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Dental Benefits Guide

Non-Insured Health Benefits Program
May 2015

Canada

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This guide provides information on the Health Canada Non-Insured Health Benefits (NIHB) Program and its policies relevant to dental providers and clients. It explains the extent and limitations of the NIHB Program's dental benefits by describing the important elements of each associated policy. It also lists website addresses to provide dental providers and clients quick access to related forms and more detailed Program information. The guide is intended to supplement the information contained in the Dental Claims Submission Kit (http://www.provider.esicanada.ca/dentists.html) which explains the process for dental providers to submit claims for payment of services rendered to eligible First Nations and Inuit clients.

1.0 Introduction

The NIHB Program provides eligible First Nations and Inuit with 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.

The benefits provided under the NIHB Program include prescription drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health services, and medical transportation to access medical services not available on-reserve or in the community of residence.

1.1 NIHB Program Dental Benefits

The NIHB Program's dental benefit covers dental services, including: diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral surgery, orthodontic and adjunctive services.

The individual services are contained in the NIHB Regional Dental Benefit Grid and are based on the Canadian Dental Association (CDA) Uniform System of Coding & List of Services, Association des chirurgiens dentistes du Québec (ACDQ) Fee Guide, Fédération des dentistes spécialistes du Québec (FDSQ) Fee Guide, and Denturist Association of Canada (DAC) Procedure Codes Guide.

Terms and conditions for coverage are detailed in section 3.0 of this guide.

1.2 Purpose of the Guide

The *Dental Benefits Guide* summarizes the terms and conditions, criteria, guidelines and policies under which the NIHB Program covers dental services provided to eligible First Nations and Inuit clients.

As policies and procedures evolve, the guide is updated accordingly and dental providers are advised of these changes through the Program's newsletters and other communication tools (such as fax, mail outs).

Dental providers are advised to read and retain the most current version of the guide to ensure continued compliance with their NIHB provider enrollment. In the event of a contradiction between document versions, the provisions of the Health Canada web-posted guide, along with the latest NIHB dental publications and regional dental grids, will prevail.

2.0 General Principles

2.1 The *NIHB Dental Benefits Guide* applies to the coverage of dental benefits by the NIHB Dental Predetermination Centre 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 coverage of dental benefits to eligible clients.

2.2 Dental benefits are covered in accordance with the mandate of the NIHB Program. NIHB clients do not pay deductibles or co-payments. The NIHB Program encourages dental providers to bill the Program directly and not to balance-bill clients so that clients do not face charges at the point of service.

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

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

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

2.6 Some dental services are not covered under the NIHB Program, (e.g. extensive rehabilitation and cosmetic treatment). These services are defined as exclusions and cannot be considered for appeal.

2.7 Consistent with the NIHB Program policies for all benefits, the Program does not cover any dental procedures related to non-eligible dental services, nor does it cover dental procedures related to a dental service reviewed by the Program where it did not meet the established policies, guidelines and criteria.

2.8 Dental benefits must be provided by a NIHB recognized dental provider, i.e. a dentist, dental specialist or denturist, who is licensed, authorized, and in good standing with the regulatory body of the province/territory in which they practice. They may provide eligible clients with medically necessary NIHB eligible dental services, provided that the services are rendered within NIHB Program policies, guidelines and criteria, frequency limitations and predetermination requirements.

2.9 When claiming for services, it is the dental provider’s responsibility to:

a. verify the eligibility of the client;
b. ensure that no limitations will be exceeded; and
c. ensure compliance with NIHB coverage criteria, guidelines and policies.

3.0 Terms and Conditions

To be eligible for payment of services rendered, dental providers must adhere to the terms and conditions of the NIHB Program. These are detailed within in the Dental Claims Submission Kit (http://www.provider.esicanada.ca/dentists.html), including the procedures for verifying client eligibility and submitting NIHB benefit claims.

Dental providers are to assist NIHB clients in completing and submitting claim forms for client reimbursements. All mandatory data elements, such as, but not limited to, supporting documents, tooth charting, tooth number, procedure code, date of service (DOS), client identification, client address, band number and/or family number and date of birth, must be completed on claim forms; provider and client (parent/legal guardian) signatures are mandatory.

4.0 Payment and Reimbursement

Dental providers are encouraged to bill the NIHB Program directly so that clients do not face charges at the point of service.

To be considered for payment/reimbursement, claims must be submitted to NIHB within one year from the date on which the service was provided. In addition, the service must be an eligible benefit under the Program and all NIHB policies and requirements for coverage apply. This applies to payments to NIHB enrolled dental providers for services rendered, and reimbursements to clients who have paid fees directly to a NIHB recognized dental provider for services.

All requests for client reimbursement of eligible benefits must include:

- Original receipt(s) for proof of payment;
- **NIHB Client Reimbursement Request Form** completed and signed; and
- **ONE** of the following:
    - Association des Chirurgiens Dentistes du Québec (ACDQ) Dental Claim and Treatment Plan Form;
    - Standard Dental Claim Form; or
    - Canadian Association of Orthodontics Information Form.

OR

- Original receipt(s) for proof of payment; and
- **NIHB Dental Claim Form (Dent-29)** completed and signed.

If applicable, a detailed statement or Explanation of Benefits (EOB) from all other health plan(s)/program(s) must be provided.

Note: Credit card/ debit (Interac) slips are not acceptable forms for proof of payment of original receipts. Original receipts are not required when they have been submitted first to the other health plan(s)/ program(s), and the detailed statement or EOB from them is attached along with a copy of the original receipt.

Claims submitted for clients who no longer have coverage with a third party must be supported with a letter from a client or the provider on behalf of the client, confirming that primary coverage does not exists.

Quick Link
NIHB Client Reimbursement Request Form
http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/form_reimburse-rembourse-eng.php
NIHB Dental Claim Form (Dent-29)
http://www.provider.express-scripts.ca/dentists.html

4.1 Coordination of Benefits

Clients are required to access any public or private health or provincial/territorial programs for which they are eligible prior to accessing the NIHB Program. 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 or benefits plan first. The other payer will provide an EOB form that must be send to NIHB. The NIHB Program will then coordinate payment with the other payer on eligible benefits.

4.2 Laboratory Fee Submission

Dental services requiring laboratory work must be submitted for predetermination. Laboratory fee submissions may be considered for coverage under the NIHB Program only in conjunction with an approved procedure code. However, Health Canada reserves the right to adjust the laboratory fee requested by dental providers.

5.0 Privacy

The NIHB Program of Health Canada is committed to protecting an individual's privacy and safeguarding the personal information in its possession.

When a benefit request is received, the NIHB Program collects, uses, discloses and retains an individual's personal information according to the applicable federal privacy legislation. The information collected is limited only to information needed for the NIHB Program to administer and verify benefit eligibility.

As a program of the federal government, NIHB must comply with the *Privacy Act*, the *Charter of Rights and Freedoms*, the *Access to Information Act*, Treasury Board policies and guidelines including, the Treasury Board of Canada Government Security Policy, and the Health Canada Security Policy.

6.0 Definitions

Exceptions: These are dental procedures that are outside the NIHB Program scope of benefits or procedures that require special consideration. Requests must be supported with a rationale and predetermination is mandatory.

