Welcome to the World of the *SABS* - Out with the PAF in with the MIG:
A review of the Application of the Minor Injury Guideline in *SABS* Claims

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On September 1, 2010, Ontario Regulation 34/10 – the Statutory Accident Benefit Schedule (the "*SABS*") came into effect. Within this regulation, there were a number of changes that have affected an insured's entitlement to accident benefits and how claims should be evaluated. At the core of these changes was the development of the Minor Injury Guideline (the "MIG") (*Guideline No.02/10*), issued in June 2010, which replaced the Pre-Authorized Framework (the "PAF") for minor injuries. In order to provide further guidance to insurance companies and professionals working in the area of automobile insurance in Ontario, the Financial Services Commission of Ontario ("FSCO") released a revised MIG (*Guideline No.02/11*) which came into effect on November 1, 2011.

The purpose of this article is to provide a brief overview and some guidance with respect to the MIG and the specific sections of the *SABS* which may apply. Additionally, I will address the MIG's objectives, the treatment phases and fee schedule which apply, and provide insight into how certain accident benefits may be affected, if an insured is found to have predominantly a "minor injury" as defined under the *SABS*. Although this article will focus primarily on matters surrounding the MIG, in consideration of the substantial changes under the *SABS*, I have also highlighted other areas that should be considered when evaluating a claim.

The MIG's objectives

The MIG was developed in consultation with insurance industry stakeholders, healthcare professionals and legal representatives drawing extensively on findings surrounding the treatment of whiplash and associated disorders. Studies showed that for both whiplash associated disorders ("WAD") and other neck pain without radicular symptoms, "*interventions that focused on regaining function and returning to work as soon as possible were relatively more effective than interventions that did not have such a focus*."[1] Accordingly, the MIG is based on the functional restoration model with a structured 12-week program broken into three phases.[2] The focus of the program is not to only provide the insured with the knowledge to effectively self-manage their condition, but most importantly, to reduce the risk of developing chronic pain. The hope is that, although the insured's impairment may not be resolved within the recommended 12-week period, they will have been provided with the knowledge, education and strategies to help return them to full function within a reasonable amount of time without further treatment.

FSCO has indicated that the objectives of the MIG are to:

> *(1) speed access to rehabilitation for persons who sustain minor injuries in auto accidents;*
>
> *(2) improve utilization of health care resources;*
>
> *(3) provide certainty around cost and payment for insurers and regulated health professionals;*

[1] Spine: 15 February 2008, Volume 33, Issue 4S (p.S5-S7).
[2] FSCO Superintendent's *Guideline No.02/11, s. 8.*

(4) be more inclusive in providing access to treatment without insurer approval for those persons with minor injuries as defined in the SABS and as set out in part 2 of the MIG.[3]

Consistent with these objectives, the MIG sets out the goods and services that will be paid for by the insurer "without prior-approval", set at a maximum amount of $2,200, provided the insured sustained a "minor injury" and the Treatment Confirmation Form (OCF-23) has been submitted within 10 business days of the initial visit with the health practitioner.[4] In response, and within 5 business days, an insurer must acknowledge receipt of the OCF-23 and advise if the person claiming benefits is an insured person with respect to the accident[5]. Following this, no further approval is required to access the pre-approved funding within the MIG. It is important to note that if the goods or services available under the MIG have not been provided within the time specified, the insured must submit a Treatment and Assessment Plan (OCF-18) for approval in order to obtain medical and rehabilitation benefits to which the MIG would otherwise apply.[6]

Defining "Minor Injury"

Although similar to the PAF guideline which was released by FSCO in 2003, the MIG provides a more defined parameter as to what constitutes a "minor injury". While the PAF included only WAD I and WAD II injuries and the complaints and/or symptoms associated with these injuries, the "*minor injury*" definition is more expansive and includes a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelae to such an injury.[7] The MIG has gone even further and has also defined the terms "sprain", "strain" and "subluxation".

Pursuant to section 18(1) of the *SABS*, the medical and rehabilitation benefits payable to an insured who sustains an impairment that is predominantly a minor injury "shall not exceed $3,500 for any one accident, less the sum of all amounts paid in respect of the insured in accordance with the MIG."[8] This amount also includes all fees and expenses for conducting assessments and examinations and preparing reports in connection with any benefit.

