OCF–23 THE PRE-APPROVED FRAMEWORK TREATMENT CONFIRMATION FORM

USER MANUAL

March 2006

Document Change History

Date	Description of Change	Reason
20050214	Revised Applicant Signature, Signature of the Initiating Health Practitioner & Prior & Concurrent Conditions, Repositioned Signature of Insurer	For consistency with revised OCF forms 01/Dec/04
20060301	Further Information and Revised Applicant Signature	Redirects Users to HCAI website and revised consent for consistency.

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–23, The Pre-Approved Framework Treatment Confirmation Form. 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–24	Pre-Approved Framework Discharge & Status Report

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 revision or development of the Pre-approved Framework Treatment Conformation Form 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.

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.

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.hcaiinfo.ca under Auto Insurance Resources>Statutory Accident Benefits>User Manuals.

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 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.

OCF-23 Pre-approved Framework Treatment Confirmation Form

Background

The health practitioner who initiates pre-approved treatment for an injury defined in a Pre-approved Framework (PAF) must fully complete a Pre-approved Framework Treatment Confirmation Form, OCF-23, in order to establish the Initiating Health Practitioner's right to reimbursement for the delivery of PAF treatment. The OCF-23 is also the form used to request insurer approval of those treatments that are permitted to be delivered together with treatment in the PAF, but which also require insurer approval.

Purpose:

- To describe the injuries which are a direct result of the motor vehicle accident.
- To identify to the insurer the relevant PAF program of care and any related pre-approved goods and services that will be provided.
- To request insurer approval of any treatments permitted in the PAF that require pre-approval.
- To provide speedy confirmation to the provider that there is an insurance policy in existence to enable reimbursement.
- To identify any prior conditions and/or barriers to recovery that could affect the claimant's response to the treatment.

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.

When is an OCF-23 required?

The initiating practitioner must submit the OCF-23 as soon as possible and no later than five days following the practitioner's first encounter with the claimant. After receipt of the OCF-23, the insurer has five days to inform the provider that there is an insurance policy in place to respond to invoices.

There will normally be only one OCF-23 per patient. However, exceptions to this can occur, including when:

- an ancillary service* is proposed by the initiating practitioner, family physician or insurer, either when the PAF is initiated or after treatment is underway. The proposal and approval of the ancillary service are documented through an OCF-23 that is signed by the initiating health practitioner or the patient's physician. Thus, if the insurer wishes to initiate an ancillary service, the insurer shall do so by contacting either the initiating practitioner or the patient's family physician, who will complete the OCF-23.
- the initiating practitioner determines, after treatment is underway, that the patient needs a good (e.g. equipment) to support treatment or that a supplementary condition exists which requires the Supplementary Condition service.
- the patient decides to change practitioners while there are resources remaining in the PAF, in which case the patient and second practitioner must inform the insurer through submission of a new OCF-23.
- the initiating provider of a WAD I PAF determines that the patient is more appropriately treated in the WAD II PAF. In this case, the total cost of PAF treatment must not exceed the cost of the WAD II PAF and must be documented in a new OCF-23.

** Refer to the **PAF Guidelines** for more information. An Activities of Normal Life Intervention (ANLI) is used to identify and evaluate areas of functional difficulty or barriers to recovery and to implement strategies for recovery.*

Who completes this form?

The health practitioner who undertakes the responsibility for treating the patient in the PAF completes and submits the OCF-23. By signing Part 5, the health practitioner is affirming that the goods and services contemplated are reasonable and necessary for the injuries described in Part 6.

The applicant or a substitute decision maker completes Part 1 and 2 and signs Part 13. 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.

The insurer completes Part 12 and returns a copy of the page to the applicant and the health practitioner.

Fee

The fee for completion of this form is embedded in the block funding structure of the PAF. Therefore, the insurer may not be billed separately for completion of this form.

Return this form to:

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

Pre-approved Framework Treatment Confirmation Form (OCF-23/198)

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

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 To be completed by the applicant	Date Of Birth (YYYYMMDD) 19490525	Gender ✓ Male ❑ 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	

To be completed by the Applicant.

