First Nations Health Authority
Health through wellness

PACIFIC BLUE CROSS

VISION FEE SUPPLEMENT

For
Clients of the First Nations Health Authority

February 2020

Version History

Version	Modified/ Effective Date	Description
Vision Fee Supplement Version 1	September 2019	Publication of Vision Service Codes and Claiming Criteria for FNHA Clients

Vision Fee Supplement Version 2	September 2019	Updates and corrections to Vision Service Codes and Claiming Criteria for FNHA Clients
		• Updated Introduction section:
		  ○ Added in pre-determinations and itemized receipts to Claiming Guidelines,
		  ○ Added Claiming Criteria section, updated text.
		• Added asterisks to Service Code Descriptions to indicate when a claim will only be paid up to the posted rule.
		• Service Code 44002 - Removed term “once” from Rule, added sight tests to Description.
		• Service Code 28000 - Removed term “once” from Rule.

Vision Fee Supplement Version 3	October 2019	• Updated Service Descriptions throughout the document to provide clarity. • Updated each section to sort alphabetically by Service Descriptions. • Updates to Early Replacement section.
Vision Fee Supplement Version 4	February 2020	• Updated headers for benefits tables. • Updated Claiming Criteria for Service Codes: 28003, 28002, 28000, 28001, 28004. • Added Service Code: 44014. • Updated Description for Service Code: 44002. • Restructured Vision Wear Service Codes to group under 7.0 Dioptre and 7.0 Dioptre and Higher service codes together.

Contents

Introduction

This Fee Supplement contains products and services the First Nations Health Authority (FNHA) provides as eligible benefits for their clients that Pacific Blue Cross (PBC) administers on their behalf.

Please note: This Fee Supplement will be updated when changes, additions or deletions are made to the contained list of products and services.

All claiming procedures are outlined in the PBC Vision Reference Guide. For benefits that require Pre-Determinations as outlined in the tables below, Pacific Blue Cross will accept paper pre-determinations submitted by mail or fax (for FNHA clients only: 604.677.0277). Incomplete forms will be rejected and must be resubmitted.

Claiming Criteria

The tables below outline Claiming Criteria requirements. The detailed requirements are summarized by three indicators: 1) Yes, 2) No, and 3) History on File.

- "**Yes**" indicates the need to submit all supporting documentation at time of claim.
    - All claims submitted will pend for adjudication
        - Service descriptions can be marked with an asterisk
            - This indicates that "claims submitted will only be considered up to the posted rule" OR,
        - Service descriptions are not marked with an asterisk
            - This indicates that claims can be considered above the posted rule

- "**No**" indicates that no documentation must be submitted at point of claim but must be retained for claim verification.
    - Some claims submitted will auto adjudicate.
        - Service descriptions can be marked with an asterisk
            - This indicates that "claims submitted will only be considered up to the posted rule" OR
        - Service descriptions are not marked with an asterisk
            - Claims submitted at or below the posted rule OR
    - Some claims submitted will pend for adjudication
        - Service descriptions that are not marked with an asterisk
            - Claims submitted is in excess of the posted rule

- "**History**" indicates that some claims may process without claiming criteria submitted at each claim if the appropriate medical history is already on the client's file.
    - Some claims submitted will auto adjudicate
        - The appropriate medical history is already on the client's file.
            - Service descriptions marked with an asterisk
                - Claims submitted at or below the posted rule OR
            - Service descriptions that are not marked with an asterisk
                - Claims submitted at or below the posted rule
    - Some claims submitted will pend for adjudication
        - The appropriate medical history is not already on the client's file and/or,
        - Service descriptions are not marked with an asterisk
            - Claims submitted is in excess of the posted rule

Claiming Guidelines

Pre-Determinations

- For expensive vision products, it is recommended that claim-payment validation is received prior to purchasing.
- Pre-determinations are a simple way to check if the vision product will be covered, and how much it will be reimbursed for.
- Pre-determinations may require specific claiming criteria to be included with the quote.
- Regardless of whether a pre-determination is submitted prior to a claim, all claims will be considered using the same claiming criteria requirements.

Provider Claims by Paper

Submit a completed PBC claim form for FNHA clients, ensuring expense itemization. Attach any additional required documentation as outlined in the table below to the claim. All records of the purchase must be retained and are subject to review.

Provider Electronic Claims

For eligible electronic claims, all records of the purchase must be retained and are subject to review. Retain any additional required documentation as outlined in the table below.

Client Claims by Paper

Submit a completed PBC claim form for FNHA clients with the attached official itemized receipt showing the expense was paid in full. Attach any additional required documentation as outlined in the table below to your claim.

Client Electronic Claims

For eligible electronic claims, retain a copy of the official itemized receipt showing the expense was paid in full. Retain any additional required documentation as outlined in the table below.

