Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

April 2007

Health Claims for Auto Insurance Rollout Guideline

Superintendent's Guideline No. 01/07

Health Claims for Auto Insurance Rollout Guideline

Introduction

The Health Claims for Auto Insurance Rollout Guideline (Rollout Guideline) is issued pursuant to s. 268.3 (1) of the *Insurance Act* for the purposes of ss. 44.1 (1) and 68 (3.2) of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996* (SABS) as amended by Regulation 533/06.

The amendments change the way that some SABS claim documents are in some circumstances to be sent to the insurers to whom this Rollout Guideline applies. A document to which this Rollout Guideline applies and that previously would have been sent directly to an insurer to whom this Rollout Guideline applies is instead to be sent to a Central Processing Agency (CPA) established by the insurance industry to receive such documents on behalf of insurers. This Rollout Guideline describes:

- Which insurers, health care facilities ("facilities") and health care providers ("providers") are subject to the Rollout Guideline and in what circumstances;
- what documents are to be delivered to the CPA and in what circumstances;
- how such documents may be delivered to the CPA; and
- how insurers are to provide information to the CPA.

This Rollout Guideline applies to documents specified in this Rollout Guideline that are delivered on or after April 2, 2007, regardless of the date of the accident to which they relate.

Insurers and Providers That Are Subject To This Rollout Guideline

The Financial Services Commission of Ontario will maintain and update from time to time a list of identified insurers and facilities/providers (or specified branch offices thereof) participating in the Health Claims for Auto Insurance (HCAI) (the "HCAI Participant List") and the dates on which their participation begins. Please

see Appendix 1 for details of how to obtain copies of the HCAI Participant List in effect at any particular time.

For the purposes of this Rollout Guideline:

- each specified branch office of an identified insurer is a Participating Insurer, and

- each specified branch office of an identified facility, and each provider operating in a specified branch office of an identified facility, is a Participating Provider.

This Rollout Guideline applies only to transactions between a Participating Provider and a Participating Insurer in respect of any claim for SABS benefits under a motor vehicle liability policy issued in Ontario.

This Rollout Guideline does not apply to the Motor Vehicle Accident Claims Fund.

Designation of Central Processing Agency – SABS s. 68 (3.2)

Health Claims for Auto Insurance Processing is the CPA for the purposes of this Rollout Guideline and s. 68 (3.2) of the SABS. Health Claims for Auto Insurance Processing is a not-for-profit Ontario corporation established and funded by the insurance industry and operated by a board of directors that includes representatives of the insurance industry and health care communities.

The primary role of the CPA is to act as the agent of insurers to receive specified documents on their behalf, to confirm that the documents are duly completed and contain all of the information required to be included in them, and then to make the documents available for access by the insurers to whom they are addressed. The CPA also acts as an intermediary for the purpose of enabling insurers to communicate information such as claims approval and payment decisions electronically to those health care goods and services providers who wish to receive such communications electronically through the CPA.

The CPA is also expected to be a primary source of the information that automobile insurers will be required under s. 101.1 of the *Insurance Act* to provide to the Superintendent of Financial Services concerning claims for goods and services for which automobile insurers are liable under contracts of automobile insurance.

Invoices
For Goods And Services That Are Subject To This Rollout Guideline – SABS s. 44.1

Any invoice for goods or services specified in Appendix 2 of this Rollout Guideline must be in the form (the Auto Insurance Standard Invoice) approved by the Superintendent of Financial Services in accordance with s. 69 of the SABS.

This requirement applies only if:

- all of the goods or services referred to in the invoice are provided in Ontario by the Participating Provider,
- the invoice is not submitted by the claimant,
- the invoice is submitted by a Participating Provider and is payable to the Participating Provider, and
- payment of the invoice is claimed against a Participating Insurer with respect to a transaction with a Participating Provider.

Where this requirement applies, s. 44.1 (1) of the SABS prohibits a Participating Insurer from paying any invoice that is not in the approved form, does not include all of the information required by the approved form, or is not sent to the CPA as required by this Rollout Guideline.

