other source in respect of those meters. All warranty cards must be completed and sent to the meter manufacturer or third party on behalf of and as instructed by the manufacturer. By seeking reimbursement for training fees, the pharmacy states that the number of cardholders indicated by the pharmacy as receiving training is accurate and no other form of reimbursement was sought for the training.

Pharmacy inventory – Purchase verification

TELUS Health may request pharmacies provide invoices and other relevant documentation to support any pharmacy inventory that has been acquired and purchased and submitted for payment to TELUS Health. TELUS Health requires these documents in order to validate claims through the regular audit processes. Failure to provide applicable invoices upon request (such as during an onsite visit or by specified deadline) may result in the reversal of all claims affected by the pharmacy inventory review.

Allergy products

Allergy products on the market that have an assigned DIN, but are manufactured specifically for individual plan members, are not to be transmitted electronically to TELUS Health. Due to the individualized nature of these products it is not possible for our system to maintain accurate pricing. These products are not online benefits for TELUS Health Assure claims cardholders. Please collect cash payment from your plan member and have them submit the receipt manually. Allergy serums that are not manufactured specifically for individual plan members (i.e. Pollinex R®) are eligible for online submission.

Clarification on how to bill suboxone & methadone

As of 2013, TELUS Health has discontinued the coverage of methadone as a compound and transferred coverage to the commercially available alternative, methadose. With this changeover, pharmacies were advised to submit methadone as a regular methadose prescription claim with the respective DINs as methadone was no longer considered a compound.

Suboxone: The billing of suboxone claims would be based on the indication from the physician in terms of the number of observed and carry doses the patient receives.

Example 1 - Methadone (brand/generic/compounded where appropriate/allowable): 1 fee will be paid for the observed dose, and 1 fee will be paid for each carry dose. i.e. in one week, TELUS Health would allow a dispense fee on the observed dose, and 1 fee for each remaining 6 carry doses in a week (7 fees total).

Example 2 - Suboxone (generic): 1 fee will be paid for the observed dose, and 1 fee will be paid for all carry doses. i.e. TELUS Health would allow a dispense fee on the observed dose, and 1 fee for all remaining carry doses in a week (2 fees total).

Split claims - how to bill high dollar claims properly

When the drug cost exceeds $9999.99 due to the CPhA standard limitation, providers must submit several, fractional claims, rather than one claim, for total payment.

Reminder:

- When splitting the claim, each claim processed through should be billed with the total days' supply that the claim needs to last
- Only one dispensing fee should be submitted for the entire quantity
- If a markup cap has been applied to the first claim, the other claims should be submitted without a markup (drug cost only)
- Please use the intervention code NA = valid claim – for each subsequent claim being processed

Example:

A pharmacy is billing a claim for 28 tablets of Sovaldi split into 4 claims. Each claim should be billed as a quantity of 7 tablets with a 28 day supply (only the first claim submitted should have a dispensing fee and the other claims should have no dispensing fee).

If the markup paid on the first claim, was reduced based on the markup cap, then each subsequent claim should be submitted without any markup (drug cost only).

Submission & eligibility guidelines for compounds

A compound is a product that a pharmacist must make by mixing two or more ingredients, and when they are combined, become a preparation that is **not commercially available**. A compound can be in the form of liquid, capsules, cream, ointment, IV bag, etc. Compounds are sometimes referred to as mixtures or extemporaneous mixtures.

Submission rules

Whenever possible, we require that you transmit compound claims using the DIN of the primary medicinal ingredient in that compound (if applicable). This will ensure an online eligibility check of the DIN/PIN you have transmitted.

For example:

- Hydrocortisone 1% cream and ketoconazole 2% cream, compounded in equal parts – submit with the ketoconazole cream DIN and the appropriate compound code since ketoconazole is the higher cost ingredient and therefore is the primary medicinal ingredient of the compound
- Hydrocortisone powder with clotrimaderm cream -- submit with the clotrimaderm cream DIN and the appropriate compound code

If your primary medicinal ingredient does not contain a DIN, you must submit using one of the eligible TELUS compound PINs. If you must use a compound PIN (e.g. 00991186, 00099984) to submit a claim, we strongly recommend that you review this document to confirm eligibility prior to submitting the claim.

Mixture breakdown requirements

TELUS Health requires the following documentation pertaining to a compound and its preparation, for all compounded products, including compounded products purchased from an off-site pharmacy.

The following information documented on each compounding record shall include, but not be limited to:

- Name, lot number and expiry of raw material if available
- Quantity required, and quantity actually weighed
- Date of preparation and expiry
- Initials of compounder and/or pharmacist responsible for the preparation and checking of hardcopy
- Written formula used
- Any other documentation required by the provincial regulatory authority
- Cost charged for each ingredient
- Mixing time charges (if applicable)
- Original authorizing prescription

Please note, all breakdowns must originate from computer generated pharmacy software. TELUS Health will not accept any hand-written documentation or auxiliary labels. Handwritten documentation and auxiliary labels are subject to recovery of the full claim amount, as it is considered failure to produce proper documentation.

Duplicating a commercially available product

If a compound mimics a commercially available product, the compound will not be covered. If the commercially available product is not available (Example: backorder), a temporary exception may be granted to allow for the compounding of the product until the commercially available product is available. In this situation, please contact the TELUS Health Assure Claims Pharmacy Support Centre at 1 800 668-1608 in order to verify the eligibility of the commercially available product.

Unlisted compound codes

0 = Compounded topical cream **1** = Compounded topical ointment **2** = Compounded external lotion **3** = Compounded internal use liquid **4** = Compounded external powder	**5** = Compounded internal powder **6** = Compounded injection or infusion **7** = Compounded eye/ear drop **8** = Compounded suppository **9** = Other compound

All compounds must be submitted with the correct corresponding unlisted compound code. There are some exceptions to this rule, e.g. Remicade®, methadone. See Appendix 6 for some common compounds that have special PINs and submission rules.

Ineligible compounds

- A commercial product is available in the same strength
- The primary medicinal ingredient is not covered under the plan member's plan
- Natural products
- Homeopathic products
- The product is for cosmetic use
- The product contains an ineligible base/ingredient (see lists below for ineligible drugs and ineligible bases) or is in an ineligible format.

Ineligible bases, ingredients and formats: The following chemicals/drugs/ formats are not eligible on any of our plans, even if combined with a prescription-requiring medication or with a product considered to be an eligible benefit.

Ineligible bases (In addition, all bases with an SPF rating are deemed ineligible)		
Alpha hydroxy acid	Formula 405	Noxzema product line
Alpha hydroxy serum	GlyDerm	Ombrelle product line
Aminophylline thigh cream	Glyquin	Pond's product line
Aveeno skin brightening	Hyaluronic acid complex cream	Porcelana
Aveeno SPF products	Kinerase	Rejuva
Benoquin (Monobenzone) (Benzoquin)	La Roche Posay product line	Renova
Biobase-G	Lubriderm SPF products	Reversa product line
Biotherm product line	Lustra product line	Solage
Dermophil lotion	M.D. Forte	Solaquin
Dilusol AHA	Marcelle product line	Ultraquin
Dormer 211 SPF	NeoStrata product line	Vichy product line
Eldopaque	Neutrogena product line	Viquin Forte
Eldoquin	Nivea product line	Vitamin E base

Ineligible ingredients		
Chlorohydroquinone	Lipoic acid	Topical triamcinolone (when mixed with distilled water & alcohol)
Glycolic acid	Mandelic acid	Topical vitamin K
Hydroquinone	Retinol	Yohimbine
Kojic acid	Titanium dioxide	Acetyl mandelic acid
Minoxidil	Hyaluronic acid/ sodium hyaluronate	

Ineligible forms/formats

Regardless of the drugs or chemicals added, compounds made into the following dosage forms (but not limited to those listed) are not eligible under all plans:

Gummies	Slow release products	Troches
Lollipops	Sustained release products	
Lozenges	Timed release products	

An ineligible ingredient/base/form may be covered by individual cardholder by exception only. Please confirm with the plan member if they have received approval for a specific compound (PIN will be provided to the plan member by their insurance carrier).

Eligible compounds

Compounds are eligible if the primary medicinal ingredient is covered on the cardholder's plan.

Important: Even though an eligible prescription requiring DIN/PIN may be accepted online, if it has been added to a compound containing an ineligible ingredient or base or is in an ineligible format, the compound will be deemed ineligible and charge backs will apply.

Comprehensive TELUS Health compound PINs

PIN	Full name	Complete eligibility criteria (primary medicinal ingredient)
00991186	Topical salicylic acid (40% or greater)	Concentrations 40% or greater
00991187	Topical antibiotics	Clindamycin Erythromycin Metronidazole Neomycin Amikacin Cefazolin Vancomycin Gentamycin Tobramycin
00991188	Compounded corticosteroid	Hydrocortisone (greater than 1%) Betamethasone Clobetasol Desonide Dexamethasone Triamcinolone
00991189	Compounded fertility treatment	Clomiphene citrate Metformin Progesterone (if suppository – PIN 00990054)
00990054	Compounded fertility treatment – progesterone suppositories	Progesterone suppositories
00991190	Compounded skin treatments	Containing coal tar/LCD (10% or greater) Sulfur (8% or greater) Doxepin Lactic acid (>17%) Methchlorethamine Sucralfate Sulfacetamide Thiabendazole Urea Verapamil
00991191	Topical pain treatments **(with or without narcotic)**	Phenytoin Gabapentin Clonidine Amitriptyline Amantadine Cyclobenzaprine Baclofen Pregabalin
00991192	Topical pain treatments **(narcotic primary ingredient)**	Morphine Oxycodone Methadone Codeine
00991193	Compounded antifungal	Ciclopirox Itraconazole Ketoconazole Clotrimazole Nystatin Miconazole
00991194	Intranasal compounds	Hydroxycobalamin Mupirocin Oxytocin Wilson's solution (gentamycin in saline) Methylprednisolone
00991195	Compounded suppositories	Diazepam Codeine Morphine Baclofen

