Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Health Claims for Auto Insurance
July 2012 Guideline

July 2012

Superintendent's Guideline No. 02/12

Health Claims for Auto Insurance July 2012 Guideline

Introduction

This Guideline replaces the Health Claims for Auto Insurance December 2011 Guideline – Superintendent's Guideline No. 03/11 issued in December 2011, and is issued pursuant to s. 268.3 (1) of the Insurance Act for the purposes of ss. 49 (1), 64 (7) and 66 of the Statutory Accident Benefits Schedule – Effective September 1, 2010 (SABS).

This Guideline applies to documents specified in this Guideline that are delivered on or after July 1, 2012, regardless of the date of the accident to which they relate, with the exception of the additional requirements on page 9 ("Additional Requirements Effective November 1, 2012"), which apply only to documents delivered on or after November 1, 2012.

A document to which this Guideline applies and that previously would have been sent directly to an insurer to whom this 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 Guideline describes:

- which insurers, health care facilities (facilities) and health care providers (providers) are subject to the 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;
- how insurers are to provide information to the CPA; and
- billing procedures.

Insurers and Providers That Are Subject To This Guideline

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

Participating Providers

The Financial Services Commission of Ontario will continue to maintain and update from time to time a list of identified health care facilities/providers (or specified branch offices thereof) participating in the Health Claims for Auto Insurance ("HCAI") system (the "HCAI Participating Provider List") and the dates that their participation begins. Please see Appendix 1 for details of how to obtain copies of the HCAI Participating Provider List in effect at any particular time.

For the purposes of this Guideline, 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.

Participating Insurers

This Guideline applies to all insurers licensed in Ontario in respect of all claims for SABS benefits under any motor vehicle liability policy issued in Ontario. Each such insurer is a Participating Insurer for the purposes of this Guideline.

This Guideline does not apply to:

- any reinsurer in respect of claims under a contract of reinsurance,
- any insurer in respect of which a winding-up order has been made under the Winding-up and Restructuring Act (Canada), or
- the Motor Vehicle Accident Claims Fund.

Designation of Central Processing Agency – SABS s. 64 (7)

Health Claims for Auto Insurance Processing is the CPA for the purposes of this Guideline and s. 64 (7) 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 to then 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 Guideline – SABS s. 49

Any invoice for goods or services specified in Appendix 2 of this Guideline for the purposes of s. 49 of the SABS must be in the form (the Auto Insurance Standard Invoice) approved by the Superintendent of Financial Services in accordance with s. 66 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. 49 (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 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. 64 (7) of the SABS. Each of these documents must be delivered to the CPA (not directly to the insurer to whom it is addressed) in accordance with this Guideline, if it is delivered to a Participating Insurer by a Participating Provider:

OCF-18	Treatment and Assessment Plan – SABS s. 38
OCF-21	Auto Insurance Standard Invoice – SABS s. 49 – but only if this Guideline requires the use of this form for the particular goods or services being billed
OCF-23	Treatment Confirmation Form – SABS s. 40

Please note that with one exception (see * below), a document that this 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. 64 (2) of the SABS.

***** An OCF-21 submitted to invoice an insurer only for the completion of a Disability Certificate (OCF-3) may be delivered either to the CPA in accordance with this Guideline, or directly to the insurer, at the option of the Participating Provider.

Section 64 (7) of the SABS provides that a document to which this Guideline applies is deemed not to have been delivered to an insurer unless it is delivered to the CPA as required by this Guideline. If such a document is delivered directly to an insurer instead of the CPA, despite the requirements of this Guideline, the insurer is under no obligation to respond to it, as the document will be deemed not to have been received by the insurer.

How To Deliver Documents To The Central Processing Agency

A document that is required by this Guideline to be delivered to the CPA shall be delivered in either of the following ways:

(1) Electronic Submission, or
(2) Paper Submission.

(1) Electronic Submission

The document may 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, once they have completed the appropriate enrolment process (see **Enrolment Of Users And Providers** below).

A Participating Provider may elect to enrol for either electronic submission or paper submission, but not both at the same time.

