



Health Claims for Auto Insurance

**OCF-18:
TREATMENT & ASSESSMENT PLAN**

Manual for DEC Users

Effective September 2010

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Document Change History

Date	Description of Change	Reason
20050214	Revised Signature of Health Practitioner & Applicant Signature, Repositioned Signature of Insurer	For consistency with revised OCF forms 01/Dec/04
<u>20060301</u>	Revised Further Information, Who completes form, Other Insurance Information, Signature of Health Practitioner & Regulated Health Professional and Health Providers	Redirects users to HCAI website for further information and reflects inclusion of Social Worker as per revised SABS
<u>2009</u>	To be inserted	
<u>20100614</u>	Form name change, Remove Part 4, Renumber the part numbers, GST field renamed TAX and PST field removed.	Changes as of September 1, 2010

Introduction

An OCF 18 is used to propose assessments, goods or treatments to an automobile insurance company for the purpose of seeking approval of funding for the goods and/or services. An OCF 18 may be used to propose an assessment only, treatment only or both at the same time. Speak with the insurer if you are uncertain how to proceed.

Where can I get more information?

Visit the www.hcaiinfo.ca website for additional information. If you are unable to locate the information, you should contact your health professional association or organization with questions relating to coding of injuries, interventions, health care services and guidelines as they relate to your specific practice.

Samples of Completed Sections of the Forms

The samples and fees used throughout the manual are entirely fictitious. They are designed to assist you in understanding how to use and complete the forms.

When Do I Use an OCF 18 Instead of an OCF 23 (PAF or MIG Confirmation)

- OCF 18s should be used to propose health assessments, goods and services for patients with injuries that are **NOT** suitable for treatment in a Pre-Approved Framework (accidents before September 1, 2010 with WAD I & II) or in the Minor Injury Guideline (accident date on or after September 1, 2010 with Minor Injury(ies)).
- Review the Pre-Approved Framework (PAF) and Minor Injury Guideline (MIG) for more information on which patients are eligible for treatment under the PAF or MIG.
- Insurer may waive the OCF 18.
 - If insurer waives OCF 18, they must provide written confirmation of what they will pay for without a treatment/assessment plan. Insurers may later request a treatment/assessment plan for future treatment/assessment.

Who completes this form to prepare it for submission to the insurer?

Important: Any health care facility (HCF) that wishes to submit OCFs through the HCAI Data Entry Centre (DEC), must have, at minimum, a regulated health professional associated with the clinic.

Who has to sign the OCF 18?

- A health practitioner (HP), as defined in the SABS, must sign the form (Part 4) to certify the reasonableness and necessity of the services proposed in the form.
- A regulated health professional (RHP) must also agree to supervise the plan by signing Part 5, UNLESS:
 - The HP that signs Part 4 agrees to supervise the plan, in which case a signature will not be required in Part 5.
 - Plan supervision may be carried out by the signer of Part 5 or – if the HP does not wish to supervise the plan - a RHP may sign Part 6, agreeing to supervise the plan. This RHP must be associated with the health care facility.
- The claimant or substitute decision maker must also sign the form, unless the insurer waives the claimant's signature.

How do I know the Data Entry Centre (DEC) received my form?

The DEC will issue a confirmation report daily to confirm they have received your plan. If you have faxed an OCF-18 to the DEC but have not received a confirmation report, contact the DEC at 1-866-348-9133.

How do I know the DEC submitted my form to the insurer?

The DEC Confirmation report will indicate whether the form was submitted successfully to the insurer. If the form was NOT successfully submitted, your practice will receive an error report within 2 business days of the fax submission to the DEC.

What is the role of the DEC in my electronic submission?

- Data entry operators will key the data contained on the paper form into the HCAI application.
- The data will be validated (checked) by HCAI.
- IF there are errors, an error report is generated and will be faxed/mailed to the health facility within 2 business days.
- IF there are no errors, the form will be submitted electronically to the insurer on the same day.

What is the Insurer's Role?

- After the form has been validated by HCAI and submitted, it is received electronically by the insurer.
- After the adjuster matches the form to their claimant, s/he will be able to adjudicate the form.
- Notification to the health care facility (HCF) will be in the form of a fax-back response.

