The Akwesasne Non-Insured Health Benefits Program Policies and Procedures Manual

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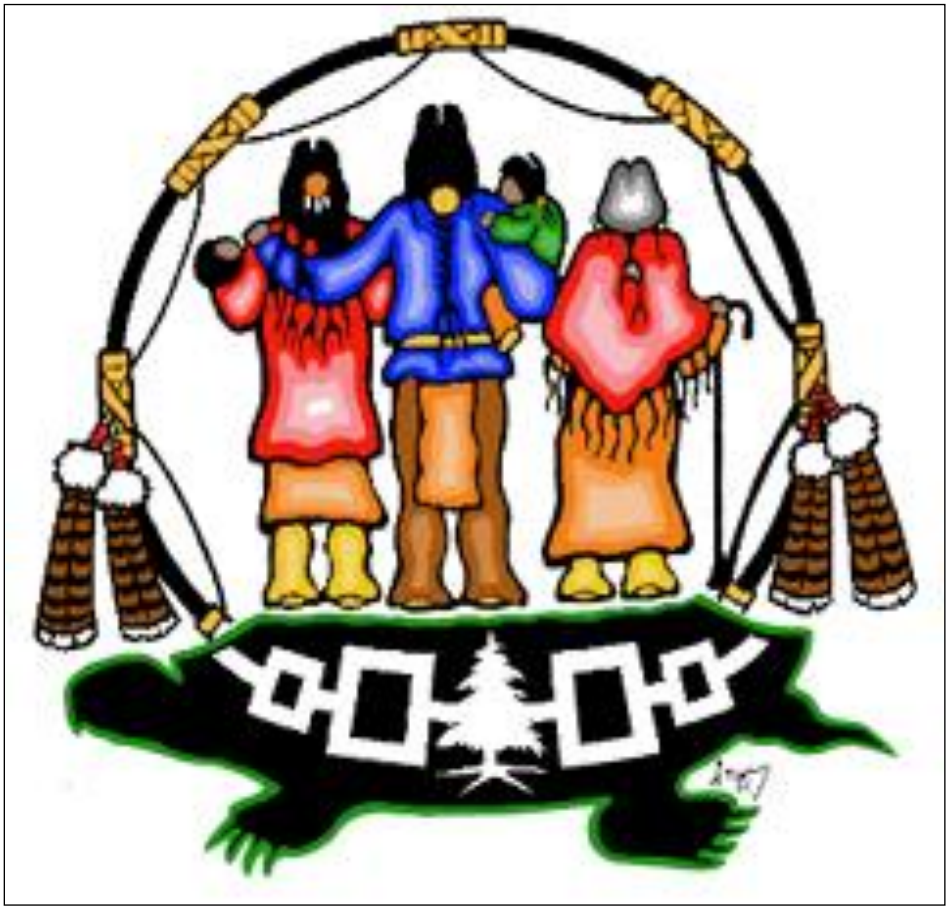
Section 1: General Information



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AKWESASNE NON-INSURED HEALTH BENEFITS

GENERAL INFORMATION SUMMARY

ELIGIBILITY CRITERIA

- Registered membership with Akwesasne with a valid 10 digit band number or eligible for membership
- Residence in Canada
- Enrollment in a provincial health insurance program such as Ontario Health Insurance Program (OHIP), the Regie d'le Assurance de Maladie de Quebec (herein after referred to as Quebec Health Insurance Plan) (RAMQ) or other provincial or territorial health insurance program based upon the respective place of residence in Canada

BENEFITS TO MCA MEMBER RESIDING ON CANADIAN PORTION OF AKWESASNE

- Medical Transportation
- Dental Services
- Pharmacy
- OHIP/RAMQ differential
- Vision
- Medical Supplies
- Medical Equipment

ELIGIBILITY CRITERIA MANAGEMENT PRACTICES

- Annual strategy developed for communicating with MCA members on accessing services
- A clear, concise brochure
- For those clients who renounce membership, staff have a responsibility to determine if they are eligible for benefits
- Out of country travel, the ANIHB unit to provide on a proactive basis, insurance coverage for students and migratory workers. Ads will be placed in newspapers & radio to advise members of out of country insurance and how to purchase it.
- Exception reviewed on a quarterly basis to assure basic services provisions of the Health Canada Agreement can be met.

REQUESTS FROM US RESIDENTS FOR ANIHB COVERAGE

- Residents of the USA are not eligible for services if they do not meet the eligibility criteria.

REQUEST FROM NON-COMMUNITY MEMBERS FOR ANIHB COVERAGE

- Client must be a registered member of The Mohawks of Akwesasne.
- Client must be directed to FNIH Regional Office for coverage unless client's band has taken control of non-insured health benefits program

ANIHB COVERAGE FOR TRANSIENT CLIENTS

Background Information

- Clients are individuals who consider their home base as Akwesasne but who live elsewhere on a temporary basis for extended periods of time
- Health/Medical Insurance coverage for students outside of Canada
- Migrant workers or worker on short term contracts
- If client has a permanent address within Canada, ANIHB will process claims providing all eligibility criteria is satisfied and services are received in Canada
- Client provides written confirmation from host organization/school they are affiliated with before the beginning of the academic school year.

COORDINATION WITH ALTERNATIVE SOURCES OF FUNDING

- ANIHB Program is a payer of last resort; therefore any available funding sources elsewhere must be accessed first.
- These may include Assistive Devices Program (ADP), Home Oxygen Program for Ontario Residents.
- Ontario Drug Benefits Program
- Trillium Drug Program
- Veterans Affairs Canada/US
- Employee benefits package (Canada Life)
- Community Support Program

APPEAL PROCEDURE

Purpose

1. To define the types of decision within NIHB that can be appealed
2. To identify a process for appeals to be rendered

1. Decisions that can be appealed

Decision made in the following areas of service can be appealed:

Medical Supplies & Equipment	Co-Payment
Dental	Vision
Allied Health	Pharmacy
Medical Transportation.	

2. Levels of Appeal

- Program Manager
- Director of Health
- Appeal Board

3. Persons not registered – Traditional Beliefs

There is flexibility for the ANIHB unit to approve services for persons entitled to be registered and who do not do so as a result of traditional beliefs concerning registration under the Indian Act or MCA membership codes. If the person is entitled to be registered by virtue of his/her parentage and yet does not do so, ANIHB under the approval of the MCA may approve provision of NIHB services as defined by the service criteria contained in other sections.

4. Newborn Infants

Newborn infants of members of MCA are provided services under the mother's/father's membership number to the age of one year. All benefits are denied pending confirmation from the Office of Vital Statistics that a parent has registered the child. It is not the responsibility of the ANIHB program to register newborn infants; however the parent will be given directions on how to register their child.

ELIGIBILITY CRITERIA EXCLUSIONS

1. Non-Insured Health Benefits are not provided to any persons confined to federal, provincial or territorial institutions (incarceration).

2. Funds allocated for management of NIHB will not be provided for services covered under the Provincial health insurance plan. The ANIHB program is for Non-Insured Services.

SERVICES NOT COVERED BY ONTARIO HEALTH INSURANCE PLAN (OHIP)

OHIP covers a wide range of health care services that are considered medically necessary. Services not covered by OHIP must be paid by client or by third party insurance. The ANIHB program is a payer of last resort and will only pay for services not covered by OHIP, provided all alternate resources have been accessed.

- OHIP covers all essential diagnostic treatment & services
- Physicians may charge for form completion, missed appointments, fitness certificates, etc.
- Podiatrists, Chiropractors, Osteopaths, OHIP pays only a portion of the cost for these services
- Chiropodists are not covered
- Eye exams are a covered benefit
- Physiotherapy benefits are covered by OHIP provided that they are in hospitals, or an approved Physiotherapy Clinic
- Dental services in hospital
- Dental services out of hospital except children enrolled in Children in Need of Treatment Program (CINOT)
- Ambulance services for OHIP residents traveling outside the province of Ontario
- Prescription drugs or medical supplies from pharmacies

SERVICES NOT COVERED BY REGIE d'ASSURANCE de MALADIE de QUEBEC (RAMQ)

- Uninsured services such as physicians billing for forms, reports, files, etc.
- Podiatrist, Chiropodist, Chiropractor, Osteopaths, Physiotherapy
- Dental services (clients greater than the age of 10 must pay for services)
- Residents 18 years of age to 64 years old are not covered for eye exams
- Cost of eyeglasses and contact lenses
- Ambulance services for age less than 65 years of age & are not recipients of social assistance
- Prescription drugs or medical supplies

HANDLING THE FILES OF DECEASED CLIENTS

- The files of deceased clients must be kept in the ANIHB office for a period of one (1) year.
- Once the one (1) year has expired, these files must be moved to archives database where they are to be held for a period of 7 years after the date of death
- Once the 7 years have passed, the contents of the files should be shredded (invoices).

SUPPLEMENTARY HEALTH INSURANCE COVERAGE FOR OUT OF COUNTRY TRAVELERS

- Client must obtain supplementary health insurance coverage when traveling outside Canada. If a client chooses not to purchase additional health insurance he/she is responsible for all medical expenses not covered by the provincial health insurance plan.
- The ANIHB Program will not cover any medical expenses incurred while traveling outside of the country.

ANIHB FUNDING AT THE DISCRETION OF THE MOHAWK COUNCIL OF AKWESASNE HEALTH PORTFOLIO

- In extenuating circumstances a client's claim for benefits coverage is rejected by the ANIHB staff. Should the client still merit some form of assistance. It is recognized that situations in life are not simple black or white and that the client's claim may fall into a "Grey Area". It is difficult for ANIHB to adjudicate. The claim is then forwarded on to the Health Portfolio, MCA for reconsideration which will include a letter with the relevant details of why the claim was rejected.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

INTRODUCTION

In examining a framework for delivery of the Non-Insured Health Benefits (ANIHB) program the following provides a useful point of reference upon which to base program decisions. This information is based upon documents developed by the HCFNIH-AFN Non-Insured Health Services Task Force.

WHAT IS THE ANIHB PROGRAM?

Based on the 1979 Indian Health Policy, FNIH provides a range of health benefits not included in provincially administered insured health care programs. NIHB complements these provincially insured programs, such as physician and hospital care as well as community-based programs and services included under the Inuit and Indian Health envelope.

Principles Underlying the Delivery of the Program

a) All registered Indians and recognized Inuit and Innu normally residents in Canada are eligible for Non-Insured health benefits regardless of location in Canada or income level.

b) Benefits will be based on professional medical and dental judgment, consistent with the best practices of health services delivery and evidence-based standards of care.

c) There shall be national consistency of mandatory benefits, equitable access and portability of benefits and services.

d) The program will be managed in a sustainable and cost-effective manner providing non-insured health benefits that are appropriate to the needs of the clients.

e) The program covers most dental procedures that treat disease or the consequences of dental disease.

f) 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.

g) Management process will involve transparency and joint review structures whenever agreed to by First Nations and Inuit organizations.

NIHB will act as the "primary facilitator of first resort" to coordinate payment for benefits from other insurers while minimizing the administrative burden on individual clients. 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.

h) 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.

Mandatory Program Benefits
Pharmacy; Medical Supplies and Equipment, Dental care, Vision care, Health Care Premiums, and Crisis Intervention Mental Health Counseling.

DEVELOPING GUIDELINES FOR SERVICE

In developing guidelines for client eligibility and for services it will be important to assure that Health Canada's guidelines are taken into consideration for the following reasons:

a) Under the terms of the contribution agreement, MCA must use as a minimum the Health Canada guidelines for services. In addition, it is clear that although the MCA can expand both its range of services and its client eligibility, MCA would be able to request additional funding to deal with any shortfalls that should arise if this decision were made.
b) It is important to consider that under Health Canada management, services would likely not be authorized beyond the basic level of services or client eligibility.

Furthermore, it is important to realize that MCA has the unique opportunity to make policy decisions to exceed the core services and to broaden exceptions to eligibility because it manages the NIHB under contribution agreement. If these programs were again managed by Health Canada, there would not be flexibility to expand services or make decisions on client eligibility.

In developing the following sections, therefore, the methodology will be to assure that the guidelines and procedures represent the minimum requirements for provision of services; and opportunities to provide:

a) A level of services which exceeds those available to other First Nations through ability to control financing and budgeting
b) Services to MCA members through determining eligibility in a fashion which makes most sense to the unique political and geographic realities of Akwesasne.
c) Minimal impacts of past and futures changes to programs as a result on nationally derived budget pressures such as deficits in other parts of the country.
d) An opportunity for Akwesasne to show leadership in health care management.
e) An opportunity to develop and integrate health and social service delivery system which can better meet the needs of community members.

BACKGROUND INFORMATION

The program has undergone significant evolution in its history of management by Medical Services Branch of Health Canada. At the outset of the program, the program was managed by regional staff with decisions made on an ad hoc basis. During this period, MSB had a direct relationship to pharmacies, dentists and optometrists and had a decentralized decision-making process in which nurses oversaw the approval of benefits at the local level. In many communities this situation evolved so that Community Health Representatives (CHR's) or clerical staff assumed various levels of responsibilities particularly in approving patient transportation.

As a response to severe criticism within the federal government for lack of controls and program consistency, MSB began moving to private industry for processing claims. The first step in this direction was with the dental program which contracted Blue Cross to process dental claims. Subsequently, a contract was tendered and Blue Cross of Ontario was selected to manage Pharmacy claims as well as dental claims. A few years later, Liberty Mutual bought out Blue Cross and assumed management of the claim system.

During the period 1990-1994, there was more consistency brought to the program incrementally. In addition, due to pressures mounting on both nurses and clerical staff at the community level, pharmacy, medical supplies and equipment and eyeglass approvals were centralized for Ontario in the regional office.

More and more interest wee being taken in the formularies for providing services in both pharmacy and dental benefits since changes to the formulary could reduce expenditures at a national level on a consistent fashion. Frequent changes also created frustration at the local service level in communities and in pharmacies and dental offices since communications on such changes tended to be inconsistent. Therefore, development of real time adjudication procedures was seen as a real advantage to pharmacies and dental services and eliminated processes of billings, potential refusals and needs to clarify and reconcile billings. However, the system was continually becoming more centralized and highly controlled.

In April 1997, the Federal Cabinet decided against instituting changes in eligibility as a way of restricting the growth of the NIHB program. Instead Cabinet directed Health Canada to take management steps to control costs and to improve targeting of services to clients as a strategy to management costs within increases which would be provided to the Indian Health envelope.

Since that time, Health Canada has taken definite steps to reduce spending. The key elements in a cost reduction strategy have been in implementing:

- Pre-determination of dental services which has yielded considerable financial control over expenditures.

- Increased provider audits and tracking of expenditures.

- A National Prior Approval Center for prescription drugs which resulted in savings particularly on certain types of high priced and commonly dispensed drugs.

- Reductions in travel rates for local travel.

- It is likely that there will be other steps required over the next two to three years unless there is relief to the envelope rate of growth which is currently restricted to 3 per cent per year.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.1: Client Eligibility Criteria

Subject: Client Eligibility Criteria for the ANIHB Program	**Policy Number: 1.01** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY:

The following is the eligibility criteria for services under Akwesasne Non Insured Health Benefits (ANIHB) Program. **All individuals must have:**

1. Registered member with Mohawks of Akwesasne with a valid INAC 10 digit band number or be eligible for membership
   a) **Persons not registered – traditional beliefs**
   There is flexibility for the ANIHB unit to approve NIHB services for persons entitled to be registered and who do not do so as a result of traditional beliefs concerning registration under the Indian Act or MCA membership codes. If the person is entitled to be registered by virtue of his parentage and yet does not do so, ANIHB will provide provisional services for a period of three (3) months while person seeks approval of the Director of Health for the provision of NIHB services as defined by the eligibility criteria.

2. Residence in Akwesasne (TsiSnaihne, Kanatakon, Kawehnoke) or Canada and

3. Enrollment in a provincial health insurance program such as the Ontario Health Insurance program (OHIP), the Regie d'Assurance de Maladie de Quebec (RAMQ) or other provincial or territorial health insurance program based upon the respective place of residence.

New Born Infants

1. New born infants of members of MCA are provided services under the mother's membership number up to the age of one year. However, early registration is to be encouraged to avoid problems in obtaining services. Coverage for any child not registered will only go back to the date of registry. No back dating of services will be allowed. For on-reserve births, the ANIHB unit should work with the Community Health Nurses and the Healthy Babies Healthy Children Program to encourage registration at birth.

2. For off-reserve circumstances, this should be part of the communications plan identified in the management practices section. Encouragement can be provided to the families as individual requests for prior approval or payment is submitted and it is evident that the child is not yet registered.

3. After one year of age and after communications directly from the ANIHB office are not successful in obtaining registration nor explanation of the circumstances, ANIHB may withhold prior approval of services.

Child Welfare and other circumstances

1. The Director has discretion to approve NIHB services for persons under child welfare, adoption and other circumstances where identity has been changed, such as persons under the witness protection program.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.1.1: Client Eligibility Criteria-Canadian Portion of Akwesasne

Subject: Eligibility Criteria: Benefits to MCA Members Living on the Canadian Portion of Akwesasne	**Policy Number: 1.01.1** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY:

There are some benefits which are accessed locally through the ANIHB office for those who meet the criteria described above. The most notable of these is medical transportation and physiotherapy.

Medical Transportation

This service is provided through the prior approval process of ANIHB and is described more fully in Section V of this manual.

Physiotherapy

This service is provided as a benefit to local residents of MCA residing on the Canadian portion of Akwesasne territories through direct services provided at the Chronic Care facilities. For off reserve members physiotherapy is reviewed on an exception basis. This service is an optional service as further discussed in Allied Health Services described in Section II of this manual. It is reviewed on a case-by-case basis.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.1.2: Client Eligibility Criteria-Services in MCA Facilities

Subject: Benefits available through NIHB services provided within MCA facilities	**Policy Number: 1.01.2** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY:

Certain NIHB benefits are available to MCA members accessing such services provided by personnel hired through MCA facilities and services. These include:

Mental Health Services
Mental Health Services are available to local residents of Akwesasne through direct services provided under the Department of Health. Services are arranged through appointments with the Mental Health Unit at 575-2341 extension 3100.

Physiotherapy
Physiotherapy is provided through contract personnel providing services at Tsionkwanonhsote, the Adult Care Facility on Kawehnoke. Appointments are made through the Home Care/Home Support Office at 936-1548, Ext 1066-1069.

NB. Members are encouraged but not required to use direct services provided at the Health facilities as a means of providing both a more economical and a more comprehensive range of services.

Independent providers working on a retail basis in the Kanonkwa'tsheri:io Health Facility.

Services in Pharmacy, Optometric dispensing and Dental are provided through independent businesses located in the Kanonkwa'tsheri:io Health facility. Services are provided on a fee for service basis under the guidelines of client eligibility and service frequency and are approved and paid for by the ANIHB unit. The dental services are provided through a privatized dental office effective February, 2010.MCA privatized the Akwesasne Dental Clinic with Dr. R. Navaneelan as the new owner. Appointments are arranged directly by the client at 575-2341 extension, 242.

N.B. Members are encouraged but not required to use independent business co-located within the Kanonkwa'tsheri:io Health Facility as a means of assuring that such businesses continue to be able to provide their services based upon ease and convenience of location.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.1.3: Client Eligibility Criteria-Living Off Reserve in Canada

Subject: Eligibility Criteria : Benefits accessed by persons living off reserve in Canada.	**Policy Number: 1.01.3** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

Pharmacy and Dental Benefits

1. Pharmacy and dental benefits for MCA members living off reserve and meeting the criteria described under Section 1.1 will be provided through the service approval and payment system established through the ANIHB office. Such benefits will be identical to those provided by Health Canada. Services are approved and paid for through the ANIHB Program and its procedures.

2. However, other benefits remain accessible to persons living off-reserve in other provinces and territories in Canada which are prior approved and paid for through the FNIH, Health Canada. These benefits include:

Mental Health Crisis Intervention Services

1. Mental Health Crisis Intervention Services are available to MCA members meeting the eligibility criteria and resident in other locations in Ontario and Canada where there is not access to the on-reserve mental health program. Such services are prior approved through First Nations and Inuit Health, Health Canada Offices since they are not an ANIHB Program benefit. *Payment for these services is not the responsibility of the ANIHB Program.*

Off-reserve Distance Transportation

1. For Members living outside of Ontario and/or requiring emergency medical procedures while traveling temporarily to these locations, transportation, and room and board costs are available through the First Nations and Inuit Health, Health Canada offices. *Payment for persons in this situation is not the responsibility of the ANIHB Program.*

Eyeglass Benefits

1. Persons living outside of Ontario and requiring eyeglass services should receive such services through the FNIH, Health Canada offices. *Payment for persons in this situation is not the responsibility of the ANIHB Program.*

Health Premiums

MCA members residing in other provinces which require payment of health premiums such as Alberta and British Columbia, should contact the FNIH, Health Canada offices for payment of premiums (ODB, dental premiums, deductibles). *Payment for premiums is not the responsibility of the ANIHB Program.*

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.1.4: Client Eligibility Criteria-Exclusions

Subject: Eligibility Criteria:-Exclusions	**Policy Number: 1.01.4** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY:

1. NIHB Program does not provide to persons confined to federal, provincial/state or territorial institutions or in the witness protection program. Appointments for clients in the care of federal, provincial or territorial institutions (e.g. incarcerated clients)

2. Funds allocated for management of NIHB's will be provided for services which are funded under the provincial health insurance programs. It must be a covered benefit before ANIHB can pay for the services.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.1.5: Eligibility Criteria-Management Practices

Subject: Eligibility Criteria: Management Practices	**Policy Number: 1.01.5** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

1. There should be an annual strategy developed for communicating with MCA members on accessing services, particularly for those not living in close proximity to Akwesasne and who would be eligible for services. Such as plan might include periodic news releases to MCA members or to providers who have a record for providing services to MCA members.

2. Part of this communication strategy should also be to stress the importance of registering new born infants and the procedure and contact information for registration of new members for MCA.

3. A clear and concise brochure of services available and the means to access these services should be a core element of the communication strategy. In addition, information regarding handling emergency dispensing of drugs, procedures for handling dental emergencies and the toll free number should also be part of the brochure of services.

4. For individuals who have "renounced" their membership in MCA, the ANIHB staff has the responsibility to determine if the person is still listed on the Status Verification System through INAC and available at Health Canada.

5. If the person is still officially on the membership list, ANIHB is required to provide services subject to the criteria described above.

6. If the person is not on the Status Verification System, the ANIHB is not required to provide services.

7. As described in the section on out of country travel, the ANIHB unit should undertake to provide on a proactive basis, insurance coverage for students and migratory workers.

8. The provision of exceptions should be reviewed on a quarterly basis in order to assure that basic service provisions of the Health Canada agreement can be met. I.E. That all MCA members residing in Canada will have as a minimum, the same level of service as provided by Health Canada.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.2.1: Children Under 1 Yr Old-Not Registered

Section: **Subject: Children Under1 Year Old Who Are Not Registered**	**Policy number: 1.02.1** **Issued: September 1999** **Revised:** **Approved by: MCA**

BACKGROUND INFORMATION

One of the eligibility criteria to receive coverage for benefits from the Akwesasne Non-Insured Health Benefits (ANIHB) Program is the fact that the client must have an INAC# that identifies the Band to which the client belongs (i.e., the Mohawks of Akwesasne), the client's family unit within the Band and the client's position in the family. If the INAC# is unavailable, the client's Band # and Family # will suffice. Parents are advised to have their newborns registered as quickly as possible prior to the first birthday. However, special client identification provisions have been established for children less than one year of age who have not yet been registered by their parents. These provisions allow adequate time for parents who satisfy the ANIHB Program eligibility criteria to have their newborn children registered.

POLICY:

A child less than one year of age, who does not yet have an acceptable client identification number, may still be eligible to receive coverage for benefits from the ANIHB Program if one of the child's parents can be verified as being an eligible client (refer to the ANIHB eligibility criteria in Section 1.1). In order for the child to be considered eligible, the following information must be provided:

1. The child's family name, given name(s) and date of birth; and
2. The parent's registered family name, given name(s), date of birth and client identification number (i.e., INAC # or the Band # and Family #).
3. Health card number of mother or father.

PROCEDURE:

1. When a request for coverage of an approved benefit is submitted to the ANIHB Program for a child less than one year of age who does not have an acceptable client identification number, the Benefit Analyst must ensure that at least one of the child's parents is eligible to receive benefits from the ANIHB Program.

2. If neither of the child's parents is eligible to receive benefits from the ANIHB Program, the claim must be rejected and the Benefit Analyst will send the parents a rejection letter.

3. If at least one of the child's parents is eligible to receive benefits, the Benefit Analyst must ensure that the following information is provided:

   1) the child's family name, given name(s) and date of birth; and
   2) the parent's registered family name, given name(s), date of birth and client identification number (i.e., INAC# or the Band # and Family #).
   3) Provincial Health card number

4. Once it has been verified that the information requirements outlined above have been satisfied, the Benefit Analyst will provide OVS, the ANIHB Supervisor or Program Manager with information to add the child into the database, then ANIHB staff can process the request for benefit coverage.

5. If the request is rejected, a rejection letter must be sent by the Benefit Analyst to the client providing the reason(s) why the request was rejected.

6. If the Benefit Analyst is ever in contact with the child's parents, he/she should advise them to have the child registered as soon as possible. The Benefit Analyst should also remind them that if the child remains unregistered after the first birthday, he/she will no longer be eligible to receive coverage for benefits under the ANIHB Program, until such time that the child becomes registered.

Note:

As a part of their post-natal visits to new mothers, community health nurses in the Department of Health provide an information sheet to new mothers (see the attached "Registration Instructions for New Moms"), which addresses the need to have all newborns registered as soon as possible after birth and definitely prior to the first birthday.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.2.2: Children 1 Yr Old or Older-Not Registered

Subject: Children One Year Old or Older Who Are Not Registered	**Policy Number: 1.02.2** **Issued: September 1999** **Revised:** **Approved by: MCA**

BACKGROUND INFORMATION

One of the eligibility criteria to receive coverage for benefits from the Akwesasne Non-Insured Health Benefits (ANIHB) Program is the fact that the client must have an INAC# that identifies the Band to which the client belongs (i.e., the Mohawks of Akwesasne), the client's family unit within the Band and the client's position in the family. If the INAC # is unavailable, the client's Band # and Family # will suffice. Parents are advised to have their newborns registered as quickly as possible prior to the first birthday. However, special client identification provisions have been established for children less than one year of age who have not yet been registered by their parents. These provisions allow adequate time for parents who satisfy the ANIHB Program eligibility criteria to have their newborn children registered.

Even with these special provisions in place, the situation still arises in which claims for benefits are submitted to the ANIHB Program for children aged one year or older who still do not have an acceptable client identification number. ANIHB staff is then left with the dilemma of deciding what to do with the claim.

POLICY

1. A child aged one year or older, who does not have an acceptable client identification number, should be considered ineligible to receive coverage for benefits from the ANIHB Program. . However, if ANIHB staff receives proof from the Office of Vital Statistics that an application has been submitted to Indian and Northern Affairs Canada (INAC) to obtain a INAC# for the child, the child's claim for benefit coverage will be processed. In order for the claim to be processed, the following information must be provided on the claim:

    1) the child's family name, given name(s) and date of birth; and
    2) the parent's registered family name, given name(s), date of birth and client identification number (i.e., INAC# or the Band # and Family #).
    3) Health card number

2. ANIHB will only pay for services from the date of registry and does not allow services to be back dated.
3. If an application for an INAC # has not been submitted to INAC for the child, the claim must be rejected and ANIHB staff will send a rejection letter to the child's parents explaining the reason(s) why the claim was rejected**.**

PROCEDURE

1. When a claim for benefit coverage is submitted to the ANIHB Program for a child aged one year or older who does not have an acceptable client identification number, the Benefit Analyst must reject the claim and send a rejection letter to the child's parents, which explains why the claim was rejected.

2. However, if there is proof submitted to the ANIHB Program by the Office of Vital Statistics that an application for an INAC# for the child has been submitted to Indian and Northern Affairs Canada (INAC), the child's claim should be processed. In order for the claim to be processed, the Benefit Analyst must ensure that the following information is provided on the claim form:

   1) the child's family name, given name(s) and date of birth; and
   2) the parent's registered family name, given name(s), date of birth and client identification number (i.e., INAC# or the Band # and Family #).

3. Once it has been verified that the information requirements outlined above have been satisfied, the Benefit Analyst can process the claim. If the claim is rejected, the Benefit Analyst must send a rejection letter to the client providing the reason(s) why the claim was rejected.

4. If the Office of Vital Statistics confirms that no application for an INAC # has been submitted to INAC for the child, the claim must be rejected. The Benefit Analyst must send a rejection letter to the child's parents indicating the reason(s) why the claim was rejected. The letter will also advise the parents to have the child registered as soon as possible in order for the child to become eligible for coverage under the ANIHB Program.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.3: Coverage for U.S. Residents

Subject: Coverage for U.S. Residents	**Policy Number: 1.03** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

In order for a client to be considered eligible to receive coverage for benefits from the Akwesasne Non-Insured Health Benefits Program:

1. The client must have acceptable client identification (i.e., a valid 10-digit Band # that is affiliated with the Mohawks of Akwesasne or an acceptable Band # and Family # combination).

2. The client must be a resident of Canada.

3. The client must have a valid OHIP or RAMQ health card #.

4. The client must not be incarcerated in a provincial, federal or territorial institution.

5. The client must not be eligible to receive the requested benefit from another source (e.g., third-party insurer), because the ANIHB Program is a payer of last resort.

6. This means that residents of the United States are not eligible to receive benefits from the ANIHB Program.

PROCEDURE

1. When the Benefit Analyst receives a claim from a resident of the United States for coverage of an approved benefit from the ANIHB Program, the residency status and other eligibility criteria (see above) must be verified for the client.

2. If the client is indeed a resident of the U.S., the Benefit Analyst must reject the claim and the client must be told that as a resident of the United States, he/she is not eligible to receive benefits from the ANIHB Program. The Benefit Analyst will send a rejection letter must be sent to the client.

3. The Benefit Analyst will advise the client to seek assistance from the St. Regis Mohawk Health Services in Akwesasne/Hogansburg, NY.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.4: ANIHB coverage for Non-Community Members

Subject: ANIHB coverage for Non-Community Members	**Policy Number: 1.04** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY:

In order to be considered eligible to receive coverage for benefits from the ANIHB Program, a client must satisfy the eligibility criteria outlined in Section 1.1. One of the requirements for eligibility is that the client must have a valid ten-digit INAC # that is affiliated with the Mohawks of Akwesasne or an acceptable Band # and Family # combination. This means that clients who are not members of the Mohawks of Akwesasne cannot be considered eligible to receive benefits from the Akwesasne Non-Insured Health Benefits Program.

PROCEDURE:

1. If the Benefit Analyst receives a claim for benefit coverage from a non-community member, the claim must be forwarded to the NIHB Program at the First Nations & Inuit Health (FNIH) Regional Office in Ottawa for processing.

Note:

If the client's home community has assumed control of its own NIHB Program from FNIH, ANIHB staff must forward the claim to the NIHB Program in the client's home community for processing.

