Royal Canadian Mounted Police | Gendarmerie royale du Canada

Benefit Provisions and Payment Guidelines for Health Services

The Benefit Provisions and Payment Guidelines (the "Guidelines") are effective December 13, 1999.

The Guidelines apply to Providers who provide treatment benefits pursuant to the *Royal Canadian Mounted Police Regulations* in consideration for payment under the Health Benefits Program administered on behalf of the Royal Canadian Mounted Police (RCMP) by Medavie Blue Cross under contract with Veterans Affairs Canada ("VAC").

1. For the purposes herein:

   "Member" means a person who is eligible to receive treatment benefits pursuant to the *Royal Canadian Mounted Police Regulations*.

   "Blue Cross" means Medavie Blue Cross under contract for certain aspects of the administration of the RCMP Health Program. Blue Cross is empowered to act on behalf of the RCMP as its agent however the establishment of policy, guidelines, and rules of the operation governing the Health Benefits Program remain the sole responsibility of the RCMP.

   "Program of Choice" (POC) is the treatment benefits within a specific group identified in the RCMP Administration Manual available to a member subject to the prescriber and pre-authorization requirements set out in the Benefit Grids related thereto.

   For greater certainty the 14 POCs are:

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

   "Prescription" means a written document that prescribes the treatment benefits recommended in relation to the member health needs and which is dated and signed by the required prescriber who is licensed or authorized for that purpose.

   "Provider" means a health professional or other person who provides a treatment benefit to a member and who submits a claim for payment under the Health Benefits Program.

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

   "Health Identification Card" means the card issued by Blue Cross that identifies an eligible member.

   "Royal Canadian Mounted Police Regulations" means the Regulations, as amended from time to time, pursuant to the *RCMP Act*.

   "Recovery" means a monetary fine imposed by Blue Cross against any Provider for failure to comply with the payment guidelines set out herein and within the respective Benefit Grids. Compliance to these guidelines is determined through the retrospective audit process as outlined under the section entitled "Claim Audits".

Providers

2. A Provider must conform to the registration, licensing or certification required pursuant to provincial enactments to be eligible to provide treatment benefits. If no such criteria exist, the Provider must meet the requirements established by the RCMP policy including the Benefit Grid.

3. The RCMP recognizes the authority and responsibility of provincial licensing bodies, pursuant to provincial enactments, to determine the eligibility of a Provider to practice a profession in a province.

4. When not consistent with and in addition to any other conditions required to comply with the Health Benefits Program administered by Medavie Blue Cross, any provider submitting a claim for payment or treatment benefits provided to a member shall be subject to the terms herein.

Claims

5. Otherwise than as provided herein, a Provider who submits a health benefit claim for payment of the cost of treatment benefits provided to a member shall:

   a) submit a claim only after the service date;

b) submit the claim to Blue Cross or to RCMP Occupational Health Services Offices, if directed to do so, using the appropriate claim form or electronic format required by the POC that applies to that treatment benefit;
c) claim no more than the amount equal to the rate payable to the Provider by a person who purchases the treatment benefit for cash;
d) be paid at the rate established for the treatment benefit pursuant to the *Royal Canadian Mounted Police Regulations* and any guidelines, policies, contracts or fee schedules established thereunder; such payment by the RCMP at that rate to be full and total consideration in respect of the claim;
e) confirm that the claim is true and accurate to the best of their knowledge and belief;
f) confirm that the claim does not include any amount in respect of a treatment benefit provided to a member, for which the Provider has otherwise been reimbursed or will be reimbursed pursuant to a provincial health care system, any provincial or federal legislative program or any municipal program;
g) confirm that the Provider has complied with the prescription requirements described in the Guidelines; and
h) when required, return health information to the appropriate RCMP Occupational Health Services Office.

6. With the exception of an electronic claim form, a health benefit claim form submitted by a Provider shall be signed by the member or, if the member is not able to sign the claim form, a family member, personal care worker or member representative must sign the claim form on behalf of the member and provide an explanation why the member was unable to sign.

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

8. A Provider shall not submit a claim for a treatment benefit in circumstances where the member has cancelled the request for the treatment benefit or the member refuses to accept delivery thereof.

Prescription Requirements

9. The following terms apply when the POC Benefit Grid requires that a member has a prescription to establish entitlement to a treatment benefit:

a) the Provider must obtain and have possession of the prescription before the treatment benefit is provided to the member. A claim will not be eligible for payment if the Provider obtains the prescription after the service date. Any amounts previously paid with respect to such a claim are recoverable from the Provider;
b) unless otherwise indicated on the respective Benefit Grid, prescriptions are required for both the initial and subsequent purchase of benefits. A prescription may authorize refills in conformity with the Benefit Grid and the Provider may provide a treatment benefit in accord with the number of refills designated in the prescription. A refill not designated on the prescription shall not be eligible for payment and any amounts previously paid with respect to such a claim are recoverable from the Provider;
c) a prescription that is not dated will be deemed invalid and a claim for a treatment benefit provided by a Provider on the authority of an undated prescription shall not be eligible for payment and any amounts previously paid with respect to such a claim are recoverable from the Provider;
d) a prescription, including all designated refills, shall be valid for only one year from the date it is written and a claim for a treatment benefit provided by a Provider on the authority of an expired or invalid prescription shall not be eligible for payment and any amounts previously paid with respect to such a claim are recoverable from the Provider.

10. POC 10 (Prescription Drugs) health benefits must be prescribed by an authorized physician, dentist, optometrist or other authorized prescriber (licensed to do so by the province).

