

# NOVA SCOTIA DEPARTMENT OF HEALTH CONTINUING CARE BRANCH

---

**Subject: Special Needs Policy - Long Term Care**

---

Original Approved Date: December 22, 2004 Revised Date: December 1, 2008

*Original signed by Keith Menzies*

Approved by:

\_\_\_\_\_  
Keith Menzies, Executive Director, Continuing Care Branch

---

## **1.0 POLICY STATEMENTS**

- 1.1 The Department of Health may provide funding of special needs for eligible residents of long term care. Special needs are provided within established frequency, quantity and cost limits. Items or services purchased as a special need will be competitively priced, cost-effective and appropriate for the resident.
- 1.2 A resident's personal resources, above a designated threshold amount, must be applied to the cost of the required item before special needs funding from the Department of Health is available.
- 1.3 Items not specifically referenced or identified in this policy are not available for funding as a special need.

## **2.0 APPLICATION OF THE POLICY**

- 2.1 This policy applies to regular bed residents of Department of Health long term care facilities who were living in a facility as of December 31, 2004 and who were receiving assistance under the Social Assistance Act, and who have chosen to maintain their special needs eligibility.

### **3.0 GLOSSARY OF TERMS**

*Assigned maximum value* - the maximum amount allowed for a specified item within policy.

*Assistive Devices* - medical equipment or devices that are basic and essential to facilitate and promote independence and improve the quality of care, as referenced within this policy.

*Attendant* - a person approved to provide one-on-one staffing as part of a resident's individual care plan. Attendant costs may be available as a benefit under the *Over Cost Fund Policy* and are not provided as a Special Need.

*Continuing Care Services* - Home Care, Self Managed Care, Long Term Care and Adult Protection services provided by Continuing Care Branch, Nova Scotia Department of Health.

*Escort* - a person who accompanies a resident to a medical appointment. The provision of an escort can serve to address various needs, including resident safety and communication issues. Resident escort may be provided by facility staff or other appropriate individuals. Escort costs may be provided to publicly assisted residents under the Special Needs Policy.

*Fiscal Year* - for the purposes of this policy is defined as the 12 month period between April 1st and the following March 31st.

*Long Term Care* - includes licensed Nursing Homes and Homes for the Aged, licensed Residential Care Facilities, and approved Community Based Options (Small Options and Community Residences) under the mandate of the Department of Health.

*Publicly assisted resident* - an individual who is in a regular bed and who has resided in a long term care facility up to and including December 31, 2004, and who was receiving financial assistance from the Department of Health exceeding \$12.75 per day and who has not opted to be assessed under the policies in effect as of January 1, 2005.

*Resident* - is a person who is receiving care in a licensed Nursing Home, Home for the Aged, Residential Care Facility or approved Community Based Option under the mandate of the Department of Health.

*Specialized Equipment Program* - a program administered by the Red Cross which provides specialized equipment to eligible residents of Department of Health long term care.

*Special Needs* - are limited to items as defined within this policy.

#### **4.0 POLICY OBJECTIVES**

The approval of special needs will be based on the following operational principles:

- 4.1 Special Needs may be provided to supplement the assistance available from the resident's personal resources, informal support network and/or other funding sources.
- 4.2 There is a specific indication that the provision of the special need is required and will benefit the resident.
- 4.3 Continuing Care will fund the most cost effective option available which meets the identified need.
- 4.4 The process for determining eligibility is consistent and equitable.
- 4.5 Cost limits defined in this policy are standardized maximum funding rates allowable for the specified item under the Special Needs Policy.
- 4.6 Residents choosing alternate or upgraded items are responsible for paying any additional costs.
- 4.7 Items available as a benefit through the Over Cost Fund or the Specialized Equipment Program are not provided or funded as a special need.

