

Health Service Provider Licensing Toolkit for Examinations/Audits

INTRODUCTION

In December 2014, the Financial Services Commission of Ontario (FSCO) began on-site audits – which they refer to as “examinations” – of licensed service providers. We will refer to the audits as examinations throughout this document. FSCO will be undertaking these examinations throughout the year to ensure that licensed service providers are in compliance with the Insurance Act and regulations.

The FSCO examination is entirely separate from “requests for information” from an insurer, or the filing of an Annual Information Return (AIR).

This guide is intended to help service providers to understand, prepare for and navigate the process of FSCO examinations. It has been created by members of the Coalition of Health Professional Associations in Automobile Insurance Services based on our understanding of the current rules and regulations governing Licensed Service Providers, as well as feedback from health care providers who have already undergone the examination.

This guide should not be viewed as authoritative document. Rather, it should be used for informational purposes only and considered within the context of other legislation (e.g. PHIPPA), FSCO bulletins, HCAI publications, and respective regulatory college requirements. These guidelines cannot take into account any unique aspects of the individual services providers’ business practice, since this is beyond the scope of this document.

BEING CHOSEN FOR AN EXAMINATION

Where possible, FSCO takes a risk based approach to choosing who to audit. Typically, this is based on information gathered from the Annual Information Return (AIR), but also includes complaint data, industry trends, volume of SABS business, etc. As the licensing of the sector is new, they are also randomly selecting to cover off all regions of the province.

TIMELINES FOR EXAMINATION

If your business is selected for examination, a FSCO compliance officer will contact the Principal Representative by phone and will work with you to find a suitable date for the examination. As a licensed provider, you do have a regulatory obligation to participate.

The actual time required to perform the examination will depend on the size of your operation – anywhere from 3 to 8 hours. Unless you are a sole practitioner working entirely on your own, you are not required or expected to close your clinic for the day in order to accommodate the compliance officer. But you do need to make sure that the Principal Representative is available to answer any questions and to provide any required documentation, so you should plan your schedule accordingly.

WHAT WILL THE EXAMINATION COVER?

The examination is intended to review your business practices related to insured individuals, policies and procedures to make sure you are complying with FSCO and Health Claims for Auto Insurance (HCAI) guidelines. When you receive a notification that you are going to be examined, they will provide a list of information that you need to prepare which includes:

- Legal Entity information like Articles of Incorporation, Master Business License, Franchise Agreement, CRA Business Number documentation etc. (where applicable)
- Samples of advertising including promotion of SABS related services (website, pamphlets, flyers, social media feeds)
- Principal Representative/Applicant memberships including accreditations, certificates
- Preferred Provider Networks (PPN), service level agreements etc.
- Staffing information including a list of staff, their health discipline, start and end dates and registration numbers (if they are regulated providers)
- Financial statements for the last 2 years (to verify the responses provided in your license application)
- Last 2 HCAI billing reconciliations
- Policies and Procedures that support billing practices (See Policies section for samples)

The compliance officer will also need access to your HCAI account, and to completed OCF forms (18, 23 and 21) in order to reconcile your billing practices, and to make sure you are adhering to all Statutory Accident Benefits Schedule (SABS) regulations and HCAI guidelines. They will select a few sample files to review, but they will also want to make sure that your files are secure. Personal information will not be collected and need not be disclosed for the purposes of the review.

WHO NEEDS TO PARTICIPATE IN THE EXAMINATION?

The Principal Representative, as the individual responsible for Service Provider compliance, should be available for the examination. If you have other staff that would be helpful to the process (for instance, admin staff who can help with access to paper and electronic files), there is no rule preventing them from participating.

PRIVACY CONCERNS

FSCO's on-site examinations of service providers are about ensuring compliance with billing and business practices only; there will be no gathering or recording of medical or personal information of the insured or your clinical notes. As with any regulatory examination, compliance officers are bound by confidentiality rules.

EXAMINATION RESULTS

The results of your examination will be provided to you by the FSCO compliance officer. The results might include observations about where you might not be meeting the requirements of the regulations, and recommendations for improving your processes. As the licensing of this sector is new, the process is collaborative and largely educational.

