The Canadian Society of Chiropractic Evaluators
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# The Superintendent of FSCO's 5 Year Review

# On

# Auto Insurance

## Submitted by the:

## Canadian Society of Chiropractic Evaluators

**July 14, 2008**

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Willie Handler, Senior Manager

Automobile Insurance Policy Unit
Financial Services Commission of Ontario
5160 Yonge Street, 15th Floor
Box 85
Toronto, Ontario, M2N 6L9.

Re: FSCO's 5 Year Review on Auto Insurance

Dear Mr. Handler,

**INTRODUCTION**

The Canadian Society of Chiropractic Evaluators (CSCE) is pleased to present it's views on Auto Insurance in Ontario over the past few years. Our national organization represents chiropractors across Canada, who provide independent chiropractic evaluations.

The Canadian Society of Chiropractic Evaluators (CSCE) is a not-for-profit organization established in 1996 as a non-share corporation. CSCE strives to promote a high level of quality, expertise and standardization in the performance of independent chiropractic evaluations and in the production of the resultant narrative report.

In preparation for this submission, we have polled our members for their views. Some of our members run multidisciplinary rehabilitation facilities, and some work in hospital settings. CSCE is a member organization of the Coalition.

We would like to provide our views in the followings areas in particular:

- OCF 22s
    a) Appropriatness
    b) Efficiency
    c) Fairness
- PAFs
- Insurer Examinations
    a) Timelines
    b) Costs
    c) Fairness
    d) Rebuttal reports
    e) Catastrophic Determination
    f) Qualifications of assessors
- Neck Pain Task Force- this document is the most comprehensive research on neck pain and WAD since the Quebec Task Force.

# 1) 0CF 22s

## Issue

**Anecdotally, we have heard that insurer's are concerned that in some cases they are receiving numerous OCF-22 requests, with proposed assessments that may not be warranted.**

## Discussion

CSCE as a key stakeholder in the Auto Insurance sector, played a significant role in the design and implementation of the use of the OCF22s. Healthcare practitioners need to do an assessment before any treatment intervention begins. An assessment is also necessary in order to determine an insured person's eligibility for benefits. In 2002, Insurers claimed that assessment costs had reached $300 million. One of the factors insurers cited was the rising cost of assessments by health practitioners. In order to limit the cost of assessments, we designed the OCF22 and the request for assessment process. We also designed the FAST-TRACK DACs, which were a paper-review process that evaluated if these assessment requests were reasonably required or not. The IBC and other stakeholders agreed that the Fast-track process and the OCF-22s were working, the last time we reviewed the process.

The OCF22 process is necessary in order to provide insured persons reasonable access to the benefits allowed in the SABS. There is a reasonable process currently in place for disputing and evaluating these applications. Insurers have significant control on what they pay for these disputed assessments, and the assessors that they want to do the paper review. They are constrained though by fairly tight timelines. It appears that the driving factors for any overuse of the OCF-22 process may be legal representatives. However, we have not heard that insurer's are reporting any suspected "bad actors" under the UDAP's.

The most common OCF22s that our members see are requests for: in-home assessments, in-home assessment follow-ups, Psychological assessments, FAEs, work-site assessments, sEMGs, Neuro/Ortho assessments and chronic pain assessments. For the majority of OCF-22 requests, in-home assessments and psychological assessments are the most

commonly deemed "reasonably required". Comprehensive FAEs, work-site assessments, sEMGs are less likely to be deemed reasonably required. We also find that Ortho/Neuro assessments just for the purpose of "determining the extent of the person's injuries" without substantiating the clinical indicators to justify their need, is also unnecessary.

There are times where there appears to be a duplication of assessments between section 42 and 24 evaluations. This may be due to a lack of guidelines for stakeholders as to when a particular type of assessment may be appropriate. For example, the Neck Pain Task Force that was just released in the journal Spine in February 2008 recommends that "Canadian C-spine Rules" be used to determine the need for C-spine x-rays, when someone is involved in a motor vehicle accident. This is a validated guideline. Similar guidelines could be developed by a multidisciplinary stakeholder group Eg. in-home assessments, functional and work site assessments, electromyography, diagnostic imaging and medical specialty consultation.

