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## **11. NIHB Dental Claims Submission Kit: Attachments**

### **11.1 Provider Statement - Dental Messages and Explanations**

The NIHB Health Information and Claims Processing Services (HICPS) system assigns three-character Reject and Warning Codes with messages that appear on the Provider Statement - Dental. A Reject Code, composed of an “R” followed by two numeric characters and a text message, explains why the Claim was rejected. A Warning Code, composed of a “W” followed by two numeric characters and a text message, explains that the Claim was adjudicated with modifications.

#### **11.1.1 Provider Statement – Dental**

The Provider Statement – Dental accompanies the Claims payment cheque or EFT notice and provides information about each Claim processed either electronically or manually. The statement may also provide additional Client identification information. If additional Client information is provided, it must be added to the Provider's records and used on all future Claim submissions.

Providers must allow Express Scripts Canada to reverse a Claim paid in error, subject to appeal. If not possible, Providers must issue a cheque payable to Express Scripts Canada within a negotiated timeframe. Cheques are to be made payable to the “Receiver General for Canada” for amounts owed to the NIHB Program for Claims administered by Express Scripts Canada. 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 Provider Statement – Dental are issued twice a month in either French or English depending on the Provider's language of choice.

#### **11.1.2 EDI Claim Submission: Provider Statement – Dental**

The Provider Statement - Dental generated with the EDI system includes all electronic Claims, which were adjudicated during the current period, as indicated to the Provider on the Explanation of Benefits (EOB). Claims which were not adjudicated in real-time due to a manual submission requirement or missing/ invalid data as well as Claims that have been reversed do not appear on the Provider Statement – Dental generated with the EDI system.

#### **11.1.3 Manual Claim Submission: Provider Statement – Dental**

The Provider Statement – Dental generated for manual submissions includes all manually submitted Claims which were adjudicated and settled during the current period: paid, reduced, rejected, pending, adjusted (settled pending and reversals); it also includes all suspended Claims entered in a previous reporting period and not yet settled.

## 11.1.4 EDI Claims Submission Messages and Explanations

For every submitted transaction, the system generates a CDAnet™/ DACnet™ and Réseau ACDQ 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 adjudicated in a matter of seconds.

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

- When a Claim cannot be adjudicated in real-time because of missing/ invalid data, a Claim acknowledgment is returned to the Provider with the CDAnet™/ DACnet™ and Réseau ACDQ response Status Code "R" indicating that the Claim is rejected because of errors. For every procedure line that has an error, a valid CDAnet™/ DACnet™ and Réseau ACDQ three-character numeric Error Code and text description are displayed.
- When a Claim cannot be adjudicated in real-time because it must be submitted manually, a Claim acknowledgment is returned to the Provider with the CDAnet™/ DACnet™ and Réseau ACDQ 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" NIHB message is generated as a result of the Claim adjudication, the EOB includes the NIHB "R" and "W" codes and message text (in the Notes field). In addition, NIHB messages on the EOB are also printed on the Provider Statement – Dental 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™/ DACnet™ and Réseau ACDQ Error Codes and text description may be displayed in the Notes field.

For additional information on the Claim acknowledgment, the EOB and the standard CDAnet™/ DACnet™ and Réseau ACDQ Codes, refer to the CDAnet™/ DACnet™ and Réseau ACDQ Dental Office User Guide. For HICPS Codes and messages, refer to the following chart of Manual Claims Submission Messages and Explanations:

<b>Manual Claims Submission Messages</b>	<b>Explanations</b>
<b>NIHB Code R04</b>	
Message:	This is not an eligible benefit.
Explanation:	The Claim has not been paid because the item is not covered under the NIHB Program.
<b>NIHB Code R05</b>	
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.
<b>NIHB Code R06</b>	
Message:	Client is not eligible for this benefit.
Explanation:	The Claim has not been paid because the claimed Procedure Code is not covered under the NIHB Program due to the age of the claimant.
<b>NIHB Code R07</b>	
Message:	This is a duplicate Claim.
Explanation:	The Claim has not been paid because it is a duplicate of a previously paid Claim.
<b>NIHB Code R10</b>	
Message:	Invalid Provider Number.
Explanation:	The Claim has not been paid because the Provider cannot be validated as an enrolled NIHB Provider.
<b>NIHB Code R12</b>	
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.

