CSCE

the EVALUATOR

Fall 2002

PRESIDENT'S REPORT

The Canadian Society of Chiropractic Evaluators has made great strides this year in establishing itself as an important and integral stakeholder. I will highlight some of our accomplishments.

In the fall of 2001, CSCE provided a written submission to the Financial Services Commission of Ontario with respect to implementation of the Automobile Insurance Standardized Invoice (AISI). We spent many hours preparing our input. I would like to thank Dr. David Dos Santos for coordinating this submission. CSCE has been participating in discussions at the OMA head office with all the major health professional organization representatives. As a group we have identified the major issues with respect to implementation of the standard invoice. We have provided a communiqué to all of our members across Ontario. You will remember I issued you a memo at the beginning of the year with respect to a fee for completion of this standard invoice form. I am pleased to report to you that CSCE has been invited to participate in a Forum on the Standard Invoice scheduled for May 17, 2002. The Financial Services Commission of Ontario sponsors this forum. The Superintendent of Insurance has invited approximately 14 health professional organizations including 14 insurance industry representatives and ourselves. The government appears to be giving the perception that they are now willing to implement the standard invoice in a collaborative fashion. I would be pleased to provide your input with respect to the key issues and suggestions on improvement of this form.

CSCE also provided a written submission on Auto Insurance Reform in November 2001 to the Ministry of Finance. The Ontario government is looking at reforming the auto insurance legislation. We provided our input in writing. We are pleased to inform you that we were requested to meet with Ministry of Finance representatives and with the Member of Parliament charged to chair this committee (Mr. John O'Toole). I am happy to inform you that the CSCE had presented its position in a concise and well-informed manner. Drs. Rajwani and Dos Santos accompanied me to this important meeting in January 2002.

Also this year, the CCA had given CSCE an opportunity to provide input to the revised Glenerin Guidelines. The College of Chiropractors of Ontario similarly provided CSCE, along with other stakeholders the opportunity to provide input into the development of standards of care. Specifically, we provided our opinion on drafting the standard for providing experimental treatment.

The Membership Committee has been busy this year identifying and soliciting potential new members. I would like to thank Drs. Koch and Dos Santos for their assistance on this committee. CSCE is pleased to announce that we have a few new members this year. Unfortunately, we failed to reach the target of 15 new members. CSCE has reviewed the criteria for independent chiropractic evaluation reports and we have modified it. This will allow expert opinions, paper reviews and Functional Abilities Evaluation reports to qualify for submission.

AT A GLANCE…….

P.S. Since writing this report, there has been a lot of activity in the development of the AISI form and other OCF forms. I will update you on the new OCF forms and the new auto. "Legs and regs" changes in the next issue. Please see the update on Bill 166 in this issue. I am pleased to report that one-third of our membership has submitted denuded reports for peer review. The Report Evaluating Committee has evaluated these reports and members should be receiving feedback in the very near future. An ongoing peer review process is a very important one. The Financial Services Commission of Ontario is now conducting peer review on DAC reports. As an organization it is important for CSCE to be able to provide this service to its members. I am confident that a majority of our members will submit reports for review in the upcoming year. This is important for quality improvement and education of our members.

Continuing education is also an important facet of our organization. The Continuing Education Committee has met on a regular basis in order to prepare and put on this conference today. I would like to thank Drs. Pikula, Dos Santos, Rajwani and Decina for helping us in putting on this exciting conference today. I am pleased to report that this year we have had the most delegates ever registered for a CSCE conference.

We have had to re-establish contacts with the Continuing Education Department of CMCC. Dr. Jerry Grod has taken over the position of Continuing Education Director. We have resubmitted all of our proposals and our draft certification program to him. We will be discussing this with him in the upcoming year. We have also started a mentoring process informally in the past year.

The Executive of CSCE have discussed the importance of having a vision for the organization. The Executive and members passed approval of the following vision: **"The CSCE strives to maintain and improve the integrity and professionalism of chiropractic to society as a whole."**

In conclusion, our organization has established itself as a credible and important stakeholder for the chiropractic profession. At this stage, we need to increase our critical mass as our limited human resources are a barrier to further growth. We have made some progress in the past year. We need to realize some growth for the upcoming year.