What if there is to be simultaneous treatment by multiple health providers in the same HCF?

- In most cases, only one form per HCF should be submitted for a given patient. It is possible to propose multi or inter-disciplinary treatment on one plan.
 - Only one HP signature is required to certify the form.
 - This permits a single, comprehensive plan, allowing for continuity of care among all health care providers.

Form Completion Fee

- The fee for completion of this form should be billed directly to the insurer. It is not a benefit of the Ministry of Health and Long-Term Care.
- It is a conflict of interest to receive any payment or benefit in addition to the insurer's fee for completion of the form.

Completion of an OCF-18 for HCAI DEC Processing

Important: If a mandatory field is left blank, your form will not be validated and an error report will be issued

Return this form to:

Refer to the list of insurers provided to you. Enter the name and mailing address of the Insurance Company responsible for handling the claim.

Important: Independent Adjusting companies are NOT licensed insurers and entering their name in this field may invalidate your submission. Obtain the name of the insurance company with whom the patient has a policy/claim.

Return this form to: ABC Insurance Company P.O. Box 123, Station 'A' Toronto, ON M1M 1M1 Att: Mary MacGregor	Treatment and Assessment Plan (OCF-18)	
	Use this form for accidents that occur on or after November 1, 1996.	
	**Claim Number:	1234567-001
	**Policy Number:	9876543
	Date of Accident: <small>(YYYYMMDD)</small>	20031001

Claim Identifiers – Speed up Claims Processing

- Claim/Policy Information
 - Persons who report injuries sustained in an automobile collision will be contacted by the insurance company to which they make the claim for benefits.
 - The insurer is required to provide the injured person (claimant) with information such as the claim number, date of loss, etc.
 - The insurance policy number can be obtained from the pink slip that is provided when the auto insurance premium is paid.
- Claim identifiers are used to identify the claimant and match the document to a specific adjuster's worklist. When a form arrives at the insurance company, the insurer must match information contained in this section of the form.

NOTE: Errors in claim identifiers may delay the insurer's ability to identify claimant and, subsequently, process the claim.

Four Key Identifiers

Four key identifiers will assist insurers to quickly validate and adjudicate the claim:

1. Claim number and/or policy number.

- a. Applicant must provide claim number if known, policy number, and the date of the accident.
- b. Claim number and policy number is usually provided to the applicant by the insurance company, or they can be obtained from the insurance adjuster.
- c. Policy number is available on the Motor Vehicle Liability Insurance Card (pink slip).
 - i. Claim Number and Policy Number may be the same.

2. Date of Accident

- a. Forms cannot be processed without date of accident.
- b. If patient has overlapping injuries from more than one accident, use the date of the accident that is most relevant to the injuries being treated.

3. Date of birth of the patient


4. Gender of the patient

Part 1 Applicant Information

Part 1 Applicant Information To be completed by the applicant	Date of Birth (YYYYMMDD)	Gender	Telephone Number	Extension
	19490525	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	(416) 555-5555	4222
	Last Name Smith			
	First Name Jonathan		Middle Name James	
	Address 123 Main Street			
	City Toronto		Province ON	Postal Code M9M 9M9

Applicant (patient) or substitute decision maker¹ should provide this information to clinic staff.

Part 2 Insurance Company Information

Part 2 Insurance Company Information To be completed by the applicant	Insurance Company Name		City or Town of Branch Office (if applicable)	
	ABC Insurance Company		North York	
	Adjuster Last Name		Adjuster First Name	
	MacGregor		Mary	
	Adjuster Telephone (416) 555-5555		Adjuster Fax	
Extension 4777		(416) 555-5555		
Name of policy holder same as:		Policy Holder Last Name	Policy Holder First Name	
<input type="checkbox"/> Applicant OR 		Smith	Jessica	

- This information may be provided by the applicant (patient) or substitute decision maker.
- If the applicant is not the policy holder, the last name of the policy holder is mandatory.
- If the name of the policy holder has not yet been determined, insert the applicant's name.

