Ontario Psychological Association Handbook for Assessment and Treatment in Auto Insurance Claims

July 29, 2010

OPA Auto Task Force

I. Introduction

A. Purpose of the Handbook and Guidelines

This handbook is a practical summary of the 2010 Ontario Psychological Association (OPA) Guidelines for Assessment and Treatment in Auto Insurance Claims. The changes to the Statutory Accident Benefits Schedule (SABS), effective September 1, 2010, will affect how you assess and provide treatment and rehabilitation. For specific details of changes to the SABS and how psychological practice will be affected, please refer to the complete 2010 Guidelines. This Handbook provides a brief overview of the SABS changes and some direction of how to proceed.

The OPA developed this Handbook and Guidelines for use by multiple audiences, including adjusters, lawyers, psychologists, and other health professionals, as well as accident victims. We provide a summary of:

- Recent clinical science;
- Practice applicable to psychological impairments, assessments, and treatment/rehabilitation; and
- Changes to the SABS and implications for practice.

We realize that this Handbook and Guidelines cannot provide definitive information regarding clinical science, practice, or the SABS. However, we intend to provide a sufficient understanding of what is, according to the latest research, both reasonable and necessary for psychological assessment and treatment/rehabilitation. We join the SABS and the science with the realities of clinical practice in Ontario. This Handbook and Guidelines will educate adjusters about clinical science and practice and inform psychologists about the SABS.

These are living documents and will be improved by feedback from all users on an ongoing basis.

B. Application and Limitations of the Handbook and Guidelines

The Handbook and Guidelines focus on individual psychological treatment of adults who suffer psycho-emotional impairments resulting from automobile accidents. Information on treatment for patient groups with other impairments may be added in future revisions. These documents describe psychological assessments and examinations, which are critical components of psychological treatment/rehabilitation for a range of patient situations.

This Handbook and Guidelines applies to treatment/rehabilitation of many patients with psychological impairments. They will be useful to psychologists proposing these services and to psychologists and others reviewing these proposals.

We focus on assessments that are part of treatment/rehabilitation. Additional assessments and examinations, such as those conducted to determine catastrophic impairment or disability status, are critical to the system but are not addressed here.

It is outside of our scope to discuss many important treatment/rehabilitation services provided by psychologists. We do not discuss services for patients with brain injuries/cognitive impairments or those provided to children, adolescents, and elderly adults. These services are effective and often vital to the recovery of the patient, but can be more variable, intensive, extensive, and therefore expensive than can be indicated in the treatment guideline tables. Exclusion from the Guidelines does not indicate a lack of support for these psychological services.

Psychologists provide a broad range of effective direct and consultative treatment/rehabilitation services which are not included in these Guidelines. These services include but are not limited to group therapy, family therapy, consultation to other educational/treatment/rehabilitation providers, and multi-disciplinary treatment/rehabilitation programs. In addition, some patients with brain injuries or severe psychological/psychiatric disorders may require inpatient assessment/treatment which we do not address here. The omission of these services from this Handbook and Guidelines should not be interpreted as minimizing their importance in returning an individual to their pre-MVA functional status.

The Handbook and Guidelines are meant to be educational, not prescriptive. They are not intended to manualize assessment or treatment. The documents reflect our current understanding of legislation, regulations, required forms, necessary processes, clinical science, and psychological practice in Ontario. We expect further updates will be required to respond to ongoing changes. Therefore, these documents should be viewed as living documents which will be continually improved and expanded upon.

C. Methodology for Development of the Handbook and Guidelines

The OPA committed to update the previous Guidelines to synthesize recent clinical science with practice information and to respond to changes in the SABS. The process was led by the OPA Auto Insurance Task Force and has included significant participation by a wide range of psychologists around the province and the OPA Board of Directors.

This update of the Guidelines has incorporated feedback we have been collecting since 2005.

We have implemented suggestions which will improve the usefulness of the Guidelines. We have incorporated feedback from insurers, lawyers, and other health professionals. We have gathered information from the perspectives of psychologists proposing/providing as well as reviewing psychological assessment/examination and treatment.

This update includes the following steps:

- We sought further input and feedback from a wide range of psychologists and others throughout the revision process;
- Before a large workshop of psychologists, we presented a summary of the SABS changes, the conceptual model of the Guidelines, and an overview of the recent research;
- We obtained input on content and structure;
- We recruited volunteers who further reviewed the documents;
- We conducted a review of relevant recent literature;
- We submitted the draft document to peer review from psychologists with a broad range of perspectives and practices, the majority of whom provided detailed feedback and suggestions;
- The OPA Board of Directors was pleased to review the Handbook and Guidelines in July 2010.
- This draft was approved in principle and will be published on the OPA website in August 2010.
- The documents will be submitted for formal approval by the Board of Directors at the fall meeting in October 2010.
- We have committed to participating in a range of continuing education efforts to facilitate use by all stakeholders.
- We have committed to ongoing development of these Handbook and Guidelines, and we will continue to seek feedback and suggestions.

II. Ontario Regulation 34/10: The New SABS

A. Accident Benefits

The SABS regulations provide the essential details about accident benefits. These include what benefits are covered, the responsibilities of the insured person, the processes for claiming and accessing benefits,

and the roles of health professionals.

First-party insurance (accident benefits) is designed to return the insured person to pre-accident levels of functioning in the family, workplace, school, and community. The insurance policy is, however, constrained by a wide variety of limits, exceptions, and exclusions.

B. Changes Effective September 1, 2010

The new SABS continues to fund goods and services which can reduce impairments and restore functioning. Benefits are maintained for patients with psychological impairments; funding is continued for reasonable and necessary assessments as well as treatments by psychologists.

There are significant changes from the previous SABS. Although benefit levels are not retroactive to accidents before September 1, 2010, many important processes apply to those already injured. The changes include but are not limited to:

- The standard level of accident benefits for accidents on or after September 1, 2010 has been reduced from $100,000 to $50,000.
- Funding for treatment of accident victims whose injury is predominantly a minor injury is capped at $3,500 (unless the patient satisfies the exceptional criteria).
- The costs of all assessments conducted on behalf of the insured person are now included in the $50,000 limit.
- A greater focus on "optional benefits" with the option to purchase $100,000 or $1,000,000 in medical/rehabilitation coverage.
- Catastrophic benefits continue to be $1,000,000. However, the application (OCF-19) must be signed by a physician, unless the impairment is only a brain injury; in such a case, a neuropsychologist is allowed to sign the application.
- The Application for Approval of an Assessment or Examination (OCF-22) has been retired. The OCF-18 is now known as the Application for Approval of Treatment and Assessment and must be signed by the patient.
- Insurers now have ten (10) business days to respond to the OCF-18 (previously, insurers were required to respond to OCF-22 forms within three (3) business days).
- There is a $2,000 cap on all assessments, whether completed on behalf of the accident victim or insurer.
- Assessments are no longer "deemed approved" if the insurer fails to meet the deadline. Insurers are obligated to pay for services provided from the eleventh (11th) day until they provide notice.
- Insurers may, but are no longer required to, obtain an Insurer Examination (IE) if they deny proposed assessment or treatment. However, they must provide a medical or other reason. Funding for rebuttal reports is no longer included in the SABS.

III. Impact of the New SABS on Psychological Practice

A. Minor Injury Definition, Minor Injury $3,500 cap, and Minor Injury Guideline (MIG)

From the SABS:

> "Minor injury" means one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury.

The regulation imposes a $3,500 cap on funding for treatment of an accident victim whose injury is "predominantly a minor injury". The only exception to this limit is when a health practitioner provides compelling evidence of a pre-existing medical condition which would prevent the insured from achieving maximal recovery from the minor injury if subject to the $3,500 limit or to only the goods and services authorized under the Minor Injury Guideline (MIG).

The MIG describes the treatment blocks and associated funding (approximately $2,200) that can be provided to a patient with a minor injury without insurer prior approval. The MIG replaces the preapproved framework (PAF) for treatment of WAD injuries. For those subject to the minor injury cap, funding beyond the MIG, to the maximum of $3,500, requires application and approval by the insurer.

Psychological impairments/disorders are not considered "minor injuries" and are not defined as such in the SABS. Consistent with this understanding, psychologists are not included within the MIG as practitioners with responsibility for initiation of treatment. There is, however, allowance for supplementary goods and services under the MIG to a total of $400. Psychologists may provide supportive intervention within this allowance.

During the time that a person is receiving treatment in the MIG, an insurer is not obligated to consider any OCF-18s. Therefore, psychologists who receive referrals must determine whether the patient is currently receiving treatment under the MIG. The insurer is obligated to consider applications for services subsequent to the period of the MIG.

B. Consolidation of the Application for Treatment and Assessment Plans

The separate form previously used for application for assessments (OCF-22) has been retired. All proposals for goods and services, including assessments, examinations, treatment, and other goods or services, are now submitted on a single form: the OCF-18.

We expect an integrated OCF-18 application may combine assessment/examination and treatment proposals (e.g. crisis intervention during initial assessment, specific assessments such as vocational aptitude, or cognitive testing during treatment). We also expect that in many cases the first stage of psychological treatment/rehabilitation, following psychological intake interview/screening, will be assessment/examination submitted on an OCF-18 followed by separate OCF-18s for further services.

