



Health Claims for Auto Insurance

# **OCF-21C:**

## **CREATE A MIG INVOICE FROM SCRATCH**

### **MANUAL FOR WEB USERS**

June 2011

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## **When Do I Use an OCF 21C**

An OCF 21C is used when invoicing for goods and services delivered in the Minor Injury Guideline (for accidents on or after Sept 1, 2010) or the Pre-Approved Framework (for accidents PRIOR to Sept 1, 2010). For all other invoicing, use the OCF 21 B.

## **What Is Included in This Manual?**

The manual provides detailed instructions for the completion of an OCF-21C using the HCAI Web application. To view codes that may be used on the forms, please refer to the HCAI information (HCAIinfo) website at [http://www.hcaiinfo.ca/Health\\_Care\\_Facility\\_Provider/Coding.asp](http://www.hcaiinfo.ca/Health_Care_Facility_Provider/Coding.asp).

### ***Where can I get more information?***

This manual will be updated from time to time. The latest updates to the manual can be downloaded from the [HCAIinfo](#) website.

Contact your health professional association for any questions relating to coding of injuries, interventions, health care services and guidelines as they relate to your specific practice.

### ***Examples of completed sections of the forms***

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

# OCF-21C: CREATE INVOICE FROM SCRATCH

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## ***Introduction***

In HCAI, the health care facility (HCF) has two options for OCF-21C creation:

1. Create an OCF-21C from scratch
  - When an OCF-23 has *not* been submitted by your facility to the insurer through HCAI; or
  - If the OCF-23 was submitted before your practice started to use HCAI.
    - *Example:* The HCF is initially activated for HCAI, and all prior forms have been submitted by fax/mail. Even though the paper form was approved, the first invoice created in HCAI will have to be created from scratch (see the OCF User Manual for “OCF-21C: Create Invoice from Scratch”).
2. Create an OCF-21C from a plan that has previously been submitted via HCAI (see the OCF User Manual for “OCF-21C: Create Invoice from an OCF-2\*3 Previously Submitted via HCAI”).

**This manual covers the first scenario, where an invoice is generated from scratch.**

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

- OCF-21s that are being prepared on the HCAI Web application must be completed by the HCF that is seeking payment by the insurer.
- The applicant signature is not required.

## ***What is the insurer’s role?***

- After the HCF completes and submits the OCF-21, it will appear in the INVOICES global tab and the WORK IN PROGRESS sub-tab. It will appear in the INVOICES worklist in the “Submitted” state, until an insurer user views the form. If the facility has submitted a form in error, that form can be withdrawn up until an insurer user views the form.
- After the adjuster matches the form to their claimant, they will be able to adjudicate the form. At that point, the form will continue to appear in the INVOICES worklist; however, it will appear in the “In Review” state.
- After the form is adjudicated, the adjudicated form will move from the Invoices Work In Progress tab to the Adjuster Response tab, where it can be viewed online or printed

## ***Fee***

There is no fee payable for completion of the standard invoice.

## Completion of OCF-21C for goods and services that have been approved by insurer

To create an OCF-21C from an OCF-23 that has been submitted and/or approved manually (i.e., not via HCAI), do the following:

- Go to the INVOICES tab and the DRAFT sub-tab (see Figure 1).
  - This action can also be done in any of the other sub-tabs
- Select OCF-21C and click **CREATE NEW**.

Figure 1: Invoices global tab and Draft sub-tab

The screenshot shows the 'Test Facility' interface for HCAI. The 'INVOICES' tab is highlighted in red. Below it, the 'DRAFT' sub-tab is also highlighted in red. The interface includes a search bar for 'Patient Last Name', a 'GO' button, and a 'LOGOUT' button. The 'Invoice Management - Draft' section shows a filter for 'All Invoices' and a 'CREATE NEW' button. The date '2009/08/10' is displayed. A table titled 'Draft (1 of 1)' lists the following items:

OCF Type	Patient	Date Modified
OCF21C	akon	2009/08/07
OCF21B	smith	2009/08/07

The footer of the interface contains the text: © 2007 Health Claims for Auto Insurance Processing | Privacy Policy | Change Password

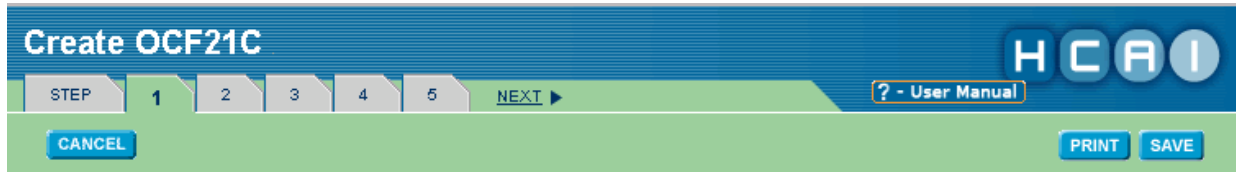
- An OCF-21C will open.

