

Commission des services financiers de l'Ontario

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services d'orthophonie et les frais de transport - applicables aux demandeurs d'indemnités d'accident automobile

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Bulletin

No. A-05/01

I.A.R.D

- AUTO

(Publié B l'origine sous le numéro A-4/02)

NOTE: Les bulletins affichés sur ce site Web vous sont offerts comme références historiques seulement. Les informations qu'ils renferment sont exactes à la date de publication, mais sont sujettes à changement et peuvent avoir été remplacées par un bulletin ultérieur. Les utilisateurs sont encouragés à vérifier ces informations avant de prendre toute décision.

Les bulletins affichés peuvent contenir des formules périmées. Pour la version actuelle des formules de la CSFO, veuillez consulter la [section formules](#) de ce site Web.

Directives concernant les services de psychologie, les services d'orthophonie et les frais de transport - applicables aux demandeurs d'indemnités d'accident automobile

À l'attention de toutes les compagnies d'assurance autorisées à vendre de l'assurance-automobile en

Ontario Directives concernant la arification et le traitement

La Commission des services financiers de l'Ontario (CSFO) a émis une [Directive concernant la tarification -](#)

[Psychologie](#) (Directive sur la tarification); une *Directive concernant l'évaluation et le traitement psychologiques*

(Directive de la surintendante); et une *Directive concernant la tarification - Orthophonistes* (Directive sur la

tarification). Ces directives sont l'aboutissement de négociations fructueuses avec le Bureau d'assurance du Canada

(BAC), l'Ontario Psychological Association (OPA) et l'Ontario Association of Speech-Language Pathologists and

Audiologists (OSLA).

Les directives établissent les tarifs horaires maximaux convenus et témoignent de la volonté des parties de mieux

coordonner leurs efforts pour offrir de meilleurs services aux demandeurs d'indemnités d'assurance-automobile.

Le tarif horaire maximal établi pour les services de psychologie cessera d'être en vigueur après le 31 décembre 2001.

L'industrie de l'assurance et l'OPA ont convenu d'examiner les questions soulevées par la *Directive concernant l'évaluation et le traitement psychologiques*, ou ses retombées, à la demande de l'une des parties, dans un délai de 18 mois après la publication de la Directive. Elles ont également accepté de procéder à l'examen obligatoire de la Directive d'ici le 31 décembre 2003.

Directive sur les frais de transport

À compter du 31 mars 2001, cette directive remplace la Directive n0 6/96. L'objectif de la *Directive sur les frais de transport* est de fournir un cadre aux assureurs et aux personnes assurées pour leur permettre de déterminer dans quel cas les frais liés au transport aller-retour aux fins de traitement des personnes assurées doivent être pris en charge par l'assureur.

Publication et autorisation

Ces quatre directives ont été publiées dans la *Gazette de l'Ontario* du 31 mars 2001.

Les directives concernant la tarification ont été émises par la surintendante des services financiers qui y est autorisée en vertu des paragraphes 14 (4), 15 (6), 17 (2) et 24 (2) de l'*Annexe sur les indemnités d'accidents légales - accidents survenus le 1er novembre 1996 ou après ce jour* (AIAL). Elles s'appliquent aux frais engagés le 31 mars 2001 ou après ce jour.

La *Directive concernant l'évaluation et le traitement psychologiques* a été émise par la surintendante des services financiers qui est autorisée en vertu de l'article 268.3 de la *Loi sur les assurances* à formuler des directives relatives à l'interprétation et l'application de l'AIAL. La Directive s'applique à tous les accidents survenus le 31 mars 2001 ou après ce jour.

La *Directive sur les frais de transport* a été émise par la surintendante des services financiers qui est autorisée en vertu de l'article 268.3 de la *Loi sur les assurances* et des paragraphes 14 (5), 15 (11) et 24 (3) de l'AIAL. Elle s'applique aux frais de transport engagés le 31 mars 2001 ou après ce jour.

Distribution des directives aux coordonnateurs du règlement extrajudiciaire des différends et des services de règlement des sinistres

Les directives émises en vertu de l'AIAL et de la Loi sont des documents d'information importants. La CSFO

recommande vivement aux compagnies d'assurance de fournir un exemplaire des directives ci-jointes à leur personnel des services de règlement des sinistres et coordonnateurs du règlement extrajudiciaire des différends (RED). Les assureurs noteront que ces directives seront incluses dans la prochaine mise à jour du code des pratiques pour le règlement des différends.

Dina Palozzi

Directrice générale et

Surintendante des services financiers

Le 6 avril 2001

Pièces jointes :

1. [Directive concernant la tarification - Psychologues](#) (anglais seulement)
2. [Directive concernant l'évaluation et le traitement psychologiques](#) (anglais seulement)
3. [Directive concernant la tarification - Orthophonistes](#) (anglais seulement)
4. [Directive concernant les frais de transport](#) (anglais seulement)

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**Financial Services
Commission
of Ontario**

**Commission des
services financiers
de l'Ontario**

March 31, 2001

Professional Fee Guidelines - Psychologists

Professional Fee Guideline No. 3/01

Professional Fees Guideline ***- Psychologists***

This guideline is issued pursuant to 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 incurred on or after March 31, 2001.

