MOTOR VEHICLE PERSONAL INJURY MANUAL for HEALTH CARE PROFESSIONALS

Guidelines for health care professionals to assist patients with obtaining benefits as a result of injuries suffered in a motor vehicle collision.

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Introduction

Welcome to the 2nd edition of our Personal Injury Manual designed for Health Care Professionals who treat patients following a car accident.

Major changes to the no-fault system were introduced in September of 2010 and these changes are reflected in this updated Manual. Importantly for you, these changes eliminated the Pre-Approved Framework (PAF) and introduced the Minor Injury Guidelines (MIG), which has its own set of forms and procedures. Please refer to the Section on MIG for further details.

This Manual is accurate as of the date of publishing. Any amendments to the legislation or practice directives following the publishing date may impact the procedures and deadlines referenced in this Manual.

We trust this Manual will be a useful tool for you and your patients. Of course, any of our lawyers would be pleased to speak with you directly if you have any questions, or require further information or guidance.

About Ferguson Barristers LLP

The lawyers at Ferguson Barristers have specialized in personal injury law for over 40 years and have the experience and knowledge to ensure that your patients are accessing all of the benefits and avenues for recovery available to them. We can financially support your patient's claim through all levels of court and will take files on a contingency fee basis.

In 2007, our senior partner, Roderic Ferguson was listed in the National Posts' ranking of Top Personal Injury Lawyers in Canada. He was one of the very few lawyers outside of Toronto or Ottawa to make this list.

Ferguson Barristers has formed a network of referring counsel throughout Ontario. This allows us to meet with your patients in their hometown whenever possible. Furthermore, we are always happy to meet with your patients for a free initial consultation.

For more information about Ferguson Barristers, please visit our website at www.fergusonbarristers.ca.

No-Fault Medical Benefits

With the introduction of the new SABS legislation (effective September 1, 2010), there is much less money available for medical and rehabilitation benefits for your patients who have not purchased Optional Benefits.

The following chart sets out the maximum limits for medical benefits available for your patient:

Type of Injury	Standard Benefits	Optional Med/Rehab Benefits	Optional Med/Rehab/ Attendant Care Benefit
Minor Injury	$3,500.00	$3,500.00	$3,500.00
Non-Catastrophic	$50,000.00	$100,000.00	Up to $1,100,000.00
Catastrophic	$1,000,000.00	$1,000,000.00	Up to $2,000,000.00

A critical fact for both you and your patient to appreciate is that the above limits *include* the costs associated with conducting assessments and examinations as well as preparing reports. However, the costs of examinations requested by the insurance company are not paid out of these limits.

Another important limit is that the cost of any one assessment or report cannot exceed $2,000.00.

To apply, Optional Benefits must be purchased *prior* to the motor vehicle accident.

It is very important that your patient carefully review their policy and contact a lawyer who specializes in the areas of personal injury and insurance law if he or she has any questions or concerns regarding the no-fault benefits they are entitled to receive.

What Happens After an Accident?

By the time your patient has his/her initial visit with you, he or she should have notified their insurance company about:

- his/her intention to claim Accident Benefits, and
- submitted his/her Application for Accident Benefits.

If they have not taken either of these steps, encourage them to do so as soon as possible.

During this initial visit, the SABS[1] ("Statutory Accident Benefits Schedule"), anticipates that one of the following three courses of action will be taken:

1. You decide that no further intervention is necessary:
   - Submit an Auto Insurance Standard Invoice (OCF-21) for the initial visit, up to the maximum of $215.00

2. You decide that your patient's injuries fall within the scope of the Minor Injury Guideline (MIG):
   - Begin treating your patient in accordance with the MIG and complete and submit a Treatment Confirmation Form (OCF-23) within 10 days of the initial visit; and
   - Submit an OCF-21 for the initial visit, up to the maximum of $215.00.

[1]* The SABS is the primary piece of legislation governing the provision of no-fault benefits to car accident victims in Ontario.