# COMPLETION OF AN OCF-21C in HCAI

## OCF-21C TABS

The OCF-21C in HCAI appears organized under five tabs.

Figure 2: OCF-21C tabs



### **Tab 1**

Claim Identifier

Invoice Identifier

Part 1 – Applicant (Patient) Information

Part 2 – Auto Insurer

### **Tab 2**

Part 3 – Invoice details

Part 4 – Payee Information and Conflict of Interest Declaration

### **Tab 3**

Part 5 – Injury and Sequelae Codes

Part 6 – Goods and Services Rendered

### **Tab 4**

Part 7 – Reimbursable Fees within the PAF Guideline

Part 8 – Other Reimbursable Services Requiring Insurer Approval

Part 9 – Other Insurance Goods and Services (Services Charged to Other Sources)

Additional Information

### **Tab 5**

Additional Comments (and/or Attachments)

## TAB 1

---

### ***Claim Identifiers – Speed up Claims Processing***

- 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 (patient/claimant) with information including the claim number, date of loss, adjuster name 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 may delay 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.
  - i. Claim number and policy number can be obtained from the insurance adjuster
  - ii. Policy number also available on the Motor Vehicle Liability Insurance Card (pink slip)
  - iii. Claim Number and Policy Number may be the same.

#### **2. The accident date must be completed. Forms will not be processed without it**

- a. If the 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**

### ***Invoice Identifier***

Information cannot be entered in this section in Tab 1.

## Part 1 – Applicant Information

- Applicant (patient) or substitute decision-maker<sup>1</sup> should provide this information to clinic staff.

Figure 3: Applicant Information

**Part 1: Applicant Information**

Please provide all information requested. Values marked with an asterisk (\*) are mandatory fields required for submission. Collection, use and disclosure of this information is subject to all applicable privacy legislation.

\* Date of Birth: 1958/06/12

\* Gender:  Male  Female

\* Last Name: Smith

\* First Name: John

Middle Name:

\* Address 1: 1123 Elm St

Address 2:

\* City: Toronto

\* Province/State: ON - Ontario

\* Postal/ZIP Code: M1M 1M1

Phone:

## Part 2 – Auto Insurer Information

- The applicant (patient/claimant) or substitute decision-maker should provide information.
- The last name of the policyholder is mandatory.

### Independent Adjusting Companies and Adjusters

- Independent adjusting companies may be hired by licensed insurance companies to adjudicate claims, but the HCAI application does not list independent adjusting companies.
- To direct claim forms appropriately, health practitioners must 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 IAs can view and adjudicate forms for those claimants for which they have been authorized.

### Policy Holder Details

- If the injured person seeking treatment is the policy holder, select “Yes” to the question “Is the Policy Holder the same as the Applicant?”.
- If the injured person is not the Policy Holder, select “No” and enter the last name of the Policy Holder. The name of the Policy Holder can be obtained from the pink slip of the proof of insurance form.

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<sup>1</sup> 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.

## TAB 2

### Part 3 Invoice Details

Figure 4: Invoice Details

**Part 3: Invoice Details**

Please provide information on known previous plans related to this claimant to aid in the decision making process. Use the drop-down support tools where provided.

Provider Invoice Number:

\* First Invoice:  No  Yes

\* Last Invoice:  No  Yes

**Previously Approved Goods and Services**

For previously approved goods and services, please complete the following:

Type of Plan, PAF or MIG	Injury Type	Plan Date	Approved Amount	Previously Billed
<input type="text" value="Minor Injury Guideline or PAF"/>	<input type="text" value="Minor Injury"/>	<input type="text" value="2010/08/03"/>	<input type="text" value="1,200.00"/>	<input type="text" value="0.00"/>

- Enter the “Provider Invoice Number.” This is where you may record your internal invoice number.
  - This number will appear in the HCAI worklist and can assist you in locating an invoice after you have submitted it.
  - It is not a mandatory field and may be left blank.
- Click “Yes” for “First Invoice” if you are beginning to treat this applicant for injuries sustained in a new motor vehicle accident or in relation to a new treatment plan.
- Click “Yes” for “Last Invoice” if the applicant has been discharged.
- If the invoice is for a previously submitted plan, indicate the type of plan, plan date, plan number, approved amount and previously invoiced amount.
  - *Type of Plan:* Select ‘Minor Injury Guideline or PAF’, indicate Injury Type (WAD I/II or Minor Injury), plan date, approved amount and previously billed.
  - The “Previously Billed” amount refers to the amount previously billed for THIS particular treatment plan

If you are invoicing for services that were proposed on a plan submitted by a different HCF, enter the information provided to you by the submitting HCF.

