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Bulletin

No. A-16/03

Property & Casualty

- Auto

Additional Automobile Insurance Regulations, Proclamation of Bill 198 Provisions, Professional Services Guideline and Revised Rate and Risk Classification Filing Guidelines

To the attention of all insurance companies licensed

to transact automobile insurance in Ontario

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is highlighting, for your reference:

- four additional regulation changes filed by the Ontario Government with the Registrar of Regulations on September 18, 2003,
- the *Professional Services Guideline* to be published in the September 27, 2003 edition of The *Ontario Gazette,* setting out maximum fees for services provided by health professionals and other providers, and
- revised rate and risk classification filing guidelines.

In addition, on September 16, 2003, the Ontario Government proclaimed October 1, 2003 as the date that section

120 of Bill 198, the Keeping the Promise for a Strong Economy Act (Budget Measures), 2002, will come into force. Section 120 will be effective in respect of accidents occurring on or after that date.

Section 120 of Bill 198 expands an injured person's right to sue for excess health care expenses to the extent they are not-at-fault, if the person has sustained permanent serious impairment of an important physical, mental or psychological function. As well, for pain and suffering awards over $100,000 and *Family Law Act* awards over $50,000, it eliminates the deductible that would otherwise apply. Finally, it provides protection to some parties who are vicariously liable for actions of protected defendants.

Regulation Changes

1. **Definition of Catastrophic Impairment for Court Proceedings** (Ontario Regulation 381/03 amending Ontario Regulation 461/96 - *Court Proceedings for Automobile Accidents that Occur on or after November 1, 1996)* Filed: September 18, 2003

With the proclamation of Section 120 of Bill 198, the threshold for suing for excess health care expenses is changed from "catastrophic impairment" to "permanent serious impairment of an important physical, mental or psychological function". As a result, section 5 of Ontario Regulation 461/96 - Court Proceedings for Automobile Accidents that Occur on or after November 1, 1996 is revoked. This amendment will be effective for all accidents that occur on or after October 1, 2003.

2. **Definition of Permanent Serious Impairment of an Important Physical, Mental or Psychological Function** (Ontario Regulation 381/03 amending Ontario Regulation 461/96 - *Court Proceedings for Automobile Accidents that Occur on or after November 1, 1996)* Filed: September 18, 2003

As outlined in an August 29, 2003 Government news release, the verbal threshold of "permanent serious impairment of an important physical, mental or psychological function" has been defined in Regulation. Also, the Regulation sets out evidence that must be adduced to prove permanent serious impairment of an important physical, mental or psychological function. This amendment will be effective for all accidents that occur on or after October 1, 2003.

3. **New Limit on Income Replacement Benefits** (Ontario Regulation 380/03 amending Ontario Regulation 403/96 - *Statutory Accident Benefits Schedule - Accidents on or after*

November 1, 2003) ("SABS") Filed: September 18, 2003

The maximum payable under the SABS for basic income replacement benefits is reduced from $400 to $300 per week. Also, insurers are required to offer consumers optional income replacement benefit coverage of $400 per week in addition to the existing optional limits of $600, $800 and $1,000 per week. This amendment will be effective for all auto insurance policies issued or renewed on or after January 1, 2004.

4. **Delivery of Written Notices** (Ontario Regulation 380/03 amending Ontario Regulation 403/96 - *Statutory Accident Benefits Schedule - Accidents on or after November 1, 1996*) ("SABS") Filed: September 18, 2003

Section 68 of the SABS, as amended effective October 1, 2003, prescribes that most notices shall be given in writing. The amendment to the notice provisions provides greater certainty respecting document delivery. When an attempt has been made to personally deliver a document at a person's place of residence and it has not been possible to do so, the new subsection 68(4) allows the document to be left with a person who appears to be an adult member of the same household. This amendment will apply to all notices delivered on or after October 1, 2003.

Professional Services Guideline

On August 28, 2003, the Minister of Finance issued a Policy Statement titled Health Care Provider *Fee Schedules under the Ontario Insurance Act* and published in the September 6, 2003 edition of *The Ontario Gazette*. The Superintendent of Financial Services has now issued the *Professional Services Guideline* in response to the Government White Paper titled *Automobile Insurance Affordability Plan for Ontario*: Next Steps and the Policy Statement. This Guideline sets out the maximum fee for the services of any of the health professions or health care providers listed in the Guideline. These maximum fees are applicable to:

- a medical benefit under clauses 14 (2) (a), (b) or (h) of the SABS;
- a rehabilitation benefit under clauses 15 (5) (a) to (g) or clause (5) (l) of the SABS;
- case management services under subsection 17 (1) of the SABS; and
- conduct of an examination or assessment or provision of a certificate, report or treatment plan under subsection 24 (1) of the SABS.

The Guideline also sets out maximum fees payable for completion of certain SABS claim forms. Also, *the Pre-approved Framework Guideline for Whiplash Associated Disorder Grade I Injuries With or Without Complaint of Back Symptoms and Pre-approved Framework Guideline for Whiplash Associated Disorder Grade II Injuries With or Without Complaint of Back Symptoms (the "Pre-approved Framework Guidelines")* have been re-issued to include revised fees.

No fee guidelines for Designated Assessment Centre (DAC) assessments are being issued at this time. As directed in the Government White Paper, a review of the DAC system is currently underway and will be completed in October 2003. The review will look at establishing standard fees for DAC assessments.

The *Professional Services Guideline* applies to expenses incurred on or after November 1, 2003.

The revised Pre-approved Framework Guidelines are effective for new Treatment Confirmation Forms submitted on or after November 1, 2003.

Copies of Guidelines

The Guidelines referred to in this Bulletin will be published in the September 27, 2003 edition of *The Ontario Gazette.* The Guidelines can also be downloaded from the FSCO website at: www.fsco.gov.on.ca

Revocation of Existing Fee, Utilization and Treatment Guidelines

With the release of the *Professional Services Guideline* and the *revised Pre-approved Framework Guidelines*, the following Guidelines, previously released by either the Superintendent of Financial Services, the Ontario Commissioner of Insurance, the Financial Services Commission of Ontario, or the Ontario Insurance Commission, are revoked:

- Professional Fee Guidelines - Occupational Therapists, February 3, 2001, *Professional Fee Guideline No. 1/01*
- Occupational Therapy Utilization Guidelines for Uncomplicated Soft Tissue Injuries, February, 3, 2001, *Superintendent Guideline No. 01/01*
- Professional Fee Guideline - Podiatrists, March 9, 1998, *Commissioner Guideline No. 01/98*
- Professional Fees Guideline - Physiotherapists, November 24, 1997

- Physiotherapy Utilization Guidelines for Soft Tissue Disorders of the Spine, November 24, 1997, *Commissioner's Guideline No. 2/97*
- Professional Fee Guidelines - Speech-Language Pathologists, March 31, 2001, *Professional Fee Guideline No. 2/01*
- Professional Fee Guidelines - Psychologists, March 31, 2001, *Professional Fee Guideline No. 3/01.*

Two other utilization guidelines were established as a result of agreements and although they do not deal with fees, they call for an automatic review three years after the guidelines are issued:

- The Insurance Bureau of Canada and the Ontario Psychological Association are requested to review the Psychological Assessment and Treatment Guidelines (Superintendent Guideline No. 2/01, March 31, 2001) and report back to the Superintendent on any proposed changes by December 31, 2003.
- The Insurance Bureau of Canada and the Ontario Podiatric Medical Association are requested to review the Podiatry Utilization Guidelines (Commissioner Guideline No. 1/98, March 9, 1998) and report back to the Superintendent on any proposed changes by December 31, 2003.

Rate and Risk Classification Filing Guidelines

FSCO is releasing a revised simplified filing guidelines package as a result of the recent auto insurance changes. In addition to reflecting the cost savings from these changes, insurers must submit a filing that will include a rate for the new optional income replacement benefit coverage of $400 per week. The revised *Bill 198 Simplified Filing Guidelines for Proposed Revisions to Automobile Insurance Rates and Risk Classification Systems* are attached.

