Claims Adjudication Process

Ordre des comptables professionnels agréés du Québec

Plan 167696
Coverage clarification and adjudication rules

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More information
If you have questions about claim submission requirements, please call a Canada Life client service representative at 1 800 957-9777.

WARNING : This document describes our most frequent claims adjudication process, it is only a summary, and does not represent all our procedures. We can modify these without any prior notice. For covered amounts and applicable maximums, please refer to your booklet.

We remind you that all claims must be submitted within 15 months from the date the expenses were incurred.
Compression hose

Your Canada Life benefits plan covers compression hose when they are prescribed by a physician and are medically required. The following information is intended to give you an overview of our requirements when you submit a claim for eligible compression hose.

Customary prices

Canada Life adjudicates claims based on the provincial reasonable and customary price for covered services and supplies.

Benefits will be determined according to the compression factor of the hose, which is measured in millimetres of mercury (mmhg). The following limits will apply (in some cases, a range is provided, since prices will vary by province):

- Hose with a compression factor of 15 to 20 millimetres of mercury (mmhg) – $50 per pair, per person
- Hose with a compression factor higher than 20 mmhg – from $180 to $225 per pair, per person
- Custom-made compression hose – from $330 to $375 per pair, per person

Make/model of hose

Be sure that the make and model number of the compression hose you’ve been supplied is clearly identified on the receipt. This information is needed to confirm that the hose includes a compression factor of at least 15 mmhg. Claims received without this information may be delayed.
Canada Life has an adjudication process in place to manage the cost of claims for drugs that are administered in a clinic or physician’s office (including injections).

Among the most common treatments performed in a physician’s office are cortisone shots, local anesthetics, ophthalmic drops, diagnostic agents and some cosmetic treatments, such as chemical peels, removal of acne scars and age spots, and other skin enhancements. Canada Life may provide coverage for the cost of drugs associated with these treatments, but not for the cost of administration of these drugs.

- Canada Life allows a maximum of $15 toward the cost of drugs/injections for each date of service. It’s been determined that this amount will cover the actual drug cost for the vast majority of claims.

**Types of receipts issued for drugs/injections**

<table>
<thead>
<tr>
<th>Type of receipt</th>
<th>Description</th>
<th>Adjudication process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispensed by a pharmacy</td>
<td>Includes the drug identification number (DIN), cost and quantity of drug being purchased.</td>
<td>Normal adjudication process for a drug purchased in a pharmacy.</td>
</tr>
<tr>
<td>Not dispensed by a pharmacy</td>
<td>Rarely provides the DIN or quantity of medication. Often impossible to determine reason for treatment and whether costs are reasonable and customary.</td>
<td>Maximum reimbursement of $15 toward the cost of drugs/injections for each date of service.</td>
</tr>
</tbody>
</table>
Applicable deductibles and reimbursement percentages will be applied to allowable amounts. Physician fees should be billed to provincial health plans or paid by the insured.

Claims for vaccines, allergy serums, fertility drugs (if eligible under the public plan), sclerotherapy treatment (sclerosing agent injections) and vitamin injections will continue to be subject to their current coverage and policy. Drugs that require intravenous infusion and are administered at an infusion clinic are commonly dispensed by a pharmacy and therefore would not be subject to this process.
**Colonoscopy, endoscopy and gastroscopy**

This section provides an overview of how Canada Life handles colonoscopy, endoscopy and gastroscopy claims from Quebec residents.

**Public / private clinic procedures**

The cost of colonoscopy, endoscopy and gastroscopy procedures is covered by the Régie de l’assurance maladie du Québec (RAMQ) when these procedures are performed in a hospital.

These procedures are sometimes performed in private clinics. In some cases, invoices from private clinics do not include a clear breakdown of the expenses associated with the procedure. These types of invoices do not give Canada Life enough information to determine eligibility for coverage.

In these situations, we will request a more detailed breakdown of the services provided. In some cases, this may result in a claim being declined.

**Non-eligible expenses**

Here are some examples of charges often included on private clinic invoices:

- Snacks
- Parking
- Sterilization of equipment (including technician’s time)
- Monitoring performed by nurses

These expenses are not eligible for coverage under your Canada Life plan or the public RAMQ plan.
If the plan includes drug coverage, any expenses for eligible drugs will be covered to a maximum of $15 per day.

Physician billing and RAMQ
In most cases, a physician in a private clinic will bill RAMQ directly for the actual cost of a colonoscopy, endoscopy or gastroscopy. In these cases, the invoice will not include a charge for this expense, since the expense is covered by RAMQ.

