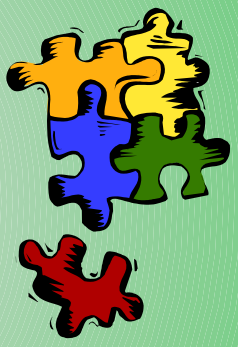
Bill 59
New Solutions to an Old Puzzle

January 25, 2002



How to use Bill 59 to support family members and accident victims in hospital

Illana Perlman, *Sunnybrook & Women's College Health Sciences Centre*

Wendy Moore Johns, *Thomson, Rogers*

Acute Care Family Support

Needs of the Patient / Family:

a. **Emotional** - crisis state
- grief or anticipated grief
- anxiety, sadness, anger

b. **Practical** - financial
- care for the family
- maintaining the home

How Bill 59 can help with the immediate needs:

a. knowledge of coverage

b. quick access to benefits

c. expenses of visitors to hospital

d. income benefit

e. housekeeping

Goals of the Patient / Family:

a. Support the family through the crisis

b. Engage the insurer

c. Set the building blocks in place for smooth transition

How Bill 59 can help the family meet their goals:

a. Access

b. Rehabilitation benefit - family counseling

c. Case Management

Attendant Care

Attendant Care in the Acute Care Setting:

a. Needs of the Patient

b. Condition

c. Limitations of Hospital Care

Bill 59 and Attendant Care in Hospital:

a. Availability

b. Providers of Care

c. Timing of payment

d. "Incurred" expenses

e. Pay pending dispute (s.39(6))

How the hospital can secure attendant care funding:

a. Establish a hospital protocol

b. Help your patients know their rights

SUNNYBROOK & WOMEN'S COLLEGE HEALTH SCIENCES CENTRE - TRAUMA PROGRAM

ATTENDANT CARE PROTOCOL ON TRAUMA WARD: ACCESSING 3RD PARTY FUNDING

1. **Obtain physician's order in the chart stipulating the need for the attendant care due to the patient's condition and care needs resulting from the injury sustained e.g. "attendant ordered due to brain injury sequelae from the MVC". Stipulate that such care is not provided by the hospital - any profession.**

2. **Notify Social Work and Patient Care Manager (PCM) of attendant care order.**

3. **Provide the PCM with the contact name and number of the lawyer/insurance adjuster/nurse case manager (for WSIB) - Social Work.**

4. **Contact the lawyer/insurer to state the need for attendant care and verify that it is not funded by the hospital - PCM.**

5. **THE PCM REQUESTS/ARRANGES A DIRECT BILLING SYSTEM IS SET UP BETWEEN THE INSURER AND THE NURSING AGENCY DIRECTLY.**

6. **Submit a "form" letter to the lawyer/insurer to document patient's diagnosis and care needs regarding the attendant care, and affirming that such is not covered by the hospital. Ensure this is signed by the Physician (ideally the attending staff) and the PCM - PCM.**

7. **For automobile insurance cases, Occupational Therapist (hospital's or externally assigned by insurer) may need to complete Assessment of Attendant Care needs form (Form 1). If completed by our OT, we can bill $75 for it.**

8. **Ward team regularly reviews extent of attendant care required by patient.**

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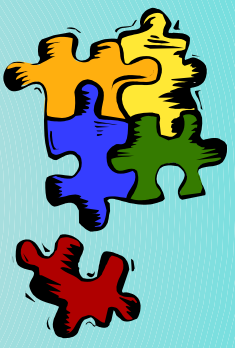


Getting to Yes for Treatment Plan Funding

Frank Martino, *C.E.O., Rehabilitation Network Canada*

David MacDonald, *Partner ,Thomson, Rogers*

Scope of Treatment Plan

all measures to assist in recovery from injury, reduction of impairments and / or reintegration into home, work community or school

Assessments Required to Determine Appropriate Treatment Plan

life skills
family
social
psychological
functional
cognitive
vocational
workplace
home
rehabilitation coordination ... to name a few

Treatment Plan Approaches

Who does the S.A.B.S. empower to assess the needs of or treat the victim?

Arbitration decisions *Gaba*, *Arbeau*, and *Parada* state the *victim can select the professional.*

Why assess before treatment plan?