## CSCE Recommendations:

- Develop guidelines for appropriate use of specific types of section 24 assessments.
- Ensure that the OCF-22 application process maintains an injured person's reasonable access to benefits in the SABS
- Extend the timelines for insurer's to respond to OCF-22 requests to 5 days from 3.
- Develop a process for reporting any consistent "bad actors" under the Unfair and Deceptive Acts

## 2. PAFs

## Issue

The Pre-approved Framework Guidelines were developed in order to facilitate an insured person's access to timely treatment, with general guidance as to what types of goods and services are appropriate. There are very few PAF disputes under the paper review process. However, anecdotally CSCE members are reporting that the PAF Guidelines appears to be underutilized. We have seen numerous initial OCF-18s being approved by insurers. Why is this the case?

## Discussion

Guidelines for the types of treatment, including frequency and duration, are important so that providers strive towards to ensuring that care is in keeping with evidence-based practice. Anecdotally, we have heard that some insurer's are not disputing initial OCF-18's for treatment that should be in a PAF. The IBC has also reported underutilization of the PAF. The PAF Guideline was one of the major cost-saving measures that was developed under Bill 198. Why is it not being enforced by insurers? This is a procedural issue and is the responsibility, and prerogative of the insurer to ensure that the proper processes are being followed. There is anecdotal perception from insurers that the "PAF doesn't work". Perhaps there was improper messaging given to the PAF initially and in subsequent years. Some stakeholders were saying that the "majority of WAD symptoms would resolve with just the PAF". This is not the case and is recently supported by the Neck Pain Task Force.

Also, there is the issue of linking and limiting other benefits (Eg. Disability and Attendant care) to the PAFs. This was never the intent of the PAFs. Anecdotally, some legal representatives have been advising healthcare practitioners not to submit the PAF Guideline (OCF23), because of the limitation of other benefits. This could be curtailed by de-linking other benefit limitation to the PAFs. Further education to all stakeholders may also increase it's utilization. It is also important to note that other

jurisdictions have a similar issue in enforcing compliance. Eg the WSIB and Programs of Care (POCs).

## CSCE Recommendation:

- The PAF Guideline could be more readily utilized by de-linking other benefit limitations to the PAFs.
- Further education on PAF utilization could result in more cost efficiencies.

## 3. Insurer Examinations (IEs)

## Issue

Since the elimination of the DACs in March 2006, there were serious concerns about maintaining fairness to consumers and how insurers would respond to this increase in power. To balance this perception, the government also implemented the Unfair and Deceptive Acts and Practices (UDAPs) and the Rebuttal report process. Recently, it was reported in the Toronto Star that "Medical assessment costs were frightening insurers". Reportedly, there has also been concern about the Catastrophic Determination process.

## Discussion

Since the elimination of the DACs, assessment centers, insurers, lawyers, assessors, injured persons and healthcare professionals have undergone considerable adjustments to the new system. Assessment Centers have adjusted to the new market pressures in order to survive. It was anticipated that "market competition" would take care of poor timelines and costly assessments. During the period of the DACs, it was reported that DACs took on average 17 days to issue their reports. It was also reported that the average Med/Rehab DAC cost about $2500 at one time. Insurers had reported in 2002, that assessments had cost the system about $300 Million. In 2004, assessment costs were decreased to $200 Million after DAC reform, a new DAC Fee guideline and the OCF22 – Fast-Track DAC system were introduced.

