Coalition

Representing Health Professionals in Automobile Insurance Reform

July 14, 2008

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: 5 Year Review of Statutory Accident Benefits Schedule

Dear Mr. Handler:

On behalf of the Coalition Representing Health Professionals in Automobile Insurance Reform, we are pleased to submit these comments and recommendations which we trust will assist in the review of the Statutory Accidents Benefits Schedule.

The coalition is strongly supportive of collaborative processes among stakeholders to improve the system for consumers, and is committed to assisting FSCO in this.

In preparation for this review, the Coalition conducted a survey of practitioners. References to this survey, which is attached as Appendix A, are made throughout this submission.

We also note the recent report of the Neck Pain Task Force of the United Nations Bone and Joint Decade which provides much significant new research in the area of neck pain. A summary of significant findings includes:

- Neck pain is common and frequently persistent or recurrent.
- There is typically no single cause and no single effective treatment for Grades 1 or 2 neck pain:

- Effective treatment options are all low risk and may provide short-term relief when provided in moderation.
- Informed patient preferences are key to treatment decisions.
- A variety of treatments may need to be tried.

- Routine imaging of Grades 1 or 2 neck pain will not increase understanding of causation.
- There is not enough evidence to support the use of invasive interventions in Grades 1 or 2 neck pain.
- Providers, policy makers and insurers need to move toward universal, validated, evidence-based treatment guidelines.

In examining the processes that support claimants' access to needed treatment it is critical to consider the variances in treatment approaches and recovery times that are associated with these conditions as demonstrated in this and other research

We have chosen to focus our comments on the following six key issues which we perceive to be the most significant SABS issues at the current time. We have addressed these with due consideration for the three areas of concern articulated by FSCO; affordability and availability, consumer protection and process.

This does not mean that the Coalition does not or will not have opinions and advice on other matters, and you are urged to consult with the Coalition on any matters of interest which are not addressed herein.

A. OCF-22 Requests for Assessments

1. Number of OCF-22 Requests for Assessment

   a. The introduction of the OCF-22 was a result of the industry's requirement that most assessments be pre-approved. Prior to this all services required approval, but not necessarily pre-approval. The OCF-22 reflects the SABS changes intended to protect insurers from uncontrolled assessment costs. This mechanism necessarily required timelines for response and potential "deemed approved" provisions to ensure timely access to services and protection of the claimant.

   b. We have heard the insurance industry concerns that there is a "deluge" of OCF-22s, which are considered to be inappropriate or unnecessary. We also understand, anecdotally from practitioners of member organizations who

conduct insurer examinations, that there are instances of multiple OCF-22s when a single form could be used and instances of multiple requests for the same assessment. In other words, the issue of the number of OCF-22s submitted is a complex one that requires more data and information to quantify or to place qualifiers such as 'inappropriate'.

c. In the practitioner survey, the following were noted:
   i. 23% of respondents reported that insurers rarely or never respond to an OCF-22 within the regulated three days. (Q14)
   ii. 17% of respondents reported that assessments proposed on an OCF-22 were denied at least 50% of the time. Conversely, this means that 85% of practitioners report that the OCF-22 is approved more than 50% of the time. (Q15).
   iii. In a related question 47% of respondents reported that 75-100% of OCF-22s sent for an insurer examination were approved by the IE assessor. (Q16)
   iv. The majority of respondents (76%) felt that the current timelines were appropriate. (Q13).

   This suggests that there is much wasted effort and costs, and delay for claimants, when OCF-22s are denied and subsequently approved by an IE assessor, and that this is a common occurrence.

2. Arbitrary nature of OCF-22 denials

   a. Claims management practices, and apparently the rate of OCF-22 denials appear to vary considerably among insurers. At times, a decision to deny seems arbitrary, a suggestion supported by the large number of subsequently approved proposals. It is possible that adjusters are sometimes placed in the situation of having insufficient knowledge, guidance, or time to thoroughly evaluate OCF-22s, and that a denial and referral to an IE is simply an expedient, safe option. It is also, unfortunately, costly for the system and therefore ultimately for consumers. Our recommendations below should help reduce the incidence of arbitrary denials.

