DAC Committee

MINISTER'S COMMITTEE ON THE DESIGNATED ASSESSMENT CENTRE SYSTEM

# INFORMATION COMMUNIQUE

***Information Communiqués should be circulated amongst all DAC Clinical and Administrative staff. They are intended to keep DAC staff informed on current issues and to provide information on the activities of the Minister's Committee on the Designated Assessment Centre System (DAC Committee).***

This issue provides information regarding: Issues of Consent with an OCF-22 Application for Approval of an Assessment or Examination, the new OCF-11 User Manual, the new Conflict of Interest Guidelines, an update of DAC Electronic Reporting, Delivery of DAC reports, Requests to Relocate a DAC, the Professional Services Guideline, reviews a recent Supreme Court of Canada case, speaks to DAC Assessor Practice Summaries, reviews recent arbitration decisions and responds to frequently-asked questions raised on the DAC hotline.

## Issues of Consent with an OCF-22 Application for Approval of an Assessment or Examination

A number of inquiries have been made with respect to the need for an OCF-14 Permission to Disclose Health Information to a DAC in the case where a claimant has not signed Part 8 of the OCF 22.

Part 8 of the OCF 22 states:

"Signature of Claimant (Optional)
If not signed, the Health Professional in Part 3 assumes responsibility for obtaining applicant's signature."

It is the view of the DAC Committee that when Part 8 of the OCF-22 is unsigned by the applicant, the insurer must include an OCF-14 with the DAC referral. If both parts Part 3 and Part 8 are unsigned, the DAC should return the referral to the insurer as incomplete.

The DAC Committee would like to remind DACs, providers, and insurers that there are actually 3 elements to the consent in the OCF-14 and the OCF-22:

1. "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."
2. "I authorize the Designated Assessment Centre to consult with my treating health professionals if necessary."

3. "I also authorize the Designated Assessment Centre to give my insurance company and treating health professionals a copy of its report."

The applicant's signature in Part 8 of the OCF-22 is optional at the discretion of the provider to assist in an efficient application process and due to the possibility that the necessary consent will already have been obtained at the time the provider is filling out the OCF-22.

The form allows for verbal consent from the claimant for submission of the application without requiring the applicant to attend the health professional's office for the sole purpose of signing the form. The regulated health professional confirms that they have obtained the applicant's consent when they sign Part 3.

## The OCF-11 DAC Referral, Plan and Summary Form User Manual

The DAC Committee is pleased to release the *OCF-11 DAC Referral, Plan and Summary Form User Manual*. This User Manual is designed to assist both automobile insurers and DACs in the completion of the OCF-11 Designated Assessment Centre Referral, Plan, and Summary Form.

The manual provides detailed instructions for completion of the fields in the order in which they appear on the forms.

The manual can be found at www.fsco.gov.on.ca or on the IBC's website along with the other user manuals at www.autoinsurancereforms.on.ca.

DACs are reminded that the DAC hotline is unable to assist with guidance on coding issues. DACs and other providers should direct those inquiries to the IBC or their professional associations.

## Conflict of Interest Guideline

The Superintendent of Financial Services has issued a Guideline to address possible conflict of interest situations arising in the new DAC selection process (Section 53 of the revised *Statutory Accident Benefits Schedule(SABS)*).

Amendments to section 53 of the SABS became effective on October 1, 2003 and change the process for selecting a DAC by permitting the claimant and insurer to jointly select a DAC.

While the SABS do not specifically direct a DAC to screen and disclose potential conflict of interest in cases where the parties jointly select a DAC, the Guideline directs both the parties and the DAC to make efforts to avoid conflict of interest situations by the following methods:

- Insurers and claimants should, where possible, obtain and share information about any potential conflicts of interest before jointly selecting a DAC.

- Where the claimant and insurer have jointly selected a DAC, the SABS does not expressly direct a DAC to determine or disclose a conflict of interest. However, under the SABS, a

DAC is in a conflict of interest if an assessor who is to conduct the assessment has previously assessed or treated the claimant (excluding DAC assessments).

- To avoid a conflict of interest situation, and to ensure impartiality, a DAC must assign assessors to the case who are free of any conflict of interest, even in situations where the insured person and the insurer have jointly selected the DAC. A DAC that is unable to do so must declare the conflict before beginning the assessment. If the conflict is not waived, the insured person or the insurer may invoke SABS s. 53 (10) on the basis that the DAC is unable to begin the assessment, and ask for another DAC to be assigned by the Superintendent via the Superintendent's DAC Selection Guideline.

This guideline may be downloaded from FSCO's website under www.fsco.gov.on.ca.

## Update on DAC Electronic Reporting

The DAC Committee is pleased to announce that the Automobile Insurance Policy Unit (AIPU) continues to successfully roll-out the next electronic reporting system to DACs.

This new web-based application resolves a number of issues arising from the old, modem-based reporting system that relied upon software installed locally on a DAC's computer. This new system enables DACs to report their activity from any computer with internet access. The new system also contains new fields to reflect recent changes in the regulation (such as Fast-Track DACs) and changes to the coding of the new claims forms.