Copies of Regulations

Ontario Regulation 381/03 amending Ontario Regulation 461/96 - *Court Proceedings for Automobile Accidents that Occur on or after November 1, 1996* and Ontario Regulation 380/03 amending Ontario Regulation 403/96 - *Statutory Accident Benefits Schedule - Accidents on or after November 1, 1996* are enclosed for your information and will be published in the October 4, 2003 edition of The Ontario Gazette. The regulations will also be available for download from the Ontario e-Laws website at: www.e-laws.gov.on.ca

Bryan P. Davies

Chief Executive Officer and

Superintendent of Financial Services

September 18, 2003

Attachments (PDF):

- Professional Services Guideline
- Pre-approved Framework Guideline for Whiplash Associated Disorder Grade I Injuries With or Without Complaint of Back Symptoms
- Pre-approved Framework Guideline for Whiplash Associated Disorder Grade II Injuries With or Without Complaint of Back Symptoms
- Bill 198 Simplified Filing Guidelines for Proposed Revisions to Automobile Insurance Rates and Risk Classification Systems
- Appendix A - Summary of Information
- Appendix B - Certificate of the Officer/Designate
- Appendix C - Current and Proposed Rates/Differentials for Optional Income Replacement Benefits
- Ontario Regulation 380/03
- Ontario Regulation 381/03

To view PDF files, you will require Adobe Acrobat® Reader version 7.0. You can download this free software from Adobe's Web site.

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Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

September 2003

Professional Services Guideline

Superintendent's Guideline No. 05/03

Professional Services Guideline

Introduction

This Guideline is pursuant to section 268.3 (1) of the *Insurance Act* for the purposes of subsections 14 (4), 15 (6), 17 (2) and 24 (2) of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996* (SABS), and applies to expenses for health care services rendered on or after November 1, 2003.

Purpose

This Guideline sets out the maximum fee payable by automobile insurers under the SABS for the services of any of the health care professions or health care providers listed in this Guideline. These maximum fees are applicable to:

- a medical benefit under clauses 14 (2) (a), (b), or (h) of the SABS;
- a rehabilitation benefit under clauses 15 (5) (a) to (g) or (l) of the SABS;
- case management services under subsection 17 (1) of the SABS; or
- conducting an examination or assessment or provision of a certificate, report or treatment plan under subsection 24 (1) of the SABS.

Maximum Fees

Automobile insurers are not liable to pay for expenses related to professional services rendered to an insured person that exceed the following maximum hourly rates:

Health Profession or Provider	Maximum Hourly Rate
Chiropractors	$95.00
Massage Therapists	$49.00
Occupational Therapists	$84.00
Physiotherapists	$84.00
Podiatrists	$84.00
Psychologists (other than Master's level) Masters of Psychology	$126.00 $93.00
Speech Language Pathologists	$94.50
Registered Nurses, Registered Practical Nurses and Nurse Practitioners	$77.00
Unregulated Providers	$49.00

Fees for Completion of Forms

Automobile insurers are not liable to pay expenses that exceed the following maximum fees for the completion for certain accident benefit forms by members of the health professions and health care providers listed in this Guideline, (These maximum fees do not apply to the assessments related to the completion of these forms).

Form	Maximum Fee for Completion of Form
Disability Certificate (OCF-3)	$62
Treatment Plan Form (OCF-18)	$62
Form 1 - Assessment of Attendant Care Needs	$62
Automobile Insurance Standard Invoice (OCF-21)	$0
Application for Approval of an Examination (OCF-22/198)	$0

Revoking of Existing Fee, Utilization and Treatment Guidelines

With the release of this Guideline and the revised Pre-Approved Guidelines for Whiplash Associated Disorder Grade I and Grade II Injuries With or Without Complaint of Back Pain, the following guidelines, previously released by the Superintendent of Financial Services, the Ontario Commissioner of Insurance, the Financial Services Commission of Ontario, or the Ontario Insurance Commission are revoked:

- Professional Fee Guidelines - Occupational Therapists,
- February 3, 2001, *Professional Fee Guideline No. 1/01*
- Occupational Therapy Utilization Guidelines for Uncomplicated Soft Tissue Injuries, February, 3, 2001, *Superintendent's Guideline No 1/01*
- Professional Fee Guideline - Podiatrists, March 9, 1998,
- Professional Fees Guideline - Physiotherapists, November 24, 1997
- Physiotherapy Utilization Guidelines for Soft Tissue Disorders of the Spine, November 24, 1997, *Commissioner's Guideline No.2/97*
- Professional Fee Guidelines - Speech-Language Pathologists, March 31, 2001, *Professional Fee Guideline No.2/01.*

The Professional Fee Guidelines - Psychologists, *Professional Fee Guideline No. 3/01*, issued March 31, 2001, expired on December 31, 2001.

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

September 2003

Pre-approved Framework Guideline for Whiplash Associated Disorder Grade I Injuries With or Without Complaint of Back Symptoms

Superintendent's Guideline No. 06/03

Pre-approved Framework Guideline for Whiplash Associated Disorder Grade I Injuries With or Without Complaint of Back Symptoms

1. Introduction

This Guideline is issued pursuant to Section 268.3 of the *Insurance Act* for the purposes of the *Statutory Accident Benefits Schedule* (SABS).

This Guideline is effective for new Treatment Confirmation Forms submitted by a initiating health practitioner on or after November 1, 2003, and replaces Pre-approved Framework Guideline for Whiplash Associated Disorder Grade I Injuries With or Without Complaint of Back Symptoms Superintendent's Guideline No. 01/03, July 2003.

This Guideline is intended to set out what goods and services may be provided without insurer approval to an insured person described below who has sustained a Whiplash Associated Disorder Grade I as described below, with or without back pain, and the cost of such services payable by the insured person's insurer.

This Guideline reflects a consensus between regulated health professionals and insurers and will be subject to review and revision as required over time.

2. Impairments that come within this Guideline

Subject to the exceptions listed in Section 3, below, an insured person's impairment comes within this Guideline if, after being assessed within 21 days of the accident, the insured person is determined to have an injury that:

(a) resulted from an acceleration-deceleration mechanism of energy transfer to the neck, presents as a complaint of neck pain, stiffness, or tenderness only, with no physical signs, and therefore meets the criteria for "Whiplash Associated Disorder Grade I" (also known as "WAD I") set out in the Société de l'assurance automobile du Québec's Task Force Report titled *Redefining "Whiplash" and its Management*, published in the April 15,1995 edition of *Spine*, and/or a complex of common symptoms associated with whiplash;[1]

(b) may include a complaint of non-radicular back pain associated with the WAD I; and

(c) is of sufficient severity that it requires the physical treatment interventions provided under this Guideline.

[1] If the insured person also presents with overt musculoskeletal sign(s), including decreased range of motion or point tenderness, refer to the Pre-approved Framework Guideline for WAD II Injuries with or Without Complaint of Back Symptoms.

An insured person who has sustained an impairment covered by this Guideline may exhibit other common symptoms including: shoulder pain; referred arm pain (not from radiculopathy); dizziness; tinnitus; headache; difficulties with hearing and memory acuity; dysphagia; and temporomandibular joint pain. These additional symptoms would not exclude an impairment from this Guideline unless they require separate treatment from that provided under this Guideline.

3. Impairments that do not come within this Guideline

An insured person's impairment does not come within this Guideline if:

(a) the insured person's impairment comes within the WAD II Pre-approved Framework Guideline; or

(b) despite being assessed within 21 days of the injury as having an injury described in Section 2, there are specific pre-existing occupational, functional or medical circumstances of the insured person that:

i. significantly distinguish the insured person's needs from the needs of other persons with similar impairments that come within this Guideline; and
ii. constitute compelling reasons why other proposed goods or services are preferable to those provided for under this Guideline.

4. Role of the initiating health practitioner

The initiating health practitioner:

(a) is a health practitioner as defined by the SABS who is authorized by law to treat the injury and has the ability to deliver all the goods and services provided for in this Guideline;

(b) initiates treatment by submitting a Treatment Confirmation Form;

(c) provides a significant portion of the goods and services;

(d) may co-ordinate the provision of any goods and services covered by this Guideline and provided to the insured person by another regulated health professional, or directly supervise the provision of any additional goods and services to the insured person by an unregulated health provider, where such treatment is needed by the insured person and is provided under this Guideline;

(e) shall have overall accountability for:

i. assessing the need for and implementing goods and services such that the treatment elements in this Guideline are addressed as required and appropriate;
ii. ensuring the use of the most appropriate provider(s);
iii. documenting, communicating and billing as required by the Guideline;

iv. reporting outcomes to the insured person and insurer when treatment is inappropriate or ceases;
v. participating in monitoring the effectiveness of the Guideline by fully completing the forms required by this Guideline; and

(f) determines the presence of any barriers which might delay recovery.

