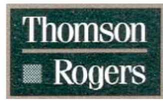
CHANGES TO ONTARIO AUTO INSURANCE
BILL 198 and Other Changes

"What the Health Care Professional Needs to Know"

Presented by:

OVERVIEW OF CHANGES TO AUTO INSURANCE

2



Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com

Significant Changes

a) Substantial changes to SABS
b) Changes to DACs
c) Pain & Suffering Deductible changes
d) Unfair or deceptive practice regulation (in force November 1, 2003)
e) Settlement of SABS claims before 1 year prohibited
f) Verbal Threshold Defined
g) New Fee Guidelines

3

Thomson Rogers

Direct Impact on Injured Persons

- Treatment Delays for failing to give notice within 7 days
- Injured Persons examined under oath
- restrictions to s.24 assessments
- Limiting fees to professionals
- Pre-Approved Framework for Whiplash
- IRB's reduced to $300 per week

4

Thomson Rogers

Direct Impact cont'd

- New and more complex forms for Assessments and Treatment
- Verbal approval by insurers
- No insurer examinations before mediation of medical/rehab benefits
- Changes to Catastrophic Definition, particularly as it relates to children
- Change to deductible
- Recovery of health care expenses

Thomson Rogers

5

New Notice Requirements

Notice within 7 days (On or after Oct. 1/03)

What Notice is sufficient

- **policy number, accident date, location**

Who should give notice?

To which insurer?

1) injured person's

2) at fault driver/owner

3) Negligent person present at scene

4) Motor Vehicle Accident Claims Fund

What happens if 7 days deadline not met?

6

Consequence of Failing to Give Notice

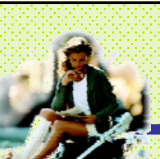
No benefit is payable until a "complete" Accident Benefit Application is received by Insurer

- Insurer can delay
  - Income Replacement Benefit
  - Med/Rehab Benefit
  - Attendant Care Benefit
  - Death Benefit

For up to 45 days from "Completed A/B Form"

Thomson Rogers

7



The New Form 1 (Attendant Care)

- For accidents on or after Oct.1/03)
- Increased Rates
  - Level 1 10.53 (vs. 9.00)
  - Level 2 7.00 (vs. 7.00)
  - Level 3 16.86 (vs. 15.00)
- New category of supervisory/skilled care
- Deletes Intermittent Care
- Adds co-ordination of attendant care

Thomson Rogers

8

Thomson Rogers

Craig L. Brown	David R. Tenszen	David A. Payne
416-868-3163	416-868-3210	416-868-3193
cbrown@thomsonrogers.com	dtenszen@thomsonrogers.com	dpayne@thomsonrogers.com

Changes Affecting Private Health Care Professionals

FEES

- reduced fees for assessment
- need for pre-approval
- reduced fees for treatment (up to 50%)
- unable to mediate or arbitrate for denied fees for treatment

9

Professional Services Fee Guideline

Superintendent's Guideline No 05-03

10

Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com

ANTI-FRAUD MEASURES

11

Unfair and Deceptive Acts and Practices (UDAP)

Paralegals

Effective November 1:

- Paralegals may not represent a person that they know or ought to have known to have a catastrophic impairment
- Paralegals must adhere to a code of conduct issued by Superintendent
  - Published in *The Ontario Gazette* on August 16, 2003 and posted on FSCO website

12

Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

UDAP Regulation Changes

Paralegals

- Changes to the definition of "unfair and deceptive acts or practices" (UDAP) prohibit paralegals from:
  - Soliciting, accepting or demanding contingency fees
  - Soliciting, accepting or demanding a referral or paying a referral fee
  - Committing an act or omission inconsistent with code of conduct
  - Failing to disclose a conflict of interest

Thomson Rogers

13

UDAP Changes Affecting Health Care Professionals

- Changes to the definition of UDAP prohibit health care and service providers from:
  - Charging for goods or services which are not provided
  - Soliciting, demanding, accepting or paying a referral fee directly or indirectly
  - Charging unreasonably excessive amounts for goods and services
  - Failing to disclose a conflict of interest
  - Using a form not approved by the Superintendent

14

Thomson Rogers

Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

Other Restrictions (UDAP)

- Claimants can only access mediation after attending DAC assessments and insurer examinations
- Prohibition on assignment of claims to allow others to pursue in claimant's name
- Prohibition on cash settlements of future benefits in first year following accidents

15

WHAT HAPPENS WHEN?

AS OF OCTOBER 1, 2003 BUT RETROACTIVE TO NOVEMBER 1, 1996:

•Assessment Approvals (OCF-22)

•Treatment Plans (OCF-18)

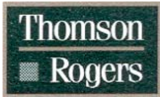
•Disability Certificates (OCF-3)

16

Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com



WHAT HAPPENS WHEN?

<u>ACCIDENTS ON OR AFTER OCTOBER 1, 2003:</u>

•Right to sue for health care

•New threshold definition

•Changes to deductible

•Attendant Care (Form 1)

•Pre-Approved Framework (OCF-23 & 24)

17

WHAT HAPPENS WHEN?

<u>ON OR AFTER NOVEMBER 1, 2003:</u>

•Fee schedule changes apply to <u>all</u> changes

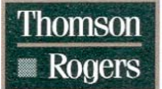
including <u>New</u> PAF fees

•Anti-Fraud Measures

<u>JANUARY 1, 2004</u>

•Reduced IRB's for policies issued or renewed after this date

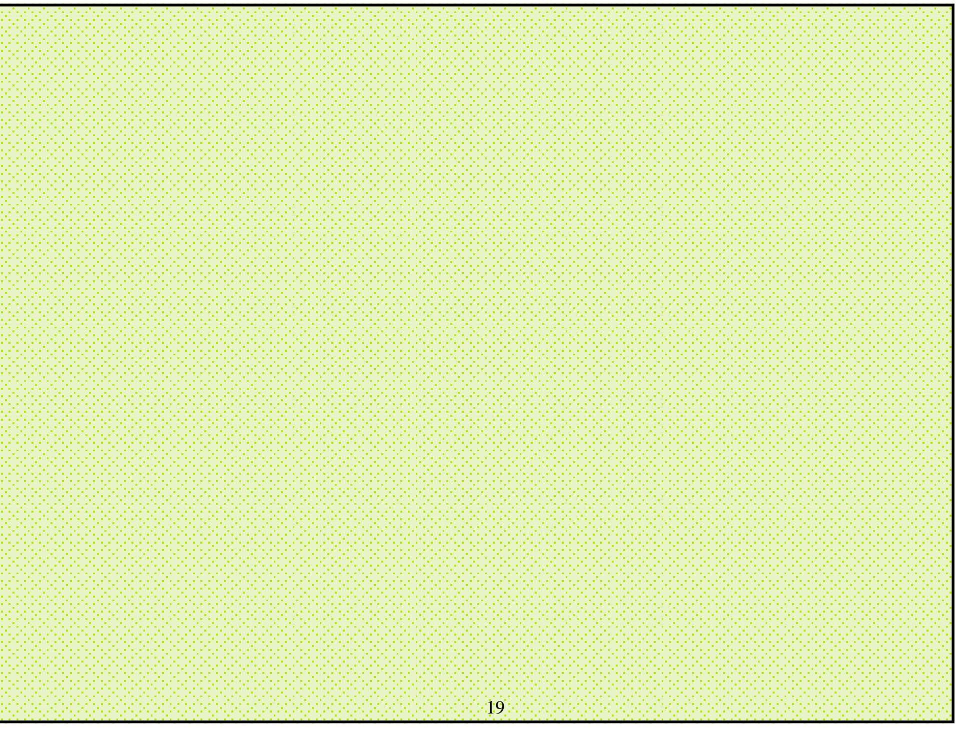
18

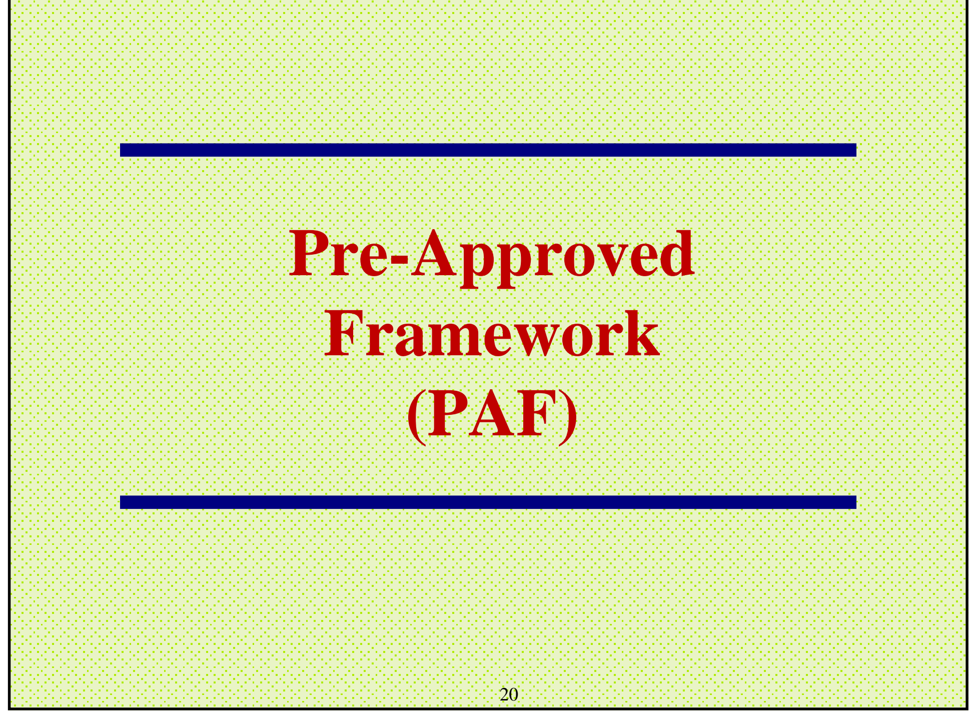


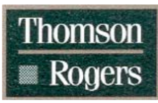
Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com







Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com

What is a “PAF”?

- A set of services for WAD I or WAD II injury for which the insurer will pay without requiring approval:
  - Appropriate for most WAD II injuries
  - Sufficient for x% of WAD II injuries
- Provided for in the SABS, set out in Superintendent’s Guidelines: mandatory where applicable
- An alternate Treatment Plan may be submitted under defined circumstances
- Additional PAFs may be developed

21

Thomson Rogers

What is “WAD I”?