00991196	Wart treatment	Cantharidin (>0.7%)
00991197	Other eligible compounds	Diltiazem Nifedipine Glutaraldehyde (10% or greater) Dimercaprol Folic acid (>1mg) Phenazopyridine Disulfiram Demeclocycline Acetyl-L-carnitine, comoglicicic acid (>2%) Magic mouthwash Neomycin
Call pharmacy support centre	Backorder – compounding	To be used when compounding a commercially available product when it is on back order. The DIN of the commercially available product must be a benefit on the members plan in order to compound it in the case of a backorder. Documentation of the backorder must be kept on file.
00999984	Topical nsaid	Diclofenac Ibuprofen Indomethacin Ketoprofen Naproxen Meloxicam Piroxicam Celecoxib Flurbiprofen
00900669	Invasive erectile dysfunction (bimix/trimix)	Papaverine (+/- prostaglandin) Phentolamine (+/- prostaglandin)
90800233	Hormone replacement therapy – progesterone	Progesterone for HRT
00990111	Hormone replacement therapy – estrogen	Estrogen (estriol/estrone/estradiol) for HRT
90800234	Hormone replacement therapy – testosterone	Testosterone for HRT
Call pharmacy support centre	Compound not eligible for provincial COB	To be used for compound claims which are eligible benefits under the TELUS Health compounding policy but which do not qualify under the provincial plan. Documentation must be kept on file with rationale of why this compound is **NOT** covered by the provincial plan but is eligible under the TELUS compound policy.
Call pharmacy support centre	Custom dose compounds (using raw ingredients)	Example: fluoxetine, omeprazole, naltrexone, T3/T4 liothyronine/levothyroxine, desiccated thyroid. Please note, the above are examples only and not the exhaustive list of eligible ingredients. Eligibility will be based on coverage of the commercially available strength. Please call the TELUS Health Assure Claims pharmacy support centre to verify eligibility of the commercially available strength.

Reimbursement time guidelines for compounds

TELUS Health receives inquiries from pharmacies regarding the allowable time charges that can be charged to TELUS Health when submitting compounds. Depending on the mixture preparation, please refer to the appropriate chart below when submitting claims. Note: For illustrative purposes only, even number of ingredients are shown in the tables below.

Cream/ointment/ lotion compounds		1 ingredient = 2 minutes (max 20 minutes), plus 2 minutes per 50 grams.
Quantity range	**No. of ingredients**	**Allowable time**
0 to 50 grams	2	6 min
	4	10 min
	6	14 min
	8	18 min
	10+	22 min
51 to 100 grams	2	8 min
	4	12 min
	6	16 min
	8	20 min
	10+	24 min
101 to 150 grams	2	10 min
	4	14 min
	6	18 min
	8	22 min
	10+	26 min
151 to 200 grams	2	12 min
	4	16 min
	6	20 min
	8	24 min
	10+	28 min
201 to 250 grams	2	14 min
	4	18 min
	6	22 min
	8	26 min
	10+	30 min
251 to 300 grams	2	16 min
	4	20 min
	6	24 min
	8	28 min
	10+	32 min
301 to 350 grams	2	18 min
	4	22 min
	6	26 min
	8	30 min
	10+	34 min
351 to 400 grams	2	20 min
	4	24 min
	6	28 min
	8	32 min
	10+	36 min
401 to 450 grams	2	22 min
	4	26 min
	6	30 min
	8	34 min
	10+	38 min
> 450 grams	2	24 min
	4	28 min
	6	32 min
	8	36 min
	10+	40 min

Powder/liquid to liquid compounds	Each ingredient = 2 minutes, max 20 minutes (no extra time for volume) * If end result are vials, add extra 5 minutes on top of ingredient charge.
No. of ingredients	**Allowable time**
2	4 min
4	8 min
6	12 min
8	16 min
10+	20 min

Capsules/tablets to liquid compounds	Each ingredient = 2 minutes, max 20 minutes (no extra time for volume) * If you must crush tablet or open capsule (i.e., powder is unavailable), add 10 minutes on top of ingredient charge.
No. of ingredients	**Allowable time**
2	4 min
4	8 min
6	12 min
8	16 min
10+	20 min

Liquid to liquid compounds	Each ingredient = 2 minutes, max 20 minutes (no extra time for volume)
No. of ingredients	**Total allowable time**
2	4 min
4	8 min
6	12 min
8	16 min
10+	20 min

Capsule compounds	Allowable time (see below) plus an additional 20 seconds per capsule, maximum 60 minutes
No. of Ingredients	**Allowable Time**
2	6 min
4	12 min
6	18 min
8	24 min
10+	30 min

Suppository compounds	Allowable time (see below) plus an additional 45 seconds per suppository, maximum 60 minutes
No. of ingredients	**Allowable time**
2	4 min
4	8 min
6	12 min
8	16 min
10+	20 min

Additional notes:

Compounding topical syringes
We allow time charge per number of ingredients (use appropriate time chart above), plus
- An additional 2 min per syringe

Compounding IV preparations and cassettes*
We allow time charge per number of ingredients (use appropriate time chart above), plus
- An additional 3 minutes per mini bag
- An additional 24 minutes per 100 ml cassette
- An additional 18 minutes per 50 ml cassette

(*Note pump bags are priced the same as cassettes)

Specialty compounding
We allow for the following select specialty compounding processes:
- Milling: 5 minutes per 30 grams
- Sterilization/filtration: 30 minutes total per compound (flat rate)

Methadose™ is not considered a compound and should not be submitted with an unlisted compound code and compounding time.

Provincial compound fee guidelines

Province	Fees
British Columbia	A compound time charge of a pre-established amount per minute, plus a regular dispensing fee.
Alberta	Compounding time is a flat rate of 1.5 times the usual and customary dispensing fee submitted in the compounding charge field. No regular dispensing fee can be charged. Dispensing fee field is left blank.
Saskatchewan	A compound time charge to a pre-established amount per minute, plus a regular dispensing fee.
Manitoba	A compound time charge to a pre-established amount per minute, plus a regular dispensing fee.
Ontario	A compound time charge to a pre-established amount per minute, plus a regular dispensing fee.
Quebec	A compound time charge based on usual and customary dispensing fee.
New-Brunswick	Compounding time is a flat rate of 1.5 times the usual and customary dispensing fee submitted in the compounding charge field. No regular dispensing fee can be charged. Dispensing fee field is left blank.
Nova Scotia	Compounding time is a flat rate of 1.5 times the usual and customary dispensing fee submitted in the compounding charge field. No regular dispensing fee can be charged. Dispensing fee field is left blank.
Newfoundland	Compounding time is a flat rate of 1.5 times the usual and customary dispensing fee submitted in the compounding charge field. No regular dispensing fee can be charged. Dispensing fee field is left blank.
Prince Edward Island	Compounding time is a flat rate of 1.5 times the usual and customary dispensing fee submitted in the compounding charge field. No regular dispensing fee can be charged. Dispensing fee field is left blank.
North West Territories, Yukon and Nunavut	Compounding time is a flat rate of 1.5 times the usual and customary dispensing fee submitted in the compounding charge field. No regular dispensing fee can be charged. Dispensing fee field is left blank.

* All guidelines are subject to modifications based on a number of factors including the usual and customary practices in different provinces.

Note:

1. Pharmacies in Atlantic Canada are not permitted to charge a regular dispensing fee on top of the compound fee.
2. In Ontario for provincial coordination of benefits (COB), TELUS Health follows ODB allowable time charges.

If you have any questions on how to transmit a compound claim, please do not hesitate to contact the TELUS Health Assure claims pharmacy support centre. Agents cannot confirm pricing information. For compound verification for a plan member, you will be asked to provide the following information:

- Plan member's name
- Plan member's drug card information
- Plan member's date of birth
- DIN or PIN of the compound

Please note that all claims for compounds are subject to review by the TELUS Health audit department. Any compound claims determined to be ineligible or submitted for compounding charges (time and/or charge per minute) in excess of ACCEPTED PHARMACY PRACTICE will be adjusted or charged back to the pharmacy.

Submission and eligibility guidelines for glucometers

Blood glucose meter claims submission

The following glucometer companies adjudicate through TELUS Health:

- Abbott
- ACM (Auto Control Medical)
- Ascensia
- LifeScan
- Roche

Please see below for details on how to submit glucometer claims through TELUS Health.

Please note that the total reimbursement amount should be submitted under the Drug Cost field. There should be no dispense fee submitted.

Abbott	
Carrier: 80 | **Group:** 330000 | **Certificate/Serial** # | **Issue** #: 01 **Serial** # found on the meter or the meter box. Use last 8 digits excluding dashes and spaces.	
Description	**PDIN**
Freestyle Lite	990970

ACM	
Carrier: 80 | **Group:** 440000 | **Certificate/Serial** # | **Issue** #: 01 **Serial** # found on the meter or the meter box. Use the last 7 digits of the serial number excluding dashes or spaces.	
Description	**PDIN**
GE 200	56560001
Bionime GM100	56560002

Ascensia	
Carrier: 80 | **Group:** 500000 | **Certificate/Serial** # | **Issue** #: 01 **Serial #** found on the warranty card excluding dashes and spaces.	
Description	**PDIN**
Contour Next	55555550
Contour Next EZ	55555554
Contour Next One	55555559
Contour Next Gen	55555564

LifeScan	
Carrier: 80 | **Group:** 600000 | **Certificate/Serial** # | **Issue** #: 01 **Serial #** found on the back of the meter or the side of the meter box.	
Description	**PDIN**
One Touch Verio System Kit	00990930 or 00990962 (ON)
One Touch Ultra Mini	990941
One Touch Ultra 2	990942
One Touch Ultra Smart	990943
One Touch Verio IQ	990944
One Touch Verio Flex System Kit	11669907
One Touch Verio Reflect	991037

How to Submit Roche Meters	
Carrier: 80 | **Group:** 710000 | **Certificate/Serial** # | **Issue** #: 01 **Serial #** found on the back of the meter.	
Description	**PDIN**
Accu-Chek Compact Plus	66661001
Accu-Chek Aviva	66661002
Accu-Chek Aviva Nano	66661003
Accu-Chek Mobile	66661004
Accu-Chek Connect	9991040
Accu-Chek Guide Set	9991041

Common Rejection/Return Messages

During glucometer claim submission, you may receive a rejection/return messages. See below for common messages and how to resolve them. If you still experience issues, please contact the TELUS Health Pharmacy Support Centre: 1-800-668-1608.