5. Providers covered by this Guideline

The initiating health practitioner may include treatment by other providers in the Treatment Confirmation Form. This Guideline covers treatment by the initiating health practitioner and other providers, including unregulated providers where the treatment is directly supervised by a regulated health professional and is not a controlled act as defined by the *Regulated Health Professions Act*, *1991.*

6. Switching initiating health practitioners

If for any reason, an insured person receiving treatment under this Guideline wishes to change his or her initiating health practitioner, the insured person and the new practitioner must inform the insurer through submission of a new Treatment Confirmation Form. In the new Treatment Confirmation Form, the insured person will give consent for the insurer to contact the original initiating health practitioner to determine what goods and services referred to in the original Treatment Confirmation Form have not been provided and the insurer will then fill in this amount in Part 9 of the Form.

7. Treatment covered by this Guideline

There will typically be one Treatment Confirmation Form which will be prepared by the initiating health practitioner.

Treatment commences with the first assessment of the insured person by the initiating health practitioner.

Treatment will have a duration of up to 28 days.

Regulated health professionals are expected to assess the insured person, develop a plan of treatment and provide up to 9 monitoring/treatment sessions for insured persons covered by this Guideline.

The focus of the Guideline is on maintaining normal activities and reducing the risk of chronicity.

From the outset, the insured person will be encouraged to maintain normal activities. The emphasis in the first week will be on assessment, education, reassurance, and pain control. Throughout treatment, emphasis will be put on the insured person's being in charge of his or her recovery and on carrying on with normal activities. The frequency of provider interventions will diminish as the insured person progresses.

If prescription medication is needed, a referral to a physician or nurse practitioner is necessary. Regulated health professionals may provide general information on the use of over-the-counter medications, but insured persons should be encouraged to consult a physician, nurse practitioner, or pharmacist on the specific use of these medications.

The course of treatment may involve the following: reassurance, pain control, mobilization/manipulation, education, and activation (normal daily activities and active exercise).

Education materials titled *Getting the Facts About Whiplash*, developed by regulated health professionals and the insurance industry, will be provided by the initiating health practitioner to all insured persons covered by this Guideline. This material may be found in Appendix D.

The importance of positive messaging is recognized, and it is therefore expected that, at the initial visit and assessment and at subsequent visits, the insured person will be provided with:

- education regarding "hurt does not equal harm;" and
- reassurance that most people with WAD I and associated complaints of back symptoms recover within the first few weeks following the injury.

Not all individuals with WAD I will require any or all of the goods and services included within this Guideline. The provider is responsible for determining the need for goods and services and whether the prescribed goods and services are producing significant progress toward recovery and should be continued under the Guideline. If the insured person has recovered before the completion of the treatment outlined in this Guideline, the insured person should be discharged from treatment.

8. Supplementary goods and/or services

Without prior insurer approval, the initiating health practitioner may provide supplementary goods and/or services where they are needed for the management of one or more minor soft tissue injury/ies which:

(a) resulted from the same accident as the WAD I and requires treatment;
(b) is/are unrelated to the WAD I with or without back pain and its common symptoms;
(c) is/are not of sufficient severity to exclude the insured person's impairment from this Guideline; and
(d) can be fully treated by the provider within the time frame of this Guideline.

The impairment addressed and the services and/or goods must be specified on the Treatment Confirmation Form and the maximum total cost payable by the insurer for the goods and services provided under this section is $120.

9. Treatment deemed insufficient or inappropriate

If the initiating health practitioner determines that the treatment under this Guideline is no longer appropriate or sufficient for the insured person because the insured person is not making sufficient progress towards recovery, the initiating health practitioner will advise the insurer and the insured person (using the WAD I/WAD II PAF Discharge & Status Report form). The initiating health practitioner's options then are as follows:

(a) submit a Treatment Plan;
(b) submit a Treatment Plan and make a referral to the insured person's physician or another regulated health professional; or
(c) make a referral to the insured person's physician or other health care professional.

While treatment/referral decisions are being considered, the initiating health practitioner may:

(d) stop the treatment where it is not appropriate (or no longer needed); or
(e) continue treatment until a decision is reached on the action recommended by the initiating health practitioner or until the end of the treatment covered by this Guideline.

The SABS provides that an insurer may reject a Treatment Plan that provides for goods and services to be received during any period in which the insured person is receiving goods and services under this Guideline and the insurer's determination is not subject to dispute.

However, the SABS also provides that nothing prevents an insured person, while receiving goods and services under this Guideline, from submitting a Treatment Plan applicable to a period other than the period covered by this Guideline. If the insurer does not approve the Treatment Plan within the time period prescribed in the SABS, that dispute may proceed to a Designated Assessment Centre for review.

10. Completing the treatment under this Guideline

Upon completion of treatment, the initiating health practitioner will prepare a final report which will indicate the insured person's outcomes from treatment.

If an insured person elects to end treatment under this Guideline, the insured person may only resume treatment at a later date if this will not extend the overall duration and expenditure limits of the Guideline.

When an insured person is receiving treatment under the Guideline, the termination options are:

i. Resolved and discharged within 4 weeks (WAD I/WAD II PAF Discharge & Status Report form completed by initiating health practitioner);
ii. Condition improving, but improvement is insufficient at the end of the treatment (further or other treatment beyond the Guideline is dependent upon the Treatment Plan application and approval process of the SABS);
iii. Not resolving (decision made as soon as possible) and the initiating health practitioner completes the WAD I/WAD II PAF Discharge & Status Report form and discharges insured person;

iv. Insured person unreasonably fails to participate in treatment. This may be inferred from the insured person's non-attendance at 2 consecutive appointments or 4 appointments overall without a reasonable explanation. Provider required to complete WAD I/WAD II PAF Discharge & Status Report form; or

v. Insured person withdraws consent.

11. Reporting requirement for initiating health practitioners

The initiating health practitioner is expected to establish clinical outcome goals for the insured person receiving treatment under this Guideline that are consistent with the goals of return to normal activities in the early stages of recovery and reducing the risk of chronicity. Throughout the course of treatment the initiating health practitioner is expected to use appropriate measures/indicators to evaluate progress towards achievement of these goals.

For the purposes of documenting the impact of the Guidelines on an insured person whose impairment comes within this Guideline and contributing to the overall evaluation of the Guideline, the initiating health practitioner must complete the WAD I/WAD II PAF Discharge & Status Report form.

12. Provider reimbursement

An initiating health practitioner who provides a good and/or service to an insured person in accordance with the Guideline must submit a Treatment Confirmation Form not later than 5 business days after first seeing the insured person.

The SABS provides that the insurer must confirm to the initiating health practitioner no later than 5 business days after receiving the Treatment Confirmation Form, that the auto insurance policy referenced to in the Treatment Confirmation Form was in force on the date of the accident. Payment to the initiating health practitioner may be denied due to coverage issues or exclusions set out in the SABS.

The insurer's payment will follow receipt of a completed Treatment Confirmation Form, Application for Accident Benefits and Auto Insurance Standard Invoice, Version C. The insurer is not obliged to make payment until after the insurer has received an Application for Accident Benefits.

In the case of the final invoice, the insurer's payment will follow receipt of a WADI/WAD II PAF Discharge & Status Report and Auto Insurance Standard Invoice, Version C.

13. Content of appendices

Appendix A sets out the payment schedule in chart form.

Appendix B sets out an overview of the expected course of treatment for an insured person whose impairment comes within this Guideline. Providers will individualize these treatment directives for the needs of each insured person.

Appendix C sets out what goods/services an insurer is not obliged to fund pursuant to this Guideline for an insured person whose impairment comes within this Guideline.

Appendix D contains the educational brochure titled *Getting the Facts About Whiplash.*

Appendix A - WAD I Payment Schedule

Health care providers are entitled to the following payments for treatment of an insured person whose impairment comes within this Guideline. Fees are payable where the insured person has received any treatment in that block, including where treatment has been discontinued.

