



ONTARIO  
PSYCHOLOGICAL  
ASSOCIATION

**Ontario Psychological Association  
Submission for the Three-Year Review of Auto Insurance  
March 31, 2014**

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## **EXECUTIVE SUMMARY:**

### Issues:

The Ontario Psychological Association (OPA) Auto Insurance Task Force has advocated for fair access to adequate benefits for accident victims with psychological disorders including brain injuries since 1989. We are very aware of the need for affordable auto insurance when considering provision of services to accident victims. Our primary focus in these comments is regarding accident victims with mental and behavioural disorders and brain injuries.

We encourage FSCO to consider the role of accident benefits as an investment in the rehabilitation of Ontario citizens. We appreciate and support initiatives to reduce fraud and waste and control costs. However, there is a need to be mindful and ensure that the cost control measures do not create excessive/unfair barriers to access to services for accident victims. In addition to being the right thing to do, the evidence supports that providing timely, appropriate assessment/treatment/rehabilitation to individuals with mental and behavioural disorders is cost effective.

In 2014, we need to emphasize that there truly can be “no health without mental health”. Psychologists have the expertise and experience to diagnose and treat the “invisible” injuries, the psychological/mental and behavioural impairments/disorders/conditions that can be as persistently debilitating as traumatic amputation or paralysis. The complexity of these conditions requires exceptional training and skill. (*Note: throughout the rest of this document we will refer to these as mental and behavioural disorders.*)

### Role of Psychology:

Psychologists (including neuropsychologists) are the health professionals with the highest level of expertise in diagnosing and treating accident victims with mental and behavioural disorders including cognitive impairments. Too often, as is seen in other health sectors, patients with mental disorders and brain injuries face lack of awareness of their needs, stigma, and lack of funding for treatment and rehabilitation. Delays and denials of timely treatment and rehabilitation needed to reduce impairments and restore function harm the individual patient and their family. These delays also shift costs to public health and social systems and result in lost productivity.

### Role of OPA:

For the past two decades, the OPA has provided a resource to psychologists, insurers and policy makers and the public. This includes education regarding mental and behavioural disorders and brain injuries. OPA also provides continuing education to psychologists regarding the requirements, structure, and protocols of the auto insurance system.

### Key Points:

#### *Provision of evidenced based psychological services contributes to affordable auto insurance:*

We are mindful of the public need for affordable auto insurance. Evidence-based psychological services are cost effective. In fact research shows that the cost is offset by reducing the need for other services. In addition psychological treatment reduces the load on physicians as well as other OHIP and publically funded services. Psychological treatment also restores function, reducing disability costs for the individual and society. The OPA has published evidence-based assessment and treatment guidelines. (See Attached)

*Mental and behavioural disorders and brain injuries are never “Minor Injuries”:*

Mental and behavioural disorders are not determined by the severity of the physical injury. They are a source of significant, often persistent disability and require adequate, timely treatment. These contrast with “psycho-social issues” (as referenced in the MIG) which are transient, do not limit function, and may present as part of a “minor” physical injury. Current data from HCAI is consistent with ongoing documentation that only a very small proportion of accident victims have incurred diagnosed mental and behavioural disorders.

*Psychological disorders and brain injuries can have “catastrophic” consequences for the individual:*

For determination of catastrophic impairment it is critical to acknowledge that mental and behavioural disorders may “significantly impede useful functioning”, which is the criterion for catastrophic impairment determination. All individuals who have sustained injuries/disorders that result in impairments of “catastrophic” severity require access to the highest level of funding regardless of whether the disorder is bodily, mental and behavioural or a combination of these. It would be discriminatory to make changes to the catastrophic impairment criteria that would require an even higher level of impairment for those with impairments due to mental and behavioral disorder than for those with impairments due to physical disorders.

*Psychologists have the highest level and most relevant expertise to diagnose and rate these disorders:*

Therefore, it makes no sense that they were excluded (2010 SABS) from confirming catastrophic impairments due to mental and behavioural disorders after 14 years carrying out this professional responsibility. Requiring a physician to adduce evidence (Insurance Act, Definition of Permanent and Serious Impairment) regarding serious and permanent mental and psychological impairment also adds unnecessary costs to the system, and in some cases may interfere with settlement.

*We support initiatives to further reduce accident benefit costs, and address fraud and waste:*

However, these initiatives must be targeted and minimize risk of further harm to accident victims with mental and behavioural disorders who are already vulnerable to under-identification and under-treatment. The soon to be implemented health facility licensing will provide an additional tool. This will help to address business practices of both health care and IE facilities. We support the need to look at other sectors such as the towing industry from a similar perspective. Together with other stakeholders we are working to further develop the HCAI system to provide timely, relevant and accessible data regarding costs of the system, increasing transparency to all. Standardized and detailed reporting to accident victims regarding expenditures will bring greater accountability.

## **ASSESSMENT AND TREATMENT OF ACCIDENT VICTIMS WITH MENTAL AND BEHAVIOURAL DISORDERS**

### SABS include benefits for treatment of impairments due to psychological disorders

The Statutory Accident Benefit System (SABS) acknowledges impairments due to psychological conditions and provides payment for services to reduce these impairments and restore function. A small proportion of accident victims develop mental and behavioural disorders. The development of these mental and behavioural disorders is independent of the degree of physical injury and may cause greater impairment/functional limitations and disability than the physical injury. (See attached)

### Barriers to access for accident victims with psychological disorders

In spite of inclusion in the SABS, accident victims with impairments due to mental and behavioural disorders face many of the same barriers to accessing appropriate and timely care as in other contexts: the focus is on the treatment of the physical condition; there continues to be social stigma; lack of awareness on the part of the public and health professional communities; as well as relatively few treatment resources. The disproportionate under-

treatment of mental and behavioural disorders is documented in *Disability and Treatment of Specific Mental and Physical Disorders*, Ormel, Petukhova, Von Korff, and Kessler, *Global Perspectives on Mental – Physical Comorbidity in the WHO World Mental Health Surveys*, edited by Michael R. Von Korff, et. al, Cambridge University Press, 2009.

*Given this greater disability of mental than physical disorders, it is disturbing to find that only a minority of even severe cases of mental disorder receive treatment and that treatment was substantially more common among comparably severe physical disorders.*

In addition, many accident victims report an experience of minimization and doubt of their claim by their insurer.

Sullivan showed that when victims feel that there is no justice and they have been overlooked, their disability is significantly prolonged. (Pain, perceived injustice and the persistence of post-traumatic stress symptoms during the course of rehabilitation for whiplash injuries Michael J.L. Sullivan, Pascal Thibault, Maureen J. Simmonds, Maria Milioto, André-Philippe Cantin, Ana M. Velly, PAIN, 2009)

#### Evidenced based OPA Guidelines for assessment and treatment of accident victims with psychological disorders

We note that the request for submissions for the three-year review emphasizes the goal of “*basing treatment of motor vehicle accident injuries on scientific and medical evidence.*” Evidenced based Guidelines are available to inform psychological assessment and treatment of accident victims with mental and behavioural disorders. Since 2001 the OPA has produced published Guidelines for assessment and treatment in auto insurance claims. (Guidelines)(See attached). These Guidelines include a review of relevant literature to guide evidence based assessment and treatment practice. The Handbook provides a practical summary. (See attached). The existence of evidenced based Guidelines is not the equivalent to mandating their use, and too often adjusters fail to consider these Guidelines when reviewing psychological treatment plans. Educating adjusters about the appropriate use of the Guidelines would serve to reduce unnecessary disputes, the costs of these disputes, and the burden on insured crash victims who are inappropriately denied or delayed psychological assessment and treatment.

#### Requirement of prior approval for payment of assessment and treatment-exception of Minor Injury Guideline

According to the SABS, all payment for services, except those provided according to the Minor Injury Guideline (MIG) for payment for services of up to \$2200 over 12 weeks for accident victims with Minor injuries require prior insurer approval. According to the SABS “minor injury” means one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury. For services within the MIG, the insurer is simply informed on a treatment confirmation form, OCF 23.

With very limited exceptions, due to pre-existing medical conditions, those with predominately minor injuries are limited to a total funding of \$3500. However, access to the additional \$1300, remaining in the in the minor injury cap of \$3500 after completion of the MIG, requires prior approval. (See attached) The need for prior approval to use these Post MIG funds within the minor injury cap, could be a potential barrier to services and create unnecessary transaction costs. Data regarding the number of post MIG applications for funding within the Minor Injury cap and patterns of insurer approval and denial and IEs would be helpful to evaluate the working of this section of Accident Benefits.

The requirement to obtain prior approval for funding for assessment and treatment for accident victims with Non-minor injuries/disorders, including mental and behavioural disorders, provides a number of checks to assure that the insurer is only obligated to pay for reasonable and necessary goods and services.

Minor Injury Guideline appropriately includes only psycho-social issues, not mental and behavioural disorders  
Mental and behavioural diagnoses and disorders are not within the Minor Injury definition. In contrast, we note that there is provision in the MIG as part of the aggregate maximum of \$400 for supplementary goods and services to provide supportive interventions to address “psycho-social issues”. This provision can be used to provide services for the psycho-social issues that are not as serious as mental and behavioural impairments and do not require the same specialized assessments/treatments. The psycho-social issues are generally described as “complaints” that are usually addressed through reassurance/education by the physical treatment provider, do not interfere with functioning, and resolve quickly. (See more complete description in OPA Guidelines and MIG Guideline)

Mental and behavioural disorders are more significant, and as diagnosed disorders in their own right require more intensive and specialized expert assessment/treatment. Therefore, application to the insurer for prior approval is required for funding of any services to address these disorders. The funding limit of \$50,000 for accident victims with mental and behavioural disorders is the same as for any accident victim with any Non-Minor disorder. (The exception is the extremely small group found to have catastrophic injuries with funding limits for med/rehab treatment of \$1,000,000, or those who have purchased the optional higher level of coverage. Although those determined to have a “minor injury” are still subject to the \$3500 cap in spite of purchase of potential access to a higher level of benefits for a non catastrophic injury.)

#### Staged process for proposing, approving and providing assessment and treatment

The OPA Guidelines describe a staged process for assessment and treatment including the following steps:

1. When there are indications of a mental and behavioural disorder, accident victims may be referred to a psychologist by any health professional or may self refer.
2. The psychologist will generally conduct a “pre-screening” to determine if it is reasonable to proceed with an “intake/screening”. In the intake screening the psychologist determines if there are indications of a mental and behavioural disorder and that psychological assessment and/or treatment is reasonable and necessary, and finally obtains informed patient consent for the proposed services including costs. This is confirmed on the OCF 18 by the patient’s signature on the application form. Note the OPA Guidelines state,

*The OCF-18 should be completed by a psychologist. The psychologist conducts a brief clinical interview/intake screening, either over the phone or in person, and psychological tests/screening measures may be included. The patient must sign the OCF-18 application providing informed consent; we therefore suggest that conducting the intake screening/interview in person is the expedient choice. Because the OCF-18 requires complaints/provisional diagnoses, decisions regarding patient need for different services, and assurance that the patient is truly providing informed consent to the assessment, this clinical screening interview should be conducted by a psychologist, rather than another health professional, an unregulated provider, or a support person. (underline added)*

AND

*We are obligated to certify that our assessment proposals are reasonable and necessary. Therefore the psychologist completing and signing the application must obtain sufficient information from the patient to confirm:*

- *The indicators for each type of proposed assessment/examination are satisfied and consistent with the criteria in the relevant assessment guideline tables; (Note: specific indicators for each type of assessment are provided later in the Guideline)*

