



The Denturist Association of Canada (DAC) – Non-Insured Health Benefits (NIHB) Program

Frequently Asked Questions (FAQ)

Updated: September 2023

These questions have been developed jointly by the NIHB Program and The DAC in response to the inquiries put forward by the denturist providers during the webinars held in December 2021 and February 2022.

Why is predetermination a requirement?

Under the NIHB Program, predetermination is a method for the administration and adjudication of dental benefits. Predetermination is seeking review prior to proceeding with treatment and enables both the dental provider and client to understand the benefit coverage commitments.

NIHB Program reviews dental predetermination requests against its established [NIHB Dental Benefits Guide](#), which outlines clear definitions of the types of benefits available to clients and their coverage criteria. If NIHB is to assume any financial obligation for the coverage of a dental service, the client's condition must meet all of the established policy, guidelines and criteria pertaining to the service in question.

The requirement of predetermination for certain dental services is an industry standard within the private and public insurance sector. As such, public and private plans may require pre-authorization/pre-approval/predetermination (including all relevant information to support the request).

Where do I submit a predetermination request?

Predetermination requests can be submitted by mail or online:

- Online submission: providers will need to [create a secure web-based account](#) on the Express Scripts Canada NIHB provider and client website.
- Mail submissions must be addressed either to:
 - [NIHB Dental Predetermination Centre \(Dental Services\) for dental predetermination requests; or](#)
 - [NIHB Dental Predetermination Centre \(Orthodontic Services\) for orthodontic predetermination requests](#)

Predetermination requests submitted by email will **not** be accepted to ensure client confidentiality.

NIHB Dental Predetermination Centre contact information:

Dental services

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Indigenous Services Canada
200 Eglantine Driveway
Address Locator 1902D
Ottawa, Ontario K1A 0K9

Toll-Free Telephone: 1-855-618-6291
Toll-Free Fax: 1-855-618-6290

Are there exclusions under the NIHB Program?

Yes. Please note that some dental services are not covered under the NIHB Program. These services are defined as *exclusions* and cannot be considered for appeal. **Examples include (not limited to):** fixed prosthodontics, implants and all implant related procedures and cosmetic services.

Are radiographs required for a denture predetermination?

When possible, the NIHB Program encourages denturists to continue submitting radiographs in order to assess client's eligibility for coverage. However, there are options other than current radiographs that can be submitted with a PD request, i.e., ONE of the following diagnostic records:

- o Stone models (upper and lower)
- o Photos of stone models (3) (upper and lower separate, and in occlusion)
- o Photos of the upper and lower jaws (3) (upper and lower separate, and in occlusion)

What is the service standard for dental predetermination requests?

Certain dental procedures require a predetermination (PD). The NIHB Regional Dental Benefit Grids for denturist providers outline procedures requiring a PD. The NIHB Program aims to have dental predeterminations adjudicated within 15-business days, 80 percent of the time, under normal circumstances.

Normal circumstances refer to the Program's available resources and the expected level of demand for regular day-to-day service operations. This service standard may not apply in special circumstances, such as holidays, unforeseen employee departures, disasters (e.g. flood, fire), human or environmental disaster (e.g. operator error, significant equipment/software failure, telecommunications and electric power outage).

The 15-business day period starts from the date that the Dental Predetermination Centre (DPC) receives the PD request (received date), and ends when the request is adjudicated and set in the HICPS system. This NIHB service standard applies for approved and denied PD requests (complete cases), as well as for PD requests put on-hold (incomplete cases due to missing information). For on hold PD requests, the 15-

business day adjudication period will restart when NIHB receives the new information at the DPC. Please note that this also applies to post-determination requests.

What is a shortened dental arch?

As defined in literature, shortened dental arch generally refers to 20 teeth made of all anterior and premolar teeth, or anterior teeth and 3 to 5 natural occlusal units. The NIHB Program applies in its dental policies the concept of “shortened dental arch +1”, meaning that it considers the above definition and one additional pair of teeth (typically molars). As outlined in the NIHB Removable Prosthodontic policy, NIHB will consider coverage for a partial denture for teeth numbered 16 to 26 and 36 to 46 inclusive, when all the clinical criteria are met.

Can services that require predetermination (“P”) and services that do not require predetermination be claimed to Express Scripts Canada on the same claim form? For example, a replacement of a complete denture and a partial denture.

Yes, both can be claimed on the same claim form. However, please ensure to include the predetermination number, where applicable, beside the corresponding claim line.

Why does code 36110 (a complete upper denture repair) include the cost of one (1) tooth when a new one is being placed?

As agreed by NIHB and The DAC in October 2015 (reiterated in 2016, 2018), the common understanding is that when the repair is solely to replace an existing missing tooth and/or teeth, the first tooth is included in the repair code fee. Each additional tooth is individually billed (using 71313 - New Tooth – each).

