Non-Insured Health Benefits (NIHB)

Dental Claims Submission Kit

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NIHB Dental Claims Submission Kit

Any comments or requests for information may be transmitted to:

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

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Table of Contents

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 terms and conditions for the submission of a claim under the NIHB Program (referred to as the Program).

For NIHB Program policies on dental benefits, please refer to the NIHB Dental Benefits Guide. The Dental Benefits Guide also lists website addresses to required dental forms.

The Kit is 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 and that all required elements are accurately completed before submitting claims. It is the providers' responsibility to obtain for reference purposes, the most current version of this Kit, which is updated annually (as required) at Express Scripts Canada's discretion. Notification of Kit updates are posted on the NIHB Claims Services Provider Website thirty (30) calendar days prior to the circulation date.

All documents (announcements, Kit, Enrolment Form, dental newsletters, NIHB Regional Dental Benefits Grids and the NIHB Dental Benefits Guide) are available on the NIHB Claims Services Provider Website. Providers who do not have Internet access or email, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to Section 8.2 Provider Claims Processing Call Centre). All questions or comments regarding the Kit should also be directed to the Provider Claims Processing Call Centre at 1 888 511-4666.

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.

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 Benefits Guide but not limited to:

- Provider eligibility requirements (Section 3 Dental Provider Enrolment)
- Client eligibility requirements (Section 4 Client Identification and Eligibility)
- Requirements for co-ordination of benefits (COB) (Section 5.5 Co-ordination of Benefits)
- Submission process and supporting documentation requirements (Section 5 General Claims Submission Procedures)

- Requirements for providers on the use of treatment codes and standard definitions, and list of services (Section 5 General Claims Submission Procedures)
- Benefit coverage and/or applicable limitations (Section 5.6.3 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 6 Provider Audit Program)
- Requirements to maintain relevant documentation and records (Section 6.3.6 Documentation Requirements for Audit Purposes)

Note: The dental office address provided **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 service in connection with the Enrolment:

- Provide 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 Dental Benefits Guide.

1.3.1. General Terms

The Kit contains terms, conditions and procedures for verifying benefits eligibility, as well as claims submission, adjudication, payment, reversals and audit. Providers are bound by and must follow the terms, conditions and procedures in, but not limited to, the Kit, the Enrolment Form and the Dental Benefit Guide. Registered First Nations and recognized Inuit clients may be eligible for dental benefits when all of the following conditions are met:

- The procedure is recommended or performed by an NIHB recognized dental provider who is licensed, authorized and in good standing with the regulatory body of the province/territory of Canada in which they practice.
- The procedure recommended or performed is eligible for coverage under the Program.
- Predetermination (PD), when required, has been provided by NIHB Dental Predetermination Centre (DPC), prior to the service being rendered.
- The procedure is not covered under a provincial/territorial or first payor health care plan.
- The client is a resident in Canada and is covered or eligible to be covered under the provincial/territorial health program.

1.3.2. 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
Canadian Dental Association Network (CDAnet)	The electronic claims network for dentists provided by the Canadian Dental Association in partnership with provincial dental associations across Canada.
Canadian Dental Hygienist Association (CDHAnet)	The electronic claims network for dental hygienists provided by the Canadian Dental Hygienists Association.
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 person who is eligible to receive NIHB dental services in accordance with the eligibility criteria in Section 4 Client Identification and Eligibility of the Kit.
Crown-Indigenous Relations and Northern Affairs (CIRNA)	Crown-Indigenous Relations and Northern Affairs is a federal department that was established in 2017.
Co-ordination/ Coordination of Benefits (COB)	Client covered by more than one health or dental plan. If the primary plan does not pay the full amount of an expense, the claim can be submitted to the other plan for the balance.
Denturist Association of Canada Network (DACnet)	The electronic claims network for denturists provided by the Denturist Association of Canada.
Delisted	A dental service provider who is no longer an eligible NIHB provider.
Dental Benefits Guide	The guide 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 the Kit. The Guide is available at canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health/reports-publications/non-insured-health-benefits/dental-benefits-guide-non-insured-health-benefits-program.html.
Dental Claim Statement	A listing of claims that were entered and settled, which includes adjudication messages. Express Scripts Canada issues the provider claim statement twice a month.
Dental Predetermination Centre (DPC)	The NIHB Dental Predetermination Centre adjudicates all predetermination, client reimbursement and appeals requests, for dental and orthodontic services.

