Health Benefits

Information Package

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FNHA Health Benefits Program

Introduction

The First Nations Health Authority (FNHA) Health Benefits program provides a specific number of health related goods and services to meet medical or dental needs not covered by provincial, territorial, or other third party health insurance for BC First Nations.

The FNHA Health Benefits program currently includes:

- Dental
- Medical Supplies & Equipment (MS&E)
- Medical Transportation
- Mental Health - Crisis Intervention (Short Term)
- MSP - BC Medical Service Plan (Care Card)
- Pharmacy
- Vision Care

The purpose of the program is to provide Health Benefits to BC First Nations peoples in a manner that:

- Is appropriate to their unique health needs
- Contributes to the achievement of an overall health status for BC First Nations comparable to that of the Canadian population as a whole
- Is sustainable from a fiscal and benefits management perspective
- Facilitates First Nations control at a time of their choosing
- Shifts the focus of health service delivery for First Nations residing in BC to wellness and prevention

The principles of the FNHA Health Benefits program are as follows:

- Benefits will be provided based on professional, medical or dental judgment, consistent with the best practices of health services delivery and evidence-based standards of care.
- The program will be managed in a cost-effective manner.
- Management process will involve transparency and joint review structures.
- In cases where a benefit is covered under another plan, the FNHA Health Benefits program will act as the primary facilitator in coordinating payment in order to ensure that the other plan meets its obligations and that clients are not denied service.

What is buy-back?

Buy-back is an arrangement between the FNHA and Health Canada where the FNHA "buys-back" the administration of claims processing and benefits review services from Health Canada. It will take some time for the FNHA to build the appropriate systems to process the tens of thousands of daily claims. The buy-back arrangement will ensure continuity of service as the FNHA builds these systems.

How long will the FNHA buy-back services?

The FNHA currently has a buy-back agreement for a term of 2 years in place. This agreement may be extended for an additional 2 years.

What are affected by the buy-back agreement?

Any system updates from Health Canada would affect the Dental, Medical Supplies and Equipment, and Pharmacy benefit areas.

The First Nations Health Authority Health Benefits program design, delivery, and transformation is driven and guided by the FNHA Vision, Values, and Directives.

Our Vision

Healthy, Self-determining and Vibrant BC First Nations Children, Families and Communities.

Our Values

Respect
Discipline
Relationships
Culture
Excellence
Fairness

Our Directives

- Community-Driven, Nation-Based
- Increase First Nations Decision-Making and Control
- Improve Services
- Foster Meaningful Collaboration and Partnership
- Develop Human and Economic Capacity
- Be Without Prejudice to First Nations Interests
- Function at a High Operational Standard

Eligibility

The FNHA Health Benefits program offers health-related goods and services to any First Nations person (or child under 1 year of age of a First Nations person who meets all of these criteria) who:

- has a Canadian status number;
- is a resident of British Columbia (as defined by BC's Medical Service Plan) and having active Medical Service Plan coverage; and
- is not covered under any other benefits provided by the Federal Government or First Nations organization through self-government or land claims agreements.

Benefits

Dental

Coverage for dental services is determined on an individual basis, taking into consideration the current oral health status, recipient history, accumulated scientific research, and availability of treatment.

What is covered?

- Diagnostic services (e.g. examinations or x-rays);
- Preventive services (e.g. cleanings);
- Restorative services (e.g. fillings);
- Endodontic services (e.g. root canals);
- Periodontal services (e.g. deep cleanings);
- Prosthodontic services (e.g. removable dentures);
- Oral surgery services (e.g. removal of teeth);
- Orthodontic services (e.g. braces); and
- Adjunctive services (e.g. general anaesthetics or sedation)

Who can provide dental benefits?

Dental services must be provided by a licensed dental professional such as a dentist, dental specialist, or denturist.

How do eligible clients access dental benefits?

Eligible clients must make an appointment with a dental provider who will complete an examination, establish a treatment plan, and discuss the services required with the individual. This benefit is delivered by NIHB for the FNHA through the short term buy-back agreement.

There are two schedules for dental services:
Schedule A: includes services that do not need prior approval
Schedule B: includes services that do require prior approval

The dental provider should advise the client what is covered by the FNHA Health Benefits program and which services require prior approval. If the provider is not aware, the recipient should contact FNHA Health Benefits office 1.800.317.7878 and speak to the dental benefit staff; or have the dental provider contact the claim centre at 1.888.511.4666 to determine what is covered.

Dental Process

Eligible FNHA client makes an appointment with Dentist.

Client is examined.

Dentist will establish a treatment plan.

Dentist will identify:
A: The services that do not need pre-determination; and
B: The services that will need pre-determination.

The dental provider forwards the request for services that need pre-determination. Pre-determination requests with supporting documentation must be mailed to FNHA.

The FNHA Health Benefits program reviews the request and determines eligibility based on program guidelines.

If necessary, the FNHA Health Benefits program refers the request to the Dental Consultant for a professional opinion on dental requirements.

Registered dental providers will receive a letter confirming benefits via fax or mail.

Client receives dental services and signs form confirming receipt of service.

Provider completes claim form and forwards to claims centre for payment.

Medical Supplies & Equipment (MS&E)

Specific Medical Supplies and Equipment are available to eligible BC First Nations for personal use when all of the following criteria are met:

- The item is on the FNHA Health Benefits program Medical Supplies & Equipment List.
- Prior Approval, if required, is granted by the FNHA Health Benefits program.
- The item is not available to clients through other federal, provincial, or other third party plan.
- The benefit is prescribed by an eligible prescriber.
- The item is provided by a FNHA recognized pharmacy or medical supply & equipment provider.

Medical Supplies & Equipment provided through the FNHA Health Benefits program include the following:

- Audiology (Hearing Aids and Supplies)
- Bathing and Toileting Aids
- Cushions and Protectors
- Environmental Aids (Dressing and Feeding)
- Lifting and Transfer Aids
- Low Vision Aids
- Miscellaneous Supplies and Equipment
- Mobility Aids (Walking Aids, Wheelchairs)
- Orthotics and Custom Footwear
- Ostomy Supplies and Devices
- Oxygen Supplies and Equipment
- Pressure Garments and Pressure Orthotics (Compression Device and Scar Management)
- Prosthetic Benefits (Breast, Eye, Limbs)
- Respiratory Supplies and Equipment
- Urinary Supplies and Devices (Catheter Supplies and Devices, Incontinence Supplies)
- Wound Dressing Supplies

This benefit is delivered by NIHB for the FNHA through the short term buy-back agreement. For a complete list of the benefits, consult the NIHB website at www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/index-eng.php which provides a description of the benefit item, the benefit code, requirements for prior approval, and expected replacement guidelines.