Purpose

This guideline sets out the maximum fee for the services of a psychologist that an insurer is liable to pay for:

- a medical benefit under Subsections 14 (2) (b) or (h) of the SABS;
- a rehabilitation benefit under Subsections 15 (5) (a) to (g) or 15 (5) (l) of the SABS; or
- conducting an examination or assessment or providing a certificate, report or treatment plan under Subsection 24 (1) (a) of the SABS.

This guideline applies only to services rendered by psychologists.

Fees for Psychologists

The maximum hourly rate for services provided by a psychologist is \$180.00 per hour effective until December 31, 2001.

The rate for ancillary personnel such as psychometrists is not covered by this guideline. The work of ancillary personnel will be separately identified on any invoice with the nature of the service provided and the hourly rate charged.

Psychology Assessment and Treatment Guidelines

Psychologists and insurers should also make reference to the Psychology Assessment and Treatment Guidelines separately published The Ontario Gazette on March 31, 2001 pursuant to Section 268.3 of the *Insurance Act*.



**Financial Services
Commission
of Ontario**

**Commission des
services financiers
de l'Ontario**

March 31, 2001

Psychology Assessment and Treatment Guidelines

Superintendent's Guideline No. 2/01

Psychology Assessment and Treatment Guidelines

APPLICATION

These guidelines are issued pursuant to Section 268.3 of the *Insurance Act*.

These guidelines apply to psychological services provided to accident victims on or after March 31, 2001.

This document sets out assessment and treatment guidelines for use by psychological practitioners¹, insurers and insured motor vehicle accident victims. Part I of the document, the Psychology Assessment Guideline, defines an assessment and sets out maximum hours of assessment required prior to the application of the Treatment Guideline described in Part II.

Patient Groups Covered by the Treatment Guideline

The Treatment Guideline described in Part II is applicable only to treatment of the following groups of patients who, after assessment, are determined to have:

1. Psychological impairments resulting from uncomplicated soft tissue injuries (Whiplash Associated Disorders (WAD) I, II, and III and Low Back Pain (LBP), and pain; or
2. Post-traumatic psychological stress reactions with no physical injuries or pain; or
3. Psychological impairments resulting from uncomplicated soft tissue injuries (WAD I, II, and III) and pain, combined with post-traumatic psychological stress reactions.

Time Frame Covered by Treatment Guideline

As indicated in Part II, Tables 1-3, this guideline is intended to portray maximum psychological treatment for these three prevalent patient groups injured in motor vehicle accidents in the first three phases of treatment consistent with a phased model of psychological treatment:

- phase I, 0-6 weeks following initiation of treatment;
- phase II, 6-12 weeks following initiation of treatment and
- phase III, 12-24 weeks following initiation of treatment.

This guideline does not address any treatment phase beyond 24 weeks.

¹ SABS define a psychologist as a person authorized by law to practice psychology. This includes Psychologists and Psychological Associates.

Patient Groups to Which Treatment Guideline Maximums Do Not Apply

The maximums in the treatment guideline do not apply to treatment of any patient presenting with the following characteristics:

- Risk of harm to self or others;
- Brain injury/ cognitive impairments;
- Other body injuries, for example, spinal cord injury, amputations, scarring, disfigurement;
- Children, adolescents and elderly;
- Contextual factors such as cultural and linguistic factors that may impede treatment progress. When reasonably available, assessment and treatment in the patient's native language should be provided to patients with limited English;
- The MVA caused catastrophic injury or death;
- Patients with pre-existing severe psychological disorders;
- Patients with alcohol and substance abuse disorders.

These characteristics suggest more complex and intense treatment needs than contemplated for the groups specifically covered by the guideline.

INTENDED USE OF THESE GUIDELINES

If, in any individual case, a conflict arises between these guidelines and the Rules of Professional Conduct and Standards of Practice for Psychology, then the rules and standards governing the profession will prevail.

As the duration and number and severity of injuries/ conditions/ impairments and functional activity limitations/ participation restrictions increase so does case complexity and there is an accompanying infeasibility of relying on standardized guides to frame patient needs. For that reason, there is no attempt in this Guideline to deal with any condition requiring psychological treatment, any patient group, nor any time frame that falls outside the stated application.

These guidelines define maximum assessment in Part I: Psychology Assessment Guideline, and maximum psychological treatment for specified groups of patients for the first 24 weeks of treatment.

Presumed Pre-Approval for Treatment in Phase I

Where a psychological treatment plan contemplates treatment which falls within these guidelines, approval of proposed treatment may be presumed where the following procedure is adopted. Where presumed pre-approval applies, the psychologist will telephone the insurer to advise that a Treatment Plan is to be expected and then the Treatment Plan will be faxed to the adjuster and clearly marked, "For Rapid Response pursuant to the Psychology Guideline". The insurer will communicate any objection to

the Phase I treatment within 3 business days of its receipt.

If the insurer does not respond within 3 business days to a treatment plan presented in accordance with this guideline, it will be presumed to have insurer pre-approval for funding for Phase I, the first six weeks, and the insurer will pay for all expenses incurred after submission of the treatment plan in respect of the psychological services described in the treatment plan, for Phase I.

Any proposed treatment in the plan for a period beyond Phase I or six weeks, shall be dealt with according to the SABS.

It is not intended that the Treatment Guideline would be used to replace or circumvent patient assessment, nor as a basis for refusing to pay for the cost of assessments pursuant to Section 24 of the SABS. Assessment before treatment is still required.