- **learn parameters of reintegration needs in home, school, work, community and family**
- **determine "goods and services required"**
- **determine "anticipated benefits"**
- **"identify impairments"**
- **determine required "duration", "frequency"**
- **determine "estimated costs"**
- **facilitate early and safe discharge planning**
- **identify and support the in hospital treatment team needs**

When should private health care professionals assess?

- **Prior to discharge: home and workplace assessments**
- **following discharge: vocational, neuropsychological, psychological, functional abilities, transferrable skills, school reentry, avocational or life skills assessments (for example)**

Importance of Assessments to determine needs and treatment

- **barriers or impairments not identified will compromise recovery and be deemed not to be caused by accident**
- **rehabilitation patchwork**
- **lack of coordination**
- **boilerplate treatment plans misspend limited rehabilitation dollars**
- **prolonged recovery**
- **increased likelihood of dispute with insurer**

Assessment Costs

SABS Section 24:

"The insurer shall pay for all reasonable expenses incurred … for the purpose of this Regulation in obtaining … an assessment".

"purpose of this Regulation:

to determine entitlement to and to provide accident victims with:

- **income replacement, caregiver or non earner**
- **medical**
- **rehabilitation**
- **rehabilitation coordination**
- **housekeeping, home modification and maintenance**
- **attendant care benefits, regardless of fault**

Tsimidis

Treatment Plan Approaches

When to call the adjuster

What do they need to hear?

-overview of your planned role
-referral source
-degree of impairment
-urgency factors

Treatment Plan Approaches

Part 6 Tips

-use schedules
-build in review at 6 weeks
-keep Tx Plan duration 8-12 weeks
-build in team meetings
-refer to s.24 assessment findings

Treatment Plan Approaches

Building Agreement

Who have you worked with at the company?

Do you do both insurer and insured work?

Can you assist with any insurer assessment mandates?

Treatment Plan Approaches

Building Agreement

Entrench adjuster confidence

Identify similar cases with successful results.

Identify specific elements of training and experience that corelate to the impairments needing intervention.

Treatment Plan Approaches

Building Agreement

Create a team approach

Invite the adjuster to a team meeting

Develop a protocol for reporting

Treatment Plan Approaches

The Treatment Plan Content

Part 6 Tips

DACs tell us:

treatment plans must be specific in identifying precise impairment, precise treatment and precise goal of treatment. Provide examples of activities enabled by recommended intervention.

Treatment Plan Approaches

remember the expansive definition of Rehabilitation when you frame the section 6 comments:

any "reasonable measure to reduce or eliminate the effects of disability or reintegrate... into family, society or the labour market." - SABS s. 15(2).

Treatment Plan Approaches

Treatment Plan Content

Part 6 Tips

Identify fall-out if Tx Plan not accepted

-Prolonged IRBs and disability
-reduced prognosis for full recovery
-prolonged attendant care needs
-prolonged housekeeping needs
-exacerbation of pain, loss of r.o.m.
-entrench emotional vulnerability
-lose currently available options to reintegrate into family, job, society.
-failure to adhere to best practices

Treatment Plan Approaches

Fourteen days or deemed approval

Fax letter on the 14th day confirming Tx starting.

Get client to sign DAC O.C.F. form at time of s. 24 assessment.

Send all treatment accounts to victim's lawyer.

Send all records and reports showing functional gains to DAC directly.

What can go wrong when insurers ignore treatment team recommendations and try to control the assessment and treatment plan process?

Persofski

"Mandating" a Cooperative Approach to Funding and Providing Treatment:

A new protocol must increase dialogue to promote an increased understanding of:

- **the accident victim's impairments;**
- **the anticipated manner by which the recommendations made by health care professionals will reduce those impairments; and to**
- **facilitate agreement to fund treatment plans,**

in order to *reduce as much as possible the human and economic toll that delayed or denied treatment has upon the victim, the victim's family, the insurer, employers, public health and society.*

Bill 59
New Solutions to an Old Puzzle

January 25, 2002

Seamless Rehabilitation - Hospital to Home

Anna Greenblatt, *Inter-Action Rehabilitation Inc.*

Leonard Kunka, *Thomson, Rogers*

4 PIECES OF THE PUZZLE

1. **Treatment Plans**
2. **Designated Assessment Centres (DAC)**
3. **Patient Profiles**
4. **Case Management**