3. Data Transparency

   a. The coalition has been and continues to be supportive of the development and introduction of Health Claims for Auto Insurance (HCAI). The universal need for accurate, comprehensive and quantifiable data on the performance of the auto insurance system remains. It is unfortunate that we are once again in the position of having limited data to inform this review process, in this case data on the use and disposition of OCF-22s. The Coalition urges FSCO to work with stakeholders to ensure the re-introduction of HCAI as soon as possible.

4. Claimant Signature Required

    a. The claimant signature on the OCF-22 is "optional" and is not intended to be "required" by an insurer, yet many insurers insist that the OCF-22 is incomplete without it. 79% of respondents to the practitioner survey indicated that insurers sometimes or always require the claimant's signature.(Q18)

    b. It is still common practice among some insurers or some adjusters to delay consideration of an OCF-22 until the claimant's signature is obtained. We understand that this practice would be considered an unfair or deceptive act or practice (UDAP). On the other hand, we acknowledge the concern by some adjusters that claimants should be fully aware of the details of any proposed assessment. Our recommendations below should help resolve this quandary.

Recommendations:

- **Consult with stakeholders on the promise of the HCAI system to mitigate issues related to timelines for insurer response to OCF-22s.**

- **Consult with stakeholders to develop a Superintendent's Guideline on the submission and handling of OCF-22s to encourage the submission of and facilitate the handling of the most appropriate OCF-22 proposals. This might address, for example:**
    - **multiple OCF-22s for the same claimant,**
    - **multidisciplinary OCF-22s,**
    - **a requirement that all OCF-22s must be copied to the claimant to ensure claimant awareness**
    - **provision for IE assessor/proposer communication, as is the case with OCF-18s**
    - **criteria for adjusters regarding denial and referral for an IE**
    - **clarification that a claimant signature is not required on an OCF-22 and/or provide for the insurer to pay any additional provider or claimants costs if a signature is required.**

It should be noted that the Coalition considered and rejected a number of other suggestions for improving the use of OCF-22s including caps on the number of OCF-22s and form changes. These assessments are necessary to determine impairments resulting from accidents, to prepare plans for treatment, and to make applications for other benefits. Therefore controls on assessments cannot be unreasonable or create de-facto denial of treatment and other benefits. Any numerical cap on assessments would be arbitrary. While a high numerical limit on assessments may provide sufficient or even excessive assessments for most claimants, a cap would necessarily discriminate against some claimants. Therefore,

the above recommendations are considered to be better options in that they have less potential negative impacts on timely and appropriate access to patient care.

B. Insurer Examination Assessors/Assessments and Rebuttals

1. The replacement of neutral assessments as the mechanism to fairly resolve accident benefit disputes between claimants and insurers with the current scheme of Insurer Examinations and Rebuttals has created a new set of difficulties.

2. The coalition is unable to assess whether or not this change has had the expected impact on cost reduction. However, we understand from member organizations that the complexity of the system and the existence of IE brokers mean that the payment to assessors is often insufficient to attract the best qualified assessors. The result is our observation that Insurer Exams are often completed by under qualified or inexperienced practitioners.

3. Member organizations report that the rebuttal reports more than occasionally result in an insurer's decision to revise their denial decision. We believe this is, in part due to the lack of expertise in some IE assessors and emphasizes the benefit to claimants of the rebuttal process.

4. It is extremely clear that if the system of Insurer rather than neutral assessments remains as the first level review of accident benefits disputes, then the provision for rebuttal assessments and reports must also remain.

Recommendation:

- **Consult with stakeholders to establish Guidelines for those performing Insurer Examinations including requirements for such things as:**
    - **Years of experience of practice in the area to be assessed**
    - **Current practice in the area to be assessed**
    - **Education, training, and ongoing professional development**

C. Pre-Approved Frameworks

1. In the practitioner survey:
    a. 47% of respondents indicated that less than 50% of their WAD patients are treated in the PAF (Q32).
    b. 46% of respondents indicated that a subsequent OCF-18 treatment plan was submitted in more than 50% of PAF cases. (Q33)

2. Speculation on whether this post-PAF treatment is or is not reasonable or required will not be productive as there is insufficient information on why this treatment is proposed, including a lack of health status information.

