



MEDICAL AND REHABILITATION DESIGNATED ASSESSMENT CENTRE

DAC ASSESSMENT MANUAL

Les directives sont également disponibles en français

August 2003

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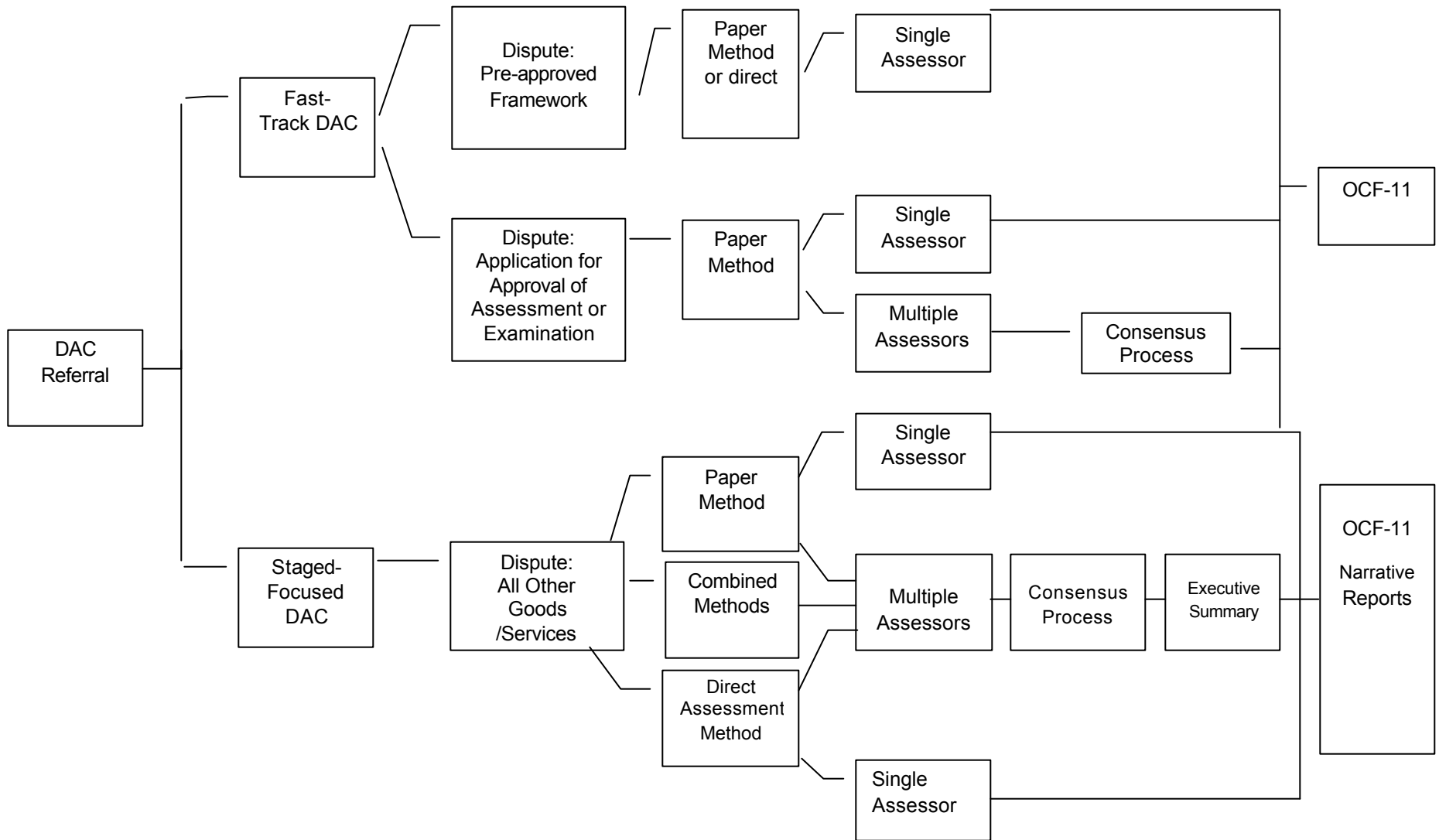
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1.0 MED/REHAB DAC OVERVIEW

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1.1 Med/Rehab DAC Overview



1.2 Key Changes to the Med/Rehab DAC Under Bill 198**DAC Quality Management**

The DAC must have the necessary infrastructure and personnel to provide an impartial service, demonstrating responsiveness, acceptability, competence, appropriateness, effectiveness, and efficiency. Compliance with the SABS Regulation, DAC Standards (outlined in this Manual), and all Guidelines issued by the Superintendent of Financial Services is required.

DAC Personnel

All DACs must identify a Primary Contact, who is accountable to the Minister's Committee on the Designated Assessment Centre System and FSCO for all functions within the DAC and the quality of DAC services.

DAC Assessment Methods

There are increased expectations and more opportunities for DACs to conduct Paper Review or Combination Method assessments. Requests for Clarification/Information from the insured person, insurer, or clinicians in the case may be used to supplement documentation or assessments when necessary. In addition, a single assessor will be used whenever appropriate.

DAC Mandate

In addition to the existing "Staged-Focused DAC" process, all Med/Rehab DACs will be required to provide a "Fast-Track DAC" process to accommodate the expanded role of DACs as a dispute resolution mechanism under Bill 198.

DAC Assessor Selection

The opportunity to complete the assessment with a single assessor will be contemplated in each referral. A single assessor will complete a significant number of Fast-Track DACs and an increasing number of Staged-Focused DACs. The DAC will be expected to select the assessor on the basis of the issues in dispute identified and the professional discipline that can completely address the issues.

DAC Assessment Plan

All Fast-Track DACs have a standard fee and process; therefore, DACs are not required to provide an assessment plan to either party.

2.0 INTRODUCTION

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2.1 Preamble

Bill 198 expands the mandate of Med/Rehab DACs to include Fast-Track DAC assessments — opinions regarding **Pre-approved Framework Guidelines** (PAF Guidelines) and **Application for Approval of an Assessment or Examination** (Application for Approval) disputes delivered within five days — and places increasing expectations on all DACs to deliver a timely, efficient, and effective DAC opinion. This Manual provides direction in conducting these Fast-Track assessments but also takes the opportunity to re-balance the approach taken for all Med/Rehab DAC assessments – now characterized as “Staged-Focused” DAC assessments.

Early DAC System development proposed a focus on the tenets of timeliness, comprehensiveness, impartiality, and cost-effectiveness. However, as the system matured, stakeholders recognized that there was extreme tension between these tenets challenging sustainability of the system. With this in mind, the Minister’s Committee on the Designated Assessment Centre System (the DAC Committee) has taken bold steps in this Manual to shift the focus of DAC processes to more visibly reflect stakeholders’ needs in the DAC system. In addition, the DAC Committee has created a conceptual “DAC Quality Management Model” (Figure #1, Section 3.1) that more closely aligns with widely accepted health-care “domains of quality” (Figure #2, Section 3.2).

For both Fast-Track and Staged-Focused DACs, this Manual takes on a new tone and intent, introducing language that emphasizes quality and accountability: Statutory Accident Benefits Schedule (SABS) Regulation, DAC Standards and Criteria, and Guidelines. This increased specificity will reduce variation across the System, enable DACs to more appropriately balance service-delivery expectations, and allow the DAC Committee to more proactively address DAC performance issues.

2.2 Format of Manual

This DAC Manual introduces several distinct changes to the Med/Rehab DAC process and places new and increased obligations on the DAC to assure quality of services.

The first significant change is the creation of this document as a “Manual” rather than a Guide — signifying increased expectations for DACs to adhere to the processes and steps herein.

In the event of any discrepancies between this Manual and DAC General Guidelines, Communiqués or Bulletins dated prior to October 1, 2003, this Manual shall apply.

Similarly, in the event of discrepancies between this Manual and the SABS, the SABS shall apply.

This Manual will specify DAC processes and steps within the framework outlined below.

Reference Number

Each DAC Standard has a **Reference Number** pertaining to the section of the Manual in which it is addressed and uses the following legend:

QM = Quality Management
DR = DAC Resources
SF = Staged-Focused DAC
FT = Fast-Track DAC

XXX: Standard Title

SABS Regulation

The “SABS Regulation” section will include SABS excerpts, indicating a DAC’s obligations. This section will highlight any SABS sections that are directly related to or impact upon the DAC’s performance or obligations. The section number will indicate the exact location in the SABS and direct quote from the SABS in *italics*. The SABS Regulation is binding and cannot be contravened under any circumstances. If this section is left blank, no provision of the SABS Regulation is directly related to the DAC Standard.

DAC Standard

A “**DAC Standard**” is a performance goal that the DAC must fulfill, established by the DAC Committee to assure quality in the DAC system. The narrative description outlines the goal of the process/step. DACs will be held accountable to the DAC Committee for compliance with these mandatory processes/steps.

Criteria

The “**Criteria**” section indicates the conditions the DAC must fulfill in order to comply with the standard and is framed by “**The DAC will ensure that:**”.

Guidelines

“**Guidelines**” are processes/steps/functions that the DAC Committee believes will help improve efficiency, reduce costs, streamline the process for all parties, and assist the DAC in meeting its obligations. Guidelines may be specified for the insurer, insured person, and/or the DAC as necessary, framed by “**The insurer should:**,” “**The insured person should:**” or “**The DAC should:**”.

Notes

The “**Notes**” section contains additional explanation and/or rationale regarding new directions or revisions to the DAC process.

2.3 Types of Medical and Rehabilitation DACs

2.3.1 Staged-Focused DAC

This Manual will take the opportunity to refocus and streamline the Med/Rehab Staged-Focused DAC process through the expansion of Paper Reviews and single assessor assessments where appropriate to the matter in dispute. In addition, many of the roles and responsibilities previously divided across the Primary Evaluator, Clinical Coordinator, Core Team, and On-Call Team will become more fluid and seamless – allowing each DAC to devise the most efficient process possible.

The objective of the Staged-Focused process is to “*stage*” the assessments so that those that have the greatest potential to resolve the issues in dispute are conducted first. The assessment is “*focused*” on conducting only assessments *necessary* to resolve the dispute. When multidisciplinary DAC assessments are required, the DAC must carefully contemplate each assessment and discipline used to ensure it has unique benefits and an explicit role in resolving the issue(s) in dispute. When multidisciplinary assessments are required, each discipline must consider whether its respective

assessment can be conducted using a Paper Review or Direct Assessment, and whether some Combination Method of Paper Review and Direct Assessment is appropriate across the multiple disciplines.

Purpose of the Staged-Focused DAC

The purpose of the Staged-Focused DAC is to offer an opinion about the Treatment Plan(s) (OCF-18) in dispute. Treatment Plans must meet the test of being *reasonable and necessary for the insured person's treatment or rehabilitation*. In the Staged-Focused DAC, the assessor(s) shall offer recommendations on *the future provision of goods and services to the insured person for his or her treatment or rehabilitation*.

2.3.2 Fast-Track DAC

This new process is designed to specifically address time-sensitive disputes occurring around Pre-approved Framework(s) (OCF-18 or OCF-23/198) or Application for Approval of Assessment or Examination (OCF-22/198).

Due to the time-sensitive nature of these disputes and the more narrowly defined matters to be addressed, new processes allowing a decision as quickly as possible have been devised. These new processes include the use of Paper Reviews using a single assessor, in addition to streamlined referral, intake, and report functions.

These Fast-Track disputes require that the DAC offer its opinion within five business days. In any circumstances where a DAC cannot meet these timelines, the referral **MUST** be returned to the insurer within 24 hours of receipt.

Purpose of the Fast-Track DAC

The purpose of the Fast-Track DAC is to offer an opinion about:

- 1) The Application for Approval of an Assessment or Examination (OCF-22/198).

Applications for Approval of fees other than fees referred to in paragraph 1 or subparagraph 2 iii of SABS section 24(1) must meet the test of being reasonable fees charged by a member of a health profession for conducting an assessment or examination and preparing a report, where the assessment or examination and the report are reasonably required in connection with a benefit claimed or the preparation of a Treatment Plan, disability certificate, Form 1 or determination of catastrophic impairment.

- 2) The Treatment Plan (OCF-18) where the insurer alleges that a PAF Guideline applies.

Treatment Plans must meet the following test based on specific objective findings:

- a) The accident-related impairment(s) of the person are not injuries to which a PAF Guideline applies, or
- b) Although the accident-related impairment(s) of the person are injuries to which a PAF Guideline might otherwise apply, there are specific pre-existing occupational, functional or medical circumstances of the person that:
 - i) Significantly distinguish the person's needs from the needs of other persons with similar impairments that come within the Guideline; and,
 - ii) Constitute compelling reasons why the goods and services proposed in the Treatment Plan are preferable to those provided for under the Guideline.

2.4 DAC Authorization

General Med/Rehab DACs are authorized to see the majority of insured persons with the exception of three groups:

- Insured persons with identified brain injury.
- Insured persons with identified spinal cord injury.
- Insured persons who are less than 16 years of age at the time of assessment (paediatric insured persons). *Note: All paediatric insured persons, regardless of their impairment/disability, may only be assessed by DACs authorized as paediatric.*

Only Med/Rehab DACs with the appropriate extended authorization(s) (see Section 4.0 – DAC Resources) are eligible to offer an opinion on insured persons falling into these three groups. This includes referrals for disputes regarding Fast-Track DAC for insured persons falling into these three groups.

Except in connection with insured persons in these three groups, all General Med/Rehab DACs will provide assessments under the new SABS Regulation pertaining to the Fast-Track DAC process.

2.5 Medical and Rehabilitation Benefits

The SABS describes the medical and rehabilitation benefits that may be claimed. It is important for Med/Rehab DACs to be fully conversant with the relevant provisions of the SABS. Sections 14 and 15 of the SABS outline what medical and rehabilitation benefits are available to the insured person.