At fist glance, as there is a more expansive definition as to what constitutes a "minor injury" in both the MIG and the *SABS*[9] and a more restrictive structure for funding, it would appear that there is little wiggle room for skirting a minor injury diagnosis and the consequential monetary limit of $3,500 which applies. However, as will be addressed below, there appears to be many areas that have been left open to interpretation.

Pre-existing medical condition and compelling evidence

The $3,500 minor injury limit on medical and rehabilitation benefits, as set out in the *SABS*, does not apply to an insured if his or her health practitioner determines and provides "compelling evidence" that the insured has a pre-existing medical condition that, if subject to the $3,500 minor injury limit or if

[3] FSCO Superintendent's *Guideline No.02/11, s. 1.*
[4] FSCO Superintendent's *Guideline No.02/11, s. 7 (c)(ii).*
[5] O. Reg. 34/10, s. 40(3).
[6] O. Reg. 34/10, s. 40(7).
[7] FSCO Superintendent's Guideline No.02/11, s. 2.
[8] O. Reg. 34/10, s. 18(1).
[9] O. Reg. 34/10, s. 3.

limited to the goods and services authorized under the MIG, will prevent the insured from achieving maximal recovery from the minor injury.[10]

The compelling evidence should be provided using an OCF-18 with attached medical documentation, if any, prepared by a health practitioner. It has yet to be determined what arbitrators or the courts will consider to be sufficient in terms of "compelling evidence". This is an area where the MIG and the *SABS* have provided little to no guidance. The MIG does outline that the existence of any pre-existing condition will not automatically exclude an insured's impairment from the MIG as "*it is intended and expected that the vast majority of pre-existing conditions will not do so*".[11]

While the exception relating to pre-existing medical conditions applies to the $3,500 minor injury limit for medical and rehabilitative benefits, it does not entitle an insured to expenses for in-home assessments and/or attendant care benefits, as I have outlined in further detail below.

Entitlement to accident benefits for predominantly a minor injury

Without providing a comprehensive list, the *SABS* outlines the following accident benefits which an insured may or may not be entitled to if he or she sustains an impairment that is predominantly a minor injury:

- ***In-home assessments****:* These assessments are not permitted under the *SABS*. Section 25(2) of the *SABS* provides that an insurer is not required to pay for an assessment or examination conducted in the insured's home unless the insured has sustained an impairment that is not a minor injury.

- ***Attendant care benefits****:* Pursuant to section 14(2) of the *SABS*, an insurer is not liable to pay attendant care benefits if the impairment is a minor injury.

- ***Caregiver and housekeeping and home maintenance benefits*****:** These benefits have been eliminated in non-CAT cases unless "optional benefits" have been purchased. If optional benefits have been purchased, even if the impairment sustained by the insured is not a catastrophic impairment, the insured is entitled to receive caregiver[12] and housekeeping and home maintenance[13] benefits regardless of whether his or her impairment is predominantly a minor injury.

  However, I note that for motor vehicle accidents which occurred after September 1, 2010, wherein the insured still had an automobile insurance policy that came into effect pre-September 1, 2010, their policies continued, for the most part, on the same terms and conditions as contracted prior to September 1, 2010 (i.e. under the old *SABS*). As such, it is always important to reference the transitional rules, found at section 68 of the *SABS*, to ensure which benefits the insured would be entitled to receive regardless if he or she was not catastrophically impaired or had not purchased optional benefits.

[10] O. Reg. 34/10, s. 18(2).
[11] FSCO Superintendent's *Guideline No.02/11, s. 4.*
[12] O. Reg. 34/10, s. 28(1)(2)(i).
[13] O. Reg. 34/10, s. 28(1)(2)(ii).

Under these circumstances, if an insured was determined to have a minor injury but had a pre-September 1, 2010 policy still in place, the insured would be entitled to caregiver and housekeeping and home maintenance benefits. The insured's entitlement to benefits would only shift to the new regime (*SABS* 2010) if the insured's policy had terminated or was renewed post-September 1, 2010, but prior to the motor vehicle accident**.**

- ***Income replacement benefits***: This benefit is not linked to a minor injury or the MIG. In order to apply for IRBs, an insured's Application for Benefits (OCF-1) must be accompanied by a Disability Certificate (OCF-3) which confirms the insured suffered a substantial inability to perform the essential tasks of his or her employment. Any form completion fee paid would be deducted from the insured's $3,500 minor injury limit on medical and rehabilitation benefits.

