EXAMINATIONS, ASSESSMENTS AND REPORTS

WHAT'S COVERED AND WHO PAYS?[1]

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On September 1, 2010, a new SABS regime takes effect. There are a number of drastic changes to the SABS that impact upon client assessments, examinations and reports, and who pays for these endeavours.

To better address the changes, you must consider the following:

- Has my patient suffered a "minor injury"?
- Has my patient suffered a "non-catastrophic impairment", yet an injury that is greater than "minor"?
- Has my patient suffered "catastrophic impairment"?
- Does my patient have access to a viable "tort claim" and, if so, will his or her counsel require reports from me outside of the scope of the SABS?

Minor Injury

Section 3 of the SABS defines minor injury as follows:

> A sprain, strain, whiplash-associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelae.

Section 3 of the SABS further defines a variety of the minor injuries listed.

A "sprain" is defined as follows:

> An injury to one or more tendons or ligaments or to one or more of each, including a partial but not a complete tear.

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A “strain” is defined as follows:

> An injury to one or more muscles, including a partial but not a complete tear.

A “whiplash-associated disorder” is defined as follows:

> A whiplash injury that
>
> (a) Does not exhibit objective, demonstrable, definable and clinically relevant neurological signs, and
>
> (b) Does not exhibit a fracture in or dislocation of the spine

A “subluxation” is defined as follows:

> A partial but not a complete dislocation of a joint.

The significance of having suffered a “minor injury” as defined, is that your patient will be subject to the “Minor Injury Guideline” (also defined in Section 3). The procedure for claiming under the “Minor Injury Guideline” is described in Sections 40 and 41 of the SABS. Below, I’ve outlined some of the limitations relating to “minor injuries”.

Section 18 of the SABS provides, in part:

> (1) **The sum of the medical and rehabilitation benefits payable** in respect of an insured person who sustains an impairment that is predominantly a minor injury **shall not exceed $3,500.00** for any one accident, **less the sum of all amounts paid in respect of the insured person in accordance with the Minor Injury Guideline.**
>
> (2) Despite subsection (1), the $3,500.00 limit in that subsection **does not apply** to an insured person **if** his or her **health practitioner determines and provides compelling evidence that the insured person has a pre-existing**

> **medical condition that will prevent the insured person from achieving maximal recovery** from the minor injury **if the insured person is subject to the $3,500.00 limit** or is limited to the goods and services authorized by the Minor Injury Guideline.
>
> (5) For the purposes of subsections (1)…**medical and rehabilitation benefits** payable in respect of an insured person **include all fees and expenses for conducting assessments and examinations and preparing reports** in connection with any benefit or payment to or for an insured person under this regulation, other than:
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> i. Fees in connection with any examination required by an insurer under Section 44 (an insurer examination); and
>
> ii. Expenses in respect of a report referred to in subsection 7(4) [an accounting report].

In-home assessments are not permitted under the "Minor Injury Guideline". More particularly, Section 25(2) of the SABS provides:

> An insurer is not required to pay for an assessment or examination conducted in the insured person's home unless the insured person has sustained an impairment that is not a minor injury.

Patients who suffer from a "minor injury" are not entitled to receive attendant care benefits (Section 14.2).

As mentioned above, the procedure for treating a person with "minor injury" is outlined in Sections 40 and 41 of the SABS. Section 40(2) identifies the need to complete a "Treatment Confirmation Form" that satisfies a variety of requirements.

Section 25(1) of the SABS provides:

> The insurer shall pay the following expenses incurred by or on behalf of an insured person:
>
> (2) Fees charged in accordance with the Minor Injury Guideline by a person authorized by the Guideline for preparing a Treatment Confirmation Form and for conducting an assessment or examination in preparing a report as authorized by the Guideline

The costs for completing this Form have yet to be determined.

If your patient has suffered a Minor Injury, and unless you can provide compelling evidence that your patient has a pre-existing medical condition that will prevent your patient from achieving maximal recovery from the injury, assessment, examination and report costs will be minimal and the fees that you propose to charge must be in accordance with a Guideline that has yet to be published.

Non-Catastrophic Impairment

For those of you familiar with Bill 198 (and its predecessor, Bill 59), you are already well acquainted with the difference between catastrophic and non-catastrophic impairment. Nevertheless, under the new regime, when treating a patient with non-catastrophic entitlements, there are some important differences that will impact upon assessment, examination and report costs.

For patients who suffer non-catastrophic impairment (but exceed the minor injury threshold), the new monetary limits for medical and rehabilitation benefits is $50,000.00 [Section 18(3) (a)].

As outlined above, Section 18(5) is significant in that it provides:

> For the purposes of subsections…(3), medical and rehabilitation benefits payable in respect of an insured person **include all fees and expenses for conducting assessments and examinations and preparing reports** in connection with any benefit or payment
>
> to or for an insured person under this regulation other than (insurer exams and accounting reports)

Assessment costs are now included within the $50,000.00 non-catastrophic medical and rehabilitation limit.

