Non-Insured Health Benefits (NIHB)

Dental

Claims Submission Kit

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EXPRESS SCRIPTS®

Any comments or requests for information may be transmitted to:
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The information contained in this document is subject to change without notice. The data used in the examples are fictitious, unless otherwise noted.

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1. Introduction

1.1 Purpose of the NIHB Dental Claims Submission Kit

Express Scripts Canada's Non-Insured Health Benefits (NIHB) Dental Claims Submission Kit (also referred to as the "Kit") sets out additional terms and conditions for the submission of Claims under the Dental Provider Enrolment Form (referred to as the "Enrolment"). In addition, the Provider Guide for Dental Benefits supports the Kit providing information on the administration of the NIHB Program (also referred to as the "Program"), its policies, and the extent and limitations of the Program's benefit coverage.

The Kit is also designed to help Providers understand how Express Scripts Canada's Health Information and Claims Processing Services (HICPS) system operates. It outlines the role of the Provider, and contains all the information Providers need to submit Claims.

It is important for the Provider to understand all of the terms and conditions defined in the Kit to ensure the accuracy of any Claims submitted. It is the Providers' responsibility to obtain for reference purposes, the most current version of this Kit, which is updated quarterly throughout each year at Express Scripts Canada's discretion. Notification of Kit updates are posted thirty (30) calendar days prior to the circulation date.

All documents (Announcements, Kit, Enrolment, Dental Newsletters, and the Provider Guide for Dental Benefits) are available for download in Portable Document Format (PDF) on the Provider Website. Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to *Section 6.2.1 Provider Claims Processing Call Centre*). All questions or comments regarding the Kit should also be directed to the Provider Claims Processing Call Centre.

1.2 Interpretation

In the event this Kit does not address a Claims submission data or data transmission matter, or in the event of uncertainty as to a term or condition, the Provider may contact Express Scripts Canada to discuss the matter, and Express Scripts Canada will address the issue or provide direction to resolve the question.

1.3 General Terms

The general terms and conditions for submitting a Claim under the Program are listed in the Express Scripts Canada Dental Provider Enrolment Form, and are described in this Kit. Express Scripts Canada reserves the right to update this Kit.

The Kit contains additional terms, conditions, and procedures for verifying Client eligibility, as well as Claims eligibility, submission, adjudication, payment, reversals, and audit. Providers are bound by, and must follow the terms, conditions, and procedures in the Kit in respect of Claims submitted by them under the enrollment form.

Dental benefits are eligible for coverage to eligible registered First Nations and recognized Inuit Clients only when all of the conditions are met:

- The procedure is recommended or performed by a qualified Dental Provider who is legally able to practice their profession in the province or territory of Canada in which the service is rendered.

- The procedure recommended or performed is eligible for coverage under the Program.
- Predetermination (PD), when required, has been provided by First Nations and Inuit Health (FNIH), Health Canada Regional Offices, the Orthodontic Review Centre (ORC) prior to the service being rendered.
- The procedure is not covered for the Client under a provincial/ territorial or first payer health care plan.
- The Client is a resident in Canada and is covered or eligible to be covered under the provincial/ territorial health program.

1.4 Defined Terms

In addition to those throughout the Kit, which are defined parenthetically, the following chart displays defined terms and definitions that are used in this Kit.

Refer to the list below of terms and definitions that are relevant background information for this Kit and the Program.

Term	Definition
AANDC (formerly INAC)	Refers to the department of Aboriginal Affairs and Northern Development Canada.
CDAnet	The Canadian Dental Association network CDAnet is an electronic communication network created by the Canadian Dental Association in partnership with provincial Dental associations across Canada.
Claim	A request for payment submitted by a Provider to Express Scripts Canada for provision of Dental services to Clients in accordance with the Kit.
Client	A natural person who is eligible to receive NIHB Dental Services in accordance with the eligibility criteria in *Section 4.1 Client Identification and Eligibility* of the Kit.
COB	The Coordination of Benefits between Dental benefit plans, whether public, private or a combination of public and private coverage.
DACnet™	The electronic Claims network for Denturists provided by the Denturist Association of Canada. Refer to **EDI**.
Delisted	A Dental service Provider who is no longer an eligible NIHB Provider.
Dental Claim Statement	A detailed listing is sent by Express Scripts Canada to the Provider, Client or first payer providing the necessary information with regard to Dental Claim payment information.
Dental Provider Enrollment Form	Enrollment allowing claims submission with Express Scripts Canada for payment for services provided to Clients who are eligible for dental benefits under Health Canada's NIHB Program, subject to the Terms and Conditions of the NIHB Program.
DRA	The provincial Dental Regulatory Authorities (DRAs) is responsible for licensing. In addition to a Dental regulatory authority, each province/ territory also has a Dental association. Membership in the provincial/ territorial and national Dental associations may be a necessary component of licensure.

Term	Definition
EDI	Electronic Data Interchange that electronically captures and processes submitted Dental Claims online in real time presenting Dental Providers with an immediate response regarding the status of the submitted Claim. Providers must have office software compliant with CDAnet Electronic Claim Standard/ Réseau de l'Association des chirurgiens dentistes du Québec (Réseau ACDQ) or Denturists Association of Canada (DACnet™). Refer to **Réseau ACDQ**. Refer to **DACnet™**.
EFT	Electronic Funds Transfer is an electronic delivery of Claim payments, directly deposited into the Provider's designated bank account on the day the payment is issued.
EOB	Explanation of Benefits is a written statement displaying all of the details of the Claims paid and not paid resulting from a request.
Express Scripts Canada **(formerly ESI Canada)**	On behalf of the Program, Express Scripts Canada is the health Claims management company responsible for processing the Claims submitted through the Program.
FNIH	First Nations and Inuit Health Clients.
FNIHB	First Nations and Inuit Health Branch of Health Canada.
Health Canada	Department of Health (Canada).
HICPS	Health Information and Claims Processing Services system. This system includes all services used to process NIHB Claims, to support Providers with the processing and settlement of their Claims, and to ensure compliance with Program Policies including audit, reporting, and financial control practices.
NDCV	The Next Day Claims Verification Program is a component of the Express Scripts Canada Provider Audit Program, which consists of a review of Claims submitted by Providers, the day following receipt by Express Scripts Canada.
NIHB Dental Claim Submission Kit (referred to as the "Kit")	The Kit is provided by Express Scripts Canada, amended from time to time and made available to the Providers by Express Scripts Canada. The Kit sets out additional terms and conditions for the submission of Claims under the Enrolment Form.
NIHB Program **(referred to as the "Program")**	Non-Insured Health Benefits Program of Health Canada. The Program manages a specified range of drugs, Dental care, eye and vision care, medical supplies and equipment, short-term crisis intervention mental health counseling, and assistance with medical transportation which are provided to eligible registered First Nations when they are recognized Inuit persons and not covered by other benefit plans.
ORC	The Orthodontic Review Centre adjudicates orthodontic treatment requests.
Other Coverage	Benefits available to Clients of the Program, in whole or in part, from a provincial/ territorial or first payer health care program.

Term	Definition
PIPEDA	Personal Information Protection and Electronic Documents Act (Canada).
PD	Predetermination is a method for the administration and adjudication of Dental benefits.
Provider	The owner or operator of Dental services who is licensed by the respective provincial/ territorial regulatory authority, and has signed the Enrolment Form therefore is eligible to submit Claims.
Provider Guide for Dental Benefits	A guide which provides information on the administration of the Program, its policies, and the extent and eligibility of the Program's benefit coverage, and is used in conjunction with this Kit.
Provider Number	A unique number assigned to the Provider as identification to facilitate the submission of Claims for adjudication and to receive payment.
PWGSC	Department of Public Works and Government Services Canada.
Regional Dental Benefit Grids	The grids are referred to by General Practitioners (GP), Specialists (SP), and Denturists (DN) to obtain the eligible NIHB procedure codes and fees used for the submission of dental claims. The procedure codes listed in the grids are based on the Canadian Dental Association (CDA) Uniform System of Coding and List of Services, Association des chirurgiens dentistes du Québec (ACDQ) and Fédération des dentistes spécialistes du Québec (FDSQ) Fee Guide, and Denturists Association of Canada (DAC) Fee Guide.
Regional Dental Officer/ Dental or Ortho Consultant	A dentist that provides professional advice to Health Canada NIHB.
Regional Office	Health Canada Regional Offices throughout Canada.
Réseau ACDQ	Réseau de l'Association des chirurgiens dentistes du Québec. Refer to **CDAnet**. Refer to **EDI.**

2. Background

2.1 Health Canada NIHB Program

Further details on Health Canada's NIHB Program can be located on Health Canada's website at *www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/index-eng.php*

Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre (refer to *Section 6.2.1 Provider Claims Processing Call Centre*).

2.2 Roles and Responsibilities of Express Scripts Canada

Express Scripts Canada administers the HICPS system for Dental benefits covered by the Program. The responsibility encompasses certain aspects of Dental benefit processing and payment of Claims, Provider enrolment, verification, audit and recovery, where deemed appropriate.

Express Scripts Canada has the authority and responsibility to ensure that Claims paid for services provided to Clients are made in accordance with the Program policies and are consistent with *Section 4. General Claims Submission Procedures* outlined in the Kit.

In the context of Dental benefit management, Express Scripts Canada is not an insurance company but is mandated to receive, analyze, verify and proceed with payment of, as applicable, all Claims submitted electronically or manually by Providers and Clients through the Program. Express Scripts Canada also communicates and responds to Providers' enquiries. All Clients reimbursements should be referred to the respective Health Canada Regional Office. A listing of the Health Canada Regional Offices can be located on the Health Canada website at *www.hc-sc.gc.ca/contact/fniah-spnia/index-eng.php#nihb*

2.3 Roles and Responsibilities of Providers

The submission of a Claim by a Provider indicates understanding and acceptance of the terms and conditions for submitting Claims through the Program; as well as the requisite Provider eligibility requirements as defined in the Kit under *Section 4.1 Client Identification and Eligibility,* and *Section 3.1.3. Terms and Conditions*.

2.3.1 Client Reimbursement

Dental Providers are encouraged to submit Claims directly so that Clients do not incur charges at the point of service when receiving Dental services under Health Canada's Program.

When a Client pays directly for Dental services, the Client may seek reimbursement upon completion of a NIHB Client Reimbursement Request Form, within one year from the date of service or date of purchase. The NIHB Client Reimbursement Request Form can be located on the Health Canada website at *www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/form_reimburse-rembourse-eng.php*

In addition, a listing of the Health Canada Regional Offices and ORC can be located on the Health Canada website at *www.hc-sc.gc.ca/contact/fniah-spnia/index-eng.php#nihb*

2.4 HICPS System

The HICPS system is the electronic Claims adjudication system which automatically receives, processes, and approves or denies Claims based on Program policies, guidelines and criteria. The Claim is entered with the mandatory data elements as stipulated in the Kit.

The HICPS system captures Claims sent electronically from the Provider via Personal Computer (PC). An electronic data network transmits the Claims and returns an electronic response. Data is transmitted respecting the format specified by the current CDAnet Electronic Claim Standard[1]/ Réseau ACDQ or DACnet ™.

A list of error messages and explanations are listed in *Section 7. Dental Statement Messages and Explanations*.

The HICPS system handles manual Claims when they are paid directly to the:

- Provider who has performed the Dental services and processed according to standard system edits (Pay Provider).

[1] To obtain a copy of the CDAnet Electronic Claim Standard, contact the Canadian Dental Association.

