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2010 Auto Reforms Webcast

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Disclaimer

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Assessments

Assessment Cost Cap

1. Are Section 42 assessments (attendant care) subject to the $2,000 cap?

Section 42 and all other medical and rehabilitation assessments are subject to the $2,000 cap.

2. Does the assessment cap of $2,000 include all assessments needed by the claimants (including functional abilities evaluation, psychology, etc.)?

The assessment/examination cap is $2,000 per assessment or examination, not $2,000 for all assessments and examinations.

3. Are Section 44 assessments (insurer examinations) limited to $2,000?

Yes.

4. Does the $2,000 cap on assessments include the examination, assessment and report writing, or is report writing an extra over and above the cap? Also, there is a discrepancy between Section 18 and Section 25 where "preparing report" is included only in Section 18. Does the $2,000 cap on assessments include transportation, translation, material review and administrative fees?

The $2,000 cap per assessment or examination is an overall cap including report preparing and other overhead fees and expenses associated with conducting the evaluation. Section 25 was amended on July 15 to include preparing reports. The $2,000 cap applies to all claimants and insurers equally.

Transportation expenses incurred by the claimant are not part of the $2,000 cap under subsection 25(5). They fall under subsection 25(4) and are also subject to the Transportation Expense Guideline issued by the Superintendent at the Financial Services Commission of Ontario (FSCO). Refer to FSCO Bulletin A 19/10.

Transportation and all other expenses incurred by or on behalf of assessors are included in the $2,000 cap because they are expenses incurred to conduct an assessment or examination. Translation/interpretation expenses incurred by a claimant do NOT fall under the SABS and are not deducted from the $2,000 cap. The SABS does not prevent insurers from covering all or part of translation expenses incurred by claimants as an adjusting expense. Health care providers should not be arranging for interpreters on their own unless they have prior approval from the insured person and his or her insurer. Refer to FSCO Bulletin A23/10.

Insurers are expected to pay harmonized sales tax (HST), if applicable, without consideration of the $2,000 cap.

5. How can health businesses cap assessment costs at $2,000 when services such as transportation and translation are provided by different providers that do not see each other's invoices?

Assessors must communicate with one another to coordinate assessment services and manage expenses associated with assessment.

Also, refer to the answer in question 4.

6. Does the $2,000 cap apply to bodily injury (BI) claims (medico-legal examinations)?

No. It applies to accident benefits (AB) claims.

7. Are there caps on assessments under Section 25?

All assessments and examinations for which insurers are required to pay are subject to a cap of $2,000 per assessment or examination, which includes the cost of preparation of reports in connection with the assessment or examination. This cap applies to all assessments and examinations, including insurer-arranged examinations (IEs).

Within this overall envelope, the new Statutory Accident Benefits Schedule (SABS), effective September 1, 2010, places other limits on assessments and examinations. According to Section 25, insurers are required to pay *reasonable fees* charged for preparing a Disability Certificate (OCF-3), Assessment of Attendant

Care Needs (Form 1) and Application for Determination of Catastrophic Impairment (OCF-19), including associated assessments or examinations. Further, insurers must only pay *reasonable fees* incurred for a Treatment and Assessment Plan (OCF-18), including associated assessments and examinations, if one or more of the proposed interventions in the OCF-18 are approved by the insurer, deemed by the regulation to be payable by the insurer, or determined to be payable by the insurer by a dispute resolution ruling. However, insurers must pay the fees charged for the initial visit and Treatment Confirmation Form (OCF-23) in the Minor Injury Guideline (MIG).

According to FSCO's Professional Services Guideline, the maximum insurers are liable to pay for completion of the OCF-3 or the OCF-18 is $200 including related assessments and examinations.

Insurer Examinations and Rebuttals

8. With the elimination of rebuttal reports, what will the process be if there is disagreement with an insurer examination report and/or an insurer's decision?

If the claimant takes issue with the results of an insurer examination or an insurer's determination, he or she or the health professional may discuss the concern with the insurance adjuster. There is no payment to the health professional from the insurer for any written or oral communication with the insurance adjuster. If the issue cannot be resolved with the insurance company, claimants can access FSCO's dispute resolution services.

9. If it is believed that an insurer examination (IE) is wrong, can a health practitioner submit an OCF-18 (Treatment and Assessment Plan) to do a rebuttal examination?

There is nothing in the SABS that prohibits submission of a Treatment and Assessment Plan (OCF-18) for any assessment. However, the insurer will decide whether or not to approve that assessment, providing medical or other reasons for any denial. If *none* of the services proposed on the OCF-18 are approved, the submitting health care facility will not be reimbursed for the OCF-18 form completion fee of $200.

10. Are rebuttals being eliminated entirely or just rebuttal exams (i.e., can one still submit a paper review rebuttal)?

Effective September 1, 2010, payment for rebuttals is completely removed from the system for new and old collisions. While there is no restriction on a provider submitting further documentation or highlighting any issues with the Section 44 examination, insurers will not pay for these submissions.

Assessment of Attendant Care Needs (Form 1)

11. If friends or family members provide attendant care, must they show economic loss in order to claim for their services? If so, does that requirement apply to all accidents, whether they occurred before or after September 1, 2010?

The new definition of incurred expense states that persons who provide attendant care must incur an economic loss or must provide the service as part of their regular employment, profession or occupation to be reimbursed for their services. This new definition does not apply to accidents that happened before September 1, 2010.

12. What is the process for proving economic loss in relation to an "incurred expense"?

There are a number of processes possible. The claimant should discuss this with his or her insurer and/or legal representative. Generally, the claimant must provide credible evidence that establishes, on the balance of probabilities, that the person who provided him or her with goods or services sustained an economic loss as a result.

Assessments and Transition

13. After September 1, 2010, are insurer examinations (as per Section 42) still used?

Yes. Insurer examinations remain available after September 1, 2010 for both new and old collisions but are governed by new rules as detailed in Section 44 of the new SABS.

14. What if there is a dispute over the issue of whether a pre-existing condition is the reason why additional goods and services are needed? What would happen with the care of the patient while this is being resolved?

Claimants who disagree with a determination that they should be treated under the MIG, or be limited to $3,500 for all medical and rehabilitation benefits, in spite of a pre-existing condition may be treated under the MIG while they use FSCO's dispute resolution services. Following the completion of treatment under the MIG the claimant may submit a Treatment and Assessment Plan (OCF-18) for additional treatment up to the $3,500 minor injury cap.

15. If claimants have been involved in motor vehicle accidents (MVAs) pre-September 1, 2010 and have not yet renewed their policy, are they still eligible to have in-home assessments conducted, and thus be eligible for housekeeping and caregiving benefits?

Claimants involved in motor vehicle accidents before September 1, 2010 are eligible for *reasonable and necessary* in-home assessments and housekeeping and caregiver benefits pursuant to the terms of the insurance coverage in effect at the time of the accident.

Applying for Benefits and Initial Assessments

16. If a health practitioner requests an assessment for a person who had an accident years ago, how can the information requested on the OCF-18 (Treatment and Assessment Plan) be supplied if the patient hasn't already been assessed? The person does not have the means to pay for assessment otherwise.

An assessment is typically requested in order to evaluate a problem (complaint, symptoms, functional limitations, etc). The problem is generally identified by the patient, when they seek your help, or by a referring health professional. To request an assessment, you should identify the problem that has brought the patient to you and describe the type of assessment you wish to carry out and why (for treatment, to determine if additional investigation is warranted, etc.). In addition, in the scenario described, you may also seek permission from your patient to review his or her past treatment records, which the insurer can release to you upon receipt of signed consent.

A fee of up to $200 is payable for completion of the Treatment and Assessment Plan (OCF-18), which covers some time to evaluate the patient's problem and complete the form. The fee is not payable if none of the goods and services requested in the OCF-18 are determined to be *reasonable and necessary*.

Medical and rehabilitation benefits are payable for expenses incurred within 10 years of the accident, unless the claimant has a catastrophic impairment or purchased optional benefits. If the claimant was less than 15 years of age at the time of the accident, the medical and rehabilitation benefits available expire on the insured person's 25th birthday. Therefore, as long as the accident occurred within these parameters, insurers are required to cover *reasonable and necessary* expenses (Section 20).

Even though the new OCF-18 combines both the treatment and the assessment plan, it is up to the regulated health professional to decide how to proceed. In many cases, depending on the claimant's condition, providers will include both assessment and treatment on one OCF-18, as was done in many cases prior to September 1, 2010.

In other cases, the health professional could first request an assessment on an OCF-18 before completing a new OCF-18 for the treatment.

Health facilities may wish to notify the insurer of their plan to assess a patient for the purpose of preparing a treatment plan to determine if the insurer may be willing to approve the assessment and waive the application.

17. Is there a time limit within which the injured person must contact a clinic for treatment to be able to claim benefits?