Manual Claims Submission Messages	Explanations
<b>NIHB Code R14</b>	
Message:	Insufficient benefit information to adjudicate Claim.
Explanation:	<p>The Claim has not been paid because it did not provide sufficient information to determine if the claimed procedure is eligible under the NIHB Program. At a minimum, this information must be provided on each Claim:</p> <ul style="list-style-type: none"> <li>a) Date of service.</li> <li>b) Procedure Code.</li> <li>c) Professional Fee.</li> </ul> <p>Check your Claim for missing or incomplete information and provide the required information.</p>
<b>NIHB Code R20</b>	
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 procedure. Direct the Claim to the appropriate plan.
<b>NIHB Code R21</b>	
Message:	Period for Submitting Claims has Expired.
Explanation:	The Claim has not been paid because the Claim was submitted more than one year after the service was rendered.
<b>NIHB Code R23</b>	
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.
<b>NIHB Code R24</b>	
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.
<b>NIHB Code R26</b>	
Message:	Predetermination Service Date Violation.
Explanation:	The Claim has not been paid because the date of service is either before the start date or after the end date of the PD approval. Check your records and submit correct information.
<b>NIHB Code R27</b>	
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.
<b>NIHB Code R28</b>	
Message:	Client, Provider or benefit details on Claim do not match the Predetermination Confirmation Letter.
Explanation:	The Claim has not been paid because the Client, Provider or benefit details on the Claim do not match those on the Confirmation Letter.

Manual Claims Submission Messages	Explanations
	If an error was made, supply the corrected information to Express Scripts Canada. If the PD requires amendment, contact the appropriate FNIH Regional Office.
<b>NIHB Code R30</b>	
Message:	Client has Alternative Coverage, Contact FNIH Regional Office.
Explanation:	The Claim has not been paid because FNIHB records indicate that the Client has alternative coverage for the claimed Procedure Code. Contact the FNIH Regional Office for direction on where to submit the Claim. Refer to the directory insert for the phone number and address of the FNIH Regional Office.
<b>NIHB Code R31</b>	
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. Contact Express Scripts Canada for direction on where to submit the Claim.
<b>NIHB Code R32</b>	
Message:	Client has alternative coverage, contact Express Scripts Canada then submit manually.
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. Contact Express Scripts Canada for direction on where to submit the Claim. When a third party payer has not reimbursed the full amount, a manual Claim may subsequently be submitted to NIHB. Contact the Provider Claims Processing Call Centre at 1-888-511-4666 (refer to Coordination with Other Health Care Plans).
<b>NIHB Code R35</b>	
Message:	Tooth condition conflicts with history.
Explanation:	<p>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:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• A Claim for space maintainer when a complete denture has been performed in the same arch.</li> </ul>
<b>NIHB Code R36</b>	
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. For example, 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

<b>Manual Claims Submission Messages</b>	<b>Explanations</b>
	with an older date of service.
<b>NIHB Code R37</b>	
Message:	Incorrect Procedure Code used.
Explanation:	The Claim has not been paid because the procedure conflicts with another paid procedure performed on the same date of service (for example, inhalation anaesthesia was claimed in combination with intravenous sedation) or the procedure does not match the number of surfaces claimed.
<b>NIHB Code R38</b>	
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.
<b>NIHB Code R39</b>	
Message:	Invalid Procedure Code.
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.
<b>NIHB Code R42</b>	
Message:	Associated dental procedure must be specified.
Explanation:	The Claim has not been paid because dental practitioners cannot submit an anaesthesia fee alone. If applicable, Claims for anaesthesia services must be accompanied by a Claim for an appropriate dental procedure performed on the same date of service.
<b>NIHB Code R43</b>	
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.
<b>NIHB Code R44</b>	
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 current NIHB Regional Dental Benefit Grid to determine which Procedure Codes may have associated laboratory fees. Expense Codes are not currently eligible under the NIHB Program.
<b>NIHB Code R45</b>	
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 current NIHB Regional