The AIPU will be contacting DACs over the next few weeks to bring each DAC on-line to ensure a smooth transition to the new system. In the meantime, the Committee wishes to thank DACs for their continued cooperation with DAC reporting activities.

## Delivery of DAC Reports: Section 68 of the Statutory Accident Benefits Schedule

Recent changes to the SABS impact the manner in which a DAC is to deliver its report to the parties under section 68.

A Fast-track DAC must deliver its report in accordance with section 68. Delivery must meet one of the following methods:

a) by faxing it to the claimant or their solicitor or authorized representative
b) by leaving a copy with the solicitor or authorized representative (or an employee), or
c) by personal delivery to the person.

Personal delivery of the document, in accordance with this section, can be done by a courier under c) and, if the claimant isn't home to receive it, the document can be left with anyone who appears to be an adult member of the same household.

Regular DAC reports (non-Fast Tracks) can be delivered by mail pursuant to 68(2)(d) and 68(3).

## DAC Committee Approval of Requests to Relocate a DAC

In some instances, a DAC may choose to change the location from which it operates as a rostered DAC facility. In these cases, the DAC needs to review *Operating Procedure 1: Moving a DAC Facility* and submit a request to move to the DAC Committee.

Recently, letters have been received from DAC facilities that have relocated prior to the move being reviewed by the DAC Committee.

All DACs are reminded that the DAC Committee should review these requests prior to any change in location. This review is necessary in order for the Committee to effectively monitor service levels and manage DAC locations across the province.

## Professional Services Guideline and Disputes Involving Cost of Treatment

The Financial Services Commission of Ontario recently released a Professional Services Guideline covering a wide range of services of health providers under the SABS. With the release, insurers are not required to pay for any goods or services covered by the guideline beyond the rates established in the SABS.

With the issuance of this guideline, DACs are no longer required to conduct an assessment on disputes involving the fees or hourly rates for the provision of services covered by the guideline. To do so would merely result in DAC reports referring the parties back to the rates established by this guideline.

Where no professional fee guideline exists, the DAC should first address the reasonable necessity of the service or treatment in dispute, and then the fee or hourly rate for the provision of that service.

## Supreme Court of Canada Decision on Chronic Pain

A decision was recently handed down by the Supreme Court of Canada which has potential application to DAC determinations. In Nova Scotia (Workers' Compensation Board) v. Martin, the Supreme Court was asked to consider the rights of chronic pain patients covered by the Workers Compensation Board of Nova Scotia.

The Supreme Court found that it was critically important that the rights and dignities of chronic pain sufferers not be harmed. Areas of concern included dismissive medical reports that challenged the reality of their suffering on the general principle that chronic pain is not real, failure to carry out adequate individualized assessments of their condition, and lack of individualized and effective therapeutic recommendations covering psychological, physical, social and vocational needs. The Supreme Court expressed its concern at all pre-emptive management which presumed that merely on the basis of passage of some specified period of time the chronic pain sufferer could be automatically deemed to have no further needs for health care or assistance with medical or vocational rehabilitation, and similarly that fixed deadlines could be set for cessation of disability on a group basis.

DACs should avoid stereotyping any claimants by concluding, without reference to the individual claimant's findings, that since certain injuries heal within a fixed period of time the claimant must necessarily be deemed to be healed, that further symptom reports are no longer considered as real, or that the claimant be regarded as without further need of care or benefits.

## DAC Assessor Practice Summaries

While the DAC Committee continues to explore quality assurance opportunities, DACs are reminded of the importance of accurate DAC Assessor Practice Summaries in ensuring the quality of the roster of DAC assessors.

The DAC Committee recently reviewed two practice summaries that contained misleading information that led the reader to believe that the health professionals had the relevant assessment experience to become DAC assessors.

When the DAC Committee became aware of the misinformation, they instructed the AIPU to reject the practice summaries. In addition, these assessors were removed from the roster of another DAC centre that had recently added these individuals to their team.

## WE'VE HAD QUESTIONS:

**Q. The Medical/Rehabilitation DAC Assessment Manual indicates that the deadline for accepting WAD II FT DAC referrals 28 days post accident (WAD I – 21 days). How should the DAC handle referrals after this entry deadline?**

A. The AIPU has received numerous calls about the new medical/rehabilitation manual and the directions contained in the manual with respect to when a DAC should accept referrals involving disputes around the Pre-approved Frameworks (PAF) and ANLI disputes.

The Manual was designed to ensure that the entry deadline for a claimant starting treatment with a PAF has not passed by the time a DAC renders it's report. The SABS, however, indicate that any dispute involving whether a claimant should be in a PAF is subject to a Fast-Track DAC.

DACs should manage all referrals dealing with the issue of whether a claimant's injuries fall within a PAF as a Fast-Track DAC, even if the DAC's report cannot be completed and issued prior to the 21 and 28 day deadlines.

