Health Canada Santé Canada

Canada

Dental Health Provider Information

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This section sets out the policies and procedures for health providers on the coverage of non-insured health benefits. It contains information describing the claim submission/payment procedures and the Terms and Conditions for dental, pharmacy, medical supplies and equipment services. It also describes the process involved in health provider audits.

Administration of the Non-Insured Health Benefits Program

The authority for the Non-Insured Health Benefits (NIHB) Program is based on the 1979 Indian Health Policy which describes the responsibility for the health of First Nations as shared amongst various levels of government, the private sector and First Nations communities. As a result of this shared responsibility, when a benefit is covered under another plan, the federal government requires the coordination of benefits to ensure that the other plan meets its obligations.

Health Canada's First Nations and Inuit Health Branch (FNIHB) is responsible for the policy and management of the Non-Insured Health Benefits (NIHB) Program.

First Canadian Health (FCH), pursuant to a contract with Public Works and Government Services, administers the Health Information and Claims Processing System (HICPS) for dental, medical supplies and equipment (MS&E) and pharmacy benefits on behalf of the NIHB Program. That responsibility encompasses all aspects of dental, MS&E and pharmacy benefits processing and payment of claims and extends to verification, recovery, and administrative audit where deemed appropriate.

As such, FCH has the authority and responsibility to ensure that claims paid on behalf of Health Canada for services provided to First Nations and Inuit clients are made in accordance with the Terms and Conditions of the NIHB Program.

As a provider, it is important that you read and understand the Terms and Conditions of the Program. The submission of a claim by you indicates your understanding and acceptance of the Terms and Conditions of the NIHB Program. Provider non-compliance with these Terms and Conditions may result in

suspension or removal of your billing privileges under the NIHB Program as well as any recovery mechanisms that may be required.

For further information call the Non-Insured Health Benefits Toll-Free Inquiry Centre to speak with a First Canadian Health Representative.

Privacy

The Non-Insured Health Benefits (NIHB) Program of Health Canada recognizes an individual's right to control who has access to his or her personal information and the purpose for which that information will be used. The NIHB Program is committed to protecting an individual's privacy and safeguarding the personal information in its possession.

When a request for benefits is received, the NIHB Program collects, uses, discloses and retains an individual's personal information according to the applicable privacy legislation. The information collected is limited only to information needed for the NIHB Program to provide and verify benefits and to ensure that claims paid on behalf of Health Canada for services provided to First Nations and Inuit clients are in accordance with the terms and conditions of the NIHB Program.

As a program of the federal government, the NIHB Program must comply with the *Privacy Act*, the *Canadian Charter of Rights and Freedoms*, the *Access to Information Act*, Treasury Board policies and guidelines including, the Treasury Board of Canada Government Security Policy, and the Health Canada Security Policy. The NIHB Privacy Code addresses the requirements of these acts and policies.

Objectives of the NIHB Privacy Code:

- To set out the commitments of the NIHB Program to ensure confidentiality through responsible and secure handling of personal information collected for program delivery, administration and management; and
- To foster transparency, accountability, and increased awareness of the NIHB Program's privacy procedures and practices.

The Non-Insured Health Benefits Privacy Code is based on the ten principles set out in the Canadian Standards Association, Model for the Protection of Personal Information (The CSA Model Code) which is also schedule 1 to the *Personal Information Protection and Electronic Documents Act (PIPEDA)*, commonly regarded as the national privacy standard for Canada.

Provider Registration

Providers wishing to provide services to NIHB clients must register with FCH. The provider start date in the NIHB Program is established on the date of registration with FCH as an NIHB provider. The provider end date in the NIHB Program is established on the date the provider notifies FCH in writing that the provider no longer chooses to be an NIHB provider or on the date stated in the letter issued by FCH informing the provider of the effective date of delisting.

Claims with a service date prior to the start date or subsequent to end date are not eligible for payment.

Date Format

The date format in use throughout the NIHB Health Information and Claims Processing System (HICPS), including the outputs from that system such as the Claims Statement, will reflect this date format:

DD/MM/CCYY
DD = day in numerical format
MM = month in numerical format
CCYY = year in numerical format (must be '18', '19'or '20')

Example:
July 21, 2001 = 21/07/2001
May 4, 1999 = 04/05/1999

Providers Start and End Dates

The start date is the effective date the provider became a registered NIHB provider with FCH. The end date is the date that the provider's registration record is closed or the provider's billing privileges is terminated either by FCH or by the provider. Termination must be confirmed in writing.

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

Non-Insured Health Benefits/First Canadian Health Provider Number

Dental providers will be assigned an individual provider number upon registration. However, Pharmacy and MS&E providers will only be assigned an individual provider number upon signing the First Canadian Health Management Corporation Inc. Pharmacy/MS&E Provider Agreement. The individual provider number must be used when submitting all claims for payment and in all communication with FCH.

Changing Provider Information

All providers may contact the Non-Insured Health Benefits Toll-Free Inquiry Centre to obtain a copy of the Provider Information Form for any of these situations:

- Registration and termination;
- Request to submit claims using the Electronic Data Interchange (EDI) or Point of Service (POS) system;
- Registration of an additional office for dental providers;
- Change of current information (e.g. address); and
- Start, change or stop electronic funds transfer.

The form is faxed for completion by providers. However, providers may choose to have the NIHB Toll-Free Inquiry Centre Representative complete the form over the phone on their behalf.

Pharmacy and MS&E providers wishing to change any of the provider information communicated upon registration may use the Sample Modifications to Pharmacy/MS&E Information form.

Terms and Conditions

These are the terms and conditions which apply to all services covered under the Non-Insured Health Benefits (NIHB) Program to which a health provider must adhere in order to be eligible for payment for services rendered:

- Client eligibility requirements;
- Provider licensure and eligibility requirements;
- Benefits covered and/or applicable limitations;
- Coordination with other health plans;
- Documentation submission process and requirements;
- Maintenance of relevant documentation and records; and
- Administrative Provider Audit Program.

Note: For Dental Only - use of treatment codes and standard definitions based on the Canadian Dental Association's Uniform System of Coding and list of services.

Program policy and claim submission/payment information will be made available to providers through:

- Regular updates on this Web site;
- Non-Insured Health Benefit Bulletins;
- Non-Insured Health Benefit Newsletters; and
- Ad Hoc broadcast messages.

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

Visit the Resources and Forms for access to NIHB contact information, bulletins, newsletters, notices and much more.

Client Identification

To facilitate verification, all client identification information must be provided for each claim and request for pre-verification, predetermination and prior approval:

- Surname (under which the client is registered);
- Given names (under which the client is registered);
- Date of birth (dd/mm/yyyy); and
- Client identification number.

All Non-Insured Health Benefits (NIHB) claims, predeterminations and prior approvals are verified to ensure that client eligibility requirements are met. Claims, predeterminations and prior approvals with missing client identification information are returned to the provider for completion.

It is highly recommended that clients present their identification card on each visit to the provider to ensure that the client information is entered correctly and to protect against mistaken identity.

For infants under one year of age who do not have an acceptable client identification number, please refer to Special Provisions for Infants Under One Year of Age (Not applicable to dental benefits).

Client Identification Information:

- Eligible First Nations
- Recognized Inuit
- Neonatal Clients (applicable only to dental benefits)
- Infants Under One Year of Age (not applicable to dental benefits)

Excluded Individuals
Advance Verification of Eligibility
Benefits Provided Through First Nations and Inuit Organizations

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Client Identification Numbers for Eligible First Nations

Provision of one of these identifiers is required for eligible First Nations clients (including registered Indians under the terms of the *Indian Act*):

i. INAC Number (also known as the Department of Indian Affairs of Northern Development (DIAND), Treaty or Status Number) - This is a 10-digit number issued by Indian and Northern Affairs Canada (INAC), formerly known as DIAND, to all eligible First Nations clients. The INAC number is the preferred method of identifying First Nations clients. This number is made up of:

   - The first 3 digits identify the band to which the client belongs;
   - The next 5 digits identify the client's family unit within the band; and
   - The last 2 digits identify the client's position in the family (for example, 01, 02, and 03).

ii. **Band Number and Family Number** - If an INAC number is not available, a band name or number and family number may also be used as client identification.

iii. **First Nations Inuit Health Branch (FNIHB) Client Identification Number (B-Number)** - In specific and exceptional cases, some clients may have numbers issued by FNIHB. This number begins with the letter"B" and is followed by 8 digits.

Client Identification Numbers for Recognized Inuit

Providing one of these identifiers is required for recognized Inuit clients:

i. **Government of the Northwest Territories (GNWT) Health Care Number** - Inuit clients from the Northwest Territories may present a Health Care Number issued by the Government of the Northwest Territories. This number is valid in any region of Canada and is cross-referenced to the FNIHB client identification number. This number begins with the letter "T" and is followed by 7 digits.

ii. **Health Care Number** - Inuit clients from Nunavut may present a Health Care Number issued by the Government of Nunavut. This number is valid in any region of Canada and is cross-referenced to the FNIHB client identification number. This is a 9-digit number starting with a "1" and ending with a "5".

iii. **FNIHB Client Identification Number (N-Number)**- This is a client identification number issued by FNIHB to recognized Inuit clients. This number begins with the letter "N" and is followed by 8 digits.