*Example:*

- Acme Rehab submits an OCF-23 and requests massage therapy services be delivered by a different company - RMT Inc (i.e., Acme Rehab does not deliver the massage therapy).
  - Acme Rehab should provide a copy of the approved plan to RMT Inc.
  - RMT Inc may submit an invoice, but should reference the OCF-23 submitted by Acme Rehab.

### Part 4 – Payee Information and Conflict of Interest Declaration

When the HCF was registered with HCAI, the facility will have chosen “Yes” or “No” to the question “Lock Payables?”

- If the HCF selected “Yes,” these fields will not be editable and the facility’s name and mailing address will be pre-populated.
- If the HCF selected “No,” the field next to “Make Cheque Payable to” must be completed.

Select “Yes” or “No” in response to the question “Is there a conflict of interest?”

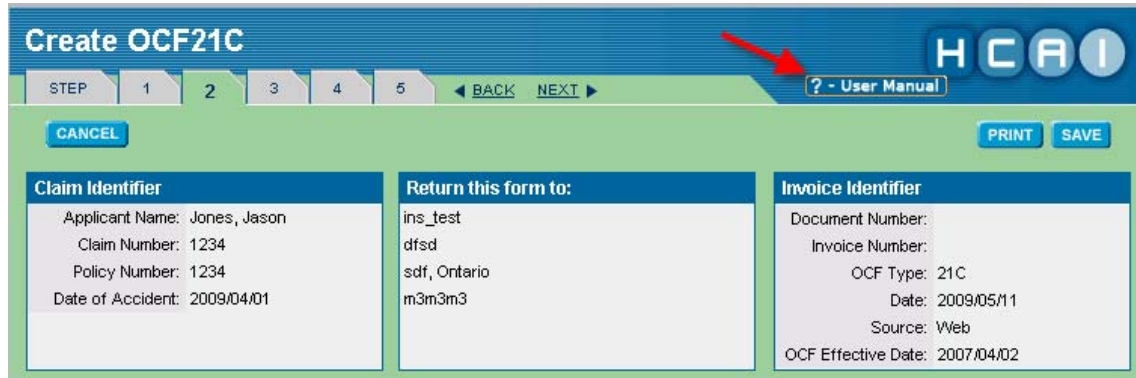
## TAB 3

### Part 5 – Injury and Sequelae Codes

Claimants treated in the Minor Injury Guideline (MIG) or in the Pre-approved Framework (PAF) generally have an injury (ies) that is consistent with the MIG or PAF Guideline.

To learn how to search for injury codes, refer to the HCAI Web User Manual, which can be accessed on any HCAI web page (top right) by clicking the symbol: 

Figure 5 – User Manual



The screenshot shows the 'Create OCF21C' form interface. At the top right, there is a 'HCAI' logo and a button labeled '? - User Manual' with a red arrow pointing to it. The form is divided into three main sections: 'Claim Identifier', 'Return this form to:', and 'Invoice Identifier'. The 'Claim Identifier' section contains fields for Applicant Name (Jones, Jason), Claim Number (1234), Policy Number (1234), and Date of Accident (2009/04/01). The 'Return this form to:' section contains fields for ins\_test, dfsd, sdf, Ontario, and m3m3m3. The 'Invoice Identifier' section contains fields for Document Number, Invoice Number, OCF Type (21C), Date (2009/05/11), Source (Web), and OCF Effective Date (2007/04/02). There are also 'CANCEL', 'PRINT', and 'SAVE' buttons.

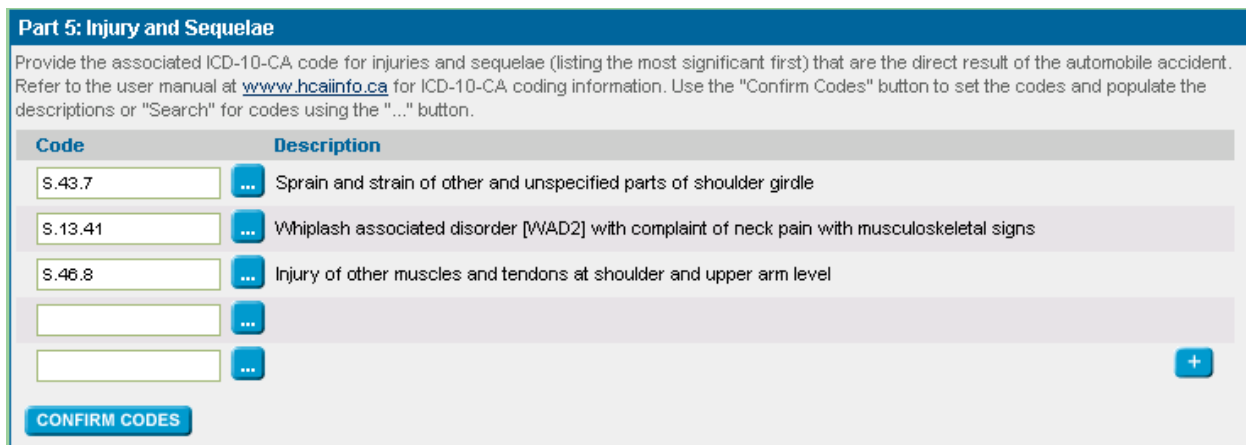
### Questions about coding

Refer any questions regarding injury coding to your provider association or access the website at [www.hcaiinfo.ca](http://www.hcaiinfo.ca)

