ADP Vendor Training

HOME OXYGEN THERAPY
Completing the Application for Funding
and submitting invoices

June 1, 2017

Ontario

Introduction

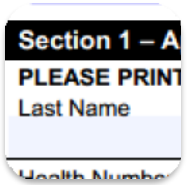
This document is a step-by-step guide to completing the ADP application for funding home oxygen.

For specific information relating to eligibility criteria, see the Home Oxygen Therapy Policy and Administration Manual.

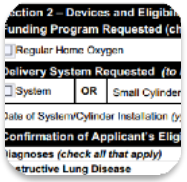
Index

Ontario

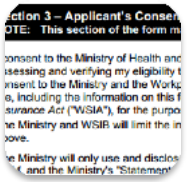
Completing the ADP Application for Funding Home Oxygen – OX1 and OX2


Section 1 – A
PLEASE PRINT
Last Name

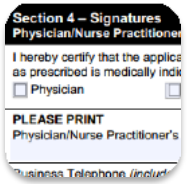
All applicant biographical information and Confirmation of Benefits must be completed in full (Section 1 Applicant's Biographical Information)


Regular Home Oxygen
System
OR
Small Cylinder
Confirmation of Applicant's Eligi
Diagnoses (check all that apply)
Obstructive Lung Disease

Complete details of funding program requested, applicant's diagnoses and test results (Section 2 – Devices and Eligibility)



Applicant or authorized agent must review and provide consent by way of signature and signed date (Section 3 – Applicant's Consent and Signature)


Section 4 – Signatures
Physician/Nurse Practitioner
Physician
PLEASE PRINT
Physician/Nurse Practitioner's

All signing parties must have knowledge of and confirm adherence to ADP policies by signing Section 4 (Signatures)

Ontario

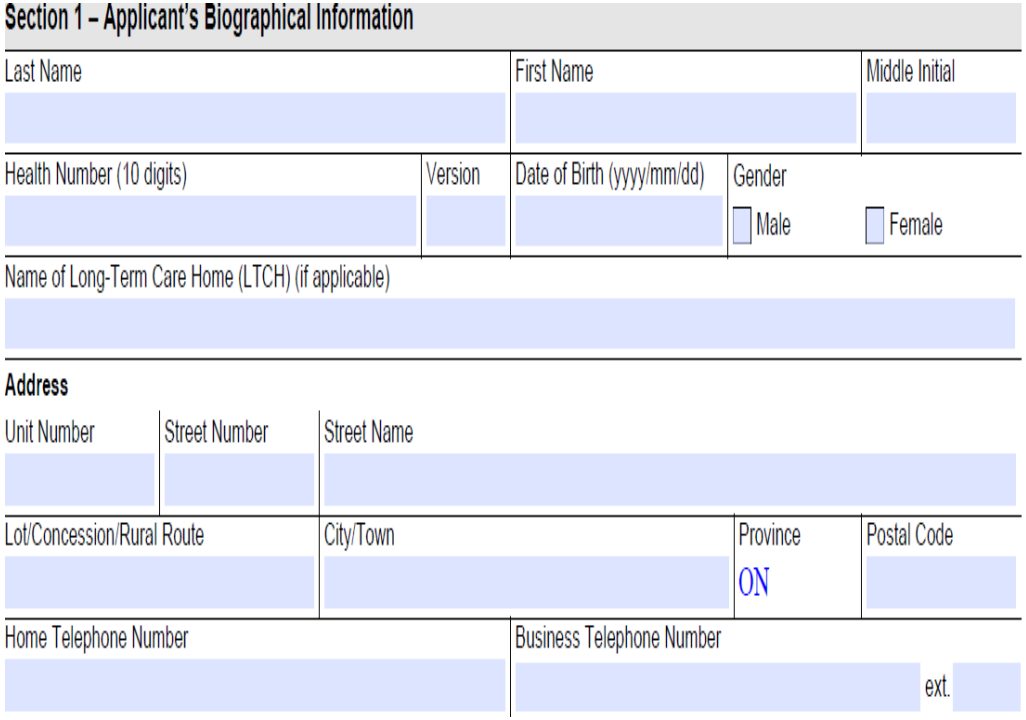
Section 1 – Application Key Areas – OX1 & OX2

Applicant's Biographical Information

All information in Section 1 – Applicant's Biographical Information) must be provided.

Important:

Confirm that applicant information recorded on the application (name, gender and date of birth) matches the information contained on applicant's health card.



Section 1 – Applicant's Biographical Information

Last Name	First Name	Middle Initial

Health Number (10 digits)	Version	Date of Birth (yyyy/mm/dd)	Gender
			☐ Male ☐ Female

Name of Long-Term Care Home (LTCH) (if applicable)

Address

Unit Number	Street Number	Street Name

Lot/Concession/Rural Route	City/Town	Province	Postal Code
		ON	

Home Telephone Number	Business Telephone Number
	ext.

Ontario

Section 1 – Application Key Areas – OX1 & OX2

Confirmation of Benefits

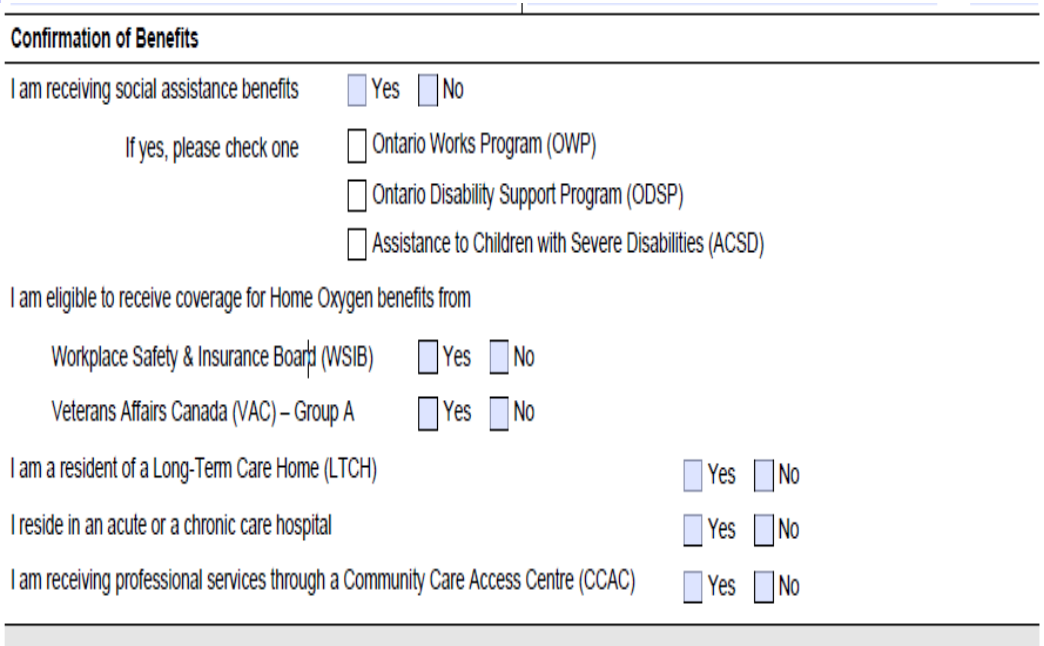
All information required in Section 1 (Confirmation of Benefits) must be provided.

