Understanding Extended Health Care:

The chiropractor's guide to patient support and administrative compliance

Ontario Chiropractic Association

Table of Contents

Table of Contents (continued)

© Ontario Chiropractic Association, 2021.
The Ontario Chiropractic Association (OCA) produced and published *Understanding Extended Health Care: The chiropractor's guide to patient support and administrative compliance.* Written consent from the OCA is required to excerpt, copy, upload or distribute *Understanding Extended Health Care: The chiropractor's guide to patient support and administrative compliance.*

Simplified quick link access

Introduction and Overview of the Guide

Welcome to Understanding Extended Health Care: The chiropractor's guide to patient support and administrative compliance. This guide is designed to be a one-stop, leading practices resource.

It is thoughtfully designed to help you care for Ontarians by facilitating accurate, efficient and transparent interactions with extended health care (EHC) insurers. It provides you with information, infographics, checklists, a glossary of terms, supplementary reading suggestions and more.

We developed this guide to in consultation with the OCA Extended Health Care Advisory Council.

Privately administered EHC insurance comes in individual and group forms. The latter is the most common. Typically employers (plan sponsors) offer it to employees (plan members) as part of their total compensation packages.[1]

EHC coverage products may include EHC insurance, health spending accounts or personal spending accounts. Many people rely on EHC coverage to pay for health services not covered by the publicly administered Ontario Health Insurance Plan (OHIP) or the Workplace Safety and Insurance Board (WSIB).

Most chiropractors deliver some, if not all, of the care they provide to patients through the private health care system. Indeed, an Environics survey commissioned in 2019 found that four out of five chiropractic patients in Ontario pay for their care through private insurance coverage.

Simplified quick link access

1 We recognize there are instances where unions and associations also sponsor EHC benefit plans. Likewise, there are situations where an employee is not necessarily enrolled in a benefits plan, and therefore not a plan member. For simplicity, we use "employee" and "employer" throughout this document.

1 Introduction and Overview of the Guide

Beyond being a crucial source of payment for chiropractic care, EHC administration is a complex and a rapidly evolving field. We developed this guide to assist you in understanding:

- How the field is changing
- What this means for your practice
- How you can use this knowledge to support your patients and build relationships of trust and transparency with EHC insurance providers

Organization of the Guide

We organized this guide into ten distinct sections covering a wide range of topics, including: how to register with third-party direct billing services; billing and receipts leading practices; virtual care; EHC insurance for products and services and fraud prevention and awareness.

This guide contains lots of practical checklists, templates, and infographics. There is also a separate Guide specifically for patients at Appendix A which includes frequently asked questions (FAQs) to help clarify commonly misunderstood issues, as well as a Glossary of Terms and Abbreviations (Appendix B) and an Additional Resources list (Appendix C).

We designed this guide to enhance the support and services we provide to you. We welcome your feedback so we can continue to provide timely and important information you need as a health care practitioner.

What is Extended Health Care Insurance?

Regulation and Policy Setting

Extended health care (EHC) insurance is paid and administered by the life and health insurance industry. There are more than 160 life and health insurers and third-party administrators operating in Canada, 99 per cent of which are represented by a trade association called the Canada Life and Health Insurance Association (CLHIA).[2]

The life and health insurance industry is regulated at national and provincial levels. Federally, the Office of the Superintendent of Financial Institutions (OSFI) is responsible for prudential regulation. This means it's responsible for ensuring the overall financial stability of the system by regulating the cash reserves insurance companies must have on hand to meet their contractual obligations to insured parties, among other things. In Ontario, the Financial Services Regulatory Authority (FSRA formerly FSCO) regulates the commercial conduct of the industry and its agents, with a core focus on consumer protection.

While the life and health insurance industry is regulated in those key areas, insurers are free to set their own polices for how benefits claims will be adjudicated, and to establish the terms of contracts with employers (plan sponsors). These policies will dictate what a particular plan will and will not cover, and any terms and conditions tied to that coverage.

Insurance providers and benefits administrators make decisions pertaining to whether a benefit will be paid, as well as whether a benefit is subject to conditions (such as orthotics pre-approval) or limitations (such as annual and per profession limits and reasonable and customary fees) based on the language of the contract.

Simplified quick link access

2 Canadian Life and Health Insurance Association (2019). "Canadian Life and Heath Insurance Facts" https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/resources/Factbook_2/$file/2019+Factbook+English.pdf.

Compliance with College of Chiropractors of Ontario (CCO) standards and guidelines is a baseline, or minimum requirement, and not an ultimate guarantee of insurability of a provider's services. Insurers may also choose to set additional requirements for continued status as an eligible provider. If a provider is found to be in violation of these policies, insurers may decide to pursue disciplinary action against that provider. In extreme cases, this may include a lifetime delisting for you as a chiropractor and potentially your entire clinic.

Insurers may also choose to file a complaint with CCO. For this reason, we encourage you to take a proactive stance in keeping up to date with insurers' policies.

You can find more information on trends in the EHC industry in section three; and on benefits abuse and fraud in section nine.

Types of Benefit Plans

Employers (plan sponsors) purchase EHC coverage from life and health insurance providers on behalf of their unionized or non-unionized employees (plan members). There are three main ways that employers provide health care benefits to employees: through traditional benefits plans, flexible (flex) plans, and spending accounts, such as health spending accounts (HSAs) and personal spending accounts (PSAs).

A traditional benefits plan offers a standard bundle of coverage to a group of employees, regardless of the demographic makeup of that group. Typically, these plans will include coverage for specified professional health services (e.g. chiropractic, physiotherapy, registered massage therapy), as well as dental care and prescription drugs.

Flex plans allow employees to select coverage levels that are suited to their needs by allocating coverage credits to different areas of the plan. Flex plans have emerged in response to the recognition that today's workforce is characterized by a high level of demographic diversity, and that employees' needs change over time. While traditional plans are by far the most common, flex plans are gaining popularity, especially among large employers.

According to the 2020 Sanofi Canada Health Care Survey, 71 per cent of plan sponsors report having a traditional plan, and 29 per cent have a flex plan, which is up from 20 per cent in 2017.

HSAs and PSAs are additional ways in which employers can offer flexibility to employees. In this arrangement, the insurer administers an account with a sum of money provided by the employer, which the employee can spend on specified goods or services. Eligible expenses under a HSA are often defined as those that qualify for the Canada Revenue Agency medical expense tax credit.

PSAs may come with fewer or different restrictions. These accounts may be offered to employees in addition to traditional benefit plans as a means of adding a degree of individual choice and customization onto a standard benefits bundle.

Coverage Levels and Premiums

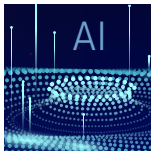
Typically, employers negotiate contracts with insurers through third-party intermediaries (e.g. insurance brokerages). Benefit levels will depend on factors such as the employers' priorities for coverage and what they are willing or able to pay, as well as the nature of the coverage included in benefits packages offered by the insurance provider. For example, insurance companies view reasonable and customary (R & C) fees as proprietary information, so benefits packages have different R & C levels for chiropractic care (and other services) depending on the insurer.

Likewise, the premiums insurers charge depend on many factors. These include the nature and extent of coverage, employee (plan member) demographics (e.g. age, gender), the type of work that employees do and "experience rating." Experience rating takes into account both past benefits usage, as well as the consistency or predictability of that usage.

Insurance contracts can vary substantially, not only between insurance carriers, but also across different contracts held by the same carrier with different employers. Furthermore, an employer may purchase different kinds of benefits packages for different groups of employees, depending on the nature of the work they do, whether they are full-time employees, part-time employees, members of management or executives.

Because of this level of diversity and changeability, we strongly recommend that you emphasize to your patients the importance of them understanding the specific details of their own benefits package.

For more details, including our Patients' extended health care coverage checklist, please visit section five of this guide.



Key Trends in Extended Health Care: Preferred Provider Networks, Cost Containment, Big Data and Artificial Intelligence

Preferred Provider Networks (PPNs)

Public or private health care insurance providers or other third-party payers establish Preferred Provider Networks (PPNs), sometimes referred to as Preferred Provider Organizations (PPOs), to connect patients to health care professionals who satisfy specific criteria.

The purpose of a PPN may be to efficiently connect patients to specialized care providers, to drive the value of care and improve outcomes and/or to contain health care costs.

According to the Financial Services Regulatory Authority (FSRA, formerly FSCO) PPNs may be characterized by one or more of the following:

- A contractual relationship between an insurer or other third-party payor and a health care professional, often including pre-arranged prices for services
- An arrangement whereby patient participation in a PPN is initiated following an insurer or other third-party payor's referral
- An arrangement whereby the insurer or other third-party payor may require pre-approval for treatments provided through a PPN, and the payor may or may not set a cap on the cost per treatment and/or the amount of treatment to be provided.[3]

Simplified quick link access

3 Christie, B. (2006). Best Practices for Preferred Provider Networks (PPNs). Financial Services Commission of Ontario. https://www.fsco.gov.on.ca/en/auto/autobulletins/2006/Pages/a-08_06.aspx

Depending on the goals of the PPN, membership within it may be determined according to different processes or criteria. For example, membership in a PPN may be determined through competitive request for proposals (RFPs) in which practitioners must demonstrate their ability to respond to the care delivery needs and goals of the funder.

PPNs may also be specific to certain employers or benefits plans to drive cost savings and/or value enhancements. For example, an employer may establish a network of preferred pharmaceutical providers and use criteria such as patient adherence to medications or pharmaceutical dispensing fees as a condition of preferred status.

Other PPNs, such as those sponsored by extended health care (EHC) insurers and based on paid memberships, may be less specialized and/or have less stringent requirements for entry and function essentially as a third-party marketing services for health care professionals.

The goal of these PPNs is to connect patients to a broad spectrum and diversity of providers by generating large, geocoded databases of health services providers and offering this information in a centralized searchable portal. In doing so, they also afford the opportunity to collect data on all those who interact with the PPN.

Things to consider before joining a paid membership PPN:

When assessing the risks and benefits associated with signing up, we strongly encourage the following:

- Understand the purpose of the PPN and assess the extent to which participation within it aligns with the goals and values of your practice
- Read the details of the PPN contract carefully before signing and keep a copy of the contract on hand for future reference in case any issues arise
- Keep good records of both the quantity and quality of the business that participation in the PPN generates for your practice. This will enable you to conduct an accurate cost benefit analysis when the time comes to renew your membership

In the paid membership model, you may initially be offered the option to join for free or at a discounted rate. After a specified period, you will then be asked to pay a monthly or yearly fee to maintain your status as "preferred" and continue to be listed at the top of the search hierarchy. However, if you opt not to pay to belong to one or more such services, you may lose your status within the search hierarchy and your name will no longer appear in top results for patients searching within that PPN.

A PPN may be either "open" or "closed." In an open network, your patients may choose a provider from outside of the network. However, the expenses reimbursed may be less than if your patient chose an in-network provider. If a network is closed, then your patient must use an in-network provider for their expenses to be eligible for reimbursement.

According to one benefits consultant, characteristics of successful EHC PPN structures include:

- A focus on preserving benefits levels for members while looking towards plan sustainability in the face of rising costs
- An emphasis on positive health outcomes as a return on investment in the health of employees
- A desire to add value rather than a punitive cost-containment tool
- An effort to develop true partnerships where everyone wins: the recipient of care, the provider of care and the insurer[4]

Cost Containment

Efforts by employers and insurers to contain rising costs are among the biggest trends identified in recent years by third-party surveys. While the growth in costs is a complex issue, some key drivers identified by the 2020 Sanofi Canada Health Care Survey are: the cost of pharmaceuticals, growth in the use of paramedical services and fraud. These results echo previous years, except fraud is new as of 2020.

Plan Sponsors' Top Five Major Concerns Regarding their Health Benefit Plan

1	42%	Drug plan sustainability
2	39%	Dental plan sustainability
3	32%	Absence/disability
4	29%	Use of paramedical benefits
5	28%	Benefits fraud/misuse

SOURCE: The Sanofi Canada Healthcare Survey. January 2020. BASE: Plan sponsors who hacve at least one major concern (n=407)

While some insurers recognize the benefits of neuromusculoskeletal (nMSK) care in illness prevention and chronic disease management, others have tended to view drug costs and paramedical benefits in more zero-sum terms. For example, some plan designs may feature a trade-off between unlimited drug coverage and other forms of coverage.

Employers and insurers pursue diverse methods of cost containment, including:

- Drug caps that set a maximum amount on what employees can spend on drugs
- Co-payments and deductibles to discourage what is perceived as unnecessary or frivolous use of benefits
- The use of pay for performance metrics, which tie reimbursement to outcomes

4 List adapted from: Sullivan, S. (2014). Planning for data-driven preferred provider networks. Benefits Canada. https://www.benefitscanada.com/benefits/health-benefits/planning-for-data-driven-preferred-provider-networks-50099

While some of these methods, such as co-payments, have proven effective in containing costs, the efficacy of others, such as pay for performance, are unclear.[5]

Another response to growing costs, which has been gaining in popularity, is Employee Life and Health Trusts (ELHTs). ELHTs are like health and welfare trusts and are scheduled to replace them completely by 2021. Health and welfare trusts allow for the provision of health care benefits *"through third-party insurance contracts (an insured plan), directly from the property of the health and welfare trust (a self-insured plan), or through a combination of both."* [6]

An ELHT may involve a single employer or a group of employers. ELHTs can be an attractive option to employers because, unlike the volatility of insurance premiums, they enable the employer to make a regular, predictable "defined" contribution to the trust. Benefits in an ELHT are pre-funded. Since ELHTs must be managed by an independent board of trustees, employers are able to divest themselves of risks associated with plan sponsorship.