Manual Claims Submission Messages	Explanations
	Dental Benefit Grid to determine lab eligibility. Expense Codes are not currently eligible under the NIHB Program.
<b>NIHB Code R48</b>	
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.
<b>NIHB Code R49</b>	
Message:	Benefit requires Predetermination.
Explanation:	The Claim has not been paid because it requires PD from FNIHB.
<b>NIHB Code R50</b>	
Message:	Service claimed exceeds the maximum allowed.
Explanation:	The Claim has not been paid because the claimed Procedure Code exceeds the maximum allowed as specified in the current NIHB Regional Dental Benefit Grid.
<b>NIHB Code R66</b>	
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.
<b>NIHB Code W06</b>	
Message:	Lab fee disallowed or reduced to NIHB guidelines.
Explanation:	The laboratory fee has been reduced or disallowed to conform to NIHB pricing guidelines. Refer to the current NIHB Regional Dental Benefit Grid.
<b>NIHB Code W09</b>	
Message:	Professional Fee is Reduced to NIHB Pricing Guidelines.
Explanation:	The professional fee has been reduced to conform to NIHB Pricing Guidelines. Refer to the current NIHB Regional Dental Benefit Grid.
<b>NIHB Code W10</b>	
Message:	This is a Claim reversal. Contact Express Scripts Canada.
Explanation:	The Claim is a reversal of a previously settled Claim.
<b>NIHB Code W11</b>	
Message:	Claim Reduced to NIHB Share.
Explanation:	The claimed Procedure Code is partially covered by a provincial, territorial or third party plan. The amount claimed is reduced to the correct NIHB share.
<b>NIHB Code W12</b>	
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 specified in the current NIHB Regional Dental Benefit Grid.

Manual Claims Submission Messages	Explanations
<b>NIHB Code W13</b>	
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.
<b>NIHB Code W15</b>	
Message:	Alternate Procedure Code applied, refer to the NIHB schedule.
Explanation:	The Claim has been adjudicated using an alternate Procedure Code. Refer to the current NIHB Regional Dental Benefit Grid.
<b>NIHB Code W17</b>	
Message:	Claim adjusted to comply with terms of Predetermination.
Explanation:	The amount claimed is reduced to comply with the terms of PD set out by FNIHB. Refer to the Predetermination Confirmation Letter for approved terms.
<b>NIHB Code W27</b>	
Message:	Pre-verification for this item has been used up by previous Claim.
Explanation:	The Pre-verification Number for the claimed Procedure Code has been used up by a previously paid Claim.
<b>NIHB Code W28</b>	
Message:	Pre-verification service date violation.
Explanation:	The Pre-verification Number is invalid because the date of service is either before the date of the issuance of the Pre-verification Number or is more than six months after the date of issuance of the Pre-verification Number.
<b>NIHB Code W29</b>	
Message:	Pre-verification Number is invalid.
Explanation:	The Pre-verification Number is invalid for the specified Client and benefit.
<b>NIHB Code W30</b>	
Message:	Claim reduced from single to additional extraction, same quadrant.
Explanation:	The professional fee has been reduced to the amount allowed for an additional extraction in the same quadrant.
<b>NIHB Code W31</b>	
Message:	Reduced to maximum surfaces allowed per tooth including previous Claim.
Explanation:	More than five surfaces have been submitted for this tooth with the same date of service (including previous Claims). The professional fee has been reduced so that the total payment for the current and previous Claims is limited to the amount allowed for five surfaces.
<b>NIHB Code W32</b>	
Message:	Duplicate surface on previous Claim. Payment limited to unique surfaces.

Manual Claims Submission Messages	Explanations
Explanation:	One or more of the claimed surfaces has already been paid for the same Procedure Code, tooth, and date of service. The professional fee has been reduced to ensure that the total payment for the current and previous Claim is limited to the number of unique surfaces. For example, if for the same Procedure Code and tooth, surfaces MO have been paid and surfaces OD are claimed, the professional fee allowed is reduced so that the total payment for the current and previous Claims is limited to the amount allowed for the three unique surfaces.

## 11.2 Submission Options and Mandatory Data to be Submitted in Dental Claims

### 11.2.1 Submission Options

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

All NIHB Claims submitted using the EDI system are either accepted or rejected in real-time; there are no pended Claims. Two types of messages are generated for Claims submitted using the EDI system: Canadian Dental Association (CDA<sup>net</sup>™), Denturist Association of Canada (DAC<sup>net</sup>™) and Réseau Association des chirurgiens dentistes du Québec (ACDQ) Error Codes and NIHB HICPS Codes and messages.



