DAC Committee

General Guideline 6

DAC Utilization of the Automobile Insurance Standard Invoice

Statement of Intent

This Guideline has been developed by the DAC Committee with the specific and sole intent of assisting Designated Assessment Centres (DACs) with the implementation of the Automobile Insurance Standard Invoice (AISI).

DACs operate within a unique framework of regulations and guidelines which permit or require certain modifications of approach to AISI submission. It is neither intended nor implied that any component of this guideline can or should be followed by any assessor or health care provider outside of the DAC system.

In designing this guideline, the DAC Committee considered concerns, questions and suggestions from DACs following the release of the invoice. The DAC Committee has also received input from the Insurance Bureau of Canada (IBC) regarding the implementation of the AISI.

Introduction

On November 12, 2001, the AISI form was introduced as OCF-21. This new form, released in a bulletin (No. A-10/01 Property& Casualty - Auto) by the Financial Services Commission of Ontario (FSCO) on October 1, 2001, requires the use of the new invoice for all Designated Assessment Centres (DACs).

DACs are required to use this invoice for all referrals received after November 12, 2001.

This guideline will assist DACs in implementing the use of the standard invoice (AISI paper form) for billing purposes but does not address issues regarding the IBC's proposals for the second implementation stage and the central data collection centre.

The DAC Committee reminds DACs that this general guideline is a living document and will be updated as issues involving the standard invoice develop.

FSCO is also organizing a forum in May, 2002 to discuss AISI issues. A DAC Committee representative will be present at this forum and this guideline will be updated subsequent to this forum if changes are required.

Consent

DACs have noted that the AISI states that "It is the responsibility of the provider and the facility to ensure that the collection, use and disclosure of the information submitted are authorized by a consent form or otherwise".

DACs further note that the AISI directs providers and facilities to use the OCF-5

Consent (Continued)

Permission to Disclose Health Information as a consent form. The DAC Committee is aware that it is inappropriate for a DAC to be required to obtain the completion of the OCF-5.

The DAC Committee has determined that DACs have already received consent to proceed with the assessment and invoice through the completion of the OCF-14 Permission to Disclose Health Information to a DAC form and the parties'approval of the assessment plan.

Therefore the DAC Committee directs DACs that the instructions on the AISI to use the OCF-5 are not applicable to DACs and that no further consent is required for DACs with respect to use of the AISI.

Issues Involving Implementation

Pre-Guideline Issues

A number of issues have been identified with respect to the ability of DACs to effectively implement the AISI in its current form.

Issues pertaining to a separate fee for the completion of the AISI, arising prior to the release of this guideline, do not justify delaying the assessment process. DACs are expected to proceed with the DAC assessment process.

DACs withholding services over any issues involving the AISI will be dealt with via the Complaint Management and Discipline Protocol and will be brought to the attention of the Operations Subcommittee.

Post-Guideline Issues: Cost of Completion

The DAC Committee has developed this guideline with a focus on simplifying the process of completing the AISI and reducing the amount of time necessary to fill out the form. As a result, no separate fee shall be charged for the completion of the standard invoice.

The Costs Subcommittee will continue to monitor issues involving the completion of the invoice to ensure that this guideline meets this objective.

Part 1: Facility Information

A DAC must first complete its facility information. This includes either the existing DAC roster identification number (such as DAC #3010) or, if the facility has registered with the IBC, then it may complete the form using its new IBC registration number. Please note that, at this time, facility registration with the IBC is voluntary.

The field for the GST number is *optional*. The DAC must also indicate the type of DAC assessment completed on the claimant.

Part 2: Claimant Information

This section asks the DAC to identify the claimant. The section can be completed with information available in the referral package. If information is missing that is required for the completion of the AISI, DACs can acquire this additional information from the parties.

Medical and Rehabilitation DACs should not complete the box that asks if there was an approved treatment plan for the claimant as this field is intended for use by service providers.

Part 3: Automobile Insurer Information

The DAC only completes this section based on information provided in the referral package. Please note that the DAC

Part 3 (Continued)

may not be aware of the name of the policy holder and, as such, this field is *optional*.

Part 4: Other Insurance Information

This section is used to collect information regarding collateral benefits.

This section is *not applicable* for DACs. DAC assessments are an expense that falls under section 24 of the Statutory Accident Benefits Schedule and are not affected by the existence of collateral benefits.

Part 5: Provider Information

Part 5 of the AISI asks the DAC to list all of the health care professionals who were involved in the assessment team. The AISI also asks for the individual's profession or occupation.