COVERED PATIENT GROUPS DEFINED

Group I: Patients with psychological impairments resulting from uncomplicated soft tissue injuries (WADI, II, and III and LBP) and pain

The first patient group addressed in these Guidelines includes patients with uncomplicated soft tissue injuries (WAD I, II, and III & LBP), including psychological reactions to continuing pain and functional limitations from these injuries. These musculoskeletal disorders comprise the most prevalent patient groups arising from motor vehicle accidents. A subgroup of patients with these injuries may have debilitating pain and functional limitations/ restrictions leading to psychological impairments. Psychologists are trained both in treating directly the psychological impairments and in teaching pain management strategies that are effective in educating patients and their families and ameliorating the frustration-anger-pain cycle.

Continuing pain can give rise to a myriad of problems in social/ family/marital or school/ occupational role functioning as well as secondary physical functioning problems such as deconditioning and weight gain. When pain impairments limit ability to function in school or occupational roles the patient may experience a significant disruption to their sense of self in addition to anxieties about their ability to maintain or regain their pre-accident life status. Social/family/marital disruption may occur with reduced participation with family or friends, as well as tendencies to avoidance and isolation. Increased irritability and difficulty controlling anger may be evident. Continuing pain and functional limitations/restrictions may also lead to adjustment, mood and anxiety disorders with affective, cognitive, and/or physiological symptoms. Sleep disorders with difficulties such as falling asleep, remaining asleep, or restless sleep are often reported and directly impact physical and emotional wellness. These psychological conditions may, in turn, cause further functional activity limitations/participation restrictions.

Timely psychological treatment to address the pain and psychological impairments is indicated to maximize efficient, effective restoration of the patient to pre-accident functional levels. Failure to address psychological factors contributes to prolonged impairments, increased medical/rehabilitation costs, and continuing functional limitations/restrictions. Later provision of psychological treatment, while often indicated and effective, may need to be more protracted due to the chronicity of the impairments and the development of secondary conditions.

Group II: Patients with post-traumatic psychological stress reactions with no physical injuries or pain

The second patient group addressed in this Guideline are those patients, with no bodily injuries or pain impairments, who have post-traumatic psychological stress reactions to the motor vehicle accident. Their psychological difficulties follow from the traumatic impact of the accident. Patients in this group present with a number of conditions such as: acute stress reactions, post-traumatic stress disorder, adjustment disorders, anxiety disorders, panic disorder, as well as specific phobias and disorders including passenger, driver and pedestrian anxiety.

Anxiety Disorders including Acute Stress Disorder (within one-month post MVA) or Post Traumatic Stress Disorder (PTSD) may develop depending upon the patient's experience of the threat to self or others of the accident. Patients may experience episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams, or nightmares, and have a sense of "numbness" and emotional blunting. Patients often show distress and avoidance of situations reminiscent of the trauma. Often patients experience motor vehicle anxiety as either driver/ passenger or a pedestrian. The anxiety may occur only in specific situations, or may generalize to other driving scenarios or to other non-vehicle situations which are experienced as threatening. There is usually a state of autonomic hyperarousal with hypervigilance, and enhanced startle reactions and insomnia. Anxiety and depression commonly co-occur. The onset of PTSD follows the trauma with a latency period that may range from a few weeks to months.

Adjustment Disorders also occur in response to a traumatic experience of a motor vehicle accident. Patients with Adjustment Disorders present with states of subjective distress and emotional disturbance, usually interfering with social functioning and performance. The manifestations may vary and include depressed mood, anxiety or worry (or mixture of these), a feeling of inability to cope, plan ahead, or continue the present situation, as well of some degree of disability in the performance of daily routine. The predominant feature may be a brief or prolonged depressive reaction, or a disturbance of other emotions or conduct.

Psychological treatment of patients with these conditions fosters efficient, effective reduction of impairments and restoration of function.

Group III: Patients with psychological impairments resulting from uncomplicated soft tissue injuries (WAD I, II, and III) and pain, combined with post-traumatic psychological stress reactions

A third frequently treated patient group addressed in this Guideline, are those patients with a combination of the injuries/impairments in the first and second groups. This group of patients present with the most complex clinical situations addressed in this Guideline. These patients typically have more impairments and more functional limitations. The pain and trauma impairments often potentiate each other. It is necessary to address each of the impairments because of their interaction. Therefore, treatment of this group of patients is often more intensive than the other two groups of patients.

ASSESSMENT AND CLINICAL DIAGNOSIS BEFORE TREATMENT

In all psychological treatment contexts, assessment must precede treatment. It is essential that the psychologist determine sufficient information about the patient's condition and situation in order to prescribe treatment. The psychologist is required to provide the patient with: 1) the results of the assessment; and 2) the plan for treatment, including the goals to be addressed, anticipated benefits, the nature of the treatment, and the costs associated. With this information the patient is able to give informed consent to the proposed treatment. An exception would be urgent crisis intervention treatment required prior to completion of the full assessment.

The requirement of assessment and clinical diagnosis prior to treatment is consistent with direction from the College of Psychologists of Ontario, responsible for regulating the practice of Psychology in accordance with the Regulated Health Professions Act, as follows:

“A member evaluating a client's treatment needs should ensure that enough information has been obtained to adequately assess the client's psychological status to establish an appropriate treatment plan ... a differential diagnosis (should) be established in order to develop a treatment plan appropriate to the client's needs².”