1. Treatment Plans

- **There is a 14 day response period allowed for the insurers**
- **Delays beyond this time period are frequent, 1 month for a response is not uncommon**
- **Doctors, dentists, physiotherapists, chiropractors, and psychologists can provide up to 15 sessions of therapy without a treatment plan**

PROBLEM:

- Treatment is delayed until funding has been approved, usually for at least 14 days
- We know of no penalties imposed on insurers for delayed responses to treatment plans
- Service providers who treat while waiting for a response to the treatment plan risk non-payment of services already provided

RECOMMENDATIONS:

- The 15 treatment funding should be extended to include Occupational Therapists, Speech Language Pathologists, Social Workers and other health care professionals
- Penalty: after 14 days if no answer has been given, the insurer should have to pay for all costs until a refusal is received by the service provider
- Therapists at the facility should write a treatment plan 2 weeks pre-discharge to cover the period of 1-3 months post discharge

LEGAL PERSPECTIVE:

- **If insurer does not respond within 14 days, one may argue that they are deemed to have accepted the treatment plan**
- **After 14 days write to the insurer advising that they are deemed to have accepted the treatment and that the treatment will be proceeding**
- **The problem is: if the insurer fails to pay for the treatment, and the insured has to file for mediation to resolve the issue, this is expensive and delays treatment**

Note however the case of *Kyriakos Poulos v. Zurich Insurance Company* (OABCS#9644) where insurer did reject treatment plan within 14 days and insured requested DAC, but insurer sent insured to IME rather than DAC, the insurer was found to have breached the denial provisions of s.38 of the Regulations.

- **This case however underscores the problem that s.38 provides no penalty for failure to comply with the procedural requirements of the Schedule.**
- **It is important for social workers and other discharge planners at hospitals to help put in place good rehab teams prior to discharge in as to ensure that the best interests of the injured party are being met.**

2. Designated Assessment Centres (DAC's)

- **When a treatment plan is refused, a DAC may be requested. The delay between a DAC being requested from the insurer to the time it is actually set up can be months.**

  The wait for a report is longer.

PROBLEM:

- **Delays have been as long as 14 months from the time a treatment plan was refused to the time we received a DAC report**
- **During this period, the injured person did not receive therapy**

LEGAL PERSPECTIVE OF THE PROBLEM:

- If time period waiting for a DAC is excessive, the treatment may no longer be beneficial and there is a risk that the DAC will not find the treatment necessary
- It is virtually impossible for a DAC to consider retrospectively what the injured party required by way of treatment
- Insurers can use the delivery of medical information to the DAC's as a way to delay the DAC process and effectively terminate treatment

RECOMMENDATIONS:

- Mandate time period for DAC report to be produced
- Require insurers to pay for recommended treatment pending receipt of the DAC report
- Settle disputes through mediation (with clear timelines for hearings)

LEGAL PERSPECTIVE:

- **both insurer and insured need to supply medical information to the DAC**
- **Time periods for arranging DAC's have to be tightened**
- **Best way to avoid this delay problem is to require insurer to pay for all recommended treatment up to the date of the DAC report, and therefore the DAC will only deal with future treatment which may be required**

  Note: s.37(3)c and s.38(16) s.39(6) requiring payment pending dispute in certain situations

3. Patient Profile

- **A patient profile was designed by the Acquired Brain Injury Network of Toronto**
- **The purpose of the profile is to provide a portable file to the injured party**
- **All test results, ambulance reports, progress reports and discharge reports would be in this file containing information from the emergency room through the acute, rehab and community phase**

PROBLEM:

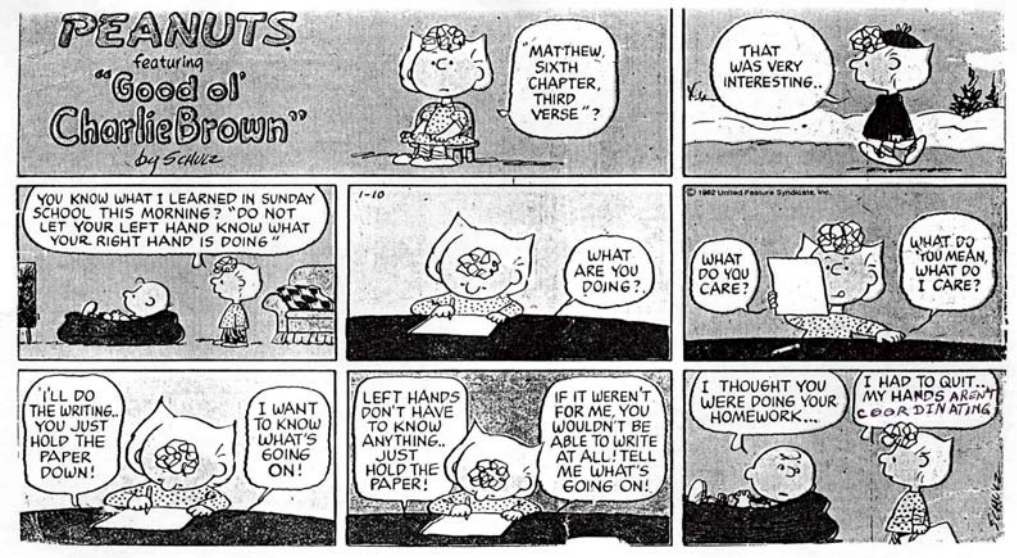
- To the best of my knowledge, this patient profile is not being used
- Significant delays occur before relevant information is available to the treating therapist
- Treatment plans which are key to funding ongoing therapy, are too often submitted without having as much information as would be desirable

RECOMMENDATIONS:

- All institutions should ensure that they fill out the patient profile prior to discharge
- Training and cooperation would be necessary at the level of the team, especially the discharge coordinators, and would be consistent through all institutions

4. Case Management

- **Only people designated as catastrophic have a right to case manager**
- **In non-catastrophic cases, if the insurer agrees, a case manager may be appointed**



PROBLEM:

- **On initial discharge crucial time is being lost arranging access to the appropriate treatment**

LEGAL PERSPECTIVE:

- Many people who have significant injuries which may not be catastrophic, still need a case manager to help co-ordinate treatment/therapy
- Insurers have been appointing "rehab co-ordinators" rather than "case managers", thereby shifting control of the injured parties treatment into the hands of the insurer.

RECOMMENDATIONS:

- Every injured party should have access to a limited amount of case management --- up to 20 hours
- In all serious injury cases, whether catastrophic or not, attempt to get insurer to agree to the use of a case manager

Effectiveness of treatment plan in facilitating treatment

Survey Highlights:

Summary:

The concerns voiced by the health care professionals in response to the thirty-two questions put to them can be grouped into two categories:

1. Inappropriate denial of health care professionals' recommendations for treatment; and

2. Impact upon accident victim of delay in access to medical and rehabilitative needs.

Inappropriate denial of health care professionals' recommendations for treatment

Survey Highlights:

(a) 58% of survey respondents found that *insurers rarely or never contacted the provider to obtain further information about the proposed treatment plan* before denying;

Inappropriate denial of health care professionals' recommendations for treatment

(b) 69% of health care professionals indicated that *insurers' denials of treatment plans were not substantiated by an opinion provided from a health care professional*.

Impact of delay in access to medical and rehabilitative needs upon accident victim.

Survey Highlights:

(a) 76% of survey respondents found that *insurers always, usually or sometimes took more than fourteen days* to approve or deny a treatment plan.

Impact of delay in access to medical and rehabilitative needs upon accident victim.

(b) 82% of respondents found that the delay in funding treatment plan recommendations *always or usually had a negative effect upon the accident victim's accident related impairments.*

Results of Inappropriate Denials

1. **increases burden on public health, social services, mental health and corrections facilities**
2. **destabilizes victim's focus on recovery**
3. **increases barriers to recovery**
4. **loss of productivity**
   a) for victim
   b) for victim's employer

5. **increases costs to insurer**
   - IRB's, attendant care, housekeeping
   - assessment expenses
   - transfer payments to OHIP
   - loss of income claims

6. **reduced likelihood of return to function**

*Recommendations Concerning the Accident Victim's Need for **Early**, **Coordinated** and **Sustained Intervention**:*

- allow funded treatment to proceed during waiting periods associated with approval of the treatment plan *and* when a disputed treatment plan is awaiting determination by a D.A.C.

*Recommendations Concerning the Accident Victim's Need for **Early**, Coordinated and **Sustained** Intervention:*

- provide for automatic approval for services recommended by professionals associated with a treating public hospital required on or for discharge.

- incorporate a pay pending resolution of dispute system for the first 12 weeks after the accident to a maximum of $4,000.00 for services provided by all health care professionals.