- Client or first payer as per the Provider's instructions.
- Client or first payer, as per the Health Canada Regional Office's and ORC instructions.
- Unless otherwise indicated, a Claim is a Pay Provider Claim.

3. Dental Provider Enrolment

Providers wishing to submit Claims for services provided to Clients must enroll by fully completing and signing an Express Scripts Canada Dental Provider Enrolment Form.

Providers enrolled with Express Scripts Canada in the Program benefit from many services, such as:

- Electronic Funds Transfer (EFT):
  - A free and secure electronic payment service that directly deposits Claim payments into a Provider's designated bank account on the day the payment is issued.
- Electronic Data Interchange (EDI):
  - A point of service Claim submission service which submits Claims electronically and directly from the Provider's office software in real time, acknowledging the result of the Claim immediately. To purchase software compliant with CDAnet/ Réseau ACDQ or DACnet™, Providers are to contact the respective association for a list of certified software vendors.
- Access to the Provider Website at *www.provider.express-scripts.ca* providing access to:
  - Alerts regarding changes to the HICPS system.
  - Late-breaking news, including Health Canada Bulletins, and Announcements.
  - Regional Dental Benefit Grids.
  - Dental Newsletters.
  - NIHB Forms.
  - Policy and Program Information (Provider Guide for Dental Benefits).

3.1 Dental Provider Enrolment Process

To be eligible for enrolment with Express Scripts Canada under the Program, the Provider shall be bound by and comply with the provisions of all applicable laws, rules and regulations of the provincial/ territorial statutory organizations and other governmental bodies having jurisdiction over Dental Offices. The Provider shall maintain, at all times, all required federal, provincial/ territorial and local licenses, certificates and permits that are necessary to allow the provision of Dental services to Clients.

Licensure is validated prior to enrolment through communication with the provincial/ territorial licensing bodies by Express Scripts Canada, Provider Relations Department.

Providers wishing to provide services to Clients must complete and sign the Express Scripts Canada Dental Provider Enrolment Form in its entirety, signifying their intent to participate in and adhere to the terms and conditions of the Program.

The term of the Enrolment shall commence on the effective date (start date) of the unique Provider Number issued by Express Scripts Canada.

Upon receipt of *all completed pages* of the Enrolment at Express Scripts Canada, the Enrolment is forwarded to the Health Canada Regional Office for review, subsequent to which the Provider's enrolment may be authorized or denied. All applications for enrolment as a Provider are subject to review by the Program.

Multiple Office Identification Numbers are maintained with the same unique Provider Number for Dental Provider's having more than one office location. All additional offices **must** be enrolled with Express Scripts Canada prior to services rendered in order to avoid disruption of service for Claims processing and payment services. Any Provider Claims submitted without first enrolling the new office with Express Scripts Canada will be returned.

A copy of the Enrolment can be located on the Provider Website at *www.provider.express-scripts.ca* available in Portable Document Format (PDF). Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to *Section 6.2.1 Provider Claims Processing Call Centre*).

3.1.1 Approval/ Unique Provider Number

If the request for enrolment is approved, Providers are then assigned a unique Provider Number by Express Scripts Canada.

This number is used to identify the Provider and to properly pay the Provider for Claims adjudicated by Express Scripts Canada, and to ensure payments for the services are directed to the correct and enrolled Dental office. The unique Provider Number **must** be used when submitting all Claims for payment and in all communications with Express Scripts Canada.

Providers are responsible for Dental services completed and claimed under a Provider Number, regardless of the business arrangements in place between the Providers in an office or clinic.

3.1.2 Dental Documentation and Updates

The Enrolment sets forth the relationship between the eligible Dental Provider and Express Scripts Canada for the Program. Providers must abide with all Program requirements as outlined in this Kit and other communications that are distributed to Providers by Health Canada and/ or Express Scripts Canada by e-mail, fax or mail and are posted to the Provider Website.

The Program policy, Claim submission, and payment information is made available to Providers through:

- The Kit.
- Bulletins.
- Provider Guide for Dental Benefits.
- Dental Newsletters.
- Broadcast Messages via Dental Claim Statement.
- Announcements.

3.1.3 Terms and Conditions

In order for a Provider to be eligible for payment of services rendered to Clients, the Provider must adhere to the Program's terms and conditions as set out in the Enrolment, this Kit, and the Dental Newsletters, which include without limitation:

- Provider Licensure and Eligibility requirements (*Section 4.1 Client Identification and Eligibility*).
- Client Eligibility Requirements (*Section 4.1 Client Identification and Eligibility*).
- Requirements for Coordination of Benefits (COB) (*Section 4.2 Coordination of Benefits*).
- Submission Process and Supporting Documentation Requirements (*Section 4.3 Electronic and Manual Claims Submission and Processing*).
- Requirements for Providers on the use of Treatment Codes and Standard Definitions, and List of Services (*Section 4.3 Electronic and Manual Claims Submission and Processing*).
- Benefit Coverage and/ or Applicable Limitations (*Section 4.4 Benefit Coverage and Limitations*).
- Requirements to submit to and assist in any audit conducted by Express Scripts Canada of Claims submitted through the Program (*Section 5. Provider Audit Program*).
- Requirements to Maintain Relevant Documentation and Records (*Section 5.3.5.6 Documentation Requirements for Audit Purposes*).

Note The address provided on the Claim for each office location **must** be the address of the location where services are rendered to Clients by the Dental Provider.

The Provider shall, without limitation, provide the following services in connection with the Enrolment:

- Verification of Client Eligibility:
  - The Provider must take steps to verify that the individual is eligible for benefits under the Program, and identify the existence of other benefit coverage, if applicable.
- Service:
  - Provide benefit items to *eac*h Client in accordance with all applicable laws and regulations, applicable Program policies, administrative requirements, procedures as stipulated in this Kit and the Provider Guide for Dental Benefits.

3.1.4 Change of Provider Information

In order to keep Provider records up-to-date and avoid unpaid Claims, and non-delivery of Health Canada and Express Scripts Canada communications via e-mail, fax, or mail (e.g., Dental Claim Statements, Dental Newsletters, etc.), the Provider **must** inform Express Scripts Canada immediately of any changes to information provided during the enrolment process.

A *verbal request* is accepted at the Provider Claims Processing Call Centre to change:

- Fax number.

- Phone number.
- E-mail address.
- Correction to current address.
- Preferred communication method (fax, e-mail, mail).
- No longer working at a specific clinic/ office.

All other types of changes need to be completed on the Modification to Dental Provider Information Form and sent to Express Scripts Canada as indicated on the form.

These include, but are not limited to:

- Name and ownership change of your clinic/ office.
- Adding an additional clinic/ office.
- Becoming an incorporated Dental Provider.
- Becoming a specialist.
- Adding/ modifying EFT information.

All additional clinics/ offices must be enrolled with Express Scripts Canada in order to avoid disruption of service for Claims processing and payment services. Any Provider Claims submitted without first enrolling the location to obtain an Office ID to use with the unique Provider Number with Express Scripts Canada will be rejected.

Providers may download a copy of the Modification to Dental Provider Information Form from the Provider Website at *www.provider.express-scripts.ca*

Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to *Section 6.2.1 Provider Claims Processing Call Centre*).

3.1.5 Termination of Provider Enrolment

Either party may terminate this Enrolment at any time without cause. The termination process will be completed on a case by case basis. Providers are to send the written notice of termination of Provider enrolment, sent by fax or registered mail to:

Fax No.:
1-855-622-0669

Mail:
Express Scripts Canada
Provider Relations Department
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5

Upon termination, Express Scripts Canada will not process further Claims from the Provider, which are dated after the termination date. The Provider may, however, submit Claims manually for services provided *prior* to the termination date, and any amounts owed to the Provider by Express Scripts Canada up to the termination date will be paid.

Termination of Provider enrolment does not terminate any rights or obligations of the Provider or Express Scripts Canada regarding the Express Scripts Canada Provider Audit Program activities, refer to *Section 5. Provider Audit Program*.

4. General Claims Submission Procedures

4.1 Client Identification and Eligibility

The Provider is responsible to verify that a Client is eligible for benefit coverage under the Program and to identify the existence of other benefit coverage, if applicable.

An eligible Client must be identified as a resident of Canada, and have status of one of the following:

- Registered First Nations must be registered Indians according to the Indian Act.
- An Inuk recognized by one of the Inuit Land Claim Organizations.

To facilitate verification, the following Client identification information must be provided for each Claim:

- Surname (under which the Client is registered).
- Given names (under which the Client is registered).
- Date of birth (YYYY-MM-DD).
- Client Identification Number.

It is recommended that Clients who have an Indian Status identification card be asked to present this on each visit to the Provider to ensure that the Client information is entered correctly and to protect against mistaken identity.

4.1.1 Required Identifiers for Recognized Inuit Clients

One of the following identifiers is required for recognized Inuit Clients:

- Government of the Northwest Territories (GNWT) Health Plan Number:
  - Inuit Clients from the Northwest Territories may present a health plan number issued by the GNWT. This number is valid in any region of Canada and is cross-referenced to the First Nations and Inuit Health Branch (FNIHB) Client Identification Number. This number begins with the letter "T" and is followed by seven digits.
- Government of Nunavut (NU) Health Plan Number:
  - Inuit Clients from Nunavut may present a health plan number issued by the Government of Nunavut. This number is valid in any region of Canada and is cross-referenced to the FNIHB Client Identification Number. This is a nine-digit number starting with a "1" and ending with a "5".
- FNIHB Client Identification Number (N-Number):
  - This is a Client Identification Number issued by FNIHB to recognized Inuit Clients. This number begins with the letter "N" and is followed by eight digits.

The NWT/ NU Health Canada Card or letter (Health Canada letterhead) identifying the individual and accompanied by picture identification is sufficient identification for Clients.

4.1.2 Required Client Identification Numbers for Eligible First Nations Clients

One of the following identifiers is required for registered First Nations Clients:

- AANDC Registration Number:
  - This is a ten-digit number issued by AANDC. The AANDC Registration Number is the preferred method of identifying First Nations Clients.

  The ten-digit AANDC Registration Number consists of the following:
  - The first three (3) digits represent the band with which the individual is associated.
  - Where applicable, the remaining seven digits uniquely identify the individual Band Number and Family Number:
- Band Number and Family Number:
  - If an AANDC Registration Number is not available, a Band Number, and Family Number may also be used as Client identification where applicable.
- FNIHB Client Identification Number (B-Number):
  - In specific and exceptional cases some Clients may have numbers issued by FNIHB. This number begins with the letter B, and is followed by eight-digits.

4.1.3 Individuals Excluded from the Program

The following individuals are *not* eligible to receive benefits through the Program:

- First Nations and Inuit Clients incarcerated in a federal, provincial/ territorial or municipal corrections facility.
- First Nations children who are in the care of provincial/ territorial social service agencies.
- Those individuals who are in a provincially/ territorially funded institutional setting, such as nursing homes.

4.1.4 NIHB Administered by First Nations and Inuit Organizations

The Program is sometimes administered by First Nations and Inuit organizations and/ or territorial Health Authorities through specific arrangements. These arrangements may lead to the creation of alternate health service delivery models.

In cases where a Client is no longer covered under the Program for a specific benefit type, Providers are notified through the Dental Newsletter of the appropriate new benefit administrator. At that time, members of those groups receive benefits through their First Nations or Inuit organizations rather than through the Program. Providers are directed to the respective First Nations or Inuit organizations for further information.

