



## ONTARIO CHIROPRACTIC ASSOCIATION ASSOCIATION CHIROPRACTIQUE DE L'ONTARIO

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May 15, 2009

Hon. Dwight Duncan  
Minister of Finance  
7 Queen's Park Cres., 7th floor  
Toronto, ON M7A 1Y7

**Re: Financial Services Commission of Ontario Report  
Five Year Review of Automobile Insurance**

Dear Minister Duncan:

Thank you for the opportunity to provide comments regarding the Five Year Review of Automobile Insurance, dated March 31, 2009, released by the Financial Services Commission of Ontario.

The Ontario Chiropractic Association supports many of the recommendations contained in the FSCO report. The focus of this submission will be on those critical areas where we feel additional feedback is required prior to decision-making by the Minister of Finance.

Our recommendations are consistent with FSCO's first recommendation:

**“When determining the merits of any future regulatory changes, consideration should be given to whether a change would increase complexity and regulatory burden. There should be a compelling reason for making a change that would add complexity to the Accident Benefits System.”**

We understand that costs have been rising in the system and that insurers seek mechanisms to ensure that services performed are necessary and of high quality. With this in mind, any alterations to the regulations should balance two key principles:

- controlling costs so that the insurance policy can remain affordable, especially in the current difficult financial circumstances, while at the same time,
- maintaining access to necessary services for those who need them.

We offer the following advice on specific FSCO recommendations. Because there are multiple FSCO recommendations aimed at addressing identified problems within the system, the coordination and consideration of the recommendations as a whole is critical.

**Key to our interrelated recommendations is the implementation of an accountability mechanism for PAF initiators and for those in a “gatekeeper” role, and the expansion of the PAF.**

1. FSCO Recommendations #15 and 21:

**Recommendation # 15: “Consider having assessment requests completed only after a referral is made by the health professional primarily responsible for the claimant’s rehabilitation (in most cases a family physician). Assessment requests would continue to be submitted by the providers providing the following referral.”**

**Recommendation # 21: “Consider having treatment plans completed only after a referral is made by the health professional primarily responsible for the claimant’s rehabilitation (in most cases a family physician). Treatment plans would continue to be submitted by the providers providing the following referral.”**

**Support in Principle**

We are in agreement with FSCO that there is fragmented healthcare delivery and a lack of accountability in the provision of access to assessments and treatment.

We are also in agreement that, for the purposes of coordination and continuity of care and to control quality of care — including a reduction or elimination of services that are of low value to claimants — the concept of a “gatekeeper” or a single health professional directing a claimant’s rehabilitation is viable.

**Gatekeepers for Musculoskeletal Injuries: Include Doctors of Chiropractic, Not Just Medical Doctors**

However, there are many reasons why the recommendation that this role should be done only by a Medical Doctor is neither feasible nor desirable.

There is a shortage of Medical Doctors in Ontario, including family physicians and general practitioners. According to the Ontario College of Family Physicians, over 800,000 Ontarians do not have a family physician, with over 500,000 of these Ontarians actively seeking care.

Secondly, the FSCO recommendation is at odds with Ministry of Health policy. The thrust of the Ministry of Health’s efforts of late has been to reduce the gatekeeper role for Medical Doctors and to increase access to health care delivery by other regulated health professionals. This is largely because of the access problem with Medical Doctors.

The Blueprint for Ontario, produced by the Ministry of Health and Long-Term Care has emphasized the importance of appropriate use of the skills of other health providers in order to offset the demands on Medical Doctors.

Doctors of Chiropractic are primary care practitioners with the duty and authority under the Regulated Health Professions Act and the Chiropractic Act to diagnose. Their practice focus is musculoskeletal, with over 96% of patients attending for musculoskeletal injuries and complaints – much of which is neck related. They are arguably the best trained practitioners for the management of most auto-related soft tissue injuries, which are the majority of claims.

Attached for your review is a June 9, 2008, letter from then Minister of Health Hon. George Smitherman. In his letter, Minister Smitherman urges the extended health insurance community to not require a Medical Doctor’s referral for access to chiropractic services. He states:

*“Ontario is experiencing a shortage of physicians, compounded by a growing demand for their services. The imposition of unnecessary requirements upon physicians creates an additional burden for Ontario’s health care system...”*

Upon reviewing other jurisdictions where “gatekeeper” roles are established, most jurisdictions do provide access to Doctors of Chiropractic in addition to Medical Doctors. The example of Saskatchewan, where the initiator of care can be a Doctor of Chiropractic, is cited in the FSCO document. This is consistent with the approach in Alberta and, as we understand it, British Columbia.

In Newfoundland and Labrador the insurance industry has, by policy directive from the IBC, required a Medical Doctor’s referral for the services of Doctors of Chiropractic to be payable. The Deputy Superintendent of Insurance issued a bulletin in February 2009 directing that this is a misinterpretation of the policy and that claimants may consult Doctors of Chiropractic directly. We understand that similar action is now advocated for Nova Scotia.

We also note that the Ontario Workplace Safety and Insurance Board, through its Form 8, permits the initiation of care for musculoskeletal injuries by Doctors of Chiropractic.