- *The proposed assessments/examinations are reasonable and necessary and consistent with the time frames in the relevant guideline tables;*
  - *The patient has provided informed consent for the proposed assessment, for communication with the insurer, and for the possible insurer examination.*
  - *Assessments/examinations proposed for treatment/rehabilitation will focus on gathering information to diagnose patients' conditions and guide their treatment. The assessing psychologist may use the information directly in providing treatment. Alternatively, assessments/examinations may be conducted as consultations to other treatment providers.*
  - *A sufficiently/appropriately qualified practitioner is available (qualifications include language considerations, such that assessment should be provided when possible by a psychologist who is able to deliver the service without the need for a translator).(See attached)*
3. Application to the insurer follows. The rationale and proposed services and costs are described on an OCF 18, assessment and treatment plan proposal (See Attached). The proposing psychologist must certify that the patient has an impairment that is *not predominately a minor injury* and that the goods and services proposed are reasonable and necessary. There is no payment for the time spent on the intake/screening if there is no insurer approval. Therefore, the process is self-limiting. It is in the interest of the psychologist to conduct an effective pre-screening and only proceed to screening and proposal for those accident victims where there are indications of a psychological/mental and behavioural disorder.
4. When the insurer receives the proposal (required to be transmitted through Health Claims Auto Insurance (HCAI) electronic submission process) they have ten business days to respond. The insurer may approve the plan in full, provide partial approval or completely deny the plan. In addition, the SABS (See attached) require the insurer to provide their reasons for the denial. The insurer may deny on the basis that it is their opinion that the claimant has a minor injury and is subject to the MIG and the MI cap.
5. The insurer may, but is not required, to obtain an Insurer Examination (IE) regarding the proposal. The OPA evidenced-based Guidelines are intended to foster a common understanding of reasonable and necessary proposals by providers and approvals by insurers/IEs. The Guidelines state,  
*We expect that psychologists completing insurer examination reviews of these proposals for psychological assessments/examinations would be referring to these same criteria.*  
 It is our understanding that this is often the case. The IE may also address if the patient has an impairment that is not predominantly a minor injury. If the Guidelines are followed, any completed proposal should be reasonable and necessary.  
 Although Insurers currently have discretion in denying a benefit without obtaining a health professional opinion, our experience is that this leads to unfair denial of benefits. *Consideration could be given to making explicit the situations in which an IE is required rather than discretionary. In addition, there should be consideration of reinstating time lines for obtaining an IE and failure to meet the timelines should result in "deemed approval".*  
 In addition, we are working to develop IE Guidelines, which if followed, will improve the quality of IEs and therefore their usefulness to resolve disputes.
6. If, after the initial plan for assessment and/or treatment is completed, the psychologist determines that an initial treatment plan or further treatment is required, the process is repeated: application to the insurer for approval of the services, insurer approval, partial approval or denial and option to obtain an IE. The Guidelines provide the following direction regarding required indications to apply for treatment,



### *INDICATORS TO PROPOSE PSYCHOLOGICAL TREATMENT*

*Factors indicating that psychological treatment consistent with accepted community and professional standards is reasonable and necessary include that an appropriate assessment has identified:*

- *A psychological impairment/condition/disorder resulting from the accident and its sequelae, and/or psychological factors that are having an effect on the treatment/rehabilitation of physical injuries (note that these are diagnosable using ICD-10 and do not need to meet DSM-IV-TR diagnostic criteria for a particular disorder to qualify for treatment);*
- *An effective or reasonable intervention exists;*
- *The patient is sufficiently motivated and can access treatment (barriers addressed);*
- *A sufficiently/ appropriately qualified practitioner is available (qualifications include language considerations, such that treatment should be provided by a psychologist who is able to deliver the service without the need for a translator).*

*Reviewers should use these as criteria when determining the reasonableness and necessity of the proposed treatment plan.*

### Specialized expertise to diagnose and treat/rehabilitate mental and behavioural disorders

Diagnosis and treatment of mental and behavioural disorders requires specialized expertise. Communication of a diagnosis of a mental and behavioural disorder is a “controlled” act that is limited to members of two professions, medicine and psychology. Within these professions there are a subset of practitioners with expertise in this area. However, although we are unaware of the frequency, we understand that there are instances where proposals are submitted and/or IEs are conducted by others without this specialized expertise who do not have the authority under RHPA to communicate a diagnosis of a mental disorder. This then increases the cost and delays as it needs to be sent to an IE with the appropriate professional who *can* diagnose. It would benefit the system if adjusters are made more familiar with the disciplines which are authorized to diagnose mental disorders in order to obtain IEs from assessors with required expertise.

### Reinforcement of the application of the OPA Guidelines to improve the present situation

Regarding opportunities to improve the present situation, we understand that there may be instances where assessment and treatment plans, OCF 18s, are being submitted without following the process outlined in the OPA Guidelines. Reinforcement of the utilization of the Guidelines by proposers, adjusters, and IE reviewers would improve the consistency and quality of the proposals and IE reviews, thus improving services to accident victims and at the same time reducing delays, disputes, and transaction costs.

In addition, although we understand it is an infrequent event, there are some instances of completion of applications for psychological assessment and/or treatment by members of other health professions without specialized expertise in the diagnosis and treatment of persons with mental and behavioral disorders. This results in poorer quality applications and insurer examinations with associated delays, disputes and costs.

A parallel problem regarding failure to involve health professionals with appropriate expertise is seen in some IEs. At times, reasonable and necessary assessment and treatment plans for accident victims with mental disorders are inappropriately denied by the insurer based solely on the nature of their physical injuries. These insurers may obtain an IE that only considers the physical injuries or lacks the specific expertise in diagnosis and treatment of mental and behavioural disorders. If an insurer intends to deny a proposal for assessment/treatment regarding a mental and behavioural disorder, they should obtain an IE from a health professional with expertise in diagnosis and treatment of mental and behavioural disorders. Likewise, in IE disability assessments, often in-home or work related functional assessment fail to consider the impact of emotional, interpersonal and/or cognitive impairments, resulting in skewed outcomes.

The problems could be addressed by requiring the application for benefits and the IE to be completed according to the OPA Guidelines. This includes that the application and/or the IE assessment be completed by a health professional with expertise in the diagnosis and treatment of mental and behavioural disorders. As noted above the OPA Guidelines describe the expectation that applications for assessment and treatment and IE review (if required by the insurer) for services to address mental and behavioural disorders be conducted by a psychologist, rather than another health professional, an unregulated provider, or a support person. (underline added). Note: recommendation would also reasonably include other regulated health professionals with expertise in diagnosis and treatment in mental and behavioural disorders and authority to perform the controlled act of communicating a diagnosis which is limited to psychologists and physicians.

## **DISTINGUISHING PSYCHO-SOCIAL ISSUES TREATED WITHIN THE MIG FROM PSYCHOLOGICAL DISORDERS WHICH ARE NOT MINOR INJURIES:**

Psycho-social issues are appropriately addressed within the MIG

Some accident victims with minor physical injuries may also present with psychosocial issues (symptoms/complaints) which are appropriately considered within the Minor Injury (MI) cap and addressed within the Minor Injury Guideline (MIG). These issues and services are illustrated in the section on supplementary goods and services in the MIG,

*“Supportive interventions such as advice/education to deal with accident-related psycho-social issues, such as but not limited to: distress; difficulties coping with the effects of his/her injury; driving problem/stress”.*

However, the inclusion of psycho-social issues must not be inappropriately expanded and forestall the appropriate identification and treatment of accident victims’ mental and behavioural disorders. These disorders are not minor injuries. To the contrary, as noted above, in relative terms, the literature is unequivocal that psychological disorders have greater adverse functional impact than do physical impairments. There is a risk of discriminating against those with less visible impairments due to mental and behavioural disorders. Patients with these disorders are subject to a high level of social stigma, their impairments tend to be minimized, and there is a disproportionate lack of services in our public health care system.

Mental and behavioural disorders are not minor injuries

*Onset and Prognosis:*

Psychosocial issues/symptoms/complaints such as upset and distress in most accident victims with minor musculoskeletal injuries are generally noted soon after the accident. In many individuals good recovery may be observed within days and usually within the general 12-week time frame of the MIG. In contrast, impairments due to mental and behavioural conditions/disorders are more likely to have later onset (the exception being acute stress disorder, post traumatic stress disorder, and specific phobias) and to be persistent. While there are effective treatments for these pervasive disorders, reduction of impairments and restoration of functioning often requires months to years, longer recovery times depending upon complicating factors and individual response to treatment.

Therefore, the subset of accident victims with impairments due to mental and behavioural disorders cannot be considered to have predominantly MIs or limited to the MIG as their onset is often delayed and prognosis is one of a more prolonged recovery. *As such, the Minor Injury definition and Minor Injury Guideline should explicitly state that mental and behavioural disorders are excluded from the MI definition and exempt from the MIG treatment Guideline, even when accompanied by minor musculoskeletal injuries.*

*Expectation of spontaneous recovery and/or recovery with supportive interventions:*

The MIG suggests that psycho-social issues in the very early post mva period are generally addressed by reassurance and monitoring by the physical treatment provider in the context of assessing and addressing the physical injuries. However, for accident victims who do not have the anticipated improvement in their psychosocial issues there should be consideration of whether they have incurred or are developing impairment due to a mental or behavioural disorder. *If the anticipated recovery does not occur, screening for impairments due to mental behavioral disorders is indicated.*

*Functional limitations:*

In addition to their persistence beyond the early post mva period, accident victims with psychological impairments due to mental and behavioural disorders can be differentiated from those with psychosocial issues/symptoms/complaints by the resultant functional limitations. While some accident victims with minor musculoskeletal injuries may have psycho-social issues/complaints, these would not be expected to limit their functioning in their personal, home, or work life. The distinction occurs where mental and behavior disorders have developed to the degree causing impairment and limitation in functioning.

The higher level of disability due to mental and behavioural disorders, is documented in *Disability and Treatment of Specific Mental and Physical Disorders*, Ormel, Petukhova, Von Korff, and Kessler, [Global Perspectives on Mental – Physical Comorbidity in the WHO World Mental Health Surveys](#), edited by Michael R. Von Korff, et. al., Cambridge University Press, 2009.

*The SDS disability ratings for mental disorders were generally higher than for physical disorders. Of the 100 possible pairwise disorder-specific mental—physical comparisons (Table 18.4), mean ratings were higher for the mental disorder in 91 comparisons in developed and 91 in developing countries.*

Therefore a, a key component of appropriate mental health expert diagnosis of a psychological disorder involves evaluation of the impact on functioning. The mental and behavioural disorders require treatment in their own right to reduce impairment and restore function.

*Assessment by a health professional with expertise in diagnosis of mental and behavioural disorders:*

It is generally assumed that the screening for psycho-social issues and the need for supportive interventions can be provided by the health professional providing the assessment and treatment of the minor musculoskeletal injuries. The assessment section of the MIG states,

*“It is understood that the review and documentation of functional status and psycho-social risk factors is within the scope of practice of the health practitioner and does not involve a formal psychological assessment”.*

Note that psychologists are not included in the list of practitioners who can complete the OCF 23, MIG treatment confirmation form (Chiropractor, Dentist, Nurse Practitioner, Occupational Therapist, Physician, Physiotherapist). This is consistent with the focus of the MI and MIG on minor physical injuries. Psychologists do not perform the assessments and examinations required by the MIG provider, including conducting the physical examination and determining the physical diagnosis.

In contrast, the determination of impairments/disorders due to mental and behavioural disorders requires specialized expertise and authority to communicate the diagnosis. (Authority to perform this controlled act is limited to some members of the psychological and medical profession) Assessments of accident victims with mental and behavioural disorders should follow the processes outlined in the OPA Assessment and Treatment Guidelines. When appropriately conducted, the psychological diagnostic process can be compared to medical laboratory testing to guide treatment/rehabilitation. If the health professional providing the physical treatment for the minor musculoskeletal injury suspects a psychological impairment, the patient should be referred for

screening and determination of the need for diagnostic assessment/treatment to a regulated health professional with expertise in diagnosis and treatment of mental and behavioural disorders.

*Treatment by health professional with expertise in treatment of mental and behavioural disorders:*

It is assumed that the supportive interventions required by accident victims with minor musculoskeletal injuries can be provided by the physical treatment provider. The discretionary interventions during treatment section of the MIG Guideline states,

*If the insured person is displaying signs of distress or difficulties coping with the effects of his/her injury, the health practitioner may introduce pain management and coping skills education (a standardized approach is recommended)”.*

In contrast, patients with mental and behavioural disorders present with a variety of highly specialized treatment/rehabilitation needs. Effective, efficient treatment/rehabilitation must incorporate both evidence based guidelines, when appropriate, and individual factors. This requires health professionals with specialized expertise. Extensive specific education and training is required to provide the treatment/rehabilitation in a sound manner. In addition, it is essential to continuously evaluate and monitor the effect of treatment and modify as needed. Therefore only health professionals with this specialized expertise should provide treatment/rehabilitation of patients with impairments due to mental and behavioural disorders (in coordination with other treatment, if required, for the patient’s physical disorders.)

