

**OCF-24 PRE-APPROVED FRAMEWORK
DISCHARGE & STATUS REPORT**

USER MANUAL

JANUARY 2005

Document Change History

Date	Description of Change	Reason
<u>20050214</u>	<u>Revised Signature of Initiating Health Practitioner</u>	<u>For consistency with revised OCF forms 01/Dec/04</u>

Changes are underlined.

Introduction

Who should use this manual?

This User Manual is designed to assist both health care providers and automobile insurers in the completion of the OCF-24, Pre-Approved Framework Discharge & Status Report. Other manuals are available to assist in the completion of:

OCF-3	Disability Certificate
OCF-18	Treatment Plan
OCF-21	Auto Insurance Standard Invoice
OCF-22	Application for Approval of an Assessment or Examination
OCF-23	The Pre-Approved Framework Treatment Confirmation Form

Facilities and health care providers dealing with victims of motor vehicle accidents are required to use these forms.

Both rehabilitation health care providers and automobile insurers have dedicated a tremendous amount of time and thought to the development of the Pre-approved Framework Discharge and Status Report and other forms. These forms will improve the accountability of all parties, streamline the process of delivering health care services to applicants, and enhance communication between insurers and health care professionals.

The forms are designed to facilitate a clear understanding of the interactions amongst an injured motorist, a health care professional and an insurer through the use of common terms and language. All forms use the national coding standards, the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Canada (ICD-10-CA)*¹, to identify injuries and the *Canadian Classification of Health Interventions (CCI)*¹ to classify health care services and procedures.

What is in this manual?

The manual provides detailed instructions for completion of the fields in the order in which they appear on the forms. The appendices include tables of standardized codes and descriptions for the various codified fields used on the forms.

Where can I get more information?

The manual will be updated from time to time. The latest updates to the manual can be downloaded from the website www.autoinsurancereforms.on.ca.

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

Samples of Completed 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.

- 1 ICD-10-CA and CCI are copyright products of the *Canadian Institute for Health Information (CIHI)* and may not be changed without the Institute's express permission.

OCF-24 Pre-approved Framework Discharge & Status Report

Background

This form has been designed for three purposes:

- (i) It is the form that the initiating provider must use to fulfill the requirement of preparing a final report, indicating the patient's status upon discharge or reaching the end of PAF treatment.
- (ii) The OCF-24 must also be used in circumstances where the initiating provider determines, at any point during PAF treatment, that significant progress toward recovery is not being made or continued.
- (iii) For WAD II patients only, this form may also be used to request an extension of the PAF, not exceeding 2 weeks and 4 visits, when the initiating provider believes that this extension will lead to resolution of the impairment and discharge from care.

This form may not be materially altered; in other words, the document cannot be changed in any manner. If this document is materially altered, it may be considered incomplete and the insurer may not accept the form.

Who completes this form?

The OCF-24 is signed and submitted by the initiating health practitioner.

When this form is used to request an extension of the PAF, the insurer indicates his or her approval decision and signs Part 6. Insurer approval constitutes authorization to proceed with the extension. If the insurer does not approve an extension, the health practitioner may submit the proposed treatment on an OCF-18 for the regular treatment plan approval process.

Return this form to: ABC Insurance Company P.O. Box 123, Station 'A' Toronto, ON M1M 1M1 Attn: Mary MacGregor	<table border="1"><tr><td colspan="2" style="text-align: center;">Pre-approved Framework Discharge & Status Report (OCF-24/198)</td></tr><tr><td colspan="2" style="text-align: center;"><small>Use this form for accidents that occur on or after October 1, 2003</small></td></tr><tr><td>Claim Number:</td><td>1234567-001</td></tr><tr><td>Policy Number:</td><td>9876543</td></tr><tr><td>Date of Accident: <small>(yyyymmdd)</small></td><td>20031001</td></tr></table>	Pre-approved Framework Discharge & Status Report (OCF-24/198)		<small>Use this form for accidents that occur on or after October 1, 2003</small>		Claim Number:	1234567-001	Policy Number:	9876543	Date of Accident: <small>(yyyymmdd)</small>	20031001
Pre-approved Framework Discharge & Status Report (OCF-24/198)											
<small>Use this form for accidents that occur on or after October 1, 2003</small>											
Claim Number:	1234567-001										
Policy Number:	9876543										
Date of Accident: <small>(yyyymmdd)</small>	20031001										

Return this form to:

Enter the name and mailing address of the Insurance Company responsible for handling the claim.

Claim Identifiers

The Applicant must indicate the claim number if known, the policy number, and the date of the accident. The claim number and policy number can be obtained from the insurance adjuster. The policy number is also available on the Motor Vehicle Liability Insurance Card (pink slip) received with the policy declaration.

The Claim Number and Policy Number may be the same.

The accident date must be completed. Forms will not be processed without it. If a patient has overlapping injuries from more than one accident, use the date of the accident that is most relevant to the injuries being treated.

Part 1 Applicant Information

Part 1 Applicant Information	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		Middle Name	
	Jonathan		James	
Address				
123 Main Street				
City		Province	Postal Code	
Toronto		ON	M9M 9M9	

To be completed by the Applicant.