Exclusions: These are dental procedures that are outside the mandate of the NIHB Program and will not be considered for coverage nor considered for appeal, such as but not limited to: fixed prosthodontics, implants and all implant related procedures, veneers, cosmetic services, ridge augmentation, and appliances to treat bruxism and snoring/sleep apnea.

Frequency Limitation: Limitations put against procedure codes so maximums are not exceeded, as specified in the current NIHB Regional Dental Benefit Grid and in the present *Dental Benefits Guide*.

Predetermination (PD): Predetermination is a method for the administration and adjudication of dental benefits. Predetermination is seeking review prior to proceeding with treatment and enables both the dental provider and client to understand the coverage commitments.

Post-determination (post-approval): Post-determination is a method for the administration and adjudication of dental benefits for service which has been rendered. This is a submission that may be considered for coverage under specific circumstances under the NIHB Program and must be supported with a rationale.

Appeal Process: This is a client-initiated process seeking reconsideration of a denied request under the NIHB Program. Please note that exclusions are not considered for appeal.

NIHB Dental Provider: Licensed and authorized dental professional enrolled with the NIHB Program.

Current Radiograph: Radiographs that are dated within one year (i.e. the last twelve months) of the submission.

7.0 Submission Requirements

The NIHB Program requires the following standard documentation and information for the review of any predetermination and post-determination (post-approval) request:

- Predetermination/post-determination request on one of the following forms: Standard Dental Claim Form, ACDQ Dental Claim and Treatment Form, computer generated form, or NIHB Dental Claim Form (Dent-29).

- Comprehensive treatment plan from the treating and/or referring dentist/specialist, indicating all completed treatment **and** pending treatment needs including restorative, periodontal, prosthodontic, endodontic, orthodontic and surgical services.

- Current conventional or digital radiographs (within last twelve months):
    a. Periapical and bitewing radiographs:
        - must be of good diagnostic quality (i.e., size, resolution, contrast); and
        - must be mounted and labelled with the date of service, client name and provider name.
    b. A panoramic radiograph may be submitted in addition to, but not in place of bitewing and periapical radiographs.

  Please note: if duplicate radiographs are submitted they must identify the right or left side of the client's mouth.

  When submitting enlarged digital radiographs, of any type, dental providers are requested to print a measurement scale on the radiograph to facilitate the assessment.

- Notation of all missing teeth.

- Periodontal charting, and/or Periodontal Screening and Recording (PSR), and/or Periodontal assessment.

- Periodontal tooth specific measurements (6 sites/tooth), where applicable. Please refer to the appropriate policy in this guide.

- All pertinent clinical findings/notes supporting the predetermination request.

- At Health Canada's request, other documentation may be required.

Please note: It is mandatory for dental providers to maintain a client chart/record documenting and supporting the services provided, claimed and paid by the NIHB Program. A procedure code and/or name are not sufficient as a client record to support payment. This statement applies to all claim requests under the NIHB Program (including predetermination and post-determination claims supported with a predetermination number).

8.0 NIHB Dental Procedures

8.1 Diagnostic Services

8.1.1 Examinations

Clients under seventeen (17) years of age are eligible for up to four (4) examinations and those seventeen (17) and older are eligible for up to three (3) examinations in any twelve (12) month period as long as these examinations are within their frequency limitations and are provided by any legally licensed dental professional.

These examinations can include:

- Examination and Diagnosis Complete;
- Examination and Diagnosis Limited, New Patient;
- Examination and Diagnosis Recall;
- Examination and Diagnosis Specific or Examination and Diagnosis Emergency.

Frequency limitations take into account overall interaction between various examination services rendered by same provider, different providers within the same office or different office, and their eligibility period.

Dental specialists and denturists examinations do not count against the eligible annual maximum examinations allowable.

Frequency Guidelines for Examinations

Dental Procedure	Frequency Guidelines
Complete Oral Examination and Diagnosis	1 in any 60 months When a Complete Examination is provided, it replaces the Recall Examination and the New Patient Limited Examination for the respective eligible period.
New Patient Limited	1 in a lifetime, with same provider or different provider in the same office 1 in any 12 months, with different provider in a different office.
Recall Examination	Age 17+: 1 in any 12 months; under age 17: 1 in any 6 months.
Specific or Emergency Examinations	1 in any 12 months.
Specialist Examinations and Diagnosis – Complete (require PD)	1 in any 60 months per specialty (with GP referral and justification for the referral). When a Specialist Complete Examination is adjudicated, it eliminates Specialist Limited Examination within the same specialty in that twelve (12) month period.

Specialist Examination and Diagnosis - Limited	1 in any 12 months/ specialty (with GP referral and justification for the referral).

8.1.2 Radiographs

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

Radiographs are considered "current" for predetermination if dated within one year of PD submission.

When submitting enlarged digital radiographs, of any type, dental providers are requested to print a measurement scale on the radiograph to facilitate the assessment.

Frequency Guidelines for Radiographs

Dental Procedure	Frequency Guidelines
Intraoral, Complete Series	1 in any 60 months Not to be covered in conjunction with a panoramic radiograph for the time period (60 months).
Intraoral (1-6 films)	6 in any 12 months
Panoramic	1 in any 120 months; up to 2 in a lifetime Not to be covered in conjunction with a complete series for the time period (60 months).

8.1.3 Laboratory tests, analysis

When submitting requests for coverage of laboratory tests/analysis, a copy of the laboratory report is required.

8.2 Preventive Services

For preventive services including polishing, scaling, fluoride treatments, pit and fissure sealants/preventive restorative resin services, please refer the Preventive and Periodontal Policy, which can be found in section 8.5 Periodontal Services.

Frequency Guidelines for Interproximal Disking of Teeth

Dental Procedure	Frequency Guidelines
Interproximal Disking of Teeth (requires PD)	1 unit in any 12 months.

8.3 Restorative Services

Repeat restorations/extensions for the same tooth performed by the same provider or different provider in the same office, excluding a core or crown, within a two (2) year time frame is subject to audit and requires a written rationale documented in the clients chart on date of service delivery.

8.3.1 Restorations, Primary Teeth

Requirements for restoration of primary incisors teeth 51, 52, 61, 62, 71, 72, 81, 82**:**

- Clients under the age of five.
- Tooth is eligible once (1) in any 12-month period by the same provider, or different provider in the same office.
- No combination of procedure codes/surfaces/classes involving, or not, distinct claim lines for the same tooth, should exceed in one visit the cost applicable to the collective number of procedure code/surfaces/classes restored, up to a maximum cost of a polycarbonate crown (the lesser amount to be paid).
- When both composite and amalgam procedure codes are billed on the same tooth, the system will pay at the cost of the lesser amount up to a maximum cost of a polycarbonate crown (the lesser amount to be paid).
- Bonded amalgams are covered at the rate of a non-bonded equivalent.