Exception: When a non-community member resides in Akwesasne and requires medical transport the ANIHB will assist and seek reimbursement from FNIH or affiliated Fist Nation in Canada.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.5 ANIHB Coverage for Transient Clients

Subject: ANIHB Coverage for Transient Clients	**Policy Number: 1.05** **Issued: September 1999** **Revised:** **Approved by: MCA**

BACKGROUND INFORMATION

Transient clients are individuals who consider their home base to be in Akwesasne but who live elsewhere on a temporary basis for extended periods of time. For example, a student might be away at school in the United States during the school year and only return home during holiday periods. Similarly, an Akwesasne resident might be working on a short-term contract in the United States or elsewhere, with every intention of returning home once the contract has expired. ANIHB staff is faced with the dilemma of having to decide what to do with claims submitted for the coverage of benefits by transient clients.

POLICY

1. If a transient client permanently resides in Canada and has an address within Canada, ANIHB staff will process all claims submitted, provided that the client satisfies the other eligibility criteria outlined in Section 1.1.

The ANIHB program will pay for out of country insurance coverage to a maximum of $1000, for students and transients (workers who must leave temporarily for employment) for a period of no longer than three (3) months. Hardship situations may be appealed or reviewed.

2. Purchase/Reimburse transient client for purchase of insurance required as part of medical coverage in school/work.

PROCEDURE

1. If a transient client has a permanent address within Canada and submits a claim for coverage of benefits, the Benefit Analyst must:

   a) Verify that the client satisfies the other eligibility criteria outlined in Section 1.1;

   b) Ensure that the claim form has the client's registered family name, given name(s), date of birth and client identification # (i.e., ten-digit INAC # or the Band # and Family #);

   c) Process the claim once these two requirements have been satisfied.

2. If a transient client (student/worker) has a temporary address outside of Canada the Benefit Analyst will provide the client with information re: purchase of out of country health insurance.

Note:
If the transient client is a student who is pursuing his/her studies outside of Canada, the student must submit written confirmation to the ANIHB Program of his/her enrollment at the school at the beginning of each academic year. If the transient client is fulfilling a short-term employment contract outside of Canada, he/she must submit written confirmation to the ANIHB Program. The ANIHB eligibility criterion that the client be a resident of Canada will only be waived for a period of three months. Once the three months have expired, the client will no longer be considered eligible to receive benefits under the ANIHB Program until such time that he/she returns to Canada. ANIHB will strongly recommend that the client purchase out of country insurance.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.6 Claims for Clients Who Chose Not To Be Registered

Subject: Handling Claims For Clients Who Have Chosen Not To Be Registered	**Policy Number: 1.06** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

Individuals who meet the eligibility criteria for membership and have chosen not to be registered are eligible for ANIHB services.

PROCEDURE:

1. ***The Program Manager/Supervisor will confirm with OVS by letter that individual is eligible for services.***
2. ***The Program Manager/Supervisor will create a client file.***
3. ***The Supervisor will place the letter OVS file.***
4. ***The Supervisor will create a pseudo-Band number. (put proper name in).***
5. ***The Benefit Analyst will then process the claim in the same manner as clients who are registered and eligible for services.***

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.7: Claims for Clients Who Renounced Membership

Subject: Handling Claims For Clients Who Have Renounced Their Membership	**Policy Number: 1.07** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

Currently there is not provision made within the Mohawk Council of Akwesasne for clients who have renounced their membership. The community abides by the existing Akwesasne Membership Code.

PROCEDURE

1) ANIHB will process claims if the client meets the criteria set forth in Section 1-C.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.8: Coordination With Alternate Sources of Funding

Subject: Coordination With Alternate Sources of Funding	**Policy Number: 1.08** **Issued: September 1999** **Revised:** **Approved by: MCA**

BACKGROUND INFORMATION

The Akwesasne Non-Insured Health Benefits Program is a payer of last resort for approved benefits. This means that before submitting a claim to the ANIHB Program for benefits coverage, the client must have first sought coverage from an alternate source of funding, if this is applicable.

There are several alternate sources of funding that may be available to certain clients. The most common of these alternate sources are briefly described below.

Assistive Devices Program (ADP) and the Home Oxygen Program (HOP)

1. Administered by the Assistive Devices Branch of the Ontario Ministry of Health.

2. Financially assists Ontario residents with long-term physical disabilities to obtain basic, competitively priced, personalized assistive devices appropriate for the individual's needs and essential for independent living.

3. ADP covers over 15,000 pieces of equipment or supplies in the following categories:

    - Prostheses
    - wheelchairs/mobility aids and specialized seating systems
    - ostomy and enteral feeding supplies
    - needles and syringes for insulin-dependent seniors
    - monitors and test strips for insulin-dependent diabetics
    - hearing aids
    - respiratory equipment
    - orthoses (braces, garments and pumps)
    - visual and communication aids

4. HOP pays for oxygen and oxygen delivery equipment, such as concentrators, cylinders, liquid systems and related supplies, such as masks and tubing.

Eligibility Criteria for the Assistive Devices Program (ADP)

1. Any resident who has a valid OHIP number issued in his/her name and who has a physical disability of six months or longer is eligible for ADP coverage. Equipment cannot be required exclusively for sports, work or school.

2. Residents with a primary diagnosis of a learning or mental disability are excluded from ADP.

3. Individuals on Workers' Compensation are excluded from ADP.

4. Specific eligibility criteria apply to each device category.

Note: Quebec residents are not eligible for ADP. Cases are reviewed on an exception basis if they do not qualify for ANIHB services.

Eligibility Criteria for the Home Oxygen Program (HOP)

1. Any Ontario resident who has a valid OHIP number issued in his/her name and who has a chronic illness or dysfunction that requires long-term oxygen therapy is eligible for HOP coverage provided he/she meets the HOP criteria.

Ontario Drug Benefit Program (ODB)

1. Administered by the Ontario Ministry of Health.

2. Covers the costs of most prescription drug products for the majority of illnesses and conditions.

3. In exceptional circumstances, a request for special coverage of a non-listed drug product not normally covered under the ODB Program can be made. This process is known as Section 8.

4. An Ontario resident who has a valid OHIP health card # and who belongs to one of the following groups will qualify for ODB coverage:

    - People aged 65 years or older
    - Residents of long-term care facilities or Homes for Special Care
    - Recipients of professional services under the Home Care Program
    - Social assistance recipients

Trillium Drug Program

1. Administered by the Ontario Ministry of Health.

2. Developed to help a single person or family pay for expensive prescription medicines.

3. Any Ontario resident with a valid OHIP health card #, who is not presently covered by the ODB Program, is eligible for coverage under the Trillium Program.

4. Residents with private drug insurance plans can apply to the Trillium Program for government assistance to pay for the difference between the cost of medication and the amount that they receive from the insurance company minus their Trillium deductible.

5. The Trillium deductible is the portion that a person is required to pay before the Ministry of Health pays for the remaining medication costs. The deductible depends on the number of dependents and the resident's previous year's net income.

Veterans Affairs Canada

1. Administered by Blue Cross of Atlantic Canada for Veterans Affairs Canada

2. The Prescription Drug Program of Veterans Affairs Canada provides drug products and other pharmaceutical benefits to eligible clients who have a demonstrated medical need and who have a prescription from their physician or dentist.
3. In order to qualify for VAC coverage, the client must have a VAC Health Care Identification Card. The card can be used to obtain benefits directly related to the treatment of the client's VAC-pensioned medical condition, or for approved benefits providing that the client has a demonstrated health need and the benefits are not available under a provincial health plan.

Employee Benefits Package

1. Many employers provide their employees with a benefits package, which includes full or partial coverage for dental services, eye care, prescription drugs and certain medical supplies and equipment.

POLICY

The Akwesasne Non-Insured Health Benefits (ANIHB) Program provides a limited range of medically necessary prescription and non-prescription drugs to clients who satisfy the eligibility criteria outlined in Section 1.1. One of the fundamental policies of the ANIHB Program is that it is a payer of last resort, which means that where

applicable, the client must have first sought coverage for prescription and non-prescription medications from an alternate source of funding, such as:

- the Assistive Devices Program (ADP) in the province of Ontario
- the Home Oxygen Program (HOP) in the province of Ontario
- the Ontario Drug Benefit (ODB) Program
- Trillium Drug Program in the province of Ontario
- Veterans Affairs Canada
- Employer benefit package
-

For all services, ANIHB will only pay the eligible cost differential (the difference between the allowable ANIHB cost for services and the insurance or program payment)

Note:
If the alternate source of funding provides no coverage or only partial coverage of the cost of the medication(s), the Akwesasne Non-Insured Health Benefits Program will pay the remainder, provided that the client satisfies the eligibility criteria outlined in Section 1.1.

PROCEDURE

1. When an eligible client requests a prescription or non-prescription medication from a provider, the provider is required to ask the client if he/she is eligible for coverage from any source other than the Akwesasne Non-Insured Health Benefits Program.

2. If the client does have third-party coverage for medications, the provider must submit the claim to the third-party provider before submitting it to the ANIHB Program.

3. If there is any outstanding payment remaining after the claim has been processed by the third-party provider, the Benefit Analyst will cover outstanding payment within the HC Policy Framework Guidelines for FNIH Benefits.

4. If the client has third-party insurance but it does not cover the requested medication, a rejection letter from the third party insurance provider must be submitted along with the claim to the ANIHB Program's Benefit Analyst.

5. If the client's claim is rejected by the Benefit Analyst a rejection letter must be sent to the client providing the reason(s) why the claim was rejected.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.9: Handling Out-of-Province Claims

Subject: Handling Out-of-Province Claims	**Policy Number: 1.09** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

All eligible clients must have a valid OHIP or RAMQ insurance plan.

1. It is the responsibility an individual to either have Ontario Health Insurance Plan (OHIP) or Regie de'la Assurance Maladie du Quebec (RAMQ) for the respective province in which they may reside.

2. It is the responsibility of an individual to ensure that the health card is updated and valid

3. It is the responsibility of an individual to present the health card at each medical visit.

4. It is the responsibility of the individual to sign any necessary forms for out of province billing that may occur at each medical visit.

PROCEDURE

1. The Benefit Analyst will reject any claims submitted to the office for payment for an individual who has let their health card lapse.

2. The Benefit Analyst will assist in directing clients to the appropriate agency in order to have the health card application processed.

3. The ANIHB office will send a rejection notice to the individual stating the reasons for the denial of payment. It will be the individual's responsibility to follow through with recommended alternatives given.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department Health
Mohawk Council of Akwesasne

Section 1.10: Handling Out-of-Country Claims

Subject: Handling Out-of-Country Claims	**Policy Number: 1.10** **Issued: September 1999** **Revised: August 2002** **Approved by: MCA**

POLICY

1. Out- of- Country claims are when an individual travels outside of Canada, whether it be for business or leisure, the client must ensure that they purchase the adequate amount of insurance coverage for this purpose.

2. Individuals who do not purchase the required insurance are then faced with the responsibility of having to pay for all medical treatment received out of country once your provincial health insurance card has paid their portion.

3. Many employees have this option as part of their insurance coverage through their respective companies.

4. It is the responsibility of the individual to ensure they purchase before they travel out- of- country.

5. The only coverage provided by the ANIHB program would be for those who are students and transient workers. The individual must provide the ANIHB program with proper documentation in order to be covered by the program.

6. The individual will be responsible for sending all medical bills to their provincial health insurance carrier for processing.

7. Should an individual not purchase the required insurance, all medical bills would be the responsibility of the client to assume payment.

8. The ANIHB program will only cover students and transient workers, who have provided the required documentation to our office for coverage.

PROCEDURE

1. The Benefit Analyst will direct the individual to the appropriate agency to purchase needed travel insurance before traveling out-of-country such as Bank of Nova Scotia, Blue Cross, etc.

2. The Benefit Analyst will assist where ever possible in helping the individual complete the required forms for payment and or purchase of insurance.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.11: Appeal Procedure

Subject: Appeal Procedure	**Policy number: 1.11** **Issued: September 1999** **Revised: January 16, 2008** **Approved by: MCA**

POLICY

1. An appeal can be requested to challenge any decision pertaining to the denial of benefits made by the Akwesasne Non-Insured Health Benefits (ANIHB) Program.

2. Appeals will be considered in the following areas:

Medical Supplies & Equipment	Co-Payment
Dental	Vision
Allied Health	Pharmacy
Medical Transportation.	

3. In instances where a member of Akwesasne feels that they require specialized health benefits not covered by ANIHB, or for incidents that challenge the current ANIHB policies, the following procedure will be followed on a case by case basis to address their need.

4. The person(s) requesting an appeal must be the Applicant or recipient/unless the child is a minor.

Note:

1. The Akwesasne Non-Insured Health Benefits Program Appeal Board is comprised of:
   a) At least two members of the Health Advisory Board
   b) At least one Health Portfolio

2. The role and function of the Appeal Board is to provide a forum for community members/clients to request a review of denials or reduction of services from The ANIHB Program.

3. The Appeal Board will meet on an ad-hoc basis as deemed necessary. All information relevant to the board will be held in strict confidence with any personal indicators to be removed prior to the board reviewing its case.

4. The appeal board will be responsible for assessing the overall facts as presented to determine the validity of the decision.

PROCEDURE

Levels of Appeal:

1. The Appeal must be completed within 10 working days, and be in the form of a letter addressed to the Program Manager of ANIHB. The letter must include person's name, address, benefit denied, and reasons the applicant should receive benefit.

2. The Program Manager is to be person of the first contact. Once the Program Manager has received the Appeal letter, they will assist the Applicant in filling out the Appeal Form (as attached) , and will review the case, document a brief history, list which ANIHB policy the benefit challenges, cost implications, and form a decision in Section A.

3. The decision of the Program Manager is indicated by circling the appropriate action.

4. If the Program Manager finds that the Appeal is beyond her/his scope of approval, the Program Manager will then prepare a letter of denial to the Applicant, and complete Section B.

5. The Applicant must then decide if he/she would like to pursue their appeal further. If he/she would like to press the appeal, he/she will then fill out the form Request to Forward the Appeal. This act forwards the Appeal to the next level, review by the Director of Health.

6. The Director of Health will review the case, form a decision and provide documentation of her/his decision in Section B of the form. Should the denial be upheld, the case will be forwarded to the next level, Section C, review by the Appeal Board.

7. The Applicant must then decide if he/she would like to pursue their appeal further. If he/she would like to press the appeal , he/she will then fill out the form Request to Forward the Appeal. This act forwards the Appeal to the next level, review by the Appeal Board.

8. The Appeal Board will be assembled to review the case facts and make a recommendation to uphold the decision of the ANIHB Program or choose and alternative action that will adequately reflect the limits of the budget constraints within the Department of Health. This will be documented in Section C of the form.

9. The ANIHB Program Manager will provide a brief unbiased outline/history of the case and present her/his comments in writing on the Appeal Form, to the Appeal Board.

10. Upon review of the case, the Appeal Board will form a recommendation based upon majority vote, which will be relayed to the client by way of correspondence from the Program Manager. If the appeal is denied at this level, justification will be provided. If members of the Appeal Board wish to indicate their decision alongside their signatures he/she may do so.

11. The decision of the Appeal Board is final and conclusive.

12. All discussions and facts relevant to the case will be documented and placed in the case files in the ANIHB office. All correspondence to the parties in the Appeal will be kept on record. Every avenue will be made available for all parties of the appeal to be heard and investigations will be complete and documented.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.12: Services not Covered by OHIP/RAMQ

Subject: Services not Covered by OHIP/RAMQ	**Policy Number: 1.12** **Issued: September 1999** **Revised:** **Approved by: MCA**

BACKGROUND INFORMATION

The Ontario Health Insurance Plan (OHIP) covers a wide range of health services that are considered to be medically necessary. Services not covered by OHIP must be paid for by the client or by a third party insurer, if the client has third party insurance coverage.

The Quebec Health Insurance Plan (RAMQ) covers a wide range of health services that are considered to be medically necessary.

The services covered by OHIP/RAMQ are described below.

Physicians

1. OHIP/RAMQ covers all essential diagnostic and treatment services.

2. Physicians may bill patients for uninsured services, such as transferring files to another physician; telephone consultations; certificates of fitness to work; reports, testimonies, certificates for legal purposes; reports or certificates for passport application, visa or insurance policy; physical examinations for schools, camps or joining an association or organization; and cosmetic procedures. Patients may also be billed for missed appointments.

Podiatrists, Chiropodists, Chiropractors and Osteopaths

1. Chiropractic services are a delisted benefit as of November 2005. ANIHB pays ISO per year with referral from a physician.

   a) The patient must pay for the costs and he/she should therefore ask the health care provider about the costs before actually receiving the services.

   b) Osteopaths are not covered.

Eye Care

1. The cost of eye exams, eyeglasses, contact lenses and the checking of contact lenses are not covered by OHIP/RAMQ.

Physiotherapy

1. OHIP pays for physiotherapy services only in:

a) Hospitals
b) Approved physiotherapy clinics where the patient may be billed for some assessments by the physiotherapists, and some medical clinics that offer physiotherapy.

2. RAMQ pays for physiotherapy services only in hospitals on an in-patient or out-patient basis.

3. Physiotherapy services offered in physiotherapy clinics or in medical clinics that offer physiotherapy are not covered by RAMQ.

Dental Services in Hospital

1. OHIP only pays for some dental surgery, including fractures or medically necessary jaw reconstruction, when done in hospital.

2. RAMQ covers oral surgery and dental services determined by regulation and performed by a dental surgeon in a hospital.

Dental Services Out of Hospital

1. All clients must pay the cost of surgical dental services provided in a dentist's office.

2. RAMQ covers basic dental services provided in a dentist's office to children under the age of 10 years and to social aid recipients.

3. RAMQ Clients greater than 10 years of age who are not social aid recipients must pay the cost of dental services provided in a dentist's office.

Ambulance Services

1. OHIP pays $190 for ambulance services for Ontario residents within the province of Ontario. The balance of $45 is paid or by ANIHB.

2. OHIP does not pay for ambulance services for Ontario residents travelling outside the province of Ontario or out of country.

3. RAMQ does not pay for ambulance services.

4. RAMQ provides full coverage to residents aged 65 and older and to social aid recipients.

Note:

OHIP/RAMQ does not pay for prescription drugs from pharmacies nor does it pay for medical supplies and equipment (e.g., wheelchairs, crutches, canes, eye patches, specially equipped beds, etc.). At present, ANIHB does not use RAMQ for medical supplies & equipment.

POLICY

1. Services not covered by RAMQ must be paid for by the client or by a third party insurer, if the client has third party insurance coverage.

2. The ANIHB Program is a payer of last resort and will only pay for services not covered by RAMQ, provided that all other potential sources of payment have been exhausted.

Ambulance Services

1. OHIP pays $190 for ambulance services for Ontario residents within the province of Ontario. The balance for ambulance services not paid for by OHIP ($45) is paid or by ANIHB.

2. ANIHB pays the balance due on local ambulance services (Quebec residents).

What does ANIHB cover other than this?

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.13 Handling the Files of Deceased Clients

Subject: Handling the Files of Deceased Clients in ANIHB database	**Policy Number: 1.13** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

The files of deceased clients must be kept in the ANIHB office for a period of one (1) year. Once the one (1) year has expired, these files must be moved to archives database where they are to be held for a period of 7 years after the date of death. Once the 7 years have passed, the contents of the files should be shredded (invoices).

PROCEDURE

1. The Supervisor will inactivate the file when notice is received from OVS.
2. In the event that a client's death cannot be officially verified the Supervisor will unofficially make a notation in the client's file.
3. The Supervisor will contact Computer Services annually to archive the files according to the MCA retention schedule.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.14: Health Insurance – Out-of-Country Travel

Subject: Supplementary Health Insurance Coverage for Out-of-Country Travelers	**Policy Number: 1.14** **Issued: September 1999** **Revised:** **Approved by: MCA**

BACKGROUND INFORMATION

Canadians travelling outside of the country for pleasure or business need to bear in mind that their provincial health insurance plan (e.g., OHIP, RAMQ, etc.) will not cover most of the health care costs incurred in another country. Health care services provided outside Canada can cost much more than the amount that will be reimbursed by provincial health plans.

For example, the Ontario Health Insurance Plan (OHIP) will only cover a maximum of $400 (Canadian) per day for emergency inpatient hospital care and $50 (Canadian) per day for all emergency outpatient services, except for dialysis patients who will receive $210 (Canadian) for each treatment as an outpatient. Also, medically necessary out-of-country physician services and other eligible practitioner services will be reimbursed based on the OHIP fee schedule or the amount billed, whichever is less. This reimbursement is limited to services provided on an emergency basis only. Ambulance services provided outside the province of Ontario are not covered by OHIP.

Similarly, the Quebec Health Insurance Plan (RAMQ) will only reimburse physician care up to the amount paid for the same services in the province of Quebec. As well, when necessitated by sudden illness or emergency, RAMQ will reimburse up to $498 per day for hospitalization including outpatient surgery or $60 for each outpatient emergency room consultation. Ambulance services provided outside Quebec are not covered by RAMQ.

Since the client is required to pay for the out-of-country medical expenses not covered by the provincial health plan, ANIHB staff is sometimes faced with the dilemma of having to adjudicate claims submitted by Akwesasne residents for out-of-country medical expenses. A clear policy is therefore required to provide guidance to ANIHB staff.

POLICY

1. All clients **must** obtain supplementary health insurance coverage when travelling outside Canada. If a client chooses not to purchase additional health insurance, he/she will be responsible for all medical expenses not covered by the provincial health insurance plan.

2. The ANIHB Program will not cover any medical expenses incurred while travelling outside of the country, if the client did not purchase additional health insurance prior to departure.

PROCEDURE

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.15: Funding at Discretion of Director of Health

Subject: ANIHB Funding at the Discretion of the Director of Health	**Policy Number: 1.15** **Issued: September 1999** **Revised:** **Approved by: MCA**

BACKGROUND INFORMATION

There will inevitably be extenuating circumstances in which a client's claim for benefits coverage is rejected by ANIHB staff because the client doesn't satisfy the eligibility criteria outlined in Section 1.1, or the item requested is not covered by the ANIHB Program. ANIHB staff may decide that although the claim has to be rejected, the circumstances resulting in the rejection of the claim were not completely within the client's control.

When such situations arise, ANIHB staff may be of the opinion that although ANIHB policy would dictate that the client's claim must be rejected, the client still merits some form of assistance from the ANIHB Program. A policy is required to guide ANIHB staff in such instances.

It is recognized that situations in life are not simply black or white and that a client's claim may fall into a grey area that makes it difficult for ANIHB staff to adjudicate.

POLICY

When an ambiguous situation arises, ANIHB staff will forward the client's claim to the attention of the Program Manager. The decision to accept or reject the client's claim will rest with the Program Manager in consultation with the Director.

PROCEDURE

1. When the Benefit Analyst encounters a client's claim that is difficult to adjudicate because through no fault of his/her own, the client does not satisfy the eligibility criteria or the item being requested is not normally covered by the ANIHB Program, he/she will forward the claim to the attention of the Program Manager.

2. The Program Manager will prepare a succinct information package for the Director, which includes all relevant details about the claim as well as the reason(s) why the claim has not simply been rejected as per ANIHB policy.

3. If the Director decides to reject the client's claim, the Program Manager will send the client a rejection letter that explains the reason(s) why the claim was rejected.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 1.16 Allocation of Surplus Funds

Subject: Allocation of Surplus Funds	**Policy Number: 1.16** **Issued: July 2007** **Revised:** **Approved by: MCA**

BACKGROUND

In Spring 2007, the Finance Office notified the ANIHB Program Manager of potential for surplus funding. As the Director and Manager had conscientiously followed policy all fiscal year, the potential seemed possible. The Director called a special meeting of the Akwesasne Health Advisory Board in anticipation of requirement for policy. The Board met to simulate and document policy.

POLICY

1. ANIHB Surplus Funding can only be spent on bills that have been denied payment.

2. It is the client's responsibility to look for other sources of funding.

PROCEDURE

1. Throughout the fiscal year, the Benefit Analyst will advise clients of items that are not covered by ANIHB and will give the client options, when available, such as referrals to other agencies.

2. When other options fail, if the client returns to ANIHB, the Benefit Analyst will notify the client of the appeals process i.e., submit letter to the Health Director for decision; if denial is upheld, then client may submit letter of appeal to the Akwesasne Health Board.

3. The potential for an ANIHB surplus will be projected and quantified by the Finance Officer and ANIHB Program Manager by March 31st of every fiscal year. Their report will be shared with the Comptroller, Health Director, and ED who will determine whether the Akwesasne Health Advisory Board should be convened to enact this policy.

4. When a surplus is declared, the Director will call a special meeting of the Akwesasne Health Advisory Board and ANIHB Program Manager with the single agenda of considering denied applications.

5. The ANIHB Program Manager will introduce each case and advise the Board of the process followed for each denial and the status, including (but not limited to) whether or not all avenues have been pursued. In all cases, client identifiers will be masked. Where fertility cases are introduced, the Program Manager will make sure

that clients have done the necessary investigations before the case is presented to the Board for consideration.

6. Board Members will determine their collective funding priorities and allocate, through vote, the entire surplus amount.

7. The ANIHB Program Manager will advise clients to whom an allocation has been made:

   a) Of the allotted funding amount

   b) That denial is over-turned only because of a surplus

   c) That there is no change to policy.

Appendix A: Appeal Documents

This appeal procedure and form for the Akwesasne Non-Insured Health Benefits Program has been duly approved by the Mohawk Council of Akwesasne, Resolution # _____
Dated: _____

Akwesasne Non-Insured Health Benefits Program
Appeal Form

I, DIAND#:_____ Health Card #:_____

Residence: _____ Kawehnoke Kanatakon Tsisnaihne
Street Address (Circle One)
Other: _____ Initial Appeal Letter attached: Yes No

Hereby request a formal appeal to the ANIHB Program Manager, Director, Appeal Board.

I have been denied the benefit of:

_____

_____

_____

The facts to my application and subsequent denial/reduction of services, as I understand them to be, as follows:

_____

_____

_____

_____

I feel that receiving these benefits is of the utmost importance because:
_____
_____
_____
_____
_____
_____
_____

I, certify that all statements made in this written request for an appeal are true and that any false statements will directly affect my eligibility.

Further, I understand that the decision of the Appeal Board is final and conclusive.

_____ _____
Initial Date

SECTION A: FOR OFFICE USE ONLY Appeal #_____ FY20_ _/20_ _

As Program Manager of ANIHB the client has been denied benefits because of ANIHB Policy#_____, violating the clause _____
_____

Brief history of the client within ANIHB:_____
_____
_____
_____
_____
_____
_____

Cost Implications: _____

In the scope of my authority, I APPROVE or DENY the aforementioned appeal, or if I feel it is not within my power to make this decision I choose to FORWARD this appeal on to the next level. **(My decision is indicated by circling the appropriate action.)**

_____ _____
ANIHB Supervisor/Program Manager **Date**

SECTION B: FOR OFFICE USE ONLY Appeal #_____ FY20_ _/20_ _

The ANIHB Program Manager has estimated the cost implication of the benefit is roughly $_____, and that the ANIHB last quarter MCA Variance report showed a SURPLUS / DEFICIT (circle one).

Recommendation of the Program Manager, or any extenuating circumstances that should be considered in reviewing the appeal.

_____
_____
_____
_____
_____
_____
_____

PM Initial: _____ Date: _____

Therefore, as Director of Health, or acting designate, it is in my authority to APPROVE or DENY the aforementioned appeal, or if I feel it is not within my power to make this decision, I choose to FORWARD this appeal on to the next level. **(My decision is indicated by circling the appropriate action.)**

Comments: _____
_____
_____
_____
_____

_____ _____
Director of Health **Date**

SECTION C: Appeal #_____ FY20_ _/20_ _

We the Appeal Board, have thoroughly reviewed the documented information listed in sections A and B. After discussion, we have come to a majority decision to _____ the Appeal.
Approve/Deny

If Denied: The decision to overturn the Appeal was rendered based upon:
_____
_____
_____
_____

Signatories of the Appeal Board: **Date: _____**

_____
_____
_____
_____
_____
_____
_____
_____

The decision of the Appeal Board is final and conclusive.

Correspondence was sent to the client on (date):_____ by (init.)_____ informing them of the outcome of the Appeal Process.

Appeal #_____ FY20_ _/20_ _

Akwesasne Non-Insured Health Benefits Program

APPEAL: REQUEST TO FORWARD THE APPEAL

I, hereby request this Appeal to be forwarded on to level to be reviewed by the Director of Health/Appeal Board.

The reasoning to do so is_____
_____
_____
_____

_____ _____
Name (Please Print) Date

_____ _____
Signature

This form may returned to the ANIHB by:
Fax: 613-575-1153,
Mail: PO Box 941 Cornwall, ON K6H5V1
Hand Delivered: 31 Hilltop Drive, Akwesasne, QC H0M1A0

Section 2: Chiropractic Services

September 2011

Updated by:
LaFrance Consulting Services
September 20, 2011

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AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 2: Chiropractic Services

Subject: Chiropractic Services	**Policy number: 2.01** **Issued:** **Revised:** **Approved by: MCA**

POLICY:

1. The ANIHB will cover the costs of Chiropractic Services provided the following conditions are met:
    a) Client must satisfy all eligibility criteria outlined in the *General Information Section.*

    b) Client must have a written referral to chiropractic services from MD. Date of referral must be within year of treatment date.

2. A maximum of $150.00 per fiscal year will be paid by ANIHB (April 1 to March 31). Any costs associated with treatment once the maximum ha been obtained are the client' responsibility and will not be reimbursed by ANIHB.

PROCEDURE:

1. Client must bring in referral to ANIHB office and provide the following:
    a. Client surname, given name and date of birth
    b. Client's 10 digit Indian Status number
    c. Written referral to chiropractic treatment from MD or RN (EC). Note: Date of referral must be prior to treatment date and must be within year of treatment date.
    d. Original invoice with client's signature.
    e. Payee information name and address if different from letterhead.
    f. Date of appointment
    g. Total appointment fee
    h. "Client Share", if any, must be clearly indicated per appointment.
    i. Balance billed to ANIHB.

2. *The Benefit Analyst will verify and process the claim.*

AKWESASNE NON-INSURED HEALTH BENEFITS

Department of Health

Mohawk Council of Akwesasne

Section: Dental **Subject: Description of Program**	**Section number: III** Page 1 of 1 **Policy number: III-A** **Issued:** **Revised:** **Approved by:**

INTRODUCTION

The Non Insured Health Benefits program is a National program available to Status Indians and eligible Inuit. This program includes payment for services in pharmacy, medical supplies and equipment, optometry and dental.

Health Canada has overall responsibility for the development of national policies governing the NIHB program. The Mohawk Council of Akwesasne (MCA) has assumed responsibility to administer this program and to deliver NIHB for its members. In keeping with opting ou provisions within the Health Information and Claim Processing system (HICPS), Mohawks of Akwesasne membership do not have their services approved or paid for through the First Canadian Health Management Corporation, Inc.

Alternatively, responsibility for authorizing or pre-authorizing dental services and the subsequent payment for these services are the responsibility of the Akwesasne Non-Insured Health Benefits (ANIHB) unit. This unit reports directly to the Director of Social Development and Health at Akwesasne.