Independent Adjusting Companies and Adjusters

- Independent Adjusting Companies may be hired by insurance companies to adjudicate claims, but the HCAI application does not list Independent Adjusting Companies.
- To direct claim forms appropriately, HPs should determine (typically by asking the patient or the Independent Adjuster) the name of the licensed insurer that insures the patient.
- Insurance companies that use Independent Adjusters (IAs) are able to give IAs access to HCAI so the IA can view and adjudicate forms for those claimants for which they have been authorized.

Part 3 Other Insurance Information

- The patient, guardian or substitute decision maker can advise whether there is other insurance.
- HCFs or HPs are not responsible for errors or omissions in information provided to them by the patient, guardian or substitute decision maker.

¹ The *Substitute Decisions Act* states that a substitute decision maker is a person with power of attorney for personal care or a court appointed guardian.

Part 3 Other Insurance Information To be completed by the health professional or social worker responsible for plan preparation and supervision with information from the applicant	OTHER INSURANCE: Is there other insurance coverage for any goods and services listed in this Treatment Plan? I have made reasonable enquiries of the applicant and have determined that:				
	<input type="checkbox"/> NO <i>There is no other insurance coverage identified for these goods and services</i>				
	<input checked="" type="checkbox"/> YES <i>There is other insurance coverage that is potentially available to cover/partially cover these goods and services.</i>				
	MOH	Is there Ministry of Health and Long-Term Care (MOH) coverage for any goods and services included in this Treatment Plan? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not applicable			
	Other Insurer 1	<table border="1"> <tr> <td>Other Insurer Name XYZ Life Insurance Company</td> <td>Other Insurance Plan Or Policy Number HSA-87851</td> </tr> <tr> <td>Name of Plan Member Jonathan Smith</td> <td>Other Insurer's Identifier 401-123-321</td> </tr> </table>	Other Insurer Name XYZ Life Insurance Company	Other Insurance Plan Or Policy Number HSA-87851	Name of Plan Member Jonathan Smith
Other Insurer Name XYZ Life Insurance Company	Other Insurance Plan Or Policy Number HSA-87851				
Name of Plan Member Jonathan Smith	Other Insurer's Identifier 401-123-321				
Other Insurer 2	<table border="1"> <tr> <td>Other Insurer Name WER Life Insurance Company</td> <td>Other Insurance Plan Or Policy Number GRP-987822-01</td> </tr> <tr> <td>Name of Plan Member Jessica Smith</td> <td>Other Insurer's Identifier 444-876-878</td> </tr> </table>	Other Insurer Name WER Life Insurance Company	Other Insurance Plan Or Policy Number GRP-987822-01	Name of Plan Member Jessica Smith	Other Insurer's Identifier 444-876-878
Other Insurer Name WER Life Insurance Company	Other Insurance Plan Or Policy Number GRP-987822-01				
Name of Plan Member Jessica Smith	Other Insurer's Identifier 444-876-878				

Part 4 Signature of Health Practitioner

Part 4 Signature of Health Practitioner Treatment and Assessment Plan Certification	Name of Health Practitioner Barry Brown		College Registration Number 123456	You are a: <input checked="" type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech-Language Pathologist
	Facility Name (if applicable) Family Care Clinic		AISI Facility Number (if applicable) T2222	
	Address 234 Second Avenue East			
	City Toronto	Province ON	Postal Code M6M 5Y6	
	Telephone Number (416) 678-3333	^A Extension 2525	^A Fax Number (416) 569-8888	
	^A Email Address bbrown@famcare.ca			
For accidents that occurred before September 1, 2010: Is this an impairment referred to in a Pre-approved Framework (PAF) Guideline? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain, in accordance with the PAF Guideline, and with express reference to the provisions of the PAF Guideline on which you rely, why this OCF-18 Treatment and Assessment Plan is being submitted instead of an OCF 23 Treatment Confirmation Form: Explanation to accident provided				
For accidents that occur on or after September 1, 2010: Is this impairment predominantly a minor injury as referred to in the Minor Injury Guideline? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain and provide compelling evidence why the applicant does not come within the Minor Injury Guideline due to a pre-existing medical condition that will prevent the applicant from achieving maximal recovery from the minor injury if the applicant is subject to the \$3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline.				
Send any attachments directly to the insurer				
I confirm that, to the best of my knowledge, the information in this Treatment and Assessment Plan is accurate, the Treatment and Assessment Plan has been reviewed with the applicant by the regulated health professional in Part 5, and the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 6. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. This information will be used for processing payments of claims; identifying and analysing the nature, effects and costs of goods and services that are provided to automobile accident victims; by health care providers; and detecting and preventing fraud.				
Name of Health Practitioner (please print) Barry Brown		Signature of Health Practitioner	Date (YYYYMMDD) <input type="text"/>	