*Recommendations Concerning the Accident Victim's Need for **Early, Coordinated** and Sustained Intervention:*

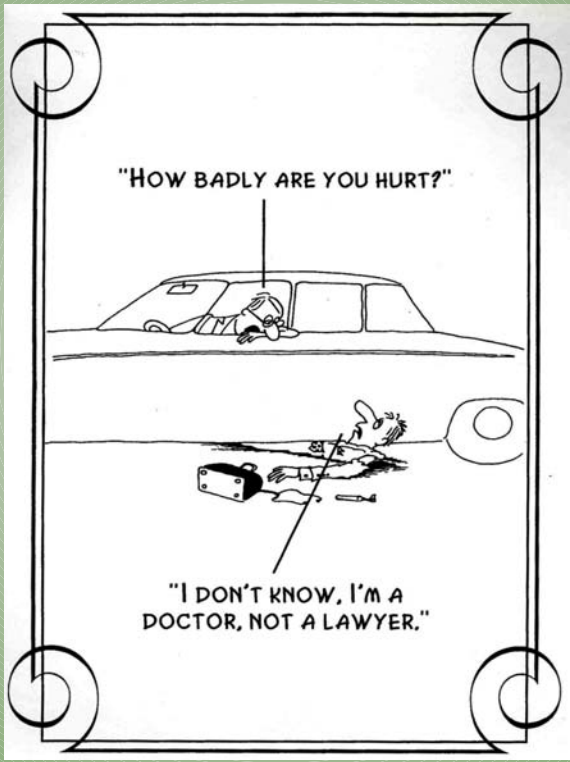
- **deem an automatic approval of the treatment plan if the insurer has not responded within 7 days;**
- **oblige the insurer to attend case conferences and team meetings for the provision and co-ordination of rehabilitation services;**
- **prevent the insurer from denying a treatment plan or a portion of a treatment plan unless the insurer:**
  - **(i) communicates by telephone or in person with the treatment provider recommending services;**
  - **(ii) obtains a written review of the treatment plan by an appropriately qualified health care professional; and**
  - **(iii) provides specific, health care professional based reasons for rejecting the treatment plan.**

Practice Standards for Adjusters

C.P.P., W.S.I.B. and O.D.S.P. Adjudicators who make treatment and disability entitlement decisions must be certified, must follow defined policies, procedures, practices and guidelines to come to a decision. Health care professionals must be certified by their colleges, must follow "best practices" mandates and their Colleges' Codes of Ethics.

If adjusters are to be given the power to second guess qualified health care professionals about their recommendations for their patients, should not *adjusters* be required to *meet similar standards of qualification, conduct and procedure and be penalized if they do not?*

SIGNIFICANT LEGAL CASES IN 2001



Co-Operators General Insurance Company and *John Pierre Moons*

(May 28, 2001) FSCO Appeal P00-00033

A claim by the insured's mother for lost wages while caring for her son was denied as a "Visitor's Expense" under s.21 of the Regulations.

Throughout the decision Director David Draper alludes to the fact that if the claim had been presented as an attendant care claim under s.16, it would have been allowed.

It is helpful in cases of this nature for the insured to obtain a letter from the nursing staff or social worker indicating that there is insufficient hospital staff to provide the degree of care necessary by the insured, and as such, that a family member was required to provide the care.

Briggs v. Maybee et al.

(2001) 53 O.R. (3d) 368

An injured party who has NOT suffered "catastrophic injuries" may nevertheless claim for housekeeping and home maintenance expenses in their tort claim.

These expenses are not considered "health care expenses" and therefore are not subject to s.267.5(3)(4) of the *Insurance Act* which allows excess health care expenses to be claimed in tort only where the injury is catastrophic.

Campeau and *Liberty Mutual Insurance Company,*

(FSCO A00-000522) Arbitrator Lawrence Blackman, released March 12, 2001

This case was one of the first of a growing number of cases which have become a major asset to counsel acting on behalf of injured parties who are making claims against their own insurer for accident benefits.

In this case, and many which have followed, the production obligations of the insurance company have been greatly expanded. The insured is now entitled to virtually all information in the insurers file including all medical reports, drafts and clinical notes (whether relied upon or not by the insurer), and all surveillance information including all videotapes, photographs, reports, notes and summaries.