The address for the ANIHB unit is:

Akwesasne Non-Insured Health Benefits Program
Box 941
Cornwall, Ontario

Phone number is (613)-575-1263
Toll free number 1-888-514-1966
Fax number is (613)-575-1153

AKWESASNE NON-INSURED HEALTH BENEFITS

Department of Social Development and Health

Mohawk Council of Akwesasne

Section: **Subject:**	**Section number:** Page 1 of **Policy number:** **Issued:** **Revised:** **Approved by:**

POLICY

PROCEDURE

AKWESASNE NON-INSURED HEALTH BENEFITS

Department of Social Development and Health

Mohawk Council of Akwesasne

Section: **Subject:**	**Section number:** Page 1 of **Policy number:** **Issued:** **Revised:** **Approved by:**

POLICY

PROCEDURE

Section:	**Section number:** Page 2 of
Subject:	**Policy number:**

PROCEDURE Cont'd.

Section: **Subject:**	**Section number:** Page 1 of **Policy number:** **Issued:** **Revised:** **Approved by:**

POLICY

PROCEDURE

AKWESASNE NON-INSURED HEALTH BENEFITS

Department of Social Development and Health

Mohawk Council of Akwesasne

Section: **Subject:**	**Section number:** Page 1 of **Policy number:** **Issued:** **Revised:** **Approved by:**

POLICY

PROCEDURE

AKWESASNE NON-INSURED HEALTH BENEFITS

Department of Social Development and Health

Mohawk Council of Akwesasne

Section: **Subject:**	**Section number:** Page 1 of **Policy number:** **Issued:** **Revised:** **Approved by:**

POLICY

PROCEDURE

AKWESASNE NON-INSURED HEALTH BENEFITS

Department of Social Development and Health

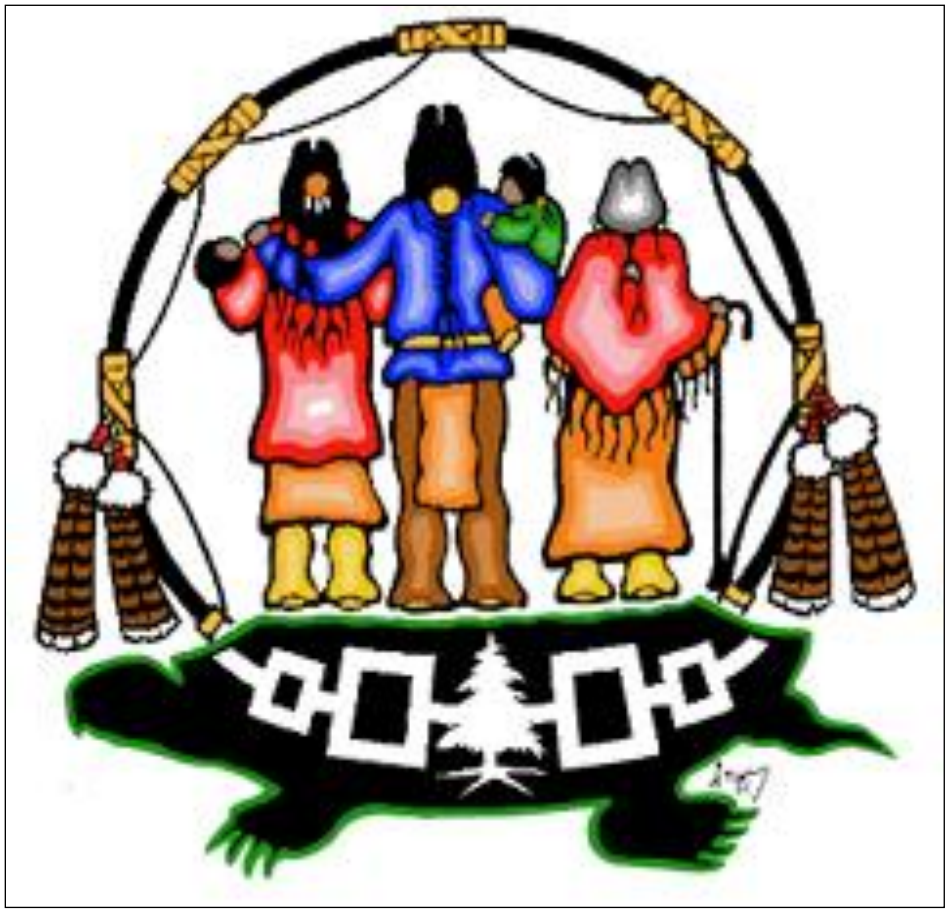
Mohawk Council of Akwesasne

Section: **Subject:**	**Section number:** Page 1 of **Policy number:** **Issued:** **Revised:** **Approved by:**

POLICY

PROCEDURE

Section 4: Medical Supplies & Equipment



September 2011

Updated by:
LaFrance Consulting Services
September 20, 2011

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AKWESASNE NON-INSURED HEALTH BENEFITS

SUMMARY

POLICY ELIGIBILITY CRITERIA

- Client must meet the eligibility criteria in *General Information Section.*
- Client must not be eligible to receive full coverage of the medical supplies and equipment from another source (third party insurance), because the ANIHB program is a payer of last resort.

ANIHB MEDICAL SUPPLIES & EQUIPMENT LIST TERMINOLOGY:

- Terms and conditions of the benefit list include the following:
    - Benefit description
    - Benefit code
    - Prior approval
    - Frequency
    - ADP Accessibility
    - Prescribing requirements

POLICY

- All equipment and many supplies require prior approval for reimbursement.
- Medical supplies benefits to eligible clients are provided the following conditions are satisfied:
- Item requested is on medical supply list.
- Item was prescribed by medical doctor or specialist.
- Prior approval was granted by the ANIHB office.
- Funding through alternate resources has been accessed.
- Should an item not be on the medical supply list, a benefit exception request will be made to the Director of Health.

PRIOR APPROVAL POLICY

- Obtain the written Rx that was issued to the client via fax.
- Obtain client's 10-digit identification band #.
- Contact the ANIHB to obtain prior approval before dispensing the item.
- ANIHB will review client's history for eligibility.

- ANIHB staff will contact Home Care/Home Support Program for availability of used items.
- A confirmation will be sent to the provider once prior approval has been sent to consultant for approval.
- Client will sign confirmation, stating that they received the item described.
- Once the client has finished with the item, it should be returned to ANIHB, as it is now their property.

PRIOR APPROVAL NOT GRANTED

- Process is the same as for approval with exception, client will be sent a rejection letter stating reasons for rejection.
- Client is given a list of alternate resources to access.

BACK DATING PRIOR APPROVALS

- Emergency situations will arise where client needs immediate assistance and the ANIHB program is unavailable to process a prior approval.
- Staff must ensure client is eligible once prior approval is presented.
- Backdating of prior approvals should not cover periods greater than 1 month in the past.

EXCEPTIONS

- Exceptions are items that are not listed on the MS&E benefit list, but which may be considered on a case-by-case basis with written medical justification and prior approval.

EXCLUSIONS

- Exclusions are items that are not listed on the MS&E benefit list and do not apply to the exception process. These items are not considered for coverage under the ANIHB program and cannot be appealed.

QUANTITY LIMITATIONS

- 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 with or without prior approval.

LOANING OF MEDICAL EQUIPMENT TO CLIENT

- In many instances the client will require certain medical equipment. This equipment which is to be used on a temporary basis can be loaned to the individual through the Home Care/Home Support Program.
- This item required will depend on the availability at the Home Care/Home Support Office.
- Clients will sign item out and will return to the Home Care/Home Support Office once they no longer need the item.
- For clients who purchased new items, once the client no longer needs the item, it should be returned to the ANIHB office. ANIHB will then give the item to the Home Care/Home Support program to be used for future needs.

REPAIRS TO MEDICAL SUPPLIES & EQUIPMENT

1. The ANIHB office will only pay for repairs on items that they have purchased through the program.
2. All items should be checked for warranty through vendors, prior to authorization of repairs.
3. Only the most recently purchased item qualifies for maintenance and repairs under the ANIHB Program.
4. Repairs must restore the item to physical condition allowing for normal wear and tear and have a warranty according to industry standard.
5. Once the warranty is expired prior approval is required for all repairs and if more cost effective the item should be replaced instead of repaired. A prescription is not needed for repairs.
6. **No authorization for repairs will be given when the client intentionally misuses the product. Any cost is the client's responsibility.**

RENTALS

- When is MS&E item is rented the rental agreement must include maintenance and repair costs because the ANIHB 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.

BILLING PROCESS

- All claims shall be submitted on a two-week basis.
- All required information shall be submitted for processing which includes Prior Approval Number, Band #, etc.
- A copy of the confirmation sheet where applicable with the client's signature, stating the client received the item.
- No changes in billing cost may be made at this time.

PROVIDERS NOT REGISTERED WITH ASSISTIVE DEVICES PROGRAM (ADP)

- Clients should be directed to a provider that is registered with Assistive Devices Program. This program will pay up to 75% of the cost of an item.
- Should a client refuse to go to a registered provider, the client will be responsible for any payment required.

ANIHB Medical Supplies and Equipment List

The Non-Insured Health Benefits (NIHB) Medical Supplies List and the NIHB Medical Equipment List provide a list of medical supplies and equipment items that are available to eligible clients under the ANIHB Program. Both lists include information that pertain to benefit codes, requirements for prior approval and frequency limitations where applicable.

The NIHB Medical Supplies List and the NIHB Medical Equipment List use the terminology outlined in the table below. It is imperative that ANIHB staff becomes familiar with these terms.

Term Used in the Medical Supplies List and Medical Equipment List	**Description of the Term**
Benefit description	Benefit items are listed within general categories (e.g., Blood Testing Supplies) in alphabetical order by category and item.
Benefit code	The 8-digit code that must be submitted to the ANIHB Program for billing purposes.
Prior approval	Identifies by general category, or by item within a category, whether or not prior approval must be obtained before the provider can dispense an item.
Frequency limitation	Identifies any frequency limitations that are applicable to an entire category of items or to a particular item within a category.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 4.1: Eligibility Criteria

Subject: Client Eligibility Criteria	**Policy number: 4.01** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

1. In order for a client to be considered eligible to receive coverage for approved medical supplies and equipment from the Akwesasne Non-Insured Health Benefits Program, the client must meet the eligibility criteria defined in the *General Information Section.*

2. The client must not be eligible to receive full coverage of the medical supplies and equipment from another source (e.g., third-party insurer), because the Akwesasne Non-Insured Health Benefits Program is a payer of last resort.

PROCEDURE

1. When processing a claim for medical supplies and equipment for a client, the Benefit Analyst must ensure that the client satisfies all of the eligibility criteria outlined above.

2. If any of the client eligibility criteria is not satisfied, the Benefit Analyst will reject the claim and the client must be informed stating the reason(s) why the claim was rejected with documentation in the client's file.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 4.2: NIHB Medical Supplies List

Subject: NIHB Medical Supplies List	**Policy number:** **4.02** **Issued:** **September 1999** **Revised:** **Approved by:** **MCA**

POLICY

1. Medical supplies benefits are available to eligible clients (refer to Policy 4.01) provided that the following conditions are satisfied:

   a) The medical supplies item is listed on the most current NIHB Medical Supplies List.

   b) The item has been prescribed or ordered by a medical doctor or medical specialist.

   c) Prior approval, when required, has been provided by authorized staff in the ANIHB Program.

2. The item is not available to the client through an alternate third-party health care plan or alternate source of funding (e.g., ADP).

3. Providers must adhere to the items listed as benefits on the attached NIHB Medical Supplies List. **This list is applicable to all providers regardless of their location (i.e., on reserve or off reserve).**

4. For those items on the list that require a prior approval, the provider must contact the ANIHB Program to obtain a prior approval before dispensing the item to the client (refer to Policy 4.05).

5. If the client is prescribed an item that is not listed on the most current NIHB Medical Supplies List, the provider should, wherever possible, offer an alternative to the prescribing physician that is on the list. If no alternative is available, the provider must obtain prior approval from the ANIHB Program to release the item to the client (refer to Policy 4.04).

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 4.3: Medical Equipment List

Subject: NIHB Medical Equipment List	**Policy number: 4.03** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

1. Medical equipment benefits are available to eligible clients (refer to Policy 4.01) provided that the following conditions are satisfied:

   a) The medical equipment item is listed on the most current NIHB Medical Equipment List.

   b) The item has been prescribed or ordered by a medical doctor or medical specialist.

   c) Prior approval, when required, has been provided by authorized staff in the ANIHB Program.

   d) The item is not available to the client through an alternate third-party health care plan or alternate source of funding (e.g., ADP).

1. Providers must adhere to the items listed as benefits on the attached NIHB Medical Equipment List. This list is applicable to all providers regardless of their location (i.e., on reserve or off reserve).

2. For those items on the list that require a prior approval, the provider must contact the ANIHB Program to obtain a prior approval before dispensing the item to the client (refer to Policy 4.04).

3. If the client is prescribed an item that is not listed on the most current NIHB Medical Equipment List, the provider should, wherever possible, offer an alternative to the prescribing physician that is on the list. If no alternative is available, the provider must contact the ANIHB Program to obtain the prior approval before dispensing the item to the client (refer to Policy 4.04).

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 4.4: Prior Approval Procedure

Subject: Prior Approval Procedure	**Policy number: 4.04** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

1. If a client is prescribed an item in the medical supplies and equipment category that requires a prior approval, as indicated on the NIHB Medical Supplies List and the NIHB Medical Equipment List, the provider must contact the ANIHB Program to obtain permission to dispense the item to the client.

2. Also, if a client's physician prescribes an item that is not on the Medical Supplies and Equipment Lists, the provider must obtain a prior approval from the ANIHB Program before dispensing the item to the client.

PROCEDURE

If a client is prescribed an item that requires a prior approval, as indicated on the Medical Supplies and Equipment Lists, the provider must do the following:

1. Obtain the written prescription that was issued by the client's medical doctor or medical specialist.

2. Obtain the client's registered family name, given name(s), date of birth and client identification number (i.e., INAC # or the Band # and Family #).

3. Contact the ANIHB Program to obtain the prior approval to dispense the item.

4. The Benefit Analyst must review the client's case history on a case by case basis and consult with Home Care Nursing, Community Health Nursing and other relevant program areas wherever necessary, to determine whether or not prior approval should be granted.

5. If prior approval is granted, the provider should record the prior approval number obtained from the ANIHB Program and make note of the prior approval details (e.g. item description, quantity, dollar value and any frequency or time limitations).

6. A written confirmation of the approval details will be mailed to the provider by the ANIHB Program and it should be retained for billing purposes.

7. If Prior Approval is not granted, the Benefit Analyst must inform the client of the reason(s) why his/her claim was rejected and document the reason(s) in the client file.

If a client is prescribed an item that is not on the Medical Supplies and Equipment Lists, the provider should do the following:

1. Obtain the written prescription that was issued by the client's medical doctor or medical specialist.

2. Obtain the client's registered family name, given name(s), date of birth and client identification number (i.e., INAC # or the Band # and Family #).

3. Wherever possible, the provider must contact the client's physician to recommend an alternative that is on the Medical Supplies and Equipment Lists.

4. If no alternative is available, the provider must contact the ANIHB Program to obtain prior approval to dispense the prescribed item.

5. The Benefit Analyst will contact the client's physician to request the completion of a "Request for Exception: Medical Supplies and Equipment" form (see attached), which once completed, must be returned to the ANIHB Program in the most expeditious manner (e.g., by fax).

6. The Program Manager will then review the completed "Request for Exception: Medical Supplies and Equipment" form and advise the ANIHB Program as to whether or not prior approval should be granted.

7. If approval is granted, the provider should record the prior approval number obtained from the ANIHB Program and make note of the prior approval details (e.g. item description, quantity, dollar value and any frequency or time limitations).

8. The Benefit Analyst will mail a written confirmation of the approval details to the provider and it should be retained for billing purposes.

8. If Prior Approval is not granted, the Benefit Analyst must inform the client of the reason(s) why his/her claim was rejected and document the reason(s) in the client file.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 4.5: Backdating a Prior Approval

Subject: Backdating a Prior Approval for Medical Supplies and Equipment	**Policy number: 4.05** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

There will be emergency situations in which there is no time available for a provider to obtain a Prior Approval from the ANIHB Program for a medical supplies and equipment item for a client. In such an instance, the Prior Approval must be obtained after the item has already been dispensed.

PROCEDURE

1. If the Benefit Analyst encounters a situation in which a Prior Approval is being requested after the item has already been dispensed, they should backdate the Prior Approval provided that:

   a) the client is eligible to receive medical supplies and equipment coverage under the ANIHB Program; and

   b) there was a legitimate reason (e.g., medical emergency, ANIHB office was closed) why the Prior Approval was not obtained before the item was actually dispensed by the provider;

2. The Benefit Analyst must ensure that the backdating of prior approvals should not cover time periods greater than 1 month in the past.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 4.6: Loaning Medical Equipment

Subject: Loaning of Medical Equipment to Clients	**Policy number: 4.06** **Issued: September 1999** **Revised:** **Approved by: MCA**

BACKGROUND

In many instances, clients will require certain pieces of medical equipment (e.g., crutches, canes, hospital type beds, etc.) on a temporary basis only. Once they have recovered from the medical condition that caused them to require an assistive medical device, the equipment is no longer useful to the client and becomes redundant. Given that the ANIHB budget is not limitless, it is more efficient for the program to purchase certain pieces of medical equipment and to loan this equipment to clients on a temporary basis. Once the client no longer requires the medical equipment, it can be loaned to another client, thereby eliminating the need to purchase the same piece of equipment for that client.

POLICY

The ANIHB Program will maintain a supply of medical equipment, such as crutches, canes, hospital type beds, etc. to be loaned to clients on a temporary basis. The equipment will remain the property of the ANIHB Program and will be returned to the program once the client no longer requires it, because he/she has either recovered from the illness or has died. The "warehouse" of medical equipment will be overseen by the Home Care/Home Support Program and their staff will ensure that clients sign out the medical equipment and eventually return it once it is no longer required.

PROCEDURE

1. When the Benefit Analyst receives a claim for medical equipment, Home Care/Home Support staff will be contacted to determine whether or not that piece of equipment is available to be loaned to the client.

2. If the equipment is indeed available, ANIHB staff will ensure that the client satisfies the eligibility criteria outlined in Policy 4.01.

3. The Benefit Analyst will then inform the client that the medical equipment is available and can be loaned to the client until such time that it is no longer required.

4. The client will be instructed to contact the Home Care/Home Support Program to make arrangements to receive the equipment on loan.

5. Home Care/Home Support Program staff will ensure that the client signs out the piece of equipment and that the equipment is returned in a timely manner once it is no longer required.

6. The client must be informed that the equipment does not belong to him/her and that every attempt should be made to return it in good condition so that it can be reused by another client.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 4.7: Repairs to Medical Equipment

Subject: Repairs to Medical Equipment	**Policy number: 4.07** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

1. The ANIHB Program will pay for repairs to medical equipment that it has purchased to be loaned to clients on a temporary basis.

2. The ANIHB Program will also pay for repairs to medical equipment that it has purchased for clients.

3. The repairs should render the equipment in acceptable working condition.

4. Should the ANIHB staff obtain proof that a client has intentionally misused the medical equipment that was purchased for him/her, rendering it in need of repair, the ANIHB Program will not pay for the cost of the repairs and the client will be held responsible for the costs incurred to repair the piece of equipment.

PROCEDURE Cindy – I drafted this – please review and approve/modify

1. The Benefit Analyst will determine if the item to be repaired was purchased by the program.
2. The Benefit Analyst will check to determine if there is a warranty through vendors for the item, prior to authorization of repairs.
3. The Benefit Analyst will examine the item upon return from repairs to verify that it has been restored to a physical condition allowing for normal wear and tear and have a warranty according to industry standard.
4. If the warranty is expired the Benefit Analyst will secure prior approval from the Program Manager for all repairs and if more cost effective the item should be replaced instead of repaired.
5. If the Benefit Analyst believes that the item was intentionally misused, no authorization for repairs will be given and the client is informed that any cost is his/her responsibility.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 4.8: Billing & Payment

Subject: Billing and Payment for Medical Supplies and Equipment	**Policy number: 4.08** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

Billing

1. Claims for medical supplies and equipment must be submitted to the ANIHB Program on plain stock or computer paper at least every two weeks.

2. All required data elements must be supplied to facilitate the efficient payment of claims (see below).

Payment

1. Payment for claim must be made within 1 year of the date of service.

PROCEDURE

1. The Benefit Analyst will review claims to ensure that the following data requirements are included in the claim form:

Data Requirements: Client Information

- Client's registered family name and given name(s)
- Client's date of birth in DD/MM/CCYY format (i.e., day-month-century-year)
- Client identification number (i.e., DIAND # or Band # and Family #)

Data Requirements: Claim Information (for each prescribed item)

- Date of service in DD/MM/CCYY format
- Item code
- Quantity (i.e. number of units of the item dispensed)
- Prescription number (assigned by the pharmacy for the dispensed item)
- Item cost

- Mark-up (i.e., dollar amount for any mark-up for the item; leave blank if not applicable)
- Third-party share (i.e., dollar amount of any portion of the claim that is billable to a third party)
- Amount claimed (i.e., sum of the item cost, dispensing fee and mark-up for the
- item minus any third-party share)
- Days' supply (i.e., estimate of the number of days of treatment contained in the prescription)
- Total (i.e., the total dollar amount claimed for all items listed on the claim form)
- Prescriber (i.e., the physician's license number)
- Prior approval number

Data Requirements: Pharmacy Information

- Pharmacy name
- Pharmacy address
- Pharmacy number (i.e., number assigned to the pharmacy upon registration as an NIHB provider)

Payment

1. The Benefit Analyst will send the provider a cheque that is based on the information received, twice per month on behalf of the Mohawk Council of Akwesasne.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 4.9: Claim Statement

Subject: Medical Supplies and Equipment Claim Statement	**Policy number: 4.09** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

1. The Medical Supplies and Equipment Claim Statement must accompany the claims payment cheque and provide information about each medical supply and equipment claim that was processed.

2. The claim statement may provide additional client identification information which the provider must add to the client's records and use for all future claims submissions for that client.

3. The Medical Supplies and Equipment Claim Statement must list all submitted and entered claims that were settled, adjusted or rejected during the current period. Rejected claims must have a reject message that explains why the claim was not paid.

4. Medical Supplies and Equipment Claim Statements are issued twice per month and may be used to reconcile providers' accounts. They should be referenced when providers are making inquiries.

5. Corrections to claims must be indicated directly below the existing information and forwarded to the ANIHB Program within 12 months of the statement date for re-adjudication of the claim.

6. The Medical Supplies and Equipment Claim Statement must include the data fields described in the table below.

FIELD NAME	EXPLANATION
Date of Service	Claims are presented on the statement in order of date of service (oldest date first).
Prescription Number	Claims with the same date of service are presented in order of prescription number.
Client Information	The information includes Client ID #, Family Name, Given Name(s) and Date of Birth.
Band # and Family #	These fields refer to the client's Band # and Family #.
Prescriber Number	This field refers to the physician's licence number.
Approval Number	This field is indicated only for those items for which a prior approval was provided.
Item Code	This field is the item code.
Quantity	This field is the quantity (number of units) of the item dispensed.
Item Cost	The total cost for all units of the item dispensed.
Dispensing Fee	The dispensing fee charged for the item dispensed.
Mark-up	The dollar amount of any mark-up for the item based on the percentage
Third Party	The dollar amount of any portion of the claim which is billable to a provincial or territorial program or other third party.
Amount Claimed	The sum of the item cost, dispensing fee and mark-up for the item.
Net Amount	This field shows the net payable amount.
Grand Total Paid	This field shows the grand total paid on the final page of the Medical Supplies and Equipment Claim Statement.

PROCEDURE – Cindy – I drafted this – please review and approve/modify

1. The Benefit Analyst will ensure that the Medical Supplies and Equipment Claim Statement accompany the claims payment cheque and provide information about each medical supply and equipment claim that was processed: settled, adjusted, rejected.

2. If a claim was rejected the Benefit Analyst must ensure that a reject message is listed that explains why the claim was not paid.

3. The Benefit Analyst will issue the Medical Supplies and Equipment Claim Statements twice per month and use it to reconcile providers' accounts. They should be referenced when providers are making inquiries.

4. When the Benefit Analyst receives corrections to claims he/she must ensure that the claim has been made within 12 months of the statement date for re-adjudication of the claim.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 4.10: Providers not Registered with the ADP

Subject: Providers not Registered With the Assistive Devices Program (ADP)	**Policy number: 4.10** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

Clients must seek services for assistive devices from providers who are registered with the Assistive Devices Program (ADP).

PROCEDURE

1. If an Akwesasne member living in Ontario goes to a provider that is not registered with the Assistive Devices Program (ADP), the Benefit Analyst will direct the client to seek services from a provider who is registered with ADP.

2. If the client refuses to obtain services from an ADP-registered provider, the Benefit Analyst will inform the client that he/she is responsible for the payment due to the provider.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 4.11: Clarification of Ownership by Providers

Subject: Clarification of Ownership by Providers	**Policy number: 4.11** **Issued: September 1999** **Revised:** **Approved by: MCA**

POLICY

1. When a provider (e.g., a pharmacy) changes ownership, it is the responsibility of the new owner to inform the ANIHB Program of the changes in ownership so that the claim cheque can be issued to the correct recipient.

2. If the ANIHB Program is not informed of the change in ownership and a claim cheque is inadvertently issued to the previous owner, it will be the current owner's responsibility to obtain the funds from the previous owner. The ANIHB Program will not issue a second cheque in the name of the new owner, unless the cheque that was issued to the previous owner is returned uncashed to the ANIHB Program.

3. If a provider is part of a conglomerate or group partnership and wishes to have the claim cheque issued to him/her as an individual rather than to the group as a whole, the provider must submit this request in writing to the ANIHB Program.

PROCEDURE Cindy – I drafted this – please review and approve/modify

1. The Benefit Analyst will update the ownership of the service when notified of a change in ownership.

2. When a provider requests to have the claim cheque issued to him/her, the Benefit Analyst will ask for a written verification of this request to the be addressed to the Program Manager.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 4.12: O_2 Renewals - Internal

Subject: O_2 Requests/Renewals - Internal	**Policy number: 4.12** **Issued: September 2010** **Revised:** **Approved by: MCA**

POLICY

All renewals/requests for Oxygen benefits must comply with the Medical Supplies and Equipment guidelines.

PROCEDURE

1. *All Rx from physicians require prior approval of the Consultant. Cindy – is this correct?*
2. Once approved, the Benefit Analyst will inform the client that he/she may contact the provider for Oxygen (Vital Aire, HDHD).
3. The provider's Respiratory Therapist will conduct ABGs (Arteiral Blood Gases) and forward the results to the ANIHB office. The ABGs are valid for one (1) year.
4. All requests, if on reserve, will be forwarded by the Benefit Analyst to the Home Care Nursing Supervisor for review.
5. Upon approval by the Home Care Nursing Supervisor, the Oxygen may be supplied for Six (6) months to one (1) year.
6. Once the prior approval is completed, the Benefit Analyst will send the Consultant the "Benefits Oxygen and Respiratory program Prior Approval Form", the RX, ABS, oximetry test and other supporting medical documentation (as required) for final approval.
7. When the equipment is no longer required, the Benefit Analyst will inform the provider that the equipment must be removed within 72 hours.
8. Long term oxygen may be considered by the ANIHB Program after an applicant's condition has been stabilized and the treatment regimen optimized.

Key to Abbreviated Prescriber Codes (ANIHB)

CA - Audiologist

DT - Dentist

ES - ENT Specialist

MD - Medical Doctor *

O - Ophthalmologist

OH - Orthotist

OP - Optometrist

OT - Occupational Therapist

P - Podiatrist

PC - Psychiatrist

PE - Pediatrician

PT - Physiotherapist

RN - Registered Nurse

RT - Respiratory Therapist

***MD is any qualified, licensed physician.**

PROVIDER GUIDE FOR MEDICAL SUPPLIES AND EQUIPMENT (MS&E) BENEFITS

NON-INSURED HEALTH BENEFITS
APRIL 2009

Canada

Benefits

This guide provides information on the Health Canada Non-Insured Health Benefits (NIHB) Program and policies relevant to medical supplies and equipment (MS&E) providers. It explains the extent and limitations of the NIHB Program's MS&E benefits by describing the important elements of each associated policy. It also lists website addresses to give providers quick access to related forms and more detailed Program information.

The guide is intended to supplement the information contained in the *Medical Supplies and Equipment (MS&E) Claims Submission Kit*, which explains the MS&E provider process for submitting claims for payment of goods rendered to eligible Clients.
(www.provider.esicanada.ca)

Health Canada's Non-Insured Health Benefits (NIHB) Program provides a limited range of medically necessary health-related goods and services to eligible registered First Nations and recognized Inuit, when these goods and services are not already provided through private insurance plans, provincial or territorial health and social programs, or other publicly funded programs.

NIHB Program benefits include a specified range of medical supplies and equipment; prescription drugs and over-the-counter medications; dental and vision care; short-term crisis mental health counselling; and transportation to access medically required health services that are not available on the reserve or in the community of residence. The Program also funds provincial health premiums for eligible Clients in British Columbia.

The *Provider Guide for Medical Supplies and Equipment (MS&E) Benefits* explains the terms and conditions, the policies, and the benefits under which the NIHB Program will reimburse medical supplies and equipment provided to eligible Clients.

As policies and procedures evolve, the guide is updated accordingly and providers are advised of these changes through the Program's newsletters and bulletins.

Providers are advised to read and retain the most current version of the guide to ensure continued compliance with their NIHB provider agreement. In the event of contradiction between document versions, the provisions of the Health Canada web-posted guide will prevail.

Quick Links

- Annual Report 2007/2008 (**http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb- ssna/2008_rpt/index-eng.php**)
- Information Booklet (**http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb- ssna/2003_booklet_livret_info/index-eng.php**)
- Medical Supplies and Equipment (MS&E) Bulletins (**http://www.hc-sc.gc.ca/fniah- spnia/pubs/nihb-ssna/index-eng.php#medequip_bull-lebull**)
- Newsletters for Medical Supplies and Equipment (MS&E) Providers (**http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/index-eng.php#medequip_bull-lebull**)
- Oxygen Benefits Notices to Providers (**http://www.hc-sc.gc.ca/fniah- spnia/pubs/nihb-ssna/index-eng.php#medequip**)
- RSS (really simple syndication) Feeds (**http://www.hc-**

sc.gc.ca/fniah-spnia/nihb- ssna/provide-fournir/rss-eng.php)

The following policies impact the benefits under which the NIHB Program will reimburse claims for medical supplies and equipment provided to eligible Clients.

Please note that all equipment and many supplies require prior approval for reimbursement. It is imperative that items requiring prior approval are not dispensed before approval is granted by the appropriate Health Canada Regional Office to avoid delays and ensure claims are reimbursed. *See* *Section 2.4: Prior Approval* for additional details.

2.1 Exceptions

Exceptions are items that are not listed on the MS&E benefit list, but which may be considered on a case-by-case basis with written medical justification and prior approval. MS&E providers should refer to the prior approval section of this guide and follow its procedures to proceed with 'exceptions'.

2.2. Exclusions

Exclusions are items that are not listed on the MS&E benefit list and do not apply to the exception process. These items are not considered for coverage under the NIHB Program and cannot be appealed.

2.3 Quantity Limitations

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 with or without prior approval.

2.4 Prior Approval Requirements

Some items not listed on NIHB MS&E benefit list may be considered for NIHB Program coverage under special circumstances, with prior approval.

