



Representing Health Professionals in Automobile Insurance Reform

December 1st, 2011

Mr. Phil Howell
CEO and Superintendent
Financial Services Commission of Ontario
5160 Yonge Street, 15th Floor
Box 85
Toronto, Ontario M2N 6L9

Dear Mr. Howell:

RE: New Billing Guidelines under HCAI

The Coalition would like to express significant concern over the latest Superintendent's Guideline No.03/11. While generally supportive of measures that will both help to reduce unethical or fraudulent billing through HCAI and to hopefully streamline the process in order to encourage prompt payment by insurers, aspects of this recently released guideline presents significant problems for health care providers who treat patients in the motor vehicle accident sector.

Our particular concern is related to new Billing Procedures, specifically the limitation of billing frequency to once every 30 days.

In our letter to FSCO dated July 21st, we indicated that we could not support this decision:

"In our initial meeting with FSCO, the Coalition made it clear that we could not support regulation of specific accounting practices that could affect providers' reasonable access to accounts receivable. While we understand that this recommendation is an effort to curtail the practice of daily billing for a client's individual treatments, thus lessening the administrative burden and cost on insurers, further discussion needs to occur before deciding on a time limit. For instance, many providers have chosen to adopt a bi-weekly billing schedule for accounts receivable as this allows better cash flow and enables providers to meet operational cost obligations. We need to strike a reasonable balance between insurer operational burden and ensuring that providers are not placed in a position where enforced billing practices negatively affect their ability to meet operational needs."

The Coalition has clearly indicated that we cannot support any change in the guideline that would serve to direct the accounting practices of our membership and we find a requirement to limit billing frequency to be extremely problematic. Further consideration needs to be given before this can be implemented, as many providers continue to bill on a bi-weekly basis in order to meet their operational needs.

This new guideline would require that providers bill for their invoices in batches, potentially by selecting a particular day of the month in which to bill. This in itself is not generally a problem and we would encourage health care facilities to adopt this approach in order to realize operational efficiencies. However, they will also have to take into consideration those treatment plans that are for 30 days or less and which have not yet been completed and remove these from batch billings in order to meet the billing guidelines. This represents a significant administrative burden on top of an already administratively complex system and the majority of providers do not have the means to implement an accounting change

of this size prior to the implementation date. It is particularly onerous if the healthcare facility requires changes to their practice management or accounting software in order to accommodate these changes.

There is some concern among providers that it will become the burden of the individual receiving treatment to pay "up front" after all treatments to support the cash flow necessity of individual clinics. This change would eliminate or significantly impede the access to health care services (not covered under public health funding) for many clients who cannot afford to pay up front.

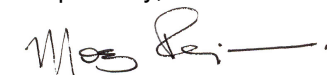
In addition, many providers have chosen to submit invoices more frequently in order to address the growing concern of late payment by insurers. Both anecdotally and through a recent survey of over 1000 healthcare providers, it has been reported that a majority of approved invoices remain unpaid after 60 days. Providers feel that delaying submission of invoices will further delay payment by insurers. There is also the issue of available funding under the \$3500 minor injury cap. It is increasingly reported that invoices for previously approved services are being denied due to the funding cap being reached. This could be due to poor claims management, or to the unexpected submission of incurred expenses that do not require prior approval. Regardless, this serves to increase anxiety among providers with respect to their ability to receive remuneration for approved services that have been delivered in good faith and contributes to the perceived need for more frequent invoicing.

We note that future changes to the HCAI system are being given several months' notice prior to implementation and wonder why providers were not given the same consideration.

We strongly urge you to reconsider the implementation of this new billing requirement for providers as it represents both a significant change to current acceptable (as well as perfectly legal and ethical) billing practices and will place an untenable administrative burden on providers.

We would suggest that the other changes within the guideline, including rules regarding duplicate invoices and invoices for services that have not been approved, be implemented first to see if this significantly eases the current issues reported by insurers and to revisit other options for operational improvements at a later date.

Respectfully,



Moez Rajwani
Coalition Co-Chair



Dorianne Sauvé
Coalition Co-Chair

Cc: Andrew Kovarcsik, Special Assistant, Policy, Minister of Finance