Every assessor involved in the assessment must be named under Part 5.

The field requesting the individual's college registration number or IBC provider identification number is *optional*. The DAC's roster number or IBC facility registration number is adequate for billing purposes.

Part 6: Injury and Sequelae Information

This section of the AISI contains a new system of injury coding not previously utilized by the Ontario insurance industry.
These codes are based on the International Classification of Diseases, version ICD-10CA.

Current industry forms, including the OCF-3 Disability Certificate and the OCF-18 Treatment Plan, utilize a different coding system. The OCF-3 and OCF-18 will continue to use this different coding system until the current industry database system, the Ontario Accident Benefits Statistical Plan, used by the industry and FSCO to collect aggregate claims information for the province, is updated.

At present, the ICD-10CA codes will not likely be found in the referral package. It is anticipated that this will change as coding becomes standard practice for all treatment providers and assessors working with motor vehicle accident claimants.

The AISI provides a "picklist" from which an assessor may select one or more codes, if they are applicable to the conditions identified during the assessment.

In those situations where the assessors believe that they cannot find the appropriate injury code(s) within the current AISI picklist, DACs may, for the present, elect to complete Part 6 by selecting from the list below of global system codes (A through Z as based on the ICD-10CA).

Each global code reflects a major system that may be the focus of a DAC assessment. (Some of these systems describe conditions that do not normally result from motor vehicle accident claims and would rarely, if ever, be included in the AISI).

Chapter, Description & ICD-10 Code

A/B	Certain infectious and parasitic diseases
C/D	Neoplasms
D	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
E	Endocrine, nutritional and metabolic diseases
F	Mental and behavioural disorders
G	Diseases of the nervous system
H	Diseases of the eye and adnexa, Diseases of the ear and mastoid process

Part 6 (Continued)

I	Diseases of the circulatory system
J	Diseases of the respiratory system
K	Diseases of the digestive system
L	Diseases of the skin and subcutaneous tissue
M	Diseases of the musculoskeletal system and connective tissue
N	Diseases of the genitourinary system
0	Pregnancy, childbirth and the puerperium
P	Certain conditions originating in the perinatal period
Q	Congenital malformations, deformations and chromosomal abnormalities
R	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
S/T	Injury, poisoning and certain other consequences of external causes
Z	Factors influencing health status and contact with health services

Non-diagnosing health care professionals should identify codes R, S/T and/or Z as appropriate.

DACs should use lines 77-79 under Part 6 to identify the global code(s) that reflects the systems assessed. For example, a DAC may complete Part 6 as follows:

Line	Injury Description	Injury Code
77	Mental & Behavioural Disorders	Code F
78	Diseases of the musculorskeletal system and connective tissue	Code M
79	Diseases of the Nervous System	Code G

At times, more than three systems may be involved in a multi-disciplinary DAC assessment and DACs are instructed to add injury reference number(s) beyond 79 if these are required to convey additional major systems. These additional codes can be identified under Part 10 of the AISI.

For the present, the DAC Committee recognizes that, while global system codes will reduce the concern of assessors at providing incorrect clinical information, this approach also provides the insurer with very little clinical information. The insurer can, however, consult the final DAC report for further details concerning the specific assessment findings.

Part 7: Service Information

Part 7 of the AISI collects the details of the service provided by the DAC. Owing to the unique nature of DAC assessments, DACs will use a modified approach.

Each DAC must complete an assessment plan and have it approved by the insurer and claimant before the DAC assessment can begin. As a result, *a DAC will always indicate "yes" to the question of preauthorization by insurer*.

If a DAC assessors' focus is on more than one major system, the assessors should indicate the relevant ICD-10CA code(s) or major system(s) code for the claimant in their service line under Part 7.

DAC Service Codes

DACs must separately identify the services they provided during the assessment process by utilizing the following four basic service codes:

A1: Document Review
A2: Assessment (and testing)
A3: Report (including preparation)
A4: Other

DAC Service Codes (Continued)

These codes reflect the basic steps of the DAC assessment process and the DAC Committee wishes to offer some additional guidance with respect to what should be captured by these four service codes.

A1 Document Review

A1 will include all clinical intake functions and file reviews.

A2 Assessment (and Testing)

A2 includes all diagnostic interviews with the claimant and testing (including other sources of information such as parent or spouse), examinations, test administration and test interpretation. This should also be used to capture situations where surveillance material had to be reviewed with the claimant.