As noted below under **Rules Governing Date of Receipt of Documents By Insurers**, any document delivered to the CPA by a Participating Provider that has not completed this enrolment process will be deemed not to have been received by the insurer, and will not be processed.

(2) Paper Submission

The CPA has established a data entry centre that is equipped to receive paper documents delivered by a Participating Provider in accordance with this Guideline. These documents will be transcribed, validated and submitted electronically from the Data Entry Centre (DEC) to the insurer.

Documents may be delivered to the CPA in paper form, by mail, fax or personal delivery in accordance with ss. 64 (2) (a), (b), (c) or (d) of the SABS if addressed to the CPA's data entry centre as follows:

HCAI Processing – Data Entry Centre
P.O. Box 254
Orangeville ON L9W 3Z5
Fax number: (866) 346-6744

Participating Providers are authorized to deliver documents in paper form as described above, once they have completed the appropriate enrolment process (see **Enrolment Of Users And Providers** below).

A Participating Provider may elect to enrol for either electronic submission or paper submission, but not both at the same time.

As noted below under **Rules Governing Date of Receipt of Documents By Insurers,** any document delivered to the CPA's data entry centre by a Participating Provider that has not completed this enrolment process will be deemed not to have been received by the insurer, and will not be processed.

Attachments To Documents That Are Subject To This Guideline

For the purposes of this Guideline, "attachments" means any material (e.g., additional pages, reports, test results) submitted in support of a document to which this Guideline applies.

If a Participating Provider determines that it is necessary to send one or more attachments 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 Participating Provider must specify, in the field provided in the document for that purpose, how many attachments are being delivered.

2. The document itself (but not the attachments) must still be delivered to the CPA (if in electronic format) or the CPA's data entry centre (if in paper form) as described above.

3. The attachments are not to be delivered to the CPA (or the CPA's data entry centre), but instead must be delivered directly to the insurer by one of the delivery methods described in s. 64 (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.

   Please note that any attachment delivered to the CPA or the CPA's data entry centre will be deemed not to have been received by the insurer, and will not be returned, but will be destroyed.

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 the claim number or policy number, the date of the accident, and the document type (i.e., OCF-18, OCF-21 or OCF-23) 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 64 of the SABS sets out the rules that determine when a document delivered to the CPA as required by this 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 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 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. 64 (20)) that a document delivered to the CPA by fax, personal delivery or by electronic submission later than 5:00 p.m. Eastern Time is deemed to have been delivered to the CPA on the following business day.

The SABS also provides (s. 64 (10)) that the CPA will be deemed to have determined, on the day a document was delivered to it in a manner specified in this 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 Guideline.

For the purposes of s. 64 (10), the manner in which the CPA is to notify the sender is by one of the delivery methods provided for in s. 64 (2) of the SABS. The CPA may also deliver the notification verbally (e.g., by a telephone call or message), provided written confirmation is given as soon as practicable afterwards by one of the delivery methods provided for in s. 64 (2) of the SABS.

As previously noted, the SABS further provides (s. 64 (7)) that a document to which this Guideline applies is deemed not to have been delivered to an insurer unless it is delivered as required by this Guideline. Any document delivered to the CPA (either directly or through its data entry centre) by a Participating Provider that has not completed the enrolment process, is not delivered as required by this Guideline and therefore shall be deemed not to have been delivered to an insurer.

Completion of Documents

A document to which this 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 Guideline.

The information in any completed field must comply with the validation rules set out in Appendix 3 of this 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 is available at www.hcaiinfo.ca.
- To describe payment categories under a Pre-approved Framework, the list of Pre-approved Framework Reimbursement Codes is available at www.hcaiinfo.ca.
- To describe payment categories under the Minor Injury Guideline, the list of Minor Injury 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 is 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 is 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 www.hcaiinfo.ca/links.asp.

