September 1, 2010 Auto Reforms: OCF 18

IBC BAC Insurance Bureau of Canada
Bureau d'assurance du Canada

HCAI

OCF-18, Pre-09/01/2010

SAVE

Plan number removed

Name of the OCF-18 changes

Treatment Plan (OCF-18)

Use this form for accidents that occur on or after November 1, 1996.

**Claim Number:	
**Policy Number:	
Date of Accident: (YYYYMMDD)	

*For this applicant, this is Treatment Plan number ____ from this health professional/facility or social worker

IBC BAC Insurance Bureau of Canada Bureau d'assurance du Canada

HCAI

OCF-18, 09/01/2010

Return this form to:

Treatment and Assessment Plan (OCF-18)

Use this form for accidents that occur on or after November 1, 1996.

**Claim Number:	
**Policy Number:	
Date of Accident: (YYYYMMDD)	

NOTE: A Treatment and Assessment Plan (OCF 18) is not required to make the following claims:

- ambulance or other goods or services provided on an emergency basis not more than 5 business days after the accident
- drugs prescribed by a regulated health professional
- goods with a cost of $250 or less per item
- dental goods or services (submitted on the Standard Dental Claim Form)

If this is an impairment that comes within the Minor Injury Guideline (for accidents that occurred on or after September 1, 2010), or within a Pre-approved Framework Guideline (for accidents that occurred before September 1, 2010), an OCF – 23 Treatment Confirmation Form is required instead of this form.

OCF-18, Pre-09/01/2010

Part 4 Conflict of Interest Definition

Conflict of Interest definition removed

A person has a conflict of interest relating to a Treatment Plan if,

financial benefit, directly or indirectly, as a result of the provision, by the related person or another he Treatment Plan, and

ii) the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services or under which goods or services of that kind are provided.

Note: After approving this Treatment Plan, if the insurer determines that there is a conflict of interest that was not disclosed, the insurer may give the applicant notice to amend the Treatment Plan to remove the conflict of interest and if no amendment is made, the insurer is not required to pay for any further expense for which there is the conflict.

OCF-18, 09/01/2010

Part 4 Signature of Health Practitioner

Treatment and Assessment Plan Certification

Previously Part 5, now Part 4

Name of Health Practitioner		College Registration Number	You are a:
Facili[...]		AISI Facility Number (if applicable)	☐ Chiropractor ☐ Dentist ☐ Nurse Practitioner ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Speech-Language Pathologist
Address			
City	Province	Postal Code	
Telephone Number	*Extension	*Fax Number	
[...]ress			

New Field

For accidents that occurred before September 1, 2010:

Is this an impairment referred to in a Pre-approved Framework (PAF) Guideline? ☐ Yes ☐ 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:

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? ☐ Yes ☐ 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)	Signature of Health Practitioner	Date (YYYYMMDD)

HCAI

OCF-18, Pre-09/01/2010

Part 5
Signature of Health Practitioner
Plan Certification

Name of Health Practitioner | College Registration Number

Facility Name (if applicable) | AISI Facility Number (if applicable)

Address

City | Province | Postal Code

Number - | *Extension | *Fax Number - -

ress

You are a:
- Chiropractor
- Dentist
- Nurse Practitioner
- Occupational Therapist
- Optometrist
- Physician
- Physiotherapist
- Psychologist
- Speech-Language Pathologist

Conflict of Interest section removed

☐ I wish to declare that I have no conflicts of interest relating to this Treatment Plan, *and* I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan.

or

☐ I am declaring the following conflicts of interest relating to this Treatment Plan:

I confirm that, to the best of my knowledge, the information in this Treatment Plan is accurate, the Treatment Plan has been reviewed with the applicant by the regulated health professional or social worker in Part 6, and the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 7.

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) | Signature of Health Practitioner | Date (YYYYMMDD)

OCF-18, 09/01/2010

Part 5
Signature of Regulated Health Professional

Treatment and Assessment Plan Preparation and Supervision

If same person as Part 4 check here ☐ and *DO NOT COMPLETE Part 5*

Name of Regulated Health Professional		College Registration Number	You are a:
Facility Name (if applicable)		AISI Facility Number (if applicable)	☐ Chiropractor ☐ Dentist ☐ Massage Therapist ☐ Nurse ☐ Occupational Therapist ☐ Optometrist ☐ Physician ☐ Physiotherapist ☐ Psychologist ☐ Speech-Language Pathologist ☐ Social Worker ☐ Other ________________
Address			
City	Province	Postal Code	
Telephone Number	*Extension	*Fax Number	
*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)	Signature of Regulated Health Professional	Date (YYYYMMDD)