Requirements for restoration of primary teeth 53, 54, 55, 63, 64, 65, 73, 74, 75, 83, 84, 85**:**

- Tooth is eligible once (1) in any 12-month period by the same provider, or different provider in the same office.
- No combination of procedure codes/surfaces/classes involving, or not, distinct claim lines for the same tooth, should exceed in one visit the cost applicable to the collective number of procedure code/surfaces/classes restored, up to a maximum cost of a stainless steel crown (SS) (the lesser amount to be paid).
- When both composite and amalgam procedure codes are billed on the same tooth, the system will pay at the cost of the lesser amount up to a maximum cost of a SS (the lesser amount to be paid).
- Bonded amalgams are covered at the rate of a non-bonded equivalent.

8.3.2 Restorations, Permanent Teeth

Requirements for restoration of permanent anterior and posterior teeth:

- Tooth is eligible once (1) in any 12-month period by the same provider, or different provider in the same office.
- No combination of procedure codes/surfaces/classes involving, or not, distinct claim lines for the same tooth, should exceed in one visit the cost applicable to the collective number of distinct surfaces restored, up to a maximum cost of a five surface restoration/complete tooth reconstruction (the lesser amount to be paid).
- When both composite and amalgam procedure codes are billed on the same tooth, the system will pay at the cost of the lesser amount up to a maximum cost of an amalgam five surface restoration/complete tooth reconstruction (the lesser amount to be paid).
- Bonded amalgams are covered at a rate of a non-bonded equivalent.

8.3.3 Caries, Trauma and Pain Control

Caries, trauma and pain control procedures will not be considered for coverage in conjunction with any of the following procedures: restorations, open and drain, pulpectomy, pulpotomy or root canal, if requested with the same date of service and for the same tooth.

Frequency Guidelines for Caries, Trauma and Pain Control

Dental Procedure	Frequency Guidelines
Caries, Trauma and Pain Control	Maximum two (2) teeth in a lifetime, as an emergency.

8.3.4 Cores and Posts

Cores are eligible **only** if the existing restoration is greater than twelve (12) months old, and may be considered for coverage **only** in conjunction with an approved predetermination crown request.

Bonded amalgam cores are covered at a rate of a non-bonded equivalent.

A prefabricated post/pin is eligible only when inadequate coronal tooth structure is remaining to retain a restoration.

Prefabricated posts in combination with core, including pin(s) where applicable, may be considered for coverage **only** in conjunction with an approved predetermination crown request. When a prefabricated post, pin(s), and a core procedure codes are requested individually for the same tooth for a crown, the Program will adjust the fee at the rate of the combination procedure code.

Cores, and prefabricated posts in combination with cores, are eligible only for clients 18 years of age and older.

Frequency Guidelines for Cores and Posts

Dental Procedure	Frequency Guidelines
Cores (require PD)	1 in any 36 months per client (permanent teeth only).
Cores and Posts (require PD)	1 in any 36 months per client (permanent teeth only).
Post Removal	1 in a lifetime, per permanent tooth.

8.3.5 Crowns

Crown Policy

1.0 General Principles

- The Non-Insured Health Benefits Program (NIHB) will consider coverage for a crown when both the eligibility and restorability criteria have been met.
- All crowns require a predetermination.
- There is a frequency limitation of one (1) crown in any three (3) year period per client.
- Only single unit metal or porcelain-fused to metal crowns are eligible under the NIHB Program.
- Porcelain/ceramic crowns, including fortified/reinforced porcelain/ceramic crowns, are not a covered benefit under the NIHB Program (exclusions).
- All basic treatment addressing any existing active biological disease (caries and periodontal), must be completed before submitting requests for crowns.
- The NIHB Program will not consider coverage for a crown:
    - to improve aesthetics;
    - to treat sensitivity due to cracked tooth syndrome, erosion, abrasion or attrition;

- to treat stress fractures or chipping on teeth that have a minimal restoration or no restoration; and
- for high caries risk individuals or those with generalized moderate to severe periodontal disease when there is evidence of long-standing, uncontrolled and/or untreated rampant biological disease (either caries or periodontal disease)**.**

2.0 Predetermination Documentation Requirements for Crowns

The NIHB Program requires the following documentation for the review of a crown predetermination request:

- Predetermination request on one of the following forms: Standard Dental Claim Form, ACDQ Dental Claim and Treatment Form, computer generated form, or NIHB Dental Claim Form (Dent-29).

- Comprehensive treatment plan from the treating and/or referring dentist/specialist, indicating all completed treatment **and** pending treatment needs including restorative, periodontal, prosthodontic, endodontic, orthodontic and surgical services.

- Current conventional or digital radiographs (within last twelve months).
    a. Periapical and bitewing radiographs:
        - must be of good diagnostic quality (i.e., size, resolution, contrast); and
        - must be mounted and labelled with the date of service, client name and provider name.
    b. A *postoperative* periapical radiograph must be submitted for a tooth that has been endodontically treated in the last 12 months.
    c. A panoramic radiograph may be submitted in addition to, but not in place of bitewing and periapical radiographs.

  Please note: if duplicate radiographs are submitted they must identify the right or left side of the client's mouth.

  When submitting enlarged digital radiographs, of any type, dental providers are requested to print a measurement scale on the radiograph to facilitate the assessment.

- Notation of all missing teeth.

- Periodontal charting, and/or Periodontal Screening and Recording (PSR), and/or Periodontal assessment.

- Periodontal measurements (6 sites/tooth) for the tooth/teeth under review.

- All pertinent clinical findings/notes supporting the predetermination request.

3.0 Tooth Eligibility

The NIHB Program will consider coverage of a single unit crown for:

- incisors, canines, bicuspids and first molars;
- second molars: may be considered for coverage where the first molar is missing and the second molar is in occlusion with a prosthetic or natural molar;
- clients 18 years of age and older; and
- eligible teeth, once per tooth in any eight (8) year period (96 months).

4.0 Tooth Restorability

The NIHB Program will consider coverage of a single unit crown on endodontically and non-endodontically treated teeth when **all** of the following criteria are met:

- Adequate periodontal support, based on alveolar bone levels (crown to root ratio of at least 1:1) visible on submitted radiographs with absence of furcation involvement;
- Absence of active periodontal disease;
- Adequate remaining non-diseased tooth structure to ensure that biologic width (3 mm) is maintained and adequate ferrule (1.5 mm) is achieved during restoration;
- An extensively restored tooth (more than four continuous surfaces), where the existing tooth structure can no longer support the direct restoration;
- A mesio-distal space (vertically and horizontally) equivalent to that of the natural tooth with no loss of space due to caries or crowding;
- A tooth that does not require any additional treatment such as crown lengthening, root re-sectioning or orthodontic treatment; and
- Endodontically treated teeth must be proven successful as demonstrated on a postoperative periapical radiograph showing that healing has occurred.

5.0 Non-Inserted Crown Policy

The NIHB Program may consider paying up to 20% of the current NIHB professional fee and 100% of the laboratory fee, if applicable, for non-inserted crowns under the following conditions:

- The crown has been completed but not inserted due to circumstances beyond the control of the dental provider;
- The provider has made substantial efforts to contact the client to schedule an insertion appointment; and
- The provider has communicated the details of the situation in writing to the NIHB Dental Predetermination Centre.

Please note: A non-inserted crown that has been claimed and paid in full, without complying with the above noted conditions, will result in recovery.