REFERENCE CHART

BENEFIT	***SABS* – Section/MIG**	**MIG – s. 40**	**MIG EXEMPT due to prior injury –s.18 (2)**	**NOT MIG/NOT CAT**
Medical & Rehabilitation Benefit	*Guideline No.02/11* *s.18(1)*	*$2,200, without prior approval* *Maximum of $3,500*	*Maximum of $50,000 (or $100,000 if pre-Sept. 2010 policy/ or $100,000/$1,100,000 if optional coverage purchased)*	*Maximum of $50,000 (or$100,000/$1,100,000 if optional coverage purchased)*
In-Home Assessments	*s.25(2)*	*NO*	*NO*	*YES*
Attendant Care Benefits	*s.14(2)*	*NO*	*NO*	*YES*
Caregiver Benefits *	*s.28(1)(2)(i)*	*YES only if pre-Sept. 2010 policy/or purchased optional coverage*	*YES only if pre-Sept. 2010 policy/or purchased optional coverage*	*YES only if pre-Sept. 2010 policy/or purchased optional coverage*
Housekeeping and Home Maintenance Benefits *	*s.28(1)(2)(ii)*	*YES only if pre-Sept. 2010 policy/or purchased optional coverage*	*YES only if pre-Sept. 2010 policy/or purchased optional coverage*	*YES only if pre-Sept. 2010 policy/or purchased optional coverage*
Income Replacement Benefits	*s.5(1)*	*YES*	*YES*	*YES*

******* *Transitional rules at section 68 of the SABS may apply*

Treatment Blocks

During the insured's initial visit with a health practitioner, $215 is allocated and pre-approved under the MIG for the assessment and completion of the OCF-23.

The pre-approved goods and services available under the MIG are divided into three blocks. Block 1 includes $775 in goods and services for the first four weeks of treatment after the accident. Block 2 makes $500 available for treatment in weeks five through eight. During the final block of treatment, Block 3 weeks nine through twelve, the insured has access to $225 of treatment. If the insured reaches maximal recovery during any of the phases, he or she should be discharged from the MIG. Once treatment under

the MIG is completed, the health practitioner should complete the Minor Injury Discharge Report (OCF-24) at a pre-approved fee of $85.

There are additional funds available under the MIG to provide supplementary goods and additional services to support restoration of functioning and address barriers to recovery up to a maximum cost of $400 without prior insurer approval. Without providing a comprehensive list, this may include treatment for additional minor injuries arising from the same accident, goods required for self-directed exercise or pain management (i.e. gym ball, hot/cold pack), assistive devices required to maintain/return to work or school and supportive interventions such as advice/education to deal with accident-related psycho-social issues (i.e. driving stress). Although the MIG and the *SABS* do not specifically speak to "psychological issues", sections 7(b) and 8(d) of the MIG seem to acknowledge the possibility that some psychological difficulties can be dealt with under the MIG.

There is also a transfer fee of $50 available, which is effectively an administration fee; it is accessed only if the insured switches service providers or facilities while being treated within the MIG. In addition, the MIG also includes an optional monitoring fee of $200 for the health practitioner to provide guidance, advice, coaching, counselling and/or reassurance to the insured in lieu of treatment. However, a fee for this intervention is conditional on certain requirements, such as: (1) no treatment or further monitoring can be provided under the subsequent blocks; and (2) it is not payable if treatment in Block 3 has commenced.

Once the MIG's pre-approved funding of $2,220 is exhausted, $1,300 remains available under the $3,500 minor injury limit as provided for under section 18(1) of the *SABS*. To access these additional funds, the insured must submit an OCF-18 and the coverage available would be $3,500, minus the amount paid for treatment under the MIG. Many in the industry believe this treatment plan will be to request a psychological assessment to show that the insured has a psychological injury to advance an argument that the insured's impairment is not predominantly a minor injury and therefore the $3,500 minor injury limit should not apply. In view of this, I would argue that the broadly termed "*any clinically associated sequelae*" under the *SABS* ought to include psychological complaints commonly associated with soft-tissue injuries, such as pain, headaches, dizziness, difficulty sleeping, anxiety, depression and fatigue. Furthermore, even if the insured has an impairment which is psychological in nature, he or she will have to prove that the predominant impairment is psychological and not a minor injury.