A3 Report (including preparation)

A3 will be used to capture all activities involved in drafting and writing DAC reports. These activities include all collaborative activities, clinical coordination, communication between assessors regarding the assessment, review of other team member's reports, and all discussions leading to the final consensus.

A4 Other

All other DAC activity will be captured by A4. If codes A1-A3 fail to describe the service provided, then a DAC can utilize A4 for the service and use the description section to describe the service.

These other activities will include administrative activities, intake activities conducted by the administrative coordinator, and no-show or cancellation expenses.

Since the injury codes are not applicable in most instances to these types of activities, a DAC should enter N/A in the injury code box.

Under current guidelines, each DAC assessor is expected to carry out a document review (A1), an assessment (A2) and collaborate in achieving a set of final, consensus conclusions, including a report (A3). Each assessor's services under A1-A3 will therefore be reported on three separate lines under Part 7.

Reporting on Time

The DAC Committee acknowledges that reporting on time is a difficult issue for DACs to address.

The following directions for reporting on time spent are not intended to reflect or capture the internal agreements between DACs and their assessors, particularly where flat fees are in place. Flat fees may not directly correlate with the time spent on the individual assessment stages and are not meant to imply an hourly rate.

The DAC Committee is aware that the amount of time spent on an assessment will greatly vary depending on the complexity of the case.

To facilitate recording and reporting service for each of A1 through A4, DACs may use a system of units of time to *approximate* the time taken on each service. Each unit of time represents 30 minutes.

When the time spent is unusually low or high on a particular file, perhaps due to the complexity of the file, mental status of the claimant, or due to language barriers, the DAC may choose to provide an explanatory

note under Part 10.

The Committee offers the following example on how a DAC may complete Part 7 Service Information:

1) *Date:* The individual assessment team member should indicate the date of their assessment of the claimant, even though their work on a DAC file may take place over several dates.

2) *Provider Reference Number*: From Part 5.

3) *Description:* Description of the service provided. For example, Functional Capacity Evaluation or psychological assessment.

4) *Service Code:* A1 to A4 as appropriate, with one service code per service line.

5) *Injury Reference Number(s)*: From Part 6.

6) *Time in Minutes*: DACs must indicate the duration of time spent on each individual service code. DACs should indicate duration here in units of 30 minutes.

7) *Hourly Fee*: If billing by time, indicate hourly rate here. The Hourly Rate box is not intended to capture the internal arrangements between each DAC and its assessors as these may be based on other, perhaps incompatible, formulations.

If billing by flat fee for that component of the assessment, then indicate "N/A".

8) *Net charge to other insurer*: *Not applicable for DACs.*

9) *Net Charge to Auto Insurer*: Enter either the flat fee for the services provided for that component of the assessment, or the total cost determined by the hourly rate multiplied by the duration in time.

10) *Pre-Authorized by Auto Insurer*: Yes

Part 8: Other Charges

Part 8 of the AISI asks the service provider to identify any other charges associated with the provision of the service. These may include items such as mileage, travel expenses or disbursements.

The section should be completed when it is applicable to the DAC assessment.

Part 9: Supplies Provided to Patient

This section requests an itemized list of the supplies provided to a patient. DACs do not provide supplies to claimants and, as such, this section is not applicable.

Part 10: Other Information

A DAC is able to use the Other Information Section to include any information they feel would better describe the expenses outlined in the invoice or provide any other information they feel would be relevant for the parties.

For example, the DAC could use this Part to describe problems with numerous cancellations or no-shows to describe a lengthy assessment, or simply document the date of the final DAC report.

This section will be particularly important for DACs and insurers as they become accustomed to using the AISI.

Require Further Direction?

Further information is available on the use of the AISI on the IBC's website:

<www.standardinvoice.on.ca>.

This website contains answers to the most commonly asked questions, a coding inquiry service as well as the standard invoice in PDF format that can completed electronically.

Questions to the IBC regarding the application of the AISI are to be directed to the IBC Consumer Information Lines at (416) 362-9528 or toll free 1-800-387-2880 (from Ontario only).

Additionally, DACs may inquire of the DAC Hotline for questions specific to the application of the AISI to DACs.

We encourage feedback regarding this Guideline. Please let us know your experiences, and provide your suggestions, so that we may continue to improve the DAC system. Comments can be directed to:

The Minister's Committee on
the Designated Assessment
Centre System
c/o
The Automobile Insurance
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Financial Services Commission
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This document is also available in French upon request.