Frequency Guidelines for Crowns

Dental Procedure	Frequency Guidelines
Crowns (require PD)	1 in any 36 months per client.
	1 per eligible tooth in any eight (8) year period (96 months).
Repair to Crowns	1 in any 36 months, per tooth.
Recementation of Crowns	1 in any 36 months, per tooth.

8.4 Endodontic Services

Important notice regarding the Endodontic Trial Project

The Endodontic Trial Project has been extended until March 31, 2016. The objective of the Endodontic Trial Project is to assess the merits, feasibility and the appropriateness of removing predetermination (PD) requirement for standard root canal treatment (RCT) procedures on bicuspids and first molars.

An Endodontic Trial Project Committee will continue to evaluate and assess randomly selected paid standard root canals against the current NIHB Endodontic Policy, guidelines and criteria.

The NIHB Program would like to remind providers that all claimed endodontic services must meet the current Endodontic Policy.

The general conditions applying to the Endodontic Trial Project extension period include:

- No predetermination required for standard root canal treatment procedure codes on permanent bicuspids and first molars. Predetermination is required for second and third molars at all times.

    - 33111, 33121, 33131, 33141
    - **Québec** : 33100, 33200, 33300, 33400, 33475, 33111 EN, 33121 EN, 33131 EN, 33141 EN, 33150 PA, 33160 PA, 33170 PA, 33180 PA

- Frequency limitation of three (3) standard root canal procedures in 36 months for all teeth. Once the frequency has been reached, subsequent standard root canal procedures will require predetermination.

- The NIHB Program will continue to conduct samplings of randomly selected paid standard root canals which will be assessed against the current NIHB Endodontic Policy. All supporting documentation must be submitted upon request, otherwise subject to payment reversal.

- Non-compliant cases are subject to payment reversal for services performed after November 1, 2013.

- While assessing predetermination submissions for other dental services (e.g. crowns), any paid standard RCT observed in the supporting documentation provided, claimed without a PD and determined non-compliant will be subject to payment reversal.

- For recurrent non-compliant providers the NIHB Program will reinstate PD requirement.

- The NIHB Program will be responsible to communicate directly with treating providers on behalf of the Endodontic Trial Project Committee the results of all cases reviewed.

- Providers can choose to continue to submit a PD request to the NIHB Dental Predetermination Centre (DPC) where the submission will be reviewed against the NIHB Endodontic Policy.

NIHB DPC maintains the right to request supporting documentation for paid endodontic cases not supported with a predetermination, which will be reviewed against the NIHB Endodontic Policy. Cases that do not meet the endodontic policy may result in payment reversal.

Endodontic Policy

1.0 General Principles

- Predetermination **is required** for root canal treatment (RCT) on premolars and molars. For the duration of the trial project, *bicuspids and first molars do not require predetermination*. However, second and third molars continue to require predetermination as per the endodontic policy.

- Predetermination **is not required** for RCT on anterior teeth (13 - 23, and 33 - 43 inclusive); however the NIHB Program reserves the right to request preoperative records to ensure compliance with the endodontic policy**.**

- There is a frequency limitation of three (3) standard RCT procedures in 36 months *for all teeth*. Once the frequency has been reached, subsequent standard RCT procedures require a predetermination.

- The NIHB Program will consider coverage for a RCT when both the eligibility and restorability criteria have been met and the need of the requested treatment for the health of the client is evident and supported in the documentation submitted.
- The NIHB Program will not consider coverage for a RCT for high caries risk individuals or those with generalized moderate to severe periodontal disease when there is evidence of long-standing, uncontrolled and/or untreated rampant biological disease (either caries or periodontal disease)**.**

2.0 Predetermination Documentation Requirements for Root Canal Treatment

The NIHB Program requires the following documentation for the review of a root canal treatment predetermination request:

- Predetermination request on one of the following forms: Standard Dental Claim Form, ACDQ Dental Claim and Treatment Form, computer generated form, or NIHB Dental Claim Form (Dent-29).

- Comprehensive treatment plan from the treating and/or referring dentist /specialist indicating all completed treatment **and** pending treatment needs including restorative, periodontal, prosthodontic, endodontic, orthodontic and surgical services.

- Current conventional or digital radiographs (within last twelve months).
    a. Periapical and bitewing radiographs:
        - must be of good diagnostic quality (i.e., size, resolution, contrast); and
        - must be mounted and labelled with the date of service, client name and provider name.
    b. A panoramic radiograph may be submitted in addition to, but not in place of bitewing and periapical radiographs.

  Please note: if duplicate radiographs are submitted they must identify the right or left side of the client's mouth.

  When submitting enlarged digital radiographs, of any type, dental providers are requested to print a measurement scale on the radiograph to facilitate the assessment.

- Notation of all missing teeth.

- Periodontal charting, and/or Periodontal Screening and Recording (PSR), and/or Periodontal assessment.

- Periodontal measurements (6 sites/tooth) for the tooth/teeth under review.

- All pertinent clinical findings/notes supporting the predetermination request.

3.0 Tooth Eligibility

The NIHB Program will consider coverage of an RCT on:

- incisors, canines, bicuspids and first molars; and
- second molars: may be considered for coverage where the first molar is missing and the second molar is in occlusion with a prosthetic or natural molar.

4.0 Tooth Restorability

The NIHB Program will consider coverage of an RCT when **all** of the following criteria are met:

- Adequate periodontal support, based on alveolar bone levels (crown to root ratio of at least 1:1) visible on submitted radiographs with absence of furcation involvement;
- Absence of active periodontal disease;
- Adequate remaining non-diseased tooth structure to ensure that biologic width (3 mm) can be maintained during restoration;
- A mesio-distal space (vertically and horizontally) equivalent to that of the natural tooth with no loss of space due to caries or crowding; and
- A tooth that does not require any additional dental treatment such as crown lengthening, root resectioning or orthodontic treatment.

Please note:

- Incomplete approved RCT requests will be paid to the equivalent of a pulpectomy**.**
- The final fee for a RCT includes the cost associated with a pulpectomy/pulpotomy and open and drain within the three month period prior to the completion of the RCT, when performed by the same provider/ same office.
- The final fee for a RCT or pulpectomy/pulpotomy includes the fee for the temporary restoration and its replacement if required.
- Coverage for pulpectomy/pulpotomy is once (1) per tooth/per lifetime.

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

Frequency Guidelines for Root Canal Therapy

Dental Procedure	Frequency Guidelines
Root Canal Therapy	3 (standard RCTs) in any 36 months for all teeth.

8.5 Periodontal Services

Preventive and Periodontal Policy

1.0 General Principles

- Predetermination (PD) is not required for scaling and root planing services up to the annual maximum allowable units; for any additional units, predetermination is required. Please refer to Table 1.1.1.

- Predetermination requests must be supported with all items listed in the **Predetermination Documentation Requirements for Preventive and Periodontal Services** (Section 1.2.3).

- All preventive and periodontal procedures claimed must be supported with proper, clear, and detailed documentation for verification against the Non-Insured Health Benefits (NIHB) Program's terms and conditions. A procedure code or procedure name is not sufficient in a client record to support payment.

