



## AN IMPORTANT NOTICE TO PROVIDERS OF VETERANS AFFAIRS CANADA TREATMENT BENEFITS

### Benefit Provisions and Payment Requirements for Treatment Benefits

The Benefit Provisions and Payment Requirements are effective July 1, 2014 and replace all previous versions of the Benefit Provisions and Payment Guidelines.

These Requirements apply to Providers who provide treatment benefits pursuant to the *Veterans Health Care Regulations* in consideration for payment under the Health Care Benefits Program - Treatment Benefits administered by Medavie Blue Cross under contract with Veterans Affairs Canada (VAC).

1. For the purposes herein:

“Benefit” under the treatment benefits refers to any product or service provided under Program of Choice (POC) 1 to 14 and, to be eligible as a VAC benefit, may require a prescription whether or not required by law (Benefit Grids should be referenced).

“Client” means a person who is eligible to receive treatment benefits pursuant to the *Veterans Health Care Regulations*.

“Blue Cross” means Medavie Blue Cross and its agents in Canada.

“Program of Choice” (POC) refers to the treatment benefits, available to a client, within a specific group as identified in the Veterans Program Policy Manual, and is subject to the prescriber, recommender and pre-authorization requirements, frequency limits and Maximum Allowable Cost provisions set out in the Benefit Grid related thereto.

The 14 POCs are:

- |  |                                 |
|--|---------------------------------|
| 1. Aids for Daily Living               | 8. Nursing Services             |
| 2. Ambulance / Medical Travel Services | 9. Oxygen Therapy (Respiratory) |
| 3. Audio (Hearing) Services            | 10. Prescription Drugs          |
| 4. Dental Services                     | 11. Prosthetics and Orthotics   |
| 5. Hospital Services                   | 12. Related Health Services     |
| 6. Medical Services                    | 13. Special Equipment           |
| 7. Medical Supplies                    | 14. Vision (Eye) Care           |

“Prescription” means, when authorizing benefits under the Oxygen Therapy program (POC 9) or the Prescription Drug program (POC 10), a written or verbal order that prescribes the treatment benefits recommended in relation to the client’s health needs. If the prescription is written, it must be dated and signed by the required prescriber who is licensed or authorized by the province for that purpose. If the prescription is verbal see section 13 herein.

For benefits that do not require a prescription by law, but are required by VAC policies, a prescription is a written document that prescribes the treatment benefits recommended in relation to the client’s health needs. The prescription must be dated and signed by the health professional who is recommending the benefit.

“Dispensing Fee” is a fee paid to a qualified provider when a prescription is required by law or as stipulated on the VAC Benefit Grid or individual drug criteria. The prescription must not only be required but also must be presented by the client or their representative to the provider and retained by the provider. A dispensing fee will not be paid unless a prescription is required.

“Provider” means a health professional or other person who provides treatment benefits to a client and who submits a claim to Blue Cross for payment under the Treatment Benefits Program.

“Service Date” means the date on which the treatment benefits are supplied to, received and accepted by a client.

“VAC Health Identification Card” means the card issued by Blue Cross, on behalf of VAC, that identifies a client and the Programs of Choice for which the client is eligible.

“*Veterans Health Care Regulations*” means the Regulations, as amended from time to time, pursuant to the *Department of Veterans Affairs Act 1985, R.S.C., chapter V-1*.

“Recovery” means a recouping of funds by VAC’s third party payer (Medavie Blue Cross), on behalf of Veterans Affairs Canada, from any Provider for failure to comply with the payment Requirements set out herein and within the respective Benefit Grids. Compliance to these Requirements is determined through the retrospective audit process as outlined under the section titled, “Claim Audits.”

“Training” means certain treatment benefits require training in their use. This training must be supplied by the provider and included as a condition of the purchase, rental or lease-to-buy agreement.

### **Treatment Benefit Providers**

2. VAC recognizes the authority and responsibility of provincial licensing bodies, pursuant to provincial enactments, to determine the eligibility of a Provider to practice a profession in a province.
3. A Provider must conform to the registration, licensing or certification required pursuant to provincial enactments to be eligible to provide treatment benefits. If no such criteria exist, the Provider must meet the requirements established by VAC policy including the Benefit Grid.

### **Claims**

4. A Provider who submits a health care benefit claim for payment of the cost of a treatment benefit provided to a client will:
  - a. submit a claim only after the service date;
  - b. submit the claim to Blue Cross using the appropriate claim form or electronic format required by the POC which applies to that treatment benefit;
  - c. claim to VAC no more than the amount equal to the rate payable to the Provider by a non-Veteran who purchases the treatment benefit for cash;
  - d. be paid, by VAC, at no more than the rate established for the treatment benefit pursuant to the *Veterans Health Care Regulations* and any guidelines, policies, benefit grids or fee schedules established thereunder. Such payment by VAC at that rate is considered to be full and total payment of the claim by VAC as follows:
    - i. Where a treatment benefit is also a fully insured service of the province in which the benefit is provided, the rate that VAC pays is the rate established by the province for that service and costs.