Neonatal Clients (Dental)

For dental services only, providers must contact the appropriate FNIHB Regional Office for neonatal clients.

Special Provisions for Infants Under One Year of Age (Not applicable to dental benefits)

Health Canada established special client identification provisions for infants less than one year of age. These provisions are in place to allow adequate time for parents eligible for benefits under the NIHB Program to register their newborn children on the appropriate register (for eligible First Nations clients) or list (for recognized Inuit clients).

To register an infant:

- **For eligible First Nations clients** , parents should be referred to their Band Office or the Registration Services Unit of the Department of Indian and Northern Affairs Canada (INAC) at (819) 953-0960;
- **For Inuit residing in the Northwest Territories and Nunavut**, parents should be referred to their respective territorial Department of Health and Social Services; and
- **For Inuit residing outside of the Northwest Territories and Nunavut**, parents should be referred to the nearest FNIHB Regional Office.

Infants under one year of age who do not have an acceptable client identification number may be eligible to receive benefits from the NIHB Program if one of the infant's parents can be verified as an eligible client (not applicable to dental benefits).

If a client identification number is not available for infants under one year of age, this information must be provided to receive benefits:

- Infant's surname, given names, and date of birth; and
- Parent's registered surname, given names, and date of birth and client identification number.

Note: To avoid benefit access rejection, parents must obtain a client identification number for the infant prior to the infant's first birthday.

Excluded Individuals

These individuals are excluded from the NIHB Program. Requests to access NIHB benefits for these individuals should be submitted to the appropriate facility:

- First Nations and Inuit clients incarcerated in a federal, provincial, territorial or municipal corrections facility are the responsibility of the correctional facility; and
- Children in the care of provincial social service agencies are the responsibility of the province.

Advance Verification of Eligibility

Providers may verify client eligibility in advance of providing services by contacting the Non-Insured Health Benefits Toll-Free Inquiry Centre.

Non-Insured Health Benefits Provided Through First Nations and Inuit Organization

The mandate of the NIHB Program is to provide non-insured health benefits to eligible clients in a manner that facilitates First Nations and Inuit control within a timeframe to be determined in consultation with them. This is currently being tested under several agreements with First Nations and Inuit organizations.

Providers are notified, through the quarterly NIHB Newsletters when individual First Nations or Inuit organizations assume responsibility for the delivery of the NIHB Program. At that time, members of those groups receive benefits through their First Nations or Inuit organizations rather than through the NIHB Program. Providers are directed to the appropriate First Nations or Inuit organizations for further information.

These First Nations/Inuit Organizations have assumed responsibility for the delivery of pharmacy, MS&E and dental benefits:

- Akwesasne Band #159
- Bigstone Cree Nation #458
- Labrador Inuit Health Commission
- Miawpukek (Conne River) Band #047
- Nisga'a Valley Health Board
- Gingolx (Kincolith) #671
- Gitakdamix (New Aiyanish) #677
- Lakalzap (Greenville) #678
- Gitwinksilkw (Canyon City) #679

Dental Information

The Non-Insured Health Benefits (NIHB) dental program funds for its eligible clients a broad range of dental care, including:

- Diagnostic services like examinations or x-rays;
- Preventive services like cleanings;
- Restorative services like fillings;
- Endodontics such as root canal treatments;
- Periodontics or the treatment of gums;
- Prosthodontics including removable dentures and fixed bridges;
- Oral surgery including the removal of teeth;
- Orthodontics to correct irregularities in teeth and jaws; and
- Adjunctive services, which include additional services such as sedation.

Dental services must be provided by a licensed dental professional such as a dentist, dental specialist or denturist.

The Billing and Payment section contains valuable information on terms and conditions for funding, billing methods, selected billing rules, dental claims payment and methods of payment.

The Policies and Procedures section outlines the dental benefit conditions, pre-verification and predetermination, the coordination with other health plans and much more.

Related Resources

Terms and conditions for funding are contained in the:

- Dental and Orthodontic Bulletins;
- Dental Policy Framework; and
- The NHIB Regional Dental Benefit Grid which contains a complete list of the individual services. If you are a health professional and would like a copy for your region, please contact the Non-Insured Health Benefits Toll-Free Inquiry Centre

Visit the Resources and Forms section for contact information, forms and additional useful resources.

Policies and Procedures

The dental care benefits are available to eligible First Nations and recognized Inuit clients only when all of these conditions are met:

The procedure is ordered or performed by a qualified dental practitioner who is legally able to practice their profession in the province or territory of Canada in which the service is rendered;

- Predetermination, when required, has been provided by First Nations Inuit Health Branch (FNIHB);
- The procedure is not available to the Non-Insured Health Benefits (NIHB) client under a provincial, territorial or third- party health care plan; and
- The client is a resident in Canada and is covered or eligible to be covered under the provincial/territorial medical program.

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Benefit Descriptions and Conditions

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Dental Care Benefits

For a complete list of eligible benefits, benefits with NIHB Program limitations and services requiring predetermination, refer to the current *NIHB Regional Dental Benefit Grid* based on the *Canadian Dental Association Uniform System of Coding & List of Services.* To obtain a copy, providers must call the Non-Insured Health Benefits Toll-Free Inquiry Centre.

Alternate Benefits

FNIHB provides for alternate benefits under the NIHB Program in four situations, namely:

- Four and five-surface amalgam/tooth coloured primary tooth restorations exceed the cost of stainless steel/polycarbonate crowns in most provincial and territorial fee schedules. As the NIHB Program limits payment of primary tooth restoration to the cost of stainless steel/polycarbonate crowns, four and five-surface restorations on primary teeth are defined as eligible benefits. Claims are reimbursed at levels equivalent to stainless steel/polycarbonate crowns as an alternate benefit.

- Fixed prostheses are not eligible benefits under the NIHB Program. However, a client is entitled to removable prosthetics as a defined benefit once per arch in any ninety-six (96) month period. If **all** prosthetic requirements within an arch are addressed, using fixed prosthetic codes listed in the current *NIHB Regional Dental Benefit Grid,* FNIHB provides an alternate benefit at a maximum allowable fee payable which is equivalent to the cost of removable prosthetics including estimated laboratory costs. An estimate for the laboratory portion of this benefit has previously been factored into maximum allowable fee payable; therefore, laboratory fees are not in addition to the fees indicated. The maximum allowable fee payable is determined using regional reimbursement rates. In all cases, predetermination is required before treatment begins.

- Bonded amalgams are not eligible benefits under the NIHB Program. However, where bonded amalgam codes are submitted for predetermination purposes, the maximum allowable fee payable is determined using the fees associated with the non-bonded amalgam as an alternate benefit.

- Where a client has one or more implants and requires a complete over denture (tissue borne, supported by implants with no attachments), the NIHB Program may fund the implant supported dentures 51721 (in Quebec 51931) (maxillary), 51722 (in Quebec 51932) (mandibular) and 51723 (combined) at the rate for the standard over dentures (tissue borne, supported by natural teeth with no attachments); procedure codes, 51711 and 51712 and 51713 respectively. The NIHB Program will provide an alternate benefit at a maximum dollar value equivalent to the cost of a standard removable prosthesis including estimated laboratory costs. The maximum dollar value is determined using regional reimbursement rates. In all cases, predetermination is required before treatment begins.

Filling Limitations

In permanent anterior, cuspid, and posterior restorative situations, when, at the same sitting, in order to conserve tooth structure, separate amalgam/tooth coloured restorations are performed on the same tooth, the fee must be determined by counting the total number of surfaces restored. The maximum allowable for amalgam/tooth coloured restoration is five surfaces per tooth.

Replacement of restorations within a two-year time frame is subject to audit and reviews by the Regional Dental Officer/Dental Consultant and requires a written rationale.

Laboratory Fee Submission

Most dental services requiring laboratory work must be predetermined.

Laboratory fee submissions not associated with a valid procedure code where a lab is allowed are rejected unless an exception has been granted through the predetermination process.

For the administrative requirements on Electronic Data Interchange and Manual claim submissions, please refer to Billing Methods.

Prescribing Drugs for NIHB Clients (Lowest Cost Alternative)

The NIHB Pharmacy Program pays for required drugs prescribed by a dentist. The program provides reimbursement for the "lowest cost alternative" - that is, the lowest cost drug available with exactly the same active ingredient as the drug originally prescribed.

If it is decided that a certain drug is needed and it is not eligible under the NIHB Program, pharmacists are familiar with the existing process to bill for exceptions.

The Drug/Pharmacy Information section provides detailed information on the NIHB Pharmacy Program.

General Anaesthesia and Facility Claims

General anaesthetic services are normally limited to children under twelve years of age and predetermination is required. All other situations require predetermination and submissions must indicate any systemic condition or special circumstance necessitating the use of this modality. In addition, the details of the dental treatment to be provided must be submitted for predetermination purposes.

Predetermination is required for all requests for facility fees and such requests are normally limited to clients under twelve years of age. This service is for the provision of dental and anaesthetic facilities including equipment and supplies when provided by a separate anaesthetist for a visiting client and their dentist. If facility fees or anaesthesia is payable by the provincial/territorial medical plan, claims must not be submitted to the NIHB program for payment.