Part I, Psychology Assessment Guideline, defines an assessment, provides a description of the assessment process and details associated costs.

The SABS provide coverage for the reasonable cost of assessments in section 24.

Practitioners should make every effort to ensure that assessments are reasonable in the context of each individual case.

² The BULLETIN The College of Psychologists of Ontario, Providing Psychological Services to Victims of Motor Vehicle Accidents: Considerations and Cautions, Vol 22 (3) Mar 1997.

Insurers should honour claims for payment for assessments unless the insurer has reason to challenge the reasonableness of the fee claimed or assessment performed. Insurers are only obligated to pay for reasonable psychological assessment expenses. However, the reasonableness cannot be disputed solely on the basis that: the insurer did not request it, the insurer did not pre-approve it, or the insurer did not choose the provider.

TREATMENT PHASES

Psychological treatment is proposed with time frames and goals and typically occurs in phases. In this Guideline three phases of treatment planning are described: 0-6 weeks, 6-12 weeks, 12-24 weeks. Treatment progress is evaluated through each phase and appropriate modifications made. Treatment typically is more intensive at the beginning and becomes less intensive toward the termination of treatment.

In some instances it may be indicated, to utilize a few sessions from the final phase at less frequent intervals in a “follow-up” phase for consolidation and relapse prevention as well as support for work/school reintegration. When required, this “follow-up” may extend beyond the 24 weeks of treatment. However, the “follow-up” phase will not add additional hours or cost to the treatment described in this Guideline.

TREATMENT REQUIRED PAST 24 WEEKS IS NOT COVERED OR EXCLUDED BY THESE GUIDELINES

A subgroup of patients may require further phases of active treatment beyond the three phases described here. This Guideline has no application when active psychological treatment of longer than 24 weeks duration is required. In patient situations where active psychological treatment is needed for longer than 24 weeks, reference should be made to the provisions in the SABS .

For patients with continuing conditions/disorders/impairments, and/or limitations/restrictions of function, an assessment and treatment plan for further treatment should be completed as soon as it becomes clear to the treating psychologist that the patient will require active treatment beyond 24 weeks.

CLINICAL PROGRESS REVIEWS, CONSULTATION AND REPORTING

Clinical progress reviews are a component of clinical treatment (including re-administration of psychometric instruments if appropriate). A review should be completed after approximately every 6-8 sessions of treatment or as clinical need dictates to determine whether the patient is engaged in treatment and responding as anticipated and if modification is required to the treatment plan. The information from the review should be succinctly reported and copied to the insurer.

COMMUNICATION

These guidelines, as with the development of a treatment plan under the regulations, work best in the context of open, timely, and ongoing communication between the patient, the insurer and the psychologist. It is the responsibility of all parties to foster this communication.

PART I: PSYCHOLOGY ASSESSMENT GUIDELINE

The cost of assessments is based on the actual time spent completing the assessment. In applicable patient situations¹, the maximum cost will not be more than \$2,700 for a general psychological assessment or \$4,500 when a combination including neuropsychological, psycho-educational, or psycho-vocational assessments are included, but the amount of time spent on each intervention may vary from case to case. Psychological assessments reasonably include the following diagnostic interventions: Clinical Diagnostic Interview(s), Clinical Diagnostic Interview with collateral source, Psychological Testing, Review of External File Materials, Consultation, Documentation, and Feedback Interview. The amount of time spent on each diagnostic intervention will vary between assessments. This guide indicates the cost of the basic intervention of each type, plus “Extent Attributes” which are additional work required, depending on the individual factors of the case. Use of extent attributes increase the cost of that intervention. It is the responsibility of the psychologist who is completing the assessment to determine which interventions and extent attributes are reasonable and necessary. When required, cost of completion of the OCF 18 is \$75, and disbursements and travel time are additional.

Diagnostic Intervention & CCI	Basic ² Hours	Cost ³	Plus Extent Attributes
Clinical Diagnostic Interview(s) 2.AZ.02	2.5	\$450	Need for additional patient interviews. Increase time as per additional interview(s) e.g. further interview(s) required due to intellectual limitations/slowness, and/or to clarify complex history, causation, clinical presentation or multiple impairments.
Clinical Diagnostic interview with collateral source 2.AZ.02			Need for collateral interviews. Increase time as per additional interview(s) e.g. with family, teacher, employer
Psychological Testing 2.AZ.08 (First Level: Clinical Health / Rehabilitation): Test administration, recording and scoring. May include: emotional/ health status, coping strategies, personality, psychopathology, mood, anxiety, pain, trauma, family/ social relationship functioning, cognitive functioning, rehabilitation status	3	\$540	Requirement for additional more extended specific test procedures to address outstanding diagnostic and impairment issues: Additional testing to elaborate findings from First Level: Clinical Health/ Rehabilitation testing- increase hours by 1-6 e.g. self- report inventories are inappropriate/insufficient; further testing re: cognitive dysfunction, psychological dysfunction, behavioural disorder, competency evaluation. Additional Specific Assessments: (see Psycho-educational / Psycho-vocational assessment and Neuropsychological assessment) Neuropsychological – increase hours by 3 – 12; Psycho-educational – increase hours by 3 – 12; Psycho-vocational – increase hours by 4 – 12.
Review of External File Material 7.SJ.30ZZ including medical chart, IMEs, DACs, school and work records	1	\$180	File contents beyond 50 pages: Increase by .25 hour for each additional 25 pages of documentation
Consultation 7.SF.12			Consultation with health professionals and the insurer required: Increase hours by 0.25 per consultation
Documentation 7.SJ.30ZZ Includes: analysis of all data; formulation of a diagnosis; plan for treatment; and preparation of an assessment report	4	\$720	Complex situations which require more extensive data analysis and documentation. Actual time reasonably spent
Feedback Interview 2.AZ.02 Review of assessment findings, treatment planning and obtaining consent for treatment and communication	1.5	\$270	Complex situations which require additional diagnostic feedback interviews: increase time as per additional interview(s) e.g. patients with intellectual limitations/slowness or with severe and multiple psychological impairments may require additional feedback interviews

