Health Canada Santé Canada

Canada

Medical Supplies and Equipment Health Provider Information

Table of Contents

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

Medical Supplies and Equipment Information

The Non-Insured Health Benefits (NIHB) medical supplies and equipment (MS&E) program funds for its eligible clients a broad range of services including:

- Audiology items, like hearing aids;
- Medical equipment including wheelchairs and walkers;
- Medical supplies like bandages and dressings;
- Orthotics and custom footwear;
- Pressure garments;
- Prosthetics;
- Oxygen therapy; and
- Respiratory therapy.

MS&E services must be prescribed by a licensed physician or medical specialist.

Related Resources

Terms and conditions for funding are contained within the Medical Supplies and Equipment Newsletters and Bulletins.

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

Policies and Procedures

Medical Supplies and Equipment (MS&E) benefits are available to eligible clients when **ALL** of the criteria are met:

- The item is on the Non-Insured Health Benefits (NIHB) MS&E List;
- The item is intended for use in a home setting or other ambulatory care settings;
- Prior approval when required is granted by the First Nations Inuit Health Branch (FNIHB) Regional Office;
- The item is not available to the client through any other federal, provincial, territorial or third party health care program;
- The item is prescribed by a physician or medical specialist as indicated in each of the benefit areas; and
- The item is provided by a recognized provider as indicated in each of the benefit categories.

For the complete list of eligible MS&E items indicating whether or not a prior approval is required, please see the medical supplies and equipment benefit lists.

Prior Approval Requirements

When an MS&E item requires a prior approval, the provider must contact a First Nations Inuit Health Branch Regional Office to initiate the prior approval process. A prior approval form must be completed in all cases and include specific medical information. Samples of the forms can be found in the Resources and Forms section.

In addition to the form, this documentation is required to support the request:

- The prescription; and
- Other supporting medical documentation (as required).

The form, the prescription and any supporting medical documentation must be returned to the FNIHB Regional Office for review. If prior approval is granted, a PA number will be provided for billing purposes. Only then should the provider proceed with the fabrication/fitting/dispensing of the item. If a prior approval is not granted the provider will be advised of the reason.

Exceptions

Items that are not on the NIHB MS&E Benefit List, and that are not exclusions under the NIHB Program, may be considered on a case by case basis when an exceptional need is demonstrated.

Exclusions

Exclusions are items that are not listed as benefits under the NIHB Program and are not available through the exception process. These items are therefore not considered for coverage under the NIHB Program and are not subject to the NIHB appeal process. Types of items that are exclusions under the NIHB Program are listed in each of the Medical Supplies and Equipment benefit categories.

Appeal Process

When a client is denied a benefit, three levels of appeal are available under the NIHB Program, which only the client can initiate. At each level, the appeal must be submitted in witing and must be

accompanied by supporting information from the health care provider. This information should be included:

- The condition (diagnosis and prognosis) for which the benefit or service is being requested;
- Alternatives that have been tried;
- Relevant diagnostic test results; and
- Justification for the proposed benefit or service.

The appeal will be reviewed by a health care consultant, who will provide a recommendation to FNIHB. The final decision will be made by FNIHB, based on the consultant's recommendation, the client's specific needs, the availability of alternatives, and NIHB policy.

Information sheets outlining the three levels of appeal and the addresses are available from the FNIHB Regional Offices and in the Procedures for Appeals section.

Items that are excluded under the NIHB Program are not subject to the appeal process.

Coupons and Promotions

NIHB clients shall not directly or indirectly benefit from special promotions or incentives, including coupons, discounts, points or rebates in the form of cash and/or, that may be offered by pharmacy or medical supply and equipment providers. To the extent permitted by such promotions and applicable law, the coupons, discounts, or rebates should be applied to the NIHB claim.

Recommended Replacement Guidelines

Equipment, devices and supplies are provided to meet the medical needs of clients. Guidelines outlining recommended quantities or replacements are based on the average medical needs of clients. Requests exceeding these guidelines may be considered on a case by case basis if a need is demonstrated.