Dental Provider Enrolment	The process where providers enroll with Express Scripts Canada to submit dental benefit claims on behalf of NIHB clients, subject to the terms and conditions of the Program.
Dental Regulatory Authorities (DRA)	The provincial/territorial dental regulatory authorities (DRAs) are 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.
Electronic Data Interchange (EDI)	Electronic data interchange 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), Canadian Dental Hygienists Association (CDHAnet) or Denturists Association of Canada (DACnet). Refer to **CDAnet** Refer to **Réseau ACDQ** Refer to **DACnet** Refer to **CDHAnet**
Electronic Funds Transfer (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.
Explanation of Benefits (EOB)	Explanation of benefits is a written statement displaying all of the details of the services paid and not paid resulting from a claim submission.
Express Scripts Canada (formerly ESI Canada)	On behalf of the NIHB Program, Express Scripts Canada is responsible for processing the claims submitted through the Program.
First Nations and Inuit Health Branch (FNIHB)	FNIHB refers to the First Nations and Inuit Branch which is part of the federal Department of Indigenous Services Canada (established in 2017). FNIHB was formerly part of Health Canada.
Health Information and Claims Processing Services (HICPS) System	This system includes all services used to process predeterminations and claims, to support providers with the processing and settlement of their claims, and to ensure compliance with the program policies including audit, reporting and financial control practices.

Indigenous and Northern Affairs Canada (INAC)	Refers to the former department of Indigenous and Northern Affairs Canada. The department was dissolved when the new federal departments CIRNA and ISC were created in 2017. (Formerly Indian and Northern Affairs Canada and Aboriginal Affairs and Northern Development Canada).
Indigenous Services Canada (ISC)	Indigenous Services Canada is a federal department (established in 2017). The Non-Insured Health Benefits Program reports to ISC.
Next Day Claims Verification Program (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 to the enrolled providers and sets out terms and conditions for the submission of claims.
Non-Insured Health Benefits Program (NIHB Program) (referred to as the Program)	The NIHB Program is ISC's national, medically necessary health benefit program that provides coverage for benefit claims for a specified range of drugs, dental care, vision care, medical supplies and equipment, mental health counselling and medical transportation for eligible First Nations people and Inuit when these benefits or services are otherwise not insured by provinces and territories or other private insurance plans.
Other Coverage	Benefits available to clients of the Program, in whole or in part from a provincial/territorial or first payor private health care program.
Personal Information Protection and Electronic Documents Act (PIPEDA)	The Personal Information Protection and Electronic Documents Act is a Canadian law relating to data privacy. It governs how private sector organizations collect, use and disclose personal information in the course of commercial business.
Provider	An NIHB recognized Dental professional that 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 of claims for adjudication and to receive payment.

Regional Dental Benefit Grids	The grids are referred to by General Practitioners (GP), Specialists (SP), Denturists (DN), and Dental Hygienists 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, Denturists Association of Canada (DAC) Fee Guide, as well as, in certain provinces the Canadian Dental Hygienist Fee Guide.
Réseau de l'assocation des chirurgiens dentistes du Québec (ACDQ)	The electronic claims network for dentists in Québec provided by the Association des chirurgiens dentistes du Québec.

2. Background

2.1. 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 and extends to registration, 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 5 General Claims Submission Procedures outlined in the Kit.

Express Scripts Canada only communicates and responds to providers' inquiries. All client inquiries should be redirected to the NIHB DPC. For contact information, refer to the Government of Canada website at canada.ca/en/indigenous-services-canada/corporate/contact-us-first-nations-inuit-health/non-insured-health-benefits.html.

2.2. Indigenous Services Canada (ISC) NIHB Program

Further details on ISC's NIHB Program can be located on Government of Canada's website at canada.ca/nihb.

Providers who do not have Internet access or email, may contact the Provider Claims Processing Call Centre (refer to Section 8.2 Provider Claims Processing Call Centre).

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 below:

- 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 Regional Dental Benefit Grids.
- Submit a treatment plan to 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 accurate and complete on the claim submission form.
- 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.

2.3.1. Client Reimbursement

Dental providers are encouraged to submit claims directly to Express Scripts Canada so clients do not incur charges at the point of service when receiving dental services under the Program.

