

PROVINCE OF BRITISH COLUMBIA

# PharmaCare Prosthetic and Orthotic Policy Manual

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Pharmaceutical Services Division – Ministry of Health

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# 1. Document Overview

This manual explains the mandate and scope of the PharmaCare Prosthetic and Orthotic (P & O) Program, and provides the information required to request pre-approval for prosthetic and orthotic devices and services, and submit claims to PharmaCare, for all benefits under the PharmaCare P & O Program.

## 1.1 How to use this manual

- The manual includes both program policies and procedures.
- This manual should be read in conjunction with the [PharmaCare Policy Manual](#), which describes the different PharmaCare plans and details PharmaCare’s overarching policies and procedures, including those on enrolling as a provider, connecting to PharmaNet, and audit procedures.
- This manual supplements the general policies set forth in the [PharmaCare Policy Manual](#).

## 1.2 Definitions of terms and acronyms

For purposes of this manual, the following definitions apply:

### *Application*

Application for Financial Assistance forms; there are separate forms for Prosthetic Benefits, Prosthetic Benefits (Non-limb), and Orthotic Benefits.

### *Basic Functionality*

Clients are assessed to determine what they need to perform basic functions. Basic functionality varies between clients. Assessment is based on factors such as a client’s age, health and activity level. See [Section 5.1.1](#) for more information.

### *Client*

An individual requiring a device such as a prosthesis, orthosis, or an eligible supply in order to achieve basic functionality.

### *Cover/Coverage*

A client is “covered” if they qualify for one or more PharmaCare plans; an item is “covered” if it is eligible for any level of reimbursement by PharmaCare. “Coverage” differs from “reimbursement” in that “coverage” indicates general eligibility, whereas “reimbursement” applies to a PharmaCare payment for an item.

### *Device*

In this document, a device refers to a prosthesis (such as a leg, arm, eye or breast), an orthosis or an eligible supply (such as liners or lymphedema arm sleeves).

### *Eligible Client*

A client may be eligible for prosthetic and orthotic benefits if they are covered under PharmaCare plans I (Fair PharmaCare), B, C or F. See [Section 4.1](#) for details on client eligibility and exclusions.

### *Financial control*

Is an entry in PharmaNet, made by PharmaCare, that allows a claim to be submitted and processed when an Application is approved. This control expires six months after the approval is received, or the date that a claim is made. The date of expiry is shown in the “Approval Ends” field of an approved Application form.

### *Health Insurance BC (HIBC)*

Health Insurance BC (HIBC) manages the day-to-day operations of PharmaCare, including adjudicating claims and providing information and support to the public and device providers.

### *Non-benefits*

Devices, supplies and/or services that are not eligible for PharmaCare coverage.

### *Orthotic benefits*

Includes orthoses and/or orthotic services that are eligible for PharmaCare coverage. Orthotic supplies are not eligible for PharmaCare coverage.

### *Osseointegration*

Is defined as the direct structural and functional connection between the living bone and surface of a load-bearing implant

### *PharmaNet*

PharmaNet is the secure province-wide computer network that links British Columbia’s community and hospital pharmacies, hospitals, online device providers, Alternate Payees and other authorized users to a central set of data systems.

### *Pre-approval*

The process of obtaining PharmaCare approval for a prosthetic or orthotic device or service. Device providers submit descriptions of and cost estimates for the proposed components and service(s) to PharmaCare. PharmaCare then reviews the Application and determines eligibility for coverage. See also *coverage* and *reimbursement*.

### *Product Identification Number (PIN)*

PharmaCare assigns a Product Identification Number (PIN) to identify a specific product or service. The PIN is submitted with the corresponding claim to allow proper adjudication of the claim in PharmaNet.

### *P & O*

Abbreviation for “Prosthetic and Orthotic”

### *Prosthetic and Orthotic Committee (P & O Committee)*

The P & O Committee is responsible for ensuring consistency and accuracy in applying PharmaCare policy to prosthetic and orthotic Applications’ adjudication.

### *Prosthetic benefits*

Includes prostheses, and prosthetic supplies and/or services that are eligible for PharmaCare coverage.

### *Providers*

Includes prosthetists, orthotists, ocularists, anaplastologists, mastectomy fitters and/or their companies or businesses (including pharmacies) who have enrolled with PharmaCare in the appropriate class(es) and subclass(es) for the product(s) they are dispensing.

*Reimbursement*

The portion of a claim that PharmaCare pays. Actual reimbursement may be less than the approved maximum amount, depending on the rules of the client's PharmaCare plan. For instance, under Fair PharmaCare, the client is responsible for all or part of the eligible costs each year until both their family deductible and maximum family co-payments have been met.

*Site ID*

The unique identification code issued to a site by HIBC (e.g., BC00000A01). The site ID is provided when applying to enrol as a PharmaCare provider.

## 2. *Prosthetic and Orthotic Program Overview*

- The Prosthetic and Orthotic (P & O) Program helps clients to achieve or maintain basic functionality.
- PharmaCare helps [eligible clients](#) pay for the cost of eligible prosthetic and orthotic benefits, subject to the rules of their PharmaCare plan, including any annual deductible requirements.

### 2.1 *How does the P&O Program Work?*

- On behalf of their clients, providers must request PharmaCare pre-approval for all eligible devices, and supplies and services of \$400 or more. PharmaCare approval must be received before the work on a device is started, a service is provided, or supplies are dispensed. Retroactive coverage is not available.
- To obtain pre-approval, the appropriate [Application](#) must be properly completed and submitted. The P & O Committee reviews each Application and approves or denies the Application, or asks for more information.
- PharmaCare approval is valid for six months. If a benefit cannot be dispensed within six months, a new Application must be submitted. The new Application must include the reason why the item was not dispensed within the initial six month approval period and should note any changes (or no change) in the client's health in the revised rationale. A new request may or may not be approved.
- A claim may only be submitted to PharmaCare after the final dispense of an approved item, supply, or completed service. PharmaCare processes the claim and reimburses either the provider or the client, as appropriate. Actual reimbursement depends on the rules of the client's PharmaCare plan. For instance, some plans reimburse 100% of the eligible claim whereas reimbursement under the Fair PharmaCare plan depends on how much of the client's family deductible and maximum family co-payment have been met.

### 2.2 *Who administers the P&O Program?*

- Health Insurance BC (HIBC) administers the PharmaCare program on behalf of the Pharmaceutical Services Division, Ministry of Health.
- HIBC's P & O Clerk is responsible for processing Applications for pre-approval.
- HIBC's Help Desk staff are responsible for processing manual claims.

### 2.3 *What does the P&O Program cover?*

- The P & O Program covers:
  - eligible prostheses, and related supplies and services that support clients in achieving, regaining or maintaining basic functionality, for B.C. residents of any age; and



- eligible orthoses, and related services that support clients in achieving, regaining or maintaining basic functionality or in preventing further deformity, for residents age 18 and under.

>> Refer to the [Reimbursement Schedule and PINs documents](#) for a list of items covered and maximum reimbursement amounts for each.

### 2.3.1 What is not covered?

- Not all prosthetic and orthotic devices and supplies are covered. For example, the following are not eligible for coverage:
  - foot orthoses
  - upper limb orthoses
  - orthoses for adults
  - orthoses required only for sports, or as a result of an acute musculoskeletal injury
  - orthoses required short-term for support after surgery
  - prosthetic fingers and toes
  - silicone partial feet ordered through a manufacturer
  - microprocessor knees (for traditional socket patients)
  - shock absorbers and rotators (for traditional socket patients)
  - elevated vacuum suspension
  - scleral contact lenses and ocular conformers

Note: The above list is not a comprehensive list of non-benefits.

## 2.4 How are eligible benefits approved?

### 2.4.1 Devices that require pre-approval

- Most prosthetic/orthotic devices (even if under \$400), and supplies, services, repairs, or adjustments of \$400 or more require PharmaCare pre-approval.
- To be eligible for reimbursement, Applications for devices/services that require pre-approval must be submitted and approved before work on a device is started, a service is provided, or a supply is dispensed.
- PharmaCare cannot pay for devices/services that are dispensed before PharmaCare approval is received.
- If you are unsure whether a device requires pre-approval, contact the [HIBC P&O Clerk](#) for clarification.

### 2.4.2 Devices that do not require pre-approval

- For policies and procedures for items that do not require pre-approval, please see procedures in [Section 7.7](#).
- Pre-approval is not required for the following:
  - eligible prosthetic supplies under \$400.00\*

- eligible prosthetic and orthotic repairs and/or adjustments under \$400\*
- lymphedema arm sleeves, and gloves/gauntlets
- regular benefit breast prostheses
- plagiocephaly helmets for clients who meet the criteria in [Section 5.7](#) of this manual

\*If additional items are found to be necessary for work related to a previously pre-approved Application, a new Application for the entire request is required. Additionally, claims made on the same day or in close proximity to each other may not be split into separate categories and claimed as under \$400, if all the items, services and supplies required for a prosthesis or orthosis total \$400 or more.

### 3. Provider Requirements

#### 3.1 Mandatory enrolment as a PharmaCare provider

- Providers must enrol with PharmaCare as a Device Provider in order to be reimbursed for products, services and supplies dispensed, and for their clients to be able to submit prosthetic and orthotic benefits claims.

For details on how to enrol, see the [PharmaCare Provider Enrolment Guide](#) and [Enrolment forms](#) on the [Medical Device Provider web page](#).

- Device providers must also enrol in the appropriate Device Provider Sub-Class(es) and confirm that each person providing benefits is recognized by the appropriate Board/manufacturer, as shown below.

If you are in enrolled in this sub-class...	Benefits can be provided only by an individual...
compression garment	who has completed training, by a compression garment manufacturer, in fitting the type of compression garments to be provided
limb prosthesis	recognized by the Canadian Board for Certification of Prosthetists and Orthotists as a person qualified to fit limb prostheses
breast prosthesis	who has completed training, by a breast prosthesis manufacturer, in fitting breast prostheses
ocular prosthesis	recognized by the National Examining Board of Ocularists, Inc. as a person qualified to fit ocular prostheses
orthosis	recognized by the Canadian Board for Certification of Prosthetists and Orthotists as a person qualified to fit orthoses

#### 3.2 Provider requirements after enrolment

- Providers must abide by the PharmaCare policies and procedures set forth in
  - the [PharmaCare Policy Manual](#)
  - this manual
  - relevant [legislation and regulations](#)
  - [PharmaCare Newsletters](#)
  - other program directives as issued from time to time

- Changes to provider information must be reported ahead of time to HIBC (e.g., change in contact information, change in manager, etc.). Failure to report these changes may result in delay or suspension of payments. See [Section 2.1 of the PharmaCare Manual](#) for notification requirements.
- Updates are announced in the [PharmaCare Newsletters](#). Anyone can subscribe to be automatically notified when a newsletter is published online.
- Changes to, or clarifications of, PharmaCare policy and procedures are included as updates in this manual and/or the [PharmaCare Policy Manual](#); updates are flagged with a notation that includes the nature of the update (policy change or policy clarification) and the effective date of the change.

## 4. Client Eligibility

### 4.1 Who is eligible for prosthetic benefits?

- Individuals are eligible for prosthetic benefits if they are covered under one or more of the following plans:
  - [Plan I \(Fair PharmaCare\)](#)
  - [Plan B \(Permanent Residents of Licensed Residential Care Facilities\)](#)
  - [Plan C \(B.C. Income Assistance\)](#)
  - [Plan F \(Children in the At Home Program\)](#)

>> See the PharmaCare Policy Manual, [Section 7.2](#), for more information on the Fair PharmaCare plan or [Section 7.3](#) for other PharmaCare plans.

