



Representing Health Professionals in Automobile Insurance Reform

May 15, 2009

The Honourable Dwight Duncan - Minister of Finance
7 Queen's Park Crescent, 7th floor
Toronto, Ontario
M7A 1Y7

Re: Response of the Coalition of Regulated Health Professions in Automobile Insurance Reform to FSCO five year review

Dear Minister Duncan:

The Coalition would like to thank you for meeting with us to discuss the FSCO recommendations and for providing us with this opportunity for input to your deliberations. We stand committed to assist the government in reaching its goals of timely access to necessary care and controlling premium costs for consumers. There are many interrelated recommendations, some we are ready to offer our support and participation as stakeholders in achieving and others that we feel, singly and collectively, will have a negative impact on many patients, especially for those considered to be seriously injured, to receive needed care.

A. RECOMMENDATIONS SUPPORTED BY THE COALITION

We believe that FSCO has made tremendous strides forward with many recommendations that are aimed at reducing complexity and achieving a system more easily navigated by all including patients. We are pleased to offer our support for the following FSCO recommendations.

Expansion of the Pre-Approved Framework Guideline

FSCO Recommendation #23 states: *"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 to include the treatment and assessment of other soft tissue injuries"*.

The Coalition is in agreement in principle with Recommendation #23.

There is much opinion on why the PAF has had less utilization than expected. This must be addressed prior to making any changes to the guideline. The following recommendations are intended to address these issues and to ensure that the PAF is appropriate and used for the majority of acute uncomplicated soft tissue injuries:

Coalition Recommendation #1

- a. **Initiate an evidence-based, multi-stakeholder, FSCO coordinated process to expand the PAF to include all soft tissue Grade I and Grade II sprains and strains.**
- b. **Review the timelines and the fees associated with the PAF in coordination with the results of the above mentioned process.**
- c. **De-link other benefits to the PAF (i.e. IRB, attendant care and other disability benefits) that represent a barrier to participation.**
- d. **Specify what additional assessments/treatments may be appropriate while a patient is being treated in the PAF.**
- e. **Confirm a mechanism for those patients who require treatment beyond the PAF to access it.**

Standards and qualifications for third party assessors

FSCO Recommendation #16 states: *“the health care professional associations and the insurance industry should jointly develop standards for the delivery of third party medical examinations as well as qualifications for assessors. FSCO would facilitate the process”.*

The Coalition agrees there is a need for these standards, supports the recommendation, and would be pleased to engage in this process of standards development. We note that a number of associations already have assessment guidelines and these could be examined as a basis for standards and qualifications for third party examiners.

Training and experience to conduct catastrophic impairment assessments

FSCO Recommendation #17 states: *“restrict the ability to conduct catastrophic impairment assessments to practitioners with appropriate training and experience”.*

The requirement of appropriate education, training and experience for conducting catastrophic impairment assessments is strongly supported by the Coalition. The Coalition would be pleased to engage in the process to determine the qualifications required.

Timelines for adjuster review of assessment requests

FSCO Recommendation #13 states: *“the time frame provided to adjusters to review assessment requests should be the same as the time frame that applies to treatment plans (10 business days) to allow for proper claims handling”.*

We appreciate the intention to allow the adjuster time for more considered review of assessment requests. While a 10 day period would make the period the same as for treatment plans, we are concerned about delays in the patient’s ability to access care in a *timely manner*. We note that the recommended 10 days is not the entire review period, only the first phase. Subsequent to this there is the time for the insurer examination, report preparation and then insurer decision making.

In addition, whatever insurer review period is determined, the “deemed approved” provisions should be retained. The deemed approved provision has been essential to allow *assessments* to proceed without requirement of prior approval when there is a risk of harm to the insured person if the assessment is delayed.

Coalition Recommendation #2

Increase the insurer’s time to respond to treatment and assessment requests from 3 to 5 days.

Insurer discretion in denying assessment and treatment requests without requirement of IE

FSCO Recommendation #19 states: *“provide adjusters with some discretion in reviewing assessment and treatment requests and modify Ontario Regulation 7/00 to reflect possible amendments to the SABS”.*

The Coalition supports in principle increased opportunity for insurer discretion provided that there is protection for patients against adjudication errors. The ability to deny some applications, for example when a request is substantially similar to a previously adjudicated application, without an IE might reduce excessive numbers of IE’s and associated costs. Alternatives to a full IE might be to provide for a paper review option in cases where the decision on similarity is challenging.

