

**OCF-22 APPLICATION FOR APPROVAL OF AN ASSESSMENT
OR EXAMINATION**

USER MANUAL

March 2006

Document Change History

Date	Description of Change	Reason
20050214	Revised Applicant Signature & Repositioned Signature of Insurer	For consistency with revised OCF forms 01/Dec/04
<u>20060301</u>	<u>Revised Further Information, Health Professional, Insurer & Applicant & revised Nature of Assessment/Examination</u>	<u>Redirects users to HCAI website, reflects inclusion of Social Worker, revisions to prior approval categories & elimination of DACs.</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-22 Application for Approval of an Assessment or Examination. Other manuals are available to assist in the completion of:

OCF-18	Treatment Plan
OCF-3	Disability Certificate
OCF-21	Auto Insurance Standard Invoice
OCF-23	Pre-Approved Framework Treatment Confirmation Form
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 of the Application for Approval of an Assessment or Examination 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)¹¹, 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.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.

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.

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-22 Application for Approval of an Assessment or Examination

Background

All services including assessments require insurer approval except those included with a Pre-approved Framework. Some assessments require *prior* approval. This form is used to request insurer approval for an assessment or examination. It should be used whenever approval, including prior approval as set out in the regulations, of an assessment is not sought through an OCF-18, OCF-11 or OCF-23.

Details of which assessments do and do not require *prior* approval are outlined in Part 4 of the form.

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 Applicant or a substitute decision maker completes Parts 1 and 2 and may sign Part 9. 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.

Any Regulated Health Professional or Social Worker can complete the rest of the form and is expected to submit the completed form directly to the insurer. The Regulated Health Professional or Social Worker responsible for the form preparation must sign Part 3.

Return this form to:	Application for Approval of an Assessment or Examination (OCF-22) <small>Use this form for accidents that occur on or after November 1, 1998</small>
ABC Insurance Company P.O. Box 123, Station 'A' Toronto, ON M1M 1M1 Attn: Mary MacGregor	
	Claim Number: 1234567-001
	Policy Number: 9876543
	Date of Accident: 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)	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 To be completed by the applicant	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	Extension	Adjuster Fax	
(416) 555-5555	4777	(416) 555-5555		
Name of policy holder same as:		Policy Holder Last Name	Policy Holder First Name	
<input type="checkbox"/> Applicant OR		Smith	Jessica	

To be completed by the Applicant.

Part 3 Signature of Regulated Health Professional

Part 3 Signature of Regulated Health Professional or Social Worker	Name of Regulated Health Professional/Social Worker		College Registration Number		You are a: <input type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Massage Therapist <input type="checkbox"/> Nurse Practitioner <input checked="" type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Social Worker <input type="checkbox"/> Speech-Language Pathologist <input type="checkbox"/> Other	
	Bob Bloom		234567			
	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						
bbloom@famcare.ca						
<input checked="" type="checkbox"/> I wish to declare that I have no conflicts of interest relating to this 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 <input type="checkbox"/> I am declaring the following conflicts of interest relating to this Application:						
I confirm that, to the best of my knowledge, the information in this form is accurate, and the services contemplated are reasonable for the assessment or examination of the applicant. In addition, I confirm that I have obtained the appropriate consent from the applicant for the collection, use and disclosure of information submitted.						
Name of Regulated Health Professional/Social Worker (please print)		Signature of Regulated Health Professional/Social Worker		Date (YYYYMMDD)		
Bob Bloom						

Regulated Health Professionals and Social Workers should include their college registration number. An AISI number is not necessary for the completion of this form; however, you can obtain more information on registration at www.hcaiinfo.ca.

Part 4 Nature of Assessment or Examination

Part 4 Nature of Assessment or Examination	Except those assessments and examinations that are payable without insurer approval pursuant to a PAF Guideline, payment for all assessments and examinations is dependent upon approval by the insurer or if disputed by an arbitration or by the courts. In addition, prior approval for payment of an assessment or examination is not required in some situations as outlined below. Please ✓ the appropriate box in the chart below to indicate what situation applies to this application.
	<p align="center">PRIOR APPROVAL IS NOT REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR THE FOLLOWING :</p> <p><input type="checkbox"/> an assessment or examination where an immediate risk of harm to the insured person or a person in the insured person's care makes obtaining the insurer's prior approval of the assessment or examination impractical;</p> <p><input type="checkbox"/> not more than three assessments or examinations if:</p> <ul style="list-style-type: none"> ▪ the cost of each assessment or examination does not exceed \$200.00, and ▪ not more than one assessment or examination is done by the same person; <p><input type="checkbox"/> an assessment or examination conducted after the insurer notifies the insured person that, before the examination is conducted, it does not require the submission of a Treatment Plan or an application under s. 38.2 of the SABS.</p> <p>PRIOR APPROVAL IS REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR:</p>

(Partial Screen Print)

Indicate the circumstances of the assessment you will be performing by checking the appropriate box.

Part 5 Provisional Clinical Information

Part 5 Provisional Clinical Information	<p>a) Clinical Information:</p> <p>i) Provide a brief description of the present complaints.</p> <p align="center">Unresolved neck pain persists 4 months post MVA.</p> <p>ii) Has the applicant already been provided treatment under your care? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>
	<p>b) Assessment Information:</p> <p>i) Describe the details of the assessment requested and the rationale for it.</p> <ul style="list-style-type: none"> • If you have already provided treatment to this applicant, include clinical indicators to substantiate the reasonableness of the proposed assessment. • For multi-disciplinary assessments, include the detail and rationale for each component of the assessment. <p align="center">Standard clinical assessment to determine</p> <ul style="list-style-type: none"> • activities of normal living, • the need for a Jobsite Analysis to include an assessment of occupational and ergonomic factors, and • the need for treatment. <p>Develop a treatment plan if appropriate.</p> <p>Applicant has been unable to return to work post MVA,</p> <p>ii) After making reasonable inquiries, are you aware of a prior assessment of this type completed for this applicant? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, provide date if possible (YYYYMMDD)? ____/____/____</p>

Provide as much information as is available regarding the present complaints. In b) explain why the assessment is necessary and provide information on the content of the assessment.

