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AMENDMENTS TO REG 403/96 – STATUTORY ACCIDENT BENEFIT SCHEDULE PURSUANT TO REGULATION 546/06.

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OVERVIEW – IMPORTANT CHANGES

- Sec. 24 costs
- social workers can now conduct assessments & applications for approval of Assessments & Examinations
- insurer approval of expenses not required in certain cases
- elimination of DACS replaced by Sec. 42 Insurer Examinations
- responding assessment or examination by insured after denial
- pre-claim examinations
- income replacement , non-earner caregiver benefit and housekeepers and home maintenance expenses now referred to as specified benefits
- additions to Unfair & Deceptive Acts and Practices - Part XVIII of the Insurance Act
- onerous timelines

SEC. 24(1) COST OF EXAMINATIONS INCURRED BY OR ON BELHALF OF INSURED PERSON

- insurer shall pay reasonable fees for enumerated services 24(1)1-10
- 24(1)11 – reasonable fees charged by member of health profession or social worker for assessment or examination reasonably required in connection with benefit claimed or preparation of treatment plan, disability certificate, assessment, attendant care needs or application for CAT determination and:
  - insured person applied for approval of assessment or examination in a treatment plan submitted 24(11)ii or:
  - insurer approved expense or approval not required 24(11)iii
  - insurer not required to pay for assessment of examination under 24(11)ii if expense incurred:
    - before approved by insurer
    - before report of s. 42 examination received

SEC. 24(1) COST OF EXAMINATIONS INCURRED BY OR ON BELHALF OF INSURED PERSON

Prior approval not required:

- for the purpose of preparing treatment plan if immediate risk of harm or obtaining prior approval impractical s. 24(1.2)1
- not more than 3 assessments or examinations for preparing treatment plan under s. 38 if not by same person and cost of each assessment does not exceed $200. s. 24(1.2)2
- assessment or examination – re disability certificate for lost educational expenses, specified benefits, or continuing entitlement does not exceed $200. s. 24(1.2)3
- assessment or examination of attendant care needs s. 24(1.2)5
- assessment or examination to determine CAT impairment – if person in hospital or long term care 24(1.2)6

SEC. 42 EXAMINATIONS

Purpose: to assist insurer in determining whether a person is entitled or continues to be entitled to a benefit.

Compare to previous wording: "for the purpose of determining whether an insured person entitled to a benefit".

How many? As often as reasonably necessary.

Who? One or more health professionals, social workers or vocational rehab specialist.

Who pays? The insurer.

Limit on cost? None

SEC. 42 EXAMINATIONS

- section does not apply to pre approved framework provisions, ancillary goods or services in s. 37.2 or funeral or death benefits
- paper review only of s. 42(10) material for: ancillary goods or services, pre approved framework & s. 38 goods or services contemplated by a treatment plan previously refused in a treatment plan in respect of the same accident
- application for approval of assessment or examination under s. 40 relating only to whether insured has a brain impairment that results in a score of 9 or less on the GCS s. 42(3)

SEC. 42 EXAMINATIONS

- insurer must provide notice of Sec. 42 request, with details including reasons for examination s. 42(4)
- insurer and insured shall must provide "all reasonably available information and documents that are relevant and necessary within 5 days after notice of examination received s. 42(10)a
- insured shall submit to all reasonable physical, psychological mental and functional examination s. 42(10)b
- if personal examination, notice must be not less than 5 business days before examination s. 42(6)
- if person conducting material review subsequently determines personal examination required, notice must be given within 2 business days of previous notice and not less than 5 business days before examination

SEC. 42 EXAMINATIONS

- if paper review, examination to determine catastrophic impairment must be completed and report provided within 10 days of the notice under s. 42(4) and within 5 days in all other cases
- if attendance of insured required for CAT determination, medical rehab benefits, attendant care benefits or specified benefits examination must be completed within 30 days after notice and;
- report delivered no later than 10 days after examination

SEC. 42 EXAMINATIONS

- if non-CAT – examination must be carried out within 10 days of notice and report delivered not less than 10 days after examination
- treating providers and assessors may consult – insurer pays s. 24(1)9 consultation fee not to exceed amount ordinarily charged for 30 minutes professional consultation by phone s. 24.1(1)3

SEC. 35 SPECIFIED BENEFITS

Income replacement benefit, non earner benefit, caregiver, housekeeping or home maintenance.