You are encouraged to discuss the results with the FSCO compliance officer and clarify any issues with them. If you strongly believe that they have provided you with misinformation, or wrongly presented the results of your examination, you can contact wendy.horrobin@fSCO.gov.on.ca.

POLICIES

The FSCO compliance officer will ask you about various policies and procedures you have in place to ensure you are meeting your obligations for licensing. Not many service providers actually have these policies in writing, but have been able to adequately explain verbally to a compliance officer. FSCO recognizes that having written policies and procedures is in some cases new to the industry. While acceptable at this stage of the examination process, you can expect that formalizing your policies and procedures would be a recommendation that the compliance officer would make.

We have provided sample policies that address the key competencies identified in the regulations and guidelines. Feel free to customize them to reflect your own business practices. And remember that some policies can be addressed or enhanced by referring to the guidelines of your regulatory college – we have indicated where use of these guidelines might be appropriate.

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The Role of the Principal Representative

Policy:

The Principal Representative is the person designated by the service provider to be the primary contact with FSCO and who will be primarily responsible for the service provider's licence and compliance with the law. The Principal Representative will have the authority to make decisions on behalf of the licensee and to communicate with FSCO with respect to matters related to the licence, and to the licensee's compliance with the Insurance Act.

Procedure:

The Principal Representative shall:

- Ensure that the licensee and every person authorized to provide specified goods or services on the licensee's behalf complies with the Insurance Act.
- Ensure that the licensee's business systems, practices and management of the licensee's operations are carried out in accordance with the law and with integrity and honesty.
- Make recommendations to the licensee regarding changes in its business systems, practices and the management of its operations, as necessary.
- Ensure that a system of supervision is in place to ensure that all requirements under the law are met.
- Provide attestations on the licensee's behalf about the licensee and about the licensee's compliance with the Act, as may be required by the Superintendent.

Where there are multiple facilities governed by one Service Provider license, a single Principal Representative shall be responsible for the compliance of all facilities.

While the Principal Representative may designate other employees of the facility to act on their behalf when they are unavailable, it is understood that the PR is nevertheless ultimately accountable for the duties outlined above.

References:

O.Reg 349/13, Section 2

O.Reg 90/14, Section 18

FSCO Service Provider FAQs

<https://www.fSCO.gov.on.ca/en/service-providers/faqs/Pages/about-the-principal-representative.aspx>

Periodic Reviews

Policy:

Periodic reviews of the forms, plans, invoices, documents and other information submitted to insurers must be conducted to ensure we are in compliance with the law and applicable guidelines, and to also ensure the reconciliation of billings.

Procedure:

The Principal Representative should ensure that a review of forms submitted to insurers is undertaken on a regular basis. The review must include, but is not limited to a reconciliation of HCAI invoices and payments with the facility's accounting or financial records.

Reviews must be conducted at least:

- Once every three (3) months, if the service provider was paid \$50,000 or more for listed expenses by automobile insurers in the calendar year before the review.
- Once every 12 months, if the service provider was paid less than \$50,000 for listed expenses by automobile insurers in the calendar year before the review.

Reconciliation of HCAI billings

The Principle Representative should ensure that any invoices submitted through HCAI correspond with the clinical notes provided for each insured person, as well as any attendance records kept by the facility. This may involve a review of the service dates, the provider(s) listed at each session, and the length of time of each service or report provided.

Where the services of a regulated health care provider is listed on the invoice, we are also required to make available for their review any invoices submitted related to their services in order that they may meet the requirements of their regulatory College. This review shall be conducted at a time and location that is convenient for both the service provider and the PR.

Any discrepancies between internal clinical records and HCAI invoices submitted should be addressed immediately by the Principle Representative.

Annual Information Return (AIR)

The Principal Representative is also responsible for the completion and submission of the Annual Information Return (AIR) to FSCO.

The AIR must be completed electronically by March 31st every year. The principal representative will receive an email from FSCO with a personalized link to the AIR. Alternatively, the principal representative may access the AIR directly from the FSCO website after they login to their account.

