

Data Entry Centre (DEC)
Instructional Manual

Version 8
Published on May 2011



This document contains information that is critical to the successful submission of OCF forms to the HCAI Data Entry Centre. Please review carefully.

Note: HCAI is not able to provide one-on-one training to health care Health Care Facilities that chose to use the DEC. Health Care Facilities must rely on the User Manual provided and refer to training materials located at www.hcaiinfo.ca. Also, you may wish to contact your health professional association for additional guidance.

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Chapter 1 Managing the Health Care Facility and the Health Providers Associated with the Facility

1.1 Why is it important to understand this section?

A Health Care Facility is a health business, clinic or practice. The Data Entry Centre (DEC) must have up to date information about the health professionals that generate revenue for your Health Care Facility. If you don't inform the DEC about changes/updates to your Health Care Facility, you will not be able to submit OCF forms successfully.

1.2 Register all health professionals that will be delivering care to your patients on behalf of your Facility.

- Health Care Providers must be registered or associated as "Providers" for your Facility. Association does not imply any compensatory relationship between your Health Care Facility and the Provider.
 - If you do **not** register a Provider with the DEC, you will not be able to submit OCFs that name that person as a Provider.
 - A Provider is any health care Provider, regulated or unregulated, that will deliver goods and/or services to patients of the Health Care Facility that is registered with HCAI.
 - A Provider may be associated with one or more different Facilities.
- Administrators and non-health Provider staff can also be registered as Providers, but they must be assigned a profession that is non-specific, such as "Other Paramedical".
- Instructions to register or update a health professional are in section 1.4.

1.2.1 How do I manage referrals to external service Providers (other health facilities) or equipment suppliers?

- Only Health Care Providers *registered* or *associated* with your facility may be referenced on OCF forms.
 - To associate a Provider with your facility, make sure s/he is registered or named as a Provider when you first enrol your Health Care Facility. If you have forgotten to add a Provider or wish to update your roster of Providers, use the change form attached to this document as Appendix B.
- If one of your health Providers makes a referral to an external company for goods or services, your OCF forms must reference the Provider (associated with your Facility) who made the referral for the provision of external services or equipment. That Provider is in effect "responsible" for the goods.
 - Use the notes section of the form to offer the insurer additional details if you wish.

Example:

Mary Smith (health Provider associated with your Facility) has recommended *theraband* for a home exercise program, and Joe Jones (health Provider associated with the facility) has recommended a *light weight vacuum cleaner*. Both of these items will be supplied by Acme Home Health Company and Acme will bill the insurer directly for the services.

Provider Reference	*Provider Type	Provider		Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate (if applicable)
		Last Name	First Name			
A	PT	Smith	Mary	4657		\$94.09
B	OT	Jones	Joe	7950		\$94.09
C						
D						
E						
F						

Part 12 Proposed Goods and Services									
To the extent possible, this Treatment Plan should include all goods and services (G/S) contemplated by the Health Professional/Facility or Social Worker for the period of this Treatment Plan									
G/S Ref	Description	*Code	*Attribute	Provider Ref	Estimate / Day			Projected	
					Quantity	*Measure	Cost	Total Count	Total Cost
1	Assessment	H00MR		A	1	HR	94.09	1	94.09
2	Exercise - multiple body sites	1ZX02		A	.25	HR	23.52	12	282.24
3	Theraband for home exercise	G0014		A	1	GD	10.00	1	10.00
4	Light weight vacuum cleaner	G0040		B	1	GD	59.00	1	59.00
5									
6									
7									
8									
9									
10									
11									
12									
13									
Estimated duration of this Treatment Plan:				6	weeks	Sub-Total:		445.33	
*How many treatment visits have you already provided:				0	*visits	Minus MOH:			
Note 1: Refer to the User Manual at www.hcaiinfo.ca for coding.						Minus Other Insurer 1 + 2:			
Attributes codes are used to further qualify the service codes and are described in the manual.						GST (if applicable):		0.50	
Payment by auto insurer is secondary to available collateral benefits.						PST (if applicable):			
						Auto Insurer Total:		445.83	
*Please indicate any additional comments regarding proposed goods and services: Theraband and vacuum will be supplied by Acme Home Health Company. Acme will invoice directly for these items.									
Are there any attachments? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
If Yes, how many? 2									
Send any attachments directly to the insurer									

1.3 Facility Change Form

If a Health Care Facility's address, phone, fax or other key details change, the DEC must be notified by means of a Facility Change Form.

This information cannot be submitted by telephone or email.