C. Assessments and Examinations (Testing) under the SABS

Less funding will now be available for all psychological assessments/examinations, given:

- the $2,000 cap;
- the reduced level of standard benefits; and
- the inclusion of assessment costs within the medical/rehabilitation benefits.

The $2,000 cap on assessments/examinations presents special challenges for provision of services to some patients with psychological impairments. Some patients will require multiple assessments/examinations. Different approaches will be required to respond to different patient situations.

In this context, the role of the psychological intake interview/screening is even more critical. The intake interview/screening determines if an assessment and/or examination (testing) is reasonable and necessary, as well as determining its nature.

We expect that assessment and treatment will now be more blended. Assessment/examination will continue into treatment and rehabilitation. Within the Handbook and Guideline we present a model that is an ongoing, iterative process; diagnosis and formulation is modified as further information is gathered during treatment. The need for further assessment/examination may be identified in the initial assessment,

or based on information gathered during treatment, and will be proposed on subsequent OCF-18s. In some situations, simultaneous assessments/examinations are required and must be proposed on a single OCF-18. An example would be a patient with traumatic brain injury/cognitive impairment with chronic pain and/or PTSD and/or a history of psychiatric disorder.

Assessments/examinations for treatment/rehabilitation will focus on gathering information to diagnose patients' conditions and guide their treatment. The assessing psychologist may use the information directly in providing treatment. Alternatively, assessments/examinations may be conducted as consultations to other treatment providers.

The assessment/examination is the foundation of the treatment/rehabilitation process. The assessment process should be efficient, but must not compromise the diagnostic/therapeutic alliance or the sufficiency of the information gathered. Report preparation and patient feedback are essential components of the assessment process; the literature supports the value of assessment as a therapeutic intervention. A positive outcome requires that the patient be given direct feedback and an opportunity to discuss their results.

Some assessments may be completed with less comprehensive reviews of medical files. Similarly, briefer clinical interviews and less extensive test batteries may be employed as part of each assessment for treatment planning. However, a focus on briefer assessments may lead to more situations where we need to highlight the limits of the assessments and conclusions. Consultation with other treatment providers continues to be critical to providing integrated treatment, and further assessments/examinations may be necessary when relevant diagnostic questions have not been adequately addressed by one assessment.

The SABS provides funding for treatment to reduce impairments. The constellation of impairments identified as the focus of treatment does not need to meet the diagnostic criteria of a clinical syndrome. Assessment interventions should therefore be tailored to identify impairments rather than assessing only for symptom presence and clinical diagnostic criteria. Psychologists conducting and reviewing assessments in this area of practice should be aware of this important difference in approaching assessments and treatment as it affects how assessments are conducted, which impairments are identified, which diagnoses are made, where to target treatment interventions, and how to measure results.

D. Impact of the New SABS on Treatment

After completing the appropriate assessment, the psychologist completes OCF-18 proposing treatment (if indicated and with patient consent) then submits it to the insurer for funding approval. The insurer must respond within ten (10) business days with full or partial approval or denial. The insurer must provide medical or other reasons for any denial and may obtain an IE. If the insurer does not meet the deadline, treatment may begin and the insurer is obligated to pay for treatment provided from the eleventh (11th) day until a response is given. However, there is no deadline for delivery of the IE report to the patient; thus, the "denial" is as of the date of Insurer denial and is not dependent upon completion of the IE.

E. Impact of the New SABS on Report Preparation

Psychologists' assessment reports may be limited in scope, and similar to clinical consultation notes, with a focus on clinical presentation and treatment needs. Reports must nonetheless identify treatable impairments resulting from the MVA. Other SABS benefit issues will generally be addressed in separate assessments and reports. These clinical reports will continue to address different issues than would a medical/legal report.

IV. Process to Determine Proposals for Reasonable and Necessary Psychological Assessments/Examinations

A. Indicators for Referral

With rare exception, insurers are obligated to pay for assessments only if health professionals apply for prior approval. The OCF-18 requires a description of the present symptoms, a rationale, and details of the proposed assessment. Therefore, the process to determine whether an assessment is indicated, and what type/scope of assessment to propose, is a critical first step in the provision of psychological treatment/rehabilitation.

We note the challenge of obtaining prior approval for an assessment. Sufficient information is necessary to complete the required fields on the OCF-18 assessment proposal. However, unless the assessment is ultimately approved, no payment is provided for the time required to prepare the OCF-18.

To determine if psychological assessment is required, patients may self-refer or be referred to psychologists by treating health professionals and others. Reasons for referral include but are not limited to questions regarding:

- Psychological symptoms
- Functional limitations
- Psychological factors that may be interfering with the patient's ability to respond to treatments for physical injuries.

Regardless of the source of the referral, the psychologist certifying the assessment proposal must determine that it is reasonable and necessary.

B. Intake Screening/Interview

The OCF-18 should be completed by a psychologist. The psychologist conducts a brief clinical interview/intake screening, either over the phone or in person, and psychological tests/screening measures may be included. The patient must sign the OCF-18 application providing informed consent; we therefore suggest that conducting the intake screening/interview in person is the expedient choice. Because the OCF-18 requires complaints/provisional diagnoses, decisions regarding patient need for different services, and assurance that the patient is truly providing informed consent to the assessment, this clinical screening interview should be conducted by a psychologist, rather than another health professional, an unregulated provider, or a support person.

We envision that assessment/examination proposals will continue to be complaint-based and limited to preliminary information. It is only reasonable to expect that many questions will remain unanswered until after the assessment/examinations are completed. Similarly, review of the health history and file are assessment components and generally are not completed as part of the proposal process.

C. Criteria to Complete an OCF-18

We are obligated to certify that our assessment proposals are reasonable and necessary. Therefore the psychologist completing and signing the application must obtain sufficient information from the patient to confirm:

- The indicators for each type of proposed assessment/examination are satisfied and consistent with the criteria in the relevant assessment guideline tables;
- The proposed assessments/examinations are reasonable and necessary and consistent with the time frames in the relevant guideline tables;
- The patient has provided informed consent for the proposed assessment, for communication with the insurer, and for the possible insurer examination.
- Assessments/examinations proposed for treatment/rehabilitation will focus on gathering information to diagnose patients' conditions and guide their treatment. The assessing psychologist may use the

information directly in providing treatment. Alternatively, assessments/examinations may be conducted as consultations to other treatment providers.
- A sufficiently/appropriately qualified practitioner is available (qualifications include language considerations, such that assessment should be provided when possible by a psychologist who is able to deliver the service without the need for a translator).

We expect that psychologists completing insurer examination reviews of these proposals for psychological assessments/examinations would be referring to these same criteria.

D. Fee for Completion of the OCF-18

The Financial Services Commission of Ontario, Superintendent's Guideline No. 06/10, Professional Services Guideline (PSG), July 2010 states:

> Forms
> The maximum fees payable for the listed forms include all examinations, assessments and expenses related to professional services (as referred to below) that are involved in such examinations and assessments, and all other activities, tasks and expenses involved in the completion and submission of the forms, whether they are made through the Health Claims for Auto Insurance (HCAI) system or otherwise. Automobile insurers are not liable to pay for any expenses related to the listed forms that exceed the maximum fees set out in the Appendix.

The July 2010 PSG also indicated the fee for the OCF-18 is $200 as of September 1, 2010. We understand from the PSG that the $200 fee includes the costs for collecting the information required to complete the OCF-18.

V. Models of Psychological Assessments and Examinations

A. "Assessments" and "Examinations"

The SABS indicates payment for assessments and examinations. In the Handbook and Guidelines, we address "assessments" and "examinations" which are an integral part of treatment/rehabilitation. We define "assessments" as a process that results in the formulation and communication of a diagnosis to guide treatment. Assessments involve direct clinical interview(s), analysis, preparation of a report, and feedback to the patient. Additional supportive components to this might be review of external sources of information (such as collateral interviews, completion of self-report inventories, and review of documents). On the other hand, we define "examinations" as any testing required to obtain data that will be incorporated into the assessment. A psychologist could conduct a brief diagnostic assessment consisting of only direct interview, analysis, report, and feedback to the client under some circumstances; however, even very extensive testing could not alone be considered a full assessment. Therefore, we have distinguished the testing as a separate "examination" that supports the "assessment". Assessments result in a full report that integrates findings from multiple sources and is used for feedback to the patient; examinations result in data that requires analysis and interpretation for inclusion in the full assessment report and is not used by itself for feedback to the patient.

Note that standardized psychometric measures may not be appropriate for some patients and most evaluations should be augmented by other measures to evaluate functional goals. In those instances when it may be inappropriate to administer formal psychometric tests (e.g. ESL), the rationale should be stated and the alternative method of evaluation should be indicated. Psychologists should use their professional judgment, including review of the current scientific literature and should follow contemporary standards of practice when determining the best strategies for evaluating outcomes and progress in treatment.