WAD stands for “Whiplash Associated Disorder”

A WAD I is an acceleration-deceleration mechanism, involving neck pain, stiffness and/or tenderness with no physical signs

Within the PAF it may include an associated complaint of **non-radicular** back pain

22

Thomson Rogers

Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

What is "WAD II"?

A WAD II is an acceleration-deceleration mechanism involving neck pain, stiffness or tenderness with musculoskeletal signs including decreased range of motion and point tenderness

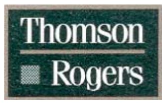
Within the PAF it may also include an associated complaint of non-radicular back pain

23

OTHER SYMPTOMS UNDER PAF

The PAF may also cover other common symptoms including shoulder pain, referred arm pain, dizziness, tinnutis, headache, hearing and memory, and TMJ as long as they do not require separate treatment from that provided under the PAF

24



Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

WAD II IMPAIRMENTS COVERED

- Most but not all WAD II:
  - Assessed within 4 weeks of injury
  - WAD II with or without non-radicular back pain
  - May have other related symptoms
  - Requires physical treatment

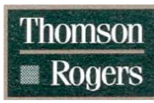
25

Thomson Rogers

INITIATING HEALTH PRACTITIONER ("IP")

- Overall responsibility and accountability for treatment, coordination of other providers and billing, monitoring outcomes, reporting, etc
- "Health Practitioner" with authority under RHPA to deliver all the PAF goods and services
- Submits the OCF-23 PAF Treatment Confirmation form
- Personally provides a significant portion of the goods and services

26



Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

INITIATING HEALTH PRACTITIONER ("IP")

- IP may:
  - refer to other Regulated Health Professionals within the PAF and/or
  - delegate services to directly supervised unregulated providers
- Generally a single IP and single PAF Treatment Confirmation form
- Patient may choose to change Initiating Provider (within the PAF resources)

27

TREATMENT/ASSESSMENTS COVERED UNDER PAF

- Intake assessment by 28 days
- Duration up to 6 or 7 weeks
- Emphasizes reassurance and self care
- Standard patient educational material
- No concurrent treatment except as specified in PAF Guideline

28

Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

TREATMENT/ASSESSMENTS COVERED UNDER PAF

- Clinical Interventions:
  - Reassurance
  - Pain control
  - Mobilization/manipulation
  - Education
  - Activation (daily activities and active exercise)
- Limited schedule of spinal X-rays not requiring insurer approval
  - Other x-rays require insurer approval

29

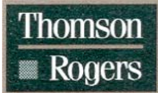
GOODS AND SERVICES NOT COVERED UNDER PAF

Include:

- Cervical pillows
- Soft collar for WAD I (>2 days for WAD II)
- Spray and stretch
- Magnetic necklaces
- Injections to the neck
- Advice for inactivity or bed rest

30

Craig L. Brown | David R. Tenszen | David A. Payne
416-868-3163 | 416-868-3210 | 416-868-3193
cbrown@thomsonrogers.com | dtenszen@thomsonrogers.com | dpayne@thomsonrogers.com



SUPPLEMENTARY GOODS AND SERVICES (PAF)

- Does not require insurer approval
- PAF resources for:
  - other minor accident-related injuries treatable within the timeframe of the PAF or
  - “goods” required for PAF treatment
- Must be reported on a PAF Treatment Confirmation Form
- Up to $200 (WAD II PAF)

31

Thomson Rogers

INSUFFICIENT OR INAPPROPRIATE TREATMENT (PAF)

- Provides for early exit if patient not recovering
- IP must submit OCF-24 (Status & Discharge):
  - Report reasons (barriers to recovery)
  - Make recommendations:
    - If WAD II, request PAF extension (Maximum 2 weeks; 4 visits), or
    - Submit OCF-18 Treatment Plan (single or multidisciplinary) and/or
    - Refer

32

Thomson Rogers

WAD II PAF Provider Payment

Block Fees	Expected Interventions	Fee
• Week 1	Assessment; up to 3 treatment visits	$240
• Weeks 2 &3	2-4 treatment or monitoring visits / week	$432
• Weeks 4, 5, & 6	1-3 treatment or monitoring visits / week	$408
Other Fees		
• End of Block 2 Discharge & Monitoring		$160
• Supplementary Goods and Services		$160
• Final Assessment; Completion of Report		$80
•Transfer fee for those patients changing IP		$48
• Activities of Normal Life Intervention (requires approval)		Up to 4 hrs
• X-ray		See Schedule

33

WAD I PAF Provider Payment

Block Fees	Expected Interventions	Fee
• Weeks 1 & 2	Assessment; Up to 4 treatment or monitoring visits	$296
• Weeks 3 & 4	Up to 5 treatment or monitoring visits	$160
Other Fees		
• End of Block 2 Discharge & Monitoring		$152
• Supplementary Goods and Services		$120
• Final Assessment; Completion of Report		$80
•Transfer fee for those patients changing IP		$48

34

Pre-Approval Framework Treatment Confirmation Form

(OCF-23/198)

OCF-23-198

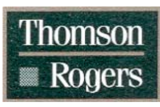
35

Pre-Approval Framework Discharge & Status Report

(OCF-24/198)

OCF-24-198

36



Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

Disability Certificate

(OCF-3)

37

Disability Certificates

- Required for IRB, non-earner, caregiver
- Insurer may require as often as necessary
- To be provided within 21 days of request
- Failure to provide could result in lapse in benefits
- Must be provided after denial and before disability DAC can proceed

38

OCF 3 10/03 revised

DRAFT

Disability Certificate (OCF-3)

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

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

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

39

OCF-3

Use this form for accidents that occur on of after November 1, 1996. If your insurance company asks you to complete this form, fill out Parts 1 to 3 and give the form to your **health practitioner (chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist).** After your health practitioner has explained your accident-related injury to you, Sign Part 4. Your health practitioner will complete the rest of the form, based on his/her most recent assessment, and return it to the insurance company. Your health practitioner must forward the form to the insurance company within **21** days of your company sending this form to you or within **14** days of your insurance company notifying you that they intend to discontinue your benefits. **Only an authorized health practitioner can complete this form. The health practitioner's opinion will be relied upon by people who review the certificate to make important decisions. Accordingly, it is necessary to be accurate and complete. Please print clearly and provide all information requested. This form may not be materially altered.**

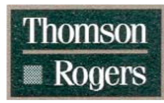
Confidentially: Collection, use and disclosure of this information is subject to all applicable privacy legislation.

40

Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com



OCF-3

Part 1 Applicant Information To be completed by the applicant	Date Of Birth (YYYYMMDD)	Gender ❑ Male ❑Female	Telephone Number Extension
	Last Name		
	First Name	Middle Name	
	Address		
	City	Province	Postal Code

41

OCF-3

Part 2 Insurance Company Information To be completed by the applicant	Name Of Insurance Company		City or Town of Branch Office (if applicable)
	Name of Insurance Company Representative:		
	Adjuster Telephone Ext.	Adjuster Fax	
	Name of policy holder same as: ❑ Applicant OR	Policy Holder Last Name	Policy Holder First Name

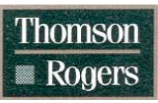
42

OCF-3

Part 3 Accident Description To be completed by the applicant	Give a brief description of the accident and what happened to you. Please describe any injuries you sustained as a direct result of the accident. ❑ additional sheets attached

OCF-3

Part 4 Applicant Signature	I authorize my treating health professional to collect, use and disclose to my insurer, any information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing health conditions that may be barriers to my recovery as a result of the automobile accident, for the purpose of providing treatment and determining my eligibility for benefits. This authorization is valid for one year form the date this form is signed. I authorize the health practitioner who completes this form to contact my employer, if this is necessary, to confirm the essential tasks of my employment and the nature and extent of any available work with modified hours or duties. I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.		
	Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)



Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

OCF-3

To the Health Practitioner:

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

Part 5 Injury and Sequelae Information This part and the rest of this form must be completed by your Health Practitioner	Provide a description (list most significant first) and associated IC-10-CA+code for any injuries and sequelae that are the direct result of the automobile accident.	
	Description	**Code**
	Note+: Refer to the User manual for ICD-10-CA coding information.	

45

OCF-3

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

46

Part 7 Disability Tests and Information

OCF-3

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

Benefit/Applicant Category	Disability Test	Onset of Disability (YYYYMMDD)	Task / Activity Limitations	Anticipated Duration
Income Replacement Benefits **Employed**: working at the time of the accident	Is the applicant substantially unable to perform the essential tasks of his/her employment at the time of the accident as a result of and within 104 weeks of the accident? ❑Yes ❑No ❑N/A		Please explain:	❑1-4 weeks ❑5-8 weeks ❑9-12 weeks ❑more than 12 weeks
	Can the applicant return to work on modified hours and /or duties? ❑Yes ❑No ❑N/A		Please explain:	❑1-4 weeks ❑5-8 weeks ❑9-12 weeks ❑more than 12 weeks
Unemployed: but worked 26 weeks during the 52 weeks before the accident	Is the applicant substantially unable to perform the essential tasks of the employment held for most of the time during the 52 weeks before the accident? ❑Yes ❑No ❑N/A		Please explain:	❑1-4 weeks ❑5-8 weeks ❑9-12 weeks ❑more than 12 weeks
Future employment: had accepted a job offer to start work within one year of the accident	Is the applicant substantially unable to perform the essential tasks of the employment he/she would have begun? ❑Yes ❑No ❑N/A		Please explain:	❑1-4 weeks ❑5-8 weeks ❑9-12 weeks ❑more than 12 weeks

47

OCF-3

Benefit/Applicant Category	Disability Test	Onset of Disability (YYYYMMDD)	Task / Activity Limitations	Anticipated Duration
Non-Earner Benefits	Does the applicant suffer a complete inability to carry on a normal life? (i.e., Has the applicant sustained an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident?) ❑Yes ❑No ❑N/A		Please explain:	❑1-4 weeks ❑5-8 weeks ❑9-12 weeks ❑more than 12 weeks
Caregiver Benefits	As the Primary Caregiver, does the applicant suffer a substantial inability to engage in the caregiving activities in which he/she engaged at the time of the accident? (Primary Caregiver means that, at the time of the accident, the applicant was residing with a person in need of care and the applicant was the primary caregiver for the person in need of care and did not receive any remuneration for engaging in caregiver activities.) ❑Yes ❑No ❑N/A		Please explain:	❑1-4 weeks ❑5-8 weeks ❑9-12 weeks ❑more than 12 weeks