2.6 SABS Terms

The SABS states:

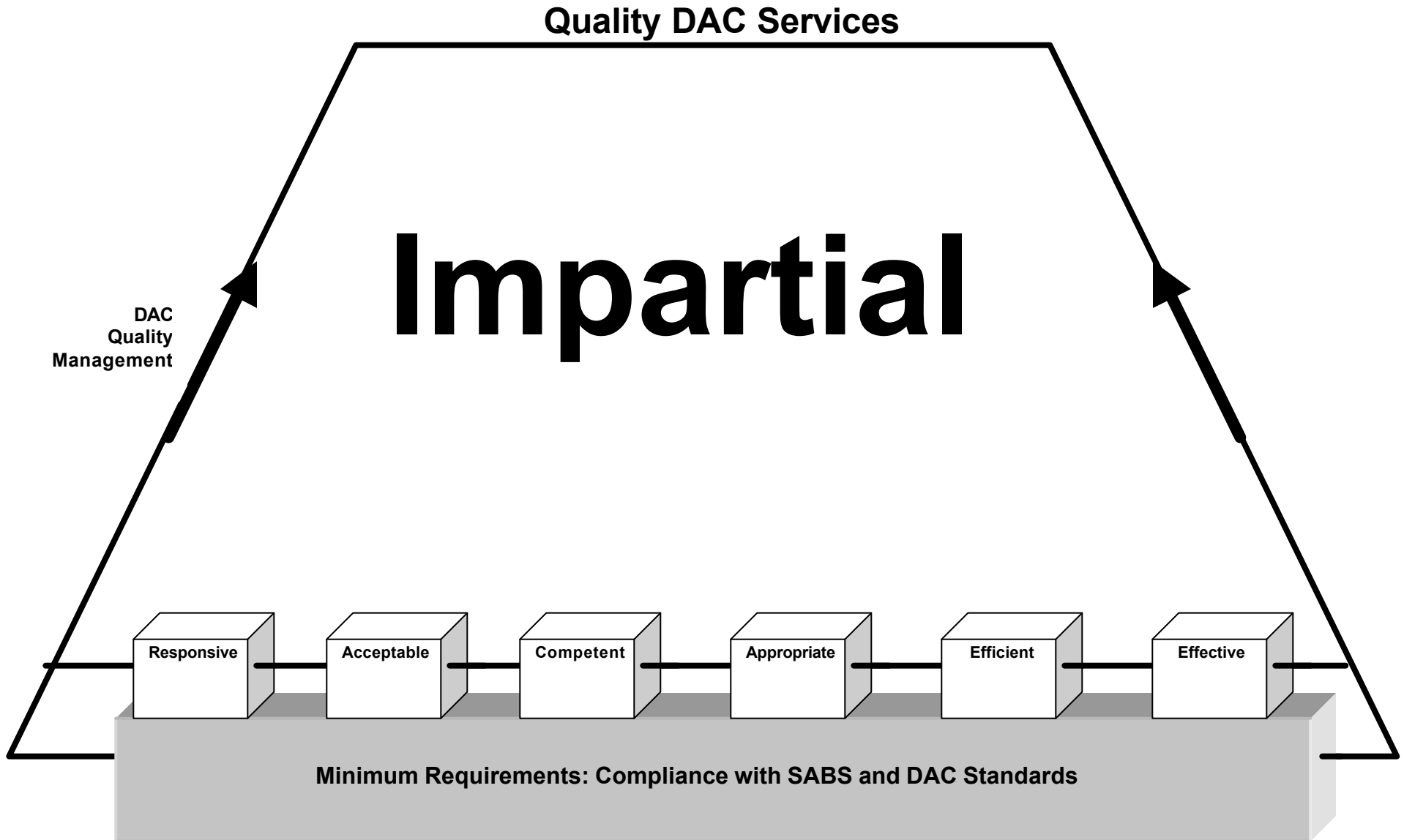
- "accident" means an incident in which the use or operation of an automobile directly causes an impairment or directly causes damage to any prescription eyewear, denture, hearing aid, prosthesis or other medical or dental device.
- "business day" means a day that is not,
 - (a) Saturday, or
 - (b) A holiday within the meaning of subsection 29 (1) of the *Interpretation Act*, other than Easter Monday and Remembrance Day.
- "designated assessment" means an assessment arranged or conducted by a designated assessment centre under section 43.
- "Guideline" means
 - (a) a guideline issued by the Superintendent under subsection 268.3 (1) of the Act that is published in *The Ontario Gazette*,
- "Pre-approved Framework Guideline" means a guideline,
 - (a) that is issued by the Superintendent under subsection 268.3 (1.1) of the Act and published in *The Ontario Gazette*, and
 - (b) that establishes, in respect of one or more impairments, a treatment framework.

3.0 DAC QUALITY MANAGEMENT

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3.1 DAC Quality Management Model

Figure #1 - DAC Quality Management



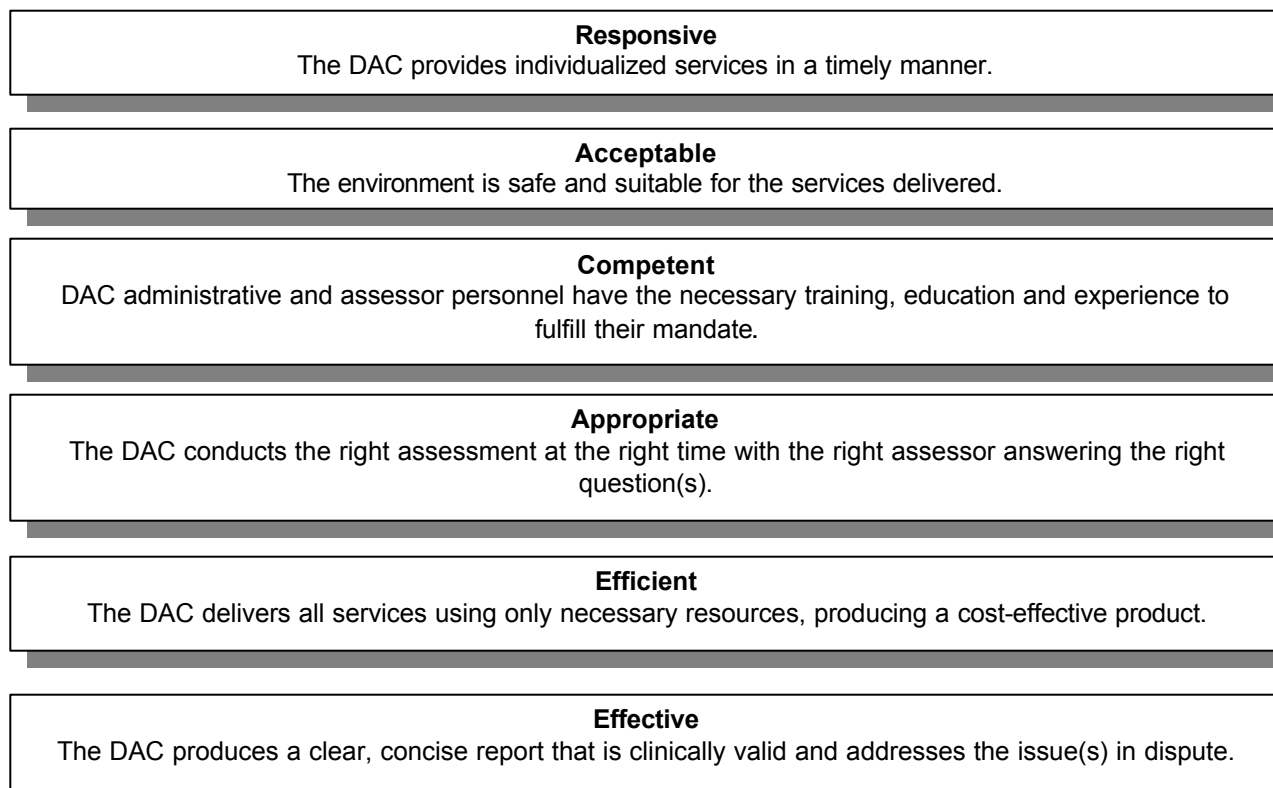
3.2 DAC Domains of Quality

Figure #1 depicts a model for **DAC Quality Management**. Quality Management entails the broad range of management practices and processes that a DAC may use to ensure it meets minimum standards and works to continuously improve the quality of all services. The foundation of the model, **Minimum Requirements: DAC Compliance with SABS and DAC Standards**, indicates that all DACs are expected to develop and maintain processes that ensure compliance with the SABS and DAC Standards as published by the DAC Committee. It is envisioned that a DAC meeting these minimum requirements will be providing quality DAC services. In addition, unique circumstances or distinct characteristics may enable individual DACs to exceed these minimum standards, providing even higher quality of service. All DACs should strive to improve the quality of their services beyond minimum requirements by examining their delivery of services through the broad domains of quality (Figure 2) typically espoused in health care - responsive, acceptable, competent, appropriate, efficient, and effective.

Unique to the DAC Quality Management model, distinct from more traditional health-care quality management, is the concept of **impartiality**. The role of the DAC is to provide a neutral, expert opinion in the alternative dispute resolution process. Impartiality can be defined as: **not having a pre-determined position supporting one person or group more than another**. The DAC must maintain impartiality in all actions – from intake of a referral to distribution of the final report. This unique characteristic of the DAC's mandate necessitates that the DAC always examine its performance and actions through the filter of **impartiality**.

As important as **impartiality** itself, is the **appearance of impartiality** ("justice must not only be done, it must be seen to be done"). In its dealings with insured persons, insurers and others, the DAC must at all times be mindful of the need to maintain the appearance of impartiality and independence.

Figure #2 Quality Domains



3.3 Quality Requirements

QM 1: Quality Management

DAC Standard

DACs will provide an impartial service that is responsive, acceptable, competent, appropriate, effective, and efficient.

Criteria

The DAC will ensure that:

1. It develops quality assurance strategies to monitor and ensure compliance with the SABS Regulation and DAC Standards.
2. It takes action to rectify any deficiencies in compliance with the SABS Regulation or DAC Standards.

Guidelines

The DAC should:

1. Develop strategies to assess, monitor, and improve performance reflecting the Quality Domains.

Notes

DACs should focus on compliance with the SABS Regulation and DAC Standards. Over time, all DACs will be expected to monitor performance in all quality domains. In addition to the Med/Rehab Self-Audit, the DAC Committee will be working to develop a System-wide framework for Quality Management that will provide more direction in this area.

QM 2: Activity Tracking

DAC Standard

DAC system activity under Bill 198 is provided in real-time.

Criteria

The DAC will ensure that:

1. It submits data for all referrals processed to the DAC Activity Tracking database every fifteen-calendar days, at a minimum.
2. It adheres to the DAC Activity Tracking System User Manual.

Notes

In order to more fully assess the impact of Bill 198 on DAC referrals and service capacity, it is imperative that the DAC Committee has current, relevant data regarding referral volumes and activity across the province.

4.0 DAC RESOURCES

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4.1 DAC Management

There is a variety of functions that are associated with the successful management and resolution of each DAC referral. This Manual establishes standards for which all Med/Rehab DACs will be held accountable, rather than directing the DAC in the management of DAC processes and organization of personnel.

DR 1: Primary Contact

DAC Standard

One individual within the DAC is designated as the Primary Contact.

Criteria

The DAC will ensure that:

1. The Primary Contact:
 - a. Is accountable to the DAC Committee and FSCO on issues pertaining to DAC service quality (including complaints, and compliance with Guidelines and SABS).
 - b. Creates and manages an infrastructure that enables the successful attainment of the DAC's mandate.
 - c. Creates and manages an infrastructure that meets the standards established in this Manual.

Notes

DAC governance structure and organization of personnel will depend on the unique circumstances and experiences of each facility. It is the DAC's responsibility to structure its personnel and administer the required processes to meet the standards described in this Manual. How administrative and clinical roles and responsibilities are delegated within the facility is left to the discretion of the individual DAC. Similarly, the DAC governance structure of which the Primary Contact is a part and/or for which the Primary Contact is held accountable for these performance issues is left to the DAC's discretion.

DR 2: Physical Resources

DAC Standard

Sufficient equipment, tools and amenities are available to conduct assessments in a safe, confidential, easily accessible environment.

Criteria

The DAC will ensure that:

1. It has the necessary resources to meet:
 - a. The requirements of each insured person, given his/her unique characteristics, impairment or disability.
 - b. The assessment requirements of a broad range of Med/Rehab goods/services {specified in the Treatment Plan (OCF-18), Pre-Approved Framework Treatment Confirmation Form (OCF-23/198) or Application for Approval (OCF-22/198)} in dispute.
2. The DAC facility:
 - a. Is accessible.
 - b. Has adequate parking and physical space.
 - c. Provides services that respect the insured person's privacy and confidentiality.
 - d. Meets all building code, fire code and health department regulations of the municipality in which it operates.
 - e. Maintains and adheres to appropriate file (paper and electronic) security, storage and retention and destruction procedures.

- f. Maintains adequate general liability insurance.
- g. Appropriately maintains all equipment.

DR 3: Assessor Competence

DAC Standard

The DAC retains the minimum level of training, education, and experience required for conducting Med/Rehab DAC assessments.

Criteria

The DAC will ensure that:

1. Each assessor on its roster:
 - a. Is a member in good standing and holds a certificate of registration with the appropriate:
 - i. Ontario regulatory College, if a regulated health professional.
 - ii. Regulatory body or association for the profession, if not a regulated health professional.
 - b. Has five years of current, balanced, relevant clinical practice*.
 - c. Possesses the necessary training, education and experience to offer an opinion regarding the specific goods and services in dispute, considering each insured person's unique characteristics and circumstances.
 - d. Is experienced in conducting:
 - i. Single assessor assessments and
 - ii. Multidisciplinary assessments with multidisciplinary decision-making.
 - e. Is able to formulate an opinion based exclusively on documented information, when necessary or appropriate.
 - f. Is fully conversant with:
 - i. Relevant sections of the SABS.
 - ii. The Med/Rehab DAC Assessment Manual.
 - iii. Relevant Guidelines.
 - iv. Relevant arbitration decisions.
 - g. Is experienced in generating impartial, concise, appropriate, relevant assessment reports.
 - h. Has a demonstrated ability to articulate assessment outcomes and rationale in plain language.
 - i. Has adequate professional liability insurance coverage.
2. It applies to the DAC Committee for any exemption of an assessor from meeting any of the above criteria, should there be a need.

Notes

***Current** means within the last five years.

Balanced means that if an assessor conducts independent assessments, it is in addition to the provision of assessment and treatment of patients either i) directly or ii) in supervising others or providing consultation to others in such provision.

Relevant means the assessment and treatment of *patients*** for the motor vehicle accident injured population.

- ****Patient** in this regard denotes a relationship between the patient and health-care professional where care is provided in a clinical setting.

DR 4: Roster of Assessors

DAC Standard

The DAC retains the minimum pool of assessors required for a Med/Rehab DAC roster.