The following First Nations/ Inuit Organizations have assumed the administration for the delivery of Dental benefits:

- Akwesasne Band #159.
- Bigstone Cree Nation #458.
- James Bay Cree (9 bands):

  - Naskapis #081.
  - Chisasibi #058.
  - Eastmain #057.
  - Nemiscau #059.
  - Waskaganish #061.
  - Waswanipi #056.
  - Wemindji #060.
  - Whapmagoostui #095.
  - Mistassini #075.
- Nunatsiavut Government (formerly the Labrador Inuit Health Commission).
- Nisga'a Valley Health Board:
  - Gingolx #671 (Kincolith).
  - Gitakdamix #677 (New Aiyanish).
  - Lakalzap #678 (Greenville).
  - Gitwinksilkw #679 (Canyon City).

4.2 Coordination of Benefits

Providers must confirm with each Client for each Claim whether Other Coverage exists. If the Client confirms that Other Coverage exists, the Provider must submit the Claim to the other payer *first* before submitting for Program coverage.

First payer carriers may be provincial/ territorial or private health care plans and can include Social Services, Workers Compensation Board (WCB), and employee benefit programs. After the first payer processes the Claim and generates an Explanation of Benefits (EOB), the EOB and a copy of the Claim can be sent to Express Scripts Canada for processing. The EOB must include the amounts paid by the first payer.

The Program only covers eligible Claims which are not covered by another first payer plan.

COB for orthodontic treatment is applied at the time of PD. Where a Client has first payer coverage, Providers must first submit their orthodontic treatment plan to the first payer carrier(s). Once the Provider receives a reply from the first payer carrier(s), the treatment plan can be submitted to the ORC. Providers must attach the first payer coverage response at the time of PD.

4.2.1 Coordination of Benefits with Provincial or Territorial Plans

The Program requires that Clients access the benefits available to them through their provincial/ territorial program. Claims submitted where the services are covered under a provincial/ or territorial program are returned.

For services rendered where the provincial/ territorial program requires a coordination of benefits, Providers must submit their request to Express Scripts Canada along with a copy of the Explanation of Benefits (EOB) from the provincial/ territorial program attached using the Procedure Code of the service performed. Benefits available under these provincial programs must be billed directly to the applicable Program:

Provincial Program	Description
Alberta	Alberta Health Care Insurance Plan - Anesthesia and facility fees may be payable by the provincial medical plan. These eligible Claims may not be submitted to Express Scripts Canada. Social Assistance – covers Dental services (basic or emergency) for low-income families.
Manitoba	Manitoba Health Services Insurance Plan - Certain Dental anaesthetic benefits are available to children through the Province of Manitoba. Social Assistance – covers Dental services (basic or emergency) for low-income families.
New Brunswick	Family and Community Services, Health Services Dental Program – covers basic services for eligible children, and limited surgical and prosthetic services for eligible adults. Social Assistance – covers Dental services (basic or emergency) for low-income families.
Newfoundland and Labrador	Newfoundland and Labrador Medical Care Plan (MCP) - The Children Dental Program for Clients up to 12 years of age inclusive. Social Assistance – covers Dental services (basic or emergency) for low-income families.
Northwest Territories	NWT Health and Social Services -- Certain Dental benefits are available to children through the Government of NWT. Social Assistance – covers Dental services (basic or emergency) for low-income families.
Nova Scotia	Nova Scotia Medical Services Insurance (MSI) - Children's Dental Program for Clients up to the end of the month in which they turn ten years of age. Social Assistance – covers Dental services (basic or emergency) for low-income families.
Nunavut	Nunavut Health and Social Services - Certain Dental benefits are available to children through the Government of Nunavut. Social Assistance – covers Dental services (basic or emergency) for low-income families.
Prince Edward Island	Public Dental Programs for Children – covers eligible children aged 3-17 inclusive. Social Assistance – covers Dental services (basic or emergency) for low-income families.
Provincial and Municipal Social Services Plans	Most provinces and municipalities provide certain Dental benefits for recipients of provincial/ municipal social assistance.
Québec	Québec Health Insurance Plan - Régime d'assurance maladie du Québec - RAMQ - Dental Services Program for Clients up to nine years of age inclusive. Social Assistance – covers Dental services (basic or emergency) for low-income families.

Provincial Program	Description
Saskatchewan	Medical Care Insurance Plan - Anesthesia services in approved hospitals for children under 14 years of age. Certain procedures performed by specialists and general practice dentists are covered for all Clients by the Saskatchewan Medical Care Insurance Plan (MCIP). Refer to the current MCIP Payment Schedule for Insured Services provided by a Dentist. Social Assistance – covers Dental services (basic or emergency) for low-income families.
Yukon	Yukon Health and Social Services - Certain Dental benefits are available to children through the YCDP (Yukon Children's Dental Program). Social Assistance - covers Dental services (basic or emergency) for low-income families.

4.2.2 Coordination with First Payer Health Care Plans

Claims submitted where the services are covered by a first payer are returned with Message R30 – “Client has Alternative Coverage. Contact the Health Canada Regional Office” or Message R31 – “Client has Alternative Coverage. Contact Express Scripts Canada”.

Providers must obtain the information on first payer coverage from Clients. If coverage exists, the Claims must be submitted directly by the Provider or the Client to the appropriate first payer. Where a first payer has paid less than the current Provincial/ Territorial Fee Guide in effect for a service and the service is also eligible under the Program, a Claim may be submitted to Express Scripts Canada. The claim form must indicate the original full fee for each service provided. Express Scripts Canada calculates based on the EOB.

4.3 Electronic and Manual Claims Submission and Processing

Claims with a service date prior to the closing of the record or the termination of billing privileges will be considered for payment up to one year from the date of service only. Claims with a service date on and subsequent to the end date of enrolment or the date of termination are not be eligible for payment to the Provider.

Eligible codes under the Program can be found in the Regional Dental Benefit Grids (General Practitioner (GP), Specialists (SP) and Denturists (DT)). All Regional Dental Benefit Grids are located on the Provider Website at *www.provider.express-scripts.ca*

Providers who do not have internet access, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to *Section 6.2.1 Provider Claims Processing Call Centre*).

4.3.1 Electronic Claims Submission

Providers wishing to submit electronic Claims using the EDI system must first register with CDAnet/ Réseau ACDQ or DACnet™ and contact the Provider Claims Processing Call Centre to notify them of their ‘EDI ready’ status. Claims submitted using the EDI system are either accepted or returned in real time. Each Dental Claim must be

submitted to Express Scripts Canada in the most current CDAnet/ Réseau ACDQ or DACnet™ Claims transmission standard for processing and payment. For details, refer to *Section 7.2 Submission Options and Mandatory Data to be Submitted in Dental Claims*.

4.3.2 Manual Claims Submission

Certain Claim submissions still require manual claim forms. If these submissions are sent electronically, an acknowledgement is returned to the Provider requesting a manual submission.

In order to expedite payments, Providers are encouraged to submit manual Claims *at least every two weeks* using one of the following forms:

- Standard Dental Claim Form.
- Computer generated form.
- ACDQ Dental Claim and Treatment Plan Form.
- NIHB Dental Claim Form (Dent-29).
- Canadian Association of Orthodontists (CAO) Certified Specialist in Orthodontics Standard Information Form.
- NIHB Client Re-imbursement Form.

Note Reversals and corrections (with the stated reason for reversal) to previously paid Claims should be submitted on the Dental Claim Statement.

Regardless of the billing method used, all required data elements must be recorded to ensure the efficient payment of Claims. Data elements must be submitted in the same order as displayed on the NIHB Dental Claim Form.

Note Quebec Dental Providers are required to submit Claims for payment using the NIHB Dental Claim Form (Dent-29), completed and signed by the Client or parent/guardian. If the Provider chooses to submit Claims using an ACDQ Dental Claim and Treatment Plan Form, which also requires signature of Client or parent/guardian, or through EDI, the Provider must retain a NIHB Dental Claim Form (Dent 29), including signature by the Client or parent/guardian in the Client chart for each Claim submitted for payment.

For a full list of required Data Elements, refer to *Section 7.2 Submission Options and Mandatory Data to be Submitted in Dental Claims*.

All Provider manual Claims should be mailed to Express Scripts Canada (*refer to Section 6.2.2 Mailing Address for Dental Claims*).

4.3.3 Claims Older than One Year

Claims older than one (1) year from the date of service are not accepted for processing and will not be considered for payment.

4.3.4 Selected Billing Rules

Orthodontic Claims are manually submitted with Orthodontic Payment Codes using the Client Reimbursement Form.

The orthodontic alpha-numeric Payment Codes or exact wording (indicated in the table below) must be provided on the claim form or the Claim is returned to the Provider unprocessed.

Payment Code	Exact Wording
P0500/ 80601	Orthodontic Observation
P1000	Examination
P1100	Diagnostic Records
P1101	Diagnostic Records and Examination
P1200	Initial Payment
P1300	Incremental Payment
P1400	Final Payment
P1450	Final Payment – Objectives Not Met
P1500	Initial Payment – Interceptive
P1600	Incremental Payment – Interceptive
P1700	Final Payment – Interceptive
P2010	Maxillary pre and post surgical work up
P2020	Mandibular pre and post surgical work up
P2030	Maxillary and Mandibular pre and post surgical work up

- Orthodontic Specialists (Ortho):
  - Use the Payment Code P0500 when submitting a Predetermination (PD) request for subsequent follow up appointments to the initial orthodontic examination visit Procedure Code P0500.

- General Practitioners (GP) and Paedodontists (Paed):
  - Continue to use Procedure Code 80601 Orthodontic Observation when submitting PD request for follow up appointments to the initial orthodontic examination visit.
- Oral Surgeons (O. Surg):
  - Use the Payment Codes P2010, P2020, and P2030 when submitting PD requests for pre and post surgical work up related to orthodontic treatments. Pre and post surgical workup treatment may only be considered for coverage when associated with a valid approval for comprehensive orthodontic treatment under the Program.

    Note Procedure Code 01901 is no longer accepted when requesting a PD for Pre and Post surgical workup for Oral Surgeon. Providers and Clients are welcomed to communicate directly with the ORC at telephone number 1-866-227-0943.
- General Anesthesia Services:
  - When submitting an EDI or a manual Claim for anesthesia services, the Claim must be accompanied by an associated Dental Procedure Code with the same Date of Service. Failure to submit the Claim without a verified associated Dental Procedure Code, results in the Claim line being returned.

- Laboratory Fees:

  a) EDI Claim Submissions Lab Fees:

  When submitting a Claim using the EDI system for Procedure Codes eligible for lab fees, the Claim must be submitted with both the professional fee amount, and the commercial lab fee amount on the same Claim line. Failure to do so results in the Claim being returned.

  If two lab fees are submitted on the same Claim, the total laboratory fee allowed is returned in the eligible amount for Lab Code 1 field.

  b) Manual Claim Submissions Lab Fees:

  When submitting a manual Claim for Procedure Codes eligible for laboratory fees, the codes must be submitted with both a professional fee amount, and a laboratory fee amount on the same Claim line. It is not mandatory for a laboratory invoice to be submitted with the Claim.

  If a Provider attaches a laboratory invoice to a Claim, and the laboratory fee claimed is different from the amount on the laboratory invoice, the Claim is returned to the Provider unprocessed.

  c) In-House Laboratory Fees:

  The Professional Fee noted on the Predetermination Confirmation Letter includes only the approved Professional Fee component of the total Denturist Fee. While the applicable In-House Laboratory Fees with the Professional Fee and will be paid at the time of Claims processing.