An insured person who intends to apply for auto insurance benefits must, according to Section 32(1) of the SABS, notify his or her insurer *no later than the seventh day after the circumstances arose that give rise to the entitlement to the benefit, or as soon as practicable after that day.*

According to Section 20 of the SABS, no *reasonable and necessary* medical/rehabilitation and attendant care benefits are payable for expenses incurred more than 10 years and 104 weeks after the accident, respectively, unless the claimant was under 15 years of age at the time of the accident, has a catastrophic impairment or purchased optional medical, rehabilitation and attendant care benefits.

Section 7 of the MIG states that the initial visit to the health practitioner *will ideally occur as soon as possible following the date of the accident*. However, a person is not exempt from the MIG, or the $3,500 cap on medical and rehabilitation benefits, if he or she does not seek treatment within a certain time following the accident, subject to Section 20 of the SABS.

18. Does the SABS still cover the initial assessment and forms on a first visit if the amount is $200 or less?

Initial assessments and forms completed on the claimant's first visit to a regulated health professional post-collision are not pre-approved unless they fall within the $215 allocated for the initial visit and completion of the Treatment Confirmation Form (OCF-23) under the MIG.

For injuries other than those that fall into the MIG, insurers are required to pay *reasonable fees* incurred for a Treatment and Assessment Plan (OCF-18), including associated assessments and examinations, to a maximum of $200 if the claimant's health practitioner is covered under FSCO's Professional Services Guideline. In other words, the $200 fee should not be considered a "flat rate."

This fee will be covered *if* one or more of the proposed interventions in the Treatment and Assessment Plan are, as per Section 25(1)(3):

i. Approved by the insurer;
ii. Deemed by the regulation to be payable by the insurer (i.e., MIG; or if the insurer does not respond to the OCF-18 within 10 business days as required by Section 38(8) – see subsection 38(11)(2)); or
iii. Determined to be payable by the insurer by a dispute resolution ruling.

19. When multiple health professionals are engaged in the care of one claimant, what happens if health provider A assesses a patient and submits an OCF-18 and health provider B assesses the patient three weeks later and submits a second OCF-18?

Health care facilities and insurers may wish to consider strategies to improve communication and coordination around a claimant's treatment. It is the responsibility of each regulated health professional to find out from the claimant or the claimant's insurer whether another regulated health professional is already providing medical and rehabilitation services.

Insurers will adjudicate each Treatment and Assessment Plan (OCF-18) individually to determine whether the assessment and treatment requests are *reasonable and necessary*.

Attendant Care and In-Home Assessments

20. Do Form 1 assessments (Assessment of Attendant Care Needs) require prior approval?

Yes. Section 38(2) is applicable to Section 38(1)(b). These two provisions indicate that *an insurer is not liable to pay an expense in respect of … an assessment or examination that was incurred before the insured person submits a treatment and*

assessment plan that satisfies the requirements of subsection (3). Under Section 39, insurers are able to waive the requirement of a Treatment and Assessment Plan (OCF-18).

21. Is it correct that in-home assessment and attendant care assessment can only be conducted by occupational therapists (OTs) and/or registered nurses (RNs)? When may assessments be completed in-home?

According to Section 42(1)(b) of the SABS, attendant care assessments can only be conducted by occupational therapists and registered nurses.

An assessment may be conducted in the person's home provided that the assessment is one authorized under Section 25(1) and provided that the person does not have a minor injury – see Section 25(2). There are no restrictions on who can conduct an in-home assessment other than attendant care assessments.

Minor Injury

Minor Injury Cap – $3,500

22. What is the relationship between the minor injury (MI) monetary cap of $3,500 and the Minor Injury Guideline (MIG) pre-approved funds of $2,200?

There is a cap of $3,500 for medical and rehabilitation expenses for persons who have sustained what are predominantly minor injuries. If a person is diagnosed with one or more predominantly minor injuries, he or she has immediate access to treatment through the MIG on a pre-approved basis up to $2,200 for *reasonable and necessary* expenses. Once the claimant has exhausted treatment under the MIG, he or she may access further treatment through an OCF-18 (Treatment and Assessment Plan), and the coverage available would be $3,500 minus the amount paid for treatment under the MIG.

23. Is medication cost included in the MIG cap of $2,200?

Pursuant to the direction of FSCO, medication and all other pre-approved goods and services costs related to assessing and treating a claimant with a minor injury within the MIG are covered in the $2,200 fee cap.

24. Does the $3,500 MI cap include prescriptions, emergency services, etc?

The $3,500 cap on medical and rehabilitation benefits for claimants with minor injuries covers all *reasonable and necessary* goods and services used to assess and treat the MI impairments.

25. For persons who sustain MI, is the $2,000 assessment cap *in addition* to the $3,500 MI cap? Or would the $2,000 in assessments be included within the MI cap of $3,500?

The minor injury cap on medical and rehabilitation benefits of $3,500, which includes the maximum of $2,200 pre-approved funds under the MIG, consists of *all reasonable and necessary* expenses for treatments and assessments. The $3,500 cap does include the cost of any assessments conducted on the claimant.

26. If a person's minor injury (MI) evolved, and symptoms persisted, and the health practitioner determined that the goods and services in the MIG or under the MI cap of $3,500 were insufficient to enable maximum recovery, would the insured person be able to make claims above the MIG and MI cap?

The person would still fall within the $3,500 minor injury benefit limit unless his or her health practitioner determines and provides compelling evidence that the insured person has a pre-existing medical condition that will prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the $3,500 limit or is limited to the goods and services authorized under the MIG.

27. Is the $3,500 funding used for assessments and treatments or just for treatments? How much of the funding is pre-approved?

The $3,500 minor injury cap for medical and rehabilitation benefits covers treatments *and* assessments. Within the $3,500 cap, funds of up to $2,200 *are* available on a pre-approved basis under the MIG. The total amount of $3,500 is *not* pre-approved.

The funds in excess of the MIG amounts are subject to insurer approval. A regulated health professional could submit a Treatment and Assessment Plan (OCF-18) to request additional intervention up to the maximum of $3,500 minus

any funds for services provided in the MIG. An insurer may also waive the need for an OCF-18 (see SABS Section 39).

28. Will the cost of OCF-18 (Treatment and Assessment Plan) completion be included in the minor injury cap?

The cost of completing the Treatment and Assessment Plan (OCF-18) for a claimant with predominantly a minor injury that requires intervention beyond the funds available in the MIG is included in the $3,500 minor injury medical and rehabilitation benefit cap.

29. How would a health practitioner proceed in the case of an individual who is initially diagnosed with a minor injury, but later it is suspected that there may be an underlying, more serious condition such as a brain injury? An assessment would be required to confirm this diagnosis. If an OCF-18 (Treatment and Assessment Plan) is submitted for the assessment, would the fee come out of the $3,500? Does the outcome of the assessment determine this?

The $3,500 minor injury cap for medical and rehabilitation benefits covers all expenses associated with treating and assessing claimants with minor injuries. Therefore, the assessment cost would be included as part of the $3,500 in medical and rehabilitation benefits available to a claimant with predominantly a minor injury. However, if the outcome of the assessment shows that the claimant's injury is not predominantly a minor injury as defined in Section 3(1) of the SABS, the claimant would no longer be subject to the $3,500 cap and the cost of the assessment would come out of the patient's $50,000 medical and rehabilitation benefits – this amount may be $100,000 or $1,100,000 if optional coverage was purchased.

30. What happens if a claimant completes the MIG successfully with one practitioner, is discharged and subsequently reappears at another office indicating that the problem has not been resolved?

If the new health practitioner thinks more treatment is indicated, he or she could submit a Treatment and Assessment Plan (OCF-18) requesting additional intervention up to $3,500 minus the cost of medical and rehabilitation goods and services already provided to the claimant. It would also be appropriate for the new practitioner to contact the previous practitioner, subject to the consent of the injured person or guardian.

31. Is there still a Part 11 in the MIG where the health practitioner can ask for additional services that are slightly beyond the MIG?

No. All goods and services in the MIG are pre-approved. If a claimant requires more treatment after completing the MIG, the health practitioner can submit a Treatment and Assessment Plan (OCF-18) requesting additional intervention up to $3,500 minus the cost of medical and rehabilitation goods and services already provided to the claimant. These interventions are subject to insurer approval (although the insurer may waive the need for an OCF-18 – see SABS Section 39).

Minor Injury Guideline (MIG)

32. Does the MIG apply to accidents that occurred before September 1, 2010?

The MIG only applies to accidents that occur on or after September 1, whether the claimant is covered by an existing policy or a new policy.

33. Is the pre-approved framework (PAF) obsolete for accidents that occur after September 1, 2010?

Injuries arising from accidents that occurred before September 1 will continue to be treated under the PAF Guideline, while injuries arising out of accidents that occur on or after September 1 will fall under the MIG.

34. Is it still necessary for the patient to complete the Application for Accident Benefits Package (OCF-1) before the auto insurance will reimburse the medical provider under the MIG?

Yes. The OCF-1 (Application for Accident Benefits Package) must be completed when a claimant applies for benefits for the first time.

35. What is the start date of the MIG? Does it start when the patient presents for care, or does it start on the day of the accident?