Thank you everyone for your assistance.

Respectfully submitted,

Rocco C. Guerriero, B.Sc., D.C., FCCSS(c), FCCRS(c)
CSCE President

Overview of the Fifth Annual General Meeting Saturday May 4, 2002

Submitted by: Dr. Gordon E. Lawson, MSc, DC, FCCSS(C)

The meeting was called to order at 8:00 a.m. by Dr. Guerriero, President, C.C.S.S. A quorum was established, the agenda was reviewed and the minutes of the previous meeting were accepted. The President reported followed by the Treasurer, Dr. Lawson. We are in financially good shape with our assets increasing by $4,000.00. We appointed the Auditor. Reports were provided for the following committees: Membership, Standard Guidelines, Communication and Continuing Education and Nomination. The nominees were presented. The election took place with the following Board Members now making up the Board:

Dr. R. Guerriero Dr. M. Rajwani
Dr. T. M. Dormon Dr. D. Dos Santos
Dr. Lawson Dr. Stants

The Annual General Meeting was completed by 9:00 a.m.

The day was followed by the "Workshop on Whiplash-Insights and Perspectives". The conference was cutting edge and very exciting. The information was presented about psychological issues by Dr. Ridgley, Ph.D., updates on the Law by Dr. Stands, and Medical Legal Issues by Dr. Carrie. Mr. Handler, provided an update on the auto insurance reform. After an enjoyable lunch, the afternoon was a panel discussion which consisted of a lawyer (Dale Elander), an insurer (Denise O'Obrien), an arbitrator (Lawrence Blackman) and Clinicians, Dr. Ridgley and Dr. Guerriero. The main focus of discussion was involved with the lawyer, the

insurance and the arbitrator, which provided insights. There was much more to discuss. The day closed at 3:30 p.m.

This is a fabulous way to get up to date information in the area of whiplash assessment and evaluations. The personal interactions are very rewarding. We are in the process of planning next year's annual general meeting. Any input or suggestions are welcome from all members.

Inter-Personal Collisions

By: Dr. Thomas Dormon

'A passenger riding in the rear seat without a seat belt becomes a deadly human projectile in a head-on collision'

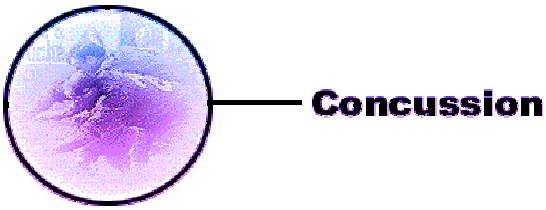
In a recent study by Japanese researcher Masao Ichikawa, it was found that front seat passengers who were wearing their seat belt were more than six times likely to be killed if there was a passenger positioned behind them who was not wearing a seatbelt. In other words, perhaps five out of the six such fatalities could have been prevented had the rear seat passengers buckled-up. The fatality rate was similar to front seat passengers who were not wearing seat belts.

The epidemiologist studied 100,000 vehicle accidents reported to Japan's traffic registry. He suggests that seat belt laws should include rear seat passengers, a practice currently required in only 14 of the 49 American states which have mandatory seat belt laws.

Ichikawa was not surprised by the statistics, "if a car that is travelling 50 km per hour is stopped dead, 80kg in the back seat are going to be thrown into the front seat with an impact strong enough to be deadly".

During an evaluation of a front-end motor vehicle accident injury, inquiry should include the presence of any passengers behind the claimant and whether or not they were wearing their seatbelts.

References: please contact Dr. Dormon at dormonrtarm@primus.ca



WHAT'S NEW IN CONCUSSIONS?

By: Dr. Rick Corbett D.C., D.A.C.B.R.

What did we used to know about Concussions?

