Canadian Academy of Audiology
Academie Canadienne d'audiologie

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Federal Health Partners Meeting – October 13th, 2023

QUESTIONS TO ALL OF THE FEDERAL HEALTH PARTNERS		
Who last represented the audiology side when it came to negotiating pricing with the various Federal Health Partners?	Negotiation for pricing for benefits and services has been on-going for a long time. Maximum prices for devices, accessories and supplies are negotiated by Hearing Industry Association of Canada (HIAC) and FHPs. This is completed through a memorandum of understanding (MOU) every 4 years. The last MOU was agreed upon in November 2022. In addition to this agreement, meetings occur on a regular basis to talk about benefit coverage and pricing related issues. The goal is to always improve benefit offerings to patients/clients through these discussions.	DND, NIHB, RCMP and VAC Responses
Why is there such a discrepancy for reimbursement for the same services when comparing the various Federal Health Partners? In cases where the reimbursement provided for a service/product is insufficient (i.e., less than the price indicated in a provincial fee guide), can we negotiate to have balance billing, where the client pays the difference in price? Why are we letting 3rd parties set our fees for us?	No comment	DND Response
	At this time, there is collaboration across the FHPs despite the utilization of a different claim's processors. Rates and fees vary across the FHP because of different departmental mandates and finances. There is a process of evolution related to funding structures and supports. There is also an interest in further aligning the fee structures across FHPs but it does take time to implement process change. *Note:* the NIHB is the only FHP using the ExpressScripts claims processor. Consequently, the item codes are different from other FHP departments.	NIHB Response
	No comment	RCMP response

	Every department has its own policies, fiscal budget, and mandates. Consequently, the fee structures will vary. The fee structures are aligned as best as possible amongst the federal health partners. *Note:* VAC, RCMP, DND use the same claims processor (MedavieBlue Cross) consequently, they are better aligned.	VAC Response
In cases where the reimbursement provided for a service/product is insufficient (i.e., less than the price indicated in a provincial fee guide), can we negotiate to have balance billing, where the client pays the difference in price? Why are we letting 3rd parties set our fees for us? When a client has topped out their allowed reimbursement for a particular service over a time period (e.g., no more billing the 3rd party for follow-ups for the rest of the year), but still needs additional help, how does the clinic help that client without providing service for free? Are clinics allowed to have 3rd party clients pay for additional service in those cases?	If a patient is in need of more services, the patient needs to see their medical provider within the DND for support and medical review. An additional application for additional services is possible provided appropriate criteria are met.	DND Response
	To NIHB's knowledge there has been no specific tracking of need for specialized earmolds OR a specific demographic. SAC Note: It was brought to the NHIB's attention that conversations of this nature are being had between service providers (aka. Audiologists) and Industry partners. The NIHB was also made aware that Sonova does not intend to change its practices for pediatric earmolds at this time. It was brought to the NIHB's attention that having pediatric adaptations (e.g., different warranties, long-term follow-up to address pediatric growth needs) are very important. The NIHB was also made aware that specialized earmould manufacturers offer a service which is more cost effective in the long run. These manufacturers are also using a different process for manufacturing earmolds which has better retention. Through this conversation the NIHB will review their process of approval related to earmold provision and coverage in special situations. Note: SAC indicated that information would be provided related to children's earmolds for NIHB	NIHB Response

	to review for coverage considerations. The NIHB pays for the full costs of the benefit so there is no cost sharing with the benefit. The items requested needs to be listed in the covered plan so that clients have no need to pay for additional services. NIHB Note: If additional services are required by the client, the hearing health care service provider can submit a request to the Program with the supporting justification for consideration.	
	No comment	RCMP Response

Different departments have different fee structures due to budget and policy differences. VAC is, , as part of and along with the FHP, conducting an in-depth review of its fees to establish any possible increases. There is a very thorough review currently in place whereby, a randomized provider survey is being sent out to select providers across Canada. This will enable receipt of information relating to examples of fees currently being used. VAC hopes that this will continue to improve the processes and reimbursement structures. The MOU with HIAC results in a set fee structure for devices, repairs etc. and these fees are on the VAC benefit grid. From the VAC perspective, the maximum fees set on the grid for other audio benefits are expected to meet most individual's needs. In some cases, there are instances where a contribution will be allowed if a client wants to obtain a higher level of technology of hearing aid than what VAC typically covers. These instances require pre-authorization and sufficient justification on a case-by-case basis. The only fee guide that VAC is aware of is the OSLA fee guide. Some example fee guides have been provided by AHIP. If any others are available, VAC stated that it would be greatly appreciated that these be shared with the FHP. It was brought to VAC's attention that there are fee discrepancies due to the purchase ordering of earmolds direct from a manufacturer. There are also independent earmold labs that do not have contracted pricing with the FHP. VAC indicated that set fees are negotiated for hearing aids, earmolds, accessories, and repairs between HIAC and the FHP. The fees are such that the Manufacturer will charge a particular price up to a ceiling level that has been negotiated between HIAC and the FHPs. The FHP department will only cover what was charged. (E.g., earmold fee not enough $45 vs. $37 then VAC will reimburse the invoice price of $37 despite the	VAC Response