Invalid issue error
- Confirm the serial numbers for the glucometer
- Add issue number 01 to the end of the serial number and submit this under certificate

Invalid Cardholder ID
- This reject message means that there is an issue with the numbers being submitted
- Verify all information is submitted correctly (Carrier ID, Group ID, Certificate/Serial #, Issue #)

Group Terminated
- This meter has been discontinued and is no longer eligible for reimbursement through TELUS Health

DIN not covered / Invalid DIN/PIN
- The DIN/PIN submitted does not match the serial number submitted
- Resubmit the correct DIN/PIN for the meter

Maximum exceeded
- Check the eligible meter price
- You may be billing more than the eligible amount, or the serial number has already been billed

RX AMT ADJUSTED
- DIN cost was adjusted to the eligible amount

DISP. FEE ADJUSTED CLAIMANT'S PLAN
- Dispense fee amount was adjusted
- No dispense fee should be submitted
- The total eligible amount should be entered under DIN cost

Section 5

Drug utilization review (DUR)

Section 5
Drug utilization review (DUR)

DUR overview

Healthcare professionals and drug manufacturers all agree on the importance of consumer education and health awareness. Many plan members are striving to learn more from their healthcare professionals about the medications they take. However, some plan members may have an inaccurate or incomplete recollection of their past drug regimens, so the advice provided may be based on limited information. In addition, while many plan members only fill their prescriptions at one pharmacy, there is an increasing percentage of plan members that frequent multiple pharmacies for convenience. This probably represents a high number of chronic medication users. These plan members may visit several healthcare professionals for different problems and these prescribers may not always be aware of all the medications the plan member is taking. The TELUS Health drug utilization review (DUR) service provides an answer to this problem.

DUR — How it works

When a pharmacist transmits a claim, the adjudication engine accesses the centralized database to search for potential problems relating to medications. It references each specific plan member's drug claim history, and checks the submitted medication against any medications dispensed within the last 100 days processed through our system from any pharmacy in Canada. Any claims processed outside the TELUS Health network will not be verified by the DUR service. The DUR is performed at the point of service and the result is sent back instantly. The criteria for these checks come from First DataBank, an international organization that provides drug information to governments, insurers, hospitals and other pharmacy benefit managers. First DataBank, a division of The Hearst Corporation, is the world's leading provider of health information. First DataBank employs a large staff of clinical experts that include clinical pharmacists, physicians and a world-renowned independent panel of clinical drug experts. The TELUS Health drug interaction database is updated every 2 weeks from First DataBank. As new scientific information about drug interactions becomes available, the DUR responses reflect them.

Drug interactions

Insurers have the flexibility to select the type of response (reject of claim or warning message only) required for each type of check. As a general rule, when the DUR detects a Level 1 drug interaction, the claim will be rejected.

DUR checks

Drug age	Indicates if the product may be harmful if the cardholder is a child or a senior.
Drug gender	Alerts the pharmacist if this medication is intended for use by a member of the opposite gender only.
Drug interaction	Looks for other known active ingredients that may interact adversely with ingredients in the current medication.
Minimum/ maximum dosage	Determines if the prescribed directions (based on the quantity and the days supply submitted) corresponds to the dosage established by the drug manufacturer.
Refill too soon/ too late	Indicates if a maintenance drug prescription is being refilled too early or too late, providing a strong indication of non-adherence or perhaps stockpiling.
Therapeutic duplication	Checks if the medication dispensed is similar to others in the cardholder's drug history. Drug class determines therapeutic duplications.

First DataBank identifies drug interactions that have been reported in the scientific literature and ranks them by potential significance levels.

Level 1	There is a possibility of significant interaction that is well documented in clinical studies and actual case reports
Level 2	This interaction is of moderate significance
Level 3	A contraindication that is only described in the manufacturer's prescribing information with no reports or publications from the scientific community will be considered to be a level 3 interactions.

Important: We request that all pharmacies transmit the proper days' supply as per the medication directions when submitting claims. For prescriptions with directions "take as needed" and "take as directed", you must base the days' supply on a reasonable estimate.

When the days' supply of medication transmitted is inaccurate, the following can result:
- Inaccurate refill too late/early messages
- Inaccurate dosage too high or too low
- Inaccurate minimum/maximum dosage check

Transmitting the proper days' supply of medication greatly reduces the number of inappropriate messages.

What to do when the DUR rejects a prescription?

For the majority of TELUS Health policies, pharmacies will receive a warning message on potential duplicate therapies. For example, this may occur with a cardholder requiring several strengths of levothyroxine or warfarin. Some policies may have selected to reject claims that are potential duplicate therapies. If the therapy is appropriate, you may override the reject code with the most appropriate intervention code from the following list:

Code	Description
UA	Consulted prescriber and filled Rx as written
UB	Consulted prescriber and changed dose
UC	Consulted prescriber and changed instructions for use
UD	Consulted prescriber and changed drug
UE	Consulted prescriber and changed quantity
UF	Patient gave adequate explanation. Rx filled as written
UG	Cautioned patient. Rx filled as written
UI	Consulted other source. Rx filled as written
UJ	Consulted other sources. Altered Rx and filled
UN	Assessed patient. Therapy is appropriate

While computer programs can facilitate screening, the pharmacist acknowledges and agrees that DUR messaging will NEVER replace the pharmacist's knowledge and responsibility in managing problems related to the cardholder's drug therapy. For questions about a drug interaction message, the pharmacy can contact the TELUS Health Assure claims pharmacy support centre.

Section 6

Audits and the audit department

Section 6
Audits and the Audit Department

It is a TELUS Health mandate to handle the insurer's funds with integrity and to confirm that pharmacies are paid in accordance with the insurer's plan and its policies. The accuracy and validity of each claim is critical, thereby requiring a comprehensive approach to auditing claims.

All claims submitted through TELUS Health are subject to audit by our audit department, and pharmacies will be contacted if a review of a claim is necessary. Successful adjudication of a claim does not prohibit a future audit of that claim. If during an audit, it is found that inappropriate information or processes have resulted in a successful adjudication result, then TELUS Health retains the right to recover payments previously made from any point in time during the provider's agreement with TELUS Health. In the event that pharmacies submit handwritten documentation for a mixture (page 25), TELUS Health reserves the right to recover the full claim amount. When a pharmacy receives a notice of adjustment from TELUS Health, please do not void any of the claims contained within the notice. Voiding claims will result in multiple deductions of funds from the provider account. If you have any questions related to the notice of adjustment, please contact the auditor who conducted the audit within the applicable arbitration period and PRIOR TO the deduction date indicated in the notice of adjustment. TELUS Health will not be held responsible for reimbursing providers for claims that have been voided in this manner.

Due to privacy and confidentiality, pharmacies are prohibited from sharing or forwarding any audit claims information and/or the notice of adjustment to other parties as per the provider agreement signed by the pharmacy and TELUS Health.

An "audit" is a follow-up to the electronic adjudication process. Audits are conducted for four main reasons:

- To ensure consistent & accurate claims submissions by the pharmacy community.
- To ensure system integrity.
- To detect and report possible fraud issues and cardholder drug abuse/misuse issues.
- To clarify with the pharmacy community on the proper ways to submit claims online (billing practices), in accordance with the TELUS Health policies and procedures manual and any and all TELUS Health pharmacy updates.

There are several different types of audits conducted by TELUS Health. On-site audits for example, are based on an in-depth investigation of a single pharmacy's claim submission practices. Desk, telephone, compound, survey and other audits are also conducted on a routine basis to monitor national claim activities. By contractual agreement with TELUS Health, it is expected that all pharmacies will adhere to the policies and procedures as outlined in this manual, and in any published TELUS Health pharmacy updates. In turn, the insurance carriers contractually obligate TELUS Health to take appropriate action where a pharmacy fails to comply with the policies and procedures herein. Any Inquiries regarding TELUS Health audits can be addressed by contacting the auditor via the phone number indicated on the audit request/response or through the TELUS Health pharmacy support centre at 1-800-668-1608.

Overview: NDCV (next day claims verification) audits

TELUS Health NDCV audits consist of reviewing claims that are transmitted by pharmacies from the previous days. On a daily basis, claims transmitted online are captured in the TELUS Health adjudication system database when certain criteria identify these claims. The purpose of NDCV audits is to monitor provider claim submission practices. In the event that claims require further verification, TELUS Health may request documentation, such as but not limited to, copies of authorized prescriptions and computer-generated signed hardcopies. These are to be faxed by the provider within 1 business day of a request.

Failure to comply with any requests for these documents may result in reversal or adjustment of the claim in question.

Overview: on-site pharmacy audits

TELUS Health on-site pharmacy audits are conducted routinely, and are part of the contractual agreement TELUS Health has with our insurance carriers. This type of audit is based on an in-depth investigation of a single pharmacy's submission practices to the TELUS Health Assure claims drug engine.