Important:

You must answer yes or no to each Confirmation of Benefits statement.

Note:

Community Care Access Centre (CCAC) have transitioned to the Local Health Integration Network



Confirmation of Benefits

I am receiving social assistance benefits ☐ Yes ☐ No

If yes, please check one
- ☐ Ontario Works Program (OWP)
- ☐ Ontario Disability Support Program (ODSP)
- ☐ Assistance to Children with Severe Disabilities (ACSD)

I am eligible to receive coverage for Home Oxygen benefits from
- Workplace Safety & Insurance Board (WSIB) ☐ Yes ☐ No
- Veterans Affairs Canada (VAC) – Group A ☐ Yes ☐ No

I am a resident of a Long-Term Care Home (LTCH) ☐ Yes ☐ No

I reside in an acute or a chronic care hospital ☐ Yes ☐ No

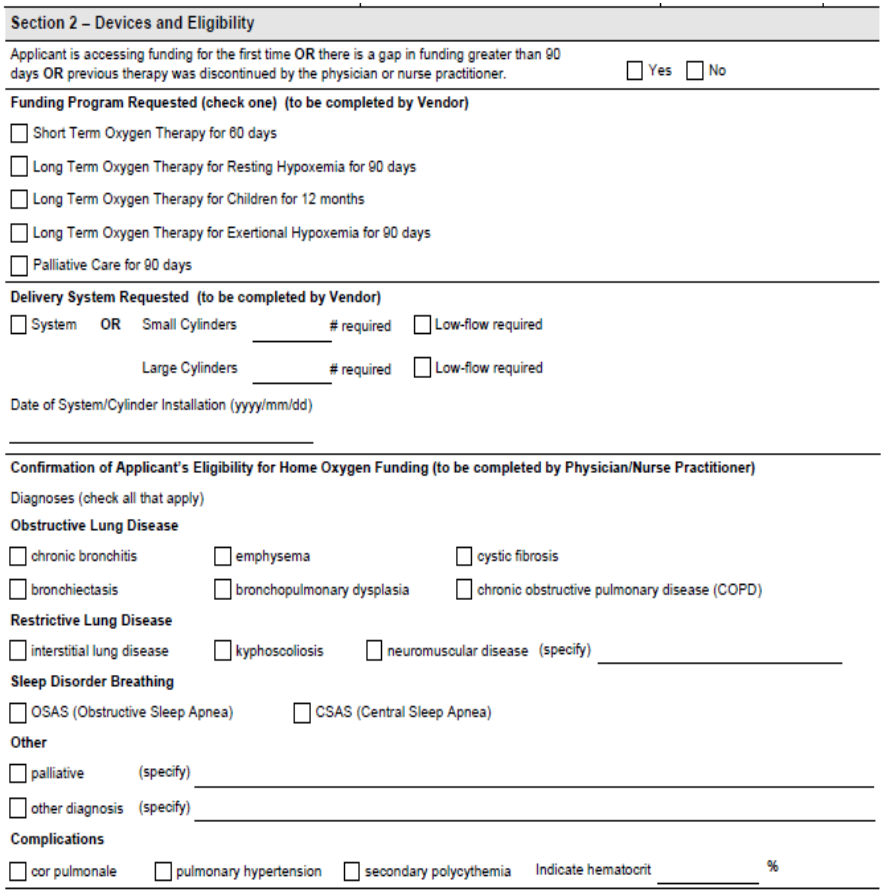
I am receiving professional services through a Community Care Access Centre (CCAC) ☐ Yes ☐ No

Section 2 – Application Key Areas – OX1

Devices and Eligibility

All information required in Section 2 (Devices and Eligibility) must be provided including:

- Confirm applicant is accessing funding for the first time/gap in funding > 90days / previous therapy discontinued;
- Funding program requested;
- Delivery system requested and **actual** equipment was installed in applicant's home; and
- Applicant's medical diagnoses/condition (to be completed by physician)



Section 2 – Devices and Eligibility

Applicant is accessing funding for the first time **OR** there is a gap in funding greater than 90 days **OR** previous therapy was discontinued by the physician or nurse practitioner. ☐ Yes ☐ No

Funding Program Requested (check one) (to be completed by Vendor)

☐ Short Term Oxygen Therapy for 60 days
☐ Long Term Oxygen Therapy for Resting Hypoxemia for 90 days
☐ Long Term Oxygen Therapy for Children for 12 months
☐ Long Term Oxygen Therapy for Exertional Hypoxemia for 90 days
☐ Palliative Care for 90 days

Delivery System Requested (to be completed by Vendor)

☐ System **OR** Small Cylinders _____ # required ☐ Low-flow required

Large Cylinders _____ # required ☐ Low-flow required

Date of System/Cylinder Installation (yyyy/mm/dd)

_____

Confirmation of Applicant's Eligibility for Home Oxygen Funding (to be completed by Physician/Nurse Practitioner)

Diagnoses (check all that apply)

Obstructive Lung Disease

☐ chronic bronchitis ☐ emphysema ☐ cystic fibrosis
☐ bronchiectasis ☐ bronchopulmonary dysplasia ☐ chronic obstructive pulmonary disease (COPD)

Restrictive Lung Disease

☐ interstitial lung disease ☐ kyphoscoliosis ☐ neuromuscular disease (specify) _____

Sleep Disorder Breathing

☐ OSAS (Obstructive Sleep Apnea) ☐ CSAS (Central Sleep Apnea)

Other

☐ palliative (specify) _____
☐ other diagnosis (specify) _____

Complications

☐ cor pulmonale ☐ pulmonary hypertension ☐ secondary polycythemia Indicate hematocrit _____ %

