PharmaCare

Prosthetic and Orthotic Program

Detailed Policy and Procedural Requirements

February 2012

Version 2.1

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1 Introduction

This *Detailed Policy and Procedural Requirements* manual provides health care providers with the information required to complete and submit claims to PharmaCare for all benefits under the Prosthetic and Orthotic Program. It also provides information on the payment processes involved and on how to request assistance.

In this document the term "health care provider" refers to prosthetists, orthotists, ocularists, anaplastologists, mastectomy fitters and/or their companies or businesses.

This manual is subject to the general policies outlined in the *Prosthetic and Orthotic Program, General Statement of Program Policy* and to general PharmaCare policies as outlined in the *PharmaCare/PharmaNet Policies and Procedures Manual*.

Health care providers must abide by the PharmaCare policies and procedures outlined in the policy manuals, and those provided in PharmaCare Newsletters, PharmaNet Bulletins, and other program directives as issued from time to time.

Note: For further information on PharmaCare Newsletters and PharmaNet Bulletins, refer to Section 1.1 below, and to the *PharmaCare/PharmaNet Policies and Procedures Manual*, Section 1.1.3.

1.1 How are policies and procedures updated?

Updates of policies and procedures are communicated in PharmaCare Newsletters, PharmaNet Bulletins, *PharmaCare/PharmaNet Policies and Procedures Manual*, or other directives as provided from time to time.

PharmaCare Newsletters are initiated by PharmaCare to:

- announce changes in PharmaCare policies and procedures;
- clarify existing policies;
- announce changes in benefit status for specific Drug Identification Numbers (DINs) and Product Information Numbers (PINs) (including delistings and restrictions); and
- announce new benefits.

PharmaCare Newsletters are produced in a consistent format, numbered consecutively by year, and dated.

PharmaNet Bulletins are initiated by PharmaCare and the College of Pharmacists to:

- announce PharmaNet-related changes, and
- educate pharmacy or health care provider staff regarding PharmaNet-related issues.

PharmaNet Bulletins are produced in a consistent format, are numbered consecutively by year, and dated.

Future PharmaCare Newsletters and PharmaNet Bulletins will contain updates that supersede the PharmaCare and PharmaNet policies and procedures outlined in this manual. PharmaCare Newsletters and PharmaNet Bulletins are available on the PharmaCare website: www.health.gov.bc.ca/pharmacare/publications.html.

PharmaCare provides an e-mail subscription service for pharmacies, health care providers and stakeholders who wish to be notified when a new PharmaCare Newsletter or PharmaNet Bulletin is posted to the PharmaCare website. You may also subscribe to receive PharmaNet alert notifications for your area of the province. To subscribe, please visit the website and complete the brief online form.

Updates to the *PharmaCare/PharmaNet Policies and Procedures Manual* may also be issued periodically. Each update will be accompanied by a summary of any substantive changes.

2 Contacting PharmaCare

Health Insurance British Columbia (HIBC) administers the PharmaCare program on behalf of the Pharmaceutical Services Division, Ministry of Health. HIBC can answer questions about both PharmaCare and the Medical Services Plan.

For information related to pharmacy/health care provider practices, refer to the *PharmaCare/PharmaNet Policies and Procedures Manual* under Chapter 2, and for information on Troubleshooting for PharmaNet problems refer to *PharmaCare/PharmaNet Policies and Procedures Manual* under Chapter 7.

2.1 PharmaCare Enquiries from Patients

The public may contact a Customer Service Representative at HIBC, regarding PharmaCare policies, from 8:00 AM to 8:00 PM Monday to Friday and from 8:00 AM to 4:00 PM on Saturday, at the following numbers:

- Vancouver/Lower Mainland, 604-683-7151; or
- Rest of British Columbia, call toll free 1-800-663-7100.

Your **patients** should use one of these numbers to contact HIBC about:

- the status of their Fair PharmaCare registration; or
- questions regarding the Prosthetic and Orthotic Program.

2.2 Fair PharmaCare Registration

All British Columbians are encouraged to register for Fair PharmaCare. B.C. residents can register:

- Online at www.healthservices.gov.bc.ca/pharmacare. This service is available **24 hours a day, 7 days a week**.
- By contacting HIBC at the telephone numbers provided in Section 2.1 above.

2.3 PharmaNet Help Desk

The PharmaNet Help Desk is a health care provider's first point of contact for PharmaCare and PharmaNet enquiries. The Help Desk is available **24 hours a day, 7 days a week**, including all statutory holidays except Christmas Day. See PharmaCare Bulletins for details on holiday hours.

Telephone the PharmaNet Help Desk to:

- order additional copies of PharmaCare forms or brochures. (When ordering, you will be asked to provide your pharmacy equivalency code [PEC]);
- determine a patient's PharmaCare plan;
- enquire about the status of PharmaCare claims; or
- request set-up for a Plan B patient's claim for an approved *Application for Financial Assistance*.

Enquiries about the status of a patient's *Application for Financial Assistance* will be handled by the Prosthetic and Orthotic Clerk, Patient and Practitioner Services, HIBC (see Section 2.4 below).

2.3.1 Help Desk Contact Numbers for Health Care Providers

Call the PharmaNet Help Desk at HIBC:

- Vancouver/Lower Mainland, 604-682-7120; or
- Rest of British Columbia, call toll free at 1-800-554-0225.

You will be greeted by a message and offered the option of accessing the PharmaCare Information Line (an automated information system for pharmacists), speaking directly to a PharmaNet Help Desk customer service representative or speaking directly to Patient Restrictions.

When prompted, press **2** to speak directly to a customer service representative.

Important: The contact numbers above are for pharmacies and health care providers only. Patients should use the numbers provided in Section 2.1 above.

2.3.2 Information Required by the PharmaNet Help Desk

When calling the PharmaNet Help Desk, **be prepared to provide** the following information:

- your pharmacy equivalency code (PEC);
- your name; and
- a brief description of the problem.

When calling **regarding a patient**, you should also have the following patient information ready:

- Personal Health Number (PHN/CareCard number);
- full name;
- address;
- gender; and
- invoice number, if applicable.

When calling **regarding a practitioner**, you should have the following practitioner information ready:

- full name;
- address;
- Medical Services Plan (MSP) Billing Number (preferably, if known) or Practitioner ID (if known); and
- gender.

2.4 Prosthetic and Orthotic Clerk, Patient and Practitioner Services

The Prosthetic and Orthotic Clerk is the point of contact for *Applications for Financial Assistance*. A Clerk is available from 8:30 AM to 4:30 PM Monday to Friday.

Contact the Prosthetic and Orthotic Clerk to:

- Request the status of a patient's current *Application for Financial Assistance*;
- Request information about a patient's old (over 6 months) *Application for Financial Assistance*;
- Request other information regarding a patient's *Application for Financial Assistance*; and
- Provide additional information to the Prosthetic and Orthotic Committee, regarding a patient's *Application for Financial Assistance*.

Contact the Prosthetic and Orthotic Clerk:

- By phone at 250-405-4251; or
- By fax at 250-405-3590.

2.5 Information Support

Information Support is the point of contact for new applications, changes to manager, ownership, operating name or address and for PharmaNet connections. A Customer Service Representative will be available from 8:30 AM to 4:30 PM Monday to Friday.

For a new application to BC PharmaCare, write to:

Manager, Operational Services
716 Yates St
Victoria BC V8W 1L4

Contact Information Support, for notification of changes to manager, ownership, operating name or address and for PharmaNet connections, changes to software or relocations:

- By fax at 250-405-3599; or
- By e-mail at Informationsupport@hibc.gov.bc.ca

2.6 PharmaCare Website

The PharmaCare website (www.health.gov.bc.ca/pharmacare) offers comprehensive information on a variety of topics including:

- PharmaCare plans;
- PharmaCare programs;
- Fair PharmaCare online registration;
- Forms;
- Information sheets;
- PharmaCare-assigned Product Identification Numbers; and
- PharmaCare Newsletters and PharmaNet Bulletins.

3 New Health Care Providers

3.1 How to Apply

Write Information Support to apply to BC PharmaCare (see Section 2.5 above).

All applications must include the following information:

- Business name;
- Business address;
- Business phone number;
- Business fax number;
- Site manager's name;
- Names of the directors for the company;
- Copy of current business license;
- Certificate showing Canadian Board for Certification of Prosthetists & Orthotists (CBCPO) accreditation, ocularists or fitters certificate, as appropriate (see Section 3.2 below); and

- If connecting to PharmaNet, you must also provide information regarding which approved compliance-tested software for PharmaNet you will be using (see Section 6 below).

The health care provider site manager will be required to sign a *BC PharmaCare Non-Pharmaceutical Supplier Participation Agreement* to be able to bill PharmaCare.