At the time of submission of the AIR, the Principal Representative shall also be responsible for submitting payment for their annual licensing fee as determined by the formula set out by FSCO.

References:

HCAI Guideline, 2014

Service Providers — Standards For Business Systems And Practices, O. Reg 90/14

Submission of Forms to Insurers

Policy:

All forms submitted to insurers must adhere to the standards and regulations set out in the Insurance Act and Associated Guidelines

Procedure:

The Principal Representative shall ensure that the facility uses the appropriate forms for submission of information to insurers, and that these forms are the most current version approved by FSCO.

The OCF 18, 21 and 23 shall be submitted via HCAI. If an OCF 21 is created for the sole purpose of invoicing for an OCF 3 (Disability Certificate), the OCF 21 may be submitted via HCAI, or directly to the insurer by fax, email or mail.

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

All providers referenced on the form shall have signed agreements with the facility to be associated with the facility.

OCF 18 and OCF 23

The OCF 18 or OCF 23 shall be reviewed with the insured prior to submission to the insurer to ensure that they understand the proposed goods and services and associated costs. The insured will be required to sign only completed forms.

Where an OCF 18 or 23 has been submitted electronically, a copy of the form including the insured's signature must be kept on file and easily retrievable should an insurer or FSCO request to see the document.

For specific policies related to submission of invoices, see **Submission of Invoices** policy.

References:

HCAI Guideline, 2014

O.Reg. 7/00 Unfair Or Deceptive Acts Or Practices Section 3(2)

Submission of Invoices

Policy:

All Service Providers shall submit invoices as per HCAI guidelines using accurate information, no duplication and the use of approved forms only.

Note: CPA = Central Processing Agency = HCAI

Procedure:

Auto Insurance Standard Invoice (OCF-21) Submission Rules

Service providers are required to enter, validate and submit the OCF-21 through HCAI.

Requirements for Submission of the OCF-21

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

Additional Information Required on an OCF-21

If the invoice is being submitted for goods and 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, 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 the OCF-21 is for goods or services that are alleged not to require an OCF-18 because of s. 38 (2) (eg: the good or service is less than \$250) or s. 38 (4) of the SABS (for dental expenses), 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.

Frequency of Invoicing

An OCF-21 submitted 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 Service Provider may choose to submit an OCF-21 in respect of that OCF-18 not more than once per calendar month.

In order to enable insurers to properly reconcile invoices, a Service 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.

If treatment is being provided under the Minor Injury Guideline (MIG), a Service 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.)

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 it is necessary to resubmit an invoice due to outstanding payment, we will contact the insurer directly, rather than through HCAI.

This facility will take reasonable steps to ensure that we do not submit duplicate versions of OCF 18s, OCF 23s and OCF21s or any other document that is required by this Guideline to be delivered through the HCAI system both during the submission process and as part of our scheduled review of billings.

Approved Goods and Services

This facility shall submit invoices for approved goods and services according to the current HCAI Guideline. Services specified in Appendix 2 of the Guideline shall be submitted separately to those not specified in Appendix 2. In addition, should we invoice for services provided outside of Ontario, these services shall be invoiced separately from those provided within the province.

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

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

Appropriate Versions

Appropriate versions of the OCF-21 must be considered for each invoice submission.

- The OCF-21A and OCF-21B are not approved for the purpose of billing any amounts under the MIG or a PAF.
- Only the OCF-21C is approved for the purpose of billing any amounts under the MIG or a PAF. When submitting an OCF-21C, the following additional information must be included:
 - The date that the treatment Block commenced.
 - The profession(s) of the Rostered Health Professional(s) who provided the treatment.

Attachments

“Attachments” means any material (e.g., additional pages, reports, test results) submitted in support of a plan or invoice. When this facility is required to send attachments, the following rules apply:

1. We shall specify, in the field provided in the document for that purpose that attachments are being sent and the number of attachments being delivered must be entered in the additional comments field.
2. The plan or invoice 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).
3. The attachments must be delivered directly to the insurer by fax, mail, email or personal delivery.
4. The attachments are not to be sent to the insurer before the plan or invoice is sent to the CPA.
5. Each attachment must be identified with the insured’s name, either the claim number or policy number, the HCAI document number, the date of the accident, and the document type (i.e., OCF-18, OCF-21 or OCF-23) to which the attachment relates.