The Coalition will be pleased to work with FSCO and other stakeholders to establish the parameters for increased discretionary options including the educational materials which will be needed to assist adjudicators.

B. RECOMMENDATIONS ON WHICH THE COALITION EXPRESSES CONCERN AND ADVICE

Reducing the cap on medical and rehabilitation benefits, and inclusion of assessment costs

FSCO Recommendation #22 states: *“Reduce the cap for medical and rehabilitation benefits for non-catastrophic claims to \$25,000. Introduce a \$100,000 optional medical and rehabilitation benefit along with the existing \$1 million optional benefit.”*

FSCO Recommendation #23 states: *“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 to include the treatment and assessment of other soft tissue injuries.”*

FSCO Recommendation #11 states: *“Section 24 assessment expenses should be subject to the same maximum monetary and time limits that apply to medical and rehabilitation benefits under section 19 of the SABS.”*

It is important to take into account the multiplying effect that these and other recommendations will have on the system.

Many patients have only acute, uncomplicated soft tissue injuries. For most of those patients a cap of \$25,000 would be sufficient. In fact, as noted in the previous section the Coalition is supportive of initiating an evidenced-based, multi-stakeholder, FSCO coordinated process to expand the PAF to include more soft tissue injuries and thereby providing a mechanism for access to care for this majority of claimants.

However, this would leave patients who are neither catastrophically impaired nor have acute uncomplicated soft tissue injuries at risk. In many cases, a \$25,000 cap is not sufficient for those who are non-catastrophic but have complex, serious, neurological or cognitive impairments to cover the cost of assessment, treatment and other goods and services included under this benefit. It is critical to note that in Ontario the cost of goods such as wheelchairs, home modifications, vocational re-training and prosthetics are included in the current \$100,000 cap. A cap of \$25,000 would be insufficient for these needs should they arise.

In addition, those awaiting catastrophic designation will quickly reach the maximum funding available to them. According to the Coalition survey of healthcare providers, 59% of MVA patients in their care had waited over 2 years from their date of injury to achieve the legislative definition of catastrophic impairment.

The concept of consumer responsibility when purchasing insurance to consider the implications of not purchasing additional coverage assumes that they will have an understanding of the actual costs of health services outside the public system. Consumers receive information from many sources including legal, insurance brokers and insurers at the time of purchase. The responsibility to support informed decision making rests equally with those who provide the information and can be stressed by the multiple drivers in the system including offering the lowest cost product and promoting a tort-based system. The government has a role to ensure that minimum coverage limits meets the best interest of the public.

If we consider that the expansion of the PAF, if done right, could cover many soft tissue injuries seen in auto insurance and maintaining the minimum cap for all other non-catastrophic injuries at \$100,000 to ensure appropriate coverage for all seriously injured we would have achieved the goal of cost reductions, maintained access to services and tackled the issue of the seriously injured without creating another complexity of an additional category. This would meet the goal of containing costs while ensuring consumer and public protection.

In recommendation #11 regarding the inclusion of Section 24 assessments under the medical rehabilitation cap there is no information or data to evaluate the impact of this decision and the resulting decrease of available benefits for seriously injured. Many FSCO recommendations are aimed at controlling inappropriate assessments. However, we consider this recommendation a poor vehicle to accomplish this because it will also harm some legitimate patients. Folding Section 24 costs into the cap will not achieve the goal of reducing these costs but simply result

in less resources being available for treatment and goods such as prostheses, mobility devices and other care needs. The Coalition, without further information regarding the actual costs associated with Section 24 assessments, cannot support Recommendation #11 for this reason.

Coalition Recommendation #3

The cap on medical and rehabilitation benefits should remain at \$100,000 and the Minister should rely on other FSCO recommendations, such as the expansion of the PAF, to control costs for minor injuries.

FSCO Recommendations Regarding Assessments

The FSCO report asserts: *“One area where stakeholders appear to be in agreement is in the overutilization of assessments in the auto insurance system”.*

There are at least 10 FSCO recommendations to improve assessment quality and limit perceived overutilization and costs of assessments. Some of the recommendations will likely improve the appropriate use and quality of assessments. However, some of the recommendations create a significant risk to access to treatment and other benefits for motor vehicle accident victims.

It is important to note that the Coalition does not have access to the data to identify which types of assessments are being over-utilized or the factors driving these processes. We are concerned that the process engaged in is not based on a full analysis of the drivers of this over-utilization and therefore seems to be a generalized response to reduce overall utilization and associated costs of all assessments regardless of merit.