New health care providers will be provided with a start up package (see Appendix 1).

3.2 Prosthetic Health Care Providers Requirements

3.2.1 Breast Prostheses and Lymphedema Arm Sleeves

Health care providers requesting to provide breast prostheses for mastectomy or lumpectomy patients through the PharmaCare program must be or must employ a certified fitter.

Health care providers requesting to provide lymphedema arm sleeves and gloves and/or gauntlets for mastectomy patients must be or must employ a recognized provider who has vendor certification attesting to expertise in the field, and who holds a certified fitter registration for lymphedema arm sleeves.

The majority of all work done fitting the patient must be provided by the certified fitters.

3.2.2 Limb Prostheses

Health care providers requesting to provide prosthetic benefits through the PharmaCare program must be or must employ Certified Prosthetists (C.P. (c)) or Certified Prosthetist Orthotist (C.P.O. (c)) as certified by the Canadian Board for Certification of Prosthetists and Orthotists (CBCPO).

The majority of the work related to the assessment, fitting and dispensing of the prosthesis to the patient must be completed by the certified prosthetist.

3.2.3 Ocular Prostheses

Health care providers requesting to provide ocular prosthetic benefits through the PharmaCare program must be or must employ a National Examining Board of Ocularists, Inc. (NEBO) certified ocularist.

The majority of the work related to the assessment, fitting and dispensing of the prosthesis to the patient must be completed by the certified ocularist.

3.3 Orthoses

Health care providers requesting to provide orthotic benefits through the PharmaCare program must be or must employ Certified Orthotists (C.O. (c)) or Certified Prosthetist Orthotist (C.P.O. (c)) as certified by the Canadian Board for Certification of Prosthetists and Orthotists (CBCPO).

The majority of the work related to the assessment, fitting and dispensing of the orthosis to the patient must be completed by the certified orthotist.

3.4 Out-of-Province Health Care Providers

PharmaCare may allow out-of-province health care providers to participate in PharmaCare, if they:

- serve British Columbia residents in border communities; and
- are closer than the nearest health care provider in British Columbia.

Occasionally, special allowances will also be made for an out-of-province health care provider who can provide special services for a patient.

To participate in BC PharmaCare, an out-of-province health care provider will be required to:

- make written application to the Manager, Operational Services (see Section 2.5 above); and
- sign and return a *BC PharmaCare Non-Pharmaceutical Supplier Participation Agreement* (see Section 3.1 above).

Out-of-province health care providers cannot connect to PharmaNet.

Out-of-province health care providers will be required to submit manual claims to PharmaCare in the same way as in-province non-pharmaceutical suppliers that are not connected to PharmaNet (see Section 9.4 below).

4 PharmaCare Plans and Programs Available

PharmaCare payments are determined by the rules and deductible requirements under the patient's PharmaCare plan. For a complete listing of PharmaCare plans and detailed information on each refer to the *PharmaCare/PharmaNet Policies and Procedures Manual* under Chapter 8.

4.1 Fair PharmaCare

The Fair PharmaCare plan provides B.C. residents with coverage for eligible prescription drugs and designated medical supplies.

Fair PharmaCare assistance is based on a family's net income as reported to the Canada Revenue Agency. Individuals and families must register with PharmaCare to receive their maximum Fair PharmaCare financial assistance.

Individuals or families who are registered with the Medical Services Plan but who do not register for Fair PharmaCare are automatically assigned the highest deductible of $10,000 per person.

For more information regarding Fair PharmaCare visit the PharmaCare website, or refer to the *PharmaCare/PharmaNet Policies and Procedures Manual*.

A patient information sheet regarding Fair PharmaCare is also available on the PharmaCare website at: www.health.gov.bc.ca/pharmacare/publications.html.

4.2 Plan B – For Permanent Residents of Licensed Residential Care Facilities.

Plan B provides assistance to British Columbia residents of residential care facilities (excluding extended-care, acute-care, multi-level and assisted living facilities) that are licensed under the *Community Care and Assisted Living Act*.

PharmaCare pays the full cost of eligible prescription drugs and certain medical supplies for Plan B beneficiaries.

Short term (also called "respite" or "swing") patients in a long term care facility are not eligible for Plan B. Short term residents receive financial assistance under Fair PharmaCare or Plan C, depending on the individual's PharmaCare plan eligibility.

Note: Pharmacies/health care providers billing for Plan B costs should refer to documentation provided by their software vendor.

4.3 Plan C – For People Receiving B.C. Income Assistance

Plan C provides PharmaCare financial assistance to British Columbia residents who are eligible for either basic or enhanced medical benefits through the Ministry of Housing and Social Development.

Under Plan C, PharmaCare covers 100 per cent of the accepted claim amount, within acceptable maximums.

Plan C eligibility is provided in real time by the Ministry of Housing and Social Development offices and is in effect from the time received on PharmaNet. It cannot be provided retroactively.

Recipients of Hardship Assistance may qualify for temporary (48 hour) PharmaCare assistance. The benefits are equivalent to Plan C for that time period. For information on Short Term Hardship Benefits, refer to Section 10.3 of the *PharmaCare/PharmaNet Policies and Procedures Manual*.

PharmaCare cannot determine Plan C eligibility. Eligibility is determined by the Ministry of Housing and Social Development.

4.4 Plan F – For Children in the At Home Program

Plan F provides eligible benefits at no charge to children who are eligible for benefits under the At Home Program of the Ministry of Children and Family Development. The At Home Program provides community-based, family-style care for severely handicapped children who would otherwise become reliant on institutional care.

PharmaCare covers 100 per cent of the accepted claim amount, within acceptable maximums.

Financial assistance under Plan F does not extend to patients in acute-care or extended-care hospitals.

PharmaCare cannot determine Plan F eligibility. Eligibility is determined by the Ministry of Children and Family Development.

4.5 Fair PharmaCare Monthly Deductible Payment Option

PharmaCare offers a Monthly Deductible Payment Option for individuals and families receiving assistance under the Fair PharmaCare plan.

This payment option benefits families who have high prescription and medical device costs and who expect to meet their deductible during the year. Once enrolled, families pay their Fair PharmaCare deductible in monthly installments and receive PharmaCare assistance with eligible costs right away.

Families are eligible for this payment option if they:

- are registered for Fair PharmaCare;
- do not have private health insurance with a drug benefit plan*; and
- have a deductible greater than $0.

Patients may enroll in the Monthly Deductible Payment Option for the current calendar year any time up to September 30th. After September 30th, patients can request enrollment for the following year.

For more information, or to enroll, please have your patients contact HIBC at:

- Vancouver/Lower Mainland, call 604-683-7151; and
- from the rest of British Columbia, call toll-free 1-800-663-7100.

A patient information sheet regarding this payment option is also available on the PharmaCare website at: www.health.gov.bc.ca/pharmacare/publications.html.

* Enrolling in the Monthly Deductible Payment Option is not permitted if a patient has private health insurance with a drug benefit plan. The private health insurer contributes towards this patient's prescription costs and the Monthly Deductible Payment Option could complicate or delay the reimbursement of the patient's private health benefits.

5 Manager/Operating Name/Ownership/Address Change

Notify Information Support (see Section 2.5 above) to obtain a *BC PharmaCare Non-pharmaceutical Supplier Participation Agreement*, which is to be signed if any one or more of the following changes are made:

- Change in health care provider site manager;
- Change in operating name; or
- Change in ownership.

A *Direct Deposit Application* form may be required to be completed if there has been a change in ownership or banking information. Information Support can provide the appropriate document.

Health care providers do not need to sign a *BC PharmaCare Non-pharmaceutical Supplier Participation Agreement* for a correction (or change) of address.

6 Connecting to PharmaNet

Connection to PharmaNet is not mandatory. The benefits of connecting to PharmaNet are:

- Claims on PharmaNet adjudicate in real time, providing immediate information on the portion of a claim to be paid by the patient and the portion (if any) covered by PharmaCare;
- Not having to submit paper forms for claims under $400 or for claims that have been pre-approved by PharmaCare; and
- Eliminating the two- to three-week turnaround time required for processing manual claims and issuing payment.

Note: PharmaNet access allows you to submit online claims but does not allow you to access your patient's full medication history.

It normally requires 50 business days (excluding statutory holidays) to set up a new site with a PharmaNet connection.

You must use approved compliance-tested software to connect to PharmaNet. A list of approved software vendors ('software service organizations') is provided on the College of Pharmacists of British Columbia's website at: www.bcpharmacists.org/library/E-Registration_Licensure/E-3_Pharmacy/5033-Guide-CommunityPcyLicensure_AppA.pdf.