4.3.5 Universal Descriptions and Codes

When submitting either an EDI or manual Claim for procedures that require a/ an **Quadrant**, **Surface**, **Arch**, or **Sextant** description, Providers must use the following codes:

Quadrant Code	Description
Code 10	Upper Right
Code 20	Upper Left
Code 30	Lower Left
Code 40	Lower Right

Surface Code	Description
Code L	Lingual
Code M	Mesial
Code I	Incisal
Code B	Buccal
Code V	Labial Anterior
Code F	Facial
Code D	Distal
Code O	Occlusal

Arch Code	Description
Code 00	Full Mouth
Code 01	Maxillary
Code 02	Mandibular

Sextant Code	Description
Code 03	Designates from 18-14
Code 04	Designates from 13-23
Code 05	Designates from 24-28
Code 06	Designates from 38-34
Code 07	Designates from 33-43
Code 08	Designates from 44-48

4.3.6 Dental Claims Reversal

EDI Claim Reversal

A Claim reversal transaction is used to reverse a previously submitted and paid EDI Claim. A Claim may only be reversed using the EDI system on the same day that it was submitted. To reverse a Claim after the date of submission, follow the manual procedures outlined in *Section 7. Dental Statement Messages and Explanations*.

Note To successfully reverse a Claim, the Provider must follow the instructions provided by the Dental software vendor.

When a Claim reversal is submitted, an electronic Claim reversal response is sent to the Provider. If the reversal is accepted, the system reverses the impact of the original Claim and it does not appear on the Dental Claim Statement. If the reversal is returned, the Provider must correct the error(s) and resubmit the Claim reversal.

Manual Claim Reversal

A manual Claim reversal is submitted on the Dental Claim Statement. For a comprehensive review of mandatory information in transmissions and submission options, refer to *Section 7. Dental Statement Messages and Explanations*.

4.4 Benefit Coverage and Limitations

Additional information of eligible benefits, Program limitations and services requiring PD, refer to the current Regional Dental Benefit Grid (General Practitioner (GP), Specialist (SP) and Denturists (DT)) located on the Provider Website at *www.provider.express-scripts.ca*

Providers who do not have internet access, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to *Section 6.2.1 Provider Claims Processing Call Centre*).Further information on the terms and conditions, criteria, guidelines and policies under which the Program covers Dental services provided to eligible First Nations and Inuit Clients (such as but not limited to, filling restrictions, laboratory fee submissions, general anesthesia/ facilities), can be found in the Provider Guide for Dental Benefits located on the Provider Website at *www.provider.express-scripts.ca* (select **Policy and Program Information**) or by contact the respective Health Canada Regional Office to request a copy.

4.4.1 Exceptions

Exceptions are Dental procedures that are outside the Program scope of benefits or procedures that require special consideration. Requests must be supported with a rationale and a PD (mandatory).

4.4.2 Exclusions

Exclusions are Dental procedures that are not covered by the Program and will not be considered for coverage nor considered for Appeal.

These services include, but are not limited to:

a) Cosmetic services such as, but not limited to:

- Veneers composite or ceramic.
- All ceramic crowns including 3/4 crowns.
- Teeth whitening.
- Inlays/ onlays in composite, precious metal or ceramic.
- Sleep apnea appliances.
- Temporo Mandibular Joint Therapy and appliances.
- Bridges /Bruxism Appliances.

b) Complex Dental treatment/Rehabilitation such as, but not limited to:

- Crown lengthening.
- Root re-sectioning.
- Implants and any associated procedures.
- Treatment for changing vertical dimension.
- Bone grafts.
- Ridge augmentation.
- Complex dentures/partials.
- Major rehabilitation.
- Precision attachment partial dentures.
- Fluorescent diagnostic light.

5. Provider Audit Program

5.1 Audit Objectives

The objective of the Express Scripts Canada Provider Audit Program is to confirm that Claims have been submitted in compliance with the terms and conditions of the Program including:

- Detect and recover for billing/ Claim irregularities.

- Ensure that Providers have retained the appropriate supporting documentation, meeting both provincial/ territorial and federal regulations as well as Program requirements to support each Claim.
- Ensure that services paid for by the Program have been received by Clients (for example, the service billed on behalf of a Client was received by that Client).
- Ensure that the services were received by eligible Clients.
- Validate active licensure of Providers.
- Ensure compliance with the Program.

Express Scripts Canada reserves the right to withhold future payments to Providers, pending receipt of monies found paid in error. Providers may contact the Provider Claims Processing Call Centre to clarify or appeal the payment error reversal.

The Express Scripts Canada Provider Audit Program does not focus on professional practice issues. If a practice related issue arises during an audit and if the issue cannot be resolved directly with the Provider, Express Scripts Canada or Health Canada may refer the matter to the respective regulatory body.

5.2 Provider Responsibilities

The Provider shall cooperate with Express Scripts Canada in all audit activities based on generally accepted industry practices. Upon request, the Provider shall grant access to its location to Express Scripts Canada to inspect, review, and reproduce during regular business hours, any Dental records maintained by the Provider pertaining to Clients as Express Scripts Canada deems necessary to determine compliance with the terms outlined in these documents.

5.3 Provider Audit Components

Express Scripts Canada contacts the Provider at least three weeks prior to the proposed on-site audit date. Every effort is made to accommodate the Provider's schedule in determining the audit date. An on-site confirmation letter is provided to the Provider confirming the agreed upon date of the on-site audit.

To carry out all audit components of the Program, Express Scripts Canada requires access to information, including, but not limited to the following:

- Client chart/ records.
- Client radiographs.
- Daily appointment records.
- Study models.
- External lab invoices.
- Documentation of service received by the Client.
- Evidence of additional coverage (to coordinate benefits).

5.3.1 Next Day Claims Verification

The Next Day Claims Verification (NDCV) Program consists of a review of Claims submitted by Providers the day following receipt by Express Scripts Canada.

5.3.2 Client Confirmation Program

Confirmation consists of a monthly mailing to a randomly selected sample of Clients to confirm the receipt of the service that has been billed on their behalf.

5.3.3 Provider Profiling Program

Profiling consists of a review of the billings of all Providers against selected criteria and the determination of the most appropriate follow up activity, if concerns are identified. All Claims are subject to an audit review.

5.3.4 Desk Audit Program

This consists of a review of a defined sample of Claims focusing on a particular issue evident in a Provider's billings. The Provider is requested to submit records to Express Scripts Canada for administrative review.

5.3.5 On-Site Audit Program

An on-site audit consists of the selection of a sample of Claims to be validated against Client records through an on-site audit. Providers may be selected as a result of information gained through many of the components of the Express Scripts Canada Provider Audit Program, and any additional information received.

5.3.5.1 Documentation Requirements for Audit Purposes

Providers must retain Client records and charts, electronic or hard copies, in accordance with provincial/ territorial requirements. Client records must support the services rendered and claimed. Express Scripts Canada uses the descriptions as outlined in the Canadian Dental Association Uniform System of Coding & List of Services, ACDQ – Québec Association Fee Guide, FDSQ – Québec Specialists Fee Guide, DAC – Denturist's Association of Canada Fee Guide excluding Alberta Denturist's Fee Guide or Provincial Dental Fee Guides (GP and Specialists) excluding Alberta.

Proper, clear, and detailed documentation is required for verification against the Program's billing criteria. A Procedure Code or procedure name is not sufficient in a Client record to support payment. Providers must document progress notes within the treatment portion of the Client record and the Providers who are fully computerized must document additional progress notes within the treatment portion of the Client record. The automatic generation of the procedure description alone is not sufficient.

5.3.5.2 Supporting Documentation

Dental Providers must maintain a Client chart/ record documenting and supporting the services provided, claimed and paid by ESC.. A procedure code and/ or name are not sufficient as a Client record to support payment.

Examples of appropriate supporting documentation include, but are not limited to:

a) Emergency or Specific Examinations:

- Area(s) of discomfort and/or infection (for example, Tooth Number, Sextant, etc.), diagnosis, treatment provided (X-rays, anaesthetic, etc.) and any other relevant information.

b) Complete Examinations:

- Complete periodontal charting, intra/ extra oral examination findings, treatment plan, occlusion, completed odontogram, furcation involvement, mobility, etc.

c) Preventive Services, Scaling, Root Planing Procedures and Curettage (the number of units serviced must be supported / documented by the clinical findings):

- Periodontal charting, recession, treatment plan, clinical examination findings, completed odontogram; and,
- Documentation of condition to include, but not limited to the amount of calculus, plaque present, bleeding, pockets, use of local anaesthetic or degree of periodontal disease and any other relevant information.

d) Restorations:

- Tooth Number, type of restorative material used, surface(s) restored, type and quantity of local anaesthetic used, area(s) of decay and/ or fracture and any other relevant information.

e) Complicated Extraction (Erupted Tooth, Surgical Approach):

- Tooth Number, anaesthetic used, surgical flap and/or sectioning of tooth and any other relevant clinical information.

f) Desensitization:

- Tooth Number and/ or area(s) of sensitivity and name of medicinal aid applied and any other relevant clinical information.

g) Denture Adjustments/ Repairs:

- Client's chief concern, area of discomfort/ pain, reason for repair, affected teeth numbers, and modification done to denture.

5.3.6 Reference Documents

For more information on the Express Scripts Canada Provider Audit Program activities, refer to the:

- Annual Report.
- Enrolment Form.
- Dental Newsletters.
- Bulletins.
- Provider Guide for Dental Benefits.
- Regional Dental Benefit Grids

Providers may refer to the Enrolment Form, Provider Guide for Dental Benefits, Regional Dental Benefit Grids, and the Dental Newsletter (issued quarterly) located on the Provider Website at *www.provider.express-scripts.ca*

Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to *Section 6.2.1 Provider Claims Processing Call Centre*).

The Annual Report may be viewed and downloaded from the Health Canada Website at *www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/index-eng.php*

5.3.7 Additional Audit Information

Providers requiring additional information about the Express Scripts Canada Provider Audit Program may contact Express Scripts Canada in writing at the following address:

Express Scripts Canada
Attention: Manager, Business Integrity - Dental
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5

6. Dental Forms and Resources

6.1 Dental Forms

The Dental forms listed below are available for download in PDF format from the Provider Website at *www.provider.express-scripts.ca*

Providers who do not have internet access or e-mail, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to *Section 6.2.1 Provider Claims Processing Call Centre*).

- Dental Provider Enrolment Form.
- NIHB Dental Claims Submission Kit.
- NIHB Dental Claim Form (Dent-29).
- Modification to Dental Provider Information Form.
- NIHB Completion of Active Orthodontic Treatment Form.
- NIHB Orthodontic Summary Sheet.
- NIHB Client Reimbursement Request Form (refer to *Section 2.3.1, Client Reimbursement*).
- ACDQ Dental Claim and Treatment Plan Form (obtain form from Réseau de l'Association des chirurgiens dentistes du Québec).
- Application for Orthodontic Work-Up Form (remote communities - travel implications) (available from the ORC - refer to Health Canada's website at *www.hc-sc.gc.ca/contact/fniah-spnia/fnih-spni/nihbpa-ssnaap-eng.php#orc*).