Pafco Insurance Company v. Lorna Howden

(OABCS # 0612)

For the purposes of calculating weekly income benefits, an injured party is entitled to include in their income, collective bargaining agreement benefits such as premiums paid for life insurance, short and long term disability insurance, contributions to private pension plans & pay equity adjustments.

TTC Insurance Company Limited v. Adosinda Correia

(OABCS # 0614)

Where an insured person had recovered from injuries suffered in a motor vehicle accident, however, sustained further injury while undergoing a Functional Capacity Examination (FCE) at the request of the insurer, the further injury was found to be "caused" by the original accident and therefore compensable under accident benefits.

Ginette Lacroix v. Halifax Insurance Company

(OABCS # 9655)

Insurer must prove that the insured received a clear and unequivocal refusal of benefits for the limitation period to start to run. Here where the insurer could point to a notice of termination but could not prove a specific date when it was sent to the insured, the insured was not barred in their application which was filed beyond the two year limitation period.

Lau v. Li

(2001) 53 O.R. (3d) 727, (leave to Divisional Court Denied)

This case has helped clarify the seemingly contradictory decisions on the issue of whether a person from Ontario who is injured in another province, may sue in Ontario applying Ontario law.

The Court in this case recognized that there can be an exception of the Lex Loci Delicti Rule (the law of the location of the accident applies), where applying the law of the place where the accident occurred creates a major injustice.

In this case an Ontario resident injured in Quebec was entitled to sue in Ontario, as their injuries were clearly catastrophic and would have met the threshold in tort. In Ontario, unlike Quebec, the claimant would be able to claim for all future care costs & medical rehab costs. This was seen as a major injustice to the injured party. In addition, Quebec has no provision for Family Law Act claims.

Nwakwesi v. Security National Insurance

(2001) OIC File A00-000607

In this case, the victim was driving a car owned by his wife (from whom he was separated) when he was involved in an accident. He applied for benefits and was denied on the basis that he ought reasonably to have known that the car was not insured.

The victim gave evidence that he was unaware that the car was not insured.

The Arbitrator held that the test to be applied was "what a reasonable person, given the information that the victim was aware of, could reasonably be expected to know". The test was not what a reasonable person would have done to inform himself.

Krusto and General Accident Assurance of Canada

(2001) OIC File A99-000392

This case involved a woman who had significant pre-accident health issues, however, who was working prior to the accident. She was unable to maintain consistent employment after the accident.

The Arbitrator held that applicants with pre-existing conditions qualify for accident benefits if the accident is a significant or material contribution to the applicant's impairment. The accident need not be the only cause of the applicant's impairment.

Mahadan and Co-operators

(2001) OIC File A00-000489

The word "accident" in the current legislation is defined more strictly than in the previous legislation. An accident must directly cause injury - whereas, in the previous legislation, an accident could be a direct or indirect cause of injury.

It is insufficient that the injured person was operating the vehicle at the time or that the injury occurred in the automobile or that the automobile was involved incidentally. A "direct cause" is the active cause that sets in motion a chain of events which brings about a result, without intervention of any force (see *Chisholm and Liberty Mutual Group* (2001) Ontario Superior Court of Justice)

Ndem and General Accident Assurance of Canada

(2001) OIC File A98-001476

French-speaking persons have the right to be assessed at a DAC by French-speaking assessors, without the assistance of interpreters.

Lombardi and State Farm Mutual Automobile Insurance (2001) OIC File A99-000957

The test to receive income replacement benefits after the first two years is a "complete inability to engage in any employment for which one is reasonably suited by education, training or experience".

The Arbitrator explained that a literal reading of these words would exclude all but the catastrophically injured person from collecting income benefits. The Arbitrator held that this was not the intent of the legislation and that one need not be catastrophically injured to qualify for the income benefit past two years. Further, the victim's education, training and work experience must be reviewed in order to determine the "any employment" test.

Hunt and Sutton Group Incentive Realty Inc. (2001) 52 O.R. (3d) 425.

In this case, an employee became intoxicated at an office party during working hours. After the party, the employee went to a restaurant and had two more drinks. The employee was seriously injured in a motor vehicle accident after leaving the restaurant.

The Court held that the employer owed a duty to the employee to safeguard the employee from harm and that the restaurant should have foreseen the consequences of allowing the employee to drive home.

