Health Network System (HNS) Changes to Support the Maximizing Quantity Dispensed for Chronic-Use Medications Initiative

Questions and Answers for Pharmacists

In accordance with subsection 18 (11.1) of Ontario Regulation 201/96 made under the *Ontario Drug Benefit Act* (ODBA), **effective October 1, 2015**, pharmacies are only entitled to receive a maximum of five (5) dispensing fees per 365-day period for certain chronic-use medications.

Dispensers are encouraged to provide most Ontario Drug Benefit (ODB) recipients with a 100 days' supply of most chronic-use medications to ensure that they receive a dispensing fee for each dispensing event.

The chronic-use medications subject to this rule are listed on the Ministry's website at: http://www.health.gov.on.ca/en/pro/programs/drugs/opdp_eo/notices/exec_office_20150917_list.pdf.

For more information on this and other initiatives implemented as of October 1, 2015, please visit the Ministry website at: http://www.health.gov.on.ca/en/pro/programs/drugs/opdp_eo/eo_communiq.aspx

Changes to the Health Network System (HNS) will be implemented, **effective June 26, 2016**, to support this initiative. The first claim for all chronic-use medications after October 1, 2015 will be counted as the first dispense. Where 5 or more dispensing fees have been paid since the date of the first dispense, pharmacies will not be entitled to receive additional fees until 365 days after the first dispense date.

In addition, effective June 26, 2016, HNS changes will be implemented to change the 2-fees per calendar month rule to 2-fees per 28 days, to better align this rule with common dispensing practices.

For any remaining questions not detailed in this document, please contact the ODB Pharmacy Help Desk at 1-800-668-6641 or email your questions to: PublicDrugPrgrms.moh@ontario.ca

1. How will the HNS changes support pharmacists in administering the 5 fees per 365-day period policy?

The number of fees for each ODB recipient for each chronic-use medication will now be tracked and reviewed by the HNS. A new claim adjudication rule in the HNS will limit the number of professional fees allowed on behalf of an ODB recipient to five fees in a 365-day period (5 fees per 365-day limit) based on dispense date for various chronic-use drug products.

When a claim for a chronic use drug is submitted, the HNS will look back over the previous 365 days, and determine how many claims for that drug (or an interchangeable equivalent) have received a fee. If five fees have been paid, the allowed professional fee will be set to zero. If less than 5 fees for the specific chronic use drug have been paid in the preceding 365 days, the pharmacist is eligible for payment of a professional fee.

Pharmacists are encouraged to provide most ODB eligible recipients with 100 days' supply of chronic use medications, when appropriate, and when permitted by their specific ODB plan coverage.

Regardless of which pharmacy the ODB recipient has attended to receive their medications, the 5 fees per 365-day period policy applies to each specific chronic-use medication. Pharmacies submitting claims for ODB recipients for whom 5 dispensing fees have been paid for a chronic-use medication will not be entitled to receive additional fees until 365 days after the initial claim for that chronic-use medication. The allowed professional fee will be set to zero in the claim response if five or more claims received a fee.

These limits apply to both paper and online claims.

2. What response code will be delivered when a chronic therapy drug for a given ODB recipient already has 5 fees submitted to the HNS?

If the five-fee limit is reached, then the allowed professional fee will be reduced to zero and the following response code will appear in the claim response:

- **87** ***Exceeds max. # of prof. fees for this drug***

3. When a claim is submitted under the 5 fees per 365-day policy, will the claim response line indicate the number of fees remaining or the next date of service eligible for submission of the professional fee if the 5 fees have been exceeded?

Yes, a message line will be returned in the claim response indicating the number of remaining fees in a period or the earliest service date when a fee may be allowable if no fees remain, for example:

- Remaining Fees: 2 Until NOV 01, 2016
- Next Fee Available: AUG 13, 2016

The information in the message line is accurate only at the moment the response is sent to the pharmacy. It is important to note that this message line will not appear in the claim response when an intervention code is submitted on the claim.

4. Will the HNS still allow the payment of the drug cost and mark-up if 5 fees or more for a given chronic therapy drug have already been submitted to the HNS?

Yes. The 5 fees per 365-day limit will cause the allowed professional fee to be set to zero, but will not cause claims to be rejected in the HNS, allowing the drug cost and applicable mark-up to be paid.

5. What are the exceptions and documentation requirements for the 5 fees per 365-day period policy?

ODB recipients who require more frequent dispensing due to an established physical, cognitive or sensory impairment, or because they are on a complex medication regimen where their safety is at risk, can continue to receive their chronic-use medications at more frequent intervals.

The conditions for payment of a dispensing fee for chronic-use medications do not apply to Ontario Works (OW) recipients, Long-Term Care Home (LTCH) residents and residents of publicly-funded residential care facilities listed on the ministry's website (i.e. Homes for Special Care). All extemporaneous preparations of chronic-use medications are also exempt from this change.

