OCF - 3 THE DISABILITY CERTIFICATE

USER MANUAL

March 2006

Document Change History

Date	Description of Change	Reason
20050214	Revised Applicant Signature	For consistency with revised OCF forms 01/Dec/04
20060301	Further Information, Revised Instruction Preamble, Revised Applicant Signature, Revised Disability Test	Redirects users to HCAI website, reflects revised timelines in SABS, revised consent and reflects removal of Future Employment as benefit/applicant category

Changes are underlined.

Introduction

Who should use this manual?

This User Manual is designed to assist both health care providers and automobile insurers in the completion of the OCF–3 Disability Certificate. Other manuals are available to assist in the completion of:

OCF–18 Treatment Plan

OCF–21 Auto Insurance Standard Invoice

OCF–22 Application for Approval of an Assessment or Examination

OCF–23 Pre-Approved Framework Treatment Confirmation Form

OCF–24 Pre-Approved Framework Discharge & Status Report

Facilities and health care providers dealing with victims of motor vehicle accidents are required to use these forms.

Both rehabilitation health care providers and automobile insurers have dedicated a tremendous amount of time and thought to the revision of the Disability Certificate and other forms. These forms will improve the accountability of all parties, streamline the process of delivering health care services to applicants, and enhance communication between insurers and health care professionals.

The forms are designed to facilitate a clear understanding of the interactions amongst an injured motorist, a health care professional and an insurer through the use of common terms and language. All forms use the national coding standards, the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Canada* (ICD-10-CA)[1], to identify injuries and the *Canadian Classification of Health Interventions* (CCI)[1] to classify health care services and procedures.

What is in this manual?

The manual provides detailed instructions for completion of the fields in the order in which they appear on the forms. The appendices include tables of standardized codes and descriptions for the various codified fields used on the forms.

Where can I get more information?

The manual will be updated from time to time. The latest updates to the manual can be downloaded from the website www.hcaiinfo.ca under Auto Insurance Resources>Statutory Accident Benefits>User Manuals.

Contact your professional association for any questions relating to coding of injuries, interventions, health care services and guidelines as they relate to your specific practice.

1 ICD-10-CA and CCI are copyright products of the *Canadian Institute for Health Information (CIHI)* and may not be changed without the Institute's express permission.

Samples of Completed Sections of the Forms

The samples and fees used throughout the manual are entirely fictitious. They are designed to assist you in understanding how to use and complete the forms.

OCF-3 Disability Certificate

Background

The Disability Certificate is a form that identifies and describes the injuries and impairments that are a direct result of a motor vehicle accident, and that provides a clinically appropriate estimate of the anticipated duration of a disability. The Certificate is used to determine the applicant's eligibility for certain benefits under the Statutory Accident Benefits Schedule (SABS).

Purposes:

- To assist insurers in determining the claimant's entitlement to certain benefit(s).
- To identify the injuries and impairments which are a direct result of the motor vehicle accident.
- To indicate the anticipated duration of the disability for which the benefits are being applied.
- To list tasks and activities limited by the injury and sequelae.
- To identify any relevant prior and concurrent conditions.
- To increase the accountability of the claimant, health care practitioner and insurer.

This form may not be materially altered; in other words, the document cannot be changed in any manner. If this document is materially altered, it may be considered incomplete and the insurer may not accept the form.

When is an OCF-3 required?

An insurer may require the completion of the Disability Certificate from the applicant's health practitioner to process the following Accident Benefits:

- Income replacement
- Caregiver
- Non-Earner
- Lost Educational Expenses
- Housekeeping and Home Maintenance Expenses

Subsequent Disability Certificates will be accepted only at the request of the insurer.

Who completes this form?

The Applicant or a substitute decision maker completes Parts 1 to 3 and signs Part 4. The *Substitute Decisions Act* states that a substitute decision maker is a person with power of attorney for personal care or a court appointed guardian.

Only an authorized health practitioner (i.e., chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist or speech-language pathologist) can complete the rest of the form. He/she is then expected to submit the completed Certificate directly to the insurer.