IMPORTANT
For accidents that occurred before or after September 1, 2010, if "Yes" is selected an explanation MUST be provided.

The HP must certify the plan by signing Part 4. When the HP signs Part 4, s/he is certifying that the following statements are true:

- *The health practitioner confirms that, to the best of his/her knowledge, the information in this Treatment and Assessment Plan is accurate, the Treatment and Assessment Plan has been reviewed with the applicant by the regulated health professional in Part 5, and the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 6.*
- *The health practitioner understands that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. S/he further understands that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. This information will be used for processing payments of claims; identifying and analysing the nature, effects and costs of goods and services that are provided to automobile accident victims, by health care providers; and detecting and preventing fraud.*

HPs are discouraged from signing blank forms.

IF your HCF requires an external (not associated) health practitioner’s signature in Part 4

Health Practitioners

According to the Statutory Accident Benefits Schedule, only HPs may sign Part 4. HPs are regulated health professionals authorized to call themselves:

- chiropractors
- dentists
- nurse practitioners
- occupational therapists
- optometrists
- physicians
- physiotherapists
- psychologists and psychological associates
- speech-language pathologists

Regulated Health Professionals

- In some cases, the HP that signs the form may not prepare the form or may not be appropriate to supervise the plan.
 - **Example:**
 - A registered massage therapist (RMT) may prepare an OCF-18 for massage therapy. S/he will sign Part 5, since the RMT will supervise the treatment.
 - The RMT must arrange to have a HP sign Part 4.
 - Part 4 may be signed by a HP that is not associated with the HCF (e.g. a family physician) or it may be signed by an associated HP (e.g. a physical therapist on staff at the HCF).

What is an “Associated Provider”

- The term “Associated” applies when a health professional (provider) is registered in HCAI as a provider for the HCF that plans to invoice for the services. This provider will be listed in the HCF’s HCAI roster or Provider List.
- The associated provider will be able to sign OCF forms and/or deliver care to patients of that HCF on behalf of that HCF.

IMPORTANT

- If the HP that signs Part 4 is **associated** with the HCF, s/he may also supervise the plan, in which case a signature in Part 5 is not required.
- If the HP that signs Part 4 is **NOT associated** with the HCF, then the RHP who signs Part 5 **MUST** be associated with the facility.

Part 5 Signature of Regulated Health Professional

“Is the health practitioner also the regulated health professional?”

If the HP that signs Part 4 is:

- associated with the HCF, and
- agrees to supervise the plan.

In this case, Part 5 does not have to be completed. Simply check off the box, as indicated, and continue to Part 6.

Part 5 Signature of Regulated Health Professional Treatment and Assessment Plan Preparation and Supervision If same person as Part 4 check here <input checked="" type="checkbox"/> and DO NOT COMPLETE Part 5	Name of Regulated Health Professional		College Registration Number		You are a: <input type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Massage Therapist <input type="checkbox"/> Nurse <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech-Language Pathologist <input type="checkbox"/> Social Worker <input type="checkbox"/> Other _____
	Facility Name (if applicable)		AISI Facility Number (if applicable)		
	Address				
	City	Province	Postal Code		
	Telephone Number	^A Extension	^A Fax Number		
	^A Email Address				
	I confirm that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.				
Name of Regulated Health Professional (please print) Jeff John		Signature of Regulated Health Professional [Redacted]		Date (YYYYMMDD) [Redacted]	

Part 5 – Plan Supervision

- If the HP selected in Part 4 is NOT associated with the HCF, Part 5 must be completed.

