Health Canada Santé Canada

Non-Insured Health Benefits

The Non-Insured Health Benefits Program provides supplementary health benefits, including dental treatment, for registered First Nations and recognized Inuit throughout Canada.
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DENTAL
POLICY FRAMEWORK
OCTOBER 2005

"Our mission is to help the people of Canada maintain and improve their health"

Canada

NON-INSURED HEALTH BENEFITS (NIHB) PROGRAM

First Nations and Inuit Health Branch

Health Canada

DENTAL POLICY FRAMEWORK
Version 1 – OCTOBER 2005

Ce document est aussi offert en français sous le titre :

CADRE DE TRAVAIL SUR LES SOINS DENTAIRES
Version 1 – OCTOBRE 2005

This document provides important information about the dental benefits available under the NIHB Program.

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INTRODUCTION

Foreword

The Non-Insured Health Benefits (NIHB) Program provides a limited range of medically necessary health-related goods and services not provided through private insurance plans, provincial/territorial health or social programs or other publicly funded programs to eligible registered First Nations and recognized Inuit (clients). The benefits provided under the NIHB Program supplement private insurance or provincial/territorial health and social programs, such as physician and hospital care and community health programs. The benefits funded include prescription drugs, over-the-counter medication, medical supplies and equipment, short-term crisis intervention mental health counselling, dental care, vision care and medical transportation to access medically required health services not provided on the reserve or in the community of residence. The NIHB Program also funds provincial health premiums for eligible clients in Alberta and British Columbia.

Framework Objective

The NIHB Dental Policy Framework defines the terms and conditions, policies and benefits under which the NIHB Program will fund dental services for eligible registered First Nations and recognized Inuit. The Framework sets out a clear definition as to the eligibility of clients, the types of benefits to be provided and criteria under which they will be funded.

1. GENERAL PRINCIPLES

1.1 The NIHB Dental Policy Framework defines the policies and benefits under which the NIHB Program will fund dental services for eligible registered First Nations and recognized Inuit (clients).

1.2 The NIHB Dental Policy Framework applies to the funding of dental benefits by the First Nations and Inuit Health Branch (FNIHB) Regional Offices or by First Nations or Inuit Health Authorities or organizations (including territorial governments) who, under a contribution agreement, have assumed responsibility for the administration and funding of dental benefits to eligible clients.

1.3 Dental benefits are funded in accordance with the mandate of the NIHB Program, which includes providing non-insured health benefits that are appropriate to the needs of the clients and are sustainable. The Program was set up with no deductibles or co-payments.

1.4 The NIHB Program provides benefits based on policies established to provide eligible recipients with access to benefits not otherwise available under federal, provincial, territorial or private health insurance plans.

1.5 The NIHB Program covers most dental procedures that treat disease or the consequences of dental disease.

1.6 Funding of dental services is determined on an individual basis taking into consideration criteria such as the client's oral health status.

1.7 As indicated in the Program policies, compliance with conditions of function and restorability is required. Extensive rehabilitation, such as cosmetic treatment and lack of compliance with policies, is not covered by this Program.

1.8 Qualified and legally licensed practitioners may provide eligible clients emergency and other necessary services identified in this framework provided that the services are rendered within Program criteria including policies, frequency limitations and predetermination limitations stated.

1.9 When claiming for services, it is the practitioner's responsibility to:
- a) verify the eligibility of the client;
- b) ensure that no limitations will be exceeded; and
- c) ensure compliance with NIHB funding criteria and policies.

2. BENEFIT DESCRIPTION AND CONDITIONS

The NIHB dental program funds a broad range of services including; diagnostic, emergency, preventive, restorative, endodontic, periodontic, prosthodontic, oral surgery, orthodontic and adjunctive services. The individual services are contained in the NIHB Regional Dental Benefit Grid and are based on codes of the *Canadian Dental Association Uniform System of Coding and List of Services* (Schedule A&B). In Québec, codes are based on the *Association des chirurgiens dentistes du Québec Fee Guide for Dental Treatment Services*. Terms and conditions for funding are contained within this Framework, the NIHB Regional Dental Benefit Grid, the Dental Provider Information Kit (DPIK) and the Non-Insured Health Benefits Dental Bulletin.

