Non-Insured Health Benefits (NIHB)

Medical Supplies and Equipment (MS&E)

Claims Submission Kit

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EXPRESS SCRIPTS®

Any comments or requests for information may be transmitted to:
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1. Introduction

1.1 Purpose of NIHB MS&E Claims Submission Kit

Express Scripts Canada's Non-Insured Health Benefits (NIHB) Medical Supplies & Equipment (MS&E) Kit (also referred to as the "Kit") sets out additional terms and conditions for the submission of Claims under the Medical Supplies & Equipment Provider Agreement (referred to as the "Agreement"). In addition, the Provider Guide for Medical Supplies & Equipment 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 the 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, as required. A notification of Kit updates is posted prior to the circulation date.

All documents (Announcements, Kit, Agreement, MS&E Newsletters, and the Provider Guide for Medical Supplies & Equipment Benefits) are available for download in Portable Document Format (PDF) on the NIHB Claims Services Provider Website (also referred to as 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 of a conflict between the terms and conditions of the Agreement and the terms and conditions of an Annex or the Kit, the terms and conditions of this Agreement shall prevail.

In the event this Kit does not address a Claims submission 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 governing the relationship between you, the Provider and Express Scripts Canada are set out in the Agreement. Express Scripts Canada reserves the right to update this Kit.

This 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 Agreement.

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 for background information for this Kit and the Program.

Term	Definition
AANDC (formerly INAC)	Refers to the department of Aboriginal Affairs and Northern Development Canada.
Benefits and Criteria List – MS&E	The MS&E Benefits and Criteria List established by Health Canada, sets out the medical supplies and equipment items for which the Provider may submit Claims to Express Scripts Canada under the Agreement, when they dispense MS&E items to Clients.
Claim	A request for payment submitted by a Provider to Express Scripts Canada for the provision of medical supplies and equipment services to Clients in accordance with the Agreement and the Kit.
Client	A person who is eligible to receive NIHB MS&E items in accordance with the eligibility criteria in *Section 4.1 Client Identification and Eligibility* of the Kit.
COB	The coordination of benefits between two or more benefit plans, whether public, private or a combination of public and private coverage.
CR	Client Reimbursement. A Health Canada approval to accept the Claim made directly by a Client or a first payer such as a Band, parent, or guardian who has paid for services rendered.
Delisted	A MS&E service Provider who is no longer an eligible NIHB Provider.
DEC	The Drug Exception Centre handles all Prior Approval requests for NIHB drug benefits. Refer to **PA**.
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.
Express Scripts Canada (formerly ESI Canada)	On behalf of the NIHB, 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.
Medical Supplies & Equipment (MS&E)	A detailed listing sent by Express Scripts Canada to the Provider, Client or first payer providing the necessary information on MS&E

Term	Definition
Claim Statement	Claim payment information.
Medical Supplies & Equipment Claims Submission Kit (referred to as the "Kit")	The Kit is provided by Express Scripts Canada, and updated and amended from time to time that is made available to the Providers by Express Scripts Canada. The Kit sets out additional terms and conditions for the submission of Claims under the Agreement.
Medical Supplies & Equipment Provider Agreement (referred to as the "Agreement")	The Express Scripts Canada Agreement, the Annexes thereto, and any amendments thereto made in writing.
Medical Supplies & Equipment (MS&E) Services	MS&E Services, such as wheelchair equipment or walking aids listed on the MS&E Benefits and Criteria List to Clients. Refer to **Benefits and Criteria List – MS&E**.
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 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.
Other Coverage	Benefits available to Clients of the Program, in whole or in part, from a provincial, territorial or first payer health care plan.
PA	Prior Approval. A Program coverage confirmation issued by a Health Canada Regional Office or the Drug Exception Centre (DEC) to a Provider to ensure that the Provider is advised that the Client is eligible for the specific drug/ medical supplies and equipment benefits or services dispensed. The approval is issued primarily for items identified as requiring authorization before being dispensed for purchase.
PIPEDA	The Personal Information Protection and Electronic Documents Act (Canada).
POS Technology	Point of Service (POS) where a claim is submitted electronically when a prescription is filled.
Prescriber ID	A reference number that a Prescriber of medication, medical supplies or professional services uses to identify themselves.
Provider	A licensed MS&E service professional by the respective provincial/ territorial regulatory authority, and has signed the Agreement thereby accepted by Express Scripts Canada.
Provider Number	A unique reference number assigned to the Provider as identification to facilitate the submission for adjudication and to receive payment.
PWGSC	Department of Public Works and Government Services Canada.

Term	Definition
Provider Guide for MS&E 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.
U&C	Usual and Customary (U&C) professional fee is the lowest price of an item included in the MS&E Benefits and Criteria List, that is charged by the Provider to customers of its business who are not Clients, and are not covered by any health insurance plan on the date that it is provided (including any discounts or special promotions offered on such date by the Provider).

2. Background

2.1 Health Canada NIHB Program

For details on Health Canada's NIHB Program, please consult 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 MS&E benefits covered by the Program. The responsibility encompasses certain aspects of MS&E benefits processing and payment of Claims and extends to 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 this Kit.

In the context of MS&E 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 manually by Providers and Clients through the Program. Express Scripts Canada also communicates and responds to Providers' inquiries. All Clients reimbursements should be referred to the nearest 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 3.1 MS&E Provider Registration Process* and *Section 3.1.3 Terms and Conditions*.

2.3.1 Client Reimbursement

MS&E Providers are encouraged to submit claims directly so that Clients do not incur charges at the POS when receiving MS&E Services, as per definition in Section 1 (8) of the Agreement.

When a Client pays directly for MS&E Services, as defined in Section 1 (8) of the Agreement, the Client may seek reimbursement with 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 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 as defined in Section 1 (2) of the Agreement based on Program policies, guidelines, and criteria.