Participating Providers are to invoice Participating Insurers for goods or services specified in Appendix 2 separately from goods or services not specified in Appendix 2. Similarly, Participating Providers are to invoice Participating Insurers for goods or services provided in Ontario separately from goods and services not provided in Ontario.

Documents That Must Be Delivered To The CPA

The following documents are specified for the purpose of s. 68 (3.2) of the SABS. Each such document must be delivered to the CPA (not directly to the insurer to whom it is addressed) in accordance with this Rollout Guideline if delivered by a Participating Provider to a Participating Insurer:

OCF-18	Treatment Plan - SABS s. 38
OCF-21	Auto Insurance Standard Invoice - SABS s. 44.1 – but only if this Rollout Guideline requires the use of this form for the particular goods or services being billed

OCF-22	Application for Approval of an Assessment or Examination - SABS s. 38.2
OCF-23/198	Pre-approved Framework Treatment Confirmation Form - SABS s. 37.1

Please note that a document that this Rollout Guideline does not require to be delivered to the CPA must be delivered directly to the insurer using one of the delivery methods provided for in s. 68 (2) of the SABS.

How To Deliver Documents To The Central Processing Agency

A document that is required by this Rollout Guideline to be delivered to the CPA shall be delivered to the CPA in electronic form in a manner that results in it being capable of being retrieved and accessed by the CPA.

Participating Providers are authorized to deliver documents to the CPA electronically as described above, and to access information electronically from the CPA, upon completion of the appropriate enrolment process (see "**Enrolment Of Users And Providers**" below).

Paper Submission

It is anticipated that in the near future the CPA will also be in a position to receive documents in paper form, delivered by mail, fax or personal delivery in accordance with ss. 68 (2) (a), (b), (c) or (d) of the SABS. It is anticipated that an amended version of this Guideline, setting out the rules that will apply to paper submissions, will be issued at that time. In the meantime, the option of delivery of forms to the CPA in paper form is not available.

Attachments to Documents That Are Subject To This Rollout Guideline

If a sender determines that it is necessary to send one or more attachments with a document rather than including in the document itself all information that the sender determines to be desirable or necessary to accomplish its purpose, the following special rules apply:

1. The sender must specify, in the field provided in the document for that purpose, how many attachments are being delivered with the document, with a brief description of each attachment.

2. The document itself (but not the attachments) must still be delivered to the CPA as described above.

3. The attachments are not to be delivered to the CPA but instead must be delivered directly to the insurer by one of the delivery methods described in s. 68 (2) of the SABS. Although it is preferable that all attachments be delivered to the insurer at the same time, it is not mandatory to do so.

4. The attachments are not to be sent to the insurer before the document is sent to the CPA.

5. Each attachment must be identified with the claimant's name, either of claim number or policy number, and date of accident, and with the document type (i.e., OCF-18, OCF-21, OCF-22 or OCF-23/198) to which the attachment relates, to enable the insurer to identify the document for which the attachment is intended.

Rules Governing Date of Receipt of Documents By Insurers

Section 68 of the SABS sets out the rules that determine when a document delivered to the CPA as required by this Rollout Guideline is deemed to be received by the insurer to whom it is addressed. Briefly summarized, those rules provide:

1. **Document with no attachments** – is deemed to be received by the insurer to whom it is addressed when the document has been delivered to the CPA in a manner specified in this Rollout Guideline, and the CPA has determined that the document is duly completed and contains all information required by the SABS to be included in it.

2. **Document with attachments** – is deemed to be received by the insurer to whom it is addressed when:

    (a) the document (exclusive of attachments) has been delivered to the CPA in a manner specified in this Rollout Guideline, and the CPA has determined that the document is duly completed and contains all information required by the SABS to be included in it; and

    (b) all of the attachments have been received by the insurer.

The SABS provides (s. 68 (7)) that a document delivered to the CPA by fax, personal delivery or by electronic submission later than 5:00 p.m. Toronto time is deemed to have been delivered to the CPA on the following business day.