However, in some cases, a physician is not eligible to bill RAMQ, and RAMQ does not cover the cost. Canada Life will cover expenses related to diagnostic and laboratory tests performed on the tissue samples taken during the actual colonoscopy, endoscopy or gastroscopy expense when it is clearly identified on the invoice. Detailed breakdown of the services are required as mentioned above.

By law, under no circumstances can doctor’s fees be reimbursed.
Orthopedic shoes and custom-made foot orthotics

In accordance with requirements adopted by other major Canadian group insurers, we are informing providers of the requirements and their responsibilities in the claims process.

Your plan includes coverage for custom-fitted orthopedic shoes:

- **Custom-made orthopedic shoes** – footwear made specifically for one patient, from raw materials, using a variety of measurements and a cast of the patient’s feet.
- **Off-the-shelf (pre-fabricated) orthopedic shoes** – footwear with specific orthopedic fit and function features.
- **Custom-fitted or modified orthopedic shoes** – a shoe is considered to be modified when the orthopedic shoe is permanently changed, for example, adding a rocker sole, or leather patches to accommodate a foot deformity.
- **Deep shoes** – type of depth shoes that cannot be used without orthotics and should be bought in a specialized establishment.
- **Custom-made foot orthotics** – a device made from a cast of the foot that can be inserted into the shoe to support, align, prevent or accommodate foot abnormalities and improve how the foot functions.
Benefits for these supplies will be paid where the expense is eligible under the benefits plan and provided all required documentation is submitted with the claim.

**What isn’t covered?**

- Off-the-shelf, non-orthopedic footwear (e.g. comfort shoes and sandals)
- Shoes purchased specifically for participation in sports or recreational activities (e.g. cleats)
- Off-the-shelf, non-custom or pre-fabricated orthotics (e.g. Dr. Scholl’s insoles)

Claim submission requirements for orthopedic shoes and custom-made foot orthotics include:

The orthopedic shoes and custom-made foot orthotics must be prescribed by a physician and purchased in a specialized establishment.

**Claims for orthopedic shoes will also be required to include:**

- The brand name and model of the shoes;
- A description of each modification made to the shoes (if applicable); and
- A breakdown of the cost of the shoes and each modification (if applicable).

**Claims for a custom-made foot orthotic will also be required to include:**

- A detailed description of the type of orthotic provided, and;
- A breakdown of the charges for the orthotic.

Biomechanical and postural examination, podoscopy, delivery and adjustments made by a podiatrist and associated with the preparation of an orthosis are refundable with the purchase of the orthotic, subject to the maximum indicated in your booklet.

In order to confirm the eligibility of your purchase as well as the amount reimbursed, we recommend that you provide a detailed cost estimate before making a purchase.

It is important to note that expenses are considered incurred on the date on which the insured receives the service or supplies.
Medical professionals, including foot care specialists, advise that generally a patient’s medical condition can be accommodated with well-constructed retail footwear or orthotics. Therefore, many patients do not require custom-made or pre-fabricated orthopedic shoes.

Further, the dispensing of orthopedic shoes and orthotics is not itself a regulated act and these supplies can be dispensed by a variety of health care providers and other individuals. As a result, there is no standard billing practice for these supplies and marketing and billing varies by the dispenser. Based on recent activity of some providers and the results of investigations we have conducted, we’ve determined it necessary to gather additional information with claim submissions to help determine whether a claim qualifies for coverage.

There are many different types of shoes marketed as “orthopedic,” as well as many different types of in-shoe devices referred to or marketed as “orthotics.” Advances in shoe design technology and widespread availability of these products in an unregulated market can make it confusing for you to obtain orthopedic shoes or orthotics eligible for coverage under your plan. The new claim submission requirements are intended to help clarify the claims requirements for you and ensure claims are adjudicated on a timely basis, and in accordance with your plan.

Yes, some claims for which benefits were previously paid may now be determined to be ineligible when documentation included in the new claim submission requirements is received. Canada Life will be providing a notice to providers of orthopedic shoes and custom-made foot orthotics to explain our new claim submission requirements

**Is this consistent handling in the industry?**

Yes. The Canadian Life and Health Insurance Association (CLHIA), whose membership accounts for 99 per cent of the life and health insurance in force in Canada, recently published a document which is posted on their public website to help consumers understand claims for footwear and orthotics. This document can be found in English on the CLHIA website at:


Canada Life, along with many other insurers, refers to this document when adjudicating claims for orthopedic shoes and custom-made foot orthotics.
Paramedical expenses

To be eligible, the provider must be a regulated member of an Association or a Corporation recognized by Canada Life and exercise under an authorized professional title.

It is strongly recommended to verify if your practitioner is eligible by contacting the group Customer Contact Service Department.

Please note that certain expenses might require a medical recommendation.