Violi and General Accident Assurance Co. of Canada

(1999) FSCO A98-000670, Arbitrator Susan Alves

In this case, the injured person sought payment of chiropractic treatments because they provide him relief from back pain, albeit temporarily, and improve his level of function. The DAC report found that the chiropractic treatment and massage were not reasonable or necessary because they had no significant impact on his ongoing recovery.

The Arbitrator found that relief of pain is a legitimate medical and rehabilitative goal. The Arbitrator rejected the DAC opinion and explained that treatment need not promote recovery to be reasonable and necessary.

The Standard Invoice

Effective November 12, 2001, all persons who bill an insurance company directly for medical or rehabilitation services are required to use the Standard Invoice. This includes: health care providers, physiotherapists, occupational therapists, chiropractors, massage therapists, kinesiologists, speech therapists, psychologists and medical doctors.

The Standard Invoice is used for:

a) medical and rehabilitation goods and services
b) patient assessments
c) examinations
d) specified certificates
e) reports and treatment plans

The form was devised to provide more efficient processing of invoices, better information about services being provided and increased accountability.

Standard codes are used to describe injuries, sequelae and services.

Registration of health care facilities and providers is voluntary.

Standard Invoices are submitted directly to insurers.

The Standard Invoice does not change what can be billed or the billing rate.

The Financial Services Commission has issued a directive to insurers to be flexible in the initial period until people become comfortable and proficient with the Standard Invoice.

Stage two contemplates:

a) Mandatory use of Standard Invoice continues

b) Web-based form for submission of invoices

c) Mandatory registration of facilities and providers

d) Software standards

e) All invoices submitted to a new agency - Auto Insurance Health Claims Centre - then forwarded to the insurers

Survey Sample

122 health care professionals responded.

The professionals were:

chiropractors,
physicians,
speech pathologists,
occupational therapists,
psychologists,
physiotherapists,
social workers,
rehabilitation counselors,
nurses,
kineseologists,

and other rehabilitation professionals.

Legislative Ramifications

Results of the survey have been presented in response to the Minister of Finance's request for submissions for changes to the current auto insurance system.

The consultation paper from the Ministry of Finance may be viewed at the Ministry of Finance web site *www.gov.on.ca/fin*.

Thomson, Rogers' submission can be found at *thomsonrogers.com.*

M.P.P. J.R. O'Toole will discuss this process at the January 25, 2002 Riverdale Conference.

Survey Results

Survey respondents' use and familiarity with treatment plan

Survey Highlights:

(a) 94.3% of respondents *participated in the preparation of a treatment plan* for victims of motor vehicle accidents;

(b) 85.2% of respondents have *rendered treatment or have provided services pursuant to an approved treatment plan.*

Effectiveness of treatment plan in facilitating treatment

Survey Highlights:

Summary:

The concerns voiced by the health care professionals in response to the thirty-two questions put to them can be grouped into two categories:

1. Inappropriate denial of health care professionals' recommendations for treatment; and

2. Impact upon accident victim of delay in access to medical and rehabilitative needs.

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(a) 58% of survey respondents found that *insurers rarely or never contacted the provider to obtain further information about the proposed treatment plan* before denying;

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Results of Inappropriate Denials

1. **increases burden on public health, social services, mental health and corrections facilities**
2. **destabilizes victim's focus on recovery**
3. **increases barriers to recovery**
4. **loss of productivity**
   a) for victim
   b) for victim's employer

5. **increases costs to insurer**
   - IRB's, attendant care, housekeeping
   - assessment expenses
   - transfer payments to OHIP
   - loss of income claims

6. **reduced likelihood of return to function**

Goal to be Achieved Through Changes to Treatment Plan Approval Process:

A treatment approval and delivery model should support the delivery of *timely* and *co-ordinated* medical and rehabilitative services and devices with the goal of returning the victim to the *maximum level of recovery* as *quickly as possible.*

Fostering a Cooperative Approach:

To reduce approval delays the process must increase dialogue and foster a co-operative approach among the victim, rehabilitation needs assessors, treatment providers and insurer.

Effects of Adversarialism:

The adversarial elements of the current process destabilizes the accident victim's focus on recovery.

As one respondent noted *"where an adversarial climate develops it can cause psychological impairments which can prolong recovery".*

Recommendations Concerning the D.A.C. Process

- D.A.C. members should be members in good standing with their affiliate colleges, and should remain bound to fulfil their ethical responsibilities and best practices in accordance with their College's code of ethics.

