

## Veterans Affairs - Blue Cross Common Codes

Toll free 1-888-261-4033

Effective Date December 1, 2000

Description	Code	Maximum Allowance	Comments – Prescriber Required marked OD or OP
<b>Lens Materials</b>			
Lens Benefit – Other	600220	Lab Cost	
Anti-reflection coating	600218	Lab Cost	OD or OP
Harden/Impact Resistant	604120	Lab Cost	
Scratch Resistant	603324	Lab Cost	
Tinting / pair -grad/solid	604122	Lab Cost	OD or OP
Photogray	603321	Lab Cost	OD or OP
Ultra violet protection	600225	Lab Cost	OD or OP
<b>Frame Materials</b>			
Frame	604115	Lab Cost	
<b>Lens Dispensing</b>			
Single Vision / pair	601323	\$46.95	OD or OP
Bifocal / pair	601886	\$64	OD or OP
Trifocal/Multifocal / pair	601945	\$84	OD or OP
Progressive	601991	\$84	OD or OP
Aphakia – post cataract	601458	\$108	OD or OP
<b>Frame Dispensing</b>			
New frame	602576	\$40	OD or OP
Old frame	602853	\$18	OD or OP
<b>Contact Lenses</b>			
Evaluation	600332	\$60	
Fitting - Initial Spherical	602560	\$150	
Fitting - Initial Toric	602156	\$150	
Lens solution	604015		
Lens replacement OD	602255	\$150	OD or OP
Lens replacement OS	602250	\$150	OD or OP



### ***Benefit Provision and Payment Guidelines***

The Benefit Provision and Payment Guidelines (the "Guidelines") are effective March 4th 1999 and replace all previous versions of the same.

The Guidelines apply to Providers who provide treatment benefits pursuant to the *Veterans Health Care Regulations* in consideration for payment under the Treatment Accounts Processing System (TAPS) administered by Blue Cross of Atlantic Canada-under contract with Veterans Affairs Canada (VAC).

1. For the purposes herein:

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

"Blue Cross" means Blue Cross of Atlantic Canada and its agents in Canada.

"Program of Choice" (POC) is the treatment benefits within a specific group identified in the *Veterans Program Policy Manual* available to a client subject to the prescriber, recommender and pre-authorization requirements set out in the Benefits Grid related thereto.

For greater certainty the fourteen POC's are:

- |                             |   |
|-----------------------------|---|
| 1. Aids to Daily Living     | 8. Nursing Services                       |
| 2. Ambulance Services       | 9. Oxygen Therapy (Respiratory Equipment) |
| 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 a written document that prescribes the treatment benefits recommended in relation to the client health needs and which is dated and signed by the required prescriber who is licensed or authorized for that purpose.

"Provider" means, a health professional or other person who provides a treatment benefit to a client and who submits a claim to Blue Cross for payment under the TAPS.

"Service, date" means the date on which the treatment benefits from a Provider are supplied to; received and accepted by a client.

"TAPS' Card" means the Health Care Identification Card issued by Blue Cross which identifies a client and the treatment 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 guidelines set out herein and within the respective Benefit Grids. Compliance to these guidelines is determined through the retrospective audit process as outlined under the section entitled 'Claim Audits'.

#### **TAPS' Providers**

- 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 exists, the Provider must meet the requirements established by VA policy including the Benefit Grid.
- 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.

#### **Claims**

- Otherwise than as provided herein, a Provider who submits a TAPS claim for payment of the cost of treatment benefits provided to a client shall:
  - submit a claim only after the service date;
  - submit the claim to Blue Cross or to VAC, if directed to do so, using the appropriate claim form or electronic format required by the POC which applies to that treatment benefit;

- c) claim no more than the amount equal to the rate payable to the Provider by a person who purchases the treatment benefit for cash;
  - d) be paid at the rate established for the treatment benefit pursuant to the *Veterans Health Care Regulations* and any guidelines, policies or fee schedules established thereunder, such payment by VAC at that rate to be full and total consideration in respect of the claim;
  - 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 pursuant to a provincial health care system, any provincial or federal legislative program or any municipal program; and
  - g) confirm that the Provider has complied with the prescription requirements described in the Guidelines.
5. With the exception of an electronic claim form, a TAP claim form submitted by a Provider shall be signed by the client or if the client is not able to sign the claim form, a family member, personal care worker or client representative must sign the claim form on behalf of the client and provide an explanation why the client was unable to sign.
  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 a treatment benefit in circumstances where the client has cancelled the request for a treatment benefit or the client refuses to accept delivery thereof.