Once the manual claim is received and data is keyed from the NIHB Medical Supplies & Equipment Claim Form into the HICPS system. The system checks to determine if the Provider, Client, and Claims are eligible.

Depending on the action taken, the Claim is either:

- Accepted (perhaps adjusted) to the Provider and paid.
- Returned to the Provider as a result of insufficient information and/ or due to ineligibility. A list of error messages, explanations, and CPhA error messages are listed in *Section 7. MS&E Statement Messages and Explanations*.
- Returned to the Provider if incomplete.

3. MS&E Provider Registration

Providers wishing to submit Claims for services provided to Clients under the Program must register by fully completing and signing an Agreement.

Registered Providers with the Program benefit from many services from Express Scripts Canada, 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.
- Access to the Provider Website at *www.provider.express-scripts.ca* which provides access to:
  - Alerts regarding changes to the HICPS system.
  - Late-breaking news, including Health Canada Bulletins, and Announcements.
  - MS&E Benefits and Criteria List.
  - MS&E Newsletters.
  - Various NIHB Forms.
  - Policy and Program Information (Provider Guide for Medical Supplies & Equipment Benefits).

3.1 MS&E Provider Registration Process

Provider's wishing to provide services to Clients must complete and sign the Agreement in its entirety signifying their intent to participate in and adhere to the terms and conditions of the Program.

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

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

Providers that have the ability and specialty to dispense multiple MS&E items; the different specialties **must** be indicated on the Agreement. In addition, a photocopy of each diploma of certificate with seal for accreditation of *each* specialty to register under the Program is required. **Wallet Registration Cards and/ or receipts from an association are *not* accepted**. Only eligible MS&E items indicated under the specialty will be eligible for payment.

A copy of the Agreement can be located and downloaded 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*).

3.1.1 Approval/ Unique Provider Number

Upon registration approval from Health Canada's Regional Office, 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 appropriate registered MS&E location. The unique Provider Number for *each* location **must** be used when submitting all Claims for payment and in all communications with Express Scripts Canada.

> All additional locations must enter into an Agreement with Express Scripts Canada in order to avoid disruption of service for Claims processing and payment services. Any Provider Claims submitted without first registering additional MS&E location with Express Scripts Canada will be returned.

3.1.2 MS&E Documentation and Updates

The Agreement sets forth the relationship between an eligible MS&E Provider and Express Scripts Canada for the Program. Providers must abide with all Program requirements as outlined in the Kit; and other communications that are distributed to Providers by Health Canada and/ or Express Scripts Canada in a timely manner via the Provider Website by e-mail, fax or mail.

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

- Kit.
- Bulletins.
- Provider Guide for Medical Supplies & Equipment Benefits.

- MS&E Newsletters.
- Broadcast Messages via MS&E Claim Statement.
- MS&E Benefits and Criteria List.
- Announcements.

It is important that Providers retain the most current documentation to ensure Program requirements are met. Additional information is outlined in the Agreement. All documents can be located on the Provider Website with the exception of claim statements.

3.1.3 Terms and Conditions

The following terms and conditions apply to all services covered under the Program.

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

- Provider Licensure and Eligibility Requirements *(Section 4.1 Client Eligibility Requirements).*
- Client Eligibility Requirements (*Section 4.1 Client Eligibility Requirements*).
- Requirements for Coordination of Benefits with Other Health Plans (*Section 4.2 Coordination of Benefits*).
- Submission Process and Supporting Documentation Requirements (*Section 4. General Claims Submission Procedures*).
- Benefit Coverage and/ or Applicable Limitations (*Section 4.6 Benefit Coverage and Limitations*).
- Requirements to submit 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*).

In addition, extra billing for an item cost is prohibited. As such, any amount billed to a Client is subject to audit recovery (refer to *Section 5.1 Audit Objectives*) (e.g. any dispensing fees exceeding the difference between the Provider's Usual and Customary (U&C) Professional Fee and the NIHB maximum allowed dispensing fee).

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

- **Verification of Client Eligibility:**

  The Provider must take steps to verify that the individual is eligible for benefits under the Program and to identify the existence of other benefit coverage, if applicable.
- **Dispensing:**

  The Provider must dispense benefit items to each 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 Medical Supplies & Equipment Benefits.

MS&E Claims may be submitted to Express Scripts Canada using a NIHB Medical Supplies & Equipment Claim Form or a computer generated form.

Claims older than one (1) year from the dispensing date are not accepted for processing and returned to the Provider.

- **Standards of Service:**

  When providing MS&E Services to Clients (including counseling services), the Provider acts in accordance with all applicable laws, and the standards of practice required by its professional body. The Provider shall not refuse to provide services to Clients who are eligible under the Program unless, in the Provider's reasonable professional judgment, such services should not be provided.

- **Compliance with Applicable Law, Permits and Licenses:**

  Refer to Section 3.1 (1) of the Agreement.

- **Utilization Review Compliance with MS&E Benefits and Criteria List and Kit:**

  The Provider and its personnel shall:

  - Cooperate with Express Scripts Canada's procedures for utilization review, as set forth from time to time in this Kit.
  - Comply with the applicable MS&E Benefits and Criteria List when dispensing benefit items to Clients.

3.1.4 Change of Provider Information

In order to keep our Provider records up-to-date, avoid unpaid Claims, and non-delivery of communications (e.g., MS&E Claim Statements, MS&E Newsletters, etc.) via e-mail, fax, or mail, the Provider must notify Express Scripts Canada of any changes to information provided in the registration process.

A *verbal request* is accepted at the Provider Claims Processing Call Centre (refer to *Section 6.2.1 Provider Claims Processing Call Centre*) to only change:

- Fax number
- Phone number
- E-mail address
- *Correction* to current address

Preferred communication method (fax, e-mail, mail).All other types of changes need to be identified and completed on the Modification to Pharmacy and Medical Supplies & Equipment Provider Information Form and sent to Express Scripts Canada as indicated on the form.