Equipment and devices will be replaced only when a substantial change in the condition of the client results in changed needs or if the equipment or device has deteriorated and cannot be economically repaired. Where a change in the medical condition has occurred, medical information documenting the change in needs must be provided.

Replacements will not be provided as a result of misuse, carelessness or client negligence.

Rental

When an MS&E item is rented, the rental agreement must include maintenance and repair costs as the NIHB Program does not pay for the maintenance or repairs of rental equipment. The rental agreement must also include a clause stipulating that should the purchase of the item become an option, the amount spent on the rental will be considered when the purchase price is set.

Warranty

All warranty coverage must be exhausted before requests for the payment of repairs are submitted to the NIHB Program. When MS&E items have warranty coverage, as a minimum, the warranty must specify that during the warranty period:

- The provider will provide or cause to be provided any service including repairs or replacements of the item device or any components free of charge; and
- Where there is repeated technical failure, the device will be replaced by the provider at no cost to the NIHB Program.

Co-ordination of Benefits

When clients are covered by another public or private health care plan, claims must first be submitted to them for coverage. Co-ordination of benefits for the NIHB Program will be based on the Canadian Life and Health Insurance Association (CLHIA) Guidelines.

Termination of Alternate Coverage

When an eligible client, who is no longer covered for benefits by another private or public health care plan, submits a claim to the NIHB Program, the claim must be accompanied by a letter from the client, or the provider on behalf of the client, stating that they are no longer eligible under their previous plan. The date the coverage ended must be included in the letter.

Quantity Limitations

MS&E items that have an annual quantity limitation must be provided and billed for no more than a three-month period at a time. This applies to items claimed with or without a prior approval.

For a listing of eligible benefits, please see the:

- Audiology Benefit List;
- General Medical Supplies and Equipment Benefit List;
- Orthotics and Custom Footwear Benefit List;
- Oxygen Therapy Benefit List;
- Pressure Garments and Pressure Orthotics Benefit List;
- Prosthetics Benefit List; and
- Respiratory Therapy Benefit List.

Billing and Payment

First Canadian Health (FCH) administers the Health Information and Claims Processing System (HICPS) on behalf of the Non-Insured Health Benefits (NIHB) Program of the First Nations and Inuit Health Branch (FNIHB) of Health Canada. As such, it is responsible for the processing and payment of all claims for medical supplies and equipment benefits provided under the Non-Insured Health Benefits (NIHB) Program.

Prior Approval Process
Confirmation
Claim Submission with a Prior Approval
Billing Methods
Special Submission Requirements - Infant Claims

Prior Approval Process

If a client is prescribed a Medical Supplies and Equipment (MS&E) item that requires prior approval, the provider must:

- Obtain from the client, the written prescription issued by a physician or medical specialist;
- Obtain client identification information as described in the Client Identification section;
- Contact the First Nations Inuit Health Branch Regional Office to initiate the prior approval process **before** dispensing the medical supplies and/or equipment item;
- Give the precise date of service (for one time item), or the dates of the service period (for multiple dispenses), to the benefit analyst of the FNIHB Regional Office;
- When required, complete the appropriate prior approval form and return it to the FNIHB Regional Office together with all required documents; and
- To avoid delays in the review of the prior approval request, please ensure that all of the fields of the prior approval form are fully completed.

The Medical Supplies and Equipment Information Policies and Procedures section provides details on the required forms and documents.

Confirmation

If a prior approval is granted, the provider will be given a Prior Approval (PA) number for billing purposes. The provider should record this number and make note of the approval details (For example, description, quantity, dollar value, and any frequency or time limitations). Only then should the provider proceed with the fabrication, fitting and dispensing of the item.

A confirmation letter with the applicable dates and prior approval details will be mailed to the provider. This confirmation letter should be retained for billing purposes.

If a prior approval is not granted, the provider will be advised of the reason.

Claim Submission with a Prior Approval

When submitting a claim for an item that has been prior approved, please ensure that the PA number, the date of service or the dates of the service period are included and correspond to the details of the confirmation letter. These dates are important as they will determine the payment of the claim.