3. There is still confusion on the part of both providers and insurers on the applicability of the PAF and the criteria for inclusion/exclusion.

4. There is anecdotal evidence that claimants' legal advisors sometimes recommend against the use of the PAF because of the impact on other benefits – Income Replacement and Attendant Care Benefits.

5. Overall, it would appear that these factors have resulted in an under-utilization of the PAF compared to the expected utilization.

Recommendations:

- **Consult with stakeholders on removing the restriction on Income Replacement Benefits and Attendant Care Benefits for claimants who receive the PAF on the expectation that this will increase participation in the PAFs.**

- **Provide for mandatory training of insurer representatives and health care practitioners on the PAF inclusion/exclusion criteria.**

D. Collateral Benefits

1. In the practitioner survey:
   a. Only 21% of respondents agreed or strongly agreed that their experience in receiving payment from extended health insurers prior to billing an auto insurer was satisfactory. (Q8)
   b. 57% of respondents indicated that auto insurers always require documentation from the extended health care insurer, and an additional 30% responded "sometimes". (Q7)
   c. 58% of respondents indicated that more than 50% of their auto insurance claimants had extended health insurance. (Q9)

2. There were a variety of practitioner suggestions for improving the collateral benefit situation ranging from making auto insurers the first payer for MVA related injuries, to providing auto insurers with the ability to collect directly from EHC insurers.

3. This remains one of the most unsatisfactory and frustrating administrative issues for both claimants and practitioners.

Recommendation:

- **Consult with stakeholders on methods of simplifying or amending the process for indentifying and collecting collateral benefits.**

E. Accident Benefits Application Package

1. In the practitioner survey:
   a. 19% of respondents indicated that they were *always* asked, and 43% of respondents indicated that they were *sometimes* asked to help claimants compete the Accident Benefits Application Package. (Q5)

   b. 10% of respondents said assessment or treatment was *always* delayed, and 61% of respondents said that assessment or treatment was *sometimes* delayed as a result of the AB package not being completed. (Q6)

   c. 43% of respondents disagreed or strongly disagreed with the statement '*On average, my patients indicate that they are provided accurate information by their adjuster that facilitates timely access to early rehabilitation and treatment.'(Q4)*

2. Overall it appears that the AB application package and process remain overly complex and a barrier to claimants receiving accident benefits in a timely manner.

Recommendation:

- **Consult with stakeholders to simplify the AB application package and process**

F. Ongoing Forum for Stakeholder Consultation

1. The Coalition appreciates this opportunity to provide input into the 5 year review of the Statutory Accident Benefits Schedule. There are a number of significant issues identified which should be addressed. We strongly believe in the value of collaborative problem solving.

2. In the past there have been a number of effective formal mechanisms for ongoing monitoring and consideration of auto insurance issues including the Accident Benefits Advisory Committee and the Minister's DAC committee.

Recommendation:

- **Establish an ongoing forum, led by FSCO, for collaboration among stakeholders in the identification and discussion of issues of concern in the automobile insurance sector, and to provide recommendations to FSCO.**

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 Society of Chiropractic Evaluators
Ontario Association of Social Workers
Ontario Association of Speech-Language Pathologists and Audiologists
Ontario Chiropractic Association
Ontario Massage Therapist Association
Ontario Physiotherapy Association
Ontario Psychological Association
Ontario Society of Occupational Therapists

Appendix A

Auto Insurance Regulations Review Survey Results

In June 2008, FSCO announced their intent to review the sections of the Insurance Act that dealt with Auto insurance in Ontario. The Coalition of Regulated Health Professions in Auto Insurance elected to make a submission to FSCO as part of their public consultation process. In order to best present the views and opinions of the health care community, the Coalition elected to distribute a survey via email to members of the associations represented by the Coalition.

Health Care Respondents

Over 750 healthcare providers responded to the survey, the majority of whom were chiropractors and occupational therapists followed by massage therapists and physiotherapists. "Other" professions included primarily vocational rehabilitation, case managers and rehabilitation consultants, as well as a few nurses and kinesiologists (and one adjudicator).

What is your profession?