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

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

#### 11.2.1.1 Claims Excluded from the Electronic Data Interchange System

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

The EDI system does not support:

- Requests for PD (must be submitted manually to the appropriate First Nations Inuit Health (FNIH) Regional Office) (refer to [Section 11.3.1 Standard Documentation and Information Required for Predetermination](#)).
- Requests for Post Determination (must be submitted manually to the appropriate FNIH Regional Office). For a copy of the Predetermination Confirmation Letter, visit the NIHB Claims Services Provider Website at [www.provider.express-scripts.ca/](http://www.provider.express-scripts.ca/)

- Claims over thirty days old (must be submitted manually to Express Scripts Canada). For a copy of the Submission Options and Mandatory Data to be Submitted in Dental Claims, visit the NIHB Claims Services Provider Website at [www.provider.express-scripts.ca](http://www.provider.express-scripts.ca)
- Reversals after the date of original submission (must be submitted manually to Express Scripts Canada; refer to *Manual Claims Submission*).
- Orthodontic incremental Payment Codes (must be submitted manually to Express Scripts Canada; refer to *Selected Billing Rules*).
- Claims for Clients under the age of consent which are not payable to the dentist (must be submitted manually to Express Scripts Canada).
- Claims payable to a third party such as a parent or guardian (must be submitted manually to Express Scripts Canada).
- Co-ordination of benefits (COB) Claims (must be submitted manually to Express Scripts Canada); refer to *Coordination with Other Health Care Plans*.
- Claims for Procedure Codes not listed on vendor's software (must be submitted manually to Express Scripts Canada).

### 11.2.2 Electronic Data Interchange (EDI) – Required Data Elements

The Required Data Elements Table applies only to Claims submitted via EDI:

Field ID	Description
<b>A02</b>	
Field Name	Office Sequence Number
Non-Insured Health Benefit Description	A number assigned by and under the control of the dental office software provided by the software vendor
<b>A03</b>	
Field Name	Format Version Number.
Non-Insured Health Benefit Description	A two-digit code identifying the Version of the CDAnet™/DACnet™ and Réseau ACDQ standard software used on the dental office software: Only Format Version Number 04 is acceptable for NIHB Claims.
<b>A04</b>	
Field Name	Transaction Code.
Non-Insured Health Benefit Description	A two-digit code usually assigned automatically by the dental office software to indicate the purpose of a transaction. Valid NIHB Codes are: <ul style="list-style-type: none"> <li>• 01 - Claim</li> <li>• 11 - Claim Acknowledgement</li> <li>• 21 - Explanation of Benefits</li> <li>• 02 - Reversal</li> <li>• 12 - Reversal Response</li> </ul>

<b>Field ID</b>	<b>Description</b>
<b>A05</b>	
Field Name	Carrier Identification Number.
Non-Insured Health Benefit Description	This six-digit unique number identifies the Claims Processor who receives the transaction. In most cases, numbers are assigned automatically by the dental office software provided by the software vendor. The Carrier Identification Number or BIN Number for NIHB dental claims transmission to Express Scripts Canada is 610124.
<b>B01</b>	
Field Name	CDA Provider Number.
Non-Insured Health Benefit Description	This unique nine-digit number has been assigned to you by CDA, and must be included in every transaction.
<b>B02</b>	
Field Name	Provider Office Number.
Non-Insured Health Benefit Description	This four character identifier has been assigned to you by CDA, and must be included in every transaction.
<b>C01</b>	
Field Name	Primary Policy/ Plan Number.
Non-Insured Health Benefit Description	This six-digit unique number identifies the Client's insurance policy number. In most cases, numbers are assigned automatically by the dental office software provided by the software vendor. The policy/ group number for NIHB dental Claims transmission to Express Scripts Canada is 080000 (leading "0" is mandatory).
<b>C02</b>	
Field Name	Subscriber Identification Number.
Non-Insured Health Benefit Description	The unique number used to identify a Client who is eligible to receive benefits under the NIHB Program.
<b>C05</b>	
Field Name	Patient's Birthday
Non-Insured Health Benefit Description	The Client's full birth date in correct format.
<b>C06</b>	
Field Name	Patient's Last Name.
Non-Insured Health Benefit Description	The surname under which the Client is enrolled as a Client.
<b>C07</b>	
Field Name	Patient's First Name.
Non-Insured Health Benefit Description	The given names under which the Client is enrolled