These include, but are not limited to:

- Change of ownership.
- New opening/ registration of an additional location.
- NIHB re-registration to Express Scripts Canada.
- Start, change or stop EFT.

Note All new locations and ownerships must be registered by completing a new Agreement. Each MS&E location is assigned its own unique Provider Number, allowing one Provider Number per location.

Providers can download a copy of the Modification to Pharmacy/ Medical Supplies & Equipment Provider Information Form from the Provider Website at *www.provider.express-scripts.ca* and submit as indicated on the form. 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*).

Change of Ownership/ Additional Location(s)

A Provider must first register with Express Scripts Canada in order to avoid disruption of service for Claims processing and payment services. Any Provider Claims submitted without first registering the change of ownership or adding an additional location to obtain a unique Provider Number will be rejected.

When changing ownership or registering/ re-registering a new retail store, please notify Express Scripts Canada immediately, allowing Express Scripts Canada adequate time to change ownership. A new completed Agreement is required, indicating the effective date of the new ownership. The Agreement can be downloaded from 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*).

There is also a need for the Provider to submit a copy of each specialty certification of in order for Express Scripts Canada and Health Canada to accept and approve claims. Any specialties to be added to the business after a Provider has registered with the Program will require a copy of the appropriate certification be sent to Express Scripts Canada.

If a copy of the specialty certification has not been sent to Express Scripts Canada prior to the Provider's first manual claim submission, the Provider can attach a copy of the specialty certification with their first manual claim submission, along with a revised copy of the Agreement noting the added specialty.

3.1.5 Termination of Provider Registration

The Provider's registration may be terminated at any time by the Provider or Express Scripts Canada as per Section 11 (1) of the Agreement.

Either party may terminate this Agreement at any time without cause upon providing the other party with forty-five (45) days written notice to terminate. 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 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 within sixty (60) days of the termination.

Termination of Provider registration does not terminate any rights or obligations of the Provider or Express Scripts Canada regarding the Express Scripts Canada Provider

Audit Program activities. Please refer to *Section 5 Provider Audit Program* or other sections of the Agreement, as per Section 11 (3) of the Agreement.

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 a registered Indian according to the Indian Act.
- An Inuk recognized by one of the Inuit Land Claim organizations.
- A child less than one year of age, whose parent is an eligible Client.

To facilitate verification, all 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 (date format YYYY-MM-DD).
- Client Identification Number.

It is recommended that Clients who have an Indian Status identification card be asked to present their card on each visit to the Provider to ensure that the Client information is entered correctly, and to protect against any 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 Registered 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 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:
  - 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 First Nations 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

These 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 Special Provision for First Nations and Inuit Children under One Year of Age

Special identification provisions for children less than one year of age are in place to allow adequate time for parents, eligible for benefits under the Program, to register their newborn children with the applicable Aboriginal organization.

If a child of less than one year of age has not been registered, Clients (parents) should be referred to the appropriate office or organization:

Clients	Office/ Organization
First Nations	Their Band Office or the Registration Services Unit of AANDC at 1-819-953-0960.
Inuit in the Northwest Territories and Nunavut	Their respective territorial Department of Health and Social Services and Inuit organization.
Inuit Residing Outside of the Northwest Territories and Nunavut	The nearest Health Canada Regional Office.

The first MS&E Claim for all children must be manually submitted to Express Scripts Canada using the NIHB Medical Supplies & Equipment Claim Form.

Subsequent Claims submitted on behalf of the child via electronic submission must include the child's parent's primary identifier (such as AANDC, Client or Band/ Family Number, FNIHB Client Identification Number, NWT or NU health plan number) in the Client Identification Number field, and the child's identifiers in the Surname, Given Name, and Date of Birth fields.

Note To ensure ongoing Client eligibility, parents must obtain a Client Identification Number from the appropriate Registrar Office/ organization for the child prior to the child's first birthday.

4.1.5 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 MS&E 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 appropriate First Nations or Inuit organization for further information.

The following First Nations/ Inuit organizations have assumed the administration for the delivery of MS&E 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 NIHB coverage.

The first payer may be provincial (e.g., Assistive Device Program), 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 copy of the Claim can be sent to Express Scripts Canada for processing. The EOB must include the amounts paid by the first payer.

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

4.3 Prior Approval Process for MS&E Benefit

If a Client is prescribed a MS&E item that requires a PA, the Provider must:

- Obtain from the Client, the written prescription issued by a physician or in certain cases, by a nurse practitioner.
- Obtain Client identification information as described in the *Section 4.1 Client Identification and Eligibility*.
- Contact the Health Canada Regional Office to initiate the PA Process before dispensing the MS&E item.
- Provide the precise Date of Service (for one time item), or the dates of the service period (for multiple dispenses) to the Benefit Analyst of the Health Canada Regional Office.
- When required, complete the appropriate Prior Approval Form, and return it to the Health Canada Regional Office together with all required documents.
- To avoid delays in the review of the PA request, ensure that all of the fields of the Prior Approval Form are fully completed.
- Once the process for the PA MS&E item has been completed by the Health Canada Regional Office, submit the Claim to Express Scripts Canada for reimbursement.

Note PAs given through the Health Canada Regional Offices are for an item, not the cost of the item, and as such Providers are prohibited from billing the Program above the Actual Acquisition Cost (AAC).

4.3.1 Confirmation

If a PA is granted, the Provider is provided with a PA Number for billing purposes for the registered MS&E location. The Provider should record this PA number and make note of the approval details (e.g., description, quantity, dollar value, and any frequency or time limitations). Only then should the Provider proceed with the fabrication, fitting and dispensing of the item.

A Prior Approval Confirmation Letter with the applicable dates and PA details is sent by mail or fax to the Provider. This Prior Approval Confirmation Letter should be retained for billing purposes.