### Conclusion

*Mental and behavioural disorders are not “clinically associated sequelae” of minor musculoskeletal injuries*

As discussed above, an accident victim with impairments due to a mental and behavioral disorder has a distinct disorder/condition, not a “clinically associated sequelae” of the minor musculoskeletal injury. The nature and severity of the mental and behavioural disorder is independent of the severity of the physical injury.

*Predominance:*

In patients with minor musculoskeletal injuries as well as impairments due to mental and behavioral disorders, the mental and behavioral disorder usually comes to over shadow that of the physical injury and becomes the predominant cause of functional limitations in home, personal and work life and creates the greater health care needs.

Therefore, in accident victims with psychological/mental and behavioural disorders, as well as minor musculoskeletal injuries, the psychological disorder is the *predominant* condition.

### Recommendation:

Reinforcement of the utilization of the OPA Guidelines would improve applications, insurer decision-making, and IE reviews.

## **THE CATASTROPHIC IMPAIRMENT DEFINITION**

Given the very small number of individuals identified with catastrophic impairment and the clarification provided by the evolution of case law, there appears to be no need to modify the current criteria. However, if required, there are ways to clarify the methodology to be utilized to apply the definitions to improve consistency and reduce disputes regarding catastrophic impairment determination. *In this regard strong consideration should be given to mandated assessor qualifications and required training.*

However, it is critical that accident victims with impairments due to mental and behavioural disorders not encounter discrimination and that there is not a higher threshold than is imposed for those with impairments due to physical injuries. As referenced above, this is especially important in the clear context of greater functional impact of psychological over physical impairments.

AMA Guides 4 Chapter 14, provides a clear methodology for determination of whether an accident victim has a marked impairment due to a mental and behavioural disorder. *Requiring adherence to this methodology would improve consistency and validity of determinations.*

AMA Guides 4 Chapter 4, table 3 provides a clear and internally consistent methodology for rating impairments due to mental and behavioural disorders. Reinforcement of the use of this approach to quantify the impairment and combine with impairment ratings from other body system would reduce disputes. Determination of the specific value within the range is addressed by interpolation based on clinical data as for any other system where the ratings are provided as ranges. We note that some have alleged that combining impairment ratings due to mental and behavioural disorders with those from physical disorders will lead to over-inclusiveness. They create a false concern that an individual with a small impairment due to a physical disorder and small impairment due to a mental and behavioural disorder would be found to have a catastrophic impairment. This is simply inaccurate. It should be noted that following the Guides methodology for combining, precludes duplicate rating or double counting. In addition, given that the combining method discounts each successive impairment, it assures that only those with very significant impairments will be found to have a 55% or more Whole Person Impairment even when the impairments due to physical disorders and mental and behavioural disorders are combined.

## **LICENSING OF HEALTH PROFESSIONALS' BUSINESS PRACTICES**

We are supportive of the process to license health professionals' business practices. We look forward to more detailed information. We understand that the process will be sensitive to the needs of accident victims to be able to access health professionals practicing in a variety of models, including sole proprietors and other small businesses. Therefore the fees and administrative burdens for these entities should be proportionate. Any procedures for complaints and removal of licensed status must include due process and protection against vexatious complaints. In addition, as health professionals will be taking on an increased cost and administrative burden, and as insurers will have confidence in the business practices of those who are licensed, it is reasonable to require direct, timely payment to the health professional by the insurer.

We encourage that the licensing model reinforce the responsibility and accountability of the health professional providing the service. As an example, there should be an expectation that the health professional conducting any assessment (whether as a treatment provider or an IE assessor) must review and approve of the final draft of the report as well as any Executive Summary produced for multi-disciplinary assessments. This would address concerns raised by some that IE company administrators are changing reports without final approval by the assessing clinician.

## **DR COTE'S REVIEW OF THE TREATMENT LITERATURE RE MINOR INJURIES**

We are fully supportive of evidence-based treatment and our association has published evidenced based guidelines for assessment and treatment of psychological disorders resulting from auto accidents. Findings from relevant research should be incorporated into the Guideline for the treatment of minor injuries.

We had the opportunity to hear Dr. Cote's initial presentation on the status of his group's work. The group has reviewed a great deal of research. Unfortunately in spite of identifying a vast number of studies (120,864), very

few (157) demonstrated the characteristics (methodological soundness) necessary to be included for further analysis. Of those retained, there are a few that show that “x” treatment is useful for “y” condition, according to the results of the particular study. However, as was stated in the presentation session, there was little basis in the research cited to provide confidence in the replicability or generalizability of any of the findings. Nor was there specific research presented regarding the applicability of these findings to those who experience auto accident injuries. In addition to the challenges of transferring the conclusions to the auto accident context due to possible differences in the population as well as the mechanism and nature of the injury, this is particularly problematic in that auto accidents often result in multiple injuries and many of the studies focus on treatment of individuals with single injuries.

We understand that Dr. Cote’s research group will now be working on developing an,  
*“evidence-based Minor Injury Treatment Protocol for the management of individuals injured in traffic collisions”*.

In the presentation materials, the terms *guideline* and *protocol* seem to be used interchangeably. However, in clinical practice there are large differences, with *protocols* generally prescribing very specific interventions to very highly defined populations with narrow and specific inclusion and exclusion criteria. In contrast, *Guidelines* acknowledge that the treating health professional must select from a range of interventions according to the needs and responses of the individual patient. If the product is intended to be applicable to large numbers of accident victims, we assume that the intention is to develop a more open and flexible *Guideline* to be modified by the health professional according to the variable needs of individual patients.

We would like more information regarding the process proposed for translation of the research evidence into the treatment Guideline. The most commonly accepted definition of evidence based practice is,

*EBP is the integration of clinical expertise, patient values, and the best research evidence into the decision making process for patient care. Clinical expertise refers to the clinician’s accumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal preferences and unique concerns, expectations, and values. The best research evidence is usually found in clinically relevant research that has been conducted using sound methodology. (Sackett D, 2002)*

During the presentation (but not included in the notes subsequently made available) Dr. Cote indicated that the Guideline would be based on four factors: Effectiveness; Cost effectiveness; Patient’s preferences; Ethics and social values- feasibility within Ontario auto insurance system, both ethical aspects and political/ regulatory aspects.

We understand that the research review may contribute to understanding of the effectiveness of various treatments and some information regarding cost effectiveness. While there may be some useful research showing what not to do, given the limitations of the studies, “absence of evidence” cannot be presumed to mean that there is documentation that a treatment is not effective.

In addition, the research presented (as well as our understanding of the study of preferences being conducted with a small selected group of insureds) does not replace the preferences of the individual patient receiving the treatment. Patient preference and decision making is a key principle in all health care.

We also note that Dr. Cote did not include the following component of evidence based practice identified in the definition above.

*“Clinical expertise refers to the clinician’s accumulated experience, education and clinical skills”*.

He may have presumed that the treating health professional always has the responsibility and authority to determine the treatment they provide to the individual patient.

We also noted in the presentation some suggestions of broadening of the minor injury definition as well as perhaps extending the time frame of the Guideline from the present model for early intervention (first 12 weeks). We note that in his materials and presentation Dr. Cote has made reference to Mild Traumatic Brain Injury (Concussion) as an additional “minor injury” to be considered for inclusion in the “minor injury treatment protocol”. To be clear, MTBI reflects a *brain injury*, and as such it cannot be considered a minor injury. The complexity of these issues is reflected in the report by the Ontario Neurotrauma Foundation (ONF) which has recently involved a large multidisciplinary group to produce the second edition of evidence based “Guidelines for Concussion/Mild Traumatic Brain Injury & Persistent Symptoms”, (2013). These guidelines are highly credible and methodologically sound, reflecting the state of the art, best practice in relation to this patient population. It is not reasonable to address brain injury in the context of the MIG. *Rather, brain injury should be explicitly exempt from the MIG.*

These issues of increasing the scope and extending the applicable time frame of the minor injury guideline appear to be related to the fourth point,

*“Ethics and social values- feasibility within Ontario auto insurance system, both ethical aspects and political/ regulatory aspects”.*

Consideration of broadening the minor injury definition to include more conditions and/or expand its applicability over time does depend on ethics and social values as well as the understanding of the political and regulatory aspects of auto insurance. We suggest that any broadening of the “minor injury” definition or Guideline model requires broader consideration by all stakeholders of all the implications.

### **ADDITIONAL TOPICS FOR THE THREE YEAR REVIEW:**

The request for submissions stated,

*Consumers and stakeholders are invited to provide comments and suggestions on how to ensure a stable, sustainable and competitive auto insurance system, including:*

#### **Reducing claims costs**

We suggest that there are a number of initiatives that have recently been introduced that will have further effects on reducing claim costs. For example, three new measures became effective February 1, 2014. The requirement for prior documentation of compelling evidence of a pre-existing condition, limitation of incurred expenses to family members, and restrictions on changing elections. In addition, work is taking place to introduce additional measures that will reduce costs such as: measures to streamline dispute resolution, the licensing of health providers businesses, and greater control of the towing industry.

We believe that improved communication and collaboration between patients, health professionals and insurers could result in cost savings. It would save transaction costs if insurers communicated routinely with their insured and/or the health professionals if they have questions regarding proposed services.

Cost savings can also be achieved by improving both the quality of insurer adjudication and the IE system. For example, we have noticed that Insurer Examinations rarely conduct paper reviews, particularly regarding assessment applications, perhaps missing another opportunity to reduce transaction costs. When the IE conducts an in person examination to determine if an assessment is required, and then a further assessment is required by the health professional who will provide the treatment, this creates unnecessary intrusion in the life of the patient and increased costs to the system. *In addition, IE training and certification to ensure assessors are knowledgeable regarding the SABS and are fully aware of the specific assessment methods required to evaluate different kinds of benefit applications, would improve the quality and value of these examinations.*

While an adjuster cannot be expected to review a file and weigh competing medical opinions, adjusters must review opinions on the application of the SABS in proposer and IE reports and not simply accept that the IE assessors understand the various SABS tests. This would reduce reliance on many badly formulated IE reports. Adjusters should be able to weigh information on the OCF 18 and other supporting information (eg, GP referral or support), and if needed, seek clarification from the proposer, or internal consultation with another psychologist prior to making a determination. The adjuster should provide a clearer explanation when denying assessment or treatment application, rather than simply asserting that the proposal is “not reasonable and necessary”. The adjuster should obtain an appropriate and current clinical opinion prior to denying an application (e.g. not rely on an Insurer Examination that is over a year old, or conducted by a health professional without relevant expertise to comment on the patient’s current condition, not rely on a insurer physical examination to comment on a patient’s psychological status.). *Finally, we note that although it may be an efficiency and cost saving to have a single assessment address several SABS benefit tests, however each benefit test actually requires a distinct methodology and this is often absent in IE reports addressing several benefits.*

Insurer Examiners should follow professional standards and guidelines, including OPA Guidelines. It is only reasonable that the Insurer Examiner be of the same discipline as the proposer so that they are credibly informed re: diagnostic considerations; treatment options and variables to be considered; likely durations; complicating factors; professional fees; etc. *If an IE assessor is reviewing a proposal for assessment for treatment or a treatment plan, the assessor should have a current clinical practice and experience in treatment in order to speak to this. Similarly, IEs doing disability assessments should have training and experience in conducting these assessments before doing them autonomously. Insurer Examinations should be expected to follow evidence-based methodology and consensus-based guidelines* (For example, quality of assessments of disability pre and post 104 weeks and catastrophic impairment are highly variable and this may cause unnecessary and costly disputes). *Methodological standards for assessments and associated requirements for training and mentoring of assessors and quality control of assessment reports would improve the quality and usefulness of IEs to resolve disputes.* Review of reports and arbitration decisions highlights the critical importance of sound method in producing credible reports and opinions. Proper adjudication by adjusters reduces delays and disputes. Sound method by IEs accomplishes the same goal.

#### Decreasing regulatory, product and administrative complexity for industry, service providers and consumers

We believe that it may be possible to simplify some of the forms.

Greater ease in working on the HCAI website is sought. For example, users should be able to disable the default setting that rewrites the date on draft plans to current date when opened.

#### Promoting greater consumer choice and protection

Consumer choice requires provision of accurate information. We understand that when purchasing auto insurance very few consumers are fully informed of their options and the implications of their decisions.

For example, it is our understanding that very few consumers are fully aware of the minor injury cap and that accident victims who are defined as having a minor injury are limited to \$3500. It is also our understanding that very few brokers provide sufficient information regarding the options to increase from the standard level of benefits to the higher level.



