Non-Insured Health Benefits (NIHB)

Medical Supplies and Equipment (MS&E) Claims Submission Kit

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NIHB MS&E 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

The information contained in this document is subject to change without notice. The data used in the examples are fictitious, unless otherwise noted.

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1. Introduction

1.1 Purpose of NIHB MS&E Claims Submission Kit

Express Scripts Canada's Non-Insured Health Benefits (NIHB) Medical Supplies & Equipment (MS&E) Claims Submission Kit (also referred to as the Kit) sets out the terms and conditions for the submission of claims under the Medical Supplies & Equipment Provider Agreement (referred to as the Agreement).

For NIHB Program policies please refer to the Guide for Medical Supplies & Equipment Benefits. The Guide for Medical Supplies and Equipment also lists website addresses to related forms.

The Kit is designed to help providers understand how the Express Scripts Canada's Health Information and Claims Processing System (HICPS) 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 completed 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 as required. A notification of Kit updates is posted on the NIHB Claims Services Provider Website of Express Scripts Canada (also referred to as the provider website) thirty (30) days prior to the circulation date.

All documents (announcements, Kit, Agreement, MS&E newsletters and the Guide for Medical Supplies & Equipment Benefits) are available on the provider website of Express Scripts Canada. 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 8.2.2. 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 of a conflict between the terms and conditions of the Medical Supplies and Equipment Provider Agreement and the terms and conditions of an annex or the Kit, the terms and conditions of the 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.

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 terms and conditions as set out in the Agreement, this Kit and the MS&E newsletters, which include without limitation:

- Provider Eligibility Requirements (Section 3 MS&E Provider Registration).
- Client Eligibility Requirements (Section 4 Client Identification and Eligibility).

- Requirements for Co-ordination of Benefits with Other Health Plans (Section 5.3 Co-ordination of Benefits).
- Submission Process and Supporting Documentation Requirements (Section 5 General Claims Submission Procedures).
- Benefit Coverage and/or Applicable Limitations (Section 5.7 Benefit Coverage and Limitations).
- Requirements to submit 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 6.3.5.6 Documentation Requirements for Audit Purposes).

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

- **Dispensing**

  The provider must dispense MS&E items to each client in accordance with all applicable laws and regulations, applicable Program policies, administrative requirements and procedures as stipulated in this Kit and the 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 and will be rejected.

- **Standards of Service**

  When providing MS&E benefits to clients, the provider acts in accordance with all applicable laws, and the standards of practice required by their 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 Benefit List and Kit**

  The provider and its personnel shall:

  - Co-operate with Express Scripts Canada's procedures for utilization review, as indicated in this Kit.
  - Comply with the applicable MS&E Benefit List when dispensing MS&E items to clients.

1.3.1. General Terms

The general terms and conditions governing the relationship between the provider and Express Scripts Canada are set out in the Agreement. Express Scripts Canada reserves the right to update this Kit at any time.

This Kit contains terms and conditions procedures for verifying benefit 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 Agreement and the Guide for Medical Supplies and Equipment Benefits.

1.3.2. Defined Terms

In addition to those terms throughout the Kit that 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
Benefit List – Medical Supplies & Equipment (MS&E)	The MS&E Benefit List is maintained by Indigenous Services Canada (ISC) and it 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, Kit and policies of the Program.
Client	A person who is eligible to receive NIHB MS&E items in accordance with the eligibility criteria in Section 4 Client Identification and Eligibility of the Kit.
Client Reimbursement (CR)	An NIHB approval to accept the claim made directly by a client or by another payor such as a band, parent or guardian who has paid for a rendered eligible MS&E benefit.
Coordination Co-ordination of Benefits (COB)	Clients covered by more than one health plan. If the plan does not pay the full amount of an expense, the claim can be submitted to the other plan for the balance.
Crown-Indigenous Relations and Northern Affairs (CIRNA)	Crown-Indigenous Relations and Northern Affairs is a federal department that was established in 2017.
Delisted Provider	A MS&E service provider who is no longer an eligible NIHB provider.
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 the details of the claims paid and not paid resulting from a request.