Certain medical supplies and all medical equipment require prior approval.
Approval procedures are provided on page 9.

The following are exclusions under the program:

- Assistive listening devices (excluding eligible hearing aids)
- Assistive speech devices (i.e., keyboard speech systems, speech enhancers)
- Cochlear implants
- Custom-made mask for ventilation
- Electric/myoelectric limb prosthetics
- Exercise devices
- Experimental equipment
- Foot products manufactured only from laser or optical scanning or computerized gait and pressure analysis systems
- Grab bars permanently fixed
- Hospital beds and mattresses
- Implants
- Items for cosmetic purposes
- Items used exclusively for sports, work or education
- Incentive spirometer
- Orthopaedic footwear “off the shelf”
- Part of a surgical procedure
- Providing oxygen for indications which do not meet the medical criteria of the NIHB Program (e.g. angina and pain relief from migraines)
- Respiratory equipment for in-patients of an institution
- Scooters
- Short-term compression stockings/ garments (i.e. post-operative: surgical stripping, sclerotherapy, and edema conditions)
- Temporary prosthetics required as part of a surgical procedure

Medical Supplies & Equipment Access Process

Eligible FNHA client receives prescription from authorized prescriber.

Client is assessed for medical supplies & equipment needs by health professional.

Health professional prepares assessment results and recommends MS&E.

Client takes assessment to recognized MS&E provider and selects products.

MS&E provider completes and forwards the request, assessment, and prescription to the FNHA Health Benefits program for Prior Approval.

The FNHA Health Benefits program reviews request and determines eligibility based on program guidelines.

If necessary, the FNHA Health Benefits program refers request to Medical Consultant for professional opinion on medical requirements.

The FNHA Health Benefits program faxes letter confirming benefits approved to MS&E provider.

Client receives MS&E and signs form confirming receipt of product.

Provider completes claim form and forwards to claims payer for payment.

Medical Transportation

Eligibility

In order to qualify for medical transportation benefits under the FNHA Health Benefits program, the individual must have a Canadian Status number. Medical transportation benefits are not provided by the FNHA Health Benefits program if the FNHA client is eligible for benefits under any other publicly funded health or social program, such as the Insurance Corporation of BC (ICBC) or the Workers Compensation Board (WCB), then the alternate coverage must be used first.

Infants under one year of age are eligible for medical transportation benefits if one of their parents is a FNHA client with a Canadian Status number. After one year of age the children must themselves, have a Canadian Status number to qualify for medical transportation benefits.

Eligible Benefits

Medical transportation benefits may be provided for clients to access medically necessary health services that are covered under the BC Medical Services Plan (MSP) and/or the FNHA Health Benefits program. Please refer to the Medical Transportation Framework for further information on eligible benefits. The Framework can be found on the website:
www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_medtransp/2005_med-transp-frame-cadre/index-eng.php

Appropriate Documentation

In order to determine eligibility for medical transportation benefits, the FNHA client in question must provide the following documentation:
- A referral from a General Practitioner or family physician
- Confirmation of appointment from the health provider/ health facility

After the appropriate medical travel arrangements have been made and the client has attended their appointment, the client must provide confirmation of attendance from the health provider/ health facility.

Travel expenses will not be reimbursed without written confirmation of attendance.

Travel Arrangements

Medical transportation benefits are provided to assist clients in accessing medically required health services at the nearest appropriate health professional or health facility. The most economical and efficient means of transportation is to be used, taking into account the urgency of the situation and the medical condition being addressed.

PLEASE REFER TO THE MEDICAL TRANSPORTATION FRAMEWORK FOR MORE DETAILED INFORMATION.

Medical Transportation Responsibilities for BC First Nations:

A FNHA client accessing medical transportation through the FNHA Health Benefits program, either through the community or the regional office, is responsible for:

- Giving sufficient notice, ideally 5-10 days (or more as per the community's policy) prior to leaving the community. This will avoid last minute confusion or having to cancel appointments because arrangements could not be made in time.
- Adhering to the Medical Transportation Framework and regional/ community policies on Medical Transportation.
- Obtaining all of the necessary paperwork for their trip prior to leaving the community (i.e. referral from GP or confirmation of appointment with specialist).
- Getting prior approval for all non-emergency trips. The only exception is in the case of a medical emergency.
- Attending their medical appointment as scheduled.
- Getting a signed Confirmation of Attendance (COA) signed by the Doctor/ Nurse stating they have attended their medical appointment. The signed COA must be returned to the Transportation Coordinator after the medical appointment.
- Protecting all of the original vouchers/warrants/receipts issued to them for their medical trip. Vouchers/warrants/receipts will not be reissued if lost or stolen.
- Giving notification when cancelling an appointment prior to the date of the appointment; including 24 hours' notice to cancel any hotel arrangements.
- Retaining and forwarding all required receipts.
- Not damaging property or abusing accommodation arrangements, such as causing excessive noise.
- Not becoming verbally abusive or threatening to the patient transportation clerk or coordinator.

Medical Transportation Access Process

Eligible FNHA client receives appointment for a specialty physician located outside of the client's resident community.

FNHA client contacts their community to see if they are covered by a contribution agreement.

If covered under contribution agreement, benefits are provided through the community.

If not covered under a contribution agreement, client contacts FNHA Health Benefits.

The client or community health representative forwards the request with the completed form, confirmation of appointment, relevant referral document, and any other supporting medical documents to FNHA Health Benefits, 5-10 days prior to leaving the community.

The FNHA Health Benefits program reviews request and determines eligibility based on forwarded information and on program guidelines.

The FNHA Health Benefits make travel arrangements using the most economical and efficient means of transportation, taking into account the urgency of the situation and the medical condition being addressed.

The FNHA Health Benefits forwards the travel arrangements to the client.

The client uses the travel arrangements and vouchers as prepared by FNHA Health Benefits, and follows the voucher's instructions as required, including signing the travel vouchers.

The client goes to the appointment as scheduled, and asks the physician's office to sign/ stamp and date the confirmation of attendance for the appointment.

The client returns to their home community as arranged.

The client or the community health representative forwards the confirmation of attendance for the appointment to the FNHA Health Benefits to complete the file for the trip.

The providers of the travel arrangements forward invoices to FNHA for payment of the services rendered, as prior approved.

Mental Health - Crisis Intervention (Short-term)

Mental Health – Clients who live on-reserve should contact their band office for mental health services. For clients who live away off-reserve, please contact FNHA Health Benefits at 1.800.317.7878 regarding crisis Intervention benefits.

