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## **12. NIHB Medical Supplies and Equipment (MS&E) Claims Submission Kit: Attachments**

### **12.1 Provider Statement – Medical Supplies and Equipment, Messages and Explanations**

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

#### **12.1.1 Provider Statement – Medical Supplies and Equipment**

The Provider Statement – Medical Supplies and Equipment accompanies the Claims payment cheque or Electronic Funds Transfer (EFT) notice, providing information about each manually processed Claim. The statement may also provide additional and/ or corrected Client identification information. If additional and/ or corrected Client information is provided, it must be added to the Provider's records and used on all future Claim submissions.

Express Scripts Canada reverses Claims paid in error, subject to appeal. If it is not possible to reverse and recover Claims paid in error, Providers must issue a cheque payable to Receiver General for Canada within a negotiated timeframe. Express Scripts Canada reserves the right to withhold future payments to Providers, pending receipt of monies found paid in error. Providers may contact the Provider Claims Processing Call Centre at 1-888-511-4666 to clarify or appeal the payment error reversal.

The Provider Statement – Medical Supplies and Equipment is issued twice a month in either French or English depending on the Provider's language of choice. It may also be used to reconcile the Provider's account and should be referenced when making inquiries. Corrections to Claims should be indicated directly below the existing information and forwarded to Express Scripts Canada within 12 months of the service date for re-adjudication of the Claim. The existing information should not be erased. A line should be used to strike through the information that needs to be changed. Providers who resubmit using a Claim Form must clearly indicate the Claim is a resubmission.

#### **12.1.2 Manual Claim Submission – Provider Statement – Medical Supplies and Equipment**

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

The following chart displays Manual Claims Submission Messages and Explanations:

Messages	Description
<b>NIHB Code R04</b>	
Message:	This is not an eligible benefit.
Explanation:	The Claim has not been paid because the item is not covered under the NIHB Program.
<b>NIHB Code R05</b>	
Message:	Claimant could not be verified as an NIHB Client.
Explanation:	The Claim cannot be paid because the claimant could not be verified as a Client. The verification problem may be due to the fact that the claimant; (a) has not used their registered surname, given names, or date of birth; or (b) has made an error in specifying the Client Identification Number. In such cases, it may only be necessary for the claimant to provide more accurate Client identification information. However, if the claimant is not registered as a Client, it is necessary for the claimant to do so before service can be provided.
<b>NIHB Code R06</b>	
Message:	Client is not eligible for this benefit.
Explanation:	The Claim has not been paid because the Item Code is not covered under the NIHB Program due to the age or gender of the claimant. This restriction applies to benefits such as incontinence supplies.
<b>NIHB Code R07</b>	
Message:	This is a duplicate Claim.
Explanation:	The Claim has not been paid because it is a duplicate of a previously paid Claim. The match is based on the following data elements of date of service, Provider Number, Client Number, and Item Number.
<b>NIHB Code R10</b>	
Message:	Invalid Provider ID.
Explanation:	The Claim has not been paid because the Provider cannot be validated as a registered NIHB Provider.
<b>NIHB Code R12</b>	
Message:	Insufficient Client Information to Adjudicate Claim.
Explanation:	The Claim did not provide sufficient information to determine if the claimant is a NIHB Client. To facilitate Client verification, this Client information must be provided for each Claim: a) Surname. b) Given names. c) Date of birth. d) Client Identification Number. Check your Claim for missing or incomplete information and provide the required information.

