Overview of Amendments to the Statutory Accident Benefits Schedule and Unfair or Deceptive Acts or Practices Regulations

Preamble

The Designated Assessment Centre (DAC) system, intended to provide neutral assessments to assist in the resolution of disputes regarding entitlement to certain accident benefits, is being eliminated through regulation amendments to the *Statutory Accident Benefits Schedule* (SABS) effective March 1, 2006.

The amending regulation will continue to allow claimants to obtain assessments from their own health care providers when applying for benefits. Insurance companies that wish to challenge the claimant's provider are required to request a separate medical examination from a health care provider of their choice prior to making a determination on benefit entitlement.

The amending regulation streamlines the claims process by eliminating DACs and allows parties with disputes over assessment or examination findings and benefit determinations to proceed directly to the dispute resolution system at the Financial Services Commission of Ontario (FSCO) or to the courts following mediation.

Section 24 Examinations

Section 24 is amended to clarify that social workers can conduct assessments and they can also submit an application for approval of an assessment or examination.

Prior approval by an insurer continues to be required before conducting an examination under section 24 with the exception of circumstances listed in the SABS. There are no longer different criteria regarding assessments to prepare a treatment plan depending on whether the insured had received treatment under a *Pre-approved Framework* (PAF) *Guideline*. In all cases, prior approval by an insurer is not required for up to 3 examinations to prepare a treatment plan if the cost of each examination is under $200 and the same person does not conduct more than one examination. Insurers must respond to applications for examinations within 3 business days.

Pre-Claim Examinations

A new category of examinations is being introduced: the voluntary pre-claim examination. With the consent of the insured, an insurer can arrange for an examination by a regulated health professional to determine entitlement to attendant care, assistive devices and home modifications. These examinations are available to an insured who is being discharged from a hospital or other facility and before an application for benefits is submitted by the insured. The insurer must obtain the written and signed consent of the insured before the pre-claim examination takes place. Within 5 business days of the pre-claim examination, the regulated health professional would provide a written copy of his or her report to the insurer, insured and the insured's health practitioner. The report is non-binding on both the insured and insurer.

Applying for Income Replacement, Non-Earner or Caregiver Benefit and Housekeeping or Home Maintenance Expenses

When applying for income replacement, non-earner or caregiver benefits and housekeeping or home maintenance expenses, an insured will be required to submit a current disability certificate. Within 10 business days of receiving a certificate, the insurer must either pay the benefit or notify the insured that an examination under section 42 of the SABS is required. An insurer cannot deny entitlement until it receives a report from the person who conducted the section 42 examination. However, the insurer may determine there is no entitlement to a specified benefit before conducting a section 42 examination in a limited number of non-medical circumstances.

Within 5 business days of receiving the section 42 examination report, the insurer has to communicate its decision regarding entitlement and provide a copy of the report to the insured and the insured's health practitioner. If the section 42 examination report is delayed, insurers are required to pay the benefit or expense until the report is received.

Determination of Continuing Entitlement to Specified Benefits

At any point, should the insurer wish to determine whether the insured continues to be entitled to a benefit that they were receiving, the insurer informs the insured that it requires a new disability certificate and that it would require the person to undergo a section 42 examination. If a certificate is not provided within 15 business days, no benefit is payable beyond that period until one is provided.

Again, an insurer is normally not able to terminate a benefit until it receives a report from the person who conducted the section 42 examination. However, a benefit may be terminated without a section 42 examination in a limited number of non-medical circumstances.

Medical and Rehabilitation Benefits

Social workers can complete a treatment plan but it must be reviewed by a health practitioner as defined in the SABS. An insurer is not required to pay for medical and rehabilitation goods and services before a treatment plan is submitted except if goods and services are provided on an emergency basis within 5 business days of the accident.

An insurer is required to respond to a treatment plan within 10 business days. The insurer's response must indicate what goods and services the insurer has agreed to pay and if the insurer does not agree to pay for all goods and services set out in the insured's treatment plan, it must notify the insured that it requires an examination under section 42 of the SABS. As well, the insurer may notify the insured that a section 42 examination is required if it is believed that the insured has an impairment that falls under a PAF Guideline. Insurers who fail to respond to treatment plans within 10 business days are required to pay for goods and services incurred up to the time they finally do respond.

Within 5 business days of receiving the section 42 examination report, the insurer must communicate its decision regarding entitlement and provide a copy of the report to the insured and the insured's health practitioner.

An insurer is normally not able to deny entitlement until it receives a report from the person who conducted the section 42 examination. However, an insurer is able to determine there is no entitlement to a specified benefit without conducting a section 42 examination if the insured fails to attend a section 42 examination. If the section 42 examination report is delayed, insurers are required to pay the benefit or expense until the report is received.

Attendant Care Benefit

The assessment of attendant care needs form is no longer attached to the SABS, but becomes a form developed by the Superintendent and incorporated by reference into the regulations, through a link to FSCO's website at www.fsco.gov.on.ca.

To apply for the attendant care benefit, an insured is required to submit an assessment of attendant care needs. Within 10 business days of receiving an assessment of attendant care needs, the insurer must pay the benefit and may notify the insured that it requires an examination under section 42 of the SABS if it did not agree with the expenses set out in the assessment of attendant care needs.

An insurer can refuse to pay the attendant care benefit if the insured failed to attend a section 42 examination. Within 5 business days of receiving the section 42 examination report, the insurer is to communicate its decision regarding entitlement and provide a copy of the report to the insured and the insured's health practitioner.