6.2 Resources

6.2.1 Provider Claims Processing Call Centre

The call centre is available to enrolled Dental Providers of the Program:

Phone No.:
1-888-511-4666

Extended Hours of Operation:
Monday to Friday 6:30 a.m. - 8:30 p.m. Eastern Time, excluding Statutory Holidays

6.2.2 Mailing Address for Dental Claims

Dental Claims are to be mailed to the following address:

Express Scripts Canada
NIHB Dental Claims
3080 Yonge St., Suite 3002
Toronto, ON M4N 3N1

6.2.3 Other Correspondence

Other correspondence for fax and mail are as follows:

Fax Number:

1-855-622-0669

Mail:

Express Scripts Canada
Provider Relations Department
5770 Hurontario St., 10th Floor
Mississauga, ON L5R 3G5

6.2.4 Express Scripts Canada Privacy Policies

Express Scripts Canada must follow all applicable privacy laws.

Express Scripts Canada's privacy policy is based on applicable privacy laws in Canada, including the federal Personal Information Protection and Electronic Documents Act (PIPEDA) and the Privacy Act.

For more information regarding Express Scripts Canada's Privacy Policy, contact:

E-mail:

ExpressScriptsCanada_Privacy@Express-Scripts.com

Website:

www.express-scripts.ca/about/privacy-policy

Telephone:

1-888-677-0111 (ask for the Privacy Officer)

Mail:

Express Scripts Canada
Attention: Privacy Office
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5

6.2.5 Really Simple Syndication Feeds

Really Simple Syndication (RSS) is a useful tool for keeping updated on your favorite websites. Updates to the site are broadcast to subscribers through an RSS feed.

Sign up for an RSS feed and a message will appear in your feed reader every time new information is added to that section of the Health Canada website. When an update is sent out, it includes a headline and a small amount of text, either a summary or the lead-in to the larger story.

RSS feeds have addresses like a website, but you can't read them directly with your browser. They have a different format than web pages, so you'll view garbled text if you try. In order to receive RSS feeds, you must have an aggregator, otherwise called a feed reader. There are a number of free aggregators online, and with a little searching you will be able to find an interface that appeals to you. In addition to availability on your computer, RSS feeds can also be read on PDAs and cell phones.

6.2.5.1 Add to your Aggregator

To add your aggregator, you can do so in one of two ways:

1. Most sites that offer an RSS feed have an RSS or XML button on their homepage that you can click on and instantly add that feed to your aggregator.
2. Depending on your aggregator, you may instead need to copy and paste the URL of the feed into the program.

By either method, the feed will be available as soon as you've added it, and your next update could arrive at any given moment. If you decide that you no longer want to receive updates, simply delete the feed or URL from your aggregator.

6.2.5.2 Add E-mail to RSS Services

There is also an added service where you can register online to have the RSS feed sent directly to your e-mail account.

The following are a few free online services that let you subscribe to RSS feeds via e-mail:

- FeedBlitz at www.feedblitz.com/
- Yahoo! Alerts at http://alerts.yahoo.com

Express Scripts Canada does not support these websites. We accept no responsibility or liability for your use of, or reliance on, content provided or any malicious programs on the websites. These links are provided for your information and convenience only.

To receive e-mail notices through an e-mail RSS service:

1. Copy the .xml URL link.
2. Paste it into the e-mail subscription page.

Websites

- Health Canada, NIHB Program:

  www.hc-sc.gc.ca/fniah-spnia/index-eng.php
- Express Scripts Canada, Corporate Website:

  www.express-scripts.ca
- Express Scripts Canada, Provider Website:

  www.provider.express-scripts.ca

For more details on Health Canada RSS feeds, visit www.hc-sc.gc.ca/home-accueil/help-aide/rss-eng.php#what

7. Dental Statement Messages and Explanations

The HICPS system assigns three-character Reject and Warning Codes with messages that appear on the Dental Claim Statement.

Reject Code		Warning Code	
Code	Text Message	Code	Text Message
"R" followed by two numeric characters.	Explains why the Claim was returned.	"W" followed by two numeric characters.	Explains that the Claim was adjudicated with modifications.

7.1 Dental Claim Statement Details

The Dental Claim Statement accompanies the Claims payment cheque and provides information about each Dental Claim processed. If payments are made through EFT, the monies are deposited in the Provider's designated bank account, and the Dental Claim Statement is mailed to the Provider's business address. The Dental Claim Statement may provide additional Client identification information, which should be added to the Client's records and be used for all future Claims submissions.

The Dental Claim Statement lists all submitted and entered Claims settled, adjusted Claims, and Claims returned all during the current period. Returned Claims include the appropriate reject message explaining the reason each Claim was not paid. Express Scripts Canada issues the Dental Claim Statement twice a month on the 1st and 16th in either English or French, depending on the Provider's language of choice.

7.1.1 Corrections to Claims using the Dental Claim Statement

Providers can use the Dental Claim Statement to reconcile accounts and to make corrections.

The existing information should not be erased. A line should be used to strike through the information that needs to be changed. Indicate the corrections to the Claims directly below the existing information on the Dental Claim statement and forward the applicable page of the statement to Express Scripts Canada within twelve (12) months from the date of service for re-adjudication of the Claim and to secure payment. Claims submitted more than twelve (12) months form the date of service will be returned with the R21 Message - Period for Submitting Claims has Expired.

7.1.2 EDI and Manual Claim Submission: Dental Claim Statement

The Dental Claim Statement includes all electronic Claims, which were adjudicated during the current period, as indicated to the Provider on the EOB.

Claims which were not adjudicated in real time due to a manual submission requirement or missing/ invalid data, as well as Claims that have been reversed, do not appear on the Dental Claim Statement generated with EDI. The Dental Claim Statement generated for manual submissions includes all manually submitted Claims which were adjudicated and settled during the current period: paid, reduced, returned, and adjusted (and reversals).

7.1.3 EDI Claims Submission Messages and Explanations

The HICPS system assigns three-character Reject and Warning Codes with messages that appear on the Dental Claim Statement.

For every submitted transaction, the system generates a CDAnet/ Réseau ACDQ or DACnet™ response Status Code to indicate to the Provider whether the transaction was accepted or returned. Once accepted, any Claim submitted using the EDI system is adjudicated in a matter of seconds.

Two types of codes/ messages may be displayed to inform Providers of the outcome of the transaction, CDAnet/ Réseau ACDQ or DACnet™ Codes/ Messages, and NIHB System Codes/ Messages:

When a Claim cannot be adjudicated in real time because …	
Missing/ Invalid Data	**It must be Submitted Manually,**
• A Claim acknowledgment is returned to the Provider with the CDAnet/ Réseau ACDQ or DACnet™ response Status Code "R" indicating that the Claim is returned because of errors. • For every procedure line that has an error, a valid CDAnet/ Réseau ACDQ or DACnet™ three-character numeric Error Code and text description are displayed.	• A Claim acknowledgment is returned to the Provider with the CDAnet/ Réseau ACDQ or DACnet™ response Status Code "048" indicating that a manual claim form must be submitted by the Provider.

When a Claim submission is accepted and processed, an electronic response called EOB is returned to the Provider with the results of the adjudication. If a reject "R" or warning "W" message is generated as a result of the Claim adjudication, the EOB includes the "R" and "W" codes and message text (in the Notes field). In addition, messages on the EOB are also printed on the Dental Claim Statement which accompanies the Claims payment cheque or electronic funds transfer notice.

When a Claim reversal is submitted, an electronic Claim reversal response is sent to the Provider. The response indicates whether the reversal is returned or accepted. CDAnet/ Réseau ACDQ or DACnet™ Error Codes and text description may be displayed in the Notes field.

7.1.3.1 Manual Claims Submission System Codes Messages and Explanations

Messages	**Explanations**
NIHB Code R04	
Message:	This is not an eligible benefit.
Explanation:	The Claim has not been paid because the item is not covered under the Program.
NIHB Code R05	
Message:	Claimant could not be verified as an NIHB Client.
Explanation:	The Claim cannot be paid because the claimant could not be verified as a Client. The verification problem may be due to the fact that the claimant; (a) has not used their enrolled surname, given names, or date of birth; or (b) has made an error in specifying the Client Identification Number. In such cases, it may only be

Messages	Explanations
	necessary for the claimant to provide more accurate Client identification information. However, if the claimant is not enrolled as a Client, it is necessary for the claimant to do so before service can be provided.
NIHB Code R06	
Message:	Client is not eligible for this benefit.
Explanation:	The Claim has not been paid due to the age of the claimant.
NIHB Code R07	
Message:	This is a duplicate Claim.
Explanation:	The Claim has not been paid because it is a duplicate of a previously paid Claim.
NIHB Code R10	
Message:	Invalid Provider Number.
Explanation:	The Claim has not been paid because the Provider cannot be validated as an enrolled NIHB Provider.
NIHB Code R12	
Message:	Insufficient Client Information to Adjudicate Claim.
Explanation:	The Claim did not provide sufficient information to determine if the claimant is a NIHB Client. To facilitate Client verification, this Client information must be provided for each Claim: a) Surname. b) Given names. c) Date of birth. d) Client Identification Number. Check your Claim for missing or incomplete information and provide the required information.
NIHB Code R14	
Message:	Insufficient benefit information to adjudicate Claim.
Explanation:	The Claim has not been paid because it did not provide sufficient information to determine if the claimed procedure is eligible under the Program. At a minimum, this information must be provided on each Claim: a) Date of service. b) Procedure Code. c) Professional Fee. Check your Claim for missing or incomplete information and provide the required information.
NIHB Code R20	
Message:	Submit Claim to Provincial or Territorial Health Plan.
Explanation:	The Claim has not been paid because a provincial/ territorial health plan covers part of the procedure. Direct the Claim to the appropriate plan.

Messages	Explanations
NIHB Code R21	
Message:	Period for Submitting Claims has Expired.
Explanation:	The Claim has not been paid because the Claim was submitted more than one year after the service was rendered.
NIHB Code R23	
Message:	Service Provided Prior to Client's Start Date.
Explanation:	The Claim cannot be paid because the date of service is prior to the start date for the Client's NIHB coverage.
NIHB Code R24	
Message:	Service Provided After Client's End Date.
Explanation:	The Claim cannot be paid because the date of service is after the end date for the Client's NIHB coverage.
NIHB Code R26	
Message:	Predetermination Service Date Violation.
Explanation:	The Claim has not been paid because the date of service is either before the start date or after the end date of the PD approval.
NIHB Code R27	
Message:	Predetermination Number is Invalid.
Explanation:	The Claim has not been paid because the PD Number does not exist on the Express Scripts Canada PD database.
NIHB Code R28	
Message:	Client, Provider or benefit details on Claim do not match the Predetermination Confirmation Letter.
Explanation:	The Claim has not been paid because the Client, Provider or benefit details on the Claim do not match those on the Confirmation Letter. If an error was made, supply the corrected information to Express Scripts Canada. If the PD requires amendment, contact the respective Health Canada Regional Office.
NIHB Code R30	
Message:	Client has Alternative Coverage, Contact Health Canada Regional Office.
Explanation:	The Claim has not been paid because FNIHB records indicate that the Client has alternative coverage for the claimed Procedure Code. Contact the Health Canada Regional Office for direction on where to submit the Claim. Refer to the directory insert for the phone number and address of the Health Canada Regional Office.
NIHB Code R31	
Message:	Client has alternative coverage, please contact Express Scripts Canada.
Explanation:	The Claim has not been paid because Express Scripts Canada's records indicate that the Client has alternative coverage for the claimed Procedure Code.

