CANADIAN SOCIETY OF MEDICAL EVALUATORS
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November 2001

Dear Society members:

After much too long a hiatus, we are pleased to be able to provide Society members with their next newsletter. We have worked long and hard at this and we hope you find it worthwhile reading.

We have divided this edition of the newsletter into five sections: **Society** Business, **National** issues, **Provincial** developments, interesting recent **Literature**, and finally, matters pertaining to the upcoming **AGM**.

A newsletter is of value only if members submit newsworthy articles and letters. Please keep contributing, so that our newsletters will continue to be enriched with your expertise and opinions.

[Apologies to Dr. Ranney: We did not have sufficient space in this edition to run your excellent article. It will be in the next newsletter].

Submissions, Comments , and Criticisms, are welcome. Please send emails to *drameis@mdacentre.com* Or fax to the personal attention of Dr. Ameis at 416-256-4730

Society Business

The Society is a vitally active entity, with an Executive and Committees pursuing members' interests in an ever-expanding set of directions.

Standards Committee has been working on updating and adding to our Society Standards and to our list of practice guidelines and checklist recommendations.

It's drafting sub-committee has proposed several new Standards and Position Statements on relevant issues. The Standards Committee will be presenting the Board and membership with the following:

Proposed New Standards:

- **The Presence of Additional Parties during a Clinical Assessment**
- **Non-Consensual Record Making during Clinical Assessment**

Proposed Position Statement

- **Necessity & Reasonableness in Acute Soft Tissue Injury (STI) Care**

Once approved, these Standards and Position Statements are intended to be used as a reference for members and by any other party interested in sharing our high standards in quality of evaluation and care.

Education Committee is planning an exciting set of Conferences and Seminars for the year 2002. One of the first of these will focus on the *Necessity and Reasonableness of Treatment Plans and of Disability Rehabilitation Programs*, tentatively to be held in Toronto in late March.

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National Affairs

GST in Medicolegal Practice

Many of you will be aware of, and more than a few of you will have direct knowledge of the recent initiative of the CCRA (former Revenue Canada), GST Division, to audit physician and IME center practices to ensure proper collection and remittance of GST for medicolegal services.

It is our understanding that in these recent audits, the GST auditors made it very clear to physicians that they must bill, collect and remit the GST on all medicolegal work.

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National Affairs, continued

Moreover, the outcome of the GST audits was that a failure to collect GST in previous years, despite apparent vagueness of RevCan policy, did not excuse the physicians and centers from remitting the GST. The auditors calculated the GST tax owing as being retroactive for several years! Thus, notwithstanding that a physician or centre had—in good faith and to their financial disadvantage - never collected the GST, the audit resulted in a large assessment for retroactive GST liability.

It is rumoured that in some cases the GST auditors were willing to discuss a reduction of the amount of the tax debt The tax owing would be calculated on the basis of work done in a period somewhat shorter than that spanned by the audit, this adjustment to be predicated on full compliance with the audit, including acceptance of the obligation to collect GST on all medicolegal work.

Paradoxically, the Canadian Medical Association recently responded to a doctor's query that it had been entirely unable to get the federal government to address the GST inequities regarding medical practice, including any offset of the GST paid in the course of medical practice for supplies etc. Ironically, the only portion of a physician's payment of GST in association with an office-related purchase or rental expense which can be offset is that which can be prorated from medicolegal activities!

It therefore makes sense for physicians, when doing medicolegal work, to take advantage of the CCRA's position on medicolegal work as being subject to GST.

Recently, Riverfront, a Toronto medicolegal service provider, challenged the CCRA's GST Division.
On their accountants' advice, Riverfront had never collected the GST for medicolegal work performed by the several physicians working for this centre, over several years (beginning in 1991). A 1998 CCRA-GST audit resulted in a demand for full retroactive payment of all the GST that should have been remitted from July/95 - Jan/98 (the audited period). This created a huge, unplanned-for tax liability.

Riverfront challenged CCRA-GST, taking the position that when billing for medicolegal services there should not be a charge to the third party for GST and thus no obligation to forward the GST to CCRA.

The appeal was heard in federal Tax Court. (Tax Court of Canada (Bell, J.T.C.C.) June 8, 2001, (1999-4412(GST)G).)

At trial, Riverfront argued that soon after the GST was implemented RevCan gave a 'verbal ruling' which seemed to assureRiverfront's accountants that medicolegal practice was GST exempt. However, CCRA countered by pointing out that RevCan had never followed up with a *written* statement supporting that position. That Riverfront and its accountants had never pursued written confirmation placed the decision to not collect the tax in peril.