Ontario

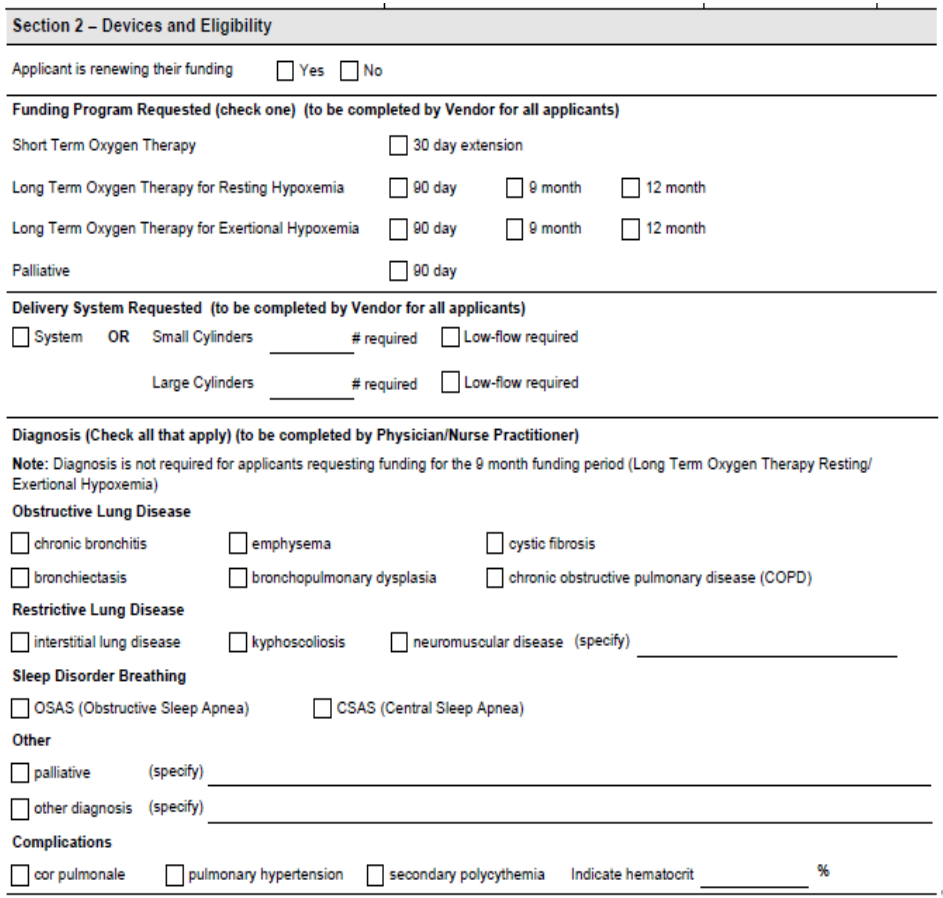
Section 2 – Application Key Areas – OX2

Devices and Eligibility

All information in Section 2 (Devices and Eligibility) must be provided including:

- Confirm applicant is renewing their funding;
- Funding program requested;
- Delivery system requested; and
- Applicant's medical diagnoses/condition

(to be completed by physician)



Section 2 – Devices and Eligibility

Applicant is renewing their funding ☐ Yes ☐ No

Funding Program Requested (check one) (to be completed by Vendor for all applicants)

Short Term Oxygen Therapy	☐ 30 day extension		
Long Term Oxygen Therapy for Resting Hypoxemia	☐ 90 day	☐ 9 month	☐ 12 month
Long Term Oxygen Therapy for Exertional Hypoxemia	☐ 90 day	☐ 9 month	☐ 12 month
Palliative	☐ 90 day		

Delivery System Requested (to be completed by Vendor for all applicants)

☐ System **OR** Small Cylinders _____ # required ☐ Low-flow required

Large Cylinders _____ # required ☐ Low-flow required

Diagnosis (Check all that apply) (to be completed by Physician/Nurse Practitioner)

Note: Diagnosis is not required for applicants requesting funding for the 9 month funding period (Long Term Oxygen Therapy Resting/ Exertional Hypoxemia)

Obstructive Lung Disease

☐ chronic bronchitis ☐ emphysema ☐ cystic fibrosis

☐ bronchiectasis ☐ bronchopulmonary dysplasia ☐ chronic obstructive pulmonary disease (COPD)

Restrictive Lung Disease

☐ interstitial lung disease ☐ kyphoscoliosis ☐ neuromuscular disease (specify) _____

Sleep Disorder Breathing

☐ OSAS (Obstructive Sleep Apnea) ☐ CSAS (Central Sleep Apnea)

Other

☐ palliative (specify) _____

☐ other diagnosis (specify) _____

Complications

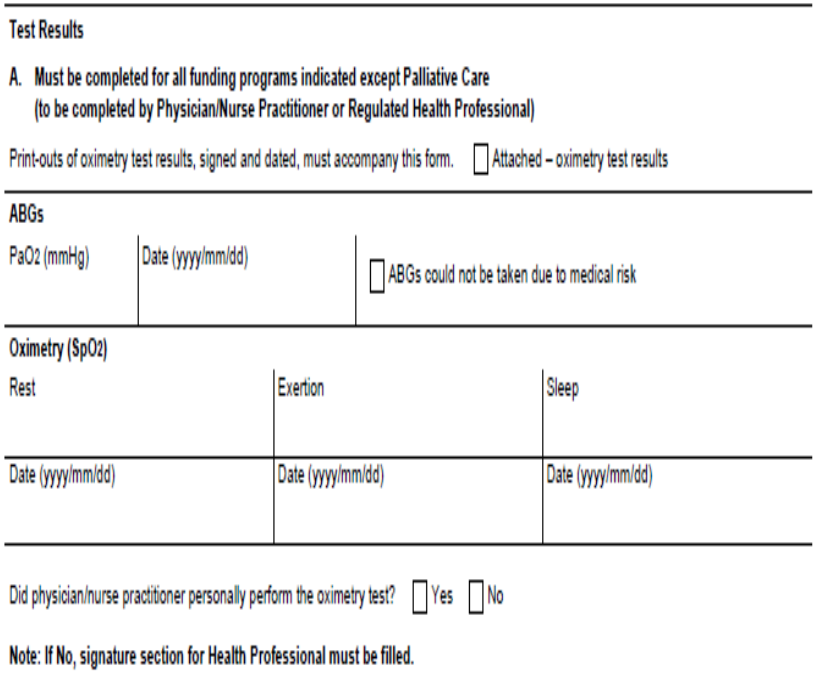
☐ cor pulmonale ☐ pulmonary hypertension ☐ secondary polycythemia Indicate hematocrit _____ %

Ontario

Section 2 – Application Key Areas – OX1 & OX2

Test Results: ABG / Oximetry Tests

- All applicable information required in Section 2 (Test Results) must be provided, including:
- ABG test results for initial 90-day funding period (long-term oxygen therapy) and 60-day funding period (short-term oxygen therapy);
- If ABG is not provided, physician or nurse practitioner to confirm ABG could not be taken due to medical risk;
- Oximetry test results to confirm applicant's eligibility (when required) must be provided; and
- Confirm if physician or nurse practitioner perform Oximetry test.