References:

HCAI Guideline December 2014

<http://www.fSCO.gov.on.ca/en/auto/autobulletins/2014/Documents/a-12-14-1.pdf>

SABS

http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_100034_e.htm#BK89

Resolving Complaints About Insurers

Policy:

Where there is a grievance about an insurer with respect to their payment for services, or where an insurer is considered to be in contravention of the SABS or associated guidelines, this organization will follow FSCO's stated process for resolving complaints.

Procedure:

Every effort will be made to address a complaint with the insurer directly, first by trying to resolve the issue with the adjudicator or their claims supervisor where appropriate. Documentation of the issue, and the insurer response, as well as any subsequent steps taken, and the final outcome, will be made in the client's file.

Where resolution cannot be achieved, we will take the following measures:

Step 1: Request a letter from the insurance company's complaint officer stating the company's final position and advising of the name and details of the independent Ombuds Service that can review the complaint.

The list of complaint officers for each company can be found at <http://www5.fSCO.gov.on.ca/Licensing/ComplaintsOfficerListing/eng/ledefault.aspx>

Step 2: Write to the independent Ombuds Service referred to in the company's final position letter. The letter should describe the complaint and why we disagree with the company's position. All documentation relating to the complaint, including a copy of the insurance company's letter stating their final position shall be included in the letter to the Ombuds Service.

If we are writing on behalf of the insured, we will include a note signed by them, authorizing us to act on their behalf. When it is not possible to obtain an authorization, we will explain the circumstances in writing.

Step 3: The Ombuds Service will assign a complaints officer to review the unresolved complaint. The complaint will be reviewed and a response provided, outlining the process and what to expect.

References:

How to Resolve a Complaint about Billing Practices in the Service Providers Sector
<http://www.fSCO.gov.on.ca/en/service-providers/Pages/how-to-resolve-a-complaint.aspx#sp>

How to Resolve a Complaint About Insurance
<http://www.fSCO.gov.on.ca/en/insurance/complaints/Pages/default.aspx>

Resolving Complaints From Insurers

Policy:

This facility shall address and resolve complaints from insurers in respect of our business systems and practices related to listed expenses.

Procedure:

Should a complaint related to the business systems and practices related to listed expenses be received from an insurer, this complaint shall be brought to the attention of the Principal Representative.

The Principal Representative will review the complaint against the policies of the facility and any associated regulations. Should the review result in identification of a contravention of these policies or regulations, the Principal Representative will take immediate steps to address this issue, including but not limited to updating of internal policies and business practices, and staff education.

The result of the review and outcomes will be communicated to the insurer, and documented in writing.

References:

O.Reg 90/14, Section 17

Record Keeping: Retention and Security

Policy:

Records retention

(1) A licensed service provider shall keep any record related to an assessment, examination, report, form, plan, good or service performed or provided by or on behalf of the service provider related to listed expenses for at least six years after the date the record is created.

(2) The service provider shall keep the records at a location in Ontario in which the service provider carries on business or, if the service provider notifies the Superintendent that the service provider keeps records at other specified premises in Ontario, at those other premises.

(3) A service provider who has electronic records may keep those records at a location other than the location or premises described in subsection (2) if the service provider can retrieve the records in usable electronic or paper form within five business days after the day the service provider receives a request for records.

(4) A service provider who has electronic records shall ensure that the service provider can retrieve the records at any time during the retention period set out in subsection (1).

Security and integrity of records

14. A licensed service provider shall take all reasonable steps to ensure its paper and electronic records are secure and cannot be falsified

Procedure:

The Principal Representative must ensure records are kept for a minimum of 6 years (or longer if so required by their respective Regulatory College) after the date the record was created.

The Principal Representative must ensure that all records are stored at an Ontario location where the service provider's business is carried out.

- Records may be stored at a different location in Ontario if the provider notifies FSCO of this location
- Electronic records do not need to be stored at the principal place of business or the location specified by the service provider, so long as they can be retrieved within five (5) business days upon request.