Today, some assessment centers are reporting a 97% compliance rate to insurers! What that means is that reports are hardly ever sent out late. Insurers have sent a clear message to assessment centers that late reports will not be tolerated. The majority of the remaining assessment centers have complied. This also means that assessment centres have complied with their fee schedule. The average single assessor IE report now costs about $1,000-1,500. Paper IEs cost $450. Insurers appear to have achieved their goal of getting timely and cost-efficient Insurer Examinations. But are they fair assessments?

The IE system will never be perceived to be as fair as Neutral assessments. However, it is a credit to insurers and the DAC Committee that "peer assessments" have been maintained and the DAC Guidelines are still being followed to some degree. Utilization of peer assessments, when there is a dispute about Medical and rehabilitation services maintains fairness and some element of neutrality in the system, which ultimately protects consumers.

The use of Rebuttal reports has not been as useful as was originally anticipated. Frequently, healthcare practitioners use this opportunity to reassess their patient and report their findings for $450. For the most part, this information has not been useful, as it just reiterates their original opinion. It hardly ever changes the insurance examiner's original opinion. Also, as predicted insurers send the Rebuttal report to the IE examiner and ask if this rebuttal report changes their opinion. This process of the "Rebuttal of the Rebuttal" exam has duplicated costs and is a waste of consumer dollars. The Rebuttal system can be made more useful and efficient, if education is provided to healthcare practitioners on it's purpose and proper use and it is limited to cases filed for arbitration and/or arbitration. The medico-legal system has a place for rebuttal reports just prior to trial.

Since the elimination of the DACs, Catastrophic Determination IEs have been appropriately performed by Assessment Centres. Timelines have improved substantially; where reports are being sent out within 10-20 days after completion of the assessment. Costs are being controlled as insurers have the opportunity of approving an assessment plan sent to them by the assessment centre within days of receiving the referral package. This system has worked well in protecting the more seriously injured person.

However, the Desbien vs Mordini decision has caused some controversy in it's interpretation and handling of claims. For the most part, it appears that assessors are accounting for the rating of Mental and Behavioural impairments separately, and at the end allowing arbitrators and judges to make the final decision.

The AMA Guides can be very confusing at first, so it is imperative that assessors are certified in it's use. Assessment Centers and independent assessors have taken it upon themselves to continue their education in this area. We have also educated other stakeholders in this area. It appears to us, that continued use of the SABS criteria of CAT Determination is both fair and appropriate for accident victims to continue to access reasonable and necessary benefits from the SABS. Consideration should be given however to updating the AMA Guides 4th edition to "current edition", as access to the 4th edition of the AMA Guides is limited in print. The majority of the states in the US are using the 5th edition of the guides and now updating to the 6th edition, that was just released earlier this year. We would recommend to increase the timeline of issuing a complex report, such as a CAT Determination, Post-104 Disability or a REC IE to 20 days instead of 10 business days. The timelines of issuing a report should start upon the last date of a multidisciplinary assessment. This allows assessors to formulate consensus and protects the clinical quality of the report. Again this protects consumers.

Finally and most importantly to CSCE members is the issue of qualifications of independent assessors. What is the perception to the public of a "New Grad" or a lesser qualified healthcare practitioner performing an independent assessment. There have been complaints from colleagues, that some assessors have very little clinical experience and they are doing assessments on more complex cases. The DAC Guidelines had reasonable expectations of independent examiners. We had specified that DAC assessors had to have a minimum of 5 years of education, training and experience in order to be considered qualified. CSCE has recently developed a "Guideline on Qualifications of Assessors" to address this issue. We highly recommend that FSCO release a similar guideline for all assessors to protect the integrity of the system and consumers.

## CSCE Recommendations:

- Provide education on appropriate use of Rebuttal assessments and limit their use to pre-arbitration and/or mediation
- Update the 4th edition of the AMA guides to the "current edition"
- Extend the timelines of complex assessments such as CAT Determination IEs, Post-104 IEs and REC IEs to 20 days after the last assessment
- FSCO develop and issue a "Guideline on Assessor qualifications" similar to CSCE's guideline

# 4. Neck Pain Task Force (NPTF)

## Issue:

This document published this year as a special edition to the Spine journal in February 2008 is the most comprehensive scientific research on neck pain and WAD since the Quebec Task Force document that was published in Spine 1995. In 1996, the Ontario Insurance Commission released a Guideline on the Quebec Task Force. Perhaps the initial messaging behind the PAF was overly optimistic and a review of the literature is appropriate to assess whether any guidelines or SABS need to be edited in response to it.