The auditor may contact the pharmacy in advance, providing the pharmacy with a date and time for the audit, as a professional courtesy. There may be instances when advanced notification of the audit is not possible, and the auditor may arrive at your pharmacy on the day of the audit. The auditor must be permitted entry to your pharmacy to conduct an audit. **Denying the TELUS Health auditor entry is considered a breach of your agreement with TELUS Health.** On-site pharmacy audits will vary in duration, determined by the number of claims selected for review and the accessibility of the supporting documentation (prescriptions, computer generated hardcopies, inventory purchases, etc.) for those claims. Availability of pharmacy staff to locate the required documentation will help to expedite the on-site portion of the audit. Permitting pharmacy staff to retrieve the required supporting documents ensures our audit personnel will only be looking at TELUS Health claims. TELUS Health auditors retain the right to be present during the pulling of the selected claims. The auditor may request to observe the dispensary as part of the validation process in understanding the pharmacy's operation TELUS Health auditors are responsible for maintaining the confidentiality of the information they collect, and are held accountable for breaches in this standard of conduct. The provision of a suitable working space for the auditor will minimize any interruption of the pharmacy's daily routine. The on-site portion of the pharmacy audit is needed to gather information for review once back at the TELUS Health offices. Information is generally not reviewed at the pharmacy.

If during an on-site pharmacy audit, the pharmacy is unable to produce supporting documents (prescriptions, computer generated hardcopies, etc.) as requested by the auditor, the claims will be charged back as "failed to produce documentation" and will NOT be considered for future submission. Please note that "reprinted" hardcopies generated at or around the time of the audit, or prescription authorizations received after claims submission, will not be accepted as original supporting documentation.

TELUS Health can audit claims from any point in time from a provider's agreement with TELUS Health.

Once the review portion of the pharmacy audit has been completed the pharmacy will receive a letter from the auditor outlining any issues that were discovered during the audit. The letter may also include a list of transactions for which payment is being fully or partially recovered, due to non-compliance with TELUS Health policies and procedures.

Our auditors are well-qualified industry experts who have extensive industry experience, both in pharmacy and in the third-party adjudication fields. As TELUS Health audits claims from all pharmacies across Canada, our auditors are well versed on each of the province's pharmacy legislation, as well as the federal legislation existing in Canada.

Physician verifications

During the course of the audit, TELUS Health may contact the physician for specific prescriptions where the physician is identified as the prescriber, to confirm if the prescriptions were authorized by them.

Arbitration period

The arbitration period for pharmacies receiving an adjustment to account notice was changed, effective August 1, 2015. This change ensures that your audit results are provided to you in a timely manner. Pharmacies will have 10 days' arbitration for next day and compound mailer audit processes and 14 days' arbitration for provider audit processes. During a provider audit, TELUS Health will not accept additional documentation for claims that were charged back for reasons of: «failed to produce documentation,» «no evidence of physician authorization,» «substitution not ordered by physician,» «overcharges» and «no evidence of inventory» during the arbitration period.

Confirmation of pick-up

Through the course of an audit, point-of-sale (POS) records may be requested to confirm whether or not a plan member has received medication claimed through electronic adjudication. POS records will only be sought where the technology exists as TELUS Health recognizes that not all pharmacies will have POS software. The audit department at TELUS Health will handle these requests. Failure to comply with such requests will result in claims being adjusted back to the pharmacy.

Delivery logs

For any medications that have been delivered to a health practitioner, patient or other pharmacy, TELUS Health will require proof of delivery receipts.

Notice of closure/change of ownership

If your pharmacy location is planning to close for business, it is required that you notify TELUS Health 30 days prior to your closure date, as per the terms in the pharmacy agreement. Furthermore, for any pharmacies that have received a request for audit or for documentation, TELUS will not process a closure or a change of ownership for that pharmacy until the audit has been closed and any outstanding funds have been settled.

Deactivation of pharmacy provider following an audit

If a pharmacy provider (and associated staff) have been deactivated following an audit by TELUS Health, no future provider numbers will be provided for this pharmacy location or associated staff by TELUS Health for a minimum of 2 years following deactivation (hereafter referred to as the waiting period). Following the waiting period, pharmacy providers may reapply to TELUS Health, through a separate application process known as the advanced accreditation process (AAP). Please see Appendix 2 for details on this process.

Deactivation of pharmacy provider – regulatory standing

If TELUS Health finds that your pharmacy location, owner or pharmacists belonging to your pharmacy have any concerns listed against them made by any provincial regulatory body, any private or public third party or by any provincial college of pharmacists, TELUS Health may deactivate your provider ID and your pharmacy will enter the waiting period.

Deactivation of pharmacy provider – mutual ownership

In the event that TELUS Health deactivates a pharmacy following a failed audit, or if the pharmacy is in poor regulatory standing with their licensing or provincial body, TELUS Health reserves the right to immediately audit any pharmacy associated to the provider via ownership or management. TELUS Health also reserves the right to deactivate said pharmacies. Deactivated pharmacies will then enter the waiting period.

Waiting period

When a pharmacy location has been deactivated by TELUS Health for the reasons listed above (following an audit, regulatory standing concerns or mutual ownership), this location and any associated staff will enter a waiting period, for a minimum of 2 years. Following this waiting period, the pharmacy location or associated staff may reapply for a TELUS Health provider number and subject to review, TELUS Health may, at its sole discretion, grant or refuse this location or associated staff a TELUS Health provider number.

The TELUS Health audit score

When a pharmacy provider is audited by TELUS Health, the pharmacy receives an audit score after their audit has been reviewed and closed. In some instances, the pharmacy provider may be deactivated by TELUS Health due to a failed audit score. The audit score is a numerical value that indicates the outcome of the audit, and takes into consideration a wide range of factors.

For example (including but not limited to):

- Relative number of claims in error
- Error composition and pattern
- Type of errors
- Performance during the audit
- Relative dollar value in error

The number of claims in error, and dollar value in error are main contributors to the audit score. The audit score will determine if any subsequent action is required and can change as per TELUS Health's discretion. A pharmacy risks losing their online billing privileges if they achieve a fail score of 500 or greater.

FINAL SCORE RESULT

Pass 0 – 219	**Conditional Pass A** 220 – 259	**Conditional Pass B** 260 – 299	**Conditional Pass C** 300 – 349	**Fail** 350 – 499	**Fail** 500 – 799	**Fail** 800+
No subsequent action required	Audit review with pharmacy Follow up audit			Audit review with pharmacy Follow up audit within 12 months	Audit review with pharmacy Follow up audit within 12 months Potential provincial regulatory college notification Potential loss of online billing privileges	Audit review with pharmacy Follow up audit within 12 months Provincial regulatory college notification Potential loss of online billing privileges

*Notwithstanding the forgoing, if TELUS Health or any of TELUS Health's payor's detect suspected or actual fraudulent activity, TELUS Health reserves the right to immediately deactivate a pharmacy provider from the TELUS Health network.

Fraud tips

The TELUS Health audit team works closely with several groups, including pharmacy associations, in order to combat fraud. Should you become aware of any issues that are in breach of the TELUS Health policies, or potential fraud related issues, please contact us at 1-800-668-1680 or audit.inquiry@telus.com. Any information received will be treated with the highest level of confidentiality, and can be made completely anonymous.

Section 7

Co-ordination of benefits

Section 7
Co-ordination of benefits

The total cost that can be covered by TELUS Health as a secondary payer, shall never exceed the actual acquisition cost (AAC) plus the appropriate provincial mark-up allowed by TELUS Health price file, which includes the amount already covered by the primary payer.

Co-ordination of benefit claims adjudicated through the TELUS Health network are subject to audit.

Provincial co-ordination of benefits (COB)

TELUS Health coordinates claim payment with most provincially administered plans unless the province is payer of last resort. All appropriate claims must initially be submitted to the provincial government for payment where applicable. Please use the intervention code DA.

The above is known as the basic submission rule for the co-ordination of benefits with a provincial plan. However, please be advised some insurance carriers will decide that they do not wish to incur provincial deductibles. These plans may retain the old rules regarding provincial liability. For example, a group in Ontario may wish to continue the practice of not paying for any portion of a claim for a senior on a drug covered by Ontario Drug Benefit (ODB). These groups would ignore the "previously paid amount" and not pay any portion of the drug. Whatever shortfall occurs would have to be collected from the plan member. It is important that you pay close attention to the paid amount on the transaction received back from TELUS Health; this is the amount covered by the private plan.

Private co-ordination of benefits (COB)

Pharmacies can submit residual claims to secondary private plans for consideration. Use the intervention code DB.

If a group has opted out of this program then the COB claim will reject with the message "Not Eligible for COB" and CPhA3 code KK. The plan member may still be able to submit the balance as a paper claim.

Limited use drugs for Ontario seniors with private drug plan coverage

Similar to regular benefits under the Ontario Drug Benefit (ODB) program, eligible claims for limited use (LU) drugs should be submitted to the public plan before they are submitted to private plans. Please ensure that seniors members covered under ODB meeting the LU criteria have their claims submitted to the public plan before coordination with the cardholder's private plan. In cases where the cardholder does not meet the specific ODB criteria for LU drug coverage, the claim may be submitted to the private plan as first payer. Through audit, if an LU code is found written on the prescription and this claim was not submitted to the public plan first the claim will be subject to an audit and may be reversed back to the pharmacy.

Spouses – 65 or over (Alberta)

In Alberta, various rules for cardholders 65 years old or over and their dependents occur. If the cardholder or spouse is over the age of 65, dependents are generally covered on the provincial plan. This means that TELUS Health is the second payer in this case. If you receive a message stating, "DIN covered by other", this means that TELUS Health is the second payer. Reverse the claim and send it to the appropriate provincial drug plan first.

Manitoba, British Colombia and Saskatchewan: Provincial registration management program

The provincial registration management program at TELUS Health allows for coordination of claims with the Saskatchewan, British Colombia and Manitoba PharmaCare programs. These programs ensure that insurance carriers are not paying for claims which should be covered under the provincial plan.

Cardholders have already been instructed by their carriers to register for the provincial plan. Cardholders who have already registered with PharmaCare programs must advise their insurance carrier that they have registered. Each carrier will determine dollar value thresholds to be used for senior and non-senior cardholders registered with the provincial plan. Only drugs eligible under PharmaCare programs will be tracked towards the thresholds.