The following program is also available for clients through FNHA Health Services

Mental Health Support Programs for Indian Residential Schools:

Services funded by Health Canada in support of those who have suffered abuses in Indian Residential Schools may include mental health counseling, transportation to attend counseling or to be assisted by an Elder or Healer, and the services of a Resolution Health Support Worker.

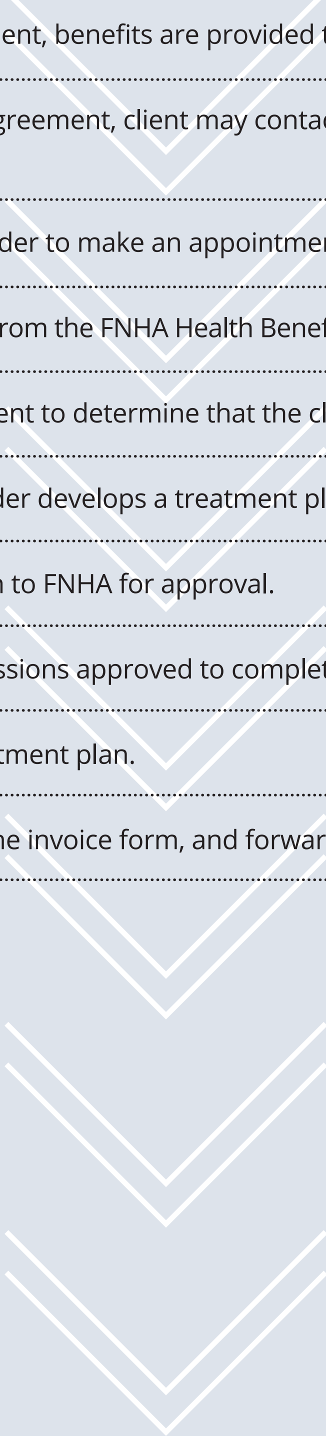
Indian Residential School Survivors Society Support Line

1.866.925.4419
(Open 24-hours a day, 7 days a week)

Indian and Residential School Mental Health Support Program

Toll-Free: 1.877.477.0775
Facsimile: 1.604.666.6458

Mental Health - Crisis Intervention Access Process



FNHA client contacts their community to see if they are covered by a contribution agreement.

If covered under contribution agreement, benefits are provided through the community.

If not covered under a contribution agreement, client may contact FNHA Health Benefits for a list of registered providers.

Client contacts FNHA registered provider to make an appointment for assessment.

The provider requests prior approval from the FNHA Health Benefits program for the initial assessment.

The provider does the initial assessment to determine that the client is at risk or in crisis.

If client is at risk or in crisis, the provider develops a treatment plan.

The provider forwards treatment plan to FNHA for approval.

Provider is informed of number of sessions approved to complete the treatment plan.

Provider and client complete the treatment plan.

Provider completes and client signs the invoice form, and forwards to FNHA for payment.

MSP – BC Medical Service Plan (Care Card)

The provincial Ministry of Health administers the BC Medical Services Plan, which ensures that all eligible BC residents have access to medically essential care. All residents in BC must apply for a BC Medical Services Health Card to receive health services within BC.

In BC, the FNHA manages the MSP program for clients residing in BC. Forms are available from local community band offices and/ or the FNHA Health Benefits program office. Once the application is received, verified, and approved, the cost of the premium is paid directly by the FNHA Health Benefits program.

It is each client's responsibility to ensure they are enrolled with the FNHA Health Benefits program for their medical health care card in order for their premiums to be paid.

Who should apply for enrolment?

- Clients and dependents who are new to BC
- Clients and dependents returning to BC (after 3 or more months away)
- Clients who have turned 19 years of age and have not yet completed a form
- Clients who had their premiums paid by an employer or other source (i.e. Ministry of Income Assistance) and are no longer on that plan.

*All applications must have copies of your birth certificate or passport and status card, **both sides**.*

When should you use a Change Form Application?

- Individual has lost their own or their dependent's Care Card
- Individual needs to correct the information shown on their Care Card, such as change of address, name change, or to add a new dependent

All change form applications require the necessary supporting documentation, such as a copy of the marriage certificate, birth certificate, etc.

MSP Enrolment or Change Form Applications should be mailed or faxed to the following:

Mail
First Nations Health Authority
Health Benefits Program
Suite 540 - 757 West Hastings Street
Vancouver, BC V6C 1A

Fax
1.888.299.9222

MSP Application Checklist

- ❑ Application is clearly printed, signed, and dated by applicant (and eligible spouse where applicable).

- ❑ A person signing on behalf of someone else must provide legal documentation granting Power of Attorney or clearly indicate signing as a witness for a client incapable of signing.

- ❑ The following mandatory information is provided:
  - Band name and number
  - Registered first name
  - Registered surname
  - Date of birth
  - Residential address (if living off-reserve you must have a street address and not a P.O. Box number)

- ❑ A copy of dependent's birth certificate (if eligible and applicable) is provided.

- ❑ For clients who are previous residents of BC or for continued enrolment at age of 19, indicate previous BC Health Care Number (if known).

- ❑ Ensure all boxes are marked off and all information is completed.

- ❑ Copies of supporting documentation are provided (i.e. birth certificate and status card, **both sides**).

- ❑ If faxing the application, BOTH sides are faxed.

PLEASE NOTE THAT APPLICATIONS MAY BE DELAYED AND/OR RETURNED IF THE ABOVE INFORMATION IS NOT PROVIDED.

NOTE: BC MEDICAL PREMIUMS THAT HAVE ALREADY BEEN PAID BY CLIENTS AND NOT THROUGH THE FNHA HEALTH BENEFITS PROGRAM ARE NON-REFUNDABLE.

MSP and PROVIDER BILLING

The following information was taken from the Medical Services Plan webpage and is meant to provide basic information only. For detailed information on MSP, please visit their webpage at: www.health.gov.bc.ca/msp

De-insurance of Provincially Insured Services

- From time to time, provinces may de-insure a health benefit. The FNHA Health Benefits program will not automatically assume responsibility for the cost of any de-insured benefit. When de-insurance occurs, a determination will be made by the FNHA Health Benefits program as to whether the benefit will be included in the program.

Extra billing

- "Extra Billing" is when a practitioner bills a client over and above the amount paid or payable by the Medical Services Plan of BC for an insured service. The FNHA will not accept responsibility for paying extra billing charges nor reimburse clients who have paid extra billing charges. If clients receive bills from a doctor or hospital which may be an "extra billing" charge, the doctor or hospital should be asked to provide an explanation of the expense in writing.