Thirty-five years ago the Committee on Head Injury Nomenclature of the Congress of Neurological Surgeons proposed a "consensus" definition of concussion. This definition endorsed by the AMA, and the International Neurotraumatology Association was, "trauma-induced alteration in mental status that may or may not involve loss of consciousness".[1]

Grading of Concussions [4]

We used to use concussion grading guidelines to grade concussions. There are/were several guidelines in use:

- American Academy of Neurology Guidelines
- Ontario Brain Injury Assoc. Guidelines
- Canadian Brain Injury Coalition Guidelines

What did we used to think were important criteria in Concussions? [4,5]

We used to grade concussions according to the criteria of how long did the concussed person have symptoms:

Less than 15 min. – Grade 1
More than 15 min. – Grade 2
Was there a L.O.C, if yes – Grade 3

So what is new in Concussions? [1]

The First International Symposium on Concussions in Sport was held in November 2001. This symposium was organized by I.I.H.F (International Ice Hockey Federation), F.I.F.A. F-MARC (Federation Internationale de Football Association, Medical Assessment and Research Centre) and I.O.C – M.C. (International Olympic Committee – Medical Commission).

The Vienna Concussion In Sport Group (CISG) draft agreement position was

published in February 2002. The following is a summary of this paper.[1]

CISG Definition of Concussion

"A complex pathophysiological process affecting the brain induced by traumatic biomechanical forces".[1]

"Five Features Common To All Concussions [1]

1. Direct Blow: Concussions may be caused either by a direct blow to the head, face, neck, or elsewhere on the body with an "impulsive" force transmitted to the head.
2. Rapid Onset of Short-Lived Impairment: Concussions typically result in the rapid onset of short-lived impairment of neurological function that resolves spontaneously.
3. Functional Disturbance: Concussions may result in neuropathological changes, but the acute symptoms largely reflect a functional disturbance rather than a structural injury
4. A. Graded set of Clinical syndromes: concussions results from a graded set of clinical syndromes
   B. Which may or may not involve loss of consciousness
   C. Resolution: resolution of the clinical and cognitive symptoms typically follows a sequential course
5. *Structural* Neuroimaging is grossly normal"

Important Factors in Predicting Concussion Severity [1]

The factors that CISG identified as the most important in predicting the severity of concussions are:

a. Amnesia
b. Nature and burden of Symptoms

In fact, the nature, burden and duration of the clinical post concussive symptoms may be more important than previously recognized, as it may correlate best with recovery, and consequently return-to-play.

Post Concussion Symptom Scale[1]

It was the opinion of the CSIG that the severity of postconcussion symptoms is more important than loss of consciousness in predicting the severity of the concussion. It is recommended that a standardized postconcussion symptoms scale be used in the clinical and evaluation of postconcussive signs and symptoms instead of the concussion grading scales.

NEUROPSYCHOLOGICAL ASSESSMENT POST CONCUSSION[1]

The application of neuropsychological testing in concussion has been shown to be of value and continues to contribute significant information in concussion evaluation

Examples of Test strategies / paradigms

- Paper and pencil tests e.g. McGill ACE, SAC
- Condensed batteries e.g. McGill ACE

Examples of Comprehensive protocols administered by neuropsychologists:

- NHL protocol, Australian Football protocol
- Computerized test platforms – ImPACT, CogSport, ANAM, Headminders

NEUROIMAGING – WHAT'S NEW?[1]

It was recognized by the Vienna CISG that "conventional structural neuroimaging is usually normal in concussive injury". CISG has the following suggestions regarding imaging in concussive injury.

- Brain CT and Brain MRI contributes little to concussion evaluation. We shouldn't order CT or MRI after head injury. Only when concussion is suspected
- When should we order CT or MRI after head injury? Whenever suspicion of a structural lesion exists.

New Structural MRI Modalities for Investigating Concussions:[1]

- Gradient echo
- Perfusion, and
- Diffusion-weighted imaging

These imaging modalities have limited usefulness in clinical application at this time for these reasons:

- Lack of published studies
- Absent pre-injury neuroimaging data

- False positives: predictive value of incidental MRI findings is not well established

Promising Newer Functional Imaging Technologies for Investigating Concussions:[1]

While demonstrating some compelling findings, these imaging modalities are still at early stages of development with respect to concussion in particular:

- PET – Positron Emission Tomography
- SPECT – Single Photon Emission CT
- FMRI – Functional MRI

Newest Technology for Investigating Concussions:[1]

- MRI- Spectroscopy (AKA MRS) – new but may be the breakthrough test
- EEG and QEEG, i.e. Brain Mapping

Other Tests:
Neurodiagnostic tests: Evoked response

RESEARCH METHODS[1]
"Promising Areas:

- Event-related potential electroencephalograms
- Balance testing
- Biochemical serum markers of brain injury

have been proposed as a means of detecting cellular damage, e.g. neuro-specific enolase (S-100b NSE), myelin basic protein (MBP)
Genetic Phenotyping

- APOE4
- Calcium subunit

Evoked Response

- Visual
- Auditory"[1]

MANAGEMENT AND REHABILITATION ACUTE RESPONSE[1]
"When a player shows **any** symptoms or signs of a concussion:

- The player should not be allowed to return to play in the current game or practice.
- The player should not be left alone, and regular monitoring for deterioration is essential.
- The player should be medically evaluated following the injury.
- Return to play must follow a medically supervised, stepwise process.
- A player should never return to play while symptomatic"

***"When in doubt, sit them out"**[1]

The Return-To-Play protocol, which CISG outlined, is from the Canadian Academy of Sport Medicine Guidelines. There are six levels in this return-to-play protocol [1]

"Level 1: No activity, complete rest. Once asymptomatic, proceed to level 2
Level 2: Light aerobic exercise such as walking or stationary cycling
Level 3: Sport specific training i.e., skating in hockey, running in soccer
Level 4: Non contact training drills
Level 5: Full contact training after medical clearance
Level 6: Game play"

"PREVENTION – IS THE BEST WAY TO MANAGE CONCUSSIONS
Of the organs that can be conditioned to withstand injury

- **The brain is not one of them"**[1]

EDUCATION[1]
"After the event happens the ability to treat or reduce the effects of concussive injury is minimal. The mainstay of progress in the field of concussions is education of: athletes, colleagues, those working with the concussed athlete, as well as the public:

- Detection of Concussions
- Clinical Features of Concussions
- Assessment Techniques
- Principles of Return to Safe Play"[1]

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2. American Academy of Neurology - Practice Parameter: The management of concussion in sports (summary statement), Neurology, 1997;48:581-5

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4. Corbett R, Categorization Or Grading Of Concussion In The Hockey Player- A Brief Review Of 3 Concussion Grading Guidelines: Journal of the American College of Chiropractic Orthopedists, 2000; 22(2), pp. 21-23.

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Dispute Resolution Issues

Proposed Changes to the Ontario Automobile Insurance System

D. Dos Santos, B.Sc., D.C., FCCRS(C)

The Ontario Government has stated that in 2002 changes will be forthcoming to the automobile insurance system. On September 16, 2002 the government released a Draft for Stakeholder Consultation. Proposed changes to the legislation and regulations (Statutory Accident Benefits Schedule) are outlined.
Action will be taken to increase accountability by all stakeholders in the system.

Specific proposals have been directed at paid intermediaries, clarification on prohibition on assignment of benefits, consolidation of arbitration proceedings, and access to dispute resolution.

Of Interest, is the proposed changes to the dispute resolution process. Currently, claimants must make themselves reasonably available for medical examinations requested by an insurer and DAC assessments prior to applying for mediation. There are presently no charges to applicants for mediations (insurers are charged $500). For arbitration, applicants are charged $100 while insurers are charged $3000. It has been proposed that claimants must attend DAC assessments and insurer examination before applying for mediation. It is also proposed that the responsibility for cost for dispute resolution be evaluated after the DAC assessment has taken place, and to increase accountability the claimant should be charged a fee.

To minimize cost pressures from the assessment process for determining reasonableness and necessity of care, proposed legislative changes to the Insurance Act will permit the creation of binding treatment guidelines for the purposes of the regulations. There will remain a need for assessments for determining reasonableness and necessity of treatment which falls "outside the box" or for individuals with multiple injuries. The government also recognizes that there are a growing number of lawsuits against DAC assessors, as a result of negative impact of DAC opinions on claimants.

It is proposed that the Insurance Act be amended to protect DAC's from lawsuits as a result of any act or omission carried out in good faith. It is also proposed that DAC reports be considered as prima facie evidence by arbitrators and courts.

As a stakeholder organization, CSCE has been asked to provide input on the Draft for Consultation. We will continue to assist the government and in the near future we will update you on any changes relevant to the dispute resolution process.