Answer Options	Response Percent
Administrator	1.6%
Chiropractor	29.8%
Massage Therapist	12.0%
Occupational Therapist	19.1%
Psychologist	7.9%
Physiotherapist	10.7%
Social Worker	2.4%
Speech Language Pathologist	2.4%
Other (please specify)	14.2%

What percentage of your caseload is MVA-related?

Answer Options	Response Percent
100%	13.7%
75-100%	18.1%
50-74%	10.4%
25-49%	10.3%
10-24%	18.1%
Under 10%	29.5%

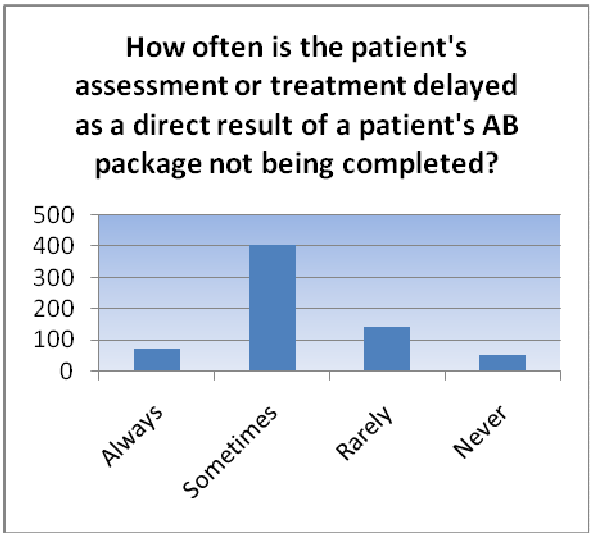
On average, nearly 30% of respondents indicated that their MVA caseload was less than 10%, but this may be explained by the large number of chiropractors who responded (more than 50% of whom indicated a caseload of less than 10%). MVA caseloads have remained constant for 50% of respondents while the remaining providers are split evenly between declining and increasing caseloads.

Initiating a claim

Providers were asked to give their impressions on certain issues around initiating a claim. Approximately 44% of respondents indicated that their patients are not provided with accurate information from their adjuster that facilitates timely access to early treatment and rehabilitation. 24% were neutral on the subject and 25% thought that adjusters did provide this information.

It was of some concern to the Coalition that the application process for accident benefits has become so complex that patients (particularly but not limited to those for whom English is a second language) are unable to complete the forms without help. The survey asked if providers were habitually helping patients to complete their applications and if treatment or assessment was ever delayed as a result of the AB package not being completed.

According to the results, 19% of respondents are “Always” asked to help a patient complete their AB packages, with 43% “Sometimes” getting this request. 39% are asked either “Rarely” or “Never”. Combined with the data that 11% of patients have a delay in treatment or assessment because of incomplete applications (with 61% “sometimes” experiencing this), the complexity of the applications seem to be putting both an undue burden on some healthcare providers while also acting as a barrier to timely intervention.

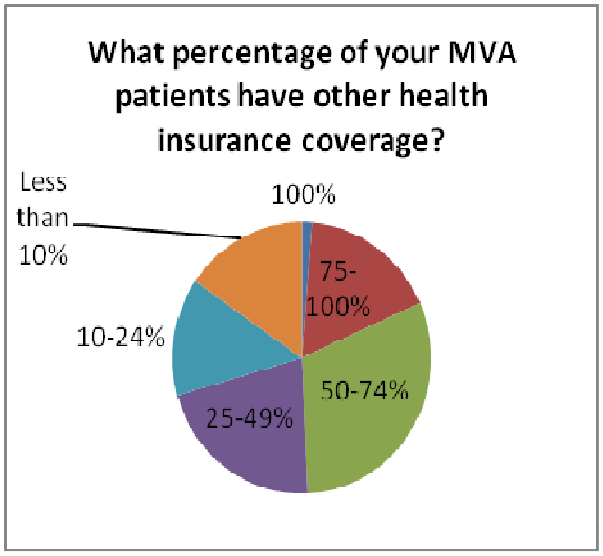


Coordination of Benefits

Legislation requires that all invoices for healthcare services must be first submitted to an extended health care plan prior to consideration by the auto insurer. While the patient is ultimately responsible for the co-ordination of their benefits, it often falls to the health care provider to submit invoices and forward explanations of benefits on behalf of the patient.

