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Uncharted Waters – Navigating the GOS-E

Q: Insurers will at times refuse to schedule an Insurer Examination to determine catastrophic impairment until they have a long list of various medical records. This practice can delay completion of the Insurance Examination by many months. Is this reasonable?

A: The request for additional documentation must be reasonable and necessary given the client's injuries and impairments. If the request for additional documentation is considered unreasonable you may want to request an explanation from the Insurer Examination vendor's clinical coordinator outlining his/her rationale for the assessment. In addition, a request could be made to proceed with the assessments and complete an addendum report when the documentation is provided. Or simply wait to complete the report once the documentation is received. In the case of the GOSE-E assessment the reports must be completed in a timely manner. The insured person's level of function needs to be assessed as close to the 6 month or 12 month GOS-E dates as possible.

If there is a dispute over the length of the delay, the insured may apply to the LAT to determine if the insurer's position is reasonable.

Q: Is an insurer obligated to pay for a second CAT assessment if an earlier application has already failed?

A: Yes, an insurer may be obligated to pay for a second CAT assessment. Often the medical status of an insured person changes and a reassessment is necessary.

Q: With regards to insurer examinations, particularly with respect to those that are time sensitive (i.e. at the 6-month or 1-year GOS-E dates), what can we do if the insurer is slow in responding to the application or if the IE dates are scheduled for months after the application?

A: Upon receipt of an Application for Determination of Catastrophic Impairment, (OCF 19), an insurer has 10 business days to issue a determination to accept or deny that the insured person has sustained a catastrophic impairment. If a determination is not made within this timeframe, it may be necessary to escalate the matter to a management level and/or involve the insurer's ombudsman. The determination needs to be issued within the mandated timeframe so that if an insurer examination is necessary the assessments can be scheduled and functional data can be recorded as close to the 6 or 12 month GOS-E dates. If there's still no determination issued in response to the OCF 19, it may be necessary to file a LAT Application.

Q: When can we expect to start seeing decisions from the LAT that deal with the new CAT criteria?

We can expect seeing decisions with regards to the new CAT criteria in October or November of 2018. The LAT is taking longer to release decisions than initially thought. There are several CAT determinations which have already been heard at the LAT where decisions have not been released.

Q: Adjusters sometimes refuse to arrange insurer examinations pending receiving hospital records; CNR's and sometimes even much less relevant records such as pharmacy, OHIP, and employment. How can we deal with such delays when time sensitive applications are submitted? What if there are delays in obtaining records that are out of the client's control?

A: If the delay for production of documentation is out of the client's control, make sure these are well documented in the event an adjuster requests documentation to establish the reason for the delay(s). We need to advocate for the assessment to be completed in a timely fashion as we need to preserve data concerning the client's functional status as close to the 6 and 12 month GOSE –E dates rather than several months later.

Q: What are the consequences of refusing components of a multi-disciplinary IE (i.e. if orthopaedic is arranged as part of a GOS-E review).

A: The insurer examination must be reasonable, necessary and relevant to the injuries and impairments in relation to the issue that is the subject of the insurer examination. If there is a question about the need for an assessment, dialogue with the adjuster is encouraged to obtain his/her rationale for the assessment(s). Further documentation may be required from the Insurer Examination vendor's clinical coordinator to determine the rationale for a particular assessment.

Section 55 of the *Schedule* contains mandatory language. In the event that an insured does not attend an insurer examination they restricted from applying to the LAT pursuant to section 55 of the *SABS*, unless they receive specific permission from the LAT to do so.

Q: What is the PIAs position regarding paying interest on protected accounts? If a company is asked to protect OT services for two years for example, they have to pay the OT but then need to wait for payment from settlement years later – which is challenging especially if that company has a number of protected accounts as you mention.

A: Before entering into a protected account arrangement, the firm and the agency providing the services need to discuss the terms of the contract. In the event that interest is specifically outlined in the protected account direction and/or contract it ought to be paid.

Q: Is the LAT accountable to hear disputes or release decisions within a certain period of time?

They had timelines where they expected to release a decision by a certain amount of time after the hearing, but these were just goals. Making decision makers accountable for acting within time constraints could be problematic, as we would never want a decision maker to rush his or her decision - particularly on an important issue like CAT determination.

Q: Do you need to submit the GOS-E structured interview forms with a narrative reports and OCF-19? Or just the narrative and OCF-19*?*

A: The insured is not required to submit the GOS-E structured interview forms as the OCF-19 is based on the GOS-E rating and the narrative reports from the neuro-psych assessment.