Test Results

A. Must be completed for all funding programs indicated except Palliative Care
(to be completed by Physician/Nurse Practitioner or Regulated Health Professional)

Print-outs of oximetry test results, signed and dated, must accompany this form. ☐ Attached – oximetry test results

ABGs

PaO_2 (mmHg)	Date (yyyy/mm/dd)	☐ ABGs could not be taken due to medical risk

Oximetry (SpO_2)

Rest	Exertion	Sleep
Date (yyyy/mm/dd)	Date (yyyy/mm/dd)	Date (yyyy/mm/dd)

Did physician/nurse practitioner personally perform the oximetry test? ☐ Yes ☐ No

Note: If No, signature section for Health Professional must be filled.

Ontario

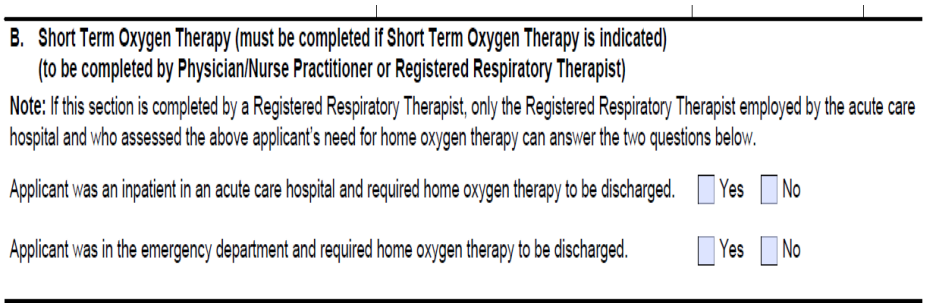
Section 2 – Application Key Areas – OX1

Short Term Oxygen Therapy

All information required in Section 2 (Short Term Oxygen Therapy) must be provided.

Important:

The physician, nurse practitioner or the Registered Respiratory Therapists employed by the acute care hospital must answer yes or no to **both** statements.



B. Short Term Oxygen Therapy (must be completed if Short Term Oxygen Therapy is indicated)
(to be completed by Physician/Nurse Practitioner or Registered Respiratory Therapist)

Note: If this section is completed by a Registered Respiratory Therapist, only the Registered Respiratory Therapist employed by the acute care hospital and who assessed the above applicant's need for home oxygen therapy can answer the two questions below.

Applicant was an inpatient in an acute care hospital and required home oxygen therapy to be discharged. ☐ Yes ☐ No

Applicant was in the emergency department and required home oxygen therapy to be discharged. ☐ Yes ☐ No

Section 2 – Application Key Areas – OX1

Independent Exercise Assessment (IEA)

All information required in Section 2 (Independent Exercise Assessment) must be provided including:

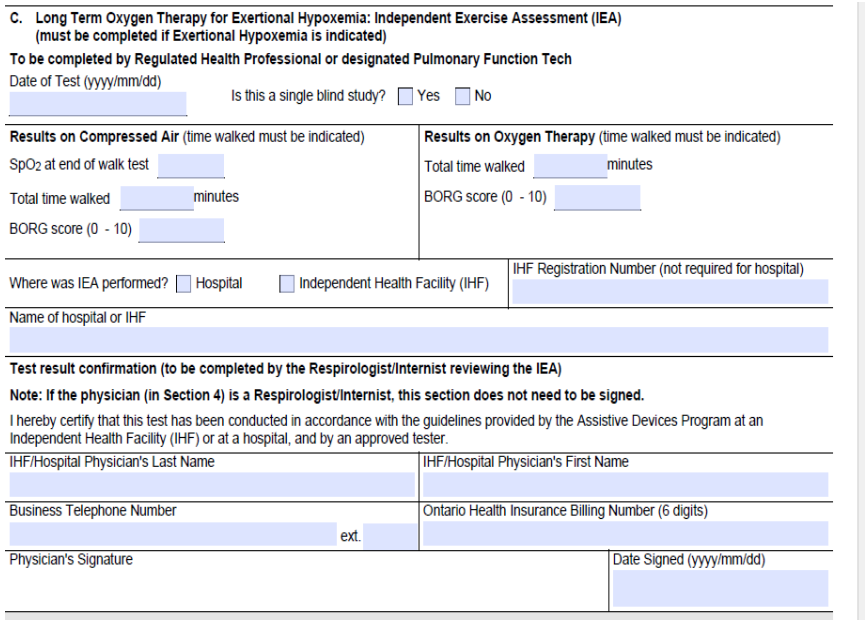
- Date of testing;
- Single blind study (yes or no);
- Type of facility (Hospital or IHF);
- IHF Registration Number (IHF only);
- Name of facility where IEA was performed; and
- Respirologist /Internist's information.

Results on Compressed Air:

- S_PO2 at end of walk test;
- Total time walked; and
- BORG score.

Results on Oxygen Therapy:

- Total time walked; and
- BORG score.



C. Long Term Oxygen Therapy for Exertional Hypoxemia: Independent Exercise Assessment (IEA)
(must be completed if Exertional Hypoxemia is indicated)

To be completed by Regulated Health Professional or designated Pulmonary Function Tech

Date of Test (yyyy/mm/dd) | Is this a single blind study? ☐ Yes ☐ No

Results on Compressed Air (time walked must be indicated)
SpO_2 at end of walk test
Total time walked ____ minutes
BORG score (0 - 10)

Results on Oxygen Therapy (time walked must be indicated)
Total time walked ____ minutes
BORG score (0 - 10)

Where was IEA performed? ☐ Hospital ☐ Independent Health Facility (IHF) | IHF Registration Number (not required for hospital)

Name of hospital or IHF

Test result confirmation (to be completed by the Respirologist/Internist reviewing the IEA)

Note: If the physician (in Section 4) is a Respirologist/Internist, this section does not need to be signed.

I hereby certify that this test has been conducted in accordance with the guidelines provided by the Assistive Devices Program at an Independent Health Facility (IHF) or at a hospital, and by an approved tester.

IHF/Hospital Physician's Last Name | IHF/Hospital Physician's First Name

Business Telephone Number ext. | Ontario Health Insurance Billing Number (6 digits)

Physician's Signature | Date Signed (yyyy/mm/dd)

Ontario

Section 2 – Application Key Areas –OX2

Independent/Vendor Exercise Assessment (IEA)

All information required in Section 2 must be provided including:

- Date of testing; and
- Single blind study (yes or no).