- application + current disability certificate
- insurer must respond within 10 business days of receiving disability certificate
- within 10 days either pays or requests further info, examination under oath or Sec. 42 exam
- insurer must provide Sec. 42 report and advise of determination of entitlement within 5 business days after report received and pay benefits within 10 days of receiving report
- if insurer fails to provide report or determination of entitlement within 15 days after examination completed, insurer is required to pay benefit until report or determination is provided

SEC. 35 SPECIFIED BENEFITS

- insurer can request new disability certificate and examination to determine if insured continues to be entitled to specified benefits
- new disability certificate must be provided within 15 business days otherwise no benefit payable until certificate provided

SEC. 38 MED-REHAB BENEFITS

- application/ and treatment plan submitted by insured
- social workers can now prepare treatment plans approved by health practitioner stating goods and services are reasonable and necessary
- insurer must give notice of determination within 10 business days indicating which goods and services it will agree to pay or not pay and request a Sec. 42 exam
- if notice not given within 10 days – insurer must pay from 11th day onward until notice is provided
- insurer must provide Sec. 42 report and its determination of entitlement within 5 business days of receiving report
- if insurer fails to provide report within 15 days after examination completed or within 10 days if no examination, it shall pay for all benefits in treatment plan until report provided

ATTENDANT CARE BENEFITS

New Form 1 rates to assess future needs of applicants

New Rates:

		New	Old
Level 1	Routine Personal	$11.23	$10.53
Level 2	Supervisory Care	$7.75	$7.00
Level 3	Complex Health Care	$17.98	$16.86

ATTENDANT CARE

- application submitted for benefit together with assessment of attendant care needs (Form 1) by person authorized to treat impairment
- insurer must give notice of determination within 10 days or request Sec. 42 exam
- insurer pays pending Sec. 42 report
- pays within 10 days based on assessment of needs provided
- insurer does not pay if insured does not attend Sec. 42 exam
- insurer must provide report within 5 business days of receipt and advise insured of its decision

ATTENDANT CARE

- if insured entitled to attendant care beyond 104 weeks, no new Sec. 42 exam permitted until 52 weeks have elapsed since last exam
- insurer shall provide Sec. 42 report within 5 days after receiving it and its determination of entitlement
- failure to attend Sec. 42 examination or provide info may permit insurer to refuse payment
- if subsequent compliance insurer can reconsider application, resume payment and pay all amounts withheld during non-compliance, provided insured has reasonable explanation and provides explanation within 10 days after non-compliance began

ATTENDANT CARE

- insurer may request new assessment of attendant care needs and further Sec. 42 exam to determine ongoing entitlement or if appropriate amount is being paid, on notice to insured
- insured must submit new assessment within 10 days
- insured can also submit new form and insurer can request Sec. 42

SEC. 40 CATASTROPHIC IMPAIRMENT

- application for catastrophic impairment submitted
- within 30 days of receiving application insurer must respond by notice either accepting catastrophic impairment or requesting Sec. 42 Examination to assist insurer in making determination
- if CAT application within 104 weeks attendant care benefits shall be paid in an amount that assumes CAT impairment
- if Sec. 42 Examination requested, insurer must notify insured and health care practitioner who prepared application within 5 business days of receiving report and provide copy of report and its determination

SEC. 40 CATASTROPHIC IMPAIRMENT

- if non-compliance with Sec. 42 Examination insurer may determine insured not catastrophic and can stop benefits which are payable only if the person is catastrophic or may refuse to pay benefits during period of non-compliance
- if subsequent compliance insurer may reconsider application and resume payments being made before examination, pay amounts withheld during non-compliance if the insured is catastrophically impaired provided insured gives a reasonable explanation of the failure to comply no later than the 10th business day after the failure or refusal or as soon as practicable after that day

SEC. 40 CATASTROPHIC IMPAIRMENT

- insurer to receive a copy of Sec. 42 Examination report no later than 15 days after the examination was completed or if no examination, no later than 15 days of when material requested under Sec. 42 (10) was provided.
- If non-compliance by insurer the benefits shall be paid until report or determination is provided.