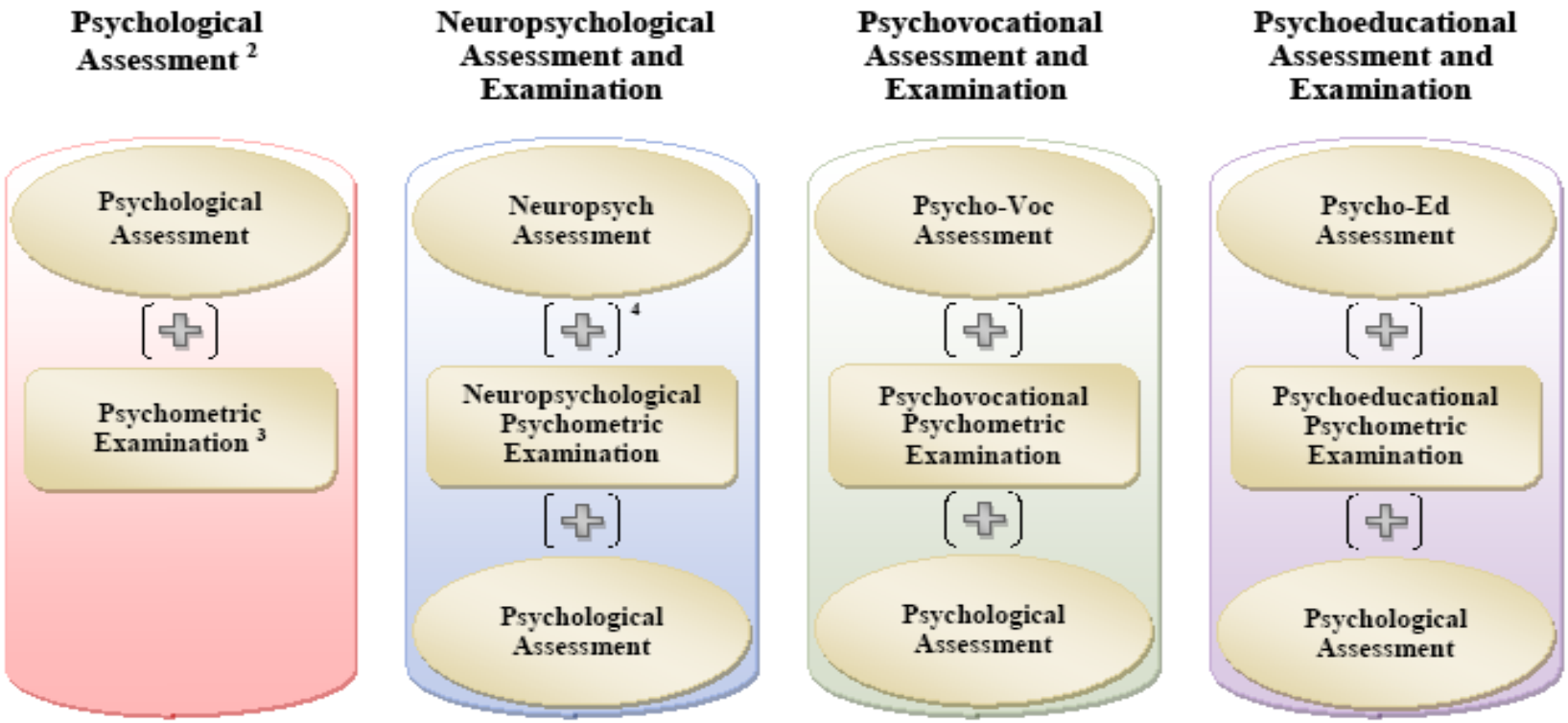
B. Model of Assessments and Examinations (Testing)

The diagram below, Psychological Assessments and Examinations in Treatment/Rehabilitation, illustrates our understanding of some of the various patterns of assessments and examinations that may be required as part of the treatment/rehabilitation of individual patients.

Completion of a Clinical/Health/Rehabilitation Psychological Assessment (and Psychometric Examination, if indicated) is foundational to assess psycho-emotional factors, and will be sufficient for many patients. Details of the indicators, assessment activities, and time ranges are described in the tables for Clinical/Health/Rehabilitation Psychological Assessment and Clinical/Health/Rehabilitation Psychometric Examination (testing). Subsequent to the completion of the foundational assessment and examination (testing), some patients will require further and/or more specific assessments/examinations to address emergent issues.

In addition, some patients will require multiple assessments and examinations due to the nature of their impairments/situations. These include but are not limited to patients with neuropsychological, psychovocational, or psychoeducational issues for treatment/rehabilitation planning. These models for assessments and examinations (testing) are illustrated in the following diagram and tables.

PSYCHOLOGICAL ASSESSMENTS AND EXAMINATIONS IN TREATMENT/REHABILITATION [1]



[1] Assessment is an iterative process, performed to guide treatment/rehabilitation. The diagnostic formulation evolves continuously through ongoing evaluation, monitoring of the patient's response to treatment. Further formal assessments and examinations may be required to address issues identified in the initial assessment and/or respond to emergent issues during treatment.

[2] Psychological Assessment includes clinical, health and rehabilitation.

[3] Psychometric Examinations (testing) are diagnostic procedures which may be required to provide additional data to be used in conjunction with an assessment.

[4] Cases with more complex presentation may require multiple assessments and concurrent psychometric examination (testing) on the same OCF-18. The proposal is expected to provide the rationale for the assessments and examination required.

Table I: Guideline for Clinical/Health/Rehabilitation Psychological Assessment

Indicators for Assessment: Assessment is reasonable and necessary when the brief psychological interview/intake screen confirms that:

- A claim has been made for the MVA to which the impairments are attributed; and
- The patient consents to the proposed assessment and necessary communications; and
- One or more of the following are suspected/reported associated with an MVA:
  - Possible psychological impairment; or
  - Reported symptoms of psychological distress or role impairment; or
  - Psychological factors affecting the patient's response to other treatments for MVA-related impairments, or
  - Possible interference in the patient/claimant/client's usual home, school, or work life, due to psychological impairments.
  - Psychological symptoms causing discomfort/distress, or impairment (e.g. driving anxiety affecting one's ability to travel comfortably, or rumination affecting one's usual cognition and ability to sleep)
- Assessments/examinations proposed for treatment/rehabilitation will focus on gathering information to diagnose patients' conditions and guide their treatment. The assessing psychologist may use the information directly in providing treatment. Alternatively, assessments/examinations may be conducted as consultations to other treatment providers.

Assessment Activities and Time Ranges: It is the responsibility of the assessing psychologist to determine the particular interventions to be employed and times required within the ranges, dependent upon individual patient needs

Multiple assessments/concurrent examinations (testing): Multiple assessments may be indicated by the initial intake screening, initial assessment, and/or responding to emergent issues in treatment. Psychometric examinations (testing) are diagnostic procedures, which may be required to provide additional data to be used in conjunction with an assessment.

Assessment Activities

Assessment Intervention (pick list for CCI Codes will be available on the OPA web site as well as at www.hcaiinfo.ca)	Ranges
Initial brief psychological interview/intake screening Time required is dependent on duration of patient interview, contact with other treatment providers, administration of initial screening instruments, brief preliminary review of available and relevant file material, etc. Identifies impairments requiring assessment, possible indications for psychological treatment, and need for crisis intervention. It is conducted to provide required information for submission of the OCF-18 for the proposed assessment. Therefore, time spent is included in the assessment proposal. Insurer is only obligated to pay if assessment is approved.	Cost included in the $200 OCF-18 fee
Clinical Interview(s) with Patient and Collateral Sources, e.g., family members Time required is dependent on factors such as intellectual limitations, language impairments/disabilities, need to clarify a complex history, issues of causation, unusual clinical presentation, or multiple impairments.	2.5 - 6
General Clinical/ Health/ Rehabilitation Self-Report Inventories Includes selection, administration, scoring, and interpretation of self-report inventories. May include self-report instruments to address the following domains: emotional/health status, coping strategies, personality, psychopathology, mood, anxiety, pain, traumatic stressors, family/social relationship functioning, rehabilitation status. Where possible, include validity measures. Time required is dependent upon the need for more depth/breadth of instruments required.	1 - 4
Disbursements Disbursements may include, for example, cost of obtaining relevant records and previous raw test data, consumable test materials, and use of external scoring services. Such items are invoiced on a cost recovery basis only.	Cost recovery basis
Selective Review of Available, Relevant File Material May include a review of medical chart, IMEs, school and work records. Time required is dependent upon the complexity and length of the file.	1 - 3
Consultation with Health Professionals, the Insurer, or Others as Required Time required is dependent upon the number of consultations required for information gathering.	.5 - 2
Documentation Includes analysis of all data, formulation of a diagnosis, planning for treatment, and preparation of an assessment report. Increase time as required for complex situations that require more extensive data analysis and documentation.	3 – 6
Feedback Interview Includes in-person explanation and review of assessment findings and report, a discussion of the treatment plan, and obtaining informed consent for treatment and communication. Time required increases with the need for longer or additional feedback interview(s), e.g., longer sessions for patients with intellectual limitations, language impairments/disabilities, or serious/multiple psychological impairments; additional sessions with parents/teachers of children/adolescents.	1 - 2

Total Assessment Hours and Maximum Costs per Assessment/Examination (Testing): Note the SABS states, *Despite any other provision of this Regulation, an insurer shall not pay, (a) more than a total of $2,000 in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it, whether it is conducted at the instance of the insured person or the insurer*. In the Professional Services Guideline the maximum hourly psychologist fee is $141.55 ($169.63 for patients with Catastrophic Impairments). This is the equivalent of approximately 14 hours (11.75 at CAT rate).