48

OCF-3

Benefit/Applicant Category	Disability Test	Onset of Disability (YYYYMMDD)	Task / Activity Limitations	Anticipated Duration
Lost Educational Expenses	Is the applicant, as a result of the accident, unable to continue in an elementary, secondary, post-secondary or continuing education program that the applicant was enrolled in at the time of the accident? ❑Yes ❑No ❑N/A		Please explain:	❑1-4 weeks ❑5-8 weeks ❑9-12 weeks ❑more than 12 weeks
Housekeeping and Home Maintenance Expenses	Does the applicant suffer a substantial inability to perform the housekeeping and home maintenance services that he or she normally performed before the accident? ❑Yes ❑No ❑N/A		Please explain:	❑1-4 weeks ❑5-8 weeks ❑9-12 weeks ❑more than 12 weeks

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

49

OCF-3

Part 8 Further Investigations or Consultations	a) Have there been any examinations, investigations, or consultations not previously reported by you? ❑No ❑Yes (please specify findings and results)
	b) Are further examinations, investigations or consultations contemplated or required? ❑No ❑Yes (please specify)

50

OCF-3

Part 9 Prior and Concurrent Conditions	
	a) Prior to the accident, did the applicant have any disease, condition or injury that affected his/her ability to perform the activities listed in Part 7? ❑No ❑Unknown ❑Yes (please explain) If yes, is the applicant currently receiving any disability benefits for the pre-existing disease, condition or injury? ❑No ❑Unknown ❑Yes (please explain) If you treated the applicant for similar conditions prior to the accident, please describe (include date of onset, any subsequent interventions, and status at the time of the accident).
	b) Since the automobile accident has the applicant developed any disease, condition or injury, not related to the accident, that could affect his/her disability? ❑No ❑Yes (please specify)

51

OCF-3

Part 10 Medications	
	a) Please list any medications (including dosage and frequency) that the applicant is currently taking for injuries related to the automobile accident. Were these medications prescribed by you? ❑No ❑Yes
	b) Please list any medications (including dosage and frequency) that the applicant is currently taking as a result of prior or concurrent conditions identified in Part 9. Were these medications prescribed by you? ❑No ❑Yes

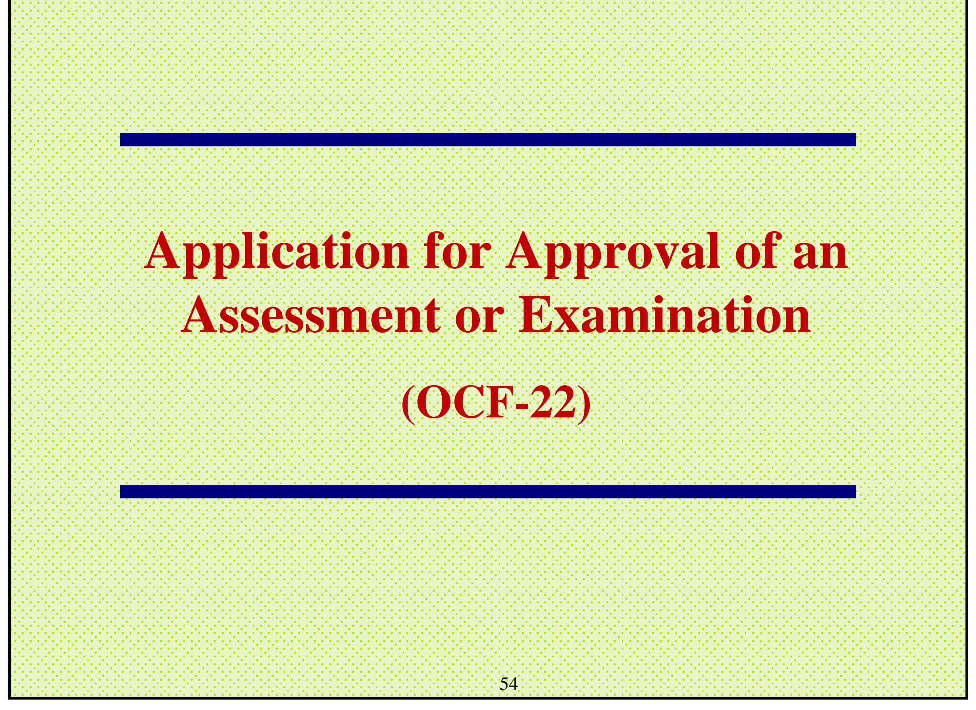
52

OCF-3

Part 11 Signature of Insurer	**Name of Health Practitioner**		**College Registration Number**		**You are a:** ❑ Chiropractor ❑ Dentist ❑ Nurse Practitioner ❑ Occupational Therapist ❑ Optometrist ❑ Physician ❑ Physiotherapist ❑ Psychologist ❑ Speech-Language Pathologist
	Facility Name (if applicable)		AISI Facility Number (if applicable)		
	Address				
	City		Province	Postal Code	
	Telephone Number	Extension	Fax Number		
	Email Address				
	I confirm that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.				
	Name of Health Practitioner (please print)		Signature of Health Practitioner		Date (YYYYMMDD)

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

53



Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

ASSESSMENT APPROVAL (OCF 22/198)

The Approval Process

- Insurer must respond to Assessment Plan in (2) business days if cost is $180 or less
- Insurer must respond to Assessment Plan in five (5) business days if cost is more than $180
- If prior approval is required but not sought, insurer not required to pay and not subject to dispute
- If approval is denied – request for assessment goes to DAC

Thomson Rogers

55

ASSESSMENT APPROVAL (OCF 22/198)

Approval must be obtained prior to an assessment – **except:**

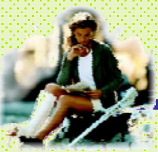
- first 3 assessments to complete a Treatment Plan do not require prior approval if:
  - 1 assessment per provider
  - assessments cost $180 or less

56

Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com



ASSESSMENT APROVAL (OCF 22/198)

- assessment to complete a Form 1
- assessment to complete a disability certificate (provided the cost is less than $180)
- assessment to complete a Treatment Plan if there is an immediate risk of harm from any delay
- assessment to complete an Application for Catastrophic Impairment (provided the claimant is still institutionalized)
- assessment is covered by the PAF
- if there is an immediate risk of harm to the insured or a person under the insured's care

57

Thomson Rogers

Assessments Without Approval

Certain assessments can be completed before insurer approval

• Form 1

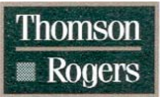
• CAT Application unless hospitalized or in long-term care facility

• where immediate risk of harm to person or dependants makes obtaining approval impractical

- What does this mean?

- If assessment not done, would safe, effective discharge be endangered?

58



Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com

ASSESSMENT APPROVAL (OCF 22/198)

WHEN?

- Assessment approval required for all accidents on or after November 1, 1996

59

OCF-22

Application for Approval of an Assessment or Examination (OCF-22/198)

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

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

OCF-22

OCF-22/198 – Application of Approval of and Assessment or Examination

To the Applicant:
Use this form to request prior approval for payment of an assessment or examination fee for which prior approval is required. Please provide all information requested.
Collection, use and disclosure of this information is subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

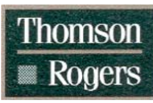
To the Health Professional/Facility: Consent:

It is the responsibility of the health professional/facility to ensure that the collection, use and disclosure of information submitted is authorized by a consent form. Health professionals/facilities should ***use the Ontario Claims Form (OCF – 5)*** *Permission to Disclose Health Information* as a consent form.

OCF-22

Part 1 Applicant Information To be completed by the applicant	Date Of Birth (YYYYMMDD)	Gender ❑ Male ❑ Female	Telephone Number Extension
	Last Name		
	First Name	Middle Name	
	Address		
	City	Province	Postal Code

Part 2 Insurance Company Information To be completed by the applicant	Company Name	City or Town of Branch Office (if applicable)	
	Adjuster Last Name	Adjuster First Name	
	Adjuster Telephone Extension	Adjuster Fax	
	Name of policy holder same as: o Applicant OR	Policy Holder Last Name	Policy Holder First Name

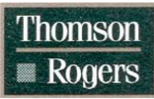


OCF-22

Part 3 Signature of Regulated Health Professional	Name of Regulated Health Professional		College Registration Number		You are a: ❑ Chiropractor ❑ Dentist ❑ Massage Therapist ❑ Nurse Practitioner ❑ Occupational Therapist ❑ Optometrist ❑ Physiotherapist ❑ Psychologist ❑ Speech-Language ❑ Pathologist ❑ Other ❑RN ____
	Facility Name (if applicable)		AISI Facility Number (if applicable)		
	Address				
	City	Province	Postal Code		
	Telephone Number Extension		Fax Number		
	Email Address				
	o I wish to declare that I have no conflicts of interest relating to this form and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this form on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this form, ***or*** o I am declaring the following conflicts of interest relating to this Application:				
	I certify that, to the best of my knowledge, the information in this form is accurate, and the services contemplated are reasonable for the assessment or examination of the applicant. In addition, I confirm that I have obtained the appropriate consent from the applicant for the collection, use and disclosure of information submitted.				
	Name of Regulated Health Professional (please print)		Signature of Regulated Health Professional	Date (YYYYMMDD)	

OCF-22

Part 4 Nature of Assessment or Examination	**Payment for all assessments and examinations is dependent upon approval by the insurer or, if disputed, by a DAC except those assessments and examinations that are payable without insurer approval pursuant to a PAF Guideline. In addition, prior approval for payment of an assessment or examination is not required in some situations as outlined below. Please 3 the appropriate box in the chart below to indicate what situation applies to this application.**



Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

OCF-22

Part 4 Nature of Assessment or Examination	▫ An assessment or examination where an immediate risk of harm to the insured person or a person in the insured person's care makes obtaining the insurer's prior approval of the assessment or examination impractical;

OCF-22

Part 4 Nature of Assessment or Examination	PRIOR APPROVAL IS NOT REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR THE FOLLOWING: ❑ not more than three assessments or examinations if: ▪ the insured person has not received treatment under a *Pre-approved Framework Guideline*, ▪ the cost of each assessment or examination does not exceed $180.00, and ▪ not more than one assessment or examination is done by the same person;

OCF-22

Part 4 Nature of Assessment or Examination	PRIOR APPROVAL IS NOT REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR THE FOLLOWING: ❑ not more than one assessment or examination if: ▪ the insured person has received treatment under a Pre-approved Framework Guideline, ▪ the cost of the assessment or examination does not exceed $180.00, and ▪ the person conducting the assessment or examination did not provide goods or services under a Pre-approved Framework Guideline in respect of the same accident;

OCF-22

Part 4 Nature of Assessment or Examination	PRIOR APPROVAL IS NOT REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR THE FOLLOWING: ❑ an assessment or examination conducted after the insurer notifies the insured person that, before the examination is conducted, it does not require the submission of a Treatment Plan or an application under s. 38.2 of the SABS; ❑ an assessment or examination conducted under the provisions of a Guideline that authorizes the assessment or examination without the prior approval of the insurer.