When a claim is submitted for cardholders of these plans who have not registered, a message is sent advising: REGISTER WITH PROVINCIAL PLAN. Please note that the threshold is not based on time, but dollar value. Therefore, upon receiving this message, there is no deadline issue involved.
However, if the cardholder is nearing the dollar threshold, the message will be: FAILURE TO ENROL MAY SUSPEND PAYMENT. Once a cardholder has reached the dollar threshold, claims will reject and the message will be INSURER REQUIRES PROV PLAN ENROLMENT.

To ensure proper payment, it is important that the above messages are relayed to the cardholder so they are aware of the need to register with the PharmaCare programs.

Information on registering with the PharmaCare programs is on these government websites:

- **Saskatchewan** – http://www.health.gov.sk.ca/ps_drug_plan_special.html
- **Manitoba** – http://www.gov.mb.ca/health/pharmacare/index.html
- **British Colombia** – https://my.gov.bc.ca/fpcare/registration/requirements

Contact the TELUS Health Assure claims pharmacy support centre should you require further assistance.

Specialty drug program (SDP)

TELUS Health offers a Specialty Drug Program ("SDP") which allows insurance carriers to coordinate benefits with provincial drug programs other than the senior's PharmaCare plan.

When a claim is submitted to TELUS Health for a drug on the SDP, and the insurer has opted into the program, the claim will reject with a 2060 code: SDP authorization required. A plan sponsor may choose to offer first time forgiveness for a drug claim on their SDP. This allows for payment of a claim while plan members begin the process of requesting provincial coverage. In this case, when the claim is adjudicated by TELUS Health, payment will be returned with a 6024 code: Apply to province or payment may be suspended. Please communicate this message to plan members in order to avoid any disruption in coverage.

If plan members do not apply for coverage with the province, or a plan sponsor does not offer first time forgiveness, subsequent claims will be rejected. Please note: there is no intervention code which can be submitted by the pharmacy to bypass the SDP.

Pharmacies should advise plan members to contact their plan administrator for additional details.

Order of processing – Manufacturer sponsored programs

If a patient requests for a brand name medication to be filled rather than its lowest cost alternative (i.e. generic) and presents a payment assistance bill direct card it is imperative that the correct order of processing is followed. The specific order of processing is typically found on the card itself. If these details cannot be located on the card, it is recommended to call the customer support center for the card program to confirm the recommended order of processing.

These claims are subject to audit and will be adjusted back to the pharmacy if the correct order of processing is not followed.

Section 8

Drug plan types

Section 8
Drug plan types

Coverage

TELUS Health administers many diverse types of drug plans. These plans range from comprehensive, with coverage of many "prescription-by-law" drugs and OTC drugs, to more restricted managed care plans that may be based on a "frozen" benefit list as of a specific date, or based on a provincial formulary. TELUS Health also administers plans on behalf of WSBC in British Columbia and WSIB in Ontario.

Our comprehensive plans generally allow:

- Prescribed medications bearing a valid drug identification number (DIN) and listed as prescription requiring in Federal or National Association of Pharmacy Regulatory Authorities (NAPRA) drug schedules.
- Selected injectable drugs, injectable vitamins, insulin, and allergy extracts bearing a valid DIN.
- Extemporaneous preparations or compounds where one of the ingredients is an eligible benefit, includes no ingredients deemed ineligible (see Ineligible compounds, page 25) and no component is considered to be cosmetic in nature.
- Disposable needles/syringes for administration of insulin (including disposable needles only, for non-disposable insulin delivery devices), lancets and chemical reagent testing materials used for monitoring diabetes.
- Selected OTCs, where the product has a Health Canada approved DIN, will be considered covered with a successful (i.e. not rejected) adjudication.

Generic plans

If a plan has a generic rider, then the adjudicated ingredient cost will be based on the equivalent lower cost alternative plus a professional fee.

Prescriptions ordered as "no substitution" by the authorized prescriber, are eligible for payment above the cost of the lowest priced interchangeable product, when the claim is flagged as "N" for "no substitution" or product selection = "1" (prescriber's choice) for CPhA3 EDI claims. Please note that certain groups may have a mandatory generic substitution plan where the equivalent lower cost alternative will still be paid even if "no substitution" is ordered by the authorized prescriber. For further details on "no substitution" claims please refer to Section 4: General policies and procedures.

Exclusions

Most TELUS Health plans exclude the following categories of products.

- Atomisers, appliances, prosthetic devices, colostomy supplies, first aid kits or equipment, electronic diagnostic monitoring or testing equipment (such as "Glucometer®"), non-disposable insulin delivery devices (such as "Novolin Pen®"), delivery or extension or spacer devices for inhaled medications (such as "Diskhaler®", "Aerochamber®"), spring loaded devices used to hold lancets, alcohol, alcohol swabs, disinfectants, cotton, bandages, or supplies and accessories for the aforementioned.
- Oral vitamins, minerals, dietary supplements, infant formulas, or injectable total parenteral nutrition (TPN) solutions, whether or not such a prescription is given for a medical reason, except where federal or provincial law requires a prescription for their sale.
- Diaphragms, condoms, contraceptive jellies/foams/sponges/suppositories, intrauterine devices (IUDs), contraceptive implants, or appliances normally used for contraception whether or not such a prescription is given for a medical reason.
- Homeopathic and herbal preparations.
- Prescriptions dispensed by a physician, dentist or in a clinic or in any non-accredited hospital pharmacy, or for treatment as an inpatient or outpatient in a hospital, including emergency status and investigational status drugs, unless otherwise approved by the insurance carrier.
- Preventative immunization vaccines and toxoids.
- Allergy extracts, compounded in a lab, and not bearing a unique DIN number.
- Products bearing a valid NPN issued by Health Canada.
- Items deemed cosmetic (even if a prescription is legally required or prescribed for a medical reason), such as topical minoxidil, topical preparations considered cosmetic in nature (Neostrata products, de-pigmenting agents), or sunscreens.
- Any medication that the person is eligible to receive under the applicable provincial drug benefit plans.

Dispensing limitations

Most plans allow a maximum of a 34-day supply for non-maintenance medications, and 100-day supply for maintenance medications if so ordered by the authorized prescriber.

Any request for quantities greater than a 100-day supply, the cardholder should contact their benefits department, otherwise the cardholder will be required to pay out of pocket for the excess supply and submit the receipt manually for reimbursement.

Maintenance classification is assigned by TELUS Health on a per DIN basis and includes most of the drugs in the following classes:

- Antiasthmatics
- Antiparkinson
- Antihypoglycemic agents
- Antibiotics for acne
- Antidepressants
- Transdermal or oral contraceptives
- Anticoagulants
- Cardiac agents
- Potassium replacements
- Anticonvulsants
- Female hormone replacement
- Thyroid agents

Where appropriate, please dispense a 100-day supply of these medications, with only one dispensing fee charged per 3 months. This is an excellent example of how pharmacies can work with TELUS Health to provide cost-efficient, quality pharmaceutical care

Note: In BC, WSBC follows the BC Pharmacare guidelines for days' supply.

Reference based pricing (RBP)

A number of plan sponsors offer managed care plans that specify the maximum amount reimbursed on a claim. This is called reference based pricing ("**RBP**") (may also be referred to as maximum allowable cost (MAC) pricing). RBP means the drug price considered by the plan is based on the price of a different product, within the same therapeutic category. The reference drug can be selected in a variety of ways, but ultimately the insurance carrier and/or the plan sponsor decides. The reference drug is not always the generic, or the cheapest drug. Depending on the drug category, a few drugs may be available below the price of the reference drug and not subject to a cutback. Often times it is the drug that is used most frequently in the affected group or province. Insurers can use this program in one DIN class or in multiple DIN classes. The reference drug is always in the same category as the drug being adjudicated.

The return code 6012 – "cross select pricing" (CPH3 code DK) – means the drug being adjudicated is part of this type of plan. The pharmacist is not expected to consult the physician to switch the drug to a lower costing one. The cardholder and the physician are free to choose any drug in the therapeutic category; however, it will only be reimbursed at the reference drug price. The value returned after claim adjudication will show how much is to be collected from the plan member, and will depend on the price difference between the chosen DIN and the reference drug.

Plan members opting to use more expensive alternatives will be required to pay the difference between the drug dispensed and the reimbursement amount.

Drug classes and drugs included in the RBP program* (as of January 2020)		
Drug class	**Specific drugs (including generics) above RBP**	**Drugs within RBP**
Angiotensin converting enzyme inhibitors	Mavik (Trandolapril) Accupril (Quinapril) Coversyl (Perindopril) Monopril (Fosinopril) Vasotec (Enalapril) Inhibace (Cilazapril) Lotensin (Benazepril) Zestril, Prinivil (Lisinopril)	Altace (Ramipril)
Angiotensin II receptor blockers	Cozaar (Losartan) Olmetec (Olemesartan) Teveten (Eprosartan) Edarbi (Azilsartan)	Diovan (Valsartan) Atacand (Candesartan) Micardis (Telmisartan) Avapro (Irbesartan)
Dihydropyridine calcium channel blockers	Plendil, Renedil (Felodipine) Adalat XL (Nifedipine)	Norvasc (Amlodipine)
HMG-CoA reductase inhibitors	Lipitor (Atorvastatin) Zocor (Simvastatin) Mevacor (Lovastatin) Pravachol (Pravastatin) Lescol (Fluvastatin)	Crestor (Rosuvastatin)
Proton pump inhibitors	Pantoloc (Pantoprazole sodium) Nexium (Esomeprazole) Dexilant (Dexlansoprazole) Prevacid (Lansoprazole) Losec (Omeprazole)	Pariet (Rabeprazole) Tecta (Pantoprazole magnesium)

*The reference drug/price is subject to change.

When you submit a drug claim that is subject to the RBP pricing program, you may receive one or both of the following return codes and translated messages, depending on your software:

Return codes from RBP pricing program		
	Message 1	**Message 2**
CPhA3 code	QR: Maximum allowable cost (MAC) paid	E9: Reduced to reference-based price
TELUS code	6028: Maximum allowable cost paid	6029: Reduced to price for DIN 12345678*

*Multiple generics from various manufacturers may be eligible at the same reference price. Due to messaging limitations, the DIN returned is just one example of many eligible products.