(Please note: For clients receiving benefits for their pensioned/awarded condition(s), VAC pays the full amount described in 4 (d). **All other VAC clients are to access their provincial health care system first for these benefits.**)

- ii. Where the treatment benefits are not a fully insured service of a province in which they are received but an association of health professionals, in respect of that province, has adopted a fee schedule for treatment benefits and costs, the Minister may approve a rate that is based on that fee schedule.

- iii. In any other case, the rate normally paid for those treatment benefits and costs in the community in which the treatment benefits are provided (usual and customary).

(Please note: The rates established under the *Veterans Health Care Regulations* apply only to treatment benefits provided to Veterans Affairs Canada clients. Canadian Forces and Royal Canadian Mounted Police members are administered under their own legislation and regulations.);

- e. confirm that the claim is true and accurate to the best of their knowledge and belief;
  - f. confirm that the claim does not include any amount in respect of a treatment benefit provided to a client, for which the Provider has otherwise been reimbursed or will be reimbursed by a third party such as a provincial health care system, private insurance company, etc.;
  - g. confirm that the Provider has complied with the prescription stipulations described in this Requirements document;
  - h. not claim for any charge above the VAC maximum allowable cost;
  - i. not request client signatures on claim forms in advance of the provision of benefits; and
  - j. by the act of submitting a claim for payment accept all the terms and conditions set forth in this document.
5. With the exception of an electronic claim form, a treatment benefit claim form submitted by a Provider must be signed by the client or a client's representative. If the client's representative signs the claim form, on behalf of the client, the representative must provide an explanation as to why the client was unable to sign. This section does not apply to an individual who has Power of Attorney (POA) for the client.

Note: The Provider of the service cannot sign for the client.

6. Claim forms must be signed by the Provider. Electronic Claim Submissions will be exempt from this process.
7. A Provider will not submit a claim for a treatment benefit in circumstances where the client has cancelled the request for the treatment benefit or the client refuses to accept delivery thereof.
8. Veterans Affairs Canada is not permitted, under the authority of the Financial Administration Act, to pay for missed appointments.
9. For those benefits which require pre-authorization, claims for benefits that have not been authorized or that exceed the number of authorized occurrences are not eligible for payment.

### **Prescription Requirements (General)**

10. The following terms apply when the POC Benefit Grid requires that a client have a prescription to establish entitlement to a treatment benefit:
  - a. the Provider must obtain and have possession of the prescription before the treatment benefit is provided to the client. A claim will not be eligible for payment if the Provider obtains the prescription after the service date. Any amounts previously paid with respect to such a claim are recoverable from the Provider;
  - b. unless otherwise indicated on the respective Benefit Grid, prescriptions are required for both the initial and subsequent purchases of benefits. A prescription may authorize refills in conformity with the Benefit Grid and the Provider may provide a treatment benefit in accordance with the number of refills designated on the prescription. A refill, not designated in the prescription, will not be eligible for payment and any amounts previously paid with respect to such a claim are recoverable from the Provider;

- c. a prescription which is not dated will be deemed invalid and a claim for a treatment benefit provided by a Provider on the authority of an undated prescription will not be eligible for payment and any amounts previously paid with respect to such a claim are recoverable from the Provider; and
  - d. a prescription, including all designated refills, will be valid for only one year from the date it is written and a claim for a treatment benefit provided by a Provider on the authority of an expired or invalid prescription will not be eligible for payment and any amounts previously paid with respect to such a claim are recoverable from the Provider.
11. POC 10 (Prescription Drugs) treatment benefits must be prescribed by an authorized physician, dentist, optometrist or any other person authorized, by the province, to prescribe drugs in that province or jurisdiction.

12. Treatment Benefits for the POCs must be prescribed by a physician or other health professional in accordance with the Benefit Grids. The electronic “link” to the VAC Benefit Grids is:

**<http://www.veterans.gc.ca/eng/services/treatment-benefits/poc>**

There are 14 Programs of Choice with corresponding Benefit Grids as follows:

- |  |                                 |
|--|---------------------------------|
| 1. Aids for Daily Living               | 8. Nursing Services             |
| 2. Ambulance / Medical Travel Services | 9. Oxygen Therapy (Respiratory) |
| 3. Audio (Hearing) Services            | 10. Prescription Drugs          |
| 4. Dental Services                     | 11. Prosthetics and Orthotics   |
| 5. Hospital Services                   | 12. Related Health Services     |
| 6. Medical Services                    | 13. Special Equipment           |
| 7. Medical Supplies                    | 14. Vision (Eye) Care           |

13. If a prescription for any Prescription Drugs program (POC 10) benefit is communicated verbally (i.e. called into a pharmacy by the authorized prescriber), the Provider may provide the benefit to the client subject to the federal and provincial / territorial laws of the jurisdiction in which the verbal order is issued. In addition, the Provider will fulfill the following VAC requirements at the time the prescriber verbally communicates the prescription details to the treatment benefits Provider.