The key reasons for the FSCO recommendation for a gatekeeper/coordinator are to reduce abuse in the system and to ensure coordinated care. The designation of only Medical Doctors for this role will not be sufficient to meet these goals.

Rather, we recommend that Doctors of Chiropractic be part of an expanded group of gatekeepers, but with significantly enhanced statutory accountability, as follows:

a. **For Pre-Approved Framework conditions**

The Administrative review of the PAF conducted by the PAF Working Group demonstrated that Doctors of Chiropractic and physiotherapists account for 95% of PAF initiators.

With the assumption that the Pre-approved Framework will be expanded, we recommend that the initiating practitioner for the Pre-approved Framework take on the coordinating role at least for the duration of the PAF. Doctors of Chiropractic presently play this role effectively.

b. **For non-Pre-Approved Framework Musculoskeletal conditions**

For those conditions where there is a musculoskeletal injury or complaint but the Pre-approved Framework does not apply, we recommend that Doctors of Chiropractic be included as coordinator/gatekeepers.

Whether or not the patient is in a PAF, a Doctor of Chiropractic is trained, capable and required by Standards of Practice to identify those patients who require other services for non-musculoskeletal injuries, such as psychological services or other services for their musculoskeletal complaint. In addition to Doctors of Chiropractic and Medical Doctors, considerations should also be given to the inclusion of physiotherapists and nurses in the extended classes for the gatekeeper/coordinator role for musculoskeletal injuries

While this is not our area of expertise, for non-MSK injuries the coordinator could be:

- The health professional who is first seen post injury, excluding the emergency department or hospital.
- The regulated health professional who coordinates hospital discharge to outpatient services.
- The health professional elected by the patient through the Application for Accident Benefits, OCF-1.

The patient should also have the right, through a proper mechanism, to change their coordinator if they feel that the services of the coordinator have not been adequate or due to other changes, such as change of address or work, etc.

### **Gatekeeper Accountability**

It is important that the coordinator be held accountable for referral and other decisions. There is currently poor data to track this, but the implementation of the HCAI system will facilitate the coordination of care and the tracking/analysis of referrals and other coordinator activity.

HCAI requires registration. This implies that a practitioner can be de-registered, and the OCA recommends this mechanism for ensuring accountability. HCAI will be used to monitor patient care. If there is a coordinator whose coordination results in abuse of the system, there should be a mechanism for de-registration. Clearly, this requires due process and safeguards, but would introduce the needed accountability.

Simply limiting who can be a gatekeeper will not in itself successfully address the concern about abuse in the system. Holding any gatekeeper accountable will do so.

### **2. FSCO Recommendation #23:**

**“In partnership with key stakeholders, FSCO should contact members of the Neck Pain Task Force to examine the feasibility of expanding the PAF guidelines to a more extensive continuum of care and to include treatment and assessment of other soft tissue injuries”.**

We believe that this recommendation is foundational to effective reform.

The OCA is supportive of the expansion of the Pre-Approved Framework and recommends an acute/sub-acute care program for all soft tissue injuries. In principle, the PAF should be expanded to include all soft tissue injuries and to eliminate disputes over whether a claimant should or should not receive the PAF. Because patients are individuals in individual circumstances and recover at varying rates, any defined program will not be sufficient for every patient. However, an acute care program can be the acute care phase for all patients with soft tissue injuries and the only care that most patients will need.

The OCA recommends utilizing the definition used in the minor soft tissue injury program in Alberta. This defines minor soft tissue injuries as a WAD I or a WAD II injury and first or second degree sprain and strain injuries.

Consideration should also be given to expanding the duration of the Pre-approved Framework. The blocks of care and criteria for moving from block to block will need to be determined. Only at the end of the PAF, if further intervention is required, would the submission of an OCF-18 Treatment Plan be considered for musculoskeletal injuries.

It seems very important, based upon our survey of members, that there be a de-linking of disability and attendant care benefits from the Pre-approved Framework. This linkage creates an incentive for claimants and their legal representatives to dispute the applicability of the PAF.

Assessment costs should be controlled during the PAF by determining specific assessments that would be appropriate during the PAF.

We cannot rely on the Neck Pain Task Force for advice on injuries beyond the neck as their research did not include other soft tissue type injuries. The task force can provide an opinion on WAD related injuries. Other stakeholders would need to be engaged for the expansion of the PAF.

3. FSCO Recommendation #22:

**Reduce the cap for medical and rehabilitation benefits for non-catastrophic claimants to \$25,000. Introduce a \$100,000 optional medical and rehabilitation benefit along with the existing \$1,000,000 optional benefit.**

According to Insurance Bureau of Canada data, 80% of injuries involved in motor vehicle accidents are soft tissue in nature. A \$25,000 – \$50,000 cap for medical and rehabilitation benefits would provide sufficient care for many of these soft tissue injuries, including most soft tissue injuries treated by Doctors of Chiropractic.

However, there are patients with complicated or multiple injuries that would fall between cap of \$25,000 – \$50,000 and the \$1,000,000 for catastrophic claimants. These claimants, those deemed to have a “serious” injury, may require additional benefits.