OCF-22

Part 4 Nature of Assessment or Examination	
	PRIOR APPROVAL IS REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS ❑ all other assessments or examinations to complete Treatment Plans, not outlined above.
	ASSESSMENTS OR EXAMINATIONS TO COMPLETE DISABILITY CERTIFICATES: ❑ Prior approval is not required in respect of an assessment or examination for a disability certificate if the cost of the assessment for the certificate does not exceed $180.00; ❑ Prior approval is required for assessments to complete disability certificates that exceed $180.00. ❑ an assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer.

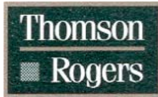
OCF-22

Part 4 Nature of Assessment or Examination	**ASSESSMENTS OR EXAMINATIONS TO PREPARE FORM 1:** ❑ **Prior approval is not required in respect of an assessment or examination for the purposes of preparing a Form 1, but not an assessment or examination relating to an impairment that comes within a Pre-approved Framework Guideline unless the Pre-approved Framework Guideline expressly states that the prior approval of the insurer is not required for the assessment or examination;** ❑ **An assessment or examination conducted under the provisions of a Guideline that authorizes the assessment or examination without the prior approval of the insurer.**

Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com



OCF-22

Part 4 Nature of Assessment or Examination	**ASSESSMENTS OR EXAMINATIONS TO DETERMINE CATASTROPHIC IMPAIRMENT** ❑ Prior approval is not required in respect of an assessment or examination for a determination of catastrophic impairment if the insured person is hospitalized or in a long-term care facility at the time of the assessment or examination. ❑ Prior approval is required in respect of an assessment or examination for a determination of catastrophic impairment if the insured person is not hospitalized or in a long-term care facility at the time of the assessment or examination. ❑ An assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer.
	ALL OTHER ASSESSMENTS OR EXAMINATIONS REQUIRING PRIOR APPROVAL: ❑ All other assessments not outlined above require prior approval.

OCF-22

Part 5 Provisional Clinical Information	a) **Clinical Information:** i) Provide a brief description of the present complaints. ***NOT A DIAGNOSIS*** As per telephone contact with Mr. Client he reports the following: Decreased mobility and balance impacting on ability to do housekeeping activities. Increased right shoulder pain and decreased mobility impacting on his ability to do self care and bathing. ii) Has the applicant already been provided treatment under your care? x No ❑ Yes

OCF-22

Part 5 Provisional Clinical Information	b) **Assessment Information:**
	i) Describe the details of the assessment requested and the rationale for it. • If you have already provided treatment to this applicant, include clinical indicators to substantiate the reasonableness of the proposed assessment. • For multi-disciplinary assessments, include the detail and rationale for each component of the assessment. **Perform an Occupational Therapy Assessment to determine the clients functional abilities, and safety in performing self care and home maintenance activities.** **To determine adaptive aids that the client may benefit from to increase safety and/or independence in activities of daily living.** iii) After making reasonable inquiries, are you aware of a prior assessment of this type completed for this applicant? ❑ No ❑ Yes If yes, provide date if possible (YYYYMMDD)? __________/______/_____

OCF-22

Applicant Name:		OCF-22/198 – FAX BACK	Policy Number:	
Provider Name:			Claim Number:	
Provider Fax:			Date of Accident:	

Part 6 Health Providers	Provider Reference	†Provider Type	Provider		*Regulated (College Registration Number)*	*Unregulated (AISI Number if applicable, or blank)*	Hourly Rate (If applicable)
			Last Name	First Name			
	A	O. T	Jones	Ann	g1223344		100
	B	RA	Smith	Jane		R14422	68
	C						
	D						
	E						
	F						

OCF-22

Part 7 Proposed Goods and Services
This Assessment Plan should include **all goods and services (G/S)** contemplated by the Health Professional/Facility.

G/S Ref	Description	† Code	† Attribute	Provider Ref	Estimated Quantity	† Measure	Total Cost
1	Assessment	7.se.02.AB-2	Home Assessment	A	120	minutes	$240.
2	Other Services	7.sj.30.LD	Detailed Report	A	120	minutes	$240.
3	Travel						
4							
5	Visit #2 Should Treatment Plan signature not be waived		:Home Visit and Travel				

OCF-22

1	Assessment	7.se.02.AB-2	Home Assessment	A	120	minutes	$240.
2	Other Services	7.sj.30.LD	Detailed Report	A	120	minutes	$240.
3							
4							
5							
6							
7							
8							

Note † : Refer to the User Manual coding guidelines posted at www.autoinsurancereforms.on.ca. Attributes codes are used to further qualify the service codes and are described in the manual.
Note + : Payment by auto insurer is secondary to available collateral benefits.

Sub-Total:	
+MOH:	
+Other Insurer 1 + 2:	
GST (if applicable):	
PST (if applicable):	
Auto Insurer Total:	

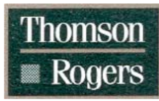
OCF-22

Part 8 Signature of Applicant (Optional) If not completed, the Health Professional in Part 3 assumes responsibility for obtaining applicant's consent	I have reviewed and confirm that the information set out in this form is accurate. I understand that payment for these services may be subject to the approval of the insurer, or if disputed by the insurer, a Designated Assessment Centre. In the event that my insurer disputes the application, I authorize my insurance company and treating health professionals to give the Designated Assessment Centre any information relating to my health condition, treatment and rehabilitation received as a result of the automobile accident, for the purpose of determining my eligibility for benefits. I authorize the Designated Assessment Centre to consult with my treating health professionals if necessary. I also authorize the Designated Assessment Centre to give my insurance company and treating health professionals a copy of its report. Subject to the Statutory Accident Benefits Schedule, in those instances where prior approval is required, I understand that, if I undertake any of the proposed services prior to approval by the insurer or the Designated Assessment Centre, I may be responsible for payment to my provider for any services rendered on my behalf.		
	Name of Applicant or Substitute Decision Maker (please print) Mr. Client	Signature of Applicant or Substitute Decision Maker Verbal Consent Obtained	Date (YYYYMMDD) 2003/10/01

OCF-22

Part 9 Signature of Insurer	❑ *I* waive the requirement for the applicant's signature on a OCF 18 Treatment Plan. *I have reviewed this form and based upon the information provided, I* ❑ Approve ❑ Partially approve (explanation to follow or attached) ❑ Do not approve (explanation to follow or attached) The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 2 business days of receiving the completed form for proposed assessments of $180.00 or less, and within 5 business days when the cost of the proposed assessment is over $180.00: 1. Give the health professional and the applicant notice of the decision. 2. If disputing the application refer the dispute to a Designated Assessment Centre. **Insurer response is required within the timeframes of the SABS or payment for proposed assessment or examination is deemed approved.**		
	Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)

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



Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

Treatment Plan

(OCF-18)

79

THE TREATMENT PLAN (OCF 18)

- Required for insurer approval of treatment (goods and services)
- Not required for claimants in the PAF (unless request for additional goods or services not covered by PAF)

Thomson Rogers

80

THE TREATMENT PLAN (OCF 18)

Obligations on the Health Professional responsible for preparing and supervising the Treatment Plan:

- **secure a consent form signed by the claimant (OCF 5)**
- **Include all goods and services contemplated by the health professional/facility**
- **ensure that there is no other coverage available or identify other coverage**

81

THE TREATMENT PLAN (OCF 18)

- **plan must be certified by Health Practitioner as reasonable and necessary – Occupational Therapists and Speech-Language Pathologists are now "Health Practitioners" and can sign off on Treatment Plans, Social Workers and Registered Massage Therapists cannot**
- **greater obligations to describe injury, sequelae and other relevant health history**
- **explain consequences of releasing health information**
- **identify other insurance**

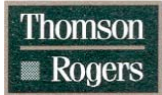
82

Thomson Rogers

Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com



THE TREATMENT PLAN (OCF 18)

- Incurred expenses are payable after 14 days if the insurer has not responded to the Treatment Plan
- Treatment Plan can also be used to obtain insurer approval for assessments (like OCF 22/198)
- If the Treatment Plan is denied – DAC within 5 days after selection of DAC (Insurer selects the DAC, if insured disagrees, FSCO selects the DAC)

83

Treatment Plan (OCF-18)

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

Claim Number:	
Policy Number:	
Date of Accident: (YYYYMMDD)	

For this applicant, this is Treatment Plan number _______ from this health professional/facility

Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com

OCF-18

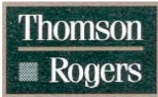
To the Applicant:
Please complete Parts 1 and 2. After your health professional or practitioner has reviewed your Treatment Plan with you, sign Part 13.
Your health professional/practitioner will complete all other parts of the form. **A health practitioner (chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist) must sign Part 5.**
Please provide all information requested.
Collection, use and disclosure of this information is subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

To the Health Professional/Facility:
Consent:
It is the responsibility of the health professional/facility to ensure that the collection, use and disclosure of information submitted are authorized by a consent form. Health professionals/facilities should use the Ontario Claims Form 5 (OCF - 5) *Permission to Disclose Health Information* as a consent form.
To the extent possible, this Treatment Plan should include **all goods and services** contemplated by this health professional/facility for the period of this Treatment Plan.
Note: If this is an impairment that comes within a PAF Guideline, you are required to complete an OCF – 23/198 Pre-approved Framework Treatment Confirmation Form instead of this Treatment Plan Form unless application is being made for additional goods or services not provided under a PAF Guideline.