#### **5.0 ELIGIBILITY CRITERIA**

A resident is eligible to apply for special needs funding through this policy under the following criteria:

- 5.1 the individual was residing in a Department of Health facility as of December 31, 2004, is publicly assisted and has chosen to maintain eligibility for special needs, and
- 5.2 the individual does not have the personal resources to cover the cost of the requested special need, and
- 5.3 the individual is not eligible to receive assistance in obtaining the requested special need from any other program or source of funding, such as a private medical or insurance plan, and
- 5.4 there is an identified and documented requirement for the special need.

## **6.0 RESIDENT CONTRIBUTION REQUIREMENT**

- 6.1 Residents are required to apply personal resources, which are above the designated threshold and which are held in the resident's savings or trust accounts, toward the cost of required items.
- 6.2 A resident's personal resources up to the amount of \$1,000.00 are not required to be applied to the cost of an approved item of special need, except in the case of an application for assistance with funeral costs. For funerals, refer to Section 17 of this policy.
- 6.3 Where a resident's personal resources, above the designated threshold amount, are sufficient to cover the cost of the required item, the Department of Health shall not pay for or contribute to the cost of the item.
- 6.4 Where a resident's personal resources, above the designated threshold amount, are not sufficient to cover the full cost of the required item, the Department of Health shall pay as a special need the difference between the resident's personal resources above the designated threshold amount and the total cost of the item.

## **7.0 APPLICATION AND APPROVAL PROCESS**

- 7.1 Requests for special needs must be submitted and approved prior to the purchase or provision of the item requested, unless otherwise stated in this policy. **Retroactive payment or coverage of special needs will not be approved.**
- 7.2 All requests must be submitted to the Care Coordinator on the approved Special Need Request and Authorization Form.
- 7.3 The Care Coordinator reviews the request to ensure it is completed properly and that all required supporting documentation is present.
- 7.4 The Care Coordinator is the approval authority for special needs requests, except where otherwise noted in the policy.
- 7.5 For recurring items, approval may be granted for a period up to one (1) year, unless otherwise stated in this policy.

## **8.0 APPROVAL OF VARIANCE**

8.1 Where there are frequency or quantity limits or an assigned maximum value defined in this policy for specific items and where the approval authority for the requested item is the Care Coordinator, a Supervisor may approve a variance from the defined limit or assigned maximum value, upon application and subject to the following conditions and requirements:

- there is written documentation to support that the maximum allowed for the item of special need is insufficient to cover the requirements in the particular case,
- two quotes for the item must be provided,
- the variance and reasons for this are documented in the client file.

## **9.0 ATTENDANT CARE**

9.1 *Coverage for attendant care is provided to eligible Department of Health long term care residents as a benefit under the Over Cost Fund Policy and is not provided as a special need.*

## **10.0 CLOTHING/FOOTWEAR ALLOWANCE**

10.1 Each eligible resident may apply for a clothing/footwear allowance to a maximum of \$300 per fiscal year.

10.2 Receipts are required for items purchased and must be submitted at the time of billing.

10.3 Unused portions of the allowance cannot be carried forward to the next fiscal year.

## **11.0 COMPRESSION SLEEVES**

11.1 Coverage for the cost of compression sleeves may be approved when there is a physician's order.

11.2 Two quotes must be obtained and submitted with the special needs request.

## **12.0 COMPRESSION STOCKINGS**

12.1 Coverage for the cost of compression stockings may be approved when there is a physician's order. The physician order must identify stocking length and level of compression.

12.2 Approval of compression stockings is subject to the following criteria and conditions:

- the level of compression is 20 mm of mercury or above.
- the resident may be approved for a maximum of two pairs per year, except where there is a change in the level of compression required, as documented by a new assessment and physician's order.
- 2 quotes must be obtained and submitted with the special needs request.

### **13.0 CO-PAYS ON PRIVATE DRUG PLANS**

13.1 Publicly funded residents who access prescription medications through a private medical insurance plan may apply to have co-pay amounts covered as a special need, provided that the medication is a covered benefit under the Nova Scotia Pharmacare Formulary.