Weeks 1 and 2	$296
Discharge anytime during weeks 1 or 2 or at end of week 2, completion of discharge report and monitoring	$152
Weeks 3 and 4	$160
Final assessment and completion of discharge report	$80
Supplementary goods and services	$120
Transfer fee if changing initiating health practitioner	$48

Appendix B - WAD I Course of treatment

Weeks 1 and 2	Goods/Services
Initial Visit:	• Up to 4 monitoring/treatment sessions expected in this block • Conduct assessment including history and physical examination to determine that criteria are met for inclusion in the Guideline, relationship of complaints to the accident, the need for the recommended goods and services and identification of any potential barriers to recovery • Complete Treatment Confirmation Form
Initial and Subsequent Visits:	• Provide advice and reassurance to maintain usual activities without interruption • Review "Getting the Facts about Whiplash" • Manage pain as appropriate (may require physician referral) • Prescribe mild home exercise to maintain range of motion • Initiate manipulation/mobilization, if appropriate, to maintain function • If unexpectedly unable to perform pre-accident activities at home or work, advise insurer and make recommendation to the insured person and/or insurer
Considerations for Providers at the End of Week 2: If WAD I improving but further goods and services required:	• Provide advice and reassurance to encourage maintenance of usual activities • Manage pain as appropriate • Prescribe mild home exercise, and if necessary provide mild supervised exercise • Utilize manipulation/mobilization and/or physical therapies if required as part of a strategy that promotes activation
Considerations for Providers at the End of Week 2: If WAD I not resolving or improving:	• Re-evaluate and advise insurer

If discharged during Week 1 or 2:	• Discharge from treatment with advice and reassurance • Complete WAD I/II PAF Discharge & Status Report • Monitor insured person

Weeks 3 and 4:	• At or about day 15 evaluate progress and plan for the next 13 days • Up to 5 treatment sessions expected in weeks 3 and 4
If WAD I resolution expected without further goods and services:	• Discharge from treatment with advice and reassurance, and • Monitor insured person
If WAD I resolution expected by the end of the treatment under the Guideline:	• Provide advice and reassurance to encourage maintenance of usual activities • Manage pain as appropriate • Prescribe mild home exercise, and if necessary provide supervised exercise • Utilize manipulation/mobilization or physical therapies if required as part of a strategy that promotes activation and mobility
If WAD I is resolving or improving but resolution not expected by end of treatment under this Guideline:	• Provide advice and reassurance to encourage maintenance of usual activities • If activities of daily living are affected, advise insurer and make recommendations to the insured person and insurer for a course of action • Manage pain as appropriate • Prescribe mild home exercise • Consider more intensive manipulation/mobilization or physical therapy as part of a strategy that promotes normal activities
If WAD I not resolving or improving:	• Advise insurer and insured person's treating health practitioner • Reassess • Submit Treatment Plan and/or refer to appropriate regulated health professional
Completion of Week 4:	• Final assessment and report to insurer and insured person using WAD I/WAD II PAF Discharge and Status Report

Appendix C - Goods and services not covered in the Guideline

An insurer is not obliged to pay pursuant to this Guideline for the following goods/services rendered to an insured person with an impairment that comes within this Guideline:

- Cervical pillows;
- Advice supporting inactivity or bedrest;
- Injections of anesthetics, sterile water or steroids to the neck;
- Soft collar;
- Spray and stretch; and
- Magnetic necklaces.

Appendix D - *Getting the Facts about Whiplash*

Getting the facts about Whiplash: Grades I and II

People injured in car accidents sometimes experience a strain of the neck muscles and surrounding soft tissue, known commonly as whiplash. This injury often occurs when a vehicle is hit from the rear or the side, causing a sharp and sudden movement of the head and neck. Whiplash may result in tender muscles (Grade I) or limited neck movement (Grade II). This type of injury is usually temporary and most people who experience it make a complete recovery. If you have suffered a whiplash injury, knowing more about the condition can help you participate in your own recovery. This brochure summarizes current scientific research related to Grade I and II whiplash injuries.

Understanding Whiplash

- Most whiplash injuries are not serious and heal fully.
- Signs of serious neck injury, such as fracture, are usually evident in early assessments. Health care professionals trained to treat whiplash are alert for these signs.
- Pain, stiffness and other symptoms of Grades I or II whiplash typically start within the first 2 days after the accident. A later onset of symptoms does not indicate a more serious injury.
- Many people experience no disruption to their normal activities after a whiplash injury. Those who do usually improve after a few days or weeks and return safely to their daily activities.
- Just as the soreness and stiffness of a sprained ankle may linger, a neck strain can also feel achy, stiff or tender for days or weeks. While some patients get better quickly, symptoms can persist over a longer period of time. For most cases of Grades I and II whiplash, these symptoms gradually decrease with a return to activity.

Daily Activity and Whiplash

- Continuing normal activities is very important to recovery.
- Resting for more than a day or two usually does not help the injury and may instead prolong pain and disability. For whiplash injuries, it appears that "rest makes rusty."
- Injured muscles can get stiff and weak when they're not used. This can add to pain and can delay recovery.
- A return to normal activity may be assisted by active treatment and exercises.
- Cervical collars, or "neck braces," prevent motion and may add to stiffness and pain. These devices are generally not recommended, as they have shown little or no benefit.
- Returning to activity maintains the health of soft-tissues and keeps them flexible - speeding recovery. Physical exercise also releases body chemicals that help to reduce pain in a natural way.
- To prevent development of chronic pain, it is important to start moving as soon as possible.

Tips For Return To Activity

- Avoid sitting in one position for long periods.
- Periodically stand and stretch.
- Sit at your workstation so that the upper part of your arm rests close to your body, and your back and feet are well supported.
- Adjust the seat when driving so that your elbows and knees are loosely bent.
- When shopping or carrying items, use a cart or hold things close to the body for support.
- Avoid contact sports or strenuous exercise for the first few weeks to prevent further injury. Ask your health professional about other sporting or recreational activities.
- Make your sleeping bed comfortable. The pillow should be adjusted to support the neck at a comfortable height.

Treating Whiplash

- Research indicates that successful whiplash treatment requires patient cooperation and active efforts to resume daily activity.
- A treating health care professional will assess your whiplash injuries, and discuss options for treatment and control of pain.
- Although prescription medications are usually unnecessary, temporary use of mild over-the-counter medication may be suggested, in addition to ice or heat.
- Your treating health care professional may recommend appropriate physical treatment.

Avoiding Chronic Pain

- Some whiplash sufferers are reluctant to return to activity, fearing it will make the injury worse. Pain or tenderness may cause them to overestimate the extent of physical damage.
- If your health professional suggests a return to activity, accept the advice and act on it.
- Stay connected with family, friends and co-workers. Social withdrawal can contribute to depression and the development of chronic pain.
- If you are discouraged or depressed about your recovery, talk to your health professional.
- Focus on getting on with your life, rather than on the injury!

Preventing Another Whiplash Injury

- Properly adjusting the height of your car seat head restraint (head rest) will help prevent whiplash injury in an accident. In an ideal adjustment, the top of the head should be in line with the top of the head restraint and there should be no more than 2 to 5 cm between the back of the head and the head restraint.

This brochure provides general information about whiplash injuries. It does not replace advice from a qualified health care professional who can properly assess a whiplash injury and recommend treatment.

The information highlights the latest available scientific research on whiplash and has been endorsed by the following groups:

Insurance Bureau of Canada (IBC)
Ontario Chiropractic Association (OCA)
Ontario Massage Therapist Association (OMTA)
Ontario Physiotherapy Association (OPA)
Ontario Society of Occupational Therapists (OSOT)

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

September 2003

Pre-approved Framework Guideline for Whiplash Associated Disorder Grade II Injuries With or Without Complaint of Back Symptoms

Superintendent's Guideline No. 07/03

Pre-approved Framework Guideline for Whiplash Associated Disorder Grade II Injuries With or Without Complaint of Back Symptoms

1. Introduction

This Guideline is issued pursuant to Section 268.3 of the *Insurance Act* for the purposes of the *Statutory Accident Benefits Schedule* (SABS).

This Guideline is effective for new Treatment Confirmation Form submitted by a initiating health practitioner on or after November 1, 2003, and replaces Pre-approved Framework Guideline for Whiplash Associated Disorder Grade II Injuries With or Without Complaint of Back Symptoms Superintendent's Guideline No. 02/03, July 2003.

This Guideline is intended to set out what goods and services may be provided without insurer approval to an insured person who has sustained a Whiplash Associated Disorder Grade II as described below, with or without back pain, and the cost of such services payable by the insured person's insurer.

This Guideline reflects a consensus between regulated health professionals and insurers and will be subject to review and revision as required over time.

2. Impairments that come within this Guideline

Subject to the exceptions listed in Section 3, below, an insured person's impairment comes within this Guideline if, after being assessed within 28 days of the accident, the insured person is determined to have sustained an injury that:

(a) resulted from an acceleration-deceleration mechanism of energy transfer to the neck, presents as a complaint of neck pain, stiffness, or tenderness, and musculoskeletal sign(s), including decreased range of motion and point tenderness, and therefore meets the criteria for "Whiplash Associated Disorder Grade II" (also known as "WAD II") set out in the Société de l'assurance automobile du Québec's Task Force Report titled *Redefining "Whiplash" and its Management*, published in the April 15, 1995 edition of *Spine*;

(b) may include a complaint of non-radicular back symptoms associated with the WAD II; and

(c) is of sufficient severity that it requires the physical treatment interventions provided under this Guideline.