Field ID	Description
	as a Client. Submission of more than one given name is preferred to facilitate Client verification. Initials are not acceptable.
<b>D05</b>	
Field Name	Subscriber's Address Line 1.
Non-Insured Health Benefit Description	First line of Client's address.
<b>D06</b>	
Field Name	Subscriber's Address Line 2.
Non-Insured Health Benefit Description	Second line of Client's address, if applicable.
<b>D07</b>	
Field Name	Subscriber's City.
Non-Insured Health Benefit Description	The Client's city of residence.
<b>D08</b>	
Field Name	Subscriber's Province.
Non-Insured Health Benefit Description	The Client's province of residence.
<b>D09</b>	
Field Name	Subscriber's Postal Code.
Non-Insured Health Benefit Description	The Client's postal code.
<b>F01</b>	
Field Name	Payee Code.
Non-Insured Health Benefit Description	This field determines who should be paid. Valid Codes are: 1 - Pay to Client (subscriber). 2 - Pay to other third party. 3 - Reserved. 4 - Pay to dentist.
<b>F03</b>	
Field Name	Predetermination Number.
Non-Insured Health Benefit Description	For a Claim that has been predetermined and approved in part or in full, the PD Number indicated on the FNIHB Confirmation Letter must be entered. When a PD Number is entered on an EDI Claim document, all Claim lines on the document must pertain to the entered PD Number.
<b>F07</b>	
Field Name	Procedure Line Number.
Non-Insured Health Benefit Description	The line number of the procedure in the Claim submission. The line number is preserved in the Claim response. In most cases, this number is assigned automatically by the dental office software provided by the software vendor.

Field ID	Description
<b>F08</b>	
Field Name	Procedure Code.
Non-Insured Health Benefit Description	Valid CDA Procedure Codes can be submitted.
<b>F09</b>	
Field Name	Date of Service.
Non-Insured Health Benefit Description	The date on which services were provided to the Client in the date format YYYY-MM-DD (for example, 1999-07-13 represents 1999 July 13). For procedures requiring more than one appointment, where an insertion is required, the date of service must be the date when the service was inserted. Contact your FNIH Regional Office if insertion cannot occur. For procedures requiring more than one appointment that do not require an insertion, the date of service must be the date when the service was completed.
<b>F10</b>	
Field Name	International Tooth, Sextant, Quad or Arch.
Non-Insured Health Benefit Description	The international Tooth Number, Quadrant, Sextant or Arch Code corresponding to the procedure for which Tooth Number, Quadrant, Sextant or arch description is mandatory.
<b>F11</b>	
Field Name	Tooth Surface.
Non-Insured Health Benefit Description	The Surface Code corresponding to a procedure for which surface description is mandatory.
<b>F12</b>	
Field Name	Dentist's Fee Claimed.
Non-Insured Health Benefit Description	The dollar amount claimed for professional services.
<b>F13</b>	
Field Name	Lab Procedure Fee # 1.
Non-Insured Health Benefit Description	The first lab Procedure Code if lab costs are associated with the claimed professional procedure.
<b>F34</b>	
Field Name	Lab Procedure Code # 1.
Non-Insured Health Benefit Description	The dollar amount claimed for the first lab Procedure Code, if applicable.
<b>F35</b>	
Field Name	Lab Procedure.
Non-Insured Health Benefit Description	Code # 2. The second lab Procedure Code associated with the claimed professional procedure, if applicable. May not be available as an input field on all dental office

Field ID	Description
	software.
<b>F36</b>	
Field Name	Lab Procedure.
Non-Insured Health Benefit Description	<p>Fee # 2.</p> <p>The dollar amount claimed for the second lab Procedure Code, if applicable. If Lab Procedure Code #1 and Lab Procedure Code #2 are entered on the Claim submission, they are added together for lab fee adjudication purposes and the lab fee allowed is returned as the amount allowed for lab procedure fee # 1.</p>

### 11.2.3 NIHB Dental Claims Requirements

Claims can be submitted manually on:

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

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

#### NIHB Dental Claim Form (Dent-29)

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

- Provider payment.
- Client Reimbursements (CR).
- Claims payable to a third party.

A NIHB Dental Claim Form (Dent-29) can only be submitted for a Post Determination, PD, Claim submission or a CR. Do not combine different types of requests on a single NIHB Dental Claim Form (Dent-29).

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

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

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

## 11.2.4 NIHB Required Data Elements

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

### Claim Information (Provider to Complete) Field Names and Descriptions



Client or parent/ guardian signature field should be completed.