## Discussion:

This "Neck Pain Task Force" publication highlights how common neck pain is, regardless of a motor vehicle accident or not. Most people can expect neck pain sometime in the life. Eg 70%. In fact, 50-85% of people with neck pain will report neck pain 1-5 years later. Neck pain is

multifactorial in origin and thankfully only 11% are limited annually in their ADL due to their neck pain. They also noted that emergency visits worldwide have been increasing due to WAD in the past 3 decades.

One interesting and pertinent statement that FSCO and the government should take note from the NPTF is that "Eliminating Insurance payments for pain and suffering and improved disability benefits were associated with a lower incidence of WAD and a faster recovery". This flies in the face of what the Ontario Bar Association is recommending ie. "Pare down accident benefits and increase tort awards". Not only is this recommendation not fair to consumers' timely access to benefits, but it goes against what the scientific literature recommends.

Other important features that the NPTF reports is it differentiates between favorable and poorer prognostic factors. It reviews all the literature on assessment of neck pain and WAD, which is important. It recommends the use of the Canadian C-spine Rules (CCR) and Nexus rules in ruling out neck fractures. The CCR was included in Alberta's treatment Guideline of soft tissue injuries in 2004. We should be educating our healthcare professionals on it's appropriate use. It recommends the use of C-T scan in evaluating for neck trauma, but states that there is no evidence that specific MRI findings are associated with neck pain, headaches or Whiplash exposure, for example. It supports the use of validated outcome measures and range of motion testing. It also recommends the use of certain Orthopedic tests in the physical exam that are useful in ruling out Cervical Radiculopathy.

The NPTF recommends a new classification system for neck pain that is on a scale of Grade I – Grade IV. There is no grade 0. This grading system applies to all neck pain and is based on a functional model as apposed to specific examination findings. It also recommends what benefits are appropriate for each category. For example, it recommends that claim for reimbursement for secondary/tertiary healthcare or temporary wage replacement may be appropriate for Grade II neck pain, whereas claim for long-term wage replacement would be more appropriate for Grade III neck pain.

The NPTF provides the latest evidence in treatment efficacy and new conceptual model for managing neck pain. Finally, it recommends future area of research, prevention and changes in public policy.

For example, as stated above it recommends "eliminating Insurance payments for pain and suffering and improved disability benefits" as these were associated with a lower incidence of WAD and a faster recovery. The Superintendent of FSCO should seriously consider adapting the NPTF into a guideline to help educate healthcare practitioners on the latest evidence related to neck pain and WAD.

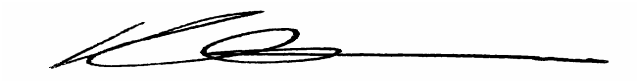
## CSCE Recommendations:

- CSCE recommends that with the assistance of the authors of the NPTF and a multi-stakeholder group assist the Superintendent at FSCO to develop a Guideline outlining the major findings of the NPTF similar to the one issued by the OIC on the Quebec Task Force 10 years ago. The purpose is to educate all the stakeholders on this important research on neck pain and WAD injuries.

## Conclusion

Recognizing that there are a variety of stakeholders providing input on auto insurance, the Canadian Society of Chiropractic Evaluators has outlined specific areas where improved efficiency, cost-effectiveness, and fairness can be achieved. We encourage ongoing development of guidelines, education for all stakeholders, improvement of the quality of assessors, and limiting potential abuses. In general, the current system is working effectively for consumers, and allows them reasonable access to benefits.

Respectfully submitted,



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