	maximum coverage of $45 set by the MOU with HIAC). After some discussion, it was noted by all that It may be beneficial to have HIAC include independent earmold manufacturers in their conversations around fee structure. The impression is that this might affect NIHB approvals more as it would likely apply to pediatric populations.	
When a client has topped out their allowed reimbursement for a	Patient/client needs to see their internal healthcare provider. Preauthorization needs to be	DND Response

particular service over a time period (e.g., no more billing the 3rd party for follow-ups for the rest of the year), but still needs additional help, how does the clinic help that client without providing service for free? Are clinics allowed to have 3rd party clients pay for additional service in those cases?	completed by the primary care physician on the base.	
	Prior approval is required. NIHB Note: The Program has increased the frequency for certain services for pediatric populations (such as for follow-up visits). Providers may contact the Program to request coverage beyond frequency limit when justified as identified in the NIHB MS&E Guide and Benefits List.	NIHB Response
	Processes are similar as to what is described by the DND. Members can access benefits up to the limit amounts outlined in the RCMP Benefits Grid. Additionally, members with a positively determined duty related injury/illness may receive pre-authorization for coverage under Occupational Health Care(OHC) benefits. This coverage does not affect the limit amounts under their supplemental health care benefit coverage. Members are to contact their respective divisional Health Services Office.	RCMP response
	From VAC perspective, any needed services that exceed the frequency on the benefit grid should involve submission of a request for pre-authorization for case-by-case review. Hearing health care providers need to contact the medical authorization center at MedavieBlue Cross. If it goes beyond the frequency set out in the structure, funding support will be considered on a case-by-case basis.	VAC Response

	Cases are typically reviewed and a decision will be provided within 10 business days. Please note that if additional information or support from a consultant is required, this timeline may be slightly exceeded. The Medical Authorization Centre (MAC) currently has several new employees and MBC is would like to ask that members be made aware of this. The MAC would ask for their continued patience while the new staff members complete their training and become fully versed with all processes and criteria.	Medavie Blue Cross Response
QUESTIONS TO THE NIHB		
What steps are the NIHB taking to address issues faced by end users as it pertains to the registration of successful claim submissions vs. items being excluded from the claim in NIHB's claims processing system?.	The NIHB cannot compare or contrast across platforms used by the different FHPs as different processes are involved at each of the agencies. The NIHB asks that if you see observe issues with their platforms that you reach out directly to the Program. The NIHB asks that individuals identify issues as they arise. The technology and processes for electronic submissions are evolving. Claims processing for Medical Supplies and Equipment applies to 13 areas (e.g., orthototics, hearing, etc.,) and changes cannot be made specifically to Audiology related benefits without impacting the other areas. There are numerous changes being implemented into the system to further enhance use. The PA forms are being changed. NIHB Note: NIHB communicates updates and relevant information to providers on quarterly basis via the Newsletter and when required through bulletins. The NIHB Guide and Benefits List contains all information related to policies and coverage while the NIHB ESC site has information on claims submission forms and prior approval forms. An issue related to submission via the NIHB portal was brought up by the NIHB. It has come to their attention that providers may not be made aware that they can submit through the portal within 1 month of service for real-time processing. They can also submit via the portal outside of one-month as manual claims Clarifications to issues arising from the use of NIHB portal should occur between the hearing health care provider and the NIHB or via the ESC provider inquiry number. NIHB noted that for questions being submitted to NIHB via SAC that it would be helpful to know where the questions are	

	coming from. NIHB reiterated that is a provider is experiencing difficulties they should engage with the Program or the claims processor without delay. Currently, in BC, ISC NIHB support/coverage is provided for Inuit clients via the NIHB Alberta Regional Office. The First Nations Health Authority (FNHA) provides coverage for eligible First Nations in BC since 2013.
Why are NIHB reimbursement levels the lowest when compared to the private market and other 3rd party public payees such as DVA, WCB despite the reality that the care recipients are often in greater need and often require more resources to serve and require greater admin resources on the part of the provider to seek pre-approval and submit reimbursement requests and monitor payment and submit resubmissions when claims are excluded for a variety of reasons?	The NIHB is currently making adjustments to their rates that should be announced soon. The NIHB is undertaking a review of the rates and how services are provided. Differences between the NIHB and other FHPs are directly related to the mandates of the organizations. Additionally, the availability of rates from associations across the country are not always available, they encourage all provider associations to develop and release their suggested rates. There is certainly a commitment to look at data in a more in-depth level.
NIHB currently covers replacement chargers for cochlear implant batteries but does not cover replacement chargers for rechargeable hearing aids (I'm aware the batteries themselves are covered). The accessory code is not enough to cover it and if a client has already used it for an accessory then they would be ineligible. Please consider a code for replacement chargers	The NIHB encourages the provider to submit a request for early replacement in these situations. Submission of a request and justification will be reviewed. This allows for funding to be left available for any accessories that might be needed in the future. Feedback provided to the NIHB related to rechargeable batteries: Rechargeable batteries are under warranty for 3-years. It is relatively rare that these fail. The NIHB indicates that typically, hearing aids warranties are for 5 years; while chargers are warrantied for 3-years. Coverage for replacement chargers may be reviewed to determine if a separate code is required in consideration of volume of requests for replacement, amongst other factors. Industry partners inquired how potential future changes to coverage of

