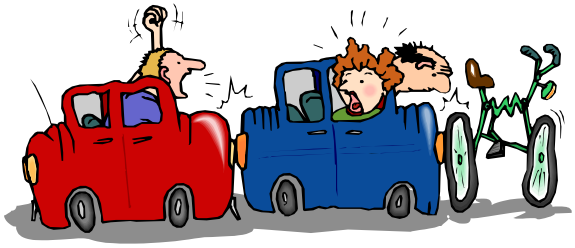
Bill 198 and the New SABS



Toronto Rehabilitation Institute

Monday, May 12, 2003

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Bill 198 History

Fall 2001 – Fall 2002

• **Auto Insurance reform has been extended consultative process which examined various legislative proposals**

September 2002

• **198 Draft Legislation and Consultation**

December 2002

• **Ontario Legislature passes Bill 198**

February 21, 2003

• **New draft regulations and SABS released**
• **Many concerns and criticisms**

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Bill 198: Key Gains versus Losses

What has been gained?

The victim's right to sue for medical rehab expenses in non-catastrophic cases.

What has been lost?

The victim's access to timely treatment due to increased complexity and delays in the system.

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The New Pre-Approved Framework (PAF)

- Affects Whiplash Associated Disorder (WAD I and II)

- No DACs, Assessments, Insurer Exams

- Limits on treatment:
  - WAD I - 4 weeks < $1200
  - WAD II - 6 weeks < $1500

- Can you get out of the PAF? How?

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Key Concern – Delay of Treatment

- Delayed assessment
- Delayed treatment
- Penalty for late notice: Delay of treatment
- More complex procedure, forms = delay
- Increased length of stay
- Increased burden on C.C.A.C.

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Early Action by your Lawyer

1) Get notice to insurer in time
2) Accident benefit application to insurer
3) Assessments completed in hospital
4) Obtain appropriate case management
5) Take care of expense forms so family can focus on accident victim
6) Facilitate treatment plan completion, submission and insurer's agreement before discharge

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Claims against the "At-Fault" Driver

What's New in pain and suffering ?

i) Threshold (no change)

ii) Deductible (none for claims over $100,000)

iii) Family Law Claims Deductible (none for claims over $50,000)

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Claims Against the "At-Fault" Driver

What's New for Health Care Expenses?

i) Auto Accidents
- threshold (permanent & serious)

ii) Non-auto Cases
- delay in compensation to end of case
- availability of advance payment

Income Loss

i) Auto accidents (80% of net pre-trial)

ii) Non-auto (gross)

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New Barriers to Treatment

- Treatment Plan increases to 5 pages from 3, with increased coding and information requirements

- Treatment Plans for multi-disciplinary centers can only be submitted once every 30 days for first 6 months and once every 60 days thereafter

- Benefits are not payable until an application has been "completed" to the insurer's satisfaction

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The Peril of Late Notice

- Notice within seven days or benefits delayed by 45 days

- Inadequate sanctions for Insurers who cause delay

- Could double treatment approval time

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Getting your Patient Assessed

- Section 24 gone
- Insurer consent now required
- If assessment denied, DAC will be involved
- Could add 21 days of delay
- Assessments for PAF limited to $180 x 3

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Other Barriers

- "If requested by the insurer, a person applying for a benefit shall submit to an examination under oath with respect to the circumstances that gave rise to the application…"(s.33(1.1))
- Insurers can reject incomplete applications

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What's New with "Catastrophic" Definition

- Loss of use or amputation of both legs
- Children CAT testing measures appear to be expanded to include use of clinical measures (proposed wording ambiguous)
- Insurer must determine CAT status in 2 yrs
- Optional benefits: care increased to $6,000
- Includes case management

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Pursuing Payment for Outstanding Treatment expenses

- Service providers can't mediate or arbitrate or sue
- Only victim can pursue
- Victims and their lawyers must work closely with treatment providers

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The New Forms

The New Treatment Plan

- All treatment on one plan
- Treatment Plans for multi-disciplinary centers can only be submitted once every 30 days for first 6 months and once every 60 days thereafter
- Benefits are not payable until an application has been “completed” to the insurer’s satisfaction

The New Treatment Plan

- Part 5: certifying for other Health Practitioners
- Part 6: OT and S.L.P can now supervise
- Part 7: increased coding requirements

OCF 18/59 120202 v1
Sunnybrook

DRAFT

Treatment Plan (OCF-18/59)

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

For this claimant, this is Treatment Plan number _____ from this health professional/facility

To the Claimant:

Use this form for accidents that occur on or after November 1, 1996. Please complete Parts 1 and 2. After your health professional or practitioner has reviewed your Treatment Plan with you, sign Part 13. Your health professional/practitioner will complete all other parts of the form. **A health practitioner (chiropractor, dentist, optometrist, physician, physiotherapist, psychologist) must sign Part 5.**

To the Health Professional/Facility: Consent:

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

To the extent possible, this Treatment Plan should include **all goods and services** contemplated by this health professional/facility for the period of this Treatment Plan.