- Individuals are **not** eligible for PharmaCare coverage if
  - they are eligible for prosthetic coverage through any other Act or program such as ICBC, WorkSafeBC, Veterans Affairs Canada, Health Canada's Non-Insured Health Benefits Program, First Nations Health Benefits Program<sup>1</sup>, or similar programs from other provinces or jurisdictions
  - they are a provincial offender being held in custody in a correctional centre or a youth custody centre, or have been released on day parole but must return to a correctional centre each night. PharmaCare **does** cover provincial offenders who have been approved to reside in a community-based residential facility. >> See the PharmaCare Policy Manual, [Section 3.4](#), for details.
  - they are a federal offender being held in custody. PharmaCare **does** cover federal offenders who have been released on day parole and approved to reside in a community-based residential facility.

>> See the PharmaCare Policy Manual, [Section 3.4](#), for details.

- the need for the benefit arose from an injury, illness or other condition alleged to have been caused by an act or omission of another person, and as a result of those allegations:
  - a court has awarded damages to the individual,
  - the individual is entitled to compensation under a settlement agreement, or
  - the individual is entitled to compensation under a plan of private insurance or another legal instrument.

*Exceptions may apply.*

>> See the PharmaCare Policy Manual, [Section 3.4](#), for details.

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<sup>1</sup> The First Nations Health Benefits Program provides prosthetic and orthotic benefits to eligible beneficiaries. Application is made directly to Pacific Blue Cross.

## 4.2 Who is eligible for orthotic benefits?

- Individuals are eligible for orthotic benefits if they are:
  - 18 years of age or younger, and covered under one or more of the following plans:
    - [Plan I \(Fair PharmaCare\)](#)
    - [Plan C \(B.C. Income Assistance\)](#)
    - [Plan F \(Children in the At Home Program\)](#)

>> See the PharmaCare Policy Manual, [Section 7.2](#), for more information on the Fair PharmaCare plan or [Section 7.3](#) for other PharmaCare plans.

- Individuals are **not** eligible for PharmaCare coverage if
  - they are eligible for orthotic coverage through any other Act or program such as ICBC, WorkSafeBC, Veterans Affairs Canada, Health Canada's Non-Insured Health Benefits Program, First Nations Health Benefits Program<sup>2</sup>, or similar programs from other provinces or jurisdictions
  - they are a provincial offender being held in custody in a correctional centre or a youth custody centre, or have been released on day parole but must return to a correctional centre each night. PharmaCare **does** cover provincial offenders who have been approved to reside in a community-based residential facility.

>> See the PharmaCare Policy, [Section 3.4](#), for details.

- they are a federal offender being held in custody. PharmaCare **does** cover federal offenders who have been released on day parole and approved to reside in a community-based residential facility.

>> See the PharmaCare Policy, [Section 3.4](#), for details.

- the need for the benefit arose from an injury, illness or other condition alleged to have been caused by an act or omission of another person, and as a result of those allegations:
  - a court has awarded damages to the individual,
  - the individual is entitled to compensation under a settlement agreement, or
  - the individual is entitled to compensation under a plan of private insurance or another legal instrument.

*Exceptions may apply.*

>> See the PharmaCare Policy Manual, [Section 3.4](#), for details.

*Note: Other government programs may provide assistance for orthoses that PharmaCare does not cover. In particular, Plan C clients or their agents should contact the Ministry of Social Development and Poverty Reduction; Plan F clients or their agents should contact the Ministry of Children and Family Development.*

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<sup>2</sup> The First Nations Health Benefits Program provides prosthetic and orthotic benefits to eligible beneficiaries. Application is made directly to Pacific Blue Cross.

### 4.3 What about clients not registered with Fair PharmaCare or another PharmaCare plan?

- Families who are eligible for Fair PharmaCare, but who have not registered with the plan, are assigned a default annual deductible/family maximum of \$10,000 **per individual**.
- Families who have registered for Fair PharmaCare, but have not consented to income verification, or for whom income verification was not possible due to unfiled tax returns, are assigned a default annual deductible/family maximum of \$10,000 **per family**.
- Non-registered individuals who are not covered under another PharmaCare plan pay the full cost of eligible prescription drugs and designated medical supplies, including prosthetic or orthotic benefits, until they reach the \$10,000 maximum per person. Once this maximum is reached, PharmaCare pays 100 percent of eligible benefits.

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**Tips:** Encouraging Families to Register for Fair PharmaCare

*All families are encouraged to register for Fair PharmaCare even if they are covered by another PharmaCare plan. Doing so ensures that if coverage through their other plan(s) ends, Fair PharmaCare coverage will begin automatically.*

*To receive the maximum allowable coverage, families have to register for Fair PharmaCare before the benefit is dispensed to the client. Fair PharmaCare does not cover retroactive claims.*

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>> See the PharmaCare Policy Manual, [Section 7.2](#), for more information about the Fair PharmaCare Plan and how to register.

### 4.4 When does coverage end?

- A client's eligibility for prosthetic and orthotic benefit coverage ends the day they leave the province to establish permanent residence elsewhere.

**IMPORTANT: Clients are required to report any address change to HIBC within 10 days of the change.**

- A client's eligibility for orthotic benefits coverage ends the day they turn 19.

## 5. Benefits

All prosthetic and orthotic benefits are subject to the policies detailed in this section, as applicable.

Any request for exceptions to these policies must be supported by sufficient justification and documentation to explain the need for an enhanced and/or more costly item. While PharmaCare considers exceptions, approval may not be granted even if justification is provided.

**IMPORTANT: PharmaCare does not fund travel, time for home and/or hospital visits or time providing assessments and/or consultations, including office visits.**

### 5.1 Policies and procedures that apply to all prosthetic and orthotic benefits

The following section describes PharmaCare policies and procedures that apply to all prosthetic and orthotic benefits, regardless of type.

*Note: Providers are required to keep client notes detailing interactions with clients, services provided, items dispensed including final dispenses, and all corresponding dates. PharmaCare may request this information at any time for auditing purposes.*

#### 5.1.1 What does “basic functionality” mean?

- PharmaCare limits the benefits covered under the P & O Program to those needed to help clients achieve, regain, or maintain basic functionality.
- Basic functionality varies from client to client. To determine whether a client needs a benefit device to achieve or regain basic functionality, PharmaCare considers the:
  - client’s age and general health
  - client’s activity level (based on professional assessment of the client’s current capabilities)
  - value of the requested claim (including consideration of less costly, but equally effective alternatives)
  - particular activities and occupational demands associated with the client’s employment
  - exceptional approvals or devices needed to allow the client to continue with their recovery

#### 5.1.2 How much will PharmaCare cover?

- If an Application is approved, PharmaCare covers up to the allowable maximum for a basic functionality device.
- PharmaCare usually covers the lowest-cost device available that meets the client’s basic functionality needs. When the same or similar component is offered at different prices by two or more suppliers, PharmaCare will cover the cost of the lowest-priced component.



- If a high-activity component has been requested, PharmaCare will also consider the component's warranty.
- Clients may request an enhanced component (i.e., a higher-cost device that goes beyond what is needed to support the client in achieving or regaining basic functionality) but must understand that:
  - PharmaCare covers only the lowest cost component that would meet the client's basic functionality needs
  - the client is responsible for any deductible they would have had to pay for a component that met their basic functionality need as well as any additional cost of the enhanced component
  - PharmaCare does not cover maintenance or repairs on an enhanced component
- The amount that PharmaCare actually reimburses may be less than the allowable maximum, depending on the client's plan and annual deductible requirements.
- The client is responsible for paying all costs not covered by PharmaCare.

### 5.1.3 Coverage of back-up/alternate devices

- PharmaCare covers only one prosthesis or orthosis per limb, per client.
- PharmaCare covers only one plagiocephaly helmet.
- Eligible exceptions are:
  - children with orthotic needs who require
    - one type of orthosis for night-time use and a different type of orthosis for the same limb for daytime use; or
    - a lower extremity orthosis and a spinal orthosis.
  - clients who have had a hemipelvectomy amputation, and who require both a sitting socket and a prosthesis
- Specialty devices, such as swim or shower legs, are **not** covered.

### 5.1.4 Devices requiring an assessment by a multi-disciplinary team or specialist physician

- Under certain circumstances, PharmaCare considers coverage for prostheses or orthoses only after receiving a written recommendation from a multi-disciplinary team.
- The multi-disciplinary team must consist of two or more health care professionals, which may include:
  - the prosthetist or orthotist
  - a physiatrist or a specialist
  - a family physician who specializes in prostheses/orthoses
  - a physiotherapist
  - an occupational therapist
- A recommendation from a multi-disciplinary team is required if any of the following apply:

- the client suffers from two or more chronic conditions that could affect their ability to make use of the prostheses or orthoses
- the client has not previously demonstrated compliance with the type of device being requested
- PharmaCare has requested additional information about the client's needs and the devices appropriate to meet those needs.

## 5.2 Limb Prosthesis

- PharmaCare covers prostheses intended to achieve or restore basic functionality.
- All Applications (including “initial” and “upgrade” applications) must include a prescription from a physician who is knowledgeable about prostheses.  
*Note: More complex cases may require a prescription from a [multi-disciplinary team](#) or specialist physician. See [Section 5.1.4](#) for details.*
- The term “initial” includes the first request for:
  - a prosthesis (e.g., in the case of a recent amputation)
  - a replacement prosthesis, if the client’s existing device was not covered by PharmaCare (i.e., purchased outside B.C., or a purchase covered by the client or another funding agency)
- Use the [Prosthetic Benefits: Application For Financial Assistance \(HLTH 5402\)](#) form for all pre-approval requests:
  - Initial
  - Upgrade
  - Replacement
  - Cosmesis
  - Repair
  - Adjustment
  - Supplies
- A pre-approval Application for a prosthesis should include all components/services the client needs (i.e., adjustment costs, supplies, etc.), based on an assessment of the client and their current components by the responsible prosthetist.

### 5.2.1 What information is required for pre-approval?

- An Application for pre-approval must provide enough information to allow PharmaCare to make an informed decision.  
*Note: This information must be included in the “[Detailed Rationale for Request](#)” section of the Application form, and in the details about the device (“Schedule C” or a work order), as appropriate.*

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**REMINDER: Cost-splitting prohibition**

- *Providers must not split the cost of supplies, components and/or services (i.e., adjustments and repairs) across two or more claims to avoid having to obtain pre-approval.*
  - *Once pre-approval is received providers cannot add additional components, supplies or fees as a separate claim under \$400. Any changes resulting in an increased claim amount must be resubmitted on a new Application for PharmaCare's pre-approval before the item is dispensed and a claim submitted.*
- 

### 5.2.2 Upgraded components

- Upgraded components are ones which provide increased or different functionality for the client (e.g., provide a higher degree of mobility) but still meet PharmaCare's basic functionality requirements.
- This includes claims that are made for a single component or for a full prosthesis that is being upgraded to meet the changing needs of the client.

#### When are upgraded components covered?

- PharmaCare will cover the cost of upgraded components for a client if:
  - the current device was approved and covered by PharmaCare
  - the upgrade is within PharmaCare's [basic functionality](#) guidelines
  - they are eligible for a replacement, and
  - the upgrade is approved by PharmaCare before being started or dispensed
- The Application for pre-approval for a component upgrade must provide enough information to allow PharmaCare to make an informed decision. It must include:
  - a rationale for the request (i.e., a detailed explanation of the client's new needs)
  - all information outlined in the "required information in a limb/prosthesis Application"
  - a completed Schedule A
- Submit Applications for pre-approval of an upgraded component on the [Prosthetic Benefits: Application for Financial Assistance \(HLTH 5402\)](#) form. Ensure "Upgrade" is checked in the "Service Information" section. All upgrades require a prescription.