Billing Procedures

a) Purpose

The purpose of this section is to set out rules for submission of the Auto Insurance Standard Invoice (OCF-21) that must be followed by all Participating Providers. This includes describing the information that must be provided on the OCF-21 in order for it to be considered to be duly completed and to include all information required to be included in it within the meaning of s. 67 of the SABS.

b) Frequency of invoicing

An OCF-21 in respect of a Treatment and Assessment Plan (OCF-18) shall not be submitted until no further approved goods or services referred to in the OCF-18 will be rendered. However, where the delivery of the goods or services referred to in an OCF-18 extends over 30 calendar days the Participating Provider may choose to submit an OCF-21 in respect of that OCF-18 once every 30 calendar days.

If treatment is being provided under the Minor Injury Guideline (MIG), a Participating Provider shall not submit an OCF-21 in respect of a treatment Block as referred to in the MIG until completion of the Block. (In the event an insured person changes providers while treatment services are being delivered, the previous provider may submit an OCF-21 for the services delivered prior to the change. However, the amount billed must comply with paragraph 6 (“Changing health practitioners within this Guideline”) of the MIG.)

c) Completion of invoices

In order to enable insurers to properly reconcile invoices, a Participating Provider shall not submit an OCF-21 that applies to more than one OCF-18 or to more than one OCF-23, or to an OCF-18 as well as an OCF-23.

When submitting an OCF-21 a Participating Provider must include, in addition to all information that the form identifies as required, the following information:

- If it is alleged that the insurer is required to pay for goods or services in accordance with s. 38 (11) of the SABS (i.e., by reason of the insurer's failure to respond to an OCF-18 within 10 business days of receipt) this must be clearly identified in the "Other Information" section of the OCF-21.

- The "Plan Number" of the OCF-18 or OCF-23 to which the OCF-21 refers must be provided where indicated in Part 3 of the OCF-21. The "Plan Number" is the unique Document Number generated by the CPA when the OCF-18 or OCF-23 to which the OCF-21 refers was submitted. However, if there is no Plan Number for a reason permitted by the SABS or this Guideline, for example because the insurer has waived the requirement for an OCF-18 or OCF-23 under s. 39 or s. 41 of the SABS as applicable, the word "exempt" must be inserted in the Plan Number field and details of the circumstances must be provided in the "Other Information" section of the OCF-21.

- If a Participating Provider is submitting an OCF-21 for goods or services that are alleged not to require an OCF-18 because of s. 38 (2) or s. 38 (4) of the SABS, the word "exempt" must be inserted in the Plan Number field in Part 3 of the OCF-21 and details of the basis on which an OCF-18 is said not to be required must be provided in the "Other Information" section of the OCF-21.

- Complete and accurate information regarding other available insurance and health care coverage must be provided in the "Other Insurance" section of the OCF-21.

An OCF-21 that does not include all required information as identified in the form or required by this Guideline will be deemed to be incomplete and not to include all the information required by the SABS.

Additional Requirements Effective November 1, 2012

The following additional requirements apply to documents delivered on or after November 1, 2012, regardless of the date of the accident to which they relate:

1. Only the OCF-21C is approved for the purpose of billing any amounts under the MIG or a Pre-approved Framework.

2. The OCF-21A and OCF-21B are no longer approved for the purpose of billing any amounts under the MIG or a Pre-approved Framework.

3. The OCF-18 is no longer approved for use with any MIG codes or Pre-approved Framework codes.

4. When submitting an OCF-21C a Participating Provider must include the following additional information:

    - The date that the treatment Block commenced.
    - The profession(s) of the health care provider(s) who provided the treatment.

d) Duplicate invoices

Re-submission of an OCF-21 that refers in whole or in part to goods or services referred to in an OCF-21 already received by the insurer according to s. 64 (9) of the SABS is not permitted through the HCAI system. Where the Participating Provider wishes to remind the insurer of an outstanding amount, the Participating Provider must contact the insurer directly.

A Participating Provider who repeatedly and/or deliberately submits duplicate OCF-21 forms through the HCAI system may be found by the CPA to be in contravention of the CPA's user terms & conditions (see **Enrolment Of Users And Providers** below). Such contravention may result in suspension, cancellation or revocation of the Participating Provider's access to the HCAI system.

e) Non-approved goods and services

A Participating Provider shall not submit an OCF-21 for goods or services (which includes assessments and examinations) that have not been:

i. approved by the insurer,
ii. deemed by the SABS to be payable by the insurer, or
iii. determined to be payable by the insurer on resolution of a dispute in accordance with ss. 279 to 283 of the Insurance Act.