An insured person who has sustained an impairment covered by this Guideline may also exhibit other common symptoms including: shoulder pain; referred arm pain (not from radiculopathy); dizziness; tinnitus; headache; difficulties with hearing and memory acuity; dysphagia; and temporomandibular joint pain. These additional symptoms would not exclude an impairment from this Guideline unless they require separate treatment from that provided under this Guideline.

3. Impairments that do not come within this Guideline

An insured person's impairment does not come within this Guideline if:

(a) The insured person's impairment comes within the WAD I Pre-approved Framework Guideline; or

(b) despite being assessed withing 28 days of the injury as having an injury described in Section 2, there are specific pre-existing occupational, functional or medical circumstances of the insured person that:

i. significantly distinguish the insured person's needs from the needs of other persons with similar impairments that come within this Guideline; and
ii. constitute compelling reasons why other proposed goods or services are preferable to those provided for under this Guideline.

4. Responsibilities of the initiating health practitioner

The initiating health practitioner:

(a) is a health practitioner as defined by the SABS who is authorized by law to treat the injury and has the ability to deliver all the goods/services provided for in this Guideline;

(b) initiates treatment by submitting a Treatment Confirmation Form;

(c) provides a significant portion of the goods and services;

(d) may co-ordinate the provision of any goods and services covered by this Guideline and provided to the insured person by another regulated health professional, or directly supervise the provision of any additional goods and services to the insured person by an unregulated provider, where such treatment is needed by the insured person and is provided under this Guideline;

(e) shall have overall accountability for:

i. assessing the need for and implementing goods and services such that the treatment elements in this Guideline are addressed as required and appropriate;
ii. ensuring the use of the most appropriate provider(s);
iii. documenting, communicating and billing as required by the Guideline;
iv. reporting outcomes to the insured person and insurer when treatment is inappropriate or ceases;
v. participating in monitoring the effectiveness of the Guideline by fully completing the forms required by this Guideline; and

(f) determines the presence of any barriers which might delay recovery.

5. Providers covered by this Guideline

The initiating health practitioner may include treatment by other providers in the Treatment Confirmation Form. This Guideline covers treatment by the initiating health practitioner and other providers, including unregulated providers where the treatment is directly supervised by a regulated health professional and is not a controlled act as defined by the *Regulated Health Professions Act, 1991*.

6. Switching initiating health practitioners

If for any reason an insured person receiving treatment under this Guideline wishes to change his or her initiating health practitioner, the insured person and the new practitioner must inform the insurer through submission of a new Treatment Confirmation Form. In the new Treatment Confirmation Form, the insured person will give consent for the insurer to contact the original initiating health practitioner to determine what goods and services referred to in the original Treatment Confirmation Form have not been provided and the insurer will then fill in this amount in Part 9 of the form.

7. Treatment/assessments covered by this Guideline

There will typically be one Treatment Confirmation Form which will be prepared by the initiating health practitioner.

The treatment commences with the insured person's first assessment by the initiating health practitioner.

If treatment is initiated during the first 7 days following an accident, the duration of treatment will be 7 weeks. If treatment is initiated between 8 and 28 days following an accident, the duration of treatment will be 6 weeks.

In the first week of treatment under the Guideline emphasis will be on assessment, education, reassurance and pain control and may include physician referral for prescription medication.

The course of treatment may involve the following: reassurance, pain control, mobilization/manipulation, education, and activation (normal daily activities and active exercise).

Education materials titled *Getting the Facts About Whiplash*, developed by regulated health professionals and the insurance industry, will be provided by the initiating health practitioner to all insured persons covered by this Guideline. This material may be found in Appendix E.

The importance of positive messaging is recognized, and it is therefore expected that, at the initial visit and assessment and at subsequent visits, the insured person will be provided with:

- education regarding "hurt does not equal harm;" and
- reassurance that most people with WAD II and associated complaints of back symptoms recover within the first few weeks following the injury.

Emphasis will be on the insured person's responsibility for his or her recovery and the return to normal activities. The frequency of goods and services will diminish as the insured person progresses.

If prescription medication is needed, a referral to a physician or nurse practitioner is necessary. Regulated health professionals may provide general information on the use of over-the-counter medications, but insured persons should be encouraged to consult a physician, nurse practitioner, or pharmacist on the specific use of these medications.

Not all individuals with WAD II will require any or all of the goods and services included within this Guideline. The provider is responsible for determining the need for goods and services and whether the prescribed goods and services are producing significant progress toward recovery and should be continued under the Guideline. If the insured person has recovered before the completion of the treatment outlined in this Guideline, the insured person should be discharged from treatment.

8. Ancillary goods or services (SABS s. 37.2)

With prior insurer approval, certain ancillary goods or services may be proposed by the initiating health practitioner or family physician or insurer and carried out by a regulated health professional while the insured person continues to be covered by this Guideline. Prior approval from the insurer must be requested on a separate Treatment Confirmation Form. If the insurer does not give its approval within 5 business days, as outlined in the SABS, that dispute may proceed to a Designated Assessment Centre for review. If the insurer fails to respond within the prescribed time period, the insurer must pay for the ancillary goods or services delivered under the Treatment Confirmation Form.

For the purposes of this Guideline, ancillary goods or services which may be requested are an Activities of Normal Life Intervention (ANLI), in order to identify and evaluate areas of functional difficulty or barriers to recovery due to the WAD II or back pain and to implement strategies for recovery. An ANLI is not an assessment for the purpose of determining eligibility for housekeeping, attendant care or weekly benefits.

The insured person must be present during the ANLI (excluding reporting back).

The ANLI will take no more than 4 hours for the regulated health professional to complete, including preparation of the report (not including travel time/mileage).

The regulated health professional must report back to the initiating health practitioner (where not the same person), insurer, insured person and family physician and comment on assessment findings, treatment interventions provided and recommendations.

If, upon completion of the ANLI, the regulated health professional identifies a need for further goods and services, she or he will complete a Treatment Plan and submit the request to the insurer.

9. Supplementary goods and/or services

Without prior insurer approval, the initiating health practitioner may provide supplementary goods and/or services where they are needed for the management of one or more minor soft tissue injury/ies which:

(a) resulted from the same accident as the WAD II and requires treatment;
(b) is/are unrelated to the WAD II with or without back pain and its common symptoms;
(c) is/are not of sufficient severity to exclude the insured person's impairment under this Guideline; and
(d) can be fully treated by the provider within the time frame of this Guideline.

The impairment addressed and the services and/or goods must be specified by the initiating health practitioner on a Treatment Confirmation Form and the maximum total cost payable by the insurer for the goods and services provided under this section is $160.

10. Treatment deemed insufficient or inappropriate

If the initiating health practitioner determines that treatment under this Guideline is no longer appropriate or sufficient for the insured person because the insured person is not making sufficient progress towards recovery, the initiating health practitioner will advise the insurer and the insured person (using the WAD I/WAD II PAF Discharge & Status Report form). The initiating health practitioner's options then are the following:

(a) submit a Treatment Plan; or
(b) submit a Treatment Plan and make a referral to the insured person's physician or another regulated health professional; or
(c) with insurer agreement, extend treatment under this Guideline for no more than 4 visits and 2 weeks beyond end of regular duration and at a price determined by the insurer and initiating health practitioner; or
(d) make a referral to the insured person's physician or another regulated health professional.

While treatment/referral decisions are being considered, the initiating health practitioner may:

(e) stop the treatment where it is not appropriate (or no longer needed); or
(f) continue treatment until a decision is reached on the action recommended by the initiating health practitioner.

The SABS provides that an insurer may reject a Treatment Plan that provides for goods and services to be received during any period in which the insured person is receiving goods and services under this Guideline and the insurer's determination is not subject to dispute.

However, the SABS also provides that nothing prevents an insured person, while receiving goods and services under this Guideline, from submitting a Treatment Plan applicable to a period other than the period covered by this Guideline. If the insurer does not approve the Treatment Plan within the time period prescribed in the SABS, that dispute may proceed to a Designated Assessment Centre for review.

11. Completing the treatment under this Guideline

Upon completion of treatment, the initiating health practitioner will prepare a final report which will indicate the insured person's outcomes from treatment.

If an insured person elects to end treatment under this Guideline, he or she may only resume treatment at a later date if this will not extend the overall duration and expenditure limits of the Guideline.