Table II: Guideline for Clinical/Health/Rehabilitation Psychometric Examination (Testing)	
Indicators for Examination (Testing): Testing is reasonable and necessary when the brief psychological interview/intake screen confirms that : • Psychometric testing is required to provide additional data to be used in conjunction with an assessment • Assessments/examinations proposed for treatment/rehabilitation will focus on gathering information to diagnose patients' conditions and guide their treatment. The assessing psychologist may use the information directly in providing treatment. Alternatively, assessments/examinations may be conducted as consultations to other treatment providers.	
Examination Activities and Time Ranges: It is the responsibility of the assessing psychologist to determine the particular interventions to be employed and times required within the ranges, dependent upon individual patient needs	
Multiple assessments/concurrent examinations (testing): Multiple assessments may be indicated by the initial intake screening, initial assessment, and/or responding to emergent issues in treatment. Psychometric examinations (testing) are diagnostic procedures which may be required to provide additional data to be used in conjunction with an assessment.	
Examination (Testing) Activities	
Examination Intervention (pick list for CCI Codes will be available on the OPA web site as well as at www.hcaiinfo.ca)	**Ranges**
General Clinical/ Health/ Rehabilitation Psychometric Testing Includes selection, administration, scoring, and interpretation of psychometric tests. May include testing the following domains: emotional/health status, coping strategies, personality, psychopathology, mood, anxiety, pain, traumatic stressors, family/social relationship functioning, general intellectual/cognitive functioning, rehabilitation status. Where possible, include validity measures. Time required is dependent upon the need for more depth/breadth of testing.	1 - 10
Total Examination Hours and Maximum Costs per Assessment/Examination (Testing): Note the SABS states, *Despite any other provision of this Regulation, an insurer shall not pay, (a) more than a total of $2,000 in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it, whether it is conducted at the instance of the insured person or the insurer*. In the Professional Services Guideline the maximum hourly psychologist fee is $141.55 ($169.63 for patients with Catastrophic Impairments). This is the equivalent of approximately 14 hours (11.75 at CAT rate).	
Psychometric Examinations (testing) may be administered by the psychologist or involve test administration by a psychometrist under the direction and supervision of the psychologist. Regardless of how the examination (testing) is organized, the total cost should not exceed the cost which would be expected if the psychologist themselves.	

Table III: Guideline for Neuropsychological Assessments	
Indicators for Neuropsychological Assessment: When neuropsychological concerns including reports of cognitive impairments/ deficits, post-concussion type symptoms, and history suggestive of concussion/ brain injury are noted, neuropsychological assessment is reasonably required. Neuropsychological assessments are diagnostic, descriptive, and prescriptive and are not limited in relevance to patients with evidence of structural brain damage, but are also necessary to document impairments in patients with possible/probable general clinical psychological and somatic (e.g. pain and sleep) disorders, as well as neuropsychological and neurobehavioural disorders, and for planning appropriate cognitive rehabilitation programs. Neuropsychological assessment provides objective documentation of cognitive and motor complaints and is useful for planning treatment and rehabilitation, educational and vocational integration. • Assessments/examinations proposed for treatment/rehabilitation will focus on gathering information to diagnose patients' conditions and guide their treatment. The assessing psychologist may use the information directly in providing treatment. Alternatively, assessments/examinations may be conducted as consultations to other treatment providers.	
Multiple assessments/concurrent examinations (testing): Multiple assessments may be indicated by the initial intake screening, initial assessment, and/or responding to emergent issues in treatment. Neuropsychometric examinations (testing) are diagnostic procedures, which may be required to provide additional data to be used in conjunction with an assessment.	
Assessment Activities and Time Ranges: Examination Activities and Time Ranges: It is the responsibility of the assessing psychologist to determine the particular interventions to be employed and times required within the ranges, dependent upon individual patient needs	
Assessment Activities	
Assessment Intervention (pick list for CCI Codes will be available on the OPA web site as well as at www.hcaiinfo.ca)	**Hours**
Initial brief neuropsychological interview/intake screening Time required is dependent on duration of patient interview, contact with other treatment providers, administration of initial screening instruments, brief preliminary review of available and relevant file material, etc. Identifies neuropsychological impairments requiring assessment, possible indications for psychological treatment/rehabilitation, and need for crisis intervention. It is conducted to provide required information for submission of the OCF-18 for the proposed assessment. Therefore, time spent is included in the assessment proposal. Insurer is only obligated to pay if assessment is approved.	Cost included in the $200 OCF-18 fee
Clinical Interview(s) with Patient and Collateral Sources, e.g., family members Time required within range is dependent on length of time needed for patient interviews and/or additional interview(s), e.g. due to intellectual limitations, language impairments/ disabilities, need to clarify complex history, causation, unusual clinical presentation, or multiple impairments.	2.5- 6
Neuropsychological Self Report Inventories Includes selection, administration, scoring and interpretation of self-report inventories. Assessment may include self-report inventories to address the following domains: emotional/health status, coping strategies, personality, psychopathology, mood, anxiety, pain, traumatic stressors, family/social relationship functioning, general cognitive functioning, adaptive abilities, rehabilitation status. Where possible include validity measures. Time required within range is dependent upon need for more depth/ breadth of self-report instruments required.	2-5
Disbursements Appropriate disbursements may include, for example, cost of obtaining relevant records and previous raw test data, consumable test materials, and use of external scoring services. Such items are invoiced on a cost recovery basis.	Billed on a cost recovery basis
Selective Review of Available, Relevant File Material Includes review of medical chart, IMEs, school and work records. Time required within range is dependent upon the complexity and length of the file.	.5 – 8
Consultation with Health Professionals, the Insurer, and Others Required Time required within range is dependent upon need for additional consultations and/or information gathering.	.5 – 2
Documentation Includes analysis of all data, formulation of a diagnosis, plan for treatment, and preparation of an assessment report. Increase time as required within range for complex situations that require more extensive data analysis and documentation.	2 – 8
Feedback Interview Includes in-person explanation and review of assessment findings and report, a discussion of the treatment plan, and obtaining informed consent for treatment and communication. Time required increases with the need for longer or additional feedback interview(s), e.g., longer sessions for patients with intellectual limitations, language impairments/disabilities, or serious/multiple psychological impairments; additional sessions with parents/teachers of children/adolescents.	1 – 3
Total Examination Hours and Maximum Costs per Assessment/Examination (Testing): Note the SABS states, *Despite any other provision of this Regulation, an insurer shall not pay, (a) more than a total of $2,000 in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it, whether it is conducted at the instance of the insured person or the insurer.* In the Professional Services Guideline the maximum hourly psychologist fee is $141.55 ($169.63 for patients with Catastrophic Impairments). This is the equivalent of approximately 14 hours (11.75 at CAT rate).	

Table IV: Guideline for Neuropsychometric Examination (testing)	
Indicators for Examination (Testing): Testing is reasonable and necessary when the brief psychological interview/intake screen confirms that: • Neuropsychometric examination testing is required to provide additional data to be used in conjunction with a Neuropsychological assessment • Assessments/examinations proposed for treatment/rehabilitation will focus on gathering information to diagnose patients' conditions and guide their treatment. The assessing psychologist may use the information directly in providing treatment. Alternatively, assessments/examinations may be conducted as consultations to other treatment providers.	
Examination Activities and Time Ranges: It is the responsibility of the assessing psychologist to determine the particular interventions to be employed and times required within the ranges, dependent upon individual patient needs	
Multiple assessments/concurrent examinations (testing): Multiple assessessments may be indicated by the initial intake screening, initial assessment, and/or responding to emergent issues in treatment. Neuropsychometric examinations (testing) are diagnostic procedures that may be required to provide additional data to be used in conjunction with an assessment.	
Examination (testing) Activities	
Examination Intervention (pick list for CCI Codes will be available on the OPA web site as well as at www.hcaiinfo.ca)	**Ranges**
Neuropsychometric Testing Examples of the various approaches include but are not limited to the following: In some situations, psychologists will be involved very early in the injured person's care to provide a baseline examination (testing) and then repeated measures to determine initial needs and changes over time. Other situations may separate examinations of broad general batteries from examinations of more highly specialized testing of specific functions. Includes selection, administration, scoring and interpretation of psychometric tests. Examination (testing) may include testing of the following domains: emotional/health status, coping strategies, personality, psychopathology, mood, anxiety, pain, traumatic stressors, family/social relationship functioning, general cognitive functioning, adaptive abilities, rehabilitation status and administration of validity measures. In addition, Neuropsychological examination (testing) may include tests of sensory abilities; motor skills; psychomotor speed; attention/concentration; language; visuo-spatial/ constructional abilities; intellectual abilities; memory and learning; executive functioning; judgment; self awareness; initiation; and self-control. Time required within range is dependent upon need for more depth/ breadth of testing required. Where possible, include validity measures. Time required is dependent upon the need for more depth/breadth of testing.	1 - 14
Total Examination Hours and Maximum Costs per Assessment/Examination (testing): Note the SABS states, *Despite any other provision of this Regulation, an insurer shall not pay, (a) more than a total of $2,000 in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it, whether it is conducted at the instance of the insured person or the insurer.* In the Professional Services Guideline the maximum hourly psychologist fee is $141.55 ($169.63 for patients with Catastrophic Impairments). This is the equivalent of approximately 14 hours (11.75 at CAT rate).	
Psychometric Examinations/testing may be administered by the psychologist or involve test administration by a psychometrist under the direction and supervision of the psychologist. Regardless of how the examination (testing) is organized, the total cost should not exceed the cost which would be expected if the psychologist themselves.	

