

ELIMINATION OF DESIGNATED ASSESSMENT CENTRES

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By: Charles E. Gluckstein
Gluckstein & Associates

Historical Perspective

Designated Assessment Centres or “DAC’s” are assessment centres which were implemented as part of the 1994 changes to the Ontario *Insurance Act* (Bill 164). The design behind DAC’s was to provide independent, unbiased assessments to resolve disagreements between accident victims and their insurance companies as to entitlement to benefits. Insurance companies are responsible for paying for the cost of the assessments and for making the arrangements to set up the assessments. Currently, there are four main types of assessment centres which assess medical and rehabilitation needs, disability benefits, attendant care services and catastrophic determination. After October 1, 2003 (Bill 198), two further DAC centres were set up; one to determine if an individual fits within the pre-approved treatment framework and a paper review DAC was implemented for medical benefits (called a Fast-Track DAC).

As a further background to the creation and implementation of DAC centres, it is useful to gain a brief perspective on how Statutory Accident Benefits came into existence. Prior to 1990 and the enactment of the Statutory Accident Benefits Schedule (SABS), recovery of most benefits were strictly recovered through a full tort system based on negligence or fault. An insured person with an accident benefit dispute had to commence an action in the civil courts, which was slow, expensive and adversarial. The insurer had the right to veto benefits in most cases (see *Mason v. Scottish & York*) and most lawyers did not pursue the issue as they could claim benefits in the tort action provided there was a refusal. Accordingly, courts were able to order a limited number of examinations to address issues around the insured person’s physical or mental condition.

In 1990, OMPP (Bill 68) restricted the right to sue, expanded accident benefits payable on a no-fault basis and created an alternative dispute resolution system while preserving the right of accident victims to commence civil actions for accident benefits. This regime allowed for

recovery in tort for third party liability if the claim met a verbal threshold defined as cases of death, permanent serious disfigurement or permanent serious impairment. Not surprisingly, only 6% of accident victims met this threshold.

In 1994, Bill 164 expanded an accident victim's access to accident benefits and lowered the threshold for claims, but also introduced a deductible on non-economic loss settlements. DAC's were set up in response to the high cost of mediating, arbitrating and litigating auto insurance claims and the alleged higher settlements which had arisen under OMPP.

The Current DAC System

Disability Assessments (Bill 164 and Bill 59)

Disability assessments respond to a dispute about the continued payment of weekly benefits. The sole purpose of a disability assessment is to determine whether the claimant, as a result of the accident, continues to be substantially unable to carry on with his or her usual pursuits such as an income earner, non-earner or caregiver.

Post 104 Week Disability DAC's (Bill 59 Only)

This is the test for entitlement for an insured person who is receiving income benefits or caregiver benefits at the 104 week mark. In order to receive income replacement benefits beyond the 104 week period, the insured person must demonstrate that he/she suffers a "complete inability to engage in any employment for which they are reasonably suited by education, training or experience". In order to receive caregiver benefits beyond the 104 week period, an insured person must demonstrate a "complete inability to carry on a normal life".

Medical and Rehabilitation Assessments (Bill 164 and Bill 59)

Medical and rehabilitation assessments deal with questions involving medical expenses, rehabilitation expenses, or both. DAC's conducting medical and rehabilitation assessments are responsible for assessing the reasonableness and necessity of proposed medical and rehabilitation goods and services required as a result of the accident. When appropriate, they are also responsible

for making recommendations for future medical treatment or rehabilitation services required as a result of the accident.

Attendant Care Assessments (Bill 164 and Bill 59)

Attendant care assessments deal with attendant care benefit issues. An attendant care assessment evaluates whether a claimant needs attendant services as a result of the accident and determines the dollar amount of the attendant care benefit.

Residual Earning Capacity Assessments (Bill 164 Only)

Residual earning capacity assessments identify an employment type that best reflects the claimant's earning capacity at the time of the assessment and the gross annual income the claimant could earn from that employment. With the introduction of Bill 59, the Loss of Earning Capacity Benefit was removed from the SABS. Therefore residual earning capacity assessments are only carried out for claimants involved in accidents on or after January 1, 1994 and before November 1, 1996.