Costs Exceeding Fee Schedules

- If a client wishes to purchase a good or service that is more expensive than the benefit provided by the FNHA Health Benefits program, the client is responsible for costs over and above the negotiated fee schedule costs.

Inter-Regional Health

- From time to time a client may access services in another province, as the location is the closest appropriate medical service. The FNHA Health Benefits program will pay the cost of approved FNHA Health Benefits program services for patients who normally receive health services in another region because of the close proximity of health services. These requests are subjected to review by the Health Benefits program.

Pharmacy

The FNHA Health Benefits program provides eligible clients specified drugs, including certain prescription drugs, over-the-counter (OTC) drugs, proprietary medicines, and extemporaneous products.

This benefit is delivered by NIHB for the FNHA through the short-term buy back agreement. All drugs approved for coverage by the FNHA Health Benefits program are listed on the NIHB Drug Benefit List. The list is published once per year with updates every three months. The complete Drug Benefit List and program policies can be found on the NIHB website at: www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/index-eng.php

Drugs that are not on the Drug Benefit List may be approved for coverage on a case-by-case basis when an exceptional need is demonstrated. These requests must go through the Drug Exception Center and are forwarded by the pharmacy.

The following drug products are exclusions under the program:

- Household products (e.g. soap and shampoos)
- Anti-obesity drugs
- Cosmetics
- Alternative therapies (e.g. glucosamine and evening primrose oil)
- Megavitamins
- Drugs with investigational/ experimental status
- Vaccinations for travel
- Hair-growth stimulants
- Fertility agents and impotence drugs
- Select over-the-counter products
- Cough preparations containing codeine

Basic Information on Generic Drugs:

The concept of a ***generic drug*** versus a ***brand name drug*** is often a confusing matter for consumers.

The purpose of the below information is to help clients understand what a generic drug is, and why a generic drug may suddenly become available at pharmacies when previously it was not.

The following is for informational purposes only and does not cover the whole spectrum of generic drugs:

Definitions

Brand name drug

A drug that has a trade name and is protected by a patent. It can be produced and sold only by the company holding the patent.

Generic drug

When the patent protection for a brand name drug expires generic versions of the drug can be sold. It often has a name indicative of its chemical contents.

Generic drugs can only be produced and sold when a patent on a brand name expires or when a patent never existed. They are generally less expensive than the equivalent brand name drug because of much lower development and marketing costs.

Generic drugs usually cost less than the brand name drug, but are chemically identical and meet the same standards for safety, purity, and effectiveness.

Drug Access Process

Eligible FNHA client visits physician.

Physician writes prescription.

FNHA client takes prescription to pharmacy.

Pharmacist enters the client and benefit information, and benefit costs at their point of sale system for drugs that are open benefits.

Pharmacist telephones the NIHB Drug Exception Centre and provides operator with client and benefit information, and benefit costs for drugs that are not on the list or are limited use drugs.

The Physician is contacted by NIHB to complete form outlining medical requirements of the drug.

The Physician returns the form to NIHB. The request and supporting information is forwarded to a Medical Consultant for a professional opinion on medical requirements.

NIHB Drug Exception Centre reviews the request and determines eligibility based on program guidelines.

Drug Exception Centre provides pharmacy with prior approval details by telephone.

FNHA client receives medication.

Pharmacist forwards claim to claims payer.

Vision Care

Eye Examination

- The FNHA Health Benefits program funds routine eye exams once every 24 months for adults between the ages of 19-64.
- BC Medical Services Plan (MPS) funds routine eye exams once every 12 months for children under the age of 19 and adults 65 and older.

Eyeglasses are available to eligible BC First Nations under the FNHA Health Benefits program when the following conditions are met:

- Prior approval has been provided by the FNHA Health Benefits program, as the request for initial or replacement eye wear or repairs meets the benefits criteria.
- The item is not available to the individual in question under a provincial, third party agency or health plan.
- The prescription meets the criteria for initial or replacement eye wear prescribed within the last 12 months by an Optometrist or Ophthalmologist.

The FNHA Health Benefits program will assist in the provision of initial eye glasses based on the following criteria:

- When there is a refractive error of at least 0.50 diopters (either eye)
- High index lenses will be approved where there is a refractive error with a total power in any meridian of at least plus or minus 7.00 diopters.

The FNHA Health Benefits program will assist in the provision of replacement eye glasses/ lenses based on the following criteria:

For clients age 19 & older:
- Where at least 24 months have elapsed since the last lenses or frames have been approved;
- Where there is a change in refractive error of at least 0.50 diopters (either eye); or
- Where there are other changes in lens requirements which may not be associated with change in refractive error subject to approval.

For clients 18 and younger:
- Where at least 12 months have elapsed since the eye glasses have been authorized; or
- Where there are changes in frame requirements relating to medical need or physiological change (i.e. growth of the child) that has been substantiated by a medical doctor, ophthalmologist or optometrist.

The FNHA Health Benefits program will assist in the repair of eye glasses provided:
- The total cost of the repair does not exceed the cost for replacement glasses; and
- The repair will render the glasses in an acceptable and serviceable condition.

***** *Please note: Replacement frames or pairs of lenses are not considered eyeglass repairs.*

The FNHA Health Benefits program pays for standard frames and lenses based on the terms and rates of the FNHA payment schedule. Any extra charges for exams and eyewear are the responsibility of the individual. The FNHA Health Benefits program is not responsible for lost or stolen eyewear.

The following are exclusions under the program (but not limited to):

- Two pairs of glasses, except in the situations listed under “bifocal lenses”
- Vision care goods and services covered by provincial/ territorial health insurance plans
- Additional carrying cases for glasses or contact lenses
- Bifocal contact lenses
- Cleaning kit
- Esthetic products
- Shampoo (e.g. “no more tears” type shampoo solution)
- Vision exams required for a job: driver’s license or to engage in sports activity
- Vision exams at the request of a 3rd party (e.g. completing a report or medical certificate)
- Contact lenses for esthetic purposes
- Contact lens solution
- Industrial safety frames or lenses for sports or professional use
- Sunglasses with no prescription
- Progressive or trifocal lenses
- Photochromic/photochromatic lenses
- Replacements or repairs as a result of misuse, carelessness or negligence
- Implants (e.g. punctual occlusion procedure)
- Refractive laser surgery
- Treatments with investigational/experimental status
- Vision training

Vision Care Access Process

Eligible FNHA client accesses licensed prescriber for an examination and obtains a prescription.

Client takes prescription to licensed vision care provider, such as an optician or an optometrist.

If the provider is registered with FNHA, they complete and forward the request, assessment, and prescription to FNHA Health Benefits for prior approval.