Complete OCF-3 based on your most recent assessment of the Applicant. An additional assessment for the purpose of completing the OCF-3 should not normally be required. Do not leave any sections blank, as the form may then be considered incomplete, possibly causing delays in determining entitlement for benefits.

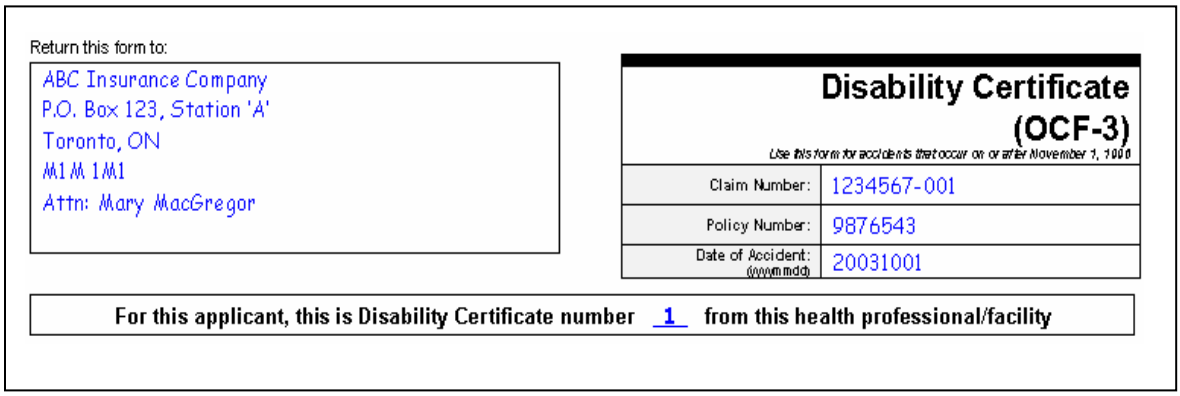
Complete this form as soon as possible following an accident, because the form must be returned to the insurer within 15 days from the date that the Applicant receives the insurer's request for a Disability Certificate. If the OCF-3 is being completed to support the claimant's application for accident benefits, it must be completed by a health practitioner no earlier than 10 business days after the date of the application. Benefits may be affected if the certificate is not received within the required timeframe.

Fee

Note: The fee for completing this certificate is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly.

The fee for completion of this form should be billed directly to the insurer. It is not a benefit of the Ministry of Health and Long-Term Care.

It is considered a conflict of interest to receive any payment or benefit in addition to the insurer's fee for completion of the form.



Return this form to:

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

Disability Certificate (OCF-3)

Use this form for accidents that occur on or after November 1, 1996

Claim Number:	1234567-001
Policy Number:	9876543
Date of Accident: (yyyymmdd)	20031001

For this applicant, this is Disability Certificate number 1 from this health professional/facility

Return this form to:

Enter the name and mailing address of the Insurance Company responsible for handling the claim.

Claim Identifiers

The Applicant must indicate the claim number if known, the policy number, and the date of the accident. The claim number and policy number can be obtained from the insurance adjuster. The policy number is also available on the Motor Vehicle Liability Insurance Card (pink slip) received with the policy declaration.

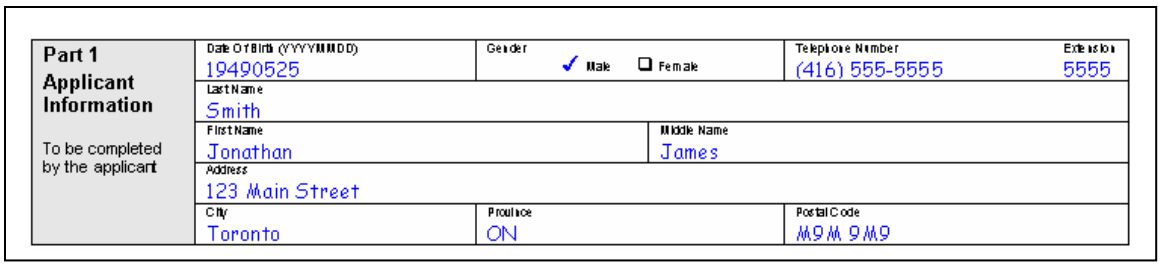
The Claim Number and Policy Number may be the same.