Part 2 Insurance Company Information

Part 2 Automobile Insurer Information To be completed by the applicant	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 ❑, OR	Policy Holder Last Name Smith	Policy Holder First Name Jessica

To be completed by the Applicant.

Part 3 Other Insurance Information

Part 3 Other Insurance Information To be completed by the Initiating Health Practitioner 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:		
	❑ **NO** *There is no other insurance coverage identified for these goods and services.*		✓ **YES** *There is other insurance coverage that is potentially available to cover/partially cover these goods and services.*
	MOH	Is there Ministry of Health and Long-Term Care (MOH) coverage for any goods and services included in this Treatment Plan? ✓ Yes ❑ No ❑ Not applicable	
	Other Insurer 1	Other Insurer Name XYZ Life Insurance Company	Other Insurance Plan Or Policy Number HSA-87651
		Name of Plan Member Jonathan Smith	Other Insurer's Identifier 401-123-321
	Other Insurer 2	Other Insurer Name WER Life Insurance Company	Other Insurance Plan Or Policy Number GRP-987622-01
		Name of Plan Member Jessica Smith	Other Insurer's Identifier 444-876-678

Other insurance may be available from the Ministry of Health and Long-Term Care (MOH) or through an applicant's personal, spousal, or parental Extended Health Care plan to cover or partially cover some or all of the goods and services listed.

Indicate if the treatment you will be providing is covered by the MOH.

Determine other insurance coverage that the applicant might have. Space is available for two other insurers in the event that the applicant is covered by more than one policy (for example, if both the applicant and the applicant's partner or legal guardian have extended health benefits).

The auto insurer is not liable for any costs which are payable by any other insurer.

Part 4 Conflict of Interest Definition

Part 4 Conflict of Interest Definition	A person has a conflict of interest relating to a Pre-approved Framework Treatment Confirmation Form if, i) the person or a related person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person or another person, of goods or services contemplated by the Pre-approved Framework Treatment Confirmation Form, 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.

Before proceeding to the rest of the form, determine if you have a conflict of interest relating to this Pre-approved Framework Treatment Confirmation Form.

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
Brown	Barry	123456

Facility Name (if applicable)	AISI Facility Number (if applicable)
Family Care Clinic	T2222

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: bbrown@famcare.ca

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

☐ I am not the first Initiating Health Practitioner.

Conflict of Interest Declaration

☑ I wish to declare that I have no conflicts of interest relating to this Pre-approved Framework Treatment Confirmation Form, **and** I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this form on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this form; *or*

☐ I am declaring the following conflicts of interest relating to this Pre-approved Framework Treatment Confirmation Form:

I certify that the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 6, and the treatment proposed is in accordance with a PAF Guideline. I have reviewed the proposed treatment with the applicant.

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 analyzing 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)	Signature of Initiating Health Practitioner	Date (yyyymmdd)
Barry Brown		

Only Health Practitioners can initiate a PAF. 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. Only the Initiating Health Practitioner or the family physician may sign Part 5. The signature is required before the form can be submitted to the insurer.

If you are not the first initiating health practitioner, you must check the box provided.

If the insurer wishes to initiate an ancillary service, the insurer shall do so by contacting either the initiating practitioner or the patient's family physician, who will complete the OCF-23.

Before signing Part 5, confirm that the requirements for informed consent have been met. 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.

Part 6 Injury and Sequelae Information

To the Health Professional:
Please complete the following information based on your most recent examination of the applicant named above and return the form to the insurance company listed in Part 2. Please print clearly.

Part 6 Injury and Sequelae Information

Provide a description (list most significant first) and associated ICD-10-CA code for injuries and sequelae that are the direct result of the automobile accident.

Injury Description	†Injury Code
Whiplash Associate Disorder (WAD 2)	S13 41
Sprain adn strain of lumber spine	S33 5
Headaches	G44

Note †: Refer to the User manual at www.hcaiinfo.ca for ICD-10-CA coding information.