If the provider is not registered with FNHA the client may apply for reimbursement (up to the FNHA benefit amount) but must provide payment first.

The FNHA Health Benefits program reviews request and determines eligibility based on program guidelines.

The FNHA Health Benefits program responds to the provider confirming benefits.

The provider then fabricates, fits, and dispenses the vision care item to the client.

Provider completes and the client signs the approval, which becomes the invoice; the provider forwards the signed invoice to FNHA for payment.

General

Appeals Process

Dental, Medical Supplies & Equipment, Medical Transportation Benefits, Mental Health & Vision

When coverage for a benefit has been denied, the recipient or parent/ guardian of the recipient have the right to appeal the decision. Please note that exclusions of the program are not appealable.

The recipient or parent/ guardian should forward their letter of appeal and supporting documentation by mail.

There are three levels of appeal available which only the recipient or parent/ guardian can initiate. In order for a case to be reviewed as an appeal, a letter from the recipient or parent/ guardian, accompanied by supporting information from the provider or prescriber must be forwarded to the Health Benefits program.

This information includes:

- The condition for which the benefit is being requested
- The diagnosis and prognosis, including what other alternatives have been tried
- Relevant diagnostic test results (ex: dental x-rays)
- Justification for the proposed treatment and any additional supporting information

If an appeal is denied and new information becomes available supporting the claim, the appeal can be escalated to the next appeal level. Upon receiving the submission, the FNHA Health Benefits program (or NIHB program) will arrange to have the case reviewed by relevant appeal level and the decision will be made based on the specific needs of the recipient, accumulated research, the availability of alternatives, and the FNHA Health Benefits program policy and/or professional review. The recipient or parent/ guardian will be provided with a written explanation of the decision made.

The recipient or parent/ guardian should forward their letter of appeal and supporting documentation by mail, clearly marked **“APPEALS - CONFIDENTIAL”**.

For more information on the appeal process or the status of your appeal, please contact the FNHA Health Benefits office at 1.800.317.7878.

APPEAL Level 1

Director, Health Benefits Operations
First Nation Health Authority
#540 - 757 West Hastings St
Vancouver, BC - V6C 1A1

APPEAL Level 2

FNHA Health Benefits Appeal Review Committee
Attention: Vice President, Health Benefits
#540 - 757 West Hastings St
Vancouver, BC - V6C 1A1

APPEAL Level 3:

CEO
First Nations Health Authority
#501 – 100 Park Royal South
West Vancouver, BC - V7T 1A2

Appeals Procedure for: Pharmacy

APPEAL Level 1:

NIHB Drug Exception Centre
First Nations and Inuit Health Branch, Health Canada
Health Canada
200 Eglantine Driveway, 2nd floor
Tunney's Pasture, Postal Locator 1902D
Ottawa, ON - K1A 0K9

APPEAL Level 2:

Benefit Management and Review Services Division
Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
200 Eglantine Driveway, 2nd floor
Tunney's Pasture, Postal Locator 1902D
Ottawa, ON - K1A 0K9

APPEAL Level 3:

CEO
First Nations Health Authority
#501 – 100 Park Royal South
West Vancouver, BC - V7T 1A2

Appeals Procedure for: Orthodontic Benefits

The following information was taken from the Health Canada NIHB webpage and is intended to provide basic information only. For detailed and up-to-date information on appeals procedures, please visit the webpage at: www.hc-sc.gc.ca/fnih-spni/nihb-ssna/benefit-prestation/appe/index_e.html

For Orthodontic Benefits, **the appeal must be forwarded before the child reaches the age of 18**.
No appeals will be considered after the recipient's 18th birthday.

The following supporting information must be provided by the Orthodontist or Dentist, including:

- The condition for which the benefit is being requested
- The diagnosis and prognosis, including what other alternatives have been tried
- Relevant information and diagnostic test results, including:
- Diagnostic Orthodontic Models - soaped and trimmed (mounted or unmounted)
- Cephalometric - radiograph(s) and tracing
- Photographs - 3 intra oral and 3 extra oral
- Panoramic radiograph or Full mouth survey
- Treatment plan, estimated duration of active and retention phases of treatment and costs forwarded either on a FNHA Health Benefits program Orthodontic Summary Sheet, CAO Standard Orthodontic Information Form, or letter on the Orthodontist's letterhead
- Completed FNHA Health Benefits program Dent-29 Form
- Parent/Guardian signature (including Band name and number and/or date of birth)
- Justification for the proposed treatment and any additional supporting information.

The recipient or parent/ guardian should forward their letter of appeal and supporting documentation by mail, clearly marked **"APPEALS - CONFIDENTIAL"**.

Upon receiving the submission, the Orthodontic Review Centre will arrange to have the case reviewed by an appeals committee of dental professionals. The decision will be made based on the specific needs of the recipient, accumulated research, the availability of alternatives and FNHA Health Benefits program policy.

At all levels of the appeal process, you will be provided with a written explanation of the decision taken. If you have not heard within one month of forwarding your appeal and wish to enquire as to its status, please call the toll-free number for the **FNHA Health Benefits program at 1.800.317.7878**.

APPEAL Level 1:

Orthodontic Consultant
NIHB Orthodontic Review Centre
Health Canada
200 Eglantine Driveway, 2nd floor
Tunney's Pasture, Postal Locator 1902D
Ottawa, ON - K1A 0K9

APPEAL Level 2:

Director, Benefit Management
NIHB Orthodontic Review Centre
Health Canada
200 Eglantine Driveway, 2nd floor
Tunney's Pasture, Postal Locator 1902D
Ottawa, ON - K1A 0K9

APPEAL Level 3:

CEO
First Nations Health Authority
#501 – 100 Park Royal South
West Vancouver, BC - V7T 1A2

Client Reimbursement

Recipient Reimbursement:

- Service providers are encouraged to bill the FNHA Health Benefits program directly so that clients do not face charges at the point of service when receiving health care goods or services.
- When a FNHA client does pay directly for goods or services, he or she may seek reimbursement from the FNHA Health Benefits program for eligible benefits. Requests for reimbursement must be received on an FNHA Health Benefits program Client Reimbursement Request Form, within one year from the date on which the services were received.
- All reimbursement requests are reviewed based on benefits criteria.
- Client Reimbursement Form (PDF 123 kb) Can also be found through www.fnha.ca/benefits

All requests for reimbursement of eligible benefits must include:

- Original receipts with cost breakdown (for example, for Pharmacy: dispensing fees, unit cost, and the Drug Identification Number (DIN); for eyewear: frames and lenses);
- Identification of Benefit Category (i.e. Dental, Medical Supplies & Equipment, Medical Transportation, Pharmacy, Vision, Short-term Crisis Intervention, or Mental Health Counselling);
- Client's name, correct mailing address, identification number, and health care number;
- A copy of the prescription, if applicable;
- A completed recipient authorization section on the FNHA Health Benefits program Client Reimbursement Request Form including recipient's signature and date; and
- Primary insurer's Explanation of Benefits, if coordination of benefits is applicable;
- Indicate Payee name and address if different from the client or the client is a minor.