11. POC 7 (Medical Supplies) treatment benefits must be prescribed by a physician or other health professional in accordance with the Benefit Grids**.**

12. For POC 7 and POC 10 treatment benefits, the Provider may provide a benefit to a member on the authority of a prescription communicated verbally by the prescriber subject to the Provider recording the following information:

- name and address of the member
- the date the prescription was verbally communicated
- the prescriber's name
- name of the benefit prescribed
- quantity of the benefit prescribed
- strength of the benefit prescribed (if applicable)
- number of refills authorized
- the indicator (V/O) for the verbal order
- the Provider's initials

Payment of Claim

13. Blue Cross shall process a claim within a reasonable period of time from receipt of a claim from a Provider and, subject to the following exceptions, pay the Provider at the appropriate rate:
    a) a claim submitted in an unacceptable format will not be processed;
    b) a claim submitted at a date later than eighteen (18) months from the service date is not eligible for payment;
    c) a claim that does not otherwise conform to the Guidelines including the POC Benefit Grid is not eligible for payment.

Claim Audits

14. Blue Cross may audit a claim to determine if the claim conforms to the Guideline requirements. In cases where Blue Cross determines that the requirements are not met, the claim will be ruled ineligible for payment or if payment was made to the Provider, that payment shall constitute a debt subject to recovery by Blue Cross.
15. Where, as the result of an audit, Blue Cross has identified a prescription is missing or invalid, the Provider may not submit prescriptions that the prescriber reissues or duplicates after the service date to support the claim of the Provider.
16. Blue Cross shall have the right to audit any claim submitted by a Provider, regardless whether the claim was paid or is outstanding for payment and including claims for which pre-authorization was obtained from the RCMP Occupational Health Services Offices.
17. Blue Cross shall have the right to access and retrieve copies of any records and information relevant to the Provider's claim including, but not limited to, any manufacturers' invoices and account statements (where the records form part of the basis for the amount billed), claim forms and prescriptions.
18. Blue Cross shall, at the conclusion of an audit, immediately notify the Provider in writing of the Audit Decision and what amount of a claim, if any, is eligible for payment or recovery.

Audit Redress Procedure

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

    National Investigative Unit
    Medavie Blue Cross
    P. O. Box 220
    Moncton NB E1C 8L3

20. For the purpose of a Review, the Provider may submit new or additional information or reasons why all or a portion of the claim is eligible for payment. The information submitted will be considered by Blue Cross and within a reasonable time period a Review Decision rendered with respect to the eligibility of the claim for payment. Blue Cross will immediately notify the Provider in writing of the Review Decision.
21. A Provider may, within fifteen (15) working days from the date of receipt of a Review Decision, request that the RCMP conduct a reconsideration of the Review Decision. The Provider must direct the request for reconsideration in writing to:

    Occupational Health & Safety Branch
    73 Leikin Drive
    Mail Stop #40
    M4 - 04 Suite 606
    Ottawa ON K1A 0R2
    Attention: Director General

22. For the purpose of a Reconsideration, the Provider may submit new or additional information or reasons why all or a portion of the claim is eligible for payment. The information submitted will be considered by the RCMP and a Reconsideration Decision rendered with respect to the eligibility of the claim for payment. The RCMP will notify the Provider in writing of the Reconsideration Decision.
23. The RCMP Reconsideration Decision shall be a final and binding disposition of the claim, subject to any other legal remedies available to the Provider.
24. At the date of an Audit Decision, Review Decision or Reconsideration Decision or the result of any other legal remedy available to the Provider and in conformity with the Decision concerning the issues in dispute between Blue Cross and the Provider with respect to a claim:
    a) any amount payable by one party (payer) to the other party (payee) shall be payable forthwith, provided that the amount exceeds the minimum recovery payment established either by RCMP policy or the Health Benefits Program; and
    b) the Provider may not resubmit a claim that was determined to be ineligible for payment and Blue Cross shall not be obligated to pay any such claim.

Member Retention of Treatment Benefit

25. Providers shall not:

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

Confidentiality

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

Provider Status

27. The RCMP reserves the right to determine who may participate as a Provider. The RCMP may refuse, suspend or revoke the status of a Health Benefits Program Provider for reasons including, but not limited to:

    a) the Provider refuses Blue Cross access to the records and information incidental to the conduct of an audit or otherwise fails to cooperate in the conduct of the audit;
    b) the Provider in any advertising material for treatment benefits that is published or distributed by the Provider refers to the RCMP in any way other than the following statement "RCMP HEALTH IDENTIFICATION CARDS ACCEPTED";
    c) the Provider, either in writing or orally, makes any claim that the RCMP endorses the treatment benefits available from that Provider over those of any other Provider;
    d) the Provider specifically directs advertising for treatment benefits to clients in order to solicit business, unless that advertising is part of a general distribution to all members and other persons;
    e) the Provider contacts members by telephone or any other means for the purpose of soliciting business;
    f) the unsatisfactory provision of treatment benefits;
    g) the Provider fails to adhere to the requirements outlined in the POC Benefit Grid; and
    h) fraud.

Sanctions

28. The RCMP may take any of the following actions based on the conclusion of an audit:

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

Retention of Records

29. Documentation must be retained in accordance with the laws of the Provider's province of business concerning retention of health records and Canada Revenue Agency requirements for taxation purposes.

Jurisdiction

30. The RCMP retains sole authority to establish the policy, guidelines and rules with respect to eligibility for treatment benefits and the Health Benefits Program. The RCMP will notify the Provider at least ten (10) working days in advance of the effective date of any amendment or revocation of these Guidelines.

Severability

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