Messages	Explanations
NIHB Code R32	
Message:	Client has alternative coverage, contact Express Scripts Canada then submit manually.
Explanation:	The EDI Claim has not been paid because Express Scripts Canada's records indicate that the Client has alternative coverage for the claimed Procedure Code.
NIHB Code R35	
Message:	Tooth condition conflicts with history.
Explanation:	The Claim has not been paid because the claimed Procedure Code conflicts with the tooth condition on an earlier date of service. Examples of conflicts include: • A Claim for an extraction, filling, pit/ fissure sealant, crown, posts and cores, abutment, root canal therapy or sedative dressing when an extraction has been performed on the same tooth.
NIHB Code R36	
Message:	Tooth condition conflicts with subsequent Claim.
Explanation:	The Claim has not been paid because the indicated procedure conflicts with the tooth condition on a later date of service (e.g., a Claim for an extraction is not paid when a Claim for a filling, pit/ fissure sealant, root canal therapy, sedative dressing, abutment or crown and post and core has already been processed with a later date of service).
NIHB Code R37	
Message:	Incorrect Procedure Code used. *(The number of submitted surfaces is in conflict with the number of surfaces allowed for the submitted Procedure Code).*
Explanation:	The Claim has not been paid because the procedure conflicts with another paid procedure performed on the same date of service (e.g., inhalation anaesthesia was claimed in combination with intravenous sedation) or the procedure does not match the number of surfaces claimed.
NIHB Code R38	
Message:	Missing or Invalid Tooth, Surface, Arch, Quadrant or Sextant Code.
Explanation:	The Claim has not been paid because the Tooth Code, Surface Code, Arch, Sextant or Quadrant Code is missing or invalid. Check the Claim for missing or incomplete information and provide the required information to Express Scripts Canada.
NIHB Code R39	
Message:	Invalid Procedure Code. *(The procedure code is not an industry recognized procedure code in the Provider's Province and Specialty or the Lab Code is not allowed as the submitted Procedure Code in the Program).*

Messages	Explanations
Explanation:	The Claim has not been paid because the Procedure Code is not valid. Check the records and provide corrected information to Express Scripts Canada.
NIHB Code R42	
Message:	Associated Dental procedure must be specified.
Explanation:	The Claim has not been paid because Dental Providers cannot submit an anaesthesia fee alone. If applicable, Claims for anesthesia services must be accompanied by a Claim for an appropriate Dental procedure performed on the same date of service.
NIHB Code R43	
Message:	Lab fee must be submitted for specified Procedure Code.
Explanation:	The Claim has not been paid because the claimed Procedure Code is a service for which a laboratory fee is applicable and may only be submitted for payment with the laboratory fee upon insertion of the appliance.
NIHB Code R44	
Message:	Lab or expense fee not allowed for specified Procedure Code.
Explanation:	The Claim has not been paid because the Claim contains a laboratory fee submitted with the claimed Procedure Code for which a laboratory fee is not eligible. Refer to the applicable NIHB Regional Dental Benefit Grid to determine which Procedure Codes may have associated laboratory fees. Expense Codes are not currently eligible under the Program.
NIHB Code R45	
Message:	Invalid lab or expense Procedure Code.
Explanation:	The Claim has not been paid because the Claim contains an invalid lab or expense Procedure Code. Refer to the applicable Regional Dental Benefit Grid to determine lab eligibility. Expense Codes are not currently eligible under the Program.
NIHB Code R48	
Message:	Predetermination for this Item has been used up by Previous Claim.
Explanation:	The Claim has not been paid because the PD has already been used up by a previous Claim.
NIHB Code R49	
Message:	Benefit requires Predetermination.
Explanation:	The Claim has not been paid because it requires PD from FNIHB.
NIHB Code R50	
Message:	Service claimed exceeds the maximum allowed.
Explanation:	The Claim has not been paid because the claimed Procedure Code exceeds the maximum allowed.

Messages	Explanations
NIHB Code R52	
Message:	Restoration paid within 12 month period
Explanation:	The Claim has not been paid because a restoration procedure code has already been submitted within 12 months of a previously claimed and paid restoration Claim with a different Date of Service from the same Provider for the same Client, same tooth number.
NIHB Code R66	
Message:	Date of Service must be after DOB.
Explanation:	The Claim has not been paid because the date of service on the Claim is before the birth date of the Client, as indicated on the NIHB Client eligibility file.
NIHB Code W06	
Message:	Lab fee disallowed or reduced to NIHB guidelines.
Explanation:	The laboratory fee has been reduced or disallowed to conform to pricing guidelines. Refer to the applicable Regional Dental Benefit Grid.
NIHB Code W09	
Message:	Professional Fee is Reduced to NIHB Pricing Guidelines.
Explanation:	The professional fee has been reduced to conform to pricing guidelines. Refer to the applicable Regional Dental Benefit Grid.
NIHB Code W10	
Message:	This is a Claim reversal. Contact Express Scripts Canada.
Explanation:	The Claim is a reversal of a previously settled Claim.
NIHB Code W11	
Message:	Claim Reduced to NIHB Share.
Explanation:	The claimed Procedure Code is partially covered by a provincial/ territorial or first payer plan. The amount claimed is reduced to the correct NIHB share.
NIHB Code W12	
Message:	Part of Claim Exceeds Frequency Maximum and is Disallowed.
Explanation:	The professional fee has been reduced to the maximum allowed according to the NIHB frequency limitation guidelines.
NIHB Code W13	
Message:	Please note corrected Provider Number for future Claims.
Explanation:	The Provider Number submitted has been corrected to reflect the current Provider Number for this address. Note the number and use it on future Claims submitted from this office address.
NIHB Code W15	
Message:	Alternate Procedure Code applied, refer to the NIHB schedule.
Explanation:	The Claim has been adjudicated using an alternate Procedure Code. Refer to the applicable Regional Dental Benefit Grid.

Messages	Explanations
NIHB Code W17	
Message:	Claim adjusted to comply with terms of Predetermination.
Explanation:	The amount claimed is reduced to comply with the terms of PD set out by FNIHB. Refer to the Predetermination Confirmation Letter for approved terms.
NIHB Code W30	
Message:	Claim reduced from single to additional extraction, same quadrant.
Explanation:	The professional fee has been reduced to the amount allowed for an additional extraction in the same quadrant.
NIHB Code W33	
Message:	Professional Fee Has Been Adjusted According to NIHB Policy.
Explanation:	Amount paid for the correct surfaces being claimed which were calculated with the collective number of distinct surfaces restored up to a maximum of five (5) surfaces when services were performed on the Same Date of Service (DOS), same tooth, and same Client. Bonded amalgam is covered at the rate of non-bonded amalgam. Combined material of composite and amalgam procedures are covered at the rate of non-bonded amalgam. Non-Bonded Composite is covered at the rate of a bonded composite.

7.2 Submission Options and Mandatory Data to be Submitted in Dental Claims

7.2.1 Claim Submission Options

Dental Providers may submit electronic Claims and same day reversals for Dental services using EDI for real time adjudication. This option is available to Dental Providers 24 hours a day, seven (7) days a week; excluding the standard service window when the system is down on Fridays, 12 a.m. to 6 a.m. as required, and the maintenance window when the system is down from Sundays, 12 a.m. to 6 a.m.

All Claims submitted using EDI are either accepted or returned in real time; there are no pended Claims. Two types of messages are generated for Claims submitted using EDI: CDAnet, DACnet™, Réseau ACDQ Error Codes, and HICPS Codes and Messages.

Note A list of required data elements for EDI Claims and an explanation of the data elements required for Claims submitted using EDI is found at Electronic Data Interchange Required Data Elements.

Missing teeth information cannot be submitted on EDI Claims. Missing teeth must be recorded for all PD submissions and all Claim submissions for Clients who are new to the practice or returning from another Dental Provider. The tooth chart must be kept in the Client's file for audit purposes.

7.2.1.1 Claims Excluded from EDI

Certain Claim submissions still require manual claim forms. If these submissions are sent electronically via EDI, an acknowledgement is returned to the Provider requesting a manual submission.

EDI does not support:

- Requests for PD (must be submitted manually to the respective Health Canada Regional Office or ORC). Refer to *Section 7.3.2 Standard Documentation/ Information Required for PDs Related to Dental Services*.
- Standard Documentation/ Information Required for PD Related to Dental Services
- Requests for Post Determination (must be submitted manually to the respective Health Canada Regional Office).
- Claims over thirty (30) calendar days old (must be submitted manually to Express Scripts Canada).
- Reversals after the date of original submission (must be submitted manually to Express Scripts Canada; refer to *Section 4.3.2 Manual Claims Submission*).
- Orthodontic incremental Payment Codes (must be submitted manually to Express Scripts Canada; refer to *Section 4.3.4 Selected Billing Rules*).
- Claims for Clients under the age of consent which are not payable to the dentist (must be submitted manually to Express Scripts Canada).
- Claims payable to a first payer such as a parent or guardian (must be submitted manually to Express Scripts Canada).
- COB Claims (must be submitted manually to Express Scripts Canada); refer to *Section 4.2 Coordination of Benefits*.
- Claims for Procedure Payment Codes not listed in the vendor's software (must be submitted manually to Express Scripts Canada).

7.2.2 Electronic Data Interchange – Required Data Elements

The following fields are required to be completed:

Field ID	Description
A02	
Field Name	Office Sequence Number
Non-Insured Health Benefit Description	A number assigned by and under the control of the Dental office software provided by the software vendor.
A03	
Field Name	Format Version Number.
Non-Insured Health Benefit Description	A two-digit code identifying the Version of the CDAnet/ DACnet™ and Réseau ACDQ standard software used on the Dental office software: Only Format Version Number 04 is acceptable for NIHB Claims.

Field ID	Description
A04	
Field Name	Transaction Code.
Non-Insured Health Benefit Description	A two-digit code usually assigned automatically by the Dental office software to indicate the purpose of a transaction. Valid NIHB Codes are: • 01 - Claim. • 11 - Claim Acknowledgement. • 21 - Explanation of Benefits. • 02 - Reversal. • 12 - Reversal Response.
A05	
Field Name	Carrier Identification Number.
Non-Insured Health Benefit Description	The Carrier Identification Number or BIN Number for Dental Claims transmission to Express Scripts Canada is 610124.This six-digit unique number in most cases, is assigned automatically by the Dental office software provided by the software vendor.
B01	
Field Name	CDA Provider Number.
Non-Insured Health Benefit Description	This unique nine-digit number has been assigned to you by CDA, and must be included in every transaction.
B02	
Field Name	Provider Office Number.
Non-Insured Health Benefit Description	This four character identifier has been assigned to you by CDA, and must be included in every transaction.
C01	
Field Name	Primary Policy/ Plan Number.
Non-Insured Health Benefit Description	This six-digit unique number identifies the Client's insurance policy number. In most cases, numbers are assigned automatically by the Dental office software provided by the software vendor. The policy/ group number for Dental Claims transmission to Express Scripts Canada is 080000 (leading "0" is mandatory).
C02	
Field Name	Subscriber Identification Number.
Non-Insured Health Benefit Description	The unique number used to identify a Client who is eligible to receive benefits under the Program.
C05	