Dental reimbursements must include:

- Completed Standard Dental Claim form or FNHA Health Benefits program Dent-29 form from provider signed by the client and provider;
- Original receipts/ Statement of Account verifying procedures paid in full;
- Primary insurer's Explanation of Benefits, if coordination of benefits is applicable.

FOR DETAILED INSTRUCTIONS ON HOW TO COMPLETE THE REIMBURSEMENT REQUEST FORM, REFER TO PAGE 2 OF THE FORM.

Leaving British Columbia

The following information was taken from the Medical Services Plan webpage and is meant to provide basic information only. For detailed information on MSP, please visit their webpage at: www.health.gov.bc.ca/msp

Temporary Absence from British Columbia:

- You may be eligible to receive coverage for up to 24 months during a temporary absence from BC. Approval is limited to once in five years for absences that exceed six months in a calendar year.

- Residents who spend part of every year outside BC must be physically present in Canada at least six months in a calendar year and continue to maintain their home in BC in order to retain coverage. If you are unsure whether you will qualify for coverage during an absence or know your eligibility will end, contact MSP with details.

- When you stay outside BC longer than the period for which you are entitled to coverage, you will be required to fulfill a waiting period upon return to the province before coverage can be renewed.

- You should be aware that your provincial coverage may not pay for all the health care costs you may incur outside the province, and the difference can be substantial. For example, BC pays $75 (Cdn) a day for emergency in-patient hospital care, while the average cost in the U.S. often exceeds $1,000 (US) a day, and can be as high as $10,000 (US) a day in intensive care. For this reason, you are strongly advised to purchase additional health insurance from a private insurer before you leave the province, whether you are going to another part of Canada or outside the country – even if you plan to be away for only a day. See **Medical Care – Outside British Columbia** on the BC MSP Webpage for more information.

Renewing Your Coverage:

- When clients turn nineteen (19) years old, they need to be the main account holder on their coverages instead of as dependents on their parents' or guardians' MSP coverages. The Health Benefits program recommends that those clients confirm that their MSP coverages are active at that time.

- If you worked in another province for part of the year, or accessed medical and/or ambulance services outside of BC, your MSP records may be flagged for residency verification. If there is confusion regarding your resident address, MSP may request for proof of residency, such as a copy of your rental or lease agreement of a BC resident address.

- If there is any interruption to your MSP coverage, you may need to reapply.

Studying Outside British Columbia:

- Residents who leave BC temporarily to attend school or university may be eligible for MSP coverage for the duration of studies, provided they are in full-time attendance at a recognized educational facility and are enrolled in a program that leads to a degree or certificate recognized in Canada.

- Generally, beneficiaries who have been studying outside BC must return to the province by the end of the month following the month in which studies are completed. Any student who will not return to BC within that timeframe, and who has been away for less than 24 months, should contact MSP to discuss their situation.

Permanent Move from British Columbia:

- **Within Canada** – coverage is provided for the balance of the month in which you leave the province plus two consecutive months. If required, coverage may be extended for up to three extra months to cover you while in transit. Upon arrival, you should immediately apply to the health plan of the new province or territory.

- **Outside Canada** – coverage is provided for the balance of the month in which you leave the province. You should advise MSP of your move as soon as possible.

Cancelling Your Coverage:

- If you will no longer be a resident of BC, you must notify MSP of the date of your departure and your new address; otherwise, premium billing may continue (Note: failure to pay premiums does not constitute notification to cancel your coverage).

Medical Care – Outside British Columbia:

- If you are eligible for coverage while temporarily absent from BC (see **Temporary Absence from British Columbia** on the BC MSP Webpage), MSP will help pay for unexpected medical services you receive anywhere in the world, provided the services are medically required, rendered by a licensed physician, and normally insured by MSP.
  Reimbursement is made in Canadian funds and does not exceed the amount payable had the same services been performed in BC. Any excess cost is the responsibility of the beneficiary.

- MSP does not cover the services of health care providers other than physicians (e.g. chiropractors or physical therapists) outside the province. Similarly, PharmaCare does not provide coverage for prescription drugs or medical supplies when obtained outside BC.

- It is also important to be aware that the Ministry of Health does not subsidize fees charged for ambulance service obtained outside of BC. If you require ambulance service while in another province or outside Canada, you will be charged the fees established by the out-of-province ambulance service provider. Fees range from several hundred to several thousand dollars. When purchasing additional out-of-province insurance, you are advised to obtain insurance that will cover emergency transportation while you are away and, if necessary, the cost of transportation back to BC.

Out of Province Emergency Medical Care:

- Most physicians in other Canadian provinces and territories (except Quebec) will bill their own provincial health plan for services provided if you present your valid BC Care Card. The provinces recover the funding monthly between each other.

- When travelling in Quebec or outside Canada, you will probably be required to pay for your medical services and seek reimbursement later from MSP (use an Out of Country Claim Form).

- BC residents are strongly advised to purchase additional health insurance when travelling to other Canadian provinces to cover the cost of services not included in the reciprocal agreement between provinces.

IT IS STRONGLY ADVISED THAT CLIENTS PURCHASE ADDITIONAL HEALTH INSURANCE WHEN TRAVELLING OUTSIDE OF CANADA.

Common Questions & Answers: FNHA Health Benefits

General Questions

Q) Do I have to pay upfront for FNHA Health Benefits?

A) Your benefit provider (e.g. your pharmacist or dentist) must inform you if you are expected to pay directly for any services or items. FNHA Health Benefits strongly encourages providers to bill FNHA Health Benefits directly; however, some do not.

Q) Can I continue to use my current provider (e.g. my pharmacist or dentist) if they do not bill FNHA Health Benefits directly?

A) Yes, that is your choice. However, it is recommended that you contact the FNHA Health Benefits office (604.666.3331; or toll free 1.800.317.7878) before purchasing any item or receiving any service to ensure that the requested item or service is eligible for coverage under FNHA Health Benefits. Remember that in such cases, you must pay your provider first and then forward the proper information to FNHA Health Benefits in order to be considered for reimbursement. You should also note that your provider may charge more than the rate covered by FNHA Health Benefits, which means that you would not be reimbursed the full amount that you paid.