The timeframe under the MIG starts upon the initial visit to the health practitioner. While the MIG encourages treatment to begin as soon as possible after the injury, there is no time limit on when the first visit can take place.

36. When a client comes a few weeks or months after their accident, can a health practitioner assume that the MIG will be pre-approved if the patient has not had prior treatment?

Treatment under the MIG is only pre-approved once. If the patient has accessed some MIG benefits in the past, only the remaining amount of the MIG ($2,200 less the funds used) will be available on a pre-approved basis. It would be prudent for the health practitioner to make efforts to determine what other treatment has been provided. This may be done by communicating with the patient and, with the patient's consent, his or her family, the insurer and/or the family doctor or other health providers.

37. If a health practitioner conducts an assessment and determines that the patient is eligible for the MIG, does the assessment cost get paid from the MIG pre-approved amount?

Yes. The initial assessment in this scenario is pre-approved and is payable at $215 and will come out of the $2,200 available in the MIG.

38. Where is the Minor Injury Guideline accessed?

The MIG is available on FSCO's website:
http://www.fsco.gov.on.ca/english/pubs/bulletins/autobulletins/2010/a-10_10.asp

39. The MIG sets an expectation on health practitioners to use "functional restoration" strategies. Prior to September 1, 2010, it was the experience of many insurers that functional restoration was the exception, while passive approaches to treatment (such as hot packs, electrical treatments) prevailed. How will the success of the MIG be monitored, and who will monitor it?

Treatment with a functional restoration focus typically relates to encouraging injured people to remain at work or return to work while continuing therapy and learning techniques to cope with the aftermath of a minor injury. Health care professionals who are regulated under the *Regulated Health Professions Act, 1991* are expected to be the primary monitors of their success in achieving recovery.

The insurance industry will be conducting a claims survey following implementation of the reforms and will report the findings of the survey to FSCO.

40. Are minimum treatments required within each block? What happens if the claimant is away or sick within the first week of the block and only attends a couple of times?

In order to bill for the initial assessment and blocks 1, 2 and 3, at least one visit must be made in each phase. Health practitioners are expected to make professional determinations about the amount of treatment indicated within the MIG framework in individual situations as well as the timeframes within which the goods and services paid under each block are provided.

41. How much funding is allotted to each block?

These are outlined in the MIG, which is available on FSCO's website:
http://www.fsco.gov.on.ca/english/pubs/bulletins/autobulletins/2010/a-10_10.asp

As of September 1, 2010, the initial visit and MIG blocks 1, 2, and 3 are allotted $215, $775, $500 and $225, respectively, for interventions. There is also an optional amount of $200 available for monitoring. This service may only be provided if block 1, block 2 or block 3 is *not* used, provided that the claimant has reached maximal medical recovery and no longer requires further treatment.

42. Are the timelines flexible or is the 12-week block absolute? For example, if the patient hasn't made it in for treatment as frequently as recommended and is progressing more slowly than expected, may the health practitioner extend the treatment timelines if they do not ask for more funding?

Yes. The MIG provides a *guideline* of 12 weeks of treatment following the claimant's initial visit. However, this timeframe can be modified by the health practitioner if the health practitioner thinks it is appropriate.

43. What if a patient was monitored after block 2 of MIG and was back at work and then the injury flared up again and required further clinical treatment? Can a health practitioner still charge the $200 fee?

Yes. A health practitioner can charge the $200 monitoring fee in block 1 instead of providing treatment, or in block 2 instead of providing treatment or in block 3

instead of providing treatment. However, the monitoring fee cannot be charged after the patient completes block 3.

If after the monitoring phase the claimant requires additional care, the health practitioner could submit a Minor Injury Treatment Discharge Report (OCF-24) to discharge the claimant from the MIG and submit a Treatment and Assessment Plan (OCF-18) requesting additional intervention up to $3,500 minus any amounts charged under the MIG for *reasonable and necessary* goods and services.

44. Is the monitoring fee only applicable within the MIG, or is it also applicable for return-to-work monitoring in the second group of clients (non-catastrophic/non-MI)?

The monitoring fee listed in the MIG is meant to be used in lieu of treatment provided in the MIG blocks. In cases of non-minor injuries, the health practitioner should confirm with the insurer on a case-by-case basis either by calling the insurer or including the service on a Treatment and Assessment Plan (OCF-18) request.

45. What if a patient makes a request to come back for further treatment during the monitoring phase? Does the health practitioner then submit an OCF-18 (Treatment and Assessment Plan) for further treatment or step back into block 3?

The $200 monitoring fee may be used to permit guidance, advice, coaching, counselling and/or reassurance in lieu of treatment. If further treatment is required, the health practitioner could submit a Minor Injury Treatment Discharge Report (OCF-24) to discharge the claimant from the MIG and submit a Treatment and Assessment Plan (OCF-18) to request additional intervention up to $3,500 minus any amounts charged for goods and services under the MIG for *reasonable and necessary* goods and services.

46. Is a claimant able to hire an occupational therapist (OT) for return-to-work issues and home pacing/functional treatment under the new MIG system? Can the OT submit for payment under the blocks to provide this treatment?

OT services (return to work/activation to normal life/school) are covered in the MIG and can be important for those claimants with minor injuries experiencing activity limitations. If a claimant or non-OT initiating health practitioner wishes to arrange for OT services, those fees are payable from the MIG limits.

47. If a person is receiving treatment at a rehab centre under the MIG and is still within the first three blocks, can an OT submit an OCF-18 (Treatment and Assessment Plan) for an education or training session at the client's home to facilitate his or her return to functioning (assuming the $3,500 cap has not been reached)?

All services provided in the MIG should be delivered in a coordinated fashion in instances where there is more than one practitioner providing treatment. This team does not need to work in the same facility but may function as a "virtual multi-disciplinary clinic."

In the example above, the OT services can be delivered as part of the MIG goods and services and should not require a Treatment and Assessment Plan (OCF-18) if the intervention is part of the pre-approved MIG, but the intervention must be funded out of the block fees provided for in the MIG.

Section 38(5) authorizes an insurer to refuse an OCF-18 in respect of any period during which the insured person is entitled to receive services under the MIG. Section 38(7) indicates that while a claimant is receiving goods and services in the MIG, a health practitioner may submit an OCF-18 for goods and services to be delivered during a period other than the period during which the claimant is receiving MIG goods and services.

48. Would social work counselling for a family or spouse be covered under the MIG blocks?

Yes. There are no prescribed or prohibited interventions in the MIG. The claimant's initiating health practitioner will use his or her clinical judgment to determine what interventions are necessary for the claimant to return to pre-accident function in his or her home and work environments. If approved by a health practitioner, a social worker's services could be covered under the MIG.

49. If a health practitioner feels that someone with a minor injury would benefit from some massage therapy along with their physiotherapy, would this funding be taken directly from the block fees?

Yes, this is possible. The MIG is a pre-approved treatment framework to be used in the delivery of goods and services for treating claimants with minor injuries. There is no prescribed treatment so it is up to health practitioners to decide what assessments and treatments are necessary for the claimant to return to pre-accident functioning in his or her home and work environments. If massage therapy is used, it would need to be funded within the block fees provided in the MIG. The initiating health practitioner is responsible for approval and coordination of services by different providers.

50. How would the block fees be affected if a patient who started in chiropractic wanted to switch to physiotherapy services?

If a claimant changes health practitioners, it is the responsibility of the new health practitioner to inform the insurer and to arrange intervention within the balance of the $2,200 minus any amounts already used in the MIG for *reasonable and necessary* goods and services. There is a $50 transfer fee available in the MIG that is payable to the new health practitioner.

51. In the MIG, if a client would benefit from massage therapy treatment, would it be included within the supplementary goods and services?

It may be included within the MIG blocks or as a supplementary service. Supplementary goods and services are available for *reasonable and necessary* expenses to support restoration of functioning and to address barriers to recovery. Massage therapy treatment could be included in the $400 of supplementary goods and services available in the MIG if approved by a health practitioner. Because there is no prescribed type or amount of treatment specified in the MIG, the health practitioner could also include massage therapy in the claimant's block treatments.

52. Was there previously a restriction in the PAF Guideline that a health practitioner could not approve massage therapy as the only treatment? If so, does the restriction apply to the MIG?

There was no such restriction in the PAF Guideline. A health practitioner could approve massage therapy as the only treatment.

However, the MIG directs an active, functional restoration approach to treatment, which may not be consistent with prescribing *only* massage therapy.

53. Are income replacement benefits linked to the MIG?

Income replacement benefits are *not* linked to the MIG. In order to apply for income replacement benefits, a claimant's Application for Accident Benefits Package (OCF-1) must be accompanied by a Disability Certificate (OCF-3), which confirms that the claimant *suffers a substantial inability to perform the essential tasks of the employment* (Section 5(1) of the SABS). If an OCF-3 is submitted and the claimant's injury is predominantly a minor injury, any form completion fee paid will be deducted from the patient's $3,500 cap on medical and rehabilitation benefits.

54. How are health providers expected to provide psychosocial counselling under the $400 provided for supplementary goods and services?