### 5.2.3 Osseointegration

- Osseointegration benefits are available to Trans-Femoral amputee who have undergone osseointegration implant surgery
- Benefits are limited to those outlined on the Osseointegration component list and include all clinical labour costs incurred in dispensing the approved items, including the following:
  - assessing and developing a treatment plan
  - fitting and alignment

- educating the client about the prosthesis, its general maintenance and care
- assessing function and client prosthetic interface
- providing a warranty that guarantees that all material and workmanship with respect to manufacture or repair of the device is free from defect for a period of 90 days from time of dispensing.

#### 5.2.4 Definitive Sockets

- Prosthetic claims related to the manufacture and dispensing of a definitive socket are reimbursed based on the type and/or level of socket being fitted.
- The maximum reimbursement amount for a definitive laminated socket includes all clinical labour costs and materials incurred in its creation and dispensing, including all of the following:
  - assessing and developing a treatment plan
  - measuring
  - casting
  - fitting and alignment
  - custom manufacture of a definitive laminated socket from a positive model obtained by means of a negative cast, or by use of computer-assisted imaging, design and milling
  - educating the client about the prosthesis, its general maintenance and care, and proper fit
  - assessing function and client prosthetic interface
  - providing a warranty that guarantees that all material and workmanship with respect to manufacture or repair of the device is free from defect for a period of 90 days from time of dispensing.

#### 5.2.5 Loaner Foot or Knee

- If a provider has a clinic-owned foot or knee that is being trialed by a client, PharmaCare will pay a fee to that provider for the maintenance of the loaned component. PharmaCare does not pay a maintenance loaner fee for a component that is on loan from the manufacturer.

#### 5.2.6 Cosmesis

- PharmaCare covers a cosmesis for new amputees once stump volume has stabilized, when a new socket or prosthesis is requested, or when an existing cosmesis is damaged and needs replacing.
- Submit Applications for pre-approval of a cosmesis on the [Prosthetic Benefits: Application for Financial Assistance \(HLTH 5402\)](#) form. If you are only requesting a cosmesis, ensure “Cosmesis” is checked in the “Service Information” section.

#### **Cosmesis—New amputee**

- PharmaCare covers the cost of a prosthetic limb cosmesis only after a new amputee’s stump volume has had time to stabilize.

- Do not include the cosmesis on the Application for the initial prosthesis. Once a new amputee’s stump volume stabilizes, submit a separate Application for the cosmesis if all stabilization work, modifications, and component replacements during the adjustment period have been completed and the rationale identifies that the client is stable in the current socket.
- Otherwise, make the request with a subsequent replacement prosthesis Application.

### Cosmesis—Amputee requiring a replacement socket or prosthesis

- If a replacement socket or prosthesis is being contemplated, request a cosmesis on the same Application as the new socket or prosthesis. Do not use a separate Application for the cosmesis.

### 5.2.7 Supplies

- Prosthetic limb supplies include items required for proper functioning of the prosthesis (e.g., socks, pins, locks, liners, etc.)

>> See below for details regarding claims for liners.

- PharmaCare does **not** cover personal hygiene items such as lotions, antiperspirants and/or cleansers. Please do **not** submit claims for these items.

### 5.2.8 Prosthetic limb liners – required information

- Depending on the type of liner requested, providers may need to include additional information about the liner as part of the Application. Refer to the table below for details.

Category	Product	Pre-approval and documentation requirements
Basic functionality liners	<ul style="list-style-type: none"> <li>• pelite liners</li> <li>• thermoplastic elastomer liners (i.e., Alps, Silipos, or Alpha)</li> <li>• co-polymer liners (i.e., Otto Bock - TPE or Balance TPE)</li> </ul>	<ul style="list-style-type: none"> <li>• Standard Application.</li> <li>• For replacement liners, the rationale should include information on why the liners need to be replaced. <i>Note: Even these basic liners require justification for approval. Some liners require additional justification as to why they are needed by the client (e.g., why does the client require a 9 mm liner rather than the standard 6 mm).</i></li> </ul>
Liners that exceed the basic functionality guidelines	<ul style="list-style-type: none"> <li>• silicone liners (i.e., Iceross Comfort or Otto Bock Silicone Gel)</li> <li>• urethane liners (i.e. Otto Bock’s Simplicity)</li> <li>• custom made liners (i.e., TEC)</li> <li>• seal-in liners (i.e., Iceross Derma or Stabilo)</li> </ul>	<ul style="list-style-type: none"> <li>• Provide appropriate written justification for the product. Documentation can include, but is not limited to: <ul style="list-style-type: none"> <li>• supporting information supplied by the dispensing prosthetist justifying the medical need</li> <li>• documentation (e.g., medical reports or prescriptions) from a physiatrist, physician, dermatologist, plastic surgeon or wound care specialist, or</li> </ul> </li> </ul>

		<ul style="list-style-type: none"> <li>• medical documents that corroborate the need for a change in the liner (i.e., cite the liner as the cause of the condition).</li> </ul> <p><i>Note 1: Although silicone liners are not considered necessary for basic functionality, some silicone liners are comparably priced to the basic functionality liners and are the liner of choice for some prosthetists. Therefore, PharmaCare may approve Applications that include a liner with the same price or a lower price than a basic functionality liner, without requiring additional clinical justification. However, the liner price may increase by the time it requires replacement. If so, the client would be responsible for any additional cost. It is therefore important that the client understand and agree to this before the original liner is requested.</i></p> <p><i>Note 2: A client who has been granted an exception from basic functionality liners <b>may</b> be eligible for ongoing approval of this exception for future requests for a liner.</i></p> <ul style="list-style-type: none"> <li>• Exceptions may end at any time without prior notice.</li> </ul>
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### 5.2.9 Partial foot prosthesis – required information

- PharmaCare does not cover prostheses for missing toes.
- A partial foot prosthesis must be ankle-height and must be for at least a trans-metatarsal amputation. Types of prostheses covered include trans-metatarsal and trans-tarsal (i.e., Chopart, Lisfranc).
- Providers must include sufficient information in the pre-approval Application for PharmaCare to determine whether the prosthesis requested is an eligible benefit.

### Insufficient information

- Repeating information already on the form
- Simply stating “partial foot prosthesis”

### Sufficient information

- Description of the portion of foot that has been amputated or the portion of the foot that remains.
- Complete description of the prosthesis being provided, such as:
  - Molded socket, ankle height, toe filler
  - Molded socket, Patella Tendon Bearing (PTB) height, toe filler
  - Molded socket (plastic), ankle height, toe filler
  - Molded socket (leather), ankle height, toe filler
  - Molded socket (in-house silicone), ankle height, toe filler
- Additional information, such as the type of foot plate or any additional components being supplied, along with the part numbers.

*Note: A Basic Functionality partial foot prosthesis does not include a silicone partial foot prosthesis fabricated by a manufacturer.*

## 5.2.10 PharmaCare calculation of component pricing

- The maximum PharmaCare reimburses for components is calculated using the [Girling Formula](#). This formula is based on a percentage markup on the list cost of the item.
- The Girling Formula is used for items purchased outside of Canada. In these cases, the list price is adjusted to Canadian dollars and then the second column of the Formula (imported item percentage markup) is used to include the additional cost of freight and duty to import the item into Canada.

### Exchange rate on components purchased outside Canada

- United States (US) exchange rates are reviewed regularly.
- The rate used to set pricing is adjusted as needed based on significant fluctuations in the posted daily average US exchange rate, as published by the [Bank of Canada](#).
- The pricing rate is adjusted when the daily average rate changes more than five cents, for a period of five or more consecutive business days. When this occurs, the pricing rate is adjusted to reflect the rate posted on the first day of this period.
- When the pricing rate is adjusted, it is published in the next [PharmaCare Newsletter](#).

### 5.2.11 Maximum reimbursement amounts

- Maximum reimbursement amounts for definitive laminated sockets are defined in the [Reimbursement Schedule for Definitive Sockets](#).
- Maximum reimbursement amounts for labour costs for repairs/adjustments for various standard prosthetic procedures, excluding definitive sockets ([noted above](#)), are defined in the [Reimbursement Schedule for Prosthetic Procedures](#).
- Maximum reimbursement amounts for osseointegration devices are defined in the [Reimbursement Schedule for Osseointegration](#).
- If no maximum reimbursement amount for a specific procedure is listed in the Reimbursement Schedule for Prosthetic Procedures, the procedure is subject to the hourly rate provided in the Reimbursement Schedule.
- Reimbursement for all prosthetic services related to the manufacture and or repair of a prosthetic limb are based on the provider's usual and customary price up to PharmaCare maximum reimbursements specified in the [Reimbursement Schedules](#).
- PharmaCare coverage is limited to one check, test, or diagnostic socket, whether static or dynamic, per definitive socket.
- Actual reimbursement depends on the client's PharmaCare plan rules, including any annual deductible requirements.

*Note: There is no coverage for individual office visits, or hospital visits/consultations.*

## 5.3 Custom Ocular Prosthesis/Services

- An ocular prosthesis is an artificial eye, custom made and fit by a certified<sup>3</sup> ocularist, that replaces an absent natural eye or fits over an injured, diseased, or underdeveloped eye. The prosthesis fits over an orbital implant or a shrunken non-functional eye, and under the eyelid.

### 5.3.1 What information is required for pre-approval?

- The Application for pre-approval must provide enough information to allow PharmaCare to make an informed decision.
- It must include, but is not limited to
  - The cause/diagnosis that results in the need for the prosthesis (e.g., motor vehicle accident, cancer, microphthalmos)
  - a full description of the type of device and/or service being requested, including the type of surgery that necessitated the ocular prosthesis (e.g., as a result of evisceration or enucleation) or the socket (i.e., anophthalmic or phthisis bulbi)
  - a rationale for the request, or a detailed explanation of why the client needs the device and/or service requested (i.e., due to growth, due to atrophy)

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<sup>3</sup> Ocularists must be certified by National Examining Board of Ocularists (NEBO).



- a prescription from a physician (mandatory for all initial Applications).
- Submit Applications for pre-approval on the [Prosthetic Benefits: Non-limb \(HLTH 5404\)](#) form.

### 5.3.2 Devices and services covered

- PharmaCare limits eligible ocular benefits to custom-manufactured ocular prostheses, as defined above.
- PharmaCare does **not** cover:
  - Scleral lenses (for persons with sight in the eye)
  - Surgical and expansion conformers
  - Conformer shells and/or expanders
- Reimbursement is subject to the client's PharmaCare plan rules, including any annual deductible requirements.

### 5.3.3 Maximum reimbursement amounts

- Reimbursement for materials and labour related to the manufacture and/or repair of an ocular prosthesis is based on the provider's usual and customary price, up to PharmaCare's maximum reimbursement described below.
- Actual reimbursement depends on the client's PharmaCare plan rules, including any annual deductible requirements.
- The maximum reimbursement for an ocular prosthesis includes all clinical labour costs and materials incurred in its creation and dispensing, including the following:
  - assessing and developing a treatment or care plan
  - creating an impression mold, measuring and casting
  - assessing function and fit of prosthesis
  - custom manufacture of the ocular prosthesis, including hand painting
  - educating the client about the prosthesis, on its general maintenance and care, and proper fit
  - providing a 90 day provider warranty, warranting that all material and workmanship with respect to manufacture or repair of the device is free from defect for a period of 90 days from time of dispensing
- The maximum reimbursement is detailed in the [Non-Limb Prostheses PINs and Reimbursement Schedule](#).