Part 6 Health Providers

Provider Reference	Provider Type	Provider		Regulated (College Registration Number)	Unregulated (AIGI Number if applicable, or blank)	Hourly Rate (if applicable)
		Last Name	First Name			
A	OT-Occ	Bob	Bloom	234567		\$70.00
B						
C						
D						
E						
F						

Health Providers or Social Workers are assigned an upper case alphabetic letter (i.e., the Provider Reference). The Provider Reference letters are used to cross-reference information on previously approved plans 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.

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

Part 7 Proposed Goods and Services

Part 7 Proposed Goods and Services							
This Assessment Plan should include all goods and services (G/S) contemplated by the Health Professional/Facility.							
G/S Ref	Description	*Code	*Attribute	Provider Ref	Estimated		
					Quantity	*Measure	Total Cost
1	Initial Assessment	2.ZZ.02		A ▾	3.00	Hr ▾	210.00
2	Travel Time	A.XX.TT		A ▾	0.33	Hr ▾	23.10
3	Mileage	A.XX.KM		A ▾	50.00	Km ▾	13.75
4				▾		Hr ▾	
5				▾		Hr ▾	
6				▾		Hr ▾	
7				▾		Hr ▾	
8				▾		Hr ▾	
9				▾		Hr ▾	
10				▾		Hr ▾	
11				▾		Hr ▾	
12				▾		Hr ▾	
13				▾		Hr ▾	
14				▾		Hr ▾	
Note 1: Refer to the User Manual coding guidelines posted at www.hcaiinfo.ca . Attribute 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.					Sub-Total:		246.85
					*MOH:		
					*Other Insurer 1 + 2:		
					GST (if applicable):		
					PST (if applicable):		
					Auto Insurer Total:		246.85

Goods/Service Reference (G/S)

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

Description

Enter a brief description of the proposed goods and services.

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

Provider Reference

Enter the Provider Reference code of the professional rendering the service.

When a service is provided by more than one health care professional or social worker, 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.

Totals

In the Totals section:

- **Sub-Total** is the sum of the cost of all proposed goods and services.
- **MOH** is the sum of all Ministry of Health and Long-Term Care amounts that are payable to you for any of the goods and services listed above; this is subtracted from the subtotal.
- **Other Insurer 1 + 2** is the sum of all amounts payable to you from other insurers; this is also subtracted from the subtotal.
- **GST** is the total GST for all goods and services listed above.
- **PST** is the total PST for all goods and services listed above.
- **Auto Insurer Total** is the sum of all amounts in this section.

Part 8 Signature of Insurer

Part 8 Signature of Insurer	<input type="checkbox"/> I waive the requirement for the applicant's signature on a OCF 18 Treatment Plan. I have reviewed this form and based upon the information provided, I		
	<input type="checkbox"/> Approve	<input type="checkbox"/> Partially approve	<input type="checkbox"/> Do not approve
<p>The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 3 business days of receiving the completed form for proposed assessments:</p> <ol style="list-style-type: none"> 1. Give the health professional or social worker and the applicant a notice approving the assessment or 2. Advise the applicant that the insurer is not agreeing to pay part or all assessments and advising the applicant that an examination is required. <p>Insurer response is required within the timeframes of the SABS or payment for proposed assessment or examination is deemed approved.</p>			
Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)	

The insurer will complete Part 8 and return the page to the applicant and the Regulated Health Professional or Social Worker indicated in Part 3.

Part 9 Signature of Applicant (Optional)

<p>Part 9 Signature of Applicant (Optional) If not completed, the Health Professional or Social Worker in Part 3 assumes responsibility for obtaining applicant's consent</p>	<p>I have reviewed and confirm the information set out in this form is accurate. I understand that payment for these services may be subject to the approval of the insurer. In the event that my insurer seeks a further review of the application, my insurance company may require that I be examined by a health professional, social worker, or vocational rehabilitation expert identified by the insurer to review the application.</p> <p>In the event that an examination is requested, I authorize my insurer and my treating health professional or social worker, to give the health professional, social worker, or vocational rehabilitation expert properly identified by the insurer to review this application, only such information relating to my health condition, treatment and rehabilitation received as a result of the accident, as is reasonably required for the purposes of determining my eligibility to benefits.</p> <p>As required by law, a copy of the examination report by the health professional, social worker, or vocational rehabilitation expert identified by the insurer to conduct the examination as well as the insurance company's determination will be sent to me.</p> <p>Subject to the Statutory Accident Benefits Schedule, in those circumstances, where prior approval is required, I understand that, if I undertake any of the proposed services prior to approval by the insurer, I may be responsible for payment to my provider for any of the services rendered on my behalf.</p> <p>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.</p>	
<p>Name of Applicant or Substitute Decision Maker (please print) John Smith</p>	<p>Signature of Applicant or Substitute Decision Maker</p>	<p>Date (YYYYMMDD)</p>

If the signature is not obtained, then the Health Professional or Social Worker in Part 3 assumes responsibility for obtaining the insured's consent to release health information.

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.