Results on Compressed Air:

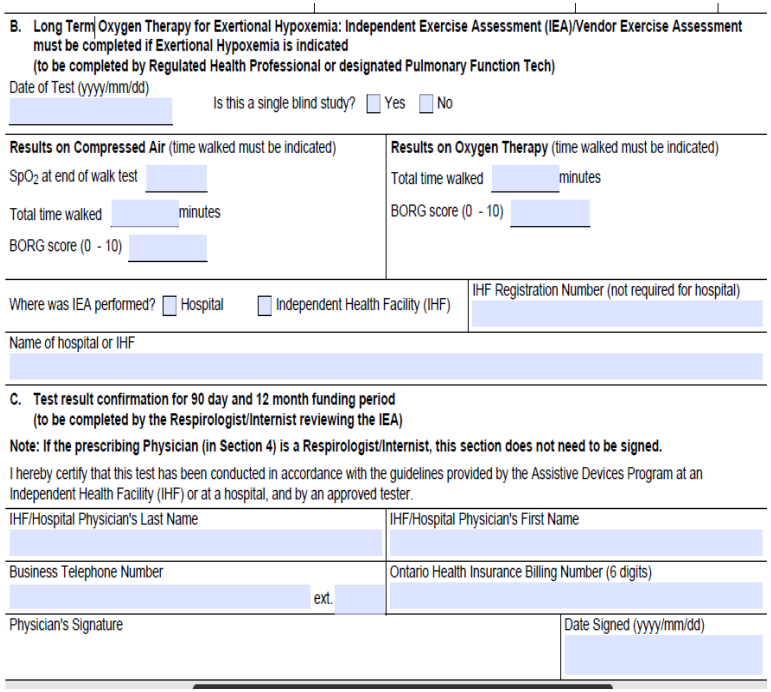
- S_PO2 at end of walk test;
- Total time walked; and
- BORG score.

Results on Oxygen Therapy:

- Total time walked; and
- BORG score.

Test Performed at Hospital or IHF:

- Type of facility (Hospital or IHF);
- IHF Registration number (IHF only):
- Name of facility where IEA was performed; and
- Respirologist /Internist's information.



B. Long Term Oxygen Therapy for Exertional Hypoxemia: Independent Exercise Assessment (IEA)/Vendor Exercise Assessment must be completed if Exertional Hypoxemia is indicated
(to be completed by Regulated Health Professional or designated Pulmonary Function Tech)

Date of Test (yyyy/mm/dd)

Is this a single blind study? ☐ Yes ☐ No

Results on Compressed Air (time walked must be indicated)

SpO_2 at end of walk test

Total time walked minutes

BORG score (0 - 10)

Results on Oxygen Therapy (time walked must be indicated)

Total time walked minutes

BORG score (0 - 10)

Where was IEA performed? ☐ Hospital ☐ Independent Health Facility (IHF)

IHF Registration Number (not required for hospital)

Name of hospital or IHF

C. Test result confirmation for 90 day and 12 month funding period
(to be completed by the Respirologist/Internist reviewing the IEA)

Note: If the prescribing Physician (in Section 4) is a Respirologist/Internist, this section does not need to be signed.

I hereby certify that this test has been conducted in accordance with the guidelines provided by the Assistive Devices Program at an Independent Health Facility (IHF) or at a hospital, and by an approved tester.

IHF/Hospital Physician's Last Name

IHF/Hospital Physician's First Name

Business Telephone Number ext.

Ontario Health Insurance Billing Number (6 digits)

Physician's Signature

Date Signed (yyyy/mm/dd)

Ontario

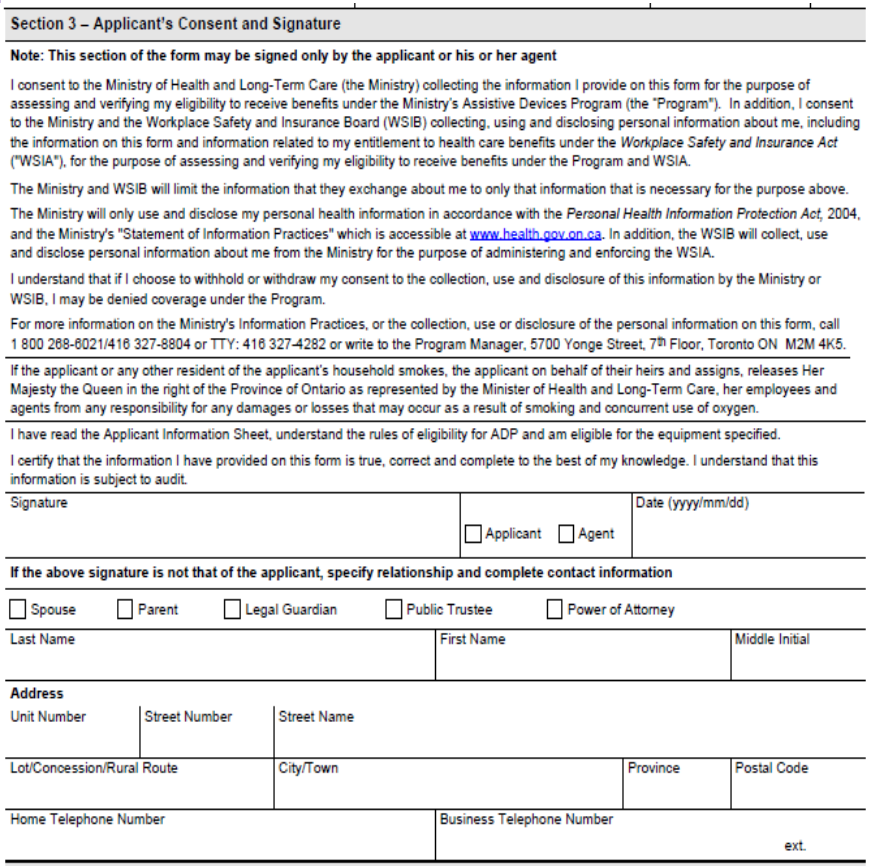
Section 3 – Application Key Areas – OX1 & OX2

Applicant's Consent & Signature

All information in Section 3 (Applicant's Consent and Signature) must be provided.

Note:

- This section of the application must be signed, in ink, by the Applicant or Agent; and
- If Agent signed, specify relationship and complete contact information.



Section 3 – Applicant's Consent and Signature

Note: This section of the form may be signed only by the applicant or his or her agent

I consent to the Ministry of Health and Long-Term Care (the Ministry) collecting the information I provide on this form for the purpose of assessing and verifying my eligibility to receive benefits under the Ministry's Assistive Devices Program (the "Program"). In addition, I consent to the Ministry and the Workplace Safety and Insurance Board (WSIB) collecting, using and disclosing personal information about me, including the information on this form and information related to my entitlement to health care benefits under the *Workplace Safety and Insurance Act* ("WSIA"), for the purpose of assessing and verifying my eligibility to receive benefits under the Program and WSIA.

The Ministry and WSIB will limit the information that they exchange about me to only that information that is necessary for the purpose above.

The Ministry will only use and disclose my personal health information in accordance with the *Personal Health Information Protection Act*, 2004, and the Ministry's "Statement of Information Practices" which is accessible at www.health.gov.on.ca. In addition, the WSIB will collect, use and disclose personal information about me from the Ministry for the purpose of administering and enforcing the WSIA.