## 5.4 Custom Ear and Nose Prostheses and Services

- An ear prosthesis is a custom made, artificial ear that replaces an absent natural ear.
- A nose prosthesis is a custom made, artificial nose that replaces an absent natural nose.
- Ear and nose prostheses are generally fit by an anaplastologist.

- PharmaCare limits eligible ear and nose prostheses to custom-manufactured ear or nose prostheses required to replace a missing ear or nose.
- Reimbursement is subject to the client's PharmaCare plan rules, including any annual deductible requirement.

#### 5.4.1 What information is required for pre-approval?

- The Application for pre-approval must provide enough information to allow PharmaCare to make an informed decision.
- It must include, but is not limited to:
  - a full description of the type of device, and/or service being requested
  - a rationale for the request (i.e., a detailed explanation of why the client needs the device and/or service being requested on this Application)
  - a prescription from a physician (mandatory for all initial Applications)
- Submit Applications for pre-approval on the [Prosthetic benefits: Non-limb \(HLTH 5404\)](#) form.

#### 5.4.2 Maximum reimbursement amounts

- Reimbursement for services related to the manufacture and/or repair of an ear or nose prosthesis is based on the provider's usual and customary price up to the PharmaCare maximum reimbursement, specified in the [Non-Limb Prostheses PINs and Reimbursement Schedule](#).
- Actual reimbursement will depend on the client's PharmaCare plan rules, including any annual deductible requirements.
- The maximum reimbursement amount for an ear or nose prosthesis includes all clinical labour costs and materials incurred in its creation and dispensing, including the following:
  - assessing and developing a treatment or care plan
  - creating an impression, mold, clay sculpture or other fitting method
  - custom manufacture of the prosthesis, including hand painting
  - assessing fit of prosthesis
  - educating the client about the prosthesis, on its general maintenance and care, and proper fit
  - providing a 90 day provider warranty, warranting that all material and workmanship with respect to manufacture or repair of the device is free from defect for a period of 90 days from the date of dispense

## 5.5 Breast Prostheses and Mastectomy Supplies

#### 5.5.1 What breast prostheses does PharmaCare cover?

- Subject to specific limits, PharmaCare covers breast prostheses and mastectomy supplies for eligible individuals who have undergone a mastectomy or lumpectomy, subject to the client's PharmaCare plan rules including any deductible requirement.

- PharmaCare does **not** cover breast prostheses required for
  - developmental delay or breasts of different sizes
  - breast size augmentation
- See the [Mastectomy PINs and Reimbursement Schedule](#) for details on maximum reimbursements.
- For information on the replacement of a mastectomy device, see [Section 6.1](#).

### 5.5.2 What information is required for a breast prosthesis Application?

- Pre-approval is **not** required for regular benefits.
- When applying for pre-approval for exceptional coverage (e.g., a second prosthesis within the replacement period), the Application must provide enough information about the exceptional circumstances to allow PharmaCare to make an informed decision.
- The information must include, but not be limited to
  - a full description of the type of device being requested, and the device being replaced
  - a rationale for the request (i.e., a detailed explanation of why the client requires consideration for exceptional coverage for a new device within the replacement period, such as significant weight gain/loss, including the amount of weight fluctuation)
  - the cost of the device
- Submit Applications for pre-approval on the [Prosthetic benefits: Non-limb \(HLTH 5404\)](#) form.

## 5.6 Orthotic Benefits for Children and Youth

- PharmaCare covers the following eligible orthotic benefits:
  - orthoses for children and youth, age 18 and younger
  - custom-manufactured, high-temperature devices required to achieve or regain basic functionality or to prevent further deformity
  - permanent, lower extremity orthoses that are at least ankle height
  - spinal orthoses required to correct spina bifida, scoliosis and similar medical conditions
  - plagiocephaly helmets
- Reimbursement is subject to the client's PharmaCare plan rules, including any annual deductible requirement.
- The term "initial devices and/or services" includes the first request for:
  - an orthosis (i.e., client has been diagnosed with a condition and requires an orthosis)
  - a replacement orthosis, if the purchase of the client's existing device was **not** covered by PharmaCare (i.e., purchased outside B.C., or the purchase cost was

covered by the client or some other funding agency such as the Insurance Corporation of BC)

### 5.6.1 Excluded orthotic devices/services

- PharmaCare does **not** cover
  - orthoses required for less than full time use (full time = a minimum six hours per day)
  - orthoses required for short-term use (i.e., less than one year)
  - low temperature or off-the-shelf orthoses
  - orthoses used only to treat injuries and/or fractures or to further support limbs after the injury or fracture (e.g., walking boots or air casts, spinal braces required to support after a fracture)
  - orthoses required for post-surgical support only (e.g., spinal braces following back surgery)
  - serial casting
  - Functional Electrical Stimulation (FES)
  - orthoses prescribed for upper extremities
  - foot orthoses (e.g., foot inserts, UCBL [University of California-Berkeley Lab or University of California Biomechanics Laboratory])
  - orthotic footwear (e.g., orthopedic shoes; larger shoes that could accommodate an orthosis)
  - orthotic benefits for adults age 19 or older

### 5.6.2 Do other programs fund orthotics?

- Ministry of Social Development and Poverty Reduction clients who are covered under PharmaCare Plan C may be able to obtain assistance through that Ministry for orthoses that PharmaCare does not cover (e.g., orthoses for adults; additional children's orthoses, such as orthoses not manufactured at a PharmaCare provider's premises, for upper extremities; foot orthoses, footwear).
- Ministry of Children and Family Development (MCFD) clients who are covered under PharmaCare Plan F may be able to obtain assistance through that Ministry for orthoses that PharmaCare does not cover (e.g., orthopedic shoes; wrist and hand orthoses; cervical collars).

### 5.6.3 What is the maximum PharmaCare covers for orthoses?

- Maximum reimbursement for orthoses is based on the type or style of orthosis. The appropriate Product Identification Number (PIN) must be used on all Applications and invoices.
- Services related to the manufacture and or repair of an orthosis are based on the provider's usual and customary price, up to PharmaCare's maximum reimbursement as specified in the [Orthoses PINs and Reimbursement Schedule](#).
- Reimbursement maximums for a basic orthosis include all clinical labour costs and materials incurred in its creation and dispensing, including the following:

- assessing and developing a treatment plan
- measuring and casting
- fitting and alignment
- custom manufacture (by the PharmaCare provider) of a high-temperature thermoplastic molded orthosis from a positive model obtained by means of a negative cast or use of computer-assisted imaging, design and milling
- educating the client about the orthosis, on its general maintenance and care, and proper fit
- assessing function and client orthotic interface
- providing a warranty, guaranteeing all material and workmanship, with respect to manufacture or repair of the device, as free from defect for a period of 90 days from the date of dispense

## 5.7 Plagiocephaly Helmets

### 5.7.1 Who is eligible for plagiocephaly helmets?

- PharmaCare covers plagiocephaly helmets only for clients who
  - have been diagnosed with plagiocephaly, brachycephaly and/or craniosynostosis (other reasons for a helmet do not meet PharmaCare’s eligibility requirements), **and**
  - are registered with [Fair PharmaCare](#) and/or covered by PharmaCare Plan C (for Recipients of B.C. Income Assistance) or Plan F (Children in the At Home Program) **before** the helmet is dispensed.
- Depending on the circumstances, pre-approval for a helmet may not be needed for PharmaCare coverage (see below for more information).

### 5.7.2 When can I dispense a plagiocephaly helmet without pre-approval?

- To be reimbursed for a plagiocephaly helmet without pre-approval, the provider must ensure that the:
  - client meets **all** the requirements for their condition as specified in the table below, and
  - criteria are fully documented, as described in [Section 5.7.3](#) below.
- **Important:** If the client is not registered for Fair PharmaCare, or covered by Plan C or Plan F before the helmet is dispensed, the family will be responsible for the full cost of the helmet. If a family does not know if they are covered by one of these plans, the [P & O Clerk](#) can confirm the client’s coverage status. If the client does not have the necessary PharmaCare coverage, the device providers can advise the family as to how to register for Fair PharmaCare or provide them with the [patient information sheet](#) about registration.

If client has:	Client must:
Plagiocephaly	<ul style="list-style-type: none"> <li>• be between the ages of 5 months and one year at the start of helmet treatment</li> <li>• have a written referral for the helmet from a recognized plagiocephaly clinic*</li> <li>• have a cranial vault asymmetry index (CVAI) equal to or greater than 6.25%**</li> </ul>
Brachycephaly	<ul style="list-style-type: none"> <li>• be between the ages of 5 months and one year at the start of helmet treatment</li> <li>• have a written referral for the helmet from a recognized plagiocephaly clinic*</li> <li>• have a cranial index (CI) equal to or greater than 95%**</li> </ul>
plagiocephaly with brachycephaly	<ul style="list-style-type: none"> <li>• be between the ages of 5 months and one year at the start of helmet treatment</li> <li>• have a written referral for the helmet from a recognized plagiocephaly clinic*</li> <li>• have a cranial vault asymmetry index (CVAI) equal to or greater than 6.25% and a cranial index (CI) equal to or greater than 90%**</li> </ul>
Craniosynostosis	<ul style="list-style-type: none"> <li>• be between the ages of 4 months and one year at the start of helmet treatment</li> <li>• have had surgery for the condition</li> <li>• have a written referral or prescription for the helmet from a pediatric neurosurgeon</li> <li>• have had a post-operative helmet cast or scan</li> <li>• <i>Note: a soft helmet for protection of the surgical site is not a PharmaCare benefit</i></li> </ul>

\* BC Children’s Hospital and the plagiocephaly clinic at the Queen Alexandra Centre for Children’s Health

*Note: The referral must state if it is from one of these sites (e.g., an email with the signature identifying the person is from that site)*

\*\* as measured by a certified orthotist

### How are cranial indices calculated?

- Cranial Index (CI) or Cephalic Ratio (CR) formula
  - $\text{cranial index} = (\text{cranial width} \div \text{cranial length}) \times 100$
- Cranial Vault Asymmetry Index (CVAI) formula
  - calculates the difference between two diagonal lines (A and B) drawn 30° from the anterior-posterior pole
  - Diagonal A is the greater of the two diagonal measurements
  - $\text{cranial vault asymmetry index} = [(\text{Diagonal A} - \text{Diagonal B}) \div \text{Diagonal A}] \times 100$

### 5.7.3 Retaining client information for audit

- The orthotist must measure and record the necessary cranial index (CI) and/or cranial vault asymmetry index (CVAI) measurements on the [PharmaCare Orthotic Benefit—Plagiocephaly Helmet \(HLTH 5450\)](#) form.
- The completed form, along with all required supporting documentation (e.g., referral from a plagiocephaly clinic, prescription from a pediatric neurosurgeon), must be kept in the client’s file as proof that the client was eligible for plagiocephaly helmet coverage.

- The device provider may be liable for costs of the item/service and any associated costs, if the completed form is not:
  - signed and dated by both the certified orthotist and the client's agent
  - retained in the client file
  - made available at the time of audit.

#### 5.7.4 When do I need to submit a pre-approval request for plagiocephaly helmets?

- The Application must follow the standard PharmaCare pre-approval process, including completing an [Application for Financial Assistance: Orthotic Benefits \(HLTH 5400\)](#) form with the appropriate rationale and documentation for the request; see [Section 7](#) of this manual for details.
- If a client does not have a written referral from a recognized plagiocephaly clinic, or does not meet the other criteria above, submit an [Application for Financial Assistance: Orthotic Benefits \(HLTH 5400\)](#) form for consideration. An appropriate rationale must be included in the Application to explain why they require a helmet at this time.