To request prior approval, the MS&E provider must:

- obtain from the Client, the written prescription issued by a physician or nurse practitioner (further details provided in the sub-benefit sections of this Guide);
- obtain Client identification information;
- contact the appropriate Health Canada Regional Office to initiate the prior approval process before dispensing the 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 Health Canada Regional Office; and,
- when required, complete and submit the appropriate prior approval form to the Health Canada Regional Office.

Note: *NIHB reserves the right to request additional information if deemed necessary.*

Prior approvals may also be generated automatically by the electronic claims adjudication system when a claim is submitted electronically. The claim may be rejected if the criteria for automated prior approval have not been met. If rejected, the provider may resubmit the claim through the system to have the prior approval reviewed by the appropriate Health Canada Regional Office. Providers should be aware that a representative of the Regional Office may call them directly to discuss the request or to collect any necessary information.

If prior approval is granted, a confirmation letter with the applicable dates and prior approval details may be faxed, mailed, or e-mailed to the provider. Only then should the provider proceed with the fabrication, fitting, or dispensing of the item. If prior approval is not granted, the provider will be advised of the reason.

Prior approvals are entered electronically on the claims processing system. The date of dispense should be indicated on the electronic claim form or to the analyst so it can be reflected in the prior approval. MS&E providers are advised to retain the confirmation letter, if applicable, for billing purposes and/or to validate any discrepancies. When submitting the claim, providers must be sure to include the date of service (dispense date).

2.5 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. *For individual items, refer to the recommended replacement guidelines in the benefit list.* Requests exceeding these guidelines may be considered on a case-by-case basis, if a need is demonstrated.

Early replacement of equipment and devices will be considered only when a substantial change in the condition of the Client results in changed needs or if the equipment or device has deteriorated during the course of normal use 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.

2.6 Coupons and Promotions

When accessing benefits through the NIHB Program, eligible Clients may not directly or indirectly benefit from **special promotions or incentives**, including coupons, discounts, points or rebates in the form of cash and/or goods that may be offered by providers. To the extent permitted by such promotions and applicable law, the coupons, discounts or rebates should be applied to the NIHB claim. As a result, the amount claimed through the NIHB Program must be the residual amount after application of the promotion.

2.7 Rentals

When an MS&E item is rented, the rental agreement must include maintenance and repair costs because 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.

2.8 Repairs

Only the most recently purchased item qualifies for maintenance and repairs under the NIHB Program. Repairs must restore the item to physical condition allowing for normal wear and tear, and have a warranty according to industry standard. Once the warranty is expired, prior approval is required for all repairs and, if more cost effective, the item should be replaced instead of repaired. Note that a prescription is not needed for repairs.

2.9 General Warranties

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;
- repairs and services are the responsibility of the vendor, manufacturer or service designate; and,
- where there is repeated technical failure, the device will be replaced by the provider at no cost to the NIHB Program.

MS&E providers should be aware that they are expected to serve as the Client's advocate to request that the manufacturer or manufacturer's service depot honour the warranty on the item.

The medical supplies and equipment component of the NIHB Program covers items that are: included on the NIHB MS&E benefit list; prescribed by a health professional licensed to prescribe in a given provincial jurisdiction, such as a physician; **and** provided by a supplier who is eligible to provide the specific MS&E item.

MS&E benefits are based on policies established by Health Canada to provide eligible Clients with access to benefits not otherwise available under federal, provincial, territorial or private health insurance plans. This includes 'open benefits' which are listed on the NIHB MS&E benefit list and do not require prior approval, and 'limited use benefits' which may have an annual quantity limitation or require prior approval.

MS&E benefits are covered in accordance with the mandate of the NIHB Program. NIHB Clients do not pay deductibles or co-payments.

MS&E Benefit List

Health Canada maintains an up-to-date list of medical supplies and equipment which are eligible NIHB benefits. Items on the MS&E benefit list are primarily used in a home or ambulatory setting. They have been included on the list based on the judgement of recognized health professionals, consistent with the best practices of health services delivery and evidence-based standards of care.

The MS&E benefit list comprises seven benefits including: general MS&E; audiology; orthotics and custom footwear; oxygen equipment and supplies; pressure garments and pressure orthotics; prosthetics; and respiratory equipment and supplies. Providers should **regularly review** these lists to ensure that they continue to be aware of the MS&E benefits included in the NIHB Program.

Quick Link

- Non-Insured Health Benefits (NIHB) Medical Supplies and Equipment (MS&E) Benefit List (A to Z list) **(http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide- fournir/med-equip/criter/a-z_index-eng.php)**

3.1 General MS&E Benefits

3.1.1 General MS&E Benefit Categories

The general benefit categories are:

- bathing and toileting aids;
- protectors;
- dressing aids;
- feeding aids;
- miscellaneous supplies and equipment;
- lifting and transfer aids;
- mobility aids, such as walking aids, walking aids accessories, wheelchairs, wheelchair cushions and wheelchair parts;
- ostomy supplies and devices;
- catheter supplies and equipment;
- incontinence supplies and equipment, such as diapers and catheters; and,
- wound dressing supplies, such as adhesive tapes and dressing strips, bandages, dressings, and other dressings.

3.1.2 Prescriber/Provider Requirements

General MS&E benefits must be prescribed by a physician or nurse practitioner, and provided by a recognized NIHB pharmacy or recognized NIHB MS&E provider.

3.1.3 Prior Approval Process

For items requiring prior approval, the provider must contact the Health Canada Regional Office to initiate the process. *For a list of these items, refer to the general MS&E benefit list.*

The *NIHB General MS&E Prior Approval Form* must be completed. In addition to the form, the following documentation is required to support the request:

- the prescription and any other information the provider/prescriber may have to support the request;
- a copy of any third-party coverage (e.g., workers' compensation board, private insurance, etc.); and,
- the medical guidelines and required information for authorizing general MS&E benefits as described in the MS&E policies section 3.1.4 of this guide.

Quick Link

- General Medical Supplies and Equipment (MS&E) Prior Approval Form **(http://www.provider.esicanada.ca/mse.html)**

3.1.4 General MS&E Benefit Policies

A. Medical Guidelines and Required Information

The Health Canada Regional Office adheres to the following medical guidelines when authorizing certain medical supplies and equipment. They also require specific information from MS&E providers to proceed with such authorizations.

a) Bath chair lift (water powered)

An occupational therapy/physiotherapy (OT/PT) report is required summarizing the Client's medical, physical, and/or functional status, such as the Client's mobility and transfer status. The report must also explain why a transfer bench with a hand-held shower will not meet the Client's need.

b) Breast pumps

Breast pumps may only be approved when the mother presents medical physical complications hindering the normal physiological process of breast feeding. Providers are required to report on the mother's condition.

c) Catheter supplies and equipment

Providers are required to give the Client's diagnosis and justification for the use of catheter supplies and equipment. *For frequency replacement, consult the general MS&E benefit grid.*

d) Dressings requiring prior approval

Providers are required to give the Health Canada Regional Office the Client's diagnosis; a wound/ulcer assessment from a nurse, a physician or an occupational therapist, including the number of wounds; the size, the site, the type of exudates; the frequency of dressing change; and all other pertinent information regarding the wounds.

e) Feeding pump

Feeding pumps may be approved if a Client cannot receive feeding through gravity.

f) Incontinence supplies

Disposable diapers and pull-up briefs
NIHB will provide a total of four to six incontinence supplies per day (i.e., five diapers or a combination of two different products for a total of six items.) Providers are required to give the following information to the appropriate Health Canada Regional Office:

- the medical diagnosis of the cause(s) for the incontinence;
- the type of incontinence (urine/stools or both);
- when the incontinence occurs (day/night or both);
- the type of incontinence supplies needed;
- the amount of incontinence supplies needed; and
- all other pertinent information.

Pant (brief) mesh
NIHB recommends three per month for Clients who have no other means to

secure in place the incontinence supplies. These pants are washable.

Disposable Underpads
NIHB recommends a maximum 50 disposable underpads per month for Clients doing regular bowel care routine.

Reusable Underpads
NIHB recommends two reusable underpads that are used to protect the mattresses of incontinent Clients with the initial request and one per year afterward.

g) Lift, hydraulic (powered)

An OT/PT report is required summarizing the Client's medical, physical, and/or functional status, such as the Client's mobility and transfer status. The report must also explain why a standard hydraulic lift will not meet the Client's need.

h) Manual wheelchairs

NIHB funds one mobility device every five years (e.g., the Client's primary mobility device). An above-the-knee or below-the-knee amputee qualifies for a manual wheelchair. An OT/PT report is required summarizing the Client's medical, physical, and/or functional status, such as the Client's mobility and transfer status. The report must also explain why this particular wheelchair is the only device that will meet the Client's need. Rental requests are assessed on a case-by-case basis.

B. Exclusions

Exclusions are items which will not be provided as benefits under the NIHB Program under any circumstances. For general MS&E benefits, exclusions include but are not limited to:

- scooters (considered a mode of transportation for outdoor use only);
- hospital beds, mattresses and bedding (considered household items and beyond the scope of NIHB Program. Costs for household items are the responsibility of the Client);
- permanently fixed equipment (e.g., grab bars, ceiling tracks for lifts, stair lifts, etc. that are fixed to a wall/ceiling);
- lift chairs (considered household furniture. Costs for household items are the responsibility of the Client);
- pressure relief mattresses and alternating air pressure overlay pads powered or non-powered (which are beyond the scope of NIHB Program); and
- environmental protection devices and supplies (e.g., masks, air cleaners, filters, UV protection garments and lotions, etc. which are beyond the scope of NIHB Program).

3.1.5 General MS&E Benefit Grid

The *General Medical Supplies and Equipment (MS&E) Benefit List* is available on the Health Canada website. (**http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/med-equip/criter/general-eng.php#list**)

3.2 Audiology Benefits

3.2.1 Audiology Benefit Categories

The audiology benefit categories are:

- hearing aid, bone conduction hearing aid, conventional analog;
- hearing aid, CROS/BiCROSS;
- hearing aid, Programmable Analog;
- hearing aid, digital entry level;
- hearing aid services, fees, repairs and supplies; and,
- hearing aid pricing.

3.2.2 Prescriber/Provider Requirements

Audiology benefits must be prescribed by a physician or nurse practitioner, and provided by a recognized NIHB audiologist or recognized NIHB hearing aid dispenser. Batteries may be provided by a recognized NIHB audiologist, hearing aid specialist, other medical supply and equipment provider, or a pharmacist. In British Columbia, providers are to continue to follow

the procedures outlined in the *hearing aid program* put in place by the NIHB British Columbia Regional Office.

A medical prescription is required to rule out medical conditions other than hearing loss and to support the need for assessment by an audiologist or other hearing aid specialist. The audiologist or other hearing aid specialist will determine the type of device required to meet Client's needs.

3.2.3 Prior Approval Process

With the exception of batteries, all audiology benefits require prior approval. This includes both new and replacement hearing aids. To initiate the prior approval process, the provider must contact the appropriate Health Canada Regional Office.

The *NIHB Hearing Aid and Hearing Aid Repair Prior Approval Form* must be completed. In addition to the form, the following documentation is required to support the request:

- the prescription;
- the most recent audiometric test (six months or less);
- the current hearing aid information (in case of a replacement aid);
- in the case of repairs (manufacturer name, model number or name, date fitted, and serial number);
- any other information the provider/physician or nurse practitioner may have to support the request;
- a copy of any third-party coverage (e.g., workers' compensation board, private insurance, etc.); and,
- the medical guidelines and required information for authorizing audiology benefits as described in the audiology policies section 3.2.4 of this guide.

Once the provider has dispensed or repaired the hearing aid, the NIHB *Hearing Aid and Hearing Aid Repair Confirmation Form* must be completed, signed and returned to the Regional Office. The provider's signature is required to confirm that the Client has received and is satisfied with the equipment or repair and instruction provided. A copy of the completed and signed form should be retained by the provider for audit purposes.

Quick Link

- Hearing Aid and Hearing Aid Repair Prior Approval Form **(http://www.provider.esicanada.ca/mse.html)**

3.2.4 Audiology Benefit Policies

A. Medical Guidelines and Required Information

The Health Canada Regional Office adheres to the following medical guidelines when authorizing certain audiology benefits. They also require specific information from MS&E providers to proceed with such authorizations.

a) Hearing aids and/or replacement of hearing aids

Providers will be required to provide a recent audiogram (less than six months); the manufacturer's name; the model and size of the requested aid; and previous NIHB funding and repairs.

b) Replacement Ear Mould

Providers will be required to use specific benefit codes and to provide complete information about the previous NIHB funding and repairs. When an initial 'behind the ear' hearing aid is dispensed, the price of the mold (although requested separately on the prior approval form) must be included in the price of the hearing aid. In these cases, no benefit code is to be used.

B. Exclusions

Items excluded from the audiology benefit list do not apply to the exception process, are not considered for coverage under the NIHB Program, and cannot be appealed. These include:

- items used for education/school such as FM equipment and assistive listening devices;
- surgical implants;
- assistive speech devices used to communicate and/or replace a person's voice;
- noise breakers used for specific tasks in work-related situations; and,
- therapy treatment, such as speech therapy.

C. Follow up

After the Client has had an opportunity to gain some experience using their device(s), further evaluation and appropriate action needs to be taken by the provider. This includes:

- appropriate reinforcement of information, instructions, and retraining on the device, if necessary*;
- any modifications to improve the comfort of the device;
- any modifications to the electroacoustic characteristics of the device based upon reactions and experiences of the Client;
- further advice or reinforcement regarding user operation;
- Client reactions to amplification and any adjustments or changes that need to be made to enhance Client benefit from the device;
- indication of the benefits perceived by the Client; and,
- any further action that is required.

Note *that any problems with hearing aid usage and/or tolerance noted by the Client to the provider should be identified and action taken.*

Follow-up after warranty has expired

After-care services are services which take place after the dispensing fee services under the manufacturer's warranty have expired (usually a minimum of two years) or services not covered by the manufacturer's warranty. Most after-care services will involve repairs or replacement of earmoulds such as:

- Adjustments to the client's fitting, including an earmould which may be necessary from time to time and that is undertaken as part of the general after-care services. These adjustments may be invoiced according to the fee schedule.
- The Client may require advice, outside a formal appointment, regarding their fitting or their hearing loss. This must be accommodated by the clinic and/or service provider.

D. Repairs

Repairs must result in restoring the hearing aid to the original performance level. While a physician or nurse practitioner prescription is not needed for repairs, prior approval must be obtained for all billable hearing aid repairs.

Out-of-office and *in-office* hearing aid repairs are not subject to service fees while the aid is in warranty by the manufacturer unless the *out-of-office* repair incurs a charge which is not covered by the warranty.

Out-of-office hearing aid repairs which incur a charge by the manufacturer (after the original manufacturer's warranty has expired) should include a warranty unless the cost of replacement is more economical. *In-office* hearing aid repairs do not have a warranty.

Repair warranty periods

Repair warranty periods must be consistent with the current Canadian Auditory Equipment Association-NIHB agreement:

- Repairs carried out on a hearing aid during the product purchase warranty period are guaranteed for a maximum of 12 months after repair or until the original product warranty expires, whichever comes first.
- All repairs and remakes carried out on a hearing aid after the warranty period expires will be subject to a maximum cost outlined in the pricing grid and will carry a 12-month warranty if the hearing device is less than five years old.
- Charges for repairs and remakes can only be billed after the warranty period, two calendar years for new aids and one calendar year after the repair or remake of an aid.
- A remake includes the provision of a new shell for the aid and replacement of required existing electronic components to ensure that the aid has been returned to the equivalent operating standard of a new aid.

Timeline

It is desirable that repairs be made at the time the Client presents with the problem. If same day repair cannot be done, a loan hearing aid should be provided if desired by the Client. A *Behind The Ear* (BTE) type hearing aid is acceptable as a loan hearing aid for *In The Ear* (ITE) and *In The Canal* (ITC) hearing aids. If the hearing aid is not repaired at the service point and needs to be sent to another point to be repaired, it should be returned to the Client as soon as possible. Batteries and repair services must be available at each permanent site during regular business hours. There should be at least one permanent site for a provider.

E. Warranties

All hearing instruments and/or devices will carry, at a minimum, a two-year warranty and one-year 'loss and damage replacement' coverage for one occurrence per aid. Hearing instruments and/or devices provided to children under 16 years of age will have a two-year 'loss and damage replacement' coverage, applicable to only one occurrence per aid. Warranties that go beyond these provisions will extend the same benefits to NIHB Clients. All items will have a 90-day return privilege at no cost to the hearing aid dispenser.

3.2.5 Audiology Benefit Grid

The *Audiology Benefit Grid* is available on the Health Canada website. (**http://www.hc- sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/med-equip/criter/audio- eng.php#list**)

3.3.1 Orthotics and Custom Footwear Benefit Categories

The orthotics and custom-made footwear benefit list covers the following items:

Orthotics:
- limb orthoses for lower and/or upper extremities;
- head, torso and/or spine orthoses;
- orthotic supplies; and,
- custom-made internal footwear devices (foot orthoses).

Custom-made footwear:
- custom-made shoes; and,
- modifications to stock footwear.

3.3.2 Prescriber/Provider Requirements

Limb and body orthotic devices must be prescribed by:
- a physician or nurse practitioner for class I (soft); or,
- a specialist in the field of physiatry, orthopedics, plastic surgery, neurology, rheumatology, pediatrics, geriatrics, or general surgery for class II (rigid) and class III (custom-made) items.

While it is recognized that access to a medical specialist may be an issue in some areas, a prescription from a specialist is required for the first issue of a Class II (rigid) and Class III limb or body orthotic device. A prescription from a general practitioner or nurse practitioner will be accepted for replacement of the same type of body or limb orthotic device.

Limb and body orthotic devices must be provided by:

- a certified orthotist (CO(c)) or certified prosthetist orthotist (CPO(c)), as certified by the Canadian Board for the Certification of Prosthetists and Orthotists (CBCPO) or a recognized NIHB pharmacist or recognized NIHB MS&E provider for class I (soft); or,
- a CO(c) or CPO(c), as certified by the CBCPO for class II (rigid) and class III (custom-made) items

Note: *foam cervical collars, abdominal supports, hernia trusses and sacral or lumbosacral supports, cloth or elastic braces with or without steel stays can be provided by pharmacy and MS&E providers.*

Custom-made shoes, custom made internal footwear devices (orthotics) or modifications to stock footwear must be prescribed by:

- a specialist in the field of physiatry, orthopedics, plastic surgery, neurology, rheumatology, pediatrics, geriatrics, oncology, general surgery or infectious diseases for custom-made shoes; or,
- a physician or nurse practitioner for custom-made internal footwear devices (foot orthotics) and modifications to stock footwear.

While it is recognized that access to a medical specialist may be an issue in some areas, a prescription from a specialist is still required for the first issue of custom-made shoes.
A prescription from a general practitioner or nurse practitioner will be accepted for replacement of custom-made shoes.

Custom-made shoes, custom-made internal footwear devices (orthotics) or modifications to stock footwear must be provided by:

- a Canadian-CO(c), Canadian-CPO(c), podiatrist (chiropodist or DPodM) registered with provincial / territorial regulatory bodies, doctor of podiatric medicine (DPM) registered with provincial or territorial regulatory bodies, or Canadian-certified pedorthist (Cped(c)) for custom-made internal footwear devices (orthotics).

3.3.3 Prior Approval Process

Prior approval is required for all orthotic devices, custom-made internal footwear devices, custom-made shoes, or modifications to stock footwear. To initiate the prior approval process, the provider must contact the appropriate Health Canada Regional Office.

The *NIHB Orthotics-Custom Shoes-Prosthetics-Pressure Garments Prior Approval Form* must be completed. In addition to the form, the following documentation is required to support the request:

- the prescription;
- detailed assessment from the provider, including requirements for custom-made shoes and custom-made internal footwear devices as specified in section 3.3.4 of this guide;
- any other information the provider/physician or nurse practitioner may have to support the request;
- a copy of any third-party coverage (e.g., workers' compensation board, private insurance, etc.); and,
- the medical guidelines and required information for authorizing orthotics and custom-made shoes as described in section 3.3.4.

Quick Link

• Orthotics-Custom Shoes-Prosthetics-Pressure Garments Prior Approval Form
(http://www.provider.esicanada.ca/mse.html)

3.3.4 Orthotics and Custom Footwear Benefit Policies

A. Medical Guidelines and Required Information

The Health Canada Regional Office adheres to the following medical guidelines when authorizing certain orthotics and custom footwear benefits. They also require specific information from MS&E providers to proceed with such authorizations.

a) Custom thoracolumbarsacral

Because orthotics for spinal fractures often need to be fitted while the Client is in an acute hospital, providers are required to give the Regional

Office the diagnosis, date of fracture, and the date of surgery, if applicable.

b) Custom-made shoes

Providers are required to give the Regional Office:

- measurements of the feet;
- templates/drawing/tracing of the contour of the feet and/or (preferred) photographs of the feet;
- the prescriber's speciality;
- the provider's qualification;
- the diagnosis and Client's biomechanical/medical assessment (i.e., significant deformities

of the feet);
- the casting technique (plaster of Paris slipper cast);
- manufacturing technique, material used, and design of shoes;
- name of the laboratory; and,
- warranty details.

c) Custom-made internal footwear device (foot orthoses) Providers are required to give the Regional Office:

- the diagnosis and Client's symptoms (e.g., heel pain, metatarsalgia, tendinitis, etc.);
- biomechanical/medical assessment (e.g., pronation, pes planus/flat feet, bunions, claw toes, etc.);
- type of device (e.g., accommodative or functional);
- casting technique (for accommodative devices, the NIHB accepted casting techniques are plaster of Paris slipper cast, foam box and contact digitizing (Amfit) and for functional devices, plaster of Paris slipper cast and contact digitizing (Amfit) only);
- manufacturing technique and material used;
- name of the laboratory; and,
- warranty details.

B. Exclusions

Items excluded from the orthotics and custom footwear benefit list do not apply to the exception process, are not considered for coverage under the NIHB Program, and cannot be appealed. These items include:

- foot products manufactured only from laser or optical scanning or computerized gait and pressure analysis systems;
- pre-fabricated foot orthotics and internal footwear devices;
- therapy treatment and/or therapy equipment such as but not limited to:
  - electrospinal orthesis;
  - transcutaneous/neuromuscular;
  - neurostimulators;
  - direct passive movement devices;
  - electromagnetic stimulators for osseous growth; and,
  - therapy, including physiotherapy.
- off-the-shelf therapeutic and orthopaedic footwear (e.g., pair of shoes, running shoes, boots, summer sandals, etc.).

C. Services included in price

The following services are to be included in the price of the benefit:

- initial assessment to determine the type of benefit required;
- casting of the body part for the manufacturing of the device;

- manufacturing of device;
- dispensing of the benefit, which includes the adjustment, fitting; and,
- follow-up visit(s).

D. Warranty

The manufacturer/provider warranty will include:

- No charge for necessary adjustments to the **custom-made internal footwear device (custom-made foot orthotics)** for a period of three months after the final fitting, except when there has been a change in the Client's medical condition which would prevent a satisfactory fit.

- Breakage guarantee for six months and no charge for necessary adjustments to a **custom-made orthoses (limb and body)** for a period of three months after the final fitting except when there has been a change in the Client's medical condition which would prevent a satisfactory fit.
- Breakage guarantee for two months and no charge for necessary adjustments to a **customized orthoses/pre-fabricated (limb and body)** for a period of 30 days after the final fitting except when there has been a change in the Client's medical condition which would prevent a satisfactory fit.
- No charge for repairs to **custom-made shoes** for one year period.

3.3.5 Orthotics and Custom Footwear Benefit Grid

The *Orthotics and Custom Footwear Benefit Grid* is available on the Health Canada website.
(http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/med- equip/criter/ortho-orthe-eng.php#list)

3.4 Oxygen Equipment and Supplies Benefits

3.4.1 Oxygen Equipment and Supplies Benefit Categories

The oxygen equipment and supplies benefit categories are divided into oxygen systems and equipment, and oxygen supplies.

3.4.2 Prescriber/Provider Requirements

Home oxygen must be prescribed by a physician. Home oxygen equipment and supplies must be prescribed by a physician or nurse practitioner, and provided by an NIHB-recognized oxygen provider with appropriate health care staff with regulatory affiliations (i.e., registered respiratory therapist/registered nurse familiar with respiratory conditions).

Providers should be aware that their Client's condition must be stabilized and the treatment regimen optimized before home oxygen may be considered by the NIHB Program.

3.4.3 Prior Approval Process

Prior approval is required for all home oxygen equipment and supplies benefits. To initiate the prior approval process, the provider must contact the appropriate Health Canada Regional Office.

The *NIHB Home Oxygen and Respiratory Equipment and Supplies Benefits Approval Form* must be completed with the Client's address. In addition to the form, the following documentation is required to support the request:

- the prescription stating the oxygen flow (litres per minute) and numbers of hours per day;
- indicate if the request is for a new application or a renewal for home oxygen;
- the expected dates of service (i.e., May 01, 2009 to July 31, 2009);
- any other information the provider/physician or nurse practitioner may have to support the request;
- a copy of any third-party coverage (e.g., workers' compensation board, private insurance, etc.); and,
- the medical guidelines and required information for authorizing orthotics and custom-made shoes as described in section 3.4.4.

Quick Link

• Home Oxygen and Respiratory Equipment and Supplies Benefits Approval Form
(http://www.provider.esicanada.ca/mse.html)

3.4.4 Oxygen Equipment and Supplies Benefit Policies

A. Medical Guidelines and Required information

The Health Canada Regional Office adheres to the following medical guidelines when authorizing certain oxygen equipment and supplies benefits. They also require specific information from MS&E providers to proceed with such authorizations.

a) Concentrators/homefill, initial request (three month approval only)

Home oxygen may be considered for NIHB coverage once the Client's condition is stabilized. To be considered, test results must be obtained when Client's condition has stabilized. Arterial blood gas (ABG) results obtained during an acute exacerbation are not acceptable. If ABG is not available, refer to section c) and d) below.

Qualifying medical indications for home oxygen include:

- a resting PaO2 on room air equal or less than 55 mm Hg;
- a resting PaO2 on room air between 56 and 59 mm Hg when there is supporting document evidence provided by a physician and ABG of cor pulmonale, pulmonary hypertension and/or secondary polycythemia;
- persistent PaO2 between 56 and 59 mm Hg, when there is evidence of:
  - exercise limitation due to hypoxemia with significantly greater exercise capability and/or significantly decreased shortness of breath on oxygen compared to room air (ABG and a walking oximetry is needed) and/or
  - nocturnal hypoxemia when nocturnal oxygen desaturation is less than 88% for 30% of the night and sleep disordered breathing is ruled out (ABG and a nocturnal oximetry is needed);
- New York Heart Association Stage IV Heart Disease with supporting documented evidence provided by a cardiologist and ABG; and
- palliative care (less than three months life expectancy) for Clients demonstrating persistent hypoxemia:
  - PaO2 on room air ≤ 60mmHG;
  - O2 saturation ≤ 92% demonstrated by a resting oximetry; and/or,

- dyspnea that cannot be improved with medication and/or comfort analgesia (ABG or a resting oximetry is needed along with a clear diagnosis supporting the end stage of palliative condition by a physician, nurse practitioner or palliative care member to document noting that the dyspnea cannot be improved with medication and/or noting that comfort analgesia are needed.

b) Concentrators/homefill renewal (after three months and 12 months from the initial starting date, and yearly afterward)

After three months and 12 months from the initial starting date of home oxygen, and yearly thereafter, providers are to give the appropriate Health Canada Regional Office the following medical indications:

- an ABG for a resting PaO2 on room air equal or less than 55 mm Hg;
- an ABG for a resting PaO2 on room air between 56 and 59 mm Hg, when there is evidence of cor pulmonale, pulmonary hypertension and/or secondary polycythemia;
- a walking oximetry for persistent PaO2 between 56 and 59 mm Hg, when there is evidence of desaturation on exertion;
- a nocturnal oximetry for persistent PaO2 between 56 and 59 mm Hg, when there is evidence of nocturnal oxygen desaturation;
- a resting oximetry for New York Heart Association Stage IV Heart Disease; and,
- a resting oximetry and a clinical assessment from a nurse or a caring physician for palliative care when the Client is bedridden and presents dyspnea that cannot be alleviate with medication and/or comfort analgesia.

c) Portable oxygen cylinders/liquid initial and renewal and oxygen for medical travelling

Providers are required to give the Regional Office the same medical information described in a) and b) above.

When applicable, NIHB funds oxygen portability for a maximum of eight hours per day away from the principle residence. NIHB oxygen coverage is authorized for primary residence only, with the exception of additional oxygen requirements due to travel for the purpose of attending a medical appointment. While supplemental oxygen for the purpose of attending medical appointments is assessed on a case-by-case basis, it is expected that the Client will use the oxygen concentrator whenever possible.

B. Exclusions

Items excluded from the oxygen benefit list do not apply to the exception process, are not considered for coverage under the NIHB Program, and cannot be appealed. These items include:

- oxygen for therapy treatment and/or therapy equipment , such as (but not limited to):
  - pain relief (e.g., migraines, cluster headaches, chronic fatigue syndrome, etc.);
  - hyperbaric treatment; and,
  - oxygen for angina in the absence of documented chronic hypoxemia;
- oxygen benefits for outings while the Client is an in-patient in an acute or long-term hospital setting (i.e., Client continues to be the responsibility of the institution);
- oxygen to run nebulizers/compressors; and,
- oxygen on an "as needed" (PRN) basis.

C. Provider Services to Support Oxygen Equipment and Supplies

The NIHB Program also requires that provider services to support oxygen therapy:

- complete set up within 24 hours of authorization (with the exception of ferry and remote site transportation limitations);
- include with set up equipment delivery, safety and care of equipment, and education for the Client on equipment use;
- a respiratory therapist (nurse) visit within 72 hours, after three months and every six months thereafter to ensure optimum oxygen therapy (i.e., review prescription, review use of equipment, educate Client on condition); and,
- removal of equipment within 72 hours of being informed that it is no longer required.

Long-term oxygen may be considered by the Program after an applicant's condition has been stabilized and the treatment regimen optimized.

3.4.5 Oxygen Equipment and Supplies Benefit Grid

The *Oxygen Equipment and Supplies Benefit Grid* is available on the Health Canada website. (**http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/med- equip/criter/oxygen-eng.php#list**)

3.5 Pressure Garments and Pressure Orthotics Benefits

3.5.1 Pressure Garments and Pressure Orthotics Benefit Categories

The pressure garments and pressure orthotics benefit list covers the following:

Compression garment and lymphedema compression device:

- custom-fitted graduated compression garment;
- custom-made graduated compression garment; and,
- lymphedema compression device sequential extremity pump for lymphedema.

Hypertrophic scar management:

- custom-fitted pressure garment;
- custom-made pressure garment;
- customized pressure orthosis; and,
- custom-made pressure orthosis.

3.5.2 Prescriber/Provider Requirements

A compression garment of 20mmHg to 30mmHg and 30mmHg to 40mmHg, as well as a lymphedema compression device, must prescribed by a physician or nurse practitioner. For compression garments over 40mmHg, and all hypertrophic scar pressure garments, the prescriber must be a vascular surgeon, orthopedic surgeon, oncologist, internist, pediatrician, plastic surgeon, physiatrist or general surgeon.

