DAC Committee

Designated Assessment Centre Timelines

Statement of Intent

This Guideline has been developed by the Minister's Committee on the Designated Assessment Centre System (DAC Committee) to clarify and review the DAC assessment process and the time frames within which an assessment is to be completed.

DACs, claimants, insurance companies, and their respective representatives must work cooperatively within this guideline to ensure that DACs continue to be a timely and effective mechanism to assist in resolving disputes over statutory accident benefits.

To calculate time under this General Guideline, the following rules should be employed to determine a reasonable time frame:

1) Where there is a reference to a number of days between two events, do not count the day that the first event occurred.
2) Where the date for doing an act under this guideline falls on a Saturday, Sunday, or statutory holiday, the act may be done on the next day that is not a Saturday, Sunday, or statutory holiday;
3) Requests or the service of documents after 4:45 PM or on a Saturday, Sunday, or statutory holiday will be considered to have been made on the next day that is not a Saturday, Sunday, or statutory holiday.

The DAC Process Overview

The DAC process has been designed in stages. Each stage contains a number of activities that are essential to the quality and integrity of the DAC process.

Within each of these stages, there are numerous opportunities to encounter delays in the process and a DAC must be diligent to ensure that any delays are kept to a minimum. The main intent of these stages is to ensure that the intake functions, file review and approval of the assessment plan are completed in order to facilitate booking the first assessment date within two weeks of the approval of the DAC assessment plan, to ensure that the assessments and investigations are completed within a two week period and that the final DAC report is issued within two weeks of the last assessment date.

Any delay encountered within the stages of the DAC process shall be communicated to the parties in writing, via courier or email. Both the claimant and the insurer have the right to a DAC assessment completed within the time lines established by the Statutory Accident Benefits Schedule (SABS). Pursuant to section 53(8) of the SABS, the parties may require that the assessment be conducted by the DAC next nearest to the insured person's residence if the closest DAC is unable to begin the assessment within two weeks of receiving the request.

The DAC Referral: The OCF 11A/B

The Designated Assessment Centre Referral form (OCF-11A) will be completed by the insurer. The insurer will send the OCF-11A to the DAC and to the claimant. The claimant is to have full disclosure of the referral questions and a list of the material sent to a DAC.

DACs may wish to include in their appointment letter a statement directing the claimant to contact their insurance company representative if they have not received their copy of the OCF-11A referral form listing the documentation included with the referral package.

It is the parties' responsibility to provide the DAC with any documents, such as recent test results, which may be useful in completing the assessment. With more complete information, the DAC will be able to conduct a more comprehensive assessment and better aid in the resolution of disputes between the insurer and claimant.

Intake Functions

The overall goal of the intake process is to decide on the appropriateness of proceeding to an assessment and, where required, select the relevant assessment team.

The intake process is structured to ensure that comprehensive information is obtained and delays are minimized.

The intake process of the assessment guide has been designed to focus the assessment appropriately and, where possible, to "stage" assessments so that only necessary investigations are undertaken.

The standard intake process employed by all DACs is designed to ensure that:

- The claimant has been referred to the appropriate DAC type, and the DAC is authorized to assess the claimant.
- The claimant understands the reason for the DAC assessment and the assessment process.
- All necessary forms are collected.
- The appropriate referral question(s) are being asked.
- All required information is collected for the assessment team.
- No conflict of interest is present or, if any is noted, it is appropriately responded to within the assessment plan or under a separate cover.
- Information is organized to maximize access for the assessment team.
- The appropriate assessment team and assessment process are selected.
- The claimant and insurer have agreed to cooperate with the assessment.

- The claimant's special needs are noted, and a plan is in place to accommodate these needs.
- Both the claimant and the insurer have had an opportunity to contribute to the assessment information.

- The assessment plan is sent to the insurer and claimant.

- Necessary appointment times are scheduled to begin the assessment after insurer and claimant agree to proceed. The first appointment should be scheduled as soon as reasonably possible following this approval.