The SABS also provides (s. 68 (3.5)) that the CPA will be deemed to have determined, on the day a document was delivered to it in a manner specified in this Rollout Guideline, that the document is duly completed and contains all

information required by the SABS to be included in it unless the CPA notifies the sender to the contrary in a manner specified in this Rollout Guideline.

For the purposes of s. 68 (3.5), the manner in which the CPA is to notify the sender is by one of the delivery methods provided for in s. 68 (2) of the SABS. The CPA may also deliver the notification verbally (for example by telephone call, or by telephone message) provided written confirmation is given as soon as practicable afterwards by one of the delivery methods provided for in s. 68 (2) of the SABS.

The SABS further provides (s. 68 (3.2)) that a document to which this Rollout Guideline applies is deemed not to have been delivered to an insurer unless it is delivered as required by this Rollout Guideline.

Completion of Documents

A document to which this Rollout Guideline applies will be deemed not to have been completed and not to contain all the information required by the SABS to be included in it unless all fields (other than those that are optional in the circumstances indicated on the form as approved by the Superintendent of Financial Services) are completed as required by this Rollout Guideline.

The information in any completed field must comply with the validation rules set out in Appendix 3 of this Rollout Guideline.

Where the form specifies the format in which certain information (e.g., a date) is to be provided, the information must be provided in that format.

If the document is delivered in paper form, all completed fields must be legible.

All attachments must be legible.

Codes To Be Used In Submitting Information

The following information shall be provided utilizing the codes specified below:

- To describe injuries and *sequelae*, codes listed in the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Canadian Enhancement (ICD-10-CA) which is maintained by the Canadian Institute for Health Information and available through www.cihi.ca. An abridgment of the ICD-10-CA list of codes, developed to assist stakeholders in the Ontario automobile insurance system, is available at www.hcaiinfo.ca.

- To describe health interventions, codes listed in the Canadian Classification of Health Interventions (CCI) which is maintained by the Canadian Institute for Health Information and available through www.cihi.ca. An abridgment of the CCI list of codes, developed to assist stakeholders in the Ontario automobile insurance system, is available at www.hcaiinfo.ca.

- To describe provider types, the list of Provider Type Codes available at www.hcaiinfo.ca.

- To describe payment categories under a Pre-approved Framework, the list of Pre-approved Framework Reimbursement Codes available at www.hcaiinfo.ca.

- To describe items billed to automobile insurers by providers that are not covered by the CCI, the list of Goods, Administration, and Other Codes available at www.hcaiinfo.ca.

- To describe unit measures and for converting minutes to hours, the list of Unit Measure Codes and the Minutes to Hour Conversion Table available at www.hcaiinfo.ca.

The information at www.hcaiinfo.ca is maintained by Insurance Bureau of Canada in cooperation with the professional associations referred to at http://www.hcaiinfo.ca/links.asp.

Requirements For Insurers

Where the SABS requires a Participating Insurer to provide information to the CPA, such information shall be delivered to the CPA in electronic form in a manner that results in it being capable of being retrieved and accessed by the CPA.

The information referred to in s. 44.1 (3) of the SABS concerning the processing of an invoice must be provided to the CPA within five business days after the invoice has been processed by the Participating Insurer.

The information referred to in s. 68 (3.8) of the SABS concerning any other document to which this Rollout Guideline applies must be provided to the CPA within five business days after the document has been processed by the Participating Insurer.

The information referred to in s. 68 (3.9) of the SABS concerning receipt of attachments must be provided to the CPA within five business days after the last attachment has been received by the Participating Insurer.

The deadlines referred to above are independent of, and not to be confused with, the deadlines within which an insurer is to process and respond to a document as set out in the SABS.

A Participating Insurer that has completed the enrolment process as an Insurer (see "Enrolment of Users And Providers" below) is authorized to deliver information to the CPA electronically and to access from the CPA information that has been delivered to the CPA by a Participating Provider.