- To submit changes you must complete Facility Change Form or Provider Change Form.
- Copies of the change forms described in this section are appended to this document. Change forms can also be obtained from www.hcaiinfo.ca and from the HCAI- Data Entry Centre Contact Centre at 1-866-348-9133.
- **Complete the Facility Change Form:**
 - Complete required sections of the form

- **The Owner/Authorizing Officer must sign the form once changes are recorded**
- **Submit form via fax (1-866-346-6744) or mail to:**

**HCAI Processing – Data Entry Centre
PO Box 254
Orangeville, ON L9W 2Z6**

- The request will be completed within 48 hours of the request being received at HCAI Processing – Data Entry Centre.

1.3.1 Change in Authorizing Officer (AO)

- When the Health Care Facility enrolled for the HCAI DEC, an authorizing officer signed a contract that authorized the Facility to use HCAI.
- Only the person that signed the original contract may authorize changes in the Facility.
- If the AO changes, the Facility Change Form must be submitted PRIOR to the change, and it must be signed by the **new** authorizing officer.

1.4 Provider Change Form

1.4.1 Adding new health Providers or correcting health Provider information

The only way that the DEC can recognize a Provider as one authorized to deliver services for the facility is through enrolment with the HCAI DEC.

NOTE: If an OCF is submitted with a Provider that has not been registered with the DEC, the form will not be submitted and an error report will be returned to the Health Care Facility.

To add a new Provider or to remove a Provider:

- Complete and submit the Provider Change Form (attached as Appendix C)
- The request will be completed within 48 hours and must be completed before you submit OCF forms proposing or invoicing for services for any new Providers.
- Each enrolled Provider must have signed the *Dependent Provider Terms and Conditions*, it should be kept on file at the facility.

Note: A Provider's signature on the *Dependent Providers Terms and Conditions* form acknowledges that the Health Care Provider has given the Health Care Facility permission to associate his/her name and registration number with the Facility for the purposes of HCAI.

The form does not authorize the Health Care Facility to use the health professional's signature for the purposes of certifying, supervising or otherwise signing OCF forms.

1.4.2 Removing departing health Providers

If a Provider ceases performing services you must remove the Provider from your facility records. Any changes in Provider information following the initial set-up must be made through the Provider Change Form (attached as Appendix C) submitted to HCAI Processing – Date Entry Centre.

Chapter 2 How to Prepare and Submit OCF (Ontario Claim Forms) to the HCAI Data Entry Centre

2.1 Which Forms Must Be Submitted to the DEC?

The following forms must be submitted to the HCAI DEC:

- OCF-18 – Treatment Plan
- OCF-23 – Pre-approved Framework Treatment Confirmation Form
- OCF-21 – Auto Insurance Standard Invoice

OCF-21As will not be accepted by the DEC unless an OCF-18 has previously been submitted to HCAI through the DEC.

All goods & services on an OCF-21A must be for the same month.

All OCF submitted to the DEC will be transcribed into an electronic form and submitted to the insurer electronically through HCAI.

Other OCFs—such as the OCF-3, OCF-19, OCF-24—should be submitted to insurers via fax or mail.

2.2 How to Avoid Common Errors (use this list as a checklist)

There are a number of common errors that will delay your ability to submit OCFs in a timely fashion to insurers. In the interest of your patients, we recommend that time is invested to learn how to complete OCFs correctly. The most common reasons for FAILED DEC submissions include:

1. Claimant and insurer information not provided
2. Formatting of dates incorrect or data (month, year) missing
3. Formatting of phone numbers (area code MUST be included)
4. Mandatory fields not completed
5. Non-applicable fields completed that should not be completed
6. Injury and intervention coding (codes not provided or invalid codes used)
7. Improper completion of goods and services lines (quantity, measure, cost, total count)
8. Illegible writing, font too small to be read

IMPORTANT: In order to successfully submit OCF via the HCAI DEC, you must take extreme care to complete OCFs properly. We urge all Health Care Facilities to carefully review the OCF User Manuals at www.hcaiinfo.ca to learn how to complete these forms properly. The DEC cannot modify your form, no matter how obvious the correction may seem to you.

2.3 Learn How to Complete OCF Correctly

Much information is available at www.hcaiinfo.ca. If you do not have a computer, these materials can be downloaded from your local library. Alternatively, you may contact your health professional association for guidance.

2.3.1 Complete Mandatory Fields & Do not Complete Non-applicable Fields

- Each OCF form has fields that must be completed. These fields are identified on the paper version of the form.
- Certain fields must only be completed when appropriate.
 - EXAMPLE: OCF-18, Part 7 b): If you select “No” to Part 7b), do not provide additional information in the field beneath the question.

2.3.2 Accurate claimant identifiers

Adjusters will not receive your OCF form (or there will be delays processing the form) unless the OCF form contains:

- Correct **claim and/or policy number**.
 - It is the responsibility of the patient/legal guardian/substitute decision maker to provide you with this important information that is required for an insurer to process the claim.
 - The policy-holder can also be asked for his insurance pink slip, which will contain the policy number.
- Correct **date of birth** formatted **yyyy/mm/dd**
- Correct **date of accident** formatted **yyyy/mm/dd**
- **Gender**
- **Totals**
 - Quantity, measures, costs, counts and totals must be completed.
 - OCF-18 – Must have number of weeks completed, or it will reject.