Most persons with minor injuries do not require assessments and/or treatment of the kind that only a psychologist or psychiatrist is permitted by law to deliver. The management of psychosocial risk factors may be addressed by other health professionals who are appropriately trained and who are authorized by their health regulatory colleges to do so.

The supplementary goods and services in the MIG describe a variety of supportive interventions that may be provided by appropriately skilled health professionals, such as advice/education to deal with collision-related psychosocial issues (distress, difficulties coping with the effects of the injury, driving problems/stress, etc.). Such intervention may also be provided within the MIG blocks subject to the corresponding fees.

As well, MIG physical treatment providers may wish to coordinate management of psychosocial risk factors with other health professionals if they feel unqualified to provide these services.

55. Are supplementary goods and services costs included in the MIG?

The MIG includes up to $400 of additional pre-approved supplementary goods and services to support restoration of function and maximal recovery.

56. If a client needs assistive devices, education and a home-based exercise program, the cost will probably exceed the $400 limit. Are extra funds available? If so, how are these funds accessed?

The total pre-approved amount ($2,200) available within the MIG can be applied to any goods and services that the health practitioner deems to be reasonable and necessary. However, it is anticipated that, generally, persons with minor injuries will not require extensive assistive devices. Home exercise programs may be managed using the MIG treatment blocks and/or monitoring phase.

57. If one health provider supplies an exercise program and uses most of the allocated fee and another service provider offers other services, how is payment allocated?

The initiating health practitioner is responsible for coordinating treatment by any health professionals involved in MIG treatment, whether in a single facility or a virtual multi-disciplinary team. In addition, all health professionals are responsible for ensuring that the patient is not being subjected to duplicate or unnecessary treatment.

A health professional providing treatment in the MIG can be paid by the initiating health practitioner with the funds provided by the insurer. Alternatively, the health professional can submit an Auto Insurance Standard Invoice (OCF-21) to the insurer, referencing in Part 3 the HCAI Document ID or date of the OCF-23 (Treatment Confirmation Form) that was submitted to the insurer by the initiating health practitioner.

58. What is expected of a health care provider when providing reassurance for patients once they return to work?

After a minor injury, many patients continue to experience symptoms. It is important for those patients to be reassured that they are not doing themselves any harm or threatening their recovery. Health professionals are in a position to establish that there are no contraindications to activities and to encourage resumption of activities.

59. Is diagnostic imaging included in the MIG?

As in the PAF, the MIG has a payment schedule for x-ray costs in addition to the other MIG fees. The payment schedule is found in Appendix C of the MIG. X-rays not covered by OHIP come out of the claimant's $3,500 minor injury cap on medical and rehabilitation benefits.

60. Under the MIG, discretionary services as noted in the initial visit session include imaging. Is this imaging service billed (1) as part of the block fee of $775 for weeks one to four, or (2) as a supplementary goods and services fee as part of the $400, or (3) as an additional fee on top of the MIG fees and/or billed via an OCF-18?

Imaging is considered a pre-approved service. There is a separate schedule for x-ray fees found in Appendix C of the MIG and these fees are in addition to other MIG fees.

61. How is the transfer fee of $50 applied?

If a claimant in the MIG changes health practitioners, the health practitioner taking on the file receives a $50 transfer fee that is available in the MIG to accommodate the activities needed to begin treatment.

62. How will collaboration occur in the MIG between gatekeepers/initiating health practitioners (IHPs) and secondary providers such as social workers and massage therapists, specifically if the secondary providers do not work within the same facility as the IHP?

An initiating health practitioner is expected to coordinate and monitor care for a patient in the MIG. The Treatment Confirmation Form (OCF-23) submitted by the health practitioner should detail the various interventions and providers. Health professionals and insurers are expected to collaborate to make sure these resources are used effectively. Health professionals should always ask the patient as well as the insurer if other treatment is being provided by another practitioner. The insurer is not required to pay for a second OCF-23 or duplicate treatment initiated by a second initiating health practitioner.

As for payment for services, a health professional providing treatment in the MIG can be paid by the initiating health practitioner with the funds provided by the insurer. Alternatively, the health professional can submit an Auto Insurance Standard Invoice (OCF-21) to the insurer, referencing in Part 3 the HCAI Document ID or date of the OCF-23 that was submitted to the insurer by the initiating health practitioner.

63. Is there a time constraint for removing a claimant from the MIG?

No. Health practitioners and claimants are not required to complete the MIG within a pre-set number of weeks. However, there are only a limited number of acceptable reasons for removing a claimant from MIG treatment. There would have to be compelling evidence of a pre-existing condition that would prevent him or her from achieving maximal medical recovery using the goods and services in the MIG or the $3,500 benefit cap. Or it may have been determined that the claimant's impairment is not predominantly a minor injury.

64. What if a claimant develops chronic pain during the 12-week cycle of the MIG? Would this take the claimant outside the MIG?

The MIG is meant for minor injuries in the acute and sub-acute phases of the injury. Generally, chronic pain is not associated with the first three months of recovery from a minor injury.

65. If a fracture is suspected, what treatment should be followed before test results are received?

The treating health practitioner must determine appropriate interventions when there is a suspected, but not yet confirmed, diagnosis.

66. What if the patient develops evidence of whiplash-associated disorder (WAD) III once MIG treatment has begun?

See the previous question. The health professional should communicate to the insurer the objective, demonstrable, definable and clinically relevant neurological signs that led to the WAD III diagnosis.

Completion of the Minor Injury Guideline

67. How is the client's overall funding affected if the client is taken out of the MIG midway through the program?

The impact on the claimant's overall funding depends on the reason he or she exited the MIG.

If the claimant has predominantly a minor injury, the funds from the cap of $3,500 less what was used in the MIG are available.

If the reason for the discharge from the MIG is that it was determined that the claimant has an impairment that is not predominantly a minor injury, the claimant can access up to $50,000 – or $100,000 or $1,100,000 if optional coverage was purchased – of benefits less the amount already spent. This funding can also be accessed if the claimant has predominantly a minor injury but there is compelling evidence that he or she has a pre-existing medical condition(s) that limits his or her recovery if the treatments are restricted to the MIG or the $3,500 cap.

68. After a patient finishes the MIG, how does a health practitioner know what amount is remaining for the purpose of an OCF-18 (Treatment and Assessment Plan)?

It is important for the initiating health practitioner to coordinate effectively the interventions provided by all providers to a claimant under the MIG. This includes coordinating treatment costs. It may be useful to stay in communication with the insurer to confirm the expenses that have been incurred to date.

69. If the patient is not eligible for the MIG or has exited the MIG, does the $2,000 assessment cap apply to assessment proposals?

Yes.

70. If a patient was discharged from treatment and didn't use up their $3,500 cap, will there be a problem getting back into the program after an absence because of a vacation?

Discharge from the MIG signifies its conclusion. However, if the insured has not been discharged, but there is a prolonged absence from treatment because of a vacation or an illness, the claimant can resume MIG treatment where they left off. If the MIG has been exhausted, the health practitioner may propose *reasonable and necessary* goods and services using a Treatment and Assessment Plan (OCF-18). The insurer also has the option of approving some or all such goods or services without the need for an OCF-18 (see SABS Section 39). If approved, these amounts will be deducted from the remainder of the $3,500 cap.

71. Could another health professional's expenses (e.g., massage therapy) come from the $1,300 (the difference between the $2,200 MIG and the $3,500 cap)?

The initiating health practitioner is responsible for coordinating care between any and all health professionals treating a patient with minor injury within the MIG. Any additional treatments using the remaining funds after the MIG will require the insurer's prior approval via a Treatment and Assessment Plan (OCF-18) but only after treatment has been completed under the MIG.

72. How would home treatment sessions or job coaching be funded for persons with minor injuries?

There will be occasions where the person with a minor injury remains at work or school while being treated in the MIG but encounters difficulty at work or at school. The MIG provides flexibility in funding for workstation or school assessments, either within one of the blocks of treatment or in the supplementary goods and services. Similarly, job coaching or home-based interventions may be delivered within the MIG but must not exceed the funding available in the MIG. In some situations these services will be provided subsequent to the MIG and will require a Treatment and Assessment Plan (OCF-18) to be submitted to use up to the remaining funds available in the $3,500 cap (although the insurer may waive the need for an OCF-18). Provider time and mileage expenses incurred during travel to the claimant's home would be deducted from the cap. Please keep in mind that Section 25(2) of the SABS restricts in-home assessments to claimants who do not have minor injuries.

Accessing Benefits Beyond the $3,500 Cap

73. If a claimant with a minor injury continues to be impaired following completion of the MIG and after exhausting the $3,500 cap, what recourse do they have?

The claimant will be responsible for expenses beyond what is available in their policy. Claimants with predominantly minor injuries have access to a maximum of $3,500 in medical and rehabilitation benefits unless they have pre-existing conditions, as determined by a health practitioner, preventing them from reaching maximal recovery under the MIG or within the cap.

74. After the $3,500 cap has been exhausted, would approval of funding of an assessment constitute the insurer's acceptance that the person's injuries are no longer considered minor, thus providing access to attendant care and extended medical/rehabilitation dollars?