A Participating Provider who repeatedly and/or deliberately submits OCF-21 forms through the HCAI system contrary to this requirement may be found by the CPA to be in contravention of the CPA's user terms & conditions (see **Enrolment Of Users And Providers** below). Such contravention may result in suspension, cancellation or revocation of the Participating Provider's access to the HCAI system.

f) Recordkeeping

For every OCF-21 submitted to a Participating Insurer, the Participating Provider must keep on file:

- an original paper version of the OCF-21 as submitted that includes the original authorized signature of the Provider, or
- an electronic true copy of the OCF-21 as submitted, provided that it is in pdf format and includes a true copy of the original authorized signature on behalf of the Provider,

and must be prepared to give the insurer access to inspect and copy the OCF-21 in accordance with s. 46.2 of the SABS where requested by the insurer.

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. 49 (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. 64 (13) of the SABS concerning any other document to which this 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. 64 (14) 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 enrol with the CPA and agree to its user terms and conditions. As noted above, providers and facilities may elect to enrol 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 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 Guideline.

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

During the period of any such suspension, the requirements of this 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. 64 (2) of the SABS.

Appendix 1

HCAI Participating Provider List

Copies of the HCAI Participating Provider List in effect from time to time may be obtained at 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 Guideline – SABS s. 49

SABS Section	Type of Service/Goods	Specified for the purposes of section 49	Not specified for the purposes of section 49
Medical Benefits			
15(1)(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
15(1)(b)	Chiropractic, psychological, occupational therapy and physiotherapy services	✓	
15(1)(c)	Medication		✓
15(1)(d)	Prescription eyewear		✓
15(1)(e)	Dentures and other dental devices		✓
15(1)(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
15(1)(g)	Transportation of the insured person to and from treatment sessions, including transportation for an aide or attendant		✓
15(1)(h)	Other goods and services of a medical nature	✓	
Rehabilitation Benefits			
16(3)(a)	Life skills training	✓	
16(3)(b)	Family counselling	✓	
16(3)(c)	Social rehabilitation counselling	✓	
16(3)(d)	Financial counselling		✓
16(3)(e)	Employment counselling		✓
16(3)(f)	Vocational assessments	✓	

SABS Section	Type of Service/Goods	Specified for the purposes of section 49	Not specified for the purposes of section 49
16(3)(g)	Vocational or academic training		✓
16(3)(h)	Workplace modification and workplace devices including communication aids		✓
16(3)(i)	Home modifications and home devices including communication aids, or a new home instead of home modifications		✓
16(3)(j)	Vehicle modifications or a new vehicle instead of modifying an existing vehicle		✓
16(3)(k)	Transportation for the insured person to and from counselling sessions, training sessions and assessments, including transportation for an aide or attendant		✓
16(3)(l)	Other goods and services other than case management, housekeeping and caregivers and any other good or service for which a benefit is otherwise provided in the SABS		✓
17	Case manager services	✓	
19	Attendant care services	Provided by health care providers and other professional care providers	Provided by family, neighbours and other non-professional care providers
Examinations, Completion of Reports/Certificates, etc.			
25	Disability Certificate (OCF-3)		✓
25	Treatment Plan (OCF-18)	✓	
25	Application for Determination of Catastrophic Impairment (OCF-19)	✓	
25	Assessment of Attendant Care Needs (Form 1)	✓	
44	Insurer Examinations	✓	