Big Data, Machine Learning and Artificial Intelligence (AI)

These technologies are transforming health care and insurance industries in profound ways with far reaching implications. AI applications are streamlining the ways insurers approach issues of risk and pricing, how they engage in sales and marketing, manage benefits claims and the techniques they use to prevent and detect benefits fraud.

Big data refers to large, complex data that cannot be analyzed using traditional methods. AI encompasses a broad range of technologies that enables systems to draw on big data, statistics and probability analyses. AI systems use these tools to mimic human cognition and produce outcomes that appear "intelligent" to human observers.

It is different than conventional computer programming in that instead of top-down programing, it uses the combination of vast data and relatively simple algorithms to support a process known as machine learning – the ability of a machine to change its behaviour based on the accumulation of new data or 'experience.'

5 There is no compelling evidence that pay-for-performance type initiatives across various health professions actually improve health outcomes or reduce health care costs." The Canadian Pharmacists Association. (2019). Major concerns remain around pay-for-performance programs in Canada. Canadian Pharmacists Journal. doi: https://dx.doi.org/10.1177%2F1715163518816666

6 Canada Revenue Agency. (2020). Income Tax Folio S2-F1-C1, Health and Welfare Trusts. https://www.canada.ca/en/revenue-agency/services/tax/technical-information/income-tax/income-tax-folios-index/series-2-employers-employees/series-2-employers-employees-folio-1-specific-plans-offered-employers-employees/income-tax-folio-s2-f1-c1-health-welfare-trusts.html

AI in fraud detection and prevention

Traditionally, computer programs analyzed health insurance claims using preprogrammed red flags, or "fraudulent indicators." In the past, fraudulent claims had to fit into a set template to be recognized. Advances in AI and machine learning allow systems to process extremely large volumes of data very quickly. They also allow systems to learn from data on their own. This means AI systems can detect novel patterns in claims data and develop or refine criteria for selecting cases as "unusual" and in need of further investigation.

Machine learning includes a range of different learning techniques, such as supervised, unsupervised, and deep learning. Algorithms associated with machine learning techniques allow systems to perform many complex tasks, including:

- Autonomously control machines like driverless cars
- Make predictions about things like consumer preferences
- Support health care professionals in clinical decision-making by incorporating previous data on similar diagnoses, practices and guidelines, and medication history

Machine learning is further used in fraud detection to filter and prioritize cases which that are likely to result in a successful resolution for the insurer. For example, to identify cases where there is a high likelihood that a claim was paid in error, or where a finding of fraud can be substantiated. AI driven systems can also make suggestions to an auditor with respect to the grounds on which a claim could be denied. This, in turn, frees up administrators to investigate flagged claims more fully.[8]

The numerous avenues in which data can be collected – from wearables to smart home technology – have allowed AI applications to use their machine learning and data processing capabilities to generate detailed customer profiles. These profiles are used to match potential customers with products and services. If you have ever received a targeted social media advertisement about a product you are thinking of buying – or have perhaps already purchased! – this may be an AI-powered match.

Big Data and PPNs

In developing the PPNs discussed previously, insurance companies are both providing a service and developing a growing pool of data. Social media platforms tend to gather data for the purposes of selling it to advertisers to generate targeted ads. While insurers have been able to gather vast quantities of consumer data through the course of ordinary busines practices that are increasingly digital, they have often found this internally generated data to be insufficiently robust for the purposes of training machine learning algorithms. The external data generated by social media, company loyalty programs and content marketing creates massive pools that insurers can purchase or draw upon to supplement their own data.[7]

7 Insurance Nexus. (2020). Executive Briefing: Barriers to Implementing External Data Analytics in Property and Casualty Insurance. Reuters Events: External Data in Insurance – Part 1 https://www.reutersevents.com/insurance/analytics/external-data-insurance-part-1

Insurance profits depend on, among other things, the extent to which future risks or usage patterns can accurately be predicted based on historical data. Detailed consumer profiles are valuable to insurers, as they can use AI to detect patterns in a wide range of health-related behaviours across different demographic or geographic profiles and time periods. This data can be used to inform risk assessment or the development of new insurance products and services.

Emerging AI Applications

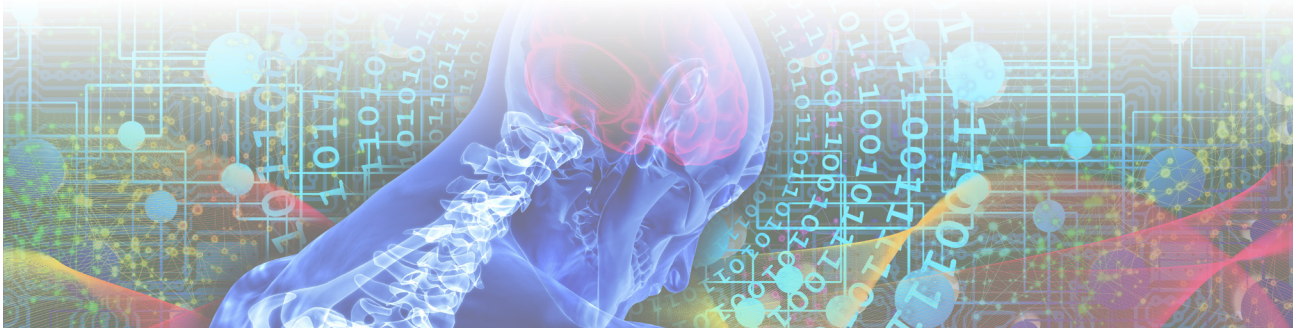
Insurance companies use data to conduct research to understand and make predictions about new and evolving trends in insurance claims. For example, responding to the growth in mental health related long-term disability (LTD) claims, Janssen Inc. analyzed the correlations across claimant level prescription drug, EHC and long-term disability data for 125,000 individuals during a three-year period. This analysis showed that employees who had two or more treatment failures cost on average three times more than employees with less than two treatment failures.[9]

This study did not have access to information about patient diagnoses or to clinical analyses of therapeutic outcomes. Rather, both illness and efficacy of treatment were inferred from the data. A treatment failure was defined as any instance where a patient switched between medications "that are typically prescribed" for Major Depressive Disorder (MDD).

Other uses of AI in health insurance continue to be identified and developed. For example, management consulting firm McKinsey & Company observes:

> *Initial use cases have been found for AI-supported systems that enhance care—for instance, in the development of customized offers for patients suffering from chronic diseases or for identifying clinical pathways that fail to adhere to guidelines.* [10]

In terms of matching your patients with customized offers, we see what this may look like through our discussion of PPNs.



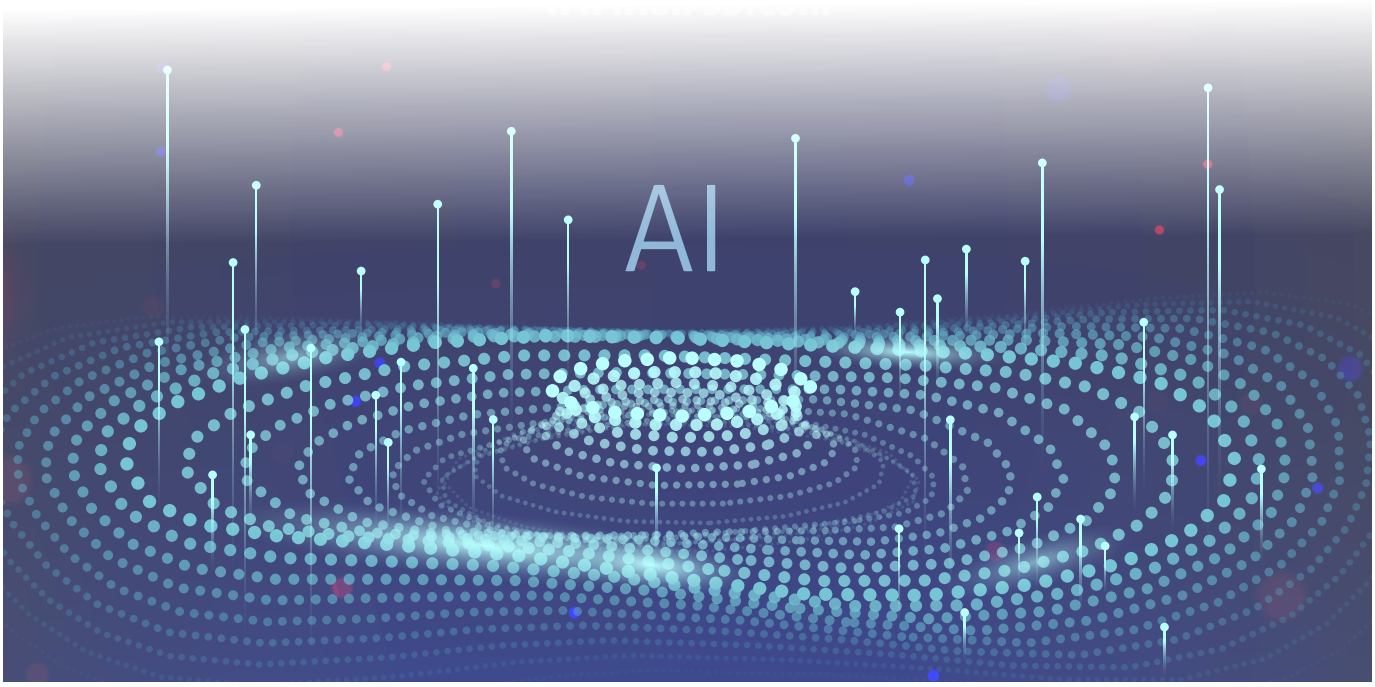
8 McKinsey & Company (2017) "Artificial intelligence in health insurance: Smart claims management with self-learning software". https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/artificial-intelligence-in-health-insurance-smart-claims-management-with-self-learning-software

9 Janssen Inc. "Results of this study show that when considering the combination of drug, long-term disability, and extended health care (service or product) claims, an employee treating depression that has had 2 or more treatment failures costs significantly more per year ($13,845) than an employee with less than two treatment failures ($4,375)."

10 McKinsey & Company (2017) "Artificial intelligence in health insurance: Smart claims management with self-learning software". https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/artificial-intelligence-in-health-insurance-smart-claims-management-with-self-learning-software

Where AI is used to identify common clinical pathways and detect deviance from these or from other evidence-based pathways, the implications for you may be far reaching. As the New Scientist, observes, "Once a network is up and running, not even its creators can know what it is doing – a largely unforeseen problem that, as AI assumes ever more decision-making powers within computer systems, researchers are increasingly having to grapple with."[11]

We continue to be actively engaged in the research and development of initiatives that support you and as an effective, and transparent partner supporting patients. For example, we partnered with the Centre for Effective Practice to develop the Manual Therapy as an Evidence-Based Referral for Musculoskeletal Pain Tool to present manual therapy, including chiropractic care, as an evidence-based alternative treatment to opioids.



11 New Scientist (2020). "The Power of Deep Learning" in Essential Guide No. 2: Artificial Intelligence, Richard Webb, ed., p. 27.

Getting Started: Registering for Direct Billing Services

Overview of Direct Billing Services

Registering with extended health care (EHC) insurance providers or third-party benefits claims management services is an important first step to receive reimbursement by benefits providers.

Whether you choose to offer direct billing services, or have patients submit their own insurance claims, most EHC insurance providers will require certain basic information about you, such as your your College of Chiropractors of Ontario (CCO) registration number, as well as the address of clinic(s) where you provide privately funded services.

Some insurance providers have their own portals for registering, whereas others use the services of third-party benefits and claims management providers. Our *Ready to Register?!* chart provides details about which benefits management services include which EHC insurers, as well as information and links to assist you in registering.

Simplified quick link access

What to know before you get started

Whether you are setting up your own practice or joining an existing clinic, there are some questions you will need to answer before you register.

If you are joining an existing clinic, discuss these questions with the clinic owner or manager. If setting up your own practice, consult an experienced chiropractor or trusted mentor when making these decisions.

- Will you be registering as an individual professional, or as an organization?[12]
- Will your patients submit their own claims, or will you/your clinic direct bill on the patients' behalf?
- If using direct billing, will your patients pay for services and be reimbursed for services/products by their EHC insurance provider? Or will the insurer reimburse you/your clinic directly?
- If you/your clinic will be reimbursed directly, what are the details of the account to which those reimbursements should be directed (bank account number, bank number and transit number of the bank)?