Itemized Receipts

Pacific Blue Cross' standards for itemized receipts follow the standards outlined by CLHIA in the Service and Supply Provider Receipt Best Practices for Group Benefit Reimbursement. Suggested fields include:

- Receipt date
- Date of service/supply
- Services Billed by Monthly Fee
- Government plan payment
- Other payment
- Provider name
- Provider address
- Provider phone number
- Provider professional identification, designation or credentials
- Patient name
- Type of service/supply provided
- Quantity provided
- Length of treatment
- Charge amount
- Taxes (as applicable)
- Receipt number
- Method of payment

Vision Benefits

Eye Exams

Service Code	Description *Indicates claims submitted will only be considered up to the posted rule.	Dollar Max/Frequency Guidelines	Claiming Criteria (Y/N/H)	Criteria
44002	*Eye Exam† *Eye Exams must be performed by Optometrists or Ophthalmologists.*	**18 Years Old or Under:** $100 per-calendar year; Set based on their first claim. **Over 18 Years Old:** $100 per 2 calendar years; Set based on their first claim.	N	Retain record of date and results of exam or sight test on file.
44014	*Sight Test *Sight Tests may be performed by Opticians* ***Please Note:** This is not eligible for clients under the age of 19 or age 65 or older.*			

† Eye Exams are eligible with the Provincial Plan (BC MSP) for individuals under age 19 and over age 65, and for individuals of any age if medically required. Please ensure you submit to MSP first and then submit the outstanding portion under the Pacific Blue Cross plan.

Vision Wear Service Codes

Service Code	Description *Indicates claims submitted will only be considered up to the posted rule.	Dollar Max/Frequency Guidelines	Claiming Criteria (Y/N/H)	Criteria
Under 7.0 Dioptre		**18 Years Old or Under:** $275 per calendar year or $415 for high-index (+/-7.00 dioptre and above in one eye); Set based on their first purchase. **Over 18 Years Old:** $275 per 2 calendar years or $415 for high-index (+/-7.00 dioptres and above in one eye); Set based on their first purchase.	N	Retain record of exam or sight test on file.
28003	*Contact Lenses			
28002	*Frames			
28000	*Glasses - complete pair (under 7.0 Dioptre)			
28001	*Lenses (under 7.0 Dioptre)			
28004	*Prescription Sunglasses (under 7.0 Dioptre)			
7.0 Dioptre and Higher			N	**Provider:** Retain a copy of the Rx from an optometrist or ophthalmologist showing the diopter requirement on file. **Client:** If submitting electronically, retain a copy of the Rx from an optometrist or ophthalmologist showing the diopter requirement. If submitting by paper, ensure receipt has diopter requirement indicated (otherwise, attach Rx).
28015	*Glasses - complete pair (7.0 Dioptre and higher)			
28016	*Lenses (7.0 Dioptre and higher)			
28014	* Prescription Sunglasses - high-index (7.0 Dioptre and higher)			

Vision Wear Repairs, Replacement, Cases and Delivery Charges

Service Code	Description *Indicates claims submitted will only be considered up to the posted rule.	Dollar Max/Frequency Guidelines	Claiming Criteria (Y/N/H)	Criteria
28051	*Glasses - case	Included in 28000 limits.	N	**Provider:** Retain record of the purchase being provided to the Client. **Client:** Submit detailed receipt of purchase.
28050	*Vision Care Products - repairs		N	**Provider:** Retain record of the type and date of repair. **Client:** Submit detailed receipt outlining the type and date of repair.
28052	*Vision Care Products – shipping/delivery		N	**Provider:** Retain record of the purchase being provided to the client. **Client:** Submit detailed receipt of purchase.
28017	Vision Wear - lost/stolen/broken	One replacement in a lifetime; If client requires more than one in a lifetime, client will need to contact FNHA.	Y	Please contact Pacific Blue Cross to check client eligibility for first replacement only. These claims will only be accepted on paper.

Additional Information

Early Replacement

- If a client requires an exception for coverage to replace their eyewear due to a new prescription before their limit renews on the next 1- or 2-year cycle, Pacific Blue Cross must receive both their previous and most recent prescriptions for review. Exception requests for additional coverage will only be approved when:
    - there is a change of at least +/- 0.50 diopters over the sphere, cylinder, or add power, or
    - there is a change in axis greater than 15 degrees for cylinder power up to 2.00 diopters or greater than 10 degrees for a cylindrical power greater than 2.00 diopters, or
    - there is a change of at least 1.00 prism diopter vertically or at least 2.00 prism diopters horizontally, and
    - the client used their best judgement and could not have anticipated the need for replacement eyewear within their frequency period.
- Approved exception requests due to a change in prescription will only cover the cost of replacement lenses, up to the client's standard benefit maximum. A complete pair of glasses will only be approved if the original pair of glasses cannot accommodate replacement lenses.

Please note: These claims will only be accepted on paper.

Lost, Stolen or Broken Vision Wear

FNHA will provide coverage for one replacement in a lifetime. If the client requires more than one replacement, the client will need to contact FNHA at 1-855-550-5454 for review.

Unclaimed Glasses

Unclaimed glasses are not a billable expense, even if eligibility was positively confirmed before dispensing.

Out-of-Country Expenses

Out-of-Country expenses are not eligible for reimbursement.

Record Retention

Company shall maintain complete and accurate records of, and supporting documentation for, the amounts claimed under this Agreement. The Company shall retain such records during the term of this Agreement and for a period of seven years after the Claim as been submitted to PBC.

PACIFIC BLUE CROSS®

Phone **604 419-2000**
Toll-free **1 877 PAC-BLUE**
Website **pac.bluecross.ca**

Mailing Address
PO Box 7000
Vancouver, BC V6B 4E1

Street Address
4250 Canada Way
Burnaby, BC

0799.009 01/20 CUPE 1816