Common Traffic Impairment (CTI) Guideline

Part A – Introduction

This Guideline is issued pursuant to s. 268.3 of the *Insurance Act* for the purposes of the *Statutory Accident Benefits Schedule - Effective September 1, 2010* as amended (SABS).

This Guideline is incorporated by reference in the SABS, and is therefore binding according to section 268.3 (2.1) of the *Insurance Act*.

This Guideline applies to accidents that take place on or after (*placeholder for effective date*).

This Guideline provides for the use of the following care pathways for the clinical management of impairments caused or exacerbated by a motor vehicle accident:

- *Guideline for the Clinical Management of Neck Pain And Its Associated Disorders (NAD)*
- *Guideline for the Clinical Management of Persistent Headaches Associated With Neck Pain*
- *Guideline for the Clinical Management of Soft Tissue Disorders of The Upper Extremity*
- *Guideline for the Clinical Management of Lower Extremity Soft Tissue Disorders*
- *Guideline for the Clinical Management of Temporomandibular Disorders*
- *Recommendation for the Clinical Management of Mild Traumatic Brain Injury (MTBI)*
- *Guideline for the Clinical Management of Low Back Pain With And Without Radiculopathy.*

These care pathways are incorporated in and form part of this Guideline and are found in the Appendix. The Appendix also includes a glossary of terms to be used for the purpose of delivering the goods and services described in the care pathways.

The care pathways incorporated in this Guideline are designed to:

1) accelerate recovery
2) reduce the intensity of symptoms
3) promote early restoration of function
4) prevent chronic pain and disability
5) improve health related quality of life
6) reduce recurrences, and
7) promote active participation in their own care by persons with common traffic impairments.

The care pathways reinforce the importance of communication and partnership in decision-making between persons with common traffic impairments and treatment providers.

For the purposes of this Guideline, each successive period of thirty consecutive days following the date of the insured person's accident is considered to be a "month", and "nurse practitioner" means a registered nurse with an extended certificate of registration as referred to in subsection 3 (1) of the SABS.

Part B – Definition of Common Traffic Impairment

Impairments resulting from motor vehicle accidents often present as clusters of physical, mental and psychological signs, symptoms, injuries or conditions.

A "Common Traffic Impairment" (CTI) means any one or more of the following impairments that result from a motor vehicle accident:

Physical impairments: grades I, II and III (cervical radiculopathy) neck pain and its associated disorders (NAD); headaches associated with neck pain; thoracic and lumbar spine pain; thoracic radiculopathy and lumbar radiculopathy (nerve root injury); grades I and II girdle and limb sprains and strains and related soft tissue injuries; grades I and II sprains and strains of the temporomandibular joint and related soft tissue injuries; skin and muscle contusions; abrasions and skin lacerations which do not extend beneath the dermis; and pain associated with any of the above listed impairments.

Mental impairments: mild traumatic brain injury (MTBI) (manifested as a loss of consciousness lasting less than 30 minutes after the accident, altered consciousness ≤ 24 hours after the accident, post-traumatic amnesia ≤ 24 hours after the accident, and an initial Glasgow Coma Scale of 13 to 15), with normal structural imaging, and with signs and symptoms resulting from the MTBI lasting no more than 3 months.

Psychological impairments: early psychological signs and symptoms, including: depressed mood, anxiety, fear, anger, frustration and poor expectation of recovery.

Part C – Impairments That Come Within This Guideline

Subject to the exceptions in Part D below, an insured person's impairment comes within this Guideline if it is a CTI.

Part D – Impairments That Do Not Come Within this Guideline

This Part sets out, for the purpose of subsection 18 (2) of the SABS, the type and standard of evidence required to establish that an insured person's impairment does not come within this Guideline.

An insured person's impairment does not come within this Guideline if a health practitioner (as identified depending on the circumstances described below), acting

impartially and within the scope of his or her expertise, confirms in writing and provides compelling evidence that:

(a) the CTI is not the most serious impairment sustained by the insured person as a result of the motor vehicle accident

OR

(b) the CTI is the most serious impairment sustained by the insured person as a result of the motor vehicle accident, but the insured person:

i. has any of the following conditions (which may pre-date the accident or develop during the course of treatment under this Guideline):

- Neurological disorder (for example, cervical spondylotic myelopathy)
- Autoimmune disorder with or without joint involvement (for example, Type 1 Diabetes in an uncontrolled state)
- Psychiatric condition (for example, active psychoses, severe PTSD)
- Other serious pathology (for example, active cancer)

AND

ii. the condition is likely to prevent the insured person from recovering if treated only under the care pathways.

Where an insured person has not received any treatment under this Guideline, the confirmation and compelling evidence referred to above must be provided by a health practitioner, as defined in the SABS, in a completed and signed OCF-18 Treatment and Assessment Plan (unless the requirement for the OCF-18 has been waived by the insurer).

