VISION CARE BENEFIT

NON-INSURED HEALTH BENEFITS

Policy Framework

The Non-Insured Health Benefits Program provides supplementary health benefits, including vision care benefits, to registered First Nations and recognized Inuit throughout Canada.
www.healthcanada.gc.ca/nihb

Canada

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NON-INSURED HEALTH BENEFITS (NIHB) PROGRAM

First Nations and Inuit Health Branch
Health Canada

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Policy Framework

Ce document est aussi offert en français sous le titre :

PRESTATIONS DES SOINS DE LA VUE – CADRE DE TRAVAIL

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The purpose of this document is to explain the overarching policies that guide the administration of vision care benefits under the Non-Insured Health Benefits Program of Health Canada's First Nations and Inuit Health Branch (FNIHB).

This policy framework is intended to provide stakeholders, providers and clients with a broad overview of the parameters of the NIHB Program policies as they relate specifically to the vision care benefit area.

1.0 THE NON-INSURED HEALTH BENEFITS PROGRAM

1.1 Overview

The *Canada Health Act* requires that provinces and territories provide coverage for "insured services" (medically necessary hospital and physician services) to all eligible residents including First Nations and Inuit. Individuals may have access to other health-related goods and services through other publicly-funded programs or through private insurance plans.

The Non-Insured Health Benefits (NIHB) Program is a national program that provides coverage to registered First Nations and recognized Inuit for a limited range of medically necessary health related goods and services to which these individuals are not entitled through other plans and programs.

1.2 Program Objectives and Principles

The objectives of the NIHB Program are to provide benefits to registered First Nations and recognized Inuit in a manner that:

- is suitable to their unique health needs;
- helps eligible First Nations and Inuit to reach an overall health status that is comparable to other Canadians;
- is cost effective; and
- will maintain and improve health, prevent disease and assist in detecting and managing illnesses, injuries, or disabilities.

The NIHB Program operates according to a number of guiding principles:

- All registered First Nations and recognized Inuit individuals who are normally residents of Canada, and not otherwise covered under a separate agreement with federal, provincial or territorial governments, are eligible for Non-Insured Health Benefits, regardless of location in Canada or income level.
- Benefits are based on the judgement of recognized medical professionals, consistent with the best practices of health services delivery and evidence-based standards of care.
- There is national consistency of mandatory benefits, equitable access and portability of benefits and services.
- The Program is to be managed in a sustainable and cost-effective manner.

- Management processes will involve transparency and joint review structures whenever agreed to with First Nations and Inuit organizations.
- In cases where a benefit is covered under another health care plan, the NIHB Program will act to coordinate payment in order to help ensure that the other plan meets its obligations and the client is not denied service.

1.3 Client Eligibility

To be eligible for NIHB Program benefits from Health Canada, a client must be a Canadian resident and have the following status:

- is a registered Indian according to the *Indian Act*; or
- an Inuk recognized by one of the following Inuit Land Claim organizations – Nunavut Tunngavik Incorporated, Inuvialuit Regional Corporation, or Makivik Corporation. For an Inuk residing outside of their land claim settlement area, a letter of recognition from one of the Inuit land claim organizations and a birth certificate are required; or
- an infant, less than age one (1), whose parent is an eligible client; and
- is currently registered or eligible for registration, under a provincial or territorial health insurance plan; and
- is not otherwise covered under a separate agreement (e.g. a self-government agreement such as the Nisga'a and Nunatsiavut agreements) with federal, provincial or territorial governments.

1.4 Coordination of Benefits

Clients are required to access any public or private health or provincial/territorial programs for which they are eligible prior to accessing the NIHB Program.

When an NIHB-eligible client is also covered by another public or private health care plan, claims must be submitted to the client's other health care/benefits plan first. The NIHB Program will then coordinate payment with the other payer on eligible benefits.

1.5 NIHB Program Client Reimbursement

Service providers are encouraged to bill the NIHB Program directly so that clients do not face charges at the point of service when receiving health care goods or services.

When a client does pay directly for goods and services, he or she may seek reimbursement from the

NIHB Program within one year from the date of service or date of purchase. In order to be reimbursed, the service or item must be an eligible benefit under the NIHB Program.

All requests for reimbursement of eligible benefits must include a completed NIHB Client Reimbursement Form, original receipts and a copy of the prescription.

Additional information on the NIHB Program client reimbursement process can be obtained from the nearest Health Canada regional office or found on the Health Canada website under the Benefits Information section at: www.healthcanada.gc.ca/nihb

1.6 NIHB Program Appeal Process

Clients eligible for the NIHB Program have the right to appeal the denial of a benefit with the exception of items that are insured services or identified as exclusions. Appeals must be initiated and submitted in writing by the client, their parent, or a legal guardian. At each stage of the appeal process, supporting information/documentation from a health care provider(s) must also be provided to justify the grounds on which the appeal is based. If an appeal is denied, the reason for the denial will be provided to the client in a timely manner.