Table V: Guideline for Psychovocational Assessments	
Indicators for Psychovocational Assessment: Psychovocational assessment is reasonable and necessary when vocational issues are anticipated, for example, difficulty returning to or maintaining level of performance in former employment, need to identify suitable alternative employment type or vocational retraining needs. • Assessments/examinations proposed for treatment/rehabilitation will focus on gathering information to diagnose patients' conditions and guide their treatment. The assessing psychologist may use the information directly in providing treatment. Alternatively, assessments/examinations may be conducted as consultations to other treatment providers.	
Multiple assessments/concurrent examinations (testing): Multiple assessments may be indicated by the initial intake screening, initial assessment, and/or responding to emergent issues in treatment. Psychovocational psychometric examinations (testing) are diagnostic procedures that may be required to provide additional data to be used in conjunction with an assessment.	
Assessment Activities and Time Ranges: Examination Activities and Time Ranges: It is the responsibility of the assessing psychologist to determine the particular interventions to be employed and times required within the ranges, dependent upon individual patient needs	
Assessment Activities	
Assessment Intervention (pick list for CCI Codes will be available on the OPA web site as well as at www.hcaiinfo.ca)	**Hours**
Initial brief psychovocational interview/intake screening Time required is dependent on duration of patient interview, contact with other treatment providers, administration of initial screening instruments, brief preliminary review of available and relevant file material, etc. Identifies psychovocational impairments requiring assessment, and possible indications for psychovocational treatment/rehabilitation. It is conducted to provide required information for submission of the OCF-18 for the proposed assessment. Therefore, time spent is included in the assessment proposal. Insurer is only obligated to pay if assessment is approved.	Cost included in the $200 OCF-18 fee
Clinical Interview(s) with Patient and Collateral Sources, e.g., employers Time required within range is dependent on length of time needed for patient interviews and/or additional interview(s), e.g. due to intellectual limitations, language impairments/ disabilities, need to clarify complex history, causation, unusual clinical presentation, or multiple impairments.	2.5- 6 hours
Psychovocational Self Report Inventories Includes selection, administration, scoring and interpretation of self-report inventories. May include self-report inventories regarding the following domains: emotional/ health status, coping strategies, personality, psychopathology, mood, anxiety, pain, traumatic stressors, family/ social relationship functioning, general cognitive functioning, adaptive abilities, rehabilitation status. Labor market assessment may be required. Time required within range is dependent upon need for more depth/ breadth of testing Where possible include validity measures. Time required within range is dependent upon need for more depth/ breadth of self-report instruments required.	2-5 hours
Disbursements Appropriate disbursements may include, for example, cost of obtaining relevant records and previous raw test data, consumable test materials, and use of external scoring services. Such items are invoiced on a cost recovery basis.	Billed on a cost recovery basis
Selective Review of Available, Relevant File Material Includes review of medical chart, IMEs, school and work records. Time required within range is dependent upon the complexity and length of the file.	.5 – 8 hours
Consultation with Health Professionals, the Insurer, and Others Required Time required within range is dependent upon need for additional consultations and/or information gathering.	.5 – 2 hours
Documentation Includes analysis of all data, formulation of a diagnosis, plan for treatment, and preparation of an assessment report. Increase time as required within range for complex situations that require more extensive data analysis and documentation.	2 – 8 hours
Feedback Interview Includes in-person explanation and review of assessment findings and report, a discussion of the treatment/rehabilitation plan, and obtaining informed consent for treatment and communication. Time required increases with the need for longer or additional feedback interview(s), e.g., longer sessions for patients with intellectual limitations, language impairments/disabilities, or serious/multiple psychological impairments; additional sessions with parents/teachers of children/adolescents.	1 – 3 hours
Total Examination Hours and Maximum Costs per Assessment/Examination (Testing): Note the SABS states, *Despite any other provision of this Regulation, an insurer shall not pay, (a) more than a total of $2,000 in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it, whether it is conducted at the instance of the insured person or the insurer.* In the Professional Services Guideline the maximum hourly psychologist fee is $141.55 ($169.63 for patients with Catastrophic Impairments). This is the equivalent of approximately 14 hours (11.75 at CAT rate).	

Table VI: Guideline for Psychovocational Psychometric Examination (testing)	
Indicators for Examination (Testing): Testing is reasonable and necessary when the brief psychological interview/intake screen confirms that: • Psychovocational psychometric examination (testing) is required to provide additional data to be used in conjunction with an assessment • Assessments/examinations proposed for treatment/rehabilitation will focus on gathering information to diagnose patients' conditions and guide their treatment. The assessing psychologist may use the information directly in providing treatment. Alternatively, assessments/examinations may be conducted as consultations to other treatment providers.	
Examination Activities and Time Ranges: It is the responsibility of the assessing psychologist to determine the particular interventions to be employed and times required within the ranges, dependent upon individual patient needs	
Multiple assessments/concurrent examinations (testing): Multiple assessments may be indicated by the initial intake screening, initial assessment, and/or responding to emergent issues in treatment. Psychovocational psychometric examinations (testing) are diagnostic procedures that may be required to provide additional data to be used in conjunction with an assessment.	
Examination (testing) Activities	
Examination Intervention (pick list for CCI Codes will be available on the OPA web site as well as at www.hcaiinfo.ca)	**Ranges**
Psychovocational psychometric Testing Includes selection, administration, scoring and interpretation of psychometric tests. May test of the following domains: emotional/ health status, coping strategies, personality, psychopathology, mood, anxiety, pain, traumatic stressors, family/ social relationship functioning, general cognitive functioning, adaptive abilities, rehabilitation status and administration of validity measures. In addition, Psychovocational Assessments may include testing of intellectual abilities; academic aptitude (reading, writing, numerical); communication/language abilities (expressive, receptive); organizational and planning skills; abstract reasoning; distractibility; vocational aptitude; vocational interests; task skills analysis; transferable skills; endurance; persistence; adaptation and flexibility; motivation; achievement need; and learning ability. Labour market assessment may be required. Where possible include validity measures. Time required within range is dependent upon need for more depth/ breadth of testing required.	1 - 14
Total Examination Hours and Maximum Costs per Assessment/Examination (Testing): Note the SABS states, *Despite any other provision of this Regulation, an insurer shall not pay, (a) more than a total of $2,000 in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it, whether it is conducted at the instance of the insured person or the insurer*. In the Professional Services Guideline the maximum hourly psychologist fee is $141.55 ($169.63 for patients with Catastrophic Impairments). This is the equivalent of approximately 14 hours (11.75 at CAT rate).	
Psychometric Examinations/testing may be administered by the psychologist or involve test administration by a psychometrist under the direction and supervision of the psychologist. Regardless of how the examination is organized, the total cost should not exceed the cost which would be expected if the psychologist themselves.	

Table VII: Guideline for Psychoeducational Assessments	
Indicators for Psychoeducational Assessment: Psychoeducational assessment is reasonable and necessary when educational concerns are anticipated, for example, difficulty returning to or maintaining level of performance and progress in former educational program, or need to identify suitable alternative modifications or supports. • Assessments/examinations proposed for treatment/rehabilitation will focus on gathering information to diagnose patients' conditions and guide their treatment. The assessing psychologist may use the information directly in providing treatment. Alternatively, assessments/examinations may be conducted as consultations to other treatment providers.	
Multiple assessments/concurrent examinations (testing): Multiple assessments may be indicated by the initial intake screening, initial assessment, and/or responding to emergent issues in treatment. Psychoeducational psychometric examinations (testing) are diagnostic procedures that may be required to provide additional data to be used in conjunction with an assessment.	
Assessment Activities and Time Ranges: Examination Activities and Time Ranges: It is the responsibility of the assessing psychologist to determine the particular interventions to be employed and times required within the ranges, dependent upon individual patient needs	
Assessment Activities	
Assessment Intervention (pick list for CCI Codes will be available on the OPA web site as well as at www.hcaiinfo.ca)	**Hours**
Initial brief psychological interview/intake screening Time required is dependent on duration of patient interview, contact with other treatment providers, administration of initial screening instruments, brief preliminary review of available and relevant file material, etc. Identifies psychovocational impairments requiring assessment, and possible indications for psychological treatment/rehabilitation. It is conducted to provide required information for submission of the OCF-18 for the proposed assessment. Therefore, time spent is included in the assessment proposal. Insurer is only obligated to pay if assessment is approved.	Cost included in the $200 OCF-18 fee
Clinical Interview(s) with Patient and Collateral Sources, e.g., family members, Time required within range is dependent on length of time needed for patient interviews and/or additional interview(s), e.g. due to intellectual limitations, language impairments/ disabilities, need to clarify complex history, causation, unusual clinical presentation, or multiple impairments.	2.5- 6
Psychoeducational Self/Parent/Teacher Report Inventories Includes selection, administration, scoring and interpretation of self/parent/teacher-report inventories. Assessment may include inventories to address the following domains: emotional/health status, coping strategies, personality, psychopathology, mood, anxiety, pain, traumatic stressors, family/social relationship functioning, general cognitive functioning, adaptive abilities, rehabilitation status. Where possible include validity measures. Time required within range is dependent upon need for more depth/ breadth of self-report instruments required.	2-5
Disbursements Appropriate disbursements may include, for example, cost of obtaining relevant records and previous raw test data, consumable test materials, and use of external scoring services. Such items are invoiced on a cost recovery basis.	Billed on a cost recovery basis
Selective Review of Available, Relevant File Material Includes review of medical chart, IMEs, school and work records. Time required within range is dependent upon the complexity and length of the file.	.5 - 8
Consultation with Health Professionals, School Teachers, the Insurer, and Others Required Time required within range is dependent upon need for additional consultations and/or information gathering.	.5 - 2
Documentation Includes analysis of all data, formulation of a diagnosis, plan for treatment/rehabilitation, and preparation of an assessment report. Increase time as required within range for complex situations that require more extensive data analysis and documentation.	2 - 8
Feedback Interview Includes in-person explanation and review of assessment findings and report, a discussion of the treatment/rehabilitation plan, and obtaining informed consent for treatment and communication. Time required increases with the need for longer or additional feedback interview(s), e.g., longer sessions for patients with intellectual limitations, language impairments/disabilities, or serious/multiple psychological impairments; additional sessions with parents/teachers of children/adolescents.	1 - 3
Total Examination Hours and Maximum Costs per Assessment/Examination (Testing): Note the SABS states, *Despite any other provision of this Regulation, an insurer shall not pay, (a) more than a total of $2,000 in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it, whether it is conducted at the instance of the insured person or the insurer.* In the Professional Services Guideline the maximum hourly psychologist fee is $141.55 ($169.63 for patients with Catastrophic Impairments). This is the equivalent of approximately 14 hours (11.75 at CAT rate).	