### Adding additional lines for injury/sequelae codes

To add lines for additional injuries, simply click the  sign near the bottom of the Part 5 box (see Figure 6).

Figure 6: Injury and Sequelae



The screenshot shows the 'Part 5: Injury and Sequelae' form. It includes a header with the title and a paragraph of instructions: 'Provide the associated ICD-10-CA code for injuries and sequelae (listing the most significant first) that are the direct result of the automobile accident. Refer to the user manual at [www.hcaiinfo.ca](http://www.hcaiinfo.ca) for ICD-10-CA coding information. Use the "Confirm Codes" button to set the codes and populate the descriptions or "Search" for codes using the "..." button.' Below this is a table with two columns: 'Code' and 'Description'. The table contains three rows of data, each with a code, a description, and a blue button with three dots. There are also two empty rows with blue buttons and a plus sign button at the bottom right. A 'CONFIRM CODES' button is located at the bottom left.

Code	Description
S.43.7	Sprain and strain of other and unspecified parts of shoulder girdle
S.13.41	Whiplash associated disorder [WAD2] with complaint of neck pain with musculoskeletal signs
S.46.8	Injury of other muscles and tendons at shoulder and upper arm level

Refer to [Appendix A](#) for a partial pick list of injury/problem codes at [www.hcaiinfo.ca](http://www.hcaiinfo.ca)

## Part 6 – Goods and Services Rendered

- This section should list all dates and details of the specific treatment interventions rendered during the course of treatment for which the HCF is seeking payment.
- **At this stage, payment information is NOT required.** Do **NOT** use the MIG (or PAF) block billing codes in this section.
- Provide details of specific interventions that were delivered; e.g. exercise, education, stimulation (TENS, laser, US, etc.).
- **Important:** MIG/PAF block billing codes and fees will be entered in Part 7 – do NOT enter them here
- **Important:** For patients with accident dates PRIOR to Sep 1, 2010, PAF - Other Reimbursable Goods and Services (e.g. Home/Work/School Onsite Intervention) that required insurer approval, should be entered in Part 8.

Figure 7: Goods and Services lines

**Part 6: Goods and Services Rendered**


Providers are required to declare the information requested below on every treatment, service and good delivered. Failure to provide this information may delay payment.

	Date Services Rendered	Code	Attr	Provider Ref.	Quantity/Measure
<input type="checkbox"/>	2009/04/29	H.XX.MR Med/Rehab	<input type="checkbox"/>	Riis, Viivi	1.00 PR
<input type="checkbox"/>	2009/04/29	1.SC.02 "Exercise, spinal...	<input type="checkbox"/>	Riis, Viivi	1.00 PR
<input type="checkbox"/>	2009/05/29	7.SP.60 "Education promn	<input type="checkbox"/>	Riis, Viivi	1.00 PR

### Date service rendered

- All dates on which the claimant attended for treatment should be listed.
- Dates should be formatted yyyy/mm/dd.
- The calendar utility may also be used.

### Code

- Enter the intervention by typing it directly into the field under “Code.” Or use the code search utility by clicking the blue button  next to the “Code” field (see Figure 7).
- If using the search utility, select either “CCI” (Canadian Classification of Interventions) or “GAP”
  - CCI are international standard codes for health interventions. However, some services were not well represented in the CCI; therefore, GAP codes were developed specifically for the auto insurance sector in Ontario.
- If using the search utility, select either “CCI” (Canadian Classification of Interventions) or GAP.
  - CCI are international standard codes for health interventions. However, some services were not well represented in the CCI; therefore, GAP codes were developed specifically for the auto insurance sector in Ontario.

## Quantity and unit measure

- Enter the quantity and unit measure of service that will be provided during a single treatment visit/session.
  - *Example*
    - 15 minutes = 0.25 HR
    - 1 procedure = 1 PR
    - 1 good (like a back support) = 1 GD
    - 10 km = 10 KM
    - 1 session = 1 SN
  - It is important to use the correct unit measure that corresponds to the service described.
    - Most treatment interventions should use the PR (procedure) or HR (hour) measure.
    - All “goods” must use the GD (goods) measure.
    - Disbursements, such as parking, may be conveyed using “Other” (AXXOT) goods and the PR or HR measure must be used.
    - Mileage expense must be conveyed using the KM (kilometre) measure.
    - The unit measure for reports, letters and documentation other than OCF forms submitted to the insurer (CCI codes 7.SJ.30 and 7.SJ.30.LB) may have unit of measure “PG”. Do not use GD for documentation review or preparation.