Extensive treatment required for children under the age of twelve or for medically-compromised individuals may be post approved where the client cannot be treated in the normal clinical setting.

Intravenous or Inhalation Sedation

Intravenous sedation cannot be claimed in combination with inhalation sedation.

Recording Missing Teeth Information Prior to Treatment

All missing teeth information must be recorded on all predetermination submissions.

See Billing Methods provides information on EDI and manual claims submissions for missing teeth administrative requirements for EDI and manual claim submissions.

Predetermination: Responsibilities, Services and Definitions

Predetermination is a needs based method for the administration of dental benefits, designed to ensure that individual clients receive dental services in a timely manner. Previously, eligible dental benefits for

clients were based on a frequency limitation model, which sometimes made it difficult for clients with specific dental problems to access all the services they needed at a given time.

Operational requirements of predetermination for the NIHB Program include FNIHB, provider and client responsibilities:

FNIHB Responsibilities for Predetermination

- Ensure that predeterminations are adjudicated within ten (10) working days from date of receipt of complete information;
- Communicate with dental providers and their associations in order to ensure the efficient and expedient predetermination of dental treatment plans and to provide relevant program information, benefit clarification and NIHB Program issues when necessary; and
- Communicate with First Nations and Inuit people 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.

FNIHB, 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 headquarters/FCH, provincial/ territorial Dental Regulatory Authorities (DRA) and other organizations as required.

Provider Responsibilities for Predetermination

- Discuss with the client their dental needs 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 FNIHB with the appropriate supporting documentation for predetermination 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 predetermination outcome; and
- Provide a referral letter when the client requires specialist services (for example, endodontic, periodontal, prosthodontic, etc.). This referral letter must outline any specific outstanding treatment requirements.

Client Responsibilities for Predetermination

- 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; and
- Initiate the Appeal Process for reconsideration of denied treatment.

Predetermination Services

Emergency Dental Services

Emergency Dental Services do not require predetermination and in most instances can be forwarded directly to FCH for payment. Routine procedures are not normally part of Emergency Dental Services.

Emergency Dental Services consist of:

- Diagnosis of specific acute dental problems including associated examination and radiographs;
- Prescriptions, sedative fillings, incision/open and drainage, pulpectomy, pulpotomy and dental extractions;
- Procedures to arrest haemorrhage of dental origin including, but not limited to, dressings, packing of tooth sockets and sutures, if initial procedure was performed by another dentist; and
- Preliminary care of trauma to the mouth including treatment in hospital under general anaesthesia/sedation (excluding provincial/territorial insured services).

See Billing Methods for information on EDI and manual claim submissions for Emergency Dental Services administrative requirements.

Post Approval Services

Post approvals may be considered for certain basic or emergency services (for example, basic services, biopsies, orthodontic extractions, urgent denture repairs (one per prosthesis per 12 month period), new carious lesion(s) discovered after predetermination has been received, children receiving treatment under general anaesthetic, extraction of acutely infected and impacted teeth requiring general anaesthesia, recall examinations or specific examinations with minor procedures which exceed frequency limitations.

Post approvals must be sent to the applicable FNIHB Regional Office - not directly to FCH. Following an evaluation, FNIHB converts the post approval to a claim and forwards it to FCH for payment. If coordination of benefits applies, the Explanation of Benefits (EOB) from the third party carrier must accompany the request for post approval.

Diagnostic Services

- When a complete examination is provided it replaces the recall examination for the period.
- When an examination is performed, another examination, without an appropriate explanation, will not be approved if conducted within the same office/group.

- A specific/emergency examination requires supportive justification and association with a non-preventive dental service (for example, extraction and one radiograph).
- Emergency procedures do not require predetermination but must be submitted to the FNIHB Regional Office with supporting radiograph(s) for post approval, indicating the treatment provided.
- Diagnostic radiographs must accompany every treatment plan.
- All radiographs submitted with a treatment plan must be recent, mounted, dated and of diagnostic quality. Also, the provider name and the client name must be indicated on the mount. 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.

Preventive Services

Supporting radiographs, periodontal charting and rationale are required for scaling/root planning (scaling/polishing - prophylaxis in Quebec) exceeding the limit of 4 units within a twelve (12) month period.

Restorative Services

An approved treatment plan for restorative services may be altered by:

- Contacting the FNIHB Regional Office, by telephone/fax; or
- Submission of a new predetermination form for the procedure.

In anterior, cuspid, and posterior restorative situations, when, at the same sitting, in order to conserve tooth structure, separate amalgam/tooth coloured restorations are performed on the same tooth, the fee is determined by counting the total number of surfaces restored. The maximum allowable for amalgam/tooth coloured restoration is five surfaces per tooth.

Replacement of restorations within a two (2) year time frame is subject to audit and requires a rationale. A report is reviewed by the Regional Dental Officer/Dental Consultant who follows up, as required.

All crowns require predetermination and all submissions must state a rationale for placement supported by radiograph(s). All other restorative, periodontal and surgical treatment must be completed prior to crown fabrication/placement.

Endodontics

Requests for root canal therapy must be supported by current diagnostic radiograph(s) and comments on the client's current oral health status, periodontal condition and past history.

According to the *Canadian Dental Association Uniform System of Coding & List of Services* , root canal therapy includes the treatment plan and the clinical procedures (for example, pulpectomy, biomechanical preparation, chemotherapeutic treatment and obturation) with appropriate radiographs.

Examples:

- If a pulpectomy/pulpotomy and/or open and drain is performed by the same provider/office within a three (3) month time period on a tooth for which root canal therapy is approved, the fee for the pulpectomy/pulpotomy and/or open and drain must be deducted from the final root canal therapy fee upon claim submissions by the provider.

- The final root canal therapy fee includes temporary restoration and replacement of any temporary restoration for a period of three (3) months post treatment.

Prosthodontics - Removable

Predeterminations from providers for removable partial dentures require supporting radiographs of the abutment teeth. All restorative/periodontal/surgical treatment must be completed prior to partial denture fabrication. If a replacement is required within the eight (8) year specified time frame; FNIHB requires the circumstances and a narrative containing the supporting rationale for consideration of replacement.

Prosthodontics - Fixed

Fixed prostheses are not eligible benefits under the NIHB Program. However, a client is entitled to removable prosthetics as a defined benefit once per arch in any ninety-six (96) month period.

If **all** prosthetic requirements within an arch are addressed, using fixed prosthetic codes listed in the current *NIHB Regional Dental Benefit Grid,* FNIHB provides an alternate benefit at a maximum allowable fee payable which is equivalent to the cost of removable prosthetics including estimated laboratory costs.

An estimate for the laboratory portion of this benefit has previously been factored into the maximum allowable fee payable; therefore, laboratory fees are not in addition to the fees indicated.

The maximum dollar value is determined using regional reimbursement rates. In all cases, predetermination is required before treatment begins.

Orthodontics

The predetermination of orthodontic benefits is required for assessment purposes by the Orthodontic Screening Committee. All assessments are based on the NIHB Orthodontic Guidelines.

Guidelines for Orthodontic Benefits as determined by NIHB

NIHB considers supporting the cost of orthodontic treatment for eligible First Nations and Inuit clients when all eight of these conditions apply:

1. The malocclusion is significant and functionally handicapping;
2. All preliminary dental treatment (periodontal and restorative) has been completed;
3. The client is caries-free and has demonstrated consistently good oral hygiene;
4. This is the appropriate time for the proposed treatment to be provided;
5. The client is less than 18 years of age at the time of the case being submitted for assessment;
6. The client and the parent/guardian have attended the treatment conference appointment, provided the consent and demonstrated a commitment to the plan;
7. A completed Orthodontic Summary Sheet, a Canadian A*** Orthodontic (CAO) Standard Orthodontic Information Form, or letter with all the required information on the orthodontist's letterhead, as well as a completed claim form must accompany the records; and
8. The overall cost of multiple phases of treatment does not exceed the total fee of what must be charged for a malocclusion of similar severity treated in one phase.
9. If in the provider's judgement oral health is being compromised or if there are non-compliance issues, the provider must discontinue treatment and advise NIHB in writing.

Adjunctive Services

General anaesthetic service is limited to children under twelve years of age and predetermination is required. All other situations require predetermination and submissions must indicate any systemic condition or special circumstance necessitating the use of this modality. In addition, the details of the dental treatment to be provided must be submitted for predetermination purposes.

Predetermination is required for all requests for facility fees and such requests are normally limited to clients under twelve years of age. This service is for the provision of dental and anaesthetic facilities including equipment and supplies when provided by a separate anaesthetist for a visiting client and their dentist. If facility fees or anaesthesia is payable by the provincial/territorial medical plan, claims must not be submitted to the NIHB Program for payment.

Extensive treatment required for children under the age of twelve or for medically-compromised individuals, may be post approved where the client cannot be treated in the normal clinical setting.

Predetermination Definitions

Listed below in **alphabetical order** are the predetermination terms and definitions used by the NIHB Program.