When an insured person is receiving treatment under the Guideline, the termination options are:

i. Resolved and discharged within 6 weeks (WAD I/WAD II PAF Discharge & Status Report completed by initiating health practitioner);
ii. Condition improving, but improvement is insufficient at the end of the treatment (further or other treatment beyond the Guideline is dependent upon the Treatment Plan application and approval process of the SABS);
iii. Not resolving (decision made as soon as possible) and the initiating health practitioner completes the WAD I/WAD II PAF Discharge & Status Report form and discharges the insured person;
iv. Insured person unreasonably fails to participate in treatment. This may be inferred from the insured person's non-attendance at 2 consecutive appointments or 4 appointments overall without a reasonable explanation. Provider required to complete WAD I/WAD II PAF Discharge & Status Report form; or
v. Insured person withdraws consent.

12. Reporting requirement for initiating health practitioners

The initiating health practitioner is expected to establish clinical outcome goals for the insured person receiving treatment under this Guideline that are consistent with the goals of return to normal activities in the early stages of recovery and reducing the risk of chronicity. Throughout the course of treatment the initiating health practitioner is expected to use appropriate measures/indicators to evaluate progress towards achievement of these goals.

For the purposes of documenting the impact of the Guidelines on an insured person whose impairment comes within this Guideline and contributing to the overall evaluation of the Guideline, the initiating health practitioner must complete the WAD I/WAD II PAF Discharge & Status Report form.

13. Provider reimbursement

An initiating health practitioner who provides a good and/or service to an insured person in accordance with the Guideline must submit a Treatment Confirmation Form not later than 5 business days after first seeing the insured person.

The SABS provides that the insurer must confirm to the initiating health practitioner no later than 5 business days after receiving the Treatment Confirmation Form, that the auto insurance policy referenced in the Treatment Confirmation Form was in force on the date of the accident. Payment

to the initiating health practitioner may be denied due to coverage issues or exclusions set out in the SABS.

The insurer's payment will follow receipt of a completed Treatment Confirmation Form, Application for Accident Benefits and Auto Insurance Standard Invoice, Version C. The insurer is not obliged to make payment until after the insurer has received an Application for Accident Benefits.

In the case of the final invoice, the insurer's payment will follow receipt of a WADI/WAD II PAF Discharge & Status Report and Auto Insurance Standard Invoice, Version C.

Where an x-ray service is provided to an insured person whose impairment comes within this Guideline by a chiropractor who is an initiating health practitioner, that service is payable without insurer approval and subject to the reimbursement schedule outlined in Appendix D to this Guideline.

14. Content of appendices

Appendix A sets out the payment schedule in chart form.

Appendix B sets out an overview of the expected course of treatment for an insured person whose impairment comes within this Guideline. Providers will individualize these treatment directives for the needs of each insured person.

Appendix C sets out what goods/services an insurer is not obliged to fund pursuant to this Guideline for an insured person whose impairment comes within this Guideline.

Appendix D outlines the payment schedule for x-rays provided pursuant to this Guideline for an insured person whose impairment comes within this Guideline. Any other x-ray service is subject to insurer approval.

Appendix E contains the educational brochure titled *Getting the Facts About Whiplash*.

Appendix A - WAD II Payment Schedule

Health care providers are entitled to the following reimbursement for treatment of an insured person whose impairment comes within this Guideline. Fees are payable where the insured person has received any treatment in that week including where treatment has been discontinued.

Week 1	$240
Weeks 2 and 3	$432
Discharge at end of Week 3 and monitoring	$160
Weeks 4, 5 and 6	$408
Final assessment and completion of report	$80
Supplementary goods and services	$160
Transfer fee if changing initiating health practitioner	$48

Appendix B - WAD II Course of treatment

Weeks 1 to 3	Treatment/Services
Initial Visit / Week 1:	• Initial visit and up to 3 treatment sessions • Conduct assessment including history, physical exam, x-rays (subject to Appendix D in Guideline) to determine if criteria met for inclusion in the Guideline, relationship of complaints to the accident, the need for the recommended goods and services if any and identification of any potential barriers to recovery • Complete Treatment Confirmation Form • Provide "Getting the Facts About Whiplash" • Manage pain as appropriate (may include physician referral for prescription medication) • Prescribe mild home exercise to improve range of motion • Initiate manipulation/mobilization, if appropriate, to improve function • Consider prognosis and need for ANLI
Visits in Weeks 2 and 3:	• 2 to 4 treatments/monitoring sessions per week expected in this block • Provide advice and reassurance to encourage return to usual activities
Considerations for Providers at the end of Week 3: If WAD improving but further goods and services required:	• Provide advice and reassurance to encourage maintenance of usual activities as soon as possible • Manage pain as appropriate • Prescribe mild home exercise and, if necessary, mild supervised exercise • Utilize manipulation/mobilization and/or physical therapies if required as part of a strategy that promotes activation and return of mobility
Considerations for Providers at the end of Week 3: If WAD II not resolving or improving:	• Re-evaluate • Consider need for ANLI
Considerations for Providers at the end of Week 3: If WAD II resolution expected without further intervention:	• Discharge from treatment with advice and reassurance • Monitor

If discharged during Weeks 2 or 3 or at end of Week 3:	• Discharge from treatment with advice and reassurance and complete WAD I/WAD II Discharge & Status Report • Monitor insured person

Weeks 4, 5 and 6	• At or about day 21 evaluate progress and plan for next 21 days • 1 - 3 treatment sessions per week expected in this block
<u>Considerations for providers during weeks 4-6:</u> If WAD II resolution expected without further interventions:	• Discharge from treatment with advise and reassurance and • Monitor
<u>Considerations for providers during weeks 4-6:</u> If WAD II resolution expected by the end of treatment under the Guideline:	• Provide advice and reassurance to encourage return to usual activities as soon as possible • Manage pain as appropriate • Prescribe mild home exercise, and if necessary, provide supervised exercise • Utilize manipulation/mobilization and/or physical therapies if required as part of a strategy that promotes activation and return of mobility
If WAD II is resolving or improving but resolution not expected by end of treatment under the Guideline:	• Advise insurer including presence of any barriers to recovery • Provide advice and reassurance to encourage return to usual activities as soon as possible • Manage pain as appropriate • Prescribe mild home exercise • Consider more intensive manipulation/mobilization and/or physical therapies as part of a strategy that promotes activation and return of mobility • Consider need for ANLI • Consider supervised exercise and conditioning program • Consider requesting an extension of treatment under this Guideline from insurer of up to 4 visits and 2 weeks or, if more treatment is needed, submit Treatment Plan to insurer
If WAD not resolving or improving:	• Advise insurer and, if appropriate, insured person's treating health practitioner • Reassess • Submit Treatment Plan and/or refer to appropriate regulated health professional
Completion of week 6:	• Final assessment and report to insurer and insured person

Appendix C - Goods and services not covered in the Guideline

An Insurer is not obliged to pay pursuant to this Guideline for the following goods/services rendered to an insured person with an impairment that comes within this Guideline:

- Cervical pillows;
- Advice supporting inactivity or bedrest;
- Injections of anaesthetics, sterile water or steroids to the neck;
- Soft collar for more than 2 days;
- Spray and stretch; and
- Magnetic necklaces.

Note: Adjunct passive modalities (transcutaneous electrical nerve stimulation, ultrasound, massage, heat/cold application, short term bedrest) are included in the funding where part of strategy promoting activation and return to mobility.

Appendix D - Payment Schedule for X-Rays

X-ray services for an insured person with an impairment that comes within this Guideline are payable under the following circumstances:

- X-rays listed below do not require insurer approval, but fees may not exceed those listed in table below. Any other x-rays require insurer/DAC approval.

- No other comparable x-rays have been taken by another health practitioner or facility since the accident.

- Any available funding from OHIP or collateral insurance is utilized before the insurer is billed.

- The insured person displays one or more of the following characteristics:

  - Suspicion of bony injury;
  - Suspicion of degenerative changes, instability, or other conditions of sufficient severity that counter indications to one or more interventions must be ruled out;
  - Suspicion of rheumatoid arthritis;
  - Suspicion of osteoporosis; or
  - History of cancer.

Description	CCI		Maximum Fee ($)
	Code	Attribute	
Cervical Spine			
2 or fewer views	3.SC.10	CXA	$35.20
3-4 views	3.SC.10	CXB	$42.00
5-6 views	3.SC.10	CXC	$48.00
more than 6 views	3.SC.10	CXD	$56.64
Thoracic Spine			
2 or fewer views	3.SC.10	THA	$32.85
3-4 views	3.SC.10	THB	$43.23
Lumbar or Lumbosacral spine			
2 or fewer views	3,SC,10	LBA or LSA	$35.20
3-4 views	3.SC.10	LBB or LSB	$42.00
5-6 views	3.SC.10	LBC or LSC	$48.00
More than 6 views	3.SC.10	LBD or LSD	$55.86

Appendix E - *Getting the Facts about Whiplash*

Getting the facts about Whiplash: Grades I and II

People injured in car accidents sometimes experience a strain of the neck muscles and surrounding soft tissue, known commonly as whiplash. This injury often occurs when a vehicle is hit from the rear or the side, causing a sharp and sudden movement of the head and neck. Whiplash may result in tender muscles (Grade I) or limited neck movement (Grade II). This type of injury is usually temporary and most people who experience it make a complete recovery. If you have suffered a whiplash injury, knowing more about the condition can help you participate in your own recovery. This brochure summarizes current scientific research related to Grade I and II whiplash injuries.