Criteria

The DAC will ensure that:

1. It retains an adequate roster that will enable the achievement of the DAC mandate, including the timeline requirement for all referrals.
2. Its roster has assessor(s) from each of:
 - a. Chiropractic
 - b. Dentistry (with particular expertise in the treatment of trauma-induced dental injuries and temporomandibular disorders)
 - c. Massage Therapy
 - d. Occupational Therapy
 - e. Medicine:
 - i. Including one of each:
 1. Neurologist or neurosurgeon
 2. Psychiatrist or rheumatologist
 3. Psychiatrist
 4. Orthopaedic surgeon
 5. Family physician.
 - f. Physiotherapy
 - g. Psychology
 - h. Speech-language pathology
 - i. Any additional disciplines that in its experience, or based on regional access, are required to fulfill its DAC assessment mandate (for example, audiologist, internist, kinesiologist, neuropsychologist, nurse, ophthalmologist, optometrist, pharmacist, prosthetist and orthotist, social worker, vocational evaluator, etc.).
3. It applies to the DAC Committee for exemption from retaining a required discipline, should there be a need.
4. For each assessor on its roster:
 - a. A complete, bi-annually updated Practice Summary is on file at the DAC.
 - b. A complete, bi-annually updated DAC Assessor Declaration is on file at FSCO.

Notes

The previous Med/Rehab Guide dictated very rigid requirements related to the concepts of “Core Team” and “On-Call Team,” creating distinctions that may have inhibited appropriate assessor selection and contributed to inefficiency. This Manual flattens the hierarchy of the Med/Rehab DAC team to a minimum set of disciplines.

DR 5: Assessor Competence for Extended Authorization

DAC Standard

The DAC retains the minimum level of training, education, and experience required for conducting Extended Authorization Med/Rehab DAC assessments.

Criteria

The DAC will ensure that:

1. All extended authorization assessors on the roster:
 - a. Meet all criteria under Assessor Competence identified in DR 3 Assessor Competence above.
 - b. Have a focus of practice in the category of the Extended Authorization, where “focus of practice” means a minimum of three years’ experience assessing and treating the population.

DR 6: Roster of Assessors for Extended Authorization

DAC Standard

The DAC retains the minimum pool of assessors on a Med/Rehab DAC's roster for:

- Identified Spinal Cord
- Identified Brain Injury
- Paediatrics.

Criteria

The DAC will ensure that:

1. If it has extended authorization for **Identified Spinal Cord**, it has on its roster one assessor from each discipline of:
 - a. Medicine with a focus of practice in spinal cord injuries
 - b. Psychology with a focus of practice in spinal cord injuries
 - c. Occupational therapy with a focus of practice in spinal cord injuries
 - d. Physiotherapy with a focus of practice in spinal cord injuries
 - e. Chiropractic with a focus of practice in spinal cord injuries
2. If it has extended authorization for **Identified Brain Injury**, it has on its roster one assessor from each discipline of:
 - a. Neurology or neurosurgery
 - b. Neuropsychology
 - c. Occupational therapy with a focus of practice in Acquired Brain Injury (ABI)
 - d. Physiotherapy with a focus of practice in ABI
 - e. Chiropractic with focus of practice in ABI
 - f. Speech-language pathology with a focus of practice in ABI
3. If it has extended authorization for **Paediatrics**, it has on its roster one assessor from each discipline of:
 - a. Medicine with specialty as a paediatrician
 - b. Neurology or neurosurgery with a focus of practice in paediatrics
 - c. Neuropsychology with a focus of practice in paediatrics
 - d. Clinical psychology with a focus of practice in paediatrics
 - e. Occupational therapy with a focus of practice in paediatrics
 - f. Speech-language pathology with a focus of practice in paediatrics
 - g. Physiotherapy with a focus of practice in paediatrics
 - h. Chiropractic with a focus of practice in paediatrics.
4. It applies to the DAC Committee for exemption from retaining a required discipline, should there be a need.
5. For each assessor on its roster:
 - a. A complete, bi-annually updated Practice Summary is on file at the DAC.
 - b. A complete, bi-annually updated DAC Assessor Declaration is on file at FSCO.

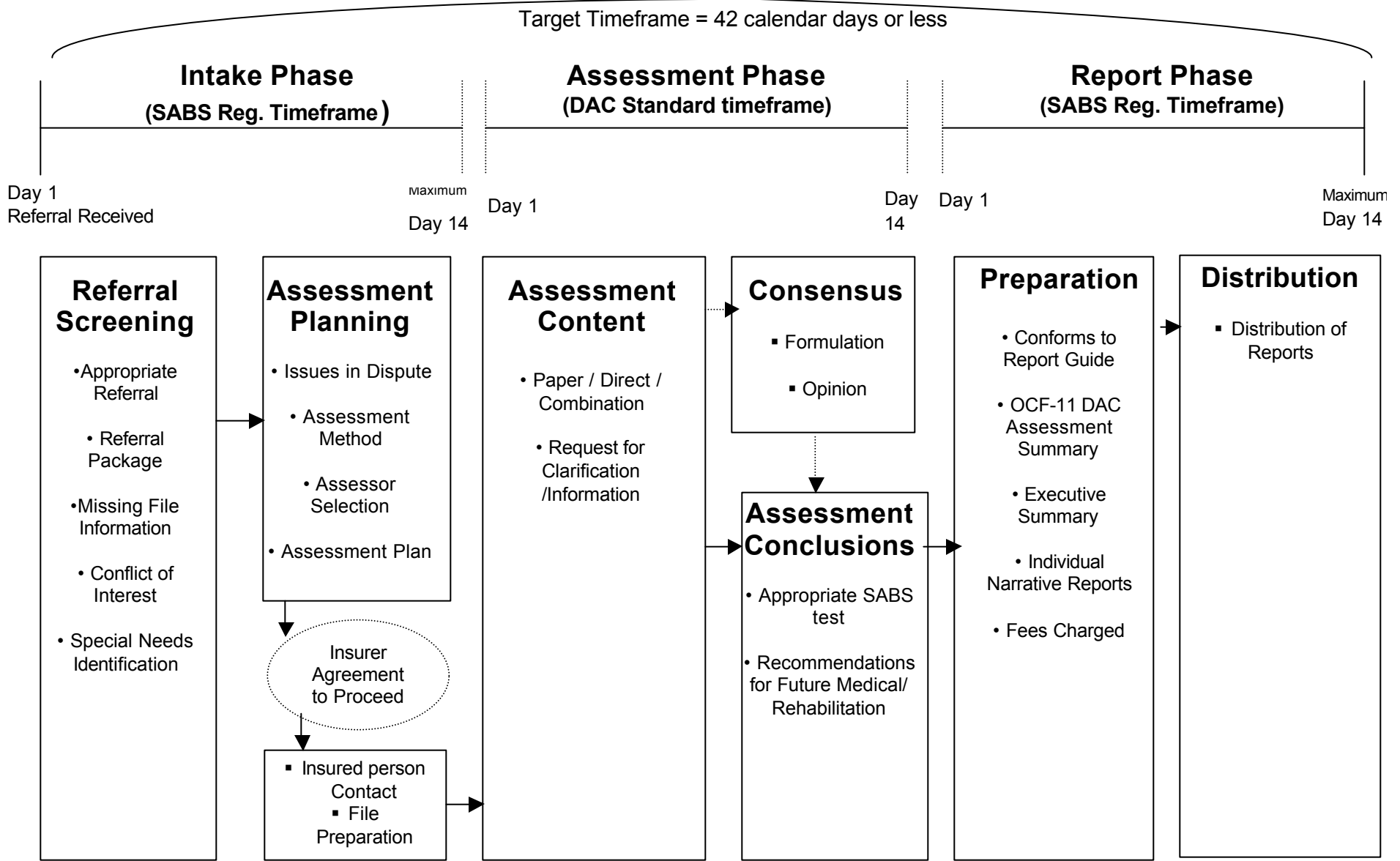
Notes

DAC governance structure and organization of personnel will depend on the unique circumstances and experiences of each facility. It is the DAC's responsibility to structure its personnel and administer the required processes to meet the standards described in this Manual. How administrative and clinical roles and responsibilities are delegated within the facility is left to the discretion of the individual DAC. Similarly, the DAC governance structure in which the Primary Contact shares and/or is held accountable for these performance issues is left to the DAC's discretion.

5.0 STAGED-FOCUSED DAC

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5.1 Staged-Focused DAC Overview



5.2 Staged-Focused DAC Intake Phase

The objective of the Staged-Focused process is to “stage” the assessments so that those that have the greatest potential to resolve the issues in dispute are conducted first. The assessment is “focused” on **conducting only those assessments necessary** to resolve the dispute. When multiple assessments are conducted, the DAC must carefully contemplate each assessment to ensure it has unique benefits and an explicit role in resolving the issue(s) in dispute. The DAC should consider opportunities to conduct a Paper Review and/or the use of a single assessor on every case. When multiple assessors are required, the opportunity for Paper Review or Combination Method assessment must be contemplated.

5.2.1 Referral Screening

SF 1: Appropriate Referral

SABS Regulation

53. (1) *A designated assessment shall be conducted by a designated assessment centre selected in accordance with this section.*

(1.1) *A designated assessment must be conducted by a designated assessment centre that,*

- (a) *is authorized to assess impairments of the type sustained by the insured person; and*
- (b) *is authorized to conduct the type of designated assessment that is required.*

(1.2) *A designated assessment must be conducted by a designated assessment centre that is located within,*

- (a) *30 kilometres of the insured person's residence, if,*
 - (i) *the insured person's residence is located in the City of Toronto or the regional municipality of Durham, Halton, Peel or York, and*
 - (ii) *a designated assessment centre that complies with subsection (1.1) is located within 30 kilometres of the insured person's residence; or*
- (b) *50 kilometres of the insured person's residence, if,*
 - (i) *the insured person's residence is not located in the City of Toronto or the regional municipality of Durham, Halton, Peel or York, and*
 - (ii) *a designated assessment centre that complies with subsection (1.1) is located within 50 kilometres of the insured person's residence.*

(1.3) *Subject to subsections (1.1) and (1.2), the insurer and the insured person may jointly select the designated assessment centre if the selection is made not later than the second business day after the insurer or the insured person, as the case may be, receives notice from the other that a designated assessment is required under this Regulation.*

(1.4) *If the insurer and the insured person do not jointly select the designated assessment centre in accordance with subsection (1.3), the Superintendent shall, subject to subsections (1.1) and (1.2), select the designated assessment centre.*

DAC Standard

The DAC ensures that it has the authorization required to conduct the assessment.

Criteria

The DAC will ensure that:

1. The insured person is referred to the correct DAC type (Med/Rehab DAC).
2. The DAC is appropriately authorized to assess the insured person (general, brain injury, spinal cord injury, paediatric).
3. An opinion can be rendered and forwarded to all parties in **a maximum** of 42 days from receipt of the complete referral documentation.
4. The referral is appropriate for the Staged-Focused DAC process (i.e., not a PAF Guideline or Application for Approval dispute).
5. The referral is returned within 24 hours of receipt, if:
 - a. It is an inappropriate referral.
 - b. The DAC is unable to meet the Staged-Focused timeframes.

SF 2: Referral Package

SABS Regulation

43. (1) 1. *The insurer shall notify the designated assessment centre within five business days.*
2. *The insured person and the insurer shall provide the person or persons who will conduct the designated assessment with such information as is reasonably necessary, within the same period of five business days referred to in paragraph 1.*

DAC Standard

All reasonably necessary DAC assessment documentation is provided with the referral package.

Criteria

The DAC will ensure that:

1. A **complete** Staged-Focused DAC Referral Package minimally consists of the following:
 - a. OCF-11
 - b. OCF-18(s)
 - c. OCF-14 (only if insurer has waived insured person signature on Part 14 on OCF-18)
 - d. Insurer's written confirmation that insurer and insured person have agreed to waive Conflict of Interest (as necessary).
 - e. Any reasonably necessary file information.
2. Any additional, reasonably necessary information received from either party is incorporated into the assessment. For example:
 - a. Relevant OCF-21(s)
 - b. Relevant medical reports
 - c. Relevant clinical records
 - d. DAC reports.
3. Video surveillance materials, or any transcript of any examination under oath pursuant to the SABS, are not accepted after the first assessment appointment is started.
4. If the OCF-18(s) is a Recurring, Similar OCF-18, it is managed as per SF 4.

Guidelines

The insurer should:

1. Provide all of the above noted Referral Package documents when the referral is initiated. For example:
 - a. Relevant OCF-21(s)
 - b. Relevant medical reports
 - c. Relevant clinical records
 - d. DAC reports.
2. Organize the referral so that:
 - a. The disputed treatment plan is immediately behind the OCF-11.

- b. Each document is itemized (date, author, purpose) on a complete document list (Part 9, OCF-11).
- c. All documents, including photocopies, are legible.
- d. The documents are organized in chronological order.
- e. Only relevant documents are included – for example, no irrelevant log notes or miscellaneous correspondence.

SF 3: Missing File Information

DAC Standard

Only **reasonably necessary** file information is pursued to ensure timely completion of the DAC assessment process.

Criteria

The DAC will ensure that:

1. The pursuit of any missing file information begins as soon as the information gaps are discovered.
2. Requests for missing file information are made via fax, e-mail or telephone (confirmed in writing, as necessary).
3. When missing file information is pursued, the insurer and insured person are notified of the referral's status.
4. When five days have elapsed since the request for file information was issued:
 - a. The DAC assessor will proceed to formulate an opinion using best clinical judgment and based on the information available if appropriate; or
 - b. If the DAC is unable to complete the assessment without this file information, the DAC will advise all parties that the DAC assessment is terminated and an *incomplete status* is recorded on the OCF-11.
5. Video surveillance materials or any transcript of any examination under oath pursuant to the SABS, are not accepted after the first assessment appointment is started.
6. Any additional file information (excluding new OCF-11s) received prior to the "consensus" process (as applicable) is considered in the final opinion.

Guidelines

The insurer should:

1. Provide requested missing file information to the DAC as is reasonably necessary within five business days.

The insured person should:

1. Provide requested missing file information to the DAC as is reasonably necessary within five business days.

SF 4: Recurring, Similar OCF-18s

DAC Standard

New treatment plan(s) [OCF-18(s)] in dispute for the same insured person after a DAC has been initiated or completed are screened for fundamentally similar content and processed accordingly.

Criteria

The DAC will ensure that:

1. An OCF-11 pertaining to a case already in process at the DAC is assimilated into the existing assessment process, providing it will not alter:
 - a. The DAC's ability to meet assessment and report timeframes for the original referral
 - b. The DAC's assessment plan.

2. When an OCF-11 pertaining to a case previously completed by this DAC is received, it is handled as a "Recurring OCF-18s Addendum" (also see SF 25), providing:
 - a. The OCF-18(s) in dispute are similar in:
 - i. The impairments described;
 - ii. Treatment goals;
 - iii. Goods and/or services; and
 - iv. Other elements described on the OCF-18 in the original dispute.
 - b. The data gathered and the analyses conducted in the original assessment are still timely and relevant.
 - c. There are no clinical indicators demonstrating a relevant change in the insured person's clinical status or treatment needs since the review of the previous OCF-18.
3. A new DAC Assessment Plan is prepared and issued to the insurer and insured person when a Recurring OCF-18(s) Addendum is appropriate, implementing Paper Review by a single assessor whenever appropriate.
4. An OCF-11 received that does not meet the above criteria, is handled as a distinct, new Staged-Focused DAC, implementing Paper Review by a single assessor whenever appropriate.

