

ONTARIO AUTO INSURANCE, BILL 198 AND OTHER CHANGES

“What the Health Care Professional Needs to Know”



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ONTARIO AUTO INSURANCE BILL 198 and Other Changes

“What the Health Care Professional Needs to Know”

OVERVIEW OF CHANGES TO AUTO INSURANCE

DISABILITY CERTIFICATE (OCF-3)

BILL 198 - COPING WITH INCREASED DELAY

CHANGES TO THE DEFINITION OF CATASTROPHIC IMPAIRMENT

OVERVIEW OF CHANGES TO AUTO INSURANCE

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Significant Changes

- a) Substantial changes to SABS
- b) Changes to DACs
- c) Pain & Suffering Deductible changes
- d) Unfair or deceptive practice regulation (*in force November 1, 2003*)
- e) Settlement of SABS claims before 1 year prohibited
- f) Verbal Threshold Defined
- g) New Fee Guidelines
- h) Expanded right to sue for health care expenses

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Direct Impact on Injured Persons

- Treatment Delays for failing to give notice within 7 days [s. 32 (1.1)(b)] and [s. 32 (6)]
- Injured Persons examined under oath [s. 33]
- Restrictions to [s.24] assessments
- Limiting fees to professionals
- Pre-Approved Framework for Whiplash [s. 37.1(1) to s. 37.2(5)]

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Direct Impact cont'd

- New and more complex forms for Assessments and Treatment
- Verbal approval by insurers [s. 24(1.4)]
- No insurer examinations before mediation of medical/rehab benefits
- Changes to Catastrophic Definition, particularly as it relates to children
- Changes to deductibles
- Recovery of health care expenses

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New Notice Requirements

Notice within 7 days (On or after Oct. 1/03) [s. 32(1.1)(b)]

What Notice is sufficient

- policy number, accident date, location
- state intention to claim

Who should give notice?

To which insurer?

In order of priority:

- 1) Injured person's insurer
- 2) Insurer of vehicle in which injured person was occupant
- 3) Insurer of any other involved vehicle
- 4) Motor Vehicle Accident Claims Fund



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What Happens if 7 Days Deadline Not Met?

Insurer can delay for up to 45 days from "Completed A/B Form" [s. 32]

- Insurer can delay:
 - Income Replacement Benefit/Non-Earner Benefit/Caregiver Benefit [s. 35]
 - Med/Rehab Benefit [s. 38]
 - Attendant Care Benefit [s. 39]
 - Death Benefit [s. 41]

Note: No benefit is payable until a "complete" Accident Benefit Application is received by Insurer.



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The New Form 1 (Attendant Care)

(Attendant Care)

- For accidents on or after Oct. 1/03
- Increased Rates
 - Level 1 10.53 (vs. 9.00)
 - Level 2 7.00 (vs. 7.00)
 - Level 3 16.86 (vs. 15.00)
- New category of supervisory/skilled care
- Deletes Intermittent Care
- Adds co-ordination of attendant care

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Changes Affecting Private Health Care Professionals

FEES

- reduced fees for assessment
- need for pre-approval
- reduced fees for treatment (up to 50%)
- unable to mediate or arbitrate for denied fees for treatment

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DISABILITY CERTIFICATE (OCF 3)

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Disability Certificates (OCF 3)

- Required for IRB, non-earner, caregiver
- Insurer may require as often as necessary
- To be provided within 21 days of request
- Failure to provide could result in lapse in benefits
- Must be provided after denial and before disability DAC can proceed

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Disability Certificate (OCF-3)

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

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

For this applicant, this is Disability Certificate number _____ from this health professional/facility

OCF-3

Use this form for accidents that occur on or after November 1, 1996. If your insurance company asks you to complete this form, fill out Parts 1 to 3 and give the form to your **health practitioner (chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist)**. After your health practitioner has explained your accident-related injury to you, Sign Part 4. Your health practitioner will complete the rest of the form, based on his/her most recent assessment, and return it to the insurance company. Your health practitioner must forward the form to the insurance company within **21** days of your company sending this form to you or within **14** days of your insurance company notifying you that they intend to discontinue your benefits. **Only an authorized health practitioner can complete this form. The health practitioner's opinion will be relied upon by people who review the certificate to make important decisions. Accordingly, it is necessary to be accurate and complete. Please print clearly and provide all information requested. This form may not be materially altered.**

Confidentially: Collection, use and disclosure of this information is subject to all applicable privacy legislation.