In addition, at this time there is no option for the consumer to purchase coverage that provides a higher level of benefits if they have what is defined as a minor injury, regardless of having purchased optional extra coverage including to the catastrophic level.

In addition, greater options for selecting to use telemetrics to reduce individual premiums should be considered, but weighed against privacy rights concerns.

#### Increasing transparency in communications between insurers, service providers, policyholders and claimants

As stated above it would be helpful if there could be greater and more frequent communication involving the patient, health professional and the adjuster. It may be possible to have a phone call at the time that the services are being proposed. Similarly the adjuster could call the patient and/or the health if they have a question regarding proposed services.

In more complex situations, case conferences (collegial team meetings) involving the patient, health professionals and insurer may be helpful. These should be proposed by any participating party. We note that too often when these conferences/consultations are proposed by the health professional, funding for the time required is denied by the insurer or IE.

We would like to collaborate with representatives of the insurance community to determine ways of facilitating greater utilization of the OPA Assessment and Treatment Guidelines, improving communication and reducing disputes.

While likely not (yet) feasible at this time, if the claimant could access their own HCAI data, this would provide access to real time information. In the interim it is important to assure that timely and complete reports of costs of services are being provided to all claimants.

#### Improving the availability of auto insurance for individuals and businesses

All of the above should help to reduce auto accident costs and therefore reduce premiums and increase availability of auto insurance.

We also recommend further exploration and application of Telemetrics which has the potential to reduce costs by tying cost to driving behaviour. We believe this will also contribute to improved driver behaviour and accident and therefore cost reduction.

Another option to reduce “distracted driving” is to further explore “cell phone shut down” while a vehicle is in motion. We note and support the recent measures to impose greater fines for distracted driving.

#### Basing treatment of motor vehicle accident injuries on scientific and medical evidence

As stated above, OPA supports evidence based practice, we have published evidence-based guidelines for assessment and treatment of mental and behavioural disorders. We would like to work with the representatives from the insurance industry to facilitate better implementation.

Similarly we support that additional current and relevant evidence be incorporated into the Guideline for treatment of minor injuries.

### Considering approaches used in other jurisdictions

We would require further information in order to comment knowledgeably about the approaches utilized in other jurisdictions.

However we are aware that there is a risk of comparing cost of Accident Benefits in different jurisdictions. These often are very different systems and the context may be missed in the comparison, for example: whether it is a private or public system, the balance of Tort vs Accident Benefits, the health and rehabilitation services available within the public sector, access to benefits rules, and etc. In addition, given differences in weather, traffic congestion, road conditions, and other factors there may be differences in the driving population and the nature/severity of the injuries.

### **CONCLUSION**

The Ontario Psychological Association Auto Insurance Task Force has been educating psychologists, other health professionals, insurers, and government about psychological disorders and brain injuries in motor vehicle accident victims for 25 years. We have seen tremendous change, a wide variety of policy initiatives over the years; and many product modifications designed to deal with both costs to the premium payer and adequate and effective treatment and rehabilitation for crash victims.

Our focus in this submission is on the evidence that investment in psychological treatment and rehabilitation is sound investment in Ontario's citizens. As a science based discipline, we have a great deal to contribute to society, but our patients face stigma, misunderstanding, and historically mental and behavioural disorders have been underfunded in the public sector. The scientific literature demonstrates the greater burden of disability produced by mental and behavioural disorders in comparison with physical disorders and we see the consequences of this everywhere in society. Auto insurance no-fault accident benefits have provided opportunity for injured citizens for timely access psychological services and many have benefited from this investment in reducing their mental disorders and rehabilitating them to satisfying roles in their family, community and workplace. Our public health system has identified the need to treat and rehabilitate individuals with mental disorders but does not have sufficient resources to do so. Under auto insurance we can continue to invest in the lives of those with mental disorders and brain injuries, but barriers must be removed.

Over the last few years a number of interrelated initiatives have reduced fraud and waste and will continue to do so. We expect the mediation/arbitration system in the future will provide more timely resolution of disputes and licensing will reduce opportunities for fraudulent billing and will increase transparency in the system.

Continuing barriers to timely investment in the rehabilitation of accident victims with impairments and functional limitations due to mental and behavioural disorders are seen in:

1. Failure to follow evidence based Guidelines by professionals and insurers;
2. Insurers' failure to communicate with their insureds and their health professionals;
3. Insurers' failure to take responsibility for adjudicating files including: delays in treatment plan reviews; failure to refer proposed treatment plans to appropriate IEs when such is clearly indicated; and failure to determine if the IE has correctly applied the SABS test;
4. Inappropriate denial of assessment and treatment of crash victims with mental disorders, including denial based on the severity of the physical injury and assertion that the Minor Injury cap applies;
5. Crash victims with serious mental disorders were denied the right in 2010 to have their psychologists confirm catastrophic mental disorders and this professional responsibility was removed from

psychologists. The group with the greatest expertise in diagnosis of mental disorders and measurement of function cannot utilize their expertise for those who require an analysis of catastrophic impairment. No scientific or policy rationale was ever advanced for limiting this role to physicians.

We encourage FSCO to consider the role of accident benefits as an investment in the rehabilitation of Ontario citizens. We appreciate and support initiatives to reduce fraud and waste and control costs. However, there is a need to be mindful and ensure that the cost control measures do not create excessive/unfair barriers to access to services for accident victims. In addition to being the right thing to do, the evidence supports that providing timely, appropriate assessment/treatment/rehabilitation to individuals with mental and behavioural disorders is cost effective.

## **ATTACHMENTS**

### **Relevant Sections of the Ontario Psychological Association Guidelines for Assessment and Treatment in Auto Insurance Claims, 2010**

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#### **PURPOSE OF THE GUIDELINE**

Consistent with the purposes of the 1990 Ontario Psychological Association (OPA) Guide to Fees and Billing Practices, the 2001 Psychology Assessment and Treatment Guidelines, published by the Financial Services Commission of Ontario (FSCO), and the 2005 OPA Guidelines for assessment and treatment in auto insurance claims, published by the Ontario Psychological Association, these Ontario Psychological Association Guidelines for Assessment and Treatment in Auto Insurance Claims are intended to provide assistance and guidance to psychologists and those using their services. We also have prepared a handbook to be a practical summary of the Guidelines. The Handbook and Guidelines are meant to be educational, not prescriptive. They are not intended to manualize assessment or treatment.

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#### **DESCRIPTION OF THE HANDBOOK AND GUIDELINES**

In these documents, we describe normative assessment and treatment practices based on current standards for practice, the scientific literature, and professional opinion regarding clinical practice in Ontario in 2010. These documents also include direction regarding how to evaluate these usual assessment and treatment practices. The Guidelines and Handbook are intended to be for multiple audiences, including psychologists, other care providers, lawyers, and adjusters. The documents are intended to provide an update and make recommendations for practice based on the applicable science and regulations, in the context of the clinical realities of practice in Ontario, so that all users can have a common set of expectations regarding what constitutes reasonable and necessary assessment and treatment proposals.

We included indicators for determining when to propose psychological assessment or treatment, direction regarding what is required to complete the new OCF-18, define when assessment and treatment are reasonable and necessary, provide a description of the assessment and examination processes, and detail reasonable associated costs for each. Typical assessment interventions and hours reasonably required for clinical/health/rehabilitation psychological assessments and the specific specialized assessments (psychovocational, psychoeducational, neuropsychological) are described and summarized. Guidelines for psychological treatment plan proposals also include considerations for ongoing evaluation and modification of treatment, treatment plan components, and reasonably required hours. A description of potential barriers to the patient's ability to participate in or complete proposed assessment or treatment is included, as is a list of potential factors that can complicate the assessment and treatment process, sometimes reasonably resulting in proposals with hours that fall in the upper end of the ranges presented.

...

The OPA expects that these guidelines will provide the standard by which to review proposed psychological assessment and treatment plans by providing criteria by which to judge the reasonableness and necessity of proposed services. We encourage IE reviewers of assessment/examination and treatment plan proposals, as well as those proposing services, to use these guidelines.

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All psychologists providing and reviewing services under auto insurance in Ontario should be familiar with the content of these Guidelines, in order to address the science and regulations that apply to practice in this area; however, legal definitions and arbitrations are not reviewed here and should be pursued by practitioners separately.

We would also suggest that those asked by insurers to review assessment and treatment proposals (Insurer Examiners) ensure their comprehension of these issues before conducting their reviews, in order to ensure full understanding of how their opinions will be used in potential future settlements, court cases, and determination of benefits. Given the amount of knowledge required to function appropriately in this practice context, it is our recommendation that assessors, treaters, and examiners only submit and review proposals for services in areas consistent with their usual practices (e.g. pain management, PTSD/ anxiety disorders, neuropsychology, psychovocational rehabilitation).

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Psychologists play an important role in Ontario's health care system. Psychological factors are central to the health and improvement of health problems of all Canadians and psychologists are the professionals best trained to assess and treat psychological factors affecting health. The development of guidelines for assessment and treatment of psychological factors affecting the health of people injured in MVAs in Ontario is intended to establish a framework for the appropriate provision of high quality services that will result in improvements for the patient, cost-effective results for insurers, and less burden to the public systems resulting from chronic conditions and disabilities.

Psychologists see a very small proportion of individuals injured in MVAs in Ontario. The majority of MVA survivors do not receive psychological services, and while we are aware of some regional variability in this respect, it is our understanding from the province-wide data that those who do tend to be complex, with multiple impairments, and may be at high risk for developing chronic disabilities that create substantial costs to multiple systems. A current review of the science suggests that sound and timely psychological assessment can identify those at risk for developing persisting impairments and ensure early and appropriate intervention. When the psychologist takes the initiative to share information, psychological assessment also conveys valuable information to other health care providers to facilitate and direct appropriate rehabilitation, and can serve as an indispensable communication tool in explaining a given patient's lack of expected progress in their physical rehabilitation. Similarly, psychological treatments can prevent and reduce disability, return patients to work, reduce suffering, improve quality of life, and provide substantial cost savings to payors.

Patient groups seen by psychologists following an MVA include those suffering with amputations, brain injuries, chronic pain, spinal cord injuries, disfigurement, or the emotional consequences related to trauma and traumatic loss, such as grief, anxiety, and depression. Psychologists also work with patients who are experiencing difficulties participating fully in physical treatments and rehabilitation, adjusting to post-MVA changes in their lives, and adhering to healthy lifestyle recommendations made by their other health providers. Psychologists assess and treat those who are trying to cope with ongoing pain, anxiety, impaired mood, behavioural change/dysregulation, changed relationships, financial strain, and limitations in functioning. In addition, psychologists provide treatment to the family members and dependents of injured people who are having their own difficulties adjusting to changed roles and responsibilities, and may experience their own emotional distress and/or behavioural alterations.

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### **Prevalence and Description of Psychological Injuries and Impairment**

Brain injuries and mental/psychological impairments are real and debilitating. Various cognitive and emotional/mental conditions can result directly or indirectly from involvement in a motor vehicle accident. Consequently, the manifestations of such conditions result in lost productivity and costs that affect everyone. The World Health Organization's (WHO) most recent data for Canada from 2009 shows that the effect on years of productive life lost secondary to disability and premature mortality for a non-physical impairment such as unipolar depression (1157 life years lost per 100,000 population) is higher than the effect of all cardiovascular diseases combined (957 per 100,000); only the effect of all cancers combined (1375) is greater. Similarly, the effects of panic disorder (97) and post-traumatic stress disorder (57) are both higher than the effects of Parkinson's disease (53), HIV/AIDS (45) and Multiple Sclerosis (36). Consistent with this, the RAND Institute (Seabury, Reville, Neuhauser, 2004) found that psychiatric injuries have the highest impact of all injury categories on disablement. When measured in terms of years lived with disability (YLD), depression is the leading cause of disability worldwide (Organization for Economic Cooperation and Development (2009).

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Mild brain trauma is an impairment of brain functioning due to trauma to the central nervous system that generally is not severe enough to require hospitalization or institutional care. Effects can be very temporary, or can persist longer term, as well as more permanently. "Mild" in this context does not reflect that the impact on the person's ability to function normally is necessarily slight or trivial, as the relative consequence to a person's functional and affective status can be significant. In effect, even "mild" brain trauma can have devastating effects on vocational, social, and everyday functioning for a subset of those with mild traumatic brain injury whose recovery is more delayed or complicated.