Additional information on the NIHB Program appeals process can be obtained from a Health Canada regional office or found on the Health Canada website under Benefits Information, in the Procedures For Appeals section at: www.healthcanada.gc.ca/nihb

1.7 NIHB Provider Audit Program

Audit activities are conducted as part of the NIHB Program's need to both comply with accountability requirements for the use of public funds and to ensure provider compliance with the terms and conditions of the Program, the NIHB Benefit Policy Frameworks and the NIHB Provider Guides provided to providers, along with other relevant documents.

The objectives of the NIHB Provider Audit Program are to:

- prevent and detect inappropriate billing practices;
- detect billing irregularities;
- validate active licensure of registered providers;
- ensure that services paid for were received by eligible NIHB Program clients; and
- ensure that providers have retained appropriate documentation to support submitted claims.

Audit activities are administrative in nature and based on accepted industry practices. Claims not meeting the billing requirements of the NIHB Program are subject to audit recovery. For additional information, please visit the Health Canada website at: www.healthcanada.gc.ca/nihb

1.8 Privacy

The Non-Insured Health Benefits Program of Health Canada is committed to protecting clients' privacy and safeguarding the personal information in its possession. When a benefit request is received, the NIHB Program collects, uses, discloses and retains an individual's personal information according to the applicable federal privacy legislation. The information collected is limited to only that information required for the NIHB Program to administer and verify benefits.

As a program of the federal government, the NIHB Program must comply with the *Privacy Act*, the *Canadian Charter of Rights and Freedoms*, the *Access to Information Act*, the Treasury Board of Canada Privacy and Data Protection Policies, the Government Security Policy, and the Health Canada Security Policy. Additional information on the protection of clients' privacy can be found on Health Canada's website under Protecting Personal Privacy at: www.healthcanada.gc.ca/nihb

2.0 VISION CARE BENEFITS

2.1 Objective

The objective of the NIHB Program vision care benefit is to provide eligible clients with access to vision care benefits and services in a fair, equitable and cost-effective manner that will:

- contribute to improving the overall health status of First Nation and Inuit clients, recognizing their individual health needs and the context of health service delivery; and
- provide coverage for a range of vision care benefits and services based on professional judgement, consistent with the current best practices of health services delivery and evidence-based standards of care.

2.2 Vision Care Coverage

Vision care benefits are set out in the *Vision Care Benefit List* (VCBL), which includes specific eligible items in the following categories:

- Visual examinations (e.g. general eye and vision examinations);
- Frames (e.g. regular eye glass frames);
- Lenses (e.g. unifocal); and
- Vision care benefit exceptions (e.g. tints and coatings).

As set out in the VCBL, some items may be subject to frequency limits.

A complete list of vision care benefits can be found in the VCBL on the Health Canada website at: www.healthcanada.gc.ca/nihb-publications

2.3 Vision Care Benefit Exceptions

Items which are not on the NIHB VCBL, and are not exclusions under the NIHB Program, may be considered on an exception basis.

Items that may be covered on an exception basis include contact lenses, tints and coatings and, in applicable regions, specific and follow-up eye examinations where the benefit is not covered by the provincial/territorial health plan.

A complete list of vision care benefit exceptions can be found in the VCBL on the Health Canada website at: www.healthcanada.gc.ca/nihb-publications

For all exception benefit items, a written prescription with proper medical justification by the prescribing Ophthalmologist or Optometrist is required as well as a completed NIHB Prior Approval (PA) form.

***Note:** Ocular prosthesis, scleral shell and low vision aids are available to eligible NIHB clients under the NIHB Program Medical Supplies and Equipment Benefit. For more information, please contact the Health Canada regional office in your region or visit the Health Canada website: www.healthcanada.gc.ca/nihb-publications

2.4 Vision Care Benefit Exclusions

Exclusions are goods and services which will not be provided as benefits under the NIHB Program under any circumstances and are not subject to the NIHB appeal process.

A complete list of vision care exclusions can be found in the VCBL on the Health Canada website at: www.healthcanada.gc.ca/nihb-publications

2.5 Vision Care Benefit Prescribers

Vision care benefits must be prescribed by an NIHB recognized prescriber. A vision care prescriber must be an Ophthalmologist or Optometrist who is licensed/certified, authorized, and in good standing with the provincial/territorial regulatory body in which they practice.

2.6 Vision Care Benefit Providers

Vision care benefits must be provided by an NIHB recognized provider. A vision care provider must be an Optometrist or Optician who is licensed/certified, authorized, and in good standing with the regulatory body of the province/territory in which they practice.