No. The SABS clearly states that medical and rehabilitation benefits in excess of $3,500, and attendant care benefits, are available only to claimants with injuries that are not predominantly minor injuries.

75. If a client with a minor injury and no pre-existing medical condition has completed blocks 1 to 3, but the current symptoms are not improving, can the client access the $50,000 medical and rehabilitation benefits?

No. There are only two circumstances in which claimants can access up to $50,000 of *reasonable and necessary* medical and rehabilitation benefits. They are claimants with:

1. Predominantly minor injuries but accompanied by pre-existing medical conditions that prevent the claimant from reaching maximal recovery in the MIG or within the $3,500 cap (the health practitioner must provide compelling evidence that maximal recovery is not possible if the insured person is subject to the $3,500 cap or limited to the goods and services authorized by the MIG); or
2. Injuries other than predominantly minor injuries.

76. If a claimant has a minor injury and they use up their $3,500 cap then submit an OCF-3 (Disability Certificate) indicating that they continue to be disabled, how does this claimant access funds for rehabilitation?

Insurers and health professionals should collaborate to address disability as soon as possible *while* a person is being treated in the MIG. After the MIG, the claimant is responsible to pay for expenses that are not covered in his or her policy.

77. If a patient starts out in the MIG then comes out due to a progressively worsening condition, can the patient begin to receive housekeeping benefits, etc. at that time?

The new standard auto insurance product does not include housekeeping benefits for claimants with non-catastrophic impairments. Claimants with non-catastrophic impairments can only access housekeeping and home maintenance benefits if their pre-September 1, 2010 auto insurance policy has not expired or if they have a policy purchased after September 1 with the optional coverage.

78. Sometimes, social work intervention for persons with minor injuries isn't accessed until after the client's physical injuries have stabilized. At that stage, the $3,500 may have been used up already. Are there any other options available for payment?

It is important for insurers and the health industry to collaborate to make sure that appropriate services are initiated as soon as they are required. There is no reason social work services cannot be provided within the MIG if authorized by a health practitioner.

79. In some instances, insured persons use up a portion of the minor injury cap and do not inform the health practitioner. When this happens, what can be done to make sure that the claimant receives the appropriate intervention?

Health businesses must clarify with their patient what services have already been provided. Health businesses may also wish to discuss with their clients how expenses that are *not* covered by the auto insurer will be paid. Finally, health businesses may also contact insurers *before* beginning assessment or intervention to determine what funds are still available.

What Is a Minor Injury?

80. Are psychosocial concerns addressed within the MIG?

Psychosocial issues include factors such as attitudes or beliefs, emotional reactions such as fear, distress as well as depression, or relational factors such as conflict or lack of support from friends and family. They are not criteria for exiting the MIG. The MIG accommodates management of psychosocial factors in the MIG blocks and/or the supplementary goods and services in the MIG.

81. Will the MIG incorporate those patients who have psychosocial issues as a result of the accident?

Yes. As noted above, supportive services may be provided to address psychosocial risk factors/issues. The initiating health practitioner may provide these services and/or may engage the services of a psychologist, social worker or other appropriate provider within the MIG.

82. If the physical treatment provider suspects psychosocial issues (anxiety/depression) related to the accident, can he or she complete a psychological screening assessment that includes a *brief* report under the MIG (and be reimbursed within the $3,500) rather than wait for the patient to exhaust their $3,500 and then have to apply for an assessment with the new OCF-18 (Treatment and Assessment Plan)?

Yes. A claimant with a minor injury and associated psychosocial risk factors can receive supportive interventions to deal with collision-related psychosocial issues within the MIG.

83. What if someone has *multiple* sprain/strains, which are all "minor injuries" individually?

According to Section 3(1) of the SABS, someone with multiple minor injuries still falls within the MIG. In addition to the three block treatment phases, the MIG addresses multiple injuries by providing supplementary goods and services to support restoration of function and to address barriers to recovery.

84. What options are available to a minor injury patient with complications or with a history of injuries that could have an impact on the prognosis?

In most cases a claimant with a minor injury will be treated within the $3,500 minor injury benefits. However, a claimant can access additional funds beyond the $3,500 if, according to Section 18(2) of the SABS, a health practitioner provides compelling evidence that the claimant has a pre-existing condition that will prevent him or her from reaching maximal recovery if limited to the MIG or $3,500 cap. This evidence must be included on or attached to the health practitioner's Treatment and Assessment Plan (OCF-18).

85. What qualifies as a pre-existing condition that would exempt a patient from being limited to the MIG? For example, would old age, psychological issues, conditions that interfere with active exercise programs, etc. qualify?

Health practitioners should address this question on a claimant-by-claimant basis. According to Part 4 of the MIG, the existence of any pre-existing condition will not automatically exclude a person's impairment from the MIG treatment process. In fact, it is intended and expected that the vast majority of claimants with pre-existing conditions will be treated within the MIG.

86. What is meant by "compelling evidence"?

There is no definition of "compelling evidence" in the SABS or the MIG. Therefore, the insurer will, acting reasonably, determine whether in its view the evidence provided by a health practitioner is compelling. If there is a dispute with the insurer about whether the evidence is compelling, claimants could access FSCO's dispute resolution services.

87. Is medical documentation such as an MRI or x-ray needed to support the compelling evidence?

Each injury and claimant must be assessed individually, with health practitioners using their professional judgment about what will be considered *compelling evidence* in a particular case.

88. What is meant by "predominantly" when referring to impairment under minor injury?

There is no definition of "predominantly" in the SABS or the MIG. The insurer will have to determine, acting reasonably, if the injury as described by the initiating health practitioner appears to be predominantly a minor injury. If there is a dispute with the insurer about whether a claimant's injury is predominantly a minor injury, the claimant could access FSCO's dispute resolution services.

Under the SABS, a person with an injury that is predominantly a minor injury enters the MIG and is eligible for up to $3,500 of *reasonable and necessary* medical and rehabilitation benefits.

89. Does a hairline fracture fall under the MIG?

No. According to Section 3(1) of the SABS, a "minor injury" is *one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury*. A fracture does not fall within this definition.

90. If a person has musculoskeletal injuries that put him or her in the MIG but he or she also has substantial psychological impairments related to the accident, does that take the person out of the MIG?

Not necessarily. The MIG block phases and the supplementary goods and services up to $400 provide funding for supportive interventions to deal with collision-related psychosocial issues. The initiating health practitioner, a regulated health professional, or an appropriate health care provider may provide the interventions that are deemed necessary by the initiating health practitioner on a pre-approved basis. However, if the *predominant* impairment is psychological (and not a minor injury as defined in the SABS), it is possible that he or she would not be eligible for the MIG.

91. Is there a cap on funding for clients who fall within an "in between" category such as WAD III or minor head injuries?

Claimants with non-minor, non-catastrophic injuries can access up to $50,000 – or up to $100,000 or $1,100,000 if they purchased optional coverage – of *reasonable and necessary* medical and rehabilitation benefits.

92. Do temporomandibular joint (TMJ) pathologies fall under the definition of minor injury?

Many TMJ conditions are considered "minor injuries" as defined by the SABS. For example, a strain/sprain of the TMJ is likely a minor injury. If there is a dispute with the insurer about whether a claimant's injury is predominantly a minor injury, the claimant could access FSCO's dispute resolution services.

93. How would an insurer know if a claimant's degenerative changes are clinically relevant?

The existence of pre-existing conditions like degenerative changes does not automatically exclude a person's impairment from the MIG. It will be up to the initiating health practitioner to communicate "compelling evidence" that the pre-existing condition will prevent maximal recovery if the claimant is subject to the goods and services amount authorized under the MIG or the $3,500 benefit cap.

94. Under which category will discogenic injuries be placed?

Refer to Section 3(1) of the SABS for the definition of "minor injury" and Section 3(2) for what constitutes a "catastrophic impairment."

95. On slide 20 of the webcast PowerPoint, is subluxation a medical or chiropractic subluxation?

The term "subluxation" is defined in Section 3(1) of the SABS as *a partial but not a complete dislocation of a joint*.

96. If a patient is pregnant at the time of the accident, she may be very limited in the modes of therapy. Will she fall out of the MIG?

The funds available in the MIG can be applied to the treatment that the initiating health practitioner believes is most appropriate for the individual. Additional treatment under the $3,500 minor injury cap must be approved by the insurer.

Minor Injuries and Optional Coverage

97. If a patient does not fall within the Minor Injury Guideline and he or she did not purchase optional coverage, what benefits is the patient entitled to, assuming the injuries are not catastrophic?

The standard auto insurance product for non-minor and non-catastrophic impairments provides up to $50,000 in *reasonable and necessary* medical and rehabilitation benefits including the cost of assessments, $36,000 in *reasonable and necessary* attendant care benefits, income replacement up to $400 per week and payment of other expenses, except housekeeping and home maintenance, which are discussed in Part 4 of the SABS.