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### **Efficacy and cost-effectiveness of psychological intervention – Pharmacotherapy vs Psychological Treatment**

By comparison, the fact that psychotherapies produce lasting effects and prevent relapse makes them economically, as well as clinically viable alternatives to medication. This is especially relevant as the cost of medications increases, since clinically effective psychological interventions have proven to cost substantially less than similarly effective psychotropic medications. For example, studies of psychological interventions, such as cognitive-behavioural therapy for anxiety disorders, indicate equivalent or better clinical effectiveness and cost savings of 10-50%, compared to pharmacological treatment (Gould, Otto, and Pollack, 1995). Results for depression are even more striking. In an extremely comprehensive cost-effectiveness analysis of cognitive-behavioral therapy, Prozac, and combination therapy that took into account factors such as lost productivity, wages, taxes, and community service during treatment, Antonuccio, et al. (1997) found that cognitive-behavioural therapy was by far the least expensive treatment. Providing Prozac alone would cost an estimated 33% more than cognitive-behavioral therapy over a two-year period, and combination therapy would cost an estimated 23% more.

Dobson (2008) also reviewed some of the literature comparing relapse rates and the resulting costs of psychological treatment and medication for depression. He found that, "prior psychotherapy, either in the form of cognitive therapy (CT) or behavioral activation (BA), had an enduring effect that was at least as efficacious as continuing patients on medication and that held for the prevention of relapse and possibly recurrence... Although psychotherapy was more expensive to provide initially... the cumulative cost of continued medications proved to be more expensive by the end of the 1<sup>st</sup> year of follow-up in this study" (p.475). These results were found to be consistent with those achieved by Antonuccio et al (1997) and Hollon et al (2005).

Thus, a convincing and growing body of evidence is producing consistent results indicating that psychological interventions are not only at least as clinically effective as medications for some disorders, they may actually be more effective, and save valuable dollars, as well. Research data also indicate that psychotherapies produce lasting effects and prevent relapse, making them economically, as well as clinically viable alternatives to medication, especially as the cost of medications increases.

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Efficacy and cost-effectiveness of psychological intervention – Cost-offsets of Psychological Intervention

However, the economic benefits of psychological interventions extend much further than simple comparisons with other treatments. In any health insurance system, patients with unmet mental health needs utilize medical services at a rate higher than the rest of the population. Often, these services involve physician consultation and medical testing for symptoms associated with mental health conditions (e.g. chest pain or parasthesias due to panic attacks). Besides improving health and increasing well-being, evidence has accumulated to show that psychological treatments can actually lower costs associated with other medical expenditures. Thus, the economic value of psychotherapy services is often defined in terms of its cost-offset. Medical cost-offset refers to the savings realized by employing appropriate psychological diagnostic and treatment services. In such analyses, the costs of administering psychological assessment and treatment and reducing other medical utilization are compared with the costs of usual care with no psychotherapy.

Efficacy and cost-effectiveness of psychological intervention – Cost-offsets in Canada

A number of economic analyses of psychological interventions have been completed within Canada that are consistent with these results, demonstrating the benefits to Canadian payor systems of including psychological interventions.

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**Anxiety Disorders and Brain Injury are not “Sequelae of Minor Injuries”**

As discussed elsewhere in this document, the causes and development of psychological conditions, such as Acute Stress Disorder, Post-Traumatic Stress Disorder, or a Specific Phobia for driving/travel, or brain injuries and resulting cognitive impairments are independent of physical injuries that may be sustained in an accident. The research and resulting diagnostic criteria for ASD, PTSD, and specific phobic behaviour following a traumatic event are clear that the mechanism by which these conditions develop is an entirely internal, subjective, cognitive-affective process for the injured person that is separate from any other actions that may be occurring at the time, including any physical injuries that may be occurring (American Psychiatric Association, 2000). As a result, this kind of anxiety disorder injury often does not correspond to the severity of physical injuries sustained, damages incurred, other losses, or the dynamics of the event. It is also clear that brain injury can occur completely separately from any sprains or strains that may occur, resulting in significant impairments in multiple domains.

As a result, it must be concluded that ASD, PTSD, Specific driving/ travel phobia, and associated conditions (e.g. agoraphobia or generalized anxiety that may result from PTSD), as well as brain injuries and resulting impairments are independent conditions and not “sequelae” of physical injuries, whether the physical injuries are or are not “minor”. In addition, the psychological impairments themselves are not “minor injuries” both as defined in the SABS and given the reality or their clinical impact and the more extensive and variable treatment needs of patients with these impairments. Therefore, while some psychological services can be administered within the MIG, it would be inappropriate to consider the kind of psychological conditions and disorders we have reviewed within this document as being similar to the “minor” physical injuries that are addressed in the MIG, minor injury definition, and by extension, treatable within the \$3500 cap.

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**Mood and Chronic Pain Disorders are not “Minor Injuries”**

Impairments of mood/depressive conditions, psychological chronic pain disorders, and the recognition of persisting impairments due to brain injury often occur later, when the patient has poor recovery from their physical injuries and is unable to resume pre-accident functioning and/or is coping with continuing, debilitating pain. These psychological conditions become a predominant focus of the patient’s treatment and rehabilitation independent of the severity of their other physical injuries. They are not “minor injuries” either in terms of the SABS definition or in terms of their clinical severity and extent and variability of treatment required. When a patient presents with impaired mood, a psychological chronic pain disorder, or cognitive/affective/behavioural dysregulation, referral to a psychologist to determine if psychological assessment and treatment is required is indicated.

Current research is clear in demonstrating the central importance of multidisciplinary treatment that involves psychological interventions in treating patients with chronic pain disorders, improving functioning, reducing and preventing disability, and off-setting the costs of disability due to chronic pain. We therefore recommend that psychologists continue to treat patients with chronic pain within multidisciplinary teams, whether in integrated programs in a single facility, or in “virtual teams” through coordination with care providers in different facilities.

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**BRIEF CLINICAL INTERVIEW/INTAKE SCREENING FOR PROPOSING PSYCHOLOGICAL ASSESSMENTS**

In order for the insurer to be obligated to pay for an assessment, health professionals must apply (with rare exceptions) for prior approval to proceed with assessments by completing an OCF- 18 Application for Approval of Treatment and Assessment with description of the present symptoms, rationale, and details of the proposed assessment. The exceptions to the requirement of prior approval are included on the OCF- 18 and are described in the SABS.

The insurer must respond to the application for approval of the assessment within 10 business days or the assessment services may be provided until the insurer decision is provided. This can create some ambiguity regarding whether to proceed with an assessment if the insurer does not respond within the time lines.

The OCF-18 should be completed by a psychologist. The psychologist conducts a brief clinical interview/intake screening, either over the phone or in person, and psychological tests/screening measures may be included. The patient must sign the OCF-18 application providing informed consent; we therefore suggest that conducting the intake screening/interview in person is the expedient choice. Because the OCF-18 requires complaints/provisional diagnoses, decisions regarding patient need for different services, and assurance that the patient is truly providing informed consent to the assessment, this clinical screening interview should be conducted by a psychologist, rather than another health professional, an unregulated provider, or a support person.

We envision that assessment/examination proposals will continue to be complaint-based and limited to preliminary information. It is only reasonable to expect that many questions will remain unanswered until after the assessment/examinations are completed. Similarly, review of the health history and file are assessment components and generally are not completed as part of the proposal process.

We are obligated to certify that our assessment proposals are reasonable and necessary. Therefore the psychologist completing and signing the application must obtain sufficient information from the patient to confirm:

- The indicators for each type of proposed assessment/examination are satisfied and consistent with the criteria in the relevant assessment guideline tables;



- The proposed assessments/examinations are reasonable and necessary and consistent with the time frames in the relevant guideline tables;
- The patient has provided informed consent for the proposed assessment, for communication with the insurer, and for the possible insurer examination.
- Assessments/examinations proposed for treatment/rehabilitation will focus on gathering information to diagnose patients' conditions and guide their treatment. The assessing psychologist may use the information directly in providing treatment. Alternatively, assessments/examinations may be conducted as consultations to other treatment providers.
- A sufficiently/appropriately qualified practitioner is available (qualifications include language considerations, such that assessment should be provided when possible by a psychologist who is able to deliver the service without the need for a translator).

We expect that psychologists completing insurer examination reviews of these proposals for psychological assessments/examinations would be referring to these same criteria.

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#### **BRIEF REVIEW OF LITERATURE AND IMPLICATIONS FOR PSYCHOLOGICAL ASSESSMENT/EXAMINATION**

Clinically sound and cost-effective treatment requires adequate assessment. Undiagnosed impairments can affect a patient's ability to respond to other physical and rehabilitative treatment as well as psychological treatment, and they can increase costs by slowing progress in therapy and continuing medical usage. Efficient diagnosis ensures that impairments are identified, the proper treatment prescribed, and therapeutic effectiveness maximized. In this way, later costs can be offset and functional limitations reduced, so that the injured person can become more independent personally and financially.

As suggested by Dorfman, "[P]sychological evaluation and testing... can assist in establishing a valid diagnosis early in treatment, crystallize a focus for brief treatment, enhance quality by effectively matching clients to treatment approaches, and reduce the length of treatment by assessing openness and attitudes toward therapy" (Dorfman, 2000, p.36). Similarly, Kubiszyn, et al. suggest that psychological assessment has demonstrated validity and utility "for several clinical health care applications... [including] the a) description of clinical symptomatology and differential diagnosis; b) description and prediction of functional behavior; c) prediction of health outcomes; d) prediction of health care utilization; e) prediction of psychotherapy, forensic, and mental health outcomes; f) identification of patient/ claimant/ client characteristics that affect treatment; and g) use of psychological assessment as treatment in itself" (p. 120).

In fact, diagnostic tests performed by psychologists are state-of-the-art tools. Meta-analytic research on assessment validity indicates that many psychological tests detect pathology at a rate indistinguishable from those of medical tests. For example, psychological tests detect dementia, depression, or psychotic disorders just as accurately as medical tests such as pap smears, mammography, magnetic resonance imaging (MRI), and electrocardiograms detect medical pathology. Moreover, some psychological tests work just as well as medical tests to detect the same outcome. For instance, the ability to detect dementia is as good with neuropsychological tests as it is with MRI (Daw, 2001). Increasingly, physicians and other health care professionals turn to psychologists for their diagnostic capabilities. These diagnostic services detect functional impairment and assess the prognosis for improvement or deterioration in functioning. Psychologists apply these results and develop treatment and rehabilitative services.

The development and delivery of effective and efficient treatment depends upon accurate diagnosis of the psychological components of illness and injury. Assessments under auto insurance must be informative to a number of readers and reviewers including patients, psychologists, other health professionals, adjusters, lawyers, mediators, arbitrators and judges. Often patients requiring psychological assessment have multiple sources of

impairment and distress, including pain, cognitive impairments, and functional limitations. In addition, pre-existing conditions and personal circumstances often contribute to already complicated presentation and treatment needs. Assessing and planning treatment needs requires a careful differential diagnosis in such situations.

With regard to diagnoses and impairments that may occur after an MVA, Schillaci et al (2009) state that “accurate differential diagnosis is essential in determining the appropriate treatment modality” (p. 44), and give specific suggestions regarding how to differentiate between PTSD and symptoms of other disorders, such as agoraphobia, specific phobias, and depression. With regard specifically to depression, Patten et al (2009) note that, “DSM-IV provides valuable sets of diagnostic criteria but the nosology is not intended to supplant clinical judgment. Successful treatment depends on an accurate diagnosis, but an accurate diagnosis does not provide a sufficient basis for clinical management. The diagnosis of MDD is always a provisional diagnosis... As such, working diagnoses may evolve over time. Nevertheless, an accurate diagnosis is the most important starting point for clinical management. The goals of assessment include: assessment of safety, establishment of rapport and a therapeutic alliance, assessment of comorbidity, patient education, and obtaining informed consent to proceed with treatment” (p.S10). Thus, caution and comprehensiveness are advised when attempting to make differential diagnoses and plan appropriate treatment for patients with multiple injuries, such as those injured in MVAs....

In addition to providing a direct therapeutic benefit, performing a proper clinical diagnostic investigation also is an investment in a procedure that ensures that efficient, effective treatment is provided often leading to reduced disability costs. It provides benefits to the client by meeting the need for appropriate treatment, it benefits the clinician by ensuring that treatment time can be targeted and efficient, and it provides a financial benefit to the system by ensuring that all impairments are captured and treated in the most efficient manner. It also provides benefit to all stakeholders as an accurate and comprehensive communication tool that can be used in avoiding disputes over benefits.