Field Name	Description
<b>Client Surname</b>	The surname under which the Client is enrolled as a Client.
<b>Given Names</b>	The given names under which the Client is enrolled as a Client. Submission of more than one given name is preferred to facilitate Client verification. Initials are not acceptable.
<b>Address</b>	The complete address of Client. Submissions that do not indicate the complete Client address including postal code are rejected.
<b>Provider Number</b>	The full unique nine-digit Provider Number assigned to the dental practitioner by Express Scripts Canada must appear on the Claim Form. Submissions that do not indicate the complete Express Scripts Canada Provider Number may be rejected.
<b>Provider Address</b>	A stamp with the Provider address is acceptable. Submissions that do not indicate the complete Provider address may be rejected.
<b>For Provider Use Only</b>	Additional information pertaining to the submission may be noted here.
<b>Pay Client/ Guardian</b>	This box is checked when the payee is other than the Provider.
<b>Payee Address</b>	This information must be provided if the payee address is different from the Client address or when the Client is under the age of consent.
<b>Office Verification/ Signature of Provider</b>	An original Provider signature or Provider name stamp is acceptable. The signature or stamp must be that of the Provider who has performed or will perform the procedure, and must match the dental practitioner's unique Provider Number indicated on a form.
<b>Date of Service</b>	The date on which services were provided to the Client in date format (YYYY-MM-DD) (for example, 1999-07-13 represents 1999 July 13). For procedures requiring more than one appointment, where an insertion is required, the date of service must be the date on which the appliance was inserted. Contact your FNIH Regional Office if insertion cannot occur.  For procedures requiring more than one appointment that do not require an insertion, the date of service must be the date when the service was completed.

Field Name	Description
<b>Procedure Code</b>	The Procedure Code corresponding to the applicable dental procedure.
<b>International Tooth Code</b>	The international Tooth Number, Quadrant, Sextant or Arch Code corresponding to the procedure for which Tooth Number, Quadrant, Sextant or arch description is mandatory.
<b>Tooth Surfaces</b>	The Surface Code corresponding to a procedure for which surface description is mandatory.
<b>Professional Fee</b>	The dollar amount claimed for professional services.
<b>Laboratory Fee</b>	The dollar amount charged for lab work. A photocopy of the lab receipt, attached to the Claim, may be required.
<b>Total Fee</b>	The total dollar amount charged for the procedure or service performed (professional fee plus laboratory fee).
<b>Predetermination Number (PD)</b>	For a Claim that has been predetermined and approved in part or in full, the PD indicated on the FNIHB Confirmation Letter must be entered beside the corresponding Claim line.  A Claim Form may be used to Claim for predetermined services, provided the appropriate PD Numbers are indicated beside the corresponding Procedure Code.
<b>FNIH(B) Approved (To Be Completed by FNIH(B))</b>	When FNIH(B) has reviewed a request for PD: YES = Predetermination has been granted. NO = Predetermination has been denied. N/A = Procedure does not require Predetermination. AC = Internal FNIHB Code.
<b>Total Fee Submitted</b>	This is the sum total dollar amount of all procedures submitted.

**CLIENT INFORMATION (Provider to Complete)**

Field Name	Description
<b>Client Identification Number</b>	Unique number used to identify a Client who is eligible to receive benefits under the NIHB Program.
<b>Band Number</b>	Three-digit Band Number only applicable to First Nations Clients.
<b>Family Number</b>	Four or five-digit number only applicable to First Nations Clients.
<b>Client's full birth date</b>	Date format YYYY-MM-DD format (for example, 1992-05-19 represents 1992 May 19).

**ADDITIONAL INFORMATION (Provider to Complete)**

Field Name	Description
a)	Are any dental benefits or services provided under any other group insurance or dental plan, Workmen Compensation Board, government plan or if a result of an accident, motor vehicle or accident insurance plan? - These answers are mandatory on all submissions.
b)	Are there any missing teeth? - These answers are mandatory on all types of submissions including Claims.

**PREDETERMINATION INFORMATION (FNIH to Complete)**

Field Name	Description
	Approved/ Not Approved - The submission is approved or not approved. FNIHB Authorizing Officer - FNIHB checks the CR box if it is a Client Reimbursement and enters the authorizing officer number, date and signature.

**11.3 Predeterminations**

Certain dental procedures require PD from FNIH(B). The current NIHB Regional Dental Benefit Grid outlines those procedures requiring PD (Schedule B). Post determinations for basic and emergency services may be considered.