Part 5 Signature of Regulated Health Professional Treatment and Assessment Plan Preparation and Supervision If same person as Part 4 check here <input type="checkbox"/> and DO NOT COMPLETE Part 5	Name of Regulated Health Professional Jeff John		College Registration Number 58112	You are a : <input checked="" type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Massage Therapist <input type="checkbox"/> Nurse <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech-Language Pathologist <input type="checkbox"/> Social Worker <input type="checkbox"/> Other _____
	Facility Name (if applicable) Extra Rehabilitation		AIST Facility Number (if applicable) T3121	
	Address 15 Elm Street			
	City Toronto	Province ON	Postal Code L8L 5T5	
	Telephone Number (416) 565-9595	^A Extension 21 21	^A Fax Number (416) 898-0789	
	^A Email Address jeffjohn@extrarehab.com			
	I confirm that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.			
Name of Regulated Health Professional (please print) Jeff John		Signature of Regulated Health Professional [Redacted]	Date (YYYYMMDD) [Redacted]	

A RHP must agree to supervise the plan. By agreeing to supervise the plan and by signing Part 5 s/he is certifying that::

- *The health professional confirms that the information provided is true and correct. The health professional understands that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. The health professional further understands that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.*

IMPORTANT:
Providers NOT regulated under the Regulated Health Professionals Act or under the Social Work and Social Service Workers Act may not sign this section.

When and why is a Signature Required in Part 5?

- Each OCF-18 treatment plan requires a RHP to be responsible for supervising the plan and ensuring treatment proceeds as outlined in the plan. If issues arise that prevent the delivery of treatment as outlined, the individual who has agreed to supervise the plan should communicate with other health professionals, as well as the insurer, to discuss strategies.
- However, the individual that agrees to supervise the treatment plan **MUST** be associated with the HCF that delivers the treatment described in the plan. **In other words, an individual that is not associated with the HCF submitting the plan cannot sign Part 5 of an OCF-18.**

Part 6 Injury and Sequelae Information

Part 6 Injury and Sequelae Information	Provide a description (list most significant first) and associated ICD-10-CA code for complaints, injuries and sequelae that are the direct result of the automobile accident (refer to the User manual at www.hcaiinfo.ca for ICD-10-CA coding information).	
	Description	Code
	Sprain and strain of lumbar spine	S33.5
	Headaches	G44
	[Redacted]	[Redacted]

IMPORTANT:

The descriptions that will appear under “Description” are defined by the ICD10-Ca code that is selected.

You may leave the description field empty. When the DEC enters the code, the description will automatically be populated.

It is not possible to change the description associated with a code.

It is not possible to add text to the standard description.

If you type information in the description section which is different from the standard code description, the insurer will NOT receive that information.

To convey details to the insurer, use the narrative text box located in Part 12 (up to 500 characters) or use additional pages (20,000 characters) at the end of the form.

- This section asks the HCF to describe the injuries sustained in the automobile collision, or the circumstances or problems related to the automobile collision that are responsible for the services being proposed in the plan.
 - Example of an injury code:
 - S42.0 – Fracture of clavicle
 - S43.0 – Dislocation of shoulder joint
 - Example of a circumstance code:
 - Z58 – Problems related to physical environment
 - Z59.1 – Problems related to housing
- Injuries/problems are described using standard codes called the International Classification of Disease, 10th version, Canadian edition (ICD-10-Ca)
 - ICD-10-CA codes may reflect a diagnosis, condition, problem or circumstance that is responsible for the services being proposed.
 - ICD-10-CA codes are not profession-specific.
 - Use of ICD-10-CA codes is intended to convey problems and is not necessarily the equivalent of communicating a diagnosis.
- A partial pick list of commonly used injury codes are available at www.hcaiinfo.ca
- Many health professional associations have developed profession-specific problem code lists. Contact your health professional association and request, if desired.

Questions about coding?

Visit www.hcaiinfo.ca for resources pertaining to coding. If you are unable to locate the information you require, contact your health professional association or organization.