Table VIII: Guideline for Psychoeducational Psychometric Examination (testing)

Indicators for Examination (Testing): Testing is reasonable and necessary when the brief psychological interview/intake screen confirms that:

- Psychoeducational Pychometric testing is required to provide additional data to be used in conjunction with an assessment
- Assessments/examinations proposed for treatment/rehabilitation will focus on gathering information to diagnose patients' conditions and guide their treatment. The assessing psychologist may use the information directly in providing treatment. Alternatively, assessments/examinations may be conducted as consultations to other treatment providers.

Examination Activities and Time Ranges: It is the responsibility of the assessing psychologist to determine the particular interventions to be employed and times required within the ranges, dependent upon individual patient needs

Multiple assessments/concurrent examinations (testing): Multiple assessments may be indicated by the initial intake screening, initial assessment, and/or responding to emergent issues in treatment. Psychoeducational psychometric examinations (testing) are diagnostic procedures that may be required to provide additional data to be used in conjunction with an assessment.

Examination (testing) Activities

Examination (Testing) Intervention (pick list for CCI Codes will be available on the OPA web site as well as at www.hcaiinfo.ca)	**Ranges**
Psychoeducational Testing Includes test selection, administration, scoring and interpretation. Assessment may include testing the following domains: emotional/ health status, coping strategies, personality, psychopathology, mood, anxiety, pain, traumatic stressors, family/ social relationship functioning, general cognitive functioning, adaptive abilities, and rehabilitation status. In addition, psychoeducational assessments may include testing of intellectual abilities; academic skills and underlying processes (reading, writing, numerical); communication/language abilities (expressive, receptive); organizational and planning skills; abstract reasoning; distractibility; vocational aptitude; vocational interests; task skills analysis; transferable skills; endurance; persistence; adaptation and flexibility; motivation; achievement need; and learning ability. Where possible, include validity measures. Time required is dependent upon the need for more depth/breadth of testing.	1 - 14

Total Examination Hours and Maximum Costs per Assessment/Examination (Testing): Note the SABS states, *Despite any other provision of this Regulation, an insurer shall not pay, (a) more than a total of $2,000 in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it, whether it is conducted at the instance of the insured person or the insurer.* In the Professional Services Guideline the maximum hourly psychologist fee is $141.55 ($169.63 for patients with Catastrophic Impairments). This is the equivalent of approximately 14 hours (11.75 at CAT rate).

Psychometric Examinations/testing may be administered by the psychologist or involve test administration by a psychometrist under the direction and supervision of the psychologist. Regardless of how the examination (testing) is organized, the total cost should not exceed the cost which would be expected if the psychologist themselves.

Total Examination Hours and Maximum Costs per Assessment/Examination (Testing): Note the SABS states, *Despite any other provision of this Regulation, an insurer shall not pay, (a) more than a total of $2,000 in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it, whether it is conducted at the instance of the insured person or the insurer.* In the Professional Services Guideline the maximum hourly psychologist fee is $141.55 ($169.63 for patients with Catastrophic Impairments). This is the equivalent of approximately 14 hours (11.75 at CAT rate).

VI. Using the OCF-18 to Propose Assessments/Examinations (Testing)

Starting September 1, 2010, psychologists must apply for prior approval for assessments by completing an OCF-18. The following discussion briefly describes using the OCF-18 to propose treatment/rehabilitation assessments.

(Note: Further discussion and case examples will be developed and provided as a part of ongoing education.)

Part 6 of the form requires information with respect to "Injuries and Sequelae". However, diagnosis of impairments is a purpose of the assessment, and therefore likely not known until the assessment is completed. There are several options available for the completion of Part 6 of the OCF-18, such as using ICD-10 codes to indicate patient complaints, or providing provisional diagnoses. If provisional diagnoses are indicated, the additional comments can be used to highlight that the diagnoses offered are provisional or "rule out".

(Note: We will post further information and pick lists of ICD-10 codes on the OPA website.)

In Part 7, the psychologist is asked to indicate prior and concurrent conditions that may affect the patient's response to treatment. If these are known at the time of the assessment application, provide this information. If not, indicate "unknown" and explore this area as part of the proposed assessment.

In Part 8, the psychologist is asked to describe activity limitations, employment issues, and modified work opportunities. Again, these will be explored during the assessment and entered as "unknown" if applicable.

In Part 9, completion of the "Plan Goals, Outcome Evaluation Methods, and Barriers to Recovery" sections may also be premature at the time of applying for approval of the assessment. These may only be identified during the assessment. If so, "not applicable" may be indicated.

In Part 10, the patient must sign the application for approval of assessment unless waived by the insurer. This is a change from the present practice on the OCF-22, where the patient's signature is optional, and may require practice changes for those psychologists who have been screening by telephone and obtaining verbal permission for submission of the OCF-22.

Part 12 requires the listing of proposed goods and services. The assessment or examination can be proposed as a unit, or "unbundled" to provide a line-item entry for every specific intervention to be included. . For example, the GAP code HXXMR is used for "*health provider initiated examinations and report*s". A single line item for an assessment or examination makes it easier to communicate its fee. Nonetheless, if a single line item is used for an entire assessment or examination, we recommend including information describing the components of the assessment/examination in the "additional comments" section.

(Note: We will post further information and pick lists of CCI and GAP codes on the OPA website)

VII. Indicators to Propose Psychological Treatment

Factors indicating that psychological treatment consistent with accepted community and professional standards is reasonable and necessary include that an appropriate assessment has identified:

- A psychological impairment/condition/disorder resulting from the accident and its sequelae, and/or

psychological factors that are having an effect on the treatment/rehabilitation of physical injuries (note that these are diagnosable using ICD-10 and do not need to meet DSM-IV-TR diagnostic criteria for a particular disorder to qualify for treatment;
- An effective or reasonable intervention exists;
- The patient is sufficiently motivated and can access treatment (barriers addressed);
- A sufficiently/ appropriately qualified practitioner is available (qualifications include language considerations, such that treatment should be provided by a psychologist who is able to deliver the service without the need for a translator).

Reviewers should use these as criteria when determining the reasonableness and necessity of the proposed treatment plan.

VIII. Treatment Guidelines

A. Staged Treatment Model

The assessment report and OCF-18 should indicate the rationale for the treatment proposed. Frequency and duration of sessions, within the total number of hours in the OPA Guideline, is to be determined by the treating psychologist according to the specific needs of the patient and may vary over the course of the treatment plan. For example, while teaching general stress management may be achievable within a traditional 50-minute hour, the current standard for treatments, such as prolonged exposure for post-traumatic stress, is 1.5–2 hour sessions (or longer).

Because the trajectory and ultimate results of treatment can vary greatly, regular re-assessment of functioning and progress in therapy is essential to providing effective, efficient, high-quality care. Psychologists should complete regular outcome evaluations of their patients in order to determine and document progress in therapy. Such outcome evaluations are a critical part of the treatment process, allowing a psychologist to modify treatment as necessary. These evaluations are to be included in the OCF-18 treatment plan, rather than generating a separate OCF-18.

We see continuing re-assessment and modification of the treatment plan as part of the staged model of treatment. In the staged model, continuation of further treatment is determined by response to each stage of treatment. For example, while it may be anticipated that a patient with long-standing and severe impairments might require a year or longer of treatment, it would be unusual to propose this in a single treatment plan. Rather, we anticipate that treatment would be proposed in blocks or stages and continuation would be dependent upon response.

It is expected that ongoing evaluation to monitor treatment progress and modify treatment when warranted must occur as an integral component of psychological treatment and rehabilitation. Re-assessment and feedback to the client should occur every 6-10 sessions, or after a significant stage of the stepped care model. Such re-assessment is required to determine whether treatment is effective in attaining the goals set at the outset of therapy, to make any required modifications to the treatment process, and to document areas of progress for the OCF-18 treatment plan, if more treatment is being recommended.