1. This Guideline does not apply to a patient who is a child, has a pre-existing severe psychological disorder, has a significant communication disorder or limited English (when reasonably available, patients should be assessed by a psychologist speaking the patient's native language). 2 The work of ancillary personnel such as psychometrists will be separately identified on any invoice with the nature of the service provided and the hourly rate charged. When ancillary personnel are utilized to administer part of the assessment, the total hours may be greater than those illustrated above, but the combined cost of their time, plus the hours of the supervising psychologist will not exceed the maximum cost of the assessment indicated above. 3. The maximum costs in this guideline are calculated on the basis of the maximum hourly rate of \$180 in effect until December 31, 2001 and are thereafter adjusted by changes in the hourly rate.

PSYCHO-EDUCATIONAL/PSYCHO-VOCATIONAL ASSESSMENT

Assessment may include the following domains:

- Intellectual abilities
 - Academic
 - Reading
 - Writing
 - Numerical
 - Communication/Language
 - Expressive
 - Receptive
- Organizational and planning skills
- Abstract Reasoning
- Distractibility
- Vocational aptitude
- Vocational interests
- Task skills analysis
- Transferable skills
- Endurance
- Persistence
- Adaptation and flexibility
- Motivation
- Achievement need
- Learning
- Personality
- Emotional

NEUROPSYCHOLOGICAL ASSESSMENT

Assessment may include the following domains:

- Sensory abilities
- Motor Skills
- Psychomotor speed
- Attention/Concentration
- Language
- Visuospatial/Constructional
- Intellectual abilities
- Memory and learning
- Executive functioning
- Judgment
- Self awareness
- Initiation
- Self Control
- Personality
- Emotional

PART II: PSYCHOLOGY ASSESSMENT AND TREATMENT GUIDELINE

Table I: Patients with psychological impairments resulting from uncomplicated soft tissue injuries (WAD I, II, and III and LBP) and pain

	Diagnostic Psychological Assessment & Preparation of a Plan for Treatment	Phase I (Treatment Weeks 0-6)		C L I N I C A L P R O G R E S S R E V I E W	Phase II (Treatment Weeks 6-12)		C L I N I C A L P R O G R E S S R E V I E W	Phase III (Treatment Weeks 12-24)	
Functional Status		Patients with impairments	Patients with impairments and functional limitations restrictions in: Personal care Occupation Family and household Functioning in the broader social context		Patients with impairments	Patients with impairments and functional limitations restrictions in: Personal care Occupation Family and household Functioning in the broader social context		Patients with impairments	Patients with impairments and functional limitations restrictions in: Personal care Occupation Family and household Functioning in the broader social context
Psychological Activity: (Clinical Health/ Rehabilitation Assessment or Therapeutic)	Clinical Diagnostic Interview; Clinical Diagnostic Interview with Collateral Source; Psychological Testing; Review of External File Material; Consultation; Documentation; Feedback Interview;	Facilitation, Counseling, Therapy, Training	Facilitation, Counseling, Therapy, Training		Facilitation, Counseling, Therapy, Training	Facilitation, Counseling, Therapy, Training		Facilitation, Counseling, Therapy, Training	Facilitation, Counseling, Therapy, Training
Treatment Duration		0-6 weeks	0-6 weeks		0-6 weeks	0-6 weeks		0-12 weeks	0-12 weeks
Maximum Assessment/ Intervention Hours ¹	12 hours plus additional time based on "extent attribute" *	6 hours	15 hours		6 hours	12 hours		8 hours	21 hours
Maximum Clinical Progress Review, Consultation and Reporting Hours ¹		1 hour	2 hours		1hour	2 hours		1 hour	3 hours
Maximum Assessment or Treatment Cost ²	\$2700* (*For details see Psychological Assessment Guideline)	\$1260	\$3060		\$1260	\$2520		\$1620	\$4320

1. The work of ancillary personnel such as psychometrists will be separately identified on any invoice with the nature of the service provided and the hourly rate charged. When ancillary personnel are utilized to administer part of the services, the total hours may be greater than those illustrated above, but the combined cost of their time, plus the hours of the supervising psychologist will not exceed the maximum cost of the assessment/treatment indicated above.

2. The maximum costs in this guideline are calculated on the basis of the maximum hourly rate of \$180 in effect until December 31, 2001 and are thereafter adjusted by changes in the hourly rate.