HCAI

OCF-18, Pre-09/01/2010

Part 10 Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery

Part 10 becomes Part 9

a) Goals:

(i) Identify the goal(s) in regard to the applicant's impairment(s), symptom(s) or pathology that this Treatment Plan seeks to achieve:

- ☐ pain reduction
- ☐ increase in strength
- ☐ increased range of motion
- ☐ other(s) (please specify)

and

(ii) Select the functional goal(s) that this Treatment Plan seeks to achieve:

- ☐ …ivities of normal living
- ☐ …dified work activities
- ☐ return to pre-accident work activities
- ☐ other(s) (please specify)

b) Evaluation:

(i) How will progress on the goal(s) in a (i) and a (ii) be evaluated?

(ii) *If this is a subsequent Treatment Plan, what was the applicant's improvement at the end of the previous plan based on your evaluation method?

Send any attachments directly to the insurer

c) Barriers to recovery:

(i) Have you identified any other barriers to recovery? ☐ No ☐ Yes (please explain)

(ii) *Do you have any recommendations and/or strategies to overcome these barriers? ☐ No ☐ Yes (please explain)

d) Concurrent Treatment:

…rrent treatment, that is not included in this Treatment Plan, will be provided by any other provider/facility?

…lain)

Part 10, Section E removed

e) Consistency:

Are there any utilization guidelines applicable to the proposed treatment?

- ☐ Yes (Identify guideline):
- ☐ No (Please explain):

IBC BAC Insurance Bureau of Canada Bureau d'assurance du Canada

HCAI

OCF-18, 09/01/2010

Part 9

Plan Goals, Outcome Evaluation Methods and Barriers to Recovery

Part 9

a) Goals:

(i) Identify the goal(s) in regard to the applicant's impairment(s), symptom(s) or pathology that this Treatment and Assessment Plan seeks to achieve:

- ☐ pain reduction
- ☐ increased range of motion
- ☐ increase in strength
- ☐ other(s)/not applicable (please specify)

and

(ii) Select the functional goal(s) that this Treatment and Assessment Plan seeks to achieve:

- ☐ return to activities of normal living
- ☐ return to pre-accident work activities
- ☐ return to modified work activities
- ☐ other(s)/not applicable (please specify)

b) Evaluation:

(i) How will progress on the goal(s) in a) (i) and a) (ii) be evaluated?

(ii) *If this is a subsequent Treatment and Assessment Plan, what was the applicant's improvement at the end of the previous plan based on your evaluation method?

Send any attachments directly to the insurer

c) Barriers to recovery:

(i) Have you identified any other barriers to recovery? ☐ No ☐ Yes (please explain)

(ii) *Do you have any recommendations and/or strategies to overcome these barriers? ☐ No ☐ Yes (please explain)

d) Concurrent Treatment:

Are you aware if any concurrent treatment not included in this Treatment and Assessment Plan will be provided by any other provider/facility?

☐ No ☐ Yes (please explain)

OCF-18, Pre-09/01/2010

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									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									

Estimated duration of this Treatment Plan: ______ weeks

*How many treatment visits have you already provided: ______ *visits

Sub-Total:	
Minus MOH:	
Minus Other Insurer 1 + 2:	
GST (If applicable):	
PST (If applicable):	
Auto Insurer Total:	

Note †: Refer to the User Manual at www.hcaiinfo.ca for coding.

Attributes codes are used to further qualify the service codes and are described in the manual.

Payment by auto insurer is secondary to available collateral benefits.

PST section and Column are removed

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

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

IBC BAC Insurance Bureau of Canada Bureau d'assurance du Canada

09/01/2010 Auto Reforms OCF-18

Part 12 Proposed Goods or Services Requiring Insurer Approval

To the extent possible, this Treatment and Assessment Plan should include all goods and services (G/S) contemplated by the Regulated Health Professional referred to in Part 5 for the period of this Treatment and Assessment Plan

G/S Ref	Description	†Code	†Attribute	Provider Ref	Estimated Quantity	Estimated †Measure	Estimated Cost	Projected Total Count	Projected Total Cost
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									

Estimat... Weeks — Sub-Total:

*How many visits ha... *visits — Minus MOH:

Minus Other Insurer 1+2:

TAX (if applicable):

Auto Insurer Total:

Note: † Refer to the User Manual coding guidelines poste...

Attributes codes are used to further qualify the service codes and are described in the manual.

Payment by auto insurer is secondary to available collateral benefits.

GST Field becomes tax field (HST)

Health Claims for Auto Insurance

For more information about the Auto Reforms visit:

www.hcaiinfo.ca

IBC BAC Insurance Bureau of Canada
Bureau d'assurance du Canada