I understand that if I choose to withhold or withdraw my consent to the collection, use and disclosure of this information by the Ministry or WSIB, I may be denied coverage under the Program.

For more information on the Ministry's Information Practices, or the collection, use or disclosure of the personal information on this form, call 1 800 268-6021/416 327-8804 or TTY: 416 327-4282 or write to the Program Manager, 5700 Yonge Street, 7th Floor, Toronto ON M2M 4K5.

If the applicant or any other resident of the applicant's household smokes, the applicant on behalf of their heirs and assigns, releases Her Majesty the Queen in the right of the Province of Ontario as represented by the Minister of Health and Long-Term Care, her employees and agents from any responsibility for any damages or losses that may occur as a result of smoking and concurrent use of oxygen.

I have read the Applicant Information Sheet, understand the rules of eligibility for ADP and am eligible for the equipment specified.

I certify that the information I have provided on this form is true, correct and complete to the best of my knowledge. I understand that this information is subject to audit.

Signature	☐ Applicant ☐ Agent	Date (yyyy/mm/dd)

If the above signature is not that of the applicant, specify relationship and complete contact information

☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Public Trustee ☐ Power of Attorney

Last Name	First Name	Middle Initial

Address

Unit Number	Street Number	Street Name		
Lot/Concession/Rural Route		**City/Town**	**Province**	**Postal Code**
Home Telephone Number		**Business Telephone Number**		
				ext.

Ontario

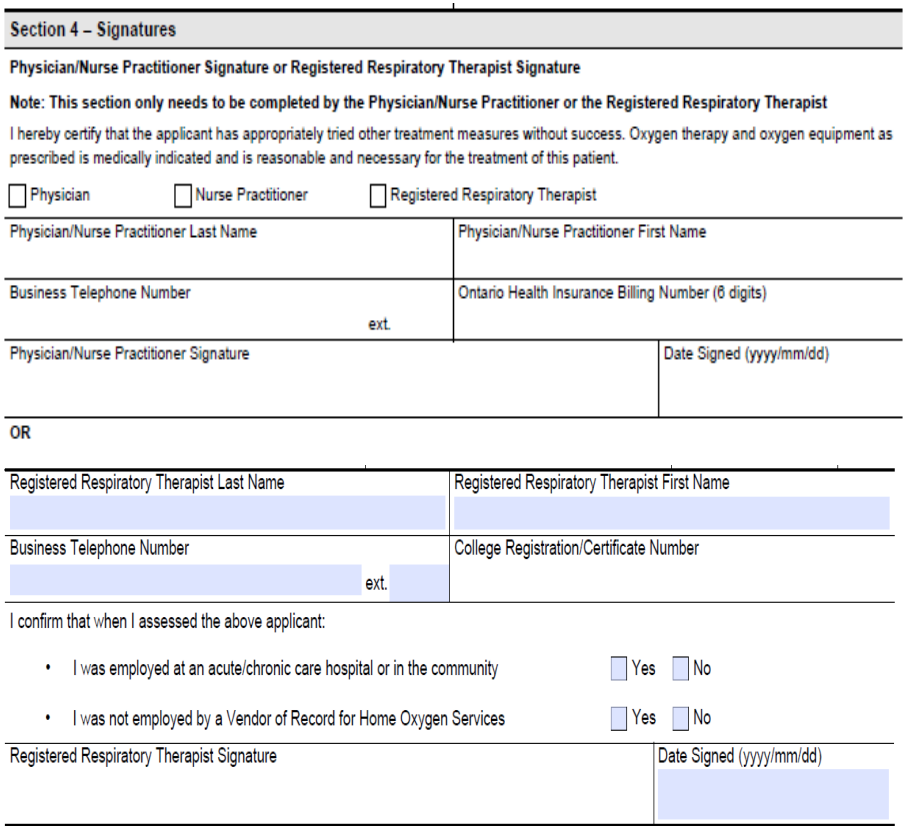
Section 4 – Application Key Areas – OX1

Signatures

All information required in Section 4 (Signatures) must be provided including:

- Health Insurance Billing Number (where applicable);
- Business telephone number;
- Signature of Physician, Nurse Practitioner or Registered Respiratory Therapist; and
- Signature date.

Important: If signed by RRT, the RRT must confirm employment status at time of assessment (answer yes or no to both questions).



Section 4 – Signatures

Physician/Nurse Practitioner Signature or Registered Respiratory Therapist Signature

Note: This section only needs to be completed by the Physician/Nurse Practitioner or the Registered Respiratory Therapist

I hereby certify that the applicant has appropriately tried other treatment measures without success. Oxygen therapy and oxygen equipment as prescribed is medically indicated and is reasonable and necessary for the treatment of this patient.

☐ Physician ☐ Nurse Practitioner ☐ Registered Respiratory Therapist

Physician/Nurse Practitioner Last Name	Physician/Nurse Practitioner First Name
Business Telephone Number ext.	Ontario Health Insurance Billing Number (6 digits)
Physician/Nurse Practitioner Signature	Date Signed (yyyy/mm/dd)

OR

Registered Respiratory Therapist Last Name	Registered Respiratory Therapist First Name
Business Telephone Number ext.	College Registration/Certificate Number

I confirm that when I assessed the above applicant:

- I was employed at an acute/chronic care hospital or in the community ☐ Yes ☐ No
- I was not employed by a Vendor of Record for Home Oxygen Services ☐ Yes ☐ No

Registered Respiratory Therapist Signature	Date Signed (yyyy/mm/dd)

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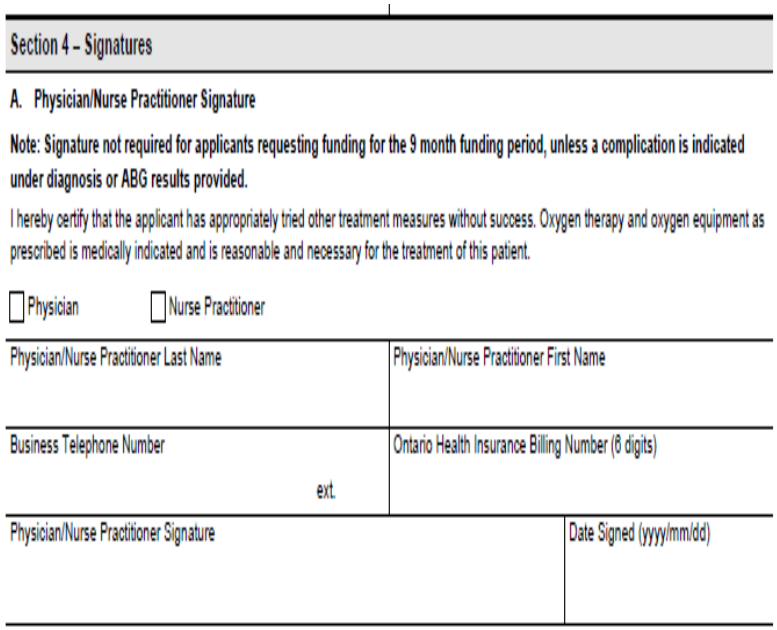
Section 4 – Application Key Areas – OX2

Signatures

All information required in Section 4 (Signatures) must be provided including:

- Health Insurance Billing Number;
- Business telephone number;
- Signature of Physician or Nurse Practitioner; and
- Signature date.