Appendix 3

Validation Rules

Item #	Data Field	Description	Related Rule ID
Common Document Submission Rules			
1	Policy/Claim Number	Either the policy number or the claim number must be filled in.	PM-CSR1
2	Date of Accident	The date of accident must be • prior to or equal to the date of submission • and prior to or equal to the current date.	PM-CSR7
3	Date of Birth	The date of birth of an applicant must be prior to or equal to all dates on the document, including • the date of submission, • the date of accident • and the current date.	PM-CSR4
4	Date of Birth	The applicant cannot be older than 120.	PM-CSR6
5	Health Care Provider Name	All health care providers listed on a document must be enrolled and validated in HCAI, except the Health Practitioner in Part 4 of the OCF-18. All such providers must be associated with a single health care facility which is enrolled and validated in HCAI.	PM-CSR28
6	Injury Code	Documents must have at least one injury code. The description of the injury or problem in the field "Description" must be an approved, standard description corresponding with one of the ICD-10-CA codes published by CIHI.	PM-CSR14
7	Quantity	The estimated quantity on all goods or services line items must be greater than 0.	PM-CSR9
8	Sub-total	All sub-totals in the document must be • greater than or equal to 0 • and equal to the sum of all the line items to which the sub-total applies.	PM-CSR10
9	Tax	Total tax must be • greater than or equal to 0 • and equal to the sum of all the line items	PM-CSR25
10	Date of Applicant's Signature	The date of an applicant's signature on treatment plans must be • prior to or equal to the current date • and equal to or after the date of accident.	PM-CSR31
Validation of unit of measure for goods and services rendered			
11	Quantity	If the measure is GD, PR, PG or SN, the quantity must be a whole number greater than 0.	BR-GPI_R12
12	Measure	For goods and services codes beginning with the letter "S", the unit of measure is either "SN" (session) or "HR" (hour).	BR-GPI_R05

Item #	Data Field	Description	Related Rule ID
13	Measure	For goods and services codes beginning with the letter "G", the unit of measure should always be "GD" (goods). • Codes not beginning with “G” must not have a measure “GD”.	BR-GPI_R06
14	Measure	For goods and services codes concluding with “TT” (travel time), the unit measure must be "HR" (hours).	BR-GPI_R07
15	Measure	For goods and services codes concluding with “KM” (mileage), the unit measure must be “KM” (kilometre).	BR-GPI_R08
16	Measure	If the measure is KM (kilometre) or HR (hour), decimals are allowed in the quantity.	BR-GPI_R13
17	Measure	For all CCI Codes, the unit of measure must be HR (hour) or PR (procedure). An exception will be made for codes beginning with "7" and concluding with "30", in which case the unit of measure "PG" (page) is also allowed. • Example: The CCI codes 7.SJ.30 and 7.SJ.30.LB may have unit of measure "PG".	BR-GPI_R04
Common Invoice (OCF-21) Submission Rules			
18	Other Service Type	If amounts are provider in the “Other Service Type” row in the “Other Insurance Amounts” section, then a description of the other service type is required.	IMBR-CS5
19	Payee Name (“Make Cheque Payable To”)	If the health care facility chooses the “lock payable” option when registering on HCAI, then the “Make Cheque Payable To” field on all invoices is the name of the payee specified by the health care facility in their configuration. Otherwise, the first and last name of the payee must be provided in the “Make Cheque Payable To” when submitting the invoice.	IMBR-CS6
20	Date of Service	The date of service of a rendered good or service must be • greater than or equal to the date of accident • and less than or equal to the date of submission.	IMBR-CS7
21	Quantity	Quantity of a rendered good or service must be greater than 0.	IMBR-CS9
22	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 for each 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
23	Insurer Total	The auto insurer total amount on the invoice must be equal to the sum of the tax amount, MOH amount, other insurer 1 & 2 amounts, proposed line-item sub-total(s) and interest.	IMBR-CR1
24	Invoice	An invoice that is created from a plan can only be associated with that one plan. An invoice for goods and services from more than one plan must be created from scratch.	IMBR-CS22
25	Interest	Interest on an invoice must be manually calculated and entered into HCAI. Interest will not be calculated from the overdue amount on the invoice.	IMBR-CS39