The DAC assessment guidelines provide an overview of the intake steps that must be followed for all DAC assessments. The DAC must first ensure that the referral package is complete. The DAC Committee defines a complete referral package to include the following documents:

- OCF-14 Permission to Disclose Health Information to the Designated Assessment Centre (a signed, faxed copy is acceptable-see DAC General Guideline #3).
- OCF-11A Designated Assessment Centre Referral Form.
- The appropriate "test" and proper Statutory Accident Benefit Schedule are noted.
- A complete document list.

Incomplete Referral Packages

When a DAC first receives a referral package, it is often necessary to review and organize the referral package to ensure the package is complete. This may involve creating a claimant file with information organized in tabbed sections to facilitate the assessment team's access.

The DAC may also have to compile a document list (this list is used for reference by other team members, is included in the "Appointment Confirmation Letter" and the DAC report) if the list included in the OCF 11A Referral Form is incomplete.

The DAC Committee expects that insurance companies will have the file organized prior to referring the claimant to a DAC. At a minimum, the DAC Committee expects that insurers will:

1) Provide a document list
2) Organize the file in chronological order
3) Provide the claimant with a copy of the OCF-11A referral form
4) Ensure all photocopies included with the referral are legible, and
5) In cases of medical/rehabilitation assessments, place the disputed OCF-18 Treatment Plan(s) behind the OCF-11A.
6) Not include material that is irrelevant to the assessment process, such as log notes and miscellaneous correspondence.

Should the DAC identify missing information from the referral package, they must decide if the assessment can begin in the absence of this information. The DAC should immediately proceed with the assessment unless the absent documentation is essential to the quality of the assessment.

DACs should be aware that there are cases where information is not included with the original referral package but may be forthcoming. DACs should communicate to the parties that missing information is

to be provided to the DAC prior to the completion of the assessment and investigations. Missing information must be provided to the DAC prior to the consensus building process. Surveillance material is the only documentation that cannot be accepted once the assessments begin.

If the DAC decides to proceed at this stage, the complete DAC report should identify what information was provided in the referral package in an appendix as well as identify those documents that the parties failed to provide to the DAC in the Executive Summary.

DACs should not be indefinitely holding DAC reports back while waiting for requested documents.

If the requested information is not forthcoming and is essential to the assessment results, the parties should be advised in writing and the DAC should impose a deadline for the information. The file should be closed and no report issued if this deadline is not met.

In these cases, a "status of assessment" letter should be sent to all parties deeming the assessment "incomplete" and advising that a report will not be issued.

If an assessment can be completed without the missing information, the DAC should issue the report, indicating in the executive summary which documents were requested and not forthcoming. In this manner, the DAC report would indicate that the information was sought but not provided.

For example, there may be situations in medical/rehabilitation assessments where the missing information is required for only one of the components of the proposed treatment. In cases where the conclusions with respect to one or more components of the disputed treatment are clear, and the incomplete information does not affect those conclusions, the DAC may send out a final report on those components where consensus has been reached.

Should it appear that any portion of the assessment process will be delayed, including the issuance of the DAC report, the DAC must notify the parties in writing of the reasons and anticipated duration of the delay. Any delays should be briefly summarized in the executive summary.

Assessment Plan and Conflict of Interest

Within three business days of a referral package being deemed to be complete by a DAC, the DAC will prepare an assessment plan that must outline the following information:

- A description of the proposed assessment (includes purpose of the assessment).
- A completed Conflict of Interest disclosure.
- A projection of the length of time required to complete each stage of the assessment (should include how many and what appointments or assessments the claimant will be required to participate in).
- A list of the health care disciplines who will be participating in the assessment.
- An estimate of cost.

The DAC should clearly indicate on the assessment plan that the parties have three business days from the receipt of the assessment plan to approve the assessment plan, unless the DAC feels that a reasonable amount of time should be granted to the parties to extend this time line.

If the DAC does not receive approval to proceed with the assessment within this time, the DAC will fax a notice to the adjuster indicating that it is proceeding with the assessment.