Coalition Recommendation #4

That FSCO coordinate a full multi-stakeholder review of the assessment component of medical rehabilitation benefits with the goal of determining the actual causes for increases in assessment costs and to make a coordinated, system-wide solution to addressing these issues.

Capping the cost of insurer examinations at \$2000:

The FSCO report states: *“...capping insurer examinations would provide appropriate balance to the system if the cost of assessments were also capped.”*

The Coalition strongly supports the need for balance in the system between insurer and claimant assessments. While we believe that assessment fees should be based on assessment guidelines and hourly fee schedules. Depending on the education, training and experience required for certain assessments the cost may vary. Identifying a hard cap that is inclusive of all assessments is difficult. We will address two concerns within the FSCO report: caps on the cost of assessments and the catastrophic assessments with the hope to increase understanding related to assessments.

Caps on the cost of assessments:

FSCO Recommendation #12 states: *“the fee for completing forms including any assessment required to complete the form should be capped at \$200. The cost of all other assessments should be capped at \$2,000”.*

FSCO Recommendation #18 states: *“the cost of insurer examinations should be capped at \$2,000”.*

There is little clarity regarding which assessments in Recommendation #12 would be a \$200 assessment and which would be \$2000 since all assessments in this sector result in a form completion unless that assessment determines there will be no further action required. The professional time required to complete an assessment is based on standards of practice, the complexity of the condition, the presence of multiple injuries and the purpose of the assessment as in the case for catastrophic injuries. Patients with multiple and/or more complex impairments including for example, combinations of severe physical injuries, mental, behavioural, emotional, cognitive, speech and language disorders or functional limitations in the home and workplace will require a more extensive assessment. Failure to ensure that fees allow for professionals to meet standards of practice and evidence-based guidelines will result in professionals leaving the sector or not taking on more complex conditions within their practice. In order to address all issues related to caps on assessments, the Coalition agrees with the following:

The fee for form completion must remain separate from the cost of doing the assessment. The completion of a form for the purpose of processing an insurance claim is documentation above and beyond what is required for health professions to meet charting requirements by the regulatory Colleges and therefore is an additional administrative cost required by the insurer above what is required to provide care. This cost should not be absorbed by the health professional. In addition, differentials in the fee for form completion are used as an incentive to encourage participation in the HCAI system of electronic submission of OCF forms. Removing this or making this less transparent will remove an important element of success for the re-introduction of the HCAI system.

The fee for assessments should be based on the hours of professional time required to complete the assessment according to standards of professional practice as well as usual and customary hourly fees for each profession. With the majority of cases - uncomplicated minor injuries – assessment fees will be under \$200. For more complex conditions, assessments will require more time and the Professional Services Guideline fees would continue to apply. For some serious injuries and for catastrophic cases the assessments have an added complexity due to the requirements under the auto insurance sector for assessments to address the following in order to meet adjudication needs for assignment of benefits:

- Assessments need to address causality of the impairment(s) and attribute to the specific event of the motor vehicle accident. Few patients come post-MVA with a clean pre-accident bill of health.

- Assessments need to address the credibility of the complaints of the patient and eliminate questions of malingering or exaggeration.

In the case of both recommendations #12 and #18, the fee for assessments is not dependent on whether the assessment is sought by the claimant or is requested by the insurer. The above statements apply in all cases.

Some have suggested that the WSIB offers a parallel comparison for processes and costs of assessments. However it must be noted that the nature of the population, injuries and especially system requirements vary significantly. WSIB assessors are not expected to address issues of causality or entitlement as these are addressed prior to the referral for the assessment.

Coalition Recommendation #5

That fees for assessments should be based on the professional time required to meet standards related to assessment and that the fees associated with the completion of forms for the purpose of adjudication and insurance processes be separate to the assessment fee.

Catastrophic Assessments

In the case of assessments to determine catastrophic designation, additional complexities drive the requirements needed to be met through assessment. These assessments are especially controversial, complex and require a high level of training and expertise. In addition, there is often significant disagreement on questions of causality and credibility requiring reviews of extensive medical files and comprehensive examinations. Often it is necessary to review a file that may be over a thousand pages long to review questions of causality and entitlement. The critical question often involves distinguishing between pre-existing vulnerabilities and co-existing disorders from conditions that result from the MVA.