PART II: PSYCHOLOGY ASSESSMENT AND TREATMENT GUIDELINE

Table II: Patients with post-traumatic psychological stress reactions with no physical injuries or pain

	Diagnostic Psychological Assessment & Preparation of a Plan for Treatment	Phase I (Treatment Weeks 0-6)			Phase II (Treatment Weeks 6-12)			Phase III (Treatment Weeks 12-24)	
Functional Status		Patients with impairments	Patients with impairments and functional limitations restrictions in: Personal care Occupation Family and household Functioning in the broader social context	C L I N I C A L P R O G R E S S R E V I E W	Patients with impairments	Patients with impairments and functional limitations restrictions in: Personal care Occupation Family and household Functioning in the broader social context	C L I N I C A L P R O G R E S S R E V I E W	Patients with impairments	Patients with impairments and functional limitations restrictions in: Personal care Occupation Family and household Functioning in the broader social context
Psychological Activity: (Clinical Health/ Rehabilitation Assessment or Therapeutic)	Clinical Diagnostic Interview; Clinical Diagnostic Interview with Collateral Source; Psychological Testing; Review of External File Material; Consultation; Documentation; Feedback Interview;	Facilitation, Counseling, Therapy, Training	Facilitation, Counseling, Therapy, Training		Facilitation, Counseling, Therapy, Training	Facilitation, Counseling, Therapy, Training		Facilitation, Counseling, Therapy, Training	Facilitation, Counseling, Therapy, Training
Treatment Duration		0-6 weeks	0-6 weeks		0-6 weeks	0-6 weeks		0-12 weeks	0-12 weeks
Maximum Assessment/ Intervention Hours ¹	12 hours plus additional time based on "extent attribute"*	6 hours	15 hours		6 hours	12 hours		8 hours	21 hours
Maximum Clinical Progress Review, Consultation and Reporting Hours ¹		1 hour	2 hours		1 hour	2 hours		1 hour	3 hours
Maximum Assessment or Treatment Cost ²	\$2700* (*For details see Psychological Assessment Guideline)	\$1260	\$3060		\$1260	\$2520		\$1620	\$4320

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2. The maximum costs in this guideline are calculated on the basis of the maximum hourly rate of \$180 in effect until December 31, 2001 and are thereafter adjusted by changes in the hourly rate.

PART II: PSYCHOLOGY ASSESSMENT AND TREATMENT GUIDELINE

Table III: Patients with psychological impairments resulting from uncomplicated soft tissue injuries (WAD I, II, and III) and pain, combined with post-traumatic psychological stress reactions

	Diagnostic Psychological Assessment & Preparation of a Plan for Treatment *	Phase I (Treatment Weeks 0-6)		C L I N I C A L P R O G R E S S R E V I E W	Phase II (Treatment Weeks 6-12)		C L I N I C A L P R O G R E S S R E V I E W	Phase III (Treatment Weeks 12-24)	
Functional Status		Patients with impairments	Patients with impairments and functional limitations restrictions in: Personal care Occupation Family and household Functioning in the broader social context		Patients with impairments	Patients with impairments and functional limitations restrictions in: Personal care Occupation Family and household Functioning in the broader social context		Patients with impairments	Patients with impairments and functional limitations restrictions in: Personal care Occupation Family and household Functioning in the broader social context
Psychological Activity: (Clinical Health/ Rehabilitation Assessment or Therapeutic)	Clinical Diagnostic Interview; Clinical Diagnostic Interview with Collateral Source; Psychological Testing; Review of External File Material; Consultation; Documentation; Feedback Interview;	Facilitation, Counseling, Therapy, Training	Facilitation, Counseling, Therapy, Training		Facilitation, Counseling, Therapy, Training	Facilitation, Counseling, Therapy, Training		Facilitation, Counseling, Therapy, Training	Facilitation, Counseling, Therapy, Training
Treatment Duration		0-6 weeks	0-6 weeks		0-6 weeks	0-6 weeks		0-12 weeks	0-12 weeks
Maximum Assessment/ Intervention Hours ¹	12 hours plus additional time based on "extent attribute" *	9 hours	18 hours		9 hours	15 hours		12 hours	24 hours
Maximum Clinical Progress Review, Consultation and Reporting Hours ¹		1 hour	2 hours		1 hour	2 hours		2 hours	3 hours
Maximum Assessment or Treatment Cost ²	\$2700* (*For details see Psychological Assessment Guideline)	\$1800	\$3600		\$1800	\$3060		\$2520	\$5040

1. The work of ancillary personnel such as psychometrists will be separately identified on any invoice with the nature of the service provided and the hourly rate charged. When ancillary personnel are utilized to administer part of the services, the total hours may be greater than those illustrated above, but the combined cost of their time, plus the hours of the supervising psychologist will not exceed the maximum cost of the assessment/treatment indicated above.

2. The maximum costs in this guideline are calculated on the basis of the maximum hourly rate of \$180 in effect until December 31, 2001 and are thereafter adjusted by changes in the hourly rate.

PSYCHOLOGY ASSESSMENT AND TREATMENT GUIDELINE: CCI DEFINITIONS

The Canadian Classification of Interventions (CCI) provides the following descriptions of diagnostic interventions and extent attributes. This coding system, with extent attribute modifiers, can be applied to the diagnostic interventions indicated in the Psychology Assessment and Treatment Guideline.