2.3.3 Completing Line Items for Treatment/Assessment Proposals

There are six mandatory fields that must be completed in order to submit your form successfully (see Figure 1). They are: intervention code, Provider reference, quantity and measure, cost and total count. Figure 1 illustrates correctly completed lines.

Figure 1

Part 12 Proposed Goods and Services									
To the extent possible, this Treatment Plan should include all goods and services (G/S) contemplated by the Health Professional/Facility or Social Worker for the period of this Treatment Plan									
G/S Ref	Description	*Code	*Attribute	Provider Ref	Estimate / Day			Projected	
					Quantity	*Measure	Cost	Total Count	Total Cost
1	Assessment	H00MR		A	1	HR	94.09	1	94.09
2	Exercise - multiple body sites	1ZX02		A	25	HR	23.52	12	282.24
3	Theraband for home exercise	G0014		A	1	GD	10.00	1	10.00
4	Light weight vacuum cleaner	G0040		B	1	GD	59.00	1	59.00
5									
6									
7									
8									
9									
10									
11									
12									
13									
Estimated duration of this Treatment Plan:					6	weeks	Sub-Total:		445.33
*How many treatment visits have you already provided:					0	*visits	Minus MOH:		
Note 1: Refer to the User Manual at www.hca.info.ca for coding.							Minus Other Insurer 1 + 2:		
Attributes codes are used to further qualify the service codes and are described in the manual.							GST (if applicable):		8.50
Payment by auto insurer is secondary to available collateral benefits.							PST (if applicable):		
							Auto Insurer Total:		445.83
*Please indicate any additional comments regarding proposed goods and services: Theraband and vacuum will be supplied by Acme Home Health Company. Acme will invoice directly for these items.									
Are there any attachments? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
If Yes, how many? 2									
Send any attachments directly to the Insurer									

2.4 Coding and description

- The codes are for purposes of classification only.
- The code used determines what description will be conveyed to the insurer.
- **Recommendation:** You may leave the description field blank as the code will populate with the standard ICD10-CA description
 - If you write something in the description field that does not match the ICD10-CA description, it will not be captured and transmitted to the insurer.
- You must have at least one valid injury and intervention code on all form types or the form will be rejected.
- If you wish to offer the insurer more details about the injury or treatment, you may do so as follows:
 - OCF-18: Parts 8, 9 or use an additional page
 - OCF-21: Use additional page
 - OCF-23: Parts 7, 8 or use an additional page
- **Duplicate codes**
 - Do not use duplicate injury codes. If a patient has multiple injury codes, refer to the T codes, which reflect multiple injuries.
 - Make sure there is a valid injury or problem code
- **OCF-21s**
 - Require the use of at least one injury/problem code.
 - When invoicing for assessments, the code should reflect the problem that drove the need for the assessment, even if the assessment uncovered no impairment.
- **AXXOT (Other):**
 - The use of this code may delay processing of your form since the adjuster will not know the type of intervention that is being proposed or billed for.
 - If you use this code, also use the narrative fields available to describe/explain what the “other” service is
 - For AXXOT code, the following units of measure can be used: HR, KM, PG, PR or SN.

2.5 Provider reference

- You must select one Provider for each line item
- If you think more than one Provider might deliver the services on different dates, only apply the name of one Provider. Select the one that is going to be MOST responsible.
 - When you invoice you will tell the insurer exactly which Provider delivered care on which date.

2.6 Quantity

- The quantity is associated with the “Unit Measure”. E.g. *quantity* of GD (goods); HR (hours); PR (procedures); PG (pages); KM (kilometres); SN (sessions).
- Quantity may be a fractional value (i.e. .25; .5; .75; 1.75; etc).
- Quantify reflects the quantity for one unit of the service being described in the line item.

2.7 Unit Measure

- Time units must be in HR (hour) units. Do not use “minutes” as the measure.
- CCI treatment interventions will work with PR (procedure) or HR (hours).
- For any goods and for codes beginning with “G”, use the measure GD (good).
- Session code is SZZPR and may only be used with the unit measure “SN”.

2.8 Cost

- This column must reflect the cost of the line item.
 - For example, If quantity is 1.5 and unit measure is HR – cost must reflect 1.5 hr of the referenced Provider’s time.
- **Do not insert the Provider hourly rate into this column.**
- If you have assigned a Provider a default hourly rate, this rate will be used to calculate the cost of the line item.