Appeal Process
: This is a client-initiated process seeking reconsideration of treatment denied by a Regional Dental Officer/Dental Consultant. In each of the three levels of appeal (Regional Dental Officer/NIHB Manager, Regional Director, Director General, NIHB), the supporting information submitted is reviewed by dental consultants (dental specialist, dentist or denturist where relevant). The decision is based on the specific needs of the client, accumulated scientific research, the availability of alternatives and NIHB policy.

Complete Treatment Plan
: This is a document that identifies the complete dental needs of a client.

Dental Auxiliaries/Support Staff
: These are individuals who provide assistance to the Regional Dental Officer/Dental Consultant to expedite the predetermination process by ensuring that each dental submission is supported by the appropriate information and documentation required to make an informed decision.

Exceptions
: These are procedures that are outside the NIHB scope of benefits or procedures that require special consideration.

Exclusions
: These are dental benefits that are outside the mandate of the NIHB Program and cannot be provided nor considered for appeal, for example:

    Implants;
    Veneers; and
    Ridge augmentation.

"P"
: This is the identifier that indicates a procedure code requiring predetermination as identified in the current *NIHB Regional Dental Benefit Grid*.

Post Approval
: This is an approval that may be granted under specific circumstances by the Regional Dental Officer/Dental Consultant after treatment has been rendered.

Predetermination

This is a review by FNIHB 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.

Predetermination Requirement

Any treatment that exceeds frequency limitations, and procedures that are identified in the current NIHB Regional Dental Benefit Grid with a "P".

Provider

A registered dentist or denturist.

NIHB Regional Dental Benefit Grid

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.*

Treatment Plan Review

This is the comprehensive review and adjudication by the Regional Dental Officer/Dental Consultant of the treatment plan submitted to achieve the client's optimal dental health.

Process of Predetermination

Each treatment plan is reviewed on an individual basis. In the review, consideration is given to the client's oral hygiene status, motivation, periodontal condition, dental history, NIHB policy and any other comments provided.

All basic treatment needs must be addressed before major procedures are requested (for example, crowns and fixed or removable prostheses). Extensive rehabilitation is not covered under the program.

A complete treatment plan must outline all needs of the client. Payment is made within the parameters of the NIHB Program, [for example, exam, radiographs, restorative, endodontic, periodontal, prosthetic, surgical, minor (cross-bite correction, habit breaking) orthodontic (if under the age of 18) and any adjunctive requirements]. The treatment plan must include a notation of treatment in progress.

Pre-Verification and Predetermination

Frequency Limitations - Pre-verification

A pre-verification service is available to ensure claims are not rejected for frequency limitation violations. The NIHB Toll-Free Inquiry Centre can pre-verify a procedure which does not require predetermination from FNIHB but which is identified as having a frequency limitation in the current *NIHB Regional Dental Benefit Grid*.

Providers are strongly encouraged to contact the Non-Insured Health Benefits Toll-Free Inquiry Centre to obtain a pre-verification number before performing a frequency-limited procedure.

To issue a pre-verification number, the FCH NIHB Toll-Free Inquiry Centre requires the:

Provider name and unique identification number;
Client identification number (the Client Identification section provides details);
Client surname, given name(s), date of birth; and
Procedure code (and where applicable tooth code, tooth surface, quadrant, sextant or arch code).

If the provider, client and procedure are valid under the NIHB Program and the proposed procedure does not exceed the frequency limitation, then a pre-verification number prefixed by the letter "V" is issued.

Where a pre-verification number has been obtained but the client decides not to have this service performed, the provider must contact the Non-Insured Health Benefits Toll-Free Inquiry Centre.

Predetermination

Certain dental procedures require predetermination from FNIHB. The current *NIHB Regional Dental Benefit Grid* outlines those procedures requiring predetermination. Post approvals for basic and emergency services can be considered (NIHB Dental Predetermination - Post Approval).

If FNIHB is to assume any financial obligation, predetermination must be obtained for these benefits:

- Orthodontic services;
- Fixed and removable prostheses;
- All "Independent Consideration" (IC codes) procedures;
- Crowns;
- Endodontic services (root canal treatment, periapical procedures);
- General anaesthetic and facility charges; and
- Any other items identified with a "P" in the current *NIHB Regional Dental Benefit Grid.*

When the NIHB client requires services which necessitate predetermination, providers **must** submit the request manually to the appropriate FNIHB Regional Office.

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 to the claim form all details about the third party carrier, and documentation such as EOB and predeterminations.

Coordination of benefits for orthodontic treatment is applied at the time of predetermination. 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. Providers **must** attach the third party coverage response at the time of predetermination.

For post-approvals (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 predetermination submissions.

All requests for predetermination **must** be submitted to the appropriate FNIHB Regional Office. Refer to the *Directory* insert for contact information. Requests for predetermination that are submitted to FCH are returned to the provider.

FNIHB reviews the predetermination request. If any requested procedure is not approved, or if additional information is required, FNIHB returns the original claim form and/or confirmation letter.

Once services have been approved a letter confirming predetermination is issued. The letter states the start and end date for each procedure line, the predetermination number and relevant approval details.

Predeterminations are valid for one (1) year from the start date with the exception of comprehensive orthodontic predeterminations, which are valid until the end date of case completion. Claims are rejected where the date of service is after the end date of the predetermination.

Submission of Supporting Documentation for Predetermination

Diagnostic radiographs and any relevant information must accompany every treatment plan. All radiographs submitted with a treatment plan must be recent, mounted, dated and of diagnostic quality. Also, the provider name and the client name must be indicated on the mount. 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.

Predeterminations for scaling/root planing (scaling/polishing -- prophylaxis -- in Quebec) exceeding the limit of 4 units within a twelve (12) month period, require supporting radiographs, periodontal charting and a rationale.

Predetermination requests for endodontics must be supported by current diagnostic radiographs and comments on client's current oral health status and periodontal condition.

Confirmation Letters for Predetermination

Once services have been approved by FNIHB, the Sample Predetermination Confirmation Letter is issued.

Post Approval

When dental services normally requiring predetermination are rendered in emergency or under specific situations (NIHB Dental Predetermination - Post Approval) 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 Approval" on the claim form. In addition, providers must complete all mandatory fields and manually submit the request form to the appropriate FNIHB Regional Office. Post approval requests cannot be submitted electronically using the EDI system.

All requests for post approval **must** be submitted to FNIHB, together with any supporting documentation (see Submission of Supporting Documentation to 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 fee guide rate, the dollar contribution by FNIHB is the difference to the maximum current provincial fee guide rate.

A confirmation letter is issued in post approval situations. Complete adjudication details are included on the provider's next NIHB Dental Claim Statement, including a payment if applicable, provided all relevant documentation has been received.

Province Codes and Provider Numbering

FCH has adopted the provincial coding system used by the Canadian Dental Association (CDA) for determining the unique 9-digit provider numbering system in use throughout Canada.

The FCH Province Codes are:

" **01** " - Newfoundland
" **02** " - Prince Edward Island
" **03** " - Nova Scotia
" **04** " - New Brunswick
" **05** " - Quebec
" **06** " - Ontario
" **07** " - Manitoba
" **08** " - Saskatchewan
" **09** " - Alberta
" **10** " - British Columbia
" **11** " - Northwest Territories
" **12** " - Yukon
" **13** " - Nunavut

Unique 9-digit provider numbers begin with one of the 2-digit numbers depending on the province where the practice is located.

For provinces where incorporation is allowed, the number 50 is added to the provincial number (for example, 01 + 50 = 51 for Newfoundland and 12 + 50 = 62 for Yukon).

Provider Numbering for Dentists

If applicable, all dental providers must claim for services rendered using their individual unique 9-digit provider number. Therefore, providers who have claimed previously using clinic or group numbers must now claim using their individual unique 9-digit provider number. FCH issues a number based on the format:

PPLLLLLSO, where

PP = Province Code
LLLLL = License Number assigned to individual dentist by the
provincial/territorial Dental Regulatory Authority (DRA)
S = Specialty
O = N/A

The full unique 9-digit provider number must be recorded and used on all communication with FCH and with FNIHB.

Provider Numbering for Denturists

Provider numbers for denturists incorporate the number assigned by the Denturist Association of Canada.

8PPSLLLL, where

8 = National indicator for denturist
PP = Province code

S = Indicates level of service that a denturist can provide
(for example, 1 = Complete; 2 = Complete and Partial).
LLLL = License number assigned to individual Denturist by theprovincial/territorial professional regulatory body

Provider Numbering for Anaesthetists

For provinces where anaesthetists are allowed to register and submit anaesthetic claims directly to FCH, the provider number is assigned as:

9PPLLLLLO, where

9 = National indicator for anaesthetist
PP = Province code
LLLLL = License number assigned to individual anaesthetist by the provincial/territorial professional regulatory body
O = N/A

Coordination with Other Health Care Plans

General Guidelines

Dental benefits which are available to eligible First Nations and recognized Inuit clients from a provincial, territorial or third party dental or health care plan are not covered under the NIHB Program.

Predetermination for partial payment may be obtained for benefits not completely covered by another plan.

Dental Practitioners must direct inquiries about benefits available to individuals with alternate coverage to the applicable FNIHB Regional Office (see *Directory* insert).