### **14.0 DENTAL SERVICES**

14.1 Publicly funded residents may be eligible to receive coverage for emergency dental care, as well as for the cost of dentures.

14.2 Dental coverage will be provided under the following circumstances:

- for the relief of pain;
- for control of prolonged bleeding;
- for treatment of swollen tissue;
- for provision of dentures or repair of broken dentures.

14.3 The cost of an initial examination for the purposes of determining the nature of the problem, any required course of treatment, and the projected cost of the treatment, will be covered without prior approval.

14.4 Dentures will be approved one time only, and will be replaced one time only.

14.5 Dentures shall be obtained by the most economical means. If dentures are provided by a dentist, the dentist must be licensed in the province of Nova Scotia to do so.

14.6 Except for the cost of an initial examination, the cost of dental services will not be reimbursed without prior approval. A detailed statement from the dentist/denturist must accompany the request and should include procedures, codes and fees. Only one quote is required for dental services.

14.7 The cost of dental services will be covered at 100% of the rate published in the current fee guides established by the Nova Scotia Dental Association and the Nova Scotia Denturist Society.

## **15.0 ESCORTS TO MEDICAL APPOINTMENTS**

15.1 Eligible residents may apply for Special Need coverage of the costs for an escort to approved medical appointments. Approved medical appointments include:

- attendance at physician appointment;
- attendance at dentist/denturist appointment
- attendance at an ambulatory care clinic;
- attendance at OT/PT assessment and treatment;
- attendance at diagnostic services.

15.2 The facility is responsible to make arrangements for the most cost effective escort for the resident. No administrative fee may be charged by the facility for arranging this service.

15.3 Coverage of escort costs are provided in accordance with the following criteria:

- there is a demonstrated need for a person to accompany the resident to the medical appointment.
- funding is not provided if the escort is provided by a facility staff person working a scheduled shift on the day of the appointment.
- funding is provided for the actual period of the resident's absence from the facility.

15.4 Escort costs may be approved by the Care Coordinator as a recurring need for a period of up to 12 months..

15.5 Family members are not paid to escort residents to appointments.

15.6 Billing submissions for escort costs must include identification of the resident, a copy of the approval form, level of provider (e.g. CCA, PCW, etc.), duration of escort period and date of occurrence for each transaction billed.

## **16.0 EQUIPMENT**

16.1 *Equipment available as a benefit through the Specialized Equipment Program is not provided as a special need.*

## 16.2 Covered Equipment

16.2.1 Coverage for the costs of positive airway devices (e.g. CPAP, BiPAP) and related supplies may be provided in accordance with the following criteria:

- ▶ the equipment is prescribed by a respirologist or sleep medicine (board certified) specialist in conjunction with a respirologist,
- ▶ there is a diagnosis of sleep apnea confirmed by one of the following:
  - polysomnography in a sleep laboratory
  - a community based respiratory study
  - oximetry and clinical presentation
- ▶ two quotes are obtained.
- ▶ the resident must undergo a trial period with the equipment to determine acceptability and appropriateness of treatment. Costs for the trial are covered as a special need and are to be deducted from the total cost of the equipment, if it is purchased.
- ▶ approval from a Supervisor is required.

16.2.2 Resident specific equipment to meet the unique needs of residents on the Children's Unit.

16.2.3 Wheelchair batteries, tires and low-cost items such as arm pads for resident specific equipment that is not provided through the Specialized Equipment Program, may be funded as a special need.

## 17.0 FUNERALS

### POLICY

17.1 When a publicly assisted resident dies and does not have sufficient financial resources, or has not made provision to cover funeral expenses, the Department of Health may assist with funeral expenses subject to the terms, conditions and rates contained in this policy.

17.2 The Department may assist with the cost of traditional or cremation funeral services. The cost of professional services or merchandise may be paid to the maximum allowable defined in the *Funeral Rates Schedule* incorporated in this policy.