- D.A.C. members should have a duty of care to victims assessed.

- D.A.C. assessors assessors should be drawn randomly from a pool of certified and qualified specialists on a blind referral basis;

Recommendations Concerning the D.A.C. Process

- make the D.A.C. system transparent:

publish individual D.A.C.s rates of approval / denial,

provide information about whether D.A.C. assessors have done or continue to do IMEs for insurers.

have all members of the DAC enclose their College's Code of Ethics with the resulting report.

*Recommendations Concerning the Accident Victim's Need for **Early**, **Coordinated** and **Sustained Intervention**:*

- allow funded treatment to proceed during waiting periods associated with approval of the treatment plan *and* when a disputed treatment plan is awaiting determination by a D.A.C.

*Recommendations Concerning the Accident Victim's Need for **Early, Coordinated** and Sustained Intervention:*

- **deem an automatic approval of the treatment plan if the insurer has not responded within 7 days;**
- **oblige the insurer to attend case conferences and team meetings for the provision and co-ordination of rehabilitation services;**
- **prevent the insurer from denying a treatment plan or a portion of a treatment plan unless the insurer:**
  - **(i) communicates by telephone or in person with the treatment provider recommending services;**
  - **(ii) obtains a written review of the treatment plan by an appropriately qualified health care professional; and**
  - **(iii) provides specific, health care professional based reasons for rejecting the treatment plan.**

*Recommendations Concerning the Accident Victim's Need for **Early**, Coordinated and **Sustained** Intervention:*

- provide for automatic approval for services recommended by professionals associated with a treating public hospital required on or for discharge.

- incorporate a pay pending resolution of dispute system for the first 12 weeks after the accident to a maximum of $4,000.00 for services provided by all health care professionals.

*Recommendations Concerning the Accident Victim's Need for Early, **Coordinated** and Sustained Intervention:*

allow Certified Rehabilitation Counsellors to be regulated under the Health Disciplines Act and/or the Financial Services Commission of Ontario to provide services such as case management in non-catastrophic cases where:

- the victim is paediatric,
- has sustained multiple trauma, or
- has sustained mild to moderate brain injury,

in addition to those who qualify for case management because of having met the catastrophic designation.

Recommendations Concerning Catastrophic / Non-catastrophic Designation:

- **deem children entitled to benefits available to those having sustained a catastrophic impairment;**
- **change the catastrophic definition to include the impact on functioning and, if there is a permanent impairment increase the funds available;**

Recommendations Concerning Catastrophic / Non-catastrophic Designation:

- a formula needs to be developed to *assess degrees of loss* rather than to *dichotomise victims* based upon whether they have or have not sustained a catastrophic impairment;

Recommendations Concerning the Form and Content of the Treatment Plan:

- allow health care professionals who have their Masters Degree in Social Work, accredited Occupational Therapists, Certified Rehabilitation Counsellors and Speech Pathologists to sign Treatment Plans

Summary of Key Recommendations and Conclusions

Delay and adversarial elements are frustrating effective rehabilitation efforts.

The solution lies in:

(a) a limited "pay pending resolution of dispute" approach to rehabilitation which allows members of all Colleges currently regulated by the Health Disciplines Act, M.S.W.s, Speech Pathologists, O.T.s or Certified Rehabilitation Counsellors to recommend and receive funding for assessment / treatment.

Treatment Plan Recommendations:

A system should be created whereby the assigned adjuster who receives a treatment plan arranges telephone contact with a treatment provider unless the insurer automatically agrees to fund the rehabilitation.

If, despite this communication, an agreement is not reached any decision not to fund the treatment plan should be made only after an appropriately qualified rehabilitation professional reviews the treatment plan, *and* has a dialogue with the recommending treatment provider.

"Mandating" a Cooperative Approach to Funding and Providing Treatment:

- **A new protocol must increase dialogue to promote an increased understanding of:**
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- **the accident victim's impairments;**
- **the anticipated manner by which the recommendations made by health care professionals will reduce those impairments; and to**
- **facilitate agreement to fund treatment plans,**

in order to *reduce as much as possible the human and economic toll that delayed or denied treatment has upon the victim, the victim's family, the insurer, employers, public health and society.*