Where an insured person has already received any treatment under this Guideline, the confirmation and compelling evidence referred to above must be provided only by a physician or nurse practitioner in a completed and signed OCF-24 (unless the requirement for the OCF-24 has been waived by the insurer).

Part E – Delivering Goods and Services through the Care Pathways

Only the following health professionals ("initiating and coordinating health professionals") are permitted to initiate and coordinate goods and services for insured persons under this Guideline:

- chiropractors
- dentists
- nurse practitioners
- physicians, and

- physiotherapists.

The insured person's initiating and coordinating health professional is expected to provide or coordinate the treatment as recorded through the OCF-23 Treatment Confirmation Form from the initial visit.

The initiating and coordinating health professional must complete the OCF-23 and deliver it to the insurer within 10 business days of the initial visit unless the insurer has waived the requirement for an OCF-23.

The insured person should be actively involved in discussions and decisions about his or her care. To ensure patient choice and participation, the initiating and coordinating health professional is expected to review the treatment recommended in all applicable care pathways with the insured person in advance of initiating a course of treatment. Treatment should include education, advice, encouragement to stay active (including return to work) and reassurance that a CTI is usually of a time-limited nature.

All goods and services delivered under this Guideline should reflect the recommendations in the care pathways incorporated in this Guideline. Treatment may be delivered by anyone legally authorized to do so. The insured person's initiating and coordinating health professional may also coordinate or directly supervise the provision of services to the insured person by other providers.

An insured person with multiple impairments that come within this Guideline should be treated using all appropriate care pathways found in the Appendix. For example, a person with one or more lower extremity soft tissue impairments and neck pain should be cared for in accordance with the *Guideline for the Clinical Management of Lower Extremity Soft Tissue Disorders* **and** the *Guideline for the Clinical Management of Neck Pain and Its Associated Disorders (NAD)*.

As set out in the care pathways, treatment under this Guideline should be discontinued as soon as the insured person reports significant improvement (for example, a report of "much improved" should be considered evidence of significant improvement).

The initiating and coordinating health professional must complete the OCF-24 in the following circumstances:

- no additional treatment is required
- the treatment provided for in this Guideline has been completed
- the insured person is non-compliant, or
- the insured person is being referred to a physician or nurse practitioner to determine whether an insured person has an impairment that comes within this Guideline.

Part F – Maximum 6 Month Timeframe for the Treatment

The care pathways incorporated in this Guideline recommend treatment up to a maximum of 6 months from the date of accident.

The care pathways set out available treatment in 2 phases: recent onset phase (0-3 months post-accident) and persistent phase (4-6 months post-accident).

Treatment should correspond to the timeframes specified in the care pathways. For example, an insured person who begins treatment at 2 months post-collision may access all of the treatment set out in the recent onset phase within the shortened period of time, as recommended, and then move to the persistent phase at 4 months post-collision if required. An insured person who begins treatment between 4 and 6 months post-accident may only access treatment set out in the persistent phase and not those recommended in the recent onset phase.

Part G – Fees Payable Under This Guideline

General

For the purpose of this Guideline and subsection 18 (1) of the SABS, the "financial limit" is $XX (TBD) per insured person. Amounts for goods and services under this Guideline are only payable in accordance with subsection 18 (1) of the SABS and the provisions set out in this Part.

Goods and services delivered in accordance with this Guideline will be paid for by the insurer without insurer approval where the OCF-23 process set out in the SABS has been followed, or where the requirement for an OCF-23 has been waived by the insurer. The fee for completion of an OCF-23 is included in the financial limit.

The cost of a completed OCF-24 and transfer fees in respect of a change by an insured person of his or her initiating and coordinating health professional are not counted for the purposes of the financial limit.

Insurers are not required under this Guideline to pay for multimodal care for an insured person with persistent non-specific low back pain outlined in the care pathway titled *Guideline for the Clinical Management of Low Back Pain With And Without Radiculopathy* (at 10.1.4.7).

Per Month and Per Phase

The maximum fee payable in respect of an insured person for all goods and services provided during the recent onset phase is $XX (TBD) and includes all goods and services (including assessments, reassessments and treatment) provided during the phase, regardless of the amount or type provided.

Despite this Guideline's financial limit of $XX (TBD) as referred to above, amounts exceeding the following sub-limits are not payable by an insurer in respect of an insured person:

- $XX (TBD) for goods and services incurred in month one
- $XX (TBD) for goods and services incurred in month two, less amounts incurred in month one
- $XX (TBD) for goods and services incurred in month three, less amounts incurred in months one and two.

The maximum fee payable in respect of an insured person for all goods and services provided during the persistent phase is $XX (TBD) and includes all goods and services (including assessments, reassessments, and treatment) provided during that phase, regardless of the amount or type provided. This fee also includes the cost of completion of the OCF-23. If an insured person with a NAD I/II in the persistent phase chooses either Iyengar yoga or Qigong as a treatment, the insurer will allocate funds out of the total maximum fee payable to reimburse the insured person for his or her out-of-pocket expenses in respect of this treatment.