All compression garment and lymphedema compression devices must be provided by a recognized NIHB pharmacist or a recognized NIHB MS&E provider who is a certified compression garment fitter or has an employee who is a certified compression garment fitter. Hypertrophic scar pressure garments must be provided by a recognized NIHB pharmacist or a recognized NIHB MS&E provider who is a certified compression garment fitter and a certified burnscar garment fitter or has an employee who is a certified compression garment fitter and a certified burnscar garment fitter.

3.5.3 Prior Approval Process

Prior approval is required for all pressure garment and pressure orthotic benefits. To initiate the prior approval process, the provider must contact the Health Canada Regional Office.

The *NIHB Orthotics-Custom Shoes-Prosthetics-Pressure Garments Prior*

Approval Form must be completed. In addition to the form, the following documentation is required to support the request:

- the prescription;
- any other information the provider/physician or nurse practitioner may have to support the request;
- a copy of any third-party coverage (e.g., workers' compensation board, private insurance, etc.); and,
- the medical guidelines and required information for authorizing pressure garment or pressure orthotic benefits as described in section 3.5.4.

Quick Link

• Orthotics-Custom Shoes-Prosthetics-Pressure Garments Prior Approval Form

(http://www.provider.esicanada.ca/mse.html)

3.5.4 Pressure Garments and Pressure Orthotics Benefit Policies

A. Medical Guidelines and Required Information

The Health Canada Regional Office adheres to the following medical guidelines when authorizing certain pressure garments and pressure orthotics benefits. They also require specific information from MS&E providers to proceed with such authorizations.

a) Compression stocking/sleeve 20-30, 30-40mmHg and high sustained compression bandages 35mmHg

Providers are required to give the Health Canada Regional Office the Client's diagnosis; the prescription indicating the requested compression; the qualifications and the title of the fitter; whether the item is custom fitted or custom made; as well as the name of the manufacturer and model of the item.

b) Compression stocking/sleeve 40mmHg and up

Providers are required to give the Health Canada Regional Office the Client's diagnosis; the prescription indicating the requested compression; the prescriber's speciality; the qualifications and the title of the fitter; whether the item is custom fitted or custom made; as well as the name of the manufacturer and model of the item.

c) Hypertrophic scar compression garment

Providers are required to give the Health Canada Regional Office the Client's diagnosis and date of onset; the site and extent (i.e., percentage of body affected); the qualifications and the title of the fitter; as well as the name of the garment's manufacturer.

d) Sequential extremity pump and accessories

Providers are required to give the Health Canada Regional Office the Client's diagnosis and cause of lymphedema; the site of the lymphedema; the qualifications of the fitter; as well as the name of the manufacturer and model of the item. Providers should be aware that a sequential extremity

pump can be rented on a trial basis for one month before final purchase, but that the rental fee should be applied to the purchase price.

B. Exclusions

Items excluded from the pressure garments and pressure orthotics benefit list do not apply to the exception process, are not considered for coverage under the NIHB Program, and cannot be appealed. These items include:

- compression garments for short-term treatment such as pre- and post-surgery, pre- and post-medical treatment, and for post-traumatic oedema because they are temporary conditions following surgical, medical or traumatic situations.

C. Services included in the price

For NIHB Program coverage, the cost of these items must include the following services:

- initial assessment to determine type of benefit required;
- taking precise measurements of the body part to manufacture the device;
- manufacturing the device;
- dispensing the benefit, including adjustment and fitting; and,
- follow-up visits, as per professional/industry standards.

3.5.5 Pressure Garments and Pressure Orthotics Benefit Grid

The *Pressure Garments and Pressure Orthotic Benefit Grid* is available on the Health Canada website. **(http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/med- equip/criter/garment-vetement-eng.php)**

3.6 Prosthetics Benefits

3.6.1 Prosthetics Benefit Categories

The prosthetics benefit list covers breast, eye (ocular), and lower and upper limb prostheses, as well as prosthetics supplies, and repairs, parts and labour.

3.6.2 Prescriber/Provider Requirements

Breast prosthesis must be prescribed by a physician or nurse practitioner, and provided by a certified mastectomy fitter or by a provider who has a certified mastectomy fitter on staff. Ocular (eye) prosthesis must be prescribed by an ophthalmologist, and provided by a member of the National Examining Board of Oculariststs' certified ocularist.

Limb prosthesis must be prescribed by a specialist in the field of physiatry, pediatrics, oncology, orthopaedics or general surgery; and provided by one of the following recognized providers:

- certified prosthetists or certified prosthetist orthotist, as certified by the CBCPO for limb prosthesis;
- recognized NIHB Pharmacy or recognized MS&E provider for regular stump socks prosthesis; and,
- recognized NIHB Pharmacy or recognized MS&E provider who has a certified compression fitter on staff, for stump shrinkers prosthesis.

While it is recognized that access to a medical specialist may be an issue in some areas, a prescription from a specialist is required for the first issue of eye prosthesis and limb prosthesis. A prescription from a general practitioner or nurse practitioner will be accepted for replacement of the eye and limb prosthesis. Providers should be aware that if the replacement is required due to a medical change before the recommended replacement guideline period, a new prescription from a medical specialist may be required.

3.6.3 Prior Approval Process

Prior approval is required for all prosthetic benefits, except for eye prosthesis polishing. To initiate the prior approval process, the provider must contact the Health Canada Regional Office.

The *NIHB Orthotics-Custom Shoes-Prosthetics-Pressure Garments Prior Approval Form* must be completed. In addition to the form, the following documentation is required to support the request:

- the prescription;

- the medical diagnosis;
- any other information the provider/physician or nurse practitioner may have to support the request;
- a copy of any third-party coverage (e.g., workers' compensation board, private insurance, etc.); and,
- the medical guidelines and required information for authorizing pressure garment or pressure orthotic benefits as described in section 3.6.4.

Quick Link

• Orthotics-Custom Shoes-Prosthetics-Pressure Garments Prior Approval Form

(http://www.provider.esicanada.ca/mse.html)

3.6.4 Prosthetics Benefit Policies

A. Medical Guidelines and Required Information

The Health Canada Regional Office adheres to the following medical guidelines when authorizing certain prosthetics benefits. They also require specific information from MS&E providers to proceed with such authorizations.

a) Breast prosthesis

Providers will be required to give the Health Canada Regional Office the date of surgery (initial request only); left, right or bilateral mastectomy; manufacturer and model number of the breast prosthesis and brassiere if questioning the price; and name of the certified mastectomy fitter. Note that breast prosthesis should not be issued before six weeks from the date of surgery.

b) Eye prosthesis/scleral shell

Providers will be required to give the Health Canada Regional Office the diagnosis and/or medical reason for the request and date of the onset.

c) Limb prosthesis definitive

Providers will be required to give the Health Canada Regional Office the date of surgery (initial request only); materials to be used; the detailed assessment (with measurements, when applicable); whether an in-house or external laboratory will be used to manufacture the device; detailed quote/breakdown of components for the prosthesis; and previous NIHB funding for devices and repairs.

d) Limb prosthesis preparatory

Providers will be required to give the Health Canada Regional Office the date of surgery; materials to be used; the detailed assessment (with measurements, when applicable); whether an in-house or external laboratory will be used to manufacture the device; and detailed quote/breakdown of components for the prosthesis.

B. Exclusions

Items excluded from the prosthetics benefit list do not apply to the exception process, are not considered for coverage under the NIHB Program, and cannot be appealed. These include:

- Breast prosthesis:
  - temporary or swim prosthesis because the NIHB Program does not cover benefits which are used only for sports and/or leisure activities;
  - silicone implants used in breast reconstruction because the Program does not provide benefits which need to be surgically inserted into the body, nor does it cover medically unnecessary, 'for cosmetic purposes' items;
  - breast prosthesis for failed breast reconstruction, when the Client has not had a mastectomy or lumpectomy;
  - Breast prosthesis for cosmetic augmentation of small breasts;
  - Breast prosthesis for change in sexual identity; or,
  - Silicone nipples.
- Limb prosthesis:
  - electric and myoelectric prosthesis because this is beyond the scope of the Program;
  - a second prosthesis for the same amputation site because NIHB funds only one prosthetic per frequency period for the same site; or,
  - early replacement of a prosthetic that has been used beyond manufacturer specifications (e.g., for weight lifting, extreme sports, or basketball).
- Testicular implants; or,
- Wigs and hairpieces.

C. Services included in the price

For NIHB Program coverage, the cost of these items must include the following services:

- initial assessment to determine type of benefit required;
- casting of the body part to manufacture the device;
- manufacturing the device;
- dispensing the benefit, including adjustment and fitting; and,
- follow-up visit(s), as per professional association guidelines.

D. Warranty

- For breast prosthesis, the warranty must guarantee that the prosthesis will remain satisfactory for fit and against defects for at least two years.
- For eye prosthesis, the warranty must guarantee no charge for necessary adjustments for three months after the final fitting except when there has been a change in the Client's medical condition which would prevent a satisfactory fit and a one-year warranty against discoloration and separation of materials.
- For limb prosthesis, the warrantee must guarantee against breakage for

six months and no charge for necessary adjustments for three months after the final fitting provided that the individual's size or medical condition has not changed significantly.

3.6.5 Prosthetics Benefit Grid

The *Prosthetic Benefit Grid* is available on the Health Canada website. **(http://www.hc- sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/med-equip/criter/prosthet- prothes-eng.php#list)**

3.7 Respiratory Equipment and Supplies Benefits

3.7.1 Respiratory Equipment and Supplies Benefit Categories

The respiratory equipment and supplies benefit list covers the following:

- breathing apparatus and supplies;
- respiratory secretion clearance; and,
- tracheostomy supplies and equipment.

3.7.2 Prescriber/Provider Requirements

Respiratory equipment and supplies benefits must be prescribed by:

- a paediatrician for an apnea monitor;
- a medical specialist such as a respirologist or an internal medicine for a bilevel device, oximeter, and volume ventilator;
- a physician for continued positive airway pressure; and,
- a physician or nurse practitioner for a compressor, flutter valve, high humidity compressor, peak flow meter, pep mask, percussor, or drainage board.

These items must be provided by a recognized NIHB pharmacist, a recognized NIHB MS&E provider or a provider with appropriate health care staff and regulatory affiliations (i.e., registered respiratory therapist/registered nurse familiar with respiratory conditions).

For breathing apparatus benefits (e.g., volume ventilators, bi-level unit, etc.), the provider must have appropriate health care staff and regulatory affiliations (i.e., registered respiratory therapist/registered nurse familiar with respiratory conditions).

3.7.3 Prior Approval Process

Prior approval is required for all respiratory equipment and supplies benefits. To initiate the prior approval process, the provider must contact the appropriate Health Canada Regional Office.

The *NIHB Home Oxygen and Respiratory Equipment and Supplies Benefits Approval Form* must be completed with the Client's address. In addition to the form, the following documentation is required to support the request:

- the prescription;
- any other information the provider/physician or nurse practitioner may have to support the request;
- a copy of any third-party coverage (e.g., workers' compensation board, private insurance, etc.); and,
- the medical guidelines and required information for authorizing respiratory equipment benefits as described in section 3.7.4.

Quick Link

• Home Oxygen and Respiratory Equipment and Supplies Benefits Approval Form

(http://www.provider.esicanada.ca/mse.html)

3.7.4 Respiratory Equipment and Supplies Benefit Policies

A. Medical Guidelines and Required Information

The Health Canada Regional Office adheres to the following medical guidelines when authorizing certain respiratory benefits. They also require specific information from MS&E providers to proceed with such authorizations.

a) Continued positive airway pressure (CPAP)

Providers will be required to give the Health Canada Regional Office the prescription from a physician as well as the following information:

For level one, full baseline and treatment polysomnogragh (PSG) demonstrating diagnosis and response to CPAP or alternative therapy, and the following clinical information:

- age, sex, height and weight, BMI, sleepiness scale (ESS or SSS); and,
- symptoms of sleep disordered breathing and associated risk factors confirmed by the referring physician.

As PSG testing may not be readily available in some regions, additional clinical information is needed, including:

- level two, sleep study (includes apnea/hypopnea index, saturation, heart rate, body position) with baseline and treatment results obtained during two separate nights **or** nocturnal oxygen saturation and heart rate alone with baseline and treatment results obtained during two separate nights;
- clinical information:
  - age, sex, height and weight, BMI, sleepiness scale (ESS or SSS);
  - symptoms of sleep disordered breathing and associated risk factors;
  - evidence that PSG testing was sought including specified waiting period confirmed by the referring physician; and,
- other supporting medical documentation (as required).

Prescriptions for interactive CPAP units will not be accepted without appropriate clinical and objective rationale.

Once it has been deemed that the Client qualifies for CPAP, the device can be rented for a three-month period as long as an interface and headgear is purchased for the trial period. After the trial, and upon receiving confirmation from the Client and/or the caring physician or nurse practitioner that the Client is compliant with the usage of the CPAP, the purchase of the CPAP device will be approved with the rental fee of the device deducted from the purchase price.

B. Exclusions

Exclusions are items which will not be provided as benefits under the NIHB Program under any circumstances. For respiratory benefits, exclusions include but are not limited to:

- respiratory benefits for outings while the Client is an in-patient in an acute or long-term hospital setting (because the Client continues to be the responsibility of the hospital);
- custom-made mask for ventilation, because clients should be provided with stock masks for ventilation;
- incentive spirometer, because they are generally used post-operatively to improve a Client's ability to breathe and exercises which have the same impact can be done effectively without an incentive spirometer; and,
- therapy treatment and/or therapy equipment, such as (but not limited to) air purifier/cleaner, volumetric exerciser, and environmental protection devices and supplies.

C. Services included in the price

The cost of respiratory benefit items must include connectors with the tubing. When a CPAP, volume ventilator/bi-level unit is purchased, one complete breathing circuit must also be included in the cost.

3.7.5 Respiratory Equipment and Supplies Benefit Grid

The *Respiratory Equipment and Supplies Benefit Grid* is available on the Health Canada website. **(http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/med- equip/criter/respirat-eng.php#list)**

4.1 Co-ordination of Benefits

When an NIHB-eligible Client is also covered by another public or private health care plan, claims must be submitted to the Client's other health care/benefits plan first.

NIHB will then co-ordinate payment with the other payor on eligible benefit. Claim submissions involving co-payment with a provincial/territorial plan or co-ordination of benefit with a third-party health care plan may be submitted manually or electronically. Manual claims must be accompanied with an Explanation of Benefits Form, available from your provincial/territorial plan or third-party plan, confirming that the Client has exhausted all other coverage.

Claims submitted for NIHB Clients who no longer have coverage with another plan must be supported by a letter from the Client or from the provider on behalf of the Client.

4.2 Dispensing and Claims Submission

Upon entering the *MS&E Provider Agreement* with the NIHB Program, providers are advised to read and retain an up-to-date *Medical Supplies and Equipment (MS&E) Claims Submission Kit*. This Kit outlines all of the accountability rules and obligations for providers to ensure that they have the information they need to dispense prescriptions to NIHB Clients and submit claims for payment. **(www.provider.esicanada.ca)**

There are a few obligations that bear repeating in this guide. MS&E providers, for example, have **one year from the date of service to secure payment**, and completion of the days supply field with the appropriate number of days of treatment **is mandatory** for all claims submitted electronically and on NIHB MS&E claim forms, when appropriate.

4.3 Terms and Conditions of Services

To be eligible for payment of services rendered, MS&E providers must adhere to the terms and conditions of the NIHB Program. These are detailed within section 5.4 of the *Medical Supplies and Equipment (MS&E) Claims Submission Kit*, including the procedures for verifying Client eligibility and submitting NIHB benefit claims.
(www.provider.esicanada.ca)

It is the MS&E provider's responsibility to verify benefit eligibility for the Client, to ensure that no limitations under the Program will be exceeded, and to ensure compliance with NIHB benefits criteria and policies.

Quick Links

- Co-ordination of Benefits Policy

(http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_medequip/2009-prov- fourn-guide/index-eng.php#_4.1)

- Medical Supplies and Equipment (MS&E) Claims Submission Kit, Section 6.2

(www.provider.esicanada.ca)

A. Glossary of Key Terms

- FNIHB: First Nations and Inuit Health Branch of Health Canada
- HICPS: Health Information and Claims Processing Services
- MS&E: Medical Supplies and Equipment
- NIHB: Non-Insured Health Benefits

B. Client Eligibility

To be eligible for NIHB Program benefits, a person must be a Canadian citizen and have the following status:

- is a registered Indian, recognized by INAC, according to the Indian Act; or
- an Inuk recognized by one of the following Inuit Land Claim organizations - Nunavut Tunngavik Incorporated, Inuvialuit Regional Corporation, Makivik Corporation. For an Inuk residing outside of their land claim settlement area, a letter of recognition from one of the Inuit land claim organizations and a birth certificate are required; or
- an infant, less than age one (1), whose parent is an eligible client; and
- is currently registered or eligible for registration, under a provincial or territorial health insurance plan; and
- is not otherwise covered under a separate agreement with federal, provincial or territorial governments.

To facilitate verification, MS&E providers should provide the following Client identification information in each claim:

- 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.

It is recommended that MS&E providers ask Clients to present their identification card upon each visit to ensure that Client information is entered correctly and to protect against mistaken identity.

For recognized Inuit Clients, one of the following identifiers is required:

1. **Government of the Northwest Territories health plan number**, which begins with the letter "T" and is followed by 7 digits. This number is valid in any region of Canada and is

cross-referenced to the First Nations and Inuit Health Regional Office client identification number.

2. **Government of Nunavut health plan number**, which is a 9-digit number starting with a "1" and ending with a "5". This number is valid in any region of Canada and is cross-referenced to the FNIH client identification number.

3. **FNIHB Client Identification Number (N-Number)**, which begins with the letter "N" and is followed by 8 digits. This is a client identification number issued by the First Nations and Inuit Health Branch at Health Canada to recognized Inuit clients.

For eligible First Nations Clients, one of the following identifiers is required:

1. **Indian and Northern Affairs Canada registration number**, which is a 10-digit number. Also known as the Department of Indian Affairs and Northern Development Treaty or Status number, this registration number is the preferred method of identifying First Nations Clients.

2. **Band Number and Family Number**, where applicable.

3. **FNIHB Client Identification Number (B-Number)**, which begins with the letter "B" and is followed by 8 digits.

For ***infants under one year of age*** who are not yet registered with Indian and Northern Affairs Canada or applicable Inuit associations, MS&E providers must submit the first claim for manual processing. Subsequent claims may be submitted for this infant via point of service with the parent's primary identifier in the client identification number field and the infant's identifiers in the surname, given name, and birth date fields.

More detailed information about Client eligibility is included in section 6.1 of the *Medical Supplies and Equipment Claims Submission Kit*. **(www.provider.esicanada.ca)**

C. Privacy Statement

The NIHB Program respects an individual's right to control who has access to their personal information and the purpose for which that information will be used. When a request for benefits is received, the Program collects, uses, discloses and retains an individual's personal information according to the applicable federal privacy legislation. The information collected is limited to only the information needed for the Program to provide and verify benefits and to ensure that claims paid are in accordance with its terms and conditions.

As a federal government program, NIHB must comply with the *Privacy Act*, the *Canadian Charter of Rights and Freedoms*, the *Access to Information*

Act, applicable Treasury Board policies and guidelines, and the Health Canada Security Policy.

D. Appeal Process

Persons eligible for the NIHB Program have the right to appeal the denial of a benefit with the exception of items that are identified as exclusions or insured services. If a Client seeks information about the appeal process, MS&E providers may direct them to the on-line appeal procedures, or to the Provider Claims Processing Call Centre (1-888-511-4666).

Quick Link

• Appeal Procedures **(http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit- prestation/appe/index-eng.php)**

E. Audit Program

The NIHB provider audit program ensures that the NIHB Program is accountable for the expenditure of public funds. The Health Information and Claims Processing Services (HICPS) contractor performs this audit function by verifying paid claims against MS&E records to confirm that the claims have been billed in compliance with the terms and conditions of the NIHB Program.

Detailed information about audit procedures and the responsibilities of MS&E providers for these audits are included in section 8.0 of the *Medical Supplies and Equipment (MS&E) Claims Submission Kit*. **(www.provider.esicanada.ca)**

Quick Link

• Medical Supplies and Equipment (MS&E) Claims Submission Kit **(www.provider.esicanada.ca)**

F. Health Canada Regional Offices - Contact Information

- **FNIH Atlantic Region**

New Brunswick, Newfoundland and Labrador, Nova Scotia, and Prince Edward Island
Office
First Nations and Inuit Health
Health Canada

Maritime Centre
1505 Barrington Street
15th Floor Suite 1525
Halifax, Nova Scotia B3J 3Y6

Telephone: 1-800-565-3294 | (in Halifax) 426-4298
Fax: 1-902-426-8675

- **FNIH Quebec Region**

First Nations and Inuit Health
Health Canada

Complexe Guy-Favreau
200 West René Lévesque Boulevard
East Tower, Suite 216

Montréal, Quebec H2Z 1X4

Telephone: 1-877-483-1575 | (in Montréal) 283-1575

● FNIH Ontario Region

First Nations and Inuit Health
Health Canada

Emerald Plaza
1547 Merivale Road
3rd Floor, Postal Locator 6103a
Nepean, Ontario K1A 0L3

Telephone: 1-800-881-3921 | (in Ottawa) 952-0145

● FNIH Manitoba Region

First Nations and Inuit Health
Health Canada

Stanley Knowles Federal Building
391 York Avenue
Suite 300
Winnipeg, Manitoba R3C 4W1

Telephone: 1-800-665-8507 | (in Winnipeg) 983-8886

● FNIH Saskatchewan Region

First Nations and Inuit Health
Health Canada

1st Floor, 2045 Broad St.
Regina, Saskatchewan S4P 3T7

Telephone (in Saskatchewan): 1-800-780-5458 | in Regina: 780-5458
Fax: 1-306-780-7741

● FNIH Alberta Region

First Nations and Inuit Health
Health Canada

Canada Place

9700 Jasper Avenue
Suite 730
Edmonton, Alberta T3J 4C3

Telephone: 1-800-232-7301 | (in Edmonton) 495-2694

• FNIH British Columbia Region

First Nations and Inuit Health
Health Canada

757 West Hastings Street
Suite 540
Vancouver, British Columbia V6C 3E6

Telephone: 1-888-321-5003
Fax: 604-666-5815

• FNIH Northern Region

Yukon, Northwest Territories and Nunavut Office

First Nations and Inuit Health
Health Canada

60 Queen Street, 14th Floor
Postal Locator 3914a
Ottawa, Ontario
K1A 0K9

Telephone: 1-888-332-9222
Fax: 1-800-949-2718

Health Canada / Santé Canada

RESUBMISSION
RE-SOUMISSION ☐

MEDICAL SUPPLIES AND EQUIPMENT CLAIM FORM

NON-INSURED HEALTH BENEFITS (NIHB)
FOR ELIGIBLE FIRST NATIONS AND INUIT

FORMULAIRE DE DEMANDE DE PAIEMENT POUR ÉQUIPEMENT MÉDICAL ET FOURNITURES MÉDICALES

PROGRAMME DES SERVICES DE SANTÉ NON ASSURÉS (SSNA)
POUR LES MEMBRES ADMISSIBLES DES PREMIÈRES NATIONS ET LES INUITS

The Asterisk (*) Identifies Mandatory Fields / Les champs marqués d'un astérisque (*) sont obligatoires.

*SURNAME/*NOM DE FAMILLE

*GIVEN NAME/*PRÉNOM

*DATE OF BIRTH (YYYY/MM/DD)/*DATE DE NAISSANCE (AAAA-MM-JJ)

*COMPLETE THIS SECTION BY FILLING IN THE CLIENT IDENTIFICATION NUMBER **OR** THE BAND NUMBER AND FAMILY NUMBER/*VEUILLEZ REMPLIR CETTE SECTION À L'AIDE DU NUMÉRO D'IDENTIFICATION DU BÉNÉFICIAIRE **OU** DU NUMÉRO DE BANDE ET DU NUMÉRO DE FAMILLE

CLIENT IDENTIFICATION NUMBER/ NUMÉRO D'IDENTIFICATION DU BÉNÉFICIAIRE

BAND NUMBER/ NUMÉRO DE BANDE | FAMILY NUMBER/ NUMÉRO DE FAMILLE

BAND NUMBER and FAMILY NUMBER do not apply to Inuit Clients/ Les NUMÉROS DE BANDE et les NUMÉROS DE FAMILLE ne s'appliquent pas aux bénéficiaires inuits

*STREET ADDRESS/*ADRESSE | APT/APP.

*CITY/*VILLE | *PROVINCE/*PROVINCE | *POSTAL CODE/*CODE POSTAL | TELEPHONE (Home)/ TÉLÉPHONE (Domicile) | TELEPHONE (Work)/ TÉLÉPHONE (Travail)

CLIENT SIGNATURE / SIGNATURE DU BÉNÉFICIAIRE

*PROVIDER/SUPPLIER NAME AND ADDRESS/*NOM ET ADRESSE DU FOURNISSEUR

*PROVIDER/SUPPLIER NUMBER/*NUMÉRO DU FOURNISSEUR

1.
*PRESCRIBER ID/ *ID DU PRESCRIPTEUR | *PRESCRIBER ID REF NUMBER/ *N^O RÉF. DU PRESCRIPTEUR | PRIOR APPROVAL NO./ N^O D'AUT. PRÉALABLE | *DATE OF SERVICE (YYYY/MM/DD)/ *DATE DU SERVICE (AAAA-MM-JJ) | *DIN/ITEM CODE/ *NIM/CODE DE L'ARTICLE

*QUANTITY/ *QUANTITÉ | *ITEM COST/ *COÛT DE L'ARTICLE | MARK UP/ MAJORATION | THIRD PARTY SHARE/ PART DE L'AUTRE RÉGIME | *DAYS SUPPLY/ *JRS APPROV. | *AMOUNT CLAIMED/ *MONTANT RÉCLAMÉ

2.
*PRESCRIBER ID/ *ID DU PRESCRIPTEUR | *PRESCRIBER ID REF NUMBER/ *N^O RÉF. DU PRESCRIPTEUR | PRIOR APPROVAL NO./ N^O D'AUT. PRÉALABLE | *DATE OF SERVICE (YYYY/MM/DD)/ *DATE DU SERVICE (AAAA-MM-JJ) | *DIN/ITEM CODE/ *NIM/CODE DE L'ARTICLE

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3.
*PRESCRIBER ID/ *ID DU PRESCRIPTEUR | *PRESCRIBER ID REF NUMBER/ *N^O RÉF. DU PRESCRIPTEUR | PRIOR APPROVAL NO./ N^O D'AUT. PRÉALABLE | *DATE OF SERVICE (YYYY/MM/DD)/ *DATE DU SERVICE (AAAA-MM-JJ) | *DIN/ITEM CODE/ *NIM/CODE DE L'ARTICLE

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4.
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*QUANTITY/ *QUANTITÉ | *ITEM COST/ *COÛT DE L'ARTICLE | MARK UP/ MAJORATION | THIRD PARTY SHARE/ PART DE L'AUTRE RÉGIME | *DAYS SUPPLY/ *JRS APPROV. | *AMOUNT CLAIMED/ *MONTANT RÉCLAMÉ

5.
*PRESCRIBER ID/ *ID DU PRESCRIPTEUR | *PRESCRIBER ID REF NUMBER/ *N^O RÉF. DU PRESCRIPTEUR | PRIOR APPROVAL NO./ N^O D'AUT. PRÉALABLE | *DATE OF SERVICE (YYYY/MM/DD)/ *DATE DU SERVICE (AAAA-MM-JJ) | *DIN/ITEM CODE/ *NIM/CODE DE L'ARTICLE

*QUANTITY/ *QUANTITÉ	*ITEM COST/ *COÛT DE L'ARTICLE	MARK UP/ MAJORATION	THIRD PARTY SHARE/ PART DE L'AUTRE RÉGIME	*DAYS SUPPLY/ *JRS APPROV.	*AM *MO

	*PRESCRIBER ID/ *ID DU PRESCRIPTEUR	*PRESCRIBER ID REF NUMBER/ *N^{O} RÉF. DU PRESCRIPTEUR	PRIOR APPROVAL NO./ N^{O} D'AUT. PRÉALABLE	*DATE OF SERVICE (YYYY/MM/DD)/ *DATE DU SERVICE (AAAA-MM-JJ)	*DIN/ITEM CODE/ *NIM/CODE DE L'ARTICLE
6.					

*QUANTITY/ *QUANTITÉ	*ITEM COST/ *COÛT DE L'ARTICLE	MARK UP/ MAJORATION	THIRD PARTY SHARE/ PART DE L'AUTRE RÉGIME	*DAYS SUPPLY/ *JRS APPROV.	*AMOUNT CLAIMED/ *MONTANT RÉCLAMÉ

	*PRESCRIBER ID/ *ID DU PRESCRIPTEUR	*PRESCRIBER ID REF NUMBER/ *N^{O} RÉF. DU PRESCRIPTEUR	PRIOR APPROVAL NO./ N^{O} D'AUT. PRÉALABLE	*DATE OF SERVICE (YYYY/MM/DD)/ *DATE DU SERVICE (AAAA-MM-JJ)	*DIN/ITEM CODE/ *NIM/CODE DE L'ARTICLE
7.					

*QUANTITY/ *QUANTITÉ	*ITEM COST/ *COÛT DE L'ARTICLE	MARK UP/ MAJORATION	THIRD PARTY SHARE/ PART DE L'AUTRE RÉGIME	*DAYS SUPPLY/ *JRS APPROV.	*AMOUNT CLAIMED/ *MONTANT RÉCLAMÉ

	*PRESCRIBER ID/ *ID DU PRESCRIPTEUR	*PRESCRIBER ID REF NUMBER/ *N^{O} RÉF. DU PRESCRIPTEUR	PRIOR APPROVAL NO./ N^{O} D'AUT. PRÉALABLE	*DATE OF SERVICE (YYYY/MM/DD)/ *DATE DU SERVICE (AAAA-MM-JJ)	*DIN/ITEM CODE/ *NIM/CODE DE L'ARTICLE
8.					

*QUANTITY/ *QUANTITÉ	*ITEM COST/ *COÛT DE L'ARTICLE	MARK UP/ MAJORATION	THIRD PARTY SHARE/ PART DE L'AUTRE RÉGIME	*DAYS SUPPLY/ *JRS APPROV.	*AMOUNT CLAIMED/ *MONTANT RÉCLAMÉ

	*PRESCRIBER ID/ *ID DU PRESCRIPTEUR	*PRESCRIBER ID REF NUMBER/ *N^{O} RÉF. DU PRESCRIPTEUR	PRIOR APPROVAL NO./ N^{O} D'AUT. PRÉALABLE	*DATE OF SERVICE (YYYY/MM/DD)/ *DATE DU SERVICE (AAAA-MM-JJ)	*DIN/ITEM CODE/ *NIM/CODE DE L'ARTICLE
9.					