2.7 Accessing Vision Care Benefits

Vision care benefits are available to eligible registered First Nations and recognized Inuit when all of the following criteria are met:

- the requested item or service is on the NIHB *Vision Care Benefit List*;
- the prescription is less than one year old;
- the vision care services/goods are provided according to established professional standards and applicable provincial/territorial laws; and
- any public or private health or provincial/territorial programs for which the client is eligible have been exhausted prior to accessing the NIHB Program.

If all the above criteria are met, the client obtains a prescription from an NIHB recognized vision care prescriber and then submits the prescription to an NIHB Program recognized provider.

In order to ensure that reimbursement for goods and services are rendered, providers must obtain prior approval from the Health Canada regional office in the province/territory in which they practice. In the case of the Northwest Territories and Nunavut, vision care benefits for eligible clients are administered by Inuit Health organizations and territorial governments who, under a contribution agreement, have assumed responsibility for the administration and funding of vision care benefits.

Clients are encouraged to:

- inform the prescriber and provider if they have coverage under any other plan;
- inform the prescriber and provider that they are eligible to receive benefits under the NIHB Program; and
- self-identify by providing their eight to ten digit identification number (treaty/status, 'N' or 'B' number), Band name and family number or other health care number.

Vision care benefits for eligible clients residing in the Northwest Territories and Nunavut are being administered by their respective territorial government on behalf of the NIHB Program through contribution agreements. Service providers need to contact the territorial government to determine the client's eligibility for services.

2.8 Prior Approval Process

In order to ensure reimbursement by NIHB for goods and services rendered, providers must obtain prior approval from the Health Canada regional office in the province/territory in which they practice. In the case of the Northwest Territories and Nunavut, vision care benefits for eligible clients are being administered by Inuit Health organizations and territorial governments who, under a contribution agreement, have assumed responsibility for the administration and funding of vision care benefits.

If prior approval is granted, a prior approval number will be provided for billing purposes. Only then should the provider proceed with the fabrication/fitting/dispensing of the item. In applicable regions, professional/dispensing fees will be authorized in accordance with the relevant NIHB Program regional payment schedule. The prior approval will also ensure efficient processing of the claim.

If the client resides in a remote area, delivery charges (including mailing and registration) may be paid by the Health Canada regional office. Request for payment of delivery charges should be included in the request for prior approval.

Prescribers and providers should contact the Health Canada regional office in the province or territory where they practice for additional information on the prior approval process. The NIHB Prior Approval form can be found on the Health Canada website at:
http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/eye-yeux/vision_care-eng.php

2.9 Unclaimed glasses – Provider Reimbursement Process

A client has four (4) months **from the order date** to pick up their glasses. The provider should make a reasonable effort to encourage the client to pick up their glasses. These efforts should be documented in the client's file. In the event that the client does not pick up their glasses within four months, two options for the provider are proposed:

1) The provider will dismantle the glasses. The provider will invoice the NIHB Program only for the lenses and other parts of the glasses, which cannot be reused, as well as for any professional fees incurred for the provision of the lenses and other parts of the glasses, which cannot be reused. The frames should go back into the provider's inventory. No dispensing fee will be provided for the frames. The lenses should be sent to the regional office. Instead of the client's signature, the provider will indicate that the client did not pick up the glasses within the four month time frame, and submit the signed invoice for payment from the regional office. The regional office will add a note in the client's file stating that the lenses will be held by the regional office until the client claims them, or the frequency period* expires (whichever comes

*The frequency period refers to the date at which the client will be eligible for new vision care benefits. For more details on the frequency guidelines, please consult the *Vision Care Benefit List.*

first). Should the client contact the regional office for the lenses, the regional office will make arrangements to have the lenses sent to an eligible provider to be fit into frames and provided to the client. At that time, NIHB will reimburse the provider for the frames and dispensing fees for the client's glasses.

Based on the provider's professional opinion, if the glasses do not consist of any reusable parts, the second option should be employed.

2) The provider will mail the glasses to the regional office. The regional office will sign for the glasses on behalf of the client. The provider will submit an invoice and be reimbursed as per the regional fee schedule. The regional office will add a note in the client's file stating that the glasses will be held by the regional office until the client claims them, or the frequency period expires (whichever comes first). Should the client contact the regional office for the glasses, the regional office will make arrangements to have the glasses sent to the client. A note indicating the date that the glasses were mailed out will be put in the client's file. If the client does not contact the provider within the frequency period, the glasses will be sent to a charitable organization for their use.

It is important to note that the NIHB Program will not reimburse providers for any frames or lenses that are beyond the scope of NIHB coverage.