3. You decide that your patient's injuries fall outside the scope of the MIG, either because they are not minor or due to pre-existing conditions:

   - Submit a Treatment and Assessment Form (OCF-18) or make an appropriate referral; and
   - Submit an OCF-21 for the initial visit, up to the maximum of $215.00.

HCAI Enrollment

Effective February 1, 2011, all Ontario health care facilities that wish to submit OCF-21's, OCF-18's and OCF-23's must enroll with Health Claims for Auto Insurance Processing ("HCAI").

When you enroll, you must choose whether you will be submitting the forms electronically or in paper format.

Once enrolled, all of the forms must be submitted directly to HCAI. Do not send the forms to the insurance company. However, any attachments must be submitted directly to the insurance company and not to HCAI.

Further information about completing the forms and enrolling with the HCAI can be found at www.hcaiinfo.ca

How To Apply for Insurance-Funded Treatment

Under the Statutory Accident Benefits Schedule ("SABS"), your patient is able to access a wide variety of non-OHIP funded assessments, treatments and medical items, including:

- Medical and surgical services
- Dental services and devices
- Speech Language services
- Chiropractic and Physiotherapy services
- Psychological services
- Occupational therapy services
- Medications
- Prescription eyewear
- Hearing aids
- Wheelchairs and other mobility devices

Subject to various monetary limits, which depend on the type of injuries suffered (i.e. minor, non-minor or catastrophic) and whether or not Optional Benefits have been purchased, the insurance company shall pay for all reasonable and necessary expenses incurred as a result of impairments suffered in a motor vehicle accident.

The Usual Procedure – Submitting an OCF-18

1. The patient must have submitted a completed Application for Accident Benefits to their insurance company.

2. A Treatment and Assessment Plan (OCF-18) must be completed and submitted to HCAI. Attachments are submitted directly to the insurance company.

3. A Regulated Health Practitioner, a Health Practitioner and the patient must sign the OCF-18. Consequently, the OCF-18 is generally completed in your office.

4. Unless notice from HCAI is received by the 2nd business day, that the OCF-18 is unsatisfactory, the OCF-18 is deemed to have been received on the later of the date it was received by HCAI or the date the last of any attachments were received by the insurance company.

5. Within 10 business days of receipt of the OCF-18, the insurance company must notify your patient that:

    a. it has agreed to pay for all of the treatments, assessments or goods outlined in the OCF-18; or

    b. it will pay for some of them; or

    c. it will pay for none of them; or

    d. it believes the MIG applies.

6. The insurance company may require that a section 44 assessment be conducted, if it has not approved the entire OCF-18. This examination may or may not require the attendance of your patient. Any report and further decision about whether or not the insurance company will pay for the disputed items, must be provided within 10 business days of the insurer receiving the assessment report.

If the insurance company refuses to pay for any of the requested treatment, your patient should contact a lawyer immediately.

The Exceptions

The following expenses do not require an OCF-18 for reimbursement:

- Ambulance or other goods or services provided on an emergency basis not more than five business days after the accident;
- Reasonable and necessary expenses related to drugs prescribed by a regulated health professional;
- Reasonable and necessary expenses related to goods with a cost of $250.00 or less per item; and
- Dental goods or services submitted on the Standard Dental Claim form.

In order to receive reimbursement for most of these expenses, an Expenses Claim Form (OCF-6) needs to be submitted directly to the insurance company, with the original invoices or receipts attached. Dental goods and services must be submitted on the Standard Dental Claim form.

Minor Injury Guideline (MIG)

The Minor Injury Guideline (MIG) sets out the goods and services that an insurance company will pay for, without insurer approval, for patients who have sustained an impairment that is predominantly a minor injury.

The MIG applies to all accidents that occur on or after September 1, 2010. For accidents that occurred before September 1, 2010, the PAF Guideline remains in effect.

Minor injuries include:

- sprains
- strains
- whiplash associated disorders
- contusions
- abrasions
- lacerations
- partial dislocations
- clinically associated sequelae

Complete tears or dislocations are not considered to be minor injuries.

Treatment is accessed by the health practitioner by:

1. Completing a Treatment Confirmation Form (OCF-23), which must be reviewed by and signed by the patient, usually during the initial visit.
2. Submitting the OCF-23 to the insurer within 10 business days of the initial visit.