Term	Definition
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 Health Authority (FNHA)	In 2013, the British Columbia (BC) First Nations Health Authority (FNHA) assumed responsibility for the design, management and delivery of supplementary health benefits, including MS&E, to First Nations residing in BC.
First Nations and Inuit Health Branch (FNIHB)	FNIHB refers to the First Nations and Inuit Health Branch, which is part of the federal Department of Indigenous Services Canada (established in 2017). FNIHB was formerly part of Health Canada.
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.
Health Information and Claims Processing Services (HICPS) 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.
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.
Medical Supplies & Equipment (MS&E) 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.
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 and is made available to the providers. 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) Benefits	MS&E benefits, such as wheelchair equipment or walking aids listed on the MS&E Benefit List to clients. Refer to **Benefit List – MS&E**.

Term	Definition
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 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 NIHB Program, in whole or in part, from a provincial, territorial or first payor health care plan.
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.
Point of Service (POS) Technology	Point of service (POS) is the submission of a claim electronically when a MS&E benefit is provided.
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.
Prescriber ID	A number, as assigned by the respective provincial or territorial regulatory authority (where applicable), which a prescriber of medication, medical supplies or professional services uses to identify themselves.
Prescriber ID Reference	Providers must enter a two (2) character alphanumeric code called a prescriber identification (ID) code, which identifies the prescriber type. The prescriber type can be a physician, nurse practitioner, or any other licensed practitioner with authorization to prescribe within the scope of practice in his/her province or territory.
Prior Approval (PA)	A Program coverage confirmation issued by a FNIHB regional office to a provider to ensure that the provider is advised that the client is eligible for specific medical supplies and equipment benefits. The approval is issued primarily for items identified as requiring authorization before being billed to the Program.

Term	Definition
Provider Number	A unique reference number assigned to the provider as identification to facilitate the submission of claims for adjudication and to receive payment.
Special Authorization (SA)	A SA is an authorization that is provided for a client for a specified period of time. It allows providers to dispense and claim certain MS&E items without having to request a PA.
Usual and Customary (U&C) Price	Usual and customary (U&C) price is the lowest price of an MS&E Benefit, 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 Roles and Responsibilities of Express Scripts Canada

Express Scripts Canada administers HICPS 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 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 this Kit.

In the context of MS&E benefit management, Express Scripts Canada is not an insurance company, but is mandated to receive, verify and proceed with payment of, as applicable, all claims submitted electronically and manually by providers and clients through the Program. Express Scripts Canada also communicates and responds to providers' inquiries.

2.2 Indigenous Services Canada (ISC) NIHB Program

For details on ISC's NIHB Program, please consult the 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 8.2.2. 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 as defined in the Kit under Section 1.3 Terms and Conditions and Section 3.1 MS&E Provider Registration Process.

2.3.1. Client Reimbursement

MS&E providers are encouraged to submit claims directly to Express Scripts Canada so that clients do not incur charges at the POS when receiving MS&E services, as per definition in Section 5.3(1) of the Agreement. When a client pays directly for MS&E services, as defined in Section 1 (10) of the Agreement, the client may seek reimbursement for eligible benefits/amounts by completing and submitting a NIHB Client Reimbursement Request Form, within one (1) year from the date of service or date of purchase. The reimbursement may also be made to a third party, for example a band, a parent/guardian who paid for the services provided

The NIHB Client Reimbursement Request Form is located on the Government of Canada website at canada.ca/fr/sante-canada/services/sante-premieres-nations-inuits/services-sante-non-assures/information-prestations/formulaire-demande-remboursement-services-sante-non-assures-sante-premieres-nations-inuits-sante-canada.html.

All client reimbursements should be referred to the nearest FNIHB regional office with the exception of client reimbursements for First Nations clients residing in BC that should be referred to the FNHA offices. A listing of the FNIHB regional offices, as well as contact information for FNHA offices is located on the Government of Canada website at canada.ca/en/health-canada/corporate/contact-us/non-insured-health-benefits.html.