One recommendation is for a three-tier system, which would include a lower cap for uncomplicated musculoskeletal injuries; a higher cap for a serious injury category, which would have an additional amount of benefit; and the present catastrophic impairment category. Although this may sound like a positive recommendation, in our opinion, this may add further complexity to the system.

Another option, which would be both effective and simple, would be to leave the cap at \$100,000 but include all Section 24 assessments in this cap.

4. FSCO Recommendation #20:

**Revoke Section 42-1 of the SABS, which allows claimants to obtain an assessment from their health care provider to address issues in an Insurer's Examination.**

FSCO had provided this option to balance the Insurer Examinations put in place when the neutral assessments of the DAC system were eliminated. We understand that the system of Insurer Examinations and Rebuttals has resulted in the practice of further “rebuttal reports” by the original insurer’s examiner so that the system is complex and costly.

However, simply removing the rebuttal assessment would leave the only expert opinion that of the insurer’s examiner, a situation that seems patently unjust.

Rather, we recommend that:

- a. Rebuttals for medical and rehabilitation benefits (Sections 14 and 15) should only be available to the claimant at the time of mediation. Upon application for mediation (which would take between 30 and 60 days), the claimant would have the ability to have one Rebuttal Examination conducted by a regulated health professional to provide an alternative opinion to that of the Insurer's Examination prior to mediation.
- b. For Disability Benefits, the claimant would have the ability to have one Disability Rebuttal per year to provide an alternative opinion on the insured’s disability status.

- c. With respect to issues of Housekeeping Benefits, Caregiving and Attendant Care, these benefits would not have a Rebuttal process.
- d. With respect to Catastrophic Impairment, this should be considered in a different discussion around the whole review of the Catastrophic Assessment process.

5. FSCO Recommendation #14:

**Availability of In-home Assessments should be limited to seriously injured claimants and should only be used to evaluate their need for attendant care services and home modifications.**

The following assumes that our recommendations for the gatekeeper/coordinator and the expansion of the PAF are accepted.

Doctors of Chiropractic provide both In-home Assessments and treatment interventions. There are cases that would require assessments in the home environment due to multiple factors that may prevent the insured from attending at a clinic for rehabilitation services.

It is therefore our recommendation that In-home Assessments be available to:

- a. Seriously injured claimants to evaluate the need for attendant care services, home modifications, and commencement of in-home treatment, caregiving and housekeeping duties.
- b. For conditions that fall within the pre-approved framework, a specified, limited range of available assessments — perhaps for limited housekeeping and caregiving benefits, assistive devices, or the commencement of in home treatment.

It is our recommendation that Doctors of Chiropractic be one of the regulated health professionals who would be able to conduct assessments in the home environment.

6. FSCO Recommendation #24:

**Only occupational therapists and nurses who have been trained on the use of Form 1 should be permitted to assess auto accident victims for attendant care benefits. This should apply to assessments conducted under both Sections 24 and 42 of the SABS.**

The recommendation above is that assessments for attendant care benefits only be available to seriously injured claimants. Given this, the need to restrict who can perform these assessments is less acute. However, if a restriction is required, it should be on the basis of competence and training rather than professional designation.

There are, for example, Doctors of Chiropractic and others whose training and experience render them competent to conduct such assessments.

7. FSCO Recommendation #29:

**Make housekeeping and home maintenance expenses and caregiving benefits optional. A reimbursement for housekeeping and home maintenance and for replacement caregiving needs to reflect actual economic loss.**

Consumers have a duty to make informed choices. However, those choices are often difficult and making these benefits optional may have unintended negative consequence for those most at risk; those low income consumers who would choose not to purchase the optional benefit.

Rather, it is our recommendation that at least minimal housekeeping and caregiving services be available as part of the mandatory policy and that additional housekeeping and home maintenance services should be available as optional benefits. The following constraints could be put in place:

- a. For seriously injured/catastrophic patients, this benefit should be available.
- b. For those who are involved in Pre-approved Framework injuries, housekeeping and caregiving tasks should be available, but on a time-limited basis.

8. FSCO Recommendation #12:

**The fees for completing forms, including an assessment required to complete the forms, should be capped at \$200. The cost of all other assessments should be capped at \$2,000.**

Based upon our experience, it is our opinion that the \$200 cost for completing general forms such as the OCF-3 and OCF-18 and Pre-approved Framework forms would be appropriate. However, there should also be a cost for payment form completion, as is presently available today.

Any assessment cost greater than \$200 would need to go through appropriate submission of an OCF-22.

It is our opinion that for complex assessments such as Functional Abilities Evaluations, In-home Assessments, Worksite Modification-type Assessments, and Section 42 assessments that fees be based on education, training, experience of the assessors and time required to complete the assessment.

Note our recommendation above that for claimants within the Pre-approved Framework there would be a limited list of available assessments.

**Conclusion**

We thank you for this opportunity to comment of the FSCO recommendations. The Ontario Chiropractic association stands committed to working with the government to ensure a viable and fair auto insurance product in Ontario.

Sincerely,



Thomas Gadsby, DC  
President