Despite this Guideline's financial limit of $XX (TBD) per insured person, amounts exceeding the following sub-limits (adjusted as necessary to reflect the insurer hold-back for insured persons who choose the Iyengar yoga or Qigong treatment) are not payable by an insurer in respect of an insured person:

- $XX (TBD) for goods and services incurred in month four
- $XX (TBD) for goods and services incurred in month five, less amounts incurred in month four
- $XX (TBD) for goods and services incurred in month six, less amounts incurred in months four and five.

Invoices

An OCF-21 Auto Insurance Standard Invoice for goods and services provided to the insured person in accordance with this Guideline may be delivered by a treatment provider not more often than once in a calendar month.

A treatment provider may invoice the insurer in a calendar month for any goods or services provided during that calendar month.

Iyengar Yoga and Qigong

According to the recommendations in the care pathways, an insured person with neck pain and associated disorders (NAD) grades I and II injuries requiring treatment in the persistent phase (4-6 months post-collision) may choose either Iyengar yoga or Qigong as a treatment. When the insured person is reassessed at the start of the persistent phase, the initiating and coordinating health professional must advise him or her of these treatment options and, where the insured person elects either Iyengar yoga or Qigong, must advise the insurer of this choice on the OCF-23.

The insurer will allocate funds for either of these treatments and reimburse the insured person directly for his or her out-of-pocket expenses in respect of these treatments. The insured person will be reimbursed in accordance with receipts or other satisfactory proof of payment provided to the insurer and up to $XX (TBD)/class.

Part H – Other Fees Payable

The fee payable by an insurer to an initiating and coordinating health professional for completing an OCF-24 is $85 (this does not apply to an OCF-24 completed for the purposes of Part D above – see next paragraph).

The fee payable by an insurer to a physician or nurse practitioner for completing an OCF-24 for the purposes of Part D above is $XX (TBD).

The transfer fee, if an insured person changes his or her initiating and coordinating health professional is $50, payable by the insurer to the new initiating and coordinating health professional.

Part I – Delivery of OCF-18 Permitted in Certain Circumstances

Despite subsection 38 (5) of the SABS, an OCF-18 must be accepted and considered on its merits by an insurer if delivered:

(a) for the purpose described in Part D above in respect of an insured person who has not received any treatment under this Guideline

OR

(b) for the purpose of proposing an assessment or examination to determine whether an insured person who has already received any treatment under this Guideline has an impairment that comes within this Guideline.

Part J – Changing Initiating and Coordinating Health Professionals Within This Guideline

An insured person who is receiving care under this Guideline may change his or her initiating and coordinating health professional. In such a case, the new initiating and coordinating health professional will inform the insurer of the change and the insurer will advise him or her as to what services have already been provided under this Guideline. The new initiating and coordinating health professional will then resume delivery of Guideline services.

In a month where more than one initiating and coordinating health professional has provided or coordinated services, amounts payable will be calculated on a pro-rated basis.

Part K – Amounts Payable under Other Insurance and Health Care Coverage

Subsection 47 (2) of the SABS provides that an auto insurer is not obligated to pay for that portion of an expense for which payment is reasonably available under other insurance or health care coverage (for the purpose of this Guideline, such coverage is collectively referred to as extended health care benefits (EHCBs)).

All EHCBs reasonably available to an insured person for services provided under this Guideline are to be deducted from the amounts otherwise payable by the auto insurer.

For example, if the insured person has $XX in EHCBs reasonably available for a treatment, this amount would be deducted from the $XX otherwise payable by the auto insurer for a month of treatment; therefore the auto insurer would pay only $XX that month. However $XX [$XX (TBD) Guideline financial limit - $XX paid by the auto insurer] would remain available for payment of the other fees outlined for treatment provided for in this Guideline. The insurer is not liable to pay for treatment not recommended in this Guideline, even where the limit has not been exhausted, for example, due to EHCB availability.

Appendix

This Guideline incorporates the following care pathways and glossary from the report entitled *Enabling Recovery From Common Traffic Injuries: A Focus on the Injured Person* as delivered to the Financial Services Commission of Ontario by the Ontario Protocol for Traffic Injury Management Collaboration:

- *Guideline for the Clinical Management of Neck Pain And Its Associated Disorders (NAD) (Section 4.0)*
- *Guideline for the Clinical Management of Persistent Headaches Associated With Neck Pain (Section 5.0)*
- *Guideline for the Clinical Management of Soft Tissue Disorders of The Upper Extremity (Section 6.0)*
- *Guideline for the Clinical Management of Lower Extremity Soft Tissue Disorders (Section 7.0)*
- *Guideline for the Clinical Management of Temporomandibular Disorders (Section 8.0)*
- *Recommendation for the Clinical Management of Mild Traumatic Brain Injury (MTBI) (Section 9.0)*
- *Guideline for the Clinical Management of Low Back Pain With And Without Radiculopathy (Section 10.0)*
- Glossary.