4.3.2 Claim Submission with a Prior Approval

When submitting a Claim for an item that has been prior approved, ensure that the PA Number on the Claim matches the PA Number on the PA Confirmation Letter and that the Date of Service is the dispense date.

4.4 Mandatory Information in Transmission and Submission Options

A comprehensive review of mandatory information in transmissions and submission options can be reviewed by referring to *Section 7. MS&E Statement Messages and Explanations*.

4.5 Billing and Payment Guidelines

All billing methods used by Providers **must** include all the required data elements to enable efficient processing and payment of Claims. Data elements must be submitted in the same order as displayed on the NIHB Medical Supplies & Equipment Claim Form.

Manual Claims should be submitted *at least every two weeks* using a computer generated form or NIHB Medical Supplies & Equipment Claim Form.

Reversals and corrections (with the stated reason for reversal) to previously paid Claims should be submitted on your MS&E Claim Statement.

A complete listing of billing and payment guidelines may be found by referring to *Section 7. MS&E Statement Messages and Explanations*.

4.6 Benefit Coverage and Limitations

For additional information on eligible benefits, Program limitations and services, refer to the Provider Guide for Medical Supplies & Equipment Benefits located on the Health Canada Website at *www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_medequip/2009-prov-fourn-guide/index-eng.php*

Providers, who do not have internet access, please contact the respective Health Canada Regional Office to request a copy by fax or mail.

MS&E benefits are available to eligible FNIH Clients when **all** of the below conditions are met:

- The item is included in the MS&E Benefits and Criteria List, located on Health Canada's website at *www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/med-equip/criter/index-eng.php*
- The item is intended for use in a home setting or other ambulatory care settings.
- A PA when required is granted by the Health Canada Regional Office.
- The item is not available to the Client through any other federal, provincial, territorial or first payer health care program.
- The item is prescribed by a physician or nurse practitioner as indicated in each of the benefit areas.
- The item is provided by a registered Provider as indicated in each of the benefit areas.

4.6.1 Rental

When an MS&E item is rented, the Rental Agreement must include maintenance and repair costs as the Program does not pay for the maintenance or repairs of rental equipment. The Rental Agreement must also include a clause stipulating that should the purchase of the item become an option, the amount spent on the rental is considered when the purchase price is set.

4.6.2 Warranty

All warranty coverage must be exhausted before requests for the payment of repairs are submitted to the Program. When MS&E items have warranty coverage, as a minimum, the warranty must specify that during the warranty period:

- The Provider will provide or cause to be provided any service including repairs or replacements of the item device or any components free of charge; and
- Where there is repeated technical failure, the device will be replaced by the Provider at no cost to the Program.

4.6.3 Quantity Limitations

MS&E items that have an annual quantity limitation must be provided and billed for no more than a three-month period at a time. This applies to items claimed with or without a PA.

For a listing of eligible benefits, refer to the:

- Audiology Benefit List.
- General MS&E Benefit List.
- Orthotics and Custom Footwear Benefit List.
- Oxygen Supplies and Equipment Benefit List.
- Pressure Garments and Pressure Orthotics Benefit List.
- Prosthetics Benefit List.
- Respiratory Supplies and Equipment Benefit List.

MS&E guidelines with recommended quantities or replacements are based on the average medical needs of Clients. Requests exceeding these guidelines may be considered on a case by case basis if a need is demonstrated.

Where a change in the medical condition has occurred, medical information documenting the change in needs must be provided.

Replacements are not provided as a result of misuse, carelessness or Client negligence.

4.6.4 Exceptions

Items that are not on the MS&E Benefits and Criteria List, and that are not exclusions under the Program, may be considered on a case by case basis when need is demonstrated.

4.6.5 Exclusions

Exclusions are items that are not listed as benefits under the Program and are not available through the exception process. These items are therefore not considered for coverage under the Program and are not subject to the Appeal Process. Types of items that are exclusions under the Program are listed in each of the MS&E benefit categories.

4.6.6 Appeal Process

When a benefit is denied, three (3) levels of appeal are available under the Program, which the Client, parent, or their legal guardian can initiate. At each level, supporting information from the Prescriber or Provider must accompany the appeal.

The following information should be included:

- The condition (diagnosis and prognosis) for which the benefit or service is being requested.
- Alternatives that have been tried.
- Relevant diagnostic test results.
- Justification for the proposed benefit or service and any additional supporting information.

Information outlining the procedures of appeal is available on the Health Canada website at *www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/appe/index-eng.php*

Items excluded under the Program are not subject to the Appeal Process. Please direct Clients to the respective Health Canada Regional Office for additional information.

4.6.7 Special Promotion/ Coupon/ Discounts

A Client shall not benefit directly or indirectly from special promotions or incentives including coupons, discounts, points or rebates in the form of cash, and/or goods that may be offered by Pharmacy or MS&E Providers. Providing free items, such as a pair of shoes along with custom made foot orthotics to Clients is not consistent with Program policies. To the extent permitted by applicable law, the Program shall receive the benefit of these promotions.

As a result, the amount claimed through the Program must be the residual amount after application of the promotion.

5. Provider Audit Program

5.1 Audit Objectives

The objectives of the Express Scripts Canada Provider Audit Program are to confirm that claims have been submitted in compliance with the Terms and Conditions of the Program including:

- Detect and recover billing/ Claim irregularities.
- Ensure appropriate billing as defined by negotiated regional schedules up to the NIHB maximum.
- Ensure appropriate billing of applicable mark-ups, up to the maximum defined by negotiated regional schedules (where applicable).
- Ensure that the services paid for were received by eligible Program 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, the auditor may refer the matter to the appropriate 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 MS&E records maintained by the Provider pertaining to Clients as Express Scripts Canada deems necessary to determine compliance with the terms outlined in *Section 5.3.6. Reference Documents and in this Kit.*

5.3 Provider Audit Components

To carry out the Next Day Claims Verification (NDCV) and On-site Audit components of the Program, Express Scripts Canada requires access to information, including, but not limited to the following:

- Client's profile.
- Original prescription.
- Shipping invoices.
- Internal invoices.
- Manufacturers' invoices (to determine Actual Acquisition Cost or applicable mark-up).
- Documentation of item received by the Client.
- Evidence of additional coverage (to coordinate benefits).