On a prior approval for a one time item (with no start and end date), the date of service on the claim must be the same or after the date of the prior approval, or the claim will be rejected.

On a prior approval with a start and end date, the date of service on the claim must be within the start and end date on the prior approval or the claim will be rejected.

On a prior approval for one of the delivery charge codes (99400819, 99400820 and 99400262), providers are required to submit a copy of the way-bill of the delivery charges in order to be reimbursed.

When a prior approval is set up for a one-year period, billing must be in accordance with client usage. No more than a three-month supply can be dispensed and billed at a time.

Billing Methods

Providers can bill FCH using one of these billing methods:

- Diskette/Tape submission;
- Computer printout; and
- NIHB MS&E Claim Form.

Regardless of the billing method used, all required data elements must be supplied to ensure the efficient payment of claims. Data elements must be submitted in the same order as on the Non-Insured Health Benefits Sample Medical Supplies and Equipment Claim Form. Providers are encouraged to submit claims to FCH at least every two weeks.

Providers may contact the Non-Insured Health Benefits Toll-Free Inquiry Centre for further information on any billing method, format or record layout.

Diskette/Tape Submission

Claims may be submitted on diskette or on tape. A list of required data elements and corresponding field lengths are identified below under NIHB Medical Supplies And Equipment Claim Form Required Data Elements.

Computer Printout

Claims may be submitted on plain stock or computer paper. A list of required data elements and corresponding field lengths are identified under NIHB Medical Supplies And Equipment Claim Form Required Data Elements.

NIHB Medical Supplies and Equipment Claim Form

Claims may be submitted on the Non-Insured Health Benefits Sample Medical Supplies and Equipment Claim Form. Inquiries related to its completion or requests for a supply of forms should be directed to the Non-Insured Health Benefits Toll-Free Inquiry Centre.

A list of the required data elements for NIHB claims are identified under NIHB Medical Supplies And Equipment Claim Form Required Data Elements.

Note: The client address section of the NIHB MS&E Claim Form must be completed prior to sending to First Canadian Health for payment. If the client address field is not completed, the form will be returned to the provider for completion.

Special Submission Requirements - Infant Claims

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 Sample Medical Supplies and Equipment Claim Form.

One Year Billing Policy

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).

NIHB Medical Supplies and Equipment Claim Form Required Data Elements

Data element descriptions for:

- Client Information;
- Claim Information for Each Prescribed Item; and
- Medical Supplies and Equipment Provider Information

The Data Elements Descriptions contains the required data elements for all NIHB MS&E claims and applies only to claims submitted on paper and computer printout.

For information about submitting claims using magnetic tape or diskettes, please see Billing Methods.

The items in the first column correspond to each field on the claim form. The number in the second column is the field length specification for claims submitted on computer printouts or diskettes. The information in the third column describes each data element.

A field length of 30 characters has been allowed for each of the surname and given name entries to ensure that the full surname and all given names 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.

Data Element Descriptions -- Client Information

List Terminology:

Field Name:
The name of the field, corresponds to the field on the claim form.
Length:
The field length specification for claims submitted on computer printouts or diskettes.
Description:
A brief description of the data element.

Fields marked with an asterisk (*) are mandatory.

Field Name: *Client Surname
Length: 30
Description: The surname under which the client is registered.

Field Name: *Client Given Name
Length: 30
Description: The given name(s) under which the client is registered. Submission of more than one given name is preferred to facilitate client verification. Initials are not acceptable.

Field Name: *Client Date Of Birth (DD/MM/YYYY)
Length: 8
Description: The full birth date in dd/mm/yyyy format (For example, 13/05/1992 represents 13 May 1992). Partial birth dates are not acceptable.

Field Name: *Address /Apt/City/
Length: Prov./Postal Code
Description: N/A
The current and exact address of the client.

Field Name: *Client Identification No.
Length: 10
Description: A unique number used to identify a client who is eligible to receive benefits under the NIHB Program. This number may be one of:

- a 9 or 10-digit number issued to eligible First Nations clients by Indian and Northern Affairs Canada (INAC),
- an alpha prefix followed by an 8-digit number issued to certain eligible First Nations and recognized Inuit clients by FNIHB, or
- an alpha prefix followed by a 7-digit health care number issued to recognized Inuit by the Government of the Northwest Territories or the Government of Nunavut.