When a client pays directly to his/her provider for dental services, the client may seek reimbursement for eligible benefits/amounts upon completion of a NIHB Client Reimbursement Request Form, within one (1) year from the date of service. The NIHB Client Reimbursement Request Form can be located on the Government of Canada website at canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health/non-insured-health-benefits/benefits-information/client-reimbursement-request-form-non-insured-health-benefits-first-nations-inuit-health-canada.html.

In addition, the contact information for the NIHB DPC is located on the Government of Canada website at canada.ca/en/indigenous-services-canada/corporate/contact-us-first-nations-inuit-health/non-insured-health-benefits.html.

Note: If “pay client/guardian” is indicated on a claim, payment will be sent directly to the client. If payment is not intended to go to the client, “pay client/guardian” should not be indicated on the claim form.

2.4. Health Information and Claims Processing Services (HICPS) System

HICPS is an electronic claims adjudication system that processes, pays, or rejects claims based on Program policies, guidelines and criteria. The claim is entered with

the mandatory data elements as stipulated in Section 5.2.1 Claims Submission - Required Data Elements.

The HICPS system captures claims sent electronically from the provider via a personal computer. 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, CDHAnet or DACnet ™.

The HICPS system handles both electronic and manual claims when they are paid directly to the:

- Provider who has performed the dental services according to standard system edits (pay provider).
- Client or other payee as per the provider's instructions.
- Client or other payee as per the NIHB DPC instructions.

Unless otherwise indicated, a claim is a pay provider claim.

A list of error messages and explanations are listed in Section 7.3 Dental Claim Statement Messages.

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/Dental Hygienist Provider Enrolment Form.

Providers enrolled with Express Scripts Canada in the Program can 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 CDHAnet, CDAnet/ Réseau ACDQ or DACnet™, providers are to contact the respective association for a list of certified software vendors.

- The NIHB Claims Services Provider Website at provider.express-scripts.ca, where the following resources are available:
  - Alerts regarding changes to the HICPS system
  - Bulletins and announcements
  - Regional Dental Benefit Grids
  - Dental newsletters

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

- NIHB forms
- Program policy information in Dental Benefits Guide

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 Form at Express Scripts Canada, the enrolment is forwarded to the NIHB Program 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.

A copy of the Dental Provider Enrolment Form/Dental Hygienist Provider Enrolment Form is located on the NIHB Claims Services Provider Website at provider.express-scripts.ca and is available in portable document format (PDF). Providers who do not have Internet access or email may contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to Section 8.2 Provider Claims Processing Call Centre).

3.1.1. Unique Provider Number

Upon enrolment approval, providers are assigned a unique provider number by Express Scripts Canada.

This number is used to identify the provider and to properly reimburse the provider for claims adjudicated by Express Scripts Canada and to ensure that 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 their provider number, regardless of the business arrangements in place between the providers in an office or clinic.

Multiple office identification numbers are maintained with the same unique provider number for dental providers 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.

Independent dental hygienists can enrol with the NIHB Program. The provider's CDHAnet number will be used as the provider number, should the hygienist want to bill through electronic claims.

3.2. 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 ISC and/or Express Scripts Canada by email, fax or mail and are posted to the provider website.

The Program policy, claim submission and payment information is made available to providers through:

- Kit
- NIHB Dental Benefits Guide
- Fax broadcast
- Dental newsletters
- Broadcast messages via dental claim statement
- Announcements

It is important that providers retain the most current documentation to ensure Program requirements are met.

3.3. Change of Provider Information

In order to keep provider records up-to-date and avoid unpaid claims and non-delivery of ISC and Express Scripts Canada communications via email, 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.

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

- Fax number
- Phone number
- Email address
- Correction to current address
- Preferred communication method (fax, email or 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

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

Providers who do not have Internet access or email, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to Section 8.2 Provider Claims Processing Call Centre).

3.4. 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, by fax or registered mail to:

Fax Number
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 the provider's responsibility regarding Express Scripts Canada's Provider Audit Program activities. For more information, please refer to Section 6 Provider Audit Program.

4. Client Identification and 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. Once client-eligibility is validated, the provider must document any alias names.

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.
- A child less than 18 months of age, whose parent is an eligible client.

For unregistered children under the age of 18 months, please call the DPC for assistance.