OCF-18

Part 1 **Applicant Information** To be completed by the applicant	Date Of Birth (YYYYMMDD)	Gender o Male o Female	Telephone Number
	Last Name		
	First Name	Middle Name	
	Address		
	City	Province	Postal Code

Part 2 **Insurance Company Information** To be completed by the applicant	Insurance Company Name	City or Town of Branch Office (if applicable)	
	Adjuster Last Name	Adjuster First Name	
	Adjuster Telephone Extension	Adjuster Fax	
	Name of policy holder same as: o Applicant OR	Policy Holder Last Name	Policy Holder First Name



Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com
David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com
David A. Payne 416-868-3193 dpayne@thomsonrogers.com

OCF-18

Part 3 **Other Insurance Information** To be completed by the health professional responsible for plan preparation and supervision with information from the applicant	**OTHER INSURANCE:** Is there other insurance coverage for any goods and services listed in this Treatment Plan? I have made reasonable enquiries of the applicant and have determined that: ❑**NO** *There is no other insurance coverage identified for these goods and services cover* ❑**YES** *There is other insurance coverage that is potentially available to cover/partially these goods and services.*		
	MOH	Is there Ministry of Health and Long-Term Care (MOH) coverage for any goods and services included in this Treatment Plan? ❑ Yes ❑ No ❑ Not applicable	
	Other Insurer 1	Other Insurer Name	Other Insurance Plan Or Policy Number
		Name of Plan Member	Other Insurer's Identifier
	Other Insurer 2	Other Insurer Name	Other Insurance Plan Or Policy Number
		Name of Plan Member	Other Insurer's Identifier

OCF-18

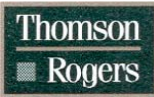
Part 4 **Conflict of Interest Definition**	A person has a conflict of interest relating to a Treatment Plan if, i) the person or a related person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person or another person, of goods or services contemplated by the Treatment Plan, and ii) the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services or under which goods or services of that kind are provided. **Note**: After approving this Treatment Plan, if the insurer determines that there is a conflict of interest that was not disclosed, the insurer may give the applicant notice to amend the Treatment Plan to remove the conflict of interest and if no amendment is made, the insurer is not required to pay for any further expense for which there is the conflict.

OCF-18

<table>
<tr><td rowspan="8">Part 5
Signature of Health Practitioner
Plan Certification</td><td colspan="2">Name of Health Professional</td><td>College Registration Number</td><td rowspan="6">You are a:
❑ Chiropractor
❑ Dentist
❑ Nurse Practitioner
❑ Occupational Therapist
❑ Optometrist
❑ Physician
❑ Physiotherapist
❑ Psychologist
❑ Speech-Language Pathologist</td></tr>
<tr><td colspan="2">Facility Name (if applicable)</td><td>AISI Faculty Number (if applicable)</td></tr>
<tr><td colspan="3">Address</td></tr>
<tr><td>City</td><td>Province</td><td>Postal Code</td></tr>
<tr><td>Telephone Number</td><td>Extension</td><td>Fax Number</td></tr>
<tr><td colspan="3">Email Address</td></tr>
<tr><td colspan="4">❑ I wish to declare that I have no conflicts of interest relating to this Treatment Plan, and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan.
or
❑ I am declaring the following conflicts of interest relating to this Treatment Plan:</td></tr>
<tr><td colspan="4">I confirm that, to the best of my knowledge, the information in this Treatment Plan is accurate, the Treatment Plan has been reviewed with the applicant by the regulated health professional in Part 6, and the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 7.
I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.</td></tr>
<tr><td></td><td colspan="2">Name of Health Practitioner (please print)</td><td>Signature of Health Practitioner</td><td>Date (YYYYMMDD)</td></tr>
</table>

OCF-18

<table>
<tr><td rowspan="8">Part 6
Signature of Regulated Health Professional
Plan Preparation and Supervision
If same person as Part 5 check here o and DO NOT COMPLETE Part 6</td><td colspan="2">Name of Regulated Health Professional</td><td>Registration Number</td><td rowspan="6">You are a:
❑ Chiropractor
❑ Dentist
❑ Massage Therapist
❑ Nurse
❑ Occupational Therapist
❑ Optometrist
❑ Physician
❑ Physiotherapist
❑ Psychologist
❑ Speech-Language Pathologist
❑ Other ____________</td></tr>
<tr><td colspan="2">Facility Name (if applicable)</td><td>AISI Faculty Number (if applicable)</td></tr>
<tr><td colspan="3">Address</td></tr>
<tr><td>City</td><td>Province</td><td>Postal Code</td></tr>
<tr><td>Telephone Number</td><td>Extension</td><td>Fax Number</td></tr>
<tr><td colspan="3">Email Address</td></tr>
<tr><td colspan="4">❑ I wish to declare that I have no conflicts of interest relating to this Treatment Plan, and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan.
or
❑ I am declaring the following conflicts of interest relating to this Treatment Plan:</td></tr>
<tr><td colspan="4">I confirm that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.</td></tr>
<tr><td></td><td colspan="2">Name of Regulated Health Practitioner (please print)</td><td>Signature of Regulated Health Practitioner</td><td>Date (YYYYMMDD)</td></tr>
</table>

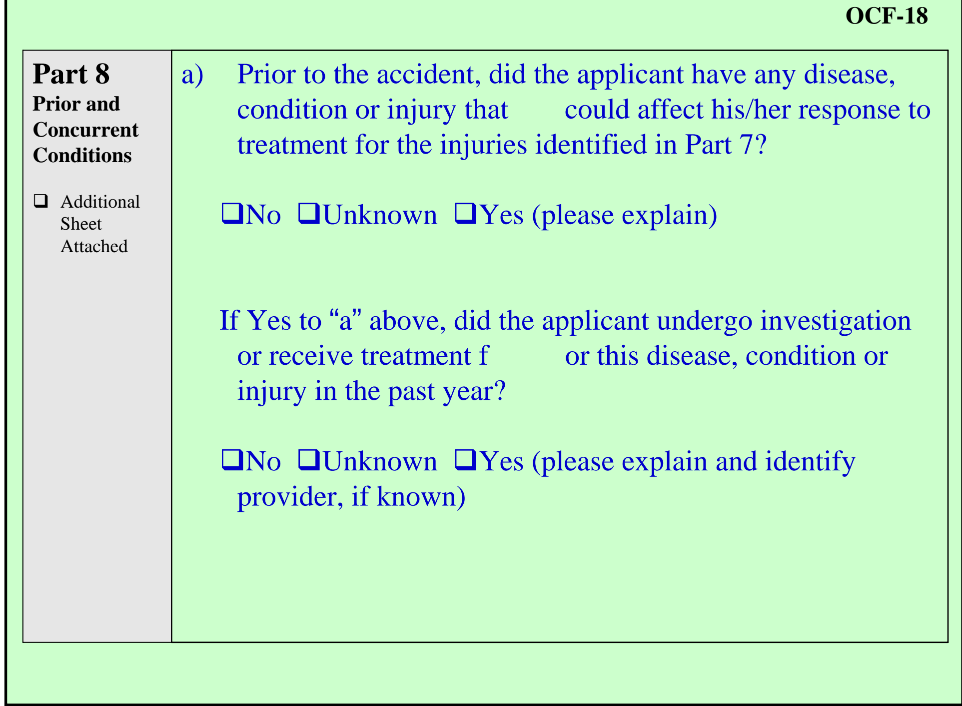


Craig L. Brown | David R. Tenszen | David A. Payne
416-868-3163 | 416-868-3210 | 416-868-3193
cbrown@thomsonrogers.com | dtenszen@thomsonrogers.com | dpayne@thomsonrogers.com

OCF-18

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

Part 7 Injury and Sequelae Information	Provide a description (list most significant first) and associated ICD-10-CA+ code for injuries and sequelae that are the direct result of the automobile accident.	
	Description	**Code**
	CODES CURRENTLY ON BACK OF TREATMENT PLAN	
	Note †: Refer to the User manual at www.autoinsurancereforms.on.ca for ICD-10-CA coding information.	


OCF-18

Part 8
Prior and Concurrent Conditions

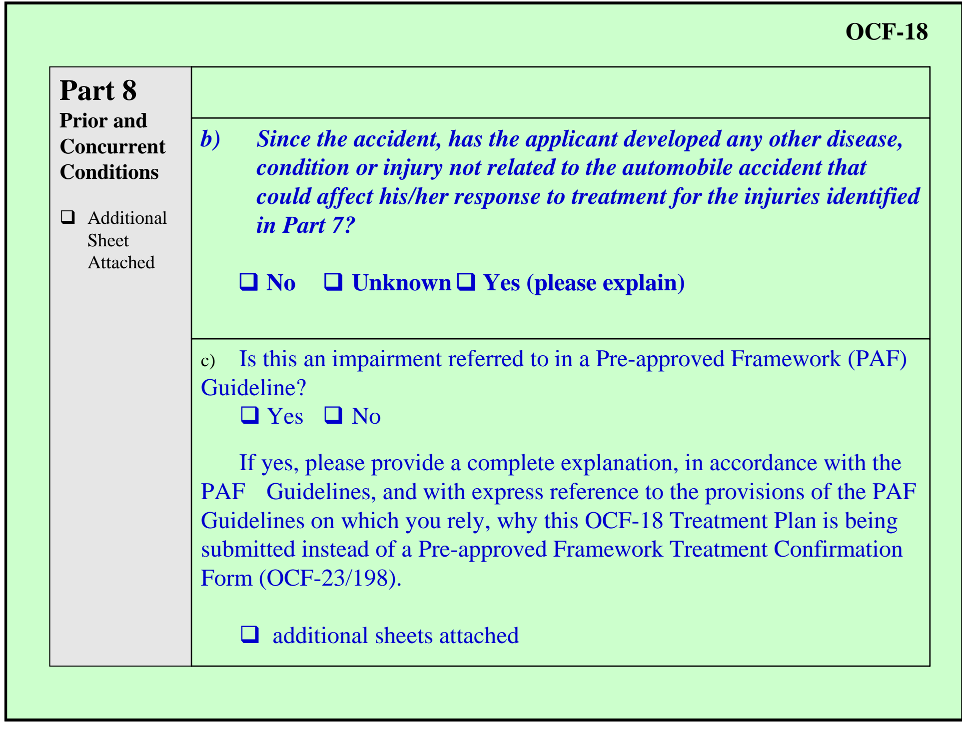
❑ Additional Sheet Attached

a) Prior to the accident, did the applicant have any disease, condition or injury that could affect his/her response to treatment for the injuries identified in Part 7?