Discharge from the MIG

To discharge an insured from the MIG, during or at the conclusion of any of the treatment phases, the health practitioner must submit an OCF-24 which indicates: *(1) no additional intervention is required; (2) additional intervention outside of the MIG is required; or (3) the insured has been discharged from treatment because he or she was non-compliant, was not attending sessions or voluntarily withdrew from treatment.* If the insured requires further treatment outside of the MIG, the heath practitioner must submit an OCF-18 together with compelling evidence to the insurer for approval.

Insurer's Denial

One interesting aspect of the *September 1, 2010 SABS*, is the ability of the insurer to refuse an OCF-18 without requesting an assessment. In the context of the MIG, section 38 of the *SABS*[14] asserts that an insurer may refuse to accept an OCF-18 for any period during which the insured is entitled to receive goods and services under the MIG. If the insurer believes the insured's impairment falls within the MIG, the Notice of Denial (the "Notice") must be provided to the insured within 10 business days which specifically advises that the MIG applies.[15] This is certainly a departure from the usual practice of requesting an independent medical assessment to determine whether an OCF-18 is reasonable and necessary and the insurer's requirements, as listed under s. 37 (2), in order to discontinue paying a specified benefit. The *SABS* clearly outlines that the insurer's refusal is final and is not subject to review[16].

In circumstances where the insurer fails to provide a Notice within the 10 day period, it will be prohibited from taking the position that the insured person has an impairment to which the MIG applies and shall pay for all goods, services and assessments and examinations described in the OCF-18, starting on the 11th business day after the insurer received the OCF-18 until the Notice is given[17]. Although this section is subject to interpretation, we believe the intent was to disentitle the insurer from relying on the MIG limit of $2,200, regardless if the insured's impairment could be treated within the MIG. As such, it will be imperative that an insurer provide the Notice pursuant to the *SABS*, failing which it may be subject to paying the full $3,500 minor injury limit in accordance with section 18(1) of the *SABS* regardless if the insured could have been treated under the MIG. An argument that may be raised is the insurer should be prohibited from relying on the $3,500 minor injury limit for "all medical and rehabilitation treatment" that may be required. However, if that was the legislator's intention, then this section of the *SABS* would arguably have stated that the insurer was "prohibited from taking the position, in connection with all treatment and assessments plans, that the insured person has sustained an impairment that is predominantly a minor injury". Ultimately, this is a question that will require clarification through arbitration and court decisions.

In a dispute with a insured over entitlement to accident benefits, if a court or arbitrator determines that the insured's impairment is predominantly a minor injury, benefits will likely be deemed to have been reasonable and necessary, at a minimum, up to the pre-approved MIG cap of $2,200. From a practical standpoint, although the amounts available under the MIG are nominal, it is recommended that insurer refer the insured, at least at the outset, for an independent medical assessment. For example, if the insured's treating practitioner files an OCF-18 (instead of the required OCF-23) indicating that his or her impairment is not predominantly a minor injury or that the impairment is predominantly a minor injury but there is compelling evidence as to why the $3,500 minor injury limit should not apply, I would recommend obtaining a s.44 assessment in order to substantiate the insurer's position which outlines that the insured has predominantly a minor injury, the treatment is not reasonable and necessary and the MIG applies.

[14] O. Reg. 34/10, s. 38 (5).
[15] O. Reg. 34/10, s. 38 (8) and (9).
[16] O. Reg. 34/10, s. 38 (6).
[17] O. Reg. 34/10, s. 38 (11).

Final Thoughts

The MIG delineates that *the SABS and the MIG are intended to encourage and promote the broadest use of the MIG, recognizing that most persons injured in car accidents in Ontario sustain minor injuries for which the goods and services provided under the MIG are appropriate.*[18] While the insurance industry is hopeful the MIG will successfully curb claim costs, there is currently an underlying fear that perceived loopholes will prevent its effectiveness, such as:

a) undefined terms like "partial-tear", "clinically associated sequelae" and "compelling evidence";

b) whether or not psychological conditions can be treated within the MIG or within the $3,500 minor injury limit; and

c) the consequence of the insurer's failure to provide a Notice within the allocated time.