To facilitate verification, all of 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

Please note that due to privacy issues it is not the responsibility of ESC to provide client ID numbers. This information must be obtained by the provider from the client during the verification of client eligibility.

4.1. 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 Non-Insured Health Benefits (NIHB) client identification number. This number begins with the letter T and is followed by seven (7) digits.
- Government of Nunavut (GNU) health plan number:
  - Inuit clients from Nunavut may present a health plan number issued by the GNU. This number is valid in any region of Canada and is cross-referenced to the NIHB client identification number. This is a nine (9) digit number starting with a one (1) and ending with a five (5).
- NIHB client identification number (N-Number)
  - This is a client identification number issued by NIHB to recognized Inuit clients. This number begins with the letter N and is followed by eight (8) digits.

The NWT/NU Health Care card or Government of Canada NIHB N# letter (Health Canada or Government of Canada letterhead) identifying the individual and accompanied by picture identification is sufficient identification for clients.

Please note that due to privacy issues it is not the responsibility of Express Scripts Canada to provide client ID numbers. This information must be obtained by the provider from the client during the verification of client eligibility.

4.2. Required Client Identification Numbers for Eligible First Nations Clients

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

- Registration number
  - This is a 10- digit number, issued by the Government of Canada (now issued by CIRNA, but formerly by INAC or AANDC), to clients registered under the Indian Act. It is commonly called a *status card*. The registration number is the preferred method of identifying First Nations clients.
- If a client does not know their registration number, providers can call the Provider Claims Processing Call Centre for assistance. Providers must have the name or number of the client's band, the client's full given name and date of birth before calling.
- NIHB client identification number (B-number)
  - In specific and exceptional cases, some First Nations clients may have numbers issued by NIHB. This number begins with the letter B and is followed by eight (8) digits.

Please note that due to privacy issues it is not the responsibility of Express Scripts Canada to provide client ID numbers. This information must be obtained by the provider from the client during the verification of client eligibility.

4.3. Individuals Excluded from the Program

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

- First Nations and Inuit who are not resident in Canada
- First Nations and Inuit individuals incarcerated in a federal, provincial/ territorial or municipal corrections facility
- First Nations and Inuit individuals who are in a provincially/territorially funded institutional setting which provides its residents with supplementary health benefits as part of their care, such as nursing homes
- First Nations and Inuit children who are in provincially/territorially funded care. However, if the NIHB Program is the first point of contact to request health benefits/services for a child who would otherwise be NIHB-eligible, the Program will provide NIHB-eligible benefits to the child and follow-up with the respective provincial/territorial agency.

4.4. 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 group 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
- First Nations Health Authoirty (British Columbia)
- James Bay Cree (10 bands)
  - Naskapis #081
  - Chisasibi #058
  - Eastmain #057
  - Nemiscau #059
  - Waskaganish #061
  - Waswanipi #056
  - Wemindji #060
  - Whapmagoostui #095
  - Mistassini #075
  - Ouje-Bougoumou Cree Nation #089
- 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)

5. General Claims Submission Procedures

Claims older than one (1) year from the date of service will not be accepted for processing and will not be eligible for payment. All claims of any type, regardless of submission method, including documentation to support COB (if applicable), must be received by Express Scripts Canada within one (1) year from the date of service to be eligible for payment (refer to section 4.0 Payment and Reimbursement of the Dental Benefits Guide)

Providers wishing to submit claims can do so manually or through EDI.

Eligible codes under the Program can be found in the Regional Dental Benefit Grids which are located on the NIHB Claims Services Provider Website at provider.express-scripts.ca.

For 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 8.2 Provider Claims Processing Call Centre).

5.1. Electronic Claims Submission

Providers wishing to submit electronic claims using the EDI system must first register with CDAnet/Réseau ACDQ, CDHAnet 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 rejected in real-time. Each dental claim must be submitted to Express Scripts Canada in the most current CDAnet/Réseau ACDQ, CDHAnet or DACnet claims transmission standard for processing and payment.

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, midnight to 6 a.m. as required, and the maintenance window when the system is down from Sundays, midnight to 6 a.m.

All claims submitted using EDI are either accepted or rejected in real-time; there are no pended claims. Two types of messages are generated for claims submitted using EDI: CDAnet, DACnet, CDHAnet, 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 in Section 7.3.2 Manual and EDI Claims Submission System Codes Messages and Explanations.