for rechargeable hearing aids. The chargers don't always last 5 years.	charger replacements would be shared with them. The NIHB indicates that this discussion will need to be held at another time as conversations around changes to fee codes may be needed. A concern was presented from the membership that in many cases, failing chargers may appear to be one-offs requiring service in a quick timeline. Consequently, awaiting changes to the NIHB's fee grid will not be responsive in a timely manner. In these cases, there are concerns that client needs will not be met without financial impacts to the hearing health care provider. Again, the NIHB indicates that this will need to be discussed at a later time.
	QUESTIONS FOR VETERANS AFFAIRS CANADA
In terms of billing, several private practice clinics provide hearing tests free of charge. What is VACs stance on the fact that most of these clinics will bill VAC for a hearing test but not their private pay patients? In many cases, private pay patients will be required to pay for things that VAC will not pay for, ex. shipping.	The provider claim submission agreement which is signed by VAC-registered providers indicates that the provider CANNOT charge the veteran more than a private pay patient. The main message is providers should not be doing this at all. Please be aware that VAC does pay for shipping fees up to $13/shipment as per the set MOU rate.
Is there anything legally (i.e., in Federal or provincial law) that prevents providers from billing the funder for a hearing diagnostic test required by ADP/ODSP if they offer free hearing tests to other patients?	The provider claim submission agreement which is signed by VAC-registered providers indicates that the provider CANNOT charge the veteran more than a private pay patient. The main message is that hearing health care providers should not be doing this at all. To VAC's knowledge there are no other legal documents to support an answer to this question.
	QUESTIONS FOR FIRST NATIONAS HEALTH AUTHORITY

In cases where the reimbursement provided for a service/product is insufficient (i.e., less than the price indicated in a provincial fee guide), can we negotiate to have balance billing, where the client pays the difference in price? Why are we letting 3rd parties	• FNHA's current provider agreement allows providers to balance bill clients for outstanding costs
	• Many FNHA clients may not be able to afford out-of-pocket costs
	  ○ Balance billing could prevent clients from accessing needed services or pose difficulties for providers in receiving payments
	• FNHA may consider payments exceeding standard reimbursement amounts through the Exception process
	  ○ Exceptions are adjudicated based on the client's medical need for the requested items and/or services
	• FNHA aims to set pricing for audiology items and services that ensures equitable claims payments and maintains program sustainability

set our fees for us?	
When a client has topped out their allowed reimbursement for a particular service over a time period (e.g., no more billing the 3rd party for follow-ups for the rest of the year), but still needs additional help, how does the clinic help that client without providing service for free? Are clinics allowed to have 3rd party clients pay for additional service in those cases?	• FNHA's provider agreement allows providers to balance bill clients for outstanding costs; many FNHA clients may not be able to afford out-of-pocket costs • Balance billing could prevent clients from accessing needed services or pose difficulties for providers in receiving payment • FNHA may consider coverage for items and services beyond the set pricing and frequency limits through the Exception process Exceptions are adjudicated based on the client's medical need for the requested items and/or services

I am about to do a fitting for a client who receives coverage through NIHB/PBC. I haven't fit anything using their grid in quite some time. I believe SAC meets with the various funding bodies from time to time. The payment for services is not sustainable. For earmolds for instance they are offering $45 for payment per earmold – this does not cover the actual cost of the mold by the manufacturer it is at least $50 (and often more depending on the manufacturer) and does not include the shipping cost. There are no fee options for impressions so our time, impression material, otoscope tips, cleaning/sanitizing supplies etc are not covered at all. The clinic	• FNHA aims to set pricing for audiology items and services that ensures equitable claims payments and maintains program sustainability
	  ○ Given ongoing inflationary pressures, FNHA's prices are currently under review
	• While prices are still under review, providers may be able to receive payment for items and services exceeding standard reimbursement amounts through the Exception process
	  ○ Exceptions are adjudicated based on the clients' medical need for the requested items and/or services
	• Per the FNHA-PBC Hearing Fee Supplement, impression fees and other associated supplies for replacement ear molds are eligible for payment under the Hearing Aid repair codes
	  ○ Codes 27052 and 20751 for left and right hearing aid repairs, respectively

is actually paying out of pocket for earmolds. The payment for hearing aids is $1083 per aid. This is also an unsustainable cost. We could not keep the clinic open and operating based on this fee schedule so in essence this fee schedule means we must offset costs from private paying clients to support the care and services we provide to this population. Hopefully at the next meeting, there can be some discussion in terms of cost recovery for the clinic.	