For providers, this is one of the most contentious issues in auto insurance.

According to the survey results, half of all respondents indicated that between 25% and 74% of their patients had access to other health insurance coverage. Only 21% of respondents agreed that their experience in receiving payment from EHB before billing the auto insurer was satisfactory with 48% disagreeing with the statement.



While the OCF-21 standard invoice allows for the reporting of payment from other insurers, many auto insurers require the submission of an Explanation of Benefits as proof that additional coverage was accessed. In fact, 58% of those surveyed indicated that insurers “always” require documentation from the EHB insurer prior to paying for services. 29% indicated that this was “sometimes” a requirement, with 10% “rarely” and 4% “never” needing to provide documentation.

When providers were asked how co-ordination of benefits could be facilitated, there were many common themes expressed:

- Change the Insurance Act so that the auto insurer is the first payor
  "Extended health insurance is a benefit from patient's employer or is purchased privately by the individual. In an MVA the car insurance should be the sole payer for any injuries related to the MVA"
- Give the auto insurer the responsibility of co-ordinating the benefits and recouping any monies owed
  "The insurer should have the collateral insurer information as part of the application, including policy number. Ideally, the insurer should obtain the information on maximum annual eligible amounts. If this is left to the practitioner, the insurer should not withhold payment based on their question as to whether there is collateral available and leaving it up to the practitioner to try to find out. This is causing delays in treating patients."
- Bill the patient directly and have them be responsible for co-ordinating their own reimbursement
- Provide case management services for every person injured in an MVA

Other benefits

Some professions have observed that auto insurers do not always provide other benefits like Attendant Care, Housekeeping etc, when they are recommended. In fact, 35% of survey respondents disagree that their clients receive recommended benefits within the regulated timelines. 18% found that the benefits were provided in a timely manner.

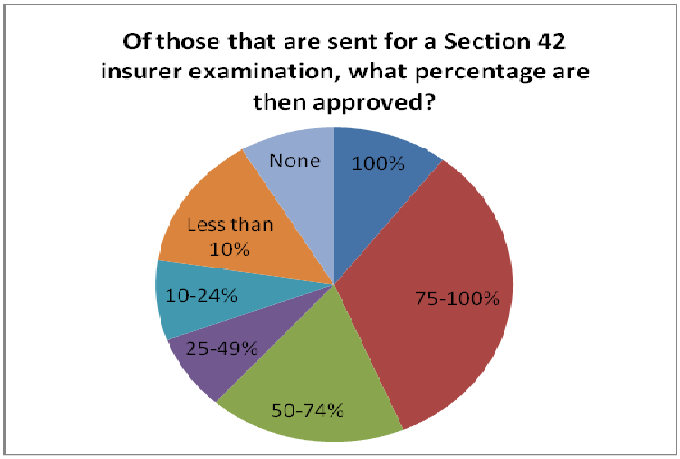
The survey responses held similar and familiar themes when commenting on other benefits. Concerns regarding the timely manner to which adjudications and assessments are implemented by insurers and the systematic method of tracking and following up on claims were the most prominent. Some suggestions that professionals had on other benefit claim requests were:

- "Hiring more insurance adjustors so caseloads are reasonable and timelines are not difficult to achieve."
- "There should be some method of tracking recommendations made regarding benefits within the insurance company, which would activate an automatic response to payment and/or a reminder to request further assessment. Too many times these recommendations get lost and the clients go for weeks without benefits. "

Application for Assessment

The SABS states that all costs for assessments require approval by the insurer, and in some instances require prior approval for which providers submit an OCF-22. Three quarters of survey respondents seem satisfied with the current required response timelines, indicating that they should remain at 3 business days. Approximately 15% of those surveyed would prefer shorter timelines while 8.5% thought they should be lengthened.

Given that the 3-day response time for insurers is regulated under Section 38.2 of the SABS, it seems strange that only 15% indicate that these timelines are "always" adhered to by insurers. In fact 24% claim that insurers "rarely" or "never" reply to an OCF-22 submission within three business days.



43% of those surveyed claimed that less than 10% of their applications for assessment or examination were sent for an insurer examination. However, just over 17% of all respondents said that more than half of their applications were flagged for an IE. The survey did not ask about the specific patient population or type of assessment being requested.