Keep in mind that the registration process may take up to three to four weeks to complete, depending on the direct billing service provider. Once you have registered with providers for direct billing, you may also need to obtain consent from your patients to direct bill on their behalf. For example, Telus Health requires patients to complete this consent form before their health care professional can submit claims electronically on their behalf.

Some services permit co-ordination of benefits, while others do not (see table for further details). Co-ordination of benefits happens when employees (plan members) and/or their dependents are eligible for benefits under more than one private health care plan. In such instances, insurers will decide among themselves which plan will be the first payor, and which will be the subsequent payor(s) of benefits. In situations where you or your administrative staff cannot directly bill the second plan, your patient will need to do so themselves.

Only insured products and services can be submitted for direct billing. When a patient is using a health spending account (HSA) to pay for products or services, they must submit their own receipts for reimbursement. One exception is when your patient uses their HSA to cover a portion of the costs of a visit that is not covered by the insurers' reasonable and customary fees. In those instances, some insurers have the option to have additional amounts automatically deducted from the plan member's HSA.

Have your patients check their member portal or contact their insurer directly for more information on this option.

Pro Tip: Banking fees

It is also important to note financial institutions charge different rates depending on the volume of transactions, such as deposits and withdrawals, passing through your accounts. These rates often differ based on whether you are using a personal or business account, and whether you have a banking fee plan that allows for a high volume of transactions. If the fee plan associated with the account you're using for direct deposits is charged on a per transaction basis, this can add up very quickly. We advise you to contact your financial institution to set up a fee plan that is appropriate to your needs given the increased volume of transactions that will result from enrolling in direct deposit services.

12 See table for more information on how Telus Health defines these categories.

Ready to Register?!

Registration and contact information	What you will need	What you can do	EHC carriers covered
TELUS Health **T:** 1-866-240-7492 Monday to Friday, 8 a.m. to 8 p.m. EST **E:** Use the Contact Us form *Note that registration is divided into two main categories. Choose: • **Independent professional** if you are "an individual practitioner or healthcare professional that practices and bills services as an independent professional." • **Organization** if you are an "Associate provider… working for an Organizational Provider."	• Clinic name (if applicable) • First and last name • Address, telephone number, & fax, as applicable • bank account number, bank number and transit number • Regulated Professionals' information (license number, issuer, and date of issuance) • Email of each person to be registered • WSIB Provider ID (1000XXXX) or WSIB-issued billing number, as applicable	• View your past transactions to ease payment reconciliation • Select whether payment should be assigned to either the health care professional or the patient • Get paid quickly through direct deposit • Access direct billing[13] • Register for WSIB billing simultaneously, if applicable • Coordinate benefits available for Canada Life only • Submit pre-determination requests to some insurance companies, which allow for this under Telus health	• Canada Life • Manulife • Sun Life • Claimsecure • Desjardins Insurance • Industrial Alliance Financial Group • Johnson • Johnston Group • First Canadian Insurance[14]
providerConnect **T:** 1-844-553-2522 **E:** support@providerconnect.ca	• Name and complete address • GST/HST registration number if you have one • Name of regulatory College and License/ registration number • Clinic/Business name • Email address and Business telephone number • Option to provide Diploma/Certificate/ Other Credentials • Option to provide a corporate/business registration number[15]	• Instantly check patient eligibility and coverage information • Submit patients' claims online for immediate adjudication • Assign payment directly to you or to your patient • Sign up for direct deposit • View your statements and claim reports[16] • Co-ordinate available benefits	• Green Shield Canada • SSQ Insurance • Empire Life • Avantages Sociaux Medic Construction

13 Telus Health, "eClaims" https://www.telus.com/en/health/health-professionals/allied-healthcare-professionals/eclaims
14 For a complete list, please visit: https://www.telus.com/en/health/health-professionals/allied-healthcare-professionals/eclaims
15 providerConnect, "Health Professional Provider of Service Account Application" https://www.providerconnect.ca/ProviderEnrolment/HPPSApplication.aspx
16 providerConnect "Welcome to providerConnect" https://www.providerconnect.ca/

Registration and contact information	What you will need	What you can do	EHC carriers covered
Medavie Blue Cross **T:** 1-800-355-9133 Monday to Friday, 8 a.m. to 8 p.m. EST **E:** provider@medavie.bluecross.ca	• Provider name • Email • Business address • License/registration number • Payment direction (to professional or to clinic) • Completed Direct deposit form • Option to attach a Provider/Certificate/ Other Credential Documents	• Directly submit claims electronically and receive payment directly into your bank account • Submit claims for services you provide • Appear in approved provider list (searchable mobile app)[17]	• Medavie Blue Cross
theclaimexchange **T:** 1-866-394-3648 Monday to Friday, 8 a.m. to 8 p.m. EST **E:** help@theclaimsXchange.com	• Clinic name and address • Provider name and position • Practitioner(s) license number • Email and telephone number	• Submit claims and request reimbursement on behalf of patients • View submission results right away & ensure payments go to the right person • Review past claims and payments.[18] • Co-ordination of benefits available	• Equitable Life • The Co-operators • Nexgen Rx

17 See: https://www.medaviebc.ca/en/health-professionals/register
18 See: https://www.cooperators.ca/en/connection/theclaimsXchange.aspx

Working with Patients and their Extended Health Care Insurance Providers

Supporting Patients to Understand their Extended Health Care Coverage

It is imperative that clear, consistent, and transparent communication take place between you, your patient, and your patient's extended health care (EHC) insurance provider. This will help you avoid any misunderstandings, delays or denials resulting in unforeseen out-of-pocket payments for your patients.

Your patients should have a clear understanding of what they are covered for, as well as any conditions (e.g. prescriptions, pre-approvals), co-payments or deductibles that the terms of their plan may be subjected to, before commencing care with you.

Patients should obtain details about their coverage directly from their insurer. Insurance providers typically make information available to employees (plan members) through online portals, mobile applications, print or digital employee benefits handbooks and through their customer service departments or online chat features.

You may also wish to inform your patients that insurance contracts often stipulate that coverage is subject to change. Insurance companies may re-evaluate their reasonable and customary fees or introduce new requirements for information or documentation to adjudicate and pay a claim. For example, an EHC insurer may introduce a requirement for your patient to submit an invoice from the lab which made the custom orthotic.

Simplified quick link access

5 Working with Patients and their Extended Health Care Insurance Providers

Where necessary, you and your administrative staff can assist patients in understanding and keeping up to date with the details of their coverage. To help with this, we developed a Patients' extended health care coverage checklist for you and your staff to support your patients. You can print or download *The Patient's Guide to Extended Health Care Coverage*, in Appendix A of this guide, to provide the checklist directly to your patients.

Your patients should obtain details about their coverage directly from their insurer. Insurance providers typically make information available to plan members through on-line portals, mobile applications, print or digital employee benefits handbooks, and through their customer service departments or on-line chat features.

Sometimes EHC insurers may be confused about whether chiropractors are licensed to practise acupuncture or not. To facilitate communication with your patients and insurers on this subject, you can use this acupuncture and chiropractic care letter template that we developed.

Submitting Predetermination Requests

For privacy reasons, insurers will not provide the details of plan member coverage to you. However, some insurers may enable predetermination requests to be submitted through third-party benefits management services. That means you can submit the pricing details of a specific treatment or product and receive information about whether it will be covered by the plan. You will also receive information about any conditions, co-payments or deductibles that may apply. This enables you to obtain answers to specific queries about coverage, without compromising your patient's privacy.

Patients' Extended Health Care Coverage Checklist

We recommend that patients understand the following details of their coverage before commencing care with you.

- ☐ 1. What are my coverage levels? Is there a maximum per profession, or an overall maximum for a group of professions (e.g. paramedical)?
- ☐ 2. Is there a health spending account (HSA) or personal spending account (PSA) included in my policy? If so, how much is available?
- ☐ 3. What are the reasonable and customary fees, or the maximum amount that I can claim per visit?
- ☐ 4. Will my claim be subjected to any co-payments or deductibles? If so, how much and how often are they applied? (Note: An insurer usually charges co-payments on a per-product or service basis at each visit. However an insurer generally charges a deductible only once per benefit period.)
- ☐ 5. What is my benefits renewal period/date? Do my benefits renew annually on January 1, or at some other interval?
- ☐ 6. How much of my coverage have I used so far? How much remains?
- ☐ 7. Are my spouse or other family members covered?
- ☐ 8. Is virtual care (telehealth) covered? Are there any terms and conditions of coverage that I should be aware of?

Additional questions for orthotics or other assistive devices

- ☐ 9. Does my benefits plan cover the product or device [make, model]?
- ☐ 10. The cost to the patient for this device is [cost].
  - a. How much of this cost will my plan cover?
  - b. Are there any fees, such as deductibles or co-payments that I should be aware of?
- ☐ 11. What are the terms and conditions of coverage that I should be aware of?
- ☐ 12. Do I need pre-approval?
- ☐ 13. Is a prescription required? Will my prescription expire after a certain time?
- ☐ 14. Under my EHC plan, which health care providers can prescribe the product or device?
- ☐ 15. Under my EHC plan, which health care providers can dispense the product or device?
- ☐ 16. Do I need to submit any other forms, paperwork or documentation to be covered?
- ☐ 17. For orthotics: What casting technique is required?

Acupuncture and Chiropractic Care Letter Template

Ontario Chiropractic Association

Date:

Recipient's Name:

Address:

Letter of Information Re: Acupuncture and the Chiropractic Scope of Practice

To Whom it May Concern:

This letter is to confirm that in Ontario, acupuncture is considered a treatment that is included in the scope of practice of several health professions, including chiropractic. This means that chiropractors can use acupuncture to treat their patients if they do so in a manner that is within their scope of practice. However, chiropractors are prohibited from calling themselves "acupuncturists" unless they are dual registrants of the College of Chiropractors of Ontario (CCO) and the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario (CTCMPAO).

Members of the CCO are authorized under Regulation 107/96 of the *Regulated Health Professions Act, 1991 (RHPA)* to perform acupuncture. Section 8 (2) of the Regulation provides an exception to the RHPA which allows specified health professions, including chiropractic, to perform "acupuncture, a procedure performed on tissue below the dermis, in accordance with the standard of practice and within the scope of practice of the health profession."

For more information on acupuncture and the chiropractic scope of practice, as well as the training and education requirements for chiropractors in the use of acupuncture as a treatment modality, please consult CCO Standard of Practice S0-17: Acupuncture.

Leading Practices: Billing and Receipts

"A member shall only issue a receipt for payments that have been received."
- CCO Standard of Practice S-012 & S-021

Billing and Receipts Overview

According to the Canadian Life and Health Insurance Association (CLHIA), following billing and receipts leading practices will help ensure timely and hassle-free adjudication and payment of claims, while fostering clear and transparent communication between you, your patients and their extended health care (EHC) insurance providers. Following billing and receipts leading practices will also enable you to contribute to prevention and awareness of benefits abuse and fraud.[19]

To demonstrate transparency and consistency to insurers, use your invoices to clearly detail the services performed in your clinic, as well as the prices you charged your patient for those services. Include any products or devices your clinic dispensed. Set and adhere to specific prices for various services, products and devices; and provide itemized invoices. This makes it clear to EHC insurers that your fees do not change based on your patients' benefits plans. This would be a red flag for insurers and could lead to your practice being audited.

Inaccurate, incomplete or inconsistent billing practices result in delayed or declined insurance payments. They may also expose you to improper or illegal activities, such as receipt tampering. As we explore further in section nine, suspected involvement, complicity or negligence regarding these issues can have serious personal and professional consequences. They can also cause damage to the reputation of our profession.

