Veterans Affairs Canada | Anciens Combattants Canada

VETERANS AFFAIRS CANADA (VAC)
PROGRAM OF CHOICE (POC) 12 – RELATED HEALTH SERVICES

November 2011

Services provided by mental health providers are vital to the well-being of our Veteran clients and their families. Veterans Affairs Canada (VAC) has committed to reducing the complexity and improving the quality and timeliness of the services provided to Veterans and providers. VAC strives to keep providers up to date on program changes and wants to ensure providers are paid efficiently and in a timely manner.

Over the next few months we will be working on making changes to improve the process of the current program. Some changes have already been made and are outlined below. This bulletin also provides you with the important information required when submitting your claims to Blue Cross. We've included a list of requirements that will help ensure your claims are processed quickly and efficiently.

WHAT CHANGES HAVE BEEN MADE?

PRE-AUTHORIZATION
Most mental health services will only require pre-authorization the first time a Veteran accesses a benefit. As long as you continue to use the same service/benefit code for the same client, you will not need to request an authorization number on a yearly basis. In most cases, you will only need to provide verification that a physician's prescription has been obtained on a yearly basis. If you provide another service to the client under a different benefit code, you will need to obtain pre-authorization to proceed.

FREQUENCY
Effective **September 15, 2011**, eligible clients will be entitled to as many as 25 occurrences (up to one hour session) per calendar year for mental health benefits. This change does not affect services rendered prior to September 15, 2011. If a client is expected to require more sessions in one calendar year, you must request authorization from the VAC Treatment Authorization Centre (TAC). In order to avoid delays in payment, it is important to request authorization for additional sessions as soon as it is evident they will be required. A progress plan will be required when requesting authorization for additional sessions. If additional sessions are approved, VAC will provide you with an authorization number that must be included when submitting this expense. Please use the VAC report templates to provide the detailed assessment and treatment recommendations. Report templates are available at vac-acc.gc.ca > **Mental Health > Working with Providers, click "Show Table of Contents" tab and, from the menu, choose Tools and Forms**.

PROGRESS REPORTS
Progress reports are no longer required every six months to continue treatment sessions. For most VAC clients, you will only need to submit a progress report if it has been determined that the frequency limit needs to be exceeded. Exceptions may be made and the VAC Case Manager will advise you on a case-by-case basis if regular progress reports are required for a particular client. An End of Treatment Summary is required at the end of your involvement with the client.

Please refer to the attached Claims Submission Requirements when submitting your claims. Claims received after 18 months from the dates of service or submitted without the required information will be rejected. (For clients participating in VAC's Rehabilitation Program, claims must be submitted within one year.)

If you have any questions regarding the above changes, please contact the VAC Treatment Authorization Centre (TAC) at 1-866-811-6060 **BEFORE** submitting your claims.

BLUE CROSS CROIX BLEUE

Canada

VETERANS AFFAIRS CANADA (VAC)
CLAIMS SUBMISSION REQUIREMENTS

As an approved registered provider for Veterans Affairs Canada, you must submit claims for payment to Blue Cross in accordance with the Terms and Conditions outlined in the *Provider's Information Manual.* Most of the services provided by mental health providers make up part of Program of Choice (POC) 12 - Related Health Services.

REQUIREMENTS

The following requirements MUST be met before providing a benefit/service:

- **PRESCRIPTION** – Most benefits in the program require a prescription from a qualified professional. The prescription is valid for one year from the date it is written and must be kept on file. You must ensure the prescription is from the type of professional outlined in accordance with the *Benefit Grid*. If the *Benefit Grid* indicates a specialist, a prescription only from that type of specialist is accepted. The prescriber for each benefit code is noted in the "Prescriber Required" column of the *Benefit Grid*.

- **PRE-AUTHORIZATION** – Some benefits require approval from VAC's Treatment Authorization Centre (TAC) prior to services being rendered. If pre-authorization is required, it is indicated in the "Pre-authorization" column on the *Benefit Grid*.

  - If services are approved in excess of the frequency limit, you will receive an approval letter from VAC that will include the *Authorization Number*, the *Benefit Code*(s) and the number of sessions/occurrences approved. This *Authorization Number* must be included on your claim submissions for each session/occurrence that has been approved.