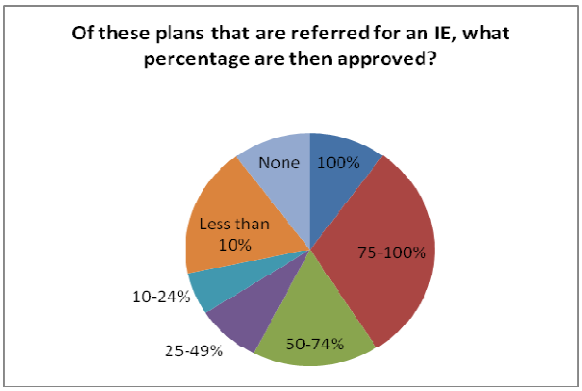
Of those assessment requests that were sent for an insurer examination, 44% of respondents indicated that more than three quarters were subsequently approved.

43% of respondents think that the OCF 22 is an efficient and effective method to communicate the rationale and details of their assessment plan. Just over a quarter of respondents do not agree. There may be some room for improvement with this form.

It was decidedly shocking to see that 79% of those surveyed claimed that insurers either "always" or "sometimes" required a client's signature on the OCF-22 form, despite the fact that it is optional. This goes directly against FSCO's requirements for forms completion and suggests either a lack of understanding of the OCF requirements, or a disregard of them.

Treatment Plans

The majority (71%) of providers seem to believe that 10 business days is too long to reply to a proposed treatment plan. More than a quarter (26.5%) preferred that the timelines remain the same. The lengthier timelines seem to allow for more insurers to respond within the regulations however, with only 15% "rarely" or "never" replying on time.



More than two thirds of those surveyed indicated that less than 25% of their treatment plans were sent for an Insurer Examination. Results of subsequent approvals after the IE are very similar to those for OCF-22 applications with 41% identifying over 75% incidence of approval post-IE.

Insurer Examinations (IEs)

A large number of respondents (39%) reported that they perform Insurer Examinations and of that, 52% perform IEs as less than 25% of their caseload.

All respondents were asked to indicate their level of agreements with specific statements pertaining to IEs and IE assessors. It is interesting to note the level of agreement that examinations are being completed by peers despite the lack of regulation in the SABS. There is slightly less confidence that IE assessors have appropriate education and experience – of particular concern given the high percentage of respondents who claim to perform such assessments. There is overwhelming support (88%) for the concept that IE assessors should also be engaged in a treatment practice concurrent with their examination role so as not to encourage a practitioner losing touch with current treatment practices. The appropriateness of timelines for IE reports are not so clear with only 44% indicating agreement. Closer examination of the data reveals that IE assessors are more likely to agree with the appropriateness of the timelines, but they are by no means a unanimous group.

See the chart for details.

Please indicate your level of agreement with the following statements:

Answer Options	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The majority of insurer examinations are completed by a peer (ie: a physiotherapist assesses a physiotherapy treatment plan)	24.2%	**42.9%**	16.4%	12.4%	4.1%
In my experience, the assessor completing the insurer examination has appropriate education, training and experience	14.7%	**36.5%**	25.5%	16.7%	6.5%
In my opinion, I believe that the assessor completing the insurer examination should be engaged in a treatment practice concurrent with their Examination role	**54.8%**	33.1%	6.7%	2.8%	2.6%
The timelines for completing and receiving the insurer examination reports are appropriate	8.8%	**35.0%**	27.3%	21.5%	7.4%
The timelines are largely adhered to	10.2%	**34.1%**	31.6%	17.9%	6.3%

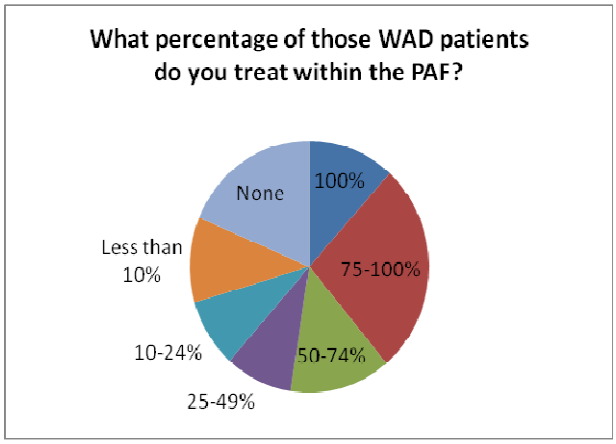
Rebuttal examinations are undertaken by nearly 54% of those surveyed. Of all respondents 36% agree that the rebuttal process is an appropriate way to address disputed issues in the IE, 33% are neutral and 31% disagree.