2.4 Health Information and Claims Processing Services System (HICPS)

HICPS is an electronic claims adjudication system that pays, processes or rejects claims as defined in Section 1 (2) of the Agreement based on Program policies, guidelines and criteria.

Once the manual claim is received and the data is keyed from the NIHB MS&E Claim Form, the claim is submitted for adjudication to the HICPS system. The system determines if the provider, client and claims are eligible. Depending on the action taken, the claim is either:

- Accepted (perhaps adjusted) and paid to the provider
- Returned to the provider as a result of insufficient information and/or due to ineligibility. A list of error messages and explanations are listed in Section 7.1 MS&E Claim Statement Messages. Please note that only pharmacy providers submitting MS&E claims will receive the messages.

3. MS&E Provider Registration

Providers wishing to submit claims for benefits provided to clients under the Program must register by fully completing and signing the 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.
- 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
  - MS&E Benefit List
  - MS&E newsletters
  - Various NIHB forms
  - Program policy information (Guide for Medical Supplies & Equipment Benefits)

3.1 MS&E Provider Registration Process

Providers wishing to submit claims for services provided 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 FNIHB 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 qualifications to dispense specialized MS&E items must indicate the applicable specialties on the Agreement. In addition, a photocopy of each diploma of certificate with seal of 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.

Where a provider employs individuals to dispense specialized MS&E services within their business, that provider is required to submit to Express Scripts Canada a copy of the diploma or certificate of each employee who will be providing such services, either at the time of registration and/or throughout the course of registration as a provider under the NIHB Program.

A copy of the Agreement can be located and downloaded from the NIHB claims services provider website at provider.express-scripts.ca. 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 8.2.2. Provider Claims Processing Call Centre).

3.1.1. Unique Provider Number

Upon registration 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 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.

3.2 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 ISC and/or Express Scripts Canada in a timely manner via the NIHB claims services provider website by email, fax or mail.

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

- Kit
- Guide for Medical Supplies & Equipment Benefits
- Fax broadcasts
- MS&E newsletters
- Broadcast messages via the MS&E claim statement
- MS&E Benefit 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 NIHB claims services provider website with the exception of claim statements.

3.3 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 email, 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 8.2.2. Provider Claims Processing Call Centre) to only change:

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

Providers can download a copy of the Modification to Pharmacy/Medical Supplies & Equipment Provider Information Form from the provider website at provider.express-scripts.ca and submit as indicated on the form. 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 8.2.2. 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 email, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to Section 8.2.2. Provider Claims Processing Call Centre).

There is also a need for the provider to submit a copy of each specialty certification in order for Express Scripts Canada and ISC 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 to 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.

3.4 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 thirty (30) 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 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 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 the provider's responsibility regarding Express Scripts Canada's Provider Audit Program activities. Please refer to Section 6 Provider Audit Program or other sections of the Agreement, as per section 11 (3) of the Agreement.

4. Client Identification and 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. 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 a registered Indian according to the Indian Act
- An Inuk recognized by one of the Inuit Land Claim organizations
- A child less than one (1) year of age, whose parent is an eligible client
    - For unregistered children over the age of one and under the age of 18 months, please call Regional office for assistance.

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.

Please note that to protect the client privacy, Express Scripts Canada is not responsible for providing a client identification number to the provider. The provider must obtain this number when verifying the identity of the client.

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 Non-Insured Health Benefits (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 (on 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 ESC 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 Registered 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.

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

Special identification provisions for children less than one (1) 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 (1) 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 CIRNA at 1 819 953-0960
Inuit residing 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 FNIHB regional office

The first MS&E claim for children under one (1) year of age, who do not have their own client number, 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 CIRNA, client or band/family number, FNIHB client identification number and 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.

4.5 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)

- First Nations Health Authority (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, including supporting documents, must be received by the NIHB Program within one (1) year from the date of service to be eligible for payment (refer to section 4.0 Payment and Reimbursement of the Guide for Medical Supplies and Equipment Benefits).