17.3 The family or representative of the deceased must make application and demonstrate financial eligibility on behalf of the deceased for all or part of the allowable funeral costs. In the absence of family or a designated alternative, the facility Administrator may act as representative for the deceased.

17.4 Application for funeral expenses to be paid for by the Department of Health as a special need **must submitted prior to proceeding with the funeral, or on the first business day following the death of the resident.**



- 17.5 It is the responsibility of the family or representative of the deceased to apply for the Canada Pension Plan Death Benefit. The CPP death benefit amount is to be applied against the maximum allowable funeral costs. In the absence of a family member or representative, the Eligibility Review Unit will apply for the Canada Pension Plan Death.
- 17.6 Funeral arrangements and payment of the client's portion of funeral costs are the responsibility of the individual representing the deceased and the funeral home.
- 17.7 The Department of Health is not responsible for any failure of the family/estate or representative of the deceased to pay the funeral director or any other person/business for funeral related expenses.

### PROCESS

- 17.8 The long term care facility will inform the next of kin of the resident's death and make arrangements for the removal of the body to an appropriate funeral home.
- 17.9 The family or representative of the deceased makes a request for assistance with funeral costs. The facility will submit a Special Needs request form on behalf of the family to the Care Coordinator. The facility is to include with the request, complete information on the following:
- the date of death,
  - the balance in the resident's trust or savings accounts, including GST account,
  - excess income in the month of death,
  - the amount of the Canada Pension Plan Death Benefit, if applicable,
  - funeral home price quotation, including the cost break out for services and disbursements.
- 17.10 The Care Coordinator will forward the Special Needs request to the Eligibility Review Unit intake with the supporting information and a copy of the resident's initial financial application and/or case notes as appropriate.
- 17.11 The Eligibility Review Unit will:
- review the application and any supporting documentation, to ensure that all chargeable income, such as private insurance, resident savings and trust accounts, CPP Death benefit amount, excess income in the month of death, etc. is applied against the maximum allowable cost of the funeral;
  - determine the resident's eligibility for funeral coverage and return the signed Special Need request form to the Care Coordinator with an identification of the approved Continuing Care contribution to the funeral costs.
- 17.12 The facility will pay the Department of Health approved amount to the funeral home and bill Continuing Care for the approved amount.

- 17.13 Billing submissions for funeral costs must include: identification of the resident, a copy of the Special Needs approval form, a copy of the funeral home quotation, and a copy of the invoice submitted by the funeral home as per the approved *Funeral Rates Schedule*. The disbursement section will be itemized. The invoice will include professional services and merchandise, disbursements and applicable taxes.

#### ALLOWABLE COSTS

- 17.14 The total maximum cost for a publicly funded funeral may not exceed the amount established in the *Funeral Rates Schedule*.

- 17.15 Any third party contribution will be applied within the cost limits established in the *Funeral Rates Schedule* and will reduce the Department of Health share of funeral costs accordingly.

#### 17.16 Funeral Rate Schedule

The funeral home may invoice for services and merchandise rendered in accordance with the following schedule of allowable expenses:

1. Professional Services and Merchandise up to a maximum total of \$2,700 plus taxes.
2. Disbursements for one or more of the following, to maximum total of \$1,100 plus taxes:
  - cemetery charges (open, close, clean up grave, burial permits, etc.)
  - grave liner (wooden)
  - crematory fee & return of ashes
  - urns
  - cemetery equipment & set up
  - radio/newspaper notices
  
  - clothing for the deceased
  - honorariums (clergy, music, etc.)
  - grave lot
3. Mileage over twenty-five kilometres for the funeral coach may be paid on a per kilometre basis at a rate of 60 cents per kilometre, to maximum of \$100.00
4. Any exceptions requested to the approved funeral costs must be approved by the Manager, Eligibility Review Unit.

