Veterans Affairs Canada | Anciens Combattants Canada

Renewal of Treatment Benefits

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This policy replaces the following VPPM 2 policy: 2.2.26 Renewal of Benefits.

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Purpose

This policy provides guidance on renewing treatment benefits provided for clients under the *Veterans Health Care Regulations (VHCR).* The objective of the policy is to allow for reasonable flexibility when VAC decision makers are processing requests for subsequent issuances of a previously approved benefit.

Policy

Definition

1. *Renewal of Benefits* means providing a replacement item and/or re-issuing a new treatment benefit that has previously been provided as an appropriate intervention to address an ongoing need. In the context of this policy, it is specifically for a chronic condition for which the level of disability is relatively stable. This is in contrast to a treatment benefit that was previously approved in response to an acute condition or in response to a chronic condition for which the level of disability is unstable. In those cases, renewing the benefit would not normally be appropriate.

General

2. Requests for re-issuances or replacements of treatment benefits should be processed in a timely manner, in accordance with eligibility. In certain circumstances, treatment benefits may be renewed without rigid application of certain administrative requirements that are associated with the original issuance of the treatment benefit in question.

3. In general, prescriber and/or recommender requirements that are in place for initial issuance may not add value when applied to replacement issue when replacement or re-issuance can reasonably occur without compromising the level of care and when the request is to renew a benefit that is relatively low in cost; when renewing the benefit is not expected to pose a risk to the client's health; and when there would be little or no value added by requiring the client to obtain a prescription. See paragraph 7 for further guidance.
4. The intent of this policy is not to automatically approve a benefit simply on the basis that the benefit was provided in the past. Rather it is to allow for discretion in determining whether it is reasonable to renew a benefit without adhering to pre-requisites that were intended for initial issuance.
5. Prescriber requirements and other benefit grid pre-requisites may only be waived when the delegated decision-maker has determined that it is reasonable to do so given the circumstances of the case.
6. This policy does not apply in the case of a VAC treatment benefit for which there is a legal requirement for a prescription (e.g. pharmaceuticals). In those cases, the prescription must be obtained before VAC can provide the benefit. No exceptions can be made in these cases.

Principles

7. Prescriber/recommender requirements that are in place for initial issuance may not apply to replacement issue when:
    a. the client has already been receiving the benefit based on a need that was confirmed by the specifically required prescriber – i.e., the original prescriber requirements were met upon initial issue; and
    b. there is evidence that the level of disability is relatively stable and that the treatment needs have not changed significantly; and
    c. there is no indication that continuing to provide the benefit will result in a health or safety risk to the client; and
    d. the benefit that the client is requesting to have replaced is the same as, or is similar to, the item that was previously approved by VAC and the need to replace the benefit is reasonable.

Application

8. Renewal of Benefits in the Absence of a Prescription - In situations where a VAC benefit was originally provided based on a prescription as per the Benefit Grids, a prescription may not be required in order to provide the same benefit or item on a subsequent occasion. The requirement of a prescription can be waived when it is deemed reasonable given the principles noted in paragraph 7.
    a. This provision does not apply in the case of a VAC treatment benefit for which there is a legal requirement for a prescription (e.g. pharmaceuticals). In those cases, the prescription must be obtained before VAC can provide the benefit. No exceptions can be made in these cases.
9. Renewal of Benefits for Clients Who No Longer Meet Benefit-Specific Approval Criteria - Where a client has been previously approved for a health care benefit from the Department, but does not meet revised benefit approval criteria (for reasons including changes in departmental policy or in the benefit grids), the requested benefits may be continued to the client even when the request does not meet the revised criteria.
10. Renewal of Benefits in the Absence of a Specialist's Prescription or Recommendation – In certain circumstances, initial issuance of a particular benefit requires the recommendation and/or prescription of a medical specialist (e.g. orthopaedic surgeon, etc.). When a client was approved the initial issuance based on a specialist's recommendation/prescription, a re-issuance or replacement may be approved without the need to have the specialist provide a subsequent recommendation and/or prescription.

11. Renewal of Benefits for Case-Managed Clients - Case-managed clients who have a request for a benefit renewal that is identified and supported in an approved case plan are generally not required to further substantiate their need.
12. Former CF Members - In some cases, VAC clients may request a renewal of a benefit that was initially provided to them by the CF. VAC may renew the benefit in those cases where a client has VAC program eligibility for the benefit and when it is deemed appropriate to renew the benefit given the Principles section.

Exclusions

13. This policy provides general principles to be considered in benefit delivery decisions and shall not supercede a specific policy provision in those cases where a program policy provides specific clinical criteria with respect to the issuance, replacement and/or continuation of a benefit (e.g. POC 3 Audio Services and POC 9 Oxygen Services,). Also, this policy does not apply to the services which are referenced in POC 12; Related Health Services as POC 12 policies provide relevant principles which address continuation of these services. The intent and principles in the policy would not normally allow for renewal of Nursing (POC 8) and other services nor for Prescription Drugs (POC 10) benefits. This policy does not apply to Health-Related Travel.
14. This policy does not apply to those clients who do not continue to maintain their eligibility to access health care programs as per Section 3 of the *Veterans Health Care Regulations*. Decisions for treatment benefits for clients who have lost their program eligibility for health care are to be in accordance with the policy on the Termination of Benefits, Services and Care.
15. This policy does not apply in circumstances when the initial issuance of a benefit was in error or was otherwise inappropriate.

References

Veterans Health Care Regulations

VAC Benefit Grids