Field Name: *Band No. *(Not Applicable To Inuit Clients)*
Length: 3
Description: A 3-digit number (For example, 002, 311) identifying the band to which the client belongs. The band number, if submitted in combination with the client's family number, is an acceptable alternative to the client identification number for an eligible First Nations client.

Field Name: *Family No. *(Not Applicable To Inuit Clients)*
Length: 5
Description: A 4 or 5-digit number (For example, 1041, 04120) identifying the family unit, within the band, to which a client belongs. The family number, if submitted in combination with the client's band number, is an acceptable alternative to the client identification number. If the family number has fewer than 5 digits, please insert the appropriate number of zeros in front of the number (For example, 125 becomes 00125).

Data Element Descriptions -- Claim Information for Each Prescribed Item

List Terminology:

Field Name:
The name of the field, corresponds to the field on the claim form.
Length:
The field length specification for claims submitted on computer printouts or diskettes.
Description:
A brief description of the data element.

Fields marked with an asterisk (*) are mandatory.

Field Name: Date Of Service (DD/MM/YYYY))
Length: 10
Description: The date on which service was provided to the client, in dd/mm/yyyy format (for example, 13/05/1992 represents 13 May 1992).

Field Name: *Din/Item Code
Length: 8
Description: The item code.

Field Name: *Quantity
Length: 5
Description: The quantity (number of units) of the item dispensed.

Field Name: *Prescription No.
Length: 9
Description: The prescription number assigned by the MS&E provider for the item dispensed.

Field Name: *Item Cost
Length: 6
Description: The total acquisition cost for all units of the item dispensed.

Field Name: Dispensing Fee
Length: 6
Description: The dispensing fee for the item. Leave blank if not applicable.

Field Name: Markup
Length: 6
Description: The dollar amount of any mark-up for the item, based on the established percentage. Leave blank if not applicable.

Field Name: *Third-Party Share
Length: 6
Description: 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.

Field Name: *Amount Claimed
Length: 6
Description: The sum of the item cost, dispensing fee, and mark-up for the item, less any third-party share.

Field Name: Days Supply
Length: 3
Description: Estimate of the number of days of treatment contained in the prescription.

Field Name: Total
Length: 6
Description: The total dollar amount claimed for all items (up to 3) listed on the claim form.

Field Name: *Prescriber
Length: 10
Description: 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 will be rejected on the NIHB MS&E Claim Statement with an **R14** error (Insufficient Benefit Information to Adjudicate Claim).

- British Columbia Physician License Number
- Alberta Physician License Number

- Saskatchewan Physician's Provincial Billing Number
- Manitoba Physician License Number
- Ontario Physician License Number
- Quebec Physician License Number
- New Brunswick Physician's Provincial Billing Number
- Nova Scotia Physician License Number
- Prince Edward Island Physician License Number
- Newfoundland Physician License Number
- Yukon Physician's Territorial Billing Number
- Northwest Territories Physician License Number
- Nunavut Physician License Number

Data Element Descriptions -- Medical Supplies and Equipment Provider Information

List Terminology:

Field Name:
The name of the field, corresponds to the field on the claim form.
Length:
The field length specification for claims submitted on computer printouts or diskettes.
Description:
A brief description of the data element.

Fields marked with an asterisk (*) are mandatory.

Field Name: *Prior Approval No.
Length: 8
Description: An authorization number, which must be issued by FNIHB before the provider dispenses certain drugs, medical supplies and most medical equipment.

Field Name: *Provider/Supplier Name
Length: N/A
Description: The name of the provider/supplier submitting the claim. May be formatted as determined by the provider/supplier.

Field Name: *Provider/Supplier Address
Length: N/A
Description: The address of the provider/supplier submitting the claim. May be formatted as determined by the provider/supplier.

Field Name: *Provider/Supplier Number
Length: 10
Description: The number assigned to the provider/supplier upon registration as an NIHB provider with FCH.