Enrolment Of Users And Providers

Before submitting information to, or receiving information from, the CPA, a provider, facility or insurer that is a Participating Provider or Participating Insurer shall enroll with the CPA and agree to its user terms and conditions. Providers and facilities may elect to enroll for either paper submission or electronic submission, but not both at the same time. The user terms and conditions may include commercially reasonable provisions to address responsibilities including confidentiality, security, liability, access, and data integrity.

Temporary Suspensions Of This Rollout Guideline

In the event that the CPA becomes unable (e.g., by reason of temporary technical issues) to properly carry out its obligations to providers, facilities or insurers, the Superintendent of Financial Services may temporarily suspend the operation of this Rollout Guideline.

The Financial Services Commission of Ontario will post notice of any suspension and subsequent resumption of operation of this Rollout Guideline on its website (www.fsco.gov.on.ca).

During the period of any such suspension, the requirements of this Rollout Guideline do not apply and documents are instead to be delivered directly to insurers using one of the standard delivery methods provided for in s. 68 (2) of the SABS.

Appendix 1

HCAI Participant List

Copies of the HCAI Participant List in effect from time to time may be obtained at http://www.fsco.gov.on.ca/english/insurance/auto/hcai.asp. Alternatively, printed copies may be obtained by contacting the Financial Services Commission of Ontario at 1-800-668-0128 extension 7123.

Appendix 2

Invoices For Goods And Services That Are Subject To This Rollout Guideline – SABS s. 44.1

SABS Section	Type of Service/Goods	Specified for the purposes of section 44.1	Not specified for the purposes of section 44.1
	Medical Benefits		
14(2)(a)	Medical, surgical, dental, optometric, hospital, nursing, ambulance, audiometric and speech-language pathology services	Medical, nursing, audiometric and speech-language pathology services	Surgical, dental, optometric, hospital and ambulance services
14 (2)(b)	Chiropractic, psychological, occupational therapy and physiotherapy services	✓	
14(2)(c)	Medication		✓
14(2)(d)	Prescription eyewear		✓
14(2)(e)	Dentures and other dental devices		✓
14(2)(f)	Hearing aids, wheelchairs or other mobility devices, prostheses, orthotics and other assistive devices	Supplies provided to the patient by health care providers	Supplies purchased by the patient
14(2)(g)	Transportation of the insured person to and from treatment sessions, including transportation for an aide or attendant		✓
14(2)(h)	Other goods and services of a medical nature	✓	
	Rehabilitation Benefits		
15(5)(a)	Life skills training	✓	
15(5)(b)	Family counseling	✓	
15(5)(c)	Social rehabilitation counseling	✓	
15(5)(d)	Financial counseling		✓
15(5)(e)	Employment counseling		✓

SABS Section	Type of Service/Goods	Specified for the purposes of section 44.1	Not specified for the purposes of section 44.1
15(5)(f)	Vocational assessments	✓	
15(5)(g)	Vocational or academic training		✓
15(5)(h)	Workplace modification and workplace devices including communication aids		✓
15(5)(i)	Home modifications and home devices including communication aids, or a new home instead of home modifications		✓
15(5)(j)	Vehicle modifications or a new vehicle instead of modifying an existing vehicle		✓
15(5)(k)	Transportation for the insured person to and from counseling sessions, training sessions and assessments, including transportation for an aide or attendant		✓
15(5)(l)	Other goods and services other than case management		✓
16	Attendant care services	Provided by health care providers and other professional care providers	Provided by family, neighbours and other non-professional care providers
17	Case manager services	✓	
24	**Reports/Certificates** • Disability Certificate (OCF-3) • Treatment Plan (OCF-18) • Application for Determination of Catastrophic Impairment (OCF-19) • Assessment of Attendant Care Needs (Form 1)	✓	
24.1	Consultations	✓	
42	Insurer Examinations	✓	
42.1	Examinations and reports per section 42.1 of SABS	✓	