## **18.0 HEARING AIDS**

- 18.1 A resident may be assisted with the purchase of hearing aids when the need is supported by a hearing assessment. Hearing assessments must be conducted by an Audiologist or a Hearing Instrument Specialist. The hearing assessment must accompany the special need request and authorization form.
- 18.2 Residents may be funded up to a maximum of \$60 to cover the cost of a hearing assessment.
- 18.3 Hearing aids are provided to meet the basic needs of the resident. Continuing Care will fund the cost of the minimum equipment essential to meet the identified need. Residents choosing upgraded items are responsible for paying any additional costs.
- 18.4 Requests to cover the costs of hearing aids must be submitted to the Care Coordinator and approved before purchasing. Two quotes, from separate providers, must be obtained and submitted to the Care Coordinator. If two quotes are not available, an explanation must be provided.
- 18.5 First time users of hearing aids must have a trial period to ensure the hearing aid is effective. The cost of the ear mold and any required deposit will be covered as a special need.
- 18.6 Hearing aid repairs are covered on an as needed basis.
- 18.7 Hearing aid batteries may be approved as a recurring special need.
- 18.8 A hearing aid will be approved one time only, and will be replaced one time only.

## **19.0 HIP PROTECTORS**

- 19.1 Coverage for the costs of hip protectors may be approved when there is a need assessed by an Occupational Therapist, a Physiotherapist or a Registered Nurse.
- 19.2 Approval for two pairs of hip protectors may be considered to a maximum of \$250.00 per year.

## **20.0 INCONTINENT SUPPLIES**

- 20.1 *Funding of incontinent supplies for residents of nursing homes is included in facility budgets and is not provided as a special need. Funding of incontinent supplies for eligible residents of Department of Health Residential Care Facilities and Community Based Options is provided under the Over Cost Fund Policy and is not provided as a special need.*

## **21.0 MEDICAL INSURANCE**

21.1 Previously approved coverage for medical insurance premiums, which was in place as of December 31, 2004, will continue to be funded as a special need.

## **22.0 MEDICAL SUPPLIES**

**22.1 *Coverage for the costs of resident specific medical supplies, which are necessary for resident care but which exceed typical and expected supply costs is provided through the Over Cost Fund and is not funded as a special need.***

## **23.0 ORTHOTICS**

23.1 Coverage for the costs of orthotics may be approved when prescribed by a specialist physician, orthotist, pedorthist, occupational therapist or physiotherapist. The prescription must accompany the special needs request and authorization form.

23.2 Orthotics, that may be considered for approval are limited to the following:

- custom made standing frame
- leg and spinal braces
- reciprocating gait orthosis
- off loading orthotics, to a maximum of \$300.00
- custom made insoles, to a maximum of \$300.00
- peripheral joint splints, to a maximum of \$300.00
- custom made footwear, to a maximum of \$400.00

23.3 Two quotes must be obtained and submitted to the Care Coordinator for consideration. If two quotes are not available, an explanation must be provided.

23.4 Orthotics may be provided once every two years.

## **24.0 OVER THE COUNTER MEDICATIONS**

**24.1 *Over the counter medications are included in Department of Health Long Term Care budgets, or are provided through the Over Cost Fund and are not provided as a special need.***

24.1 Herbal medications are not funded as a special need.

24.2 Alcohol is not funded as a special need.

## **25.0 OXYGEN SERVICES**

25.1 Oxygen services are provided to Continuing Care clients in accordance with the criteria identified in the *Continuing Care Home Oxygen Services, Procedures and Guidelines*. Refer to this document for additional information.

## **26.0 PERSONAL USE ALLOWANCE**

26.1 The Department of Health shall provide a Personal Use Allowance (PUA) to eligible residents in accordance with the criteria established in the *Resident Charge Policy - Section 6*. The facility shall provide the PUA to the resident and bill this amount to the Department of Health on a monthly basis.