Understanding Whiplash

- Most whiplash injuries are not serious and heal fully.
- Signs of serious neck injury, such as fracture, are usually evident in early assessments. Health care professionals trained to treat whiplash are alert for these signs.
- Pain, stiffness and other symptoms of Grades I or II whiplash typically start within the first 2 days after the accident. A later onset of symptoms does not indicate a more serious injury.

- Many people experience no disruption to their normal activities after a whiplash injury. Those who do usually improve after a few days or weeks and return safely to their daily activities.
- Just as the soreness and stiffness of a sprained ankle may linger, a neck strain can also feel achy, stiff or tender for days or weeks. While some patients get better quickly, symptoms can persist over a longer period of time. For most cases of Grades I and II whiplash, these symptoms gradually decrease with a return to activity.

Daily Activity and Whiplash

- Continuing normal activities is very important to recovery.
- Resting for more than a day or two usually does not help the injury and may instead prolong pain and disability. For whiplash injuries, it appears that "rest makes rusty."
- Injured muscles can get stiff and weak when they're not used. This can add to pain and can delay recovery.
- A return to normal activity may be assisted by active treatment and exercises.
- Cervical collars, or "neck braces," prevent motion and may add to stiffness and pain. These devices are generally not recommended, as they have shown little or no benefit.
- Returning to activity maintains the health of soft-tissues and keeps them flexible - speeding recovery. Physical exercise also releases body chemicals that help to reduce pain in a natural way.
- To prevent development of chronic pain, it is important to start moving as soon as possible.

Tips For Return To Activity

- Avoid sitting in one position for long periods.
- Periodically stand and stretch.
- Sit at your workstation so that the upper part of your arm rests close to your body, and your back and feet are well supported.
- Adjust the seat when driving so that your elbows and knees are loosely bent.
- When shopping or carrying items, use a cart or hold things close to the body for support.
- Avoid contact sports or strenuous exercise for the first few weeks to prevent further injury. Ask your health professional about other sporting or recreational activities.
- Make your sleeping bed comfortable. The pillow should be adjusted to support the neck at a comfortable height.

Treating Whiplash

- Research indicates that successful whiplash treatment requires patient cooperation and active efforts to resume daily activity.
- A treating health care professional will assess your whiplash injuries, and discuss options for treatment and control of pain.
- Although prescription medications are usually unnecessary, temporary use of mild over-the-counter medication may be suggested, in addition to ice or heat.
- Your treating health care professional may recommend appropriate physical treatment.

Avoiding Chronic Pain

- Some whiplash sufferers are reluctant to return to activity, fearing it will make the injury worse. Pain or tenderness may cause them to overestimate the extent of physical damage.

- If your health professional suggests a return to activity, accept the advice and act on it.
- Stay connected with family, friends and co-workers. Social withdrawal can contribute to depression and the development of chronic pain.
- If you are discouraged or depressed about your recovery, talk to your health professional.

- Focus on getting on with your life, rather than on the injury!

Preventing Another Whiplash Injury

- Properly adjusting the height of your car seat head restraint (head rest) will help prevent whiplash injury in an accident. In an ideal adjustment, the top of the head should be in line with the top of the head restraint and there should be no more than 2 to 5 cm between the back of the head and the head restraint.

This brochure provides general information about whiplash injuries. It does not replace advice from a qualified health care professional who can properly assess a whiplash injury and recommend treatment.

The information highlights the latest available scientific research on whiplash and has been endorsed by the following groups:

Insurance Bureau of Canada (IBC)
Ontario Chiropractic Association (OCA)
Ontario Massage Therapist Association (OMTA)
Ontario Physiotherapy Association (OPA)
Ontario Society of Occupational Therapists (OSOT)

Financial Services Commission of Ontario

Bill 198 Simplified Filing Guidelines for Proposed Revisions to Automobile Insurance Rates and Risk Classification Systems

A. GENERAL INFORMATION

Provisions of Bill 198, *Keeping the Promise for a Strong Economy Act (Budget Measures)* and the *Statutory Accident Benefits Schedule* and the majority of the regulations will become effective October 1, 2003. Regulations pertaining to paralegals will become effective November 1, 2003. A Superintendent's Guideline on Professional Fees is also effective November 1, 2003. A regulation change that reduces the basic income replacement benefit from $400 to $300 is effective for new or renewal policies on or after January 1, 2004. Insurers are also required to offer consumers an optional income replacement benefit of $400.

Insurers are to reflect the cost impact of auto insurance reform changes in their rate filings.

Filings

As a result of the auto insurance reform, insurers that write non-fleet automobile insurance on OAP 1 or OPF 2 must file for rate changes using these simplified filing guidelines. Insurers must have a rate in place for the $400 optional income replacement benefit.

The conditions for filing other changes under this simplified format are:

- on an all coverages combined basis the rate change is a decrease;
- the rate change for a particular coverage must be applicable to each territory; and
- no changes to differentials or risk classification elements may be proposed.

The filing must be received by FSCO no later than September 30, 2003. If changes other than the above are being proposed, the insurer must use the standard Section 412 or Section 413 Filing Guidelines, as appropriate.

Filing Process

An insurer must provide a separate filing for each category of insurance that it writes if it intends to charge different rates or have a different risk classification system for each category.

Each filing should contain the following informational sections, in the order indicated below:

Section	Contents
1.	Table of contents
2.	Summary of information (Appendix A)
3.	Certificate of the Officer/Designate (Appendix B)
4.	Rating algorithm
5.	Base rates, differentials, and discounts/surcharges

6.	Dependent Categories (if applicable)
Section	Contents (CONT'D)
7.	Proposed manual pages
8.	Rating examples (Appendix C)

Upon receipt of a filing, each insurer will receive an acknowledgement letter from FSCO. The filing will then be reviewed for completeness based on these filing guidelines and the insurer will be informed of any information required to complete the filing. Until such time as a filing is complete, the time frames in the *Insurance Act* are not effective.

Once a filing is complete, FSCO will review the technical components of the application. FSCO may request further information from the insurer.

Filings should be submitted to:

Financial Services Commission of Ontario
Automobile Insurance Division
Rates and Classifications Branch
Box 85, 16th Floor
5160 Yonge Street
North York ON M2N 6L9

Once an insurer has received notification of approval or authorization from FSCO of its filing, it must file a copy of its rate manual, containing the revised rates with FSCO.

B. GUIDELINES

An insurer must provide a separate filing for each category of insurance that it writes. The format of the filing should be as follows:

SECTION 1: TABLE OF CONTENTS

The table of contents should list the page number of each section of the filing. The pages of the filing, including exhibits, should be numbered consecutively and dated.

SECTION 2: SUMMARY OF INFORMATION

The summary section contains certain key information on the nature of the filed rate level or risk classification system changes. The form to be used is attached to this document as Appendix A.

SECTION 3: CERTIFICATE OF THE OFFICER/DESIGNATE

Each filing must be accompanied by an original singed authorized Certificate of the Officer/Designate. A copy of the Officer/Designate form is attached as Appendix B. Authorized officers are the President, CEO, COO, CFO or Chief Agent for Canada. Alternatively, the President, CEO, COO, or CFO may authorize a designate to sign the Certificate of Officer/Designate. The Designate should be Vice-President rank or above.

SECTION 4: RATING ALGORITHM

Each insurer is required to file its rating algorithm for all coverages.

SECTION 5: BASE RATES, DIFFERENTIALS, AND DISCOUNTS/SURCHARGES

a. Base Rates

Each insurer must file current and proposed base rates for all coverages.

b. Differentials

Each insurer must file its current differentials for all coverages. Insurers must file proposed differentials for the optional income replacement benefit level of $400.

c. Discounts and Surcharges

Each insurer must file its current discounts and surcharges. Insurers may not change discounts or surcharges under the simplified filing process.