#### 5.7.5 Maximum reimbursement amounts

- PharmaCare policy allows for a lifetime limit of one plagiocephaly helmet to treat positional plagiocephaly.
- The maximum PharmaCare reimburses for a helmet is listed in the [Orthoses Reimbursement Schedule and PINs](#). Maximum reimbursement amounts include clinical labour and costs as specified in [Section 5.6.3](#).

## 5.8 Lost and Stolen Items

- PharmaCare does not cover replacement of damaged, lost or stolen prostheses, orthoses or prosthetic supplies.

*Note: Damaged, lost or stolen items may be covered by a client's home or other insurance policy.*

## 5.9 Adjustments and Repairs

- Providers should consider making adjustments or repairs if doing so could extend the useful life of a device (i.e., delaying the need to replace the device).

*Note: PharmaCare will not approve, or provide coverage for, both an adjustment or repair and a new prosthesis.*

### 5.9.1 When are adjustments and repairs covered?

- The P & O Program covers adjustments and repairs to prostheses and orthoses only when:
  - pre-approval has been obtained for all adjustments or repairs costing \$400 or more
  - the warranty period for the original approved and dispensed device has expired<sup>4</sup>
  - the repairs are limited to restoration of basic functionality (i.e., the repair or adjustment is not intended to enhance the device's functionality)
  - PharmaCare approved and paid for the device being repaired
  - the repairs extend the useful life of the device (i.e., they will delay the need to replace the device)
  - the cost of the repair/adjustment is substantially less than the cost of the replacement.
- PharmaCare does not reimburse the repair or adjustment costs on components that exceed the basic functionality devices approved by PharmaCare. (For example, PharmaCare does not cover repair or maintenance costs if a traditional socket amputee has obtained a micro-processor knee instead of a basic functionality knee.)
- Providers may claim either:
  - the repair or replacement of worn or damaged components required to complete the repair, (plus the [Girling Formula](#)); or
  - the actual cost of the manufacturer's repair to the device (no Girling mark-up) plus the actual shipping and/or brokerage costs.
- Adjustments may include the costs of the measurable materials and labour required to maintain or improve the fit of a device (e.g., stretching an orthosis for growth, shrinking a socket for atrophy etc.). Items such as leather, Dacron, pads, carbon cloth and others should be detailed with the amount (i.e., ½ metre) and the price being charged. Items such as teaspoons of glue and short lengths of Velcro should not be listed as they are considered shop supplies and are not a PharmaCare benefit.

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<sup>4</sup> Providers are required to warrant that all material and workmanship with respect to the manufacture or repair of the device be free from defect for a period of 90 days from time of completion. PharmaCare does not cover adjustments or repairs during this period that are not the result of significant physiological change, as they should be covered by the provider's 90-day in-house warranty.



## 5.9.2 What information is required for pre-approval of an adjustment or repair?

- The Application for pre-approval must provide enough information to allow PharmaCare to make an informed decision. It must include:
  - a full description of the adjustment(s)/repair(s) to be made, for example, what needs to be adjusted/repared
  - a description of the adjustment(s)/repair(s) including:
    - the time (may be billed in small increments, such as a tenth of an hour) and materials (must be itemized, providing a description and the cost) required
    - manufacturer's repair estimate
    - a full description of the repair(s) to be made, including what specific items will be repaired
  - a rationale for the request, including:
    - a description of the client's needs and an explanation of how the specific adjustments/repairs will help address the client's ability to function and quality of life
    - the client's physiological change being addressed by the adjustments/repairs, including measurement changes when available
  - a prescription from a medical practitioner, if one was provided
- Applications for pre-approval must be submitted on the appropriate form:
  - [Orthotic benefits \(HLTH 5400\)](#)
  - [Prosthetic benefits \(HLTH 5402\)](#)
  - [Prosthetic benefits: Non-Limb \(HLTH 5404\)](#)
- Adequate documentation to support claims for repairs and adjustments must be kept on file, available for audit. This includes, but is not limited to, :
  - invoices for parts required for the repair or adjustment or for the repairs done by the manufacturer
  - copies of work orders/cost estimates/quotes from the manufacturer
  - invoices for any supplementary costs such as shipping and brokerage costs

## 6. Replacement Policies

### 6.1 Prosthetic device replacement

- Prosthetic devices (excluding mastectomy prostheses) may be replaced:
  - no sooner than three years from the previous approval; and
  - only if the provider demonstrates that the existing device no longer meets the client's basic functionality needs.
- The three year minimum limit may be waived if it is clearly demonstrated, in writing, that the client's changing health or other circumstances require replacement of the socket to maintain basic functionality. Potential rationales may include:
  - major growth in young children, or
  - **significant** physiological changes that require socket replacement, particularly in the first year after fitting a socket.

*Note: In the event of significant physiological change, the prosthetist may submit an Application that includes team assessments, physician recommendations, and/or other written documentation, to demonstrate the client's need for a new socket. However, even during the first year, every effort should be taken to limit a client to one definitive socket. All best practices should be used before the fitting of the laminated, definitive socket, such as pre-fitting edema control (shrinkers) and dynamic diagnostic sockets.*

- A mastectomy device may not be replaced for at least 24 months from the previous approval, and then only upon demonstration that the existing device no longer meets the client's basic functionality needs. (See [Mastectomy PINs](#)).
  - As providers may only access records up to 14 months previous in PharmaNet, call the [PharmaNet Help Desk](#) before supplying a new prosthesis or supply. Calling the Help Desk will ensure the correct amount of time has passed since PharmaCare last approved coverage.
  - Adjudication in PharmaNet does not mean that two years have elapsed. Call the Help Desk to confirm the client is entitled to the benefit and that the claim adjudicates accurately.

#### 6.1.1 When a client changes providers

- If a client switches providers for any reason, they are subject to the same PharmaCare coverage rules governing replacements and are entitled to only one prosthesis every three years.
- PharmaCare will consider a new Application, with appropriate justification, for portions of a device recommended by a new provider, but clients should be aware that most components must be reused. For example, PharmaCare may consider the provision of a new socket, if it is warranted, but the new prosthetist will be required to reuse all the other components of the previous device.

### 6.1.2 Replacement due to physiological change - Required documentation

When a replacement device is requested due to physiological change, providers should ensure that they provide adequate information for PharmaCare to make a decision.

#### Insufficient information

- Repeating information already on the form
- Simply stating “stump atrophy” or “socket ill fitting”

#### Sufficient information

- Details about your client, including but not limited to the following:
  - number of ply socks the client is wearing
  - whether padding has been added to the prosthesis
  - stump measurements (new and old)
  - adjustments made that may not have been included in a previously approved Application (e.g., adjustments under \$400, so pre-approval was not required)

### 6.1.3 Replacement due to wear and tear - Required documentation

- When a replacement device is requested due to wear and tear, providers should ensure that they provide adequate information for PharmaCare to make a decision.

#### Insufficient information

- Repeating information already on the form
- Simply stating “worn out” or “damaged”
- Stating that components are “past warranty”

#### Sufficient information

- Description of which parts are worn out and the nature of the wear or damage such as:
  - holes in liners or socks
  - socket delaminating or cracking

### 6.1.4 Replacement quantity/time limits for prosthetic supplies

- The following quantities are covered subject to the time limits specified:

Item	Quantity/time
Shrinkers	six per year
Liners	two per year
Sealing suspension sleeves	two every four months
Neoprene suspension sleeves	four every four months
Silo sheaths	four every four months
Prosthetic gloves	two per year

Item	Quantity/time
Socks, cotton socks and stump socks	no more than: <ul style="list-style-type: none"> <li>• 12 per year, per ply, if client does not wear a liner</li> <li>• 6 per year, per ply, if client wears a liner</li> </ul>

## 6.2 Orthotic device replacement

- Orthoses may be replaced:
  - no sooner than one year from the previous approval; and
  - only if the orthotist demonstrates that the existing device no longer meets the client’s basic functionality needs.

*Exception:*

*Replacement of an orthosis before the time limit may be approved if it is clearly demonstrated, in writing, that the client’s changing health or other circumstances require replacement of the orthosis to maintain basic functionality. Team assessments, physician recommendations, and/or written documentation may be submitted to demonstrate this requirement. See [Section 5.1.4](#) for information regarding Teams.*

### 6.2.1 Replacement due to physiological change - Required documentation

- When a replacement device is requested due to growth or physiological change, providers should ensure that they provide adequate information for PharmaCare to make a decision.

**Insufficient information**

- Repeating information already on the form
- Simply stating “growth”, “outgrown” or “too tight”

**Sufficient information**

- Details about your request, including but not limited to the following:
  - whether adjustments have already been attempted on current orthosis
  - changes in measurements (i.e. Note significant change(s) on [Limb Measurements form](#))
  - adjustments made that may not have been included in a previously approved Applications (e.g., adjustments under \$400, so pre-approval was not required)

### 6.2.2 Replacement due to wear and tear - Required documentation

- When a replacement device is requested due to wear and tear, providers should ensure that they provide adequate information for PharmaCare to make a decision.

### **Insufficient information**

- Repeating information already on the form
- Simply stating “worn out” or “damaged”

### **Sufficient information**

- Details about your request, including but not limited to the following:
  - description of the parts that are worn out
  - straps need replacing (e.g., no longer holding)
  - the plastic has fractured and, if so, whether there is something that can be changed for the next one to make it last longer.

## **6.2.3 When a client changes providers**

- If a client switches providers for any reason, they are subject to the same PharmaCare coverage rules governing replacements, and are entitled to only one orthosis per year, and then only if the orthotist demonstrates the device no longer meets the client’s basic functionality needs.
- PharmaCare will consider a new Application, with appropriate justification, for a device recommended by a new provider, but clients should be aware that the device may not be approved.

## 7. Applying for Pre-Approval and Submitting Claims

### 7.1 Procedure for Applications for pre-approval

#### 7.1.1 General instructions for pre-approval forms

1. Download the appropriate form from the PharmaCare website:
  - a. [Orthotic benefits \(HLTH 5400\)](#)
  - b. [Prosthetic benefits \(HLTH 5402\)](#)
  - c. [Prosthetic benefits: Non-Limb \(HLTH 5404\)](#)
2. Complete the Application, consulting with the client as required to ensure client information is complete and correct.
3. **Fully** complete the form, including a:
  - full description of the item/service to be provided, including appropriate part numbers or description of labour being provided (include work order, or complete Schedule 'C' on the form)
  - detailed explanation of why the client needs the device or service, including a thorough explanation of how the device or service will help the client achieve or regain basic functionality. (Note: this should be done after an assessment of the client, the client's needs and a review of any old devices and/or supplies.)

*Note: Indicate on the form if the Application is on behalf of a client who is a resident of a licensed residential care facility (Plan B). For information on PharmaCare Plans, refer to Section 7 of the [PharmaCare Policy Manual](#).*

4. Attach all supporting documentation, such as a prescription for the device (required for all initial and upgraded prostheses and orthoses). More complex cases may require a prescription from a [specialist physician](#).
5. Ensure both the provider and the client (or the client's agent, if the client is a minor) have signed and dated the Application form.
6. Fax the completed Application and supporting documentation to HIBC at 250 405-3590 or mail the completed and signed Application to:

Health Insurance BC – PharmaCare  
Attn: P & O Clerk  
PO Box 9655 Stn Prov Govt  
Victoria BC V8W 9P2

**IMPORTANT: Please make sure that the information is complete, accurate and legible. Incomplete, inaccurate and/or illegible Applications will be returned. Providers will have to revise and resubmit the appropriate part of the form or provide additional information, as requested.**

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***REMINDER: Changing Adjudication Result is Not Allowed***

- *Backdating of claims on PharmaNet is permitted only for the purpose of correcting a previously adjudicated claim, not to alter adjudication results*
  - *Also, claims must be made at the time of dispense, and cannot be held and entered at a later date to get a better adjudication result.*
- 

### **7.1.2 Form Section Details**

- All pre-approval Application forms require the following:
  - Client information
  - Device provider information
  - Service information
  - Detailed rationale
  - Details of request
  - PharmaCare Eligibility Personal Injury
  - Client certification
  - Provider certification
- Specific instructions for these sections follow below.
- Note: some Applications will require additional information, as applicable.