Appendix 3

Validation Rules

Item #	Data Field	Description	Validation #
OCF-18 Submission Rules			
1	Policy/claim number	Either the policy number or the claim number must be filled in.	PM-CSR1
2	Date of accident	Date of accident must be equal to or prior to the current date.	PM-CSR7
3	Date of birth	Date of birth of an applicant must be equal or prior to date of accident.	PM-CSR4
4	Date of birth	Applicant cannot be older than 120.	PM-CSR6
5	Facility Name	All Facility and providers listed in the form must be enrolled in HCAI, except the health practitioner in Part 5 of the OCF-18.	PM-CSR28
6	Profession	Health practitioner's profession must be one of the practitioner professions listed in the SABS.	PM-18R9
7	Date of Signature	Date of the signature of the Health Practitioner must be equal to or after the date of accident.	PM-18R7
8	Profession	Regulated Health Professional profession must be one of the regulated health professions listed on the form or named as 'other'.	PM-18R10
9	Date of Signature	Date of the signature of the Regulated Health Professional or Social worker must be equal to or after the date of accident.	PM-18R6
10	Injury Code	Document must have at least one injury.	PM-CSR14
11	Line Item	There must be at least one goods and service line item. A line item can be a treatment session.	PM-18R5
12	Quantity	Estimated quantity of a goods or services item must be greater than 0 for all line items.	PM-CSR9
13	Quantity	If measure is GD, PR, PG, SN, quantity must be whole number and greater than 0.	N/A
14	Measure	If section code is S, measure must be SN.	N/A
15	Measure	If section code is G, measure must be GD.	N/A
16	Measure	If intervention code is TT, measure must be HR.	N/A
17	Measure	If intervention code is KM, measure must be KM.	N/A
18	Count	The projected count for each goods and services line item must be greater than 0.	PM-18R2

Item #	Data Field	Description	Validation #
19	Total Cost	The projected total cost for each goods and services line item must be • greater than 0 • and must be equal to cost times projected total count	PM-18R1
20	Subtotal	Subtotal of the document must be equal to the sum of all the line items.	PM-CSR10
21	GST	Total GST must be greater than or equal to 0.	PM-CSR11
22	PST	Total PST must be greater than or equal to 0.	PM-CSR12
23	Insurer total	Auto insurer total amount of the plan must be • greater than 0 • and equal to the sum of the subtotal, GST, PST, MOH, other insurer 1 & 2 amounts and interest. Note: MOH and other insurer 1 & 2 amount can be (+/-). (-) indicates an amount to be received. (+) indicates an amount that was previously identified for payment but ruled ineligible	PM-CSR13
24	Duration of Treatment	Estimated duration of the treatment plan (in weeks) must be greater than 0.	PM-18R3
25	Date of applicant's signature	Date of an applicant's signature must be • equal or prior to the current date • and equal to or after the date of accident	PM-CSR31
OCF-22 Submission Rules			
1	Policy/claim number	Either the policy number or the claim number must be filled in.	PM-CSR1
2	Date of accident	Date of accident must be equal to or prior to the current date.	PM-CSR7
3	Date of birth	Date of birth of an applicant must be equal or prior to date of accident.	PM-CSR4
4	Date of birth	Applicant cannot be older than 120.	PM-CSR6
5	Facility Name	All Facility and providers listed in the form must be enrolled in HCAI.	PM-CSR28
6	Profession	Regulated Health Professional's profession must be one of the regulated health professions listed in the form or named as 'other'.	PM-22R5
7	Date of signature	Date of the signature of the Regulated Health Professional or Social Worker must be equal to or after the date of accident.	PM-22R4
8	Nature of Assessment or Examination	One box must be selected.	N/A