Note: Not required for applicants requesting funding for the 9-month funding period, unless a complication is indicated under diagnosis or ABG results are provided.



Section 4 – Signatures

A. Physician/Nurse Practitioner Signature

Note: Signature not required for applicants requesting funding for the 9 month funding period, unless a complication is indicated under diagnosis or ABG results provided.

I hereby certify that the applicant has appropriately tried other treatment measures without success. Oxygen therapy and oxygen equipment as prescribed is medically indicated and is reasonable and necessary for the treatment of this patient.

☐ Physician ☐ Nurse Practitioner

Physician/Nurse Practitioner Last Name	Physician/Nurse Practitioner First Name
Business Telephone Number ext.	Ontario Health Insurance Billing Number (6 digits)
Physician/Nurse Practitioner Signature	Date Signed (yyyy/mm/dd)

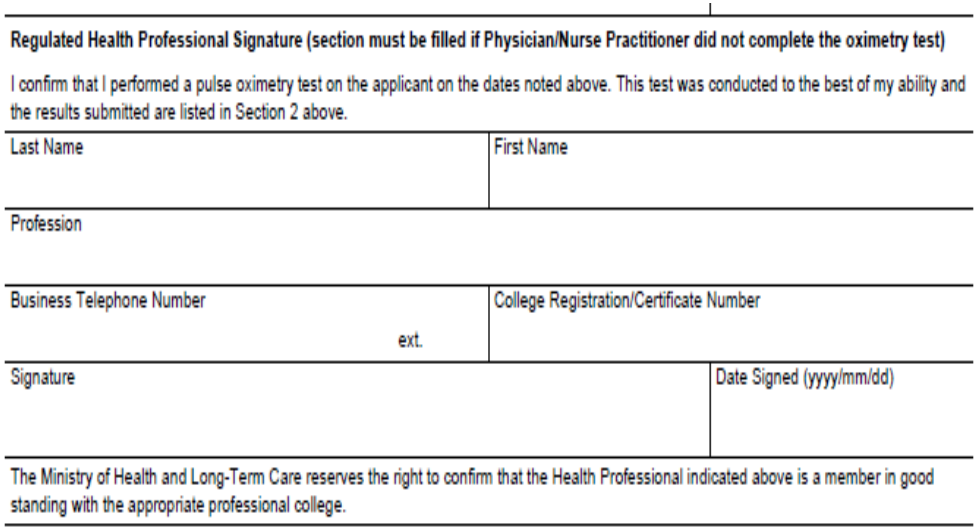
Ontario

Section 4 – Application Key Areas – OX1 & OX2

Regulated Health Professional Signature

All information required in Section 4 (Regulated Health Professional Signature) must be provided if:

- Oximetry results are provided in Section 2 (Test Results); and
- Physician or nurse practitioner confirmed they did not perform the oximetry study (answered no in Section 2 – Test Results).



Regulated Health Professional Signature (section must be filled if Physician/Nurse Practitioner did not complete the oximetry test)

I confirm that I performed a pulse oximetry test on the applicant on the dates noted above. This test was conducted to the best of my ability and the results submitted are listed in Section 2 above.

Last Name	First Name
Profession	
Business Telephone Number ext.	College Registration/Certificate Number
Signature	Date Signed (yyyy/mm/dd)

The Ministry of Health and Long-Term Care reserves the right to confirm that the Health Professional indicated above is a member in good standing with the appropriate professional college.

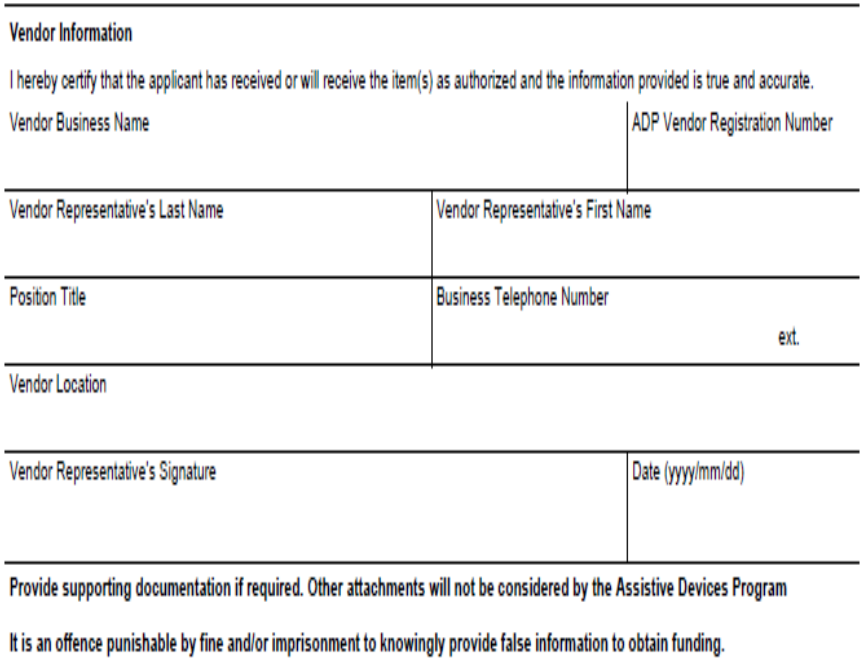
Ontario

Section 4 – Application Key Areas – OX1 & OX2

Vendor Information

All information required in Section 4 (Vendor Information) must be completed.

- Vendor Business Name;
- Vendor Registration Number;
- Vendor Signature and Date;
- Vendor Location and Phone number; and
- Vendor Representative First and Last name, and position title.



Vendor Information

I hereby certify that the applicant has received or will receive the item(s) as authorized and the information provided is true and accurate.

Vendor Business Name	ADP Vendor Registration Number

Vendor Representative's Last Name	Vendor Representative's First Name

Position Title	Business Telephone Number ext.

Vendor Location

Vendor Representative's Signature	Date (yyyy/mm/dd)

Provide supporting documentation if required. Other attachments will not be considered by the Assistive Devices Program

It is an offence punishable by fine and/or imprisonment to knowingly provide false information to obtain funding.

Submitting the Application Form – OX1 & OX2

Submit Original Application, Signed in Ink

Note:

Photocopies of application; scanned/e-mailed application and faxed application will not be accepted.

