BILL 198

"What the Health Care Professional Needs to Know"

Presented by:

Thomson Rogers

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OVERVIEW OF REGULATORY CHANGES

Overview of Regulatory Changes

- New Regulations under the Insurance Act were made on July 2, 2003 and will
- Come into force on October 1, 2003.
- Two more Regulation come into force on October 1, 2003

These new Regulations include:

a) Major changes to the Statutory Accident Benefits Schedule (SABS)

b) Changes to the DAC Referral Process

c) An increase of the monetary deductible which reduces pain and suffering claims by $30,000 – an increase from the current $15,000 deductible

d) An Unfair or Deceptive Acts or Practice Regulation which could impose sanctions on Treatment Providers (in force November 1, 2003)

e) Restrictions of the right to settle a claim within one year of the accident and on persons who may represent injured victims

Important changes to the SABS include:

- **Injured automobile drivers, passengers and pedestrians risk delayed treatment and benefits if they fail to give notice to the Accident Benefit Insurance Company within seven (7) days of the accident**
- **Injured victims have greater obligations not only to provide notice but to participate in examinations under oath by a representative hired by the insurance company**
- **There are limits on assessments without prior approval of the insurer (no more s.24 assessments)**
- **There are fee restrictions for professionals who conduct assessments**
- **A pre-approved treatment framework (PAF) has been developed for modest injuries which are defined as WAD I or WAD II injuries**

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Important changes to the SABS include:

- **New forms for Assessment Plans and Treatment Plans have been introduced and are more complex**
- **Insurers can give verbal approval for assessments to prepare treatment plans**
- **Insurers are prevented from obtaining insurer examinations (I.E.s) for medical and rehabilitation benefits until a mediator and a no fault dispute resolution process is commenced (s.20(1) amends s.42(1))**
  i.e. no in hospital OT assessments
- **Changes to the definition of Catastrophic Impairment (most importantly for children)**

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- WAD II, but pre-existing occupational, functional or medical circumstances that:
  - Significantly distinguish the person's needs from other patients with WAD II, and
  - Constitute compelling reasons why goods and services other than the PAF are preferable to the PAF

TREATMENT OTHER THAN PAF

- Claimants continue to submit TPs for prior approval:
  - Non–WAD I or II
  - Additional, post PAF treatment for WAD injuries
  - WAD I or II with special circumstances
- Insurers can challenge a TP on the basis a PAF should apply and/or on the proposed treatment

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Regulation of Paralegals

- New requirements for SABS representatives (paralegals) come into force on November 1, 2003
- Exclusions:
  - Lawyers acting in the usual course of the practice of law
  - Employees of lawyers if lawyer retained by client and supervising employees
  - Insurer representatives
  - Unpaid representatives (friends, family)

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Who is a SABS Representative?

Will be considered a SABS representative if you:

- Provide advice regarding the SABS
- Assist in completing application forms
- Negotiate with an insurer
- Attend a dispute resolution proceeding
- Negotiate a settlement of a SABS claim

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Insurance Act Changes

- Section 284.1 prohibits someone from being represented by a person who is not a lawyer in a dispute resolution proceeding except in accordance to the regulations
- Section 398 prevents a person other than a lawyer from a number activities related to SABS claims unless the person complies with terms and conditions in the regulations

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Regulation Changes

- Not represent a person that they know or ought to have known to have a catastrophic impairment
- Adhere to a code of conduct issued by Superintendent
  - Published in *The Ontario Gazette* on August 16, 2003 and posted on FSCO website

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UDAP Regulation Changes

- Changes to the definition of "unfair and deceptive acts or practices" (UDAP) prohibit paralegals from:
  - Soliciting, accepting or demanding contingency fees
  - Soliciting, accepting or demanding a referral or paying a referral fee
  - Committing an act or omission inconsistent with code of conduct
  - Failing to disclose a conflict of interest

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Possible Regulatory Action

- Superintendent may take the following action if UDAP has been committed:
  - Order a person to cease from engaging in specific activities
  - Order a person to perform specific remedial acts
  - Initiate a prosecution under the *Insurance Act*

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Other UDAP Regulation Changes

- Changes to the definition of UDAP prohibit health care and service providers from:
  - Charging for goods or services which are not provided
  - Soliciting, demanding, accepting or paying a referral fee directly or indirectly
  - Charging unreasonably excessive amounts for goods and services
  - Failing to disclose a conflict of interest
  - Using a form not approved by the Superintendent

Other Fraud Prevention Measures

- No weekly benefits under SABS to persons using a vehicle to commit a crime for which they are convicted
- Time period to notify insurer of intention to make a SABS claim reduced from 30 to 7 days
- Insurers must notify claimant within 14 days if application missing essential information
- Insurers permitted to request a claimant under an examination under oath under certain conditions

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Application for Approval of an Assessment or Examination

(OCF-22)

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THE ASSESSMENT PLAN (OCF 22/198)

- No more s.24 Assessments
- Insurer approval is required before an assessment (some exceptions)

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THE ASSESSMENT PLAN (OCF 22/198)