SAMPLE OF BENEFIT GRID

PROGRAM OF CHOICE: 12 - RELATED HEALTH SERVICES

BENEFIT DESCRIPTION	BENEFIT CODE	EFF. DATE / TERM. DATE	PRESCRIBER REQUIRED	RECOMMENDER REQUIRED	PRE-AUTHORIZATION GROUP A	PRE-AUTHORIZATION GROUP B	FREQUENCY	MAXIMUM AMOUNT\VAC FEE	PROVINCIAL COVERAGE	COMMENT
PSYCHOLOGIST - INDIVIDUAL VISIT	249040	19-04-2009	MD		TAC	TAC		$		SEE NOTE 18, SEE GENERAL NOTE

SAMPLE OF CLAIM FORM

Client / Member of (check applicable department) • Client / Membre de (Cochez le ministère pertinent.)
☑ VAC - ACC ☐ Canadian Forces (CF) - Forces canadiennes (FC)

CLAIM INFORMATION • RENSEIGNEMENTS

P O C	P D C	Authorization No. N° d'autorisation	Date of Service/Rental Date de service/location From - De D-J M-M Y-A	To - À D-J M-M Y-A	Benefit Code Code d'avantage	Make / Model Marque / Modèle	Warranty Exp. Date Exp. de la garantie	Serial No. N° de série	P *	R **	Qty Qté	Unit Price Prix à l'unité	Total Charge Montant total	Less Prov. or Terr. Share Moins les frais à la prov. / terr.	Bill to Health Benefits Program Facturé au programme d'avantages de soins de santé
12		12345v1234	01-Jan-2011	-	123456	n/a	n/a	n/a	MD		2	100.00	200.00	n/a	200.00

The following is a list of ALL information required when submitting claims to Blue Cross:

- Your Name and Provider Number
- Authorization Number (if required)
- Individual dates of service
- Benefit Code for each date of service
- Prescriber (if required)
- Number of occurrences/sessions (refer to the "Frequency" column on Benefit Grid)
- Cost per occurrence/session and the Total Cost
- Client Name and Identification Number
- Client Signature
- Original Provider Signature / Stamp

DEFINITIONS

AUTHORIZATION NUMBER – A 10-digit number provided to you by the TAC when services are authorized. The number will appear in this format (00000**V**0000).

Generally, the *Authorization Number* will only need to be included on your claim form the first time you submit a claim and for additional sessions/occurrences in excess of 25 per calendar year for the same benefit code. If additional sessions/occurrences are approved, you will be provided with a separate *Authorization Number*.

BENEFIT CODE – Six-digit numerical code(s) found on the *Benefit Grid* that relates to specific benefits/services. This number is required when submitting claims to Blue Cross.

BENEFIT GRID – A document listing *Benefit Codes* related to benefits/services and the requirements for each code. The most up-to-date Benefit Grids can be found on the VAC web site at vac-acc.gc.ca > Services and Benefits, scroll down to Health Care Benefits, click on “Show Table of Contents” tab from the menu choose Benefit Grid.

CLAIM FORM – A form used to submit claims to Blue Cross. Claim forms are available in paper and electronic format. You may choose to submit claims using your own invoices; however, your invoice must include ALL information previously listed in the Requirements section.

OCCURRENCE – An occurrence may be equal to .5 hour or 1 hour depending on your province. Please refer to the *Benefit Grid* for details.

PROVIDER’S INFORMATION MANUAL – A guide that explains VAC’s programs and processes. This information package is sent to you when you become an approved registered VAC provider.

CONTACT INFORMATION

If you have any questions, please contact us **BEFORE** submitting your claim(s).

VAC TREATMENT AUTHORIZATION CENTRE(S) (TAC)

1-866-811-6060 (English) **1-866-812-5050** (French)
For questions or requests related to client eligibility and/or benefit authorization

VAC WEBSITE **www.vac-acc.gc.ca**

For information on VAC programs and services and how they can help your patients/clients

BLUE CROSS FEDERAL INQUIRY UNIT

1-888-261-4033
For questions related to claim submissions and payments and requests for Provider’s Information Manual, Benefit Grids and/or paper claim forms

BLUE CROSS WEBSITE **www.medavie.bluecross.ca**

For access to provider bulletins and electronic claim forms