The accident date must be completed. Forms will not be processed without it. If a patient has overlapping injuries from more than one accident, use the date of the accident that is most relevant to the injuries being treated.

Disability Certificate Number

Enter a number indicating how many times you have completed a Disability Certificate for this applicant and this motor vehicle accident.

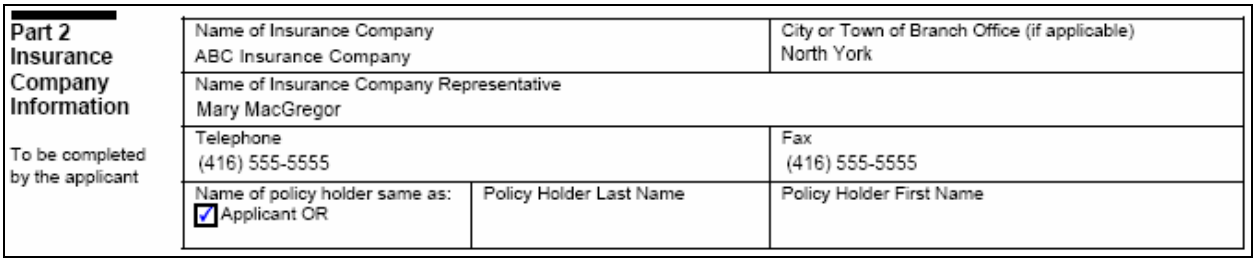
Part 1 Applicant Information



Part 1 Applicant Information To be completed by the applicant	Date Of Birth (YYYYMMDD) 19490525	Gender ✓ Male ☐ Female	Telephone Number (416) 555-5555	Extension 5555
	Last Name Smith			
	First Name Jonathan	Middle Name James		
	Address 123 Main Street			
	City Toronto	Province ON	Postal Code M9M 9M9	

To be completed by the Applicant.

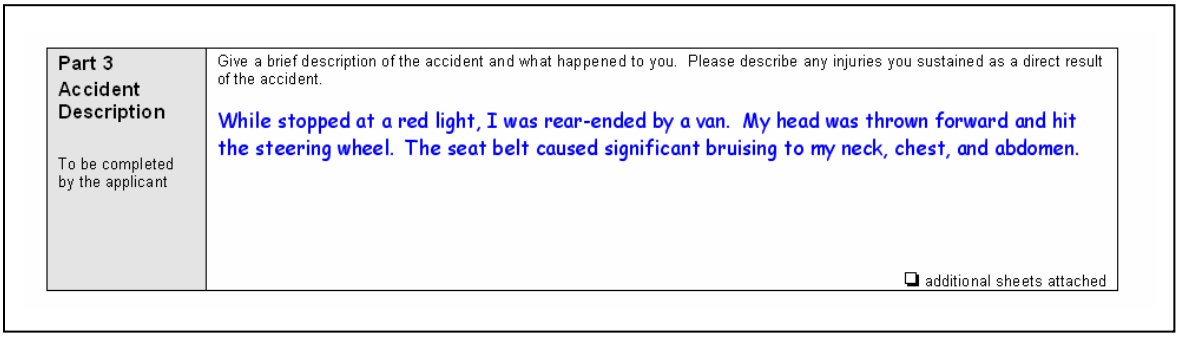
Part 2 Insurance Company Information



Part 2 Insurance Company Information To be completed by the applicant	Name of Insurance Company ABC Insurance Company		City or Town of Branch Office (if applicable) North York
	Name of Insurance Company Representative Mary MacGregor		
	Telephone (416) 555-5555		Fax (416) 555-5555
	Name of policy holder same as: ☑ Applicant OR	Policy Holder Last Name	Policy Holder First Name

To be completed by the Applicant.