Parent Information (required for infants under one year of age)

An infant under one year of age who does not yet have a client identification number may receive benefits if one of the infant's parents can be verified as an eligible 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 (**Note**: these claims may only be submitted using the Non-Insured Health Benefits Sample Medical Supplies and Equipment Claim Form) , and this information about the parent must be provided:

List Terminology:

Field Name:
The name of the field, corresponds to the field on the claim form.
Length:
The field length specification for claims submitted on computer printouts or diskettes.
Description:
A brief description of the data element.

Fields marked with an asterisk (*) are mandatory.

Field Name: *Parent's Surname
Length: 30
Description: The surname under which the parent is registered.

Field Name: *Parent's Given Names
Length: 30
Description: The given names under which the parent is registered. Submission of more than one given name is preferred to facilitate client verification. Initials are not acceptable.

Field Name: *Parent's Date Of Birth (DD/MM/YYYY)
Length: 8
Description: The parent's full birth date in day-month-century-year format (for example, 13/05/1956 represents 13 May 1956). Partial birth dates are not acceptable.

Field Name: * Address /Apt/ City / Prov./Postal Code
Length: N/A
Description: The current and exact address of the parent.

Field Name: *Parent's Client Identification No.
Length: 10
Description: The unique number under which the parent is registered. This number may be one of:

- 9 or 10-digit number issued by Indian and Northern Affairs Canada (INAC),
- 3-digit band number, immediately followed by the 4 or 5-digit family number identifying the family unit within the client's band,
- An alpha prefix followed by 8 digit number issued to certain eligible clients by FNIHB, or
- A health care number issued by the Government of the Northwest Territories or Nunavut.

Field Name: *Parent's Band No. *(Not Applicable To Inuit Clients)*
Length: 3
Description: A 3-digit number (For example, 002, 311) identifying the band to which the infant's parent belongs. The band number, if submitted in combination with the family number, is an acceptable alternative to the INAC client identification number.

Field Name: Parent's Family No. *(Not Applicable To Inuit Clients)*
Length: 5
Description: A 4 or 5-digit number (For example, 1041, 04120) identifying the family unit, within the band, to which the infant's parent belongs. The family number, if submitted in combination with the band number, is an acceptable alternative to the INAC client identification number. If the family number has fewer than 5 digits, please insert the appropriate number of zeros in front of the number.

Claim Payment Options

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 Sample Modifications to Pharmacy/Medical Supplies and Equipment Information Form. Inquiries related to the payment of claims or the EFT option should be directed to the Non-Insured Health Benefits Toll-Free Inquiry Centre.

Note: In order to ensure cheque payments are mailed properly, providers should ensure that FCH has current address information at all times.

Non-Insured Health Benefits Medical Supplies and Equipment Claim Statement

The Non-Insured Health Benefits Sample Medical Supplies and Equipment Claim Statement accompanies the claims payment cheque and provides information about each medical supply and equipment claim processed. If payments are made through EFT, the NIHB MS&E Claim Statement is mailed to the provider's business address. The statement may provide additional client identification information which should be added to the client's records and be used for all future submissions.

The NIHB MS&E Claim Statement lists all submitted and entered claims which were settled in the current period, adjusted claims during the current period, and claims rejected during the current period. Rejected claims include the appropriate reject message explaining the reason why each claim was not paid. NIHB MS&E Claim Statements are issued twice a month in either French or English, depending on the provider's language of choice.

The NIHB MS&E Claim Statement may be used to reconcile the providers' account and should be referenced when making inquiries. Corrections to claims should be indicated directly below the existing information and forwarded to FCH within 12 months of the service date for re-adjudication of the claim. ***The existing information should not be altered or erased***. Providers who resubmit using a claim form must clearly indicate the claim is a resubmission.

An administrative fee of $25.00 applies to requests 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 duplicate statement being requested has not been cashed and enough time has passed that the original statement should have been received in the mail, the $25.00 administrative fee will not apply and the provider's $25.00 cheque will be returned with the copy of the statement.

Note: In order to ensure cheque payments are mailed properly, providers should ensure that FCH has the current address information at all times.