Catastrophic Impairment DAC's (Bill 59 Only)

Catastrophic impairment assessments identify whether an insured person has sustained a "catastrophic impairment" as more particularly defined in the SABS. The classification of catastrophic impairment is important because it will allow the insured person to access a million dollar cap from supplementary medical and rehabilitation benefits which would be payable for life. In addition, there is entitlement to the six thousand dollar monthly cap for attendant care benefits with an overall limit of one million dollars. As well, access will be available to a case manager.

Proposed Changes to the DAC System

The Ontario government wants to improve auto insurance by taking away the cumbersome assessment system in Ontario as it seems more money is being spent on assessments than on medical care or other services for accident victims. Critics have claimed that the DAC process is redundant, favours insurers and exposes those insured to probing assessments that either create or result in roadblocks to benefits. Critics also say that the DAC process is too costly, too slow,

is a duplication to the insurer's examination, is a monopoly, is not accountable, does not provide training for assessors, is not competitive, needs an accreditation process, and is biased.

The proposed amendments will eliminate DAC's and allow parties with disputes over assessments or examination findings and benefits to proceed directly to the dispute resolution system at FSCO or to the Courts following mediation. The changes will allow claimants to obtain assessments from their own health care providers when applying for benefits. Insurers who wish to challenge this will have to request a separate medical exam from a health care provider of their choice prior to making a determination of benefit entitlement.

Section 24 Examinations (Statutory Accident Benefits Schedule – Bill 59/198)

Amendments to this section will allow providers who are not regulated health professionals to conduct assessments, though the application for approval of that assessment must be submitted by a regulated health professional. Prior approval from the insurer would continue to be required before conducting an examination under s.24 (with the exception of circumstances listed in the SABS).

There would no longer be different criteria regarding assessments to prepare a treatment plan depending on whether the insured had received treatment under a pre-approved framework. In all cases, prior insurer approval would not be required for up to three examinations to prepare a treatment plan if the cost of each examination is under \$180.00. The same person cannot conduct more than one examination. Also, insurers must respond to applications for examinations within two days.

Pre-Claim Examinations

This is a new category of examination which would be introduced in the SABS. With the written and signed consent of the insured, an insurer would be able to arrange an examination of the insured by a regulated health professional. The regulated health professional that conducts the examination would be able to complete applications (i.e., treatment plans or disability certificates) on behalf of the insured. Within five days of the pre-claim examination, the

regulated health professional would have to provide a written copy of his or her report to the insurer, insured and insured's health practitioner.

IRB, NEB or Caregiver & Housekeeping or Home Maintenance Expenses

When applying for these benefits, the insured will have to submit a disability certificate. Within 14 days, the insurer must either pay the benefit or notify that a s.42 examination is required. An insurer cannot deny entitlement until it receives a s.42 report, although the insurer would be able to determine that an insured is not entitled to a specified benefit before conducting a s.42 exam if the insured fails to provide a disability certificate requested by the insurer, fails to attend a s.42 examination, or fails to obtain treatment, participate in rehabilitation or make efforts to return to employment. Within five days of receiving the s.42 report, the insurer will have to communicate its decision regarding entitlement and provide the report to the insured and his or her health practitioner.

Determination of Continuing Entitlement to Specified

If at any point the insurer wishes to determine whether the insured continues to be entitled to a benefit, the insurer would inform the insured that they require a new disability certificate and that they require the person to undergo a s.42 examination. An insurer would normally not be able to terminate a benefit until it receives a s.42 report. However, a benefit could be terminated without a s.42 examination if the insured fails to provide a disability certificate, fails to attend a s.42 examination or fails to obtain treatment, participate in rehabilitation or make efforts to return to employment.

Medical and Rehabilitation Benefits

An insurer will still have to respond to a treatment plan within 14 days. The insurer's response would indicate what goods and/or services the insurer has agreed to cover. If the insurer does not agree to pay for all of the goods and/or services set out in the insured's treatment plan, it will have to notify the insured that it requires a s.42 examination. The insurer also has to notify the insured that it requires a s.42 examination if it believes the insured has an impairment that falls under a pre-approved framework (PAF). As is currently the case, insurers who fail to respond to treatment plans within 14 days would be required to pay for goods and/or services incurred up to the time they did finally respond. Within five days of receiving the s.42 report, the insurer will

have to communicate its decision regarding entitlement and provide a copy of the report to the insured and the insured's health practitioner.