98. Can persons with minor injuries access housekeeping benefits? If so, is a housekeeping benefit paid on top of minor coverage?

Insured persons with minor injuries can access *reasonable and necessary* housekeeping and home maintenance benefits only if they purchased the

optional benefits or their policy was purchased before September 1, 2010 and had not yet expired before their accident.

99. Are persons with minor injuries able to access attendant care benefits?

No. See Section 14 of the SABS.

100. If the health care provider supplies compelling evidence that the person requires more treatment than the MIG or $3,500 cap can provide, can the person access attendant care or an in-home assessment?

No. In order to do so, the health provider has to demonstrate that the injury is not a minor injury as defined in Section 3(1) of the SABS. See sections 14 and 25(2) of the SABS.

101. If a person with a minor injury has optional coverage and, therefore, access to homemaking/housekeeping benefits, can an in-home assessment be conducted?

No. Section 25(2) of the SABS states that insurers are not required to pay for assessments in the person's home for patients with minor injuries.

Minor Injury – Other

102. Can multi-disciplinary care for a patient with a minor injury (i.e., in the MIG) be carried out in more than one health care facility? If so, how are claims and payments handled?

Yes. The initiating health practitioner is expected to submit a Treatment Confirmation Form (OCF-23) outlining *all* of the treatments to be delivered within the MIG. The initiating health practitioner must ensure that care – and funding of care – is coordinated. Each health care facility providing treatment in the MIG can be paid by the initiating health practitioner with the funds provided by the insurer. Alternatively, each health professional can submit an Auto Insurance Standard Invoice (OCF-21) to the insurer, referencing in Part 3 the HCAI Document ID or date of the OCF-23 that was submitted to the insurer by the initiating health practitioner.

103. What is the role of a physician in the minor injury cap of $3,500?

Physicians, like other health practitioners, can determine whether or not a claimant has predominantly a minor injury and authorize assessment and treatment plans. Physicians may also be involved in delivering various therapies within the MIG.

Claim Forms

Treatment and Assessment Plan (OCF-18)

104. Which forms can be completed by which health professionals?

OCF-3 (Disability Certificate) – Only health practitioners can sign the OCF-3.

OCF-18 (Treatment and Assessment Plan) – According to Section 38(3) of the SABS, a regulated health professional can complete the OCF-18 but it must be certified by a health practitioner.

OCF-19 (Application for Determination of Catastrophic Impairment) – According to Section 45(2) of the SABS, only physicians – or in cases of brain injuries without other injuries, neuropsychologists – can conduct catastrophic assessments and complete the OCF-19.

OCF-23 (Treatment Confirmation Form) – According to Section 40(2) of the SABS, any health practitioner who is authorized by law and the MIG to treat the claimant's impairment and who will be the health practitioner responsible for providing MIG interventions can complete the OCF-23.

OCF-24 (Minor Injury Treatment Discharge Report) – The health practitioner who initiates treatment under the MIG can complete the OCF-24.

Form 1 (Assessment of Attendant Care Needs) – According to Section 42(1)(b) of the SABS, only occupational therapists or registered nurses can complete Form 1.

105. Are items that cost less than $250 pre-approved?

No. While a Treatment and Assessment Plan (OCF-18) is not required for goods that cost less than $250 per item, insurers must still review the claim and will only cover costs that, according to Section 38(2)(c) of the SABS, are *reasonable and necessary as a result of the impairment sustained by the insured person* subject to medical and rehabilitation benefit limits.

If there is a dispute about the reasonableness or necessity of the item that has already been purchased, the claimant can pursue FSCO's dispute resolution services.

106. If a patient is supplied a product that costs less than $250 without submission of an OCF-18 (Treatment and Assessment Plan), is it still possible for the insurer to deny that item if it is not "reasonable or necessary"?

It is important that the claimant always be well informed. Since the health practitioner recommends and often provides products, it would be prudent for the health practitioner to recommend only goods and services that are *reasonable and necessary* for the caring of the insured person and to be cognizant of the coverage limits and amount of funds still available to the claimant. If there is concern that the item might not be approved, the health practitioner may wish to contact the insurer to obtain verbal pre-approval of the item.

107. Can we combine multiple goods and services, with each item under $250, on the same form?

Multiple goods under $250 can be combined on the same Treatment and Assessment Plan (OCF-18). However, according to Section 38(2)(c)(ii) of the SABS, goods with a cost under $250 do not have to be included on the OCF-18. However, they will be adjudicated by the insurer based on being *reasonable and necessary*.

108. If a claimant cannot afford the initial cost of an item, is it possible to obtain the item without requiring the claimant to pay upfront?

The health practitioner may wish to contact the insurer to obtain verbal pre-approval of the item. The health care facility may also obtain insurer approval by including the item on the Treatment and Assessment Plan (OCF-18).

109. If acquiring an item under $250, does the claimant have to produce proof of purchase (e.g., a receipt)?

Yes.

110. Dentists are listed as health practitioners on the OCF-18 (Treatment and Assessment Plan). Are dentists required to complete the form for treatment?

A dentist is permitted under Section 38(4) of the SABS to submit a standard dental claim form, but is also free to submit an OCF-18.

111. A dentist's estimate usually simply outlines the cost of what a dentist proposes to perform without an explanation as to why. If a treatment plan is not completed, this information will not be available, so how can it be assessed? Is a dental estimate included in the SABS?

The standard dental claim form includes a field where the dentist can provide additional information about the claimant's needs. The SABS applies to dental claim forms, which are adjudicated in the same manner as Treatment and Assessment Plans (OCF-18).

112. In merging the OCF-22 (Request for Assessment) with the OCF-18 (Treatment and Assessment Plan), was there some reason why the clinical information and assessment rationale sections (formerly Part 5 of OCF-22) were omitted?

The new Treatment and Assessment Plan (OCF-18) permits this information to be included as follows:

- Part 6: Injury and Sequelae Code. An assessment is triggered by a problem experienced by the claimant. The problem may not be a known diagnosis.

The code used should reflect the problem for which an assessment is required. For example, the code R46.6 reflects *Undue concern and preoccupation with stressful events*. The code may also reflect circumstances that require assessment, e.g., if an assessment is being proposed to evaluate accessibility of a home for a person with spinal cord injury, the code could be: Z59.1 – *inadequate housing*.

- Parts 7, 8 and 9: May also permit explanation of why an assessment is required.
- Part 12: Additional comments may also be added to explain why the assessment is required.

113. When a chiropractor signs an OCF-18 (Treatment and Assessment Plan) for a registered massage therapist (RMT), how do they bill for completing the OCF-18?

There is a form completion fee of up to $200, including assessment costs, that is payable, subject to FSCO's Professional Services Guideline. In this example, how the fee is divided between the chiropractor and the RMT is a private matter between the two providers.

114. Under which section does the cost for completing OCF-18s (Treatment and Assessment Plans) for non-minor injuries fall? Section 18(5) only specifies the cost of the assessment/examination and preparing the report.

The cost for completing a Treatment and Assessment Plan (OCF-18) is covered in the medical and rehabilitation benefits under Section 25(1) of the SABS. Insurers will compensate regulated health professionals for completing the forms if one or more of the goods, services, assessments or examinations proposed in the OCF-18 are approved by the insurer, deemed by the SABS to be payable by the insurer or determined to be payable by the insurer based on a dispute resolution. The maximum fee of $200 that can be charged for the assessment and form completion is set in FSCO's Professional Services Guideline.

115. Can health care businesses charge for completion of an OCF-23 (Treatment Confirmation Form)?

The form completion fee for the MIG is covered by the block fee of $215, including the initial treatment, for the initial visit.

116. If the patient has a non-minor injury, is the cost of the assessment and preparation of OCF-18 (Treatment and Assessment Plan) and OCF-3 (Disability Certificate) still pre-approved?

No. According to Section 38(2), a request for approval of an assessment has to be reviewed for its reasonableness and approved before the insurer will be liable to pay for it. In the case of a Treatment and Assessment Plan (OCF-18) and Disability Certificate (OCF-3), FSCO's Professional Services Guideline applies and defines *reasonable fee* as up to $200 for the forms and related assessments.

In the case of completion of an Application for Determination of Catastrophic Impairment (OCF-19) and Assessment of Attendant Care Needs (Form 1), the reasonableness of the proposed fee will be considered by the insurer when the OCF-18 requesting one of the assessments is submitted.

117. At times, very acute clients are discharged from a hospital and a request is made for treatment and an initial assessment to be made at home. Obtaining the client signature can be very problematic, and 10 days may be too long to wait for approval to visit. Could this be considered an emergency so the initial visit could be made without pre-approval then the OCF-18 (Treatment and Assessment Plan) submitted?

Should a Treatment and Assessment Plan (OCF-18) be necessary, the signature may be obtained from the client or his or her guardian or representative. It is up to the initiating health practitioner to decide whether or not the claimant has needs on an emergent basis. In cases such as these, consultation with the insurer is advisable.

If an Assessment of Attendant Care Needs (Form 1) is required, Section 38(1)(b) and Section 38(2) authorize an insurer to require submission of an OCF-18, and prior approval is needed for the OT or RN to proceed.