As per jointly developed article published in the NIHB 2018 Fall Newsletter at <https://nihb-ssna.express-scripts.ca/en/0205140506092019/04/0414>:

**When the repair is solely to add teeth, the first tooth is included in the fee for code 36110.*

***Code 71313 is to be used for the addition of any subsequent tooth.*

Can predeterminations for Complete Immediate Dentures be sent via fax?

Yes, predeterminations for complete immediate dentures can be faxed to the NIHB Dental Predetermination Centre (DPC) at 1 855 618-6290. Please consult question “Where do I submit a predetermination request?” for other options of submitting predetermination requests.

How do I submit laboratory fees?

When submitting claims via Electronic Data Interchange (EDI), the lab fee must be on the same line as the professional fee.

If the Provider has a software limitation and is unable to enter the lab fee on the same line as the professional fee, then the provider must submit manually.

When submitting manually, the lab fee can be on the same line as the professional fee, or on a separate line with the lab fee code 98888 (Note: ESC Claims team will enter it on one line when processing.) It is not mandatory for a laboratory invoice to be submitted with the claim.

When submitting claims, manually, EDI or secure web account, denturists should submit procedure code 98888 for laboratory fees (commercial and internal) eligible under the NIHB Program (excluding 71309, 71310, 71311, 71313, 71314, 71315, 71010, 72021 and 72022).

Note: procedure codes 71006/71007 (Partial Maxillary/Mandibular Cast Frame) are not eligible services under the NIHB Program; however, will be considered for coverage on an exception basis. Predetermination is mandatory and the requests must be supported with documentation.

Can a provider charge fees for services over the NIHB Regional Dental Benefit Grids?

Yes; however, note that the NIHB Program has set regional fees that represent maximum coverage amounts payable by the Program for eligible services. With that, the NIHB Program encourages enrolled dental Providers to bill the Program directly and not to balance-bill Clients so that Clients do not face charges at the point of service. For some Clients, balance billing and charging up front for services are barriers to accessing medically necessary dental services. The Provider is responsible to discuss with the Client their dental condition and costs relating to any proposed treatment plan **prior** to services being rendered.

For more details on different service categories and their respective fees, clients and providers may consult the NIHB Regional Dental Benefit Grids, which are published annually on the Express Scripts Canada NIHB Provider and Client website at: <https://nihb-ssna.express-scripts.ca/en/0205140506092019/04/0407>.

How do I know what fee is approved for a procedure following a predetermination approval?

The predetermination confirmation letter includes details on the approved fee for each eligible procedure code approved under the NIHB Program. Please refer to all notes on the predetermination confirmation letter, if applicable.

How is coordination of benefits applied for dental claims under NIHB?

Providers are reminded that when a Client has other coverage available to them through a public (provincial/territorial health insurance plan or social program) or private health care plan, claims must be submitted to the other plan/program first. This process enables the Client to take full advantage of both private and public coverage available to them.

The other plan/program will provide an “Explanation of Benefits” (EOB) which will be required when seeking Provider payment or Client reimbursement from NIHB for the remaining eligible amounts. The NIHB Program will then coordinate payment with the other payer on eligible benefits.

Claims involving coordination of benefits (COB) must be submitted manually to Express Scripts Canada (ESC) accompanied by a detailed EOB, which must clearly show client information, services rendered, the amount paid by the other plan or an explanation of why coverage was declined in order to be processed.

However, in situations where the Client’s other plan/program will not process dental claims as a first payer, the NIHB Program requires a written notification, such as a letter or policy statement from the other payer. In such instances, the NIHB Program may act as a primary payer.

Where a Client is no longer eligible for coverage from another payer, the Provider or Client can contact Express Scripts Canada to update their profile.

Example:

Provider requested amount	\$250
Eligible dental expense (respective P/T association fee guide)	\$200
NIHB fee (as per published grid)	\$180
COB third party share	\$150

Step 1: Determine the lesser amount between the eligible dental expense and the provider requested amount \$200

Step 2: Calculate the difference between lesser amount and COB third party share $\$200 - \$150 = \$50$

Step 3: Compare above difference with NIHB fee (NIHB pays up to \$180)
Balance is \$50 - NIHB share is \$50

Can a client seek reimbursement from the NIHB Program?

Yes; however, the NIHB Program encourages enrolled dental Providers to bill the Program directly and not to balance-bill Clients so that Clients do not face charges at the point of service. For some Clients, balance billing and charging up front for services are barriers to accessing medically necessary dental services.

The Provider is responsible to discuss with the Client their dental condition and costs relating to any proposed treatment plan **prior** to services being rendered. When a Client pays directly for dental services, the Client may seek reimbursement from the NIHB Program for eligible services/amounts within one (1) year from the date of service.