Dr. John Carlisle of the College of Physicians & Surgeons of Ontario was asked by Riverfront to testify. He explained CPSO's position: a physician-patient relationship existed in all medical activities including medicolegal work. The recipients of IME services are "patients". Evidently, his testimony, along with some English hospital law, was influential in Judge Bell's decision: medicolegal examinations are a form of medical care, and IME centers are equivalent to hospitals; medicolegal work is GST exempt.

The decision supported Riverfront in not collecting GST and dismissed any GST liability by the auditor.

We sympathize with Riverfront's circumstance: an unexpected GST debt unrecoverable from past 3rd party payors. However, the larger issue for CSME members may be that physicians performing medicolegal work obtain a small but distinct financial benefit from being subject to GST. This Tax Court decision directly threatens that benefit.

If this results in a policy change by CCRA it will benefit the insurance companies as they do not collect GST on premiums (hence no input credits).

Making third party services no longer subject to the GST will be financial detrimental to physicians in that we will no longer be able to receive credits for GST on goods and services such as rent, legal and accounting fees.

The CCRA has appealed the federal court decision. Unless the decision is sustained on appeal, and then conceded by the CCRA, physicians/ centers should continue to collect and remit GST on 3rd party assessments. [In Ontario, be sure to include GST in completing the new AISI]!

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Society Business, continued

Communications Committee has continued the review and enhancement program for our two CSME Patient Education pamphlets—applicable to either Physicians or Psychiatists.

Externally, members have been advocating on behalf of Society interests with a considerable number of major 'stakeholders', through informal meetings and formal presentations.

Some new projects have been proposed for further discussion:

*Participation in the development of a useful *clinical* data base using the Auto Industry Standard Invoice (AISI).
*Conjoint initiative with CMA, IBC and pharmacists to spearhead an educational program directed towards increased awareness of the propensity for hypersomnolence-related accidents soon after starting new medications or with dosage changes.
*Collaboration with CMPA in the evolution of their medicolegal checklist.

For the **Executive t**he year just past has been far from uneventful. After long service, giving us unstintingly of her time, our office administrator Diana Clarke found it necessary to take permanent leave. Heavily committed to her full time job, she felt she deserved a personal life.

Concurrently, some of the Executive were coping with serious personal and health difficulties, which compounded by Diana's withdrawal, resulted in a less than efficient office.

Nevertheless, Society activities have continued, albeit with the Education Committee's seminars and conferences, and Membership development, scaled down temporarily.

*All that has changed***.** We have retained the excellent services of Base Consulting. A professional group, Base specializes in providing administrative services to non-profit, volunteer-run organizations like CSME. Instead of us relying on our own small staff, Base will provide the expertise to handle virtually all of the Society's infrastructural needs. Members can expect, in short order, to find a rejuvenated website, a responsive office phone system, and a new slate of relevant educational and social activities.

We wish a speedy recovery to Drs. Jack Richman, and Sol Goldenberg!

National Affairs, continued

The other area of concern to CSME members is the CPSO's opinion that there is a physician-patient relationship between us and any person referred for evaluation by a third party. We have gone to great lengths in our protocols and consent procedures to make it clear to all parties that there is NO doctor-patient relationship in the traditional and practical sense. Certainly, we have a responsibility to act like professionals. However, we are not involved in directing the immediate or continuing care of the people referred to us. The services we provide are NOT medically necessary or they would be covered under public health funding such as OHIP's 'essential services'. It is our duty to provide impartial professional opinions and not to become involved in the delivery of medical care to the people we assess, (other than in an emergency situation).

Your executive will seek discussion with CPSO and others, over the question of our fiduciary duties. We will keep members informed.

NB: Urgency Incontinence Clinics are always busy...most patients can't wait to go!

REMINDER

Membership fees are due January 31st 2002

Provincial Affairs

Ontario

Ontario Minister's Committee on the Designated Assessment Centre (DAC) System

In November 2001 Dr. Arthur Ameis, President of CSME, was appointed by the Ontario Finance Minister, to serve on this policy setting committee as representative of the Ontario Medical Association, for a three year term. Dr. Ameis will replace Dr. Harold Becker who served the profession well as the OMA's inaugural representative on the Committee.

Certification Initiative

Executive and general Members have participated in efforts to obtain formal recognition of CSME's certification and educational program from the Financial Services Corporation of Ontario, and IBC and others.

FSCO is embarking on an ambitious program towards quality assurance and improvement for the pool of DAC assessors. IBC is asking the evaluator community to take leadership in addressing insurance-related issues of rehabilitation, disability certification., and independent evaluator quality.