In most cases, the health practitioner will submit the OCF-23 to the HCAI. Unless notice is received by the 2nd business day after it was received by HCAI that the form is unsatisfactory, the OCF-23 will be deemed to have been received by the insurance company on the date it was received by HCAI or the date the last of any attachments were received by the insurance company.

Within 5 business days, the insurance company shall confirm to both the patient and the health practitioner that the OCF-23 has been received and that patient is an insured person.

Provided the patient's Application for Accident Benefits has been accepted, the insurer must pay for every invoice for goods and services that are provided in accordance with the MIG. Benefits covered include:

- chiropractic services
- psychological services
- occupational therapy
- physiotherapy
- massage therapy and
- rehabilitation benefits

Treatment is covered for up to 12 weeks, split into three treatment blocks, each subject to a different maximum fee:

Block 1:	$775.00;
Block 2:	$500.00; and
Block 3:	$225.00.

Detailed information about the recommended and discretionary interventions for the initial visit and each treatment block are outlined in the MIG.[2]

At any point during this 12 week time period and/or at the end of the 12 weeks, a Minor Injury Treatment Discharge Report (OCF-24) must be completed.

Pre-existing Condition

If your patient has suffered a minor injury in a car accident, but you are of the view that a pre-existing condition will prevent your patient from achieving maximal recovery under MIG (i.e. due to the $3,500.00 limit and/or due to the limited goods and services covered by the MIG), there is the ability to exclude your patient's treatment from the MIG. To do so, you must provide compelling evidence using a Treatment and Assessment Form (OCF-18) and attach any appropriate medical documentation.

When FSCO released the MIG, its accompanying bulletin advised that the MIG was intended to be interim and that it would be replaced with a more comprehensive Guideline. To date, the MIG remains in force.

[2] A copy of the current MIG can be found at www.fsco.gov.ca

Concerns with the MIG for your Patients

The primary concern with the MIG is the limit on the length and amount of treatment available to patients as well as the anticipated difficulty removing patients from the MIG in circumstances where pre-existing conditions mean that maximum recovery will not be achieved within the MIG framework.

In this regard, it is noteworthy that the $3,500.00 cap includes the costs of any expenses for conducting assessments and examinations and preparing reports.

Important Note

It is very important to remain mindful that you are able to complete an OCF-18 at any point during those first 12 weeks if you are of the view that additional interventions outside the MIG are required, either due to a pre-existing condition or otherwise, for your patient to achieve maximal recovery.

Where Does Your Patient Send Their Application Forms

NOTE – In this section ***you*** refers to the ***patient***. This information is taken directly from the Application for Accident Benefits form itself (OCF-1).

Please follow the instructions below.

1. **<u>If you Own, Lease, or Have Regular Use of a Company Automobile</u>**

As of the date of the accident did you, your spouse or someone you are dependent on (please check all the options that apply to you):

☐ Own an automobile?

☐ Lease or have a contract to rent an automobile for more than 30 days?

☐ Drive a company automobile which was made available for your regular use?

Based on your answers to the above question, proceed as follows:

A. If you did not check any options, continue to #2.

B. If you checked **only one**, send the forms to the insurance company that insures this automobile.

C. If you checked **more than one**, send the forms to the insurance company of the vehicle in which you were an occupant at the time of the accident.

D. If you checked **more than one and were not an occupant** in either of the automobiles, send the forms to the insurer of either vehicle (you choose).

2. If You are a Listed Driver

Are you listed as a driver on somebody's insurance policy?

☐ Yes – If yes, send your forms to the insurance company that issued the policy you are listed on.

☐ No – If no, continue to #3.

<u>The following 4 categories only apply if:</u>

- You, your spouse or someone that you are dependent upon does not own, lease, or regularly use a company automobile and
- You are not listed as a driver on a policy.

3. Occupant of Somebody Else's Automobile

Were you an occupant of somebody else's automobile that was insured at the time of the accident?

☐ Yes – If yes, send your forms to the insurance company that insures this automobile.