An insurer normally would not be able to deny entitlement until it receives a report from the s.42 examiner; however the insurer would be able to determine that there was no entitlement to a specified benefit before conducting a s.42 examination if the insured fails to attend a s.42 examination.

Attendant Care Benefit

The Form 1 (Assessment) would become a form approved by the Superintendent of FSCO and no longer under the SABS. To apply for an attendant care benefit, an insured would be required to submit an assessment of attendant care needs. Within 14 days, the insurer would have to pay the benefit and notify the insured that it requires a s.42 examination if it did not agree with the expenses. An insurer can refuse to pay if the insured does not attend a s.42 examination. Within five days of receiving the s.42 examination report, the insurer would have to communicate its decision regarding entitlement and provide the report to the insured and his or her health practitioner. The insurer does not have to pay for expenses incurred before the Form 1 is submitted.

Determination of Catastrophic Impairment

The insured will still be required to submit an application for determination of catastrophic impairment to his or her insurer. Within 30 days of receiving this application, the insurer has to either notify the insured that it has accepted the application or that it requires an examination under s.42. An insurer will be able to refuse to pay any benefits that are payable only if the insured failed to attend a s.42 examination. Within five days of receiving the s.42 examination report, the insurers will have to communicate their decision regarding entitlement and provide a copy of the report to the insured and the insured's health practitioner.

Examinations Required by Insurers

S.42 examinations are the vehicles by which an insurer can respond to applications for benefits or to determine whether an insured continues to be entitled to a benefit. Examinations are to be conducted by regulated health professionals or experts in vocational rehabilitation. Treatment and assessments under a PAF would not be subject to a s.42 examination. When an insurer requests an examination, it must notify the insured of the reasons, whether it would only involve a paper review, who will be conducting the examination, and the date, time and place of the examination. Notices can be verbal but would also have to be confirmed in writing. Paper reviews would only be conducted to evaluate requisitions of s.24 exams or to determine whether a proposed treatment plan involves an impairment that falls under a PAF. Examinations must be scheduled with at least five days' notice but not more than ten days after the insured receives the notice from the insurer. For catastrophic determinations the examination must be scheduled with at least five days' notice but not more than 20 days after the insured receives notice of the fact that the insurer requires an examination.

Transition Period

DAC assessments would continue to be conducted for a short time following the implementation date. In the event that a benefit denial has 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 be required to 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 still have to use a DAC.

Addressing Insurer Breaches under the *Unfair and Deceptive Practices Act*

Some of the breaches under the *Unfair and Deceptive Practices Act* include the refusal to pay promptly where the insurers fail to give notice as required, denying entitlement without obtaining

a report when required by regulations to do so, and requesting s.42 examinations when the insurer ought to know they are not reasonably required.

The Association of DACs' Position

The Association of DAC's believe that the proposed regulations will eliminate neutral assessment and disenfranchise accident victims from benefits, forcing them into protracted mediation/arbitration that could delay benefits. They believe that DAC's are an excellent vehicle for reporting potential inappropriate conduct to the Superintendent of Insurance because DAC's are neutral and do not have a vested interest. Also, a DAC decision is binding on parties, pending further dispute resolution challenging it. The Association endorses the DAC's ability to provide both accident victims and insurers with a measure of protection and ensure that a level playing field existing for resolving benefits disputes.

The Association asserts that without DAC's, dispute resolution will become increasingly unpredictable, result in more delays with a need for more interim arbitration orders and put significant upward cost pressures on the system. They claim that insurance companies will be handed all the power to deny benefits and accident victims will face significant financial and time delay hurdles when accident benefits are denied and disputed.

Conclusion

The elimination of the DAC system will enable car accident victims to obtain help from their own doctors and health care providers. If implemented, the proposed changes will finally tip a balance of fairness providing greater rights for accident victims who have been discriminated against and denied coverage due to biased results from the DAC's.