Claim submissions involving co-payment with a provincial/territorial plan or coordination of benefit with a third party health care plan may only be submitted manually.

Coordination with Provincial or Territorial Plans

The NIHB Program requires that eligible First Nations and recognized Inuit clients must access the benefits available to them through their provincial or territorial program. Claims submitted where the services are covered under a provincial or territorial program are rejected with message **R20** (Submit Claim To Provincial/Territorial Health Plan).

For services rendered where the provincial or territorial program requires a co-payment, providers must submit the co-payment to FCH using the procedure code of the service performed. The amount declared as co-payment on the claim form **must** exactly equal the co-payment as indicated on the EOB.

Benefits available under these provincial programs must be billed directly to the applicable program.

Newfoundland
Newfoundland and Labrador Medical Care Plan (MCP) -- The Children's Dental Program for clients up to 12 years of age inclusive.

Nova Scotia
Nova Scotia Medical Services Insurance (MSI) -- Children's Dental Program for clients up to the end of the month in which they turn 10 years of age.

Quebec
Quebec Health Insurance Plan -- Régie de l'assurance maladie du Quebec -- RAMQ -- Dental Services Program for clients up to 9 years of age inclusive.

Saskatchewan
Medical Care Insurance Plan -- Anaesthesia services in approved hospitals for children under 14 years of age.

Certain procedures performed by specialists and general practice dentists are covered for all clients by the Saskatchewan Medical Care Insurance Plan (MCIP). Refer to the current *MCIP Payment Schedule for Insured Services provided by a Dentist.*

Alberta
Alberta Health Care Insurance Plan -- Anaesthesia and facility fees may be payable by the provincial medical plan. These eligible claims may not be submitted to FCH.

Manitoba
Manitoba Health Services Insurance Plan -- Certain dental benefits are available to children through the province of Manitoba.

Yukon
Yukon Health and Social Services -- Certain dental benefits are available to children through the YCDP (Yukon Children's Dental Program).

Northwest Territories
NWT Health and Social Services -- Certain dental benefits are available to children through the Government of NWT.

Nunavut
Nunavut Health and Social Services -- Certain dental benefits are available to children through the Government of Nunavut.

Provincial and Municipal Social Services Plans
Most provinces and municipalities provide certain dental benefits for recipients of provincial or municipal social assistance.

Coordination with Third Party Health Care Plans

Claims submitted where the services are covered by a third party are rejected with message **R30** (client has alternative coverage. Contact FNIHB) or message **R31** (Client has alternative coverage. Contact FCH). Dental practitioners must obtain the information on other third party coverage from clients. If

coverage exists, the claims must be submitted directly by the provider or the client to the appropriate third party payer.

Where a third party payer has reimbursed less than the current provincial/territorial fee guide in effect for a service and the service is also eligible under the NIHB Program, a claim may be submitted to FNIHB. The claim form must indicate the original full fee for each service provided. FCH calculates the third party coverage and pays the balance owing. An EOB **must** be submitted with the claim form. For further information, providers must contact the Non-Insured Health Benefits Toll-Free Inquiry Centre.

Billing and Payment

The Non-Insured Health Benefits (NIHB) Program allows dental practitioners to bill First Canadian Health (FCH) using one of these methods:

- Electronic claim submissions using the Electronic Data Interchange (EDI) system;
- Manual claim form submissions; or
- Computer printout claim submissions.

Regardless of the billing method used, all required data elements must be supplied to enable the efficient processing and payment of claims.

Providers have one year from the date of service to secure payment. Claims submitted with dates of service more than **one year** after services have been rendered are rejected with the **R21** message (period for submitting claims has expired).

Inquiries related to any of the available billing methods, format, record layout or completion of a claim form must be directed to the Non-Insured Health Benefits Toll-Free Inquiry Centre.

Billing Methods

Electronic Claim Submissions -- Electronic Data Interchange (EDI)

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, 7 days a week.

All NIHB claims submitted using the EDI system are either accepted or rejected in real-time; there are no suspended claims. Two types of messages are generated for claims submitted using the EDI system: Canadian Dental Association (CDAnet) and *Réseau Association des chirurgiens dentists du Québec (ACDQ)* error codes and NIHB Health Information and Claims Processing System (HICPS) codes messages (see Dental Claim Submissions Messages and Explanations)

Note: 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 predetermination 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.

Claims Excluded from the Electronic Data Interchange (EDI) 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 predetermination (must be submitted manually to the appropriate First Nations Inuit Health Branch (FNIHB) Regional Office); refer to Submission of Supporting Documentation for Predetermination
- Requests for post approval (must be submitted manually to the appropriate FNIHB Regional Office); refer to Sample Predetermination Confirmation Letter;
- Claims over seven days old (must be submitted manually to FCH); refer to Dental Claims Submission -- Required Data Elements;
- Reversals after the date of original submission (must be submitted manually to FCH; refer to Manual Claims Submission
- Orthodontic incremental payment codes (must be submitted manually to FCH; 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 FCH);
- Claims payable to a third party such as a parent or guardian (must be submitted manually to FCH);
- Co-ordination of benefits (COB) claims (must be submitted manually to FCH); refer to Coordination with Other Health Care Plans; and

- Claims for procedure codes not listed on vendor's software (must be submitted manually to FCH).

Manual Claim Submissions

Claims can be submitted manually on:

- Standard Dental Claim form;
- Computer generated form;
- ACDQ Dental Claim and Treatment Plan form; and
- Non-Insured Health Benefits DENT-29 form (PDF version).

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 to the claim form all predetermination details from the third party carrier and the Explanation of Benefits (EOB).

All missing teeth information must be recorded on all predetermination submissions.

Photocopies of claims are not accepted by FCH. An exception is made if the original claim was not received by FCH. In this case, the provider can submit a photocopy of the claim with "Resubmission" written on it. In all other cases, the claim will be returned to the provider unprocessed.

Computer Printout Claim Submissions

Computer printouts and standard dental claim forms can be submitted if all data elements are present.

Billing for Pre-verified Treatment

Electronic Data Interchange Claim Submissions - Pre-verified Treatment

When submitting a claim for a pre-verified procedure using the EDI system, providers must record the pre-verification number in the correct field (refer to Electronic Data Interchange -- Required Data Elements) Since the EDI system allows only one pre-verification number per claim, services involving multiple procedures issued with different pre-verification numbers must be submitted as separate claims.

Manual Claim Submissions - Pre-verified Treatment

When submitting a manual claim for a pre-verified procedure, providers must record the applicable pre-verification number on the claim line for the procedure code(s) submitted. If more than one procedure code has been issued a pre-verification number, write the pre-verification number next to each applicable claim line. Failure to write the pre-verification 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 for the client.

Restrictions - Pre-verified Treatment

A pre-verification number is valid for up to six (6) months from the date of issuance. Where a pre-verification number has been issued and there is a third party coverage, an EOB form **must** accompany the claim. Failure to submit with a service date within this timeframe results in claims being adjudicated with warning message **W28** (pre-verification service date violation) or **W29** (pre-verification number is invalid).

Billing for Predetermined Treatment

EDI Claim Submissions - Predetermined Treatment

Although predetermination 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 predetermination number from the Predetermination Confirmation Letter in the correct field (refer to Electronic Data Interchange -- Required Data Elements). Since EDI allows only one predetermination number per claim, services involving multiple procedures issued with different predetermination numbers must be submitted as separate claims.

Manual Claim Submissions- Predetermined Treatment

When submitting a manual claim for a predetermined procedure, providers must record the applicable predetermination number on the claim line for the approved procedure code. If more than one procedure code has been issued a predetermination number, write the predetermination number next to each applicable claim line. Failure to write the predetermination 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.

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 reimbursement. Claims submitted against a predetermination 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).

Selected Billing Rules

The NIHB Program places billing restrictions on certain dental services:

- Orthodontic Payment Codes;
- Anaesthesia Services;
- Laboratory Fees;
- Dentures; and
- Universal Descriptions and Code.

Orthodontic Payment Codes (not procedure codes)

Claims for comprehensive orthodontic services **can only** be submitted manually. Payment codes or the exact wording indicated must be used, or the claim form will be returned to the provider unprocessed. Claims submitted using the existing comprehensive procedure codes in the fee guide are rejected.

These are the orthodontic alpha-numeric payment codes, exact wording must be used.

Examination -- payment code P1000
Diagnostic Records -- payment code P1100
Diagnostic Records and Examination -- payment code P1101
Initial Payment -- payment code P1200
Incremental Payment -- payment code P1300
Final Payment -- payment code P1400

Anaesthesia Services

When submitting an EDI or a manual claim for anaesthesia services, the claim must be accompanied by the associated dental procedure code with the same date of service. Failure to submit claim without a verified associated code results in the claim line being rejected with message **R42** (associated dental procedure must be specified).

Laboratory Fees

EDI Claim Submissions - Lab Fees

When submitting a claim using the EDI system for procedure codes eligible for lab fees, the claim must be submitted with both the professional fee amount and the lab fee amount on the same claim line. Failure to do so results in the claim being rejected with message **R43** (lab fee must be submitted for specified procedure code). While commercial invoices cannot accompany EDI submitted laboratory fees, providers may be required to produce an original lab invoice upon request by FCH for audit purposes. For denturists, when the laboratory cost is included in the professional fee, a laboratory invoice is not necessary.