Coding Tips:

- Each code should only be listed once, regardless of how many health professionals will be engaged in treatment.
- Main Problem:
 - The first line item should reflect the problem that is most responsible for the services on the plan. In other words it should reflect the primary reason you are proposing services.
 - Example
 - If psychological services are required after a brain injury, the first code listed should reflect the reason that psychology services are being proposed.
 - E.g., F07.2 – Postconcussional Syndrome.
 - In a case where multiple injuries may be classified, put the injury requiring the most services first.
- Other Problems
 - Resolved Injuries

- If an injury has resolved (e.g. a healed fracture), or is no longer the most responsible condition requiring the services in the plan, that problem can be listed below the “Main” problem.
 - Prior and Concurrent Conditions
 - Use Part 8 to list “Prior and Concurrent Conditions”.
 - Example
 - Original injury is S73 – Fractured femur. Surgeon reports that fracture is healed.
 - The femoral fracture is resolved, but ongoing treatment is required to manage pain and gait re-education. In this case, the Main problems listed could be:
 - M79.6 – Pain in limb; and
 - R26 – Abnormalities of Gait;
 - The fracture (S73) is no longer the Main Problem and can be listed below the main problems

Common Codes

- Single physical injury – refer to S codes.
- Multiple injuries and bilateral injuries – refer to T codes (do not list duplicate codes for bilateral injuries).
- Mental and Behavioural disorders – refer to F codes.
- Symptoms, signs and abnormal clinical and lab finding, not elsewhere classified – refer to R codes.

Refer to **Appendix A** for further information on ICD-10-CA.

Refer any questions about injury coding to your provider association or access the website at www.hcaiinfo.ca under Coding.

Part 7 Prior and Concurrent Conditions

Part 7 Prior and Concurrent Conditions	<p>a) Prior to the accident, did the applicant have any disease, condition or injury that could affect his/her response to treatment for the injuries identified in Part 6?</p> <p> <input type="checkbox"/> No <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Yes (please explain) </p> <p style="color: blue;">Periodic low back pain. Last episode March 2003</p> <hr/> <p>If Yes to "a" above, did the applicant undergo investigation or receive treatment for this disease, condition or injury in the past year?</p> <p> <input type="checkbox"/> No <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Yes (please explain and identify provider, if known) </p> <p style="color: blue;">Low back strain injury of March 2003 treated with heat therapy and gradual progression to an active exercise program. Home exercise and use of a lumbar support belt for lifting allowed return to modified work in June.</p> <hr/> <p>b) Since the accident, has the applicant developed any other disease, condition or injury not related to the automobile accident that could affect his/her response to treatment for the injuries identified in Part 6?</p> <p> <input type="checkbox"/> No <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Yes (please explain) </p> <p style="color: blue;">Depression – sudden death of mother</p>
Send any attachments directly to the insurer	

- Assists insurer to better understand applicant’s pre-accident status
 - A) - Informs insurer of any pre-existing condition(s) that may affect the applicant’s response to treatment. .
 - B) - Provides additional information around circumstances that may affect recovery, which are not indicated as a prior or concurrent condition. Note: If you are aware that a

patient will receive treatment for a concurrent condition, this can be documented in Part 10.

- Provide relevant information to the best of your knowledge and based on information from the applicant. A response of “Unknown” may prompt a request for further clarification from the insurer.
- If additional space is required, use the space under “Are there any attachments” at the bottom of Part 12.

Part 8 Activity Limitations

Part 8 Activity Limitations	a) Does the applicant's impairment(s) from the injuries identified in Part 6 affect his/her ability to carry out: His/her tasks of employment <input type="checkbox"/> Not employed <input type="checkbox"/> No <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Yes His/her activities of normal life <input type="checkbox"/> No <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Yes
	b) If <u>Yes</u> to either of the questions above, briefly describe the activities limited by the impairment and their impacts on the applicant's ability to function. <u>Maintaining and changing body position, lifting, carrying, driving, preparing meals, housework, shopping,</u>
	c) If the applicant is unable to carry out pre-accident employment activity, is the employer able to provide suitable modified employment to the applicant? <input type="checkbox"/> Not employed <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> No (please explain) <input type="text"/> <u>Not available</u>

The responses are based on your current knowledge and information provided by the applicant. If any of the responses to the questions in section a) are “yes”, provide a brief description of the activity limitations the applicant is experiencing.