The Approval Process

- Insurer must respond to Assessment Plan in (2) business days if cost is $180 or less
- Insurer must respond to Assessment Plan in five (5) business days if cost is more than $180
- If prior approval is required but not sought, insurer not required to pay and not subject to dispute
- If approval is denied – request for assessment goes to DAC

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THE ASSESSMENT PLAN (OCF 22/198)

Approval must be obtained prior to an assessment – **except:**

- first 3 assessments to complete a Treatment Plan do not require prior approval if:
  - 1 assessment per provider
  - assessments cost $180 or less
- assessment to complete a Form 1
- assessment to complete a disability certificate (provided the cost is less than $180)
- assessment to complete a Treatment Plan if there is an immediate risk of harm from any delay
- assessment to complete an Application for Catastrophic Impairment (provided the claimant is still institutionalized)
- assessment is covered by the PAF

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THE ASSESSMENT PLAN (OCF 22/198)

- Assessment Plans required for all accidents after November 1, 1996

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Implementing Bill 198: New and Revised Statutory Accident Benefits Claims Forms

OCF-22/198 – Application for Approval of an Assessment or Examination

With special thanks to RMI – Lori Borovoy

OCF-22/198 – Application of Approval of and Assessment or Examination

Application for Approval of an Assessment or Examination (OCF-22/198)

Use this form for accidents that occur on or after November 1, 1996

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

OCF-22/198 – Application of Approval of and Assessment or Examination

To the Applicant:
Use this form to request prior approval for payment of an assessment or examination fee for which prior approval is required. Please provide all information requested.
Collection, use and disclosure of this information is subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

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 is authorized by a consent form. Health professionals/facilities should ***use the Ontario Claims Form (OCF – 5)*** *Permission to Disclose Health Information* as a consent form.

Part 1 Applicant Information To be completed by the applicant	Date Of Birth (YYYYMMDD)	Gender o Male o Female	Telephone Number Extension
	Last Name		
	First Name	Middle Name	
	Address		
	City	Province	Postal Code

Part 2 Insurance Company Information To be completed by the applicant	Company Name	City or Town of Branch Office (if applicable)
	Adjuster Last Name	Adjuster First Name
	Adjuster Telephone Extension	Adjuster Fax
	Name of policy holder same as: o Applicant OR	**Policy Holder Last Name** / **Policy Holder First Name**

Part 3 Signature of Regulated Health Professional	Name of Regulated Health Professional		College Registration Number	**You are a:** o Chiropractor o Dentist o Massage Therapist o Nurse Practitioner o Occupational Therapist o Optometrist o Physiotherapist o Psychologist o Speech-Language Pathologist oOther **oRN**
	Facility Name (if applicable)		AISI Facility Number (if applicable)	
	Address			
	City	Province	Postal Code	
	Telephone Number	Extension	Fax Number	
	Email Address			
	o I wish to declare that I have no conflicts of interest relating to this form and I have determined, after making reasonable inquiries, that there are no conflicts of interest relating to this form on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this form, ***or*** o I am declaring the following conflicts of interest relating to this Application:			
	I certify that, to the best of my knowledge, the information in this form is accurate, and the services contemplated are reasonable for the assessment or examination of the applicant. In addition, I confirm that I have obtained the appropriate consent from the applicant for the collection, use and disclosure of information submitted.			
	Name of Regulated Health Professional (please print)	Signature of Regulated Health Professional	Date (YYYYMMDD)	

Part 4 Nature of Assessment or Examination	***Payment for all assessments and examinations is dependent upon approval by the insurer or, if disputed, by a DAC except those assessments and examinations that are payable without insurer approval pursuant to a PAF Guideline. In addition, prior approval for payment of an assessment or examination is not required in some situations as outlined below. Please 3 the appropriate box in the chart below to indicate what situation applies to this application.***
	insurer.

Part 4
Nature of Assessment or Examination

- An assessment or examination where an immediate risk of harm to the insured person or a person in the insured person's care makes obtaining the insurer's prior approval of the assessment or examination impractical;

Part 4
Nature of Assessment or Examination

PRIOR APPROVAL IS NOT REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR THE FOLLOWING:

- not more than three assessments or examinations if:
  - the insured person has not received treatment under a *Pre-approved Framework Guideline*,
  - the cost of each assessment or examination does not exceed $180.00, and
  - not more than one assessment or examination is done by the same person;
-

Part 4 Nature of Assessment or Examination	PRIOR APPROVAL IS NOT REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR THE FOLLOWING:

- ;
- not more than one assessment or examination if:
  - the insured person has received treatment under a Pre-approved Framework Guideline,
  - the cost of the assessment or examination does not exceed $180.00, and
  - the person conducting the assessment or examination did not provide goods or services under a Pre-approved Framework Guideline in respect of the same accident;

Part 4 Nature of Assessment or Examination	PRIOR APPROVAL IS NOT REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR THE FOLLOWING:

- an assessment or examination conducted after the insurer notifies the insured person that, before the examination is conducted, it does not require the submission of a Treatment Plan or an application under s. 38.2 of the SABS;
- an assessment or examination conducted under the provisions of a Guideline that authorizes the assessment or examination without the prior approval of the insurer.