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#### **INDICATORS TO PROPOSE PSYCHOLOGICAL TREATMENT**

Factors indicating that psychological treatment consistent with accepted community and professional standards is reasonable and necessary include that an appropriate assessment has identified:

- A psychological impairment/condition/disorder resulting from the accident and its sequelae, and/or psychological factors that are having an effect on the treatment/rehabilitation of physical injuries (note that these are diagnosable using ICD-10 and do not need to meet DSM-IV-TR diagnostic criteria for a particular disorder to qualify for treatment;
- An effective or reasonable intervention exists;
- The patient is sufficiently motivated and can access treatment (barriers addressed);
- A sufficiently/ appropriately qualified practitioner is available (qualifications include language considerations, such that treatment should be provided by a psychologist who is able to deliver the service without the need for a translator).

Reviewers should use these as criteria when determining the reasonableness and necessity of the proposed treatment plan.

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#### **Treatment Interventions**

A robust literature now indicates that psychological treatment interventions are the gold standard treatments of choice for many conditions and impairments. In many cases, these interventions produce treatment effects that are equivalent or superior to those achieved with medication. Additionally, psychological interventions have been

found to be effective in helping clients with stress and anger management, facilitating lifestyle changes necessitated by various medical conditions (such as heart conditions, hypertension, and diabetes), and in adjusting to major illness (such as cancer), and disabilities (such as chronic pain or spinal cord injuries) (see Hunsley, 2003 for a review of this literature). The fact that psychological interventions are associated with far less symptom relapse than medications and have virtually no side effects may make them a more appealing alternative to some patients.

There is evidence to indicate that these results also apply to treatment of psychological injuries after an auto accident. A significant amount of research has been published on the successful treatment of post-traumatic stress after an auto accident in the past several years. Some of this research has been manualized into an intervention for MVA-related post-traumatic stress (Hickling and Blanchard, 2006). However, while specific diagnosis-based protocols may be directly applicable to a subset of patients with psychological impairments due to an MVA (such as post-traumatic stress), many patients require treatments that are more individualized and intensive due to the complicated and interactive nature of their multiple impairments (e.g. post-traumatic stress, TBI, and chronic pain).

Diagnosis-based treatment protocols are designed for treatment of single conditions, and often are more effective for more straightforward, standard symptom or condition presentations. Given the small fraction of injured people in Ontario who receive psychological services, and the general information suggesting that the ones who do are those with multiple impairments, injuries, pre-existing conditions, and vulnerabilities, manualized interventions for single disorders will at best, address only one piece of a very complex symptom presentation. Much of the research in the existing literature has documented the extra challenge of addressing the needs of many patients presenting for psychological treatment after auto accidents with very complex treatment needs. As a result, some of the literature on poly-trauma, multi-symptom presentations following traumatic injuries and events may be more applicable in determining how to sequence rehabilitation in multiple domains.

## Relevant Sections of the Statutory Accident Benefits Schedule

### **Insurance Act**

#### **ONTARIO REGULATION 34/10**

#### **STATUTORY ACCIDENT BENEFITS SCHEDULE — EFFECTIVE SEPTEMBER 1, 2010**

**Consolidation Period:** From December 17, 2013 to the e-Laws currency date.

#### **PART I GENERAL**

##### **Citation**

1. This Regulation may be cited as the *Statutory Accident Benefits Schedule — Effective September 1, 2010*. O. Reg. 34/10, s. 1.

##### **Definitions and interpretation**

3. (1) In this Regulation,
  - “health practitioner” means, in respect of a particular impairment,
    - (a) a physician,
    - (b) a chiropractor, if the impairment is one that a chiropractor is authorized by law to treat,
    - (c) a dentist, if the impairment is one that a dentist is authorized by law to treat,
    - (d) an occupational therapist, if the impairment is one that an occupational therapist is authorized by law to treat,
    - (e) an optometrist, if the impairment is one that an optometrist is authorized by law to treat,
    - (f) a psychologist, if the impairment is one that a psychologist is authorized by law to treat,

- (g) a physiotherapist, if the impairment is one that a physiotherapist is authorized by law to treat,
- (h) a registered nurse with an extended certificate of registration, if the impairment is one that the nurse is authorized by law to treat, or
- (i) a speech-language pathologist, if the impairment is one that a speech-language pathologist is authorized by law to treat; (“praticien de la santé”)

“impairment” means a loss or abnormality of a psychological, physiological or anatomical structure or function; (“déficience”)

“minor injury” means one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury; (“blessure légère”)

“Minor Injury Guideline” means a guideline,

- (a) that is issued by the Superintendent under subsection 268.3 (1.1) of the Act and published in *The Ontario Gazette*, and
- (b) that establishes a treatment framework in respect of one or more minor injuries; (“Directive sur les blessures légères”)

“neuropsychologist” means a psychologist authorized by law to practise neuropsychology; (“neuropsychologue”)

“psychologist” means a person authorized by law to practise psychology; (“psychologue”)

“regulated health profession” means a profession governed by a College as defined in the *Regulated Health Professions Act, 1991* or the Ontario College of Social Workers and Social Service Workers under the *Social Work and Social Service Work Act, 1998*; (“profession de la santé réglementée”)

“regulated health professional” means a member of a regulated health profession; (“professionnel de la santé réglementé”)

“sprain” means an injury to one or more tendons or ligaments or to one or more of each, including a partial but not a complete tear; (“entorse”)

“strain” means an injury to one or more muscles, including a partial but not a complete tear; (“foulure”)

“subluxation” means a partial but not a complete dislocation of a joint; (“subluxation”)

“whiplash associated disorder” means a whiplash injury that,

- (a) does not exhibit objective, demonstrable, definable and clinically relevant neurological signs, and
- (b) does not exhibit a fracture in or dislocation of the spine; (“entorse cervicale”)

“whiplash injury” means an injury that occurs to a person’s neck following a sudden acceleration-deceleration force. (“coup de fouet cervical”) O. Reg. 34/10, s. 3 (1); O. Reg. 289/10, s. 1 (1).

(2) For the purposes of this Regulation, a catastrophic impairment caused by an accident is,

- (a) paraplegia or quadriplegia;
- (b) the amputation of an arm or leg or another impairment causing the total and permanent loss of use of an arm or a leg;
- (c) the total loss of vision in both eyes;
- (d) subject to subsection (4), brain impairment that 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
- (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;

(e) subject to subsections (4), (5) and (6), an 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

(f) subject to subsections (4), (5) and (6), an impairment 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. O. Reg. 34/10, s. 3 (2).

(3) Subsection (4) applies if an insured person is under the age of 16 years at the time of the accident and none of the Glasgow Coma Scale, the Glasgow Outcome Scale or the American Medical Association’s *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, referred to in clause (2) (d), (e) or (f) can be applied by reason of the age of the insured person. O. Reg. 34/10, s. 3 (3).

(4) For the purposes of clauses (2) (d), (e) and (f), an impairment sustained in an accident by an insured person described in subsection (3) that can reasonably be believed to be a catastrophic impairment shall be deemed to be the impairment that is most

analogous to the impairment referred to in clause (2) (d), (e) or (f), after taking into consideration the developmental implications of the impairment. O. Reg. 34/10, s. 3 (4).

- (5) Clauses (2) (e) and (f) do not apply in respect of an insured person who sustains an impairment as a result of an accident unless,
- (a) a physician or, in the case of an impairment that is only a brain impairment, either a physician or a neuropsychologist states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or
  - (b) two years have elapsed since the accident. O. Reg. 289/10, s. 1 (2).

(6) For the purpose of clauses (2) (e) and (f), 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 is deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person. O. Reg. 34/10, s. 3 (6).

### **PART III MEDICAL, REHABILITATION AND ATTENDANT CARE BENEFITS**

#### **Insurer liable to pay benefits**

14. Except as otherwise provided in this Regulation, an insurer is liable to pay the following benefits to or on behalf of an insured person who sustains an impairment as a result of an accident:

1. Medical and rehabilitation benefits under sections 15 to 17.
2. If the impairment is not a minor injury, attendant care benefits under section 19. O. Reg. 34/10, s. 14.

#### **Medical benefits**

15. (1) Subject to section 18, medical benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for,

- (a) medical, surgical, dental, optometric, hospital, nursing, ambulance, audiometric and speech-language pathology services;
  - (b) chiropractic, psychological, occupational therapy and physiotherapy services;
  - (c) medication;
  - (d) prescription eyewear;
  - (e) dentures and other dental devices;
  - (f) hearing aids, wheelchairs or other mobility devices, prostheses, orthotics and other assistive devices;
  - (g) transportation for the insured person to and from treatment sessions, including transportation for an aide or attendant;
  - (h) other goods and services of a medical nature that the insured person requires, other than goods or services for which a benefit is otherwise provided in this Regulation. O. Reg. 34/10, s. 15 (1).
- (2) Despite subsection (1), the insurer is not liable to pay medical benefits,
- (a) for goods or services that are experimental in nature;
  - (b) for expenses related to goods and services described in subsection (1) rendered to an insured person that exceed the maximum rate or amount of expenses established under the Guidelines, other than for expenses related to the services described in clause (1) (g); or
  - (c) for transportation expenses other than authorized transportation expenses. O. Reg. 34/10, s. 15 (2); O. Reg. 14/13, s. 1.

#### **Rehabilitation benefits**

16. (1) Subject to section 18, rehabilitation benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person in undertaking activities and measures described in subsection (3) that are reasonable and necessary for the purpose of reducing or eliminating the effects of any disability resulting from the impairment or to facilitate the person's reintegration into his or her family, the rest of society and the labour market. O. Reg. 34/10, s. 16 (1).

- (2) Measures to reintegrate an insured person into the labour market are considered reasonable and necessary, taking into consideration the person's personal and vocational characteristics, if they enable the person to,
- (a) engage in employment or self-employment that is as similar as possible to the employment or self-employment in which he or she was engaged at the time of the accident; or
  - (b) lead as normal a work life as possible. O. Reg. 34/10, s. 16 (2).
- (3) The activities and measures referred to in subsection (1) are,
- (a) life skills training;

- (b) family counselling;
- (c) social rehabilitation counselling;
- (d) financial counselling;
- (e) employment counselling;
- (f) vocational assessments;
- (g) vocational or academic training;
- (h) workplace modifications and workplace devices, including communications aids, to accommodate the needs of the insured person;
- (i) home modifications and home devices, including communications aids, to accommodate the needs of the insured person, or the purchase of a new home if it is more reasonable to purchase a new home to accommodate the needs of the insured person than to renovate his or her existing home;
- (j) vehicle modifications to accommodate the needs of the insured person, or the purchase of a new vehicle if it is more reasonable to purchase a new vehicle to accommodate the needs of the insured person than to modify an existing vehicle;
- (k) transportation for the insured person to and from counselling and training sessions, including transportation for an aide or attendant;
- (l) other goods and services that the insured person requires, except,
  - (i) services provided by a case manager,
  - (ii) housekeeping and caregiver expenses, and
  - (iii) any goods or services for which a benefit is otherwise provided in this Regulation. O. Reg. 34/10, s. 16 (3).

**Monetary limits re medical and rehabilitation benefits**

18. (1) The sum of the medical and rehabilitation benefits payable in respect of an insured person who sustains an impairment that is predominantly a minor injury shall not exceed \$3,500 for any one accident, less the sum of all amounts paid in respect of the insured person in accordance with the Minor Injury Guideline. O. Reg. 34/10, s. 18 (1).

(2) Despite subsection (1), the \$3,500 limit in that subsection does not apply to an insured person if his or her health practitioner determines and provides compelling evidence that the insured person has a pre-existing medical condition that will prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the \$3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline. O. Reg. 34/10, s. 18 (2).

**Note: On February 1, 2014, subsection (2) is amended by striking out “a pre-existing medical condition that will prevent” and substituting “a pre-existing medical condition that was documented by a health practitioner before the accident and that will prevent”. (See: O. Reg. 347/13, ss. 1, 5)**

(3) The sum of the medical and rehabilitation benefits paid in respect of an insured person who is not subject to the financial limit in subsection (1) shall not exceed, for any one accident,

- (a) \$50,000; or
- (b) if the insured person sustained a catastrophic impairment as a result of the accident, \$1,000,000. O. Reg. 34/10, s. 18 (3).