Q: When a Law firm completes in Home Cat assessment is this assessment subject to the $2000 cap? If so how is travel to remote areas handled?

A: Yes, if the law firm wishes the assessment to be covered by the insurer, as per the *Professional Services Guideline*, section 25(5), there is a $2000 cap for any one assessment of examination proposed in an OCF-18. The *Guideline* is silent on the breakdown of the fees proposed.

Q: We just heard that the claimant would be discharged from a major trauma unit or Rehab hospital are these the majority of GOS-E cases that you are looking at or which additional scenarios may you be looking at?

A: The GOS-E assessment is based on overall level of functioning after proof of a brain injury on imaging. Admission to a trauma hospital is not necessary. There are scenarios where imaging has been delayed for several days or weeks, but the client ultimately seeks medical attention and imaging is completed.

Q: If a referral is made late, and a GOS-E is done after the 6 month mark, i.e., at 8 months, and the person is meeting the CAT definition at that time, is that a valid application?

A: The assessment is still arguably valid, and the application ought to be considered. However, ideally, you want the assessment done as close to the 3, 6 or 12 month GOS-E mark as you want to capture functional data at those timeframes. If an insured person has applied for catastrophic impairment under the GOS-E at 6 months and the Insurer Examination is not completed until 9 to 10 months post-accident, the findings of the report can be disputed as not relevant and not capturing the insured person's functional status at the required point in time (6 months post-accident).

Q: How important is timing for GOS-E assessments? What if someone wants to assess a client 8-month post-accident or 14 months post-accident?

A: GOS-E assessments are not limited to be completed at exactly the 6 and the 12-month marks. So if you missed the milestone, it can certainly be done later, as long is there sufficient collateral and documented information to confirm the findings. The timelines are important in so far that brain injury recovery progresses with each month and treatment, so obtaining the most accurate results would be better to be completed closer to these timeframes.

Q: Why is 8-hour independence in the home important versus 24-hours?

A: This time distinction is essentially the difference between Upper and Lower Severe Disability on the GOS-E scale under the Independence Inside the Home domain, where if you identify the client as being able to be on their own during the day (perhaps with telephone/skype check-ins) but requiring supervision at night then they qualify for 8 hour independence, and if they are not able to do that, then they qualify for 24-hour supervision. The factors relating to supervision should be based on symptoms related to their ABI.

Q: What is the difference between GOS and GOS-E?

A: The GOS assessment was used prior to June 2016 SABS changes at the 6-month mark, where the client had to meet Severe Disability criterion to be considered Catastrophic. It is a 5 level rating system. The GOS-E assessment is used for accidents post the June 1, 2016 mark, and has a more extensive grading criteria where the main levels of Severe Disability, Moderate Disability and Good Recovery are split up into Upper and Lower categories, to better capture the level of impairment.

Q: Could you do GOS-E assessments as part of a treatment program?

A: Yes, absolutely. If you document and collect information pertaining to the five domains as part of your treatment sessions, such as their ability to complete self-care (with/without prompts or assistance from a PSW), as well as to access the community. GOS-E assessments can also be integrated into progress reports to show a client's functional status after an ABI. The key is to ensure that you are denoting impairments that are ABI related vs impairments due to other reasons (i.e. musculoskeletal impairments).

Q: What are the key differences between the upper and lower severe disability (as relevant at 6-months for GOS-E) and the lower moderate disability (as only relevant at the 1-year and after anniversary).

A: If the client is Lower Severe Disability, then they are unable to be at home for 24 hours by themselves. If they are Upper Severe Disability, then they can be left unsupervised for up to periods of 8 hours at a time. For the Lower Moderate Disability, this is distinguished by the level of impairment in the three domains (Work, Social & Leisure, Family & Friendships) and the client's ability to participate in these activities.

Q: Since the GOSE at 12 month mark for work has to be done in the situation but most of these very serious clients are not appropriate to return work even for an assessment. Is this skipped or done virtually?

A: If they are unable to return to work at the 12-month mark, then one would just indicate that they are unable to work as per their previous capacity outlining the ABI impairment identified that prevent the return to work. If they are working with accommodations or in a sheltered setting, then collateral from their supervisor and colleagues would be essential for the narrative.

Q: I understand that the GOS-E requires the assessor to answer the questions based on the client's function in the past week. How critical is that point with respect to the validity of the assessment?