☐ No - If no, continue to #4.

4. Pedestrian or Bicyclist

Were you a pedestrian or a bicyclist struck by an automobile that was insured at the time of the accident?

☐ Yes - If yes, send your forms to the insurance company of the automobile that struck you.

☐ No – If no, continue to #5.

5. Uninsured Automobile

Were you an occupant of an automobile that was not insured at the time of the accident?

☐ Yes – If yes, send your forms to the insurance company of any other automobile that was involved in the accident.

☐ No – If no, continue to #6.

6. None of the Above Apply

If you do not have automobile insurance and no other automobile involved in the accident either has automobile insurance or can be identified, you may be entitled to obtain accident benefits from the Motor Vehicle Accident Claims Fund. Please complete the entire application package and see Part 10 (of the OCF-1).

Denied or Terminated Benefits

The procedure for denying or terminating a benefit has changed dramatically with the introduction of the new Statutory Accident Benefits Schedule (SABS), effective September 1, 2010.

An insurance company no longer needs to conduct an Insurer Examination (I.E.) to deny or terminate benefits and the ability of Health Practitioners to prepare Rebuttal Reports has been eliminated. The insurance company does have the option to conduct a section 44 assessment, either by way of paper review or in person assessment, to determine if a benefit is payable or remains payable.

Mediation/Arbitration/Litigation

If your patient has been denied a benefit, the procedure available to dispute this decision is to apply to the Financial Services Commission of Ontario (FSCO) to mediate the denial. Detailed information about this procedure can be found on the FSCO website at www.fsco.gov.on.ca or can be obtained by calling their toll free number 1-800-668-0128.

If a benefit has been terminated or denied by the insurer, action must be taken to dispute the termination or denial of the benefit within two years after the insurance company refuses to pay the amount claimed. Furthermore, prior to commencing litigation or filing for arbitration, a mediation proceeding or evaluation must have been commenced.

Your patient should contact a lawyer immediately if a benefit has been terminated or denied.

Frequently Asked Questions

1. What is the difference between no-fault and tort benefits?

In Ontario, there are two different regimes that cover possible recovery for injuries suffered in a motor vehicle accident.

A. No-Fault Benefits

In general, no-fault benefits are available to all Ontario motorists, regardless of whether they were at-fault for the accident or not.

The current Regulation governing these benefits is called the Statutory Accident Benefits Schedule – Accidents on or after September 1, 2010 (the new SABS) and the benefits available are often referred to as Accident Benefits.

Typically, a patient receives these benefits from his or her own insurance company. The primary types of benefits available are Income Replacement, Medical and Rehabilitation, Attendant Care and Death and Funeral benefits.

For patients with minor or moderate injuries, a lawyer will generally only be consulted if a benefit is denied or terminated.

B. Tort Action

In addition to no-fault benefits, there is a limited ability to sue an at-fault driver for damages for pain and suffering, past and future loss of income as well as past and future health care expenses.

Damages for pain and suffering are limited to cases where the threshold has been met and are subject to a deductible. The threshold is a defined term but in general, means that the injuries must be permanent and serious. The current deductible for an insurance policy with the Standard Limits is $30,000.00. The deductible may be reduced to $20,000 if Optional Coverage has been purchased.

In order to determine if your patient has the ability to sue the at-fault driver and what benefits might be claimable, a personal injury lawyer should be consulted.

2. When should the patient contact his or her insurance company?

It is very important that the patient contact his/her own insurance company as soon as they are able. Your patient should telephone their insurance broker who will direct the claim to the appropriate person at the insurance company.

If it is a serious accident, the adjuster for the at-fault driver of the other vehicle will undoubtedly try to contact and interview your patient. There is no legal obligation on the injured patient to speak with a representative from the other driver's insurance company and we usually would recommend against it.

If your patient is contacted by a representative from the other driver's insurance company, your patient should speak with a lawyer before agreeing to speak with the representative or sign any statements or other paperwork.

3. Should your patient contact the police?

If your patient was involved in a car accident, your patient should immediately report the accident to the police.