Simplified quick link access

19 Canadian Life and Health Insurance Association. (2019). Service and Supply Provider Receipt Best Practices for Group Benefit Reimbursement. https://www.clhia.ca/web/clhia_lp4w_lnd_webstation.nsf/page/8DE2AE93CA08C9D585257893004A0194!OpenDocument
See also: https://fraudisfraud.ca/healthcare-providers

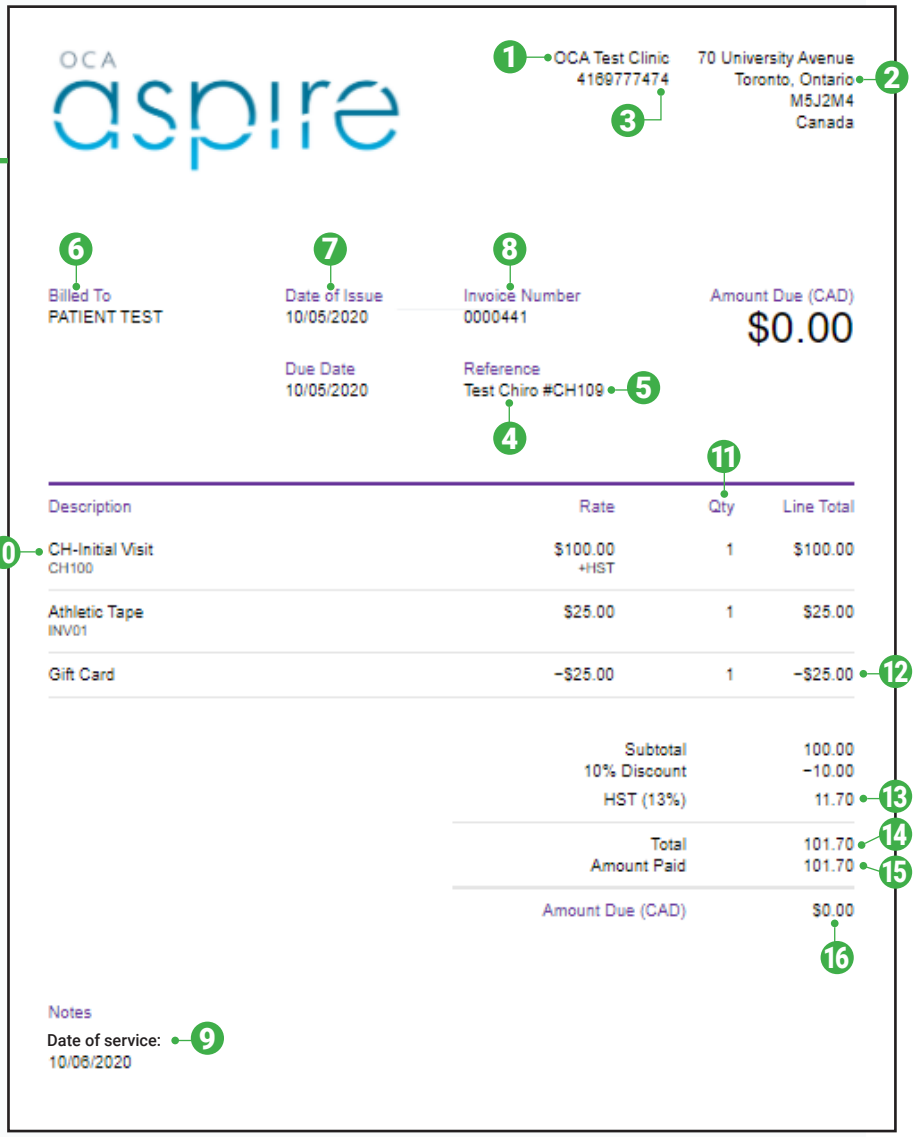
Billing and Receipts "Golden Rules"

1. You should have clear, consistent fee schedules that are publicly accessible. For example, having signage in your office and posting accurate and current schedules on practice or clinic websites is a good way to ensure that your patients, EHC insurance provider and the public have access to this information.
2. You and your administrative staff should keep detailed, accurate records of payment, which include the method of payment and the date that payment for services/ products was received.
3. In normal circumstances, the amounts displayed on bills and receipts for products and services should correspond to published fee schedules.[20]
4. A bill or an invoice is a document that is issued to inform your patient of the costs incurred for service(s) or products. It should indicate whether a balance is paid in full, unpaid, or partially paid with the corresponding dollar amounts clearly displayed. If using direct billing, it is not acceptable to waive any unpaid portion of the claim.
5. A receipt is a document issued to your patient after you have received payment from them or from the insurer, in the case of direct billing. Receipts or invoices marked "paid" should never be issued until after the payment for the service has been received by you. The date the payment was received should be clearly displayed. If you issue an invoice marked "paid" to your patient prior to receiving payment, EHC insurers consider this to be insurance fraud because it asks the insurer to compensate the patient for funds the patient has not paid.
6. Bills and invoices should not contain blank fields, as this may enable tampering. Such fields should be marked with zeros or N/A as applicable.
7. When care is delivered virtually, receipts and invoices should clearly indicate this.
8. Duplicate receipts should always be clearly marked **"Duplicate Receipt – Original Issued on (insert date)"**
9. The name of your patient on the invoice should correspond to the name of your patient receiving care.
10. Once you provide the service or product, you must sign your name and registration number to the receipt. This is true for fully licensed chiropractors as well as those practising with provisional licenses.

20 There are some exceptions to this. An example is when you agree to provide your patient with a discounted product or service for compassionate reasons. In such instances, the reason for the discount and the agreed-upon amount of payment should be clearly documented in your patient's file. We developed a template for a letter of agreement between you and your patient. It is available at the end of this section.

Billing and Receipts Infographic: A visual guide to industry standards

This infographic was adapted from the Canadian Life and Health Insurance Association's *Service and Supply Provider Receipt Best Practices for Group Benefits Reimbursement*. It provides a visual guide to the key elements of the guide. We recommend that you consult the document directly for full details.



Legend:

1. Clinic Name. In practice settings where there are multiple providers, both the clinic name and the providers name should appear on the receipt.
2. Provider address. Indicate the physical location of the provider who rendered the service.
3. Provider phone number. Indicate the business phone number of the person who provided the service.
4. Provider name. Indicate the first and last name of the health care professional who delivered the service or product.
5. Professional identification and credentials. Indicate the providers' license/registration number and their professional designations (e.g. DC, ND, RMT, etc.).
6. Patient name. First and last name of the person who received the service or product.
7. Receipt date. If the date the receipt was issued is different than the date a service or supply was rendered, both must appear and be accurately labeled.
8. Receipt/invoice number. Each receipt should have a unique identification number. Duplicate receipts should always be clearly marked **"Duplicate Receipt – Original Issued on (Date)"**
9. Date of service (if different from above). If there are multiple service dates being billed on the same receipt, the date of each service should be displayed.
10. Type of service provided.
11. Quantity of service provided. If there are multiple treatments on different dates, all dates should be shown on the receipt.
12. Government payment plan and/or other payment. If payment is made from a government plan to a provider, the receipt must indicate this and show the amount. For "other payment" indicate the type of payment (e.g. primary insurance, coupon, gift card, etc.).
13. Taxes. Charge and display as applicable.
14. Charge amount. The cost to the patient, after any discounts are applied should be indicated. This will be the amount considered eligible for reimbursement by the patient's group benefits plan.
15. Method of payment. Clearly indicate the method(s) of payment received.
16. No blank fields. Providers should not leave any blank fields on receipts as this may allow for tampering. Fill all such fields with $0.00 or N/A, as applicable.

Compassionate Care Letter Template

This letter can be used when offering discounts to a patient for compassionate reasons. You should include it in your patient's file as documentation.

[Clinic/Practitioner Letterhead]

[Date]

I, _____Patient Name_____, hereby acknowledge that, for compassionate reasons, _____Clinic/Chiropractor Name_____ has agreed to reduce my fees for my treatment. The cost of the treatment per visit will be $ ____Amount____.

This reduced fee for treatment will begin on _____Date_____, and this agreement will be valid for ____length of time____. After that time, this agreement will be re-evaluated by me and ____Clinic/ Chiropractor Name_____.

I, _____Patient Name_____, agree that the terms of this agreement are subject to my observance of the normal policies and procedures of _____Clinic/Chiropractor Name_____.

Comments:

Patient Signature: _____ Date:_____

Treating Chiropractor Signature: _____ Date:_____

Leading Practices: Virtual Care

Virtual care is any interaction between patients and/or members of their circle of care, occurring remotely using any forms of communication or information technology with the aim of facilitating/maximizing the quality and effectiveness of patient care.

- CCO Standard of Practice S-012 & S-021

Virtual Care and the Chiropractic Scope of Practice

The COVID-19 pandemic has triggered accelerated adoption of virtual care. Virtual care (sometimes referred to as telehealth) refers to the remote delivery of care to patients using information and communications technology. Virtual care can be delivered and received using a telephone (landline, mobile phone, smartphone) and/or real time web-based audio or video conferencing applications on computers, tablets and smartphones.

The same standards of care and professionalism apply to virtual care as to an in-person visit. Virtual chiropractic care must be within the chiropractic scope of practice, and *"comply with all College of Chiropractors of Ontario (CCO) regulations, standards of practice, policies and guidelines."*[21]

As of January 2021, CCO guidance on virtual care is temporary and CCO indicated that it will issue permanent guidance at a future date. Effective April 17, 2020 in addition to seeing patients for follow-up visits, chiropractors are permitted to see patients virtually on a first visit, which CCO defines as a visit with *"an individual who does not have a pre-existing, in-person doctor/patient relationship with the member."* CCO deemed this to be essential for the effective delivery of care: *"Without obtaining initial information from the patient, members cannot be in a position to advise if the patient requires urgent/emergency in-person treatment."*

Simplified quick link access

21 College of Chiropractors of Ontario. (2020). President's Messages: www.cco.on.ca

While CCO's standard for virtual care remains temporary, regulatory colleges in Alberta, Quebec, New Brunswick, PEI, and Newfoundland have all made their virtual care directives permanent. In Ontario, the Workplace Safety and Insurance Board (WSIB) is supporting virtual care for the delivery of programs and services.

Major national insurance carriers also indicated they will continue to cover virtual care for the foreseeable future. We recommend you check insurance provider websites periodically for updates. Patients should also confirm the details of coverage for virtual care with their insurance provider.

Privacy Requirements

When using video conferencing to connect with your patients, you must ensure that it meets *Personal Health Information and Privacy Act, 2004* (PHIPA) requirements, including the use of encrypted video.

Fortunately, there are many different platforms that exist to support this. Ontario MD has put together a detailed list of many of the available virtual care options, with links for more information. To view the list, please visit www.ontariomd.vc and scroll to "Video Visit Platforms Created for Medical Care."

Virtual Care Guidelines

In addition to CCO Return to Practice Guidance and President's Messages, excellent supplementary resources have been developed to inform the virtual delivery of neuromusculoskeletal (nMSK) care.

The Canadian Chiropractic Guideline Initiative (CCGI) has produced three documents. The first, entitled Best Practices for Telehealth/Virtual Appointments identifies eight evidence-based recommendations for care that can be delivered virtually, including:

- Screening for risk factors of serious pathology
- Assessing barriers to recovery
- Conducting clinical assessments, including a thorough health review
- Providing patient education and self-management strategies
- Monitoring patient progress

Additionally, the CCGI's Clinical Guide for telehealth is designed to support the delivery of virtual chiropractic care. Its' Patients' Guide to virtual care assists in preparing patents for virtual appointments.

The Interprofessional Spine Assessment and Education Clinics (ISAEC) also developed a toolkit, entitled Low Back Rapid Access Clinic: Virtual Assessment and Education Toolkit. Each of these documents provide valuable detailed information.

For a discussion of virtual medical care in the publicly funded health care system, see Virtual Care: Recommendations for scaling up virtual medical services Report of the Virtual Care Taskforce.

Virtual Chiropractic Care Checklist

Virtual care has many advantages including: overcoming physical distancing requirements; improving access to care for patients with mobility challenges and those living in remote, rural and underserved communities; and more timely and convenient care for patients. Used appropriately, virtual care may also result in lower health care costs.[22] However, virtual care also raises unique challenges and considerations, such as patient privacy and health and safety.

In recognition of these unique dimensions of virtual care, we adapted the CCGI's Best Practices for Tele-health/Virtual Appointments into this Virtual Care Checklist to assist you in preparing for and conducting virtual appointments.

Patient and clinician location requirements:

- ☐ 1. Ensure there is good lighting so that you and your patient can see one another.
- ☐ 2. Ensure that camera/device placement enables you to see your patient's whole body so you can observe your patient performing any exercises or other movements that may be required for assessment, diagnosis and/or treatment.

Patient and clinician location requirements:

- ☐ 3. Ensure all electronics are plugged in or charged.
- ☐ 4. Ensure the Internet connection has sufficient connection speed and signal strength to enable clear and uninterrupted communication.
- ☐ 5. Ensure your patient has access to wireless earbuds or adequate computer speakers so that communication can continue while demonstrating or reviewing exercises.
- ☐ 6. Develop a contingency plan with your patient in case of technological issues (e.g., have the patient's telephone number to continue a videoconferencing visit as a telephone call visit in case of disruption due to an inadequate or unstable Internet connection)

Prop and equipment requirements:

- ☐ 7. Ensure your patient is wearing clothing appropriate to the conduct of the appointment, for example loose clothing for ease of movement.
- ☐ 8. Ensure that your patient has sufficient space and flooring for exercises.
- ☐ 9. Ensure your patient has access to any necessary props for movements or exercises (e.g. wall or chair for balance, weights, resistance bands etc.).
- ☐ 10. Ensure you have capacity for coexisting documentation, including informed verbal consent, space and flooring for exercise prescription.
- ☐ 11. Ensure you have access to supporting documents such as pictorial or video instructions.

22 See: Virtual Care Taskforce. (2020). Virtual Care: Recommendations for scaling up virtual medical care services. https://www.cma.ca/sites/default/files/pdf/virtual-care/ReportoftheVirtualCareTaskForce.pdf. The Taskforce notes: "There is some fear, although little evidence, that lowering the barriers to care through virtual tools will lead to higher volumes of unnecessary care. The OTN [Ontario Telemedicine Network] evaluation of virtual care pilots, for example, does not support this conclusion" (pp. 33).