NIHB Medical Supplies and Equipment Claim Statement Messages and Explanations

The NIHB HICPS system assigns three-character reject and warning codes along with messages that appear on the NIHB MS&E Claim Statement. 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.

Here are explanations of all codes and messages, which may appear on the NIHB MS&E Claim Statement:

List Terminology:

Code: Either a reject or warning code issued by the system.
Message: A brief text message explaining why the claim was rejected or adjudicated.
Explanation: The detailed explanation as to why the claim was rejected or adjudicated.

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 cannot be paid because the claimant could not be verified as an NIHB client. The verification problem may be due to the fact that the claimant

a. has not used his or her 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 an NIHB client, it will be necessary for the claimant to do so before service can be provided.

Code: R06
Message: Client is not eligible for this benefit
Explanation: The claim has not been paid because the item 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.

Code: R07
Message: This is a duplicate claim
Explanation: The claim cannot be paid because it is a duplicate of a claim previously submitted by the provider.

Code: R10
Message: Invalid provider ID
Explanation: Provider is not registered as an NIHB provider on date of service.

Code: R12
Message: Insufficient client information to adjudicate claim
Explanation: The claim 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:

a. Surname;
b. Given Names;
c. Date of Birth; and
d. Client Identification Number.

Please check your claim for missing or incomplete information and provide the required information by following the claims correction procedures outlined in Non-Insured Health Benefits Sample Medical Supplies and Equipment Claim Statement. Further information on client identification requirements is provided in Client Identification section.

Code: R14
Message: Insufficient benefit information to adjudicate claim
Explanation: The claim did not provide sufficient information to determine if the claimed item is eligible under the NIHB Program. This information must be provided on each claim:

a. Date of Service;
b. Quantity;
c. Item Code;
d. Item Cost;
e. Prescription Number; and
f. Prescriber ID.

The provider should check the claim for missing or incomplete information and provide the required information by following the claims correction procedures outlined in Non-Insured Health Benefits Sample Medical Supplies and Equipment Claim Statement.

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 item. This includes cases in which a provincial or territorial patient co-pay or user fee system exists and NIHB has already paid the maximum amount for which the client is responsible. Please 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 cannot be 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 cannot be paid because the date of service is after the end date for the client's NIHB coverage.

Code: R25
Message: Claim does not comply with 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 Confirmation.

Code: R26
Message: Prior approval service date violation
Explanation: The claim has not been paid because the date of service is either before the approval date or after the expiry date of the prior approval.

Code: R27
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 Non-Insured Health Benefits Sample Medical Supplies and Equipment Claim Statement.

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 indicated item. In some cases, the client may belong to a band that has assumed responsibility of the NIHB Program. Please contact the applicable FNIHB Regional Office for direction on where to submit the claim. The numbers and addresses of the FNIHB Regional Offices are provided at the beginning of the Kit.

Code: R47
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.

Code: R48
Message: Prior approval for this item used up by previous claim
Explanation: The claim has not been paid because prior approval for this item has been used up by a previous claim. Refer to your copy of the Prior Approval Confirmation.

Code: R49
Message: Benefit requires prior approval
Explanation: The claim has not been paid because it requires prior approval from the FNIHB Regional Office. Benefits, which require prior approval, are indicated in Non-Insured Health Benefits Medical Supplies and Equipment Benefit Lists. Prior approval procedures are detailed in Prior Approval Process.

Code: R50
Message: Frequency of the claim exceeds maximum allowed
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 Lists. Benefits with frequency limits that do not require prior approval must be prior approved if the claim exceeds the maximum allowed.

Code: R66
Message: Date of service must be after DOB
Explanation: The claim has not been paid because the client's date of birth is after the date of service.

Code: W05
Message: Claims paid on parent ID 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 will be rejected if the infant cannot be verified as an NIHB client. Additional information on client identification requirements for infants is provided in Client Identification.

Code: W09
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. Please refer to the details of the NIHB pricing guidelines in your region.