Note: If two lab fees are submitted on the same claim, the total lab fee allowed is returned in the eligible amount for lab code 1 field.

Manual Claim Submissions - Lab Fees

When submitting a manual claim for procedure codes eligible for laboratory fees, the codes must be submitted with both a professional fee amount and a lab fee amount on the same claim line. It is not mandatory for a laboratory invoice to be submitted with the claim; however, providers may be required to produce an original laboratory invoice upon request by FCH for audit purposes.

Note: If a provider attach a laboratory invoice to a claim and the lab fee claimed is different from the amount on the laboratory invoice, the claim will be returned to the provider unprocessed.

Dentures Lab Fees

When submitting either an EDI or manual claim for dentures for which the denture code does not indicate either upper or lower arch (for example, unilateral dentures) the provision of a quadrant code, arch or a tooth code is mandatory. The arch identifier code must appear in the int. tooth code field of the claim form. Failure to supply the associated quadrant, arch or tooth code results in the claim being rejected with message **R38** (missing or invalid tooth, surface, arch, quadrant or sextant code).

Universal Descriptions and Codes

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

Quadrant Codes and Descriptions:

- Code 10 for Upper Right
- Code 20 for Upper Left
- Code 30 for Lower Left
- Code 40 for Lower Right

Surface Codes and Descriptions:

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

Arch Codes and Descriptions:

- Code 00 for Full Mouth
- Code 01 for Maxillary
- Code 02 for Mandibular

Sextant Codes and Descriptions:

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

Dental Claims Reversal

Electronic Data Interchange Claim Reversal

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

To successfully reverse a claim, the provider must follow the instructions provided by the dental software vendor.

When a claim reversal is submitted, an electronic claim reversal response is sent to the provider . If the reversal is accepted, the system reverses the impact of the original claim and the original claim does not appear on the provider's statement. If the reversal is rejected, the provider must correct the error(s) and resubmit the claim reversal.

Manual Claim Reversal

A manual claim reversal is submitted on the NIHB Dental Claim statement as outlined in Non-Insured Health Benefits Dental Claim Statement Messages and Explanations.

Dental Claim Submissions Messages and Explanations

EDI Claim Submissions - Messages and Explanations

For every submitted transaction, the system generates a CDAnet and *Réseau ACDQ* response status code to indicate to the provider whether the transaction was accepted or rejected. Once accepted, claims submitted using the EDI system are adjudicated in a matter of seconds. Two types of codes/messages may be displayed to inform providers of the outcome of the transaction: CDAnet 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 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 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 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 Explanation of Benefits (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 NIHB Dental Claim Statement which accompanies the claims payment cheque or electronic funds transfer notice.

- When a claim reversal is submitted, an electronic claim reversal response is sent to the provider. The response indicates whether the reversal is rejected or accepted. CDAnet 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 and *Réseau ACDQ* codes refer to your CDAnet and *Réseau ACDQ* Dental Office User Guide; for NIHB Health Information and Claims Processing System (HICPS) codes and messages.

Manual Claim Submissions - Messages and Explanations

For manual claims, reject *"R"* or warning *"W"* NIHB messages generated as a result of the claim adjudication are displayed on the NIHB Dental Claim Statement which accompanies the claims payment cheque or electronic funds transfer notice.

Dental Claims Payment

Claim payments to registered NIHB providers are issued twice per month and contain payment for claims settled and paid through the HICPS system administered by FCH (see Non-Insured Health Benefits Dental Claim Statement Messages and Explanations.)

If the provider elects to have a claim cheque issued, the cheque is sent out via regular mail with the NIHB Dental Claim Statement which contains any additional information (for example, suspended/rejected claims). If the provider has selected Electronic Funds Transfer (see Method of Payment) rather than a cheque, the funds are deposited and the NIHB Dental Claim Statement is sent out via regular mail.

If the provider works in more than one office, the provider receives separate cheques/electronic deposits and statements for each office that has submitted claims within the period, provided the unique identification number for each distinct office has been utilized on claim submissions.

An administrative fee of $25.00 applies for duplicate statement requests. Requests must be made in writing to FCH and include a cheque for $25.00. If the FCH payment cheque corresponding to the statement has not been cashed and a sufficient amount of time has passed, the $25.00 administrative fee is not applied and the provider's $25.00 cheque is returned with the requested copy of the statement.

Method of Payment

Providers may elect to receive payment for eligible claims directly through electronic funds transfer into the provider's designated bank account. This method of payment ensures that the provider normally receives funds on the same day as payment is issued by FCH, and that payment is assured in the event of postal disruption.

Upon completing the Provider Information Form, the provider must elect to have payment through cheque or electronic funds transfer. In addition, the provider may choose to change to electronic funds transfer at any time. Simply complete the Provider Information Form (contact the FCH Toll-Free Inquiry Centre to obtain a copy of this form *)* and fax or mail it to the attention of FCH Provider Relations. This change may take two (2) weeks to enact due to bank cut-off dates, but the electronic funds transfer commences no later than the second claims statement period after remitting the change.

Claim Submissions -- Required Data Elements

Electronic Data Interchange (EDI) -- Required Data Elements

The required data elements apply only to claims submitted using the EDI system. Additional data elements may be required by the dental office software provided by the software vendor. For information about required data elements for manual claim submissions, see Manual Claims Submission-- Required Data Elements.

Note: The names of the required fields displayed on the dental office software may be different from the names of the required data elements. For clarification of the field names on the dental office software or assistance in submitting the required data elements, providers may contact the software vendor.

EDI Claim Submission Required Data Elements for CDAnet and Réseau ACDQ

List Terminology:

Field ID
Identifier given to the field.
Field Name
Text name given to the field.
Non-Insured Health Benefit Description
A description of what the field is used for

Field ID: A02
Field Name: Office Sequence Number
Non-Insured Health Benefit Description: A number assigned by and under the control of the dental office software provided by the software vendor.

Code: A03
Field Name: Format Version Number
Non-Insured Health Benefit Description: A 2-digit code identifying the Version of the CDAnet and *Réseau ACDQ* standard software used on the dental office software: either 02 or 04.

In most cases, numbers are assigned automatically by the dental office software provided by the software vendor. Only Version 4 is acceptable for NIHB claims.

Code: A04
Field Name: Transaction Code
Non-Insured Health Benefit Description: A 2-digit code usually assigned automatically by the dental office software to indicate the purpose of a transaction: valid NIHB codes are:

01 - Claim
11 - Claim Acknowledgement
21 - Explanation of Benefits
02 - Reversal
12 - Reversal Response

Code: A05
Field Name: Carrier Identification Number
Non-Insured Health Benefit Description: This 6-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 FCH is 610124.

Code: B01
Field Name: CDA Provider Number
Non-Insured Health Benefit Description: This unique, 9-digit number has been assigned to you by CDA, and must be included in every transaction.

Code: B02
Field Name: Provider Office Number
Non-Insured Health Benefit Description: This 4-character identifier has been assigned to you by CDA, and must be included in every transaction.

Code: C01
Field Name: Primary Policy/Plan Number
Non-Insured Health Benefit Description: This 6-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 FCH is 080000 (leading "0" is mandatory).

Code: C02
Field Name: Subscriber Identification Number
Non-Insured Health Benefit Description: The unique number used to identify a client who is eligible to receive benefits under the NIHB Program.

Code: C05
Field Name: Patient's Birthday
Non-Insured Health Benefit Description: The client's full birth date in correct format.

Code: C06
Field Name: Patient's Last Name
Non-Insured Health Benefit Description: The surname under which the client is registered as an NIHB client.

Code: C07
Field Name: Patient's First Name
Non-Insured Health Benefit Description: The given names under which the client is registered as an NIHB client. Submission of more than one given name is preferred to facilitate client verification. Initials are not acceptable.

Code: D05
Field Name: Subscriber's Address Line 1
Non-Insured Health Benefit Description: First line of client's address.

Code: D06
Field Name: Subscriber's Address Line 2
Non-Insured Health Benefit Description: Second line of client's address, if applicable.

Code: D07
Field Name: Subscriber's City
Non-Insured Health Benefit Description: The client's city.

Code: D08
Field Name: Subscriber's Province
The client's province.

Code: D09
Field Name: Subscriber's Postal Code
Non-Insured Health Benefit Description: The client's postal code

Code: F01
Field Name: Payee Code
Non-Insured Health Benefit Description: This field determines who should be paid. Valid codes are:

1 - Pay to client (subscriber)
2 - Pay to other third party
3 - Reserved
4 - Pay to dentist

Code: F03
Field Name: Predetermination Number
Non-Insured Health Benefit Description: For a claim that has been predetermined and approved in part or in full, the predetermination number indicated on the FNIHB confirmation letter must be entered.

For a claim for pre-verified services, the pre-verification number (V-prefixed number) must be entered.

When a predetermination or pre-verification number is entered on an EDI claim document, all claim lines on the document must pertain to the entered predetermination or pre-verification number.