Catastrophic impairment assessments must provide a whole person impairment rating (WPI) to determine if the person has an impairment of 55% or more. This WPI rating may involve several body systems requiring expertise of various medical specialists, for example physiatry, neurology, opthamology. In addition, it may be necessary to address questions of cognitive impairments due to brain injury and mental and behavioural disorders. Often no single health professional has the expertise necessary to complete the range of examinations required. These component examinations must be integrated to produce an opinion as to whether the person has a catastrophic impairment. Therefore it is essential that there be sufficient funding for a team of expert examiners when indicated by the conditions to be assessed.

Coalition Recommendation #6

Fees for catastrophic impairments should be based on the hourly rates as with any other assessment.

Removal of “rebuttal examinations”:

FSCO Recommendation #20 states: *“revoke section 42.1 of the SABS which allows claimants to obtain an assessment from their health care provider to address issues raised in an insurer examination”.*

The Coalition strongly recommends that this provision be retained because the “rebuttal examinations” provide a necessary check and balance in the system.

The FSCO report states that the claimant would continue to have access to FSCO’s dispute resolution services. However, without the rebuttal examination the patient may not be in a position to determine whether they have a basis to dispute the decision of the insurer to deny a benefit. The rebuttal allows the insured person the ability to obtain an informed opinion about whether there are significant flaws in the insurer examination and a basis on which to contest the opinion.

We do not have data that allows us to comment on how frequently the rebuttal examinations are being utilized, how often they result in an immediate reversal of a decision, or their utility in mediation or arbitration. However, we are aware that there are already some limits in place regarding the utilization and costs of rebuttal examinations.

We anticipate that if other measures are taken to improve the quality of the insurer examinations, the use of the rebuttal may decrease. However, it will still be a useful mechanism to address those situations, for example, where the IE has failed to consider relevant factors or made an error in analysis.

Coalition Recommendation #7

Retain the assessments under Section 42.1 to ensure balance within the system between the insurer’s and patient’s interest.

Primary Health Professional Role

FSCO Recommendation #15 states: *“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 providers following a referral.”*

FSCO Recommendation #21 states: *“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 providers following a referral.”*

The recommendation of a “Primary Health Professional (PHP)” to “manage, oversee, coordinate, and direct” the patient’s rehabilitation appears to have been made by FSCO as a method to decrease perceived duplication of services, especially assessments, and to enhance the patient’s ability to access coordinated care. FSCO recommends that in most cases family doctors fulfill this role.

It is the opinion of the Coalition that this recommendation is not in keeping with current practice of interprofessional collaboration encouraged by the Ministry of Health in Ontario. Recently the Minister of Health introduced amendments to expand the scope of practice of 14 health professionals in Ontario, and Premier McGuinty was quoted as saying, “No one professional can possibly meet all a patients’ needs.” He further stated, “The next best thing is to ensure we minimize the number of stops a patient makes while traveling through the health care system.”

The Coalition cannot support this FSCO recommendation that contradicts current clinical practice and is not in keeping with the recommendations of the Premier. We feel that having one single profession designated as a PHP will create an additional barrier resulting in delay or inability to access treatment and actually increase costs. It also creates an increased risk of conflict of interest.

We understand, however that government strongly supports the development of this PHP role. If a PHP model is the model of choice by the government, we have concerns about preference given to family physicians as the only regulated profession to fulfill this role. The Coalition strongly contends that other regulated health professionals and regulated social workers are able to fulfill this role.

There are numerous issues of accessibility and appropriateness associated with having family physicians as the only or primary PHP:

- The family physician is not always the most appropriate health care professional to assess an automobile accident victim to determine the need for further assessments or care. In some situations other health professionals are better equipped for this role by virtue of their education, training and experience as well as patient need and preference.
- As many as 800,000 Ontarians do not have family doctors (The College of Family Physicians of Ontario). The results of a survey recently completed by the Coalition reinforce these concerns. Survey respondents were asked to indicate the percentage of their MVA patients who did not have access to a family physician. Nearly a quarter of

the respondents indicated this group made up more than 20% of their MVA caseload. For those who have a family physician, there are often delays in access due to caseload issues.