Missing teeth information cannot be submitted on EDI claims. Missing teeth must be recorded on all PD submissions to DPC and all manual claim submissions to Express Scripts Canada. The tooth chart must be kept in the client's file for audit purposes.

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**.

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 rejected if another claim for the same procedure has already been processed.

5.1.1. 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 NIHB DPC)

- Standard documentation/ information required for PD related to dental services
- Requests for post determination (must be submitted manually to the NIHB DPC)
- 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 5.2 Manual Claims Submission)
- Orthodontic incremental payment codes (must be submitted manually to Express Scripts Canada; refer to Section 5.6.2 Orthodontic Services)
- 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 payor 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 5.5 Co-ordination of Benefits)
- Claims for procedure payment codes not listed in the vendor's software (must be submitted manually to Express Scripts Canada).

5.2. Manual Claims Submission

The dental forms listed below are available for download in PDF format from the NIHB claims services provider website at provider.express-scripts.ca.

Providers who do not have Internet access or email, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to Section 8.2 Provider Claims Processing Call Centre).

When submitting manual claims, providers must use 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 Reimbursement Form

Note: Reversal and correction requests (with the stated reason for reversal) to previously paid claims can be submitted on the dental claim statement.

*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 5.2.1 Claims Submission - Required Data Elements.

All provider manual claims should be mailed to Express Scripts Canada.

5.2.1. Claims Submission - Required Data Element

Providers should clearly indicate the following on the claim form:

- 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.

5.2.1.1. NIHB Dental Claim Form (Dent-29) Field Description

When completing the Dent-29 form, the following data elements are required.

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

Field Name	Description
Surname	The surname under which the client is registered.
Given Name	The given names under which the client is registered. 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 No.	The full unique nine (9) 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.
Client Identification No.	Unique number used to identify a client who is eligible to receive benefits under the Program.
Band No.	Three (3) digit band number only applicable to First Nations clients.
Family No.	Four (4) or five (5) digit number only applicable to First Nations clients.
Date of Birth	Date format YYYY-MM-DD

Field Name	Description
Provider Clinic Address	A stamp with the provider address is acceptable. Submissions that do not indicate the complete provider address may be returned.
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.
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.
Date of Service	The date on which services were provided to the client in date format (YYYY-MM-DD). 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 the NIHB DPC 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 Code	The procedure/ payment code corresponding to the applicable dental procedure or exact orthodontic wording. For further details, refer to *Section 5.6.2 Orthodontic Services*.
Int. 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 +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 NIHB

Field Name	Description
	confirmation letter must be entered beside the corresponding claim line.

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.

5.3. 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 lab fee amount on the same claim line. Failure to do so results in the claim being rejected.

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 for Denturists

When submitting claims, either manually or electronically, denturists should submit procedure code 98888 for laboratory fees eligible under the NIHB Program (excluding 71309, 71310, 71311, 71313, 71314, 71315, 71010 and 72021). Note that the use of procedure code 98889 has been discontinued by the Denturists Association of Canada, and therefore under the NIHB Program.

5.4. Universal Description and Codes

When submitting either an EDI or manual claim for procedures that require a **quadrant, surface, arch**, or **sextant** description, providers must use the following codes:

Quadrant Code	Description
Code 10	Upper Right

Quadrant Code	Description
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 14-18
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

5.5. Co-ordination of Benefits

Some NIHB clients may have coverage provided through a provincial/territorial or private health care plans, which can include social services, Workers Compensation Board (WCB), and employee benefit programs. Claims for NIHB clients with alternate coverage should be submitted to the other plan or program first.

Claims submitted to Express Scripts Canada involving co-ordination of benefits (COB) must clearly show the amount paid by the other plan or a written explanation of the

way coverage was declined in order to be processed. The NIHB Program will then co-ordinate payment for eligible benefits based on the payment or decision of the other plan.

Where a client is no longer eligible for coverage that was previously available, the provider can contact Express Scripts Canada or the client can contact the DPC to update the file.

Note that claims submitted for services that are insured through certain provincial or territorial health plan will be rejected.

COB for orthodontic treatment is applied at the time of PD. Where a client has other coverage, providers must first submit their orthodontic treatment plan to that plan. Once the provider receives a reply from the other plan or plans, the treatment plan can be submitted to the DPC. Providers must attach the coverage response from the other plan at the time of PD.