Can claims be sent electronically through an NIHB web account at Express Scripts Canada?

In general, claims can be sent electronically to Express Scripts Canada through Electronic Data Interchange (EDI), which submits claims electronically and directly from the Provider's office software in real time, acknowledging the result of the claim immediately. This is a supported transaction that the software vendor should already have configured in the office system.

If a Provider has created a secure NIHB web account (see below), they have the option of submitting a claim through their web account and will receive the adjudication results immediately. The system will show that the claim has been either "paid" or "rejected."

Is there a fee to the Provider to create a secure web account?

No. Providers are encouraged to create a secure web-based account through the Express Scripts Canada NIHB Provider and Client website and submit their documents electronically, as an alternative to faxing or mailing. To create a web account and submit online, click on the link: <https://nihb-ssna.express-scripts.ca/en/0514181512> and follow the prompts.

If you select on-line as your communication request for PD confirmation letters, will you receive any notification that there is a new letter available, or do you just have to check periodically?

Providers will not receive notifications from the on-line portal. To view communications, Providers will need to log into their secure web-based account.

How can I confirm if a dentist is setup for claims and predeterminations under NIHB?

Providers / provider offices or Clients can contact Express Scripts Canada to check if a Provider is enrolled. A dental Provider must enroll with the NIHB Program to submit claims and predeterminations. Providers can find information on how to enroll with the Program at <https://nihb-ssna.express-scripts.ca/en/0514181512>.

If Providers have questions about their enrolment, please contact Express Scripts Canada at 1 888 511-4666.

What do I do if an approved treatment (procedure code) has changed?

Dental Providers are reminded to use the procedure code corresponding to the treatment rendered. Procedure codes and their descriptive are clearly defined in the dental associations' fee guides and cannot be used interchangeably. Providers who would like to change the treatment plan must contact the NIHB Dental Predetermination Centre to amend the predetermination prior to submitting their claim to Express Scripts Canada for payment. Failure to do so will result in a denied payment or the recovery of monies paid.

Does the NIHB Program compensate Providers for non-inserted dentures?

The NIHB Program will consider paying dental Providers up to 50% of the current NIHB professional fee for eligible standard / immediate partial and complete dentures. Up to 100% of a reasonable laboratory fee associated with the fabrication of a denture will be paid, if applicable, under specific circumstances.

The requests pertaining to non-inserted dentures must be submitted to the NIHB Dental Predetermination Centre. Providers must use the procedure code for the denture in question and must communicate the details of the situation in writing to the NIHB Dental Predetermination Centre.

What if a Client fails to cancel / misses a dental appointment?

If a Client is unable to attend a scheduled dental appointment, they are encouraged to contact the dental clinic as soon as possible to cancel and reschedule the appointment for another time.

The NIHB Program does **not** cover fees for missed appointments.

Is there an appeal process for Clients?

Following the denial for coverage of a dental service, NIHB Clients have the right to appeal the Program's decision, except for dental services considered as exclusions under the NIHB Program.

- There are three (3) levels of appeal
- At any level, appeals must be initiated in writing and signed by the Client, parent or legal guardian, or a client representative
- At each stage, the appeal must be accompanied by complete supporting documentation, including any additional or new supporting information from the dental provider

Although it is up to the Client/parent/guardian to initiate the appeal process, Providers are encouraged to assist NIHB Clients with their submissions, as supporting documentation (e.g. photos, rationale) is often required.

Does the NIHB Program provide coverage to Clients living in British Columbia?

For First Nations Clients living in BC, dental benefits are provided by the First Nations Health Authority (FNHA). You may contact the FNHA Health Benefits Program by email at healthbenefits@fnha.ca or by calling toll free 1 855 550-5454.

For Inuit and non-resident First Nations in BC, dental benefits are provided by the NIHB Program.

Where can I find further information on the NIHB Program?

Please visit the Government of Canada website for policy and Program information at www.canada.ca/nihb-dental.

Please visit the Express Scripts Canada NIHB Provider and Client website for bulletins, announcements, regional Dental Benefit Grids, newsletters, Dental Claims Submission Kit, and the Dental Benefits Guide at <https://nihb-ssna.express-scripts.ca/en/0205140506092019/04>.

Forms needed to submit a claim or PD request can be found on the Express Scripts Canada NIHB Provider and Client website at <https://nihb-ssna.express-scripts.ca/en/0205140506092019/04/0406>.

Information on the Provider claim verification program can be found in the Dental Claims Submission Kit (Express Scripts Canada NIHB Provider and Client website) at <https://nihb-ssna.express-scripts.ca/en/0205140506092019/04/0403>.