SEC. 42.1 ASSESSMENT OR EXAMINATION AFTER DENIAL OF BENEFITSS - RESPONDING REPORTS BY INSURED

"Original Provider" – a member of a health profession who approved a treatment plan, prepared an assessment of attendant care needs, completed a disability certificate or prepared an application for catastrophic impairment,

- if insured undergoes a Sec. 42 examination & the insurer determines there in no entitlement to benefit or that the insured person does not have a catastrophic impairment the insurer shall pay for an assessment or examination and preparation of report to respond to those issues in the Sec. 42 report with which insured does not agree, and which are relevant,
- the assessment must be conducted by a health care professional who is authorized under sec. 42.1 to conduct the assessment

SEC. 42.1 ASSESSMENT OR EXAMINATION AFTER DENIAL OF BENEFITS - RESPONDING REPORTS BY INSURED

- for catastrophic impairment the responding report must be delivered to insurer within 80 days after notice given to insured of its determination
- if non catastrophic, impairment responding report must be delivered to insurer within 40 days after notice given to insured of its determination
- examination or assessment must be prepared by original provider

SEC. 42.1 ASSESSMENT OR EXAMINATION AFTER DENIAL OF BENEFITS - RESPONDING REPORTS BY INSURED

- examination or assessment may be conducted by any person if:
  - the original provider is not a member of the same health profession as the sec. 42 examiner
  - the original provider, although a member of the same health profession as the Sec. 42 examiner, is not legally authorized to practice the same specialty as the sec 42. examiner
- if two or more health professionals completed the Sec. 42 assessment authorization the responding assessment or examination may be conducted by one or more persons other than the original provider

LIMITATIONS ON RESPONDING REPORT

- responding assessment or examination limited to examination of material provided under Sec. 42(10) if the person conducting the assessment under 42 is a member of the same health profession as the original provider and is legally authorized to practice in same specialty
  - and examination under Sec. 42 was limited to examination of material provided under Sec. 42(10)
  - or if the assessment or examination relates to a claim for med/rehab benefits and assessment or examination of the insured person with respect to same accident has been conducted within previous 12 months. (i.e. one responding assessment or examination per year in respect of same accident otherwise paper review)

LIMITATIONS ON RESPONDING REPORT

- if non CAT assessment or examination the fee payable for a report or assessment or examination shall not exceed:
  - examination of material provided under 42(10) - $450
  - if assessment not limited to material review, insurer will pay $900, if assessment or examination is conducted by one or more members of health profession, at least one is a physician with a specialty other than family medicine
  - assessment or examination conducted by one or more health professionals and none are physicians who have specialty other than family medicine $775
  - no monetary limits if assessment or examination relates to catastrophic impairment
  - amounts for reports payable in 30 days after receipt of invoice

LIMITATIONS ON RESPONDING REPORT

- assessment or examination used only for assisting in resolution of dispute in mediation, arbitration or litigation
- insurer is not required, as a result of receiving responding report, to allow any application or pay any benefits that it otherwise would not have allowed or paid

SEC 32.1 PRE-CLAIM EXAMINATIONS

- applies to insured person admitted to hospital or long term care facility or who has been discharged within previous three days
- no application for benefits has been made
- pre-claim exam to assist insurer in making a determination if the insured person is entitled to medical benefit, rehab benefit or attendant care benefit
- written consent of insured required – OCF 26
- report to be provided to insurer and insured within 5 days
- failure to consent does not affect insured's right to benefits
- report cannot be relied upon by insurer in making a determination that insured person not entitled to benefit

SOME IMPORTANT TIMELINES

- accidents before Oct 1, 2003, insured must notify insurer within 30 days
- accidents after Oct 1, 2003, insured must notify insurer within 7days
- insurer then provides application promptly and insured has 30 days to file
- if application incomplete, insurer must notify insured within 10 days advising what info is missing – no benefit payable until info provided
- requests by insurer to submit additional applications shall be submitted by insured within 30 days after receiving additional application

SOME IMPORTANT TIMELINES

- if insured fails to notify insurer of circumstances giving rise to claim, without reasonable explanation – insurer can delay making determination until later of 45 days after application submitted or 10 business days after insured provides info requested by insurer in Sec 33.1
- Sec. 33 creates duty on applicant to provide information to insurer within 10 business days of a request
  1. any information reasonably required to assist insurer in determining entitlement
  2. statutory declaration
  3. residence address
  4. proof of identity
  5. examination under oath at insured expense

- failure to comply relieves insurer of liability to pay benefit but if subsequent compliance insurer shall resume payments, if a benefit was being paid, and benefits that were withheld during non-compliance shall be paid if insured has reasonable explanation for delay in compliance.