The Principal Representative must ensure that reasonable steps are undertaken to make sure that paper and electronic records are secure and cannot be falsified

- Ensure capacity to securely lock paper records when not in use;
 - ensure use and ongoing management of passwords for computers and electronic records;
 - ensure means of documenting and identifying individuals who have access to any record that must be retained under the policy
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References:

Applicable Regulatory College Guidelines

O. Reg. 90/14, Sections 13 and 14

http://www.e-laws.gov.on.ca/html/source/regs/english/2014/elaws_src_regs_r14090_e.htm#BK14

Responding to Requests for Information: Insured

Policy:

All responses to requests for information shall be mindful of health professional obligations to protect the insured's health information and obtain informed consent for communication of health information. All requests for information shall be responded to in a reasonable manner that is consistent with the regulations. The health professional shall make reasonable efforts to provide relevant information in a timely manner.

Procedure:

All requests for information by the insured shall be responded to within 10 business days.

The insured shall be provided with information regarding all reports, forms, applications and records of services provided and invoicing for these services to their insurer.

The request for the information and the provision of the documents to the insured should be documented in the insured's file.

References:

O. Reg. 90/14

http://www.e-laws.gov.on.ca/html/source/regs/english/2014/elaws_src_regs_r14090_e.htm#BK14

Responding to Requests for Information - Insurer

Policy:

All responses to requests for information shall be mindful of health professional obligations to protect the insured's health information and obtain informed consent for communication of health information. All requests for information shall be responded to in a reasonable manner that is consistent with the regulations. The health professional shall make reasonable efforts to provide relevant information in a timely manner.

Procedure:

The following information, if requested by the insurer, must be provided via paper or electronic format within 10 business days:

- The licence number issued to the service provider.
 - The name(s) of any regulated health professional(s), social worker(s) or any other authorized person associated with the service provider that provide goods and services in connection with listed expenses.
 - The registration number issued to a regulated health professional or to a social worker associated with the service provider.
 - The name of any regulated health professional, social worker or any other authorized person, previously associated with the service provider and the time period in which such person(s) was so authorized, within the six (6) year period before the date of the request.
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References:

O. Reg. 90/14

http://www.e-laws.gov.on.ca/html/source/regs/english/2014/elaws_src_regs_r14090_e.htm#BK14

Responding to Requests for Information - FSCO

Policy:

All responses to requests for information shall be mindful of health professional obligations to protect the insured's health information and obtain informed consent for communication of health information. All requests for information shall be responded to in a reasonable manner that is consistent with the regulations. The health professional shall make reasonable efforts to provide relevant information in a timely manner.

Procedure:

FSCO must be notified by the service provider within five (5) business days of the following changes:

- A change in the mailing address, email address, telephone number or fax number.
- A change in the location of principal place of business or any facility, branch, office or location in Ontario.
- A change in the opening, closing, acquiring, amalgamating, or transfer of any other office that is open to the public.
- A change in a Director, Office, or Partner, as applicable.
- A change in the identified Principal Representative.

Facility information to FSCO must be confirmed on an annual basis in the Annual Information Return (AIR) which shall be completed online by the Principal Representative.

References:

O. Reg. 90/14

http://www.e-laws.gov.on.ca/html/source/regs/english/2014/elaws_src_regs_r14090_e.htm#BK14

Submitting/Maintaining Accurate Information – Verifying Identity of the Insured

Policy:

A licensed service provider shall take all reasonable steps to verify the identity of each individual in respect of whom it performs or provides assessments, examinations, reports, forms, plans, goods or services in respect of which payment for a listed expense may be requested from an insurer.

Procedure:

All service providers must take reasonable steps to verify the identity of any insured person that is listed on an invoice.