Time to accomplish this during and at the completion of the treatment plan should be included on the treatment plan proposal. Ongoing evaluation could include, for example: clinical observation, patient self-report, reports from significant others, and completion of satisfaction questionnaires. Formal re-assessment will usually require re-administration of psychological tests. If the need for additional specialized assessments (such as psychovocational assessment) is identified, a separate OCF-18 may be submitted. This is an essential component of providing treatment, and cannot be cut from a treatment plan.

(Note: We will post further information and pick lists of ICD 10, CCI and GAP codes on the OPA website.)

B. Treatment Interventions

In keeping with the above information, treatment is evidence-based where applicable evidence exists to support the use of a particular intervention; otherwise psychologists use a reasonable approach. When more than one type of psychological treatment is proposed, the rationale for each type of intervention should be provided in the report (all interventions utilized are described within the language of the Canadian Classification of Interventions (CCI) and an associated intervention code is provided). However, if couple, family, or parenting sessions are indicated, it is also possible to submit these under a claim for the non-injured family member.

Frequency and duration of sessions within the total number of hours in the Guideline is to be determined by the individual treating psychologist according to the specific needs of the patient and may vary over the course of the treatment plan. However, we note from the current treatment literature the varying time requirements for administering effective treatments. While teaching general stress management may be achievable within a traditional 50-minute hour, the current standard for treatment of post-traumatic stress is 1.5 – 2 hour sessions (or longer), and we note that the literature on relapse prevention and provision of booster sessions generally allocates time on an as-needed basis.

We note that our mandate within the SABS is to return injured people to their pre-MVA level of functioning (or, as close as possible to this), not simply reduce symptoms or distress. Psychologists must be aware that treatment to symptom remission does not necessarily result in a return to functioning. Therefore, while the literature cited above focuses on treatment of symptoms and disorders, we also must emphasize interventions that focus on improving functioning, returning to previous activity, and reducing and preventing disability. Several kinds of psychological rehabilitation services have not been reviewed here, including parenting skill training, cognitive rehabilitation for brain injuries, and vocational rehabilitation for those who are unable to return to their previous employment. Times required for such services necessarily also fall outside of those proposed and this Guideline. The fact that these interventions are not included within the scope of this Guideline should not be taken to mean that these kinds of rehabilitation are not supported by the literature or recommended by the OPA. Rather, they were simply outside the scope of this review. It should be recognized by users of this Guideline that any additional interventions of these kinds will require extra time to implement.

Note that, as reported by several researchers, treatment/rehabilitation in multiple domains is not expected to proceed in a straightforward, linear fashion; rather, it often involves improvements and lapses as treatment proceeds through stages/ modules. As a result, delivery requires flexibility and the ability to move between modules, as needed.

C. Review of External File Information as Received

During the course of therapy, new documents and reports often will be completed on the patient that are relevant to treatment (e.g. medical reports from treating physicians, physiotherapists, chiropractors, occupational therapists, independent psychological examinations, treatment plan review reports, disability assessment reports, Functional Abilities Evaluations (FAEs), in-vivo driver re-training progress reports, etc.). In order to maintain adequate and informed treatment and appropriate continuity within the circle of care among treatment providers, these documents should be reviewed by the treating psychologist as they are received. The treatment plan therefore should include time that is anticipated to be required for review of external file information received during the course of treatment.

D. Consultation, Collaboration, and Communication

Ongoing consultation, collaboration, and communication with treatment providers and others (e.g. phone calls, team meetings, contact with other treatment providers, insurers, teachers, employers) is an essential component of the treatment and rehabilitation process. This ongoing communication is necessary to provide integrated treatment and avoid duplication. The communication allows multiple independent treatment providers to function as a "virtual clinic" to meet the needs of the patient in the most effective and efficient manner. In those instances where in-person team meetings are required, the specific rationale should be described and the additional time indicated. The treatment plan includes the time that is anticipated to be required for consultation, collaboration, and communication.

E. Ongoing Evaluation, Formal re-Assessment, and Modification of Treatment

Because the trajectory and ultimate results of treatment can vary so greatly, regular re-assessment of functioning and progress in therapy is essential to providing effective, efficient, high quality care. All psychologists, regardless of their orientation, education, or training, should engage in regular outcome evaluation of their patients in order to determine and document progress in therapy. Such outcome evaluations to document progress and modify treatment as necessary are a critical part of the treatment process, and are to be included in the OCF-18 treatment plan, rather than requiring a separate OCF-18.

We see continuing re-assessment and modification of the treatment plan as part of the staged model of treatment. In the staged model, continuation of further treatment is determined by response to each stage of treatment. For example, while it may be anticipated that a patient with long-standing and severe impairments might require a year or longer of treatment, it would be unusual to propose this in a single treatment plan. Rather, we anticipate that treatment would be proposed in blocks or stages and continuation would be dependent upon response.

It is expected that ongoing evaluation to monitor treatment progress and modify treatment when warranted must occur as an integral component of psychological treatment and rehabilitation. Re-assessment and feedback to the client should occur every 6-10 sessions, or after a significant stage of the stepped care model. Such re-assessment is required to determine whether treatment is effective in attaining the goals set at the outset of therapy, to make any required modifications to the treatment process, and to document areas of progress for the OCF-18 treatment plan, if more treatment is being recommended.

Time to accomplish this during and at the completion of the treatment plan should be included on the treatment plan proposal. Ongoing evaluation could include for example, clinical observation, patient self report, reports from significant others and completion of satisfaction questionnaires. Formal re-assessment will require re-administration of psychological tests (If the need for additional specialized assessments, for example, psychovocational assessment, is identified, a separate OCF-18 should be submitted). This is an essential component of providing treatment, and cannot be cut from a treatment plan.

Note that standardized psychometric measures may not be appropriate for some patients and most evaluations should be augmented by other measures to evaluate functional goals. In those instances when it may be inappropriate to administer formal psychometric tests (e.g. ESL), the rationale should be stated and the alternative method of evaluation should be indicated. Psychologists should use their professional judgment, including review of the current scientific literature and should follow contemporary standards of practice when determining the best strategies for evaluating outcomes and progress in treatment.

F. Preparation of Progress Reports, Discharge Reports, and/or Subsequent Treatment Plans

Results of formal assessments should be communicated to the patient, other treating health professionals, and the insurer, as available, with patient consent and as consistent with current legislation (e.g. PHIPA). This is an essential component of effective, integrated care of the patient. However, while communication with other care providers, referral sources, adjusters, or others may occur in written format, feedback to the patient requires face-to-face individual discussion in order to ensure real effectiveness of the feedback for treatment. Direct discussion allows the psychologist to clarify areas of confusion, and ensure adequate understanding of the results and must be conducted if feedback is to be billed. A feedback session is a vital part of the treatment and rehabilitation process. The literature on Therapeutic Assessment applies to feedback for progress reports as much as initial assessment results. Patients are the primary recipients of their treatment plans and progress reports. In order for them to be able to use the information provided, they must understand and have an opportunity to address any disagreements. Thus, individualized, in-office feedback of interim progress reports and applications for further treatment is critical to the rehabilitation process and should not be skipped.

Readers are also reminded of the need to obtain informed consent and the patient's signature on any OCF-18 for continued treatment. This is the time for feedback of assessment results and discussion regarding plans for further treatment. Reviewing progress on treatment to date and continuing needs is a critical component to allowing informed consent to further treatment. Therefore, it is expected that this feedback occur prior to the patient providing their signature on an OCF-18. Thus, time for preparation of progress reports, discharge reports and/or subsequent treatment plans and feedback to the client should be included in the treatment plan, and should not be cut or skipped.

G. Outcomes

Evaluation of the patient's progress in therapy at formal evaluation point(s) will yield information regarding whether the patient requires further psychological treatment, referral to another provider and/or whether to proceed to either discharge or submitting a plan for extension of treatment.

Table IX: TREATMENT GUIDELINES: Initial Clinical/Health/Rehabilitation Psychological Treatment Plans

Factors indicating that psychological treatment consistent with accepted community and professional standards is reasonable and necessary include that an appropriate assessment has identified:

- A psychological impairment/condition/disorder resulting from the accident and its sequelae, and/or psychological factors that are having an effect on the treatment/rehabilitation of physical injuries (note that these are diagnosable using ICD-10 and do not need to meet DSM-IV-TR diagnostic criteria for a particular disorder to qualify for treatment;
- An effective or reasonable intervention exists;
- The patient is sufficiently motivated and can access treatment (barriers addressed);
- A sufficiently/ appropriately qualified practitioner is available (qualifications include language considerations, such that treatment should be provided by a psychologist who is able to deliver the service without the need for a translator).