NIHB Regional Dental Benefit Grid

The NIHB Regional Dental Benefit Grid clarifies what services require predetermination by placing benefits into one of the following two schedules:

Schedule A: outlines services that may be completed and billed directly to First Canadian Health (FCH) for payment. Preverification is advised to confirm services are within frequency limitation.

Schedule B: outlines services that require predetermination.

For a complete list of NIHB benefits please refer to Schedule A & B of your grid.

Terms and Conditions of Services

The terms and conditions applied to individual service codes are identified in the NIHB Regional Dental Benefit Grid. General terms and conditions of service are provided below for each area of dental services.

Diagnostic Services

Clients under 17 are eligible for up to four examinations and those 17 and older are eligible for up to three examinations in any twelve month period provided these examinations are within the guideline limits which include: complete, recall, specific and emergency examination services provided by any dental professional.

When a complete examination is provided it replaces the recall examination for the period.

When an examination is performed, another examination, without an appropriate explanation, will not be approved if conducted within the same office/group.

Diagnostic radiographs must accompany procedures requiring predetermination, where relevant and as outlined in the NIHB Regional Dental Benefit Grid and Policy.

All radiographs submitted with a treatment plan must be recent, mounted, dated, and of diagnostic quality. The provider name and the client name must be indicated on the mount. Whenever duplicate radiographs are submitted, the provider must indicate on the radiograph whether the radiograph is on the right or left side of the client's mouth.

Preventive Services

Supporting radiographs, periodontal charting and rationale are required for scaling root planing (scaling/polishing-prophylaxis in Québec) exceeding the limit of 4 units within a twelve (12) month period. See Periodontic Policy on page 15.

Pit and fissure sealants/preventive resins are funded for children under the age of 14, on recently exposed permanent molar teeth where the occlusal surface is unrestored and the lingual surface of permanent maxillary incisors.

Children under the age of 12 are eligible for 1 unit of scaling or root planing in a 12 month period for the following procedure codes for all provinces/specialities: 11111, 11117, 43421, 43427 (in Québec 43411). See Periodontic Policy on page 15.

Occlusal adjustment will be funded at the cost of one half unit.

Restorative Services

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

Four and five- surface amalgam/tooth coloured primary tooth restorations exceed the cost of stainless steel/polycarbonate crowns in most provincial and territorial fee schedules. The NIHB Program limits payment of primary tooth restorations to the cost of stainless steel/polycarbonate crowns.

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

Replacement of restorations within a two (2) year time frame is subject to audit and requires rationale.

Restorations on primary incisor teeth number 51, 52, 61, 62, 71, 72, 81, 82 will only be eligible for children under the age of 5.

Endodontics

Endodontic therapy on anterior teeth (13-23, 33-43 inclusive) may be completed without predetermination. However, it is expected that the provider will ensure that the functionality and restorability of the anterior teeth requiring endodontic therapy will meet the criteria as listed in the policy (see page 13) prior to proceeding with treatment.

Predetermination for bicuspid and molar teeth remains mandatory.

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

Pulpotomies and pulpectomies are not eligible on primary incisor teeth number 51, 52, 61, 62, 71, 72, 81, 82.

Incomplete root canal therapy will be funded to the equivalent of a pulpectomy.

Periodontics

Periodontal appliance maintenance, including repairs and adjustments, are limited to 3/36 month period, per life of appliance. See Periodontic Policy on page 15.

Prosthodontics

The fee paid for dentures includes three months post-insertion care including adjustments and modification. FNIHB does not, therefore, cover any other denture

procedures (for example: adjustments) during this period. For immediate dentures, an additional reline is permitted.

Appliances for the replacement of a posterior edentulous space equivalent to, or less than the width of a standard molar, is not a funded benefit of the Program.

Non-Inserted Denture Policy

Dentures that are not inserted, but the provider has informed NIHB, the program will pay 100% of the lab and 20% of the professional fee when the lab has been completed on a denture. The billing service date to be used when submitting a claim, is the date of the last visit to the provider/office.