Disability Certificate (OCF-3)

118. Is the OCF-3 (Disability Certificate) still used?

The Disability Certificate (OCF-3) is still used after September 1, 2010 to qualify for lost educational expenses, income replacement benefits, non-earner benefits, and when optional benefits are purchased, caregiver benefits, housekeeping and home maintenance benefits or continuing entitlement for these benefits.

The maximum amount payable to complete the form and conduct the assessment is $200, as set out in FSCO's Professional Services Guideline.

Auto Insurance Standard Invoice (OCF-21) and Billing

119. Has the OCF-21 (Auto Insurance Standard Invoice) changed?

There have been minor changes to the Auto Insurance Standard Invoice (OCF-21), in particular to accommodate the harmonized sales tax (HST). The new form can be viewed at the FSCO website:
http://www.fsco.gov.on.ca/english/forms/autoforms/claims/documents/1208E.pdf

120. Have the fee guidelines for practitioners remained the same?

FSCO's Professional Services Guideline was last updated in July 2010 and was effective as of September 1, 2010.

Explanation of Benefits Payable by Insurance Company (OCF-9)

121. The OCF-9 (Explanation of Benefits Payable by Insurance Company) is no longer authorized by the Superintendent. If we continue to use the OCF-9, can we make changes to the form if required to ensure that information being sent is correct?

Yes. As of September 1, 2010, the Superintendent no longer approves the Explanation of Benefits Payable by Insurance Company (OCF-9). Insurers will

still be obligated to provide claimants with an explanation of benefits and to inform claimants of their rights to dispute (see SABS Section 54). However, insurers can use their own forms; the insurer can choose to model the form after the OCF-9.

As well, HCAI maintains the OCF-9 in its system so that it can still be used to explain medical and rehabilitation benefits to claimants.

122. If insurers no longer use the OCF-9 (Explanation of Benefits Payable by Insurance Company), how are insurers protected in relation to Smith vs. Co-operators?

Insurers are still obliged to provide an explanation of benefits (EOB) to the claimant that meets the criteria set out in the Smith vs. Co-operators decision.

Extended Health Care Coverage

123. If we have been trying to collect on invoices billed to extended health care insurance providers for over a year, is it still considered "reasonably available"? Can we then bill the adjuster?

The provisions with reference to extended health care insurance providers have not changed. Auto insurers continue to be the second payer. However, if the extended health care insurance provider denies a claim, it is safe to say that the payment was not "reasonably available."

124. How does the role of a patient's extended health plan coverage affect Minor Injury Guideline funds? For example, if the patient has $500 maximum per year of extended health care (EHC) funds, does this get subtracted from $2,200 the MIG sets out?

The rules about first payer have not changed. Auto insurers are obligated to pay for benefits that are not payable by another insurer or coverage. Benefits covered by other insurers or extended health care coverages will be deducted from the amounts otherwise payable according to the fee schedule found in Appendix B of the MIG. In the example supplied, the auto insurer would only be responsible for paying up to the remaining $1,700 for minor injuries in the MIG. But please note that amounts covered by other sources do not reduce the overall $3,500 cap for medical and rehabilitation benefits.

125. When using the pre-approved framework (PAF) block fees, if someone has extended health insurance as well, the health practitioner will bill per appointment with private insurance but later per block with car insurance (after getting some of the payment from private). Is there a way to make the billing process smoother?

You should bill the extended health insurer for all visits provided in the time period that coincides with a block under the MIG. You would bill the extended health carrier by "visit" or "treatment" (depending on their requirements). The amount remaining per block can then be billed to the auto insurer. Block fee amounts can be any amount up to the maximum block fee cited in the MIG.

Approval/Denial of Benefits

126. Are there new timelines with respect to responses to OCFs?

As of September 1, 2010, insurers must respond to a:

- Treatment and Assessment Plan (OCF-18) request within 10 business days
- Treatment Confirmation Form (OCF-23) within 5 business days
- Disability Certificate (OCF-3) within 10 business days

- Application for Determination of Catastrophic Impairment (OCF-19) within 10 business days
- Assessment of Attendant Care Needs (Form 1) within 10 business days

127. Are OCF-18s (Treatment and Assessment Plans) still deemed approved if insurance companies fail to respond within the 10-day guideline?

Generally speaking, the insurer has 10 business days to decide whether or not to approve, partially approve or deny a Treatment and Assessment Plan (OCF-18). According to Section 38(11) of the SABS, if the insurer fails to provide a response within 10 business days, the insurer is prohibited from taking the position that the claimant's injury is subject to the MIG and must pay for all goods, services, assessments and examinations described in the OCF-18 from the 11th business day until the day the insurer gives notice of its decision on the OCF-18.

However, health care facilities are advised to check with the insurer to determine if there are circumstances that prevent adjudication.

The HCAI system may help in this regard. If there is a reason why an insurer cannot adjudicate an application, they can place it into a "pending" state and provide a reason why they are not able to adjudicate. The most common reason is that the insured person has not submitted an Application for Accident Benefits Package (OCF-1). However, please note that HCAI's "pending" state does not serve to extend the 10-business-day response deadline in Section 38(8) of the SABS.

128. What is the process for adjudication when a health practitioner submits an OCF-18 (Treatment and Assessment Plan) for a claimant with a predominantly minor injury with a pre-accident medical condition (along with provision of compelling evidence that maximal recovery is not possible within the MIG or the $3,500 cap)?

The insurer will evaluate the evidence to determine if a compelling case has been made for managing the claimant outside the MIG and minor injury cap. The insurer may also use an insurer examination in these circumstances. FSCO's dispute resolution is available to settle any disputes that may arise.

129. Where do insurer examinations (IEs) fall in the new legislation?

Insurer examinations are covered in the SABS under Section 44, and the cost of IEs is not deducted from the insured person's medical and rehabilitation limits.

130. If the insurer denies an initial treatment plan, is the insurer obligated to schedule an in-person or paper review to support placing the patient into the MIG? Also, what are the timelines associated with such an IE?

No. The insurer is not obligated to schedule an insurer examination if it denies an initial treatment plan. After receiving the initial treatment plan, the insurer must approve, partially approve or deny the requested intervention within 10 business days. If the insurer chooses to schedule an insurer exam, there is no timeframe set out in the SABS for completing the exam. FSCO's dispute resolution is available to settle any disputes that may arise, and the claimant does not have to wait for the results of the insurer exam before filing for mediation.

131. Must an insurer provide a medical reason for all denials of a benefit? What if the denial was due to impaired driving or driving with no insurance?

The insurer must provide a medical and/or *other reason*. Examples of providing *other reasons* include when the injury is not caused by the accident or there is no policy associated with the injury.

Health Claims for Auto Insurance (HCAI)

132. How does a dentist submit a standard dental claim form given the HCAI requirements?

Dental claim forms will be submitted to insurers by fax or mail. Dentists also have the option of using the OCF-18 (Treatment and Assessment Plan).

133. Will the OCF-24 (Minor Injury Treatment Discharge Report) be incorporated into HCAI?

The Minor Injury Treatment Discharge Report (OCF-24) is not currently accommodated in HCAI, but it may be incorporated at some time in the future.

134. Health care facilities require an OCF-18 (Treatment and Assessment Plan) to be certified by a health practitioner. Currently, we can ask an external health practitioner (one who is not associated with our business but who treats the patient) to certify an OCF-18. Is this possible in HCAI?

Yes.

135. If a health care facility is using HCAI, do they need to fax or mail OCFs 18 (Treatment and Assessment Plan), 21 (Auto Insurance Standard Invoice) and 23 (Treatment Confirmation Form) to insurers in addition to submitting them by HCAI?

No. Any hard-copy OCF submitted by an HCAI-participating health business to an insurer will be deemed "not received." Only *attachments* (i.e., non-OCF documents) will continue to be faxed or mailed to insurers.

136. In HCAI, how is the patient's signature obtained?

In order to obtain informed consent, any treatment and assessment plan should be printed. The plan should be reviewed with the claimant and he or she should sign it. The signed original must be filed at the health care facility and produced if requested by the insurer or claimant. A signature is not sent via HCAI; however, a declaration is made in HCAI that the patient's signature is on file (unless the insurer waives the patient's signature).

Health professionals are responsible to keep the forms on file for as long as their college requires and must provide it to insurers upon request.

137. How do health practitioners submit an OCF-24 (Minor Injury Treatment Discharge Report) since it is not available on HCAI?

The Minor Injury Treatment Discharge Report (OCF-24) will continue to be submitted via mail or fax directly to the insurer.

138. SABS timelines are not always respected, and communication between insurers and health care providers is difficult due to workload. Will this be remedied by the new HCAI system?

HCAI will not police the SABS timelines. However, the HCAI web application offers efficiencies that have the potential to improve communication between insurers and health care facilities. For example, after reviewing a submitted form, an insurer can use HCAI to transmit a question about the form to the health care facility. The facility can respond via HCAI and a message log records the communication. This process can eliminate much telephone tag and other communication that could delay determinations.