Health and Safety:

- ☐ 12. Ensure your patient has inspected the area for any possible health and safety hazards (e.g. trip hazards such as toys).
- ☐ 13. Ensure you have the address of the location of your patient, as well as local emergency contact information for them in case an emergency arises, and no one is with your patient to contact Emergency Medical Services (EMS).
- ☐ 14. Consider developing a pre-virtual care video for your patient to review prior to their assessment to help them prepare for the consultation, and review expectations

Privacy and Consent:

- ☐ 15. Ensure your patient and you have a private, quiet, space to conduct the appointment without interruption.
- ☐ 16. Ensure the technology being used to conduct the virtual visit is secure.
- ☐ 17. Verify the identity of your new patients.
- ☐ 18. Inform your patients of any limitations to examination, their right to privacy, their right to opt out at any time if they feel uncomfortable, and of any risks associated with virtual care.
- ☐ 19. Give your disclosure and obtain your patient's consent if the visit is being recorded.

Leading Practices: Orthotics and Other Assistive Devices

"A member shall only prescribe or dispense an assistive device for a patient when the examination and diagnosis or clinical impression indicate a condition within the chiropractic scope of practice that would reasonably benefit the patient from that assistive device. If a prescription has been ordered by another regulated health professional and is related to the chiropractic scope of practice, the member may dispense that device.""

- CCO Standard of Practice S-021 Assistive Devices

Assistive Devices Overview

There are many assistive devices that you might prescribe or dispense while practising within the chiropractic scope of practice. Assistive devices are those that support patients living with pain or disability to become more independent in their daily activities. These include orthotics, orthopedic braces, compression stockings, and back and cervical support products. Some of these products, such as braces, compression stockings and orthotics, come in both off-the-shelf and custom-made options.

There are additional products that you may offer for sale to your patients to assist them in gaining independence in their rehabilitation or overall wellness programs. These may include exercise equipment, such as therapy balls, balance boards, tubing for resistance-based rehabilitation exercises and TENS machines, as well as vitamins, herbal products or creams (e.g. topical analgesics). These may or may not be reimbursable through extended health care (EHC) insurance plans or health spending accounts (HSAs).

Ask your patients to check the details of their benefits plan or consult the Canada Revenue Agency's medical expense tax credit page to determine whether a product is likely to be reimbursable through an HSA.

Simplified quick link access

Clear, Complete and Clinically Supported Documentation

Assistive devices can be expensive, especially if a custom product is needed. It's understandable that your patients will want to know the details of any insurance coverage they may have access to before committing to the purchase of the device. It's also important that your patients understand the documentation and process requirements of their specific plan. You can assist your patients by:

- Providing them with key information about the device (e.g. make, model, cost) as well as a copy of our Patients' Extended Health Care Coverage Checklist, so they can make preliminary inquiries to understand the nature of their coverage.
- Submitting a pre-determination request on your patient's behalf, where such an option exists. This is especially helpful for products with significant costs as this will decrease the likelihood of any issues arising with the claim after it is made.
- Providing them with documentation for pre-approval, where this is required by their EHC insurer.

In all cases, clear, complete and clinically supported documentation is essential.

For pre-approval or reimbursement an insurer will normally require:

- Prescription setting out a medical diagnosis from a health care professional authorized under the patient's plan. The treating health care professional can assist their patients in obtaining timely and appropriate prescriptions by providing them with clinical documentation to share with the prescribing health care professional. This will help the prescribing professional understand the patient's condition and needs.
- Itemized invoice from the chiropractor and receipt marked "paid"
- Itemized invoice/proof of manufacturing from the manufacturer

For orthotics, documentation should also include:

- Copy of gait analysis or biomechanical assessment
- Description of the casting technique, materials and process used, including make and model of a stock shoe being modified
- The date on which the device was casted, as well as the date it was dispensed
- Name of prescriber and name of dispenser (if different)
- Date of payment

It's also important to ensure that your patients understand that a product or device cannot be prescribed or dispensed simply because coverage for it exists in their EHC insurance package.

EHC insurance plans are *"designed and intended to assist in providing coverage for the expenses of medically necessary services and supplies."* [23] The College of Chiropractors of Ontario's (CCO)'s Standard of Practice on Assistive Devices (S-021) stipulates that there must be a valid clinical reason for prescribing or dispensing these products.

23 Canadian Life and Health Insurance Association (2019). Supplementary Health Care Insurance Explained: For Healthcare Providers. https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/resources/Consumer+Brochures/$file/SUPPLEMENTARY+HEALTH+INSURANCE+EXPLAINED.pdf

Pricing and Billing for Devices

Set and adhere to specific prices for various services related to devices and provide itemized invoices. This makes it clear to insurers that your fees do not change based on your patient's benefits plan. (For compassionate care exceptions please see section six.) Some insurance companies have begun to use their historical claims data to direct plan members towards providers whose pricing for services and devices falls within the insurer's maximum reimbursable expenses.[24]

CCO Standards of Practice stipulate the cost of orthotics and other assistive devices *"must reasonably relate to the time and expertise of, and cost to, the member."*[25] While this means you have some latitude to set your fees within these parameters, individual EHC insurance providers make their own decisions about whether reimbursement for devices will be subject to "reasonable and customary" fee limitations and, if so, what those limitations are.

EHC insurers determine their "reasonable and customary" amounts using their own historical and geographic data to determine the average cost to patients of specific products and services. If costs claimed for a product or service substantially exceed such "reasonable and customary" amounts, an audit or an investigation may be triggered. Insurers will seek to understand the reason for an apparent variation from the norm. Another trigger could be if all or a significant number of your patients appear to be dispensed a particular device.

In most cases, insurers require invoices for assistive devices to be paid in the following order:

1. You pay the manufacturer or supplier for the device
2. Your patient pays you for the device and associated professional fees
3. Claim is submitted to insurer and insurer pays covered portions to your patient

If you issue an invoice marked "paid" to your patient prior to receiving payment, insurers consider this to be insurance fraud because it asks the insurer to compensate the patient for funds the patient has not paid.

For more details and information on leading practices in orthotics insurance, we recommend you review the following excellent resources:

- OCA Orthotics Quick Reference Guide
- OCA Orthotics Insurance Best Practices Guide
- CLHIA Reference Document: Understanding Claims for Footwear and Foot Orthotics

Also, consult the CLHIA's Service and Supply Provider Receipt Best Practices for Group Benefits Reimbursement. This document (discussed in section 6) provides detailed guidance on issuing receipts for medical supplies.

24 See, for example: Sun Life (2018). Custom orthotics claims: changes to what will be covered and eligible dispensers. Focus Update. https://www.sunlife.ca/static/canada/Sponsor/About%20Group%20Benefits/Focus%20Update/2018/813/813_Focus.pdf

25 College of Chiropractors of Ontario. (2018). Standard of Practice S-021: Assistive Devices. https://cco.on.ca/wp-content/uploads/2019/02/S-021.pdf
See also: College of Chiropractors of Ontario. (2014). Standard of Practice S-012: Orthotics. https://cco.on.ca/wp-content/uploads/2017/10/S-012.pdf

Patients' Coverage Checklist for Orthotics or Other Assistive Devices

- ☐ 1. Does my benefits plan cover the product or device [make, model]?
- ☐ 2. The cost to the patient for this device is [cost].
  - a. How much of this cost will my plan cover?
  - b. Are there any fees, such as deductibles or co-payments that I should be aware of?
- ☐ 3. What are the terms and conditions of coverage that I should be aware of?
- ☐ 4. Do I need pre-approval?
- ☐ 5. Is a prescription required? Will my prescription expire after a certain time?
- ☐ 6. Under my EHC plan, which health care providers can prescribe the product or device?
- ☐ 7. Under my EHC plan, which health care providers can dispense the product or device?
- ☐ 8. Do I need to submit any other forms of paperwork or documentation to be covered?
- ☐ 9. For orthotics: What casting technique is required?

Benefits Fraud and Abuse

Overview of the Problem

According to the Canadian Life and Health Insurance Association (CLHIA), hundreds of millions of health care dollars are lost to fraud in North America every year.[26]

Benefits fraud impacts all extended health care (EHC) stakeholders. It increases the cost of premiums paid by employers who sponsor group insurance plans. It jeopardizes the sustainability of coverage levels offered to employees who depend on their group benefits to access the care and drugs they need for themselves and their families.

It also negatively impacts health care professionals who face additional administrative scrutiny and reputational harm because of the actions of a small minority. There is a growing focus on this issue across EHC stakeholders.

For example, the 2020 Sanofi Canada Health Care Survey reported that fraud is now among the top five concerns of plan sponsors, ranking among other longer-standing concerns such as drug and dental plan sustainability, absence/disability, and the use of paramedical benefits.

Moreover, a significant majority of both employers (plan sponsors) and employees (plan members) are *"willing to get certain products and services, such as orthopedic shoes or massage therapy, from a list of approved providers— and at discounted rates—in order to prevent benefits fraud."*[27] It is in the best interests of all parties to understand what benefits fraud and abuse look like, how it can be prevented and what the consequences are.

26 Canadian Life and Health Insurance Association Fraud = Fraud "Help Prevent Benefits Fraud" https://www.clhia.ca/antifraud

27 Sanofi Canada Healthcare Survey (2020) Future Forward: Frontline Perspectives on the Future of Health Benefit Plans. https://www.sanofi.ca/-/media/Project/One-Sanofi-Web/Websites/North-America/Sanofi-CA/Home/en/Products-and-Resources/sanofi-canada-health-survey/sanofi-canada-healthcare-survey-2020-EN.pdf?la=en&hash=F1C763AA6B2F32C0BF2E623851FD05FD

Simplified quick link access

Recognizing Benefits Fraud

According to the Canadian Life and Health Insurance Association (CLHIA) benefits fraud *"occurs when you intentionally submit false or misleading information to your insurance provider for the purpose of financial gain and it can take many forms.*

Examples include (but are not limited to):

- *Billing for health or dental services that were never received*
- *Submitting the same claim to multiple insurers to double your reimbursement*
- *Letting someone not covered by your plan use your benefits."* [28]

The definition of "misleading" includes submitting incomplete information (e.g. omitting an incentive and its cost to the patient on a receipt). A finding of fraud or abuse can have serious consequences for health care providers – it can and has resulted in some providers and their clinics being delisted by major insurance providers, for an indefinite period. It can also result in loss of reputation, income or even the loss of your license to practice chiropractic care.

According to CLHIA, all of the following actions constitute benefits fraud:

- Pressuring patients to get unnecessary products or procedures
- Encouraging patients to claim products or services that they didn't receive, and/or are not covered by their plan
- Providing products or services tailored to the details of the patients' insurance coverage rather than providing the right product or service
- Including incorrect or misleading information on a receipt or encouraging a patient to include incorrect or misleading information in a claim
- Asking patients to sign a blank claim form (which could be completed later with misleading information)
- Using a patients' insurance plan membership information to charge for products and services the patient never received
- Offering cash or other incentives in exchange for a patients' policy information[29]

Abuse of EHC Benefits

The EHC industry considers benefits abuse to have taken place when employees "use up benefits" whether or not there is a medical or clinically necessary reason. This type of benefits abuse is different than fraud in that it's not illegal. However, it may contravene the intent of EHC insurance, and jeopardize the sustainability of group plans.

Insurers define medical necessity in the language of plan contracts. For example, they may define eligible services as those which are medically necessary for the treatment of an illness or injury. These contractual

28 Canadian Life and Health Insurance Association. (2019). Frequently Asked Questions: What is health and dental benefits fraud? https://fraudisfraud.ca/what-is-benefits-fraud

29 Canadian Life and Health Insurance Association. (2019). You can stop benefits fraud. https://fraudisfraud.ca/what-can-you-do

definitions are intended to ensure that treatment responds to the patients' condition or diagnosis, not the specifics of their insurance coverage.

Insurers may request to see your clinical notes and documents if they have questions regarding the relationship between the number or type(s) of visits and conditions or diagnoses being treated. This is among the reasons why it is important to keep accurate and detailed records.

Preventing Fraud and Abuse, Protecting Sustainability

CLHIA has taken an active role in raising awareness of these a issues through an anti-fraud campaign, launched in 2018.

Through its own research efforts, CLHIA determined that many Canadians underestimate the consequences of benefits fraud. Indeed, some 75 per cent of people surveyed believe that the most significant consequences arising from benefits fraud are rising premiums or the obligation to reimburse inaccurate or misleading claims.

The CLHIA anti-fraud campaign seeks to counter these beliefs by highlighting that fraud is *"a real crime with real consequences,"*[33] which may include job loss, criminal charges and jail time. The campaign has had a significant impact on public perception of the issues of benefits fraud and abuse. CLHIA reported *"more engagement on its anti-fraud websites and more [fraud related] tips coming in."*[34]

This is one example of the many ways the EHC insurance industry is taking an increasingly collaborative approach to fraud and abuse. Previously, Canada's life and health insurance providers tended to view fraud detection capacities as a competitive advantage. Today, there is movement within the industry to collaborate on this issue through data sharing. Access to wider and deeper data

Emerging Pain Research: Nordic Maintenance Care Study

There are instances where the science around what constitutes a recognized Illness evolves. As the Canadian Pain Task Force observes, chronic primary pain has only been recognized as a disease in its own right very recently.[30] In 2018, the World Health Organization announced its intention to include chronic primary pain in the 11th edition of the International Classification of Diseases (ICD), which comes into effect in January 2022.[31] Furthermore, there is emerging clinical evidence that maintenance care (MC) can result in "statistically and clinically significantly fewer days with bothersome (activity-limiting)" low back pain (LBP) in specific populations of patients.[32]

The research on MC is evolving and, in some cases, these developments may not yet be widely recognized in EHC plans. Chiropractors caring for patients who may benefit from MC for LBP should advise their patients to confirm with their insurer whether it is considered eligible before commencing this form of care.