5.3.1 Next Day Claims Verification Program

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

Providers may be contacted to provide copies of prescriptions, records/ charts, and/ or internal invoices, as well as any other supporting financial data. If the requested documents are not available for review, or if any errors are detected through this process, the audited Claim amount will be adjusted or denied for payment.

5.3.2 Client Confirmation Program

Confirmation consists of a monthly mail-out to a randomly selected sample of Clients to confirm the receipt of the benefit 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

The purpose of the on-site audit is to verify paid Claims against Client records through an on-site audit. Providers may be selected as a result of information gained through the components of the Express Scripts Canada Provider Audit Program, and any additional information received.

5.3.5.1 Stages of an On-Site Audit

Express Scripts Canada contacts the Provider at least (3) three weeks prior to the proposed on-site audit date. Wherever possible, every effort is made to accommodate the audit date with the Provider's schedule. The date agreed upon for the on-site audit is confirmed by fax with the Provider by way of an On-site Audit Confirmation Letter.

The MS&E Auditor Specialist(s) requires:

- Work space, chairs.
- Access to an electrical outlet(s).
- Access to and assistance in retrieving computerized Client profiles with a staff member.
- A dedicated staff member on-site to retrieve hard copy prescriptions and associated information. i.e., PAs.
- Access to the individual who will be responding to the audit report.

The MS&E Audit Specialist will arrive at approximately 9 a.m. or at mutually agreed upon time. The audit is expected to take place until 5 p.m. each scheduled audit day (unless otherwise mutually agreed-upon). At 9 a.m. on the first day of the audit, the MS&E Audit Specialist provides a brief orientation to the audit process, and answers any questions.

5.3.5.2 Pre-Audit/ Entrance Interview

The Provider is asked to describe the records filing system for tracking prescriptions/ charts/ records, and whether the documentation for Claim transactions is maintained on hard copy or electronically on the Client's profile. The Provider is requested to have a dedicated staff member on-site to retrieve the records for the MS&E Audit Specialists to review. The MS&E Audit Specialists will indicate to the Provider that a Post-Audit Summary will be supplied at the end of the on-site audit.

5.3.5.3 Conduct of the Onsite Audit

Remaining claims documentation not provided on-site will be listed for recovery in the Initial Audit Report. Claims not supported by the required documentation appear as recoveries in the Initial Audit Letter and Initial Audit Report to the Provider.

5.3.5.4 Post-Audit Interview

At the end of the on-site audit, the MS&E Audit Specialist provides a general overview of the categories of errors found. The final audit results are not complete until the MS&E Audit Specialist has conducted additional analysis, such as, but not limited to, Client and Prescriber confirmations. During the Post-Audit Exit Interview the Provider is provided with a standard checklist to complete and send to Express Scripts Canada, which serves to confirm the audit process conducted at the respective on-site audit.

5.3.5.5 Audit Report

A report of the audit findings is sent to the Provider within sixty (60) days of the on-site audit. If there are delays in meeting this deadline, a letter is sent to the Provider advising of the delay and the revised delivery date for sending the Audit Letter and Audit Report. Once the Initial Audit Letter and Audit Report are received, and in the event that there are audit observations resulting in recovery of Claims, the Provider has thirty (30) days to respond to Express Scripts Canada. If the Provider needs additional time to respond, a request for additional time is to be sent in writing to Express Scripts Canada.

Within sixty (60) days of the response from the Provider, Express Scripts Canada sends a letter and report of the final audit findings to the Provider. In the event that there are final audit findings resulting in recovery of Claims, the Provider has thirty (30) days from the date of the letter in which to submit a cheque (payable to the Receiver General for Canada) to Express Scripts Canada for the reimbursement of the identified overpayment. Failure to respond within thirty (30) days of the date of the letter, a withhold is placed against the Provider's payment statements until recovery is paid in full.

5.3.5.6 Documentation Requirements for Audit Purposes

Providers must retain a copy of the original documentation on file for two (2) years or as long as it is being dispensed against, if longer than two (2) years in accordance with provincial or territorial requirements. Claims for which the original prescription or supporting documentation is not available for review including those with PAs may be recovered through the Express Scripts Canada Provider Audit Program.

5.3.5.7 Supporting Documentation

Proper documentation of any intervention is required for verification against the Program's billing criteria. Appropriate supporting documentation includes but is not limited to:

- Date of intervention.
- Summary of the intervention by the Provider.
- Documented communication with the physician, caregiver, and/ or Client.
- Manufacturer's invoices required to substantiate invoice cost plus applicable negotiated maximum NIHB mark-up.
- Shipping invoices.
- Internal invoices.
- Evidence of additional coverage (to support COB).
- Items awaiting pick-up (to verify pickup within thirty (30) days of fill or Claim reversal is required).
- Documentation to verify that the Clients are eligible as registered First Nations or recognized Inuit.

A separate valid prescription (as defined by federal and provincial legislation) is required for each member of a family for the reimbursement of Claims submitted through the Program.

5.3.6 Reference Documents

For more information about the Provider Audit Program activities, refer to the below sources:

- NIHB Annual Report.

- Agreement.
- MS&E Newsletters.
- Provider Guide for Medical Supplies & Equipment Benefits.
- MS&E Benefits and Criteria List.