(4) The maximum amounts set out in subsection (3) apply unless modified by any optional benefits that are available under paragraph 3 or 5 of subsection 28 (1). O. Reg. 34/10, s. 18 (4).

**Cost of examinations**

25. (1) The insurer shall pay the following expenses incurred by or on behalf of an insured person:

1. Reasonable fees charged for preparing a disability certificate if required under section 21, 36 or 37, including any assessment or examination necessary for that purpose.
2. Fees charged in accordance with the Minor Injury Guideline by a person authorized by the Guideline for preparing a treatment confirmation form and for conducting an assessment or examination and preparing a report as authorized by the Guideline.
3. Reasonable fees charged by a health practitioner for reviewing and approving a treatment and assessment plan under section 38, including any assessment or examination necessary for that purpose, if any one or more of the goods, services, assessments or examinations described in the treatment and assessment plan have been:
  - i. approved by the insurer,
  - ii. deemed by this Regulation to be payable by the insurer, or

- iii. determined to be payable by the insurer on the resolution of a dispute in accordance with sections 279 to 283 of the Act.
  - 4. Reasonable fees charged by an occupational therapist or a registered nurse for preparing an assessment of attendant care needs under section 42, including any assessment or examination necessary for that purpose.
  - 5. Reasonable fees charged for preparing an application under section 45 for a determination of whether the insured person has sustained a catastrophic impairment, including any assessment or examination necessary for that purpose. O. Reg. 34/10, s. 25 (1).
- (2) Despite subsection (1), an insurer is not required to pay for an assessment or examination conducted in the insured person's home unless the insured person has sustained an impairment that is not a minor injury. O. Reg. 34/10, s. 25 (2).
- (3) The insurer is not liable under subsection (1) for expenses related to professional services rendered to an insured person that exceed the maximum rate or amount of expenses established under the Guidelines. O. Reg. 34/10, s. 25 (3); O. Reg. 14/13, s. 3.
- (4) The insurer shall pay reasonable expenses incurred by or on behalf of an insured person for authorized transportation expenses incurred in transporting the insured person to and from an assessment or examination referred to in subsection (1), including transportation expenses for an aide or an attendant. O. Reg. 34/10, s. 25 (4).
- (5) Despite any other provision of this Regulation, an insurer shall not pay,
- (a) more than a total of \$2,000 in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it, whether it is conducted at the instance of the insured person or the insurer; or

## PART VIII PROCEDURES FOR CLAIMING BENEFITS

### CLAIM FOR MEDICAL OR REHABILITATION BENEFITS

#### Claims for medical and rehabilitation benefits and for approval of assessments, etc.

38. (1) This section applies to,
- (a) medical and rehabilitation benefits other than benefits payable in accordance with the Minor Injury Guideline; and
  - (b) all applications for approval of assessments or examinations. O. Reg. 34/10, s. 38 (1).
- (2) An insurer is not liable to pay an expense in respect of a medical or rehabilitation benefit or an assessment or examination that was incurred before the insured person submits a treatment and assessment plan that satisfies the requirements of subsection (3) unless,
- (a) the insurer gives the insured person a notice under subsection 39 (1) stating that the insurer will pay the expense without a treatment and assessment plan;
  - (b) the expense is for an ambulance or other goods or services provided on an emergency basis not more than five business days after the accident to which the application relates; or
  - (c) the expense is reasonable and necessary as a result of the impairment sustained by the insured person for,
    - (i) drugs prescribed by a regulated health professional, or
    - (ii) goods with a cost of \$250 or less per item. O. Reg. 34/10, s. 38 (2).
- (3) A treatment and assessment plan must,
- (a) be signed by the insured person unless the insurer waives that requirement;
  - (b) be completed and signed by a regulated health professional; and
  - (c) include a statement by a health practitioner approving the treatment and assessment plan and stating that he or she is of the opinion that the goods, services, assessments and examinations described in the treatment and assessment plan and their proposed costs are reasonable and necessary for the insured person's treatment or rehabilitation and,
    - (i) stating, if the treatment and assessment plan is in respect of an accident that occurred on or after September 1, 2010,
      - (A) that the insured person's impairment is not predominantly a minor injury, or
      - (B) that the insured person's impairment is predominantly a minor injury but, based on compelling evidence provided by the health practitioner, the insured person does not come within the Minor Injury Guideline because the insured person has a pre-existing medical condition that will prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the \$3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline, or

**Note: On February 1, 2014, sub-subclause (B) is amended by striking out "a pre-existing medical condition that will prevent" and substituting "a pre-existing medical condition that was documented by a health practitioner before the accident and that will prevent". (See: O. Reg. 347/13, ss. 4, 5)**

- (ii) stating, if the treatment and assessment plan is in respect of an accident that occurred before September 1, 2010,

- (A) that the expenses contemplated by the treatment and assessment plan are reasonable and necessary for the insured person's treatment or rehabilitation, and
- (B) that the impairment sustained by the insured person does not come within a *Pre-approved Framework Guideline* referred to in the Old Regulation. O. Reg. 34/10, s. 38 (3).

(5) An insurer may refuse to accept a treatment and assessment plan if the plan describes goods or services to be received or an assessment or examination to be conducted in respect of any period during which the insured person is entitled to receive goods or services under the Minor Injury Guideline in respect of the impairment. O. Reg. 34/10, s. 38 (5).

(6) An insurer's refusal to accept a treatment and assessment plan under subsection (5) is final and is not subject to review. O. Reg. 34/10, s. 38 (6).

(7) Nothing in subsection (5) prevents an insured person, while receiving goods or services under the Minor Injury Guideline, from submitting a treatment and assessment plan applicable to a period other than the period for which the insured person is receiving goods or services under the Minor Injury Guideline. O. Reg. 34/10, s. 38 (7).

(8) Within 10 business days after it receives the treatment and assessment plan, the insurer shall give the insured person a notice that identifies the goods, services, assessments and examinations described in the treatment and assessment plan that the insurer agrees to pay for, any the insurer does not agree to pay for and the medical reasons and all of the other reasons why the insurer considers any goods, services, assessments and examinations, or the proposed costs of them, not to be reasonable and necessary. O. Reg. 34/10, s. 38 (8); O. Reg. 14/13, s. 5.

(9) If the insurer believes that the Minor Injury Guideline applies to the insured person's impairment, the notice under subsection (8) must so advise the insured person. O. Reg. 34/10, s. 38 (9).

(10) If the insurer has not agreed to pay for all goods, services, assessments and examinations described in the treatment and assessment plan or believes that the Minor Injury Guideline applies to the insured person's impairment, the notice under subsection (8) may notify the insured person that the insurer requires the insured person to undergo an examination under section 44. O. Reg. 34/10, s. 38 (10).

(11) If the insurer fails to give a notice in accordance with subsection (8) in connection with a treatment and assessment plan, the following rules apply:

1. The insurer is prohibited from taking the position that the insured person has an impairment to which the Minor Injury Guideline applies.
2. The insurer shall pay for all goods, services, assessments and examinations described in the treatment and assessment plan that relate to the period starting on the 11th business day after the day the insurer received the application and ending on the day the insurer gives a notice described in subsection (8). O. Reg. 34/10, s. 38 (11).

(12) If an insurer advises an insured person that the Minor Injury Guideline applies, the insured person may submit a treatment confirmation form under section 40 and, pending the insurer's determination, may receive goods and services in accordance with the Minor Injury Guideline. O. Reg. 34/10, s. 38 (12).

(13) Within 10 business days after receiving the report of an examination conducted under section 44 for the purpose of the treatment and assessment plan, the insurer shall give a copy of the report to the insured person and to the regulated health professional who prepared the treatment and assessment plan. O. Reg. 34/10, s. 38 (13).

(14) Within 10 business days after receiving the report, the insurer shall,

- (a) provide the insured person with a notice indicating the goods and services described in the treatment and assessment plan that the insurer agrees to pay for, the goods and services the insurer refuses to pay for and the medical and any other reasons for the insurer's decision; or
- (b) if the insurer determines that the Minor Injury Guideline applies, advise the insured person that the Minor Injury Guideline applies to the insured person's impairment and provide medical and any other reasons for the insurer's determination. O. Reg. 34/10, s. 38 (14).

(15) The insurer shall pay for goods and services the insurer agreed to pay for in the notice under subsection (8) or (14) or is required to pay for under this section within 30 days after receiving an invoice for them. O. Reg. 34/10, s. 38 (15).

#### CLAIM FOR MEDICAL OR REHABILITATION BENEFITS TO WHICH MINOR INJURY GUIDELINE APPLIES

##### **Minor Injury Guideline**

40. (1) This section applies to a person if,

- (a) the person sustains, as a result of an accident, a minor injury to which the Minor Injury Guideline applies; and
- (b) the person submits or intends to submit an application under section 32 for medical or rehabilitation benefits. O. Reg. 34/10, s. 40 (1).

(2) The person shall submit, within the time specified in the Minor Injury Guideline, a treatment confirmation form that satisfies the following requirements:



1. The treatment confirmation form must be prepared and signed by a health practitioner,
    - i. who is authorized by law to treat the impairment that is the subject of the form,
    - ii. who is authorized under the Minor Injury Guideline to complete the treatment confirmation form, and
    - iii. who will be the health practitioner responsible for providing the goods and services described in the treatment confirmation form.
  2. The treatment confirmation form must contain details concerning the impairment and specify the provisions of the Minor Injury Guideline that apply.
  3. The treatment confirmation form must be signed by the person claiming benefits, unless the insurer waives this requirement. O. Reg. 34/10, s. 40 (2).
- (3) Within five business days after receiving a treatment confirmation form, the insurer shall send a notice to the person claiming benefits and to the health practitioner,
- (a) acknowledging receipt by the insurer of the treatment confirmation form; and
  - (b) advising if the person claiming benefits is an insured person with respect to the accident. O. Reg. 34/10, s. 40 (3).
- (4) If the person also submits a completed and signed application under section 32 and the insurer accepts the claim for benefits, the insurer shall, within 30 days of receipt, pay every invoice for goods and services described in section 15 or 16 that are provided in accordance with the Minor Injury Guideline. O. Reg. 34/10, s. 40 (4).
- (5) An insured person shall submit an amended treatment confirmation form if, during the course of treatment under the Minor Injury Guideline, he or she changes the health practitioner who is responsible for providing goods and services described in the treatment confirmation form. O. Reg. 34/10, s. 40 (5).
- (6) The insurer is liable to pay for goods and services described in an amended treatment confirmation form only to the extent the goods and services have not already been provided in accordance with the Minor Injury Guideline. O. Reg. 34/10, s. 40 (6).
- (7) If goods or services available under the Minor Injury Guideline are not provided within the times specified in that Guideline, the insured person shall submit a treatment and assessment plan under section 38 if he or she wishes to obtain medical or rehabilitation benefits to which the Minor Injury Guideline would otherwise apply. O. Reg. 34/10, s. 40 (7).
- (8) If a court or arbitrator determines, in any dispute about an insured person's entitlement to medical or rehabilitation benefits or related assessments or examinations, that the Minor Injury Guideline applies to an insured person and the insured person received benefits or underwent assessments or examinations under that Guideline,
- (a) the benefits are deemed to have been reasonable and necessary for the purposes of sections 15 and 16; and
  - (b) the assessments and examinations are deemed to have been reasonably required for the purposes of section 25. O. Reg. 34/10, s. 40 (8).

#### ADDITIONAL MATTERS

##### **Examination required by insurer**

44. (1) For the purposes of assisting an insurer to determine if an insured person is or continues to be entitled to a benefit under this Regulation for which an application is made, but not more often than is reasonably necessary, an insurer may require an insured person to be examined under this section by one or more persons chosen by the insurer who are regulated health professionals or who have expertise in vocational rehabilitation. O. Reg. 34/10, s. 44 (1).

##### **Determination of catastrophic impairment**

45. (1) An insured person who sustains an impairment as a result of an accident may apply to the insurer for a determination of whether the impairment is a catastrophic impairment. O. Reg. 34/10, s. 45 (1).