Q) Why should I keep my private insurance if I am eligible for FNHA Health Benefits?

A) It is important to note that as a registered FNHA client, you should maintain any private, employer-sponsored, or other public health care coverage you may have, as some of the benefits you may currently be receiving may not be eligible benefits under FNHA Health Benefits (e.g. physiotherapy and chiropractic treatment). For benefits that are available under both your private plan and FNHA Health Benefits, your claims must first be forwarded to your current plan or program before forwarding them to FNHA Health Benefits. For FNHA Health Benefits eligible benefits, the remaining amount of your claim not paid for by your private plan can then be forwarded to FNHA Health Benefits in order to be considered for reimbursement.

Q) Does FNHA Health Benefits provide out-of-country coverage?

A) FNHA Health Benefits may cover the cost of privately acquired supplemental health insurance premiums for approved clients who may be students or migrant workers. Supplementary health insurance coverage for all other outside of country travel (e.g. vacation travel) is not a benefit under FNHA Health Benefits. When travelling outside of Canada, it is recommended that you buy travel health insurance in case of an emergency.

Q) What is the difference between an exception and exclusion?

A) FNHA Health Benefits may provide coverage as an **exception** for goods and services that are not included in the NIHB benefit lists and that are not an exclusion of the Program. Exception requests will be considered on a case-by-case basis upon receipt of written medical justification from the provider.

Exclusion items are goods and services which are not listed as benefits on FNHA Health Benefits benefit lists and are not available through the exception process or subject to appeal. Therefore, excluded items will not be covered by FNHA Health Benefits under any circumstance. These may include, but are not limited to, items used exclusively for sports, work, education, cosmetic reasons, are experimental, or are part of a surgical procedure.

Q) Can I appeal a decision and how would I go about it?

A) When coverage for a benefit through FNHA Health Benefits has been denied, the recipient or parent/guardian of the recipient, has the right to appeal the decision. Appeals must be forwarded in writing and can be initiated by the client or legal guardian. An interpreter, advocate, CHR, or support liaison may assist the client in compiling the appeal, but the client must request the appeal by giving input into it **and** signing the letter to initiate the appeal process. There are three levels of appeal available. At each stage, the appeal must be accompanied by supporting information from the provider or prescriber 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 FNHA Health Benefits. At all levels of the appeal process, the client will be provided with a written explanation of the decision made. Please note that **exclusions** of the program are **not** subject to appeal.

AMBULANCE BILLS

Q) Why have I received a bill for ambulance services?

A) Ambulance services are not covered through the BC Medical Services Plan; however, they can be covered through FNHA Health Benefits. The service provider (BC Ambulance) may not have been provided with your 10 digit status number at the time of the service. Clients must provide their status number to the service provider in order for them to invoice FNHA Health Benefits. Call the provider or send back the bill with your 10 digit status number, date of birth and registered status name. Once the provider has the status number and date of birth the invoice will be sent to the FNHA Health Benefits office for review.

Ambulance Services Billings Department: 1.800.665.7199

BC MEDICAL SERVICES PLAN (MSP)

Q) I filed my income tax return and the Canada Revenue Agency is indicating that I owe for unpaid MSP premiums.

A) The Medical Services Plan premiums are being billed directly to the FNHA client rather than to FNHA Health Benefits. This may occur when a FNHA client is registered under another plan (i.e. through their employer) and is not registered through FNHA Health Benefits. Once they leave their job, the employer has taken them off their list and MSP automatically begins invoicing the client. It is important for clients who are receiving MSP benefits through another plan to notify the FNHA Health Benefits office. The FNHA client needs to complete an MSP application form and forward it to the Health Benefits office, with the attached bill and a photocopy of the individual's birth certificate so they can be registered on the FNHA Health Benefits group number. If the FNHA client is having difficulties with their income taxes because of unpaid premiums they may contact the FNHA Health Benefits office.

Q) Can you tell me what services the CareCard (or its replacement, the BC Services Card) does not cover?

A) Some exclusion for MSP include: surgery for alteration of appearance (cosmetic surgery), reversal of sterilization, in-vitro fertilization, artificial insemination, genetic screening and other genetic investigations including DNA probes, acupuncture, hypnotherapy, acupressure, and procedures still in the experimental or developmental phase. Clients should contact MSP for a complete list of what is covered and what is not.

Q) Do I have to replace my MSP card?

A) Having FNHA coverage for the MSP premiums does not change the Personal Health Number (PHN). However, the new BC Services Card are now being issued with the goal of eventually replacing all existing CareCards by 2018. The new cards have enhanced security features to help protect personal information. The new cards can be processed by an ICBC driver licensing office or ServiceBC can be contacted toll free at: 1.800.663.7867 for an alternate approach. For more information about the BC Services Card, please visit www.gov.bc.ca/bcservicescard

Q) I received an ambulance and hospital bill for medical care incurred in the United States and, unfortunately, I did not buy the supplemental coverage for travel outside of Canada. Can FNHA Health Benefits assist in paying?

A) No, FNHA Health Benefits will not cover supplemental coverage. You may want to contact the Ministry of Health Services out-of-country claims department to discuss any other coverage you may have through the BC medical plan.

Q) Are chiropractic, massage therapy, naturopathy, physical therapy and podiatry services covered through MSP or FNHA Health Benefits?

A) These services are not generally covered through MSP. There is an exception for clients whose premiums are being paid by FNHA. MSP pays a set amount per visit for a combined annual limit of 10 visits each calendar year for the following services: chiropractic, massage therapy, naturopathy, physical therapy, and non-surgical podiatry. Clients should contact MSP to determine eligibility and the amount they will cover.

Q) Are there any exceptions for additional physical therapy, chiropractic or massage therapy, and can the user fees be reimbursed by FNHA Health Benefits?

A) No, FNHA Health Benefits does not pay for these services and does not reimburse any user fees.

Q) Are removable air casts a benefit?

A) Air casts for the treatment of injuries such as sprains or broken bones are not a benefit under FNHA Health Benefits. Treatment of these conditions is usually provided by a hospital as a provincially insured service (i.e. plaster casts). Removable air casts may be considered as an exception with appropriate justification, such as diagnosis and treatment of Diabetic Plantar Neuropathic / Ischaemic foot ulcers.

PHARMACY BENEFITS

Q) I have been prescribed a drug by my physician and the pharmacy has told me that it is not covered through FNHA Health Benefits. Why?