## Attribute

In addition to the CCI code, healthcare services can be further specified with Attribute Codes. These codes are used to indicate how the service was delivered or the number of views in an X-ray study.

The absence of attribute codes means that a service was rendered directly (“in person”), to one individual by an individual provider, and required continuous attendance. Refer to Appendix B for more information about attributes. .

## Provider reference

- Use the dropdown list to select the health care provider who delivered care on a given date.

## Insert one provider for multiple line items

There is a shortcut for inserting one provider name in multiple line items, as follows:

Figure 8: Apply one provider to several line items

Part 6: Goods and Services Rendered						
Providers are required to declare the information requested below on every treatment, service and good delivered. Failure to provide this information may delay payment.						
Date Services Rendered	Code	Description	Attr.	Provider Reference	Quantity	Measure
2010/08/04	H.XX.MR	Med/Rehab		...	1	PR
2010/08/04	1.TA.07	"Hyperthermy, shoulder joint"		...	.25	HR
2010/08/05	1.TA.07	"Hyperthermy, shoulder joint"		...	.25	HR
2010/08/05	1.TZ.02	"Exercise, arm NEC"		...	.5	HR

1. Complete all fields except for the “Provider Ref” fields.

2. Tick each box to the left of the each completed line item (see red box in Figure 8).
3. Click **APPLY PROVIDERS**. Select the name of the provider from the dropdown list and that name will populate all lines under "Provider Ref."

### Quantity and unit measure

- Enter the quantity and unit measure of service that will be provided during a single treatment visit/session.
  - *Example*
    - 15 minutes = 0.25 HR
    - 1 procedure = 1 PR
    - 1 good (like a back support) = 1 GD
    - 10 km = 10 KM
    - 1 session = 1 SN
  - It is important to use the correct unit measure that corresponds to the service described.
    - Most treatment interventions should use the PR (procedure) or HR (hour) measure.
    - All "goods" must use the GD (goods) measure.
    - Disbursements, such as parking, may be conveyed using "Other" (AXXOT) goods and the GD measure must be used.
    - Mileage expense must be conveyed using the KM (kilometre) measure.
    - Do not use GD for documentation review or preparation.

### Attribute

In addition to the CCI code, healthcare services can be further specified with Attribute Codes. These codes are used to indicate how the service was delivered or the number of views in an X-ray study.

The absence of attribute codes means that a service was rendered directly ("in person"), to one individual by an individual provider, and required continuous attendance. Refer to Appendix B for more information about attributes.

## TAB 4

### **Part 7 – Reimbursable Block Fees within the MIG (PAF if injury prior to Sept 1, 2010) Guideline**

Figure 9 – Search for MIG Codes

#### Search Goods and Services Codes

The *Canadian Classification of Health Interventions*, referred to as CCI, are developed by the *Canadian Institute for Health Information* (CIHI). It is a comprehensive list of codes for diagnostic, therapeutic, and support interventions. For the purposes of the *Automobile Insurance Industry*, a number of non-CCI codes were developed in consultation with CIHI to complement the existing set of CCI codes. These codes are noted with an asterisk (\*) and are not part of CCI.

GAP codes are developed by Insurance Bureau of Canada in conjunction with automobile insurers and health care providers to cover those items billed to automobile insurers by providers that are not covered by CCI. Items that fall outside of the realm of a medical procedure, intervention, or service, are coded by using GAP codes. These include goods, supplies, assistive devices, mileage, travel time, and independent medical examinations.

Click either “**CCI**” or “**GAP**” codes. To begin the search select the “**Section**” that is appropriate for your clinical situation. To narrow down the search results, select an “**Intervention**” and a “**Group**” prior to clicking the “**Search**” button.

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**Code Domain**

CCI  GAP (including PAF Codes)

**Section**

.....

**Intervention**

.....

**Group**

.....

**CANCEL**

- If you search for codes for Part 7, make sure you select “GAP” (see Figure 9)
- Include only MIG codes and fees here. PAF codes only apply if the date of accident was on or after Sept 1, 2010.
- Note: If PAF (date of accident on or after Sept 1, 2010) do **NOT** include Home/worksite/school visit and intervention here.

- Pre-approved MIG Blocks are listed in Appendix B of the Minor Injury Guideline
- Pre-approved PAF Blocks are listed in Appendix B of the PAF Guideline.
- The codes for pre-approved services are all GAP codes.
- The maximum fees payable by insurers for pre-approved services are listed in the MIG (PAF) Guideline.
- To learn which services are pre-approved, read the MIG Guideline published by the Financial Services Commission of Ontario and available on the FSCO website ([www.fSCO.gov.on.ca](http://www.fSCO.gov.on.ca)).