2.9 Total Count

- This must be a **whole number**. Do not use fractions in this column.
- Total count reflects the number of times you plan to deliver the particular intervention during the course of a treatment plan.
 - For example, if you plan to deliver exercises during each visit and the patient will attend twice per week for 6 weeks, you would insert 12 under “Total Count”.

2.10 Incomplete line items

- Do not submit partially completed lines for goods and services.
- Even if you leave a cost field blank because you are not charging anything for the service, you must insert 0.00.
- The DEC will not guess at what you intend if you leave a field blank.

2.11 Part 9 of OCF 23: X-Ray codes to be used for line 3 in the description field.

X-Ray of the cervical spine -> CXA or CXB or CXC or CXD

X-Ray of the thoracic spine -> THA or THB

X-Ray of the lumbar spinal -> LBA or LBB or LBC or LBD

X-Ray of the lumbosacral spinal -> LSA or LSB or LSC or LSD

X-RAY CHART:

Code	Type	Description
3SC10	CXA	Cervical Spine (2 or fewer)
3SC10	CXB	Cervical Spine (3 to 4)
3SC10	CXC	Cervical Spine (5 to 6)
3SC10	CXD	Cervical Spine (More than 6)
3SC10	LBA	Lumbar Spinal (2 or fewer)
3SC10	LBB	Lumbar Spinal (3 to 4)
3SC10	LBC	Lumbar Spinal (5 to 6)
3SC10	LBD	Lumbar Spinal (More than 6)
3SC10	LSA	Lumbosacral Spinal (2 or fewer)
3SC10	LSB	Lumbosacral Spinal (3 to 4)
3SC10	LSC	Lumbosacral Spinal (5 to 6)
3SC10	LSD	Lumbosacral Spinal (More than 6)
3SC10	THA	Thoracic Spine (2 or fewer)
3SC10	THB	Thoracic Spine (3 to 4)

2.12 Mandatory Fields

- Forms with blank mandatory fields will receive an error report and will not be processed until all information has been received.
 - The DEC will not guess at what you meant, no matter how obvious it seems to you.

2.13 Calculations and Templates

- If you use Word or Excel templates to prepare OCFs, you must ensure that all **calculations are done to 2 decimal points**. This refers to calculations in each line of goods and services, as well as sub-totals and totals.
 - If your calculations are to more than 2 decimal points, the program may round the amount up or down. This results in an error message because the DEC and HCAI calculations are only done to 2 decimal places.

2.14 Legibility

- **Font**
 - If you use a font smaller than 10 pt and/or bolding, it may render the data illegible to DEC personnel and your OCF may be returned with an error report.
- **Handwriting**
 - If you submit handwritten documents, please take care to print legibly.
 - An illegible form will trigger an error report.

2.15 Providers

- All Providers referenced on the OCF must be associated with your Health Care Facility as a Provider.
- A Provider error may be generated if:
 - The name of the Provider is spelled differently than the spelling submitted to the DEC when the Provider was registered.
 - The DEC has not been informed that the Provider is associated/registered with your facility.
 - The registration number of the Provider is incorrect.

2.16 Signatures

- All signatures required on an OCF must be provided.

2.17 Additional pages with OCF-related Information

- If you need to use additional pages to explain information in the OCF that otherwise does not fit into the fields provided, you may use an additional page. Additional information can be up to 20,000 characters—however, this information must be **faxed or mailed directly to the insurer and will not be transcribed**.

2.18 Associated Documents (attachments)

- Any non-OCF documents sent to the DEC will be destroyed (e.g. other medical reports discharge or progress reports, etc).
- Fax or mail associated documents or attachments directly to the insurer.
 - **Keep the Original or a Copy on file at your Facility.**

2.19 Templates

- If your Facility uses Excel or Word or other templates for the creation of OCF forms, take note of the following:

2.19.1 Incomplete lines of goods and services

If your template shows incomplete lines of goods and services (e.g. intervention code shows on template but service/or good will not be delivered to claimant), put a line through them so the DEC doesn't interpret them as incomplete, which will generate an error report.

2.19.2 Calculations

- If you use Word or Excel templates to prepare OCFs, you must ensure that any **calculations are done to 2 decimal points**. This refers to calculations in each line of goods and services as well as sub-totals and totals.
 - If your calculations are to more than 2 decimal points, the program may round the amount up or down. This results in an error message because the DEC and HCAI calculations are only done to 2 decimal places.

2.20 How to submit a completed OCF to the HCAI DEC

- OCFs can be **faxed** or **mailed**.
 - **By fax**, please send to (866)346-6744
 - **By mail**, please send to
 - HCAI Processing – Data Entry Centre
PO Box 254
Orangeville, ON L9W 3Z5

2.21 How to submit attachments (associated documents) to insurers

- Associated documents¹ which the Insurer requires prior to adjudicating an OCF must be sent directly to the Adjuster handling the claim.
- Adjudication of an OCF submitted via the HCAI DEC may not begin until the Adjuster has received the associated documents.