1.1 Preventive Services

1.1.1 Polishing, Fluoride Treatment, Scaling and Root Planing

Age	0-11 years	12-16 years	17+ years
Recall Exam Annual Maximum*	1 in any 6 month period	1 in any 6 month period	1 in any 12 month period
Polishing Annual Maximum	1 time in any 6 month period	1 time in any 6 month period	1 time in any 12 month period
Fluoride Annual Maximum	1 treatment in any 6 month period	1 treatment in any 6 month period	Not covered
Scaling in combination with Root Planing Annual Maximum (no PD)	0.5 unit in any 6 month period	1 unit in any 6 month period	4 units in any 12 month period

* Please refer to 8.1. Diagnostic Services section for frequency guidelines.

1.1.2 Sealants and Preventive Resin Restorations

- Clients under the age of fourteen (14) are covered for sealants and preventive resin restorations on the occlusal surface of permanent molar teeth (16, 26, 36, 46, 17, 27, 37, 47) and on the lingual surface of permanent maxillary incisor teeth (11, 12, 21, 22) where surfaces are unrestored.

1.2 Periodontal Services

1.2.1 Scaling and Root Planing (additional units)

- A predetermination is required for the NIHB Program to consider coverage for additional units of scaling and root planing in any 12 month period over the maximum allowable units covered without a predetermination. Please refer to Table 1.1.1.

- Eligibility for additional units of scaling and root planing will be based on several factors including, but not limited to:
    - The severity of periodontal disease based on current (within the last 12 months) clinical notes, diagnosis and prognosis, complete periodontal charting, and radiographs;
    - Comprehensive treatment plan addressing all client oral health needs;
    - The date of the last visit for periodontal and preventive services;
    - The regularity and compliance of periodontal maintenance; and
    - Medical condition relative to periodontal diseases including any prescribed medication.

1.2.2 Surgical Services

- Periodontal surgeries are **not** eligible services under the NIHB Program, however certain surgeries may be considered for coverage on an exception basis (PD required):
    - Gingivoplasties/gingivectomies for the treatment of drug-induced gingival hyperplasia that is unresponsive to non-surgical periodontal therapy; and
    - Gingival grafts for the treatment of gingival recession leading to minimally attached/keratinized gingiva on a tooth that is a critical abutment for a removable

prosthesis.
Note: Coverage for gingival grafts on teeth that show chronic periodontal disease or to improve esthetics will not be considered.

1.2.3 Predetermination Documentation Requirements for Preventive and Periodontal Services

The NIHB Program requires the following documentation for the review of a preventive/periodontal service predetermination request:

- Predetermination request on one of the following forms: Standard Dental Claim Form, ACDQ Dental Claim and Treatment Form, computer generated form, or NIHB Dental Claim Form (Dent-29).

- Comprehensive treatment plan from the treating and/or referring dentist/specialist, indicating all completed treatment **and** pending treatment needs including restorative, periodontal, prosthodontic, endodontic, orthodontic, and surgical services.

- Current conventional or digital radiographs (within the last twelve months).
    a. Periapical and bitewing radiographs:
        - must be of good diagnostic quality (e.g., size, resolution, contrast); and
        - must be mounted and labeled with the date of service, client name, and provider name.
    b. A panoramic radiograph may be submitted in addition to, but not in place of bitewing and periapical radiographs.

  Please note: If duplicate radiographs are submitted, they must identify the right or left side of the client's mouth.

  When submitting enlarged digital radiographs, of any type, dental providers are requested to print a measurement scale on the radiograph to facilitate the assessment.

- Periodontal charting with information regarding:
    - Missing teeth;
    - Probing depths (6 sites/tooth);
    - Recession;
    - Area of minimal attached gingiva;
    - Mobility;
    - Bleeding on probing, suppuration;
    - Plaque (generalized/localized, minimal/moderate/abundant);
    - Calculus (generalized/localized, minimal/moderate/abundant);
    - Furcation; and
    - Abscess/fistula.

- Periodontal diagnosis and prognosis.

- All pertinent clinical findings/notes supporting the predetermination request.

Frequency Guidelines for the Management of Oral Disease

Dental Procedure	Frequency Guidelines
Management of Oral Disease (require PD)	Eligible once (1) in any twelve (12) month period.

8.6 Removable Prosthodontic Services

Removable Prosthodontic Policy

1.0 General Principles

- Predetermination is required for complete and partial dentures.
- Complete and partial dentures supported by implants along with all implant related procedures are *not* a covered benefit under the Non-Insured Health Benefits (NIHB) Program (exclusions).
- The fee for dentures includes three (3) months post-insertion care including adjustments and modifications. NIHB does not cover *any* other denture-related procedures during this period.
- The fee for immediate dentures includes the tissue conditioner, but not the processed reline/rebase.
- The overall cost of replacement for a denture may be adjusted in situations where the client's history shows that claims for reline/rebase were paid within three months prior to the request.

2.0 Removable Partial Dentures

2.1 General Principles

Removable partial dentures are covered once in any eight (8) year period (96 months) per arch. Within this period, replacement with any type of removable denture (including complete dentures) may not be considered for coverage; however, they may be considered for modifications as per the needs of the client.

2.2 Predetermination Documentation Requirements for Partial Dentures

The NIHB Program requires the following documentation for the review of a partial denture predetermination request:

- Predetermination request on one of the following forms: Standard Dental Claim Form, ACDQ Dental Claim and Treatment Form, computer generated form, or NIHB Dental Claim Form (Dent-29).
- Comprehensive treatment plan from the treating and/or referring dentist/specialist indicating all completed treatment **and** pending treatment needs including restorative, periodontal, prosthodontic, endodontic, orthodontic and surgical services.
- Current conventional or digital radiographs (within last twelve months):
    a. Periapical radiographs of abutment teeth and bitewing radiographs:
        - must be of good diagnostic quality (i.e., size, resolution, contrast); and
        - must be mounted and labelled with the date of service, client name and provider name.
    b. A panoramic radiograph may be submitted in addition to, but not in place

of bitewing and periapical radiographs.

Please note: if duplicate radiographs are submitted they must identify the right or left side of the client's mouth.

When submitting enlarged digital radiographs, of any type, dental providers are requested to print a measurement scale on the radiograph to facilitate the assessment.

- Notation of all missing teeth.
- Periodontal charting, and/or Periodontal Screening and Recording (PSR), and/or Periodontal assessment.
- Periodontal measurements (6 sites/tooth) for all of the abutment teeth.
- All pertinent clinical findings/notes supporting the predetermination request.

Please note: At Health Canada's request, diagnostic models or other documentation may be required.

2.3 Eligibility

The NIHB Program will consider coverage for a partial denture for teeth numbered 16 to 26 and 36 to 46 inclusive, under the following conditions:

- **General conditions:**
  - All basic treatment must be completed including:
    - control of caries and of periodontal and periapical disease for all teeth; and
    - restoration of major structural defects in the abutment teeth;
  - The space to be replaced is greater than or equal to the corresponding natural teeth (vertically and horizontally);
  - All abutment teeth must have:
    - adequate periodontal support, based on alveolar bone levels (crown to root ratio of at least 1:1) visible on submitted radiographs; and
    - absence of active periodontal disease; and
  - If there is an existing partial denture, it must be at least eight (8) years old.