Part 3 Accident Description



Part 3 Accident Description To be completed by the applicant	Give a brief description of the accident and what happened to you. Please describe any injuries you sustained as a direct result of the accident. While stopped at a red light, I was rear-ended by a van. My head was thrown forward and hit the steering wheel. The seat belt caused significant bruising to my neck, chest, and abdomen. ☐ additional sheets attached

The Applicant must describe both the accident and the injury sustained as a direct result of the accident. Additional sheets may be attached if necessary.

Part 4 Applicant Signature

Part 4 Applicant Signature

I authorize my treating health professional to collect, use and disclose to my insurer or to a health professional, social worker, or rehabilitation expert properly identified by my insurer to conduct an examination, only such information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing or subsequently occurring health conditions that may be barriers to my recovery as a result of the automobile accident, as is reasonably required for the purpose of providing treatment and determining my eligibility for benefits. I authorize the health practitioner who completes this form to contact my employer, if this is necessary, to confirm the essential tasks of my employment and the nature and extent of any available work with modified hours or duties.

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)
John Smith		

After you have explained the injuries, the Applicant or the Applicant's substitute decision maker, as defined in the *Substitute Decisions Act*, must sign here.

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

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

Part 5 Injury and Sequelae Information

To the Health Practitioner:
Please complete the following information based on your most recent examination of the applicant named in Part 1 and return the form to the insurance company listed in Part 2. Please print clearly.

Part 5 Injury and Sequelae Information

This part and the rest of this form must be completed by your Health Practitioner

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

Description	Code
Sprain and strain of lumbar spine	S33 5
Headaches	G44
Multiple superficial injuries of thorax	s20.7

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

List the injuries and sequelae that are a direct result of the automobile accident. Provide a brief description of the injury and the corresponding injury code (ICD-10-CA code). Up to six injuries/sequelae may be entered including the description and a valid ICD-10-CA code.

List the most significant injury first; describe the patient's most significant condition that is directly related to the automobile accident and that requires health care services. In a case where multiple injuries may be classified as the most significant, list the injury requiring the most services.

It is anticipated that, with the use of "multiple injury" codes (see Appendix A), there will likely not be more than six injury/sequelae codes needed. However, should more space be required, you may attach an additional page.

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

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

Part 6 Relevant Dates

Part 6 Relevant Dates	Date symptoms first appeared: (YYYYMMDD) 20031001	Date of most recent examination: (YYYYMMDD) 20031006
	Date of first post- accident examination: (YYYYMMDD) 20031006	a) Applicant was seen by me prior to the accident? ✓Yes ☐ No b) If answer to a) is yes, enter date on which the applicant was first seen: (YYYYMMDD) 19820115

The question referring to the period of time under your care helps the insurer to understand your history of caregiving with this Applicant.

Part 7 Disability Tests and Information

Part 7 Disability Tests and Information

a) Based on your current knowledge and information provided by the applicant, please provide a response to each Benefit/Applicant Category

Benefit/Applicant Category	Disability Test	Onset of Disability (yyyymmdd)	Task/Activity Limitations	Anticipated Duration
Income Replacement Benefits **Employed:** working at the time of the accident	Is the applicant substantially unable to perform the essential tasks of his/her employment at the time of the accident as a result of and within 104 weeks of the accident? ✓ Yes ☐ No ☐ N/A	20031001	Please explain: • No lifting • No prolonged sitting	✓ 1-4 weeks ☐ 5-8 weeks ☐ 9-12 weeks ☐ more than 12 weeks
	Can the applicant return to work on modified hours and or duties? ☐ Yes ✓ No ☐ N/A		Please explain: Modified work hours and duties unavailable.	✓ 1-4 weeks ☐ 5-8 weeks ☐ 9-12 weeks ☐ more than 12 weeks

(*Partial screen print*)

b) If you responded Anticipated Duration 'more than 12 weeks' to any disability test above, please explain why the task/activity limitations are likely to persist beyond 12 weeks.

In order for the claimant to receive all the benefits for which he/she may be eligible, you must provide a response for each category, even if you answer N/A (not applicable). Provide examples for each “Yes” or “No” answer. For more information on Disability Test and Benefit categories, contact the insurer.