- Each authorized health professional associated with a service provider must be able to verify that the person in respect of whom they will provide an assessment, examination, report, form, goods or services, is the person who was involved in the subject motor vehicle accident.
 - Verification of the insured's identity should occur prior to the provision of the service or as soon as reasonably possible thereafter.
 - Verification methods may include, but are not necessarily limited to; requesting to view photo identification (e.g. driver's licence); by proxy via a review of hospital records/confirmation by hospital staff or family (if person is still in hospital and cannot confirm own identity), a review of the accident/police report, etc.
 - The Principal Representative should ensure follow through by all authorized health professionals providing services on behalf of the service provider.
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References:

Service Provider Compliance Guidelines

<http://www.fsco.gov.on.ca/en/service-providers/etoolkit/Pages/compliance-guidelines.aspx>

O. Reg. 90/14, Section 5

http://www.e-laws.gov.on.ca/html/source/regs/english/2014/elaws_src_regs_r14090_e.htm#BK14

Submitting/Maintaining Accurate Information – Employee, Associated Provider Records

Policy:

The health facility shall create and maintain accurate documentation of all health service provider agreements and records of services provided by each provider. The facility shall be able to produce these records in a timely manner.

Procedure:

The documentation must include:

- a listing of all service providers associated with the facility in the past 6 years;
- the start and termination date (if applicable) of all service providers;
- for all regulated health professionals (or social workers) it must include their registration number

Documentation may be kept in either electronic or paper form.

Should this information be requested by FSCO or a Participating insurer, the information shall be provided within the timelines set out in the Guideline for Service Providers, O. Reg 90/14.

References:

O. Reg. 90/14, Section 3

http://www.e-laws.gov.on.ca/html/source/regs/english/2014/elaws_src_regs_r14090_e.htm#BK14

FSCO website, Service Provider, Frequently Asked Questions

Submitting/Maintaining Accurate Information – False Misleading or Deceptive Information

Policy:

All Service Providers shall submit and maintain to the best knowledge of the Service Provider, accurate and complete information that is materially free of false, misleading, or deceptive information.

Procedure:

Do Not Submit Inaccurate, False or Deceptive Information

Information (i.e., forms, plans, invoices or any other documents) relating to a claim for statutory accident benefits or to a listed expense should not be submitted to an automobile insurer if there is a reason to believe:

- It contains inaccurate, false, misleading or deceptive information.
- The insured person was not involved in an accident for which the accident benefit claim is made.
- The insured person did not sustain an impairment as a result of the accident.

If any provider at this facility has reason to believe any of the above circumstances exist, they shall report it to the Principal Representative immediately. The Principle Representative must advise the insurer, within **two (2) business days** of forming such a belief, of the inaccurate, false, misleading or deceptive information along with the correct information.

Notify FSCO of Any Changes to Service Provider Information

FSCO must be notified by the service provider within **five (5) business days** of the following changes:

- A change in the mailing address, email address, telephone number or fax number.
- A change in the location of principal place of business or any facility, branch, office or location in Ontario.
- A change in the opening, closing, acquiring, amalgamating, or transfer of any other office that is open to the public.
- A change in a Director, Office, or Partner, as applicable.
- A change in the identified Principal Representative.

Invoices Kept on File

For every OCF-21 submitted via HCAI, the facility shall keep on file:

- an original paper version of the OCF-21 as submitted that includes the original authorized signature of the regulated health professional providing treatment, 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 regulated health professional, 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.

These forms shall be kept according to the policy on **Record Keeping**.

Maintain and Monitor a Service Provider Email Address

The email address that is provided to FSCO must be monitored regularly, and the service provider must make sure the email address is valid and current at all times.

References:

FSCO - Service Provider Compliance Guidelines

<http://www.fSCO.gov.on.ca/en/service-providers/etoolkit/Pages/compliance-guidelines.aspx>

Service Providers – Standards For Business Systems and Practices (O.Reg.90/14)

Referral Fees

Policy:

This facility does not solicit, accept or pay a referral fee, either directly or indirectly, for the provision of services under the Statutory Accident Benefits Schedule.

Procedure:

The Principle Representative shall ensure that all service providers associated with this facility are aware of and abide by the policy on Referral Fees.

All service providers at this facility are obligated to immediately report to the Principle Representative any behaviour that is contrary to this policy. If a regulated health professional is found to be in contravention of this policy, the matter may also be brought to the attention of their regulatory college.

References:

O.Reg 7/00, Section 3(2)

Relevant Regulatory College Guidelines