2018 Meeting with the Federal Healthcare Partnership

October 19, 2018

Present:Barb Bentley, Erica Zaia, Justyn Pisa, Janine Verge – CAA, Colleen Fahey-Budd, Andree McLennan – Medievue Blue Cross, Chantal Kealey – SAC, Franz Hubert-Sully – NIHB, Sue Schlatter, Peggy McDougall – VAC, Donna Koughan - VAC
Regrets: Pierre Lamontagne – DND, Candace Leake, Peggy McDougall, Dragana Pantic – RCMP, FNHA

NIHB

1. Instead of needing to seek prior approval for re-test and adjustments with client letter, it should be allowed say so many years after fitting should client find issues.

   NIHB Reply

   The NIHB Program will explore reviewing its current policy concerning re-test to reduce the administrative burden for the audiology provider and improve access for the clients.

   Also for accessories. It`s max of $50 1 time per 2 years but if client only gets say a day kit which is $20, then we can't bill anything else for 2 years so you are almost forced to give them more stuff they may not need now at one shot to get the $50.

   NIHB Reply

   The NIHB has initiated a review of the coverage policy for accessories. Once completed audiology providers, CAA and SAC will be informed.

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2. The process to get prior approval and payment is so lengthy and time consuming. In this day and age, I don't understand why these processes can't be done online. Currently we must fax our prior approvals, then wait 3-4 weeks for approval. Often, we have to refax because our original fax was never received or lost or distributed to the wrong individual.

   NIHB Reply

   The NIHB regional office normally reviews audiology requests within 2 to 10 days (depending if advice is sought from the Medical Equipment and Supplies Review Centre (MSERC)). The process which requires the submission of the manufacturer invoice for prior approval to be settled will be reviewed.

   The NIHB Program will implement a new process this fall whereby requests for hearing aids replacement (i.e. not the initial request to NIHB) for adults that are within the frequency guidelines will no longer going to be reviewed by the NIHB audiology consultants. These

requests will be reviewed at the regional level which would expedite the prior approval process. Consultants would then deal with first requests and requests for children.

Providers with electronic data interchange technology can have their claims electronically captured and processed online in real time. This offers audiology providers with an immediate response regarding the status of their submitted claim.

The Program is currently collaborating with Express Script Canada (NIHB's Claims Processor) for the new procurement in March 2020 to develop a provider portal with the intent of expediting claim adjudication and payment. The portal would allow provider to enroll; modify some of their profile information, such as their alternate mailing address or communication preference; submit prior approval; submit claims directly to Express Scripts Canada and to have access to forms in various formats.

Unless the applicable agreement provides otherwise, the MS&E provider is paid on a twice-per-month schedule. The payment run date takes place automatically twice a month. The payment date is within two (2) business days following the Payment Run Date, unless a weekend or statutory holiday falls between. Payment date is the day that cheques, Electronic Funds Transfer (EFT) payments and statements are released.

3. The time from the initial fitting to the payment is too long. Most often it is 3-4 months, plus we have to call several times just to get our prior approvals.

   NIHB Reply

   Please see #2

4. For pediatrics we should be able to be paid for an evaluation at least once every 6 months if the child has a diagnosed hearing loss. We know that this is best practice, but I can only bill once every 2 years, which means I do a minimum of 2-3 evaluations at no charge.

   NIHB Reply:

   NIHB has initiated the work to assess the feasibility of developing requirements that are specific to a pediatric population. Once completed audiology providers, SAC and CAA will be informed. Target is early 2019

5. We should be able to bill for pediatric hearing aid follow-ups. For each child fit there has to be at LEAST 3 follow-ups within the first year and then at least one a year afterwards but instead there is only the initial fitting fee of $486.20 per aid.

NIHB Reply

Please see #4

6. I got in trouble for calling a pediatric patient's family to remind them that we needed to see the child for a hearing aid follow up and audiological re-evaluation. NIHB accused me of soliciting. I tried to explain that this is not soliciting, this is best practice. It would be unethical for me to fit this child and not see them for follow-up.

NIHB Reply:

Saskatchewan NIHB office is not aware of the situation. Can the provider or SAC provide additional information to NIHB?
SAC has followed up and connected the audiologist with NIHB.

VAC

1. We are being inundated with CF members and VAC clients with tinnitus. Would you be able to clarify how services to these clients are funded. We are paid for initial assessments. If the client is with VAC and we can fit hearing aids, we can follow up on how treatment is going. If the client is not ready to try amplification, but we have recommended the use of other solutions in lieu of aids or tinnitus retraining therapy, how are we to be paid for follow up? **Tinnitus Therapy Benefit Code 600446 may be used to bill for follow up when the tinnitus therapy does not involve using hearing aids.** Can we bill for TRT if we are not doing formal TRT with the client? **Yes, the description of Benefit Code 600446 used to be Tinnitus Retraining Therapy but this was changed to Tinnitus Therapy to allow for more flexibility in treatment.** How frequently can we bill for follow up? **The frequency on this Benefit Code is 4 visits per 12 calendar months. Authorization of additional visits can be considered with rationale.** It is important to us to follow up on these clients since many of them are also experiencing PTSD which exacerbates their perception of the tinnitus. Sending them off without follow up is not the quality of care they need or deserve.

   There is a chicken and egg situation when we are assessing tinnitus. The last category requires that we write a prescription for a device. With hearing aids, we go through a consultation process. Would it be acceptable to write a generic prescription like an MD would write, i.e., needs personal masker in the form of hearing aids instead of having to specify the make and model? Then we can have the client back to do a full consultation re: the best device. **Regarding the prescription, VAC will update direction to Medavie Blue Cross to advise that the specific make /model of the personal masker is not required on the prescription. The prescription should indicate tinnitus therapy or tinnitus masker (if it's a device). The make / model of a device is only required at the time of the authorization request.**

2. It would be very helpful for us if VAC and DND would get on the same page with tinnitus. VAC will authorise hearing aids as a treatment for tinnitus. What changes when the member retires? CF members would benefit from the same treatment even if their hearing is "normal".

Unfortunately, DND and VAC are nowhere close to getting on the same page with reference to tinnitus management. VAC has been providing hearing aids to their tinnitus suffering clients for many years and are reluctant to remove this from their list of eligible benefit because they have nothing to replace it with and removing it would cause quite an uproar. As for DND, our entire Spectrum of Care is based on "evidence-based medicine", which, at this time, does not support the effectiveness of providing hearing aids to tinnitus sufferers when in the presence of normal hearing.

As for CAPD, it's pretty much the same story. The medical community is at odds with the management of this disorder with no clear guidance. We have enlisted the services of an Otolaryngologist to look into this, as recently as a few months ago and he does not recommend giving these patients hearing aids.

These two issues will remain as is, until well-conducted evaluations of intervention using randomized controlled trials methodology become available.

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DND

1. We know that many of the CF members are suffering from CAPD as the result of noise induced neural damage. Is there a policy regarding assessments for these members? It would facilitate their care if we knew that we could refer them for assessment and assure them that it will be funded.