5.6. Predeterminations

Certain dental procedures require a PD. The NIHB Regional Dental Benefit Grids outlines procedures requiring a PD/post determination.

When the client requires services which require a PD, providers **must** submit all requests to the DPC with the applicable supporting documents. For additional details, please refer to Section 6.2 Provider Responsibilities.

Mailing addresses can be found in the NIHB Dental Claim Form (Dent-29) or on the Contact the Non-Insured Health Benefits Program web page. For post determinations (where the service has already been rendered), the first payor EOB must accompany the claim form to allow for co-ordination 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 NIHB DPC. Requests for PDs that are submitted to Express Scripts Canada will be returned to the provider.

The DPC adjudication process can result in the following outcomes: approved, denied or on-hold (further information is required). A PD confirmation letter is sent to the provider's office via fax or mail, according to provider's preferred option of communication.

The letter states the start and end date for each procedure line, the PD number and relevant details related to the PD outcome. PDs are valid for one (1) year from the start date on the predetermination confirmation letter. Claims are rejected where the date of service is after the end date indicated on the predetermination confirmation letter.

The NIHB Program aims to have dental predeterminations adjudicated within 15 business days, 80 percent of the time, under normal circumstances.

Normal circumstances refers to the Program's available resources and the expected level of demand for regular day-to-day service operations.

The 15 business day period starts from the date that the DPC receives the PD request (received date), and ends when the request is adjudicated and set in the HICPS system. This NIHB service standard applies for approved and denied PD

requests (complete cases), as well as for PD requests put on-hold (incomplete cases due to missing information). For on hold PD requests, the 15 business day adjudication period will restart when NIHB receives the new information at the DPC.

This service standard may not apply in **special circumstances**, such as: holidays, unforeseen employee departures, disasters (e.g. flood, fire), human or environmental disaster (e.g. operator error, significant equipment/software failure, telecommunications and electric power outage).

5.6.1. 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 laboratory fee has also been approved. Only the provider that has requested and received the predetermination confirmation letter is eligible to claim for payment.

5.6.2. Orthodontic Services

Orthodontic claims are manually submitted with orthodontic payment codes.

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 rejected in HICPS.

Payment Code	Exact Wording
P0500	Orthodontic Observation
P1000	Examination
P1100	Diagnostic Records
P1200	Initial Payment – Comprehensive Treatment
P1201	Initial Payment – Prior Eligibility Start Date
P1300	Incremental Payment – Comprehensive Treatment
P1400	Final Payment – Comprehensive Treatment
P1450	Final Payment – Objectives Not Met
P1500	Initial Payment – Interceptive Treatment
P1501	Initial Payment - Interceptive Treatment - Prior Eligibility Start Date
P1600	Incremental Payment – Interceptive Treatment
P1700	Final Payment – Interceptive Treatment
P2010	Pre and post-surgical work up – Orthognathic Surgery (Maxillary Arch)
P2020	Pre and post-surgical work up – Orthognathic Surgery (Mandibular Arch)
P2030	Pre and post-surgical work up – Orthognathic Surgery (Maxillary plus Mandibular combined)

5.6.3. Benefit Coverage and Limitations

Further information on the criteria, guidelines and policies under which the Program covers dental services provided to eligible First Nations and Inuit clients can be found in the NIHB Dental Benefits Guide located on the provider website at provider.express-scripts.ca (select **Policy and Program Information**) or by contacting the Provider Claims Processing Centre to request a copy.

5.6.4. Exceptions

Exceptions are dental procedures that are outside the Program scope of benefits or procedures that require special consideration. Predetermination is mandatory. Requests must be sent to DPC and must be supported with a rationale and other supporting documentation as per the NIHB Program's policies. Claims submissions to ESC must be supported with a PD number.

5.6.5. Exclusions

Exclusions are dental procedures that are outside the mandate of the NIHB Program and will not be considered for coverage nor considered for appeal.

These services include:

- Veneers composite or ceramic
- All ceramic crowns including 3/4 crowns
- Teeth whitening
- Inlays/onlays in composite, precious metal or ceramic
- Sleep apnea appliances
- Temporomandibular joint therapy and appliances
- Fixed prosthodontics (bridges)
- Bruxism appliances.
- Crown lengthening
- Root re-sectioning
- Implants and any associated procedures
- Treatment for changing vertical dimension
- Bone grafts
- Ridge augmentation
- Complex dentures/partials
- Extensive rehabilitation
- Precision attachment partial dentures
- Fluorescent diagnostic light

5.7. 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 7.3 Dental Claim Statement Messages.