Item #	Data Field	Description	Validation #
9	Date of prior assessment	If the date of prior assessment is completed, it must be after or equal to the applicant's date of birth	PM-22R1
10	Line item	There must be at least one goods and service line item.	PM-22R3
11	Quantity	Estimated quantity of a goods or services item must be greater than 0 for all line items.	PM-CSR9
12	Quantity	If measure is GD, PR, PG, SN, quantity must be whole number and greater than 0.	N/A
13	Measure	If section code is S, measure must be SN.	N/A
14	Measure	If section code is G, measure must be GD.	N/A
15	Measure	If intervention code is TT, measure must be HR.	N/A
16	Measure	If intervention code is KM, measure must be KM.	N/A
17	Subtotal	Subtotal of the document must be equal to the sum of all the line items.	PM-CSR10
18	GST	Total GST must be greater than or equal to 0.	PM-CSR11
19	PST	Total PST must be greater than or equal to 0.	PM-CSR12
20	Insurer total	Auto insurer total amount of the plan must be • greater than 0 • and equal to the sum of the subtotal, GST, PST, MOH, other insurer 1 & 2 amounts and interest. Note: MOH and other insurer 1 & 2 amount can be (+/-). (-) indicates an amount to be received. (+) indicates an amount that was previously identified for payment but ruled ineligible	PM-CSR13
21	Date of applicant's signature	Date of an applicant's signature must be • equal or prior to the current date • and equal to or after the date of accident	PM-CSR31
OCF-23 Submission Rules			
1	Policy/claim number	Either the policy number or the claim number must be filled in.	PM-CSR1
2	Date of accident	Date of accident must be equal to or prior to the current date.	PM-CSR7
3	Date of birth	Date of birth of an applicant must be equal or prior to date of accident.	PM-CSR4
4	Date of birth	Applicant cannot be older than 120.	PM-CSR6
5	Facility Name	All Facility and providers listed in the form must be enrolled in HCAI.	PM-CSR28
6	Injury Code	Document must have at least one injury.	PM-CSR14
7	Profession	Regulated Health Practitioner's profession must be one of the health practitioner professions listed in the SABS.	PM-23R16
8	Date of signature	Date of the signature of the Health Practitioner must be equal to or after the date of accident.	PM-23R10

Item #	Data Field	Description	Validation #
9	Quantity	Estimated quantity of a goods or services item must be greater than 0 for all line items.	PM-CSR9
10	Quantity	If measure is GD, PR, PG, SN, quantity must be whole number and greater than 0.	N/A
11	Measure	If section code is S, measure must be SN.	N/A
12	Measure	If section code is G, measure must be GD.	N/A
13	Measure	If intervention code is TT, measure must be HR.	N/A
14	Measure	If intervention code is KM, measure must be KM.	N/A
15	Subtotal	Subtotal of Part 9 in the document must be equal to the sum of all the line items in Part 9.	PM-CSR
16	Subtotal	Subtotal of Part 11 in the document must be equal to the sum of all the line items in Part 11.	PM-CSR
17	Total	Total of the document must be equal to the sum of the Part 9 sub-total and Part 11sub-total.	
18	PAF Type	PAF type must be • Whiplash Associated Disorder, grade 1 (WAD I) • or Whiplash Associated Disorder, grade 2 (WAD II)	PM-23R2
19	Fees	For a WAD I the following services may be listed and are covered under PAF: • Supplementary goods and services, maximum per WAD I Payment Schedule Note: • Transfer fee is only valid if the health practitioner is not the initiating health practitioner	PM-23R4
20	Goods and Services	For a WAD II, the only goods and services that may be associated with “other goods and services within PAF guidelines requiring insurer approval” are: • Activities of Normal Living Intervention (ANLI) • Travel Time, measure must be HR. • Mileage, measure must be KM. • PAF Extension Visits (P.W2.EV) • X-rays not listed in WAD II Payment Schedule for X-Rays	PM-23R8
21	Fee	Total PAF Fee must be greater than 0	PM-23R24
22	Date of applicant's signature	Date of an applicant’s signature must be • equal or prior to the current date • and equal to or after the date of accident	PM-CSR31
OCF-21A Submission Rules			
1	Policy/claim number	Either the policy number or the claim number must be filled in.	PM-CSR1
2	Date of accident	Date of accident must be equal to or prior to the current date.	PM-CSR7