If the provider has wrongfully billed the Program and it is found in an audit or through the predetermination process, there will be a zero tolerance and all monies will be removed.

Note: For immediate dentures as long as a different provider will be doing the insertion after the extractions, compensation once the denture has been completed will be 100% professional fee and 100% lab. In the case of Denturists this will always be the case.

Prosthodontics - Removable

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

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

Maryland Bridge Policy

As a result of improving cementing resins, increased retention, and the fact that Maryland Bridges offer a simpler functional and more aesthetic replacement modality than partial dentures, Maryland Bridges will be considered on an exception basis when the client's needs meet the following criteria:

1. No more than three units per bridge.
2. Limited to anterior sextants.
3. Proposed permanent tooth abutments must have nil to minimal restorations.

Appliances for a single space in a posterior situation are not a funded benefit of the Program.

Prosthodontics - Fixed

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

Oral Surgery

Implants and ridge augmentation are not funded benefits under this Program.

Orthodontics

The NIHB Program covers a limited range of orthodontic benefits. Clients must meet the clinical criteria and guidelines established by the NIHB Program for their orthodontic treatment to be funded. Health Canada relies on practitioners to assist individuals to submit the required information in order for a review to take place.

Adjunctive Services

General Anaesthesia and Facility Claims

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

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

Intravenous or Inhalation Sedation

Intravenous sedation and inhalation sedation cannot be billed as separate procedures.

3. POLICIES

Crown Policy

The objective of this policy is to clarify the decision making process as currently applied when funding single crowns (metal or porcelain-fused to metal) as well as any associated treatment.

All crowns will require predetermination.

The following criteria must be met with each submission for consideration of funding for single unit crowns:

Complete Documentation Including:

- completed Standard Dental Claim Form, l'Association des chirurgiens dentistes du Québec (ACDQ) Dental Claim and Treatment Form, computer generated form, or NIHB DENT-29 Form;
- current radiographs including bitewings, panoramic radiographs, and/or any periapical films specific to the requested treatment;
- radiographs should identify the client, provider and must be mounted, dated and of acceptable quality to enable predetermination of the proposed treatment; and
- a comprehensive treatment plan addressing all treatment needs for the mouth. If active biological disease is present (caries and periodontal disease), all treatment to address that disease must be completed before submitting for single unit crowns.

Funding for a single unit crown will be approved when both the functionality and restorability of the tooth (teeth) requested have been met.

Determination of Functionality of Teeth

- NIHB will consider funding of a single unit crown for functional teeth that have been previously endodontically treated and/or are extensively restored, are deemed to be essential in maintaining a stable occlusion, and/or are critical abutments for any planned removable prosthodontic treatment; and
- A vital or non-vital tooth that has an existing extensive restoration that can no longer function as an independent restoration. Endodontically treated teeth will be considered for a single unit crown following completion of endodontic therapy, and demonstrated success as evidenced by a current post-treatment periapical film and (if required) provider comments.

Determination of Restorable Teeth

Restorability will be established by reviewing all submitted documentation for:

- a favourable crown-root ratio (at least 1:1);
- adequate periodontal support, based on alveolar bone levels (at least greater than 50%) visible on submitted radiographs with absence of furcation involvement, in addition to further supporting documentation, where necessary, indicating mobility and attachment loss;
- adequate remaining non-diseased tooth structure to ensure that biologic width is maintained; and
- no need for complex treatment such as crown lengthening, root re-sectioning or orthodontic treatment.

Single unit crowns will not be funded when:

- the functionality and restorability of the tooth/teeth cannot be established;
- there is evidence of uncontrolled biological disease (either caries or periodontal disease);
- the client is under the age of 18 years;
- the crown is being placed to improve esthetics; and
- an existing crown is less than 8 years old, and replacement is being requested. All requests for replacement must include the age of the existing crown in addition to a rationale for replacement.

Non-Inserted Crown Policy

Crowns that are not inserted, but the provider has informed NIHB, the program will pay 100% of the lab and 20% of the professional fee when lab has been completed on a crown. The billing service date to be used when submitting a claim is the date of the last visit to the provider/office.