30 Canadian Pain Task Force. (2020). Working Together to Better Understand, Prevent, and Manage Chronic Pain: What We Heard. Health Canada https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/canadian-pain-task-force/report-2020-rapport/report-2020.pdf

31 World Health Organization. (2018). WHO releases new International Classification of Diseases (ICD 11 https://www.who.int/news/item/18-06-2018-who-releases-new-international-classification-of-diseases-(icd-11)

32 Eklund, A., Hagberg, J., Jensen, I. et al. (2020). The Nordic maintenance care program: maintenance care reduces the number of days with pain in acute episodes and increases the length of pain free periods for dysfunctional patients with recurrent and persistent low back pain - a secondary analysis of a pragmatic randomized controlled trial. Chiropractic and Manual Therapies 28 (19). https://doi.org/10.1186/s12998-020-00309-6

33 Canadian Life and Health Insurance Association. (2019). Fraud = Fraud, https://www.fraudisfraud.ca

34 Frank, S. quoted in Life Health Professional (2019). Benefits fraud not a victimless crime: CLHIA. https://www.lifehealthpro.ca/news/benefits-fraud-not-a-victimless-crime-clhia-321585.aspx

pools enables the industry to use artificial intelligence and machine learning to more efficiently and reliably detect and resolve patterns that would otherwise be much more difficult.

Protect yourself against professional identity theft

Professional identity theft occurs when your College of Chiropractors of Ontario (CCO) registration number and your signature are used by a clinic or clinician to submit fake claims.

CLHIA identifies four steps that you can take to protect yourself against professional identity theft:

Step 1: Do not give out your license/provider number until ***after*** being hired by a clinic.

Step 2: Ensure all your clinic administrative staff, health care professionals and owner(s) have an agreement as to the appropriate use of professional information, including a protocol for how information will be used after a service is delivered and the invoice/claim is made. To confirm the protocol is being observed in practise, frequently review all invoices/claims made with your license to catch any problems, administrative errors and/or fraud.

Step 3: If you are a prescriber, guard your prescription documents.

Step 4: When you stop working for any clinic, have an agreement that no further invoices/claims will be made with your CCO number and name after your date of departure. Contact CCO and advise that you no longer work at the location.[35]

Spotlight on Incentives

When a product or device is given for free or sold at a reduced price as a complement to a different product or service, this is called an incentive. The CCO does not prohibit chiropractors from offering discounts and incentives to patients, so long as there is no third-party payor involved (e.g. the patient is paying for products and/or services themselves, and does not submit the expense to their EHC plan).

The CCO Guideline on Advertising (G-016) stipulates that:
A member is not permitted to bill any third-party payor or ask for the patient's health insurance information for complimentary diagnostic or treatment services as this practice is unethical and may be professional misconduct.[36]

Insurance companies prohibit the practice of offering incentives of greater than nominal value because it may result in excessive or unnecessary use of benefits.

With the exception of nominal incentives (e.g. a toothbrush with their dental hygiene appointment, a water bottle with their physiotherapy treatment, or a sample foot lotion with their orthotics appointment) it is not

35 Adapted from Canadian Life and Health Insurance Association. (2017). How healthcare providers can protect themselves from identity theft. https://www.clhia.ca/web/clhia_lp4w_lnd_webstation.nsf/page/4A27FF363D4BA7508525832F005F5459!OpenDocument

36 College of Chiropractors of Ontario. (2019). Guideline G-016 Advertising. https://www.cco.on.ca/wp-content/uploads/2019/06/G-016-June2019.pdf
See also: CCO Standard S-016: Advertising which stipulates: "A member may advertise their fee(s) for chiropractic services provided:
(c) the member does not bill a third-party payor for the complimentary portion of the diagnostic or treatment service". College of Chiropractors of Ontario. (2019). Standard S-016: Advertising. https://www.cco.on.ca/wp-content/uploads/2020/02/S-016.pdf

okay to offer incentives with covered services or supplies. Incorporating the cost of incentives into the cost of covered services or supplies or offering free or ineligible services or supplies to persuade patients to use their coverage when it is not medically necessary, is considered benefits fraud.[37] For example, some orthotics dispensers have tried offering "free" footwear to patients when they order orthotics. In many cases, the cost of that footwear is recouped by increasing professional fees for patient evaluations. This essentially means that the insurer is bearing the cost of the dispenser's loss leader.

According to one fraud risk manager, *"In the past, we delisted for abuse and fraud and inappropriate business practices. We also now delist for offering incentives, because what we noticed was that facilities are issuing incentives or providing incentives that are beyond a nominal value or not related to the product being dispensed."*[38]

For more information on insurance best practices, detecting and preventing fraud look for the OCA Webinar: Health Insurance: Your Patients & Chiropractic Services on the Insurance section of our website (Presented by CLHIA). We recommend you watch and share this webinar with your administrative staff, as it offers important information for your entire team.

37 Canadian Life and Health Insurance Association (2019). "Health Care Providers" Fraud=Fraud https://fraudisfraud.ca/
38 Askin, G. cited in Murphy, R. (2017). A free purse with a benefits claim? How incentives can land providers, employees in trouble. Benefits Canada. https://www.benefitscanada.com/news/a-free-purse-with-a-benefits-claim-how-incentives-can-land-providers-employees-in-trouble-105181

Appendix A:
The Patient's Guide to Extended Health Care Coverage

Ontario Chiropractic Association

Welcome to the patient's guide to extended health care (EHC) for chiropractic coverage.

We produced this resource to help you understand your EHC coverage for chiropractic care.

Many EHC plans cover chiropractic care as a 'paramedical service.' If you and your family have EHC insurance coverage, it likely includes chiropractic care.

This guide consists of two main components:

A checklist that you can use to help you understand the important details of your EHC coverage for chiropractic services, and for any devices that your chiropractor may prescribe and/or dispense

A list of "frequently asked questions" with detailed responses to common patient queries and concerns that you may have

What is Extended Health Care (EHC) for Chiropractic Coverage?

Privately administered EHC coverage comes in individual and group forms. Group coverage is the most common form. Employers, unions or associations (plan sponsors) typically offer group coverage to unionized or non-unionized employees or association members (plan members). Your compensation package includes EHC, which is an important way to share the costs and risks of illness across groups of people. Self-employed people may purchase individual plans for themselves and their family members.

EHC plans are sometimes called supplementary health or supplementary medical plans because their purpose is to supplement provincial health care coverage. EHC coverage may come in the form of EHC insurance, a health spending account or a personal spending account. It is an important way people can access health services that the publicly administered Ontario Health Insurance Program (OHIP) or the Workplace Insurance and Safety Board (WSIB) do not cover.

In fact, the OCA commissioned an Environics survey in 2019 that found four out of five chiropractic patients in Ontario pay for their care through private insurance coverage.

Eligible Expenses and Chiropractic Coverage Levels

Insurers often set certain conditions or limitations when they define eligible EHC expenses. Conditions might be things like deductibles, co-payments and/or pre-approvals for products such as orthotics. Common limitations include annual spending limits, limits on what you can spend on specific health care professionals or products, and limits on the amount of money that can be reimbursed per visit.

Your insurance provider or benefits administrator will make decisions about whether a health care expense is eligible for reimbursement under your specific EHC plan. They'll also decide whether a benefit is subject to conditions or limitations, based on the language of your benefits contract.

Your plan's level of coverage for chiropractic services depends on the types of plans your insurance provider offers. It's also affected by the difficult decisions employers, unions, and workers make about what they can afford and what kind of coverage is most valuable to them.

As a patient and a plan member, your voice matters. If you have questions or concerns about the level of your chiropractic coverage, you can raise them with your employer, union or association that purchases EHC coverage on your behalf. .

When Chiropractic is Covered, Everyone Benefits!

Research shows the following economic and patient benefits of chiropractic care:

- Employees who access chiropractic care tend to incur fewer costs because they are less likely to be prescribed medications or end up with complex medical procedures.[38]
- Manual therapy is a common treatment used by chiropractors. It shows an economic advantage compared to other interventions used for managing spine, muscle or joint (musculoskeletal) conditions.[39]
- Patients receiving chiropractic care have lower disability recurrences and for shorter durations compared to patients receiving care from other health care professionals.[40]

Check this fact sheet to learn how everyone benefits when chiropractic care is covered.

We designed this fact sheet to enhance the support and services Ontario chiropractors provide to you as their patients. We welcome your feedback so we can continue to improve the information we share with you.

38 Allen, H., Wright, M., Craigh, T., Mardekian, J., Cheung, R., Sanchez, R., Bunn, W. and Rogers, W. (2014) Tracking low back problems in a major self-insured workforce: toward improvement in the patient's journey. Journal of Occupational and Environmental Medicine, 56(6), 604-620. Retrievable: http://www.ncbi.nlm.nih.gov/pubmed/24854253

39 Tsertsvadze, A., Clar, C., Court, R., Clarke, A., Mistry, H. & Sutcliffe, P. (2014). Cost-effectiveness of manual therapy for the management of musculoskeletal conditions: A systematic review and narrative synthesis of evidence from randomized controlled trials. Journal of Manipulative and Physiological Therapeutics, 37(6), 343-362. Retrievable: www.jmptonline.org/article/S0161-4754(14)00087-6/abstract

40 Allen et al. (2014) Tracking low back problems in a major self-insured workforce

Patients' Extended Health Care Coverage Checklist

We recommend you learn about the following details of your insurance coverage before beginning treatment with your chiropractor:

- ☐ 1. What are my coverage levels? Is there a maximum per profession or an overall maximum for a group of professions (e.g. paramedical)?
- ☐ 2. Does my policy include a health spending account (HSA) or a personal spending account (PSA)? If so, how much is available?
- ☐ 3. What are reasonable and customary fees, or what is the maximum amount that I can claim per visit?
- ☐ 4. Will my claim require any co-payments or include any deductibles? If so, how much are they and how often will my insurer apply them? (Note: An insurer usually applies co-payments per visit. However, an insurer generally applies deductibles only once per benefit period.)
- ☐ 5. What is my benefits renewal period/date? Do my benefits renew annually on January 1, or at some other interval?
- ☐ 6. How much of my coverage have I used so far? How much remains?
- ☐ 7. Is my spouse or are my other family members covered?
- ☐ 8. Is virtual care (telehealth) covered? Are there any terms and conditions of coverage that I should be aware of?

Additional questions for orthotics or other assistive devices

- ☐ 9. Does my benefits plan cover the product or device [make, model]?
- ☐ 10. The cost to the patient for this device is [cost].
  - a. How much of this cost will my plan cover?
  - b. Are there any fees, such as deductibles or co-payments, that I may need to pay?
- ☐ 11. What are the terms and conditions of coverage that I should be aware of?
- ☐ 12. Do I need pre-approval?
- ☐ 13. Do I require a prescription? Will my prescription expire after a certain time?
- ☐ 14. Under my EHC plan, which health care professionals can prescribe the product or device?
- ☐ 15. Under my EHC plan, which health care professionals can dispense the product or device?
- ☐ 16. Do I need to submit any other forms, paperwork or documents to be covered?
- ☐ 17. For orthotics: What casting technique is required?

FAQs

Q1: Can my chiropractor or their administrative staff, contact my insurance provider to get information about my insurance overage for me?

A: For privacy reasons, insurers will not provide the details about your coverage to your chiropractor. You'll need to get details about your coverage directly from your insurer or from your employee benefits resources.

Your insurance provider makes information available to you in a variety of ways: through your employee portal, mobile applications and through its customer service department, which you can usually reach either by a toll-free telephone number or online chat. When possible, request information from your insurer in writing.

It's a good idea for you to understand the details of your coverage before your treatment begins. That way you know what your plan will cover and you can plan for any out-of-pocket costs that you may have to pay.

Your chiropractor and their administrative staff are happy to assist you. Here is a checklist to help you know what questions to ask your insurance provider.

Another option that may be available to you is called a predetermination request, which is like an estimate.

If this service is available to you, your chiropractor can submit the cost of a specific treatment or product to a third-party service provider. Your chiropractor will then receive information about whether your plan will cover it. You'll also receive information about any conditions, co-payments or deductibles that may apply to you.

Through the predetermination process, your chiropractor can save you time. They can get answers to specific questions about your coverage, without compromising your privacy and patient/chiropractor confidentiality.

Q2: How do I submit a claim? What do I need to submit?

A: You can submit your claims in one of three ways:

- Your chiropractor or other health care professional can submit them directly to your insurance provider on your behalf
- You can submit them electronically through your insurance provider's portal
- You can complete and mail in signed paper forms with supporting documents to your insurance provider's claims department

We recommend you contact your insurance provider and ask for details about any supporting documents you need to be reimbursed for any products or services you receive. You may require specific documents for certain devices (e.g., orthotics).