In these circumstances, the general rule of a maximum of two dispensing fees per 28 days (revised from the two dispensing fees per calendar month rule, effective April 14, 2016) applies, unless the dispensing event is also exempt from that rule.

For more information, please consult the Max Quantity: Enforcement and Exceptions document, posted at:
http://www.health.gov.on.ca/en/pro/programs/drugs/odbf/exempted_medications.pdf

6. What intervention code will be used to submit claims for more frequent dispensing for ODB recipients who meet the established exemption criteria?

The intervention code **UN *Assessed patient, therapy is appropriate*** will override the 5 fees per 365-day limit where an ODB recipient meets the established exemption criteria to permit more frequent dispensing. Documentation to support the application of each intervention code is required. Pharmacists must keep this information on file at the pharmacy for not less than two years for audit purposes.

A claim will be rejected with the **65 *Intervention/Exception Code Error*** if the UN intervention code is used unnecessarily. For example, for the first 5 claims for a chronic use medication in a 365 day period, that are eligible for payment of a dispensing fee, if the UN intervention code is submitted, the claim will be rejected with response code 65.

7. Does the UN intervention code need to be submitted with each claim submitted to the HNS where an ODB recipient meets the established exemption criteria to allow more frequent dispensing?

The UN intervention code is only required to be submitted with claims in excess of the 5 fees per 365-day policy where a patient meets the established exemption criteria for more frequent dispensing. As noted above, the UN intervention code must not be submitted on the first 5 claims per 365-day period that are eligible for payment of a dispensing fee.

8. What response code will be delivered when an individual meets the established exemption criteria for this policy and a claim is submitted in excess of the new 2 fees per 28-day rule?

In these instances and in accordance with the new 2 fees per 28-day rule, the following response code will appear in the claim response:

- **88 *Zero Dispensing Fee 28-Day Limit Exceeded***

9. Will the UN intervention code over-ride the 2 fees per 28-day period rule?

No, the UN intervention code will only over-ride the 5 fees per 365-day period rule. In a weekly dispensing scenario, for a patient who meets the established exception criteria for exemption from the 5 fees per 365-day period rule, after 5 claims have received a fee, a pharmacy can submit a UN intervention code AND a fee, and 2 claims/28 days will receive a fee, and for the other 2 claims/28 day period, the claim will pay, the fee will be reduced to zero, and a response code of “88” will be returned to the pharmacy. Claims can continue in this manner (i.e. with a fee and a UN intervention code) until the start of the next 365 day period, at which time the claim will reject with a “65” response code. This will signal the beginning of the next 365 day period, at which time the UN intervention code must be removed until 5 fees/ “new” 365 day period have been paid.

10. If a patient meets the established criteria for exemption from the 5 fees per 365-day policy, how many fees are eligible for payment for chronic use medications?

If a patient is eligible for exemption from the 5 fees per 365-day period policy, the 2 fees per 28-day period policy applies. For chronic use medications, no more than 2 fees per 28-day period are eligible for payment.

11. When the 2 fees per calendar month policy was in effect, in order to receive payment of a fee, in a weekly dispensing scenario, pharmacies had to submit the fee with the first 2 claims of the calendar month. Will this requirement still exist?

No. Effective June 26, 2016, when the 2 fees per calendar month rule is replaced by the 2 fees per 28-day period rule, when a claim for a chronic use medication is submitted, the HNS

will look for all claims for the specific chronic use medication, and will limit the number of payable fees to 2, regardless of which identified claims received a fee. For example, in a weekly dispensing scenario, fees can be submitted in weeks 1 and 3, and will be eligible for payment, provided no more than 2 fees are paid in any 28-day period.

12. In cases where an ODB recipient does not meet the established exemption criteria to the 5 fees per 365-day period policy but currently receives their medications in compliance packaging, are pharmacists entitled to charge the ODB recipient to continue receiving this service?

ODB recipients who require more frequent dispensing for a valid clinical reason will qualify under the established exemption criteria. For all other ODB recipients who do not meet the established exemption criteria, the pharmacist shall not pass on any ODB-ineligible dispensing fees – that is, fees beyond the fifth dispensing transaction in a 365-day period– to either the ODB recipient or their private insurer (if applicable). Passing new costs to ODB recipients is not the intent of this initiative.

13. For an ODB recipient who meets the established exemption criteria for more frequent dispensing, how often must the recipient's status be assessed?

Authorizations for more frequent dispensing are only valid for a period of 365 days. A dispenser's assessment that a patient requires more frequent dispensing because of a physical, cognitive or sensory impairment or because the patient is on a complex medication regime, must be re-assessed annually. Records of this annual assessment must be maintained as part of the ODB recipient's permanent pharmacy health record.

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