If the provider has wrongfully billed the program and it is found in an audit or through the predetermination process, there will be a zero tolerance and all monies will be recovered.

Endodontic Policy

The objective of this policy is to clarify the decision making process as currently applied when funding endodontic treatment.

Endodontic therapy on anterior teeth (13-23, 33-43 inclusive) (procedure codes 33111 and 33100) may be completed without predetermination. Predetermination for bicuspid and molar teeth remains mandatory. However, it is expected that the provider will ensure that the functionality and restorability of the anterior teeth requiring endodontic therapy will meet the criteria as listed below prior to proceeding with treatment.

Incomplete root canal therapy will be funded to the equivalent of a pulpectomy.

The following information must be included when requesting funding for endodontic treatment:

Complete Documentation Including:

- a completed Standard Dental Claim Form, ACDQ Dental Claim and Treatment Form, computer generated form, or NIHB DENT-29 Form;
- current radiographs including periapical films specific to the requested treatment, and or bitewings, panoramic radiographs;
- radiographs should identify the client, provider, and must be mounted, dated and of acceptable quality to enable predetermination of the proposed treatment; and
- a comprehensive treatment plan. If rampant biological disease is present, treatment plans should include all restorative, periodontal, preventive, prosthodontic and endodontic treatment, with the understanding that endodontic treatment will be undertaken only after active caries and/or periodontal disease has been addressed.

Endodontic treatment will be approved for funding when both functionality and restorability of the tooth (teeth) requested have been met.

Determination of Functionality of Teeth

- NIHB will consider funding endodontic treatment for teeth numbered 16 to 26 and 36 to 46, inclusive. Teeth numbered 17, 18, 27, 28, 37, 38, 47 and 48 may be considered only if they are deemed to be essential in maintaining a stable occlusion. Teeth will be considered functional if they are seen to be a critical abutment for any planned removable prosthodontic treatment.

Determination of Restorable Teeth

- a favourable crown-root ratio (at least 1:1);
- adequate periodontal support, based on alveolar bone levels (greater than 50%) visible on submitted radiographs and degree of furcation involvement, in addition to further supporting documentation, where necessary, indicating mobility and attachment loss.
- adequate remaining non-diseased tooth structure to ensure that biologic width can be maintained during restoration; and
- no need for further complex dental treatment such as crown lengthening, root re-sectioning or orthodontic movement.

Endodontic treatment will not be funded when:

- the functionality and restorability of the tooth/teeth cannot be established; and
- when there is evidence of uncontrolled and/or untreated rampant biological disease (either caries or periodontal disease).

Periodontic Policy

The objective of this policy is to clarify the decision making process as currently applied when funding supportive periodontal therapy and associated procedures.

The following criteria must be met with each submission for consideration of funding for additional periodontal treatment:

Complete Documentation Including:

- completed Standard Dental Claim form, ACDQ Dental Claim and Treatment form, computer generated form or NIHB DENT-29 Form;
- current radiographs including bitewings, panoramic radiographs, and/or any periapical films specific to the requested treatment;
- radiographs should identify the client, provider, and must be mounted, dated and of acceptable quality to enable predetermination of the proposed treatment;
- a comprehensive treatment plan addressing all treatment needs in addition to the requested periodontal therapy;
- documentation of pocket depths and locations (full mouth probings, or periodontal screening indices such as « Community Periodontal Index of Treatment Needs » (CPITN) and « Probing, Screening and Recording » (PSR) etc are acceptable); and
- an additional assessment of gingival contours, mobility of teeth and occlusion of teeth.

The following periodontal treatment does not require predetermination, and will be funded based on program guidelines:

- scaling in combination with root planing, will be funded to a maximum of 4 units/12 months for clients 12 years of age and older; and
- scaling in combination with root planing will be funded to a maximum of 1 unit/12 months for clients under12 years.

Additional extensive periodontal therapy will be considered for each of the following categories when the criteria listed below have been met.

