

The background of the slide is a sepia-toned map with a compass rose in the upper left corner. The map shows a coastline with the label 'CAPE SABLE' visible. The compass rose has markings for 'N', 'SE', '120', '140', and '160'.

## **SOLUTIONS FOR ASSISTING INJURED PERSONS UNDER THE NEW REGULATIONS**

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March 31, 2006

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## **OVERVIEW OF S.42 EXAMINATIONS**

## OVERVIEW – IMPORTANT CHANGES

- elimination of DACS replaced by Sec. 42 Insurer Examinations
- responding assessment or examination 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. 42 EXAMINATIONS

To assist insurer in determining whether a person is entitled or continues to be 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

- insurer must provide notice of Sec. 42 request, with details including reasons for examination
- insured must provide “All reasonably available information and documents that are relevant and necessary within 5 days after notice of examination received
- can be paper review of material requested or personal examination
- if paper review, referral must be made within 2 business days of notice
- if personal examination, referral must be made within 5 business days

## SEC. 42 EXAMINATIONS

- personal examination to be completed within 10 business days or within 30 business days for catastrophic determination
- treating providers and assessors may consult - insurer pays
- report to be provided to insurer within 10 business days of examination or 5 business days if no personal examination or within 10 business days of catastrophic review



## **Questions & Comments**



## **SPECIFIED AND MEDICAL/REHABILITATION BENEFITS - S. 35 & S.38**

## 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
- if insurer requests Sec. 42 report, insurer has 30 business days to conduct assessment and evaluator has 10 business days to deliver report to insurer

## SEC. 35 SPECIFIED BENEFITS

- insurer can request new disability certificate and examination “as often as reasonably necessary” 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**

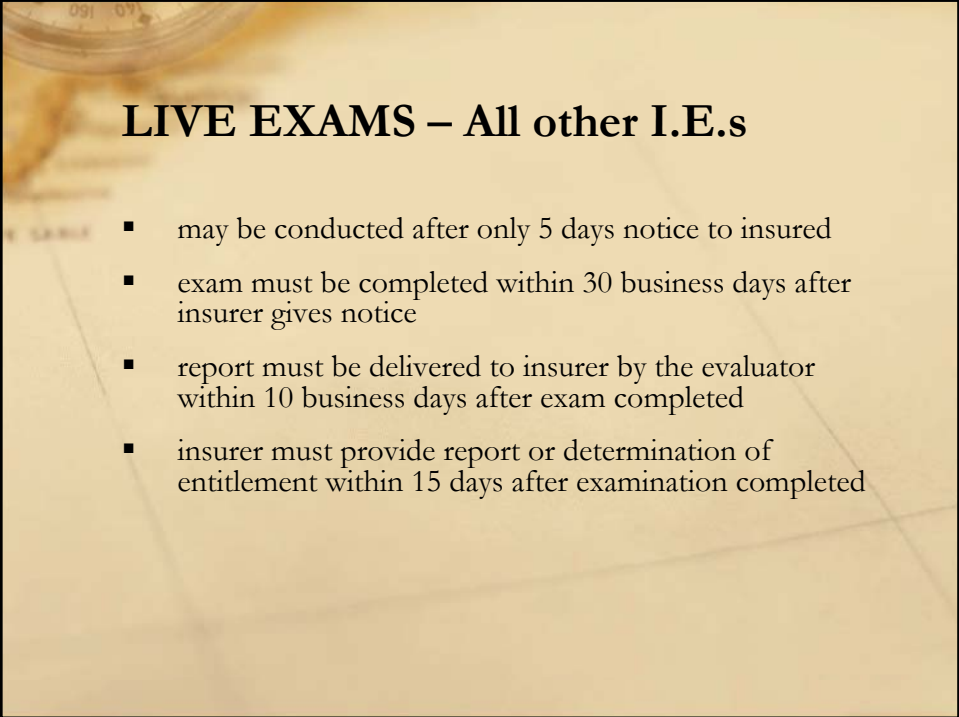
- social workers can now prepare treatment plans and OCF 22 forms (Application for Approval of Assessments or Examinations)
- insurer must give notice of determination within 10 business days indicating which goods and services it will agree to pay or not pay and request a Sec. 42 exam
- if notice not given within 10 days – insurer must pay from 11<sup>th</sup> day onward until notice is provided