Part 4 Nature of Assessment or Examination	**PRIOR APPROVAL IS REQUIRED FOR ASSESSMENTS OR EXAMINATIONS TO COMPLETE TREATMENT PLANS FOR:** o all other assessments or examinations to complete Treatment Plans, not outlined above.
	ASSESSMENTS OR EXAMINATIONS TO COMPLETE DISABILITY CERTIFICATES: o Prior approval is not required in respect of an assessment or examination for a disability certificate if the cost of the assessment for the certificate does not exceed $180.00; o Prior approval is required for assessments to complete disability certificates that exceed $180.00. o an assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer.

Part 4 Nature of Assessment or Examination	**ASSESSMENTS OR EXAMINATIONS TO PREPARE A FORM 1:** o **Prior approval is not required in respect of an assessment or examination for the purposes of preparing a Form 1, but not an assessment or examination relating to an impairment that comes within a Pre-approved Framework Guideline unless the Pre-approved Framework Guideline expressly states that the prior approval of the insurer is not required for the assessment or examination;** o **an assessment or examination conducted under the provisions of a Guideline that authorizes the assessment or examination without the prior approval of the insurer.**

Part 4 **Nature of Assessment or Examination**	**ASSESSMENTS OR EXAMINATIONS TO DETERMINE CATASTROPHIC IMPAIRMENT:** o Prior approval is not required in respect of an assessment or examination for a determination of catastrophic impairment if the insured person is hospitalized or in a long-term care facility at the time of the assessment or examination. o Prior approval is required in respect of an assessment or examination for a determination of catastrophic impairment if the insured person is not hospitalized or in a long-term care facility at the time of the assessment or examination. o an assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer.
	ALL OTHER ASSESSMENTS OR EXAMINATIONS REQUIRING PRIOR APPROVAL: o All other assessments not outlined above require prior approval.

Part 5 **Provisional Clinical Information**	**a) Clinical Information:** i) Provide a brief description of the present complaints. ***NOT A DIAGNOSIS*** As per telephone contact with Mr. Client he reports the following: ▪Decreased mobility and balance impacting on ability to do housekeeping activities. ▪ Increased right shoulder pain and decreased mobility impacting on his ability to do self care and bathing. ii) Has the applicant already been provided treatment under your care? xNo o Yes

Part 5 Provisional Clinical Information	
	b) **Assessment Information:** i) Describe the details of the assessment requested and the rationale for it. • If you have already provided treatment to this applicant, include clinical indicators to substantiate the reasonableness of the proposed assessment. • For multi-disciplinary assessments, include the detail and rationale for each component of the assessment. **Perform an Occupational Therapy Assessment to determine the clients functional abilities, and safety in performing self care and home maintenance activities.** **To determine adaptive aids that the client may benefit from to increase safety and/or independence in activities of daily living.** iii) After making reasonable inquiries, are you aware of a prior assessment of this type completed for this applicant? o No o Yes If yes, provide date if possible (YYYYMMDD)? _____/_____/_____

Applicant Name:		OCF-22/198 – FAX BACK	Policy Number:	
Provider Name:			Claim Number:	
Provider Fax:			Date of Accident:	

Part 6 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	O. T	Jones	Ann	g1223344		100
	B	RA	Smith	Jane		R14422	68
	C						
	D						
	E						
	F						

Part 7 Proposed Goods and Services

This Assessment Plan should include all goods and services (G/S) contemplated by the Health Professional/Facility.

G/S Ref	Description	† Code	† Attribute	Provider Ref	Estimated		
					Quantity	† Measure	Total Cost
1	Assessment	7.se.02.AB-2	Home Assessment	A	120	minutes	$240.
2	Other Services	7.sj.30.LD	Detailed Report	A	120	minutes	$240.
3	Travel						
4							
5	Visit #2 Should Treatment Plan signature not be waived		:Home Visit and Travel				

1	Assessment	7.se.02.AB-2	Home Assessment	A	120	minutes	$240.
2	Other Services	7.sj.30.LD	Detailed Report	A	120	minutes	$240.
3							
4							
5							
6							
7							
8							

Note †: Refer to the User Manual coding guidelines posted at www.autoinsurancereforms.on.ca.
Attributes codes are used to further qualify the service codes and are described in the manual.

Note +: Payment by auto insurer is secondary to available collateral benefits.