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 7.3 Dental Claim Statement Messages

5.8. Claims Payment when Billing Privileges Are Terminated

All requests for payment for claims prior to the termination of billing privileges must be made within one (1) year from the date of service. Claims with a service date on and subsequent to the date of termination are not eligible for payment to the provider.

5.9. 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 rejected.

6. Provider Audit Program

6.1. 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 billing/claim irregularities.
- Ensure that providers have retained the appropriate supporting documentation, meeting both provincial/territorial regulations as well as program requirements to support each claim.
- Ensure that services paid 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's terms and conditions.

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 ISC may refer the matter to the respective regulatory body.

6.2. Provider Responsibilities

The provider shall co-operate with Express Scripts Canada in all audit activities. Upon request, the provider shall grant access to its location to Express Scripts Canada to, 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.

6.3. Provider Audit Components

Express Scripts Canada contacts the provider at least three (3) weeks prior to the proposed onsite audit date. Every effort is made to accommodate the provider's schedule in determining the audit date. An audit confirmation letter is signed by the provider confirming the agreed- upon date of the onsite audit.

To carry out all audit components of the Program, Express Scripts Canada requires access to information including:

- Client chart/records
- Client radiographs
- Daily appointment records
- Study models
- External lab invoices
- Documentation of service received by the client
- Evidence of additional coverage (e.g., co-ordination of benefits)

6.3.1. Next Day Claims Verifications

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

6.3.2. Client Confirmation Program

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

6.3.3. 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.

6.3.4. Desk Audit Program

A desk audit 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.

6.3.5. On-Site Audit Program

An onsite audit consists of the selection of a sample of claims to be validated against client records through an onsite 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.

6.3.6. 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.

Clear and detailed appropriate documentation is required for verification against the Program's billing criteria. A procedure code or procedure name on its own 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.

6.3.7. Supporting Documentation

Dental providers must maintain a client chart/ record documenting and supporting the services provided, claimed and paid by Express Scripts Canada. A procedure code and/or name on its own are not sufficient as a client record to support payment.

Examples of appropriate supporting documentation include:

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.
- Documentation of condition to include 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.

6.3.8. Reference Documents

For Express Scripts Canada Provider Audit Program reference documents, refer to the:

- Annual report
- Enrolment form
- Dental newsletters
- Bulletins
- Dental Benefits Guide
- Regional Dental Benefit Grids

Providers may refer to the Enrolment Form, NIHB Dental Benefits Guide, and the dental newsletter (issued quarterly) located on the provider website at provider.express-scripts.ca.

For providers who do not have Internet access or email, may contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to Section 7.2 Provider Claims Processing Call Centre).

The annual report may be viewed and downloaded from the NIHB Provider website at provider.express-scripts.ca/annual_report.

6.3.9. Additional Audit Information

Providers requiring additional information about the Express Scripts Canada Provider Audit Program may contact Express Scripts Canada:

By phone

1 888 511-4666

By mail

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

7. Dental Claim Statement

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 rejected all during the current period. Rejected 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 in either English or French, depending on the provider's language of choice.

7.1. 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. Indicate the corrections to the claims directly below the existing information on the dental claim statement and forward the applicable page to Express Scripts Canada within twelve (12) months from the date of service for reprocessing of the claim. 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.

7.2. Dental Claim Statement – Electronic and Manual Claims

The dental claim statement includes all electronic claims, which were adjudicated during the current period. 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 processed and settled during the current period: paid, reduced, rejected and adjusted (and reversals).

7.3. Dental Claim Statement Messages

The HICPS system assigns three (3) 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 rejected.	W followed by two numeric characters.	Explains that the claim was adjudicated with modifications.

7.3.1. EDI Claims Submissions Messages and Explanations

For every submitted transaction, the system generates a CDAnet/ Réseau ACDQ, CDHAnet or DACnet response status code to indicate to the provider whether the transaction was accepted or rejected. Once accepted, any claim submitted using the EDI system is processed in a matter of seconds.