Figure 10: MIG block billing

**Part 7: Reimbursable Fees within the Minor Injury Guideline or Pre-approved Framework**

Guideline to which this invoice applies: Minor Injury

	Code		Description	Attr.	Cost
<input type="checkbox"/>	M.I.G.00	...	Initial visit (1 Session)	<input type="checkbox"/>	215.00
<input type="checkbox"/>	M.I.G.01	...	Block 1 (weeks 1 to 4)	<input type="checkbox"/>	775.00
<input type="checkbox"/>	M.I.G.02	...	Block 2 (weeks 5 to 8)	<input type="checkbox"/>	500.00
<input type="checkbox"/>	M.I.G.SG	...	Supplementary goods and services	<input type="checkbox"/>	120.00
<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	...		<input type="checkbox"/>	<input style="width: 50px;" type="text"/>

Use this button with the checkboxes on the left.

Add more Items:

Estimated MIG or PAF Sub-total: 1,610.00

- When you are satisfied that you have included the blocks you wish to charge for, click . The system will complete the math for you.

***Part 8 – Other Reimbursable Services Requiring Insurer Approval (Only applies to accident dates PRIOR to Sept 1, 2010)***

- **Part 8 should ONLY be completed if the client’s date of accident was PRIOR to Sept 1, 2010**
- This section should be completed only if the insurer approved services in Part 11 of the OCF-23.
- The services that may be billed in this section are limited to those specified in the PAF Guideline (see Table 1 below) in Appendix B “Additional PAF Interventions.”
- The codes for these are all GAP codes.
- The maximum fees payable by insurers for pre-approved services are listed in the PAF Guideline.
- Refer to the PAF Guideline that is published by the Financial Services Commission of Ontario and available on the FSCO website ([www.fSCO.gov.on.ca](http://www.fSCO.gov.on.ca)).

**Table 1: Other PAF Services Requiring Insurer Approval (only for patients with an accident date PRIOR to Sept 1, 2010).**

Service	Code	Unit Measure	Maximum Fee Payable by Insurer
Onsite work/home/school review and intervention	P.WW.OR	HR (hour); or PR (procedure)	See PAF Guideline
Travel time	A.XX.TT	HR	Negotiated between health facility and insurer
Mileage	A.XX.KM	KM	Negotiated between health facility and insurer
Post-PAF phase extension	P.WW.EV	HR; or PR	See PAF Guideline
Transfer	P.WW.TR	PR	See PAF Guideline

Complete each line of goods and services. Completed lines in Part 8 will appear similar to those shown in Figure 11.

Figure 11: Other reimbursable Goods and Services Approved by the Insurer

**Part 8: Other Reimbursable Goods and Services Approved by the Insurer**

Other reimbursable goods and services must be within the PAF Guidelines.

If HST applies to a good or service, check the Proposed Tax checkbox on that line item.

	Date Services Rendered	Code	Attr.	Provider Reference	Quantity/Measure	Cost	Tax
<input type="checkbox"/>	2010/08/03	P.WW.OR	<input type="checkbox"/>	Occupational, The...	1 PR	200.00	<input type="checkbox"/>
<input type="checkbox"/>	2010/08/03	A.XX.KM	<input type="checkbox"/>	Occupational, The...	78 KM	30.40	<input type="checkbox"/>
<input type="checkbox"/>	2010/08/03	A.XX.TT	<input type="checkbox"/>	Occupational, The...	1 HR	94.37	<input type="checkbox"/>
<input type="checkbox"/>			<input type="checkbox"/>				<input type="checkbox"/>
<input type="checkbox"/>			<input type="checkbox"/>				<input type="checkbox"/>

Add more Items: 5 Items

Use these buttons with the checkboxes on the left.

Completion of Part 8 is done similarly to completion of Part 6. The only difference is that you will assign costs and may assign Tax to services. Completing lines in Part 8 is described below.

**Date service rendered**

Use the calendar utility to select the date on which the service was delivered, or insert the date (yyyy/mm/dd).

## Code

- Enter the intervention by typing it directly into the field under “Code.” Or use the code search utility by clicking the blue button next to the “Code” field.
- If using the “Code” search utility, select GAP.
- The codes required to populate Part 8 are all GAP codes.

## Attribute

Refer to page 14/15 for information on Attributes.

## Provider reference

- Use the dropdown list to select the health care provider who delivered care.
- To add one provider to multiple lines, refer to page 14.

## Quantity and Unit Measure

- Enter the quantity and unit measure of service that was provided during the insurer approved intervention.