<b>Messages</b>	<b>Description</b>
<b>NIHB Code R17</b>	
Message:	DIN/ GP #/ PIN ERROR.
Explanation:	All eight (8) positions must be valued, cannot be all zeros, and must be valid item number that exists on the Express Scripts Canada database.
<b>NIHB Code R18</b>	
Message:	Quantity Error.
Explanation:	The quantity must be numeric and greater than zero.
<b>NIHB Code R20</b>	
Message:	Submit Claim to Provincial or Territorial Health Plan.
Explanation:	The Claim has not been paid because a provincial or territorial health plan covers part of the item. Direct the Claim to the appropriate plan.
<b>NIHB Code R21</b>	
Message:	Period for Submitting Claims has Expired.
Explanation:	The Claim has not been paid because the Claim was submitted more than one year after the service was rendered.
<b>NIHB Code R22</b>	
Message:	Prescriber ID Error.
Explanation:	The prescriber identification number can be alphanumeric and cannot be zeros.
<b>NIHB Code R23</b>	
Message:	Service Provided Prior to Client's Start Date.
Explanation:	The Claim cannot be paid because the date of service is prior to the start date for the Client's NIHB coverage.
<b>NIHB Code R24</b>	
Message:	Service Provided After Client's End Date.
Explanation:	The Claim cannot be paid because the date of service is after the end date for the Client's NIHB coverage.
<b>NIHB Code R25</b>	
Message:	Claim does not Comply with the Terms of Prior Approval.
Explanation:	The Claim has not been paid because it does not comply with the terms of the NIHB prior approval. Refer to your copy of the Prior Approval (PA) Confirmation.
<b>NIHB Code R26</b>	
Message:	Prior Approval Service Date Violation.
Explanation:	The Claim has not been paid because the date of service is either before the approval date or after the expiry date of the Prior Approval.

<b>Messages</b>	<b>Description</b>
<b>NIHB Code R27</b>	
Message:	Prior Approval Number is Invalid.
Explanation:	The Claim has not been paid because the Prior Approval Number is invalid for the specified Client and benefit. The Provider should check their records to determine if the Prior Approval Number, the associated Client Identification Number, and the Item Codes were submitted correctly. If an error was made, supply the correct information following the Claims correction procedures outlined in Provider Statement – Medical Supplies and Equipment.
<b>NIHB Code R28</b>	
Message:	Drug Cost/ Product Value Error.
Explanation:	The drug and/ or item cost must be numeric and greater than zero.
<b>NIHB Code R29</b>	
Message:	Claim is Post Dated.
Explanation:	This must be in a valid date format (YYYY-MM-DD) and cannot be future date. If check fails, a message is generated.
<b>NIHB Code R30</b>	
Message:	Client has Alternative Coverage, Contact FNIH Regional Office.
Explanation:	The Claim has not been paid because FNIHB records indicate that the Client has alternative coverage for the Claimed Item Code. Contact the FNIH Regional Office for direction on where to submit the Claim.
<b>NIHB Code R47</b>	
Message:	Special Authorization for this Item used up by Previous Claim
Explanation:	The Claim has not been paid because special authorization for this item has been used up by a previous Claim.
<b>NIHB Code R48</b>	
Message:	Prior Approval for this Item has been used up by Previous Claim.
Explanation:	The Claim has not been paid because the prior approval has already been used up by a previous Claim. Refer to your copy of the Prior Approval (PA) Confirmation.
<b>NIHB Code R49</b>	
Message:	Benefit requires Prior Approval.
Explanation:	The Claim has not been paid because it requires Prior Approval from FNIH Regional Office. Benefits, which require Prior Approval, are indicated in Non-Insured Health Benefits Medical Supplies and Equipment Benefit Items List. Prior Approval Procedures are detailed in the Prior Approval Section of the NIHB Medical Supplies and Equipment Claims Submission Kit.