1. Scaling and root planing beyond 4 units

NIHB will consider funding when:

- the client has not had routine treatment periodontal care in the past 24 months and 4 units are inadequate for complete debridement. An additional 4 units may be funded to a maximum of 8 units per 12 months;

- the client has recurrent gingivitis without additional attachment loss. An additional 4 units may be funded to a maximum of 8 units per 12 months (4 units semi-annually);
- the client presents with chronic periodontal disease (as demonstrated by attachment loss), or has completed initial debridement. An additional 12 units may be funded for maintenance to a maximum of 16 units per 12 months, allowing NIHB to fund periodontal maintenance at 3 month intervals; and
- the client presents with chronic periodontal disease and has been following a program of periodontal maintenance, but presents with areas of refractory disease. NIHB will consider, on a one time basis, funding of up to an additional 16 units (in four consecutive treatment sessions) to address the disease.

2. Gingivoplasty, Gingivectomy

NIHB will consider funding following the completion of preliminary gingival therapy (scaling/root planning) and:

- the provider has indicated the presence of gingival hyperplasia associated with a positive drug history of known gingival hyperplastic agents.

3. Gingival Grafts

NIHB will consider funding when:

- the provider has indicated the presence of pathologic loss of gingiva, leading to inadequate gingival width for a tooth (teeth) that has been established as a critical abutment for the support of any removable prosthetics.

NIHB will not consider funding when:

- the tooth (teeth) for which grafting is requested shows severe, chronic periodontal disease; and
- gingival grafts are to improve esthetics.

4. Periodontal Surgery

NIHB does not customarily fund periodontal surgery, although, it may be considered on an exception basis. Requests for the maintenance of chronic periodontal disease beyond adequate oral hygiene and scaling/root planing are beyond the scope of the program.

5. Bruxism Appliance

NIHB will consider funding when:

- the provider has indicated excessive attrition of the teeth as evidenced by age inappropriate wear facets or extensive multiple wear facets;
- the client presents with neuralgiform complaints in the form of muscle pain, spasm, or asymmetric or inhibited mandibular movements; and
- the client presents with abnormal joint mobility, clicking, pain, swelling and/or asymmetric movements.

Unmounted diagnostic models may be requested for a bruxism appliance.

NIHB will not consider funding when:

- the client does not have a fully erupted permanent dentition;
- the client presents with asymptomatic clenching/bruxism/clicking; and
- the appliance is to be used as a sports mouthguard.

Periodontic Policy - Québec Region

The objective of this policy is to clarify the decision making process as currently applied when funding supportive periodontal therapy and associated procedures.

The following periodontal treatment does not require predetermination, and will be funded based on program guidelines:

Prophylaxis in combination with scaling codes will be funded to a maximum of 4 units/12 months. Clients under the age of 17 are funded for 2 prophylaxis and 2 units of scaling. For clients 17 years of age and older are funded for 1 prophylaxis and 3 units of scaling.

The following criteria must be met with each submission for consideration of funding for additional periodontal treatment:

Complete documentation including:

- completed Standard Dental Claim form, ACDQ Dental Claim and Treatment Form, computer generated form or NIHB DENT-29 Form;
- current radiographs including bitewings, panoramic radiographs, and/or any periapical films specific to the requested treatment;
- radiographs should identify the client, provider, and must be mounted, dated and of acceptable quality to enable predetermination of the proposed treatment;
- a comprehensive treatment plan addressing all treatment needs in addition to the requested periodontal therapy;
- documentation of pocket depths and locations (full mouth probings, or periodontal screening indices such as CPITN, PSR, etc are acceptable);
- an additional assessment of gingival contours, mobility of teeth and occlusion of teeth; and
- unmounted diagnostic models are required for a bruxism appliance.

Additional extensive periodontal therapy will be considered for each of the following categories when the criteria listed below have been met.

1. Prophylaxis in combination with scaling beyond 4 units

NIHB will consider funding for scaling when:

- the client has not had routine treatment periodontal care in the past 24 months and 4 units are inadequate for complete debridment. Additional units may be funded.

2. Periodontal Curretage and Root Planing

NIHB will consider additional funding when:

- the client presents with chronic periodontal disease (as demonstrated by attachment loss), and has completed initial debridment; and
- the client presents with chronic periodontal disease**,** has been following a program of periodontal maintenance, but presents with areas of refractory disease.