Note: The compliance evaluation process is performed by PharmaCare's Quality Assurance staff plus a member of the Ministry of Health and a member of a regulatory body where appropriate. The evaluation confirms that the local software complies with all requirements and that all local system functions and processes provide accurate results. The compliance evaluation process evaluates all aspects of PharmaNet functionality available on the local software regardless of whether or not the functionality is used by the pharmacy/health care provider.

7 Application for Benefits

Apply for PharmaCare benefits on behalf of your patients by submitting one of the following forms to PharmaCare:

- *PharmaCare Prosthetic Benefits - Application for Financial Assistance*
- *PharmaCare Orthotic Benefits – Application for Financial Assistance*
- *PharmaCare Prosthetic Benefits (Non-Limb) – Application for Financial Assistance*

Forms and instructions on how to complete them are available online from the PharmaCare website at www.health.gov.bc.ca/pharmacare/suppliers.html.

Pre-approval is required for all benefits valued at $400 or more. **In the absence of pre-approval, PharmaCare will not pay for benefits provided to patients**. Approvals are valid for six (6) months following the approval date on the letter or form.

7.1 Application for Financial Assistance Process (Pre-Approval Mandatory)

You must obtain pre-approval on an *Application of Financial Assistance* form, on behalf of your patients, for any claims of $400 or more (manual or online) for coverage under PharmaCare's Prosthetic and Orthotic Program. (Application forms are available from the PharmaCare website at www.health.gov.bc.ca/pharmacare/suppliers.html.)

In addition, written requests for pre-approvals must be submitted on the *PharmaCare Prosthetic Benefits (Non-Limb) – Application for Financial Assistance* for:

- replacements of breast prostheses, before the two year limit (even if less than $400); and
- exceptions to be considered on mastectomy prostheses and supplies.

Complete the appropriate *Application for Financial Assistance* form, describing fully the prosthesis or orthosis being requested and the reasons why it is required. The application form must be signed by both the certified health care provider and by the patient.

Indicate on the form if the application is on behalf of a patient who is a resident of a licensed residential care facility (Plan B).

Approval letters/forms provide the Plan information of the patient at the time the *Application for Financial Assistance* was received and may be subject to change at any time. You should verify the patient's Plan information with the patient when fitting of the device is complete to ensure their Plan information is still correct.

Note: For information on **PharmaCare Plans** see Section 4 above or refer to the *PharmaCare/PharmaNet Policies and Procedures Manual* under Chapter 8.

7.2 Completion of Applications for Financial Assistance

All *Applications for Financial Assistance* forms should be fully completed and include a full description of the need for the device (why they need it). For example, the rationale should include a full description of why you are requesting a new or replacement prosthesis for the patient, or why you feel that the patient requires an articulated Ankle-Foot Orthosis (AFO) rather than a rigid one.

Information from all sources should be documented to justify your decision, including information regarding:

- The patient's current needs and abilities;
- Gait analysis;
- Ability to use the device;
- Occupational requirements;
- Functional ability; and
- Whether this is their dominant hand, etc.

Information located on the form already should not be stated as a reason for requiring the device. For example, information that should not be included as it is already on the form includes:

- Stating age (birth date is already on the form, if the form is complete);
- Stating diagnosis (already on the form, if the form is complete); or
- Level of amputation (already on the form, if the form is complete).

A description of the prosthesis/orthosis and/or service is required on the *Application for Financial Assistance* form.

The application should include all relevant documentation including prescriptions and instructions from the physician, where available.

Applications for Financial Assistance forms that are incomplete, or that have "Worn out", "First Prosthesis", etc. as the rationale for replacement, will **not** be processed and will be returned to the health care provider for more information and resubmission.

Note: If the "Weight", "Referring Physician" and "Other Agencies Involved" boxes are not completed, the application will be considered incomplete.

7.2.1 Supporting Documentation for New Amputee Prosthesis

For a new amputee, "First Prosthesis" or "Primary Amputee" is not a sufficient reason for providing a prosthesis. Justification should be based on the patient's health, needs and expected outcomes. For example, you should also include relevant information on your patient including, but not limited to the following:

- What did you do to determine that the patient will be a successful prosthetic user?
- Who did the assessments? Was a Team involved?
- Information regarding cognition;
- Information regarding gait and mobility (e.g., mostly required for home use, or community use; only required for transferring);
- Is the patient returning to work, or being retrained?
- Changes to the patient that affect fit (i.e., changes in height, weight, and/or limb size); and,
- Are there special considerations for their current health, age, or work requirements?

7.2.2 Supporting Information for Prosthesis Replacement — Physiological Change

Simply stating "Stump Atrophy" or "socket ill fitting" is not a sufficient explanation for replacement. For example, you should also provide details about your patient, including but not limited to the following:

- What ply socks is the patient wearing?
- Has padding been added to the prosthesis/orthosis?
- Changes in stump measurements; and
- What adjustments have been done, that may not have been sent in a previously approved application (e.g., adjustments under $400, so pre-approval was not required).

7.2.3 Supporting Information for Prosthesis Replacement — Wear and Tear

Simply stating "Worn out" is not a sufficient reason for replacement. Describe what is worn out and whether or not some parts can be replaced without replacing the full device. For example, include the following:

- Can the straps be replaced without making a new ankle foot orthosis?
- Does it have a hole in it? If so, where? What caused it?
- Is there any delamination? and
- Has the plastic fractured? If so, is there something that can be changed for the next one to make it last longer?

7.2.4 Supporting Information for a Partial Foot Prosthesis

When filling out an application for a partial foot prosthesis, provide a complete description of the item so that PharmaCare can more accurately track what is being provided.

Here are some sample descriptions, for reference:

- Shoe insert with longitudinal arch, toe filler
- Molded socket, ankle height, toe filler
- Molded socket, PTB height, toe filler
- Molded socket (plastic), ankle height, toe filler
- Molded socket (leather), ankle height, toe filler
- Molded socket (silicone), ankle height, toe filler

Additional information, such as the type of foot plate or any additional components being supplied, may also be listed.

7.3 Review of Applications for Financial Assistance

PharmaCare's Prosthetic and Orthotic Committee reviews all *Applications for Financial Assistance*, taking into consideration:

- whether the device/service is in keeping with PharmaCare's mandate and policies;
- the cost of the device/service requested (i.e., least costly, equally effective);
- the devices/services previously approved for the patient (from the patient file);
- warranty coverage for the devices; and
- replacement periods.

Applications are reviewed to ensure they meet PharmaCare policy and are therefore eligible for funding assistance. The health care provider is responsible for ensuring that the parts dispensed are safe for the patient (e.g., special heavier components required for patients over 220 pounds). Careful consideration should be taken in determining what components are provided to the patient to ensure the components will meet the patient's basic functionality requirements until at least the end of PharmaCare's established time limits for the replacement of the product or device (see Section 5, *Prosthetic and Orthotic Program – General Statement of Program Policy*).

7.4 Approval Letter or Form

When an application is approved, health care providers receive an approval letter or form from PharmaCare detailing:

- the patient's name;
- the products/services approved; and
    - for a Plan B (Residential Care), Plan C (B.C. Income Assistance) or Plan F (At Home Program) patient, the total dollar amount approved; or,

- for Fair PharmaCare patients, an approved amount, subject to determination of the patient's deductible.*

***** For Fair PharmaCare patients, PharmaCare cannot determine in advance the portion of the claim it will pay because this amount will depend on the patient's deductible at the time the claim is processed, so the approval is based on the maximum amount that would be approved by PharmaCare. The actual payment amount is the maximum approved amount less the patient's deductible and co-pay, at the time the claim is processed.

Fair PharmaCare patients who have not registered will have a deductible of $10,000 and the costs accumulate towards their deductible but they will not be eligible for any retroactive reimbursements (see Section 2.2).

Patients may choose to register for the Monthly Deductible Payment Option to assist them, by spreading the deductible portion of their payments over the remainder or the year (see Section 4.5 above).

7.5 Denied Applications

Notification if an application is denied will be provided including an explanation on why approval was not granted.

7.6 Submissions that Exceed Basic Functionality

Occasionally patients who are eligible for PharmaCare coverage may request components or devices that exceed basic functionality requirements. Usually these patients have private insurance to cover the additional costs, and require a denial letter from PharmaCare in order to access the funding from the private insurer.

In these circumstances, submit two separate *Application for Financial Assistance* forms. The first application includes all components that meet the basic functionality guidelines. The second application includes the components that the patient will be supplied which exceed PharmaCare's basic functionality guidelines.

You will receive an approval letter or form for the application that meets the basic functionality needs of the patient, and a denial letter for the application that exceeds the basic functionality requirements. PharmaCare will only provide funding, subject to your patient's usual PharmaCare plan rules and deductibles, up to the approved value for the device that meets the basic functionality criteria.