The DAC may choose to direct this notice to the Accident Benefit Claims Manager at the insurance company if they know the adjuster is unavailable.

Each DAC should maintain its own roster of assessors who provide service to the DAC. This should include, for each assessor, his/her affiliations (where he/she works, what relevant ownerships/ partnerships he/she and related persons have).

As referral material is assembled and reviewed, the screening for conflict continues. The DAC General Guideline 5 should be consulted for detailed instructions regarding conflict screening and the DAC's responsibilities when a conflict is discovered.

The DAC is responsible for establishing whether or not there is a conflict of interest. The DAC will declare in writing to the insurance company and the claimant the nature of any conflict that arises prior to an assessment.

Upon receiving the written conflict of interest declaration contained within the DAC assessment plan, the insurance company and the claimant may agree to use the original DAC, if it is felt by both parties that the declared conflict will not interfere with the assessment.

If the insurance company and the claimant cannot agree, the original DAC will be informed by either the insurance company or claimant and the referral information will be returned immediately to the insurance company. The insurance company must then arrange, at its expense, to refer the claimant to the next nearest DAC that is qualified to assess the claimant.

Approval To Proceed

The assessment guidelines indicate that it is only following the approval of the assessment plan that the claimant is contacted and the assessment dates are scheduled.

The "Standard Appointment Confirmation Letter" (copied to the insurer) is sent to the claimant and includes the approved assessment plan. Copying this to the insurance company ensures that the claimant and insurer receive the same information. A list of documents sent by the insurance company is included, and the claimant is invited to provide any additional documents he/she believes are necessary for the DAC to review. A "DAC Assessor Practice Summary" for each assessor on the team should be included.

The claimant is contacted by telephone to confirm his/her appointment date(s).

Conducting the Assessment

Once the insured and insurer approve the assessment plan, the DAC shall schedule all of the assessments within two weeks. This assessment period can be extended in cases where the parties agree that it is reasonable to hold the assessment over a longer period of time. Assessments may also be booked in less than two weeks if the parties approve.

Any delays in completing the assessment within two weeks must be communicated to the parties with details on the reason for the delays and anticipated time to completion. These

delays should also be summarized in the executive summary of the DAC report.

The staged approach to assessments should be employed by all DAC types to ensure that only those assessments and tests required to answer the referral question are complete. In keeping with the staged assessment model, DACs should book the more important assessments first based upon their file reviews.

If, following these assessments, the DAC has come to a conclusion, then it may stop the assessment process and issue its report. This will assist in keeping the cost of DAC assessments down when nothing further would be gained by completing the remaining assessments.

Once a DAC has reached a clear, clinical opinion in a case, and nothing further would be gained by additional assessments, then the team can begin the consensus building process and prepare the final report. This stage may be reached before all of the assessments/investigations planned for the claimant have been completed. DACs must exercise their clinical judgement to determine whether a sound, defendable conclusion has been reached.

There may be situations in medical/rehabilitation assessments, for example, where the incomplete assessments deal with one type of proposed treatment but all other components of the assessment have been completed. In cases where the conclusions with respect to one or more components of the disputed treatment are clear, and the incomplete portions of the assessment do not affect those conclusions, the DAC may send out a final report on those components where consensus has been reached.

For example, if a medical/rehabilitation DAC has a treatment plan for physiotherapy and psychotherapy, and all of the components have been completed for the physiotherapy, but one appointment was missed to address the psychotherapy, then the DAC may proceed to report to the parties with respect to the physiotherapy.

In all other type of assessments, no partial reports are permitted.

The Consensus Building Process

The consensus process is a key DAC activity that makes the DAC system distinct from other types of insurance assessments. ***The DAC Committee expects a consensus building process to be employed in all DAC assessments where more than one assessor is involved.***

This process will vary depending on the applicability of the staged approach to assessments.

At this point in the assessment, information has been collected from the clinical examination(s) and the history generated by the claimant. The primary evaluator must now determine if the assessors have reached a consensus opinion in the case, or if the team needs to weigh the individual assessment data/results to render a consensus opinion.