#### **Detailed Rationale for Request section**

- Your Application for pre-approval must provide enough information to allow PharmaCare to make an informed decision. It must include, but is not limited to:
  - a full description of the device and/or service being requested, and part numbers if applicable (e.g., type of device, device components, component costs, labour costs (including type of work to be completed), supplies, etc.)
  - a rationale for the request (i.e., a detailed explanation of the client's needs and current abilities, or a detailed explanation of what is wrong with the current device)
  - a prescription from a physician knowledgeable about prostheses or orthoses (mandatory for the provision of all initial [including transferred from out-of-province or after revision surgery] and upgraded devices/services).

### Insufficient information

- Simple re-statement of client's
  - age (birth date is already on the form)
  - diagnosis (already on the form)
  - level of amputation (already on the form)
- Stating what the client did in the past, without identifying when or what the client is able to do now.

### Sufficient information

- Details about the client's:
  - current needs and abilities
  - gait analysis
  - ability to use the device
  - occupational requirement(s)
  - functional ability (note this needs to identify the client's current ability, may include what they would like to return to but this will not be given as much weight as their current ability)
  - cognitive ability
  - degree of use (i.e., whether this is their dominant hand, etc.)
  - current supports (e.g., has supportive family (spouse/children); is enrolled in rehab training; etc.)
- Information from all other sources (e.g., medical reports, physician statements, physiotherapy notes, etc.).
- For a sample of an initial prosthesis rationale, see box below.

- Rationales for all work should provide justification for the request based on the client's health, needs, and expected outcomes. Some examples of specific rationales include:
  - a description of the biomechanical problems that an orthosis is expected to correct
  - the reasons why the client needs a specific device (e.g., an articulated Ankle-Foot Orthosis rather than a rigid one)
  - the current capabilities, cognition and home supports of a client requiring a prosthesis
  - the reasons why a device should be replaced rather than repaired
  - Why a client requires a plagiocephaly helmet when they don't meet criteria



*An example of a good rationale for a new amputee's first limb prosthesis:*

- The client's limb is well healed and desensitized
- The client has worn shrinker socks for 4 weeks
- The client has very good motivation for prosthetic use
- The client has good cognitive awareness
- The client has no limitations to their range of motion (ROM) or strength – grade 5 muscle strength for upper & lower extremities
- The client has been attending outpatient physiotherapy
- The client is able to hop 10 metres in parallel bars
- The client is expected to become a successful community ambulator

- More complex cases may require a prescription from a [specialist physician](#).

*Note: Providers may attach a work order to an Application if it gives sufficient detail about the work to be done and the rationale for the device. If a work order is not attached, providers must complete Schedule 'C' along with a detailed rationale for the device.*

## Details of Request

- Applications must include the appropriate PIN. When replacing a significant component such as a foot, knee or hand/hook, use the appropriate PIN for that level of amputation, **not** the PINs for supplies.
- Providers may request approval for no more than two separate PINs on each Application, all appropriate details for each device must be included.
- The following ancillary documents provide PINs for use on pre-approval and invoice forms. Where abbreviations are allowed, they are noted in these documents.
  - [Definitive Sockets](#) and [Osseointegration PINs](#) and Reimbursement Schedules
  - [Prosthetic Procedures PINs and Reimbursement Schedule](#)
  - [Non-Limb Prostheses PINs and Reimbursement Schedule](#)
  - [Orthoses PINs and Reimbursement Schedule](#)
  - [Mastectomy PINs and Reimbursement Schedule](#)
- Enter the PIN for the entire benefit. PINs can be found in the [Reimbursement Schedules](#).
- Benefit PINs refer to the type of device or service (e.g., trans-tibial prosthesis, ankle-foot orthosis), not specific components.
- If providing several items on one device, use the PIN that accounts for the majority of the cost (e.g., when replacing a foot on a trans-tibial prosthesis, adding a new cosmesis and making an adjustment, code all the costs to the trans-tibial PIN; when adding in pads for \$240 and making adjustments for \$120, use the repair PIN)

## PharmaCare Eligibility Personal Injury

- Only the client or the client's agent (if the client is a minor or not capable of signing on their own) should complete this section of the form. If the client requires an agent, have the agent

note the legal relationship between the agent and the client on the form, next to the agent's signature.

- Completion of this section certifies the client is not adequately covered by other funding sources, including court awards or settlements for damages (the client must answer a significant number of questions regarding possible sources of other funding. If the client has received, or will receive, other funding, they must fill in [PharmaCare Eligibility Personal Injury \(HLTH 5467\)](#))

### **Client Certification section**

- Only the client should sign this section of the form, unless the client is a minor or not capable of signing on their own. If the client requires an agent, have the agent note the legal relationship between the agent and the client on the form, next to the agent's signature. For children in care, or foster children, the social worker **must** sign for the care.
- Never ask the client to sign a blank form and leave it at the site for future use. The information in the Client Certification section may change and the client is required to confirm that they have read and understood the rest of the form. PharmaCare may delay or deny payments to providers who request that clients sign blank forms.
- The client's signature certifies that the client:
  - understands the function of the device or service to be provided to them
  - understands the replacement policy for that device
  - understands that they are responsible for any costs not reimbursed by PharmaCare and that, if the item is dispensed before their family is registered in Fair PharmaCare, reimbursement will be based on the default PharmaCare annual individual deductible of \$10,000.00
  - understands that PharmaCare will recover the cost of any benefits that they were not entitled to receive
  - confirms that the information provided on the form is true and correct, to the best of their knowledge.

### **Provider Certification section**

- This signature certifies that the prosthetist/orthotist/health care provider:
  - confirms that the information provided on the form is true and correct, to the best of their knowledge
  - is the professional responsible for providing the device or service
  - has explained the pre-approval Application to the client.

### **PharmaCare Use Only section**

- This section will be completed by PharmaCare and will contain the decision from PharmaCare when it is returned to you. Please see [Understanding PharmaCare's decision](#) for more details.

## Form 5402

### Schedule A

Schedule A (Past Medical History) is to be completed by the client or the provider (based on client/practitioner input). It is important to check all boxes that apply. Completion of Schedule A and a prescription must accompany all initial and upgraded requests (e.g., clients who have had revision surgery).

### Schedule B

Schedule B (Upper Extremity Amputee) is to be completed and submitted by the provider for each upper extremity Application. Must include information on who will be providing training on the electro/myo-electro device and what training they have had to qualify them as the trainer. Must include information on who will be providing the functional training for the arm and what training they have had to qualify them as the trainer.

### Schedule C

Schedule C (Detailed Information) is to be completed to outline the components requested for the client. Providers must include PharmaCare pricing and totals on this schedule. Providers may include their work order instead of Schedule C but it must include the same basic information in the same format (i.e. PharmaCare pricing and detailed part #) as on Schedule C.

If clients will be receiving an upgraded component and paying the extra cost, the basic PharmaCare coverage amounts should be shown in the PharmaCare Price column, and the upgraded pricing and details should be shown in the Provider Price column. For example:

Component	Quantity/Part #/Details	PharmaCare Price	Provider Price
Socket insert/liners	2 Alpha Locking ALL-5066e 6mm* <small>*ALC-5066e is the part number for the cushion style.</small>	\$1,040.00	\$1,119.00
	1 Iceross Seal-in X5 I-3663XX		

## 7.2 Time frame for providing items/services

- Pre-approval is valid for six months from the date that the approved Application form is returned to the health care provider. The expiry date is indicated in the **Approval Ends** field of the returned Application form.
- All work must be completed—and all items delivered to the client—by the **Approval Ends** date specified on the returned Application. If all work is not completed and dispensed before that date, the approval expires and a new approval must be requested.
- Requests for a new approval must include in the rationale:
  - a reason for why the work could not be completed within the six months

- any changes to the client’s health that may have occurred during the delay
- There is no guarantee that the new request will be approved.

### **7.3 Resubmitting Applications**

- Sometimes a provider needs to resubmit an Application to address questions from the P & O Committee or the client’s changing health needs. To expedite the resubmission and reduce the number of pages being faxed, please:
  1. Create a new page 2 (or copy your original). Do not use the form that was faxed back to you with the denial or request for more information section already completed on the form.
  2. Ensure there is no information in the **PharmaCare Use Only** portion of the Application.
  3. Include any required information on changes in the Detailed Rationale section, and/or add a cover letter to include any information that was missing, incomplete, or required updating from pages 2-4 of your original Application.
  4. On the new page 2, check the “Resubmission” box. Mark “Resubmitted” in block letters above the **Date of Application** field at the top of any other pages resubmitted.
  5. Fax the new page 2, any cover letter and/or updated pages of the Application, to HIBC using the fax number on the Application.
- This process may be repeated if the response does not address the issues or brings up new issues.

### **7.4 Dispensing supplies during a hospital stay**

- Exceptions to PharmaCare pre-approval requirements may be granted when
  - a client requires a device or service (as stated in bullet three below) in the course of active treatment in a hospital setting or a rehabilitation situation; **AND**
  - waiting for pre-approval would significantly delay or interfere with treatment; **AND**
  - an Application for pre-approval has already been submitted to PharmaCare and the provider is waiting for approval of the Application of a basic functionality device.
- In these exceptional cases, PharmaCare waiving the need for pre-approval does not guarantee that PharmaCare will approve the requested device or services. For example, if a client’s injury and subsequent amputation was due to a car crash, the client’s vehicle insurance would cover the necessary prosthesis. Additionally, items or services are not approved if they exceed basic functionality requirements.
- The following benefits, when dispensed during active treatment or in a time-sensitive rehabilitation situation, do not always require pre-approval before they are dispensed, but do require approval before a claim can be made:
  - Immediate Post-Operative Prosthesis (IPOP)
  - Burgess cast/rigid cast/protector (with a prescription)

- Supplies (e.g., shrinkers) when required to ensure the continued success of treatment
- Casting and making a diagnostic socket requested by a physician

*Note: replacements for these supplies (after active treatment) require pre-approval, if the cost for replacement is \$400 or more.*

- In these exceptional cases, complete and submit the appropriate Application as soon as possible following the procedure in [Section 7.1](#) (i.e., after the device has been dispensed to the client, in the case of an IPOP, before providing the device to the patient, in the case of shrinkers or a diagnostic socket).
- Once you have received approval for the device/service, you may then start work on the device/service. Do not submit an invoice to PharmaCare until after the final dispense of the device and/or supply and after the completion of all related services.