## **TIMELINES FOR SEC. 42 I.E.s**

- counting from the day the Sec. 42 notice is given to the insured, the exam must be completed and the report given to the insurer:

### **Paper Review**

- PAF – 5 business days
- OCF 22 – 5 business days
- CAT (only GSC of 9) - 10 business days after all necessary documents are made available

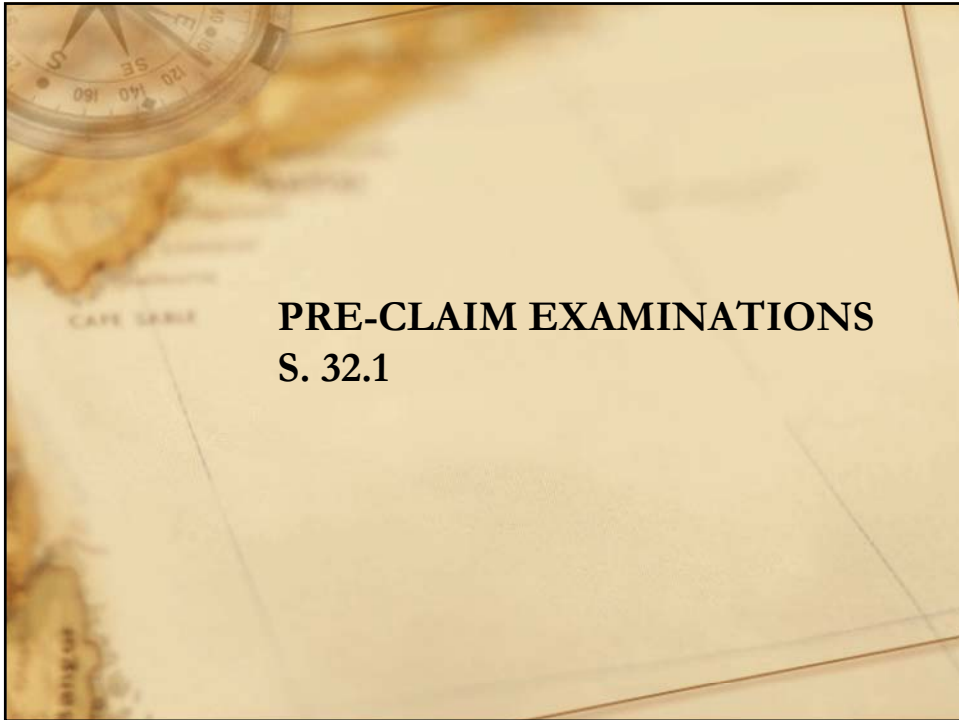


## **LIVE EXAMS – All other I.E.s**

- may be conducted after only 5 days notice to insured
- exam must be completed within 30 business days after insurer gives notice
- report must be delivered to insurer by the evaluator within 10 business days after exam completed
- insurer must provide report or determination of entitlement within 15 days after examination completed



## **Questions & Comments**



## **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
- written consent of insured required
- 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





## **SEC 32.1 PRE-CLAIM EXAMINATIONS RECOMMENDATIONS**

- avoid pre-claim examinations as they are of little benefit to the insured since insurer has no obligation to follow recommendations of the assessment
- underscores importance of getting legal counsel involved as early as possible to ensure:
  - application for A/B's completed as quickly as possible;
  - occupational therapist becomes involved, who should complete Form 1 & in-home Assessment as soon as possible;
  - case manager should be appointed, who hospital team & counsel are content with, to assist in creating a treatment team



**Questions & Comments**



## **OVERVIEW OF CHANGES TO ATTENDANT CARE**



## **ATTENDANT CARE**

### **Attendant care process:**

- no requirement for assessment pre-approval (24(1)6.)
- treating OT does Form 1 and narrative report
- insurer has 10 business days to agree
- if denies any portion, must arrange s. 42 exam and
  - must pay amount on Form 1 until s. 42 report received by insurer
  - must be in person s. 42 evaluation

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## ATTENDANT CARE

Form 1 should only show “need”, not how needs met.

If Form 1 deducts for services being provided>>>

- may be an unfair and deceptive act or practice, since it may be an:

“examination that does not comply with the requirements of the regulations”

- see our A.C. presentation at [www.thomsonrogers.com](http://www.thomsonrogers.com)

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## Questions & Comments