Code: F07
Field Name: Procedure Line Number
Non-Insured Health Benefit Description: The line number of the procedure in the claim submission. The line number will be preserved in the Claim Response. In most cases, this number is assigned automatically by the dental office software provided by the software vendor.

Code: F08
Field Name: Procedure Code
The procedure code corresponding to the applicable procedure.

Code: F09
Field Name: Date Of Service
Non-Insured Health Benefit Description: The date on which services were provided to the client in day/month/year format (for example, 13/07/1999 represents 13 July 1999). 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 FNIHB 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.

bcF10
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.

Code: F11
Field Name: Tooth Surface
Non-Insured Health Benefit Description: The surface code corresponding to a procedure for which surface description is mandatory.

Code: F12
Field Name: Dentist's Fee Claimed
Non-Insured Health Benefit Description: The dollar amount claimed for professional services.

Code: F13
Field Name: Lab Procedure Fee # 1
Non-Insured Health Benefit Description: The first lab procedure code if lab costs are associated with the claimed professional procedure

Code: F34
Field Name: Lab Procedure Code # 1
Non-Insured Health Benefit Description: The dollar amount claimed for the first lab procedure code, if applicable.

Code: F35
Field Name: Lab Procedure
Non-Insured Health Benefit Description: Code # 2
The second lab procedure code associated with the claimed professional procedure, if applicable. May not be available as an input field on all dental office software.

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

Manual Claim Submissions Required Data Elements

FCH and FNIHB Regional Offices accept these forms for manual claim and predetermination submissions:

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

All mandatory data elements (for example supporting documents, tooth charting, client identification, or band number and family number, date of birth) must be completed on the claim form, with the exception of the client signature.

The NIHB Dent- 29 form must still be used for:

- Pay client claims;
- Client reimbursements; and
- Claims payable to a third party.

Do not combine different types of requests on a single claim form. A claim form can only be submitted for a post approval, predetermination, claim submission or a client reimbursement.

These data elements are required for post approvals, predeterminations, claim submissions, and client reimbursements. The field names in the left column correspond to fields on the NIHB DENT-29 form. Shaded Sections of the NIHB DENT-29 form are reserved for use by FNIHB Regional Offices. The these 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.

NIHB Required Data Elements

For **Post Approval** - To indicate if the submission is for a post approval request.
For **Predetermination** - To indicate if the submission is for a predetermination request.
For **Claim** - To indicate if the submission is for a claim.

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

Client Surname - The surname under which the client is registered as an NIHB client.

Given Names - The given names under which the client is registered as an NIHB client. Submission of more than one given name is preferred to facilitate client verification. Initials are not acceptable.

Address - The complete address of client. Submissions that do not indicate the complete client address including postal code are rejected.

Provider No. - If applicable, the full unique 9-digit provider number assigned to the dental practitioner by FCH must appear on the claim form. Submissions that do not indicate the complete FCH provider number may be rejected.

Provider Address - A stamp with the provider address is acceptable. The provider address must appear on the claim form, if applicable. Submissions that do not indicate the complete provider address may be rejected.

For Provider Use Only - Additional information pertaining to the submission may be noted here.

Pay Client / Guardian - This box is checked when the payee is other than the provider.

Payee Address - This information must be provided if the payee address is different from the client address or when the client is under the age of consent.

Office Verification/Signature Of Provider - An original provider signature or provider name stamp is acceptable. The signature or stamp must be that of the provider who has performed or will perform the procedure, and must match the dental practitioner's unique provider number indicated on a claim form.

Date Of Service - The date on which services were provided to the client in day/month/year format (for example, 13/07/1999 represents 13 July 1999). For procedures requiring more than one appointment, where an insertion is required, the date of service must be the date when the service wasinserted. Contact your FNIHB Regional Office if insertion cannot occur.

For procedures requiring more than one appointment that do not require an insertion, the date of service must be the date when the service was completed.

Procedure Code - The procedure code corresponding to the applicable procedure.

Int. Tooth Code - The international tooth number, quadrant, sextant or arch code corresponding to the procedure for which tooth number, quadrant, sextant or arch description is mandatory.

Tooth Surfaces - The surface code corresponding to a procedure for which surface description is mandatory.

Professional Fee - The dollar amount claimed for professional services.

Laboratory Fee - The dollar amount charged for lab work. An original invoice or photocopy must be attached to the claim.

Total Fee - The total dollar amount charged for the procedure or service performed (professional fee + laboratory fee).

Predetermination / Pre-verification No. - For a claim that has been predetermined and approved in part or in full, the predetermination number indicated on the FNIHB confirmation letter must be entered beside the corresponding claim line.

For a claim for pre-verified services, the pre-verification number (V-prefixed number) must be entered beside the corresponding claim line.

A claim form may be used to claim for both predetermined and pre-verified services, provided the appropriate authorizing numbers are indicated beside the corresponding procedure codes.

FNIHB Approved (To Be Completed By FNIHB) - When FNIHB has reviewed a request for predetermination:

YES = predetermination has been granted
NO = predetermination has been denied
N/A = procedure does not require predetermination
AC = internal FNIHB code

Total Fee Submitted - This is the sum total dollar amount of all procedures submitted.

Client Information (Provider to Complete) Field Names and Descriptions:

Client Identification No. - The unique number used to identify a client who is eligible to receive benefits under the NIHB Program.

Band No. - The 3-digit band number is only applicable to First Nations clients.

Family No. - The 4 or 5-digit family number is only applicable to First Nations clients.

Date Of Birth - The client's full birth date in day-month-year format (for example, 13/05/1992 represents 13 May 1992).

Additional Information (Provider To Complete) Field Names and Descriptions:

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, A Motor Vehicle Or Accident Insurance Plan? - The answers are mandatory on all submissions.

B. Are There Any Missing Teeth? - The answers are mandatory on all predetermination and post approval submissions.

Predetermination Information (FNIHB To Complete) Field Names and Descriptions

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.

No. - The pre-printed document number (composed of an alpha prefix followed by eight digits) is the document number which also appears on the NIHB Dental Claim Statement (doc no.).

This number may also serve as the predetermination/post approval number when the NIHB DENT-29 form is submitted to FNIHB as a predetermination/post approval request.

Non-Insured Health Benefits Dental Claim Statement

The NIHB Dental Claim Statement accompanies the claims payment cheque or electronic funds transfer 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 FCH to reverse a claim paid in error, subject to appeal. If not possible, providers must issue a cheque payable to FCH within a negotiated timeframe. FCH reserves the right to withhold future payments to providers, pending receipt of monies found paid in error. Providers may contact the Non-Insured Health Benefits Toll-Free Inquiry Centre to clarify or appeal the payment error reversal.

NIHB Dental Claims Statements are issued twice a month in either French or English depending on the provider's language of choice.

EDI Claim Submissions - Dental Claim Statement

The NIHB Dental Claim Statement 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. Claims which were not adjudicated in real-time due to a manual submission requirement or missing/invalid data as well as claims which have been reversed do not appear on the NIHB Dental Claims Statement generated with the EDI system.

Manual Claim Submissions -Dental Claim Statement

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

Non-Insured Health Benefits Dental Claim Statement Messages and Explanations

During the adjudication of dental claims, the NIHB claims processing system may assign three-character reject and warning codes along with messages in order to explain to providers the outcome of the claim adjudication. A reject code, composed of an "R" followed by two numeric characters and a corresponding text message, explains why the claim was rejected. A warning code, composed of a "W" followed by two numeric characters and a corresponding text message, explains that the claim was adjudicated with modifications.

For claims submitted using the EDI system, the NIHB messages are displayed on the Explanation of Benefit (EOB) and printed on the NIHB Dental Claim Statement. For claims submitted manually, the NIHB messages only appear on the NIHB Dental Claim Statement.

The NIHB Dental Claim Statement may also be used to reconcile accounts and must be referenced when making inquiries to FCH. Corrections to claims (including reversals) must be indicated directly below the existing information and forwarded to FCH within 60 days of the statement date for re-adjudication of the

claim. *Providers must not alter or erase the existing information.* If a claim form is used for a correction to a previously submitted claim, then all mandatory data elements must be filled out accordingly, and all supporting documentation (i.e., lab invoice, etc.) must be submitted with the claim form.

These are explanations of all NIHB codes and messages that may appear on the EOB and on the NIHB Dental Claim Statement.

List Terminology:

Field ID
Identifier given to the field.
Field Name
Text name given to the field.
Non-Insured Health Benefit Description
A description of what the field is used for

Code: R04
Message: This is not an eligible benefit
Explanation: The claim has not been paid because the item is not covered under the NIHB Program.

Code: R05
Message: Claimant could not be verified as an NIHB client
Explanation: The claim has not been paid because the claimant could not be verified as an NIHB client. The verification problem may be due to the fact that the claimant:

- Has not used his or her registered surname, given names or date of birth; or
- 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 has not registered as an NIHB client, it is necessary for the claimant to do so before service can be provided. Contact the FNIHB Regional Office (see *Directory* insert).

Code: R06
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.

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.

Code: R10
Message: Invalid provider no.
Explanation: The claim has not been paid because the provider cannot be validated as a registered NIHB provider.