Any future adjustments or repairs required on the device or components that exceed basic functionality will not be covered by PharmaCare.

7.7 Switching Health Care Providers

Some patients are dissatisfied with either the health care provider or the product that was supplied and, as a result, may switch to a different health care provider for service even though the replacement period is not complete.

These patients are still subject to the same PharmaCare coverage rules even though their health care provider has changed. For example, they are still only entitled to one prosthesis every three years or one orthosis per year.

If a patient chooses to switch to a new health care provider, PharmaCare will consider a new application but the patient should not expect that they will be entitled to a new device. For instance, PharmaCare may consider the provision of a new socket, if it is warranted, but the new prosthetist will be required to reuse all the other components.

7.8 Liners

Applications for Financial Assistance (applications) submitted for pre-approval should be based on PharmaCare policy, and component choices within the application should reflect the Basic Functionality and Lowest Cost Device policies, with any exceptional requests supported by sufficient justification and documentation to explain the need for a more costly component.

Basic functionality liners include:

- pelite liners;
- thermoplastic elastomer liners (i.e. Alps, Silipos, or Alpha); and
- co-polymer liners (i.e. Otto Bock - TPE or Balance TPE).

Liners that exceed the basic functionality guidelines include:

- silicone liners (i.e. Iceross Comfort or Otto Bock Silicone Gel);
- urethane liners (i.e. Otto Bock's Simplicity);
- custom made liners (i.e. TEC); and
- seal-in liners (i.e. Iceross Derma or Stabilo).

Liners that are requested that exceed the basic functionality guideline will require appropriate justification. Justification can include, but is not limited to:

- information supplied by the prescribing prosthetist;
- documentation from a physiatrist, physician, dermatologist, plastic surgeon or wound care specialist (i.e. medical reports and prescriptions); or
- medical documents that corroborate the need for a change in the liner (i.e. cite the liner as the cause of the condition).

The guideline will be grandfathered for existing patients. This will allow special consideration to patients who **currently** have a liner which is not one of the basic functionality liners listed above. Appropriate documentation must accompany each application to show why it is important to keep the patient in their current type of liner, and why the exception was made.

Note: Although silicone liners are not considered to be basic functionality there are some silicone liners that are priced comparable to basic functionality liners and the liner of choice for some prosthetists. So, on an ongoing exceptional basis PharmaCare will approve applications including any liner that is priced

comparable to a basic functionality liner (i.e. same price or lower) without additional clinical justification being required.

8 Maximum Reimbursement Amounts

8.1 For Prostheses

Services related to the manufacture and or repair of a prosthetic device are reimbursed based on the health care provider's usual and customary price up to PharmaCare's maximum reimbursement amounts as follows:

8.1.1 Definitive Sockets

Prosthetic procedures related to the dispensing of a definitive socket are reimbursed based on the type/level of socket being fitted. The appropriate Product Information Number (PIN) should be used on all applications and invoices.

Pricing approvals are based on the health care provider's usual and customary price up to PharmaCare's maximum reimbursement amount as identified in the Reimbursement Schedule for Definitive Sockets available in Appendix 2.

A definitive socket includes all clinical labour costs and materials incurred in the creation and dispensing of the socket, including:

- Assessing and developing a treatment plan;
- Measuring and casting;
- Fitting and alignment;
- Custom manufacture of a definitive socket from a positive model obtained by means of a negative cast or use of computer assisted imaging, design and milling;
- Educating the patient about the prosthesis, on its general maintenance and care, and proper fit;
- Assessing function and patient prosthetic interface;
- 90 day health care provider warranty – warrant that all material and workmanship with respect to manufacture or repair of the device is free from defect for a period of 90 days from time of dispensing.

8.1.2 Other Prosthetic Procedures

Maximum reimbursement amounts for an hourly rate and various standard prosthetic procedures, excluding definitive sockets as above, have been included in a Reimbursement Schedule for Prosthetic Procedures (excluding definitive sockets) available at Appendix 3. Pricing for procedures will be reimbursed at the health care provider's usual and customary price up to PharmaCare's Maximum Reimbursement. Many of the procedure amounts

include the cost of some small components and the labour required to complete the procedure.

PharmaCare coverage is limited to one check, test, dynamic or diagnostic socket per definitive socket.

8.1.3 Component pricing

Maximum PharmaCare reimbursement amounts for components is calculated according to the Girling Formula. This formula is based on a percentage markup on the list cost of the item. The Girling Formula is available at Appendix 4.

The Girling Formula can be used for items purchased outside of Canada. The list price is adjusted to Canadian dollars and then the second column of the Formula (imported item % mark up) is used to allow for additional freight and duty costs.

8.1.4 Exchange Rate on Components Purchased Outside Canada

United States (US) exchange rates are reviewed regularly and adjusted as needed based on the posted close-of-business US Exchange rate published by the Bank of Canada (www.bank-banque-canada.ca/en/rates/exchange-look.html). In times of significant fluctuation, the rate is adjusted whenever it changes more than five cents and remains at a variance of five cents or more for a minimum of five working days.

When the US Exchange rate changes, the new rate is posted in the next PharmaCare Newsletter.

8.1.5 Prosthetic Adjustments and Repairs

Claims for repairs and adjustments should be considered when:

- the cost of the repair/adjustment is substantially less than the cost of the replacement;
- the repair or adjustment extends the useful life of the device; or
- the device is under the three year replacement period.

No claims for repairs or adjustments should be made to PharmaCare when:

- the products are under a manufacturer's or health care provider's warranty;
- the device or component does not meet PharmaCare's basic functionality criteria; or
- the device was purchased by a patient, their private insurance, another insurer such as ICBC, WorkSafeBC, Veterans Affairs Canada, Health Canada's Non-Insured Health Benefits Program, similar programs from other provinces or jurisdictions, or under an award for damages.

Adjustments and repair costs include:

- labour;

- cost of components required for the health care provider to complete the repair, plus the Girling Formula; and
- the actual cost of the manufacturer's repair to the device (include a copy of the work order/cost estimate from the manufacturer) plus the actual shipping and/or brokerage costs (invoices must be available for audit verification).

8.1.6 Prosthetic Supplies

Prosthetic supplies include items that are either part of the prosthesis or are required to support the proper functioning of the prosthesis such as socks, pins, locks, liners, etc.

Personal hygiene items such as lotions, antiperspirants and/or cleansers, are not PharmaCare eligible benefits. You may not claim personal hygiene supplies to PharmaCare as part of a pre-approved claim or as a claim under $400, not requiring pre-approval.

8.2 For Orthoses

Maximum reimbursement amounts for orthoses are based on the type of orthosis being fitted. The appropriate PIN should be used on all applications and invoices.

Services related to the manufacture and or repair of an orthosis will be approved based on the health care provider's usual and customary price up to PharmaCare's maximum reimbursement amount as specified in the Reimbursement Schedule for Orthoses (see Appendix 5).

A basic orthosis includes all clinical labour costs and materials incurred in the creation and dispensing of the orthosis, including:

- Assessing and developing a treatment plan;
- Measuring and casting;
- Fitting and alignment;
- Custom manufacture of a thermoplastic molded orthosis from a positive model obtained by means of a negative cast or use of computer assisted imaging, design and milling;
- Educating the patient about the orthosis, on its general maintenance and care, and proper fit;
- Assessing function and patient orthotic interface; and
- 90 day health care provider warranty – warrant that all material and workmanship with respect to manufacture or repair of the device is free from defect for a period of 90 days from time of dispensing.

8.3 For Ocular Prosthesis

Services related to the manufacture and or repair of an ocular prosthesis will be reimbursed based on the approved fee as identified on the approval letter or form. The maximum

reimbursement amount will be $2,000 per ocular prosthesis, with an additional $100 available for patients who require additional fitting time due to their unique circumstances. Any exceptions to this maximum reimbursement amount should include a detailed explanation providing rationale for any additional material or time required.

8.4 For Mastectomy Products

Maximum reimbursement amounts for mastectomy products have been included in a Reimbursement Schedule for Mastectomy Products available in Appendix 6. The appropriate PIN should be used on all applications and invoices.

9 Claims

9.1 Submission of Claims after Mandatory Pre-Approval Received

Submit your claim to PharmaNet:

- Within the six month time limit on the approval letter/form for all claims of $400 or more; and
- After all the work/service is complete, and the device has been dispensed to the patient.

9.2 Financial Control in PharmaNet

PharmaNet includes a financial control that limits processing of claims of $400 or more, to the six month window of the pre-approval time limit. As each *Application for Financial Assistance* is approved, a financial control is entered into PharmaNet to allow for the processing of the claim over the next six months.