Extent attribute

Extent attribute is used to indicate, where appropriate, a quantitative measure related to the intervention (e.g. length of laceration repaired, number of anatomical structures involved).³

Clinical Diagnostic Interview

2.AZ.02 Assessment, psychiatric, Includes:

Assessment, criminal responsibility; Assessment, capacity for self harm; Assessment, capacity for violence;

Assessment, financial competence; Assessment, cognitive status; Assessment, mental status; Determination, mental status (medico-legal, testamentary); Evaluation, forensic psychiatric;

Note: Involves diagnostic interview and evaluation.

Code also: Any certification of psychiatric status or competency (see 7.SJ.30.^)

2.AZ.02.ZZ, using technique NEC ("not elsewhere classified")⁴

Psychological Testing

2.AZ.08 Test, psychological, Includes:

Assessment, psychological (psychodiagnostic); Test, developmental (e.g. infant, intelligence); Test, psychometric; Test, reality;

2.AZ.08.YL, using visual technique (e.g. Bender, Benton); 2.AZ.08.AH, using inventory technique (e.g. Minnesota Multiphasic Personality Inventory: MMPI); 2.AZ.08.AJ, using memory scale technique (e.g. Weschler scale); 2.AZ.08.ZZ, using other technique NEC (e.g. Bayley's scale of infant development)

Review of External File Material

7.SJ.30ZZ Documentation, support activity

³ Extent Attribute is used in the Psychology Assessment Guideline to describe the assessment required for treatment plan preparation to indicate extension and further work and time units required in the component activity, for example, further specific psychological testing.

⁴ The OPA has been informed by Canadian Institute for Health Information (CIHI) that the description of this activity is being amended to include clinical diagnostic interviews completed by psychologists.

Consultation

7.SF.12.Planning, service (Includes: Conference, team; Planning, care; Planning, discharge; Programming, activity; Rounds, clinical service; Rounds, ward.

Documentation

7.SJ.30ZZ Documentation, support activity, See above

Feedback Interview

2.AZ.02 Assessment, psychiatric

OCF-18 Preparation

7.SJ.30LB Completion, claim forms (e.g. insurance, third party payer, worker's compensation)

CCI DEFINITIONS OF INTERVENTIONS USED IN TABLES I, II, AND III

Facilitation: Helping a client (by organizing, making arrangements, providing encouragement or supervision) to engage in activities that, for health reasons, would otherwise be impossible or very difficult to do independently.

Counseling: Providing health advice to a client that identifies health problems (or risks), encourages a change of client attitude or behaviour in order to initiate a willingness to modify lifestyle or behaviour that will result in an elimination of the health problem or risk.

Therapy: The general treatment of a condition, disease or dysfunction to eradicate its cause, manage or reduce the symptoms, or alleviate other associated disabling conditions by using appropriate selected techniques.

Training: Teaching new or different skills to assist a client in overcoming a functional problem (or impairment) that usually involves a complex learning process before those skills are acquired or integrated.

Classification Systems for Description of Injury, Impairments, Functional ACTIVITY LIMITATIONS/PARTICIPATION RESTRICTIONS and Treatment

This Guideline is structured using two relevant classification systems: the ICD-10⁵ for injury/disorder/condition and impairment description, and the Canadian Classification of Interventions (CCI)⁶ for describing the treatment/intervention employed by the psychologist. These systems, rigorously developed, reviewed and revised on an ongoing basis, are in wide use both in Canada and internationally. The classification systems have been recommended for use in the *Standard Invoice*. Communication between practitioners, patients and insurers will be facilitated by the use of these same classification systems in the Assessment and Treatment Guideline.

Injury and Impairment Description and Multiaxial Clinical Diagnosis:

The International Statistical Classification of Diseases & Related Health Problems, Tenth Revision (ICD-10) has been developed by the World Health Organization (WHO), with Canadian input coordinated by the Canadian Institute for Health Information (CIHI). The ICD-10 has been approved by the Conference of Deputy Ministers of Health as the new national standard for health problem classification (1999).

Psychologists generally employ a multiaxial approach to assessment, clinical diagnosis, treatment planning and provision of treatment/ rehabilitation. As stated in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, a classification system presently used by many psychologists, "The use of the multiaxial system facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psychosocial and environmental problems, and level of functioning that might be overlooked if the focus were on assessing a single presenting problem. A multiaxial system provides a convenient format for organizing and communicating clinical information, for capturing the complexity of clinical situations, and for describing the heterogeneity of individuals presenting with the same diagnosis."

The ICD-10 also provides description of a multiaxial approach. While somewhat different from the DSM IV, using three rather than five axes, it incorporates the same conceptual approach and communicates generally similar information. In the ICD-10 system:

Axis I is the Clinical Diagnosis including: mental disorders, physical disorders, and personality disorders;

⁵ International Statistical Classification of Diseases and Related Health Problems, Tenth Revision; World Health Organization, 1993 Geneva.

⁶ Canadian Classification of Interventions

Axis II is used to describe any activity limitations/ participation restrictions in specific areas of functioning including: personal care; occupation; family and household; and functioning in the broader social context. Patients who are experiencing functional limitations/ restrictions in one or more of these domains, generally have more intense treatment needs;

Axis III is used to describe contextual factors, which are environmental and life style factors relevant to pathogenesis and course of the patient's illness. The ICD-10 describes these influencing factors as relevant to patient description when, "some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury... may be recorded as an additional factor to be borne in mind when the person is receiving care for some illness or injury" (ICD-10, Vol. 1).