<b>Messages</b>	<b>Description</b>
<b>NIHB Code R50</b>	
Message:	Quantity Exceeds Frequency Limits.
Explanation:	The Claim has not been paid because the frequency limit for the item has been exceeded. Benefits with frequency limits are indicated in each of the benefit categories found in the Medical Supplies and Equipment Benefit Items List. For benefits with frequency limits that do not normally require Prior Approval, Prior Approval must be requested if the Claim exceeds the maximum allowed.
<b>NIHB Code R66</b>	
Message:	Date of Service must be after DOB.
Explanation:	The Claim has not been paid because the date of service on the Claim is before the birth date of the Client, as indicated on the NIHB Client eligibility file.
<b>NIHB Code W05</b>	
Message:	Claims paid on Parent Identification until first birthday only.
Explanation:	The claimant could not be verified as an NIHB Client. However, since the claimant is an infant under one year of age, and the infant's parent was verified as an NIHB Client, the Claim has been paid. This provision allows time for parents to register the infant and only applies until the infant's first birthday. Claims for services provided after the infant's first birthday are rejected if the infant cannot be verified as an NIHB Client. Additional information on Client identification requirements for infants is provided in the Parent's Information – Data Elements Section.
<b>NIHB Code W09</b>	
Message:	Drug/ Item Cost is Reduced to NIHB Pricing Guidelines
Explanation:	The amount claimed for the item cost has been reduced to conform to NIHB Pricing Guidelines. Refer to the details of the NIHB Pricing Guidelines in your region.
<b>NIHB Code W11</b>	
Message:	Claim Reduced to NIHB Share.
Explanation:	The claimed Item Code is partially covered by a provincial, territorial or third party plan. The amount claimed is reduced to the correct NIHB share.
<b>NIHB Code W12</b>	
Message:	Part of Claim Exceeds Frequency Maximum and is Disallowed.
Explanation:	The quantity amount claimed has been reduced to conform to the frequency limitation allowed.
<b>NIHB Code W13</b>	
Message:	Quantity of Claim is Reduced to Maximum Allowed.
Explanation:	The amount claimed has been reduced to conform to the maximum allowable.

Messages	Description
<b>NIHB Code W17</b>	
Message:	Claim adjusted to comply with terms of Prior Approval.
Explanation:	The amount claimed is reduced to comply with the terms of Prior Approval set out by FNIHB. The Provider should refer to the Prior Approval Form or the Prior Approval Confirmation.
<b>NIHB Code W19</b>	
Message:	Dispensing Fee is Disallowed or Reduced to NIHB Guidelines.
Explanation:	The dispensing fee has been disallowed or reduced to conform to NIHB dispensing fee guidelines. Refer to the details of the NIHB Pricing in your region.
<b>NIHB Code W20</b>	
Message:	Mark-up is disallowed or reduced to NIHB Pricing Guidelines.
Explanation:	The mark-up has been disallowed or reduced to conform to NIHB Pricing Guidelines. Refer to details of the NIHB Pricing Guidelines in your region.

## 12.2 Mandatory Information in Transmission and Submission Options

### 12.2.1 Submission Options

#### NIHB Medical Supplies and Equipment Claim Form

Claims may be submitted on the Non-Insured Health Benefits Medical Supplies and Equipment Claim Form. Inquiries related to its completion or requests for a supply of forms should be directed to the Provider Claims Processing Call Centre at 1-888-511-4666.



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

#### Computer Printout

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

#### Electronic Submission

For authorized MS&E Providers who have the pharmacy vendor software, they can submit Claims electronically for MS&E items.



Providers have one year from the date of service to secure payment. Claims submitted with Dates of Service (DOS) more than one year after services have been rendered are rejected with the R21 Message - Period for Submitting Claims has Expired.

### 12.2.2 Claims Submission Information


Claims for infants under one year of age who do not have an acceptable Client Identification Number should be submitted with supporting parent identification using the Non-Insured Health Benefits Medical Supplies and Equipment Claim Form.

The following describes the required data elements for each Section of the NIHB MS&E Claim Form including: Client information, information for each prescribed item, MS&E Provider information, and parent information.

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

#### 12.2.2.1 Client Information: Data Elements

Field Name	Description
Client Surname	The surname under which the Client is registered as an eligible First Nations or recognized Inuit Client. A field length of 30 characters has been allowed for the surname entry to ensure that the full name presented by the claimant can be submitted on the Claim. Submission of all required Client data elements is necessary to verify the claimant as an NIHB Client.