Intervention	Patient condition	
	Mild and/or Uncomplicated	Moderate/Serious or Complicated (See Table X: Complicating Features)
	Treatment Plan: 8–18 weeks*	Treatment Plan: 19–40 weeks*
Treatment: psychotherapy (individual, couple, family group, in-vivo sessions), psycho-education, cognitive therapy rehabilitation	8–36 hours** To be proposed/provided in stages with outcome evaluation and confirmation of the appropriateness of continuation of treatment at each stage	19–80 hours** To be proposed/provided in stages with outcome evaluation and confirmation of the appropriateness of continuation of treatment at each stage
Review of external file material as received	0–2 hours	0–3 hours
Consultation, collaboration, and communication with treatment providers and others (e.g. phone, email and team meetings with other treating health professionals; contact with insurers, teachers, and employers)	0–4 hours	1–6 hours
Ongoing progress evaluation and formal reassessment: includes continuous evaluation of progress and formal re-administration, scoring, and interpretation of psychometric tests	1–4 hours (occurring every 6 to 8 sessions)	3–6 hours (occurring every 6 to 8 sessions)
Preparation of progress reports, discharge reports, and/or subsequent treatment plans	2–4 hours	4–6 hours
Disbursements and consumable goods used in therapy, e.g. books, manuals, workbooks, and tapes or CDs to support therapy; consumable test materials; use of external scoring services; and the cost of obtaining relevant records.	Billed on a cost recovery basis	Billed on a cost recovery basis
Total Treatment Plan Hours	12–50 hours***	27–101 hours***

* It may be appropriate to use a few sessions at less frequent intervals in a "follow-up" phase for consolidation and relapse prevention as well as support for work/school reintegration. Such follow-up should be anticipated in the treatment plan. Although delivery of such sessions may extend the number of weeks of treatment, they should be included in the total number of hours recommended for treatment. In this way, the follow-up phase will not add additional hours or cost to the treatment described in this Guideline and Handbook.

** Treatment should be proposed and provided in a *staged* manner. For some patients it may be realistic to predict that they will require an extensive course of treatment. However, continuation should be dependent upon re-evaluation and demonstration that response to treatment supports continuation.

*** Patients with exceptional characteristics may reasonably require additional time and costs beyond the ranges described in these Guidelines and Handbook.

Outcomes: Discharge or submit new treatment plan according to patient status

- Impairment resolved, function restored, no further treatment required; or
- Impairment continues, functional limitations continue, but no further psychological treatment is indicated; or
- Impairment continues, functional limitations continue, further psychological assessment/examination and/or treatment/rehabilitation is indicated;

AND/OR

- Other assessment/examination and/or treatment is indicated.

IX. Barriers and Complicating Factors

A. Barriers

Using the new OCF-18 to propose assessments and treatment requires that psychologists now consider whether any barriers to recovery exist. Barriers to recovery are factors that, if not addressed, could reasonably be expected to interfere with the patient's ability to attend or participate fully in psychological assessment and/or treatment, e.g., lacking transportation to and from appointments, lacking childcare, having scheduling difficulties, or lack of services available in the client's native language.

When including potential barriers to assessment or treatment, psychologists must also indicate any recommendations or strategies to overcome these barriers, such as funding for transportation for a patient who otherwise is unable to attend appointments.

Similarly, translation services can be useful for an assessment when services in the patient's native language are impossible, but assessment and treatment should be provided in the patient's language. Ideally, psychological treatment and rehabilitation interventions will not be provided using a translator. It is our recommendation that the psychologist consider it an obligation to discuss potential referral for services in the patient's first language if reasonably available.

B. Complicating Factors

Complicating factors may affect the amount of time required to complete an assessment or provide treatment. When a psychologist anticipates that the assessment, examination, or treatment will require more time, he or she should describe the reasons on the OCF-18, referring to the particular complicating factors. Complicating factors are patient-related factors affecting assessment, examination, or treatment; these are different from the requirements of specialized assessments (e.g., neuropsychological, psychovocational, or psychoeducational). A list of potential complicating factors is included in the following table.

Table X - Complicating Factors
Age • Assessment of children, adolescents, or geriatric adults often requires greater time for clinical interviews, consultation with other health providers, and feedback interviews.
Presence of pre-existing and co-existing psychological and physical vulnerabilities not related to the MVA, such as: • Previous exposure to traumatic events, especially recurrent childhood traumatic exposure • Depression, anxiety disorders, pain disorder • Physical injuries, acute and chronic debilitating medical conditions • Impaired cognition • Disability status, including learning disabilities • Significant problems with attentional or behavioural control and regulation • Developmental delay, ADHD, behavioural or conduct disorder
Absent or poor social supports or environmental resources, such as: • Poor parenting skills or dysfunction within the family • Difficulties with school re-entry, or limited resources within the school and community • Poor marital relationship • Limited social support network • Problematic work environment, currently off work and no modified work available if needed, or no return to work program available when needed • Limited education and/or transferable vocational skills • Limited social skills • Lack of access to timely and appropriate medical care and other needed treatment • Presence of multiple external stressors/stressful life events • Language/ cultural barriers to optimal communication
More complex/serious injury/impairment/presentation as a result of the MVA, such as: • Significant injuries to other family members in the MVA • The MVA resulted in death to another person • Slower than expected/incomplete recovery from physical injuries • More complex/serious/persistent psychological symptoms/ impairments • Multiple diagnoses (physical and/ or psychological), impairments, and limitations in functioning • Presence of post-traumatic numbing • Cognitive impairments • More time elapsed since MVA (e.g., greater than two years) • High distress associated with health/ claim/ litigation processes, and a sense of loss of control over life
Significant functional impairments in the home, school or workplace as a result of the accident injuries

X. HCAI

When the Health Claims for Auto Insurance (HCAI) system is fully implemented, all OCF-18s to propose assessment and treatment and all OCF-21's to invoice for services will be submitted through the HCAI processes. Psychologists who wish to remain paper-based will be able to fax their forms to the Data Entry Center (DEC). However, there is also a web-based application, and Practice Management Systems can be used for direct submission for greater efficiency. The required use of the HCAI will support development of a database to provide commonly-accessible information regarding auto accident injuries, treatments, associated costs, etc. Further information regarding HCAI is available on the OPA website and at www.hcaiinfo.ca.

XI. Coding

Completion of OCF-18s and OCF-21's requires use of ICD-10 codes to describe impairments and diagnoses. The Canadian Classification of Intervention (CCI) codes and Goods And Services codes (GAP) codes are used to describe interventions, goods and services provided. Description of the structure of these codes is available at www.hcaiinfo.ca. In addition, updated pick lists of codes most relevant to patients with psychological impairments, and provision of psychological assessment and treatment, will be posted on the OPA website.

XII. Conclusion

Survivors of MVAs present with a wide variety of problems; it is the responsibility of the individual psychologist to determine how to approach these problems. The Guidelines are not meant to dictate a particular approach or to prescribe a particular theoretical orientation or set of techniques or interventions for treating survivors of MVAs. Rather, they are presented as assessment and treatment principles, independent of particular models or theories; each psychologist is responsible to draw on the state of the science in the area of concern (e.g. traumatic brain injury, PTSD), and to supplement this with his/her own clinical training and experience in order to ensure that appropriate service is rendered to the individual adult, adolescent, or child MVA survivor. Whether the psychologist is submitting or reviewing an application, the rationale and principles addressed in these guidelines should be borne in mind. In addition, as noted above, patient presentation and clinical needs tend to be more complex than are generally seen in more traditional mental health contexts.

While it is expected that all psychologists are knowledgeable about a range of evidence–based assessments and treatments, it is also expected that the responsible treating psychologist will apply the techniques and procedures that are appropriate to the individual MVA survivor and his/her specific situation. Just as it is expected that psychologists will only propose assessments and treatments within their areas of competence, it is also expected that psychologists working as Insurer Examiner reviewers will only review plans within their areas of practice and competence. It is also recommended that both those proposing and those reviewing applications are familiar with arbitration decisions affecting access to benefits.

Treatment approaches must be similarly evidence-based where applicable, but flexible, and employed within the context of an empathetic therapeutic relationship. For instance, although it is expected that valid, reliable assessments and re-evaluation will be employed before, during, and after therapy in order to document progress and determine outcomes, it must be noted that assessment instruments and treatment approaches may vary widely. It is incumbent upon IE examiners to pay special attention to presented evidence of patient progress to date, complicating/extenuating circumstances which may have resulted in a premature plateau in recovery, and appreciate the notion of staged clinical and functional intervention phases and evidence of outstanding rehabilitation barriers to maximal recovery.

The severity of the impairment/ condition and presence of Complicating Factors also contribute to variability within the Guideline ranges. For these reasons, these Guidelines describe usual ranges and recommended re-assessments for professional time and associated costs for assessments and treatment plans for most patients, rather than prescribe specific hours and procedures for particular patient presentations. As a result, these Guidelines are not intended to prescribe a set assessment or treatment plan duration for all MVA victims. Nor do these Guidelines dictate the use of particular approaches; rather, they are intended to encourage the utilization of sensitive, flexible, evidence-based assessment and treatment approaches.

Psychologists do not see the majority of MVA survivors. However, the scientific literature that is fast growing in this area indicates that the small subgroup MVA survivors who suffer significant psychological impairments can result in a large drain on any system in which they are subscribers. A psychological assessment can identify those at risk for developing such impairments, convey this information to others in order to prescribe and direct appropriate interventions, and serve as an indispensable communication tool in explaining a given patient's progress in their rehabilitation. Psychologists also provide treatment that prevents and reduces disability, returns patients to work, improves their quality of life, and provides substantial cost savings to payor systems. The value of the role of psychology in assessing and treating auto accident victims is increasingly understood and must be reflected in current expectations for care. These Guidelines and the accompanying Handbook represent the current state of the knowledge in assessment and treatment of MVA victims; they should be seen as living documents that will evolve over time.