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 (2) 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 7.1 MS&E Claim Statement Messages

5.1 Claims Submission Options

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 email to download the PDF, please contact the Provider Claims Processing Call Centre to request a copy by fax or mail (refer to Section 8.2.2 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.

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

5.2 Claims Submission - Required Data Elements

The first MS&E claim for all children under one (1) year of age and do not have their own identification number 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.

Field Name	Description
Surname	The surname under which the client is registered as an eligible First Nations or recognized Inuit client.
Given Name	The given name under which the client is registered as an eligible First Nations or recognized Inuit client. Submission of more than one given name is preferred to facilitate client verification. Initials are not acceptable.
Date of Birth (YYYY-MM-DD)	Client's full birth date (in the correct year-month-day format). Partial birth dates are not acceptable.
Street 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 comprised of one of the following:

Field Name	Description
	• A ten (10) digit number currently issued to eligible First Nations clients by CIRNA. • A three (3) digit band number, immediately followed by the five (5) digit family number identifying the family unit within the eligible First Nations client's band. • An alpha prefix followed by an eight (8) digit number issued to certain registered First Nations and recognized Inuit clients by NIHB. • A health plan number issued to recognized Inuit clients by the Governments of NWT and Nunavut.
Band Number	A three (3) 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 (5) 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 (5) digits, the appropriate number of zeros in front of the number needs to be inserted.

5.2.1 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.
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 payor. 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 Fee	The total dollar amount claimed for all items (up to 10) listed on the Claim Form.

Field Name	Description
Prescriber ID	The prescriber ID as entered by the provider on the claim submission must be the same as required by the provincial/territorial health care Program.
Prior Approval Number	A prior approval number, which must be issued by the appropriate FNIHB regional office before the provider dispenses certain medical supplies and most medical equipment.

5.2.2 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.

5.2.3 Parent Information (Children Less than One Year of Age): Data Elements

A child under one (1) year of age, who has not been registered as a First Nations or recognized Inuit 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. All other requirements as described above in Section 5.2. Claims Submission - Required Data Elements should reflect the parent's information.

5.3 Co-ordination of Benefits

Some NIHB clients may have coverage provided through a provincial/territorial (e.g., Assistive Device Program) or private health care plan, 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 or the client is asked to communicate this to the FNIHB Regional Office so that the client's file can be updated.

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

5.4 Unclaimed Medical Supplies and Equipment Items

Any item that has not been picked up by a client may be partially reimbursed by the NIHB Program. This situation may arise if the client:

- Has passed away
- No longer requires the item due to a changed or improved condition
- is unable to pick up the item

The provider will return to stock allowable items, or dismantle the MS&E item, and invoice for only the custom-made parts that cannot be reused, as well as for professional fees incurred for the creation of the item.

If the item is a special order, the provider may be reimbursed for any re-stocking fees associated with sending the item back to the manufacturer. Please contact your local FNIHB regional office to initiate this process. Each submission will be reviewed on a case-by-case basis.

5.5 Prior Approval Process for MS&E Benefit

For MS&E items that require a Prior Approval (PA), providers are required to submit forms to their respective FNIHB regional office. The following describes the process. Providers must:

- Obtain the client's written prescription issued by a physician, a nurse practitioner or other health professional recognized by the Program. Consult the Guide for further information on recognized health professionals.
- Obtain client identification information as described in Section 4 Client Identification and Eligibility.
- Obtain a copy of any third-party coverage (e.g. workers' compensation board, private insurance etc.).
- Contact the FNIHB 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 FNIHB regional office.
- When required, complete the appropriate Prior Approval Form, and return it to the FNIHB 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 FNIHB regional office, submit the claim to Express Scripts Canada for reimbursement.

Note: PAs of a benefit are given through the FNIHB regional offices according to the price file or regional mark-up guidelines.

For additional information on the PA process, refer to the Guide located on the Government of Canada website at canada.ca/en/health-canada/services/first-nations-inuit-health/reports-publications/non-insured-health-benefits/guide-medical-supplies-equipment-benefits-non-insured-health-benefits-2017.html.

