

Hitchhiker's Guide to the Minor Injury Guideline: a Perspective for Psychologists

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The Minor Injury Guideline, came into effect in September 2010, and outlines the goods and services to be funded for the rehabilitation for persons who sustain minor injuries in auto accidents. The guideline includes the definition of Minor Injury, and includes a funding cap of \$3500 for the provision of services to the group that is captured within this definition. The objective is fundamentally to provide cost containment and certainty for the insurance industry. There is an expectation of the MIG being broadly applied, and the stated objective of government is to capture in the vicinity of 75-80% of claimants within the MIG.

The role of Psychology within the MIG

The guideline defines a Minor injury as follows:

*A “minor injury means a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any **clinically associated sequelae**. This term is to be interpreted to apply where a person sustains any one or more of these injuries”.*

Treatment takes a functional restoration approach that helps the insured person to reduce or manage their “**pain and associated psycho-social symptoms.**”

The first visit to the health care provider who initiates the treatment includes documentation of **psycho-social issues and risk factors and does not include a formal psychological assessment.**

There is a provision for \$400 for supplementary goods and additional services including supportive interventions such as but not limited to: **distress; difficulties coping with the effects of the injury, and driving problems/stress.**

There is a “Facts about Whiplash” brochure that includes handy tips about avoiding chronic pain in an appendix that states: “**If you are discouraged or depressed about your recovery, talk to your health care professional.**”

And in case you missed it, those were the sum total of references to psychology in the guideline. The message in this is that the role of psychologists in treating claimants who fall within the guideline is expected to be limited. The emphasis in the MIG is on physical treatment of minor physical injuries. In fact psychologists are not included in the list of health practitioners who can initiate the MIG.



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This is broadly consistent with our experience that more serious psychological reactions tend to occur with more serious accidents, and that even so only a few develop frank disorders, although this is a far from perfect relationship. It is with non-MIG type claimants that most of our work traditionally resides.

There will, however, be some small subset of individuals whose physical injuries fall within the MIG definition, but who go on to develop psychological impairments as a result of debilitating pain and functional limitations, or who will have psychological stress reactions in response to the trauma of the accident.

The *Psychological Assessment and Treatment Guidelines* March 31, 2001 describe patients similar to the MIG group:

The first patient group addressed in these Guidelines includes patients with uncomplicated soft tissue injuries (WAD I, II, and III & LBP), including psychological reactions to continuing pain and functional limitations from these injuries. These musculoskeletal disorders comprise the most prevalent patient groups arising from motor vehicle accidents. A subgroup of patients with these injuries may have debilitating pain and functional limitations/restrictions leading to psychological impairments.

In these cases the guidelines recommend a one-hour consultation and 6 hours of care over 6 weeks, to provide psychosocial support and psycho-education and coping strategies for those with sub-syndromal symptoms.

Coincidentally the cost of this was estimated at just under \$1300, which is the amount of undesignated residual funding in the Minor Injury Cap, potentially available to psychologist through an OCF-18 application. This could be applied for without first proposing that the claimant be exempt from the \$3500 cap and therefore triggering a minor injury challenge, and may be a more direct access to funding to psychologists who wish to plan such a program.

Of this subset of claimants who experience psychological stress following a minor injury, a few will develop frank disorders. This is a restrictive framework, and therefore individual cases merit individual attention in order to identify these individuals, who will not find adequate funding for treatment within the minor injury funding for needed psychological assessment and treatment.

When a claimant with significant psychological distress is referred to a psychologist for treatment, the psychologist submits an OCF-18 treatment and assessment plan identifying that likelihood that the claimant should be exempt from the minor injury cap in light of the psychological injuries, and proposes an intervention. The September 1, 2010 SABS also allows the insurer to make decisions about benefit entitlement without first obtaining and IE. Alternatively they have the option of referring the question to an independent evaluation, not necessarily to a psychologist, to determine if the claimant's injury conforms to the MIG, or if they should be exempt from it.

Why is working with the MIG so challenging?

Psychologists are ambivalent about this legislation. Ultimately it is a cost containment strategy, and is restrictive in a way that psychologists are not always comfortable. We feel the pressure to contain costs for the sake of a sustainable future for the availability of psychological services under the SABS... but we prefer to advocate for the injured...but we are also dismayed by the fraud in the system that is interfering with the availability of funds to those who need them including the cost efficient provision of quality treatment.

Obtaining psychological treatment funding for those who are initially placed within the MIG can be challenging. In large part this is because of the obvious: this is a new and restrictive legislations that is premised on the assumption that with minor injuries and minor accidents, there should be little expectation of the need for psychological treatment. It is possible to advocate for, and apply for funding to treat, claimants who likely should be exempt from the MIG. This should be easier with a clearer guide to identifying these individuals, and characterizing the basis for the OCF-18 application. Since these applications can only be approved if the insured is removed from the minor injury cap, requests for treatment assessment are rarely sent for file reviews. As removal from the MIG increases access to treatment funding from \$3500 to \$50,000, this is a

weighty decision that if not made directly by the adjuster, is generally made in a single assessor or multidisciplinary in-person IE.