Guidelines

The insurer should:

1. Send a new Referral Package including a new OCF-11, OCF-18, and any relevant documentation to the DAC if it is disputing recurring, similar OCF-18(s).
2. Not reissue any referral documentation previously sent to the DAC. In this instance, the insurer should note on the OCF-11 referral form the documentation previously sent to the DAC.

Notes

A variety of circumstances lead to subsequent OCF-18s. In some instances, a subsequent similar OCF-18 is submitted to re-apply for treatment that has previously been denied by the insurer and assessed by a DAC. However, subsequent OCF-18s may also be submitted in a variety of other circumstances including for example: to continue an initial treatment plan; to address different/new goals according to the stage of recovery; to provide alternative treatments for the impairment; or to provide goods and services to address different impairments. The DAC must determine if the new OCF-18 can be handled according to the criteria described above for a "Recurring OCF-18(s) Addendum" (also see SF 25)

SF 5: Conflict of Interest

SABS Regulation

53 (11) For the purpose of this section, a designated assessment centre has a conflict of interest relating to a designated assessment if,

- (a) *the insurer, the insured person or a lawyer or other representative acting on behalf of the insurer or the insured person has a financial interest in the designated assessment centre; or*
- (b) *the designated assessment centre, a related person, an assessor or consultant who will carry out all or part of the designated assessment or a facility owned or controlled, directly or indirectly, in whole or in part, by the centre or a related person,*
 - (i) *has provided goods or services to the person to be assessed, other than a previous designated assessment,*
 - (ii) *prepared or approved a treatment confirmation form under section 37.1, a treatment plan under section 38 or an application for approval of an assessment or examination under section 38.2 for the person to be assessed, or*

- (iii) *is identified by a treatment confirmation form, treatment plan or an application for approval of an assessment or examination as a person who will provide goods or services to the person to be assessed.*

(12) *In clause (11) (b),*

“related person” means, in respect of a designated assessment centre, an owner, partner or another person who has a financial interest in the designated assessment centre, but does not include a person who has a financial interest in the designated assessment centre by reason only of being a creditor who deals at arm’s length with the designated assessment centre.

DAC Standard

The DAC and its personnel are free of any conflict of interest.

Criteria

The DAC will ensure that:

1. The conflict of interest screen is applied for all DAC personnel and assessors on the DAC’s roster.
2. The conflict of interest screen begins as soon as the referral is received.
3. Any conflicts identified are declared on OCF-11 Part 15 and faxed within three business days to the insurer and delivered to the insured person in a manner appropriate in the circumstances.
4. An insurer-signed OCF-11 Part 16, confirming that the insured person and insurer have agreed to waive the identified conflicts of interest, is received before proceeding with the assessment.

Guidelines

The insurer should:

1. Contact the insured person to confirm agreement to waive the identified conflict of interest if the insurer feels it is appropriate to waive the conflict of interest.
2. Complete, sign and return OCF-11 Part 16 to the DAC within 72 hours.
3. Refer the dispute to FSCO to select the DAC to conduct the assessment, when the insurer or insured person are not prepared to waive the identified conflict of interest.

The insured person should:

1. Agree with the insurer to waive any identified conflict of interest if the insured person feels it is appropriate to do so.
2. Agree to proceed with the assessment plan as proposed by the DAC.

SF 6: Special Needs Identification

DAC Standard

Reasonable accommodations are made for special/unique insured person needs.

Criteria

The DAC will ensure that:

1. Any special/unique insured person needs are identified, including but not limited to accessibility and interpreters.
2. Reasonable accommodations are made as a routine course of business and do not delay scheduling the DAC assessment process in any way.

Guidelines

The insurer should:

1. Notify the DAC of any special/unique insured person needs on the OCF-11, Part 1, when known.

The insured person should:

1. Notify the DAC of any special/unique needs, upon receipt of notification of assessment.

5.2.2 Assessment Planning**SF 7: Issue(s) in Dispute****DAC Standard**

The purpose and scope of the DAC assessment is identified.

Criteria**The DAC will ensure that:**

1. Issues in dispute form the basis of the assessment.
2. An assessment plan is formulated that addresses only the issues in dispute.
3. A process is formulated that stages the assessment and stops when further assessment:
 - a. Will not alter the outcome, or
 - b. Is not deemed necessary by virtue of the results of preceding assessments.

SF 8: Assessment Method**DAC Standard**

An efficient and effective process (Paper Review, Direct Assessment, or Combination Method) is used to provide a valid opinion.

Criteria**The DAC will ensure that:**

1. A Paper Review is contemplated for every referral and utilized whenever appropriate.
2. A single assessor assessment is utilized whenever appropriate.
3. In multidisciplinary assessments, a Combination methodology is utilized whenever appropriate.
4. In Combination Method assessments, one assessor will conduct a Direct Assessment and the additional assessors will conduct Paper Reviews, whenever appropriate.
5. The Direct Assessment method is used when required.

Notes

There are a number of issues in dispute on which a DAC should be able to offer an opinion using the Paper Review — for example, Recurring, Similar OCF-18s, cost, or experimental goods/services. When a Paper Review is not possible for these issues, the reason for selecting the Direct Assessment should be clearly articulated in the appropriate section of the final DAC Report. Similarly, there are a number of other possible issues in dispute that will require a Direct Assessment — for example, diagnosis or causality.

Aside from these two extremes, there remain a significant number of issues in dispute that reside in the "gray zone." They could be addressed using the Paper Review but will require individual consideration of the situation and the quality of documentation available. In addition, a Combination Method of Paper Review and Direct Assessment may be appropriate in multidisciplinary assessments.

SF 9: Assessor Selection

DAC Standard

The appropriate assessor(s) is selected to conduct the assessment.

Criteria

The DAC will ensure that:

1. A single assessor assessment is utilized whenever appropriate.
2. When the treatment plan in dispute involves only a single health professional, a single DAC assessor will complete the review.
3. When multiple assessors are required, each assessor has a distinct role and function.
4. When multidisciplinary assessments are required, a Combination Method assessment will be used whenever appropriate.
5. The assessor(s) is selected on the basis of the issues in dispute identified and the professional discipline that is most able to address all the issues in dispute.
6. An additional assessor(s) is added only to address those issues in dispute that could not be appropriately addressed by the single assessor.
7. When selecting the DAC assessor, the DAC considers the issues in dispute as identified by the insurer in the OCF 11 Section 2 Part 6C. These may include:
 - a. The reasonableness and necessity of:
 - i. The proposed goods and services
 - ii. Quantity, measure, cost (estimate/day)
 - iii. Duration
 - iv. Projected total count
 - v. Projected total cost
 - vi. All of the above
 - vii. Concurrent treatment.
 - b. Associated disputes regarding injury/impairment:
 - i. Impairment description/diagnosis
 - ii. Status
 - iii. Causality.
8. The assessor selected has specific expertise in the proposed treatment interventions and associated costs in dispute. Depending on which issues are in dispute, in most instances the DAC assessor is a regulated health professional peer whose current clinical practice (See DR 3) includes the delivery of the specific goods and/or services that are in dispute.
9. When technical/auxiliary personnel are the service providers, the service is reviewed by a regulated health professional whose scope of practice includes the delivery of the goods and/or services in dispute.
10. An assessor is not added to the assessment to explore other impairments and/or issues that are not identified as issues in dispute.
11. An assessor is not added to the assessment team to solely provide recommendations for future med/rehab goods and services.

Guidelines

The insurer should:

1. Specify the issue(s) in dispute on the OCF-11 to assist the DAC in selecting the appropriate assessor(s).

Notes

Review of Multidisciplinary Treatment Plans

When the Treatment Plan in dispute contains multiple types of goods or services or multiple providers, the DAC will need to consider OCF-11 Section 2 Part 6C as outlined above to ensure that the DAC is only addressing the issue(s) in dispute – for example, one type of treatment within the plan, the cost of a specific component within the plan, etc. In selecting the appropriate assessor(s) to

review the case, the DAC must contemplate what specific expertise in treatment interventions and associated costs is required.

If multiple components of the treatment plan are in dispute, the DAC may need to assign more than one discipline to appropriately review the components of the case in dispute. In this case, the DAC contemplates the use of a Combination Method assessment using Direct Assessment and additional Paper Reviews, as appropriate.

Whenever multiple assessors are involved, a consensus process is required.

SF 10: DAC Assessment Plan

DAC Standard

The insurer and insured person are advised of the assessment method, assessor(s) required and expected costs.

Criteria

The DAC will ensure that:

1. For all Staged-Focused DAC assessments, a DAC Assessment Plan (OCF-11, Section 4) is submitted for approval to the insurer and copied to the insured person.
2. When a Recurring, Similar OCF-18 is being reviewed, a DAC Assessment Plan is prepared and submitted for approval to the insurer and copied to the insured person (see SF 4).

Notes

A standard DAC Assessment Plan is OCF-11 Section 4. This new standard form will provide uniformity to the assessment plan content and increase the transparency of DAC assessment expenses. In addition, it will provide more information regarding the relationship of the assessment plan and associated cost to the issues in dispute.

SF 11: Approval to Proceed

DAC Standard

Intent to proceed with the DAC is confirmed.

Criteria

The DAC will ensure that:

1. It receives an insurer-signed OCF-11 Assessment Plan, Part 16 prior to commencement of the assessment.
2. If an approval is not received within 72 hours, it provides written notice to the insurance company's Accident Benefits Claims Manager that the DAC assessment will proceed.

Guidelines

The insurer should:

1. Respond to the DAC's Assessment Plan within 72 hours of receipt.

SF 12: Insured Person Contact

SABS Regulation

43. (1) 3. *The designated assessment centre shall promptly notify the insured person and arrange for the designated assessment.*
68. (1) *All notices required or permitted under this Regulation, other than a notice under subsection 24 (1.3), 32 (1) or (3.1) or paragraph 3 of subsection 43 (1), shall be in writing.*

DAC Standard

The insured person is appropriately notified regarding the assessment process.

Criteria

The DAC will ensure that:

1. When Direct Assessment is required, the insured person is contacted to arrange the necessary assessment appointments.
2. All appointments are confirmed in writing with an appointment confirmation letter (see sample in Appendix) that includes:
 - a. Adequate information regarding the purpose of the DAC assessment
 - b. The DAC's contact information and location
 - c. Any assessment preparation requirements or expectations
 - d. Request for any missing information (as per OCF-11, Part 10)
 - e. Assessment plan
 - f. Assessor name(s) and practice summary(ies)
 - g. Cancellation notification policies.
3. The insured person is willing to participate, when a Direct Assessment is required.
4. When a Paper Review is contemplated, the DAC provides written notification to the insured person advising:
 - a. That the nature of the dispute enables an opinion to be rendered on a Paper Review
 - b. The DAC's contact information and location
 - c. The anticipated Paper Review completion date
 - d. Assessor name(s) and practice summary(ies)

Guidelines

The insured person should:

1. Make him/herself reasonably available for any Direct Assessment.

SF 13: File Preparation

DAC Standard

The referral documentation is organized to expedite assessment by the assessor.

Criteria

The DAC will ensure that:

1. The referral documentation is organized to maximize efficient completion of the assessment process.

Guidelines

The insurer should:

1. Organize the referral so that:
 - a. The disputed treatment plan is immediately behind the OCF-11.
 - b. Each document is itemized (date, author, purpose) on a complete document list.
 - c. All documents, including photocopies, are legible.

- d. The documents are organized in chronological order.
- e. Only relevant documents are included – for example, no log notes or miscellaneous correspondence.

Notes

Previously the Med/Rehab DAC Guide suggested that DACs prepare “Document Highlights” to facilitate assessor review of the file. DACs are encouraged to implement whatever process is most efficient and effective for their assessor personnel.

5.3 Staged-Focused DAC Assessment Phase

5.3.1 Assessment Content

SF 14: Assessment Content (Direct Assessment, Paper Review, Combination Method)

SABS Regulation

43. (1) 4. *The insured person shall submit to all reasonable physical, psychological, mental and functional examinations requested by the person or persons who conduct the designated assessment.*

DAC Standard

An impartial, valid, clinical opinion is provided.

Criteria

The DAC will ensure that:

1. In a Paper Review the assessor uses appropriate clinical judgment and experience, including consideration of:
 - a. Documented insured person clinical status (including clinical status at time OCF-18 was completed)
 - b. File information
 - c. Clarification/information findings, when applicable (see SF 15)
 - d. Accepted clinical practice
 - e. Clinical practice guidelines
2. In a Direct Assessment, the assessor uses appropriate clinical judgment and experience, including consideration of:
 - a. All items of a Paper Review (as per #1a to 1e above)
 - b. The insured person’s input (for example, ideas, concerns, and expectations regarding impairment and recovery)
 - c. Assessment findings.
3. When a Combination Method is used, the assessor(s) uses appropriate clinical judgment and experience, including consideration of all items of a Paper Review (as per #1a to 1e above) and Direct Assessment (as per #2b and 2c above).
4. When the DAC has determined that the assessment can be completed using a Paper Review, and video surveillance is included with the referral package, the DAC will:
 - a. Review the video to establish its relevance to the formulation of an opinion regarding the issues in dispute.
 - b. If the video is deemed relevant, provide an opportunity* for the insured person to comment on the content of the video within the required DAC assessment timeframes.
5. The Direct Assessment is discontinued if the insured person’s health or safety is at risk.
6. The insured person’s primary care practitioner is notified in the event of any immediate risk to health or safety.

7. The assessor does not provide the insured person with specific clinical feedback (except in situations where there is immediate risk to health or safety) or opinions regarding the outcome of the assessment during the Direct Assessment. Results are communicated to the parties through the report.

Guidelines

The insurer should:

1. Only include video surveillance material when there is compelling information that it believes will impact the DAC assessment outcome. Insurers must be mindful of the DAC's obligations under #4 above, and the possible impact on cost and duration of the DAC assessment process.

The insured person should:

1. Co-operate with the assessment process.

Notes

*Video Surveillance (in addition, refer to General Guideline #1):

- In providing the insured person an opportunity to view and comment on the video, an assessor is not conducting a direct assessment.
- The appropriate review of video surveillance material does not delay completion of the DAC assessment process within the required timeframes.
- Why the video surveillance was used/not used in the formulation of an opinion must be articulated in the final DAC report, whether or not the insured person availed himself/herself of the opportunity to view the video surveillance.