Further, Section 25 of the SABS caps assessment and examination costs at a maximum of $2,000.00. More particularly, Section 25(5) provides:

> Despite any other provision of this Regulation, an insurer **shall not pay**
>
> (a) **More than $2,000.00** in respect of fees for any one assessment or examination whether conducted at the insistence of the insured person or the insurer

The above-noted change will undoubtedly cause hardship to your patient (and perhaps the insurer). How does one undertake a neuropsychological assessment at a maximum cost of $2,000.00? Is the $2,000.00 cap intended to cover the entire CAT assessment or is it a per discipline limitation (although FSCO has suggested that it is not intended to cover the entire CAT assessment, the fact that the Regulation is silent may create controversy and litigation uncertainty). Are report costs included in the $2,000.00 fee (the subsection speaks only to assessments or examinations - not reports)?

What are my reports supposed to address?

Subject to the purchase of "optional benefits", non-catastrophic patients will not be entitled to receive the following benefits:

- Housekeeping benefits (Section 23);
- Caregiver (Section 13);
- Case Management Services (Section 17).

Further, Section 25(5) (b) of the SABS provides:

> Despite any other provision of this Regulation, **an insurer shall not pay any amount in respect of fees for preparing a Future Care Plan**, a Life Care Plan or a similar plan for any assessment or examination conducted in connection with the preparation of the plan

Unless you are an occupational therapist or a registered nurse, you are not authorized to complete an Assessment of Attendant Care Needs [Section 42(1)], and as such, you will not be paid for doing so.

In short, a "health practitioner" (as defined in Section 3) is entitled to prepare a report addressing disability (i.e. entitlement to income replacement benefits and/or non-earner benefits) and/or entitlement to medical and rehabilitation benefits. The cost of any such assessment or examination (and perhaps report) shall not exceed the sum of $2,000.00 and the cost of these efforts will be subtracted from the patient's $50,000.00 non-CAT med/rehab limit. Only nurses and occupational therapists are authorized to complete an Assessment of Attendant Care Needs.

Catastrophic Impairment

The definition of catastrophic impairment has been expanded to include single limb amputees [Section 3(2) (b)]. However, there are further restrictions regarding when an Application for Catastrophic Determination can be made and who is authorized to complete an assessment or examination in connection with the catastrophic impairment determination.

Your patient is precluded from applying for catastrophic determination for two years post-accident pursuant to the Whole Person Impairment Test, or the Marked Extreme Mental or Behavioural Disorder Test, unless a brain injury is present [Section 3(5) (c)].

Only a physician can complete an assessment or examination in connection with a catastrophic impairment determination, unless the impairment is solely a brain impairment, in which case, a "neuropsychologist" may complete the examination or assessment (Section 45).

At present, there is great uncertainty regarding the CAT determination process. Section 45(2) 3 of the SABS provides:

> If a Guideline specifies conditions, restrictions or limits with respect to the determination of whether an impairment is a catastrophic impairment, the determination must be made in accordance with those conditions, restrictions and limits.

Almost identical language is contained within the insurer examination section (Section 44(2)). In both sections, the reference to "Guideline" is non-specific, and may refer to a future Guideline yet to be drafted.

As outlined above, the following remains unclear:

- Is the $2,000.00 cap with respect to the entire catastrophic determination process or is it a per discipline cap?

- Are persons other than physicians and/or neuropsychologists to be utilized in the CAT determination process?

- What if the type of assessment reasonably required exceeds the $2,000.00 cap, without which, the patient cannot demonstrate catastrophic impairment?

These important questions remain unanswered by the SABS, as currently drafted.

Tort Claims

To the extent that your patient has a viable tort claim, reports will be necessary to prove "all aspects" of the patient's loss (whether covered by the SABS and, more importantly, when entitlements are not covered).

Under the SABS, rebuttal reports have been entirely eliminated. Now, more than ever, accident benefit shortfalls and denials will be subsumed within appropriate tort claims. As such, lawyers may well be seeking more reports from health care professionals to assist in the prosecution of tort claims.

Tort lawyers and rehabilitation professionals will need to work together and consider the following:

- Is the patient/client more likely to be deemed catastrophic if "additional" report costs are paid for by counsel?

- If a more comprehensive assessment is required than that which can be undertaken at a cost of $2,000.00, will the patient/client's tort claim be better served by counsel paying for a more comprehensive report?

- If the patient/client has suffered non-catastrophic impairment, but has a viable tort claim, what evidence will be required to pursue tort entitlements

(i.e. housekeeping/home maintenance, caregiver claims, attendant care shortfalls, etc…)?

- In a non-catastrophic case, where the client is likely to utilize the entire $50,000.00 med-rehab limit, should all of the report costs be borne by the lawyer so as to maximize access to med/rehab funding for the patient/client?

Conclusion

There have been drastic changes to the SABS. Costs associated with many assessments, examinations and reports have been wiped out by eliminating access to a variety of benefits. Further, costs have been slashed and reduced by the imposition of a cost cap of $2,000.00 and by the inclusion of such costs in the med/rehab limit (both CAT and non-CAT).

With each change to the SABS, your patient's entitlements become further restricted. The need to maximize tort entitlement will be, by necessity, of greater importance and your efforts will be required to obtain fair and reasonable outcomes.

In consultation with a Thomson, Rogers lawyer, we will fund assessments in appropriate cases.