Important: Associated documents or attachments sent to the HCAI DEC will be destroyed. Associated documents must be sent directly to the insurer.

2.22 Should I also Fax/Mail OCF to Insurers?

- No. Only when you are asked to produce the original copy of the OCF submitted via HCAI (for the purpose of audit) should the OCF be faxed or mailed to Insurers.

¹ E.g. progress reports, radiology reports, FAE reports, assessment reports, etc.

Chapter 3 Follow Up on OCF Forms

3.1 How will I know if an OCF has reached the insurer

- The DEC will generate a *Confirmation Report*.
- The *Confirmation Report* will be sent daily, by fax, to any Health Care Facility that has submitted an OCF to the DEC.
 - If a facility has not submitted any forms to the DEC, a *Confirmation Report* will not be issued.
- The *Confirmation Report* will confirm:
 - Successful OCF submissions (i.e. that have reached the insurer)
 - Unsuccessful OCF submissions (that have not reached the insurer).
 - For each unsuccessful submission, the Health Care Facility will receive by fax, within 2 days after the date the OCF form was submitted to the DEC, an error report that lists the fields that require correction.
 - Once corrections are submitted by the Facility to the DEC, the DEC will submit the OCF to the insurer again.

3.2 When will an insurer receive the form after I have submitted it to the DEC?

- Forms submitted to the DEC prior to 5:00 pm on will be processed and submitted to HCAI the same day *assuming no errors are found on the form*.
 - Example: An OCF is received by the DEC at 4:59 pm on Monday. If there are no errors on the form, it will be successfully processed by the DEC and it will be deemed received by the insurer on Monday.
 - The day the form is received (deemed received) by the insurer is day zero.
- Once successfully processed by the DEC, forms are available immediately for the insurer to review.
- Forms received after 5 pm or on a weekend or holiday will be processed on the next business day (assuming no errors on the form).
 - **Important:** A form with no errors means that:
 - the entries were all legible;
 - the codes were all valid;
 - all mandatory fields are completed and in the required format (e.g. dates);
 - all Providers referenced on the form have been enrolled by your Facility.
 - If there are errors/omissions in your submissions to the DEC, you will be notified at the end of the business day via the confirmation report.
 - You will receive an error report within 2 business days.

DO not CALL THE DEC TO LEARN THE STATUS OF YOUR OCF!

Once a form has been successfully processed by the DEC, it is transmitted to the insurer. After successful transmission:

- You will receive a confirmation report at the end of the business day from the DEC notifying you whether an OCF has been successfully submitted.
- DEC staff do not know if a given insurer has seen, reviewed or adjudicated a form.
- DEC Staff do not have access to the HCAI system to obtain the status of a form.
- Do not contact the DEC to confirm whether insurers have received your form.

3.3 How will I know if an OCF has not reached the insurer?

On days in which you have submitted OCFs to the DEC, you will receive a confirmation report.

- The confirmation report will alert you of any form(s) that have and that have not been successfully submitted to the insurer.
- You should not resubmit an OCF that was not successfully submitted.
- Wait to receive the error report and then submit the corrections on the error report.

3.3.1 Should I resubmit OCF that were not successfully submitted?

- **NO.** Do not resubmit.
 - You will receive an error report by fax within 2 business days after you submitted the OCF to the DEC.
- If you resubmit an OCF, it will be treated as a new form, which may create confusion.

3.4 How to read and respond to an error report

For reasons of privacy, the error report will **not** contain the patient's personal identifying information. The following identifying information **will** be returned on the error report:

- | | |
|------------------------------|---------------------------|
| ➤ date of submission | ➤ gender |
| ➤ claim number | ➤ total amount |
| ➤ policy number | ➤ plan or invoice number |
| ➤ date of accident | ➤ patient's first initial |
| ➤ date of birth of applicant | ➤ patient's last initial |

- The error report contains details of the error.
- Enter the correction in the fields supplied and fax or mail the error form back to the DEC.
- If the errors are in the goods and services section, correct the errors on the OCF form and fax the goods and services section with the error report.
- Forms cannot be submitted to the insurer until all errors have been corrected.
- If you have received multiple error reports, fax all error reports