*QUANTITY/ *QUANTITÉ	*ITEM COST/ *COÛT DE L'ARTICLE	MARK UP/ MAJORATION	THIRD PARTY SHARE/ PART DE L'AUTRE RÉGIME	*DAYS SUPPLY/ *JRS APPROV.	*AMOUNT CLAIMED/ *MONTANT RÉCLAMÉ

	*PRESCRIBER ID/ *ID DU PRESCRIPTEUR	*PRESCRIBER ID REF NUMBER/ *N^{O} RÉF. DU PRESCRIPTEUR	PRIOR APPROVAL NO./ N^{O} D'AUT. PRÉALABLE	*DATE OF SERVICE (YYYY/MM/DD)/ *DATE DU SERVICE (AAAA-MM-JJ)	*DIN/ITEM CODE/ *NIM/CODE DE L'ARTICLE
10.					

*QUANTITY/ *QUANTITÉ	*ITEM COST/ *COÛT DE L'ARTICLE	MARK UP/ MAJORATION	THIRD PARTY SHARE/ PART DE L'AUTRE RÉGIME	*DAYS SUPPLY/ *JRS APPROV.	*AMOUNT CLAIMED/ *MONTANT RÉCLAMÉ

Total ▸

*DATE OF DISPENSE MUST BE AFTER THE PRIOR APPROVAL DATE OR BETWEEN THE START AND END DATE OF THE PRIOR APPROVAL.
*LA DATE DE PRESTATION DU SERVICE DOIT ÊTRE POSTÉRIEURE À LA DATE D'AUTORISATION PRÉALABLE OU SE SITUER ENTRE LA DATE D'EFFET ET LA DATE D'EXPIRATION L'AUTORISATION PRÉALABLE.

*IF CLIENT IS UNDER ONE YEAR OF AGE AND NOT REGISTERED, PLEASE PROVIDE PARENT'S INFORMATION
*SI LE BÉNÉFICIAIRE EST ÂGÉ DE MOINS D'UN AN ET QU'IL N'EST PAS INSCRIT, VEUILLEZ FOURNIR LES RENSEIGNEMENTS SUR LES PARENTS

*SURNAME/*NOM DE FAMILLE

*GIVEN NAME/*PRÉNOM

*DATE OF BIRTH (YYYY/MM/DD)/ *DATE DE NAISSANCE (AAAA-MM-JJ)

*COMPLETE THIS SECTION BY FILLING IN THE CLIENT IDENTIFICATION NUMBER **OR** THE BAND NUMBER AND FAMILY NUMBER/*VEUILLEZ REMPLIR CETTE SECTION À L'AIDE DU NUMÉRO D'IDENTIFICATION DU BÉNÉFICIAIRE **OU** DU NUMÉRO DE BANDE ET DU NUMÉRO DE FAMILLE

CLIENT IDENTIFICATION NUMBER/NUMÉRO D'IDENTIFICATION DU BÉNÉFICIAIRE

BAND NUMBER/ NUMÉRO DE BANDE

FAMILY NUMBER/ NUMÉRO DE FAMILLE

BAND NUMBER and FAMILY NUMBER do not apply to Inuit Clients/
Les numéros de bande et de famille NE S'APPLIQUENT PAS aux bénéficiaires inuits

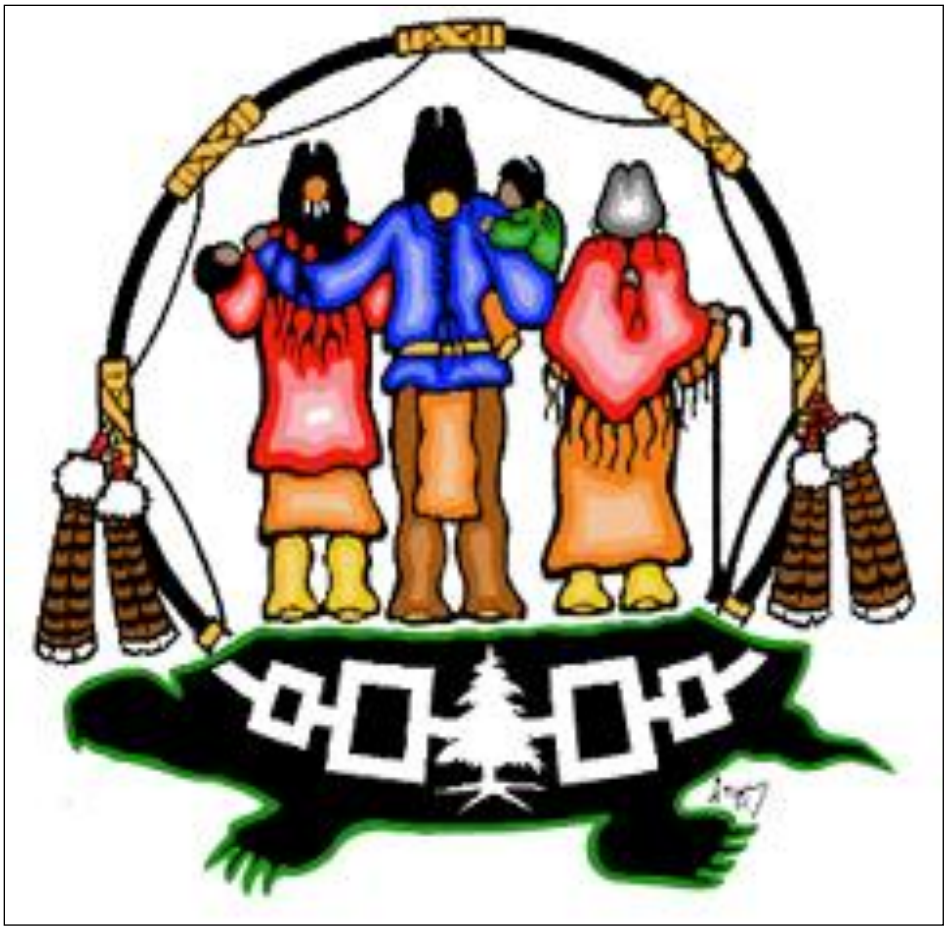
1) Mail the original completed form to: ESI Canada
Postez l'original du formulaire dûment rempli à : NIHB Claims Department/ Service de règlement des demandes de paiement des SSNA
3080 Yonge Street, Suite 3002
Toronto, Ontario M4N 3N1

2) Please make a copy of the completed form and retain for your files.
Veuillez conserver une copie du formulaire rempli dans vos dossiers.

FIRST NATIONS AND INUIT HEALTH CONTACT INFORMATION/ COORDONNÉES DES BUREAUX RÉGIONAUX DE LA
DIRECTION DE LA SANTÉ DES PREMIÈRES NATIONS ET DES INUITS

FNIH ATLANTIC REGION NEW BRUNSWICK, NEWFOUNDLAND AND LABRADOR, NOVA SCOTIA, AND PRINCE EDWARD ISLAND OFFICE FIRST NATIONS AND INUIT HEALTH HEALTH CANADA MARITIME CENTRE 1505 BARRINGTON STREET 15TH FLOOR SUITE 1525 HALIFAX, NS B3J 3Y6 1-800-565-3294 | (IN HALIFAX) 426-2656 FAX: 1-902-426-8675	DSPNI DE LA RÉGION DE L'ATLANTIQUE BUREAU DU NOUVEAU-BRUNSWICK, DE TERRE-NEUVE-ET-LABRADOR, DE LA NOUVELLE-ÉCOSSE ET DE L'ÎLE-DU-PRINCE-ÉDOUARD DIRECTION DE LA SANTÉ DES PREMIÈRES NATIONS ET DES INUITS SANTÉ CANADA MARITIME CENTRE 1505, RUE BARRINGTON 15E ÉTAGE, BUREAU 1525 HALIFAX (NOUVELLE-ÉCOSSE) B3J 3Y6 SANS FRAIS 1 800 565-4446 À HALIFAX : 902 426-3710 TÉLEC. : 902 426-8675	FNIH SASKATCHEWAN REGION FIRST NATIONS AND INUIT HEALTH HEALTH CANADA NON-INSURED HEALTH BENEFITS PROGRAM 1ST FLOOR, 2045 BROAD ST. REGINA, SASKATCHEWAN S4P 3T7 SASK. TOLL FREE 1-800-780--5458 REGINA : 780-5458 FAX: 1-306-780-7741	DSPNI DE LA RÉGION DE LA SASKATCHEWAN DIRECTION DE LA SANTÉ DES PREMIÈRES NATIONS ET DES INUITS SANTÉ CANADA PROGRAMME DES SERVICES DE SANTÉ NON ASSURÉS 1ER ÉTAGE, 2045, RUE BROAD REGINA (SASKATCHEWAN) S4P 3T7 SANS FRAIS : 1 800 667-3515 À REGINA : 306 780-5458 TÉLEC. : 1 306 780-7741
FNIH QUÉBEC REGION FIRST NATIONS AND INUIT HEALTH HEALTH CANADA COMPLEX GUY-FAVREAU 200 WEST RENÉ LÉVESQUE BOULEVARD EAST TOWER, SUITE 404 MONTRÉAL, QC H2Z 1X4 1-877-483-1575 *(IN MONTRÉAL)* 283-1575	DSPNI DE LA RÉGION DU QUÉBEC DIRECTION DE LA SANTÉ DES PREMIÈRES NATIONS ET DES INUITS SANTÉ CANADA COMPLEXE GUY-FAVREAU 200, BOUL. RENÉ-LÉVESQUE OUEST TOUR EST, BUREAU 404 MONTRÉAL (QUÉBEC) H2Z 1X4 SANS FRAIS : 1 877 483-1575 À MONTRÉAL : 514 283-1575	FNIH ALBERTA REGION FIRST NATIONS AND INUIT HEALTH HEALTH CANADA CANADA PLACE 9700 JASPER AVENUE SUITE 730 EDMONTON, AB T3J 4C3 1-800-232-7301 *(IN EDMONTON)* 495-2694	DSPNI DE LA RÉGION DE L'ALBERTA DIRECTION DE LA SANTÉ DES PREMIÈRES NATIONS ET DES INUITS SANTÉ CANADA CANADA PLACE 9700, AV. JASPER, BUREAU 730 EDMONTON (ALBERTA) T5J 4C3 SANS FRAIS : 1 800 232-7301 À EDMONTON : 780 495-2694
FNIH ONTARIO REGION FIRST NATIONS AND INUIT HEALTH HEALTH CANADA EMERALD PLAZA 1547 MERIVALE ROAD 3RD FLOOR, POSTAL LOCATOR 6103A NEPEAN, ON K1A 0L3 1-800-881-3921 *(IN OTTAWA)* 952-0145	DSPNI DE LA RÉGION DE L'ONTARIO DIRECTION DE LA SANTÉ DES PREMIÈRES NATIONS ET DES INUITS SANTÉ CANADA EMERALD PLAZA 1547, MERIVALE ROAD 3E ÉTAGE, LOCALISATION POSTALE 6103A NEPEAN (ONTARIO) K1A 0L3 SANS FRAIS 1 800 881-3921 À OTTAWA : 613 952-0145	FNIH BC REGION FIRST NATIONS AND INUIT HEALTH HEALTH CANADA 757 WEST HASTINGS STREET SUITE 540 VANCOUVER, BC V6C 3E6 1-888-321-5003 | FAX: 604-666-5815	DSPNI DE LA RÉGION DE LA COLOMBIE-BRITANNIQUE DIRECTION DE LA SANTÉ DES PREMIÈRES NATIONS ET DES INUITS SANTÉ CANADA 757, RUE WEST HASTINGS, BUREAU 540 VANCOUVER (COLOMBIE-BRITANNIQUE) V6C 3E6 SANS FRAIS 1 88 665-2289 TÉLEC. : 1 888 299-9222
FNIH MANITOBA REGION FIRST NATIONS AND INUIT HEALTH HEALTH CANADA STANLEY KNOWLES FEDERAL BUILDING 391 YORK AVENUE SUITE 300 WINNIPEG, MB R3C 4W1 1-800-665-8507 *(IN WINNIPEG)* 983-8886	DSPNI DE LA RÉGION DU MANITOBA DIRECTION DE LA SANTÉ DES PREMIÈRES NATIONS ET DES INUITS SANTÉ CANADA ÉDIFICE FÉDÉRAL STANLEY KNOWLES 391, AV. YORK, BUREAU 300 WINNIPEG (MANITOBA) R3C 4W1 SANS FRAIS : 1 800 665-8507 À WINNIPEG : 204 983-8886	FNIH NORTHERN REGION YUKON, NORTHWEST TERRITORIES AND NUNAVUT OFFICE FIRST NATIONS AND INUIT HEALTH HEALTH CANADA 60 QUEEN STREET, 14TH FLOOR POSTAL LOCATOR 3914A OTTAWA, ONTARIO K1A 0K9 TELEPHONE (TOLL FREE) : 1-888-332-9222 FAX: 1-800-949-2718	DSPNI DE LA RÉGION DU NORD CANADIEN BUREAU DU YUKON, DES TERRITOIRES DU NORD-OUEST ET DU NUNAVUT DIRECTION DE LA SANTÉ DES PREMIÈRES NATIONS ET DES INUITS SANTÉ CANADA 60, RUE QUEEN, 14E ÉTAGE LOCALISATION POSTALE 3914A OTTAWA (ONTARIO) K1A 0K9 TÉL. SANS FRAIS : 1 888 332-9222 TÉLEC. : 1 800 949-2718

Section 5: Medical Transportation



September 2011

Updated by:
LaFrance Consulting Services
September 20, 2011

Table of Contents

AKWESASNE NON-INSURED HEALTH BENEFITS
SECTION 5: MEDICAL TRANSPORTATION

SUMMARY

1. Medical transportation benefits are funded in accordance with the policies to assist clients to access medically required health services that cannot be obtained on the reserve or in the community of residence, when access would otherwise be denied. Exceptions may be granted, with justification and ANIHB approval, to meet exceptional needs.

2. Access to medically required health services may include financial assistance to the client or arranging for the provision of services from the reserve or community of residence when the following conditions are met:

    a) The client has exhausted all other available sources of benefits for which they are eligible under provincial/territorial health or social programs, other publicly funded programs (e.g., motor vehicle insurance, workers' compensation) or private insurance plans;

    b) Travel is to the nearest appropriate health professional or health facility (when health professionals are brought into the community to provide the service, the community facility is considered the nearest appropriate facility);

    c) The most economical and efficient means of transportation is used, taking into consideration the urgency of the situation and medical condition of the client;

    d) A DOH representative or on-site medical professional has determined that medically required health services are not available on the reserve or community of residence;

    e) Transportation to health services is coordinated to ensure maximum cost effectiveness;

    f) Transportation benefits are provided when prior approved by ANIHB or DOH Health Advisory Board or post approved upon medical justification if consistent with the policies;

    g) In emergency situations, when prior approval has not been obtained, expenses may be reimbursed by ANIHB when appropriate medical justification is provided to support the medical emergency and approved after the fact; and

    h) When public transit is not available.

3. Medical transportation benefits may be provided for clients to access the following types of medically required health services:

    a) medical services defined as insured services by
    b) provincial/territorial health plans (e.g., appointments with
    c) physician, hospital care);
    d) diagnostic tests and medical treatments covered by

e) provincial/territorial health plans;
f) alcohol, solvent, drug abuse and detox treatment;
g) traditional healers; and
h) Non-Insured Health Benefits (vision, dental, mental health).

4. Medical transportation benefits include ground, water and air travel, meals and accommodation.

5. Medical transportation benefits may be provided for an approved escort.

6. In cases where a client is required to travel repeatedly on a long term basis to access medical care/treatment, medical transportation benefits will be provided for up to four months. During this time, an assessment will be conducted involving the treating physician, other relevant health professional(s) and the client to determine the provision of further benefits, taking into consideration the client's medical condition.

7. Medical transportation benefits may be provided when the client is referred by the provincial health care authority for medically required health services to a facility outside of Canada when such services are covered by a provincial health plan and the medical transportation benefits are not covered by provincial health or social programs, other publicly funded programs or private insurance.

    a) When a request for medical transportation is denied, an appeal process is available. Appeals must be initiated by the client or by a designate acting on their behalf.

AKWESASNE NON-INSURED HEALTH SERVICES
Department of Health
Mohawk Council of Akwesasne

Section 5.1 Client Eligibility Criteria

Subject: Client Eligibility Criteria	**Policy number: 5.01** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

In order for a client to be considered eligible to receive coverage for approved medical transportation benefits (refer to Policy 5.02) from the ANIHB Program, the following eligibility criteria must be satisfied:

1. The client must be an enrolled member of the Mohawks of Akwesasne.

2. The client must have a valid Regie d'Assurance de Maladie de Quebec (RAMQ) health card # or a valid Ontario Health Insurance Plan (OHIP) health card #. This will be required in order for the client to access health services in either the province of Quebec or the province of Ontario.

3. The client must be a resident of the Territory of Akwesasne within the jurisdiction of the Mohawk Council of Akwesasne (i.e. the districts of Kana:takon, TsiSnaihe and Kawehnoke).

4. The client must <u>not</u> be requesting transportation assistance for local travel, which is defined as travel within a radius of less than 40 kilometres (or 25 miles) from the client's home.

5. The client must <u>not</u> be eligible to receive coverage for medical transportation from another source (e.g., Social Assistance, Home Care/Home Support, Adult Care facilities), because the ANIHB Program is a payer of last resort.

6. Exceptions will be reviewed on a case-by-case basis for special medical transportation needs.

PROCEDURE

1. When processing an application for medical transportation for a client, ANIHB Coordinator must ensure that the client satisfies all of the eligibility criteria outlined above.

2. If any of the client eligibility criteria is not satisfied, the application must be rejected by the Program Manager/Supervisor and the client must be contacted stating the reason(s) why the application was rejected. The application form will be completed indicating the denial and reason(s) for rejection.

Section 5.2: Approved Benefits

Subject: Approved Benefits	**Policy number: 5.02** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

Clients who satisfy the eligibility criteria outlined in the *General Information Section* and Policy 5.01 will receive coverage for approved medical transportation benefits only. The ANIHB Program may pay for eligible medical transportation expenses. The most efficient and economical method of transportation must be used, consistent with the client's medical condition.

The list of approved medical transportation benefits is provided below:

1. Transportation to access health services that cannot be obtained in the client's home community within the Province of Ontario, provided that the health facility is located 40 kilometres (or 25 miles) or more from the client's home.

   Note 1:
   Clients receiving services through the Home Care/Home Support Program are eligible for local medical transportation assistance from the Home Care/Home Support Program.

   Note 2:

   Although local medical transportation is not considered to be a benefit under the ANIHB Program, it is recognized that some clients who have local medical appointments may not be able to attend these appointments without receiving transportation assistance from the ANIHB Program. For example, the client may not have any family member or friend available to provide transportation, or he/she may not be able to hire a driver due to financial constraints. These cases will be reviewed on a case-by-case basis in order to determine whether or not the ANIHB Program should provide transportation assistance.

2. Emergency visits to a dentist and to obtain dental services not available locally, provided that the dental facility is located 40 km (or 25 mi) or more from the client's home.

3. Transportation of high-risk mothers for prenatal and post-natal medical assessments, provided that the appointment is not at a local health care facility.

4. Transportation for an escort required for medical or legal reasons (e.g., mentally incompetent client who requires a legal guardian to sign consent forms), provided that this does not involve local travel.

5. Medical evacuation by air ambulance not covered by health benefits.

6. Transportation assistance to visit a Traditional Healer provided that the healer is not providing services locally (i.e., within a radius of 40 kilometres or 25 miles from the client's home).

7. Transportation to a recognized medical facility to receive specialty medical care when referred by a physician, provided that the facility is not located locally.

8. Transportation assistance for compassionate travel is not a benefit. However based on patient's condition that warrants accompaniment, power of attorney, ability to communicate, need for translation, etc. the service will be reviewed on a case-by-case basis
9. Transportation to a hospital or other appropriate health care facility when the client is referred by a health care provider (e.g., physician or nurse), provided that the hospital or facility is not located locally.

10. Transportation for a community health assessment, such as clinics for the investigation or treatment of pulmonary tuberculosis (including chest X-rays and TB skin testing), meningococcal disease prophylaxis clinics, etc. provided that the appointment is not at a local facility.

11. Assistance with meals may be provided where the time away from home to attend the medically required appointment is more than 6 hours in one day. The assistance will be provided as per the ANIHB rates for either a lunch or a dinner, depending on the time of day the travel is occurring. Breakfast is not payable for same day trips. Assistance with a meal when the time away is less than 6 hours may be provided in circumstances where meals are a required component of the medical treatment and a meal is not provided by the facility.

12. Assistance with overnight accommodation may be provided on a case by case basis, which may include the review of the medical justification, time of appointment, distance travelled and scheduled and/or coordinated medical transportation.
13. When accommodation is provided in a private home, assistance not to exceed the regional rate set out for private accommodation may be reimbursed. Reimbursements will only be issued to the client.

14. Other expenses are the responsibility of the client (e.g., telephone charges, room damage, movie rentals, game rentals, room service, tips, gratuities, etc.) and will not be reimbursed.

15. In cases where a client is required to reside close to medical treatment outside their reserve or community of residence for an extended period, the cost of meals, accommodation and in-city transportation to access the medical care/treatment, when they are not covered by provincial/territorial health or social programs, other publicly funded programs or private insurance plans, may be covered for up to a three month transition period only. The accommodation rate will follow the *FNIH Medical*

Transportation Framework. A weekly food allowance as per ANIHB rates may be provided.

PROCEDURE

1. When an application is submitted to the ANIHB Coordinator for medical transportation benefits, the ANIHB Coordinator must:

   a) ensure that the client satisfies the eligibility criteria outlined in Policy 5.01 and

   b) ensure that the transportation benefit being requested is on the list of approved transportation benefits outlined above.

2. If both of these conditions are met, ANIHB Coordinator can process the application and seek approval from the Program Manager/Supervisor.

3. If the application is rejected, ANIHB Coordinator must inform the client outlining the reason(s) why the application was rejected and record this contact on the client's *Medical Transportation Checklist.*

Section 5.3: Non-Benefits

Subject: Non-Benefits	**Policy number: 5.03** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

The ANIHB Program will only provide coverage for medical transportation if:

a) the client satisfies the eligibility criteria outlined in *General Information Section* and Policy 5.01; and

b) the transportation benefit being requested is on the list of approved benefits (refer to Policy 5.02).

If the requested transportation benefit is not on the list of approved benefits, ANIHB Coordinator will reject the application, unless there is an extenuating circumstance and the ANIHB Program Manager brings the case to the attention of the Director of Health for discretionary funding to be considered (refer to *General Information section*).

The following is a list of non-benefits:

1. Local travel will be reviewed on a case-by-case basis to determine level of the client's need. This is defined as travel within a radius of less than 40 kilometres (or 25 miles) from the client's home. Assistance through other MCA programs can be provided (See Policy 5.02)

2. Transportation back to Akwesasne if the client has discharged himself/herself against the advice from an addictions treatment facility prior to the completion of prescribed treatment. Further requests for transportation assistance to return to complete the treatment will be done through the ANIHB Appeals Process.

3. Transportation assistance for compassionate travel is not a benefit. Any special circumstances will be reviewed on a case-by-case basis. However based on patient's condition that warrants accompaniment, power of attorney, ability to communicate, need for translation, etc. the service will be reviewed on a case-by-case basis For example, no assistance will be provided to a family member or friend who has been asked to accompany a client to a medical appointment in order to provide emotional support.

4. Meals and accommodation while in transit to access health care services will not be covered. However, meals and accommodation will be covered if the client has to be away for more than 6 hours and the health care facility is located 40 kilometres (or 25 miles) or more from the client's home.

5. The ANIHB Program will not provide transportation assistance solely for the purpose of renewing a prescription for a drug or medical supply or equipment, eyeglasses/contact lenses.

6. Transportation to a non-Canadian destination point is not a benefit. The exception to this is for "in transit" occurrences and *1.7 General Principles* as in the *FNIH Medical Transport Framework.*

PROCEDURE

1. When an application is submitted to the Transportation Coordinator for medical transportation benefits, the Coordinator must:
   a) ensure that the client satisfies the eligibility criteria outlined in the *General Information Section* and Policy 5.01; and
   b) ensure that the transportation benefit being requested is not, in fact, a non-benefit as outlined in the list above.

2. If the requested transportation benefit is considered to be a non-benefit, the application must be rejected and the Transportation Coordinator must inform the client outlining the reason(s) why the application was rejected and document the rejection on the client's *Medical Transportation Checklist.*

Section 5.4: Processing Applications

Subject: Processing Applications for Medical Transportation Assistance	**Policy number: 5.04** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

1. All applications for medical transportation assistance require prior approval from the Transportation Coordinator. The only exception is for emergency medical situations in which approval will have to be granted retroactively, because medical transportation will already have been provided to the client by the time that the application is submitted to the Coordinator. The client is responsible for contacting the ANIHB Program within 72 hours of the emergency. Exceptions will be reviewed on a case-by-case basis.

2. In order to obtain transportation assistance from the ANIHB Program, a client must be informed that the health facility/provider will assist with completion of the *Medical Transportation Assistance Application Form* for submission to the Transportation Coordinator, along with the referral form/letter from his/her health care provider and a signed *Patient Waiver*.

3. The Transportation Coordinator will have each client sign the *Release of Information Form*, which will allow them to obtain confirmation from the Community Support Program as to whether or not the client is receiving Social Assistance.

PROCEDURE

1. The client must submit a *Medical Transportation Assistance Application Form* along with a signed *Patient Waiver* to the ANIHB Program. The referral form/letter from his/her health care provider must also accompany the application. The Social Worker at the health facility may also FAX the form to the Transportation Coordinator for processing along with the signed *Release of Information Form*.

2. The client must sign the *Release of Information Form*, which allows the Transportation Coordinator to verify whether or not the client is receiving Social Assistance.

3. In order to process the application all information on the *Medical Transportation Assistance Application Form* and the *Medical Transportation Checklist* must be completed by the Transportation Coordinator.

   Note: The client must ensure that at least 2 weeks is available for Transportation Coordinator to process the application.

5. The Transportation Coordinator must ensure that the client satisfies all of the eligibility criteria outlined in *General Information Section* and Policy 5.01.

6. The Transportation Coordinator must also ensure that the requested benefit is on the list of approved medical transportation benefits (refer to Policy 5.02).

7. If all requirements have been satisfied, the application must be forwarded to the ANIHB Program Manager / Supervisor for approval.

8. If the requested benefit is not an approved benefit, the application must be rejected and the Transportation Coordinator must inform the client outlining the reason(s) why the application was rejected and document the rejection on the client's *Medical Transportation Checklist.*

9. If the application is approved, the Transportation Coordinator must notify the client by telephone and if necessary provide the client with the name of a suitable driver.

   Note:
   All drivers who transport clients for the ANIHB Program must be formally registered with the program. They must have provided the Transportation Coordinator with proof of insurance, vehicle registration as well as a valid driver's license. They must also have signed the *Driver Waiver*.

10. Once the client has been transported to his/her medical appointment, the driver must complete the *Patient Transportation Log* to the ANIHB Program. All the information required for the log must be completed prior to submission to the ANIHB Coordinator.

Note:
In order to be more efficient, the driver may choose to use one *Patient Transportation Log* to submit the details about several trips that he has made during a specified time period, instead of submitting one trip per log.

11. If the application for transportation assistance is being submitted retroactively because medical transportation was already provided to the client during an emergency medical situation, ANIHB Coordinator must:

a) Ensure that the client satisfies the eligibility criteria outlined in Policy 5.01 and

b) Verify that there was medical justification for the provision of emergency health care services to the client (i.e., obtain a justification letter from the client's physician).

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Section 5.5: Transportation Assistance for Clients on Social Assistance

Subject: Transportation Assistance for Clients on Social Assistance	**Policy number: 5.05** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

1. The ANIHB Program is a payer of last resort. This means that clients must first exhaust all other potential sources of medical transportation assistance before submitting an application for transportation assistance to the ANIHB Program.

2. Clients on Social Assistance may be eligible to receive support for medical transportation. These clients must therefore apply for transportation assistance from their social assistance provider before applying to the ANIHB Program for assistance.

PROCEDURE

1. When an application for transportation assistance is submitted to the ANIHB Program by a client who is on Social Assistance, the Transportation Coordinator must:

   a) ensure that the client has already sought transportation assistance from his/her social assistance provider; the client must provide the Transportation Coordinator with either a rejection letter from the provider or a letter stating how much assistance will be provided;
   b) ensure that the client satisfies the eligibility criteria outlined in Policy 5.01; and
   c) ensure that the benefit being requested is an approved transportation benefit (refer to Policy 5.02).

2. If the client has not yet approached his/her social assistance provider for transportation assistance, the Transportation Coordinator must instruct the client to do so immediately. The client will be informed of the reason(s) why the application was rejected and the Coordinator will document the rejection on the client's *Medical Transportation Checklist.* In many instances, the social assistance provider will request to see the ANIHB rejection letter before agreeing to process the client's request for transportation assistance.

3. If the social assistance provider rejects the application for transportation assistance, the client must provide the Coordinator with a copy of the rejection letter from the social assistance provider when applying to the ANIHB Program for transportation assistance.

   Note:

   If the social assistance provider agrees to pay for only a portion of the medical Transportation costs, the ANIHB Program will pay for the remainder of the costs.

However, the client must provide the Transportation Coordinator with a letter from the social assistance Provider, which identifies the dollar amount of the assistance that was approved.

Section 5.6: Transportation Assistance for Residents of Iakhihsotha & Tsiionkwanonhso:te

Subject: Transportation Assistance for the Residents of the Iakhihsohtha and Tsiionkwanonhso:te Facilities	**Policy number: 5.06** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

1. The ANIHB Program recognizes that the residents of adult care facilities/homes for the aged usually have a need for regular follow-up visits with health care providers who practice outside of the facility. This is due to the fact that the elderly often have chronic diseases (e.g., diabetes, heart disease) that require long-term follow-up.

2. In order to minimize the bureaucracy associated with the processing of applications for transportation assistance for the residents of the Iakhihsohtha and Tsiionkwanonhso:te facilities, the ANIHB Program will provide ongoing approval of medical transportation assistance for these clients - there is no subsequent need for the resident to re-apply for transportation assistance.

3. Once the Transportation Coordinator has determined that a resident of the Tsiionkwanonhso:te or Iakhihsohtha adult care facility satisfies the eligibility criteria outlined in Policy 5.01 all subsequent medical transportation costs incurred by that resident will be covered automatically by the ANIHB Program.

Note:

Although local medical transportation is not considered to be a benefit under the ANIHB Program, it is recognized that some nursing home residents who have local medical appointments may not be able to attend these appointments without receiving transportation assistance from the ANIHB Program. For example, the client may not have any family member or friend available to provide transportation, or he/she may not be able to hire a driver due to financial constraints. These cases will be reviewed on a case-by-case basis in order to determine whether or not the ANIHB Program should provide transportation assistance.

PROCEDURE

1. When an application for medical transportation assistance is submitted to the ANIHB Program for a resident of the Iakhihsohtha or Tsiionkwanonhso:te adult care facility, ANIHB staff must ensure that the eligibility criteria outlined in Policy 5.01are satisfied.

2. If the resident is found to be eligible for transportation assistance, the ANIHB Coordinator must inform administration of the facility by FAX that no subsequent application for transportation assistance will be required for that resident.

3. For each transport the ANIHB Coordinator will complete the xxx form and FAX it back to the administration of the facility.

4. All the information required on the *Patient Transportation Log* must be completed by the driver.

5. The driver will be paid once the ANIHB Coordinator has reconfirmed the resident's eligibility to receive transportation assistance from the ANIHB Program and the log is submitted.