4. Who can bring a Family Law Act Claim?

If your patient is in a motor vehicle accident or has suffered an injury from any other accident, he or she may be entitled to sue the at-fault party. As well, members of your patient's family, including spouses, children, grandchildren, parents, grandparents, brothers and sisters might also be entitled to bring Family Law Act claims.

5. What is the legal process?

The legal process commences with an interview with the lawyer to obtain basic information and to obtain authorizations to collect various medical and income records, as well as a discussion about possible medical or other reports that may be necessary for the proper presentation of the patient's case.

Once the lawyer is satisfied that the case is ready to be settled, the lawyer will contact the other party's insurance adjuster and try to settle the case.

If this is not successful, the law firm will commence a lawsuit and continue to negotiate with the other party's lawyer to get the claim settled. The vast majority of personal injury matters will settle before going to trial.

The legal stages that the patient may have to attend include Examinations for Discovery, Mediations, Pre-Trials and Trials.

6. How long does the process take?

Typically, an experienced personal injury lawyer will not attempt to settle the case until he or she is satisfied that the patient's condition has been fully investigated and there is an accurate diagnosis and prognosis. It is only at that time that a lawyer can properly assess the patient's case.

Depending on the nature of the injuries and any liability investigation which may be required, it may take up to two years before the claim can be assessed. Following that, most cases are settled out of court.

If the matter has to go through the entire court process to trial, it will, in all likelihood, take another two years, depending on the backlog of cases in the judicial system and the jurisdiction in which the case has been brought.

7. How much will the patient have to pay?

Most personal injury law firms, including Ferguson Barristers, typically work on a Contingency Fee or percentage basis. In other words, if the lawyers don't win or settle your case, they don't get paid their legal fees.

It is important to understand that the patient will usually still be responsible to pay any disbursements.

The Contingency fee agreement will be reviewed in detail with the patient during the free initial consultation.

8. How will your patient's damages be assessed?

Compensation for injuries or "damages" suffered in a motor vehicle accident arises from many different losses. Some examples include pain and suffering for both physical and psychological injuries, loss of past and future income, medical expenses and loss of the ability to compete in the workforce.

The theory behind any assessment is to put your patient back in the same place they would have been, had they not been injured.

9. Between the time of their accident and the time their tort claim is settled, how can my patient make ends meet?

Benefits received through your patient's no-fault insurance company will help to cover lost income as well as medical expenses. Your patient may also have short or long-term disability benefits available to them through their employment.

Other sources of financial assistance might include ODSP, CPP Disability or Employment Insurance.

Your patient should discuss this issue thoroughly with his or her personal injury lawyer.

When and How to Get Legal Counsel

Motor Vehicle Accidents

If your patient has been injured in a motor vehicle accident, he or she should contact a personal injury lawyer immediately in the following cases:

- A no-fault benefit has been denied or terminated; or
- His or her injuries appear to be serious and permanent.

Other Accidents

If your patient is injured in a fall or by some other means other than a motor vehicle accident, he or she should contact a lawyer immediately, as short limitation periods and deadlines may apply, depending on how and where the accident occurred.

Personal Injury Lawyers

When your patient is looking for legal counsel, there are a number of important factors to consider.

It is critical that your patient retain counsel who specializes in the area of personal injury law. These lawyers will be familiar with both the no-fault and tort aspects of motor vehicle litigation as well as the maze of limitation periods and other deadlines in all types of personal injury matters.

Most personal injury lawyers will not charge for an initial interview and will be willing to take the file on a contingency basis, meaning less money up front from your patient.

Another consideration for an injured patient is the ability to get to the lawyer's office.

Ferguson Barristers LLP

Ferguson Barristers has specialized in personal injury law for over 40 years, is generally willing to take cases on a contingency fee basis and will travel to your patient's home town in order to ensure he or she is accessing all the benefits and avenues for recovery available to them.

Deadlines and Limitation Periods

A limitation period is the period of time between the date of the accident and when an action must be started. It is difficult to overstate the importance of limitation periods.

If your patient does not commence an action within the specified limitation period, their right to recover damages may be lost.