Provide a brief description of the injury and the corresponding injury code (ICD-10-CA code). List the PAF injury first. Up to four injuries/sequelae may be entered including the description and a valid ICD-10-CA code.

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

Refer any questions regarding injury coding to your provider association or access the website at www.hcaiinfo.ca under Auto Insurance Resources>Statutory Accident Benefits>Codes and Appendices.

Part 7 Prior and Concurrent Conditions

Part 7 Prior and Concurrent Conditions

a) Was the applicant employed at the time of the accident?
☑ Yes ☐ No

b) 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?
☑ No ☐ Unknown ☐ Yes (please explain)

c) If Yes to "b" above, did the applicant undergo investigation or receive treatment for this disease, condition or injury in the past year?
☐ No ☐ Unknown ☐ Yes (please explain and identify provider, if known)

The information provided in this section will help the insurer to better understand the applicant's pre-accident status and informs the insurer in advance of any pre-existing condition that may affect the applicant's response to the treatment given within the PAF. Provide relevant information in response to these questions 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.

Inclusion of the question on employment status expands on the insurer's understanding of the applicant's pre-accident status.

Part 8 Barriers to Recovery

Part 8 Barriers to Recovery	a) Have you identified any barriers to recovery that may affect the success of this treatment for this particular applicant? (For assistance in identifying barriers to recovery, please refer to the user manual at www.hcaiinfo.ca.) ☑ No ☐ Yes (please explain)

Identify any barriers to recovery, including any "yellow flags" identified in the PAF outline that may affect the success of this treatment.

*Refer to **Appendix G** for further information on "yellow flags" specific to the PAF.*

Part 9 PAF Pre-approved Services

Part 9 PAF Pre-Approved Services			
Category	Description	Maximum Fee	Estimated Fee
PAF (identify which PAF Guideline)	WAD II	1160.00	1160.00
Supplementary Goods & Condition Services	Exercise Ball	160.00	40.00
Other Pre-Approved Services (including radiology)	X-rays of cervical spine	42.00	42.00
	Part 9 Sub-Total	1,362.00	1,242.00

Identify the PAF guideline under which you are treating (e.g., WAD II PAF) and indicate the maximum fee allowed under this PAF as well as your estimated fee for provision of the services. These two numbers may be different if you anticipate that not all blocks of the PAF will be required in order to treat and discharge this patient.

Identify any pre-approved Supplemental Goods, Condition Services or other pre-approved services allowed under the PAF guideline that the patient will require, and insert the associated maximum and estimated costs.

Part 10 Other Health Providers

Part 10 Other Health Providers (required only if Part 11 Services are rendered by Other Providers)

Provider Type List

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	OT-O	Bloom	Bob	234567		
B						
C						
D						

This part should be filled in only if there are goods and services requiring prior approval (Part 11).

Health Providers are assigned an upper case alphabetic letter (i.e., the Provider Reference). The Provider Reference letters are used to cross-reference information on the Pre-approved Framework Treatment Confirmation Form 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.*

If you are a regulated health professional, provide your college registration number and leave the AISI number blank. If you are an unregulated provider, you can obtain an AISI number by registering at www.hcaiinfo.ca.

NB Future implementation of the HCAI system may eliminate the need for an AISI number.

Because hourly rates are generally not applicable to Pre-approved Frameworks, enter N/A (not applicable). The exception to this is the Activities of Normal Living Intervention (ANLI), for which the hourly rate of the provider must be entered.

Part 11 Other Goods or Services within the PAF Guidelines Requiring Insurer Approval

Part 11 Other Goods or Services Within the PAF Guidelines Requiring Insurer Approval

Description	†Code	†Attribute	Provider Reference	Estimated		
				Quantity	†Measure	Cost
Activities of Normal Living	P.W2.AN		A	3.0000	Hr	210.00
Travel Time	A.XX.TT		A	0.3300	Hr	23.10
Mileage	A.XX.KM		A	50.0000	Km	13.75
					Part 11 Sub-Total:	246.85
					Total:	246.85

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

Briefly explain why the goods and services in Part 11 are being proposed and the treatment goal:

Insurer has requested an ANLI because the nature of the work and unusual physical demands of the patient's job.