This approach to patient description is consistent with how psychological practitioners provide assessment, diagnosis and treatment/rehabilitation to individual patients, i.e. they diagnose the disorders/conditions and impairments of physical and psychological function and describe any associated functional limitations/restrictions. The goals of treatment often include: treatment of the disorder/ condition; reduction of the impairment(s); restoration of functional ability; reduction or prevention of disability; and facilitation, in so far as possible, of a return to pre-injury normal life pursuits. The nature and intensity of the treatment must also take into consideration contextual factors.

In other words, the description communicates more than just a diagnosis that alone is often insufficient to describe the health problem. For example, two people with the same diagnosis will typically experience a different "impact" of the diagnosed condition on their lives, and will often have markedly different treatment/rehabilitation needs.

Patients with activity limitations/ participation restrictions generally have greater treatment/ rehabilitation needs. Each of the three Treatment Guideline tables further divides patients into two subgroups within each phase, those with only disorders/conditions/impairments and those with disorders/conditions/impairments causing functional limitations/restrictions in:

- personal care
- occupation
- family & household
- functioning in broader social context.

Those patients with only disorders/conditions/impairments require timely intervention to prevent development of functional limitations/participation restrictions, while those patients who also have functional limitations/restrictions often require more intensive intervention. These varying levels of treatment are reflected in Tables 1-3 in Part II.

Intervention/Treatment Classification:

The Canadian Institute for Health Information (CIHI) is the developer of a new classification of interventions that will replace the existing "*Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures*" (CCP). The new classification system is referred to as *Canadian Classification of Health Interventions* (CCI). This multi-disciplinary intervention classification system has been approved by the Conference of Deputy Ministers of Health as the new national standard for health problem classification (1999). The interventions described in the CCI, also correspond to the descriptions provided in the Schedule of Services, Guide to Fees and Billing Practices, Ontario Psychological Association, 1988.



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March 31, 2001

**Professional Fee Guidelines -
Speech - Language
Pathologists**

Professional Fee Guideline No. 2/01

<i>Professional Fee Guideline - Speech-Language Pathologists</i>
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This guideline is issued pursuant to Subsections 14 (4), 15 (6), and 24 (2) of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996* (SABS) and applies to expenses incurred on or after March 31, 2001.

Purpose

This guideline sets out the maximum fee for the services of a speech-language pathologist that an insurer is liable to pay for:

- a medical benefit under Subsections 14 (2) (a) or (h) of the SABS;
- a rehabilitation benefit under Subsections 15 (5) (a) to (g) or 15 (5) (l) of the SABS; or
- conducting an examination or assessment or providing a certificate, report or treatment plan under Subsection 24 (1) (a) of the SABS.

This guideline applies only to reasonable and necessary services rendered by registered speech-language pathologists.

Fees for Speech-Language Pathologists

The maximum hourly rate for services provided by a speech-language pathologist is \$135.00 per hour for professional time.



**Financial Services
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March 31, 2001

Transportation Expense Guidelines

Superintendent's Guideline No. 3/01

Transportation Expense Guidelines

These guidelines are issued pursuant to subsections 14(5), 15(11) and 24(3) of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996* (SABS) and section 268.3 of the *Insurance Act*. These guidelines replace Guideline No. 6/96 effective March 31, 2001.

Purpose

The purpose of the *Transportation Expense Guidelines* is to provide a framework for insurers and insured persons to determine the circumstances under which expenses related to transportation of an insured person to and from treatment sessions must be paid by an insurer. The guidelines set out authorized expenses and applicable rates for the purpose of subsections 14(5), 15(11) and 24(3) of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996*.

Authorized Expenses

The insurer is liable to pay for all reasonable and necessary transportation expenses for each trip that the insured person makes to and from treatment sessions, counselling sessions, training sessions, examinations and assessments. The insurer is also liable to pay for all reasonable and necessary transportation expenses of the insured person's aide or attendant. Transportation expenses are calculated based on the most direct route. Transportation expenses include parking fees incurred.

The mode of transportation selected should be the most economical, practical for the distance to be travelled and appropriate under the specific circumstances.

Use of Automobiles

The insurer is liable to pay a mileage expense for transportation of the insured person and their aide or attendant, to and from treatment sessions, counselling sessions, training sessions, examinations and assessments using the insured person's automobile, excluding the first 50 kilometres of each round-trip. The 50 kilometre "deductible" is only applicable once in any round-trip. This applies to minors who are driven to treatment sessions, examinations or assessments.

For the purpose of these guidelines, the "insured person's automobile" includes any automobile owned or leased by the insured person or any other automobile to which the insured person has access.

The rate that is to be used to calculate transportation expenses for the use of the insured person's automobile is 27.5¢ per kilometre (27.5¢/km) travelled.

Use of Taxis

The insurer is liable to pay for reasonable and necessary taxi fare incurred by an insured person and their aide or attendant provided that,

- the insured person does not own or have access to an automobile; or
- the insured person is unable to operate an automobile; or
- it is reasonable and practical in the circumstances to take a taxi.

Other Modes of Transportation

Insurers are liable to pay for reasonable and necessary expenses for other modes of transportation where circumstances warrant. Before an insured person incurs expenses for air, rail and bus transportation services, he or she should discuss the matter with their insurer.