(2) The following rules apply with respect to an application under subsection (1):

1. An assessment or examination in connection with a determination of catastrophic impairment shall be conducted only by a physician but the physician may be assisted by such other regulated health professionals as he or she may reasonably require.
2. Despite paragraph 1, if the impairment is a brain impairment only, the assessment or examination may be conducted by a neuropsychologist who may be assisted by such other regulated health professionals as he or she may reasonably require.
3. If a Guideline specifies conditions, restrictions or limits with respect to the determination of whether an impairment is a catastrophic impairment, the determination must be made in accordance with those conditions, restrictions and limits. O. Reg. 34/10, s. 45 (2); O. Reg. 289/10, s. 5.

(3) Within 10 business days after receiving an application under subsection (1) prepared and signed by the person who conducted the assessment or examination under subsection (2), the insurer shall give the insured person,

- (a) a notice stating that the insurer has determined that the impairment is a catastrophic impairment; or
  - (b) a notice stating that the insurer has determined that the impairment is not a catastrophic impairment and specifying the medical and any other reasons for the insurer's decision and, if the insurer requires an examination under section 44 relating to whether the impairment is a catastrophic impairment, so advising the insured person. O. Reg. 34/10, s. 45 (3).
- (4) If an application is made under this section not more than 104 weeks after the accident and, immediately before the application was made, the insured person was receiving attendant care benefits,
- (a) the insurer shall continue to pay attendant care benefits to the insured person during the period before the insurer makes a determination under this section; and
  - (b) the amount of the attendant care benefits for the period referred to in clause (a) shall be determined on the assumption that the insured person's impairment is a catastrophic impairment. O. Reg. 34/10, s. 45 (4).
- (5) Within 10 business days after receiving the report of an examination under section 44, the insurer shall,
- (a) give a copy of the report to the insured person and to the person who prepared the application under this section; and
  - (b) provide the insured person with a notice stating that the insurer has determined that the impairment is a catastrophic impairment or is not a catastrophic impairment and setting out the medical and any other reasons for the insurer's determination. O. Reg. 34/10, s. 45 (5).
- (6) If an insured person is determined to have sustained a catastrophic impairment as a result of an accident, the insured person is entitled to payment of all expenses incurred before the date of the determination and to which the insured person would otherwise be entitled to payment under this Regulation by virtue of having sustained a catastrophic impairment. O. Reg. 34/10, s. 45 (6).

#### **PART X**

#### **RESPONSIBILITY TO OBTAIN TREATMENT, PARTICIPATE IN REHABILITATION AND SEEK EMPLOYMENT OR SELF-EMPLOYMENT**

##### **Treatment and rehabilitation**

57. (1) This section applies to an insured person if compliance with subsection (2) would not be detrimental to his or her treatment or recovery. O. Reg. 34/10, s. 57 (1).

(2) An insured person who is entitled to an income replacement, non-earner or caregiver benefit shall obtain such treatment and participate in such rehabilitation as is reasonable, available and necessary to,

- (a) permit the insured person to engage in employment or self-employment in accordance with the criteria set out in subsection (3), in the case of an insured person entitled to an income replacement benefit; or
- (b) shorten the period during which the benefit is payable, in any other case. O. Reg. 34/10, s. 57 (2).

#### Relevant Sections of the Minor Injury Guideline, February 2014

For the purposes of this Guideline, the terms “injury” and “injuries” have the same meaning as “impairment” and “impairments” respectively as used in the SABS, and “regulated health professional” and “health practitioner” have the same meanings as in the SABS.

The objectives of this Guideline are to:

- a) Speed access to rehabilitation for persons who sustain minor injuries in auto accidents;
- b) Improve utilization of health care resources;
- c) Provide certainty around cost and payment for insurers and regulated health professionals; and
- d) Be more inclusive in providing immediate access to treatment without insurer approval for those persons with minor injuries as defined in the SABS and set out in Part 2 of this Guideline.

The SABS and this Guideline are intended to encourage and promote the broadest use of this Guideline, recognizing that most persons injured in car accidents in Ontario sustain minor injuries for which the goods and services provided under this Guideline are appropriate.

Usage of the Guideline by all stakeholders will be monitored on an ongoing basis, with a view to early identification and response to inappropriate application or interpretation of the SABS and the Guideline.

For the purposes of this Guideline:

- a) **minor injury** means a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelae. This term is to be interpreted to apply where a person sustains any one or more of these injuries.
- b) **sprain** means an injury to one or more tendons or ligaments or to one or more of each, including a partial but not a complete tear.
- c) **strain** means an injury to one or more muscles, including a partial but not a complete tear.
- d) **subluxation** means a partial but not a complete dislocation of a joint.
- e) **whiplash injury** means an injury that occurs to a person's neck following a sudden acceleration-deceleration force.
- f) **whiplash associated disorder** means a whiplash injury that:
  - (i) does not exhibit objective, demonstrable, definable and clinically relevant neurological signs, and
  - (ii) does not exhibit a fracture in or dislocation of the spine.

### **3. Impairments that come within this Guideline**

Subject to the exception in Section 4 below, an insured person's impairment comes within this Guideline if the impairment is predominantly a minor injury.

### **4. Impairments that do not come within this Guideline**

An insured person's impairment does not come within this Guideline if the insured person's impairment is predominantly a minor injury but, based on compelling evidence provided by his or her health practitioner, the insured person has a pre-existing medical condition that was documented by a health practitioner before the accident and that will prevent the insured person from achieving maximal recovery from the minor injury if he or she is subject to the \$3,500 limit referred to in section 18(1) of the SABS or is limited to the goods and services authorized under this Guideline.

Compelling evidence is to be provided using the Treatment and Assessment Plan (OCF-18) with attached medical documentation, if any, prepared by a health practitioner.

The existence of any pre-existing condition will not automatically exclude a person's impairment from this Guideline. It is intended and expected that the vast majority of pre-existing conditions will not do so.

Only in extremely limited instances, where compelling evidence provided by a health practitioner satisfactorily demonstrates that a pre-existing condition that was documented by a health practitioner before the accident, and that will prevent a person from achieving maximal recovery from the minor injury for the reasons described above, is the person's impairment to be determined not to come within this Guideline. Exclusion of a person from this Guideline based on reasons or evidence falling short of this requirement is inconsistent with the intent of the SABS and this Guideline.

### **5. Providers able to deliver services within this Guideline**

Providers who are able to deliver services within this Guideline are any health practitioners, as defined by the SABS, who are authorized by law to treat the injury and who have the ability to deliver the interventions referred to in this Guideline. The health practitioner may also co-ordinate or directly supervise the provision of services to the insured person by other appropriate health care providers.

### **7. The initial visit**

#### **a) Timing of the initial visit**

The initial visit will ideally occur as soon as possible following the date of accident and health practitioners are encouraged to commence intervention during the initial visit.

## b) Components of the initial visit

### i. Assessment

In assessing the insured person, the health practitioner will be responsible for:

- Undertaking a history, including, but not limited to: demographics; prior injuries; current injury.
- Completing a physical examination, including, but not limited to: range of motion determination; neurological examination; assessment of associated injuries.
- Reviewing and documenting functional status and psychosocial risk factors associated with the injury including, but not limited to: changes in functional status; psycho-social issues; other risk factors or barriers to recovery. It is understood that the review and documentation of functional status and psycho-social risk factors is within the scope of practice of the health practitioner and does not involve a formal psychological assessment. While it is recommended that the health practitioner employ standardized tools and instruments in the review of functional status and psychosocial risk factors, the specific tools used are left to the discretion of the individual health practitioner. *(underline added)*
- Identifying the diagnosis and/or impairment description, including: the Primary Diagnosis/Impairment Description (ICD 10 Codes); and the Secondary Diagnosis/Impairment Description (ICD 10 Codes).
- Obtaining and recording the insured person's informed consent to treatment.
- Reviewing the completed Treatment Confirmation Form (OCF-23) with the insured person and obtaining the insured person's signature on the Form unless the insurer has waived the requirement for the form.

**Recommended interventions during the initial visit** The interventions that are recommended during the initial visit include:

- Activity prescription Encouraging the insured person, when appropriate, to remain active and maintain normal activities as an important factor in facilitating recovery.
- Reassurance Providing reassurance, when appropriate, to the insured person regarding his/her injuries and the recovery process.
- Education Distributing the brochure "Getting the Facts About Whiplash" (attached as Appendix A), when appropriate, and providing education regarding minor injuries, symptoms, the natural healing process and prognosis for recovery.
- Home exercise program Demonstrating and providing advice, when appropriate, on how the insured person should exercise his/her injury; and customizing an exercise program for the insured person to engage in at home, work or school.

### iii. Discretionary interventions during the initial visit

At the discretion of the health practitioner, and to facilitate the insured person's recovery and return to function, these include:

- **Exercise and functional activities** The interventions should be based on the specific needs and functional requirements of the insured person and may include: range of motion exercises; muscle re-education; and low load isometric exercise.
- **Mobilization and manipulation** The health practitioner may provide these interventions if the insured person would benefit from mobilization and/or manipulation.
- **Diagnostic imaging** X-rays may be undertaken without the prior approval of the insurer under the following circumstances: ...
- **Other interventions that facilitate pain management, activation and return to function**

If the insured person would benefit from other specific interventions to facilitate pain management, activation and return to function, these interventions may be provided during the initial or subsequent visits. These may include, but are not limited to: massage therapy; intervention for psycho-social issues; coping skills education; advice

regarding hurt versus harm and maintaining active engagement; energy conservation techniques; etc. (underline added)

## **8. The treatment phase**

If the health practitioner determines that the Guideline applies to the insured person and that intervention under the Guideline is required to facilitate recovery and return to function, the insured person continues on to the treatment phase.

### **a) Timing and duration in the treatment phase**

The treatment phase sessions are treatments provided in addition to any intervention delivered during the initial visit and will not typically exceed twelve weeks in duration following the date of the initial visit. The appropriate health care provider will deliver treatment sessions based on the needs of the insured person and the health practitioner's clinical judgement. *(underline added)*

### **b) Components of the treatment phase**

#### **Recommended and discretionary interventions**

#### **i. Recommended interventions during the treatment phase**

##### **• Continuing clinical review**

Regular review of the insured person's clinical status and progress toward functional restoration, based on which the health practitioner will make any necessary modifications in the approach to intervention.

##### **• Activity prescription; Reassurance; Education; and Home Exercise Program (as described above under the initial visit)**

#### **Discretionary interventions during the treatment phase**

##### **• Exercise and functional activities; Mobilization and manipulation (as described above under the initial visit)**

##### **• Pain management and coping skills education**

If the insured person is displaying signs of distress or difficulties coping with the effects of his/her injury, the health practitioner may introduce pain management and coping skills education (a standardized approach is recommended). *(Underline added)*

##### **• Diagnostic imaging (as described above under the initial visit)**

##### **• Other Interventions that will facilitate pain management, activation and return to function (as described above under the initial visit)**

### **d) Supplementary goods and services during the treatment phase**

Additional funds are available to provide supplementary goods and additional services to support restoration of functioning and address barriers to recovery. The supplementary goods and services may include but are not limited to:

• Treatment services for the additional minor injuries arising from the same accident.

• Goods required for self-directed exercise and/or pain management such as, but not limited to: theraband; gym ball; hot/cold packs; back support; lumbar roll; etc.

• Assistive devices required to maintain/return to work/school/home or personal activity such as but not limited to: head set; trolley; braces.

• Supportive interventions such as advice/education to deal with accident-related psycho-social issues, such as but not limited to: distress; difficulties coping with the effects of his/her injury; driving problem/stress. *(underline added)*

The health practitioner, a regulated health professional or an appropriate health care provider may provide the supplementary goods and/or services that are deemed necessary, up to a maximum cost of \$400.00, without approval of the insurer.

Relevant Sections of the Treatment and Assessment Plan (OCF-18)

For accidents that occur on or after September 1, 2010:

Is this impairment predominantly a minor injury as referred to in the Minor Injury Guideline?

Yes No

If yes, please explain and provide compelling evidence why the applicant does not come within the Minor Injury Guideline due to a pre-existing medical condition that will prevent the applicant from achieving maximal recovery from the minor injury if the applicant is subject to the \$3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline.

Relevant Sections of Treatment Confirmation Form OCF 23

For accidents that occur on or after September 1, 2010, this form is to be used for goods and services provided in accordance with the Minor Injury Guideline

**Part 4: Signature of Initiating Health Practitioner**

**You are a:**

- Chiropractor
- Dentist
- Nurse Practitioner
- Occupational Therapist
- Physician
- Physiotherapist