**Q. When is a Peer Review approach to assessments appropriate in a medical/rehabilitation DAC assessment?**

A. In assessments involving an Application for Approval of an Assessment or Examination, or the Pre-approved Framework Guidelines, DACs are asked to utilize a single assessor who is a professional peer of the service provider or initiating health practitioner whose treatment/assessment is in dispute.

For approval of more complicated multi-disciplinary assessments, the DAC should use its clinical judgement to determine whether or not they need to assign more than one discipline to appropriately review the components in dispute.

In Staged Focussed Med/Rehab DAC assessments in most instances the DAC assessor is a regulated health professional peer whose scope of current clinical practice includes the delivery of the specific goods and/or services that are in dispute.

DACs are reminded that single assessment DACs must be completed by a regulated health professional and that unregulated health professionals should not be conducting single-assessor medical/rehabilitation DACs.

**Q. When a DAC is evaluating an OCF-22 Request for Approval, should it consider concurrent assessments being conducted under section 42 of the SABS?**

A. When a DAC is conducting a Fast-Track assessment on a dispute involving an OCF-22, the fact that a similar assessment has been arranged for or conducted at the request of an insurance company under section 42 of the SABS is not sufficient grounds for the DAC to find that the OCF-22 is not reasonably required.

Assessments conducted under section 24 and section 42 serve different purposes under the SABS and, as a result, are not necessarily duplications of goods and services under the regulation.

**Q. When the DAC is responding to a dispute regarding assessment or treatment proposed to be provided by a physician, should the DAC comment on whether the services are OHIP covered services?**

A. In reviewing proposals for physician services, the DAC should not consider whether or not the services are OHIP covered services as a basis for approving or not approving the treatment plan.

A determination of whether a proposed goods or service is reasonable or necessary for the claimant in question under the SABS should be independent of the funding source for the services, whether, auto, extended health benefits or OHIP. Decisions on funding ultimately rest with the funding parties.

It is appropriate, however, for the DAC to provide an opinion when there is a dispute about a reasonable fee for the services. In the case of an electromyograph or a medical specialist evaluation, for example, a DAC may look to the OMA or OHIP fee guidelines. It is noted that the Superintendent's Professional Services Guideline does not include fee schedules for physicians or dentists.

## ARBITRATION DECISIONS

The DAC Committee believes that DACs will better understand the important role they play in the dispute resolution process by reviewing examples of how arbitrators have used DAC reports in the decision-making process.

In fact, arbitration decisions often provide an effective analysis of the assessment guidelines issued by the DAC Committee. Arbitrators will often comment on DAC compliance with the DAC Committee's guidelines and all DACs should be aware of how clinical judgement may impact an arbitrator's view of the effectiveness of the DAC assessment.

DACs are also reminded that arbitration decisions that are critical of assessment processes may lead to revisions to the assessment guidelines. They may also highlight a DAC's failure to understand and apply these guidelines. In these cases, the Complaint Management and Discipline Protocol require the DAC Committee to review these cases as a complaint and, if necessary, take appropriate remedial action. At this time, the DAC Committee wishes to remind all DACs of the importance of these decisions.

DAC assessors should be aware of these decisions and follow best practices as outlined in the DAC Guidelines in conducting and completing their assessments. Copies of FSCO's arbitration and appeal decisions are available on the FSCO website.

To access these decisions, users are required to obtain a user name and password from the Arbitrations Unit at (416) 590-7202. There is no cost for this service.

While DACs are entitled to accept or consider clinically relevant materials provided by referring parties, the DAC Committee believes that DAC administrators should decline to accept unsolicited legal submissions that seek to 'inform' the DAC assessors of Arbitration of Court decision which the referrer believes to be relevant to a particular case.

**Arbitration Decision A02-001608**

***Applicant argues that deviations from the Disability Assessment Guidelines resulted in a flawed disability assessment that led to an improper termination of benefits under section 37 of the SABS.***

In this arbitration decision, the applicant argued that a disability DAC failed to follow the disability assessment guidelines in a number of aspects, including the utilization of a single assessor that led to inadequate assessment of her actual work activities, no independent assessment of her work activities, lack of a case co-ordinator, final report or case conference. As a result, the applicant argued that the DAC assessment was so flawed that the termination of weekly benefits was improper.

The arbitrator ultimately found that these deviations from the assessment guidelines were not so significant that the applicant was denied her right to be assessed by a Disability DAC and, as a result, termination of the weekly benefits was not improper.

The arbitrator found that the assessors were already in possession of relevant medical information and that, as a result, a disability DAC need not contemplate an independent assessment of a claimant's work activities on every case. Rather, a disability DAC should undertake a job site assessment only in a unique case.

While the DAC Committee wishes to emphasize the need to understand and effectively apply all of the assessment guidelines, it also encourages the use of clinical judgement to ensure that all DAC assessments are conducted in an efficient and cost-effective manner. The ultimate decision made by a DAC in determining what tests or assessments are required may be a determining factor as to whether or not the termination of benefits was done in accordance with the regulation or whether a new assessment is required due to deficiencies in the assessment process.

**We encourage feedback regarding this Information Communiqué. 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:**

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