It's important that you check with your insurer **before** you receive a device. That way, you can ensure you submit the correct information with your claim. Usually, insurers will require, at minimum, a receipt or paid invoice. Your chiropractor will complete the paid invoice for you.

Q3: Can my chiropractor submit my health spending account (HSA) claims on my behalf? How do I know what expenses are eligible under my HSA or personal spending account (PSA)?

A: Ordinarily, you will need to submit HSA/PSA claims directly to your insurer. Most HSAs define eligible expenses as those that qualify for the Canada Revenue Agency's (CRA)'s medical expense tax credit.

You can get details about your coverage directly from your insurer or from your employee benefits resources.

Your insurance provider makes information available to you in a variety of ways. These ways include: through your employee portal, through mobile applications and through its customer service department, which you can usually be reach either by a toll-free telephone number or online chat. When possible, request information from your insurer in writing.

Q4: We are doing exercises. Can you bill this as physiotherapy? Can you bill my acupuncture benefits?

A: Your chiropractor cannot bill for physiotherapy services unless they are a dual registrant of both the College of Chiropractors of Ontario (CCO) and the College of Physiotherapists of Ontario (CPO).

Physiotherapy and chiropractic care are distinct health professions, with scopes of practice governed by law in the province of Ontario. This means that by law, chiropractors and physiotherapists must treat patients within their respective scopes of practice.

Sometimes there is overlap between the scope of practice of two or more health professions. For example, prescribing or supervising therapeutic exercises is within the scope of practice for chiropractors and physiotherapists. However, this scenario does not mean that a chiropractor is performing physiotherapy.

Like therapeutic exercises, acupuncture is considered a treatment that's included in the scope of several health professions. This means that your chiropractor can use acupuncture in your treatment if they do so in a manner that is within their scope of practice.

Whether your insurance company will reimburse the cost of acupuncture your chiropractor administers will depend on its policies. We suggest you ask your insurance provider about your coverage before you receive acupuncture treatments from your chiropractor.

Q5: I know someone who received free shoes when they purchased orthotics from their health care professional. Can I have free shoes too? I have a friend who buys a package of 10 visits from their health care professional and gets 1 free visit. Do you have any packages available?

A: Chiropractors' regulatory college allows them to offer discounts and incentives to you as their patient. However, the practice of giving free product or services with paid services is called an incentive.

Insurance companies do not cover the costs of paid products or services that are bundled in this way.

If you receive free shoes or any other incentives, your insurance company will not reimburse the cost of the product of service that you paid for to receive the shoes (or any other incentives). Even if the incentive is given free of charge, it must still appear on any receipt or invoice that's submitted to your insurer, with the cost to you clearly displayed as "$0.00."

The Canadian Life and Health Insurance Association (CLHIA) defines fraud as submitting "false or misleading information" as part of a benefits claim. This includes submitting incomplete information (e.g. omitting an incentive on a receipt). A finding of fraud or abuse can have serious consequences for patients and health care professionals. For more information on benefits fraud and abuse, please visit: Fraud is Fraud.

Q6: My spouse/friend/family member has coverage for services they do not use. Can I use my spouse, friend or family member's benefits coverage?

A: No. Billing services under a name other than that of the person who received those services is benefits fraud. It doesn't matter that the person does not use their coverage. Making a claim under their name is considered submitting "false or misleading information" to your insurer.

Q7: Can you bill for an extra visit that I don't attend to cover the cost of my deductible and/or co-payment? Can I bill my insurance company for a missed appointment? Can you waive my co-payment?

A: No. Some health care professionals may charge patients for missed appointments to compensate for their time. These appointments cannot be billed to your insurance company. Extended health care benefits (EHC) are intended to cover the cost of medically necessary products or services. Typically, EHC benefits do not cover the cost of financial penalties.

Beyond the specific instance of billing for missed appointments, health care professionals cannot charge you for visits that did not occur. Submitting a bill for a visit that did not occur to your insurer is benefits fraud.

Likewise, your chiropractor cannot issue payment receipts for amounts that are different than what you paid for products and/or services you received. Doing this is considered giving your extended health care provider false or misleading information, which is benefits fraud. These practices could have serious consequences for you and/or your chiropractor.

Some benefit plans include deductibles and co-payments are part of their design. Your chiropractor does not have the ability to waive these fees that the insurance company charges and builds into its reimbursement process. For example, if your chiropractor submits a bill for a visit that cost $100.00 and there is a five per cent co-payment, the insurer will automatically deduct five dollars and the amount you receive in reimbursement will be $95.00.

Q8: My insurance coverage is changing/ending. Can you charge me more so I can have a credit to use for future visits? Could I purchase a gift card with my remaining insurance benefits to use next year? Can you charge me before I receive my orthotic so I can make a claim before I lose coverage?

A: No. Extended health care insurance is intended to cover the cost of medically necessary services or products. Each receipt that is submitted to your insurance provider must correspond to specific service(s) or product(s) that your plan covers and that you have already received and paid for. Submitting false or misleading information to your insurance provider is benefits fraud. This could have serious consequences for you and/or your chiropractor.

If your insurance coverage is ending and you need an orthotic but the cost is a financial hardship for you, we suggest you contact your insurance provider. Ask them if they can make an exception in your circumstances to allow you to submit a claim after the date when your coverage will change or end.

Alternatively, some chiropractors may offer reduced fees on compassionate grounds, on a case-by-case basis. Speak to your chiropractor for further information.

Q9: Can we not tell my auto insurer about my extended health care coverage so I can save that for later in case I need it?

A: No. Under the *Insurance Act, 1990*, you must by law use your extended health care insurance before accessing motor vehicle accident (MVA) insurance.

Q10: I do not have extended health care insurance. Can you give me a discount?

A: Some chiropractors may offer reduced fees on compassionate grounds, on a case-by-case basis. Speak to your chiropractor for further information.

Adjudicate means to make a formal judgement or decision about a problem or disputed matter.

Artificial Intelligence (AI) encompasses a broad range of technologies that enable systems to draw on big data, statistics and probability analyses. They function in ways that attempt to mimic human cognition and produce outcomes that appear "intelligent" to human observers. AI underlies the ability of devices controlled by computers to perform complex tasks normally done by humans like driving a car or playing a game of chess. AI differs from conventional computer programing that uses top-down programing. Instead, AI combines vast data (known as "big data") and relatively simple algorithms to support a process known as machine learning.
This is what gives AI the ability to change its behaviour, based on the accumulation of new data or 'experience.'
(See also: Machine learning; Big data)

Assistive devices are those prescribed by health care professionals to maintain or improve a person's functioning, independence to perform the tasks of everyday life, and to enhance their overall well-being. They can also help prevent impairments and secondary health conditions. Orthopaedic braces and supports are examples of assistive devices.

Big data refers to very large data sets that artificial intelligence (AI) systems analyze to reveal patterns that cannot be observed or revealed using traditional methods. AI systems use the ability to detect these patterns to mimic human behaviour in executing specific tasks. The ability of an AI system to mimic human behavior depends to a significant extent on the quality of the big data that is used to train the AI system. (See also: Artificial intelligence; Machine learning)

Benefits fraud occurs, according to the Canadian Life and Health Insurance Association (CLHIA), when someone
"intentionally submits false or misleading information to an insurance provider for the purpose of financial gain.
It can take many forms.
Examples include (but are not limited to):

- *Billing for health or dental services that were never received*
- *Submitting the same claim to multiple insurers to double your reimbursement*
- *Letting someone not covered by your plan use your benefits."*

A finding of fraud or abuse can have serious consequences for health care professionals. It can and has resulted in major insurance providers delisting health care professionals and their clinics, for an indefinite period. It can also result in loss of reputation, income or even the loss of your license to practise chiropractic care.

Canada Revenue Agency (CRA) is the revenue service of the government of Canada. It collects taxes, administers tax law and policy. It also delivers benefit programs and tax credits for the federal government, as well as most provincial and territorial governments. The CRA also oversees the registration of charities in Canada.

Canadian Chiropractic Guideline Initiative (CCGI) develops evidence-based clinical practice guidelines and best practice recommendations. It also facilitates their dissemination and implementation within the chiropractic profession.

Canadian Life and Health Insurance Association (CLHIA) is a not-for-profit membership-based organization that represents 99 per cent of Canada's life and health insurance companies and benefits administrators.

College of Chiropractors of Ontario (CCO) is the governing body established by the provincial government to regulate chiropractors in Ontario. Every practising chiropractor must be registered with the CCO.

Coordination of benefits refers to a provision that determines the sequencing of coverage when employees and their dependents (plan members) are eligible for benefits under more than one private health care plan. For example, coordination of benefits allows two people with health care plan coverage, who are married or in a common law

relationship, to be covered as dependents by each other's plans. The children or dependents of spouses who both have health care coverage may also be covered under both plans through coordination of benefits.

Cost containment is the business practice of maintaining expense levels to prevent unnecessary spending, or otherwise attempting to reduce expenses. Its goal is to improve profitability without damaging the long-term success of the company.

Co-payment is part of an insurance claim that you must pay out of pocket when you make a claim before the insurer will reimburse you the remaining insured portion of the claim. Some benefit plans include deductibles and/or co-payments as part of their design. An insurer generally applies a deductible once per benefit renewal period. However, an insurer usually charges co-payments on a per-product or service basis at each visit. For example, if a patient or their health care provider submits a claim for a visit that cost $100.00 and there is a five per cent co-payment, the insurer will automatically deduct five dollars and the amount they pay in reimbursement will be $95.00. (See also: Deductible).

Deductible is a payment that you must pay out of pocket when you make an insurance claim before the insurer reimburses your claim. Some benefit plans include deductibles and/or co-payments as part of their design. Unlike a co-payment, which is generally charged on a per-product or service basis, a deductible is typically charged once per benefit period (e.g. annually). For example, if a plan has a $25 deductible for paramedical claims this means that a one-time fee of $25 will be deducted from the first paramedical claim paid in a benefits cycle. (See also: Co-payment).

Employee Life and Health Trust (ELHT) is a savings and investment vehicle through which an employer, union or association can provide life and health benefits to its employees or members.

Experience rating is a technique used by the insurance industry to determine the level of insurance risk associated with a particular employer, and to adjust premiums for the employer, normally on an annual basis. Experience rating is based on the claim's history of the insured group, as well as the nature of the work that employees do.

Extended health care (EHC) refers to insurance benefits that help employees and their eligible dependents (plan members) pay for health care expenses that are not covered by their provincial plans.

Financial Services Regulatory Authority (FSRA) is an independent regulatory agency that regulates financial service providers, such as insurance companies and pension plan administrators. FSRA has a mandate to protect consumers and pension plan beneficiaries in the province of Ontario. The agency is self-funded and designed to operate at arms length from the government.

Fraud refers to intentional deception intended to result in financial or personal gain. (See also: benefits fraud).

Geocoding is a process of transforming a description of a location (i.e., coordinates, address etc.) to a location on the earth's surface.

Guidelines are issued by the College of Chiropractors of Ontario (CCO) as instructions for practice that are approved of by Council. (See also: Standard of Practice).

Health Spending Account (HSA), also known as a Health Care Spending Account (HCSA), is a way that employers can offer additional flexibility to employees in their health benefits coverage. In this arrangement, the insurer administers an account with a sum of money provided by the employer, which the employee can spend on specified goods or services. Eligible expenses under a health spending account are often defined as those that

qualify for the Canada Revenue Agency medical expense tax credit. (See also: Personal Spending Account).

Identity theft is when your personal or financial information is used by someone else to commit fraud.

Incentive is a product or device given for free or sold at a reduced price as a complement to a different product or service. The College of Chiropractors of Ontario (CCO) does not prohibit chiropractors from offering discounts and incentives to patients, so long as there is no third-party payor involved (e.g. the patient is paying for the products and/or services themselves and does not submit the expense to their EHC plan). Insurance companies do prohibit the practice of offering incentives of greater than nominal value because it may result in excessive or unnecessary use of benefits.

Infographic is a collection of images, charts and information that gives people an intuitive, easy to understand overview of a topic.

Insurance brokerage refers to the business of giving people or organizations independent advice about what insurance is available from different companies and helping them to decide on the best plan and provider for their specific needs.

Interprofessional Spine Assessment and Education Clinics (ISAEC) are specialized clinics that provide care to help Ontarians manage their low back pain and related symptoms. ISAEC clinic services are funded by the Ministry of Health and Long-Term Care and are fully covered by OHIP. Patients receive rapid low back assessments, education and evidence-based self-management plans. The ISAEC model is an innovative, upstream, shared care model, designed to help combat the unmanageable chronic low back pain and reduce unnecessary diagnostic imaging and unnecessary specialist referrals.

Legislation refers to statutes enacted by the elected members of the legislature through the parliamentary process, as well as the regulations that are set out to assist in their application and interpretation. (See also: Regulation).

