Veterans Affairs Canada
Anciens Combattants Canada

Service Provisions and Payment Requirements

Veterans Independence Program

Effective July 10, 2014

BLUE CROSS CROIX BLEUE

Canada

Service Provisions and Payment Requirements
Veterans Independence Program

The Service Provisions and Payment Requirements (SPPR) are effective July 10, 2014, for the Veterans Independence Program (VIP) Providers and replace all previous versions of the Service Provisions and Payment Requirements.

The Requirements apply to Providers who provide VIP services pursuant to the *Veterans Health Care Regulations* in consideration for payment under the Health Care Program administered by Medavie Blue Cross under contract with Veterans Affairs Canada (VAC).

1. For the purposes herein:

   Client means a person who is eligible to receive health benefits or services pursuant to the *Veterans Health Care Regulations.*

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

   Veterans Independence Program is a specific group of services identified in the *Veterans Health Care Regulations* available to a client subject to eligibility rules, a needs assessment and preauthorization requirements by VAC Area Office staff as set out in the Benefit Grid related thereto.

   Provider means a health professional or other person who provides service to a client and who submits a claim to Blue Cross for payment under the VIP.

   Service Date means the date on which the services from a Provider 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 health benefits 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 monetary fine imposed by VAC's agent (Blue Cross) against any Provider for failure to comply with the payment requirements set out herein and within the respective Benefit Grid. Compliance to these requirements is determined through the retrospective audit process as outlined under the section entitled, Claim Audits.

VIP Service Providers

2. A Provider must meet the criteria and requirements established by VAC policy including the VIP Schedule of Benefits/ Services.

3. If a Provider opts to have a subcontractor perform services on his/her behalf, the Provider is responsible for ensuring that the subcontractor meets all the criteria and requirements of VIP Service Providers.

Submitting of VIP Claims

4. Otherwise than as provided herein, a Provider who submits a VIP Service claim for payment of the cost of a VIP service(s) provided to a client shall:

    a. submit a claim only after the service date;
    b. submit the claim to Blue Cross, or to VAC, if directed to do so, using the appropriate claim form and benefit code that applies to the VIP service(s);
    c. claim no more than the amount equal to the rate payable to the Provider by a non-Veteran who purchases the service for cash;
    d. be paid at the rate established for the service pursuant to the *Veterans Health Care Regulations* and any requirements, policies, benefit grids or fee schedules established thereunder, such payment by VAC at that rate to be full and total consideration in respect of the claim at the usual and customary rate that is charged for this service or care in the community;
    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 VIP service provided to a client for which the Provider has otherwise been reimbursed or will be reimbursed pursuant to a provincial health care system, any provincial or federal legislative program, any municipal program or any other third party payer;
    g. confirm eligibility of the benefit/service as per the VIP Schedule of Benefits/Services prior to supplying the benefit/service to the client;
    h. confirm that the claim complies with the requirements specified in the VIP Schedule of Benefits/Services;
    i. not bill for any charge above the VAC maximum allowable cost; and
    j. ensure that any corrections that were required on a claim form, chit, work order, or invoice have been brought to the attention of and initialled by the client at the time service was rendered and prior to submitting the claim for payment.

5. With the exception of an electronic claim form, a VIP Service claim form submitted by a Provider will be signed by the client or a client's representative. An invoice, chit or work order indicating the date the service was rendered and hours worked is acceptable as long as it is signed by the client or client's representative. In the case of a Provider submitting a claim for Nursing Home Intermediate Care or Adult Residential Care services, an annual confirmation form signed by either the client or client's representative will be accepted. In the case of a representative signing on behalf of the client, a note must be provided indicating why the client was unable to sign the form.

    Note: The Provider of the service cannot sign on behalf of the client, nor can claim forms, work orders or chits be signed in advance of the work being completed.

6. Claim forms must be signed by the Provider. Electronic Claim Submissions will be exempt from this process.

7. A Provider shall not submit a claim for VIP service in circumstances where the service is not provided. These circumstances include, but are not limited to, the following:

    a. where the client has cancelled the request for the service;
    b. where the scheduled service was to be provided on a Statutory Holiday;
    c. where a lockout has occurred; and,
    d. where the Provider fails to render anticipated services.

8. All services must be preauthorized by either VAC or the client.

9. Providers billing for services under the VIP benefit code for Health and Support Services must not bill for the same services under the POC 8 - Nursing Services, as this would be considered overbilling the program and could result in a recovery of the amount billed.

10. Providers billing for services under the VIP benefit code for Access to Nutrition must not bill for the same services under the POC 2 - Ambulance/Medical Travel Services, as this would be considered overbilling the program and could result in a recovery of the amount billed.