Drug plan coverage based on drug price

TELUS Health offers a variety of coverage options for plan design and reimbursement. In addition to the standard plans that offer coverage at specific percentage levels and/or fixed dollar deductible amounts, certain plans provide the option of reimbursing specific DINs at a customized price.

Unlike a standard price cutback, which is based on the standard TELUS Health price file and cannot be passed on to the plan member where TELUS Health is the primary payer, this customized price is considered the amount reimbursed by the plan. Similar to a plan that covers 80%, with the plan member paying the remaining 20%, the customized price of the DIN is considered the coverage amount, and theplan member must pay the price difference. The following return codes are associated with these claims.

	Message
CPhA3 code	FG: Drug cost paid as per provider agreement
TELUS code	6030: Drug cost paid as per provider agreement

The customized price may be based on a generic price, a MAC program or may simply be a fixed percentage of the price of a particular drug.

Example:

A plan that previously provided 90% coverage may also cover specific drugs based on a customized price of only 70% (the whole as determined by the plan sponsor):

A claim for dispensing fee = $8 and DIN cost = $100 (therefore total cost at the pharmacy is $108)
The DIN cost eligible will be reduced to $70 (as chosen by the plan sponsor –customized price – coverage at 70%)
The claim will be paid at 90% but subject to a $70 cap on the DIN cost - which means 90% of $70

Dispensing fee = $7.20 (90% of $8) and DIN cost $63 (90% of $70)

The plan member will be responsible for $37.80.

Section 9

The trial drug, maintenance, prior authorization and step therapy programs

Section 9
The trial drug, maintenance, prior authorization and step therapy programs

The TELUS Health trial, maintenance, prior authorization and step therapy programs are available options for employers/plan sponsors to select for their drug plans. As a result, only certain cardholders will be subject to these programs. These programs can be used independently or in combination with other programs.

Trial drug program

The trial drug program is a voluntary program designed to promote the dispensing of smaller quantities of prescription drugs that have a high incidence of side effects, and are a new treatment for the cardholder. This prevents waste if the medication is not tolerated.

Procedure for trial program:

1. For drugs eligible under the trial drug program, you will receive the message "INVALID DAYS SUPPLY – TRIAL DRUG PROGRAM."
2. Ask the cardholder if they would like to participate in the trial drug program. If the cardholder refuses, use the override code UG. If the cardholder accepts, you can resubmit a 7-day supply of the medication.
3. Contact the cardholder after 5 or 6 days to determine if the drug is effective and tolerated.
4. If the drug is tolerated, the balance of the prescription can be filled and the pharmacy is eligible to receive a second dispensing fee.
5. If the drug is not tolerated, you may choose to contact the prescribing physician to request an alternative therapy.
6. You can submit a claim for the alternative therapy, which may also be subject to the trial drug program.
7. If no alternative therapy is prescribed after consultation with the prescribing physician, you may be eligible to receive an $8.00 cognitive fee. The cognitive fee can be billed to TELUS Health using PIN number 19000001.

Examples of drug classes included in the TELUS Health trial drug program:

- Angiotensin-converting enzyme (ACE) inhibitors
- Angiotensin II receptor blockers
- Beta blockers
- Calcium channel blockers
- Lipid lowering agents
- Proton pump inhibitors

Maintenance program

The maintenance program is a voluntary program designed to encourage the dispensing of a larger days' supply to cardholders who are taking a medication on a continuous basis.

Procedure for maintenance program (for drugs considered maintenance by TELUS Health):

For cardholders on this program, claims for drugs considered by TELUS Health to be maintenance drugs will get the warning message "DRUG ELIGIBLE FOR 100 DAY MAINT QUANTITY." This is to encourage cardholders to get a larger drug supply for medication intended for treatment of a chronic condition. You may need to contact the physician for authorization to dispense a 100-day supply of the medication.

Procedure for maintenance program (for drugs considered acute by TELUS Health):

1. For drugs eligible under the maintenance program, you will receive the message "RESUBMIT ONE MONTH SUPPLY."
2. Ask the cardholder if they would like to participate in the maintenance program. If the cardholder refuses, use the override code UG to opt out of the program. This will allow the claim to be processed; however, since the cardholder has opted out of the program the claim is still subject to any days supply limitations (e.g., 34 days) set by the insurance carrier.
3. If the cardholder accepts, you must adjust the drug quantity and days' supply and resubmit the claim with a 30-day supply.
4. After three consecutive one-month prescriptions, the cardholder will be eligible to receive a three-month supply. When filling the third one-month supply, you will be prompted with the message "SUBMIT 3 MONTHS NEXT."
5. The rejection message "RESUBMIT 3 MONTH SUPPLY" will appear when you fill the fourth prescription for a 30-day supply.
6. You may need to contact the doctor to increase the days' supply. Upon receiving approval from the physician, adjust the drug quantity and days' supply and resubmit the claim for three months. The pharmacy may be eligible to receive an $8.00 cognitive fee. The cognitive fee can be billed to TELUS Health using PIN number 00999072.

Trial drug and maintenance programs combined

Procedure for combined trial drug and maintenance programs:

1. The trial drug program takes precedence over the maintenance program.
2. Follow the steps as described in the trial drug program.
3. When you submit the balance of the prescription, the days' supply cannot exceed 34 days. Caution: If a claim with a day's supply greater than 34 days is submitted, the drug cost will be cut back to the cost of a 34-day supply, and the system will return a message notifying you of the adjustment.
4. The balance of the original prescription will be included in the maintenance Program steps.
5. Follow the steps for the maintenance program.

TELUS Health may add or remove drugs from the program or change the clinical protocols when deemed necessary.

If for any reason the cardholder chooses not to participate in these voluntary programs, or if you feel it is appropriate to override the programs, the following codes may be used:

- UG consulted patient – dispensed as written
- MG override – various reasons

For audit purposes, TELUS Health requires that the pharmacy document all relevant details about the prescription to support the selection of overrides and the submission of claims for cognitive fees.

Prior authorization program

The prior authorization program is designed to target high volume and/or expensive medications that are not necessarily first-line therapies or may be used for non-approved indications. Individuals will be reimbursed for the drug only if they meet the medical criteria as defined by clinical guidelines. These guidelines are similar to those established by provincial formularies as well as Health Canada approved information on the product monograph of the medications. Cardholders have the option of paying for the medication if they do not want to delay starting therapy. Note that if the plan sponsor selects the prior authorization program, you cannot override the reject at the pharmacy.

For a list of current medications on the TELUS Health prior authorization program, refer to the following link:
https://www.telushealth.co/prior-authorization-forms/

Please note that many insurance carriers use their own customized prior authorization list and may or may not include the same drugs as the TELUS Health prior authorization program. In these cases, the plan member should be redirected to their plan administrator/ insurance carrier for further information. TELUS Health or the insurance carrier may add or delete drugs from their respective prior authorization programs and/or the clinical criteria when necessary.

Procedure for prior authorization program:

1. For plan members on this program, a claim for a targeted drug will be declined with the message "PRIOR AUTH REQUIRED." Please note that if a claim is rejected with the messages "DIN NOT COVERED", "DIN/PIN NOT A BENEFIT", "CARRIER AUTH REQUIRED" or "CRDHLDR TO CONTACT INSURER FOR AUTH FORM" at the end of the message sentence, then the plan member is not eligible for prior authorization and this program does not apply.
2. The plan member is required to obtain the appropriate prior authorization program request form from either their employer or their insurer's website.
3. The form must be completed by the plan member and the plan member's prescriber and faxed to TELUS Health pharmacy services department at 1-866-840-1509. A complete request must include signature of the plan member (or parent/legal guardian) and the physician before it is processed.
4. Upon receiving the form containing all the required information, the request will be evaluated within two to five business days. Pharmacy services will then contact the cardholder, or the pharmacy as indicated on the form, with the result.
5. Once the request is approved, further prior authorization application is seldom needed, unless required by the cardholder's drug plan. In some cases, payments are subject to annual limitations or total dollar maximums.

Please note: The pharmacy name and phone number are optional information the cardholder can supply to us on the prior authorization program's reimbursement request form. This information allows TELUS Health to contact the plan member's pharmacy with the result of the request. The pharmacy may opt to discuss alternative therapies with the cardholder if the request is declined, or to contact them to collect their approved prescription.

Step therapy program

The TELUS Health step therapy program is a program designed to promote the use of less-costly, first-line treatments prior to granting coverage for more costly, second-line or later alternatives. If a drug is subject to step therapy, plan members would be eligible for coverage only after trying an alternative "first-line" drug that has proven through clinical evidence, to be safe and cost-effective. Insurance carriers can create custom step therapy programs or choose to implement one of TELUS Health's step therapy programs.

Procedure for step therapy program:

1. For drugs eligible under the step therapy program, you will receive the message "PREFERENCE OR STEP DRUG AVAILABLE" if the requirements for a prior step have not been satisfied.
2. Please refer to the TELUS Health step therapy reference guide for further detail on each TELUS step therapy program.

Examples of TELUS Health step therapy programs:

- Diabetes: For oral and non-insulin diabetes medications. (e.g. metformin, glyburide, empagliflozin, liraglutide, sitagliptin)
- Glucose sensors: To ensure patients are insulin dependent prior to approving claims for certain glucose sensors

Section 10

PSHCP

Section 10
PSHCP

TELUS Health is the pharmacy benefits manager for the Public Service Health Care Plan ("PSHCP"). The PSHCP offers a pay-direct drug program for all PSHCP members and their eligible dependents. Pharmacies can submit drug claims and some medical supply claims electronically on behalf of PSHCP plan members.