<p>Part 1 Applicant Information</p> <p>To be completed by the applicant</p>	Date Of Birth (YYYYMMDD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number	Extension
	Last Name			
	First Name		Middle Name	
	Address			
	City		Province	Postal Code

<p>Part 2 Insurance Company Information</p> <p>To be completed by the applicant</p>	Name Of Insurance Company		City or Town of Branch Office (if applicable)	
	Name of Insurance Company Representative:			
	Adjuster Telephone	Ext.	Adjuster Fax	
	Name of policy holder same as: <input type="checkbox"/> Applicant OR		Policy Holder Last Name	Policy Holder First Name

**Part 3
Accident
Description**

To be completed
by the applicant

Give a brief description of the accident and what happened to you. Please describe any injuries you sustained as a direct result of the accident.

additional sheets attached

**Part 4
Applicant
Signature**

I authorize my treating health professional to collect, use and disclose to my insurer, any information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing health conditions that may be barriers to my recovery as a result of the automobile accident, for the purpose of providing treatment and determining my eligibility for benefits. This authorization is valid for one year from the date this form is signed.

I authorize the health practitioner who completes this form to contact my employer, if this is necessary, to confirm the essential tasks of my employment and the nature and extent of any available work with modified hours or duties.

I certify 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 Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)
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To the Health Practitioner:

Please complete the following information based on our most recent examination of the applicant named in Part 1 and return the form to the insurance company listed in Part 2. Please print clearly.

<p>Part 5 Injury and Sequelae Information</p> <p>This part and the rest of this form must be completed by your Health Practitioner</p>	Provide a description (list most significant first) and associated IC-10-CA+code for any injuries and sequelae that are the direct result of the automobile accident.	
	Description	Code
<p>Note: Refer to the User manual for ICD-10-CA coding information.</p>		

<p>Part 6 Relevant Dates</p>	Date symptoms first appeared: (YYYYMMDD)	Date of most recent examination: (YYYYMMDD)
	Date of first post-accident examination: (YYYYMMDD)	<p>a) Applicant was seen by me prior to the accident. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>b) If answer to (a) is yes, enter date on which applicant was first seen: _____</p>

Part 7 Disability Tests and Information

OCF-3

a) Based on your current knowledge and information provided by the applicant, please provide a response to each Benefit/Applicant Category

Benefit/Applicant Category	Disability Test	Onset of Disability (YYYYMMDD)	Task / Activity Limitations	Anticipated Duration
Income Replacement Benefits Employed: working at the time of the accident	Is the applicant substantially unable to perform the essential tasks of his/her employment at the time of the accident as a result of and within 104 weeks of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
	Can the applicant return to work on modified hours and /or duties? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
Unemployed: but worked 26 weeks during the 52 weeks before the accident	Is the applicant substantially unable to perform the essential tasks of the employment held for most of the time during the 52 weeks before the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
Future employment: had accepted a job offer to start work within one year of the accident	Is the applicant substantially unable to perform the essential tasks of the employment he/she would have begun? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks

OCF-3

Benefit/Applicant Category	Disability Test	Onset of Disability (YYYYMMDD)	Task / Activity Limitations	Anticipated Duration
Non-Earner Benefits	Does the applicant suffer a complete inability to carry on a normal life? (i.e., Has the applicant sustained an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident?) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
Caregiver Benefits	As the Primary Caregiver, does the applicant suffer a substantial inability to engage in the caregiving activities in which he/she engaged at the time of the accident? (Primary Caregiver means that, at the time of the accident, the applicant was residing with a person in need of care and the applicant was the primary caregiver for the person in need of care and did not receive any remuneration for engaging in caregiver activities.) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks

Benefit/Applicant Category	Disability Test	Onset of Disability (YYYYMMDD)	Task / Activity Limitations	Anticipated Duration
Lost Educational Expenses	Is the applicant, as a result of the accident, unable to continue in an elementary, secondary, post-secondary or continuing education program that the applicant was enrolled in at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
Housekeeping and Home Maintenance Expenses	Does the applicant suffer a substantial inability to perform the housekeeping and home maintenance services that he or she normally performed before the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Please explain:	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
<p>b) If you responded Anticipated Duration 'more than 12 weeks' to any disability test above, please explain why the task/activity limitations are likely to persist beyond 12 weeks.</p>				

<p>Part 8 Further Investigations or Consultations</p>	<p>a) Have there been any examinations, investigations, or consultations not previously reported by you? <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify findings and results)</p>
	<p>b) Are further examinations, investigations or consultations contemplated or required? <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify)</p>

**Part 9
Prior and
Concurrent
Conditions**

a) Prior to the accident, did the applicant have any disease, condition or injury that affected his/her ability to perform the activities listed in Part 7?
No Unknown Yes (please explain)

If yes, is the applicant currently receiving any disability benefits for the pre-existing disease, condition or injury?

No Unknown Yes (please explain)

If you treated the applicant for similar conditions prior to the accident, please describe (include date of onset, any subsequent interventions, and status at the time of the accident).

b) Since the automobile accident has the applicant developed any disease, condition or injury, not related to the accident, that could affect his/her disability?
No Yes (please specify)

**Part 10
Medications**

a) Please list any medications (including dosage and frequency) that the applicant is currently taking for injuries related to the automobile accident.