Figure 2.1: Image of an Error Report

HCAI Data Entry Centre Error Report		2/19/2010
Facility Name: IVANOVA FACILITY Address: 52 TRISH DR City: TORONTO Province: ON Postal Code: L4E 5C4 Fax Number: 5199419393	Document Form Type: OCF22 Facility Plan Number: Claim Number: 1212 Policy Number: Date of Accident: 20110101 Date of Birth: 19500101 Gender: Received: 2010-02-17 09:00:00 DEC Scan ID: IC10000000674 Batch ID: ICL00000410-00018 Applicant First Initial: Applicant Last Initial: Invoice Number: Amount:	
<p>The information in the fields identified below was missing, inadmissible or illegible. Please fill in the missing information in the "Correction" column below and fax back the resulting form to the HCAI Data Entry Centre at 1-866-346-6744. The claim will not be processed until all errors are corrected.</p> <p>If you are unable to fax us back, you can mail a printed copy of the form to the HCAI Data Entry Centre at the following address:</p> <p>HCAI Processing - Data Entry Centre PO Box 254 Orangeville, ON L9W 3Z5</p>		
Document Header		
Field	Validation Error Message	Correction
Date Of Accident	Date Of Accident must be prior to or equal to today. Please verify that the date is properly formatted (yyyymmdd).	
DEC Date Received	DEC Received Date cannot be prior to Date of Accident.	
Part 1 - Applicant Information		
Field	Validation Error Message	Correction
First Name	Applicant First Name must be provided.	
Last Name	Applicant Last Name must be provided.	
Gender	Gender must be provided.	
Postal Code	Applicant Postal/Zip Code must be provided.	
Part 2 - Insurance Company Information		
Field	Validation Error Message	Correction
Insurer ID	Insurer must be provided.	
Branch ID	Branch must be provided.	
Insurer ID	Specified insurer does not exists in HCAI	
Part 3 - Signature of Regulated Health Professional or Social		
Field	Validation Error Message	Correction
Page: 1 of 2		

3.5 Adjudication of OCF Forms by Insurers

An OCF form can only be adjudicated if it is successfully submitted. To ensure your submissions are successful, please review Section 2.2 called "Avoid Common Errors"

3.5.1 Do SABS timelines apply to DEC submitted forms?

The use of the DEC does not change the obligation of the insurer to comply with SABS timelines. Please review the SABS and the Health Claims for Auto Insurance September 2010 Guideline to familiarize yourself with the SABS timelines. These are available from the Financial Services Commission of Ontario (www.fsco.gov.on.ca).

3.5.2 If I submit attachments, separately from the OCF, does this change the adjudication process?

If an OCF form is submitted with a notice on the last page that “attachments” are being submitted to the insurer, the adjudication of the form may not begin until the insurer has received all the attachments as described on the last page of the form.

3.6 How will I know if the insurer has adjudicated my OCF?

- Insurers will send your Health Care Facility a fax back notice with their decision.
- The patient will also receive notice of the insurer’s decision.

3.7 How do I know what the adjuster decision is on the OCF submitted to the DEC?

The DEC cannot answer this question for you. Do not contact the DEC for this information!

- The Insurer will return the form with the decision to the facility by fax.
- If there is no fax number provided, the response will be returned by mail.

3.8 What if the Insurer Has Waived the Signature of the Applicant?

When completing a plan OCF-18 or OCF-23 and the insurer has waived the applicant signature, please indicate this on Part 14 in the Signature of Applicant or Substitute Decision Maker field enter the word “Waived”.

3.9 How do I read the Confirmation Report?

The confirmation report coding is as follows. For codes that appear on the confirmation report that are not listed in the table below, please contact the DEC for further clarification.

CODE	DESCRIPTION
HCAIERROR	Form has an error, an error report will be faxed to the facility
SFEXPORTED6	Exported to insurer
HBEXPORTED5	Exported to insurer
SFEXPORTED5	Exported to insurer
HCAIEXPORTED4	Processing completed at the DEC, ready for export to insurer
HCAIEXPORTED3	Processing completed at the DEC, ready for export to insurer
CPTCORREADY2	Error Report processing is in progress at the DEC
CPTREADY2	Original Form has been received by the DEC and the form is in process
CPTCORREADY1	Error Report processing is in progress at the DEC
CPTREADY1	Original Form has been received by the DEC and the form is in process

Chapter 4 Who to Contact if you need help

4.1 Questions regarding enrolment and OCF form processing

The HCAI Processing – DEC contact centre is available 8:00 am to 5:00 pm EST Monday to Friday excluding statutory holidays.

- **Phone: 1-866-348-9133**
- **Fax: 1-866-346-6744**
- **Mail: HCAI Processing – Data Entry Centre
PO Box 254
Orangeville, ON L9W 3Z5**

4.2 Questions regarding form completion

Refer to www.hcaiinfo.ca for access to coding pick lists, OCF form completion instruction manuals and the DEC user manual. If you cannot locate the information you require on the website, please contact your Health Professional Association or the FSCO website.

4.3 High level questions about HCAI

Please visit the HCAI Information website at www.hcaiinfo.ca or email providersupport@hcaiinfo.ca.

If you do not have email please contact 1-888-422-4123.