5.5.1 Confirmation Letter

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.

5.5.2 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.

5.5.3 Special Authorization Confirmation Letters

An approval may be given by ISC via a special authorization (SA) confirmation letter to the provider for specific items.

The confirmation letter of approval is sent directly to the provider, presenting:

- Item code
- Item name
- Eligibility
- Start date
- End date

In addition, the confirmation letter states: where indicated as eligible, please bill directly. Claims submitted against this SA will not be adjudicated correctly if the claim is submitted with a prior approval (PA) number with any additional comments. Please note that the PA number should not be included in the billing if there is an SA number assigned.

5.6 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 7.1 MS&E Claim Statement Messages.

5.7 Benefit Coverage and Limitations

For additional information on eligible benefits, Program limitations and services, as well as exceptions, please refer to the Guide for Medical Supplies & Equipment Benefits located on the Government of Canada website at: canada.ca/en/health-canada/services/first-nations-inuit-health/reports-publications/non-insured-health-benefits/guide-medical-supplies-equipment-benefits-non-insured-health-benefits-2017.html

Providers without access to the Internet may contact their respective FNIHB regional office to request a copy by fax or mail.

5.7.1 Medical Supplies and Equipment Benefit List

The MS&E Benefit List is a listing of the items eligible under the NIHB Program and includes pricing for some items. For more information, please visit canada.ca/en/health-canada/services/first-nations-inuit-health/non-insured-health-benefits/health-provider-information/medical-supplies-equipment-information/benefits-criteria.html.

5.7.2 Special Promotions, Coupons and Discounts

In situations where a promotion, coupon and/or discount applies to a client, providers must deduct their total value from the claim. The amount claimed through the Program must be the residual amount after application of any promotion, coupon and/or discount.

Please see the Guide for Medical Supplies and Equipment for complete policy (canada.ca/en/health-canada/services/first-nations-inuit-health/reports-publications/non-insured-health-benefits/guide-medical-supplies-equipment-benefits-non-insured-health-benefits-2017.html).

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.

6. Provider Audit Program

6.1 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 policies

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.

6.2 Provider Responsibilities

The provider shall co-operate 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 6.3.6. Reference Documents in this Kit.

6.3 Provider Audit Components

The Express Scripts Canada Provider Audit Program involves multiple components, as outlined below. To carry out the next day claims verification (NDCV) and onsite audit components of the Program, Express Scripts Canada requires access to information, including:

- Client's profile
- Original prescription
- Shipping invoices
- Internal invoices
- Manufacturers' invoices (to determine Actual Acquisition Cost and applicable mark-up)
- Documentation of item received by the client
- Evidence of additional coverage (e.g. co-ordination of benefits)
- Prior approval forms and confirmation document

6.3.1 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 by Express Scripts Canada 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.

6.3.2 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.

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

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.

6.3.5 On-Site Audit Program

The purpose of the onsite audit is to verify paid claims against client records through an onsite 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.

6.3.5.1 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 onsite 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)
- 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.

6.3.5.2 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.

6.3.5.3 Conduct of the Onsite Audit

The purpose of the onsite audit is to verify paid claims against MS&E records. 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.

6.3.5.4 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 given a high level summary of the audit observations as well as a checklist to complete and return to Express Scripts Canada. The checklist confirms that the audit process was conducted at the respective onsite audit and provides an opportunity for comments.

6.3.5.5 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 hold is placed against the provider's payment statements until recovery is paid in full.

6.3.5.6 Documentation Requirements for Audit Purposes

Providers must retain a copy of the original prescription and documentation on file for three (3) years or as long as it is being dispensed against, if longer than two (2) years in accordance with provincial/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.

6.3.5.7 Supporting Documentation

Proper documentation of any intervention is required for verification against the Program's billing criteria.