Were these medications prescribed by you? No Yes

b) Please list any medications (including dosage and frequency) that the applicant is currently taking as a result of prior or concurrent conditions identified in Part 9.

Were these medications prescribed by you? No Yes

Part 11 Signature of Insurer	Name of Health Practitioner		College Registration Number		You are a: <input type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech-Language Pathologist
	Facility Name (if applicable)		AISI Facility Number (if applicable)		
	Address				
	City		Province	Postal Code	
	Telephone Number	Extension	Fax Number		
	Email Address				
	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 Health Practitioner (please print)		Signature of Health Practitioner		Date (YYYYMMDD)	

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..



BILL 198

COPING WITH INCREASED DELAY



Causes of Increased Delay

- 7 Day Notice otherwise 45 Days from A/B Application
- A/B Application Must be Complete
- Examination under Oath
 - Scheduling and Reporting
- OCF 22 Approval
- OCF 18 Approval
- Increased DAC Involvement

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Solutions to Delay

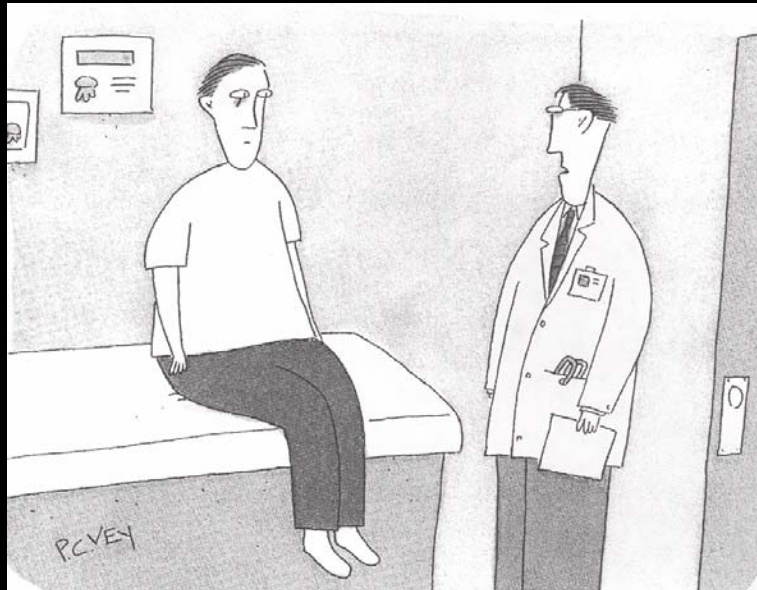
- 1) Notice on time, confirm in writing to proper insurer
- 2) Call insurer and lawyer to prompt quick intervention
- 3) Acute centre recommends assessments
- 4) Acute centre notes concerns re: “immediate risk of harm to injured person or family”; urgency; or safety
- 5) Acute centre notes urgency re: pending discharge
- 6) List types of disciplines required in Treatment Plan

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CHANGES TO THE DEFINITION OF CATASTROPHIC IMPAIRMENT

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



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., <i>Management of Head Injuries</i> , 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., <i>Assessment of Outcome After Severe Brain Damage</i> , 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 <i>Guides to the Evaluation of Permanent Impairment</i> , 4th edition, 1993, results in 55 per cent or more impairment of the whole person,	same

or



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 <i>Guides to the Evaluation of Permanent Impairment</i> , 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



Catastrophic cont'd

“Catastrophic Impairment” means,

OLD	NEW
***	<p>(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 <i>Guides to the Evaluation of Permanent Impairment</i>, 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.</p> <p>O. Reg. 281/03, s.1 (5)</p>



Catastrophic cont'd

“Catastrophic Impairment” means,

OLD	NEW
***	<p>(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.</p> <p>O.Reg. 281/03, s. 1(5).</p>



Elements of Section 2 (1.4)

IF

- Under 16
- GCS, GOS, 55% impairment, and class IV and/or V impairment cannot be applied
- Impairment reasonably believed catastrophic and
- Analogy to other tests considering developmental implications

Then deemed Catastrophic

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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) 2 years have elapsed since the accident. O. Reg. 281/03, s 1(7).

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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, 4 th 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



How to use the AMA Guides

Section 2.2 of AMA Guides (Page 8)

*“If in spite of an observation or test result, the medical evidence appears not to be of **sufficient weight to verify that an impairment of a certain magnitude exists, the physician should modify the impairment estimates accordingly, describing the modification and explaining the reason in writing.**”*



How to use the AMA Guides

Section 2(3) of the SABS can be used to help children

“...an impairment... that is not listed in the AMA Guides... shall be deemed to be the impairment that is listed... and most analogous...”

Thank You