Please provide all information requested. This form may not be materially altered.
Confidentiality:Collection, use and disclosure of this information is subject to all applicable privacy legislation.

Part 5 Signature of Health Practitioner	Name of Health Practitioner		Registration Number	You are a: ❑ Chiropractor ❑ Dentist ❑ Optometrist ❑ Physician ❑ Physiotherapist ❑ Psychologist
	Facility Name (if applicable)		AISI Number (if applicable)	
	Address			
	City	Province	Postal Code	
	Telephone Number	Extension	Fax Number	
	Email Address			

N/A I wish to declare that I have no conflicts of interest relating to this Treatment Plan, *and* I have determined, after making reasonable inquiries, that there are no conflicts of interest on the part of any person who referred the claimant to me with respect to this Treatment Plan
or

N/A I am declaring the following conflicts of interest relating to this Treatment Plan:

N/A I certify that, to the best of my knowledge, the information in this Treatment Plan is accurate, the treatment plan has been reviewed with the claimant by the regulated health professional in Part 6, and the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the claimant for the injuries identified in Part 7.

Name of Health Professional (please print)	Signature of Health Practitioner	Date (YYYYMMDD)

Part 6 Signature of Regulated Health Professional

Responsible for Plan Preparation and Supervision
If same person as Part 5 check here ❑ and

Name of Regulated Health Professional		Registration Number	**You are a:** ❑ Chiropractor ❑ Dentist ❑ Massage Therapist ❑ Nurse ❑ Occupational Therapist ❑ Optometrist ❑ Physician ❑ Physiotherapist ❑ Psychologist ❑ Speech Language ❑ Other - Social Worker
Facility Name (if applicable)		AISI Number (if applicable)	
Address			
City	Province	Postal Code	
Telephone Number	Extension	Fax Number	
Email Address			

N/A
I wish to declare that I have no conflicts of interest relating to this Treatment Plan, ***and*** I have determined, after making reasonable inquiries, that there are no conflicts of interest on the part of any person who referred the claimant to me with respect to this Treatment Plan
or
N/A I am declaring the following conflicts of interest relating to this Treatment Plan:

I certify that, to the best of my knowledge, the information provided by me is accurate.

Name of Regulated Health Professional (please print)	Signature of Regulated Health Professional	Date (YYYYMMDD)

Part 7 Injury and Sequelae Information

Provide description (list most significant first) and associated ICD-10-CA code for injuries and sequelae that are the direct result of the automobile accident.

Injury Description	Injury Code
Brain Injury	F06
Fractured Femur	S72
Lumbar Spine Strain	S33
Spinal Cord Injury	G90

Part 8 Prior and Concurrent Conditions	a)Prior to the accident, did the claimant have any disease, condition or injury that could affect his/her response to treatment for the injuries identified in Part 7? ❑ No X Unknown ❑ Yes (please explain) If Yes to "a" above, did the claimant undergo investigation or receive treatment for this disease, condition or injury in the past year? ❑ No X Unknown ❑ Yes (please explain and identify provider, if known)
	b)Since the accident, has the claimant developed any other disease, condition or injury not related to the automobile accident that could affect his/her response to treatment for the injuries identified in Part 7? ❑ No X Unknown ❑ Yes (please explain)

Part 9 Activity Limitations	a) Does the claimant's impairment(s) from the injuries identified in Part 7 affect his/her ability to carry out: His/her tasks of employment ❑ Not employed ❑ No ❑ Unknown ❑ Yes His/her activities of normal life ❑ No ❑ Unknown ❑ Yes
	b) If Yes to either of the questions above, briefly describe the activities limited by the impairment and their impacts on the claimant's ability to function.
	c) If the claimant is unable to carry out pre-accident employment activity, is the employer able to provide suitable modified employment to the claimant? ❑ Not employed ❑ Yes ❑ Unknown ❑ No (please explain)