Sub-Total:	
+MOH:	
+Other Insurer 1 + 2:	
GST (if applicable):	
PST (if applicable):	
Auto Insurer Total:	

Part 8 Signature of Applicant (Optional) If not completed, the Health Professional in Part 3 assumes responsibility for obtaining applicant's consent	I have reviewed and confirm that the information set out in this form is accurate. I understand that payment for these services may be subject to the approval of the insurer, or if disputed by the insurer, a Designated Assessment Centre. In the event that my insurer disputes the application, I authorize my insurance company and treating health professionals to give the Designated Assessment Centre any information relating to my health condition, treatment and rehabilitation received as a result of the automobile accident, for the purpose of determining my eligibility for benefits. I authorize the Designated Assessment Centre to consult with my treating health professionals if necessary. I also authorize the Designated Assessment Centre to give my insurance company and treating health professionals a copy of its report. Subject to the Statutory Accident Benefits Schedule, in those instances where prior approval is required, I understand that, if I undertake any of the proposed services prior to approval by the insurer or the Designated Assessment Centre, I may be responsible for payment to my provider for any services rendered on my behalf.		
	Name of Applicant or Substitute Decision Maker (please print) Mr. Client	Signature of Applicant or Substitute Decision Maker Verbal Consent Obtained	Date (YYYYMMDD) 2003/10/01

Part 9 Signature of Insurer	o *I waive the requirement for the applicant's signature on a OCF 18 Treatment Plan.* *I have reviewed this form and based upon the information provided, I* o Approve o Partially approve (explanation to follow or attached) o Do not approve (explanation to follow or attached) The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 2 business days of receiving the completed form for proposed assessments of $180.00 or less, and within 5 business days when the cost of the proposed assessment is over $180.00: 1. Give the health professional and the applicant notice of the decision. 2. If disputing the application refer the dispute to a Designated Assessment Centre. **Insurer response is required within the timeframes of the SABS or payment for proposed assessment or examination is deemed approved.**		
	Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)

The fee for completing this form is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly.

Treatment Plan

(OCF-18)

THE TREATMENT PLAN (OCF 18)

- Required for insurer approval of treatment (goods and services)
- Not required for claimants in the PAF (unless request for additional goods or services not covered by PAF)

THE TREATMENT PLAN (OCF 18)

Obligations on the Health Professional responsible for preparing and supervising the Treatment Plan

- **secure a consent form signed by the claimant (OCF 5)**
- **Include all goods and services contemplated by the health professional/facility**
- **ensure that there is no other coverage available or identify other coverage**
- **plan must be certified by Health Practitioner as reasonable and necessary – Occupational Therapists and Speech-Language Pathologists are now "Health Practitioners" and can sign off on Treatment Plans, Social Workers and Registered Massage Therapists cannot**
- **greater obligations to describe injury, sequelae and other relevant health history**
- **explain consequences of releasing health information**

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THE TREATMENT PLAN (OCF 18)

- **Incurred expenses are payable after 14 days if the insurer has not responded to the Treatment Plan**
- **Treatment Plan can also be used to obtain insurer approval for assessments (like OCF 22/198)**
- **If the Treatment Plan is denied – DAC within 5 days after selection of DAC (Insurer selects the DAC, if insured disagrees, FSCO selects the DAC)**

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Implementing Bill 198: New and Revised Statutory Accident Benefits Claims Forms

OCF-18 – Treatment Plan

With special thanks to RMI – Lori Borovoy

OCF-18 – TREATMENT PLAN

Treatment Plan (OCF-18)

Use this form for accidents that occur on or after November 1, 1996.

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

OCF-18 – TREATMENT PLAN

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

OCF-18 – TREATMENT PLAN

To the Applicant:
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, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist) must sign Part 5.**
Please provide all information requested. Collection, use and disclosure of this information is subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

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.
Note: If this is an impairment that comes within a PAF Guideline, you are required to complete an OCF – 23/198 Pre-approved Framework Treatment Confirmation Form instead of this Treatment Plan Form unless application is being made for additional goods or services not provided under a PAF Guideline.

Part 1 Applicant Information To be completed by the applicant	Date Of Birth (YYYYMMDD)	Gender o Male o Female	Telephone Number
	Last Name		
	First Name	Middle Name	
	Address		
	City	Province	Postal Code

Part 2 Insurance Company Information To be completed by the applicant	Insurance Company Name	City or Town of Branch Office (if applicable)
	Adjuster Last Name	Adjuster First Name
	Adjuster Telephone Extension	Adjuster Fax
	Name of policy holder same as: o Applicant OR	Policy Holder Last Name / Policy Holder First Name

Part 3 Other Insurance Information To be completed by the health professional responsible for plan preparation and supervision with information from the applicant	**OTHER INSURANCE:** Is there other insurance coverage for any goods and services listed in this Treatment Plan? I have made reasonable enquiries of the applicant and have determined that: o **NO** *There is no other insurance coverage identified for these goods and services cover* o **YES** *There is other insurance coverage that is potentially available to cover/partially these goods and services.*	
	MOH	Is there Ministry of Health and Long-Term Care (MOH) coverage for any goods and services included in this Treatment Plan? o Yes o No o Not applicable
	Other Insurer 1	Other Insurer Name / Other Insurance Plan Or Policy Number
		Name of Plan Member / Other Insurer's Identifier
	Other Insurer 2	Other Insurer Name / Other Insurance Plan Or Policy Number
		Name of Plan Member / Other Insurer's Identifier

Part 4 **Conflict of Interest Definition**	A person has a conflict of interest relating to a Treatment Plan if, i) the person or a related person may receive a financial benefit, directly or indirectly, as a result of the provision, by the related person or another person, of goods or services contemplated by the Treatment Plan, and ii) the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services or under which goods or services of that kind are provided. **Note**: After approving this Treatment Plan, if the insurer determines that there is a conflict of interest that was not disclosed, the insurer may give the applicant notice to amend the Treatment Plan to remove the conflict of interest and if no amendment is made, the insurer is not required to pay for any further expense for which there is the conflict.