Part 2 Insurance Company Information

Part 2 Insurance Company Information	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	Adjuster Extension	Adjuster Fax	
(416) 555-5555	4777	(416) 555-5555		
Name of policy holder: Same as Applicant <input type="checkbox"/>	Policy Holder Last Name	Policy Holder First Name		
	Smith	Jessica		

To be completed by the Applicant.

Part 3 Patient Status

Part 3 Patient Status	<input type="checkbox"/> Impairment resolved and patient discharged
	<input checked="" type="checkbox"/> Impairment improving
	<input type="checkbox"/> Impairment not resolving
	<input type="checkbox"/> Discharged because patient unreasonably failed to fully participate in the PAF
	<input type="checkbox"/> Discharged because patient withdrew consent to treatment

Check off the appropriate patient status option.

Part 4 Provider's Recommendation and PAF Extension Request

Part 4 Provider's Recommendation and PAF Extension Request	<input type="checkbox"/> Further or other treatment is being proposed through a Treatment Plan (OCF-18), and/or <input type="checkbox"/> Patient referred to another regulated health professional <input checked="" type="checkbox"/> Request for PAF Extension		
	Number of treatment visits:	4	Total Cost: \$168.00

Check off your recommendation. If this is a request for extension as outlined in the PAF guidelines, indicate the proposed number of treatment visits and estimated cost.

Part 5 Signature of Initiating Health Practitioner

Part 5 Signature of Initiating Health Practitioner	Initiating Health Practitioner Last Name	Initiating Health Practitioner First Name		College Registration Number	You are a: <input 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 checked="" type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech-Language Pathologist
	Bronson	Betsy		123456	
	Facility Name (if applicable)	Family Care Clinic		AISI Facility Number (if applicable)	
	Address				
	234 Second Avenue East				
	City	Province	Postal Code		
	Toronto	ON	M2M 2M2		
	Telephone Number	Extension	Fax Number		
	(416) 555-5555	2424	(416) 555-5555		
	Email Address bbronson@famcare.ca				
<small>I certify 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. This information will be used for processing payments of claims, identifying and analysing the nature, affects and costs of goods and services that are provided to automobile accident victims by health care providers; and detecting and preventing fraud.</small>					
Name of Initiating Health Practitioner (please print)		Signature of Initiating Health Practitioner		Date (yyyyymmdd)	
Betsy Bronson					

This form must be signed by the Initiating Health Practitioner. The inclusion of a revised statement of understanding identifies for the Initiating Health Practitioner the range of specific uses that will be made of information related to providing services to injured auto insurance claimants.

According to the Statutory Accident Benefits Schedule (SABS), health practitioners are chiropractors, dentists, nurse practitioners, occupational therapists, optometrists, physicians, physiotherapists, psychologists and speech language pathologists.

Part 6 Approval

Part 6 Approval	To the insurer: Please complete the following and return this page to the Health Practitioner.		
	<input checked="" type="checkbox"/> Extension Approved	<input type="checkbox"/> Extension Partially approved (explanation to follow or attached)	<input type="checkbox"/> Extension Not approved (explanation to follow or attached)
	Name of Adjuster (please print)	Signature of Adjuster	Date (yyyyymmdd)
	Mary MacGregor		20031218

When this form is used to request a PAF extension, the insurer indicates his or her approval decision and signs Part 6. If the insurer does not approve an extension, the health practitioner may submit the proposed treatment on an OCF-18 for the regular treatment plan approval process.

Part 7 Functional Status

Part 7 Functional Status	Functional Status a) If employed at the time of the accident, has the applicant returned to his/her usual work activities? <input type="checkbox"/> Not Employed <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b) Has the applicant returned to his/her usual non-work activities? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No c) Has the applicant recovered to his/her pre-accident level of overall function? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No d) Has the applicant returned to his/her caregiving activities <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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Indicate the functional status of the client by checking off the appropriate answers. If the answer is no to any of the questions, indicating that the client has not returned to pre-accident status, complete Part 8.

Part 8 Factors Related to Applicant Status

Complete the remainder of this form only if the answer to one or more questions above is 'No'.

Part 8 Factors related to Applicant Status (Required only if any answer in Part 7 is 'No')	Employment Status <i>If the applicant was employed at the time of the accident, please complete the following questions.</i> a) If the applicant lost time from work has he/she returned to: <input type="checkbox"/> Regular duties <input checked="" type="checkbox"/> Modified duties/time <i>If modified duties / time, please describe:</i> Returned to work half days, 3 days a week. b) If not at work, has the employer been contacted to obtain work history and inquire about availability of modified duties / time? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, explain why:</i>
	Complicating Physical Factors a) Are there complicating physical factors that may predispose the applicant to slow recovery? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please specify:</i> Fell down stairs - fractured clavicle prohibits full participation for a period of time b) Has the applicant been referred to a health practitioner with respect to the identified physical factors? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No i) Date of Referral (YYYYMMDD): ____/____/____ ii) Type Health Practitioner: _____

(Partial Screen Print)

Respond to all of the questions in Part 8 that are relevant to this patient.