If FNIHB is to assume any financial obligation, PD must be obtained, prior to the commencement of the service for, but not limited to, these benefits:

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

When the Client requires services which require PD, Providers **must** submit the orthodontic requests manually to the Orthodontic Review Centre and all other requests manually to the appropriate FNIH Regional Office with applicable supporting documents. The coordinates of either office can be found at the back of the NIHB Dental Claim Form (Dent29).

If there are any dental benefits or services provided under any other group insurance or dental plan, Workers Compensation Board (WCB), government plan or, if a result of an accident, a motor vehicle or accident insurance plan, the Provider is obliged to attach all details about the third party carrier, and documentation such as EOB and PDs.

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

For post-determinations (where the service has already been rendered), the third party EOB must accompany the Claim Form to allow for coordination of benefits. If there is any missing teeth information, it must be recorded for all types of submissions. All requests for PD must be submitted to the appropriate FNIH Regional Office. Requests for PD that are submitted to Express Scripts Canada are returned to the Provider.

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

### **11.3.1 Standard Documentation and Information Required for Predetermination**

Complete Standard Dental Claim Form, or ACDQ Dental Claim and Treatment Form, or computer generated form, or NIHB Dental Claim Form (Dent-29); Current radiographs: must include Periapical Films specific to the requested treatment and, bitewings or panoramic radiographs, identifying the Client and Provider; these must be mounted, dated and of acceptable diagnostic quality. Whenever duplicate radiographs are submitted, the Provider must indicate on the radiograph whether the radiograph is on the right or left side of the Client's mouth;

- Comprehensive treatment plan from the treating dentist and/ or referring dentist addressing all treatment needs for the mouth.
- Notation of all missing teeth.

Charting documentation must support procedures claimed to NIHB. Radiographs are considered current for PD if dated within one year of the PD submission.

For scaling, root planning (scaling/ polishing, prophylaxis in Quebec), PD is mandatory and charting documentation must support procedures exceeding the limit of four units within a twelve (12) month period.

#### **Confirmation Letters for Predetermination**

Once services have been adjudicated by FNIH(B), the PD Confirmation Letter is issued.

### **11.3.2 Post Determination**

When dental services normally requiring PD are rendered in emergency or under specific situations (NIHB Dental PD - Post Determination) Providers must complete a Claim Form clearly indicating the special circumstances in the box marked "For Provider Use Only - For Additional Information, Diagnosis, Procedures, or Special Consideration". Providers must indicate "Post Determination" on the Claim Form. In addition, Providers must complete all mandatory data elements and manually submit the request form to the appropriate FNIH Regional Office. Post Determination requests cannot be submitted electronically using the EDI system. A Confirmation Letter is issued in post determination situations.

All requests for post determination must be submitted to FNIH Regional Office, together with any supporting documentation (refer to the above Section Standard Documentation and Information Required for Predetermination). If the Client has Other Coverage, an EOB from the primary carrier must accompany the Claim Form to allow for coordination of

benefits. If the primary carrier's dollar contribution toward this treatment is less than current provincial/ territorial fee guide rate, the dollar contribution by FNIHB is the difference to the maximum current provincial/ territorial fee guide rate.

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

### **11.3.3 Operational Requirements of Predetermination for the NIHB Program include FNIHB, Provider and Client Responsibilities**

#### **11.3.3.1 FNIH(B) Responsibilities**

- Ensure that PDs are adjudicated within ten (10) working days from date of receipt of complete information.
- Communicate with Providers and their associations in order to ensure the efficient and expedient PD of dental treatment plans and to provide relevant program information, benefit clarification and NIHB Program issues when necessary.
- Communicate with First Nations and Inuit clients and their associations in order to enhance the understanding of issues associated with the NIHB Program, benefit information or clarification and to ensure awareness of the appeal process available to their members.

FNIH(B), including Regional Dental Officers/ Dental Consultants is obliged to address anomalies in treatment, billing and policy administration by Providers. Substantiated concerns are to be handled in consultation with NIHB Head Quarters (HQ)/ Express Scripts Canada, provincial/ territorial Dental Regulatory Authorities (DRA) and other organizations as required.

#### **11.3.3.2 Provider Responsibilities**

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

#### **11.3.3.3 Client Responsibilities**

- Maintain an optimum oral health standard in order to retain all dental services provided to them.

- Review the Claim contents after completion of the services.
- Initiate the Appeal process for reconsideration of denied treatment.