Item #	Data Field	Description	Related Rule ID
26	Line Item	There must be at least one line item for goods and service rendered. A line item can be a treatment session. The description of the intervention in the field "Description" must be an approved, standard description corresponding to the CCI or GAP codes published by CIHI or HCAI, respectively.	IMBR-CS16
27		The Plan Number field cannot be left blank.	IMBR-CS46
28		The only acceptable values that can be entered in the Plan Number field are as follows: • A valid HCAI Document Number; OR • The word "exempt" (see Note) Note: In the case of a valid business scenario in which there is no Plan Number, the facility must enter the word "**exempt**" in the Plan Number field and cannot leave it blank.	IMBR-CS47
29		If a Plan Number is entered, it must not be the HCAI Document Number of a plan that has been withdrawn or voided by the facility .	IMBR-CS48
30		If a Plan Number is entered, it must be for the insurer (or insurer group) to which the plan was submitted.	IMBR-CS49
31		The OCF-21 may be submitted for a plan originated by another facility.	IMBR-CS50
32		If a Plan Number is entered on an OCF-21 and the OCF-21B portion of the form is completed, the Plan Number can refer only to an OCF-18, not an OCF-23	IMBR-CS51
33		If a Plan Number is entered on an OCF-21 and the OCF-21C portion of the form is completed, the Plan Number can refer only to an OCF-23, not an OCF-18	IMBR-CS52
OCF-21C Submission Rules – effective November 1, 2012			
34		First Date of Service in the "Reimbursable Fees Within the Minor Injury Guideline or Pre-approved Framework" section must be: • greater or equal to the date of accident. • and less than or equal to the date of submission *Note*: For block fees this is the date that the block of services was initiated	IMBR-CS53
35		If the "Reimbursable Fees Within the Minor Injury Guideline or Pre-approved Framework" section of the OCF-21C contains one or more line items, at least one provider reference must be given on each line.	IMBR-CS54
36		Only MIG/PAF codes are allowed in the "Reimbursable Fees Within the Minor Injury Guideline or Pre-approved Framework" section on the OCF-21C.	IMBR-CS55
OCF-21B Submission Rules – effective November 1, 2012			
37		No MIG/PAF codes are allowed on the OCF-21B.	IMBR-CS56
OCF-18 Submission Rules			

Item #	Data Field	Description	Related Rule ID
38	Profession	A Health Practitioner's profession must be one of the practitioner professions listed in the Statutory Accident Benefits Schedule (SABS).	PM-18R9
39	Date of Signature	The date of the signature of the Health Practitioner must be • on or after the date of accident • and on or before the date of submission.	PM-18R7
40	Profession	The Regulated Health Professional's profession must be one of the regulated health professions listed in the regulations.	PM-18R10
41	Date of Signature	The date of the signature of the Regulated Health Professional must be • on or after the date of accident • and on or before the date of submission.	PM-18R6
42	Line Item	There must be at least one goods and service line item. A line item can be a treatment session. The description of the intervention in the field "Description" must be an approved, standard description corresponding to the CCI or GAP codes published by CIHI or HCAI, respectively.	PM-18R5
43	Count	The projected count for each goods and services line item must be greater than 0.	PM-18R2
44	Total Cost	The projected total cost for each goods and services line item must be • greater than or equal to 0 • and equal to the estimated cost per day times the projected count.	PM-18R1
45	Duration of Treatment	The estimated duration of the treatment plan (in weeks) must be greater than 0.	PM-18R3
46	Number of Treatment Visits	The number of treatment visits previously provided must be either blank or greater than or equal to 0.	PM-18R4
47	Auto Insurer Total	The auto insurer total amount on treatment plans must be equal to the sum of the sub-total, tax, MOH and other insurer 1 & 2 amounts.	PM-18R11
48	Total Count	The total count of all the goods and services must be equal to the sum of the total counts of each of the line items.	PM-CSR26
49		Effective November 1, 2012, no MIG/PAF codes are allowed on the OCF-18	PM-18R12
OCF-23 Submission Rules			
50	Profession	The Health Practitioner's profession in Part 4,Signature of Initiating Health Practitioner section of the OCF-23, must be one of the following: • Chiropractor • Dentist • Nurse Practitioner • Occupational Therapist • Physician • Physiotherapist	PM-23R18