Code: W11
Message: Claim is reduced to NIHB share
Explanation: The item is partially covered by a provincial, territorial, or third party plan. The amount claimed is reduced to the correct NIHB share.

Code: W13
Message: Quantity of claim is reduced to maximum allowed
Explanation: The amount claimed has been reduced to conform to the maximum allowed.

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.

Please use the corrected client ID on future claims to facilitate client verification.

Code: W17
Message: Claim adjusted to comply with terms of prior approval
Explanation: The amount claimed is reduced to comply with the terms of the prior approval set out by the FNIHB Regional Office. The provider should refer to the Prior Approval Form or the Prior Approval Confirmation.

Code: W19
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. Please refer to the details of the NIHB pricing in your region.

Code: W20
Message: Markup is disallowed or reduced to NIHB pricing guidelines
Explanation: The mark-up has been disallowed or reduced to conform to NIHB pricing guidelines. Please refer to details of the NIHB pricing guidelines in your region.

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

Code: W99
Message: This claim is in suspense
Explanation: This claim requires additional investigation before it can be fully adjudicated. No action is required by the provider at this time. The adjudication result will appear on a future statement.

Provider Audits - Medical Supplies and Equipment

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 objective of the audit program is to ensure that the Non-Insured Health Benefits (NIHB) Program is appropriately billed by providers for the benefits and services provided in conformity with NIHB policy.

Overview

The overview is intended to provide a better understanding of the medical supplies and equipment (MS&E) provider audit process and the requirements for claims adjudication under the NIHB Program. The audit activities are based on generally accepted industry practices and accounting principles and may be carried out, up to two years from the date a prescription is dispensed.

As a publicly funded Program, it is a federal requirement to account for the expenditure of those public funds. The MS&E Provider Audit Program contributes to the fulfillment of this overall requirement. The agreement signed by providers allows First Canadian Health (FCH) to verify paid claims against MS&E records.

On behalf of the NIHB Program, FCH conducts administrative audits of paid claims for services rendered to NIHB clients. All audit activities, from the selection of providers for audit, to issuance of audit documentation to providers regarding the findings, are approved by representatives of the NIHB Program.

The NIHB Program and FCH Management Inc. highly regard and value the services provided to NIHB Program clients. The purpose of the Audit Program is to share with providers information about proper billing conditions, and to verify paid claims against the NIHB Program requirements.

The following overview outlines the objectives and components relating to the audit of claims on behalf of the NIHB Program.

Audit Objectives

The objectives of the FCH Provider Audit Program are as follows:

- to ensure that providers have retained appropriate documentation, meeting both provincial and federal regulations as well as program requirements, in support of each claim, in accordance with the Pharmacy/MS&E Provider Agreement;
- to ensure that services paid for were received by NIHB clients;
- to detect billing irregularities;
- to validate active licensure of the providers.

Audit Components

The components of the FCH Provider Audit Program are outlined below. To carry out the Next Day Claims Verification and On-Site Audit Program, FCH requires access to the following information:

- Client's profile
- Original prescription
- Shipping invoices
- Internal invoices
- Documentation of item receipt by the client
- Evidence of additional coverage (to coordinate benefits)

Next Day Claims Verification Program - Consists of a review of a defined sample of claims submitted by service providers the day following receipt by FCH. Service providers may be contacted to provide copies of prescriptions and/or invoices as well as any other supporting financial data. Any errors detected through this process will result in the claim being reversed.

Client Confirmation Program - Consists of a quarterly mailout to a randomly selected sample of NIHB clients to confirm the receipt of the benefit that has been billed on their behalf.

Provider Profiling Program - Consists of a review of the billings of all service providers against selected criteria and the determination of the most appropriate follow up activity if concerns are identified. All claims are subject to review by audit. Any claims not meeting Program criteria will be subject to audit reclaim.

On-Site Audit Program - Consists of the selection of a sample of claims for validation with a service provider's records through an on-site audit.

On-Site Audit Program

Providers are not randomly selected for audit. Providers may be selected for an on-site audit as a result of information gained through the above three components and any additional information received. FCH contacts the provider at least three weeks prior to the proposed on-site audit date. Every effort is made to accommodate the audit date with the provider's schedule. The date agreed upon for the on-site audit is confirmed by fax with the provider.

