PSHCP BULLETIN

Number 8 http://www.njc-cnm.gc.ca **November 1999**

In this issue:	Services of a naturopath	Prostatic Specific Antigen (PSA) tests	Electrolysis treatments	Out-of-province referral benefit

The services of a naturopath

The Public Service Health Care Plan (PSHCP) Health Practitioners Benefit provides reimbursement for the services of a number of health practitioners, including the services of a **naturopath**. For the purposes of the PSHCP, a “naturopath” means a member of the Canadian Naturopathic Association or any provincial association affiliated with it, or in the absence of such an association, a person with comparable qualifications as determined by the Administrator.

Where a provincial association exists, a naturopath must be registered with it in order to practice in that particular province. In Ontario, for example, the Drugless Practitioners Act requires that naturopathic doctors register with the Board of Directors of Drugless Therapy – Naturopathy. Claims for the services of a naturopath practicing in Ontario but not registered with the Board of Directors of Drugless Therapy are **not** eligible under the PSHCP.

In British Columbia, many naturopathic services are covered by the provincial health plan. As long as the provincial health plan pays for a portion of naturopathic services, however, British Columbia legislation prevents a supplementary health plan from considering any amounts that exceed the fee schedule. Plan members in British Columbia may only submit expenses for naturopathic services to the PSHCP once they reach the maximum amount covered by their provincial plan.

Under the PSHCP, the current maximum eligible expense for naturopathic services is $300 per calendar year. Eligible expenses for naturopathic services are reimbursed at 80%, after the plan’s annual deductible amount is satisfied. This means that if you claim the full $300, your maximum reimbursement will be $240 (80% of $300).

Prostatic Specific Antigen (PSA) test

A Prostatic Specific Antigen (PSA) test is an eligible expense under the PSHCP when it is used to monitor PSA levels to assess treatment success **following** the detection of prostate cancer. A PSA test performed for initial or routine screening purposes is not eligible under the plan. When submitting claims, please ensure that the invoice clearly indicates the reason for the test.

A PSA test used for monitoring purposes is eligible under the physician’s services provision of the Health Practitioners Benefit. Under the PSHCP, a physician’s service must be medically necessary **for the treatment of a disease or injury**. A PSA test used for monitoring purposes forms part of the physician’s treatment of a disease, and is therefore an eligible expense. A PSA test used for screening purposes does not fall in this category.

Electrolysis treatments

The PSHCP provides reimbursement for the removal of excessive hair from exposed areas of the face and neck in cases where the plan member suffers from severe emotional trauma as a result of this condition.

Electrolysis treatments for the above purpose are eligible under the PSHCP if performed by either a **physician (including a dermatologist) or an electrologist**. If an electrologist performs the services, however, the PSHCP requires a psychologist's or psychiatrist's prescription. An original prescription from a psychologist or psychiatrist is valid for a three-year period, at which time it must be renewed to confirm continuing medical necessity.

Needle electrolysis is the only method eligible for reimbursement under the PSHCP because currently it is the only medically proven treatment that results in **permanent** hair removal.

The current maximum eligible expense for electrolysis treatments is $20 per visit. Eligible expenses are reimbursed at 80%, after the plan's annual deductible amount is satisfied. This means that if you claim $20 or more for each visit, your maximum reimbursement will be $16 (80% of $20).

Out-of-province referral benefit

In certain situations where medical treatments or services **are not offered in your province of residence**, the PSHCP out-of-province referral benefit may provide reimbursement for expenses that exceed the amount covered by your provincial health plan. This includes medical treatments or services rendered in another province or outside Canada.

The PSHCP out-of-province referral benefit covers only public ward accommodation in a general hospital, and the services of a physician or surgeon. You must have a referral from the attending physician **in your province of residence** for the plan to consider these expenses.

Since these costs are often significant, before receiving a medical treatment or service outside your province, the Board suggests that you first contact the Administrator, Sun Life, to determine whether or not the expense is eligible under the PSHCP.

If the particular medical treatment or service is offered in your province of residence, such expenses incurred outside your province are not eligible under the PSHCP, even if factors such as distance or waiting lists are involved.

The maximum eligible expense under the out-of-province referral benefit is $25,000 per illness. Eligible expenses are reimbursed at 80%, after the plan's annual deductible amount is satisfied. This means that if you claim the full $25,000, your maximum reimbursement will be $20,000 (80% of $25,000).

The *PSHCP Bulletin* is produced by the Public Service Health Care Plan (PSHCP) Board of Management to provide you with benefit and administrative information about your health care plan.