Part 10 Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery	a) Goals (i) Identify the goal(s) in regard to the claimant's impairment(s), symptom(s) or pathology that this Treatment Plan seeks to achieve: ❑ pain reduction ❑ increased range of motion ❑ increase in strength ❑ other(s) (please specify) Reduce impairments And (i) Select the functional goal(s) that this Treatment Plan seeks to achieve: ❑ return to activities of normal living ❑ return to pre-accident work activities ❑ return to modified work activities ❑ other(s) (please specify) maximize recovery
	b) Evaluation: (i) How will progress on the goal(s) in c (i) and c (ii) be evaluated? E.g. By public and private health care professionals following discharge from hospital (ii) If this is a subsequent Treatment Plan, what was the claimant's improvement at the end of the previous plan based on your evaluation method?

c) Have you identified any other barriers to recovery? XNo ❑ Yes (please explain) Do you have any recommendations and/or strategies to overcome these barriers? XNo ❑ Yes (please explain)
d) Are you aware if any concurrent treatment, that is not included in this Treatment Plan, will be provided by any other provider/facility? xNo ❑ Yes (please explain)
e) Is the proposed Treatment Plan consistent with any treatment/utilization/practice guideline? X Yes Identify guideline: Consistent with hospital discharge recommendations and protocol ❑ No (please explain)

Part 11 Health Providers	Provider Reference	†Provider Type	Provider		Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate (if applicable)
			Last Name	First Name			
	A	PT	unknown				
	B	OT	unknown				
	C	Psy	unknown				
	D	SP	unknown				
	E	SW					
	F						

Part 12 Proposed Goods and Services

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

G/S Ref	Description	†Code	†Attribute	Provider Ref	Estimate / Day			Projected	
					Quantity	†Measure	Cost	Total Count	Total Cost
1	Assessment PT, SP, OT, Care, Home…				1x30 days				
2	Physiotherapy				5x 1Hr weekly				
3	Occupational Therapy				5x 1Hr weekly				
4	Speech Therapy				3x1Hr weekly				
5	Nursing				12 hours daily				

6	Nutritional Counselling				1 X in 14days				
7	Counselling				2 X weekly				
8	Neuropsychological testing				Within 2 months of discharge				
9	Care Support Worker				3 hours daily				
10	Life Skills Coach				3 x 3hrs weekly				

Estimated duration of this Treatment Plan: Until Private therapists submit treatment plan	**weeks**	**Sub-Total:**	???	
How many treatment visits have you already provided:	N/A		**✦Minus MOH:**	
Note †: Refer to User Manual coding guidelines **Note ✦:** Payment by auto insurer is secondary to available collateral benefits.			**✦Minus Other Insurer 1 + 2:**	
			GST (if applicable):	

Part 13 Signature of Claimant Must be completed unless waived by insurer	I have reviewed and agree with this Treatment Plan. I understand that payment for this Treatment Plan is subject to the approval of the insurer. In the event that the Treatment Plan is disputed by my insurer I understand that I will have 7 days to respond in writing if I wish to withdraw this treatment plan. If I wish to proceed, the insurer has 15 days from the date of the insurer's denial to arrange for a DAC assessment. I authorize my insurer to send the Treatment Plan and other relevant health information to the appropriate DAC. I authorize the DAC to consult with my health professional(s) and provide copies of the DAC report to the insurer. This authorization replaces the need for the completion of a separate OCF-14 form. Subject to the Statutory Accident Benefits Schedule, I understand that, if I undertake any of the proposed treatments prior to the approval of this Treatment Plan by the insurer or the DAC, I may be responsible for payment to my provider for any services rendered on my behalf.		
	Name of Claimant or Substitute Decision Maker (please print)	**Signature of Claimant or Substitute Decision Maker**	Date (YYYYMMDD)

How Lawyers Help

1) Complex Insurance Law
2) Time limits - Notice for SABS
   - Notice for Tort
3) Information regarding victim/family rights
4) Guidance and advice in completing forms
5) Persuading insurers to meet obligations to victims
6) Everything in place for discharge (housing, transportation, equipment, therapy, care)

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Bill 198

When does it Happen?

August or September

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Thank You

For actual draft regulations and forms:
www.thomsonrogers.com
Click on the *"What's New"* button

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