Messages/codes may be displayed to inform providers of the outcome of the transaction, either from CDAnet/ Réseau ACDQ, CDHAnet, DACnet™ and/or NIHB system.

When a claim cannot be submitted electronically, a claim acknowledgement is returned to the provider with the 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 rejected or accepted. CDAnet/ Réseau ACDQ, CDHAnet or DACnet error codes and text description may be displayed in the notes field.

7.3.2. Manual and EDI Claims Submission System Codes Messages and Explanations

Messages	Explanations
NIHB Code 048	
Message	Manual claim form must be submitted by the provider.
Explanation	Please submit the claim form manually. For more information, please refer to Section 4.1.1. Required Client Identification Numbers for Eligible First Nations Clients
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 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

Messages	Explanations
	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.
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 (1) 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.

Messages	Explanations
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	Claim does not match PD or line is on hold, transferred or denied.
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 NIHB DPC.
NIHB Code R29	
Message	This is an excluded benefit and cannot be considered for appeal.
Explanation	Dental procedures that are outside the mandate of the NIHB Program.
NIHB Code R30	
Message	Client has Alternative Coverage, Contact the NIHB DPC.
Explanation	The claim has not been paid because NIHB records indicate that the client has alternative coverage for the claimed procedure code. Contact the NIHB Dental Predetermination Centre for direction on where to submit the claim. Refer to canada.ca/en/indigenous-services-canada/corporate/contact-us-first-nations-inuit-health/non-insured-health-benefits.html for the phone number and address of the NIHB DPC.
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.
NIHB Code R32	
Message	Client has alternative coverage, contact Express Scripts Canada then submit manually.

Messages	Explanations
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

Messages	Explanations
	(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).
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 anesthesia 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.

Messages	Explanations
NIHB Code R49	
Message	Benefit requires Predetermination
Explanation	The claim has not been paid because it requires PD from NIHB.
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.
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 twelve (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	Internal lab fee disallowed or reduced to NIHB guidelines.
Explanation	The internal laboratory fee has been reduced or disallowed to conform to pricing guidelines. Refer to the applicable Regional Dental Benefit Grid.
NIHB Code W07	
Message	Commercial lab fee disallowed or reduced to NIHB guidelines.
Explanation	The commercial laboratory fee has been reduced or disallowed to conform to pricing guidelines. Refer to the applicable Regional Dental Benefit Grid.
NIHB Code W08	
Message	Laboratory Fees 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	

Messages	Explanations
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 payor 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.
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 NIHB. Refer to the Predetermination Confirmation letter for approved terms.
NIHB Code W30	
Message	Claim reduced from single to additional extraction, same quadrant.

Messages	Explanations
Explanation	The professional fee has been reduced to the amount allowed for an additional extraction in the same quadrant.
NIHB Code W32	
Message	Duplicate surface on previous claim. Payment limited to unique surfaces.
Explanation	The professional fee has been reduced to the unique surfaces.
NIHB Code W33	
Message	Professional fee has been adjusted according to NIHB Program 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.

8. Resources

8.1. Really Simple Syndication Fees

Really Simple Syndication (RSS) is a useful tool to receive updates from websites. Updates are broadcasted 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 Government of 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 cannot be viewed in an Internet browser since the formats are different. In order to receive RSS feeds, you must have an aggregator, or a feed reader. There are a number of free aggregator interfaces available online. In addition to availability on your computer, RSS feeds can also be read on mobile devices.

8.1.1. Adding an Aggregator

To add an 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.

8.1.1.1. Adding an Email Address to the RSS Service

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

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 email notices through an email RSS service:

1. Copy the .xml URL link.
2. Paste it into the email subscription page.

Websites

- Government of Canada, NIHB Program:

  canada.ca/nihb
- Express Scripts Canada, corporate website:

  express-scripts.ca
- Express Scripts Canada, NIHB claims services provider website:

  provider.express-scripts.ca

For more details on RSS feeds, visit open.canada.ca/en/rss-feeds

8.2. Provider Claims Processing Call Centre

The Provider Claims Processing Call Centre is available to enroll dental providers in the Program:

Phone Number
1 888 511-4666

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

8.3. 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

8.4. 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

9. 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, please contact:

Email

ExpressScriptsCanada_Privacy@Express-Scripts.com

Website

express-scripts.ca/about/privacy-policy

Telephone

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

Mail

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