Item #	Data Field	Description	Related Rule ID
51	Date of Signature	The date of the signature of the Health Practitioner must be • on or after the date of accident • and on or before the date of submission.	PM-23R10
52	Guideline	If the date of accident is on or before Aug. 31, 2010, the Guideline identified in Part 9 must be “PAF WAD I/II”. Otherwise, the Guideline identified in Part 9 must be “Minor Injury“.	PM-23R25
53	Part 11	If the Guideline is “Minor Injury”, there must be no line items in Part 11.	PM-23R26
54	Total	The document total must be equal to the sum of the Part 9 sub-total and Part 11 sub-total.	PM-23R17
55	Guideline Estimated Fee	The Guideline Estimated Fee must be greater than or equal to zero.	PM-23R27
56	Supplementary Goods & Services Estimated Fee	The Supplementary Goods & Services Estimated Fee must be greater than or equal to zero.	PM-23R28
OCF-21A Submission Rules- applies to DEC only			
57	Plan Number	The Data Entry Centre will not accept an OCF-21A if a Treatment & Assessment Plan (OCF-18) has not been received by the DEC previously. In this case, an OCF-21B must be submitted.	BR-DEC-00
OCF-21B Submission Rules			
		Refer to Common Invoice Submission Rules.	
58	Mandatory Fields for Rendered Goods and Services	The following fields for rendered goods and services line items are mandatory: • Date of service • Goods and services code • Provider reference • Quantity • Measure • Tax, i.e. must be either “Yes” (checked) or “No” (unchecked) • Cost	IMBR-CS10
OCF-21C Submission Rules			
59	Version	Invoice OCF-21, Version C must be used for billing goods and services within a Guideline issued by the Ontario Superintendent of Insurance.	IMBR-CS1
60	PAF/Guideline Type	The PAF/Guideline type for an invoice must be the same as the PAF/Guideline Type on the originating plan. The allowed values in the Type field in Part 3 are: • Minor Injury • WAD I/II Injury	IMBR-CS28
61	Fees	The "Reimbursable Fees Within the Minor Injury Guideline or Pre-approved Framework" section of an OCF-21C may contain zero line items. If it contains one or more line items, the Proposed Cost of each such line item must be greater than or equal to zero. The Proposed Sub-total for this section must be greater than or equal to zero.	IMBR-CS44

Item #	Data Field	Description	Related Rule ID
62	Fees	The PAF/Guideline fee totals must equal the sum of all the individual reimbursable fees.	IMBR-CS30
63	Other Reimbursable Goods & Services	There must be no line items in the Other Reimbursable Goods and Services section if the PAF/Guideline is the Minor Injury Guideline.	IMBR-CS45
Facility Registry			
64	Facility Registry	Facilities that bill automobile insurers must be enrolled in HCAI through the online self-registry or by submitting the paper enrolment form to the paper processing centre. Facilities register individual health care providers.	BR-DS-A01
65	Facility Registry	Facilities must be activated by the Provider Adoption Support Team (PAST) to be available on HCAI for forms processing. The PAST activates the facility upon receipt of the signed enrolment form.	BR-DS-A02
66	Provider Registration Number	Regulated health care providers must supply college registration numbers.	BR-DS-A03
67	Facility Registry	Until the PAST activates the facility, the facility authorizing officer is only able to log in to HCAI to modify facility information and add health care providers.	BR-DS-A04
68	User Management	Upon activation of the facility by the PAST, which occurs after receipt of the signed enrolment form, the facility's authorizing officer will be able to set up users and access HCAI functions.	BR-DS-A05
69	Provider forms	Each time a health care provider is added to HCAI, the facility must print the appropriate enrolment form, obtain the providers signature and retain the paper copy.	BR-DS-A06
70	Provider End Date	To unlink a health care provider from a facility, the facility administrator must set the end date for the provider. If a provider's user account exists, it will be disabled as of the end date.	BR-DS-A07
71	PMS Integration	If PMS integration is selected, the PMS vendor name is required.	BR-DS-A08
72	Facility End Date	If the end date for a health care facility is entered, all user accounts will be disabled after 15 days and no form submission will be allowed after the end date.	BR-DS-A09
73	Provider	Once enrolled, a health care provider's name and professions cannot be modified.	BR-DS-A10
74	Provider	For a health care provider name change, the end date is entered and provider must be set up with new name.	BR-DS-A11