11. Providers billing for services under the VIP benefit code for Social Transportation must not bill for the same services under the POC 2 - Ambulance/Medical Travel Services, as this would be considered overbilling the program and could result in a recovery of the amount billed.

12. Providers billing for services under the VIP benefit code for Ambulatory Care must not bill for the same services under the POC 2 - Ambulance/Medical Travel Services, as this would be considered overbilling the program and could result in a recovery of the amount billed.

Payment of Claim

13. 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 that does not follow the conditions outlined in the preceding sections of this document will not be processed;
    b. a claim submitted at a date later than eighteen (18) months from the service date is not eligible for payment; and,
    c. a claim that does not otherwise conform to the Requirements or is not in accordance with the Schedule of Benefits/Services is not eligible for payment.

Claim Audits

14. Blue Cross may audit a VIP Service claim to determine if the claim conforms to the requirements. 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.

15. Blue Cross shall have the right to audit any claim submitted by a Provider, regardless of whether the claim was paid or is outstanding for payment and including claims for which preauthorization was obtained from VAC Head Office or Area Offices.

16. Blue Cross shall have the right to access and photocopy any records and information relevant to the Provider's claim including, but not limited to, any invoices, account statements (where the records form part of the basis for the amount billed) and claim forms.

17. 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.

18. Where, as a result of an audit, Blue Cross has determined that the client's signature, required to verify the service rendered, is missing or invalid, the Provider may not acquire, resubmit, or duplicate the client's signature to substantiate the claim and therefore the claim shall constitute a debt recovery by Blue Cross.

19. Blue Cross shall, at the conclusion of an audit, immediately notify the Provider in writing of the Audit Decision and what amount of a claim, if any, has been identified for payment or recovery.

20. Providers shall not, unless authorized by VAC, request that a client reimburse the Provider or VAC for any VIP service in circumstances where the Provider's claim is ruled ineligible for payment or the claim was recovered by Blue Cross pursuant to an audit.

Audit Redress Procedure

21. 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

22. For the purpose of a Review, the Provider may 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 a reasonable time period a Review Decision rendered with respect to the eligibility of the claim for payment. Blue Cross will immediately notify the Provider in writing of the Review Decision.

23. 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:

Veterans Affairs Canada
Manager, Veterans Independence Program
161 Grafton Street
PO Box 7700,
Charlottetown, PE C1A 8M9

24. For the purpose of a reconsideration, the Provider may 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 VAC and a reconsideration decision rendered with respect to the eligibility of the claim for payment. VAC will immediately notify the Provider in writing of the reconsideration decision.

25. The VAC reconsideration decision will be a final and binding disposition of the claim, subject to any other legal remedies available to the Provider.

26. At the date of an Audit Decision, Review Decision 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 VIP; 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.

Privacy and Ownership of Information

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

Provider Status

28. VAC reserves the right to determine who may participate as a VIP Service Provider. Non-compliance with the SPPR may result in privileges to invoice Veterans Affairs Canada as a registered Provider for the VIP being revoked. VAC may refuse, suspend or revoke the status of a service or services for reasons including, but not limited to:

    a. the Provider refuses 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;
    b. the Provider publishes or distributes any advertising material for services, which makes reference to VAC in any way other than the following statement: **VAC Health Identification Cards Accepted**;
    c. the Provider specifically directs advertising for services to clients in order to solicit business, unless that advertising is part of a general distribution to all clients and other persons;
    d. the Provider, either in writing or orally, makes any claim that VAC endorses the services available from that Provider over those of any other Provider;
    e. the Provider enters into a contractual relationship with the Client under terms that contravene the SPPR;
    f. the Provider contacts clients by telephone or any other means for purposes of soliciting business;
    g. the Provider fails to conduct business in a professional manner;
    h. the unsatisfactory provision of services;
    i. the Provider fails to adhere to the requirements outlined in the VIP Schedule of Benefits/Services;
    j. the Provider fails to continue to meet the criteria and requirements established by VAC for VIP Service Providers;
    k. fraud; and
    l. the Provider has not submitted an invoice within the past 18 months.

Sanctions

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

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

Jurisdiction

30. VAC retains sole authority to establish the policy, requirements and rules with respect to eligibility for health care benefits and the health care program. VAC will notify the Provider at least ten (10) working days in advance of the effective date of any amendment or revocation of these Requirements.

Severability

31. If any provision of the Service 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 affecting the validity or enforceability of such provision or its application to other parties or circumstances.

Help Combat Health Care Fraud and Abuse

32. The Medavie Blue Cross National Investigative Unit conducts the audit function on behalf of VAC. The mandate of this Unit is to protect the financial integrity of VAC's Health Care Programs. 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 in 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.