26.2 The Personal Use Allowance is a recurring special need and does not require annual authorization.

26.3 A Personal Use Allowance (PUA) is provided for the personal comfort and enjoyment of the resident. There are no restrictions on the use of these funds by the resident.

26.4 Long term care facilities will hold the Personal Use Allowance and any accumulation in a resident trust account. There is no maximum on the amount of PUA funds that a resident may accumulate.

26.5 The Personal Use Allowance shall be issued to the resident on the first day of each month.

## **27.0 PHYSICIAN FEES**

Coverage for the costs of fees charged by physicians to complete forms or to provide uninsured services is not provided as a special need.

## **28.0 PODIATRY/FOOT CARE**

28.1 Requests for coverage of the cost of foot care services for residents must be accompanied by a physician referral.

28.2 Funding of foot care services may be approved to a maximum of \$360.00 per year.

### **Nursing Home Residents**

28.3 Basic and advanced nursing level foot care is provided by facility staff and is not funded as a special need.

- 28.4 When the foot care service required by the resident is beyond the scope of nursing practice as defined by the professional nursing colleges in Nova Scotia, coverage for the cost of the foot care service may be approved as a special need. A request for coverage as a special need must be supported by a signed rationale from the facility's designated foot care nurse.

**Residents of Community Based Options and Residential Care Facilities**

- 28.5 The costs for basic and advanced nursing level foot care may be covered as a special need.
- 28.6 A physician's referral must be made to the appropriate health care professional, e.g. foot clinic or podiatrist.
- 28.7 Foot care services may be approved as a recurring need on an annual basis.

**29.0 PROGRAMS/COURSES**

- 29.1 Residents may be assisted with the cost of a program when the goals of that program meet the unique intellectual, mental health and/or behavioral needs of the resident, as identified in the resident's approved care plan.
- 29.2 Coverage for the costs of programs/courses requires approval from a Supervisor and may be approved for a maximum period of one year.
- 29.3 The costs for Seniors/Adult day programs will not be funded as a special need for residents of Nursing Homes or Residential Care Facilities.

**Travel Costs**

- 29.4 Where there are travel costs associated with the resident's participation in an approved program, these must be included in the special needs request as a separately identified cost.
- 29.5 Costs of the resident's travel to an approved program may be funded to a maximum amount of \$150.00 per month.
- 29.6 It is the responsibility of the facility to make arrangements for the most cost effective means of transportation for the resident.

**30.0 SMOKING CESSATION PRODUCTS**

- 30.1 Request forms should be completed and submitted to the Care Coordinator.
- 30.2 Smoking cessation products will be funded as a one time only special need.

- 30.3 With a medical prescription from the resident's physician, the following smoking cessation products may be approved:
- a) The nicotine patch will be funded as a special need for a period of three (3) months.
  - b) A nicotine inhalator will be funded as a special need for a period of three (3) months.
  - c) One full treatment of bupropion (Zyban™) may be funded as a special need.

### **31.0 SPECIAL DIETS**

- 31.1 *The costs of special diets are included in long term care facility budgets and are not provided as a special need. Additional costs for tube feeds may be covered in accordance with the Over Cost Fund policy.*

### **32.0 SPECIMEN COLLECTION SERVICES**

*Note: Specimen collection services means the collection of the specimen and the transport of the specimen to the laboratory site.*

#### **32.1 Nursing Home Residents**

- Specimen collection services are the responsibility of the facility and are not covered as a special need.

#### **32.2 Residents of Community Based Options and Residential Care Facilities**

- Coverage for the cost of specimen collection services may be approved when there is a physician's order.
- The facility is responsible to make arrangements for the most cost effective means of specimen collection services.
- Costs for ongoing specimen collection may be approved as a recurring need, for a period not to exceed twelve months. Examples of situations requiring ongoing specimen collection include INR, management of therapeutic drug levels, etc.