The responses should be based on your current knowledge and information provided by the client.

In order to provide accurate information regarding Income Replacement Benefits and modified hours or duties you may benefit from contacting the employer, but a job site assessment is not required to complete this form.

Anticipated duration of the disability is to be based on your best judgement, NOT the claimant’s determination. Hence, you must fully explain why the limitations will continue, if you check “more than 12 weeks.”

<u>Future Employment is no longer an eligible Benefit/Applicant category.</u>

Part 8 Further Investigations or Consultations

Part 8 Further Investigations or Consultations	a) Have there been any examinations, investigations, or consultations not previously reported by you? ❑ No ✓ Yes (please specify findings and results) Examination conducted by the orthopaedic surgeon, October 5, 2003 indicates injury of radial nerve at forearm level.
	b) Are further examinations, investigations or consultations contemplated or required? ❑ No ✓ Yes (please specify) Follow-up visit with the orthopaedic surgeon scheduled for November 15, 2003

Describe the results of any relevant prior investigations and consultations, if any, and whether any further investigations and examinations are required.

Part 9 Prior and Concurrent Conditions

Part 9 Prior and Concurrent Conditions	a) Prior to the accident, did the applicant have any disease, condition or injury that affected his/her ability to perform the activities listed in Part 7? ❑ No ❑ Unknown ✓ Yes (please explain) Periodic low back pain. Last episode March 2003. If yes, is the applicant currently receiving any disability benefits for the pre-existing disease, condition or injury? ✓ No ❑ Unknown ❑ Yes (please explain) Patient returned to modified work June 2003. WSIB benefits discontinued at that time. If you treated the applicant for similar conditions prior to the accident, please describe (include date of onset, any subsequent interventions, and status at the time of the accident). Low back strain injury of March 2003 treated with heat therapy and gradual progression to an active exercise program. Home exercise and use of a lumbar support belt for lifting allowed return to modified work in June.
	b) Since the automobile accident, has the applicant developed any disease, condition or injury, not related to the accident, that could affect his/her disability? ❑ No ❑ Unknown ✓ Yes (please explain) Depression – sudden death of mother.

Provide relevant information in response to these questions to the best of your knowledge and based on information from the claimant. A response of “Unknown” may prompt a request for further clarification from the insurer.

Part 10 Medications

Part 10 Medications	
	a) Please list any medications (including dosage and frequency) that the applicant is currently taking for injuries related to the automobile accident. Naprosyn 275 mg (1 every 8 hours as needed) Tylenol 3 (1 every 4 to 6 hours as needed) Were these medications prescribed by you? ☐ No ✓ Yes
	b) Please list any medications (including dosage and frequency) that the applicant is currently taking as a result of prior or concurrent conditions identified in Part 9. Zoloft 25 mg / day Were these medications prescribed by you? ☐ No ✓ Yes

If you are unaware of any medications, ask the claimant for this information.

Part 11 Health Practitioner Signature

Part 11 Health Practitioner Signature

Name of Health Practitioner Barry Brown		College Registration Number 123456	You are a: ☐ Chiropractor ☐ Dentist ☐ Nurse Practitioner ☐ Occupational Therapist ☐ Optometrist ☑ Physician ☐ Physiotherapist ☐ Psychologist ☐ Speech-Language Pathologist
Facility Name (if applicable) Family Care Clinic		AISI Facility Number (if applicable) T2222	
Address 234 Second Avenue East			
City Toronto		Province ON	Postal Code M2M 2M2
Telephone Number (416) 555-5555	Extension 2424	Fax Number (416) 555-5555	
Email Address bbrown@famcare.ca			
I confirm that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.			
Name of Health Practitioner (please print) Barry Brown		Signature of Health Practitioner	Date (YYYYMMDD)

Regulated Health Professionals should include their college registration numbers. An AISI (Automobile Insurance Standard Invoice) number is not necessary for the completion of this form; however, you can obtain more information on registration at www.hcaiinfo.ca.

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