If you receive the following message “Patient Not Entitled” when you process a claim, you should check the claim to ensure:

- That you have received an approved *Application for Financial Assistance* for the claim that you are processing;
- That you are processing the claim under the appropriate PIN, for the correct Personal Health Number (PHN), and under the correct pharmacy equivalency code (PEC); and
- That you are processing the claim within six months from the approval date.

If you have confirmed the above information is correct and you still cannot complete the claim then contact the Prosthetic and Orthotic Clerk at HIBC for assistance (see Section 2.4 above).

9.3 Online Claims

Online claims are accepted for **prostheses and prosthetic services** under Fair PharmaCare, Plan B (Residential Care), Plan C (Income Assistance) and Plan F (At Home Program).

Online claims are accepted for **orthoses and orthotic services** under Fair PharmaCare, Plan C (Income Assistance) and Plan F (At Home Program).

Software vendors provide software-specific training on submitting claims to PharmaNet.

Online claims must be submitted on PharmaNet using the PINs assigned by PharmaCare. These PINs are available at www.health.gov.bc.ca/pharmacare/pins/prospins.html.

When processing claims on PharmaNet:

- Enter the intervention code:
  - **MO** for all claims between $500.00 and $999.99; and
  - **MP** for all claims between $1,000.00 and $9,999.99.
- All claims that exceed $9,999.99 must be split and submitted as separate claims of $9,999.99 or less.
- In the **Prescriber ID** field, enter the referring physician's **Practitioner ID** assigned by the College of Physicians and Surgeons of BC. For unusual cases where there is no referring physician (i.e., supplies have been dispensed by the prosthetist/orthotist, or small repairs have been made) you may enter your **Practitioner ID** assigned to you by the College of Pharmacists of BC.

Remittance Advice Forms are sent to online health care providers only when a payment adjustment is made. To access payment data (except payment adjustment information) on PharmaNet use the Retrieve Daily Totals (TDT) transaction. All health care provider software vendor products contain a feature for retrieving daily totals although it may be named differently. Please consult your user manual or call your software vendor for information on this feature.

9.3.1 Online Claims for Residents of Residential Care Facilities

Submit all claims for residents of residential care facilities under Plan B.

- Claims of $400 or more - the Plan B claim number (also known as the "facility number") is provided in the PharmaCare approval.
- Claims of less than $400 - the PharmaNet Help Desk will provide you with a Plan B claim number when you call to arrange for submission of the claims.
- Submit online Plan B claims with the facility's Plan B claim number in the **Group ID** field.

Contact the PharmaNet Help Desk to make arrangements to submit online claims on the following day (see contact details in Section 2.3.1).

9.4 Manual Claims

Manual claims are accepted for **prostheses and prosthetic services** under Fair PharmaCare, Plan B (Residential Care), Plan C (Income Assistance) and Plan F (At Home Program).

Manual claims are accepted for **orthoses and orthotic services** under Fair PharmaCare, Plan C (Income Assistance) and Plan F (At Home Program).

Manual claims of $400 or more must be accompanied by a copy of the PharmaCare approval letter or form.

Patients are responsible for payments if their Fair PharmaCare deductible has not been met.

For claims less than $400, PharmaCare pre-approval is not required. Health care providers may prefer that their patient pays in full and submits a manual claim directly to PharmaCare, rather than submitting on the patient's behalf. This minimizes the possibility that the health care provider will receive a zero payment letter (see Section 9.4.2 below) from PharmaCare because the patient has not met their deductible.

9.4.1 Documents Required

Manual claims for Fair PharmaCare, Plan B (Residential Care), Plan C (Income Assistance) or Plan F (At Home Program) must include:

- a PharmaCare Invoice identifying:
  - the product or service, identified by applicable PIN;
  - the approved PharmaCare cost being claimed; and
  - **for patient submission's only**, a health care provider's invoice identifying the items dispensed, the cost paid and the applicable PINs for each item (invoice should be marked "PAID IN FULL"); and
- a copy of the patient's PharmaCare pre-approval letter or form.

The PharmaCare *Prosthetic Benefits - Invoice* and *Orthotic Benefits - Invoice* forms and instructions on how to complete them are available online from the PharmaCare website at www.health.gov.bc.ca/pharmacare/suppliers.html.

9.4.2 Zero Payment Letters

If a Fair PharmaCare patient has not met their annual deductible or family maximum when a claim is processed, some (or all) of the eligible claim amount will accumulate toward the patient's deductible.

PharmaCare will pay for the appropriate portion above the patient's deductible and/or family maximum.

If the PharmaCare portion of a Fair PharmaCare claim is $0.00 because the patient has not met their deductible, PharmaCare will send the health care provider a zero-payment letter.

In this case, the health care provider will need to obtain payment from the patient or the patient's private insurer.

Whenever a zero-payment letter is sent to you, please advise the patient to submit a paid receipt to PharmaCare so that the PharmaCare benefit can be added to their patient record.

Note: Health care providers may contact HIBC (see Section 2.3.1) to confirm that a patient has registered for Fair PharmaCare, however, under the *Freedom of Information and Protection of Privacy Act*; HIBC cannot divulge financial information about patients. Only the patient can elect to advise you of their deductible or family maximum. Patients can provide this information verbally or by presenting their *Confirmation of Assistance* form. Patients may contact HIBC (see Section 2.1) to confirm their registration, deductible and family maximum.

9.5 Where to Send Completed Claims

Submit manual claims by:

Fax: 250-405-3587

or

Mail: PharmaCare
P.O. Box 9655 Stn Prov Govt
Victoria, BC V8W 9P2

10 Payment

All health care provider claims – both manual and online – are processed on PharmaNet. The Ministry of Finance then issues payments to the health care provider weekly for accepted claims.

To receive payment by direct deposit, complete a BC Government *Direct Deposit Application*. Submit the application and an original void cheque to:

PharmaCare
P.O. Box 9655 Stn Prov Govt
Victoria, BC V8W 9P2

The *Direct Deposit Application* is included in the PharmaCare documents package (see Appendix 1). If the health care provider requires another copy they can contact Information Support (see to Section 2.5 for contact information.)

Note: For further information on completing this form, refer to the *PharmaCare/PharmaNet Policies and Procedures Manual* Section 6.1.1.

10.1 Payment for Manual Claims

Manual claims submitted to PharmaCare, where pre-approval has been received, will be reviewed and compared to the approval letter/form.

Note: For more detailed information on the payments refer to the *PharmaCare/PharmaNet Policies and Procedures Manual* Section 6.

For manual claims, health care providers will receive a *Remittance Advice Form* from PharmaCare with each payment issued by the Ministry of Finance. The *Advice Form* shows all claims processed by the site during the billing period.

PharmaCare processes manual claims on PharmaNet and pays its portion of each claim received (determined by PharmaNet) directly to the health care provider site. Any balance should be obtained from the patient or his/her private insurer.

Note: If the approval letter or form for the claim is stale-dated, or if the claim amount is higher than the approved amount, PharmaCare will postpone processing of the Fair PharmaCare, Plan B (Residential Care), Plan C (Income Assistance) or Plan F (At Home Program) claim and send the health care provider an enquiry letter (see Section 10.5).

See Section 9.4.2 for information on claims for patients covered under Fair PharmaCare that result in a 'zero-payment letter.'

10.2 Payment for Online Claims

For online claims, a *Remittance Advice Form* is issued only for adjustments to previous claims. To access other payment data, use your PharmaNet-compliant software's feature for retrieving daily totals (described in Section 9.3).

10.3 Claims Rejected by PharmaCare

If PharmaCare rejects any of your claims, the claim form is returned to you.

Claims accepted by PharmaCare are not returned.

10.4 Incomplete or Incorrect Claims

PharmaCare returns all incomplete or incorrect invoice claim forms to the health care provider for correction or completion.

If an incomplete or incorrect invoice is returned to you:

1. Correct or complete the original invoice. Do not submit a new invoice.
2. Ensure that the date on the invoice is the date the product or service was **received by the patient**.
3. Re-submit the invoice.

Note: The invoice is also returned if the claim is rejected due to patient ineligibility. If the patient is ineligible, the invoice should not be re-submitted.

10.5 PharmaCare Enquiry Letters

PharmaCare will postpone the processing of your manual Fair PharmaCare, Plan B (Residential Care), Plan C (Income Assistance) or Plan F (At Home Program) invoice, and will send an enquiry letter to you, in the following situations:

- the approval letter or claim is stale-dated;
- the invoice requires further clarification; or
- the amount is higher than the approved amount.

Approval is valid for six months from the date on the approval letter or form. If the date on the approval letter is more than six months before the date of service PharmaCare receives on the invoice, an enquiry letter is sent requesting an explanation.