## Cost

- Report the cost per service as described in the line.
  - *Example:* If the service was delivered for 0.5 HR, the “Cost” column should reflect the cost to deliver that service by the provider listed for 0.5 HR. Note: Do not insert the hourly rate in this column. You may also calculate costs using the provider’s default hourly rate.
  - *Example:* 15 minutes of massage. 0.25 HR by a massage therapist = 25% of the RMT’s hourly fee.  $0.25 \times \$53.66 = \$13.41$ . This amount should be entered in the field under the “Cost” column.
- If Tax is applicable to a line item, check the appropriate box(es).

## Part 9 – Other Insurance Goods and Services (Services Charged to Other Sources)

Figure 12: Other insurance

Part 9: Other Insurance Goods and Services					
Enter the total amounts received or estimated to be payable to you on this invoice for goods and services from other insurance sources (e.g., Ministry of Health and Long-Term Care and Extended Health Care plans to which the applicant is eligible). Categorize amounts by Chiropractic, Physiotherapy, Massage Therapy, and Other. When the category "Other" is used, specify the type of services covered (e.g., dental, psychological, optometric). Amounts may be signed (+/-) or unsigned. When you are indicating the amount payable or not payable from an Other Insurer: Use a negative sign (-) to indicate the amount you have received or will receive directly from the collateral source or applicant. This will allow collateral insurance payments to be subtracted from the sub-total to determine the amount owed by the automobile insurer.					
	Chiropractic	Physiotherapy	Massage Therapy	**Other Services	Total
MOH	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	0.00
Insurer 1	<input type="text" value="-250.00"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="-50.00"/>	(300.00)
Insurer 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	0.00
**Other Service Type Specified:	<input type="text" value="Occupational therapy"/>				<input type="button" value="CALCULATE"/>

**Note:** Amounts for services that have been paid or are estimated to be payable by other insurance sources must be entered with a negative sign.

1. Categorize amounts by chiropractic, physiotherapy, massage therapy and other. When the category "Other" is used, specify the type of services covered (e.g., dental, psychological, optometric).
2. Amounts may be signed (+/-) or unsigned.
  - a. If amounts are payable by another insurer, collateral source or the applicant, use a negative (-) sign. These amounts will be deducted from the amount owed by the auto insurer.
  - b. For amounts previously identified for payment by another insurer but subsequently ruled ineligible, use a plus (+) sign or leave unsigned. These amounts will be added to the sub-total automatically.
3. Click **CALCULATE**.

## Totalling

Figure 13: Totalling

Totalling		
	Proposed	Calculated
Pre-approved Sub-total:	0.00	
Other Goods and Services:	30.00	
* Minus MOH:	0.00	
* Minus Other Insurer (1 + 2):	0.00	
Tax (if applicable):	<input type="text" value="0.00"/>	0.00
Prior Balance:	<input type="text" value="0.00"/>	
Payment Received from Auto Insurer:	<input type="text" value="0.00"/>	
Overdue Amount:	<input type="text" value="0.00"/>	
Interest:	<input type="text" value="0.00"/>	
Auto Insurer Total:	30.00	

† HCAI populates the proposed and calculated tax columns with the HST rate (13%). You may overwrite the Proposed Tax amount if you are charging a tax value that is different from HST.

**CALCULATE**

Recalculate proposed tax to reflect HST on selected taxable items

There are 11 lines in this section. Note that the field also compares the amount proposed on the treatment plan to the actual amount being invoiced. It is possible to invoice for amounts greater than or less than those proposed on a plan, but the insurer may request an explanation.

- Lines 1, 2, 3 and 4 are populated by HCAI using the information entered.
  - *Pre-approved Sub-total* – sum of the cost of all pre-approved services documented in Part 7.
  - *Other Goods and Services* – sum of the cost of other goods and services as described in Part 8.
  - *Minus MOH* – sum of all Ministry of Health and Long-Term Care amounts. This amount is taken from the “Charged Services” MOH line.
    - Amounts paid to you or expected to be paid to you are subtracted from the amount billed to the auto insurer. Amounts that you previously stated were available for you to receive but that you were unable to collect are added to the auto insurer’s invoice.
  - *Minus Other Insurer (1 + 2)* – sum of all amounts received or payable to you from other insurers. This amount is taken from the “Charged Services” lines 2 and 3.
    - Amounts paid to you or expected to be paid to you are subtracted from the amount billed to the auto insurer. Amounts that you previously stated were available for you to receive but that you were unable to collect are added to the auto insurer’s invoice.
- Line 5 represents Tax.
- Lines 6, 7, 8 and 9 are used as the basis for interest charges that have accumulated and will be calculated into the total for this invoice.
  - NB: Only the interest charges will be calculated into the total payable by the auto insurer.
  - Enter *Prior Balance* (the “Auto Insurer Total” from your last invoice).
  - Subtract *Payments Received* since your last invoice to calculate *Overdue Amount*.
  - Enter the interest owing as a result of the *Overdue Amount*.
- Line 10 is the *Auto Insurer Total* – the sum of all amounts in this section.