Field ID	Description
Field Name	Client's Birthday
Non-Insured Health Benefit Description	The Client's full birth date in correct format.
C06	
Field Name	Client's Last Name.
Non-Insured Health Benefit Description	The surname under which the Client is enrolled as a Client.
C07	
Field Name	Client's First Name.
Non-Insured Health Benefit Description	The given names under which the Client is enrolled as a Client. Submission of more than one given name is preferred to facilitate Client verification. Initials are not acceptable.
D05	
Field Name	Subscriber's Address Line 1.
Non-Insured Health Benefit Description	First line of Client's address.
D06	
Field Name	Subscriber's Address Line 2.
Non-Insured Health Benefit Description	Second line of Client's address, if applicable.
D07	
Field Name	Subscriber's City.
Non-Insured Health Benefit Description	The Client's city of residence.
D08	
Field Name	Subscriber's Province.
Non-Insured Health Benefit Description	The Client's province of residence.
D09	
Field Name	Subscriber's Postal Code.
Non-Insured Health Benefit Description	The Client's postal code.
F01	
Field Name	Payee Code.
Non-Insured Health Benefit Description	This field determines who should be paid. Valid Codes are: 1 - Pay to Client (subscriber). 2 - Pay to other third party. 3 - Reserved. 4 - Pay to dentist.
F03	
Field Name	Predetermination Number.
Non-Insured Health Benefit Description	For a Claim that has been predetermined and approved in part or in full, the PD Number indicated on the FNIHB Confirmation Letter must be entered. When a PD Number is entered on an EDI Claim

Field ID	Description
	document, all Claim lines on the document must pertain to the entered PD Number.
F07	
Field Name	Procedure Line Number.
Non-Insured Health Benefit Description	The line number of the procedure in the Claim submission. The line number is preserved in the Claim response. In most cases, this number is assigned automatically by the Dental office software provided by the software vendor.
F08	
Field Name	Procedure Code.
Non-Insured Health Benefit Description	Valid CDA Procedure Codes can be submitted.
F09	
Field Name	Date of Service.
Non-Insured Health Benefit Description	The date on which services were provided to the Client in the date format YYYY-MM-DD (e.g., 1999-07-13 represents 1999 July 13). For procedures requiring more than one appointment, where an insertion is required, the date of service must be the date when the service was inserted. Contact your Health Canada Regional Office if insertion cannot occur. For procedures requiring more than one appointment that do not require an insertion, the date of service must be the date when the service was completed.
F10	
Field Name	International Tooth, Sextant, Quad or Arch.
Non-Insured Health Benefit Description	The international Tooth Number, Quadrant, Sextant or Arch Code corresponding to the procedure for which Tooth Number, Quadrant, Sextant or arch description is mandatory.
F11	
Field Name	Tooth Surface.
Non-Insured Health Benefit Description	The Surface Code corresponding to a procedure for which surface description is mandatory.
F12	
Field Name	Dentist's Fee Claimed.
Non-Insured Health Benefit Description	The dollar amount claimed for professional services.
F13	
Field Name	Lab Procedure Fee # 1.
Non-Insured Health Benefit Description	The first lab Procedure Code if lab costs are associated with the claimed professional procedure.

Field ID	Description
F34	
Field Name	Lab Procedure Code # 1.
Non-Insured Health Benefit Description	The dollar amount claimed for the first lab Procedure Code, if applicable.
F35	
Field Name	Lab Procedure.
Non-Insured Health Benefit Description	Code # 2. The second lab Procedure Code associated with the claimed professional procedure, if applicable. May not be available as an input field on all Dental office software.
F36	
Field Name	Lab Procedure.
Non-Insured Health Benefit Description	Fee # 2. The dollar amount claimed for the second lab Procedure Code, if applicable. If Lab Procedure Code #1 and Lab Procedure Code #2 are entered on the Claim submission, they are added together for lab fee adjudication purposes and the lab fee allowed is returned as the amount allowed for lab procedure fee # 1.

7.2.3 Dental Claims Requirements

Claims can be submitted manually on:

- Standard Dental Claim Form.
- Computer generated form.
- ACDQ Dental Claim and Treatment Plan Form.
- NIHB Dental Claim Form (Dent-29).

All mandatory data elements (e.g., tooth charting, Client identification, or Band Number and Family Number, date of birth) must be completed on the claim form.

NIHB Dental Claim Form (Dent-29)

The NIHB Dental Claim Form (Dent-29) must still be used for:

- Provider payment (Quebec only).
- NIHB Client Reimbursements (CR).
- Claims payable to a Third Party.
- Post Determination - To indicate if the submission is for a Post Determination request.
- Predetermination - To indicate if the submission is for a PD request.
- Claim - To indicate if the submission is for a Claim.

Note Client Reimbursement Claims, as well as Claims payable to a first payer must be submitted to the applicable Health Canada Regional Office or the ORC.

A NIHB Dental Claim Form (Dent-29).can only be submitted for a Post Determination, PD, Claim submission, Claims payable to a first payer or a CR.

If a Provider chooses to submit Claims using an ACDQ Dental Claim and Treatment Plan Form, which also requires signature of Client or parent/ guardian, or through EDI, the Provider must retain a NIHB Dental Claim Form (Dent-29), completed and signed by the Client or parent/ guardian, in the Client chart for each Claim submitted for payment.

The shaded sections of the NIHB Dental Claim Form (Dent-29) are reserved for use by Health Canada Regional Offices. The data elements must also be included on the claim form if a Standard Dental Claim Form, a computer generated form, or ACDQ Dental Claim and Treatment Plan Form is used.

7.2.4 Required Data Elements

- Post Determination - To indicate if the submission is for a Post Determination request.
- Predetermination - To indicate if the submission is for a PD request.
- Claim - To indicate if the submission is for a Claim.

The data elements listed below are required for Post Determinations, PDs, Claim submissions, and CRs.

NIHB Dental Claim Form (Dent-29) Field Description

CLAIM INFORMATION (PROVIDER TO COMPLETE) FIELD NAMES AND DESCRIPTIONS

Note Client or parent/ guardian signature field must be completed.

Field Name	Description
Client Surname	The surname under which the Client is enrolled as a Client.
Given Names	The given names under which the Client is enrolled as a Client. Submission of more than one given name is preferred to facilitate Client verification. Initials are not acceptable.
Address	The current and exact address of Client. Submissions that do not indicate the complete Client address including postal code are returned.
Provider Number	The full unique nine-digit Provider Number assigned to the Dental Provider by Express Scripts Canada must appear on the claim form. Submissions that do not indicate the complete Express Scripts Canada unique Provider Number may be returned.
Provider Address	A stamp with the Provider address is acceptable. Submissions that do not indicate the complete Provider address may be returned.
For Provider Use Only	Additional information pertaining to the submission may be noted here.
Pay Client/ Guardian	This box is checked when the payee is other than the Provider.
Payee Address	This information must be provided if the payee name and address is different from the Client. Payee must be 16 years of age.

Field Name	Description
Office Verification/ Signature of Provider	An original Provider signature or Provider name stamp is acceptable. The signature or stamp must be that of the Provider who has performed or will perform the procedure, and must match the Dental Provider's unique Provider Number indicated on a form.
Date of Service	The date on which services were provided to the Client in date format (YYYY-MM-DD) (e.g., 1999-07-13 represents 1999 July 13). For procedures requiring more than one appointment, where an insertion is required, the date of service must be the date on which the appliance was inserted. Contact your Health Canada Regional Office if insertion cannot occur. For procedures requiring more than one appointment that do not require an insertion, the date of service must be the date when the service was completed.
Procedure/ Payment Code	The Procedure/ Payment Code corresponding to the applicable Dental procedure or exact orthodontic wording. For further details, refer to *Section 4.3.4 Selected Billing Rules*.
International Tooth Code	The international Tooth Number, Quadrant, Sextant or Arch Code corresponding to the procedure for which Tooth Number, Quadrant, Sextant or arch description is mandatory.
Tooth Surfaces	The Surface Codes corresponding to a procedure for which surface description is mandatory.
Professional Fee	The dollar amount claimed for professional services.
Laboratory Fee (L+)	The dollar amount charged for lab work. A photocopy of the lab receipt, attached to the Claim, may be required. A "+L" indicated on the Predetermination Confirmation Letter beside the "Maximum Amount Approved" column indicates that a Lab Fee has also been approved. Only the Provider that has requested and received the Predetermination Confirmation Letter is eligible to Claim for payment.
Total Fee	The total dollar amount charged for the procedure or service performed (professional fee plus laboratory fee).
Predetermination Number (PD)	For a Claim that has been predetermined and approved in part or in full, the PD number indicated on the FNIHB Confirmation Letter must be entered beside the corresponding Claim line.
FNIH(B) Approved (To Be Completed by FNIH(B))	When FNIH(B) has reviewed a request for PD: YES = Predetermination has been granted. NO = Predetermination has been denied. N/A = Procedure does not require Predetermination. AC = Internal FNIHB Code.
Total Fee Submitted	This is the sum total dollar amount of all procedures submitted.

CLIENT INFORMATION (Provider to Complete)

Field Name	Description
Client Identification Number	Unique number used to identify a Client who is eligible to receive benefits under the Program.
Band Number	Three-digit Band Number only applicable to First Nations Clients.

Field Name	Description
Family Number	Four or five-digit number only applicable to First Nations Clients.
Client's full birth date	Date format YYYY-MM-DD format (e.g., 1992-05-19 represents 1992 May 19).

ADDITIONAL INFORMATION (Provider to Complete)

a) Are any Dental benefits or services provided under any other group insurance or Dental plan, Workmen Compensation Board, government plan or if a result of an accident, motor vehicle or accident insurance plan?
   - These answers are mandatory on all submissions.

b) Are there any missing teeth?
   - These answers are mandatory on all types of submissions including Claims.

PREDETERMINATION INFORMATION (Health Canada Regional Office to Complete)

Approved/ Not Approved - The submission is approved or not approved.

Health Canada Regional Office Authorizing Officer - Health Canada Regional Office checks the CR box if it is a Client Reimbursement and enters the authorizing officer number, date and signature.

7.3 Predeterminations

Certain Dental procedures require a PD. The current Regional Dental Benefit Grid outlines procedures requiring a PD Post Determinations for basic and emergency services may be considered.

A PD must be obtained prior to the commencement of the service for, but not limited to, these benefits:

- Orthodontic Services.
- Fixed and removable Prostheses.
- All "Independent Consideration" (IC) code procedures.
- Crowns.
- Endodontic services (root canal treatment for posterior teeth, and periapical procedures).
- General Anaesthetic and Facility Charges.
- Any other items identified with a "P" in the current Regional Dental Benefit Grid.

When the Client requires services which require a PD, Providers **must** submit:

- Orthodontic requests manually to the ORC (all related requirements should be noted here, COB applied at the time of PD, etc.). For additional details, please refer to *Section 7.3.1 Provider Responsibilities*.
- All other PD requests (including post PDs) manually to the respective Health Canada Regional Office with applicable supporting documents.

The coordinates of either office can be found at the back of the NIHB Dental Claim Form (Dent-29) or visit the Health Canada website at *www.hc-sc.gc.ca/contact/fniah-spnia/index-eng.php#nihb* Post Determinations (where the service has already been

rendered), the first payer EOB must accompany the claim form to allow for coordination of benefits. If there is any missing teeth information, it must be recorded for all types of submissions. All requests for PD must be submitted to the respective Health Canada Regional Office or ORC. Requests for PD that are submitted to Express Scripts Canada are returned to the Provider.

If any requested procedure is not approved, or if additional information is required, FNIH(B) returns the original submission form and/ or the Provider is informed through the Predetermination Confirmation Letter. Once services have been approved, a letter confirming PD is issued. The letter states the start and end date for each procedure line, the PD number and relevant approval details. PDs are valid for one (1) year from the start date on the Predetermination Confirmation Letter. Claims are returned where the date of service is after the end date indicated on the Predetermination Confirmation Letter.

Operational requirements of PD for the Program include FNIHB, Provider and Client responsibilities.