If the claim amount is higher than the PharmaCare approved amount, an explanation of the difference is required, as the health care provider should have resubmitted the application for pre-approval of the new amount. Billing over the pre-approved amount for items that were not included in the original request, or for changes made to the original request, are not allowable expenses, even if the change is for under $400.

10.6 Health Care Provider's Role in Assisting Patients Submitting Manual Claims

Health care providers may choose to have the patient pay the full amount of the device/services and then make application to PharmaCare directly. In this instance the health care provider must still apply for pre-approval for all claims of $400 or more.

Fair PharmaCare patients may submit a claim for a prosthetic or orthotic device/service directly to PharmaCare only if they have paid the entire cost to the health care provider.

Assist patients in making claims to PharmaCare by ensuring they have the correct information and documents, and understand the process.

Health care providers should provide the patient with:

- a PharmaCare invoice;
- a copy of the health care provider invoice marked paid; and
- a copy of the PharmaCare approval letter or form.

10.7 Patient's Deductible Not Yet Reached

If a Fair PharmaCare patient's annual deductible has not been met when the claims are processed, some (or all) of the claim amount may accumulate towards the patient's deductible.

PharmaCare will send a zero-payment letter to the health care provider when the PharmaCare portion is $0.00 for a Fair PharmaCare invoice (see Section 9.4.2).

Whether the patient has reached their deductable or not, it is important to get pre-approval for the claim, and submit the claim to PharmaCare, if it is a PharmaCare eligible claim.

11 Audit

11.1 PharmaCare Audit

PharmaCare Audit:

- performs health care provider audits and writes health care provider audit reports;
- makes recommendations to the PharmaCare Audit Review Committee concerning overpayment recoveries as a result of health care provider audits;
- makes policy and procedure recommendations to PharmaCare based on audit outcomes; and
- manages the Confirmation Letter Program.

The mandate of PharmaCare Audit is to provide reasonable assurance to the taxpayers of BC and the Ministry of Health that health care providers and individuals are adhering to proper claims practices as required by the *Non-pharmaceutical Suppliers Participation Agreement* and PharmaCare policies and procedures.

Note: For more information regarding PharmaCare Audit refer to the *PharmaCare/PharmaNet Policies and Procedures Manual* Section 6.7.

11.2 Audit Program

As stated in the *Non-pharmaceutical Suppliers Participation Agreement*, health care providers shall, upon the request of a duly authorized government representative of the PharmaCare Program, supply all relevant information for the purposes of audit.

11.2.1 Selection Process

Health care provider audit selection is by analysis of data and information, by geographic random methods, or by “tips”.

Regardless of the method of selection, the PharmaCare Audit Review Committee (PARC) from the Ministry of Health must approve all audits. For information on this Committee, refer to the *PharmaCare/PharmaNet Policies and Procedures Manual* Section 6.7.2.

Other information received concerning a health care provider’s claims practice is carefully reviewed with respect to data analysis reports.

11.2.2 Health Care Provider Notification

Formal notice of an audit is normally provided. A notification letter, including the appointment letter of the auditors, as duly authorized government representatives, is sent by courier to the health care provider to confirm audit dates. A follow-up phone call from the Audit Manager, or lead auditor, will occur a few days before the arrival date to confirm arrangements.

11.2.3 Confidentiality

The confidentiality of the information used for the audit is guaranteed by the public service *Oath of Employment* taken by the auditors when hired as government employees. Once they arrive at a health care provider, the auditors and the site manager complete a *Health-Care Provider Designated Support Person Confidentiality Undertaking* form.

For more information, refer to the *PharmaCare/PharmaNet Policies and Procedures Manual* Section 3.2 “Confidentiality Undertakings”.

11.2.4 Records and Documentation

Auditors must be permitted, at all reasonable times, access to the health care provider’s site or other location where the records are located; to inspect and copy, or to remove those records for the purpose of copying; and to conduct an audit of those records related to claims paid in whole or in part by PharmaCare.

In the event that the audit team removes any such records from the health care provider’s site or the location where the records are located, the records will be returned within 20 business days, except for prescription records, which will be returned within 5 business days.

Note: The audit team will complete a *Temporary Removal of Documents* form with the health care provider manager when records are removed.

Upon request, the health care provider must inform the auditors of the location of the records if not kept at the health care provider site. If records are located out of province, they must be provided for audit within 20 business days.

In the event the health care provider is under audit at the time that any three-year period of required record retention is due to expire, the health care provider must retain those records and any supporting documentation until such time as the health care provider is advised in writing by the Ministry of Health that the audit is concluded.

All original documentation must be kept for a minimum three years. Premature destruction, incomplete records, missing (not found) or damaged records as a result of inadequate filing systems will not be accepted as a reason for incomplete documentation. Unsubstantiated claims are subject to recovery by the Ministry of Health as a PharmaCare overpayment. Patient records should include supporting documentation for all claims. PharmaCare may deduct the amount of the overpayment from any money owing to the health care provider.

Please note that patient files should include supporting documentation for all claims regardless of the amount paid by PharmaCare (this includes claims under $400).

11.2.5 Audit Scope

All claims (manual or online) paid in whole or in part by PharmaCare are subject to audit by duly authorized government representatives of the PharmaCare program. PharmaCare Auditors will require access to those claims.

All PharmaCare policies and procedures may be the subject of a health care provider audit.

Health care providers must abide by all requirements of any professional College, licensing or certification boards (such as the Canadian Board for Certification of Prosthetists and Orthotists), the *Pharmacy Operations and Drug Scheduling Act* (if connected to PharmaNet), and any other federal and provincial requirements. PharmaCare payments resulting from failure to do so are subject to recovery by the Ministry of Health and may be reported to the appropriate regulatory authority.

Audit staff will review patient files to verify:

- the original prescription from the physician, authorizing the prosthesis or orthosis (except for mastectomy prostheses and supplies);
- all original hand written notes in the patient file, identifying what occurred on each visit and what was dispensed to the patient; and
- original copies of the *Application for Financial Assistance* forms, approval letters/forms and invoices with the original patient signatures.

Audits include the review of patient files to verify that amounts have been paid for valid claims and that the authorizing practitioner's dispensing instructions were followed.

Note: In situations where criminal conduct is suspected, cases will be forwarded to the RCMP for investigation.

11.2.6 Draft Audit Report

A Draft Audit Report is mailed to the health care provider for response. The health care provider is given an opportunity to produce any documentation not previously found.

It is very important for the health care provider to carefully review the Draft Audit Report and identify any errors in fact or in the report's conclusions. Also, if there is additional information that is relevant, or which might have been overlooked during the audit, it should be included in the health care provider's response. This response will be considered and all or part of it may be incorporated into the Final Audit Report approved and issued by PARC.

Note: There is a 30-day limit to the Draft Audit Report feedback process.

11.2.7 Final Audit Report

The Final Audit Report will contain the decision of PARC. The audit may be concluded with no further action or with a required recovery of funds.

In the event of a recovery of funds, the covering letter of the Final Audit Report will outline the repayment options. As per the Ministry's Financial Administration Policy, the date of the Final Audit Report covering letter is the due date for the calculations and repayment purposes. When the recovery amount is 30 days overdue it will be subject to interest as per the *Financial Administration Act* Section 20 and the Interest on Overdue Accounts Receivable Regulation.

Results of audits may be referred to regulatory bodies as applicable and if appropriate.

11.2.8 Alternative Dispute Resolution

In the event of a dispute, an Alternative Dispute Resolution (ADR) meeting date may be requested in writing by the health care provider manager/owner in response to the Final Audit Report.

The ADR process provides health care providers with several options for settling disputes, ranging from informal problem solving to structured negotiation. The ADR process is intended to:

- encourage a co-operative, non-adversarial climate;
- achieve flexible, fair, and appropriate settlements; and
- avoid the excessive financial, psychological, and procedural costs associated with formal court proceedings.

While it is believed that most audit disputes can and should be settled through the ADR process, it is recognized that some cases will continue and be carried forward to a formal court proceeding.

The ADR process has a maximum 90-day time limit from the date of the first ADR meeting.

If all or some of the disputed issues are resolved, the recovery amount, including interest, will be adjusted accordingly.

If a mutually acceptable recommendation is not arrived upon within 90 days, the conclusions and recovery amount from the Final Audit Report will stand for the purposes of

repayment. Repayments owing to PharmaCare as a result of the ADR process are subject to interest from the due date.

11.2.9 Right of Recovery

Section 37 of the *Financial Administration Act* requires the recovery and collection of overpayments made by government. Further, Section 38 of the *Act* - "Set-off of amounts owed" allows money to be recovered by set-off. (A set-off allows money to be deducted from any money owing by government.)