A) FNHA Health Benefits has a comprehensive Drug Benefit List to which the pharmacy has access. In most cases the drugs prescribed are on the list and the pharmacist can dispense them immediately; however, some drugs prescribed need prior approval and must go through the Drug Exception Centre (DEC). These are considered exceptions. Once the pharmacist initiates an exception and it has been denied by the Drug Exception Center, then the FNHA client may appeal the decision. Some drugs are excluded from the drug benefit list and are not subject to the appeal process.

DENTAL BENEFITS

Q) My dentist is charging me for treatment. Why?

A) FNHA Health Benefits Dental program has its own fee schedule, which may not cover all the fees charged by the provider. Any charges exceeding FNHA Health Benefits fees are not eligible for reimbursement. Please confirm with your provider what, if any, your financial responsibility is prior to receiving treatment.

Q) Why does my dental provider have to send in a request before performing some services?

A) Predetermination, or prior approval, is common to most public and private dental plans. The predetermination process ensures that both the dental provider and FNHA client are informed of the policies and understand the coverage commitments. Clients must meet all of the clinical criteria and guidelines established by FNHA Health Benefits for the dental treatment to be considered for coverage.

Q) My dentist informed me that treatment was not approved. Why?

A) FNHA Health Benefits evaluates all dental predeterminations against its Dental Framework which outlines the types of benefits available to clients and their coverage criteria. To provide coverage, all established policies, guidelines and criteria must be met.

Contact Information

General

Toll-Free: 1.855.550.5454
Email: healthbenefits@fnha.ca

Operations (Claim Specific)

Dental
Medical Supplies & Equipment
Medical Transportation
Mental Health Crisis Intervention
MSP Coverage
Pharmacy
Vision

Toll-Free: 1.800.317.7878
Dental Toll-Free: 1.888.321.5003
Fax: 1.888.299.9222
Please have your Status card and CareCard ready

In-person Inquiries

1166 Alberni Street, Room 701
Vancouver, BC V6E 3Z3

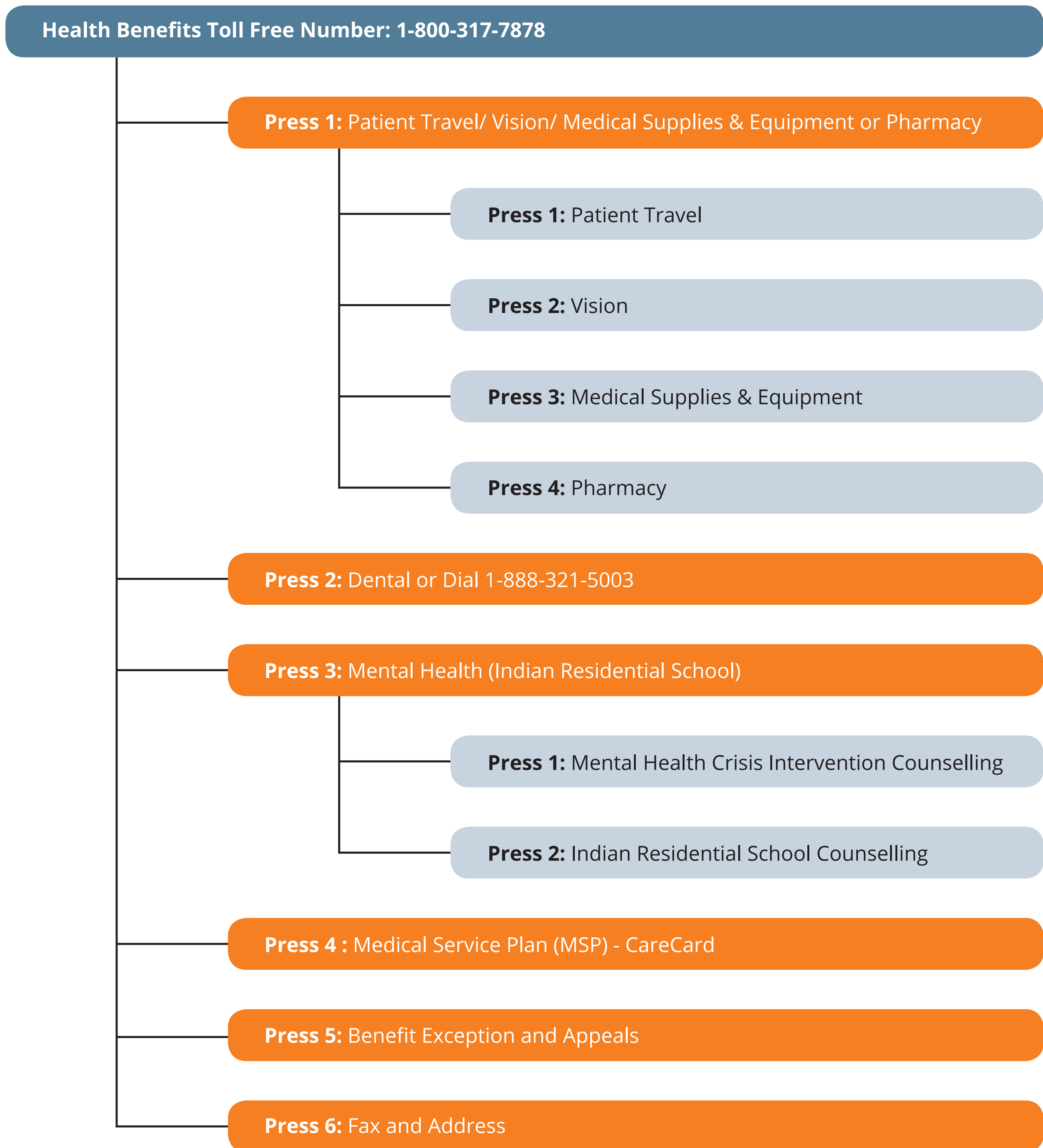
Mailing Address

First Nations Health Authority
Health Benefits Program - Client Services
540 - 757 West Hastings Street
Vancouver, BC V6C 1A1

Online

www.fnha.ca/**benefits**

Health Benefits Operations Toll-Free Number Tree Map



First Nations Health Authority Health Benefits Contact Information

General

Toll-Free: 1.855.550.5454
Email: healthbenefits@fnha.ca

Operations (Claim Specific)

Dental
Medical Supplies & Equipment
Medical Transportation
Mental Health Crisis Intervention
MSP Coverage
Pharmacy
Vision

Toll-Free: 1.800.317.7878
Dental Toll-Free: 1.888.321.5003
Fax: 1.888.299.9222
Please have your Status card and CareCard ready

In-person Inquiries

1166 Alberni Street, Room 701
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Health through wellness