A: For the most part, if the client is Severely or Moderately Disabled (depending on the time that the assessment is being completed) if a true functional assessment is completed where they are engaged in tasks that evaluate their ability to tolerate the domains of Independence Inside The Home, Independence Outside The Home, and Work as well as the collateral information for Social and Leisure Activities as well as Family and Friendships is incorporated into the narrative, then you can get a clear picture of the client's ability within the last week which will point to their ongoing status.

Q: When an OT is waiting for the hospital records, it could be beyond the 6 month mark, so can they do a GOS-E without the imaging? Also, some mild TBIs do not show on imaging, so can they still do the GOS-E?

A: The catastrophic impairment criterion under which the GOS-E falls is specific to requiring imaging to confirm intracranial pathology. Completing a GOS-E is disputable without the presence of the intracranial pathology as the client will not satisfy the full requirement of the catastrophic impairment criterion.

Unfortunately mild TBI's where there is an absence of positive imaging will not meet the definition requirements and as such completing the GOS-E is moot. The impairments should then be reviewed under other catastrophic impairment criterion (i.e. Criterion 6).

Q: Would it not be a recommended best practice to start the application process for GOSE case 1 month prior to the 6 month/12 month marks to ensure timely assessments?

A: GOS-E process can be started immediately after the date of the accident, where documentation of the client's difficulties and progress is essential in understanding the case file and developing a functional assessment.

Q: Who is qualified to do GOS-E. Is it only an OT?

A: The GOS-E was developed by a psychologist and administered by a nurse initially. So no, it is not just restricted to an Occupational Therapist. Physiotherapists have also completed some of these assessments. However, the basic training that OTs receive with respect to the three domains of self-care, leisure and productivity along with having a sound knowledge of the impact of cognitive symptoms on these spheres is essential in creating a sound functional assessment.

Q: Are insurers obligated to pay out protected accounts once a person is declared CAT?

A: No, they are not. The insurer will pay things that are considered reasonable and necessary. Refer to https://oatleyvigmond.com/latupdate/protecting-future-rights-payment-coverage-limits-exhausted/ for more information.

Q: Should the cost of the CAT assessment/ GOS-E come out of the client's med/rehab limits? Most adjusters don't seem to be abiding by Henderson vs Wawanesa decision and are deducting the assessment costs from the limits.

A: No.

Q: If the hourly rate for the attendant care is below minimum, how much does a family member get paid assuming they meet the incurred test and they lose more than the minimum wage to provide services?

A: The hourly rate is matched to what is incurred as a loss from their job up to the Form-1 rate.

Q: Which types of evidence would be considered most valid of change in areas related to strained relations or social isolation? Is input from family and friends enough to create a strong narrative or should we request more objective reports early on such as resumes, report cards, performance appraisals etc.?

A: Yes, all objective reports obtained from the get-go are essential in terms of creating a strong narrative. Collateral input from family and friends adds value to what is being said, especially for these two domains. In addition, objective information that would be considered as strong evidence with respect to communication and strained relations or social isolation would be perseveration on thoughts/topics, forgetting conversations, being unable to articulate thoughts or ideas, miscommunication and reduced comprehension during conversations with others, as well as difficulty communicating changes in moods/lability. If any of these signs are observed during testing, then this adds as evidence in your narrative, especially from a speech-language point of view.

Q: The GOS-E does not directly distinguish between disability due to brain injury and disability due to other bodily injuries. However, in the spirit of the SABS, the assessor should rate according ONLY to the functional impact of the brain injury. How is the OT making that distinction in their assessment?

A: With a strong understanding of the physical, cognitive and emotional impact that a brain injury can have, OTs with experience in assessing and treating acquired brain injuries can distinguish between what functional difficulties are caused by the bodily injuries vs. the brain injuries. You may also refer to the ABI symptoms chart that has been created by Omega and posted as a resource with this webinar link to better understand what we consider as symptoms relating to a brain injury in order to help us make the distinction.

Q: What is the difference between 6-month assessment and 12-month assessment?

A: At the 6-month mark, the GOS-E assessment focuses on the first two domains of Independence Inside the Home and Independence Outside the Home, where if they meet the criteria for Upper or Lower Severe Disability, then they are determined to meet the catastrophic impairment threshold. However, if the client does not meet this criterion at the 6-month mark, then they can be assessed at the 12-month mark again, to see if they meet Lower Moderate Disability criterion based on a substantial focus on the last three domains of Work, Social and Leisure Activities, and Family and Friendships. Alternatively, the client can also be initially assessed at the 12-month mark (if they missed the 6-month assessment), and if they meet Lower Moderate Disability then they can be determined to meet the catastrophic impairment threshold.