SF 15: DAC Requests for Clarification / Information

DAC Standard

Clarification/information is sought to enhance available documentation when necessary, allowing expedient resolution to the dispute.

Criteria

The DAC will ensure that:

1. Clarification/information is sought to provide greater insight or reduce possible misinterpretation of the file documentation, when necessary.
2. Clarification/information sources are limited to the insured person, clinician(s) or insurer.
3. All communications take the most expeditious form – fax, telephone, or e-mail.
4. All communications are focused on only information necessary to formulate an opinion.
5. DAC assessors are cognizant of the potential bias introduced by these communications and diligently weigh all facts of the case.
6. The final report indicates from whom clarification/information was sought, when, how, and the outcome of each contact.
7. Interpreters are accessed as necessary.
8. When 14 calendar days have elapsed since the request for clarification/information was issued:
 - a. The DAC assessor will proceed to formulate an opinion using best clinical judgment and based on the information available if appropriate; or,
 - b. If the DAC is unable to complete the assessment without this clarification/information, the DAC will advise all parties that the DAC assessment is terminated, and an *incomplete status report* is completed [(recorded on the OCF-11 (see SF 20)].

Guidelines

The insurer should:

1. Respond to any request for clarification/information as quickly as possible to enable the assessor to proceed appropriately.

The insured person should:

1. Respond to any request for clarification/information as quickly as possible to enable the assessor to proceed appropriately.

5.3.2 Consensus Process**SF 16: Consensus Formulation****DAC Standard**

Discrepancies in findings, conclusions, or recommendations are identified and addressed.

Criteria**The DAC will ensure that:**

1. When multiple assessors are required in an assessment, the findings, opinions, conclusions, and recommendations across all assessors are discussed to formulate a consensus conclusion.
2. When concurrent care is an issue in dispute, the assessor(s) with specific expertise in the treatments described will provide the opinion regarding the concurrent care.
3. DAC personnel responsible for the consensus formulation use the most efficient means possible (e.g., conference calls, e-mail, assessment tracking logs, etc.) to arrive at a consensus conclusion.
4. When individual assessments are addressing issues independent from each other, consensus formulation may not be necessary.
5. When individual assessments agree in areas such as clinical findings, insured person history, file facts, opinions and conclusions, a consensus formulation may not be necessary.

SF 17: Consensus Conclusion**DAC Standard**

Clear assessment findings, consensus conclusions and recommendations are provided to all parties.

Criteria**The DAC will ensure that:**

1. When individual assessment reports differ in areas such as clinical findings, insured person history, file facts, opinions or conclusions, these differences are explained in the Executive Summary of the DAC Report.
2. The Executive Summary of the DAC Report indicates the consensus conclusion regarding issue(s) in dispute and recommendations for future med/rehab.
3. A consensus conclusion does not require each assessor to have exactly the same opinion. Rather, assessors discuss points of divergence and formulate a conclusion that is acceptable to all of them, given the particular circumstances of the case.
4. When assessors do not have similar opinions, the Executive Summary should outline the consensus process used and describe factors given precedence in the consensus conclusion.

5.3.3 Assessment Conclusions

SF 18: Reasonable and Necessary Test

SABS Regulation

Section 14 of the SABS states that "The insurer shall pay an insured person who sustains an impairment as a result of an accident a medical benefit" and "The medical benefit shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident".

Section 43 (8) If the designated assessment is required under section 38, the report of the designated assessment shall,

- (a) state whether the goods or services to be provided under the treatment plan are reasonable and necessary and shall include recommendations relating to the future provision of goods and services to the insured person for his or her treatment and rehabilitation, if the purpose of the designated assessment is to determine if the goods and services are reasonable and necessary;*

DAC Standard

The issues in dispute are addressed.

Criteria

The DAC will ensure that:

1. The assessor weighs all information and analyzes findings to formulate the assessment conclusion.
2. The conclusions are time-sensitive, differentiating between proposed, in progress, and consumed goods/services.
3. The conclusion indicates what portions, if any, of the goods and services in dispute are/were reasonable and necessary.

SF 19: Recommendations for Future Medical / Rehabilitation Goods and Services

SABS Regulation

43 (8) If the designated assessment is required under section 38, the report of the designated assessment shall,

- (a) state whether the goods or services to be provided under the treatment plan are reasonable and necessary and shall include recommendations relating to the future provision of goods and services to the insured person for his or her treatment and rehabilitation, if the purpose of the designated assessment is to determine if the goods and services are reasonable and necessary*

DAC Standard

Recommendations for future medical and rehabilitation goods and services are made, as appropriate.

Criteria

The DAC will ensure that:

1. Recommendations flow from the assessment outcomes.
2. Recommendations pertaining to the goods/services in dispute are specific, addressing nature, frequency, duration, and cost.
3. Recommendations for goods/services outside the scope of the treatment in dispute are more general in nature and are limited to recommendations for further investigation/assessment by an appropriate expert.
4. Recommendations do not suggest definite outcomes. Rather, they express anticipated outcomes.

5. Recommendations do not preclude future clinical assessment and treatment plan applications.
6. An assessor is not added to the team solely to address recommendations for future med/rehab.
7. Recommendations are neutral, with no specific provider or facility identified.

Notes

If the DAC assessor, in completing a Paper Review, deems that making recommendations regarding future med/rehab goods and services would not be clinically valid, this is to be noted in the recommendations section of DAC Report. This is distinctly different from an opinion that “No recommendations for future medical/rehabilitation goods and services are made at this time.”

5.4 Staged-Focused DAC Report Phase

5.4.1. Preparation

SF 20: Cover Materials

DAC Standard

A brief summary of DAC assessment results is provided.

Criteria

The DAC will ensure that:

1. At the front of every Staged-Focused DAC report there is:
 - a. A complete DAC Report Cover Sheet (see Appendix - Samples) followed by,
 - b. A legible, accurate copy of the OCF-11 Section 6 DAC Assessment Summary, clearly indicating the outcome of the Staged-Focused DAC is included.
2. When a DAC is deemed incomplete (see SF 3, SF 15), this status is indicated on the DAC Assessment Summary and the DAC Report Cover Sheet, which form the cover materials of a short narrative that indicates the reason for the incomplete status.

SF 21: Format and Structure

DAC Standard

Staged-Focused DAC Reports are formatted to enhance readability.

Criteria

The DAC will ensure that:

1. The DAC report:
 - a. Has a header/footer on each page that includes the insured person’s name and date of loss, the DAC’s name and identification number.
 - b. Is salutation-free and addressed to both parties.
 - c. Is free of any individual assessor’s letterhead.
 - d. Is free of any reference to qualifications of the assessor. Practice Summaries serve the purpose of communicating the assessor’s professional qualifications.
 - e. Places conclusions and recommendations at the front of each report, with the assessment process and clinical data details available in subsequent pages.
 - f. Uses appropriate and necessary headings to facilitate flow and communication of information.
 - g. Places the List of Documents reviewed in an appendix.
 - h. Places raw test scores/data in appendices, as necessary.

SF 22: Overall Content

SABS Regulation

43. (7) *If the designated assessment is required under section 37.2, the report of the designated assessment shall state whether the ancillary goods and services claimed in the treatment confirmation form are reasonable and necessary.*

(8) *If the designated assessment is required under section 38, the report of the designated assessment shall,*

- (a) *state whether the goods or services to be provided under the treatment plan are reasonable and necessary and shall include recommendations relating to the future provision of goods and services to the insured person for his or her treatment and rehabilitation, if the purpose of the designated assessment is to determine if the goods and services are reasonable and necessary; and*
- (b) *state whether the impairment comes within a Pre-approved Framework Guideline, if the purpose of the designated assessment is to determine if the insured person has an impairment to which a Pre-approved Framework Guideline applies.*

(9) *In the case of a designated assessment described in clause (8) (b), the report of the designated assessment centre shall also state whether the goods or services to be provided under the treatment plan are reasonable and necessary and shall include recommendations relating to the future provision of goods and services to the insured person for his or her treatment and rehabilitation, if the report states that the impairment does not come within a Pre-approved Framework Guideline.*

(10) *If the designated assessment is required under section 38.2, the report of the designated assessment shall state whether an expense in respect of an assessment or examination is payable under section 24.*

(11) *Despite subsection 53 (9), if the designated assessment is conducted to determine whether there are medical or rehabilitation benefits payable otherwise than under a Pre-approved Framework Guideline or the designated assessment is required under section 38.2, the designated assessment centre shall deliver its report to the insured person and the insurer within five business days after the later of,*

- (a) *the day it receives the information required to be provided under paragraph 2 of subsection (1); or*
- (b) *the day any conflict of interest disclosed by the designated assessment centre under section 53 in respect of the designated assessment is resolved pursuant to that section.*

DAC Standard

Staged-Focused DAC reports are impartial, concise, appropriate, and relevant.

Criteria

The DAC will ensure that the report:

1. Is internally consistent by being:
 - a. Free of typographical, grammatical and administrative errors.
 - b. Accurate in facts and details about the case (for example, all reports should indicate the same date of accident, same gender).
2. Conveys that the assessment team understands the purpose of the assessment and its role in the dispute resolution process.
3. Demonstrates that the DAC understands the scope of the Med/Rehab assessment and does not enter into issues that are not subject to the Med/Rehab dispute.
4. Is readable to the average lay reader by:
 - a. Confining clinical and technical terms to the sections of the report that describe clinical history, test results, and clinical findings.
 - b. Explaining the interpretations, implications, and analysis of data and findings.

5. Presents clear facts, findings, and opinions with information sources clearly indicated. (For example: "The report by Dr. XX indicates..." "The insured person states..." "My opinion is..."). Opinions should be explicitly stated, without inferences, innuendoes, or any need to 'read between the lines'.
6. Is free of statements, language, style, and inferences that could be construed as representing a bias. (For example: "Thank you for referring this insured person..." or "I hope this report is useful to you.", etc.)

SF 23: Executive Summary

DAC Standard

When required, an Executive Summary is provided, with a concise, clear summary of the DAC assessment consensus findings, opinions, conclusions, and recommendations.

Criteria

The DAC will ensure that:

1. The Executive Summary:
 - a. Is provided in all DAC reports involving multiple assessors as per SF 9.
 - b. Is concise, three pages or less in length.
 - c. Is comprehensive by highlighting the key facts of the case, including:
 - i. Issue(s) in dispute
 - ii. All impairments and their cause (if in dispute)
 - iii. Overall consensus conclusion(s)
 - iv. Overall consensus recommendation(s).
 - d. Addresses any discrepancies across individual reports.
 - e. Comments on the consensus process used, and explains what factors prevailed in the final consensus conclusion(s) and recommendation(s).
 - f. Addresses any extenuating circumstances impacting the assessment process, including as applicable:
 - i. The number and dates of missed, cancelled, or re-scheduled appointments
 - ii. An explanation of timeframes and/or lengthy gaps in the process that exceed the expected standard
 - iii. Why the final assessment differed from the assessment proposal in cost, team membership, or assessment quantity.

Notes

In extended authorization DACs or complex cases, the Executive Summary may exceed the three-page limit if necessary.

The List of Documents reviewed is included as an appendix to the DAC report.

SF 24: Individual Assessor Reports

DAC Standard

The assessor provides an impartial, concise, appropriate, and relevant assessment report.

Criteria

The DAC will ensure that:

1. Assessor reports:
 - a. Are concise, while conveying adequate detail regarding:
 - i. What transpired during the assessment
 - ii. Insured person's history and contextual information
 - iii. Identified impairments (within scope of practice), and

- iv. Exam findings to demonstrate an appropriate and complete assessment.
 - b. Articulate the assessor's analysis and considerations in formulating his/her conclusion(s). The assessor uses clinical judgment and experience, including but not limited to consideration of:
 - i. File information
 - ii. The insured person's clinical status (at the appropriate point in time)
 - iii. Clarification/information findings, as appropriate
 - iv. Accepted clinical practice, and
 - v. Clinical practice guidelines (where they exist).
 - c. Articulate conclusions:
 - i. Well supported by the findings and analysis documented in the report.
 - ii. Regarding the issue(s) in dispute, including the outcome of the "reasonable and necessary" test with specific reference to the frequency, duration, and cost.
 - iii. That are time-sensitive, discriminating between proposed, in progress, and consumed treatment(s).
 - d. Articulate recommendations:
 - i. Consistent with clinical findings and within the scope of the current dispute. Recommendations for provision of future goods and services are specific, commenting on treatment modalities, duration, frequency, and cost, as necessary.
 - ii. In a neutral manner, with no reference to specific providers or facilities.
 - e. Limit recommendations regarding issues or impairments identified that fall outside the scope of the current dispute or assessing discipline, to statements such as "An assessment by a XXX (insert the appropriate discipline) is recommended to address XYZ (insert the issue/impairments/etc.)". These recommendations do not address treatment modalities, duration, frequency, or cost.
 2. Where appropriate, other assessor reports may be referenced to minimize duplication of information.

Notes

When a single assessor is used, an Executive Summary is not required, and the List of Documents reviewed is included as an appendix to the individual assessor's DAC report.

SF 25: Addenda

DAC Standard

An Addendum is used to clarify an existing report or comment on recurring, similar OCF-18(s).

Criteria

The DAC will ensure that:

1. A Report Addendum is used to clarify issues, or to correct errors or omissions in the DAC report.
2. A Recurring OCF-18(s) Addendum is used to provide an opinion regarding the fundamentally similar OCF-18(s) received after a DAC has been completed on a case, considering:
 - a. The original DAC report
 - b. The original Referral Package
 - c. Any new documentation
 - d. The Recurring Similar OCF-18(s) in dispute.
3. The DAC determines that the data gathered and the analyses conducted in the original assessment are still timely and relevant. The DAC establishes that there are no clinical indicators demonstrating a relevant change in the patient's clinical status or treatment needs since the review of the previous OCF-18.

SF 26: Fees Charged

SABS Regulation

- 24 (1) *The insurer shall pay the following expenses incurred by or on behalf of an insured person:*
2. *Fees charged,*
 - i. *for a designated assessment of the insured person*

DAC Standard

DAC fees conform to published Guidelines.

Criteria

The DAC will ensure that:

1. DAC fees comply with all Guidelines as referred to in the SABS.
2. The Pre-Assessment Cancellation Fee Schedule (see Website www.fsco.gov.on.ca) is adhered to for all cancellations, no shows, and rescheduling of Direct Assessment.

Notes

Interpretation service providers must bill directly to the insurance company.

Transportation service providers must bill directly to the insurance company.