If the health care provider fails to make the repayment required in the Final Audit Report, and fails to reach an agreement via the ADR process, then PharmaCare may deduct the amount of the overpayment from any money owing to the health care provider.

11.2.10 Confirmation Letter Program

The Confirmation Letter Program confirms information about prosthetic and orthotic claims. Two types of confirmation letters are sent as described below.

Random Patient Letters

The Confirmation Letter Program randomly confirms information with patients concerning PharmaCare-paid claims.

Each month, approximately one health care provider is randomly sampled. A random sample of patients, from that health care provider, are mailed a confirmation letter. Approximately 100 letters in total are mailed to patients requesting confirmation of designated medical devices and/or services received in the previous two months.

Patients sometimes misinterpret the intention of the confirmation letter.

Health care providers should reassure the patient that the Confirmation Letter is not issued to question the patient's claim but rather to confirm that the patient did indeed receive the medical device that was paid for by PharmaCare on their behalf.

Each letter is mailed with a self-addressed, pre-stamped envelope. If the first letter is not returned within six weeks, a second request is mailed.

Health care providers should encourage patients to return the letters to PharmaCare Audit using the envelope provided.

Note: Phone numbers for the public are included in the letter for any person wishing to contact PharmaCare Audit.

Select Verification Letters

As part of a health care provider audit, letters may be mailed to physicians or patients to verify information. Help Desk phone numbers for enquiries are provided on each verification letter, and a self-addressed, pre-stamped envelope is included. Physician verification letters also contain the lead auditor's name and direct telephone number. Second request letters are mailed six weeks after the first mailing.

APPENDIX 1 – PharmaCare Documents for Health Care Providers

PharmaCare provides each new health care provider with a start-up information package that includes:

- *Non-Pharmaceutical Supplier Participation Agreement*
- Fair PharmaCare brochures and Registration Information Slips
- *Direct Deposit Application* form
- List of Prosthetic/Orthotic PINs (4 pages)
- *Form 5400 - Orthotic Benefits – Application for Financial Assistance*
- *Instructions for Form 5400*
- *Form 5401 - Orthotic Benefits - Invoice*
- *Instructions for Form 5401*
- *Form 5402 - Prosthetic Benefits – Application for Financial Assistance*
- *Instructions for Form 5402*
- *Form 5403 - Prosthetic Benefits – Invoice*
- *Instructions for Form 5403*
- *Form 5404 - Prosthetic Benefits (Non-Limb) – Application for Financial Assistance*
- *Instructions for Form 5404*

You may request additional copies of these documents by telephoning the HIBC PharmaNet Help Desk (see Section 2.3.1 for contact numbers).

APPENDIX 2 - Reimbursement Schedule for Definitive Sockets

Reimbursement for prosthetic procedures resulting in the provision of a laminated definitive socket is based on the type/level of socket being fitted. The appropriate PIN should be used on all applications and invoices. For additional information about reimbursements for definitive sockets refer to Section 8.1.1 above.

PIN Left	PIN Right	Prosthetic Level	Maximum Reimbursement
LOWER BODY			
77123207	77123190	Trans-metatarsal (TM)	*by approval*
77123402	77123396	Trans-tarsal (TC) *Note: includes Lisfranc/Tarso-Metatarsal and Chopart/Mid-Tarsal*	$1,700
77123384	77123372	Symes (SY)	$2,880
77123360	77123347	Trans-tibial (TT)	$2,760
77123526	77123527	Rotationplasty (RP) *Note: includes Van Nes*	$3,160
77123487	77123475	Knee Disarticulation (KD)	$4,140
77123359	77123335	Trans-femoral (TF)	$3,740
77123524	77123525	Proximal Femoral Focal Deficiency (PD)	$4,200
77123440	77123438	Hip Disarticulation (HD)	$4,370
77123522	77123523	Hemipelvectomy (HP)	$4,485
UPPER BODY			
77123505		Hand Prosthesis (PH)	*by approval*
77123518	77123519	Wrist Disarticulation (WD)	$2,650
77123281	77123268	Trans –radial (TR)	$2,300
77123520	77123521	Elbow Disarticulation (ED)	$3,220
77123270	77123256	Trans-humeral (TH)	$2,800
77123463	77123451	Shoulder Disarticulation (SD)	$3,570

APPENDIX 3 – Reimbursement Schedule for Prosthetic Procedures (excluding Definitive Sockets)

Additional prosthetic procedures have been limited to a PharmaCare maximum reimbursement as set out in the following table. Pricing for procedures will be reimbursed at the health care provider's usual and customary price up to the PharmaCare maximum reimbursement amount specified below.

Immediate Post Operative Prosthesis can be billed separately, or it can be included with the first *Application for Financial Assistance* completed for the patient's first prosthetic device.

PharmaCare coverage is limited to one check, test, dynamic or diagnostic socket per laminated definitive socket.

Procedure	Maximum Reimbursement
Burgess cast – initial (with pylon, foot, forkstrap & waistbelt)	$705
Burgess cast – change	$605
Cast, rigid	$300
Cosmesis, endoskeletal finish – Trans- tibial (TT)	$455
Cosmesis, endoskeletal finish – Trans-femoral (TF)	$850
Hourly Rate	$120
Immediate Post Operative Prosthesis (IPOP)	$1,125
Liner, Fit and trim (pair) (only when replacing liners and not the definitive socket)	$60
Liner – Pelite	$350
Liner – Pelite and leather	$450
Liner – Pelite, leather and PPT	$550
Liner – Trans-femoral (TF), thermolyn with valve	$600
Loaner - Foot	$50
Loaner - Knee	$100
Prosthetic Glove, install	$60
Shuttle Lock Procedure (during fabrication of definitive socket)	$205
Strap, Patellar Tendon Bearing (PTB)	$170
Suction Procedure (TF only)	$300
Test socket – diagnostic, dynamic, trans-femoral (TF)	$600
Test socket – diagnostic, dynamic, trans-tibial (TT)	$500
Test socket – diagnostic, static, trans-femoral (TF)	$450
Test socket – diagnostic, static, trans-tibial (TT)	$350
Test socket – diagnostic, static, trans-radial (TR)	$350
Test socket – diagnostic, static, trans-humeral (TH)	$350

Note: Many of the maximum reimbursement amounts listed above may include the cost of some small components and the labour required to complete the procedure.

APPENDIX 4 - Girling Formula

Percentage Increment Chart

Catalogue price in Can $	Markup (%)	Markup Amount ($)	Costed out at	Imported item mark up (%)	Imported item costed out at
Up to $500	100%	$500	$1,000	120%	$1,100
$501 - $600	95%	$595	$1,195	95%	$1,295
$601 - $700	85%	$680	$1,380	85%	$1,480
$701 - $800	75%	$755	$1,555	75%	$1,655
$801 - $900	65%	$820	$1,720	65%	$1,820
$901 - $1,000	55%	$875	$1,875	55%	$1,975
$1,001 -$1,100	45%	$920	$2,020	45%	$2,120
$1,101 - $1,200	35%	$955	$2,155	35%	$2,255
$1,201 - $1,300	25%	$980	$2,280	25%	$2,280
$1,301 - $1,400	25%	$1,005	$2,405	25%	$2,505
$1,401 - $1,500	25%	$1,030	$2,530	25%	$2,630
$1,501 - $1,600	25%	$1,055	$2,655	25%	$2,755
$1,601 - $1,700	25%	$1,080	$2,780	25%	$2,880
$1,701 - $1,800	25%	$1,105	$2,905	25%	$3,005
$1,801 - $1,900	25%	$1,130	$3,030	25%	$3,130
$1,901 - $2,000	25%	$1,155	$3,155	25%	$3,255
$2,001 - $2,100	25%	$1,180	$3,280	25%	$3,380
$2,101 - $2,200	25%	$1,205	$3,405	25%	$3,505
$2,201 - $2,300	25%	$1,230	$3,530	25%	$3,630
$2,301 - $2,400	25%	$1,255	$3,655	25%	$3,755
$2,401 - $2,500	25%	$1,280	$3,780	25%	$3,880
$2,501 - $2,600	25%	$1,305	$3,905	25%	$4,005
$2,601 - $2,700	25%	$1,330	$4,030	25%	$4,130
$2,701 - $2,800	25%	$1,355	$4,155	25%	$4,255
$2,801 - $2,900	25%	$1,380	$4,280	25%	$4,380
$2,901 - $3,000	25%	$1,405	$4,405	25%	$4,505
etc.					

The partial $100 is worked out at the percentage rate for the next $100 increment.