CSME has made representations arguing that existing certification and education programs sustain and offer very real indicators of evaluator competence. We believe that mere duplication of efforts through alternative forms of education or competence certification are pointless. Indeed, who better to identify need and teach physicians...than physicians! The dialogue continues.

Auto Insurance Standard Invoice

Spear-headed in Ontario, this will eventually become a national initiative of the Insurance Bureau of Canada. It is intended to be of equal benefit to Insurers and to Service Providers including those who conduct claimant evaluations.

Although touted by IBC as a 'standard invoice', this is in reality an activity reporting *Form* intended to digitize, universalize and standardize information about the nature of injuries, the types and costs of treatments and assessments, <u>and</u> the identity,workprofile and fees of their providers. According to IBC the advantage to the IME community is a more efficient, rapid turnaround on accounts payable. For the Insurer, the standardization is expected to enhance data collection efforts so that regional policy decisions can be made on a timely, informed basis.

To date, aside from FSCO data collection, there has been no single, reliable, detailed source of information on insured injured persons in any region. Each company keeps it's own statistics, with little cross-compatibility.

An early, immediate benefit to a standard invoice form would be an accurate snapshot of the duration of stay in the system, by diagnosis, as well as the cost and type of care.

Another benefit might be an efficient system of screening service providers and evaluators by areas of competence, since each provider must cite a College or Board licence number. This will identify that small cohort of providers or evaluators who might be acting outside of their areas of competence; or who, despite strings of lettered 'credentials', are not regulated health professionals!

However, we are concerned that provision of diagnostic and practice data to any central agency begs careful scrutiny, and vetting by the privacy commissioner. (In order to submit the standardized invoice form, physicians are also required to obtain *consent* for release of medical information).

For example, analysis of the information on the forms will allow insurers to readily create practice profiles and financial information on individual health professionals: all fees billed, to whom, and why, will presumably be available. To date no mechanism is in place to ensure accuracy of data collected, or to provide a means of correcting data, or to ensure that information is not released other than in a generic, anonymous form.

We support the Insurance industry's efforts to detect fraudulent billers, or those who would sacrifice quality for quantity.

However, the data base will also document exactly how much time a physician spends doing (1) a clinical assessment, (2) performing a documentation review or (3) preparing a report. Such information can only be interpreted in context, which the data base will not provide. Clearly, expert medical input is essential if the Insurance Industry is to understand and make proper use of this new, powerful data base of professional activities and claimant profiles.

That consultative and collaborative process is <u>not</u> in place.

Members will likely find the history of the project's development to date to be of more than passing interest.

Over the past several months, health professionals and other stakeholders have become increasingly concerned that the Insurance Bureau of Canada has been pressing ahead with unusual haste, and perhaps even aggressiveness in implementing their AISI development team's program. Towards that

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Provincial Affairs, continued

end, the IBC proclaimed successful consultation and collaboration with stakeholders including the Ontario Medical Association. In fact, only perfunctory, transient contact was the rule.

This led to a deep concern among stakeholders that the development team's ultimate goal might not be data collection leading to informed and collaborative policy decisions but rather a selective unilateral use of the data to drive down the costs of auto insurance claims, including both treatment and assessment services. The latter appears to include an effort to reduce the number of multidisciplinary centers of excellence which some Insurers perceive as either too costly or not sufficiently supportive of their interests (ie too neutral in their determinations?).

It must be noted that CSME is held in high regard for it's neutrality and resources of knowledge and practical experience, by various stakeholders interested in this process. CSME members were amongst the few professionals actually consulted in depth by researchers advising the standard invoice form development team. Unfortunately, the AISI development team seemed to not pay close attention to some of the advice given to them, including a suitable short list of relevant diagnostic codes. Members of your Executive have since pointed out to senior members of the IBC that the planned collection of data compels important concerns over who will analyze the statistics, who might have access to raw data and how errors, including those pertaining to claimant diagnostic records and physician practice profiles would be rectified. Our input evidently has contributed to a decision by IBC to delay implementation of the development team's plan for a central data collection entity.

Very recently, a Committee of Concern was formed by representatives of professional associations including Medicine, Physio, OT, Chiro, Psychology, Massage and Kinesiology, along with CSME, CSCE and ADAC. A joint letter of concern was presented to the Ontario Minister of Finance. As a result of these efforts, the Financial Services Corporation of Ontario has instructed stakeholders to consider the Standard Invoice to be a Form, still in the development phase, with attendant limitations on reliance by Insurers.