These Independent Evaluations bring their own challenges. First of all, there is no standard question to address the legislative test of whether an injured person is exempt from the Minor Injury definition from a psychological perspective. Other tests are straight forward, such as: Is the treatment plan reasonable and necessary? A clear question facilitates a clear decision making process, and a definitive response that is understandable to the adjuster and the claimant. Having reviewed a number of referral requests from adjusters for MIG evaluations, it appears that there is no standard question set. Only one company appeared to use a standard set of questions within their own company, different of course to other companies. Otherwise the collection of questions in any one referral is somewhat idiosyncratic, and seems to be as unique to the particular adjusters, each trying to interpret the MIG for themselves. I have found from one to 15 separate questions being asked within any one referral. It used to be that an IE assessment could address one benefit, now there is no limit. Some subset of the questions may be part of multidisciplinary assessments, and other questions for the same evaluation are stand alone, with multiple benefits to be addressed simultaneously.

Pre-existing conditions are more explicitly queried in MIG assessments, but there is often no or thin documentation available pertaining to pre-accident adjustment and health, and this is often challenging to obtain early in a claim.

The MIG includes a challenging combination of clinical and legal/administrative constructs. So for example injury is equivalent to impairment for the purposes of the MIG, though for psychologists we may see the injury as distinct from the resultant functional impairment. We must also interpret terms like predominance, and wonder if we are addressing a clinical question or a legal question.

Typically a MIG evaluation will also have previously or concurrently been undertaken by a Physician, but it may have been conducted months earlier, making consultation difficult. The physical assessors have something of an advantage as the minor injury definition is stated in largely medical terms, and doctors can address the applicability of the definition directly by identifying specific listed physical injuries using standard methods. By comparison psychological conditions are not specified. Psychologists are also expected to compare psychological to physical injuries when addressing predominance.

Psychologists have no guideline to rely upon in making MIG decisions, so each practitioner is interpreting unfamiliar terms, and determining their own criteria in response to a unique set of questions.

Finally, there has been no feedback on the decisions that we have been making for the last 18 months from arbitration, and therefore no definition of the boundaries around this legislation by which to evaluate our interpretations and the criteria we are establishing.

So with no standard question, limited medical record information, no guideline from our profession, and a set of medical and legal terms to negotiate that are not related to our profession, each assessor meditates on each case and all of its particulars, seeks enlightenment and comes up with an opinion, and then receives no feedback from the governing body. I refer to this fondly as Zen and the art of MI assessment.

Independent Evaluation Questions that get at the Legislative Test of the MIG

In attempting to determine if an insured person does or does not fall within the minor injury definition, and sifting through a collection of questions from from an assessment referral where the applicability of the minor injury definition is at issue, the questions will generally include or approximate the following four.

1. Did the claimant sustain and impairment as a result of the accident (and how serious is it)?

An answer could helpfully include a description of symptoms and a diagnosis. There may be additional questions about validity of findings and observation or measurement of symptom magnification, whether the symptoms are an aggravation of a pre-existing condition, and if it is a normal reaction to the minor injury?

2. Are the injuries sustained in the motor vehicle accident a minor injury as defined by the SABS?

This is the criterion of Inclusion. Does the injury fall within the MI definition? Many adjustors will also ask if the injury is predominantly a minor injury? The answer could address predominance, the seriousness of the psychological injury, the need for treatment, and a rationale for the decision.

3. Is there compelling evidence of a pre-existing condition that will prevent them from achieving maximal recovery from the minor injury if subject to the \$3500.00 cap?

This is the criterion of exclusion, and is dicussed further below.

4. Is the treatment plan OCF-18 reasonable and necessary, or do you have other recommendations for treatment to assist the client?

An approval of treatment is premised upon the decision with respect to MI definition exemption. It is possible to recommend treatment within the MI cap for marginal cases where the claimant does not meet criteria for exemption from the MI definition, but some psychosocial support would be of benefit.

Considerations for addressing the legislative test of the Minor Injury

Below are some considerations for decision making with respect to MI inclusion or exemption from a psychological perspective. Ultimately it would be of benefit to develop a professional guideline through a consensus process. This is a work in progress and is meant to be somewhat provocative to encourage discussion.

1. Diagnosis:

Is there a frank disorder? What is the diagnosis and does the injured person meet the full diagnostic criteria? A sub-syndromal disorder is less likely to merit an exemption from the MIG

Is the disorder associated with the trauma of the accident? There is a distinction between diagnoses associated with the trauma of the accident (PTSD and Specific Phobia, GAD), and those associated with the minor injury. This distinction has been observed in the Psychological Assessment and Treatment Guidelines. A diagnosis associated with the trauma of the accident is less likely to be consistent with the MI definition.

Is the disorder associated with the minor injury? An Adjustment Disorder may be related to the minor injury, and therefore is an associated sequela, as is Pain. Below a compelling level of intensity and functional interference they seem to be associated sequelae, and more likely to be included in the MIG.