Field Name	Description
<b>Client Given Name</b>	The given name under which the Client is registered as an eligible First Nations or recognized Inuit Client. Submission of more than one given name is preferred to facilitate Client verification. Initials are not acceptable. A field length of 30 characters has been allowed for the given name entries to ensure that all given names presented by the claimant can be submitted on the Claim.
<b>Client Date of Birth (YYYY-MM-DD)</b>	Client's full birth date in the correct year-month-day format (for example, 1992-05-13 represents 1992 May 13). Partial birth dates are not acceptable.
<b>Address / Apt/ City/ Province/ Postal Code</b>	The current and exact address of the Client.
<b>Client Identification Number</b>	<p>A unique number used to identify a Client who is eligible to receive benefits under the NIHB Program. This number may be one of:</p> <ul style="list-style-type: none"> <li>• A 10-digit number currently issued to eligible First Nations Clients by INAC.</li> <li>• A three-digit band number, immediately followed by the five-digit family number identifying the family unit within the eligible First Nations Client's band.</li> <li>• An alpha prefix followed by an eight-digit number issued to certain eligible First Nations and recognized Inuit Clients by FNIHB.</li> <li>• A health plan number issued to recognized Inuit Clients by the Governments of NWT and Nunavut.</li> </ul> <p> Previously, INAC issued nine-digit numbers to their Clients (some of which may still be in use today). These numbers consisted of a four-digit family number immediately following the three-digit band number. Please insert a zero in front of the four-digit family number.</p>
<b>Band Number</b>	A three-digit number (for example, 002, 311) identifying the band to which an eligible First Nations Client belongs. The band number, when submitted in combination with the Client's Family Number, is an acceptable alternative to the Client Identification Number for an eligible First Nations Client.
<b>Family Number</b>	A five-digit number (for example: 04120) identifying the family unit within the band to which an eligible First Nations Client belongs. The family number, when submitted in combination with the Client's band number, is an acceptable alternative to the Client identification number for an eligible First Nations Client. If the family number on the eligible First Nations Client's registration card has fewer than five digits, insert the appropriate number of zeros in front of the number.

**12.2.2.2 Information for Each Prescribed Item: Data Elements**

Field Name	Description
<b>Date of Service (YYYY-MM-DD)</b>	The date on which the item was provided to the Client in the year-month-day format (for example, 1992-05-13 represents 1992 May 13).
<b>DIN/ Item Code</b>	The item code.

<b>Field Name</b>	<b>Description</b>
<b>Client Date of Birth</b>	Client's full birth date in year-month-day format (for example, 1992-05-13 represents 1992 May 13). Partial birth dates are not acceptable.
<b>Quantity/ Item Cost</b>	The total acquisition/ manufacturer cost for all units of the item dispensed.
<b>Mark-up</b>	The dollar amount of any mark-up for the item, based on the established percentage. Leave blank if not applicable.
<b>Third-Party Share</b>	The dollar amount of any portion of the Claim which is billable to a provincial or territorial program or other third party. Leave blank if not applicable.
<b>Amount Claimed</b>	The sum of the item cost, and mark-up for the item, less any third-party share.
<b>Day's Supply</b>	Estimate of number of days of treatment contained in the prescription.
<b>Total</b>	The total dollar amount claimed for all items (up to 10) listed on the Claim form.
<b>Prescriber</b>	<p>The Prescriber number as entered by the Provider on the Claim submission must be the same as required by the provincial/ territorial Pharmacare program. Claims for repair, labour, and replacement parts must be submitted with "999Repair" in the Prescriber field, or they are rejected on the Provider Statement – Medical Supplies and Equipment:</p> <ul style="list-style-type: none"> <li>• British Columbia - Physician or Nurse Practitioner License Number</li> <li>• Alberta - Physician or Nurse Practitioner License Number</li> <li>• Saskatchewan - Physician's Provincial Billing Number or Nurse Practitioner License Number</li> <li>• Manitoba - Physician License Number or Nurse Practitioner License Number</li> <li>• Ontario - Physician or Nurse Practitioner License Number</li> <li>• Quebec - Physician or Nurse Practitioner License Number</li> <li>• New Brunswick - Physician's Provincial Billing Number or Nurse Practitioner License Number</li> <li>• Nova Scotia - Physician or Nurse Practitioner License Number</li> <li>• Prince Edward Island - Physician or Nurse Practitioner License Number</li> <li>• Newfoundland and Labrador - Physician or Nurse Practitioner License Number</li> <li>• Yukon - Physician's Territorial Billing Number</li> <li>• Northwest Territories - Physician or Nurse Practitioner License Number</li> <li>• Nunavut - Physician or Nurse Practitioner License Number</li> </ul>
<b>Prior Approval Number</b>	An authorization number, which must be issued by FNIHB before the Provider dispenses certain medical supplies and most medical equipment.