SECTION 6: SECTION 413 DEPENDENT CATEGORIES

For those categories of automobile insurance that are dependent on the rate filing submitted, please provide the following:

(i) the rate level effects of the proposed changes.
(ii) the calculations that validate the rate level effect of the proposed changes,
(iii) a copy of the rating rule that stipulates the linkage to the category of automobile insurance, and
(iv) rating examples must be completed for the dependent category of automobile insurance. Rating examples are attached as Appendix C to the Section 413 filing guidelines.

SECTION 7: PROPOSED MANUAL PAGES CONTAINING RATES AND RISK CLASSIFICATIONS SYSTEM

Each insurer must file its proposed manual pages containing the proposed rates, discounts, surcharges, and rating rules (including definitions).

SECTION 8: RATING EXAMPLES

Each insurer must file with the FSCO the rating examples reflecting the rates it is proposing to charge. Please refer to the Standard Section 410 or 413 Filing Guidelines for a copy of the relevant rating examples and instructions for completion. Each insurer must file the rates for optional income replacement benefits as outlined in Appendix C.

Company Name: _____

Group Name: _____

Category of Insurance: _____

SUMMARY OF INFORMATION

1. Describe the proposed changes by checking the item that apply to this filing:

   ❑ Base rate change, not due to off-balancing differential or discount changes, that is uniform by territory

   ☒ Optional income replacement benefits

2. Proposed effective date for ***new*** policies: _____

   Proposed effective date for ***renewal*** policies: _____

   (Insurers should take into consideration the 45 day notice period to brokers and 30 day notice period to insureds required under section 236 of the Act in determining effective dates. The rate changes for optional income replacement benefits are effective on January 1, 2004.)

3. Indicate the distribution of risks by policy term:

3 month	_____	%
6 month	_____	%
12 month	_____	%
Other	_____	%
Total	_____	%

4. Please state the proposed rate level changes and premium weights using direct written premiums that have been adjusted for previous rate changes. (If direct written premiums are not available, please use direct earned premiums.)

Please indicate whether the changes by coverage are weighted by written or earned premiums by placing a checkmark (✔) in the appropriate box, and state the source and date of data.

❑ ***direct written premium*** ❑ ***direct earned premium***

Source and date of data: _____

Coverage	**Proposed Rate Level Change**	**Direct Written (or Earned) Premium $000**	**Weights**
Liability - Bodily Injury	%		
Liability - Property Damage	%		
Accident Benefits	%		
Uninsured Automobile	%		
Direct Compensation - Property Damage	%		
All Compulsory Coverages	%		
Specified Perils	%		
Comprehensive	%		
Collision or Upset	%		
All Perils	%		
OPCF 44	%		
All Optional Coverages	%		
All Coverages Combined	%		100.00%

5a. State the dates and rate level change percentages that were effective in the last eighteen months (please round the figures to two decimals):

Effective Date for Renewal Business				
Coverage	**Prior Change**	**2nd Prior Change**	**3rd Prior Change**	**4th Prior Change**
Liability - Bodily Injury	%	%	%	%
Liability - Property Damage	%	%	%	%
Accident Benefits	%	%	%	%
Uninsured Automobile	%	%	%	%
Direct Compensation - Property Damage	%	%	%	%
All Compulsory Coverages	%	%	%	%
Specified Perils	%	%	%	%
Comprehensive	%	%	%	%
Collision or Upset	%	%	%	%
All Perils	%	%	%	%
OPCF 44R	%	%	%	%
All Optional Coverages	%	%	%	%
All Coverages Combined	%	%	%	%

5b. State the *Average Cumulative Rate Change* for all coverages. It is based on the *All Coverages Combined Proposed Rate Level Change* (as stated in the response to question 4) and the *All Coverages Combined Rate Level Change(s)* (as stated in the response to question 5a), that occurred after January 1 of the year in which the proposed rate change is expected to be effective for renewal business.

The *Average Cumulative Rate Change* for all coverages is: _____%.

6. State other categories of automobile insurance that may be affected by the proposed rate change of this category of automobile insurance (e.g., motorhome rates that are dependent on private passenger rates), and the rate level change percentage *(as per section 6 of the Bill 198 Simplified filing guidelines)*. All changes must be based solely on the changes associated with the dependent category. Any other changes not dependent must be submitted in a separate Bill 198 Simplified filing.

Dependent Category (check where applicable)	**Filing included with this submission**	**If not included - state the expected filing date**	**Rate Level Change impact for each category (%)**
Personal Vehicles - Motorcycles	☐ **Yes** ☐ **No**		
Personal Vehicles - Motorhomes	☐ **Yes** ☐ **No**		
Personal Vehicles - Trailers and Camper Units	☐ **Yes** ☐ **No**		
Personal Vehicles - Off-Road Vehicles	☐ **Yes** ☐ **No**		
Personal Vehicles - Motorized Snow Vehicles	☐ **Yes** ☐ **No**		
Personal Vehicles - Historic Vehicles	☐ **Yes** ☐ **No**		
Commercial Vehicles	☐ **Yes** ☐ **No**		
Public Vehicles - Taxi and Limousines	☐ **Yes** ☐ **No**		
Public Vehicles - Other Than Taxi and Limousines	☐ **Yes** ☐ **No**		
	☐ **Yes** ☐ **No**		
	☐ **Yes** ☐ **No**		

7. Individual to whom questions concerning this filing may be addressed:

Name: _____

Title: _____

Company: _____

Address: _____

_____

_____

_____

Phone No.: _____

Facsimile No.: _____

E-mail Address: _____

CERTIFICATE OF THE OFFICER/DESIGNATE

I, _____ , _____
(Name of Officer) *(Office held: President, CEO, COO, CFO, or Chief Agent for Canada)*

of _____ (the "Insurer")
(Official Name of Company)

CERTIFY THAT:

1. The filing has been prepared for _____ .
(Category of Automobile Insurance)

to be effective January 1, 2004 for optional income replacement benefits and

other changes to be effective as of _____ for new
(Date of Implementation)

business and _____ for renewal business.
(Date of Implementation)

2. I have knowledge of the matters that are the subject of this certificate.

3. The changes requested are in compliance with the Bill 198 Simplified Filing Guidelines requirements.

4. The information and each document contained in the filing accompanying this certificate are complete and accurate.

5. The proposed rates are just and reasonable, do not impair the solvency of the Insurer, and are not excessive in relation to the financial circumstances of the Insurer.

_____ _____
Signature of Officer *Date, Location*

Category of Automobile Insurance: _____ *Appendix C*

Company Name: _____

CURRENT AND PROPOSED RATES/DIFFERENTIALS FOR OPTIONAL INCOME REPLACEMENT BENEFITS

(Include flat rate or % basis)

Income Replacement Level	Current	Proposed
$400		
$600		
$800		
$1,000		

Category of Automobile Insurance: _____ *Appendix C*

Company Name: _____

CASE 1

Risk Description

Operator 1
- Male, age 45 (husband)
- Licensed 25 years, class G licence
- No chargeable accidents or convictions in last 10 years
- Drive to work - 50 km. one way, annual mileage < 40,000 km.
- 1999 Honda Accord EX 4 door (VICC Code 0213)
- New business application to company

Operator #1a
- Single male, age 19
- Licensed 3 years with driver training: 1 year G1, 2 years G2, newly licensed as G
- 1 minor conviction at G2 level

Operator #2
- Female, age 40 (wife)
- Licensed 20 years, class G licence
- No chargeable accidents or convictions in the last 6 years
- Pleasure use only, annual mileage < 10,000 km.
- 1996 Plymouth Voyager (VICC Code 2646)
- New business application to company

Operator #2a
- Female, age 22
- Licensed 2 years without driver training: 1 year G1, 1 year G2, newly licensed as G
- No chargeable accidents or convictions since licensed

Coverages
- Income replacement at $400, $600, $800,and $1,000

Territory	Income Replacement Benefit Level			
Toronto (M4Y)	$400	$600	$800	$1,000
Current				
Proposed				
% +/- to Current Rates				

Category of Automobile Insurance: _____ *Appendix C*

Company Name: _____

CASE 2 -

Risk Description

Operator # 1

- Male, age 38 (husband), Licensed 20 years, class G licence
- No chargeable accidents or convictions in last 6 years
- Drive to work, 10 km. one way, annual mileage < 16,000 km.
- New business application to company
- 1998 Ford Taurus LX 4 door (VICC Code 3427)

Operator #2

- Female, age 35 (wife), Licensed 15 years, class G licence
- No chargeable accidents or convictions in the last 6 years

Coverages

- Income replacement at $400, $600, $800,and $1,000

Territory	Income Replacement Benefit Level			
Toronto (M4Y)	**$400**	**$600**	**$800**	**$1,000**
Current				
Proposed				
% +/- to Current Rates				

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