Stages of the On-Site Audit

Pre-Audit/Entrance Interview

Upon arrival, the auditors will introduce themselves, meet with the business staff who will be involved in the audit, and provide an explanation of the audit process. The provider will be asked to describe the records filing system for clients, and whether the documentation for claim transactions are maintained on hard copy or electronically on the client's profile. The provider will be asked whether the prescription records under review are to be retrieved by the provider staff or the auditors. The auditors will indicate to the provider that a post-audit summary will be provided at the end of the on-site audit.

Conduct of the On-Site Audit

The purpose of the on-site audit is to verify paid claims against provider records. At the end of each audit day, a list of prescriptions or documents not found by the auditor will be provided to the provider. The provider has the opportunity to locate and supply the documentation to the auditor the next audit day. If any documents are not located by the end of the on-site audit, the provider has the opportunity to send these documents to the auditor within two weeks of the end of the audit. Claims not supported by the required documentation will appear as recoveries in the audit letter and report to the provider.

Post-Audit Interview

At the end of the on-site audit, the auditor will provide a general overview of the categories of errors found. The final audit results will not be complete until the auditor has conducted additional analysis, such as, but not limited

to, client and prescriber confirmations. During the post-audit exit interview the provider will be given a standard checklist to complete and send to FCH, which serves to confirm the audit process conducted at the respective on-site audit.

Audit Report

A report of the audit findings will be sent to the provider within 60 days of the on-site audit. If there are delays in meeting this deadline, a letter will be sent to the provider advising of the delay and the revised delivery date for sending the audit letter and report. Once the audit letter and report are received, and in the event that there are audit observations resulting in recovery of claims, the provider has 30 days to respond to FCH. If the provider needs additional time to respond, a request for additional time can be sent in writing to FCH.

Within 60 days of the response from the provider, FCH will send a letter and a report of the final audit findings to the provider. In the event that there are final audit findings resulting in recovery of claims, the provider has 30 days from the date of the letter to respond to FCH. Failure to respond within 30 days of the 2nd letter, will result in a withhold against the provider's payment statements until recovery is paid in full.

Guidelines

The audit activities are based on generally accepted industry practices and accounting principles and may be carried out up to a maximum of five years from the date of service.

The provider must maintain records relating to NIHB clients and their prescriptions in accordance with all applicable laws. All records shall be treated as confidential so as to comply with all applicable provincial and federal legislation regarding the confidentiality of patient records. A separate valid prescription (as defined by federal and provincial legislation) is required for each member of a family for the reimbursement of claims submitted under the NIHB Program.

As part of the audit process, FCH may contact the prescribing physician to verify clients and prescriptions and contact the client to substantiate the receipt of the item and the specific claim information.

As a provider registered to submit claims under the NIHB Program, the provider in accordance with the First Canadian Health Management Corporation Inc. Pharmacy/MS&E Provider Agreement will assist FCH, or a third party authorized by FCH, by:

- Granting access to the provider's premises, during the provider's normal business hours, to inspect, review and reproduce any medical supplies and equipment records maintained by the provider pertaining to NIHB claims;
- Providing access to all relevant documentation such as, but not limited to, client's profile, original prescriptions and cancelled or revoked prescriptions; shipping invoices; and
- Responding to requests for documentation via mail or fax within the specified response time.

Providers will be advised of any audit findings and will have the opportunity to respond to the audit findings within 30 days from the receipt of the audit report. FCH will consider further documentation a provider may wish to submit in support of its claim. Once the audit report has been finalized, all overpayments must be corrected by the provider remitting a cheque payable to FCH.

NIHB may refer concerns arising from such audits, to the appropriate federal, provincial or territorial professional regulatory bodies or the RCMP.

Reference Documents

- FCH MS&E Provider Agreement
- FCH MS&E Provider Information Kit

- NIHB/FCH Newsletters – issued quarterly
- NIHB Program MS&E Bulletins
- NIHB/FCH MS&E Newsletters

Additional Information

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