At the time of writing, this Committee is in active discussion with government and the IBC, directed towards developing a truly consultative process and a more suitable invoice Form, with beta testing, as well as a suitable fee ($100-$200 dependent on time spent completing the Form).

In parallel, representatives of various medical sections of the OMA have held a joint meeting with IBC representatives offering to collaborate on a practitioner-friendly form with medically relevant diagnostic codes (AISI's 'pick list' of 'typical' codes include diagnoses of "panniculitis" and "lumbago".

CSME will assemble any member reports of AISI payment problems , for presentation to IBC and FSCO.

Editor's note:
With Ontario the hot bed/ test bed of medicolegal developments, it is not surprising that Society members from Ontario submit a lot of information updates for the newsletter. *Make no mistake, CSME is a* ***national*** *Society*. In future, submissions from other provinces will be given priority to balance this edition's regional disparity. While we are changing email addresses, over the next several weeks, please email current or significant information from your province to Dr. Ameis, Society President, at his office email: **drameis@mdacentre.com**

In the Recent Literature

Spine 2001 Jul 1;26(13):1411-6

Radiofrequency facet joint denervation in the treatment of low back pain: a placebo-controlled clinical trial to assess efficacy.

Leclaire R, Fortin L, Lambert R, Bergeron YM, Rossignol M.

SYNOPSIS: Despite a small positive effect on functional disability in the treatment group at 4 weeks, by 12 weeks there was no continuing treatment effect as measured by Roland-Morris score, Oswestry or Visual Analog Scale.

The authors concluded: "*Although radiofrequency facet joint denervation may provide some short-term improvement in functional disability among patients with chronic low back pain, the efficacy of this treatment has not been established*".

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Practical Suggestion: If taking weight in an ortho exam, get height too. BMI is more relevant that kgs.
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In the Recent Literature, continued

Clin Rehabil 2001 Jun;15(3): 266-73

Base rate of post-concussion symptoms among normal people and its neuropsychological correlates.

Chan RC.

SYNOPSIS: The authors examined the base rate of symptoms similar to those of post-concussion symptoms (PCS) among a group of volunteers with no history of head injury. A bank of neuropsychological tests was administered. The authors found:
"…*A relatively high proportion of the participants reported symptoms similar to those of patients with PCS. These included longer time to think (65.9%), forgetfulness (58.9%), poor concentration (58.9%), fatigue easily (53.5%), and sleep disturbances (50.6%)...Moreover, there was no difference found between low symptom reporters and high symptom reporters in terms of attention, working memory, mental fluency, and strategy allocation.*

The authors concluded that concussion-like symptoms are relatively common in healthy, non-head injured persons. Also, non-head injured "*persons reporting a high score of concussion-like symptoms did not perform less well than those reporting a low score of symptoms in attention, working memory, mental fluency and strategy allocation*".

Clin Rehabil 2001 Aug;15(4): 371-9

A new, comprehensive normative database of lumbar spine ranges of motion.

Troke M, Moore AP, Maillardet FJ, Hough A, Cheek E.

SYNOPSIS: The authors wished to generate gender-specific and broadly based age-related indices for normative lumbar ranges of motion for all planes of movement. Asymptomatic subjects aged 16-90 years, from sedentary, mixed and physically demanding occupations underwent standing lumbar spine range of motion measurements following a standardized protocol for sagittal flexion/extension, coronal lateral flexion and horizontal axial rotation movements.

"RESULTS: Male and female normative flexion ranges declined by approximately 40% (72-40 degrees) across the age spectrum. Extension declined the greatest, by approximately 76% (29-6 degrees) overall. In lateral flexion male and female ranges declined approximately 43% (29-15 degrees) in each direction (total 58-30 degrees). In axial rotation no age-related decline was observed and ranges of motion remained at approximately 7 degrees in each direction (total 14 degrees) across all the ages of the subject group".

[*Editor's note*: The AMA Guides to Evaluation of Permanent Impairment recommend that Diagnosis Related Estimates (DREs) be used instead of range of motion in determining impairment because of the many variables, especially effort. This study points out the additional need to always consider age when assessing apparent loss of ROM].

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Practical Suggestion: *before testing ROM it may be prudent to give patients a set of 'warm up' stretches to reverse benign tightening, particularly after prolonged waiting room time followed by a long interview.*

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Disability and Rehabilitation Vol: 23 No: 8 pp 341-351

Coming to terms with the shift in one's capabilities: a study of the adaptive process in persons with poliomyelitis sequelae

Anna-Lisa Thoren-Jonsson

SYNOPSIS: Using polio as a model, the process of adaptation was explored. Two integrated processes are described, one involving realization & reorganization, the other a set of patterns of behaviour in daily activities. Key areas of extensive dependence included cleaning, shopping and transportation.