Item #	Data Field	Description	Validation #
3	Date of birth	Date of birth of an applicant must be equal to or prior to date of accident.	PM-CSR4
4	Date of birth	Applicant cannot be older than 120.	PM-CSR6
5	Facility Name	All Facility and providers listed in the form must be enrolled in HCAI.	PM-CSR28
6	Injury Code	Document must have at least one injury.	PM-CSR14
7	Payee Name	The payee for an invoice must be the facility associated with the user creating the invoice.	IMBR-CS6
8	Signature date	Signature date of the authorized signatory must be later than or equal to the date of accident.	IMBR-CS42
9	Invoice	An invoice that is created from a plan can only be associated with that plan. An invoice for goods and services from more than one plan must be created from scratch.	IMBR-CS22
10	Date of Service	Date of Service of a rendered Good or Service must be equal to or after the date of accident.	IMBR-CS7
11	Provider Reference	Each rendered good or service may be performed by more than one health care provider, however only one provider can be specified on the invoice per rendered good or service. The primary provider must be specified. The primary provider is the one who spends the most time rendering the good or service	IMBR-CS14
12	Other Service Type	If 'Other Service Type' is specified under other insurance amounts, then a description of the 'Other Service Type' is required.	IMBR-CS5
13	Subtotal	Subtotal of the document must be • equal to the sum of all the line items, plus • equal to the sum of GST and PST shown on each line item	PM-CSR10
14	Insurer Total	Auto insurer total amount of the plan must be • greater than or equal to 0 • and equal to the sum of the subtotal (which includes GST and PST, MOH, other insurer 1 & 2 amounts and interest)	IMBR-CR1
OCF-21B Submission Rules			
1	Policy/claim number	Either the policy number or the claim number must be filled in.	PM-CSR1
2	Date of accident	Date of accident must be equal to or prior to the current date.	PM-CSR7
3	Date of birth	Date of birth of an applicant must be equal or prior to date of accident	PM-CSR4
4	Date of birth	Applicant cannot be older than 120.	PM-CSR6
5	Facility Name	All Facility and providers listed in the form must be enrolled in HCAI.	PM-CSR28

Item #	Data Field	Description	Validation #
6	Injury Code	Document must have at least one injury.	PM-CSR14
7	Payee Name	The payee for an invoice must be the facility associated with the user creating the invoice.	IMBR-CS6
8	Signature date	Signature date of the authorized signatory must be later than or equal to the date of accident.	IMBR-CS42
9	Invoice	An invoice that is created from a plan can only be associated with that plan. An invoice for goods and services from more than one plan must be created from scratch.	IMBR-CS22
10	Quantity	Estimated quantity of a goods or services item must be greater than 0 for all line items.	PM-CSR9
11	Quantity	If measure is GD, PR, PG, SN, quantity must be whole number and greater than 0.	N/A
12	Measure	If section code is S, measure must be SN.	N/A
13	Measure	If section code is G, measure must be GD.	N/A
14	Measure	If intervention code is TT, measure must be HR.	N/A
15	Measure	If intervention code is KM, measure must be KM.	N/A
16	Date of Service	Date of Service of a rendered Good or Service must be equal to or after the date of accident.	IMBR-CS7
17	Quantity	Quantity of a rendered Good or Service must be greater than 0.	IMBR-CS9
18	Provider Reference	Each rendered good or service may be performed by more than one health care provider, however only one provider can be specified on the invoice per rendered good or service. The primary provider must be specified. The primary provider is the one who spends the most time rendering the good or service	IMBR-CS14
19	Other Service Type	If 'Other Service Type' is specified under other insurance amounts, then a description of the 'Other Service Type' is required.	IMBR-CS5
20	Subtotal	Subtotal of the document must be • equal to the sum of all the line items, plus • equal to the sum of GST and PST shown on each line item	PM-CSR10