**12.2.2.3 MS&E Provider Information: Data Elements**

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

**12.2.2.4 Parent Information (Required for Infants less than One Year of Age): Data Elements**

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

In such a case, the infant's surname, all given names, and the date of birth must be entered in the appropriate fields in the Client Information Section of the Claim Form and this information about the parent must be provided:

Field Name	Description
<b>Parent's Surname</b>	The surname under which the parent is registered as an eligible First Nations or recognized Inuit Client.
<b>Parent's Given Names</b>	The given names under which the parent is registered as an eligible First Nations or recognized Inuit Client. Submission of more than one given name is preferred to facilitate Client verification. Initials are not acceptable.
<b>Parent's Date of Birth (YYYY-MM-DD)</b>	The parent's full birth date in year-month-day format (for example, 1956-05-13 represents 1956 May 13). Partial birth dates are not acceptable.
<b>Parent's Client Identification Number</b>	The number under which the parent is identified as an eligible First Nations or recognized Inuit Client. This number may be one of: <ul style="list-style-type: none"> <li>• A ten-digit number is issued to eligible First Nations Clients by INAC.</li> <li>• A three-digit band number is immediately followed by a five-digit family number identifying the family unit within the eligible First Nations Client's band.</li> <li>• An alpha prefix followed by an eight-digit number issued to certain eligible First Nations and recognized Inuit Clients by FNIHB.</li> <li>• A health plan number issued to recognized Inuit Clients by the Governments of NWT and Nunavut.</li> </ul>
<b>Parent's Band Number</b>	A three-digit number (for example, 002, 311) identifying the band to which an eligible First Nations Client's parent belongs. The band number, when submitted in combination with the family number, is an acceptable alternative to the Client Identification Number for an eligible First Nations Client.
<b>Parent's Family Number</b>	A five-digit number (for example, 04120) identifying the family unit within the band to which an eligible First Nations Client belongs. The family number, when submitted in combination with

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

**Payment Schedule**

Claims are paid on behalf of Health Canada twice a month (mid and end of month). Payment is made by cheque or through direct-deposit, also known as Electronic Funds Transfer (EFT). To apply for the EFT payment option, complete the Express Scripts Canada Modification to Pharmacy and Medical Supplies and Equipment (MS&E) Provider Information Form. Inquiries related to the payment of Claims or the EFT option should be directed to the Provider Claims Processing Call Centre at 1-888-511-4666.



In order to ensure cheque payments are mailed properly, Providers should ensure that Express Scripts Canada has current address information at all times.

## 12.3 **Benefits and Criteria – Medical Supplies and Equipment**

The NIHB Medical Supplies and Equipment Benefit Items List is available on the NIHB Claims Services Provider Website at [www.provider.express-scripts.ca](http://www.provider.express-scripts.ca) or Health Canada's Website at [www.hc-sc.gc.ca](http://www.hc-sc.gc.ca) (select First Nations, Inuit & Aboriginal Health, Non-Insured Health Benefits).