A response of “no” in section c) requires further explanation and may require contacting the employer, but is not intended to signify the need for a job site assessment.

Part 9 Plan Goals, Outcome Evaluation Methods and Barriers to Recovery

This section is intended to outline:

1. Treatment goals; and
2. How the health care provider will evaluate treatment progress; and
3. Information around other barriers to recovery that may not indicated as a prior or concurrent condition; and
4. Any concurrent treatment being provided to the patient.

Part 11 Health Care Providers

IMPORTANT: All health providers that you list on an OCF-18 MUST be associated with your HCF.

This means that the DEC must have received documentation associating the provider with your practice.

If a provider is listed but has not been registered through the DEC, your form will be invalid and an error report will be generated.

Part 11 Health Care Providers	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	DC	Brown	Barry	123456		
	B	KN	Brannigan	Sally		KN-1234	\$40.00
	C						
	D						
	E						
	F						

Health Providers are assigned an upper case alphabetic letter (i.e., the Provider Reference). The Provider Reference is used to cross-reference information in Part 12 of the Treatment Plan and the Automobile Insurance Standard Invoice.

Assign a Provider Type code for each of the health professionals rendering services or prescribing goods.

Refer to **Appendix E** for a complete list of Provider Type codes.

The AISI number may be left blank.

If appropriate, enter the hourly billing rate for each of the providers listed. If you will not be billing for the proposed services using an hourly rate, enter N/A.

Part 12 Proposed Goods and Treatment Service

IMPORTANT: The third column from the right (Cost) should NOT be populated with a provider's hourly rate. Doing so will invalidate your submission.

The correct "Cost" is the product of quantity x measure x hourly rate

Part 12 Proposed Goods or Services Requiring Insurer Approval	G/S Ref	Description	† Code	† Attribute	Provider Ref	Estimated			Projected	
						Quantity	† Measure	Cost	Total Count	Total Cost
	1	MedRehab Assessment	HXXMR		A	1.5	HR	141.13	1	141.13
	2	Exercise, ankle joint	1WA02		B	0.25	HR	23.52	12	282.24
	3	Stimulation, muscles of lower leg	1VR09		B	5	HR	47.04	12	564.48
To the extent	4									

Goods/Service Reference (G/S)

This refers to the line item. Assign a G/S reference number to each good or service you will be providing to the applicant. **Remember to use the same G/S reference number from the Treatment Plan when completing Version A of the Automobile Insurance Standard Invoice (OCF-21).**

Description

IMPORTANT:

The descriptions that will appear under “Description” are defined by the CCI or GAP code that is selected.

You may leave the description field empty. When the DEC enters the code, the description will automatically be populated.

It is not possible to change the description associated with a code. If you type information under the description section which is different from the standard code description, the insurer will not receive that information.

To convey details to the insurer, use the narrative text box located in Part 12 (up to 500 characters) or use additional pages (20,000 characters). If using the additional page, this should be faxed directly to the insurer and not submitted to the DEC.

Code and Attributes

For those services representing a diagnostic, therapeutic, or health care support intervention, enter a valid CCI code and attribute if required.

Refer to **Appendix B** for a list of CCI codes and corresponding Attribute Codes

For goods, administration and other codes (GAP) not included in the CCI code set, enter a valid GAP code.

Refer to **Appendix C** for a list of valid GAP codes.

Refer any questions about injury coding to your provider association or access the website at http://www.hcaiinfo.ca/Health_Care_Facility_Provider/Coding.asp

Provider Reference

Enter the Provider Reference code of the HP who will render the service or is prescribing the good (from Part 11).

Multiple providers delivering one services

If a service is to be provided by more than one health care professional, enter the ONE who will be most responsible.

Estimated

In the three columns under this heading, you are to enter the information that is needed to calculate the estimated total cost of each good and service that will be delivered during each day of anticipated treatment.