### **Prescription Requirements**

8. The following terms apply when the POC Benefit Grid requires that a client have a prescription to establish entitlement to 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 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 purchase of benefits. A prescription may authorize refills in conformity with the Benefit Grid and the Provider may provide a treatment benefit in accord with the number of refills designated in the prescription. A refill not designated in the prescription shall 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 shall not be eligible for payment and any amounts previously paid with respect to such a claim are recoverable from the Provider;
  - d) a prescription, including all designated refills shall 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 shall not be eligible for payment and any amounts previously paid with respect to such a claim are recoverable from the Provider;
9. POC 10 (prescription drugs) treatment benefits must be prescribed by a physician or dentist.
10. POC 7 (medical supplies) treatment benefits must be prescribed by a physician or other health professional in accordance with the Benefit Grids.
11. For POC 7 and POC 10 treatment benefits, the Provider may provide a benefit to a client on the authority of a prescription communicated verbally by the prescriber subject to the Provider recording the following information:
  - name and address of the client
  - the date the prescription was verbally communicated
  - the prescriber's name
  - name of the benefit prescribed
  - quantity of the benefit prescribed
  - strength of the benefit prescribed (if applicable)
  - number of refills authorized
  - the indicator (V/O) for the verbal order
  - the Provider's initials

### **Payment of Claim**

12. Blue Cross shall process a claim within a reasonable period of time from receipt of a claim from a Provider and, subject to the following exceptions, pay the Provider at the appropriate rate:
  - a) a claim submitted in an unacceptable format 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,
- c) a claim that does not otherwise conform to the Guidelines including the POC Benefit Grid is not eligible for payment.

#### Claim Audits

13. Blue Cross may audit a claim to determine if the claim conforms to the Guideline 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 shall constitute a debt subject to recovery by Blue Cross.
14. 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.
15. Blue Cross shall have 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 or VAC Region or District Offices.
16. Blue Cross shall have the right to access and photocopy any records and information relevant to the Provider claim including, but not limited to, any manufacturer invoices and account statements (where the records form part of the basis for the amount billed), claim forms and prescriptions.
17. 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, is eligible for payment or recovery.

#### Audit Redress Procedure

18. 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:
 

The Compliance Unit,  
Blue Cross of Atlantic Canada  
P. O. Box 220  
Moncton, New Brunswick E1C 8L3
19. 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.
20. A Provider may, within fifteen (15) working days from the date of receipt of a Review Decision, request that VAC conduct reconsideration of the Review Decision. The Provider must direct the request for reconsideration in writing to:
 

Veterans Affairs Canada  
P. O. Box 7700  
Charlottetown, PE  
C1A 8M9  
Attention: Director, Health Care Systems
21. For the purpose of a Reconsideration, the Provider may submit new 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.
22. The VAC Reconsideration Decision shall be a final and binding disposition of the claim, subject to the legal remedies available to the Provider.
23. 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) shall be payable forthwith, provided that the amount exceeds the minimum recovery payment established either by VAC policy or TAPS; and
  - b) the Provider may not resubmit a claim that was determined to be ineligible for payment and Blue Cross shall not be obligated to pay any such claim.

**Client Retention of Treatment Benefit**

24. Providers shall not:

- a) unless authorized by VAC, request a client to return a treatment benefit for which the Provider submitted a claim,
- b) request a client to 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.

**Confidentiality**

25. The records maintained by a Provider with respect to a client are confidential and may not be disclosed, other than to VAC and Blue Cross without the individual's consent, unless in accordance with the applicable legislation on access to information and privacy.

**Provider Status for TAPS**

26. VAC reserves the right to determine who may participate as a Provider. VAC may refuse, suspend or revoke the status of a TAPS' Provider 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 in any advertising material for treatment benefits that is published or distributed by the Provider refers to VAC in any way other than the following statement: "DVA TAPS' CARDS ACCEPTED";
- c) the Provider, either in writing or orally, makes any claim that VAC endorses the treatment benefits available from that Provider over those of any other Provider;
- d) the Provider specifically directs 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;
- e) the Provider contacts clients by telephone or any other means for the purpose of soliciting business;
- f) the unsatisfactory provision of treatment benefits;
- g) the Provider fails to adhere to the requirements outlined in the BC Benefit Grid; and
- h) fraud.

**Sanctions**

27. 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
- reinstate 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**

28. VAC retains sole authority to establish the policy, guidelines and rules. With respect to eligibility for treatment benefits and TAPS. VAC will notify the Provider at least ten (10) working days in advance of the effective date of any amendment or revocation of these Guidelines.

**Severability**

29. If any provision of the Benefit Provision and Payment Guidelines or its application to any part or circumstances is restricted, prohibited or unenforceable, such provision shall 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.