Part 5 **Signature of Health Practitioner** Plan Certification	Name of Health Professional		College Registration Number	**You are a:** o Chiropractor o Dentist o Nurse Practitioner o Occupational Therapist o Optometrist o Physician o Physiotherapist o Psychologist o Speech-Language Pathologist
	Facility Name (if applicable)		AISI Faculty Number (if applicable)	
	Address			
	City	Province	Postal Code	
	Telephone Number	Extension	Fax Number	
	Email Address			
	o 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 relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan. ***or*** o I am declaring the following conflicts of interest relating to this Treatment Plan:			
	I confirm that, to the best of my knowledge, the information in this Treatment Plan is accurate, the Treatment Plan has been reviewed with the applicant 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 applicant for the injuries identified in Part 7. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.			
	Name of Health Practitioner (please print)		Signature of Health Practitioner	Date (YYYYMMDD)

Part 6
Signature of Regulated Health Professional
Plan Preparation and Supervision
If same person as Part 5 check here o and
DO NOT COMPLETE Part 6

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

o 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 relating to this Treatment Plan on the part of any person who referred the applicant to a person who will provide goods or services contemplated in this Treatment Plan.
or
o I am declaring the following conflicts of interest relating to this Treatment Plan:

I confirm that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

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

To the Health Professional:
Please complete the following information based on your most recent examination of the applicant named above and return the form to the insurance company listed in Part 2. **Please print clearly.**

Part 7
Injury and Sequelae Information

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

Description	Code
CODES CURRENTLY ON BACK OF TREATMENT PLAN	

Note †: Refer to the User manual at www.autoinsurancereforms.on.ca for ICD-10-CA coding information.

Part 8 **Prior and Concurrent Conditions** o Additional Sheet Attached	a) Prior to the accident, did the applicant have any disease, condition or injury that could affect his/her response to treatment for the injuries identified in Part 7? oNo o Unknown o Yes (please explain) If Yes to "a" above, did the applicant undergo investigation or receive treatment f or this disease, condition or injury in the past year? oNo o Unknown o Yes (please explain and identify provider, if known)

Part 8 **Prior and Concurrent Conditions** o Additional Sheet Attached	
	b) Since the accident, has the applicant 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? ***o No o Unknown o Yes (please explain)***
	c) Is this an impairment referred to in a Pre-approved Framework (PAF) Guideline? o Yes o No If yes, please provide a complete explanation, in accordance with the PAF Guidelines, and with express reference to the provisions of the PAF Guidelines on which you rely, why this OCF-18 Treatment Plan is being submitted instead of a Pre-approved Framework Treatment Confirmation Form (OCF-23/198). o additional sheets attached

Part 9 **Activity Limitations**	*a) Does the applicant's impairments) from the injuries identified in Part 7 affect his/her ability to carry out:* *His/her tasks of employment* *o Not employed o No o Unknown o Yes* *His/her activities of normal life* *o No o Unknown o Yes*
	b) *If Yes to either of the questions above, briefly describe the activities limited by the impairment and their impacts on the applicant's ability to function.*

Part 9 **Activity Limitations**	
	c) If the applicant is unable to carry out pre-accident employment activity, is the employer able to provide suitable modified employment to the applicant? **oNot employed o Yes o Unknown** **oNo (please explain)** **Opportunity to put this on the OCF 22 as part of our assessment as appropriate, or this would be part of the plan.**

Part 10 Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery	**a) Goals:** **(i) Identify the goal(s) in regard to the applicant's impairment(s), symptom(s) or pathology that this Treatment Plan seeks to achieve:** **o pain reduction** **o increased range of motion** **o increase in strength and Others** **(ii) Select the functional goal(s) that this Treatment Plan seeks to achieve:** **o return to activities of normal living** **o return to pre-accident work activities** **o return to modified work activities** **X other(s)** ***Establish Vocational Direction** ***Establish Return to Work Plan** ***Establish Unpaid Work Trial**

Part 10 Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery	a
	b) Evaluation: **(i) How will progress on the goal(s) in a (i) and a (ii) be evaluated?** **X Completed Vocational Direction** **X Resume Completed** **X Work Trial Completed** **X Observation and Demonstration of specific activity** **(ii)If this is a subsequent Treatment Plan, what was the applicant's improvement at the end of the previous plan based on your evaluation method?** **o additional sheets attached**

Part 10 Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery	**Barriers to recovery:** **(i) Have you identified any other barriers to recovery?** **o No o Yes (please explain)** **Fear of Driving** **(ii) Do you have any recommendations and/or strategies to overcome these barriers?** **o No o Yes (please explain)** **Desensitization Program which includes use of psychologist and in car training.**

Part 10 Treatment Plan Goals, Outcome Evaluation Methods and Barriers to Recovery	**d) Concurrent Treatment:** Are you aware if any concurrent treatment, that is not included in this Treatment Plan, will be provided by any other provider/facility? o No o Yes (please explain)
	e) Consistency: Are there any utilization guidelines applicable to the proposed treatment? o Yes (Identify guideline): o No (Please explain):