❑No ❑Unknown ❑Yes (please explain)

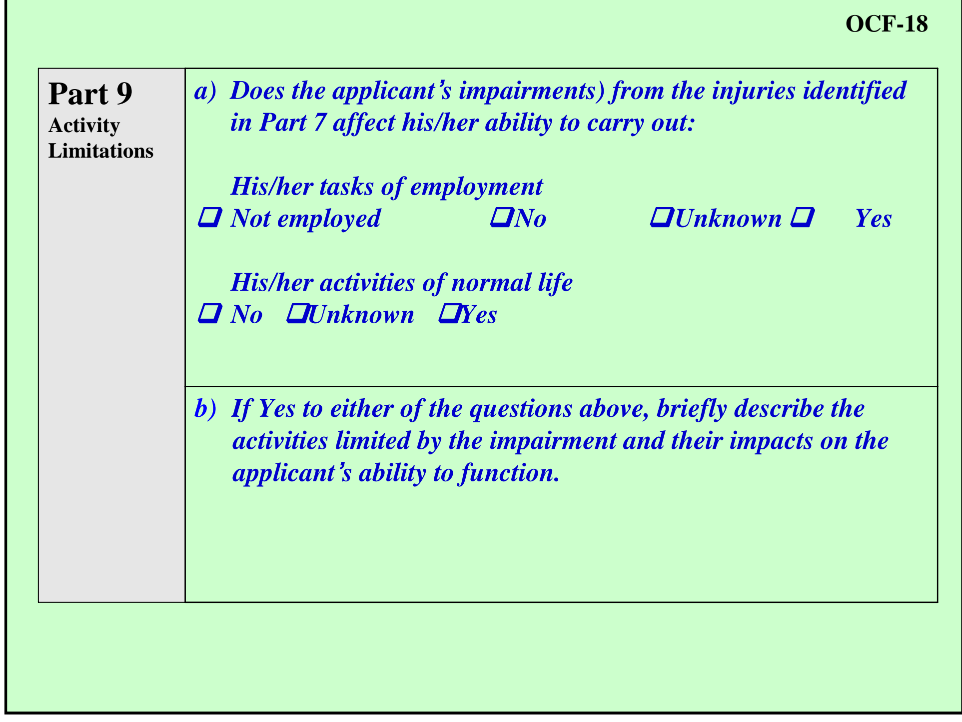
If Yes to “a” above, did the applicant undergo investigation or receive treatment f or this disease, condition or injury in the past year?

❑No ❑Unknown ❑Yes (please explain and identify provider, if known)



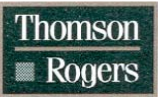
OCF-18

Part 8 **Prior and Concurrent Conditions** ❑ Additional Sheet Attached	
	b) Since the accident, has the applicant developed any other disease, condition or injury not related to the automobile accident that could affect his/her response to treatment for the injuries identified in Part 7? **❑ No ❑ Unknown ❑ Yes (please explain)**
	c) Is this an impairment referred to in a Pre-approved Framework (PAF) Guideline? ❑ Yes ❑ No If yes, please provide a complete explanation, in accordance with the PAF Guidelines, and with express reference to the provisions of the PAF Guidelines on which you rely, why this OCF-18 Treatment Plan is being submitted instead of a Pre-approved Framework Treatment Confirmation Form (OCF-23/198). ❑ additional sheets attached



OCF-18

Part 9 **Activity Limitations**	***a) Does the applicant's impairments) from the injuries identified in Part 7 affect his/her ability to carry out:*** ***His/her tasks of employment*** ***❑ Not employed ❑No ❑Unknown ❑ Yes*** ***His/her activities of normal life*** ***❑ No ❑Unknown ❑Yes***
	b) If Yes to either of the questions above, briefly describe the activities limited by the impairment and their impacts on the applicant's ability to function.



Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

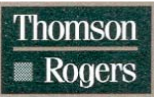
David A. Payne
416-868-3193
dpayne@thomsonrogers.com

OCF-18

Part 9 Activity Limitations	**c) If the applicant is unable to carry out pre-accident employment activity, is the employer able to provide suitable modified employment to the applicant?** ❑Not employed ❑Yes ❑Unknown ❑No (please explain) **Opportunity to put this on the OCF 22 as part of our assessment as appropriate, or this would be part of the plan.**

OCF-18

Part 10 Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery	**a) Goals:** **(i) Identify the goal(s) in regard to the applicant's impairment(s), symptom(s) or pathology that this Treatment Plan seeks to achieve:** ❑ pain reduction ❑ increased range of motion ❑ increase in strength and Others **(ii) Select the functional goal(s) that this Treatment Plan seeks to achieve:** ❑ return to activities of normal living ❑ return to pre-accident work activities ❑return to modified work activities X other(s) *Establish Vocational Direction *Establish Return to Work Plan *Establish Unpaid Work Trial



Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

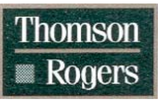
David A. Payne
416-868-3193
dpayne@thomsonrogers.com

OCF-18

Part 10 Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery	**b) Evaluation:** (i) How will progress on the goal(s) in a (i) and a (ii) be evaluated? X Completed Vocational Direction X Resume Completed X Work Trial Completed X Observation and Demonstration of specific activity (ii) If this is a subsequent Treatment Plan, what was the applicant's improvement at the end of the previous plan based on your evaluation method? ❑ additional sheets attached

OCF-18

Part 10 Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery	**Barriers to recovery:** (i) Have you identified any other barriers to recovery? ❑No ❑Yes (please explain) Fear of Driving (ii) Do you have any recommendations and/or strategies to overcome these barriers? ❑No ❑Yes (please explain) Desensitization Program which includes use of psychologist and in car training.



Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com

OCF-18

Part 10
Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery

d) Concurrent Treatment:

Are you aware if any concurrent treatment, that is not included in this Treatment Plan, will be provided by any other provider/facility?

❑No ❑Yes (please explain)

e) Consistency:

Are there any utilization guidelines applicable to the proposed treatment?

❑ Yes (Identify guideline):
❑ No (Please explain):

OCF-18

Applicant Name:		INSURER FAX BACK	Claim Number:	
Policy Number:			Date of Accident:	

Part 11 Health Providers	Provider Reference	†Provider Type	Provider		Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate (If applicable)
			Last Name	First Name			
	A	O.T.	Kay	Mary	0000001		100.00
	B	O.T.	Doe	Jane	000012		100.00
	C	CM	Smith	Elaine		RHH234	100.00
	D	RA	Jones	Pat		OTH444	68.00
	E						
	F						

Part 12 **Proposed Goods and Services** **OCF-18**

To the extent possible, this Treatment Plan should include **all goods and services (G/S)** contemplated by the Health Professional/Facility for the period of this Treatment Plan.

G/S Ref	Description	† Code	† Attribute	Provider Ref	Estimate / Day			Projected	
					Quantity	† Measure	Cost	Total Count	Total Cost
1	Case Management	7.SF.15		C	90	Minutes	150.	4	600
2	Training Motor Functions	6.va.50	O.T. Services	A or B	120	Minutes	200.	5	1000
3	Travel				90 to 120	Minutes	150. To200.	6	900. to 1200.
4	Other Services	7.SJ.30.LD	Detailed Report	C	120 to 180	Minutes	200 to 300	1	300
5	Reassessment	RNA	Rehabilitation Needs Assessment	C	90	Minutes	150	1	150
6	Mileage, Planning, Consultation								

Estimated duration of this Treatment Plan:	weeks	Sub-Total:	
How many treatment visits have you already provided:	visits	- Minus MOH:	
		- Minus Other Insurer 1 + 2:	
		GST (if applicable):	
		PST (if applicable):	
		Auto Insurer Total:	

Note †: Refer to the User Manual coding guidelines posted at www.autoinsurancereforms.on.ca.
Attributes codes are used to further qualify the service codes and are described in the manual.

Note -: Payment by auto insurer is secondary to available collateral benefits.

Please indicate any additional comments regarding proposed goods and services:

❑ additional sheets attached

OCF-18

Part 13
Signature of Applicant
Must be completed unless waived by insurer

I have reviewed and agree with this Treatment Plan. I understand that payment for this Treatment Plan is subject to the approval of the insurer. **In the event that the Treatment Plan is disputed by my insurer I understand that I will have 5 business days to respond in writing if I wish to withdraw this Treatment Plan. If I wish to proceed, a Designated Assessment Centre shall be selected in the manner set out in the Statutory Accident Benefits Schedule. Once a Designated Assessment Centre has been selected, the insurer has 5 business days to arrange for the assessment.**

I authorize my insurance company and treating health professionals to give the Designated Assessment Centre any information relating to my health condition, treatment and rehabilitation received as a result of the automobile accident, for the purpose of determining my eligibility for benefits.

I authorize the Designated Assessment Centre to consult with my treating health professionals if necessary.