Code: R11
Message: Invalid dental office number
Explanation: The claim has not been paid because the "Provider Office Number" cannot be validated against the CDA Provider Number. Check the claim and re-submit with the corrected information.

Code: R12
Message: Insufficient client information to adjudicate claim
Explanation: The claim has not been paid because it did not provide sufficient information to determine if the claimant is an NIHB client. To facilitate client verification, this client information must be provided for each claim:

- Surname.
- Given Names.
- Date of Birth.
- Client Identification Number.

Check the claim for missing or incomplete information and provide the required information to FCH.

Code: R14
Message: Insufficient benefit information to adjudicate claim
Explanation: The claim has not been paid because it did not provide sufficient information to determine if the claimed procedure is eligible under the NIHB Program. At a minimum, this information must be provided on each claim:

- Date of Service.
- Procedure Code.
- Professional Fee.

Check the claim for missing or incomplete information and provide the required information to FCH.

Code: R20
Message: Submit claim to provincial/ territorial health plan
Explanation: The claim has not been paid because a provincial or territorial health plan covers the procedure. Direct the claim to the appropriate plan.

Code: R21
Message: Period for submitting claims has expired
Explanation: The claim has not been paid because the claim was submitted more than one year after the service was rendered.

Code: R23
Message: Service provided prior to client's start date
Explanation: The claim has not been paid because the date of service is prior to the start date for the client's NIHB coverage.

Code: R24
Message: Service provided after client's end date
Explanation: The claim has not been paid because the date of service is after the end date for the client's NIHB coverage.

Code: R26
Message: Predetermination service date violation
Explanation: The claim has not been paid because the date of service is either before the start date or after the end date of the predetermination approval.

Code: R27
Message: Predetermination number is invalid

Explanation: The claim has not been paid because the predetermination number does not exist on our predetermination database. Check the records and submit corrected information to FCH.

Code: R28
Message: Client, provider or benefit details on claim do not match pd letter
Explanation: The claim has not been paid because the client, provider or benefit details on the claim do not match those on the confirmation letter. If an error was made, supply the corrected information to FCH. If the predetermination requires amendment, contact the appropriate FNIHB Regional Office.

Code: R30
Message: Client has alternative coverage. Contact FNIHB

Explanation: The claim has not been paid because FNIHB records indicate that the client has alternative coverage for the claimed procedure code. Contact the FNIHB Regional Office for direction on where to submit the claim. See *Directory* insert for the phone number and address of the FNIHB Regional Office.

Code: R31
Message: Client has alternative coverage. Contact FCH
Explanation: The claim has not been paid because FCH's records indicate that the client has alternative coverage for the claimed procedure code. Contact FCH for direction on where to submit the claim.

Code: R32
Message: Client has alternative coverage. Contact FCH then submit manually
Explanation: The claim has not been paid because FCH's records indicate that the client has alternative coverage for the claimed procedure code. Contact FCH 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 (refer to Coordination with Other Health Care Plans).

Code: R35
Message: Tooth condition conflicts with previous claim
Explanation: The claim has not been paid because the claimed procedure code conflicts with the tooth condition on an earlier date of service. Examples of conflicts include:

- A claim for an extraction, filling, pit/fissure sealant, crown, posts and cores, abutment, root canal therapy or sedative dressing when an extraction has been performed on the same tooth;
- A claim for space maintainer when a complete denture has been performed in the same arch.

Code: R36
Message: Tooth condition conflicts with subsequent claim
Explanation: The claim has not been paid because the indicated procedure conflicts with the tooth condition on a later date of service. 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 with a later date of service.

Code: R37
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 (e.g., inhalation anaesthesia was claimed in combination with intravenous sedation) or the procedure does not match the number of surfaces claimed.

Code: R38
Message: Missing or invalid tooth, surface, arch, quadrant or sextant code

Explanation: The claim has not been paid because the tooth code, surface code, arch, sextant or quadrant code is missing or invalid. Check the claim for missing or incomplete information and provide the required information to FCH.

Code: R39
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 FCH.

Code: R42
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.

Code: R43
Message: Lab fee must be submitted for specified procedure code
Explanation: The claim has not been paid because the claimed procedure code is a service for which a laboratory fee is applicable and may only be submitted for payment with the laboratory fee upon insertion of the appliance.

Code: R44
Message: Lab or expense fee not allowed for specified procedure code
Explanation: The claim has not been paid because the claim contains a laboratory fee submitted with the claimed procedure code for which a laboratory fee is not eligible. See 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.

Code: R45
Message: Invalid lab or expense procedure code
Explanation: The claim has not been paid because the claim contains an invalid lab or expense procedure code. See the current *NIHB Regional Dental Benefit Grid* to determine lab eligibility. Expense codes are not currently eligible under the NIHB Program.

Code: R48
Message: Predetermination for this item has been used up by previous claim
Explanation: The claim has not been paid because the predetermination has already been used up by a previous claim.

Code: R49
Message: Benefit requires predetermination
Explanation: The claim has not been paid because it requires predetermination from FNIHB. Predetermination procedures are outlined in Pre-verification and Predetermination.

Code: R50
Message: Frequency of the claim 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.*

Code: R66
Message: Date of service must be after DOB
Explanation: The claim has not been paid because the date of service on the claim is before the birth date of the client, as indicated on the NIHB client eligibility file.

Code: W06
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.*

Code: W09
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.*

Code: W10
Message: This is a claim reversal
Explanation: The claim is a reversal of a previously settled claim.

Code: W11
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.

Code: W12
Message: Part of claim exceeds frequency maximum and is disallowed
Explanation: The professional fee has been reduced to the maximum allowed according to the NIHB frequency limitation guidelines specified in the current *NIHB Regional Dental Benefit Grid*.

Code: W13
Message: Please note corrected provider no. 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.

Code: W14
Message: Please note corrected client id for future claims
Explanation: The claimant was verified as an NIHB client on the basis of the client information provided. However, the submitted client information has been corrected to exactly match the identifiers under which the client is registered as an NIHB client. The corrections may include:

- Provision of the full client identification number in cases where only the client's band number and family number were submitted; or
- Correction of a submitted band number, family number, surname, given names or date of birth.

Update the client's file and use the corrected client ID on future claims to facilitate client verification.

Code: W15
Message: Alternate procedure code applied, see NIHB schedule
Explanation: The claim has been adjudicated using an alternate procedure code. Refer to the current *NIHB Regional Dental Benefit Grid* .

Code: W17
Message: Claim adjusted to comply with terms of predetermination
Explanation: The amount claimed is reduced to comply with the terms of predetermination set out by FNIHB. See the Predetermination Confirmation Letter for approved terms.

Code: W27
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.

Code: W28
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.

Code: W29
Message: Pre-verification number is invalid
Explanation: The pre-verification number is invalid for the specified client and benefit.

Code: W30
Message: Claim reduced from single to additional extraction, same quadrant
Explanation: The professional fee has been reduced to the amount allowed for an additional extraction in the same quadrant.

Code: W31
Message: 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.

Code: W32
Message: Duplicate surface on previous claim. Payment limited to unique surfaces
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 3 unique surfaces.

Code: W82
Message: Client has not provided consent
Explanation: The NIHB Program has not been provided with a signed Consent Form from this client.

Code: W99
Message: This claim is in suspense
Explanation: The claim requires additional investigation before it can be fully adjudicated and continues to print on future statements with a W99 message until it has been settled. No action is required at this time. The adjudication result appears on a future statement.

Provider Audits - Dental

The Provider Audit Program assesses that provider claims are billed in compliance with the Terms and Conditions of the Non-Insured Health Benefits Program.

The objectives of the First Canadian Health (FCH) Dental Provider Audit Program are to ensure that all payments made against the Non-Insured Health Benefits (NIHB) Program are in compliance with the Terms and Conditions of the NIHB Program. More specifically this may include, but is not limited to the following:

- Verification of licensure of providers;
- Detection of unsubstantiated claims;
- Presence of appropriate signatures on submitted claims;
- Existence of appropriate documentation supporting the payments made against the NIHB Program.

Next Day Claim Verification Program
Client Confirmation Program
Provider Profiling Program
On-Site Audit Program
Reference Documents
Additional Information

The four (4) components of the FCH Dental Provider Audit Program are outlined below:

Next Day Claim Verification Program

The Next Day Claim Verification Program consists of a review of a defined sample of claims submitted by providers the day following receipt by FCH. Claims meeting specified criteria set by the program are reviewed to ensure adherence to program policy as well as standard accepted definitions and practices;

Client Confirmation Program

The Client Confirmation Program consists of a quarterly mail out to a randomly selected number of NIHB clients to confirm the receipt of the benefit that has been billed on their behalf;

Provider Profiling Program

The Provider Profiling Program 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, and

On-Site Audit Program

The On-Site Audit Program consists of the selection of a focused sample of claims for administrative validation with a provider's records through an on-site audit. The sample of claims reviewed is proportionate to the volume of NIHB clients serviced by the provider.

Reference Documents

- FCH Provider Information Kit;
- NIHB/FCH Newsletters -- issued quarterly; and
- NIHB Program Dental Bulletins.

Additional Information

Providers requiring additional information about the FCH/NIHB Provider Audit Program may contact the FCH Director of Provider Audit in writing.