The person to whom the prescription is communicated by the prescriber must convert the prescription to a written format and must include the following details:

- the name and address of the client;
- the date the prescription was verbally communicated;
- the prescriber’s name;
- the name of the benefit prescribed;
- the quantity of the benefit prescribed;
- the strength of the benefit prescribed;
- the directions for use;
- number of refills authorized;
- a handwritten indication that the prescription is a verbal order;
- the handwritten initials or signature of the pharmacist who received the prescription;
- the handwritten initials of the pharmacist who dispensed the benefit.

If the verbal prescription is a renewal prescription, it is acceptable to use an electronically generated label /hardcopy from the previous prescription provided to identify that there are no changes from the previous prescription. In this case, the following is required:

- the written date;
- an indication that the prescription is a verbal order;
- the pharmacist’s handwritten initials or signature on the prescription.

Electronically generated labels / hardcopies without the above information will not be accepted.

The validity period for a verbal prescription will be no longer than one year from the date the prescription was transcribed. The provider must keep the prescription on file for a period of no less than one year.

## **Generic Substitution**

14. Veterans Affairs Canada only pays for the generic form of a formulation. If a prescribing physician wishes to prescribe the brand name product, the patient must be trialed on the generic formulation for at least three months. If at the end of the trial period, the brand name is still considered to be the most appropriate form of treatment, the prescribing physician must write in their own handwriting "No substitution".

## **Frequent Dispensing**

15. For certain "high risk" chronically used drugs, where safety and compliance are of concern, a less than 28-day supply will be compensated. The request for a reduced supply may originate with either the pharmacist or the prescriber. The drug categories for which less than a 28-day supply will be compensated are:

- antidepressants;
- anti-psychotics;
- opioids;
- benzodiazepines;
- certain high-cost cancer drugs.

Through provider audit, special attention will be given to these drug categories to ensure the appropriateness of short-term dispensing in all cases. VAC will audit and recover where inappropriate quantity reduction occurs.

## **Payment of Claim**

16. Blue Cross will process a claim within the standards specified from the contract with a Provider and, subject to the following exceptions, pay the Provider at the appropriate rate:
  - a. a claim submitted which does not follow the conditions outlined in the preceding sections 1 through 13 of this document, will not be processed;
  - b. a claim submitted at a date later than eighteen (18) months (12 months if the benefit is received under the Rehabilitation program) from the service date is not eligible for payment;
  - c. a claim that does not otherwise conform to the Requirements is not eligible for payment.

## **Claim Audits**

17. Blue Cross may audit a claim to determine if the claim conforms to this document. In cases where Blue Cross determines that the requirements are not met, the claim will be ruled ineligible for payment or if payment was made to the Provider, that payment will constitute a debt subject to recovery by Blue Cross.
18. Where, as the result of an audit, Blue Cross has identified a prescription is missing or invalid, the Provider may not submit prescriptions that the prescriber reissues or duplicates after the service date to support the claim of the Provider.
19. Where, as a result of an audit, Blue Cross has identified records are missing or invalid, the Provider may not submit reissued or duplicate records, including but not limited to time sheets, invoices, case notes, or treatment plans after the audit date to support claims of the Provider.
20. Blue Cross has the right to audit any claim submitted by a Provider, regardless whether the claim was paid or is outstanding for payment and including claims for which pre-authorization was obtained from VAC Head Office, VAC Area offices or Treatment Authorization Centres.

21. Blue Cross has the right to access and copy any records and information relevant to the Provider's claim including, but not limited to, any manufacturers' invoices and account statements (where the records form part of the basis for the amount billed), claim forms and prescriptions.
22. Blue Cross will, at the conclusion of an audit, notify the Provider in writing of the Audit Decision and what amount of a claim, if any, has been identified for payment or recovery.