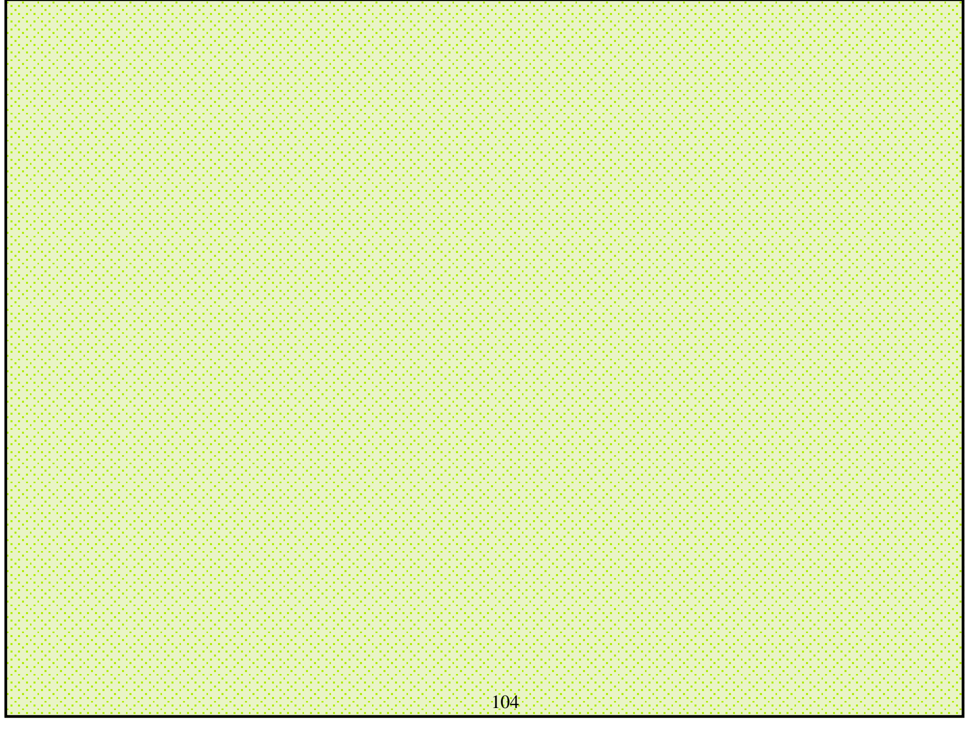
I also authorize the Designated Assessment Centre to give my insurance company and treating health professionals a copy of its report. Subject to the Statutory Accident Benefits Schedule, I understand that, if I undertake any of the proposed treatments prior to the approval of this Treatment Plan by the insurer or the Designated Assessment Centre, I may be responsible for payment to my provider for any services rendered on my behalf.

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

OCF-18

Part 14 **Signature of Insurer**	o **I waive the requirement for the Applicant's signature.** I have reviewed this Treatment Plan and based upon the information provided, I: o Approve the Treatment Plan o Partially approve (explanation attached) o Do not approve (explanation attached) The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 14 days of receiving the completed application (within 5 business days if the insurer rejects the Treatment Plan on the basis that a PAF Guideline applies) give the applicant notice of their decision on the Treatment Plan.		
	Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)
	To the insurer: Please provide a copy of this page to the applicant, the Health Practitioner indicated in Part 5 and the Regulated Health Professional, if applicable, indicated in Part 6.		

Note: The fee for completing this certificate is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly. The Health Practitioner will contact each of the health professionals listed in Part 11 and provide details of the services and other charges that have been approved and are payable under this Treatment Plan.



BILL 198

COPING WITH INCREASED DELAY

105

Causes of Increased Delay

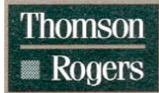
- 7 Day Notice otherwise 45 Days from A/B Application
- A/B Application Must be Complete
- Examination under Oath
  - Scheduling and Reporting
- OCF 22 Approval
- OCF 18 Approval
- Increased DAC Involvement

106

Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com



Solutions to Delay

1) Notice on time, confirm in writing to proper insurer
2) Call insurer and lawyer to prompt quick intervention
3) Acute centre recommends Assessments
4) Acute center notes concerns re: "immediate risk of harm to injured person or family" or urgency or safety concerns
5) Acute centre notes urgency re: pending discharge
6) Put recommendation for Assessments in Quasi Treatment Plan
7) List types of disciplines required in Treatment Plan
8) Examination under Oath – not if physically or mentally incapable

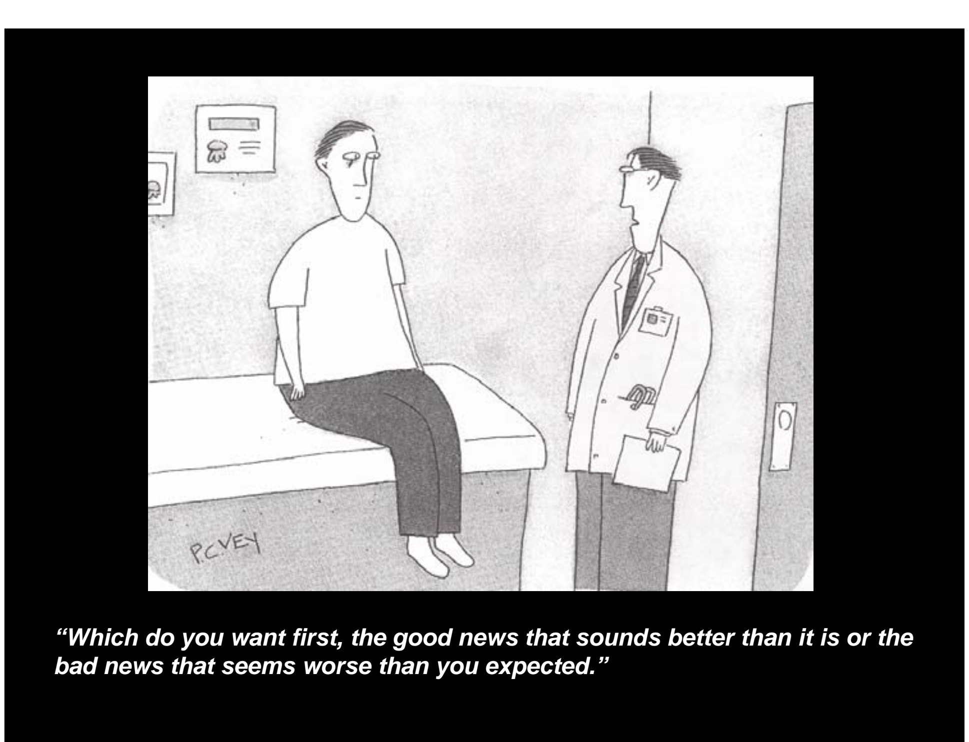
Thomson Rogers

107

108

CHANGES TO THE DEFINITION OF CATASTROPHIC IMPAIRMENT

109

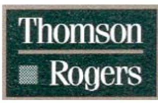


"Which do you want first, the good news that sounds better than it is or the bad news that seems worse than you expected."

Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com



Catastrophic

"Catastrophic Impairment" means,

OLD	NEW
(a) Paraplegia or quadriplegia	same
(b) Amputation or other impairment causing the total and permanent loss of use of both arms,	Amputation or other impairment causing the total and permanent loss of use of both arms **or both legs;**
(c) Amputation or other impairment causing the total and permanent loss of use of both an arm and a leg,	Amputation or other impairment causing the total and permanent loss of use of **one or both arms** and **one or both legs;**
(d) Total loss of vision in both eyes,	same

111

Catastrophic cont'd

"Catastrophic Impairment" means,

OLD	NEW
(e) **Brain impairment that, in respect of an accident, results in,** i. a score of 9 or less on the Glasgow Coma Scale, as published in Jennett, B. and Teasdale, G., *Management of Head Injuries,* Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or	same
ii. a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage,* Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose,	same

112

Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

Catastrophic cont'd

"Catastrophic Impairment" means,

OLD	NEW
(f) Subject to subsection (2) and (3), any impairment or combination of impairments that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* 4th edition, 1993, results in 55 per cent or more impairment of the whole person, or	same

113

Catastrophic cont'd

"Catastrophic Impairment" means,

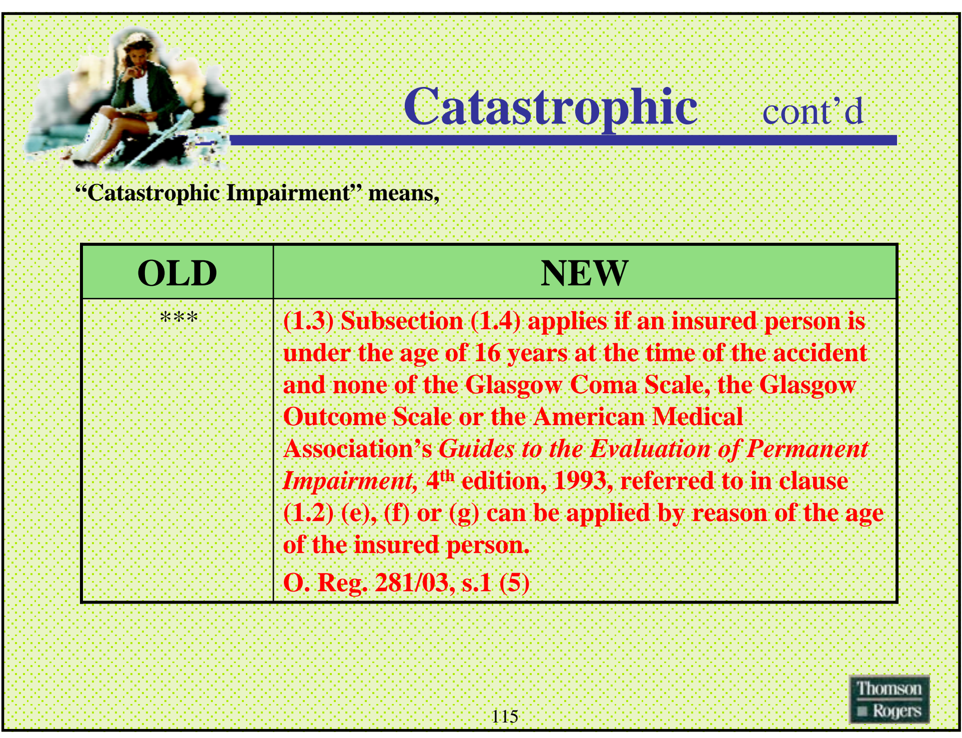
OLD	NEW
(g) Subject to subsection (2) and (3), any impairment or combination of impairments that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder; ("deficience invalidante")	same