3. Gingivoplasty, Gingivectomy

NIHB will consider funding when after completion of preliminary gingival therapy (scaling/root planing):

- the provider has indicated the presence of gingival hyperplasia associated with a positive drug history of known gingival hyperplastic agents.

4. Gingival Grafts

NIHB will consider funding when:

- the provider has indicated the presence of progressive pathologic loss of gingiva, leading to inadequate gingival width for a tooth (teeth) that has been established as a critical abutment for the support of any removable prosthetics.

NIHB will not consider funding when:

- the tooth (teeth) for which grafting is requested shows severe, chronic periodontal disease; and
- gingival grafts are to improve esthetics.

5. Periodontal Surgery

NIHB does not customarily fund periodontal surgery, although, it may be considered on an exception basis where refractory periodontal disease can be demonstrated. Requests for the maintenance of chronic periodontal disease beyond adequate oral hygiene and scaling/root planing are beyond the scope of the program.

6. Bruxism Appliance

NIHB will consider funding when:

- the provider has indicated excessive attrition of the teeth as evidenced by inappropriate wear facets or extensive multiple wear facets;
- the client presents with neuralgiform complaints in the form of muscle pain, spasm, or asymmetric or inhibited mandibular movements; and
- the client presents with abnormal joint mobility, clicking, pain, swelling and/or asymmetric movements.

NIHB will not consider funding when:

- the client does not have a fully erupted permanent dentition;
- the client presents with asymptomatic clenching/bruxism/clicking; and
- the appliance is to be used as a sports mouthguard.

Orthodontic Policy

The NIHB Program covers a limited range of orthodontic benefits for First Nations and Inuit clients. Clients must meet the clinical criteria (a severe and functionally handicapping malocclusion) and guidelines established by the NIHB Program for their orthodontic treatment to be funded. Health Canada relies on practitioners to assist individuals submit the required information in order for a review to take place.

A severe and functionally handicapping malocclusion is characterized as:

- dento-facial anomalies such as cleft lip and palate. No age restriction.
- a combination of marked skeletal discrepancy (Antero-posterior (AP), transverse, and/or vertical), with associated severe functional limitations.

The purpose of the treatment must be to resolve the identified discrepancies. Age restriction of under 18 years at the time of the case being submitted for assessment.

Orthodontic treatment funding requests submitted to the Orthodontic Review Centre must include:

A. Narrative

- identify the condition for which the treatment is being requested;
- explain diagnosis and prognosis;
- note basic treatment completed to date, including patient's oral hygiene status and motivation;
- include detailed treatment plan;
- estimate duration of active and retention phases of treatment and cost(s); and
- identify additional relevant supporting information.

B. Complete Diagnostic Records

- diagnostic orthodontic models (trimmed);
- cephalometric radiographs(s) and tracing;
- photographs, 3 intra oral, 3 extra oral; and
- panoramic radiograph or full mouth survey

One of the following forms is to be submitted with the funding request; a Standard Dental Claim Form, ACDQ Dental Claim and Treatment Form, computer generated form, or NIHB DENT-29 form for all dental services.

Interceptive Treatment Submission Requirements

As a prevention initiative, funding will be considered for the provision of interceptive orthodontic treatment (8000 series procedures) in the mixed dentition phase of dental development.

Interceptive funding request submitted to the Orthodontic Review Centre must include:

- diagnostic records including working models and a panoramic radiograph;
- a narrative indicating treatment objectives(s), a treatment plan, projected active treatment time and anticipated fee; and
- appropriate form as above.

4. PREDETERMINATION

Predetermination

Services outlined in Schedule B of the NIHB Regional Dental Benefit Grid require predetermination prior to the commencement of treatment.

Preverification

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

5. PAYMENT AND REIMBURSEMENT

Claims Payment Policy

Claims must be submitted to NIHB within one year of the date on which the services were provided. This policy applies to payments to providers for services rendered and reimbursements to clients who have paid fees directly to a provider for services.

Client Reimbursement Policy

Submissions for retroactive coverage must be received within one year from the date of service.