Providers may refer to the Agreement, Provider Guide for Medical Supplies & Equipment Benefits, MS&E Benefits and Criteria List, and the MS&E Newsletters which are 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 NIHB Annual Report may be viewed and downloaded from Health Canada's website at *www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/2011_rpt/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 – Pharmacy and MS&E
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5

6. MS&E Forms and Resources

6.1 MS&E Forms

All MS&E forms listed below are available for download in PDF 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*).

- Medical Supplies & Equipment Provider Agreement.
- NIHB Medical Supplies & Equipment Claims Submission Kit.
- NIHB Medical Supplies & Equipment Claim Form.
- Modification to Pharmacy and Medical Supplies & Equipment Provider Information Form.
- NIHB Hearing Aid and Hearing Aid Repair Confirmation Form.
- NIHB Hearing Aid and Hearing Aid Repair Prior Approval Form.
- NIHB General Medical Supplies & Equipment Prior Approval Form.
- NIHB Orthotics - Custom Footwear - Prosthetics - Pressure Garments Prior Approval Form.
- NIHB Oxygen and Respiratory Medical Supplies & Equipment Prior Approval Form.

6.2 Resources

6.2.1 Provider Claims Processing Call Centre

The call centre is available to registered MS&E Providers of the Program:

Phone No.:
1-888-511-4666

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

6.2.2 Mailing Address for MS&E Claims

MS&E Claims are to be mailed to the following address:

Express Scripts Canada
NIHB MS&E Claims
P.O. Box 1365, Station K
Toronto, ON M4P 3J4

6.2.3 Other Correspondence

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:
905-712-8615 or 1-888-677-0111 (ask for the Privacy Officer)

Mail:
Express Scripts Canada
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 http://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, NIHB Claims Services 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. MS&E Statement Messages and Explanations

The HICPS system assigns three-character reject and warning codes with messages that appear on the MS&E Claim Statement.

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

7.1 MS&E Claim Statement Details

The MS&E Claim Statement accompanies the Claims payment cheque, and provides information about each drug, medical supply and equipment Claim processed. If payments are made through EFT, the monies are deposited in the Provider's designated bank account, and the MS&E Claim Statement is mailed to the Provider's business address where the service was rendered. The MS&E 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.

Note As a registered MS&E Provider who also has an active registered Pharmacy Provider Number may submit general MS&E item claims using the Pharmacy Provider Number.

The MS&E 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 MS&E Claim Statement twice a month on the 1st and 16th of the month in either English or French, depending on the Provider's language of choice.

7.1.1 Corrections to Claims using the MS&E Claim Statement

Providers can use the MS&E 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 MS&E Claim Statement and forward the applicable page of the statement to Express Scripts Canada within twelve (12) months from the service date for re-adjudication of the Claim and to secure payment. Claims submitted more than twelve (12) months from the date of service will be rejected with the R21 Message - Period for Submitting Claims has Expired.

Providers who re-submit using a Medical Supplies & Equipment Pharmacy Claim Form must clearly indicate the Claim is a re-submission by checking the “Resubmission” box located at the top of the claim form.

7.2 Codes, Messages and Explanations

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

A Reject Code, composed of an "R" followed by two numeric characters and a text message, explains why the Claim was rejected. A Warning Code, composed of a “W” followed by two numeric characters and a text message, explains that the Claim was adjudicated with modifications or warning is being sent to Provider.

The MS&E Claim Statement is generated for manual submissions and includes all manually submitted Claims which were adjudicated and settled during the current period: paid, reduced, rejected, adjusted (settled and reversed); it also includes all suspended Claims entered in a previous reporting period and not yet settled.

The following chart displays Manual Claims Submission Messages and Explanations:

Messages	Description
NIHB Code R04	
Message:	This is not an eligible benefit.
Explanation:	The Claim has not been paid because the item is not on the Program MS&E Benefit and Criteria List.
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 registered 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 necessary for the claimant to provide more accurate Client identification information. However, if the claimant is not registered 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 because the Item Code is not covered under the Program due to the age or gender of the claimant. This restriction applies to benefits such as incontinence supplies.
NIHB Code R07	
Message:	This is a duplicate Claim.
Explanation:	The Claim has not been paid because it is a duplicate of a

Messages	Description
	previously paid Claim. The match is based on the following data elements of date of service, Provider Number, Client Number, and Item Number.
NIHB Code R10	
Message:	Invalid Provider ID.
Explanation:	The Claim has not been paid because the Provider cannot be validated as a registered 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 R17	
Message:	DIN/ GP #/ PIN ERROR.
Explanation:	All eight (8) positions must be valued, cannot be all zeros, and must be a valid item number that exists on the Express Scripts Canada database.
NIHB Code R18	
Message:	Quantity Error.
Explanation:	The quantity must be numeric and greater than zero.
NIHB Code R20	
Message:	Submit Claim to Provincial or Territorial Health Plan.
Explanation:	The Claim has not been paid because a provincial or territorial health plan covers part of the item. Direct the Claim to the appropriate plan first.
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 R22	
Message:	Prescriber ID Error.
Explanation:	The Prescriber ID number can be alphanumeric and cannot be zeros.
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

Messages	Description
	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 R25	
Message:	Claim does not Comply with the Terms of Prior Approval.
Explanation:	The Claim has not been paid because it does not comply with the terms of the PA. Refer to your copy of the Prior Approval Confirmation Letter.
NIHB Code R26	
Message:	Prior Approval Service Date Violation.
Explanation:	The Claim has not been paid because the date of service is either before the approval date or after the expiry date of the PA.
NIHB Code R27	
Message:	Prior Approval Number is Invalid.
Explanation:	The Claim has not been paid because the PA Number is invalid for the specified Client and benefit. The Provider should check their records to determine if the PA Number, the associated Client Identification Number, and the Item Codes were submitted correctly. If an error was made, supply the correct information following the Claims correction procedures outlined in MS&E Claim Statement.
NIHB Code R28	
Message:	Drug Cost/ Product Value Error.
Explanation:	The drug and/ or item cost must be numeric and greater than zero.
NIHB Code R29	
Message:	Claim is Post Dated.
Explanation:	This must be in a valid date format (YYYY-MM-DD) and cannot be future date. If check fails, a message is generated.
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 benefit. Contact the Health Canada Regional Office for direction on where to submit the Claim.
NIHB Code R47	
Message:	Special Authorization for this Item used up by Previous Claim.
Explanation:	The Claim has not been paid because special authorization