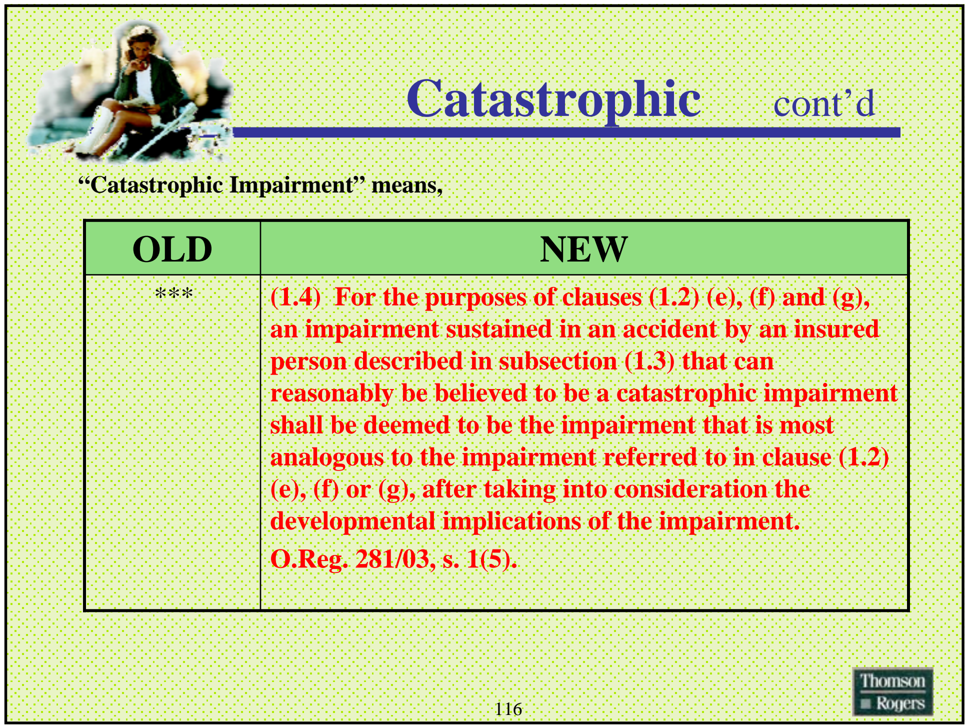
114

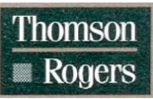
Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com







Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

Catastrophic cont'd

(2) Clauses (f) and (g) of the definition of "catastrophic impairment" in subsection (1) do not apply in respect of an insured person who sustains an impairment as a result of an accident unless,

OLD	NEW
(a) the insured person's health practitioner states in writing that the insured person's condition has stabilized and is not likely to improve with treatment; or	(a) the insured person's health practitioner states in writing that the insured person's condition is **unlikely to cease to be a catastrophic impairment**; or
(b) three years have elapsed since the accident. O. Reg. 403/96, s. 2(2)	(b) 2 years have elapsed since the accident. O. Reg. 281/03, s 1(7).

117

Catastrophic cont'd

"Catastrophic Impairment" means,

OLD	NEW
(3) For the purposes of clauses (f) and (g) of the definition of "catastrophic impairment" in subsection (1), an impairment that is sustained by an insured person but is not listed in the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993 shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.	same

118

CHANGES TO CLAIMS AGAINST THE AT FAULT PARTY

119

CHANGES TO DEDUCTIBLES

- from $15,00 to $30,000 for pain and suffering awards
- from $7,500 to $15,000 for family claims
- No deductible for pain and suffering > $100,000
- No deductible for family claims > $50,000

Thomson Rogers

120

Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com

RECOVERY OF HEALTH CARE EXPENSES

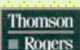
ALL INJURED PERSONS WHO MEET THRESHOLD MAY NOW SUE FOR HEALTH CARE EXPENSES

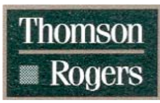
121

DEFINING THE VERBAL THRESHOLD

4.1 For the purpose of section 267.5 of the Act **"permanent serious impairment of an important physical, mental or psychological function"** means impairment of a person that meets the criteria set out in section 4.2.

122





Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com

TORT CLAIM

4.2(I) A person suffers from permanent serious impairment of an important physical mental or psychological function if **all of the following criteria are met [highlighting added]:**

123

IMPAIRMENT

1. The *impairment* must,

i. substantially interfere with the person's ability to continue his or her employment, despite reasonable efforts to accommodate the person's impairment to allow the person to continue employment (but subject to the person making reasonable efforts to use the accommodation of his or her impairment to allow the person to continue his or her employment)

124

Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com

IMPAIRMENT

ii. **substantially interfere with the person's ability to continue training for a career in a field in which the person *<u>was being trained before the incident,</u>* despite reasonable efforts to accommodate the person's impairment to allow the person to continue his or her career training, (but subject to the person making reasonable efforts to use the accommodation of his or her impairment to allow the person to continue his or her training) <u>or</u>**

125

IMPAIRMENT

iii. **substantially interfere with most of the usual activities of daily living, considering the person's age.**

126

IMPORTANT FUNCTION

2. For the function that is impaired to be an *important function* of the impaired person, the function must:,

i. be necessary to perform the activities that are essential of the person's regular or usual employment, taking into account reasonable efforts to accommodate the person's impairment to allow the person to continue employment, (but subject to the person making reasonable efforts to use the accommodation of his or her impairment to allow the person to continue his or her employment.

127

IMPORTANT FUNCTION

ii. be necessary to perform the activities that are essential tasks of the person's training for a career in a field which the person was being trained before the incident, taking into account reasonable efforts to accommodate the person's impairment to allow the person to continue his or her career training, (but subject to the person making reasonable efforts to use the accommodation of his or her impairment to allow the person to continue his or her training)

128

iii. be necessary for the person to provide for his or her own care or well being <u>or</u>

129

iv. be important to the usual activities of daily living considering the person's age.

130

PERMANENT

3. For the impairment to be *permanent*, the impairment must:,

i. have been continuous since the accident and must, based on medical evidence and subject to the person reasonably participating in the recommended treatment of the impairment be expected not to substantially improve.

131

PERMANENT

ii. continue to meet the criteria in paragraph 1, and

132

Craig L. Brown 416-868-3163 cbrown@thomsonrogers.com

David R. Tenszen 416-868-3210 dtenszen@thomsonrogers.com

David A. Payne 416-868-3193 dpayne@thomsonrogers.com

PERMANENT

iii. be of a nature that is expected to continue without substantial improvement when sustained by persons in similar circumstances.

133

PASSING THE VERBAL THRESHOLD – REQUIRED PROOF

134

43. (1) a person shall in addition to any other evidence, adduce the evidence set out in this section to support the person's claim that he or she has sustained permanent serious impairment of an important physical mental or psychological function for the purposes of section 267.5 of the Act.

135

(2) the person shall adduce evidence of one or more physician in accordance with this section, that explains,

a) the nature of the impairment;
b) the permanence of the impairment;
c) the specific function that is impaired; and
d) the importance of the specific function to the person.

136

Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

David A. Payne
416-868-3193
dpayne@thomsonrogers.com

(3) The evidence of the physician,

a) shall be adduced by a physician who is trained for and experienced in the assessment or treatment of the type of impairment that is alleged; and

b) shall be based on medical evidence, in accordance with generally accepted guidelines or standards of the practice of medicine.

Thomson Rogers

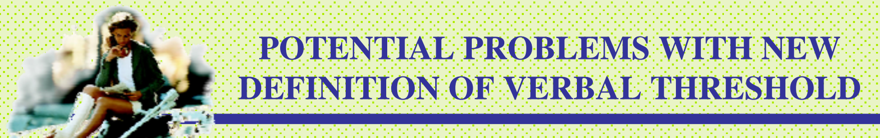
137

(4) The evidence of the physician shall include a conclusion that the impairment is directly or indirectly sustained as the result of the use or operation of an automobile.

138

(5) In addition to the evidence of the physician the person shall adduce evidence that corroborates the change in the function that is alleged to be a permanent serious impairment of an important physical mental or psychological function.

139



POTENTIAL PROBLEMS WITH NEW DEFINITION OF VERBAL THRESHOLD

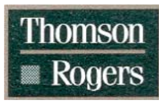
•Needs to be tested in court

•Brings less certainty

•More restrictive, to detriment of innocent injured persons

•Not responsive to insurance problem

140



Craig L. Brown
416-868-3163
cbrown@thomsonrogers.com

David R. Tenszen
416-868-3210
dtenszen@thomsonrogers.com

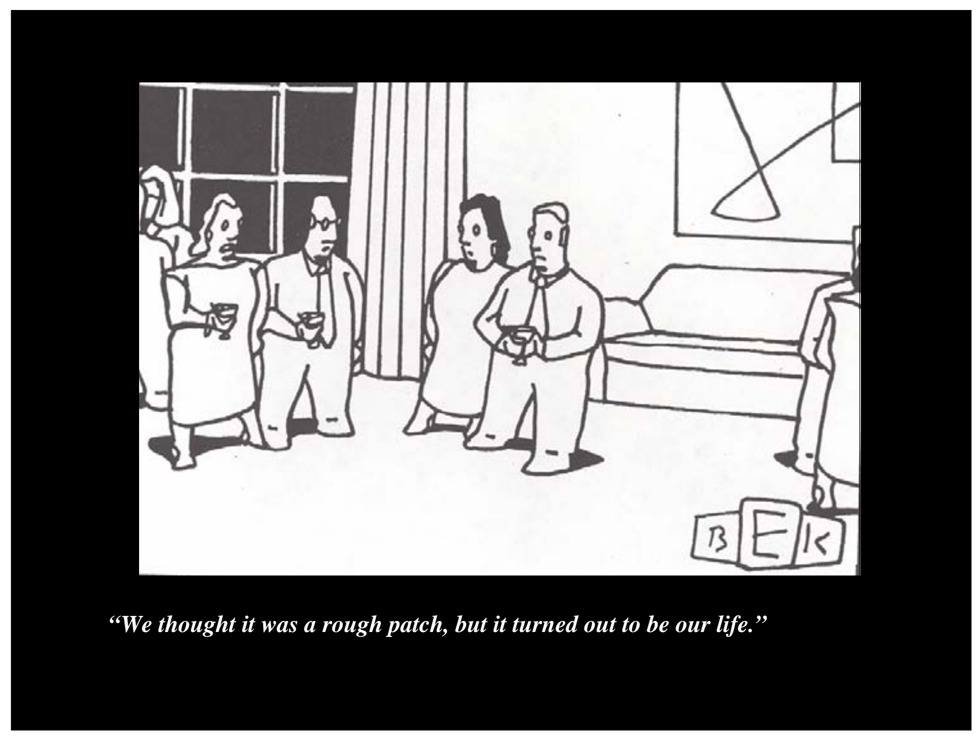
David A. Payne
416-868-3193
dpayne@thomsonrogers.com

WHAT HAPPENS WHEN?

AS OF OCTOBER 1, 2003 BUT RETROACTIVE TO NOVEMBER 1, 1996:

- Assessment Approvals (OCF-22)
- Treatment Plans (OCF-18)
- Disability Certificates (OCF-3)

141



"We thought it was a rough patch, but it turned out to be our life."

Thank You
143