Machine learning refers to the ability of a machine to change its behaviour based on the accumulation of new data or 'experience.' This includes a range of different learning techniques, such as supervised, unsupervised and deep learning. Algorithms associated with these techniques enable systems to:

- Autonomously control machines like driverless cars
- Make predictions about things like consumer preferences

Support health care professionals in clinical decision-making by incorporating previous data on similar diagnoses, medication history, practices and guidelines (See also: Artificial intelligence; Big data)

Medical expense tax credit is a non-refundable tax credit that you can use to reduce the tax you pay to the Canada Revenue Agency (CRA). Money spent on eligible items is considered non-taxable income. Therefore, it reduces the dollar amount of the taxable portion of the income you report.

Office of the Superintendent of Financial Institutions (OSFI) is an independent federal government agency responsible for federally regulated financial institutions, such as banks, investment companies, insurance providers and pension plans. OSFI is tasked with regulating and supervising these entities to determine whether they are in good financial condition and meeting their requirements.

Ontario Health Insurance Plan (OHIP) is the publicly administered, tax funded insurance plan through which province of Ontario pays for many physicians, hospital-based, home and community care services.

Orthotics refers to the branch of health care that deals with the provision and use of artificial devices, such as splints and braces. Shoe orthotics are inserts that are prescribed to treat foot, leg or back problems by supporting and aligning the foot.

Paramedical services are treatments provided by health care professionals, such as physiotherapists, chiropractors, massage therapists, podiatrists and acupuncturists, among others.

Pay for performance is a method of incentivizing employees or other agents by rewarding them for achieving specific agreed upon goals or objectives.

Personal Health Information and Privacy Act, 2004 (PHIPA) is provincial legislation that sets out rules for the collection, use and disclosure of personal health information. The legislation balances the rights of individuals to keep their own personal health information private, with the legitimate needs of people and organizations who provide health care services to access and share this information.

Personal Spending Accounts (PSA) is an arrangement where the insurer administers an account with a sum of money provided by the employer, which the employee can spend on specified goods or services. Whereas health care spending accounts (HSAs) often restrict eligible expenses to those that qualify for the Canada Revenue Agency medical expense tax credit, personal spending accounts may come with fewer or different restrictions. These accounts may be offered to employees in addition to traditional benefit plans as a means of adding an additional degree of individual choice and customization to a standard benefits bundle. (See also: Health Spending Account).

Plan member refers to an employee or member of an organization, such as a union or association, who is enrolled in an extended heath care insurance plan, and potentially their eligible spouse and/or children.

Plan sponsor refers to an organization, such as an employer, union or association, that sets up a health care or retirement plan for the benefit of the organization's members.

Pre-approval refers to a situation where an extended health care insurer agrees in advance to cover the cost, or a portion thereof, of a specific product or service, subject to any applicable terms and conditions. Pre-approval may be required by insurers in some instances, for example in orthotics insurance claims.

Pre-determination request refers to a voluntary, written request by a health care professional to determine if a proposed treatment or service is covered under their patient's health benefits plan.

Preferred Provider Networks (PPNs) are lists of health care professionals and health care organizations that a third-party payer, such as a government agency or an insurance company, has contracted with to provide health care to eligible recipients.

Preferred Provider Organizations (PPOs) are health care arrangements in which health care professionals and facilities provide services to subscribed clients at reduced rates.

Premium is an amount an insured party pays for an insurance policy, normally re-evaluated on an annual basis.

Reasonable and Customary (R & C) fees are the established maximum charges or typical fee ranges within which an insurer will reimburse costs for specific products or services.

Regulation is a law that is set out to assist in their application and interpretation of a statute. A regulation deals with topics related to the statute under which it is made. Its purpose is to provide details to give effect to the policy established by the statute. Regulations are considered "delegated legislation" because the authority to make them is delegated by the legislature in a statute. Usually, the authority is given to the lieutenant governor in council. Sometimes the authority is given to a minister of the government or to another person or body. The process for amending a regulation is usually shorter than the process for amending a statute. (See also: Legislation)

Standard of Practice is an authoritative statement that sets out the framework of the legal and professional basis of chiropractic practice in Ontario. Set out by the College of Chiropractors of Ontario (CCO), Standards of Practice provide a guide to the knowledge, skills, judgment and values needed to practise chiropractic safely and ethically. Standards of practice are approved of by Council after public consultation. (See also: Guideline)

Telehealth (sometimes called virtual care) refers to the remote delivery of care to patients using information and communications technology. Telehealth can be delivered and received using a telephone (landline, mobile phone, smart phone) and/or by using encrypted real time web-based audio or video conferencing applications on computers, tablets and smart phones. (See also: Virtual care)

Third-party direct billing services is when a health care provider submits insurance claims for qualifying treatments directly to a patient's insurance company. The provider then receives the payment directly from the patient's insurance provider, removing the patient from the payment and claims submission loop.

Virtual care (sometimes called telehealth) refers to the remote delivery of care to patients using information and communications technology. Virtual care can be delivered and received using a telephone (landline, mobile phone, smart phone) and/or real time web-based audio or video conferencing applications on computers, tablets and smart phones. (See also: Telehealth)

Workplace Safety and Insurance Board (WSIB) is a publicly administered insurance provider that provides compensation and other benefits to workers who become sick or injured because of their job. The WSIB is also mandated to provide compensation to the family members of workers who die because of their job. Workplace insurance is a "no fault" system based on collective employer liability. That means that inured workers and/or their families receive WSIB compensation in exchange for the right to sue the employer. The WSIB is an agency of the Ontario government responsible for administering the workplace safety and insurance system in accordance with the *Workplace Safety and Insurance Act, 1997*. The board is responsible for promoting workplace health and safety, helping injured workers return to work and re-enter into the labour market and providing compensation and other benefits to injured workers and their survivors.

Canada Revenue Agency. (2020). *Lines 33099 and 33199 – Eligible medical expenses you can claim on your tax return.* https://www.canada.ca/en/revenue-agency/services/tax/individuals/topics/about-your-tax-return/tax-return/completing-a-tax-return/deductions-credits-expenses/lines-33099-33199-eligible-medical-expenses-you-claim-on-your-tax-return.html

Canadian Chiropractic Guideline Initiative. (2020). *Best Practices for Telehealth/Virtual Appointments.* https://5fd9fdec-587d-4499-9f32-a02895f41f3b.filesusr.com/ugd/21ecf4_00a116e324c34a5180a99f74583058e8.pdf

Canadian Chiropractic Guideline Initiative. (2020). *Telehealth/Virtual Health Care Patients' Guide.* https://5fd9fdec-587d-4499-9f32-a02895f41f3b.filesusr.com/ugd/21ecf4_7ff2df275db34a57be415c31ab9893d9.pdf

Canadian Chiropractic Guideline Initiative. (2020). *Clinician Summary – Telehealth.* https://5fd9fdec-587d-4499-9f32-a02895f41f3b.filesusr.com/ugd/21ecf4_04eb7a75debd47dea6ad41922dac3c15.pdf

Canadian Life and Health Insurance Association (2019 November 19). *Health Insurance: Your Patients & Chiropractic Services* [Webinar]. Ontario Chiropractic Association. https://chiropractic.on.ca/event/health-insurance-your-patients-and-chiropractic-services/

Canadian Life and Health Insurance Association. (2019). *Supplementary Health Care Insurance Explained: For Health-care Providers.* https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/resources/Consumer+Brochures/$file/SUPPLEMENTARY+HEALTH+INSURANCE+EXPLAINED.pdf

Canadian Life and Health Insurance Association. (2019). *Service and Supply Provider Receipt Best Practices for Group Benefits Reimbursement.* https://www.clhia.ca/web/clhia_lp4w_lnd_webstation.nsf/page/8DE2AE93CA08C-9D585257893004A0194/$file/Receipts_Best_Practices_June%202019_en.pdf

Canadian Life and Health Insurance Association. (2019). *Canadian Life and Heath Insurance Facts.* https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/resources/Factbook_2/$file/2019+Factbook+English.pdf

Canadian Life and Health Insurance Association. (2019). *Fraud = Fraud* https://fraudisfraud.ca

Canadian Life and Health Insurance Association. (2017). *How healthcare providers can protect themselves from identity theft.* https://www.clhia.ca/web/clhia_lp4w_lnd_webstation.nsf/page/4A27FF363D4BA7508525832F-005F5459!OpenDocument

Canadian Life and Health Insurance Association. (2017). *Reference Document: Understanding Claims for Footwear and Foot Orthotics.* https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/page/7BC4EF1D20CCDF-D085257A08004F6144/$file/Orthotics%20Reference%20Document%20ENG.pdf

Canadian Pain Task Force. (2020). *Working Together to Better Understand, Prevent, and Manage Chronic Pain: What We Heard Health Canada.* https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/canadian-pain-task-force/report-2020-rapport/report-2020.pdf

Christie, B. (2006). *Best Practices for Preferred Provider Networks (PPNs).* Financial Services Commission of Ontario. https://www.fsco.gov.on.ca/en/auto/autobulletins/2006/Pages/a-08_06.aspx

Canadian Pharmacists Association. (2019). "Major concerns remain around pay-for-performance programs in Canada" *Canadian Pharmacists Journal.* Vol. 152 (1) pp. 54-55. doi: 10.1177/1715163518816666

College of Chiropractors of Ontario. (2020). *Return to Practice Guidance.* https://www.cco.on.ca/wp-content/uploads/2020/06/GuidanceCOVIDJune92020CL2.pdf

College of Chiropractors of Ontario. (2020). *President's Messages* https://www.cco.on.ca

College of Chiropractors of Ontario. (2019). *Standard of Practice S-017: Acupuncture.* https://cco.on.ca/wp-content/uploads/2019/05/S-017.pdf

College of Chiropractors of Ontario. (2019). *Standard S-016: Advertising.* https://www.cco.on.ca/wp-content/uploads/2020/02/S-016.pdf

College of Chiropractors of Ontario. (2019). *Guideline G-016 Advertising.* https://www.cco.on.ca/wp-content/uploads/2019/06/G-016-June2019.pdf

College of Chiropractors of Ontario. (2018). *Standard of Practice S-021: Assistive Devices.* https://cco.on.ca/wp-content/uploads/2019/02/S-021.pdf

College of Chiropractors of Ontario. (2014). *Standard of Practice S-012: Orthotics.* https://cco.on.ca/wp-content/uploads/2017/10/S-012.pdf

Eklund, A., Hagberg, J., Jensen, I. et al. (2020). The Nordic maintenance care program: maintenance care reduces the number of days with pain in acute episodes and increases the length of pain free periods for dysfunctional patients with recurrent and persistent low back pain - a secondary analysis of a pragmatic randomized controlled trial. *Chiropractic & Manual Therapies.* Vol. 28 (19). https://doi.org/10.1186/s12998-020-00309-6

Environics Research. (2019). *Attitudes of Ontarians Towards Chiropractic Care.*

Inter-professional Spine Assessment and Education Clinics. (2020). *Low Back Rapid Access Clinic Virtual Assessment and Education Tool Kit.* (2020). https://www.isaec.org/uploads/1/3/1/2/13123559/final_doc_july_20_isaec_lb_rac_virtual_care_toolkit.pdf

McKinsey & Company. (2017). *Artificial intelligence in health insurance: Smart claims management with self-learning software.* https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/artificial-intelligence-in-health-insurance-smart-claims-management-with-self-learning-software

Ontario Chiropractic Association (2016). *Orthotics Insurance Best Practices Reference Guide* https://chiropractic.on.ca/wp-content/uploads/orthotics_insurance_best_practices_guide_feb2016.pdf

Ontario Chiropractic Association (2016). *Orthotics Insurance Quick Reference Guide.* https://chirolongevity.com/wp-content/uploads/2019/03/orthotics_insurance_quick_reference_guide_feb2016.pdf

Sanofi Canada Healthcare Survey. (2020). *Future Forward: Frontline Perspectives on the Future of Health Benefit Plans.* https://www.sanofi.ca/-/media/Project/One-Sanofi-Web/Websites/North-America/Sanofi-CA/Home/en/Products-and-Resources/sanofi-canada-health-survey/sanofi-canada-healthcare-survey-2020-EN.pdf?la=en&hash=F1C763AA6B2F-32C0BF2E623851FD05FD

Sullivan, M. (2014). *Planning for data-driven preferred provider networks.* Benefits Canada. https://www.benefitscanada.com/benefits/health-benefits/planning-for-data-driven-preferred-provider-networks-50099

Virtual Care Taskforce. (2020). *Virtual Care: Recommendations for scaling up virtual medical care services*. https://www.cma.ca/sites/default/files/pdf/virtual-care/ReportoftheVirtualCareTaskForce.pdf

World Health Organization (2018) WHO releases new International Classification of Diseases (ICD 11). https://www.who.int/news/item/18-06-2018-who-releases-new-international-classification-of-diseases-(icd-11)

chiropractic.on.ca
Tel: 416-860-0070 | Toll-free: 1-877-327-2273
oca@chiropractic.on.ca | Fax: 416-860-0857
70 University Ave., Ste. 201, Toronto, ON M5J 2M4

Ontario
Chiropractic
Association