This process can be held on an ongoing basis or, if all components of the assessment plan are completed, the process can be started on the last day of the assessment. The process should be completed within five days of the final assessment. This consensus meeting may be held in person, via telephone or, in simple cases, via email, for example.

The team should share assessment outcomes and formulate the discussion, rationale and conclusion of the report. The executive summary of the DAC report should clearly indicate how and why the consensus opinion was reached, particularly when that consensus opinion differs from an individual assessor's report.

Early Reporting

Once the consensus process is complete, the assessment team has reached a clear, clinical opinion that must be communicated to the parties in the DAC report.

In some cases, a DAC may receive requests for an interim report on the DAC's findings due to a pressing need for the outcome of the DAC assessment.

DACs may issue the Executive Summary and/or the OCF-11B in advance of the complete report under the following two mandatory conditions:

1) The consensus opinion has been reached and the executive summary is able to be issued with clear, conclusive findings of the consensus opinion, and
2) Both parties agree to the advance report.

These early reports may be useful in situations where delays in issuing a complete report will undermine the usefulness of the DAC report, such as requiring the outcome for a pending mediation, arbitration or court hearing or in other circumstances where an individual assessors' report will be significantly delayed due to illness.

The early issuance of the OCF-11B and the executive summary ***must not*** delay the issuance of the complete report.

Medical and rehabilitation assessments also offer an opportunity to issue an early report in some instances. In many cases, a medical/rehabilitation DAC are assessing dispute treatment plans containing a number of different treatment modalities (such as chiropractic care and psychological treatment). In addition, there may be instances where parts of the assessment process are incomplete due to cancelled/missed appointments, or documentation required for the DAC to reach a conclusion on one of the modalities is incomplete and is unlikely to be obtained by the DAC.

If the medical/rehabilitation DAC has completed everything required to render an opinion on one of the disputed treatment plans or components, then it may issue a report covering the completed treatment plan or treatment component.

For example, if all of the assessment and testing is completed and the DAC is able to render an opinion on the chiropractic treatment, it may do so, even though the psychological treatment component is incomplete.

These partial reports are only allowed for medical/rehabilitation assessments where the DAC can clearly communicate an opinion on one completed part of the overall assessment plan.

The Complete DAC Report

All DACs should complete the DAC report within two weeks of the final assessment.

As previously stated, the early issuance of the OCF-11B and the executive summary ***must not*** delay the issuance of the complete DAC report.

The DAC activity reporting system shows that, on average, it took 23 days in 2001 to issue a DAC report following the completion of the assessment. This is up significantly from the 18 days it took in 2000 and 15 days for 1999.

The primary evaluator is responsible for ensuring the report is complete, reaches a well-supported conclusion and is consistent with both the DAC guidelines and the SABS. The primary evaluator is also responsible for completing the Executive Summary. The report must be sent within two weeks of completing the last assessment.
A DAC can employ scanned signatures for their reports and executive summaries when all of the following conditions are met:

1) They indicate that the signatures are scanned.
2) They indicate that the original signatures exist and are on file.
3) The practitioner has given authorization for the DAC to use the scanned signature.
4) It can only be used once the assessor has read and agreed with the content of the report.

Scanned signatures will only be permitted in situations where the above conditions are met. This is a measure that the DAC Committee is prepared to allow to enable DACs to meet the timeline requirements for releasing reports.

The DAC Committee acknowledges that compliance with this guideline may require DACs to alter existing practices. The Committee is also interested in any additional ideas that will assist in making the DAC system more efficient.

We encourage feedback regarding this Guideline. Please let us know your experiences, and provide your suggestions, so that we may continue to improve the DAC system. Comments can be directed to:

The Minister's Committee on the Designated Assessment Centre System
c/o
The Automobile Insurance Policy Unit
Financial Services Commission of Ontario
5160 Yonge Street,
Box 85, 15th Floor
North York, ON
M2N 6L9

This document is also available in French upon request.