### **33.0 THERAPY SERVICES**

- 33.1 Coverage for the costs of Occupational Therapy and Physiotherapy services for the purposes of individual assessment and treatment plans may be approved, when these services are not funded in the facility's budget.

### **34.0 TRANSPORTATION**

34.1 *Transportation available as a benefit under the Over Cost Fund Policy is not provided as a special need.*

#### Emergency Transportation

34.2 Emergency transportation means transport by ambulance resulting from a 911 call.

34.3 Where an eligible resident is transported by ambulance in an emergency, the facility is required to submit a Special Need Request/Authorization form, to the Care Coordinator for billing approval purposes. For each transaction billed, the information provided is to include identification of the resident, date of the transport, reason for the emergency transport and a copy of the ambulance bill.

#### Non-emergency Transportation

34.4 Eligible residents may apply for Special Need coverage for the cost of inter-facility transfers or non-emergency transportation to approved medical appointments only. Approved medical appointments include:

- attendance at physician/dental appointment;
- attendance at ambulatory care clinics;
- attendance at OT/PT assessment and treatment;
- attendance at diagnostic services.

34.5 Coverage of transportation costs is only provided where the medical service required by the resident is not provided in the facility.

34.6 The facility is responsible to make arrangements for the most cost-effective transport of residents.

34.7 Non-emergency transportation to medical appointments may be approved by the Care Coordinator for a period of up to 12 months. Approval of transportation on a recurring basis is subject to the following criteria and conditions:

- the requested transportation is for an approved medical appointment,
- the request for approval indicates a specific mode of transportation to be used and details of the resident's specific needs supporting the identified mode,
- any change in the mode of transportation, which will result in an increase in cost, requires the submission and approval of a new request prior to the appointment,



- billing submissions for transportation costs must include identification of the resident, a copy of the approval form and the date and appointment type for each transaction billed.

34.6 Mileage or other expenses for family members to provide transportation for residents is not provided as a special need.

### **35.0 VISUAL AIDS**

35.1 Eyeglasses and intraocular lenses are provided to meet the basic needs of the resident.

35.2 Approval to cover the costs of visual aids must be received before items are purchased.

#### **35.3 Eyeglasses**

- A resident may be assisted with the purchase of eyeglasses when prescribed by an optometrist or physician. The prescription must accompany the special need Request and Authorization Form.
- Residents may be eligible for the cost of eyeglasses subject to the following restrictions.

The maximum rates for eyeglasses are:

- \$90 for single vision orders with regular glass or CR39 plastic lenses complete with frame;
- \$110 for bifocal orders with Kryptok (round segment) or flat-top glass or CR39 plastic complete with frame.

Special lenses, at additional cost, may be covered when prescribed by an optometrist or specialist physician subject to the following restrictions:

- no coverage will be provided, under any circumstances, for any cosmetic purpose. This includes, without limiting the generality of the previous statement, progressive (invisible) bifocals and anti-reflective coatings, except on high index lenses.

High index lenses will only be provided if the prescription equals or exceeds -5.0 diopter.

The provision of eyeglasses will be limited to a maximum of once every two years, unless there is a medically substantiated reason for new eye wear by the optometrist or physician.

Residents choosing upgraded or optional items are responsible for paying any additional costs.

Eyeglass repairs are covered on an as needed basis.

- Residents under the age of 65 may be funded for the cost of a routine eye examination to a maximum of \$50.00, once every two years. Eye examinations for residents over the age of 65 are covered by MSI.

#### 35.4 Intraocular Lenses

- The costs associated with polyacrylic intraocular lenses will be covered when recommended by the specialist physician. The rate paid for pre-surgery examinations and lenses are those set by the District Health Authority.

### 36.0 APPEALS

Appeals related to Special Needs are made under the *Financial Decision Review Policy* contained in Continuing Care's Long Term Care Policy Manual. This manual may be viewed at

<http://www.gov.ns.ca/health/ccs/>.