## **Tax**

Taxes are included in the MIG block billing fees.

The OCF 21C only permits taxes to be selected for line items in Part 8. NOTE: Part 8 should NOT be used for MIG patients. It only applies to PAF patients whose accident date is PRIOR to Sept 1, 2010.

## ***Prior Balance, Overdue Amounts and Interest Charges***

- If the facility has submitted an invoice prior to the current invoice, but it has not been fully paid, you may document the outstanding amount and associated interest on this invoice
- Insert the Prior Balance – which is the amount of the previous invoice
- Insert the amount of payment already received on the previous invoice
- Insert the overdue amount from the previous invoice
- Insert the tax as calculated on the overdue amount

**IMPORTANT:** The overdue amount will NOT be added to the Auto Insurer Total on this new invoice. Only the interest amount will be added to this invoice. The previous invoice is still effective and amounts from prior invoices should not be added to new invoices.

### ***Additional Information***

- In Tab 4, near the bottom of the HCAI page, there is space that permits comments if there is a need to provide the insurer additional explanations/clarifications.
- Only 500 characters are allowed here. If more space is needed, use Tab 5.

Figure 14: Additional Information

**Additional Information**

Make cheque payable to: Acme Rehab

Other Information:

**CANCEL** **PRINT** **SAVE** **SUBMIT**

## TAB 5

---

### ***Additional Comments (& Attachments)***

Figure 15: Additional Comments and Attachments

**Additional Comments**

Please note that the document is not considered complete until the attachments, if any are indicated, are received by the insurer. It is mandatory to indicate the number and types of documents/reports that are being sent.

Attachments being sent, if any.

Family physician report enclosed

- HCAI permits health facilities to:
  - Offer more information to adjusters by using the space provided in Tab 5.
  - Advise adjusters that additional documentation (attachments) is being sent which the insurer requires to adjudicate the form.
    - Attachments must be faxed/mailed directly to the insurance adjuster

#### **Where Should Attachments Be Sent?**

- Attachments must be faxed/mailed directly to the insurance adjuster
- Attachments cannot be sent electronically via HCAI and should not be sent to HCAI
- To indicate that an attachment is being sent to the adjuster, tick the box beside “Attachments being sent, if any.” If this box is ticked, the health facility must use the space below to describe the attachment being sent.

### ***How do I know my form has been submitted?***

When your form is complete, you may save it and a version will remain in the DRAFT tab for future use for this or another patient.

When you are ready to submit the form, click on the button at the top or bottom of tabs 4 or 5 that says SUBMIT.

Figure 16: Successful submission notice

**Create OCF21C** HCAI

Claim Identifier	Return this form to:	Invoice Identifier
Applicant Name: Test, Case Claim Number: 456 Policy Number: 456 Date of Accident: 2008/04/22	_Prof. Assoc. Insurer 1 Main St. Toronto, Ontario M1M 1M1	Document Number: 09032000003 Invoice Number: 1 OCF Type: 21C Date Submitted: 2009/03/20 Source: Web OCF Effective Date: 2006/03/01

You have submitted document number 09032000003. Please note that the document is not considered complete until the attachments, if any are indicated, are received by the insurer.

[CLOSE WINDOW](#)

- Figure 16 is an example of what you will see if your form has been successfully submitted to the insurer.
- Each form is assigned a unique document number by HCAI that can be used to track the form and distinguish it from others submitted for the same patient.

### What if HCAI won't submit the form?

- Look for the error message in orange
- HCAI validates data entered in the application as you move through the first four tabs.
- Errors will be flagged by an orange tab (see Figure 17) or through error messages in orange (see Figure 18).

Figure 17: Error notice [orange tab]

**Create OCF21C** HCAI

STEP 1 2 3 4 5 [BACK](#) [NEXT](#) [? - User Manual](#)

[CANCEL](#) [PRINT](#) [SAVE](#)

When you select a tab with an error, a description will appear next to the field with the error (see Figure 18).

Figure 18: Error explanation

**Part 8: Other Reimbursable Goods and Services Approved by the Insurer**

**Line 1 has the following errors:**

- The measure (HR) is invalid for the goods and services code (AXXKM).

Date Services Rendered	Code	Attr	Provider Ref.	Quantity/Measure	Cost	Proposed Tax
<input type="checkbox"/> 2009/03/17	A.XX.KM	<input type="checkbox"/>	Davis, Wendy	65.00 HR	26.00	<input type="checkbox"/> PST <input type="checkbox"/> GST
<input type="checkbox"/> 2009/03/17	P.WW.OR	<input type="checkbox"/>	Davis, Wendy	1.00 PR	416.98	<input type="checkbox"/> PST <input type="checkbox"/> GST

Onsite work/home/...