Note:

Families who own cars are expected to provide transportation for family members who reside at the Iakhihsohtha or Tsiionkwanonhso:te facility. Transportation assistance from the ANIHB Program is not intended to replace a family's responsibility to care for its own family members.

Section 5.7: Escorts for Beneficiaries

Subject: Escorts for Beneficiaries	**Policy number: 5.07** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

1. *The ANIHB Program recognizes that there are circumstances in which a client who has been approved for medical transportation assistance will require a medical or a non-medical escort.* ***Prior approval of transportation assistance is required for non-medical escorts but it is <u>not</u> required for medical escorts. This requires more discussion with Cindy.***

2. The ANIHB Program will provide the escort with financial assistance for transportation costs and for meals and accommodation, provided that the escort is considered to be a legitimate patient escort, as described below. **Financial assistance for meals and accommodation will only be provided if the escort has to be away from home for greater than 24 hours**

Medical Escorts

1. **Medical escorts do not require prior approval by the ANIHB Coordinator.**

2. A physician or nurse escort will be required for a client who has a medical condition that requires monitoring and/or stabilization during travel (e.g., seizure disorder, unstable angina, etc.).

Non-Medical Escorts (Including Family Members)

1. **A non-medical escort will require prior approval by the ANIHB Coordinator.** The following are scenarios in which a non-medical escort will be considered to be a legitimate patient escort by the ANIHB Program. **It is understood that no local travel will be involved [i.e. the facility must be located 40 km (or 25 mi) or more from the client's home].**

   a) A non-medical escort accompanies a child less than 16 years of age who requires medical transportation to facilities located outside of Akwesasne.

   b) A non-medical escort accompanies a child aged 16 to 18 years, if it is anticipated that the signing of consent forms for treatment procedures will be required.

c) A non-medical escort accompanies an adult when there is a legal requirement for the signing of consent forms for treatment procedures due to the client's mental incompetence.

d) A non-medical escort accompanies an adult when there is physical or mental disability that prohibits the client from travelling without an escort.

e) The client is medically incapacitated.

f) There is a need for legal consent by a parent or guardian.

g) To accompany a minor (as determined by provincial legislation) who is accessing medically required health services.

h) The client's attending physician requests that a family member be present at the location where the health care service is provided, in order to receive instruction about certain essential home medical/nursing procedures that the client will require.

i) A mother is allowed to accompany her infant who has been hospitalized, in order to continue breastfeeding.

j) The attending physician deems it medically necessary for a family member to be present at the location where the health care service is to be provided. In this case, only <u>one</u> family member will be authorized to function as a patient escort.

PROCEDURE

1. When an application is submitted to the ANIHB program for transportation assistance for a non-medical escort, the Transportation Coordinator must ensure that the individual is a legitimate non-medical escort as described above.

2. If it is determined that the individual would not be a legitimate patient escort, the application for assistance must be rejected and the Transportation Coordinator must inform the client outlining the reason(s) why the application was rejected and document the rejection on the client's *Medical Transportation Checklist.*

<u>Note</u>:
The ANIHB Program will not normally approve a non-medical patient escort to function as an interpreter. If the quality of health services provided to the client will be jeopardized without the client having access to an interpreter and no family member is available to function as an interpreter, the ANIHB Program will provide travel assistance for an interpreter to accompany the client to his/her medical appointment, provided that the appointment is <u>not</u> at a local health care facility.

Section 5.8: Medical Transportation Driver's Application

Subject: Medical Transportation Driver's Application	**Policy number: 5.08** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

1. The Akwesasne Non-Insured Health Benefits Program will require all drivers to complete the *Medical Transportation Drivers Application* before they are allowed to provide transportation to clients and to receive compensation.

2. All drivers must sign and date the *Driver Waiver* before they are allowed to provide transportation to clients and to receive compensation.

3. All drivers must have a CPIC to transport patients. The only exception is in an emergency, a driver who is not a listed driver and is transporting a family member is not required to complete a CPIC.

PROCEDURE

1. *The Transportation Coordinator will provide potential drivers with the appropriate forms to complete (see Appendix A).*

2. *The Transportation Coordinator will request the potential drivers to complete a CPIC.*

3. *Once all the documentation has been returned and the applicant has been successful, the Transportation Coordinator will have the new driver sign and date the Driver Wavier.*

Section 5.9: Vehicle Gas Report

Subject: Medical Transportation Vehicle Gas Report	**Policy number: 5.09** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

1. The Akwesasne Non-Insured Health Benefits Program will require all drivers to complete the *Medical Transportation Vehicle Gas Report ANIHB* and submit to the Transportation Coordinator on a monthly basis.

PROCEDURE

1. *The Transportation Coordinator will review the report with all new drivers and request them to submit the report monthly.*

Section 5.10: Payment Schedules

Subject: Payment Schedules	**Policy number: 5.10** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

1. The Akwesasne Non-Insured Health Benefits Program will reimburse transportation carriers such as taxis, buses, trains, airline companies and other forms of public transportation in accordance with regionally established rates.

2. Private vehicles will receive private mileage reimbursement at a rate that does not exceed the rate set by the Mohawk Council of Akwesasne.

PROCEDURE

AKWESASNE NON-INSURED HEALTH SERVICES
Department of Health
Mohawk Council of Akwesasne

Section 5.11: Meals and Accommodation

Subject: Meals and Accommodation	**Policy number: 5.11** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

1. Eligible clients and their approved escorts will receive financial assistance for accommodation provided that they have had to spend greater than 24 hours away from home and the appointment is not at a local health care facility.

2. Eligible clients and their approved escorts will receive financial assistance for meals at a daily rate that does not exceed the rate established by the ANIHB Program, provided that they have had to spend greater than 6 hours away from home.

3. Assistance with meal costs will not be provided to eligible clients and their approved escorts if they stay in boarding homes where meals are included in the per diem boarding home rates.

PROCEDURE

1. When a claim is submitted by an eligible client or by his/her approved escort for reimbursement of out-of-pocket expenses incurred for meals and accommodation, the Transportation Coordinator must ensure that receipts have been submitted with the claim to support the amount of reimbursement being requested.

2. If no receipts have been submitted, the claim must be rejected and the Transportation Coordinator must send a rejection letter to the client or to his/her escort explaining why the claim was rejected.

3. If the client or his/her escort submits receipts for meals that exceed the per diem rate allowed by the ANIHB Program, he/she must be reimbursed at the ANIHB rate and an explanatory letter must accompany the cheque when it is mailed to the claimant.

4. A letter should accompany the reimbursement cheque when it is mailed to the claimant.

5. If the client or his/her escort submits receipts for accommodation that appear to be excessive, the ANIHB Program must determine what a reasonable for accommodation is in the location where the service was provided. The client or his/her escort must then be reimbursed using the rate as a guide. For example, the Transportation Coordinator will review past claims for the same accommodation to determine the reasonable rate.

Section 5.12: Advance Notice

Subject: Advance Notice to Arrange Medical Transportation for a Client	**Policy number: 5.12** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

1. When a client submits an application for transportation assistance to the ANIHB Program, he/she must ensure that the Transportation Coordinator has **at least two (2) weeks** to process the application.

2. Clients must be informed that if less than two (2) weeks notice is given to the Transportation Coordinator, there is no guarantee that the application for transportation assistance will be processed in time for the client to make it to his/her medical appointment.

PROCEDURE

1. *When the Transportation Coordinator receives a request from a client he/she will inform the client that at least 2 weeks notice is required so that the application can be processed.*

2. *In the event a client fails to provide 2 weeks notice, the Transportation Coordinator will inform the client that he/she cannot guarantee that a driver will be available for the transport and the client may need to make other arrangements.*

Section 5.13: Reimbursement of Travel Expenses

Subject: Reimbursement of Travel Expenses	**Policy number: 5.13** **Issued: June 2010** **Revised:** **Approved by: MCA**

POLICY

1. Reimbursement to clients, approved escorts and service providers will be in accordance with the transportation policies and benefits of the NIHB Program and based on or the actual expense of a commercial carrier/service with the submission of original itemized receipts.

2. Only service providers who have a negotiated contractual arrangement or who have been approved by ANIHB will be reimbursed for medical transportation benefits they have provided.

3. All invoices submitted for payment for the reimbursement of expenses for medical transportation benefits must be submitted within 1 year of the service being provided. Requests for reimbursements submitted more than 1 year after the service is rendered will be rejected.

4. Medical transportation benefits include coverage for some or all of the travel expenses incurred by clients to access medically required health services at the nearest appropriate facility. If clients wish to access equivalent services elsewhere, they will be responsible for the difference in the cost of such travel. In cases where scheduled and/or coordinated medical transportation benefits are provided by ANIHB, the clients will be responsible for the full cost.

5. Reimbursement to the client for meal allowances and private accommodation will be as per the ANIHB rates. For more information, refer to Section 9 (Meals and Accommodation) and Appendix C (Meal, Accommodation and Kilometre Allowances).

6. When private vehicles are used, reimbursement to the client will be as per the ANIHB rate.

EXCEPTIONS

Certain types of travel may be considered on an exceptional basis with the appropriate justification. These types of travel include, but are not limited to the following:

1. Diagnostic tests for educational purposes, such as psychological assessment and hearing tests for children required by the school;
2. Speech assessment and therapy when coordinated with other medical travel and cost

3. of treatment is covered under OHIP/QHIP or educational institution;
4. Medical Supplies and Equipment benefits where a fitting is required and these fittings cannot be made on the reserve or in the community of residence;
5. Transportation for clients to visit a pharmacy for pharmacist-supervised methadone ingestion may be provided for up to four months for methadone patients in order to allow stabilization for carries (e.g., where the patient takes doses home) or alternate arrangements to be made.

1. Extensions with justification may be considered;
   a) Provincially supported preventative screening programs when coordinated with other medical travel and the cost of the testing is covered under OHIP/QHIP;
   b) Other requests for travel will be reviewed on a case by case basis with appropriate justification.

EXCLUSIONS

Certain types of travel, benefits and services will NOT be provided as benefits under the ANIHB Program under any circumstances and are not subject to the NIHB appeal process. These include assistance with:

1. Compassionate travel;
2. Appointments for clients in the care of federal, provincial or territorial institutions (e.g., incarcerated clients);
3. Court-ordered treatment/assessment, or as a condition of parole, coordinated by the justice system;
4. Appointments while travelling outside of Canada, other than as outlined in the *General Principles*;
5. Travel for clients residing in an off-reserve location where the appropriate health services are available locally;
6. Travel for the purposes of a third-party requested medical examination.
7. The return trip home in cases of an illness while away from home other than for approved travel to access medically required health services;
8. Travel only to pick-up new or repeat prescriptions or vision care products;
9. Travel to access non-eligible health related services, unless coordinated;
10. Payment of professional fee(s) for preparation of doctor's note /document preparation to support provision of benefits;
11. Transportation to adult day care, respite care and/or interval/safe houses.

PROCEDURE

1. *The Transportation Coordinator will reimburse the client based on the actual expense of a commercial carrier/service with the submission of original itemized receipts.*

2. *The Transportation Coordinator will reimburse service providers who have a negotiated contractual arrangement or who have been approved by ANIHB for medical transportation benefits they have provided.*

3. *If a service provider fails to submit his/her invoices for expenses within 1 year of the service being provided the Transportation Coordinator must reject the claim.*

4. *If a client requests to access medical services beyond the nearest appropriate facility the Transportation Coordinator will inform the client that they will be responsible for the difference in the cost of such travel. In cases where scheduled and/or coordinated medical transportation benefits are provided by ANIHB, The Transportation Coordinator will inform the clients that they will be responsible for the full cost.*

Section 5.14: Patient Waiver

Subject: Patient Waiver	**Policy number: 5.14** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

1. **Transportation assistance will not be provided to a client unless the client signs the *Patient Waiver*.** This form absolves the Mohawk Council of Akwesasne (MCA) of any responsibility for damages or loss of personal property that may occur while the client is being transported. It also absolves the MCA of any liability for physical injuries or death that may occur while the client is being transported.

PROCEDURE

1. *The Benefit Analyst will have the client sign the Patient Waiver before any services are provided.*

2. *If the client refuses to sign the Patient Waiver, the Transportation Coordinator must reject his/her application for transportation assistance and provide the client with an explain for the reason why the client's application has been rejected and document the rejection in the Medical Transportation Checklist.*

Section 5.15: Driver Waiver

Subject: Driver Waiver	**Policy number: 5.15** **Issued: March 2000** **Revised:** **Approved by: MCA**

POLICY

1. A driver will not be allowed to transport a client to a medical appointment unless the driver signs the *Driver Waiver*.

2. If a driver refuses to sign the *Driver Waiver* he/she will not be allowed to transport clients to their medical appointments.

Note: This form absolves the Mohawk Council of Akwesasne (MCA) of liability for any damages or repairs to the vehicle in the event of an accident or mechanical breakdown during the transportation of the client. It also absolves the MCA of any responsibility for damages, loss of personal property, physical injury or death that may occur to the driver, client or client's family member that is present in the vehicle, while the client is being transported to his/her medical appointment.

PROCEDURE

1. *The Benefit Analyst will have the driver sign the Driver Waiver before any services are provided.*

2. *If the driver refuses to sign the Driver Waiver, the Transportation Coordinator must inform the applicant that he/she will not be allowed to transport clients until the form is signed.*

Section 5.16: Addictions Treatment Travel Policy

Subject: Addictions Treatment Travel Policy	**Policy number: 5.16** **Issued: June 2010** **Revised:** **Approved by: MCA**

POLICY

1. Travel will be funded to the closest appropriate NNADAP funded/referred facility in Ontario/Quebec only. Exceptions are made to travel outside the province only when the required treatment is not available in the province or when a neighboring province's treatment centre is the closest centre and approved by the ANIHB Coordinator.
2. Family trips to the treatment facility will not be authorized unless it is a documented part of the treatment program and approved prior to starting treatment.

PROCEDURE

1. *The Transportation Coordinator will ensure that the client has met all treatment centre entry requirements prior to authorizing medical transportation benefits.*

2. *The Transportation Coordinator will authorize only the most efficient and economical method of transportation while taking into account the medical condition of the client.*

3. *The Transportation Coordinator will authorize an escort for a client as defined in The Medical Transportation Policy Framework Section 5 (Client Escorts).*

4. *The Transportation Coordinator will authorize trips home during the course of treatment only if it is part of the treatment plan as established by the facility and approved prior to starting treatment.*

5. *Should a client discharge themselves from treatment, against advice from the treatment centre counselor, before completing the program the Transportation Coordinator will not provide transportation assistance to return the client to the community; exceptions may be considered for clients who are minors or in cases when proper justification is provided and approved by the Transportation Coordinator.*

6. *When a client needs to travel to access additional treatment within a one year period the Transportation Coordinator must approve it first.*

7. *The Transportation Coordinator will only approve medical transportation benefits for clients while in the care of the treatment centre.*

8. *The Transportation Coordinator may authorize exceptions with appropriate justification.*

Section 5.17: Traditional Healers Services

Subject: Traditional Healers Services Travel Policy	**Policy number: 5.17** **Issued: June 2010** **Revised:** **Approved by: MCA**

POLICY

Medical transportation benefits, within the client's region/territory of residence, may be provided for clients to travel to see a traditional healer or, where economical, for a traditional healer to travel to the community.

1. When the traditional healers selected by the client are outside of the region, travel costs will be reimbursed for travel to the regional border only.
2. The following criteria must be considered prior to approving medical transportation benefits for traditional healer services:
    a) The traditional healer is recognized as such by MCA
    b) The traditional healer is located in the region;
    c) A licensed physician, or a community health professional or ANIHB representative has confirmed that the client has a medical condition.
3. The ANIHB Program does not pay for any associated honoraria, ceremonial expenses or medicines. These costs remain the sole responsibility of the client.

PROCEDURE

1. *The Transportation Coordinator will notify the appropriate programs that medical transportation benefits to access traditional healer services must be preauthorized by ANIHB.*
    a. *On an exception basis, the Transportation Coordinator may authorize transportation after the fact when appropriate medical justification is provided and approved.*

Appendix A: ANIHB PROGRAM FORMS

AKWESASNE NON-INSURED HEALTH BENEFITS

MEDICAL TRANSPORTATION ASSISTANCE APPLICATION

****

CLIENT INFORMATION

NAME: _____ BAND #: _____

ADDRESS: _____

PHONE #:_____ DATE OF BIRTH: _____

****

ASSISTANCE INFORMATION

PURPOSE: _____

DESTINATION: _____

PHYSICIAN: _____

DATE/TIME OF APPOINTMENT: _____

WILL YOU REQUIRE FOLLOW-UP/ON-GOING CARE? YES _____ NO _____

IF (YES), APPROXIMATELY HOW LONG? _____

(ATTACH PHYSICIAN'S MEDICAL STATEMENT OUTLINING TYPE OF TREATMENT AND DURATION.)

****

TRANSPORTATION INFORMATION

WHO WILL PROVIDE THE TRANSPORTATION? _____

DO YOU HAVE OTHER MEANS OF TRANSPORTATION? YES _____ NO _____

WHAT TYPE OF ASSISTANCE ARE YOU ON IF ANY?

COMMUNITY SUPPORT: AKWESASNE _____ CORNWALL _____ OTHER:_____

****

The information listed above is accurate to the best of my knowledge and I have provided all required documentation. I authorize the release of information contained in this application to the ANIHB Program for processing all claims on my behalf.

_____ _____

SIGNATURE **DATE**

****

OFFICE USE ONLY:

_____ Routine _____ Eligibility Verified

_____ Chronic/ EMR / Treatment _____ Physician Referral Attached

_____ Approved _____Driver/Patient Waver Attached

_____Denied

Comments: _____

Revised September 2009

DRIVER WAIVER

I, _____, understand and acknowledge that the Mohawk Council of Akwesasne is not liable for any damages or repairs to my vehicle in the event of an accident or mechanical breakdown which may occur during the transportation of a patient whom I have consented to transport for medical care.

I understand and acknowledge that the Mohawk Council of Akwesasne provides only financial assistance to this patient for medical transportation. The MCA is no way liable for damages or loss of personal property, either in my regard or in regard to the patient or family members present in the vehicle.

I understand and acknowledge that the MCA is in no way liable for physical injuries or death occurring during the transport, either in my regard or in regard to the patient or family members present in the vehicle.

I affirm that I have a good record as a safe driver and that my driver's license was never revoked following a conviction for impaired driving, accumulation of demerit points, or following an inability to respect laws and regulations concerning the use of a motor vehicle in Akwesasne, Quebec, Ontario, New York or any other jurisdiction.

I affirm that I have a valid driver's license and that I carry the insurance that the law requires to legally operate a motor vehicle.

_____ _____

DRIVER SIGNATURE **DATE**

_____ _____

WITNESS SIGNATURE **DATE**

Filename: drwaiver

MEDICAL TRANSPORTATION DRIVERS APPLICATION

****

DRIVER INFORMATION

NAME:_____ BAND #: _____

ADDRESS: _____

PHONE #:_____ CELL PHONE # _____

DATE OF BIRTH: _____

****

VEHICLE INFORMATION

CPIC _____ DATE_____ RESULTS _____

DRIVERS ABSTRACT **(3 YEAR)**

_____

INSURANCE _____ POLICY # _____

REGISTRATION _____ EXP DATE _____

DRIVERS LICENSE (US)_____ (CAN)_____

EXP DATE _____

****

The information listed above is accurate to the best of my knowledge and I have provided all required documentation. I authorize the release of information contained in this application to the ANIHB Program for processing all claims on my behalf.

_____ _____

SIGNATURE **DATE**

****

OFFICE USE ONLY:

_____ Approved

_____Denied

_____DRIVER WAIVER

_____CLEAR CPIC

_____ABSTRACT (3 YR)

Revised August 2009

Akwesasne Non-Insured Health Benefits
P.O. Box 941
Cornwall, Ontario K6H 5V1
613-575-2341

ANIHB DRIVER CPIC REQUEST

Akwesasne Mohawk Police Department
P.O. Box 10
Akwesasne, Quebec H0M 1A0

Date:_____

To whom it may concern:

This letter is to inform you that we have implemented mandatory **CPIC** and Drivers Abstract for all Medical Transportation Drivers who are registered with the program.

Please accept this letter as a request to perform the required CPIC check for

Name: _____ Date of Birth: _____

Address: _____City: _____

Province: _____Postal: _____Phone:_____

1. **Criminal Records Check (CPIC)**
The CPIC can be obtained by stopping by the Akwesasne Mohawk Police Department (AMPS) during normal business hours between the hours of 8:00-4:00 p.m. Please ensure that you bring **2-pieces of Picture Identification** with you. I have been informed that the cost of the search is **$20.00**, which is payable in **cash** only. The ANIHB program will reimburse this cost to the driver by submitting the official receipt issued by the AMPS. Please ensure you obtain receipts for these services as they are required for reimbursement purposes from the ANIHB.

Thank you for your cooperation and understanding on this matter.

Sincerely,

Cynthia Francis-Mitchell,
Program Manager/ANIHB

PATIENT WAIVER

I, _____, understand and acknowledge that the Mohawk Council of Akwesasne is not responsible for any damages or loss of personal property occurring during the transport and is in no way liable for physical injuries or death occurring during the transport, either in my regard or in regard to any family members present during the transport.

I acknowledge that the Mohawk Council of Akwesasne provides only financial assistance to enable me to obtain medical care.

_____ _____

PATIENT SIGNATURE

DATE

_____ _____

WITNESS SIGNATURE

DATE

Filename: patwaiver

DRIVER WAIVER

I, _____, understand and acknowledge that the Mohawk Council of Akwesasne is not liable for any damages or repairs to my vehicle in the event of an accident or mechanical breakdown which may occur during the transportation of a patient whom I have consented to transport for medical care.

I understand and acknowledge that the Mohawk Council of Akwesasne provides only financial assistance to this patient for medical transportation. The MCA is no way liable for damages or loss of personal property, either in my regard or in regard to the patient or family members present in the vehicle.

I understand and acknowledge that the MCA is in no way liable for physical injuries or death occurring during the transport, either in my regard or in regard to the patient or family members present in the vehicle.

I affirm that I have a good record as a safe driver and that my driver's license was never revoked following a conviction for impaired driving, accumulation of demerit points, or following an inability to respect laws and regulations concerning the use of a motor vehicle in Akwesasne, Quebec, Ontario, New York or any other jurisdiction.

I affirm that I have a valid driver's license and that I carry the insurance that the law requires to legally operate a motor vehicle.

_____ _____

DRIVER SIGNATURE **DATE**

_____ _____

WITNESS SIGNATURE **DATE**

Filename: drwaiver

APPENDIX B: Health Canada Non-Insured Health Benefits Medical Transportation Policy Framework

Non-Insured Health Benefits

The NIHB Program provides supplementary health benefits, including medical transportation, for registered First Nations and recognized Inuit throughout Canada.
Visit our Web site at: www.hc-sc.gc.ca/fnihb/nihb

MEDICAL TRANSPORTATION POLICY FRAMEWORK JULY 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

MEDICAL TRANSPORTATION POLICY FRAMEWORK

Ce document est aussi offert en français sous le titre :

CADRE DE TRAVAIL SUR LE TRANSPORT POUR RAISON MÉDICALE

Effective date: July 2005

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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. 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, 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 Medical Transportation Policy Framework defines the policies and benefits under which the NIHB Program will fund eligible registered First Nations and recognized Inuit (clients) with access to medically required health services not provided on the reserve or in the community of residence. Medical transportation 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 sustainable. The NIHB Medical Transportation Policy 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.

The NIHB Medical Transportation Policy Framework applies to the funding of medical transportation 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 medical transportation benefits to eligible clients.

3 GENERAL PRINCIPLES

2.1 Medical transportation benefits are funded in accordance with the policies set out in this framework, to assist clients to access medically required health services that cannot be obtained on the reserve or in the community of residence, when access would otherwise be denied. Exceptions may be granted, with justification and FNIHB approval, to meet exceptional needs.

2.2 Access to medically required health services may include financial assistance to the client or arranging for the provision of services from the reserve or community of residence when the following conditions are met:

1 The client has exhausted all other available sources of benefits for which they are eligible under provincial/territorial health or social programs, other publicly funded programs (e.g., motor vehicle insurance, workers' compensation) or private insurance plans;

2 Travel is to the nearest appropriate health professional or health facility (when health professionals are brought into the community to provide the service, the community facility is considered the nearest appropriate facility);

3 The most economical and efficient means of transportation is used, taking into consideration the urgency of the situation and medical condition of the client;

4 A FNIHB or First Nations or Inuit Health Authority or organization representative or on-site medical professional has determined that medically required health services are not available on the reserve or community of residence;

5 Transportation to health services is coordinated to ensure maximum cost-effectiveness;

6 Transportation benefits are provided when prior approved by FNIHB or a First Nations or Inuit Health Authority or organization or post approved upon medical justification if consistent with the framework;

7 In emergency situations, when prior approval has not been obtained, expenses may be reimbursed by FNIHB or a First Nations or Inuit Health Authority or organization when appropriate medical justification is provided to support the medical emergency and approved after the fact; and

8 When public transit is not available.

3.1 Medical transportation benefits may be provided for clients to access the following types of medically required health services:

- medical services defined as insured services by provincial/territorial health plans (e.g., appointments with physician, hospital care);
- diagnostic tests and medical treatments covered by provincial/territorial health plans;
- alcohol, solvent, drug abuse and detox treatment;
- traditional healers; and
- Non-Insured Health Benefits (vision, dental, mental health).

3.2 Medical transportation benefits include ground, water and air travel, meals and accommodation. For more information, refer to Sections 3 (Modes of Transportation), 4 (Emergency Transportation) and 9 (Meals and Accommodation).

3.3 Medical transportation benefits may be provided for an approved escort. Refer to Section 5 (Client Escorts).

3.4 In cases where a client is required to travel repeatedly on a long term basis to access medical care/treatment, medical transportation benefits will be provided for up to four months. During this time, an assessment will be conducted involving the treating physician, other relevant health professional(s) and the client to determine the provision of further benefits, taking into consideration the client's medical condition.

3.5 Medical transportation benefits may be provided when the client is referred by the provincial/territorial health care authority for medically required health services to a facility outside of Canada when such services are covered by a provincial/territorial health plan and the medical transportation benefits are not covered by provincial/territorial health or social programs, other publicly funded programs or private insurance.

3.6 When a request for medical transportation is denied, an appeal process is available. Appeals must be initiated by the client or by a designate acting on their behalf. For more information, refer to Appendix E (Appeal Process), or contact the NIHB Regional Office.

2. COORDINATED TRAVEL

2.1 When more than one client is travelling to the same location, where practical and economical, appointments and travel arrangements will be coordinated to ensure optimum cost-effectiveness.

2.2 When more than one medically required service is required in a week and/or more than one family member needs to access a medically required service in the same week, where practical and economical, appointments and travel arrangements will be scheduled for the same day to ensure optimum cost-effectiveness.

2.3 When more than one client is travelling in the same vehicle, the rate reimbursed will be for one trip only. Where applicable, an appropriate schedule of fixed rates will be established.

3. MODES OF TRANSPORTATION

3.1 The most efficient and economical mode of transportation consistent with the urgency of the situation and the medical condition of the client is to be utilized at all times as approved by FNIHB or a First Nations or Inuit Health Authority or organization. Clients who choose to use another mode of transportation will be responsible for the difference in the cost between the two.

3.2 When scheduled and/or coordinated medical transportation benefits are provided by FNIHB or a First Nations or Inuit Health Authority or organization, clients who choose to use another mode of transportation will be responsible for the full cost. For more information please refer to Section 2 (Coordinated Travel).

3.3 The following modes of transportation (including special needs vehicles) may be utilized for medical transportation benefits:

Ground travel

- Private vehicle
- Commercial taxi
- Fee for service driver and vehicle
- Band vehicle
- Bus
- Train
- Snowmobile taxi
- Ground ambulance

Water travel

- Motorized boat
- Boat taxi
- Ferry

Air travel

- Scheduled flights
- Chartered flights
- Helicopter
- Air ambulance
- Medevac

Private Vehicles

a) When it has been determined by FNIHB or a First Nations or Inuit Health Authority or organization that a private vehicle is the most appropriate, efficient and economical means of transportation, the payment of a per kilometre allowance may be authorized for the use of a private vehicle by a client to access medically required health services. For more information, refer to Appendix C (Meal, Accommodation and Kilometre Allowances).

The payment of a private vehicle per kilometre allowance will not be approved when scheduled and/or coordinated medical transportation is available from FNIHB or a First Nations or Inuit Health Authority or organization.

Reimbursement of the per kilometre allowance for the use of a private vehicle will be issued to the client. With the authorization of the client, Band or community nursing personnel, reimbursement can be issued to the driver or the Band if applicable.

When public transportation is available and the client chooses to use his/her own private vehicle, reimbursement will be made at either the equivalent public transportation rate or at the established private vehicle per kilometre allowance rate, whichever is the lesser.

Fee for Service Driver and Vehicle, Commercial Taxi

3.5 a) The use of fee for service drivers and vehicles or commercial taxis may be authorized when they have been determined by FNIHB or a First Nations or Inuit Health Authority or organization to be the most appropriate, efficient, and economical mode of transportation. Where applicable, an appropriate schedule of fixed rates will be established.

b) The use of fee for service drivers and vehicles or commercial taxis will not be approved when scheduled and/or coordinated medical transportation is available from FNIHB or a First Nations or Inuit Health Authority or organization.

c) Fee for service drivers and vehicles who are not regulated by a regulatory body, FNIHB or a First Nations or Inuit Health Authority or organization must ensure that a copy of the appropriate driver licenses, vehicle registration and certificate of insurance as a public carrier are kept on file with FNIHB or a First Nations or Inuit Health Authority or organization.

Indemnification

3.6 Whether Band vehicle and drivers or fee for service drivers are used to provide medical transportation benefits, FNIHB or a First Nations or Inuit Health Authority or organization shall ensure:

a) All medical drivers carry and maintain a valid provincial/territorial driving permit and appropriate liability insurance in relation to the carriage of passengers by vehicle or other motorized conveyances;

b) All medical drivers undergo a screening process, including background checks and references, whereby the general trustworthiness of the driver is assessed, bearing in mind that the driver will not only be operating a motor vehicle, but also entrusted with the transport of medical patients and will frequently be alone with such persons for extended periods;

c) All vehicles carry and maintain a valid license, registration and appropriate liability insurance in relation to the carriage of passengers by vehicle or other motorized conveyances;

d) All vehicles used for medical transportation are in good working order, including seat belts and child safety seats, and that all laws applicable to transportation are adhered to by all drivers.

Public Transportation (air, bus, train, ferry)

- The use of public transportation may be authorized when it has been determined to be the most appropriate, efficient, and economical means of transportation, consistent with the urgency of the situation and the medical condition of the client, and it is provided to access the nearest appropriate facility.

Charter Flights

- In the case of air travel, when a group of clients is travelling to the same location, where applicable and when more economical, charter flights will be arranged rather than individual scheduled flights. Clients may not opt to use the regularly scheduled flight unless they assume the full cost of the air travel.

EMERGENCY TRANSPORTATION

Assistance with the cost of ambulance services will be provided when such services are required for emergency situations.

Salaries for doctors or nurses accompanying clients on the ambulance are not covered.

Licensed ambulance operators will be reimbursed according to the terms, conditions and rules of the regionally negotiated payment schedules.