Applicant Name:		INSURER FAX BACK	Claim Number:	
Policy Number:			Date of Accident:	

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	O.T.	Kay	Mary	000001		100.00
	B	O.T.	Doe	Jane	000012		100.00
	C	CM	Smith	Elaine		RHH234	100.00
	D	RA	Jones	Pat		OTH444	68.00
	E						
	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	Case Management	7.SF.15		C	90	Minutes	150.	4	600
2	Training Motor Functions	6.va.50	O.T. Services	A or B	120	Minutes	200.	5	1000
3	Travel				90 to 120	Minutes	150. To 200.	6	900. to 1200.
4	Other Services	7.SJ.30.LD	Detailed Report	C	120 to 180	Minutes	200 to 300	1	300
5	Reassessment	RNA	Rehabilitation Needs Assessment	C	90	Minutes	150	1	150
6	Milage, Planning, Consultation								

Estimated duration of this Treatment Plan:	weeks	Sub-Total:	
How many treatment visits have you already provided:	visits	- Minus MOH:	
Note †: Refer to the User Manual coding guidelines posted at www.autoinsuranceforms.on.ca		- Minus Other Insurer 1 + 2:	

Part 13 Signature of Applicant 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 5 business days to respond in writing if I wish to withdraw this Treatment Plan. If I wish to proceed, a Designated Assessment Centre shall be selected in the manner set out in the Statutory Accident Benefits Schedule. Once a Designated Assessment Centre has been selected, the insurer has 5 business days to arrange for the assessment.** I authorize my insurance company and treating health professionals to give the Designated Assessment Centre any information relating to my health condition, treatment and rehabilitation received as a result of the automobile accident, for the purpose of determining my eligibility for benefits. I authorize the Designated Assessment Centre to consult with my treating health professionals if necessary. I also authorize the Designated Assessment Centre to give my insurance company and treating health professionals a copy of its report. 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 Designated Assessment Centre, I may be responsible for payment to my provider for any services rendered on my behalf.		
	Name of Applicant or Substitute Decision Maker (please print)	**Signature of Applicant or Substitute Decision Maker**	**Date (YYYYMMDD)**

Part 14 Signature of Insurer	o **I waive the requirement for the Applicant's signature.** I have reviewed this Treatment Plan and based upon the information provided, I: o Approve the Treatment Plan o Partially approve (explanation attached) o Do not approve (explanation attached) The Statutory Accident Benefits Schedule states that subject to the conflict of interest provisions, the insurer shall, within 14 days of receiving the completed application (within 5 business days if the insurer rejects the Treatment Plan on the basis that a PAF Guideline applies) give the applicant notice of their decision on the Treatment Plan.		
	Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)
	To the insurer: Please provide a copy of this page to the applicant, the Health Practitioner indicated in Part 5 and the Regulated Health Professional, if applicable, indicated in Part 6.		

Note:	The fee for completing this certificate is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly. The Health Practitioner will contact each of the health professionals listed in Part 11 and provide details of the services and other charges that have been approved and are payable under this Treatment Plan.

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Bill 198 vs Bill 59
Timing Comparison

70

BILL 59

50 Days

BILL 198

107 Days

71

Bill 198 vs Bill 59 cont'd

Jonah suffered a mild brain injury and femur fracture. Jonah is non-English speaking.

DAY	Example of Impact of Delay on Seriously Injured and Treatment Provider caused by Draft Bill 198 regulations:
1	Jonah is hospitalized;
5	Jonah is discharged - as patient unaware of 7 day notice required, notice was not given to insurer, he is discharged into the care of the local Community Care Access Centre for follow-up;

On discharge and for six (6) weeks Jonah is non-weight bearing;

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Bill 198 vs Bill 59 cont'd

DAY	Example of Impact of Delay on Seriously Injured and Treatment Provider caused by Draft Bill 198 regulations:
8	Jonah retains a lawyer and the lawyer puts insurer on notice of accident;
9	An Occupational Therapist attends to do home assessment; cannot do so until she/he submits Assessment Plan and Assessment Plan is approved;
10	Assessment Plan submitted; Lawyer submits A/B Application Form;

Bill 198 vs Bill 59 cont'd

DAY	Example of Impact of Delay on Seriously Injured and Treatment Provider caused by Draft Bill 198 regulations:
11	Insurer gives notice that, for failure to put insurer on notice of accident within seven (7) days, Jonah may have to wait forty-five (45) days from receipt of a "complete Accident Benefit Application" before any Treatment Plan may be approved by insurer;
12 to 17	**Day 12** Insurer receives A/B Application; **Day 16** Assessment Plan is disputed by insurer; (Insurer has 5 days to respond to Assessment Plan costing > $200.00) and sends Assessment Plan to DAC; Insurer fails to provide hospital records submitted with Assessment Plan;