The O. Reg.34/10 (*SABS 2010)*, like the old regulation O. Reg 403/96, are an ongoing, evolving process that will take shape through the current development of the regulation, and guidelines and later through arbitration and judicial process. Notwithstanding, we must acknowledge that the MIG will be interpreted by judicial members with historical perspectives, normative values and decision-making patterns that have evolved within the context of the *SABS* over the last several years.

Recently, FSCO released the first and only arbitral or judicial decision considering the application of the MIG - *Scarlett v. Belair Insurance Company Inc*. (FSCO A12-001079) (March 26, 2013) ("Scarlett"). The issue to be decided in this Motion was whether or not the insured, Mr. Scarlett, was precluded from claiming benefits which were not available to him under the MIG and beyond the $3,500 minor injury limit. Arbitrator Wilson found that the insured was "not precluded from claiming" housekeeping, attendant care, as well as medical expenses beyond the $3,500.00 limit. However, it is important to note, that there was no finding with respect to the insured's "impairment" or "entitlement" to any of these benefits. Arbitrator Wilson ruled that the only way to fully reconcile conflicting medical opinions, with any certainty, would be to undertake a full trial of the issue with all experts subject to cross-examination.

In Obiter, he also commented on the following issues:

- The MIG was a non-binding interpretive tool despite its reference directly in the *SABS*. This determination was reached as, according to the legislature which passed the *Insurance Act*, "guidelines" are informational and non-binding, providing only that they be "considered".

- The minor injury limits for medical and rehabilitation benefits and the prohibition on claiming attendant care benefits are an exception to or a limitation on coverage. As a result, once the insured satisfies the burden of proving he or she is an "insured" and has suffered an impairment as a result of the accident, the burden shifts to the insurer to prove that the insured comes under the specified exception (MIG) that would justify non-payment either in part of in full.

- The evidentiary burden for "compelling evidence", to establish that an insured has a pre-existing medical condition and is not subject to the MIG limits, is on a balance of probabilities.

[18] FSCO Superintendent's *Guideline No.02/11, s. 1.*

- Temporamandicular joint pain ("TMJ"), chronic pain syndrome, and post-traumatic stress disorder ("PTSD") were separate and distinct injuries rather than a secondary consequence or a result of soft-tissue injuries. Unfortunately, Arbitrator Wilson did not give any reasons for this finding nor did he explain whether or not the insured sustained an impairment that was "predominantly a minor injury" to exceed the $3,500 limit, as required under s. 18(1) of the *SABS.*

As an appeal is likely, together with the fact that the issues related to the MIG were addressed in Obiter, it has yet to be seen what weight, if any, the *Scarlett* case will have on subsequent arbitral or judicial decisions.

As the MIG issues work their way through the courts and FSCO, I have put together a list of questions insurers ought to consider when evaluating claims:

1) *When did the motor vehicle accident occur (pre or post September 1, 2010)?*

2) *Do the transitional provisions under section 68 of the SABS apply (when did the insured renew his/her policy pre or post September 1, 2010)?*

3) *Did the insured purchase optional benefits as to provide entitlement to caregiver and/or housekeeping and home maintenance benefits, etc.?*

4) *Did the insured purchase other optional benefits as listed in Part VI, s. 28 (1) of the SABS as to increase the limits of income replacement, medical and rehabilitation and/or attendant care benefits?*

5) *Has the insured sustained an impairment that is predominantly a "minor injury" as defined under s. 3 of the SABS?*

6) *What other injuries or impairments, if any, is the insured being treated for?*

7) *Can the insured be treated under the MIG?*

8) *Are there any exceptions which apply to the monetary limits provided under s.18 (1) of the SABS (which would increase the $3,500 minor injury limit)?*

9) *Has the insured's health practitioner provided any compelling evidence?*

Disclaimer

Although this Article is designed to provide accurate information, we note that every case is fact specific. If legal advice or other expert assistance is required, please contact the author directly.