Messages	Description
	for this item has been used up by a previous Claim.
NIHB Code R48	
Message:	Prior Approval for this Item has been used up by Previous Claim.
Explanation:	The Claim has not been paid because the PA has already been used up by a previous Claim. Refer to your copy of the Prior Approval Confirmation Letter.
NIHB Code R49	
Message:	Benefit requires Prior Approval.
Explanation:	The Claim has not been paid because it requires PA from Health Canada Regional Office. Benefits which require a PA are indicated in MS&E Benefits and Criteria List. For more details on PA procedures, refer to *Section 4.3 Prior Approval Process for MS&E Providers*.
NIHB Code R50	
Message:	Quantity Exceeds Frequency Limits.
Explanation:	The Claim has not been paid because the frequency limit for the item has been exceeded. Benefits with frequency limits are indicated in each of the benefit categories found in the MS&E Benefits and Criteria List. For benefits with frequency limits that do not normally require PA, a PA must be requested if the Claim exceeds the maximum allowed.
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 Client eligibility file.
NIHB Code W05	
Message:	Claims paid on Parent Identification until first birthday only.
Explanation:	The claimant could not be verified as an NIHB Client. However, since the claimant is a child less than one year of age, and the child's parent was verified as an NIHB Client, the Claim has been paid. This provision allows time for parents to register the child and only applies until the child's first birthday. Claims for services provided after the child's first birthday are rejected if the child cannot be verified as an NIHB Client. Additional information on Client identification requirements for children is provided in the Parent's Information – Data Elements Section.
NIHB Code W09	
Message:	Drug/ Item Cost is Reduced to NIHB Pricing Guidelines
Explanation:	The amount claimed for the item cost has been reduced to

Messages	Description
	conform to pricing guidelines. Refer to the details of the NIHB pricing guidelines in the respective region.
NIHB Code W11	
Message:	Claim Reduced to NIHB Share.
Explanation:	The claimed Item 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 quantity amount claimed has been reduced to conform to the frequency limitation allowed.
NIHB Code W13	
Message:	Quantity of Claim is Reduced to Maximum Allowed.
Explanation:	The amount claimed has been reduced to conform to the maximum allowable.
NIHB Code W17	
Message:	Claim adjusted to comply with terms of Prior Approval.
Explanation:	The amount claimed is reduced to comply with the terms of PA set out by FNIHB. The Provider should refer to the Prior Approval Form or the Prior Approval Confirmation Letter.
NIHB Code W19	
Message:	Dispensing Fee is Disallowed or Reduced to NIHB Guidelines.
Explanation:	The dispensing fee has been disallowed or reduced to conform to NIHB dispensing fee guidelines. Refer to the details of the NIHB pricing in the respective region.
NIHB Code W20	
Message:	Mark-up is disallowed or reduced to NIHB Pricing Guidelines.
Explanation:	The mark-up has been disallowed or reduced to conform to NIHB Pricing Guidelines.

7.3 Submission Options and Mandatory Data to be Submitted in MS&E Claims

Outlined below is the information on submission options and mandatory data requirements for submission of MS&E Claims.

7.3.1 Claim Submission Options

NIHB Medical Supplies & Equipment Claim Form

Claims may be submitted on the NIHB Medical Supplies & Equipment Claim Form. Inquiries related to its completion should be directed to the Provider Claims Processing Call Centre Providers who do not have internet access or e-mail to download the PDF,

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*).

Note The Client address within the Client Information Section of the NIHB Medical Supplies & Equipment Claim Form must be completed prior to sending to Express Scripts Canada for payment. If the Client address is not completed, the Claim form is returned to the Provider for completion.

Computer Generated Form

Claims may be submitted manually on plain stock or computer paper.

7.3.2 Claims Submission - Required Data Elements

The first MS&E Claim for all children must be manually submitted to Express Scripts Canada using the NIHB Medical Supplies & Equipment Claim Form.

The following section describes the required data elements for each Section of the NIHB Medical Supplies & Equipment Claim Form including:

- Client Information
- Claim Information for each Prescribed Item
- MS&E Provider Information and Parent Information.

Submission of all required Client data elements is necessary to verify the claimant as an NIHB Client.

7.3.2.1 Client Information: Data Elements

Field Name	Description
Client Surname	The surname under which the Client is registered as registered First Nations or recognized Inuit Client.
Client Given Name	The given name under which the Client is registered as a registered First Nations or recognized Inuit Client. Submission of more than one given name is preferred to facilitate Client verification. Initials are not acceptable.
Client Date of Birth (YYYY-MM-DD)	Client's full birth date in the correct year-month-day format (e.g., 1992-05-13 represents 1992 May 13). Partial birth dates are not acceptable.
Address / Apt/ City/ Province/ Postal Code	The current and exact address of the Client.
Client Identification Number	A unique number used to identify a Client who is eligible to receive benefits under the Program. This number may be one of: • A 10-digit number is currently issued to register First Nations Clients by AANDC. • A three-digit band number, immediately followed by the five-digit family number identifying the family unit within the registered First Nations Client's band. • An alpha prefix followed by an eight-digit number issued to certain registered First Nations and recognized Inuit Clients by FNIHB. • A health plan number is issued to recognized Inuit Clients by the Governments of NWT and Nunavut.