5.4.2 Report Distribution

SF 27: Distribution

SABS Regulation

- 43 (4) *After conducting a designated assessment, the persons or persons who conducted the designated assessment shall prepare a report and provide a copy of the report to,*
- (a) *the insurer;*
 - (b) *the insured person; and*
 - (c) *the insured person's health practitioner.*

(5) *Subject to subsection (11), the designated assessment centre shall deliver the report within 14 days of the completion of the designated assessment.*

DAC Standard

The DAC Report is efficiently issued to the parties at the same time and in accordance with the requirements of the SABS.

Criteria

The DAC will ensure that:

1. The complete DAC Report is issued concurrently to all parties within 14 calendar days of the final assessment.
2. With release and consent, a copy of the report is sent to the insured person's authorized representative(s).
3. Any technology that can support and advance the efficient processing of reports is used.
4. Electronic signatures are used to expedite release of reports to all parties, when the following conditions are met:
 - a. The assessor has given authorization for the DAC to use the scanned signature.
 - b. The report(s) indicates that the signatures are scanned.
 - c. The report(s) indicates that original signatures will be retained on file.
 - d. The report(s) indicates that the assessor has read and agrees with the report(s).

5. A copy of the DAC Report, including OCF-11, Executive Summary (as necessary), and Individual Assessor Reports with original signatures, is retained on file by the DAC.
6. Original signatures for the DAC file copy are secured from the assessor within 14 calendar days of releasing the DAC report.
7. When separate or independent issues are in dispute, results of one issue do not delay issuing results of the other (see Notes below).
8. In exceptional circumstances, when illness or absence of an assessor delays the timely issuing of a full DAC report, the DAC issues the OCF-11 and/or Executive Summary (as applicable) as soon as the results are known (and consensus is reached where applicable).

Notes

If separate or independent issues are in dispute (e.g., psychology and chiropractic) the DAC may issue the result of the psychology assessment prior to the result of the chiropractic assessment.

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6.1 Fast-Track DAC Overview

SABS Regulation Maximum Timeframe = 5 business days

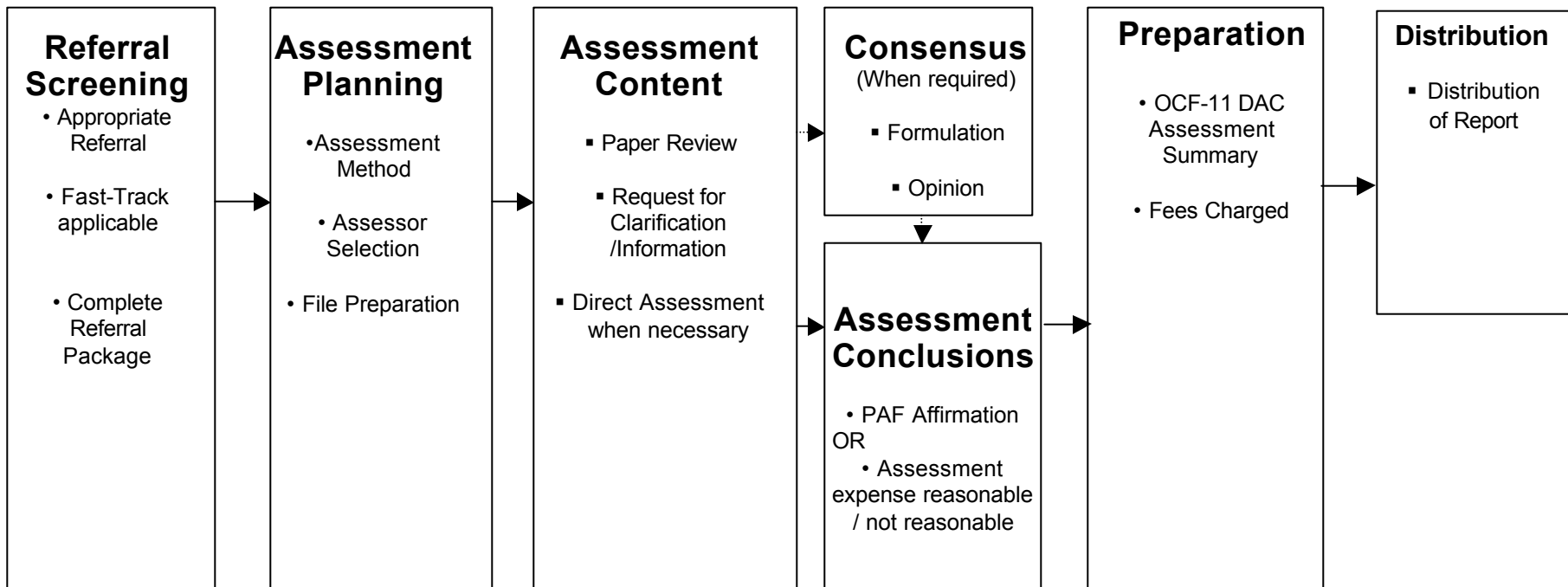
Intake Phase

Assessment Phase

Report Phase

Day 1
Complete Referral Received

Day 5
Report to Parties



6.2 Types of Fast-Track DACs

6.2.1 Application for Approval of an Assessment or Examination

Pursuant to the SABS, there are some assessments or examinations that do not require the approval of an insurer. There are other types of assessments or examinations that require an OCF-22/198 Application for Approval of an Assessment or Examination. This process shall be referred to as Application for Approval throughout the Manual.

SABS section 24 states that:

- (1.1) *An insurer is not required to pay an expense referred to in subparagraph 3 ii of subsection (1) if the expense is incurred,*
- (a) *before obtaining the approval of the insurer; or*
 - (b) *before a designated assessment is conducted and the report of the person or persons who conducted the designated assessment is delivered to the insured person and the insurer, in the case where an application for approval for an assessment or examination was made under section 38.2 and denied by the insurer.*

Application for Approval may take a variety of forms and can be generally classified into the following categories:

- Investigative or diagnostic procedures (for example, MRIs, CAT scans)
- The treating professional is seeking information to better plan/manage care and would like to refer the insured person to another provider for an assessment intended to establish point in time status or conduct the assessment him/herself (for example, FAEs, job-site analysis, in-home assessment);
- An assessment to plan treatment
- Assessments to complete disability certificates
- Assessments to complete Form 1 for attendant care
- Assessments to complete Catastrophic Impairment Applications
- Assessments for other entitlement to benefits

1) Prior approval is not required for assessment or examinations to complete treatment plans for the following:

- a) An assessment or examination where an immediate risk of harm to the insured or a person in the insured's care makes obtaining the insurer's prior approval to the assessment or examination impractical;
- b) Not more than three assessments or examinations if:
 - i) the insured has not received treatment under a *Pre-approved Framework Guideline*,
 - ii) the cost of each assessment or examination does not exceed \$180, and
 - iii) not more than one assessment or examination is done by the same person;
- c) Not more than one assessment or examination if:
 - i) the insured has received treatment under a *Pre-approved Framework Guideline*,
 - ii) the cost of the examination or assessment does not exceed \$180, and
 - iii) the person conducting the examination or assessment did not provide goods or services under a *Pre-approved Framework Guideline* in respect of the same accident;
- d) *an assessment or examination conducted after the insurer notifies the insured that, before the examination is conducted, it does not require the submission of a Treatment Plan or an application under s.38.2;
- e) **an assessment or examination conducted under the provisions of a *Guideline* that authorizes the assessment or examination without the prior approval of the insurer;

2) Prior approval is required for assessments or examinations to complete treatment plans for the following:

- a) All other assessments to complete treatment plans, not outlined above, require prior approval.

3) Assessments or examinations to complete Disability Certificates:

- a) Prior approval is not required in respect of an assessment or examination for a disability certificate if the cost of the assessment or examination for the certificate does not exceed \$180.
- b) Prior approval is required for an assessment or examination to complete disability certificates that exceed \$180.

4) Assessments or examinations to complete Form 1:

- a) Prior approval is not required in respect of an assessment or examination for the purposes of preparing a Form 1, but not an assessment or examination relating to an impairment that comes within a *Pre-approved Framework Guideline* unless the *Guideline* expressly states that the prior approval of the insurer is not required for the assessment or examination.

5) Assessments or examinations to determine Catastrophic Impairment

- a) Prior approval is not required in respect of an assessment or examination for a determination of catastrophic impairment if the insured is hospitalized or in a long-term care facility at the time of the assessment or examination. See also 1) d) * and 1) e) ** above.
- b) Prior approval is required in respect of an assessment or examination for a determination of catastrophic impairment if the insured person is not hospitalized or in a long-term care facility at the time of the assessment or examination.

6) All other assessments or examinations needing prior approval:

- a) All other assessments or examinations not outlined above require prior approval.

6.2.2 Disputes Involving a Pre-approved Framework Guideline

The intent of this section is to provide DACs with an overview of dealing with PAF Guideline referrals. The individual details of each PAF Guideline will be available on the FSCO Website {www.fSCO.gov.on.ca}, and DACs will receive regular communication regarding the development and publication of new/updated PAF Guidelines. In addition, DACs may receive periodic addenda to this Manual if new PAF Guidelines become available that could not be appropriately managed by the DAC assessment processes outlined here.

All assessments involving PAF Guideline disputes must be completed using the Fast-Track DAC process, with the DAC's opinion rendered within five business days of receipt of the complete referral. The counting of the days to completion starts the next business day after the complete DAC referral is received.

Types of PAF Guideline Disputes

There are two broad categories of disputes relating to impairments covered by a PAF Guideline.

1) Initiation of Treatment under a PAF Guideline**a) Impairment Based:**

A dispute may develop regarding the initiation of treatment under a PAF Guideline when an insurer receives an OCF-18 from a health practitioner that has made a diagnosis and prepared a Treatment Plan for an impairment that the insurer believes comes within a PAF Guideline.

b) Treatment Based:

Disputes may develop when treatment is proposed for impairments that an insurer believes come within a PAF Guideline. In these cases, the insurer will have received a Treatment Plan (OCF-18) for services other than within a PAF Guideline. Any health professional(s) proposing treatment other than within a PAF Guideline must confirm that:

- i) The accident-related impairment(s) of the person are not injuries to which a PAF Guideline applies, or
- ii) Although the accident-related impairment(s) of the person are injuries to which a PAF Guideline would otherwise apply, there are specific pre-existing occupational, functional or medical circumstances of the person that:
 - (1) Significantly distinguish the person's needs from the needs of other persons with similar impairments that come within the Guideline; and

- (2) Constitute compelling reasons why the goods and services proposed in the Treatment Plan are preferable to those provided for under the Guideline.

2) Concurrent services while under a PAF Guideline (specific to each individual impairment group)

The model of each PAF Guideline limits situations that can be subject to dispute and referral to a DAC while the patient is receiving treatment. Except for those specific situations outlined in a PAF Guideline where a patient is allowed to concurrently receive both treatment under a PAF Guideline and goods/services under a Treatment Plan, there will not be any disputes referred to DACs for concurrent treatment while the patient is under the PAF Guideline (as described in the boxes below). In determining whether the concurrent treatment proposed (OCF-18) is appropriate for a patient who is receiving treatment within a PAF Guideline, the DAC assessor must have thorough knowledge and understanding of the exceptions and parameters under which the specific concurrent services of the PAF Guideline in question are appropriate. The DAC assessor is addressing whether the proposed concurrent service is reasonable and necessary.

In both of these scenarios, the DAC assessor must have a thorough knowledge and understanding of the treatment provided within all PAF Guidelines related to the impairment or treatment in question. The DAC assessor is addressing whether the proposed treatment is reasonable and necessary.

WAD I PAF Concurrent Services

While the patient is being treated under the WAD I PAF Guideline, there may be a dispute for concurrent services:

- a) An OCF-18 completed by the Initiating Health Practitioner or another health professional on referral from the Initiating Health Practitioner.

WAD II PAF Concurrent Services

While the patient is being treated under the WAD II PAF Guideline, there may be a dispute for concurrent services:

- a) Regarding the Activities of Normal Living Intervention service; or
 b) An OCF-18 completed by the Initiating Health Practitioner or another health professional on referral from the Initiating Health Practitioner.

6.3 Fast-Track DAC Intake Phase

6.3.1 Referral Screening

FT 1: Appropriate Referral

SABS Regulation

53. (1) A designated assessment shall be conducted by a designated assessment centre selected in accordance with this section.

(1.1) A designated assessment must be conducted by a designated assessment centre that,

- (a) is authorized to assess impairments of the type sustained by the insured person; and
 (b) is authorized to conduct the type of designated assessment that is required.

(1.2) A designated assessment must be conducted by a designated assessment centre that is located within,

- (a) 30 kilometres of the insured person's residence, if,

(i) the insured person's residence is located in the City of Toronto or the regional municipality of Durham, Halton, Peel or York, and

(ii) a designated assessment centre that complies with subsection (1.1) is located within 30 kilometres of the insured person's residence; or

(b) 50 kilometres of the insured person's residence, if,

(i) the insured person's residence is not located in the City of Toronto or the regional municipality of Durham, Halton, Peel or York, and

(ii) a designated assessment centre that complies with subsection (1.1) is located within 50 kilometres of the insured person's residence.

(1.3) Subject to subsections (1.1) and (1.2), the insurer and the insured person may jointly select the designated assessment centre if the selection is made not later than the second business day after the insurer or the insured person, as the case may be, receives notice from the other that a designated assessment is required under this Regulation.

(1.4) If the insurer and the insured person do not jointly select the designated assessment centre in accordance with subsection (1.3), the Superintendent shall, subject to subsections (1.1) and (1.2), select the designated assessment centre.

DAC Standard

The DAC ensures that it has the authorization required to conduct the assessment.

Criteria

The DAC will ensure that:

1. The insured person is referred to the correct DAC type.
2. The DAC is appropriately authorized to assess the insured person (general, spinal cord, brain injury, paediatrics).
3. An opinion can be rendered and forwarded to all parties in a maximum of five business days from receipt of the complete referral documentation.
4. The referral is returned within 24 hours of receipt if:
 - a. It is an inappropriate referral
 - b. The DAC is unable to meet the Fast-Track timeframes.

FT 2: Fast-Track Required

SABS Regulation

43. (11) Despite subsection 53 (9), if the designated assessment is conducted to determine whether there are medical or rehabilitation benefits payable otherwise than under a Pre-approved Framework Guideline or the designated assessment is required under section 38.2, the designated assessment centre shall deliver its report to the insured person and the insurer within five business days after the later of,

- (a) the day it receives the information required to be provided under paragraph 2 of subsection (1); or
- (b) the day any conflict of interest disclosed by the designated assessment centre under section 53 in respect of the designated assessment is resolved under that section.

DAC Standard

The referral is processed according to the issue in dispute (i.e., Fast-Track or Staged-Focused DAC).