In addition to limitation periods, there are also important deadlines your patient should meet. Failure to meet these deadlines will likely not impact your patient's ability to recover damages, but will delay and undoubtedly complicate the process.

Outlined below are important limitation and notice periods for patients involved in car accidents. This is only a Guideline. Your patient should obtain legal advice to determine all of the applicable notice requirements and limitation periods that apply in their case.

Accident Benefits

- Notice to own insurance company that patient intends to apply for Accident Benefits – **within 7 days** of the accident or as soon as practicable
- Patient to submit completed Application for Accident Benefits – **within 30 days** of receipt of application forms
- Apply to mediate any denial or termination of benefit – **within 2 years** of the date of denial or termination

- Commence an action or arbitration for a denied or terminated benefit – **within 2 years** of the date of denial or termination – This is a limitation period.

Tort – Motor Vehicle

- Written notice to at-fault driver that patient intends to sue for damages – **within 120 days** of the accident
- Commence an action against the at-fault driver - **within 2 years** of the date of the accident. This is a limitation period.

Other Personal Injury Matters

In general there is a 2 year limitation period for your patient to commence an action against the at-fault party.

There are however some very short notice periods depending on who you are suing and where the accident occurred.

For example, if your patient is suing a Municipality for a failure to maintain a municipal roadway, notice must be given **within 10 days** and the action must be commenced **within 2 years**.

Additional Resources For Your Patient

Canada Pension Plan (CPP) Disability Benefit

www.hrsdc.gc.ca Telephone #: 1-800-277-9914

The CPP disability benefit provides a monthly benefit to replace basic earnings to eligible contributors. In addition to having made the required contributions, you must also be incapable of regularly working due to a severe and prolonged physical and/or mental disability.

Canadian Paraplegic Association Ontario (CPA Ontario)

CPA Ontario's mission is to assist persons with spinal cord injuries and other physical disabilities to achieve independence, self-reliance and full community participation. The local offices provide services in the areas of peer support, employment, advocacy, information and attendant services.

To find your local CPA Ontario office, visit www.cpaont.org.

Employment Insurance Sickness Benefits

www.servicecanada.gc.ca Telephone #: 1-800-206-7218

Sickness benefits may be paid up to a maximum of 15 weeks if you cannot work because of sickness or injury. In order to qualify, you must have paid EI premiums and accumulated sufficient hours in your qualifying period.

Ontario Brain Injury Association

www.obia.ca Telephone #: 1-800-263-5404

This charitable organization provides support programs and resources for persons suffering from the effects of an acquired brain injury.

The service is free and offers support, empowerment, advocacy and education to survivors, family members and friends.

Ontario Community Care Access Centres (CCAC)

There are 14 CCACs in communities across Ontario. These organizations are funded by OHIP and help people stay in their home by providing and co-ordinating care in the home and community. They also provide information about long-term care homes.

To find your nearest CCAC, visit www.ccac-ont.ca or call 310-2222.

Ontario Disability Support Program (ODSP)

This program helps people with disabilities who are in financial need pay for living expenses. It also assists people with disabilities to prepare for and find employment.

To find your local ODSP office, visit: www.mcss.gov.on.ca/en/mcss/programs/social/odsp

Ontario March of Dimes

www.marchofdimes.ca Telephone #: 1-800-263-3463

The goal of this charity is to enhance the independence and community participation of people with physical disabilities. Programs and services include acquired brain injury services, an assistive device program, attendant services, employment services, a home and vehicle modification program as well as information and advocacy services.

Ontario Works

If you qualify and are in temporary financial need, Ontario Works can provide you with money and help you find a job.

To find your local Ontario Works office, visit: www.mcss.gov.on.ca/en/mcss/programs/social/ow

Work Place Safety and Insurance Board (WSIB)

www.wsib.on.ca Telephone #: 1-800-387-0750

WSIB administers no-fault workplace insurance in Ontario. Among other things, WSIB provides disability benefits to eligible injured workers and assists with their return to work.

If injured while on the job, you may qualify for various WSIB benefits.