Bill 198 vs Bill 59 cont'd

DAY	Example of Impact of Delay on Seriously Injured and Treatment Provider caused by Draft Bill 198 regulations:
17	Jonah returns to surgeon for follow-up visit. Surgeon recommends Physiotherapy and Occupational Therapy services;
23	Orthophysio Associates submits Treatment Plan for Physiotherapy and Occupational Therapy services;
24	Insurer receives Orthophysio Associates Treatment Plan;
26	DAC requests hospital records from insurer;
30	Insurer provides DAC with hospital records;

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Bill 198 vs Bill 59 cont'd

DAY	Example of Impact of Delay on Seriously Injured and Treatment Provider caused by Draft Bill 198 regulations:
37	Insurer advises Orthophysio Associates that consideration of Treatment Plan may be delayed for up to forty-five (45) days because of late reporting of accident on day 8 while insurer investigates claim;
43	DAC re Assessment Plan begins assessment;
44	DAC re Assessment Plan completes assessment; (and must deliver Assessment within 7 days)
50	DAC delivers its report to the insurer indicating that the Assessment Plan was reasonable under Section 24;

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Bill 198 vs Bill 59 cont'd

DAY	Example of Impact of Delay on Seriously Injured and Treatment Provider caused by Draft Bill 198 regulations:
53	Home Assessment is completed by occupational therapist identifying home modification needs;
54	Treatment Plan identifying goods and services required to modify home for non-weight bearing patient with cognitive impairments is sent to insurer. Because of failure to give notice within seven (7) days of accident, insurer still has up to forty-five (45) days to consider treatment plan; see Days 11, 37
68	Insurer denies Treatment Plan for Physio and OT support; (received Day 24)

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Bill 198 vs Bill 59 cont'd

DAY	Example of Impact of Delay on Seriously Injured and Treatment Provider caused by Draft Bill 198 regulations:
69	Insurer finds Home Assessment Treatment Plan not necessary and reasonable;
75	Insurer sends both Treatment Plans to DAC;
77	Insurer appoints counsel to get appointment to examine insured under oath;
85	Insurer's lawyer examines insured under oath in court reporter's office with insured party's lawyer present;
87	Insurer writes DAC asking DAC to delay assessment until transcripts of the examination are ready;

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Bill 198 vs Bill 59 cont'd

DAY	Example of Impact of Delay on Seriously Injured and Treatment Provider caused by Draft Bill 198 regulations:
92	DAC re Treatment Plan (see Day 75) completes assessment;
100	Transcripts ready and sent to DAC;
107	DAC completes report and mails it to insurer and insured. DAC indicates that home modifications were reasonable and necessary at the time they were recommended but not necessary now, as patient is now ambulating. DAC provides that it is reasonable and necessary for future treatment to include physiotherapy and occupational therapy to ameliorate effect of fracture of femur and cognitive impairments;

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Bill 198 vs Bill 59 cont'd

The above examples illustrate that:

1	Assessments are an integral part to the preparation of the Treatment Plan;
2	Example Number 1 reveals the manner by which an insurer could respond to a health care professional's recommendations in a process that would delay the provision of active treatment by one hundred and seven (107) days and still be in compliance with the SABs requirements under Bill 198;
3	Example Number 2 reveals that to obtain the same result under Bill 59 would take less than half the time than it takes under the draft Bill 198 SABs when using the maximum periods of time available under Bill 59;

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Bill 198 vs Bill 59 cont'd

4	Many victims will either not know of the seven (7) day requirement or will not be physically, cognitive or emotionally able to satisfy that requirement. The most seriously injured will be more likely to offend the (7) day requirement than those with modest injuries. The most seriously injured require the insurers co-operation and partnership in funding treatment on discharge most of all and cannot cope with the additional delays imposed;
5	The delay caused by the approval process for the Assessment Plan is a delay that will also engender additional delay in the provision of treatment as assessments are required for the purpose of putting forward accurate and responsible recommendations;

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SOLUTIONS TO DELAY

Solutions to Delay

1) Notice on time
2) Acute centre recommends Assessments
3) Acute center notes concerns re: “imminent risk of harm to injured person or family”
4) Acute centre notes injury re: pending discharge
5) Put recommendation for Assessment in Treatment Plan

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CHANGES TO THE DEFINITION OF CATASTROPHIC IMPAIRMENT

Catastrophic

"Catastrophic Impairment" means,

OLD	NEW
(a) Paraplegia or quadriplegia	same
(b) Amputation or other impairment causing the total and permanent loss of use of both arms,	Amputation or other impairment causing the total and permanent loss of use of both arms **or both legs;**
(c) Amputation or other impairment causing the total and permanent loss of use of both an arm and a leg,	Amputation or other impairment causing the total and permanent loss of use of **one or both arms** and **one or both legs;**
(d) Total loss of vision in both eyes,	same

Catastrophic cont'd

"Catastrophic Impairment" means,

OLD	NEW
(e) **Brain impairment that, in respect of an accident, results in,**	same
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,	same

Catastrophic cont'd

"Catastrophic Impairment" means,

OLD	NEW
(f) Subject to subsection (2) and (3), any 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	same

Catastrophic cont'd

"Catastrophic Impairment" means,

OLD	NEW
(g) Subject to subsection (2) and (3), any 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 a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder; ("deficience invalidante")	same