All requests for reimbursement of eligible benefits must include:

- original receipts; and
- a Standard Dental Claim Form, ACDQ Dental Claim and Treatment Form, computer generated form or NIHB DENT-29 form with the NIHB Client Reimbursement Request Form attached.

To obtain a NIHB Client Reimbursement Request Form, contact your FNIHB Regional Office, or visit our website at: www.healthcanada.gc.ca/nihb

Coordination of Benefits Policy

The NIHB Program provides benefits based on policies established to provide eligible recipients with access to benefits not otherwise available under federal, provincial, territorial or private health insurance plans. The Program's policy for providing access to these benefits is that NIHB will not provide coverage to eligible recipients for NIHB benefits that are provided under other health insurance plans.

Claim submissions involving co-payment with a provincial/territorial plan or coordination of benefit with a third party health care plan may only be submitted manually, and must be accompanied with an Explanation of Benefits (EOB). Predetermination of services is required on Schedule B services.

Electronic Claim Submissions - Electronic Data Interchange (EDI)

Dental providers may submit electronic claims and same day reversals for dental services using the EDI system, for real time adjudication. This option is available to dental practitioners 24 hours a day, 7 days a week.

For more information pertaining to claims payment, please refer to the DPIK.

6. EXCEPTIONS

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

7. EXCLUSIONS

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

- Implants
- Veneers
- Ridge augmentation
- Halstrom appliances
- Cosmetic services

APPENDIX A

DEFINITIONS

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

Complete Treatment Plan
A complete treatment plan identifies all the dental needs of a client.

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

Emergency Dental Services
Emergency Dental Services in most instances can be forwarded directly to FCH for payment.

Emergency Dental Services consist of the following:

- diagnosis of specific acute dental problems including associated examination and radiographs;
- procedures to arrest hemorrhage of dental origin including, but not limited to, dressings, packing of tooth sockets and sutures, if initial procedure was performed by another dentist; and
- preliminary case of trauma to the mouth including treatment in hospital under general anaesthesia/sedation (excluding provincial/territorial insured services).

Routine procedures are not normally part of Emergency Dental Services.

Laboratory Fee Submission
Most dental services requiring laboratory work must be predetermined.

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

NIHB Regional Dental Benefit Grid/Association des chirurgiens dentistes du Québec Fee Guide for Dental Treatment Services

This is a document that outlines the dental benefits covered by the NIHB Program and is based on the *Canadian Dental Association Uniform System of Coding & List of Services* and the *Association des chirurgiens dentistes du Québec Fee Guide for Dental Treatment Services*.

"P"

This is the identifier that indicates a procedure code requiring predetermination as identified in Schedule B of the current NIHB Regional Dental Benefit Grid.

Predetermination

Predetermination is a method for the administration and adjudication of dental benefits, which enables both the practitioner and client to understand the proposed treatment and funding commitments.

Prescribing Drugs for NIHB Clients (Lowest Cost Alternative)

The NIHB pharmacy program pays for required drugs prescribed by a dentist. The program provides reimbursement for the "lowest cost alternative" that is, the lowest cost drug available with exactly the same active ingredient as the drug originally prescribed. If it is decided that a certain drug is needed and it is not eligible under the NIHB Program, pharmacists are familiar with the existing process to bill for exceptions.

Preverification

The FCH NIHB Toll-Free Inquiry Centre can preverify eligibility of a procedure which does not require predetermination from FNIHB but which is identified as having a frequency limitation in the current NIHB Dental Benefit Grid.

Provider

A registered dentist or denturist.

APPENDIX B

NIHB CLIENT ELIGIBILITY

To be eligible to receive benefits under the NIHB Program a person must be:

- a registered Indian according to the *Indian Act* (effective December 2002 this includes Innu members of Davis Inlet and Sheshatshiu); or

- an Inuk recognized by one of the Inuit Land Claim organizations - Nunavut Tunngavik Incorporated, Inuvialuit Regional Corporation, Makivik Corporation, or Labrador Inuit Association. For Inuit residing outside of their land claim settlement area, a letter of recognition from one of the Inuit land claim organizations and a long form birth certificate are required; or

- a James Bay Cree and Northern Québec Inuk who lives permanently outside the area covered by the James Bay Northern Québec Agreement or who was not living in the territory at the time the agreement was signed; and

- currently registered or eligible for registration under a provincial or territorial health insurance plan; and

- residing in Canada or a student or migrant worker outside of Canada who is registered or eligible for registration under a provincial or territorial health insurance plan.