## **7.5 Orthotic benefits for clients requiring management of spasticity or increased tone**

- If the client is receiving, or is wait-listed for, procedures for the management of spasticity or increased tone, indicate this on the [Application for pre-approval for the orthosis \(HLTH 5400\)](#).
- If any such procedure is planned, indicate whether the procedure is medical or surgical.
  - Indicate whether the planned procedure may affect bracing in the very near future. An appointment with a specialist, an appointment for Botox, or an upcoming surgery date should delay replacement of the current bracing in order to allow for changes.
  - Include the date/planned date of surgical intervention for management of spasticity/increased tone, or the date/planned date of the most recent evaluation of your client's spasticity/ increased tone, if it may make bracing difficult.
  - If there is a pending appointment or surgical date, include additional information in the **Rationale for Request** box including information regarding when the device is expected to be required by the client (e.g., after the date of surgery), and if it is before the planned procedure, why it is required before or whether it will be usable after the procedure as well.

## **7.6 Pre-approval for devices that exceed basic functionality**

- Occasionally clients may request components or devices that exceed basic functionality.
- As PharmaCare will only approve and reimburse for basic functionality components, providers should follow the procedures below for submitting an Application.
- PharmaCare will only approve basic functionality components that would meet the patient's needs if they were not upgrading.

- Clients, third-party insurance or other funding agencies are responsible for all costs above basic functionality.

### 7.6.1 When the client agrees to pay for the extra cost

- Inform the client that PharmaCare cannot determine, in advance, the portion of the claim it will pay, because reimbursement depends on the client's deductible status at the time the claim is adjudicated. If the Application is approved, the returned Application will state the maximum amount that *could* be paid by PharmaCare. Clients are advised to check their current Fair PharmaCare deductible/co-payment levels by phoning HIBC before making the decision to purchase an enhanced device.
- Inform the client that PharmaCare does not cover repair or adjustment costs for components that exceed the basic functionality specified by PharmaCare. For example, PharmaCare will not cover the maintenance and/or repair costs when the client has obtained a microprocessor knee instead of a basic functionality knee.
- If the client agrees to assume the additional costs (including any future repair or adjustment costs), submit an Application for the component/device/service that meets the basic functionality criteria and put the cost of that device in the PharmaCare Price column. Add a second line with the details of the upgraded device and put the price of that device in the Provider Price column. If all basic functionality criteria are met, the provider will receive approval for the cost of the device/service in the PharmaCare Price column that meets the client's basic functionality needs.
- Note in the client file that an enhanced device/service was provided, and PharmaCare was billed for the basic device/service as approved.

## 7.7 Items that do not require pre-approval

- The following items do not require pre-approval before being dispensed and claimed:
  - eligible prosthetic supplies under \$400 (See "[Cost-splitting and item additions](#)")
  - eligible prosthetic and orthotic repairs and/or adjustments under \$400 (See "[Cost-splitting and item additions](#)")
  - lymphedema arm sleeves, and gloves/gauntlets
  - regular benefit breast prostheses

*Note: To request an exception, complete [Prosthetic Benefits \(Non-Limb\): Application for Financial Assistance \(HLTH 5404\)](#)*

  - plagiocephaly helmets for clients who meet the criteria in [Section 5.7](#) of this Manual.

*Note: to submit a claim for a plagiocephaly helmet that does not require pre-approval, complete [Plagiocephaly Helmet \(HLTH 5450\)](#)*

### 7.7.1 Cost-splitting and item additions or deletions

- Cost-splitting to avoid pre-approval requirements is strictly prohibited. All items, components, supplies and services related to a given prosthetic or orthotic device must be included on a single Application for pre-approval.
- If a provider finds that additional components are necessary for a device after the Application for pre-approval has been submitted, the provider must submit a new Application for pre-approval that includes the additional components before the device is created and dispensed.
- After the Application for pre-approval has been submitted, if a provider finds that not all requested components/services are necessary for a device, the provider may submit a claim for a lesser amount for the device that was created and dispensed. The provider does not have to submit a new Application form. However, if submitting a manual claim, they should identify on the invoice what was not provided and why.
- If a provider is not able to complete all requested components/services for an approved device (e.g., patient deceased; patient moved to new provider) after the Application for pre-approval has been submitted, the provider may submit a new Application for pre-approval that includes all the components/services provided that can not be sent back or used by a different client. The provider requires pre-approval of the items dispensed before a claim can be made. (See [section 7.9.3](#)).

### 7.7.2 Keeping documentation on file when pre-approval is not required

- When pre-approval is not required (see [Section 2.4.2](#)), providers must keep adequate documentation on file. The client notes, invoices, and supporting documents should provide, but not be limited to:
  - a full description of the device and/or service provided (e.g., type of device, components [including part numbers], component costs, labour costs [including type of work completed, time required and hourly rate charged], supplies, etc.)
  - a rationale that supports the claim for benefits (i.e., an explanation of why the client needs the device and/or service) and how it meets PharmaCare's eligibility requirements.
  - the date the device and/or service is dispensed

*NOTE: the pricing, components and services must meet PharmaCare's basic functionality guidelines and fees, and are only applicable for eligible PharmaCare benefits*

- The documentation must provide enough detail to meet PharmaCare audit requirements, but it can be done in point form.

## 7.8 Understanding PharmaCare's decision

- The PharmaCare P & O Committee reviews all Applications, taking into consideration:
  - whether the device/service is in keeping with the PharmaCare mandate and policies
  - basic functionality for the client

- the cost of the device/service requested (i.e., least costly but effective device/service)
- the devices/services previously approved for the client (from the client file)
- warranty coverage for the devices
- replacement periods

### 7.8.1 Approval notification

- PharmaCare sends the provider an annotated copy of the Application form stating if coverage has been approved. The approval includes:
  - the date on which the decision was made
  - the devices/services approved, if different from those requested
  - the maximum reimbursement amount approved
  - the expiry date of the approval (Approval Ends date)
- Providers will not be reimbursed for any items/services dispensed before they receive PharmaCare approval.

### 7.8.2 Understanding the “PharmaCare Only” section

- This area is completed by the P & O Committee members and/or HIBC staff.
- Providers must read this section carefully, as it contains the reimbursement amount, the client’s current plan and relevant dates.

### Request Approved/More Information Required/Request Not Approved

- In this section PharmaCare indicates whether or not an Application has been approved, if more information is required, or if a request has been denied.
- If the Application is approved, the maximum PharmaCare reimbursement is recorded (“Approved Amount”). This is the maximum PharmaCare could pay. The actual amount PharmaCare reimburses depends on the client’s PharmaCare plan rules and deductibles at the time of dispense.
- If more information is required, PharmaCare identifies the specific additional information or documentation needed in the “Comments” field. The provider must gather the required information and resubmit the Application for further consideration. See [Section 7.3](#) for more information.
- If an Application is denied, PharmaCare returns the Application form indicating “Request Not Approved”. The explanation of why approval was not granted is noted in the “Comments” field.

### PharmaCare Plan

- The approved Application form states the plan under which the client was covered at the time PharmaCare received the Application (“PharmaCare Plan”). If a client’s plan has changed by the time of dispense, the out-of-pocket costs may also change. For instance, if the client has switched from a plan that offers 100% coverage to a plan that has a family deductible and co-payment, PharmaCare may cover



- only part of the claim, or
- none of the claim
- Clients are responsible for any outstanding balance not covered by their PharmaCare plan.
- To ensure the client’s PharmaCare plan information is still correct, verify the information with the client before the device is dispensed to them.

*Note: To be eligible for income-based coverage, clients must be registered for Fair PharmaCare **before** the item is dispensed. Retroactive coverage cannot be provided.*

- If the Plan on the approved Application form is identified as **N/R** or **N/Reg**, it means the client is not registered for Fair PharmaCare. The client must register for Fair PharmaCare before receiving the device or service in order to receive the maximum income-based PharmaCare assistance to which they can be entitled. If the client does not register, they will have a \$10,000 deductible, and will be responsible for the first \$10,000 of the claim.

### Approval Ends

- When pre-approval is granted, PharmaCare enters a financial control into PharmaNet to allow a claim to be submitted and processed. This control expires six months after PharmaCare returns the approved form to the provider (“Approval Ends”), or on the date that the first claim for that PIN is entered.
- If the device is not ready before this date, or if the service is not provided before this date, the provider must apply using a *new* pre-approval Application (see [Section 7.2](#)).

### 7.8.3 How much will PharmaCare reimburse?

- For Plan B (Residential Care), Plan C (B.C. Income Assistance) or Plan F (Children in the At Home Program) clients, PharmaCare reimburses the full cost claimed, up to the PharmaCare-approved maximum amount for that device or service.
- For Fair PharmaCare (Plan I) clients, the amount<sup>5</sup> that PharmaCare actually reimburses may be less than the PharmaCare approved maximum amount.

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<sup>5</sup> PharmaCare cannot determine the portion of the claim it will pay for Fair PharmaCare clients in advance because reimbursement depends on the client’s deductible status **at the time the claim is adjudicated**. For this reason, the amount on the approved form specifies the maximum amount that *could* be paid by PharmaCare.

Actual reimbursement is calculated as follows: Actual reimbursement = (maximum approved reimbursement) - (client’s deductible and co-pay at the time the claim is adjudicated)

## 7.9 Dispensing the Product/Service

- All Providers:
  - are responsible for ensuring that items dispensed and services provided are appropriate for the client, and should make every reasonable effort to ensure the components will meet the client's basic functionality requirements until at least the end of PharmaCare's established time limits for the replacement of the item/service.
  - **must** complete a PharmaCare invoice, including the client and provider certification sections (see [Section 7.9.2](#) below)

### 7.9.1 When can I dispense the product or service?

- PharmaCare does not reimburse providers for products or services that are dispensed before the Application form is approved and faxed back to the provider.
- Devices/services must be dispensed within six months of the date on the approved Application form (see the "[Approval Ends](#)" field on the form).
- If devices/services cannot be dispensed within the six month period, a new Application must be submitted to PharmaCare for pre-approval (see [Section 7.2](#)).
- Claims for devices that do not require pre-approval must be submitted on the date of dispense (see "[Submitting claims](#)" below). Ensure all required PharmaCare Invoice forms and other documents are completed and signed at the time of dispense.

### 7.9.2 When and how do I complete an invoice form?

- A [PharmaCare Invoice form](#) acts as a record of the products/services dispensed and of the client's acceptance of the dispense and its terms and conditions.
- All providers, both manual and online, must complete all relevant fields on the appropriate PharmaCare Invoice on or before the date of dispense.
- On the date of dispense, all providers must have the client (or the client's agent) sign and date the invoice in the **Client Certification** section.
- Providers who fail to obtain the client's signature on the date of dispense, or ask the client to sign a blank invoice may not be eligible for payments.
- If the item required pre-approval, providers must ensure that the quantities and PIN(s) on the invoice correspond to those on the approved Application form.
  - [Mastectomy Benefits Invoice \(HLTH 5415\)](#)
  - [Ostomy Benefits Invoice \(HLTH 5416\)](#)
  - [Prosthetic \(Limb\) and Orthotic Benefits Invoice \(HLTH 5417\)](#)
- All providers **must** keep a signed copy of the PharmaCare invoice in the client file for PharmaCare review.

### 7.9.3 Client death prior to dispense

- When a client dies after pre-approval has been given and **before** the final device is provided, PharmaCare may provide partial reimbursement for the actual work that has been completed.
- Providers should complete and submit a new pre-approval Application form itemizing the custom work **completed prior to the client's death**, and the parts and components that cannot be returned or reused elsewhere. Include details about what is being requested, and why, in the rationale of the new pre-approval Application. Submit the Application for pre-approval through the normal process.
- Once PharmaCare gives pre-approval for the new request, the provider should complete the invoice using a dispense date prior to the date the client died. Submit the invoice to the PharmaCare HelpDesk for special processing.

## 7.10 Submitting Claims

### 7.10.1 When do I submit the claim?

- Prosthetic or orthotic benefits claims must be submitted to PharmaCare only after all the work/service is complete, and the device, if any, has been dispensed to the client (i.e., not the day the work is completed, or the day that the approval is received).