139. Will independent adjuster companies register under HCAI?

No. Only licensed insurers will register with HCAI. Independent adjusting companies are hired or contracted by insurance companies and act as agents of the insurance company. If an insurance company wishes an independent adjuster (IA) to adjudicate forms, the insurance company will give the IA access to those claims.

This is similar to a situation where a health business contracts treatment providers to provide care to patients of the health business. The OCF is still submitted by the health care business treating the patient. The sub-contracted health provider does not act or invoice independently of the health business that submits the OCF.

Ontario Regulation 283/95

140. The new amendment to Ontario Regulation 283/95 Disputes Between Insurers states that claimants with MVA-related injuries should submit their applications for benefits to only one insurer rather than to all insurers who may be liable. How is this resolved if the insurer who receives the form is the wrong insurer?

In cases where the first insurer to receive the Application for Accident Benefits Package (OCF-1) takes the position that another insurer should be paying for a given claimant's benefits, the first insurer will pay the benefits and in the meantime use the processes set out in Ontario Regulation 283/95 to resolve the issue with the other insurer.

Harmonized Sales Tax (HST)

141. Do hourly rates include HST?

Hourly rates do not include HST. FSCO's Professional Services Guideline states that HST is payable by an insurer in addition to the fees set out in the guideline.

142. If a health care business is currently not charging HST, will the invoices be rejected by the HCAI system? What should HST be charged on?

HCAI serves no screening function with respect to applicable taxes. HCAI accepts forms, whether or not taxes are applied. There is a box on the HCAI form that should be checked to state whether HST is applicable. Refer to Canada Revenue Agency or your professional association for guidance on how to apply taxes to your professional services and on what HST should be charged on.

Transitional Issues

143. If a patient has an insurance policy that doesn't renew until October 1, 2010 and they had an accident after September 1, 2010, does their coverage fall under the *new* guidelines or the *old* guidelines in terms of caps?

As a general rule, coverages and coverage limits in policies written under the old SABS will remain unchanged until the policy expires or is terminated or if the named insured and insurer agree otherwise in writing. These policies retain the $100,000 medical and rehabilitation benefit, the $72,000 attendant care benefit and the housekeeping, home maintenance and caregiver benefit – all of which are optional in the new standard package. Some of the changes that do affect policies written before September 1, 2010 include the $3,500 minor injury cap, the MIG, the $2,000 cap per assessment or examination and the elimination of rebuttal exams. The revised claim forms apply to all claims made on and after September 1, 2010. For more information on all transitional rules, please see FSCO's bulletin:
http://www.fsco.gov.on.ca/english/pubs/bulletins/autobulletins/2010/a-04_10.asp

144. What happens with insurer examinations (IEs) and rebuttals for accidents that happened before September 1, 2010 and treatment plans denied before September 1?

Regardless of when the accident occurred, the availability of rebuttal examinations does not exist on or after September 1, 2010. The new rules for insurer examinations apply to all denials made on or after September 1, 2010.

145. If a claimant had a non-catastrophic injury in 2008 and the policyholder is unrelated to the claimant, are the claimant's benefits reduced after September 1, 2010 if the policyholder does not purchase extra coverage when he or she renews the policy?

The reforms do not change coverages and benefits that claimants are eligible to receive after September 1, 2010 if they were injured prior to September 1. However, the new SABS will govern claims processing and assessment caps.

146. May a chiropractor submit an Application for Determination of Catastrophic Impairment (OCF-19) for MVAs that occurred before September 1, 2010?

No. Only physicians – and in cases with only brain injuries, neuropsychologists – may submit applications for catastrophic impairment determinations on or after September 1, 2010 even if the accident occurred before September 1, 2010.

147. Are health practitioners required to complete an OCF-18 (Treatment and Assessment Plan) if the injuries are not within the MIG? Before September 1, 2010, health practitioners were able to complete three assessments under $200 without completing an OCF-22 (Request for Assessment).

Yes. A Treatment and Assessment Plan (OCF-18) is required for all assessments unless the requirement is waived by the insurer. The new forms (as of September 1, 2010) must be used in all cases, including old accidents. Similarly, the new SABS rules governing processes and requirements for insurer prior approval must be followed.

148. Can the new OCF-23 (Treatment Confirmation Form) be filled out for MVAs that occurred before September 1, 2010, or should the older OCF-23 be completed?

The new forms can only be used for accidents that occurred on or after September 1, 2010.

149. If an accident took place before September 1, 2010 and an OCF-18 (Treatment and Assessment Plan) was approved, is a new OCF-18 required after September 1, 2010?

A new OCF-18 is not required unless the health practitioner wishes to request approval for additional services.

150. Does the 10-day response rule for application for assessments apply to accidents that occurred before September 1, 2010?

The 10-business-day timeframe applies to all new applications for approval of assessments submitted on or after September 1, 2010 for accidents that occurred before or after September 1.

151. If a verbal approval is given by an adjuster, is anything provided in writing to ensure that the verbal approval is honoured?

Yes. When an insurer waives the requirement of an OCF-18 (Treatment and Assessment Plan) or an OCF-23 (Treatment Confirmation Form), they are required to provide the claimant with written notice of the services and costs they have agreed to.

Benefit Statements

152. What information needs to be included in the bi-monthly benefit statement sent to the insured?

According to Section 50 of the SABS, the statement of benefits must be sent to claimants with catastrophic impairments at least once a year, starting within 12 months after the date it was determined that the claimant had a catastrophic impairment, and to claimants with non-catastrophic impairments at least once every two months, starting within two months after the claimant applied for benefits. Included in the statement of benefits are:

- The amount paid in medical and rehabilitation benefits;
- The amount remaining in medical and rehabilitation benefits;
- The amount paid in attendant care benefits;
- The amount remaining in attendant care benefits; and
- The amount paid by the insurer for insurer examinations.

153. According to Section 50, is the insurer required to issue a benefit statement two months after the date of loss if no payments have been made under medical/rehabilitation, attendant care or cost of examinations?

As long as medical, rehabilitation and attendant care benefits are being claimed, an insurer must send a statement of benefits to the claimant. Nonetheless, according to Section 50(5), an insurer does not have to send a statement of benefits every two months for non-catastrophic injuries and every one year for catastrophic injuries if the amount of benefits is unchanged from the previous statement.

Other

154. Many insurers use a preferred provider network and transfer their customers to clinics during the initial call. Does Section 46(2) now require the customer to provide something in writing to an insurer before such a referral can be made?

Yes. The insurer must provide a written notice to the claimant, and Section 46(2) of the SABS requires that the insurer get written consent from a claimant to use a preferred provider. The insurer must first provide a notice to the claimant specifying:

- The nature of the relationship between the insurer and the preferred provider;
- The type, amount and duration of interventions that will be provided;
- The claimant's right to decline the proposed referral; and
- The claimant's right to choose another provider in accordance with the SABS.

Section 64(2) of the SABS sets out the various methods that an insurer may use to deliver the written notice to the claimant and methods that a claimant may use to deliver his or her written consent to the insurer. This includes email, if the parties agree to communication by email (see subsection 64(2)(e) and 64(6)).

155. If an insurance company uses a preferred vendor to undertake treatment of their MIG clients, is the preferred vendor obligated to complete a Treatment Confirmation Form (OCF-23) and submit it via HCAI?

Yes, unless the insurer waives the requirement for the OCF-23.

156. How do insurers plan to explain optional benefits to clients? How can health practitioners ensure that clients will be fully informed prior to making a decision?

Prior to June 30, 2010, insurers sent out Early Awareness Mailers to their policyholders to inform them about the September 1, 2010 reforms and that more

information would be provided with their renewal. Included with each policyholder's renewal will be the Point of Sale Disclosure Document and the More Choice Mailer, both of which have detailed information about the new standard auto insurance product and the new options available to policyholders. New policyholders with policies written between September 1, 2010 and August 31, 2011 will receive only the More Choice Mailer. FSCO developed these three communication documents with its Consumer Information Working Group.

157. How has the Unfair or Deceptive Acts or Practices (UDAP) regulation changed?

Ontario Regulation 7/00: Unfair or Deceptive Acts or Practices (UDAP) was amended, and effective September 1, 2010 it prohibits auto insurers and their intermediaries from using credit information for most automobile insurance purposes and requires affiliated insurers and their intermediaries to offer consumers the lowest rate available, subject to FSCO-approved declination rules and having regard to all circumstances, including the means of distribution.

158. How will health professionals be able to find out if a client has optional coverages and what the coverages are? Are there privacy issues? How can a health professional be sure the client has purchased optional benefits?

Regulated health professionals can confirm a claimant's coverage by asking the claimant and obtaining the claimant's consent to ask their insurer.

159. Do these reforms encourage inter-disciplinary cooperation or will the physiotherapist, chiropractor, registered massage therapist and orthopedic specialist now be in direct competition regarding caring for a person involved in an MVA?

Communication, coordination and accommodation among health professionals are key to the new system working effectively and ensuring consistently high rehabilitation outcomes for claimants/patients.