- The majority of family physicians are fully occupied with their present responsibilities and do not have the time or the resources to meet the demands of this additional PHP role. The demands of the PHP role could not be met without taking time from other patient care. Thus, this recommendation appears contrary to the Ministry of Health initiatives to reduce demands on physician resources.
- Some Ontarians go to walk-in clinics and use ambulatory care centres. There is often little opportunity for continuity of care in these facilities and the physicians in these clinics generally do not assume the role of ongoing service coordinator.
- Costs will be added to the *public system* as family physicians would need to assess the patient to make appropriate referrals or referrals for treatment. Costs will be added to the *insurance system* as family physicians would seek compensation for fulfilling the PHP role.
- Direct referrals are appropriately made to community services and service providers by hospital discharge planners and other in-patient program liaisons. In many instances it would be impractical and would delay and increase cost to hospital discharge if these referrals had to go through the family physician.
- Many family physicians lack familiarity with the SABS, find the completion of additional forms distracts from provision of care to their patients, and have not engaged with the HCAI process.
- Other regulated health professionals have the educational, training and current experience to provide coordination to the patient's rehabilitation and make appropriate referrals for assessments and treatment.

Coalition Recommendation #8

- The PHP role cannot be limited to physicians and medical specialists.**
- The following 8 professions could fulfill the role of PHP providing both care to the patient and coordination of referrals to other services and service providers: Chiropractor; Nurse Practitioner; Occupational Therapist; Physician; Physical Therapist; Psychologist; Social Worker; Speech Language Pathologist.**
- Patients may self-refer to the PAF provider of their choice for initiation of the PAF. This facilitates direct and timely access to these services. A PHP would not be required.**

Role and parameters of the PHP recommendations:

PHP directs referrals:

The PHP will direct referrals to services and service providers for assessments and treatment plans. On receipt of the referral the service provider will submit assessment requests and treatment plans to the insurer without requirement of further certification by the PHP. This process is intended to facilitate access to appropriate services and service providers while reducing duplication and unwarranted services. To coordinate this process PHP should be incorporated into the HCAI system being re-launched in 2010.

Patient Choice:

The patient ought to be given the choice of which of the regulated health professionals or regulated social workers will fulfill this PHP role in their care. In Catastrophic cases the case manager may play the role of PHP.

In addition, a mechanism to allow the patient to change their PHP throughout their rehabilitation process should be incorporated

Addressing conflict of interest:

We note in the report that, *"FSCO also believes that designating a health professional who is not delivering services to coordinate rehabilitation would eliminate the potential conflict of interest situation inherent in the existing delivery model. As such, the designated health professional could not be another provider at the facility or clinic where the claimant is receiving treatment."*

"Conflict of interest", in the provision of medical and rehabilitation services has been described in the past by FSCO specifically as benefit from referral to another person.

We agree that addressing "conflict of interest" and "referrals for profit" is an important issue. However this should not be confused with the appropriate and necessary role of the health professional assessing and treating their own patient. This is fundamental to health care delivery and does not constitute a "conflict of interest".

We note the FSCO *Guideline Respecting Conflict of Interest in the Provision of Medical and Rehabilitation Services* published by FSCO, August 26, 1997, which indicates that no conflict of interest exists if the health professional who prepares the Treatment Plan is the person who will treat the insured person, or if the person completing the Treatment Plan is employed by or is under contract with the same facility that provides the treatment (see Appendix A).

Similarly health care research has indicated the value of an integrated multidisciplinary team care for some patients. Internal team referrals for integrated treatments are not considered a conflict of interest.

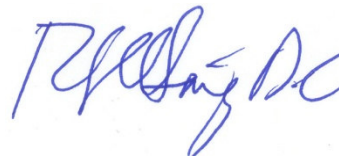
In contrast, it is a conflict of interest for the treating PHP to refer their patient to another service or service provider where there is a covert relationship or financial benefit to the PHP. Conflict of interest and financial relationship to the other service or service provider receiving a referral must be declared. In these instances, both the patient and the insurer would need to waive the conflict for the referral to proceed. Fees for referrals are unacceptable, illegal, and already prohibited in the regulations. We support the enforcement of these provisions.

We trust that these comments will assist FSCO. We are available to discuss this document or any other issues.

Sincerely,



Dorianne Sauvé
Coalition Co-Chair
CEO, Ontario Physiotherapy Association



Robert Haig, DC
Coalition Co-Chair
ED, Ontario Chiropractic Association

On behalf of the following members of the Coalition representing Health Professionals in Automobile Insurance Reform:

Canadian Academy of Psychologists in Disability Assessment
Canadian Society of Chiropractic Evaluators
Ontario Association of Social Workers
Ontario Association of Speech-Language Pathologists and Audiologists
Ontario Dental Association
Ontario Chiropractic Association
Ontario Dental Association
Ontario Physiotherapy Association
Ontario Psychological Association
Ontario Society of Occupational Therapists