Item #	Data Field	Description	Validation #
21	Insurer Total	Auto insurer total amount of the plan must be • greater than or equal to 0 • and equal to the sum of the subtotal (which includes GST and PST, MOH, other insurer 1 & 2 amounts and interest.) Note: MOH and other insurer 1 & 2 amount can be (+/-). (-) indicates an amount to be received. (+) indicates an amount that was previously identified for payment but ruled ineligible	IMBR-CR1
OCF-21C Submission Rules			
1	Policy/Claim Number	Either the policy number or the claim number must be filled in.	PM-CSR1
2	Date of accident	Date of accident must be equal to or prior to the current date.	PM-CSR7
3	Date of birth	Date of birth of an applicant must be equal or prior to date of accident.	PM-CSR4
4	Date of birth	Applicant cannot be older than 120.	PM-CSR6
5	Facility Name	All Facility and providers listed in the form must be enrolled in HCAI.	PM-CSR28
6	Payee Name	The payee for an invoice must be the facility associated with the user creating the invoice.	IMBR-CS6
7	Signature date	Signature date of the authorized signatory must be later than or equal to the date of accident	IMBR-CS42
8	Injury Code	Document must have at least one injury	PM-CSR14
9	Goods and Services	Invoice OCF-21, Version C must be used for billing goods and services within the guidelines of a Pre-approved Framework	IMBR-CS1
10	Quantity	Estimated quantity of a goods or services item must be greater than 0 for all line items.	PM-CSR9
11	Quantity	If measure is GD, PR, PG, SN, quantity must be whole number and greater than 0.	N/A
12	Measure	If section code is S, measure must be SN.	N/A
13	Measure	If section code is G, measure must be GD.	N/A
14	Measure	If intervention code is TT, measure must be HR.	N/A
15	Measure	If intervention code is KM, measure must be KM.	N/A
16	Date of Service	Date of Service of a rendered Good or Service must be equal to or after the date of accident.	IMBR-CS7
17	Quantity	Quantity of a rendered Good or Service must be greater than 0.	IMBR-CS9

Item #	Data Field	Description	Validation #
18	Provider Reference	Each rendered good or service may be performed by more than one health care provider, however only one provider can be specified on the invoice per rendered good or service. The primary provider must be specified. The primary provider is the one who spends the most time rendering the good or service	IMBR-CS14
19	Fees	For an OCF-21C, Estimated Fees for line items in Reimbursable Fees Within the PAF guidelines Approved by the Insurer" must not exceed their maximum amount as specified in the current version of Pre-approved Framework Guidelines for WAD I and WAD II.	IMBR-CS
20	PAF Types	For an OCF-21C, the PAF type for an invoice must be the same as the PAF Type on the originating plan.	IMBR-CS28
21	Fees	For an OCF-21C, there must be a minimum of one reimbursable fee within the PAF guideline	IMBR-CS29
22	Fees	For an OCF-21C, PAF fee totals must equal the sum of the all individual reimbursable fees.	IMBR-CS30
23	Other Service Type	If 'Other Service Type' is specified under other insurance amounts, then a description of the 'Other Service Type' is required.	IMBR-CS5
24	Other Services	For a WAD I PAF, other pre-approved services are not applicable and a provider cannot bill for other pre-approved services.	IMBR-CS26
25	Other Reimbursable Goods	For a WAD II PAF, the Other Reimbursable Goods and Services Approved section on OCF-21 Version C can only include the following goods and services: • Activities of Normal Living Intervention (ANLI) • Travel Time • Mileage • PAF Extension Visits (P.W2.EV) • X-rays not listed in WAD II Payment Schedule for X-Rays	IMBR-CS27
26	Totals	For an OCF-21C, the other goods and services total must equal the sum of all the individual other reimbursable goods and services specified.	IMBR-CS31
27	Subtotal	Subtotal of the document must be equal to the sum of all the line items.	PM-CSR10
28	GST	Total GST must be greater than or equal to 0.	PM-CSR11
29	PST	Total PST must be greater than or equal to 0.	PM-CSR12

Item #	Data Field	Description	Validation #
30	Insurer Total	Auto insurer total amount of the plan must be • greater than or equal to 0 • and equal to the sum of the subtotal (which includes GST and PST, MOH, other insurer 1 & 2 amounts and interest.) Note: MOH and other insurer 1 & 2 amount can be (+/-). (-) indicates an amount to be received. (+) indicates an amount that was previously identified for payment but ruled ineligible	IMBR-CR1