Before you begin, consider the unit measure that will be used for this service, e.g., hourly (HR), by procedure (PR), goods (GD) etc.

- Enter the quantity of the good or service that will be delivered during each visit or treatment day. This will appear as a number (e.g., if an intervention will take 15 minutes, you would enter 0.25 and use the unit measure “HR”).
- Identify the unit of measure (e.g., *hours* of service, number of *pages*, *kilometres* of travel) for the quantity of service you are proposing to deliver each treatment day.

IMPORTANT: Only use unit measures that are described in Appendix F. If you use other unit measures such as minutes, or “each”, your form will be invalidated. http://www.hcaiinfo.ca/Health_Care_Facility_Provider/documents/appendices/AppendixFFINAL.pdf

- Third, report the cost per service for each day. **Do NOT enter the providers hourly rate in the Cost column**

Refer to **Appendix F** for valid Unit Measure Codes and a Conversion Table to convert minutes to hours.

Projected Total Count

For each Good/Service Reference line, enter the total number of the good(s) or service(s) anticipated over the course of this treatment plan.

Projected Total Cost

For each Good/Service Reference line, enter the total cost of the good(s) or service(s) anticipated over the course of this treatment plan. This is calculated by multiplying cost by projected total count.

Totals

Estimated duration of this Plan:	Weeks	Sub-Total:	987.85
*How many visits have you already provided:	*visits	Minus MOH:	
Note: † Refer to the User Manual coding guidelines posted at www.hcaiinfo.ca .		Minus Other Insurer 1+2:	
Attributes codes are used to further qualify the service codes and are described in the manual.		TAX (if applicable):	12.35
Payment by auto insurer is secondary to available collateral benefits.		Auto Insurer Total:	1000.2

In the Totals section:

- **Weeks** is the estimated duration of this plan.
- **Visits** is the number of visits already provided.
- **Sub-Total** is the sum of the cost of all goods and services included in this treatment plan.
- **MOH** is the sum of all Ministry of Health and Long-Term Care amounts that are payable to you for any of the goods and services listed above; this is subtracted from the sub-total.
- **Other Insurer 1 + 2** is the sum of all amounts payable to you from other insurers; this is also subtracted from the sub-total. A negative sign should be used to indicate amounts paid by other insurers.
- **TAX** is the total HST for all goods and services listed above.
- **Auto Insurer Total** is the sum of all amounts in this section.

Attachments

*Please indicate any additional comments regarding proposed goods and services:

Are there any attachments? Yes No
 If Yes, how many? 3
 Send any attachments directly to the insurer

- If you have supporting documents for this Treatment Plan, check off **Yes** and indicate how many pages will be faxed or mail to the Insurer.
- If no attachments will be sent, check off **No**.

Part 13 Signature of Insurer

Part 13 Signature of Insurer	<input type="checkbox"/> **I waive the requirement of the Applicant's signature.		
	I have reviewed this Treatment and Assessment Plan and based upon the information provided, I:		
	<input checked="" type="checkbox"/> Approve this Treatment and Assessment Plan	<input type="checkbox"/> Partially approve	<input type="checkbox"/> Do not approve
	The Statutory Accident Benefits Schedule states that the insurer shall, within 10 business days of receiving this Treatment and Assessment Plan, give the applicant a notice stating the goods and services contemplated by the Treatment and Assessment Plan for which the insurer will or will not pay.		
Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)	
Mary MacGregor			
To the Insurer: Please provide a copy of this page to the applicant, the Health Practitioner indicated in Part 4 and the Regulated Health Professional indicated in Part 5.			
Note: The fee for completing this form is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly. The Regulated Health Professional referred to in Part 5 will contact each of the health care providers listed in Part 11 and provide details of the services and other charges that have been approved and are payable under this Treatment and Assessment Plan.			

The insurer will complete Part 13 and return page 5 to the applicant and the HP indicated in Part 4. The health practitioner should contact each of the health professionals listed in Part 11 and provide details of the services and other charges that have been approved and are payable under this Treatment Plan.

If the insurer partially approves or does not approve the treatment, they must provide an explanation as to why the treatment plan has been declined.