### 7.10.2 Deadlines for manual or online claims

- Online claims must be submitted to PharmaNet at the time of dispense.

*Do **not** batch online claims and submit weekly.*

- The “dispense date” must be on or before the “Approval Ends” date stated on the approved Application form. PharmaNet will not process claims for a service date beyond the approval ends period.
- Because manual claims must be recorded in PharmaNet by March 31 of the year following the date the item was dispensed, manual invoices must be submitted to HIBC early to allow time for staff to process the claim and enter it into PharmaNet before the March 31 deadline.

### 7.10.3 Submitting online claims

For details about online claims submission, please see [Section 3](#) of the PharmaCare Policy Manual. For details on completion of PharmaCare invoices, please see [Section 7.9.2](#) above.

If you receive a “client not entitled” response:

- Check the claim to ensure that you have submitted the correct:
  - Product Identification Number (PIN) for the device/service
  - Personal Health Number (PHN) for the client
  - Site ID for your business
  - Date of Dispense

- If the device/service required PharmaCare pre-approval, make sure you have
  - received pre-approval for the claim that you are submitting (the system will not allow the claim to be entered into PharmaNet until the Application is approved)
  - submitted the claim on or before the date in the “Approval Ends” field on the approved Application form.

**IMPORTANT: If the “Approval Ends” date has passed, you will need to (a) complete a new Application requesting pre-approval and (b) indicate, in the rationale, the reason why the work was not completed within the six months.**

- If you have confirmed the above information is correct and the claim is still not accepted, contact the P & O Clerk at HIBC for assistance (see [Section 8.2](#)).

### Residents in Plan B facilities

- Submit all claims for residents of Plan B residential care facilities as follows:
  - One business day before submitting your claim, contact the PharmaNet Help Desk (See [Section 8.1](#)) to request the residential care facility’s Plan B claim number (also known as the “facility number.”)
  - When submitting the claim, enter the facility’s Plan B claim number in the **Group ID** field.

### 7.10.4 Submitting manual claims

#### Documentation Requirements

- Documentation requirements apply to claims submitted by both providers and clients.
- A Fair PharmaCare client may submit a manual claim for a prosthetic or orthotic device/service directly to PharmaCare only if they have paid the health care provider the **entire** cost of the device or service. Otherwise the provider should submit the invoice and collect only the balance from the client, once PharmaCare has paid its portion of the total cost.
- Manual claims for Fair PharmaCare, Plan B (Residential Care), Plan C (B.C. Income Assistance) and Plan F (Children in the At Home Program) must include:
  - a copy of page 2 (where the approval shows) of the approved Application and a copy of the work order or Schedule C for prosthetic claims, if pre-approval was required

OR

- for plagiocephaly helmets that do not require pre-approval, a copy of both pages of the completed and signed [PharmaCare Orthotic Benefit—Plagiocephaly Helmet \(HLTH 5450\)](#) form.

AND

- a completed PharmaCare Invoice (i.e., either the Prosthetic/Orthotic Benefits Invoice or the Mastectomy Benefits Invoice)
- Completed invoice forms must include the:
  - invoice number

- date the device or service is dispensed  
Note: If pre-approval is required, this date must be within six months of the “[Approval Ends](#)” field of the approved Application form.
  - details of each device or service along with its applicable PIN and PharmaCare cost
  - total approved PharmaCare cost being claimed
  - client certification portion of the invoice, signed and dated at the time of dispense, which acknowledges the client’s receipt of the product/service and all the information in the certification block
  - the appropriate provider’s signature, and the date they discussed the form with the client
- If a provider chooses to have the client pay the full amount of the items/services and apply directly to PharmaCare for reimbursement, the provider remains responsible for:
    - obtaining any required pre-approvals
    - completing the appropriate PharmaCare Invoice
    - ensuring the client has all the required supporting documentation for the claim (see “[Documentation Requirements](#)” above)
    - retaining required documentation in the client’s file
    - ensuring the client understands the claims submission deadlines and procedures.
    - providing the client with:
      - a completed copy of the appropriate PharmaCare Invoice, including the applicable PINs, that has been completed, signed and dated by both the client and the provider
      - a receipt identifying the items dispensed, the cost paid, and the applicable PINs for each device and marked “PAID IN FULL”
      - where appropriate, a copy of page two of the PharmaCare-approved Application form
      - for plagiocephaly helmets that do not require pre-approval, the completed and signed [PharmaCare Orthotic Benefit: Plagiocephaly \(HLTH 5450\)](#) form, signed and dated by the orthotist and the client’s agent. (Note: Keep a copy of the written referral from an authorized clinic in the client’s file.)

*Note: Providers are encouraged to fax clients’ claims to HIBC, even when payment is due to the client, not the provider.*

### **Submission procedures**

- Fax invoices and supporting documents to the HIBC PharmaNet Help Desk at 250 405-3587  
or
- Mail the documents to:
 

PharmaNet Help Desk  
Health Insurance BC  
P.O. Box 9655 Stn Prov Govt  
Victoria, BC V8W 9P2

*Note: the Pharmaceutical Services Act and the Provider Regulation allow for the Ministry of Health to take actions against providers who make inappropriate claims. These actions can include, but are not limited to, the recovery of the funds, the imposition of limits and conditions, or cancellation of the provider's enrolment in the PharmaCare program.*

## 7.11 Receiving Payment

- All provider claims—both manual and online—are processed on PharmaNet. Once client eligibility has been confirmed, PharmaNet adjudicates the claim to determine the portion, if any, of the claim that PharmaCare will reimburse. Fair PharmaCare clients must meet their family deductible before PharmaCare issues any reimbursement.
- The Ministry of Finance issues payments for accepted claims to the provider each week.
- If the PharmaCare portion of a Fair PharmaCare manual claim is \$0.00 because the client has not met their deductible, PharmaCare will send the provider a zero-payment letter. In this case, the provider will need to obtain payment from the client or the client's private insurer.
- Whenever a zero-payment letter is sent to the provider, the provider should advise the client to submit the paid receipt to PharmaCare, so the benefit amount can be added to their claims record and be counted toward their Fair PharmaCare deductible.

### 7.11.1 How can I arrange for direct deposit?

- To receive payment by direct deposit, complete a BC Government Direct Deposit Application. Submit the Application and an original void cheque to:

Information Support  
Health Insurance BC  
P.O. Box 9655 Stn Prov Govt  
Victoria, BC V8W 9P2

- A Direct Deposit Application was included in the PharmaCare welcome package you received after enrolling. If you change your banking information, you can find additional copies of the form ([FIN 312](#)) online.

*Note: For more information on completing this form, refer to the PharmaCare Policy Manual, [Section 8.12](#).*

## 7.12 Why was my claim rejected?

- PharmaCare may reject a claim for any of the following reasons:
  - the client is not eligible for the device (e.g., is not a resident of B.C., is not registered in a PharmaCare plan, does not meet the medical criteria for the claimed device/service)

- pre-approval was not obtained before the device/service was dispensed
- the device or service is not covered by PharmaCare
- the client has already received a similar device/service and is not currently eligible for another device
- the device was dispensed after the “Approval Ends” date
- If PharmaCare rejects a claim, the claim form is returned with an explanation of why the invoice was not processed.
- PharmaCare does not return forms for accepted claims.

#### 7.12.1 How can I fix an incorrect or incomplete claim?

- PharmaCare returns all incomplete or incorrect claims to the submitter (provider or client) for further details, correction or completion.
- If an incomplete or incorrect invoice form is returned to you:
  - Correct or complete the original invoice. Do NOT submit a new invoice.
  - Ensure that the date of service on the invoice is **the date the device/service was dispensed** to the client.
  - Ensure that the date of service is **on or before the “Approval Ends” date** on the approval form.
  - Ensure that the client certification portion of the invoice has been signed and dated **at the time of dispense** to acknowledge receipt of the device/service and to verify the information in the certification block.
  - Ensure that the appropriate provider has signed and dated the provider certification section of the form, indicating when they discussed the form with the client.
  - Re-submit the invoice.

#### 7.12.2 Claiming more than the PharmaCare approved amount

- The maximum amount paid will be the PharmaCare approved amount.
- PharmaCare does not pay for devices that were not included in an original Application, or for costs due to changes made to the original Application, even if the change is for under \$400.
- If a change to an Application is required, you must resubmit a pre-approval Application, containing the updated rationale, and details of all original and new devices/services.

### 7.13 When does PharmaCare audit claims?

- All PharmaCare claims are subject to audit to confirm their compliance with the terms of the *PharmaCare Provider Enrolment Agreement* and with PharmaCare policies and procedures.
- For details on PharmaCare Audit policy and procedures, see the PharmaCare Policy Manual, [Section 10](#).

## 8. Contacting PharmaCare

### 8.1 PharmaNet Help Desk

- The HIBC PharmaNet Help Desk is available to providers 24 hours a day, 7 days a week, including all statutory holidays except Christmas day.
- When calling the Help Desk, please be prepared to provide your Site ID.
- Telephone the HIBC PharmaNet Help Desk to:
  - order additional copies of PharmaCare forms or brochures
  - determine a client's PharmaCare plan
  - enquire about the status of PharmaCare claims
  - request set-up for a Plan B (Residential Care) resident's claim for an approved Application

*Note: The Help Desk cannot provide information about a client's Fair PharmaCare deductible, family maximum, or co-payment to a provider; only clients can obtain that information.*

- Dial the PharmaNet Help Desk:
  - From Vancouver/Lower Mainland 604 682-7120
  - Toll-free 1 800 554-0225

*Note: Provider-only telephone numbers should not be given out to the public.*

- To enquire about the status of a client's Application, telephone the P & O Clerk.

### 8.2 Prosthetic and Orthotic Clerk

- The P & O Clerk is the provider's point of contact for the P & O Program and Application forms. A clerk is available from 8:30 AM to 4:30 PM Monday to Friday.
- Contact the P & O Clerk to:
  - request the status of a client's current Application
  - request information about a client's old (over six months) Application
  - request other information regarding a client's Application
  - provide additional information regarding a client's Application to the P & O Committee
  - enquire about a financial control set in PharmaNet
- Contact the P & O Clerk:
  - by phone at 250 405-4251
  - by fax at 250 405-3590



## 8.3 Forms, manuals and documents

- The PharmaCare website contains all the Application forms, manuals, and information sheets that device providers require, including:
  - All prosthetic and orthotic Applications (available as fill-and-print PDFs) on the [Device Provider](#) web page.
  - The current version of the [PharmaCare Policy Manual](#).
  - [PharmaCare Newsletters](#)—Providers are required to abide by all policies and procedures communicated in the PharmaCare Newsletter. Individuals can receive e-mail notification whenever a PharmaCare Newsletter is posted to the website. To subscribe to this service, visit the [subscription page](#).
  - The PharmaCare Prosthetic and Orthotic Program [Quick Facts for Health Care Professionals information sheet to assist providers in explaining the P & O Program to physicians, nurse practitioners, and others](#)
  - Plain language information for clients:
    - [Prosthetic and Orthotic Program Information Sheet](#), which offers information on the program in plain language
    - [Plagiocephaly Helmet Coverage Information Sheet](#), which describes PharmaCare coverage of plagiocephaly helmets
    - [Fair PharmaCare and other topics](#)
- Clients can call [Health Insurance BC](#) for:
  - assistance with registering for Fair PharmaCare
  - information on their plan coverage, current Fair PharmaCare plan family deductible and family maximum, co-payment level
  - General information about the PharmaCare program and other PharmaCare plans.