### **Audit Redress Procedure**

23. A Provider may, within fifteen (15) working days from the date of receipt of the Audit Decision, request that Blue Cross conduct a Review of that decision. The Provider must direct the request for a Review in writing to:

National Investigative Unit  
Medavie Blue Cross  
PO Box 220  
Moncton NB E1C 8L3

24. For the purpose of a Review, the Provider may, within sixty (60) days of the written notification of the audit results, submit new or additional information or reasons why all or a portion of the claim is eligible for payment. The information submitted will be considered by Blue Cross and, within thirty (30) days (longer if extenuating circumstances prevail causing a delay) a Review Decision will be rendered with respect to the eligibility of the claim for payment. Blue Cross will notify the Provider in writing of the Review Decision.
25. A Provider may, within fifteen (15) working days from the date of receipt of a Review Decision, request that VAC conduct a reconsideration of the Review Decision. The Provider must direct the request for reconsideration in writing to:

Attn: Director Health Care, Rehabilitation and Income Support Programs  
Veterans Affairs Canada  
PO Box 7700  
Charlottetown PE C1A 8M9

26. For the purpose of a Reconsideration, the Provider may submit, within thirty (30) days of a written notification from Blue Cross, new or additional information or reasons why all, or a portion of the claim is eligible for payment. The information submitted will be considered by VAC and a reconsideration decision rendered with respect to the eligibility of the claim for payment. VAC will notify the Provider in writing of the reconsideration decision.
27. The VAC reconsideration decision will be a final and binding disposition of the claim, subject to any other legal remedies available to the Provider.
28. At the date of an Audit, Review or Reconsideration Decision (or the result of any other legal remedy available to the Provider) and in conformity with the Decision concerning the issues in dispute between Blue Cross and the Provider with respect to a claim:
  - a. any amount payable by one party (payer) to the other party (payee) will be payable forthwith, provided that the amount exceeds the minimum recovery payment established either by VAC policy or the treatment benefits program; and
  - b. the Provider may not resubmit a claim that was determined to be ineligible for payment and Blue Cross will not be obligated to pay any such claim.

## **Client Retention of Treatment Benefits**

29. Providers will not:

- a. unless authorized by VAC, request that a client return a treatment benefit for which the Provider submitted a claim;
- b. request that a client either pay for or return a treatment benefit, in circumstances where the Provider's claim is ruled ineligible for payment or the claim amount previously paid is recovered by Blue Cross pursuant to an audit.

## **Privacy and Ownership of Information**

30. It is the providers' responsibility to adhere to all applicable legislation in relation to the protection of personal information in their possession.

## **Provider Status**

31. VAC reserves the right to determine who may register or be approved as a Provider. VAC may refuse, suspend or revoke the status of a Provider for reasons including, but not limited to, the following:

- refusing Blue Cross access to the records and information incidental to the conduct of an audit or otherwise fails to cooperate in the conduct of the audit;
- publishing or distributing any advertising material for treatment benefits, which makes reference to VAC in any way other than the following statement: "VAC Health Identification Cards Accepted";
- either in writing or orally, making any claim that VAC endorses the treatment benefits available from that Provider over those of any other Provider;
- specifically directing advertising for treatment benefits to clients in order to solicit business, unless that advertising is part of a general distribution to all clients and other persons;
- specifically targeting VAC clients by telephone or any other means for purposes of soliciting business;
- the unsatisfactory provision of treatment benefits;
- failing to adhere to the requirements outlined in the POC Benefit Grid;
- no longer meeting registration criteria as established by VAC;
- fraud;
- not submitting an invoice within the past 24 months.

## **Sanctions**

32. VAC may take any of the following actions based on the conclusion of an audit:

- cancel a Provider's status;
- suspend a Provider's status;
- re-instate a Provider's status;
- criminal prosecution;
- civil litigation;
- recover an overpayment by direct cash settlement, by deducting the amount from subsequent payments for eligible claims or other negotiated repayment options;
- refer a matter to an appropriate licensing authority for investigation; and
- no further action.

## **Jurisdiction**

33. VAC retains sole authority to establish the policy, guidelines and rules with respect to eligibility for treatment benefits and the Treatment Benefit Program.

## **Severability**

34. If any provision of the Benefit Provisions and Payment Requirements or its application to any part or circumstances is restricted, prohibited or unenforceable, such provision will be ineffective only to the extent of such restriction, prohibition or unenforceability without invalidating the remaining provisions hereof without effecting the validity or enforceability of such provision or its application to other parties or circumstances.

## **Help Combat Healthcare Fraud and Abuse**

35. The Medavie Blue Cross National Investigative Unit conducts the audit function on behalf of Veterans Affairs Canada (VAC). The mandate of this Unit is to protect the financial integrity of VAC's Health Care Benefits Program – Treatment Benefits. The Unit is accountable to deter, detect, investigate, and prosecute cases of health care fraud and abuse committed by both participating health care providers and cardholders. Fraud is becoming a major concern within the insurance industry. Not only is insurance fraud a criminal offence in Canada, it also negatively impacts the cost of insurance for everyone.

If you become aware of fraudulent and / or abusive activity relating to any of VAC's Health Care Programs, please contact the National Investigative Unit's Fraud Hotline at 1-866-485-5500 or by e-mail at [BC\\_FAPInvestigations@medavie.bluecross.ca](mailto:BC_FAPInvestigations@medavie.bluecross.ca).