"*Conclusions: Flexibility in choosing strategies facilitated participation in daily occupations. Requirements for this adaptive pattern were time, energy and ability to solve problems, accessible environments, access to information and support, and readiness to compensate with assistive devices*".

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In the Recent Literature, continued

J Rheumatol 2001;28:2096-9)

Physician Resistance to the Late Whiplash Syndrome

SHAINOOR NIZARALI VIRANI, ROBERT FERRARI, and ANTHONY SCIENCE RUSSELL

SYNOPSIS: *"The biopsychosocial model of the late whiplash syndrome is based in part on the concept of symptom expectation -- that the commonly held view of whiplash injury as a serious injury and anticipation of chronic pain and disability engenders a post-injury behavior that encourages chronic pain*".

The authors suspected that physician accident victims might be expected to view whiplash as benign compared to most lay persons, leading to a more benign outcome. Indeed this is what they found.

Despite similar accident rates, acute whiplash symptoms were likely to develop in only 2/3 of physician-victims. Of these, there were striking differences in symptom persistence, and disability from work.

With 71% of physicians and 60% of nonphysician hospital workers recalling being in an MVA, "*about 31% of physicians recalled acute symptoms, compared to 46% of nonphysicians. Symptoms tended to be short-lived for physicians (days to weeks) while nonphysicians more often had symptoms lasting over 6 months. Only 9% of physicians recalled symptoms lasting for more than one year compared to 32% of nonphysicians. Physicians took no more than one week off work, whereas among nonphysicians, it was common to take more than 6 months off*'.

*"**Conclusion:** Physicians appear, however, to be more resistant than non-physicians to the progression from acute pain to chronic pain and disability*".

THE STANDARDS COMMITTEE REQUESTS…

We are currently exploring the need for a Position Statement on TBI over-treatment since 'no-fault'. We ask the membership to advise of any literature or current research on the question:

Do Compensable Head Injured Patients get more treatment, and if so with what effect on outcome?

Our concerns have been amplified by an excellent Podium Presentation at the recent Eighth Annual Academic Day for Ontario Physiatrists, entitled "*Comparison of One Year Outcomes in TBI for Insured vs. Non-Insured Patients*". An issue already under discussion in our Committee, this presentation provided a glimpse into research of relevance to head injury rehabilitation in Ontario. The on-going study is being authored by Drs. B. Cayen, N. Cullen and M. Bayley of TRI.

To synopsize the presentation, the authors compared TBI patients involved in auto accidents (Insured), with those injured in falls, or blunt or penetrating trauma (uninsured).

They observed that Insured patients were receiving more service hours with more variety of services and multiple caregivers: up to three times as much care being received by the Insured patients, in contrast to non-insured. Nevertheless, in preliminary findings there appeared to be no appreciable difference in outcomes such as community integration, neuropsychologic test results, or satisfaction with life.

The CSME Standards Committee is concerned that this may speak directly to the value of that enormous 'second tier' of enhanced care services and providers which has emerged in Ontario in response to substantial increases in no-fault insurance funding for trauma rehabilitation].

Such findings would beg the question of whether there is any benefit to be had from providing additional rehab, beyond what the health care system offers.

In the alternative it begs the question of whether the particular types of supplementary care currently being requested by insurers, or offered by private rehab persons, represent the best forms of additional care.

At issue are those cases in which Insurers are not guided by specific requests from attending physicians. The offer of further services and further providers comes from private providers, who may promise great results. Sometimes the funding is demanded or even compelled by legal pressure, again without input from those attending physicians most familiar with TBI rehab.

The Standards Committee plan to look at this closely, with a view to a possible Position Statement on the reasonableness of extended investigation, and/or treatment peculiar to compensable patient populations.

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Know a good medical evaluator? Be a sponsor. Refer him/her to our Membership Committee.
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WE'VE MOVED

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Notice of Annual General Meeting

The AGM will take place at 6:00pm on Wednesday, December 19, 2001.
It will be hosted at the MultiDisciplinary Assessment Centre.
3200 Dufferin St., Suite 500, Toronto

The nominating committee is presenting the slate listing below to fill openings on the executive:

Robert Grossman
Howard Seiden
George Rado

The following will continue to fulfill the balance of their two year term:

Arthur Ameis
David Goldstein
Alf Margulies

Additional nominations can be made by contacting the nomination committee directly at muckleid@total.net or by request of any member of the Board at the AGM

The election of the executive will take place at the AGM.