  Please note: If there is evidence of periodontal disease, the NIHB Program will not consider coverage for a cast partial denture. However, in such situations, the Program may consider coverage for an acrylic partial denture.

- **Specific conditions:**
  - There must be *one or more* missing teeth in the anterior sextant; or
  - There must be *two or more* missing posterior teeth in a quadrant excluding second and third molars.

3.0 Complete Dentures

3.1 General Principles

- Complete dentures are covered once in any eight (8) year period per arch.

- For replacement of a standard complete denture that is at least eight (8) years old, dental providers have the option to fax their request directly to the NIHB Dental Predetermination Centre. Dental providers must confirm clients' eligibility with Express Scripts Canada before faxing the request. All requests must comply with current supporting documentation requirements.

3.2 Predetermination Documentation Requirements for Complete Dentures

The NIHB Program requires the following documentation for the review of a complete denture predetermination request:

- Predetermination request on one of the following forms: ~~Complete~~ Standard Dental Claim Form, ACDQ Dental Claim and Treatment Form, computer generated form, or NIHB Dental Claim Form (Dent-29).
- Notation of all missing teeth or planned extractions.
- Panoramic X-ray (if available).
- All pertinent clinical findings/notes supporting the predetermination request.

Please note: At Health Canada's request, diagnostic models or other documentation may be required.

3.3 Eligibility

The NIHB Program will consider coverage for a complete denture:

- For an initial placement; or
- For replacement of an *existing* complete denture that is at least eight (8) years old.

4.0 Non-Inserted Removable Prosthodontic Policy

4.1 Standard Partial Dentures and Complete Dentures

The NIHB Program may consider paying up to 20% of the current NIHB professional fee and 100% of the laboratory fee, if applicable, for non-inserted dentures under the following conditions:

- The denture has been completed but not inserted due to circumstances beyond the control of the dental provider;
- The provider has made substantial efforts to contact the client to schedule an insertion appointment; and
- The provider has communicated the details of the situation in writing to the NIHB Dental Predetermination Centre.

4.2 Immediate Dentures

The NIHB Program may consider paying up to 100% of the current NIHB professional fee and 100% of the laboratory fee, if applicable, for non-inserted *immediate* dentures under the following conditions:

- The provider who fabricated the immediate denture is different from the provider who was scheduled to do the extraction(s) and insertion;

- Substantial efforts have been made by *both* providers to contact the client to reschedule the missed extraction/insertion appointment; and
- The provider who fabricated the immediate denture has communicated the details of the situation in writing to the NIHB Dental Predetermination Centre.

Please note: A non-inserted denture (any type) that has been claimed and paid in full, without complying with the above noted conditions, will result in recovery.

Frequency Guidelines for Dentures

Dental Procedure	Frequency Guidelines
Complete/ Partial/ Immediate Dentures (require PD)	1 per arch in any 96 months.
Repairs/Additions	1 per prosthesis in any 12 months.
Reline/Rebase	1 per prosthesis in any 24 months.
Tissue Conditioning	1 per prosthesis in any 24 months.

8.7 Oral Surgery Services

Implants and ridge augmentation are exclusions under the NIHB Program.

Complicated, surgical extractions and major surgical procedures require predetermination and must be supported by clinical findings/notes and radiographs.

Complicated, surgical extraction requests may be submitted as post-determinations and must be supported by clinical findings/notes and radiographs in order to be considered for coverage.

8.8 Orthodontic Services

Orthodontic Policy

1.0 General Principles

- The Non-Insured Health Benefits (NIHB) Program provides coverage for a limited range of orthodontic services for eligible First Nations and Inuit clients when there is a **severe and functionally handicapping malocclusion**, as set out by the established clinical criteria, which are a combination of marked skeletal and dental discrepancies (see section 2.0).

- The NIHB Program covers three (3) types of orthodontic treatment:

    1. Comprehensive;
    2. Limited; and
    3. Interceptive.

- Clients are eligible for coverage for orthodontic services once in a lifetime.

- The overall cost of multiple phases of orthodontic treatment will not exceed the total fee of one comprehensive phase up to the maximum regional NIHB fee.

- Predetermination **is required for all** orthodontic services, with the exception of orthodontic examination and orthodontic diagnostic records.

- Predetermination requests must be supported with all items listed in the **Predetermination Documentation Requirements for Orthodontic Services** (see

section 3.0).

- The NIHB Program will consider coverage for orthodontic treatment when eligibility and clinical criteria have been met (see section 2.0).

- The NIHB Program reserves the right to deny coverage for an orthodontic treatment when client's current oral health condition is not adequate for orthodontic treatment.

- If in the treating provider's judgment, oral health is being compromised, or if there are non-compliance issues, the treating provider should discontinue treatment and advise NIHB in writing.

- The NIHB Program **will not consider** coverage for orthodontic services to address the following:

    - Facial esthetics;
    - Psychological conditions such as self-esteem; or
    - Temporomandibular disorders.

2.0 Client Eligibility and Clinical Criteria

- **Client Age Eligibility**

  Coverage for orthodontic services will be considered for the following categories:

    - Clients under 18 years of age;
    - Clients of any age with dentofacial anomalies such as cleft lip and palate.

- **Client Oral Health Status**

    - Client has been caries-free for a period of six (6) months prior to submitting the predetermination request; in other words, all basic dental treatment addressing any existing caries, must be completed six (6) months prior to submission;
    - Client has maintained a good oral hygiene for a period of six (6) months prior to submitting the predetermination request.

- **Clinical Criteria**

  To be eligible for coverage for orthodontic treatment, client's condition must have a combination of marked skeletal and dental discrepancies such as, but not limited to:

    - Crossbite associated with a significant and clear functional shift;
    - Severe overbite with evident soft tissue injury (> 2/3 overlap with impinging of the palate);
    - Severe open bite (≥ 5mm);
    - Severe overjet, positive (≥ 7mm) or negative (≤ -4mm).

3.0 Predetermination Documentation Requirements for Orthodontic Services

Important: Complete cases must be received by the NIHB Program prior to client's 18th birthday to be eligible for review.

The NIHB Program requires the following documentation for the review of a predetermination request:

- Predetermination request on one of the following completed forms:

    - Canadian Association of Orthodontist (CAO) Standard Orthodontic Information Form;
    - Standard Dental Claim Form;
    - Association des Chirurgiens Dentistes du Québec (ACDQ) Dental Claim and Treatment Plan Form;
    - Computer generated form; or
    - NIHB Dental Claim Form (DENT-29).

- Pre-treatment diagnostic records that must include the following:

    - Diagnostic orthodontic models (trimmed in **centric occlusion).** If a dental provider chooses to send photographs in place of diagnostic orthodontic models, a complete set of six (6) views is required for the review. However, the NIHB Program reserves the right to ask for diagnostic orthodontic models.
    - Cephalometric radiograph and tracing;
    - Photographs three (3) intraoral, three (3) extraoral; and
    - Panoramic radiograph.