7.3.1 Provider Responsibilities

- Discuss with the Client their Dental condition and costs relating to any proposed treatment plan prior to services being rendered.
- Advise Clients regarding which services can and cannot be rendered in accordance with the limitations stated within the current Regional Dental Benefit Grid.
- Submit a treatment plan to HC with the appropriate supporting documentation for PD purposes prior to the commencement of treatment.
- Provide the Dental service(s) based on informed consent.
- Ensure that all required data elements are completed on the Claim submission. The Claims Submissions - Required Data Elements page, details all data element requirements on EDI and manual Claim submissions.
- Advise the Client of PD outcome.
- Provide a Referral Letter when the Client requires specialist services (e.g., endodontic, periodontal, and prosthodontic, etc.). This Referral Letter must outline any specific outstanding treatment requirements.

7.3.2 Standard Documentation/ Information Required for PDs Related to Dental Services

Request a PD using *one* of the following forms:

- Complete Standard Dental Claim Form.
- ACDQ Dental Claim and Treatment Plan Form.
- Computer generated form.
- NIHB Dental Claim Form (Dent-29).

Current conventional or digital radiographs (within last twelve months):

- Periapical and bitewing radiographs:
    - Must be of good diagnostic quality (i.e., size, resolution, contrast); and

- Must be mounted and labeled with the date, Client name, and Provider name.

Note If duplicate radiographs are submitted they must identify the right or left side of the Clients' mouth.

- A panoramic radiograph may be submitted in addition to, but not in place of bitewing and periapical radiographs.
- Comprehensive treatment plan: from the treating dentist and/or referring dentist indicating all completed treatment and pending treatment needs including restorative, periodontal, prosthodontic, endodontic and surgical services.
- Notation of all missing teeth.
- Periodontal charting, or Periodontal Screening and Recording (PSR), or periodontal assessment.

It is mandatory for Dental Providers to maintain a Client chart/ record documenting and supporting the services provided, claimed and paid by the Program. A procedure code and/ or name are not sufficient as a Client record to support payment. This statement applies to all Claim requests under the Program (including Pre and Post Determination Claims supported with a PD number).

7.3.3 Standard Documentation/ Information Required for PDs Related to Orthodontic Services

Requests for Comprehensive Orthodontic Treatment must be accompanied by:

1. A narrative including:

- Condition for which the orthodontics is being requested.
- Diagnosis and prognosis (including alternative which have been tried).
- A notation of basic treatment that has been completed or in progress, Client's oral hygiene status, motivation and other relevant comments should be provided.
- The definitive treatment plan including other orthodontic related treatment (e.g., extractions and surgery).
- The projected time frame of active and retention phases of treatment and costs submitted either on a NIHB Orthodontic Summary Sheet, CAO Standard Orthodontic Information Form, or letter on the Orthodontist's letterhead.
- Any additional supporting relevant information.

2. Complete diagnostic records including:

- Current diagnostic orthodontic models (soaped & trimmed) with occlusal registration(s) that can be articulated.
- Current cephalometric: radiograph(s) and tracing.
- Current photographs: (3) intra-oral and (3) extra-oral.
- Current panoramic radiograph or Full-Mouth-Survey (FMS).

3. A completed Claim Form including:

One of the following forms must be submitted with a coverage request:

- NIHB Dental Claim Form (Dent-29).
- Standard Dental Claim Form.
- ACDQ Dental Claim Form.
- Canadian Association of Orthodontists (CAO)/ Association canadienne des orthodontistes) Certified Specialist in Orthodontics Standard Information Form.
- Computer generated form that includes the following:
  - Parent/ Guardian signature and/ or Client signature.
  - Client ID# and Client date of birth.
  - Indication of PD or Claim.
  - Provider signature.
  - Appropriate coding or accepted wording.

7.3.3.1 Requests for Interceptive Orthodontic treatment (including Habit Appliances)

Requests for interceptive orthodontic treatment must be accompanied by:

1. A narrative including:

- Same requirements as Comprehensive Orthodontic Treatment.

2. Complete diagnostic records including:

- Current working models with occlusal registration(s) that can be articulated.
- Current panoramic radiograph or relevant elements of a Full-Mouth-Survey (FMS).

3. A completed Claim form including:

- Same requirements as Comprehensive Orthodontic Treatment.
- Complete Standard Dental Claim Form, ACDQ Dental Claim and Treatment Plan Form, computer generated form, or NIHB Dental Claim Form (Dent-29).
- Current radiographs (such as, periapical films specific to the requested treatment, bitewings and/ or panoramic radiographs), identifying the Client and Provider; must be mounted, dated and of acceptable diagnostic quality. Whenever duplicate radiographs are submitted, the Provider must indicate on the radiograph whether the radiograph is on the right or left side of the Client's mouth.
- Comprehensive treatment plan from the treating dentist and/ or referring dentist addressing all treatment needs for the mouth.
- Notation of all missing teeth.
- Charting documentation must support all procedures claimed under the Program. Radiographs are considered current for PD if dated within one year of the PD submission.

7.3.4 Post Determination

When Dental services normally requiring PD are rendered in emergency or under specific situations (Dental PD - Post Determination), submissions must include a claim form clearly indicating the special circumstances in the box marked "For Provider Use Only - For Additional Information, Diagnosis, Procedures, or Special Consideration".

Providers must indicate "Post Determination" and complete all mandatory data elements on the Claim form, and manually submit to the respective Health Canada Regional Office. PD or Post Determination requests cannot be submitted manually to Express Scripts Canada or electronically using EDI. A Predetermination Confirmation Letter is issued in Post Determination situations.

7.3.4.1 Emergency Dental Services

Emergencies, in most instances can be forwarded directly to Express Scripts Canada for Claim adjudication. Emergency Dental Services consist of the following but are not limited to:

- Diagnosis of specific acute Dental problems including associated examination and radiographs.
- Procedures to arrest hemorrhage of Dental origin including, but not limited to, dressings, packing of tooth sockets and sutures, if initial procedure was performed by another dentist.
- Preliminary case of trauma to the mouth including treatment in hospital under general anaesthesia/ sedation (excluding provincial/ territorial insured services); and,
- Procedures for the immediate relief of pain and infection of Dental origin including, but not limited to prescriptions, sedative dressings, incision/ open and drainage, pulpectomy, pulpotomy, and Dental extractions; and,
- Orthodontic related services.

Routine procedures are not normally part of Emergency Dental Services.

7.3.4.2 Submissions

All requests for Post Determination must be submitted to Health Canada Regional Office/ ORC, together with any supporting documentation (refer to the above *Section 7.3.2 Standard Documentation/ Information Required for PDs Related to Dental Services*).

If the Client has Other Coverage, an EOB from the primary carrier must accompany the claim form to allow for coordination of benefits. If the primary carrier's dollar contribution toward this treatment is less than current provincial/ territorial fee guide rate, the dollar contribution by the Program is the difference to the maximum current provincial/ territorial fee guide rate without exceeding the approved current NIHB fee.

Complete Claim details are included on the Provider's next Dental Claim Statement, including a payment if applicable, provided all relevant documentation has been received.

7.3.4.3 Provider Responsibilities

- Discuss with the Client their Dental condition and costs relating to any proposed treatment plan.

- Advise Clients regarding which services can and cannot be rendered in accordance with the limitations stated within the current Regional Dental Benefit Grid.
- Submit a treatment plan to Health Canada with the appropriate supporting documentation for PD purposes prior to the commencement of treatment.
- Provide the Dental service(s) based on informed consent.
- Ensure that all required data elements are completed on the Claim submission. The Claims Submissions - Required Data Elements page, details all data element requirements on EDI and manual Claim submissions.
- Advise the Client of PD outcome.
- Provide a Referral Letter when the Client requires specialist services (e.g., endodontic, periodontal, and prosthodontic, etc.). This Referral Letter must outline any specific outstanding treatment requirements.

7.3.5 Predetermination Definitions

Term	Description
Appeal Process	This is a Client-initiated process seeking reconsideration of treatment denial by Regional Dental Office/ Dental Consultant or the ORC. In each of the three levels of appeal (Dental level 1 - Regional Dental Officer/ NIHB Manager, level 2 -Regional Director, level 3 - Director General NIHB; for Orthodontic level 1 – Director, Benefit Review Services Division (BRSD), level 2 Director Benefit Management Division (BMD), level 3 - Director General NIHB), the supporting information submitted is reviewed by Dental Consultants (Dental Specialists, Dentist or Denturist where relevant). The decision is based on the specific needs of the Client condition, accumulated scientific research, and NIHB Policy. Exclusions are not considered for appeal.
Complete Treatment Plan	This is a document that identifies the complete Dental needs of a Client.
Dental Auxiliaries/ Support Staff	These are individuals who provide assistance to the Regional Dental Officer/ Dental Consultant/ ORC managers to expedite the PD process by ensuring that each Dental submission is supported by the appropriate information and documentation required to make an informed decision.
Exceptions	These are Dental procedures that are outside the Program scope of benefits or procedures that require special consideration. Requests must be supported with a rationale, and a mandatory PD.
Exclusions	These are Dental procedures that are outside the mandate of the Program and will not be considered for coverage nor considered for appeal.
Post Determination (Post Approval)	Post Determination is a method for the administration and adjudication of Dental benefits for service which has been rendered. This is a submission that may be considered for coverage under specific circumstances under the Program and must be supported with a rationale.

Term	Description
Predetermination (PD)	Predetermination is a method for the administration and adjudication of Dental benefits.
Predetermination Requirement	Any treatment that exceeds frequency limitations (GP/ SP Schedules) and in the NIHB Denturist Grid and procedures that are identified in the applicable Program.
Provider	A qualified and legally licensed Dental professional enrolled with the Program and Express Scripts Canada (e.g., Dentist, Denturist).
Regional Dental Benefit Grid	This is a document that outlines the Dental benefits covered by the Program.
Treatment Plan Review	This is the comprehensive review and adjudication by FNIH(B) of the treatment plan submitted to achieve the Client's optimal Dental health.
Process of Predetermination	Each request is reviewed on an individual basis. In reviewing requests, cases are evaluated against the Program's established Provider Guide and the Dental Policy Framework which clearly outlines and defines the types of benefits available to Clients and their coverage. For NIHB to cover a Dental procedure the Client's condition must meet all of the established guidelines and criteria.

7.3.6 Billing for Predetermined Treatment

The details on the Claim submission must match the details on the Predetermination Confirmation Letter (e.g., Client identifiers, Procedure Codes, Tooth Numbers, Surface Codes, Quadrant, Sextant or Arch Codes). A "+L" indicated on the Predetermination Confirmation Letter beside the "Maximum Amount Approved" column indicates that a lab fee has also been approved. Only the Provider that has requested and received the Predetermination Confirmation Letter is eligible to Claim for payment.

7.3.6.1 EDI Claim Submissions – Predetermined Treatment

Although PD requests cannot be submitted using EDI, the resulting Claims may be submitted electronically. When submitting a Claim for predetermined services using EDI, Providers must record the PD Number from the Predetermination Confirmation Letter in the correct field. Since EDI allows only one PD Number per Claim, services involving multiple procedures issued with different PD Numbers must be submitted as separate Claims.

7.3.6.2 Manual Claim Submissions – Predetermined Treatment

When submitting a manual Claim for a predetermined procedure, Providers must record the applicable PD Number on the Claim line for the approved Procedure Code. If more than one Procedure Code has been issued a PD Number, write the PD Number next to each applicable Claim line. Failure to write the PD Number next to each applicable Claim line may result in the Claim being returned if another Claim for the same procedure has already been processed.