There were nearly 200 comments and suggestions to improve the IE and rebuttal process. Many practitioners held similar views as many sense that room for improvement is available, especially with regards to:

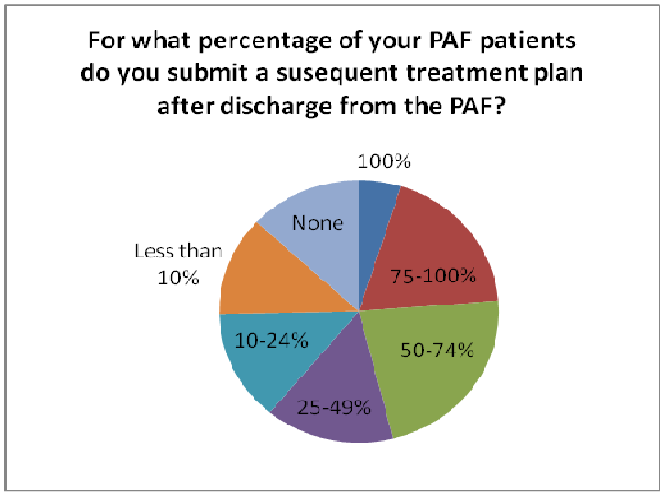
- “I don't believe denying a claim for $500 in services and then paying $450-900 for a rebuttal report best serves the patient. I understand there needs to be a concern about the "bottom line", but rebuttals & IEs delay care, increase stress and ultimately negatively impact the patient's outcome”
- “Ensure that all examiners have over 5 years of experience in the area being assessed.”
- “While it (the rebuttal process) provides me an opportunity to outline issues in an IE examination I have never seen an issue under dispute resolved solely based on the rebuttal system. I understand that these reports are used primarily for mediations and trials but that slows the process down. Furthermore, the fees for rebuttals are ridiculously low.”

Pre-Approved Framework

Nearly two-thirds of all respondents reported that they treat patients with acute Grade I or II WAD (making them potentially eligible for treatment under the Pre-Approved Framework Guideline). Of those, 39% identify that more than 75% of patients with that injury are treated in the PAF. However, 30% of those surveyed claimed that they treated fewer than 10% of those injuries in the PAF.



There is some concern in the industry that further treatment is requested after discharge from the PAF. While we are unable to speculate why this might be so, including inadequate treatment provided for and funded by the PAF, forced streaming of inappropriate patients into the PAF, etc, the data seems to support that this practice is definitely occurring. See chart for details.



Self-reported barriers for keeping people out of the PAF include:

Multiple peripheral injuries, psycho-social issues, multiple MVA’s in a short timeframe, more chronic injuries when seen after the first 28 days, patients returning to work too soon due to financial concerns, concurrent medical conditions, involvement of a lawyer.

Additional Comments and Concerns

Similar issues were raised by professionals in most of the comments sections of the survey. Each concern is deserving of review, however, we have limited the themes to the following:

- WAD classification and the accuracy of defining injury is flawed.
- Compliancy with paperwork seems to take precedence over the focus on the patient.
- There should be an onus on insurers to provide more supporting information in order to deny a proposed treatment or assessment plan.
- Improve levels of accountability for insurers who do not abide by the guidelines. Facilitate ability for providers to understand the UDAP process.
- IE system needs to be re-examined in terms of fees, regulation of assessors, disclosure of information to patients.
- Review, interpretation and application of the SABS should take into account cultural and individual variations in client population.

These issues and the results of this survey provide sufficient evidence that professional confidence in the MVA process is quite low. Nearly half of those surveyed were dissatisfied or highly dissatisfied while only 22% showed any level of satisfaction. 28% were neither satisfied nor dissatisfied.