Criteria

The DAC will ensure that:

1. The referral is appropriate for the Fast-Track DAC process (i.e., Application for Approval of Assessment or Examination disputes).
2. If the referral should be managed as a Staged-Focused DAC process, the insurer is contacted immediately to:
 - a. Confirm transfer of the referral to the appropriate DAC process.
 - b. Confirm the insurer's and insured person's desire to proceed.
 - c. Address any need for resubmission of the Referral Package.

3. Any transfer from Fast-Track to Staged-Focused does not excessively delay the DAC process.

Guidelines

The insurer should:

1. Carefully review the referral package to ensure:
 - a. only referrals for eligible Application for Approval of an Assessment or Examination disputes are made.
 - b. any disputes related to the PAF Guideline adhere to timeframe restrictions (as outlined in Notes below).
2. Correct Section 2, OCF-11 to reflect the appropriate DAC process when an error has been made in the referral.
3. Reissue the correct OCF-11 and any other necessary referral package information to the DAC.

Notes

PAF Guideline Timeframe Restrictions

Critical Timeframes	WAD I PAF Calendar Days	WAD II PAF Calendar Days
Maximum Duration	28 Days total	70 Days total
Entry Deadline	Day 21 post accident	Day 28 post accident
Any dispute regarding impairment or treatment must be received by the DAC no later than:	Day 14 post accident	Day 21 post accident
Any dispute regarding supplementary services must be received by the DAC no later than:	N/A	Day 35 of PAF

Given that PAF Guidelines are time-limited in their application, all PAF Guidelines will be subject to strict timeframes under which a dispute can be reasonably initiated, referred to a DAC, assessed, and concluded. These processes must all be completed within the window of time that the insured person is eligible for services in/simultaneous under a PAF Guideline. For each PAF Guideline the DAC will need to ensure that it is only accepting referrals that can be appropriately processed within these insured person eligibility timeframes. Each PAF Guideline will articulate the time restraints associated with the DAC dispute resolution mechanism.

In the early stages of Bill 198 there may be some information gaps and inappropriate channeling of disputes into the Fast-Track DAC processes. DACs and insurers are expected to work collaboratively during this transition phase, until all parties have an opportunity to become fully conversant with the requirements.

FT 3: Referral Package

SABS Regulation

43 (1) *The following rules apply if a designated assessment is required under this Regulation:*

1. *The insurer shall notify the designated assessment centre within five business days.*
2. *The insured person and the insurer shall provide the person or persons who will conduct the designated assessment with such information as is reasonably necessary, within the same period of five business days referred to in paragraph 1.*

DAC Standard

All reasonably necessary assessment documentation is provided with the referral package.

Criteria**The DAC will ensure that:**

1. An **Application for Approval Referral Package** is deemed **complete** when it includes:
 - a. OCF-11
 - b. OCF-22/198 (Application for Approval of an Assessment or Examination)
 - c. OCF-14 or OCF-5 (if consent is not provided on the OCF 18 or OCF-22/198)
 - d. Insurer-signed confirmation that the insured person and the insurer have agreed to waive any Conflict of Interest (OCF-11, Part 16, as necessary).
2. A **PAF Guideline DAC Referral Package** is deemed **complete** when it includes:
 - a. OCF 11
 - b. OCF-18 or OCF-24/198 or Appendix C (as applicable)
 - c. OCF-14 or OCF-5
 - d. Insurer-signed confirmation that the insured person and the insurer have agreed to waive any Conflict of Interest (OCF-11, Part 16, as necessary).
 - e. The narrative report substantiating the service provider's objective evidence and compelling reasons for submitting the OCF-18 instead of treatment under a PAF Guideline (within 48 hours of being notified of the referral to the DAC, the service provider must submit this information to the insurer or directly to the DAC). If this information is not present in the referral package, the DAC should refer to Request for Clarification/Information FT-11.
3. Any reasonably necessary additional clinical reports and medical documentation received as part of the referral package are incorporated into the assessment. For example:
 - a. Relevant previous assessments of same/similar nature
 - b. Clinical status reports relevant to OCF-22/198 in dispute.
4. Video surveillance material is not accepted in any Fast-Track DAC.
5. The five business day timeframe for completion of the Fast-Track DAC begins on the day the complete referral is received.
6. The DAC's determination is based only on the available Referral Package and Requests for Clarification/Information (see FT-11). There is no opportunity to pursue missing file documentation.

Guidelines**The insurer should:**

1. Provide all of the above noted Referral Package documents when the referral is initiated.
2. Not submit video surveillance material for Fast-Track DACs (Application for Approval or PAF Guideline).
3. Organize the referral so that:
 - a. The disputed OCF-18 or OCF-22/198(s) is immediately behind the OCF-11.
 - b. All documents, including photocopies, are legible.
 - c. The documents are in chronological order.
 - d. Only relevant clinical reports and medical documents are included.

Notes

Initially, there may be some information gaps and inappropriate channeling of disputes into the Fast-Track DAC processes. DACs and insurers are expected to work collaboratively during this transition phase, until all parties have an opportunity to become fully conversant with the requirements.

Due to the time-sensitive nature of Fast-Track DACs, video surveillance material cannot be appropriately considered by the DAC.

FT 4: Conflict of Interest**SABS Regulation:**

53 (11) For the purpose of this section, a designated assessment centre has a conflict of interest relating to a designated assessment if,

- (a) the insurer, the insured person or a lawyer or other representative acting on behalf of the insurer or the insured person has a financial interest in the designated assessment centre; or
- (b) the designated assessment centre, a related person, an assessor or consultant who will carry out all or part of the designated assessment or a facility owned or controlled, directly or indirectly, in whole or in part, by the centre or a related person,
 - (i) has provided goods or services to the person to be assessed, other than a previous designated assessment,
 - (ii) prepared or approved a treatment confirmation form under section 37.1, a treatment plan under section 38 or an application for approval of an assessment or examination under section 38.2 for the person to be assessed, or
 - (iii) is identified by a treatment confirmation form, treatment plan or an application for approval of an assessment or examination as a person who will provide goods or services to the person to be assessed.

(12) In clause (11) (b),

“related person” means, in respect of a designated assessment centre, an owner, partner or another person who has a financial interest in the designated assessment centre, but does not include a person who has a financial interest in the designated assessment centre by reason only of being a creditor who deals at arm’s length with the designated assessment centre.

DAC Standard

The DAC and its personnel are free of any conflict of interest.

Criteria

The DAC will ensure that:

1. The conflict of interest screen is applied for all DAC personnel and assessors on the DAC’s roster.
2. The conflict of interest screen begins when the referral is received.
3. Any conflicts identified are declared on OCF-11 Part 15 and faxed to the insurer within three business days of receipt of referral.
4. An insurer-signed OCF-11, Part 16 confirming that the insurer and insured person waive the identified Conflicts of Interest, is received before proceeding with the assessment.

Guidelines:

The insurer should:

1. Contact the insured person to confirm agreement to waive the identified conflict of interest if the insurer feels it is appropriate to waive the conflict of interest.
2. Complete, sign and return the OCF-11 Part 16, to the DAC as soon as possible.
3. Request for the return of the DAC file if conflict of interest is not waived and issue a referral to another DAC in accordance with the SABS.

The insured person should:

1. Agree with the insurer to waive any identified conflict of interest if the insured person feels it is appropriate to do so.

6.3.2 Assessment Planning

FT 5: Assessment Method

DAC Standard

These assessments are intended to be completed with a Paper Review process.

Criteria

The DAC will ensure that:

1. A Paper Review assessment method is first contemplated for all Fast-Track DAC Referrals.

FT 6: Assessor Selection (Single Assessor or Multidisciplinary)

DAC Standard

The appropriate assessor(s) to conduct the assessment is selected.

Criteria

The DAC will ensure that:

1. In all **Application for Approval disputes**
 - a. The assessor is selected on the basis of the dispute (Dispute Relating to an Application for Approval of an Examination or Assessment, OCF-11, Part 6A).
 - b. When the Application for Approval dispute involves only a single health professional, a single DAC assessor will complete the review.
 - c. When multiple assessors are used, each assessor has a distinct role and function. An assessor is added only to address those issues in dispute that could not be appropriately addressed by a single discipline.
 - d. The assessor selected:
 - i. Has specific expertise with the impairments described.
 - ii. Is a regulated health professional peer whose current clinical practice (see DR 3) includes the use of the assessment methodologies in the Application for Approval in dispute.
 - iii. Has specific expertise in the associated costs of the issues in dispute.
 - e. When technical/auxiliary personnel are the assessment providers, the dispute is reviewed by a regulated health professional whose scope of practice includes the use of the assessment methodologies in the Application for Approval in dispute.
2. In all **PAF Guideline DACs**:
 - a. A single assessor assessment is conducted.
 - b. The DAC assessor is a professional peer of the service provider or initiating health practitioner whose treatment is in dispute (OCF-18, Part 5 or Part 11 & 12; OCF-24/198, Part 5).
 - c. The assessor has expertise in the impairment(s) treated under the PAF Guideline in dispute.
 - d. The assessor has expertise regarding the goods and services delivered and expected outcomes within the PAF Guideline in dispute.

Notes

Applications for Approval of Multidisciplinary Assessments

When the Application for Approval (OCF-22/198) contains multiple types of assessments or multiple assessment providers, the DAC will need to pay particular attention to the Reason for Referral (OCF-11, Part 6A) to ensure that the DAC is only addressing the issue(s) in dispute – for example, one assessment within the plan, the cost of a specific component within the plan, etc. In selecting the appropriate assessor to review the case, the DAC must contemplate what specific expertise in assessment interventions and associated costs is required.

If only one assessment or some component of the plan is in dispute, the DAC should proceed to assign the professional peer of the provider (OCF-22/198, Part 9) whose assessment or component of assessment is in dispute.

If multiple assessments within the plan are in dispute, the DAC may or may not need to assign more than one discipline to appropriately review the components in dispute.

If the issue is appropriateness of the multidisciplinary approach or combination of assessments being proposed, the DAC will be guided in its assessor selection by the provider(s) listed in OCF-22/198, Part 9. In these cases, the DAC may need to take a much more active role by facilitating a consensus opinion of the DAC assessors.

FT 7: Insured Person Contact

SABS Regulation

43 (1) *The following rules apply if a designated assessment is required under this Regulation:*

1. *The insurer shall notify the designated assessment centre within five business days.*
2. *The insured person and the insurer shall provide the person or persons who will conduct the designated assessment with such information as is reasonably necessary, within the same period of five business days referred to in paragraph 1.*
3. *The designated assessment centre shall promptly notify the insured person and arrange for the designated assessment.*

DAC Standard

Appropriate notification regarding the assessment process is provided to the insured person.

Criteria

The DAC will ensure that:

1. It provides the insured person with notice of the DAC (the notice may, but need not be, in writing (i.e., verbal notice, for example by telephone, would be adequate.) If in writing, the notice may be delivered in any one of the methods described in SABS s. 68).

Guidelines

The insurer should:

1. Inform the insured person of the need to provide the DAC “with such information as is reasonably necessary, within the same period of five business days referred to in paragraph 1.”

FT 8: Assessment Plan

DAC Standard

Fast-Track DACs have a standard fee and process, eliminating the need for an Assessment Plan.

Criteria

The DAC will ensure that:

1. It adheres to the standard fee and process for Fast-Track DACs.

FT 9: File Preparation

DAC Standard

The referral documentation is organized to expedite assessment by the assessor.

Criteria

The DAC will ensure that:

1. The referral documentation is organized to maximize efficient completion of the assessment process.

Guidelines

The insurer should:

1. Organize the referral so that:
 - a. The disputed OCF-18(s) or OCF-22/198(s) is immediately behind the OCF-11.
 - b. All documents, including photocopies, are legible.
 - c. The documents are in chronological order.
 - d. Only relevant clinical reports and medical documents are included.

6.4 Fast-Track DAC Assessment Phase

6.4.1 Assessment Content

FT 10: Assessment Content (Paper Review)

DAC Standard

An impartial, valid, expert opinion regarding the issues in dispute is provided.

Criteria

The DAC will ensure that:

1. In all **Application for Approval disputes**, the assessor uses clinical judgment and experience, including consideration of:
 - a. File documentation
 - b. Clarification/information findings, if applicable
 - c. Insured person's clinical status (at appropriate point in time)
 - d. Accepted clinical practice
 - e. Clinical practice guidelines.

The DAC will ensure that:

1. In all **PAF Guideline disputes**, the assessor duly considers:
 - a. File documentation
 - b. Clarification/information findings, if applicable
 - c. The appropriate test as set out in the PAF Guidelines, i.e., whether:
 - i. The accident-related impairment(s) of the person are not injuries to which a PAF Guideline applies, or
 - ii. Although the accident-related impairment(s) of the person are injuries to which a PAF Guideline might otherwise apply, there are specific pre-existing occupational, functional or medical circumstances of the person that:
 1. significantly distinguish the person's needs from the needs of other persons with similar impairments that come within the Guideline; and
 2. constitute compelling reasons why the goods and services proposed in the treatment plan are preferable to those provided for under the Guideline.

FT 11: Requests for Clarification / Information

DAC Standard

Clarification/information is sought to enhance available documentation when necessary, allowing expedient assessment of the issue(s) in dispute.

Criteria

The DAC will ensure that:

1. Clarification/information is sought to provide greater insight or reduce possible misinterpretation of the file documentation, when necessary.
2. Clarification/information sources are limited to the insured person, clinician(s) or insurer.
3. All communications take the most expeditious form – fax, telephone, or e-mail.
4. All communications are focused only on information necessary to formulate an opinion.
5. DAC assessors are cognizant of the potential bias introduced by these communications and diligently weigh all facts of the case.
6. The final report indicates from whom clarification/information was sought, when, how, and the outcome of each contact.
7. Interpreters are accessed as necessary.
8. When 48 hours have elapsed since initiation of the request for clarification/information and no information has been received, the assessor will proceed to formulate an opinion using best clinical judgment and based on the information available.

9. The request for clarification/information does not delay the distribution of the report beyond the five business day period stipulated in the SABS.

Guidelines

The insurer should:

1. Respond to any request for clarification/information as quickly as possible to enable the assessor to proceed appropriately.

The insured person should:

1. Respond to any request for clarification/information as quickly as possible to enable the assessor to proceed appropriately.

6.4.2 Consensus Process

FT 12: Consensus Formulation (Application for Approval Only)

DAC Standard

Discrepancies in findings or conclusions are identified and addressed.