Examples of appropriate supporting documentation include:

- 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
- Prior approval forms
- Evidence of additional coverage (to support COB)
- Items awaiting pickup (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

6.3.6 Reference Documents

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

- NIHB annual report
- Agreement
- MS&E newsletters
- Guide for Medical Supplies & Equipment Benefits
- MS&E Benefits List

Providers may refer to the Agreement, Guide for Medical Supplies & Equipment Benefits, MS&E Benefit List, and the MS&E newsletters which are located on 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 8.2.2. Provider Claims Processing Call Centre).

The NIHB Annual Report may be viewed and downloaded from NIHB Claims Processing Provider website website at provider.express-scripts.ca/annual_report.

6.3.7 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

7. MS&E Claim Statement

The MS&E Claim Statement accompanies the claims payment cheque, and provides information about the 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, claims adjusted, 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 in either English or French, depending on the provider's language of choice.

7.1 MS&E Claim Statement Messages

A reject code, composed of an R followed by two (2) numeric characters and a text message, explains why the claim was rejected. A warning code, composed of a W followed by two (2) numeric characters and a text message, explains that the claim was adjudicated with modifications or warning is being sent to provider.

Reject Code		Warning Code	
R followed by two (2) numeric characters	Text message explains why the claim was rejected.	W followed by two (2) numeric characters	Text message explains the claim was adjudicated with modifications.

7.1.1 Codes, Messages and Explanations

The MS&E Claim Statement is generated for all claim submissions and includes all manually submitted claims which were adjudicated and settled during the current period: paid, reduced, rejected and adjusted (settled and reversed).

The following chart displays manual claims submission messages and explanations. *For pharmacy providers submitting claims for MS&E, please review the CPhA Pharmacy Claims Standard for code descriptions.*

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 previously paid claim. The match is based on the following data elements of date of

Messages	Description
	service, provider number, client number and item number.
NIHB Code R09	
Message:	Claim Does Not Comply with Terms of Spec Auth
Explanation:	This message is set for SA claims whose data elements do not match those specified in the SA or is excluded for coverage by the SA.
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	

Messages	Description
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 (1) 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 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:	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

Messages	Description
	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 FNIHB regional office
Explanation:	The claim has not been paid because FNIHB records indicate that the client has alternative coverage for the benefit. Contact the FNIHB regional office for direction on where to submit the 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 FNIHB regional office. Benefits which require a PA are indicated in MS&E Benefits List. For more details on PA procedures, refer to section 5.5 Prior Approval Process for MS&E Benefit
NIHB Code R50	
Message:	Quantity exceeds frequency limits

Messages	Description
Explanation:	The claim has not been paid because the frequency limit for the item has already been exceeded. Benefits with frequency limits are indicated in each of the benefit categories found in the MS&E Benefits List. For benefits with frequency limits that do not normally require a 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: R77/CPhA Code: A3	
Message	Rx# previously paid for same DOS Client - provider
Explanation	The payment has been denied because all the data elements match the data elements of a previously settled claim already on 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 (1) 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

Messages	Description
Explanation:	The amount claimed for the item cost has been reduced to 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 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 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 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.

7.2 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. Indicate the corrections to the claims directly below the existing information on the MS&E claim statement. 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.

7.3. 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 twice a month. 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.

8. MS&E Forms and Resources

8.1 MS&E Documents and Forms

All MS&E documents and forms listed below are available for download in PDF 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 8.2.2 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 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

8.2 Resources

8.2.1 Really Simple Syndication Feeds

Really Simple Syndication (RSS) feeds are 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 accurately 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.

8.2.1.1 Adding an Aggregator

To add an aggregator:

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

By either method, the feed will be available as soon as it has been added, and the next update could arrive at any given moment. To remove RSS feed updates, delete the feed or URL from your aggregator.

8.2.1.2 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 the 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:

- ISC, NIHB Program:
  canada.com/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

8.2.2 Provider Claims Processing Call Centre

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

Phone Number
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

8.2.3 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

8.2.4 Other Correspondence

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, contact:

Email
ExpressScriptsCanada_Privacy@Express-Scripts.com

Website
express-scripts.ca/privacy-policy

Telephone Number
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