Field Name	Description
Band Number	A three-digit number (for example, 002, 311) identifying the band to which a registered First Nations Client belongs. The band number, when submitted in combination with the Client's Family Number, is an acceptable alternative to the Client Identification Number for a registered First Nations Client.
Family Number	A five-digit number (for example: 04120) identifying the family unit within the band to which a registered First Nations Client belongs. The family number, when submitted in combination with the Client's band number, is an acceptable alternative to the Client identification number for a registered First Nations Client. If the family number on the registered First Nations Client's registration card has fewer than five digits, insert the appropriate number of zeros in front of the number.

7.3.2.2 Claim Information for Each Prescribed Item: Data Elements

Field Name	Description
Date of Service (YYYY-MM-DD)	The date on which the item was provided to the Client in the year-month-day format (e.g., 1992-05-13 represents 1992 May 13).
DIN/ Item Code	The Item Code.
Client Date of Birth	Client's full birth date in year-month-day format (e.g., 1992-05-13 represents 1992 May 13). Partial birth dates are not acceptable.
Quantity/ Item Cost	The total acquisition/ manufacturer cost for all units of the item dispensed.
Mark-up	The dollar amount of any mark-up for the item, based on the established percentage. Leave blank if not applicable.
Third-Party Share	The dollar amount of any portion of the Claim which is billable to a provincial or territorial program or other first payer. Leave blank if not applicable.
Amount Claimed	The sum of the item cost, and mark-up for the item, less any third-party share.
Day's Supply	Estimate of number of days of treatment contained in the prescription.
Total	The total dollar amount claimed for all items (up to 10) listed on the Claim form.
Prescriber ID	The Prescriber number as entered by the Provider on the Claim submission must be the same as required by the provincial/ territorial healthcare Program.
Prior Approval Number	An authorization number, which must be issued by the appropriate Health Canada Regional Office before the Provider dispenses certain medical supplies and most medical equipment.

7.3.2.3 MS&E Provider Information: Data Elements

Field Name	Description
Provider/ Supplier Name	The name of the Provider/ supplier submitting the Claim.
Provider/ Supplier Address	The address of the Provider/ supplier submitting the Claim.
Provider/ Supplier Number	The number assigned to the Provider/ supplier upon registration as an NIHB Provider with Express Scripts Canada.

7.3.2.4 Parent Information (Required for Children Less than One Year of Age): Data Elements

A child under one year of age, who has not been registered as a registered First Nations or recognized Inuit Client may receive benefits if one of the child's parents can be verified as a registered First Nations or recognized Inuit Client.

In such a case, the child's surname, all given names, and the date of birth (date format YYYY-MM-DD) must be entered in the appropriate fields in the Client Information Section of the NIHB Medical Supplies & Equipment Claim Form and this information about the parent must be provided:

Field Name	Description
Parent's Surname	The surname under which the parent is registered as a registered First Nations or recognized Inuit Client.
Parent's Given Names	The given names under which the parent is registered as a registered First Nations or recognized Inuit Client. Submission of more than one given name is preferred to facilitate Client verification. Initials are not acceptable.
Parent's Date of Birth (YYYY-MM-DD)	The parent's full birth date in year-month-day format (e.g., 1956-05-13 represents 1956 May 13). Partial birth dates are not acceptable.
Parent's Client Identification Number	The number under which the parent is identified as a registered First Nations or recognized Inuit Client. This number may be one of: • A ten-digit number is issued to register First Nations Clients by AANDC. • A three-digit band number is immediately followed by a five- digit family number identifying the family unit within the registered First Nations Client's band. • An alpha prefix followed by an eight-digit number issued to certain registered First Nations and recognized Inuit Clients by FNIHB. • A health plan number issued to recognized Inuit Clients by the Governments of NWT and Nunavut.
Parent's Band Number	A three-digit number (e.g., 002, 311) identifying the band to which a registered First Nations Client's parent belongs. The band number, when submitted in combination with the family number, is an acceptable alternative to the Client Identification Number for a registered First Nations Client.
Parent's Family Number	A five-digit number (e.g., 04120) identifying the family unit within the band to which a registered First Nations Client belongs. The family number, when submitted in combination

Field Name	Description
	with the Client's Band Number, is an acceptable alternative to the Client Identification Number for a registered First Nations Client. If the family number on the registered First Nations Client's registration card has fewer than five digits, insert the appropriate number of zeros in front of the number.

7.3.3 Payment Information

Reimbursement

MS&E Providers are reimbursed in a timely manner, in accordance with the terms and conditions of the applicable Agreement and of the Kit, and following a specific and predetermined method of payment.

Payment Schedule

Unless the applicable Agreement provides otherwise, the MS&E Provider shall be paid on a twice-per-month schedule. The payment run date takes place automatically on the 1st and 16th of every month. Payment run date for the 1st include Claims processed from the 16th to end of the month (e.g., February 28th or 29th or the 30th or 31st as the case may be for the remaining months); payment run date for the 16th include Claims processed from the 1st to the 15th.

The payment date is within two (2) business days following the Payment Run Date, unless a weekend or statutory holiday falls between. Payment date is the day that cheques, Electronic Funds Transfer (EFT) payments and statements are released.

Payment Method

EFT payment is available to MS&E Providers providing Express Scripts Canada with access to a bank account for payment deposit. If EFT is elected as the preferred method of payment, complete the Express Scripts Canada Modification to Pharmacy and Medical Supplies & Equipment Provider Information Form. Providers which do not provide EFT information are paid by cheque. For timely receipt of payments, ensure that the correct mailing address is captured in the Express Scripts Canada Modification to Pharmacy and Medical Supplies & Equipment Provider Information Form.

A MS&E Provider receiving payments by cheque and wishing to switch to EFT payment can do so at any time by completing the Express Scripts Canada Modification to Pharmacy and Medical Supplies & Equipment Provider Information Form and forwarding the request to Express Scripts Canada.