Criteria

The DAC will ensure that:

1. When multiple assessors are required in an assessment, the findings, opinions, and conclusions from all assessors are discussed to formulate a consensus conclusion.
2. The assessors specifically provide an opinion regarding the appropriateness of the multidisciplinary approach or combination of assessments being proposed, when either is an issue in dispute.
3. DAC personnel responsible for the consensus process use the most efficient means possible (e.g., conference calls, e-mail, assessment tracking logs, etc.) to arrive at a consensus opinion.
4. When individual assessments are addressing issues independent from each other, a consensus process may not be necessary.

FT 13: Consensus Conclusion (Application for Approval Only)

DAC Standard

Clear assessment findings and conclusions are provided to all parties.

Criteria

The DAC will ensure that:

1. The consensus conclusion is provided on the OCF-11.
2. A consensus conclusion does not require each assessor to have exactly the same opinion. Rather, assessors discuss points of divergence and formulate a conclusion that is acceptable to all of them, given the particular circumstances of the case.
3. When assessors do not have similar opinions, the Executive Summary should outline the consensus process used and describe factors given precedence in the consensus conclusion.

6.4.3 Assessment Conclusions

FT 14: Reasonable Fee and Reasonably Required

SABS Regulation

43 (10) If the designated assessment is required under section 38.2, the report of the designated assessment shall state whether an expense in respect of an assessment or examination is payable under section 24.

DAC Standard

The DAC establishes whether the expense proposed in the Application for Approval of an Assessment or Examination is a reasonable fee charged, or the expense is reasonably required in relation to a benefit or determination.

Criteria

The DAC will ensure that:

1. The assessor weighs all information and analyzes findings to formulate the assessment conclusion.
2. The conclusion indicates whether the expense proposed in the Application for Approval of an Assessment or Examination is:
 - a. A reasonable fee for an examination or assessment; and
 - b. If the expense is reasonably required in relation to a benefit claimed, or for the preparation of a treatment plan, disability certificate, Form 1, or determination of catastrophic impairment.
3. If the DAC determines that the expense proposed in the Application for Approval of an Assessment or Examination is not payable in accordance with section 24, the DAC will state what part of the proposed expense it determines is payable in accordance with section 24.

FT 15: PAF Guideline Affirmation

SABS Regulation

43 (7) *If the designated assessment is required under section 37.2, the report of the designated assessment shall state whether the ancillary goods and services claimed in the treatment confirmation form are reasonable and necessary.*

(8) *If the designated assessment is required under section 38, the report of the designated assessment shall, (b) state whether the impairment comes within a Pre-approved Framework Guideline, if the purpose of the designated assessment is to determine if the insured person has an impairment to which a Pre-approved Framework Guideline applies.*

(9) *In the case of a designated assessment described in clause (8) (b), the report of the designated assessment centre shall also state whether the goods or services to be provided under the treatment plan are reasonable and necessary and shall include recommendations relating to the future provision of goods and services to the insured person for his or her treatment and rehabilitation, if the report states that the impairment does not come within a Pre-approved Framework Guideline.*

DAC Standard

The appropriateness of the PAF Guideline to the impairment is established.

Criteria

The DAC will ensure that:

1. The conclusions are well supported by the findings and analysis documented in the report.
2. The assessor specifically indicates whether based on specific objective findings:
 - i. The accident-related impairment(s) of the person are injuries to which a PAF guideline applies.
 - ii. The accident-related impairment(s) of the person are not injuries to which a PAF Guideline applies and whether the goods or services to be provided under the treatment plan are reasonable and necessary for the impairment. The report shall also include recommendations relating to the future provision of goods and services to the insured person for his or her treatment and rehabilitation.
 - iii. Although the accident-related impairment(s) of the person are injuries to which a PAF Guideline might otherwise apply, there are specific pre-existing occupational, functional or medical circumstances of the person that:
 1. significantly distinguish the person's needs from the needs of other persons with similar impairments that come within the Guideline; and
 2. constitute compelling reasons why the goods and services proposed in the treatment plan are preferable to those provided for under the Guideline.

6.5 Fast-Track DAC Report Phase

6.5.1 Preparation

FT 16: Fast-Track DAC Report

DAC Standard

The DAC Report clearly articulates the assessment finding in accordance with the SABS.

Criteria

The DAC will ensure that:

1. The OCF-11, Section 6 DAC Assessment Summary constitutes the final, full Fast-Track DAC report.
2. The form is completed accurately and legibly.
3. The form clearly indicates the outcome of the DAC assessment.

FT 17: Fees Charged

DAC Standard

DAC fees conform to published Guidelines.

Criteria

The DAC will ensure that:

1. DAC fees comply with all Guidelines as referred to in the SABS.
2. Fast-Track DACs will not encounter cancellations and therefore do not charge any related fees.

Notes

Interpretation service providers must bill directly to the insurance company.

6.5.2 Report Distribution

FT 18: Report Distribution

SABS Regulation

43 (4) *After conducting the designated assessment, the persons or persons who conducted the designated assessment shall prepare a report and provide a copy of the report to,*

- (a) *the insurer;*
- (b) *the insured person; and*
- (c) *the insured person's health practitioner.*

DAC Standard

The DAC Report is efficiently issued to the parties at the same time.

Criteria

The DAC will ensure that:

1. The form is sent to the parties within five business days of the receipt of a complete referral.
2. The completed form is sent from the DAC facility.

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Sample: Notice of Staged-Focused Designated Assessment

Claim Number:	
Policy Number:	
Date of Accident:	

**Part 1
Information
Regarding
Paper Review
Assessment**

Our Designated Assessment Centre (DAC) will be conducting a Paper Review assessment to resolve a dispute between you and your insurance company. You should have received an OCF-11 notice regarding this assessment from your insurance company. We are required to provide an opinion regarding this dispute within 14 days of completing the assessment (Staged-Focused DAC).

The dispute is regarding:

Treatment Plan (OCF-18) dated: _____

This assessment will be conducted according to the Medical and Rehabilitation Designated Assessment Centre – DAC Assessment Manual issued by the Minister’s Committee on the Designated Assessment Centre System, August 2003. A copy of the Assessment Manual is available from the Financial Services Commission of Ontario at www.fsco.gov.on.ca or by calling 1-800-668-0128.

The nature of the dispute enables us to complete our assessment by reviewing documentation provided by the health professional completing the Treatment Plan noted above. If there is video surveillance information in the referral package from your insurance company, we will review it. If this video surveillance information is deemed relevant to us in forming our opinion, we will telephone you to arrange a time for you to view the video surveillance with a DAC assessor. In addition, if we have any other questions or require clarification/information regarding your situation, we will telephone you.

You are **not required** to attend any appointments or examinations at this time.

We will forward the results of our Review to you, your health practitioner, your authorized legal representative (if you have one), and your insurer when it is complete.

Name of DAC Representative (please print)	Signature of DAC Representative	Date (YYYYMMDD)
---	---------------------------------	-----------------

**Part 2
Designated
Assessment
Centre
Information**

To be completed by the DAC

Facility Name		DAC Number	
Address			
City		Province	Postal Code
Contact Last Name		Contact First Name	
Telephone Number	Fax Number	E-mail	

Sample: Notice of Fast-Track Designated Assessment

Claim Number:	
Policy Number:	
Date of Accident:	

**Part 1
Information
Regarding
Paper Review
Assessment**

Our Designated Assessment Centre (DAC) will be conducting a Paper Review assessment to resolve a dispute between you and your insurance company. We are required to provide an opinion regarding this dispute within five business days (Fast-Track DAC) of its referral to us. You should have received notice regarding this assessment from your insurance company.

The dispute is regarding:

- Treatment Plan (OCF-18) dated: _____
- Treatment Confirmation form (OCF-23/198):
 - Ancillary Goods and Services (WAD II)
 - Other Services within the PAF Guideline requiring insurer approval
- Application for Approval of an Assessment or Examination (OCF-22/198) dated: _____

This assessment will be conducted according to the Medical and Rehabilitation Designated Assessment Centre – DAC Assessment Manual issued by the Minister’s Committee on the Designated Assessment Centre System, August 2003. A copy of the Assessment Manual is available from the Financial Services Commission of Ontario at www.fSCO.gov.on.ca or by calling 1-800-668-0128.

The nature of the dispute enables us to complete our assessment by reviewing documentation provided by the health professional completing the Treatment Plan or the Request for Approval of Examination or Assessment noted above. If we have any questions or require clarification/information regarding your situation, we will telephone you. You are **not required** to attend any appointments or examinations.

We will forward the results of our Review to you, your health practitioner and insurer when it is complete.

Name of DAC Representative (please print)	Signature of DAC Representative	Date (YYYYMMDD)

**Part 2
Designated
Assessment
Centre
Information**
To be completed by the
DAC

Facility Name		DAC Number	
Address			
City	Province	Postal Code	
Contact Last Name		Contact First Name	
Telephone Number	Fax Number	E-mail	

Sample: Notice of Staged-Focused Direct Assessment

The notice to the insured person regarding the Med/Rehab DAC direct assessment includes, but is not limited to, the following details:

- The purpose of the assessment
- The date(s) of appointment(s)
- A copy of the DAC Assessment Plan
- A copy of each assessor's Practice Summary
- List of Documents, outlining how to contribute to it
- What the person needs to do to participate in the assessment (for example, wear loose clothing, etc.)
- What the person needs to bring to the assessment (for example, list of medications, etc.)
- What will be involved in the assessment
- Information regarding interpreters or other special accommodations
- Location of DAC with directions and map
- Information regarding whom the insured person should contact with questions of the DAC.

This information may be divided into two documents – an appointment letter and Med/Rehab DAC Assessment Information. Examples are outlined below.

Appointment Letter:

Dear (Insured Person),

As per the OCF-11 form we received from your insurance company, we have scheduled a DAC Medical and Rehabilitation Assessment for you at our clinic. The purpose of this designated assessment is to assess your motor vehicle accident related injuries and to determine the reasonableness and necessity of your treatment/expenses in dispute.

A XX will see you. This assessor's Practice Summary is enclosed, along with general **Information for Insured Persons**, outlining what to expect in the assessment.

Your assessment is scheduled for:

XXXX

XXXX

XXXX

If you require prescription eyewear, please bring it with you to the assessment. In addition, bring any X-rays, lab results, medications, or copies of any medical reports that may relate to your present problem. An Assessment Plan, including a list of documents received from your insurance company, is enclosed for your information and review.

If you require an interpreter or any physical assistance, please notify us as soon as possible. If you require further information or assistance after reading the enclosed information, please contact XXX

Sincerely,

cc: Insurer
Authorized legal representative

Med/Rehab DAC Information for Insured Persons

What is a Designated Assessment Centre?

Designated Assessment Centres (DACs) are independent clinics with many kinds of medical and rehabilitation professionals on staff. These clinics are not run by insurance companies or by the government. Like all doctors, nurses, physiotherapists, chiropractors, and other health-care professionals, professional colleges regulate DAC assessors. As well, the Minister's Committee on the DAC System (DAC Committee) must approve each DAC operating in Ontario.

DACs conduct assessments of automobile accident claimants. When a claimant and his/her insurance company cannot agree and need an unbiased opinion, a referral is made to a DAC. This means the DAC assessment is fair to both you and your insurance company and provides an opinion that is based on an appropriate assessment.

Once we have completed our assessment, a copy of our report will be sent to you, your insurance company, your health-care practitioner, and your authorized legal representative (if you have one). If you disagree with the results of the assessment, you may dispute the findings by applying for mediation with the Financial Services Commission of Ontario (FSCO). You can get an application form from your insurance company. For further information or assistance, call FSCO at 1-800-668-0128, or see the FSCO Web site at www.fSCO.gov.on.ca.

What will the assessment involve?

The purpose of your assessment is detailed in the enclosed Assessment Plan. The assessment follows the Insurance Act of Ontario, the Statutory Accident Benefits Schedule, and the Med/Rehab DAC Assessment Manual published by the DAC Committee. The Assessment Plan is a written outline of how we intend to proceed with your assessment and an estimate of how much it will cost. Your insurance company is required by law to pay for the assessment, and you are expected to co-operate with the assessment process. We have already reviewed documents sent to us by your insurance company. If you have other information you believe is relevant to our assessment, you should phone us to arrange for this information to be sent as soon as possible. The final two items you will find enclosed are "Assessor Practice Summaries" and the appointment confirmation letter. The practice summaries provide you with a brief overview of the qualifications and experience of the health-care professionals who will be part of your assessment team. If you find that you have been previously assessed by or treated by one of these individuals, you should call us with this information.

Your assessment will involve coming to our centre for your appointment(s). Each member of our assessment team will interview you and explain the part of the assessment he/she is completing, and give you an opportunity for input or to ask any questions. Please note your appointment(s) on your calendar and let us know at once if you will have a problem keeping the appointment(s).

What do I need to bring?

You should bring your X-rays, prescription eyeglasses (if used) and any aids or adaptations that you have been using since your accident that might make you more comfortable or assist you. You will be asked about any medications that you are taking, so it will be helpful to write these down and bring this list with you.

You should wear comfortable clothing and shoes, and bring shorts and a T-shirt. DACs do not provide childcare. Please do not bring children who require supervision with you to the assessment.

Special Assistance

If English is your second language and you would like an interpreter, we will make the necessary arrangements. In all probability, this has already been arranged for you. If you are physically challenged or require any other special assistance, please telephone XXX immediately, so we can make the necessary arrangements to accommodate you.

What is expected of me?

The Statutory Accident Benefits Schedule says that you must co-operate with this assessment and make any necessary information available to the assessors. This means that you should make the assessment a priority, not miss your appointment(s), and assist by co-operating with the assessment. Co-operating with the assessment will mean giving the assessors information they need to understand your situation and ongoing medical problems. If you do not co-operate with the DAC or you do not show up for your appointment(s), your insurer may terminate your benefits. Please speak to your insurer or legal representative for further details.

Cancellation

Please note that we require five (5) full business days' notice in case of cancellation. A fee will be charged for a late cancellation or a missed appointment.

Whom can I contact if I have questions?

If you have questions about the assessment or any problems that you think will interfere with your ability to attend the assessment, please contact: XXX

How do I find the assessment centre?

Please see the map and directions attached.

Sample: Report Cover Sheet

Designated Assessment Centre - Medical & Rehabilitation Assessment Report
Cover Sheet
 (DAC name) (DAC id. #)

DAC File Number:

	Claimant	Insurer	Legal Representative	Claimant Practitioner
Name:				
Address:				
Phone:				
Fax:				
Claim #				
DOL				

DAC Assessment Team:

Assessor Name	Discipline/Speciality	Date(s) of Assessment	Number Missed / Cancelled (if any)

Process Dates:

Referral Received Date	
Complete Referral Received Date (if different)	
Assessment Plan Sent Date	
Approval Received Date	
Assessment Start Date	
Assessment Completion Date	
Report Completion Date	
DAC Assessment Cancellation Date (as applicable)	
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