Chapter 5 Appendix A – Dependent Provider HCAI Terms and Conditions

This form must be signed by Health Providers delivering services on behalf of an HCAI-enrolled facility and not interfacing directly with HCAI in electronic format.

A Health Provider's signature on this form does not permit the Health Care Facility to use the Provider's signature on OCF forms. If a Provider's signature is to be used on an OCF form, the Provider must sign a hard copy of the form each time.

Health Claims for Auto Insurance Processing ("HCAI") operates a central accident benefits health claims transactions processing system (known as the "HCAI System") that permits health care and rehabilitation treatment and assessment plans and invoices ("Claim Requests") to be submitted centrally to automobile insurers ("Insurers") by health care and rehabilitation Providers or their intermediaries ("Providers"). Health care and rehabilitation businesses, clinics or practices ("Facility" or "Facilities") and Providers who submit claims on their own behalf must be individually enrolled with HCAI. A Facility that is enrolled in HCAI (i.e., one that has executed an HCAI Enrolment Form) is referred to in the following as an "HCAI-Enrolled Facility". Any use of the HCAI system, including the submission of any Claim Requests, and any services provided by HCAI are subject to the applicable HCAI Terms and Conditions (set out at <<http://www.hcaiinfo.ca>>). Providers who deliver services to a claimant through and on behalf of an HCAI-Enrolled Facility, for whose services payment is made to the HCAI-Enrolled Facility and are not submitting claims directly in electronic format to HCAI do not need, for the purposes of their work on behalf of the HCAI-Enrolled Facility, to enrol on an individual basis with HCAI. However, such Providers must agree to the following terms and conditions. This is required for HCAI to permit the HCAI-Enrolled Facility to submit claims for work performed by such Providers without requiring the Providers to enrol directly with HCAI:

1.1 No Liability. The individual Provider executing these Dependent Provider HCAI Terms and Conditions (referred to in the following as the "Undersigned Provider") agrees that he or she (i) will not directly access through electronic means the HCAI System in respect of work performed for the HCAI-Enrolled Facility named below; and (ii) will not submit, or permit to be submitted, any Claim Requests in respect of services performed by the Undersigned Provider other than on behalf of the HCAI-Enrolled Facility named below (although the Undersigned Provider is not precluded from executing additional copies of this agreement in respect of other HCAI-enrolled Facilities and is also not precluded from enrolling in HCAI for the purpose of submitting claims directly on the Provider's own behalf). Further, the Undersigned Provider acknowledges and agrees that HCAI is not providing services to the Undersigned Provider and that any obligation or liability is owed exclusively to the HCAI-enrolled Facility, which has agreed that any use of the HCAI System, including the submission of any Claim Requests, and any services provided by HCAI are subject to the applicable HCAI Terms and Conditions. The Undersigned Provider agrees to waive any and all claims against HCAI or any other entity for any damages or other liability arising from the provision or failure to provide any service by HCAI or any other matter arising or related to any claims submitted to HCAI in respect of work performed by such Undersigned Provider.

1.2 Privacy. HCAI will protect personal information and personal health information in accordance with the applicable HCAI Terms and Conditions (including applicable laws). The Undersigned Provider authorizes HCAI to: (1) collect, retain and use the information provided by the Undersigned Provider to the HCAI-Enrolled Facility, the Undersigned Provider's other contact information, the Undersigned Provider's treating/prescribing information and any claims submitted by the Undersigned Provider or on the Undersigned Provider's behalf, only as required by HCAI to discharge its obligations under the Statutory Accident Benefits Schedule (O. Reg. 403/96 as amended from time to time) ("SABS"), (2) disclose this information to Insurers from whom the HCAI-Enrolled Facility or patients treated by the Undersigned Provider seek payment of health benefit claims under the SABS, only as required by such Insurers in order that they may investigate and process such claims as required by law, and (3) disclose this information (excluding any personal information that would identify a specific patient) to the Insurance Bureau of Canada (IBC) for the purposes of (i) preventing fraud, and detecting fraud where there are reasonable grounds to suspect fraud; and (ii) without using names, professional registration numbers or any other information that would identify a Provider or HCAI-Enrolled Facility, identifying and analyzing the nature and costs of goods and services that are provided to automobile accident victims including by classes or types of health care Providers. HCAI's privacy statement is available at <http://www.hcaiinfo.ca>.

The Undersigned Provider acknowledges that HCAI will be relying upon the Undersigned Provider's agreement to these Terms and Conditions, and for further certainty agrees that HCAI shall be entitled to the benefit of these Terms and Conditions in the event the Undersigned Provider initiates a claim or proceeding against HCAI or any other entity that HCAI has agreed to indemnify in respect of the operation of the HCAI- provided services.