Contact the pharmacy support centre:
Tel.: 1-800-668-1608
Fax: 1-866-840-1466
Monday - Sunday: 5:30 a.m. to 2 a.m. ET

When contacting the pharmacy support centre, please have your special PSHCP 10-digit provider number available. These phone lines are for pharmacies ONLY. Please DO NOT give cardholders the pharmacy support centre telephone number. If cardholders have any questions or concerns, they should contact their benefits department or plan administrator at their place of employment.

More helpful information can be found on our website at: https://www.telushealth.co/health-solutions/claims-and-benefits-management/pshcp-provider-information/overview/
Members of the PSHCP will have a carrier code of 12 on their pay-direct drug cards. Examples of the cards can be found on the TELUS Health website, under 'PSHCP Information'.
PSHCP diabetic supplies pseudo DIN list: http://page.telushealth.com/diabetic-pseudo-din-list

Appendix 1

Application for an account

Pharmacy locations performing the regulated act of dispensing (including but not limited to satellite or remote pharmacies), seeking to connect to the TELUS Health service network and system are required to apply for a provider number.

When applying for a provider number with TELUS Health third-party insurer clients and the Public Services Health Care Plan (PSHCP), the designated pharmacy manager/owner must complete the online application form located on the TELUS Health pharmacy support webpage, https://www.telus.com/en/health/health-professionals/pharmacies/support-documents.
TELUS Health reserves the right to verify any of the information submitted from the designated pharmacy manager/owner at any point in time. TELUS Health reserves the right to accept or refuse an application for an account.

If you are buying a pharmacy, please complete a thorough due diligence to ensure that the pharmacy is in good standing with TELUS Health and can submit claims on our pharmacy network. Consider contract wording and have methods in place to protect the purchaser.

Application requirements

Please thoroughly follow the instructions within the application form. Failure to provide legible, valid documents will result in the refusal of the application.

The following documents must be submitted with the application:

- Pre-printed void cheque or bank letter
- Proof of accreditation from the provincial pharmacy governing body
- Proof of articles of incorporation
- Copies of government-issued photo identification
- Shareholder certificate

TELUS Health will only issue and/or activate any provider numbers to the applicant once the provider's respective provincial licensing body has verified your credentials. If you have not yet received licencing or accreditation confirmation from the provincial body, please proceed with the application and we will contact you after your submission to obtain this information.

Request to update provider profile

Whenever a pharmacy has a change in any of the categories listed below, the designated pharmacy manager, owner, or signing authority must inform TELUS Health so the provider profile can be updated.

To submit a pharmacy profile update, fill out the update request form which can be located within the TELUS Health pharmacy provider portal and on the TELUS Health pharmacy support webpage, https://www.telus.com/en/health/health-professionals/pharmacies/support-documents. Please note that updates submitted will be applied to both your Assure and PSHCP provider numbers.

Please notify TELUS Health in writing two (2) weeks in advance of any changes to pharmacy information. Failure to submit legible, valid documents where required will delay the processing of the change(s).

To view the existing profile TELUS Health has on file for your pharmacy, use the profile review option located within the TELUS Health pharmacy portal.

Types of pharmacy profile updates:

- Update of pharmacy contact information such as the address, phone number, fax number or email address
- New dispensing fee (BC, ON and the Territories only)
- Change to the existing payment option
- Change in bank account
- New designated pharmacy manager

If your pharmacy has had a change in legal name or pharmacy ownership (which includes but is not limited to an asset or share purchase), a new application to become a TELUS Health pharmacy provider must be submitted.

Why is it important to inform TELUS Health about any changes?

Your pharmacy provider number is directly linked to your provider profile. In order to ensure you are paid properly and according to the payment instructions you have given to TELUS Health, you must provide the most current information. A change in any of the above categories may affect you financially.

If the pharmacy profile change includes a change of bank account, please verify that the proper payment has gone into your new account the day after the effective date of your account change or on your next settlement period, depending on the payment option you've selected. If there are any discrepancies, please contact the TELUS Health Assure claims pharmacy support centre immediately, as you are responsible for the information you provide to TELUS Health.

Appendix 2

Advanced accreditation process

In the instance that your pharmacy is reapplying to TELUS Health following the waiting period, you must proceed through the advanced accreditation process (AAP) that is used to validate a pharmacy's application. The AAP can also be requested at TELUS' discretion in order to supplement an application. The AAP is an enhanced application process with a number of components, including the standard application for account.

TELUS Health reserves the right to verify any of the information submitted for the AAP from the designated pharmacy manager/owner at any point in time. TELUS Health reserves the right to accept or refuse an application for an account based on the results of the advanced accreditation process.

Components of the advanced accreditation process:

1. Standard TELUS Health application for account
2. Addendum to the TELUS Health application for account: The advanced accreditation process
    a. Background check and in-person interview
    b. Follow up on-site audit
    c. Administrative fee
    d. Deposit

Standard application for account

Pharmacies must complete the standard application for account. Failure to provide TELUS Health with a complete form may delay the application process or may result in a refusal of the application.

Addendum to the TELUS Health application for account: The advanced accreditation process

Component 1: Background check and in-person interview

TELUS Health requires a background check to be completed for the individuals listed below. TELUS Health has partnered with Sterling BackCheck to conduct these checks for key stakeholders in your pharmacy. The individuals that require a background check, along with the components of a background check that will be conducted, are listed here:

- Owner(s)
    - Enhanced police information check
    - Credit bureau inquiry
    - Credential verification (if-applicable)
    - Disciplinary action search (if-applicable)
- Manager(s)
    - Enhanced police information check
    - Credit bureau inquiry
    - Credential verification
    - Disciplinary action search
- On-staff pharmacists
    - Credential verification
    - Disciplinary action search

TELUS Health will receive the results of the background check from Sterling. Contingent on the results of the background check, TELUS Health reserves the right to conduct a follow-up in-person-interview with any of the aforementioned individuals. The in-person-interview will take place in Toronto at the TELUS Health office at 25 York Street, and will be at least 30 minutes in duration with the TELUS Health audit manager. The interview questions aim to clarify and explore results of the background check with the candidate(s).

Component 2: Follow up on-site audit
In the event that your pharmacy completes the AAP and receives a provider ID from TELUS Health, TELUS Health reserves the right to complete an on-site follow up audit from any point in time at least 3 months after a provider number has been issued to your pharmacy.

In the event that TELUS Health finds your pharmacy in breach of any of its obligations under the provider agreement, including the pharmacy manual, TELUS Health may terminate the provider agreement or deactivate your pharmacy's use of services under the provider agreement.

Component 3: Administrative fee
There is an administrative fee associated with the advanced accreditation process. This fee must be paid in full to TELUS Health prior to TELUS Health beginning any assessment of your application. The administrative fee covers the application processing, along with the background checks administered to the individuals listed in Component A (Background check and in-person interview).

The fee structure will vary based on the number of staff proceeding through the background check.

The fee is **$2,500.00** for the processing of the application and covers up to four persons completing a background check.

For every additional person completing a background check, there is an additional fee of **$200.00**.

When the addendum to your application for account is received by TELUS Health, TELUS Health will confirm receipt and inform you of your administrative fee. The fee must be paid to TELUS Health in full, and once TELUS Health has confirmed receipt of your fee, TELUS Health will begin assessment of your application.

Component 4: Deposit
In the event that your pharmacy is approved through the AAP, TELUS Health will administer you a provider ID. TELUS Health requires a deposit to be paid before your provider ID is activated and your pharmacy may begin to submit claims. This deposit will be held by TELUS Health for the duration of your provider agreement with TELUS Health.

In the event that your pharmacy terminates your provider agreement with TELUS Health with 30-days' notice, is in good standing with TELUS Health and has no outstanding amounts owing, the deposit will be returned to your pharmacy in full.

In the event that your pharmacy is deactivated by TELUS Health as per the terms in the provider agreement, and has a balance owing to TELUS Health, any balance owing will be deducted from the deposit and kept by TELUS Health – the difference will be returned to your pharmacy.

In the event that your pharmacy is deactivated by TELUS Health and has a balance owing in excess of the deposit, your pharmacy will not receive any portion of the deposit back from TELUS Health.

The value of the deposit is unique to your pharmacy location and is based on the pharmacy's historical relationship with TELUS Health.

1. If your pharmacy location is reapplying to TELUS Health after a deactivation, and your ownership is the same as it was at the time of deactivation, the deposit structure will be:
    a. **$50,000.00 or 5 times the value of your previous audit error**, whichever is higher
    b. In addition, if your pharmacy had an outstanding balance owing to TELUS Health at the time of deactivation, this will need to be paid in full to TELUS Health in addition to providing the deposit as per the above terms
2. If your pharmacy location is reapplying to TELUS Health after a deactivation, and your ownership is different than what it was at the time of deactivation, the deposit structure will be:
    a. **$50,000.00**
3. If you as an owner have been subject to deactivation by TELUS Health, and you are applying to TELUS Health with a new pharmacy location, the deposit structure will be:
    a. **$50,000.00 or 5 times the value of your previous audit error**, whichever is higher

This deposit amount must be paid to TELUS Health in full in the event that your Application for Account has been approved. Once TELUS Health has confirmed receipt of your deposit, your provider ID will be activated and your pharmacy may begin submitting claims to TELUS Health.

How to complete the advanced accreditation process

Your pharmacy will need to submit the standard online application form to become a TELUS Health pharmacy provider. Once the provider registry team identifies your pharmacy as a pharmacy that has passed the minimum two year waiting period, the team will send you the addendum to application for account – advanced accreditation process form. You will need to fill this form out in full and submit it to the TELUS Health provider registry team. At this point, the provider registry team will inform you of your administrative fee amount. Once the administrative fee is paid in full, TELUS Health will begin assessment of your application and you will be contacted by Sterling to complete the background check.

AAP assessment and timelines

TELUS Health will conduct a complete assessment of your application once all components of the advanced accreditation process are fulfilled. The assessment will depend on the results of the background check, relationship mapping, claims analysis, in-person interview (if needed), and details disclosed on the application for account. Please note that the timeline for this process does not follow the standard application for account timeline. The timeline for a decision will depend on the nature of the file.