Copies of missing application must be re-signed, in ink, by all parties and send by post office/courier.

The use of correction fluid/tape to edit information will not be accepted.

Vendors must retain a copy of the original application for their records.

Application Processing

Getting Application Approved

Applications that are complete, accurate and submitted for individuals who meet medical eligibility criteria as found in the ADP's policy and administration manuals will be approved for funding.

Errors and Omissions in Application Completion Result Delays

Applications that are not complete, not accurate or submitted for individuals who do not meet medical eligibility criteria as found in the ADP's policy and administration manuals will not be approved for funding.

The application will be rejected/denied and a notification will be sent to the vendor via the Application Status Report or to the vendor/physician by post office with copy of application.

Application Status Report

Vendor should review the Application Status Report regularly. The Application Status Report will list all applications with activity during the reporting period.

Status Types

Approved: Vendor is notified via the Application Status Report.

Not Approved: Applicant does not meet eligibility criteria or there are claim-related errors. The report identifies the reason that a claim is not approved. If the claim has been denied because the applicant does not meet medical eligibility criteria, only the prescriber can appeal the decision. For claim related errors, the vendor must arrange for the correction.

In Progress: The application has been received, has been entered into the ADP database system and is pending adjudication.

Invoices

Completing the Invoice

There are the essential data fields required for all invoices

- Vendor Registration Number
- Claim number
- Client health number (last 4 digits only)
- Vendor invoice number (a unique number)
- Invoice date
- Delivery date
- Service start date
- Service end date
- ADP Device Code
- Serial number (leave blank)
- Device Placement (L)eft, (R)ight, (N/A) (leave blank)
- Quantity
- Unit price
- ADP portion
- Client portion
- Benefit code*

* One of the following codes must be used

BENEFIT CODE

ODS – Ontario Disability Support Program

OWP – Ontario Works

ACS – Assistance to Children with Severe Disabilities

LTC – Client who resides in a long-term care home

CCA – Client who receives professional services through the CCAC

SEN – Client who is 65 years or older

REG – Client who is not under a program listed above

Submitting the Invoice

Vendors should follow step-by-step the Assistive Devices/Home Oxygen Program Technical Specifications for Electronic Invoice Submission

Invoice Processing

Status Types

- Invoices that conform to the ADP payment policies will be processed.
- A valid and payable invoice received by the ADP within twelve (12) months of service end date will be paid.

Inadmissible Files

- Invoices with an invalid or ineligible file format will not be accepted and a report will be returned immediately to the vendor outlining the problem.
- Invoices submitted in the valid format but containing incorrect or inaccurate data will result in the invoice being placed “on hold” until the vendor corrects the invoice. The invoice status report will provide details of the error and the “on hold” invoice will be retained in the database for a maximum of ninety (90) days.
- An invoice with a delivery date or service date more than twelve (12) months prior to the receipt of the invoice by the ADP is considered stale-dated and will not be paid to the vendor.
- An invoice requiring a correction must be resubmitted as a revised invoice file (no other means will be accepted).

Remittance Advice

A Remittance Advice is produced when a payment is being made to a vendor. It provides vendors with the details of the payment, such as the invoices paid and credit notes applied. This report is provided every two weeks, when a payment to the vendor has been generated.

Remittance Advice Details

- Invoice Number
- Invoice Date
- Claim Number
- Client Name
- Payment Date
- Payment Amount

Invoice Status Report

- The Invoice Status Report accompanies the Remittance Advice and lists all new or changed invoices and the status of those invoices, every two weeks. Invoices that are “on hold” will include a description of the error.

Status Types

- If the vendor experiences a two week period where there have been no new invoices submitted, nor any changes to existing invoices, the Invoice Status Report will not be issued.

Inadmissible Files

- Invoices on hold due to errors may only be corrected through a revised electronic invoice file.
- Invoices not corrected within 90 days are deleted.
- An invoice with a delivery date or service date more than 12 months prior to the receipt of the invoice is considered stale-dated and will not be paid to the vendor.

Invoice Status Types

Status Types:

- **On Hold**: Refers to invoices that cannot be processed and errors are identified.
- **Invoice Deleted**: Is an invoice “on hold” due to errors that have been deleted by the system as it has not been corrected within the ninety (90) window provided.

Invoice Error Messages

Adjudication Error Messages	Next Step / How to resolve?/Check
ADP Vendor is not authorized for the device type Short Term/Regular/Exertional/Palliative Oxygen System as of the Service Start Date.	Verify validity of the Vendor registration number and registration date and re-invoice.
Client Health Card Number on the invoice does not match the Client Health Card Number on the claim.	Correct the Health Card Number and re-invoice.
Client is 65 years old as of the Service Start Date and eligible for 100 % funding.	Re-invoice for 100% funding. Subsequent invoices must also be for 100% funding.
Client is deceased before the end of the Service period.	Re-invoice with the correct end date (deceased date).
Client is ineligible for health services (OHIP) as of the Service Start Date provided on the invoice.	Health Card Number was invalid or inactive as of the service start date. Client must approach OHIP and verify. Also client may be deceased resulting in an inactive Health Card number.

Invoice Error Messages

Adjudication Error Messages	Next Step / How to resolve?/Check
Client is receiving Professional Services through CCAC as of the Service Start Date and is eligible for 100% funding.	Re-invoice for 100% funding. Most recent status update available indicates that client is receiving professional services through CCAC and is therefore eligible for 100% funding. CCAC services are temporary and subject to change.
Client was a resident of an Acute or a Chronic Care hospital between Service Start Date and Service End Date therefore is not eligible for funding during this period.	Vendor must provide proof that the client was not in hospital during the service period
Incorrect Service period. Service end Date is after Home Oxygen Therapy Discontinued Date.	The service has been discontinued and a new application must be submitted for the client.
ADP Device Code on the invoice does not belong to the approved device type.	Verify if the claim was approved as Short Term, Regular, Exertional or Palliative and re-invoice with the code for the correct device type.

Invoice Error Messages

Adjudication Error Messages	Next Step / How to resolve?/Check
Unit Price exceeds the ADP Approved Price as of the Service Start Date.	Approved device type (Short Term, Regular, Exertional and Palliative) or code may be inappropriate for Northern or Southern rate. Correct and re-invoice.
Invoice must include whole Palliative Care Period.	Re-invoice for the Full Period.
Invoice Received Date is more than one year after the Service End Date.	Verify accuracy of dates – if one year or more has passed since service end date, claim is stale dated.
Social Assistance Benefits cannot be verified for 100% funding.	Unable to verify Social Assistance status. Vendor or client must provide proof from the clients case worker.
Vendor invoice number has been previously used and must be unique.	The same invoice number may be used if the invoice is on hold only. For deleted invoices use a new invoice number.

Program Information

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