HCAI-Enrolled Facility :

Facility Name _____

Print Provider Name: _____

Date: _____ Signature: _____

Note: This form must be retained by the HCAI-Enrolled Facility for a period of three (3) years following the last date upon which a Claim Request is submitted on behalf of the Provider executing this form.

Chapter 6 Appendix B – Facility Information Change Request Form



Health Claims for Auto Insurance

Facility Information Change Request

HCAI Processing – Data Entry Centre

PO Box 254

Orangeville, Ontario

L9W 3Z5

Tel.: (866) 348-9133

Fax.: (866) 346-6744

To change contact details or other information about your facility in the HCAI system, a *Facility Information Change Request* form must be submitted to the HCAI Processing – Data Entry Centre. Every time your facility’s information changes, you must submit this form in order for your facility to continue to use the data entry centre for transcription of OCFs. The data entry centre shall make changes to your facility’s information in the HCAI system within one Health Care Facility day of receiving the *Facility Information Change Request* form. Once your facility’s information is updated in the HCAI system, the new information will be used for submission of OCFs.

Please follow these instructions:

- Complete **all** fields in the **Facility Details – Existing Information** section of this form and provide the new information for any fields that are to be updated.
- If you are completing the form by hand, please PRINT clearly.
- Return the completed form by fax (1-866-346-6744) or regular mail.

Facility Details

Facility Name:

Facility Number (if electronic)

Corporation Number:

Address:

City:

Province:

Postal Code:

Telephone:

Fax:

Existing Information

New Information

Authorizing Officer

Name:

Email (if applicable):

Contact One

Name:

Title:

Email (if applicable):

Telephone:

Contact Two

Name:

Title:

Email (if applicable):

Telephone:

Payee Information

Cheque Payable To:

Lock Payable:

YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
------------------------------	-----------------------------	------------------------------	-----------------------------

Payee Name (if applicable):

Submission Method

Paper to Electronic

Do you want to change your facility's submission method from data entry centre submission to electronic submission?

YES NO (If you answered yes, please fill in the three blanks below.)

Owner/authorizing officer's email: _____

Owner/authorizing officer's username 1st choice: _____

Owner/authorizing officer's username 2nd choice*: _____

*Note: The username must be unique to HCAI, therefore it is important to provide an alternate choice, in case the first choice is not available.

Electronic to Paper

Note: All access to HCAI system will be removed when switching from electronic to paper submission method. The Health Care Facility is responsible for ensuring all forms that have been submitted electronically are adjudicated and complete prior to submitting this request to the data entry centre.

Do you want to change your facility's submission method from electronic submission to paper submission at the data entry centre?

YES NO (If switching to data entry centre please ensure all Providers are set up.)

Owner/Authorizing Officer's Signature

Name: _____

Signature: _____ Date: _____

Chapter 7 Appendix C – Provider Change Request Form



Health Claims for Auto Insurance

7.1.1.1.1.1

Request to Add/Deactivate Provider

HCAI Processing – Data Entry Centre

PO Box 254

Orangeville, Ontario

L9W 3Z5

Tel.: (866) 348-9133

Fax.: (866) 346-6744

In order to submit OCFs for a health care Provider who is delivering services to your patients on behalf of your facility, you must add that Provider to HCAI's records for your facility. Similarly, if a Provider stops providing services for your facility, you must remove that Provider from HCAI's records for your facility. A *Request to Add/Deactivate Provider* form must be submitted to the HCAI Processing – Data Entry Centre to make these changes. The additions or deactivations shall be made on the HCAI System by the data entry centre within one Health Care Facility day of receiving the *Request to Add/Deactivate Provider* form. Once the information is updated, you may begin submitting OCFs for the new Provider(s).

Note: If you are adding or deactivating a large number of Providers, multiple lines can be added to the tables on this form.

Please follow these instructions:

- To add a Provider: In the first table below, enter the name, profession and registration number of the health Provider.
- To deactivate a Provider: In the second table below, enter the name, profession and registration number of the health Provider, and the deactivation date.
- Ensure the facility's owner or authorizing officer signs the form.
- If you are completing the form by hand, please PRINT clearly.
- Return the completed form by fax (1-866-346-6744) or regular mail.

Facility Information

Facility Name: _____

Address: _____

Date of Request: _____
(yyyy/mm/dd)

Provider(s) to be added (please add extra rows if required):

Dependent Provider HCAI Terms and Conditions must be completed and signed by all health Providers performing services at the facility. These records must remain on file at the facility.

Provider first name	Provider last name	Profession	Registration number

Provider(s) to be deactivated (please add extra rows if required):

Provider first name	Provider last name	Profession	Registration number	Deactivate yyyy/mm/dd

Owner/Authorizing Officer's Signature

Name: _____
(Please print your name)

Signature: _____ **Date:** _____
(yyyy/mm/dd)