Appendix 3

Diabetic pseudo-DIN list

An updated list can be accessed online at:
https://www.telus.com/en/health/health-professionals/pharmacies/support-documents

Prescription requirements

Eligibility for coverage requires a documented prescription (satisfying all Canadian legal requirements), which also includes a specified list of diabetic supplies. This list should include, but is not limited to:

- Product name
- Package size
- Quantity

Appendix 4

Glossary of terms

Actual acquisition cost (AAC)	The real cost paid to obtain a drug. This may be the purchase price direct from the manufacturer or from a recognized pharmaceutical wholesaler.
Adjudication	Processing a claim through a series of edits that determine appropriate payment.
Authorized prescriber	An authorized prescriber is a physician, surgeon, dentist or other healthcare professional prescriber in good standing with their governing body, where provincial laws permit these persons to prescribe. Any provincial restrictions placed on the prescribing practices of the above listed professions are followed by TELUS Health (e.g. a specific list of drugs that a practitioner can prescribe from)
Cardholder	Refers to the primary plan member who the insurance policy belongs to. (e.g. cardholder)
Cardholder exception	The plan sponsor has instructed the insurance carrier to allow coverage of one drug or a group of drugs for a specific cardholder. Other family members and employees at that company are not eligible unless they too have had an exception authorized.
Carrier	Insurance company insuring the plan or providing administration services.
Co-insurance	A percentage (e.g. 10% or 20%) of the cost of the drug or prescription that must be paid on each item every time a prescription is dispensed.
Co-pay	A set dollar amount applied to each individual prescription dispensed (e.g. $2.00 or $5.00 per prescription).
CPhA3	The standard established by the Canadian pharmacists association for electronic exchange of claim information.
Deductible	A set dollar amount that must be paid by the cardholder and/or dependent's before coverage of health benefits can begin. Deductibles are normally reset annually. (e.g. $10.00/$50. 00), and do not necessarily coincide with a new calendar year.
Dependent coverage	The employee has insurance that would include coverage for a spouse and/or eligible children.
Dispensing fee cap	The plan sponsor may opt to pay only a fixed dollar value towards the dispensing fee. This may be set at various levels, depending on the plan.
Drug utilization review (DUR)	Most pharmacies utilize software programs that identify levels of potential drug interactions. TELUS Health DUR check goes one-step further, in that the check is run against all claims for the cardholder processed through the TELUS Assure claims card. TELUS Health then alerts the pharmacy staff of potential interactions with drugs dispensed in any other pharmacy.
Electronic data interchange (EDI)	The transfer of data between the pharmacy and TELUS Health using networks, and/or the Internet. EDI is increasingly important as an easy mechanism for secure exchange of confidential information.
Electronic funds transfer	The paperless transfer of money from one bank account to another.
Electronic reimbursement	Online verification of coverage and eligibility resulting in claim settlement in real time.
Telus health assure claims national formulary	This is TELUS Health own managed care plan. It is not necessarily related to any specific drug plan.
Formulary	A specific list of eligible drugs. Formularies may mimic provincial formularies, and be updated to reflect provincial changes. A formulary may also be created at the request of an employer and maintained on their behalf.
Issue number	This two-digit number (usually 01) acts as a control if a card is lost or stolen. It is essential to make sure that the most current issue number is recorded.

Lowest cost alternative	The lowest unit cost established for a drug within a set of inter-changeable generics. A plan with a generic rider will reimburse the pharmacist to the level of the lowest cost generic.
Maintenance and non-maintenance drug	Maintenance drugs are those that are used long term, e.g. thyroid drugs, blood pressure drugs. Non-maintenance or acute drugs are those taken for a shorter period of time, e.g. antibiotics and cough suppressants.
Maintenance program	A voluntary program designed to encourage the dispensing of a larger days' supply to cardholders who are taking maintenance or acute medication for a long duration and have been established on the therapy.
Pharmacy benefit manager (PBM)	A company (such as TELUS Health) that adjudicates online prescription claims from registered pharmacies where a signed provider agreement exists.
Plan member	Refers to any person covered under the cardholders policy. (e.g. spouse, child underage, child overage)
Plan sponsor	The employer or organization that pays for the insurance.
Policy year	The anniversary of the date when the coverage came into effect. This may determine when the annual deductible is reset; however, on some plans deductibles are managed on a calendar year basis.
Preferred provider network (PPN) or preferred provider option (PPO)	Employers may decide to have their members' prescriptions filled from certain pharmacies or chains of pharmacies. These pharmacies have agreed to provide additional control services on prescribed drugs at the point of sale.
Primary cardholder	Person for which the benefits have been setup. Usually the employee or member of the plan sponsor.
Provider	The pharmacy where the service is being provided. Each provider is linked to an individual provider number assigned by TELUS Health.
Reference based pricing (RBP)	The drug price paid by the plan is based on a different product within the same therapeutic category. May also be referred to as maximum allowable cost (MAC) pricing.
Settlement period	The payment schedule determined by the pharmacy. Options include next day electronic fund transfer, twice monthly or every thirty days.
Sliding co-pay	Employers will pay a percentage of the first "x" dollars spent and then a different percentage of all claims above that limit.
Trial program	A voluntary program designed to promote the dispensing of smaller quantities of prescription drugs that have a high incidence of side effects, when the cardholder has not used the medication previously.
Unlisted compound code	The number supplied by the software company to indicate whether the extemporaneous compound is a cream, ointment, liquid for internal use, etc.

Appendix 5

Common reasons for rejection

1. **DIN not covered**
   This reject message indicates that the DIN/PIN is not a benefit under the plan. The cardholder must pay cash for the prescription or contact their physician to see if an alternative could be prescribed.

2. **Card not effective**
   When this message appears, it indicates that the card is not currently active. The cardholder must contact their plan administrator to correct the problem. The cardholder must pay for the prescription.

3. **Card terminated**
   When this message appears, it indicates that coverage has been cancelled. The cardholder must contact their plan administrator to correct the problem. The cardholder must pay for the prescription.

4. **Cardholder has single coverage only**
   This indicates that the cardholder has not registered any dependents under their benefits plan. The cardholder must contact their plan administrator to correct the problem. The cardholder must pay for the prescription.

5. **Overage dependent not registered**
   Once a dependent reaches the maximum age (18, 19, or 21 for example) they must register as an overage dependent. The cardholder must contact their plan administrator to correct the problem. The cardholder must pay for the prescription.

6. **Cardholder information is incorrect (usually DOB difference)**
   Please verify that the correct relationship code and date of birth have been entered for the cardholder. If you are still having difficulties, please see Incorrect date of birth, section 4 on page 16 or contact the pharmacy support centre for further assistance.

7. **Prior auth required**
   If you receive this reject message, the cardholder is required to obtain the appropriate prior authorization program request form from either their employer or their insurer's website. The cardholder and their physician must complete the form. Once approved pharmacy services will then contact you or the cardholder, as indicated on the form, with the result. In addition, once the claim is approved, further prior authorization application is not required, unless prompted by our system. In some cases, payments are subject to annual limitations or total dollar maximums.

8. **Carrier auth required**
   If you receive this reject message or "CRDHLDR TO CONTACT INSURER FOR AUTH FORM" then the cardholder is not eligible for prior authorization. The cardholder must contact their plan administrator directly to obtain approval for coverage of the drug in question.

Appendix 6

PINS for common compounds

Notes:

Use of these PINs will determine eligibility only. If any ineligible bases, ingredients or formats are used in the compound, it can be still deemed ineligible during review.

Pharmacies are advised to submit methadone as a regular methadose prescription claim with the respective DINs as methadone is no longer considered a compound (see page 24 for further details).

	PIN/DIN to be used	Notes
Methadone	Varies by province (see below)	Submit without using an unlisted compound code, cost should include all compounding charges (fee submitted separately).
British Columbia (pins for maintenance)	66999997	Methadose 10mg/ml intervention
	66999998	Methadose 10mg/ml no intervention
	66999999	Methadose 10mg/ml intervention, delivery
	67000000	Methadose 10mg/ml no intervention, delivery
British Columbia	N/A	Methadone compounds no longer eligible in BC, pharmacies to use Methadose
Alberta	N/A	Methadone compounds no longer eligible in Alberta as of Sept 1, 2013
Saskatchewan	00990043	
Manitoba	N/A	Methadone compounds no longer eligible in Manitoba as of Jan 19, 2015
Ontario	N/A	Methadone compounds no longer eligible in Ontario as of Sept 1, 2014
Quebec	00907561	
New Brunswick	00999734	
Prince Edward Island	N/A	Methadone compounds no longer eligible in PEI as of Feb 17, 2014
Nova Scotia	00999734	
Newfoundland	N/A	Methadone compounds no longer eligible in Newfoundland as of Feb 1, 2015
NIHB (COB Claims only)	00908835	
Methadone capsules	00990103	
BC Methadone for pain management	66124065	Methadone pain suppositories
	66124066	Methadone pain 1mg/ml
	66124067	Methadone pain 2mg/ml
	66124068	Methadone pain 5mg/ml
	66124069	Methadone pain 10mg/ml
	66124070	Methadone pain 20mg/ml
	66124071	Methadone pain 25mg/ml
Progesterone suppositories	00990054	For all strengths. NOTE: excludes 100mg as it mimics Endometrin®.
Progesterone topical compounds	90800233	For all strengths.
Remicade®	Product DIN	Submit without an unlisted compound code, cost should include compounding time.
Testosterone topical compounds	90800234	For all strengths. NOTE: for testosterone, not covered if it mimics Androgel® or Androderm®
Topical estrogen(s) compounds (containing estriol/estrone/estradiol)	00990111	
Topical non-steroidal anti-inflammatory drugs (NSAIDs)	00999984	For all strengths. NOTE: for diclofenac, not covered if it mimics Pennsaid™ or Voltaren Emulgel™
Diclofenac topical		
Ibuprofen topical		
Indomethacin topical		
Ketoprofen topical		
Naproxen topical		

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