Return this form to:

ABC Insurance Company
 P.O. Box 123, Station 'A'
 Toronto, ON
 M1M 1M1
 Attn: Mary MacGregor

Pre-approved Framework Discharge & Status Report (OCF-24/198)

Use this form for accidents that occur on or after October 1, 2003

Claim Number:	1234567-001
Policy Number:	9876543
Date of Accident: (yyyymmdd)	20031001

To the Health Professional/Facility:

Consent: It is the responsibility of the health professional/facility to ensure that the collection, use and disclosure of information submitted are authorized by a consent form. Health professionals/facilities should use the Ontario Claims Form 5 (OCF-5) *Permission to Disclose Health Information* as a consent form, although additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

Collection, use and disclosure of this information is subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

Use this form in accordance with the Pre-approved Framework Guidelines.

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

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

Part 3 Patient Status	<input type="radio"/> Impairment resolved and patient discharged <input checked="" type="radio"/> Impairment improving <input type="radio"/> Impairment not resolving <input type="radio"/> Discharged because patient unreasonably failed to fully participate in the PAF <input type="radio"/> Discharged because patient withdrew consent to treatment
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Part 4 Provider's Recommendation and PAF Extension Request	<input type="radio"/> Further or other treatment is being proposed through a Treatment Plan (OCF-18), and/or <input type="radio"/> Patient referred to another regulated health professional <input checked="" type="radio"/> Request for PAF Extension Number of treatment visits: <input checked="" type="checkbox"/> Total Cost: \$168.00
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Part 5 Signature of Initiating Health Practitioner	Initiating Health Practitioner Last Name Bronson		Initiating Health Practitioner First Name Betsy		College Registration Number 123456		You are a: <input 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 checked="" 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 M2M 2M2		
	Telephone Number (416) 555-5555		Extension 2424	Fax Number (416) 555-5555			
	Email Address bbronson@famcare.ca						
	I certify 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. 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 Initiating Health Practitioner (please print) Betsy Bronson			Signature of Initiating Health Practitioner		Date (yyyymmdd)		

Part 6 Approval	To the insurer: Please complete the following and return this page to the Health Practitioner.		
	<input checked="" type="checkbox"/> Extension Approved	<input type="checkbox"/> Extension Partially approved (explanation to follow or attached)	<input type="checkbox"/> Extension Not approved (explanation to follow or attached)
	Name of Adjuster (please print) Mary MacGregor	Signature of Adjuster	Date (yyyymmdd) 20031218

Part 7 Functional Status	Functional Status
	a) If employed at the time of the accident, has the applicant returned to his/her usual work activities? <input type="checkbox"/> Not Employed <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	b) Has the applicant returned to his/her usual non-work activities? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	c) Has the applicant recovered to his/her pre-accident level of overall function? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	d) Has the applicant returned to his/her caregiving activities <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Complete the remainder of this form only if the answer to one or more questions above is 'No'.

Part 8 Factors related to Applicant Status (Required only if any answer in Part 7 is 'No')	Employment Status <i>If the applicant was employed at the time of the accident, please complete the following questions.</i>
	a) If the applicant lost time from work has he/she returned to: <input type="checkbox"/> Regular duties <input checked="" type="checkbox"/> Modified duties/time <i>If modified duties / time, please describe:</i> Returned to work half days, 3 days a week.
	b) If not at work, has the employer been contacted to obtain work history and inquire about availability of modified duties / time? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, explain why:</i>
	Complicating Physical Factors
	a) Are there complicating physical factors that may predispose the applicant to slow recovery? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please specify:</i> Fell down stairs - fractured clavicle prohibits full participation for a period of time
b) Has the applicant been referred to a health practitioner with respect to the identified physical factors? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No i) Date of Referral (YYYYMMDD): ___/___/___ ii) Type Health Practitioner: _____	
c) Is the applicant improving but slowly? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
d) Will the applicant benefit from continuation of specific therapies already being used? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, what benefits are anticipated?</i> Return to regular work duties and hours	
Applicant Non-Participation	
a) Was the applicant able and willing to engage in active therapies? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If no, explain why:</i> Fractured clavicle delayed participation in treatment sessions.	
b) Did the applicant miss more than 2 consecutive days or 4 days overall of treatment without a reasonable explanation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
c) Was there evidence of non-participation in home exercises without a reasonable explanation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
d) Was there any other evidence of non-participation in the treatment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If yes, please specify:</i>	

Barriers to Recovery (Please refer to the User Manual for completion of this section)

a) What barriers to recovery have been identified?

None

b) When were they identified (YYYYMMDD)? _____/____/____

c) Have you attempted to address barriers to recovery in the treatment?

Yes No

If yes, with what results?

d) Is the applicant showing signs of emotional disturbance that requires further consideration to determine if it results from the injury and requires treatment?

Yes No

e) Has the applicant been referred to a health practitioner with respect to the identified factors?

Yes No

i) Date of Referral (YYYYMMDD): _____/____/____

ii) Type Health Practitioner: _____

o Additional sheets attached

Sample