Over the interim, if you have any questions or comments, please do not hesitate to contact Dr. R. Guerriero or myself.

UPDATE ON BILL 166

September 16, 2002
By: Dr. R. Guerriero

Officially, Bill 166 is dead! Mr. Robert Sampson confirmed that Bill 166 will be taken off the table. Subsequent to our update last week, Mr. Sampson's private member's Bill 166 was introduced in the legislature on or about June 27, 2002.

A coalition of service providers, including myself and Dr. Stants, met with Mr. Sampson, government officials and representatives of the insurance industry to propose solutions to contain rising assessment and Med/Rehab costs in the treatment of motor vehicle accident-related injuries.

Bill 166 gave insurers much more control in the provision of health care. This bill proposed preferred providers, which the list would be rostered by the Superintendent of Insurance. It also proposed that health care practitioners would be removed from the list if their treatment had been deemed not reasonable and necessary on multiple occasions.

Mr. Sampson confirmed that he will introduce a new government bill in the legislature, most likely in the first week of October 2002. The highlights of this new bill will be contained in this short report. Mr. Sampson reports that there will be limited consultations on September 23, 24 and 25, 2002.

I will summarize the highlights of the new auto insurance reform, which will be revealed shortly.

Draft regulations to auto insurance reform will significantly change Section 38 of the *Statutory Accident Benefits Schedule* (SABS). This curtails medical and rehabilitation benefits. Traditionally, insurers paid up to 15 physiotherapy and chiropractic treatments. This minimum has been eliminated. The new section will focus on **Treatment in Accordance with Guidelines (TAG)**; i.e., the black box. This guideline which is to be developed by a minister's committee on auto insurance will be issued by the Superintendent of FSCO. If an impairment is the subject of a guideline, then the person is required to get that program of treatment. A treatment plan does not have to be submitted for this initial treatment. A new fast track report, OCF-18A, will describe the impairment and treatment in accordance with the guideline.

If there are impairments that are outside of the guideline, then they are still subject to prior approval by the insurer. The traditional treatment plan (OCF-18) will be submitted to the insurer for approval. If their treatment is not approved, then the disputed treatment plans(s) must be sent to a Medical and Rehabilitation Designated Assessment Centre. The process of referral to the DAC will remain almost the same, with minor changes.

The new draft regulations will increase accountability of consumers, service providers and insurers. Both service providers and insurers may be reported to the regulatory bodies for inappropriate action. A Provincial Offences Act will be introduced to deal with dishonest claimants.

One of the most significant changes is removal of most section 24 assessments. The insurer shall still pay for reasonable expenses for the purposes of an assessment in accordance with the guideline that is to be developed by the health professionals and negotiated with the insurers. This section alters the assessment procedure by restricting Section 24 costs to guideline cases (in the box per the guideline). Cases outside the box involve the provider taking a business risk, that the insurer and the DAC will agree with the assessment costs. The same provision calls for payment of DAC fees. Insurer's Examinations are removed from medical and rehabilitation claims.

The 15 treatment/6-week provision for chiropractic and physiotherapy is now replaced by the "black box" concept.

There will be an amendment to empower the removal of DACs. This provision allows a committee to recommend the removal of a DAC to the Superintendent.

The Medical and Rehabilitation DAC reports will be given *prima facie* evidence. There is a provision for the protection of DAC assessors. This is intended to provide some protection against complaints and lawsuits.

Finally, the function of all the DACs will basically remain the same. It is important to note that DACs have been criticized similarly, as they have been in the past. There were discussions to have alternative dispute resolution processes. However, it was realized that the present DAC system appears to be the most suitable in providing independent, unbiased opinions.

In conclusion, it is evident that the government is introducing a government bill in October 2002. It will likely be passed before the end of the year. The timeline for implementation of this new bill will likely be January 2003.

More details will be provided to you upon receipt. All of this information was confidential until this date.

If you have any questions, please feel free to contact Laura at csce@nyrc.ca She will provide you with as much information as reasonably possible.

Please feel free to give us your input on this newsletter format. If you would like to contribute to The EVALUATOR with articles or advertisement, please email us at csce@nyrc.ca or contact Laura Mba at 416-497-4477

We are always looking for new and creative ways to get information across to our members.