Information pertaining to client identification numbers for eligible registered First Nations and recognized Inuit may be found in the DPIK, Section 1.1.

APPENDIX C

PRIVACY

The NIHB Program of Health Canada is committed to protecting an individual's privacy and safeguarding the personal information in its possession. When a benefit request 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 administer and verify benefits.

As a program of the federal government, NIHB must comply with the *Privacy Act*, the *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, increase awareness of the NIHB Program's privacy procedures and practices.

The NIHB 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). This is commonly regarded as the national privacy standard for Canada.

The Privacy Code can be found on the Health Canada website at www.healthcanada.gc.ca/nihb, or obtained from First Nations and Inuit Health Branch Offices.

The Non-Insured Health Benefits Privacy Code will be reviewed and revised on an ongoing basis as Federal Government privacy policies, legislation and/or program changes require. The program would be pleased to receive stakeholder advice on the Code at anytime.

APPENDIX D

APPEAL PROCESS

A client has the right to appeal a denial of a dental benefit under the NIHB Program. There are three levels of appeal available. Appeals must be submitted in writing and can be initiated by the client, legal guardian or interpreter. At each stage, the appeal must be accompanied by supporting information to justify the exceptional need.

At each level of appeal, the information will be reviewed by an independent appeal structure that will provide recommendation to the Program based on the client's needs, availability of alternatives and NIHB policies.

Level 1 Appeal

The first level of appeal is the NIHB Regional Dental Officer/NIHB Regional Manager, First Nations & Inuit Health Branch.

Level 2 Appeal

If the client does not agree with the Level 1 Appeal decision and wishes to proceed further, the second level of appeal is the Regional Director, First Nations & Inuit Health Branch. Joint regional structures may be in place.

Level 3 Appeal

If the appeal is denied at Level 2 and the client does not agree with the decision, they may take their request to the final appeal level. The third and final level of appeal is the Director General, Non-Insured Health Benefits, First Nations and Inuit Health Branch, Jeanne Mance Building, Address Locator 1919A, Room 1909A, Tunney's Pasture, Ottawa, Ontario K1A 0K9.

At all levels of the appeal process, the client will be provided with a written explanation of the decision taken.

Note: At all three levels of Orthodontic Appeal, submissions are sent to the Orthodontic Review Centre, whereby the case is reviewed by an independent appeal structure.

APPENDIX E

NIHB PROVIDER AUDIT PROGRAM

The NIHB Program reserves the right to undertake ongoing provider audit activities. These administrative activities are required to comply with accountability requirements for the use of public funds and to ensure compliance with the terms and conditions of the Program. The quality of a diagnosis, treatment plan or the treatment result is the responsibility of the Dental Regulator Authority (DRA) of the jurisdiction in question.

The objectives of the NIHB Provider Audit Program are to:

- detect billing/claim irregularities, whether through error or fraudulent claims;
- ensure that the services paid for were received by the NIHB client;
- ensure that appropriate documentation in support of each claim is retained, in accordance with the terms and conditions of the Program; and
- ensure compliance with Program policy.

The components of the Provider Audit Program include:

- Next Day Claims Verification (NDCV) Program which consists of a review of a denfined sample of claims submitted by providers the day following receipt by FCH;
- Client Confirmation Program (CCP) which consists of a quarterly mail-out to a randomly selected number of NIHB clients to confirm the receipt of the benefit that has been billed on their behalf;
- Provider Profiling Program which consists of a review of the billings of all providers against selected criteria and the determination of the most appropriate follow-up activity if concerns are identified;
- On-Site Audit Program which consists of the selection of a sample of claims for administrative validation with a provider's records through an on-site visit.

The audit activities are based on accepted industry practices and accounting principles. Records relating to NIHB clients must be maintained for all services provided in accordance with all applicable laws. All records shall be treated as confidential so as to comply with all applicable provincial/territorial and federal legislation.