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Catastrophic cont'd

"Catastrophic Impairment" means,

OLD	NEW
***	**(1.3) Subsection (1.4) 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 (1.2) (e), (f) or (g) can be applied by reason of the age of the insured person.** **O. Reg. 281/03, s.1 (5)**

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Catastrophic cont'd

"Catastrophic Impairment" means,

OLD	NEW
***	**(1.4) For the purposes of clauses (1.2) (e), (f) and (g), an impairment sustained in an accident by an insured person described in subsection (1.3) 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 (1.2) (e), (f) or (g), after taking into consideration the developmental implications of the impairment. O.Reg. 281/03, s. 1(5).**

Catastrophic cont'd

(2) Clauses (f) and (g) of the definition of "catastrophic impairment" in subsection (1) do not apply in respect of an insured person who sustains an impairment as a result of an accident unless,

OLD	NEW
(a) the insured person's health practitioner states in writing that the insured person's condition has stabilized and is not likely to improve with treatment; or	(a) the insured person's health practitioner states in writing that the insured person's condition is **unlikely to cease to be a catastrophic impairment**; or
(b) three years have elapsed since the accident. O. Reg. 403/96, s. 2(2)	(b) have elapsed since the accident. O. Reg. 281/03, s 1(7).

Catastrophic cont'd

"Catastrophic Impairment" means,

OLD	NEW
(3) For the purposes of clauses (f) and (g) of the definition of "catastrophic impairment" in subsection (1), 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 shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.	same

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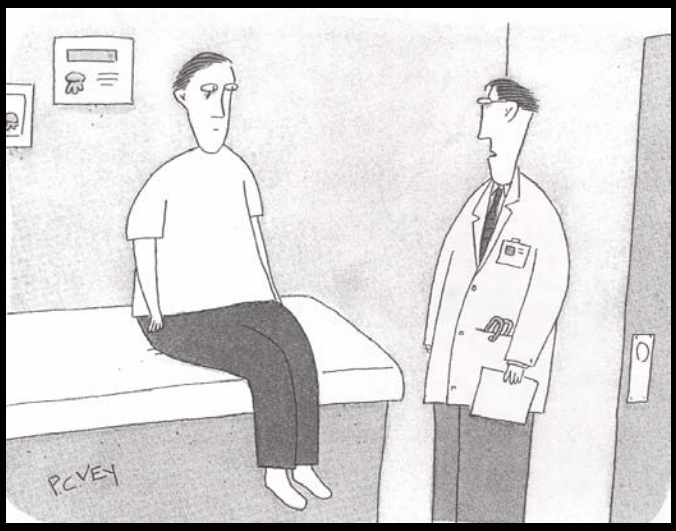
CHANGES TO THE CATASTROPHIC IMPAIRMENT APPLICATION PROCESS



"Which do you want first, the good news that sounds better than it is or the bad news that seems worse than you expected."

Prior Approval for Catastrophic Assessment Required

Except where:

"The insured person is hospitalized or in a long-term care facility at the time of the assessment or examination"

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APPLY
EARLY AND OFTEN

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An application for Catastrophic impairment as a result of a 55% whole person impairment or marked or extreme mental or behavioral disorder may now be made 2 years after the accident.

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This closes the 1 year gap between the end of non-catastrophic benefits and the 3rd anniversary application threshold under Bill 59.

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TORT CHANGES

Two Methods to Seek Compensation

- Claims against your own insurance company (the accident benefit claim)
- Claims against the at-fault driver(s) (the tort claim)

Claims against the At-fault Driver(s)

What you can sue for:

- Pain and Suffering
- Excess Income Loss
- Housekeeping and Home maintenance
- Claims on behalf of family
- Only if injury is Catastrophic – Healthcare expenses

Restrictions on your right to sue the At-fault Driver

The Threshold – permanent and serious impairment of an important physical, mental or psychological function or permanent and serious scarring

The Deductible - $15,000 for pain and suffering claims and $7,500 for family claims

Changes under the new Regulations

Increased Deductible

- From $15,000 to $30,000 for pain and suffering claims
- From $7,500 to $15,000 for family claims

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STRICTER THRESHOLD DEFINITIONS (?)

IMPAIRMENT

i. the impairment must substantially interfere with a person's ability to continue their employment;

or

ii. the impairment must substantially interfere with a persons ability to continue training for a career in a field in which the person was being trained before the accident, despite reasonable efforts to accommodate the impairment;

or

iii. the impairment must substantially interfere with most of the usual activities of daily living, considering the person's age.

IMPORTANT FUNCTION

To be important the function must be necessary to perform one's:

a) essential tasks of employment despite accommodations;

or

b) essential tasks of the person's training for a career despite accommodation;

or

c) Self care

d) Usual activities of daily living considering the person's age

PERMANENT

i. continuous since the accident despite efforts to treat

ii. continues to interfere with a person's ability to perform their work, their training for a career or their activities of daily living

iii. be of a nature that is expected to continue without substantial improvement when sustained by persons in similar circumstances

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"We thought it was a rough patch, but it turned out to be our life."