    The radiographs and photographs must be of good diagnostic quality (i.e. size, resolution, and contrast). The radiographs must be mounted and labeled with the service date, client name and provider name. If duplicate radiographs are submitted, the right or left side of the client's mouth must be identified. When submitting enlarged digital radiographs, of any type, dental providers are requested to print a measurement scale on the radiograph to facilitate the assessment.

- Orthodontic treatment plan that must include the following:

    - Orthodontic diagnosis;
    - Overbite/Overjet measurements, where applicable;
    - Orthodontic prognosis;
    - Estimated duration of active and retentive phases of treatment; and
    - Requested treatment fees**.**

    Orthodontic treatment plan can be submitted on one of the following forms:

    - NIHB Orthodontic Summary Sheet;
    - CAO Standard Orthodontic Information Form; or
    - On the provider's letterhead.

- Written confirmation on client's oral health status from the general practitioner.

8.9 Adjunctive Services

8.9.1 Sedation and General Anaesthesia Policy

1.0 General Principles

- All 90000 series codes, which include sedation, general anaesthesia and/or facility fees, require predetermination.

- The Non-Insured Health Benefits (NIHB) Program provides coverage for the following 90000 related services (including facilities, where applicable):

    - Deep sedation and general anaesthesia;
    - Moderate sedation:
        a. parenteral conscious sedation (intravenous and/or intramuscular);
        b. combined technique of inhalation plus intravenous and/or intramuscular injection; and
        c. nitrous oxide with oral sedation (multiple sedative drugs);

    - Minimal sedation:
        a. oral sedation;
        b. nitrous oxide; and
        c. nitrous oxide with oral sedation (single sedative drug).

- All sedation codes include the cost of sedation medication**.**

- Providers must adhere to the conditions of licensing, certification, accreditation and registration as per provincial/territorial and/or dental regulations to submit a claim to the NIHB Program.

- If provinces/territories provide and cover general anaesthesia and deep sedation for dental services to residents at no charge through their provincial/territorial health care insurance plan, social programs, publicly funded programs, *NIHB will not cover these benefits provided in any facility*. Clients under the NIHB Program will be expected to access these dental services through their provincial/territorial health care insurance plan, social program, publicly funded program or private insurance plan.

1.1 Utilization of Private Facilities

- NIHB will not provide coverage for the use of private facilities if the client has coverage for this under their private insurance plan, provincial/territorial health care insurance plan, social program or other publicly funded program**.** *If clients choose to use a private facility, they will be responsible for the costs incurred.*

- The NIHB Program may consider coverage for the use of a private facility on an exception basis, subject to the Program criteria and guidelines and unique regional, provincial/territorial circumstances. If NIHB is to assume any financial costs, *predetermination must be obtained prior to the dental services being rendered*.

2.0 Predetermination Documentation Requirements for Sedation and General Anaesthesia

The NIHB Program requires the following documentation for the review of a sedation/general anaesthesia predetermination request:

- Predetermination request on one of the following forms: Standard Dental Claim Form, ACDQ Dental Claim and Treatment Form, computer generated form, or NIHB Dental Claim Form (Dent-29).

- Comprehensive treatment plan from the treating and/or referring dentist/specialist indicating all completed treatment **and** pending treatment needs including restorative, periodontal, prosthodontic, endodontic, orthodontic, and surgical services.

- Rationale and/or documents to support the request for sedation or general anaesthesia. Please refer to specific eligibility criteria for each method of sedation.

- Current conventional or digital radiographs (within the last twelve months).
    a. Preoperative periapical and bitewing radiographs (if preoperative radiographs cannot be taken due to uncooperative behaviour, perioperative or postoperative radiographs must be submitted):
        - must be of good diagnostic quality (e.g., size, resolution, contrast); and
        - must be mounted and labelled with the date of service, client name and provider name.
    b. A panoramic radiograph may be submitted in addition to, but not in place of bitewing and periapical radiographs.

    Please note: if duplicate radiographs are submitted they must identify the right or left side of the client's mouth.

    When submitting enlarged digital radiographs, of any type, dental providers are requested to print a measurement scale on the radiograph to facilitate the assessment.

- Notation of missing teeth.
- At Health Canada's request, other documentation may be required.

3.0 General Anaesthesia and Deep Sedation

3.1 General Principles

- A frequency limitation of *once in any twelve (12) month period* applies.

- The NIHB Program will cover up to a *regional maximum dollar value* of general anaesthesia/deep sedation and facility fees in any 12 month period.

- To limit the associated risks with repeat general anaesthesia and deep sedation, dental providers should ensure, *where possible*, that all dental services performed under general anaesthesia and deep sedation are completed in one session.

- If multiple appointments are required, providers must submit a predetermination request along with a comprehensive treatment plan and supporting documentation (please see section 2.0., for the complete list) prior to the initiation of the treatment.

    Please note: Stainless steel crowns and plastic crowns should be considered for:
    - high caries risk clients under the age of four;
    - restoration of primary molars and anterior teeth with two or more carious surfaces; and/or
    - restoration of primary molars following a pulpotomy or pulpectomy.

- Providers must ensure that other adjunctive services such as minimal or moderate sedation have been considered prior to requesting general anaesthesia or deep sedation.

3.2 Coverage eligibility for clients under 12 years of age

To be eligible for coverage for general anaesthesia or deep sedation, clients under 12 years of age must have:
- complex or extensive treatment needs; and
- all deciduous teeth should be erupted;

and
- severe age related behaviour management limitations; or
- a significant medical condition or physical impairment.

Please note: If there are unerupted deciduous teeth present in the mouth please contact your respective dental predetermination office to discuss the predetermination request prior to proceeding with treatment.

3.3 Coverage eligibility for clients 12 years of age and older

General anaesthesia and deep sedation are not covered for the management of dental anxiety.

To be eligible for coverage for general anaesthesia or deep sedation, clients 12 years of age and older must:

- require significant surgical procedures[1] that are medically necessary; or
- have a significant medical condition or physical impairment.

4.0 Moderate Sedation

4.1 General Principles

- A frequency limitation of *once in any twelve (12) month period* applies.
- The NIHB Program will cover up to a *regional maximum dollar value* of moderate sedation modalities in any 12 month period.
- Applies to parenteral sedation, combined technique of inhalation plus intravenous and/or intramuscular injection, and nitrous oxide combined with oral sedative drugs.
- To limit the associated risks with repeat moderate sedation, dental providers should ensure, *where possible*, that all dental services performed under moderate sedation are completed in one session.
- If multiple appointments are required, providers must submit a predetermination request along with a comprehensive treatment plan and supporting documentation (please see section 2.0., for the complete list) prior to the initiation of the treatment.
- Providers must also ensure that other adjunctive services such as minimal sedation have been considered prior to requesting moderate sedation.

4.2 Coverage eligibility for clients under 12 years of age

To be eligible for coverage for moderate sedation, clients under 12 years of age must have:

- severe age related behaviour management limitations; or
- a significant medical condition or physical impairment;

and

- complex or extensive treatment needs.

4.3 Coverage eligibility for clients 12 years of age and older

Moderate sedation is not covered for the management of dental anxiety.