An insurer would not be required to pay for expenses incurred before an assessment of attendant care needs is submitted. If the section 42 examination report is delayed, the insurer is required to continue to pay the benefit until the report is received.

Determination of Catastrophic Impairment

To apply for a catastrophic impairment determination, an insured is required to submit an application for determination of catastrophic impairment. Within 30 days of receiving an application for determination of catastrophic impairment, the insurer must either notify the insured that it has accepted the application or that it requires an examination under section 42 of the SABS.

If the insured has applied for a catastrophic impairment determination and fails to attend a section 42 examination, the insurer may refuse to pay a benefit.

Within 5 business days of receiving the section 42 examination report, the insurer is to communicate its decision regarding entitlement and provide a copy of the report to the insured

and the insured's health practitioner.

In cases awaiting a catastrophic impairment determination, the monthly attendant care benefit cap is increased to $6,000 pending the outcome of the section 42 examination. For these same cases, entitlement to the attendant care benefit is extended beyond 2 years pending the outcome of the section 42 examination.

Examinations Required by Insurers

Examinations under section 42 of the SABS can be requested by an insurer to respond to applications for benefits or to determine whether the insured continues to be entitled to a benefit. Examinations are conducted by a regulated health professional, social worker or an expert in vocational rehabilitation. Treatment and assessments under a PAF Guideline are not subject to a section 42 examination other than claims for ancillary goods and services.

When an insurer requests that an insured undergo a section 42 examination, the insurer notifies the insured of the reasons for the examination, whether it will only involve a paper review (based on criteria in the SABS), who will be conducting the examination, and the date, time and place of the examination. Notices can be verbal but also have to be confirmed in writing. The assessor, based on a review of a referral, may determine that a physical examination is needed despite the fact that the regulations provide for a paper review.

Where no physical examination is required, the referral is made within 2 business days of notification; otherwise, referral is made within 5 business days. An examination is to be completed within 10 business days with the exception of catastrophic impairment cases or determinations, in which case the examination is to be completed within 30 business days.

Examinations are to be conducted within 30 kilometres of the insured's residence if they live in the Greater Toronto Area (GTA) and within 50 kilometres for those outside the GTA. The insured can agree to an examination outside this range but cannot be compelled to travel beyond this range. If the insurer is unable to arrange for a qualified person to conduct the examination within these distances, the insurer may arrange an examination at a location that is reasonable in the circumstances.

During and after the section 42 examination, treating providers and assessors can consult on treatment issues in order to resolve differences and the insurer is required to pay for such a consultation. Assessors are to provide a report to the insurer within 10 business days of the examination. Reports are provided within 5 business days if there is no physical examination required unless it involves a catastrophic impairment in which case the assessor has 10 business days.

Assessments or Examinations after Denial of Benefits

Where an insurer has denied entitlement to a benefit as a result of a section 42 examination, in

certain circumstances, the insured can obtain an assessment from their health care provider to address issues raised in the section 42 examination. In some cases, the insured's heath care provider is limited to only a paper review of the section 42 examination. However, there are situations set out in the SABS where the health care provider can conduct another physical examination of the insured. Where the section 42 examination has been conducted by someone who is not a member of the same health profession or specialty as the insured's provider, the provider may refer the insured to another health care provider for the examination.

The insured has 40 business days to have the examination completed. If the insured has a catastrophic impairment or is being considered for one, then the insured has 80 business days to have the examination completed. The fees for these examinations are capped. Examinations by medical specialists are capped at $900, all other examinations are capped at $775, and paper reviews are capped at $450. However, if the insured has a catastrophic impairment or is being considered for one, then these caps do not apply.

Transition

DAC assessments would continue to be conducted for a short time following the implementation date of March 1, 2006. In the event that a benefit denial would have already been issued by an insurer before the implementation date, the insurer would have to use a DAC. If the insurer initiates a DAC assessment for a catastrophic impairment determination or to assess attendant care needs before the implementation date, the insurer would still use a DAC. As well, if the insurer does not respond to an application for benefits within the time frames in the SABS before the implementation date, the insurer would have to use a DAC. Finally, if no DAC is available to conduct an assessment on an insured after March 1, 2006, the insurer can arrange for a section 42 examination instead.

Mediation Proceedings

An insured will no longer be prohibited from commencing a mediation if they have failed to attend a section 42 examination. However, the insurer is not required to pay those benefits that are subject to the examination during the period that the insured fails to attend the examination.

Unfair or Deceptive Acts or Practices

The following new actions are included in the regulation prescribing unfair and deceptive acts or practices:

- Refusal to pay promptly where an insurer fails to give notice as required and is consequently obliged to pay for goods and services.

- Denying entitlement without use of, or without obtaining, a report when required by the regulations to obtain one.

- Any statement that misrepresents the opinion of a health professional conducting an examination.

- Obtaining a report from a person who the insurer ought to know is not reasonably qualified to provide the opinion.

- Requesting examinations when the insurer ought to know they are not reasonably required for the purposes authorized.

- Service providers (to include tow truck operators, storage facilities and collision repair shops) who charge an amount in consideration for the provision of goods or services if the goods or services are not provided.

- Soliciting or demanding a referral fee, directly or indirectly, by or from a service provider.

- Acceptance of a referral fee, directly or indirectly, by or from a service provider.

- The payment of a referral fee, directly or indirectly, to or by a service provider.

- Charging an amount in consideration for the provision of goods or services where the amount charged unreasonably exceeds the amount charged to other persons for similar goods or services.