Ground Ambulance

4.4 Medical transportation benefits for emergency ground ambulance include only the portion of the services not covered by provincial/territorial health or social programs, other publicly funded programs, or private health insurance plans (equivalent amount billed to other provincial/territorial residents).

Air Ambulance/Medevac

4.5 Medical transportation benefits for emergency air ambulance/medevac services include only the portion of the services not covered by provincial/territorial health or social programs, other publicly funded programs or private health insurance plans (equivalent amount billed to other provincial/territorial residents).

4.6 Medical transportation benefits include air ambulance/medevac transportation for a client in emergency situations when:

a) A medical assessment has been conducted by an on-site nurse or physician and the need for emergency transportation to a hospital for either immediate or emergency treatment has been established and transportation by a commercial scheduled flight could compromise the client's condition;

or

b) The emergency occurs in a remote location and neither an on-site nurse nor physician is available to conduct a medical assessment and the air ambulance/medevac has been authorized by a representative of FNIHB or of a First Nations or Inuit Health Authority or organization.

5. CLIENT ESCORTS

5.1 Medical transportation benefits may include the provision of transportation, accommodation and meals for medical or non-medical escorts for clients travelling to access medically required health services.

5.2 The use of an escort must be preauthorized by FNIHB or a First Nations or Inuit Health Authority or organization. The length of time for which the escort is authorized will be determined by the client's medical condition or legal requirements.

5.3 Medical transportation benefits do not include the payment of a fee, honorarium or salary to medical or non-medical escorts.

Medical Escorts

- Medical escorts, either a physician or registered nurse, may be approved in cases which involve a client with a health condition where monitoring and/or stabilization are required during travel and such services are not covered by the provincial/territorial health or social program, other publicly funded program or private insurance.

Non-Medical Escorts

- The provision of a non-medical escort may be approved, following a doctor's or community health professional's request, only when there is a legal or medical requirement such as:

  Where the client has a physical/mental disability of a nature that he or she is unable to travel unassisted;

  Where the client is medically incapacitated;

  Where the client has been declared "mentally incompetent" by a court of competent jurisdiction and assistance to access medically required health services, legal consent or help with activities of daily living is required;

  When there is a need for legal consent by a parent or guardian;

  To accompany a minor (as determined by provincial/territorial legislation) who is accessing medically required health services;

f) When a language barrier exists to access medically required health services and these services are not available at the referred location; or

g) To receive instructions on specific and essential home medical/nursing procedures that cannot be given to the client only.

5.6 When an escort has been authorized, the following criteria should be considered in selecting the escort:

a) A family member who is required to sign consent forms or provide a patient history;

b) A reliable member of the community;

c) Physically capable of taking care of themselves and the client and not requiring assistance or an escort themselves;

d) Proficient in translating from local language to English/French;

e) Able to share personal space to support client;

f) Interested in the well being of the client; and

g) Able to serve as driver when client is unable to transport him/herself to or from appointment.

5.7 Unless there is a medical or legal requirement for an escort to stay longer, or it is more practical financially to have the escort stay longer, the escort shall return to the community by the earliest and most economical reasonable means.

6. APPOINTMENTS

6.1 When accessing medical transportation benefits, confirmation that the client has accessed a medically required health service must be obtained from the health care professional or his/her representative and submitted to FNIHB or a First Nations or Inuit Health Authority or organization.

6.2 When a client does not attend a scheduled appointment and medical transportation benefits have been provided, the client may have to assume the cost of the return trip or of the next trip to access medically required health services unless proper justification is provided to explain why the client was unable to attend or to notify the appropriate public carrier of the cancellation.

ADDICTIONS TREATMENT TRAVEL POLICY

Travel will be funded to the closest appropriate NNADAP funded/referred facility in the home province only. Exceptions are made to travel outside the province only when the required treatment is not available in the home province or when a neighbouring province's treatment centre is the closest centre and approved by the NIHB Regional Office.

Clients are required to meet all treatment centre entry requirements prior to medical transportation benefits being authorized.

Only the most efficient and economical method of transportation will be authorized, taking into account the medical condition of the client.

An escort is only provided for a client as defined in *Medical Transportation Policy Framework* Section 5 (Client Escorts).

Trips home during the course of treatment will not be authorized unless part of the treatment plan as established by the facility and approved prior to starting treatment.

Family trips to the treatment facility will not be authorized unless it is a documented part of the treatment program and approved prior to starting treatment.

Transportation to return the client to the community will not be provided for clients who discharge themselves from treatment, against advice from the treatment centre counselor, before completing the program; exceptions may be considered for clients who are minors or in cases when proper justification is provided and approved by the NIHB Regional Office.

Travel to access additional treatment within a one year period requires approval from the NIHB Regional Office.

Medical transportation benefits will only be provided for clients while in the care of the treatment centre when approved by the NIHB Regional Office.

Exceptions may be authorized, with appropriate justification, when approved by the NIHB Regional Office.

8. TRADITIONAL HEALER SERVICES TRAVEL POLICY

8.1 Medical transportation benefits, within the client's region/territory of residence, may be provided for clients to travel to see a traditional healer or, where economical, for a traditional healer to travel to the community.

8.2 Medical transportation benefits to access traditional healer services must be preauthorized by FNIHB or a First Nations or Inuit Health Authority or organization. On an exception basis, authorization may be granted after the fact by FNIHB or a First Nations or Inuit Health Authority or organization when appropriate medical justification is provided and approved.

8.3 When the traditional healers selected by the client are outside of the client's region/territory of residence, travel costs will be reimbursed for travel to the region/territorial border only.

8.4 The following criteria must be considered prior to approving medical transportation benefits for traditional healer services:

- The traditional healer is recognized as such by the local Band, Tribal Council or health professional;
- The traditional healer is located in the client's region/territory of residence;
- A licensed physician, or if a licensed physician is not routinely available in the community, a community health professional or FNIHB representative has confirmed that the client has a medical condition.

8.6 The NIHB Program does not pay for any associated honoraria, ceremonial expenses or medicines. These costs remain the sole responsibility of the client.

9. MEALS AND ACCOMMODATION

9.1 Medical transportation benefits may include assistance with meals and accommodation when these expenses are incurred while in transit for approved transportation to access medically required health services. For more information, refer to Appendix B (Client Eligibility).

9.2 Where the trip includes an overnight or extended stay away from the client's residence, the most efficient and economical type of accommodation will be chosen, taking into consideration the client's health condition, location of accommodation and travel requirements to access medically required health services.

9.3 Accommodation arrangements will be made by FNIHB or a First Nations or Inuit Health Authority or organization. Clients who choose to make different accommodation arrangements will be responsible for the difference in the cost between the two.

9.4 When available, meals and accommodation must be obtained from the boarding homes or commercial establishments with which FNIHB or a First Nations or Inuit Health Authority or organization have a negotiated Standing Offer or other contractual agreement.

9.5 Where special arrangements have not been made (e.g., boarding homes), meals taken in commercial establishments will be reimbursed as per established regional rates, in accordance with this framework.

9.6 Assistance with meals may be provided where the time away from home to attend the medically required appointment is more than 6 hours in one day. The assistance will be provided as per the regional rates for either a lunch or a dinner, depending on the time of day the travel is occurring. Breakfast is not payable for same day trips. Assistance with a meal when the time away is less than 6 hours may be provided in circumstances where meals are a required component of the medical treatment and a meal is not provided by the facility.

9.7 Assistance with overnight accommodation may be provided on a case by case basis, which may include the review of the medical justification, time of appointment, distance travelled and scheduled and/or coordinated medical transportation.

9.8 When accommodation is provided in a private home, assistance not to exceed the regional rate set out for private accommodation may be reimbursed. Reimbursements will only be issued to the client. For more information, refer to

Appendix C (Meal, Accommodation and Kilometre Allowances).

- Other expenses are the responsibility of the client (e.g., telephone charges, room damage, movie rentals, game rentals, room service, tips, gratuities, etc.) and will not be reimbursed.

- In cases where a client is required to reside close to medical treatment outside their reserve or community of residence for an extended period, the cost of meals, accommodation and in-city transportation to access the medical care/treatment, when they are not covered by provincial/territorial health or social programs, other publicly funded programs or private insurance plans, may be covered for up to a three month transition period only. A weekly food allowance as per the regional rate may be provided.

10. REIMBURSEMENT OF TRAVEL EXPENSES

10.1 Reimbursement to clients, approved escorts and service providers will be in accordance with the transportation policies and benefits of the NIHB Program and based on:

a) Negotiated rates;

b) Rates set out in the terms and conditions of the relevant contribution agreement;

c) Published FNIHB rate(s);

d) The actual expense of a commercial carrier/service with the submission of original itemized receipts.

10.2 Only service providers who have a negotiated contractual arrangement or who have been approved by FNIHB or a First Nations or Inuit Health Authority or organization will be reimbursed for medical transportation benefits they have provided.

10.3 All invoices submitted for payment for the reimbursement of expenses for medical transportation benefits must be submitted within 1 year of the service being provided. Requests for reimbursements submitted more than 1 year after the service is rendered will be rejected.

10.4 Medical transportation benefits include coverage for some or all of the travel expenses incurred by clients to access medically required health services at the nearest appropriate facility. If clients wish to access equivalent services elsewhere, they will be responsible for the difference in the cost of such travel. In cases where scheduled and/or coordinated medical transportation benefits are provided by FNIHB or a First Nations or Inuit Health Authority or organization, the clients will be responsible for the full cost.

10.5 Reimbursement to the client for meal allowances and private accommodation will be as per the regional rates. For more information, refer to Section 9 (Meals and Accommodation) and Appendix C (Meal, Accommodation and Kilometre Allowances).

10.6 When private vehicles are used, reimbursement to the client will be as per the regional rate. For more information, refer to Appendix C (Meal, Accommodation and Kilometre Allowances).

EXCEPTIONS

Certain types of travel may be considered on an exceptional basis with the appropriate justification. These types of travel include, but are not limited to the following:

Diagnostic tests for educational purposes, such as hearing tests for children required by the school;

Speech assessment and therapy when coordinated with other medical travel and cost of treatment is covered under the provincial/territorial health plan or educational institution;

Medical Supplies and Equipment benefits where a fitting is required and these fittings cannot be made on the reserve or in the community of residence;

Transportation for clients to visit a pharmacy for pharmacist-supervised methadone ingestion may be provided for up to four months for methadone patients in order to allow stabilization for carries (e.g., where the patient takes doses home) or alternate arrangements to be made. Extensions with justification may be considered;

Provincially/territorially supported preventative screening programs when coordinated with other medical travel and the cost of the testing is covered under the provincial/territorial health plan;

Other requests for travel will be reviewed on a case by case basis with appropriate justification.

12. EXCLUSIONS

12.1 Certain types of travel, benefits and services will NOT be provided as benefits under the NIHB Program under any circumstances and are not subject to the NIHB appeal process. These include assistance with:

a) Compassionate travel;

b) Appointments for clients in the care of federal, provincial or territorial institutions (e.g., incarcerated clients);

c) Court-ordered treatment/assessment, or as a condition of parole, coordinated by the justice system;

d) Appointments while travelling outside of Canada, other than as outlined in Section 1 (General Principles);

e) Travel for clients residing in an off-reserve location where the appropriate health services are available locally;

f) Travel for the purposes of a third-party requested medical examination;

g) The return trip home in cases of an illness while away from home other than for approved travel to access medically required health services;

h) Travel only to pick-up new or repeat prescriptions or vision care products;

i) Travel to access health related services that are not identified in section 1.3, unless coordinated;

j) Payment of professional fee(s) for preparation of doctor's note /document preparation to support provision of benefits;

k) Transportation to adult day care, respite care and/or interval/safe houses.

APPENDIX A

DEFINITIONS

"Appeal Process" is a three level process which allows clients to appeal a decision when they have been denied a medical transportation benefit.

"**Band Driver and Vehicle**" means a driver who is hired by a Band and who drives vehicles owned/leased and operated by a Band to drive clients to medically required health services.

"Boarding Home" means an establishment providing board, accommodation and associated support services while in transit.

"**Client"** means a recognized Inuit or registered Indian according to the *Indian Act* who is eligible to receive medical transportation benefits under the NIHB Program.

"Commercial Establishment " means for-profit commercial accommodation, such as hotels and motels, which provide overnight lodging.

"Community Health Professional" means a health professional who is a member in good standing of a professional association.

"Community of Residence" means the geographic or urban area in which the client resides.

"Exception" means goods, services and/or travel which are not defined benefits but which may be approved with appropriate justification.

"Exclusion" means goods, services and/or requested travel which will not be provided as benefits under the NIHB Program under any circumstances and are not subject to the NIHB appeal process.

"**Fee-for-service Driver and Vehicle"** means a driver who is recommended by Chief and Council, who is approved and recognized by FNIHB or a First Nations or Inuit Health Authority or organization and who uses their own vehicle to drive clients to medically required health services not available on the reserve or in the community of residence.

"**First Nations or Inuit Health Authority or organization**" means a First Nations or Inuit Health Authority or organization (including territorial government) who is accountable for the provision of medical transportation benefits to eligible clients and who receives funds from Health Canada in accordance with the terms and conditions of a signed Contribution Agreement.

"FNIHB" means the First Nations and Inuit Health Branch of Health Canada.

"**Insured Service"** means health care services and treatment as defined by the *Canada Health Act* and Provincial/Territorial Health Care program for the province/territory in which the client resides.

"Meal Allowance" means an allowance that is provided to assist with meal costs for clients travelling away from home.

"**Medevac**" means a medical evacuation by air charter for clients in emergency situations.

"Medical Escort" means either a physician, registered nurse, paramedic or any other health professional (e.g., nurse practitioner).

"**Medical Transportation Benefits**" means the travel expenses incurred by clients and escorts for ground, water and air travel, meals, and accommodation to access medically required health services not available on the reserve or in the community of residence.

"Medically Incapacitated" means a client who is travelling immediately prior to or after medical treatment and the physician or medical institution has indicated he/she is unable to travel without an escort.

"**Medically Required Health Services**" means those services that are required for medical reasons and are covered under a provincial/territorial health insurance plan and are not available on the reserve or in the community of residence.

"**Nearest Appropriate Facility**" means the facility located closest to the client's place of residence which is capable of providing the medically required health service appropriate to the client's medical condition. When health professionals are brought into the community to provide the service, the community facility is considered the nearest appropriate facility.

"**NIHB**" means the Non-Insured Health Benefits Program of the First Nations and Inuit Health Branch of Health Canada.

"Private Accommodation" means overnight accommodation that is not in a commercial establishment but rather at the home of a relative, friend or acquaintance.

"Private Vehicle Kilometre Allowance" means a kilometre rate that is payable for the use of privately owned vehicles to transport clients to medically required health services.

"**Reserve"** means land set aside by the federal government for the use and occupancy of an Indian group or band.

"Scheduled and/or Coordinated Medical Transportation Benefits" means medical transportation services that are provided on a regular basis from the community by FNIHB or First Nations or Inuit Health Authorities or organizations for the client to access services.

"**Service Providers**" means individuals or companies who provide medical transportation benefits and are reimbursed by FNIHB or First Nations or Inuit Health Authorities or organizations for the services they provide. They may include band and fee-for-service drivers, public transportation carriers, hotels, motels, boarding homes and restaurants.

APPENDIX B

CLIENT ELIGIBILITY

To be eligible to receive medical transportation benefits under the Non-Insured Health Benefits Program, a person must be:

a) A registered Indian according to the *Indian Act*; or

b) 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 claim organizations and a long form birth certificate are required; or

c) An infant up to one year old of an eligible parent; and

d) Currently registered or eligible for registration, under a provincial or territorial health insurance plan.

APPENDIX C

MEAL, ACCOMMODATION AND KILOMETRE ALLOWANCES

Approved medical transportation benefits may include meal, accommodation and kilometre allowances when these expenses are incurred while in transit to access medically required health services at the nearest appropriate facility. For more information, refer to Section 9 (Meals and Accommodation).

Daily Meal Allowances

When no commercial establishments or boarding homes with negotiated arrangements are available, meals are to be taken in commercial establishments and a meal allowance as per the regional rates may be provided.

Weekly Food Allowance for Extended Stays

In cases where a client is required to be close to medical treatment for extended periods of time for ongoing medical care/treatment and is residing in a self-catering accommodation, a weekly allowance as per the regional rate may be provided to assist with the purchase of food items while away from home.

Accommodation Allowance

The most efficient and economical accommodation consistent with the medical condition of the client and the costs incurred to travel to and from the accommodation to the medically required health services is to be utilized at all times.

When an approved boarding home is available, accommodation in a commercial establishment will not be authorized. When a boarding home is not available or it is full, commercial accommodation will be authorized and reimbursement will be at the rate negotiated with the establishment. Clients who choose alternate accommodation will be responsible for the difference in costs between the two or the full cost if accommodation is not reimbursable.

When staying in private accommodation, to assist the host for the costs incurred in providing overnight accommodation, an allowance as per the regional rate may be provided.

In cases where an extended stay, up to a three month period, is required, every effort must be made to utilize the most efficient and economical medical transportation benefits, including self-catering accommodation.

Private Vehicle Kilometre Allowance

The most efficient and economical mode of transportation consistent with the urgency of the situation and the medical condition of the client is to be utilized at all times. This includes scheduled and/or coordinated medical transportation benefits provided by FNIHB or a First Nations or Inuit Health Authority or organization. When this mode of transportation is the use of a private vehicle, an allowance may be paid as per the regional rate to cover the operating costs of the owner's vehicle. Clients who choose to use their private vehicle when a more efficient and economical mode of transportation is available will be responsible for the difference in cost between the two.

Exceptions to the foregoing allowance may be considered by FNIHB, where it can be demonstrated that due to extreme conditions or unique community location the private vehicle kilometre allowance is clearly inadequate.

APPENDIX D

PRIVACY

The Non-Insured Health Benefits (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 *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, increased 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.hc-sc.gc.ca/fnihb/nihb, or obtained from First Nations and Inuit Health Branch Regional 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 E

APPEAL PROCESS

A client has the right to appeal a denial of a medical transportation benefit under the Non-Insured Health Benefits (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 recommendations 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 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 review 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.

APPENDIX F

NIHB AUDIT PROGRAM

Medical transportation benefit audits are performed to meet program accountability and verify compliance with program requirements and the terms and conditions of applicable contribution agreements.

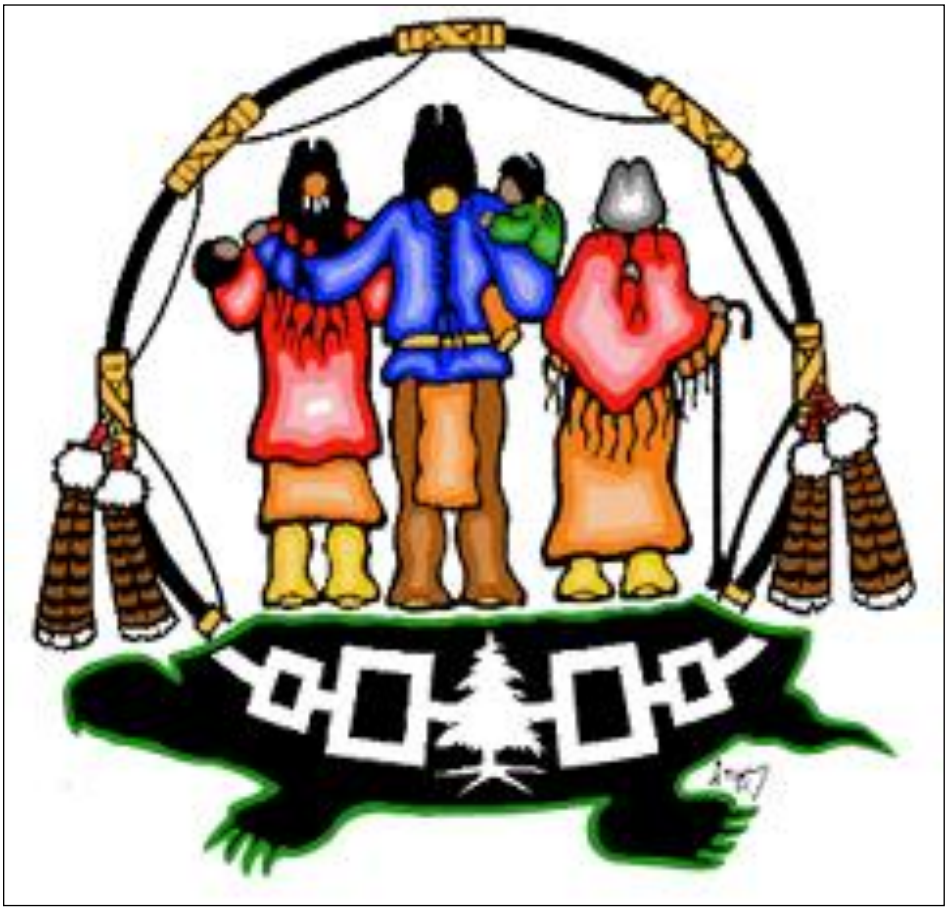
The objectives of the NIHB Audit Program are to:

- 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.

The audit activities are based on accepted industry practices and accounting principles and may be carried out up to a maximum of two years from the date of service. Providers must retain a copy of the original authorizing voucher/warrant and receipt in accordance with provincial or territorial requirements, and any other information to support a claim on file for two years from the date of service for audit purposes. Claims for which the original authorizing voucher/warrant and receipt or supporting documentation is not available for review, including those with prior approvals, may be recovered through the audit program.

Records relating to NIHB clients must be maintained and the authorizing voucher/warrant and receipt for all the 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 privacy legislation.

Section 6: Foot Care



September 2011

Updated by:
LaFrance Consulting Services
September 20, 2011

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AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 6.1: Foot Care Treatment

Subject: Foot Care Treatment	**Policy number: 6.01** **Issued: August 23, 2005** **Revised:** **Approved by: MCA**

POLICY

ANIHB will cover the costs for limited foot care treatment not covered by the client's health plan.

1. *Clients wherever possible should be scheduled with on-site physicians for this procedure to be done.*

2. *No reimbursement will be made for clients who seek treatment without referral from the Foot Clinic.*

PROCEDURE

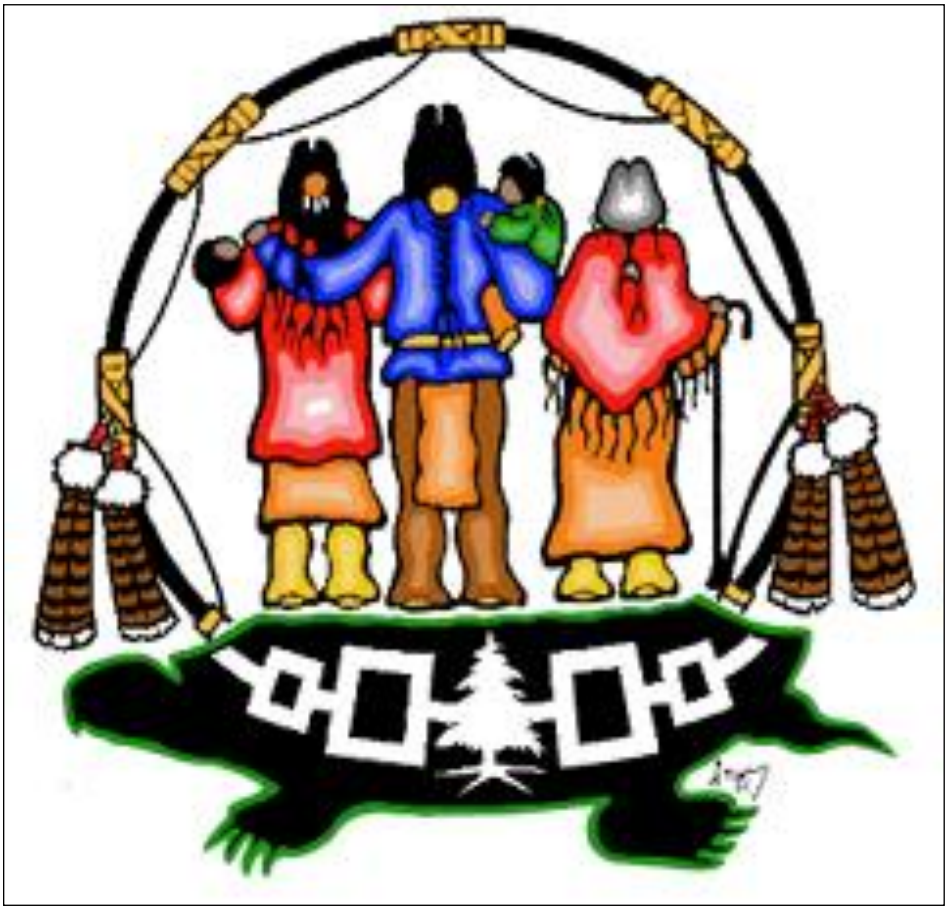
1. *The Benefit Analyst will advise providers that every attempt should be made to have the client seen in Consultation with Surgeons to access the clients need for surgery.*
2. *The Benefit Analyst will advise providers that clients should be directed to access the Foot Care Clinic provided by the Home Care Program.*

3. *The Benefit Analyst will advise providers and clients that services will only be provided by the Chiropodist through the Home Care Program. Appointments are scheduled and the individual will be assessed by Chiropodist.*

4. *The Benefit Analyst will advise providers that treatment plans and recommendations will be forwarded to the ANIHB office for approval of plans and cost associated with the treatment.*

ANIHB – Section 7 – Missing

Section 8: Vision



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AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Purpose

This directive shall provide the overall direction for the management of the vision care program as administered by the Akwesasne Non-Insured Health Benefits Program (ANIHB). The Vision Care Program is managed through an automated system called the Health Information and Claim Processing System (HICPS) which was developed by First Nations & Inuit Health, Ontario Region

Management Practices

The HICPS represents the management and documentation process for Vision Care and thus represents the basis for detailed management of the program. The version being used by ANIHB provides for more flexibility that the most recent Health Canada version of the HICPS. Thus it is recommended that the ANIHB not migrate to the updated Health Canada version.

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 8.1: Benefits

Subject: Benefits	**Policy number: 8.01** **Issued:** **Revised:** **Approved by: MCA**

The ANIHB unit is responsible for issuing pre-verification and payment for persons receiving services in Ontario or within the "Canadian" portion of Akwesasne. Persons receiving services in other provinces or territories should be directed to the respective regional NIHB offices of Health Canada for approval and payment of vision care services.

General Benefits for Service Population

- Glass or Plastic Lenses
- Scratch resistant coating for plastic lenses
- Thermal or chemical hardening for glass lenses
- Oversize lenses for eye size frames 56mm and over (only if standard frames are impossible to fit to conform to the face of the client
- Frames (maximum paid $50.00). This means, however that Cleaning kits and cases are no longer provided as a benefit. This is of limited value however, since most cases and cleaning kits are available for a couple of dollars
- Contact Lenses as an alternative benefit to prescription eyeglasses regardless of correction required meaning diopters for 10 and a medical reason. This system is calculated as maximum allowable contribution using equivalent form HICPS system. This alternative benefit excludes any costs for solutions or cleaners
- Cost of one eye exam for Quebec residents yearly under the age of 18
- Cost of one eye exam for Quebec residents every two years for over the age of 18 up to a maximum of $39.15 per eye exam

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 8.2: Benefits Available Upon Medical Justification

Subject: Benefits **-Available upon Appropriate Written Medical Justification**	**Policy number: 8.02** **Issued:** **Revised:** **Approved by: MCA**

Benefits Available Bases upon Written Medical Justification

- Anti-reflective coating
- High Index lenses (greater than 6.0 diopters)
- Special design lenses
- Tinted lenses (photogray, photobrown)
- Ultra Violet coating (UV 400)
- Contact lenses (10 diopters)
- Trifocals

AKWESASNE NON-INSURED HEALTH BENEFITS
Department of Health
Mohawk Council of Akwesasne

Section 8.3: Benefits – Services Not Provided as Benefits

Subject: Benefits **-Services Not Provided as Benefits**	**Policy number: 8.03** **Issued:** **Revised:** **Approved by: MCA**

Services Not Provided as Benefits

- Eye exams for Ontario Residents covered by Ontario Health Insurance Plan (OHIP)
- Eye exams for residents of U.S. portion of the reserve – Not Eligible
- Progressive or invisible bifocals/trifocals. The ANIHB program will not authorize the difference between a regular bifocal or trifocal and the invisible features
- Prescription Sunglasses
- Faceting
- Grooving for nylon wire or replacement of nylon wire
- Sports glasses
- Safety glasses
- Oversize frames or lenses for cosmetic purposes only

NIHB EYE AND VISION PRODUCTS AND SERVICES PRIOR APPROVAL AND CLAIMS FORM

Health Canada Protected
Provider to Complete

[ ] For Prior Approval
[ ] For Claim

PART 1 - CLIENT INFORMATION

_____
SURNAME GIVEN NAME(S)

_____
ADDRESS APT CITY

_____(_____) _____
PROVINCE POSTAL CODE AREA CODE TELEPHONE

_____D.O.B._____/_____/_____
CLIENT ID NO. DD MM YY

_____
BAND NO. FAMILY NO.

PART 2 - CLIENT INJURY HISTORY

Is request due to an injury? Yes 9 No 9

If yes, where did the injury occur:

Home 9 Work 9 Other 9

If other, please specify: _____

Date of injury: _____/_____/_____
DD MM YY

Are these expenses eligible under another plan or program? Yes 9 No 9

If yes, please specify: _____

Claim No.: _____

PART 3 - PROVIDER INFORMATION

(Please use office stamp if available)

_____
PROVIDER NO.

_(_____)_____
AREA CODE TELEPHONE

_____
PROVIDER SIGNATURE

PART 4 - OPTICAL INFORMATION/PRESCRIPTION

Oculo-visual Measure	Sphere	Cyl	Axis	Prism	Base	Add
Right						
Left						

DIAGNOSIS & OTHER RELEVANT INFORMATION:

BENEFITS REQUESTED: (please complete information as is applicable in the region where benefit is accessed, for each product or service)

Benefit Description, Items	Initial Request (/)	Replacement (/)	Acquisition cost	Mark-up in $	Total Cost	MFR Product Name	Product Number	Warranty Yes(/)	Warranty No(/)
EYE AND VISION EXAMS (ONLY in regions where applicable)									
Eye/vision exam, general (full, major, routine)									
DISPENSING FEES (ONLY in regions where applicable)									
Fame dispensing fee, existing frame									
Frame dispensing fee, new									
Laboratory fee									
Lenses dispensing fee, bifocal									
Lenses dispensing fee, unifocal									
Delivery (remote areas, mailing & registration)									
FRAMES & FRAME REPAIRS									
Regular									
Frame repairs, major									
Frame repairs, minor									
LENSES, OPTHALMIC									
Aspheric lens, left									
Aspheric lens, right									
Bifocal lens, left									
Bifocal lens, right									
High index, left									
High index, right									
Unifocal (Crown glass or plastic CR-39)									
Other									

PART 5 – CLIENT SIGNATURE

Client: I have received the above item(s) or service(s).

_____/_____/_____

SIGNATURE OF CLIENT, PARENT OR GUARDIAN **Relationship to Patient if Guardian** **Date** **DD** **MM** **YY**

PART 6 – FOR NIHB OFFICE USE ONLY

D ate _____ **Authorizing Officer**_____ **May, 2005**

PA A pproval Number _____