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[1] Significant surgical procedures may include, without being limited to:
- three (3) or more extractions of fully or partially impacted teeth;
- full mouth clearance involving 10 or more teeth.

To be eligible for coverage for moderate sedation, clients 12 years of age and older must:

- require significant surgical procedures[2] that are medically necessary; or
- have a significant medical condition or physical impairment and require complex or extensive treatment.

5.0 Minimal Sedation

5.1 General Principles

- The NIHB Program will cover up to a *regional maximum dollar value* of minimal sedation in any 12 month period.

- Applies to nitrous oxide, a single oral sedative drug, or a combination of nitrous oxide/oxygen and a single sedative drug.

5.2 Coverage eligibility for clients under 12 years of age

To be eligible for coverage for minimal sedation, clients under 12 years of age must have:

- severe age related behaviour management limitations;
- a significant medical condition or physical impairment;
- complex or extensive treatment needs; or
- a strong gag reflex that prevents dental care.

5.3 Coverage eligibility for clients 12 years of age and older

Minimal sedation is not covered for the management of dental anxiety, however it may be considered for the management of a *documented* dental phobia[3].

To be eligible for coverage for minimal sedation, clients 12 years of age and older must:

- require significant surgical procedures that are medically necessary; or
- have a significant medical condition or physical impairment.

9.0 Appendices

A. NIHB Regional Dental Grid

The NIHB Regional Dental Benefit Grid lists what services are eligible by placing benefits into two schedules:

Schedule A: outlines services that may be completed and billed directly to the claims processor for payment.

Schedule B: outlines services that require predetermination.

Providers are reminded to use their individual User ID and Password to access the NIHB Regional Dental Benefit Grid lists located on the Express Scripts Canada Website at http://www.provider.esicanada.ca/

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[2] Id., previous footnote.

[3] A letter from a physician, psychiatrist or recognized psychologist must be submitted with the predetermination request.

B. Health Canada NIHB Dental Predetermination Centre Contact Information

Dental Services

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada

Address Locator 1902D
2nd Floor, Jeanne Mance Building
200 Eglantine Driveway
Ottawa, Ontario K1A 0K9

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

Orthodontic Services

Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada

Address Locator 1902C
2nd Floor, Jeanne Mance Building
200 Eglantine Driveway
Ottawa, ON K1A 0K9

Toll-Free Telephone: 1-866-227-0943
Toll-Free Fax: 1-866-227-0957

C. Client Eligibility

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

- a registered Indian 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 one year of age (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 (e.g. a self government agreement) with federal, provincial or territorial governments.

Please note:

The following individuals are excluded from the NIHB Program:

- First Nations and Inuit clients incarcerated in a federal provincial/territorial or municipal corrections facility;
- First Nations children who are in the care of a provincial/territorial social service agency; and
- Those individuals who are in a provincially/territorially funded institutional setting, such as nursing homes.

Health benefit requests for these individuals should be submitted to the appropriate organization.

To facilitate verification, dental 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 dental 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 seven digits. This number is valid in any region of Canada and is cross-referenced to the First Nations and Inuit Health (FNIH) Regional Office client identification number.
2. **Government of Nunavut health plan number**, which is a nine-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 eight digits. This is a client identification number issued by the First Nations and Inuit Health Branch at Health Canada to recognized Inuit clients.

For registered First Nations clients, one of the following identifiers is required:

1. **Aboriginal Affairs and Northern Development Canada registration number**, which is a 10-digit number. Also known as the **Aboriginal Affairs and Northern Development Canada**, 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 eight digits.

For ***infants under one year of age*** who are not yet registered with **Aboriginal Affairs and Northern Development Canada** or applicable Inuit associations, dental providers communicate with the appropriate Health Canada regional office.

More detailed information about client eligibility is included in section 6.1 of the Dental Claims Submission Kit which can be found on the ESC Provider Website at http://www.provider.esicanada.ca/dentists.html.

D. Appeal Process

General Information (for Dental and Orthodontic Services)

Clients 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.

There are three levels of appeal available to NIHB clients. Appeals must be submitted in writing and must be initiated by the client/parent/guardian. At each stage, the appeal must be accompanied by supporting documentation.

At each level of the appeal process, the information will be reviewed by a different dental professional that will provide recommendations to the Program.

Following the review, at each level of the appeal process, the client/parent/guardian will be provided with a written explanation of the decision taken.

Specific information for Orthodontic Services

In order for a client to be eligible for an appeal for orthodontic services, a Predetermination (PD) submission must have been received by NIHB Dental Predetermination Centre (Orthodontic Services) prior to client's 18th birthday.

If coverage for orthodontic treatment has been denied, the client, the parent or the legal guardian of the client has the right to appeal the decision. All three levels of appeal must be accompanied with the supporting documentation provided by the dental practitioner and be completed prior to the client's 19th birthday.

The review for all three levels of appeal will be based on the most current records obtained prior to the commencement of orthodontic treatment.

If a client decides to start an orthodontic treatment after the request for coverage was denied by the NIHB Program, the client may still access the appeal process, as long as the treatment was predetermined before the age of 18, and all levels of appeal are completed before the age of 19. If a client chooses to start an orthodontic treatment following a denial for coverage of orthodontic services under the NIHB Program, all three (3) levels of appeal must be initiated and submitted with all the documentation and information required for predetermination within one year period from the date of service/ insertion date (for the complete list of submission requirements, refer to Orthodontic Policy, section Predetermination Documentation Requirements for Orthodontic Services).

Mailing instructions

Please mark your submission "APPEALS – CONFIDENTIAL" and address it either to the *NIHB Dental Predetermination Centre (Dental Services)* for dental appeals, or *NIHB Dental Predetermination Centre (Orthodontic Services)* for orthodontic appeals.

- **Level 1 Appeal:**
  The client/parent/guardian must initiate the appeal process and address their submission to the Manager, Dental Policy Unit, Benefit Management and Review Services Division, and forward their documentation to the NIHB Dental Predetermination Centre.
- **Level 2 Appeal:**
  If the client/parent/guardian does not agree with the Level 1 appeal decision, they may

initiate the second level of appeal. The submission should be addressed to the Director, Benefit Management and Review Services Division, and the documentation forwarded to the NIHB Dental Predetermination Centre.

- **Level 3 Appeal:**
  If the client/parent/guardian does not agree with the Level 2 appeal decision, they may initiate the third and final level of appeal. The submission should be addressed to the NIHB Director General, and the documentation forwarded to the NIHB Dental Predetermination Centre.

Quick Link
Appeal Process http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/appe/index-eng.php **NIHB Contact Information** http://www.hc-sc.gc.ca/contact/fniah-spnia/fnih-spni/nihbr-ssnar-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 dental records to confirm that the claims have been billed in compliance with the terms and conditions of the NIHB Program.

If under any circumstance (e.g. through pre or post determination, audit programs) it is found that a dental provider has inappropriately billed the Program, all monies will be recovered.

Detailed information about audit procedures and the responsibilities of dental providers for these audits are included in section section 5. Provider Audit Program of the Dental Claims Submission Kit which can be found on the ESC Provider Website at http://www.provider.esicanada.ca/dentists.html