### 11.3.4 Predetermination Definitions

Term	Description
<b>Appeal Process</b>	This is a Client-initiated process seeking reconsideration of treatment denial by Regional Dental Office/ Dental Consultant or the Orthodontic Review Centre (ORC). In each of the three levels of appeal (Regional Dental Officer/ NIHB Manager, Regional Director, Director General NIHB) (for Orthodontic level 1 – Director, BRSD, level 2 Director BMD, level 3 Director General NIHB. The supporting information submitted is reviewed by Dental Consultants (Dental Specialists, Dentist or Denturist where relevant). The decision is based on the specific needs of the Client condition, accumulated scientific research, the availability of alternatives and NIHB Policy.
<b>Complete Treatment Plan</b>	This is a document that identifies the complete dental needs of a Client.
<b>Dental Auxiliaries/ Support Staff</b>	These are individuals who provide assistance to the Regional Dental Officer/ Dental Consultant to expedite the PD process by ensuring that each dental submission is supported by the appropriate information and documentation required to make an informed decision.
<b>Exceptions</b>	These are procedures that are outside the NIHB scope of benefits or procedures that require special consideration.
<b>Exclusions</b>	These are dental benefits that are outside the mandate of the NIHB Program and cannot be provided nor considered for appeal.
<b>"P"</b>	This is the identifier that indicates a Procedure Code requiring PD as identified in the current NIHB Regional Dental Benefit Grid.
<b>Post Approval</b>	An approval that may be granted under specific circumstances by FNIH Regional Office after treatment has been rendered.
<b>Predetermination</b>	<p>This is a specific authorization given by FNIH Regional Office to allow the Claims processing contractor to pay for certain NIHB eligible services, such as:</p> <ul style="list-style-type: none"> <li>• Schedule B.</li> <li>• Schedule A services for which a frequency limit has been reached.</li> </ul> <p>This is a review by FHIHB of the proposed treatment plan submitted to the Regional Dental Officer/ Dental Consultant prior to the commencement of treatment and includes a proposed dollar cost and relevant treatment information. Schedules A and B are included with the NIHB Regional Dental Benefit Grids located on the NIHB Claims Services Provider Website at</p>

Term	Description
	<a href="http://www.provider.express-scripts.ca">www.provider.express-scripts.ca</a>
<b>Predetermination Requirement</b>	Any treatment that exceeds frequency limitations (Schedules A & B), and procedures that are identified in the current NIHB Regional Dental Benefit Grid with a "P" (Schedule B).
<b>Provider</b>	A dental professional enrolled with Express Scripts Canada (i.e., Dentist, Denturist).
<b>NIHB Regional Dental Benefit Grid</b>	This is a document that outlines the dental benefits covered by the NIHB Program and is based on the Canadian Dental Association Uniform System of Coding & List of Services, and ACDQ, FDSQ, DAC.
<b>Treatment Plan Review</b>	This is the comprehensive review and adjudication by FNIH(B) of the treatment plan submitted to achieve the Client's optimal dental health.
<b>Process of Predetermination</b>	Each request is reviewed on an individual basis. In reviewing requests, cases are evaluated against the NIHB Program's established Dental Policy Framework which clearly outlines and defines the types of benefits available to Clients and their coverage. If NIHB is to assume any financial obligation for the coverage of eligible dental services, the Client's condition must meet all of the established guidelines and criteria of functionality and restorability. All basic treatment needs must be addressed before major procedures are requested (for example, crowns). A complete treatment plan must outline all needs of the Client.

## 11.3.5 Billing for Predetermined Treatment

### 11.3.5.1 EDI Claim Submissions – Predetermined Treatment

Although PD requests cannot be submitted using the EDI system, the resulting Claims may be submitted electronically. When submitting a Claim for predetermined services using the EDI system, 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.

### 11.3.5.2 Manual Claim Submissions – Predetermined Treatment

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

### **11.3.5.3 Restrictions – Predetermined Treatment**

The details on the Claim submission must match the details on the Predetermination Confirmation Letter (for example, Client identifiers, Procedure Codes, Tooth Numbers, Surface Codes, Quadrant, Sextant or Arch Codes). A "+L" indicated on the Predetermination Confirmation Letter beside the "Maximum Amount Approved" column indicates that a lab fee has also been approved. Only the Provider that has requested and received the Predetermination Confirmation Letter is eligible to Claim for payment. Claims submitted against a PD where details do not match the information on the Predetermination Confirmation Letter are rejected with Message R27 - Predetermination Number is invalid or R28 - Client, Provider or Benefit Details on Claim do not Match PD Letter.