Is there a TBI/concussion? TBI/concussions are not included in the minor injury definition and therefore more likely to be excluded, possibly depending on seriousness of the documented injury.

2. Seriousness:

What is the impact of the psychological injury on overall level of functioning? In order to meet criteria for most diagnostic conditions, the symptoms must be serious enough to significantly interfere with functioning. A psychological injury that meets this threshold is more likely to support an exemption from the MIG.

Is GAF score a useful guide for estimating seriousness?: This is arguably an estimate of overall level of functioning and carrying out activities of daily functioning, it is defined in the DSM-IV as relating to psychological, social and occupational functioning, not due to physical and environmental limitations. The guideline takes a *function restoration* approach emphasizing return to primary

roles, which is consistent with the GAF. There are opinions in the literature that treatment is not required with a GAF score of over 65, and this is one possible guide for an upper limit of exemption from the MIG. However moderate difficulty in functioning falls between 51-60 and there may be more support for a MIG exemption in this range. It would be challenging to achieve consensus on particular cut off scores.

Meeting the full diagnostic criteria of a disorder generally requires significant impairment in functioning due to the disorder. For example the DSM 5 criteria for PTSD is anticipated to include criterion G: “The symptoms bring about considerable distress and/or interfere greatly with a number of different areas of a persons life.”

Is it a normal reaction to the minor injury? In a great majority of cases this is so, and the injured persons in this category should therefore not be exempt.

Is it compelling enough to require treatment? In the great majority of cases, psychological sequellae of minor injuries resolve spontaneously. Is this a case where symptoms are unlikely to resolve without treatment?

Is it an exacerbation of a pre-existing condition? In these cases an effort could be made to estimate the contribution of the accident to the reported symptoms and consider if there is a serious reduction in functioning because of this exacerbation, and if the degree of exacerbation is a compelling case for treatment. This is difficult to do, particularly without pre-accident medical documentation of the condition.

3. Predominance:

Is it predominantly a Minor Injury? Is it mostly a minor injury or is it mostly something else? Is the psychological injury of sufficient severity that the physical injuries take something of a back seat if they are minor?

Look at what is causing the impairment. If the impairment was caused by the trauma of the accident, and is serious, it balances more away from the side of minor injury. If the impairment was caused by the pain and functional limitations associated with the minor injury, it balances toward a predominantly minor injury, unless severity of symptoms and degree of functional limitation is such that the psychological injury is more predominant.

4. Pre-existing Conditions

Is there compelling evidence of a pre-existing mental health condition would prevent the person from recovering from the accident-related injuries (physical or psychological) within the MIG treatment protocol?

The Psychological Assessment and Treatment Guideline listed patient groups to whom treatment maximums did not apply. Some of these categories are candidates for compelling pre-existing conditions: Risk of harm to self or others, brain injury/cognitive impairments (intellectual deficits), age (children/the elderly), where the accident causes a catastrophic injury or death of another, severe pre-existing psychological disorders, substance abuse disorders. Other considerations might be chronic pain syndrome, chronic fatigue, or obesity.

The issue of *thin skull* versus *crumbling skull* concepts are an issue here, because the pre-existing problems may dwarf the response to the minor injury.

Consideration should be given to how recent, how severe, and how symptomatic the insured was at the time of the accident, is the condition acute or chronic and progressive. Is there ongoing medication or other treatment. Is functionality impaired? There must be a clear mechanism by which the condition would interfere with the normal speed or course of recovery or participation in rehabilitation, and therefore there would be an increased rehabilitative burden. The evidence that the pre-existing condition exists is expected to be “compelling.” Should there be imminent vulnerability of poor recovery without additional access to treatment funding. This is of course difficult to predict.

5. Is treatment reasonable and necessary?

Will treatment be helpful? Treatment is not always helpful or necessary in return to pre-accident functioning. Ultimately this should be evidence based. Is psychological treatment likely to result in a significant improvement in functioning or suffering, such that the injured person benefits significantly from exemption from the MIG.

Are they likely to get better without treatment? If there is a high degree of likelihood that the injured person will recover in a timely fashion from the psychological impairment, this suggests a review of the benefit of exemption from the MIG.

6. Individual cases merit individual consideration:

Is there a special circumstance that influences the degree of suffering or impairment in functioning? Driving Phobia is something of a special case in that the degree to which the fear of driving is disruptive is key. If everyone who was nervous driving after an accident was exempt from the MIG there would be no one in the MIG. Certain people however, who for example drive for a living, or are involved in emergency road services, are more vulnerable and more likely to require treatment.

7. Consider all opinions and information:

There is an expectation that all opinions and file materials be considered in the determination. When a pre-existing condition is critical, it may be necessary to seek medical records. There will generally be medical assessors opinion with respect to the minor injury definition, making the IE assessment a multidisciplinary one. Consultation can be important in marginal cases.

8. State the conclusion precisely and with a rationale:

Psychological injuries are invisible and intangible, lay people prefer a diagnosis, and a rationale that has face value and is understandable.