This section is for services allowable under the PAF Guideline, but still requiring insurer approval.

Description

Enter a description of the good or service provided.

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 regarding goods and service coding to your provider association or access the website at www.hcaiinfo.ca.

Provider Reference

Enter the Provider Reference code of the professional who will render the service or is prescribing the good (from Part 10).

When a service is to be provided by more than one health care professional, enter all Provider Reference codes (separated by commas).

Estimated

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

- First, enter the total quantity of the good or service that will be delivered; this will appear as a number (e.g., 75, 6, 52…).
- Second, 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.
- Third, report the cost per service.

Sub-Total

Enter the total cost of goods or services proposed in Part 11.

Total

Enter the combined total of the estimated fees from Part 9 and Part 11.

Part 12 Signature of Insurer

Part 12 Signature of Insurer	☐ I waive the requirement of the Applicant's signature. ☒ I have reviewed this Pre-approved Framework Treatment Confirmation Form, and based upon the information provided, I confirm that the policy referred to on page 1 was in force at the time of the accident.		
	If other goods or services requiring insurer approval have been proposed in Part 11, I:		
	☒ Approve	☐ Partially approve (explanation to follow or attached)	☐ Do not approve (explanation to follow or attached)
	Name of Adjuster (please print) Mary MacGregor	Signature of Adjuster	Date (YYYYMMDD) 20031010
	Please provide a copy of this page to the Applicant and the Initiating Health Practitioner indicated in Part 5.		

The insurer will complete this section and return page 3 to the applicant and the Initiating Health Practitioner indicated in Part 5. If there is a service requiring insurer approval on the plan, and the insurer partially approves or does not approve the treatment, it must provide an explanation as to why the additional service has been declined. In this case, the provider may submit a Treatment Plan (OCF-18) for the declined services, and approval will be subject to the SABS

Part 13 Signature of Applicant

Part 13 Signature of Applicant

I have reviewed this form. I have been informed about and agree with the proposed treatment. I certify that, to the best of my knowledge, the information I have provided is accurate. Payment for this treatment is pre-approved, and/or subject to the approval of the insurer. For services requiring insurer approval, I understand that, if I undertake those services prior to approval by the insurer, I may be responsible to my provider for any goods or services provided. All services are subject to coverage issues or exclusions.

I consent to sharing of personal information between my Initiating Health Practitioner and my insurer. If this OCF-23/198 is not being completed by the first Initiating Health Practitioner, I consent to the insurer contacting the first Initiating Health Practitioner to determine the amount of the PAF goods and services that have been consumed.

TO THE INSURER TO WHOM THIS APPLICATION IS BEING SUBMITTED:

I UNDERSTAND that you, and persons acting for you, will collect and use personal information and personal health information about me that is related to my claims for accident benefits arising out of the accident described in this application, and that all such information will be collected directly from me, or from any other person with my consent.

I ALSO UNDERSTAND that this information will be collected and used only as reasonably necessary for the purposes of:

- Investigating my claims and processing my claims as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to my claims in order to determine entitlement and the proper amount of payment;
- Recovering payment from insurers and others liable in law for amounts that you pay in connection with my claims;
- Identifying and analyzing the nature and costs of goods and services that are provided to automobile accident victims by health care providers;
- Preventing fraud, and detecting fraud where there are reasonable grounds to suspect fraud;
- Compiling anonymized statistics for government agencies; and
- Assessing underwriting risks and claims experience.

(Partial Print Screen)

After you have reviewed the form with the applicant, the applicant or the applicant's Substitute Decision Maker, as defined in the *Substitute Decisions Act*, must sign here. The insurer may elect to waive the requirement of the applicant signature, but this should be ascertained in advance.

The consent for the use of information has been revised to reflect the current privacy legislation and other legislation with which insurers must comply. Insurers are responsible for ensuring that claimants understand these conditions when initiating a claim through the submission of an OCF-1.

Should the claimant require more information about the consent and their obligations, please refer him/her to their insurance claims adjuster.