Example 1: To calculate the cost-out amount for items with a catalogue price of below $500 multiply the price by two. For the imported items with a Canadian dollar price of below $500 multiply the amount by 2.2 to allow for the brokerage and extra freight charges.

Example 2: For an item that costs $788. From the chart go to line “$601 - $700” percentage markup is 85% so cost out is $1,380, for the first $700. To calculate the $88 go to the next line down “$701 - $800” for the percentage mark up which is 75%. So 75% of $88 is $66. Add the $66 to the $88 and to the $1,380 and you determine the total cost of $1,534.

APPENDIX 5 - Reimbursement Schedule for Orthoses

Reimbursement for orthoses are based on type. The appropriate PIN should be used on all applications and invoices. Pricing approvals are based on the health care provider's usual and customary price up to the PharmaCare maximum reimbursement amount specified below. For additional information about reimbursements for orthoses refer to Section 8.2.

PIN	Type of Orthosis (Abbreviation)	Description	Maximum Reimbursement

77123507	Supramalleolar Orthosis – Child's brace (SMO)	• Must be made from high temperature plastic
		• Must be custom fabricated from patient model
		• Extends to just above malleoli (ankle) and to the toes
		• Note that the following orthoses are NOT PharmaCare benefits:
		  ○ Foot orthoses
		  ○ UCBL (University of California Biomechanics Laboratory)
			$800

77123508	Ankle foot orthosis, rigid – Child's brace (AFO)	• Must be made from high temperature plastic • Must be custom fabricated from patient model • Extends from below the knee down to and includes the foot • Does NOT include an ankle joint, but may be made from flexible plastic which will allow some movement	$950
77123509	Ankle foot orthosis, articulated – Child's brace (AFO)	• Must be made from high temperature plastic • Must be custom fabricated from patient model • Extends from below the knee down to and includes the foot • Include an ankle joint	$1,150
77123510	Ankle foot orthosis, with supramalleolar orthosis – Child's brace (AFO w/SMO)	• Must be made from high temperature plastic • Must be custom fabricated from patient model • The SMO is molded and then a different type of AFO is molded over the top of the SMO; they can then be worn separately or together (i.e. SMO for circle time or floor play and AFO with SMO for walking)	$1,200 for rigid; $1,400 for articulated

PIN	Type of Orthosis (Abbreviation)	Description	Maximum Reimbursement
77123511	Ankle foot orthosis (AFO), patella tendon bearing (PTB)/ground reaction – Child's brace **Note:** This PIN also includes Chevron and Double-wrap AFOs	• Must be made from high temperature plastic • Must be custom fabricated from patient model • Extends from below the knee down to and includes the foot • Ankle joint may or may not be included, depending on type of orthosis	$1,200 for rigid; $1,400 for articulated, Chevron or Double wrap
	PTB	• Must include both a posterior and an anterior shell – double mold • **M**ust be used to offload weight from below the knee (i.e. tibia, fibula or ankle joint)	$1,200 for rigid; $1,400 for articulated
	Anti-crouch (ground reaction)	• Must include both a posterior and an anterior shell – double mold • Must be used to limit or assist in controlling dorsi-flexion and assist in controlling knee extension	$1,200 for rigid; $1,400 for articulated
	Chevron / Double Wrap	• A posterior leaf spring (PLS) style AFO, consists of a calf cuff that tapers to a narrow band behind the ankle (the "leaf") and widens back out to capture the heel and extend to the tip of the toes • "Chevron" describes the shape of the posterior reinforcement of the dual layer AFO • The principle of the AFO is ESR (energy, storage and return)	$1,400
77123512	Hip Abduction orthosis – Child's brace	• Note that the following orthoses are NOT PharmaCare benefits: ○ Dennis Browne boots and/or bars	

	Congenital Dislocation of Hip (CDH)/hip dysplasia	• Must be custom fit to patient or to patient model
		• Will be used only for very young children (infants)
		• This would include the following types of orthoses:
		  ○ Wheaton Brace
		  ○ Pavlik Harness
		  ○ Rhino/Rhino Cruiser (cruiser – up to 3 years)
		  ○ Von Rosen
			by approval

PIN	Type of Orthosis (Abbreviation)	Description	Maximum Reimbursement
	Standing, Walking and Sitting Hip Orthosis (SWASH)	• Used generally for Cerebral Palsy patients • Must be custom fit to patient or to patient model • Should be determined by a Team Assessment	by approval
	Legg-Calve-Perthes Disease	• Must be custom fit to patient or patient model • This would include the following types of orthoses: ○ Scottish-Rite	by approval
77123513	Knee ankle foot orthosis, rigid ankle – Child's brace (KAFO)	• Shells must be made from high temperature plastic or similar • Should include metal sidebars • Must be custom fabricated from patient model • Extends from above the knee to below knee, where it can attach to an AFO • Includes a knee joint but NOT an ankle joint • Please specify if this is just a knee extension orthosis to be used with an AFO and does not include the cost of the full AFO	$1050 for knee extension ONLY; $2,040 for full KAFO
77123514	Knee ankle foot orthosis, articulated ankle – Child's brace (KAFO)	• Shells must be made from high temperature plastic or similar • Should include metal sidebars • Must be custom fabricated from patient model • Extends from above the knee to below knee, where it can attach to an AFO • Includes the cost for ankle joint plus a knee joint and the additional time requirements	$2,240
77123515	Hip knee ankle foot orthosis – Child's brace	• Must be made from high temperature plastic or similar • Must be custom fabricated from patient model • Extends from hip down, where it can attach to a KAFO • Includes the cost for ankle joint, a knee joint plus a hip joint and the additional time requirements	$4,000

PIN	Type of Orthosis (Abbreviation)	Description	Maximum Reimbursement
77123516	Reciprocating gait orthosis – Child's brace	MUST result from a Team Assessment with appropriate Team support	by approval
77123517	Spinal orthosis – Child's brace	• Must be custom fabricated to patient or patient model • Needed to provide spinal stability for patients with spina bifida, scoliosis, Cerebral Palsy (or other neuromuscular conditions) and similar medical conditions • All requests for Cheneau-style braces must include appropriate documentation showing that the team responsible for the patient has taken the Cheneau training. At a minimum the team must include an orthotist and a physiotherapist. • Note that the following orthoses are NOT PharmaCare benefits: o Cervical collars (alone) o Cervicothoracic Orthosis (i.e. SOMI – Sternal-Occipital-Mandibular Immobilizer) o Minerva Brace o Aspen Brace o Halo Devices o Spinal Orthosis required post surgery o Spinal Orthosis to treat spinal fractures o SpineCor Brace	
	LSO	• LSO is the acronym for Lumbar-Sacral Orthosis	$1,835

PIN	Type of Orthosis (Abbreviation)	Description	Maximum Reimbursement
	TLSO	• TLSO is the acronym for Thoracic-Lumbar-Sacral Orthosis • A custom-molded plastic body jacket, or thoracolumbosacroal orthosis (TLSO), is fabricated from polypropylene or plastic. This orthosis is frequently a two-piece plastic clamshell design (it may be a single piece that opens in the front or rear) that extends from the pelvis to just below the collar bones • May include a feeding tube in the design • All requests for Cheneau-style braces must include appropriate documentation showing that the team responsible for the patient has taken the Cheneau training. At a minimum the team must include an orthotist and a physiotherapist. • This would include the following types of braces: o Boston Brace o Hybrid TLSO o Bi-valved TLSO o Clamshell TLSO o Milwaukee Brace o Charleston Bending Brace o Cheneau-style Brace	$2,010
	CTLSO	• CTLSO is the acronym for Cervical-Thoracic-Lumbar-Sacral Orthosis • This would include the following types of orthosis: o Milwaukee Brace	$2,210
77123499	Plagiocephaly orthosis – Child's helmet		$2,850
77123504	Orthotic repairs and adjustments **Use ONLY if pre-approval <u>NOT</u> required**	This PIN should ONLY be used for eligible PharmaCare claims under $400 that do not require pre-approval.	$400
77123528	Orthotic repairs and adjustments **Use if pre-approval required**		by approval

APPENDIX 6 - Reimbursement Schedule for Mastectomy Supplies

Reimbursement for mastectomy products are based on the type of product being supplied. The appropriate PIN should be used on all applications and invoices.

PIN	Description	Maximum Reimbursement
77123116	Breast Prosthesis - Left	$350
77123104	Breast Prosthesis - Right	$350
77123117	Lumpectomy - Left	$300
77123118	Lumpectomy - Right	$300
77123533	Off-Shelf Glove or Gauntlet	$150
77123534	Custom Glove or Gauntlet	$300
77123130	Lymphedema Arm Sleeve	regular retail
77123128	Post Mastectomy Brassiere	regular retail